1. Introduction

1.1 Background

In response to the coronavirus disease 2019 (COVID-19) pandemic, the World Health Organization (WHO) has developed this guidance for the health sector, and other sectors engaged with vulnerable populations, in the Western Pacific Region on how best to support population groups living in vulnerable situations to prevent, prepare for and respond to community transmission of COVID-19. For the purposes of this guidance, vulnerability encompasses conditions that result in inequitable access to resources and increased susceptibility to adverse health outcomes of COVID-19.

Vulnerable populations addressed in detail in this document include: people experiencing homelessness; people living in overcrowded housing, collective sites, informal settlements and slums; forcibly displaced people; migrant workers; people with disabilities; people living in closed facilities; people living in rural and remote locations; people living in poverty; people affected by intersecting, compounding and other vulnerabilities; and people affected by the digital divide.

Vulnerable populations are often at a higher risk of infection transmission and/or disease severity due to poorer baseline health status or lower health literacy, fewer opportunities to seek care, and increased barriers to access the health systems. Population groups in situations of vulnerability vary across and within country contexts. Countries may have additional vulnerable populations not mentioned in this guidance, and the COVID-19 pandemic may cause the emergence of new vulnerable populations or exacerbate conditions for existing vulnerable populations. Individuals may also experience multiple vulnerabilities, potentially compounding barriers and impacts.

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.

The Annex 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 provide guidance on the care and protection of vulnerable populations to minimize infection and spread of COVID-19 among them.

The objectives of this document include:
1. to work across sectors to ensure the creation of a safe and enabling environment for the protection of vulnerable populations from COVID-19;
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 and discrimination of vulnerable populations due to COVID-19; and
4. to engage, empower and centre vulnerable populations in the COVID-19 response.
1.3 Intended audience

This guidance is intended for Member States, WHO country offices, and relevant government, civil society and private sector stakeholders. This guidance describes actions to strengthen the care and protection of vulnerable populations during community transmission of COVID-19. Actions should fit within national COVID-19 plans and be adapted to the needs and context of vulnerable populations.

2. Guiding principles

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

- country led
- community owned
- partnership driven
- evidence informed
- available, accessible, acceptable and of quality
- equitable
- health promoting
- person centred.

3. Priority areas

The following priority areas and actions include crosscutting strategies that may be relevant to all vulnerable populations discussed in this guidance.

3.1 Establish an accessible and acceptable preparedness and response plan

Contextualized and culturally appropriate service delivery

- Ensure the inclusion and adequate access of vulnerable populations to emergency government and social services and national, subnational and local response and relief programmes.
- Perform risk assessments and analyse barriers to ensure response measures are accessible and acceptable, considering local behaviours, knowledge and practices. This exercise should consider intersecting vulnerabilities such as health literacy, decision-making autonomy and baseline health status.

- Review and adapt WHO-recommended basic protective measures against COVID-19 for the public to the specific needs of vulnerable populations (see Annex for some proposed measures).
- Ensure all vulnerable populations are informed of and can access national health-care initiatives for COVID-19 treatment through established pathways of care and have equal access to testing in appropriate languages.¹
- Establish equitable and non-discriminatory alternatives to deliver essential medical care such as immunization,² sexual and reproductive health, and care for survivors of gender-based violence (e.g. mobile outreach clinics, e-health) to people experiencing barriers to seeking health care. Services should consider how they can reach people, rather than how people can reach them.
- 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. Conduct capacity-building to enhance knowledge and skills of health-care staff to provide appropriate mental health and psychosocial support services, as well as awareness-raising sessions on mental health and psychosocial support available for vulnerable populations.
- Identify and address stigmatization and discrimination associated with vulnerable populations by ensuring service providers are trained appropriately.
- 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 the integration of a human rights-based approach to decision-making, implementation and response. For example, delink COVID-19 guidelines from the criminal justice system to reduce fears and concerns of being reprimanded, especially for vulnerable people of precarious legal status.
Accessible resources

- 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.  
- 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.  
- In situations of food insecurity, provide food conducive to the storage capacity (e.g. space availability and temperature control) of vulnerable populations and sufficiently nutritious to address pre-existing nutritional deficiencies (especially children).

Movement reduction

- To reduce daily movements to access food, bathrooms and other basic needs, provide food aid, water, sanitation and hygiene (WASH) products, and other social protection in bulk. Consider implementing temporary infrastructure, such as toilets with running water and soap, in accessible areas to adhere to hygiene and sanitation basic needs.  
- Ensure that safe water is affordable and accessible to all, noting that women and girls often are responsible for water collection from common collection sites. Minimize waiting times and establish systems to enable sufficient volume of water collection systems to reduce frequency of visits.  
- Encourage the reduction of frequent movements within and between urban and rural areas by providing communities with alternative mechanisms to engage with family (e.g. phone credit and SIM cards).

