India COVID-19 Emergency Response

CRS RESPONDS TO THE COVID-19 PANDEMIC IN INDIA THAT THREATENS THE HEALTH AND SURVIVAL OF MILLIONS. | MAY 1, 2021 – APRIL 30, 2022

CRS
CATHOLIC RELIEF SERVICES

Cover: A nurse checks the vitals of a patient at Bangalore's St. Philomena's Hospital, which is among the health facilities receiving medical supplies and support, such as Personal Protective Equipment, from CRS.
Photo by Ramita Rathod for CRS/Caritas India

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For more information, please contact:
Senthil Kumar Gurunathan
India Country Representative
+91 11 648 7256
senthil.kumar@crs.org

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OVERVIEW

In April and May 2021, India recorded the highest number of daily COVID-19 cases globally.[1] In addition, the figures in India are widely acknowledged as being undercounted due to reduced testing as hospitals struggle to properly confirm, treat and document all cases.

India's low vaccination rates[2] are enabling the continued spread of COVID-19, primarily the more contagious B.1.1.7 and B.1.617 variants. Vaccines are accessible through a government website[3], but require internet access and functional literacy—a significant challenge, especially in rural areas. Additionally, vaccine supplies are limited in many states, a problem compounded by ambivalent vaccine policies that have led to issues of vaccine inequity. It is not only a challenge of availability: Gavi, the Vaccine Alliance, estimates that slow uptake can be linked to hesitancy and the perception that vaccine development was rushed. The alliance also reports complacency stemming from the false belief that the pandemic has been waning in India.[4]

Upon the outbreak of the second wave, Catholic Relief Services (CRS) immediately launched assessments that focused on the clinical needs within India's healthcare system, as well as the social needs of populations most affected by COVID-19. Based on the assessment findings in the first weeks of the outbreak, CRS supported partners to distribute hygiene and living supply kits, as well as assistance to mitigate the health and socio-economic impacts of COVID-19.

While much of the media attention and aid shipments have focused on hard-hit major metropolitan areas such as Mumbai, Delhi and Bangalore, the lockdowns and restrictions of movement in urban areas have resulted in millions of migrant workers returning to their hometowns across the country. This has led to new vectors for disease transmission, raising concerns for a potential third wave across peri-urban and rural areas.

Frontline community health workers—also known as accredited social health activists (ASHAs)—are the first points of contact for families in both urban and rural areas. As part of the Government of India's plan to prevent and control COVID-19, ASHAs support surveillance; raise awareness of

1. World Health Organization. COVID-19 Weekly Epidemiological Update. Data received as of 18 May 2021.
2. WHO Coronavirus (COVD-19) Dashboard, Situation by Region, Country, Territory & Area as of 7 May 2021.
3. 45+ age group can access them, where available, directly at health centers, but the problem is significant for 18-45 age group.
4. https://www.gavi.org/vaccineswork/why-indias-covid-19-pandemic-skyrocketing

symptoms, testing and household isolation procedures; and educate families on the benefit of vaccinations and means for registration. Assessments have indicated that while ASHAs are trusted among the communities in which they serve, families wait several days before reporting symptoms and seeking advice. ASHAs are also dealing with disinformation and the need to communicate health advice and information in a rapidly changing environment.

Many families who are especially vulnerable have lost their assets, income and employment during the pandemic, and lack the means to pay for basic life essentials. Many are also without savings and capital to restart their lost livelihoods. These families will need significant support to recover.

As COVID-19 spreads across India, it leaves increasing numbers of vulnerable children in its wake. Families facing extreme economic loss might look to reduce their economic burden by considering child labor or early marriage—both of which are gateways for child trafficking. A large number of children are at risk of dropping out of school with no hope of going back, which will only further contribute to children being pushed into labor or early marriage. Additionally, an increasing number of orphaned children are at risk of entering childcare institutions. Children who are already institutionalized are either being sent back home to potentially unsafe environments, or residing in institutions that have yet to be upgraded for COVID-19 prevention.

CRS will support local partners to lead the emergency response efforts, and provide them with technical assistance in program areas, as well as support to manage financial resources and comply with donor, government and humanitarian standards. For years, CRS has supported these same partners with capacity building for effective, dignified humanitarian programming.

