Actions for consideration in the care and protection of vulnerable population groups from COVID-19

Interim guidance

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World Health Organization
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1. Introduction

1.1 Background

In response to the novel coronavirus disease (COVID-19) outbreak, which was declared a public health emergency of international concern (PHEIC) and characterized as a pandemic, the World Health Organization (WHO) has developed this guidance for the health sector in the Western Pacific Region on how best to support vulnerable populations to prevent, prepare for and respond to possible community transmission of COVID-19. Vulnerable populations addressed in detail in this document include: people experiencing homelessness; people living in overcrowded housing, collective sites and slums; migrant workers; refugees; people with disabilities; people living in closed facilities; people living in remote locations (including highlands and island provinces); and people living in poverty and extreme poverty. The causes and impacts of vulnerabilities experienced by each group are described in further detail in each section and range from barriers of geographical, legal, language, financial or physical nature and many more – each contributing to unique needs for priority actions per population group. Population groups in situations of vulnerability vary across country contexts, and individuals may experience multiple vulnerabilities, potentially compounding barriers and impacts. Ethnic minorities, indigenous populations, and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) individuals are referred to in this guidance but may require further considerations.

It is crucial to recognize that adherence to WHO recommendations developed for the general population may not be feasible for people living in challenging circumstances or with limited resources. Vulnerable groups may have a higher risk of infection due to poorer baseline health status and fewer opportunities to seek care. They may have higher exposure to infection due to transient or crowded living conditions and face barriers to accessing sanitation. They also may be less likely to be reached with contextually appropriate and actionable information in local languages about protective measures and less able to carry them out. They may have less capacity for response to infection due to limited access to health and essential services, as well as unfavourable living conditions. People in such vulnerable groups may not be able to complain of symptoms or have atypical symptoms or may not be able to communicate their needs for care. When planning preparedness and responses to COVID-19, such considerations ensure recommendations are effective, accessible and acceptable to all, leaving no one behind. Annex 1 provides practical suggestions for ensuring WHO COVID-19 response recommendations are appropriate and accessible to vulnerable populations. Member States can use these suggestions to expand on this guidance in response to the specific vulnerable populations identified within their country.

1.2 Purpose and objectives

The purpose of this interim guidance is to minimize infection and spread of COVID-19 among vulnerable groups, with the specific objectives:

1. to work across sectors to ensure an enabling environment for vulnerable groups;
2. to strengthen surveillance to adequately measure and monitor the intensity, pattern and adverse impact of COVID-19 spread in vulnerable populations;
3. to prevent the stigmatization of vulnerable groups as a result of COVID-19; and
4. to engage and empower vulnerable groups in the response.

1.3 Intended audience

This guidance is intended for Member States, WHO country offices and relevant partners who are likely to differ between vulnerable groups. It describes actions to strengthen the care and protection of vulnerable people during community transmission of COVID-19. Actions should fit within national COVID-19 plans and be adapted to the needs and context of vulnerable groups.

2. Guiding principles

A COVID-19 response that recognizes and responds to the needs of vulnerable populations should be:

- country led,
- community owned,
- partnership driven,
- evidence informed,
- available, accessible, acceptable and of quality.

3. Priority areas

3.1 Establish an accessible and acceptable response

- Advocate for inclusion of vulnerable population groups in national COVID-19 prevention and response plans.
- Identify and partner with trusted, well-recognized community leaders for response development and implementation.
- Facilitate discussions between different stakeholders (including the people most affected by the outbreak) to identify the needs and challenges for preventing the spread of COVID-19, as well as to explore localized solutions.
- Leverage existing systems and mechanisms within communities to listen to community needs and drive effective response implementation.
- Perform risk assessments and map vulnerable groups to ensure response measures are accessible and acceptable, considering local behaviours, knowledge and practices.
- Review and adapt WHO-recommended basic protective measures against COVID-19 for the public to the specific needs of vulnerable groups (see Annex 1 for alternative solutions).
- Deliver essential supplies to communities, including basic medication for fever, food, safe water and hand hygiene stations.
- Train communities, service providers and other people working with vulnerable populations (including military personnel, police, village health volunteers and community health workers) on how to recognize symptoms, prevent infection and respond using a rights-based, gender-sensitive and culturally appropriate approach.
- Establish equitable and non-discriminatory alternatives to deliver medical care (mobile outreach clinics, eHealth) to people experiencing barriers to seeking health care. Services should consider how they can reach people, rather than how people can reach them.
- If acceptable and feasible, distribute resources to support safe home-based care, coupled with necessary personnel training, to enable sick individuals to recover within the home.
- Identify and address stigmatization and discrimination associated with vulnerable groups by ensuring service providers are trained appropriately.
- Coordinate with partner organizations that are already engaged with vulnerable groups to avoid duplication.
- Coordinate across United Nations agencies, governments and partners to provide livelihood support and food security to the most vulnerable.
- Ensure the integration of a human rights-based approach to decision-making, implementation and response.