3.2 Provide adequate social protection

- Expand upon and adapt existing social protection systems and delivery infrastructure to ensure inclusive social protection responses. Examples include income security through cash transfers, in-kind support and adaptation of programme delivery to align with movement restrictions.  
- Collaborate with relevant sectors (labour, social development, finance) and partners to rapidly develop and deploy an emergency social protection scheme for people who have lost their income in the formal and informal sectors.  
- Target social assistance programmes to those disproportionately impacted by the socioeconomic impacts of COVID-19, such as those engaged in agriculture and aquaculture, the informal sector (e.g. market vendors) and garment manufacturers.  
- Advocate to both formal and informal sectors to continue to honour financial commitments to employees in case they have contracted COVID-19, need to quarantine and/or require medical assistance.  
- Implement social assistance and protection schemes that are aligned to the spending habits of vulnerable populations, such as using cash transfers and providing small regular payments instead of one large lump sum.  
- For those who are in situations of exploitation, and confined due to movement restrictions, ensure alternative access to protection services and social support from their local communities, such as hotlines, SMS, digital and community outreach services.

3.3 Conduct surveillance and risk assessment

- Include vulnerable populations in government census and other public data systems to create context-specific response strategies.  
- Use multiple sources of information, including national and community-level 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 confidential, and addresses the concerns of vulnerable populations.  
- Develop and enhance community surveillance systems for direct reporting of events requiring investigation to ensure vulnerable populations are captured in reporting, analysis and evaluation of the data.
- Include targeted genomic sequencing, including variants of concern, to detect COVID-19 in vulnerable populations.
- 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 population groups who are already known and trusted.
- Collect and report data disaggregated by at least sex and age on (a) tested individuals, (b) confirmed cases, (c) severity of disease, (d) underlying comorbidities 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, homelessness, geographical location, ethnicity, migration status, sex, gender, disability and other population groups referenced in this interim guidance.
- Invest in research and intersectional gender, equity and rights-based analysis of data on the adverse social and economic impacts of COVID-19 and related guidelines, such as movement restrictions.
- Conduct risk assessments to analyse how working and living conditions, legal status, and cultural and social norms within communities can exacerbate vulnerabilities to COVID-19.
- Encourage factual and fair national reporting that combats misinformation, stereotypes and stigmatization by distributing and broadcasting contextualized evidence-based information.

3.4 Empower and engage communities

Trust building
- Identify and partner with trusted, recognized, diverse and representative community leaders, influencers and community-based organizations with systems, capacity, resources and expertise that can be leveraged for the COVID-19 response.
- Approach and invite trusted community representatives, including from community-based organizations and ethnic or faith-based media, to deliver key health messages and to capture community feedback to inform national decision-making.
- Work with trusted community partners to reach, engage and empower vulnerable populations, especially those who have had previous negative experiences with health and other authorities, which may have resulted in a lack of trust in institutions.
- Engage community organizations and labour unions to address social stigma, which can undermine both social cohesion and COVID-19 containment measures by preventing health-seeking behaviour and driving individuals to hide symptoms to avoid discrimination and potential employment loss. These organizations can support the fostering of trust and alleviate unwarranted fears, such as the fear of eviction from homes due to squatting or living on unplanned land.

Community-led response
- Engage communities to facilitate the collection and analysis of community concerns, barriers experienced, needs and suggestions to secure localized solutions that can be integrated in further planning strategies.
- 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.
- 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.
- Include community representatives as part of the service delivery team who deliver care to vulnerable populations, such as managing handwashing facilities and providing referral
services for counselling and other basic necessities.

- Include community leaders or members of vulnerable population groups as key stakeholders in relevant decision-making dialogues in the development of COVID-19 response plans, strategies, policies and practices.

Using community engagement to address contextualized needs

- Work 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 populations, are translated into relevant local languages, depict diverse groups, and prevent stigmatization with checks for accuracy and cultural relevance.

- Build the capacity of community representatives, leaders and caregivers to disseminate information, address concerns and facilitate dialogue based on specific needs of groups (including people with lower literacy rates, visual, hearing, intellectual and physical impairment). This includes advice on seeking timely health care, as well as preventive and protective measures.

