**Individuals :**

**“Young people, when informed and empowered, when they realize that what they do truly makes a difference, can indeed change the world.”**

**Jane Goodall**

Can promote guidance and guidelines and address the COVID-19 related needs of the most vulnerable in their communities.

Can provide guidance on thorough handwashing practices to reduce the spread of the virus.

Can safely help seniors and other at-risk groups to access supplies, such as food and medication.

Can provide tools for physical activities and sport using social media, during the confinement.

Can find ways to check on, and support others’ mental health through social media.

Can also contribute to data-collection and monitoring, including in relation to marginalized communities, to assess the COVID-19 response.

**Communities**

Public health is a complicated issue. This has become particularly evident during this worldwide pandemic of COVID-19. ***On May 25, 2020, Mr. George Floyd, an African American man residing in Minneapolis was killed in police custody. For 8 minutes and 46 seconds, the arresting officer had his knee pressed on Mr. Floyd’s neck, ultimately killing him through asphyxiation. This event ignited a movement of fiery protests fueled by the current status of racial discrimination and socioeconomic and healthcare disparities in America, much of which is still ongoing as I write this letter on June 2, 2020.***

There is mounting evidence that suggests that minorities experience a greater incidence and worse cases of diseases compared to white Americans. The root causes of these health disparities have been heavily studied; racism and discrimination make access to healthcare resources difficult and, sometimes, impossible. When it comes to COVID-19, key risk factors, such as age, sex, and comorbidities (i.e., hypertension, diabetes, and cardiovascular disease), are linked to worse outcomes. Unfortunately, these factors are compounded with the disparities noted with race and socioeconomic status. Poorer communities and people of color experience limited access to health education, hygiene management, and healthy foods. Additionally, they live in areas with denser populations, which makes it difficult to maintain appropriate social distancing, specifically regarding COVID-19.

**STATE ACTORS**

**State of Public Health Care in India:**The Indian government’s expenditure on health as a percentage of GDP still hovers around 1·5%, one of the lowest in the world. For around 52% of households in urban areas, and 44% of households in rural areas, the private sector is the main source of health care when they are sick, according to government data. It is insufficient to take on a pandemic like COVID-19.

**Misinformation and Stigma:** Stigma has further aggravated the problem. Misinformation and Stigmatisation has led many people running away from the quarantine centres / hospitals and people are not coming forward. The issue of stigmatization stems from fear, prejudice, divisiveness, sometimes from racism, and lack of correct information.

**Water and Sanitation:** The preventive measures require frequent washing of hands apart from maintaining physical distance and practising isolation. Despite tackling the challenge in a mission mode, there remains critical gaps in access of people to potable water and sanitation facilities.

**Impact of Lockdown:**The nation-wide lockdown has led to loss of livelihood, education, access to family planning and sexual and reproductive health services among young couples and young people. There is an increase in reported cases of gendered and [domestic violence.](https://wearerestless.org/2020/06/10/domestic-violence-a-shadow-pandemic/?fbclid=IwAR3c6TxtOeMwQqd7hKa6S-U8giYi1kogMh4M20_AmVqaDXxeuyPolHvosVc)

Pillar 1: Country-level coordination, planning, and monitoring National public health emergency management mechanisms should be activated with engagement of relevant ministries such as health, education, travel and tourism, public works, environment, social protection, and agriculture, to provide coordinated management of COVID-19 preparedness and response. NAPHS and PIPPs, if available, should also be adapted to address COVID-19.

