Ethics

Key questions to ask

when facing dilemmas during COVID-19 response in humanitarian settings

HEALTH CLUSTER

Acknowledgements

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[1] *The USAID funded READY initiative aims to augment global capacity to respond to major outbreaks of infectious disease with epidemic or pandemic potential. READY is led by Save the Children in partnership with the Johns Hopkins Center for Humanitarian Health, the Johns Hopkins Center for Communication Programs, UK-Med, EcoHealth Alliance, and Mercy Malaysia*

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1. Background

Health clusters and partners are facing considerable technical and operational challenges in humanitarian settings to safely deliver COVID-19 response and provide essential health care. Increased operational challenges such as movement restrictions, diversions of resources, supplies and funding as well as increased operational costs are forcing health clusters and partners to make difficult decisions on what and how to safely provide COVID-19 response. Country health clusters and partners have identified the need for support when having to make incredibly difficult decisions. In a survey conducted with health clusters and partners responding to the COVID-19 crisis in August 2020, 31% requested technical guidance on ethical questions to help make decisions where there are inadequate resources.[2]

[2] For further findings see *Health Cluster Survey Findings and Health Cluster Study Findings*; Global Health Cluster; November 2020.

2. Purpose

The aim of this tool is to help health clusters and health cluster partners make difficult decisions when providing assistance during COVID-19 in situations where resources are scarce and response options limited.

Health cluster partners already use ethics in their decision-making (whether knowingly or not) by following key humanitarian commitments. These include *Humanitarian Principles* (1,2), *Sphere* (3), *IASC commitments to protection (*4, 5, 6) and *Quality of Care in Humanitarian Settings* (7). However, in scenarios where resources are overwhelmed, humanitarian commitments may be difficult to fully achieve. In situations when available response options result in some degree of inequity or harm, this tool provides some key ethical questions and processes for partners to utilise to help work through and manage these dilemmas.

This document hopes to simplify what may otherwise be seen as complex ethics principles and describe how these interrelate with many humanitarian commitments. Furthermore, it will suggest processes to put in place and key questions to ask when health clusters and partners are having to manage a dilemma, followed by a case study from the health cluster in Cox's Bazar, Bangladesh.

This document can be used by any humanitarian worker, i.e., from frontline to management, as well as collaboratively by the health cluster and partners, when confronted by an ethical dilemma. While written with the lens of a health response, it may be useful for any sector.

3. What is ethics?

Ethics is an area of study and practice focused on the discussion and development of standards to guide right actions. It is a discipline that helps identify and ideally agree upon common guiding principles and values. Indeed, ethical theory has evolved over hundreds of years and across all cultures and disciplines. So, while there is some agreement about 'the right thing to do', there are few universally accepted truths in ethics.

Ethics can help guide us towards making the right decision when there is a clash of values. Ethics is not just about using the right principles but ensuring that decisions are taken in the right way (sometimes referred to as procedural ethics). Indeed, when faced with the most complex ethical challenge, sometimes the best and only option to resolving it is to rely on agreed-upon ethical processes.

Ethics can be applied in many different fields of work, such as human rights, research ethics or health care (or medical) ethics when working with patients.

4. When to use ethics frameworks in humanitarian settings?

In general, partners working in humanitarian settings are already aiming to work ethically and to 'do good' to meet the needs of affected populations in a crisis. Key humanitarian commitments and guidance help steer response such as the humanitarian imperative (8), humanitarian principles (1,2), *Sphere's Humanitarian Charter* (3,), IASC commitments to protection (4, 5, 6), *Accountability to Affected populations* (9), and *Quality of Care in Humanitarian Settings* (7), all of which inevitably overlap and are grounded in a human rights-based approach. *(See Figure 1 and Annex 1)*

Affected populations face barriers to equitably access care and services due to displacement, conflict or food insecurity, etc. These risks may increase with exisiting vulnerabilities and marginalisation due to gender, age, language, ethnic group, disability, living with conditions associated with stigma etc. In response, humanitarian partners aim to meet these needs, but they themselves often face operational constraints including the inabilty to access populations, lack of resources and limited response capacities. Health clusters and partners, therefore, often are already confronted with ethical dilemmas related to providing assistance against competing needs.

Figure 1: Key humanitarian commitments and guidance

- Humanitarian imperative from the ICRC Code of Conduct
- Humanitarian principles
- IASC commitments to centrality of protection, accountability to affected populations, protection mainstreaming
- Sphere including Humanitarian Charter and Core Humanitarian Standards
- Quality of Care in Humanitarian Settings, Global Health Cluster position paper

See Annex 1 for further explanation

Unfortunately, during heighted crises, such as COVID-19, additional constraints arise due to increased operational challenges (such as public health and social measures implemented by national authorities, movement restrictions), as well as increasing resource scarcity (such as insufficient supplies, human resources or funding being diverted). Health clusters and partners may therefore face scenarios where difficult decisions will need to be made, where humanitarian obligations will be difficult to achieve and all available response options may result in inequity (or indeed harm to some groups). Examples include deciding which severe or critical COVID-19 patient should receive oxygen if only a limited amount of oxygen is available, or which essential health services should be halted if there are insufficient health care workers, supplies or funding. *See Figure 2* for further examples from health clusters and partners.

Health clusters and partners should, therefore, **anticipate these dilemmas and prepare accordingly**. This includes supporting frontline workers, managers and health clusters to foster an organisational and sector wide culture focused on preparedness, creating mechanisms (or frameworks) for ethical decision making, removing substantial burden from frontline workers, avoiding ad hoc or individual decision making, and to ensure continued collaboration around advocacy.

