

COVID-19 Program Adaptations

RISK MITIGATION FOR THE DURATION OF THE GLOBAL PANDEMIC

This document is a companion to the overall **Program Framework and Guidance**, and is intended to provide direct and clear guidance on how to mitigate risks during and throughout the phases of a pandemic (an expected duration of over 12-18 months or more.) This document provides examples of activities and how to ensure they are safe for staff – both SCA and partner staff – as well as program participants and volunteers. As with all programming, **Save the Children must first aim to do no harm, and this Program Adaptation document is centered on that principle.**

The recommendations and guidance below represent the minimum measures required in order to ensure the safe continuity of programming in the context of a COVID-19 outbreak. “Program Activity” refers mainly to the modality of program delivery, and anticipates risk associated with ongoing service delivery in the context of COVID-19 transmission. **This guidance applies to all program sectors.** It is important to stress that **programming will be affected by local actions and prevention measures taken by local actors and Governments.** All Country Offices should follow the guidance provided locally. In the absence of locally provided guidance, teams should follow the guidance below, implement the mitigation measures, and suspend programs when thresholds are met, or mitigation measures cannot be applied. **If the CO does not have the resources or ability to implement the mitigation measures, then the program should be temporarily suspended, as continuation of the program unchanged is considered an unacceptable risk to staff and program participants.**

The guidance below takes into account two things:

- 1) Context in the country as described in terms of the **Program Phase** (Preparedness, Initial Response, Large-Scale Response, Recovery)
- 2) The nature of activities carried out in the Country Office in terms of **Program Criticality**

Program Phases: As the pandemic spreads across the globe, countries are expected to move in and out of different phases from Preparedness to Response and Recovery, and likely back into preparedness and response for subsequent pandemic waves. The program phase will depend on identified cases as well as market disruptions, school closures and overall impact on ways of life. There are 3 distinct Program Phases:

- Preparedness
- Initial Response
- Large-Scale Response

Program Criticality Guidance: Country Offices should look at Program Criticality (PC 1-4) of all activities:

- PC 1 = life-saving interventions (e.g. clinical care for emergency conditions, emergency WASH, emergency food distributions, cash, care and support for unaccompanied children, family reunification, protection and response to SGBV).
- PC2 = life-sustaining interventions + those with potential impact on COVID-19 (e.g. life-sustaining = primary health care including the provision of reproductive health care, vaccination, MCH; impact on COVID = any community engagement activities that promote detection, prevention and mitigation).

When countries are in the Initial Response or Large-Scale Response, PC1 and PC2 activities should continue once risk mitigation measures outlined below are in place. If risk mitigation measures cannot be implemented, activities should be temporarily suspended.

- PC3 = life-dignifying
- PC4 = life-enhancing

PC3 and PC4 activities should be modified or temporarily suspended once Countries are in the Initial Response Phase.

Adaptations for Existing Programs

| Program Activity | Risks | Options for Mitigation Measures | Resources Needed | Actions per Program Phase / Program Criticality |
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| All Sectors | | | | |
| Safety and security for all activities | <ol style="list-style-type: none"> Risk of infection of large sections of the population due to continued face-to-face interventions COVID-19 will increase anxiety, tensions and rumors in communities about aid services = escalated risk of generalized violence Rumors of international staff bringing COVID-19 to communities (e.g. Nigeria case from Italy) = escalated risk of targeted violence | <ol style="list-style-type: none"> Review contingency plans for staff safety Review methods for team communication Modify program implementation plans to lessen occasions when SC staff may be isolated, lacking means to evacuate from program sites. Recognize that increased tensions mean that SC staff may be more stressed, may need increased provision of psychosocial support for staff Review access to healthcare/collect and disseminate local service directory for staff Ensure gender and social inclusion analysis informs decisions on staff and community safety and security plans. | <ol style="list-style-type: none"> Vehicles to remain present with staff at remote field locations; Increase number of phones and handsets for all staff in field locations; Security teams to assist in development of plans PFA capacity | ACROSS ALL PHASES <ul style="list-style-type: none"> Safety and security planning for all activities. |
| Mass Meetings / Gatherings <i>Definition: Meeting or gathering over 25 people</i> Examples: Community gatherings for awareness raising, information dissemination, and community engagement, child participation, large trainings or staff meetings, etc. | <ol style="list-style-type: none"> Individuals with COVID-19 attend the meeting and spread the infection to other people and staff (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) SC staff who is sick attends the meeting and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) Significant risk of worsening community transmission | <ol style="list-style-type: none"> All large gatherings should be avoided. Strongly consider alternative approaches for awareness raising, information dissemination, and community engagement, child participation e.g. telecommunications, smaller groupings with safe distancing, house-to-house (see below) Review criticality of meetings – postpone non-critical meetings (PC3 and PC4) Identify alternative delivery format for the meeting: telecommunications, webinar etc. Limit the number of people attending to ensure social distancing can be practiced. Adjust venue for meeting to be in a bigger space to enable social distancing (2m) and good ventilation. Ensure gender and age-appropriate (including child-friendly and youth friendly) risk communication information is available at the venue and that all staff are able to share key messages and answer common questions on COVID-19. Ensure no-one with cough or fever or shortness of breath attends. | <ol style="list-style-type: none"> Staff trained on COVID-19 prevention. Telecommunications | PREPAREDNESS: <ol style="list-style-type: none"> Identification of relevant meetings and gatherings, both for staff and communities. Conduct awareness raising with staff, children and communities about potential changes to activities. Readying of telecommunications resources, if applicable INITIAL RESPONSE: <ol style="list-style-type: none"> All large-scale gatherings should be avoided Postpone non-critical meetings (PC3 and PC4) Implement modification measures for critical meetings (PC1 and PC2) and suspend all in-person mass meetings if modifications can't be met. LARGE SCALE RESPONSE: <ol style="list-style-type: none"> Suspend all types of in-person meetings. |
| Smaller Meetings / Gatherings <i>Definition: Meeting or gathering under 25 people</i> Examples: mother-to-mother support groups, staff/volunteer trainings, youth groups, child resilience groups, workshops, group | <ol style="list-style-type: none"> Individuals with COVID-19 attend the meeting and spread the infection to other people and staff (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) SC staff who is sick attends the meeting and transmits the infection to others (or conditions with similar symptoms, initiating | <ol style="list-style-type: none"> Gatherings should be avoided. Strongly consider alternative approaches for related activities. Explore alternative approaches together with community members and children (when still safe to do so) Review criticality of meetings – postpone non-critical meetings (PC3 and PC4) Can these meetings happen in a different format not face-to-face, e.g. telecommunications, webinar etc.? | <ol style="list-style-type: none"> mitigate the immediate secondary impacts that result from efforts to contain the spread of the disease - particularly economic and social impacts through loss of income, loss of access to normal services and increased isolation | PREPAREDNESS: <ol style="list-style-type: none"> Identification of relevant meetings and gatherings, both for staff, children and communities. Consult with children to learn where and how they gather, child friendly ideas on methods of remote communication and participation during social distancing Conduct awareness raising with staff, children and communities about potential changes to activities. |

