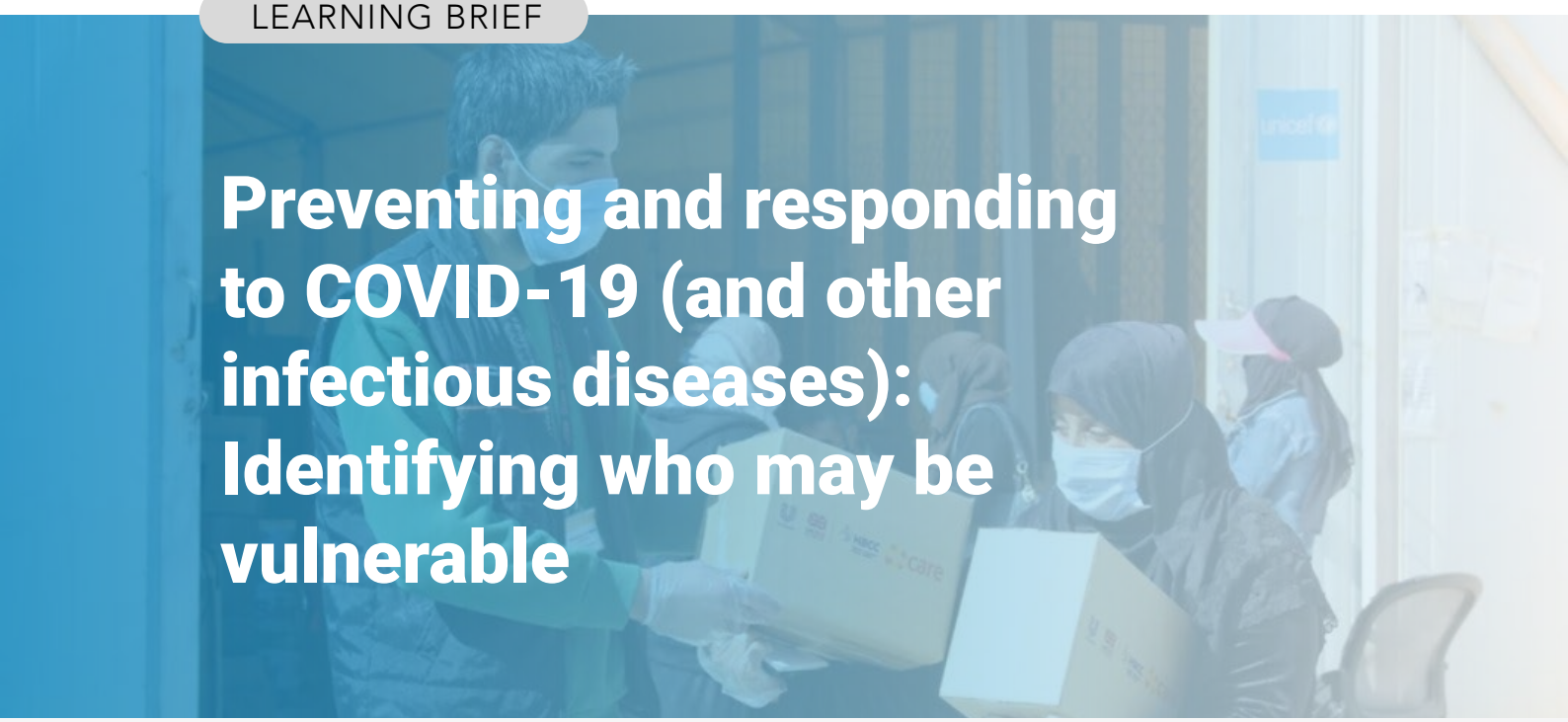
COVID-19 HygieneHub

LEARNING BRIEF



Preventing and responding to COVID-19 (and other infectious diseases): Identifying who may be vulnerable

Source: Unilever

What this brief covers

This brief summarises key strategies to ensure inclusion of vulnerable people when both planning and implementing COVID-19 (and other infectious diseases) prevention and response programmes in low- and middle-income countries (LMICs). The brief covers:

- How we define vulnerability
- Why COVID-19 (and other infectious diseases) prevention and response programmes should be inclusive of populations who may be vulnerable; and
- Key learnings to improve the identification and inclusion of groups who may be vulnerable in COVID-19 (and other infectious diseases) programmes.

