ZeroHedge | On a long enough timeline the survival rate for everyone drops to zero.

The CDC Planned Quarantine Camps Nationwide

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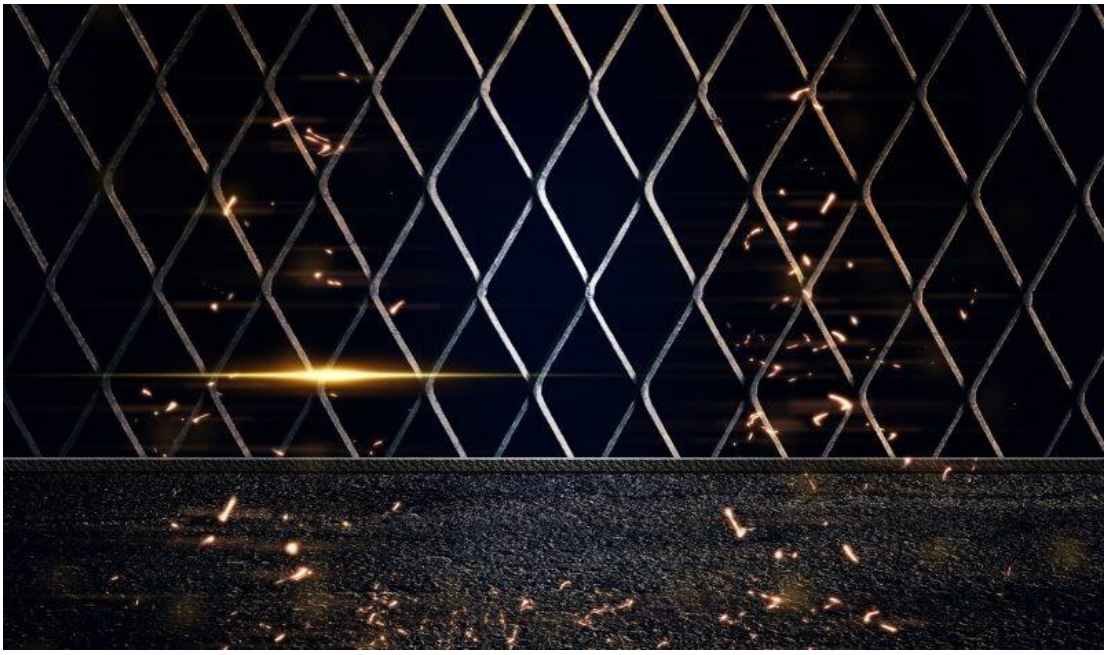
No matter how bad you think Covid policies were, they were intended to be worse.



Consider the vaccine passports alone. Six cities were locked down to include only the vaccinated in public indoor places. They were New York City, Boston, Chicago, New Orleans, Washington, D.C., and Seattle. The plan was to enforce this with a vaccine passport. It broke. Once the news leaked that the shot didn't stop infection or transmission, the planners lost public support and the scheme collapsed.

It was undoubtedly planned to be permanent and nationwide if not worldwide. Instead, the scheme had to be dialed back.

Features of the CDC's edicts did incredible damage. It imposed the rent moratorium. It decreed the ridiculous "six feet of distance" and mask mandates. It forced Plexiglas as the interface for commercial transactions. It implied that mail-in balloting must be the norm, which probably flipped the election. It delayed the reopening as long as possible. It was sadistic.

Even with all that, worse was planned. On July 26, 2020, with the George Floyd riots having finally settled down, the CDC issued a plan for establishing nationwide quarantine camps. People were to be isolated, given only food and some cleaning supplies. They would be banned from participating in any religious services. The plan included contingencies for preventing suicide. There were no provisions made for any legal appeals or even the right to legal counsel.

The plan's authors were unnamed but included 26 footnotes. It was completely official. The document was only removed on about March 26, 2023. During the entire intervening time, the plan survived on the CDC's public site with little to no public notice or controversy.