3.2 Conduct surveillance and risk assessment

- Use multiple sources of information, including traditional surveillance systems and informal information, to identify cases, contacts, clusters and high-risk settings, as well as to monitor the intensity and pattern of COVID-19 spread in vulnerable populations in a manner that respects rights, is culturally sensitive and addresses the concerns (e.g. fear of detention) of marginalized populations.
- Develop and enhance community surveillance systems for direct reporting of events requiring investigation. Through strong community engagement, community surveillance should be viewed as a benefit in protecting the community.
- Enhance reporting and expand contact tracing in vulnerable populations by engaging and training staff and volunteers working at shelters, prisons and long-term care institutions. Ensure that this is not carried out in a targeted, discriminatory or coercive manner. Efforts should be made to engage, train and use contact tracers from the same or similar vulnerable population.
- Collect and report data disaggregated by at least sex and age on (a) tested individuals, (b) confirmed cases, (c) severity of disease, (d) underlying co-morbidities and other risk factors, (e) hospitalization rates, (f) recovery rates and (g) mortality rates.
- If possible, report data on important dimensions of inequality, including socioeconomic status, geographical location, ethnicity, migration status, gender identity and disability.
- Invest in research and intersectional gender, equity and rights-based analysis of data on the adverse social and economic impacts of COVID-19, including the measures taken to tackle the pandemic.

3.3 Empower and engage communities

- Work with communities to identify existing approaches to minimizing the impact of COVID-19.
- Strengthen community ownership of the COVID-19 response by identifying or establishing community engagement mechanisms that will facilitate the collection and analysis of community concerns, barriers experienced, needs and suggestions to secure localized solutions that can be integrated to further planning strategies.
- Invite and include community leaders or members of vulnerable population groups in relevant decision-making dialogues to identify and incorporate the voices of those communities most affected and most vulnerable to the outbreak in the development of COVID-19 response plans, strategies, policies and practices.
- Work together with communities through community leaders and government officials to develop and disseminate local and culturally appropriate guidance on COVID-19 preparedness at locations that are frequented by vulnerable groups, translated into relevant local languages.
- Identify leaders and influencers who are trusted voices for vulnerable communities and engage them to empower communities.
- Map and leverage existing community engagement networks to respond rapidly through trusted mechanisms.
- Build the capacity of community representatives, leaders and caregivers to disseminate information and facilitate dialogue based on specific needs of groups (including people with visual, hearing, intellectual and physical impairment). This includes advice on seeking timely health care, as well as preventive and protective measures. They can also collect and send community feedback from the subnational to the national level to inform response decision-making.
- Establish mechanisms to monitor and evaluate the effectiveness and appropriateness of community engagement for COVID-19.
- Coordinate with partner organizations when promoting mitigation strategies for better acceptance and improved compliance with recommendations among the target groups.

For further information, refer to *Role of Community Engagement in Situations of Extensive Community Transmission of COVID-19*.

4. Considerations and recommendations for specific vulnerable populations

4.1 People experiencing homelessness

Given their unique living conditions, people experiencing homelessness are considered particularly vulnerable to both contracting and spreading COVID-19.[1] Mass communication messages might not reach individuals living in these circumstances. Further, they may not have access to safe water or sanitation, preventing them from following general precautions to curb the population-level spread of COVID-19, such as frequent handwashing with safe water and soap.[2] They may also have reduced trust in authorities, requiring alternative contact channels.

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people experiencing homelessness:

- Facilitate local dialogue to identify and establish appropriate sites in the community to quarantine or isolate and care for mild COVID-19 patients, repurposing facilities with adequate basic infrastructure, including safe water, toilets, electricity, ventilation, laundry, waste and sewage disposal.[3]
- Refer them to safe temporary shelters or alternative care facilities with adequate water, sanitation and hygiene (WASH) areas separated by gender when possible. If available and acceptable to the individual. Consider repurposing convention centres, community centres, schools (if not presently operating) and other venues as shelters or alternative care facilities.[3]
    - Ensure hygiene products are available, including alcohol-based hand sanitizer, menstrual hygiene products, medical masks (or alternate cloth masks for the public), facial tissues and rubbish bags.
- Engage trusted community leaders or service providers to share information on key protective behaviours and capture community feedback to inform national decision-making.
- Ensure service providers are able to continue essential health services during community quarantine periods, including immunization.[4]
- Deliver aforementioned hygiene products to encampments and settlements (if shelters and alternative care facilities are unavailable), particularly in densely populated informal settlements in urban areas.[5]
- Establish accessible (WASH) areas in and around encampments, comprised of handwashing stations with safe water, soap and drying materials.[6] Clearly indicate when a water source is not suitable for drinking. When possible, separate facilities should be available by gender, well-lit and prioritize privacy.
- Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options.
- Pay attention to people affected by alcohol and other substance use disorders.

Additional resources include:

- *COVID-19 Guidance Note: Protecting Those Living in Homelessness*
- *Interim Guidance for Homeless Service Providers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)*
- *Mental Health and Psychosocial Considerations during the COVID-19 Outbreak*
- *Routine immunization services during the COVID-19 pandemic*

4.2 People living in overcrowded housing, collective sites and slums

The risk for COVID-19 may be higher for people living in camps and camp-like contexts (referred to as collective sites), overcrowded housing and slums.[7] Physical distancing may be difficult to achieve in settings where overcrowding is common and frequent movement of individuals occurs between dwellings.[8] Often, families living in overcrowded conditions and collective sites share one or two bedrooms, have limited or no access to water and share common toilet facilities with a large household or the community. People living in informal settlements and slums may be more likely to mistrust government, which can enable rumours and misinformation to spread across communities. Individuals may lose all income without access to social protection that is only available for those in the formal labour sector. Importantly, people living in overcrowded housing, collective sites and slums face intersecting socioeconomic barriers that risk being exacerbated by COVID-19 and can also exacerbate the spread of COVID-19. These challenges include pre-existing health conditions (e.g. chronic illnesses such as diabetes, diseases such as tuberculosis and dengue, and mental health conditions), safety and injury risks (e.g. violence and unsafe infrastructure), and environmental risks (e.g. floods, drought or typhoons).