Safeguarding and Protection against Sexual Abuse and Exploitation will also be a priority for CRS' capacity support to partners, and the development of feedback mechanisms will form a core component of the response.

In New Delhi, India, women mourn a person who died of COVID-19. *Photo by Vijay Pandey, ZUMA Wire, Alamy*

CRS will conduct activities in accordance with global humanitarian best practices and standards, as well as with CRS' policies and procedures for Monitoring, Evaluation, Accountability and Learning (MEAL). CRS will closely coordinate with communities, humanitarian actors and government authorities to ensure that all activities are appropriate to the local context.

ABOUT CRS AND PARTNERS

CRS is the international humanitarian agency of the Catholic community in the United States, and provides assistance based on need, regardless of race, caste, creed, or nationality. Throughout its 75-year history, CRS has become a global leader in fighting fast-moving disease outbreaks, such as cholera, Ebola and polio. In the past year alone, CRS has reached more than 20 million people globally with comprehensive programming to prevent the spread of COVID-19, bolster the capacity of local health responders, and assist extremely vulnerable families.

In India, as part of the CORE Group Polio Project, CRS and its partners succeeded in vaccinating 125,000 children under five years of age in some of the most vaccine-hesitant populations of Uttar Pradesh. This took place through the implementation of social and behavior-change communication interventions led by community action groups and community mobilization coordinators.

In collaboration with National Health Mission and the Ministry of Health and Family Welfare in Uttar Pradesh, CRS is reaching the *sanginis* (supervisors) of 8,000 ASHA with our digital health model that helps them to provide supportive supervision to approximately 150,000 ASHA workers. These efforts will potentially improve the health outcomes for 174.6 million people.

Building local leadership capacity is central to the mission and work of CRS, and critical as we collaborate with Caritas India, Catholic Health Association of India and government partners.

Caritas India is the social services wing of the Catholic Bishop's Conference of India, and coordinates the work of 170 diocesan social service societies across the country. With five decades of experience in promoting integral human development, the Caritas India network is in the process of establishing 60 first-level COVID-19 treatment centers across 12 states. These centers will provide primary medical treatment, nutrition and complementary Risk Communication and Community Engagement.

The Catholic Health Association of India (CHAI) is the second largest healthcare provider in India after the government. Its network of 3,572 hospitals, health clinics, other member institutions—as well as its 76,000 medical professionals—serves at least 21 million patients annually. Most of these patients are from scheduled castes, scheduled tribes and other historically marginalized and underserved communities bearing the disproportionate brunt of the pandemic's impact. CHAI has been rendering critical healthcare services for 75 years. To date, CHAI member institutions have received little to none of the pledged international in-kind aid, much of which is stuck at airports or at other points along the supply chain.

