Concept for Community Based Shielding Model - Al-hegerah الهجرة

(When the tribes protect some individuals/ groups in community, the most vulnerable people are one of these group)

Community Based Protection for those most at Risk;

In the context where there's COVID 19 outbreak, no individual is fully immune to the COVID 19 disease and can get infected. Everyone is expected to maintain recommended preventive measures. However, global data and disease patterns suggests that there are certain groups of individuals who are at higher risk of severe infection and require hospitalization compared to other groups. Health systems are overwhelmed and / collapsing and have limited capacity and potential to ensure timely and effective case management. Moreover, pre-existing high vulnerability, limited access to regular health services and levels of chronic disease put many Yemeni populations at greater risk of COVID-19.

This Note provides a model of community lead prevention as a means of protection from COVID-19, ad considers non-covid-19 related measures to empower community and populations with mechanism to protect their high-risk persons and prevent further deterioration of other, non-covid-19 health and humanitarian needs. This model also recognizes a response, as local as possible, with capacity to manage, will also limit potential risk of reduced access / movement with curfew / restrictions imposed.

Interventions and preventative at the lowest level to provide communities with the capacity, knowledge and options to prevention themselves and their high-risk groups is giving them the best possibility of protection from infection. It is important to note that the success of this strategic guidance will be dependent on clear communication with the household and communities and their acceptance and ability to apply the recommended measures.

Objective:

To reduce the risk of exposure of the vulnerable and high-risk members of the households and communities to COVID-19 Infection, thereby increasing their chances of survival and reducing pressure on health facilities / systems.

Proposed Structure:

Whilst the model is community based and lead, a chain of guidance, technical support, services and accountability and risk reduction follows from community modelling. This can be seen in Diagram 1.

Training / capacity building / guidance on community-based modelling can be provided.

National Level; Proposed partnership / construct (UNICEF- multi-sectoral service, RCCE, supply, ECT and ICRC / INGOs– Technical oversight, guidance and leadership with YRCS as well as the multi-sectoral Covid-19 Support Team: Yemeni Red Crescent, supported by ICRC – leading the community-based interventions, working closely with and through networks, with respected community members to act as focal points to community to protection themselves and enable them to shield.

Targeting

Whilst the model considers a countrywide approach through RCCE and messaging on those at high-risk and behaviors for them and their caretakers / family members. The full preventive support rolls out considers a prioritization of areas at higher risk; Namely;

- Overcrowding.: buildings per area/width of streets / Urban areas.
- Population densities and demographics (if feasible / relevant)
- Areas with limited access to networked water / <20L water proviso (/ Acute water needs)
- Social stability & Protection risks (% Population IDPs, mulhamasheen, vulnerability, etc.)
- Level of Health access / severity indicators

Identifying those at High Risk.

- Ideally based on training on YRCS, and Community representatives' focal points – they could guidance communities on explaining who the people at greater risk of severe infection are. Therefore, community led / self-identification.
- Additional Data / Info sources – for targeting / triangulation / risk and power dynamics reduction – MPCA data, ECT data, UNHCR >50ss / vulnerable, FSAC – Food distribute lists (VaM)
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Proposed Activities:

To Support the below guidance and action for Shielding of persons at High Risk of COVID-19, the following activities are proposed at community level:

➔ Appropriate and clear messaging through RCCE actors, community volunteers, media channels, health centers, CHVs, and trusted community representatives.
➔ Supporting community led identification of high risk / vulnerable groups – linking with different vulnerability existing data (i.e. FSAC Food list)
➔ Once HH identified, Support community-based mapping -> needs for services (what / how) and which service providers available to be linked. Considering safety protocols - means to empower shielding.
➔ For identified HH, Frontload supply / support; i.e. NCD, give 1-month meds, 2-month MPCA, CHKS / IPC Kits, to enable populations to be less reliant on what may happen, reduce imperative to go out.

Enable shielding

➔ Decentralizing supply and linking up to needs; Support local management of supply and reduce movement restrictions risk, curfews.
➔ Providing link up and coordination / focal point between different services points and service providers (i.e. health referral, MPHSS, etc.) – community liaison and support team.
➔ Ensuring Alerts and early warning raised.
➔ Sharing information and contacts of nearest HFs and HCWs to support for support to access health care, medical follow up for chronic conditions and medicines.
➔ Guidance on (and provision of) PPE for any required visits to health facilities for follow up of treatment for chronic disease (cloth over face, and handwashing / gloves)

Knowledge attitudes and Practices for High Risk.

Who is at high-risk of COVID 19, and what?

Based on medical expertise, those at high-risk for severe illness from COVID-19 are:

1. People 50 years and older

2. People of any ages with the following underlying medical conditions, including:
    - People with lung disease or asthma
    - People who have serious heart conditions or cardiovascular problems.
    - People who are immunocompromised; Can be by cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, and prolonged use of corticosteroids
    - People who very overweight
    - People with diabetes, chronic kidney disease, liver disease, hypertension.

