

TECHNICAL REPORT

Guidance for the prevention and control of COVID-19 in temporary reception centres in the context of the large numbers of people fleeing Ukraine

18 March 2022

Key messages

- This report focuses on COVID-19 vulnerabilities and the need for infection prevention and control in temporary reception centres, in the context of the large numbers of people currently fleeing Ukraine. It is important to note, however, that these are just few of the risks to the health and well-being of the displaced people, and the measures described should be part of more generalised public health approach in support of those fleeing Ukraine.
- Reception centres for displaced people are known to represent a greater risk for COVID-19 and other infectious disease outbreaks. Factors that contribute to increased risk of COVID-19 outbreaks include low vaccination coverage, limited access to healthcare, including testing, and overcrowding.
- Vaccination for COVID-19 remains the most essential intervention. In the absence of documented evidence of prior vaccination, eligible children and adults should be offered a primary vaccination course against COVID-19, as well as a booster dose. However, the elderly, pregnant women, those who are immunocompromised and individuals with underlying conditions at greater risk of severe disease should be prioritised.
- Strategies and service delivery models to ensure access to vaccination for individuals at reception centres may be adapted based on local capacity and infrastructure. Community engagement and community-based approaches to improve trust, counter misinformation and strengthen uptake should be considered. Health communication strategies that are adapted in accordance with language, cultural and health literacy needs will lead to greater uptake of vaccination.
- A physical or digital record of vaccination should be provided, including proof of vaccination for those who are immunised for future reference, which is particularly important for those in transit to another country.
- Where possible, implementation of distancing and infection prevention and control measures in confined places should follow general distancing recommendations to prevent SARS-CoV-2 spread.
- To improve understanding and compliance with infection prevention and control measures and to promote vaccination, multilingual signage (information/infographics with pictograms) could be made available in reception centres.
- To reduce the risk of introducing COVID-19 cases into reception centres, testing of all displaced persons on arrival should be considered. If feasible, separate spaces should be provided for positive cases. If testing capacities are limited, priority should be given to the testing of those displaying symptoms compatible with COVID-19. If no SARS-CoV-2 testing capability exists, those exhibiting COVID-19-compatible symptoms should be triaged and managed as possible cases, with appropriate supportive care.
- Procedures for the management of confirmed COVID-19 cases should be planned and collectively agreed upon by the public health authorities of the host country, local health authorities and representatives from the communities.
- Efforts should be made to provide displaced people with psychological first aid, with a special focus on children. Addressing these underlying needs will improve the success of COVID-19 prevention and control efforts.

Scope and audience

This document offers public health guidance for the prevention and control of COVID-19 in reception centres, and other temporary accommodation facilities, in the context of the mass influx of Ukrainian people into the European Union (EU), the European Economic Area (EEA) and the Republic of Moldova.

The target audience for this technical report includes national policymakers, public health and healthcare planners and staff working in reception centres.

This technical report is an adaptation of [ECDC's guidance on infection prevention and control of COVID-19 in migrant and refugee reception and detention centres](#) published in 2020 [1].

Given the mass influx of displaced people from Ukraine, ECDC recognises that resources and capacities in reception centres may be limited and subject to change at short notice and therefore, the recommendations should be adapted, as appropriate.

Background

Since the onset of Russia's aggression towards Ukraine on 24 February 2022, and as of 16 March 2022, more than 3.1 million Ukrainians have fled to Poland, Hungary, Slovakia, Romania and the Republic of Moldova, and from there a proportion of these people are dispersing into other EU/EEA countries¹. UNHCR projects that upwards of four million people may flee Ukraine in the coming months.

According to information received by ECDC from the countries bordering Ukraine, the majority of those arriving are being dispersed into the community or are in transit to other EU countries. However, an increasing number of displaced people arriving in EU/EEA countries are being hosted in reception centres, where there is a greater risk of communicable disease outbreaks [1,2].

The European Commission (EC) has provided operational guidelines² to facilitate border crossings at the external borders to Ukraine [3] and the European Council has adopted a Temporary Protection Directive for Ukrainians fleeing to neighbouring EU Member States [4]. The Temporary Protection Directive offers an appropriate response to the present situation by providing immediate protection and rights, including residency rights, access to the labour market, access to housing, social welfare assistance, medical or other assistance and means of subsistence.