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people living in overcrowded housing, collective sites and slums:

- Develop a contingency plan in the event a COVID-19 case is confirmed at an overcrowded site, including identifying individuals at highest risk of serious complications, mapping out local aid organizations involved in the COVID-19 response and designating community areas for isolation and quarantine.
  - Consider isolation of affected areas at the local boundary level (such as a neighborhood or slum) when confirmed cases reach a certain threshold to prevent large-scale community transmission.
- Establish or enhance inter-agency and intersectoral referral pathways to ensure that children and families with other concerns, such as protection or survival needs, can access needed services promptly.
- Ensure that people in overcrowded housing have easy access to the core recommendations for home care of people with mild COVID-19 symptoms.[9] Decongesting living conditions through alternate housing options (hotels, etc.) and/or the use of community quarantine and isolation facilities may be necessary for optimal results. For household members in overcrowded housing where at least one person presents with mild symptoms:
  - If possible, stay in a separate room or maintain a distance of at least 1 metre from the person(s) presenting with symptoms. For example, sleep in separate beds. Also, when symptomatic people leave their room such as to use the bathroom, ensure they wear a mask and perform hand hygiene beforehand.
  - If not possible, use sheets, curtains or other temporary barriers to divide off an area for the sick person(s) to stay within. If using sheets or curtains, leave 1 metre between the bed and the barrier, where possible, and wash them regularly.
  - If a separate bathroom is not available, consider whether they can use alternate options such as a pit latrine. If there is only one bathroom, clean it rigorously with detergent and household disinfectant (wipe down toilet, seat, all handles, basin, etc.) after it is used by the sick person(s).
  - Limit the number of caregivers by assigning one person who is in good health with no underlying conditions.
  - Practise hand hygiene after any type of contact with the symptomatic person(s), as well as before and after preparing food, before eating, and after using the toilet, making sure to wash hands with soap and water whenever hands are visibly dirty.
  - Use gloves and protective clothing (e.g. plastic aprons and alternatives such as plastic bags to cover hands or larger bin liners cut out to be a clothing cover) when

cleaning surfaces or handling clothing or linen soiled with body fluids. If unable to use protective clothing or gloves, practise hand hygiene after these activities. Launder used cleaning cloths before reuse or dispose of them in a sealed bag placed with other home waste for removal.
  - Use dedicated linen and eating utensils for the sick person(s). Clean these with soap and water after use.
  - Avoid other types of exposure to contaminated items from the immediate environment of the sick person(s). Do not share toothbrushes, cigarettes, eating utensils, dishes, drinks, towels, washcloths and bed linen, etc.
- Create financial grants for community-led initiatives to leverage community assets (people's capacities and abilities) and support economic activities and income generation during preparedness and response of COVID-19 in overcrowded housing communities, informal settlements or slums (e.g. soap-making from local materials, cloth mask production, sanitizer production, meal preparation and waste management).[10]
- Collaborate with relevant sectors (labour, social development, finance) to rapidly develop and deploy an emergency social protection scheme for people who have lost their income in the informal sector.[10]
- Deliver hygiene products to collective sites and slums, including alcohol-based hand sanitizer, menstrual hygiene products, medical masks (or alternate cloth masks for the public), facial tissues, menstrual hygiene products and rubbish bags, particularly in densely populated informal settlements or slums in urban areas.[5]
- Establish accessible WASH areas in and around encampments and slums, comprised of handwashing stations with safe water, soap and drying materials.[6] To reduce the risk of gender-based violence, establish separate washing and isolation areas for men and women that are well-lit and ensure privacy.
- Facilitate local dialogue to identify and establish appropriate sites in the community to quarantine, isolate or care for mild COVID-19 patients, repurposing facilities with adequate basic infrastructure including safe water, toilets, electricity, outlets to charge cell phones, ventilation, laundry, and waste and sewage disposal.[3]
- Engage trusted community leaders or service providers to share information on key protective behaviours and capture community feedback to inform national decision-making; ideally community leaders should be from the population group themselves.
- Ensure access to essential and routine medical services, considering options such as mobile clinics.
- Ensure that accurate information about COVID-19 is readily available and accessible.
- Pay attention to people affected by alcohol and other substance use disorders.
- Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options, and disseminate information on helpful coping strategies.
- Address the mental health and basic needs of people with pre-existing mental health conditions.

Additional resources include:

- *Home Care for Patients with COVID-19 Presenting with Mild Symptoms and Management of Their Contacts*
- *Interim Guidance: Scaling-Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations, Including Camps and Camp-Like Settings*
- *Key Messages: COVID and Informal Settlements*
- *Key Considerations: COVID-19 in Informal Urban Settlements*
- *Handwashing Compendium for Low Resource Settings: A Living Document*
- *Mental Health and Psychosocial Support Aspects of the COVID-19 Response*

4.3 Refugees

Refugees may live under conditions that make them particularly vulnerable to respiratory infections, including COVID-19. These include situations such as overcrowded living and precarious working conditions that impact physical and mental health and well-being due to lack of housing, food and safe water.[11] Barriers to accessing health services increase their health risks, stemming from stigma, language barriers, physical or legal barriers, and administrative and financial obstacles.[12]

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of refugees:

- Advocate for the inclusion and non-discriminatory access of refugees to public health services, ensuring equal access to information, as well as affordable testing and health care, regardless of immigration status.[12]
- Work with members of refugee communities to ensure public risk communication resources are translated into the language of local refugee populations, with checks for accuracy and cultural relevance.[12]
- Approach and invite trusted actors of relevance to local refugee populations to deliver key health messages, including community-based organizations and ethnic or faith-based media, and to capture community feedback to inform national decision-making.[7]
- Work with faith-based community leaders if beliefs of a community prevent or conflict with recommended behaviours or advice to identify and disseminate appropriate grounds-up solutions.
- Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options.
- Ensure refugees have access to quarantine and isolation facilities; consider repurposing facilities with the recommended attributes in 4.1.

