

# Guidance on Home Quarantine & Isolation in Overcrowded Settings

Lebanon

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### List of abbreviations

COVID-19	Corona Virus Disease 2019
IPC	Infection Prevention & Control
IS	Informal Settlement
LCRP	Lebanon Crisis Response Plan
MoPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
NGO	Non-Governmental Organization
NAK	New Arrival Kit
PHC	Primary Health CarePrimary Health Care
PHC	Primary Healthcare Centers
PHU	Public Health Unit
PPE	Personal Protective Equipment
SDCs	Social Development Centers
SOP	Standard Operating Procedure
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation & Hygiene
WHO	World Health Organization

# 1 Introduction

On December 29, 2019, a hospital in Wuhan, Hubei Province, China reported an outbreak of severe unexplained viral pneumonia. The Chinese government notified World Health Organization (WHO) about the outbreak after verification. On January 8, 2020, the pathogen of this outbreak was identified as the novel coronavirus 2019 (2019-nCoV), and its gene sequence was submitted to WHO. On 30 January 2020, the World Health Organization (WHO) declared the 2019 coronavirus disease (COVID-19) outbreak a public health emergency of international concern (PHEIC)<sup>[1]</sup> and on March 11, WHO declared COVID-19 as a pandemic. In Lebanon, on 21 February 2020, the first case of COVID-19 was confirmed. Since then, more cases have been reported with history of travel or contact with confirmed cases with a travel history.

Home isolation/ quarantine is a public health technique employed to tackle the spread of disease. The transmission of COVID-19 can be greatly reduced by keeping a confirmed or suspected individual separated from the rest of the population. The ability to use this technique in overcrowded settings is particularly challenging, where the space in homes and shelters is limited and typically shared by many people. Overcrowding is defined as a situation in which a person is living in a space that is less than 4.5m<sup>2</sup> per person. This situation is applicable across shelter and settlement types (residential, non-residential and non-permanent structures) however, is most apparent in informal settlements and collective shelters (CS). It is estimated that 19% of refugees live in Informal Settlements<sup>1</sup> (IS), 11% in non-residential building, among which 42 % are overcrowded, and 26% are in residential shelters.<sup>[1]</sup> Overcrowded settings can be in urban and semi-urban areas and host a diverse population, including nationals and non-nationals.

The purpose of this document is to provide guidance on how quarantine and isolation can be achieved if there is a suspected or confirmed case in an overcrowded setting. It will focus on informal settlements and collective shelters, but the guidance can be applied in non-refugee settings as well, such as detention centres and crowded neighborhoods. This guidance aims to support a coordinated and efficient response. It supports detailed planning at the regional level and is meant to be adapted to the local context. Households residing outside of these shelter types will be expected to follow the self-isolation circular provided by the MoPH. It is preferable, whenever feasible, that people are supported to remain in their homes. This guidance note will be continuously adapted as needed from the National level.

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<sup>1</sup> ~5,746 Informal Settlements are distributed across the country comprising 57,605 HH; 302,295 persons. There is an average of 5.24 individuals per household.

## 1.1 Case Definitions

The Ministry of Public Health developed case definitions for suspected, probable and confirmed cases of COVID-19 (note that the following case definitions may change with outbreak evolution<sup>2</sup>);

### 1.1.1 Suspected Case:

- A. Patient with acute respiratory infection (fever and at least one symptom of respiratory disease),
  - AND with no other etiology that fully explains the clinical presentation,
  - AND a history of travel to or residence in a country/area reporting local transmission of COVID-19 during the 14 days prior to symptom onset.
- B. Or a patient with any acute respiratory illness
  - AND having contact with a confirmed/probable COVID-19 case in the last 14 days prior to symptom onset.
- C. A patient with severe acute respiratory infection (fever and at least one symptom of respiratory disease),
  - AND requiring hospitalization,
  - AND with no other etiology that fully explains the clinical presentation.

### 1.1.2 Probable Case:

- A suspect case for whom testing for COVID-19 is inconclusive.

### 1.1.3 Confirmed Case:

- A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms. Confirmatory tests include positive serology in paired serum samples, specific Polymerase chain reaction (PCR), or genome sequencing.

### 1.1.4 Caregiver:

- Caregivers are defined as a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person. Caregivers shall be identified and trained ideally by health care professionals when possible or another trained

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<sup>2</sup> <https://www.moph.gov.lb/en/Media/view/27343/novel-coronavirus-2019->

partner. Infants and children under the age of 18 should not be separated from their caregivers at any point, unless otherwise decided by the parent and based on the principles of best interest .

#### 1.1.5 [Isolation vs Quarantine:](#)

- Quarantine is a technique used to separate healthy individuals, who may have been exposed to the virus, from the rest of the population, with the objective of monitoring symptoms and early case identification.
- Isolation is a technique used to separate infected persons (confirmed cases) from those who are not infected (suspected/ non suspected cases), in order to prevent spread or contamination.
- A quarantined person is considered infected for the duration of the quarantine period, therefore the same rules and procedures apply to both categories (i.e. quarantine and isolation) in terms of the Infection Prevention & Control Infection Prevention & Control IPC measures to be in place.
- People in quarantine should not be mixed with confirmed cases in isolation.

## 2 Home Quarantine/ Isolation in Overcrowded Settings

Home quarantine/ isolation measures could apply to asymptomatic cases that have been exposed to the virus and need to be quarantined. It can also apply to cases who are confirmed and have mild symptoms that require isolation in their homes rather than in a health facility.

If a person is quarantined or isolated in a household with several other individuals, precautionary measures should be taken to keep them separated. This is especially important for household members who are elderly or chronically ill. The isolated/quarantined person should not leave the home and will be dependent on the household members to meet their basic needs, such as providing them with food or removing any waste.

The ability of individuals and families to quarantine or isolate themselves will depend on the type of house and/or shelter where they live. Home quarantine or isolation in informal settlements, collective shelters or other overcrowded settings will follow the guidance provided by MoPH on how to self-isolate, assuming they are well enough and do not require hospitalization. These individuals need to be supported by a caregiver. Throughout the process of quarantine or isolation, specific considerations will need to be adopted for vulnerable groups (i.e. older persons

without caregivers, unaccompanied and/or separated children, persons with disabilities, children headed households and breastfed babies).<sup>3</sup>

To achieve quarantine or isolation, a separate ventilated bedroom is required where the quarantined or self-isolated person can recover without sharing an immediate space with others. If this cannot be achieved in the household's current housing arrangement, specific facilities will be set-up for this purpose.

In accordance with WHO guidelines, quarantined or self-isolated persons should have safe and dignified access to an adequately ventilated single rooms, with dedicated toilet, hand hygiene and washing facilities<sup>4</sup>. Where this cannot be achieved, mitigation measures shall be put in place in order, to the extent possible, to comply.

Training materials for caregivers are being developed and a rollout plan agreed, including who and how caregivers are identified, how their additional needs would be met, and who will monitor the quality of support given. Caregivers should be provided and equipped with basic PPE to protect themselves from any potential transmission. The PPE provided should follow WHO guidance<sup>5</sup>. They should also be provided with information to access MHPSS support.

Cases that need to be quarantined/isolated will be identified based on the most updated MoPH case definition and they will follow the national referral pathway for case identification. Parents/caregivers and children suspected of COVID-19 should ideally be quarantined/isolated together. If not possible, steps should be taken to allow family members to visit their children (at place of isolation) to give them food and talk to them, for example by wearing protective gear based on existing guidelines. The Child Protection Psycho-Social Support working group will be developing guidance note on the provision of emotional support which can be used by caregivers.

All existing modalities for community outreach will be adapted and used to provide information on COVID-19 which will help to reduce stress and anxiety. This will include information on the expected role of the community and available hotlines (health and protection). It will also

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5 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

encourage individuals to confidentially report suspected cases of COVID-19 and serve to promote acceptance in the community for identified cases. Community members such as volunteers, focal points, community groups and networks will proactively contact individuals and families who are particularly vulnerable in order to share information on preventative and response measures. These mobilized community members will help to provide insights into community perceptions and practices around COVID-19 which will help to inform the response. Remote protection monitoring in refugee communities will be used to increase efficiency of the response by identifying trends to adapt communication and case identification.

The trigger for a response is outlined below:

1. A person in need of isolation or to be quarantined can be identified through various different ways:
  - a. Self-reporting to UNHCR call-center
  - b. Identified by partner organization
  - c. Mobilized community members
  - d. Positive test-result reported through the UNHCR referral care programme/NEXtCARE/MoPH
2. A rapid response team consisting of health, shelter, WASH and protection is alerted, preferably through one identified focal point;
3. An initial assessment is done by the health focal point by telephone or video to establish if it is necessary to do a field visit. Basic information is obtained about possible assistance required as well as guidance provided on immediate precautionary measures to take, including how to contact MoPH if this has not already been done;
4. Based on the initial assessment, a rapid response team consisting of health, shelter, WASH and protection is deployed as required:
  - a. Health to estimate the number of cases that will need isolation/quarantine within the location in the near future;
  - b. Shelter/wash assesses the capacity of the location for isolation and quarantine and establish need for further construction
  - c. Protection assesses specific protection needs and engages the community in the plan and their role, ensuring full participation of women and other groups. Persons in need of mental health support or case management should be referred as per the referral pathways.
5. Depending on assessment, decision on which number and type of facilities and provision of basic information to location management. Provision of health guidelines and limited number of PPEs for initial ad-hoc isolation are provided.
6. Shelter and WASH partners to provide appropriate response based on the identified need, e.g. preparation of existing shelter or empty tent or set up of separate facility;
7. Information to people in need of isolation, caregivers and management to be disseminated to the community (as per the engagement plan agreed on) and passed on to eventual new cases that need isolation.

The above is a general guideline that should be adapted to take into consideration various factors such as the percentage of affected households, the size and housing capacity of different



overcrowded settings, the capacity of the community to self-manage and the different levels outlined below.

### 2.1.1 Level.0 No suspected or confirmed case

At this stage the water sector shall mitigate the risk of contamination through preventive activities. Hygiene promotion messages are intensively addressed to the communities, following the training module specifically designed on COVID-19. The training is accessible on-line, see Annex 3. UNHCR, through its refugee communication platform, will inform refugees on general COVID19 awareness, what to do if a person has symptoms, and the premise of quarantine/ self-isolation and social distancing. Training will be provided to the rapid response team on the emergency response and tools. It is recommended that they also be trained on Psychological First Aid. The vacant capacity of the IS or CS will be determined as well as possible alternative facilities in case of need.

