**IRC COVID Readiness and Response**

**Concept Note**

6th March 2020

**Situation description**

The 2019 novel coronavirus, now officially named COVID-19 by the WHO, is a new virus that causes “flu-like” illness in people and can spread from person to person. However, at the time of writing, COVID-19 has a higher case fatality compared to influenza, and appears to be more infectious. This virus was first discovered in December 2019 in a seafood market in Wuhan, China. On 30 January 2020, the WHO declared a Public Health Emergency of International Concern for the current COVID-19 outbreak. Now with more than 100,000 cases in at least 83 countries, the outbreak is evolving rapidly and showing no signs of slowing. Over the past week there has been a surge in new cases outside China, including more than 36 countries reporting first confirmed cases of COVID-19. Large clusters of cases of local transmission are reported in Iran, Italy, and South Korea. While not officially declared a pandemic, because of its rapid spread and global nature, the WHO has since advised to prepare for a pandemic. The IRC believes early action in planning, preparing for, and responding to a pandemic is essential, and has thus already pivoted towards pandemic mitigation and response.

By definition, the impact of a pandemic is far-reaching. Pandemics can overwhelm the resources of a society and affect the availability of routine services and supplies, with the impact being felt across a broad spectrum of sectors: human health, livelihoods, governance and security, social and humanitarian needs, and entire economic systems. Of particular concern for humanitarian actors, the IRC expects to see high illness and potentially high death rates, overstretched health facilities and systems, and a disproportionate impact on vulnerable populations and countries with weak health systems. As the outbreak continues, the interruption of public services, food and income loss from decreased economic activity, and subsequent deterioration of coping and support mechanisms will mean greater need for humanitarian assistance, while actors will be facing higher barriers to delivering aid safely.

To mitigate the multiple impacts of the outbreak, urgent action is required on unprecedented scale. The IRC’s programmatic response strategy has two pillars: 1) adapt our existing programs to ensure the continuity of life-saving activities and that our approaches do not place clients at greater risk of contracting COVID-19 and 2) where possible, scale up frontline response in local communities where we work to further mitigate the effects of, and respond to, the outbreak. At the same time, we will take immediate steps to safeguard our staff. **The estimated cost of these measures over the next six months is $28.8 million.**

**Initial analysis**

As a new virus, the outbreak trajectory cannot be predicted with certainty. Planning is based on the current knowledge of COVID-19 and evidence available on mitigating the impact of a moderate-to-severe influenza pandemic, as the best available model. While difficult to predict, we anticipate all global offices and programs will be affected, with significant portions of target populations of our humanitarian activities impacted as well.

The IRC will need to make significant investments to fulfil its duty of care and adapt its ways of working, including for technological investments needed to enhance remote collaboration and communication; for staff absences that would typically be disallowed by grant funding, and for rapidly updating technical guidance for our programs as we learn more about COVID-19.

A pandemic may come in waves of varying intensity over time. These waves do not happen at the same time or to the same extent in every part of a country, so the IRC will implement measures at different phases and in different places at different times throughout this outbreak. The IRC’s COVID-19 risk categorization index (attached) will be utilized to identify the most appropriate time for implementation of mitigation measures from a catalogue of key activities. This will require dedicated technical support at a global level to conduct constant monitoring, updating and dissemination of the latest analysis and guidance. All 44 offices will require some basic supplies and additional staffing to ensure appropriate office controls and cleaning measures, as well as information and communications technology (ICT) support to enable remote work where necessary as a social distancing measure. We anticipate 12 country programs without health programming will have to make program adaptations at a lower cost, while 16 country offices with existing health programs will require significant stocks of personal protective equipment (PPE) and increased technical support to make more significant changes. Resettlement and integration offices will face their own challenges, including increased messaging needs to inform clients of risks and protective measures, as well as providing hygiene and quarantine supplies to clients who made need them.

Finally, unlike other emergencies, the capacity of the IRC to ensure continuity of services will be most related to human resources. For an influenza pandemic, we would estimate 30% of the total workforce to be affected in some capacity. As such, the IRC estimates that in the next six months, significant portions of our staff will be required to self-isolate for 14 days at least one time due to potential exposure; become infected with COVID-19 and need to seek treatment; or be asked to work from home for an extended period.

**Outline of intervention strategy and activities**

Based on the IRC’s experience in both recent Ebola outbreaks and technical knowledge of both the medical implications of disease outbreaks and of best practice in working with communities to survive them, the IRC has designed a bold approach to disrupt and diminish the outbreak in communities where we work. The foundation of the IRC’s response consists of a risk mitigation approach, in order to adapt our pre-existing programs to keep our clients safe and continue services as much as possible, scale additional activities where feasible to support our local communities and further outbreak mitigation, and ensure staff safety. As a result, the aim of the IRC’s COVID-19 response is to slow the spread and minimize transmission of COVID-19 so that we not only contribute to outbreak response, but also reduce the secondary impacts of the outbreak.

