Companion Annex:

Climate Smart Disaster Risk Management Programming during the COVID-19 Pandemic

This document is intended to provide **concise user-friendly** guidance, to be attached as a 'Companion Annex' to any future circulation of the targeted nine (9) IFRC DRR and climate-related tools[1].

When pertinent, it summarizes or points to (but does <u>not repeat</u>) existing guidance for programming during outbreaks, epidemics and pandemics.

This document is intended to be used by IFRC and National Societies, including Partner National Societies. It is also expected to be useful to a wide range of development and humanitarian actors.

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[1] The nine IFRC DRR and climate-related tools are:

1. <u>Road Map to Community Resilience (R2R)</u> and <u>Enhanced Vulnerability and Capacity Assessment</u> (EVCA);
2. <u>Community-Based Disaster Risk Reduction for Field Practitioners;</u>
3. <u>Guide to Mainstreaming Disaster Risk Reduction and Climate Change Adaptation</u>;
4. <u>Better Programming Initiative</u>;
5. <u>Building Urban Resilience: A guide for RCRC Engagement and Contribution;</u>
6. <u>Community Early Warning Systems (CEWS): Guiding Principles</u>;
7. <u>Forecast based Financing (FbF) Manual</u>;
8. <u>Climate training kit;</u>
9. <u>Public Awareness and Public Education for Disaster Risk Reduction: Action-oriented key messages for Households and Schools</u>

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1. Introduction

Purpose, audience and use

Over the year 2020, over 80 million cases of the Coronavirus disease (COVID-19) were confirmed worldwide, forcing institutions and humanitarian agencies to make changes addressing program-related safety needs. What has not changed are the risks and hazards present before the emergence of the pandemic. Climate variation, intense heat, displacement, disasters and other health-related emergencies have not slowed with the spread of this virus. Rather, the pandemic and its far-reaching spread have compounded vulnerabilities and widened existing inequalities with cumulating effects, calling for a multi-hazard approach to risk management.

This document aims to ensure that **disaster risk management programming** undertaken by the International Federation of Red Cross and Red Crescent Societies (IFRC) and its National Societies (NS) can continue safely and effectively **in the current COVID-19 pandemic context**. It is designed for IFRC and National Society staff and volunteers involved in disaster risk reduction (DRR), climate change adaptation and resilience strengthening activities, to complement other information available online [2]. Program managers, facilitators and practitioners whose work relates to community-focused disaster risk management will also find this document relevant.

This document should be **attached as an annex** to any future circulation of the most frequently-used IFRC DRR and climate-related tools [3]. It is based on up-to-date scientific information published by the World Health Organization and the U.S. Center of Infectious Disease (CDC) [4] and should be periodically reviewed as research advances and more knowledge is gained about COVID-19.

Terminology

An epidemic, as defined by WHO [5], is the "occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy". An outbreak carries the same definition of epidemic but is often used for a more limited geographic area [6]. A pandemic is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people".

Epidemics and pandemics are health threats that belong to the category of "biological hazards" [7] and are sparked either by the re-emergence of known pathogens (e.g., measles, yellow fever) that threaten new, immunologically vulnerable populations (e.g., non-vaccinated individuals), or are newly emerging pathogens such as SARS-CoV-2, the pathogen that causes COVID-19. Changes in weather and climate, vector patterns, population dynamics and human behaviour affect the emergence and re-emergence of pathogens.

The mode of transmission that leads to an infection is different for each pathogen. SARS-CoV-2, the pathogen that causes COVID-19, is carried in the air we breathe, or droplets, or to a lesser extent is

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[2] https://preparecenter.org/toolkit/healthhelpdesk/

[3] See footnote, cover

[4] WHO COVID-19 website: https://www.who.int/emergencies/diseases/novel-coronavirus-2019, CDC COVID-19 website: https://www.cdc.gov/coronavirus/2019-nCoV/index.html

[5] https://www.who.int/hac/about/definitions/en/

[6] https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html

[7] https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/definition-of-hazard/biological-hazards-epidemics/

transmitted by touching contaminated surfaces. This is called respiratory, droplet and contact transmission.

Refer to your IFRC or National Society health expert for up-to-date national and local epidemiological information and guidance.

Principles

The following principles have informed the development of this guidance:

Safety: By this we mean everyone's safety, including of staff, volunteers, local leaders, and people of all ages from the communities we aim to assist. The purpose of the Red Cross and Red Crescent Movement[8] is to protect life and health, which is exactly what this guidance is for. It is also important to remember that health is not only physical. The additional stress caused by fear, the public health measures required to control an epidemic and hearing experiences of loss, affects mental health. The guidance addresses both[9].

Inclusion: The Movement is also based on the principle of impartiality. We make no discrimination between humans on the grounds of nationality, race, religious beliefs, class, political opinions or any other factors. Through epidemics, which can exacerbate or lead to forms of discrimination, our actions must continue to provide dignity, access and the opportunity for participation for all people.

Cohesion: By this we mean the extent of connectedness and solidarity among groups in society. Epidemics can divide people through fear of passing on or getting an infection, and beliefs and practices related to avoiding and/or coping with the disease. This guidance is intended to facilitate and strengthen cohesion within and between communities, staff and stakeholders in various contexts.

Accountability: The Movement is committed to providing trustworthy and timely information to communities and collecting and acting upon feedback. The COVID19 epidemic has generated extraordinary amounts of misinformation (Infodemic[10]), and the measures to slow infection rates have reduced the possibilities for direct physical contact. This guidance is intended to enable meaningful communication and interaction in circumstances where physical contact is limited.

Localization: In line with commitments to promote local leadership of humanitarian action, this guidance supports local decision-making in epidemics based on current, sound knowledge and safe practices. We also promote localization as one way to limit transmission of contagious diseases i.e., by building local capacity and limiting movement between regions at crucial times.

Digitization: This guidance supports the IFRC's strategic commitment to using digital technologies to maximize connection opportunities between people, whether those are for sharing knowledge and skills, communicating information, or collecting data that is important for programs and services.

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[8] *https://www.ifrc.org/en/who-we-are/vision-and-mission/the-seven-fundamental-principles/humanity/*

[9] See also https://preparecenter.org/resource/staff-and-volunteers-health-and-wellbeing-health-help-desk-covid-19/

[10] As defined by WHO, Infodemic is an overabundance of information, both online and offline. It includes deliberate attempts to disseminate wrong information to undermine the public health response and advance alternative agendas of groups or individuals. https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation

Tips for using this guidance

This guidance has five sections. Figure 1 shows users how to navigate this document to find what they need.

