

Interim Guidance

PUBLIC HEALTH AND SOCIAL MEASURES FOR COVID-19 PREPAREDNESS AND RESPONSE IN LOW CAPACITY AND HUMANITARIAN SETTINGS

Version 1

Developed by ICRC, IFRC, IOM, NRC,
UNICEF, UN-HABITAT, UNHCR, WHO in
consultation with IASC members

May 2020

Interim Guidance

Public Health and Social Measures for COVID-19 Preparedness and Response Operations in Low Capacity and Humanitarian Settings

The coronavirus disease 2019 (COVID-19) pandemic has changed the lives of individuals, communities and societies across the world. To date, the most important insight from the global response has been that to successfully slow transmission, it is essential to diagnose, isolate and care for all cases of COVID-19, including those with mild disease. In order to stop cases from becoming clusters and clusters to progress into vast and rapid transmission, speed, scale and equity must be the guiding principles.

People affected by humanitarian crises and those living in low capacity settings are differently impacted by the COVID-19 outbreak. In these settings, critical measures for COVID-19 prevention and control that have been a feature of the response in higher resource settings, such as physical distancing, movement restrictions and home confinement, hand washing with water and soap, closure of schools and workplaces may be more difficult to implement and some of them potentially harmful to the survival of many community members. In addition, capacities for testing, isolating and treating those who develop the disease, tracing and quarantining contacts may be severely lacking locally owing to weaker health systems.

For the purpose of this guidance, these low capacity and humanitarian settings refer to settings characterized by some or all of the following, regardless of the social, humanitarian, citizenship, migration and asylum status of its residents and where these settings are located:

1. Overcrowding and inadequate dwellings or shelter/ insufficient settlement infrastructure
2. Lack of availability of clean water and sanitation
3. High dependence on informal economy and daily wages
4. Poor access to health care and basic services
5. Disrupted health system
6. Prevalent food insecurity and malnutrition
7. Armed conflict and violence
8. Weak institutions/ challenged governance and lack of emergency response capacities
9. Prevalence of highly marginalized and underserved communities

Notwithstanding, strong community ties, structures and systems present in most of these settings as well as the individual and collective resilience of the community are the strengths that will determine the effective adaptation and implementation of important public health and social measures aimed at preventing and controlling the COVID-19 outbreak. Each setting remains unique, urban slums would be different from humanitarian camps, and therefore these measures could only be effective when appropriately adapted to individual contexts.

Public health and social measures in these settings need to be balanced against other risks affecting their communities, such as lack of income, access to basic services and social nets, and food insecurity. Whilst poorly implemented measures can increase risks of COVID-19 transmission, inadequately adapted interventions can have adverse impacts on overall public health as well as a range of far-reaching economic, social and political consequences (e.g. people dying of other diseases or left jobless and destitute, increased gender-based violence – GBV, increased violence against children, social unrest, etc.). As far as possible, public health and social measures need to be accompanied by efforts to mitigate social and economic impact to maximise the effectiveness of COVID-19 transmission reduction, while minimising these wider consequences and not negatively affecting other lifesaving assistance and development efforts. They also need to be pragmatic and leverage the strengths of the local structures and systems, notably through social mobilization and strong community engagement.

OBJECTIVES AND TARGET AUDIENCE

This Interim Guidance outlines **how** key public health and social measures needed to reduce the risk of COVID-19 spread and the impact of the disease **can be adapted** for use in low capacity and humanitarian settings. The recommendations outlined here need to be adjusted to the [scale of transmission](#)¹, context and resources, in order to achieve the objective of managing COVID-19, namely **to reduce transmission and facilitate the detection and management of infected and exposed individuals within the population**. The Guidance is intended for **humanitarian and development actors** of all operational levels working with communities, as well as **local authorities** involved in COVID-19 preparedness and response operations in these settings, in support of national and local governments and plans. Additional considerations for support to residents of urban informal settlements and slums are available in [Annex 1](#).

ADAPTING COVID-19 PREPAREDNESS AND RESPONSE TO LOW CAPACITY AND HUMANITARIAN SETTINGS

Recommended public health and social measures need to be adapted to context and resources in order to be effective. In low capacity and humanitarian settings, the trajectory of the COVID-19 outbreak will also depend on the complex interplay of demographics, socio-cultural strengths and disparities, the prevalence of other diseases, the density of the living conditions, environmental and potentially other different factors associated with poor COVID-19 outcomes.

The recommendations for COVID-19 public health and social measures delineated in the sections below are those recommended for all settings. For low capacity and humanitarian settings, practical adaptations need to be made considering the context of each setting, but they also need to remain anchored to the public health principles underlying each measure and commensurate to the risks identified. These principles along with approaches to adaptations and enablers for implementation as well as key actions for these settings are laid out for each recommendation in the sections below.

Critical measures such as hand hygiene in the community and healthcare settings will require the maximum mobilization of available and external resources and partners to ensure the availability of sufficient quantities of safe water and handwashing supplies throughout the outbreak response; this investment needs to subsequently be maintained to contribute to longer term benefits and prevention of future outbreaks. Although clinical management of severe and critical cases may require resources and capacities exceeding those available, similar efforts should be made, including through a coordinated international assistance; increasing clinical management capacities for COVID-19 will also contribute to longer term improvement of health service delivery when properly sustained. The recommendations and adaptations below will be updated as new information become available.

¹ The [scale of transmission of COVID-19](#) in countries, and within sub-national administrative areas, can be categorized as follow:

- **No reported cases;**
- **Sporadic cases:** one or more cases, imported or locally detected;
- **Clusters of cases:** cases clustered in time, geographic location and/or by common exposure;
- **Community transmission:** larger outbreaks of local transmission defined through an assessment of factors including, but not limited to large numbers of cases not linkable to transmission chains, large number of cases from sentinel lab surveillance, multiple unrelated clusters in several areas of the country/ territory/ area.

Public Health and Social Measures for COVID-19 Preparedness and Response Operations in Low-Capacity and Humanitarian Settings

	Mobilize all sectors & communities	Prevent, suppress & slow transmission	Find, test, isolate & treat cases, quarantine contact	Provide appropriate clinical care
Who?	Community leaders and members, health care workers, volunteers, local authorities, NGOs/ international organizations			
Where?	Community, camps, slums, informal settlements, places of detention			Health care facilities
Recommended measures	<ol style="list-style-type: none"> 1. Conduct risk assessment 2. Develop COVID-19 plan for the setting 3. Risk communication & community engagement 4. Engage & train community health workers in response actions 5. Provide economic & social support 6. Arrange safe burials 	<ol style="list-style-type: none"> 7. Physical distancing, limit movement & minimize gatherings 8. Hand hygiene & respiratory etiquette 9. Medical masks for HCW, sick people & caregivers & others (also non medical mask) according to setting and risks 10. Strengthen prevention measures for individuals at risk of severe disease 	<ol style="list-style-type: none"> 11. Screening and referral for suspect cases 12. Test all suspect cases according to local strategy 13. Isolate & treat all mild/ moderate cases in designated facilities 14. Identify, monitor and quarantine contacts 	<ol style="list-style-type: none"> 15. Treat severe and critical cases and those at risk of developing severe disease in equipped health facilities
Key actions including adaptations	<ol style="list-style-type: none"> 1. Engage communities to assess risks of COVID-19 spread for appropriate response 2. Empower community leadership & local authorities to develop the plan – map resources 3. Work with local influencers & networks, focus on what can be done – monitor & adapt to feedback – address stigma 4. Map measures for CHWs & community actors to implement and oversee 5. Provide support including cash-based assistance to cover basic needs & services – protect food systems – strengthen social protection – improve/ provide shelter 6. Adapt burials ceremonies following local tradition to reduce transmission 	<ol style="list-style-type: none"> 7. Establish one-way pedestrian circuits – schedule different times for different groups to leave & return home – identify alternatives to gatherings 8. Mobilize resources & partners to ensure safe water supply & hand washing facilities 9. Temporary measures when in shortage of PPEs: extended use, reprocessing or use alternatives – mask usage by healthy individuals and type of masks to be based on risk and only with other measures (not to replace); methods to put on & off, discard or clean to be supervised 10. Support staying at home – prevention measures at the household level (physical barrier, wear mask, surface disinfection) 	<ol style="list-style-type: none"> 11. Enhance early warning & case detection in HCF & community – establish reporting & referral system to designated isolation facilities 12. Prioritize testing based on capacity – use syndromic approach & diagnosis of exclusion 13. Use hierarchy of isolation – establish/ assign community/ temporary structures for isolation based on severity 14. Add strict daily monitoring of contacts when they cannot remain in quarantine 	<ol style="list-style-type: none"> 15. Mobilize resources and partners to strengthen oxygen supply system – isolation and treatment of moderate diseases with risk factors, severe and critical cases can be done in community facilities that have appropriate capacity – sustain treatment of symptoms and co-infections
<p>SUSTAIN ESSENTIAL HEALTH AND SOCIAL SERVICES</p>				

Assumptions

Given the lack of documented experience in dealing with COVID-19 in low capacity and humanitarian settings, this guidance has been developed with the following assumptions:

- Due to the characteristics described above and based on experience with previous outbreaks of acute respiratory diseases, it is possible that COVID-19, once introduced, will spread rapidly in low capacity and humanitarian settings due to the high density of living and lack of water and sanitation in the community.
- The high prevalence of other diseases in these settings, including malnutrition, common childhood diseases, tuberculosis and other respiratory and communicable diseases, potentially HIV as well as a range of other socio-demographic factors and existing disparities may result in different proportions of severe and critical COVID-19 cases; it will be important to closely monitor how the disease is manifested differently in these settings.
- The capacity of the health system to deliver essential services is likely to be inadequate prior to the epidemic (particularly if degraded by armed conflict, broader economic constraints, limited capacity to respond to emergencies) and it will be challenging to scale up rapidly, especially for the treatment of severe and critical cases; overstretching the already fragile and disrupted system would result in higher avoidable mortality from morbidity other than COVID-19.
- Capacities for testing may be extremely weak, if not absent, and the ability to isolate cases, quarantine contacts and manage cases in the community is most likely to be limited.
- Once available, it is possible that COVID-19 specific treatment and vaccines may take a longer time to become available in these settings.
- Achieving reasonable control measures such as hygiene, physical distancing, and adherence to confinement, will likely be difficult and some of the restrictive measures such as home confinement may directly result in more harmful negative socio-economic and overall public health consequences compared to better resourced settings; state capacities (financing, human resources, institutions) to mitigate COVID-19 risks and associated negative consequences are also likely to be inadequate.
- In some of these settings there may be pockets inside the communities who are socially excluded because of their gender, ethnicity, caste, religion, disability, migration status and other socio-cultural attributes, and in fragmented societies, strong community ties may exist within sub-communities, but not across them; poorly adapted public health and social measures may exacerbate these existing inequalities and conditions of vulnerability.

