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# Considerations for COVID-19 management in reception centers for refugees, asylum seekers, and migrants, Spain 2020 <sup>☆,☆☆</sup>

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## ABSTRACT

Shortly after the declaration of the COVID-19 pandemic, governments around the world were urged to leave no population behind. Following a COVID-19 risk evaluation in a refugee and asylum seekers reception center, in September 2020, we considered the priorities of managing COVID-19 in these settings. We encourage actions on the following four fronts to reduce the COVID-19-associated burden among these vulnerable populations based on our interviews, observations, and recommendations: (i) decongestion, (ii) facilitated testing, (iii) screening for symptoms, and (iv) targeted public health and risk communication.

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## Introduction

Shortly after the declaration of the COVID-19 pandemic in March 2020, several agencies and institutions called for the inclusion of migrants and refugees in the COVID-19 responses and urged governments to leave no one behind ([Lancet Migration, 2020](#)). Early in 2020, Europe experienced a further influx of irregular migrants, and reception facilities, many of which were at high or full capacity before the pandemic ([EASO, 2020](#)), encountered barriers in responding to their residents' needs. The implementation of pre-

vention and control measures such as hand washing, physical distancing, self-isolation, and quarantine in these settings was hindered by the suboptimal hygiene conditions and overcrowded living arrangements, which increased susceptibility to respiratory and other infections. Furthermore, with supporting hospitals and diagnostic laboratories operating at or beyond full capacity, access to testing and case management of refugees, asylum seekers, and migrants in reception centers became more challenging. Following a risk evaluation performed by the authors in response to a COVID-19 outbreak in a reception center for refugees, asylum seekers, and migrants in September 2020, we here considered the priorities in managing COVID-19 in these settings.

## Setting and population

Half of the residents of the center investigated lived in temporary facilities that were established in response to the 2015 migration crisis. Over the five-day deployment, we interviewed health care workers, management, teachers, and social workers at the center in addition to residents from different countries and

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age groups. Interviews were conducted in the residents' language alongside a social worker or interpreter. The interviewees were selected with the help of the center's social workers and included individuals that had overcome the SARS-CoV-2 infection in the center, contacts of confirmed cases, and other residents. The residents were predominantly male, with over 70% aged between 18 years and 34 years. In the absence of comorbidities, a population of this age distribution is unlikely to experience severe symptoms resulting from COVID-19, and based on our observations, adherence with implemented control measures was limited among the residents. Note that at the time of this risk assessment, COVID-19 vaccines were not yet available and therefore did not factor into our recommendations.

## Recommendations

We considered actions on the following four fronts to reduce the COVID-19-associated burden among these vulnerable populations based on our interviews, observations, and recommendations: (i) decongestion, (ii) facilitated testing, (iii) screening for symptoms, and (iv) targeted public health and risk communication.

### Decongestion

The European Centre for Disease Prevention and Control (ECDC) recommends that when physical distancing and risk-containment measures cannot be implemented in reception centers, measures to decongest and evacuate residents should be considered (ECDC, 2020). Lopez et al. commented on the low effectiveness of wearing personal protective equipment (PPE) in overcrowded settings and suggested prioritizing hazard "elimination" by releasing people from detention centers in the USA (Lopez et al., 2021). In the case of reception centers, decongestion by evacuation is challenging in terms of legal, administrative, and logistical aspects. Despite these barriers, this solution will not only be an important step in protecting public health, but it will also protect the rights of refugees, asylum seekers, and migrants (Brandenberger et al., 2020). In many situations, reception centers have required the support of additional facilities to manage their COVID-19 cases. Our recommendation was to initiate decongestion by moving residents with a negative COVID-19 RT-PCR result or those known to have recently overcome COVID-19 to these temporary support facilities rather than active cases. This would make it possible to subsequently repatriate (depending on context) or relocate the residents that have been granted asylum to less congested facilities after a pre-determined quarantine time and a second negative test (based on the regional COVID-19 protocols). This would establish a pipeline to facilitate further rounds of decongestion because these centers would be liberated and remain COVID-19 free. In addition, the logistical requirements of a support center designed for residents that have tested negative for an active infection of SARS-CoV-2 or positive for past infections would be significantly reduced compared with a site managing active cases.

This form of controlled decongestion would significantly facilitate the implementation of prevention and control measures to protect those remaining in the main site. Such measures include outbreak investigations, early detection as well as the isolation and management of cases and of contacts. Any active cases and their contacts could then be managed in designated areas of the reception centers by the attending health care and support personnel who are already familiar with the residents and able to achieve a higher compliance. Ultimately, this form of decongestion does not only improve the effectiveness of other COVID-19 risk mitigating strategies, but it also significantly improves the living and hygiene conditions at the center.