### 2.1.2 Level.1 Quarantine or Self-Isolation at Home (Household Level)

Level 1 quarantine or self-isolation is considered applicable where there is existing capacity within the IS or CS in which suspected or confirmed individuals can achieve quarantine or isolation. This capacity is determined by the availability of vacant rooms, tents or housing units within the IS or CS. The existing referral pathways will be used if non-health partners identify cases.

Upon identification, the rapid response team will visit the IS or collective shelter if support can not be provided remotely. The health partner will make an initial determination of the number of suspected cases within the IS or CS. The suspected case will be advised to quarantine within one sleeping area of the IS or CS. The rapid response team<sup>6</sup> will provide a briefing and a guidance note to the household/ caregiver of the suspected/ confirmed case detailing practical tips on how to undertake minor shelter modifications in order to achieve WHO quarantine/ isolation criteria. Trainings of caregivers<sup>7</sup> shall be undertaken and supplied with basic PPEs (if needed), such as gloves and masks. The necessary shelter, water, sanitation and hygiene items will be provided to ensure adequacy of isolation spaces in accordance with the set guidelines of the WASH and Shelter sectors outlined in Appendixes 1 and 3.

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<sup>6</sup> Well informed, trained and equipped with protective measures to mitigate risk, the team should be limited to minimal number of members needed for the assessment

<sup>7</sup> When applicable (child case/ person with specific need/ medical condition/ etc), caretaker is a consenting adult, who accept to take care of the isolated case XXX more details XXXX

Additional support (i.e. emergency cash) will be considered to ensure ongoing access to basic needs, such as food. The ability to provide this support will be limited by staff capacity, ability of individuals or community members to do it themselves, contextual situation and funding levels. The proposed Level 1 support will be based on a standardized assessment, and is likely to include;

- a) Provision of shelter items to create partitions if required/ feasible;
- b) Provision of doors and door frames, if not present between the isolation room and rest of the shelter;
- c) Provision of a temporary toilet (if feasible) or advice/ guidance on the allocation of an existing toilet to be used exclusively by the suspected case;
- d) Regular desludging (IS only);
- e) Installation of a handwashing facility nearby the latrine (if not already present);
- f) Provision of a suitable amount of soap and disinfection products to permit regular cleaning of the isolation room and other areas of the tent;
- g) Provision of PPE materials in accordance with WHO guidelines;
- h) Connection of the isolation room directly to the existing water tank (if feasible).

The advantages of this option include, minimal involvement of field staff, maintaining the suspected case in the IS or CS, reduced risk of transmission associated with transport (i.e. less movement = less risk), ease of implementation, and keeps the case close to caretaker. The disadvantages are that it requires a high level of commitment and cooperation from the IS or CS population.

### 2.1.3 Level.2 Quarantine or Isolation (Community Level)

This option is considered applicable when there is no or limited capacity within the IS or CS to facilitate the quarantine or isolation of a suspected or confirmed case(s) identified. In this level, the IS or CS does not have a sufficient number of vacant rooms, tents or housing units to achieve the quarantining or isolation of suspected or confirmed cases. As such, a dedicated temporary 'facility' is constructed within the plot boundary of the IS or CS (space permitting) to permit quarantining or isolation of suspected or confirmed cases. Note, as suspected and confirmed cases must not be mixed, it is likely that level 1 and 2 may run in parallel, for example, suspected cases may be quarantined at the household level (level 1) and confirmed cases aggregated at the community level (level 2).

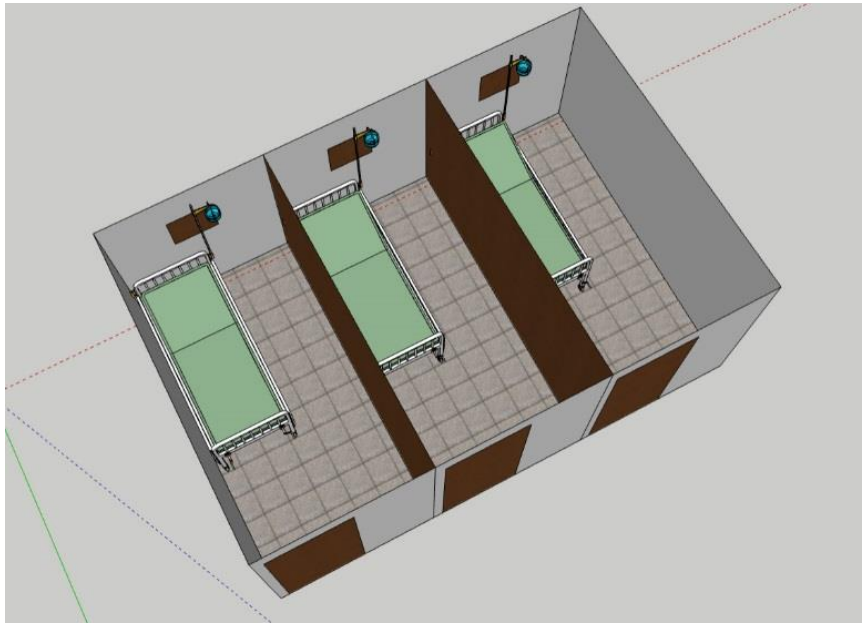
As per level 1, the rapid response team visit the IS or collective shelter and makes an initial determination of the number of suspected and confirmed cases within the IS or CS. Once it is determined that capacity does not exist to achieve satisfactory quarantine or isolation the rapid response team will determine feasibility of establishment of a standalone facility within the plot

boundary of the IS or CS. The size of the proposed facility will be guided by the current and projected number of suspected cases within the IS or CS.

The construction of a temporary facility shall be based on standardized design options, as outlined in Appendix 1. The design shall be modified by the shelter partner with support, if necessary, from the regional shelter coordinator. Modifications to the design are expected to be required in accordance with space availability, ground conditions, landlord preference, community preference, specific needs (disability) number of suspected or confirmed cases, and number of projected suspected or confirmed (i.e. design capacity). It should also take into considerations gender specification such as male and female separation, space for prayer, etc.

The shelter partner shall, using UNHCR materials (timber, plywood, plastic sheeting, etc.) be responsible for the construction of the temporary facility and shall procure the necessary cement and aggregate for the casting of a concrete base. Exceptionally, prefabricated units may be installed, space permitting and where the use of the shelter materials cited above is not feasible. On the basis of emergency, it is understood that MoSA will permit the casting of concrete bases, obtain landlord permissions (if necessary) and that no rent shall be payable by the refugee community,

The facility would have protection measures put in place (separation and isolation levels) to prevent risks of SGBV and child harassment and abuse and to protect infants and breastfeeding mothers. It would have clear complaints and feedback mechanism in place. The proposed layout (design) is within Appendix 1 and can be modified in accordance with site requirements, shelter and health sector guidance. The facility will be temporary in nature, made of wood and plastic sheeting. Physical partitions between individuals will ensure safety and dignity of those being accommodated. Non-Food Items will be provided based on identified needs.



Level 2 – Module 1



Level 2 – Module 2

While Appendixes 1 and 3 detail the shelter and WASH specifics, the proposed Level 2 support will be based on a standardized assessment, and is likely to include;

- a) Site assessment to determine appropriate location for the establishment of temporary facility;
- b) Adjustment to the standard temporary facility layout (design), if required;
- c) Site preparation and construction of temporary facility, if required;
- d) Identification of an outdoor play/ relax area designated for suspected or confirmed cases (especially children), if space permits;

- e) Installation of temporary toilets (one per 15 people maximum, separated by gender);
- f) Installation of handwashing facilities adjacent to toilets, regularly supplied with soap;
- g) Water tank installation with connection to the temporary facility and handwashing facilities;
- h) Provision of safe water and desludging services (services providers will be trained on IPC and provided with prevention equipment).
- i) As per Level 1 the water sector will provide soap, chlorine, disinfectant products, awareness sessions, safe water and desludging services and at least one public handwashing facility;
- j) The caregiver will be required to ensure the cleaning and disinfection of isolation rooms, latrines and hand washing facilities, after each use, especially when shared between suspected cases.

The advantages of this option are in line with those of level 1. Disadvantages are that it requires space within IS or CS (if space is not present, non-affected HHs may be requested to move to other settlements or to a level 3 facility, see below). It is estimated to take one day to construct the structure, especially if the rapid response team has not done it before. There may also be elevated protection risks and necessity to have separate facilities. Community may reject the establishment of facility or create further stigma within the IS or CS. This should be addressed through community engagement and sharing appropriate information by the health partners working within the site, in advance. Establishing a facility within an existing IS with suspected cases exposes field staff to the risk of transmission. This should be addressed by community management and 'stay at home' to staff messaging prior to the implementation of work.

#### 2.1.4 [Level.3 Municipal or Area Level Quarantine or Isolation](#)

This option is considered applicable when there is no capacity within the IS or CS to facilitate the quarantine or isolation of a major number of suspected or confirmed cases. Note, all attempts should be made to find a solution within the informal settlement or collective shelter prior to moving to level 3. In this level, the IS or CS does not have a sufficient number of vacant rooms, tents or housing units to achieve the quarantining or isolation of suspected or confirmed cases. As such, a dedicated facility is constructed or found at the area or municipal level to permit quarantining or isolation of suspected or confirmed cases. Note, as suspected and confirmed cases must not be mixed, it is possible that levels 1, 2 and 3 may run in parallel, for example, suspected cases may be quarantined at the household level (level 1), a portion of confirmed cases may be aggregated at the community level (level 2), and the remaining confirmed cases may be moved to the area or municipal level 3 facility.

Upon identification of this need, the authorities will be consulted to activate one of the pre-identified locations, in close proximity to the cluster of IS and/ or CS in which a major number of suspected cases are located/ likely to occur.

This facility may will be implemented through the erection of a rubbhall, a sequence of prefabricated structures or through the occupation of an existing building. In level 0, the rapid response teams in each region have and continue to identify, in conjunction with MoSA/ MoIM, suitable lands or existing buildings for level 3 facilities.

