

Online event report

Operationalizing standards: Sphere and the COVID-19 response in camp settings

2 April 2020

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On 2 April, the International Association of Professionals in Humanitarian Assistance and Protection (PHAP) and the Camp Coordination and Camp Management (CCCM) Cluster organized a webinar on COVID-19 prevention measures critical to the work of Camp Managers and others working in displacement settings, with a particular focus on operationalizing the relevant standards of the Sphere Handbook. This report includes the participation statistics, a summary of the webinar as well as a transcript, and a compilation of the follow-up Q&A. For video and audio recordings of the sessions, please visit <https://phap.org/2apr2020>

Key statistics:

 **2682** event registrations

 **1303** participants in the live webinar¹

 **328** in the event platform

 **889** in the YouTube video livestream

 **86** in the audio only livestream

 **1227** viewers and listeners of recorded event to date²

 **154** Adobe Connect recording views

 **786** YouTube recording views

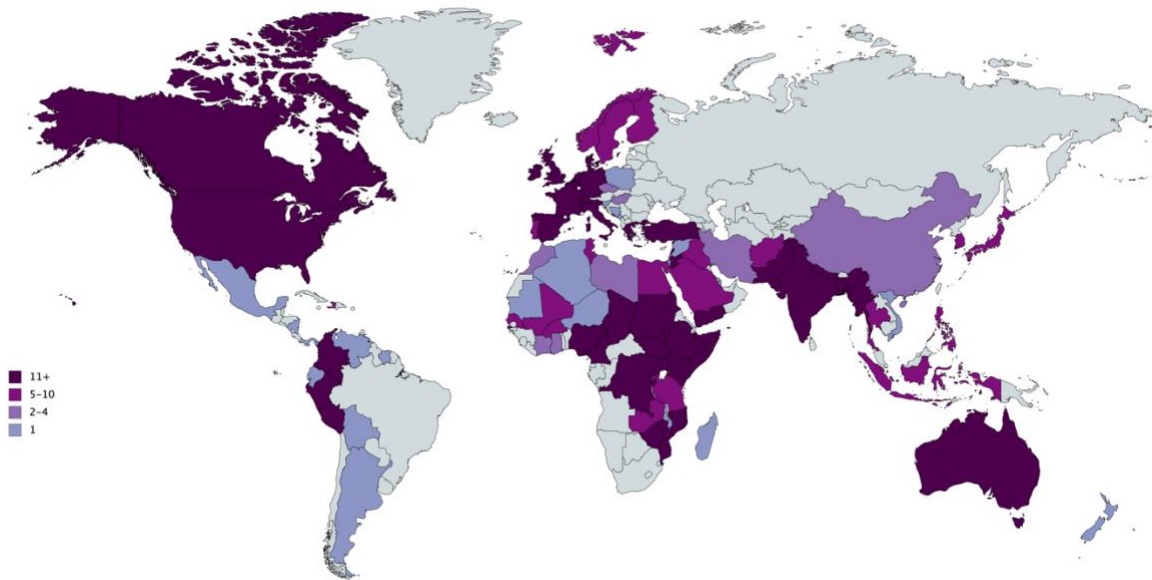
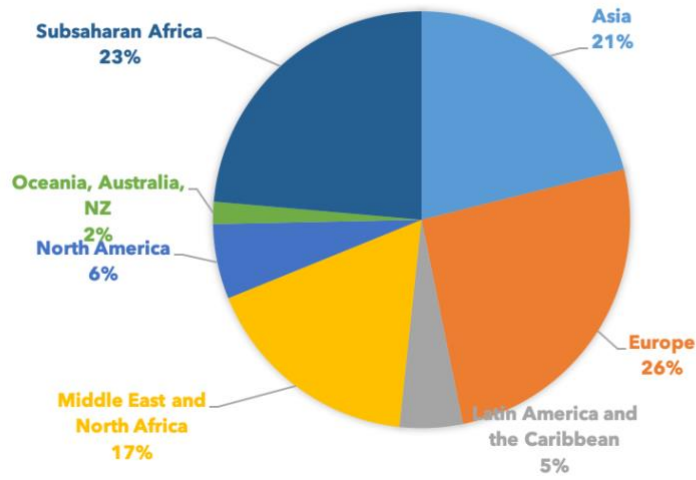
 **287** Audio podcast downloads

¹ The count of live participants only includes unique logins. Most webinars organized by PHAP are attended also by groups of varying sizes logging in jointly, which are however only counted once.

² Recording statistics compiled on 31 May 2020

Registrant geography

REGION BASED IN



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Countries with registrants: 134

Top 10 countries:

1. BANGLADESH	158
2. UNITED KINGDOM	153
3. UNITED STATES	121
4. PHILIPPINES	101
5. SWITZERLAND	95
6. KENYA	89
7. IRAQ	88
8. JORDAN	81
9. NIGERIA	81
10. UGANDA	77

Webinar summary



Event Overview

As the novel coronavirus disease, or COVID-19, continues to spread globally, the risk it presents to populations living in camps and camp-like settings is growing. Camp managers are working quickly to adjust their programs to accommodate social distancing while continuing to communicate with communities and working with partners to improve communal sanitation.

Sphere recently released guidance for how the Sphere Handbook can help guide humanitarian staff in the response to the COVID-19 outbreak. But how should camp managers apply those standards and strengthen the prevention measures recommended by technical sectors?

On 2 April, the CCCM Cluster and PHAP organized a webinar on COVID-19 prevention measures critical to the work of Camp Managers and others working in displacement settings. We heard from WASH specialists, as well as experienced Camp program staff who have recently been involved in setting up special measures to prevent the spread of disease and develop key messages for populations living in temporary settlements. A representative from Sphere also provided guidance for how the Sphere Handbook can be a useful tool for practitioners in this situation.

This webinar was the first in a series of webinars and discussions organized by the CCCM Cluster on COVID-19, focusing on how to manage CCCM services during emergencies. For more information, please visit the CCCM Cluster page on COVID-19.

A full transcript of the event is available in *Appendix 1*. Recordings of the event are available at <https://phap.org/2apr2020>

Many more questions were submitted by participants than there was time to answer during the Q&A session. The speakers responded to many of these after the event so that they could be published online and shared with the participants. These questions are available in *Appendix 2*.

Speakers



Kit Dyer, WASH Adviser, Norwegian Church Aid



Judith Harvie, Health Chapter Author, Sphere Handbook 2018 edition



Dher Hayo, Senior Durable Solutions Coordinator, UNHCR



Sibylla Kitsios, Camp Manager for the Salamiyah camp in Iraq, ACTED



Virginia Moncrieff, Crisis Response Program Manager (acting), Translators Without Borders (TWB)



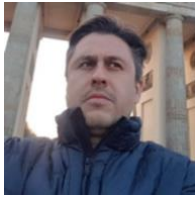
Aninia Nadig, Policy and Practice Manager, Sphere



Richard Okello, CCCM Cluster Coordinator, South Sudan



Manuel Pereira, Deputy Chief of Mission in Bangladesh, IOM



Antonio Torres, Global Wash Coordinator, IOM

Event host



Angharad Laing, Executive Director, PHAP

Event summary

Bringing together a panel with expertise in WASH, health, camp management, as well as humanitarian standards, the event focused on camp settings, planned camps, unplanned camps, collective sites, and transit centers, and how we can apply the technical guidance available in the Sphere standards in the new COVID-19 operational environment.

Response overviews

The event started with a brief overview by Dher Hayo, Senior Durable Solutions Coordinator with UNHCR, of what the situation currently looked like in camps in the **Syria response**, where remote management had already been a necessity for several years. With more than 6 million IDPs, camps were running beyond capacity. There were already previously challenges to access camps in Syria, with remote management being the default mode of operation. With COVID-19, he particularly highlighted the importance of maintaining established communication channels with the camps. They were working with the Health, WASH, and CCCM clusters to provide services and develop communications to be ready in case of a breakout.

Sybilla Kitsios, Camp Manager with ACTED, provided an overview of the current situation in the **Salamiyah camp in Iraq** regarding COVID-19. With several hundred cases confirmed in the country, but none yet in the camps, a response plan had been developed for the camp based on the requirements from the Department of Health and input from the CCCM, WASH, and Health clusters. The government had also created a working group under the Iraqi Ministry of Migration and Displacement to help coordinate between the different camps. An issue had been the food supply, as camp residents normally go to outside markets for many goods, which had been resolved by instead bringing this into the camps.

Participants were briefed on the situation in **South Sudan** by Richard Okello, CCCM Cluster Coordinator. There were no known cases of COVID-19, but the borders had been closed and some business were also in lockdown. There was a particular challenge with the congested nature of the POC sites. To help de-congest the camps, residents were being informed about the possibility to get assistance with leaving the camp and camp contingency sites were being turned into isolation units.

Manuel Pereira, Deputy Chief of Mission in Bangladesh with IOM, underlined that as the first cases had now been identified in the host community in Cox's Bazar, there was now fear among both the host community and refugees of the virus. There were strong access control measures for the camps put in place by the military, and overall, it was necessary to determine how best to

meet the challenges of this new situation. The camps were crowded, which made the situation more complicated, and it was not possible to de-crowd them. Instead it was necessary to look at increasing awareness and changing the modalities for service delivery.

Standards

Aninia Nadig, Policy and Practice Manager with Sphere, provided a brief overview of the Sphere standards, how they applied to camp management in general, and their relevance for responding to COVID-19. The standards bring together community engagement, technical standards, and guidance for contextualizing and coordinating response, which makes it suitable for any public health intervention. She also highlighted some of the underlying principles of the standards, in particular the rights of affected people to dignity, assistance, protection, and security. In camp management, the Sphere standards were useful as they help underline the need to consider how the different technical sectors work together and provides a common language when trying to break down silos.

She pointed out that the draft Camp Management Standards were also an important reference point in this regards, and expressed hope that these could be included in the Humanitarian Standards Partnership in the future.

Community engagement

Virginia Moncrieff, Crisis Response Program Manager (acting) with Translators Without Borders (TWB), highlighted the role of camp management to provide a cross-sectoral overview of people's needs and concerns through community engagement. With COVID-19, there were communication challenges in many camps with reduced staffing combined with restricted access to populations who in general prefer face-to-face communication.

- Use methods that can deliver unified messaging in camps.
- Use systems to feedback what people are thinking, both via rumor tracking and more general belief structures
- Ensure that communication is done in appropriate language was critical, especially in camps where multiple languages were spoken. Social stigma is otherwise a risk among populations who do not understand the messaging regarding COVID-19 and as a result do not follow social distancing guidelines.
- Be honest with people in camps about the changes needed and the reasons behind, while avoiding creating panic.

Virginia mentioned the benefit of rumor tracking in camps, which could also be done remotely during COVID-19.

Situation in camps

In Cox's Bazar they had been using focus groups that looked at the underlying understanding among people of the COVID-19 messaging.

In the Salamiyah camp, the camp assistants and community mobilizers had been identifying rumors and had worked ways of dispelling these into their key messaging. The community engagement campaign had helped build support for the restrictive measures for the camp.

WASH

Kit Dyer, WASH Adviser with Norwegian Church Aid and an author of the Sphere WASH chapter, gave a brief description of how the WASH sector was responding to COVID-19 by on the one hand combating the spread of the disease and support the response to it, and on the other reducing the stress on already overwhelmed health services. She had used the "S-diagram" of fecal-oral transmission to create a COVID-specific "cough diagram" to show the transmission routes of COVID-19 via coughs and sneezes and via contact transmission, and the

corresponding barriers of transmission. Apart from hygiene-related barriers, such as hand washing and covering sneezes and coughs, other practices could be introduced, such as

- Improve physical distancing at water points, laundries, and toilets, to reduce the amount of time spent in queues
- Increase the number of water delivery points
- Ensure sufficient water storage containers for camp residents
- Reduce the number of people visiting waterpoints by using a caretaker system
- Try to introduce more water into the system
- Provide personal protective equipment for those collecting solid waste.

She underlined the importance of maintaining other WASH functions during COVID-19, and both meet the new challenges related to COVID-19, and to continue to try to work to increase access to water and sanitation.

Some additional points that came up in response to questions from the participants included

- Soap and water or hand sanitizer was recommended over chlorine solution
- Disinfecting household surfaces, as well as surfaces in public spaces, is important, and there is useful WHO guidance on this.
- The Sphere standards are formulated in a qualitative way that requires contextualization. Specific targets for the standards would need to be determined depending on what is appropriate for the situation.

Situation in camps

In Cox's Bazar, additional handwashing points had been installed and messaging regarding handwashing had been improved, but it was very complicated to increase the quantity of water.

In the Salamiyah camp, additional taps had been set up with the assistance of UNICEF, and posters and videos had been used to get messaging out regarding good WASH practices.

In South Sudan, the congested nature of the camps was a concern, and information was being provided to residents about their options

Health

Judith Harvie, Health Chapter Author, Sphere Handbook 2018 edition, highlighted three different areas related to COVID-19 and the Sphere health standards: systems and structures; education and messaging; and dignified management of the dead.