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

There are multiple experiences of homelessness, and they vary in terms of duration, frequency and shelter. Homelessness can include visible experiences such as people who are unsheltered and are living on the streets or public areas that are highly visible. It also includes invisible experiences of homelessness where populations are in non-public spaces including temporary shelters, hostels and other temporary spaces. COVID-19 public health measures such as closures of public spaces have increased the likelihood of this group being deprived of shelter and living rough. Given their limited access to affordable and adequate housing and transient and mobile nature, people experiencing homelessness are considered particularly vulnerable to both contracting and transmitting COVID-19 and at risk of experiencing more severe health outcomes as a result.

The following recommendations can guide the development of a COVID-19 response that supports the needs of people experiencing homelessness:

- Where possible, refer people experiencing homelessness to safe temporary shelters or alternative care facilities with adequate WASH areas separated by gender when possible, and ensure privacy and the ability to maintain physical distancing measures. If available and acceptable to the individual, consider repurposing convention centres, hotels, community centres, schools (if not presently operating) and other venues as shelters or alternative care facilities.

- Ensure personal protective equipment (PPE) and hygiene products are available, including alcohol-based hand sanitizer, menstrual hygiene products, medical or alternate cloth masks, facial tissues and rubbish bags.

- In situations and environments where PPE is mandatory, provide affordable and accessible products as to not restrict access to public services. Deliver PPE and hygiene products to encampments and settlements (if shelters and alternative care facilities are unavailable), particularly in densely populated informal settlements in urban areas.

- Establish accessible WASH areas in and around encampments, comprised of handwashing stations with safe water, soap and drying materials. Clearly show when a water source is not suitable for drinking. When possible, facilities should be separated by gender, well-lit and prioritize privacy.

- For people who use substances, provide supportive protective practices and share information about the risks of sharing supplies. Ensure access to mental health and psychosocial support services, including on-
Actions for consideration in the care and protection of vulnerable populations from COVID-19

- Analyse how cultural norms may perpetuate social exclusion and stigma towards people experiencing homelessness. For example, the cultural value of self-sufficiency prevents many from applying for social assistance and welfare provided by the government.
- In the event of closures of community centres, libraries and other public services, establish mechanisms to enable continued access to information and support services, including preventive health messaging, social assistance schemes and connections with peers.
- Ensure people experiencing homelessness are not unjustly and disproportionately impacted by penalties due to systematic barriers to comply with protocols and risk legal implications for attempting to access basic needs. For example, fairly enforce curfew and containment measures that do not discriminate against people experiencing homelessness who may not have access to accommodation to abide by curfew and containment measures.
- Adopt a gender and equity lens approach when developing policy. Given overrepresentation of older male adults as rough sleepers, consider expanding social systems in place that disproportionately protect women and children at risk of homelessness.

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, informal settlements and slums

A key consideration of communities living in overcrowded housing is that residential areas may be on illegally occupied land and unplanned settlements in areas where housing is not permitted under existing building or planning regulations. Many of these shelters are self-built out of temporary building materials and are underserviced, including lack of adequate access to sanitation facilities, health services and social safety nets. This group is vulnerable to increased risks of eviction, overcrowding, poor ventilation and low-quality housing. The risk for COVID-19 may be higher for people living in camps or collective sites, overcrowded housing and slums. Physical distancing may be difficult in settings where overcrowding is common and frequent movement of individuals occurs between dwellings. Often, families living in overcrowded conditions and collective sites share one or two bedrooms, have limited or no access to water and use common toilet facilities shared with a large household or the community.

The following recommendations can guide the development of 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 (e.g. neighbourhood or slum) when confirmed cases reach a certain threshold to prevent large-scale community transmission.
  - Conduct a risk assessment of how the location of the settlement may impact transmission and risk. Consider, for example, the distance from waste sites and any dangerous foundation the site it built upon.
- Map the availability of free space and physical characteristics of the settlements for suitable quarantine areas and opportunities to decrease overcrowding.

• Ensure that people in overcrowded housing (e.g. kin-based households and homes centred in communal sharing) have easy access to the core recommendations for home care of people with mild COVID-19 symptoms and provide adequate supply of the recommended articles and equipment as required by all in the household. 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 symptomatic person(s). 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 rubbish bags 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, clean hands after these activities.
- Wash 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 COVID-19 preparedness and response 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).4

• Deliver hygiene products to collective sites and slums, including alcohol-based hand sanitizer, menstrual hygiene products, medical masks or alternate cloth masks, facial tissues, menstrual hygiene products and rubbish bags, particularly in densely populated informal settlements or slums in urban areas.11

• Establish accessible wash areas in and around encampments and slums, comprised of handwashing stations with safe water, soap and drying materials.12 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.