Figure 1: How to use this guidance

I need to know more about…	✓ This guide's purpose and audience ✓ Terminology ✓ Principles	**Go to Section 1**
	✓ COVID-19 and Disaster Risk ✓ COVID-19 and the Multi-hazard Approach ✓ COVID-19 and Resilience	**Go to Section 2**
	✓ COVID-19 and Context Analysis ✓ COVID-19 and Risk Assessment ✓ COVID-19 and Contingency Planning ✓ COVID-19 and EWEA & FbF ✓ COVID-19 and Schools	**Go to Section 3**
	✓ COVID-19 and Key Informant Interviews ✓ COVID-19 and Surveys ✓ COVID-19 and Focus Groups ✓ COVID-19 and Observation ✓ COVID-19 and Mapping	**Go to Section 4**
	✓ COVID-19 and Training ✓ COVID-19 and Travel ✓ COVID-19 and Program Management	**Go to Section 5**

2. COVID-19 and Disaster Risk Management concepts

This section explains how COVID-19 relates to key concepts in climate-smart disaster risk management, namely disaster risk, multi-hazard approach, and resilience. It highlights entry points for incorporating COVID-19 into RCRC's disaster risk management programming.

2.1. Disaster Risk

IFRC uses the risk formula Hazard X Exposure X Vulnerability/Capacity[11] in its DRR and climate-related work to enable staff, volunteers and community members to analyse disaster risk and design appropriate risk reduction measures. The same formula is applicable to COVID-19 pandemic risk, as shown in the table below. This provides an entry point for NS to incorporate COVID-19 into ongoing DRR and climate-related programs and strengthen relevant capacity, as well as for new COVID-19 related interventions.

The HAZARD/ THREAT is defined by its:	EXPOSURE relates to:	VULNERABILITY relates to
- Potential of spread (transmissibility) - Virulence (individual severity of illness) - Intensity (spread) - Novel character - Symptomatic, asymptomatic and presymptomatic presentation	- Household density - Population density - Large gatherings/ festivities - Migration/mobility: for labour/holidays - Extended families/living-housing patterns - Social/labour interaction patterns	- Vulnerable groups, based on age/gender and pre-existing health conditions (cardiovascular, diabetes, obesity, pulmonary diseases) - Poor water sanitation infrastructure and inequalities in access to these services. - Poor access to reliable COVID-19 information/belief in misinformation - Public health epidemic response capacity and inequalities in accessing to existing health facilities (poor health system capacity, testing capacity, protective equipment, contact tracing, quarantine and isolation facilities) - Lack of knowledge of good hygiene practices - High food/economic insecurity - Lack of social cohesion/solidarity mechanisms/inclusiveness. - Stigmatization/division

2.2 Multi-hazard approach

IFRC's multi-hazard approach to DRM is the key entry point for COVID-19 into any existing program. This approach encourages NS to consider the interaction of multiple hazards. including health threats, and how an action intended to reduce the risk related to one hazard or threat could affect people's vulnerability or exposure to another. For example, a routine evacuation of villagers before a cyclone may increase their risk of COVID-19 if they have to remain in a communal shelter where preventive measures and physical distancing are not observed. Conversely, holding a disaster management committee meeting outdoors to reduce the risk of transmission of COVID-19 may increase exposure to extreme heat.

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[11] Adapted from Towards a Risk-informed COVID-19 Approach, IFRC 2020

2.3 Resilience

For COVID-19 alone, there are a range of evolving threats and hazards. Programs that aim to build resilience are, by nature, multi-hazard, and therefore are well-suited to incorporating COVID-19. IFRC's approach to resilience is based on strengthening the characteristics and behaviours of a community that enable it to anticipate, prepare for, reduce the impact of, cope with and recover from the effects of shocks and stresses without compromising its long-term prospects. These characteristics and behaviours are called 'dimensions of community resilience'. In the table[12] below, the dimensions are listed on the left column, and examples of actions and attributes that reduce the risk of transmission of COVID-19 are listed in the right column:

Dimensions	Relevant attributes and actions
A resilient community…	
…knows and manages its risks	• Communicates public awareness messages on preventive measures such as physical distancing and handwashing; • Has access to reliable and up to date information from official, reputable sources; • Is able to discern between reliable and unreliable information sources (e.g., disinformation on social media) • Has schools that promote behaviors that reduce COVID-19's spread, maintain healthy environments and learning operations, and support in the preparedness and potentially immediate response for when someone gets sick. • Has identified and prioritises those most vulnerable to the epidemic, particularly the elderly and those with reduced immunity or underlying health conditions RCRC working in the community • Incorporates health hazards into risk reduction and Preparedness for Effective Response programming; • Explores application of Forecast-based Financing/preventive action by tackling outbreaks before they become epidemics.
…is healthy	• Has access to quality preventive (e.g. vaccines) and curative health services, including diagnostic tests and appropriate levels of care for people infected with the virus • Has sufficient protective personal equipment (PPE) for health staff and volunteers • Has effective contact-tracing to isolate and quarantine suspected and positive cases in a timely manner • Has an effective referral system for moderate and severe cases who need clinical care • Information sharing reaches the most-at-risk individuals • Adopts timely and evidenced-based public health measures RCRC Working in the community:[13] • Adopts a One-Health Approach that considers the human-animal-environment health interface
…is able to meet its basic water and sanitation needs[14]	• Disseminates information on relevant sanitation and hygiene measures • Has access to safe and sufficient water and soap, especially for volunteers

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[12] Adapted from Towards a Risk-informed COVID-19 Approach, IFRC 2020

[13] National societies can access specific health guidance using these links:
https://preparecenter.org/resource/maintaining-essential-services-help-desk-covid-19/

https://preparecenter.org/toolkit/healthhelpdesk/ (for updated recommendations)

