STREET CHILD

COVID-19 CRISIS RESPONSE

RAPID ASSESSMENT REPORT

MAY 2020

STREET CHILD

Street Child is an international humanitarian organisation with its central office in London, United Kingdom, and branch offices in various countries across Europe, South Asia, Sub-Saharan Africa and the United States of America. Street Child seeks that all children are in school and learning, and specialises in working with children and communities in low resource environments and emergencies.

Since 2008, where we commenced working with 100 street-connected children in Sierra Leone, we have continued to increase the scope and scale of our work in fragile, conflict and crisis-affected countries. At present, we have operations across 14 countries across South Asia and Sub-Saharan Africa, including Afghanistan, Bangladesh, Burundi, Cameroon, the Democratic Republic of Congo, Kenya, Liberia, Mozambique, Nepal, Nigeria, Rwanda, Sierra Leone, Sri Lanka and Uganda.

As an emergencies specialist, our first rapid response was to an infectious disease epidemic in Liberia and Sierra Leone, through our 2014-2016 Ebola Emergency Response. Further interventions include climate-change induced crises in Nepal and Mozambique, protracted political crises in Afghanistan, Cameroon and North-East Nigeria, and refugee responses in Bangladesh and Uganda, as principal partners of the Department for International Development [DFID], European Union [EU], US State Department, and United Nations [UN], amongst others. The scale and scope of our operations is underpinned by a deep, diverse network of >80 national partners across these 14 countries.

In 2020, Street Child launched a Global COVID-19 Crisis Response to –

1. Prevent the proliferation of COVID-19, especially for the most affected, most marginalised children and communities;
2. Prepare and plan to mitigate and manage the humanitarian impact of COVID-19, especially for the most affected, most marginalised children and communities;
3. Respond to the humanitarian impact of COVID-19 by –
    3.1. Protecting most marginalised children and communities;
    3.2. Promoting learning for most marginalised children; and
    3.3. Increasing coping capacities for most marginalized communities.
4. Accelerate localization and transform local level capacities to prevent, prepare and respond to COVID-19.

As at 20 May 2020, Street Child has reached over 951, 884 beneficiaries in under-reached, under-resourced areas of the countries where we work. This rapid assessment makes a critical contribution towards a more targeted, tailored response for affected populations.

ACKNOWLEDGEMENTS

Street Child has a strong, sustained commitment to championing local actors and accelerating localisation, stated as one of our four strategic priorities in our COVID-19 Crisis Response Plan –

'Street Child will accelerate localisation and transform local level capacities to prevent, prepare and respond to COVID-19

Street Child worked with 50+ local level actors and organisations to administer the rapid assessment. This included previous and present partners from existing, established relationships and prospective partners from emerging relationships for example, via cluster coordination architecture. This partnered approach was instrumental in procuring permissions to administer the assessment and in allowing access to communities. In several cases, partners covered their own costs and in all cases their effort exceeded any cost contributions.

This rapid assessment was made possible by our 50+ national partners, who reached out to 12,100 people across 13 contexts, to collect critical real-time information on needs and gaps.

Street Child is grateful for their critical commitment to conducting and completing this exercise. Partnerships will continue to be a cornerstone of our response to the recommendations emerging from this rapid assessment, to ensure effective, efficient and relevant impact for the children and communities we serve.

- Aasmaan Nepal
- ACAD
- Almaijiri Child Rights Initiative
- APG Inkingi
- Afghan Women's Educational Centre
- African Women and Youth Action for Development
- Associations of Persons Living with Disabilities
- Build Africa Kenya
- Build Africa Uganda
- Blessing a for Women and Children
- Basic Rights Counsel Initiative
- Cameroon Humanitarian Educational Leadership for Peace and Development
- Centre for Human Rights and Peace Advocacy
- Child Aid Uganda
- Coordination Unit of Associations for Person with Disabilities
- Eben Ezer Ministry International
- Environmental Protection and Development Association
- Foundation of Hope Centre
- Gender Equality Peace and Development Centre
- Global Forum for the Defence of the Less Privileged
- Grace Chins Foundation
- Humanitarian Association of Dynamic Youths
- Helpo
- Herwa Community Development Initiative
- Human is Right
- Intercommunity Development Social Organisation
- Integrated Youth Empowerment Centre
- Keenly Humanitarian Assistance for New Afghanistan
- Kulima
- LUKMEF
- Lumiere Pour Tous
- Mediothek
- Miracle Charity Foundation
- NADEV
- Reach Out
- Restoration of Hope Initiative
- Reaching People in Need
- Social Action for Development
- SAHAS Nepal
- Strategic Humanitarian Services
- Society for the Promotion of Initiatives in Sustainable Development and Welfare
- Street Child of Liberia
- Street Child of Sierra Leone
- Sustainable Development and Humanitarian Services Foundation
- UATAF-AFC
- Value Health Africa
- Vision GRAM
- Young African Refugees for Integral Development
- Others

SUMMARY

The COVID-19 pandemic is having a disproportionate impact on the poorest parts of the world. Street Child has launched a global response to the intensified needs of children and communities in fragile, conflict and crisis affected countries.

The complex, changing circumstances of the COVID-19 pandemic poses a challenge to assuring assistance for affected children and communities, and require robust information about the greatest needs and gaps. Street Child conducted a rapid assessment aimed at understanding these needs and gaps across our countries of operation from 27 April 2020 and 8 May 2020. The rapid assessment aligns to our response priorities and aims to understand the proliferation of prevention and preparedness information and resultant actions; to understand the education and protection needs of children and communities; and to understand current coping strategies and communities' need for assistance.

Our rapid assessment was conducted with 12, 100 respondents across 13 countries - one of the largest global surveys of the COVID-19 crisis to date.

13
COUNTRIES

50+
PARTNERS

12,100
RESPONDENTS

1,300
SAMPLES

Street Child worked with a deep, diverse network of 50+ partners to prioritise the poorest and most marginalised populations in hard-to-reach, remote and rural areas and high-risk urban areas. The selection of respondents is intended to represent the needs of these populations and as such the assessment results and trends should be interpreted in relation to these populations. The number of respondents in each country context was contingent on stated priorities and programmatic and operational capacities. As the number and sampling strategies ranged across contexts, this report sets out the results of the rapid assessment adjusted for the range in number of respondents using a sample of 100 randomised respondents per country; however, it refers to all available data for substantiation as relevant or required.
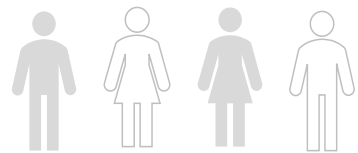
FINDINGS

- **There is a significant gap between awareness and action to prevent or prepare for the pandemic**
    - 97% of respondents report that they have received information on the infection, but a much lesser proportion of respondents report that they have tried to prevent or prepare
    - 40% of respondents do not report that they are avoiding crowded or congested areas and 59% of respondents do not report that they are avoiding touching, sitting or standing close to others
    - 33% of respondents do not report increasing hand washing with soap and sanitiser and 85% of respondents do not report increasing surface hygiene

- **The pandemic is exacerbating existing inequities in access to education and exacerbating exposure to protection risks**
    - 51% of respondents reported that children do not have access to any alternative learning
    - 96% of respondents report concerns relating to increased risk of forced labour, forced marriage and/or recruitment into armed groups affecting children

- **An increased cost of living is coupling with loss of income and livelihoods to create an advancing risk of hunger and starvation**
    - 56% of respondents report hunger and starvation as the first and foremost issue of significant concern
    - 54% of all respondents report an increase in the cost of food, fuel and transport as an issue of significant concern
    - 36% of respondents report a loss of income and 18% of respondents report a loss of livelihoods, suggesting an increasing gap between costs and coping capacities

- **An alarming lack of assistance is lessening the coping capacities of communities**
    - 44% of respondents report that they have received no assistance
    - 56% of respondents report that they have received assistance, much which of which was one-time assistance that is since exhausted

The rapid assessment results and report find that the intensified needs of children and communities in fragile, conflict and crisis affected communities are interacting with existing vulnerabilities to create an advancing set of challenges. The report calls for targeted, tailored and in-time assistance to protect against the adoption of adverse coping strategies.

STREET CHILD CONDUCTED A RAPID ASSESSMENT AIMED AT UNDERSTANDING THESE NEEDS AND GAPS ACROSS OUR COUNTRIES OF OPERATION.
THE ASSESSMENT WAS ADMINSTERED ACROSS 13 CONTEXTS WITH A TOTAL OF 12 100 RESPONDENTS.

THE RESULTS AND REPORT FIND THAT THE INTENSIFIED NEEDS OF CHILDREN AND COMMUNITIES IN FRAGILE, CONFLICT AND CRISIS AFFECTED COMMUNITIES ARE INTERACTING WITH EXISTING VULNERABILITIES TO CREATE AN ADVANCING SET OF CHALLENGES.

12 100 RESPONDENTS X 13 COUNTRIES

97%
OF RESPONDENTS REPORT THAT THEY HAVE RECEIVED INFORMATION ON COVID-19 THROUGH -

Personal Communication Channels 43%

Digital Communication Channels 13%

Mass Communication Channels 44%

- BUT THERE IS SIGNIFICANT GAP BETWEEN AWARNESS AND ACTION TO PREPARE OR PREPARE FOR THE PANDEMIC

60% RESPONDENTS REPORT AVOIDING CROWDED OR CONGESTED AREAS

41% OF RESPONDENTS REPORT AVOIDING TOUCHING, SITTING OR STANDING CLOSE TO OTHERS

67% OF RESPONDENTS REPORT INCREASING HANDWASHING WITH SOAP AND SANITISER

15% OF RESPONDENTS REPORT INCREASING SURFACE HYGIENE

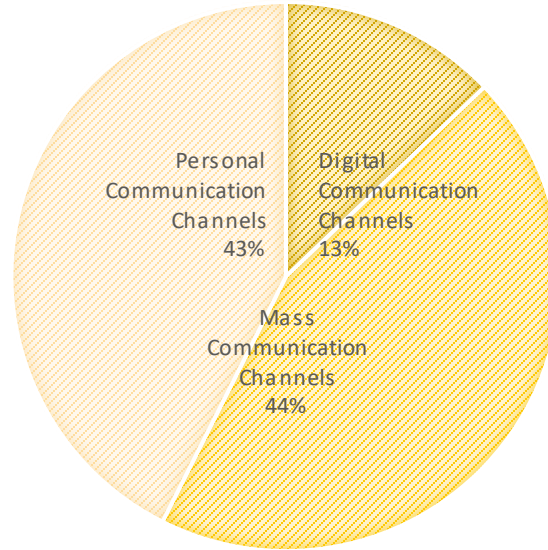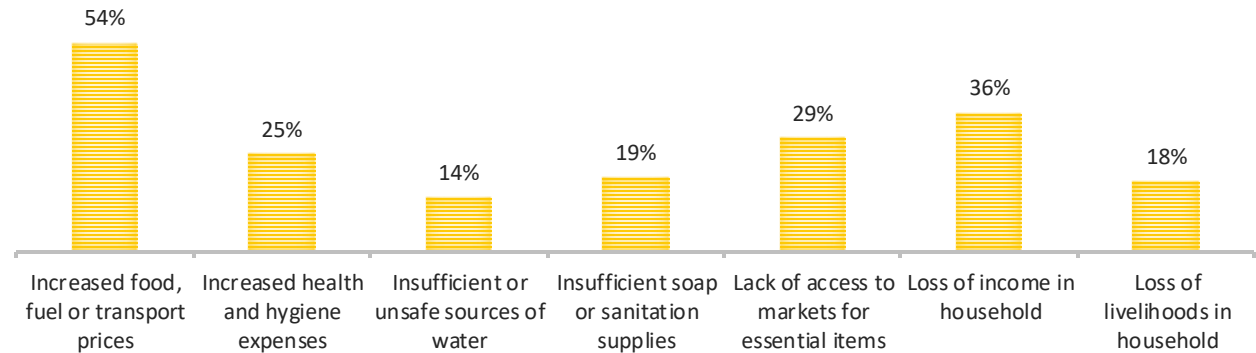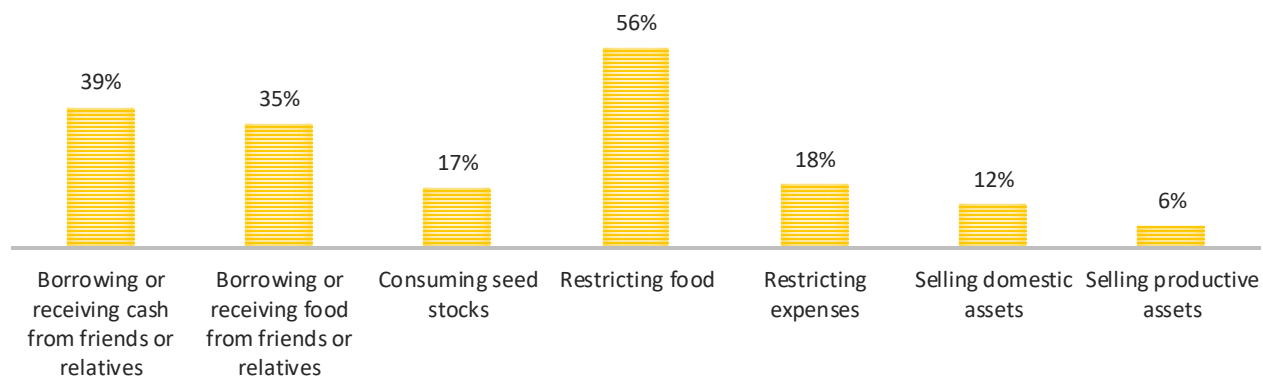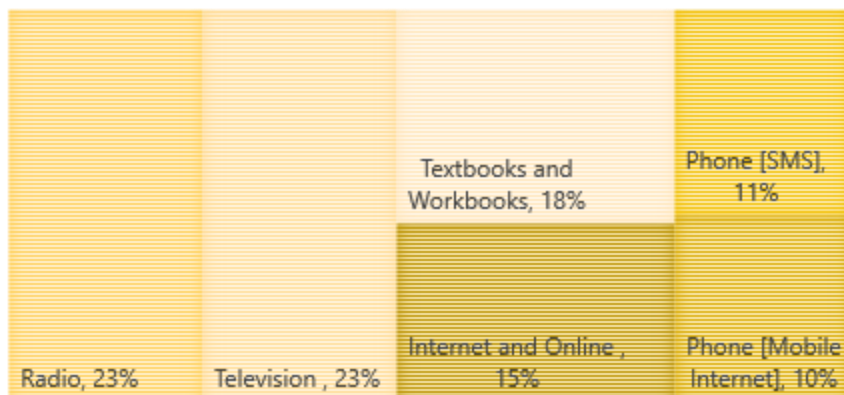1 IN 2 CHILDREN DO NOT HAVE ACCESS TO ANY ALTERNATIVE LEARNING OPPORTUNITIES

96%
OF RESPONDENTS REPORT PROTECTION RISKS FOR CHILDREN INCLUDING EXPOSURE TO EXPLOITATION

56%
OF RESPONDENTS REPORT RISK OF HUNGER AND STARVATION AS A SIGNIFICANT ISSUE

CHALLENGES

Increased food, fuel or transport prices	Increased health and hygiene expenses	Insufficient or unsafe sources of water	Insufficient soap or sanitation supplies	Lack of access to markets for essential items	Loss of income in household	Loss of livelihoods in household
54%	25%	14%	19%	29%	36%	18%

AVENUES OF ALTERNATIVE LEARNING

Radio, 23%

Television , 23%

Textbooks and Workbooks, 18%

Internet and Online , 15%

Phone [SMS], 11%

Phone [Mobile Internet], 10%

COPING STRATEGIES

Borrowing or receiving cash from friends or relatives	Borrowing or receiving food from friends or relatives	Consuming seed stocks	Restricting food	Restricting expenses	Selling domestic assets	Selling productive assets
39%	35%	17%	56%	18%	12%	6%

44%
OF RESPONDENTS REPORT THAT THEY HAVE RECEIVED NO ASSISTANCE TO DATE

ASSESSMENT APPROACH

This rapid assessment is intended into inform our response across the countries and contexts assessed. Thus, the analytical framework and assessment tool reflected our response priorities -

1. **[Question 1]** Prevent the proliferation of COVID-19, especially for the most affected, most marginalised children and communities;
2. **[Question 2]** Prepare and plan to mitigate and manage the humanitarian impact of COVID-19, especially for the most affected, most marginalised children and communities;
3. Respond to the humanitarian impact of COVID-19 by –
   3.1.**[Questions 4-6]** Protecting most marginalised children and communities;
   3.2.**[Question 3]** Promoting learning for most marginalised children; and
   3.3.**[Questions 7-9]** Increasing coping capacities for most marginalized communities.

