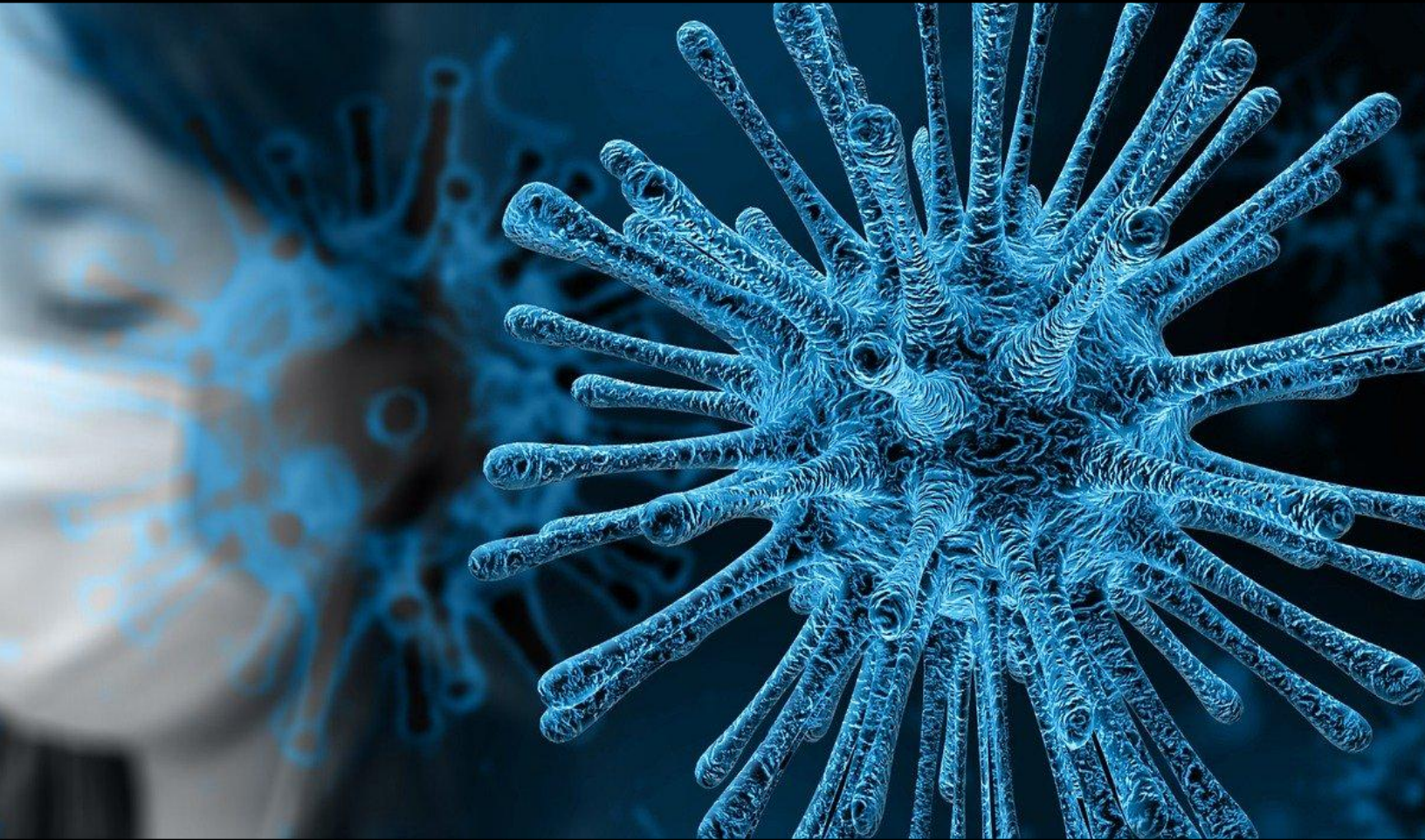


Child Welfare and Pandemics Literature Scan



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Table of Contents

List of Tables	vi
Acronyms.....	vii
Executive Summary.....	viii
1.0 Introduction.....	9
1.1 Objectives.....	9
1.2 Organization of Literature Scan	15
2.0 Differentiating Between Outbreaks, Epidemics and Pandemics.....	16
3.0 A Socio-Ecological Approach to Child Protection During Pandemics	20
3.1 Socio-Ecological Model and Child Protection	20
3.2 Applying the Socio-Ecological Model to Child Protection During Pandemics—The Case of COVID-19.....	23
4.0 Child Protection Risks Presented by Pandemics—The Case of COVID- 19	26
5.0 Child Protection Strategies During Epidemics—Increased Coordination and Collaboration	30
6.0 Child Protection Strategies During Epidemics—Child Specific Programming	30
7.0 Child Protection Strategies During Epidemics—Residential Care	33
8.0 Strengthening Child Welfare Systems Before, During and After Epidemics	34
8.1 Emergency Preparedness Before an Epidemic	35
8.2 Emergency Preparedness During an Epidemic.....	35
8.3 Emergency Preparedness After an Epidemic	35
9.0 Conclusions.....	36
References.....	37
Endnotes	44

List of Tables/Figures

List of Tables

Table 1 Children and Youth in Out-of-Home Care, Province/Territory.....	10
Table 2 Growing Concerns Around the COVID-19 Epidemic—A Child Welfare Perspective from the United States	11
Table 3 Differentiating Between Outbreaks, Epidemics and Pandemics.....	17
Table 4 World Health Organization, Pandemic Phases.....	19
Table 5 The Four Levels of the Socia-Ecological Model.....	22
Table 6 Child Maltreatment Prevention Programs According to Level of Focus	23
Table 7 Child Protection Risks Presented by COVID-19, Related Measures and Their Causes.....	26
Table 8 Child Protection Strategies During Epidemics—Child Specific Programming	31

List of Figures

Figure 1 Socio-Ecological Model—A Framework for Prevention.....	21
Figure 2 Social-Ecological Impact of COVID-19	25

Acronyms

ACPHA	Alliance for Child Protection In Humanitarian Action
AIDS	Acquired Immunodeficiency Syndrome
COVID-19	Coronavirus Disease 2019
CPS	Child Protection Strategy
GBV	Gender Based Violence
HIV	Human Immune-deficiency Virus
MHPSS	Mental Health and Psychosocial Support
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS	Severe Acute Respiratory Syndrome
UNCTAD	United Nations United Nations Conference on Trade and Development
UNICEF	United Nations International Children’s Emergency Fund
WHO	World Health Organization

Executive Summary

On March 11, 2020, Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO classified the COVID-19 situation as a pandemic on the basis of alarming levels of spread and severity, and by the alarming levels of inaction. Since the corona virus first emerged in China's Hubei province, it has spread to 181 countries, infected 245,888 people globally and killed 10,048. In addition to the tragic human consequences of COVID-19, the United Nation's trade and development agency estimates that the slowdown in the global economy caused by COVID-19 is likely to cost at least US\$1 trillion. Amid the unfolding pandemic, government efforts are underway to contain the virus and mitigate its effects on populations; however, organizations such as child welfare agencies responsible for helping the most vulnerable in society are struggling to provide the necessary supports and services as are children who rely on them for their survival.

This literature scan identifies and synthesizes existing literature examining the effects of pandemics and the identification of policy solutions to mitigate their effects on a well defined group of Canada's population—children in the care of Canada's child welfare system. This particular segment of Canada's population warrants attention for several reasons. First, compared to other developed countries, Canada has an exceptionally high rate of children in care. Second, considered to be among Canada's most vulnerable population, children in care either have no parents or for a number of different reasons—socioeconomic circumstances, behavioural issues, abuse, family conflict, neglect or parental incompetence—are taken from their parents by the child welfare system or courts. Third, pandemics can significantly limit the capacity of public agencies to operate and provide services and supports to populations during a period of heightened demand and uncertainty. It is especially important for child welfare agencies responsible for vulnerable populations such as abused and neglected children to ensure continuity of care during this period.

A scan of existing literature reveals that children in care are at a heightened risk of harm from not only the current COVID-19 pandemic, but in many cases, from government policies being implemented to contain the epidemic. This includes increased risks of: physical and emotional maltreatment; gender based violence; mental health and psychosocial distress; exploitative labour; separation from caregivers; and social exclusion. Early feedback from key stakeholders—children, youth, parents, foster and adoptive parents, caseworkers, probation officers, judges and others—suggests system resources and capacity are under considerable pressure as agencies and child protection workers struggle to provide services and supports to clients. Child welfare systems and agencies, require policy makers to formulate, articulate and implement child protection strategies that: allow for and encourage increased coordination across all sectors that involve children in care; build on the strengths and positive coping mechanisms of communities, families, caregivers and children; address the challenges of highly vulnerable populations such as youth in residential care; and provide for the required resources and supports to function not only during an epidemic but also in pre- and post-pandemic environments.