174.6 million

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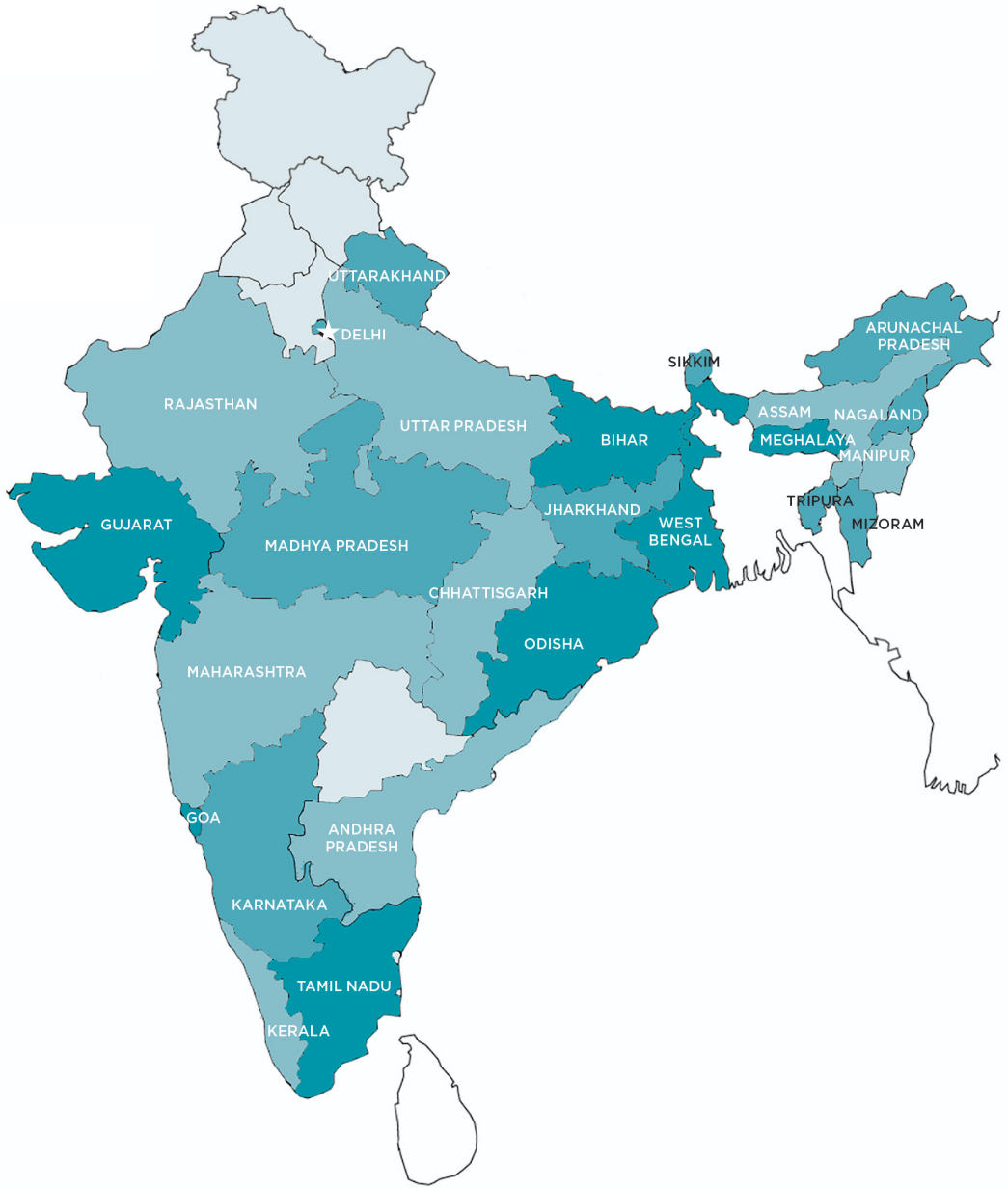
GEOGRAPHIC TARGETING

States in India reached by CRS/Caritas / CHAI COVID-19 programming

Andhra Pradesh
Arunachal Pradesh
Assam
Bihar
Chhattisgarh
Delhi (Union Territory)
Goa
Gujarat
Haryana
Himachal Pradesh
Jammu
Jharkhand
Karnataka
Kerala
Madhya Pradesh
Maharashtra
Manipur
Meghalaya
Mizoram
Nagaland
Odisha
Punjab
Rajasthan
Sikkim
Tamil Nadu
Telengana
Tripura
Uttar Pradesh
Uttarakhand
West Bengal



CRS RESPONSE

CRS and partners aim to mitigate the health impacts of COVID-19 through a multipronged approach that includes clinical and social components, and leverages the consortium's position to deliver results at scale. This consortium of Catholic nongovernmental organizations—CRS, CHAI and Caritas India—is uniquely placed to ensure a rapid rollout of a holistic COVID-19 response through its existing health facilities and community presence. In our collective and collaborative efforts, we aim to support 71 million people—including 20,000 frontline healthcare workers and 35,000 community health workers and volunteers—across 29 states and 100 health facilities. We will also support 50,000 people to meet their basic human needs.[5]