Figure 2. Examples of ethical dilemmas being faced by health clusters and partners during COVID -19

"We have a lot of infectious diseases which also require infection prevention control (IPC). We noticed that our healthcare workers are not using IPC [because] we didn't have enough PPEs available for all." - Iraq

Where do we do home isolation?! In South Sudan where the number of people in household/ hut is more than 6. The home isolation is just a source of spread of COVID 19 because poverty and overcrowding at household level. - South Sudan

"What to do with this type of patient who is critically ill, but you do not have capacity to treat them with the right therapeutics or tools? I do not even have oxygen and such like" - Yemen

"Maintaining infection prevention & control, no PPEs for staff, stress and burnout and lack of mental health support. If we don't work how will the population get help?" - Somalia

"When asymptomatic contacts of COVID-19 patients are preferring to stay at home. We are in a difficult dilemma to advise the contacts to use dedicated quarantine facilities or allow them to remain at home. Considering camps' overcrowding, quarantine at quarantine health facilities are also a better option. At the same time, we respect personal choice." – Cox's Bazar, Bangladesh

"When the community because of many reasons such as stigma, fear, and lack of enough information, did not want to be tested in spite of COVID-19 like symptoms. Health partners are in dilemma what to do. You cannot force [testing] at the same time it is important to conduct COVID-19 tests for patients meeting case definitions" - Cox's Bazar, Bangladesh

5. Some useful concepts

Many ethics concepts exist which are often presented in different guidance and tools including for COVID-19 response.[3] To help demystify and simplify what can be complex concepts, this section describes some concepts that are commonly presented that have been selected as useful and relevant to the challenges being faced in humanitarian settings i.e., where the affected population have increased risks and needs but also where the operational environment is challenging with insufficient resources to meet these needs. The concepts presented will be related to existing humanitarian commitments and guidance to reflect how health clusters and partners are already using an ethical approach to provide assistance.[4]

Figure 3. Some key ethical concepts adapted from *Guidance for managing ethical issues in infectious disease outbreaks,* WHO 2016

Distributive justice relates to **equity** and the distribution of resources, opportunities, and outcomes. It includes treating people with similar vulnerabilities and capacities alike, avoiding discrimination and being sensitive to meet the needs of those who are vulnerable and at risk.[5] This is echoed in many humanitarian commitments such as the humanitarian Imperative (that everyone has the right to receive assistance), humanitarian principles (1,2) of humanity, impartiality and neutrality and *IASC Protection Mainstreaming* guidance (6*)* i.e. humanitarian response is based on need and provided to all without discrimination. Both IASC protection commitments *(*4, 5, 6) as well as the *Quality of Care in Humanitarian Settings* (7) Position Paper recognise that vulnerable and at-risk individuals, groups or populations may need special attention and resources to have access to the same opportunities and/ or achieve the same outcomes.

[3] See Annex 3 Useful Resources for references to other guidance

[4] Many of these concepts are presented in *Guidance for managing ethical issues in infectious disease outbreaks,* WHO; 2016 and should also be referred to

[5] "At risk individual / groups / population: Persons who might be subject to protection violations and abuse. Taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, those with conditions associated with stigma, and persons belonging to sexual and other minorities or marginalised communities". *Draft Joint Operational Framework to Improve Integrated Programming and Coordination Between Health and Protection,* Global Health Cluster and Global Protection Cluster.

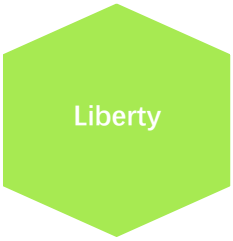
Procedural justice refers to ensuring a fair process for making decisions. This includes transparency, community engagement, inclusion, accountability and oversight. These are echoed in *IASC Commitments on Accountability to Affected Populations* (9), *Protection Mainstreaming* (6), *Core Humanitarian Standard on Quality and Accountability* (3,10) (CHS Commitments 1, 4 and 5 that humanitarian response is appropriate and relevant, based on communication, participation and feedback, complaints are welcomed and addressed) as well as ensuring people centredness in *Quality of Care* (7).

Utility entails making the best use of scarce resources. Actions that are taken to promote the well-being of individuals and communities, but to maximise it requires balancing i) benefits against harm, as well as ii) efficiency i.e., the greatest benefit at the lowest cost. This is mirrored in *Quality of Care* (7), which aims to improve health outcomes of both the individual and community, but also that efficiency is also needed. This is also mirrored in the *IASC Policy on Protection* (5) which calls for collective protection outcomes through, a multidisciplinary approach that can result in the reduction of risks faced by individuals and communities. Efficiency also iterated in CHS (Commitment 9) (3, 10) promoting that resources are managed and used responsibly.

Beneficence refers to acts that are done for the benefit of others which itself is a cornerstone of humanitarian assistance. It is iterated in the Humanitarian Imperative of the ICRC Code of Conduct (8) and the Sphere Humanitarian Charter (3) expressed as the basic human right of all people to assistance and services. It is a pinnacle of medical ethics and health care, and intrinsic to improving health outcomes for quality of care (7).

Respect for persons recognises an individual's inherent rights including respecting their dignity, values and preferences (including social, religious and cultural beliefs). This includes respecting **autonomy** (often articulated as a distinct ethical concept in clinical medicine and refers to the ability of an individual to be their own person, to make their own choices on the basis of their own motivations, without manipulation by external forces)[6]. All of these are mirrored in the Sphere *Humanitarian Charter* (3), *IASC Policy on Protection* (5) and under the domain of people centredness for *Quality of Care* (7). Furthermore, ensuring informed consent, respect for privacy and confidentiality (also encompassed within this concept) are considered rights, and breaches of these are a potential protection violation also compromising quality of care as increases risk of harm to the patient (i.e., unsafe).

[6] See *Global Health Training Centre Glossary* [webpage], Global Health Network.



