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UKPHS COVID-19 Response Fund: annex 1

Appropriate responses

While planning any COVID-19 intervention, it is important to recognise that responses should be underpinned by these core design principles highlighted by the FCDO in order to maximise effectiveness:

* **Apply a context-sensitive approach**: one size does not fit all. All approaches will not be possible in all contexts, particularly in fragile and conflict-affected states. Context also affects ranking of approaches.
* **Co-create solutions with communities affected**, recognising there are diverse needs at community level by age, gender, disability, and other factors. Communities are best placed to identify opportunities, challenges, and practical solutions in their contexts. This will also build trust and improve compliance.
* **Balance benefits for disease control against negative indirect impacts** to minimise the overall impact on poverty and development, including on wider health outcomes.
* **Build on existing systems** and avoid creating parallel systems wherever possible.
* **Identify and focus on areas of high transmission and/or high risk**: COVID-19 is likely to spread most quickly in densely populated urban areas, and more slowly in sparsely populated areas. Measures should be targeted to where they will have greatest impact.
* **Use data to target escalation and de-escalation of measures** to maximise the effect on disease control and minimise indirect impacts – through building stronger data systems where possible that disaggregate data to allow clearer targeting of the response and recovery.
* **Coordinate approaches with all relevant partners, led by government**: including humanitarian agencies and local and nationally representative rights organisations to ensure key groups are reached.
* **Prioritise inclusion** including women alongside men, people with disabilities, older people, and the poorest and most marginalised communities. This is critical to leaving no one behind, but also to controlling the pandemic as failure to reach these groups will allow the disease to continue spreading.
* **Global innovation flow**: encourage creativity, innovation and resourcefulness in the face of resource constraint via bi-directional learning.

All interventions should align with national governments plans and priorities and support the COVID-19 response through collaboration with the relevant Ministry of Health.

**Examples of acceptable uses of funding**

The table below shows a few examples of possible funding options. These aim to be a starting point for partnerships to think about the type of project/intervention they could apply for funding support for and is not an exhaustive list. We would expect to see these options to develop as we learn more about the needs, contexts, and ideas from partnerships and advisors.