It was called "Interim Operational Considerations for Implementing the Shielding Approach to Prevent COVID-19 Infections in Humanitarian Settings."

> *"This document presents considerations from the perspective of the U.S. Centers for Disease Control & Prevention (CDC) for implementing the shielding approach in humanitarian settings as outlined in guidance documents focused on camps, displaced populations and low-resource settings. This approach has never been documented and has raised questions and concerns among humanitarian partners who support response activities in these settings. The purpose of this document is to highlight potential implementation challenges of the shielding approach from CDC's perspective and guide thinking around implementation in the absence of empirical data. Considerations are based on current evidence known about the transmission and severity of coronavirus disease 2019 (COVID-19) and may need to be revised as more information becomes available."*

By absence of empirical data, the meaning is: nothing like this has ever been tried. The point of the document was to map out how it could be possible and alert authorities to possible pitfalls to be avoided.

The meaning of “shielding” is “to reduce the number of severe Covid-19 cases by limiting contact between individuals at higher risk of developing severe disease (‘high-risk’) and the general population (‘low-risk’). High-risk individuals would be temporarily relocated to safe or ‘green zones’ established at the household, neighborhood, camp/sector, or community level depending on the context and setting. They would have minimal contact with family members and other low-risk residents.”

In other words, this is what used to be concentration camps.

Who are these people who would be rounded up? They are “older adults and people of any age who have serious underlying medical conditions.” Who determines this? Public health authorities. The purpose? The CDC explains: “physically separating high-risk individuals from the general population” allows authorities “to prioritize the use of the limited available resources.”

This sounds a lot like condemning people to death in the name of protecting them.

The model establishes three levels.

First is the **household level**.

Here high-risk people are“physically isolated from other household members.” That alone is objectionable. Elders need people to take care of them. They need love and to be surrounded by family. The CDC should never imagine that it would intervene in households to force old people into separate places.

The model jumps from households to the “**neighborhood level.**”

Here we have the same approach: forced separation of those deemed vulnerable.

From there, the model jumps again to the “**camp/sector level**.”

Here it is different. “**A group of shelters such as schools, community buildings within a camp/sector (max 50 high-risk individuals per single green zone) where high-risk individuals are physically isolated together**. One entry point is used for exchange of food, supplies, etc. A meeting area is used for residents and visitors to interact while practicing physical distancing (2 meters). **No movement into or outside the green zone.”**

Yes, you read that correctly. The CDC is here proposing concentration camps for the sick or anyone they deem to be in danger of medically significant consequences of infection.

Further: “to minimize external contact, each green zone should include able-bodied high-risk individuals capable of caring for residents who have disabilities or are less mobile. Otherwise, designate low-risk individuals for these tasks, preferably who have recovered from confirmed COVID-19 and are assumed to be immune.”

The plan says in passing, contradicting thousands of years of experience, “Currently, we do not know if prior infection confers immunity.” Therefore the only solution is to minimize all exposure throughout the whole population. Getting sick is criminalized.

These camps require a “dedicated staff” to “monitor each green zone. Monitoring includes both adherence to protocols and potential adverse effects or outcomes due to isolation and stigma. It may be necessary to assign someone within the green zone, if feasible, to minimize movement in/out of green zones.”

The people housed in these camps need to have good explanations of why they are denied even basic religious freedom. The report explains:

“Proactive planning ahead of time, including strong community engagement and risk communication is needed to better understand the issues and concerns of restricting individuals from participating in communal practices because they are being shielded. Failure to do so could lead to both interpersonal and communal violence.”

Further, there must be some mechanisms to prohibit suicide:

> Additional stress and worry are common during any epidemic and may be more pronounced with COVID-19 due to the novelty of the disease and increased fear of infection, increased childcare responsibilities due to school closures, and loss of livelihoods. Thus, in addition to the risk of stigmatization and feeling of isolation, this shielding approach may have an important psychological impact and may lead to significant emotional distress, exacerbate existing mental illness or contribute to **anxiety, depression, helplessness, grief, substance abuse, or thoughts of suicide among those who are separated or have been left behind**. Shielded individuals with concurrent severe mental health conditions should not be left alone. There must be a caregiver allocated to them to prevent further protection risks such as neglect and abuse.

