

KEY CONSIDERATIONS:

EMERGING EVIDENCE ON SHIELDING VULNERABLE GROUPS DURING COVID-19

Shielding is a term used to describe the protection of individuals at high risk of severe COVID-19 illness by separating them from the general population. An initial analysis of key considerations regarding shielding was set forth in the previous Social Science in Humanitarian Action Platform (SSHAP) publication on shielding;¹ this new analysis should be read in conjunction with that brief, which defines terms and outlines general principles essential to understanding the concept, including: what shielding means, why we shield and who should shield, how high-risk individuals might shield and key infection prevention and control (IPC) measures, implementation process, the challenges inherent to shielding and how they could be mitigated. These general principles are not repeated here. Instead, this brief focuses on emerging evidence relevant to shielding, including research regarding social acceptability and implementation of shielding. The evidence is primarily drawn from low- and middle-income countries.

As more evidence is made available, we will produce further updates. Contact SSHAP to provide feedback, new evidence, and to engage. The brief was developed for SSHAP by IDS (led by Megan Schmidt-Sane) with Anthrologica (Leslie Jones and Olivia Tulloch). The brief is the responsibility of SSHAP.

SUMMARY CONSIDERATIONS FOR ADOPTING SHIELDING

When considering shielding, it is important to plan for socioeconomic impacts on the shielded, including psychosocial well-being, income generation, food access, and health service access. These are trade-offs that communities and individuals must weigh against the positive effects of shielding in the broader context of COVID-19 containment measures.

- **Shielding will need to be adapted** based on state and non-state capacity to provide social and economic support for shielded individuals and their households, and must be co-designed with target communities. Major concerns of shielding are **loss of**

livelihood for those shielded, potential unpaid caregiving by family members, and overall economic impact on the household. **Social, medical, and practical support is essential** for shielding to be successful, but may not be realistic in many settings where community members or humanitarians will likely play a significant role. It is also important to recognise that the economic impact of shielding will be far less than the impact of a strict population-wide lockdown.⁴⁶

- **Terminology and meaning should be made clear.** There is confusion about the differences in shielding, quarantine, and isolation. The distinction between these needs to be clearly communicated by those advocating shielding.
- **Mandatory shielding policies are unlikely to assure compliance.** People are more likely to comply with policies that allow individuals to make their own decisions about whether to shield based on their own assessment of risk and personal situations. **The decision to shield or not must lie entirely with a family and its high-risk individual(s).** Information and support should be provided, but the decision must happen without coercion from local leaders, authorities or humanitarian organisations.
- **Shielding requires cross-sectoral management** and buy-in from government, and those supporting from civil society and communities. Government and humanitarian systems can be inadequately connected, yet shielding will require coordination among a variety of sectors (e.g., health, WASH, social, and economic). A COVID-19 task force that includes these various actors and sectors could be a place to encourage cross-sectoral management, coordination, and implementation of shielding.
- **Humanitarian organisations that facilitate shielding** should do so as part of a larger health and WASH promotion response, (e.g. including water supply, provision of soap, COVID-19 awareness, and linkages to assistance). These other activities are important entry points that can enhance community buy-in and build trust with the humanitarian organisation. Where shielding is not feasible or may contribute to the risk level, organisations should focus on non-shielding response measures.
- **Ongoing risk analysis must be integrated within any shielding intervention.** For example, if a high-risk individual loses access to critical health treatment because of shielding, the risk of shielding may outweigh the benefit. Based on the unique needs and circumstances of each family and its members, the determination whether to shield, or rather focus on other prevention measures, should be supported.
- **Risk of domestic violence and abuse of women, girls and older adults has increased in some populations during COVID-19 lockdown.** Shielded individuals should be provided with information on locally-appropriate avenues to report cases and receive emergency support after an incident has occurred.

INTERPRETATIONS OF SHIELDING

Shielding is the practice of limiting contact between individuals at high risk of severe disease and those who are at lower risk but may transmit the virus. As countries begin to relax lockdown policies, shielding vulnerable groups has been proposed to protect those most at risk of severe outcomes from COVID-19, while allowing the rest of society and the economy to re-open.² Other terms may be used instead of shielding in different contexts and may represent different shielding practices, such as stratify-and-shield, cocooning, *confinement préventif*, *quarantine des personnes à haut risque* or reverse quarantine. Shielding may also be conducted without being separately identified, as when it is part of a broader package of measures to protect the vulnerable.