The assessment questionnaire aimed to amass actionable information. The depth and length of the tool was determined as appropriate to allow its use in person, as well as on the phone.

The tool was designed and developed in English. However to allow for its application across a range of countries and contexts, the tool was translated into over 10 languages including Bengali, Dari, French, Kirundi, Nepali, Pashto, Portuguese, Swahili and Tamil. The translation was conducted by an individual fluent in both languages and informed of the objectives of the assessment, the intent of each question, and humanitarian terminologies. The tool was delivered in analogue and digital mode. Teams asked to adopt familiar modes to minimise the need for training on digital data collection; therefore, the tool was transposed onto Kobo Collect and Survey Monkey to offer a range of options.

The assessment encountered a range of limitations due to its inclusion of a range of countries and contexts, and the tight timeframe for administration. The tight timeframe required rapid translation; in an ideal assessment, the initial translation would have been back-translated and verified. The results revealed certain inconsistencies arising from mistranslation: in Burundi, respondents asked about access to alternative learning understood it as access to information, leading to an inflation of results. Issues of translation also arose in Bangladesh where the tool was administered amongst the Rohingya Refugees. Rohingya is an oral language with no accepted script and whilst it is related to the Chittagonian language that takes the Devanagari script, the Government of Bangladesh prohibits the presentation of the Devanagari script in the Rohingya Refugee camps as a result of a reluctance to allow local language learning. As a result, enumerators required to read and record responses using the English language tool. This limitation is also noted in Nigeria, where enumerators required to read and record responses in Hausa or Kanuri using the English language tool.

AGE DISTRIBUTION OF RESPONDENTS

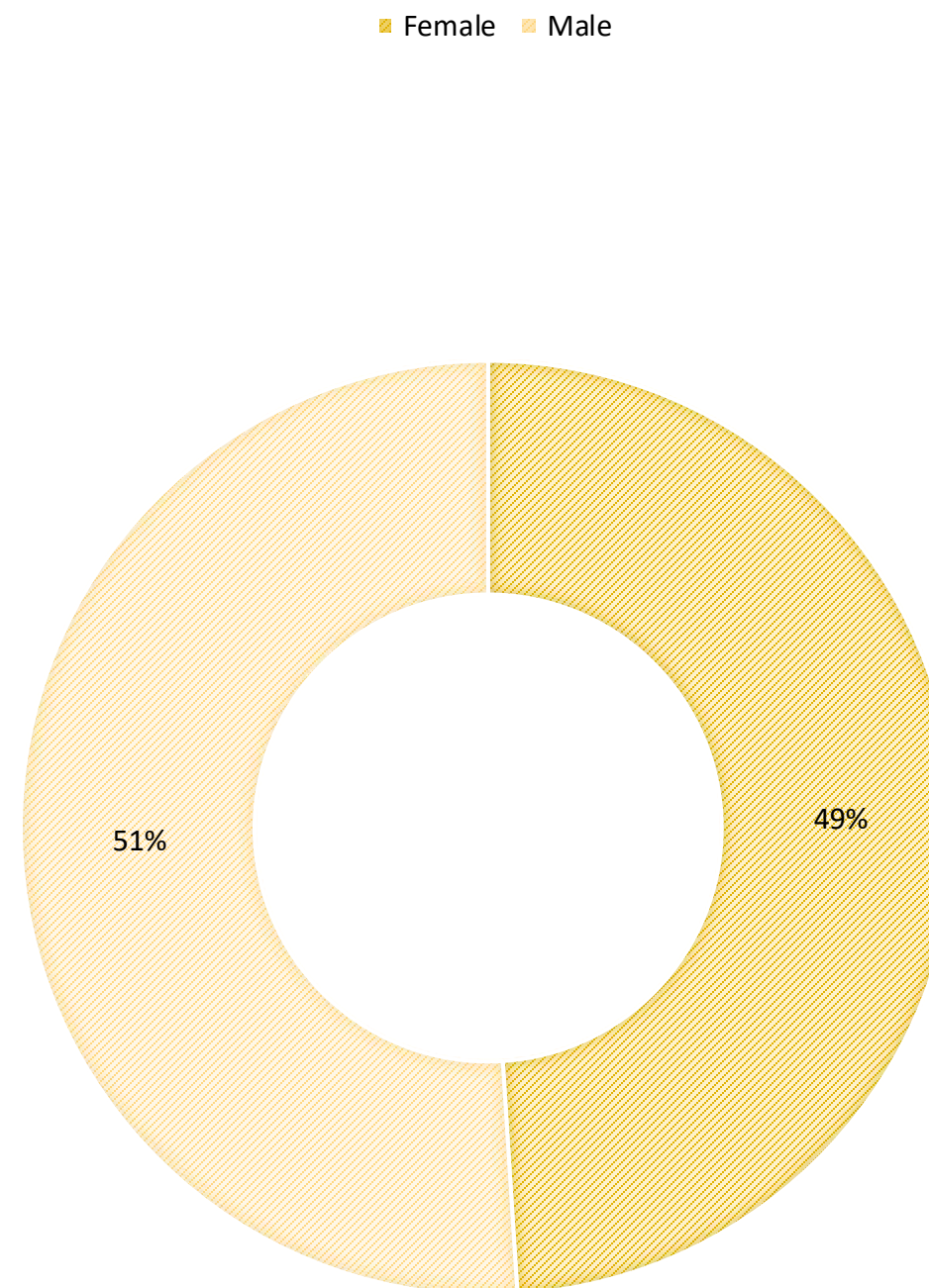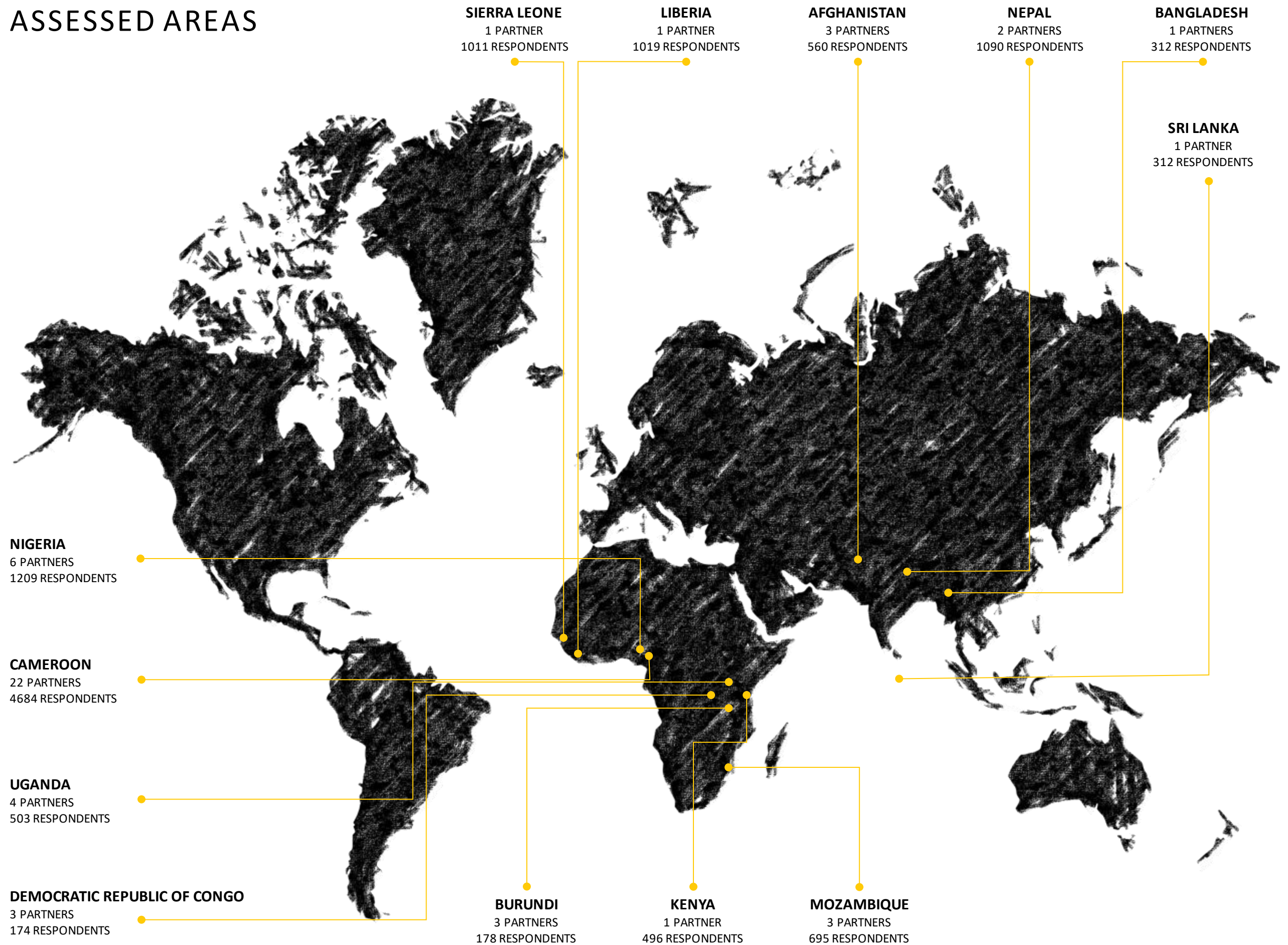| Age	Percentage
18 - 20	4%
21 - 30	28%
31 - 40	28%
41 - 50	20%
51 - 60	11%
61 - 70	6%
71 - 80	3%
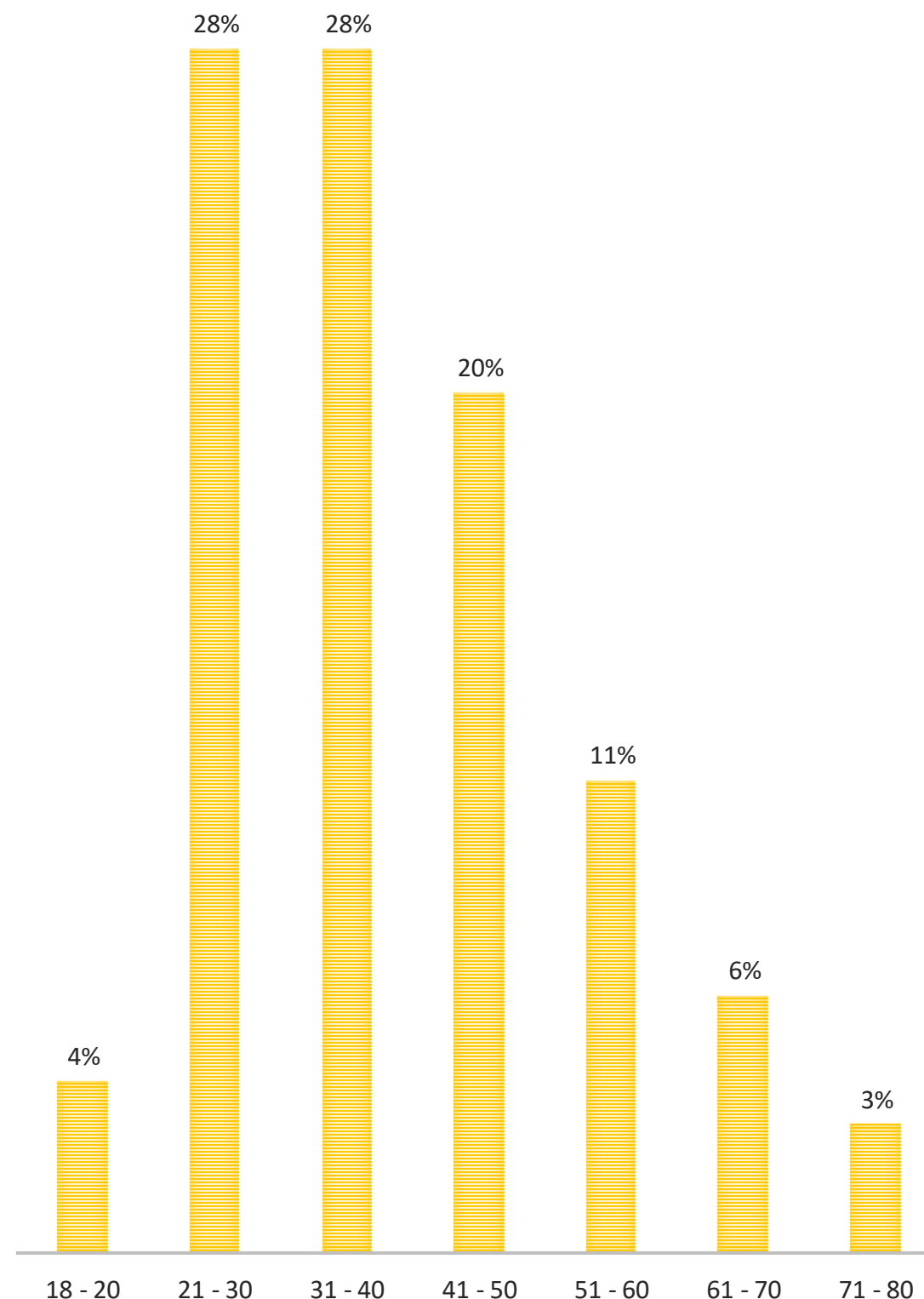
ASSESSMENT APPROACH

Sampling strategies varied across countries and contexts. In all cases, a careful analysis of the context was conducted to account for access, gaps in information and recommendations from other actors, and programmatic priorities. In certain countries, this resulted in sampling of specific areas or groups. For example in Bangladesh, the rapid assessment focused on refugees and in the Democratic Republic of Congo, concentrated on South Kivu. In other countries, this informed national assessments across a range of areas and groups; in Nepal and Sierra Leone, the rapid assessment included respondents from all regions. In certain cases, the assessment covered a range of areas or groups where partner or programme presence made it possible to assess; for example in Nigeria, the assessment concentrated on Borno State but also covered respondents in Adamawa, Cross River, Kano, Katsina and Plateau. Surveying strategies gave careful consideration to the medium and mode of data collection and collation. The choice of medium and mode accounted for access and the availability of technologies, given the range of restrictions operating across the target countries and contexts. For example, in Afghanistan and Cameroon the assessment was conducted in person using the analogue tool; however in Nigeria and Nepal, the assessment was conducted over the phone using the digital tool due to lockdown. The tight timeframe increased reliance on convenience sampling, where the assessment was administered in areas where partners are operating programmes. This is reflected in both in-person access and phone-access, where assessment administration over the phone required a phone database. In Nigeria, for example, this limited the sampled population to previous and programme participants. In Nepal, snowball sampling was used to assess a random respondents across multiple provinces. In certain cases, restrictions on movement limited the potential pool of respondents. Even in the case of free movement, partners reported insufficient time to travel to insecure, remote or rural areas to ensure their representation in the results. It is noted that respondents in these areas tend to experience greater degree of difficulties in accessing information and thus, greater gaps in prevention, preparedness and response.