Who this brief is for

The brief is mainly for organisations working to improve hygiene-related behaviours such as hand-washing with soap and water, safe water chain practices when collecting and storing drinking water, and latrine use. These will be largely (but not exclusively) within the Water, Sanitation and Hygiene (WASH) sector. It is also useful for public health-related behaviours such as mask use and vaccine uptake.

How we prepared this brief

This brief is based on the lessons from two rounds of programming funded by the Hygiene and Behaviour Change Coalition (HBCC); from individuals working within the WASH sector and a desktop review of publications about the pandemic response. We include direct quotes where possible, giving the organisational source rather than named individuals.

The Hygiene and Behaviour Change Coalition (HBCC)

The HBCC is a partnership between Unilever and the UK's Foreign, Commonwealth and Development Office (FCDO) that initially provided £125 million (US$ 155 million) to fund COVID-19 response programmes aimed at raising hygiene awareness and demonstrating hygiene principles. Programmes were undertaken by 21 organisations in 38 countries between March 2020 and December 2021 (HBCC-1).

The second round of the HBCC – HBCC-2 – was designed to support preparedness for future health-related crises by strengthening local capacity. Programmes were undertaken by 10 organisations in 18 countries between April 2022 and March 2023. Project partners were asked to place a greater emphasis on the inclusion of populations who may be vulnerable or at risk.

For the purposes of HBCC-2, the FCDO defined groups who may be vulnerable as internally displaced people, refugees, urban poor, rural poor, women, children and people with disabilities. Groups who may be at risk were defined as 'at-risk of COVID-19', which included adults over the age of 60 years, people with immuno-suppression, people with several health issues at once, carers and healthcare workers. How the COVID-19 Hygiene Hub understands vulnerability is outlined later in this brief.

Image 1: HBCC hygiene campaign: Hands–Face–Space–Surface. Source: WSUP

Other Hygiene Hub resources may also be of interest, including:

- Defining and conceptualising vulnerability in COVID-19 response programmes and developing and implementing inclusive COVID-19 responses.
- Including people with disabilities, older adults, and their caregivers in COVID-19 prevention programmes
- Considering disability and ageing in COVID-19 response programmes (And the associated COVID-19 Inclusive WASH Checklist).
- Inclusion resources related to other groups who may be vulnerable.

How do we define vulnerability?

Vulnerability is a key concept to consider when designing and implementing infectious disease programmes, as it can influence health outcomes and healthcare access among other factors. Moreover, crises typically make existing vulnerabilities and power imbalances worse. People with poor health also suffer more in disease outbreaks than people in good health, increasing the health divide.

Whilst there has been an increasing focus on vulnerability within the global health sector in recent decades, there is no universal definition and approaches to the term vary. This can cause confusion and impede evidence-based learning, contributing to the pattern of response programmes failing populations who may be vulnerable e.g., COVID-19, natural disasters and Ebola.

Whilst there are numerous definitions, it is generally accepted that vulnerability is a dynamic and multifaceted phenomenon, which operates across multiple dimensions. In the health sector, it is typically conceptualised as either a determinant of poor health or a barrier to achieving good health. The concept is inextricably linked to the notion of power and populations experiencing high rates of vulnerability are invariably difficult to reach, under supported and "invisible" due to inadequate data.

For the purpose of this resource, we will define vulnerability as "the degree to which a population or an individual is unable to anticipate, cope with, resist and recover from the impacts of disasters. It is a function of "susceptibility and resilience" (WHO). This definition speaks to the fact that vulnerability is considered to be the "human dimension of disaster" and is both a driver and outcome of risk. See this page from the United Nations Office for Disaster Risk Reduction (UNDRR) for further information.

Image 2: Formula for calculating disaster risk. Source: UNDRR

As the formula demonstrates (Image 2), vulnerability is influenced by hazard and exposure and can be developed through various routes. For instance, people with pre-existing health conditions have a higher **hazard** response to SARS-CoV-2 as they are more likely to develop serious complications. Groups who are prone to exclusion and discrimination also have a higher hazard response. Others might experience disproportionately high **exposure** to the virus – for instance, frontline health workers. Then you have groups who have **both** a higher hazard and exposure response, such as migrant workers, female health workers or older people, who are at risk of severe complications and face exposure via carers and health workers. It is important to understand how vulnerability is developed in these groups, as different responses are required.

For further insight on defining and conceptualising vulnerability, see our resource here.

Why COVID-19 (and other infectious diseases) prevention and response programmes should be inclusive of populations who may be vulnerable.