Shielding may take place at almost any level within a community, this brief focuses mainly on a household shielding approach where, as described in guidance developed by the London School of Hygiene and Tropical Medicine (LSHTM),^{3,4} high-risk individuals (and potentially carers) live separately from the other household's members in a designated "green zone" or room within the household, while specific IPC measures are applied to minimise their risk of becoming infected. Through a community-based governance mechanism, shielded individuals are provided food, medical care, and water and sanitation services and other relevant services (depending on local needs) during the shielding period.⁴

EMERGING EVIDENCE FROM LMIC CONTEXTS

Although most shielding at the time of writing has occurred in high-income countries,⁵⁻⁷ early evidence has begun to emerge from LMICs. Cases are presented below, based on acceptability studies from Sudan, the Democratic Republic of the Congo (DRC) and Northwest Syria, and implementation evidence from parts of India, Yemen, and Ethiopia. There are significant practical obstacles to shielding in LMICs, where material and social support may be lacking or where households are large but housing space is limited. We review the newly emerging evidence to understand the experiences of those engaged in shielding interventions, and the implications of those experiences for shielding in LMICs more generally.

Community Attitudes and Shielding Perceptions: Sudan

Sudan recently relaxed its strict COVID-19 lockdown in an effort to mitigate its impact on the country's existing economic crisis.⁸ In advance of this change, a qualitative research

study was conducted to explore the acceptability and feasibility of shielding. Preliminary findings are presented here.⁹ Participants were eligible for the study if at least one member of their household was at high risk of severe COVID-19 outcomes. Researchers found that risk perception of and belief in COVID-19 varied within the group, with a majority believing that it existed and was a threat. Others felt COVID-19 did not exist or did not perceive it as an immediate risk to their health. Although there were misconceptions about what shielding entailed, the practice was deemed largely acceptable, as it matched a cultural commitment to protecting older adults and the vulnerable.⁹ Shielding at the household level, e.g. individuals at high-risk would shield in a dedicated room while other household members travel freely, was considered highly acceptable and feasible, while moving vulnerable individuals to other households or community facilities was not widely acceptable. Alternatively, delegating one person to leave the house and be responsible for all extra-household activities was also deemed acceptable. That designated person would live separately at home, allowing other vulnerable persons and family members to move freely within the house. Key recommendations for shielding from the study included:

- Involve the community as much as possible, throughout all stages of shielding.
- Develop strategies to communicate risks associated with COVID-19 that do not impart fear, and include tailored messages for those who deny the existence of the disease.
- Promote concrete and practical ways to shield, making sure the difference between shielding and quarantine is clearly communicated.
- Provide alternative options for shielding when household-level shielding is deemed acceptable but not feasible due to physical space or economic constraints. For example, an alternative option might be to shield with extended family if there is not space within the immediate family's home.
- Provide financial and social support to the shielded individuals and their households. Ensure the ability to continue service provision, including access to health care, remote health worker consultation, access to food and nutritional needs, and so on, so as to “do no harm” through shielding.
- Establish referral and accountability mechanisms to alert local health systems of COVID-19 systems and link the symptomatic individual to care.

Community Attitudes and Shielding Perceptions: Democratic Republic of the Congo (DRC)

Two studies have been published on shielding in DRC.¹⁰⁻¹⁴ Shielding was evaluated as part of a broader study to understand perceptions of COVID-19 and barriers to prevention and

control measures in Goma, DRC.¹² Participants often confused shielding (*‘quarantaine des personnes à haut risque’*) with quarantine or isolation, and more information was needed to distinguish between these measures. Half of the participants felt capable of protecting (shielding) a vulnerable family member, and 22% perceived shielding as a key preventive measure. Participants raised practical concerns about shielding, due to lack of sufficient space in the household¹² and the need for provision of basic items such food, water, and IPC materials. Perceived risk of COVID-19 was low, except among those with an underlying medical condition. Further, study participants reported a need for more information on COVID-19 risks and on shielding. Acceptability of the concept of shielding vulnerable individuals outside the household (i.e., in a group facility) was low (34%); individuals cited social unacceptability and an elevated risk of COVID-19 for the shielded.¹²

