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SECTOR-SPECIFIC APPROACHES TO PRIORITISE, ADAPT, AND MAINTAIN PROGRAMMING IN COVID-19 RESPONSE

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This guidance has been developed by CARE. It is a living document and will be updated through an iterative process based on evolving needs and the latest evidence. Note this is a global document and should be adapted to the local context.

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CARE Field Program Operations Guidance

Best practices on maintaining humanitarian programming in a restrictive environment

Each CARE country office – in consultation with the corresponding CARE member and their decision-making framework – is now having to decide what programming needs to be *temporarily suspended* and what programming can be *adapted and maintained* in the current country environment. Country offices should be asking themselves: *If we pause/suspend programming, how do we do it in the least harmful way? If we continue, what are some immediate changes we can make to mitigate risk?*

It is not possible to provide absolute answers or definitive guidance – every CO and program team will need to make the best decisions they can in their context and with the information they currently have. However, in situations where CARE is continuing to implement programming against the backdrop of a COVID-19 pandemic, here you will find information and a series of good practices for mitigating risk while maintaining humanitarian programming.

All current COVID-19 programming should be guided by the **do no harm** programming principle which states: *“We analyse the intended and unintended impacts of our programmes, encourage honest learning, and take action to prevent and respond to any unintended harms. We place special focus on preventing and addressing gender-based violence in all of our programmes.”*

NOTE: This guidance is intended to be tailored according to local contexts and CO policies while upholding the **do no harm** principle.

Guiding principles

When implementing field programs, it is important to plan, maintain awareness of all risks of exposure or transmission to COVID-19, know how to protect yourself, and identify opportunities to add value to the work you do in the community. Below are some principles to keep in mind when implementing programmes.

- **Principle 1: Planning.** Know where you are going and what you will be doing. Walk through the agenda, plan ahead and consider all the activities and environments (*i.e. does it require the gathering of people?*). Analyze them for risk and potential risk of exposure or transmission of COVID-19. Identify in advance as a team how you will reduce risks and ensure you have the resources to limit your exposure and risk of transmission.
- **Principle 2: Maintain awareness.** Be aware of your environment and who you are interacting with. Stay flexible and solution oriented. For some, it is helpful to adopt a mindset where you may carry the COVID-19 virus and use this in how you handle, touch or approach objects and people in the environment.
- **Principle 3: Less points of contact.** In theory, the less points of contact you have with people or locations, the safer you are from contracting or transmitting the virus.
- **Principle 4: Act to prevent.** Design, adapt, and plan activities to include the least possible points of contact and most hands-off approach. Monitor yourself and train your teams to understand the risks and how to prevent exposure.

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- **Principle 5: Seize opportunities.** Look for creative ways that CARE can help prevent spread of COVID-19 or otherwise safeguard the community. Communicate critical risk information and counter misinformation. Share with others the good practices you've adopted and bring your ideas to leadership who can work with to implement them.
 - **Principle 6: Safety goes both ways.** Know that we do not want our staff to catch the virus. Also know that we do not want to be the carrier that brings the virus to anyone else. Take care of yourselves at home and use the same level of precautions and care in your home life as we require at CARE. If you are feeling ill, do not come to work and refrain from visiting other vulnerable communities.

General risk mitigation measures

As we adapt and prioritise our programming, it is important to plan for program activities by utilizing the above principles and take the following actions to protect yourself and the communities we serve.

- Limit the number of group activities and if these activities need to be carried out, reduce the number of participants (recommend no more than 10 persons).
- Limit activities involving household visits and if these visits need to take place, refrain from entering indoors and conduct activity outside.
- Maintain spatial distance of two meters between persons.
- Staff and community members should wash hands before the start of any activity, in between each activity, and immediately at the end of the activity.
- Avoid touching your nose, mouth, and eyes.
- If any staff or community members develop flu-like symptoms, they should be excused from activities.

Guidance on Personal Protective Equipment (PPE) During COVID-19 Emergency Response

Infection prevention and control (IPC) includes hand hygiene, personal protective equipment (PPE) and waste management materials. PPE consists of garments to protect health care workers and usually comprise of gloves, N-95 masks, surgical masks, gowns and depending on source of transmission may also face shields, gowns, shoe covers, rubber boots and so on. All PPE are intended for one-time use and are disposable. For the purpose of this guidance on PPE and COVID-19, we are specifically referring to surgical masks, gloves, face shields, eye protection (such as goggles) and gowns/aprons.

