Protection Mainstreaming and Mental Health Psychosocial Support Guidance

This brief is intended to provide program staff with an overview of key Protection Mainstreaming and Mental Health Psychosocial Support (MHPSS) risks in the context of COVID-19, as well as potential ways to mitigate these protection risks or adapt programs in ways that enhance people's safety, dignity, and rights, and ensure access to impartial assistance.

PRINCIPLES FOR COVID-RELATED GUIDANCE

In undertaking programming activities, CRS project staff and partners should:

▶ *Ask ourselves how critical it is* to carry out the activity against risk to staff, partners and participants.

▶ *Adopt a "Do No Harm" approach.* CRS and partners need to understand how COVID-19 is transmitted and implement general basic preventative measure to both protect themselves and reduce the risk of spreading the virus during program implementation (See WHO, COVID 19). These measures include the following for all people with whom we work, including CRS staff, partners, volunteers, program participants and community members, service providers, vendors, etc.

- ◆ Maintain Physical Distancing.

- ◆ Follow Recommended Hygiene Practices, especially hand washing, cough etiquette and not touching your eyes, mouth and nose.

- ◆ Do Not Participate in Program Activities when Feeling Unwell; anyone who is feeling unwell should stay home; if exhibiting signs/symptoms of COVID-19, they should follow Ministry of Health (MOH) protocols for seeking medical support/advice (e.g. calling before seeking medical care).

People should operate under the assumption that anyone they encounter is a suspected COVID-19 case. Maintain transparent communication with communities about activities, changes, and the community's comfort level and needs related to the health implications of continued programming.

▶ *Keep up-to-date on and follow WHO and Government/Ministry of Health (MOH) protocols and messaging around COVID-19.*

- ◆ Follow government restrictions and request authorization for carrying out essential services/activities, as needed;

- ◆ Work with local health actors/cluster to ensure health messaging related to COVID-19 is consistent and contextualized.

▶ *Adapt programming guidance to your context and be ready to further adjust as the situation evolves.* Elements of the guidance may need to be modified based upon community risk levels, types of programming undertaken, perceptions, local capacities, operating environment and feedback from donors. For assistance, please contact the COVID-19 focal points in your Region and/or on HRD or the relevant programming technical advisor.

This document provides additional recommendations from CRS, to be used in conjunction with and to supplement guidance provided by Inter-Agency Standing Committee (IASC), WHO and the local MOH as relevant.

Disclaimer: CRS COVID-19 program resources and guidance are developed after consideration of international guidance from relevant international organizations such as the World Health Organization (WHO), Inter-Agency Standing Committee (IASC), and other humanitarian bodies. CRS COVID-19 program resources and guidelines are updated regularly as new information becomes available. Partner and peer organizations wishing to refer to and use CRS resources and guidance should ensure that they are also referring to the latest information available from WHO and IASC.

PROTECTION RISKS[1]

Sexual and Gender Based Violence (S/GBV)

►*Increased risk of domestic/intimate partner violence:* Although research is limited how outbreaks can exacerbate different forms of violence against women and girls, emerging evidence suggests that forced coexistence, economic stress, and fears about the virus may be increasing household tension and domestic violence. Concurrently, survivors of domestic violence and other forms of GBV may face reduced access to support services as these are reduced or closed, or resources diverted to COVID-19 response. Others may refrain from seeking services or support due to fear of infection.

►*Social norms that put a heavy caregiving burden on women and girls.* Women and girls are likely to take on increased caregiving responsibilities in addition to ongoing domestic and/or income-generating tasks. This is likely to affect their physical and mental health and impede their access to education, livelihoods, and other critical support. Food may become scarcer during a public health emergency, forcing households to engage in negative coping mechanisms, such as consuming less food. Where women eat last and least, this can lead to additional health complications, including increased susceptibility to COVID-19. Additionally, men and women may be unable to access their livelihoods, whether due to travel restrictions or quarantine or fear of being stigmatized due to association with the disease (e.g. preliminary reports indicate migrant and refugee populations may already be facing increased discrimination and forced restrictions on mobility). Frontline healthcare workers, particularly women, are facing harassment and abuse both in the workplace and in public.

►*Increased risk of sexual exploitation and abuse.* Increase in persons responding to crisis (potentially non-traditional humanitarian responders), high demand for services, and unequal supply of food and health supplies, increased risks of sexual exploitation by NGO workers particularly for women and girls. Additionally, there are initial reports of intimidation and sexual exploitation by armed forces and other officials enforcing community level quarantines. Female-headed households are more likely to have inadequate shelter than male-headed households, exposing them to a greater risk of illness or abuse.