Since the start of the COVID-19 pandemic and as of 16 March 2022, a total of 4 917 757 confirmed SARS-CoV-2 infections and 107 340 COVID-19 deaths have been recorded in Ukraine [5]. Data as of 23 February 2022 show that uptake of a primary COVID-19 vaccination series in the total Ukrainian population (35.0%) [6] is substantially lower than the EU/EEA average (71.7% as of 1 March 2022) [7]. Vaccine uptake is uniformly low across adult age groups, including those aged over 60 years, who are at greatest risk of severe disease [8]. According to the World Health Organization (WHO), there is a high risk of excess mortality and morbidity due to COVID-19 [9]. Additional background information on COVID-19 can be found on the websites of [ECDC](#) and [WHO](#).

Preparedness in reception centres

Like all congregate settings, reception centres for refugees and other displaced populations have been known to be at greater risk of disease outbreaks, including COVID-19. Factors that have contributed to increased risk of COVID-19 outbreaks include low vaccination coverage, limited access to healthcare including testing and overcrowding.

To prevent and control the transmission of communicable disease in reception centres, it is important that the centres assess their needs for communicable disease control, particularly in the specific context of a mass influx of displaced people from Ukraine. In addition to the current guidance document, ECDC's preparedness checklist tool against communicable disease outbreaks at migrant reception centres³ is available to public health authorities to help secure optimal prevention and control measures in these settings.

The checklist tool is designed to achieve three key objectives: outbreak prevention, outbreak control, and coping with sudden influxes of refugees. The tool addresses seven key dimensions that are important for the control of communicable diseases, including COVID-19, in reception centres. These are human resources, medicines and vaccines, physical infrastructure, sanitation and hygiene, health financing, coordination and health information.

¹ Data from UNHCR. Available at: <https://data2.unhcr.org/en/situations/ukraine>

² EU Commission Operational guidelines for external border management to facilitate border crossings at the EU-Ukraine borders 2022/C 104 I/01. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=OJ%3AJOC_2022_104_I_0001&qid=1646422292305

³ ECDC's preparedness checklist tool is available at: www.ecdc.europa.eu/en/publications-data/ecdc-preparedness-checklist-tool

The Inter-Agency Standing Committee (IASC) has produced interim guidance on scaling up COVID-19 outbreak readiness and response operations in humanitarian settings⁴ [10]. 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. WHO has also produced guidance for prevention and control of COVID-19 for refugees and migrants in non-camp settings⁵ [6]. This document addresses similar issues and also provides input on point-of-entry screening and occupational health and safety measures.

Considerations for the prevention and control of COVID-19

Vaccination

Vaccination for COVID-19 remains the most essential intervention to prevent harmful sequelae of infection, such as hospitalisation and death. Ensuring continuity of routine vaccinations and addressing gaps in prior vaccination histories is an essential element of the public health support for displaced people [12]. It is therefore critical to ensure that displaced people from Ukraine are integrated into any mass vaccination or routine immunisation activities against vaccine-preventable diseases being carried out in the host countries. Those staying in reception centres should be included in priority groups for COVID-19 vaccination.

- COVID-19 vaccination should be offered to all eligible children and adults according to COVID-19 vaccination guidelines in the host countries, although the elderly, pregnant women, those who are immunocompromised and individuals with underlying conditions at greater risk of severe disease should be prioritised [13].
- Vaccination status for displaced people should be assessed using available documentation, physical or electronic. In the absence of documented evidence of prior vaccination, eligible individuals should be offered a primary vaccination course against COVID-19 and a booster dose.
- Strategies and service delivery models to ensure access to COVID-19 vaccination for individuals at reception centres and other temporary accommodation facilities can be adapted to suit local capacity and infrastructure (e.g. if feasible, on-site vaccination services to maximise uptake, or linkage to mainstream vaccination centres, community-based services or mobile units).
- Community engagement and community-based approaches should be considered to improve trust, counter misinformation and strengthen vaccination uptake.
- User-friendly information materials in Ukrainian should be available, addressing the benefits of COVID-19 vaccination, access to vaccination services, recommended vaccines in the EU, concerns related to vaccination, adverse reactions and actions to take in case of serious adverse events following immunisation.
- A physical or digital record of vaccination should be provided, including proof of vaccination for those who are immunised for future reference, which is particularly important for those in transit to another country.
- While facilitating access to COVID-19 vaccination, [other priority vaccinations could be delivered to eligible children and adults](#) [14].
- Frontline workers (healthcare workers, volunteers, etc.) in reception centres should receive a complete primary course of COVID-19 vaccination and a booster dose.