Activate multi-sectoral, multi-partner coordination mechanisms to support preparedness and response

 Engage with national authorities and key partners to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response, or preferably adapt, where available, an existing Influenza Pandemic Preparedness Plan

 Conduct initial capacity assessment and risk analysis, including mapping of vulnerable populations  Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures 2

 Establish an incident management team, including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available

 Identify, train, and designate spokespeople

 Engage with local donors and existing programmes to mobilize/allocate resources and capacities to implement operational plan

 Review regulatory requirements and legal basis of all potential public health measures

 Monitor implementation of CPRP based on key performance indicators in SPRP and produce regular situation report 3

 Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary

 Conduct after action reviews in accordance with IHR (2005) as required

 Use COVID‑19 outbreak to test/learn from existing plans, systems and lesson-learning exercises to inform future preparedness and response activities

Pillar 2: Risk communication and community engagement It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumours and misinformation. Changes in preparedness and response interventions should be announced and explained ahead of time, and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust.

Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures (use the existing procedures for pandemic influenza if available)

 Conduct rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels

 Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups

 Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women’s groups, youth groups, business groups, traditional healers, etc.) 2

 Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels

 Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication

 Utilize two-way ‘channels’ for community and public information sharing such as hotlines (text and talk), responsive social media such as U-Report where available, and radio shows, with systems to detect and rapidly respond to and counter misinformation

 Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations 3

 Systematically establish community information and feedback mechanisms including through: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations

 Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic.

 Document lessons learned to inform future preparedness and response activities

PILLAR 3: SURVEILLANCE, RAPID-RESPONSE TEAMS, AND CASE INVESTIGATION

In countries with high-risk of imported cases or local transmission, surveillance objectives will focus on rapid detection of imported cases, comprehensive and rapid contact tracing, and case identification. In a scenario in which sustained community transmission has been detected, objectives will expand to include monitoring the geographical spread of the virus, transmission intensity, disease trends, characterization of virologic features, and the assessment of impacts on healthcare services. In some countries, surveillance priorities will differ at subnational levels. Robust COVID‑19 surveillance data are essential to calibrate appropriate and proportionate public health measures.

Step Actions to be taken

1  Disseminate case definition in line with WHO guidance and investigation protocols to healthcare workers (public and private sectors)  Activate active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI)  Assess gaps in active case finding and event-based surveillance systems

2  Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19

 Undertake case-based reporting to WHO within 24 hours under IHR (2005)

 Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children

 Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours

3  Provide robust and timely epidemiological and social science data analysis to continuously inform risk assessment and support operational decision making for the response

 Test the existing system and plan through actual experience and/or table-top or simulation exercises, and document findings to inform future preparedness and response activities

 Produce weekly epidemiological and social science reports and disseminate to all levels and international partners

PILLAR 4: POINTS OF ENTRY: Efforts and resources at points of entry (POEs) should focus on supporting surveillance and risk communication activities.

Step Actions to be taken

1  Develop and implement a points of entry public health emergency plan

2  Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s)

 Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities

 Communicate information about COVID-19 to travellers

3  Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate.

PILLAR 5: NATIONAL LABORATORIES :Countries should prepare laboratory capacity to manage large-scale testing for COVID-19 — either domestically, or through arrangements with international reference laboratories. If COVID-19 testing capacity does not exist at national level, samples should be sent to a regional or international reference laboratory with appropriate capacity. In the event of widespread community transmission, surge plans should be activated to manage the increased volume of samples from suspected cases. WHO can provide support to access relevant reference laboratories, protocols, reagents, and supplies.

Step Actions to be taken

1  Establish access to a designated international COVID-19 reference laboratory

 Adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing

 Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks

 Adopt standardized systems for molecular testing, supported by assured access to reagents and kits

2  Ensure specimen collection, management, and referral network and procedures are functional

 Share genetic sequence data and virus materials according to established protocols for COVID-19

 Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis

 Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission

3  Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned

 Develop a quality assurance mechanism for point-of-care testing, including quality indicators

PILLAR 6: INFECTION PREVENTION AND CONTROL : Infection prevention and control (IPC) practices in communities and health facilities should be reviewed and enhanced to prepare for treatment of patients with COVID‑19, and prevent transmission to staff, all patients/visitors and in the community.