Operations

Currently CARE does not warehouse PPE stock, nor do we have any immediate plan to centralize procurement due to shortage of supply, extensive lead-time, and limited resources and staff capacity. However, we are working with our corporate sponsorship teams to see about possible opportunities to procure and donate relevant PPE supplies. All organisations are facing challenges with provision of essential supplies and availability of PPE items at the global and national level. As confirmed by the global logistics cluster under WFP, there is an on-going effort coordinated by WHO to source critical items following centralized procurement approach and making them available to the countries with critical needs. There is work currently ongoing to consolidate the demands through the logistics cluster (where they exist) or through the lead agency designated by the humanitarian/resident coordinator to collate and coordinate demand at national level. The immediate priority is to first make PPE available to just the health care workers and support staff who are involved in treating critical and severe COVID-19 cases.

Given that an adapted corporate emergency was declared by CARE on March 18, 2020 for a period of 6 months, emergency procurement procedures under CARE International Procurement Policy can be activated. Country directors or, in the case of non-presence countries, the emergency team leader or regional directors have the authority to change some procurement policies and procedures during the emergency period provided changes are compliant with donor regulations and waivers from the donors are obtained and documented, as applicable.

For assistance with procuring PPE locally we recommend the following:

- Country offices should be participating in the local logistics clusters (where they exist) or through the lead agencies designated by the humanitarian/resident coordinator/ministry of health to get the most up to date information about PPE availability, shipping and other relevant logistical information.
- Country offices should be consolidating all procurement requests for PPE through country-level health and logistics clusters/coordination bodies.
- For specific guidance on CARE procurement and logistics contact Dilip Niroula, humanitarian program support and logistics manager at dilip.niroula@care.org

Programming Guidance for PPE

The WHO has stated that people only need to wear face masks if they have respiratory symptoms or if they are treating someone who is infected with the COVID-19 coronavirus. Note that anyone who has respiratory symptoms should be advised to stay home. This applies to CARE staff, partners and community members. The

WHO has also said that wearing masks may create a false sense of security among the general public. Doctors agree that the best defense against the COVID-19 coronavirus and influenza is washing your hands, avoiding touching your face, practicing “social distancing” and respiratory hygiene by coughing or sneezing into a bent elbow or tissue (and then immediately disposing of the tissue).

Based on a CARE office’s ability to procure and obtain PPE and to encourage the rational use of PPE within CARE’s programming in the context of COVID-19, the following is recommended to be prioritized for PPE distribution:

- **Health service delivery provided directly by CARE staff in a CARE health facility.**
PPE will be calculated and stocked at the health facility as per WHO’s *Guidelines on the Rational Use of Personal Protective Equipment for COVID-19*.
- **Health service delivery provided by Ministry of Health (MOH) staff in a MOH health facility supported by CARE.**
CARE health staff are encouraged to work with the MOH, health, and wash clusters to streamline national orders of PPE and to receive and distribute PPE according to national allotments. Where gaps are identified, please contact CARE PPE focal points for logistics and programming guidance.

For programming guidance on PPE, contact:

Rapid Response Team emergency SRHR specialist – Seema Manohar – seema.manohar@care.ca

For PPE procurement and logistics support, contact:

Humanitarian program support and logistics specialist – Dilip Niroula – dilip.niroula@care.org

SECTOR-SPECIFIC GUIDANCE



Water, Sanitation, and Hygiene (WASH)

Prioritise

Adapt

Maintain

PRIORITISE reviewing your existing WASH operations. What are the highest priority to maintain (based on most lifesaving, highest number reached, or other criteria)? Start determining your top three priorities, modifying standard operating procedures to reflect the COVID

ADAPT community-based hygiene promotion to ensure it is delivered with a ‘do no harm’ approach.

MAINTAIN links with the community. Communication with community focal points (for example, to share news of diarrhea outbreaks) is more important than ever when CARE staff and partners are not able to travel to the field.

context.

Considerations for WASH programming during the COVID-19 pandemic.

1. Water

- a. Water trucking: Are contractors still working? How do you monitor deliveries and water quality if staff can't access the field (are community committees/representatives an option)? Bank transfers to contractors.
- b. Support to water systems and utilities: What additional support is needed (e.g. upfront funds or materials to maintain water supply)?
- c. Operation and maintenance of small-scale infrastructure (handpumps, tap stands etc.), supply of fuel for pumping: Pre-position spare parts and chlorine in community (with clear safety and security measures); empowerment of committees to undertake O&M; allocation/transfer of funds to committees to purchase fuel. Prioritize water infrastructure support to clinics.
- d. Water point access: Promote distancing in water point queues where possible.
- e. Cash / vouchers: Can alternative measures be implemented to guarantee safe water supply, for example through the private sector?

