HI DRR Guidance Note on inclusive Community-Based Preparedness and Response in Covid 19 Context

<u>Last update: April 20th 2020</u>

All these orientations are subject to the possibility to ensure the safety of the volunteers, their families our partners and our beneficiaries and to follow the safeguards instructions and guidance from the national and local authorities. These measures would also need to be adapted according to the scale of transmission of COVID-19 in the area and local capacities.

Main findings and needs that may require inclusive DRR mobilization:
- Vulnerable populations and persons with disabilities are disproportionately impacted by the COVID-19 pandemic in health, economic and social terms. Some individuals, households and communities face increased risks and consequences due to the higher exposure and barriers they face in accessing critical information, protection and other essential services.
- In countries facing a high transmission level, Health services tend to be overwhelmed. Health facilities are unequally distributed and equipped across the territories, and understaffed to cope with the contagiousness of the virus. Their local capacities for promoting Infection Prevention and Control are severely lacking.
- Institutional emergency responders, who may be able to reduce the risks of transmission and to provide assistance to people who are in confinement or in quarantine, including persons with disabilities and vulnerable populations, are rarely in capacity to meet their basic and specific needs.
- In this context, community risk management committees' members/volunteers are being called upon to play a role in inclusively responding to the future or already ongoing health, economic and social crisis, in support of and in agreement with health and emergency response authorities. As surge staff, their capacity to autonomously implement IPC preparedness and response protocols will be the key to containing the epidemic, despite managing epidemiological risks are rarely part of their initial mission and background.

1. **At the institutional level, alongside the other emergency responders, humanitarian community (in link with iHA and protection interventions)**

- **Support multi-agency assessments, preparedness and response plans/ vulnerability analysis/ targeting and prioritization criteria and standard operational procedures to be inclusive.**
  Review and ensure that emergency systems for epidemics, preparedness and response plans are inclusive for the most at risk populations (DGA and more specific Covid factors of exclusion and vulnerabilities) Promote inclusive programming, MEAL and disaggregation of data by disability, gender, age and other relevant criteria Promote use of and share data and learnings on factors of risk and discrimination, such as in-country data on disability, gender and age specific access/participation/protection issues, barriers and facilitators assessments, and learnings on inclusion in similar situations

- **Support emergency responder, humanitarian community, including humanitarian country teams, cluster leads, working groups and partners to make their messaging and Risk Communication and Community Engagement strategies accessible and inclusive of the most at risk populations (including persons with disabilities;**
  Accessible health and protection messaging which is child-friendly, gender and disability sensitive; ensure available in sign language, braille, easy to read, and local language (see below). Make social media messages and digital technology accessible to providing captioning,

relay services, text messages. Mobilize HI Teams, partners and other experts with relevant expertise in those revisions (e.g. OPDs printing braille versions, producing sign language video or Easy To Read formats, child-friendly messages, sub-scripts and captioning for video/infographics, accessibility requirements for information platforms and digital messages) as well to identify and address barriers in accessing information and communication.

- Support meaningful participation of **men, women, boys and girls with and without disabilities, OPDs and other CSOs (with relevant expertise at all levels) to be engaged in decision-making** throughout the stages and activities of the response and coordination.

- **Share and promote the use of data on factors of risk and discrimination**, such as in-country data on disability, gender and age specific access/participation/protection issues, findings from barriers and facilitators assessments, and share learnings on inclusion from similar situations

- **Conduct a rapid assessment on perception, knowledge, attitudes, barriers, needs and gaps related to COVID-19 response mechanisms by men and women with disabilities, their families and care-givers (lead by OPDs),** notably to explore impact on their protection, wellbeing and access to essential services and protective measurements, to figure out their preferred communication patterns/channels and trusted sources, and good practices to champion in access protection measurements and essential services including treatment

- **Monitor and address gaps in the response**, as well as stigma, misperception and protection risks on basis of disability, gender, age or other factors, using global and in-country data (e.g. Need of continuity of care; denial of access to health services and intensive care; protection of those living in institutions, residential schools; provision of reasonable accommodation; long-term funding to reduce impact of COVID). Share learnings, tip sheets, practical recommendations, organize learning sessions and support key staff engaged in response (health workers /community mobilizers, hygiene promotors, protection officers); Support identification and advocate for reasonable accommodation needs and modified modalities (additional amounts of protective gear, water and soap; assistance for social support; transportation costs; home-based interventions to ensure continuity of care).