Across all countries, enumerators were introduced to the tool in detail and the administration of the tool was demonstrated during training. The training also emerged errors in questioning or response recording and allowed them to be addressed prior to administration. All enumerators were given guidance on introduction and informed consent. In all instances, enumerators took care to confirm consent from respondents and to assure them that the information would remain confidential to avoid potential perceptions of risk arising from participation in the assessment. In addition, anonymous responses were permitted if respondents preferred not to provide their names. In certain contexts, small sample sizes suggest a high margin of error and restrict disaggregation of results by age, gender and geographies. It is therefore critical to note that the results of the rapid assessment are not representative and are not of statistical significance due to variations in sampling strategies. Rather, the results are indicative of the situation in assessed areas at the time of assessment. Rapid changes in circumstances associated with the COVID-19 pandemic mean that results do not account for any changes in the situation since.

GENDER DISTRIBUTION OF RESPONDENTS

■ Female   ■ Male

51%   49%

ASSESSED AREAS

SIERRA LEONE
1 PARTNER
1011 RESPONDENTS

LIBERIA
1 PARTNER
1019 RESPONDENTS

AFGHANISTAN
3 PARTNERS
560 RESPONDENTS

NEPAL
2 PARTNERS
1090 RESPONDENTS

BANGLADESH
1 PARTNERS
312 RESPONDENTS

SRI LANKA
1 PARTNER
312 RESPONDENTS

NIGERIA
6 PARTNERS
1209 RESPONDENTS

CAMEROON
22 PARTNERS
4684 RESPONDENTS

UGANDA
4 PARTNERS
503 RESPONDENTS

DEMOCRATIC REPUBLIC OF CONGO
3 PARTNERS
174 RESPONDENTS

BURUNDI
3 PARTNERS
178 RESPONDENTS

KENYA
1 PARTNER
496 RESPONDENTS

MOZAMBIQUE
3 PARTNERS
695 RESPONDENTS

AWARENESS

97% of respondents across South Asia and Sub-Saharan Africa report that they have received information on COVID-19; 3% of respondents report that they have received no information to date. There is a gender difference in access to information where 4% of females compared to 3% of males have received no information; however this slight variation is not of statistical significance.
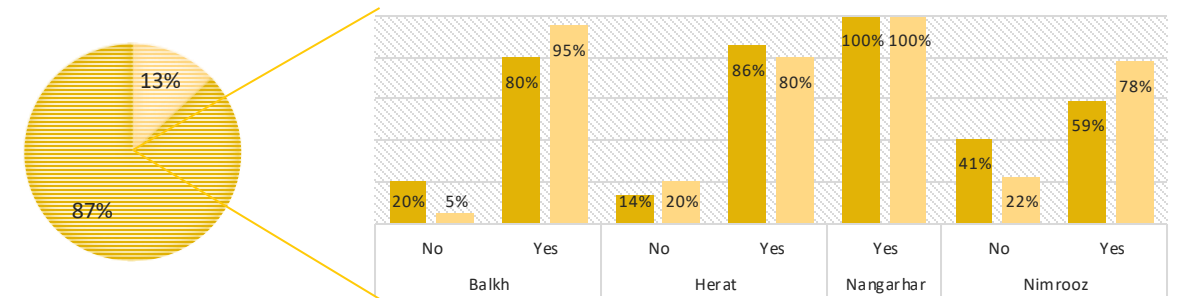
At the country level, in almost all cases the proportion of respondents reporting that they have received no information ranged from 0 to 5%. Afghanistan is a significant outlier: 13% of respondents report that they have received no information with discernible differences across gender and geographies. In all cases, it is possible that the results reflect methodological decisions: for example, partners in Liberia, Nigeria and Sierra Leone sampled populations in areas where they are operating programmes and thus it is possible that respondents have received information from them. This is to an extent reflected in the fact that 18% of respondents report receiving information from non-governmental organisations.

In any case, the results reveal regional disparities in access to information: a higher proportion of respondents in rural and remote areas report that they have received no information, suggesting that distance is a significant factor influencing information penetration. Afghanistan demonstrates dramatic disparities across provinces. For example, 41% of female respondents and 22% of male respondents in Nimroz report that they have received no information to date. Street Child notes that the areas assessed are border provinces where there is a higher rate of penetration of governmental and non-governmental interventions, indicating that the information gap is much larger in the rural and remote interiors.
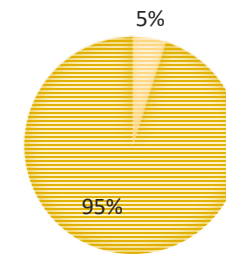
The results also reveal disparities in access to information amongst particular population groups: for example, the 5% of respondents in Bangladesh and 7% of respondents in Uganda reporting that they have received no information reflect lower levels of awareness amongst refugee populations [Rohingya refugees in Bangladesh and South Sudanese refugees in Uganda]. In Uganda, 69% of respondents reporting that they have not received information are from the refugee settlements in Palabek. Analyses suggest the language of government messages and a resultant reliance on non-governmental messaging as possible reasons. In all cases, although surveys did not sample across age groups, there is an observable gap in access to information amongst older age groups. For example in Nigeria, respondents under the age of 50 were almost three times likelier to have heard of COVID-19 than respondents over the age of 50.

Overall, the results of the rapid assessment demonstrate that almost all respondents had received information to influence prevention and preparedness efforts. However, in addition to minor disparities across age, gender, geographies and groups, responses revealed instances of misinformation – for example, with respondents asserting that avoiding cold food and increasing their intake of wine would protect them from infection.
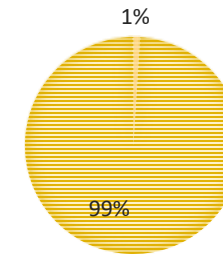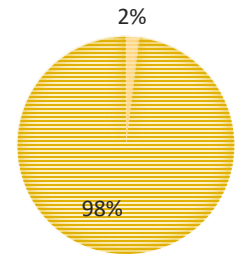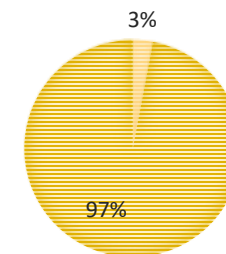

AFGHANISTAN

Female Male

	No	Yes	No	Yes	Yes	No	Yes
Female	20%	80%	14%	86%	100%	41%	59%
Male	5%	95%	20%	80%	100%	22%	78%
	Balkh		Herat		Nangarhar	Nimrooz	

Afghanistan pie: 13% / 87%

BANGLADESH	BURUNDI	CAMEROON
5% / 95%	1% / 99%	2% / 98%

DR CONGO	KENYA	LIBERIA
3% / 97%	1% / 99%	0% / 100%
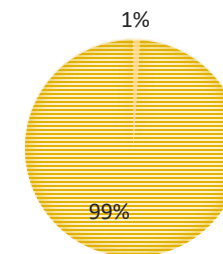
MOZAMBIQUE	NEPAL	NIGERIA
1% / 96%	1% / 99%	4% / 96%
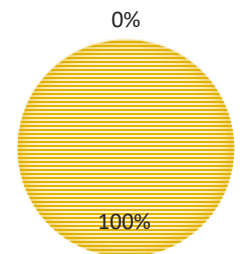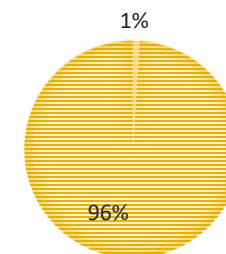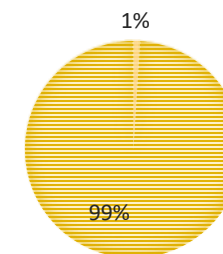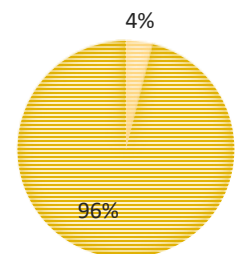
SIERRA LEONE	SRI LANKA	UGANDA
4% / 96%	1% / 99%	7% / 93%
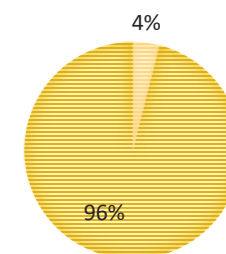
AWARENESS

Of the 97% of respondents who report they have received information on COVID-19 –

- 81% of respondents report receiving information through word-of-mouth modes with 32% receiving information from family and 45% receiving information from friends
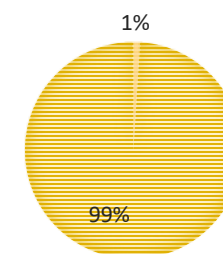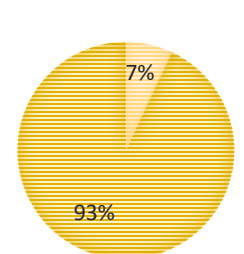- 94% of respondents report receiving information through mass messaging modes with 57% receiving information via radio and 37% receiving information via television
- 35% of respondents report receiving information through mobile messaging modes with 24% receiving information via Facebook, 3% receiving information via Twitter, 3% receiving information via WhatsApp and 5% receiving information via YouTube
- 56% of respondents report receiving information through government officials, non-governmental organisations and hospitals and health posts with ~ 20% in each case.

All respondents who have received information report receiving it from multiple sources. It is noted that responses related to governmental and non-governmental actors tended to reference direct provision – for example, through door to door sensitisation – rather than mass or mobile modes of messaging operated through governmental or non-governmental programmes. It is also noted that the increased reliance on family, friends and popular platforms increases the risk of inaccurate information, misinformation and rumours. For example, a number of respondents in Afghanistan noted that the infection affected urban areas alone, suggesting an intensified need for information that is authenticated and regulated in areas of low-prevalence.

There are discernible differences in how respondents received information across regions. Although radio and television are the most common modes of messaging across all regions, in South Asia, a significant proportion of respondents report receiving information through digital platforms: 39% of respondents received information through Facebook, 10% received information through Twitter and 14% received information through YouTube.

There are also differences in regions; for example in Cameroon, respondents in conflict-affected Anglophone regions tended to receive information from family and friends, whereas respondents in Francophone regions tended to receive information from radio and television. It is essential to note that the data reflects modes of messaging in areas where respondents were reachable. It is possible that the preference or prevalence of particular modes might shift in hard-to-reach, remote and rural areas where there is no access to mobile information, and little access to mass information through radio and television. For example in Cameroon, it is noted that the survey could not capture conflict-affected populations thought to have gone underground to avoid attack – without access to mass messaging or mobile messaging modes.

There is no discernible difference in how female and male respondents report receiving information. However, it is observed that 13% of female respondents report receiving information through their families compared to 11% of male respondents, consistent with studies that suggest females are likelier to depend on their families for access to information. 10% of male respondents report receiving information through Facebook compared to 8% of female respondents, consistent with studies that show that males have higher rates of access to digital devices.

MODES OF PREVENTION MESSAGING

EAST AFRICA   WEST AFRICA   SOUTH ASIA
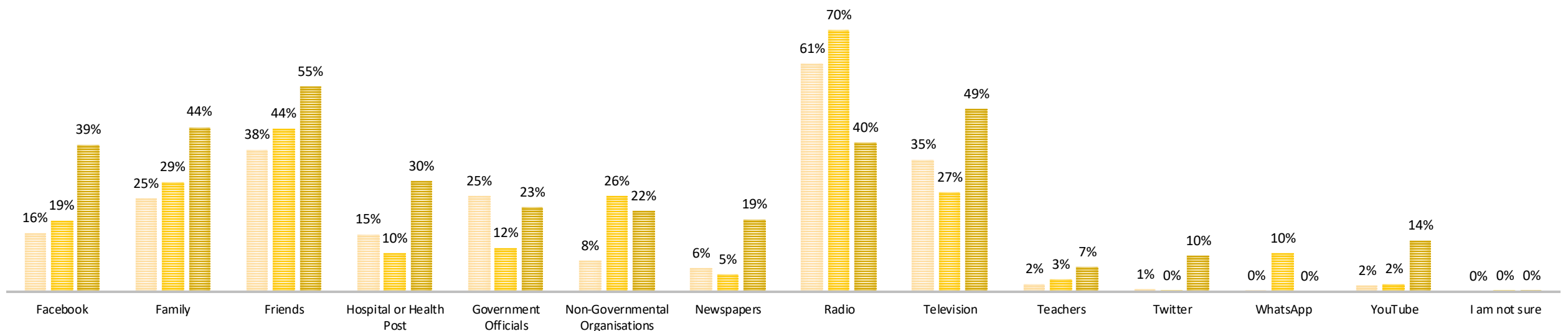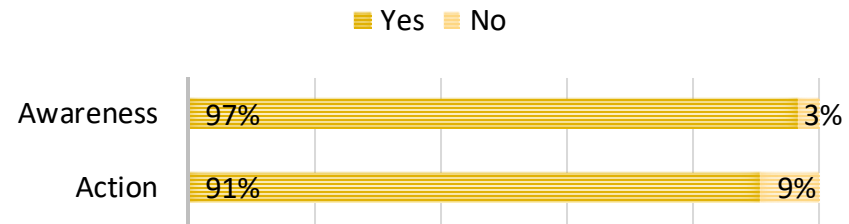
PREVENTION AND PREPAREDNESS

91% of respondents across South Asia and Sub-Saharan Africa report that they have attempted at least one strategy to prevent or prepare for COVID-19. 9% of respondents report that they have not taken any action to prevent or prepare to date. There is a slight gender difference in attempts to take action where only 89% of females compared to 92% of males have made an attempt to prevent or prepare; however this slight variation is not of statistical significance.