14 National Societies can access specific guidance on WASH using this link: https://watsanmissionassistant.org/covid-19/

	• Observes safety/PPE measures at common WASH facilities, such as common latrines/toilets, showers, water points, etc., especially for volunteers
…can meet its basic shelter needs	• Has available and accessible places for self-isolation/shielding • Has appropriate ventilation measures in place in common shelter/indoor areas • Has indoor and outdoor air quality that meets health standards. • Indicates and observes capacity limits at common shelter/indoor facilities to ensure physical distance • Observes safety/PPE and hygiene measures in common shelter/indoor facilities
…can meet its basic food needs	• Accesses nutritious and adequate food. • Applies appropriate safety protocols to observe physical distance in marketplaces, community kitchens, food distributions and other high traffic people and food related events • Practices home gardening, community gardening (physically distanced) and urban gardening, ensuring a local supply of nutritious food • Applies financial solidarity mechanisms • Has safe food delivery systems to the isolated individuals, families and communities. RCRC working in the community • Carries out/supports physically distanced/remote cash distributions to deal with secondary impacts and to facilitate preventive action - e.g. cash grants to facilitate quarantine for daily wage workers and informal sector labourers.
…is socially cohesive	• Implements effective community-based support systems • Has support systems for advocating against evictions during pandemic. • Promotes and carries out contact tracing to isolate and quarantine suspected and positive cases RCRC working in the community • Applies a Better Programming Initiative lens (RCRC programming that intentionally aims to strengthen the relationships and the sense of solidarity among members of a community) with a specific focus on the way DRM programming may inadvertently increase exposure to biological hazards
…is inclusive	• Ensures that the most vulnerable and marginalized individuals have adequate access to information and warning messages in their main languages) testing, care facilities and benefits, including appropriate protective measures. RCRC working in the community • NS staff and volunteers are trained in protection, gender, and inclusion analysis to implement inclusion measures for those at high-risk (gender/age-sensitive, excluded groups such as migrants and ethnic minorities) • Ensures at high-risk groups can influence COVID19 related decision-making processes at local and national levels.
…has diverse economic opportunities	• Ensures all the essential professionals and workers who are in touch with people use appropriate protection • National Societies and micro, small and medium businesses have Business Continuity Plans • Informal sectors business owners and workers have access to protection and prevention measures.

	• Support systems are available for micro and small business to restart after any isolation or quarantine periods.
…has well-maintained infrastructure and assets	• Can dedicate specific areas for safely distanced, public activities during the epidemic • Has adequate and accessible water and sanitation infrastructure • Has adequate health care facilities and staff.
…manages its natural assets in a sustainable manner	• Manages and disposes of waste, including biological waste such as contaminated PPE, according to up-to-date and national protocols RCRC working in the community Supports efforts to protect and/or restore ecosystems.
…is connected	• Uses appropriate technology to receive / transmit up to date information • Has effective relationships with authorities and public service providers in neighbouring areas.

3. COVID-19 and Disaster Risk Management actions

COVID-19 has brought abrupt changes to or slowed efforts planned across the world that aimed to promote climate-smart disaster risk management. This section explains how to adapt climate-smart disaster risk management actions to the COVID-19 context. It includes specific guidance on context analysis, risk assessment, contingency planning, Early Warning, Early Action and forecast-based financing, and DRM in and through schools.[15] However, it does not aim to guide the management of humanitarian response during during the COVID-19 pandemic

All of guidance provided below should be applied in accordance with nationally and locally mandated COVID-19 protocols.

3.1 Context analysis

IFRC is committed to doing a **context analysis** *to inform every program design/launch/management*, based on the principle of **do no harm**.[16] Context analysis is the simple but deliberate and rigorous effort to scan the context to find ways the planned program will influence it, and in return, how the context will affect the program. Implementing a program during an epidemic without factoring this context into the plans, may unintentionally introduce heightened exposure of individuals and communities and overlook the need for a safe programming approach.

To ensure that the contexts in which you are planning or implementing programs are carefully screened in relation to COVID-19, apply one of the following options:

- **If you have already planned a Context Analysis to guide the program design**, check *(interalia)* that it includes a scan of national and sub-national health data on COVID-19 for the areas your program is targeting or may target. Check in with your NS health expert to set up a process for you to stay informed of trends in transmission and related public health measures. Proactively adapt your programming accordingly, using the COVID-19 Data Collection Methods in Section 4 of this document and the guidance for specific program components in this Section.
- **If you are designing or implementing a program and have <u>not</u> conducted a Context Analysis**: take time to convince your peers and donors as soon as possible of the importance to anchor your program (underway or under development) in a comprehensive multi-hazard analysis of the context. This should include COVID-19 and any other hazards that may disrupt or change the path of your programming, as well as any program activities that could increase exposure, vulnerability or contribute to the hazard. Set aside time to write up your context analysis in a concise text that becomes part of the program proposal or files.

3.2 Risk assessment

IFRC and NS have traditionally used Vulnerability and Capacity Assessments (VCA) as the foundation for DRR programming. More recently, this methodology has become the Enhanced VCA (EVCA) and integrated into the IFRC guidance on resilience programming. For NS that have started a VCA or had planned to start one, the following guidance applies:

- Engage or re-engage (if activities have been put on hold) the community on the topic of risk reduction through remote/physically distanced meetings with their leaders and established safe

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[15] This section does not include guidance by sector of intervention (WASH, shelter etc.) as IFRC technical teams are developing these or have already done so.

[16] IFRC adapted this principle as the Better Programming Initiative (BPI, 1999).

communications methods, such as community radio, posters/notices in public places, and word of mouth.

- Use Section 2 of this guide to explain connections between COVID-19 and risk reduction or resilience-building to the community leadership. Explain that natural hazards continue to be a threat during the COVID-19 pandemic and the importance of a multi-hazard approach to enable the community to be prepared and resilient.
- Use Section 5 for training the facilitation team that will carry out the EVCA/risk assessment.
- Use Section 4 for data collection for the risk assessment,
- Consider a virtual workshop with community leaders to analyze the data collected during the risk assessment and prioritize actions; if this is not possible and local public health measures permit, hold a series of physically distanced meetings with community leaders and other representatives using the guidance for focus group discussions in Section 4.
- Once the community has prioritized actions, support its leaders remotely and/or through physically distanced visits to build a DRR plan, communicate it, and motivate/enable community members to start to implement it. For examples, retrofitting people's homes can be carried out by the household members, distributions of materials can be done in a physically distanced, touchless manner, and disaster management plans can be drawn up between small groups that interact safely, consulting the community via local media, virtual media and social media. While progress may be slow, these adaptations will enable NS to safely advance DRR programming during the COVID-19 pandemic.

3.3 Contingency Planning

Contingency planning is about assessing potential impact, identifying suitable capacities and resources and making decisions about preparedness, mitigation and response before hazard events occur, in order to prevent or reduce the impact. Contingency planning should be multi-hazard and in the context of COVID-19 it should follow the same steps as for other pertinent hazards (see Disaster Response and Contingency Planning Guide)[17] with the following additional considerations:

1.Inter-institutional coordination	Think broadly because COVID-19 and the measures to contain/control it affects all parts of society. Include disaster management authorities, health authorities/partners and representatives of sectors such as water and sanitation, education, social protection, commerce, industry and agriculture, and others specific to each country.
2.Hazard, vulnerability, capacity and risk analyses	See Section 3.2
3.Resource identification and mobilization	Safe programming includes the provision of enough and quality PPE for volunteers and staff based on individual risk, exposure and vulnerability. Provide training in appropriate PPE use and in relevant infection prevention and control protocols. Procure materials approved by authorities and in close coordination with them, to avoid depleting supplies needed by health workers/at the frontline. Consider working with partners and donors who specifically support risk management for epidemics.
4.Early-warning, alert systems and triggers	See Section 3.3

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[17] https://www.ifrc.org/Global/Publications/disasters/disaster-response-en.pdf

5.Linkages and communications	See Section 3.5
6.Drills and simulations	Official public health measures are likely to prevent large drills or simulations taking place during peaks of the COVID-19 pandemic. Aim for individual agency/institution-level drills – even if partial - if they can be done safely. Carry out remote/virtual adapted drills to maintain awareness and readiness.