Additional resources include:

- *Interim Guidance for Refugee and Migrant Health in Relation to COVID-19 in the WHO European Region*
- *Preparedness, Prevention and Control of Coronavirus Disease (COVID-19) for Refugees and Migrants in Non-camp Settings*

4.4 Migrant Workers

Similar to refugee populations, foreign migrant workers may live in overcrowded housing such as dormitories and face challenges to accessing health services as a result of language, stigma, physical or financial barriers.[11,12] Stigma may result in individuals hiding symptoms of their illness to avoid discrimination, delay individuals from seeking health care or prevent individuals from taking up promoted health behaviours.[13] Since the start of the COVID-19 pandemic, countries have also seen the return of foreign migrants, in some cases tens of thousands of individuals.[14] This may increase the potential for importing COVID-19 and cause large crowds at points of entry into countries. Once across the point of entry, returning migrant workers may disperse across the country, including to remote areas.

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of migrants (foreign and overseas workers or returning migrant worker):

- Ensure migrant workers are informed of and able to access national health-care initiatives through established pathways of care and have equal access to testing.[12]
- Work with members of the migrant community to ensure public risk communication resources are translated into the language of local migrant populations, with checks for accuracy and cultural relevance.[9]

- Ensure information about prevention, symptoms and how to seek care are accessible to foreign migrant workers. If most information and guidance is online or on mobile apps, consider Wi-Fi availability in housing or dormitories, access to smartphones or computers, and alternative methods of disseminating information such as posters, radio programmes or trained volunteers who speak the language(s) of the migrant worker community for one-on-one education.
- For optimal results, decongest living conditions such as dormitories, if necessary.
- Ensure materials, products and communication depict diverse ethnic groups and populations affected by COVID-19 to prevent stigmatization of migrants.[13]
- Encourage balanced national reporting that combats misinformation, stereotypes and stigmatization by distributing and broadcasting contextualized evidence-based information.[13]
- For returning migrant workers and overseas foreign workers:
  - Support the establishment of COVID-19 screening and information stations at major points of entry (borders) and spaces that migrants visit often, building capacity of staff working at points of entry and providing guidance on screening and management of unwell travellers. Put in place safeguards to ensure non-discrimination and non-stigmatization when screening at borders.[15]
  - Ensure infection control measures are met at border crossings such as physical distancing in all areas and accessible supplies for hand hygiene.
  - Request quarantine at designated facilities or stringent, supervised home quarantine for 14 days from the date of border crossing with self-monitoring and instructions for reporting onset of signs and symptoms.
  - Ensure clear appropriate guidelines on infection prevention and control for home and/or facility-based quarantine are available and disseminated at border crossings, ensuring individuals understand the criteria set out by the national quarantine agencies. When possible, disperse the same information across the country to community leaders, local governments and so forth to ensure local availability when migrant workers reach their final destination.
  - For major influxes of returning foreign migrants, consider operationalizing field quarantine facilities through schools (if not in operation), sports facilities such as gymnasiums, hotels and other venues. Leverage existing networks and repurposed staff such as the military or police, with plans for provision of food and medicine.
  - Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options.

Additional resources include:

- *Interim Guidance for Refugee and Migrant Health in Relation to COVID-19 in the WHO European Region*
- *Preparedness, Prevention and Control of Coronavirus Disease (COVID-19) for Refugees and Migrants in Non-camp Settings*
- *COVID-19 and the Human Rights of Migrants: Guidance*

4.5 People with disabilities

People with disabilities may be at greater risk of contracting COVID-19 due to a variety of factors. These include barriers to basic hygiene measures such as handwashing, difficulty enacting physical distancing because of additional support needs, the need to obtain information from their environment through touch and barriers to accessing public health information.[16] Furthermore, people with disabilities may be at greater risk of developing more severe illness from COVID-19 or potential co-infection if they have underlying health conditions related to respiratory function, immune system function, heart disease, diabetes or other conditions.[17] Redirecting health resources towards the COVID-19 response may disrupt other routine health services that people with disabilities rely on, causing individuals to be disproportionately impacted and experience greater marginalization.[11]

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people with disabilities:

- Work with appropriate partners (such as relevant nongovernmental organizations, community representatives and disabled people's organizations) to develop and disseminate advice on protective behaviours that considers the unique circumstances of people with different kinds of disability.
- Ensure products are easy to read and comprehensible for people with intellectual disability or cognitive impairment.[16]
- Ensure products can be adapted for use by people with neurocognitive impairments, including people who are unable to complain of symptoms.
- Ensure COVID-19 hotlines are available in multiple formats, including telephone and email, for people with disabilities to communicate with health service providers to ask questions and raise concerns.[16] Alternatively, identify community focal points for people to speak to in person if they do not have access to technology.
- Include simultaneous interpretation into the locally relevant sign language and transcripts during press conferences and major announcements.[16]
- Promote alternative avenues of minimal contact for people with disabilities to access food and medication, including online telehealth, orders and delivery.[17]
- Ensure formal and informal caregivers of people with disabilities are considered part of the essential workforce and exempted from curfews and other movement restrictions that may affect the continued provision of support services.[16]
- Encourage caregivers of people with disabilities to minimize contact with others as much as possible. In the case of institutional caregivers, ensure they are only working in designated locations – one, if possible – to prevent cross-contamination across institutions.
- If caregivers need to be moved into quarantine, make plans to ensure continued assistance for people with disabilities who need care and support.
- Support people with disabilities and caregivers to develop contingency measures in case caregivers are unable provide regular support services due to workforce shortages or heightened risk of infection.[18]
- Prioritize caregivers for people with disabilities for access to no-cost personal protective equipment, including masks, aprons, gloves and hand sanitizer, as well as free access to health care, including testing if symptomatic.[20]