In terms of systems, it was critical that support was provided to health staff, both to keep them from becoming infected and to cope with the extra pressure in terms of anxiety and information requests from the community. Triage of both symptomatic from asymptomatic and emergency from non-emergency cases becomes very important. How best to structure health services and cohorting depended heavily on the context, but overall, it would be necessary to prioritize certain services in order to reduce the risk of crowding.

Misinformation regarding prevention and treatments was widespread needed to be met with clear messaging.

As in most camp situations people would be dying at home rather than in a hospital, in terms of palliative care, it was important to provide clear, honest, and basic information about how the processes work.

To ensure safe and respectful management of the dead, have honest conversations with community and religious leaders and the community and plan for an area that can be used for burial. Key messages for handling dead bodies should include avoiding touching the body. Clothing the body and covering the mouth helps, but body bags are not needed according to

WHO guidance. Gloves and masks should be worn by attendants and their clothes washed using chlorine

Some additional points came up in response to questions submitted by participants:

- Gloves and masks were not recommended for people in general, as if they don't wear them correctly, they can increase the risk of transmission.
- There was no evidence to date that the virus can transmit via stool.
- There was no evidence to date that chloroquine, hydroxychloroquine, or azithromycin were effective treatments for COVID-19.

Situation in camps

In Bangladesh, one of the main issues looked was re-structuring teams to be able to provide isolation for those who test positive, but there was still much left to be done in this regard.

In the Salamiyah camp, the health staff had been provided training and the materials made available from WHO. Camp residents had been observed to avoid going to the clinic to avoid the risk of becoming quarantined. As many were asking about vaccination against COVID-10, there had been an opportunity to advocate regarding vaccinations in general and get additional children vaccinated. An isolation space had been set up in the clinic for suspected cases and they were currently working on identifying a site for additional isolation space.

In South Sudan, they were running an exercise for how to manage an eventual outbreak in the POC sites. Construction was pending for an isolation unit. Handwashing and temperature measurement stations had been set up at the entry points to the POC sites.

Appendix 1: Webinar transcript

Operationalizing standards: Sphere and the COVID-19 response in camp settings

April 2, 2020

NOTE: This transcript may contain inaccuracies. For a complete recording of the webinar, please visit <https://phap.org/2apr2020>

>> ANGHARAD LAING: Okay. We can get started then. Good morning, good afternoon, and good evening, depending on where in the world you are connecting from today. My name is Angharad Laing. I'm the Executive Director of PHAP. That's short for the International Association of Professionals in Humanitarian Assistance and Protection. I'm delighted to be serving as your host today for this webinar entitled Operationalizing Standards: Sphere and the COVID-19 Response in Camp Settings organized by the Camp Coordination and Camp Management Cluster, CCCM cluster, and PHAP.

Now this is clearly a topic that is engaging a lot of people today, and it's great to see so many of you not only in the main event room here, but I understand we have more than 500 people right now on the livestream channels, which is fantastic. We actually had more than 2,000 people register for today's event, so that's why we've been emphasizing the livestream. Thanks so much to those of you logging in no matter how you're logging in. It's great to be able to bring everyone together. We are looking forward not only to today's two-hour discussion, but also future opportunities to bring you all back together again as well. This will be an ongoing discussion over the coming weeks.

Now all over the world, everyone's focus is currently on the novel coronavirus and COVID-19 and the effects it's having on health services and both global and local economic systems. People are however affected differently by the current situation. Some are, of course, more vulnerable than others to both the illness and the overall disruption. Among these, displaced persons are often especially vulnerable. They are the focus of this webinar where we will be looking at preventative measures taken to protect them from COVID-19 and how we respond once there is an outbreak in the population.

While displaced people will be living in different types of contexts, to help us focus the discussion today, we're going to be looking in particular at camp settings, planned camps, unplanned camps, collective sites, and transit centers, and how we can apply technical guidance in standards to this new situation. For those of you working in other types of response contexts, I hope that you'll be able to draw some relevant lessons from the discussion today. The CCCM cluster will then be organizing additional webinars related to COVID-19 which will be looking more at area-based approaches and other types of responsibilities for camp managers.

We have already received many questions from you in advance and we'll be covering a lot of these in the discussions today. But, again, I do encourage you to really engage in real-time in the discussion, in the chat, and also to submit new questions, especially reacting to what you hear from our speakers and what you see in the chat, what you hear from your fellow participants. Please do submit additional questions in real-time throughout the event. We'll cover as many as

possible during the event. And for those that we don't have time for in the live session today, we will be following up with the speakers afterwards to see if they'd be willing to provide an answer in writing that we can then share with you and with all of the registrants as an ongoing resource.

In today's event, we'll be looking at standards and how they provide guidance for response in camp settings in the new COVID-19 operational environment that we're all facing. In particular, we'll be looking at the Sphere standards and we'll be hearing from Aninia Nadig, Policy and Practice Manager at Sphere, about the overall relevance of the standards and the recent COVID-19 guidance published by Sphere. Welcome to you, Aninia. Great to have you on the line.

>> ANINIA NADIG: Thank you. Thank you very much. Happy to be here.

>> ANGHARAD LAING: We also have two of the lead authors of the WASH and Health Chapters of the 2018 revision of the Sphere Handbook on how these standards translate into our current reality. We're joined by Judith Harvie, currently a practicing clinician in the UK at National Health Service, was lead author for the Health Chapter. Welcome, Jude.

>> JUDITH HARVIE: Good morning.

>> ANGHARAD LAING: Good morning to you. Also, Kit Dyer, WASH Adviser with Norwegian Church Aid, who was a lead author for the WASH Chapter. Welcome to you, Kit.

>> KIT DYER: Morning all. Good to see you virtually.

>> ANGHARAD LAING: Yes. Yes. Indeed. Great to have you virtually here with us. And also, together with Antonino Torres, Global WASH Coordinator with IOM. Welcome, Antonio.

>> ANTONIO TORRES: Thank you. Hello, everyone.

>> ANGHARAD LAING: Great. Great. Glad that you're connected, Antonio. Also, an important aspect of the response in camps is how we engage communities, and I'm very happy to have with us Virginia Moncrieff, Acting Response Manager at Translators without Borders, who will help to give us some overall pointers in this regard. Welcome, Virginia.

>> VIRGINIA MONCRIEFF: Hi. Thank you very much. Glad to be here.

>> ANGHARAD LAING: And, importantly, all of the guidance needs to be applied to fit the local context. We'll also be hearing from camp managers who are currently facing COVID-19 in the camps they are working with from which we'll hopefully be able to draw inspiration for how we act in our own response context. In that regard, we have with us Manuel Pereira, Deputy Chief of Mission in Bangladesh with IOM. He's working on the response in Cox's Bazaar but connecting from Bangkok due to the travel restrictions. We're still working on getting that connection. We believe he's had an emergency come up, so hopefully we'll be able to bring him in very shortly. We do have on the line Richard Okello, CCCM Cluster Coordinator in South Sudan. Welcome, Richard.

>> RICHARD OKELLO: Thank you. Good morning, everyone. Nice meeting you virtually over this screen.

>> ANGHARAD LAING: Indeed. Good morning and welcome, Richard. And connecting from Iraq, we have Sybilla Kitsios, Camp Manager for the Salamiyah camp with ACTED. Welcome to you, Sybilla.

>> SYBILLA KITSIOS: Hello, everyone. Very happy to connect with everybody and share experiences.

>> ANGHARAD LAING: Perfect. Thank you, Sybilla. And finally, we're joined by Dher Hayo, Senior Durable Solutions Coordinator with UNHCR and previously the whole of Syria coordinator for the CCCM Cluster. Welcome, Dher.

>> DHER HAYO: Thank you very much. Glad to be here.

>> ANGHARAD LAING: Terrific. Thank you.

Now, so to set the stage, and, Dher, I'm going to stick with you, I'd like to turn to you first: What can you tell us about what is happening in Syria right now in terms of the camps in this new context of COVID-19?

>> DHER HAYO: Currently, related information on the displacement inside Syria, we have more than 6 million internally displaced persons. The camps are scattered all around the country, which the humanitarian actors are facing immense difficulties to access and provide services physically in these camps. In this, we are mainly focusing on the areas where we are able as the Cluster and the Cluster members to provide assistance. I am referring in particular to these camps that are located in northwest Syria, in Idlib Governorate, which is already a very intense conflict zone. In Idlib Governorate, there are 3 million people, of which nearly half of them are internally displaced people. Part of this, more than one million internally displaced people, nearly 700,000, one-quarter are living in these IDP camps. [indiscernible 00:09:06], the camps go beyond the [indiscernible 00:09:08]. Most of these camps are self-contained, so they lack the many months capacity to respond to any emergency situation, such as COVID potential breakouts. Some of these camps are running beyond their capacities by 400%. They are very much overcrowded, and such services are highly over-stretched in these conditions.

The humanitarian response is done remotely, and gradually it has become more and more remote from 2013 onwards. The assistance is provided through international borders from southern Turkey. The coordination is based in southern Turkey, [indiscernible 00:09:56] and the key organization. This part of the organization is largely tasked with local organizations based inside Syria where they translate the information they provide from here into actual services inside these camps. What we are doing and what's happening with regard to the response currently, we are translating the standards into operationality. We have been studying all the possible scenarios and preparing contingency folks inside these locations and in the vicinities of the areas. In some of the camps, in particular we are referring to the reception centers where the IDPs are living jointly in large tents that we currently have, these basically we are prioritizing to evacuate the IDPs in case something happens and it will be nearly impossible to control the situation. And then inside, we are working closely with the Health Cluster and their actors in health services. Many of those locations are not located inside the camps but in the area whereby we are informing the health service providers about the situation in the camps, numbers, and the experiences of the vulnerable and especially vulnerable of the camps.

We are, most importantly, building some communication with the population of the camps and with the host communities because it is very normal that where we don't have access, the

host community doesn't have access, and this fact also could cause these camps a threat because of their special situation. Again, we cannot ensure how communication is important in these kinds of situations. We, of course, work also beyond health. We work very closely with the WASH Chapter actors to ensure that these scenarios are in place in case we lose complete access and there are possible ways to reach those IDPs. We are definitely working with Health Cluster and CCCM Cluster to try to deliver some items. There are, when possible, some processes already established by the specialized partners of the Cluster and Health Cluster to be ready for any potential breakout. We're hoping this will not happen, but to be ready to respond in case there is anything. Over.

>> ANGHARAD LAING: Great. Thank you so much, Dher. We've received a number of questions, including from Danielle in Chad, now from Gulam in Pakistan, Faye in South Korea, Eric in the U.S., Patrick in Zambia. All of them are wondering about the new access situation to camps in the context of COVID-19 and how to manage remotely if access is not possible. I hear that you have – you do have experience in this regard, of course. This question will be a thread throughout the event, but I'd like to ask you first as you have been remotely coordinating partners working in camps in Syria: What would you highlight from that experience as lessons or wisdom that you could share with those working in other contexts who may now have greater access restrictions for the camps that they are working with in the COVID-19 context whereas they didn't have such restrictions before? How have you seen things change? Really, what – briefly, what would you highlight that could be lessons that could be taken to other contexts. Over to you.

>> DHER HAYO: In this situation, it is important to make sure that the standards and the messaging is delivered to the remote context. The key slogan that all of us are using now with regard to the COVID-19 situation and where we see everything is stay home. In camps, unfortunately, this is very much irrelevant because the definition of home is very different and the people are not home, so they have to stay in the camps.

For us, with the lack of access, we have to make sure that beyond the management only, the coordination is basically maintained and tested to the extent possible to make sure that if we are going to improve the access easily, these steps and these contingencies are going to operate independent from us. This is going to happen mainly not only through us and through our partners whereby we might improve access but also by testing very close communication channels with the residents of the camps that are the focus for us inside these camps. Testing the services becomes extremely important because you don't want to find yourself missing some key physical aspect when you completely lose access.

Again, I cannot emphasize enough on testing or communication on testing all the areas where I think these folks are reachable for the IDP and making sure that the key lifesaving services are not cut from these camps. Also, from the coordination perspective here, the role of the camp coordination and management cluster and the camp adviser to make sure that you maintain close contact with the other clusters because the situation in the camps, again, might be very much different. People out of the camps have the privileges and the capacity to stay home. The camps will not close because people have to go outside to access food, basic services, and anything else for small children that they are staying with.

It is important to continue the services and communication with the host communities and, in fact, to all authorities in the area, to keep explaining to them the situation in the camp. What is most important, again, keep yourselves always ready to receive the information, because once you lose the direct access, information will be the only way for you to tell what would be next,

which kinds of services you have to continue providing in these camps in the management context. This was basically the experiences that we have had for Iraq when the access was not possible. It's Somalia and Syria currently. Over. Thank you.

>> ANGHARAD LAING: Great. Thank you so much, Dher. That's very useful, indeed.

Now to continue on this path of helping to orient our participants, I'd like to just briefly turn to our colleagues on the line who are working in other camp situations. I'll first turn to Sybilla. Are there any confirmed COVID-19 cases in the country where you're working, in the camp where you're working? And what kinds of measures is the government putting in place that are affecting the camps? I'll turn first to Sybilla and then to Richard. Over to you, Sybilla.