Human rights and protection considerations

The core principles of human rights include accountability, equality, non-discrimination and participation. These apply to all people, including during public health and other emergencies. The use of emergency powers to respond to the COVID 19 pandemic must take account of these core principles, and must be proportional, be neither discriminatory nor arbitrary, and be grounded in applicable legal frameworks.

In formulating and implementing COVID 19 prevention, mitigation and response measures, extra care should be taken to assess their possible impact on the most vulnerable among populations to avoid disproportionate or discriminatory impacts, even if unintended. It is important to recognize the extent to which the COVID-19 outbreak may affect people differently according to their age, sexual orientation and gender identity, ethnicity, disability, education, employment, displacement, migration status and other socio-cultural attributes. The risks of exacerbating existing inequities through the implementation of COVID-19 prevention and control measures need to be carefully evaluated and mitigated.

Populations living in low capacity settings face enhanced vulnerabilities in the COVID 19 context. Persons who are homeless, displaced, whether internally or as a refugee or an asylum-seeker, those who are stateless and migrants with tenuous legal status face additional compounding risk factors which may dramatically increase the risks they face in the context of the COVID pandemic. It is essential to include these groups in all national mitigation and response measures, and to maintain two-way communication with them to listen to their concerns and to incorporate these into adjustments to national approaches.

Women and girls

[Women and girls are likely to experience distinct challenges and risks associated with the COVID-19 outbreak, exacerbating already existing gender inequalities.](#) Increased responsibility related to caregiving and within the household may limit women and girls' access to information and services. During an outbreak, where women have less power in decision making than men, their needs may largely be unmet and life-saving resources for reproductive and sexual health may be diverted to the emergency response. In addition, life-saving care and support to GBV survivors may be disrupted. Women and girls are also at heightened risk of intimate partner and other forms of domestic violence as a result of increased food insecurity and heightened tensions in the household. Negative economic impacts may increase the likelihood of survival sex, transactional sex and risk of sexual exploitation and abuse in the community and within projects, all of which greatly enhance exposure to the COVID-19 virus as well as sexually transmitted diseases.

Children

Hundreds of millions of children are out of school and confined to their homes, which for many means confinement to cramped living conditions. Confinement and additional restrictions increase risks of children being exposed to violence in the home and limit their ability to seek help. In all decisions involving children, their best interests must be a primary consideration. Maintenance of family unity is a key right of the child and must be prioritized. Family separation should be a last resort, for the shortest possible time and reunification should be prioritized. States must recognize the right of parents and guardians to make decisions about their children. Special consideration will be taken for those children already socially excluded and affected by discrimination, such as those in street situations or in institutions or otherwise without parental/family care as they will become even more vulnerable due to lockdowns and closure of social services, and they may face arbitrary arrests and detention, where they are also vulnerable to sexual violence (abuse and exploitation).

Conflict and displacement

Armed conflict, violence and insecurity make responding to COVID-19 more difficult. If not adapted to context, heavy-handed responses to COVID-19 in such settings may create **more** conflict and violence, and thus more vulnerable groups who need to be factored into the response. On the pretext of public health, the potential for arbitrary arrest and detention as well as “coercive isolation” is a particular risk. Law enforcement and other armed actors may have important roles to play in responding to COVID-19 and should be engaged constructively and pragmatically.

Displacement resulting from armed conflict and violence may cause additional barriers to access to health. Displaced people may be erroneously blamed, stigmatized and harassed for transmitting the disease. Interventions to address these barriers and improve displacement-affected people’s access to health services must be an important consideration in national public health strategies.

For undocumented migrants, anxieties of detention or other repercussions may lead to health-avoiding behaviours. For refugee-hosting areas there are risks of potential exclusion, neglect, or de-prioritisation from national and local planning and resourcing. Authorities may also attempt to forcibly close camps, which will need to be averted for both public health and protection purposes. The closures of borders as containment measure will also have a profound effect on displaced people. For people fleeing from armed conflict and seeking international protection, access to asylum must be preserved.

Protection of health care workers

The protection of health workers is critically important; violence against the health system would be extremely disruptive for the effectiveness of the response to COVID-19. Health workers are not only a vital part of the response to COVID19, but often come from the same communities that are affected. Given the already insufficient health workforce in many low capacity and humanitarian settings, losing health workers would result in reduced availability of essential health services and increased mortality. Their protection, and that of ambulances, health facilities and patients, should be assured through the concerted efforts of the authorities and communities, so that they are able to perform their duties in a safe and secure condition. [International Humanitarian Law also protects health workers in armed conflicts.](#)

Detainees

Detainees are likely to be more vulnerable to COVID-19 than the general population because of the confined conditions in which they – and staff – live for prolonged periods. Detainees may present pre-existing conditions and vulnerabilities (tuberculosis, malnutrition, etc already identified with negative COVID-19 outcomes), yet penitentiary surveillance and health systems are almost invariably less robust than national health systems. Moreover, experience shows that places of detention may act as sources of infection, amplification, and transmission of infectious diseases within and **beyond** prisons. [Contingency planning is essential in ensuring an adequate health response and maintaining secure, safe and humane detention settings.](#)

A. MOBILIZE ALL SECTORS AND COMMUNITIES TO ENSURE “WHOLE OF SOCIETY” OWNERSHIP AND PARTICIPATION

1. Conduct risk assessment specific to the setting

Key references: [Rapid risk assessment of acute public health events](#); [Considerations in adjusting public health and social measures in the context of COVID-19](#); [Interim guidance: risk assessment and management of exposure of health care workers in the context of COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

While the risk of rapid spread of COVID-19 in these settings is likely, all affected populations are not at the same risk for both exposure and transmission. Site-specific risk assessment should be undertaken for each setting to determine the risk to human health and socio-economic well-being by the COVID-19 outbreak. Support community-led risk assessment building on local knowledge and ensuring local ownership of the data and aggregation into local government-led databases and assessments if applicable. Rapid behaviour assessment will be needed to understand belief systems, perceptions, concerns, power-dynamics and preferred communication channels. The risk assessment will determine response including its urgency, magnitude, design and critical control measures where responders must prioritize resources depending on key areas and high-risk populations.

Pay attention to the needs and existing community capacities. Despite their challenges, these settings may also be highly organized, with well-established leadership structures. Understanding the complex relationships in these settings requires a good knowledge of the communities' socio-cultural diversity. [Annex 1](#) provides more details on urban informal settings and slums.

In the risk assessment, determine who in the community is most vulnerable based on demographics and co-morbidities (including those with evidence or those suspected of increased likelihood of severe illness). Consider existing and emerging protection risks for vulnerable or marginalized groups as a consequence not only of COVID-19 but also of public health or social measures. These include increased risks of 1) harmful coping strategies such as child labour, 2) increases in GBV and violence in the home, and 3) risks of family separation due to policies related to isolation, quarantine or hospitalization. Moreover, to avoid migrants avoiding seeking health care due to their status, make access to healthcare independent of migration status, eliminate all questions on migration status during the registration of all patients, establish a clear firewall between health care services and immigration enforcement and communicate that policy widely.

Include a review of existing services, such as water, sanitation and hygiene availability (or not), food and essential supplies necessary to address secondary socio-economic impacts. Assess the impact of the in-flow of resources during a crisis so they do not exacerbate tensions between different groups.

[Annex 2](#) provides an adoptable rapid risk assessment framework where the pathogen, exposure of the population and contextual factors are taken into consideration. The framework has sample risk questions that will enable risk characterization.

Key actions

Engage communities and local Civil Society Organizations (CSO) to assess the risks of COVID-19 introduction and/or spread in their community to enable appropriate and contextualized response

Considerations according to transmission scenarios

For no reported cases: assess risk of introduction and spread of COVID-19 outbreak for the whole community. National, regional and global risks should be considered if communities are in border areas or with an influx of population from other countries.

For sporadic cases: review risk assessment to determine the risk of sporadic cases spreading to clusters or community transmission. Pay special attention to assessing the capacity to identify, test and isolate new cases, contact tracing.

For clusters of cases: rapidly identify risks that will stop transmission increasing from clusters to community transmission.

For community transmission: assess the risk of transmission increasing to catastrophic community transmission with widespread severe cases and increasing deaths.

2. Develop a COVID-19 emergency plan specific to the setting, based on identified risks and capacities

Key reference: [Operational planning guidelines to support country preparedness and response](#)

Public health principles, approaches to adaptations and enablers for implementation

An emergency plan for each setting needs to be developed derived from the national COVID-19 plan by the designated authority and supported by partners; it should balance the potential benefits of strict outbreak control measures with the socio-economic and protection consequences. See [Annex 1](#) for more considerations for urban informal settlements and slums.

Community engagement and empowerment are essential in ensuring an applicable and feasible emergency plan for each setting. This plan needs to:

- Set out different scenarios based on the risk assessment, consider the estimated number of cases at the peak of the outbreak² and the duration of the outbreak, and consequently the number, location and modalities of isolation and treatment facilities needed and a referral system including the corresponding quantities of health personnel, and essential items;
- Set out role and responsibilities of key stakeholders, including outbreak response teams, community structures, community level protection actors and social services, social protection and child welfare workforce, and partners present
- Establish a strategy for transmission prevention, early case detection, testing, isolation and treatment, the communication and reporting channels, and a system for monitoring and adaptation
- Include clear rapid actions for minimum infection prevention and control (IPC) requirements including IPC focal points, training, infrastructures, surge capacity, processes and availability of essential IPC supplies to limit the spread of the virus within the healthcare system and along [food supply chains](#) and trade flows; follow the [WHO guidance on IPC during health care when COVID-19 infection is suspected](#).
- Designate and equip alternative care services, train providers to ensure continuation of services and access to essential commodities.

Emergency plans must consider prevailing gender norms and cultural aspects in a given setting that could lead to unequal access to services (i.e. separate spaces or modalities for isolation and treatment of men and women) and should also include risk mitigation measures for GBV, violence against children, other forms of violence and discrimination. Where an influx of displaced people or migrants, including unaccompanied and separated children (UASC) may be expected, plans should include designating and training staff who are conducting initial registration and health screening to identify and refer UASC to trained child welfare workers or members of community-based protection mechanisms who can act on a child's best interest.

Key actions

Empower the leadership of communities and local authorities³ in the development of this plan

Map resources that are available and mobilizable and identify remaining gaps for external support

3. Communicate risks clearly, regularly and honestly and adjust community engagement approaches and measures according to feedback

Key references: [COVID-19 technical guidance: risk communication and community engagement](#)

Public health principles, approaches to adaptations and enablers for implementation

Working through people's preferred and most used communication channels (e.g. community radio) and languages will be key part of the response. Identify and work with local influencers in the community and local networks to play an active participatory role across the response and enable them to effectively, accurately and consistently share trustworthy information on risks, including what is still unknown, what is being done to find answers, what actions are being taken by health authorities, and what actions at-risk people can do to prevent COVID-19 transmission in the community, avoid contracting the disease and which actions to take if they think they may have the disease. This should be accompanied by

² Sound methods for estimating attack rates are encouraged; in the absence of any estimation, a rate of 50% to 70% in this type of setting is acceptable.