Section 5.1 of this document provides guidance on how to facilitate meetings between actors between whom coordination is needed to produce or update the contingency plan.

3.4 Early Warning, Early Action and Forecast-based Financing

If your National Society is engaged in activities focused on providing support to **Early Warning Systems (EWS)[18]** at national and/or community levels, work with stakeholders at each level to make sure that COVID-19 is included whenever pertinent. The monitoring and forecasting data for each threat come from different technical sources and authorities. Adding new threats such as COVID-19 to an existing early warning system may require the National Society or Branch office to serve as a connector or convener between different actors or ministries (for example, those monitoring hydrometeorological threats and others focused on health/biological threats).

In parallel, for more than a decade IFRC has embraced "Early warning/early action" (EWEA) as efforts that entail the provision of timely and meaningful information enabling people to take steps to reduce the impact of hazards" including epidemics. Typical examples of early actions include directing people to shelters, protecting assets and livelihoods by early harvesting, cash transfers, and reinforcing housing or classrooms. For COVID-19, early actions may include stockpiling PPE, sanitizer, etc and staging awareness campaigns for physical distancing (see the rest of this guidance for more detail). As such, EWEA typically features multi-hazard approaches including health threats. The early actions require genuine ownership of, and participation by, communities and other stakeholders.

It is critical to screen your EWS, EWEA and Forecast-based Financing activities/programs.
- Check if it is pertinent to include COVID-19 among the targeted threats in an EWS or EWEA effort, and if updated needs assessments confirm it, lobby pertinent authorities to formally add this threat. With the support of your health colleagues, review and adapt Community-based Surveillance and other early action measures to include COVID-19 if appropriate.[19]
- Coordinate with the Ministry of Health, and Disaster Management Authorities at national and local levels to obtain and monitor key health data. The NS health experts should be able to establish if COVID-19 is critical in your location and what forecasts/warnings or more subjective/expert judgments can inform early actions implemented in a safe manner.
- If COVID-19 is already included as a targeted threat in your EWS or EWEA effort, use this and other IFRC-issued guidance (including ECV and CBS tools) to establish **lists of early actions** that are appropriate and safe to implement once a COVID-19 outbreak threshold is crossed. Response thresholds are to be aligned with Ministry of Health data, as available. Include community health promotion and community-based surveillance activities.

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[18] RCRC efforts focused on Early Warning Systems predate the concept of Forecast-based forecasting and EWS and FbF have evolved in parallel, often with little integration. Research by IFRC is in progress to find synergies between the two.

[19] See also https://www.cbsrc.org/ and https://preparecenter.org/resource/public-health-response-health-help-desk-covid-19/

Some common early actions for fast onset hazards, such as evacuations, may not be advisable due to COVID-19 restrictions. When evacuation is required, check early with health authorities on how to mobilize communities in the safest possible manner.

Use of health outbreaks in **Forecast-based Financing** is still a "work in progress". No matter the threats targeted, however, if your National Society or program includes Forecast-based Financing, carefully screen all approved Early Action Protocols (EAP) to be certain that the actions comply with good practice to protect against COVID-19.

Even if COVID-19 is not a specific target of your programs, during the COVID-19 pandemic, volunteers trained to support early actions may not be easy to mobilize due to lockdowns with curfews, etc. If COVID-19 is prevalent, make sure that a broader range of community representatives are briefed on initial actions and set up phone chains with volunteers and between them and other community members to be ready for remote instructions.

3.5 Risk management in and through schools

Education is an essential component of risk reduction and many NS DRR programs include or even focus on schools. Not only are schools where children and young people spend a large amount of time and are receptive to new ideas and information, they also serve as reference points for the wider community, even when physical attendance by children at school is not possible. As such, the staff and administrators of schools are trusted risk management actors in their communities and need to be prepared to take a leadership role .

The information included below for schools has been adapted from the Key Messages and Action for COVID-19 Prevention and Control in Schools a joint document with UNICEF, WHO, and IFRC. If your program includes schools, use it to guide decision-making and program adaptations for COVID-19.

Key Messages and Actions for RC actors on COVID-19 Prevention and Control in Schools[20]	
Governmental and non-governmental actors and RCRC should provide dedicated training and support to schools, administrators, and teachers in the following critical areas: resourcing to purchase PPE and to implement other preventive measures (e.g. physical distance), additional staff support (nurses and health staff deployed to schools for example), and time/space for teachers and staff to learn and adapt to the new norms, to enable them to:	
Basic principles	• Promote physical distancing, enforce sanitary measures, and know sources of water for hand washing.
Know the latest facts	• Be up to date on COVID-19 facts, including its symptoms, paths of transmission and how to prevent transmission • Be able to counteract fake or superstitious information
Ensure safe school operations	• Have an updated contingency plan and work with officials to ensure the school grounds are not used as gathering centres during the COVID-19 pandemic.
Establish procedures if students or staff become unwell	• Plan ahead with health authorities; have procedure and safe space for isolating sick staff or students and informing the necessary contacts for quarantine. • Educate parents/care givers to keep children in school if they are not displaying symptoms and keep them home if they are unwell.
Promote information sharing	• Coordinate and follow health guidelines from national health and education authorities, and share this information with caregivers. • Ask parents/caregivers to ensure household members wash their hands often and properly, especially before and after eating

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[20] Key Messages and Actions for COVID-19 Prevention and Control in Schools (who.int)

Adapt school policies where appropriate	• Develop flexible attendance and sick leave policies, identify critical job functions and positions, and plan for academic calendar changes
Monitor school attendance	• Track student and staff absences and alert local health authorities about large absenteeism connected to respiratory illness
Plan for continuity of learning	• Support continued access to education in the case of absenteeism/sick leave or temporary school closures
Implement targeted health education	• Integrate health literacy and inclusive-minded disease prevention and control in daily activities, clubs and lessons at all times, and scale up during periods of heightened risk. • Foster healthy habits and raise awareness of risky behaviours
Address Mental Health/Psychosocial support needs	• Encourage children and staff to address questions and concerns • Encourage parents/caregivers to respond to children's stress (e.g., bedwetting, anxiety, anger, difficulty sleeping) in a supportive way
Support vulnerable populations	• Work with social service systems, ensure the needs of marginalized populations, and examine implications for students or staff for increased risks at home or school

3.6 Communication

Communication is fundamental to enabling people to understand risks and how to manage them, a prime factor not just in disseminating information but also in establishing and maintaining relationships within the IFRC and with local communities. In this guidance, Communication includes household and community levels, public awareness raising and internal IFRC/RCRC communication.

