

Interim Guidance

SCALING-UP COVID-19 OUTBREAK READINESS AND RESPONSE OPERATIONS IN HUMANITARIAN SITUATIONS

Including Camps and Camp-Like Settings

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Scaling-Up Covid-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Including Camps and Camp-Like Settings

People affected by humanitarian crises, particularly those displaced and/or living in camps and camp-like settings, are often faced with specific challenges and vulnerabilities that must be taken into consideration when planning for readiness and response operations for the COVID-19 outbreak. They are frequently neglected, stigmatized, and may face difficulties in accessing health services that are otherwise available to the general population. In the context of this Interim Guidance, the people in humanitarian situations affected by this guidance may include internally displaced persons (IDPs), host communities, asylum seekers, refugees and returnees, and migrants when in similar situations. While further adaptations might be needed for some population groups, including those living in slums this interim guidance is issued to assist field staff to immediately respond to urgent needs,

It is of extreme importance from a protection, human-rights and public health perspectives, that people affected by humanitarian crises are included in all COVID-19 outbreak readiness and response strategies, plan and operations. There is a strong public health rationale to extend all measures to everyone, regardless of status and ensuring inclusiveness.

OBJECTIVES

This Interim Guidance addresses specific needs and considerations required in humanitarian situations, including camps and camp-like settings and the surrounding host communities, in scaling-up readiness and response operations for the COVID-19 outbreak through effective multi-sectoral partnership. The Guidance is developed in alignment with the WHO COVID-19 Strategic Preparedness and Response Plan (link: <https://www.who.int/publications-detail/strategic-preparedness-and-response-plan-for-the-new-coronavirus>), and WHO Technical guidance for COVID-19 (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>), particularly in relation to the following objectives:

1. Limit human-to-human transmission, including reducing secondary infections among close contacts and healthcare workers, preventing transmission amplification events, strengthening health facilities
2. Identify and provide optimised care for infected patients early
3. Communicate critical risk and information to all communities, and counter misinformation
4. Ensure protection remains central to the response and through multi-sectoral partnerships, the detection of protection challenges and monitoring of protection needs to provide response to identified protection risks
5. Minimize social and economic impact through multi-sectoral partnerships.

This Interim Guidance is intended for field coordinators, camp managers and public health personnel, as well as national and local governments and the wider humanitarian community working in humanitarian situations, including camps and camp-like settings, who are involved in the decision making and implementation of multi-sectorial COVID-19 outbreak readiness and response activities – the Guidance is therefore relevant for all Humanitarian Clusters and their partners.

For simplicity, these humanitarian situations, including camps and camp-like situations shall be referred to as collective sites from hereon in the document. More specific guidance in relation to persons living in slums may be sought from UN Habitat. While this Guidance emphasises the importance of ensuring that all people affected by humanitarian crises are included in such readiness and response operations, it does recognise the increased risk for populations living in collective sites.

SPECIFIC CONSIDERATIONS FOR COLLECTIVE SITES

While human rights apply to all people in humanitarian situations, their legal status and their living and accommodation arrangements may be inhibiting factors to their full enjoyment of their rights. This requires special considerations for inclusion in national and local COVID-19 readiness and response operations:

- The legal status of people affected by humanitarian crises, whether recognized or unrecognized, regular or irregular, may determine their level of, ability and willingness to access to health care and other services, the availability of culturally and linguistically-sensitive services to them, and their utilization of these services based on other social determinants (discrimination, criminalization, exploitation, etc.).
- Although many people in humanitarian situations find individual accommodation in predominantly urban areas, the living arrangements of some of them may include high-density formal or informal collective sites, such as camps, reception/ transit/ evacuation centres, collective centres or informal and spontaneous settlements and urban slums, all of which may be of a temporary/ transitory or long-term nature. These settings require adaptations to multi-sectorial the COVID-19 readiness and response measures implemented for the general population. For more information on how to address the needs of persons living in slums, please refer to existing UN-Habitat guidance.
- In regards to food distributions in camps and camp-like settlements and collective sites, these Guidelines should be read in conjunction with the Standard Operating Procedures developed by WFP and partners on how to adjust food distributions in the context of the COVID-19 outbreak.