2. Sanitation

- a. Camp latrines: Pre-position materials (slabs, superstructure, locks) for rehabilitation of new construction in the event of flooding, filling up etc. Take preventative measures to improve latrines to minimize flood damage.
- b. Urban sanitation, such as emptying septic tanks or support to sewage and solid waste systems/authorities: Similar to the above measures for water trucking (i.e. for desludging, waste collection) and support to utilities.

3. Hygiene promotion

- a. Hygiene kit distributions: Promote *do no harm* measures at distribution sites (increased spacing in queues, provision for handwashing, alternatives to large distributions – including cash/vouchers); double/triple hygiene kit distribution quantities to cover possible future lockdowns and market disruption (include soap, laundry soap, water containers, female sanitary materials).
- b. Handwashing promotion: Use WASH 'Em materials for simple handwashing promotion with a focus on COVID-19 prevention. Identify opportunities for scaling up provision of handwashing facilities.
- c. Community engagement and risk communication: Participatory approaches and community meetings are core to effective hygiene promotion; however offices need to consider common-sense approaches to minimizing social contact during hygiene activities. Promote physical distancing as much as possible, including use of loudspeakers, limiting groups to no more than 10 people with two meters distance between each person, and handwashing before the start of any activity. Can activities be transferred to indirect methods such as radio or SMS/social media messaging?
- d. Coordinate with regional and local health authorities on setting up or reinstating community-based surveillance and reporting measures, engage community leaders, including women and youth on this.

4. Cholera preparedness and response

- a. Focus on above measures for maintaining supply of chlorinated water and hygiene promotion. Pre-positioning is equally vital in cholera hotspots due to the need for rapid response. Liaise with health authorities as to additional support they need to maintain services.

5. Gender

- a. All of the above activities need to be planned and implemented in line with CARE’s approaches to mainstreaming gender and vulnerability (elderly and underlying illness). More information can be found in the WASH Minimum Commitments on Gender.
- b. Ensure ongoing activities are not putting vulnerable people at risk – WASH/GBV continued focus.

6. WASH Coordination

- a. Collaborate with peer agencies/WASH cluster on prioritization and maintenance of activities.

CARE WASH/COVID-19 Contact

Emergency WASH Team Leader – Nick Brooks– brooksn@careinternational.org

Health/Sexual and Reproductive Health and Rights (SRHR)



Prioritise

Adapt

Maintain

PRIORITISE coordination with the MOH, health cluster, and SRH working group, also robust implementation of IPC standards at health facilities and households.

ADAPT community-level outreach to include remote engagement strategies, risk communication, community engagement, and community-based surveillance.

MAINTAIN provision of primary health care services, including SRH, and enhance the use of SRHRiE Minimum Commitments to Gender and Inclusion during COVID-19 response.

Considerations for health/SRHR programming during the COVID-19 pandemic.

1. **Strengthen coordination with MOH, the health cluster, WHO, UNICEF, and MOH incident management groups to:**
 - a. Support national COVID-19 response and work in conjunction on localized strategies, messaging, requests for supplies and preparedness planning.
 - b. Collaborate on scenario planning to ensure continuity of lifesaving services while protecting health workers, slowing the spread of COVID-19 and reducing mortality from the virus.
2. **Adapt community level outreach and conduct risk communication and community engagement by:**
 - a. Exploring remote engagement strategies and using physical distancing as much as possible, including use of loudspeakers, SMS or digital approaches. If not possible, for crucial community-level activities, limit groups to no more than 10 people with two meters of space between each person and handwashing before start of any activity. During household visits, community health workers should avoid going indoors and if providing commodities should place the commodity in a space between