Child Welfare and Pandemics

1.0 Introduction

Pandemics have a wide range of economic, political and social consequences that extend beyond the spread of a disease and efforts by government leaders to contain and mitigate effects on populations. Activities once considered routine are no longer carried out with ease. Resources and access to resources required for daily activities are often limited and in some cases non-existent. Faced by increased demand, existing systems and structures designed to provide populations with supports and services are often taxed beyond their capacity. The resulting consequences on a country and its citizens, particularly for the most vulnerable are often dire.

1.1 Objectives

This literature scan identifies and synthesizes existing literature examining the effects of pandemics and the identification of policy solutions to mitigate their effects on a well defined group of Canada's population—children in the care of Canada's child welfare system. This particular segment of Canada's population warrants attention for several reasons.

First, compared to other developed countries, Canada has an exceptionally high rate of children in care (Brownell, Chartier, Au et al., 2015: ix) and a disproportionate number of Indigenous¹ (Statistics Canada, 2016a) and visible minority² children in care (Mosher and Hewitt, 2018; Ontario Human Rights Commission, 2018; Fallon, Black, Van Wert et al., 2016; Residential Services Review Panel, 2016; Turner, 2016; Contenta, Monsebraaten and Rankin, 2015, 2014; Peel Children's Aid Society's Annual Report, 2013; United Nations Committee on the Rights of the Child, 2012; McMurtry and Curling, 2008). In 2016, there were an estimated 43,880 children in foster care across Canada of which 35,735 (81 percent) of children were between 0 and 17 years of age (Newfoundland and Labrador Statistics Agency, Department of Finance, n.d). Table one provides a snapshot of children and youth in out-of-home care according to province and territory.³

Child Welfare and Pandemics

Table 1 Children and Youth in Out-of-Home Care, Province/Territory

Province/Territory (Year)	Children in Care	Child Population		Rate Per 1,000 ¹
		Age	Total	
British Columbia (2018)	6,950	0-18	895,180	7.7
Alberta (2017)	7,329	0-17	923,175	7.9
Manitoba (2018)	10,328	0-17	293,240	35.2
Saskatchewan (2018)	5,227	0-15	229,100	22.8
Ontario (2016)	7,730 ²	0-17	2,726,180 ³	2.8
Quebec (2008)	7,840 ²	0-17	1,540,094 ³	5.1
New Brunswick (2007)	1,388	0-18	154,395	9.0
Nova Scotia (2007)	1,706	0-17	194,389	8.8
Prince Edward Island (2016)	196	0-17	27,805	7.0
Newfoundland and Labrador (2018)	970	0-15	79,710	12.2
Yukon (2016)	152	0-18	7,840	19.4
Northwest Territories (2007)	395	0-18	12,810	30.8
Nunuvut (2017)	226	0-15	12,315	18.3

Notes: Unless otherwise indicated, table data was extracted from the Canadian Child Welfare Research Portal: Canadian Statistics (n.d.).

1 Caution is advised when comparing rates due to variations in provincial and territorial child welfare systems and legal frameworks.

2 Newfoundland and Labrador Statistics Agency, Department of Finance (n.d).

3 As of July 1, 2016. Statistics Canada (2016b).

Second, considered to be among Canada’s most vulnerable population, children in care either have no parents or for a number of different reasons—socioeconomic circumstances, behavioural issues, abuse, family conflict, neglect or parental incompetence—are taken from their parents by the child welfare system or courts (Sherlock and Culbert, 2015; Esposito, Trocmé, Chabot et al., 2013). Once they enter care, children are often confronted with numerous challenges as they navigate Canada’s child welfare system. According to Amelia Merhar, a former foster child and now a Ph.D. candidate at the University of Waterloo, “[t]here are children in Canada’s child welfare system who can’t count the number of homes they have been in...Kids always hear the phrase, ‘the placement didn’t work out’ ...You’re already often coming from a family on social assistance or with addiction or abuse issues. Then you’re just bounced around and never really told why and it perpetuates feelings of shame and worthlessness” (Treleaven, 2019). According to child welfare advocates, most children in care are “resilient and determined to survive on their

Child Welfare and Pandemics

own. But while some find varying degrees of success, others fall down” (Sherlock and Culbert, 2015).

Third, pandemics such as the current Coronavirus Disease (COVID-19) can have significant effects on the capacity of public agencies to operate and provide services and supports to populations during a period of heightened demand and uncertainty. It is especially important for child welfare agencies responsible for vulnerable populations such as abused and neglected children to ensure continuity of care during this period (O’Brien, Webster and Herrick, 2007: 1). Given the dynamic nature of the current COVID-19 pandemic, it is difficult to provide a clear picture of how COVID-19 is affecting child welfare systems’ ability to function. However, early feedback from key stakeholders—children, youth, parents, foster and adoptive parents, caseworkers, probation officers, judges and others—suggests system resources and capacity are under considerable pressure as agencies and child protection workers struggle to provide services and supports to clients (Fecteau, 2020; Kelly and Hansel, 2020). Table two provides a snapshot of what key stakeholders in the field are reporting amid the growing COVID-19 pandemic.

Table 2 Growing Concerns Around the COVID-19 Epidemic—A Child Welfare Perspective from the United States

Issue	Description
Investigating Maltreatment	<ul style="list-style-type: none">As of March 12, more than 10,000 schools have closed for some period of time, decisions that affect almost 5 million kids. For mid- to upper-class households where all the adults work, finding child care options could be a costly and onerous task. But it will be the working poor, who are disproportionately involved in the child welfare system, that will struggle the most to have children looked after. This cannot become a funnel to child welfare cases, where leaving kids at home during work shifts becomes a basis for a surge in neglect cases. The government response must be to find free or very low-cost child care options for those parents who need to work and can’t take days off.
Nutrition	<ul style="list-style-type: none">Free- and reduced-price lunch programs, and similar breakfast programs, are a major benefit to low-income families – nearly 22 million students receive school meals. If schools close, this will present another fiscal challenge for strapped households that can generally rely on help with the cost of meals throughout the week.
Source: Kelly, J. and Hansel, H. (2020). “Coronavirus: What Child Welfare Systems Need to Think About,” <i>The Chronicle of Social Change</i> , (11 March). Retrieved from https://chronicleofsocialchange.org/child-welfare-2/coronavirus-what-child-welfare-systems-need-to-think-about/41220	

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Child Welfare and Pandemics

Table 2 Growing Concerns Around the COVID-19 Epidemic—A Child Welfare Perspective from the United States

Issue	Description
In Home Services	<ul style="list-style-type: none"> The vast majority of children involved in child welfare cases live at home. Parents are often ordered to participate in certain programs (or requested to do so voluntarily), while caseworkers make regular visits to check on the situation in the home. Systems must assume they will experience staffing challenges in the coming months, and have a plan to ensure that there are “eyes on” children. Contingency plans, if court-ordered services aren’t available because of a quarantine, will be an even tougher problem to solve.
Substance Use Disorders	<ul style="list-style-type: none"> Many parents involved in child welfare cases are in treatment to fight drug addiction. Systems will have to determine safe and just contingency plans if traditional elements of court-ordered treatment, such as urine tests and group counseling sessions, become untenable with public closures. Many system-involved parents are in treatment for opioid and heroin use, and some of them received methadone or other medication to help them recover. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently sent out guidance stressing that any symptomatic patients should not have to attend programs, and that take-home orders of the medication be used for anyone eligible. SAMHSA also recommended that opioid treatment programs facilitate “appropriate alternatives” to program attendance for those patients who are not authorized for unsupervised doses of methadone or similar medication.
Visitation and Reunification Services	<ul style="list-style-type: none"> The primary goal once a child has been removed from home is to get them back to the parent or parents. A major part of that effort is continued visitation while the child is in foster care. The centers used for supervised visits will need to be deep cleaned on a daily basis, and agencies should arrange Facetime or other video options between foster homes, group homes and parents. Systems must also be creative in figuring out how to ensure that reunification services continue despite any travel restrictions or quarantines. It is grossly unjust to prolong the time a family is apart because of unavailable services.