Liberty relates to the protection of fundamental rights, thus overlaps with *'respect for persons*.' It also includes freedoms such as freedom of movement, peaceful assembly and of speech. Within health and *Quality of Care* (7), this is respected through the key domains of people centredness and equity, acknowledging that traditional harmful practices and negative coping mechanisms are often behaviours that health actors have to carefully address to improve health outcomes.

Reciprocity means to provide 'fitting and proportional returns' for contributions people have made, for example, in an epidemic response effort. Within the COVID-19 context in humanitarian settings given the increased risk of health care acquired infections by health care workers, as well as violence against health care providers reported[7], this concept requires appropriate protections be made available for those providing frontline work. Furthermore, the extreme stressors faced by health care workers when services are overwhelmed, including the increased provision of bereavement support to families and difficult decisions to be made regarding treatment allocation when resources are scarce, necessitate organisations to provide adequate support, including MHPSS, to their staff. The safety of staff (as well as patients) is iterated as critical to providing quality health care in humanitarian settings (7), and support to staff is also iterated in CHS Commitment 8 (3,10).

Solidarity is where a group stands together engendering collective action in the face of common threats. It helps to support addressing inequalities that undermine the well-being and welfare of vulnerable and at-risk groups. This concept is well grounded and operationalised in humanitarian settings where the cluster system is activated. Indeed, the purpose of the health cluster is to have all participating organisations working together in partnership, for the benefit of the affected population and towards collective outcomes (11). Ensuring humanitarian response is coordinated and complementary is also reflected in CHS Commitment 6 (3, 10).

In the provision of health care, especially when working directly with patients, a common set of ethical principles promoted are **justice, beneficence, non-maleficence,** and **autonomy.**[8] Non – maleficence in essence means to do no harm and serves as a key tenet of humanitarian response defined *in IASC commitments to Protection* including *Centrality of Protection* (4), *Policy on Protection* (5), and *protection mainstreaming* (6), *Sphere Protection Principles* (3) as well as a critical foundation to ensure safety of both staff and patients as part of *Quality of Care* (7).

[7] For further information see *Surveillance System for attacks on health care* [webpage], WHO and "*600 violence incidents recorded against health care providers, patients due to COVID-19*" ICRC News Release, 18 August 2020

[8] See World Medical Association *Medical Ethics Manual 3rd Edition*, WMA 2015 adopted by the *EMT Initiative* and referenced in *The Sphere Handbook.*

6. Creating a process to manage dilemmas: key questions to ask

A common dilemma faced in public health, especially during crises or outbreaks when health care services are overwhelmed and resources are insufficient to care for all, is when having to **balance between addressing the needs of the public against the clinical needs of an individual**; the need to maximise resources required to support the well-being of the wider community vs that of a patient i.e., when utility is at odds with justice (equity / distributive justice) and even beneficence and non-maleficence.

When facing a dilemma, there is no simple right answer nor clear directive for which ethical concept is the 'most' correct to use nor hierarchy for which ought to take priority in a given context. Each context and community will have different priorities and impacts. It is necessary, however, to clearly create a process to

- analyse the dilemma being faced using ethical concepts (and indeed humanitarian commitments and guidance as reflected the useful concepts in section 5)
- create possible solutions or response options to determine which may be the best to manage these dilemmas
- agree on the best response option acknowledging that some degree of inequity or indeed harm, may result
- take measures to mitigate anticipated negative impacts of the response option

Key considerations

The objective of developing such a process is to ensure that when dilemmas are faced, decisions made are

- consistent and not ad hoc i.e., it is not made by an individual, and it is equally applied to all people
- removes burden from frontline workers who may not have the relevant expertise
- maintains public trust

The process itself (as well as possible solutions created) need to be

- transparent, consultative and communicate to all
- allows communities to be engaged when making decisions and to challenge them
- ensures frontline workers receive appropriate support when managing ethical dilemmas, including MHPSS *(see Figure 4)*

Figure 4. Mental health and psychosocial support to health care workers

Threats to health care workers' mental health during COVID-19 include higher demands in the work setting, increased witness to suffering and death, increased volume of clinical services leading to overburdening, tension between public health priorities and patients' wishes, overall situational anxiety, and infection risk (compounded by lack of PPE) for health care workers themselves, their families their communities and their patients[1] . Health care workers' mental health should be prioritized to be able to support their capacity to work in the long term as well as for short-term crisis response. Managers should

- Assess and minimize additional COVID-19-related occupational psychosocial risks for stress e.g., around job demands, social support, physical environment, job security, access to information and communication about their work in a rapidly evolving environment (12, 13).
- Ensure access to and provision of mental health and psychosocial support services (MHPSS) for health workers involved in the COVID-19 response. This includes basic psychosocial support as the first line of care for healthcare workers who are distressed, as well as facilitating suicide prevention through early identification. Aim for at least one trained MHPSS worker for every health facility to manage priority conditions
- Promote a culture for health care workers to seek help and provide evidence-based resources on basic psychosocial skills for health. Establish approaches to discuss challenges and dilemmas, organize schedules to include breaks, minimize other work-related stress and activate peer support.
- Train health leads in basic psychosocial skills and regular supportive monitoring of staff mental wellbeing, including protection from COVID-19-related stress. Training in basic psychosocial skills such as psychological first aid can benefit leads/managers and workers in having the skills to provide the necessary support to colleagues (13, 14, 15).
- Ensure health workers with mental health conditions originating from COVID-19 have the same rights to treatment and access to care as the general population

See Annex 3 for useful resources on MHPSS

[9] For further information on challenges being faced by health care workers see *Health Cluster Study Findings: Key Informant Interviews from Six Countries*, Global Health Cluster, November 2020.

