INTERNATIONAL RESCUE COMMITTEE

Adapting to COVID-19:
Seven stories of the IRC's response

The coronavirus doesn't respect borders… it hits the vulnerable hardest…So people living in conflict-affected countries are at considerably greater risk.

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With the support of Sida

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Introduction

Adapting to COVID-19 has been a **matter of life or death** with the pandemic affecting each of the 40 countries where the International Rescue Committee (IRC) operates[1], many of which are already experiencing complex emergencies.

In January, the IRC established a **dedicated COVID-19 leadership team** to develop a synchronized strategy and communicate key status updates. By April, sector-specific toolkits had been shared and a **six-month response plan was rolled out** by the Crisis Response, Recovery and Development (CRRD) department to support country programs' adaptations.

Figure 1: COVID-19 timeline[2]

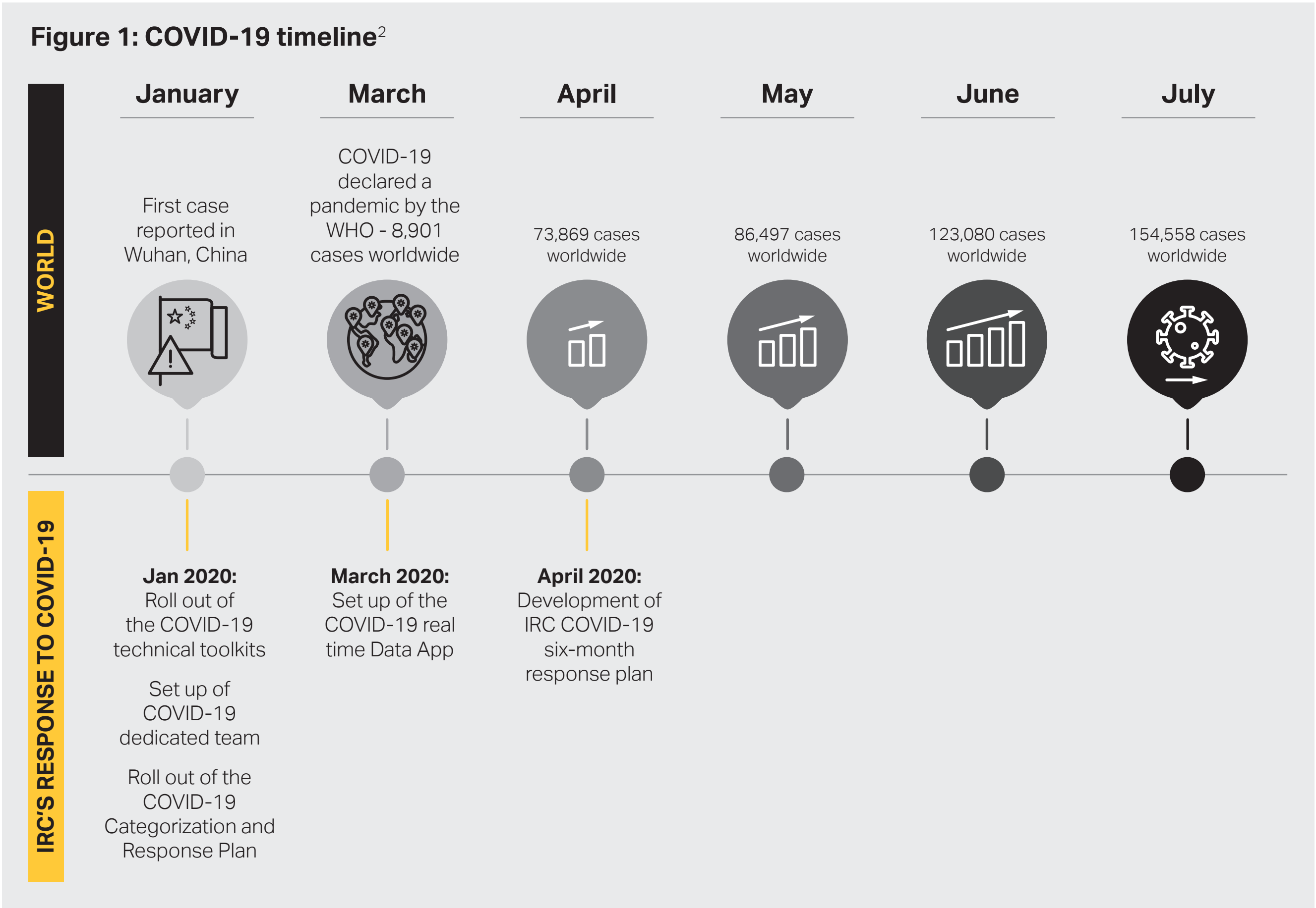
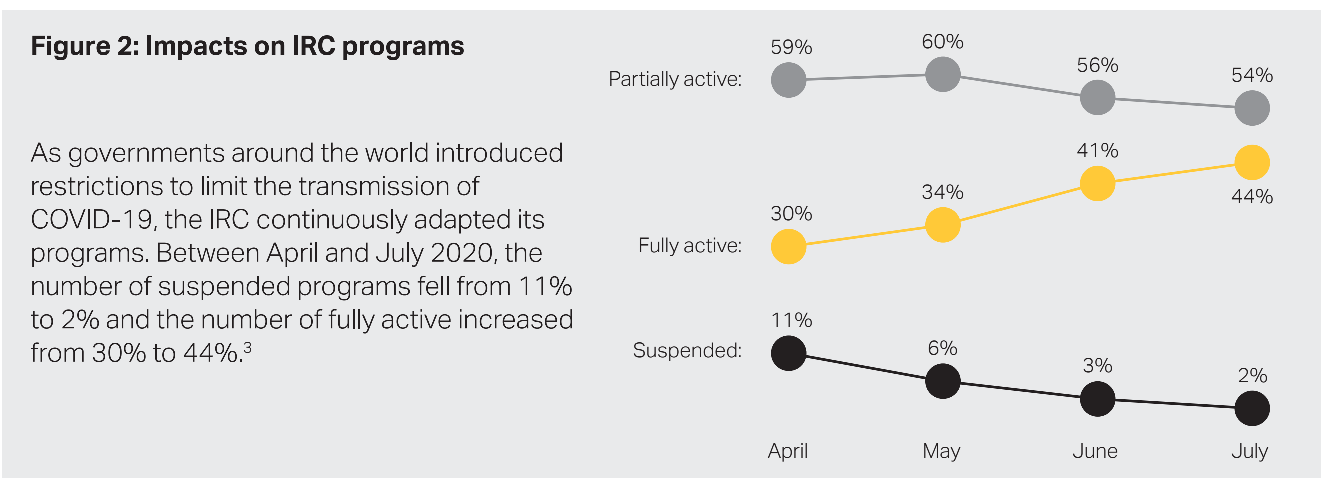