Source: Kelly, J. and Hansel, H. (2020). “Coronavirus: What Child Welfare Systems Need to Think About,” *The Chronicle of Social Change*, (11 March). Retrieved from <https://chronicleofsocialchange.org/child-welfare-2/coronavirus-what-child-welfare-systems-need-to-think-about/41220>

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Child Welfare and Pandemics

Table 2 Growing Concerns Around the COVID-19 Epidemic—A Child Welfare Perspective from the United States

Issue	Description
Court Appearances	<ul style="list-style-type: none"> • A huge looming question will be whether dependency and juvenile courts continue to function at a normal pace, or if the docket will slow down tremendously. As with the above point on visitation and reunification, it would be truly unfair to have court slowdowns delay children from being reunited with their parents.
Protecting Youth with Pre-Conditions	<ul style="list-style-type: none"> • A high rate of youth in foster care have acute medical needs, some of which put them at increased risk of complications from coronavirus. These children need to be identified and targeted for increased monitoring. Their caregivers must be given a direct line to instant support in a crisis.
Foster Parent Employment	<ul style="list-style-type: none"> • Many foster households work during the day, and most will continue to do so. Systems should expect that there will be a spike in the need for respite and child care during a prolonged period where schools are not in session.
Possible Spike in “Re-Placement” Needs	<ul style="list-style-type: none"> • One foster parent, using the Twitter handle @Fosterhood, <i>shared that</i> she is aware of some families served by the same agency who will ask for placement changes if kids are not going to school during the year or in summer school. Those families “return [kids] for respite the only two weeks they’re home in August,” the tweet said. “This could be a mess.” Systems should anticipate that the cancellation of school could be a serious disruption in this way, and discuss how to handle higher-than-usual requests for transfers of children.
Elder Caregivers	<ul style="list-style-type: none"> • Research on kinship care out of California suggests that about half of relative caregivers are grandparents, most of them single or widowed. Many of these caregivers, based on their age, are in the group most at-risk of severe complications from coronavirus. Systems should line up contingency plans and supports for any children living with an elderly caregiver.
<p>Source: Kelly, J. and Hansel, H. (2020). “Coronavirus: What Child Welfare Systems Need to Think About,” <i>The Chronicle of Social Change</i>, (11 March). Retrieved from https://chronicleofsocialchange.org/child-welfare-2/coronavirus-what-child-welfare-systems-need-to-think-about/41220</p>	

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Child Welfare and Pandemics

Table 2 Growing Concerns Around the COVID-19 Epidemic—A Child Welfare Perspective from the United States

Issue	Description
Outbreaks at Institutional Settings	<ul style="list-style-type: none"> Residential settings such as group homes and institutions, where many young people live in relatively close quarters, are at heightened risk with a virus this easily transmitted. This is especially dangerous for children with pre-conditions such as heart disease, diabetes or any chronic respiratory condition. Systems and agencies that operate these facilities must have plans in advance for dealing with the need to quarantine youth or staff; be prepared for large relocation of children; and have agreed-upon medical centers to take children to in an emergency situation.
Foster Youth on College Campuses	<ul style="list-style-type: none"> The statistics on college graduation for foster youth are dire—less than three percent get a degree from a four-year college—and the decisions made by colleges during coronavirus can make the lives of these students even harder. Thus far, most college campuses that have limited in-person classes have kept residence halls open. But if dorms and campus apartments are shuttered, while most of their classmates head home to wait out the pandemic, many current and former foster youths will struggle to find another place to live. And some will likely lack the necessary computer and Wi-Fi access necessary to continue class work in an online setting. Jenny Pokempner, a senior attorney for the Juvenile Law Center and an expert on extended foster care policy for young adults, recommended that states consider using their federal funds from the Chafee Independent Living account to help support any youth experiencing housing instability during school shutdowns.
<p>Source: Kelly, J. and Hansel, H. (2020). "Coronavirus: What Child Welfare Systems Need to Think About," <i>The Chronicle of Social Change</i>, (11 March). Retrieved from https://chronicleofsocialchange.org/child-welfare-2/coronavirus-what-child-welfare-systems-need-to-think-about/41220</p>	

1.2 Organization of Literature Scan

The literature scan is organized according to nine sections. Following an introduction to the topic, section two operationalizes three different disaster scenarios: outbreaks, epidemics and pandemics. Key distinguishing features are highlighted and examples of corresponding crises in history are provided. Section three provides a brief discussion of the socio-ecological model, an approach which has framed most maltreatment prevention efforts within the past three decades. Child protection efforts are framed using insights from the model and their effects on children during pandemics are discussed in the context of the current COVID-19 pandemic. Section four identifies and elaborates on the potential risks to the continued protection of children during a pandemic. Again, the current COVID-19 pandemic is used for purposes of illustration and analysis. Sections five, six, seven and eight identify and discuss measures and policies designed to mitigate the effects of pandemics on children and ensure continuity of care. The final section of the review—section nine—provides a synthesis of the findings and concluding remarks.

It is important to note that sections three through six of this review draw heavily on existing research published by the Alliance For Child Protection In Humanitarian Action (ACPHA), a global agency that provides guidance to actors engaged in child protection services in humanitarian settings (Alliance For Child Protection In Humanitarian Action, 2019a: 15, 2019b; Fischer, Elliott, Bertrand, 2018).⁴ Although the central focus of the [ACPHA's] work is on child protection services in humanitarian settings, the ACPHA's body of research provides valuable lessons learned that can be translated and utilized by child welfare practitioners for the broader child welfare population level as well as specific groups of children in care such as Indigenous children who are known for being more vulnerable due to socio-economic inequalities, inadequate living conditions, the burden of chronic disease and living in more remote areas (Wright, 2020). Child protection in the context of humanitarian crises involves the "prevention of and response to abuse, neglect, exploitation and violence against children" (Alliance For Child Protection In Humanitarian Action, 2019a: 19). The child protection risks children face during humanitarian crises, the factors that influence them and the necessary actions to prevent and respond to these risks parallel those faced by children in care. Child protection risks include: family separation; physical or sexual abuse; psychosocial distress or mental disorders; economic exploitation; injury; and death (Alliance For Child Protection In Humanitarian Action, 2019a: 19). These risks are dependent on factors, that include: the nature and scale of the emergency; the number of children affected; sociocultural norms; pre-existing child protection risks; community-level preparedness; and stability and capacity of the state before and during the crisis (Alliance For Child Protection In Humanitarian Action, 2019a: 19). Child protection interventions in humanitarian crises are designed to:

- prevent and respond to all forms of abuse, neglect, exploitation and violence;
- build on existing capacities and strengthen preparedness before a crisis occurs;
- support the physical and emotional health, dignity and well-being of children, families and communities;

- include specific activities conducted by local, national and international child protection actors; [and]
- [include the participation of] non-child protection actors who seek to prevent and address abuse, neglect, exploitation and violence against children...whether through mainstreamed or integrated programming” (Alliance For Child Protection in Humanitarian Action, 2019a: 19-20).

2.0 Differentiating Between Outbreaks, Epidemics and Pandemics

Since the corona virus first emerged in China’s Hubei province, it has spread to 181 countries, infected 245,888 people globally and killed 10,048 (Worldometer, 2020).⁵ On March 11, 2020, the COVID-19 crisis was officially classified as a pandemic by Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO (Bedford, Enria, Giesecke et al., 2020; WHO, 2020).

Outbreaks such food borne botulism, epidemics such as Severe Acute Respiratory Syndrome (SARS) and pandemics such as COVID-19, each have unique characteristics; however a key defining feature which helps to distinguish between the three scenarios of disease spread is the scale of the event (Fischer, 2020) or the amount of a particular disease that is present in the community (Centers for Disease Control and Prevention, 2012).

- *Outbreaks* are considered to be “small, but unusual” typically exhibiting noticeable, but small increases in the number of expected cases (Fischer, 2020) over a limited geographic area (Centers for Disease Control and Prevention, 2012).
- *Epidemics* are “bigger and spreading” as they occur over a larger geographic area and at a faster rate (Fischer, 2020). The increase in the amount of the disease in a specific community is often sudden and in excess of what is typically found the affected population (Centers for Disease Control and Prevention, 2012).
- *Pandemics* are epidemics that are “international and out of control” in scope as they spread to multiple countries or regions of the world, typically affecting a large numbers of people (Fischer, 2020; Centers for Disease Control and Prevention, 2012).⁶

Table three differentiates between the three scenarios of disease spread, identifying key characteristics and recent examples for each category.