Additional resources include:

  - *Disability Considerations during the COVID-19 Outbreak*
  - *Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines*
  - *Policy Brief: A Disability-Inclusive Response to COVID-19*
  - *Toward a Disability-Inclusive COVID-19 Response: 10 Recommendations from the International Disability Alliance*

4.6 People living in closed facilities

People living in closed facilities, including prisons and detention centres, are especially vulnerable to both contracting and spreading COVID-19. Alongside the generally poor and unsanitary conditions prevalent in such facilities, many closed facilities are overcrowded, have limited ventilation and extreme temperatures, and offer insufficient supplies for maintaining personal hygiene[20] – all of which are conditions that may heighten the risk of COVID-19. Protecting people living in closed facilities is not only crucial for those specific communities, but it is also paramount to ensure the effectiveness of national COVID-19 responses. Data suggest that without adequate testing, treatment and care in closed facilities, efforts to control COVID-19 in the general population may fail.[21]

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people living in closed facilities:

- Build capacity among facility staff to safeguard the humane treatment of those under their care, including proactively providing transparent communication for COVID-19, enhancing access to communication with families, ensuring access to needed health care, and preventing the misuse or misperception of isolation as a form of punishment.[3]
- Inform decision-makers and staff working at closed facilities on the importance of respiratory and hand hygiene[11] to prevent the spread of COVID-19, as well as the importance of adequate waste management and environmental cleaning (sanitation and disinfection).[21]
- Encourage facilities to modify or restrict visitor policies to closed facilities. Consider increasing the availability of other forms of communication to those outside the facility such as telephone or video calls.
- Encourage facilities to conduct regular symptom and temperature monitoring of workers, visitors and residents, for example on entry to the facility or on a routine daily basis (closed facility).[21]
- Encourage facilities to adopt measures that could ensure for at least 1-metre spacing between each bed. Examples include organizing head-to-feet sleeping arrangements or placing barriers between beds, if available.
- Stagger mealtimes to ensure physical distancing is still met in food halls as needed.[21]
- Consider expanding isolation or treatment wards of facilities to accommodate for surges in capacity needs.

Additional resources include:

  - *Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention*
  - *Interim Guidance: COVID-19: Focus on Persons Deprived of Their Liberty*

Closed facilities may also include nursing homes or care facilities providing residential care for older people or people with neurocognitive impairments and other communal living arrangements for older people. For further information on COVID-19 and the aged care sector, refer to:

  - *Guidance on COVID-19 for the Care of Older People and People Living in Long-Term Care Facilities, Other Non-acute Care Facilities and Home Care*

4.7 People living in remote locations

People living in remote locations may be at greater risk of acquiring and spreading COVID-19 due to barriers accessing up-to-date health information in a timely manner, exercising basic protective measures and accessing health-care facilities. For example, remote locations often lack infrastructure, such as handwashing facilities, that would enable hand hygiene.[22] Similarly, people living in remote locations may experience physical barriers (distance), financial barriers (cost of transportation) or language barriers (minority populations) that hinder them from seeking care early. Returning migrant workers may also disperse after points of entry to remote areas of countries unless restricted. These populations may also be less easily reached through standard communication channels.

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people living in remote locations:

- Advocate national COVID-19 risk communication strategies to include plans to disseminate information to people living in remote locations using context-based delivery approaches and culturally appropriate messages.[23]
- In remote locations where there are barriers to accessing safe water and soap, encourage use of alternative water sources (e.g. boiled water from cooking/seawater) and culturally appropriate, locally available friction-generating materials to assist with hand hygiene practices (e.g. sand, ash, indigenous flora, fibrous substances such as coconut husk or tree bark).[24]

- Explore the possibility of implementing alternative or innovative ways to deliver medical care to persons living in remote locations such as mobile outreach clinics, village health volunteers, community health workers and eHealth. Seek existing and potential partners for implementation.
- Where possible, organize systems to connect patients with severe COVID-19 symptoms with medical care (e.g. deployment of medical doctors or community nurses and partnerships with local taxi/motorcycle taxi services).

4.8 People living in poverty or extreme poverty

Often, many of the protective measures recommended to the public during infectious disease outbreaks are not useful or applicable to people living in poverty or extreme poverty. People who cannot afford formal housing or single-parent households may experience difficulties in practising physical distancing to protect themselves from getting infected or self-isolating to protect others.[11] Similarly, for people living in poverty or extreme poverty who do not have access to clean drinking water, it is unlikely that they will have access to safe water to wash their hands frequently. Even where some of these behaviours are possible, mass communication methods (e.g. through television or social media) are less likely to reach these audiences, preventing access to information on how to keep safe. There may be limited trust in authorities, further preventing the uptake of guidance. Individuals earning income through the informal economy are often paid low wages, work in dangerous conditions and lack any form of social security or welfare safety net. COVID-19 has caused a sudden and significant decrease of jobs in the informal sector, exposing individuals and their families to greater levels of financial insecurity and poverty.