### Facilitated testing

At the beginning of the pandemic, the WHO discouraged unfounded testing among refugees and migrants (WHO, 2020). More than a year into this pandemic, testing practices have changed, and the ECDC has recommended prioritizing testing in reception centers because the risk of transmission is higher (ECDC, 2020). With increased testing capacity, new point-of-care tests, and the improved knowledge of transmission, we have seen testing strategies effectively implemented to mitigate ongoing outbreaks in other settings (Hagan et al., 2020). The estimated seroprevalence and incidence should be taken into consideration when evaluating which testing strategy to pursue. In scenarios with low incidence or no epidemiologic links, RT-PCRs are the preferred method of screening or should be used to confirm positive Ag-RDT tests results, whereas when there is a high incidence and strong epidemiologic link, Ag-RDTs can be used as confirmatory tests.

Such large-scale testing can only be effective if there is adequate space for case management and isolation, which would enable breaking transmission chains and would thus rely on a previous decongestion as per our first recommendation. Asymptomatic and mild cases can isolate in cohorts if necessary, reducing the space requirements and making isolation more feasible (Hargreaves et al., 2020). During our risk evaluation, we observed that because of testing constraints in the local diagnostic laboratory, testing was limited to those with symptoms compatible with COVID-19. On many occasions, close contacts of confirmed cases could not be tested. Because our risk assessment considered the risk of a large-scale outbreak within the reception center as high, we recommended a screening of the residents in a short period of time to identify and isolate any active cases and to obtain an accurate depiction of the current situation.

### Screening for symptoms

Strengthening the surveillance of symptoms is another key measure to prevent and control COVID-19 outbreaks in such settings. Active surveillance in parallel with body-temperature checks and monitoring of influenza-like illness in reception centers with limited testing capacity have proven to be successful in detecting cases (Ceccarelli et al., 2021). The center's health care staff commented that the workload associated with COVID-19 prevention and management, in addition to the routine activities of the on-site health clinics, is heavy, and including daily symptom monitoring of cases and contacts was not feasible. That being said, it remains crucial to actively monitor the residents for symptoms to maintain control of COVID-19 incidence. We furthermore recommended the installation of thermal imaging cameras in strategic locations to identify residents and staff with elevated body temperatures to contribute to the timely detection of cases and corresponding action. However, because most cases in this generally young population were asymptomatic, this recommendation works best for a sustainable long-term management of COVID-19 in such facilities rather than the early detection of further cases during an outbreak. Efforts such as the screening for symptoms are most effectively implemented alongside previous recommendations made.

### Targeted public health and risk communication

Targeted public health and risk communication is fundamental for the successful implementation of the aforementioned COVID-19 control measures. Because of resource constraints, health education and risk communication activities in reception centers may not occur as frequently as they did at the beginning of the pandemic. Based on our interviews, the residents, understandably, felt trapped by the pandemic and had come to see it as an obstacle to

their migration status. We therefore consider it of utmost importance that public health communications are specifically designed and regularly delivered to people in these settings, emphasizing the future benefits associated with individual compliance with the control measures. Messages should be transparent, inclusive, and adapted to the needs of the population in the center, accounting for language and cultural differences, ideally involving community members in their development and distribution (ECDC, 2020; UNHCR, 2020). Moreover, various channels of information, including verified news outlets from the residents' countries of origin, targeting diverse groups of reception center residents should be employed (ECDC, 2020; UNHCR, 2020). Raising awareness about the disease, symptoms, risks, and prevention measures could enhance health care seeking behavior, facilitate active surveillance, address misinformation, and improve compliance to basic public health measures in the future, including vaccine uptake.

## Discussion

As pandemic fatigue spreads throughout Europe, it is more important than ever to leave no one behind and support COVID-19 prevention and control activities in reception centers for refugees, asylum seekers, and migrants. We encourage similar risk evaluations to be conducted because it enabled the authors of this manuscript to inform and tailor recommendations to most effectively utilize the limited resources available at the time for the mitigation of COVID-19 in such settings.

Because this intervention was performed during September 2020, long before there was a rollout of vaccination campaigns, the recommendations presented here rely on the tools available at the time. In line with international efforts to provide equitable access to life-saving vaccines for all, the prioritization of vulnerable groups in refugee and reception centers should remain a priority to alleviate the burden experienced by both the residents and the staff of these centers. Vaccination activities should be accompanied by specifically tailored messages to address concerns regarding safety, effectiveness, and any other doubts. Until such access to vaccines can be achieved, the strategies described within this perspective may provide guidance on effective risk mitigation strategies.

## Author contributions

Andreas Hoefler, Despina Pampaka, Daniel Castrillejo, and Jorge del Diego-Salas participated in the field deployment to perform the risk evaluation in the reception center. All of them participated in the drafts and final versions of this manuscript. José Luenga-Cabrera and Martha Paisi performed the data analysis and extensive revision of the manuscript for publication. Silvia Herrera-León and Noemí López-Perea supported the field deployment, the writing and revision of the manuscript, and the institutional approval process.

## Transparency Statement

The corresponding author on behalf of the other authors guarantees the accuracy, transparency, and honesty of the data and information contained in the study, that no relevant information has been omitted, and that all discrepancies between authors have been adequately resolved and described.

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## Declaration of Competing Interest

The authors declared no conflicts of interest.

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