Key questions to ask

When developing a process to analyse the ethical dilemma and determine response options, key questions should be asked throughout the process and is described in Figure 6 *Key questions to Ask.* These can be applied to other ethical analysis frameworks such as Humanitarian Health Ethics Analysis Tool *(see Annex 2*). Although similar to these tools, the questions presented in Figure 6 gives specificities relating to humanitarian settings where the cluster is activated. Figure 5 describes the role of health cluster and partners facing ethical dilemmas, and how they may collaboratively work to address dilemmas

Figure 5. Role of health clusters and health cluster partners facing ethical dilemmas

In cluster settings **health clusters and health cluster partners** should collaboratively work to address ethical dilemmas. This includes

- **Collaboratively develop a process** to analyse the dilemma and collectively agree on the best response option
- **Maximising existing resources and capacities** e.g., improve referral, increase coverage of a service by a partner if another partner has to decrease or suspend theirs
- Ensure scaling up **palliative care** when resource scarcity means patients at the end of life or suffering are unable to receive full care that should be afforded to them
- **Supporting frontline workers**, or partners making difficult decisions through creating technical working groups developing SOPs that all partners will follow
- Ensuring **advocacy** is occurring to highlight unmet needs to Humanitarian Coordination Team (HCT) and other stakeholders as necessary

Figure 6. Key questions to ask, when creating a process to analyse and manage a dilemma

What should the process look like?

The objective

of developing a process is to ensure when facing a dilemma, the decisions made:

- Are consistent, i.e., not relying on ad hoc or individual decision making
- Take away the burden from individuals, especially frontline health care workers
- Maintains public trust

The process needs to:

- Be transparent
- Engage communities i.e., including them in the process to develop solutions, provide feedback and to be able to challenge decisions
- Ensure frontline workers have appropriate support e.g., from senior staff, supervisors, wider sector, through agreement on SOPs etc.

1 Is this an ethical dilemma? Define it.

- Is this an exceptional scenario where I need to choose among a range of bad decisions?
- What are the ethical principles being challenged?
- What rationale or logic is currently being used to make the decisions?
- What are my own biases and cultural differences compared to that of others and the community? How does it affect how I understand this dilemma
- What are the pros and cons of each possible response option in the dilemma?

2 Who is currently having to address this dilemma?

- Individual frontline workers
- Cadres of workers
- Organisation, i.e., health cluster partners including MoH
- health cluster
- everyone
- Other

3 Who is affected by this dilemma?

- Entire populations
- Individuals within the population
- Certain groups are disproportionately affected, and if so which

4 What is the community perception of this dilemma?

- Is the population informed about the dilemma and different options?
- What do they think about the different options? Are some more acceptable than others?
- Do they have trust in the existing system?
- Are they able to engage in decision making process? What feedback mechanisms exist?
- Is their viewpoint different or at odds with mine or the humanitarian community?

5 Who can or should support in addressing the dilemma? And how?

Who:

- organisation's supervisors, managers, peer groups, health cluster with health cluster partners including MoH, Humanitarian Country Team (HCT), national authorities, etc
- Communities, religious leaders, national leaders etc.

How:

- For dilemmas needing immediate action, senior support from a supervisor should be taken
- Organizational or collective / cluster SOPs
- Organization and cluster wide environment open for all stakeholders to be able to collectively discuss dilemmas and give support
- Advocacy with HCT and others

6 What more information is needed? From where?

Do I need more information on

- Vulnerable and at-risk groups
- Community perceptions
- Impact of treatments or interventions on different part of the community (including vulnerable and at risk groups)

Where can I find information?

- Protection risk assessments
- Reports by agencies or Clusters, RCCE actors, sector, or AAP platforms

7 How can we collectively determine an appropriate solution?

- Create a working group of key stakeholders to collectively address the situation (e.g., within organisation, or under the health cluster with partners, MoH, etc.) ensuring engagement with communities
- For dilemmas needing immediate action: frontline workers should discuss with a supervisor
- Decide what ethical principles (or humanitarian commitments) should be used to examine the dilemma to help analyse pros and cons for each response option
- Decide on a "best option," while being honest about its impact on people, including those who will lose out
- Collectively develop SOPs for the scenario as necessary

8 What are the next steps?

- Where immediate response was taken, escalate with senior management for review and discussion
- Support dissemination and uptake of SOPs developed across organisation, health cluster and community
- Communicate with communities about decisions or SOPs made. Ensure feedback mechanisms exist including how to challenge decisions / SOPs made
- Provide MHPSS support to frontline workers who may be distressed facing ethical dilemmas, implementing SOPs
- Collectively work with health cluster to ensure advocacy e.g., to HCT for unmet needs
- Review the dilemma, response, and its impact collecting feedback from stakeholders, within an agreed timeframe changing response and SOPs as needed

How a health cluster collectively anticipated facing an ethical dilemma, an example from Cox's Bazar, Bangladesh

1

Is this an ethical dilemma? Define it.

Scenario:

Location: Cox's Bazar Kutupalong and Ukhia refugee camps
Total population: 745,000
Cluster: Cox's Bazar Health Sector Working Group
Number of partners: 151 (58 INGOs, 61 NNGOs, 9 UN, 6 National authorities, 7 donors, 10 observers)

- Projected caseloads for COVID-19 were anticipated to overwhelm existing capacity
- Existing national protocols require inpatient care for all positive or suspected cases
- camps are very crowded, densely populated, with insufficient WASH,
- Households had multiple residents with only one or two rooms. Therefore, isolation of confirmed or suspected COVID-19 family members within the household poses risks of transmission to others
- Community stated unwillingness to use community facilities to 'shield' high risk people (e.g., older people)
- National protocols allowed homebased care (of mild and moderate COVID-19 cases) for the host population as they were perceived to have more resources and space to be able to isolate at home adequately

The ethical dilemma:
In high transmission scenarios where health systems are overwhelmed (insufficient bed, supplies, HR etc.), what would be the best way to manage patients? Given the limited resources that would be available and given that home based care for mild and moderate COVID-19 cases also carries risks, what would be the best option?