People living in collective sites are vulnerable to COVID-19 in part because of the health risks associated with movement/ displacement, overcrowding, increased climatic exposure due to sub-standard shelter, and poor nutritional and health status among affected populations. This may also be exacerbated by modalities of services/ assistance provision, which can involve large crowds. While adaptations of site plans may not be feasible, maximizing site planning for better distancing among residents and crowd management, adherence to infection prevention and control (IPC) standards, strong risk communication and community engagement (RCCE) and a good surveillance system to detect initial cases early can greatly reduce the propensity for COVID-19 to spread within such settings. Appropriate case management can reduce mortality among those infected with the virus.

PROTECTION CONSIDERATIONS

Health is a human right protected by articles in Human Rights Law (<https://www.un.org/en/universal-declaration-human-rights/index.html>), in the WHO Constitution (https://www.who.int/governance/eb/who_constitution_en.pdf), the 1951 Refugee Convention (<https://www.unhcr.org/3b66c2aa10>) and in other relevant Declarations, Resolutions and Frameworks. All States have an obligation to protect and promote this right for all persons on their territory, without discrimination.

Due to particular vulnerabilities of displaced and other populations living in collective sites and their likely partial or full dependence on local networks, informal livelihood opportunities and markets as well as humanitarian assistance for satisfaction of basic needs, any measures recommended or imposed in the context of COVID-19 outbreak readiness and response activities (e.g. self-isolation requirement, closure of local markets, postponement of food distributions, limitation on free movement in and out of sites) have to be informed by a thorough gender and protection sensitive assessment of the impact on the well-being and satisfaction of basic needs of the men, women, boys and girls affected, and a plan for alternative provision of services and assistance to the individuals as well as the community must be prepared.

Ensure that refugees, asylum seekers, IDPs and migrants who may be present in collective sites are:

- not scapegoated, stigmatized or otherwise targeted with specific, discriminatory measures
- are provided with timely and accurate information in accessible forms and appropriate languages
- are involved in the design of readiness and response plans, policies and strategies and incentivized, including, for example, through the declaration of temporary amnesties, to fully participate.

Travel restrictions may be put in place by individual governments and may be applied to refugees, asylum seekers, IDPs and migrants. Close monitoring is required to ensure that these do not unduly affect the right to access territory and seek asylum, that there is no refoulement based on real or perceived fears of COVID-19 transmission, and that

restrictions on freedom of movement, or other measures instituted by governments, are applied to refugees, asylum seekers, IDPs and migrants in a nondiscriminatory way and in a way that protects their health and wellbeing including Mental health considerations.