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| <p>classes, Focus Group Discussions, etc.</p> | <p>3 COVID-19 suspicion and self-quarantine) Significant risk of worsening community transmission</p> | <ol style="list-style-type: none"> 4. Limit the number of people attending to ensure social distancing can be practiced. 5. Adjust venue for meeting to be in a bigger space to enable social distancing (2m) and good ventilation. 6. Ensure gender and age-appropriate (including child-friendly and youth - friendly) risk communication information is available at the venue and that all staff are able to share key messages and answer common questions on COVID-19. 7. Ensure no-one with cough or fever or shortness of breath attends the meeting. 8. Strict staff sickness policy implemented – staff to not attend work if displaying symptoms. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. | | <ol style="list-style-type: none"> 4. Readying of telecommunications resources, remote communication options if applicable <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Postpone non-critical meetings (PC3 and PC4) 2. Implement modification measures for critical meetings (PC1 and PC2) and suspend all in-person meetings if modifications can't be met. 3. Ensure that small group activities or mobile and digital channels are interactive and ask for community problem solving instead of uni-directional messaging 4. Commence use of telecommunications – if applicable <p>LARGE SCALE RESPONSE:</p> <ul style="list-style-type: none"> • Suspend of all types of in-person meetings. |
| <p>Household Visits</p> <p>Examples: baseline/endline survey interviews, beneficiary verification, case management, contact tracing, etc.</p> | <ol style="list-style-type: none"> 1. SC staff conducting home visits come into contact with someone with COVID-19 resulting in possible infection (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 2. SC staff with COVID-19 conducts home visit and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 3. Restrictions on movement in communities by local authorities | <ol style="list-style-type: none"> 1. Use of telecommunications for case management follow-up and counselling, if feasible. 2. Conduct visit maintaining social distancing (no touch, safe distance of 2m). 3. Conduct visit outside in wide-open, well ventilated space rather than inside the household. (Please consider with technical advisors which types of cases could be managed in this way without risking confidentiality.) 4. Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection (depending on nature of the visit could be a facemask). 5. Ensure all staff are able to share key messages and answer common questions on COVID-19. 6. Strict staff sickness policy implemented – staff to not attend work if displaying cough or fever or shortness of breath. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. 7. Suspension of activities non-essential activities. | <ol style="list-style-type: none"> 1. Staff trained on COVID-19 prevention and no-touch guidance, if applicable 2. Equipment for modified visits (phones, credit, etc.) 3. Staff safety supplies for essential visits (hand sanitizer, etc.) Staff trained on the identification of domestic/gender-based violence and familiar with referral system | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Identification of critical versus non-critical HH visits 2. Explore telecommunications feasibility 3. Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging 4. Procure and preposition needed supplies 5. Conduct community awareness raising about potential changes to activities <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary suspension of household visits for PC3 and PC4 activities. 2. Household visits for PC1 and PC2 activities: Implement mitigation measures, but if unable to implement all mitigation measures due to funding, supplies, human resources, temporary program suspension should be considered in order to minimize risk for SC staff and clients until adequate mitigation measures can be implemented. <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Suspend all HH visits except for response critical, life-saving activities such as contact tracing, life-saving distributions of food or nutrition supplies (all mitigation measures must be in place) |
| <p>SC-Run Program Spaces</p> <p><i>Definition: SC operated facility, SC staff, resources provided by SC</i></p> <p>Examples: Child Friendly Spaces, Adolescent Friendly</p> | <ol style="list-style-type: none"> 1. Individuals with COVID-19 attend the space and spread the infection to other people and staff, including caretakers at home. (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) | <ol style="list-style-type: none"> 1. Strict staff sickness policy implemented – staff to not attend work if displaying symptoms. Must be discussed and agreed with HR and communicated to all staff types to remove the incentive to attend work sick. | <ol style="list-style-type: none"> 1. Staff/local partners trained on COVID-19 prevention, IPC guidance, and screening methods 2. Hand hygiene materials and supplies 3. Cleaning and disinfection supplies | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Adapt SOPs/protocols 2. Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging 3. Preposition needed supplies |

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| <p>Spaces, temporary learning spaces, etc.</p> | <ol style="list-style-type: none"> 2. SC staff with COVID-19 attends work and transmits the infection to others. (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 3. Potentially large numbers of individuals in a confined space which would promote the spread of a respiratory pathogen. 4. Poor environmental cleaning resulting in increased fomite transmission of COVID-19. 5. Very young children – difficulties in implementing individual level prevention measures (social distancing, no touch, hand hygiene, etc.). | <ol style="list-style-type: none"> 2. Strict participant sickness policy implemented – participants must not attend if displaying symptoms. 3. Implement hand hygiene and cough/sneeze etiquette measures at the space. Including age-sensitive and child/youth friendly messages and learning on COVID-19 and ensuring participants and visitors practice hand hygiene and cough/sneeze etiquette on entry to the space. 4. Screen all participants and visitors for symptoms – do not permit access to anyone who is unwell or has a fever. 5. Reduce the number of participants attending spaces. 6. Ensure gender and age-appropriate (including child/youth-friendly) risk communication information is available at the venue and that all staff are able to share key messages and answer common questions on COVID-19. 7. Implement cleaning and disinfection measures. 8. In situations of widespread COVID-19 transmission in SC areas of operation, temporary closure of SC spaces. [Closure of safe spaces and schools has in the past resulted in increased cases of child maltreatment and SGBV – anticipate, increased need for case management services following temporary program suspension] 9. <i>See Protection, Education and other relevant sectors below for more detail.</i> | <ol style="list-style-type: none"> 4. Access control supplies – hand hygiene, thermometers. | <ol style="list-style-type: none"> 4. Plan for alternative delivery of critical services (non face-to-face) through telecommunications 5. Facilitate problem solving and awareness raising sessions with staff, children/youth and communities about current changes, potential for further disruption to activities and services and alternative services. 6. Develop & provide families with take home tips on learning and psychosocial support and play activities for kids (including adolescent specific) at home <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Implement mitigation measures. If unable to implement all mitigation measures due to funding, supplies, human resources – temporary program suspension should be considered in order to minimize risk for SC staff and clients. <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary closure of SC spaces. 2. Distribution of child friendly learning and activity kits for home (including for adolescents). |
| <p>Distributions</p> <p>Examples: NFIs, food, cash/vouchers, etc.</p> | <ol style="list-style-type: none"> 1. Individuals with COVID-19 attend the distribution and spread the infection to other people and staff (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 2. SC staff who is sick participates in the distribution and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 3. Significant risk of worsening community transmission 4. Distribution sites overcrowded due to increase in demand led by disrupted markets and loss of livelihoods | <ol style="list-style-type: none"> 1. During the early stages of the outbreak (prior to community transmission), anticipate future community needs and considerations to enable social distancing for several weeks at a time, e.g. consider larger distributions to take place before community transmission to minimize the need for a distribution during the height of the outbreak. 2. Consider localized distribution and smaller/staggered gatherings 3. Review criticality of the distribution – if non-critical then delay (PC3 and PC4). 4. Consider possible social/economic disruptions to markets and households when reviewing criticality of programming and safe distribution. 5. If critical: 6. Perform multiple distributions rather than one large distribution in order to reduce the number of people attending. | <ol style="list-style-type: none"> 1. Staff trained on COVID-19 prevention. 2. Preposition supplies – distribution items 3. Preposition supplies needed for hand hygiene 4. Adapting the Distribution SOP in context of Disease outbreak | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Identification and mapping of critical versus non-critical distributions 2. Preposition supplies, arrange larger pre-emptive distribution of supplies/items to populations ahead of COVID-19 transmission in area of operations 3. Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging 4. Explore alternative options for distributions. 5. Identify additional local sites for distribution <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary suspension of PC3 and PC4 level distributions. 2. Implement mitigation measures. <p>LARGE SCALE RESPONSE:</p> |