Figure 2: Impacts on IRC programs

As governments around the world introduced restrictions to limit the transmission of COVID-19, the IRC continuously adapted its programs. Between April and July 2020, the number of suspended programs fell from 11% to 2% and the number of fully active increased from 30% to 44%.[3]



1 https://www.rescue.org/topic/coronavirus-response#who-is-most-at-risk-from-the-coronavirus

2 Source for live COVID-19 stats: https://covid19.who.int/

3 Source: IRC COVID-19 Data App.

The seven stories selected for this report come from a **mapping of over 80 unique examples** of COVID-19 specific interventions documented between May and July 2020[4]. Country teams have had to adapt to the rise in COVID-19 cases and to government restrictions that have impacted the delivery of services to vulnerable populations. With the support of the COVID-19 team and technical units, changes have occurred **across IRC's global portfolio** and in **every pillar of the CRRD six-month response plan**. Country teams have developed new interventions (e.g., infection prevention and control, agriculture support, creative risk communication and community engagement), adapted pre-existing delivery methods (e.g., cash, education and training, protection case management), developed new collaborations with local, national and international actors, while coming up with new strategies to manage teams remotely and sustain our programs' quality. This report tells just **a few of the many stories** of how the IRC and partners have risen to this historic humanitarian challenge and adapted their programs accordingly.

Figure 3: COVID-19 CRRD six-month response plan and selected stories

	Contain the spread, protect communities and care for people affected by COVID-19	Meet basic and food security needs	Provide essential services
RESPONSE PILLARS	• Risk Communication and Community Engagement • Infection Prevention and Control • Surveillance and Contact Tracing	• Cash, Vouchers or in-kind assistance • Water, Sanitation and Hygiene services	• Essential health services • Mental health and psychosocial support services • Emergency case management protection services • Essential education services
SELECTED STORIES	1. Promoting children's and caregivers' resilience in the Middle East 2. Leveraging Ebola expertise and community mechanisms in the Democratic Republic of Congo	3. Adapting cash distributions in Yemen 4. Creating cost-efficient hygiene solutions in Cameroon	5. Facilitating technology-enabled education in Pakistan 6. Providing remote support to Gender-Based Violence survivors in Uganda 7. Developing telemedicine in Colombia

4 The selection process was informed by the following criteria: 1) representation of countries across our six regions of operations; 2) a range of examples across the three pillars of the response; and 3) diversity in terms of sectors and types of adaptations presented.

The seven stories of IRC's response

Safety

Health

Education

Economic wellbeing

Power

1.

In the Middle East, the Ahlan SimSim program developed interactive materials to disseminate COVID-19 preventive measures and stress management tips alongside remote early child development activities. This opened up new ways to successfully reach and build the resilience of vulnerable children and their caregivers.

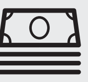
More information on page 6.

2.

In the Democratic Republic of Congo, the IRC integrated its response to COVID-19 into its larger Ebola Virus Disease programming to leverage pre-existing expertise, resources, and strong local networks. The response contributed to addressing misinformation and related fears and sustaining access to services.

More information on page 8.

3.



In Yemen, the IRC led a timely life-saving cash response by adapting and scaling up pre-existing programming. The team tested new delivery methods for enhanced support and a greater client reach.

More information on page 10.

4.

In Cameroon, the IRC developed an innovative design for a foot-operated hand-washing station, which were established near community structures to improve access to water and inclusive hygiene practices.

More information on page 12.

5.

In Pakistan, the IRC adapted a set of learning and teaching materials disseminated through various channels across the country to make home-based education a reality.

More information on page 14.

6.

In Uganda, the IRC worked closely with its partner KAWUO to set up remote operating case management to identify and reach survivors of gender-based violence confined with their perpetrators.

More information on page 16.

7.

In Colombia, the IRC developed a comprehensive outreach intervention for the delivery of primary and reproductive health care during the lockdown, including a unique telemedicine strategy, to make health care accessible to migrants and host communities.

More information on page 18.

Key lessons

The selected stories highlight the ingenuity and dedication of IRC's country teams and partners. Their ability to effectively adapt to COVID-19 has been facilitated by several success factors and has raised critical questions to consider in order to tackle future uncertainty. While it is still too early to assess the full impact of these interventions, changes that were forced upon teams and clients also opened new opportunities and solutions for future programming.

- **Strong pre-existing capacities, experiences, and resources** have laid the foundation for successful adaptive management across all teams. It encourages us to continue exploring ways to empower teams to make adaptive decisions, exchange learning, and build technical expertise on how to prepare and respond to unprecedented situations.

- **The staff willingness and dedication** to overcome their own fears and restrictions, go above and beyond their usual assignments, embrace new technology and innovate based on the changing needs and feedback from the population, has led to timely, cross-sector, and creative solutions to respond to the people's needs and sustain the provision of services. Contributors to the below stories have continuously praised the mutual support they have received from each other and from IRC technical units.

- **The ability to successfully leverage technology** to reach out to vulnerable people relies on the quality and diversity of the material and dissemination channels – as evidenced in the Middle East and in Pakistan – but also on the team's ability to develop new partnerships for appropriate technology support and the existence of well-established community networks as highlighted in Colombia.

- **Several remote delivery methods** have appeared to be more cost-efficient than traditional methods across many countries but would require further evidence of the underlying conditions of success and the impact on the achievement of our outcomes to assess when and how remote methods are the most appropriate.

- **Building and maintaining partnerships** with authorities, local organizations, and community members have been key to providing relevant and comprehensive responses, as highlighted in the DRC, but also to the acceptance and sustainability of the response, as evidenced in Uganda and Cameroon. How local networks and partners continue to be enhanced and supported, while ensuring their safety, is key to the success of future similar interventions.

- **Advocacy with local and national authorities** to recognize the full range of a pandemic's impacts on vulnerable people and the importance of interventions, such as cash support (as in Yemen) and protection (as in Uganda and the DRC), has been crucial to improve and save people's lives during the pandemic.