If your DRR programming involves communication, here are some simple steps[21] you can take to support your communications in the COVID-19 context:

Public Communication
Information at the community and local levels is often in person but can take many forms, including radio and television, printed and social media, and others.

- When communicating with communities regarding COVID-19, align information to the Ministry of Health and WHO for the latest evidence-based information and epidemiological data regarding the phase of the epidemic and encourage communities to share it.
- Support the development and regular updating of a communication strategy for COVID-19 including strengthening channels to receive and respond to questions and feedback with alignment to Community Engagement and Accountability guidelines
- For any in person communications, support preventive and personal protection messages around physical distancing while following national health protocols.
- Work with community knowledge-holders including government officials, health actors, traditional healers, and formal, informal and religious leaders and their channels of sharing information.
- Assess what information the community needs to have and various platforms through which information is best shared and accessed, including social media, WhatsApp, etc.
- Be inclusive of vulnerable communities such as persons with disabilities, migrants, ethnic minorities, and prioritize those with high-risk of severe outcomes of COVID-19 such as the elderly and people with underlying chronic health conditions during the strategizing and communication process.
- Promote awareness with action-oriented risk communication that includes an instruction to follow, a behaviour to adopt, and information to share with family and peers [22]

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[21] Adapted from Community Engagement and Accountability and NS Risk Communication and Community Engagement.
[22] See Risk communication and community engagement – Annex 1 *nCov_RCCE_Guide_29-01-2020.pdf (windows.net)

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- Pilot test messaging using a representative sample of your target population to ensure information is understandable, relevant and persuasive.

Internal Communication

Internal communication occurs between RCRC staff and volunteers. These communication networks are diverse, with virtual means of communication playing a larger part than before COVID-19.

- Know your internal communication channel and how any important updates will be received or should be shared.
- Regularly share up to date key messages, public awareness messages, and evidence-based information regarding COVID-19 and its impacts on your sector/tool.
- Be aware of the mental toll and stress in changes in communication for internal members and know and have ready arrangements for mental and psychosocial support[23]
- Communicate capacity of NS to provide insurance to staff and volunteers in case of sickness (NB: in general, insurance policies for volunteers do NOT cover epidemic risk)
- Prepare for shifts in communication in moving from office, to field, or to home.
- Identify and communicate capacities of response teams within and between National Societies
- Ensure volunteers and staff are supported and adequately trained in communicating, listening, and collecting feedback

Misinformation and the unknown[24]

Technology plays crucial roles in dissemination of information during health crises, particularly during the COVID-19 pandemic; however, it also provides an accessible platform for mis and disinformation regarding the epidemic. This unverified and at times agenda driven information can lead to dangerous consumption of information, particularly for those who want a quick fix or explanation for the uncertainties and stressors of the epidemic. Mis- and disinformation, referred to by WHO as an "Infodemic[25]"; is very common during outbreaks and epidemics and the effects can be as disastrous as the epidemic itself causing distractions from health messages and distrust of RCRC services as well as risky or unwanted behavior. The Infodemic, however, can also provide a platform to collect performance feedback for the RCRC. **Always refer to international and national official and up to date information and data, such as WHO, Ministry of Health, U.S Centers for Disease Control (CDC), etc.** Refer also to the COVID-19 Health Help Desk for the latest COVID-19 data contextualized to the Red Cross/Red Crescent.

- Assess the risk that COVID-19 misinformation has on evidence-based scientific guidelines to determine the appropriate and urgency of a response
- Build on existing and trusted relationships as ways to listen and incorporate community feedback into the design and deliverance of information related to COVID-19
- Engage with local knowledge holders and community-based networks to understand why certain non-accurate messages and misinformation are taking precedence over evidence-based ones using channels such as focus group discussions, local media, or conversations with volunteers or local staff
- Work with communities to assess the accessibility of information about COVID-19 and learn about the preferred local communication channels to continue DRM communications and disseminate evidence-based information and data.

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[23] See Mental Health and Psychosocial Support for Staff, Volunteers and Communities in an Outbreak of Novel Coronavirus MHPSS_in_nCoV_2020_layout.pdf (windows.net)

[24] Adapted from Risk communication and community engagement Guidance Note— Annex 6 *nCov_RCCE_Guide_29-01-2020.pdf (windows.net)

[25] https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation

- Consider the sociocultural, economic, and environmental context in planning– crises can complicate issues of access to communication as well as foster stigma and violence against already vulnerable groups (e.g. against children, women, migrants, IDPs, etc.)[26]
- Utilize National Society rumor management systems and ensure staff and volunteers (especially community mobilizers) are informed on the latest rumours or misinformation
- Re-emphasize evidence-based and up to date messaging while also tailoring messages to address any negative behaviour related to COVID-19 and the safety of utilizing DRR information. It is essential to establish and/or maintain trust with work partners and within local communities to track misinformation, make communication channels more sustainable, and support resilient communities. [27]
- Tailor messages in respect of local beliefs and ensure messages shared in response to mis- or disinformation are being received, understood, and believed by the community.

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[26] See PRACTICAL GUIDANCE FOR RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE) for Refugees, Internally Displaced Persons (IDPs), Migrants, and Host Communities Particularly Vulnerable to COVID-19
[19] Pandemic Practical-Guidance-RCCE-Refugees-IDPs-Migrants.pdf (ifrc.org)
[27] See Community Engagement and Accountability in COVID-19 Community Engagement & Accountability in the COVID-19 Response - International Federation of Red Cross and Red Crescent Societies (ifrc.org)

4. COVID-19 and data collection

This section explains how COVID-19 affects the types of primary data collection that are part of DRR and climate-related programming, namely key informant interviews, surveys, focus groups and observation/mapping. For each one, guidance is provided on how to adapt it to programming during the COVID-19 pandemic.