Programmes working to improve hygiene related behaviours (largely, but not exclusively, WASH programmes) to prevent and respond to pandemics should be inclusive of populations who may be vulnerable from the start and continue to be inclusive throughout because:

- Inclusive programming could lead to long-term sustainable improvements in hygiene behaviour practices and therefore better health for everyone.
- Putting people centre stage – and particularly those who may be the most vulnerable – results in better outcomes when fighting disease outbreaks.
- Access to WASH is recognised as a fundamental human right, including during humanitarian emergencies.
- The enjoyment of the highest attainable standard of physical and mental health is a human right, and therefore no-one should be excluded from programmes seeking to achieve this.
- The right to a clean, healthy and sustainable environment is also a human right.

WASH programmes to prevent and respond to COVID-19 and other infectious diseases need to continually assess human vulnerability. This ensures that all groups who may be vulnerable can be identified and engaged with, and resources are allocated effectively.

Key learnings to improve the identification and inclusion of groups who may be vulnerable in COVID-19 (and other infectious disease) prevention and response programmes.

We have identified a number of lessons for including people who may be vulnerable. These are useful when planning and implementing WASH programmes to prevent and respond to COVID-19 and other infectious diseases. These are:

1. Organisational culture matters: train staff and integrate inclusivity in work processes.
2. Engage funders and funding: specify, fund and monitor inclusion.
3. Data already exists: quickly identify groups who may be vulnerable.
4. Imperative: collaborate with local government and local organisations to identify groups who may be vulnerable.
5. Your community can help: engage them to identify who may be vulnerable, or who may perceive themselves to be vulnerable.
6. Vulnerability changes over time: continue to map vulnerability throughout the lifespan of a project.
7. Lessons to learn for your next programme: debrief to learn lessons for future projects.

Lesson 1: Organisational culture matters: train staff and integrate inclusivity in work processes.

When organisations are committed to inclusivity, carefully considering vulnerability at every step of the process is key. This helps identify people who may be vulnerable when you are planning and implementing programmes. Inclusion then simply becomes "a necessary part of the content creation process" with "processes set-up to address (roadblocks or challenges)" (International Non-Governmental Organisation, INGO).

Organisations who have clear budgets for standard work processes and tools such as the COVID-19 Inclusive WASH Checklist (Case Study 1) will be better positioned to prevent and respond to infectious diseases such as COVID-19. In such organisations, "designing a COVID-19 prevention and response programme (does not) demand any different approach to vulnerable populations than regular WASH programmes - but with the caveat that definitions of vulnerability may be different in a COVID-19 programme" (INGO).

Case Study 1: The Hygiene Hub's COVID-19 Inclusive WASH checklist

The Hygiene Hub has developed a COVID-19 Inclusive WASH Checklist by reviewing and merging existing human rights frameworks and inclusive WASH checklists. It specifically supports the inclusion of people with disabilities, older adults and caregivers. They are at an increased risk from COVID-19. It can be applied when planning, designing, monitoring and evaluating WASH programmes.

Ensuring integration, developing staff

Policies, tools and budgets are necessary, but to ensure that team members have the knowledge and skills required to identify groups who may be vulnerable, at the organisational- and community-level is key. The timing of the training is important: ideally, team members will receive training on joining an organisation, and the start-up phase of programmes should also allocate time for training if needed (for example, for new programme-specific team members, or as a general refresher). Having tools in place to share continuous learning on inclusion can also support mindset shifts within an organisation.

There are (free) online courses available, for example, Kaya's Introduction to Needs Assessments in Emergencies and Equality, Diversity and Inclusion. Some organisations may choose to have in-house training courses (see Case study 2). These can be opened to partners such as community health workers if needed.

Case study 2: WaterAid's HBCC programme in Ethiopia, Nepal, Nigeria and Zambia.

WaterAid's HBCC programme trained 34 programme staff across its four countries in Equity and Inclusion to equip staff with the knowledge and skills to improve hygiene behaviour change (HBC) programming targeting groups who may be vulnerable and at risk.

WaterAid's HBCC programme in Ethiopia trained 54 health extension workers (HEWs) to deliver HBC interventions. The course covered topics such as COVID-19 vaccine uptake (including vaccine hesitancy), masking-up in public places and crowded conditions, physical distancing under crowded conditions, cleaning contact surfaces; and other secondary behavioural topics like household safe water treatment, handling and storage, handwashing after latrine uses and at other critical times, and food hygiene. The training highlighted aspects of inclusion for groups who may be vulnerable and at-risk. It gave practical insights on ensuring inclusion for these people within community sessions, and targeting households that include people who may be vulnerable or at risk for specific HBC sessions.