Additional resources include:

- Home Care for Patients with COVID-19 Presenting with Mild Symptoms and Management of Their Contacts
4.3 Forcibly displaced people

Forcibly displaced groups may live under conditions that make them particularly vulnerable to 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. Barriers to accessing health services increase their risks, stemming from stigma, language barriers, physical or legal barriers, and administrative and financial obstacles.¹

Forcibly displaced groups include refugees, asylum seekers, and internally displaced, undocumented and stateless people. While there are distinct differences related to legal status and level of protection between refugees and other forcibly displaced groups, the following section encompasses all these conceptualizations under the broader understanding of persons in need of international protection.

The following recommendations can guide the development of a COVID-19 response that meets the needs of forcibly displaced people:

- Advocate for the inclusive and non-discriminatory access of forcibly displaced people to public health services, as well as the expansion of existing social protection services, ensuring equal access to information in appropriate languages, as well as affordable testing and health care, regardless of legal status.¹
- Within encampments, settlements and communities, ensure that there is the ability to meet water and sanitation needs in spaces that are safe and dignified, especially for women and children.
- Provide non-discriminatory testing, regardless of legal status. Give reassurances that testing and good health-seeking behaviour will not result in legal ramifications, such as detention or deportation.
- Promote communication materials that ensure attitudes and perceptions towards migrants and forcibly displaced groups are not stigmatized and does not perpetuate fear among these populations from seeking testing, disclosing symptoms and receiving timely treatment.
- Ensure access to mental health and psychosocial support services, including on-site services, telephone-based support and other remote options. Given that people who have been forcibly displaced may have experienced traumatic events related to war, oppression, violence and natural disasters and are at a higher risk of experiencing mental health issues, adequate psychosocial support should be delivered and accessible to those who need it. Engage the community, such as faith-based organizations, to provide social support to aid psychological and emotional well-being and facilitate the sociocultural adaptation of migrants and forcibly displaced groups to the host community.
- Acknowledge that many large families often resort to smaller residences and live in higher-density households. Identify the underlying reasons, such as financial constraints, and provide resources and support to enable families reduce this overcrowding.
- Ensure information about prevention, symptoms and how to seek care are accessible to forcibly displaced people. 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 community for one-on-one education.

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

Migrant workers include foreign and overseas workers or returning migrant workers. Similar to migrants and forcibly displaced populations, migrant workers may live in overcrowded housing such as dormitories and face challenges in accessing health services as a result of language, stigma, physical or financial barriers. Their status in the country may be tied to their employer, resulting in an unequal power balance that increases worker vulnerability. Stigma may result in individuals hiding symptoms of their illness to avoid discrimination, reduced or deducted pay, and forced time off without compensation, delay individuals from seeking health care, or prevent individuals from taking up promoted health behaviours. Since the start of the COVID-19 pandemic, countries have also seen many returning migrant workers from abroad, in some cases tens of thousands of individuals. This may increase the potential for importing COVID-19 and cause large crowds at points of entry into countries and then dispersal across the country, including to remote areas. Some factors driving these migration patterns include poverty, conflict, lack of human rights protection, education and lack of employment opportunities.

The following recommendations can guide the development of a COVID-19 response that meets the needs of migrant workers:

- Communicate to reassure migrant workers that, despite their legal precarity, they should seek testing and treatment without fear of arrest, detention and deportation.
- Forge and develop partnerships within and beyond the health sector, including partnerships with labour ministries, labour unions, immigration agencies and relevant foreign embassies to implement cohesive COVID-19 interventions for foreign migrant workers.
- Provide accessible information to enable migrant workers to understand their rights and to access information on support systems available to their families in their home countries, especially in the event they can no longer provide remittances.
- Prevent marginalization by eliminating barriers that exclude migrant workers from accessing social protection programmes, including financial support packages, wage subsidies, income support and other social protection provided by host governments. Note that barriers may stem from the lack of legal recognition of migrant workers in the workforce, as well as employment and immigration laws that do not regard those engaged in the informal sector as workers.
- Advocate for the implementation of employment promotion initiatives and retention policies to assist migrants and unemployed workers to seek opportunities through job matching and job search programmes to fill shortages in the labour market.
- Implement safeguards to reduce exploitation, such as unfair working hours, unpaid leave during lockdowns, unfair additional workloads, and lack of PPE or safe practices, due to movement restrictions and irregular migration status.
- Mental health services should be accessible and culturally appropriate, with special consideration to unique issues causing increased stress and anxiety, such as being unable to send remittances to family, losing one’s job and adapting to a new culture.
- Work with landlords, housing agencies and other formal or informal housing authorities, to decongest accommodation facilities such as migrant worker dormitories and improve living conditions, if necessary.
- Address rumours and misconceptions that may increase xenophobia from both host and origin countries. Use community organizations to reduce fear and hostility for returning and new migrant workers. The disclosure of ethnicity, nationality and occupational information of confirmed COVID-19 cases in the media must provide context and not generalize.
- Adopt a gender and equity lens by considering the growing number of migrant women working in particular sectors such as domestic, elderly and child care, housekeeping, garment manufacturing.
hospitability and health care, which are frontline and essential services. They should thus be included and considered when developing strategies for frontline and essential workers.