A typical influenza pandemic may come in several waves over 12 months or more; for COVID-19 this is unknown. This concept note covers projected needs over the next six months, and actions will be adapted as the outbreak evolves. Primary objectives and actions are summarized below, and the detailed technical plan is attached.

***Ensure staff safety***

The first priority is that IRC staff have the knowledge and supplies needed to work safely, and the organization has the right policies and safeguards in place to support staff, and mitigate risk for staff. The IRC aims to further support the interruption of virus transmission through measures supportive towards self-isolation, self-referral and testing, effectively reducing staffs fears of repercussions or loss of income or job. These measures are critical to ensure the IRC maintains human resource capacity to continue to deliver critical humanitarian aid around the world, and respond to COVID-19.

Key measures for this include:

* Additional dedicated human resources for safety and security, epidemiology, and medical experts, responsible for monitoring the outbreak, creating technical and operational guidance, and disseminating it effectively across the organization. This will include creating online training and tools to support essential individual preventative measures (e.g. hand hygiene, respiratory etiquette, social distancing and self-isolation/quarantine), as well as defining mitigation measures for transmission risk within the office environment, including online training, dissemination of key messages regarding key preventative measures for all staff, implement a system of Coronavirus focal points per CP, coordination with state and local health officials, routine environmental cleaning and if necessary, access control and safety measures at IRC offices, and preparation for lock down and quarantine and staff relocation and evacuation.
* Coverage of sick leave time for those that become infected, as well as possible medical evacuation.
* Safety measures and supplies in 100% of offices including personal level preventative measures (soap, sanitiser, masks, etc.), plus organisational preparation (training, posters, environmental and office cleaning, etc.).
* In addition to the above, we currently estimate 25% of offices will require extra safety measures, including the need to preposition supplies such as fuel and hibernation kits for possible imposed quarantine. This could be change, depending on the outbreak trajectory.
* Purchase an additional global PPE stock as supplies become available within the next 6 months.
* Boosted HR and IT support to enable flexible work arrangements.
* Coverage of staff absence for those in roles who cannot work from home, which is disallowed under grant funding.
* Global prepositioning of PPE, including relevant logistics, as stock outs are expected.

***Continue life-saving programming safely***

Program business continuity is the IRC’s second priority, ensuring the safe continuity of IRC pre-existing programs and services, contributing to outbreak response and minimising the negative secondary impacts of the outbreak on affected populations. The IRC will use the principles within the [UN Program Criticality Framework](https://rescue.box.com/s/9ln8r94ladxznc8dws8gypx2q7okbbi6) when prioritizing and determining critical versus non-critical activities, recognizing that in some instances the need to temporarily suspend programming in order to minimize risk and contribute to reducing transmission may arise. Therefore this priority includes:

* + 1. Technical training for all IRC staff and critical implementing partners in the readiness stance, and the additional technical support required to do so.
		2. Program business continuity and response planning, and the implementation of program adaptation measures.
		3. Prepositioning of supplies.
		4. Leveraging IRC’s pre-existing multisector programs to support COVID-19 risk communication and community engagement – ensuring dissemination of key CVOID-19 prevention messages.
		5. Global prepositioning of PPE, including relevant logistics, as stock outs are expected.

***Scaling Frontline Response***

Finally, the IRC proposes where feasible to scale additional outbreak support and response to mitigate the impact of the outbreak within communities where the IRC works. While the nature of a pandemic will limit global response and surge support, the IRC is prioritising strengthening existing IRC in-country capacity, particularly in locations with existing health programming. As such, the IRC will leverage existing program sectors and capacity to provide support for a range of activities, depending on local needs:

1. **Infection Prevention and Control (IPC)** at supported health facilities to ensure that facilities safely remain open during an outbreak to both offer services to patients with COVID-19, and continue to provide emergency health services for other conditions, including case management where local capacity exists.
2. **Risk communication and community engagement** activities – ensuring the communities within which the IRC currently works receive essential, localized and adapted (gender, age etc.) messages on COVID-19, key preventative measures, and where to seek support.
3. Training on **Psychological First Aid** for all program sectors to respond to increases in fear, anxiety, and stress associated with any outbreak.
4. Targeted **distributions of essential supplies** – include supplies required for possible periods of enforced quarantine, as well as hygiene/IPC materials.
5. **Community level surveillance activities** – including detection of cases and contact tracing, where existing health programming and staff levels allow
6. **Global prepositioning of PPE**, including relevant logistics, as stock outs are expected.
7. **Technical global and regional support** (HR, IT and tool development) for COVID-19 response, including deployment of a global COVID-19 Safety and Security Coordinator