Child Protection[2]

►*Children may face increased risk of abuse, neglect, exploitation, violence or separation.* School closures disrupt children's routines, learning opportunities, peer and teacher support, and potentially a reliable source of food, while also placing increased stress on parents and caregivers who may have to find new childcare options or forego work. Increased household tensions can fuel parental frustration and corporal punishment, as well as expose children to domestic violence and abuse by/between caregivers. Children may be separated from caregivers who are hospitalized or who have died, increasing their vulnerability to maltreatment (by temporary caregivers) and psychosocial distress. Household economic pressures may particularly affect adolescent girls, who may be at risk of early marriage, school drop-out, and sexual exploitation or abuse.

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[1] Some common protection risks are detailed above and a mapping of wider risks is available in Annex 1: *Protection Risks COVID19.*
[2] For further CRS guidance on Child Protection programming, please see here and here.

Social Exclusion and Isolation

►*Diverse groups may face additional social exclusion or isolation.* Groups which may already be at risk of social exclusion or isolation in the home — e.g. older people, people with chronic illnesses, and people with disabilities — may be increasingly so under quarantine, especially when other sources of social support are reduced (e.g. family visits, engagement with religious institutions, and community events). Such groups may be difficult to reach with accurate and timely information, particularly in remote areas or when they lack access to phones or other technologies.

►*Exclusion of diverse groups from participation and leadership roles.* Diverse groups risk exclusion from participation in COVID-19 response planning efforts: women may face an increased work burden in the home; older persons and persons with disabilities may leave the home even less or not at all under quarantine; refugees may face stigma and discrimination; and all these groups may lack the necessary technologies or alternatives to engage remotely. And despite the fact that women constitute a majority of frontline healthcare workers, they continue to form only small minorities in national and global health leadership.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT RISKS

►*Impact on social fabric.* Impacts of COVID-19 may include school closures, loss of jobs or income, goods and services becoming scarcer, loss of opportunities for community or religious gatherings as a source of support and strength, and loss of family members. These additions to the current situation, may result in:

- Loss of hope
- Feeling powerless to protect or care for those you love
- Frustration over not having resources to keep yourself safe
- Shame and stigma
- Increased stress and violence in household
- Deterioration in those with existing mental illness or psychosocial disabilities

►*Rise in tension and violence.* Higher emotional states, anger and aggression are possible during pandemics. In urban or densely settled settings, unique stresses can arise, such as tension between and within households. These tensions can result in erosion of social networks, violence or abandonment. Aggression against government and frontline workers is also possible, as well as anger and aggression against children, spouses, partners and family members.

RECOMMENDED PROTECTION MAINSTREAMING MEASURES[3]

Risk Communication/Information Sharing. There is a need to consider targeted approaches to reaching all social groups with risk communication and services, taking into account gender, age, disability, education, migrant or refugee status, and other relevant diversity factors. Evidence from other outbreaks suggests that education status impacted knowledge uptake for certain groups. In addition, recognition needs to be made of the specific health and communication needs of especially marginalized groups, including LGBTQI persons, people living with HIV, children, people with disabilities, and migrants.

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[3] For further guidance, please see Annex 2: *Protection Mainstreaming Working Group (PMWG): Emergency checklist for protection mainstreaming and COVID-19. March 2020.*

► *Ensure information is tailored to diverse groups.* Given social norms around women's caregiving responsibility, it will be critical to ensure that women are able to get information about how to prevent and respond to the epidemic in ways they can understand. Women play a major role as conduits of information in their communities, and yet they have typically less access to information (and cell phones) than men. COVID-19 information, education and communication (IEC) strategies and materials should also consider ways to reach people with reduced mobility or other disabilities or chronic conditions, older people, and others who may not be able to leave their homes. Consider ways to disseminate clear, child-friendly messaging on children's unique risks and vulnerabilities related to the outbreak. Examples of child-friendly messaging can be found here and here.

► *Consider how information can reach diverse groups.* Consider barriers to accessing information for different groups and plan communication strategies/methods accordingly. Share information through a range of communication methods appropriate to the COVID-19 context (formats, language and media) that are appropriate to the needs of the community, especially the most vulnerable and marginalized groups. Ensure at least one chosen method is specifically targeted to women, children and other high-risk groups (people with different types of disabilities, refugees, elderly etc.). WHO's Risk communication and community engagement (RCCE) readiness and response to the 2019 novel coronavirus provides more detailed guidance about information sharing and community engagement strategies. (2019-nCoV): interim guidance (26 Jan 2020)

► *Provide clear statements of zero tolerance of inaction on sexual exploitation and abuse (SEA).* Ensure information sharing materials include messages regarding CRS' zero tolerance approach to inaction on abuse and exploitation, and expected behavior of staff.

Mapping and Referral. Given that COVID-19 may exacerbate protection issues such as GBV; child abuse-separation, exploitation, violence or neglect; or reduced access to health care, there is a need to prepare staff for a potential surge in the populations we serve and equip them to respond appropriately and ethically and make referrals if necessary.