>> SYBILLA KITSIOS: As of this morning, the Iraqi Ministry of Health has confirmed 728 cases of COVID in Iraq, with 52 fatalities and 182 patients who have recovered from the virus. Inside our camps, we currently do not have any cases confirmed. The government of Iraq and the Kurdish regional government were quite quick to respond to the confirmed cases and they have extended curfews and government restrictions until the 19th of April. The Iraqi airport is currently closed. At present, all the major airlines have suspended normal passenger operations to Iraq. The Minister of Health has also called upon Iraqi citizens to be proactive in coming forward if they have flu-like symptoms, stating that the majority of fatalities have observed due to delays in seeking medical attention. They also have established a hotline that people can call. There has been a new laboratory opened in Baghdad for the testing of COVID-19 which adds to the country's medical capacity.

In Iraq, the first cases – the first case of corona was confirmed on the 21st of February and the Directors of Health was quite quick to respond to this. They visited our camp three days later to provide awareness sessions on the virus to camp residents, interested residents, and staff. The DOH, the Directors of Health, also informed us as camp management about several measures that must be taken given that detection of the virus inside Iraq had been declared, such as restriction of movement. Based on this and some inputs from the CCCM, WASH, and Health Cluster, we then developed a four-step response plan, which in the second phase included a response to a suspected case in camp. We had that once and we religiously informed the Directors of Health and they came with the support of our health partner to sterilize the camp. The Iraqi Ministry of Migration and Displacement has also created a working group with all camp managers and health actors in the country to be able to coordinate between each other fast and quickly respond to the situation.

An interesting point also is that we have some groups organized inside the camps during the lockdown of the country, such as in many countries around the world. It was difficult for IDPs to move out of the camps to the markets in Mosul and nearby villages to stock up their markets and purchase items such as vegetables, fruit, and milk that usually are not available in the family food situation, but we did get it in. We then quickly raised this concern to the mayor and he provided an access letter for these individuals to be able to set up their markets outside and come back with the supplies so that IDPs could still purchase the vegetables, for example, inside the camp during a lockdown.

As of now, as I said, we don't have any confirmed cases in camps. But in the region where our camp is located, we had five confirmed cases. Today, this morning, I received a phone call from our health care nursing that the first test had been negative, so the patients are recovering. In 24 hours, we will know – there will be another diagnostic test and we will know if the patients, the

five, have recovered, making the area where our camp is located free from coronavirus. Thank you very much.

>> ANGHARAD LAING: Great. Thank you very much, Sybilla. Could I turn now to Richard? Same question for you but different context. Could you tell us just briefly a bit about the current situation where you're working in South Sudan? Are there confirmed COVID-19 cases? What kinds of measures are in place, et cetera? But briefly, over to you, Richard.

>> RICHARD OKELLO: Thank you very much. Hi, again, from South Sudan.

South Sudan, as of today, there is no known case that has been declared. The actions that have been working by both the humanitarian and the government and preventive measures. We are well aware that South Sudan does not have the capacity of diagnostics. They cannot be able to respond to any cases of COVID. Right now, what has happened, the airport has been closed, all borders connecting to other neighboring countries because all the neighboring countries to South Sudan have all declared COVID [indiscernible 00:22:29]. There is no known case. The borders have been closed. The bars have also been closed, including restaurants. You can only take home.

Going back to the displaced population, South Sudan has 11 million people, but out of these, 1.3 are living in displacement operations with really highly congested living situations. Briefly, that's all about South Sudan. I will come back later on to discuss what we are doing as camp management and the cluster. Thank you very much.

>> ANGHARAD LAING: Great. Thank you, Richard.

Now I'd like to check if we have Manuel on the line. Could we test if you're there, Manuel?

>> MANUEL PEREIRA: Hi. Can you hear me?

>> ANGHARAD LAING: Yes, loud and clear. That's terrific. Yes. Perfect timing. I'd love to turn to you now for this kind of framing, orienting our participants on the situation in different locations around the world. Could you tell us a bit about the situation in Cox's Bazaar regarding confirmed COVID cases, what kinds of preventative or mitigation measures are in place? Over to you.

>> MANUEL PEREIRA: Thank you. Thank you so much for that. In Cox's Bazaar, the first cases have been identified on the host community, not in the camps. But as you may all understand, there is fear among the refugee community and among the host community. The arrangements made for social distancing and trying to create measures to mitigate spread and increase awareness are clashing with the restriction of freedom of movement of the refugees and then you get these perceptions and bias against humanitarians and refugees. The military has now put a very strong control access to the camps. There is pressure to reduce as much of the operations and access of humanitarians to the refugees. It's quite concerning at this point, the lack of understanding of the work that needs to continue and which is the work that could actually be halted, which diverts us also from trying to provide some resources in mitigating the situation with the host community. It's a quite complex situation.

>> ANGHARAD LAING: Great. Thank you. Thank you for that, Manuel.

And just a note to our participants, now if you have questions, as you can see, we have covered a number of different specific contexts here and we have great resources on the line in the form of Dher, Manuel, Sybilla, Richard. If you have questions for any of them regarding the context where they're working or have been working, please post those in the Q&A and we'll be coming back to all of them, of course, later in the session, so we can post some specific follow-up questions there.

Now turning at this point to how we respond to the current situation, we all come across standards of different kinds in our work, but the Sphere standards stand out in the humanitarian sector with widespread familiarity and practitioners across the sector referring to them.

Aninia, turning to you, the latest revision of the Sphere Handbook was in 2018 and I assume that there was no pandemic of this scale primarily in mind when drafting the guidance. Could I ask you then: What guidance can Sphere offer in the COVID-19 operational environment? Over to you, Aninia.

>> ANINIA NADIG: Thank you. Thank you very much. I'm happy to be here. I'm going to bring in quite a different perspective from what we've just heard. It's very intense and humbling to hear what is going on around the world at this moment. Yes, the Sphere standards have been published in their current version in 2018. No, we didn't have a COVID-19 response at the time, but we do, I think – we did learn from in particular from the Ebola crisis. Thanks to our WASH and Health authors, we have stronger and more visible guidance on community engagement in the handbook now than we did before. I can walk you through this a little bit. I will stay at a very high level and can then go into more details if you like.

On the next slide – yeah. Thank you. On this slide, I want to show you how we went into the COVID-19 guidance that we've developed a few weeks ago and which had a lot of uptake. The starting point was to say you cannot do the response like this if you don't have people and communities on board. There are three arguments to this. The first one is that you need to treat people as individuals, as humans, and not as cases. This element of human dignity is very strong in the humanitarian charter. Now you might say, well, the charter is just something aspirational and relatively abstract, and I would like to say that elements like the humanitarian charter or the protection principles, which we'll get to in a minute, are particularly important when it comes to a situation like the COVID-19 response. The humanitarian charter mentions the three key rights, which are the right to a life with dignity. And in a health situation, it's also the right to death with dignity, which goes all the way to the new palliative care standard in the handbook. It's the right to receive assistance, and it's the right to protection and security. All of those are key rights that we need to uphold and address as good as possible in this response. The next element is the community engagement, which is key in the WASH and Health Chapters, but also in the others. The WASH Chapter has the strongest focus on it because it works so much on hygiene promotion, and that is key to this response again. Then thirdly, we mentioned the fact that you cannot just work on a COVID-19 response. You need to maintain all other aspects of health and other needs of people as well. That is where psychosocial support, palliative care, and all other standards in the handbook are of critical importance. We may not lose that perspective.

On the next slide, I want to discuss briefly the three elements that Sphere brings together and which will help you in your response. The first is, again, the community engagement, the second is technical standards, technical knowledge, and the third is contextualization and coordination, and here specifically in camp settings. Community engagement and technical good medical response, those two are key factors for a public health response. In that sense, I would argue that the Sphere Handbook is a very good tool for any public health intervention. Community

engagement, we've seen it, we've touched upon it. It's about hand washing. It's about the engagement, the exchange with communities, knowing where communities are, knowing where the people are and what their needs are. Technical standards in terms of the COVID-19 response are in particular the hygiene promotion standard in WASH, standard six of the WASH Chapter which talks about WASH support in disease outbreaks and which is a very good example of WASH and Health sectors working together. And then actually all health standards, but in particular the first part, and then the communicable disease response section. Those are the important technical standards. Then context and coordination in camp settings, we're going to get back to that in a minute.

I wanted to go to the next slide, though, because you'll find it in the WASH introduction chapter, in the introduction to the WASH Chapter. It really brings together the three key elements of community engagement. In the white part on top, the three white boxes talk about analysis. It is context, people, and behavior and practice. You then have the light green squares on the right. They are specific to programming. It's about information sharing and communication. It's about capacity-building with staff, partners, communities. It's about accountability, welcoming and addressing complaints. It's about participation. It's about monitoring, evaluation, and learning. And then the external engagements are the two darker green squares on the left, advocacy and coordination and collaboration with national, international, local actors. Here, you also see a very strong connection to the core humanitarian standard and its nine commitments which are now part of Sphere and which also directly influence community engagement and your technical work. What I wanted to mention also is for this integrated approach is that the technical standards are a direct expression of those rights of community engagement that we see in the first part of the handbook. You cannot do technical work, according to Sphere, without stumbling over guidance again and again about inclusion, about communicating with people. That makes the handbook as such quite a coherent tool.

In the next slide, I want to briefly mention the importance of Sphere for camp management. First, the context. I mean, we've heard now a few contexts where you are working to cite the COVID-19 outbreak. Context is so important. These are global standards that express globally agreed rights of people and you need to put those into context. I don't have the time now to do that specifically. But what's so key for your situation is the coordination. You have the camp management role that needs to work with all sectors, with local authorities. We've seen that. That needs to really break down those silos between different technical sectors. You see them in the handbook as kind of silos because simply the handbook is a continuous – it needs to group the information along chapters. But to really work with all together and come to a joint coordinated approach so that you don't hinder each other but support each other is really key. The other thing about contextualization, which you know better than I do, is that if there is a real problem in one sector, you may have another sector that can come in and support. Here you see that shelter, food security, nutrition, that I haven't mentioned so far, are completely part of this response that you need to be doing. This is where Sphere can help. I would like to end with this. Sphere will give you this common language that you can agree on. Even though you may feel that the standards are impossible to reach, it still gives you a common language, common benchmarks that you need to develop. Hopefully that sends a more coherent approach that Sphere should support you in the holistic approach that you need in camp settings. Thank you.

>> ANGHARAD LAING: Thank you so much, Aninia.

I have a question that's just come in from Madeline in DRC. Madeline writes: Will the ongoing pandemic affect drastically our way of working, including our standards? She writes I want to believe that the pandemic will stop like other recent sanitary crises. We had previously HIV,

Ebola, and the SARS pandemic which did not affect the standards. But what will be the impact of COVID-19 on the Sphere standards? Over to you for any thoughts on this, Aninia.

>> ANINIA NADIG: Thank you. Well, I'm certain that this pandemic will influence the standards. What the standards can do is build on past knowledge, on accumulated knowledge that builds on past events. I would say that HIV and Ebola have found their way into the Sphere Handbook. There is a section on HIV in the health sector. There is an HIV standard. Ebola, as I said, has really brought forward how to respond to disease outbreak, and in particular how important the community engagement is because, otherwise, if people don't trust you, if people don't engage with you, you cannot – Ebola showed that you cannot do a proper response. SARS, probably a bit less, but Ebola and HIV, I think, are in the handbook. And so will COVID-19 be in the next iteration.

>> ANGHARAD LAING: Great. Thank you very much.

Now we have another question, but I'm going to use this question to pivot, I think, over to Virginia. The question is from Ramesh who writes: 'This emergency is different from others as we're all saying we need to keep social distance. But in this scenario, how can community engagement be ensured if we're trying to keep social distance? Any approach or way out of this dilemma? It picks up on points raised by Aninia on community engagement. To stay on this topic and respond to this very timely question from Ramesh, Virginia, can we turn to you and ask: Looking at COVID-19 more specifically, why is community engagement important in a crisis of this type? How do you see the role of camp managers in this regard? And just wondering if you have any reflections on this challenging question raised by Ramesh, this apparent dilemma between social distancing and community engagement. Over to you, Virginia.

>> VIRGINIA MONCRIEFF: Well, first, I'd just like to say that I think that camp management has a really unique ability to have a really strong cross-sectoral overview of people's needs and their concerns and the needs of community engagement during something like COVID-19. This became really clear to me when I actually had spent years working in the IIP sector and then went to work for IOM in Bangladesh for 18 months. It just became incredibly stark to me the unique ability and insight of camp management teams to working community engagement, to have an insight into the whole of camp needs, and to meet the real obligations of leading coordination and ensuring community engagement strategies are transparent and effective.

In terms of the way we approach COVID-19 in camp settings, it is a challenge given a lot of people are working with diminished staff, a lot of people have withdrawn a large amount of staff, and that we know that most of the people who live within those camps really prefer face-to-face communication. You've got a double whammy here of sort of communication issues that you're trying to look at. I think that a lot of ways that people are doing community engagement at the moment can actually be effectively recalibrated for this crisis, turning to our speakers, for example, and using sort of USB and recorded messages across the camps so that there is a consistent and updated system of people receiving a unified message is one of the things that this brings to mind and I think will just be really very simple and effective. One of the most important things, I think, though, is making sure that you collect the information from the people on the ground as to what they're hearing. These few are even going to set up – even tomorrow, you can set up a WhatsApp group of your skeleton staff on the ground and they can just continue to feed back to you what is being said and what people are thinking, not necessarily rumor tracking, but just where people's belief systems are working and what their fears are. You can really start reorganizing your programming and repurposing your programming.

