A woman cleans her hands at the Alexandria refugee camp in northern Greece. 2016. Credit: Tara Todras-Whitehill / IRC

Combating the Spread of Coronavirus to the World's Most Vulnerable

Many of the first known cases of the novel coronavirus (COVID-19) were present near a seafood market in Wuhan, China in late 2019. By the end of December 2019, cases grew from just a handful to dozens. On December 31, the Chinese government alerted the World Health Organization of the outbreak which by then was affecting thousands. A high rate of transmission and consistent in and outbound travel from Wuhan soon catalysed the spread of the virus to the rest of the world. By the end of January, outbreaks were occurring in over 30 cities, within which the pandemic took root as the virus began spreading locally from person to person. By early March, Italy, Iran and South Korea took China's place as the main drivers of the outbreak. Today, there are currently 372,147 confirmed cases of COVID-19 to date, 16,310 of them fatal.

With IRC's years of expedient, effective emergency response programmes and a global team of technical emergency response experts, our organisation is uniquely positioned to address this rapidly evolving pandemic. Our IRC COVID-19 response leadership team is comprised of public health experts who ran Ebola infection prevention and control programmes at the height of the Ebola outbreaks in West Africa and the Democratic Republic of Congo, from which we have synthesised lessons learned to apply to pandemics like the one currently ravaging the globe.

Based on the IRC's eight decades of experience of responding to public health emergencies, working in the world's harshest locations, the IRC has designed a bold approach to disrupt the spread, and diminish the impact of the COVID-19 disease on the communities we assist. We are ramping up our efforts in response to COVID-19 with a focus on crisis zones with especially weak health systems. In countries experiencing active conflict like Yemen, Syria, Eastern Democratic Republic of the Congo, Northeast Nigeria and Burkina Faso, it will be more difficult and vital to mitigate the spread of COVID-19 which will put the lives of hundreds of thousands of vulnerable civilians at increased risk.

IRC's GLOBAL RESPONSE PRIORITIES

The IRC is providing life-saving programmes in countries threatened by the disease. We are prioritising work across the following three key areas to:

1. Protect IRC staff as they work tirelessly to combat COVID-19 while sustaining existing programming. From Colombia to Afghanistan, we are equipping our staff with the supplies and knowledge necessary to work safely. Additionally, we have deployed a strategy to mitigate the impact of a global shortage of equipment used to protect healthcare workers from coronavirus transmission.

2. Disrupt the spread of COVID-19 by adapting and sustaining IRC's critical life-saving program-

ming across 40 high risk countries. Refugees, displaced from their homes and those still living in crisis will be hit the hardest by this pandemic. COVID-19 will thrive in active war zones like Yemen and Syria, putting the lives of hundreds of thousands of civilians in even more danger. The outbreak will only compound the many and serious threats to life civilians face from conflict, violence and food insecurity. The IRC is moving rapidly to adapt the way our programmes are delivered, to keep them open without adding to risk of Covid-19 transmission. IRC staff will be working ever harder to reach people in need where they are, and relying increasingly on technology to share information to raise awareness.

3. Mitigate and respond to the spread of COVID-19 within vulnerable communities. We are training healthcare workers across the globe to identify and respond to COVID-19. From Burkina Faso to Thailand, we are implementing community-level education on disease prevention and bolstering local health facility capacity and programmes to provide vital medical services.

IRC & RISK MANAGEMENT

COVID-19 is a pandemic. Every country in the world could soon have to confront the stark reality of a viral outbreak, potentially at different times and locations. Effective mitigation measures require proportionate and localised responses appropriate to the local transmission dynamics.

The IRC has developed our own Risk Categorisation Index (see here). This is designed to provide clear trigger points for categorisation based on risk. The Index takes into account transmission type and intensity as well as country-specific vulnerabilities. Daily updates of our risk categorisations allows the IRC to act strategically, prioritising actions and allocating funding to our programmes accordingly. Our Risk Categorisation Index is summarised below:

CATEGORY 1 | Includes countries with a capable health system and no known cases of COVID-19. Category 1 prompts actions including personal hygiene measures, social distancing and general respiratory etiquette. IRC offices and Country Programmes are responsible for regular updates and sharing of key prevention messages to all staff.