WaterAid's HBCC project team in Zambia attended an orientation session on equity and inclusion in HBC programming particularly for the targeted persons living with disability and older people. The training inspired changes to the HBC guides on how to conduct HBC activities in communities. The trained hygiene champions will now roll out HBC sessions in different settings in target areas.

Image 3: A handwashing demonstration in Zambia.
Source: WaterAid

The need for training was also noted in the evaluation of HBCC interventions for people with disability, older people, and caregivers in Bangladesh, Kenya, Indonesia, Sierra Leone and Zambia. The evaluation concluded that:

a) Program staff involved in intervention design need intensive training on disability and ageing inclusiveness; and
b) Staff involved in intervention delivery and monitoring need project and intervention-specific training on considering disability and ageing during intervention delivery.

Lesson 2: Engage funders and funding: specify, fund and monitor inclusion.

Research noted that HBCC-1 interventions were less inclusive for people with disabilities and older people than for people without disabilities or who were younger (Case study 3). The funding mandate for HBCC-1 projects did not specifically tell organisations to include people with disability and older people.

Case study 3: HBCC-1 interventions were less inclusive for people with disability, older people, and their caregivers in Bangladesh, Kenya, Indonesia, Sierra Leone and Zambia

An evaluation of HBCC-1 interventions in five countries found that although they impacted the lives of the people to practise key hygiene measures to reduce COVID-19 infection, the interventions were less inclusive for people with disability and older people than for people without disabilities and younger populations.

Although most organisations identified people with disabilities, older adults and caregivers as target groups, specific activities to include them were scarce. Where efforts were made, practical, physical needs were addressed rather than integrating these target groups in the overall process. For example, the construction of accessible handwashing facilities featured more prominently than ensuring the participation of these groups.

The reach of the messages among people with disability and older people was low compared to their comparison groups, especially for people with communication, self-care, remembering, and hearing functional limitations. The funding mandate did not specifically tell organisations to include people with disability and older people. The interventions that considered inclusion did so because they normally included disability and/or ageing in all their (non-HBCC) programmes. However, they still failed to reach the full diversity of disabilities.

Image 4: Interviewing a person with disabilities. Source: icddr,b

Engage funders and funding

Drawing on the lessons from HBCC-1, HBCC-2, partners were asked by the donor to place a greater emphasis on the inclusion of populations who may be vulnerable to COVID-19 or at higher risk of contracting, being ill and dying from, the disease. One project partner appreciated such direction. They found that it supported internal advocacy efforts to promote the inclusion of populations who may be vulnerable as "when you … say the donor is thinking this is really important, and to say that from day one very, very firmly, even as we're signing the contract, is helpful" (INGO).

Measuring inclusion

However, as one project partner stated, "vulnerability needs to be defined at the local level" and "adopting a standard definition of vulnerability across different geographic locations [should be avoided]" (INGO).

It is therefore suggested that project mandates specify the need for inclusivity and define vulnerability criteria but leave project partners to subsequently identify local populations who may be vulnerable within their programmes. Funders should embed accountability measures in project reporting requirements throughout the life of the programme (Case study 4).

Case study 4: Reviewing the inclusion of disability and aging in COVID-19 hygiene behaviour change interventions using the COVID-19 Inclusive WASH Checklist

The COVID-19 Inclusive WASH Checklist was developed to support the inclusion of disability, aging and caregivers in interventions. The checklist can be applied during the planning, design, monitoring and evaluation of projects, and recommendations can be made to enhance inclusion throughout the project cycle.

The Checklist was used to review the inclusion of HBCC-1 programmes (Case Study 3), noting that the inclusion of disability and aging was not part of the donors' funding criteria.

The review found that although the FCDO stated funding should be disability-inclusive, proposals and reporting formats did not explicitly encourage or require the inclusion of disability and aging within interventions. Reporting templates were revised to support the documentation of the inclusion of people with disabilities, older adults and caregivers in their projects, for example, by including disaggregated data across these groups.

Vulnerability mapping exercises and monitoring and evaluation activities that have explicit requirements for disaggregated data cost more. Tracking the participation of people who may be vulnerable in programmes is complex. Some people may be hidden from view. It would be helpful if funders identified specific funding.

Box 1: How to measure the inclusion of people who may be vulnerable in programmes

Many organisations collect data on the reach of their programmes, including for the purposes of reporting to funders. The disaggregation of data to track the participation of people who may be vulnerable in programmes is complex. As one HBCC partner commented, "we've … struggled with things like, how do we count?" (INGO).