71 million

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Goal: Mitigating the impacts of the COVID-19 crisis on the most vulnerable		
SO1: Health impacts of COVID-19 are mitigated for affected individuals and communities.	**SO2:** Economic and social impacts of COVID-19 are mitigated for affected individuals and communities.	**SO3:** Protection is strengthened; and trafficking risks are reduced for extremely vulnerable children affected by COVID-19.
IR1.1: Health systems provide quality COVID-19 services across the continuum of care.	**IR2.1:** Individuals and communities meet food and other basic needs.	**IR 3.1:** Child protection structures provide improved services and protection information to COVID-19-affected/vulnerable families and children.
IR1.2: Individuals and communities demonstrate improved COVID-19 prevention behaviors.	**IR 2.2:** Impacted households and small businesses withstand livelihood disruptions and restart income-generating activities.	**IR 3.2:** Childcare institutions and communities establish COVID-19 prevention and child protection activities.

Crosscutting principles

- Gender and protection mainstreaming that addresses the unique needs of different populations, and helps to create an environment that prevents stigma, abuse and sexual exploitation of all people.
- Psychosocial support for frontline health workers, volunteers, extremely vulnerable children and CRS and partner staff.
- Strengthened capacity of community-based organizations to provide quality and timely services that meet the needs of populations affected by COVID-19.

5. CRS, CHAI and Caritas India response has potential for significant scale-up to reach up to 200 million individuals should additional resources become available.

CRS RESPONSE

SO1: Health impacts of COVID-19 are mitigated for affected individuals and communities.

IR1.1: Health systems provide quality COVID-19 services across the continuum of care.

In coordination with the policies and procedures of the National Health Mission and the Ministry of Health and Family Welfare (MoHFW), CRS and CHAI will support 100 hospitals across India to provide quality COVID-19 services. This will be achieved through a locally-led, systematic approach focusing on identified gaps in each facility, including infrastructure, supplies and staffing. The services will be geared primarily toward socio-economically vulnerable populations accessing healthcare in these hospitals, in addition to all people requiring COVID-19 services. We will reach an estimated 330,000 people (both patients and healthcare workers) with these interventions.

CRS is providing critical medical supplies and hospital support, including the personal protective equipment worn by this nurse at St. Martha's Hospital in Bangalore. *Photo by Ramita Rathod for CRS/Caritas India*

All facilities will benefit from the support of medical supplies in alignment with World Health Organization regulations, including Personal Protective Equipment, pharmaceuticals, and disinfectants. CHAI can leverage its sophisticated supply chain management platform, and its existing relationships with vendors, to procure supplies in the local market. CHAI will ensure that in-care patients receive food, hygiene items and other essential services.

CRS and CHAI will also support hospitals to make sure they have adequate staffing so that healthcare workers are able to locate, screen, refer, test, isolate and treat patients in accordance with government guidelines. As such, CRS will cover per diem, transportation, and accommodation for up to 20,000 staff and volunteers.

CRS RESPONSE

CRS will put strategies in place to address the psychosocial well-being of frontline staff to help reduce attrition and personal impacts. Finally, CRS and partners will offer vaccination support through VacciNet,[6] with the goal of supporting 300,000 vaccinations.

IR1.2: Individuals and communities demonstrate improved COVID-19 prevention behaviors.

Health sector leaders[7] have made significant investments to develop information, education and communication materials approved by MoHFW. CRS will take advantage of Caritas India's vast volunteer network, ASHAs and their *sanginis* to utilize these materials to promote COVID-19 appropriate behavior in communities. To strengthen the efficacy of messaging, CRS will partner with a specialized behavior-change entity to refine and deliver a social behavior-change and communication approach. Through a collaborative and adaptive approach, we will meet the needs of high-risk populations and frontline health workers in the evolving context.

The CRS/Caritas India approach has significant scaling potential. CRS will support 14,000 Caritas India community volunteers, and 35,000 ASHAs across 29 states, aiming to reach 71 million people through the messaging outreach. We will leverage the following existing networks:

- **Messaging delivered by ASHAs** (community frontline health workers) in high-risk districts of Uttar Pradesh will reach 43 million people.
- Through the **Core Group Polio Program**, 218 community mobilization coordinators and community action group members—who have long-established relationships with families in their areas, and are well-trained on disease surveillance and vaccine hesitancy—will reach up to 240,000 people with messaging and information.
- Through Caritas India's network of **Diocesan Social Service Societies**, we will work with up to 14,000 volunteers to reach as many as 28 million people. CRS and Caritas India will explore expanding the scale of this program based on funds available.

