Guidance on infection prevention and control of coronavirus disease (COVID-19) in migrant and refugee reception and detention centres in the EU/EEA and the United Kingdom

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Key messages

- The COVID-19 pandemic exacerbates the vulnerabilities of migrants and refugees living in reception and detention centres.

- Whilst there is no evidence to suggest that SARS-CoV-2 transmission is higher amongst migrants and refugees, environmental factors such as overcrowding in reception and detention centres may increase their exposure to the disease. Outbreaks in reception and detention centres can also spread quickly in the absence of adequate prevention measures.

- All principles of physical distancing applied in the community should be applied in migrant reception and detention settings. If physical distancing and risk-containment measures cannot be safely implemented, measures to de-congest and evacuate residents should be considered.

- In addition to physical distancing, hand and respiratory hygiene are the main non-pharmaceutical measures that should be considered and implemented in migrant reception and detention centres.

- Providing free and equitable prevention, testing, treatment and care to migrants and refugees in settings of reception and detention is critical at all times, but particularly in the context of COVID-19.

- There is no evidence that quarantining whole camps effectively limits transmission of SARS-CoV-2 in settings of reception and detention, or provides any additional protective effects for the general population, outside those that could be achieved by conventional containment and protection measures.

- Migrant and refugee reception and detention centres should be given priority for testing, due to the risk of rapid spread of SARS-CoV-2 in these settings. All individuals with COVID-19 compatible symptoms should be tested on arrival, and possible, probable or confirmed COVID-19 cases not needing hospitalisation should be isolated or separated from others in the premises. Contact tracing should occur for all cases identified as positive. Asymptomatic new arrivals can also be considered for testing to reduce the risk of introduction of cases in reception and detention centres; however, a negative test does not exclude the possibility of the person becoming infectious in the next 14 days.

- Communicating about the risks and prevention of COVID-19 with migrant and refugees currently housed in reception and detention centres requires community engagement and health communication strategies that are adapted to meet the different language, cultural and literacy needs of the different populations.

Scope and audience

The main objective of this guidance is to provide scientific advice on public health principles and considerations for infection and prevention control of COVID-19 in migrant and refugee reception and detention centres in the European Union and European Economic Area (EU/EEA) and the United Kingdom (UK).

The target audience for this guidance includes national, regional and international policymakers, public health and healthcare planners, staff working in migrant/refugee reception and detention centres, health researchers, health professionals, and civil society organisations working with migrant populations.

This guidance is informed in large part by existing ECDC guidance and technical reports on COVID-19 related to infection prevention and control [1], physical distancing [2], face masks [3], surveillance [4], testing strategies [5], risk assessments [6-9], discharge and ending isolation [10], migrant screening of infectious diseases [11,12], contact tracing [13,14], syndromic surveillance [15], preparedness [16], community engagement [17].

Target population and definitions

Target population

The target population for this guidance are migrants and refugees, including asylum seekers, migrants in an irregular situation, and others who reside in reception and detention centres in EU/EEA countries and the UK.

Definitions

A **migrant**, as defined by the European Migration Network (EMN) [18], is 'a person who either: (i) establishes their usual residence in the territory of an EU/EFTA Member State for a period that is, or is expected to be, of at least 12 months, having previously been usually resident in another EU/EFTA Member State or a third country; or (ii) having previously been usually resident in the territory of the EU/EFTA Member State, ceases to have their usual residence in the EU/EFTA Member State for a period that is, or is expected to be, of at least 12 months.'

In this guidance we are referring to migrants and refugees who have arrived from third countries (see definition below).

A **third country** is a country that is not a member of the European Union as well as a country or territory whose citizens do not enjoy the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code) [18].

An **asylum seeker** is 'a third-country national or stateless person who has made an application for protection under the Geneva Refugee Convention and Protocol in respect of which a final decision has not yet been taken [18].'

A **refugee** is 'either a third-country national who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to such fear, is unwilling to avail themselves of the protection of that country, or a stateless person, who, being outside of the country of former habitual residence for the same reasons as mentioned above, is unable or, owing to such fear, unwilling to return to it, and to whom Art. 12 (Exclusion) of Directive 2011/95/EU (Recast Qualification Directive) does not apply [18].'

An **irregular migrant**, also sometimes referred to as undocumented migrant, is 'a third-country national present on the territory of a Schengen State who does not fulfil, or no longer fulfils, the conditions of entry as set out in the Regulation (EU) 2016/399 (Schengen Borders Code), or other conditions for entry [18].'

For the purposes of this guidance, we will use the term 'migrant and refugees' to mean asylum seekers, refugees and irregular migrants in reception and detention centres.

A **reception centre** is defined as 'a location with facilities for receiving, processing and attending to the immediate needs of refugees or asylum seekers as they arrive in a country of asylum [18].'

A **detention centre/facility** is defined as 'a specialised facility to keep in detention a third-country national who is the subject of return procedures in order to prepare the return and/or carry out the removal process, in particular when (a) there is a risk of absconding; or (b) the third-country national concerned avoids or hampers the preparation of return or the removal process [18].' The length of time that an irregular migrant can be held in a detention centre can be up to 18 months [19].

Background

The unprecedented rise in rates of migration to and within the EU/EEA and the UK in recent years has led to increased attention on migrant health in the region. Similar to other crises, migrants and refugees living in reception and detention centres may be particularly vulnerable to the impact of COVID-19 [20,21]. Certain migrant populations may face numerous barriers to seeking healthcare, and engagement with these communities remains a challenge. Barriers can vary from organisational-level barriers such as the need for interpretation, cultural mediators, and geographical and transport challenges, to individual-level barriers including poor socioeconomic status, social isolation, lack of support, discrimination, and stigmatisation [22].

Migrants on average show the same health needs as the host population, and may be even healthier in some cases [23]. Migrants do not generally pose a health threat to the host population with respect to infectious diseases [8,9]. However, in a number of EU/EEA countries and the UK, there are sub-populations of migrants that are disproportionately affected by some infectious diseases, such as tuberculosis, HIV, and hepatitis B and C [11,12]. Also, there are sub-populations of migrants and who are disproportionally affected by chronic diseases which make them particularly vulnerable to SARS-CoV-2 [11,24].

As the points of entry of migrants and refugees usually differ from the official points of entry in the EU/EEA and the UK, several reception centres may be located away from large urban areas where most healthcare resources are usually located, which can further hamper access to health care.

Number of migrants and refugees in the EU/EEA and the UK

The EU/EEA and the UK comprises 31 countries, with a total population of 519 million. Migrants, here defined as people born in a different country than the one they reside, made up 12% of this population in 2019, with 4% being born in another EU/EEA country or the UK and 8% originating from outside the EU/EEA and the UK [25]. Since 2015, millions of people have fled their homes to seek shelter in Europe. According to the United Nations High Commissioner for Refugees (UNHCR), more than three million refugees and asylum seekers (pending cases) were registered in the EU/EEA Member States and the UK in 2018 [26]. In addition, around four million irregular migrants are estimated to live in Europe [27], but it is not known how many of these irregular migrants reside in reception and detention centres in EU/EEA countries and the UK.

Migrants and refugees are often hosted in facilities run by governments or non-governmental organisations (NGOs). The quality of these centres differs widely between and within countries. In some cases, refugees are hosted in spontaneous unstructured camps, living in temporary shelters and cared for by NGOs. The exact number of these facilities or centres in Europe is difficult to estimate, as is the number of migrants living in these settings.