³ Beyond health authorities, including where relevant: penitentiary, law enforcement, military/ armed forces and mayoral authorities

continuous messaging on importance of accessing essential health services, to avoid unintentionally signalling that people should stay home and avoid health facilities. Key influencers include trusted people in the community, religious leaders, teachers, role models, community volunteers, SCOs, women and adolescent groups, etc. Promote the use of digital platforms and ensure availability of electric power supply in contexts where this is needed, and leverage those that could particularly work on low-end (or free of data charge) devices when possible. See [Annex 1](#) for more considerations for urban informal settlements and slums.

To be able to engage the right groups, an audience analysis needs to be quickly undertaken. Understanding people's knowledge, behaviours, and perceptions becomes a key step in shaping not only messaging but also in understanding enablers and barriers to the uptake of preventive behaviours and hence community engagement approaches.

Provide empowering behaviour-focused and forward-looking messages rather than messages that could instil fear, confusion or suspicion. Communities must be fully engaged to prevent transmission and understand that measures required to bring the outbreak under control will need to be supported by all even when they are disrupting the social and economic life. Behaviour messages to communities should also encourage households to plan for situations in which caregivers may become incapacitated or are otherwise unable to care for children by identifying alternative kinship or other family-based care for children in the household.

Systematically monitor and respond to perceptions, rumours, questions, suggestions and feedback from communities through trusted and culturally appropriate, available and accessible, remote or face-to-face channels, especially to address fears, concerns, misinformation and stigmatization associated with people infected with COVID-19 and/ or responders; subsequently, adapt response approaches based on these. Present this feedback to decision makers to make the required course corrections to the response in time. Where possible and relevant, responses to important concerns raised by the communities must be fed back to them– thus closing the consultative loop.

The risk communication strategy must include [actions to address social stigma](#) through capacity building and provision of support to those who are facing it. Responsive, empathic, transparent and consistent messaging that is child friendly and gender, age and disability-sensitive, in local languages through trusted and appropriate channels of communication is required. Ensure messages are appropriate for and reach those who may not have access to usual channels including those with disabilities, women and girls, those without access to digital channels and those who may be illiterate.

Key actions

Work with local influencers in the community and local networks to provide timely, accurate, user-friendly, audience appropriate and trusted information responding to different people's needs and focusing on what they can do to halt the spread of the outbreak

Monitor and respond to perceptions, rumours, questions and feedback through trusted channels and adapt response approaches

[Address social stigma](#) through capacity building and provision of support to those facing it

4. Engage and train community health workforce to take part in preparedness, readiness and response actions

Key references: Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic; [Home care for patients with COVID-19 resenting with mild symptoms and management of their contacts](#)

Public health principles, approaches to adaptations and enablers for implementation

The community health workforce (including detainees in prisons) can carry out activities including risk communication and community engagement, community surveillance, contact tracing, referral, promotion of IPC and hygiene practices in different environments, home care (when needed) and support to people who are self-isolating. Community health workers (CHWs) are crucial in the follow up of and support to those with mild illness cared for outside health facilities and the referral to designated COVID-19 hospital if they develop any signs of worsening of illness. In addition, CHWs are key to ensure continued delivery of essential health services, particularly in the context of restricted movement. CHWs will also be key in ensuring risk communication, using community-based networks and key influencers and building capacity of local entities.

Leverage the existing community health workforce for an immediate response and quantify the need for additional workers with skills among other community members to fill critical gaps in coverage and capacity, at regular intervals. Ensure that tasks are allocated realistically, responsibilities are distributed equally and that work conditions are reasonable. Leverage digital solutions, where available, to train and support the community health workforce, enable communications with the

households in their catchments, and to reduce in person encounters and group gatherings. Care should be taken to adequately resource, train, equip and supervise all CHWs. Link the community health workforce with trained and engaged community level social service and protection actors to help identify and address risks to vulnerable populations (including single parent households, children, older people, homeless people, those affected by violence etc.) and support referral pathways for multi-sectoral support.

Where the COVID-19 context necessitates workload modifications of the community health workforce and on the basis of COVID19 transmission dynamics and capacity of the health system to absorb shocks:

- Conduct rapid assessments of community health workforce coverage and capacity; recruit a surge cohort if needed, and encourage female health workforce participation
- Clearly define roles for the community health workforce in the context of the COVID-19 response and involve them in planning and decision-making
- Ensure the community health workforce and other critical personnel (e.g. for supply chain) are classified as essential and that they are exempted from mobility restrictions; through appropriate communication protect them and avoid their stigmatization as “spreader” of disease
- Recognise and remunerate the community health workforce with payments and non-performance-based incentives for supporting the COVID-19 response; remuneration schemes need to be agreed upon prior to implementation, with clear criteria for activation and deactivation
- Ensure the safety and health of all CHWs and other essential workers through administrative, environmental and engineering control measures (e.g. hand hygiene supplies, installation of physical barriers, use of natural ventilation, environmental clearing practices), by providing the necessary trainings and ensuring the availability of IPC supplies and [personal protective equipment \(PPE\) appropriate to the tasks performed](#); protect workers against violence and harassment, offer mental health and psychosocial support resources, and ensure treatment and care for those who become infected
- Modify supportive supervision modalities to minimise in person encounters while strengthening two-way referral links with primary care facilities and ensure the community health workforce has sufficient phone credit to engage with clients, access information, seek advice from supervisors, send data and receive payments using mobile phones where available and ensure referral modalities are available
- Ensure that the community health workforce is factored into supply chain quantification and coordination efforts with partners and suppliers, including pre-positioned and buffer stock of supplies and medicines for providing essential services at the community level
- Incorporate data collected by the community health workforce into the health information management system; and collect and monitor data on community health workforce COVID19 infections and deaths, disaggregated by gender, age and tasks performed
- Leverage trusted community resources such as local authorities and leaders, community advocates and influencers, and faith and religious leaders to promote helpful information, prevent and reduce fear, stigma and inequities, and provide reassurance and solidarity to people in their communities
- Identify low-risk community members who are willing to play key roles to support the sick and the most vulnerable during outbreak response.

Key actions

Map community-based measures for which CHWs and community-based actors can play an important role in implementation and oversight

Assign responsibilities, train and provide the necessary support to the community health workforce accordingly

5. Provide economic and social support to affected communities

Key reference: [Shared responsibility, global solidarity: responding to the socio-economic impacts of COVID-19; UNHCR case assistance and COVID-19: emerging field practices](#)

Public health principles, approaches to adaptations and enablers for implementation

Establish a mechanism for households that have suspected or confirmed cases to meet their basic needs, either through cash-based or in-kind assistance, e.g. through the provision of food, water, hygiene materials and other basic items for cases and contacts throughout their stay in isolation and quarantine facilities (or, if these are unavailable, at home). Identify safe ways to allow contact of isolated and quarantine individuals with family members, friends and legal representatives for detainees (use of communication technology, set up of physical barriers between patients and visitors, etc.) and to also access relevant information and communicate with service providers. Depending on context, explore arrangements of door-

to-door deliveries for households living in confinement, either through community support or through local business agents/distributors.

Plan for the continuation of daily essential activities in the community (trade, public services) and functioning community governance structures and mechanisms that respects physical distancing and hand hygiene to the extent possible. Support governments and their social protection systems, including with their routine cash transfer programs, ensuring the most marginalized are not left behind as systems and programs adapt to the outbreak. Where social protection systems are weak, set up emergency cash transfer by leveraging existing cash delivery systems and ensure there is no duplication among partners.

The heavy reliance on the informal sector in these capacity and humanitarian settings will necessitate people to continue working, including through sub-optimal conditions. Therefore, engagement with employers to encourage working adaptations to reduce transmission risks and to protect livelihoods (including allowing paid leave and preventing unfair dismissals) will be important. This may be supported through exploring the possibility of reducing attendance, scheduling and channeling movements to avoid large crowds and peak periods, performing some of the duties from home. For households that subsequently lose their sources of income or are forced to choose between earning an income and isolation, explore options of inclusion into social protection schemes or safety nets (or, if necessary and appropriate, multipurpose cash distributions).

Mobilize resources to provide shelter to those who are homeless or who live in inadequate dwellings, especially individuals who are at higher risk of severe COVID-19 disease. Advocate for a moratorium on evictions for tenants during the period. Furthermore, ensure that utilities (water, electricity, cooking and heating fuels, waste management) also continue to operate through periods of lockdown, isolation, and quarantine.

Where possible, local markets and food systems should be supported throughout the implementation of containment measures though access to agricultural inputs and facilities (agriculture, livestock, fishery, forestry), and humanitarian assistance when needed. For vulnerable households, consider arrangements that protect their access to staples, exploring the possibility of having access to land and carry out agricultural production.

Key actions

Provide socio-economic support (including cash-based and vouchers assistance) for COVID-19 affected families to cover basic needs and access to essential services, and address inequities

Support local markets and food systems, including through humanitarian assistance

Engage employers to encourage working adaptations to reduce transmission risks and to protect livelihoods (including preventing unfair dismissals)

Strengthen national social protection schemes through horizontal and or vertical expansion to address the socio-economic impact of COVID-19 and support the continuation of essential services and community functions

Ensure the homeless and most marginalized are not left behind as systems and programs adapt to the outbreak

6. Arrange safe burials

Key reference: [IPC for the safe management of a dead body in the context of COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

Anticipate the numbers of burials when there is largely uncontrolled spread in the community and at the same time comply to the extent possible with religious/traditional beliefs and practices. Prepare for adapted burial of the dead, with ceremonies that do not compromise physical distancing. Communities should be supported to use community case definitions to determine burial protocols in the absence of testing capacities in most low capacity and humanitarian settings. In places of detention, authorities should conduct routine investigations into deaths in custody.

The risk of viral transmission while preparing the body of a person infected with COVID-19 is low and mainly through contact with contaminated surfaces, therefore the systematic application of standard precautions is crucial to prevent transmission. In scenarios of community burial, family members, traditional and religious leaders, healthcare workers and others who are typically involved in preparing the body for burial should be supported with the information and IPC supplies and equipment needed to reduce the risk of transmission. People at high risk of severe illness, such as the elderly and those with comorbidities, should be discouraged from participating in preparing the body. They do not need to be excluded from the service.

In close communication with communities, agree upon burial ceremonies that meet the need for IPC, and meet cultural, social and religious needs. It is a common myth that persons who have died of a communicable disease should be cremated, but this is not true. Cremation is a matter of cultural choice and available resources. In addition to adaptations to individual burials, communities should be supported to prepare for the management of mass fatalities, including identifying systems to alert the death of someone who may have COVID-19 requiring burial support; transportation, identification and storage of unidentified bodies prior to burial; and expected burial sites. Mass graves, burial of unidentified bodies, and culturally inappropriate cremation are usually unnecessary and should be avoided to the extent possible, as they have the potential to cause long-lasting psychological, social and legal problems for families of the deceased.