Though the proportion of respondents reporting that they have attempted to prevent or prepare is promising, there is a significant gap in the percentage of respondents reporting awareness [97%] and the percentage of respondents reporting action [91%].
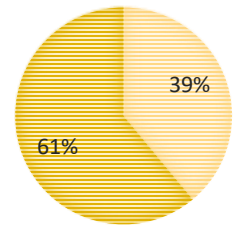
At the country level, there are significant gaps between awareness and action in Bangladesh and the Great Lakes. In Bangladesh, where the rapid assessment was conducted in the Rohingya Refugee camps, only 61% of respondents report attempting to prevent or prepare for the pandemic. This figure indicates a reasonable rate of information penetration through governmental and non-governmental actors [95% of respondents report that they have received information] but a lack of essential supplies such as soap and sanitiser required to take prevention and preparedness actions. It also appears to indicate the inherent challenges of adopting strategies such as social distancing in crowded, congested camps.

In the Great Lakes, where the rapid assessment was conducted in across a range of rural and urban regions in Burundi and the Democratic Republic of Congo, an average of 98% of respondents report that they have received information. However, only 77% of respondents in Burundi and 79% of respondents in the Democratic Republic of Congo report taking action. It is possible that these are driven by different factors. In the case of Burundi, this is attributed to a low level of effort and enforcement from the government: evidence suggest that the government is not encouraging people to avoid congregating, even encouraging them to participate in electoral campaigns.

MAPPING THE GAP
FROM AWARENESS TO ACTION
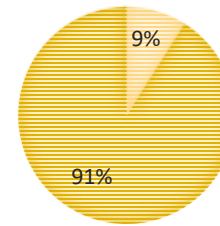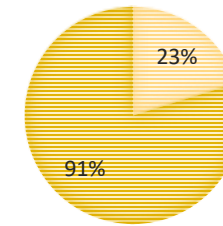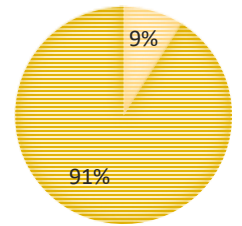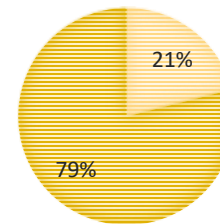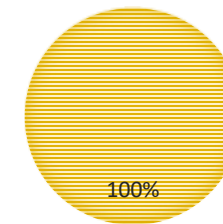
■ Yes ■ No

Awareness 97% 3%
Action 91% 9%

BANGLADESH
39% / 61%

AFGHANISTAN
9% / 91%

BURUNDI
23% / 91%

CAMEROON
9% / 91%

DR CONGO
21% / 79%

KENYA
0% / 100%

LIBERIA
1% / 99%

MOZAMBIQUE
8% / 92%
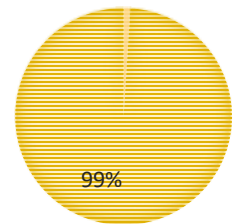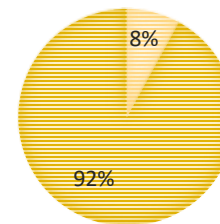
NEPAL
4% / 96%
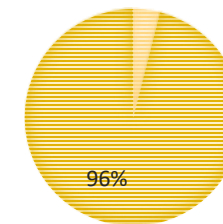
NIGERIA
0% / 100%
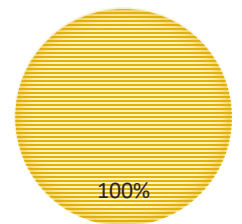
SIERRA LEONE
8% / 92%
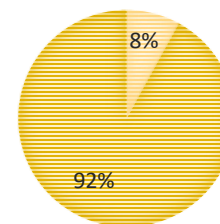
SRI LANKA
1% / 99%

UGANDA
5% / 95%

PREVENTION AND PREPAREDNESS

Although 91% of respondents across South Asia and Sub-Saharan Africa report that they have attempted to prevent or prepare for COVID-19, analysis of reported actions reveals alarming gaps.

In certain cases, responses reflect the lack of infrastructure and supplies for sanitation. 33% of respondents report that they have not increased hand washing with soap and sanitiser, and 85% of respondents report that they have not increased cleaning of surfaces. The lack of infrastructure and supplies are substantiated later in the report, where 14% of respondents report a lack of safe, sufficient sources of water and 19% of respondents report a lack of soap and sanitiser.

Responses also reflect the lack of an enabling environment to adopt specific strategies. 40% of respondents report that they have not attempted to avoid crowded or congested areas, suggesting significant challenges in adopting social distancing strategies in camps and urban slums and settlements. In certain cases, families are forced to go to markets with high footfall for food; for example, markets remain open in Mozambique but lack specific strategies for social distancing. In certain cases, responses correspond to the extent that government directives demand action. For example, masks do not feature in government recommendations in Burundi and Uganda and as a result, less than 50% of respondents report that they have adopted this as a strategy to increase hygiene.

There are cases of significant concern reflected in the responses. 59% of respondents do not report attempts to avoid touching, sitting or standing close to others. 80% of respondents do not report attempts to avoid coughing and sneezing around others. These strategies require self-reliance and self-regulation and do not require infrastructure or supplies for successful adoption. In some cases, this suggests the lack of advice or conflicting advice; in Burundi for example, the government has conducted sensitisation on hand washing and hygiene, and simultaneously encouraged electoral campaigns with crowds in the tens of thousands. In other cases, it suggests a lack of understanding that requires targeted, tailored sensitisation and support. In Bangladesh for example, a low proportion of respondents reported adopting social distancing measures: 62% of respondents did not report avoiding crowded and congested areas, and 62% of respondents did not report avoiding touching, sitting or standing close to others. These result reflect the realities of refugees in over-crowded settlements who struggle to maintain adequate social distancing measures regardless of information received.
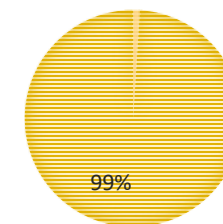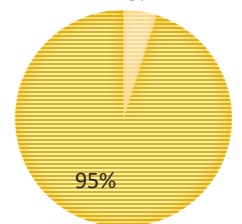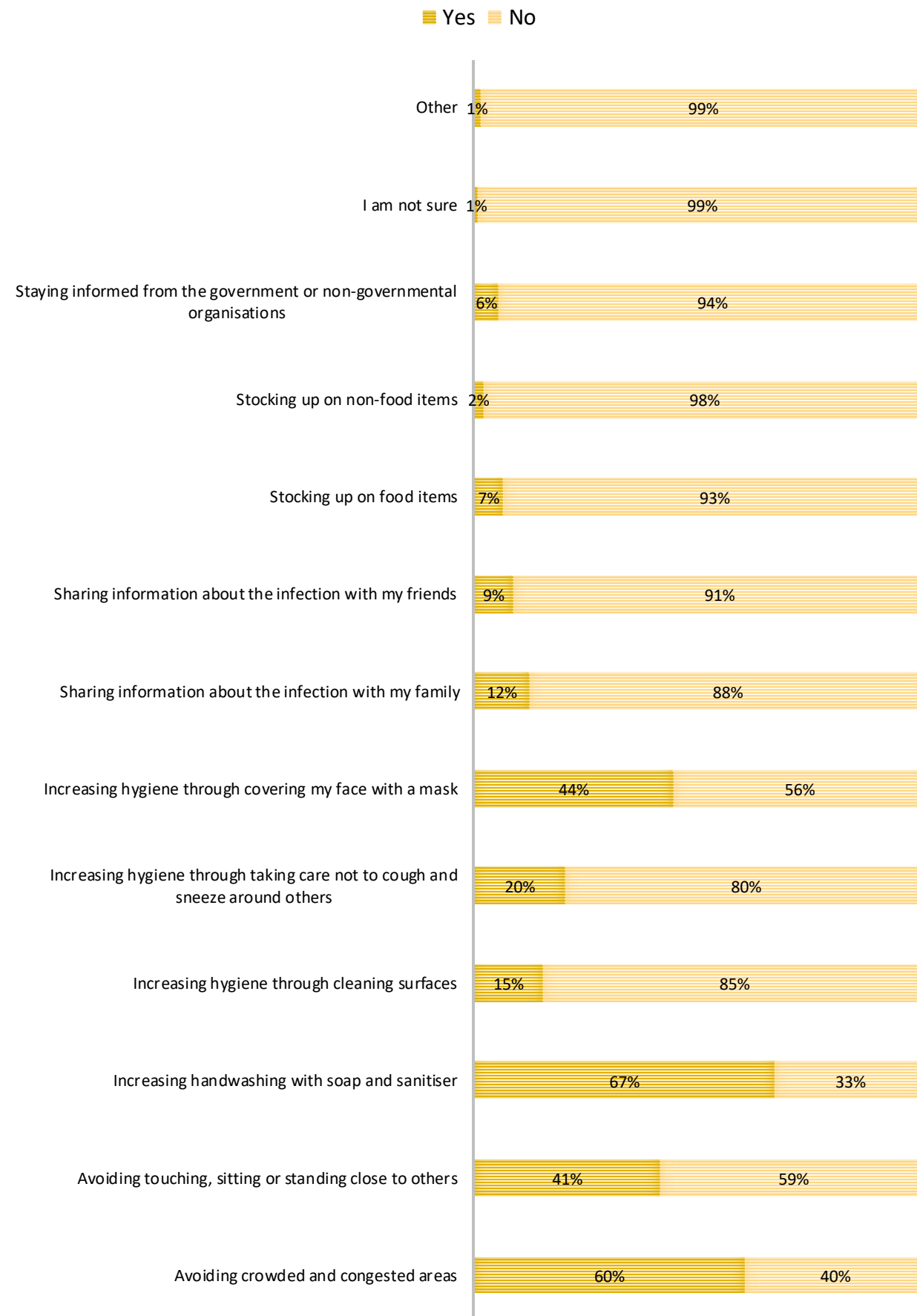
It is noted that next to no respondents report that they attempted to stock up on food [less than 10% of respondents] or non-food items [less than 5% of respondents]; this is consistent across contexts that have endured long lockdowns. This reflects that almost all of our respondents lack savings to stockpile - this is also substantiated later in the report, where respondents report hunger and starvation, as well as the consumption of seeds stocks and selling of domestic and productive assets as coping strategies.

METHODS OF PREVENTION AND PREPAREDNESS

■ Yes ■ No

Method	Yes	No
Other	1%	99%
I am not sure	1%	99%
Staying informed from the government or non-governmental organisations	6%	94%
Stocking up on non-food items	2%	98%
Stocking up on food items	7%	93%
Sharing information about the infection with my friends	9%	91%
Sharing information about the infection with my family	12%	88%
Increasing hygiene through covering my face with a mask	44%	56%
Increasing hygiene through taking care not to cough and sneeze around others	20%	80%
Increasing hygiene through cleaning surfaces	15%	85%
Increasing handwashing with soap and sanitiser	67%	33%
Avoiding touching, sitting or standing close to others	41%	59%
Avoiding crowded and congested areas	60%	40%

METHODS OF PREVENTION AND PREPAREDNESS

- ▇ Avoiding crowded and congested areas
- ▇ Avoiding touching, sitting or standing close to others
- ▇ Increasing handwashing with soap or sanitiser
- ▇ Increasing hygiene through covering face with mask

Country	Avoiding crowded and congested areas	Avoiding touching, sitting or standing close to others	Increasing handwashing with soap or sanitiser	Increasing hygiene through covering face with mask
Afghanistan	75%	44%	53%	37%
Bangladesh	40%	38%	34%	11%
Burundi	24%	34%	48%	6%
Cameroon	67%	31%	75%	68%
DR Congo	47%	36%	56%	25%
Kenya	69%	20%	80%	78%
Liberia	56%	18%	76%	42%
Mozambique	1%	54%	70%	72%
Nepal	89%	45%	71%	65%
Nigeria	80%	44%	71%	32%
Sierra Leone	67%	54%	83%	27%
Sri Lanka	92%	70%	80%	98%
Uganda	72%	50%	69%	14%
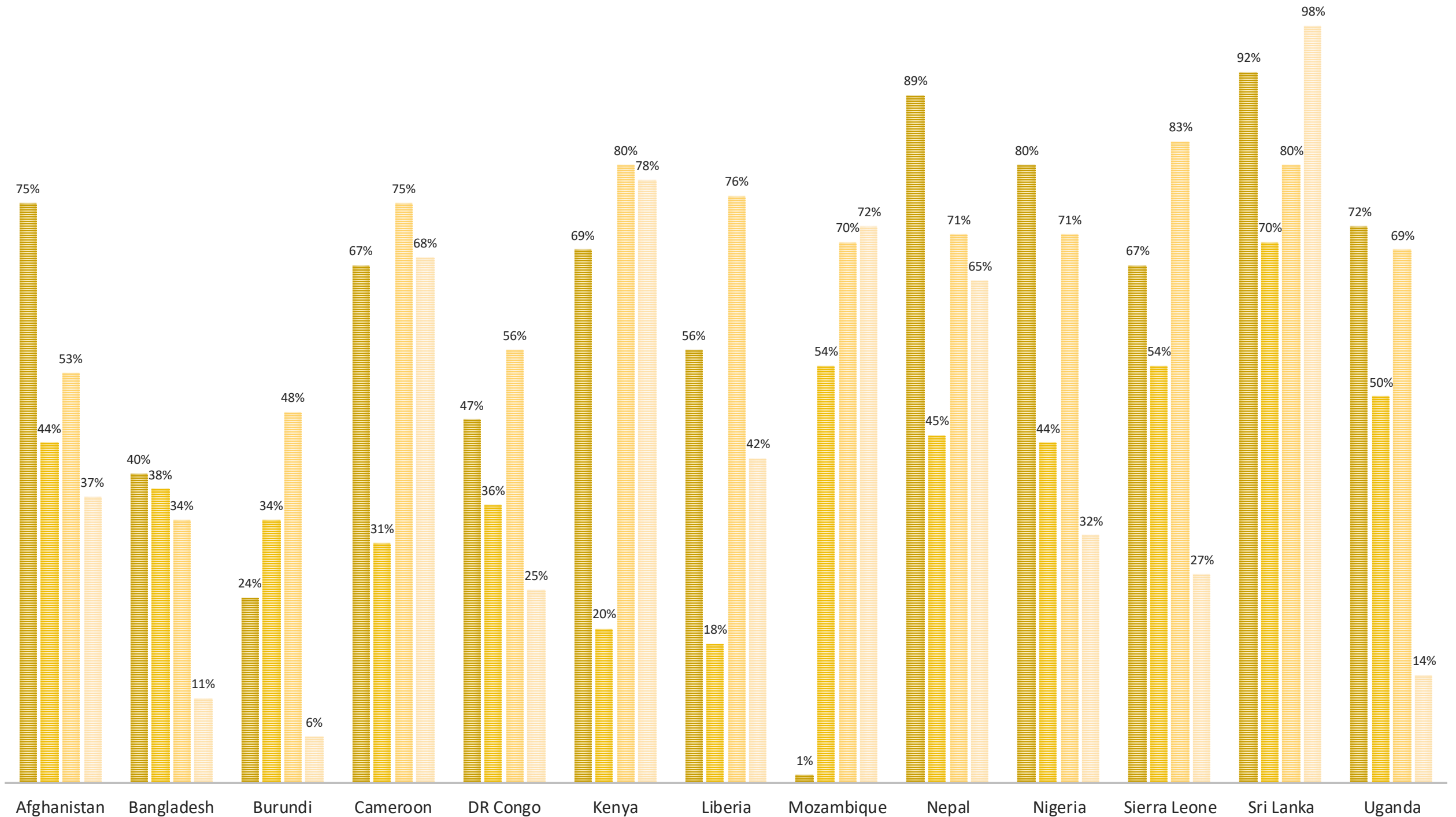
PROMOTING LEARNING

51% of our sample of 1300 respondents across South Asia and Sub Saharan Africa report that children do not have any access to learning at the time of the COVID-19 crisis; it is noted that this is a reflection of respondent perceptions and requires further interrogation to establish actual access to learning in the target areas.