Access to healthcare in reception and detention centres

The right to health is a basic social right. The United Nations (UN) International Covenant on Economic, Social and Cultural Rights, which has been ratified by all EU/EEA Member States and the UK, enshrines 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (Article 12). According to the UN Committee on Economic, Social and Cultural Rights – the body entrusted with supervising the application of the Covenant – core obligations derived from this right apply to everyone and do not depend on the regular status of the persons concerned [28]. Therefore, they also apply to migrants, both in a regular and an irregular situation, including asylum applicants (although under EU law the extent of the enjoyment of such right may change depending on the status the person has). States are under an 'obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including […] asylum-seekers and [irregular] immigrants' [28]. More specifically, refugees under the 1951 Geneva Convention enjoy the same treatment with respect to public relief and assistance, including healthcare, as is accorded to nationals of the host country (Article 23).

At the EU level, the Charter of Fundamental Rights of the European Union (the Charter) includes the right to healthcare under Article 35, which stipulates that 'everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices' [29]. The Charter's application is limited to those matters that fall within the scope of EU law. In accordance with Article 168 of the Treaty on the Functioning of the European Union, the EU's role in the field of health is limited to complementing the national policies of the EU Member States, with a focus on improving public health and increasing health security, including surveillance of communicable diseases.

EU secondary law regulates entitlements to healthcare for asylum seekers, refugees and irregular migrants, including those placed in detention or staying in reception centres as follows:

- **Asylum applicants** are entitled to necessary healthcare, which must include at least emergency care and essential treatment of illness, as well as necessary medical or other assistance for those who have special needs. Member States also need to ensure that material reception conditions provide an adequate standard of living for applicants, which guarantees their subsistence and protects their physical and mental health [30].

- **Refugees and other people granted international protection** have equal access to healthcare to that of a Member State national [31].
- **Migrants in an irregular situation pending removal** are entitled to 'emergency healthcare and essential treatment of illness' as far as possible. Such health services must be provided to irregular migrants in pre-removal detention as well [19].

In practice, due to limited healthcare infrastructure in detention and reception centres as well as practical obstacles in accessing healthcare services, these categories of people may face barriers in actually accessing health care they are entitled to.

Disease background

COVID-19 is caused by a novel coronavirus, first described in China after a cluster of pneumonia cases of unknown aetiology was reported in Wuhan, Hubei Province on 31 December 2019. This novel coronavirus was classified as SARS-CoV-2, as it is closely related to the severe acute respiratory syndrome-related coronavirus (SARS-CoV) [32-34].

SARS-CoV-2 and other coronaviruses are believed to be transmitted from person-to-person via respiratory droplets, either being inhaled or deposited on mucosal surfaces. Other routes of transmission such as contact with contaminated fomites and inhalation of aerosols, have been found plausible and cannot be excluded as potential transmission routes [35]. Pre-symptomatic (peaking at 0.7 days before onset of symptoms) and asymptomatic transmission of SARS-CoV-2 (with present knowledge estimated to be up to 40%), contribute significantly to the transmission of the virus[36].

The median incubation period for COVID-19 has been estimated to last from five to six days, with a range from one to up to 14 days [37,38]. The most commonly reported clinical symptoms from 59 793 laboratory-confirmed cases reported to The European Surveillance System (TESSy), as of 27 May 2020, [39] were fever/chills (50%), dry or productive cough (39%), pain (19%), general weakness (14%), headache (12%), muscular pain (12%), sore throat (9%), runny nose (8%), shortness of breath (8%), diarrhoea (5%), nausea/vomiting (3%) and irritability/ confusion (1%),.

Underlying health conditions reported among patients with COVID-19 with more severe disease admitted to intensive care units (ICU) include hypertension, diabetes, cardiovascular disease, chronic respiratory disease, immune compromised status, cancer and obesity [40-48].

More up-to-date disease background information is available online from ECDC [49], WHO [50] and in ECDC's Rapid Risk Assessments [6,51].

COVID-19 in the context of migrant reception and detention centres

Reception and detention centres include closed environments and camp-like settings, which are known to be at higher risk for outbreaks of COVID-19 [52]. Examples of COVID-19 outbreaks that have been detected in camp-settings include in the Ritsona and Malakasa camps in Greece [53-57], in the Hal Far open centre in Malta [58], all of which were subsequently put under quarantine, the Ellwangen reception centre in Germany [59], and in the Sneek reception centre in the Netherlands [60].

An outbreak with 150 positive cases occurred in Kranidi in Greece in a hotel serving as a migrant shelter, which was then also placed under quarantine [53,56,61,62]. Notably, the COVID-19 case in Ritsona camp and the first case in the hotel in Kranidi were detected during hospital visits by residents, underlying the need for extensive testing for early detection of outbreaks in these settings.

Following the introduction of COVID-19 into reception and detention centres, there is the potential for rapid further spread within these settings in the absence of adequate measures. For instance, during the outbreak of COVID-19 in the Ellwangen reception centre in Germany, cases of COVID-19 reportedly rose from seven to 259 in one week, despite the facility having been placed under quarantine [59]. By the end of April, 68% of all 600 asylum seekers in the quarantined reception centre had been infected [59]. A review of publicly reported outbreaks of COVID-19 in temporary housing for asylum seekers and refugees in Germany identified 42 centres in 11 German states being affected. Among the 9 785 asylum seekers, 1 769 had been tested positive, corresponding to a pooled incidence risk of 17,0 % (95% KI: 12,0–23,0) [63]. Thirty of 42 centres had been put under mass quarantine. In Lisbon, Portugal, 138 of the 187 asylum seekers living in the Aykibom hostel were infected with COVID-19 [64].

Quarantine in reception and detention centres

- One public health approach to COVID-19 cases in reception and detention centres has been mandated mass quarantine of large parts or the entire facility, sometimes with repeated extensions (beyond 14 days) triggered by the occurrence of further cases during the quarantine period [53,58,65]. In some cases, physical barriers have been set up and quarantine is controlled by police forces or private security agencies [63]. This strategy has the rationale of limiting transmission between residents of the centre and the general population outside, but it has resulted in increased stigma towards migrants and refugees. However, there is no evidence that quarantine of whole camps a) effectively limits transmission among residents of the centre, or b) entails any additional protective effects beyond those that could be achieved by conventional containment and protection measures for the general population. Furthermore, evidence suggests that in settings with insufficient possibilities for physical distancing (such as cruise ships), mass quarantine can be counter-productive with adverse effects on mental health [66,67], sexual and gender-based violence [68] and non-communicable disease [69]. In those contexts, early evacuation may be more effective in reducing transmission [70]. In addition, Amnesty International has reported disruptions to normal water and food deliveries during such quarantines, while restrictions on movement have also hindered residents' access to shops, even when their purchases are self-funded [71].
- According to WHO; quarantine as a public health measure is only acceptable if basic principles and precautions can be applied, meaning: when in place, quarantine measures must apply equally to all without discrimination, as per guidelines, 'persons who are quarantined need to be provided with healthcare, financial, social and psychosocial support, and basic needs including food, water and other essentials' [21,72]. Importantly, any action which stigmatises residents of centres or enforces quarantine by physical barriers (fences) and securitisation should be avoided.

Preparedness in settings of migrant reception and detention

As WHO notes, all states have the obligation to protect and promote the right to health for all people in their territory, including refugees and migrants [73]. The COVID-19 pandemic poses particular challenges for protecting health in settings such as migrant reception and detention centres [68].

To prevent and control the transmission of any communicable disease in migrant reception and detention centres, it is important that the centres assess their needs for communicable disease control, particularly in the event of a sudden influx of migrants. In addition to the current guidance document, the *ECDC preparedness checklist tool against communicable disease outbreaks at migrant reception centres* can be a support to public health authorities in the current COVID-19 outbreak and securing optimal prevention and control measure in these setting [16].

The checklist tool addresses seven key dimensions that are important for the control of communicable diseases, including COVID-19, in migrant reception centres. These are: human resources, medicines and vaccines, physical infrastructure, sanitation and hygiene, health financing, coordination, and health information [15].

