Global Working Group on Community Shielding

Situation Update #2: October 2020

Global COVID-19 Context in Humanitarian Crises

The reality of the COVID-19 pandemic within crisis settings remains unclear and presents challenges to the design and implementation of well-adapted responses. Due to limited data availability, much of the modeling done for humanitarian settings has relied on parameters from non-humanitarian contexts, mostly from high-income countries. **The expected numbers of cases and deaths however, have not materialized.** In addition, the limited number of seroprevalence surveys conducted thus far in humanitarian settings do not allow for drawing accurate conclusions as to the extent of the COVID-19 spread. Anecdotal reports in many humanitarian settings suggest a large number of disease-related events, such as attended deaths. These deaths within major population centers may potentially be compatible with COVID-19 disease[1], indicating that a large proportion of cases and deaths might not have been captured through official reporting.

Efforts to more concretely quantify the transmission and impact of the pandemic have been hampered by limited data. This might result from limited health system capacity, but also from health-seeking behaviours vis-à-vis COVID-19. Within Cox's Bazaar, research suggests that the limited number of reported cases have been due to an unwillingness of the Rohingya population to seek out testing or care due to negative perceptions of potential repercussions on the community[2]. Most of the laboratory-confirmed cases have been mild or asymptomatic suggesting that there potentially may be more undetected cases. **However, in well-monitored camp settings, it is unlikely that a COVID-19 surge in mortality could remain undetected**. Further research is underway to determine the extent of the pandemic within crises settings.

Key Learning: Context Relevant Shielding - Activation or Preparedness?

Transmission Risk Level

Determining the correct "activation" point for full compliance to green zone arrangements is not clear cut and requires the consideration of multiple factors. First assessing to the greatest extent possible how "at-risk" are the targeted community in terms of likelihood of virus transmission. Though it requires contextualization, one point of guidance is as soon as *a case is confirmed within a district, area, or equivalent*, the targeted camps or neighborhoods should be alerted to activate shielding as soon as possible. Alternatively, if shielding is not feasible for some reason, alerting of the cases and recommendation to ensure strict compliance to basic prevention measures especially for families with high-risk individuals. Ideally, a health actor is responsible for monitoring the situation and alerting the community directly or triggering the shielding lead agency in the area to share the alert to the community. Shielding generally should be activated before an outbreak or community level transmission is occurring in the area to minimize risk of infection for high risk individuals. However, in contrast to group shields with

[1] https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/covid-19/report-31-syria/
[2] https://www.acaps.org/sites/acaps/files/products/files/covid-19_explained_-_edition_7_the_stories_being_told.pdf

a high number of individuals, as long as shields are family level with one individual, the impact of a high-risk person shielding unknowingly with the virus is not greater than without shielding. With two family members shielding, the impact of one shielding individual being unknowingly infected (asymptomatic or pre-symptomatic) and shielding with another is higher, however the risk of this would be considered lower than the alternative of not shielding at all. To partially mitigate this, any shields with more than one person should have individuals tested prior to activating shielding if possible, or if not to ensure no one has symptoms or has been exposed to someone with the virus.

Perception of Risk and Willingness to Shield

In addition to the risk level as assessed by prevalence data or reported by a health actor, **the *perceived* risk level is also a critical factor determining to what extent people will comply with shielding** and the practices it entails. Having an understanding of this is important because it should not be assumed that because the risk level as reported by health data or health actors is moderate or high that the perception of the community is positively correlated. The risk perception or willingness to adopt prevention behaviors can be based on a combination of factors including a lack of knowledge on COVID, or because non-COVID related risk factors mean that COVID is de-prioritized.

Family commitment to complying with community shielding will be most effective when perception of risk is at least at a moderate level. Before any cases have been suspected or confirmed in an area, getting commitment from a family to activate the shielding arrangement would be difficult and potentially counterproductive; if activated too early, shielding can be exhausting for a family and they may disband the shielding arrangement before the risk level is high in their area, and then be exposed at a peak period later. The toll on well-being and potentially on family resources should be considered when advising on activation points and ensuring that community focal points are adequately trained to identify situations where shielding could inadvertently increase other risk factors for a family. To note also that the compliance to shielding and thus its efficacy depends primarily on the ability and willingness of families and individuals to adopt behavioral changes over an extended period of time. This can be enabled by humanitarian assistance including shelter support, soap provision, and distribution of disinfection kits however ultimately if families do not believe in the concept or do not have the resources to comply, “enabling” assistance will only contribute minimally. The **level of community buy-in, understanding and ownership over the approach will be influential** as well as the quality and scope of communication, activation alert and other pillars of shielding community implementation.