Table 3 Differentiating Between Outbreaks, Epidemics and Pandemics

Category	Characteristics ¹	Examples
Outbreak	<ul style="list-style-type: none"> • a sudden rise in the number of cases of a disease • may occur in a community or geographical area, or may affect several countries. • may last for a few days or weeks, or even for several years • [s]ome outbreaks are expected each year, such as influenza • [s]ometimes a single case of an infectious disease may be considered an outbreak; [t]his may be true if the disease is rare or has serious public health implications 	<ul style="list-style-type: none"> • food borne botulism¹ • bioterrorism agent such as anthrax¹
Epidemic	<ul style="list-style-type: none"> • occurs when an infectious disease spreads rapidly to many people 	<ul style="list-style-type: none"> • SARS (2002-2003)—death toll 774³

Sources: ¹Association for Professionals in Infection Control and Epidemiology. (n.d.). Outbreaks, Epidemics And Pandemics—What You Need To Know. Arlington, Virginia: Association for Professionals in Infection Control and Epidemiology. Retrieved from https://apic.org/monthly_alerts/outbreaks-epidemics-and-pandemics-what-you-need-to-know/

² MPHonline. (n.d.). Outbreak: 10 of the Worst Pandemics in History. Retrieved from <https://www.mphonline.org/worst-pandemics-in-history/>

³ Centers for Disease Control and Prevention. (2017). SARS Basic Fact Sheet. Arlington, Virginia: Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/sars/about/fs-sars.html>

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Child Welfare and Pandemics

Table 3 Differentiating Between Outbreaks, Epidemics and Pandemics

Category	Characteristics ¹	Examples
Pandemic	<ul style="list-style-type: none"> • [a] global disease outbreak • differs from an outbreak or epidemic because: <ul style="list-style-type: none"> • [it] affects a wider geographical area, often worldwide • [it] infects a greater number of people than an epidemic • is often caused by a new virus or a strain of virus that has not circulated among people for a long time • [h]umans usually have little to no immunity against it • [t]he virus spreads quickly from person-to-person worldwide • [it] causes much higher numbers of deaths than epidemics • often creates social disruption, economic loss, and general hardship 	<ul style="list-style-type: none"> • COVID-19 (2019-current)² • HIV/AIDS (2005-2012 peak)—death toll 36 million² • Hong Kong Influenza (1968)—death toll 1 million² • Asian Influenza (1956-1958)—death toll 2 million • Spanish Influenza² (1918)—death toll 20 to 50 million² • Sixth Cholera Pandemic (1910-1911)—death toll 800,000+² • Influenza Pandemic (1889-1890)—death toll 1 million • Third Cholera Pandemic (1852-1860)—death toll 1 million² • Bubonic Plague (1346-1353)—death toll 75 to 200 million² • Bubonic Plague (541-542)—death toll 25 million² • “Plague of Gallen” (165 AD)—death toll 5 million²

Sources: ¹Association for Professionals in Infection Control and Epidemiology. (n.d.). Outbreaks, Epidemics And Pandemics—What You Need To Know. Arlington, Virginia: Association for Professionals in Infection Control and Epidemiology. Retrieved from https://apic.org/monthly_alerts/outbreaks-epidemics-and-pandemics-what-you-need-to-know/

² MPHonline. (n.d.). Outbreak: 10 of the Worst Pandemics in History. Retrieved from <https://www.mphonline.org/worst-pandemics-in-history/>

³ Centers for Disease Control and Prevention. (2017). SARS Basic Fact Sheet. Arlington, Virginia: Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/sars/about/fs-sars.html>

The World Health Organization (WHO) identifies six phases of a pandemic: “[p]hases one through three correlate with preparedness, including capacity development and response planning activities, while [p]hases four through six...signal the need for response and mitigation efforts” (World Health Organization, 2009). According to the WHO (2009), “[t]his phased approach is intended to help countries and other stakeholders to anticipate

Child Welfare and Pandemics

when certain situations will require decisions and decide at which point main actions should be implemented.” Table four provides brief summaries of each phase.

Table 4 World Health Organization, Pandemic Phases

Phase	Definition	Required Actions
Phase 1	[N]o viruses circulating among animals have been reported to cause infections in humans.	Preparedness
Phase 2	[A]n animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans, and is therefore considered a potential pandemic threat.	Preparedness
Phase 3	[A]n animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.	Preparedness
Phase 4	[C]haracterized by verified human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause “community-level outbreaks”. The ability to cause sustained disease outbreaks in a community marks a significant upwards shift in the risk of a pandemic. Any country that suspects or has verified such an event should urgently consult with WHO so that the situation can be jointly assessed and a decision made by the affected country if implementation of a rapid pandemic containment operation is warranted. Phase 4 indicates a significant increase in risk of a pandemic but does not necessarily mean that a pandemic is a foregone conclusion.	Response and Mitigation

Source: World Health Organization. (2009). *Pandemic Influenza Preparedness and Response: A WHO Guidance Document. The WHO Pandemic Phases*. Geneva, Switzerland: World Health Organization; 2009. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK143061/>

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Table 4 World Health Organization, Pandemic Phases

Phase	Definition	Required Actions
Phase 5	[C]haracterized by human-to-human spread of the virus into at least two countries in one WHO region. While most countries will not be affected at this stage, the declaration of Phase 5 is a strong signal that a pandemic is imminent and that the time to finalize the organization, communication, and implementation of the planned mitigation measures is short.	Response and Mitigation
Phase 6	[T]he pandemic phase, is characterized by community level outbreaks in at least one other country in a different WHO region in addition to the criteria defined in <i>Phase 5</i> . Designation of this phase will indicate that a global pandemic is under way.	Response and Mitigation
Source: World Health Organization. (2009). <i>Pandemic Influenza Preparedness and Response: A WHO Guidance Document. The WHO Pandemic Phases</i> . Geneva, Switzerland: World Health Organization; 2009. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK143061/		

The WHO (2009) notes that “[d]uring the *post-peak* period, pandemic disease levels in most countries with adequate surveillance will have dropped below peak observed levels.” During this period, pandemic activity is decreasing; however, waves of disease activity usually follow over a period of months (WHO, 2009). It is not until the *post-pandemic period* that disease activity will have returned to “normal” levels, requiring intensive surveillance and reassessments of pandemic preparedness and response plans (WHO, 2009).

3.0 A Socio-Ecological Approach to Child Protection During Pandemics

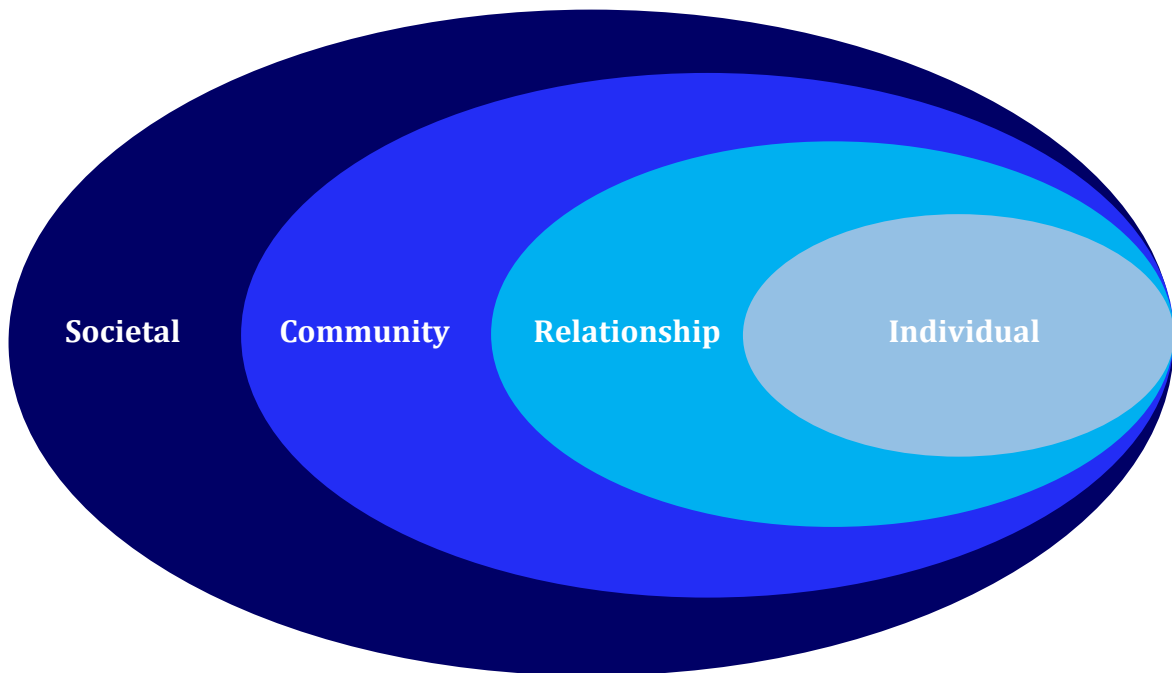
3.1 Socio-Ecological Model and Child Protection