- **Flexible funding**, from both institutional and private donors, has been critical to support the COVID-19 responses highlighted in this report. Most country programs benefited from flexible donor support and/or accessed COVID-19 internal emergency funds. USAID enabled the extension of the Pakistan Reading Project and flexible mechanisms, such as the Program-Based Approach supported by Sida, facilitated swift needs' analysis, testing of new approaches, and appropriate iterations, as evidenced in Cameroon and Yemen.

1. Promoting children's and caregivers' resilience during COVID-19 in the Middle East

More than **6.6 million Syrians have been forced to flee their country** since 2011 and another 6.7 million have been driven from their homes but remain trapped inside the country[5]. Many Syrian refugees have found safety in neighbouring countries like Jordan and Lebanon where they constitute a significant portion of the population (15% in Jordan). In response to COVID-19, the Middle East countries instigated strict measures, such as nationwide curfews, social distancing and mask wearing, which disrupted access to services and required the regional Ahlan Simsim program to significantly adapt its approach.

Ahlan Simsim[6], a partnership between Sesame Workshop and the IRC in Iraq, Jordan, Lebanon and Syria, is a lifeline for children affected by the Syrian war, healing emotional and development wounds with critical early childhood development. As program delivery had to be put on hold for safety concerns during COVID-19, the IRC's Ahlan Simsim team shifted its approach away from group settings and home visits to pilot **digital tools and remote delivery** to reach out to refugee and vulnerable children and their caregivers. While activities were inspired by existing curricula, many of them needed to be re-designed to adapt to the new situation. Using characters and animation from the regional Ahlan Simsim TV show, the team created messages with **photos, videos, and voice notes** that caregivers

Main image: The sprawling and dusty Zaatari camp in Jordan is now home to thousands of refugees fleeing Syria's civil war – Kids with Kite, Sesame Workshop/Ryan Donnell

5 https://www.unrefugees.org/news/syria-refugee-crisis-explained/

6 "Welcome Sesame" in Arabic: https://www.sesameworkshop.org/what-we-do/shows/ahlan-simsim

received via **WhatsApp**. Caregivers could read and watch them at home to understand COVID-19 prevention measures, manage their own stress, and create a nurturing and predictable home-learning environment to foster children's resilience.

An example of a message focused on hand-washing disseminated via WhatsApp:

> *Do you know simple ways to protect yourself and your family from the coronavirus? All you need to do is to wash your hands frequently with soap and water for twenty seconds. Make the time to wash hands fun by singing a song with your child. You can also use cleansing alcohol and teach your child how to do it. When you take care of yourself, you are caring for others. Now watch Elmo wash his hands with soap and water.*

The initial response to this new modality has been very positive, with caregivers reporting that the information and tips shared had **positively influenced their interaction with their children:** they were able to teach their children the alphabet, talk about emotions, and ultimately give them the skills they need to heal and thrive. The use of local languages, such as Kurdish and local dialects as opposed to Modern Standard Arabic, was particularly appreciated and the integration of images and videos improved user experience. The pilot has **improved over time to integrate clients' feedback**. For example, the IRC is now partnering with Viamo (a global social enterprise improving lives via mobile) to ensure two-way communication between IRC teams and caregivers. As of October 2020, **21,519 children and caregivers** were reached via WhatsApp. The IRC and Sesame Workshop are now partnering with New York University on a research study and evaluation program to measure the success of their program including the new content and channels used to disseminate early child development and resilience messages during COVID-19. Results are expected in 2021.

Another example of a program adaptation involves IRC-trained **facilitators calling clients twice a week to enquire about their well-being**, communicate key protection and resilience messages (pre-defined in scripts) and provide support on responsive caregiving. These +/- 30-minute calls were also leveraged to refer children and caregivers to other IRC and INGOs' services focused on psychosocial support or protection case management where needed. The pilot, initially tested in Jordan, has expanded to the whole regional program.

> *Talia says: "I'm drawing someone washing their hands. I learnt from Elmo that you have to wash your hands for twenty seconds and I always sing the alphabet song when washing them which helps me know it's been twenty seconds"*

Against the backdrop of the COVID-19 pandemic, the successful development of **practical** new materials and the **diversity** of delivery modalities has positioned the Ahlan Simsim program for sustained reach and engagement with children and caregivers during the pandemic. In Jordan, for example, a two-week Pilot School Readiness Program was developed in collaboration with the Ministry of Education. The objective was to equip caregivers to support their children preparing for first grade during COVID-19. The program consisted of 14 phone calls of 30 minutes each covering topics like pre-numeracy, pre-literacy, and socio-emotional skills. Beyond the pandemic, this program provides a **model for potential application in other crisis-affected places** where in-person programming is often not possible. It also highlights the importance of working in partnership with partners and local actors for collective impact.

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2. Leveraging Ebola expertise and community mechanisms in the Democratic Republic of Congo

The Democratic Republic of Congo has spent decades in the grip of violent conflict and economic unrest. Since 2017, over 5 million people have been displaced and today 15.7 million need urgent humanitarian assistance[7]. The people of DR Congo have grappled with **several Ebola outbreaks** since 2018 and from April 2020 had to face the dual challenge of the COVID-19 outbreak.

Many of the key approaches in tackling Ebola, such as contact tracing, infection prevention and control (IPC), and isolating patients and suspected cases, became core to the IRC's COVID-19 response in North Kivu. The **Ebola response activities continued to be relevant**, but **small adaptations** were made to different aspects of the program to include COVID-19 prevention measures. The IRC team set up committees dedicated to COVID-19 in every location of the program to monitor the local situation and mitigation measures for rapid programmatic decisions. IRC identified five priority health facilities with high consultation rates and/or large facilities for the **extension of existing triage and isolation units** to care for patients with either Ebola or COVID-19 and strengthened referral system according to national protocols. Personal Protective Equipment (PPE) included COVID-19-specific PPE (e.g., face masks and

Main image: A health worker disinfects Case Du Salut health facility in Mabalako, North Kivu, Democratic Republic of Congo, one of the 37 health facilities being supported by the International Rescue Committee (2019), IRC - K. Ryan