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| **The UKPHS COVID-19 Response will fund:** | **Examples of activities:** |
| **Supporting Infection Prevention Control initiatives approved by the WHO** | Guidance on the production and formulation of substances necessary for effective IPC (e.g. soap, ingredients for making hand sanitiser etc.) approved by the WHO. Please note that this fund will not fund the procurement of either the raw materials used to make antibacterial substances or the substances themselves. Please also see this example project - [*Targeted placement of alcohol-based hand rubs, Ndola, Zambia*](https://apps.who.int/iris/bitstream/handle/10665/176272/WHO_HIS_SDS_2015.13_eng.pdf;jsessionid=853C0258155A298E48B77631F3B959A8?sequence=1) |
| Training health and humanitarian workers on PPE use and core measures (e.g. handwashing, cleaning of surfaces and equipment, waste management, bed spacing, ventilation, and early recognition and case isolation) |
| Implementation of procedures for screening for all patients at point of first contact with health services, separate waiting areas (with medical masks), and if admitted keep in separate wards (including maternity units) ideally with a designated team of health workers. |
| Signs for patients' rooms, labelled bins for disposing of contaminated equipment etc. |
| Promote positive behaviours to reduce transmission empowering individuals to protect themselves e.g. handwashing with soap, coughing into elbows, avoiding touching eyes / nose / mouth, no hand-shaking, staying 1m apart. Use Behaviour Change Communication principles |
| Occupational health initiatives such as developing cleaning protocols and ensuring ventilation of sites |
| **Remote training, mentoring and supervision on responding to COVID-19** | Training on case management and correct handling of patients infected with COVID-19 |
| Translating guidance and trainings into practice for the local context |
| Repackaging materials for communities in local languages and for illiterate populations |
| Providing platforms for remote training sessions to take place |
| **Supporting appropriate surveillance and data collection related to COVID-19** | Capacity development in clinical data collection, reporting, analysis, and modelling to better evaluate the situation and changing contexts |
| Support the collection and analysis of sex and gender disaggregated data related to COVID-19 |
| Conduct a population analysis of COVID-19 cases to inform planning and response, including both primary short-term and long-term impacts |
| Strengthen existing surveillance systems through integration, training, and investment to improve data quality in the wider health information systems e.g. confirmed cases, primary and secondary care data, and death registrations |
| **Advice and guidance to national teams to consider response strategies and implementation** | Support the development of plans which address the length and severity of the pandemic, including for essential services effected by the pandemic |
| **Support for the development and/or distribution of public health information/ communication materials (in line with WHO guidance and national strategies)** | Campaigns to spread information, or dispel myths and fears through social media, SMS helplines, or radio communications |
| Develop and distribute leaflets or posters to remind all health workers, as well as patients and visitors, about hand hygiene as part of a multifaceted approach to support behaviour change |
| Liaise with national Ministry of Health and/or local health leaders, diaspora, religious leaders, community leaders, community-based organisations and local NGOs through virtual gatherings and virtual speeches to explain the purpose and give them appropriate information and/or materials to support the implementation of social distancing, self-isolation, recognising symptoms etc., enabling them to reach and provide this information to their communities |
| Protect children attending school by informing children / teachers how to protect themselves and prevent stress and stigma, cleaning / disinfection, and increasing ventilation |
| Encourage activities to be held outdoors where possible e.g. school classes, religious services, and increase ventilation of public spaces, transport etc. as much as possible |
| **Facilitate travel and family support for health worker, in line with government’s recommendations and when appropriate to local context** | Arranging for bus or taxi companies to pick up health workers and drive them to/from work safely in the absence of normal forms of public transport and to mitigate risks associated with public transport |
| Facilitating communication between healthcare workers and their families (especially if they must move away from them) by providing access to phones and/or internet connection |
| **Interventions which support the psychological resilience or well-being of health workers** | Coordinating and administering remote psychological trainings, for example, trainings in [*pre-trauma exposure*](https://www.aomrc.org.uk/wp-content/uploads/2020/03/Guidance-for-planners-of-the-psychological-response-to-stress-experienced-by-HCWs-COVID-trauma-response-working-group.pdf) as well as [*moral dilemmas*](https://www.kcl.ac.uk/news/ensuring-the-mental-health-of-healthcare-workers-in-the-covid-19-pandemic)*.* Other training topics could include “how to cope with stress” or “personal wellbeing check-ups”as shared by the Academy of Medical Royal Colleges. Where appropriate these resources should also build on experiences from Ebola and the mental health interventions and systems used during that outbreak |
| Mentoring/buddying, for example through: implementation of [*Schwartz Rounds*](https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/); psychological first aid; online drop-in sessions for staff with employee wellbeing experience, engaging and enabling staff with mental-health experience to provide support. |
| Engaging with or coordinating local and informal virtual peer support networks, for example through an online forum or WhatsApp groups, providing a space where healthcare workers can share thoughts and provide peer support |
| Providing resources (see example [*here*](https://www.mentalhealthatwork.org.uk/toolkit/supporting-healthcare-workers-mental-health/)), including: space, safe/calm places for staff to rest on shift; sustenance; beds or other pieces of furniture for breakrooms; and access to showers and toiletries for frontline staff |
| Providing spiritual support |
| Facilitating access to mental health helplines and listening services through subscription services |
| Leadership development for team leaders and guidance on the facilitation of support groups, for example training on how managers can monitor and ensure team's wellbeing and provide consistency in the workplace |
| Working with institutional management to ensure accommodation is made available on site in hospitals for health workers with vulnerable individuals in their household |
| **Support for essential health services** | Ensuring infection prevention and control measures are in place to guarantee safe service delivery (not including the purchase of IPC materials or equipment) |
| Adjusting governance and coordination mechanisms to support timely action |
| Prioritising essential services - identifying what can be delayed and what cannot; assessing what can be relocated to areas that are less affected by COVID-19; working out the particular needs of marginalized populations including indigenous peoples, sex workers, migrants and refugees |
| Reassigning health workers from areas with low or zero COVID-19 transmission, or from places with excess capacity, to boost the workforce in hard-hit zones so that essential services can be maintained |