Just one other thing I want to say while we're talking about this is that obviously you have to involve the community as the main driver of information, and so we have to always be really concerned about language. Information must be delivered in a language and a method that enables people to make the best decisions for themselves, their families, and the community as a whole. And this may not be such an issue in places like Bangladesh where you have a camp full of people who speak mainly one language, but I've just spent a year in Northeast Nigeria and there you have camps where people are speaking in five or six different languages in one camp. If you don't take language into account when you are dealing in that kind of camp setting, you're really setting yourself up for failure, and you're also possibly setting up whole communities for stigma if they are not following kind of instructions that everybody else has got about social distancing and appropriate behavior. They haven't received that information, so they're behaving differently from everybody else in the camp, but also they may become infected. That's a whole other reason, obviously, other than the sheer humanitarian standards of making sure that people are receiving information in a language that they understand.

>> ANGHARAD LAING: Great. Thank you. Thanks so much, Virginia.

Looking globally at camps in different contexts, what would be some of your main recommendations for what practitioners should keep in mind in the COVID-19 response? There are a number of participants wondering about this I see, including a question from Maria in Spain, simply wondering about your key recommendations looking at different contexts. Back to you, Virginia.

>> VIRGINIA MONCRIEFF: Obviously, the key recommendation from Translators without Borders is make sure that people have the information in a language that they understand and that you utilize national staff and community mobilizers within your camp to make sure that that information is shared with people in a way that they completely understand and are relaxed with the delivery. I think with COVID-19, one of the things that would accept information and the way they act on us, and so therefore the way we're talking to people, we really need to be honest with them. We need to make people alert and realize that they need to take specific actions that may turn their daily routines upside down and which they may consider sort of urgent or kind of something that they're not really comfortable with. We need to kind of make sure that we indicate that there's an urgency within the action, but we don't panic people so much that they completely immobilize, or they act irrationally, or they act dangerously. I think if that balance of not reassuring people that everything is going to be okay and that we've all got the answers and that everything is under control, but also not being worried, sometimes fear is a motivator. We are all motivated by fear, and so we do have to sort of calibrate our responses so that they are appropriate and honest and we're not trying to hide things from people or infantilize our response.

>> ANGHARAD LAING: Great. Thank you.

I have a question here coming in from Philip in Spain. He writes: How can we best adapt participatory approaches to generating and disseminating key messages dealing with misinformation and rumors, et cetera, when social distancing measures are in place? Back to you, Virginia.

>> VIRGINIA MONCRIEFF: Thank you. I know that Manuel from Cox's Bazaar will be talking about that shortly. Rumor tracking is actually really important, and it can be done, like I was referring to before with the work with refugees and what have you, it can be done remotely.

It is essential for recalibrating your communication messages and your daily updates, et cetera. It's when people in camps, for example, in Cox's Bazaar so heavily rely on their religious and sometimes mythical understandings of why their life is like it is and it has proven a great crutch to them, when rumors, et cetera, come through that prism, if you like, it's extremely hard to disrupt, but it doesn't mean we should stop trying. When you're doing social distancing, it's a great idea if people already have those contacts in the camps with their key influences, the leaders of women, people who are imams or trusted people who you know will be able to speak to you and speak to the community with integrity. They are the people that we should be really relying on at this point when we are in a skeleton situation where we are unable to have, as you say, various kinds of mass meetings or mass disseminations and discussions with people.

>> ANGHARAD LAING: Perfect. Thank you so much, Virginia. I see we have other questions, so hopefully we'll be able to come back to you later in this session.

In the meantime, though, I would like to jump over to Manuel on this topic of rumor tracking. Manuel, I understand you have been using rumor tracking in Cox's Bazaar. Has that helped you in the response? Over to you, Manuel.

>> MANUEL PEREIRA: The way that we are able to understand their fears and their needs for information and the rumor tracking is the fundamental piece of that. So far, we have done that with smaller focus group discussions and trying to get a sample of a broader community of the refugees and then process those focus group discussions and put out messages for sectors to understand how refugees are perceiving the crisis, because in that process, the questions that are being raised in complaint feedback mechanisms during these focus group discussions can then be constantly approached from an explanation point of view. We launched a system called COVID Explained which is this recurrent assessment of how the refugees are interpreting the messages and their concerns and we have to continue adapting our systems and our practices. Distribution has started door to door because people didn't feel confident or they were scared to go to distributions. Social distancing in distribution has reduced the amount of people that can have access to humanitarian assistance every day, either gas distribution, soap distribution, or in the cleaning. And so there are a lot of these small adjustments to operations that come from the perception and the rumor, fighting the perception and the rumors that we are gathering live from the community. I hope that within the next couple of days with the reopening of communications and internet access, we will be able to do this through open source, WhatsApp groups, and be able to allow refugees to reach out to these WhatsApp groups and give their own questions for which we as a group, a community of humanitarian actors will be able to provide clarifications and explanations basically on audio records, not on messages because a lot of the people are illiterate, but being able to have refugee volunteers that record audio messages that then are massively disseminated and people can exchange among themselves in their own language to answer their own questions.

>> ANGHARAD LAING: Excellent. Thanks so much for that, Manuel.

I would like to turn now to the technical standards in the Sphere Handbook. So jumping back to the Sphere world here, Kit, in the Sphere chapter on WASH, what specific guidance would you highlight for the COVID-19 response? Over to you, Kit.

>> KIT DYER: Thanks, Angharad. I'm going to take a slightly different approach and I'm going to look at how we are looking at responding in the sector. We've got two main things we want to be focusing on. The first is how we as a sector combat the spread of the disease and

support the response to it, and the second is reducing the stress on already overwhelmed health services.

In the first phase, I think what I want to do is to go back to basics for a moment or two. Asking the question: What is WASH and why do we do it? Thank you for the first slide. Oh, I can. That's a bit past. For those of you who haven't got much experience in WASH, this is our S-diagram and it explains the fundamentals of why we do WASH, which is primarily to interrupt the transmission of communicable diseases. The S-diagram, as you can see it, shows the main fecal-oral transmission routes of diarrheal disease. The thin arrowed lines between the green squares, which are these transmission routes, are linking feces to faces. And also, how we can interrupt this transmission by putting up specific barriers through the provision of safe drinking water, sanitation and good hygiene practices, which are both smaller green letters that you can see on the transmission line. They're our barriers.

The S-diagram is about fecal-oral transmission of diarrheal disease, but it's pretty applicable to any pathogen that causes diseases. What I've done is I've created a COVID-specific diagram, which we're calling the cough diagram thanks to Antonio from IOM for that suggestion. Again, if we have a look at both thin green lines, the transmission routes for COVID-19, WHO tells us there are two primary routes, the first through coughs and sneezes, that's that top direct line from face to face, the respiratory transmission line, and the second through hands or surfaces, through contact transmission. If we think about these modes of transmission, then our primary barriers are largely hygiene related, covering your sneezes and coughs, good hand washing practices, and cleaning high-risk surfaces in public places and schools and other institutions.

However, there are other things we can also do in our WASH program to enhance that physical distancing at water points, at laundries, at communal or shared toilets so that we can decrease the time people have to spend in queues. We can increase the number of water deliveries or perhaps to more and temporary water points. We can introduce spaced queues for services, such as water points or distribution points. I think WFP and IASC guidance has been issued on that and it should be available on the net. Here is a wee picture from WaterAid I think in India that came to me courtesy of Brian Reed that shows how local communities are looking to develop both physical distancing practices at a water point. This is a fairly busy small village which could perhaps be also applicable to a camp. We can also make sure that people have enough household water storage containers so they can choose when they go to queues to fetch more. We can reduce the number of people touching the water points by perhaps introducing or re-introducing caretakers. As difficult as this is, we probably need to be trying to introduce more water into the system, the Ws that I'm showing up there, more water for handwashing, but also for other cleaning and laundry.

One thing that we've also seen from the WHO guidance is that we need to make sure that the people collecting solid waste from households or community collection points have the right kind of personal protection and that households are able to space out how their waste gets into that custom. The big critical thing for us is that we need to make sure that settlement managers see people working to deliver WASH services as essential staff. They should not be redirected to other tasks and they need to be protected when they're doing their job.

I wanted to say that the three hygiene promotion standards in Sphere are a good place to start looking at what we can do. As Aninia, as Virginia, as other people have focused on, our community engagement teams are a good place to start with a good hand hygiene messaging and encouraging good behaviors. And at the same time, we can use them for other good behaviors and other key messaging, like health seeking behavior, for example, in a Malaria context and

physical distancing and de-stigmatization, which I think was something that Virginia had touched on as well. In crowded conditions like camps and transit or reception centers, the social distancing and isolation is going to be difficult. I think hand hygiene becomes more important than ever. Delivering these messages will not be easy. We've heard from Virginia some ideas about how that can be done in this context. If we then take a look at the five key actions recommended in the S-guidance on COVID-19 in camps, WASH works directly in all of them.

The last piece I wanted to touch on was, and probably it is as important, and hopefully my colleague Jude from Health will also talk about this, is that as people are seeking support from local health centers, there is a standard that helps us to identify, as WASH actors, what we can do best, what we need to be prioritizing in these healthcare settings. I think in hindsight, this standard that we developed was actually made for this kind of condition, this kind of context. That's something that can give us some areas where we can prioritize the sorts of activities we need to be doing as WASH actors in those contexts.

That was a description of the first kind of direct actions that we can do in this response. I think that so many of us are already very much focused where we're mobilizing funding, where we're getting people out there, and where our donors are actually already helping us. However, it's just as critical that we make sure that we can continue to provide at least basic WASH services to people in these high-risk environments. Dr. Premendra, I'm not sure where you're from, but mentioned fecal sludge management in camp settings. It is critical that we don't let that fall over. What I and other WASH people think about a lot, wakes us up at 2:00 in the morning, is what happens if people become scared of shared or communal toilets or communal water sources because of COVID-19. What can we do about that? What happens to all of the women and girls in our camps who are trying to manage their menstruation when they don't have the space, supplies, or the water because of the COVID-19 response? What can we do about a water supply service that doesn't have the necessary supplies or personnel to treat the water due to a logistic breakdown? What are we going to do about surge services so that the funds pay for electricity because the local economy has tanked? And what are we going to do about seasonal outbreaks, such as Malaria, ripping through an IDP camp in a place already overwhelmed by COVID-19? On top of that, as we all know, we've already got two billion people without access to a safe toilet. What are we going to do in this response to ensure that those people are trying to gain access? We can't stop doing what we're already doing. If we go back to the Sphere standards, they help us to go back to the basics and to prioritize what we can be doing, what we perhaps can leave until after the response has calmed down a bit, but what we need to be doing now in our context. Thanks, Angharad. Back to you.

>> ANGHARAD LAING: Terrific. Thank you. Yes, we have a lot of questions coming in, Kit, some technical questions, some broader questions as well. I'd like to try and tackle a few of those if possible. First of all, from Safwa Toole connecting from Bangladesh writing: Camps where water is scarce – in camps where water is scarce, frequent handwashing with soap may not be feasible. Is a 0.05% chlorine solution for handwashing adequate to kill coronavirus? Over to you, Kit.

>> KIT DYER: Yeah. This is a good question. It's something that we also tried to look into and address and had a lot of thought about for the Ebola response where hand hygiene was equally important. One thing we know about chlorine is that it attaches to the particles on our hands that aren't necessarily the virus. It might attach first to the dirt, the sweat, to the dead skin cells, so it won't be as effective in targeting the virus as soap will be. The other problem is that it's the rinsing action that you do to get the soap off your hands which is part of the process of making your hands clean. Finally, chlorine is really not a nice substance to be handling. It can

damage your hands quite badly. We certainly saw that in the Ebola response as well. Our recommendation, and I think most of the guidance documents you'll see out there, is soap and water or hand sanitizer if you can.

>> ANGHARAD LAING: Great. Thank you so much. We have also a couple of questions regarding disinfection. We have a question from Aud in France who writes: What about home disinfection for houses with suspected or confirmed cases? Is this relevant or not? Or should home demonstration sessions of disinfection of household surfaces be carried out instead, combined with the distribution of hygiene kits with disinfectant? And a related question from Petras connecting from Greece: Standards for disinfection of public – of office spaces, of communal spaces, and residential spaces, any guidance on this? Could I turn back to you, Kit, for these two related questions?

>> KIT DYER: Yeah, sure. If we go back to the cough diagram, the secondary transmission routes, definitely by surfaces. Disinfection is an important thing. How you go about it, it's going to have to be a little contextual. I think Aud's suggestion of doing – of teaching people how to do it themselves and giving them the supplies that they can do it is a big place to start. There is guidance from WHO about what to use for disinfection. I'll get a link up if I can to the WHO guidance on WASH in the COVID response. In relation to the second question, in places that are high-risk where a lot of people go to and a lot of people do use, I think there needs to be a really concentrated effort on getting those services disinfected. Again, we can go back to the WHO guidance to find some really practical advice. I think it should be part of the SOPs for managing public spaces. It's unavoidable. We cannot close absolutely where people will need to be seeking help and support. We've got to make sure those places are safe for them to use.