The primary goal of child maltreatment prevention services is to prevent maltreatment from occurring by decreasing factors that put children at risk of maltreatment and enhancing those that protect or buffer against maltreatment (National Research Council, 1993; Wisconsin Child Abuse and Neglect Prevention Board, n.d: *What is Child Maltreatment?*). The social-ecological model, which has framed most maltreatment prevention efforts within the past three decades, organizes these risk and protective factors into nested levels that all mutually influence each other: these are the levels of the individual, the close social bonds they form (i.e. relationships), the communities they are a

part of, and the wider society (Alliance for Child Protection in Humanitarian Action 2019a; Centers for Disease Control and Prevention, n.d.: *The Social-Ecological Model*; National Research Council, 1993).⁷

Figure one provides a visualization of the model.

Figure 1 Socio-Ecological Model—A Framework for Prevention



Source: Centers for Disease Control and Prevention. (n.d.). *The Social-Ecological Model: A Framework for Prevention*. Retrieved from <https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html>

A closer examination of the model reveals what levels of interacting factors need to be addressed by maltreatment prevention strategies and why they should all be tackled. Table five provides a synthesis of these factors and reasons for each of the four levels identified by the model.

Table 5 The Four Levels of the Socio-Ecological Model

Level	Description
Individual	The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include education and life skills training.
Relationship	The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behavior and contributes to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs, and mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships.
Community	The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the climate, processes, and policies within school and workplace settings.
Societal	The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.
Source: Centers for Disease Control and Prevention. (n.d.). <i>The Social-Ecological Model: A Framework for Prevention</i> . Retrieved from https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html	

Given the complex interplay of these factors across levels, researchers have underlined the importance of addressing multiple levels at once for prevention efforts to be effective (Centers for Disease Control and Prevention, n.d: *The Social-Ecological Model*). Prevention interventions can take place at various moments along the service continuum (Australian Institute of Family Studies, 2014). Namely, primary and secondary interventions happen

before maltreatment occurs and target all individuals or high-risk individuals respectively, whereas tertiary interventions take place after maltreatment occurs to prevent its reoccurrence or consequences and allow for reunification (Australian Institute of Family Studies, 2014; MacMillan et al., 2009).⁸ As such, a myriad of distinct services can be offered at the individual, family and community level to prevent maltreatment throughout the various stages of a child’s life. Table six provides examples of such services.

Table 6 Child Maltreatment Prevention Programs According to Level of Focus

Focus	Intervention Level		
	Primary	Secondary	Tertiary
Child	Personal safety programs	Assertiveness training for “at risk” children	Therapeutic programs
Parents/ Family	Universal nurse home visiting programs	Parent education programs	Child protection service referrals
Community	General media awareness campaigns	Targeted media campaigns in “at risk” communities	Intensive community interventions

Source: Australian Institute of Family Studies. (2014). *Defining the Public Health Model for the Child Welfare Services Context*. Child Family Community Australia Resource Sheet. December. Retrieved from <https://aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-services-context>

3.2 Applying the Socio-Ecological Model to Child Protection During Pandemics—The Case of COVID-19

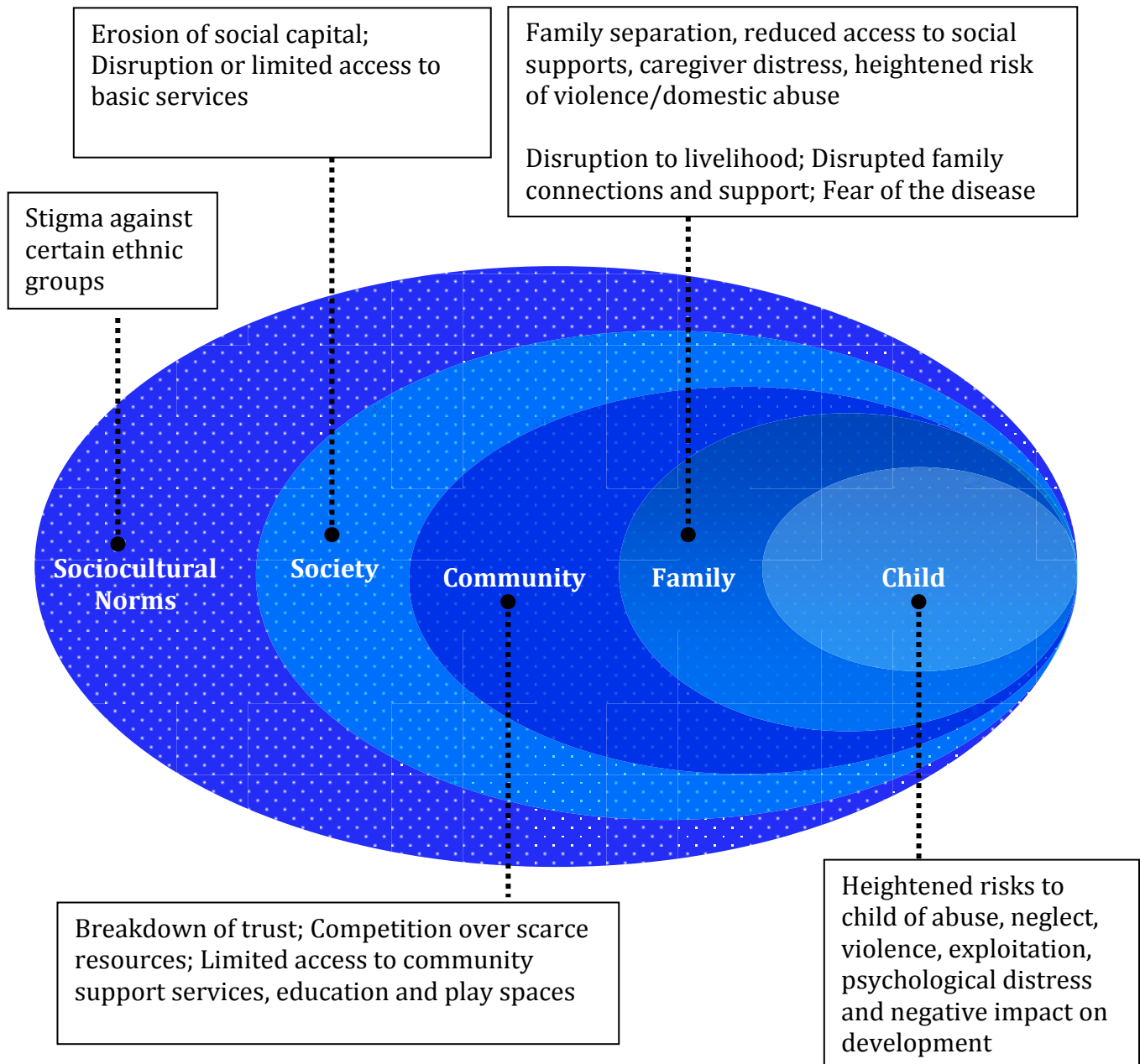
In their analysis of COVID-19 and its effects on child protection, the Alliance for Child Protection in Humanitarian Action (ACPHA) found that pandemics such as COVID-19 and measures taken to control the spread of disease drastically alter the environment in which children live, therefore increasing their susceptibility to abuse, neglect, violence, exploitation, psychological distress and impaired development (Alliance for Child Protection in Humanitarian Action, 2019b: 2; Fischer, Elliott and Betrand, 2018: 9-10) For example,

- [q]uarantine measures such as school closures and restrictions on movements disrupt children's routine and social support while also placing new stressors on parents and caregivers who may have to find new childcare options or forgo work.
- Stigma and discrimination related to COVID-19 may make children more vulnerable to violence and psychosocial distress.