Main ethical principles being challenged:
Beneficence, doing good for the patient: Given the environmental factors within camps, facility-based care for mild, moderate, severe and critical patients is the safest setting for individual patient to recover.

Beneficence, doing good for the population: providing facility-based care mitigates COVID-19 transmission within the community where household isolation is challenging.

Utility (doing good for the most amount of people, most efficiently):
In the case where services could be overwhelmed, it is important to use the available resources most efficiently to treat the most amount of people, with least negative consequences. While facility-based care mitigates transmission in the community, it is costly. In the scenario where services are overwhelmed, this could deprive severe and critical cases of COVID-19 of inpatient care.

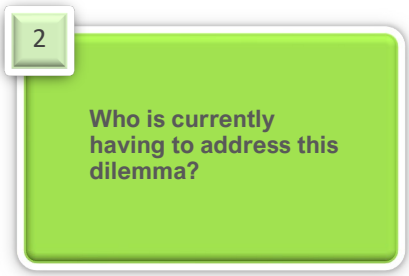
Liberty / respect for persons / autonomy: respecting populations' desire to choose their treatment option e.g., mandating patients to have facility-based care where mild or moderate cases which could be managed at home, is in opposition to liberty / respect for persons / autonomy.

Possible response options

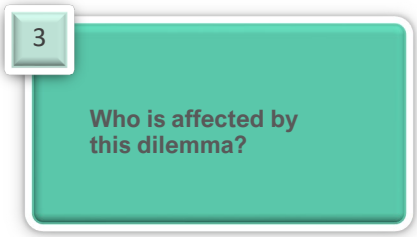
Option1: admit all patients irrelevant of severity. When hospitals reach capacity, do not to admit any additional patients whether mild or severe or critical case. The risks involve using resources in hospitals on well patients, and potentially denying care to severe and critical patients

Option 2: prioritise home-base case for mild and moderate cases. Risks are inability to isolate patient at home, thus, transmitting COVID-19 further throughout the community.

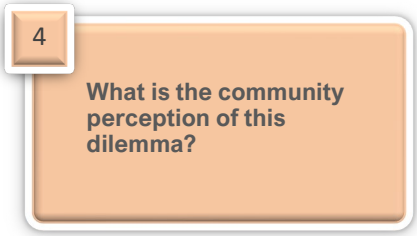
Option 3: as with option 2 but also prioritise severe cases to have homebased care depending on risk factors, depending on level of support needed



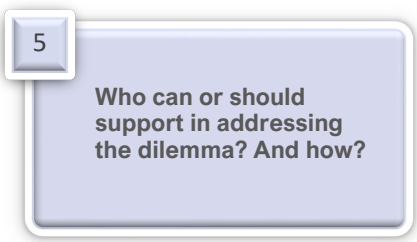
Currently not being faced but is anticipated. Frontline health care workers in SARI treatment centres run by health cluster partners, centres would have to individually face this situation if no preparedness actions taken.



Refugee populations with COVID-19 will be affected especially those categorised as severe or critical cases. If systems are overwhelmed and there is no bed space available, these patients will not have access to adequate care. Those within the community, (non COVID-19) may be exposed to infection if mild and moderate cases have home based care but unable to isolate.



Insufficient information was available on community perceptions of this as it was a preparedness action. However, it was already known from community feedback platforms that communities were reluctant to receive inpatient care due to fear and mistrust of health care services, stigma of having COVID-19 as well as being separated from family members.



Health care workers within facilities, health cluster partners managing treatment centres, health cluster with all health cluster partners making sectoral decision, national authorities both Ministry of Health and authorities (overseeing the Rohyngya refugee popuatlion), other sectors such as WASH, shelter, nutrition / food security (to assist with supporting home based care), Humanitarian Country Team to ensure advocacy.

6

What more information is needed? From where?

Further information on community perceptions and acceptance of home based care, coping mechanisms to self isolate is needed
Ability of high risk groups, e.g. people with disabilities, older people to self isolate if COVID-19 positive.

7

How can we collectively determine an appropriate solution?

The health cluster established a working group to review and identify solutions. The working group examined COVID-19 modelling projections, determined scenarios of how to deliver care to all types of cases (mild to critical).

Ethical concepts prioritised:
utility (maximising resources for most people, what is operationally feasible)
beneficence: looked at how to ensure positive outcomes for those unable to receive inpatient care

Appropriate 'solution' / best option identified: An SOP was developed such that when treatment centres reached 75% bed occupancy, or 1500 suspected cases being seen a day, home based care would be initiated for mild and moderate cases with best available medical care possible at home being provided.

Risks: Isolation at home would not be adequately maintained and household transmission may occur.

Mitigation measures include: Provision of supplies for a patient receiving home-based care, including medical masks, soap, tent for isolation, curtain as a barrier if sleeping in same room and isolation not possible. Daily follow up and monitoring by community health workers with the patient and the household.

8

What are the next steps?

The health cluster and members adopted the SOP. National authorities gave formal approval of the SOP. SOP has not yet been triggered (bed occupancy and daily cases have not yet reached threshold). Anticipatory steps to communicate with communities, strengthening feedback mechanisms etc. to be taken.