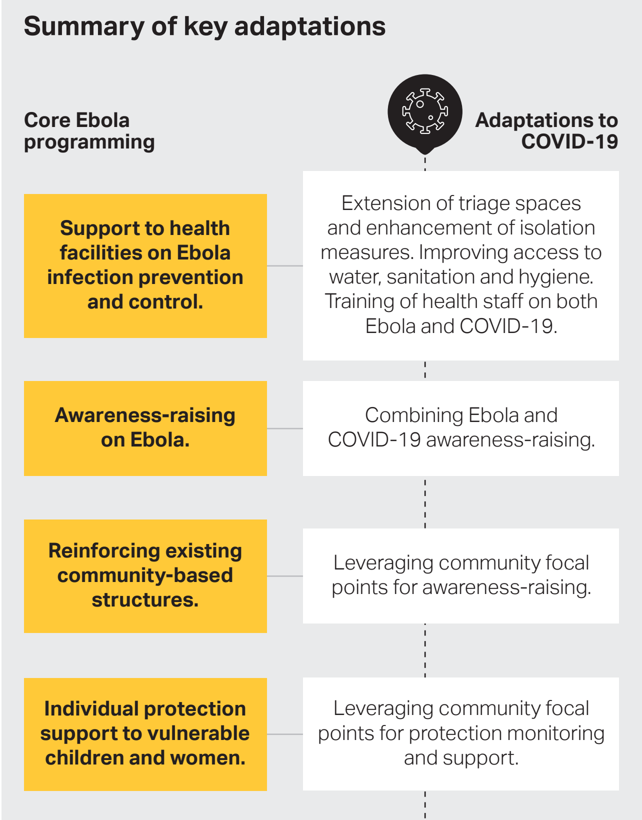
7 https://data.humdata.org/dataset/dr-congo-humanitarian-response-plan

shields, gloves) in all 54 supported health facilities including for health care and construction workers. **Hand-washing points** were reinforced in triage and patient care including through the provision of soap, chlorine and cleaning kits. **Training and supervision** of health workers and traditional healers were adjusted to include a focus on COVID-19 and on respiratory distress and hygiene (in smaller groups enforcing social distancing and with strict hygiene measures).

Using pre-existing channels for community outreach and feedback, the IRC was able to quickly identify information gaps and requests and adjust its messaging and activities to address misinformation and related fears emerging from the COVID-19 outbreak. Questions that were referred to the IRC included, for example: *Can children below 15 get COVID-19? What is COVID-19 and how to prevent it? Am I particularly at risk as a shopkeeper?* The close ties that the IRC established with the communities during Ebola as well as the communities' readiness to adopt precautionary measures were foundational to the COVID-19 response. **Community focal points**[8] played a **crucial role in building trust** by raising awareness on prevention measures, providing information on available care services, and monitoring and responding to protection concerns, which escalated with the outbreak of COVID-19. Awareness-raising messaging was adapted to combine information around both COVID-19 and Ebola and was disseminated through radio broadcast or small group gatherings. A total estimated number of 67,000 people were sensitized between January and September 2020.

Children washing hands, - material used for both Ebola and COVID-19 prevention messaging, IRC

Before the arrival of COVID-19, the focal points had already been trained on how to monitor for and respond to gender-based violence, child abuse and the impact of Ebola on vulnerable individuals. With the increased risks and restrictions brought by COVID-19 and the inability to access services in the usual way, community focal points once again became a lifeline for vulnerable individuals. In close coordination with the IRC team, they maintained **direct contact with people in need of protection services**, either by phone or in person (while respecting hygiene and social distancing measures), depending on the severity of needs, to ensure timely referral to protection and health services.



Past experiences battling the Ebola outbreak enabled the local IRC team to quickly integrate and adapt its health and risk communication and protection response to meet the specific needs of COVID-19 in North Kivu. It showcases the importance of **managing people's fears and misinformation** alongside a **holistic and inclusive response**. While facing an array of restrictions and the shutdown of certain community structures, the IRC was able to continue to disseminate crucial awareness-raising and response messages thanks to a strong community network and feedback mechanism. While the response to COVID-19 and related adaptations have been much slower in the Tanganyika province, due to the absence of experience, limited capacities, and the lack of preparation and access, it seems all the more important to **continue exploring ways to disseminate knowledge** across regions and countries and build local expertise to adequately prepare for such pandemics.

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8 Community focal points are members of existing community networks who are mobilized by IRC teams to support community engagement, risk communication and awareness raising.

3.

Adapting cash distributions in Yemen

The pandemic arrived in Yemen after more than five years of conflict. In 2019, the country was on the brink of famine and over 3.6 million people are still displaced due to the situation. In response to the outbreak of COVID-19, precautionary measures introduced by the authorities, including movement restrictions and the closure of markets, affected formal and informal business activities, disrupted access to humanitarian assistance and resulted in **increased prices of both food and non-food items**. Research findings from the IRC and the wider humanitarian sector in Yemen determined that cash assistance would save lives.[9]

Prior to COVID-19, the IRC Yemen team had built a **strong cash and voucher program**, with partner financial service providers in the governorates of Abyan, Aden and Al'Dhale[10], that had reached nearly 100,000 clients with cash and food-specific assistance. Complementing its cash program, the team had in place robust mechanisms to understand client needs and feedback, coupled with stable and flexible funding.[11] As such, it was **well-positioned to quickly adapt** when the COVID-19 outbreak was declared. Staff were equipped with personal protective equipment and trained by the health team on the importance of hygiene practices and social distancing. This allowed the IRC to capitalize on cash distributions as an opportunity to deliver key messages on COVID-19 risks and preventive measures.

Main image: Internally displaced people living in schools or other buildings in Aden city, IRC - Rachel Unkovic

9 Sources included IRC clients' feedback, the Yemen Cash Working Group (a multi organization group coordinated by OCHA), and peer organisation NRC's needs assessment.