I COORDINATION AND PLANNING

- A site-specific epidemiological risk assessment needs to be conducted to determine the risk of COVID-19 introduction and propagation, based on the national risk assessment, the epidemiological situation of the area where the site is located, the travel and trade connections between the site, its host communities and areas reporting COVID-19 cases, as well as the characteristics of the site which may act as amplifiers of transmission.
- The coordination of COVID-19 outbreak readiness and response operations in collective sites needs to be aligned with existing humanitarian coordination mechanisms across clusters already in place at national, local and site levels where possible.
- Specific COVID-19 outbreak readiness and response plan needs to be developed for each collective site, in alignment with national and local plans, and be based on the prevailing risks, capacities and gaps present at the site level. It should articulate which measures need to be put in place and how these will be implemented. A multi-disciplinary outbreak response team needs to be established to implement this plan, with a clear distribution of roles and responsibilities, and lines of communication and reporting. Should a team already be in place, it needs to be re-oriented to COVID-19 response, which includes women in decision making for outbreak preparedness and response, and ensures women's representation in camp management and COVID-19 policy spaces.
- A mapping should be undertaken to identify the areas most at risk: areas where people are living in particularly overcrowded conditions, with higher densities, with less space for expansion, more in contact with population at risk or with higher proportion of vulnerable population. Wherever possible, mitigation measures to reduce overcrowding should be put in place: Collective sites in which households are sharing the same shelter should be upgraded as much as possible to achieve minimum shelter standards of personal covered living space and household partitions rather than collective. People living in individual accommodation below minimum shelter standards should be supported to improve those standards, particularly by increasing the covered living space in cases of overcrowding. Vulnerable populations should be prioritized. In places where several households are sharing latrines or cooking facilities, additional facilities should be built to reduce the number of households using the same basic facilities. Additional land should be negotiated to allow for these expansions.
- Measures should be taken for physical re-planning of the site, to the extent possible, taking into consideration adequate IPC, social distancing, crowd management and to prevent large gathering of people. Modalities of service and assistance provision and activities on site (food and other distributions, registration/ enrolment for assistance, education, etc.) need to be planned in light of these measures to prevent the large gatherings and movement of people; alternative means to provide for such need to be considered. This will be of importance when a COVID-19 case is confirmed from the site and/or self-isolation is recommended. Negotiation for additional space for potential isolation needs to be carried out as part of preparedness, ahead of cases being identified.
- Personnel working in collective sites need to understand the risks of COVID-19 introduction and propagation in the site, be trained and monitored on self-protection measures and the rational use of Personal Protection Equipment (PPE) (technical guidance link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>). Personnel with potential risks of exposure to COVID-19 off-site shall not come to work for 14 days since the day of exposure, to prevent contamination to residents and host communities; those experiencing signs and symptoms suggestive of COVID-19 should not be allowed to work at the site either, until COVID-19 is ruled out and/or full recovery is attained. Measures need to be developed to ensure the temporary transfer of responsibilities of affected personnel to their colleagues.
- Should a COVID-19 case be confirmed at a site, personnel and residents who are identified as contacts shall follow the procedures applied by the country for contacts, for self-quarantine and/or monitoring. There should be mechanisms in place to ensure that residents on isolation are able to continue receiving essential services available on site.

- Site business continuity plans should be developed for the event of a temporary absence of a significant number of personnel and external disruptions related to COVID-19 propagation, to ensure essential services are maintained at the best extent possible, including through strengthening of community mechanism for governance and self-management.
- Should it be feasible and required, a plan for site decongestion needs to be developed which should be co-ordinating with all clusters to ensure the availability of hygiene supplies crucial to prevent COVID-19 infections

II RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT (RCCE)

- Identify and work with local influencers in the site community (such as community leaders, religious leaders, youth and women leaders, health workers, community volunteers) and local networks (women's groups, youth groups, traditional healers, etc.). Where and when possible, work with camp management teams, camp/site committees and/or community leaders to carry out consultations on risk assessment, identification of high-risk population group, existing trusted communication channels (formal and informal), and setting up of surveillance focal points per blocks and sections, as well as community task teams, etc.
- Community mobilization approaches and risk communication information from national and local health authorities and WHO should be used and adapted according to specific information needs, perceptions of site residents in, as well as their host communities. Languages understood, literacy levels, access to communication channels and existing barriers for prevention, within different groups should be taken into consideration when sharing information.
- Provide clear and unequivocal messages focusing on what people can do to reduce risk or which actions to take if they think they may have COVID-19. Do not instill fear and suspicion among the population. Do not use medical language in communication with the general public (for example say 'people who may have COVID-19' instead of 'suspected cases').
- Perceptions, rumours and feedback from camp residents and host communities should be monitored and responded to through trusted communication channels, especially to address negative behaviours and social stigma associated with the outbreak.
- Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices, in line with the national public health containment recommendations, and ensure that people affected by humanitarian situations are not scapegoated.
- Special arrangements need to be developed in relation to site-specific potential transmission amplification events, such as food distribution and market attendance – all potential transmission amplification events should be identified for specific measures to be developed. Community engagement approaches will be important to facilitate the implementation of measures to reduce the risk of virus transmission during such event. For example, food and other distribution, and market attendance may need to be done in phases to avoid congregation of too many people at once. In situations of community transmission, some activities, such as recreational and other group activities, may need to be temporarily suspended, which will require the cooperation of all residents.
- Awareness raising activities may also represent an opportunity to include joint messaging and an occasion for MHPSS actors to provide psychological first aid (PFA) to alleviate the stress and anxiety resulting from the situation.
- If the response to disease outbreaks such as COVID-19 is to be effective, it is important to ensure that gender norms, roles, and relations that influence women's and men's differential vulnerabilities and status in the societies are considered and addressed
- Additional guidance on RCCE can be obtained from the WHO COVID-19 technical guidance web page (link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>).