The biggest risk, the document explains, is as follows: “While the shielding approach is not meant to be coercive, it may appear forced or be misunderstood in humanitarian settings.”

(It should go without saying but this “shielding” approach suggested here has nothing to do with focused protection of the Great Barrington Declaration. Focused protection specifically says: “schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from

home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.")

In four years of research, and encountering truly shocking documents and evidence of what happened in the Covid years, this one certainly ranks up at the top of the list of totalitarian schemes for pathogenic control prior to vaccination. It is quite simply mind-blowing that such a scheme could ever be contemplated.

Who wrote it? What kind of deep institutional pathology exists that enabled this to be contemplated? The CDC has 10,600 full-time employees and contractors and a budget of $11.5 billion. In light of this report, and everything else that has gone on there for four years, both numbers should be zero.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim Operational Considerations for Implementing the Shielding Approach to Prevent COVID-19 Infections in Humanitarian Settings

Interim Operational Considerations for Implementing the Shielding Approach to Prevent COVID-19 Infections in Humanitarian Settings

Updated July 26, 2020

Print

This document presents considerations from the perspective of the U.S. Centers for Disease Control & Prevention (CDC) for implementing the shielding approach in humanitarian settings as outlined in guidance documents focused on camps, displaced populations and low-resource settings.[1,2] This approach has never been documented and has raised questions and concerns among humanitarian partners who support response activities in these settings. The purpose of this document is to highlight potential implementation challenges of the shielding approach from CDC's perspective and guide thinking around implementation in the absence of empirical data. Considerations are based on current evidence known about the transmission and severity of coronavirus disease 2019 (COVID-19) and may need to be revised as more information becomes available. Please check the CDC website periodically for updates.

What is the Shielding Approach[1]?

The shielding approach aims to reduce the number of severe COVID-19 cases by limiting contact between individuals at higher risk of developing severe disease ("high-risk") and the general population ("low-risk"). High-risk individuals would be temporarily relocated to safe or "green zones" established at the household, neighborhood, camp/sector or community level depending on the context and setting.[1,2] They would have minimal contact with family members and other low-risk residents.

Current evidence indicates that older adults and people of any age who have serious underlying medical conditions are at higher risk for severe illness from COVID-19.[3] In most humanitarian settings, older population groups make up a small percentage of the total population.[4,5] For this reason, the shielding approach suggests physically separating high-risk individuals from the general population to prioritize the use of the limited available resources and avoid implementing long-term containment measures among the general population.

In theory, shielding may serve its objective to protect high-risk populations from disease and death. However, implementation of the approach necessitates strict adherence[1,6,7], to protocol. Inadvertent introduction of the virus into a green zone may result in rapid transmission among the most vulnerable populations the approach is trying to protect.

A summary of the shielding approach described by Favas is shown in Table 1. See *Guidance for the prevention of COVID-19 infections among high-risk individuals in low-resource, displaced and camp and camp-like settings* [1,2] for full details.

Table 1: Summary of the Shielding Approach[1]

Level	Movement/ Interactions
Household (HH) Level: A specific room/area designated for high-risk individuals who are physically isolated from other HH members.	Low-risk HH members should not enter the green zone. If entry is necessary, it should be done only by healthy individuals after washing hands and using face coverings. Interactions should be at a safe distance (approx. 2

	meters). Minimum movement of high-risk individuals outside the green zone. Low-risk HH members continue to follow social distancing and hygiene practices outside the house.
Neighborhood Level: A designated shelter/group of shelters (max 5-10 households), within a small camp or area where high-risk members are grouped together. Neighbors “swap” households to accommodate high-risk individuals.	Same as above
Camp/Sector Level: A group of shelters such as schools, community buildings within a camp/sector (max 50 high-risk individuals per single green zone) where high-risk individuals are physically isolated together.	One entry point is used for exchange of food, supplies, etc. A meeting area is used for residents and visitors to interact while practicing physical distancing (2 meters). No movement into or outside the green zone.

