

South Sudan

Overall Public Health Guidance on COVID-19

Preparedness and Response in refugee settings



Dr Atar speaks to patients at Bunj hospital in Maban County.

- **Alarming global COVID-19 situation:**
 - South Sudan and all the surrounding countries have reported cases and it is increasing, with ongoing intense local transmission.
 - As of 26 May 2020, two COVID-19 cases have been identified among refugees in South Sudan, on patients who came on medical referrals to Juba.
- **Evolving COVID-19 Pandemic with lack of experience in camp settings:**
 - Useful Guidance:
 - Interim Guidance Scaling-up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations <https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp>
 - Epidemic Preparedness and Response in Refugee Camp Settings (<https://www.unhcr.org/protection/health/4f707f509/epidemic->

[preparednes-response-refugee-camp-settings-guidance-public-health.html](#)

- UNHCR and partners preparedness is to support the national system; thus, the state MoH /CHDs need to also liaise with the national level focal persons to get additional support.
 - Compounding factors influencing camp and camp-like settings (<https://www.lshtm.ac.uk/newsevents/news/2020/covid-19-control-low-income-settings-and-displaced-populations-what-can>)
- **General considerations**
 - In case of the outbreak, in deep field where meaningful medical response for moderate and critical cases may not be readily available, it will be very challenging. Hence, the need to scale up prevention considerably and urgently.
 - Include the surrounding host populations as well as urban refugees in the planning / preparedness/response plans.
 - Ensure working with the respective MoH organs and with Focal Points of WHO, UNICEF, WFP, and other relevant partners.
 - Given the crowded nature of camps, which favours intense community transmissions, we expect greater morbidity/mortality rates if we do not act now. Mortality inside the camps will cause panic and alarm. Communities will start to question what assistance we as humanitarians are providing. Hence the need to carry out transparency and accountability along with the refugee population and others of concern on what we do. This includes sensitization and more awareness at community and household levels to ensure they understand the severity of COVID-19
 - Some camps may experience movement of refugees; if infected they will go to other villages or even across border and be carriers; this will be very devastating. Therefore, sensitization messages should include information to our POCs not to leave the camps and report any new arrivals coming to the camps so that they can be screened as this will form part of the precautionary measures of COVID-19 pandemic.
 - COVID-19 outbreak will create special circumstances where cultural perspective may be defied to save lives.
 - Protecting our healthcare workforce, including community health care workers, should be a top priority too. Hence, the urgent need to make asking PPE's available.
 - What will we do if the outbreak occurs in a camp/s and the Government locks down the camp as part of its effort to stem coronavirus pandemic? This situation may require skills mapping (the use of community leaders, CHWs, health promoters and hygiene promoters) in refugee communities, enhancing their capacities and providing them with communication gadgets where possible (a satellite and smart phones) for regular update/information from the camp and remote monitoring and support.
 - Updates, guidance, guidelines, and SOPs will be shared regularly.

- Contingency plan is in place to support the effort of the government; now expanded to include other sectors.
- **Public Health Operations continuity plan (OCP)**
 - Each partner to have a specific camp-based plan.
 - Ensure critical staff are identified so who does what in case the OCP plan is triggered.
- **COVID-19 Modelling Summary – East and Horn of Africa**
 - Key Points
 - Implementation of physical distancing measures in the camps could reduce infections by 21-45% depending on the degree of those measures.
 - The epidemic may take 4-8 weeks to peak from the day of infection introduction into the camp
 - Camps with a higher proportion of older age group and particularly those aged over 60 will have higher mortality rate, number of hospitalizations including ICU admissions compared with camps with a younger population.
 - South Sudan (e.g. Maban)
 - Mortality rate: 0.5%
 - Hospital admissions: 5.2%
 - ICU admissions: 1.2%
 - Ventilation requirement: 0.6%
- **Core priority areas a:**
 - **Coordination and information sharing:**
 - Regular information sharing and coordination including with non-Public Health Partners (protection, camp management, Education, Shelter, etc.) and the State MoH/CHDs.
 - **Prevention, infection containment and control:**
 - Given the realities of the context we are working in, it is of paramount importance to quickly understand and decide what is applicable in practice on the ground.
 - Based on the CDC quick analysis, the following will help to make urgent decisions from a public health perspective:
 - In case of COVID-19 outbreak, conceptualize the population in three groups of people
 - Those not infected;
 - Those infected with no or mild symptoms (representing a major source of transmission); and
 - Those with severe symptoms i.e. the sick.
 - Managing large numbers of sick people, while ideal, may be extremely difficult, if not feasible, in the context (and is challenging even in the highly developed countries) we are working in; we will be completely overwhelmed. It requires trained staff, specialist equipment and so on;

furthermore, it will not contain transmission. Modelling suggests that we may expect around 20% to become sick. Limiting the transmission requires a focus on the other 80% of the people.