Infection prevention and control

Displaced people often live in confined and overcrowded spaces. Due to the limited space in reception centres, physical distancing is particularly difficult. Nevertheless, where possible, distancing measures should be implemented in accordance with general distancing recommendations to prevent spread, while balancing the need to take account of mental health and psychosocial factors.

In addition to physical distancing there are other infection prevention and control (IPC) measures that can be considered at reception sites:

- **Hand hygiene and sanitation:** displaced people in reception sites often reside in environments where hygiene and sanitation are compromised. Depending on the resources available, accessibility to clean water, soap, and sanitiser should be ensured and proper hand hygiene encouraged.
- **Respiratory etiquette:** nose and mouth should be covered with paper tissue when sneezing or coughing. Clean paper tissues should be available at reception sites. Paper tissues should be disposed of immediately

⁴ IASC interim guidance available at: <https://interagencystandingcommittee.org/system/files/2021-05/IASC%20Interim%20Guidance%20on%20Scaling-up%20COVID-19%20Outbreak%20Readiness%20and%20Response%20Operations%20in%20Camps%20and%20Camp-like%20Settings.pdf>

⁵ WHO guidance available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/humanitarian-operations-camps-and-other-fragile-settings>

after use, ideally in bins with covers, and hands should be washed/cleaned. If paper tissues are not available, coughing or sneezing into the elbow is recommended.

- **Face masks:** when proper physical distancing cannot be maintained, the use of medical and non-medical face masks by guests and staff should be considered at reception sites as a means of reducing the spread of infection by minimising the excretion of respiratory droplets from infected individuals. A regular supply of masks should be provided for this purpose. Appropriate use of face masks (wearing, removing and disposal) is important.
- **Ventilation:** poor ventilation of indoor spaces is related to an increase in the transmission of respiratory infections. Natural or mechanical ventilation could be used to increase the number of air exchanges per hour and to supply as much outdoor air as possible to decrease any potential risk of aerosol transmission.

Additional information on the measures above can be found in ECDC's guidance on infection prevention and control of COVID-19 in migrant and refugee reception and detention centres [1].

To improve understanding and compliance with infection prevention and control measures, multilingual signage (information/infographics with pictograms) that promote the importance of hand hygiene and explain the appropriate procedure for hand washing, respiratory etiquette and proper use and handling of facemasks should be available in different areas of reception centres.

Cleaning and disinfection in the context of COVID-19

- In the event of a confirmed case of COVID-19 having been present in a specific indoor space, the space should be well ventilated with fresh air and carefully cleaned with a neutral detergent, followed by decontamination of surfaces using a disinfectant effective against viruses (e.g. 0.05–0.1% sodium hypochlorite (NaClO) or ethanol (at least 70%)).
- 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, tabletops, light switches, etc.
- The use of a neutral detergent should be sufficient for the cleaning of surfaces in general premises.
- Shared toilets, bathroom sinks and sanitary facilities should be cleaned carefully. 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 (e.g. gloves) is removed.
- Waste material produced during cleaning should be placed in the unsorted rubbish.
- Similar instructions should be given to displaced people with regard to the cleaning of their accommodation (e.g. trailers).
- All textiles (e.g. towels, bed linens, curtains, etc.) should be washed using a hot-water cycle 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.

Considerations for SARS-CoV-2 testing

Prioritised testing in resource-constrained settings

To reduce the risk of introducing asymptomatic, pre-symptomatic or symptomatic COVID-19 cases into the receiving country or reception centres, testing of all displaced persons should be considered on arrival at a reception centre, or all residents in the event of an outbreak being detected at a centre.

If testing capacities are limited, priority should be given to displaced persons with COVID-19-compatible symptoms arriving or residing at reception centres, or symptomatic individuals working there. The focus should be on:

- symptomatic individuals detected through syndromic surveillance (staff or residents);
- symptomatic individuals screened for tuberculosis or belonging to risk groups for severe COVID-19 outcomes (the elderly or those with chronic conditions).

In critical situations where no SARS-CoV-2 testing capability exists, those exhibiting COVID-19-compatible symptoms should be triaged and managed as possible cases, with appropriate supportive care, relevant advice for isolation and the implementation of non-pharmaceutical measures.

Testing for SARS-CoV-2

Although laboratory-based nucleic acid amplification techniques (NAAT) - e.g. rRT-PCR - remain the diagnostic reference standard, rapid antigen diagnostic tests (RADTs) are less resource-intensive, provide immediately actionable results and can be deployed easily in decentralised settings.

