


COVID-19: INCLUSIVE PROGRAMMING – ENSURING ASSISTANCE AND PROTECTION ADDRESSES THE NEEDS OF MARGINALIZED AND AT-RISK PEOPLE



This paper brings together guidance and messages from the ICRC's Operations Diversity Inclusion, Sexual Violence and Protection from Sexual Exploitation and Abuse teams, in collaboration with the Global Adviser on Children. Its purpose is to support the ICRC's delegations and métiers in their response to COVID-19. The guidance focuses on the initial phases of the response, including contingency planning, adapting and possibly scaling back current activities and strengthening and establishing new activities and partnerships to respond to the virus in the humanitarian contexts in which it works.

INCLUSIVE PROGRAMMING – WHY?

In emergencies, already marginalized people are often rendered even more vulnerable. COVID-19 is no different; it will have disproportionate effects on various groups in society, in communities and even within households. We must be mindful of this in our response and strive to identify and respond to the needs of everyone: the visible and vocal and the less visible/invisible and silent. In this way, we can support marginalized and at-risk populations, by offering them priority assistance and engaging them in decision-making processes around the response, resilience building and risk reduction.

INCLUSIVE PROGRAMMING – WHO?

In most societies in general, women, older people, children, adolescents and young people, persons with disabilities, internally displaced persons (IDPs), people from minority groups and persons deprived of their liberty experience, to different degrees, greater socio-economic marginalization than others. Where more than one of these factors intersect or combine with others (e.g. an adolescent girl from a minority group with a disability or a young gay man in detention), the degree of vulnerability increases.

During the COVID-19 health emergency, the individuals and groups most at risk include those who have underlying health conditions or are receiving treatment/care; those who are in closed environ-



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ments (e.g. deprived of their liberty); those who have relatively unequal and inadequate access to basic social services, including health and sanitation (e.g. clean water for hand washing); those who have relatively little local and national influence; those who depend heavily on the informal economy; those who have limited capacities, choices, strategies and opportunities to cope and adapt; and those with limited or no access to communication and information channels (including language minorities, people with low literacy and people that communication campaigns do not take into account and do not therefore reach with their messages).

Initial analysis, review of secondary data and expert advice indicate that the following groups will face significant challenges and that the ICRC's assistance should be adapted to meet their needs.

People living in existing humanitarian emergency settings: With regard to our core mandate, it is now clear that people already living in humanitarian emergency settings will be the population group most severely affected by this health crisis. As we know from the contexts in which we operate, this emergency will compound the needs of people living in areas with limited infrastructure or where infrastructure has been destroyed or damaged, and COVID-19 is likely to spread quickly in places with poor and cramped conditions and without proper sanitation. Access to adequate shelter, food, clean water, health care, and family and community support may also be disrupted and limited. As a result, people affected by existing crises may not have had access to adequate nutrition and health care for the duration of the emergency, which can lead to weakened immune systems and, therefore, a heightened risk of contracting the virus. We know from past experience how difficult it is to disseminate appropriate information rapidly in emergencies and that people in these circumstances may not have access to information about outbreaks and response services or access to life-saving health services, including essential medicines, for financial or security reasons. In addition, the presence of new humanitarian actors raises the risk of sexual exploitation and abuse (SEA), as in any emergency.

The response needs to be adapted to the circumstances and needs of the following groups of people within the affected populations.

Women and adolescent girls make up a large part of the health workforce | are largely the primary caregivers to children, older people and the sick | will face heightened risks of sexual and gender-based violence (SGBV), including sexual exploitation, in health clinics and quarantine centres | are often excluded from spaces, forums and channels where information is provided on outbreaks and the availability of services and where decisions are made about the response | are often at a distinct disadvantage in terms of access to health care | may have their access to health services, including sexual and reproductive health care, interrupted | may not be able to access health services independently or be seen by male service providers (depending on the cultural context) | may have their access to pre- and post-natal services interrupted by the diversion of resources | may, in continuing to use pre- and post-natal services, be exposed to an increased risk of infection, especially in health facilities with inadequate infection control measures.