Case Studies: Lebanon and Yemen

Lebanon: Competing Crises and Hesitance to Shield

In Lebanon, the current economic and political upheaval and the ongoing humanitarian crisis exacerbated by the explosion in August, have meant that despite COVID-19 prevalence being high in the country with almost 40,000 cases confirmed at the end of September, the hesitation to adopt shielding is at least partially due to a focus on meeting basic needs for survival. Within Action Against Hunger’s (AAH) community shielding pilot project, **stigma was a predominant concern raised related to family-level shielding.** This is understood to be linked to fear of perception, (though unfounded), that self-isolating (shielding) families are *more exposed and present added risk* to the community, rather than if the entire community was being included within the shielding initiative. Respondents were also concerned on how the presence of one positive or suspected case could impact the whole community. **Concerns related**

to the impact on movement, access to income opportunities and tensions within communities were also raised as AAH engaged families and communities on the concept. All respondents in AAH's community consultations also refused the idea of placing older adults and people with underlying health conditions in a separate tent, due to concerns of leaving children alone and the inability to live without those family members. Focus group discussion participants did indicate however, they would be willing to separate those at highest-risk in a separate room inside the same tent, showing that similar to Yemen, family-level shielding is generally more accepted than community-level shielding among interviewed communities.

Yemen: Low Perceived Risk and Shielding Preparedness

In Yemen, the first case of COVID-19 was confirmed in Hadhramaut on April 10 and as of September 17, 2,023 cases have been confirmed (WHO), though the actual number is believed to be higher. While the true extent of prevalence is difficult to know due to limited surveillance and reporting mechanisms, **displaced populations, notably those in camps appear to have been spared for the time being.** Few cases have been confirmed in over 200 IDP sites managed by DRC, NRC, ACTED and IOM within the **ECHO-funded Yemen Displacement Response Consortium**, however the risk level should not be diminished; reporting, surveillance and health capacities in the country are weak and a second-wave could be on the horizon. DRC has found recently that people in IDP camps do not consider COVID-19 prevention as a priority for their families, due to the number of confirmed cases being low in the country and camp areas specifically, and because of other acute risks related to the humanitarian crisis. Notably including securing access to food, recovering from flooding, and concerns of existing and untreated chronic illnesses. In DRC-managed IDP sites targeted with shielding engagement, **60% of high-risk families self-reported to be shielding in family level monitoring in July,** however since then, risk perceptions appear to have decreased for the reasons previously mentioned. DRC's next monitoring phase in October will aid in confirming to what extent the previously shielding families continue to practice shielding behaviors, and will expand its focus from monitoring shielding compliance to include evaluating families' preparedness to shield in the future, and provide support as needed.

Despite the current perceived low-risk, shielding lead agencies in Yemen endeavor to maintain COVID-19 centered programming and continue to target high-risk families with prevention and shielding engagement. Even in areas where the risk level may not be high, community shielding efforts to train families and establish green zones are continuing with the aim of having family level green zones **agreed on and in place, ready to activate** with full compliance should infection risk be confirmed in a surrounding area. In NRC-managed IDP sites in Yemen, there has also been effort to address land agreement constraints in order for families to allocate green zone shelters to shield when the risk-level requires it. **For a family to be prepared to activate shielding**, they need to 1) have agreed as a family on the green zone arrangement, 2) know how to shield including IPC procedures and having a plan to support the shielding individual, and 3) know when to activate - as soon as a case is confirmed in the surrounding area or they are recommended to shield by a trusted health actor or humanitarian partner. IOM and DRC are also providing disinfection kits to high risk families, to enable compliance to prevention behaviors and to incentivize and support families to engage in shielding should the risk level of the virus increase and activation be recommended.

Please refer to the Global Community Shielding Working Group **Situation Update # 1 August 2020** for more information and related resources.