- In reception centres, for symptomatic individuals countries should consider using RADTs which are readily available in national programmes and meet the minimum performance requirements of $\geq 80\%$ sensitivity and $\geq 97\%$ specificity compared to NAAT [15]. RADTs that are clinically validated to detect Omicron or those targeting the less divergent nucleoprotein (rather than spike protein alone) should be prioritised for use. An EU common list of RADT assays is regularly updated by the European Commission [16].
- For optimal performance of RADTs, swabbing should be performed by a trained healthcare worker as per the manufacturer's guidelines and in alignment with locally established protocols [17]. However, if there is limited availability of healthcare staff, COVID-19 self-testing should be offered [18]. Where self-testing is offered, clear instructions should be provided on how to report and respond to a positive test — see 'Management of COVID-19 cases'.
- Pooling of specimens for RT-PCR testing from asymptomatic persons or individuals from the same family, or from those who were in close contact during travel, can be considered as a cost-effective solution for screening, especially in low prevalence settings [116]. However, pooling requires additional logistics (e.g. storage of samples until the results are available for re-testing of positive pools) and is generally not recommended for symptomatic patients or when SARS-CoV-2 prevalence in the community is high.

Management of COVID-19 cases and contacts

Procedures and algorithms need to be planned and agreed upon collectively by the public health authorities of the host country, local health authorities and representatives from the communities. The role of a reception centre coordinator should be considered. This person would be responsible for liaising with a designated contact point in the local or national public health service and arranging for diagnostic testing and, if appropriate following initial assessment, safe transfer to a designated acute care facility for further diagnostic evaluation and care.

Multilingual specific signage (information/infographics) should be available on COVID-19, with instructions on what to do in the event of symptoms. Leaflets or SMS messages with this information could also be considered.

Management of COVID-19 cases

Additional information for the management of COVID-19 cases at reception centres can be found in the ECDC guidance on COVID-19 in migrant and refugee reception centres [1].

Guidance on ending isolation in COVID-19 cases can be found in the latest [ECDC document](#) [21].

- All guests presenting with symptoms of acute respiratory infection (ARI) should be tested for COVID-19.
- If testing capacities are limited, individuals presenting with COVID-19-like symptoms should be considered probable cases.
- COVID-19 cases or suspected cases not requiring hospitalisation should be isolated on the premises, or at least separated from other staff and guests and they should wear a medical face mask.
- If possible, dedicated toilet facilities should be made available and meals should be served separately.
- Non-essential contacts between COVID-19 cases and others should be prohibited. A dedicated team of staff caring exclusively for COVID-19 cases can minimise transmission within the facility.
- Access to specialist care and hospital intensive care units should be guaranteed for everyone.

Management of contacts

Contact tracing is a public health measure, which aims to rapidly identify persons who have been in contact with a COVID-19 case to reduce further onward transmission. Information on contact tracing, definition of a COVID-19 contact, and management of contacts can be found in ECDC's latest [contact tracing guidance](#) [22]. Additional information for contact tracing under circumstances where there is extreme pressure on healthcare systems and society can be found on ECDC's dedicated webpage on [contact tracing](#) [23].

Contact identification and follow up

In the current crisis, contact tracing may not be feasible and focus should instead be placed on infection prevention and control measures, as listed in the section above. Contact tracing should be initiated by the healthcare staff servicing the reception centre, with the assistance or guidance of the local public health authorities, in accordance with national guidelines. The quarantining of an entire reception centre does not replace, and is not an appropriate alternative to, contact tracing.

Where resources are limited, some of the contact tracing elements to consider include:

- identifying and isolating COVID-19 cases and close contacts/family members (e.g. those equivalent to household members);
- length of quarantine/isolation, testing is dependent on resources and protocols/guidance in the host country.

Where resources allow, the key steps for effective contact tracing in reception centre settings are set out below.

- After a possible COVID-19 case has been identified in a reception centre, consider interviewing the case to collect information on clinical history, vaccination status and possible contacts that occurred from 48 hours before symptom onset (or 48 hours before the positive test result if asymptomatic).
- Contacts should be identified by vaccination status, where possible classifying them as high-risk exposure ('close contact') or low-risk exposure contacts, and managing them in accordance with the latest [contact tracing guidance](#) [22]. Additional information can be found on ECDC's dedicated [contact tracing webpage](#) [23].
- If symptoms of illness occur, contacts should be provided with medical attention and tested.
- The testing of asymptomatic contacts for SARS-CoV-2 should also be considered.
- If available, the installation and use of mobile contact tracing apps by the people living and working at the reception centre can be encouraged as an adjunct to manual contact tracing.

