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GUIDANCE FOR UNICEF ETHIOPIA PROGRAMMES

Risk reduction and operational continuity in the COVID-19 outbreak

This guidance is for UNICEF staff in Ethiopia, to guide programmatic and implementation decision making and to ensure that we consider the care needs of our partners and the communities we serve. The document sets out overall principles and then explores safe ways to ensure continued delivery of services; taking precaution to protect everyone, especially the most vulnerable. In Annex 1, a Question Guide is provided to aid decision making.

This should be read together with technical guidance and human resource documents developed by UNICEF, by WHO on their dedicated platform and through inter-agency efforts including clusters. A selection of resources on COVID-19 is provided in Annex 2.

Guidance objectives

1- Provide guidance and advice to minimize the transmission risks of COVID-19 to personnel, partners (CSOs/NGOs and Government) and communities;

2- Ensure that lifesaving assistance and critical interventions continue to be delivered, in line with programme criticality agreements; and with appropriate safeguards;

3- Ensure that specific vulnerabilities and risks to children, youth, women and men are mitigated and addressed, especially when access to services may be limited. This includes risks of Gender based Violence (GBV) and sexual exploitation and abuse (SEA) due to disease outbreak and/or due to restrictive measures imposed to fight COVID-19.

I. General principles

UNICEF has a responsibility to stay and deliver. We must put in place precautions to ensure that how we deliver does not spread the virus or create more harm, is non-discriminatory and is needs based. In addition to implementing duty of care to UNICEF staff, we must protect those ensuring frontline service delivery and those to whom our programmes are delivered. [1]

All UNICEF Ethiopia programming should be guided by a **do no harm and a risk reduction approach when it comes to virus transmission.** The risk reduction approach, in a COVID-19 context, refers to actions and measures aimed at **reducing the risks and negative effects** of operating in a constrained, hazardous and shifting environment due to COVID-19 outbreak **on the staff, partners and communities** as well as addressing the risks **within our programming**.

It is essential to review agreements with all partners including government and CSOs/NGOs, and to ensure that their duty of care to their staff, volunteers and communities is clear, and that they have considered how to ensure protective measures protective measures such as: frequent

[1] See *UNICEF Response to COVID-19 Duty of Care Arrangements and Measures to Reduce Risk* and *Administrative Guidelines for Offices on the Novel Coronavirus (COVID-19) Outbreak*.

handwashing, social distancing and respiratory hygiene [2] are followed. Some considerations on employee wellbeing are included in Annex 4.

Principles to be applied to guide our individual, group, partner and community interactions:

- **SAFETY (of staff and others):** Avoid **physical contact** between partners and communities or between communities, unless absolutely necessary (e.g. health/nutrition case management), and adhering to all safeguards and measures to minimize risk of transmission (i.e. use well-ventilated rooms, use of personal protective equipment (PPE), etc.)
- Anyone **experiencing symptoms** or who has come in contact with a confirmed case should self-isolate. There should be systems in place to cover staff availability: all personnel must understand the importance of ensuring that even other respiratory infections must not be introduced.
- Anyone who has been **exposed** to suspected or confirmed cases should contact the relevant hotline number or surveillance focal point (see list in Annex 3).

- **DO NO HARM:** At all sites of programme implementation, **handwashing stations** with water and soap, and / or sanitizers must be available to partners and communities.
- **Community engagement** is critical to raise awareness to contain the spread of the disease and to reduce fear, misinformation, confusion and tension. All risk communication should be based on approved UNICEF risk communication products. Community engagement in turn, if not managed carefully could act as an entry point for the transmission of COVID-19. Mass gatherings must be discouraged and prevented.
- **Approach** to all activities usually requiring face to face contact or gathering in groups should be approved and planned carefully in line with established procedures, and specific protective measures introduced. [3]
- All community members must be able to access UNICEF-supported services without risk of exploitation, abuse or any hurtful or humiliating treatment by an UNICEF staff member or by an employee of a partner in a UNICEF-funded project.