The Inter-Agency Standing Committee (IASC) has produced interim guidance on scaling up COVID-19 outbreak readiness and response operations in humanitarian settings. This guidance addresses coordination and planning; risk communication and community engagement; surveillance; case investigation and outbreak rapid response teams; individual health screenings; laboratory systems; infection prevention and control; case management; and logistics and supply chain management [74]. Similarly, WHO has produced guidance for prevention and control of COVID-19 for refugees and migrants in non-camp settings. This document addresses similar issues and also provides input into matters such as points of entry screening and occupational health and safety measures [73].

Considerations for mitigating transmission of COVID-19 in reception and detention centres

Screening for infectious and chronic diseases

Providing free and equitable screening for infectious and chronic diseases to migrants and refugees in settings of reception and detention is critical at all times, but particularly in the context of COVID-19 [11,12], as there are specific sub-populations of migrants and refugees who are affected by underlying diseases which make them particularly vulnerable to SARS-CoV-2 [11,24].

Health services need to be able to detect cases early and link people to care, as well as identify people with underlying health conditions that make them particularly vulnerable to SARS-CoV-2, and ensuring mitigating measures are taken to protect those at increased risk for COVID-19 [75].

Overall data for COVID-19 have shown that advanced age, ethnicity, and underlying health conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease, immune compromised status, and cancer are more often associated with the need of hospitalisation in ICUs [6,76]. In order to minimise the impact on any already stretched local healthcare system, patients that are at higher risk to develop severe symptoms should be identified and protected early by means of special arrangements [for the housing] which allows measures of physical distancing.

Residents in settings of reception and detention in areas with widespread COVID-19 transmission should be screened for vulnerabilities based on the risk for developing severe disease or complications. In particular, such screening should be conducted upon admission to a reception or detention centre. After identification, a 'cocooning' strategy (see below) of moving these vulnerable groups to less crowded settings may assist in reducing transmission, improving health outcomes and reducing the pressure on local healthcare services. According to WHO guidance, safeguards should be in place to ensure non-discrimination.

In line with WHO guidance, ECDC recommends that safeguards should be in place to ensure that screening for infectious and chronic diseases are performed in a non-discriminatory and non-stigmatising way, also ensuring the respect for privacy and dignity for all migrants and refugees [52].

Living conditions in settings of migrant reception and detention

Migrants may be at increased risk of communicable disease in their destination country due to factors such as limited access to healthcare, lack of vaccination, low socioeconomic status and poor living conditions [20,77-79]. Poor and overcrowded living conditions can increase the risk of respiratory diseases, such as COVID-19. This is particularly evident in reception/detention centres, including camp settings, which may house many more residents than the originally intended capacity.

Overcrowding, shared bathrooms, and poor hygiene make it virtually impossible to adhere to the most basic sanitary measures to prevent COVID-19 transmission. There are examples of reception centres that lack sanitation and sewer systems and do not have adequate testing capacity nor medical care for the detainees, even at a time when the COVID-19 is transmitting in the general population in most EU countries [80].

According to the European Immigration Detention Rules, 'such facilities should provide accommodation which is adequately furnished, clean and in a good state of repair, and which offers sufficient living space for the numbers involved [81]. However, the EU Directive on modalities for material reception conditions specifies that accommodation centres guarantee an adequate standard of living without reference to sanitation, hygiene or sewer system [82].

In some places in Europe, the number of refugees residing in reception centres exceeds the capacity of the facility [83,84]. Due to the confined and limited space in reception and detention sites, physical distancing, quarantining and isolation are particularly difficult.

Restriction of movement has been put in place in the five reception and identification centres on the Aegean islands as a result of the challenges posed by COVID-19. As a result, migrants have been stranded in severely overcrowded centres where conditions of healthcare, shelter, and water and sanitation are suboptimal and conducive for COVID-19 transmission [85]. In addition, prolonged restrictions of movement has led to increased attack rates within the centres and challenges regarding supply for basic needs - including food, barriers to care access for issues other than COVID-19 such as mental health and other social issues. In the absence of emergency plans to protect the residents of these centres, the possibility of the spread of COVID-19 remains high.

Physical distancing

Challenges in implementation of physical distancing

- The term 'physical distancing'[1] refers to efforts that aim to decrease or interrupt transmission of COVID-19 in a population. This is accomplished by minimising the number of contacts and increasing physical distance between potentially infected individuals and healthy individuals, or between population groups with high rates of transmission and population groups with no or low level transmission. See the ECDC guidance document for further details [2].
- However, the conditions in many reception and detention centres, where people may live closely together in confined spaces, can present significant challenges for the application of the physical distancing measures needed to prevent transmission of COVID-19 [86,87]. This is particularly evident in camp settings, which may house many more residents than the originally intended capacity.

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[1] The term 'physical distancing' is often used interchangeably with the term 'social distancing'. However, it is increasingly recognised that 'social distancing' as a term does not reflect the actual intention of the actions taken, which is to create *physical* distance between people as a means of reducing infection risk, while not separating them socially. ECDC is now therefore using the term 'physical distancing' to describe these measures.

- • For instance, on 15 May 2020, Greek authorities reported that the total number of asylum seekers residing in reception and identification centres across five Islands of the Aegean was 33 357, over five-fold the original intended capacity of 6 095 [83]. This leads to unavoidable overcrowding: the population density in Moria Reception and Identification centre Lesvos, is estimated at 203 800 people per km^2 [88], and families of five or six have to sleep in spaces of no more than three m^2 [89]. A recent report from Médecins Sans Frontières (MSF) reported that as of March 2020, some parts of the reception and identification centres in Lesvos had only one water tap per 1 300 people, with no soap available, while residents at a facility in Ellwangen, Germany, have reported that toilets and baths are typically shared between 50 to 80 people [59]. Limited hygiene facilities can result in residents in camp settings being unable to follow general government guidance on frequent hand-washing [90]. Such circumstances also makes isolation and quarantine very challenging, as separating sick and potentially exposed individuals from healthy persons is resource-intensive, and it requires extensive testing facilities that may not exist [14].
- • Some migrants and refugees reside in settings with inadequate housing such as tents, without cooking or hygiene facilities, and often with young children. These living conditions make it challenging, if not impossible, to implement physical distancing strategies involving stay-at-home recommendations, either for the healthy population or for those individuals at a higher risk of developing serious disease and who should therefore be 'cocooned'. Furthermore, scarce and infrequent provision of services within camp settings has the effect of clustering individuals within the camp, who often have to queue to access food, healthcare, hygiene facilities and asylum services. Such conditions can increase the risk of the rapid propagation of a communicable disease such as COVID-19.

Infection prevention and control

Some migrants and refugees live in confined and overcrowded spaces. Due to the confined and limited space in reception and detention sites, physical distancing, quarantining and isolation are particularly difficult. Nevertheless, implementation of distancing measures in confined places should follow general distancing recommendations in order to prevent the spread as much as possible.

Essential public health measures include ensuring adequate living conditions, access to timely and free healthcare services, screening for infectious and chronic diseases and prompt linkage to care and treatment [11,12].

- • In addition to physical distancing, hand and respiratory hygiene are the main non-pharmaceutical measures that should be considered and implemented in migrant reception and detention centres.
- • Multilingual signage (information/infographics with pictograms) that promote the importance of hand hygiene and explain how to perform appropriate hand washing, respiratory etiquette and proper use and handling of facemasks should be available in different areas of reception and detention centres.

Hand hygiene and hygiene facilities

COVID-19 is mainly transmitted from person-to-person through respiratory transmission or through contact with contaminated fomites, which requires high standards of hand hygiene and respiratory etiquette [35]. However, current evidence also suggests environmental transmission through faecal contamination [91-94]. Although transmission through faecal contamination does not appear to be a significant driver in the transmission of SARS-CoV-2, further research is needed to assess its contribution to the spread of SARS-CoV-2 [7,95].