Children seem less likely to become severely ill with the virus but can transmit it to caregivers who may be more susceptible to infection | might not have access to or might find it difficult to understand public information on COVID-19, and unaccompanied and separated children, in particular, may not have access to information or services | may be separated from their caregiver if that person is infected, quarantined or dies and, therefore, not receive the care they need | may experience safety and security issues where a caregiver must leave the house to work, leaving them alone | may experience increased levels of violence, including sexual violence, in the home as a result of heightened anxiety, frustration and isolation | may experience anxiety due to the prolonged closure of schools and movement restrictions | may face increased risks of sexual abuse in closed settings, such as displacement camps, where they might be isolated in close quarters with their abuser and with limited access to support services | may face increased caregiving burdens, particularly girls caring for younger siblings or for their own children.

Older people are most vulnerable to the virus and have a higher fatality rate | may not be able to get to health facilities due to mobility issues and social isolation | may have difficulty caring for themselves



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if someone they depend on is social distancing | may not understand or have difficulty reading/hearing the information provided | may be exposed to a higher risk of SGBV, including SEA by caregivers (for example, in assisted living facilities).

Persons with disabilities (including people with sensory, physical and developmental disabilities) often have unequal access to information on outbreaks and the availability of services | are often excluded from decision-making spaces, especially when they have specific communication needs and/or are socially isolated with little or no access to the community | may be exposed to a higher risk of SGBV by caregivers and in assisted living facilities | may not be able to socially distance as they rely on others for many daily tasks.

People with pre-existing medical conditions and health needs are generally at higher risk of developing serious illness because their immune systems are compromised | may be unable to access the care/treatment regime they were already following | may not receive or have access to specific information on how to protect themselves from infection taking into account their underlying condition | may experience stigma and discrimination in health-care settings and be denied access to essential medicines (e.g. people living with HIV who receive anti-retroviral treatment) due to overburdened health systems.

People deprived of their liberty are vulnerable to the virus due to the closed living environment, limited access to sanitation and the prevalence of co-morbidities (e.g. tuberculosis and blood-borne diseases) | may be unable to access the necessary care/treatment regime if unavailable in their context or may see their continuity of care for existing conditions disrupted | may experience limited or no access to otherwise publicly available preventative materials, health care and social services | may see their visiting rights restricted, which will have an impact on access to hygiene items such as soap.

Sexual and gender-based violence survivors may face a heightened risk of SGBV as a result of containment and quarantine since this form of violence, which is life threatening, is most prevalent in the home | may experience a disruption in care and support due to the shift in resources to the COVID-19 crisis response | may also see the temporary cessation of services at one-stop crisis centres in tertiary hospitals | may see an increase in violence as a result of quarantine and isolation measures (likelihood of being in close quarters with their abuser) which could exacerbate gender inequality and the rigidity of gender roles.

Migrants, including refugees and asylum seekers, may experience limited or no access to otherwise publicly available preventative materials, health care and social services due to their legal status, discrimination and language barriers | may not receive official information or be included in the national response strategies/plans/operations | may be difficult to reach, particularly when they are on the move or have crossed borders | may be turned away at border crossings that were previously open due to increased travel restrictions, which could result in the emergence of more informal settlements and camps with limited infrastructure | may see their access to life-saving health services hindered by their lack of documentation and financial resources | may travel irregularly and inadvertently circumvent health screening and services at border points | may be exposed, when travelling irregularly, to sexual violence by host communities and to SEA by public officials at screening points | may face an increased risk of contracting COVID-19 in closed settings, such as refugee camps and administrative detention facilities | may face a heightened risk of SGBV | may face accusations of carrying the virus and suffer the associated backlash.

Female migrant domestic workers may be fearful for their visa status if diagnosed with COVID-19 or when seeking health care | are likely to experience an increased care workload due to movement restrictions and a larger number of people in the home | may experience an increased risk of SGBV due to isolation and close quarters | may lose their livelihoods and visa support and face challenges returning to their home countries.

Sexual and gender minorities often already face challenges in accessing health-care systems due to stigma and discrimination and, in contexts where they are criminalized, face threats to their safety and lives | are also often isolated from the rest of the community, and messages may not be targeted to reach them.