Where applicable, the use of internationally recognised standards for the collection of data is recommended. For example, using the Washington Group Short Set of Questions on disability to collect data on disability.

It may not be possible to collect standardised data on some types of vulnerability (for example, people who perceive themselves to be vulnerable) and disaggregating data alone (for example, by disability or age cohort) is not usually sufficient to inform programme design.

The complementary use of qualitative approaches is therefore also recommended. For example, conducting interviews (in a safe way) with community members to discuss their perceptions of both vulnerability and their inclusion in the programme.

Lesson 3: Data already exists: quickly identify groups who may be vulnerable.

Mapping groups who may be vulnerable requires data. This takes time and resources, which are both limited in disease outbreaks. Identifying individuals and households is especially time-consuming. Working quickly at scale with limited data may lack precision but delays may cost lives. Speeding up the data collection process helps vulnerable people to be included sooner.

Some quantitative and/or qualitative data may be readily available that supports the identification of groups that may be vulnerable due to widely accepted vulnerability criteria, for example, due to age and/or gender. Sources of such data include government agencies, UN agencies, WHO, NGOs, community groups, medical centres, humanitarian data providers and satellite imagery (see Box 2 for examples). This not only saves resources, but also limits the risk of respondents experiencing participation fatigue.

It is recommended that data is cross-checked against three different sources (triangulation). Ensure that the methodology, stakeholders and results meet your needs before using other people's data.

Box 2: Helpful websites for accessing existing data

- ACAPS: Summaries quantitative information about crisis severity.
- Global Disaster Alert and Coordination System: Provides real-time access to web-based disaster information systems and related coordination tools.
- IOM Displacement Tracking Matrix: Gathers and analyses data on the mobility, vulnerabilities, and needs of displaced and mobile populations.
- Global WASH Cluster/REACH's WASH Severity Classification: A set of tools and protocols to classify the severity and drivers of WASH needs and vulnerabilities based on established standards.
- REACH Webmaps and Dashboards: Humanitarian data gathered and analysed to create visual dashboards and interactive maps.
- Relief web: Monitors and collects information from sources including humanitarian agencies at the international and local levels, governments, think-tanks and research institutions, and the media.
- UN OCHA: Situation reports and Humanitarian Data Exchange (data about the context in which a humanitarian crisis is occurring (for example, geospatial data); data about the people affected by the crisis and their needs; and data about the response by organisations and people seeking to help those who need assistance). Look also for local sources of data, such as Integrated Outbreaks Analytics (IOA/CAI) in Democratic Republic of Congo. IOA/CAI consolidates multiple sources of data including surveillance data, programme data and health service data, to understand health trends and outbreak dynamics.

Research conducted after the Ebola virus disease outbreak in Liberia suggests that census and household survey data could have been used to relatively quickly map the location of households and populations considered to be socially vulnerable to the disease (in this instance, using poverty as a proxy for vulnerability).

Such an approach could be used in the context of other infectious diseases, but its limitations should be recognised. Quantitative indicators and widely accepted vulnerability criteria are helpful in that they make vulnerability measurable and identifiable. However, they do not capture changes to vulnerability over time; how vulnerability is perceived by individuals and communities; or vulnerabilities that may be context-specific.

Such mapping can be a helpful first-step in planning where and how to allocate resources. A more detailed analysis is required within the highlighted geographical areas to inform programme design (see 4. Imperative: Collaborate with local government and local organisations to identify groups who may be vulnerable; and 5. Your community can help: Engage with the community to identify who may be vulnerable, or who may perceive themselves to be vulnerable).

Lesson 4: Imperative: collaborate with local government and local organisations to identify groups who may be vulnerable

When starting a project, you should not assume vulnerable groups are neglected. Gathering information about existing organisations and programmes can save time, maximise resources, provide data and support local action after the project has finished.

Collaboration with local governments and local organisations that represent marginalised groups (Rights Holding Organisations, RHOs) can facilitate the identification of people who may be vulnerable within the community. For example, in the context of COVID-19, working with child safeguarding groups, Organisations of People with Disabilities (OPDs), Old People's Associations (OPAs) and women's groups.