10 In 2020, cash and livelihood programming stopped in Hodeidah due to access conditions.

11 The stable and flexible fund support included OFDA, ECHO, Sida, and private donations.

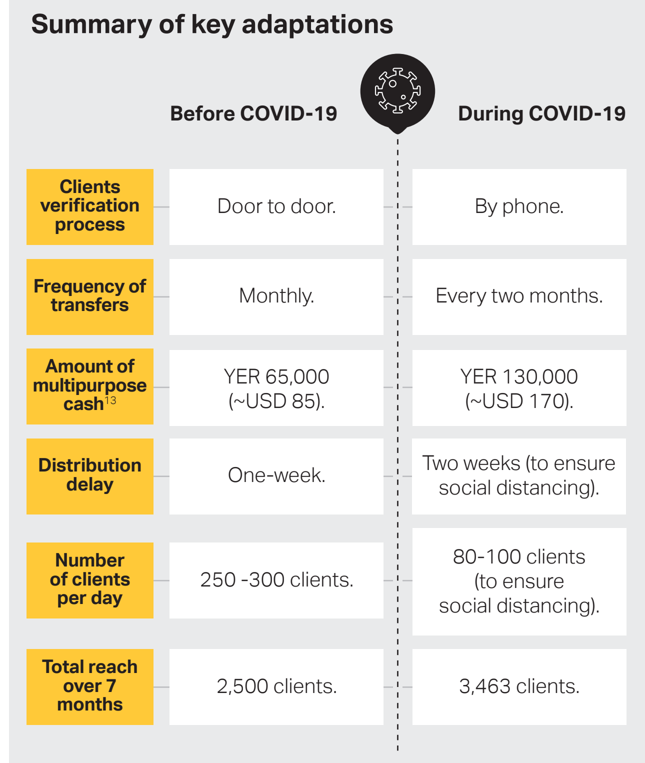
The **distributions were spread over two weeks instead of one, with a reduced number of clients per day** (80-100 per day instead of 250-300 prior to COVID-19) to ensure that social distancing and hygiene practices were followed. **Monthly distribution rounds were combined** into bi-monthly rounds to respond to clients' feedback, which indicated a need to stock sufficient food items and limit interactions at cash distribution and marketplaces. The cash distribution protocols and procedures were adapted in line with technical guidance[12]. As highlighted by the Economic Recovery & Development coordinator,

> *"the IRC released its **technical toolkit** two months before the (inter-agency) cluster. It was highly beneficial to help us adapt in a timely manner".*

The team's **advocacy efforts** also influenced the decision-making of local authorities to permit cash assistance as a lifesaving activity.

Cash distribution point in Abyan, IRC

A total of 3,463 vulnerable households affected by COVID-19 benefited from cash assistance between March and September, which is about **30% above our normal reach**. In Al Dhale, top-up emergency cash assistance was provided in March and April 2020 to a total of 1,000 households who had recently completed a six-month cash assistance program and were therefore already registered. In Aden, the identification of 1,305 vulnerable households in need was adapted, expedited, and completed before the lockdown. While it used to be conducted in person through door-to-door verification processes, during COVID-19, it was conducted **by phone** to minimize staff-client contact or through relief committees to reach the most vulnerable people (e.g., those who did not have phones). As a result, IRC's clients were able to sustain their purchasing power and none of them reported resorting to negative coping strategies (e.g., cutting back on meals). Remote processes were initially difficult for communities to adhere to, due to rumors and uncertainty, thus **local stakeholders**, such as village relief committees, were engaged in disseminating key information and reaching out to the most vulnerable people. Distribution points were also selected in close coordination with the IRC Safety & Security department and the relief committees to ensure ease of access for the targeted households.



Summary of key adaptations

	Before COVID-19	During COVID-19
Clients verification process	Door to door.	By phone.
Frequency of transfers	Monthly.	Every two months.
Amount of multipurpose cash[13]	YER 65,000 (~USD 85).	YER 130,000 (~USD 170).
Distribution delay	One-week.	Two weeks (to ensure social distancing).
Number of clients per day	250 -300 clients.	80-100 clients (to ensure social distancing).
Total reach over 7 months	2,500 clients.	3,463 clients.

The pre-existing cash program set the team up for successful adaptations in response to COVID-19 and allowed them to lead timely cash assistance in targeted areas. The IRC team's efforts working with local authorities to get permission to conduct activities, combined with adequate staff preparation to remain safe and manage remote processes, were critical to operationalize these adaptations. The integration of health, nutrition and protection awareness-raising messages played a key role in providing comprehensive assistance to the most vulnerable households (e.g., client referrals to cash and protection services). Although adaptations **meant slower processes and reaching less people at a time**, it has been a valuable opportunity for the team to understand that **changes are possible** during program implementation and **even necessary** to improve programming and maintain the relevance of our interventions. IRC Yemen's experience illustrates the importance of testing remote management and delivery tools to bring **more efficiency** to future programming in a context that often poses challenges and risks in terms of access, safety and security.

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Joel Crisco, Cash Relief Technical Advisor

12 Whereas guidance was released by the cash Cluster two months later.

13 Multipurpose cash was distributed in Aden and Al Dhale. In Abyan, cash for food was distributed. The amount of cash for food increased from YER 45,000 (~USD 59) to YER 106,000 (~USD 139). The Exchange rate was between 750 and 775 YER for one USD.

4. Creating cost-efficient hygiene solutions in Cameroon

Violence has left approximately 6.2 million people in need of humanitarian aid in Cameroon[14]. While hand-washing is one of the central means of stopping the spread of COVID-19, an assessment conducted by the IRC in the Far North of the country in February found that only 51% of respondents had access to safe water, with 62% of water points surveyed either dysfunctional or out of order[15]. Consequently, the number of people relying on each functional water point reached up to 2,215 people[16], therefore posing a **high risk that these water sources could become a point of transmission**. This analysis, together with requests from health facility staff for improved hygiene facilities, prompted the WASH team to look for new solutions to contain the spread of COVID-19.

The WASH and logistics teams worked with a local supplier to develop a **prototype for a pedal operated hand-washing station**. The purpose of the station was to help with sanitizing hands without physically touching the water tap and soap dispensers, thereby reducing the potential for contamination at public places. The station is operated by foot, therefore it is accessible to both children and persons with disabilities. It is built with locally available materials (iron tubes and motor bike brake cables), making it a replicable and sustainable solution. It was first tested by the team in Kousseri and then rolled out in the targeted communities of Afade, Biamo, Makari and Fotokol. The design was initially supported by unrestricted flexible funding, with the expansion of hand-washing stations supported by OFDA and Sida PBA flexible funding[17].

Main image: Kolofata IDP Camp, Far North Cameroon, IRC.

14 https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/cmr_hrp20_glance_2a4-en_covid_20072020_final.pdf

15 The assessment was conducted in eleven localities with concentrated displaced populations in Logone-et-Chari, Mayo Sava, and Mayo Tsanaga Departments.

16 SPHERE standards recommend the limitation of 500 people per water station.

17 The PBA (Programme-Based Approach) is a funding modality supported by Sida by which IRC receives soft earmarked funding towards country program strategy and benefits from significant flexibility to be responsive and adaptive to the evolution of needs and context.