A shielding perception study^{10, 11, 13, 14} across five areas in DRC included a case study of internally-displaced persons in Bunia, Ituri Province. Nearly all (96%) of the participants reported major difficulties finding space to shield due to overcrowded conditions and lack of access to water, sanitation and hygiene (WASH) facilities.¹³ Shielding (*‘confinement préventif’*) would be acceptable if basic needs were met and private and safe spaces were available. Participants also highlighted the need to communicate with loved ones while shielding. Community members identified several strategies to protect the most vulnerable, including provision of hygiene supplies and access to additional shelter for each household. Evidence from DRC suggests that:

- Appropriate risk communication messaging can be used to improve public understanding of COVID-19 risk and the specific risks for the clinically vulnerable.
- Shielding is acceptable if kept within the household or family unit; shielding in group-based facilities is less likely to be acceptable.
- Practical challenges to shielding need to be addressed. Community partners can be engaged to co-design locally appropriate strategies, find acceptable space, and leverage existing informal or formal socioeconomic support systems to ensure that basic needs are met.

Shielding displaced people: Northwest Syria

Initial responses to COVID-19 research in Northwest Syria (Idlib Province) included exploration of factors related to the acceptability of shielding. Evidence from that research provided key considerations for shielding in the context of internally-displaced person (IDP) camps.

The research suggested that different shielding strategies may be needed for informal and formal IDP camps. Most camps in the study area were informal with a lack of adequate shelter or WASH. Shelter consists of tents, both larger and smaller, and inadequate space for shielding within the shelter is a major concern. Shielding within an informal camp would be logistically challenging. Health professionals suggested that one possible way to shield would be to establish a separate isolation camp for shielded individuals. However, community acceptability of this approach is likely to be low. Also, this can be implemented within formal camps mostly, while it is likely to be challenging within informal dispersed camps that have little control over who goes in or out. Researchers also noted that IDPs have experienced multiple forced displacements due to the conflict. Applying some COVID-19 prevention measures such as movement restrictions might cause lack of control over their own livelihoods and increase existing feelings of marginalisation and lack of agency. Within this context, attempts to shield may be perceived negatively as well.

The Idlib area is currently controlled by opposition forces including several armed groups and the health system is managed by independent civil bodies (such as Idlib Health Directorate). Within this patchwork governance, public health guidance is imperfect, delayed, and sometimes not comprehensive. The main concern for IDPs is not COVID-19, but rather how to find adequate shelter, food, and water. COVID-19 is often perceived as God's will, and some have expressed a lack of control over risk, believing instead that God will protect them from further forms of suffering.¹⁵ Evidence from Syria suggests:

- Different strategies are needed for informal and formal camps. Shielding is unlikely to be successful in an informal camp setting, and so a separate site would need to be established for the shielded, if deemed acceptable by the informal camp residents.
- Any efforts to implement shielding in IDP populations should be designed with sensitivity to lived experiences and the added impact of isolation to this group.
- Clear communication about the risks of COVID-19, the purpose of shielding and essential implementation principles.
- Shielding design should be co-designed and co-led with the community, following a process led by the community so that they own the approach and can design the shielding arrangements that would work best for them locally.

Shielding Implementation: Kerala and Gujarat, India

Shielding ('reverse quarantine') has been implemented in at least two states in India with others considering the policy.¹⁶ As the nationwide lockdown has eased in India, Kerala has

continued to strongly advise older adults (65+) to isolate within their homes.¹⁷ State government, local officials, and volunteers have supported the social and economic needs of the shielded, for example with food deliveries, consistent with Kerala's history of social protections for the vulnerable. Despite these measures, isolated older adults reported loneliness and challenges to mental well-being. In response, the state's *Kudumbashree* women's empowerment organisation launched an outreach program for the elderly to improve social connectedness.¹⁷ Kerala's police departments also provided support to the elderly by delivering essential medicines and other provisions. Police officers were provided with additional training to handle these requests and to provide basic counselling services.¹⁷ In addition, although shielding is nominally voluntary, there have been reports of police enforcement of the recommendations, including threats of arrest. In Gujarat state, rural Ahmedabad began implementing reverse quarantine in May, advising 200,000 older adults and 17,000 pregnant women to isolate at home.¹⁸ There, local youth councils and healthcare workers have been tasked with carrying out the process and looking after the isolated.¹⁹ No other information is available at the time of writing.