ASHAs engage with families on messaging for risk prevention, outbreak tracking, isolation [quarantine] practices, safe behaviors, and facilitation to vaccine access. ASHAs and volunteers will receive washable/reusable Personal Protective Equipment (plastic shield, cloth masks and hand sanitizer); carry out a remote, phone-based approach to messaging; and engage community leaders to raise awareness through low-risk methods (loudspeaker, posters and flyers).

Utilizing an evidence-based approach,[8] volunteers will also work with community leaders to implement a peer-monitoring approach to the use of masks in public places. Community leaders and volunteers will promote the quarantine/isolation of COVID-19 patients, and access to essential items while they recover.

CRS acknowledges that training alone is not enough, and will ensure support to government employees and ASHAs via eSanjeevani, an online telemedicine platform staffed by medical doctors to support the care of health care workers. For volunteers, CRS and Caritas India will facilitate coaching opportunities and peer-to-peer exchanges, and establish a hotline to address frequently asked questions. Volunteers will be encouraged to participate in sharing/learning sessions to address their own mental health and well-being, and will have access to counseling.

6. http://vaccinet.life/
7. https://indiafightscovid.com/
8. Abulak, J, et. al. Normalizing Community Mask-Wearing: A Cluster Randomized Control Trial in Bangladesh, Cowles Foundation for Research in Economics, Yale University, April 2021. https://cowles.yale.edu/sites/default/files/files/pub/d22/d2284.pdf

CRS RESPONSE

To bolster prevention, CRS and Caritas India will utilize a data-oriented approach to increase coverage of messaging in areas that indicate a likely surge in cases, and will adapt throughout the response.

CRS, CHAI and Caritas India will promote and support access to vaccination services for the most vulnerable populations. In rural areas, individuals and families that have experienced a loss of income will receive financial support for transportation to vaccination sites. Volunteers will also support registration on government vaccination websites, and respond to frequently asked questions.

SO2: Economic and social impacts of COVID-19 are mitigated for affected individuals and communities.

IR2.1: Individuals and communities meet food and other basic needs.

CRS and partners will leverage relevant, existing social protection programs—as well as gaps in government and multilateral programs—to help people have access to food and critical supplies given the economic impacts of job and income loss. Cash assistance will provide families with the flexibility to meet their unique and changing needs. We will support people in both high-density urban poverty areas as well as rural areas affected by disrupted supply chains and constrained agricultural production. CRS aims to support 13,000 families (52,000 people) with this assistance.

13,000

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IR. 2.2: Impacted households and small businesses withstand livelihood disruptions and restart income-generating activities.

CRS and partners will support local economies to mitigate the pandemic's catastrophic economic impacts. We will provide life-saving cash or other assistance for migrant or daily laborers, inject cash into local economies through market-based programming, and ensure safe access to local markets[9] to reduce transmission risk. In the short- and medium-term, this means support to small businesses and employers, and the promotion of income-generating activities. CRS and our partners aim to support—not displace—strained commercial supply chains and markets. Our strategies will help stabilize critical market systems and livelihoods in advance of a possible future resurgence of the COVID-19 pandemic.

SO3: Protection is strengthened; institutionalization and trafficking risks are reduced for extremely vulnerable children affected by COVID-19.

IR. 3.1: Child protection structures provide improved services and protection information to COVID-19-affected/vulnerable families and children.

CRS and partners in Odisha and Tamil Nadu states will work with the government's child protection system, along with community structures for child protection, to ensure that families and vulnerable children receive quality child protection services. We will promote the identification and facilitation of children who have lost parents or caregivers, to ensure they are placed in family-based care. Our partner teams will virtually monitor high-risk children, and track vulnerable families in respect to health, food security, protection, education and mental health. The information will be reviewed frequently by District Child Protection Unit teams and partners to provide real-time follow-

9. CRS will employ COVID-safe practices, such as ensuring there are handwashing stations equipped with soap, signage indicating social distancing, and appropriate information on COVID-safe behaviors.

up support, including referrals to mitigate the risk of separation. In addition, partners will collaborate with the District Child Protection Unit teams to monitor children who have returned from childcare institutions to assess family capacity to support the children, and identify any increased vulnerability.