- **PRAGMATISM:** Programmes should actively seek opportunities to maximize community engagement, combining activities where this can increase impact (e.g.: soap delivery alongside IEC material delivery) or simply as a risk reduction measure (1 distribution instead of 2). Community engagement should be done at individual or household level basis and not in groups, unless physical distancing is ensured.

- **NON-DISCRIMINATION:** Do not contribute to **stigma** towards individuals with a suspected case of, or affected by, COVID-19, survivors or their families. Messaging should not relate the disease to ethnicity, religion, gender, etc.

[2] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

[3] This includes activities such as assessments, outreach, surveys, analysis on health seeking behavior and beliefs, tracking and responding to misinformation.

- **HUMANISM:** All assistance should be provided without moral judgements against any individual or group. People with a suspected case of, or affected by COVID-19, need to be seen as human beings not just cases, and should be treated with the same dignity, respect and compassion as everyone else.
- **EQUITY OF ACCESS TO SERVICES:** UNICEF and partners must continue to ensure equal access to impartial assistance according to need and without discrimination. Programmes need to consider how barriers to accessing services impact different groups and may increase during COVID-19 disease outbreak for some groups – such as women, children, and people with disabilities, and plan for measures to ensure assistance is accessible to all. Ensure that children, women and caregivers respectively are reached with information about how to prevent and respond to the epidemic in ways they can understand. Use of **local languages** is essential.

- **COORDINATION:** Coordinate with other agencies, in particular EPHI, NDRMC and clusters and internally to maximize the reach of messaging on risk reduction and the effectiveness of protective measures where gatherings do occur.

- **ACCOUNTABILITY:** UNICEF is accountable for quality and safety of its programmes and assistance. UNICEF and its partners will ensure that measures for Protection from Sexual Exploitation and Abuse (PSEA) are in place, including safe, confidential and accessible reporting and complaints mechanisms in all programme sites, and that survivors of SEA have access to them, and to support and redress assistance. All staff must understand that there is ZERO TOLERANCE for sexual exploitation and abuse.[4]

II. Face to face interaction

The following measures apply for external meetings, trainings and other capacity building events[5], while UNICEF internal meetings are covered by UNICEF internal procedures.

Virtual meetings are highly recommended. Chiefs of Field Offices and Sections should review and prioritize meetings and training/capacity building events for key influencers, structures and intermediaries on a regular basis and consider ways to scale back or delay these. Surge personnel deployed into government ministries must be given clear guidance to ensure these personnel can implement and model the above protective measures.

Face to face meetings and trainings are to be reduced to the absolute essential ones, with no more than 15 participants in a well-ventilated location where physical distancing (at least two-meter spacing between participants) can be ensured. Handwashing stations with water and soap and/or hand sanitizer must be available. IEC materials should be displayed.

[4] *Secretary-General's Bulletin on Special Measures for Protection from Sexual Exploitation and Abuse (PSEA)* ST/SGB/2003/13

[5] These measures are aligned with *SOP: OCHA Ethiopia Field Operations during COVID-19* and *Information Circular from the Designated Official (DO) and UN Resident and Humanitarian Coordinator on COVID-19 Outbreak- Precautions and Mitigation Measures*

Invited participants must be advised to stay home if they have any fever or respiratory symptoms (sneezing, cough, etc.) or are otherwise unwell or if they have been in contact with a confirmed or suspected COVID-19 patient, even if they do not show symptoms. Ensure participants have access to COVID-19 hotline contacts or to the COVID-19 surveillance focal person. Ensure accessibility and safety of the location for both female and male participants.

III. Field missions

Within UNICEF, non-essential field missions outside the duty station should be temporarily suspended. Only essential missions based on program criticality should be approved (these include assessment, data collection and monitoring missions), with approval by the Representative on a case by case basis. For partners, consider the purpose, the methodology and the safety measures being put in place. Approval of missions must follow partners' internal protocols.