► *Ensure field and frontline staff have up-to-date information readily available-on referral pathways.* In particular, they should have information for locations of health centers, women- and girl-friendly spaces which are still providing services, as well as hotlines and remote counseling services which are still operational. The Protection Cluster (or GBV and Child Protection sub-clusters) should provide this information if operational, or the relevant government authorities/ministries. Ensure staff have hard/soft copies when conducting field activities.

► *Conduct remote trainings or briefings for staff on Psychological First Aid (PFA).* Clear protocols should be in place for how to make referrals for family separation, GBV, child protection and other types of protection issues. The IASC GBV Pocket Guide (in 4 languages) and WHO PFA Guide (in 29 languages) may be useful resources to share with all staff. Where staff capacity in making referrals may be a concern, consider designating a staff focal point with protection, gender, social work, or OVC experience who can assist with referrals or directly guide/support staff on the process.

Staff Conduct and Staff Care. In a climate of increased demand for assistance, goods, and services, power differentials and increased potential for exploitation and abuse, it will be critical to ensure staff, volunteers, vendors, and other affiliates understand and have signed the organization's Code of Conduct and Safeguarding Policy. Equally, self-care is critical to our ability to care for ourselves, our own families and others.

► *Consider developing a short version of the Code of Conduct in local languages.* Ensure the do's and don'ts—and how to report any incident—can be more easily communicated.

►*Consider staff care issues.* For example, train staff on good hygiene practices and provide staff with easy access to handwashing/disinfection materials while in the field, pair up staff when they visit field sites, ensure staff know the protocols if they display symptoms (based on the Ministry of Health Guidelines), train staff on basic Psychological First Aid, and ensure they receive regular breaks and time-off.

►*Consider the make-up of field teams prior to field activities.* Ensure representation of male and female staff where possible. If suspicion of specific groups (including of foreigners) is growing in your context, consider who is best placed to visit field sites.

Participation. Given their role in caregiving, facilitating participation of women and girls in consultation and decision-making processes will be critical to effective COVID-19 prevention and response, and at the same time may be more challenging due to increased workload burden, confinement in the household, and community engagement structures that traditionally have marginalized them.

►*Identify community influencers and trusted networks in local communities.* In particular, identify women's groups/associations, community health volunteers, youth associations, religious groups—who can help with community engagement and reaching more vulnerable community members.

Feedback and Complaints. Given the rapidly shifting context, changes in the scale and approach of programs, and increased risk of abuse and exploitation, the continuation of feedback and response mechanisms will be crucial to flag any issues of abuse and exploitation. They will need to be reviewed and adapted to the context.

►*Consider using mechanisms that do not involve face-to-face contact.* This could include WhatsApp messaging or phone calls, bearing in mind certain groups (such as women, children, older people, etc.) may not have access to phones (such as women, children, older people etc.).

►*Put in place measures to reduce risk of transmission.* Where to face-to-face contact is the best option, put in place measures to reduce the risk of transmission by respecting local Ministry of Health or WHO recommended minimum distance between one another.

Analysis and Targeting. Different groups will be differently affected in COVID-19 outbreaks. For example, an older woman living alone or without any support systems or women migrant workers may have particular vulnerabilities and require specific outreach and assistance.

►*Use the above protection risk analysis.* This should be contextualized to each country's specific situation and should be accompanied by a comprehensive gender analysis. These should inform protection mainstreaming provisions included in all project design processes and proposals.

►*Consult protection mainstreaming checklists.* Checklists are available for various sectors. For further resources please contact Amy Anderson, the Protection Mainstreaming and PSEA Team Lead.

RECOMMENDED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MEASURES

►*Include key MHPSS messages along with other messaging.* This can include hygiene instructions, normal reactions to pandemics and to isolation, as well as simple suggestions for coping that are appropriate to the community. Consider adapting messages for different audiences including children using appropriate language.

►*Train all field and frontline staff in Psychological First Aid (PFA).* Trainings can be conducted remotely (staff conducting assessments, registrations or data collection,

health and nutrition workers, WASH and Hygiene promoters, Shelter staff, Case workers, should be trained face-to-face where possible).

►*Engage community leaders in understanding primary stressors.* This should include raising awareness of stressors that are developing as a result of isolation and strained resources for health practices, as well as how community support networks function. Consider training those with access to communities in PFA, and/or PFA for children. Capitalizing on existing altruism and supports early on will help in preventing erosion of networks and trust.

►*Consider family dynamics of long periods of isolation.* If possible, provide a handout on positive activities or games that families can do together, particularly between caregivers and children.

►*Ensure staff care plan is adjusted.* The plan should address additional strains related to social distancing and self-isolation, including communication strategies, time allotted for procuring basic needs if store hours are limited, regular supervision and check ins, and counseling resources if needed.

REFERENCES

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