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| | | <ol style="list-style-type: none"> 7. Consider alternative delivery options (including where available, e-commerce). 8. Perform the distribution outside, in a large and well ventilated space following strict hygiene measures. 9. Crowd control measures to enable social distancing of at least 2m between people. 10. Ensure gender- and age-appropriate (including child/youth-friendly) risk communication information is available at the venue and that all staff are able to share key messages and answer common questions on COVID-19. 11. Strict staff sickness policy implemented – staff to not attend work if sick. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. | | <ol style="list-style-type: none"> 1. If the SC is unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risk for SC staff and clients. |
| Health | | | | |
| SC-supported Health Facilities | <ol style="list-style-type: none"> 1. Individuals with COVID-19 attend the health facility and spread the infection to staff and patients. 2. SC staff who is sick attends work and transmits the infection to others. 3. Health facilities overstretched due to increases in demand for services 4. Poor infection prevention and control practices results in increases in fomite transmission of COVID-19 (infection from contact with contaminated surfaces and objects). 5. Patient with COVID-19 not detected and referred to another facility, thus increasing transmission to other facilities. 6. Insufficient numbers of healthcare workers due to staff illness/caring for sick relatives, fear, significant increases in demand for services. 7. Reduced availability of PPE due to global supply chain issues resulting in stock outs. 8. Inability to provide routine lifesaving services e.g. basic emergency obstetric and newborn care, resulting in increased maternal and newborn mortality and morbidity. | <ol style="list-style-type: none"> 1. Triage and screening established at the entrances to all health facilities. This must include redesigning patient flow and waiting areas to minimize congestion and risk of COVID-19 infections. 2. Standard and transmission based IPC precautions implemented at health facilities. 3. Isolation area identified. 4. Provision of PPE 5. Strict staff sickness policy implemented – staff to not attend work if sick. Must be discussed and agreed with HR and communicated to all staff types to remove the incentive to attend work sick. 6. Implementation of home based treatment protocols for mildly unwell patients (in-collaboration with MOH decision). 7. Cancellation of routine/non-urgent services and procedures (includes cancellation of mass gatherings for health education sessions) - PC3 and PC4 activities. 8. Prepare for disruptions in patient access – consider distributing increased supply of contraceptives, emergency medication supplies to patients with chronic conditions, etc. 9. Consider moving some reproductive health services to the community level e.g. plan for community-based management of antenatal and post-natal women. 10. Limit visitors and movements within health facilities. Limiting number of health workers with contact with any one patient, limiting exams if not necessary. 11. Patient transfer protocols and use of face masks for patients when referring to limit transmission to others. | <ol style="list-style-type: none"> 1. Trained HCWs 2. Physical materials, human resources and protocols for triage and screening 3. Personal protective equipment 4. IPC SOPs and protocols 5. Case management SOPs and protocols 6. Referral SOPs and protocols 7. Extra staff 8. Staff trained on the identification of domestic/gender-based violence and familiar with referral system | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Reinforce screening/surveillance practices 2. Reinforce standard IPC precaution application (these measures should be in place at all times for all patients in all facilities) 3. Apply PPE conservation strategies 4. Preposition PPE if funding available and PPE available 5. Preposition Reproductive Health kits for emergencies <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Reinforce screening/surveillance practices 2. Reinforce standard IPC precaution application 3. Train HCWs 4. Preposition supplies and PPE 5. Contextualize protocols and SOPs 6. Apply PPE conservation strategies <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Implement all mitigation measures – if C is unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risk for SC staff and clients <ul style="list-style-type: none"> ○ In order to safeguard negative impacts of temporary withdrawal from health facilities, it is recommended to first implement partial suspension of non-emergency services such as routine or follow-up visits and preventive services such as vaccination, ante-natal care etc. |

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| | | <ol style="list-style-type: none"> 12. Surge capacity to cope with increased staffing needs and reduced numbers of staff. 13. PPE conservation strategies. | | |
| <p>Community-based Interventions</p> <p>Examples: Community Case Management, Community Health Worker outreach, etc.</p> | <ol style="list-style-type: none"> 1. CHWs might get infected from sick children or their carers 2. CHW who is sick attends patients and transmits the infection to others. 3. Poor IPC in CHW's practice might transmit the infection from one patient to the next 4. CHWs might mistreat children with COVID. 5. CHWs might not refer patients to designated health facility for COVID, thus increase transmission risk in other facilities | <ol style="list-style-type: none"> 1. Check for referral pathway for their normal job and in case of COVID 2. Standard and transmission-based IPC precautions implemented with CHWs 3. Consider advocacy with national and local governments to ensure continuation of community-based services and rapid adaptation of national protocols to ensure safe service delivery 4. Consider immediate training initiatives for CHWs on COVID-19, including no-touch protocols and relevant risk communication messaging 5. Provision of appropriate personal protective gear and buffer stocks of medications, supplies, tools 6. Identification and agreement on alternative approaches for clinical supervision and referrals, including consideration for enhanced telecommunications for all CHWs to enable remote supervision, continuing education, and reporting (where possible) 7. Build into mobile and other digital channels opportunities for feedback loops such as WhatsApp groups for peer problem solving, mentoring and supervision. | <ol style="list-style-type: none"> 1. Oriented and trained CHWs on COVID-19 including case definition and where to refer 2. Provision of PPE 3. Provision of job aids (ie decision-making tools CHWs use to diagnose and treat) 4. Provision of contact information for referral and phone credit to facilitate referrals 5. Staff trained on the identification of domestic/gender-based violence and familiar with referral system | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Train CHWs 2. Provide suffer stock of supplies 3. Procure PPEs, extra tools, job aid needed for possible service modification 4. Provide training on possible scenarios for service modification and triggers to modify services 5. Conduct community awareness raising about potential changes to activities <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Initiate contact tracing, Community surveillance and Community messaging <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 2. CHWs in supporting community members home based isolation for suspected cases or positive case 3. Contact tracing 4. Community based surveillance 5. Information sharing on available services and where to get them 6. If unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risk for SC staff and clients |
| Nutrition | | | | |
| <p>Outpatient Treatment Centers and Stabilization Centers – not attached to health facilities</p> | <ol style="list-style-type: none"> 1. Individuals with COVID-19 attend the nutrition center and spread the infection to staff and other patients. 2. SC staff who is sick attends work and transmits the infection to others. 3. Large numbers of children in confined space which would promote the spread of a respiratory pathogen. 4. Poor environmental cleaning resulting in increased fomite transmission of COVID-19. 5. Very young children – difficulties in implementing individual level prevention measures (social distancing, no touch, hand hygiene etc.) 6. Clinical staff are redeployed by the MoH leading to reduced trained clinical staff to manage inpatient services. | <ol style="list-style-type: none"> 1. Triage and screening established at the entrances to all nutrition sites. This must include redesigning patient flow and waiting areas to minimize congestion and risk of COVID-19 infections 2. Isolation area identified. 3. Provision of appropriate PPE and conservation strategies 4. Strict staff sickness policy implemented – staff to not attend work if sick. Must be discussed and agreed with HR and communicated to all staff types to remove the incentive to attend work sick. 5. Implement hand hygiene measures. Screen all participants and visitors for a fever and respiratory symptoms. Do not permit access to anyone who is unwell or has a fever and respiratory symptoms. 6. Implement environmental cleaning and disinfection measures, including disinfection measures, including safe use and cleaning of any kitchenware, utensils and cups for food and water provided to patients in the space and/or staff. | <ol style="list-style-type: none"> 1. Staff trained on COVID-19 prevention. 2. COVID-19 awareness raising and behavior changing using effective RCCE, e.g., 3. Staff trained on the identification of domestic/gender-based violence and familiar with referral system 4. Hand hygiene materials and supplies 5. PPE supplies 6. Cleaning and disinfection supplies 7. Access control supplies – hand hygiene, thermoflash 8. additional staff | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Reinforce triage practices 2. Reinforce standard IPC precaution application (these measures should be in place at all times for all patients in all facilities) 3. Apply PPE conservation strategies 4. Preposition PPE if funding available and PPE available 5. Planning and preparation – train staff, awareness raising and behavior change strategies with clients and participants (see effective RCCE), preposition needed supplies, plan for alternative delivery of services, plan for disruption in service delivery. <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Reinforce screening/surveillance practices 2. Reinforce standard IPC precaution application 3. Train HCWs 4. Preposition supplies and PPE 5. Contextualize protocols and SOPs |