A total of **50 systems/devices were set up** near schools, health facilities and community structures and the design was then replicated by other humanitarian peer organizations. Community volunteers or security guards – all equipped with the necessary protective equipment were responsible for orienting the population to the hand-washing stations and ensuring the supply of water and soap. A notable difference has been reported in the way community structures used and maintained the device. Community structures supported by the IRC and involved in IRC programming were more engaged in sustaining the hand-washing stations with an adequate supply of water and soap and reporting of any issues encountered.

Various iterations to the hand-washing station have been made to improve its operation and facilitate its maintenance. The size of the tank has been reduced to be more easily refilled (from 80 to 60L) and more robust materials have been identified for the taps to make them more durable. The liquid soap has been replaced by solid soap as it is five times cheaper (and with due consideration that solid soap does not transmit diseases). COVID-19 awareness-raising sessions were mainstreamed in all IRC program activities with posters located next to the stations.

As highlighted by Avbadam Seini, Deputy Head of Biamo Health Center:

> *"The presence of these hand-washing stations at the Biamo Health Center will help prevent and fight against COVID-19. This project came at the right time.... My community is facing health and hygiene problems; in the past, we did not have hand-washing facilities at the health center for patients and visitors.... I am aware of the importance of handwashing to reduce the risk of illnesses related to poor hygiene. We have made sure that all visitors and patients at the Biamo Health Center use the hand-washing kit."*

Biamo – Use of the hand-washing station by a woman, IRC.

The IRC Cameroon team's focus on client-centered solutions, coupled with the availability of unrestricted flexible funding, made this timely innovation possible. The solution is **cost-efficient and locally sourced**, and it promotes more **frequent and inclusive** hand-washing practices. Similar devices have been developed in other IRC programs, such as Colombia. Improvements will continue to be made based on the clients' and partners' feedback and other programs' lessons learned - to make the station more durable, user-friendly, and sustainable. While the device could be easily replicated in all WASH interventions in the future, sustainability aspects need to be thoughtfully considered from the start.

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5.

Facilitating technology-enabled education in Pakistan

Pakistan's long-lasting challenge of ensuring that school-age children attend, stay, and learn in school has been further exacerbated by the four months of school closures during the COVID-19 pandemic. While such closures helped enforce social distancing measures, they had a **considerable impact on students' learning nationwide**. It was estimated that potentially *"79 percent of children will not learn to read by age 10, up from 75 percent last year."*[18] This situation required the Pakistan Reading Project (PRP) team to make urgent adaptations to ensure that thousands of children and teachers were able to continue to read and learn while at home.

The Pakistan Reading Project (PRP) is a seven-year project aimed at improving learning and reading outcomes through improved classroom learning environment, education policies, and community-based support. In close partnership with the Government of Pakistan, the project was completed in June and achieved its expected outcomes by reaching 27,176 teachers and 1,716,502 grade 1-5 learners and strengthening government systems across the seven provinces of Pakistan, which resulted in a policy change around reading time allocation[19]. However, achieving their goals did not stop them from making further impacts. During the pandemic, the PRP team **utilized technology to deliver educational content, along with COVID-19 awareness messages**, through diverse mediums, including WhatsApp, SMS, interactive voice response (IVR) system, and online webinars.

Main image: Over one million houses have been destroyed by floodwater, leaving an estimated eight million people homeless. 2019, Swat Mingora

18 http://documents1.worldbank.org/curated/en/515601602051102483/pdf/Learning-Losses-in-Pakistan-Due-to-COVID-19-School-Closures-A-Technical-Note-on-Simulation-Results.pdf

19 https://www.pakreading.org.pk/en/who-we-are-0

To accommodate different needs due to varying levels of knowledge, literacy, internet access, language skills, and preferences, they produced content in **various formats and seven different languages**, including Urdu, Sindhi, Pashto, Balochi and English. For example, they started recording stories in an audio format and disseminating through the IVR system, an automated storytelling system, to include people who do not have smart phones. The IVR allowed people who use landlines or other phones to dial in and select their preferred stories in their primary language. IVR dial-in information was sent to 47,000 recipients. A total of 88 stories were shared and they were accessed by 70,000 recipients.

In addition, the PRP leveraged the **WhatsApp mobile platform** to channel both the key information about COVID-19 safety measures and educational content, including decodable stories and video and audio stories. The PRP WhatsApp channel gained substantial viewership and it was accessed 570,000 times by the end of the initiative in September 2020. Additionally, the PRP team organized **16 online webinars for teachers' professional development** during the pandemic on key knowledge refresher topics, such as "Fluency with Comprehension," which engaged 2,432 teachers of which 1,460 were male and 972 were female. The first webinar had 25 teachers in attendance, which then gradually increased up to 500 teachers regularly attending the sessions. The recording of the webinars was shared with around 48,000 recipients and viewed by 1,200 users. Teachers acknowledged that the content of the webinars helped improve their reading instructional practices.

The PRP's adaptations demonstrated to the Government of Pakistan **how different technologies could be used** to increase reading and learning outcomes. For example, the project developed ten reading lessons for the Federal Director of Education TV channel that was used for distance teaching during the pandemic. Reading materials and stories commonly appeared on the official websites, TV channels, textbooks, and curriculums. Dr. Naeem

Reading materials and video stories available on www.pakreading.org.pk

Sohail, who led the project, linked the success of this project to how they leveraged technology and existing resources to create awareness and engage children for reading and learning activities. For educational programming, it is crucial to consider the **entertainment aspect** as it was evidenced that PRP stories that had more visuals and animations were more impactful. Another key takeaway was to effectively use **multiple mediums at a time** to ensure that our programs reach different segments of the population. The PRP's experience illustrates the team's ingenuity and flexibility that helped them adjust conventional approaches when the pandemic posed numerous practical challenges – from limited access to time constraints and financial difficulties. The PRP experience exemplifies how using technology can be more **cost-effective** compared to the traditional ways of disseminating information, such as conferences and in-classroom activities, and it can be scaled up to reach more communities.

Contributors:

Dr Naeem Sohail, Chief of Party, Pakistan Reading Project

Albino Luciani, Measurement Action Coordinator

6.