The evaluation of HBCC interventions for people with disability, older people, and caregivers in Bangladesh, Kenya, Indonesia, Sierra Leone and Zambia concluded that collaborating with government and non-governmental organizations in designing and implementing activities helps to promote inclusive programmes, but noted that such participation needs to be meaningful with strong engagement in the programme, working as partners. This can be supported by, for example, allocating funding for collaborative programme involvement as many such organisations are already overburdened and underfunded. Including them in training can build partnerships. Water for Women's guidance on effective collaboration between WASH sector organisations and RHOs provides further practical recommendations (see image 5 on following page).

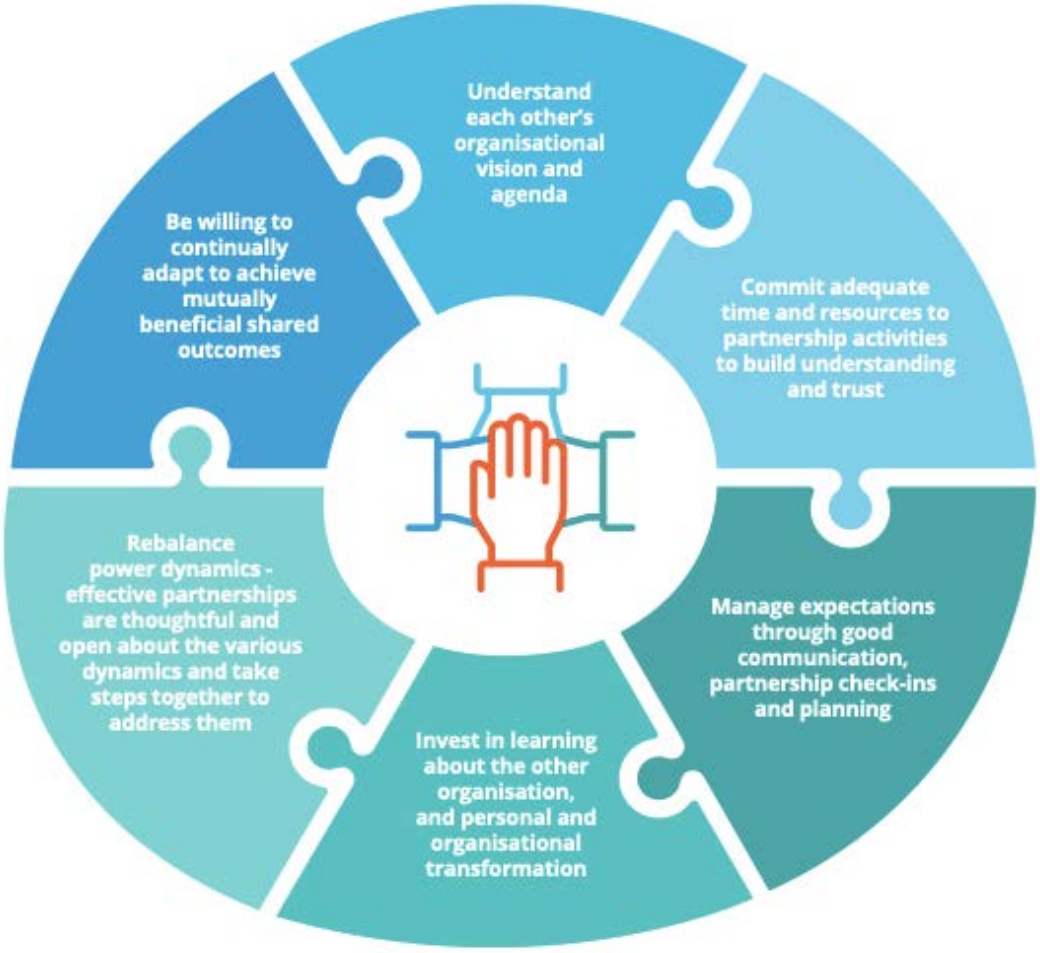


Image 5: Top tips for effective partnerships between WASH organisations and RHOs.
Source: Women for Water

Who to approach will vary depending on context. One INGO found that in Nepal, the National Government was active in collating data on groups who may be vulnerable; whereas in Myanmar, religious and community leaders were the key persons to work with.

The earlier the engagement is started, the better. For example, one INGO "tried to involve [the representative groups in HBCC projects] … when we started designing materials, and also asking them if they could set-up focus group discussions to try to access particular members who are part of their society" (INGO).
Such engagement to map where people who may be vulnerable can be resource intensive. Working with others may even slow down progress initially as teams are formed. For example, it will "[extend the] consultation period … before you actually start doing fieldwork … spending longer deciding how we were going to do things" (INGO). Yet such an investment can result in better outcomes when fighting pandemics and better health for everyone longer-term due to sustainable improvements in hygiene practice. Ideally, funders will identify specific funding for such vulnerability mapping exercises (see 2. Engage funders and funding: specify, fund and monitor inclusion).