Key actions

Adapt burial ceremonies to reduce transmission risks but meet local cultural, social and religious needs

B. PREVENT, SUPPRESS AND SLOW TRANSMISSION

7. Promote physical distancing, limit movement and minimize gatherings

Key reference: [Considerations in adjusting public health and social measures in the context of COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and close contact, including indirect contact with objects or surfaces in the immediate environment contaminated with respiratory droplets from an infected person. Physical distancing is a critical measure for COVID-19 prevention (along with hand hygiene described below). This is also important when humanitarian agencies are organising the distribution of food and non-food items such as hygiene kits.

Engage communities, recognized leaders, social influencers, local authorities (including armed forces and law enforcement) and partners to collectively identify the best methods to promote physical distancing. The simplest measure that can be implemented by everyone is non-contact greetings and maintaining physical distance from other people. Gatherings, including for religious purposes, should be minimized. In low capacity and humanitarian settings, confinement may not be feasible; it can even be dangerous for the livelihoods of community members, many of whom work in the informal sector and depend on daily work and/or income to live. In such situations, with the community, identify alternatives that maximise physical distancing and hygiene measures, and minimize the risk of exposure and transmission associated with movement.

Discuss with communities the feasibility of organizing people's essential movement inside their community. For example, establish one-way flows to reduce congregations of people and maintain physical distance (e.g. a traffic control that will allow people to move in a single direction to, from and inside markets, clinics, etc). Adapt flows within high-traffic and bottle-necked areas with higher risk for community contact (e.g. markings on ground). Consider limiting the number of people in a given area at the same time and assign schedules per group of dwellings/ neighbourhood for the access to communal facilities and shared spaces such as markets and places of worship. Ensure gender norms are taken into consideration when planning these, including child care. See [Annex 1](#) for more considerations for urban informal settlements and slums.

These methods will need to be adjusted to the scale and phase of the outbreak transmission but are never too early to be planned for. Methods should be consistent with human rights, non-exploitive, proportional to the risks, and not contribute to social tensions. Violent enforcement of this measure is not justified under any circumstances. Vulnerabilities of and risks to women, children and people living with disabilities should be considered in designing and implementing such restrictions.

Key actions

Establish one-way system for pedestrian, ground markings and set up physical barriers in the communal facilities to support physical distancing

Schedule different times for different groups to leave and return home where context allows

Identify alternatives to gatherings using locally accepted media

8. Promote hand hygiene and respiratory etiquette

Key references: [Recommendations for Member States to improve hand hygiene practices to help prevent the transmission of the COVID-19 virus](#); [Water, sanitation, hygiene, and waste management for the COVID-19 virus](#); [Considerations in adjusting public health and social measures in the context of COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

Hand hygiene and respiratory etiquette are critical measures to prevent COVID 19 based on the mode of transmission. The simplest actions that should be implemented by everyone and which require no additional resources are not to touch one's face (especially eyes, nose and mouth), and to cover the mouth and nose with flexed elbow when coughing and sneezing.

Regular hand washing should occur before preparing food, before and after eating, after using the toilet or changing a child's diaper, and after touching animals. Functioning handwashing facilities with water and soap should be available as close as possible to toilets. Set up hand hygiene stations at the entrance of the community setting, at important structures, transportation hubs (bus terminal, moto-taxi stand) and other strategic locations in the community (markets, public buildings, places of worship, etc).

Mobilize resources and partners to ensure access to sufficient quantities of safe water and soap. Improving water access at scale may require support to formal and informal water service providers (including hardware, consumables, and human resources) to ensure water supply, rapid installation of water points, and set up of portable hand hygiene facilities, including to "critical facilities" (such as prisons or migration centres). In contexts in which water access cannot be provided, hand sanitizers' provision should be ensured.

In support of water service providers, ensure sustained access to chemical consumables for water treatment as well as spare parts and adequate resources to carry-out maintenance and repairs necessary to allow for the operational continuity in service delivery. Ensure that cleaning agents are handled responsibly when being used, while in storage, and during disposal. In support of critical facilities, enable them to carry-out large-scale environmental cleaning and disinfection. Facility staff may require guidance on basic disinfection and require supplies (e.g. cleaning agents) to carry out this task on all exposed surfaces on a regular daily basis.

Key actions

Make every effort, mobilise resources and partners to make sure safe water is available adequately. When water cannot be provided, hand sanitizers' provision should be ensured

Ensure sufficient hand hygiene stations exist, are supplied and functioning at all gathering places (markets, health care facilities, places of worship, public facilities) and in households

9. Provide medical masks to health care workers, sick people and their caregivers – other individuals may opt to use masks (including non-medical mask) if their setting and risks require it

Key reference: [Advice on the use of masks in the context of COVID-19](#); [WHO guidance on the rational use of PPE for COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

Although using masks is the most visible control measure, it should not be relied on as a primary prevention strategy. Medical masks must be prioritized for HCWs, sick individuals in the community and their caretakers, and respirators (N95, FFP2, FFP3) be reserved for HCW. For HCWs, additional PPE need to be used according to the [WHO guidance on the rational use of PPE](#). In situations where social service and community workers have face-to-face interaction with sick individuals or their direct contacts, they should also be provided with medical masks and other protective gear as locally mandated and according to the same guidance.

For other individuals such as healthy people in the community, national and local authorities may opt for the usage of masks based on the risks of exposure to the COVID-19 virus and the type of setting such as low capacity and humanitarian settings. There are potential advantages of the use of masks, which include reducing potential exposure risk from an infected person during the 'pre-symptomatic' period or if an infected person is asymptomatic and avoid stigmatization of individuals wearing masks for source control (those who are already infected). However, there are also potential risks with the widespread use of mask, including increased potential for a person to become infected with COVID-19 if the mask is contaminated by dirty hands and/ or the mask is not discarded or cleaned properly if reusable (e.g. due to lack of water) after use. Wearing a mask can also give a false sense of security, with neglect of other essential measures, such as hand hygiene practices and

physical distancing. It is critical to emphasize that a mask alone is not a sufficient measure to prevent infection, and it should only be considered when proper cleaning is possible and correct measures are taken to put it on and take it off. Any decision on the use of masks should include measures such as hand hygiene before and after wearing masks, cleaning and disinfection of the environment, proper handling of used masks, etc.

[Current WHO guidance](#) provides consideration on masks to be worn by healthy individuals in the community if the national government makes the decision to implement it. For non-medical masks (also known as cloth masks), the type of fabric used, number of layers, combination of material used, mask shape and maintenance of mask are important considerations to ensure increased effectiveness. Non-medical (Cloth masks) are not considered PPE and as such it is not recommended for health care workers. As for other PPE items, if production of masks for use in health care settings is proposed locally in situations of shortage or stock out, a local authority should assess the proposed PPE according to specific minimum standards and technical specifications.

Key actions

Medical masks are reserved for HCWs, sick people, their caretakers and other workers who may be exposed to COVID-19 cases, e.g. in prisons and long-term care facilities

Temporary measures may be opted in situations of shortage of PPEs: extended use, reprocessing or use of alternative PPE (table 2 of [WHO guidance](#))

Decisions for mask usage by healthy individuals need to be based on a risk evaluation and supported by resources to make them sufficiently available for safe usage – mask usage cannot replace other critical measures: physical distancing and hygiene

10. Strengthen prevention measures for individuals at risk of complications and poor outcomes

Key references: [Considerations in adjusting public health and social measures in the context of COVID-19](#); [Advice on the use of masks in the context of COVID-19](#); [WHO guidance on IPC for long-term care facilities in the context of COVID-19](#)

Public health principles, approaches to adaptations and enablers for implementation

Bear in mind that there may be additional risk factors in low capacity and humanitarian settings that are not well documented. For individuals with known risk factors for complications (e.g. advanced age, hypertension, diabetes, cardiovascular diseases, chronic respiratory diseases, immunosuppression), it is particularly important to ensure critical measures (physical distancing and hygiene) are implemented, and that they may be detected when they fall ill and cared for as early possible. Complementary measures, such as the wearing of mask, may be considered in addition to these measures.

Efforts to strengthen COVID-19 prevention for at risk individuals should be implemented at the household level, with the support of the family. If a separate room is not available, physical distancing can be supported by adding a physical barrier within the house for example. Environmental cleaning, especially the cleaning of frequently touched surfaces in the house, needs to be emphasised. These same measures need to be extended to other individuals at risk as the knowledge on other risk factors become available. For households in which high risk individuals are children's primary caregivers, alternative care arrangements must be made, preferably through kinship care identified by the family or other family-based care.

Existing collective accommodations for older people should be monitored closely for potential cases and staff working in these accommodations need to fully comply with the [required IPC measures](#). Additional placement of individuals at high risk of poor outcomes in a separate facility or location **should be avoided**. The risk of introduction of the virus into such facilities is most likely unmanageable, as shown by experience in high resource settings. This measure is also most likely unsustainable in the long run given available resources, which should be prioritized for critical measures that are known to be working.

Key actions

Identify mechanisms to support individuals at risk of complications to adhere to staying at home and maintaining safe physical distancing

Identify and put in place additional prevention measures for individuals at risk of complications at the household level supported by the family, such as physical barrier if a separate room is not available, the proper wearing of mask, environmental cleaning, etc

C. FIND, TEST, ISOLATE AND TREAT THOSE WHO ARE SICK, IDENTIFY AND QUARANTINE CONTACTS

11. Establish a detection, reporting and referral system for suspect cases

Key references: [COVID-19 technical guidance: surveillance and case definitions](#)

Public health principles, approaches to adaptations and enablers for implementation

With the leadership of the community and local authorities (including armed forces and law enforcement), establish local mechanisms to detect and report individuals who could have COVID-19 to the designated health authority as early as possible. Low capacity and humanitarian settings with established early warning, alert and response systems (EWAR) can receive suspected COVID-19 alerts from both the primary health care centers using the standard [WHO COVID-19 case definition \(Annex 3\)](#) or a nationally adopted case definition, from the community using community-based surveillance (CBS) with an adjusted case definition and more informally based on rumors of illness in the community. In conflict settings surveillance systems may be disrupted or in control of different powers; tailored solutions for combined reporting and may be required.

Significant number of people infected with COVID-19 will seek healthcare for their illness, making health care facilities very important in case detection. Clinicians should suspect COVID-19 based on standard case definition and should report suspected cases via existing surveillance or early warning systems. COVID-19 case definitions should be shared with all reporting primary healthcare centers and clinicians, and displayed at each consultation room as feasible. It is also important to continue to monitor any significant increase in acute respiratory infections which may indicate undetected community transmission of COVID-19 that may require further investigation.