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| | | <ol style="list-style-type: none"> 7. Consider adapting the nutrition center site – providing services outside in a well-ventilated area, enabling social distancing between clients (2m). Temporary large tents can be utilized to increase capacity and distancing if required. Depending on the program set-up and proximity to a health facility, suitable isolation capacity prior to referral to health facilities will be required. Depending on the context, the SC might need to establish a triage/screening – see above for health facilities. 8. Prepare for disruptions in patient access – consider distributing larger nutrition supplies to cover for break/gap in service delivery, reduce visits. 9. Temporary closure of nutrition centers. 10. Ensure gender- and age-appropriate (including child-friendly) risk communication information is available at the venue and that all staff are able to share key messages and answer common questions on COVID-19. | | <ol style="list-style-type: none"> 6. Apply PPE conservation strategies <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Implement all mitigation measures – if SC is unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risks |
| <p>All community nutrition programming (IYCF-E/CMAM/CMAMI etc.)</p> | <ol style="list-style-type: none"> 1. Individuals with COVID-19 attend the distribution and spread the infection to other people and staff (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 2. SC staff who is sick participates in the distribution and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 3. Significant risk of worsening and facilitating community transmission | <ol style="list-style-type: none"> 1. Please follow guidance on gatherings (large and small), household visits and community RCCE etc. as appropriate 2. Reduce frequency of distribution of commodities 3. Reduce frequency of follow up. Consider remote follow up by phone or other remote modalities 4. Consider combined distribution and messaging with other sectors using social and mobile and mass media, including a feedback loop with audiences. Ensure gender – and age-appropriate (including child/youth-friendly) risk communication information is available at venues/activities and that all staff are able to share key messages and answer common questions on COVID-19. Implement remote supervision of programs 5. Increase community management of nutrition programs (as inpatient and OTP services decrease) | <ol style="list-style-type: none"> 1. Preposition supplies – distribution items 2. Preposition supplies needed for hand hygiene 3. Teleconferencing/mobile telecommunications 4. Staff trained on the identification of domestic/gender-based violence and familiar with referral system 5. Remote supervision tools | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Identification and mapping of critical versus non-critical distributions 2. Identification of beneficiaries that will require modified distribution of items and method 3. Preposition supplies, arrange larger pre-emptive distribution of supplies/items to populations ahead of COVID-19 transmission in area of operations 4. Train staff on COVID-19 prevention, no-touch guidance, and risk communication and effective community engagement 5. Explore alternative options for distributions. 6. Map recipients of assistance from other sectors. <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary suspension of PC3 and PC4 level distributions. 2. Implement mitigation measures. 3. Consider suspension of all widespread community assessments. Do not undertake in P3/4. Assess critical need for P1/2 <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. If the SC is unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risk for SC staff and clients. |

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| | | | | 2. Do not undertake any large scale assessments. |
| WASH | | | | |
| Community construction/rehab (e.g. WASH) | <ol style="list-style-type: none"> 1. Individuals with COVID-19 are in the community being supported. 2. SC staff who is sick goes into a community while ill. 3. Water supply services and sanitation facilities disrupted during the outbreak. 4. Lack of functioning handwashing station and availability of soap /hand sanitizer due to the shortage of global supply chain, border closed and 'panic buying' during the outbreak. 5. Decreasing solid waste management and medical waste management services in are where the outbreak occurred. 6. Lack of availability disinfectant consumable and equipment due to high frequently use, and high demand global supply chain shortage. 7. Insufficient/availability skilled labor and fear of contamination within the community during the rehab/construction period | <ol style="list-style-type: none"> 1. Review location of work and levels of congestion (e.g. urban versus rural) 2. Review criticality of work – suspend non-critical work (PC3 and PC4) 3. Modify critical work – alternate work plan to have smaller teams and limit face-to-face interaction etc. 4. Ensure hand washing/hygiene measures are available. 5. Strict staff sickness policy implemented – staff to not attend work if sick. Must be discussed and agreed with HR and communicated to all staff types to remove the incentive to attend work sick. 6. Ensure gender- and age-appropriate (including child-friendly) risk communication information is available at venues/activities and that all staff are able to share key messages and answer common questions on COVID-19. 7. Assess capacity of water source and WASH infrastructure in community and health centres; Increase access to WASH facilities in health center. In coordination with Local authority /water and sanitation department for backup plan Ensure the contingency plan/contingency stock for handwashing NFI related, disinfectant consumable and equipment update and mapping the functioning handwashing facilities in coverage area 8. Developing safe construction protocol for the construction labor guidance. 9. Assessing the capacity of solid waste and medical waste management and in coordination with local authority to develop back up plan for outbreak scenario | <ol style="list-style-type: none"> 1. Staff and partners trained on COVID-19 prevention. 2. Preposition supplies needed for construction and WASH lifesaving i.e. emergency water supply assuming disrupted supply chains during outbreak 3. Supplies needed for hand hygiene related to NFI. 4. Preposition emergency tool kits for construction of emergency water supply, emergency sanitation including handwashing station and decontamination point. 5. Preposition of Disinfectant consumable and equipment i.e. spray booster, Chlorine NaDCC 55%. 6. Preposition Incinerator for both waste management and medical waste 7. Preposition of emergency water supply storage, water treatment plant (equipment and Chemical consumable) for supporting community and health services during the disrupted /water supply shortages. | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Conduct discussions with staff, children and communities about current changes, potential for further disruption to activities and services and alternative services. 2. Work together with Child Protection staff to deliver child-friendly, age-appropriate information on correct hand washing and hygiene measures. 3. Maintain close coordination with WASH Cluster in camps and national WASH Working group for joint preparedness plan 4. Ensuring the Contingency plan modify and update it related to Covid-19 5. Develop/Adapt and Disseminate IPC protocol /WASH protocol related to Covid-19ve and ensuring all WASH staff and partner have access for their awareness and acceptance <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Planning and preparation – identification of critical Vs non-critical activities (See Program Criticality Guidance above), preposition supplies, train staff. 2. Implement mitigation measure 1 - Temporary suspension of PC3 and PC4 activities. 3. For PC1 and PC2 activities - Implement mitigation measures 3 to 4 – if the SC is unable to implement all mitigation measures due to funding, supplies, human resources – Temporary program suspension should be considered in order to minimize risk for SC staff and clients. 4. Conduct awareness raising (please use the term discussion here as explained) with staff, children and communities about current changes, potential for further disruption to activities and services and alternative services. Implementing identified intervention as per preparedness doc/mitigation plan <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary suspension of construction activities. 2. Conducting need assessment and situation analysis to identify justification , capacity and capability /technical recommendation for launch emergency WASH intervention as per Preparedness docs /response plan doc |
| Education | | | | |