Shielding Implementation: Yemen

Yemen has a collapsing health system, weak clinical management of COVID-19, and multiple social and economic challenges as a result of protracted conflict.^{20, 21} COVID-19 testing and contact tracing are not feasible or realistic at the required scale to be effective. In the north of the country, there is a complete denial of COVID-19 and a refusal to report cases, driven in part by the ongoing political situation. Shielding has been introduced in 17 districts, targeting about 57,000 people and led by the Camp Coordination and Camp Management (CCCM) and WASH Clusters and other humanitarian organisations. Shielding implementation started with community consultation in IDP sites in Abs District in the north of Yemen, and on the West Coast of southern Hudaydah. Sessions were facilitated by humanitarian organisations with local leaders and communities who co-designed the strategy, and confirmed that a focus on shielding at the household or extended family level was the culturally appropriate level at which shielding could occur.²²⁻²⁶ Grouping high-risk individuals together outside of their homes was deemed socially unacceptable, and there was a strong preference for not mixing with other households due to cultural norms around privacy. Among extended families living in compounds made up of multiple homes, it was suggested that one shelter could be dedicated to shielding for high-risk family members, especially of the same gender.

Evidence suggests that shielding resonates with a strong local tradition of protecting the elderly and the most vulnerable. In response to this, local and international humanitarian

NGOs are including shielding in their policies and it is being considered for the national response strategy.

Based on learning from camp-like settings / IDP sites, humanitarian actors in Yemen have developed a shielding implementation strategy for communities. High risk individuals were identified, and communities and households consulted. Geographic prioritisation was based on specific criteria, including: areas of high population density, urban centres, areas of low access to health and WASH services, as well as high vulnerability. Initial consultation suggested authorities and populations accepted the approach. Registration of high-risk individuals and implementation of household shielding commenced, with monitoring and evaluation to understand compliance and acceptance and collect lessons learned. Early lessons from shielding in Yemen include:

- A majority of participants in focus group discussions were **aware of who is at high risk** of COVID-19. Sheikhs, community leaders, and NGOs were trusted sources of information and were involved in risk communication and community engagement activities, which helped to shape these perceptions.
- **Systematic community consultation** was effective to manage, plan, and implement shielding in Yemen, when paired with trusted and locally known humanitarian staff. Pre-existing presence of humanitarian actors in an area increased community acceptance and thus feasibility.
- **Household shielding was preferred**, so as to keep the family unit together. The idea of a “communal” block or camp-level green zone was widely met with hesitation or concern. Sending family members away would also represent an abandonment of vulnerable family members, which was socially unacceptable.
- **Shielded individuals who already receive food support** should be supported with deliveries or adapted mechanisms of receiving assistance. Community representatives, leaders, and authorities were encouraged to support others to access food and other forms of assistance.
- **IPC messages and training to community focal points relating to shielding were adapted to this context** and covered cleaning toilets, washing hands, eating in separate places and other basic advice such as how to prepare a disinfecting solution. Messaging also provided guidance on behaviour change for high-risk individuals and protection of well-being.
- **Supportive kits are recommended to increase community buy-in and limit infection spread.** Households that were shielding a high-risk member were provided with a disinfection kit that included disinfectant, reusable heavy rubber gloves, a cleaning

bucket, cleaning cloths, scrub brush, garbage bags, soap, laundry washing powder, face mask, and an IPC brochure.

- **Daily follow-up with shielding families** was helpful to provide information, understand barriers, and discuss issues for follow-up. WASH, camp management, and protection actors with regular presence in implementation areas and pre-existing knowledge and relationships with the community can be helpful in gaining an accurate understanding of the support and information needed to shield effectively.