- 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.\(^{19}\)
  - Ensure infection control measures (e.g. physical distancing in all areas and accessible supplies for hand hygiene) are met at border crossings.
  - 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

Persons with disabilities (PWD) include all people who have long-term physical, mental, intellectual or sensory impairments that vary in complexity and severity.\(^{20}\) They may be at greater risk of contracting COVID-19 due to a variety of factors, including barriers to accessing 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.\(^{21}\) Furthermore, PWD 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.\(^{22}\) Redirecting health resources towards the COVID-19 response may disrupt other routine health services that PWD rely on, causing individuals to be disproportionately impacted and experience greater marginalization.\(^{15}\)

The following recommendations can guide the development of a COVID-19 response that meets the needs of PWD:

**Communication strategy**

- Ensure products are easy to read, at a suitable literacy level and comprehensible for people with intellectual disability or cognitive impairment.\(^{21}\)
- Ensure products can be adapted for use by people with neurocognitive impairments, including people who are unable to report symptoms.
• Alternative communication strategies such as sign language interpretation and use of various communication channels (e.g., radio, television, websites, telephone-based services) are needed to ensure that PWD are not deprived of public health information and able to communicate with health service providers to ask questions and raise concerns. 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.
• Provide capacity-building to health-care workers, social and other frontline public sector workers to communicate with PWD, especially those with psychosocial and development delays, to understand the implications and need of containment measures.

Access to services
• Ensure testing and health-care services are accessible by implementing local accessibility guidelines.
• Promote alternative avenues of minimal contact for PWD to access essential services, including online telehealth, shopping orders and food delivery.
• Create easy-to-access pathways for health care and testing and clearly communicate these pathways to PWD, their caregivers and service providers.

Caregivers
• Provide caregivers and personal health workers with adequate PPE, testing and access to health services.
• Ensure formal and informal caregivers of PWD are considered part of the essential workforce and exempted from curfews and other movement restrictions that may affect the continued provision of support services.
• Encourage caregivers of PWD 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 PWD who need care and support for daily living, maintaining self-hygiene, attending appointments and accessing other basic needs.
• Support PWD and caregivers to develop contingency measures in case caregivers are unable provide regular support services due to workforce shortages or heightened risk of infection.
• Prioritize caregivers for PWD for access to no-cost PPE, including masks, aprons, gloves and hand sanitizer, as well as free access to health care, including testing if symptomatic.

Other considerations
• For PWD living in institutionalized care arrangements, provide opportunities for continued social engagement, such as access to email and phone credit.
• When applying for social protection, considerations are needed for cost, waiting period, physically inaccessible application points and administrative hurdles that may act as a barrier for PWD. Adapt enrolment procedures, such as decentralizing and streamlining enrolment through a community-based registration drive, to increase enrolment in disability-targeted programmes.
• For PWD who have increased reliance on physical contact with the environment, provide the required PPE and hygiene products to reduce transmission risk due to this contact.

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 potentially 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 — all of which are conditions that may heighten the risk of COVID-19 transmission. Protecting people living in closed facilities is not only crucial for those specific communities but also paramount to ensure the effectiveness of national pandemic responses. Data suggest that without adequate testing, treatment and care in closed facilities, efforts to control COVID-19 in the general population may fail.14

Closed facilities can often be faced with shortages in staff, lower quality health-care services in the facilities, and unsafe conditions for both staff and people living in closed facilities during the COVID-19 pandemic.25