Annexes

Annex 1 Key humanitarian guiding principles

Humanitarian response is steered by International Human Rights Law, International Humanitarian Law and other key international legal instruments.[10] Central guiding principles have been established by the IASC and other bodies to improve the accountability and quality of humanitarian response. These are intended to be adopted in country Humanitarian Response Plans and Health Cluster response. These commitments similarly overlap and re-iterate the general principles of Quality of Care that should be provided by health actors in any situation.

The Humanitarian Imperative is the first principle from **the ICRC Code of Conduct (8)** for International Red Cross and Red Crescent Movement and NGOs in Disaster relief drawn up in 1992. It highlights the right to receive humanitarian assistance and to offer it is a fundamental humanitarian principle which should enjoyed by all citizens of all countries. It recognises the prime motivation of disaster response is to alleviate human suffering amongst those least able to withstand the stress caused by disaster.

Humanitarian Principles Of humanity, impartiality, neutrality, and independence were codified in UN General Assembly Resolutions 6/182 in 1991 **(1)** and Res 58/114 in 2004 **(2).** Within these it highlights that humanitarian response should be based on need alone and provided to all the affected population without discrimination.

IASC policies and guidance

Accountability to Affected Populations (AAP) (9) puts people in the centre of the response, and ensures that all parts of the affected population are involved in programme design, implementation, monitoring and feedback of any humanitarian response

Protection against sexual abuse and exploitation (PSEA) (9) is a commitment that all humanitarian partners will introduce policies and practices that aim to end sexual exploitation and sexual abuse by humanitarian workers (and their own personnel) and to ensure that allegations of SEA are responded to in a timely and appropriate manner.

[10] For further information see *Annex I, IASC Policy on Protection in Humanitarian Action IASC 2016;* and *Annex I, The Sphere Handbook, Sphere 2018*

Centrality of Protection (4), **the IASC Policy on Protection (5)** and **Protection mainstreaming (6)** commits organisations to ensure that the provision of aid should not itself create risk or harm to the affected population. Furthermore, it stipulates that all parts of the population, including those at risk, have meaningful access to the full range of services they are entitled to. This involves having to understand and address the various needs of all.

Other guidance

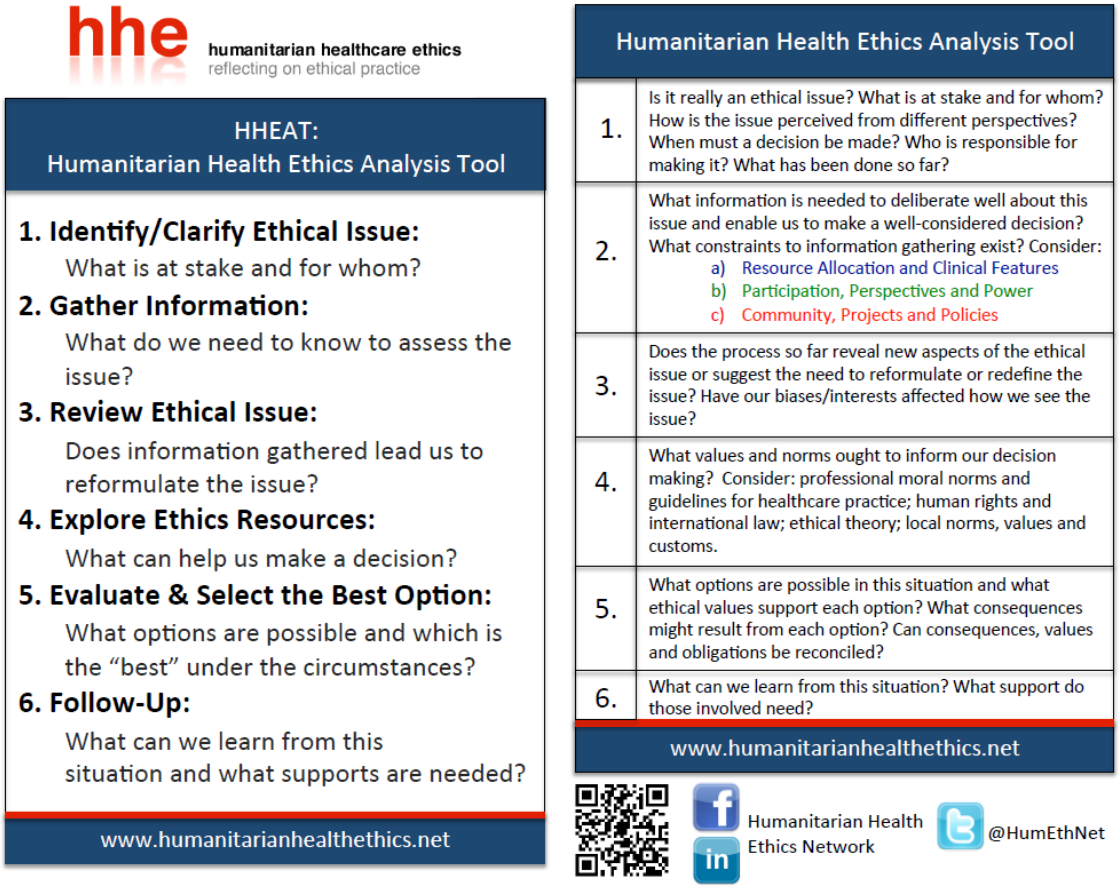
The Sphere Handbook (3) was first introduced in 1998 and comprises of the Humanitarian Charter, Protection Principles, Core Humanitarian Standards and Minimum (technical) Standards. The **Humanitarian Charter** articulates the conviction of humanitarian actors that all people affected by crisis have a right to receive protection and assistance, ensuring basic conditions for life with dignity. It provides the ethical and legal backdrop to the Protection Principles, the CHS and Minimum standards. The **Protection Principles** are a practical translation of the legal principles and right outlined in the Humanitarian Charter. The **Core Humanitarian Standards (10)** place communities and people at the centre of humanitarian action. It outlines policies and practices that an organization needs to achieve to deliver quality assistance while first being accountable to communities and people affected by crisis.