>> ANGHARAD LAING: Great. Thank you so much, Kit. We'll see if we can come back to you again later. In the meantime, I would like to turn to the individuals we have who are working in camps around the world to ask, in your context, how have you approached handwashing which is so central to the response now, especially in the context of COVID. What have you done to get information across to camp residents? Are there other WASH-related concerns that you see arising? Could I turn first to Manuel?

>> MANUEL PEREIRA: Hi. Thank you. Well, handwashing in Bangladesh due to unavailability of water is complicated. There has been a significant increase of handwashing points in the majority of the facilities where humanitarians perform actions, but also there has been the import of some technology like the taps which use very little amount of water and they can be correlated where we can have the soap on a string. But it essentially continues to try and explain to people that the handwashing is vital to be performed every time they go to where there are higher concentrations of people if possible during the day-to-day whenever they find a water point. It's going to be very complicated to manage the availability of water quantity over the next few months.

>> ANGHARAD LAING: Got it. Thank you. And Sybilla, how is the situation where you are when it comes to WASH and general handwashing in specific. Over to you, Sybilla.

>> SYBILLA KITSIOS: Yes. Thank you. We have launched key messages on banners that we spread about several different locations in the camp, especially at water collection points where IDPs usually come often. These key messages were all based on the inputs from the WASH Cluster and the Health Cluster and also in line with the guidance that we got from the Ministry of Health and the Directors of Health. In addition to this, we also set up with the support of

UNICEF some mobile taps in each mini management caravan. These caravans are usually places where IDPs can come to air their complaints or provide feedback or share concerns to basically encourage people to wash their hands. Thirdly, we launched videos on IDP – on WhatsApp and Facebook groups in which we knew that IDPs were using. We have used a lot of – we have had some meetings with representatives and we worked with them to ask if they could launch a campaign in which a medical agency was explaining with video how to wash your hands possibly preventing the spread of the virus. Thank you very much.

>> ANGHARAD LAING: Great. Thank you so much, Sybilla. I'd like to really invite all of the participants, both in the Adobe platform and we still have more than 800 people following the livestream. If you have experiences that you can share from the context where you're working, please do share those in the chat so we can have that as part of the discussion. It will be a very rich way for all of us to share our experience. We can also then follow up with you on those points, on those examples after the event.

Richard, can I turn to you? Same question. Having heard from Kit about WASH-related concerns, specifically about handwashing, but other challenges as well, what's the situation, what's been done, and how are you getting information to camp residents in your context? Over to Richard.

>> RICHARD OKELLO: Thank you very much. In South Sudan, as I said in the beginning, we are working on preventive measures. The crowded nature of the context we're working in currently, so we've come up with some five key messages to encourage the IDPs to make informed decisions where to stay in the displacement location with crowded conditions. Of course, we are providing the background of the COVID, the infection method. If you live in a congested area, then you are more exposed to spread the information. By inviting them to make informed decisions whether they want to stay or if they have another place where they want to go and how they can be supported to move where they want to go, but also we provide information. If you say you're going to area A, we provide you with information in terms of the services that are available in that location, in terms of the partners, what they are doing there, in terms of the security. Of course, South Sudan still has the ongoing security situation going on. When you choose a place which has ongoing conflict, then you are advised maybe to consider where you want to go. We also have information on those who want to stay, if you choose to stay, which is primarily your choice, but then we provide the information that services will continue, but this is dependent on two levels. One, if there is an outbreak of COVID in the country, there could be some disruption in the services that are being provided to the displaced persons in the camp, but also the other part, if there's an outbreak in the displacement site itself, maybe the government would place a complete lockdown, no movement of people inside the camp, and what services can still be provided. This is meant to empower them with the information so that they make an informed decision whether to stay or to go.

Apart from that, what was done, we've coordinated with all of our partners working in the displacement locations and come up with a contingency plan. A contingency plan is established in three phases. The first phase is what they are doing now in terms of preventive measures on contracting COVID, how they're dealing with the distribution. We've created a water supply in the displacement sites. The other phase is when there is an outbreak in the country, what activities the partners in the particular site will be doing and the activities they will do when there is an outbreak inside that POC. That's what we are doing currently. Thank you very much.

>> ANGHARAD LAING: Great. Thank you very much, Richard. I'd like to turn now back to Aninia briefly. We've had a number of questions coming in regarding other potentially

applicable standards. There was a question about the camp management standards, about the HSP. Could I turn over to you, Aninia, to share with us any additional points that you can do on that? Over to you, Aninia.

>> ANINIA NADIG: Yes, thank you. Thanks very much. There are camp management standards in the making. They are indeed available in draft format. I pulled them up here. I'll read them to you very briefly. There are five commitments in there accompanied by standards and they very much cover what we have been discussing. Commitment one, standard one talks about coverage, it talks about displaced populations have access to the services that the site management agency provides, which very much also links to the Sphere protection principle two, access. Commitment two is about representation. Site governance and site committees are representative of and accountable to the displaced population. Commitment three says services provided through a network of site-level agencies meet the needs of the displaced and host populations. Commitment four talks about the site environment which is safe and physically, socially, and culturally appropriate for inhabitants. Very important. And then commitment five talks about site closure and exit planning, keeping the safety and dignity of people in mind. These coordination standards complement very much the standards that are in the humanitarian standards partnership, that is Sphere and six other handbooks that cover humanitarian sectors. Those are in particular child protection, education, livestock and livelihoods, economic recovery, and market analysis, cash-based programming. We are hoping eventually to welcome the camp management standards into that humanitarian standards partnership and that will reinforce these messages throughout because we all cross-reference each other and enforce each other hopefully. Thank you. Over.

>> ANGHARAD LAING: That's perfect. Thank you so much, Aninia. I'd also like to jump over quickly to Sybilla. Would you come in just very briefly on that issue of key messages and combatting rumors that came up previously? I think you have some input on this. Over to you, Sybilla.

>> SYBILLA KITSIOS: All right. Yes, thank you. Definitely. Exactly what was mentioned. In order to fight the disease, we need people to adhere to the guidelines and preventative measures that they can take themselves. It can only be done, of course, if the community is informed and understands the methods. What we did in our camp is we asked the camp assistants or community mobilizers to keep walking around the blocks basically to identify any rumors and we also launched very quickly the key messages with the WASH and Health Clusters in order to ensure simple and accurate information sharing and ensure also that it's all coherent to avoid any rumors. We actually tried to also dispel some rumors that we have heard before through our key messages, such as dispelling the myth that putting chlorine on your skin will not protect you from catching the virus and can actually be dangerous, as was mentioned before by our colleagues. IDPs came up to us and thanked us for the flyers because, for them, they see any information coming from camp management as an official source of information rather than the information that could sometimes be false information through social media. It's very interesting because, actually, we witnessed a change of stance of the camp residents a couple of weeks before when the first cases just were confirmed in Iraq. We received the recommendations of the Directors of Health to restrict movement in and out of camp as a response to the outbreak. At first, we saw the camp residents were quite furious about the restriction of their movement. But after a while, after we launched the campaign, and we, of course, worked a lot through the camp residents' structures as well, women and youth committees, and sector leaders, we witnessed actually a change of stance and we actually witnessed several people asking us to have even stricter measures because they started to understand the severity of the message. I completely agree on information sharing. It's crucial. Thank you.

>> ANGHARAD LAING: Thank you so much. That's very interesting and very encouraging, Sybilla. Thank you so much for sharing. I'd like to turn now to another key technical area covered by this Sphere Handbook and, of course, very centrally relevant in the discussion we're having today. That is health. Turning to Jude from the Health Chapter, what guidance would you highlight for the COVID-19 response? Over to you, Jude.

>> JUDITH HARVIE: Hi. Good morning, everyone. I am going to avoid – one, avoid duplicating what Kit and Aninia have both spoken about, but concentrate on three main areas that seem most relevant and could potentially have the greatest impact on our sources of concern. The first will be looking at the systems and structures, the second will be looking at education and messaging more specific areas, and then something looking at safe and dignified management of the dead. The first point really is that everyone will really need to be looking after healthcare workers, whether that's doctors or nurses or community workers or other workers. Throughout this, especially with more and more remote working, they're going to become increasingly vulnerable not just in terms of being exposed to the infection, but also from huge amounts of anxiety and concern from within the community. They're going to be asked questions. They're going to be put under pressure in very personally and professionally stressful situations. There are many ways that this can be done. Again, it will be very, very context specific.

Next, just to talk about structure. This is looking at healthcare structure. Again, this is going to be very, very different depending on the context. There is a lot of discussion at all levels about cohorting, either this is separating out confirmed cases or suspect cases or more realistically separating out suspect cases where there is no way to confirm them from people that are asymptomatic. Whether this can be done from within the same house facility, whether the creation of a tent is possible, or if you do have to have facilities near each other or have them completely separate. One concern obviously is if you have a large cohort bay that then gets very full, are you increasing risk? Something that has worked well within some settings is actually having separate entrances. Obviously, these would be for maternity care. What you don't want is having pregnant women who need to continue to seek care sharing entrances with people who are potentially infected. Another issue that's sort of been brought up a couple of times is the issue of crowding. Prioritize your services. Realistically, not all manners in healthcare can continue. Potentially, something that can be done is having a different area of the camp have access to services each day, all under five, or saying, look, we will prioritize older people. I think that would need to be looked at in each individual circumstance.

Moving onto systems. Triage is going to be really, really, really important. Whether this is triage of symptomatic cases from asymptomatic cases, that's one thing, but also emergency care from non-emergency care. It all comes again down to the prioritization. The infection prevention and control. Kit has already discussed this within the context of health facilities. It's very much going back to best practice. This is industry standard, but also WHO has created some new COVID-specific documents. But, again, it comes back down to the basics of best practice. Washing your hands. This is for what everyone, but healthcare workers within facilities and patients within facilities. PPE, I will come back to this in just a moment. This is, again, a huge source of anxiety and a huge worry about availability or lack of availability.

The other issue is finding a way to continue your basic services. Immunization has to continue. Different ways of working out how to do this to ensure social distancing, to avoid large crowds. Again, this is very context specific. HIV and TB, whether it's possible to manage these programs remotely, which can be done in some contexts. Some suggestions – some people have said it's

been possible to give a longer duration of medication; however, the supply chain, again, that might not be possible. But working out a way, again, to make sure those continue. Similarly, with managing services, as mentioned before.

Just going onto the next slide. As has been mentioned multiple times already, there are huge issues related to misinformation. Most relevant to us, really, obviously, is to deal with infection prevention, but also potential cures. We had lots of damaging stories about people using all kinds of medications, but also some very negative coping strategies to start to pay for medical care when there is essentially no treatment at this stage for COVID. Clear, simple messages about the use of facilities. I notice someone mentioned earlier on that actually people were very worried about coming to facilities and PPE. I think it's really worth making it clear when discussing with the community why they're in PPE and it's for everyone's protection. Another relevant chapter related to COVID is the palliative – the relevant standard is the palliative care standard. This is something that goes from healthcare personnel to people communicating within the communities, whether that's volunteers or village leaders, but just the understanding that this is going to be a – there are going to be people who are going to need to be palliated. And then education and messages about burial for those who die at home. Realistically, unless you have very expansive healthcare facilities, most people are going to be – most people are going to be dying at home, so just making the processes clear, honest, and basic about how that should be managed. Next slide.

This is a very, very brief summary on safe and respectful management of the disease. This is based on the most recent WHO guidance. Something that's very important to say is that lots of countries have their own guidance, especially when it comes to whether bodies can be buried. WHO says that this is safe, but other countries say it's not. Again, there are lots of beliefs, religious and traditional, around this that need to be discussed and communicated.

The third point when it comes to respectful management of the deceased is at this stage, have honest conversations with community leaders, religious leaders, and the community to create a plan and to find an area where people can be buried, to look at transporters of the disease, to look at who is going to do it. The last thing that anyone would want is for this to be rushed and more distressing and then for infection control also then to be an issue. Again, community awareness, transparent conversations. There will be a point, I'm sure, where it will be necessary to stop visitors coming to health facilities to see family members. It might then be a situation where you have people dying in health facilities who can't be identified. Just really working out how we make sure that people are identifiable. And then education of traditional burial attendants. Again, there is actually some WHO guidance on management of the dead in the resource section where traditional burial attendants will be used.

The key messages are, and this comes back to the fact that the virus lives on the surface, any surface, and that includes the body surface, but also it's transmitted by aerosol, so avoid unnecessary touching of the body. This is healthcare workers, family, burial attendants, especially at funerals, any kissing and touching of the body should be avoided where possible. Again, this is going to be a very honest conversation with the community. Wrapping the body in cloths and covering the mouth should reduce the risk of infection because you've lost that surface. There is no need to use body bags based on WHO guidance, and they can often not be available. Again, this is back to the PPE for traditional birth attendants. Gloves need to be worn and masks, if possible. Again, I know that supplies are going to be short, so washing the clothes that they are wearing immediately. We'll come back to the chlorine. That's a kind of minimum standard for the clothes that the traditional burial attendants wear. Similarly, the clothes of the deceased would need to be washed in a similar way. I know there was discussion earlier on about washing

surfaces within the household and that's what that comes down to. That's what that comes back to as well. And then, again, yes, local guidance, if it exists, that can be about burial information.