Operational Considerations

The shielding approach requires several prerequisites for effective implementation. Several are addressed, including access to healthcare and provision of food. However, there are several prerequisites which require additional considerations. Table 2 presents the prerequisites or suggestions as stated in the shielding guidance document (column 1) and CDC presents additional questions and considerations alongside these prerequisites (column 2).

Table 2: Suggested Prerequisites per the shielding documents and CDC’s Operational Considerations for Implementation

Suggested Prerequisites *As stated in the shielding document*	Considerations as suggested by CDC
• Each green zone has a dedicated latrine/bathing facility for high-risk individuals	• The shielding approach advises against any new facility construction to establish green zones; however, few settings will have existing shelters or communal facilities with designated latrines/bathing facilities to accommodate high-risk individuals. In these settings, most latrines used by HHs are located outside the home and often shared by multiple HHs. • If dedicated facilities are available, ensure safety measures such as proper lighting, handwashing/hygiene infrastructure, maintenance and disinfection of latrines. • Ensure facilities can accommodate high-risk individuals with disabilities, children and separate genders at the neighborhood/camp-level.
• To minimize external contact, each green zone should include able-bodied high-risk individuals capable of caring for residents who have disabilities or are less mobile. Otherwise, designate low-risk individuals for these tasks, preferably who have recovered from confirmed COVID-19 and are assumed to be immune.	• This may be difficult to sustain, especially if the caregivers are also high risk. As caregivers may often will be family members, ensure that this strategy is socially or culturally acceptable. • Currently, we do not know if prior infection confers immunity.

• The green zone and living areas for high-risk residents should be aligned with minimum humanitarian (SPHERE) standards.[6]	• The shielding approach requires strict adherence to infection, prevention and control (IPC) measures. They require, uninterrupted availability of soap, water, hygiene/cleaning supplies, masks or cloth face coverings, etc. for all individuals in green zones. Thus, it is necessary to ensure minimum public health standards[6] are maintained and possibly supplemented to decrease the risk of other outbreaks outside of COVID-19. Attaining and maintaining minimum SPHERE[6] standards is difficult in these settings for the general population.[8,9,10] Users should consider that provision of services and supplies to high risk individuals could be at the expense of low-risk residents, putting them at increased risk for other outbreaks.
• Monitor and evaluate the implementation of the shielding approach.	• Monitoring protocols will need to be developed for each type of green zone. • Dedicated staff need to be identified to monitor each green zone. Monitoring includes both adherence to protocols and potential adverse effects or outcomes due to isolation and stigma. It may be necessary to assign someone within the green zone, if feasible, to minimize movement in/out of green zones.
• Men and women, and individuals with tuberculosis (TB), severe immunodeficiencies, or dementia should be isolated separately	• Multiple green zones would be needed to achieve this level of separation, each requiring additional inputs/resources. Further considerations include challenges of accommodating different ethnicities, socio-cultural groups, or religions within one setting.
• Community acceptance and involvement in the design and implementation	• Even with community involvement, there may be a risk of stigmatization.[11,12] Isolation/separation from family members, loss of freedom and personal interactions may require additional psychosocial support structures/systems. See section on additional considerations below.
• High-risk minors should be accompanied into isolation by a single caregiver who will also be considered a green zone resident in terms of movements and contacts with those outside the green zone.	• Protection measures are critical to implementation. Ensure there is appropriate, adequate, and acceptable care of other minors or individuals with disabilities or mental health conditions who remain in the HH if separated from their primary caregiver.
• Green zone shelters should always be kept clean. Residents should be provided with the necessary cleaning products and materials to clean their living spaces.	• High-risk individuals will be responsible for cleaning and maintaining their own living space and facilities. This may not be feasible for persons with disabilities or decreased mobility.[11] Maintaining hygiene conditions in communal facilities is difficult during non-outbreak settings.[7,8,9] consequently it may be necessary to provide additional human resource support.
• Green zones should be more spacious in terms of shelter area per capita than the surrounding	• Ensure that targeting high-risk individuals does not negate mitigation measures among low-risk

camp/sector, even at the cost of greater crowding of low-risk people.	individuals (physical distancing in markets or water points, where feasible, etc.). Differences in space based on risk status may increase the potential risk of exposure among the rest of the low-risk residents and may be unacceptable or impracticable, considering space limitations and overcrowding in many settings.