Lesson 5: Your community can help: engage them to identify who may be vulnerable, or who may perceive themselves to be vulnerable

External mappings of a community will not a full picture. Communities are well-placed to determine who may be vulnerable, who is at risk of becoming vulnerable, and who may perceive themselves as being vulnerable (which may be defined differently to how it is defined by others).

Community engagement should therefore feature in all strategies to identify who may be vulnerable or who may perceive themselves to be vulnerable. Engagement should be guided by standards such as UNICEF's Minimum Standards for Community Engagement to ensure that fundamental principles including Do No Harm (Box 3) are embedded throughout all community engagement activities.

Where vulnerability criteria exist, engagement with the community should include people who may be vulnerable according to the vulnerability criteria with all efforts made to ensure that participation is not tokenistic. For example, in the context of COVID-19, working directly with people who are the poorest in communities instead of relying on the community to identify them.

Standards 1 (Participation), 3 (Inclusion) and 7 (Informed design) of UNICEF's Minimum Standards for Community Engagement suggest using vulnerability mapping exercises to identify under-represented, disadvantaged, vulnerable and marginalised groups in communities. Organisations will likely have in-house vulnerability assessments, but guidance does exist for those wishing to review what is currently being used, including Tearfund: Beneficiary selection during COVID-19.

Box 3: The principle of Do No Harm

(UNICEF, 2020)

"Community engagement bears risks and opportunities for individuals and communities. While community engagement can increase ownership, empowerment, participation, service utilisation and local capacity, it can incur physical, economic, political and social costs. It has been demonstrated, in many cases, to exacerbate discrimination, unequal distribution of resources, stigmatisation and abuse. Furthermore, insecure management of community engagement data can lead to privacy and security concerns for affected populations".

Case study 5: Vulnerability mapping exercises during an infectious disease outbreak: a few words of caution

Care should be taken to ensure that conducting vulnerability assessments does not put people who may be vulnerable at further risk, for example, by exposing them to the risk of infection during a face-to-face interview.

Remote data collection via phone or SMS may be an option, for example, mobile surveys were used to analyse food security in Guinea, Liberia, and Sierra Leone in support of the Ebola emergency response. But remote data collection has its limitations.

The Overseas Development Institute (ODI) reported that interviewees during the COVID-19 outbreak found that remote data collection is less accurate that in-person data collection as, for example, it can struggle to measure more complex concepts such as changes to livelihood or well-being so such data must still be verified in-person.

Digital assessments may also fail to reach the most marginalised who likely lack access to digital devices (the 'digital divide'): in Bidi Bidi camp, Uganda, women are 47% less likely to own a mobile phone and 89% less likely to access the internet through a mobile phone than men.

Finally, digital assessments must ensure that they 'do no digital harm', for example, by mitigating risks that the data collected is not misused or exploited by others. Due to such concerns, ODI concluded that "in some ways, the COVID-19 crisis has confirmed the aid sector's reliance on face-to-face approaches".

Also, be aware that publicly labelling someone, or a group, as potentially vulnerable could also lead to stigma. Measures to mitigate against such stigma include conducting assessments discretely (for example, securely online or in a comfortable, private location where other people cannot hear), and campaigns to de-stigmatise health conditions that are associated with vulnerability, but which are associated with stigma.

Whose reality counts? Listen and learn from multiple sources

Data should be collected (from multiple sources including existing resources; local government and local organisations; and the local community). Determining the selection criteria – and the assistance to be provided – should also be done in consultation with partners and community members (again, consider doing this remotely). It then needs to be clearly communicated. The criteria can then be used to identify and engage directly with the people selected, for example, by self-selection, use of a survey, or by working with existing systems such as health centres and schools, who know the local community.

Funders should identify specific funding for such vulnerability mapping exercises (see lesson 2. Engage funders and funding: specify, fund and monitor inclusion).

Case study 6: WaterAid's Rapid COVID-19 Vulnerability Assessment in Lusaka, Zambia

WaterAid worked with the Zambian Ministry of Health, Lusaka City Council and other partners with support from Development Data (a consultancy firm based in Zambia) to conduct a Rapid COVID-19 Vulnerability Assessment in Lusaka. The vulnerability assessment focused on the physical, social, and economic vulnerabilities people were facing; the coping mechanisms they employed; and investigated knowledge, attitudes, and practices on COVID-19. The assessment included a quantitative survey (431 participants) and 20 focus group discussions.

