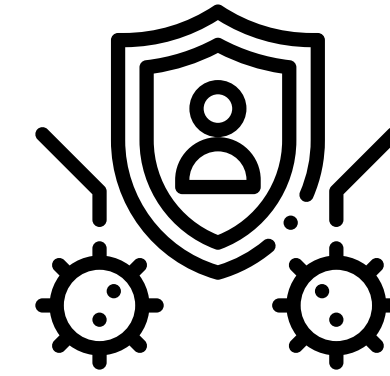


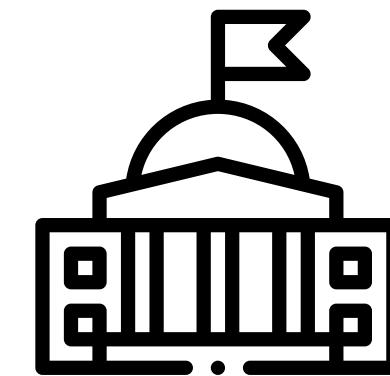
## **ADOPTING A SHIELDING APPROACH**

Shielding can be an effective containment measure. However, communities and individuals must understand and plan for potential adverse effects on the shielded, including on their psychosocial wellbeing, income generation, food access, and health service access.



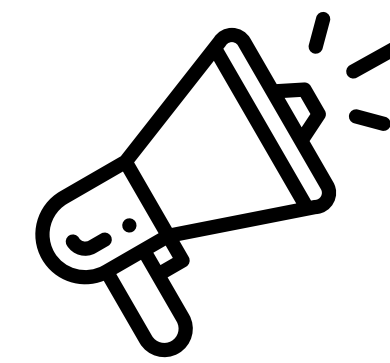
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To protect individuals at high risk of severe COVID-19, separating and 'shielding' them from the general population is just one approach.



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Shielding should be co-designed and co-managed with the community and other key sectors (government, civil society, NGO, humanitarian).



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The public health sector should start comprehensive communication early on, and it should include definitions of shielding and issues of risk and infection prevention.



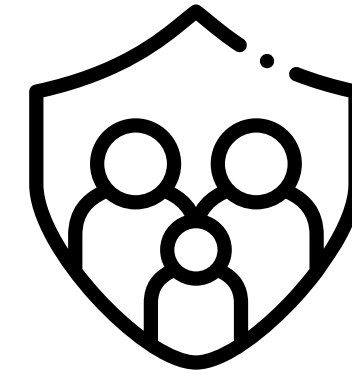
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Shielding must be voluntary and accompanied by social, medical, and other practical support for the shielded individuals so that their health and wellbeing are not negatively affected.

## COVID-19: SHIELDING VULNERABLE GROUPS

# SHIELDING IN LOW AND MIDDLE-INCOME COUNTRIES

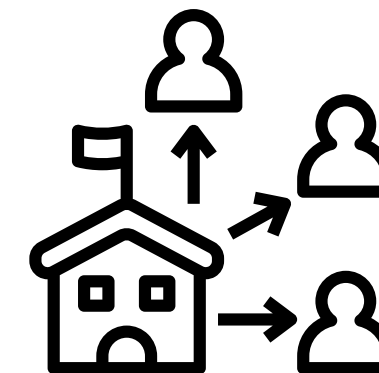
Most shielding has occurred in high-income countries (such as the UK). There are significant obstacles to shielding in low and middle-income countries, where resources, support, or space may be lacking. Early lessons have been learned from acceptability studies in Sudan, DRC, and Syria, and from implementation in Yemen.



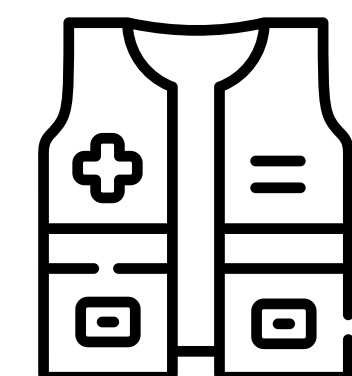
Evidence from low and middle-income countries shows shielding within the household was most acceptable in Sudan but was not feasible due to lack of physical space or economic constraints. An alternative might be to shield with extended family.



Appropriate risk communication messaging has been used to improve public understanding of COVID-19 risk and specific risks for the clinically vulnerable in the DRC.



Efforts to implement shielding among internally-displaced populations should be designed with sensitivity to the experiences and added impact of isolation to this group – as evident in North-West Syria.



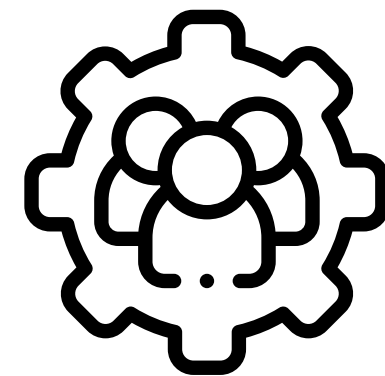
Shielding implementation in Yemen confirmed that community consultation was effective to manage, plan, and implement shielding, alongside trusted humanitarian staff.

# PRACTICAL CONSIDERATIONS OF SHIELDING



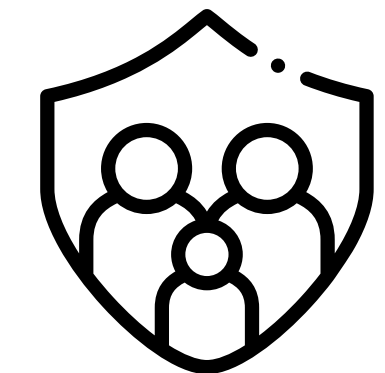
For vulnerable people to shield, they must trust and understand the public health response and the measures that are expected of them. Implementation should be led by trusted local partners.

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Approaches should be driven by and co-designed with communities rather than imposed on them. Any approach should avoid a simplistic framing of “community” and recognise possible tensions within a community or household.

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Shielding design can draw on existing local concepts of protection. In low- and middle-income countries that have considered shielding, support for the vulnerable remains primarily a family and household responsibility.

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The potential psychosocial impact of shielding should be considered from the early stages in order to identify the barriers to access, risks, and specific needs of shielding individuals and their families.