Step Actions to be taken

1  Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices and pharmacies. Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations

 Assess IPC capacity in public places and community spaces where risk of communtiy transmission is considered high

 Review and update existing national IPC guidance: health guidance should include defined patient-referral pathway including an IPC focal point, in collaboration with case management. Community guidance should include specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport as well as community, household, and family practices

 Develop and implement a plan for monitoring of healthcare personnel exposed to confirmed cases of COVID‑19 for respiratory illness  Develop a national plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity (numbers and competence)

2  Engage trained staff with authority and technical expertise to implement IPC activities, prioritizing based on risk assessment and local care-seeking patterns

 Record, report, and investigate all cases of healthcare-associated infections

 Disseminate IPC guidance for home and community care providers

 Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette

 Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk

3  Monitor IPC and WASH implementation in selected healthcare facilities and public spaces using the Infection Prevention and Control Assessment Framework, the Hand Hygiene Self-Assessment Framework, hand hygiene compliance observation tools, and the WASH Facilities Improvement Tool

 Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources, training

 Carry out training to address any skills and performance deficits.

PILLAR 7: CASE MANAGEMENT : Healthcare facilities should prepare for large increases in the number of suspected cases of COVID‑19. Staff should be familiar with the suspected COVID‑19 case definition, and able to deliver the appropriate care pathway. Patients with, or at risk of, severe illness should be given priority over mild cases. A high volume of cases will put staff, facilities and supplies under pressure. Guidance should be made available on how to manage mild cases in self-isolation, when appropriate. Plans to provide business continuity and provision of other essential healthcare services should be reviewed. Special considerations and programmes should be implemented for vulnerable populations (elderly, patients with chronic diseases, pregnant and lactating women, and children).

Step Actions to be taken

1  Map vulnerable populations and public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities that may be used to provide treatment

 Identify Intensive Care Unit capacity

 Continuously assess burden on local health system, and capacity to safely deliver primary healthcare services

 Ensure that guidance is made available for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is recommended

2  Disseminate regularly updated information, train, and refresh medical/ambulatory teams in the management of severe acute respiratory infections and COVID‑19-specific protocols based on international standards and WHO clinical guidance; set up triage and screening areas at all healthcare facilities

 Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity

 Ensure comprehensive medical, nutritional, and psycho-social care for those with COVID-19

 Participate in clinical expert network to aid in the clinical characterization of COVID‑19 infection, address challenges in clinical care, and foster global collaboration (optional based on country capacity) 3  Prepare to assess diagnostics, therapeutics, and vaccines for compassionate use, clinical trials, regulatory approval, market authorization, and/or post-market surveillance, as appropriate

 Adopt international R&D blueprint guidance and WHO protocols for special studies (companionate use, Monitored Emergency Use of Unregistered and Investigational Interventions) to investigate additional epidemiological, virologic, and clinical characteristics; designate a clinical trial or study sponsor

 Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, immunocompromised), and adjust guidance and/or address implementation gaps as necessary

PILLAR 8: OPERATIONAL SUPPORT AND LOGISTICS

Logistical arrangements to support incident management and operations should be reviewed. Expedited procedures may be required in key areas (e.g. surge staff deployments, procurement of essential supplies, staff payments).

Step Actions to be taken

1  Map available resources and supply systems in health and other sectors; conduct in-country inventory review of supplies based on WHO’s a) Disease Commodity Package (DCP) and b) COVID-19 patient kit, and develop a central stock reserve for COVID-19 case management

2  Review supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies, including COVID-19 DCP and patient kit reserve in-country  Review procurement processes (including importation and customs) for medical and other essential supplies, and encourage local sourcing to ensure sustainbility

 Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms

 Prepare staff surge capacity and deployment mechanisms; health advisories (guidelines and SOPs); pre- and post-deployment package (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support, including peer support groups) to ensure staff well-being

3  Identify and support critical functions that must continue during a widespread outbreak of COVID-19 (e.g. water and sanitation; fuel and energy; food; telecommunications/internet; finance; law and order; education; and transportation), necessary resources, and essential workforce