CBS allows trained volunteers to report possible COVID-19 while doing other health promotion or risk communication activities. Adapt [community case definition](#) from the WHO COVID-19 suspected case definition. Train CHWs to report back to supervisors and health authorities for further investigation and follow-up. Persons meeting the community case definition should be reported within 24 hours of identification. In low capacity and humanitarian settings, CBS can act as the link between the community and health facilities, filling existing gaps in the surveillance system, allowing for earlier detection and earlier action to limit transmission within the community. Surveillance through CBS can and should be paired with COVID-19 related health promotion activities, including maintaining physical distancing, key messaging on hand hygiene and respiratory etiquette.

Mechanisms should be available for community members to report rumours or events of public health importance via hotlines and other means. Pay attention to rumours of clusters of cases or deaths due to/following fever and difficulty in breathing, cases/deaths due to fever and difficulty in breathing following travel, rumour of having contact with a patient with Covid-19 then developing fever, cough/ difficulty in breathing/or death. These may signal potential public health threats, which may or may not be due to COVID-19. These rumours should be verified and followed up to determine the cause rapidly, and care be provided to all who need it.

Systematic screening of individuals entering/leaving the community or attending public facilities, commercial buildings, workplaces should also be implemented. Screening is also important for specific groups, such as displaced people and migrants. Should health screening be implemented, do not depend on temperature measurement alone. Observe for visual signs of respiratory illness and ask questions on history of fever and respiratory symptoms, and questions on history of contact with a potential COVID-19 case. The same case definitions for COVID-19 cases and contacts should be used for screening. PPE is not required for screening if a physical distance of at least 1 meter can be maintained. Otherwise, screeners should wear a medical mask and eye protection to conduct screening. Health screening also serves as an opportunity to provide information on prevention measures, important behaviour and habits to maintain. Incorporate measures to prevent family separation and preserve family unity, as well as child safeguarding and protection measures against sexual exploitation and abuse into the set-up and management of screening locations.

Screening patients before entry to a healthcare facility should be implemented. This is not merely for case detection but to maintain safe health facilities for all patients. Suspected COVID-19 cases identified during screening should be managed as per the COVID-19 response strategy for the setting, including triage, reporting, referral, treatment and isolation through a safe dedicated pathway. All screened patients with respiratory symptoms, should be given medical face masks and advised to practice good hand hygiene and respiratory etiquette.

Regardless of the reporting location, once an alert of a potential suspect case is raised, verification, investigation, confirmation and reporting should occur as per national protocols. Referral systems should clearly delineate communication with and transportation to the designated isolation and treatment facilities; this includes establishing payment arrangements

for transportation when needed. During transport, [PPE and precautionary measures](#) should be adjusted to the level of risk to ensure safety of providers and patients.

Referral services should include protection of individuals, including children whose vulnerabilities may be exacerbated by the virus or containment and treatment measures. This includes services for children whose caregivers may become incapacitated or be otherwise unable to care for them as a result of the virus or containment measures. If a child is suspected of having COVID-19, he/she should be accompanied by a parent/guardian/caregiver in PPE during the whole referral, isolation and treatment period. In conflict areas, referrals may have to be done cross line and in coordination with a variety of stakeholders and protection agencies. Safe corridors for the referral of COVID cases may have to be negotiated through CIVMIL actors and/or with parties to the conflict.

All surveillance activities must be done in a manner that is [non-stigmatizing](#) and doesn't alienate people.

Key actions

Enhance early warning and case detection and reporting capacities in the health care facilities and the community

Implement health screening at community entry/ exit points and other strategic locations; health screeners should wear a mask and eye protection when safe distance cannot be maintained

Establish a referral system and safe pathway for the suspected cases to the designated local isolation facilities, in conflict situations through cross-line coordination

Considerations according to transmission scenarios

For no reported cases: enhance early warning, alerts and response in all reporting sites and in the community; monitor changes in reporting of respiratory illnesses and deaths

For sporadic and clusters of cases: conduct case investigation and line listing for all probable, confirmed, and suspected COVID-19 cases, after establishing COVID-19 infection in the population. Suspected cases, in places where testing is not available, should be considered probable. Enhance rapid alert notification pathways from health centres and communities using text messages, voice call, hotlines in the absence of existing electronic systems. Surveillance should be enhanced in areas with links to affected areas. Continue to monitor any significant increase in acute respiratory infections which may indicate undetected community transmission of COVID-19.

For community transmission: if reporting and verification of all suspected cases and their contacts are impossible, at least detection and verification of suspected cases with severe signs and symptoms or presented to health facilities should be carried out; the community should continue to report cases and deaths in the community using early warning systems.

12. Test all suspect cases according to local testing strategy

Key reference: [Laboratory testing strategy recommendations for COVID-19](#)

Public health principles and approaches to adaptations and enablers for implementation

Laboratory testing is required to ascertain confirmation of COVID-19 circulation in a population. WHO recommends that all suspect cases be tested for COVID-19 according to WHO case definitions, however in areas with high incidence and/or lack of diagnostic capacities, it is important to implement prioritized testing and measures that can reduce spread. In this situation, testing should be prioritized for suspect cases who are:

- Individuals at risk of developing severe disease
- Those who will require hospitalization and advanced care for COVID-19
- Health workers (including emergency services and non-clinical staff) regardless of whether they are a contact of a confirmed case (to protect health workers and reduce the risk of nosocomial transmission)
- The first symptomatic individuals in a closed setting (e.g. schools, long term living facilities, prisons, hospitals)
- Vulnerable populations

All suspect cases who cannot be tested for whatever reason must be treated as COVID-19 cases. When testing capacities are extremely limited, following the confirmation of the presence of the virus through the testing of the first few cases in the area, a syndromic case definition could be adopted, where the presence of signs and symptoms of COVID-19 would be sufficient to guide the clinical management of a case. In such a situation, a diagnosis of exclusion needs to be done and testing for all other aetiologies for which tests are more readily available should be performed. It is important to assess total

lab capacity to retain capacity to diagnose other pathogens with a higher clinical relevance of diagnoses and continue increasing testing capacities.

Key actions

Develop prioritised laboratory testing strategy for the setting based on testing capacity

When testing capacities are limited, use a syndromic approach to guide clinical management, following the confirmation of the presence of the virus in the area

Ensure other morbidities can be detected and treated especially those with more readily available tests

Considerations according to transmission scenarios

For no reported cases: if laboratory capacity exists, all suspected cases should be tested. If not, perform laboratory tests on patients with severe clinical presentation; in the absence of any suspected COVID-19, consider testing suspected influenza cases and/or severe acute respiratory illness (SARI) with severe clinical signs and symptoms.

For sporadic and clusters of cases: if laboratory capacity exists, all suspected cases should be tested. If not, perform laboratory tests on patients with severe clinical presentation. If capacity exists, all symptomatic contacts should be tested. If not, as feasible, perform tests on health care contacts, vulnerable close contacts and any contact with severe clinical signs and symptoms.

For community transmission: testing capacity may be severely overwhelmed in community transmission. Thus, testing should be reserved for health care workers suspected of COVID-19 and suspected COVID-19 cases or contacts who have or may develop severe disease.

13. Isolate and treat all mild and moderate cases with no risk factors in designated facilities

Key reference: [IPC during health care when COVID-19 infection is suspected](#); [Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts](#); [Operational considerations for case management of COVID-19 in health facility and community](#)

Public health principles and approaches to adaptations and enablers for implementation

Identifying and isolating probable and confirmed cases as early as possible are the most important measures to control the outbreak. With testing most likely not available, following the confirmation of the presence of COVID-19 cases in the area, suspect cases who cannot be tested should be isolated and managed as COVID-19 cases, and all other potential aetiologies diagnosed. Preservation of family unity, particularly for young children, should remain a key principle in all isolation efforts. Where possible, children should be isolated together with a caregiver.

In most instances, there may not be sufficient space in health facilities to treat all cases, and these facilities also need to be preserved for the treatment of non-COVID-19 cases, such as maternity wards. Identify in advance empty spaces, ideally next to the local health facility, where a new (temporary) structure could be put in place for isolation and treatment, or existing community facilities (i.e. community hall, sports hall, etc.) that can be repurposed for the isolation and treatment of mild and low to moderate risk cases as well as the isolation and monitoring of contacts of cases. This needs to be done hand in hand with ample communication to and engagement of the community to address concerns and potentials for resistance. Subsequently, plan for human resources, materials, equipment needed for the operation of these isolation facilities.

The hierarchy of isolation priority is as follow: all suspect and confirmed cases need to be isolated at a health care facility if resources allow, or at designated community or additional temporary facility (or designated area in the detention facility) - look for locally-adapted approach to support cases and their families during isolation to ensure their safety and wellbeing. All efforts must be made to increase the capacity of these collective isolation facilities, including through external support. Home care should only be done when these other options are not feasible, or because of protection considerations for children and other vulnerable individuals; it should be done for a short period of time and only if the home/accommodation conditions allow and while waiting for transfer to a designated facility. In such situation, refer to home-based care for self-isolation: stay in room, own utensils and linen, no contact with anyone else but caregiver who should wear a mask. Individuals requiring isolation and treatment who do not have an adequate shelter should be prioritized for facility isolation.

If an individual develops symptoms that may correspond to progression of disease and complications, it is important to organize the rapid referral of these cases from isolation facilities to hospital.

Modalities of isolation and treatment should be voluntary to minimize avoidance and consider greater protections or alternative measures for those who are at highest risk of poor outcomes if infected, including older caregivers or individuals with underlying health conditions.

Key actions

Use hierarchy of isolation priority to isolate and treat mild and moderate cases without risk factors

Mobilize resources and establish community structures and/ or construct additional (temporary) structures for isolation of cases based on the levels of severity

Considerations according to transmission scenarios

For no reported cases: identify community facilities that can be repurposed for the isolation and treatment of COVID-19 cases according to the level of severity, or available land where new/temporary structures can be set up, ideally next to a health facility; recruit and train HCWs, plan for logistics and materials for the operations of these isolation facilities

For sporadic and clusters of cases: operationalize these isolation facilities as described above

For community transmission: when the number of COVID-19 cases exceed the capacity of isolation facilities, prioritize the more severe cases in the facilities, and home care for milder cases until isolation space becomes available. In isolation facilities, if there is not enough space for droplet isolation, screens should be placed between patients to limit potential transmission.

14. Identify, monitor and quarantine contacts

Key references: [Considerations for quarantine of individuals in the context of containment for COVID-19](#)

Public health principles and approaches to adaptations and enablers for implementation

Contact tracing should take place for all probable and confirmed cases. Suspected cases who cannot be tested should be considered as probable cases, and their contacts traced accordingly.

Identify the contacts of each case and monitor their health status for the potential development of COVID-19 signs and symptoms for 14 days since the last day of possible contact. Use the network of trained CHWs described above for this purpose – the community will be a major contributor to ensure contact tracing and monitoring are done properly, and that contacts follow the quarantine recommendations. Ideally, during this period, all contacts should be quarantined in a dedicated facility⁴. Consider protection of family members left behind during the quarantine period.