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| <p>SC-supported learning spaces</p> <p>(formal schools, community-based schools, non-formal learning spaces, Early Children Care and Development Centers, adolescents/youth training)</p> | <ol style="list-style-type: none"> 1. Children and youth or teachers with COVID-19 attend learning facilities and spread the infection to other children and staff. 2. Large numbers of children in confined space which would promote the spread of a respiratory pathogen. 3. SC staff who is sick attends work and transmits the infection to others. 4. Poor environmental cleaning/lack of adequate wash facilities resulting in increased fomite transmission of COVID-19. 5. Very young children – difficulties in implementing individual level prevention measures (social distancing, no touch, hand hygiene etc.). 6. Government closes all schools and learning spaces, leading to a loss of learning, loss of social programs/support offered by the school (including access to meals), and decline in children's wellbeing 7. Teachers lose their salary/incentive if schools and learning spaces close, leading to a loss of livelihood and a reduction in the supply of teachers when schools reopen. | <ol style="list-style-type: none"> 1. Consider approaches to reduce class size and decongest learning facilities in order to practice social distancing practices (e.g. staggering start and end of the day, reduce large events, ensure minimal space between children's desks, avoid contact). 2. Implement standard operating procedures in the case of learner or teacher sickness in line with national health guidance around quarantine and isolation practices. 3. Implement hand hygiene measures. Screen participants/ visitors for a fever wherever feasible. Do not permit access to anyone who is unwell or has a fever. 4. Implement environmental cleaning and disinfection measures, including safe use and cleaning of any kitchenware, utensils and cups for food and water provided to children in the space and/or staff. 5. Government action to close formal schools (on a local, regional, or national basis) should be applied to all SC-support schools and learning spaces, including non-formal spaces that may not explicitly be covered by government policy. 6. Temporarily suspend all face to face teacher training, parent education sessions, and learners' extra-curricular activities, in order to support the social distancing intended through school closures. 7. Where SC is supporting teachers/volunteers with cash or non-cash transfers, continue to pay teachers wherever possible. Where MoE is paying teachers, advocate for a continuation of teacher payments throughout school closures. 8. Identify critical programming that must continue (ex meals to children) 9. Identify existing programme activities that can continue whilst schools are closed (for example: construction, materials development, cluster coordination). 10. Implement environmental cleaning and disinfection measures, in order to ensure schools are safe for both teachers and students to return (critical where spaces have been used as health centres) 11. Ensuring adequate wash facilities/resources are available/accessible to implement hand hygiene measures. 12. Depending on the status of community transmissions, consider implementing measures outlined above (A). 13. See Programme Framework for programmatic interventions during this phase. | <ol style="list-style-type: none"> 1. Staff trained on COVID-19 prevention. 2. COVID-19 awareness raising targeting children and caregivers. 3. Hand hygiene materials and supplies 4. Cleaning and disinfection supplies 5. Access control supplies – hand hygiene, thermoflash | <p>PREPAREDNESS <i>(When schools and learning spaces remain open)</i></p> <ol style="list-style-type: none"> 1. Consider approaches to reduce class size and decongest learning facilities in order to practice social distancing practices (e.g. staggering start and end of the day, reduce large events, ensure minimal space between children's desks, avoid contact). 2. Implement standard operating procedures in the case of learner or teacher sickness in line with national health guidance around quarantine and isolation practices. 3. Implement hand hygiene measures. Screen all participants/ and visitors for a fever wherever feasible. Do not permit access to anyone who is unwell or has a fever. 4. Implement environmental cleaning and disinfection measures, including safe use and cleaning of any kitchenware, utensils and cups for food and water provided to children in the space and/or staff. 5. Plan for potential school closures – See Programme Framework for programmatic interventions during this phase. <p>INITIAL RESPONSE AND LARGE SCALE RESPONSE <i>(If and when schools and learning spaces are closed)</i></p> <ol style="list-style-type: none"> 1. Government action to close formal schools (on a local, regional, or national basis) should be applied to all SC-support schools and learning spaces, including non-formal spaces that may not explicitly be covered by government policy. 2. Temporarily suspend all face to face teacher training, parent education sessions, and learners' extra-curricular activities, in order to support the social distancing intended through school closures. 3. Where SC is supporting teachers/volunteers with cash or non-cash incentives, continue to pay teachers wherever possible. Where MoE is paying teachers, advocate for a continuation of teacher payments throughout school closures. 4. Identify existing programme activities that can continue whilst schools are closed (for example: construction, materials development, cluster coordination). 5. To ensure education continuity and support to children's (including adolescents) wellbeing at home – See Programme Framework for programmatic interventions during this phase. <p>RECOVERY <i>(schools re-open):</i></p> |
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| Child Protection | | | | |
| <p>Child Protection Case Follow Ups – in home and in office</p> <p>Examples: follow up meetings with families and children, case conferences, in the community and/or in the CP or social welfare office</p> | <ol style="list-style-type: none"> 1. CP Case Workers/Social Workers conducting home visits come into contact with someone with COVID-19 resulting in possible infection (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 2. CP Case Workers/Social Workers with COVID-19 conducts home visit and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 8. Restrictions on movement in communities by local authorities 9. Children at risk of violence and abuse who cannot receive follow up services are placed at further risk in isolation. | <ol style="list-style-type: none"> 1. Use of telecommunications for follow-up and counselling, if feasible. 2. Conduct visit maintaining social distancing (no touch, safe distance of 2m). 3. Conduct visit outside in wide-open, well-ventilated space rather than inside the household. (Please consider with technical advisors which types of cases could be managed in this way without risking confidentiality.) 4. Where safe and appropriate, identify options for community follow up of cases – this could include by an extended family member, neighbor, etc. and should consider financial/ logistical issues (e.g. phone credit). Any community follow up should respect confidentiality. 5. Ensure strict informed consent/assent procedures are in place – if parents/ caregivers do not agree to a visit because of COVID 19, work with them to find an alternative solution. 6. Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection (depending on nature of the visit could be a facemask). 7. Strict staff sickness policy implemented – staff to not attend work if displaying cough or fever or shortness of breath. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. 8. Suspension of activities non-essential activities. 9. Conduct a risk and priority analysis on child protection cases to identify children who would be most at risk without supervision or follow up and prioritize based on options above and potentially increase follow up if at a distance, | <ol style="list-style-type: none"> 1. CP Case Workers/Social Workers trained on COVID-19 prevention and no-touch guidance, if applicable 2. Equipment for modified visits (phones, credit, etc.) <ul style="list-style-type: none"> ○ Staff safety supplies for essential visits (hand sanitizer, etc.) | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Identification of critical versus non-critical follow up 2. Develop team plan on when, how often follow ups can be adapted/ revised 3. Ensure CP Case workers have plans in place for each case and discuss with children and families what the continuity plans are during each case follow up so that children are prepared and know what to expect. 4. Develop a vulnerability and prioritization criteria for child protection cases, identify cases where children are further at risk of violence, abuse, exploitation or neglect without supervision or follow up to prioritize for preparedness planning 5. Include a gender and social inclusion gender analysis informs prioritization and planning. 6. Explore telecommunications feasibility 7. Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging 8. Procure and preposition needed supplies 9. Conduct community awareness raising about potential changes to activities 10. For Alternative Care and ICC centers, reach out to global TA for support in developing preparedness and adaptation plans as per guidelines <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Temporary suspension of household visits for PC3 and PC4 activities. 2. Household visits for PC1 and PC2 activities: Implement mitigation measures, but if unable to implement all mitigation measures due to funding, supplies, human resources, temporary program suspension should be considered in order to minimize |

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| | | 10. Ensure all staff are able to share gender and age appropriate key messages and answer common questions on COVID-19 | | <p>risk for SC staff and clients until adequate mitigation measures can be implemented.</p> <p>3. Implement telecommunications follow ups where possible.</p> <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Suspend all HH visits except for response critical, life-saving activities such as contact tracing, life-saving distributions of food or nutrition supplies (all mitigation measures must be in place), 2. Highly complex CP Cases (for example, unaccompanied children) to be followed on by social worker, case manager with COVID-19 training and personal protective materials |
| Food Security and Livelihoods (including youth livelihoods) | | | | |
| <p>Examples: VSLA, livelihood, vocational training, financial services</p> <p>See also “ALL SC supported learning spaces above” for FSL trainings and “small gatherings” for VSLA type activities</p> | <ol style="list-style-type: none"> 1. Workers conducting FSL activities come into contact with someone with COVID-19 resulting in possible infection (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) 2. Reduction in food production, price rises and other interruptions of the food and other commodities supply chain could have devastating impacts on livelihoods 3. Concerns around the availability of food and loss of income can create unforeseen disruptions and safety concerns. | <ol style="list-style-type: none"> 1. Ensure alternatives to face to face gatherings and trainings are considered 2. Ensure all staff are able to share gender and age appropriate key messages during remote trainings and VSLA gatherings (see guidance on small gatherings) 3. Develop contingency plans to change modalities between in-kind/vouchers and cash to support the needs of the poorest 4. Support the poorest and most marginalized with remote access to financial services as well as employment services 5. Monitor markets and key producers affected by COVID-19 6. Engage youth in development of innovative solutions and pay particular attention to girls' and young womens' ability to continue learning and attending remotely as they are more likely to drop out due to increased care burden and household work | <ol style="list-style-type: none"> 1. Workers trained on COVID-19 prevention and no-touch guidance, if appropriate 2. Preposition of materials/seeds/fertilizers 3. Overview of available safety nets and social protection schemes, financial and employment services for the poorest families 4. Some additional support and resources may be useful to support producers impacted by COVID-10 | <ol style="list-style-type: none"> 1. In line with advice above consider how best to provide support – perhaps in electronic cash transfers. 2. Consider suspending non-essential community monitoring activities |
| Social Protection/Cash | | | | |
| <p>Cash transfers and voucher assistance (any delivery mechanism)</p> | <ol style="list-style-type: none"> 1. Supply chain are disrupted, and local vendors are unable to restock on a regular basis: prices increase and/or items are unavailable 2. Financial services are disrupted, and our financial service providers can no longer meet the agreed service level requirements 3. Access to markets is limited by restrictions on movement in communities by local authorities | <ol style="list-style-type: none"> 1. Monitor relevant supply chains on a weekly basis, or more frequently in peaks of the emergency, through primary data collection from local suppliers or through secondary data (e.g. Cash Working Group; other INGOs, WFP) 2. Get regular updates from financial service suppliers around their capacity to deliver, and act accordingly 3. Have in place a contingency plan for switching to in-kind, which may include procuring and warehousing food parcels and non-food items 4. Keep the targeted households and the Village Relief Committees informed, possibly through channels that do not | <ol style="list-style-type: none"> 1. Food and non-food items in warehouse 2. Market monitoring tools 3. Checklist to assess financial service providers capacity to deliver as per contract 4. List and contact details of local traders of food and non-food items 5. List and contact details of focal points within Financial Service Providers 6. A staff member regularly attending national/local Cash WG 7. Phone numbers of targeted households | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Conduct awareness raising with staff, children and communities about potential changes to activities. 2. Readying of telecommunications resources <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Implement modification measures for all in-person meetings <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Suspend all types of in-person meetings. 2. Switch to e-delivery or in-kind distributions following strict guidance to avoid person to person contagion |