4.1 General Considerations

In general, physically-distanced and safe data collection requires more preparation and management time than normal face-to-face collection. This is not only because it is relatively new to some collectors, but also because there are additional dynamics, logistics and pressures to manage, including social clues that are harder to discern at a distance. The manager will need to work with the client/donor to adapt the methodology and obtain more flexible deadlines, considerably reduce the number of expected respondent/informants and find safe alternative ways to obtain data. For example:

- Using more secondary data that was available prior to the epidemic[28] thereby reducing the need for extensive primary data collection.
- Spreading primary data collection over a longer period permits the collector to conduct more individual and small group interviews with physical distancing instead of larger, focus group discussions. It also opens up opportunities to adapt questions to what is being learned from the epidemic.
- Physical distancing during all encounters, personal and workspace hygiene, cleaning and disinfection of equipment and premises, air sanitization, and use of personal protective equipment are mandatory elements that need to be addressed **prior to collecting data**. During heatwaves, data collection using PPE may need to be slower, to allow for collectors to take cooling breaks.

In all cases of data collection, be sure to ask for consent in advance and be clear about who you are and why you are collecting information. This is no less a requirement with remote collection.

As epidemics abate, the pace and scope of in-person interactions at community-level can increase. Data collection templates suited for epidemics and outbreaks to understand local risk are made available with data gathered including health services and needs and identified communication channels and needs,

4.2 Key informant interviews (KII)

If your DRR programming normally involves interviews, what simple steps can you take to adapt those activities during the COVID-19 pandemic?

Key informant interviews (KII) are semi-structured discussions typically held between an interviewer and one or two individuals identified as informal spokespersons for a specific profile or group (for example: a religious leader, the director of a savings group, a teacher, a local merchant, a fisher, a parent, etc.). These interviewees are assumed to roughly represent a larger group of people with the same profile, or a group for whom the speaker is a more formal leader. KIIs can be of two forms:

1. In local field work for qualitative research, KIIs are **regularly conducted face to face <u>in person, or physical</u>**.
2. In national/ local efforts that include consultation with distant group of informants (neighbouring countries or informants sitting in global headquarters) and in global data collection efforts, KIIs are **commonly held <u>over the internet</u>** (zoom, teams, skype etc.) **or over cell phone technology** (both, with and without video). These are often called **remote or virtual** interviews.

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[28] For example, contributing to HDX (https://data.humdata.org/) and Missing Maps (https://www.missingmaps.org/)

While physical and remote/virtual KIIs have distinct advantages and disadvantages, **both are valid tools that can successfully collect good quality data from key informants.**

When your work relies on KIIs, please consider the following notions *to safeguard your interviewing*:

During the COVID-19 pandemic:
- **Set up remote KI Interviews whenever possible**. To help you do this, some ideas (not in any order) include:
- Whenever feasible, establish a **wide list of potential KIIs** that includes location (including time zone when pertinent), phone numbers, Whatsapp or Skype ID, and whether the informant has access to laptop or smart phone. This will provide a set of options for data collection both managed remotely and in the event of a sudden need to abruptly close a physical data collection effort.
- **Make remote KIs comfortable and create personal bonds:** Try to conduct remote KIIs using the technology most familiar to the informant; this will save you time and also makes the informant more comfortable to focus on her/his answers. When technology/bandwidth enables it, use video--at least in the first few moments or introductions. This allows the interview to be more personalized or 'intimate'. Do not assume video is always better. When video is not feasible, schedule additional time to get acquainted with the informant. Sometimes additional small talk at the start of an audio-only call can start to develop the 'positive vibrations' that a video facilitates more rapidly.
- **Articulate even more clearly and get comfortable with silence.** Audio calls, by definition, lack the ability to read facial and body language—which sometimes accelerates communication. When the attention of both interviewer and interviewee is limited to audio clues, silence becomes more pronounced; do not worry, sometimes informants need time to think.
- **Identify volunteers in/near target communities** that have greater computer or cell phone access (such as smart phones and data plans) than others around them. Explore ways you can incentivize these volunteers to serve as a conduit between the interviewer and the KI (e.g., providing top-up cards and engaging them as research assistants). Ensure they observe physical distancing and other health and safety protocols. This process is somewhat synonymous with localization.
- **When physical KIIs are retained**, always follow national health protocols and measures for prevention of contagion, which includes among others to have a stock of masks handy (i.e., one per informant) and hand sanitizer during the discussion, conduct the KI outside whenever feasible, check the health status of the people who will participate, and keep physical distance of at least 2 meters between you and the KI. Keep check-in records of contact details, in case tracing is required. If the location is experiencing high temperatures, plan your interviews at moments of each day with the lowest temperatures, such as mornings, evenings. Set up space in appropriately shaded areas outside (ideally with a breeze), wear a hat (and provide one to each KI who does not bring his/her own) and plan to have a small portable cooler with cool water that you can offer each informant.

4.3 Surveys

If your DRR programming involves surveys, what simple steps can you take to adapt them during the COVID-19 pandemic?

Surveys are a data collection technique for many IFRC processes/tools when the aim is to collect mainly quantifiable/multiple choice data from a distinct group of individuals sampled to represent a larger group. Surveys come in many forms, and all of them can produce good data when managed carefully. They can be conducted in the ways featured in Table X, starting with the formats requiring the greatest social contact and ending with those requiring least contact.

Format	Questions are…	Answers are…
a. Face to face in person	Asked by interviewer	Written by interviewer
b. On paper (handed out)	Read by interviewee	Written by interviewee
c. By SMS or on paper (mailed)	Read by interviewee	Written by interviewee

| d. By internet/email | Read by interviewee or interviewer | Written by interviewee or interviewer |
| e. By telephone (with/without video) | Asked by interviewer | Written by interviewer |

During the COVID-19 pandemic:
- Reorganize all surveys you planned face to face (a) by exploring which of the other more socially distanced options (b, c, d, or e in Table above) are safer and feasible in your context.
- Sometimes offering survey respondents multiple safe options (i.e., those in the table) will allow you to increase the response rates.

4.4 Focus group discussions (FGD)

If your DRR programming involves FGDs, what simple steps can you take to adapt them during a COVID-19 pandemic?

Focus group discussions (FGDs) are--by definition--a data collection technique that relies on social interaction. The aim is to capture general knowledge on a specific theme from individuals that share a main characteristic. In humanitarian and international programming, **face to face FGDs typically address up to 10 questions for maximum 120 minutes for groups of six to 12 people**. The private sector has long perfected the concept of virtual (remote) focus groups using technology. There are typically two forms of real-time (live) online focus groups: one managed as a text chat online and the other using video and audio.