Communication is essential to promoting cooperation with the contact tracing team and honest, non-threatening and transparent communication, ideally with the assistance of an interpreter and/or cultural mediator, will increase the likelihood of obtaining accurate information.

Mental health considerations

There is ample evidence suggesting that displaced people experience high levels of mental illness due to the traumatic experiences encountered before, during and after displacement [24]. Adverse living conditions at some reception centres may inhibit people's ability to self-isolate or follow the preventive measures and hygiene recommendations that they have become used to. The situation may be further aggravated by rumours and misinformation about COVID-19, compounded by potential challenges in accessing updated and verified information in the Ukrainian language.

The following suggestions are given as a basis for ensuring the provision of mental health and psychosocial services for people displaced from their homes in Ukraine, and who have since been housed in reception centres in the EU:

- Efforts should be made to provide displaced people with psychological first aid (PFA), either on-site at reception centres by teams of trained mental health and psychosocial service staff [25], or through remote PFA (tele-counselling) via mobile phones [26].
- Special emphasis should be given to the mental health and psychosocial needs of children.
- Access to PFA should be advertised in Ukrainian at reception centres.
- Given the large number of displaced people who have been fleeing Ukraine and the limited numbers of trained mental health and psychosocial service staff at reception centres, it could be beneficial to provide PFA training to primary healthcare workers, centre management personnel, and community outreach volunteers so that they too can provide PFA when necessary [27].
- Ukrainian civil society actors may wish to consider setting-up PFA hotlines.
- Peer-to-peer support networks should be facilitated at reception centres, as should regular online communication with family members and friends in other places.
- Efforts should be made to ensure that people who have chronic mental health problems continue to receive their medications and other necessary support.
- Provision should be made for residents of reception centres to engage in physical activity, both for their physical health and mental wellbeing.

Risk communication and community engagement

Risk communication initiatives should facilitate the access of the displaced population to information from trusted sources on the risks and prevention of COVID-19, as well as local recommendations, adapted to meet their language and health literacy needs. Key considerations are set out below.

- **Actionable messages with a focus on:**
 - Information regarding the benefits of COVID-19 vaccination, how to access vaccination services and recommended vaccines in the EU. This should also include information on adverse reactions and actions to take in case of serious adverse events following immunisation.
 - Evidence-based practice to prevent transmission, how to seek healthcare support, and messages to promote psychosocial well-being [28].
 - What people can do to reduce the risk of disease spread (how to perform appropriate handwashing, respiratory etiquette, proper use and handling of facemasks), as well as actions to take if they think they have COVID-19. Messaging should take into consideration the challenges people may be facing, for example for physical distancing.
 - Address questions and concerns related to measures and requirements that may be different in the host country, for example in relation to vaccination, mask-wearing, isolation.
 - Messaging should also address the staff and volunteers working in the reception centres, to raise awareness of preventive measures in place and the importance of being fully vaccinated.
- **Community engagement:** engage with community representatives and organisations familiar with Ukrainian culture and norms to assist with facilitating communication [29]. Where available, working with local organisations and volunteers, for example Ukrainians already established in the host country and NGOs working with displaced populations, can help to increase trust in the messaging and ensure better understanding of how the displaced populations can protect themselves. This will also help them to feel safer about communicating or coming forward for testing if they have symptoms.
- **Information on trusted sources:** signpost available trusted sources with health messages on COVID-19 and prevention (e.g. from public health organisations [30,31] and sources that provide information on local recommendations and requirements). Where available, this could include official websites translated into Ukrainian and social media accounts. Some organisations have translated messages about COVID-19 and vaccination into Ukrainian [32,33].
- **Materials adapted to health literacy:** in order to take into account levels of health literacy, a wide range of different formats should be used, if available – e.g. photos or infographics [34] and other forms of visual communication.
- **Address rumours and fear:** fears, rumours and misperceptions circulating in the displaced community need to be explored and addressed.
- **Address stigma and discrimination:** any misconceptions in host communities relating to displaced populations carrying infectious diseases need to be addressed to avoid stigma and discrimination. Media can play an important role in relaying factual information to host populations [35].
- **Assessing risk perceptions, knowledge, attitudes and practices:** if resources allow and where feasible, knowledge could be gathered on culture, health-information-seeking behaviour, trusted sources and levels of health literacy which could be applied to adapt communication appropriately [36].

Consulted experts (in alphabetical order)

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