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Ethnic minorities may have no access or relatively less access to health and other services | may not receive information on preventative actions in their own language | may not be able/permitted to leave an affected area and may experience stigma and discrimination in health-care settings.

INCLUSIVE PROGRAMMING – HOW?

Engaging with women in the response is critical; it has a multiplier effect. Previous epidemics have illustrated this important point. Women make up most of the health workforce, and they are the primary caregivers to children, older people and the sick. In addition, evidence has shown that those who are carers may be fearful to seek health care as it could compromise their care duties. Therefore, women must be informed about what to do to protect themselves and those in their care. This means tailoring our response accordingly, including our community engagement activities and engagement with health-care workers. For example, when addressing women and adolescent girls as primary caregivers, strict “isolation” and “don’t touch” messages are often not feasible. Communications should therefore include relevant messages, such as how to care for a child or older or sick person in the family in quarantine and how to stay safe while taking care of dependents.

This is not just a health crisis; it is a crisis that will exacerbate existing inequalities and possibly cause a spike in SGBV and other protection concerns. In engagement with local authorities, ensure that this message is conveyed and that plans to address the concern are developed. For example, it is critical to ensure that referral pathways to health care, mental health and psychosocial support (MHPSS) and economic support are updated regularly, including how to access care in the case of isolation restrictions, and that the new information is disseminated in appropriate ways.

Consult local SGBV actors and update referral pathways for protection issues regularly to reflect any changes in service delivery and communicate these to those most at risk (e.g. women, adolescent girls, children, older people, men and boys in closed settings). Ensure that information about services available in the community is tracked and updated. As many services for survivors of violence may change their opening hours, eligibility criteria or focus at this time and domestic violence and abuse shelters are forecast to reach capacity quickly, such changes should be rapidly communicated via appropriate channels. Likewise, communicate changes in the ICRC’s operations to the local SGBV coordination mechanism so that their messaging regarding available ICRC services is updated.

Remain vigilant to the risk of family separation in the context of COVID-19. This includes where caregivers are quarantined and, therefore, separated from their children, where community-level quarantine measures are imposed while family members are apart and where children are sent away to stay with other family members in less affected areas. We must consider and share with relevant authorities how family separation can be addressed. This might include ensuring that contact between children and their caregiver(s) is maintained and engaging Restoring Family Links (RFL) where possible.

Consider the inclusiveness of information channels used to provide messages to community members on your activities and how traditional communication is impacted by COVID-19. Ensure that an appropriate format is used for the delivery of messages in locations and via channels that are accessible to different groups, including women, children and older people staying at home and persons with sensory and physical disabilities.

Consider also the language used, including the need for translation into local languages. Provide clear and simple messages adapted to people with low literacy, children, etc.

Noting the difficulty of reaching people who are in their homes, in quarantine facilities or in other static locations, many agencies are exploring remote support and messaging, such as radio, text, social media and app-based communication.

Ensure that different groups within affected communities are systematically informed about their entitlements, their right to protection from sexual exploitation and abuse (PSEA), what standards of conduct to expect from our staff and partners and how to report observed misconduct.

Use community engagement messages for the prevention of SGBV, including domestic violence and SEA. In coordination with other actors involved in SGBV prevention and PSEA in your context, revise and disseminate “life-saving” SGBV messages.



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IN CONTINGENCY PLANNING:

- **Ensure sexual violence issues and approaches continue to be integrated** (and, where possible, ensure that sexual violence operations managers are specifically integrated into métier planning) so that survivors of sexual violence receive continuity of support (especially considering that there is a heightened risk of sexual violence in this emergency).
- **Apply a diversity lens to analyse the occurrence and impact of COVID-19 in your context.** Analyse which groups are more likely to be physically exposed and why, which groups are likely to be excluded and what barriers to information and services they are likely to experience. Use the findings of this analysis to refine your response and messages, including in your dialogue with partners, authorities and other stakeholders.
- **Collect, analyse and use data disaggregated by sex, age, disability and other relevant diversity metrics.** This will help you to understand who is accessing the support you provide and who is not. With this information, adjustments can be made to programmes to ensure they reach those who are marginalized and most at risk.