Any **approved UNICEF and partner missions** should use the following protocols[6]:

- The mission leader shall request confirmation that all participants are in good health before departure. Participants who show signs of fever or respiratory symptoms should not be allowed on missions. They should self-isolate and notify the COVID-19 rapid response team.[7]
- The mission leader should ensure physical distancing in the vehicle, with a maximum of three passengers per vehicle including the driver (one in front and two in the back).
- The mission leader shall ensure that hand washing detergents and/or sanitizers are packed in the mission car and regularly used by participants during the mission. Gloves and masks should also be included alongside the First Aid kit and available in every vehicle to be used as needed[8].
- Guidance on meetings above will apply. During interactions with communities including IDPs/returnees/refugees: observe 2-meter physical distancing, no body contact including for greetings, regular handwashing with soap or sanitizers. Communities should be alerted in advance to nominate representatives and prevent mass gatherings.
- Mission participants should take with them IEC materials (in the local language) and disseminate them to visited communities. Other opportunities to combine activities such as provision of soap, should be considered.

For assessments and monitoring missions: [9]

- Consider relying on secondary information or remote data collection methods (including phone or WhatsApp) to avoid field visits. Postpone or cancel non-critical non-life saving assessments, surveys, focus group discussions, verification and authentication exercises.
- Adapt methodologies to reduce face to face contact and ensure no crowds gather. Interviews / focus group discussions must ensure there is no physical contact, 2-meter distance and 15

[6] Adapted from *SOP: OCHA Ethiopia Field Operations during COVID-19*.
[7] The list of toll-free numbers can be found in Annex 3.
[8] For any type of mask, appropriate use and disposal are essential to ensure that they are effective and to avoid any increase in transmission.
[9] See also *Technical Note: Response of the UNICEF Evaluation Function to the COVID-19 Crisis*

people maximum at a time. Think about a venue with adequate space for group discussions. If holding it outdoors, ensure no crowds will gather.

- Ensure that remote and direct methodologies ensure representation of communities according to gender, age and disability and other dimensions such as displacement. Communities (in particular, women and girls) should be consulted on preferred options for remote communication (phone, online, other). Remind partners of PSEA obligations, including Codes of Conduct and the responsibility to report SEA allegations to UNICEF, especially for all healthcare providers.
- Ensure handwashing area is set up with adequate supply of water and soap. Guide community members to ensure they utilize the hand washing service.
- Ensure field teams carry adequate amount of hand sanitizers and use them at all times before, during and after the activities, in addition to handwashing with soap where available.
- Mission participants should take with them IEC materials (in the local language) and disseminate them to visited communities. Other opportunities to combine activities such as provision of soap, should be explored.
- Think of how to maintain regular contact with intermediaries, and measures to enable this (e.g. phone credit to purchase data) to facilitate follow up.

IV. Community-based programme delivery

Key Recommendations [10]

- **Priority is to actively sustain continuity of essential community-based services including providing essential maternal and newborn care** and child health services that reduce morbidity and mortality noting that **malaria, pneumonia and diarrhea and wasting,** the primary killers of children under the age of five years
- **Define core and essential services** which should continue in the community and primary health care facilities (in consultation and with support to and from national authorities)
- **Define roles for CHWs and supervisors and other community actors,** particularly women leaders and young women, in provision of core service delivery; consider co-designing workflow modifications and task sharing
- **Revise and update guidelines and SOPs for safe health worker-client interaction**; consider workflow modifications necessary to continue primary health care services based on epidemiological scenarios
- **Avoid community level service delivery approaches that entail large gatherings of people** (e.g. large-scale campaigns, calling persons to fixed posts for the receipt of commodities, etc.)

[10] From Interim UNICEF Internal Guidance on Community-based Programme Support in the Context of the COVID-19 Pandemic (DRAFT)

- **Encourage and facilitate referrals for Primary Health Care** (antenatal, delivery, postnatal, EPI/ immunizations, other SRH services, experiences of violence, and cases of severe disease).
- Support review of policies to **ensure continued access to medications and supplies for chronic conditions (esp. HIV, TB)** through release of stocks for multiple months when access to providers and travel is restricted
- **Quantification and pre-positioning** of sufficient routine and emergency **supplies for 2-3 months**

The following should be observed during delivery of community-based services:

- Dissemination of approved risk education messaging must be mainstreamed in all community-based activities. Messages must be available in local languages.
- The default should be to cancel all mass distributions or community group activities. They will be approved on a case by case basis, if the activity is lifesaving[11] and no other delivery option is available, and with a set of specific measures that are agreed prior to delivery, follow technical sector guidance and principles of engagement. A careful analysis of all risks should be done prior, to be agreed and implemented.[12]
- Activities that require substantial community mobilization should be cancelled, e.g. community led total sanitation approaches, mass hygiene promotion activities in public spaces or religious gatherings.
- For essential activities that support implementation of protective measures, decide how this can be done while minimizing contact, maintaining 2-meter distance between communities and between communities and partners, and without creating a crowd (maximum group size should be 15 people). Consider whether frequency of activity can be reduced, or it can be done in rounds or shifts.
- Consider increased barriers to women's and girls' access and participation during disease outbreak, and ensure that programming approaches (i.e. location, time, frequency and activity format) facilitate their participation, but also minimize and mitigate risks of GBV and SEA[13].
- **Provide relevant sector specific guidance**, as required to all service providers, partners or other intermediaries (see Annex 2 for a selection of relevant policies and guidelines).
- Calendar should be prepared and communicated to the administration and community leaders in advance to ensure measures are understood and adhered to.

[11] Example: "Immunization is a core health service that should be prioritized for the prevention of communicable diseases and safeguarded for continuity during the COVID-19 pandemic" (Guiding principles for immunization activities during the COVID-19 pandemic – interim guidance)
[12] Entry, exit points and required spacing should be clearly marked and handwashing stations need to be in place. A mechanism to check that these precautions are implemented must be set up.
[13] For further guidance see: IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action and the UNICEF Gender-Based Violence in Emergencies (GBViE) Programme Resource Pack

V. Service delivery in institutional settings

Infection prevention and control enhancements are a critical measure in institutional settings such as health facilities, schools, detention facilities, and orphanages, etc. where there is a higher risk of infection. Protection risks including children's and women's vulnerability to violence, GBV and SEA are also heightened at a time of increasing formal and community control and regulation. Increased focus needs to be placed on risk assessments and mitigation measures in quarantine facilities and areas with restricted movement and under curfew, especially for women and children and other groups at heightened risk of GBV and SEA.[14]

The below are key considerations to be discussed and implemented by UNICEF partners and closely monitored by UNICEF staff:

- Provision of safe water supply, handwashing and cleaning materials must be coordinated and prioritized between sectors (health, nutrition, wash, education, child protection)
- Personal protective equipment including masks must be provided to personnel providing direct case management contact with patients (health, nutrition, MHPSS). These personnel must be trained in how to protect themselves and communities.
- Entrance and exit points and waiting areas should be reviewed to introduce 2-meter safe distance while accessing services, particularly in health facilities (nutrition, vaccination, health and hygiene promotion, postnatal and obstetric consultations). This should be done alongside equipping facilities for isolation / segregation of anyone with COVID-19 symptoms.
- Standards, quality controls and a feedback system are needed to ensure regular and effective cleaning and disinfection of surfaces and appropriate waste management control measures are in place; this applies also to ensuring that handwashing supplies and school cleaning supplies destined for pre-primary and primary schools are distributed based on need and, equitably.
- Partners should implement or reinforce the PSEA Codes of Conduct for staff and partners and ensure accessible and safe feedback and complaint mechanisms are in place to receive and handle sensitive complaints, including SEA. Where in-person channels are suspended because of social distancing, ensure that other appropriate channels (i.e. hotline, SMS, etc.) are put in place, with full consideration to ensuring safety and confidentiality.

To ensure continuity of service, consider the following in addition to sector-specific guidance:

- All activities will need to be reviewed to ensure that they are either: a) cancelled because they are too risky; b) maintained or adapted with new risk management measures; c) identified as the most critical activities that must be maintained, with an adapted approach taking the new context into consideration.
- In settings where individuals, especially children are co-existing with others that have comorbidities, ensure that preventative measures are taken and explored to reduce vulnerability and to serve the needs of everyone, equitably. For example, the quality of care

[14] This could include health delivery points, alternative care settings, stabilization centers, schools, and other settings where women and children depend on assistance.