- In the South Sudan context including the refugee camps the most vulnerable would include over 50s, TB and HIV affected, and malnourished children (although there is insufficient empirical data at this time to substantiate the additional vulnerability of malnourished children vis a vis COVID-19).
 - Note that the community understands the unprecedented situation/ circumstances in COVID-19, whereby they will be open and willing to undertake actions if given appropriate messages even if these defy some social norms, cultural aspects, etc.
- **Actions:**
- Ensure surveillance is in place in each camp using the surveillance document shared; it includes case definitions.
 - Consider an attack rate of up to 25% (i.e. at least 25% of the camp population may be infected).
 - Scale up prevention activities as top priority while preparing to take care of the moderately to critical sick persons. This will slow the pace of transmission, stagger the caseload of sick people to avoid becoming overwhelmed with sick.
 - Consider disinfection of public facilities, communal areas and household levels



1UNHCR staff explains the signs and symptoms of COVID-19 to a female community leader in Mahad IDP settlement. © UNHCR/Vi Tran

- **Risk communication, messaging and community engagement:**
 - Continue to constantly communicate to staff and persons of concern. House to house sensitization is a key modality for COVID-19 messaging; so, consider community house to house (door to door) sensitization/ messaging as is already being done in some camps.
 - Use IEC materials sent (English, Arabic, French); Annuak will follow.
 - Share the messages you are passing onto partners, refugees, and host community with UNHCR.
 - Show how we are delivering and the impact we are making: Photos and videos on handwashing, IEC distribution, demonstration, and mass communication; e.g. at water points, hand washing and demonstrations, soap distribution, social distancing (no crowds or tight queues), food distribution, sharing of information - posters/ briefings; people listening to COVID news (for instance someone on loud megaphone, checking of temperature etc. Ensure UNHCR branding is legible and obvious.
 - Constant communication with the communities (host and refugees), through community health outreach workers and hygiene promoters.
 - Use of loudspeakers mounted on vehicles and megaphones (public address systems).
 - Having a solarized charging system for the community to charge phones and other devices.
 - Consider what else could be done in case of outbreak; explore and use anything appropriate to influence the community's opinion with right kind of messaging.; take ideas from the communities as well.
 - Consider using all means for messaging including smartphones, media, household shelters and water points.
 - Prepare for possible home-based care for some serious cases.
- **Protection aspect:**
 - Mapping of people with special needs and provision of information and services are key in case they cannot access services:
 - Have discussion/consultation with PSNs for their thoughts on the formation and uptake of possible isolation zones for them or options to protect them in case of outbreak to limit transmission. Hearing their opinions would be great in guiding a way forward, then giving them the right to choose based on information and available options.
 - There is work ongoing on possible household isolation of vulnerable population to limit transmission, for possible home-based care, and for support.
 - Conduct community consultation with vulnerable people, in addition to community leaders, to share information.
 - Target vulnerable persons/households with appropriate life-saving services e.g. latrines, hygiene materials.
 - Informed choice is a critical component and there would be other protection and human rights/ ethical implications.

- Public Health Sectors should work with other sectors including Community Based Protection.
- Work together with community health workers, community leaders and community protection teams (CPTs), and as necessary involve Police in ensuring crowd control during GFD and any such services.
- **Disease control:**
 - Consider the non-infected, mild to moderate cases, and the critical categories. About 60% attack rate (80% mild; 20% serious); this is also a key to ensure prevention scale up.
 - Identification of cases: The core element of any communicable disease is to identify cases through testing. UNHCR is working with COVID-19 TF and the MoH to establish testing facilities in Bunj Hospital and in Pamir; however, it is very unlikely that we will be able to get all we need to test.
 - Need to make use of COVID-19 clinical definitions to detect cases and be ready to use it once an outbreak is confirmed as testing kits may always not be available.