- Disease control measures that do not consider the gender-specific needs and vulnerabilities of women and girls may also increase their protection risks and lead to negative coping mechanisms.
- Children and families who are already vulnerable due to socio-economic exclusion or those who live in overcrowded settings are particularly at risk (Alliance for Child Protection in Humanitarian Action, 2019b: 2).

Figure two illustrates how COVID-19 drastically alters a child's environment and the implications for child protection by framing the impacts within a socio-ecological framework. It is effective in illustrating how "[d]isruptions to families, friendships and the wider community can have detrimental consequences for children's well-being, development and their protection" (Fischer, Elliott and Bertrand, 2018: 9-11).

Figure 2 Social-Ecological Impact of COVID-19



Source: Alliance for Child Protection in Humanitarian Action. (2019b). *Technical Note: Protection of Children during the Coronavirus Pandemic, Version 1*. (March). Page 2. Retrieved from https://alliancecpa.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

4.0 Child Protection Risks Presented by Pandemics—The Case of COVID-19

Observations by the ACPHA (2019b: 1-2) of developments in the current COVID-19 pandemic reveal a number of increased risks to child protection. Table seven provides a list of these risks as well as potential risks identified in previous infectious disease outbreaks (Alliance for Child Protection in Humanitarian Action, 2019b: 1).

Table 7 Child Protection Risks Presented by COVID-19, Related Measures and Their Causes

Child Protection Risk	Risks Presented by COVID-19 and Related Control Measures	Causes of Risks
Physical and Emotional Maltreatment	<ul style="list-style-type: none"> • Reduced supervision and neglect of children • Increase in child abuse and domestic/ interpersonal violence • Poisoning and other danger and risks of injuries to children • Pressure on or lack of access to child protection services 	<ul style="list-style-type: none"> • Childcare/school closures, continued work requirements for caregivers, illness, quarantine/isolation of caregivers • Increased psychosocial distress among caregivers and community members • Availability and misuse of toxic disinfectants and alcohol • Increased obstacles to reporting incidents
Gender-Based Violence (GBV)	<ul style="list-style-type: none"> • Increased risk of sexual exploitation of children, including sex for assistance, commercial sexual exploitation of children and forced early marriage • Pressure on or lack of access to child protection/GBV services 	<ul style="list-style-type: none"> • Reduced family protection of children • Reduced household income and/or reliance on outsiders to transport goods and services to the community • Girls' gender-imposed household responsibilities such as caring for family members or doing chores • Increased obstacles to reporting incidents and seeking medical treatment or other supports

Source: The Alliance for Child Protection in Humanitarian Action. (2019b). *Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1*. (March). Pages 1-2. Retrieved from https://alliancecpa.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

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Child Welfare and Pandemics

Table 7 Child Protection Risks Presented by COVID-19, Related Measures and Their Causes

Child Protection Risk	Risks presented by COVID-19 and related control measures	Causes of Risks
Mental Health and Psychosocial Distress	<ul style="list-style-type: none"> • Distress of children due to the death, illness, or separation of a loved one or fear of disease • Worsening of pre-existing mental health conditions • Pressure on or lack of access to MHPSS services 	<ul style="list-style-type: none"> • Increased stress levels due to isolation in treatment units or home-based quarantine • Children and parents/caregivers with pre-existing mental health conditions may not be able to access usual supports or treatments • Quarantine measures can create fear and panic in the community, especially in children, if they do not understand what is happening
Child Labour	<ul style="list-style-type: none"> • Increased engagement of children in hazardous or exploitative labour 	<ul style="list-style-type: none"> • Loss or reduction in household income • Opportunity or expectation to work due to school closure
Unaccompanied and Separated Children	<ul style="list-style-type: none"> • Separation • Becoming unaccompanied or child head of household • Being placed in institutions 	<ul style="list-style-type: none"> • Loss of parents/caregivers due to disease • Isolation/quarantine of caregiver(s) apart from child(ren) • Children sent away by parents to stay with other family in non-affected areas

Source: The Alliance for Child Protection in Humanitarian Action. (2019b). *Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1*. (March). Pages 1-2. Retrieved from https://alliancecpha.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

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Table 7 Child Protection Risks Presented by COVID-19, Related Measures and Their Causes

Child Protection Risk	Risks presented by COVID-19 and related control measures	Causes of Risks
Social Exclusion	<ul style="list-style-type: none"> • Social stigmatization of infected individuals or individuals/groups suspected to be infected • Increased risk/limited support for children living/working on the street and other children already at risk Increased risk/limited support to children in conflict with the law, including those in detention 	<ul style="list-style-type: none"> • Social and racial discrimination of individuals/groups suspected to be infected • Disproportionate impact on more disadvantaged and marginalized groups • Closure/inaccessibility of basic services for vulnerable children and/or families • Disruption to birth registration processes due to quarantine

Source: Alliance for Child Protection in Humanitarian Action. (2019b). *Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1*. (March). Pages 1-2. Retrieved from https://alliancecpa.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

In their analysis of the current COVID-19 pandemic, UNICEF (n.d.: 1) has identified three main potential secondary impacts on children and their caregivers in term of child protection: neglect and lack of parental care; mental health and psychosocial distress; and increased exposure to violence, including sexual violence, physical and emotional abuse. “Children with disabilities, marginalized children and other vulnerable groups are at higher risk of these secondary impacts” (UNICEF, n.d.: 1).

- *Neglect and Lack of Parental Care*: Children may lose parental care when their caregivers die, are hospitalized, fall ill, or are quarantined. Children who are themselves hospitalized or quarantined may also be deprived of parental care. Measures put in place to control the disease e.g. school closure, may also leave children without parental care during the day (as their parents are at work). Given the concerns and fear around COVID-19, the traditional care support systems that would step in the absence of parental care (extended family, community members) may be disrupted (UNICEF, n.d.: 1).

- *Mental Health and Psychosocial Distress:* Children affected by COVID-19 and their families face various stressors including social isolation, health related fears, and fears about contamination or spreading the disease. Persons suspected or confirmed of having COVID-19 have to face not only fear but also isolation in medical facilities. People who have been medically cleared as well as family members and care providers may also face social isolation, rumors, exclusion and even violence in their communities. Important rituals of grieving such funeral and burial practices may be disrupted. Front line staff are confronted with stressful working environments of witnessing considerable suffering and grief among children affected and their families. They have to battle their own fear and concerns about the disease (UNICEF, n.d.: 1).
- *Increased Exposure to Violence, Including Sexual Violence, Physical and Emotional Abuse.* This may result from caregivers and other adult family members becoming increasingly distressed, a sense of support and belonging to a community being disrupted and the use of dysfunctional coping mechanisms to cope with the challenging environment (i.e. alcohol, etc.) (UNICEF, n.d.: 1).

What actions and measures must be taken to mitigate adverse impacts of epidemics and ensure continued protection of children during epidemics? Sections five, six and seven provide an overview of three broad categories of child protection strategies to mitigate adverse impacts on children during epidemics. These are: increased coordination and collaboration across all sectors (see section 5.0 *Child Protection Strategies During Epidemics—Increased Coordination and Collaboration*); the development of child specific programming (see section 6.0 *Child Protection Strategies During Epidemics—Child Specific Programming*); the care of youth in residential care (see section 7.0 *Child Protection Strategies During Epidemics—Residential Care*); and emergency preparedness of institutional bodies responsible for the provision of supports and services to children, youth and their families (see section 8.0 *Strengthening Child Welfare Systems Before, During and After Epidemics*).

5.0 Child Protection Strategies During Epidemics—Increased Coordination and Collaboration

Increasingly complex emergencies such as the current COVID-19 pandemic pose new challenges and risks to the protection and well-being of children which requires increased collaboration and coordination across all sectors for the mitigation of harm and risk (Alliance for Child Protection in Humanitarian Action, 2019a: 223-295; 2019b: 2). This includes sectors responsible for: education; livelihoods; food security; education; health; nutrition, water, sanitation and hygiene; and shelter.⁹ According to the ACPHA, multi-sectoral responses are necessary because childrens' needs cross all institutional and jurisdictional boundaries. More specifically,

child protection risks are closely linked with the work of other sectors because children have needs that fall under all sectors....[N]o single sector that operates in a crisis has the knowledge, skills and resources to fully prevent risks, respond to children's protection needs and promote children's rights and well-being...Sectoral programming that fails to account for child protection risks can lead to: [i]nefficient use of resources; [a]dditional harm or increased risks; and [r]educed results for children (Alliance for Child Protection in Humanitarian Action, 2019a: 223).