CATEGORY 2 | Includes countries with capable health systems and imported cases of COVID-19 or countries with weak health systems and no current cases. Category 2 prompts actions including personal hygiene promotion, respiratory etiquette and social distancing. IRC Offices and Country Programmes must provide regular updates to local staff, identify coronavirus focal points, coordinate with state and local health officials and perform routine environmental cleaning.

CATEGORY 3 | Includes imported cases in countries with weak health systems or instances of community transmission in countries with capable health systems. Category 3 prompts actions like personal hygiene promotion, respiratory etiquette and social distancing. IRC Offices must provide regular updates to all staff, identify coronavirus focal points, coordinate with state and local health officials, assess control and safety measures at all IRC offices, workforce and critical function planning, preparation for imposed lock down/quarantine or plan for staff relocation and evacuation. IRC programmes must provide technical trainings for staff, in-country stock analysis and communications with IRC clients.

CATEGORY 4 | Includes countries with local transmission and weak health systems. Category 4 designation prompts actions like personal hygiene promotion, respiratory etiquette and social distancing. IRC offices must keep all staff informed and coordinate with local and state health officials and preparation for possible quarantine or evacuation. IRC programmes must provide technical training for staff and prepare and/or implement business continuity and response plans.

CATEGORY 5 | Includes countries with widespread transmission or presence of multiple clusters/outbreaks of community transmission. Category 5 designation prompts actions like personal hygiene promotion, respiratory etiquette and social distancing. IRC offices must comply with actions including but not limited to openly communicating with staff on local COVID-19 state of play, engage in workforce and critical function planning, preparing for and implementing staff relocation/evacuation. IRC programmes must provide technical training to all programme staff, communicate clearly with IRC clients and plan programme business continuity and response along with in-country stock analysis and prep-positioning of supplies.

LEVERAGING THE CRISIS RESPONSE FUND FOR COVID-19

Timely action is more crucial than ever. Traditional funding can take six weeks or longer to negotiate – a lifetime in an emergency. Immediate access to funding allows frontline responders to take urgent action. This is how the IRC's Crisis Response Fund has supported immediate action, from Thailand to US offices to Uganda. To date, the IRC has launched nine responses, most approved within the same day requested.

OUR EMERGENCY RESPONSE PRIORITIES IN ACTION

KEEPING STAFF SAFE | In Thailand, all IRC staff have been trained on the basics of COVID-19, and frontline health staff have received extensive training to identify suspected COVID-19 cases. We have also set up triage, screening and isolation rooms at health facilities within refugee camps, and are holding weekly meetings with refugee camp leadership on the situation and to inform them of preparedness and response activities. Finally, we are working with the Ministry of Health to secure protective gear and supplies for frontline health workers within the refugee camps.

PROGRAMME ADAPTATION | In Kakuma Refugee Camp in Northern Kenya, the IRC has trained health workers on COVID-19, how to protect themselves, and reinforced proper hygiene and self-isolation procedures. We have increased surveillance for potential cases around the camp and reinforced infection, prevention and control at health facilities, as well as identified isolation units at the IRC-run General Hospital for potential COVID-19 cases.

COVID-19 RESPONSE SERVICES | In Italy, the IRC is using our Refugee.info platform, supported by Google and Twilio, to share COVID-19 information with refugees and vulnerable populations and ensure they know how to protect themselves, identify the signs and symptoms of the disease and where to seek support if they fall ill. The first COVID-19 information post reached 100,000 people, with 10,500 interacting with the vital health information.

URGENT FUNDING NEEDS

IRC is appealing for US $30 million to help us protect vulnerable populations and displaced people from the coronavirus. The international community, especially major donors like US, UK and Europe, must invest immediately in health systems of vulnerable countries to be able to prevent, detect and respond to this disease.

IRC Ebola-response staff wash their hands in chlorinated water outside an IRC Ebola triage space in the hospital in Goma, DRC. 2019 Credit: O. Acland/ IRC