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

- Review facility policies and build capacity among facility staff to ensure 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.4
- Inform decision-makers and facility staff, as well as the people living in closed facilities, on the importance of respiratory and hand hygiene to prevent the spread of COVID-19, as well as the importance of adequate waste management and environmental cleaning (sanitation and disinfection).14
- Expand the responsibilities of individuals working in the facilities to strengthen sanitary conditions, to include implementing infection control practices such as disinfecting surfaces, ensuring good ventilation and wearing PPE when caring for infected or quarantined persons living in closed facilities.
- Conduct medical risk assessments to identify people living in closed facilities with comorbidities and other high-risk individuals living in closed facilities, paying special attention to identifying those who are pregnant or older or have comorbidities including HIV, tuberculosis and hepatitis. Provide medical examinations for new individuals.
- 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).14
- Encourage facilities to adopt measures that ensure 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.14
- Consider expanding isolation or treatment wards of facilities to accommodate for surges in capacity needs. Enable testing and contract tracing of confirmed and suspect cases.
- Ensure access to WASH, water, soap and hand sanitizer. In cases of lack of infrastructure (e.g. non-availability of taps in each cell or dormitory) or supplies (e.g. hand sanitizer containing alcohol and thus a contraband in many facilities), provide alternatives, such as PPE and soap.
- Consider conditional releases or decarceration for asylum seekers and low-risk offenders, or early and conditional releases, to decongest spaces.
- In situations with limited access to qualified mental health professionals, train facility staff in counselling to provide people living in closed facilities with emotional and psychological support or establish a 24-hour hotline for psychological counselling.
• In situations where work, recreational, educational, vocational and related programmes provided in facilities have been suspended to reduce COVID-19 transmission, offer accessible alternatives such as online equivalents.

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 rural and remote locations

People living in rural and remote locations may be at greater risk of acquiring and spreading COVID-19 due to physical and institutional barriers to accessing up-to-date health information in a timely manner, exercising basic protective measures and accessing health-care facilities. For example, rural and remote locations often lack water and sanitation infrastructure, such as handwashing facilities that would enable hand hygiene. Similarly, people living in these locations may experience physical barriers (distance), financial barriers (cost of transportation) or language barriers (minority populations) that hinder them from seeking care early. Note that rural communities have high reliance on agriculture for subsistence and livelihood and may experience barriers to access social protection. These populations may also be less easily reached through standard communication channels.

The following recommendations can guide the development of a COVID-19 response that meets the needs of people living in rural and remote locations:

• Advocate national COVID-19 risk communication strategies to include plans to disseminate information to people living in rural and remote locations using context-based delivery approaches and culturally appropriate messages.27
• 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).28
• Explore 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 e-health. 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).
• Decentralize point-of-care and testing locations by increasing the capacity of rural health service centres to promote accessibility and reducing the time between sample collection and release of results. If decentralization is not possible, provide transport, with adequate physical distancing, to enable people to access point-of-care and testing facilities.
• Develop maximum health-care capacity thresholds in rural and remote areas to monitor when services are overstretched, especially in already under-resourced health systems.
• In the event of shortages of health-care workers, opt for alternative employment regimes, such as increased short-term employment, with employees living in accommodations provided by the employment agency.
• Develop mechanisms for attracting and retaining employees in rural and remote areas.
• In situations where clinics must close due to lack of resources, provide alternative routes such as digital health or use community organizations to expand service delivery. The scale-up of telehealth services must be complemented with fair and reliable access to internet connectivity. Ensure that service providers have adequate capacity to deliver health care through the alternative routes and that sufficient communication of the changes reach communities.
• Provide surge capacity of health services to address physiological risk factors such as higher prevalence of ageing, chronic conditions and decreased access to diverse diets among the rural poor. These risk factors increase their vulnerability to infection and recovery from COVID-19.
• When developing plans for social assistance, assess and quantify the changing community structure and population due to potential influxes of urban residents into rural communities due to COVID-19 lockdown measures and loss of employment.
• Analyse how the geographical remoteness of communities and environmental challenges such as extreme weather events pose additional complexities in strengthening and delivering WASH services across these communities.

4.8 People living in poverty

Poverty is caused by lack of access to income and can impact on aspects of life such as living conditions, education and health. Health impacts may include hunger, malnutrition, stigma and discrimination, and lack of access to health and other essential services. People living in poverty may not afford housing and can experience difficulties in practising physical distancing to protect themselves from infection or self-isolating to protect others. Similarly, for people living in poverty who do not have access to clean drinking water, it is unlikely safe water for handwashing will be accessible. 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.

Individuals earning income through the informal economy are often paid low wages, are at increased risk of exploitation, 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. Further, the socioeconomic impact of COVID-19 has caused an increase in people falling into poverty, many of whom are educated and were previously of a higher socioeconomic status.