Interrogation of the data suggests that the average of 51% masks dramatic differences in access to education across country contexts. For example, 75% of respondents in Kenya report that children can access alternative learning, whereas only 29% of respondents in Afghanistan and Sierra Leone report that children have access to education. In certain contexts, this reflects state capacities to offer alternative learning. For example in Kenya and Uganda, the state has substituted for school closures through the provision of remote radio lessons [although noting that these are not accessible to all children including for example, refugee children]. In other contexts, these efforts have been fragile or fragmented, with an increased reliance on non-state initiatives. For example, in Liberia and Sierra Leone, the state has outsourced the provision of remote radio lessons to a range of non-governmental organisations [noting that this has created access gaps]. In certain cases, it is critical to note that these results reflect a pre-crisis context rather than the consequences of school closures resulting from COVID-19. For example in Afghanistan and Nigeria, almost half of all school age children are already out of school due to conflict; it is possible that the intensified gap in access to learning reflects a reduction of both government education and non-governmental education initiatives as a result of lockdown.

MAPPING THE GAP IN ACCESS TO ALTERNATIVE LEARNING

■ No, children do not have access to alternative learning ■ Yes, children have access to alternative learning

50% 50%
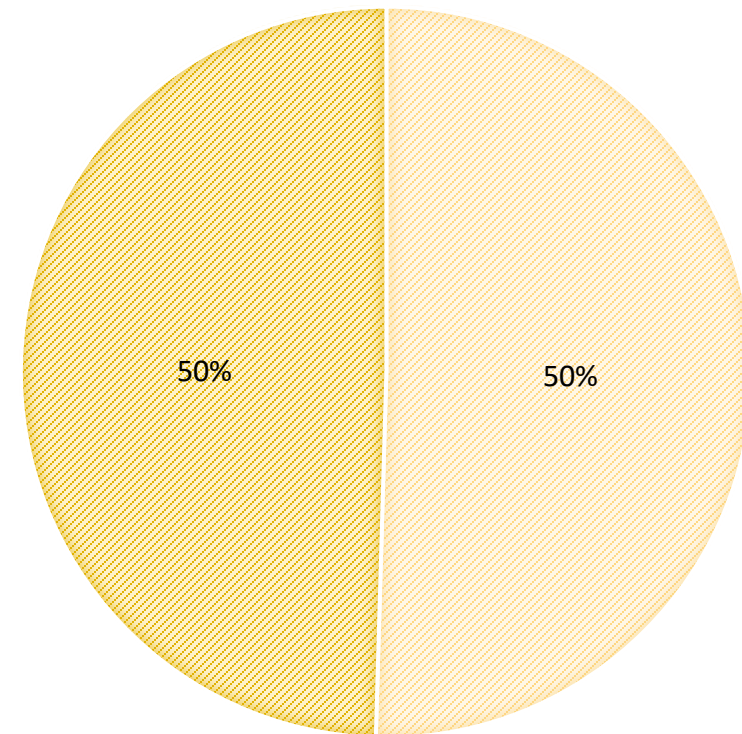
At the time of assessment, schools remained closed in 12 of the 13 countries
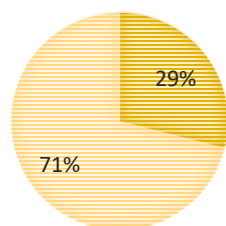
AFGHANISTAN	BANGLADESH	CAMEROON	DR CONGO	KENYA	LIBERIA
29% / 71%	23% / 77%	40% / 60%	37% / 63%	28% / 72%	49% / 51%
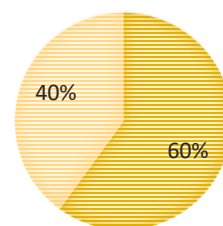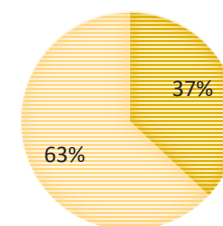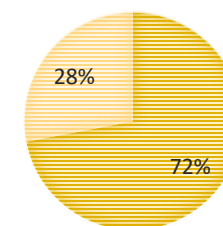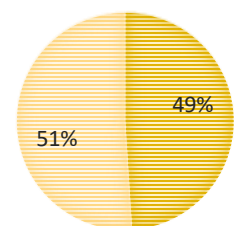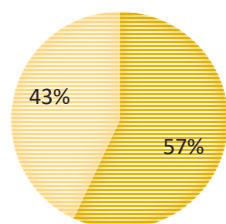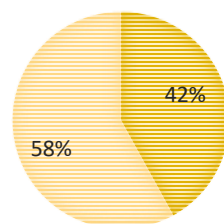
MOZAMBIQUE	NEPAL	NIGERIA	SIERRA LEONE	SRI LANKA	UGANDA
43% / 57%	42% / 58%	34% / 66%	29% / 71%	7% / 93%	43% / 57%
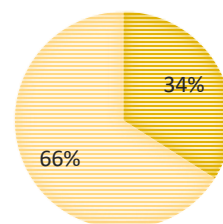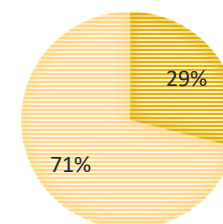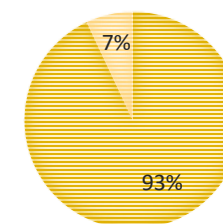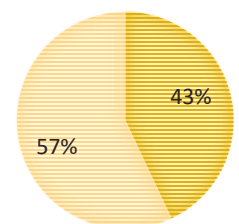
PROMOTING LEARNING

The results of the rapid assessment illustrate that almost all children are out of school and 50.5% of children do not have access to any alternative learning at all. Of the 49.5% of children reported to have access to learning -

- 15% of respondents report that children are using digital learning tools, using the internet and mobile internet;
- 11% of respondents report that children are using mobile learning tools that do not require an internet connection; and
- 46% of respondents report that children are learning through radio and television, with ~23% in each case.
- 18% of respondents report that children are self learning, using textbooks and workbooks.

It is noted that 6% of respondents reported that children are learning in school, all in East Africa. It is possible that these results reflect the fact that schools remain open in Burundi. As the rapid assessment relied on respondent reporting, it did not attempt to differentiate access across categories of children. However, it is noted that the results mask dramatic disparities in access across gender, geographies and groups of children including, for example, children with disabilities. Further research is recommended to understand rates of access to alternative learning, as well as the adapted types of alternative learning available in these instances.

There are notable variations in access to alternative learning across regions. For example, there is a higher rate of prevalence of digital learning tools across South Asia with 49% of respondents reporting that children are using digital learning tools. It appears that this reflects a higher rate of mobile internet penetra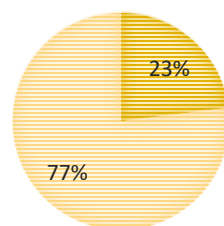tion in this region: however analysis suggests large variations across the region, with less than 10% of respondents in Afghanistan and Bangladesh and over 87% of respondents in Sri Lanka reporting access to digital learning. 16% of respondents in West Africa report that children are using mobile learning tools - including short messaging services [SMS] - compared to 8% of respondents in East Africa and 6% of respondents in South Asia.

The major portion of respondents in East and West Africa report that children are learning through radio and television: 54% of respondents in East Africa and 37% of respondents in West Africa. In both cases, radio is reported to be more prevalent than television. It is noted that in the cases of government provision, one form of alternative learning tended to be reported at much higher rates: for example, television in Cameroon [42%], Kenya [60%] and Nepal [29%] and radio in Liberia [28%] and Sierra Leone [19%]. In other cases, for example in the Democratic Republic of Congo, there tends to be a larger spread of responses, suggested more fragmentation in provision or regional variations.

28% of respondents in South Asia report that children are self-learning; in some cases comments suggest that children are supported to self-learning with assistance from siblings. This is compared to 14% of respondents in East Africa and 13% of respondents in West Africa.

PROVISION OF LEARNING

▤ In School ▤ Internet and Online Learning ▤ Phone [Mobile Internet] ▤ Phone [SMS] ▤ Radio ▤ Television ▤ Textbooks and Workbooks
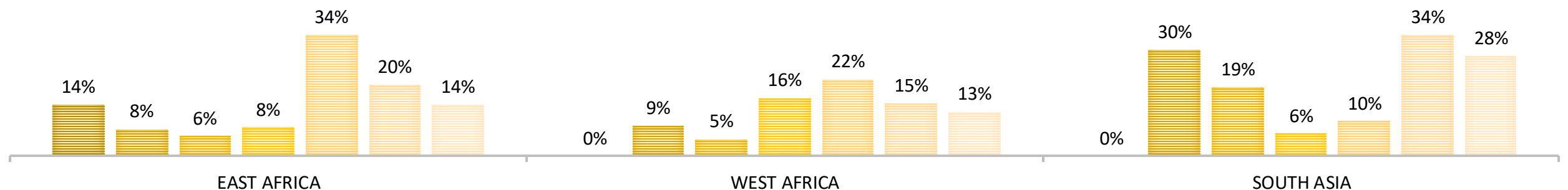
PROMOTING LEARNING

Of the 49.5% of children reported to have access to learning -

- 28% of respondents report that the government is providing access to alternative learning;
- 17% of respondents report that non-governmental organisations are providing access to alternative learning; and
- 17% of respondents report that children are learning from community groups;
- 22% of respondents report that children are learning from caregivers or parents;
- 10% of respondents report that children are learning from religious leaders.

It is difficult to discern patterns in provision across regions and countries, with respondents reporting a range of providers.

In certain cases, responses reflect limitations on governmental and non-governmental learning provision due to lockdown. In Bangladesh, for example, the Refugee Relief and Repatriation Commissioner (RRRC) has issued a suspension of all education activities in camps. As a result, there appears to be an increased reliance on communities inside camps to provide learning. It is noted that a number of respondents appear to have reported on the pre-crisis context rather than on access to education in the time of COVID-19. For example in Bangladesh, 23% of respondents report that the government and non-governmental organisations are providing learning, despite the halting of all education activities.

In other cases, responses reflect a high reliance on non-governmental organisations. In Nigeria, for example, 23% of respondents report that non-governmental organisations are providing access to alternative learning in North East Nigeria, where there is a high proportion of non-governmental provision to supplement government provision in conflict-affected areas.

LEARNING PROVIDERS

■ EAST AFRICA   ■ WEST AFRICA   ☐ SOUTH ASIA
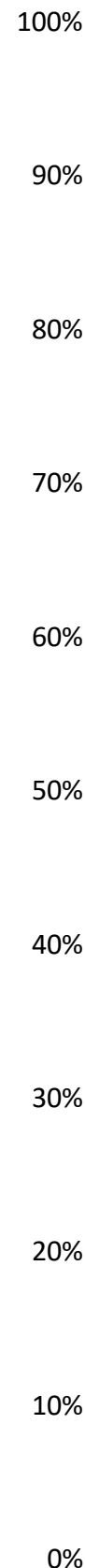
Overall, respondents report low levels of learning provision.