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- CHW and client to maintain physical distancing.
- b. Conducting health promotion and risk communication on prevention of COVID-19, how and when to report symptoms, addressing myths and misconceptions and where to seek care.
 - c. Coordinating with regional and local health authorities on setting up or reinstating community-based surveillance and reporting measures.
 - d. Engaging community leaders, including women and youth on health promotion and community-based surveillance activities.
 - e. Encouraging community partners to inquire about the nature of specific rumors and misconceptions and inform local health authorities to support better targeting of contextualized communications.
3. **Maintain access to primary health care (PHC) services including SRHR by:**
- a. Providing routine PHC services in accordance to WHO standards of infection, prevention and control and the rational use of PPE
 - b. Training all CARE supported health facility workers including non-clinical health workers on IPC measures to be taken during COVID-19
 - c. Establishing a patient flow that includes triage before entrance into the health facility; a designated isolation area to escort those exhibiting COVID-19 symptoms; separate donning and doffing stations for health care workers directly interacting with patients in the isolation room and waiting areas, consultation rooms and hallways all abide to physical distancing of individuals being spaced two meters apart.
 - d. Ensure continuation of SRHR services in line with the [Minimum Initial Service Package for SRH in crisis settings](#). Where CARE is not implementing the full MISP, coordinate with other actors to strengthen the referral mechanism to access lifesaving services (such as clinical management of rape, emergency obstetric newborn care, contraception, syndromic management of STIs).
 - e. Ensure pregnant women or girls exhibiting COVID-19 symptoms have a separate isolation area, particularly for delivery and post-partum recovery.
 - f. Consider use of cash and voucher assistance to support transportation, cost of services, mobile phone credit for staff at functional health facilities, etc.
 - g. Consider the unique needs of pregnant women, adolescent girls, people living with HIV, displaced persons, elderly, and other vulnerable groups.
4. **Enhance use of [SRHRiE Minimum Commitments for Gender and Inclusion](#).**

CARE Health/SRHR Contacts for COVID-19

Lead for Public Health in Emergencies: allison.prather@care.org

Lead for SRHR in Emergencies – Anushka Kalyanpur – anushka.kalyanpur@care.org

Shelter and Settlements



Prioritise

Adapt

Maintain

PRIORITISE risk analysis, decongestion in camps, partitions in shelters, and coordination with WASH actors.

ADAPT modalities to self-implementation, cards not cash, local labour rather than external.

MAINTAIN shelter NFI distributions to allow households to have separate spaces and sole use of NFIs.

Considerations for shelter and settlement programming during the COVID-19 pandemic.

- 1. Avoiding overcrowding in all types of shelter is vital to help reduce virus transmission.** Where people live, the space they have inside their homes for isolation, levels of overcrowding in collective centres and camps are all hugely relevant to the speed and likelihood of coronavirus transmission.
- 2. Camps and informal settlements.** Camp improvements should take place based on a **risk analysis** of where congestion occurs, such as shared infrastructure used by many people. Avoid narrow circulation routes, people bottlenecks, crowded water points, meeting spaces, distribution points, informal social spaces. Actions could include; widening of passages/pathways, new pathways, decentralisation of distributions, imposing physical distancing rules during necessary gatherings, cancellation of all non-essential community gatherings.
- 3. Shelter NFIs/household items.** Shelter material distributions (e.g. tarpaulins) can assist families in constructing internal partitions/isolation booths for infected family members. Any new distributions should be planned very carefully to avoid creating congested gatherings and allowing more people to get infected. Having enough household items such as kitchen sets, stoves, blankets, mattresses for different household members to use rather than sharing can also help to reduce transmission of the virus.
- 4. Housing and land property rights.** A loss in income could link to an inability to pay rent, which could lead to sexual exploitation and abuse by landlords, or threats of eviction. Evictions could lead to further overcrowding in other accommodation. Women could be particularly at risk of losing their homes as they are not always named on ownership documents if male family members die from COVID-19.
- 5. Integration with other sectors.** Shelters and housing without kitchens, bathrooms or separate toilets will be difficult to keep clean. Ensure all shelter programmes are accompanied by a strong WASH component; both hardware and software. For cash-for-shelter programming, see the cash section for guidance or contact the Shelter Team at the email address below.
- 6. Gender/GBV.** Women are often responsible for cleaning/cooking/housework and maintenance inside the home. Adequate shelter and household items will help them to manage an increase in this work. Being forced to isolate at home and overcrowding in shelters can lead to an increase in GBV (including intimate-partner violence, sexual exploitation, and early marriage). Prioritise decongestion and shelter NFI

distributions to reduce these risks.

- 7. Advocate.** It is important to advocate for decongestion strategies in camps and settlements. Government and local stakeholders hold the power to free up land around camps and donors can help fund camp and shelter improvements as well as camp extensions.

CARE Shelter/COVID-19 Contact

For more information on adapting your shelter programming in light of COVID-19, contact: emergencysshelter@careinternational.org.

The Global Shelter Cluster is gathering relevant information on COVID [here](#). Specific guidance for camps and camp-like settings is [here](#).