Providing remote response to Gender-Based Violence survivors in Uganda

Every year in Uganda more than one million women are exposed to Gender-Based Violence (GBV)[20]. With the nationwide lockdown instituted by the government and Ministry of Health due to the outbreak of COVID-19, survivors were confined in the same space with perpetrators, which made it harder for them to seek support discretely if at all. As a result, the number of **cases of intimate partner violence dramatically increased** in the Karamoja sub-region[21] and so did the number of survivors supported by the IRC and its partner KAWUO (figure 4 on next page). The breakdown of incidents between January and September 2020 included: 90 survivors of rape, 26 survivors of sexual assault, 326 survivors of economical violence, 498 survivors of physical assault, 79 survivors of forced marriage and 227 survivors of psychological abuse.

The situation of Intimate Partner Violence survivors was further exacerbated by transport restrictions and poor access to contraceptives, family planning services, and legal support. The urgency of the pandemic **overrode Gender Based Violence (GBV) issues on the government's agenda**. This urged the IRC and its partners to think creatively and act swiftly to support the women and girls in a safer manner without exposing them to more risks and harm.

Since the beginning of 2015, the IRC has been closely collaborating with the Ministry of Health, the Ministry of Gender Labour and Social Development and the Karamoja Women Umbrella Organization (KAWUO)[22] to respond to GBV by developing strong district and community networks and improving the quality and accessibility of clinical care and GBV services for survivors. To sustain safe access to critical GBV

Main image: Women in Karamoja, IRC, C.Watson

20 According to the 2016 Uganda Demographic and Health Survey, up to 22% of women aged 15 to 49 had experienced some form of sexual violence in Uganda: https://www.un.org/africarenewal/news/uganda-violence-against-women-unabated-despite-laws-and-policies

21 The figures are reported by KAWUO and uploaded into the national GBV database.

22 KAWUO is a women's network created in 2007 by grassroots women in Uganda.

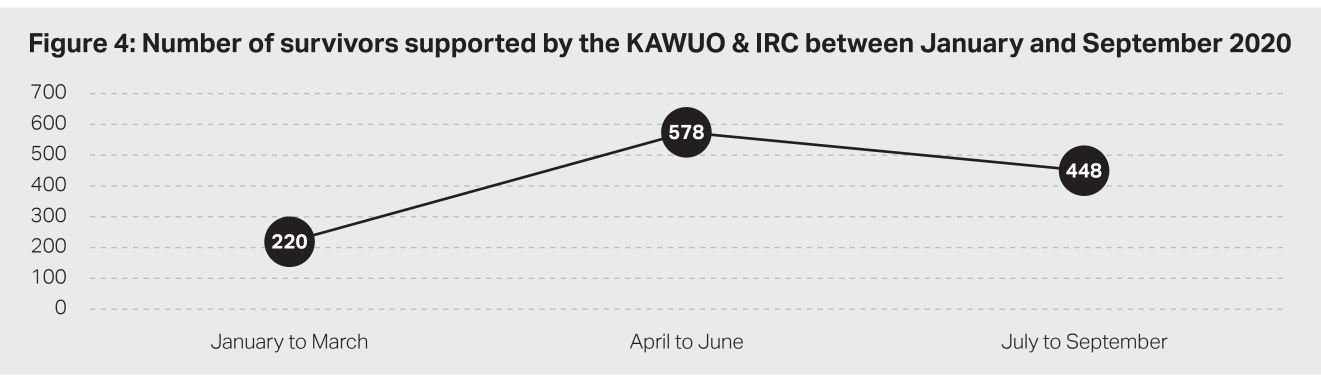

Figure 4: Number of survivors supported by the KAWUO & IRC between January and September 2020

services during COVID-19, the IRC and KAWUO started implementing **remote case management** aimed at providing **psychosocial and medical support** to survivors as well as support to those seeking **legal redress**. The KAWUO team was trained and regularly coached by the IRC's technical team via bi-weekly **teleconference calls** (to overcome poor internet connection) on key topics requested by KAWUO such as GBV guiding principles, data management and protection, survivor-centred case management, collaboration, and networking.

KAWUO's 617 women groups, officers and volunteer community-based case managers effectively sustained **awareness-raising efforts and advocated** for GBV services to remain high on the local district agenda despite COVID-19. They directly engaged with survivors to establish **'verbal passwords'** at the beginning of every call, which is meant to signal that it is not safe for the survivor to speak on the phone. When the password is used, the caseworker re-directed the conversation to other topics – such as COVID-19 preventative measures – at times even inviting the perpetrator to join in, to deter suspicion that could expose the survivor to further abuse. Another innovation that KAWUO is implementing is the use of a **'phone beep system'**. Depending on the number of times that a survivor 'beeps' the caseworker, the latter knows how to respond accordingly. KAWUO was able to rely on **strongly established networks of local stakeholders** that include police units specialized in GBV and legal issues for legal support, religious leaders, SASA! Activists[23] and male champion groups for community outreach and sensitization, Boda Boda (a term for motorcycles) for survivors' transportation, health facilities, and the COVID-19 district task force for comprehensive health service provision. As of September 2020, 1,246 survivors have been individually supported (e.g., with medical information, transportation, provision of dignity kits) and referred to different service providers, including legal, police and health and livelihood actors.

As Thomas Odelok, the head of KAWUO highlighted,

> ***"the IRC and KAWUO have worked as one*** *organization to continue supporting survivors during COVID-19".*

KAWUO Women's network in Uganda

The long-standing engagement of both organizations in the targeted communities, combined with the teams' resilience and commitment to continuously adapt and respond to the needs of the affected population, have helped them successfully overcome restrictions and the exacerbated needs of survivors and women and girls. For both organizations, this experience has reiterated the importance of **working closely with community representatives** to enhance the interventions' acceptance and relevance. It also calls for a collective reflection on **how to best anticipate and prepare for changes** in the future when designing strategic program orientations while keeping our staff safe in any circumstances.

Contributors:

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Babra Kulume, IRC Senior Manager, Women Protection

Harriet Kezaabu, Gender-Based Violence WPE Coordinator

Caroline Lai, Deputy Director of Programs

23 SASA! Is a community mobilization approach developed by Raising Voices in Uganda for preventing violence against women and HIV.