BANGLADESH

NIGERIA
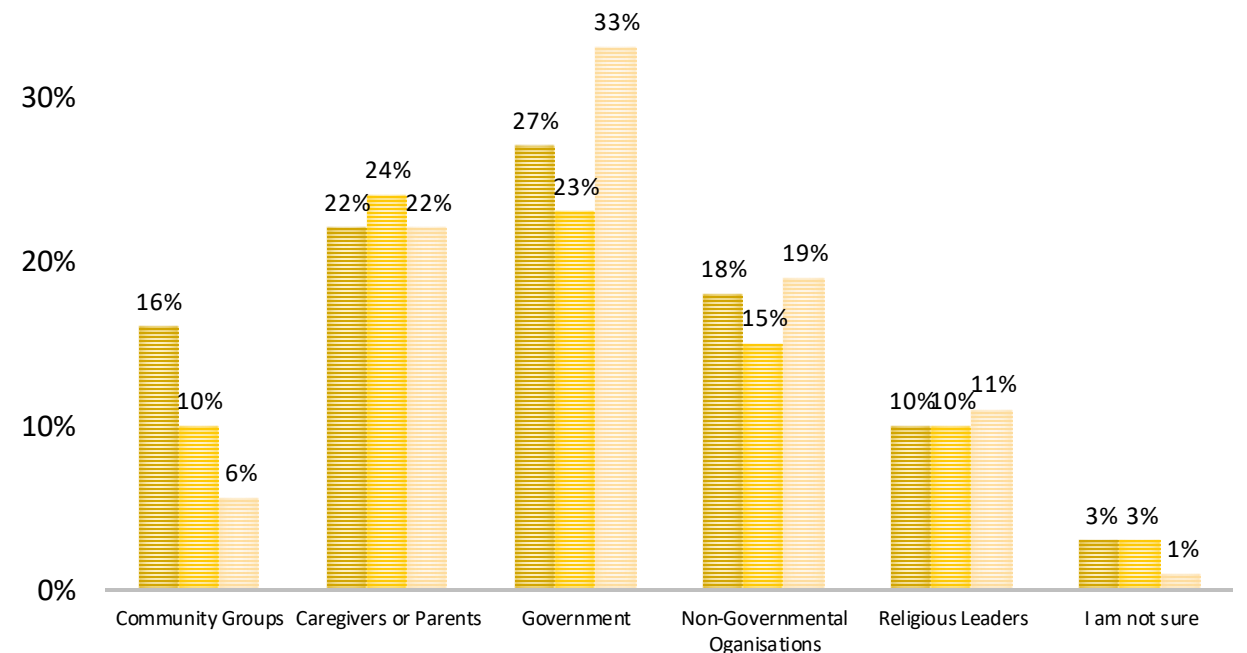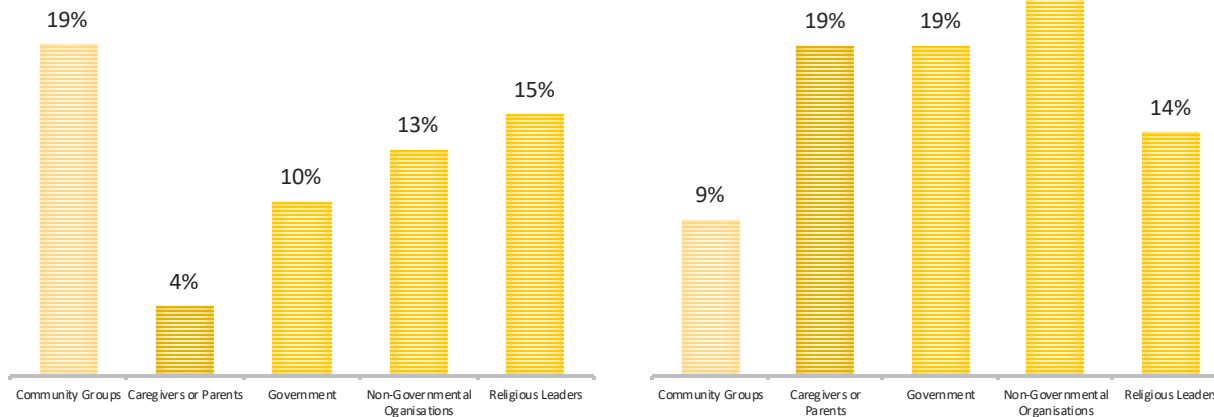
PROTECTION

61% of respondents identified the aged as a population at the highest risk of harm in the COVID-19 pandemic, suggesting a strong understanding of the disproportionate rates of infection amongst aged populations. 27% of respondents identified an increase in risks for those suffering from illness and 15% identified particular risks for people with disabilities. This could either relate to those affected in the current pandemic, or to those with co-morbidities; the latter reflects an understanding of how co-morbidities can compound the risks of contracting COVID-19.

26% of respondents recognised that children and adolescents are at risk of harm; this could correspond with the closure of schools, with responses in other categories noting the consequent lack of learning opportunities as an important issue. A smaller percentage of respondents noted particular gender-related risks for both boys and girls.

28% of respondents reported that the extreme poor are at high risk of harm, recognising the effects of lockdown, lack of access to markets and loss of livelihoods on populations who have limited savings or stocks. In Sierra Leone, where respondents demonstrated a clear and consistent understanding of the effects of the Ebola epidemic on the extreme poor, 50% of respondents noted that poor populations are at risk as they are unable to afford soap and sanitation supplies required for prevention and preparedness.

Respondents noted the range of risk exposure across rural and urban areas; 6% of respondents suggested that people in rural areas are at risk, perhaps due to a lack of information, services or supplies and 12.5% of respondents suggested that people in urban areas are at risk. In Cameroon, for example, this corresponds to the perception of crowding and congestion in urban centres that creates challenges for social distancing. In Afghanistan, for example, this also corresponds to the high rate of returns from Iran to Afghanistan, with returnees concentrated in urban areas. Returnees are suspected to be carriers of the infection, and face challenges in observing sanitation and social distancing in returnee camps. 8% of respondents identified responders including the police and public health officials as experiencing increased risk of exposure, while 8% of respondents identified that everyone was at risk of harm due to the multi-dimensional impacts of the pandemic.

It is important to note that these categories are not necessarily distinct; whilst the enumerators were offered a range of options to allow for verbatim recording or responses, it is possible that the categories of ethnic groups, linguistic groups and religious groups are less reflected in the results as they tend to correspond to poor or displaced/refugee/returnee populations. In certain instances, it appears that the administration of this question was affected by a lack of understanding of the intent of the question and the humanitarian terminologies associated with it. For example, in Mozambique, feedback from partners suggests that there is a low level of understanding of protection and thus, the responses reflect protection risks that are a direct result of the pandemic – including infection and illness – and do not incorporate risks resulting from restrictive measures associated with the pandemic.

AFGHANISTAN
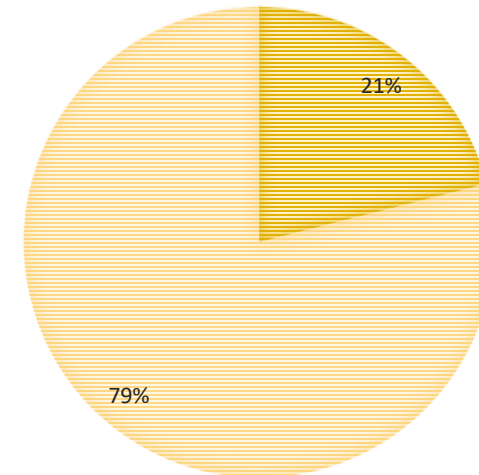
21% of respondents in Afghanistan recognised the risks of harm for displaced, refugee and returnee populations. This corresponds to the high rate of returns from Iran into Afghanistan, where returnees are suspected to be carriers of the infection, and susceptible to exploitation upon return. This coincides with the recognition of risk in urban areas with a high concentration of returnees.

CAMEROON
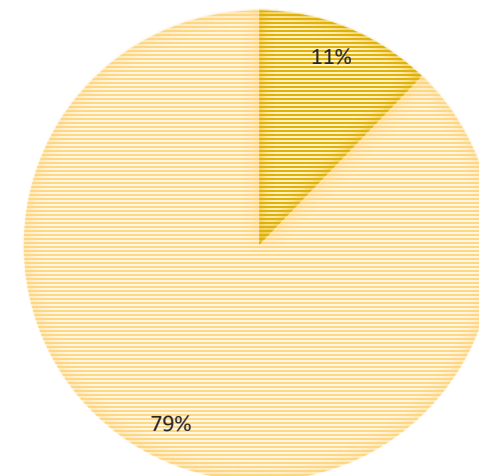
11% of respondents in Cameroon recognised the risks of harm for people in urban areas. This corresponds to crowding and congestion in urban centres that create challenges for sanitation and social distancing. The major portion of all confirmed cases of COVID-19 in Cameroon are in urban centres, adding to the perception of heightened risk.

SIERRA LEONE
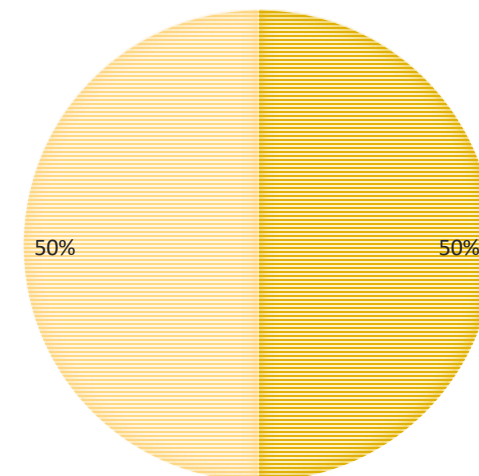
50% of respondents in Sierra Leone recognised the risks of harm for extreme poor populations. Respondents in Liberia and Sierra Leone appeared to have a clear understanding of both the health and humanitarian impacts of the pandemic – perhaps as a result of their experience of the Ebola epidemic. Respondents linked loss of livelihoods to the risk of exposure to exploitation.

RESPONDENT PERCEPTIONS OF POPULATIONS AT RISK

Category	Percentage
Aged	61%
Children and Adolescents	28%
Girls	7%
Boys	9%
Extreme Poor	29%
Everyone	8%
People with Disabilities	15%
People who suffer from Illness	25%
People in rural areas	8%
People in urban areas	10%
Displaced/Refugee/Returnee Populations	9%
Ethnic Group	1%
Linguistic Group	0%
Religious Group	1%
Responders	6%
I am not sure	5%
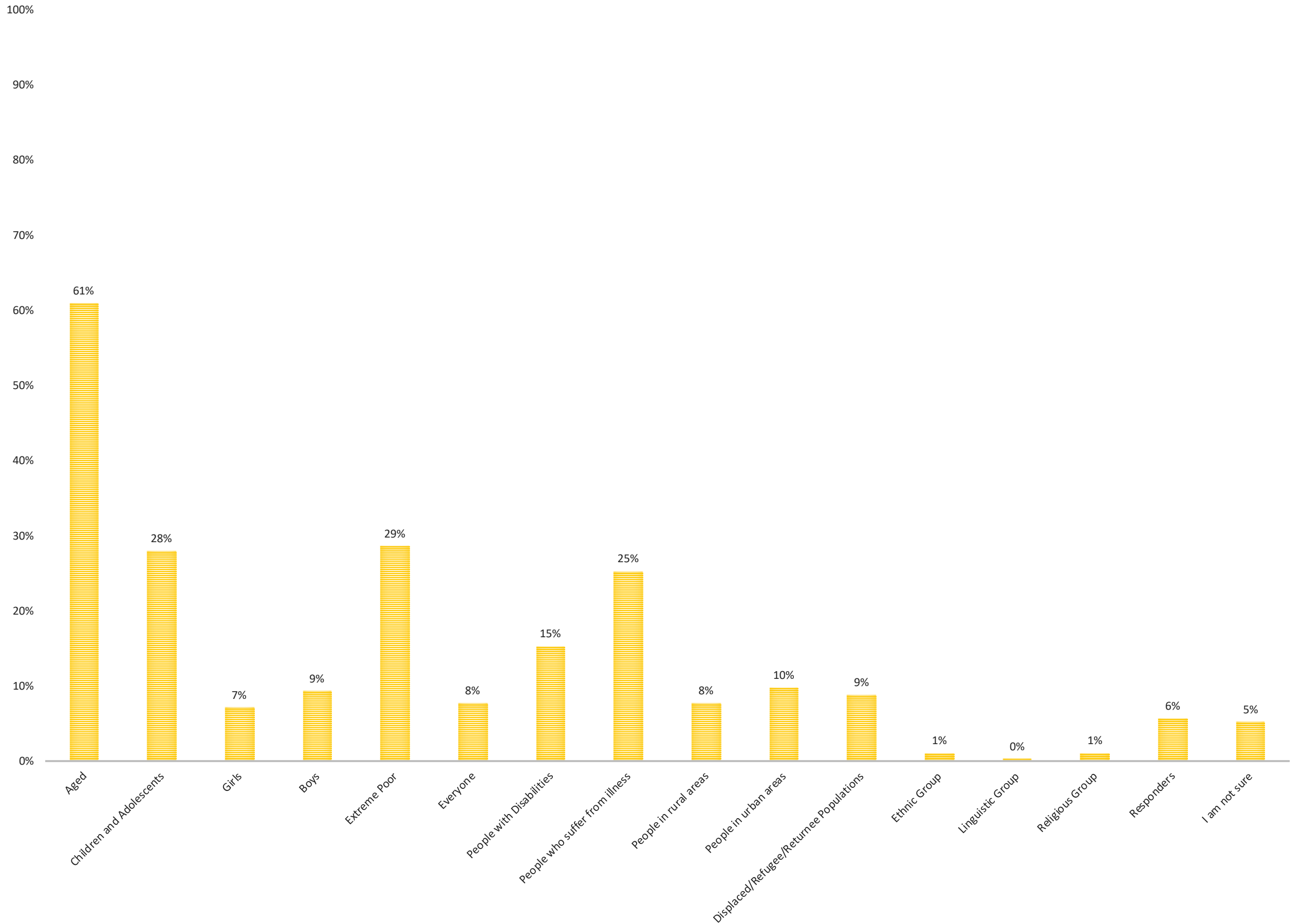
PROTECTION

56% of respondents reported the risk of hunger and starvation as a significant issue; this was a consistent theme across gender, geographies and other categories or respondents. There a range of factors associated with this response, including loss of income, loss of livelihoods and lives resulting from lockdown and lack of access to markets.

83% of respondents in Bangladesh report risks of abuse or aggression from armed groups, and 30% report risk of abuse or aggression from government authorities, suggesting that the perceived risk of persecution remains high amongst Rohingya refugee populations. Between 20 and 35% of respondents in Kenya, Liberia and Uganda also report risk of abuse or aggression from armed groups; in certain contexts, this is thought to be attributable to the presence of armed forces enforcing lockdown.

Respondents across Afghanistan, Bangladesh and Nepal report particular risk of exploitation through forced labour and forced marriage. These elements are echoed in reports from the Democratic Republic of Congo, where almost 20% of respondents report forced marriage as a particular risk resulting from the pandemic, corresponding to the recognition that children and adolescents are exposed to increased risk of harm. It is interesting to note that there is a higher rate of recognition of this risk amongst 23% and 42% of respondents in the Territories of Kabare and Kalehe; however only 0% and 5% of respondents in Marungu and Minembwe on the High Plateau reported this as a risk despite 61% of girls being married under the age of 18 in this area [SC 2018]. It is possible that the normalisation of this practice informs perceptions of risks.

Respondents across Liberia and Sierra Leone report particular risk of teenage pregnancy, with 28% of respondents in Sierra Leone stating this as a concern. Teenage pregnancy rates in both countries increased as a result of the Ebola epidemic, believed to be both as a result of increased risk related to school closures, and an increased reliance on transactional sex as a negative coping mechanism to compensate for loss of household income. Perhaps drawing on this experience, respondents explicitly related teenage pregnancy to an increase in transactional sex, where transactional sex is seen as a strategy to cope with the loss of income or livelihoods.

26% of respondents report risk of discrimination in access to information or relief. This is acute in areas where inter-communal conflict is persistent or protracted. 73% of respondents in Sri Lanka report risk of discrimination, suggesting that the provision of information and relief is perceived to be partial. In almost all cases, this was reported by respondents in the Eastern and Northern provinces affected in the civil conflict. 34% of respondents in Cameroon and 32% of respondents in Kenya note stigmatisation as a particular risk. In Kenya, this relates to the mandate to quarantine those who test positive; as people are apprehensive about contracting the infection through contact with those infected, this results in the stigmatisation of anyone returning from affected areas. For example, travellers returning from Nairobi to rural areas are discriminated against, as Nairobi is seen as a hotspot for transmission.