- **If requested, support civil protection services, health authorities and/or DRM stakeholders in developing inclusive preparedness and response plans at the provincial/regional level**

2. **At the community level (alongside the municipalities, community DRRM committees and local civil protection branches…):**

2.1 Prepare the volunteers:

- **Reactivate local or community DRRM committees and/or local civil protection branches** (usually referred to as 'Community Disaster Risk Management Committees and Volunteers') in line with DRM and health authorities. Help the committees to register the committee members who would be willing to volunteer during the outbreak response (with a role similar to community health workers (CHW).

- **Conduct awareness sessions, dedicated to local DRM committees**, **on covid19** signs and symptoms, PPE using and disposal, transmission modes, health promotion, preventive actions as part of an IPC (Infection Prevention and Control) induction ; **Prepare them to conduct inclusive C19 prevention campaigns as part of a RCCE strategy** (Risk Communication and Community Engagement) which aims to proactively communicate what is known, what is unknown, and what is being done/planned to locally build trust in the C19 preparedness and response. **Prepare them to communicate to the entire community at every step of the C19 transmission** (at least in anticipation of the 2 scenarios and warning thresholds mentioned in the coming C19 community Emergency response plans (in 2.2).

- **In coordination with health authorities: pre-position Personal Protective Equipment (PPE)** at the municipal or community level, in anticipation of distributions to the volunteers, care givers (and eventually their family members) and contaminated persons (depending on health protocols); In coordination with WASH, health and PSS stakeholders, you'll certainly have to pre-position **Covid19 DGA sensitive IEC tools**. Consider the need to stock-pill **community and family emergency kits**; Communication equipment could also be necessary, to keep exchanging with the local DRM committees in the event of a complete lock down.

<u>2.2 Prepare the communities and the most at risk population:</u>

- **Develop or contribute to an inclusive RCCE strategy and start raising awareness of COVID-19 and Infection prevention and control (IPC) basic practices among communities and households at risks**, in support of WASH and health initiatives. While physical distancing, movement restriction benefits and hand hygiene may not be easily applicable for the entire community, efforts should be made to apply them for at risk individuals. Ensure staff involved in the dissemination of health messaging are trained on inclusive communication and that IEC tools are accessible to everyone. In parallel with mass media risk communication campaign, amplify appropriate messaging/risk communication and community awareness through local and traditional media (including key community focal points) to women and men, boys and girls, with disabilities and other groups at risk of discrimination in accessible formats and through accessible channels.

- This might include prevention and protection messages, contingency planning and information about services Ensure messaging/risk communication is available in local languages and language spoken by displaced populations and are disability, gender and age sensitive. Messaging should challenge gender, age, and disability stereotypes, be respectful and free of bias (For example, challenge association of COVID-19 transmission with persons with disabilities, persons living on street or older persons) ; Ensure that information and messages are provided in a diversity of accessible formats including braille, easy-read format, sign language, and high contrast print with use of accessible technologies where possible. Information and messages should also be available through numerous accessible channels (mass media, social and traditional media, key community focal points, etc).

  Set up an inclusive Community Feedback System' that monitor, address and answer information gaps, questions, anxiety, distress, misconceptions and rumors within communities (everyone in the community should be able to share their concerns/questions). Maintain as much as possible a two-way communication to understand and respond to their concerns, attitudes, beliefs, and barriers (as part of your RCCE strategy). It's crucial to enhance understanding and acceptance of key containment actions and other covid-related protocols. This CFS will also help the committees to cope with risks of discrimination of certain groups due to misperceptions...reducing stigmatization of old persons, people experiencing respiratory symptoms, people who have been curved/completed the quarantine etc.

- **Carry out inclusive local/community C19 emergency preparedness and response plans and, as much as possible, HH contingency planning (**extended to the protection of their livelihoods – cf. Business continuity planning) once the most at risk persons and families have been identified. **Volunteers should be trained on identification of the most at risk families and individuals in a Covid context**. As part of the plan, it is important to identify and map individuals who are at higher risk of poor disease outcomes (the elderly and those with hypertension, diabetes, cardiovascular and chronic respiratory diseases), as well as vulnerable individuals with specific needs of assistance (in particular in a confinement context). In addition to DGA, consider in vulnerability criteria: health concerns (persons with hypertension, diabetes, cardiovascular and chronic respiratory diseases), access to protective measures, coping and mitigation strategies, access to critical food, medication etc.