If facility quarantine is not possible, contacts must self-quarantine at home. Each contact should be provided with clear information about the contact tracing process, self-monitoring of symptoms and signs together with resources (soap, face masks if become symptomatic, etc) adequate for the tracing period. Information not coupled with resources may only enhance COVID-19 infection in the household and the community. If tracing of all contacts is not feasible, at least identification of health care contacts, household and close contacts should take place. Consideration should be made to supporting the nutrition and livelihood of quarantined contacts who are unable to provide for themselves and/or their dependants because of quarantine.

Close contacts should self-quarantine at home, and if they must leave their homes then temperature checks must be done every day for the duration of quarantine. Other contacts will need to continue to be monitored daily. High-risk contact (elderly, with comorbidities) should be monitored vigilantly as their existing conditions may worsen in lieu of developing any respiratory symptoms, or their clinical course may be more rapid than with other contacts who develop the disease.

Establish alternate accommodations for high-risk household members during the contact tracing period. Consider transferring them to an alternative shelter/household for the tracing period following thorough assessment of the secondary household for safety of transfer.

Where quarantine will affect caregiving arrangements, the best interests of the child or other dependant should be a primary consideration. Preservation of family unity, particularly for young children, should remain a key principle and where possible, children should be quarantined together with a caregiver. In all measures for quarantine, take necessary measures to prevent family separation in collaboration with child protection actors and facilitate communication with family members.

⁴ Quarantine is only intended for contacts – those with clearly established exposure; history to areas with reported cases is not criteria for quarantine.

Encourage use of technological solutions to conduct contact tracing, where and when feasible (SMS, WhatsApp, specific software like GODATA). If non-touch thermometers are not available to check fever, actively enquire about signs and symptoms. In the absence of testing, any contact who shows relevant symptoms and signs should be considered as a probable COVID-19 case.

Key actions

Add strict daily monitoring of contacts, especially close contacts, when they cannot remain in quarantine

Considerations according to transmission scenarios

For no reported cases: establish contact tracing mechanism, train and equip CHWs for the task

For sporadic and cluster of cases: systematically identify and list all contacts and trace them on a daily basis

For community transmission: if listing and tracing of all contacts are not possible, prioritize close contacts, household members, vulnerable contacts and healthcare contacts. Pay special attention to the vulnerable contacts and reporting of their clinical signs and symptoms.

D. REDUCE MORTALITY BY PROVIDING APPROPRIATE CLINICAL CARE

15. Treat all severe and critical cases and those at risk of developing severe disease in equipped health facilities

Key references: [COVID-19 technical guidance: patient management](#); [IPC during health care when COVID-19 infection is suspected](#)

Public health principles and approaches to adaptations and enablers for implementation

All moderate cases with risk factors and all severe and critical cases must be treated at a health facility capable of managing the level of care demanded. Based on current knowledge of the disease, the majority of people infected with COVID-19 will develop mild and moderate (including pneumonia) disease for which isolation and treatment at a community facility can be done. However, approximately 20-30% of cases will require clinical care at a hospital with respiratory support, and this needs to be carefully planned in advance: which hospitals have the capacity to treat severe cases, should COVID-19 hospitals be designated, how many beds and how many hospitals are needed based on the estimated number of cases and what biomedical equipment and staff are available and needed.

Efforts and partners should be mobilized to urgently strengthen oxygen supply systems, including through external support. This should look at already available systems and how to surge (i.e. PSA plants), and introduction of new oxygen supply systems (i.e. concentrators, liquid oxygen) according to absorptive capacity. Ensure all consumables and accessories are available, including splitters and delivery services. Ensure pulse oximeters are available at all care points. Essential care includes: pulse oximetry monitoring, treatment for co-infections such as bacterial pneumonia, malaria, diarrhoea, malnutrition with appropriate use of antimalarials/ antibiotics and provision of oxygen therapy, when appropriate.

If capacity is lacking and additional beds are created, do this in a holistic way making sure not only the structural elements such as beds, building, equipment are available but also trained human resources and PPEs proportional to the increase in beds. Emergency medical teams can augment local health services capacities. Refer to [WHO SARI Treatment Facility](#) for design principles to ensure all IPC circuits for patient and health worker movement are well defined.

Follow established protocols for clinical management. Ensure dynamic adaptations to the protocols following the evolution of collective knowledge of COVID-19.

Key actions

Make every effort, mobilize resources and partners to strengthen oxygen supply system

Isolation and treatment of mild/ moderate cases should be prioritized in community facilities and those with moderate diseases and risk factors, severe and critical cases can be done in designated community facilities that have appropriate clinical care capacity if hospital beds are insufficient

Sustain treatment of symptoms and co-infections

E. SUSTAIN ESSENTIAL HEALTH AND SOCIAL SERVICES

16. Maintain essential health and social services for all

Key references: [COVID-19: operational guidance for maintaining essential health services during an outbreak](#); Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic (hyperlink to be added when guidance is published shortly)

Public health principles and approaches to adaptations and enablers for implementation

Protect non-COVID-19 health services and their patients by cohorting COVID-19 patients in separate wards and/or (temporary) structures. Prioritise safe water, IPC, PPE, personal and environmental hygiene resources to staff working in all health facilities and allocate such resources appropriately between COVID-19 and essential services.

When normal services become compromised by COVID-19 caseload and when reassignment of staff to dedicated COVID-19 treatment wards or facilities is needed, service providers need to put in place measures to ensure maintenance of essential health services for all. Current experience indicates that stringent public health and social measures combined with fear of people becoming infected in a health facility reduce utilization of essential services to below 50%. Increased health needs should be anticipated for when routine services are being restored, to address the backlog of patients and increased needs resulting from the disrupted services and emergency conditions, including domestic violence and GBV.

The selection of essential health services versus services that can be suspended will be guided by the health system's baseline capacity and burden of disease, the socio-economic conditions of the communities and the COVID-19 transmission context. High priority categories for continuity include preventing and treating communicable diseases (malaria, tuberculosis, HIV, etc), averting maternal and child morbidity and mortality, preventing acute exacerbations of chronic conditions by maintaining established treatment regimens, continuity of critical inpatient therapies, managing emergency conditions requiring time-sensitive intervention, and auxiliary services as diagnostic imaging, laboratory and blood-banks. Routine health promotion visits and elective encounters may be limited, and delivery of vaccinations, antenatal and postnatal care will likely need to be adapted. Transmission of COVID-19 through breast milk and breastfeeding has not been detected to date hence standard WHO recommendations regarding breastfeeding apply.

Optimize service delivery settings and platforms by leveraging existing mechanisms, including modification of platform of delivery of care (e.g. through outreach activities), staggering and managing patient flows (including distancing in waiting areas, hand hygiene for outpatients when they enter and leave the facility); adequate IPC and physical distancing of distributors and beneficiaries of essential commodities (e.g. ARVs, TB medicines) and supplies (e.g. ITNs) during community-based distribution should be ensured.

Chronic non-communicable diseases (NCD) treatment may likely be temporarily suspended if longer continuity of existing treatment regimens can be ensured; people with chronic NCDs can avoid health care facilities unless they have acute symptoms or other urgent needs. The role of primary care level facilities can be enhanced in absorbing much of the non-COVID cases where possible e.g. through redirecting acute management of NCDs from hospitals to PHC level.

Rapidly redistribute the health workforce capacity where available or consider the recruitment of volunteers, including by reassignment and task sharing (for example assigning more responsibilities to supervised CHWs). Explore the rapid recruitment of additional health workers. Along with capacity development measures to bolster IPC and risk communication, consider incentives for staff working during the epidemic, as they are at higher risk. Incentives scales need to be collectively agreed with communities and local authorities, with clear activation and deactivation plans.

Ensure risk communication to the community to reduce fear of coming to a health facility with symptoms other than associated with COVID-19, to reduce delays in seeking care and to promote safe care seeking for morbidity for which essential services are being maintained.

Assign a designated focal point for non-COVID-19 essential health services as a member of the COVID-19 emergency team, to ensure appropriate prioritisation for the continuity of non-COVID-19 essential services, and balanced resource allocation for it with the resources required for COVID-19 control.

Key actions

Identify high priority essential services according to context and burden of disease and map them to the resource requirements

Ensure appropriate balance in allocation of PPE and IPC resources for staff between essential services and dedicated COVID-19 services, and other care providers e.g. in detention and long-term care facilities

Identify context specific alternative platforms and approaches to service delivery

Reassignment of staff and task sharing, identify context specific mechanisms for incentives for staff

Apply hands-off outpatient consultation approach

Anticipate increased needs for essential services after their suspension and/or disruption, when COVID-19 becomes under control, and lockdown measures are being lifted

Considerations according to transmission scenarios

For no reported cases: this is an opportune time to plan, if not already done, for prioritisation of non-COVID-19 essential services and put measures in place to ensure continuity of services when transmission increases, and services start being compromised.

For sporadic and clusters of cases: disruption of essential services may be minimal and limited to affected geographical areas and facilities in affected regions may still be able to redirect patients to unaffected nearby facilities for routine services.

For community transmission: the risk of disruption of non-COVID-19 essential services is greatest in this scenario. As the demand for services and resources increases, alternative models of provision of services that are context friendly are needed. Physical space may become a challenge and options such as use of community centres, mobile clinics etc for non-COVID essential services may be considered. Health workforce to support essential services may become limited, options to explore surge capacity could include remunerated overtime; health workers from non-affected regions; licensed retirees; medical trainees for appropriate supervised roles; workers from non-health sectors to support with supportive roles e.g. transport, administration, maintenance etc.

17. Suspend user fees of essential services

Key reference: [Health systems governance and financing & COVID-19](#)

Public health principles and approaches to adaptations and enablers for implementation

When COVID-19 is declared a national emergency, advocate for the suspension of user fees for essential health and other services by all providers for the duration of the crisis. Establish a system through front-loading budgets and pre-funding public and private providers. When this is not feasible, consider reimbursement mechanisms to compensate for loss of revenue.

Consider cash and voucher assistance targeted to health needs and indirect expenditures, to ensure people are still able to access essential health services, if cost is a barrier, and that the risk-benefit of such assistance has been evaluated. When households start losing income due to the lockdown measures, social cash transfers (multi-purpose cash) will also contribute to reduced financial barriers to access health services.