BANGLADESH
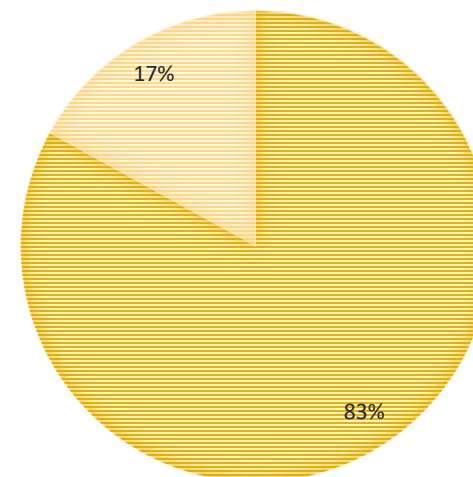
83% of respondents reported risk of abuse of violence from armed groups in Bangladesh. A recent intensification in abductions and deaths attributed to the Arakan Rohingya Salvation Army [ARSA] is a possible factor for these responses; it is possible that a reduced humanitarian presence has increased opportunities for armed groups to operate.

DEMOCRATIC REPUBLIC OF CONGO
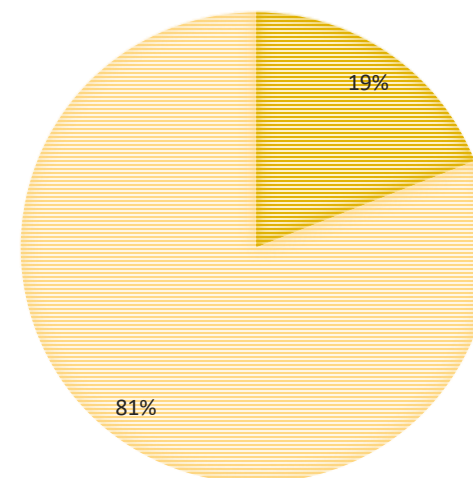
Almost 20% of respondents reported an increase in the risk of forced marriage in the Democratic Republic of Congo; this corresponds to the 23% of respondents who recognise children and adolescents as one of the categories at highest risk of harm due to the pandemic. A smaller number of respondents noted this as a risk in areas where over 61% of girls experience early marriage.

SRI LANKA
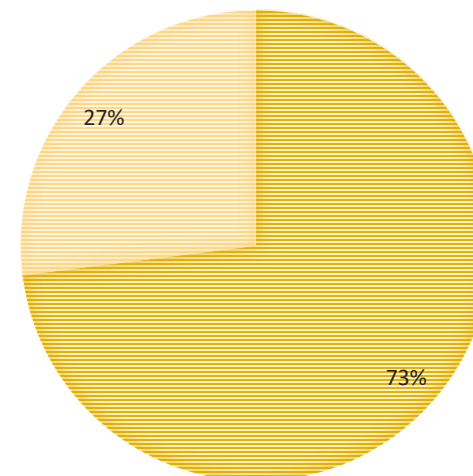
73% of respondents reported risk of discrimination in access to information and relief in Sri Lanka. In almost all cases, this was reported in the Eastern and Northern provinces, where the Tamil communities are concentrated. This corresponds to reports during regular flooding, where Tamil communities are cut off from access to relief due to the persistent impact of the civil conflict.

RESPONDENT PERCEPTIONS OF RISKS

Category	Value
Abuse or violence from armed groups	21%
Abuse or violence from government authorities	14%
Discrimination in access to information or relief	26%
Forced labour	11%
Forced marriage	7%
Forced recruitment into armed groups	3%
Hunger or starvation	56%
Infection or severe illness	24%
Lack of opportunities for learning or recreation	21%
Stigmatisation	13%
Sexual abuse or violence	6%
Teenage pregnancies	6%
Trafficking	3%
I am not sure	11%

PROTECTION

Respondents reported an overall low level of provision of protection services. 38% of all respondents report the availability of counselling services, and 16% of respondents report the availability of case management services. 24% of respondents report the availability of social workers. It is not clear whether these services are set up to respond to the protection risks related to the COVID-19 pandemic, or whether and how often respondents have accessed these services.

28% of all respondents reported on hotlines or toll-free numbers; in many cases, these correspond to government initiatives for information sharing at scale. It almost all cases, these are centred on the provision of prevention and preparedness information, with only a couple of instances where these numbers offer referrals to psychosocial support or other protection services. In certain contexts, it is noted that these services are concentrated in urban areas, with little to no service provision in rural or remote areas; for example, in Sierra Leone, it was noted that 8.6% of respondents reported availability of child friendly spaces; 7.24% reported availability of institutional care, and 2.5% reported availability of safe spaces; however, analysis suggests that these respondents are reporting on urban areas alone.

The appears to be a lack of awareness of any provision of protection services across East Africa, with 57% of respondents unsure about the availability of such services.
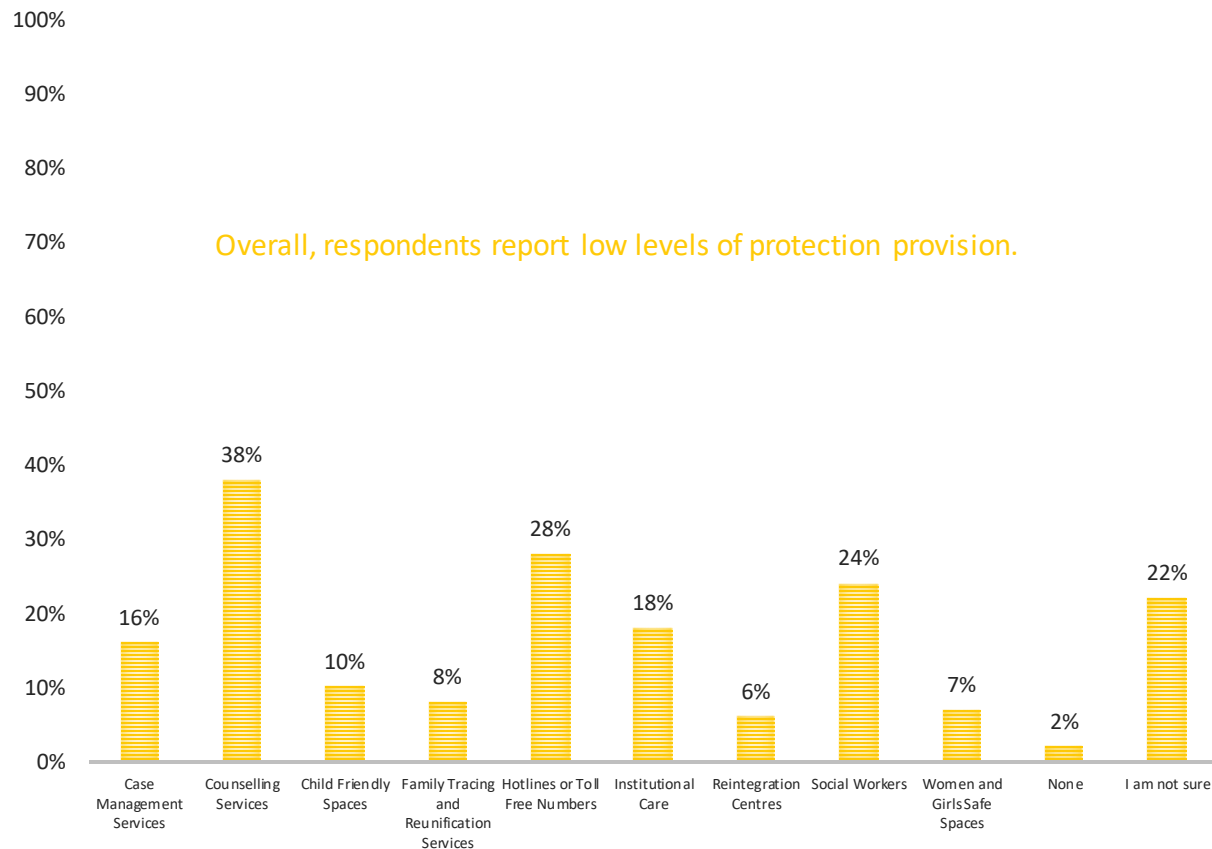
PROVISION OF PROTECTION SERVICES IN EAST AFRICA

Category	%
I am not sure	57%
None	5%
Women and Girls Safe Spaces	2%
Social Workers	18%
Reintegration Centres	4%
Institutional Care	19%
Hotlines or Toll Free Numbers	18%
Family Tracing and Reunification Services	5%
Child Friendly Spaces	4%
Counselling Services	27%
Case Management Services	17%

PROVISION OF PROTECTION SERVICES

Overall, respondents report low levels of protection provision.

Category	%
Case Management Services	16%
Counselling Services	38%
Child Friendly Spaces	10%
Family Tracing and Reunification Services	8%
Hotlines or Toll Free Numbers	28%
Institutional Care	18%
Reintegration Centres	6%
Social Workers	24%
Women and Girls Safe Spaces	7%
None	2%
I am not sure	22%

PROVISION OF PROTECTION SERVICES IN WEST AFRICA

Category	%
I am not sure	16%
None	0%
Women and Girls Safe Spaces	3%
Social Workers	25%
Reintegration Centres	5%
Institutional Care	18%
Hotlines or Toll Free Numbers	34%
Family Tracing and Reunification Services	4%
Child Friendly Spaces	12%
Counselling Services	40%
Case Management Services	17%
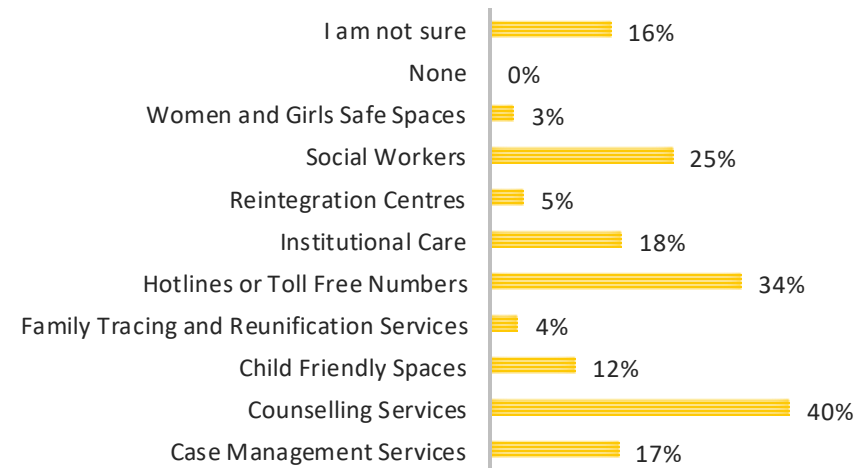
PROVISION OF PROTECTION SERVICES IN SOUTH ASIA

Category	%
I am not sure	18%
None	3%
Women and Girls Safe Spaces	15%
Social Workers	30%
Reintegration Centres	9%
Institutional Care	19%
Hotlines or Toll Free Numbers	34%
Family Tracing and Reunification Services	18%
Child Friendly Spaces	17%
Counselling Services	48%
Case Management Services	13%
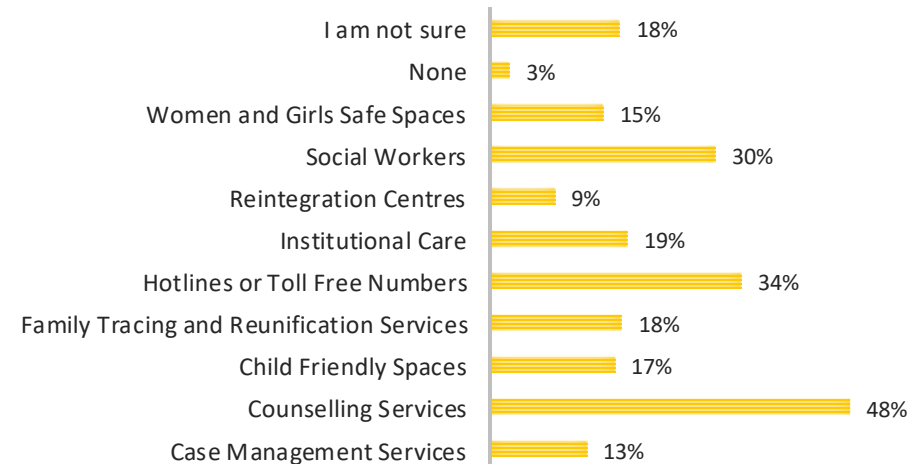
CHALLENGES

54% of all respondents identified an increase in the cost of food, fuel and transport as the most significant issue faced due to border closures, slowing or suspension of commerce and other contextual factors including, for example, recent flooding in eastern Democratic Republic of Congo and intensified conflict in Cabo Delgado in Mozambique. The close correlation between increased costs and containment measures is noted including, for example, government directives to control crowding on transportation that have resulted in a significant increase in transport fares – of up to thrice the original amount - in Kenya and Sierra Leone.

A number of respondents reported specific issues related to the importance of prevention and preparedness, with **25% stating increased health and hygiene expenses, 14% stating insufficient or unsafe sources of water, and 19% stating insufficient soap or sanitation supplies**. These issues substantiate the observed gap between awareness and action, suggesting that in some cases, respondents lack the infrastructure and supplies to adopt prevention or preparedness actions. 14% of all respondents reported insufficient or unsafe sources of water. At country level the highest proportion of respondents reporting a lack of access to safe water was Afghanistan.

36% of respondents report a loss of income and 18% of respondents report a loss of livelihoods, suggesting an increasing gap between costs and coping capacities and substantiated by reports of increased risk of hunger and starvation.

In certain countries, this increases risk of adoption of adverse coping strategies including, for example, the risk of relapse into debt bondage for marginalised groups in Nepal. An increased risk of forced marriage is also noted in Afghanistan and the Democratic Republic of Congo. 61% of respondents in Bangladesh and 42% of respondents in Kenya report fear of increased aggression from government authorities. In Bangladesh, this is substantiated through reports of increasing restrictions on refugees and a shrinking space for humanitarian services.

9% of all respondents reported increased aggression from armed groups. The country with the highest rate of reported aggression from armed groups was Bangladesh with 25% of respondents reporting this as an issue. A gendered analysis reveals that a higher proportion of males identified armed groups as an issue [35% of males compared to 13% of females]. In studies of protection risks faced by Rohingya refugees, males – particularly young men and adolescents – frequently report forcible recruitment to armed groups operating in the camps as a prominent risk.