Informal Shielding: Evidence from Ethiopia

Early evidence of informal shielding has begun to emerge from Ethiopia, where cultural emphasis on placing community over individual needs has shaped the COVID-19 response.²⁷ Shielding has built on existing local concepts of protection for the elderly and other vulnerable groups. Researchers have identified key groups for shielding, including older adults (60+ years) and those with serious medical conditions, estimated to be 10% of Ethiopia's population.²⁷ While the national government has not yet formally implemented shielding, regional health bureaus have instructed local-level community health workers to inform households about shielding and identify clinically vulnerable individuals. Once individuals are shielded within the home, local community groups and NGOs provide a basic level of support in the form of food, infection prevention supplies, and economic assistance. Nevertheless, shielding is a particular challenge for low-income households where at-risk individuals often must leave the home to seek a livelihood. The ability to shield is also limited by number of rooms and available space in the household.

PRACTICAL CONSIDERATIONS FOR SHIELDING

Emerging evidence on shielding in LMICs and conflict-affected settings reveals that it is subject to many of the same challenges as physical distancing (see the SSHAP brief on this topic).²⁸ Yet shielding presents unique practical and social challenges. This section reviews some of these considerations and suggests ways to address them when formulating shielding strategies.

Trust: For vulnerable people to be willing to shield, high-risk individuals and the communities they live in must trust in the public health response and the measures that are expected of them. Trust in the health system and relevant authorities drives uptake of public health measures^{29, 30} and has emphasised the need to better understand the wider political and economic context of trust.³¹ **To enable effective shielding, trusted**

community and institutional actors should be identified and sufficiently supported and engaged in the decision-making processes and in implementation.¹

Risk identification and communication: Adoption of preventive health behaviours is correlated with perceived risk of COVID-19.³² As the above evidence highlights, perceptions of COVID-19 risk are extremely variable between and within communities. As a consequence, risk communication should be tailored to the local context, to correct misconceptions about COVID-19³³ and accurately communicate risk via preferred media (e.g. radio, posters). In addition, rather than focusing solely on biomedical risks, communities may want to consider multidimensional risk assessments³⁴ using tools, like one developed by RIKA India, that can be tailored to context to assess risk along key factors like health, behaviour, exposure, and social policy.³⁵ Shielding may also present additional risks, such as abuse, in certain vulnerable groups. In Colombia, GBV reports increased by 175% compared to the past year.⁴⁷ A survey in India found that 71% of elderly respondents felt that cases of abuse against them increased during the COVID-19 lockdown.⁴⁸ **Community involvement in the design and implementation would require planning shielding locations, designing shielding arrangements, enabling support for the shielded, and so on. To complement this, governments, humanitarian actors, task forces, and local authorities can serve as coordinating mechanisms and provide socioeconomic support for shielded families.**

Community-driven shielding: Approaches to shielding should be driven by and co-designed with communities rather than imposed from above,⁴ and should recognise local dynamics and practical realities. Community engagement should be in place from the early stages of response planning,³⁶⁻³⁹ once communities are involved, locally appropriate strategies can be identified to mitigate issues such as finding physical space for shielding, improving public buy-in for shielding, communicating risk messages, and addressing the socioeconomic impacts of shielding. However, any approach should avoid a simplistic framing of “community” and recognize heterogeneity and tensions within a community or household space.³⁸ Informal settlements, in particular, will require careful consideration; residents are likely to be diverse and to need extra resources to support shielding implementation. This is where local and national governments can provide support. **Community involvement in design and implementation would include planning shielding locations, enabling support for the shielded, and so on. To complement this, governments, humanitarian actors, task forces, and local authorities can serve as coordinating mechanisms and provide socioeconomic support.**

Local concepts of protection and caregiving: In LMICs that have tested shielding, including those highlighted here, support for the vulnerable remains primarily a family and household responsibility, supplemented by informal mechanisms such as extended kinship networks and mutual aid societies in the community. These local protection systems serve to mitigate the lack of formal social welfare schemes in areas where it is essentially non-existent.⁴⁰ Local protection systems should be leveraged to minimize the impact of shielding. Further, shielding design can draw on existing local concepts of protection for the elderly, which have included concepts of respect and reciprocity in care.⁴¹ **Policy makers and communities may consider encouraging families of the shielded to designate a family member to take on the caregiver role and providing necessary infection prevention and control training, social, and economic support.**