Just one other point, but I've seen this come up, is about people using gloves and masks and then being distributed in kits to families. The main issue with distribution of gloves is that the gloves themselves would need to be washed as you would wash hands. Actually, handwashing is adequate. The problem is if people are wearing gloves, they feel sort of falsely protected. This isn't healthcare workers. This is just people who aren't working in healthcare. But they feel falsely protected, therefore don't wash their hands but actually increase the transmission. Similarly, with masks, the guidance is that in actual caring for someone with COVID or you yourself are symptomatic, the use of masks isn't recommended at this point.

>> ANGHARAD LAING: Great. Thank you so much, Jude. We have a lot of questions that have come in here. I'm going to bring up just a few of them and then we are going to move on to hear again from our colleagues in different camp contexts around the world. But first of all, this is – it's an essential question, although a basic one. Could you please clarify the ways in which the coronavirus spreads? That was a question from Ahmed in Nigeria, but I've also seen in the chat and in the Q&A people are wondering is it to be considered an airborne disease? Someone said he heard that the coronavirus was detected in wastewater, so he's wondering if that's a transmission issue. Could you briefly clarify how it spreads? Over to you.

>> JUDITH HARVIE: Okay. So, yes, it's an airborne, aerosol disease. Just to go over a few things. The two-meter transmission radius is what was given as the radius for when there is aerosol generated. That is a certain medical procedure. The one-meter radius would be normal contact, normal breathing. There we go. There are two different radii there. That is airborne. Something that's important is that between 10 and 20% of patients present with – while there is limited evidence that it can be – well, there's no fecal-oral transmission evidence, obviously we're still at the very early stages of learning about this. Good infection prevention control that you would normally use for diarrhea would need to be followed. It's surfaces. When you have an aerosol generated, it's surfaces that are the issue. Two to three days it probably lives on surfaces, 24 hours on cardboard, and it stays between two to four hours on paper. It's there. It's touching things. It's touching an object and touching your face. That's where the washing really, really comes in. Whenever you touch anything, that risk of transmission comes in.

>> ANGHARAD LAING: Great. Thank you so much, Jude.

I understand from Sybilla that there has been a question coming up in her context. Sybilla, can I turn to you to hear more about that?

>> SYBILLA KITSIOS: Yes. Thank you very much. Yes. I was wondering if it turns out the virus can be transmitted by stool, we are concerned about the latrines that people share in our camp. Thank you.

>> JUDITH HARVIE: So, yes, this is something that I think that Kit can also answer. There is no evidence of it being transmitted by stool; however, obviously, there is still a lot to be learned. Any stool management, so shared latrines, everything should be – the best practice should be used. If that doesn't give an absolute answer, good waste management is what's needed to continue.

>> ANGHARAD LAING: Thanks, Jude.

Could I turn to Kit to come in on that as well?

>> KIT DYER: Yeah, absolutely. There is an excellent guidance note that came out of WHO and UNICEF. We'll definitely share the link to it. If you search the topic, it should be WHO, WASH, COVID-19. It will be in the top three whatever results come back. There is a bit of research that's been pulled together looking at the persistence of COVID-19 virus in drinking water. This is along the surfaces. There are risks, absolutely, but they are low. On surfaces, they are higher because of the way the virus transmits. If we go back to the diagram that I presented, that little cut down S-diagram, the cough diagram, that shows the main transmission routes, and it shows the main barriers as well. They are the things we need to be focusing on. Over.

>> ANGHARAD LAING: Okay, great. Thank you for that.

Back to you, Jude. A quick one here. We have questions from Sara in Iraq and also Pauline in Kenya asking something similar. They're wondering if chloroquine, hydroxychloroquine, and azithromycin are working in treating COVID-19 and whether or not those can be used as preventive drugs. Over to you, Jude.

>> JUDITH HARVIE: It's a very, very good question. At this point, there is no evidence that they're effective in treatment or prevention. That isn't to say that some countries aren't using them. The only prevention at this point is, well, social isolation where possible and good infection control and handwashing. It might be that that guidance changes. But at this stage, in very difficult settings, it wouldn't be where there is recommendation to change efforts.

>> ANGHARAD LAING: Excellent. Thank you so much for that.

Now, as mentioned, I'd like to turn back again if I can to Manuel, Sybilla, Richard to hear about the situations in your contexts when it comes to the issues and the guidance that we've heard coming from Jude on the health questions. How are the health concerns being expressed in your contexts? Have you had to look at retraining staff or reassigning roles in the face of emerging health needs? And how are liaisons with the ministries of health working in terms of data collection, testing? Anything you can share with us from the contexts where you are? First, to Manuel. Over to you.

>> MANUEL PEREIRA: Thank you, Angharad. I think that once more on this, we would go back for the extreme importance of camp management to contribute to the coordination and the support of the intersection of the different areas of work that are needed. WASH and Health and Site Management and Shelter, we need to work more together to make it more effective. In terms of Health, I think the first thing that has been happening is, at least in Bangladesh, the re-analysis of the structure of the teams to be able to be ready to provide isolation to people that test positive and trying to understand how testing can be done knowing that it takes time is difficult and will not be available in large scale for what we for now know, and so this repurposing on teams. And I also think that the staff in Bangladesh at large has been extraordinary in making themselves available to be repurposed to be part of the restructuring of the health teams in all functions from the cleaners to the caregivers to the medical staff in itself. I think it's that solidarity that is very, very important.

>> ANGHARAD LAING: Thanks so much, Manuel.

Sybilla, could I turn to you?

>> SYBILLA KITSIOS: Yes. Thank you. Most definitely. You had three points of the question. I will start with the training of our staff. Yes, we train them. We actually had one – the third case was confirmed of COVID in Iraq. The health partner immediately provided a training to all camp managers. We then shared this training with our staff. We trained our staff. We shared many materials that were available – made available through WHO.

Then on your question on health concerns, how they're being expressed. Our health partner runs a health clinic in camp. Normally camp residents will express issues with their general health concerns, of course, it's a bit different when it concerns sexual health concerns. However, in the past week, in this current context, we have witnessed that people with high temperature are hesitant to go to doctors. They would rather wait for a few days before going because they feel like just I will wait it out, saying that if they would proceed to the clinic in camp, they might immediately be referred to the hospital and be placed in quarantine for the upcoming 14 days. This is a bit problematic. We keep also stressing to camp residents and partners to refer any person that is showing fever symptoms to the health clinic, especially given the advice of the Ministry of Health that the earlier the virus is detected, the better the outcome. But on another note, people would ask for vaccinations against COVID-19 and the health partner took it as an opportunity to actually re-advocate on vaccinations in general and has vaccinated many children that were previously no-shows.

You were asking also about the data collection. Our health actors are in constant coordination with the Directors of Health and the Ministry of Health. Whenever there is a suspected case in camp, luckily it happened only once, within three days, it was confirmed negative. But when this happened, they immediately referred the case to the hospital for testing and they informed us and we informed the CCCM Cluster. It was mentioned here before as well that coordination is very important. We are in constant coordination with our health partner and also with our WASH partner, especially in this context. We set up a tent or an isolation space for our health partner on the medical terrain so that they have the space to be able to isolate a suspected case should they suspect a case. For the time being, the referral is made to the hospital. Once the referral is made, a special designated ambulance that was given by WHO to the Directors of Health would come to pick up the suspected patient. For the time being, this patient is isolated in a separate space inside the clinics. Lastly, we are currently working on identifying perhaps a site located near to the camp in which we can support our health partner should we request more – should we see the need for more isolation spaces. They have informed us that should we create isolation spaces, it is very important that each individual would receive his or her own tent. Thank you.

>> ANGHARAD LAING: Thank you, Sybilla.

And Richard, could I turn to you with the same questions regarding the health issues and guidelines related to the COVID-19 response in your context in South Sudan? Over to you, Richard.

>> RICHARD OKELLO: Thank you very much. As I mentioned in the beginning, South Sudan, as of today, we don't have any known case, but preparation work has already been done led by the Ministry of Health. The CCCM Cluster will link to the path that has been set through our technical working group. We've set a technical working group through communication and community engagement that is linked with a taskforce because the taskforce also came up with a response plan. And one of the pillars of the response plan is communication and community engagement. That falls under our umbrella through our technical working group. We're working closely. Even the message that I talked about earlier on, working closely with the ministry,

working closely with everyone else [indiscernible 01:45:57] that we are going to share with the IDP population. But also, the other context that I needed to be brought clear is that we don't have any case that has been identified, but the health system in the country is broken. The government has set up an isolation unit in one of the hospitals here. We are told it is a 20-bed hospital, and 5 ventilators. We don't know how many test kits are available. It's really going to be difficult if we don't continue with these preventive measures that we are doing.

Part of the capacity building of the staff, I talked about the contingency plan. We are now doing a several step exercise in all the POCs, Protection of Civilian sites. This will be a new term for the people who are listening to me online. The camps are in the base of the peacekeeping force. We call them Protection of Civilian sites, POC. What we are doing now is an exercise running the worst-case scenario when there is an outbreak in the site and what we need to do. The partners that are involved have identified the IDPs themselves. If we are not able to access the site, we will eventually be able to provide some services. Training is ongoing. We identified a number of key gaps in the exercise. Now we are going to get the partners doing the training, testing up. This will help them doing the recruitment of the IDPs themselves to get them ready during the capacity building response. I think that is all now from here. Yes.

About the isolation unit. We have identified in every POC – I hope I'm comfortable now to use the term POC. In every POC we identified, isolation site, no construction has taken place yet because we are still in the state of – not sure what really to do at the time, at the moment. Apart from that, camp management is working with the peacekeeping force and reinforcing the entry because the POC is required to be barricaded with fences. At the entry and exit of the POC, we have set up the handwashing points, we are taking temperature of those who are coming in. Every time whenever you come in, you have to wash your hands, your temperature is taken. That is what we are doing at the moment in South Sudan. Thank you.

>> ANGHARAD LAING: Thank you, Richard.

Now I'd like to turn to Dher to see if he can say a few words on key points to consider in relation to the standards but looking at remote management scenarios. Over to you, Dher.

>> DHER HAYO: Thank you. I hope you are hearing me well. What I would like to highlight is that we are dealing with a situation that has a multi-layer of complexity. Do you copy? Hello? Yes.

>> ANGHARAD LAING: Yes. We hear you very well. Go right ahead.

>> DHER HAYO: Thank you. Thank you. One is the particularity of the camps and [indiscernible 01:49:54] against COVID-19, and the second, which is also important, is that we are going to potentially experience an unmanageable situation. Here we need to conduct some key messages with consideration. One of them is considering to relocate and to decongest the camps prior to the situation. Here it is very important for us to keep a very strong messaging with the communities both in and out of camps that these actions are taken as preventive actions, not as a response to avoid any kind of fears, concern, and chaos in the area. The other thing is to identify the weaknesses and the risk areas in many of the camps that we are operating. As an example, some of the camps have higher rates of elders. There are some receptions centers that are much more exposed to risks.

It is also important for us to identify some of the key actors that might be still able to reach these camps in case we experience [indiscernible 01:50:58] context. Key medical NGOs, MSF, in

my case, is one, and, of course, the Red Crescent and the Civil Defense, these actors have been able to reach when situations have been much more difficult. It is also very important to start already putting measure in place which I also think that some colleagues have mentioned. These measures could be [indiscernible 01:51:25] with also promoting masks where we find it very difficult for us to manage and to keep social distance. Redefining peripheral pathways to [indiscernible 01:51:44] is important. And again, the communication with communities, both IDPs and the host communities, on the scenario of having risk management to keep them abreast. We might not be able to reach them after the situation if there is a kind of lockdown situation. If a situation gets more deteriorated, this scenario is a scenario that they must be aware of. In this situation, to do no harm is an important principle to consider. Also, the staff of the organizations are more anxious to provide – continue to provide services in case any of them are infected. It is important to alert us of their presence if they present harm to the staff and to the IDPs themselves, and to reduce the movement to the extent possible [indiscernible 01:52:46] if this is possible. Most importantly in these circumstances, out of our experience in refugee countries, I would like to highlight that several communications online and by email and by phone is important to always remember the data privacy when you mention the names of the people and the names of the sites. We always have to take into consideration the situation and the data privacy issue.

Just to conclude on my input, I would like to highlight that the camp management funders have been challenged with the management situation. As the global CCCM Cluster, there are some documents available and experiences that could be shared by the COVID workers on how to apply within the camp management context. Our colleague, Jennifer, is dialed in and listening to us, and also the other global health care teams now are taking note. Please always feel free to reach us should you need advice on a response in remote management context. Over from my side.

>> ANGHARAD LAING: Perfect. Thanks so much for that offer, Dher. Very much appreciated.