Hand hygiene and sanitation is important in the prevention and control of COVID-19 infection through contamination with fomites and respiratory droplets. Migrants and refugees in reception and detention settings often reside in hygiene and sanitation compromised environments. The lack of adequate sanitation facilities, drinking water, shaving utensils/equipment, rubbish collection and cleaning services is a major concern in the prevention and control of COVID-19 in these areas. It is therefore important to ensure the accessibility and use of clean water, soap, and sanitizer. Overcrowding, poor sanitation and limited access to health services can also facilitate the spread of antimicrobial resistance among migrants in reception and detention centres.

Hand hygiene should be practiced frequently: particularly before eating, drinking or smoking, before handling food items, after handling garbage or changing baby diapers. Easy access to hand washing facilities with soap, single use paper towels or automatic dryers for drying hands, and alcohol based hand rub solutions (containing at least 70% of alcohol) are possible options that should be widely available according to resources. It is important to avoid crowding and long queues at the handwashing stations, e.g. increasing the number of available sinks taps.

Respiratory etiquette

Respiratory hygiene plays also a key role in the prevention and control of the spread of COVID-19, particularly for persons with COVID-19 compatible symptoms. Strict respiratory etiquette should be advised: nose and mouth should be covered with paper tissue when sneezing or coughing. Clean paper tissues should be available in migrant reception and detention centres and at hand and ready to be used. Paper tissues should be disposed immediately after use, ideally into bins with covers, and hands should be washed/cleaned right away using the correct procedure. If paper tissues are not available, coughing or sneezing in to the elbow is recommended.

Face masks

The use of medical or non-medical face masks[2] by migrants in reception and detention centres can be considered as a means of source control (i.e. to prevent the spreading of droplets from infected people with or without symptoms) when in proximity to other people, particularly in crowded settings, where physical distancing cannot be maintained or properly implemented [3].

- The use of face masks should be considered only as a complementary measure, not replacing core preventive measures such as hand washing, respiratory etiquette and physical distancing.
- Appropriate use of face masks is important. The face mask should completely cover the face from the bridge of the nose down to the chin.
- Information about the proper use of face masks should be available highlighting the importance of cleaning hands with soap and water or alcohol-based hand rub solutions before wearing and after removing the face mask.
- Medical and non-medical face masks are acceptable in migrant reception and detention centres, taking into account issues of availability and ensuring that medical face masks are prioritised for use in healthcare settings.
- The use of filtering face piece (FFP) respirators is not recommended for general population, as they should be saved for their use in healthcare settings by healthcare workers. Healthcare workers providing healthcare in reception and detention centres should use respirators according to national guidance and procedures for examining and/or sampling possible or probable COVID-19 cases.
- In case of the use of non-single use fabric face masks, it is recommended to ensure that they can be frequently washed or disinfected, according to the manufacturer instructions.

Ventilation

Poor ventilation of indoor spaces is related to increased transmission of respiratory infections [96]. The primary mode of transmission of COVID-19 is believed to be through respiratory droplets. The role of aerosols, which may linger in air for longer, has also to be taken into account particularly in crowded and poorly ventilated spaces. However, numerous events of COVID-19 transmission have been linked to presence in confined indoor spaces [77-79]. Increasing the number of air exchanges per hour and supplying as much outdoor air as possible is likely to decrease any potential risk of aerosol transmission and this can be achieved by natural or mechanical ventilation, depending on the establishment [79,97].

When mechanical ventilation systems are used, maintenance of artificial ventilation systems, especially in relation to cleaning and change of filters, in accordance with the manufacturer's instructions is essential.

General cleaning and disinfection in reception and detention centres in the context of COVID-19

- Frequently touched surfaces should be cleaned as often as possible (at least daily and if possible more frequently), particularly in public spaces. Examples of these surfaces are doorknobs and door bars, chairs and armrests, table tops, light switches, etc.
- The use of a neutral detergent for the cleaning of surfaces in general premises (i.e. not for premises where a possible, probable or confirmed case of COVID-19 has been) should be sufficient.
- The cleaning of shared toilets, bathroom sinks and sanitary facilities should be carefully performed. Consider the use of a disinfectant effective against viruses, such as 0.1% sodium hypochlorite, or other licensed virucidal products following the instructions for use provided by the manufacturer.
- Cleaning staff should wear personal protective equipment (PPE) (e.g. uniform – which is removed and frequently washed in warm water and detergent – and gloves) when performing cleaning activities.
- The cleaning material (cloths, mops, etc.) should be properly cleaned in warm water and detergent at the end of every cleaning section.
- Hand hygiene should be performed each time PPE, such as gloves are removed.
- Waste material produced during the cleaning should be placed in the unsorted garbage.
- Similar instructions should be given to migrants for cleaning their accommodation (e.g. trailers).
- All textiles (e.g. towels, bed linens, curtains, re-usable non-medical face masks etc.) should be washed using a hot-water cycle (90°C) with regular laundry detergent. If a hot-water cycle cannot be used due to the characteristics of the material, bleach or other laundry products for decontamination of textiles need to be added to the wash cycle.

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[2] A medical face mask (also known as surgical mask) is a medical device covering the mouth, nose and chin ensuring a barrier that limits the transition of an infective agent between the hospital staff and the patient. They are used by healthcare workers to prevent large respiratory droplets and splashes from reaching the mouth and the nose of the wearer and help reduce and/or control at the source the spread of large respiratory droplets from the person wearing the face mask. Non-medical face masks (or 'community' masks) include various forms of self-made or commercial masks or face covers made of cloth, other textiles or other materials such as paper. They are not standardised and are not intended for use in healthcare settings or by healthcare professionals.

Physical distancing measures and some examples of good practice

Although migrant detention and reception centres may be overcrowded and lack adequate facilities, the principles of human rights and equity require that every effort should nonetheless be made to apply the same standards of physical distancing as those that are applied in the wider community. Within the context of these centres, there is a range of possible physical distancing measures; some examples are given below (in no particular order of priority), including several good practice examples reported from different countries in the EU/ EEA and the UK. Note that as a principle, a needs assessment should always be conducted prior to organising or implementing any physical distancing measures. In addition, other than those with underlying health conditions, some refugees, asylum seekers and migrants are more vulnerable than others, such as pregnant woman and minors – their needs should be prioritised.

- Mitigation measures to reduce crowding in communal areas of reception and detention centres.
- Physical distancing measures should be implemented to ensure sufficient distance between residents. For instance, in Denmark, meal-times are organised in shifts to reduce crowding, while in Croatia, floor-markings are used in communal areas to facilitate people keeping two metres apart [98].
    - In settings where physical distancing measures are challenging to implement, a 'fire-break' approach could be used, whereby the population of a centre is divided into different groups or sections who are then unable to come into contact with each other [99]. This can include having groups eating in shifts, accessing hygiene facilities at different locations, or accessing health facilities at different times and/or locations. This approach aims to limit the potential spread of COVID-19 should an outbreak occur, by containing it to one section of a centre's population.
    - Consideration should be given to providing accommodation in single rooms, with a minimum of shared facilities. This could involve the use of private housing.
- Isolation of COVID-19 cases and of people with COVID-19 compatible symptoms in general. Self-isolation of individuals with symptoms of a respiratory infection is one of the most important measures for reducing disease transmission and limiting the spread of the virus [100]. People with probable or confirmed infection who do not need hospitalisation should remain in a designated setting – a single, dedicated, adequately ventilated room, which ideally has its own dedicated toilet. For more on isolation, please see section on 'Management of possible, probable or confirmed COVID-19 cases in reception/detention settings;' and also consider the principle that the same standards should be applied for those housed in reception and detention facilities as are available to the host community.
- Quarantine of the contacts of COVID-19 cases. Contact tracing is a core public health measure that plays an important role in the control of COVID-19 [13]. Contacts of COVID-19 cases (see definition below) – who may have been exposed to infection but who remain well – must be separated from unexposed people in order to avoid transmission if disease develops, even during the asymptomatic or pre-symptomatic phases of the disease. Individuals in quarantine should be monitored for the appearance of COVID-19-compatible symptoms, and if symptoms are reported, a test should be carried out promptly. Contacts should be isolated and/or monitored in accordance with national or ECDC guidance [13]. If symptoms of illness occur, the quarantined persons should then be isolated and medical advice should be sought.
- Restricting visitors to reception and detention centres, and minimising, where possible, unnecessary changeover of staff can help to reduce the risk of imported cases into a centre. While this measure can theoretically be applied, it may be challenging due to the size of many centres which require a significant number of personnel combined with a high turnover in order to maintain basic functioning. Any visitor restrictions should not affect the availability of legal counsel, medical services or other essential services, or of family visits [101], and, unless local incidence of COVID-19 remains high, they should also not extend for longer than epidemiologically necessary.
- Ensure that only healthy staff come to work. Under no circumstances should any member of staff who is experiencing symptoms of respiratory illness and/or fever be permitted to enter the facility. In order to minimise the risk of staff coming to work when potentially sick, measures should be put in place to ensure that they do not lose out financially for missing work under these circumstances [17]. Testing facilities for COVID-19 should also be made easily accessible to staff (as to those living within the facilities), and they should be vigilant in daily self-monitoring for COVID-19 compatible symptoms.