During the COVID-19 pandemic:
- It is preferable to stop all face-to-face FGDs **unless** they can be done while keeping advised physical distance, preferably outside, and retaining the ability to hear each other for the discussion. See section on KIIs on what to do in locations experiencing high temperatures.
- If it is safer to move the **FGDs to remote.** When you do, consider the following:
  - The information from one FGD can often be reasonably obtained by 3 to 4 interviews (see KII above). This may add time to your data collection effort.
  - Another issue is that **single interviews do not typically allow you to see how participants act among themselves**. You will not be able to capture very illuminating anecdotes on how they may respond to each other. If such dynamics are important to your effort, make note of this weakness. In such a case you can introduce specific questions into an interview that asks respondents, for example, "what would you say if you heard a colleague say X?".
  - Remote FGDs also require **more preparation than in person FGD.** Plan time to carefully script many moving parts of a virtual focus group discussion.
  - **Remote FGDs rely on technology.** Make sure you have what is required and take time to make sure all participants master it.
  - Consider carefully the aim of our data collection and the profile of your target group and sample. Technology remains elitist for some segments of the society. Today, it may still exclude many individuals who do not own or master the technology, as well as others who require video to communicate (i.e., lip reading).
  - Technology-based FGDs are **typically kept smaller and shorter** (limit to 60minutes online, also with fewer questions) to be manageable. They also require additional support from a facilitator, a notetaker and an observer. Rather than track body and facial movement, the observers are responsible to track questions, raised hands and other signs from participants depending on the platform used.

4.5 Mapping

Mapping risk elements (capacity, vulnerability, hazards, exposure) is typically an activity carried out in a group discussion (FGD). For guidance on FGD, see above.   When mapping entails a guided transect walk around an area during the COVID-19 pandemic, keep the following elements in mind:

- Maintain physical distance as advised at all times.
- Carry a supply of masks, sharing one with every person that you stop to speak with. If the aim is to interact with other people, your guide(s) and you should wear a mask throughout the walk. If the community is unaware of alternatives to hand shaking, introduce the greeting gesture that is most appropriate and advised by the medical experts.
- If the goal is only to view the outdoor or indoor settings but not to discuss with others, it is still important to keep social distance between you and your guide/host(s) and wear a mask.
- In addition to your main focus/theme, take mental note as you walk of whether community members are wearing masks and physical and social distancing, and if so, which profiles and/or age groups participate. Such observations will be useful to share with your RCRC Health colleagues. If those profiles seem centred in one area, ask why and add it to the physical map created.
- If the mapping is to be used and updated frequently during the COVID-19 pandemic, include the location of clusters and any designated areas for isolation, treatment, vaccinations, etc.

4.6 Observation

Observation makes a unique contribution to a robust understanding of human behaviour across all sectors in humanitarian action/DRM. Putting an indefinite end to observation as an integral part of data collection during epidemics results in new knowledge not being generated and programs that may fail, leading to wasted resources and unrealized potential.

To enhance how **physical observations** contribute to all data collection techniques (see above) during the COVID-19 pandemic, consider the following:

- A video-based interview gives you a peek into the private space of an informant. Do not use a virtual background and ask your interviewee not to do so either. Depending on the objectives, you may ask about things you see on the video—behind them or on their desk. Try to determine what they may be looking at that you can't see through the camera.
- If video is not possible, ask informants to describe where they are, what it looks like, what the air is like, what it smells like even. What is outside their window? Ask to set up video interviews when an interviewee is in different locations (home, office, etc.) to see a different perspective.
- To compare across contexts, ask respondents to record a short video or voice memo describing a particular "scene" or reflecting on an experience immediately after it. For instance, you cannot accompany a volunteer to a village, but a voice memo reflection to you may capture some of the observations or emotions that are felt. Your interviewee could also record an in-person conversation with somebody else—a colleague, spouse, child—with the other person's permission, of course.

5. COVID-19 and type of program implementation

5.1. Training/workshop facilitator

During the COVID-19 pandemic **consider remote training/meeting options first**. Use Zoom and other platforms to deliver training and hold workshops without the need for travel, gathering people in one place, and overnight stays.
- If you decide to hold the workshop or training in-person and if temperatures permit, consider outside locations with natural ventilation such as under a large tree, in a shady courtyard, etc.
- If you must hold the workshop/training indoors:
- Limit participants in accordance with local protocols and the space available (e.g. considering how many individual tables set up 2 metres/6 feet apart the space can accommodate)
- Ventilation: choose a location with natural ventilation as the preferred option, if not feasible or possible, the use of air conditioning must be managed in complementarity with natural ventilation to ensure air flow in and out of the location and avoid internal flow only.

For all locations (outdoors and indoors):
- Provide all materials in advance so that participants can read them and come prepared, thereby focusing the time together on interactive activities rather than those that can be done alone.
- Keep check-in records of contact details, in case contact tracing is required.
- Facilitate and enforce physical distancing at all times.
- Screen participants and trainers regularly for symptoms of acute respiratory disease, check body temperature on daily basis to all participants at the entrance. Participants who present symptoms and fever above 37.5 C should not be allowed to participate in the training and must be referred to a health care provider.
- Do not permit other people to enter the training space (cleaners, servers, etc.).
- Identify where diagnostic tests can be taken and the procedures for processing.
- Identify an isolation area for suspected cases and identify the nearest health facility for referral, including the safe transportation of the suspected case.
- Maintain heightened sanitation and health protocols and preventive and personal protection measures: wearing masks at all times, cleaning surfaces and washrooms, hand sanitizing schedule.
- Use warm up exercises that do not require mingling
- Move groupwork activities to skype/zoom
- Provide food in individual portions (not buffet style) and arrange seating at least 6 feet apart ; require participants to bring their own water bottles.
- Provide materials/equipment per person.
- Allow late cancellations/dropouts in order to prevent symptomatic or exposed people attending because they already paid.

If conducting a training/workshop remotely:
- Assess the technological literacy of staff, volunteers, and partners and build in time and effort for the technological learning curve.
- Format documents to be downloaded or viewed on a computer or phone.
- Create trainings or modules centred around effective communication.

5.2 Traveller

During the COVID-19 pandemic we have seen intense community transmission of the disease. For this reason, in-country and international travel is an activity that increases exposure to the virus and therefore increases the risk of getting infected. For this reason, any DRM activity that requires travel at national or international level in the context of COVID-19 must follow a series of preventive and personal protection measures to limit the exposure to the virus and therefore reduce the risk of contagion.