I'd like to jump over now to Kit. Quickly, we've had a number of questions coming in asking about specific numbers. Can we find specific numbers in Sphere, in the other relevant standards, when it comes to the amount of water, soap. There are other very specific questions coming. Would you like to jump in perhaps with some thoughts about, again, how we can use the relevant standards when thinking about COVID-19 response in these different areas. Over to you, Kit.

>> KIT DYER: Yeah. I would be delighted to jump in. Okay. I think there are two key words when we're talking about standards, context and coordination. Our OPIC 2 standards from the book – I've got it sitting in front of me – the hygiene promotion standard 1.2 about the identification, access to, and use of hygiene items, the appropriate items to support hygiene, health, dignity, and wellbeing, are available and used by the affected people. The second one is that people have equitable and affordable access to sufficient quantity of safe water to meet their drinking and domestic needs. Those standards are a qualitative expression of our intent to give a minimum package to people. The numbers coming in the guidance, the numbers are also very much contextualized. What is appropriate, adequate, sustainable, locally accepted in one context will not necessarily be in another. In places where you have a WASH Cluster, or any cluster really, the standards are contextualized. You will find them in the SOT's for the different clusters. In places where they are not, go to a local government, probably a health official, a ministry of health and find out what are you going to do in this context, what is going to be your minimum standard that you are going to reach. The way that they get applied is to come back to that

barrier diagram, the transmission route and what barriers are you going to put in place in order to break the transmission. What do you need in order to break the transmission? How much are you going to have to get out there in order to break the transmission? How often are you going to have to get it delivered to people? What kind of messaging are you going to have to get out to people and talk to people and engage with people in order to break the transmission? It always comes back to breaking the transmission. It affects context and coordination. Over.

>> ANGHARAD LAING: Great. Thank you for that, Kit. Just a quick note for everyone, as you can see, we're going slightly over time here. We just have so many questions coming in. Thankfully, our panelists are available for a few more minutes. We're talking some liberties with the time. If you're not able to stay with us in the event, you can certainly come back to enjoy the recording afterwards. We will be going over just a few minutes here so that we can address a couple more critical issues.

I'd like to jump back now to Jude with some follow-up questions regarding health guidelines and health systems in response. First, there was a question from Anna who wrote: In Europe, people are being told not to go to health facilities if they only display mild symptoms. Shouldn't this similarly be the case among people in camps to help reduce spread? There is a question about advice for people with mild symptoms, should they be advised to go to health facilities or not, the comparison between advice that we're hearing in Europe and then advice that's being shared with people living in camps. I'd also like to pose to you there is a question coming in from a few people, so in Bangladesh, Mali, Somalia, asking about how to approach a situation when there is no option available for testing and how you deal in particular with community expectations regarding the possibility for testing. If there are different maybe health guidelines that you would have in a context when there is no option available for testing for the COVID-19. And then finally, this is a related question, but also in situations with less well-equipped health systems, especially we've heard about a lack of ventilators and other important equipment for treating severe cases, is there guidance available for health workers and others in such situations with the really dire lack of essential equipment? Over to you, Jude.

>> JUDITH HARVIE: Okay. Thank you. So, yes. First of all, with relevance to the – with reference to the stay at home advice, now this, again, is going to be very context specific. If you – I mean, one, if the Ministry of Health is saying that people have to present to a health facility, even within a refugee camp, then that's the guidance. However, you also need to bear in mind that very quickly the health facilities will get full and may themselves become an infection risk. Realistically, if you have full, small, overcrowded health facilities that serve multiple purposes, it is much more flexible for people to stay at home and limit the number of people that they are in contact with. Of course, multiple people are sharing rooms. However, if possible, just have one person caring for them at home and keep that contact to a minimum number of people. Pragmatically, realistically, yes, mild symptoms, definitely better to stay at home. However, if you are very confident that you can have a good isolation facility that has a large capacity, then obviously the advice would be different. I think something then that comes down to good communication with the community, but it's not that people are refusing to treat them. It's just that there isn't a treatment especially for mild cases.

I will just then sort of move on to the third question about ventilators. Yes. The supply of ventilators in most countries is going to be minimal. Potentially, more relevantly, the supply of people who can use the ventilators safely, keep the ventilators clean is also a huge issue. Even with huge numbers of ventilators being delivered to certain contexts, it's just not going to help. The treatment then comes down to supported care and that's at the stage which is meant to be oxygen, again, where you have it. This will be a matter of prioritization. The amount of oxygen

that's needed for some patients is huge amounts. Almost everywhere will be dependent on filling this. Again, that's just not a viable option. And then it comes to keeping people comfortable, as I discussed before, the palliation, keeping people comfortable, managing their symptoms wherever possible. There are many clinics who will have methodizers. The WHO guidance classes these as aerosol generating procedures, thusly decreasing the risk to people around them. If you don't have the adequate PPE, then you really need to think about whether it's safe to use the methodizers. That's something that the medical teams will discuss in more detail with you and then to be able to communicate to people. The options and the available testing, which, again, is probably the majority of context at the moment, there are – and I will post some links – there are case definitions that are being used. There is varying sensitivity as to how many cases that they pick up. Realistically, they are probably picking up more cases than are actually there. Don't forget that the pneumonias will continue, all your other elements that give you a high temperature. Kit mentioned earlier Malaria, that gives you a high temperature, all of your other – Dengue fever also gives you a high temperature. Having that as a case definition, you might end up with more cases. It will just require a kind of constant review by healthcare personnel, by ministries of health as to whether these are COVID, whether there's another outbreak going on, and yet communicating that honestly to the communities is, I think, very difficult. The testing hopefully will become more available and will actually be much easier than it is at the moment, but that is going to take time.

>> ANGHARAD LAING: Okay. Thank you so much, Jude. I know you must have very limited time, but we may try to follow up with you with a few more critical questions, but after the event as we're already over time.

I would like to touch on how COVID-19 leads to questions related to crowdedness and shelter. This has been a major theme of the questions coming in also in the chat. We have participants working in camps in different response contexts, but all have concerns about the crowded nature of those camps and how that affects the possibility of social distancing, and also wondering if decongestion should be a priority. I saw someone asking it's all very well and good to be focusing on handwashing, but shouldn't we also have as a top priority decongestion or social distancing? Manuel, could I come to you first? What are the relevant standards that we should be looking at here? And how are you approaching questions of crowdedness and social distancing in Cox's Bazaar? Over to you, Manuel.

>> MANUEL PEREIRA: Thank you.

>> ANGHARAD LAING: Sorry, just a moment. Okay, yes, we have you now on the line. You can go ahead, Manuel.

>> MANUEL PEREIRA: I was saying that we have through the Sphere standards always targeted 3.5 square meters per person. I think we all also know that across the world there are few cases where we for context specificities are able to meet that, which brings the situation of decongestion to the top of the agenda, especially in a situation of an outbreak, a health outbreak. In Bangladesh, it's a very, very complex situation because the over-crowdedness is very significant. The average space is 10-12 square meters per family of 4.2, the average, it doesn't apply to all the families, which has deemed a stronger effort on all the complimentary measures. We cannot de-crowd the camps. We have to increase awareness. We have to decrease the infection. You will see on the slides a few pictures of activities being done, again, across the lines that all the other participants have indicated, more awareness and more communication with individuals, changing the modalities of assistance from door-to-door with distance and precautions, but also social distancing and avoiding large crowds, improving water facilities and

structuring access to health and health support, and it will eventually end with also specific isolation areas because there will be no possibility for the majority of the families if they have an individual with a more significant infection or symptoms to be at home. They will need to be isolated. The individuals are not going to be able to share with the patients with severe symptoms of 10 square meters for four persons. It's going to be very complicated. The different sectors, health, WASH, site management, shelter, are trying to understand how best to address that. But, effectively, if we look at these, we would go back to the fact that well planned settlements, following as much as possible the Sphere standards, that are not crowded have the potential to mitigate outbreaks. A lot of us, unfortunately, work against that situation because we are presented operations where we cannot afford that. That's when advocacy enters in. We have to continue fighting for the application of the standards, fighting for the improvement of the living conditions of IDPs and refugees. Thank you.

>> ANGHARAD LAING: Thank you, Manuel.

Sybilla, turning to you now, we have some questions coming in from Zorra in Pakistan, from Vincent in Dakar, from Samuel in Nigeria, and Shayrose in Bangladesh, wondering how do you handle separating those who either have or are at risk of contracting COVID-19 from others, especially when self-isolation is clearly not an option in camp settings? Sybilla, any thoughts on that? Over to you.

>> SYBILLA KITSIOS: We have identified with the health actor the persons that are at higher risk of getting the virus and the health actors are following up on these cases on a regular basis. Until now, we have dealt only with suspected cases. There are no confirmed. There has not been any confirmed COVID case in camp. The only thing, unfortunately, we can do for the moment is to increase awareness and really ensure that the camp residents adhere to the principles of social distancing while we're trying to assess the possibility of creating another site where we could isolate people at high risk or, for example, new arrivals that will be coming to the camp. What's interesting as well is that we have heard the Imam, the person that supports at a mosque to lead prayer, now is adding the sentence to pray at home, so hinting to not come to the mosque. We try to encourage these kinds of initiatives in camp as well to really stress upon people that they can – it's difficult in crowded camps, but through adapting personal behavior, we try to change a little bit the spread of the virus. Thank you.

>> ANGHARAD LAING: Thanks, Sybilla. And Richard, from your side, anything to add from the South Sudan context?

>> RICHARD OKELLO: Thank you. In the South Sudan context, as Manuel quoted, it's very difficult to meet the minimum standard in terms of the living space. Most of the camps here are awfully overcrowded. But what we are doing as a solution is a working group. They have opened up a professional desk. Those who want to be supported to move out of the POC, we are fast-tracking that and they are being supported. The peacekeeping mission has offered their equipment to air-lift those who want to move. That way will maybe improve the condition in the POC. But, again, the context is quite complex. While places are returning to normalcy, things are returning, other places there is conflict going on. While we are seeing the conditions slide, on Monday, over 120 people entered the POC. You can see what we have to deal with. We are now talking about expanding the camp, but that's also a matter that discussing we need to do because we had a contingency site. Every site has a contingency site that is planned to take in if there would be some influx in the POC. Then these contingency sites, we are turning them into isolation units. Then we are seeing some places have increase of IDPs who might have to put their family in tents in those areas. The practice of social distancing, the government has banned

religious meetings. There are no prayers. People should pray at home. Social gatherings like marriages or weddings have been banned. You need to do that at home just to reduce the person to person contact. Thank you.

>> ANGHARAD LAING: Thank you, Richard.

Now as we are over time now, I do want to however go once more around this virtual room and ask each of our speakers today if they have some very brief final point to share with us, a really important takeaway, or perhaps a greatest concern, or a greatest hope for the immediate future. I'll go first to Aninia. Could I turn to you, please, for a final comment?

>> ANINIA NADIG: Yes. Thank you very much. Basically, I've learned a lot today. I see a lot that will somehow go into the next handbook. Especially what I'm picking up is the social distancing element, crowdedness, remote programming, very big theme, and the further strengthening of intersectoriality. I'm also happy to work further with the camp management standards which help us move into that direction quite well. Thank you. And thanks for having me. It was really great.

>> ANGHARAD LAING: Thanks, Aninia. It was terrific to have you as well.

Kit, could I turn to you for a final comment?

>> KIT DYER: Yeah. I mirror Aninia's comment and thanks for being involved. For me, I think the key is that there is so much thirst for information out there. The comments and questions from people really pushed that home for me in a big way. I would say there are three take-home things for me. One, take a look at those barriers that we as WASH people need to be putting in place to stop the transmission; two, to put that into your context, figure out how it's going to work where you are; and third, coordinate with other people. That's it. Over.

>> ANGHARAD LAING: Terrific. Thanks a lot, Kit.

And Jude, over to you.

>> JUDITH HARVIE: Well, yes, also from me, thank you. Thank you for letting me be involved. I have also learnt a lot. I mean, obviously, as Kit has said, there is [indiscernible 02:15:36] because of the need to break this transmission. I think another thing to say is wherever possible, really, really working with ministries of health and – because this is going to have to be a huge effort. It's an international effort. Keep up all those communications with them, and similarly the communication with your community to get buy-in on everything that you're doing in your very, very specific context. I think the sharing of experience, if that can just carry on however it can be done, that's hugely important.

>> ANGHARAD LAING: Terrific. Thank you. Thank you so much.

And could I turn to Antonio for a comment? I know you were very active in the course of the event and behind the scenes as well with your colleagues but love to have you come on the air for your thoughts at this point. Over to you, Antonio.

>> ANTONIO TORRES: Thank you very much for this opportunity. It has been a great pleasure to try to contribute to this. I just want to say a final word. While we address COVID-19 with our WASH responses, which we've not overlooked the competence of the comprehensive

WASH response, it will allow us to avoid comorbidity, at the same time alleviate the stresses on our health services in camps. Thank you.

>> ANGHARAD LAING: Thank you, Antonio.

And Sybilla, connecting from Iraq, could I turn to you, please, for your final comments today?