- 'Cocooning' or 'segmentation and shielding' of high-risk groups. People over the age of 60 years and those with underlying health conditions such as high blood pressure, diabetes, immune suppression and overweight/obesity, should be kept as physically isolated from other residents as is feasible in order to minimise their risk of infection. For example, they may be removed from the centres into altogether different facilities, or they could be placed in separate areas of the reception or detention centre where they are housed [102]. A risk assessment can be part of general entry assessments or as part of routine medical care, but it should be performed immediately after arrival in a centre. In outbreaks, evacuation of those identified as high-risk groups is of immediate importance. Emphasis should be placed on moving family units together, which allows for continued support for vulnerable person(s). Moreover, if vulnerable persons are moved into a specific facility, a medical screening including testing for COVID-19 followed by a 14-day quarantine should be considered in order to limit the potential for introduction of COVID-19 within that facility. Countries following this approach include: Austria, Belgium, Germany, Ireland, Latvia [98]. The UNHCR has moved older and immunocompromised persons out of reception centres on Greek islands to locations where they are exposed to a lower risk of contagion, while the agency additionally supports state-supported transfers to the mainland with logistics, interpretation and PPE distribution [103]. It is important to stress that testing at entry should act as a complement not as a replacement to the implementation of effective measures of physical distancing and mitigation measures to reduce crowding. It should also not be used as a tool for excluding refugees who test positive from entering the asylum-seeker procedure.
- Identification of alternative facilities or accommodation, both to reduce the occupancy rate of current reception and detention facilities and to provide accommodation for new arrivals of asylum-seekers, refugees and migrants in the event that a current facility is placed under quarantine. This has occurred in Austria, Sweden [98], and Germany [63]. Emergency shelters have also been created to increase capacity and decrease occupancy rate in, for example, Belgium, Czechia, France, Greece, Ireland, the Netherlands, Norway, Germany, Denmark, Switzerland [87].
- Halting the placement of new arrivals into detention centres, and considering the release of currently detained migrants may be considered in centres that are already overcrowded or that are at risk of becoming overcrowded, or in centres where appropriate measures to contain the spread of the virus cannot be implemented due to layout, inadequate facilities etc. Alternative accommodation may be found in settings such as hotels, hostels, accommodation run by civil society actors, or with family members or friends in the community. Note that halting placements should not result in new arrivals finding themselves unable to submit applications for international protection and thus be assigned to reception places. Rather, what is needed is a process to safely screen, test and integrate new arrivals into reception structures while also promoting decongestion. Countries releasing residents of reception and detention centres or who have reduced new arrivals include: Austria, Belgium, Luxembourg, Norway, Spain, Switzerland and the United Kingdom [98,101,104-109]. Caution should be taken in organising the release of asylum-seekers, refugees and irregular migrants to ensure they are not left without accommodation or support.
- Use of masks in crowded areas. The use of face masks by migrants and staff in a reception or detention centre may serve as a means of reducing the spread of infection by minimising the excretion of respiratory droplets from infected individuals. For this, a regular supply of masks should be provided. It is not known how much the use of masks can contribute to a decrease in transmission, so face masks should be considered in busy or overcrowded parts of a reception and detention centre as a measure that complements other physical distancing measures [3]. If non-disposable masks are used it must be guaranteed that they can be disinfected appropriately.
- If education is provided in reception or detention centres, it is important to ensure that children residing in such facilities have access to safe systems of education. Online education is preferred. Alternatively, if face-to-face education continues to be provided, physical distancing recommendations should be implemented to the same standard as in schools in the rest of the country.
- Facilitation of online application procedures for (i) asylum claims and for (ii) applications to social protection assistance has occurred in Poland for the country's integration and social assistance programmes [103], while Norway started conducting personal interviews using video conferencing software on 1 April 2020. Applicants are interviewed from the reception centre, with the interpreter connected from another location and immigration staff sitting in interview rooms in Oslo [87].

Syndromic surveillance in settings of migrant reception and detention centres

In often over-crowded settings such as migrant reception or detention centres, it is essential to ensure the early detection of COVID-19 outbreaks. In order to facilitate this, syndromic surveillance systems tailored not only to COVID-19 but also to other relevant communicable diseases should be established [15]. This relies upon clear communication on the symptoms of COVID-19 to all staff and residents.

The objective of syndromic surveillance is to identify infected clusters early before definitive diagnosis, and mobilise a rapid response [110]. Implementing syndromic surveillance in migrant reception/detention centres is appropriate as they face specific challenges in preventing and controlling communicable disease transmission, in general [111]. Prior to COVID-19, many countries in Europe had implemented syndromic surveillance systems in such settings [112-114].

ECDC has previously published a Handbook on implementing syndromic surveillance in migrant reception/detention centres and other refugee settings [15]. Syndromic surveillance is intended to enable rapid public health action, but it is not a substitute for routine screening or reporting procedures.

Typically, establishing a syndromic surveillance system involves a preparatory, pilot, and implementation phase. Given the urgency of the situation concerning COVID-19, it is advised to move quickly through the preparatory and pilot phases. The existing suggestions for syndromic surveillance provided by ECDC in Annex II of its guidance [15] may be slightly modified to account for syndromic surveillance of COVID-19. This would involve:

- expanding the case definition for 'acute respiratory infection' to account for the symptoms of COVID-19, including anosmia, ageusia and dysgeusia [4,5].

As noted in the ECDC Handbook [15], data should be collected daily in a syndromic surveillance system. Minimum daily data requirements should include:

- number of newly observed syndromes (numerator), stratified by age group, not by gender;
- number of healthcare consultations in the setting (proxy for denominator);
- estimation of migrants hosted in the setting (denominator).

Only new patients are reported, while patients presenting for follow-up consultations and already reported to the system on first consultation should not be reported again. Stratification by age group should be limited to a few age groups consistent with the epidemiology of the syndromes under surveillance. Given the epidemiology of COVID-19, this may be in the first instance as simple as 0-15, 15-35, 35-70, >70. Syndromic and testing data should be reported on a daily basis to local or national public health authorities.

Testing considerations for newly-arrived migrants and refugees

In case of symptomatic incoming migrants/refugees, healthcare attention should be provided according to the severity of the symptoms, and when possible, healthcare providers should be contacted following the procedures according to national health authorities. Symptomatic individuals should be tested and contact tracing should commence according to the national policy. Depending on the availability of resources, asymptomatic persons may be tested when they are identified as close contacts of cases during contact tracing [75]. The receiving authorities should follow relevant national guidelines (e.g. about quarantine) of the respective receiving country.