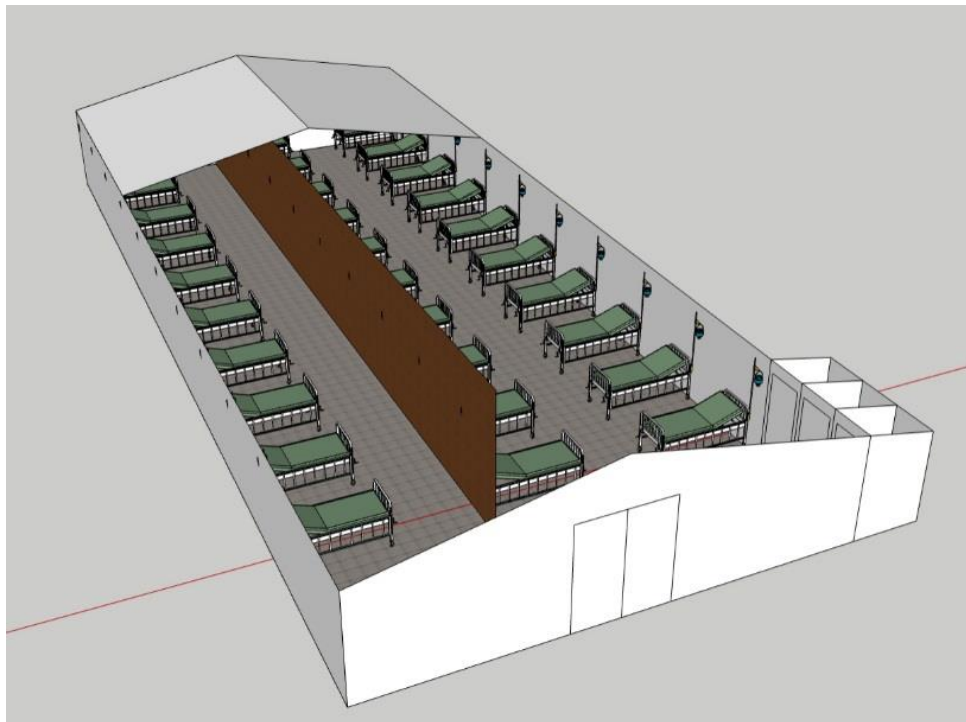
The shelter and WASH sectors will be responsible for the technical assessment of the proposed lands for the installation of a rubbhall and/or prefabricated structures, refer to Appendix 1 for the assessment form and associated designs. Once deemed suitable, UNHCR, through contractors, will undertake the construction of the level 3 facility with support from partners. In the case of existing buildings, the shelter and WASH sectors shall be required to assess the suitability of the structures for occupancy and determine the need for minor rehabilitation works (if any).

It is preferred that the level 3 facility is managed by the local authorities with support from humanitarian actors. However, if this is not feasible health partners (or non-health partners with health partner support) shall be identified to manage the level 3 facilities. Even if a level 3 facility is used for confirmed cases, it is important to notice that its main function is not to deliver health care. The “tenants” would only exhibit mild symptoms, not be in need of hospital care and if housing arrangements would have allowed, they would have been advised to stay in their own homes without any medical assistance. A certain level of monitoring would however be recommended in order to identify cases whose condition is deteriorating and are in need of transfer to a hospital.

Refer to Appendix 5 for details of the scope of services of level 3 facility management.

Special measures, such as physical separation between individuals will need to be put in place to reduce the risk of violence, such as SGBV. Access of persons with disabilities should also be built into the facility. The facility will be available to

both the hosting community and refugees to reduce tension. Messages will be developed to ensure communication of the strategy and steps being taken to ensure protection for all. Municipalities will be involved as much as possible in the identification of the location and/or facility. For example, in some areas the refurbishment of buildings could be seen positively as



contributing to the community in the longer term. It can take an extended period of time to construct the structure, especially if the rapid response team has not done it before. Food and other kind of support need to be explored to ensure success of implementation for this option.

Similar to level 2, an outdoor area designated for both children and adults will be provided for play and relaxation (if space permits).

The advantages of this option are that it permits centralized treatment of confirmed cases, and locations can be pre-identified in similar manner to Cholera treatment Centers. Disadvantages are it require movement of suspected cases away from community/ family caregivers, requires financial resources and investment (constr. of structure/ latrines/ prov. of food, mattresses, blankets, etc.), and relies or needs safe transport arrangements (LRC or similar).

#### [2.1.5 Level.4 Full IS Quarantine or Isolation](#)

This option is considered applicable when the number of suspected and/ or confirmed case(s) identified within IS or CS occupy more than 50% of the tents (IS) or housing units. The entire IS

or CS will be placed under a state of quarantine/ isolation with restriction in movement for a period of time. A decision to restrict movements to and from an IS or CS might be taken at an earlier stage. This depends on risk assessment and municipal authority decisions.

In the level 4 scenario it might also be considered to use level 2 or 3 structures to house asymptomatic people from vulnerable groups (elderly/chronic illnesses etc.) to protect them from infections.

The response to level 4 mirrors that of level 1 in which guidance is provided to the full IS or CS on how to achieve the necessary shelter adjustments to achieve quarantine/ isolation objectives. As all households are considered suspected or confirmed cases, additional WASH facilities may not be required. However, there should be efforts placed to ensure that suspected and confirmed cases are not in contact or sharing common WASH facilities.

Food and other kind of support need to be organized to ensure success of implementation for this option.

While the above sections outline broad guidance on the parameters used to undertake level determination and the associated options to achieve quarantine or isolation, there will be a host of other factors that should be taken into account. As such, it is likely that various levels may be running in parallel to achieve the required quarantine/ isolation objectives.

### 3 Planning, Coordination and Logistics

The different levels will need separate implementation plans, and a set of specific triggers for activation (number of confirmed cases/ where/ when/ etc.). The plan relies on set and clear referral criteria, for instance the confirmation of home-isolation advice/ need will be exclusively decided by MoPH, designated authorized teams. The MoPH team and through hot-line can assess, advise and, when required, develop quarantine conditions in line with MoPH guidelines.

#### 3.1 Case Transport to hospitals or level-3 facilities

Coordination with LRC on case transport is required and continues to apply. When number of cases increases, MoPH and LRC will advise on suitable alternatives case transport options.

#### 3.2 Implementation modality



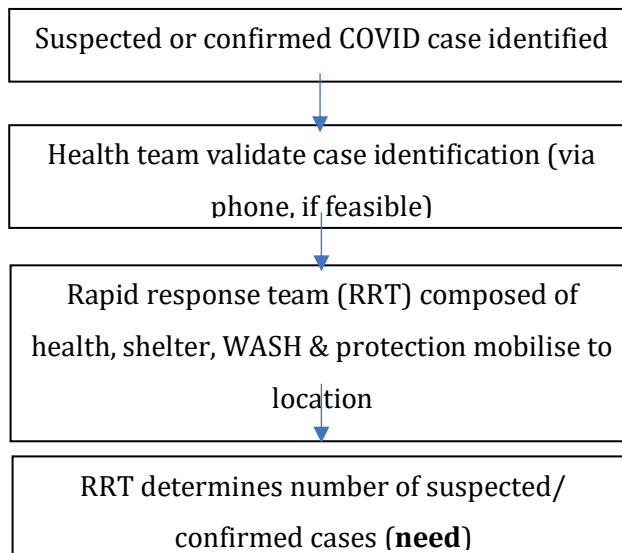
A network of multi-functional teams composed of partners from different sectors (Health, WASH, Shelter, Protection, CwC) are being formed on regional levels (or other modality) to intervene in support in any of the four scenarios.

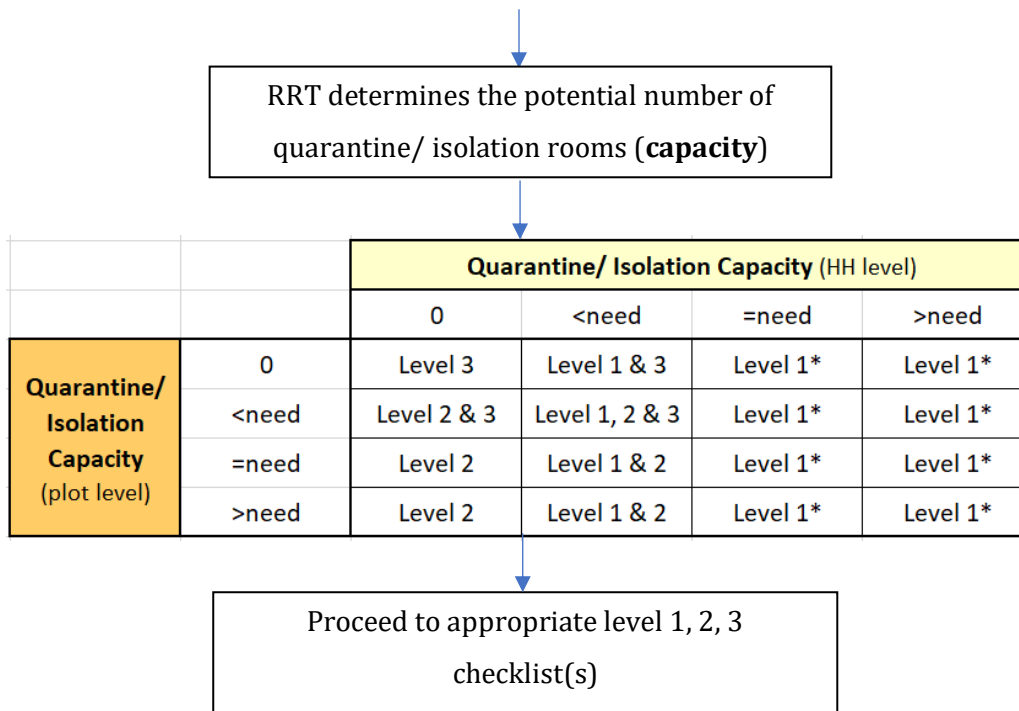
### 1. Objective

The objective of this note is to support the Health sector in proposing design solutions for temporary standalone isolation facilities in IS or CS for both **level 2** (community level) and **level 3** (municipal/ area level). The following criteria guided the proposed design options:

- The facility shall be temporary in nature thus installed with temporary materials;
- Considerations shall allow for design flexibility, site constraints, adapting available surface area;
- The facility shall ensure no or minimum interaction between the suspected cases and the inhabitants of the IS or CS;
- For level 2, suspected and confirmed cases shall be quarantined or isolated in dedicated non communicating spaces;
- The facility shall include necessary services including temporary toilets (one per 15 people maximum, separated by gender), and other amenities as needed (space for care taker);

### 2. COVID19 – Level Determination & Associated Checklists





Guidance notes on above table for level determination;

- The above table provides guidance on level determination based on confirmed need (i.e. suspected & confirmed cases) and available quarantine/ isolation rooms (capacity) at both HH and plot level.
- For example;
- 10 cases are identified as suspected/ confirmed (by the health member of the RRT in 10 different apartments of a collective shelter);
- Based on discussions with the community/ HH representatives it is thought that there is potential quarantine/ isolation capacity within 4 (only) of the 10 apartments;
- Utilising the level 1 checklist (below), the shelter member of the RRT validates satisfactory quarantine/ isolation space within 5 apartments;
- Using the level 2 checklist, space is identified within the building plot of the CS for the feasible establishment of a level 2 facility (prefab or tented structure) which can accommodate 4 suspected or confirmed cases.
- As such the following levels are deemed relevant;

		Quarantine/ Isolation Capacity (HH level)			
		0	<need	=need	>need
Quarantine/ Isolation Capacity (plot level)	0	Level 3	Level 1 & 3	Level 1*	Level 1*
	<need	Level 2 & 3	Level 1, 2 & 3	Level 1*	Level 1*
	=need	Level 2	Level 1 & 2	Level 1*	Level 1*
	>need	Level 2	Level 1 & 2	Level 1*	Level 1*

- i.e. HH quarantine/ isolation capacity is less than the need (5 of 10), the plot level capacity (in conjunction with the HH capacity) is also less than the need (a further 4 of 10) noting that 1 remaining case shall be accommodated within a level 3 facility.

### **Level 1 Checklist**

This checklist applies to all available potential quarantine/ isolation rooms at location (occupied and unoccupied). Extent of level 1 material assistance is proposed as;

Plastic sheeting (LRK);

And/ or 8mm plywood and associated timber (for door installation);

FO can determine capacity to provide further assistance (if needed).

- Quarantine/ isolation room is intact and properly weatherproofed from external elements;
  - If no, distribute LRK;
  - If LRK is insufficient then proposed quarantine/ isolation room is not adequate.
- Minimum size of isolation/ quarantine room 2m x 2.5m= 5sqm;
  - If no then proposed quarantine/ isolation room is not adequate.
- Quarantine/ isolation room door is lockable and adequately seals from the rest of the shelter;
  - If no, distribute plywood & timber to install door.
- The quarantine/ isolation room has a window/ventilation outlet;
  - If no,
    - In IS, advise HH to roll up plastic sheeting off the sides of the tent to allow for ventilation;
    - In CS, consider another room with window/ventilation outlet, or support with the opening of window/ ventilation outlet if there is capacity and material availability.
- The quarantine/ isolation room has one lighting point and electrical outlet, preferable but not essential.
- For WASH requirements, refer to water sector guidance.

## **Level 2 Checklist**

This checklist applies to identification and assessment of suitability of available space/ land at location for the establishment of additional quarantine/ isolation capacity.

1. Is there space/ land space available within the plot boundary or building line of location?
  - 1.1. If no, refer to level 3.
  
2. Is the available space/ land expected to flood between April-September?
  - 2.1. If yes, can the flood be mitigated through site improvement works?
    - 2.1.1.If no, end assessment.
  
3. How many cases can the available space/ land accommodate?

[Please refer to attached guidelines for level 2 facility design.  
Rule of thumb: 9m<sup>2</sup> required per person (includes rooms, circulation & setbacks).  
Number of quarantine/ isolation rooms should be sufficient to accommodate the number of cases which cannot be quarantined/ isolated at level 1 in addition to the number of caretakers designated by the community].

  - 3.1. For cases which cannot be accommodated at level 2, refer to level 3.
  
4. Is the available space/ land accessible by service delivery vehicles (water-trucking, desludging, solid-waste collection, other)?
  - 4.1. If yes, conclude assessment;
  - 4.2. If no, is service delivery still manageable?
    - 4.2.1.If yes, conclude assessment;
    - 4.2.2.If no, site is not suitable for establishment of level 2 quarantine/ isolation rooms.
  
5. For WASH requirements, refer to water sector guidance.

## **Level 3 Checklist – Green Field Sites**

This checklist applies to identification and assessment of suitable sites that can host cases coming from IS or CS that have insufficient capacity to facilitate the quarantine or isolation of cases at level 1 and/ or level 2;

*Legal / Communal Aspect*

1. Does the identified site have an identified legal owner or legal representative?
2. If yes, is the legal owner/representative willing to allocate the land for the establishment of a Level 3 facility including acceptance of installation of WASH facilities for a period of at least 6 months?
3. If yes, does the local authority accept to establish a level 3 facility on the identified site?

#### *Topography*

4. Is the site subject to potential floods between April and September?
5. Is the access road subject to blockage due to expected floods from April to September?
6. What is the site slope percentage?
  - a. Flat: 0-2%
  - b. Slight: 2-4%
  - c. Steep: 4% and above
7. Is there existing vegetation on the site?
8. Is there evidence/risk of landslide?
9. Does the soil nature of the site permit levelling using compacted selected gravel?
10. Does the soil nature of the site permit establishment of a reinforced concrete slab without further foundations?

#### *Physical Accessibility*

11. Does the site have direct access by road?
12. Does the site have connection to, or can be easily connected to;
  - a. Water network/ suitable water source;
  - b. Sewerage network;
  - c. Electrical grid.

#### *Site capacity*

13. What is the estimated surface area of the identified site?
14. How many cases can the identified site host based on required 9m<sup>2</sup> per case (rule of thumb)?

#### *Security*

15. Is there any information about potential existence of land mines and UXOs within and/or near this site?
16. Is the site location less than 500 meters in proximity to Police, Army checkpoint and military base?
17. What is the distance from borders?
18. Is this site vulnerable to security risks? (i.e. clashes or other security events)

### **Level 3 Checklist – Existing Buildings**

#### *General information*

1. What is the identified building name?
2. What is the building type? (School / Public facility / Warehouse / Mosque / Church / Hotel / Other-please specify)

### *Legal / Communal Aspect*

3. Does the identified building have an identified legal owner or legal representative?
4. If yes, is the legal owner/representative willing to allocate the building for the establishment of a Level 3 facility for a period of at least 6 months?
5. If yes, does the legal owner/representative permit to conduct required minor repair/construction?
6. If yes, does the local authority accept to establish a level 3 facility in the identified building?

### *Physical Accessibility*

7. Does the building have direct access by road?
8. Does the building have connection to, or can be easily connected to;
  - a. Water network/ suitable water source;
  - b. Sewerage network;
  - c. Electrical grid/generator (#of KVA);

### *Surrounding*

9. Are the surrounding sites expected to flood between April and September and to impact the identified building?
10. Does stormwater/wastewater accumulate in vicinity of shelter.
11. Is Drain/soakage pit available to dispose of wastewater safely.

### *Security*

12. Is there any information about potential existence of land mines and UXOs within and/or near this building?
13. Is the building location less than 500 meters in proximity to Police, Army checkpoint and military base?
14. What is the distance of the building from borders?

### *Building capacity*

15. What is the number of rooms in the identified buildings?
16. How many isolation spaces can the identified buildings host based on suitable rooms (space per bed is estimated to 5m<sup>2</sup> including internal room circulation).
17. What is the number of available toilets?
18. What is the average number of cases per toilet?
19. Does the building have a car parking? (what is the number of lots?)

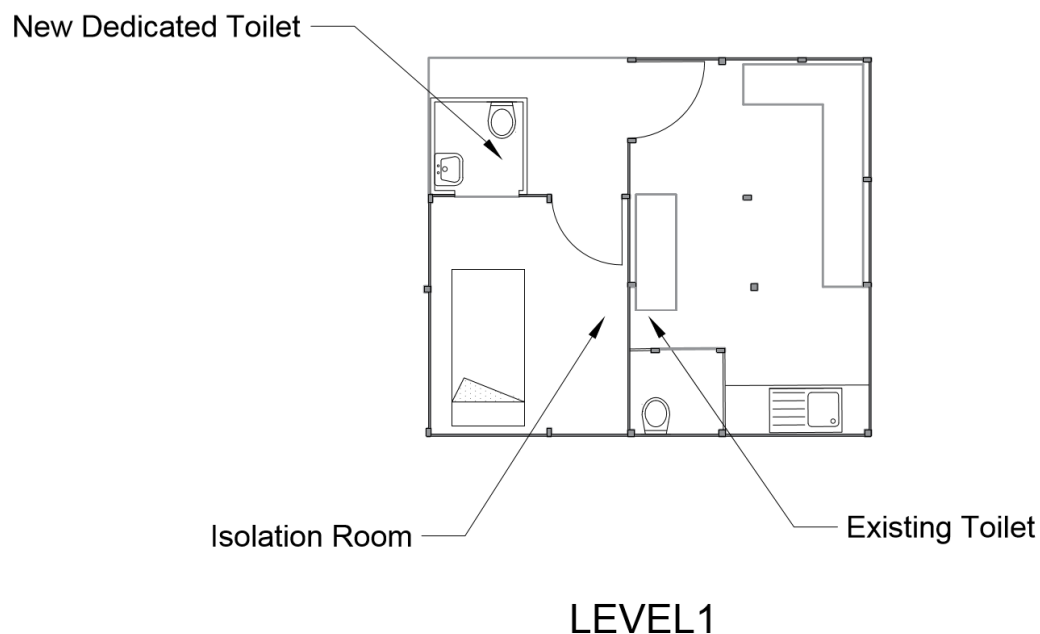
### *Building physical assessment*

20. What is the building physical conditions?
  - a. Safe - no repairs needed
  - b. Safe - minor repairs needed
  - c. Safe – major repairs needed
  - d. Not safe

21. What is the ease level for PWSN access (railing on circulation stairs, and ramps)?
  - a. Poor
  - b. Fair
  - c. Good
22. What are the available service rooms? (i.e. fuel room, water pump room)
23. What is the list of required repairs?
  - a. Weatherproofing of walls and ceiling against the elements;
  - b. Rainwater management through screed for better water evacuation;
  - c. Provision/repair of lockable external/internal doors;
  - d. Installation/repair of lockable windows in rooms to be used for isolation purposes;
  - e. Water connection including internal and external water piping linking to water source;
  - f. Provision of toilet seats, lavatories, sinks, showers, water tabs, hot water tank
  - g. Sewage connection including internal evacuation piping and external outlets leading to sewerage network/septic tank/other);
  - h. Construction of septic tank;
  - i. Provision of water tanks of 1 m<sup>3</sup> capacity;
  - j. Lighting and cabling/repair of exposed wires in the common area and rooms of the Building (light Bulbs with sockets and cover).