Always assume that the most socially or economically disadvantaged groups in the community will experience protection risks related to the emergency, including marginalization, stigma, violence, SEA and domestic violence. Take measures to identify these risks, such as asking about protection-related consequences of the crisis in discussions with such groups or including protection staff in health-care triage procedures so that they can identify at-risk individuals and formulate follow-up plans.

Verify the availability of risk mitigation measures in quarantine facilities and in areas under curfew, especially for groups at heightened risk of sexual violence, including SEA. Identify and respond to additional protection issues in these contexts.

Take into account too that, given the global advice on social distancing and the closure of work places and schools, women and children at home, in particular, and people who are dependent on others for care face the risk of increased violence, including SGBV.

Always assume that groups most at risk from the COVID-19 virus are likely to be the very people with relatively less access to health care, including for ongoing medical needs. Proactively analyse their specific risks, needs and resources as well as the measures needed to ensure equal access and participation in the response.

Map local organizations, committees and trusted individuals that represent different groups of people (e.g. disabled persons' organizations (DPOs), sexual and gender minority leaders and representatives of migrants and refugees) and consult them to better understand medical, protection, economic and other impacts of the crisis on the different groups. Encourage them to participate in consultations related to the response and to establish channels for the effective transmission of information to the groups they represent.

In quarantine facilities, ensure that information is updated regularly in accessible formats, including information on standards of conduct expected from health, humanitarian and care staff and on feedback mechanisms for concerns related to SEA and any other issues.

Advocate with local authorities and international donors to ensure that they understand that this is not just a health crisis, but a crisis that will exacerbate existing inequalities, resulting, for example, in an increased prevalence of SGBV, and that people already living in humanitarian settings or in detention are likely to be among the most vulnerable. Where existing inequalities are exacerbated, gains made through development and humanitarian responses are quickly undone, and national authorities should tailor their national and local materials in accordance with diversity and inclusion factors to reach different groups successfully, increase resilience and ensure an effective response that “leaves no one behind” and is non-discriminatory.

For PSEA, ensure staff, especially newly recruited members, volunteers from National Societies, implementing partners and suppliers understand the rules of conduct as outlined in the ICRC Code of Conduct easy-to-read version and the Code of Conduct policy on prevention of and response to sexual misconduct. Send out systematic reminders and include relevant information in all materials disseminated on COVID-19.

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OTHER USEFUL GUIDANCE

NOT ALL THE DOCUMENTS LISTED HERE ARE AVAILABLE BEYOND THE MOVEMENT

Specific guidance on COVID-19

IFRC, March 2020, [Protection, gender and inclusion in the response to COVID-19 – technical guidance note](#)

IFRC, 17 March 2020, [COVID-19: Protection, gender and inclusion considerations](#)

CARE International, March 2020, [Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings](#)

HelpAge International, 2020, [COVID-19: Guidance and advice for older people](#)

Norwegian Refugee Council (NRC), March 2020, [10 things you should know about coronavirus and refugees](#) (on refugees, IDPs and migrants)

Diversity and Inclusion

ICRC, 2020, Diversity Inclusion for Operations, [Set of basic questions on Diversity Inclusion for field teams](#) and [Diversity Inclusion Good Practices](#)

SGBV guidance

Inter-Agency Standing Committee (IASC), 2018, How to support survivors of gender-based violence when a GBV actor is not available in your area, in the [GBV Pocket Guide](#)

ICRC Sexual Violence Toolkit and manual will be online soon and available on the Addressing Sexual Violence Communities page – <https://communities.ext.icrc.org/community/opdir/addressing-sexual-violence/projects/practical-guide> – where guidance on this subject is already available.

PSEA guidance

[ICRC Code of Conduct policy on prevention of and response to sexual misconduct](#)

ICRC, 2020, [Easy-to-Read Guide to the Code of Conduct](#)

Child protection

The Alliance for Child Protection in Humanitarian Action, March 2020, Technical Note: [Protection of Children during the COVID-19 Pandemic](#)

The ICRC helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.