To reduce the risk of introduction of asymptomatic, pre- symptomatic or symptomatic COVID-19 cases in the receiving country or centre, testing arriving migrants and refugees could be considered. For SARS-CoV-2 detection, a highly sensitive and specific molecular (e.g. RT-PCR) test should be used. In order to be meaningful, the test results need to be reported in a timely manner (optimally within 1-2 days) to the person tested, to the centre and to public health contact point to allow contact tracing and IPC measures. It needs to be noted that a negative test does not exclude the possibility of the tested person becoming infectious in the following 14 days that is the known incubation period of the virus. In case of quarantining all newly-arrived migrants and refugees that arrive in groups, testing individuals after the quarantine period could be considered.

Pooling of specimens for RT-PCR testing, from asymptomatic persons or individuals from the same family or that were in close contact during travel, can be considered after thorough validation of the methodology by the testing laboratory [115,116]. In such settings with limited resources, pooling of specimens from asymptomatic persons can be a cost-effective solution for screening, especially in low prevalence situations. The original specimens must be stored until the result is available; if needed, positive pools may be re-tested to get individual results to initiate contact tracing and to ensure adequate clinical management. Pooling is not suggested for symptomatic patients or when the SARS-CoV-2 prevalence in the community is high.

Testing considerations in reception and detention centres

All migrants and refugees with symptoms compatible with COVID-19 arriving to reception centres, or symptomatic persons residing or working in detention centres, should be tested for SARS-CoV-2 according to the ECDC testing strategy [54]. Given the potential for large outbreaks in these settings and depending on the availability of resources, asymptomatic individuals may be tested when they are identified as close contacts of cases during contact tracing [75].

In cases with limited or no testing capacity and high prevalence of SARS-CoV-2 in the centres, it is important to have criteria for prioritisation and implementation of non-pharmaceutical measures to mitigate the spread of the virus in the setting. If there is limited laboratory capacity, laboratory tests should be performed on the following priority groups:

- Subsets of patients from the syndromic surveillance system (see above); at least the first symptomatic individuals in the setting, whether staff or residents, to quickly identify outbreaks and implement containment measures and contact tracing.

- Staff that go in and out of the centres should be tested if they are symptomatic and they should refrain from returning to their duties in the centre until the end-isolation criteria are fulfilled, according to the national guidelines (preferably eight days after symptom onset AND until clinical symptoms improve AND three days without fever) [10].
- In centres where migrants are not free to exit and enter, it is advised to regularly test staff that are identified as being at a higher risk of transmitting the disease when there is an ongoing outbreak in the centre or sustained community transmission (e.g. staff that go in and out of the centres). Depending on the available resources, countries can decide on the frequency of testing.
- In case of an ongoing outbreak in the centre, the symptomatic cases and their contacts, as well as asymptomatic individuals that are in high risk for developing severe disease (e.g. elderly persons or with other comorbidities) should be tested.
- For all symptomatic patients screened for tuberculosis, COVID-19 testing should be offered [11,12].

When testing capacities are very limited, following the confirmation of the first cases in the setting, a syndromic approach could be used, where the presence of symptoms compatible with COVID-19 guide the clinical management of possible or probable cases and IPC measure implementation. In this situation, presumed cases should be managed as COVID-19 cases in terms of IPC measure implementation [95].

Respiratory diagnostic specimens (nasopharyngeal swab, oropharyngeal (throat) swab, nasopharyngeal aspirate, or nasal wash) should be collected as soon as possible after symptom onset from all individuals with symptoms. Sample collection should ideally be performed by a healthcare worker on site or at a dedicated facility following the appropriate biosafety precautions [117]. For the specimen collection, the setting should ensure adequate specimen collection and packaging supplies, as well as PPE for the protection of the specimen collector [1]. Swabbing and/or transport of specimens and easy access to a testing facility/laboratory that performs validated molecular diagnostics should be proactively planned to ensure sufficient capacity and timeliness of results. In a situation where nasopharyngeal or other above mentioned specimen is not accepted, saliva could be considered as an alternative specimen, based on a recent meta-analysis [118]. Saliva is a non-invasive specimen type that can also be considered for self-sampling.

It is critical to use clinically well-validated diagnostic molecular detection assays. No rapid antigen tests have been clinically validated at the time of writing of this report; a list of assays and available clinical validation results are published via the European Commission, FIND and WHO. The testing that will determine the current infectious status of the individual, should be performed at a testing facility/laboratory that performs a validated molecular diagnostic test for COVID-19. Laboratory diagnostics should focus on SARS-CoV-2 and include influenza (including the determination of the viral type and subtype) when influenza is circulating.

If resources allow, serological specimen collection for antibody detection can be considered for later assessment of seropositivity in vulnerable populations. Environmental specimens, i.e. water, wastewater, air and surface sampling, could also be considered based on the host country or regional capacity.

Management of possible, probable or confirmed COVID-19 cases in reception and detention settings

Procedures and algorithms need to be planned and agreed upon in collaboration between the public health authorities of the hosting country, local health authorities and representatives from the migrant communities. The role of a camp coordinator or focal point with the public health services should be considered.

Multilingual specific signage (information/infographics) should be available for migrants about signs and symptoms of COVID-19 with instructions what to do in case they develop symptoms. Leaflets or SMS messages with this information could also be considered.

Clinical staff should evaluate individuals with COVID-19 compatible symptoms in a designated medical post to determine whether they should be tested or further action taken.

In geographic areas with community transmission or facilities with COVID-19 circulating, all patients presenting with symptoms of acute respiratory infection are considered as possible or probable cases and should be tested for COVID-19.

In areas without community transmission or if no cases have been diagnosed in the facility, persons fulfilling the criteria of the European case definition for surveillance and/or the relevant national case definition for COVID-19 should be tested [4].

Management of possible, probable or confirmed COVID-19 cases within the premises

Possible, probable or confirmed COVID-19 cases not necessitating hospitalisation should be isolated in the premises, or at least separated from other staff and migrants. They should wear a medical face mask and should be provided with instructions on how to safely put it on and discard it. If medical masks as not available, a face cover or tissue to cover their mouth should be provided, with instructions to practise appropriate hand hygiene. In detention centres, all COVID-19 cases (possible, probable or confirmed) should be moved to a single occupancy cell.

In case reception or detention centres are overwhelmed by the number of cases or single accommodation is not available, then 'cohorting' cases can be an alternative solution for mild cases with the appropriate observation.

If possible, dedicated toilet facilities should be made available for use by possible or probable cases as well as for confirmed cases and meals should be served separately.

Non-essential contacts between symptomatic cases and other persons should be prohibited or minimised as much as possible. A dedicated team of staff caring exclusively for possible, probable or confirmed cases can minimise transmission within the facility.

Clinical management of a possible, probable or confirmed case

The reception or detention centre coordinator should contact a designated contact point with the local or national public health service and arrange for diagnostic testing and, if appropriate following initial assessment, safe transfer to a designated acute care facility for further diagnostic evaluation and care.

For mild cases treated in settings of reception and detention, supportive care is needed (antipyretics/analgesics, hydration, O_2 monitoring).

Cases with mild symptomatology can end their isolation either in the camp premises or return to the community setting they were living, eight days after the onset of symptoms and after resolution of fever and clinical improvement of other symptoms for at least three days [10].

The access to specialist care and even to the ICU should be guaranteed for all refugees and irregular migrants.