Additional Considerations

The shielding approach outlines the general "logistics" of implementation –who, what, where, how. However, there may be additional logistical challenges to implementing these strategies as a result of unavailable commodities, transport restrictions, limited staff capacity and availability to meet the increased needs. The approach does not address the potential emotional, social/cultural, psychological impact for separated individuals nor for the households with separated members. Additional considerations to address these challenges are presented below.

Population characteristics and demographics

Consideration: The number of green zones required may be greater than anticipated, as they are based on the total number of high-risk individuals, disease categories, and the socio-demographics of the area and not just the proportion of elderly population.

Explanation: Older adults represent a small percentage of the population in many camps in humanitarian settings (approximately 3-5%[4,5]), however in some humanitarian settings more than one quarter of the population may fall under high risk categories[13,14,15] based on underlying medical conditions which may increase a person's risk for severe COVID-19 illness which include chronic kidney disease, obesity, serious heart conditions, sickle cell disease, and type 2 diabetes. Additionally, many camps and settlements host multiple nationalities which may require additional separation, for example, Kakuma Refugee Camp in Kenya accommodates refugees from 19 countries.[16]

Timeline considerations

Consideration: Plan for an extended duration of implementation time, at least 6 months.

Explanation: The shielding approach proposes that green zones be maintained until one of the following circumstances arises: (i) sufficient hospitalization capacity is established; (ii) effective vaccine or therapeutic options become widely available; or (iii) the COVID-19 epidemic affecting the population subsides.

Given the limited resources and healthcare available to populations in humanitarian settings prior to the pandemic, it is unlikely sufficient hospitalization capacity (beds, personal protective equipment, ventilators, and staff) will be achievable during widespread transmission. The national capacity in many of the countries where these settings are located (e.g., Chad, Myanmar, and Syria) is limited. Resources may become quickly overwhelmed during the peak of transmission and may not be accessible to the emergency affected populations.

Vaccine trials are underway, but with no definite timeline. Reaching the suppression phase where the epidemic subsides can take several months and cases may resurge in a second or even third wave. Herd immunity (the depletion of susceptible people) for COVID-19 has not been demonstrated to date. It is also unclear if an infected person develops immunity and the duration of potential immunity is unknown. Thus, contingency plans to account for a possibly extended operational timeline are critical.

Other logistical considerations

Consideration: Plan to identify additional resources and outline supply chain mechanisms to support green zones.

Explanation: The implementation and operation of green zones requires strong coordination among several sectors which may require substantial additional resources: supplies and staff to maintain these spaces – shelters, IPC, water, sanitation, and hygiene (WASH), non-food items (NFIs) (beds, linens, dishes/utensils, water containers), psychosocial support

and hygiene (WASH), non-food items (NFIs) (beds, linens, dishes/utensils, water containers), psychosocial support, monitors/supervisors, caretakers/attendants, risk communication and community engagement, security, etc. Considering global reductions in commodity shortages,[17] movement restrictions, border closures, and decreased trucking and flights, it is important to outline what additional resources will be needed and how they will be procured.

Protection

Consideration: Ensure safe and protective environments for all individuals, including minors and individuals who require additional care whether they are in the green zone or remain in a household after the primary caregiver or income provider has moved to the green zone.