for children treated in stabilization centers that are also co-located in isolation centers or where stabilization centers are used as isolation centers for COVID-19. This is also relevant in the use of any child institution, including an orphanage or a school as an isolation or treatment location. [15]

- Ensure systems to manage supply chains for essential items is maintained and adapted if necessary, to reduce secondary impacts and defaults.
- Any capacity building or training activities will be approved on a case by case basis, after thorough review of criticality and measures to minimize exposure. Online options should be prioritized. For partners with low PSEA capacity, particularly for health care providers, training on PSEA & GBV should be considered a high priority to minimize risks of SEA and GBV.
- This also applies to follow up, quality control and monitoring activities related to facility-based services: consider adjusting the frequency and method for monitoring.
- Ensure referral mechanisms are in place for children in contexts of isolation or observation, and that alternative care arrangements are in place, avoiding institutionalization and separation. [16]
- As the situation evolves, and based on previous experiences and technical guidance, recommend context-specific alternatives/ actions and measures to ensure critical services are adequately provided.

VI. Innovation, use of new technologies and remote methodology

Beyond "Do No Harm", other ways of reducing risk of contamination while maintaining operational continuity include revisiting the methods used for planning, delivering and monitoring programmes, and considering alternative approaches and technologies. [17]

The use of new technology for disseminating risk education, and for surveys, will need to be explored. Thorough review of strategies for implementing and monitoring will be essential to reduce risk, further building on experience and lessons learned from limited access environments and enhanced risk delivery contexts such as Somalia, Syria, the 2014-15 West Africa Ebola response or the DRC Ebola responses.

An example UNICEF working with the Ministry of Education and other education actors may choose to broadcast pre-primary and primary education learning content on mainstream media (radio/tv) and other distance learning platforms.

VII. Complex delivery environments: ensuring we reach the most vulnerable

Marginalized and vulnerable groups become even more exposed to and least protected from risks in emergencies. This is due to factors such as their lack of access to effective surveillance and early-warning systems, and health services in addition to the breakdown of social fabric and

[15] *UNICEF Ethiopia: Avoiding and mitigating separation of children from siblings, parents and caregivers affected by COVID-19* and *Key recommendations from the CP/GBV AoR*
[16] *UNICEF Ethiopia: Avoiding and mitigating separation of children from siblings, parents and caregivers affected by COVID-19*
[17] See also *Technical Note: Response of the UNICEF Evaluation Function to the COVID-19 Crisis*

exacerbation of existing gender and socio-economic inequalities among women, men, IDPs, refugees, and host community people. The COVID-19 outbreak is predicted to have significant impacts on various sectors and groups.

Displacement situations including refugees and IDPs require special consideration, due to overcrowding, movement restrictions and disparities in access to services.[18] The impact of COVID-19 may lead to increased protection risks, including risks of GBV and sexual exploitation and abuse, and other harmful impacts, particularly for women and girls, due to their unequal social status and unsafe conditions (i.e. poor housing and overcrowding conditions, dangerous location, lack of, or risky livelihoods, lack of preparedness information and skills). We must ensure that our programmes and responses don't create further harm, with particular attention to GBV and SEA risk mitigation within sectoral responses.

Planning

- Assess availability of and access to primary and reproductive health care services and interventions, especially for communities in quarantine and affected by other emergencies.
- Consider how barriers to accessing services impact different groups and may increase during the pandemic for some groups – such as refugees, IDPs, women and girls, and people with disabilities, and plan for measures to ensure timely access to life-saving health, reproductive health (clinical management of rape) and protection services for all vulnerable groups.
- Undertake effective risk assessments that include risks of GBV and SEA to minimize harm that may be caused by programing[19]and share assessment analysis with other sectors. Identify and address any specific protection risks, including GBV and SEA in line with the IASC GBV guidelines. Ensure reporting and referral mechanisms are active. Follow up.
- In coordination with other partners, ensure health workers are familiar with GBV referral pathways and disseminate messages emphasizing the importance of seeking medical assistance for sexual violence survivors (within 72 hrs.).
- Ensure conflict sensitive response planning in hosting regions for refugees and IDPs, taking care not to exacerbate underlying tensions, reflecting on the potential perceptions around serving one group over another.