The following recommendations can guide the development of a COVID-19 response that meets the needs of people living in poverty:

• Establish temporary handwashing stations in key locations of poor neighbourhoods, including in high-density public places such as markets and bus stations. To reduce the risk of gender-based violence, establish separate washing areas for men and women.
• Engage 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.
• Provide communities with financial reimbursement for medical care visits, particularly in dense, deprived and informal settlements across cities.
• Coordinate with different sectors and existing partner networks to ensure the delivery of provisions for families who newly fall into poverty due to COVID-19, including in-kind assistance such as nutritious food.
• Provide people living in poverty with free or affordable access to 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.
4.9 People affected by intersecting, compounding and other vulnerabilities

Intersectionality is an analytical lens that examines how different social stratifiers (gender, class, education, ethnicity, age, geographic location, religion, migration status, ability, disability, sexuality, etc.) interact to create different experiences of privilege, vulnerability and/or marginalization. Intersectional factors and socioeconomic barriers exacerbated by COVID-19 can also intensify the spread of COVID-19. They include poverty, health-related expenses, lower access to formal education, inability to avoid infection and receive adequate health care, social isolation, security, stigmatization, violence, abuse, discrimination, exploitation, limited opportunities to participate in the labour market, and lack of access to culturally appropriate resources. For example, people experiencing homelessness are also likely to be living in extreme poverty; remote communities may comprise indigenous or ethnic minority populations. Intersections between populations may create unique and additional barriers for individuals to remain safe during the COVID-19 pandemic.

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 overcrowded housing. Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) individuals may face stigma or fear in reporting symptoms or receiving care, complicating contact tracing or access to services, similar to the challenges mentioned for migrant workers or forcibly displaced people.

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 PWD. Other challenges include safety and injury risks (e.g. violence and unsafe infrastructure), and environmental risks (e.g. floods, drought and typhoons).

Emergency situations can exacerbate existing gender inequalities, increasing the risk of gender-based violence in homes and communities. 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. The Annex may be used to tailor this guidance to match the context and needs of vulnerable populations in a country.

Ethnic minorities, informal sector workers, indigenous populations and LGBTQI individuals are referred to in this guidance but may require further considerations.

The following regional documents provide consideration for other specific vulnerable populations:

- Mental Health and Psychosocial Support Aspects of the COVID-19 Response
- Addressing Noncommunicable Diseases in the COVID-19 Response
- 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
- Exploration of COVID-19 Health-Care Worker Cases: Implications for Action
- Disaster Evacuation Shelters in the Context of COVID-19
- Considerations for Community Hand Hygiene Practices in Low-Resource Situations

4.10 People affected by the digital divide

The digital divide considers the difference between those who have access to adequate digital technologies and those who do not. The world has adapted social, education, health and economic systems by accelerating and applying technology through remote working, distance education, telemedicine, government procedures and more. While availability and affordability to quality internet connectivity remains an issue...
across the Western Pacific Region, other key factors contributing to digital inequalities include digital literacy, the gender digital divide and digital readiness. The digital divide remains significant between rich and poor, urban and rural, young and old, and men and women in many communities.32

The accelerated shift towards digital health-care services stems from physical distancing measures and movement restrictions implemented to curtail the spread of the virus. However, as the use of digital health technologies increases, disparities in digital literacy and accessibility to internet pose a critical challenge in delivering equitable health services.

The following recommendations can guide the development of a COVID-19 response to address the digital divide:

- Invest in digital readiness in rural areas, such as online platforms and mobile applications, to maintain essential services.
- Provide women and girls with opportunities to learn, connect and access online services.
- In recognition of the limited internet penetration across various areas, use non-internet systems, such as SMS, and provide remote support to those in need.

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

In early 2020, WHO published a set of recommended basic protective measures for the public against SARS-CoV-2, the virus that causes COVID-19. Due to the particular circumstances of vulnerable populations, 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 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, forcibly displaced people 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 response and measures to the contexts and needs of vulnerable populations is not only important for ensuring a more equitable impact, but research from previous epidemics shows 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 virus, 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.
### Actions for consideration in the care and protection of vulnerable populations from COVID-19