The ACPHA suggests that multi-sectoral interventions should emphasize: “[s]tandard procedures for documenting and referring children's cases that may need follow-up; [c]lear protocols to prevent/reduce...child protection risks; [r]educe stigma and social exclusion that may result from the disease; and [c]lear, coordinated, child-friendly community messaging on children's unique risks and vulnerabilities related to the outbreak (Alliance for Child Protection in Humanitarian Action, 2019b: 2-3).

6.0 Child Protection Strategies During Epidemics—Child Specific Programming

To protect children during the current COVID-19 pandemic, it is essential that, in addition to mitigating risks, child welfare practitioners “build on the strengths and positive coping mechanisms of communities, families, caregivers and children” (Alliance for Child Protection in Humanitarian Action, 2019b: 4). This involves the development of child protection strategies focused on: individual and group activities for child well-being; strengthening family and caregiving environments; community-level approaches; case management; and alternative care (Alliance for Child Protection in Humanitarian Action, 2019b: 4; 2019a).¹⁰ Table eight discusses the necessary actions to formulate and implement these strategies.

Child Welfare and Pandemics

Table 8 Child Protection Strategies During Epidemics—Child Specific Programming

Preparedness Actions	Response Actions
Child Protection Strategy—Individual and Group Activities for Child Well Being	
<ul style="list-style-type: none"> • In consultation with others, identify alternative mental health and psychosocial support (MHPSS) and educational activities for children. • Consult children and adolescents, including girls, in the design of interventions. 	<ul style="list-style-type: none"> • Train health, education, child services and MHPSS staff on COVID-19-related child protection risks. • Identify strategies for providing psychosocial support to children, especially to those under quarantine. • Conduct remote, age and gender appropriate awareness raising. • Adapt existing referral pathways.
Child Protection Strategy—Strengthening Family and Caregiving Environments	
<ul style="list-style-type: none"> • Work with children, caregivers and other stakeholders to understand cultural beliefs and practices that could protect or endanger children during an outbreak. • Identify awareness raising opportunities to highlight the importance of responsive parent-child relationships. • Develop an inter-agency plan, in collaboration with relevant authorities, to strengthen the care of vulnerable children. 	<ul style="list-style-type: none"> • Provide targeted support to interim care centres and families, including child-headed households and foster families, to emotionally support children and engage in appropriate self-care. • Provide financial and material assistance to families whose income-generating opportunities have been affected. • Encourage and create safe opportunities to support routine contact between children and family members who are physically separated. • Work with other sectoral actors, including governments, to put in place measures to prevent child-family separation.
<p>Source: The Alliance for Child Protection in Humanitarian Action. (2019b). <i>Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1</i>. (March). Pages 4-5. Retrieved from https://alliancecpha.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184</p>	

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Table 8 Child Protection Strategies During Epidemics—Child Specific Programming

Preparedness Actions	Response Actions
Child Protection Strategy—Community-Level Approaches	
<ul style="list-style-type: none"> • Identify what role communities can play in raising awareness and in protecting children and families. • Work with communities to identify strategies to prevent and protect vulnerable groups (e.g. refugees, children in alternative care, those at risk of stigmatization and social exclusion). 	<ul style="list-style-type: none"> • Work with community members to develop child-friendly messages on COVID-19, associated risks and referral pathways Identify flexible strategies to communicate with communities remotely. • Together with communities, carry out activities to end stigmatization, promote safe coping mechanisms, and support affected populations. • Work with traditional and religious leaders to adapt traditional practices, if necessary (i.e. greetings, burial and grieving ceremonies, etc.).
Child Protection Strategy—Case Management	
<ul style="list-style-type: none"> • Provide training and support to caseworkers and existing child help lines on COVID-19, including basic facts and myths, impact on CP concerns, and support services. • Work with health actors to develop strategies to include marginalized and hard to-reach children. • Identify risk mitigation measures for caseworkers and alternative methods for follow-up if home visits become impossible. • Facilitate referral for other specialized services including GBV services. 	<ul style="list-style-type: none"> • Revise or develop SOPs with the health sector and others to ensure the safe identification and referral of children at risk. • Establish mechanisms to ensure that communities facing restrictions on movement have continued access to child-friendly, holistic care for children experiencing violence. • Identify children whose excluded status renders them more vulnerable (i.e. children without family care; children who are refugees, internally displaced, migrants or stateless; children living and/or working on the street; children with disabilities; etc.).
<p>Source: The Alliance for Child Protection in Humanitarian Action. (2019b). <i>Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1</i>. (March). Pages 5-6. Retrieved from https://alliancecpha.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184</p>	

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Table 8 Child Protection Strategies During Epidemics—Child Specific Programming

Preparedness Actions	Response Actions
Child Protection Strategy—Alternative Care	
<ul style="list-style-type: none"> • Identify, train and mentor local health actors in preventing family separation and identifying and referring children who are unaccompanied and separated (UASC). • Identify and train persons across communities who are well-placed to care for UASC in case of a COVID-19 outbreak. • Build the capacity of systems to prevent separation, engage in family tracing and reunification, and provide family-based alternative care for UASC. 	<ul style="list-style-type: none"> • Establish safe, family-based alternative care arrangements (preferably kinship care). • Ensure children who are separated from their caregivers have regular opportunities to communicate with them. • Avoid disseminating information that might unintentionally encourage families to neglect or abandon their children. • Work with relevant authorities to establish a registration system to prevent long-term separation and to facilitate reunification.

Source: The Alliance for Child Protection in Humanitarian Action. (2019b). *Technical Note: Protection Of Children During The Coronavirus Pandemic, Version 1*. (March). Page 6. Retrieved from https://alliancecpha.org/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

7.0 Child Protection Strategies During Epidemics—Residential Care

Ensuring the health and well being of seniors, particularly those living in residential care facilities during the COVID-19 pandemic has become a priority for many governments (Hyslop, 2020). However, child welfare advocates point out that seniors are not the only people living in residential facilities (Hyslop, 2020). In British Columbia, it is estimated that 3,400 individuals live in residential care facilities of which 2,600 are adults with developmental and physical disabilities and nearly 800 are children and youth in government care contracted residential facilities like group homes (Hyslop, 2020). As discussed earlier, youth living in residential facilities are at a heightened risk of infection with viruses that are easily transmitted such as COVID-19 because of communal living arrangements, a situation which is even more dire for children and youth with pre-existing health conditions (Fecteau, 2020; Kelly and Hansel, 2020; Hyslop, 2020). Rita Soronen, President and Chief Executive Officer of the Dave Thomas Foundation—a public nonprofit charity in the United States that is focused exclusively on foster care adoption—notes that children in care, particularly those living in institutional or group homes, who come from

disadvantaged backgrounds and already face significant challenges, are highly susceptible to further harm resulting from the current COVID-19 pandemic:

the pandemic has "multiple layers" for children, some of whom might be with extended family members, in foster care or in institutional or group homes. When you look at the pandemic in terms of those children who are in maybe institutional or group homes, they're already socially isolated in a way... They're at a higher risk of perhaps getting the virus, simply because they're in a group situation, no matter how good everybody is at quickly making sure things are sterile." [Even if they're healthy, Soronen said there are risks.] They tend not to have that same kind of technology available to them, and so they're just adding to the layers of trauma that they already have. They become much more socially isolated and that can cause much more psychological harm" (Fecteau, 2020).

As more governments enact emergency declarations amid the COVID-19 pandemic, invoking closures of key institutions and the suspension of services, group home residents are faced with very few if any alternatives in terms of housing and other supports (Fecteau, 2020; Kelly and Hansel, 2020; Hyslop, 2020). In cases where residential facilities are mandated to remain open, the necessary resources for staff to continue to provide the necessary services and supports to clients are quickly being depleted while demand for services increases (Hyslop, 2020). For many residential facilities who operate on limited budgets, the loss of essential personnel and the need to continue to pay personnel unable to work is unsustainable and made even more difficult with limited direction and communication from government leaders (Hyslop, 2020). According child welfare advocates, it is critical that "[s]ystems and agencies that operate these facilities..have plans in advance for dealing with the need to quarantine youth or staff; be prepared for large relocation of children; and have agreed-upon medical centers to take children to in an emergency situation (Fecteau, 2020; Kelly and Hansel, 2020; Hyslop, 2020).