Service delivery

- Ensure equitable access to diagnostics, care and treatment services. Facilities that are already over-subscribed due to an increase in the catchment population should be prioritized for support.
- Consider whether specific barriers to accessing or seeking health services apply and how to overcome them.

[18] See IASC guidance and the Ethiopia protection cluster guidance.

[19] For further guidance and tools for GBV risk mitigation see IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action and the UNICEF Gender-Based Violence in Emergencies (GBViE) Programme Resource Pack.

- Continue to prioritize life-saving CP and GBV activities, including case management and referrals, Psychological First Aid (PFA) and individual psychosocial support[20] and alternative care/family-based care to children who are separated from their caregivers and families.

Monitoring and feedback mechanisms

- Raise awareness on PSEA and reporting mechanisms that include UNICEF PSEA Focal Points and programme staff among partners and the affected community; ensure partners staff are familiar with and have updated GBV referral pathways.
- Open communication with women and girls and caregivers about COVID-19 and potential changes in your service delivery methods (or cancellation of some services) is essential.
- If a switch to remote service delivery is necessary, review case management protocols with staff, including what phones and phone numbers will be used, and review your guidelines on what technology and modalities will be used for remote support etc.
- Prepare for possible closure of physical locations for case management, and make sure safe storage of documents will still be possible.
- Update and adapt the referral pathways based on available services and safe medical places for referral of GBV and protection related, non-COVID cases.

[20] Please refer to IASC Pocket Guide for humanitarian practitioners on how to support survivors of gender-based violence when a GBV actor is not available in your area. The interactive Pocket Guide mobile app can be downloaded to your phone.

Annex 1 – Question Guide

This question guide is provided to support decision making and help you prioritize key actions that UNICEF needs to put in place, to better manage risk and serve children, women and men within the affected community.

Based on these questions, Sections and Field Offices may wish to adapt the approach taken for community engagement, delivery of services, assessments, quality control and monitoring of programmes.

- ☐ Have you considered Duty of Care to seconded or surge personnel? Do they have clear guidance on how to protect themselves, others and communities in their day to day work? Have you checked UNICEF HR policies?
- ☐ Have you checked your PCA with your partner? Is your partner clear about their Duty of Care to staff, volunteers, counterparts and communities? Do they have protocols on minimizing risk? Y/N
- ☐ Have you checked sector specific guidance applicable to your programme (see Annex 2)? Have you reviewed your programme to identify activities that are life-saving and essential?
- ☐ Are child safeguarding risks, GBV and PSEA risks clearly identified? Do you have reporting and referral mechanisms in place?
- ☐ Is the meeting, training or capacity building event you are planning essential: Is there another channel through which you can at least partly reach the expected result?
- ☐ Is the field mission you are planning essential and lifesaving? Have you reviewed the SOPs for field missions? Do you have the necessary protective equipment?
- ☐ Is a distribution or mass activity essential ? How can you stagger the distribution to reduce the crowd size to 15 people, and maintain distance? Are protective measures in place for handwashing and crowd control?
- ☐ Have you reviewed your monitoring strategy, and adapted your monitoring plan to minimize direct contact with communities and make use of remote technologies?
- ☐ Are institutions you support changing site layout? Is there a safe waiting space for communities, clear entry and exit protocols? Can you ensure handwashing station is functional and in use?
- ☐ Are institutions you support receiving materials for handwashing and cleaning? Do you have a system to ensure cleaning and waste management meet required standards, and to follow up?
- ☐ Have you given special consideration to IDPs and refugees in camp settings, or people in other precarious or overcrowded living conditions?