16% of all respondents report an increase in psychosocial stress and trauma, with regional variances. In Burundi for example, this is noted as a rural phenomenon with only 10% of respondents in urban areas noting psychosocial issues compared to 55% and 69% in rural areas; perhaps explained by an increase in fear and uncertainties linked to a lack of information, misinformation or rumours related to the pandemic.

Chart 1: Cameroon 38%, DR Congo 36%, Liberia 42%, Mozambique 28%, Nigeria 34%
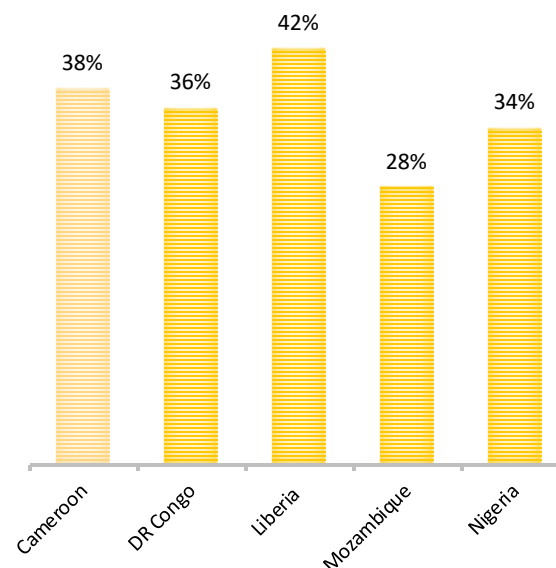
INCREASED HEALTH AND HYGIENE EXPENSES

An increase in health and hygiene expenses was observed across Africa, indicating shortages in health and hygiene services or supplies that are leading to an inflation in costs. This is especially acute in Liberia, with 42% of respondents reporting an increase in health and hygiene expenses as one of the top three issues faced due to the pandemic.

Chart 2: Afghanistan 45%, Bangladesh 28%, Kenya 19%, Nigeria 25%, Sierra Leone 20%
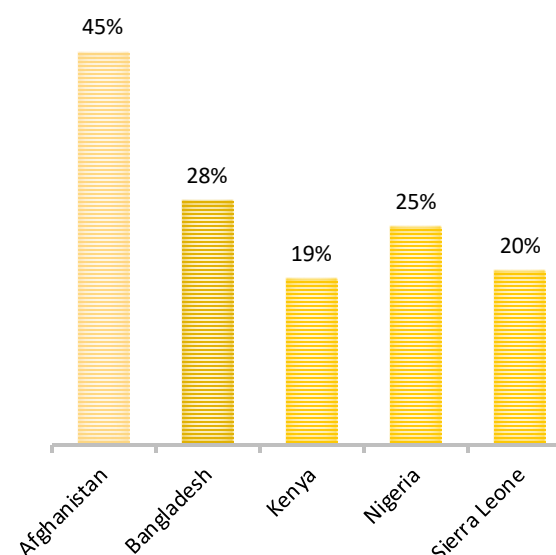
INSUFFICIENT OR UNSAFE SOURCES OF WATER

A lack of access to safe and sufficient sources of water was observed as an issue across Africa and Asia and was of particular relevance in conflict and crisis-affected communities. This is especially acute in Afghanistan, with 45% of all respondents reporting that the lack of safe, sufficient sources of water affects all aspects of their lives – including handwashing and hygiene.

Chart 3: Afghanistan 46%, Cameroon 28%, Kenya 27%, Nepal 21%, Uganda 22%
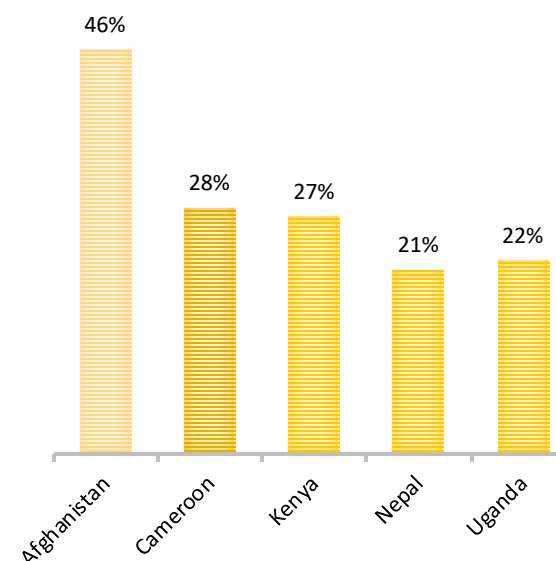
INSUFFICIENT SOAP OR SANITATION SUPPLIES

A lack of sufficient soap and sanitation supplies was observed as an issue in almost all contexts, with regional disparities corresponding to rural and remote areas, and conflict affected contexts facing shortages of supplies. In Afghanistan, this couples with the lack of safe and sufficient sources of water to create severe constraints on prevention and preparedness.

RESPONDENT PERCEPTIONS OF CHALLENGES

Bar chart showing respondent perceptions of challenges:

- Increased aggression from government authorities: 17%
- Increased aggression from armed groups: 9%
- Increased food, fuel or transport prices: 54%
- Increased health and hygiene expenses: 25%
- Increase in household responsbilities: 28%
- Insufficient or unsafe sources of water: 14%
- Insufficient soap or sanitation supplies: 19%
- Lack of access to markets for essential items: 29%
- Loss of income in household: 36%
- Loss of livelihoods in household: 18%
- Loss of lives in household: 6%
- Psychosocial stress or trauma: 16%
- I am not sure: 2%

COPING STRATEGIES

74% of all respondents reported borrowing cash or food from friends and relatives to cope with increased costs and shortage of supplies and services. Peer networks are recognised as a common coping mechanism, of particular relevance where restrictions on movement limit access to markets. In Bangladesh, for example, where refugees are dependent on aid arriving into camps, movement restrictions as a resultant shortage of aid has increased reliance no communal assistance. In Liberia and Sierra Leone, a culture of communal living is noted as underscoring such strategies.

56% of respondents reported restricting the amount or number of meals in the household and 18% reported restricting other expenses. It is interesting to note that restricting food is one of the most common strategies identified across 75% of respondents in West Africa, compared to 48% in East Africa and South Asia. It it often the case that adults restrict the amount and number of meals to ensure food for children. A potential explanation is the extreme poverty in parts of Liberia and Sierra Leone surveyed, where there are limited possibilities for borrowing from friends or relatives; respondents in Sierra Leone noted that a preference for stretching resources as far as feasible before resorting to other strategies.

In certain cases, there are gendered differences in the choice of coping strategies. In Bangladesh, for example, male respondents reported an increased likelihood of borrowing from friends or relatives [65% of male respondents compared to 43% of female respondents] whereas female respondents reported an increased likelihood of restricting the amount and number of meals [43% of female respondents compared to 33% of male respondents] and reducing expenses to be able to purchase soap and sanitation supplies [32% of female respondents compared to 14% of male respondents].

17% of respondents reported consuming seed stocks held for the following season; 12% reported selling domestic assets and 6% reported selling productive assets. The former is more observable in rural areas, and the latter in urban areas. Almost all the coping strategies reported indicate a depletion of resources which will continue to affect communities in the long term; for example, an analysis of responses in Nigeria notes the potential challenges for crop planting in the next season.

15% of respondents reported seeking alternative or additional employment. Sri Lanka reported the highest of respondents seeking alternative or additional employment, with 34% of respondents reporting such coping strategies. Since the onset of the COVID-19 pandemic Sri Lanka had been under lockdown enforced by a strict curfew [22 000 curfew violators were arrested in less than a month] in place at the time of data collection. Unable to engage in regular commerce, many Sri Lankans resorted to alternative forms of livelihood such as home gardening to help meet food security needs at household level.

Contextual analyses suggest an increase in the adoption of these strategies over time, as the economic effects of the pandemic become more pronounced.

Coping Strategy	Percentage
I am not sure	14%
Relocating or returning to rural areas	7%
Selling productive assets	6%
Selling domestic assets	12%
Seeking alternative or additional employment	15%
Restricting expenses	18%
Restricting food	56%
Consuing seed stocks held for next season	17%
Borrowing or receiving food from friends or relatives	35%
Borrowing or receiving cash from friends or relatives	39%

PROVISION OF ASSISTANCE

The rapid assessment reflects a low level of assistance provision across almost all country contexts; this is substantiated by reports of movement restrictions affecting the flow of services and supplies to affected areas.

16% of respondents report receiving health assistance and 17% of respondents report receiving hygiene assistance; this is substantiated with evidence of governments and non-governmental organisations arranging provision of soap, sanitiser, masks and other materials to prevent and protect against infection.

14% of respondents report receiving cash assistance, and 23% of respondents report receiving food assistance reflecting that these are identified as the most immediate needs to avoid hunger and starvation. 52% of respondents in Kenya and 51% of respondents in Nepal reported receiving food assistance. In Nepal, it is noted that there are large variances in access to food assistance across the provinces. This is also the case in Uganda, where 59% of respondents reported food assistance in urban areas as a result of government provision whereas only 2-6% of respondents in rural areas reported receiving food assistance.

It is noted that in areas affected by conflict or crisis, current humanitarian actors have pivoted to provide assistance for prevention and preparedness in the pandemic: in Cameroon, for example, psychosocial support was reported in the North West and South West but not in Littoral and the West. In Uganda, 20% of respondents in refugee settlements reported receiving rations from the United Nations High Commissioner for Refugees [UNHCR]. It is also noted that the rapid assessment requests respondents to refer to recent assistance only; however in some cases, it is possible that respondents referenced assistance received prior to the pandemic. In Bangladesh, for example, 40% of respondents report education assistance; however, education activities have been suspended to avoid crowding or congestion in classrooms during to the pandemic.

Overall, the level of assistance received is minimal compared to the level of risk recognised by respondents; it is also essential to note that in many instances, respondents reported one-time assistance that is since exhausted. 22% of respondents report receiving no assistance at all to date, with a further 22% unsure about any assistance, suggesting that almost half of all respondents have not received any meaningful assistance. This is especially acute in East Africa, where 67% of respondents in Burundi, 64% of respondents in the Democratic Republic of Congo and 92% of respondents in Mozambique reported receiving no assistance at all. A low level of assistance is noted across all the country contexts surveyed in West Africa.

It is noted that the nature of these questions can often affect the response; it is observed that respondents tended to report that they have received no relief in order to encourage the perception that they require relief and ensure provision. It is possible that this was more pronounced during door-to-door administration of the assessment, where partners often presented with organisational logos visible.

PROVISION OF ASSISTANCE IN EAST AFRICA

PROVISION OF ASSISTANCE IN WEST AFRICA

PROVISION OF ASSISTANCE IN SOUTH ASIA

RESPONDENT PERCEPTIONS OF PROVISION OF ASSISTANCE

Overall, the level of assistance received is minimal compared to the level of risk recognised by respondents, in many instances, respondents reported one-time assistance.

Category	Percentage
Cash	14%
Caregiving	12%
Education	12%
Employment	5%
Food	23%
Health	16%
Hygiene	17%
Livelihoods	6%
Protection	6%
Psychosocial Support	10%
None	22%
I am not sure	22%

RECOMMENDATIONS

These recommendations respond to the patterns and trends arising from the rapid assessment. in all instances, it is proposed that these strategies are planned and implemented with strong, sustained involvement from local level actors to ensure effective, efficient response and impact.

- **Map and ensure targeted, tailored assistance to address social and economic vulnerabilities in the COVID-19 context**

  Mapping who is the most marginalised and most vulnerable in the COVID-19 crisis is critical to consider how the complex circumstances complex change and/or interact with chronic vulnerabilities. For example, populations that have lost livelihoods and lives as a direct result of the pandemic might have lower levels of resilience than those who live at subsistence levels and have intrinsic strategies to cope with the consequences of the crisis. Populations already receiving assistance, such as refugees, might have greater access to resources to cushion them in the crisis that those without established channels of assistance. It is essential that the extreme poor are prioritised; in particular, in contexts where there are insufficient social safety nets. It is equally essential that most marginalised groups, including those marginalised on account of disabilities or their ethnic, linguistic or religious group] are included with intensive investments of resources required to reach them.

- **Collaborate with local communities, government and non-governmental organisations to create an enabling environment for pandemic prevention and preparedness**

  Local, low-cost and scalable solutions are essential to promoting prevention and preparedness in low-resource environments where at present, the lack of essential infrastructure, services and supplies is prohibiting the adoption of preventative strategies. There is an immediate imperative to work hand in hand with local communities, government and non-governmental organisations to propose practicable, applicable action plans: including mapping areas of risk, promoting measures to increase safety and social distancing in public spaces like markets, and supporting the adopting of self-reliant, self-regulation strategies such as avoiding crowded and congested areas and avoiding touching are critical to slowing the spread of infection. Resource allocations should address the lack of essential supplies and seek to increase the availability and accessibility of soap, sanitiser and sources of water for the poorest and most marginalised populations.

- **Enable access to alternative learning for all children, ensure support for safe return to school, and invest in increasing resilience in emergencies**

  It is critical that children have access to education even, and especially, in emergencies. As the pandemic exposes existing inequities in education, self-sufficient strategies to support learning in areas without access to internet, radio or televisions are required to ensure all children can continue to learn. It is equally essential that children, caregivers and teachers are given targeted, tailored support for safe return to school, ensuring that their concerns are given careful consideration to assure attendance and enabling catch-up classes for children to mitigate against disengagement and dropout. Schools should seek opportunities to prepare and improve resilience to emergencies – engaging children, caregivers and communities to ensure that learning can continue even in the event of school closures.

- **Improve the availability and accessibility of psychosocial support and specialised services for protection**

  The evolving effects of the pandemic are resulting in intensified exposure to protection risks; in particular, for the poorest and the most marginalised. Immediate, in-time psychosocial support and specialised services are critical to protect against the adoption of [or relapse into] adverse coping strategies, including child labour, forced labour and forced marriage, forced recruitment into armed groups and transactional sex. Protection considerations cut across all areas of need identified, and all responses should reflect the intentional inclusion of protection support to address risk factors, increasing coping capacities and improve resilience.

- **Commit to in-time investments in relief, recovery and resilience to protect against the impacts of the pandemic**

  In-time investment in cash to close the gap between increasing costs and reduced income for the poorest and most marginalised populations is essential to ensuring that the immediate loss of income and livelihoods does not translate into destitution in the long-term. These populations are already reducing essential expenditure on food, education and health , consuming seed stocks and selling domestic and productive assets for survival – an intensification of these strategies exaggerates exposure to adverse coping strategies. In-time investments in cash, in-kind or monetary agricultural inputs and other forms of livelihoods assistance can support survival and ensure resilience to the long term impact of the pandemic.

On 28 March 2020
Street Child launched a global response to the intensified needs of children and communities across 14 fragile, conflict and crisis affected countries in the COVID-19 pandemic.

For further information on our response see
www.street-child.co.uk/covid-19-appeal