Decontamination in premises where probable or confirmed cases of COVID-19 were accommodated

- In the event a possible, probable or confirmed case of COVID-19 has been present in a specific indoor space, the space should be well ventilated with fresh air for a minimum of one hour.
- After ventilation, the areas should be carefully cleaned with a neutral detergent, followed by decontamination of surfaces using a disinfectant effective against viruses. Several products with virucidal activity are licensed in the national markets and can be used following the manufacturer's instructions. Alternatively, 0.05-0.1% sodium hypochlorite (NaClO) (dilution 1:50, if household bleach is used, which is usually at an initial concentration of 2.5-5%) is suggested. For surfaces that can be damaged by sodium hypochlorite, products based on ethanol (at least 70%) can be used for decontamination after cleaning with a neutral detergent.
- Cleaning of toilets, bathroom sinks and sanitary facilities need to be carefully performed, avoiding splashes. Disinfection should follow normal cleaning using a disinfectant effective against viruses, or 0.1% sodium hypochlorite.
- All textiles (e.g. towels, bed linens, curtains, etc.) should be washed using a hot-water cycle (90°C) with regular laundry detergent. If a hot-water cycle cannot be used due to the characteristics of the material, bleach or other laundry products for decontamination of textiles need to be added to the wash cycle.
- The use of single-use disposable cleaning equipment (e.g. disposable towels) is recommended. If disposable cleaning equipment is not available, the cleaning material (cloth, sponge etc.) should be placed in a disinfectant solution effective against viruses, or 0.1% sodium hypochlorite. If neither solution is available, the material should be discarded and not reused.
- Cleaning staff responsible for this activity should wear personal protective equipment (PPE) as follows:
    - surgical mask
    - their work uniform and single-use plastic apron
    - gloves
- Hand hygiene should be performed each time after removing gloves or mask.
- Waste material produced during the cleaning should be placed in a separate bag, which can be disposed in the unsorted garbage [119].

Management of contacts

What is contact tracing?

Contact tracing is a public health measure, which aims to rapidly identify persons who have been in contact with a COVID-19 case, in order to reduce further onward transmission [13].

The purpose of identifying and managing the contacts of probable or confirmed COVID-19 cases is to rapidly identify secondary cases that may arise after transmission from the primary known cases in order to intervene and interrupt further onward transmission. This is achieved through:

- the prompt identification of contacts of a possible, probable or confirmed case of COVID-19;
- instructing contacts to self-quarantine, practice proper hand hygiene and respiratory etiquette measures, and advise what to do if they develop symptoms;
- timely laboratory testing for all those with symptoms.

Definition of a COVID-19 contact

Any person who has had contact with a laboratory-confirmed COVID-19 case within a timeframe ranging from 48 hours before the onset of symptoms of the case to 14 days after the onset of symptoms is defined as a COVID-19 contact. If the case had no symptoms, a contact person is defined as someone who has had contact with the case within a timeframe ranging from 48 hours before the sample, which led to confirmation was taken, to 14 days after the sample was taken.

The associated risk of infection depends on the level of exposure, which will, in turn, determine the type of management and monitoring:

Table 1. Classification of contact based on level of exposure

High-risk exposure (close contact)	Low-risk exposure
A person: • having had face-to-face contact with a COVID-19 case within two metres for more than 15 minutes; • having had physical contact with a COVID-19 case; • having unprotected direct contact with infectious secretions of a COVID-19 case (e.g. being coughed on); • who was in a closed environment (e.g. meeting room, prison cell, etc.) with a COVID-19 case for more than 15 minutes; • travelling in close proximity (within two metres) with a COVID-19 patient in any kind of conveyance. • A healthcare worker or other person providing care to a COVID-19 case, or laboratory workers handling specimens from a COVID-19 case, without recommended PPE or with a possible breach of PPE.	A person: • having had face-to-face contact with a COVID-19 case within two metres for less than 15 minutes; • who was in a closed environment with a COVID-19 case for less than 15 minutes; • A healthcare worker or other person providing care to a COVID-19 case, or laboratory workers handling specimens from a COVID-19 case, wearing the recommended PPE.

Source: ECDC: Contact tracing: Public health management of persons, including healthcare workers, having had contact with COVID-19 cases in the European Union - second update [13]

Contact identification and follow up in a migrant reception or detention centre

Contact tracing should begin immediately after a possible COVID-19 case has been identified in a migrant reception or detention centre, particularly if there were previous reports of confirmed cases or clusters of acute respiratory infection, to avoid any delays in reducing transmission through public health action. Contact tracing in a migrant reception or detention centre should be initiated by the healthcare staff servicing the centre with the assistance or guidance of the local public health authorities, according to national guidance. Quarantine of whole centres does not replace, and is not an appropriate alternative to, contact tracing.

The key steps for effective contact tracing in settings of migrant reception and detention include:

- Interviewing the case to collect information on clinical history and possible contacts that occurred from 48 hours before symptom onset until they were isolated. This should happen in a non-threatening way with the assistance of an interpreter and/or cultural mediator in order to obtain accurate information. It also needs to take into account the specific context of an asylum request and the possible trauma of the migrants.
- Identifying contacts and classifying them, where possible, into high-risk exposure ('close contact') or low-risk exposure, inside the reception or detention centre and in the community.
- Prompt quarantine of high-risk contacts.
- Arranging for testing of symptomatic contacts for SARS-CoV-2.
- According to the availability of resources, consider testing asymptomatic contacts for SARS-CoV-2.
- Providing information to contacts about infection control measures and symptom monitoring.

All high-risk exposure contacts in migrant reception and detention centres should be actively monitored by healthcare staff in the reception or detention centre and should be quarantined, ideally in an accommodation on their own, or cohorted with the other high-risk contacts. If symptoms of illness occur, contacts should be isolated, if not already, provided with medical attention and tested.

Low-risk contacts of COVID-19 cases can be advised to self-monitor for symptoms while observing physical distancing measures and strict hand hygiene and respiratory etiquette, with periodic checks from the healthcare staff of the camp.

Mental health considerations

Mental health and detention

There is ample evidence to indicate that asylum seekers and refugees experience high levels of mental health problems due to traumatic experiences encountered pre, during and after migration. Being placed in immigration detention centres or camps after arriving in a country is itself a recognised risk factor for inducing mental health problems for those already vulnerable, and it can also further exacerbate pre-existing mental health issues [120].

A systematic review of the impact of immigration detention on mental health across a wide range of settings and jurisdictions revealed that anxiety, depression and post-traumatic stress disorder were most commonly reported during and following detention. Detention duration was also positively associated with severity of mental health symptoms [120], while minors and people aged 18 to 24 have reported more adverse mental health impacts as a result of their detention than older detainees [121].

Other studies have shown prevalence rates for mental disorders in detainees to be much higher than those in the general population [122], with a study in Switzerland finding that 76% of detainees experienced some sort of mental health disorder, the most common being affective disorders (36%), anxiety disorders (34%) and post-traumatic stress disorder (23%) [122].

Another study, conducted in populations housed in immigration detention in the UK, found a 74% prevalence rate of any mental health, developmental or personality disorder within this population [123]. Specific groups of people face particular challenges, such as members of the LGBTQI community, who often arrive alone in the receiving country, and who therefore lack the support of family or friends in their country of origin. Many experience homo/transphobia within and outside of refugee populations in addition to the racism and xenophobia that they may face from people in the receiving country [124].

Additional mental health challenges in the context of COVID-19

There is a substantial risk that the already high levels of mental health issues experienced by migrants and refugees could be exacerbated by the COVID-19 pandemic. Adverse living conditions in some reception and detention centres might not allow migrants to self-isolate or follow preventive measures and hygiene recommendations, and this could lead to elevated fear of infection, distress and anger. Fear and anxiety among migrants could also be aggravated by rumours and misinformation about COVID-19, compounded by potential challenges in accessing updated and verified information in their own language [125]. Further, the suspension of asylum applications and programmes for resettlement, assisted voluntary returns and humanitarian returns, brought about by movement restrictions or camp closures, could worsen pre-existing stress, uncertainty and fear about the future among detainees [121,125,126].

Movement restrictions also have the potential to reduce access to mental health services and medication and thus negatively affect migrants with pre-existing mental health care needs [125-127]. In short, COVID-19 has the potential to make an already difficult mental health situation substantially more challenging for many migrants and refugees. Therefore, isolation and quarantine measures must be chosen only if deemed appropriate based on proven infections or presumed infections based on contact tracing. Indiscriminate movement restrictions of all camp residents regardless of contact with cases places an avoidable burden on residents.