Protection of mental health and well-being: The potential psychosocial impact of shielding should be considered from the early stages of shielding in order to identify locally the barriers to access, the risks, and specific needs of shielding individuals and their families. HelpAge International, an organisation that advocates for older adults globally, raised concerns over singling out older adults for shielding, as well as reduced access to health care for the shielded, the likely psychosocial impact on older adults of long-term isolation and the potential for abuse within the home by caregivers. The emerging evidence echoes concerns over the long-term impact of shielding on mental health and the idea that shielded individuals may not be able to lead socially and economically engaged lives for an undefinable length of time.

Some evidence has emerged from higher income countries that have implemented other kinds of protection measures for elderly populations, with relevant lessons for shielding. In a cross-sectional study⁴² conducted among older long-term care facility (LTCF) residents in the Netherlands, well-being of older residents was severely affected. Six to ten weeks after implementation of a shielding visitor-ban, high levels of loneliness, depression and a significant exacerbation in mood and behavioural problems were reported. Residents without severe cognitive impairment seemed to be the most affected. In another panel study⁴³ among Dutch older people living independently, loneliness of older people increased, but mental health remained roughly stable. Personal losses, worries about the pandemic, and a decline in trust in societal institutions were associated with increased mental health problems and especially emotional loneliness. Ethnographic research⁴⁴ among the same populations showed that for older people what they really find frightening is not death, but the impossibility of being together at life's end due to isolation measures. From the perspective of groups who are vulnerable not only physically, but also socially, such as people with severe psychiatric problems,

other mental health challenges, and homeless people, it was found⁴⁵ that the biggest challenges of isolation includes a loss of perspective and meaning, combined with the loss of day activities and structures. Overall, the implementation of isolation measures in the Netherlands has reduced the incidence of COVID-19 infections and thus the number of deaths in LTCF, however, a better balance between physical safety and well-being is necessary, as social isolation is a serious health threat in itself. **Based on this emerging evidence additional psychosocial support is needed for the shielded, and adapted to local contexts.**

Further Resources (illustrative, not exhaustive):

Butler, N., & Tulloch, O. (2020). Considerations and principles for shielding people at high risk of severe outcomes from COVID-19.

<https://www.socialscienceinaction.org/resources/considerations-principles-shielding-people-high-risk-severe-outcomes-covid-19/>

Chatterjee, R., Bajwa, S., Dwivedi, D., Kanji, R., Ahammed, M., & Shaw, R. (2020). COVID-19 risk assessment tool: Dual application of risk communication and risk governance. *Progress in Disaster Science*, 100109. <https://doi.org/10.1016/j.pdisas.2020.100109>

Health in Humanitarian Crises Centre. (2020). COVID-19 guidance documents for shielding. <https://www.lshtm.ac.uk/research/centres/health-humanitarian-crises-centre/covid-19-response>

ACKNOWLEDGEMENTS

We would like to thank the following colleagues for providing valuable comments and critique on this document:

Caroline Favas (LSHTM), Nada Abdelmagid (LSHTM), Mervat Alhaffar (LSHTM), Emma Tuck (UNICEF), Lauren McCarthy (Danish Refugee Council), Simone Carter (UNICEF), Daniel de Vries (University of Amsterdam), Fergus McBean (FCDO), Ron Waldman (George Washington University), Joe Timothy (LSHTM), Ken Bluestone (Age International), Bridget Sleaf (HelpAge), Patricia Conboy (HelpAge), Ivy Chuomo (Africa Population and Health Research Center), Darryl Stellmach (Médicins Sans Frontières), Ciara Silke (FCDO), Chris Porter (FCDO), Nadeem Hasan (FCDO) and David McConalogue (FCDO).

CONTACT

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviattulloch@anthrologica.com). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).



The Social Science in Humanitarian Action is a partnership between the Institute of Development Studies, Anthrologica and the London School of Hygiene and Tropical Medicine. Funding to support the Platform's response to COVID-19 has been provided by the Wellcome Trust and FCDO.

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