During travel, these measures will depend on a number of factors but mainly on *the epidemiological situation in the country/locality of transit and arrival (e.g. number of new positive cases increasing or decreasing and the overall current incidence [# new cases per population]), the pattern of transmission (no cases, sporadic cases, active community transmission, clusters of cases limited to a specific group or area[29]) and the type of activity/work to be performed at the destination (e.g. face to face meetings, field visits, training, etc.).*

The following actions are recommended **before any type and form of travel to limit exposure to the virus** and reduce the risk of infection during an epidemic of COVID-19:

- **Assess the epidemiological situation and infection transmission pattern at transit and destination sites:** Because the COVID-19 epidemiological situation will vary among countries and also within territories of the same country, travellers should obtain up to date official local epidemiology data regarding the trend of positive cases of COVID-19 in the area to be visited: what is the current total burden of disease? Are new positive cases increasing, decreasing or stable? What is the transmission pattern in the locality to be visited? For further and detailed guidance, consult with Staff Health at IFRC or refer to your NS health expert.
- **Familiarize yourself with national and local public health and social measures that are in place to control transmission of the pathogen**: which could include compulsory use of personal protection equipment in public places (e.g., face masks), measures to facilitate contact tracing, measures to prevent gatherings, existence of curfews, restrictions of movement in public places, special considerations for the mobility of people at high risk of infection, etc.
- **Check the health status of the people that will be travelling together:** People with confirmed or suspected COVID-19 cases should be in isolation and not traveling. Anyone who has had contact with someone else confirmed with COVID-19 cases in the last 14 days should be in quarantine and not travel. People who have fever, cough and other symptoms and signs of flu-like and/or respiratory disease must not travel. People aged 60 and over, and those with serious chronic illnesses or underlying health conditions should postpone travel if they are travelling to or from a place with high incidence of cases.
- **Adequate use of appropriate personal protection equipment (PPE) at all times during travel:** such as the use of face masks, face shields, eye visor and/or protective goggles. In hot conditions, PPE should be replaced more frequently.
- **Follow personal hygiene precautions**: Wash hands frequently with soap or use an alcohol-based hand product for routinely decontaminating hands if regular hand washing with water and soup is not feasible. Clean surfaces in your seat area (e.g., tray table, armrests, window shades) with disinfectant wipes. Limit the use of on-board services (meals, duty free, even bathrooms where possible).
- **Respiratory hygiene and cough etiquette** at all times: when you cough or sneeze, always cover your mouse and nose into a bent elbow or tissue in addition to the face mask.
- Try to maintain a **physical distance of at least two metres from others and avoid any physical contact** at all times during travel. Follow established protocol for the maximum number of people allowed to travel in a vehicle.

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[29] No cases: Countries/ territories/ areas with no reported cases: Sporadic cases: Countries/territories/areas with one or more cases, imported or locally detected: Clusters: Countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures; Community transmission: Countries/area/territories experiencing larger outbreaks of local transmission.

- **Ventilate** the vehicle using natural ventilation if needed and avoid the use of air conditioning as much as possible to reduce the risk of transmission of disease via respiratory aerosol. In hot conditions that require the use of air conditioning and fans, keep a slight opening in the windows to allow air exchange within the vehicle.
- **Sanitize the vehicle** before and after travel has taken place.

The following specific measures are recommended for all travellers--before **international travel** takes place:
- **Check official national health data** regarding the epidemic transmission pattern[30] in the country of transit and destination: Refer to World Health Organization and CDC websites to get updated international travel information by destination.
- **Familiarize yourself with national and local health regulations and travel advisories** for international travellers in departure, arrival destinations and transit points, such as compulsory use of face masks, evidence of a recent negative test 48 hours prior to the trip, online health declarations, quarantine requirements and restrictions of entry of foreign nationals from specific countries.
- **Familiarize yourself with and follow the recommendations of the travel authorities** regarding policies at the airport of departure and arrival as well as of the airline for the flight.
- **Avoid as much as possible transit through multiple countries and airports** to reduce additional exposure and risk of infection.

Given the circumstances related to COVID-19, when official business travel is absolutely necessary, managers are encouraged to have individual discussions with staff about their willingness and ability to travel, taking into consideration exigencies of service, personal circumstances and risk factors for the individuals (including their family members). Managers should exercise maximum flexibility, full understanding and care during these discussions.

5.3 Manager of a project/ program with community groups

Face to face in-person activities and assessments are a significant part of capacity building for IFRC staff, volunteers and communities. National Societies collaborate across sectors, with schools, governments, civil societies, NGOs and households to prevent, prepare for and respond to disasters.

COVID-19 has required project and program managers to redesign programs. Physical distancing has called for shifts in the way facilitators conduct workshops, trainings and public awareness campaigns. Online platforms have become increasingly important to conducting programs, enabling managers to seek ways to maintain the level of engagement with staff and/or community members that occurred in person. See below for recommendations on how to adapt key aspects of program management to the context of COVID-19.

Financial management
- Request flexibility from donors to use funds differently and change timelines. Communicate the benefits of including preparedness (for any hazard, including COVID-19) in programs.
- Consider requesting/reallocating funding for response to needs created by losses to livelihoods and income-generating activities.
- Allocate a budget for additional logistical, PPE, program delivery and monitoring expenses

Human Resources
- Encourage staff and volunteers to work from home where possible, or on rotation within smaller cohorts.

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[30] See reference in footnote 23.

- Provide PPE, training and support (psychosocial if needed) to staff and volunteers who continue to deliver the program.
- Establish a self-screening and reporting protocol to be used daily.

Coordination
- Establish remote coordination mechanisms where possible, such as Whatsapp groups, zoom calls and other digital platforms.
- Coordinate with authorities for communities to have free access to medical services and testing facilities; inform communities about this and encourage them to use them.
- Identify close partners and discuss coordination efforts in epidemic risk management (e.g. government authorities, UNICEF, private sector, media, etc.)[31].
- Form a network/sub-committee of an existing group with other organisations working with the same population to share epidemic-related information. National societies can engage with the National Risk Communication and Community Engagement working group.
- Distinguish staff and volunteers in working with communities, authorities, and partners (e.g. use of clearly defined emblem for medical teams).
- Adopt a One Health[32] approach in alignment with the country's health security agenda

Assistance
- Provide assistance by cash transfer, where possible and where markets are still accessible, to avoid unnecessary contact.
- Include a health information component in the program (in any mobile communities' own languages).
- Include a PPE distribution and messaging (distance, by social media, in the communities' own language) component int the program, especially for beneficiaries who need to work but do not have sufficient resources to buy PPE.
- If aid items need to be delivered, use 'drop-and-go' delivery to specific locations or homes and coordinate pick up from there.
- Include Prevention and Control policies and procedures that support first responders.

M&E & Accountability
- Select and train (remotely) M&E monitors from within the community; coordinate with them by cell phone/social media with privacy settings to monitor key indicators and activities. Provide them with suitable PPE and funds to work safely, according to an agreed schedule.
- Establish a hotline for: general information, request for help/advice, questions and answers, complaints and suggestions. Ensure there are sufficient/scalable human resources to run the hotline as there may be more demand than anticipated.

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[31] Preparedness for Effective Response: Annex- Considerations for epidemic preparedness *PER-epi-considerations_EN_20032020.pdf (ifrc.org)
[32] One Health Basics | One Health | CDC