>> SYBILLA KITSIOS: Yes. Thank you very much. Thank you for organizing this important webinar. As a final comment, I would say key is information and coordination really. We have at the beginning of this slide as we received many, many offers to, for example, offer a WASH hygiene kit, it's important to really identify the need in your camp so that offers like these would better be invested in other camps, for example, that would need it more, if the need obviously is okay inside the area of your responsibility. Coordination with the authorities as well, I think, really describes the need to integrate a holistic response. Coordination is crucial for that. And then communication with communities, keep them informed, try to be ahead of rumors, and ensure people understand the severity of the message, but do not create panic. And speak to professionals. Consult guidelines. See how you can implement them best in your context. For example, also the distribution, think about how you could change practices inside your own context. Thank you very much.

>> ANGHARAD LAING: Thank you, Sybilla. Thanks for being with us.

Richard, I'd like to turn to you for your final thoughts to share with everyone.

>> RICHARD OKELLO: Yeah. Thank you very much. To me, it has been a great pleasure to interface with the community of proxy, people looking at standards, looking at the welfare of those who have been displaced. They are not leaving their own homes. My take-away from this discussion, let me echo what my colleagues have already said, both coordination and the participation of the affected population [indiscernible 02:19:30] where the IDPs are taking the responsibility and ensuring that there is handwashing everywhere. The hygiene of the displaced [indiscernible 02:19:40] improved within just one week because communication has empowered them and taken ownership of the process. Thank you very much.

>> ANGHARAD LAING: Thank you, Richard.

And Virginia, I'd like to turn to you next for your final thoughts.

>> VIRGINIA MONCRIEFF: It's going to be very difficult for us to adhere to very strict standards of what is appropriate physical distancing, et cetera, et cetera, in the complexity of the camps that we run because there are so many different complexities that we've heard tonight. I think what is really important is that we always keep in mind the context that we're working in, make sure that as camp managers that we coordinate, coordinate, coordinate, coordinate, say it once, say it three times. But also the last thing I want to say is that it's always really important to work with the response. We're there to help them, assist them, serve them, and so we need to assist them with the most and the best possible information that we can give them in order for them to make the best decisions for themselves, their families, and their communities.

>> ANGHARAD LAING: Thank you, Virginia. Thanks so much for joining us today.

Over to you, Dher, for your final thoughts to share with the participants.

>> DHER HAYO: This event was blessed with many questions. We acknowledge that we did not have the time to answer all of these questions. I continue encouraging the colleagues to exchange amongst themselves and keep sending questions to the global consort in case of any unanswered questions. What is most important is to try to operationalize the standards in context and always challenge how the situation might deteriorate into a remote management context, which is worse [indiscernible 02:22:00] area. I also cannot emphasize colleagues have already mentioned on the importance of coordination and keep reminding that this is a cross-cutting cluster. Any question is valid. Thank you, Angharad and other colleagues again. [indiscernible 02:22:17]. Over from my side. Thank you.

>> ANGHARAD LAING: Thank you, Dher. Really appreciate your inputs.

And then last but not least, Manuel in Bangkok, turning to you for your final thoughts for the day. Over to you.

>> MANUEL PEREIRA: Thank you. Thank you to you, to all the persons that are listening to all those that participated. There is very little for me to say. But I wanted to stress that many of us are working on a crisis today on top of a crisis that already existed. We collectively will be tested beyond our plans, beyond our capacities, but we are also the intermediaries of the concerns, the fears, and the hopes of many millions of people around the world and we need to stand strong and united to provide that service to those individuals and listen to them and make them part of our efforts and, of course, coordinate with all the possible actors because this crisis, as I mentioned, is that we still don't know and we need to continue learning. Thank you so much. Keep the fight.

>> ANGHARAD LAING: Thank you, Manuel. Thank you to all of our speakers today. It was tremendous to have you all on the line. I'm so glad we were able to connect with all of you. I'd also like to give a little shout-out to our captioner, Pat, for overcoming the tough technical difficulties. It's been really helpful to have the captioning. Thanks so much for keeping up the fight on your end as well to ensure the accessibility of this discussion for everyone.

Speaking of which, we have been making a recording of the complete event, both in video format and in audio only format, so that will be available in podcast form, the audio format, and then we'll also have the full video recording available in the coming days. That will be on the event page. You'll receive an email alerting you to when those are available for you. You can also share them, of course, with colleagues.

The CCCM Cluster will be organizing a series on COVID-19 and camp management. The next event on the 7th of April will be on Community Engagement: Participation and the Response to COVID-19. You can click on the link there to register. It will be followed by events on capacity building and remote management, adapting community center activities, digital communication with communities, and engaging with state and non-state actors in remote management. You can find information about these events on CCCMCluster.org/events.

I'd also like to invite you to join PHAP and NRC on the 16th of April for a webinar in which we will be discussing lessons learned regarding access and protection in restricted operational contexts and how they can be applied to the COVID-19 operational environment. You can register at the link you see there, and also click on the link for more information on the event page. We'll also aim to continue the discussion and, as I said, follow up on some of the many, many excellent questions that came in that we weren't able to deal with in real-time today but

we'd like to follow up with those with our speakers in the discussion forum and in other venues, so you'll be hearing from us about other follow-up opportunities soon.

With that, I'd like to thank everyone, both our panelists, our participants, for a very interesting discussion, as well as the technical teams and substance teams behind the scenes for putting this all together today. Thank you so much. And looking forward to connecting with you again in the near future. This is Angharad Laing signing off from Geneva.

Appendix 3: Webinar follow-up responses

While many of the questions from participants were answered during the event (listen to these in the event recording), there were more questions than there was time for, and the guest experts have answered follow-up questions in writing. The responses are listed in this appendix.

Health

“What is the PPE that field implementers should consider when conducting social mobilization and risk communication messaging? If a camp/ community does not have cases confirmed due to the lack of testing, it is unknown whether there is risk exposure. So what is the proper PPE to consider? WHO guidelines are not clear on this.”

- *Edna, Mozambique*

Judith Harvie:

If testing is not possible then it is reasonable to work in a way that assumes that the infection is there in everyone. The guidance would depend on where and how you are doing the mobilisation and the need to reduce risks to the mobilisers and those taking part.

1. Keep a distance of 2 metres from anyone you are talking to and explain the those that you are delivering information to that this is important and they should not walk towards you. This includes children.
2. Try not to meet inside or confined spaces as this makes distancing very hard and also increases the risk of surface contact.

“What would be the standard recommended PPE to use for humanitarian workers?”

- *Cyril, Nigeria*

Judith Harvie:

This is a big question and the best guidance to use is the WHO guidance at the moment. However, as we are all aware there is a global shortage. I would recommend seeing which categories of workers you are talking about and using clear posters for what people should be wearing and when.

The relevant WHO guidance is:

"Rational use of personal protective equipment for coronavirus disease (COVID-19)"

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

“What measures can we take to protect the elderly in camps against COVID-19, especially those who already have chronic diseases?”

- *Nawaf, Saudi Arabia*

Judith Harvie:

This is difficult but there are several considerations – here are some:

1. Try to avoid them having to go to hospitals and clinics e.g. manage health issues via phone or away from healthcentres. E.g., old people who are well enough could come one by one to another building to have a BP check if very much needed.
2. IF you have an adequate supply of medicines you COULD consider giving them more of their chronic disease medicines to avoid them leaving the house. However this could create shortages, so be careful. If not, consider visiting.
3. Support them in self-isolation if possible.
4. For chronic diseases such as cancer – try to prioritise and keep patients away from COVID patients if there is a need to treat. Have very honest conversations with patients about treatment.
5. The use of shielding may be helpful and will need to be considered context by context. See the guidance from the London School of Hygiene and Tropical Medicine – "Prevention of COVID-19 among high-risk individuals in camps and camp-like settings": <https://www.lshtm.ac.uk/sites/default/files/2020-04/Guidance%20for%20the%20prevention%20of%20COVID-19%20infections%20among%20high-risk%20individuals%20in%20camps%20and%20camp-like%20settings.pdf>

“Cremation seems to be the best way to dispose the remains of those who have passed away due to COVID-19. However, such practice is not allowed by Islam and in fact a directive has been issued by Muslim leaders insisting on no cremation for COVID-19 victims. Would the Muslim way of burying the COVID-positive dead here in the Philippines pose health problems to nearby communities?”

- *Anonymous*

Judith Harvie:

The best resource on the safe management of dead bodies is from WHO, "Infection Prevention and Control for the safe management of a dead body in the context of COVID-19" – this is regularly updated (the link below is for the parent page because the link keeps changing):

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

Regarding cremation, this is an excerpt from the interim guidance published on 24 March 2020 (check the link above if there is a more recent version):

"Except in cases of hemorrhagic fevers (such as Ebola, Marburg) and cholera, dead bodies are generally not infectious. Only the lungs of patients with pandemic influenza, if handled improperly during an autopsy, can be infectious. Otherwise, cadavers do not transmit disease. It is a common myth that persons who have died of a communicable disease should be cremated, but this is not true. Cremation is a matter of cultural choice and available resources;"

“As there are still testing kit limitations in the whole of Bangladesh, if there will be camp community transmission of COVID-19, how it can be traced?”

- *Anonymous*

Judith Harvie:

You will need to use case definitions. Many countries have their own and have implemented surveillance based on this. However, if this is not available then use the following from WHO:

[https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov))

If the camp setting that you work in is not included in national surveillance, then you will need to establish a system, or make sure that you report cases into the national system.

While there is a lot to read, the following documents from WHO have information on surveillance systems and reporting:

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions>

Camp Management

“What are the best practices in receiving new arrivals during a pandemic?”

- *Marianna, Greece*

Richard Okello:

Dealing with new arrivals may take place at the point of registration at the reception point. It is important to ensure that there is a screening process including temperature check. Identification of prevailing signs and symptoms of COVID-19, as well as the risks of exposure, for example: observation of visual signs of respiratory illness, coupled with questions on presence of fever or respiratory symptoms, and questions on travel history or contact with a potential COVID-19 case. In a camp setting, it is important to establish a temporary isolation/withholding centre or quarantine centers to keep away individuals meeting the case definition of a suspect case, from all other residents of the site, until a referral process is completed, or a negative result is obtained. For the

South Sudan context, in the POCs the CCCM partners have identified potential spaces for use as temporary isolation sites. However, there are still discussions on who will manage the center and the need to develop a guideline on how best to operate the center. Nonetheless, it is crucial to ensure that screening points within the camps and camp like settings are managed by trained Public Health Officers and clinical officers while ensuring an appropriate gender balance where possible. Ensuring that hand washing points in strategic locations within the displacement site including setting up committees dedicated to training and monitoring site residents to ensure regular handwashing – linked to WASH and need for rapid increase in supply and hand washing stations at all possible points of concern.

“How will you recommend balancing the need for physical distancing with the reality of camp settings, and determining how much effort is placed on prevention and mitigation versus treatment?”

- *Nicholas, United States*

Richard Okello:

This is something camp management is trying to grapple with. We are aware of the limited spaces in the displacement sites and sometimes the overcrowded living conditions in camps. However, measures have been taken to ensure physical

distancing in areas or activities that normally pull a large crowd for example in distributions and water points. The CCCM Cluster has also developed a guidance note to help partners to begin

having home deliveries of distributed items. For water points, apart from the increased amount of water released per day, a distance of 4 meters has been marked to give enough physical space to those waiting to take water in South Sudan.

“What are the long-term consequences of COVID-19?”

- *Gaelle, United Kingdom*

Richard Okello:

No one has the right answer to this. Nonetheless, COVID will have a long term effect in every community not only camps and camp-like setting. For persons who have been forced to flee their homes owing to generalized violence, human rights abuse or natural disasters, will have very few options to leave the sites as long as conditions that forced them into displacement still exist.

“What could happen if COVID-19 spreads all over camps? What will be the consequences? How could we prevent COVID-19 from spreading?”

- *Zahangir, Bangladesh*

Richard Okello:

The consequence of COVID spreading into camps and camp-like setting will be dire. This might also lead to a total lockdown in which residents will not be allowed to exit the sites. Humanitarian agencies may be prevented from accessing the sites as well. There are a number of things that need to be done. We need to develop a contingency plan building into scenarios. Spell out what agencies will do when there is a COVID case within the site and how the activities will be implemented. One of such methods could include remote management, training the displaced persons to be the frontline responders in the event that you are unable to access the sites.

“How to conduct CFM in times of COVID-19 outbreak?”

- *Henry, Nigeria*

Richard Okello:

Camp Management has been advised by the CCCM Cluster to devise new modalities for working with committees inside sites that helps to minimize group gatherings. In particular, depending on the camp size holding meeting at section or block levels. Camp management must set limits to the number of people that can be in one meeting. Some meetings can be cancelled and different forms of information flow will

need to be enacted. For Complaint and Feedback Mechanism (FCM), you can put into place community-based reporting and monitoring mechanisms besides setting up a toll free phone line where camp residents can reach to you to file their complaints.

“How do you decide when to evacuate camps, where to evacuate to and how do you ensure that evacuation takes risks of coronavirus into account?”

- *Hester*

Richard Okello:

In this period of COVID, options for evacuation should be limited to the bare minimum. It should be avoided as much as possible. Remember, there is no safe place for COVID. You should rather spend a lot of time to encourage camp residents to practice preventive measures.