- *At the community level (community Emergency Response Plan):*

- *Who is most at risk within our community? Where are the high-risk sites for contamination in the community (crowds, queues…) and how to limit the risks of transmission - to be adjusted to the scale of the outbreak transmission (by scheduling, limiting the densities…)? When PPE and kits should be delivered, and to whom in priority? How do we refer suspected cases to public health services (cf. communication and reporting channels)? Which health facility to go for treatment – and do they really recommend us to bring all suspected cases (it might depend on the severity of cases, on their capacity to treat severe cases, on the safeguarding capacities of the health staff and other non-C19 patients…)? Which location and modalities of isolation and care are we supposed to promote within our community? Which existing community structures (community hall, sports hall, etc.) can be repurposed for the isolation and care? How do we provide home care (provision of food, water, hygiene materials and other daily needs) and which are the basic needs of people in confinement and/or complete isolation (even young adults might concerned… as they often work in the informal sector and depend on daily work and/or income to live)? How do we collectively reduce exchanges with the surrounding villages/districts, should we conduct health screening at the entries etc.?*

- Such emergency P&Response plan could be based on <u>at least 2 scenarios and warning thresholds</u>: a) There are confirmed cases in the surrounding villages/districts b) There is at least 1 suspected case in the locality

- *At the HH level (including IGA/needs for business continuity):*

- Take the opportunity of the HH contingency planning for promoting business continuity planning to better prepare their main activity and livelihoods for a coming shock and a potential quarantine, leading to loss of income, based on a 4 to 6 weeks of reduced working capacities and lack of supplies, market access etc.

- Make sure everyone in the HH has access to preventive information (hygiene/health prevention messaging and community engagement initiatives) and to a community feedback system;

- Help them defining how they could put in place C19 prevention measures (e.g. handwashing, etc.) or improve IPC practices (in case someone has symptoms) at home;

- Help them preparing family contingency kits for at least 3 weeks of confinement, supplemented by potential in kind donations and/or cash transfers.

- Map medial, social and rehabilitation care they need in a context of potential disruption of continuity of care (exacerbated by Physical distancing, collapse of social support systems and/or separation of caregivers). If they have an underlying health condition, make sure they have access to any medications that they are currently using. Prepare for assistants or caregivers in hospitalization and/or quarantine

- Most at risk HH should stay connected via telephone or social media. Ensure they activate their social contacts to provide you with assistance, if needed.

- Volunteers to make sure they don't suffer from stigma, violence or abuse. Pay also attention to the risks of domestic violence exacerbated by the confinement (cf. HI Protection guidelines).;

- **Depending on their mandate, capacities, and the content of their emergency response: Train volunteers to:**

- **i) Early detect** (syndromic cases – as recommended by WHO), **ii) Report & Refer to health services (**to possibly trigger health interventions and/or 'feed' their C19 Information System), **iii) ensure inclusive and protective isolation center and/or home Care management** and **iv) Transfer the patients to health facilities in line with health authorities' protocols**

- Deliver Inclusive cash support for our extreme poor beneficiaries if the markets are still open and there is no confinement. In contexts where most of the population is confined and most of the markets are closed or unsafe, in-kind distributions are the most relevant modality of assistance (refer first to the HI C19 Cash Transfer and Emergency Livelihood guidelines);

  Inclusive installation/provision of hand washing stations, of NFI kits (HH items), shelter kits…

- Consider MHPSS interventions led by the volunteers, depending on their capacities. Consider PSS support to the volunteers, as they might feel under pressure and stress. They may also experience avoidance by their family or community owing to stigma or fear (-> refer first to HI MHPSS guidelines and tools).

School/Child-centered and hospitals possible extensions:

Schools and child-centered DRR in C19 context: Extensions of inclusive C19 school-based and/or child-centered prevention might be considered (please refer to the dedicated chapter of the C19 IDRR ToolBox – which also includes IE tools).

Hospital / health preparedness: it is recommended to continue engaging with communities and persons with disability in developing community-led emergency referral systems for epidemics including inclusive emergency response plans and engage with health units in reinforcing and making inclusive their mass casualties management systems.