Key actions

Establish a system through front-loading budgets and pre-funding public and private providers, contracting and reimbursement mechanisms, equity funds or voucher systems

Consider cash and voucher assistance targeted to health needs and indirect expenditures

Negotiate with agencies implementing social cash transfers to include a proportion for health

Make access to health care independent of migration status

ACKNOWLEDGEMENT

This Interim Guidance was jointly developed by personnel of IASC member organizations and partners. In particular, we would like to thank: Graham Alabaster (UN-HABITAT), Raya Alchukr (UNFPA), Benedetta Allegranzi (WHO), Ida M. Ameda (UNICEF), Maya Ariei (UNICEF), Maaiké Arts (UNICEF), Joseph Ashmore (IOM), Ombretta Baggio (IFRC), April Baller (WHO), Amrish Baidjoe (ICRC), Federica Battista (FAO), Viorica Berdaga (UNICEF), Anjana Bhushan (WHO), Christine Brown (WHO), Gregory Bulit (UNICEF), Tatjana Buzeti (WHO), Maurizio Campailla (ICRC), Penelope Campbell (UNICEF), Simone Carter (UNICEF), William Carter (NRC), Alessandro Cassini (WHO), Jorge Castilla Echenique (WHO), Anirban Chatterjee (UNICEF), Kathleen Clark (IFRC), Anna Coates (WHO), Giorgio Cometto (WHO), Ana P Coutinho Rehse (WHO), Carla Daher

(UNICEF), Henia Dakkak (UNFPA), Fernando de Medina Rosales (NRC), Roger Dean (NRC), Filiep Decorte (UN-HABITAT), Sandra Del Pino (WHO), Anne Detjean (UNICEF), Charles Deutscher (ICRC), Janet V. Diaz (WHO), Hannah S. Dini (UNICEF), Gwendolen Eamer (IFRC), Jain Eijkenaar (UNICEF), Rene E. Ekpini (UNICEF), Zahra El Amine (WHO), Gabriele Fontana (UNICEF), Gregory Garras (UNHCR), Thomas George (UNICEF), Tasha Gill (UNICEF), Suvajee Good (WHO), Andre Griekspoor (WHO), Farah Husain (US-CDC), Aynur Kadıhasanoglu (IFRC), Catherine Kane (WHO), Sarah Karmin (UNICEF), Edward T. Kelley (WHO), Brigid Kennedy Pfister (UNICEF), Hyo Jeong Kim (WHO), Theadora Koller (WHO), Christine Knudsen (UN-HABITAT), Fernanda Lessa (WHO), Rosamund Lewis (WHO), Ramona Ludolph (WHO), Ruth Mabry (WHO), Sophie Maes (WHO), Allen Maina (UNHCR), Christopher Maher (WHO), Franck Mahoney (IFRC), Hani Mansourian (UNICEF), Claire Mariani (UNICEF), Rosanne Marchesich (FAO), Adelheid Marschang (WHO), Madison Moon (WHO), Naureen Naqvi (UNICEF), Carlos Navarro Colorado (UNICEF), Andre Peter Obat Mbala (IOM), Taiwo Oyelade (WHO), Maria C. Padoveze Fonseca (WHO), Boris Pavlin (WHO), Jerome Pfaffmann-Zambruni (UNICEF), Catherine Poulton (UNICEF), Daniela Raiman (UNHCR), Pryanka Relan (WHO), Sophie Reshamwalla (IFRC), Braeden Rogers (UNICEF), Anna Ronzoni (WHO), Marc Rubin (UNICEF), Paul Rutter (UNICEF), Sohel Saikat (WHO), Gina Samaan (WHO), Cecilia Sanchez Bodaz (UNICEF), Ela Serdaroglu (IFRC), Pramila Shrestha (WHO), Mirela Shuteriqi (ICVA), Princess Nothemba Simelela (WHO), Alice Simniceanu (WHO), Wan S. Sophonpanich (IOM), David Stewart (UNICEF), Soumya Swaminathan (WHO), Aicha Taybi (WHO), Antonio Torres (IOM), Nicole Valentine (WHO), Maria Van Kerkhove (WHO), Katelijn A.H. Vandemaele (WHO), Yaron Waldman (UNICEF), Kolitha P. Wickramage (IOM), Niluka Wijekoon Kannangarage (WHO), Alice Wimmer (IOM), Isabel Yordi (WHO), Teresa Zakaria (WHO), Zandile Zibwowa (WHO), Dominik Zenner (IOM).

For further correspondence on the guidance:

- FAO: Federica Battista (Federica.battista@fao.org)
- ICRC : Charles Deutscher (cdeutscher@icrc.org)
- IFRC: Gwendolen Eamer (gwen.eamer@ifrc.org)
- IOM: Alice Wimmer (awimmer@iom.int)
- NRC: William Carter (william.carter@nrc.no)
- UN-HABITAT: Filiep Decorte (decorte@un.org)
- UNICEF: Carlos Navarro Colorado (cnavarrocolorado@unicef.org)
- UNFPA: Henia Dakkak (dakkak@unfpa.org)
- UNHCR: Allen Maina (mainaa@unhcr.org)
- WHO: Teresa Zakaria (zakariat@who.int)

Annex 1.

Special Considerations for Covid-19 Outbreak Readiness and Response to support those who reside in Urban Informal Settlements and Slums

The global crisis caused by COVID-19 pandemic is likely to have severe health and socio-economic impacts on urban populations, particularly on the poorest of the poor, and those living in informal settlements and slums. Currently, around 56 per cent of the world's population- 4.4 billion- lives in cities, with over a billion living in slums and informal settlements. There are specific challenges and issues which arise due to exacerbating chronic vulnerabilities in these settings, which must be seen together with the health and socio-economic impact of COVID-19. The potential scale and impact of COVID-19 in these challenging environments, calls for urgency to enable us to be better prepared and ready to respond.

OBJECTIVES

It is of critical importance from a protection, gender and inclusion, human-rights and public health perspective, that people living in urban informal settlements and slums are included in all COVID-19 outbreak preparedness, response and recovery planning. This interim guidance is in alignment with the WHO COVID-19 Strategic Preparedness and Response Plan and WHO Technical guidance for COVID-19, and mainly targets the wider humanitarian/development community working in humanitarian situations. Those who are involved in the decision-making and implementation of multi-sectorial COVID-19 outbreak readiness and response activities, need to understand how to respond appropriately and effectively in the informal settlements in urban settings. It is not intended to be comprehensive and cross-references are made to other relevant IASC Guidance Notes and briefs.

SPECIAL CONSIDERATIONS FOR INFORMAL SETTLEMENTS

This Guidance, drawing from a brief developed by Social Science in Humanitarian Action Platform [\[link\]](#), sets out key considerations for protecting informal urban settlements from the spread and impacts of COVID-19. The guidance issued on "Scaling-Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Including Camps and Camp-Like Settings" [\[link\]](#) is also relevant but informal settlements need additional focus, as informal settlements have no formal management through a designated entities, their residents have a very diverse profile and they tend to be outside the scope of government responses due to their informal nature.

Main characteristics

Informal settlements and slums are unplanned. Many are overcrowded, both at the neighborhood and house level, with very limited public space, and lack access (or have limited access) to basic services such as affordable water, sanitation and health facilities. In informal settlements, housing and land tenure is often insecure with threats of eviction from landlords and from the local governments, which often prevent any interventions to improve the collective conditions. There is a need to pay particular attention to the needs of vulnerable groups identified, especially those in need of specific assistance and support in this crisis, including both medical and social vulnerabilities [\[link\]](#).

Many of the broader recommendations to protect from COVID-19 (to frequently wash hands, self-isolate and physical distancing) are almost impossible to implement. Lack of in-house access to water and sanitation services, coupled with household level overcrowding, make strict self-isolation or lockdowns extremely difficult. Slums are concentrations of urban poverty and consequently, slum dwellers have very limited capacity to manage socio-economic shocks. Staying home for the urban poor is often not a feasible option, as they live day-to-day, both for their work and access to food. Access to education is at the best of times, difficult for many young people in slums, is negatively impacted by the crisis.

The informality of these communities means they are not officially recognized by governments. Little data is available on their size and socio-economic profile, with statistics at city-level masking the inequities. This exclusion often translates into ignorance about the community, stigmatization, mutual distrust and exclusion of government-led responses. The reach of formal governance structures is limited, and residents have great difficulty in having their voice heard. Informal governance mechanisms are important, but they risk fragmentation and are often contested.

Aside from their apparent informality, many slums are highly organized, with well-established leadership structures. Informal settlements and slums tend to have a wide variety of community-based organizations each with their own level of legitimacy that often fill gaps in service provisions (ex. garbage collection, safety). These include women and youth groups, faith groups, traditional community structures, etc. Traditional leadership structures sometimes overlap with criminal or other groups. Understanding these complex relationships requires a good knowledge of their socio-cultural diversity, framed by their areas of origin and ethnicity. Larger slums are not homogeneous but can have several smaller "villages" with different customs and social behaviors.

Inhabitants of informal settlements and slums maintain strong links to their rural homes, sending revenue, and travelling frequently for work and social reasons. They will also return when sick, or to return their deceased relatives to the family home. This mobility often contributes greatly to the spreading of pandemics.

These challenges are further exacerbated for some inhabitants, due to their gender, age, disability, refugee or migrant status, sexual orientation, faith and other intersectional identity factors. Displaced persons often find informal settlements and slums the only affordable housing option when moving to urban areas. Special attention should be paid to youth and children, particularly child headed households, which may already be particularly vulnerable. Evidence from previous pandemics (as well as preliminary information from the COVID-19 outbreak) shows that several factors increase the risk of sexual and gender-based violence (SGBV) and harm to women, children and other vulnerable groups. In addition, many people who live in informal settlements are not able to work from home and so this raises issues with youth and children who are left at home, with lack of access to education and being vulnerable to violence.

The following are key special considerations for inclusion in national and local COVID-19 readiness and response operations:

Key principles for preparedness, response and recovery

1. Support community leaders to operationalize a preparedness and a response plan, mobilizing the assets and response capacity of all community-based organizations
2. Adopt an area-based integrated multi-sectoral response, that recognizes the spatial characteristics as well as social and cultural norms and power dynamics
3. Ensure that the new operational modalities in response to COVID 19 are relevant to and improve long term preparedness and risk reduction efforts
4. Prioritize emergency interventions that can be sustained and consolidated in the recovery phase

Data and assessments

5. Invest early in profiling informal settlements and slums, both in terms of its population (chronic and acute vulnerabilities – health, food security, income/expenditures, diverse socio-cultural profiles) and its spatial organization (ex. water, sanitation and solid waste points, markets, transport hubs)
6. Map the different self-organized groups and community-based organizations, their current roles and interrelations and their potential as assets in a humanitarian response
7. Support community-led data collection, building on local knowledge, ensuring ownership of the data collected and aggregation into local government-led databases and assessments
8. Map and monitor the relations and movements within and between specific informal settlements and slums communities and their areas of origin

Governance

9. Facilitate connections between formal and informal governance mechanisms (incl. local government – communities) to give voice to the urban poor and ensure they can help shape interventions
10. Harmonize the specific assets of existing community-based organizations for a more effective response, while aiming to strengthen inclusive representation
11. Assess the impact of the in-flow of resources during a crisis so they do not exacerbate tensions between different groups