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| <p>Distribution of physical cash transfers and paper vouchers</p> <p>See above guidance on “Distributions and Mass gathering”</p> | <ol style="list-style-type: none"> 1. Recipients of physical cash transfers and / or paper vouchers come into contact with the virus when at the distribution point 2. Staff involved in the physical cash transfers and paper voucher distributions come into contact with the virus when at the distribution point 3. Staff with COvid-19 involved in the physical cash transfers and paper voucher distributions transmits the infection to others 4. Restrictions on movement in communities by local authorities | <p>require close physical contact (e.g. SMS, loud-speaker’s announcements)</p> <ol style="list-style-type: none"> 1. Where possible, switch to electronic cash transfers: rapidly scope market of electronic financial services and source them where available 2. Reduce number of people admitted at each distribution point 3. Design the layout of the distribution points in a way to ensure social distancing (no touch, safe distance of 2m) among attendants and staff (whether it’s Save the Children or Financial Service Provider staff) 4. Provide all distribution points with hand-sanitizers to be used before and after signing off papers and collecting cash or vouchers 5. Conduct distributions outside in wide-open, well-ventilated space rather than inside the household. (Please consider with technical advisors which types of cases could be managed in this way without risking confidentiality.) 6. Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection (depending on nature of the visit could be a facemask). 7. Strict staff sickness policy implemented – staff to not attend work if displaying cough or fever or shortness of breath. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. | <ol style="list-style-type: none"> 1. Supplies of hand sanitizers 2. Wide-open, well-ventilated space for distributions 3. Layout for safe distributions | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Identification of relevant meetings and gatherings, both for staff and communities. 2. Conduct awareness raising with staff, children and communities about potential changes to activities. 3. Readying of telecommunications resources, if applicable <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Postpone non-critical meetings (PC3 and PC4) 2. Implement modification measures for critical meetings (PC1 and PC2) and suspend all in-person mass meetings if modifications can’t be met. <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Suspend all types of in-person meetings. 2. Switch to e-delivery or in-kind distributions |
| <p>Child Rights Governance</p> | | | | |

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| <p>Social Accountability and Child Rights Reporting (monitoring and demanding rights mechanisms)</p> <p>E.g. Social Accountability groups, action planning meetings with service providers; Non-SC Complaint & response mechanisms (e.g. to provide feedback to government); consultations to monitor rights violations.</p> <p>Budget advocacy</p> | <p>As above in SC-run programme spaces and small and mass gatherings, plus:</p> <ol style="list-style-type: none"> 3. Limit on what is achievable in the short-term risks raising unrealistic expectations. 4. Service providers/duty-bearers' engagement with communities/children seen as less of a priority, demands and views of children therefore not heard or responded to. 5. Appropriate and child/youth friendly information not prioritized by government/authorities 6. Complaint/feedback mechanisms involving physical contact (e.g. complaint boxes) risk transmitting infection. 7. Risk of not including marginalised groups in new or adapted mechanisms. 8. Governments diverting financing from sectors relevant for children 9. Long term impact on inter-Governmental coordination and collaboration with civil society around child-centered policy, legislation and plans 10. Governments withhold basic information and underreport cases of infection. Governments take unreasonable actions against journalists and healthcare workers who are reporting on the pandemic. Effectiveness of communication about the onset of the disease undermines trust in government actions. | <ol style="list-style-type: none"> 1. Clear communication of the roles and responsibilities of service providers/duty-bearers, feasibility of meeting and making demands in this emergency situations. 2. Alternative complaints/feedback and social accountability mechanisms, usable by children in isolation. 3. Monitoring of rights and write up of alternative reports to not include large scale public consultations 4. Identify and engage marginalised individuals and groups, and plan for their participation in CRG processes. 5. Continue monitoring government's budgetary allocations and spending, and advocate to ensure that children's rights and needs are considered in COVID-19 measures. Also advocate that ODA is not cut down due to COVID-19 responses 6. Identify relevant secondary data (e.g. from CRSAs, CR reporting and children's consultations) and review lessons learned from other public health crises and disease outbreaks in relevant contexts to inform the response/accountability strategies 7. Offer support to local or national Government to assist coordination and collaboration on child-centred policy, legislation and plans required under a COVID-19 response. | <ol style="list-style-type: none"> 1. COVID-19 awareness raising targeting children and caregivers. 2. | <p>PREPAREDNESS:</p> <ol style="list-style-type: none"> 1. Assess criticality (PC1-4) of planned child rights activities and processes. 2. Map out and engage existing children's and youth groups/networks in early planning, risk assessment/mitigation and preparedness 3. Explore and plan for alternative meeting platforms, including the use of technology for group calls/video. 4. Raise awareness that children's rights should be protected, even in emergency situations, with government officials, service providers/duty-bearers, children, and communities. 5. Conduct awareness raising with staff, partners, children and communities about current changes, potential for further disruption to activities and services and alternative services. 6. Identify national and local government budgetary lines benefiting children, so to be prepared to monitor the lines from where funds should not be diverted 7. Support to Government to assist coordination and collaboration on child centred policy, legislation and plans required under a COVID-19 response. <p>INITIAL RESPONSE:</p> <ol style="list-style-type: none"> 1. Postpone activities assessed to be PC3 or PC4 that cannot be remote. 2. Temporary closure of SC-run forums (e.g. social accountability meetings, child rights monitoring fora) 3. Raise awareness that children's rights should be protected, even in emergency situations, with service providers/duty-bearers 4. Support to Government to assist coordination and collaboration on child centred policy, legislation and plans required under a COVID-19 response. <p>LARGE SCALE RESPONSE:</p> <ol style="list-style-type: none"> 1. Use of alternative (possibly virtual) meeting spaces. 2. Postpone activities assessed to be PC3 or PC4 that cannot be remote. 3. Support child rights reporting groups/partners to engage with and raise with Government/duty bearers (in a contextually appropriate manner and in consultation with all responding sectors) any concerns about collaboration with civil society or undermining of child rights |
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Other Crosscutting Considerations