### 3. Technical drawings and specifications:

For level 1, the below guidance note should be provided to the household/ caregiver of the suspected/ confirmed case detailing practical tips on how to undertake minor shelter modifications in order to achieve WHO quarantine/ isolation criteria.



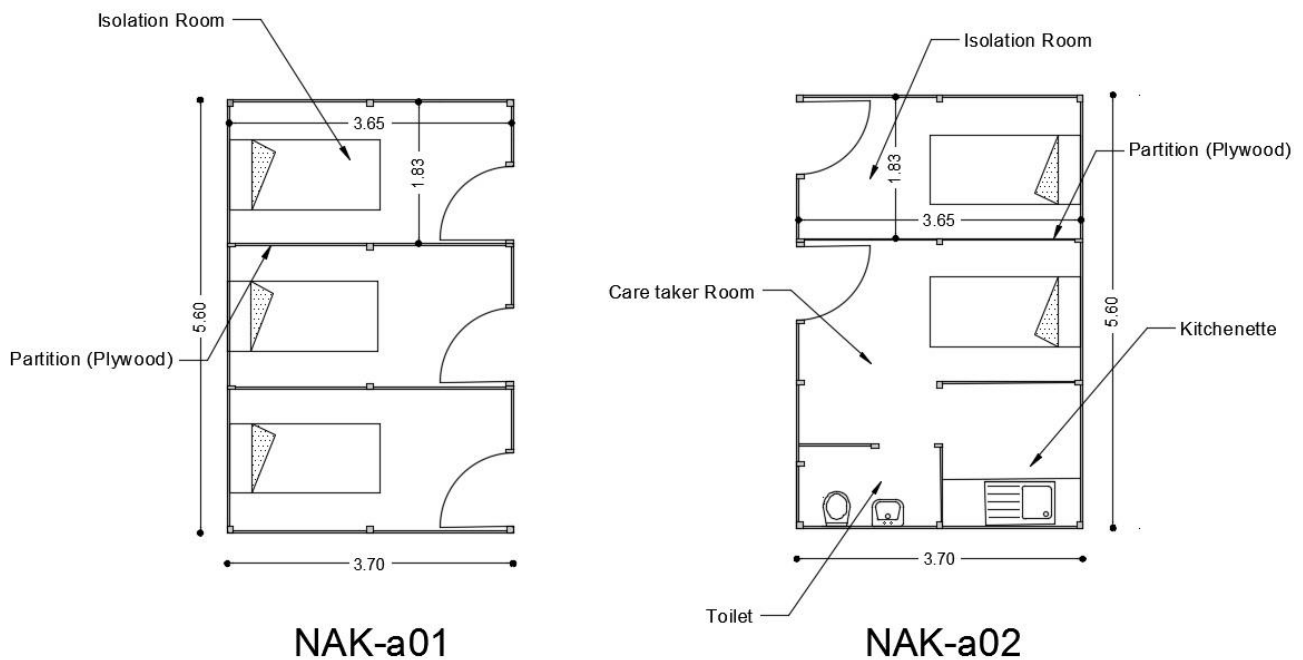
**Level 2;**

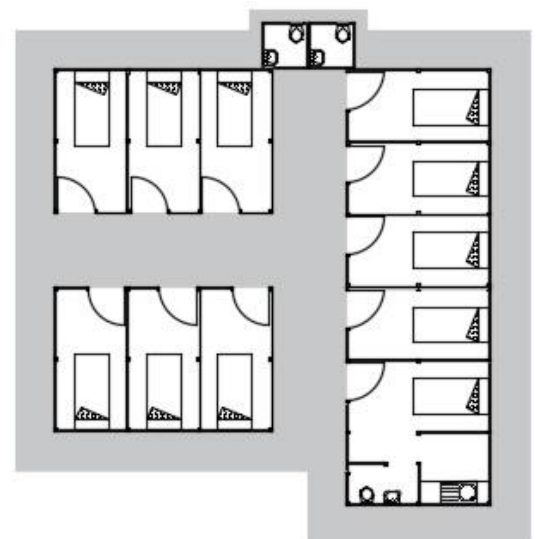
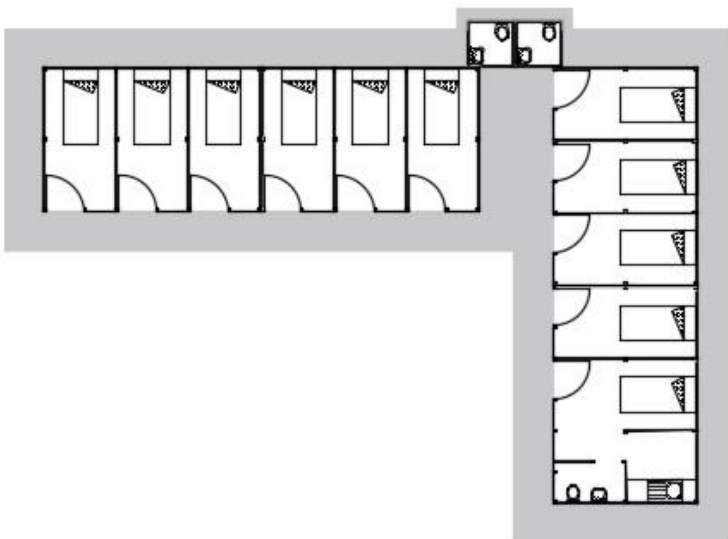
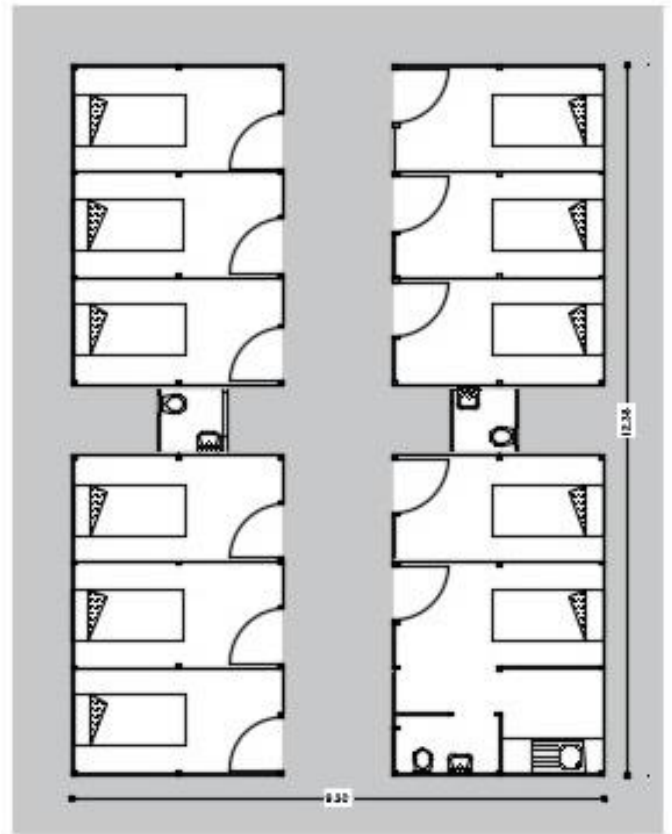
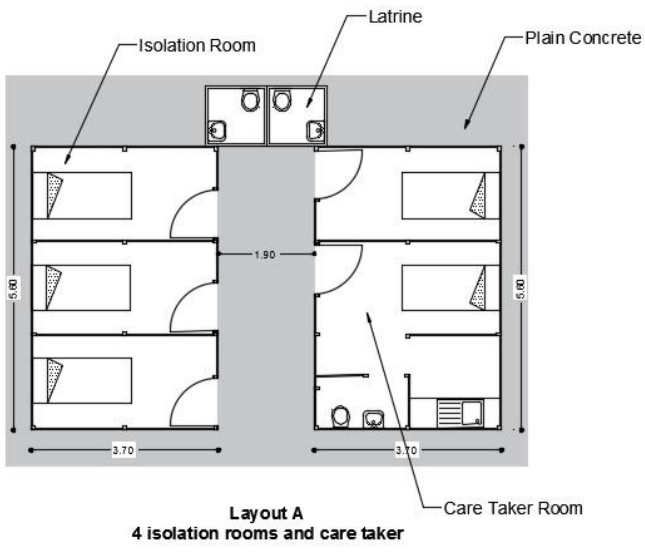


Level 2 facilities are constructed from typical shelter materials (wood, plywood, plastic sheeting) utilizing the New Arrival Kit (NAK) as a modular block, refer to layouts A-B-C below). Installed on a concrete slab, level 2 facilities shall be linked to external WASH facilities.

The proposed NAK design is modified to fit the quarantine isolation requirements in two models, NAK-a01 and NAK-a02 as follows:

- NAK-a01: can accommodate up to 3 suspected cases, each in non-connecting room sizes (3.7x1.8), partitioned using timber pieces and plywood.
- NAK-a02 is composed of 2 separated/none connecting spaces hosting one suspected case and one caretaker. NAK02 is installed based on need and whereby the isolation context requires presence of a care taker.