The following recommendations can guide the health sector in developing a COVID-19 response that meets the needs of people living in poverty or extreme poverty:

- Ensure that messaging, information and education is available at appropriate literacy levels and accessible in non-digital formats to reach all communities.
- Provide people living in poverty or extreme poverty with safe water, soap, masks, facial tissues, menstrual hygiene products, thermometers, hygiene kits, hand sanitizer and other basic supplies, particularly in dense, deprived and informal settlements across cities.[3]
- Establish temporary handwashing stations in key locations of poor neighbourhoods, including in high-density public places such as markets and bus stations.[6] To reduce the risk of gender-based violence, establish separate washing areas for men and women.
- Seek support from local nongovernmental organization existing and or existing networks to actively engage community leaders and groups and train them to manage handwashing facilities, disseminate information about COVID-19 and ensure community feedback informs national decision-making.[25]
- Engage with the community in poor neighbourhoods to identify, prepare and manage alternative self-isolation facilities to care for those with mild COVID-19 symptoms to prevent further transmission.[25]
- Provide technical guidance for local authorities and community health workers to support with processes that enable isolation, such as making non-clinical spaces for isolation available to communities and directing individuals with mild symptoms to these spaces.[26]
- Provide communities with financial reimbursement for medical care visits, particularly in dense, deprived and informal settlements across cities.[26]
- Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options.
- Coordinate with different sectors and existing partner networks to ensure the delivery of provisions for families who fall into poverty due to COVID-19.

4.9 Intersecting and compounding vulnerabilities

Individuals living in vulnerable situations may correspond to multiple populations included in this document or vulnerabilities beyond the scope of the guidance. For example, people experiencing homelessness are also likely to be living in extreme poverty, remote communities may comprise indigenous or ethnic minority populations, LGBTQI individuals may be members of any of these populations, and so forth. Intersections between populations may create unique and additional barriers for individuals to remain safe during the COVID-19 pandemic. Priority actions listed throughout this document may require advocating the needs of vulnerable populations. For a practical guide to successful advocacy, refer to *Stop the Global Epidemic of Chronic Disease* and others.[27] A community-centred and -owned approach, specific to the unique context of any vulnerable population will be vital to ensuring the complex needs of the most vulnerable are met.

Countries may have additional vulnerable populations not mentioned in this guidance, and the COVID-19 pandemic may cause the emergence of new vulnerable groups or exacerbate conditions for existing vulnerable groups. Many risk factors and risk mitigation strategies referenced may be relevant when developing response plans for other populations. For example, tribal and indigenous families often live in multigenerational households, which may expose them to similar COVID-19 risk factors as people living in overcrowding housing. LGBTQI individuals may face stigma or fear in reporting symptoms or receiving care, complicating contact tracing or access to services, similar to aforementioned challenges for foreign migrants or refugees. Individuals with pre-existing medical conditions including noncommunicable diseases (e.g. cardiovascular disease, hypertension, diabetes, chronic respiratory disease and cancer) are at an increased risk of developing severe disease. Individuals with pre-existing mental health and substance use conditions, noncommunicable diseases or communicable diseases (such as HIV and tuberculosis) may face challenges to accessing routine care, similar to people with disabilities. Recommendations around caregiver contingency measures may be helpful in developing COVID-19 action plans. Emergency situations can exacerbate existing gender inequalities, increasing the risk of violence against women and girls in the home and community. Restrictions on movement, a lack of basic services, reduced health workforce, and weakened social and protective networks create an environment where women and children are at heightened risk. Annex 1 may be used to tailor this guidance to match the context and needs of vulnerable populations in a country.

5. Guidance development

5.1 Acknowledgements

This document was developed in consultation with WHO country offices by a guideline development group composed of staff from the WHO Regional Office for the Western Pacific (Division of Healthy Environments and Populations and WHO Health Emergencies Programme, in particular the Incident Management Support Team).

5.2 Guidance development methods

This document was developed based on a review of relevant literature and guidance on vulnerable populations. A rapid literature search was conducted using the following search terms: coronavirus; homelessness; slums; overcrowding; temporary housing; migrant; refugee; disability; prisons; care facilities; remote communities; isolated communities; poverty; low socioeconomic status. Grey literature was identified through the WHO digital library IRIS, repositories of other United Nations organizations, and the websites of other global and regional partners. Relevant academic literature was identified through MEDLINE and PubMed searches. The guideline development group reached consensus on the recommendations through group discussion for guidance relevant to limited resource settings and vulnerable populations.

5.3 Declaration of interests

Interests have been declared in line with WHO policy, and no conflicts of interest were identified from any of the contributors. All guideline development group members completed a standard WHO Declaration of Interests before participating in any activities related to the development of the guidance. All findings from the statements received were managed in accordance with the WHO guidelines on a case-by-case basis.

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Annex. Short- and long-term strategies to address barriers hindering vulnerable groups from adopting WHO-recommended basic protective measures against COVID-19

In early 2020, WHO published a set of recommended basic protective measures against the new coronavirus for the public. Due to the particular circumstances of vulnerable groups, however, many of these recommended measures are not relevant or realistic. As a result, many people find themselves with less agency to comply with the recommendations. For example, people living in poverty or extreme poverty who cannot afford to live in formal housing, or who currently live in multifamily/crowded households, will often experience a difficult time both practising physical distancing to protect themselves from getting sick and self-isolating to prevent others from getting sick. Similarly, for refugees or migrants who cannot afford safe water to drink, it is unlikely that they will attain safe water to wash their hands frequently. Adapting the COVID-19 measures and response to the contexts and needs of vulnerable populations is not only important for ensuring a more equitable impact, but research from previous epidemics show that, unless the outbreak is controlled within those groups most affected by the outbreak, national efforts will likely fail as well.