Guidance / messaging and IEC

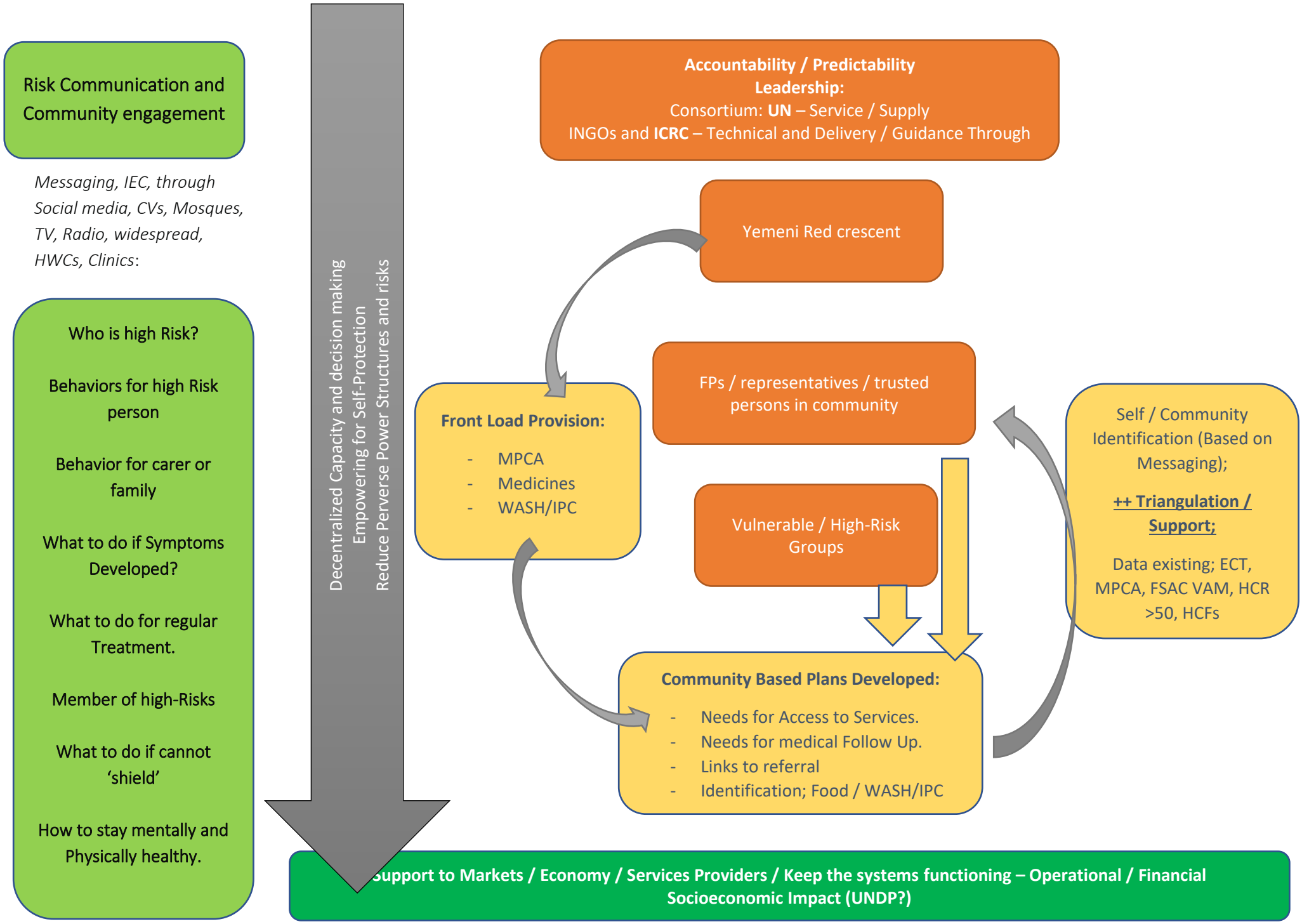
Lead by Pillar 2, and spread through all RCCE networks and actors and channels, including;

- Posters, flyers, social media, radio, mosques, Community Volunteers, outreach workers.
- Messaging to include;

Who is High-risk and behaviors / safest approach for protection for;

- High-risk person
- Include caretaker / family members / those living with high-risk

- What behaviors and practices to follow if shielding is not possible, for?
    - High risk person
    - Others (family, community members, etc.)


Risk Communication and Community engagement
Messaging, IEC, through Social media, CVs, Mosques, TV, Radio, widespread, HWCs, Clinics:
Who is high Risk?
Behaviors for high Risk person
Behavior for carer or family
What to do if Symptoms Developed?
What to do for regular Treatment.
Member of high-Risks
What to do if cannot 'shield'
How to stay mentally and Physically healthy.
Decentralized Capacity and decision making
Empowering for Self-Protection
Reduce Perverse Power Structures and risks
Accountability / Predictability
Leadership:
Consortium: UN – Service / Supply
INGOs and ICRC – Technical and Delivery / Guidance Through
Yemeni Red crescent
FPs / representatives / trusted persons in community
Front Load Provision:
- MPCA
- Medicines
- WASH/IPC
Vulnerable / High-Risk Groups
Self / Community Identification (Based on Messaging);
++ Triangulation / Support;
Data existing; ECT, MPCA, FSAC VAM, HCR >50, HCFs
Community Based Plans Developed:
- Needs for Access to Services.
- Needs for medical Follow Up.
- Links to referral
- Identification; Food / WASH/IPC
Support to Markets / Economy / Services Providers / Keep the systems functioning – Operational / Financial
Socioeconomic Impact (UNDP?)