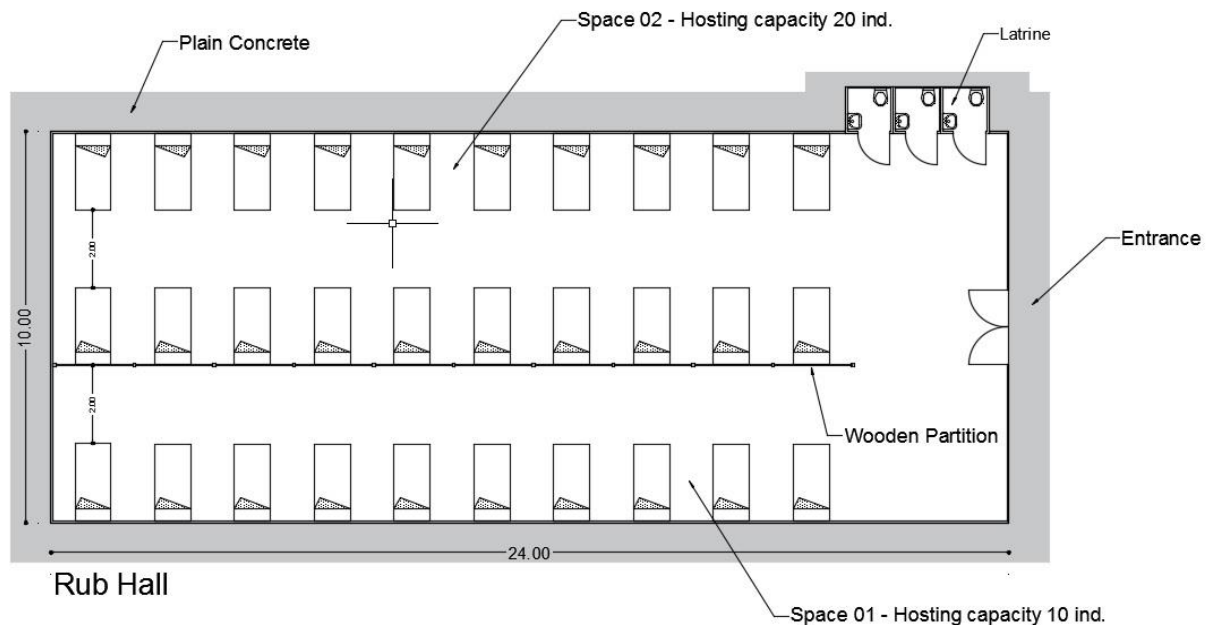


**Layout C&D**  
10 isolation rooms and care taker

Ref#	Works	Shelter Sector	WASH Sector
<b>Shelter</b>			
1	Installation of Module01	X	
2	Installation of Module02	X	
<b>Site and Concrete Works</b>			
3	Site leveling & compacting by a bulldozer (4 tones/m2) + roller & remove debris out to an approved location.	X	
4	Structural backfilling (Base course) with selected imported granular fill materials, curing and compaction in layers not exceeding 15 mm thick after compaction to required density, complete including laboratory and in-situ tests.	X	
5	Supply, deliver, install 8cm thick concrete slab - ready mix concrete only - complete with 6mm reenforcing grid at 30cm centers	X	
<b>Plumbing fixtures</b>			
6	Arabic Water closet supplied and installed with all required accessories		X
7	Lavatory with tap supplied and installed with all required accessories		X
8	Kitchen sink: Stainless Steel(1 compartments) with tap supplied and installed with all required accessories		X
9	Supply and installation of UPVC fitting including all required accessories (10 lm per site)		X
10	Supply and installation of PPR pipes including all required accessories (10 lm per site)		X
11	Latrines/superstructure supplied and installed ( gender separated)		X
	Shower Facility supplied and installed		X
12	Supply and installation of PE water tank of 1m3 capacity with all required accessories (1 per site)		X
13	Reinforced concrete manhole with metal cover (60x60 - 1 per site)		X

### Level 3

Rub halls are metallic structures covered with plastic sheets easy to install, dismantle and move. To serve level 3, they shall be installed on concrete flooring, linked to prefab WASH facilities as required. Internal spaces shall be divided using plywood and timber pieces into 2 open spaces that can accommodate up to 30 individuals.



Ref#	Works	Shelter Sector	WASH Sector
<b>Site Works</b>			
1	Site leveling & compacting by a bulldozer (4 tones/m2) + roller & remove debris out to an approved location.	X	
2	Structural backfilling (Base course) with selected imported granular fill materials, curing and compaction in layers not exceeding 250 mm thick after compaction to required density, complete including laboratory and in-situ tests.	X	
<b>Concrete Works</b>			
4	Supply, deliver, install 10cm thick concrete slab - ready mix concrete only - complete with 10mm reinforcing grid at 30cm centers (poured in 3m x 3m grid framework of timber)	X	
<b>WASH Facilities</b>			
5	Latrines/superstructure supplied and installed ( gender separated)		X
6	Shower Facility supplied and installed		X
7	Supply and installation of PE water tank of 1m3 capacity with all required accessories (1 per site)		X
8	Reinforced concrete manhole with metal cover (60x60 - 1 per site)		X
<b>Metal Works</b>			

9	Purchase and installation to erection site of WiiKHall Aluminum Structure 10x24 with all needed accessories	X	
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#### 4. Planning figures

The below planning figures have been calculated using the IAMP as a baseline with estimations on suspected cases per scenario as advised by the Health sector which were then applied to the expected shelter response for each of the self-isolation levels outlined above;

Field Office	Level 2		Level 3	
	No of cases	Required NAK	No of cases	Required RUB HALLS
Zahle	2202	734	1200	43
Tripoli	615	205	336	12
Tyre	135	45	74	3
BML	63	21	34	1
<b>Total</b>	<b>3015</b>	<b>1005</b>	<b>1644</b>	<b>59</b>

## Appendix 2 Protection Considerations (To be further prioritized)

**Objective:** The objective of this note is to support the Health sector in proposing design solutions for temporary standalone isolation/quarantine facilities in IS or CS for Level 1 (self-Isolation), Level 2 (Community level) and Level 3 (Municipal/ area level) and in ensuring the integration of protection principles and safeguards.

Furthermore, given that actions can be sensitive and technical in nature, it is suggested to reach out to sector specialists for further guidance.

The protection sector is proposing the following:

### **a) Prioritize Safety and Dignity, and Avoid Harm**

- Ensure that the proposed locations for the rub halls (or the building) is identified as early as possible and take into account the need to mitigate the risks of social tensions, stigma, physical attacks, threats to safety including risks related to the environment, and the risks of eviction (proximity to main roads and security installations). Engage legal staff in the selection, as needed and engage in discussion as early as possible with the Ministry of Social Affairs, the relevant local authorities and communities.
- Ensure that the measures proposed are not putting community members at further harm, including members of the HH of suspected cases, those who will host relatives of suspected cases and the caretaker.
- Ensure the provision of necessary food and non-food items and medicine for persons in isolation, and access to WASH facilities in safety and dignity.
- Ensure that all shelter and wash facilities established/rehabilitated for isolation do not present safety risks, esp. for children, persons with disability, elderly.
- Ensure specific collection and disposal of waste - which may be considered contaminated waste. Ensure adequate access to clean water and waste disposal in the community; soap, narrow necked water containers, and covered buckets for households.
- Develop clear SOPs for management of confinement areas/rub halls/buildings (who should be in isolation, who should be the caretakers, what are the protocols to be respected, etc) and have a strong training and monitoring process in place to ensure compliance with SOPs. Given the fears many have to be infected with COVID-19, it will be critical to ensure that people involved in the management of confinement facilities, and caretakers are well trained on infection control and provided with the necessary PPEs and training on how to use and dispose these.

- Provide training and equipment for the possible caretakers, with specific attention paid to women who are the most common caretakers.
- Ensure that all measures and procedures are in place to prevent PSEA.

#### **b) Share Information and Ensure Communication**

- Remain updated with the rapidly changing information on COVID-19 and ensure that updated, accurate and adapted information reaches refugee men, women, girls and boys of diverse backgrounds. This can be done by providing them with the information on how and where to access trusted communication channels, such as MOPH, UNICEF, WHO and UNHCR websites or channels. This can be shared through various channels including WhatsApp, SMS, phone calls including through mobilized or already engaged community members who are trusted (and trained) such as volunteers, focal points, community groups networks and networks. The latter must be aware of precautionary measures and not be put at risk, for example by asking them to share info in groups or during home visits.
- Use different formats (such as audio messages, video, leaflets in different languages) and channels, including high tech, low tech and no tech, accessible to different groups or profiles. Promote creativity. Ensure outreach to the most at risk, especially older persons, persons with disabilities and persons with pre-existing or underlying medical conditions such as asthma, diabetes and heart diseases.
- Medical terminology concerning coronavirus/COVID-19, that may not be easily understandable, should not be used when communicating with communities. For instance, instead of using “suspect case”, use ‘people who may have COVID-19’.
- Emphasis on hand washing and respiratory measures and early symptom identification.
- Share hotline for medical advice and support (MoPH Hotline), as well as numbers/hotlines of partners and UNHCR for possible support and guidance.

#### **c) Support Persons with Specific Needs**

- Individuals with disabilities and older persons without caregivers may not be able to care for themselves or access services. Plan additional measures to reach persons with disabilities and older persons through adapted communication means (see above). This can be done by mobilized community members or NGOs regularly contacting specific groups to provide information and create a buddy system.
- When caregivers need to be moved into isolation/quarantine, plans must be made to ensure continued support for people with disabilities who need care and support. In such

situations, community-based structures, groups, volunteers, networks and leaders in the community can be useful partners in communicating and providing MHPSS and other needed support.

- Ensure that the alternative bathrooms are adapted to persons with disabilities and older persons, and accessible and safe for young children; i.e. not located far from the tent for confirmed cases.
- Ensure regular contact with caregivers of PWSN in quarantine (by phone) by PWSN case management agencies, to ensure that they are not facing additional protection risks.

#### **d) Ensure the Protection of Children**

- Always strive to preserve family unity and preventing the separation of children from their caregivers during all stages of the response. Specific guidance to be provided for breastfed babies and lactating mothers.
- Parents/caregivers and children suspected of COVID-19 should ideally be placed together while awaiting test results. They could only be separated in the case of divergent results, and taking into account the views of the parents and the children and the best interest of the child. Provide caretakers with tablets/ phones/ or credit if necessary to ensure patients can have face time through online channel (e.g. skype) with their children or close relatives.
- Ensure UASCs particularly and their caregivers receive necessary support and that the same measures are in place to avoid separation.
- Use child friendly messaging including games, videos and activities to ensure that children have received a message they can comprehend.
- In case parents/caregivers are put in isolation, ensure child protection agencies are involved in the immediate identification of alternative care arrangements (e.g. with relatives in the community).
- In the very exceptional case where a child would be put in isolation without her/his parent or caregiver, ensure that the caretaker is trained in caring for children.