Global Health Cluster guidance

Adopting the renewed focus and guidance on quality of care by WHO, the Global Health Cluster developed a position paper **Quality of Care in Humanitarian Settings (7)** with the collaboration of 30 partners and observers in 2020. It defines that quality of care relates to the degree to which health services for both individuals and populations increase the likelihood of desired health outcomes and is comprised of 6 key domains: **people centredness, equity, safety, timeliness, effectiveness, efficiency, integration**. It emphasises the overlap and complementarity of protection mainstreaming and accountability to affected populations.

Annex 2 Humanitarian Health Ethics Analysis Tool

Developed by the Humanitarian Health Ethics Group the Humanitarian Health Ethics Analysis Tool is a useful tool often recommended in different guidance to help understand and create response options to manage an ethical dilemma. Figure 7 shows the summary page, the full tool can be accessed at:
https://humanitarianhealthethics.net/home/hheat/hheat/



Annex 3 Useful resources

COVID-19

- *Coronavirus disease (COVID-19): Ethics, resource allocation and priority setting.* Geneva: World Health Organization; 2020. (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/coronavirus-disease-covid-19-ethics-resource-allocation-and-priority-setting, accessed 5 December 2020.)

- *COVID-19 Palliative Care Guidelines for Families.* South Africa: African Federation for Emergency Medicine; 2020. (https://afem.africa/resources/, accessed 5 December 2020 accessed 5 December 2020)

- *Ethical considerations for emergency care during COVID-19 in Africa.* South Africa: African Federation of Emergency Medicine. (https://www.dropbox.com/s/b8gyhv6mwppvmgh/COVID%20Ethics%20guidlinesv2.pdf?dl=0, Accessed 5 December 2020)

- *Health Cluster Survey Findings.* Geneva: Global Health Cluster; November 2020. (https://www.who.int/health-cluster/en/ , Accessed 5 December 2020)

- *Health Cluster Study Findings: Key Informant Interviews for Six Countries.* Geneva: Global Health Cluster; November 2020. (https://www.who.int/health-cluster/en/ , Accessed 5 December 2020)

- *Resolve, Legal and Ethical Considerations for Public Health and Social Measures.* New York: Prevent Epidemics. (https://preventepidemics.org/covid19/phsm/legal-and-ethical-considerations-for-public-health-and-social-measures/, accessed 5 December 2020)

- *WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination.* Geneva: World Health Organization; 2020. (https://www.who.int/publications/i/item/who-sage-values-framework-for-the-allocation-and-prioritization-of-covid-19-vaccination, accessed 5 December 2020)

COVID-19 and MHPSS

- *Doing what matters in times of stress: an illustrated guide.* Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240003927 , accessed 5 December 2020)

- *Health care workers: stories and key resources on supporting the mental health of health care workers on the front-lines of pandemic responses* [webpage]. Geneva and London: Mental Health Innovation Network; 2020.

  (https://www.mhinnovation.net/health-care-workers , accessed 5 December 2020)

- *IASC guidance on basic psychosocial skills: a guide for COVID-19 responders*. Geneva: Inter-Agency Standing Committee; 2020

  (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergencysettings/iasc-guidance-basic , accessed 5 December 2020)

- *IASC Guidance on Operational considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic*. Geneva: Inter-Agency Standing Committee; 2020. (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance, Accessed 5 December 2020)

- *Interim briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak.* Geneva: Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support; 2020 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing , accessed 5 December 2020)

- *Mental health and psychosocial considerations during the COVID-19 outbreak.* Geneva: World Health Organization; 2020.

  (https://www.who.int/publications/i/item/WHO-2019-nCoV-MentalHealth-2020.1, accessed 5 December 2020).

- *Health workforce policy and management in the context of the COVID-19 pandemic response: Interim guidance*, World Health Organization; 2020:

  (https://www.who.int/publications/i/item/health-workforce-policy-and-management-in-the-context-of-the-covid-19-pandemic-response accessed 5 December 2020)

Other

- Global Health Training Centre Glossary [website]. (https://globalhealthtrainingcentre.tghn.org/research-ethics-epidemics-pandemics-and-disaster-situations/glossary/, accessed 5 December 2020)

- [Draft] *Joint Operational Framework to Improve Integrated Programming and Coordination Between Health and Protection.* [to be published] Global Health Cluster and Global Protection Cluster.

- Humanitarian Health Ethics Assessment Tool (HHEAT) (https://humanitarianhealthethics.net/home/hheat/hheat/ accessed 5 December 2020)

- *Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters*. Geneva: World Health Organization; 2013. (https://extranet.who.int/emt/guidelines-andpublications , accessed 5 December 2020)

- Epidemics Ethics Research and Response [webpage]. (https://epidemicethics.tghn.org/resources/ , accessed 5 December 2020)

- Management of limb injuries during disasters and conflicts. Geneva: ICRC.(https://reliefweb.int/report/world/management-limb-injuries-during-disasters-and-conflicts, Accessed 1 December 2020)
- *Medical Ethics Manual.* 3rd Edition. World Medical Association; 2015 (https://www.wma.net/what-we-do/education/medical-ethics-manual/ , accessed 5 December 2020)
- Sinding, Christina et al. (2010) " 'Playing God Because you Have to': Health Professionals' Narratives of Rationing Care in Humanitarian and Development Work," *Public Health Ethics* 2010; 1-11 (https://academic.oup.com/phe/article abstract/3/2/147/1461656?redirectedFrom=fulltext , accessed 5 December 2020)
- *Surveillance System on Attacks on Health Care* [website]. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/attacks-on-health-care/surveillancesystem/en/, accessed 5 December 2020)
- *Tragic Choices Ethical Uncertainty in Humanitarian Healthcare* [Presentation]. World Association for Disaster and Emergency Medicine https://www.youtube.com/watch?time_continue=1800&v=XoJe5h6zxtk&feature=emb_title, accessed 5 December 2020)