Communication

12. Establish trust and ensure mutual understanding so people living in informal settlements fully understand the risks and are able to mobilize their communities to take all possible measures, while overcoming distrust in public messaging and to counter disinformation
13. Identify community leaders among different social groups and areas and leverage their influence to disseminate the right messages and information
14. Ensure that communication methods and messaging is sensitive to the diverse socio-cultural backgrounds in a specific settlement, translating material into the languages used, in multiple and accessible formats, including for people with hearing, visual and intellectual impairments and people with low literacy
15. Ensure feedback mechanisms on the feasibility of imposed mitigation measures and assistance are in place
16. Prepare and share public communication to address and prevent stigma and discrimination that can prevent people from seeking healthcare. Messaging about “high risk groups” should be sensitive to minimize negative impact on those groups

Access of basic and survival services in informal settlements

17. Work with local governments and service providers to rapidly scale-up affordable provision of safe water, sanitation and solid waste management, ensuring sufficient coverage, in light of likely increases in demand. Water utilities should be encouraged to extend service lines and to make water provision for free services, and work closely with informal service providers
18. Position adequate handwashing stations in strategic locations (ex. near toilets, markets, transport hubs, information centres, main entry and exit routes) and use them as main hubs for awareness raising around COVID-19

19. Devise strategies for food and water provision that consider that households may not have enough capacity for storage for several days and find creative ways to facilitate physical distancing (ex. dispersed mini-markets, home deliveries)
20. Monitor food insecurity and access to and affordability of nutritious food carefully and promote mitigation measures (ex. urban agriculture, replacement programmes for school feeding)
21. Focus on creative ways to provide children with alternatives to school and play, to mitigate school closures and restrictions on movements in the absence of community or household level space, which disrupt children's routine while also placing new stressors on caregivers. This should include early learning opportunities for the youngest, that may entail providing parenting tips and ideas for engaging their children at home

Shelter and settlements

22. Analyse the spatial set-up of the settlement to provide guidance on movement control, improved coverage of basic service provisions, alternative food distribution systems, etc.
23. Map spaces and buildings (ex. vacant buildings, hotels, schools, etc.) in or nearby informal settlements and slums that can be used for isolation of the most vulnerable, triage of potential cases and limited quarantine while also taking into consideration their current use
24. Provide low-cost options to facilitate isolation for low risk cases in single room dwellings considering options for partitioning

Livelihoods and mobility

25. Promote and tailor social safety nets to the reality of the informal settlements and slums (incl. very limited savings or capacity to save), ensuring access to health services, water and food, while being sensitive to internal inequalities as to avoid disruptive tensions
26. Prioritize cash-based assistance to help cover rent, utilities, and other housing related needs.
27. Make provisions so that essential informal services such as food selling, provision of water, hygienic articles, care for children, persons with disabilities, older persons, and those with illnesses, can be sustained in the safest possible way, including during lock down
28. Map movements between urban informal settlements and slums and rural areas of origin and consider working with local leaders and communities on both ends to implement control strategies, focusing also on transport hubs and points of entry

Protection

29. 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, with a focus also on health workers, service providers, etc
30. Monitor increases in community and household level tensions and violence carefully and work with community-based organizations and leaders to raise awareness and mitigate, paying attention to gender-based violence. Further guidance on addressing gender equality and women empowerment can be adapted from the [IASC Gender Alert](#)
31. Ensure that isolation of family members does not deprive people of their social support systems and coping mechanisms or exacerbate stigmatization, including the use of public health measures as a pretext to address the informal status of the settlement of slum.
32. Monitor the risk of possible evictions, as families risk to fail on rental payments, as marginalized members of the community, victims of the disease or health care providers risk to be stigmatized
33. Advocate for the suspension of all residential evictions for the duration of the health emergency since evictions can greatly heighten the risks of community transmission and work with governments to set up monitoring and intervention systems to avoid also informal evictions
34. Ensure any measures to quarantine or separate sick or vulnerable groups should be temporary, so they can return home once the risk is gone. Such guarantees will be essential to build community trust in quarantine measures, reducing the chances of resistance to these measures which could hinder protection and mitigation actions
35. Monitor the protection needs of pregnant women, gender-based violence survivors, indigenous people, refugees, migrants, internally displaced persons, people with disabilities and older people

[UN-Habitat COVID-19 Response \[link\]](#)

Annex 2. Rapid risk assessment for humanitarian emergencies and displaced population

Risk assessment involves three factors: the hazard i.e. SARS CoV-2, exposure and context. Based on current evidence, the hazard is assumed to be a constant. Thus, the difference in risk can be largely attributed to exposure and context elements.

Basic steps to conduct a rapid risk assessment:

1. Finalize risk questions based on current situation/site.
2. Assign a risk level for each question (green, yellow, red see table 2). This will be subjective but determined via consensus of key stakeholders.
3. Aggregate categories to obtain a composite score to determine overall risk level: minimal, minor, moderate, major, severe (See figure 1). This can be for an area (example, by camp or zone) or for the overall population.

The risk assessment identifies risks that can be effectively mitigated. The risk assessment should be closely coupled with mitigation actions and response plan. It should be reviewed or repeated whenever significant changes occur in transmission or in each risk component (i.e. influx of new arrivals, mutation in virus, etc.).

Table 1 provides key questions to consider in order to determine exposure and context risk levels. They are based on basic epidemiological data: who, what, where, when and how. These will need to be adapted and prioritized for each site as well as for the level of the assessors (health care, non-health care etc.).

Table 1. Risk characterization process



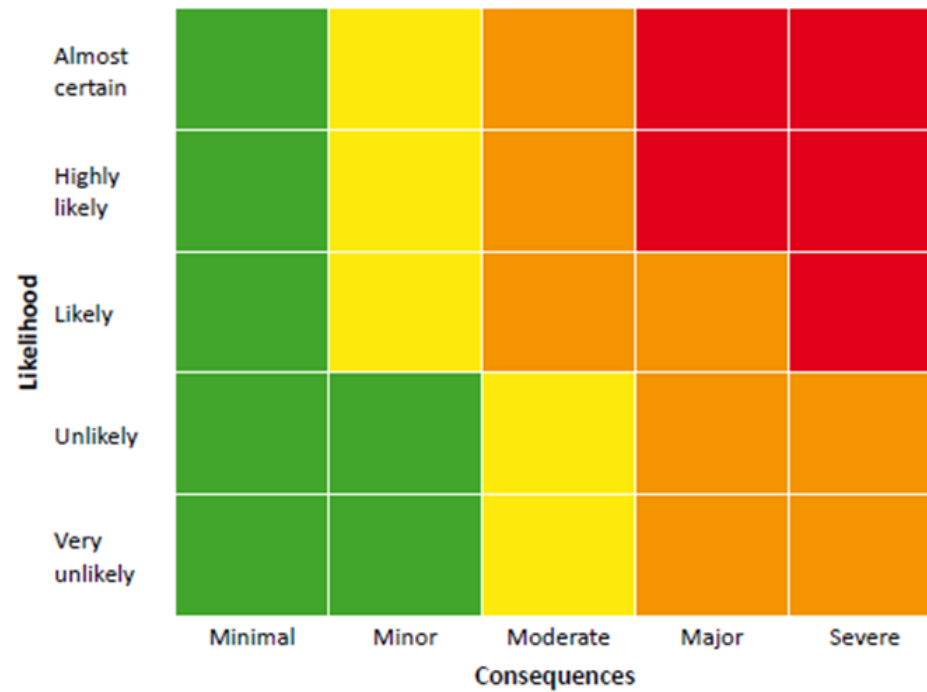
	Process			
	Hazard assessment/COVID 19	Exposure assessment	Context assessment (per site, district, camp, etc.)	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Operational and risk communication</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Inform response groups via regular meetings, public with IEC materials, radio jingles etc</p>	<ul style="list-style-type: none"> • What are clinical signs and symptoms? • Who is most vulnerable for COVID-19? Age group(s), sex or occupational group(s)? • How severe is the disease? • Is the disease preventable and how? Is there a vaccine? • What is the natural outcome of the disease? • Is there an effective treatment available? • What can be said about the rapidity of spread of disease? 	<ul style="list-style-type: none"> • Number of people likely to be susceptible? • New arrivals? From where? • Potential for transmission? • Number of people already affected? • Number of clusters of infection? • No. of HCWs infected? • Number of people dead/ CFR? • Number of immune-compromised people? HIV/TB? Malnutrition? Elderly? • Concurrent, ongoing outbreaks (cholera, measles, etc.)? 	<p>What is the national risk? How many confirmed cases/locations? Is there local transmission, particularly, among the host community?</p> <p>Is there an early warning alert and response (EWAR) surveillance system in place that can trigger quick alert notification for COVID-19 for the affected population?</p> <p>What is the population density? HH size?</p> <p>Is the site near high traffic/travel area (major airport, highway, bus, border)?</p> <p>What is the health system capacity? Available beds, isolation tents, staff, supplies, etc.?</p> <p>Is the area easily accessible? If there is a suspected case, how will it be verified/investigated?</p> <p>Is there access to adequate handwashing facilities at the household level?</p> <p>Are there cultural practices/traditions holidays/events which affect COVID transmission? Mass gatherings at funerals, weddings, etc.</p> <p>Are their known barriers to early health seeking behavior?</p> <p>Is there triage, referral, isolation procedures in place for suspected case?</p> <p>Are relevant surveillance/health staff trained on the use of case definitions, case management, isolation process?</p> <p>Is there an Identified RRT who can quickly conduct investigation and response among the population?</p> <p>Is there access to reference laboratories for COVID-19 testing?</p> <p>What is the transport and communication method between lab and health facility? Do you have adequate specimen collection, packaging and transportation supplies, PPE?</p> <p>Are there identified community members to support COVID 19 surveillance? Key informants, community volunteers, CHW, leaders, teachers, etc. who will assist with case detection, contact tracing and IEC?</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Risk monitoring and review</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Ongoing process of risk monitoring and review during the outbreak</p>
				
	<p>Risk characterization</p>			
				
<p>Risk mitigation action</p> <p>Select risks for mitigation actions, implement, review implementation</p>				

Table 2. Risk levels

Colour	Risk	Action
Green	Low	Managed according to standard surveillance response protocols
Yellow	Medium	Needs improvement, strengthening, additional control measures required (e.g. enhanced surveillance, isolation facilities, contact tracing)
Red	High	Immediate response required

Figure 1. Risk matrix with define boundaries to aid risk characterization process



Annex 3. COVID-19 case and contact definition

Case and contact definitions are based on the current available information and are regularly revised as new information accumulates. Countries may need to adapt case definitions depending on their local epidemiological situation and other factors. All countries are encouraged to publish definitions used online and in regular situation reports, and to document periodic updates to definitions which may affect the interpretation of surveillance data.

Suspect case

- A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset;
OR
- B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;
OR
- C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

- A. A suspect case for whom testing for the COVID-19 virus is inconclusive.
OR
- B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

- 1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes
- 2. Direct physical contact with a probable or confirmed case
- 3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment OR
- 4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after *the date on which the sample was taken* which led to confirmation.

Community case definition – example to be adapted

- 1. Fever + dry cough + difficulty in breathing OR
- 2. Unusual cluster of illnesses or deaths in a community