III SURVEILLANCE, CASE INVESTIGATION AND OUTBREAK RAPID RESPONSE TEAM

- Epidemiological surveillance, alert notification, case investigation and case reporting need to be implemented in camp settings following national guidelines and WHO's technical guidance (technical guidance link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>). In refugee settings using UNHCR's health information system the case definitions should be integrated into the list of acute conditions under surveillance based on national or global WHO case definitions. In other settings EWARS should be utilized where it is feasible/ applicable. Regardless of the surveillance tools used, staff need to be trained, case definitions made available, and monitoring and supervision on the application done. Surveillance staff need to be trained on contact tracing arrangements adapted to the collective site, before they detect any case. Once a case is confirmed, proper reporting to national authorities and the IHR focal person(s) need to be done, following national guidelines.
- When a COVID-19 case is confirmed at a collective site, contacts need to be identified and monitored for 14 days, even when quarantine or isolation is not possible. Emphasis should be on restriction of contact with others and limitation of movements outside of home. Of importance in this context is the consideration of negative (or cultural/social) coping mechanisms linked to the scarcity of space in available accommodation and the resulting grouping of people based on other than family relationships (e.g. children and women of several families sleeping together, teenage and single adult men sharing an accommodation). Consideration should also be given to address obstacles to women's and girls' access to support services, especially those subject to violence or who may be at risk of violence in quarantine.
- Community-based surveillance (CBS) should be encouraged whenever it is feasible. Site residents and representatives of host communities are important allies for the early detection of COVID-19 cases in sites and surrounding communities. When cases have been reported from sites and surrounding communities, CBS will be important for contact monitoring, even in the absence of quarantine and isolation. Community health volunteers and other community elements of the site and surrounding communities can be trained on a simplified case definition and alert notification procedures. Case investigation needs to be ensured following alert notification.
- The presence or rapid deployment of an outbreak rapid response team needs to be ensured in collective sites for investigation of alerts and referrals of suspected cases for diagnostics, potential isolation and case management. The team needs to be familiar with the specific considerations related to the site residents and adherence to protection principles.
- The outbreak rapid response team for collective sites needs to also be available to respond to alerts coming from surrounding host communities.

IV INDIVIDUAL HEALTH SCREENING

- For newly arrived residents at collective sites, individual health screening for target conditions may be provided. This may take place upon first arrival/registration at the border, at the reception centre or at the collective site. If new residents are coming from a place where there is community transmission of COVID-19, or that the exposure to the virus is likely, it is important to ensure that the screening process covers identification of signs and symptoms of COVID-19, as well as the risks of exposure, for example: observation visual signs of respiratory illness, coupled with questions on presence of fever or respiratory symptoms, and questions on history of contact with a potential COVID-19 case.
- Health screening should never depend on temperature measurement alone. It is also critical that subsequent steps for case investigation, diagnostics and initial clinical management be ensured prior to starting any health screening. Temporary isolation needs to be arranged in advance, to keep away individuals meeting the case definition of a suspect case, from all other residents of the site and host community members, until a referral process is completed, or a negative result is obtained.
- Health screening also serves as an opportunity to provide information on prevention measures, important behaviour and habits to maintain.
- Health screening can also serve as an opportunity to identify pregnant and lactating women and to provide information on prevention measures and important behaviour and habits to maintain during pregnancy, delivery and for lactating.

V LABORATORY SYSTEM

- An equipped referral laboratory facility needs to be identified for each collective site and its surrounding host community. National protocols shall be followed for safe specimen collection and transportation.
- Specimen collection techniques, viral transport medium, transport materials should be made available at each collective site together with PPE, if the national protocol stipulates on-site sample taking.

VI INFECTION PREVENTION AND CONTROL (IPC)

- IPC measures need to be developed for households, as well as common spaces tailored to the characteristics of each collective site. Residents need to be engaged to ensure adherence to these measures. Standard IPC protocols need to be followed (technical guidance link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>).
- If a health facility is present on-site, IPC measures for health facilities need to be followed (https://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/Sphere/SPHERE2%20-%20chapter%202%20-%20Min%20standards%20in%20water,%20sanitation%20and%20hygiene%20prom.pdf). This needs to ensure a functional triage system, training of staff, materials and supplies, including PPE. WASH services in health facilities are critical and require enhanced minimum standards in handwashing, enhanced water supply, sanitation as well as adapted management of medical waste.
- The implementation of all IPC measures will require optimal coordination, planning and supervision with the Health, WASH Shelter and CCCM Clusters and their partners.