By presenting findings of an analysis based on global WHO-recommended basic protective measures against the novel coronavirus, the table below hopes to inspire similar analyses carried out at national and local levels to establish how to best adapt the COVID-19 response to the contexts and needs of vulnerable populations. Specifically, the table aims:

- to highlight the vulnerable populations with less agency to comply with WHO-recommended basic protective measures against COVID-19 for the public;
- to highlight the potential barriers that may hinder vulnerable populations from exercising basic protective measures against COVID-19; and
- to provide context-based short-term strategies that may mitigate the identified barriers and long-term strategies that may address the wider structural determinants creating these barriers.

When feasible, it is recommended that similar types of analysis be conducted in *all* settings.

Intended audience: Member States, WHO country offices and partners across the Western Pacific Region working on the COVID-19 response

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
Wash hands or perform hand hygiene.	That there is safe water, soap, drying materials and hand sanitizer available. That all people have physical and financial access to safe water, soap, drying materials and hand sanitizer. That all people are physically able to wash their hands or perform hand hygiene.	People experiencing homelessness and people living in slums People living in poverty or extreme poverty People living in remote locations Refugees and migrants People with disabilities People living in closed facilities	People have not received clear, accurate and culturally appropriate information on how to protect themselves from acquiring or transmitting the virus. No availability of safe water in areas where people live. No availability of soap, hand sanitizer or drying materials in areas where people live. People do not have access to safe water, soap, hand sanitizer or drying materials due to: • Physical barriers Movement restrictions prevent people from going outside to get water/soap/hand sanitizer. • Financial barriers People working in informal economies do not have constant income.	Develop a tailored community public information and/or community engagement campaign targeting those most profoundly affected by COVID-19 to provide clear, accurate and culturally appropriate information on how to protect from acquiring or transmitting the virus. Provide communities with safe water, soap, hand sanitizer, drying materials, hygiene kits and other basic supplies, particularly in dense, deprived, and informal settlements across different cities.[a] Disseminate information on low-cost approaches for hand sanitation, such as guidance for local production of handrub formulation.[b,c,d] Encourage the use of traditional culturally and locally appropriate friction-generating material (sand, ash, borax, soil, coconut fibre, indigenous flora, etc.).[a] Encourage the use of alternative water sources (boiled water, rainwater, river water, seawater, etc.).[a] Clearly communicate that alternative sources of handwashing water may not be fit for human consumption.	Invest in the necessary infrastructure to deliver the prerequisites for sustainable water, sanitation and hygiene (WASH) services that are appropriate and acceptable to vulnerable groups.[a] Work with the community and stakeholders to ensure that the delivery of WASH services is reliable and meets community needs, including continuity and sustainability. Seek support from nongovernmental organizations to encourage community-level identification, collection or production of friction-generating material from locally available material.[a]

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
			• Organizational barriers Prisoners are not allowed to wash their hands when they need to. Available handwashing stations have not been adapted to the needs of people with disabilities.	Establish *accessible* handwashing/hand hygiene stations in key locations in informal settlements and high-density public places such as markets and bus stations. Actively engage community or other influential leaders and groups through existing networks (e.g. faith-based, women's or grassroots groups) and train them to manage handwashing/hand hygiene facilities and to disseminate information about COVID-19. Using interim WHO guidance, build capacity among prison/detention centre decision-makers, personnel (health-care and social workers) and people living in closed facilities on preparedness, prevention and control of COVID-19 in prisons and other places of detention.[e]	Work across sectors to ensure that disadvantaged communities have the critical inputs for safeguarding health, especially during situations of emergency.[f]

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
Maintain physical distancing, quarantine and isolation.	That people live in housing. That people live in housing that is big enough to allow for physical distancing. That people live with at least 1 metre between them and the next person within any living situation (including those experiencing homelessness, etc.). That people can survive without continuing to work. That people living in prisons or other places of detention have a choice to observe physical distancing. That people with disabilities can survive in isolation without outside support.	People experiencing homelessness and people living in slums People living in poverty or extreme poverty Refugees and migrants People living in closed facilities People living in remote locations People with disabilities	People have not received clear, accurate and culturally appropriate information on how to protect themselves from acquiring or transmitting the virus. People do not live in formal housing (i.e. people experiencing homelessness). In dormitories or intergenerational housing, there is not enough space inside or outside housing to keep at least 1 metre between people. People are unable to observe physical distancing because of financial barriers (i.e. they have to continue going to work to maintain a steady income). People living in prisons or other places of detention do not have the freedom to choose physical distancing or to self-isolate.	Develop a tailored community public information and/or community engagement campaign targeting those most profoundly affected by COVID-19 to provide clear, accurate and culturally appropriate information on how to take care of sick individuals at home or shared living facilities and how to observe physical distancing. Engage with the community to identify, prepare and manage alternative self-isolation facilities to care for those with mild symptoms to prevent further transmission. Provide technical guidance for local authorities and community health workers to support with processes that enable isolation, such as making non-clinical spaces for isolation available to communities and directing individuals with mild symptoms to these spaces. Using interim WHO guidance, build capacity among prison/detention centre decision-maker, personnel (i.e. health-care and social workers) and people living in closed facilities on preparedness, prevention and control of COVID-19 in prisons and other places of detention.[e]	Advocate not applying fees and charges associated with breaking quarantine to women and/or children leaving dangerous households. Advocate the provision and expansion of sick pay/leave across sectors.[f] Promote intersectoral action to deploy and expand existing safety nets, such as cash transfer programmes, to provide temporary relief for households whose incomes have been impacted during emergency situations. Advocate the provision of adequate housing (temporary and permanent) with access to water and sanitation, including emergency housing. Advocate not -levying punishment