Some suggested good practices aimed at promoting mental health

The UN has called for ensuring the availability and continuation of mental health and psychosocial services for refugees and for those displaced during the COVID-19 pandemic: 'These services must be considered 'essential' services and form part of national responses to COVID-19' [128]. The following principles and suggestions are given as a means towards this goal, specifically targeting migrants and refugees who are housed in reception and detention centres:

- Provision of and continued access to appropriate mental health services for asylum seekers and refugees, including regular migrants is essential[125]. This could include mental health screening, counselling and psychoeducation services carried out by mobile teams of trained MHPSS staff [129,130] or through remote PFA and virtual psychosocial support via mobile phones [125,131]. Special emphasis should be given to the needs of groups that may be considered vulnerable such as children, pregnant and lactating women, women and girls, older adults, people at risk of and exposed to gender-based violence, and people with disabilities [132].

- Training primary healthcare workers, camp management personnel, community outreach volunteers and telephone hotline staff in Psychological First Aid [133] to ensure mental health is part of a holistic approach to health - physical, social and psychological.
- Identification or establishment of appropriate and acceptable social and occupational activities within the migrant reception and detention centres that can be undertaken in person or virtually, such as religious rituals by radio, or social media; peer-to-peer support networks; and regular communication with family members and friends [125].
- Inclusive risk communication and information campaigns for COVID-19 to facilitate migrants' access to regular information updates and guidelines from trusted sources available in the appropriate languages. Information should include evidence-based practice for preventing transmission, how and where to seek healthcare support, as well as messages to promote psychosocial wellbeing [132].
- Engaging with community leaders who are already involved in COVID-19 prevention and response to raise awareness on mental health and on coping with distress [133].
- LGBTQI refugees should have continued access to health services such as hormone treatments and psychological support as well as social counselling [124].
- It is important for all people, regardless of whether they are in detention or not, to engage in regular physical activity [134]. This is important both for physical health and mental wellbeing, and provisions should be made in detention centres to facilitate these activities. Encouraging other self-care strategies, such as breathing exercises, relaxation exercises or other cultural practices is also key to maintaining mental wellbeing [132].

Risk communication and community engagement

Communicating about the risks and prevention of COVID-19 with refugees, asylum seekers and other migrants currently housed in reception and detention centres/camps requires health communication strategies that are adapted to meet the different language, cultural and literacy needs of the different populations.

Importance of community engagement and trusted sources

- Lessons learned from past outbreaks in these contexts highlight that community engagement is a key element in ensuring that public health strategies are effective, including the rapid uptake of vaccinations once available [135].
- It is important to engage with local influencers in the site community [74] and with partners and organisations that are familiar with the different cultures and norms of those populations in order for them to assist with facilitating with communication [136].
- Lessons learned from 2003 severe acute respiratory syndrome (SARS) epidemic show communication and trust are important for displaced populations [137], thus involving community leaders within the centres in adapting and sharing different health messages will help to increase trust in the messaging within the different populations [136]. It will also help to ensure better understanding of how to protect themselves, feeling safe to communicate when they have symptoms and to come forward for testing. It is important to be inclusive of gender-sensitive profiles and persons with disabilities[138].
- In settings where different services are being reduced due to the risk of bringing in the virus, some NGOs are involving communities, such as leaders of youth and women's groups, teachers and religious leaders, to explain facts about the virus to residents instead of having aid workers do it directly [139].

Language, culturally appropriate communication and preferred channels

- Reliable, up-to-date, accurate information and health messages about COVID-19 prevention and control should be adapted and translated into a wide range of different relevant languages in order for messages to be understood. The pre-testing of messages is also important to ensure they are culturally appropriate [52]. For example, several organisations have translated messages based on relevant country government guidelines on COVID-19 [140] or translated general information about COVID-19 [141,142].
- In order to take into account levels of literacy, a wide range of different formats such as photos or infographics [143] and other forms of visual communication should be used if available.
- Using a diverse range of channels for providing information about COVID-19 may be more effective for better understanding and comprehension. Channels such as radio, SMS, audio recordings, and videos can complement written information in communities where literacy levels are low and written communication less effective [144].
- For areas with limited connectivity, information can be provided via centralised distribution points such as: SMS or micro-SD cards which migrants can insert into mobile phones for offline viewing [144]. WHO has provided an SMS message library on COVID-19 general information to be adapted and translated into different languages [145].
- Other practical examples of multiple channels of information are establishing multilingual Covid-19 hotlines [98] and using loudspeakers to provide health messages in migrant camp settings [146].

Actionable messaging

- The context of overcrowding and a lack of facilities for hand washing in reception and detention centres can make it challenging to implement physical distancing and hygiene measures. This presents challenges for providing appropriate and practical messaging about prevention of infection with COVID-19, as per the warnings of MSF in reference to Greek camps: '*Cramped conditions make infection prevention impossible*' [147].
- There should be clear messaging that focuses on what people can practically do to reduce the risk, and what actions to take if they think they have COVID-19.
- Working with community leaders to promote contextually appropriate behaviour, change strategies such as nudges and design of handwashing facilities to encourage hand hygiene behaviour is one strategy being used. Other strategies include easily accessible location of the facilities, signposting, doable instructions, linking handwashing with social norms [148].

Assessing risk perception, knowledge, attitudes and practices

- An international meeting on risk communication addressing migrant populations [149] highlighted methods to be applied where possible, in order to gather knowledge about culture, health information seeking behaviour, trusted sources and levels of health literacy:
  - Using formative research (focus groups, intercept interviews, Knowledge, Attitude and Practices studies) to understand risky behaviours, health beliefs and barriers to prevention.
  - Sources of information can also include news reports, social media postings, websites of civil society organisations and community groups, government statistics and reports, academic papers and reports from Think Tanks.
  - Mapping exercises allow better understanding of leaders, influencers and networks within a community.
- An example of a practical tool for organising focus groups with community volunteers is available from the International Federation of Red Cross and Red Crescent Societies (IFRC) (also available in other languages) [150]. It provides an understanding of questions, rumours, suggestions and concerns in the community in the context of the pandemic.

Addressing rumours and fears

- Fears, rumours and misperceptions circulating in the migrant community need to be explored and addressed, as these can affect preventative behaviour and impede people from seeking medical care, both for possible and probable Covid-19 infection but also for routine healthcare services.
- An example of how rumours circulating in a refugee camp can be documented and how these inform proposals for culturally appropriate communication is provided by BBC Media Action and Translators without Borders. It is based on interviews with Rohingya refugees and NGO volunteers in the Cox's Bazar camp in Bangladesh [151].

Addressing stigma and discrimination

- Misconceptions in host communities need to be addressed to avoid stigma and discrimination. As documented by the Mig-HealthCare project [152], a common misconception regarding migrants is that they carry infectious diseases. However, it is estimated that there is a very low risk of transmitting communicable diseases from the refugee and migrant population to the host population in the WHO European Region. A number of factors make migrants vulnerable to infectious diseases, for example if living conditions are poor in the destination country [153].
- The risk communication approach to such misconceptions should thus focus on acknowledging the concerns and responding with facts [149].
- Media can play an important role in relaying factual information to host populations, with adherence to the core principles of ethical journalism that avoida stigmatisation, stereotyping, as well as ethnic or religious finger-pointing [154].
- More information on approaches to prevent and address the social stigma associated with COVID-19 that some people experience is available from the International Federation of Red Cross, the United Nations Children's Fund (UNICEF) and WHO [155].
- Storytelling could be considered as one of the approaches to provide insights and understanding about the life of refugees and inform about measures in place to prevent spread of the disease. For example, UNICEF has published such stories, with photo-essays and videos [156].

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