VII CASE MANAGEMENT AND CONTINUITY OF ESSENTIAL HEALTH SERVICES

- Health facilities capable of providing clinical care for suspect and confirmed cases of COVID-19 need to be identified, and the necessary coordination established for referral, treatment and discharge.
- Protocols for the management of suspected cases, isolation and referral need to be developed in alignment with the national protocol and WHO technical guidance (technical guidance link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>) and adjusted to the level of health services available to the host community. These protocols need to be adapted following the evolution of collective knowledge on COVID-19.
- When necessary and feasible, home-based care for suspect COVID-19 cases can be implemented, following national protocols and WHO technical guidance (technical guidance link: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>). Adequate attention needs to be given to reducing the risk of secondary infection at the household level and adequate support and information should be provided to home care providers with personal protective equipment.
- Measures need to be put in place to ensure routine health services remain available to all site residents and host communities inside the health facility's catchment area. It is important to separate people accessing routine services from suspect and confirmed COVID-19 cases.
- Protocols for the management of COVID-19 in pregnancy and delivery need to be developed, in line with national protocols. For example, in the absence of obstetric complications or risk factors, consideration could be given to advising women to stay at home for early labour if limitation of contacts is feasible (complete self-isolation is not advised for labouring women). Access to emergency obstetric care and skilled birth attendance for all deliveries needs to be ensured for all women and girls in need, including post-partum monitoring. In case isolation of COVID-19 confirmed patients is not possible, the recommended 24-hour post-partum monitoring at health facility level may need to be shortened to reduce the risk of transmission to the mother and newborn.
- If the national authorities recommend self-isolation, it is important from a humanitarian perspective that these measures also include engagement or monitoring with community health workers or others; as there may be instances where those in self-isolation may deteriorate and not have access to support and care if fully isolated.

- If someone who is breastfeeding becomes ill, it is important to continue breastfeeding. The baby who has already been exposed to the virus by the mother and/or family will benefit most from continued direct breastfeeding. Hence, any interruption of breastfeeding may actually increase the infant's risk of becoming ill and even of becoming severely ill.
- Measures need to be put in place to limit potential exposure of patients with chronic conditions to COVID-19 infection by reducing visits to health facilities, e.g., by providing three months of treatment for stable NCD patients and those with Mental Health conditions, HIV and TB and follow up at home by community health workers if feasible. At the same time, the continuous clinical management of individuals with chronic diseases needs to be ensured, especially for conditions that are associated with the more severe forms of COVID-19 and higher risks of death. This will also require attention on drug supply chain management, taking into consideration potential market disruptions. Coordination needs to be made with national health authorities for diseases for which vertical programmes exist.
- Measure should also be considered to limit potential exposure of women and girls to COVID-19, especially for those who are seeking modern contraceptives. This can be done by reducing visits to health facilities, e.g. by providing 3 months of supply in regards to required (Pills, injectables and Condoms) and follow-up at home by community health workers if feasible. Attention to supply chain management of contraceptives needs to be maintained taking into consideration of potential market disruptions.

VIII LOGISTICS, PROCUREMENT AND SUPPLY MANAGEMENT

- Procurement plans need to take into consideration the size of the population to be served – site residents and surrounding host communities and potential market disruptions. This includes planning for the management of potential COVID-19 cases and their contacts, general household and site IPC equipment and supplies, as well as those needed for all routine services, including stockpiling of medicines and hygiene supplies for long term treatment needed.
- Referral health facilities need to be adequately equipped with oxygen cylinders and a system for replenishment, oxygen concentrators, and other essential equipment and supplies, calculated based on prevailing risks of COVID-19 incidence among site residents and surrounding host communities. Ventilators may be considered for higher level secondary care facilities but require trained nursing and medical staff and a stable power supply. These requirements are often not in place in many resource limited settings.