*A refugee housing unit is being set up as an isolation ward at Hakima PHCC in Ajong Thok refugee camp.
 © UNHCR/Elizabeth Stuart*

- **Isolation and Case management:**
 - Despite inclusion of refugees in the national preparedness and response plan, given the context we are in and the capacities of the MOH structures, we need to be ready to do the interventions to large extent:
 - Each camp and each referral health facility should have at least two isolation facilities with female and male wards with total beds capacities of at least 18 and additional structure for health workers and for supplies; so also change room and WASH facilities; and a referral mechanism to the ICUs to be established.
 - Will follow the South Sudan case management strategy as much as possible where mild to moderate cases may have to be taken care of at home level if possible; if not and the attack rate is lower moderate cases can also be treated at isolation centres.

- Cases should be managed at isolation centres only by trained medical staff.
- Personal Protective Equipment (PPE) must always be worn by medical staff when handling patients in order to minimize risks of infections and transmission. This includes face masks, overalls, hand gloves, alcohol-based sanitizers, etc.). Other front line (response) staff exposed to risks should also wear PPE.
- Referrals for admission: Bunj hospital; Hope PHCC in Pamir; Pariang Hospital; it is anticipated that WHO and MOH may establish ICUs in Yei Civil Hospital in Yei, and in Yambio Hospital in Western Equatoria.
 - Refugee housing units and tents can be used as isolation and treatment sites.
 - Schools/ religious places/ distribution centres to be put in mind as places that can be used in case of very high numbers.
- **Patients on chronic illnesses:** Consider issuing at least a three months doses upon detection of the first case in the camp: TB, HIV, malnourished persons, mental health cases, diabetes, hypertension, among others.
- Incorporate **mental health and psychosocial support** considerations in the interventions / plans.
- **Screenings** (i.e. temperature & medical):
 - Holding sites required when screening at receptions/entry points.
 - Border crossing points screening: Supposed to be done by IOM as they are responsible for point of entry. Further clarification will be sought on this.
- **Nutrition and Food Security:**
 - Separate guidance will be sent on this.
 - **Key considerations:**
 - Precautions
 - Risk communication
 - Community mobilisation and active screening
 - Nutrition service provision user flow of activities
 - Prescription of rations and follow up visits
 - Infant and Young Child Feeding counselling
 - Maternal, Infant and Young Child Nutrition (*MIYCN*) counselling at the community level
 - Food assistance
 - Blanket Supplementary Feeding Programme
 - **Nutrition in the context of COVID-19 resource links**
- **Medical/Nutrition/WASH items and IPC materials**
 - Partners will quantify and submit to UNHCR.
 - UNHCR will review and procure based on funding availability.
 - Partners may be advised to procure in some cases.
- **Infection prevention and Control: WASH**
 - Business continuity plan is must

- Adequate water supply provision: Communities, health facilities, isolation sites, screening sites, ICUs. Consider increasing water pumping times.
 - Enough Latrines, including emergency latrines.
 - Hand washing sites.
 - Access to soap for hand washing.
 - Mobilization and training of community volunteers, wash committees, different partner volunteers being done.
 - Coordination of WASH activities in the context of COVID-19 being put in place
 - COVID-19 prevention messaging\
 - Procurement of sanitizing materials.
 - Soap procurement as part of hygiene and infection prevention and control.
 - Medical waste management
 - Solid wastes management.
 - Disinfection with chlorine
- **Information sharing and updates**
- UNHCR will disseminate relevant updates, information, guidelines, etc. on regular basis. Information and guidelines being sent from UNHCR PHU in Juba should be shared widely with the rest of the staff.
 - Partners to share information on regular basis, at least twice a week on what is being implemented.
 - PH team to provide inputs on COVID-19 daily updates submitted to the Regional Office (twice a week).
 - Teleconference meetings of UNHCR PH team and Partners.
- **Trainings**
- Should be carried out in all locations. Country level partner focal persons / medical coordinators need to support the field.
 - Each partner to train its clinical staff on case management urgent including continuing medical educations in consultation with UNHCR, MoH, and WHO.
- **Communication**
- Communication channels in case of suspected case (based on case definitions) or an outbreak should provide guidance for communication between partners, UNHCR and external parties.
 - UNHCR Health partner shall inform UNHCR Public Health Officer or focal person in each location, who will share the information with key staff in UNHCR, including the Head of Office. The Partner or the UNHCR focal person will liaise with UNHCR PHU in Juba for further assistance on mobilizing COVID-19 TF team in Juba to undertake rapid field trip to collect sample and carry out the test, in the case where no testing kit is available at the health facility.
 - The partner can also call the national hotline 6666.