7. Developing telemedicine in Colombia

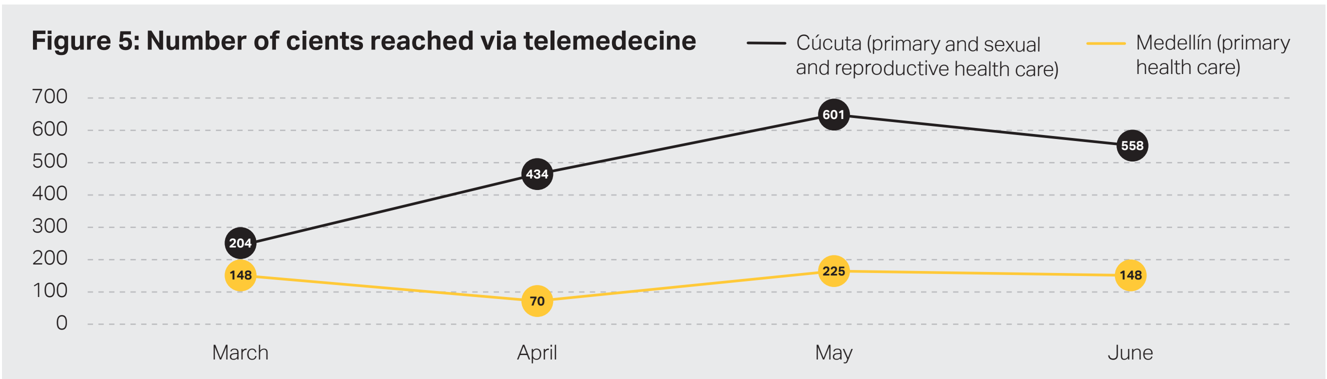
An estimated **1.3 million Venezuelans have sought safety in Colombia**, with more than 35,000 reaching official crossing points every day to work, purchase food, and receive vital medical assistance. Colombia's government locked down the country in late March in response to COVID-19.[24] Movement restrictions made it even more difficult for vulnerable people – migrants and host communities – to access basic health and reproductive health services. In addition, thousands of Venezuelans have been heading back to Venezuela by foot as they were no longer able to work, therefore increasing the number of people entering and leaving the country, and thereby increasing the risks of transmission.

One week after the lockdown was declared, the IRC team had come together to define a new outreach strategy. It was decided to maintain minimum direct health care services (with appropriate social distancing measures), but also to develop a **complementary and comprehensive telemedicine strategy** to ensure the continuous provision and accessibility of medical care for migrants and host communities already benefiting from IRC services. Phone messages and informative flyers were disseminated about the availability of services and two phone lines were activated. To respond adequately to the crisis, the IRC Colombia team hired more staff, and all staff members were trained in telemedicine[25]. When clients called, they were either attended to immediately or given a medical phone appointment for later. In cases when specialist care and medicines were required, the team coordinated with health service providers it had longstanding

Main image: Simon Bolivar Bridge, Colombia. IRC, Herman Volker

24 https://covid19.who.int/region/amro/country/co

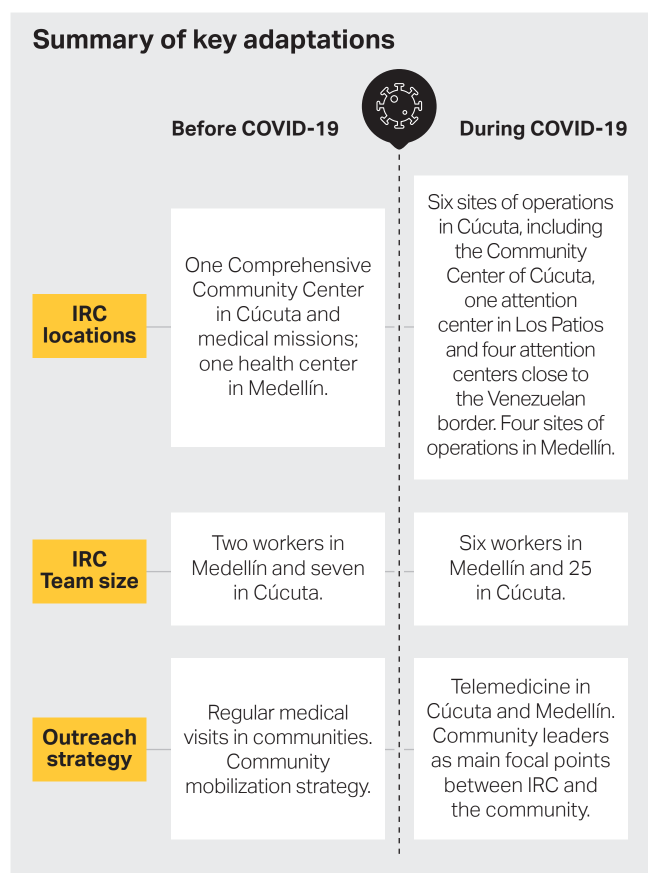
25 Training was delivered over July and August by the University of Caldas



relationships with. Medicine was available from multiple locations in the city for ease of access to clients. Beyond leveraging technology, the use of **community networks** (developed through a community mobilization strategy in Cúcuta and Medellín) was also critical to locate people and disseminate information about the existing services and COVID-19. The IRC leveraged social networks and WhatsApp to maintain communication with leaders and grassroots organizations and to help clients access remote services.

In addition to telemedicine, the IRC's health team and the **number of operation points more than doubled** during COVID-19. Health services, including COVID-19 testing, were provided closer to the Colombia-Venezuela border to attend to migrants and returnees. These services were provided in close coordination with the Departmental Health Service and complementarity with other organizations. In May and June, 4,000 people benefited from these services at the border. The operations team doubled its efforts to keep up with procurement and logistical needs, including personal protective equipment stock for staff and partners, hygiene kits, food baskets, educational material, daily transportation, and meals for health staff who were deployed in different sites.

This story showcases a unique experience of providing health services in a socially distant manner, which kept beneficiaries and health care providers safe from COVID-19. Like any health service, this modality requires **active promotion in the community through local leaders and existing patients as entry points to community networks**. There are challenges to be overcome in terms of access to technology for patients as well as in ensuring the continuous operations of a **"call center"**. The IRC needs the appropriate technology tools to effectively manage the volume of incoming calls and follow up with patients through social network profiles and software.



Looking forward, the field manager in Cúcuta highlighted

> *"the importance of addressing structural issues and continuing advocacy efforts to achieve more stable and sensitive care services for migrant populations during pandemics. Migrants settle in vulnerable communities; it is therefore necessary to reflect on how to effectively sensitize the population to prevent health issues and enhance the social fabric".*

Contributors:

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