Explanation: Separating families and disrupting and deconstructing multigenerational households may have long-term negative consequences. Shielding strategies need to consider sociocultural gender norms in order to adequately assess and address risks to individuals, particularly women and girls. [18,19,20] Restrictive gender norms may be exacerbated by isolation strategies such as shielding. At the household level, isolating individuals and limiting their interaction, compounded with social and economic disruption has raised concerns of potential increased risk of partner violence. Households participating in house swaps or sector-wide cohorting are at particular risk for gender-based violence, harassment, abuse, and exploitation as remaining household members may not be decision-makers or responsible for households needs.[18,19,20]

Social/Cultural/Religious Practices

Consideration: Plan for potential disruption of social networks.

Explanation: Community celebrations (religious holidays), bereavement (funerals) and other rites of passage are cornerstones of many societies. Proactive planning ahead of time, including strong community engagement and risk communication is needed to better understand the issues and concerns of restricting individuals from participating in communal practices because they are being shielded. Failure to do so could lead to both interpersonal and communal violence.[21,22]

Mental Health

Consideration: Ensure mental health and psychosocial support*,[23] structures are in place to address increased stress and anxiety.

Explanation: Additional stress and worry are common during any epidemic and may be more pronounced with COVID-19 due to the novelty of the disease and increased fear of infection, increased childcare responsibilities due to school closures, and loss of livelihoods. Thus, in addition to the risk of stigmatization and feeling of isolation, this shielding approach may have an important psychological impact and may lead to significant emotional distress, exacerbate existing mental illness or contribute to anxiety, depression, helplessness, grief, substance abuse, or thoughts of suicide among those who are separated or have been left behind. Shielded individuals with concurrent severe mental health conditions should not be left alone. There must be a caregiver allocated to them to prevent further protection risks such as neglect and abuse.

Summary

The shielding approach is an ambitious undertaking, which may prove effective in preventing COVID-19 infection among high-risk populations if well managed. While the premise is based on mitigation strategies used in the United Kingdom,[24,25] there is no empirical evidence whether this approach will increase, decrease or have no effect on morbidity and mortality during the COVID-19 epidemic in various humanitarian settings. This document highlights a) risks and challenges of implementing this approach, b) need for additional resources in areas with limited or reduced capacity, c) indefinite timeline, and d) possible short-term and long-term adverse consequences.

Public health not only focuses on the eradication of disease but addresses the entire spectrum of health and wellbeing. Populations displaced, due to natural disasters or war and, conflict are already fragile and have experienced increased mental, physical and/or emotional trauma. While the shielding approach is not meant to be coercive, it may appear forced or be misunderstood in humanitarian settings. As with many community interventions meant to decrease COVID-19 morbidity and mortality, compliance and behavior change are the primary rate-limiting steps and may be driven by social and emotional factors. These changes are difficult in developed, stable settings; thus, they may be particularly challenging in humanitarian settings which bring their own set of multi-faceted challenges that need to be taken into account.

Household-level shielding seems to be the most feasible and dignified as it allows for the least disruption to family structure and lifestyle, critical components to maintaining compliance. However, it is most susceptible to the introduction of a virus due to necessary movement or interaction outside the green zone, less oversight, and often large household sizes. It may be less feasible in settings where family shelters are small and do not have multiple compartments. In humanitarian settings, small village, sector/block, or camp-level shielding may allow for greater adherence to proposed protocol, but at the expense of longer-term social impacts triggered by separation from friends and family, feelings of isolation, and stigmatization. Most importantly, accidental introduction of the virus into a green zone may result in rapid transmission and increased morbidity and mortality as observed in assisted care facilities in the US.[26]

The shielding approach is intended to alleviate stress on the healthcare system and circumvent the negative economic consequences of long-term containment measures and lockdowns by protecting the most vulnerable.[1,24,25] Implementation of this approach will involve careful planning, additional resources, strict adherence and strong multi-sector coordination, requiring agencies to consider the potential repercussion among populations that have collectively experienced physical and psychological trauma which makes them more vulnerable to adverse psychosocial consequences. In addition, thoughtful consideration of the potential benefit versus the social and financial cost of implementation will be needed in humanitarian settings.

*Specific psychosocial support guidance during COVID-19 as specific subject areas are beyond the scope of this document.

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