Annex 2 – Selected technical guidance on COVID-19

UNICEF Global guidance

- EMOPS *Novel* Coronavirus COVID-19 Info Platform SharePoint folder
- Novel Coronavirus Programme Guidance
- Interim UNICEF Internal Guidance on Community-based Programme Support in the Context of the COVID-19 Pandemic
- Administrative Guidelines for Offices on the Novel Coronavirus (COVID-19) Outbreak.
- UNICEF response to Covid-19 Duty of Care arrangements and measures to reduce risk
- Guidance note on considerations for children and adults with disabilities
- Risk Communication & Community Engagement: Practical Tips on Engaging Adolescents and Youth in the COVID-19 Response
- UNICEF WASH Programme contribution to COVID- 19 prevention and response

WHO & Health Cluster Global guidance

- Technical guidance notes are available on a dedicated COVID-19 page
- WHO interim guidance: Advice on the use of masks in the context of COVID-19
- Polio eradication programme continuity planning: Measures to ensure continuity of operations in the context of the COVID-19 pandemic
- Guiding principles for immunization activities during the COVID-19 pandemic – interim guidance
- Disability considerations during the COVID-19 outbreak

UNICEF-led Inter-Agency guidance

- Coronavirus Disease (COVID 19) Summary of Guidance for Nutrition in Emergencies Practitioners (Global Technical Assistance Mechanism for Nutrition)
- Infant and Young Child Feeding in the Context of the COVID-19 Pandemic
- Management of child wasting in the context of COVID-19
- Technical Note: Protection of Children during the Coronavirus Pandemic (The Alliance for child protection in humanitarian action)

Other global guidance: IASC, Global clusters, other Inter-Agency & UN guidance

- Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings (IFRC, IOM, UNHCR and WHO)
- General Guidelines for Food and Nutrition Assistance in the context of the COVID-19 Outbreak (WFP)
- Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic
- Briefing note on addressing mental health and psychosocial aspects of the COVID-19 outbreak
- IASC Interim Guidance on COVID-19 - Protection from Sexual Exploitation and Abuse
- Interim Recommendations for Adjusting Food Distribution Standard Operation Procedures in the context of the COVID-19 outbreak (IASC)
- Guidance for cash-based transfers in the context of the Covid-19 outbreak (WFP)

Ethiopia specific guidance

- Avoiding and mitigating separation of children from siblings, parents and caregivers affected by COVID-19 (UNICEF)
- Key Protection Concerns from the National Protection Cluster (Protection cluster)
- SMS Guidance on Implementation in Sites and Site-like Settings (IOM)
- Key recommendations from the CP/GBV AoR (CP/GBV AoR)
- SOP: OCHA Ethiopia Field Operations during COVID-19 (OCHA)
- MoH/EPHI Guide for Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19)

See also: https://www.unicef.org/ethiopia/coronavirus-disease-covid-19

Annex 3 – Essential Contacts

For information about Coronavirus

WHO Health Alert (Whatsapp) in English +41798931892

Hotline numbers for case reporting and surveillance:

Addis Ababa: 8335 or 952
Oromia: 6955
Tigray: 6244
Amhara: 6981
Somali: 6599
Dire Dawa: 6407
SNNP: 6929
Afar: 6220

For non-emergency related information:

Please call the regular line +251 0118-276-796 or email ephieoc@gmail.com

Annex 4 – Employee Wellbeing [21]

In an emergency, staff wellness may be threatened by the increase in severity, incidence, frequency and volume of traumatic and distressing events, and difficult working conditions. Teams can expect to need to be more autonomous and flexible to meet the demands of the context, and workloads can increase to achieve project objectives that change quickly and often evolve in response to the crisis.

Basic needs (safety and security, safe health behaviors etc.) must be addressed. In addition, staff should be aware of the potential psychological impact of the work on themselves and their colleagues and be familiar with the signs and symptoms of stress. Protocols should be known and followed where they exist.

An agreed system should be identified for communication using appropriate language to flag distress and the need for extra support. The fundamental principle of 'do no harm' applies to aid workers as well as crisis-affected people.

A shared responsibility exists between staff and organizations to support wellness. If you are not well, you cannot help others. Organizations have a moral and legal duty of care to staff, and individuals have a personal responsibility to recognize their own needs and contribute to the support of others in the program.

Teams can anticipate the potential disruption they may face and create plans and 'work-arounds' to provide more flexibility. They can foster a healthy culture of attention to one another's needs, triggers and coping mechanisms. Teams should ensure that they have effective communication methods and channels in place to identify and mitigate the negative impact of emergencies.

[21] Adapted from *IRC Emergency Capacity Building Training*.