Humanitarian Food and Nutrition



Prioritise

Adapt

Maintain

PRIORITISE risk analysis, protection, lifesaving activities, and coordination with health actors.

ADAPT standing operating procedures for implementation to ensure they use a 'do no harm' approach.

MAINTAIN a gender lens in targeting to ensure the elderly, children under five, and other vulnerable groups' food needs are adequately addressed in planning food baskets.

Considerations for humanitarian food and nutrition programming during the COVID-19 pandemic.

1. Distributions (food and cash)

- Targeting:** Current caseloads will likely go up due to the changing economic situation, loss of casual labour opportunities, loss of income related to business closure, and disruption of commodity and labour markets. Review targeted caseloads regularly to include and support those who are no longer able to meet their food needs.
- Delivery modalities and mechanisms:** Prioritise modalities and mechanisms that reduce human contact specifically cash and voucher assistance through e-transfers where markets and technology allow. If you conduct physical distributions, then avoid overcrowding, communicate preventive measures for handwashing, social distancing, and use of personal protection equipment.
- COVID-19 awareness:** Make awareness and preventive guidance available at all distribution sites including the CVA outlets. Where possible, have the messages translated into local language.
- Feedback mechanisms:** Avoid face to face feedback methods and instead provide phone numbers

where beneficiaries can provide feedback.

2. Acute malnutrition management

- a. Include messages on hygiene, COVID-19 symptoms, prevention, and support safe feeding for all children.
- b. Strengthen capacities of mothers, caregivers, and community health workers to detect, monitor children's nutritional status and provide treatment for uncomplicated wasting at community level.
- c. Reduce overcrowding in stabilization centres applying recommended infection prevention and control measures.

3. Coordination

- a. Participate in food and nutrition cluster forums, coordinate, and share information with other partners.
- b. Create networks with healthcare partners to share referral related information.

4. Gender/GBV

- a. Safe food handling/preparation is critical in prevention of COVID-19 transmission. Women, men, boys, and girls should equally be made aware about safe food handling methods. Ensure food handling advice is included in the COVID-19 prevention messages shared with all genders.
- b. Ensure food rations are targeted fairly to reach female headed households, child headed households, the elderly, the sick, and other vulnerable groups to prevent GBV.
- c. Ensure the elderly population and under five children food needs are considered adequately in planning food baskets
- d. Seek advice on food, nutrition, and livelihoods from CARE's Minimum Commitments on Gender.

5. Advocacy

- a. Work with governments to adjust social protection programmes by increasing monthly transfer amounts; scale up of nutritional support; and increased food distributions to the most vulnerable families; and tax exemptions on basic foods.
- b. Support channels of supplying fresh foods to markets and avoidance of any trade restrictions that impair free flow of food and agricultural inputs across borders.

CARE Humanitarian Food and Nutrition/COVID-19 Contacts

Humanitarian FNS Team Leader – Justus Liku – Justus.liku@care.org

Gender



Prioritise

Adapt

Maintain

PRIORITISE RGAs, GBV, women's leadership, using the CARE Gender Marker.

ADAPT by mainstreaming gender across all programming, including SRHR and cash, VSLAs, and girls education.

MAINTAIN gender specialist staffing, support systems for vulnerable staff, gender equity and diversity training.

Considerations for gender programming during the COVID-19 pandemic. *Priorities are based on the findings of the Global Rapid Gender Analysis (RGA) on COVID-19. Links to resources will be updated as they become available.*

1. Understand how COVID-19 is affecting women, men, boys and girls in the programmes and locations where you work. This can be done as part of preparedness or response using an adapted [Rapid Gender Analysis \(RGA\)](#). Remote RGA training is [available](#).
 - a. Read the Global [RGA on COVID-19](#) and relevant Regional RGAs (e.g. [Pacific](#)).
 - b. Use the *Rapid Gender Analysis COVID-19 Guidance Note* to develop national RGAs on COVID-19. This can be done remotely. Share your findings internally and externally. Plan to update the RGA on COVID-19 as the situation changes.
2. GBV is increasing because of COVID-19. Programming addressing GBV, especially intimate-partner violence is lifesaving. GBV prevention, mitigation and response programming must be prioritized as part of your COVID-19 response work. *GBV Risk Mitigation Training* online is currently being finalized.
 - a. Use the global and national [GBV AoR Gender-Based Violence Guidance on COVID-19](#) to prioritise, adapt and maintain prevention, risk mitigation and response work.
 - b. Maintain CARE's commitment to [zero-tolerance towards sexual exploitation and abuse](#); brief staff, share GBV service provider contacts, and review/adapt community-based and internal reporting mechanisms.
3. Women's leadership is missing in COVID-19 decision-making and women's unpaid care roles are increasing. CARE can address this through programmes and through its organizational response.
 - a. Prioritise programming like [Women Lead in Emergencies](#), social norms change, engagement of men and boys and women's and partnerships with women-led organisations that support women's participation and decision-making.
 - b. Include women in internal and external COVID-19 decision-making; ensure a gender specialist is part of regional and national task-teams; adopt flexible working practices for all staff; use information, education, and communication to promote men's equal responsibility for unpaid care roles.
4. [Learn lessons](#) from previous crises and use the CARE Gender Marker right from the start. The [CARE Gender Marker tool](#) will help you to make sure gender is not missed out. Online training is [available](#).