| Program Activity | Risks | Options for Mitigation Measures | Resources Needed | Actions per Program Phase / Program Criticality |
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| <p>Community Engagement, and Risk Communication (RCCE) (See also small and mass gatherings and child rights governance for this section)</p> | <ul style="list-style-type: none"> 1.. COVID-19 will increase anxiety, tensions and rumors in communities, including about certain groups within the community 2..This can result in stigma, discrimination and violence against community groups, decreasing their access to information and services Community dialogues, action groups and other mobilization activities bear risk of infection transmission Failures in adequate community engagement as part of effective RCCE will decrease trust in the COVID-19 Response and may harm long-term acceptance of Save the Children within communities. 5. Without community mechanisms, children and communities cannot effectively contribute to response solutions and be part of risk communication feedback loops such as management of community WhatsApp groups. | <ul style="list-style-type: none"> Review contingency plans for safety of the affected population (including potentially stigmatized groups and their additional needs for services) Based on effective community entry, assess and monitor strength of misconceptions, key barriers and distrust Ensure non-stigmatizing, gender- and age-appropriate RCCE materials are available at venues/activities and that all staff are able to share key messages and answer common questions on COVID-19. Before deciding to develop new materials check here if they already exist: https://thecompassforsbc.org/trending-topics/coronavirus Work with community leaders and existing community platforms on use of SBC materials Prepare with community leaders for social distancing scenarios and select available radio, mobile and social media or other channels for remote engagement (e.g., collect phone numbers, set up WhatsApp group, and inform community members not connected digitally with physical community displays). Engage with regional/national inter-agency communication and community engagement efforts to avoid duplication. Collaborate with mHealth platforms, digital and mass media for online dissemination of information and development of feedback loop with community members including tracking of frequent misconceptions. Ensure that community engagement activities or mobile and digital channels are interactive and ask for community problem solving inputs | <ul style="list-style-type: none"> Conduct and ensure gender and social inclusion analysis informs RCCE and risk mitigation strategy) Updates COVID-19 RCCE Guidance including message harmonization for initial awareness, and Guidance to tailor RCCE for different audiences and effective community entry and trust building. Access to regularly updated RCCE materials for different audiences and in multiple language here: 'https://thecompassforsbc.org/trending-topics/coronavirus ENSURE THAT SOCIAL AND MASS MEDIA CHANNELS SELECTED AND USED ARE NOT SPOUTING MISINFORMATION THROUGH OTHER PROGRAMMING | <p>PREPAREDNESS:</p> <ul style="list-style-type: none"> Analyze context (including gender and social inclusion analysis), prioritize key audiences and a set of key behaviors and understand key barriers and facilitators for change Collaborate across teams and with other stakeholders to Develop and test, accurate, and tailored SBC materials, keeping local language and literacy levels in mind. Identify trusted dissemination approaches that are appropriate for such audience (including for children), timely, and inclusive of the most marginalized. <u>Analyze context, prioritize set of key behaviors and understand key barriers and facilitators</u> Engage with regional/national inter-agency RCCE efforts (including effective community entry and e.g., message harmonization, rumor tracking) to avoid duplication of efforts, Review existing SBC channels for reach at community levels (men, women, people with disabilities, youth and children) including social and mobile media. Map existing community groups and Conduct discussions with staff, children and communities about current changes, potential for further disruption to activities and services and alternative services. <p>INITIAL RESPONSE</p> <ul style="list-style-type: none"> Ensure rapid and sensitive communication with children and communities about changes to program activities. Reach children and communities with tailored (e.g., child-friendly and gender-inclusive) key messages through trusted and accessible channels , to raise awareness,, prevent stigma and combat rumors Assess and track strength of misconceptions, key barriers and distrust; and – paying particular attention to the groups/people who may be most impacted. Practice effective community entry and local leader advocacy to create trust Work with community leaders and existing community platforms (including children's |

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| | | | | <p>groups/networks) on use of SBC materials and to mobilize safe community systems of support</p> <ul style="list-style-type: none"> Engage with regional/national inter-agency RCCE efforts to avoid duplication of effort. Collaborate with mHealth platforms, digital and mass media for online dissemination of information and development of feedback loop with community members including monitoring of frequent misconceptions and exposure data <p>LARGE SCALE RESPONSE</p> <ul style="list-style-type: none"> RCCE Information sharing approaches shift to online platforms and methods that do not require face-to-face interaction, where necessary – taking into account access limitations faced by the most marginalized. \ Ensure all RCCE is informed by gender and social inclusion analysis, e.g. understanding of why men and boys are more impacted by the disease itself and the secondary impact of social isolation of women and girls. Ensure communication with children and communities about changes in our program activities Widely distribute accurate, accessible child-friendly and age and gender-sensitive materials through trusted channels. Track and address new rumors/misinformation that may be circulating – paying particular attention to the groups/people who may be most impacted Work with community leaders and existing community platforms (including children’s groups/networks) on use of SBC materials Engage with regional/national inter-agency RCCE efforts. Collaborate with mhealth platforms, digital and mass media for online dissemination of information and development of feedback loop with community members including monitoring of frequent misconceptions and exposure data |
| <p>Child Participation</p> | <ul style="list-style-type: none"> Risks related to small/mass gatherings limit opportunities for child participation Without child participation mechanisms, children cannot communicate with us and we may not be able to identify safe programming/safeguarding risks, quality issues and the needs of children and communities | <ul style="list-style-type: none"> See small and mass gatherings, child rights governance and risk communication and community engagement Ensure gender- and age-appropriate (including child-friendly) SBC materials/ risk communication information are available at venues/activities and that all staff are able to share key messages and answer common questions on COVID-19. Train children’s groups on use of SBC materials | <ul style="list-style-type: none"> Child-friendly COVID-19 RCCE Guidance | <p>PREPAREDNESS:</p> <ul style="list-style-type: none"> Assess criticality (PC1-4) of planned child participation activities. Explore alternatives with children. Develop and test, accurate, accessible child-friendly SBC materials, keeping local language and literacy levels in mind. Map and review existing, trusted SBC channels for reach at community levels (men, women, marginalized youth, children) including social media and mobile channels |

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| | | <ul style="list-style-type: none"> • Ensure that child participation activities or mobile and digital channels are interactive and ask for community problem solving instead of uni-directional messaging • Conduct and ensure gender and social inclusion analysis informs participation strategies • Together with children, seek innovative options for remote engagement – taking into account the realities of marginalized groups | | <ul style="list-style-type: none"> • Map existing children's groups and networks (e.g. child clubs) to engage with. • Define safe/community relevant options for information sharing, awareness raising and children's engagement in safe risk communication activities (for example: radio or online options); consult with children on their preferences. • Conduct awareness raising with staff, children and communities about current changes, potential for further disruption to activities and services and alternative services. • See: Child Rights Governance <p>INITIAL RESPONSE:</p> <ul style="list-style-type: none"> • Suspend all child participation and community engagement activities assessed to be PC3 or PC4. • With adequate risk mitigation in place, consult with children and families to understand how their lives have been affected by COVID-19 and current rumors, and adapt interventions based on that information. • Conduct awareness raising with staff, children and communities about current changes, potential for further disruption to activities and services and alternative services. <p>LARGE SCALE RESPONSE:</p> <ul style="list-style-type: none"> • Suspend all child participation and community engagement activities assessed to be PC3 or PC4. • Where possible, move PC1 and PC2 activities to use the remote communication channels identified during preparedness. |
| <p>MHPSS</p> | <ul style="list-style-type: none"> • Increased anxiety and tension may lead to acute mental health conditions or exacerbation of existing conditions, posing an increased risk of self-harm / suicide within the community • Staff themselves (facing increasing demand on services and experiencing directly the impact of the outbreak) at increased risk of burn out. | <ul style="list-style-type: none"> • Use of telecommunications for follow-up and counselling, if feasible. • Conduct visit maintaining social distancing (no touch, safe distance of 2m). • Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection. • Strict staff sickness policy implemented – staff to not attend work if displaying symptoms. Must be discussed and agreed with HR and communicated to all staff types to remove the incentive to attend work sick. • Cancellation of non-urgent services, with a refocus on ensuring remote support of more urgent presentations • Conduct a risk and priority analysis on cases to identify persons who would be | <ul style="list-style-type: none"> • Staff trained on COVID-19 prevention. • Hand hygiene materials and supplies. • Telecommunications materials (e.g. phone / computer and appropriate software) • One staff focal point for suicide risk assessment / management (who has been trained on SC protocols) • Staff-wellbeing focal point to ensure psychosocial support to staff | <p>PREPAREDNESS:</p> <ul style="list-style-type: none"> • Train all frontline staff (across sectors) on psychological first aid (PFA) to ensure emotionally supportive communication and train one focal point on suicide protocol • Explore feasibility of telecommunications • Conduct community awareness raising on proactive coping strategies and stigma reduction, ensuring access to timely and accurate information about COVID • Identify a staff-wellbeing focal point (in collaboration with HR) <p>INITIAL RESPONSE:</p> <ul style="list-style-type: none"> • Review prioritization of activities as critical vs non-critical and consider suspension of those considered not critical |