<table>
<thead>
<tr>
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<tr>
<td>Wash hands or perform hand hygiene.</td>
<td>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.</td>
<td>People experiencing homelessness People living in overcrowded housing, collective sites, informal settlements and slums People living in poverty People living in rural and remote locations Forcibly displaced people People with disabilities People living in closed facilities.</td>
<td>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 that prevent people from going outside to get water, soap, hand sanitizer or drying materials • Financial barriers People working in informal economies do not have constant income.</td>
<td>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. Disseminate information on low-cost approaches for hand sanitation, such as guidance for local production of hand rub formulation. Encourage the use of alternative water sources (boiled water, rainwater, river water, seawater, etc.). Clearly communicate that alternative sources of handwashing water may not be fit for human consumption.</td>
<td>Invest in the necessary infrastructure to deliver the prerequisites for sustainable water, sanitation and hygiene (WASH) services that are appropriate and acceptable to vulnerable populations. 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.</td>
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<td></td>
<td>Organizational barriers</td>
<td>• Organizational barriers</td>
<td>Establish <em>accessible</em> handwashing/hand hygiene stations in key locations in informal settlements and high-density public places such as markets and bus stations.</td>
<td>Work across sectors to ensure that disadvantaged communities have the critical inputs for safeguarding health, especially during situations of emergency.</td>
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<td>Prisoners are not allowed to wash their hands when they need to.</td>
<td>Prisoners are not allowed to wash their hands when they need to.</td>
<td>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.</td>
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<td>Available handwashing stations have not been adapted to the needs of people with disabilities.</td>
<td>Available handwashing stations have not been adapted to the needs of people with disabilities.</td>
<td>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.</td>
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<td>Maintain physical distancing, quarantine and isolation.</td>
<td>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 or pre-existing medical conditions can survive in isolation without outside support.</td>
<td>People experiencing homelessness People living in overcrowded housing, collective sites, informal settlements and slums People living in poverty Forcibly displaced people People living in closed facilities People living in rural and remote locations People with disabilities</td>
<td>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.</td>
<td>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.</td>
<td>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. 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 against those with no or inadequate housing.</td>
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| 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  
People living in overcrowded housing, collective sites, informal settlements and slums  
People living in poverty  
People living in rural and remote locations  
Forcibly displaced people  
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. | 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. | 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. |
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<td>Practise respiratory hygiene and mask wearing.*</td>
<td>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 wear/use and wash (if reusable) and dispose of masks. That all people are physically able to cover coughs and sneezes or to put on a mask by themselves.</td>
<td>People experiencing homelessness People living in overcrowded housing, collective sites, informal settlements and slums People living in poverty People living in rural and remote locations Forcibly displaced people People living in closed facilities People with disabilities</td>
<td>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.</td>
<td>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 adaptation of face mask wearing techniques to account for particular physical, sensory or behavioural issues people with disabilities may experience.</td>
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<tr>
<td>If you have fever, cough and difficulty breathing, seek medical care early.</td>
<td>That all people can check their temperature.</td>
<td>People experiencing homelessness</td>
<td>People have not received clear, accurate and culturally appropriate information on when and how to seek medical care for COVID-19.</td>
<td>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.</td>
<td>Advocate the inclusion and non-discriminatory access of refugees and migrants to public health services.⁶</td>
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<td>That medical care is available to all people.</td>
<td>People living in overcrowded housing, collective sites, informal settlements and slums</td>
<td>People are not clear what symptoms to monitor.</td>
<td>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.</td>
<td>Advocate the removal of financial barriers to services related to the outbreak, making services free at the point of use for all people.⁷</td>
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<td>That all people know where and how to access medical care.</td>
<td>People living in closed facilities</td>
<td>People cannot distinguish accurately between mild and severe symptoms.</td>
<td>Establish alternative ways to deliver medical care to people experiencing physical barriers to health care (e.g. mobile outreach clinics and e-health).</td>
<td>Increase health system capacity in disadvantaged areas or settlements.⁷</td>
</tr>
<tr>
<td></td>
<td>That all people are physically and financially able to access medical care.</td>
<td>Forcibly displaced people</td>
<td>People do not have a thermometer to check their temperature.</td>
<td>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.</td>
<td>Tackle discrimination and xenophobia.</td>
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<td>That all people feel comfortable seeking medical care.</td>
<td>People living in rural and remote locations</td>
<td>There is no medical care available in areas where people live.</td>
<td>Reimburse communities for travel costs to and from clinics, particularly in dense, deprived and informal settlements across different cities.</td>
<td>Engage with the police and military to ensure that undocumented migrants and stateless people are not harassed or imprisoned if they seek care.</td>
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<td></td>
<td>People with disabilities</td>
<td>People do not know where they can access medical care.</td>
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<td></td>
<td></td>
<td>People do not feel comfortable seeking medical care due to cultural/gender-based reasons.</td>
<td>Reimburse communities for medical care visits, particularly in dense, deprived and informal settlements across different cities.</td>
<td>Build capacity among health-care professionals to provide COVID-19 medical care that is gender sensitive, youth friendly and culturally appropriate.</td>
<td>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.</td>
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<td>Ensure caregivers understand the importance of seeking early treatment for people with disabilities experiencing respiratory distress.</td>
<td>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.</td>
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* 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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Sources:

g. COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement. Reliefweb; 2020.
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COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement. Reliefweb; 2020.