8.0 Strengthening Child Welfare Systems Before, During and After Epidemics

In the face of pandemics such as COVID-19, it is essential that child welfare systems have the capacity and resources to: respond to increased demands for supports and services; minimize the effects on vulnerable populations; and ensure continuity of care. This requires: the formulation and articulation of a pandemic plan *before* a pandemic begins to unfold; effective implementation of the plan *during* a pandemic; and an evaluation of the plan *after* the pandemic (Child Welfare Information Gateway, 2016, 2015; Self-Brown, Anderson, Edwards et al., 2013; Annie E. Casey Foundation, 2009; Daughtery and Blome, 2009; O'Brien, Webster, Herrick, 2007; O'Brien and Webster, 2006).

8.1 Emergency Preparedness Before an Epidemic

Research has shown that disasters—natural, man-made or medical such as epidemics—“can leave child welfare agencies and other service agencies scrambling to continue operations, which can be difficult to nearly impossible without ample planning and preparation” (Child Welfare Information Gateway, 2016: 2; Tye, 2020; O’Brien, Webster, Herrick, 2007). Although planning for an event that may never occur is difficult, particularly for child welfare agencies whose services and resources are taxed with everyday emergencies and exceptionally high caseloads, it is imperative that agencies formulate a comprehensive plan that ensures they are able serve and protect the well-being of children, youth and families (Child Welfare Information Gateway, 2016: 2). When formulating a plan, child welfare agencies should take into consideration the following:

- [how agencies will] identify, locate, and continue the availability of services for children under care or supervision who are displaced or adversely affected;
- [how agencies will] respond to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases;
- [how agencies will] remain in communication with caseworkers and other essential child welfare personnel who are displaced;
- [how agencies will] preserve essential program records; and
- [how agencies will] coordinate services and share information with other [levels of government] (Child Welfare Information Gateway, 2016: 2).

Plans should ensure that critical infrastructure is in place to allow for coordination with key players, the communication of vital information; and the preparation of staff, families, youth, and service providers (O’Brien, Webster, Herrick, 2007: 3-29).

8.2 Emergency Preparedness During an Epidemic

Plans that address key elements and critical infrastructure help to guide responses during a pandemic (O’Brien, Webster, Herrick, 2007: 30). However, effective implementation requires: good management of resources, essential functions and assigned roles; coordination with key partners; communication of vital information; and access to critical information systems by staff (O’Brien, Webster, Herrick, 2007: 30-37).

8.3 Emergency Preparedness After an Epidemic

The period after a pandemic provides an opportunity for child welfare agencies to “assess their experiences, revise their plans and rebuild stronger and more effective systems” (O’Brien, Webster, Herrick, 2007: 2).

9.0 Conclusions

On March 11, 2020, Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO classified the COVID-19 situation as a pandemic on the basis of “alarming levels of spread and severity, and by the alarming levels of inaction” (Bedford, Enria, Giesecke et al., 2020; WHO, 2020). Since the corona virus first emerged in China’s Hubei province, it has spread to 181 countries, infected 245,888 people globally and killed 10,048 (Worldometer, 2020).¹¹ In addition to the tragic human consequences of COVID-19, the United Nation’s trade and development agency—UNCTAD—estimates that the “slowdown in the global economy caused by COVID-19 is likely to cost at least US\$1 trillion” (United Nations, 2020). Amid the unfolding pandemic, government efforts are underway to contain the virus and mitigate its effects on populations; however, organizations such as child welfare agencies responsible for helping the most vulnerable in society are struggling to provide the necessary supports and services as are children who rely on them for their survival. A scan of existing literature reveals that children in care—already at disadvantage relative to their peers in the broader population—are at a heightened risk of harm from not only the current COVID-19 pandemic, but in many cases, from government policies being implemented to contain the epidemic. This includes increased risks of: physical and emotional maltreatment; GBV; mental health and psychosocial distress; engagement in exploitative labour; separation from caregivers; and social exclusion. Child welfare systems and agencies, whose resources and capacity to provide the necessary services and supports are under considerable pressures require policy makers to formulate, articulate and implement child protection strategies that: allow for and encourage increased coordination across all sectors that involve children in care; build on the strengths and positive coping mechanisms of communities, families, caregivers and children; address the challenges of highly vulnerable populations such as youth in residential care; and provide for the required resources and supports to function not only during an epidemic but also in pre- and post-pandemic environments.

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Endnotes

¹ The term “Indigenous” refers to all Aboriginal peoples of Canada. As defined by the Government of Canada, Aboriginal identity refers to whether a person identifies with the Aboriginal peoples of Canada. This includes those who are First Nations (North American Indian), Métis or Inuk (Inuit) and/or those who are Registered or Treaty Indians (that is, registered under the Indian Act of Canada), and/or those who have membership in a First Nation or Indian band. Aboriginal peoples of Canada are defined in the Constitution Act, 1982, Section 35 (2) as including the Indian, Inuit and Métis peoples of Canada (Statistics Canada, 2017b). Although the term “Indigenous” is used as a collective term for all Indigenous peoples and identities, it is important to note that Indigenous peoples are not a homogeneous group. Indigenous Peoples of Canada are a diverse population with distinct histories, languages, cultural practices and spiritual beliefs (Government of Canada, 2017; Voyageur and Calliou, 2000/2001).

² Section three of Canada’s *Employment Equity Act* defines visible minorities as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.”

³ It is important to note that “[b]ecause child welfare services fall under the jurisdiction of provincial and territorial authorities each province has different legislation pertaining to child protection interventions, making it difficult to compare rates of children in out-of-home care across provinces” (Canadian Child Welfare Research Portal: Canadian Statistics, n.d.). Among the most significant differences between provinces are provincial mandates regarding “the age to which children are eligible for services, the length of time a child can receive out-of-home care and the definition of out-of-home care” (Canadian Child Welfare Research Portal: Canadian Statistics, n.d.).

⁴ More specifically, “co-led by UNICEF and Save the Children, [the ACPHA] is a global level interagency group that focuses on standard setting and provision of technical support and guidance to actors in the field of child protection in humanitarian settings. The overall goal of the [ACPHA] is to support the efforts of national and international actors to provide high quality and effective support and services for children to prevent and respond to violence, exploitation, abuse and neglect in humanitarian settings. In pursuit of this goal the group, undertakes work in four areas, organized as permanent working groups with the following outcomes: a) minimum standards for child protection in humanitarian action; b) assessment, measurement and evidence; c) learning and development; and d) advocacy” (World Health Organization, n.d.: Alliance for Child Protection in Humanitarian Action).

⁵ As of March 20, 2020.

⁶ An additional criteria used by some epidemiologists to classify a situation as a pandemic is whether a “disease is sustained in some of the newly affected regions through local transmission” (Fischer, 2020). If community transmission is found, the situation is confirmed as a pandemic.

⁷ For a discussion of the Ecological Model, see Belsky (1980) and the Bronfenbrenner Center for Translational Research for the consolidated work of Urie Bronfenbrenner. For a discussion of Ecological Systems Theory, see Bronfenbrenner (1979) and the Bronfenbrenner Center for Translational Research.

⁸ This is based on the public health model approach to child welfare services. “The public health model is a concept with currency in many disciplines, including health, education and welfare. It is an epidemiological model that attempts to prevent or reduce a particular illness or social problem in a population by identifying risk indicators. Public health models aim to prevent problems occurring in the first place by targeting policies and interventions at the known risk indicators for the problem, quickly identifying and responding to problems if they do occur, and minimizing the long-term effects of the problems (World Health Organization, 2006). In the public health model of disease prevention, preventative interventions are described as either primary, secondary, or tertiary interventions (Tomison and Poole, 2000). When applied to the child protection and child welfare sector, the public health model provides a theoretical framework that spans the service continuum from primary intervention services that target everyone, to secondary intervention services that target families in need, through to tertiary intervention services that target families where abuse or neglect has already occurred. The targeting of prevention programs at different groups with varying degrees of risk for child maltreatment is referred to as a “composite approach” to prevention” (Australian Institute of Family Studies, 2014: *Defining*).

⁹ The ACPHA suggests that individuals responsible for child protection should also work in conjunction with religious and traditional leaders (Alliance for Child Protection in Humanitarian Action, 2019b: 2). This is of particular relevance when dealing with Indigenous populations where Elders and spiritual leaders play critical roles in their communities.

¹⁰ See also United Nations International Children's Emergency Fund (n.d.: 4-9).

¹¹ As of March 20, 2020.