Partners will launch a communications campaign focusing on child protection risks that are worsened during COVID-19, including trauma, violence in the home, trafficking, child labor and early marriage. We will promote a child hotline and child welfare committees as primary contact points for reporting suspected cases of trafficking, abuse, child labor or early marriage. When safe to do so, partners will engage communities in Tree of Life exercises that focus on child protection and rooting a child in a safe environment. Adolescent and youth groups will be engaged in activities that are COVID-19 safe and focused on stories of courage, healing and motivation. We will also organize virtual trainings, and share tools and guidance with the government workforce on child protection messages to integrate into public health messaging. Extremely vulnerable families will be linked to activities that help to increase their income and food security.

CRS Response Timeline (Months)[10]	0-3	3-6	6-9	9-12
IR1.1: Health systems provide quality COVID-19 services across the continuum of care.	■	■		
IR1.2: Individuals and communities demonstrate improved COVID-19 prevention behaviors.	■	■	■	■
IR2.1: Individuals and communities meet food and other basic needs.	■	■		
IR 2.2: Impacted households and small businesses withstand livelihood disruptions and restart income-generating activities.			■	■
IR 3.1: Child protection structures provide improved services and protection information to COVID-19-affected/vulnerable families and children.	■	■	■	■
IR 3.2: Childcare institutions and communities establish COVID-19 prevention and child protection activities.	■			

10. The suggested timeline is based on the current COVID-19 surge, and this may change based on additional surges.

8,000

CRS will target 8,000 vulnerable children and their families, as well as 50 childcare institutions.

CRS and partners will work with government and community structures to ensure that protection and trafficking risks are reduced for extremely vulnerable children affected by COVID-19. CRS will target 8,000 vulnerable children and their families, as well as 50 childcare institutions.

CRS RESPONSE

IR. 3.2: Childcare institutions and communities establish COVID-19 prevention and child protection activities.

While CRS has been focused on alternative family-based care for orphaned and at-risk children since 2017, we recognize that children who remain in childcare institutions are extremely vulnerable during the COVID-19 pandemic. CRS will support 50 childcare institutions with the following:

- Monitoring materials and Personal Protection Equipment (thermal scanners, oximeters, hygiene materials)
- Guidance on government procedures for isolation and control of cases in shared spaces
- Trainings for caretakers on child-friendly activities to raise awareness and address fears or trauma about COVID-19

We will link childcare institutions to existing state government psychosocial support systems. Also, children (especially those who lost parents and guardians to COVID-19) will have access to telehealth counselors for grief counseling. CRS will first target institutions with which we have existing programs in Odisha, Tamil Nadu and Maharashtra, and consider expansion based on need and availability of funds.

Crosscutting principle: Gender and protection mainstreaming that addresses the unique needs of different populations, and helps to create an environment that prevents stigma, abuse and sexual exploitation of all people

CRS recognizes that to be accountable to affected populations, our feedback mechanisms, safeguarding and protection mainstreaming must be adequately designed, funded, staffed and implemented at the CRS and partner levels. CRS will conduct a comprehensive gender and protection assessment and analysis to inform this process. We will also develop training curriculums to better engage and support women, men, girls, boys, and people with special needs, including people living with disabilities.

Based on assessments, our programs will budget for and implement feedback mechanisms, protection and gender mainstreaming activities, and additional staffing, as needed. We will also support partners to establish or strengthen policies and procedures for Safeguarding and Protection against Sexual Abuse and Exploitation, feedback mechanisms and referral pathways.

CRS and partners are providing critical medical supplies and hospital support.
Photo by Ramita Rathod for CRS/Caritas India

CRS RESPONSE

Crosscutting principle: Psychosocial support is provided for frontline health workers, volunteers, extremely vulnerable children and CRS and partner staff.