Annex 4 Further reading

COVID-19

- *Ethical considerations in responding to the COVID-19 pandemic.* London: Nuffield Council on Bioethics; 2020. (https://www.nuffieldbioethics.org/assets/pdfs/Ethical-considerations-in-responding-to-the-COVID-19-pandemic.pdf, accessed 5 December 2020)
- Resources on ethics and COVID-19 [webpage]. World Health Organization; 2020. https://www.who.int/ethics/topics/outbreaks-emergencies/covid-19/en/

Other

- *Global Health Ethics: Key Issues.* Geneva: World Health Organization (https://www.who.int/ethics/publications/en/, accessed 5 December 2020)
- Hunt, Matthew et al. (2020) "Addressing obstacles to the inclusion of palliative care in humanitarian health projects: a qualitative study of humanitarian health professionals' and policy makers' perceptions," *Conflict and Health; 14 (70). (* https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-020-00314-9, accessed 5 December 2020))
- Hunt, Matthew (2011). "Establishing moral bearings: ethics and expatriate health care professionals in humanitarian work," *Disasters* 2011; 35:3. *(https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-7717.2011.01232.x, accessed 5 December 2020)*
- Hunt, Matthew. (2012). "Tragic Choices in Humanitarian Health Work," *The Journal of Clinical Ethics;* 23: 4 (Winter 2012): 333-44. (https://www.researchgate.net/publication/235884088_Tragic_choices_in_humanitarian_health_work, accessed 5 December 2020)
- Hunt, Matthew (2014). "The Ethics of Engaged Presence: a framework for health professionals in humanitarian assistance and development work," *Developing World Bioethics*; 14:1. (https://pubmed.ncbi.nlm.nih.gov/23279367/, accessed 5 December 2020)
- Schwartz, Lisa et al. (2012). "Models for Humanitarian Health Care Ethics," *Public Health Ethics* (https://www.researchgate.net/publication/273623676_Models_for_Humanitarian_Health_Care_Ethics, accessed 5 December 2020)

Annex 5 References

1. UN General Assembly Resolutions 46/182 of 19 December 1991. New York: United Nations 1991. (https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/46/182, accessed 5 December 2020)

2. UN General Assembly Resolution A/Res/58/114 of 5 February 2004. New York: United Nations; 2004 (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/58/114, accessed 5 December 2020)

3. *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response.* Fourth Edition, Geneva: Sphere Association; 2018 (https://spherestandards.org/handbook-2018/ , accessed 5 December 2020)

4. *IASC Principals' Statement, The Centrality of Protection in Humanitarian Action*. Geneva: Inter-Agency Standing Committee; 2013 (https://interagencystandingcommittee.org/system/files/2020-11/The%20Centrality%20of%20Protection%20in%20Humanitarian%20Action%20%28English%29.pdf , accessed 5 December 2020)

5. *IASC Policy on Protection in Humanitarian Action.* Geneva: Inter-Agency Standing Committee; 2016 (https://interagencystandingcommittee.org/iasc-protection-priority-global-protection-cluster/iasc-policy-protection-humanitarian-action-2016 , accessed 5 December 2020)

6. *Protection Mainstreaming Toolkit.* Geneva: Global Protection Cluster; 2017 (https://www.globalprotectioncluster.org/wp-content/uploads/GPC-PM_Toolkit-ENGscreen.pdf , accessed 5 December 2020)

7. *Quality of Care in Humanitarian Settings position paper.* Geneva: Global Health Cluster; 2020 (https://www.who.int/health-cluster/about/work/task-teams/Quality-of-Care-in-Humanitarian-Settings-June-2020.pdf?ua=1, accessed 5 December 2020)

8. *Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief.* Geneva: International Federation of Red Cross and Red Crescent Societies and the ICRC; 1994.

   (https://www.icrc.org/en/doc/resources/documents/publication/p1067.htm, accessed 5 December 2020)

9. *IASC Revised AAP Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse*. Geneva: Inter-Agency Standing Committee; 2017 (originally developed in 2011) (https://interagencystandingcommittee.org/system/files/iasc_caap_endorsed_nov_2017.pdf , accessed 5 December 2020)

10. *Core Humanitarian Standard on Quality and Accountability* [website]. Geneva: CHS; 2014 (https://corehumanitarianstandard.org/ , accessed 5 December 2020)

11. *The Health Cluster Guide.* Geneva: Global Health Cluster; 2020. (https://www.who.int/health-cluster/resources/publications/hc-guide/en/, accessed 5 December 2020)

12. *Stress prevention at work checkpoints: practical improvements for stress prevention in the workplace.* Geneva: International Labour Organization; 2012 (https://www.ilo.org/global/publications/books/WCMS_168053/lang--en/index.htm accessed 5 December 2020)

13. *IASC interim briefing note on mental health and psychosocial aspects of COVID-19 outbreak,* Inter-Agency Standing Committee; 2020 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing accessed 5 December 2020)

14. *IASC Guidance on Basic Psychosocial Skills- A Guide for COVID-19 Responders* Inter-Agency Standing Committee; 2020 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance-basic accessed 5 December 2020)

15. *WHO Psychological first aid: Guide for field workers*, World Health Organization, 2011 (https://www.who.int/publications/i/item/9789241548205 accessed 5 December 2020)