- a. Use the CARE Gender Marker to review and improve your COVID-19 Response Strategy and your proposals, including for Emergency Response Funding.
- b. Use the data from the CARE Gender Marker in PIIRS to review how your programming is including gender equality.

CARE Contact for Gender in Emergencies (GiE)

GiE Coordinator – Isadora Quay – quay@careinternational.org

Cash and Voucher Assistance (CVA)



Considerations for CVA programming during the COVID-19 pandemic.

1. Is it safe, feasible, and possible to implement your current or planned projects using cash and voucher assistance? Has the situation changed dramatically, such that implementation would put CARE staff, partners, or participants at risk? Can you add behavioral change or sensitization sessions related to disease prevention to existing or planned projects? Does your feedback mechanism still work? If you are not sure or need adaptation assistance, contact global advisors Holly Welcome Radice (holly.radice@care.org, English and Spanish) and Sani Aoude (Sani.DanAoude@care.org, French and English).
2. Do you understand how COVID-19 is affecting your target populations? [Use rapid market assessment tools](#) to determine how access and functionality of markets (goods, services, labor) has been affected, whether functionality is static or changing, and who has access to what. If you are not sure of how to do this, use the steps in the [CaLP Program Quality Toolkit](#), the [Minimum Economic Recovery Standards](#) and [CARE's Guidelines](#).
3. Have you checked with your participants or at-risk communities? Globally, CARE is analyzing the gendered implications of the COVID-19 pandemic through a [global policy paper](#) and Rapid Gender Analysis. At context-specific levels, do you understand how to use a [gender-sensitive approach to CVA](#) to address challenges and take advantage of opportunities during the evolution of the crisis? (This resource is also available in [Spanish](#), [French](#), [Arabic](#) and [Portuguese](#)). Remember that women in isolation will be more prone to violence. Public health and gender experts have already connected [GBV to this crisis](#). Have you checked in with your program participants? Do you know how to reduce GBV risks in CVA? Use the [CVA and GBV Compendium](#), also available in [Spanish](#), [French](#), and [Arabic](#).
4. Have you documented any restrictions to using, sending or receiving money or goods during the pandemic? Are there government or private sector restrictions on access to payment areas? Can you your financial service provider (FSP) deliver in all of the places that you are targeting (Can they reach safely? Is enough cash in circulation? Are the products available for vouchers)? Talk to the FSP at capital and payout locations, as this may vary by location. Remember that access and regulation may change along as the crisis evolves. If you don't have an FSP, do this to help [prepare an analysis](#) to potentially use CVA after the pandemic is contained.
5. Have you identified points of entry for CVA once the COVID-19 emergency period passes? Are there community or government mechanisms that will help support recovery? Are there VSLAs in the

community? Do you have a sense of how this will impact products' availability (e.g. produce, beans) or normal seasonal diseases? Do you know when and where in the [value chain you could support](#) communities?

6. Do you know what other CVA actors are doing, thinking, and planning? Find out what peer organizations are planning. Mercy Corps released [CVA and COVID-19](#) guidance that gives great food for thought on the appropriateness of different actions. Cash, sectoral (e.g. food security, WASH), and social protection working groups will discuss CVA in the coming weeks. To understand how best to participate and contribute to cash coordination, see the [CaLP guidance](#). CaLP Members are contributing to a [crowd-sourced document](#) on CVA amid the COVID-19 crisis.

CARE CVA/COVID-19 Contact

For programming guidance on CVA in light of COVID-19, contact:

Global cash advisor – Holly Radice – holly.radice@care.org