#### **e) Prevent instances of Sexual and Gender Based Violence**

- Consider gender sensitive programming throughout by addressing the specific protection concerns of women and girls, particularly female headed households, women at risk, survivors of SGBV, adolescent girls, married girls and women or girls who will act as caretakers etc.
- If required for safety, ensure that separate living areas are available to certain groups such as single women, people with disabilities and unaccompanied children, who are being



asked to relocate shelters or who are placed in isolation tents/hall/shelters. In addition, ensure that these areas are protected from abuse or violence.

- Plan safe and separated gendered bathrooms and toilets for suspected and confirmed cases of COVID-19 in isolation.
- Ensure that survivors who are moved to quarantine are being followed by SGBV case management agencies regularly (by phone), to ensure that they are not facing additional protection risks.

#### **f) Mental Health and Psychosocial Support**

- Ensure that staff in direct contacts (incl. over the phone) with communities is trained on Psychological First Aid and is aware of the MHPSS helpline and other MHPSS numbers.
- Have a pool of trained staff among case management partners who know how to communicate with COVID-19 patient, caregivers and children.
- Ensure that all, including persons confirmed/suspected for the COVID-19, and their relative have access to specialized MHPSS services. Specific attention shall be paid to persons placed in isolation, and those with preexisting MHPSS issues.
- Precautions should be taken to ensure that people with mental health and substance abuse disorders continue to access medication and support during the outbreak, both in the community as well as in institutions.
- Equip the communities with all the required numbers and tools (in coordination with MHPSS TF), as well as in breathing and meditation techniques as a way to manage stress.
- Encourage social connectedness (through social media, and/or contact friends and family).
- Encourage positive coping skills including maintain healthy lifestyle, draw on skills used in past during difficult times to manage emotions, etc.

#### **g) Community Participation and Support**

- Ensure that the community is aware of key messages on prevention, mitigation and response around COVID-19. This can be done through the above-mentioned communication channels.
- With the community, prevent stigmatization and marginalization of COVID-19 cases from the onset, as well as support re-integrating survivors back into the community.
- Build trust with the community in finding joint solutions. Community members, including diverse groups among them and COVID-19 patients, should be engaged in the response measures to be put in place, to the extent possible. For example, diverse refugee groups

including COVID-19 patients in certain location can be asked to help identify safe locations for the rub halls or relocation of tents, and to discuss age and adapted setting for the isolation tents/shelters/rub halls, as well as the community's role.

- Reinforce the community's self-help capacity by supporting groups that are less mobile and would need support to access services.
- Work with the community and relevant protection actors to identify community caregivers who can support persons with specific needs, including persons with disabilities, older persons and unaccompanied and separated children.
- Ensure consultation with host communities, MOPH, as well as refugee, men, women, boys and girls. Involve persons with disabilities and older persons in the ongoing COVID-19 needs assessments and monitoring in order to have accurate information about their specific needs.
- Create a list of refugee and local community members who are trusted in the community who will be helpful during an outbreak. These may also include community leaders, volunteers, community group members, networks, representatives from different groups, local community members, LRC teams etc. The identified persons need to be trained on issues such as COVID-19 awareness, precautionary health measures, code of conduct/humanitarian principles and duty of care. Ensure at least 50% participation of women among community members mobilized for COVID-19 related prevention and response.
- Maintain regular contact with the community and establish regular dialogue with communities to understand fears, beliefs, perception, practices and challenges. They can play a key role in containment and can develop ways to implement mitigation measures.

#### **h) Ensure access to Protection Cash**

- Ensure that persons in needs, incl. female headed households, older persons and persons with disability, have access to NFIs or ECA in a timely manner. Vulnerable individuals facing protection situation can continue to be referred to partners for PCAP as per the usual procedures.
- Establish safe distribution methods of NFIs particularly for COVID19 patients.

#### **i) Capacity building**

- Develop training materials for caregivers and discuss a rollout plan (*including who and how will caregivers be identified, what equipment would they need, who will provide them with the equipment and who will monitor the quality of support*).

**Level 0 Specific WASH Guidance**

Hygiene promotion training can be found at;

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/online-training>

Sensitization campaigns should be supported by the distribution of soap and flyers. GoL's approved and endorsed flyers and posters can be found on-line:

[https://www.dropbox.com/sh/c8prp4negm3qwlx/AAA86WCR5x04pyD6Zukwd02ua/0.%20COVID19%3A%20Risk%20Communication%20%26%20Community%20Engagement%20\(RCC%20E\)/STRATEGIC%20RCCE%20Documents%20and%20Materials?dl=0&subfolder\\_nav\\_tracking=1](https://www.dropbox.com/sh/c8prp4negm3qwlx/AAA86WCR5x04pyD6Zukwd02ua/0.%20COVID19%3A%20Risk%20Communication%20%26%20Community%20Engagement%20(RCC%20E)/STRATEGIC%20RCCE%20Documents%20and%20Materials?dl=0&subfolder_nav_tracking=1)

In order to contribute to promote hand washing, the quantity of water available is increased from 35 to 40 l/pers/day.

With no suspected cases, service providers and Hygiene Promoters, which will have to come in and out of the quarantine area, will have to follow standard protections: Hand Washing, cough etiquette, distance, etc. No PPE is required or suggested.

Outcome	L0	Standards before COVID-19	New Standards level 0
<b>At risk populations have immediate access to adequate safe water, hygiene and sanitation through life saving activities</b>		<ul style="list-style-type: none"> <li>• Distribution of 1m<sup>3</sup> water storage tanks per tent</li> <li>• Provision of 35 l/pers/day water supplies via existing infrastructures or bulk tanker delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• Distribution of 1m<sup>3</sup> water storage tanks per tent if non existent.</li> <li>• Provision of minimum 40 l/pers/day with increase when possible to 60 L/pers/day water supplies via existing infrastructures or bulk tanker delivery.</li> </ul>
		<ul style="list-style-type: none"> <li>• Construction/rehabilitation of one latrines/toilets per 15 persons</li> <li>• Provide equipment and tools to facilitate regular maintenance of a hygienic environment through waste minimisation, collection &amp; disposal.</li> <li>• Regular desludging</li> </ul>	<ul style="list-style-type: none"> <li>• Construction/rehabilitation of one latrines/toilets per family accommodating the needs of PWSN, disables and elderlies</li> <li>• Provide equipment and tools to facilitate regular maintenance of a hygienic environment through waste minimisation, collection &amp; disposal.</li> </ul>
		<ul style="list-style-type: none"> <li>• Promote Hygienic safe spaces within all convergent environments through Public Health campaigns. .</li> </ul>	<ul style="list-style-type: none"> <li>• Engage communities and local actors plus Outreach Volunteers (OV) in spreading awareness within all convergent environments through Public Health intensive campaigns focussed on COVID-19 specificities</li> <li>• Distribute minimum one flyer per family</li> </ul>

			<ul style="list-style-type: none"> <li>Distribute one soap (125 gr) per person every 2 months.</li> </ul>
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### Level 1 Specific WASH Guidance

The quantity of water provided to the IS will be increased from 40 to 60 l/pers/day to promote disinfection, washing and cleaning. Elderly and people with low immune system will be prioritized. Handwashing facilities will be installed, if possible, at the main entry, and other common places, and regularly provided with soap and/or chlorinated water.

In addition, caregivers, service providers and Hygiene Promoters, which will have to come in and out of the quarantine/ isolation room, will have to follow a protection protocol after being trained on working in quarantine zone. They will be provided with PPE as necessary.

Outcome	L1	Standards level 0	Standards level 1
<b>At risk populations have immediate access to adequate safe water, hygiene and sanitation through life saving activities</b>		<ul style="list-style-type: none"> <li>Distribution of 1m3 water storage tanks per tent</li> <li>Provision of 40 l/pers/day water supplies via existing infrastructures or bulk tanker delivery.</li> </ul>	<ul style="list-style-type: none"> <li>Distribution of 1m3 water storage tanks per tent with potential increase if the supplier cannot deliver more frequently</li> <li>Provision of 60 l/pers/day water supplies via existing infrastructures or bulk tanker delivery.</li> <li>Direct connection of the isolated rooms to the water tanks</li> </ul>
		<ul style="list-style-type: none"> <li>Construction/rehabilitation of one latrine/toilet per family</li> <li>Provide equipment and tools to facilitate regular maintenance of a hygienic environment through waste minimisation, collection &amp; disposal.</li> <li>Regular desludging</li> </ul>	<ul style="list-style-type: none"> <li>Construction/rehabilitation of one latrine/toilet per affected family PWSN and PWD friendly when needed;</li> <li>Construction or allocation of a dedicated toilet for each isolation room, with a handwashing facility, in collaboration with shelter partner</li> <li>Provide equipment and tools to facilitate intensive maintenance of a hygienic environment through cleaning, disinfection, waste minimisation and proper management, collection &amp; disposal.</li> <li>More frequent desludging due to increased delivery of water</li> </ul>
		<ul style="list-style-type: none"> <li>Promote Hygienic safe spaces within all convergent environments through Public Health intensive campaigns focussed on COVID-19 specificities</li> <li>Distribute one flyer per family</li> <li>Distribute one soap (125 gr) per person every 2 months.</li> </ul>	<ul style="list-style-type: none"> <li>Promote Hygienic safe spaces within all convergent environments through Public Health intensive campaigns focussed on COVID-19 specificities, the Waster sector will develop the best modalities for Hygiene promotion activities during COVID 19 outbreak;</li> <li>Distribute one flyer per family</li> <li>Distribute one soap (125 gr) per person every 2 months.</li> </ul>

			<ul style="list-style-type: none"> <li>• Distribution of one IPC kit per Household with explanation on IPC measures and their importance.</li> <li>• Rely on OVs, LRC, faith and other local organisations to spread awareness and to assist in the distribution.</li> </ul>
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### Level 2 Specific Guidance

Similar to the services provided to the person isolated in level 1, the Water sector will strongly coordinate with the Shelter Sector to ensure that the temporary confinement “facility”, taken into consideration the guidance of WaSH facilities for PwSN and PwD, is equipped with:

- a. temporary toilets (one per 15 people maximum, separated by gender) regularly cleaned and disinfected;
- b. handwashing facilities adjacent to toilets, regularly supplied with soap/chlorinated water;
- c. Water tank installation with connection to the temporary facility and handwashing facilities;
- d. Provision of sufficient and safe water and desludging services (services providers will be trained on IPC and provided with prevention equipment)
- e. Provision of a suitable amount of soap and disinfection products to permit regular cleaning and disinfection of the isolation room and other areas of the tent;

As per Level 1 and 2, the Water sector will provide soap, chlorine, disinfectant products, awareness sessions, 60 l/pers/day safe water and desludging services to all the households living in the affected ISs and at least one public handwashing facility per IS.