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
			Some people with disabilities are unable to survive in isolation alone; caregivers may be required for meals, daily activities and other care.	Ensure appropriate monitoring of isolation mechanisms/procedures so that people with disabilities who may not be able to voice their concerns during isolation are protected from potential harm or abuse.	against those with no or inadequate housing.
Avoid touching eyes, nose and mouth.	That all people have received clear, accurate and culturally appropriate information on how to protect themselves from acquiring or transmitting the virus.	People experiencing homelessness and people living in slums People living in poverty or extreme poverty People living in remote locations Refugees and migrants People living in closed facilities People with disabilities	People have not received clear, accurate and culturally appropriate information on how to protect themselves from acquiring or transmitting the virus. People using masks who are at risk of touching their eyes, nose and mouth more when putting on and taking off the masks.	Develop a tailored community public information campaign targeting those most profoundly affected by COVID-19 to provide clear, accurate and culturally appropriate information on how to protect from acquiring or transmitting the virus. Work jointly with the representatives or leaders of the groups, relevant service providers or nongovernmental organizations to find the most adequate solutions to providing clear, simple, realistic and actionable messages. Collaborate with communities by developing and disseminating locally and culturally appropriate guidance for communities on COVID-19 prevention.	

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
Practise respiratory hygiene and mask wearing.*	That there are enough masks available for all people in need That all people have physical and financial access to masks. That all people are aware of and understand how to practise respiratory hygiene, including how to cover coughs and sneezes, and how to properly use a mask. That all people are physically able to cover coughs and sneezes or to put on a mask by themselves.	People experiencing homelessness and people living in slums People living in poverty or extreme poverty People living in remote locations Refugees and migrants People living in closed facilities People with disabilities	People have not received clear, accurate and culturally appropriate information on how to protect themselves from acquiring or transmitting the virus. No availability of masks in areas where people live. People cannot access masks due to physical barriers (e.g. movement restrictions prevent travel to purchase masks). People cannot buy masks due to financial barriers. People are unaware of how to practise respiratory hygiene, including how to properly use a mask. People are unable to physically put on a mask by themselves.	Provide communities with masks, particularly in dense, deprived and informal settlements across different cities. Develop a tailored community public information campaign targeting those most profoundly affected by COVID-19 to provide clear, accurate and culturally appropriate information on how to practise respiratory hygiene, including how to cover coughs and sneezes and when and how to properly use a mask. Provide information for caregivers of people with disabilities on respiratory hygiene, including how to cover coughs and sneezes and how to properly use a mask. Work with allied health and other professionals to support the adaption of face mask wearing techniques to account for particular physical, sensory or behavioural issues people with disabilities may experience.	

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
If you have fever, cough and difficulty breathing, seek medical care early.	That all people can check their temperature. That medical care is available to all people. That all people *know* where they can access medical care. That all people are physically and financially able to access medical care. That all people feel comfortable seeking medical care.	People experiencing homelessness and people living in slums People living in closed facilities Refugees and migrants People living in remote locations People with disabilities	People have not received clear, accurate and culturally appropriate information on when and how to seek medical care for COVID-19. People are not clear what symptoms to monitor. People cannot distinguish accurately between mild and severe symptoms. People do not have a thermometer to check their temperature. There is no medical care available in areas where people live. People do not know where they can access medical care. People cannot access medical care due to financial barriers. People cannot access medical care due to physical barriers (e.g. people with disabilities unable to travel to health centres).	Develop a tailored community public information campaign targeting those most profoundly affected by COVID-19 to provide clear, accurate and culturally appropriate information on when and how to seek medical care. Provide communities with thermometers, particularly in dense, deprived and informal settlements across different cities, as well as instructions on how to use and read them. Establish alternative ways to deliver medical care to people experiencing physical barriers to health care (e.g. mobile outreach clinics and eHealth). Build capacity within communities to seek early medical care by collaborating on developing and disseminating locally and culturally appropriate guidance for communities on how and where to seek testing or treatment for COVID-19 prevention. Reimburse communities for travel costs to and from clinics, particularly in dense, deprived and informal settlements across different cities.	Advocate the inclusion and non-discriminatory access of refugees and migrants to public health services.[g] Advocate the removal of financial barriers to services related to the outbreak, making services free at the point of use for all people.[f] Increase health system capacity in disadvantaged areas or settlements.[f] Tackle discrimination and xenophobia. Engage with the police and military to ensure that undocumented migrants and stateless people are not harassed or imprisoned if they seek care.

WHO recommendation	Assumptions	Groups with less agency to comply with recommendations	Potential barriers	Mitigation strategies	Long-term strategies
			People do not feel comfortable seeking medical care due to cultural/gender-based reasons.	Reimburse communities for medical care visits, particularly in dense, deprived and informal settlements across different cities. Build capacity among health-care professionals to provide COVID-19 medical care that is gender sensitive, youth friendly and culturally appropriate. Provide information for caregivers of people with disabilities on the importance of recognizing emergency warning signs such as shortness of breath and of seeking early medical care. Ensure caregivers understand the importance of seeking early treatment for people with disabilities experiencing respiratory distress. Ensure that people with disabilities and older adults are linked with primary health care services to provide a monitoring mechanism to protect them from potential harm or abuse through neglect from caregivers not seeking appropriate support.	

* There is currently limited evidence that wearing a mask (whether medical or other types) by healthy people in the wider community setting can prevent infection with respiratory viruses, including COVID-19. For further information, refer to *Advice on the Use of Masks in the Context of COVID-19*

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