The results helped to generate evidence to inform planning and programming of the COVID-19 response. For example, the most vulnerable groups in the surveyed areas were identified as women and girls; people living with disabilities; older people and others with serious medical conditions; children; and orphans. However, as 88.7% of the parents were willing for their children to go back to school, the need to have a further survey to capture all WASH related issues to managing and containing COVID-19 in schools was identified.

Image 6: Handwashing stations.
Source: WaterAid Zambia

It is also worth noting that vulnerability assessments may not translate into action, as "even when the partner/facilitators know who the most vulnerable households in a community are, it doesn't mean that they can reach them, due to the limited capacity of the partner, or even permission to reach all households" (INGO).

Lesson 6: Vulnerability changes over time: continue to map vulnerability throughout the lifespan of a project.

Vulnerability mapping is not a one-time exercise: "vulnerability markers are likely to change through a COVID-19 response – for example, as vaccines became available, those who chose not to be vaccinated, regardless of any other vulnerability criteria, were more vulnerable" (INGO). It is therefore important to continue to identify – and engage with – groups who may be vulnerable throughout the planning, assessment, design, implementation, and monitoring and evaluation stages of programmes.

To do so, keep contact details of all communities, organisations (for example OPDs and OPAs) and individuals spoken to up to date, and ensure feedback mechanisms are in place for any suggestions to affected communities selection criteria to be made.

Lesson 7: Lessons to learn for your next programme: debrief to learn lessons for future projects.

This Learning Brief is based on limited information and initial experiences of the COVID -19 response. There are more lessons to be learnt. Some will be general, and some may be specific to the context. All the previous lessons in this learning brief can be improved through your experience. Reflecting on lessons learned using, for example, after action reviews and debrief exercises, helps to embed inclusivity in organisational culture. Training sessions can be used at the end of a project to make sure that new knowledge is not lost.

One INGO commented that "One of the things that came up as an area where we did not address very well [in HBCC-1] in the final learning workshop was inclusivity … so that really put a little bit of thought process going in our country offices and ourselves also, to make sure that in the next iteration we do well when it comes to inclusivity" (INGO).

The same INGO has since worked with country offices to review HBCC-2 projects, looking specifically at what stage addressing inclusivity was considered; whether consultations with groups who may be vulnerable were held; if they were, what were the success stories of doing so; and what were the challenges.

This process found that in HBCC-2 projects, inclusivity was considered by all country offices from planning through to evaluation which resulted in a number of success stories (Case Study 7).

Case study 7: Save the Children's HBCC programme in Ethiopia, India, Pakistan and Zimbabwe

Success stories as a result of engaging with groups who may be vulnerable included:

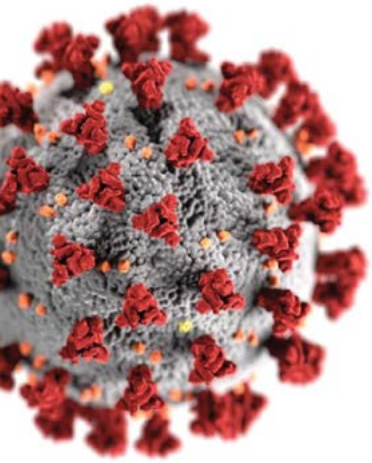
- In Ethiopia, visual displays of hygiene messages were updated to include sign language images.
- In India, the project team identified a school in Maharashtra with 100 'differently abled' children enrolled and held handwashing with soap sessions with the teachers; and
- In Zimbabwe, handwashing stations that could not previously be used by people who use a wheelchair were redesigned to make them easier-to-use (for example, by lowering the height), and relocated in places that could be accessed by people who use a wheelchair.

Key learning points

Vulnerability' is a dynamic and multifaceted phenomenon. Mapping who may be vulnerable (adhering to the principle of Do No Harm) will require engagement with local governments; local organisations; and the local community throughout the duration of the project.

Identifying and engaging with groups who may be vulnerable during infectious disease prevention and response programmes can result in a) better outcomes when fighting disease outbreaks and b) better health for everyone longer-term.

Funders should specify the need for inclusive programming in funding mandates and embed accountability measures in project reporting requirements. Funds should therefore be allocated for vulnerability assessments and subsequent monitoring and evaluation activities.



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