### Level 3 Specific Guidance

Similar to level 2, the Water Sector will assist the Shelter and Health Sectors in the construction of the rubble hall through the provision of associated WASH facilities and deliver the same package as per level 2 to all the households living in the affected ISs. All waste that has been in contact with a suspected or confirmed COVID-19 case, including used tissues, and masks if used, should be put in a plastic garbage bag and tied. The plastic bag should then be placed in a second plastic bag and tied. Measures should be adapted to ensure that the waste is disposed of at a sanitary landfill and not at an unmonitored open dump and should be treated as medical waste. The Social Stability Sector through the Solid Waste Task Force will work with DRM and municipalities to identify appropriate solutions.

General guidance

A pre-condition for isolation to work under these circumstances is that the individuals in isolation are well enough to manage without much assistance. Individuals with severe symptoms and those at risk of developing severe symptoms (elderly or with pre-existing conditions) should be referred for hospital care and not be in self-isolation. Both isolated and caregivers need careful instructions that even if symptoms initially are mild they might worsen and they might need referral to hospital. A clear guide what symptoms should lead to hospital referral should be communicated.

Practical guidance on specific cases

- If a minority of household members have been exposed to the virus (known contact with confirmed case) but have no symptoms, these household members should go for quarantine while the remaining household members should be regarded as not at risk and live normally.
- If a minority of household members are confirmed infected these should be going into isolation. The rest of the household should be quarantined. The quarantined can stay in their original tent but should not be in contact with other people in the settlement for 14 days. If they start to develop symptoms they should go into isolation. (Optimally after confirmed COVID testing but this is dependent on MOPH guidelines and capacity).
- Breastfeeding mothers should never be separated from their children and if necessary, they should go into isolation together. Basic instructions to be given about hygiene and general prevention.
- It should be avoided to isolate small children on their own. Solutions should be considered to allow children to be isolated with a caregiver in a separate facility/tent. It should always be considered that small children are less likely to get the infection and less likely to develop severe symptoms.
- For mothers and children solutions involving use of strict IPC precautions and PPEs are to be preferred before separation.
- Regarding elderly and people with chronic illnesses who are confirmed infected, hospitalization is preferred rather than self-isolation.
- Regarding elderly and people with chronic illnesses who are without symptoms in a settlement with many cases it can be considered to let them stay in a separate tent in order to protect them from infection from other settlement dwellers.

## Appendix 5 Level 3 facility management

### Services to be provided in a level 3 facility

#### General:

- Security services shall be present to ensure a secure and safe environment day and night;
- Cleaning services shall be provided to ensure regular and thorough cleaning and disinfection of the facility day and night;
- Food and water shall be provided to the occupants of the facility 3 times a day;
- Solid waste shall be separated between infected and non-infected and disposed of appropriately;
- Clothes, bedsheets and towels will be provided.
- Laundry services shall be provided to ensure the regular cleaning of bedsheets and other items;
- Desludging and water trucking services shall be coordinated with the water sector partners;
- Wifi shall be installed and maintained for the use by occupants;
- A safe locker (locker with key) shall be provided and maintained;
- Air conditioning units shall be installed and maintained to ensure suitable temperatures are maintained day and night.
- Community around the facility may be engaged, as possible and as agreed on with them, to provide certain services in and around the site and given the means to do so based on the scale. This can include provision of warm meals, site maintenance (based on skills), support in promoting waste management around site, provide feedback on community practices and fears, address stigma and support reintegration of recovered patients into their homes. They may also support in managing crowds on site and ensuring information reach to neighboring residents and separated families. Training, equipment, space, organization of roles and overall organizational management may need to be provided. Role of refugees with health backgrounds can be explored.
- SOPs for the facility will be developed, which includes roles and responsibilities of all

#### Health:

Monitoring of symptoms of the isolated. No need for constant presence of medical staff in the facility. Recommended morning and evening rounds by nurse with checking of temperature and asking about breathing problems. Distribution of antipyretics (paracetamol). Nurse to be on standby 24/7 and means for contact in case of deterioration of symptoms of any of the isolated and need for referral to hospital.

Ideally these tasks could be performed by staff from a nearby health facility (outreach nurse?) that could at the same time perform other tasks elsewhere. I.e. no need for full time health staff per level 3 facility.

Appendix 6 Recommended type of PPE and procedure to be used based on the four levels of home isolation<sup>8\*</sup>

Isolation Level	Target Persons	Activity	PPE Type or Procedure
<b>Level 0:</b> No cases	Frontline workers	Conducting assessments, distributions and/or awareness sessions / activities	No PPE required  The activities should be performed outside the house or outdoors. If it is necessary to enter the household, maintain spatial distance of at least 1 m and do not touch anything in the household environment in addition to applying the other preventive measures for COVID-19 disease as mentioned in the text here above
<b>Level 1:</b> Self isolation at home	Patient	N/A	<ul style="list-style-type: none"> <li>• Maintain spatial distance of at least 1m</li> <li>• Provide medical mask if tolerated, except when sleeping</li> </ul>
	Caregiver	Entering the patient's room, but not providing direct care or assistance	Medical mask
		Providing direct care or when handling stool, urine or waste from COVID-19 patient being cared for at home	<ul style="list-style-type: none"> <li>• Gloves</li> <li>• Medical mask</li> <li>• Apron (if risk of splash)</li> </ul>
	Frontline workers	Providing direct care or assistance to a COVID-19 patient at home	<ul style="list-style-type: none"> <li>• Medical mask</li> <li>• Gown</li> <li>• Gloves</li> <li>• Eye protection</li> </ul>
<b>Level 2:</b> Community isolation or isolation within the community & <b>Level 3:</b> Municipal or area level isolation	Patient	N/A	<ul style="list-style-type: none"> <li>• Maintain spatial distance of at least 1m</li> <li>• Provide medical mask if tolerated, except when sleeping</li> </ul>
	Frontline workers	Providing direct care to COVID-19 patients	<ul style="list-style-type: none"> <li>• Medical mask</li> <li>• Gown</li> </ul>

<sup>8</sup> Please see full guidance on use of PPEs in home isolation settings



			<ul style="list-style-type: none"> <li>• Gloves</li> <li>• Eye protection (goggles or face shield)</li> </ul>
		Entering the room of COVID-19 patients	<ul style="list-style-type: none"> <li>• Medical mask</li> <li>• Gown</li> <li>• Heavy duty gloves (for cleaning)</li> <li>• Eye protection</li> <li>• Boots or closed work shoes</li> </ul>
	Visitors**	Entering the room of a COVID-19 patient	<ul style="list-style-type: none"> <li>• Medical mask</li> <li>• Gown</li> <li>• Gloves</li> </ul>
<b>Level 4:</b> IS full quarantine	At the level of isolating the whole IS, some cases might be isolated at home (level 1) subject of the physical space while other cases might be isolated in the isolation center (level 2 or 3). The same PEE procedure applies as mentioned above.		

\* In addition to using the appropriate PPE, frequent hand hygiene and respiratory hygiene should always be performed. PPE should be discarded in an appropriate waste container after use, and hand hygiene should be performed before putting on and after taking off PPE.

\*\* The number of visitors should be restricted. If visitors must enter a COVID-19 patient’s room, they should be provided with clear instructions about how to put on and remove PPE and about performing hand hygiene before putting on and after removing PPE; this should be supervised by a healthcare worker.

## Appendix 7 Provision of Food Assistance

The Food security and agriculture sector (FSS) is mapping and coordinating partners’ interventions in relation to food assistance that can be provided in the context of isolation and quarantine in informal settlements.

A number of partners of the FSS sector are planning to provide support to refugees living in informal settlements in the form of food parcels or hibernation kits, that include food. This support will be triggered once the mobility of a large part of the refugees is affected, specifically under scenarios 3 and 4 on IS quarantine identified by this Guidance, and as advised by MoHP.

Widespread restricted mobility will hinder refugees' access to food. If they receive cash-based food assistance, because of widespread isolation or quarantine they will not be able to redeem their assistance at ATMs or at WFP-contracted shops. If they do not receive assistance, their access to income generating opportunities will also be hampered. It will be therefore needed to ensure that a blanket distribution of in-kind food assistance will be provided under the quarantine scenario.

The preferred modality of assistance would be the delivery of food parcels under the assumption that refugees will continue to have access to fuel, water for cooking and cooking facilities. The content of the food parcel will cover to start with 1 month of assistance and will be adapted if mobility restrictions are prolonged. Given the nutrition composition of the food parcel, this type of assistance cannot be prolonged for more than 3 months.

It is suggested to partners to follow the revised "Guidance on the content of food parcels" developed by FSS, when procuring the food parcels. The guidance, initially developed to cover one third of monthly food needs, is being recalculated to cover extended isolation scenario up to one month of duration.

The partners should follow during the distribution of food parcels the IASC " Interim Recommendations for Adjusting food distribution standard operating procedures in the context of the Covid-19 outbreak , Version 2 , March 2020", developed by WFP. The recommendations aim at minimizing to the risk of exposure of distributing partners' personnel and beneficiaries.

When possible and feasible, the distribution will be conducted in cooperation with other partners from other sectors distributing hygiene kits and providing awareness sessions for beneficiaries. At the same time, negotiations have to be held with local authorities to guarantee that partners have safe access to the IS to distribute the food parcels.