Prior experience of disease outbreaks has taught us that psychological well-being can erode quickly. CRS and partners will incorporate strategies that address the well-being of formal and informal care providers to help reduce their attrition and personal impacts. These will include professional counseling, self-care tips and referrals. We will also will provide referrals for therapy sessions in childcare institutions and promote support pathways for children who are the head of their households or who have lost caregivers.

Crosscutting principle: Strengthen the capacity of community-based organizations to provide quality and timely services that meet the needs of populations affected by COVID-19.

The localization of aid is one of the Grand Bargain's priorities for reform because of the increasing evidence that locally-led efforts deliver more effective, impactful humanitarian responses. Yet, approaches taken to localization in the majority of humanitarian responses continue to be reactive, driven by emergencies, and shaped by ad-hoc interactions at the point of crisis. Localization requires a significant shift in the way we currently fund, invest in and deliver humanitarian aid.

Our focus will be on enabling local actors to respond at scale and in a quality manner to the emergencies they face. CRS will do this by investing in their organizational sustainability and response capacity during and after a crisis. As a result, we will do less harm and create more sustainable, effective solutions for development.

Bay Dau has been unemployed for months as a result of pandemic, and is struggling to pay rent and care for his family.
Photo by Amit Kumar for CRS/Caritas India

MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

CRS and partners are providing critical medical supplies and hospital support, like to St. Martha's Hospital in Bangalore pictured here.
Photo by Ramita Rathod for CRS/Caritas India

CRS prioritizes accountability to ensure that staff listen to and learn from program participants.

CRS will conduct these activities in accordance with global humanitarian best practices and standards, and our MEAL policies and procedures. We will operationalize a MEAL system for rapid start-up. A combination of formal and informal monitoring approaches will enable us to track project performance, as well as capture and respond to changing contexts.

CRS prioritizes accountability to ensure that staff listen to and learn from program participants so that their perspective, experience and input can best inform our management decisions. We will establish locally appropriate and COVID-19-safe feedback mechanisms—for example, feedback boxes at offices and distribution points, dedicated phone lines, and communication through trusted community leaders or field staff. Communities will receive information about what constitutes acceptable and unacceptable behavior and expectations for staff conduct, as well as how they can report concerns and complaints through confidential channels.

CRS will also conduct a final evaluation to determine how well the project achieved its intended results. The evaluation will focus on the appropriateness of the response, effectiveness of activities, efficiency in implementation, coverage, impact on target populations, sustainability, and accountability to program participants.

SCALE AND DISSEMINATION OF RESOURCES

This nationwide pandemic should be met with a nationwide response. CRS' emergency response strategy is focused on leveraging our networks and existing relationships to achieve significant outcomes at scale. In addition to our direct response, CRS will dedicate staff time and funding to sharing with external stakeholders solutions that are grounded in our learning and evidence. Our expectation is that sharing of resources and evidence-based results—and collaborating with government, private sector and civil society actors—will help amplify positive impacts in preventing and controlling the spread of COVID-19.

CRS will actively engage in coordination forums and with relevant government departments at state and national levels. Where appropriate, CRS will act as a convener of key stakeholders to facilitate collaboration, learning and adapting the response to meet the changing context.

In India, CRS brings expertise in health systems strengthening, vaccination campaigns, livelihoods, refugee-focused programs, rapid emergency response and recovery, and the protection of women and children. CRS will draw a connection between our COVID-19 response program and populations at high risk related to our long-standing program areas. We will engage with stakeholders to further examine and identify urgent relief and recovery needs and explore an expanding scope in the emergency response based on funding availability. We will continue to leverage our expertise and programs to mitigate the health impacts of COVID-19 on the most vulnerable individuals, families, and communities so that they may not only survive, but fully recover.

Health care workers receive training, personal protective equipment and counseling support from CRS and partners. *Photo by Ramita Rathod for CRS/Caritas India*

In addition to our direct response, CRS will dedicate staff time and funding to sharing with external stakeholders solutions that are grounded in our learning and evidence.

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Catholic Relief Services | 228 W. Lexington Street, Baltimore, MD 21201, USA | crs.org
For more information, please contact CRS India Country Representative at Senthil Kumar Gurunathan at senthil.kumar@crs.org.