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| | | <p>most at risk without follow up and prioritize accordingly.</p> <ul style="list-style-type: none"> • Ensure at least one staff member is familiar with suicide risk management protocols and procedures (identification and basic management) and is known as the focal point for such cases should they be identified. • Ensure psychosocial support is age and gender sensitive (e.g. consider the specific impact of social distancing on adolescents) • Ensure psychosocial support is available for staff. | | <ul style="list-style-type: none"> • Support frontline staff (across sectors) to include MHPSS considerations during response <p>LARGE SCALE RESPONSE:</p> <ul style="list-style-type: none"> • MHPSS support to be provided remotely with a suspension on HH visits with an exception for critical cases (e.g. suicide management) in which appropriate infection control protocol should be observed • Widespread distribution of community messages reinforcing proactive coping strategies for stress reduction and messaging targeting parents on how to communicate with children about COVID |
| <p>Feedback and Reporting Channels (Accountability)</p> <p>For example: hotlines, feedback boxes, feedback surveys, FGDs, helpdesks, social media platforms, e-mail</p> <p><i>(more detailed guidance on individual Feedback and Reporting Channels to follow)</i></p> | <ol style="list-style-type: none"> 1. Feedback and Reporting channels involving face-to-face interaction (e.g. direct interaction with staff to share feedback, FGDs) could lead to transmission of the infection 2. Feedback and Reporting channels involving physical contact (e.g. feedback boxes) could increase the risk of transmission 3. Feedback and Reporting channels that are only remotely accessible are often the least accessible to children, and deprived and marginalized groups. 4. Lack of access to communities may make it harder to implement Feedback and Reporting channels, to follow-up and to close the feedback loop 5. Without functioning Feedback and Reporting Channels, children and communities cannot communicate with us and we may not be able to identify safe programming/safeguarding/fraud risks, quality issues and the needs of children and communities 6. A lack of functioning Feedback and Reporting channels may damage the relationship between Save the Children and children and communities (e.g. due to inaction, lack of communication, etc.) | <p>As above in SC-run programme spaces, household visits, small gatherings, and child participation, plus:</p> <ul style="list-style-type: none"> • Risk assess all Feedback and Reporting channels and identify appropriate mitigation measures (adaptation), including the de-activation of some of them (e.g. do sufficient alternative channels exist if face-to-face options are no longer feasible). • Where safe, engage children and community members in defining adapted Feedback and Reporting channels • Evaluate access of deprived and marginalized groups to adapted Feedback and Reporting channels, or to those that are not based on face-to-face interaction • Establish or strengthen Feedback and Reporting channels that are remotely accessible, such as hotlines, feedback surveys over phone, social media platforms or e-mail • Raise awareness on remote Feedback and Reporting channels) that will be available to children and communities and what they can expect in terms of our ability to handle and resolve feedback (e.g. time to respond will increase) • For any Feedback and Reporting channels that are based on face-to-face interaction: <ul style="list-style-type: none"> ○ Staff to maintain social distancing (no touch, safe distance of 2m). ○ Collect feedback outside or in wide-open, well ventilated space rather than inside the household, (assess whether this is appropriate in case of sensitive concerns) | <ul style="list-style-type: none"> • Staff trained on COVID-19 Prevention • Hand hygiene supplies and other protection materials where relevant • Telecommunications and other technology/IT systems • Contextualised/adapted Feedback Handling Standard Operating Procedures in place and known to staff | <p>PREPAREDNESS:</p> <ul style="list-style-type: none"> • Conduct risk assessments of all Reporting and Feedback channels (in consultation with CSG focal points); identify appropriate mitigation measures, including decisions on adaptation and de-activation, (where possible, together with children and community members) • Conduct awareness raising about remotely-accessible feedback and reporting channels (such as hotlines or email) that children and adults can use to share safeguarding concerns or other urgent feedback; our staff and partners also need to be aware of changes to the feedback and reporting channels available to them • Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging <p>INITIAL RESPONSE:</p> <ul style="list-style-type: none"> • Switch to remotely accessible Feedback and Reporting channels as much as possible • For face-to-face Feedback and Reporting channels which cannot be replaced with remote channels: implement mitigation measures, but if unable to implement all mitigation measures due to funding, supplies, human resources, temporary suspension should be considered in order to minimize risk for SC staff and clients until adequate mitigation measures can be implemented. <p>LARGE SCALE RESPONSE:</p> <ul style="list-style-type: none"> • Remotely accessible Feedback and Reporting channels are available and functioning; these should remain active even if project activities are suspended |

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| | <p>A lack of functioning Feedback and Reporting channels may damage the relationship between Save the Children and children and communities (e.g. due to inaction, lack of communication, etc.)</p> | <ul style="list-style-type: none"> ○ Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection • Integrate Feedback and Reporting Channels and other opportunities for children to be heard into adapted programme or response activities, such as distance learning models or community engagement via telecommunications. • Ensure child-friendly age-appropriate risk communication information is available at venues/activities and that all staff are able to share key messages and answer common questions on COVID-19. | | <ul style="list-style-type: none"> • PC1 and PC2 project activities should only be implemented if appropriate Feedback and Reporting channels are in place. If remote channels are not appropriate for the context, but face to face channels are not possible (e.g. because mitigation actions can't be implemented), going ahead with activities may place children and communities at risk and do harm |
| <p>Data collection (as part of assessments, monitoring, evaluations, etc.)</p> <p>For example: Focus Group Discussions, Surveys, learning events</p> | <ul style="list-style-type: none"> • SC staff collecting data come into contact with someone with COVID-19 resulting in possible infection (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) • SC staff with COVID-19 collects data and transmits the infection to others (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) • Individuals with COVID-19 attend a Focus Group Discussion (or other group-based data collection) and spread the infection to other people and staff (or conditions with similar symptoms, initiating COVID-19 suspicion and self-quarantine) • Restrictions on movement in communities by local authorities <p>See also:</p> <ul style="list-style-type: none"> • “Household visits” for one-to-one data collection • “Smaller meetings/gatherings” for group-based data collection • “Child participation” for child-focused data collection | <ul style="list-style-type: none"> • Review data that has already been collected for other projects or programmes that can be (re-)used, when primary data is no longer possible • Identify other sources of data (secondary sources, data collected by other organisations, etc.) that can be used to replace primary data collection • Identify and use remote data collection methods where possible (e.g. surveys done online or per mobile phone) • For any data collection through face-to-face interaction: <ul style="list-style-type: none"> ○ Staff to maintain social distancing (no touch, safe distance of 2m). ○ Collect data outside or in wide-open, well ventilated space rather than inside the household, but do assess whether this is appropriate in case of sensitive concerns ○ Provide staff with supplies for hand hygiene (alcohol hand-gel) and protection (depending on nature of the visit could be a facemask). ○ Strict staff sickness policy implemented – staff to not attend work if displaying cough or fever or shortness of breath. Must be discussed and agreed with HR and communicated to all staff to remove the incentive to attend work sick. • Ensure that all staff are able to share key messages and answer common questions on COVID-19; as well as answer key questions about Save the Children’s work <p>See for mitigation measures:</p> <ul style="list-style-type: none"> • “Household visits” for one-to-one data collection • “Smaller meetings/gatherings” for group-based data collection | <ul style="list-style-type: none"> • Staff trained on COVID-19 Prevention • Hand hygiene supplies and other protection materials where relevant • Telecommunications and other technology/IT systems | <p>PREPAREDNESS:</p> <ul style="list-style-type: none"> • Identification of critical and time-sensitive versus non-critical and time-sensitive data collection • Ensure that risks assessments include do-no-harm considerations, and responsible data management considerations, especially when collecting personal and sensitive personal data • Explore telecommunications and other technology/IT solutions for remote data collections, for example surveys done online or per mobile phone • Train staff on COVID-19 prevention, no-touch guidance, and risk communication messaging • Identify alternative sources of data – data collected from other projects, secondary sources, other organisations – that can be used if primary data collection is no longer possible <p>INITIAL RESPONSE:</p> <ul style="list-style-type: none"> • Postpone data collection that is not critical and/or time-sensitive. • Adapt critical and time-sensitive MEAL activities where necessary, to ensure remote data collection • If critical and time-sensitive MEAL activities can only take place through face-to-face interaction, ensure mitigation measures are implemented. If unable to implement all mitigation measures due to funding, supplies, human resources, temporary suspension should be considered in order to minimize risk for SC staff and clients until adequate mitigation measures can be implemented. <p>LARGE SCALE RESPONSE:</p> <ul style="list-style-type: none"> • Postpone all data collection that requires face to face interaction; use remote data collection options only or use alternative data sources. |

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| | | <ul style="list-style-type: none">• “Child participation” for child-focused data collection | | <ul style="list-style-type: none">• For PC1 and PC2 activities, identify what critical data needs to be collected and how this can be done in a safe way, with all relevant mitigation measures in place (to be identified with relevant Technical Advisors) |
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