

HOME ISOLATION IN OVERCROWDED SETTINGS INTERIM GUIDANCE AND BEST PRACTICE AFGHANISTAN APRIL 2020

The following document presents a collection of global best practice for home-isolation, tailored for Afghanistan's unique context. Best practice identified in the guidance can support individuals and communities applying home-isolation orders, should the Ministry of Public Health and governing authorities deem that the best approach to limit the spread of COVID-19 in Afghanistan.

Key messages:

- The humanitarian community does not support the establishment of camps to isolate people returning to Afghanistan. The establishment of camps is not in line with current Government of Afghanistan recommendations¹ or global best practice and has proven an ineffective tool in other contexts.
- Achieving home-isolation in Afghanistan presents notable challenges, including due to the prevalence of over-crowded shelters, population density in IDP sites and other formal and informal settlements. The following requires a multi-stakeholder approach to resourcing, implementing and supporting any government-issued stay-at-home directives.
- In many situations, home-isolation may not be feasible due to limited resources, physical space or the inability to modify existing shelters. Alternative options, such as the repurposing of existing buildings or public facilities, should be considered.

1 Introduction

Home isolation is the best way for people who may have been exposed to COVID-19 but do not yet have symptoms to protect their community from further spread. Home isolation is a public health technique employed to tackle the spread of disease. The transmission of COVID-19 can be greatly reduced by keeping people confirmed to have contracted, or those who have been exposed to and may have contracted COVID-19 separated from the rest of the population. However, the ability to use this technique in overcrowded² settings is particularly challenging as space in homes and shelters is limited and typically shared by many people.

In Afghanistan, more than 4.1 million people have been displaced since 2012 and remain in urban and rural informal settlements, residing in sub-standard shelters characterised by lack of privacy; overcrowding; poor ventilation; lack of access to safe water and sanitation facilities. Over one-third of households displaced for more than six months (1.4 million people) still live in makeshift shelters or tents, in overcrowded conditions, with limited access to services. Some 57 per cent of displaced households have insufficient water. More than 65 per cent of returnees live in settlements that do not have access to any WASH services; the remaining 35 per cent have integrated into host communities where services are already stretched. In the majority of situations, houses in Afghanistan tend to be home to large families with multiple members sharing sleeping space. Latrines, if they are available, are also shared.

The overall shelter situation and absence of centralised access to services for these and other vulnerable groups leaves large populations (including IDPs, returnees, and host communities) at heightened risk of widespread transmission of COVID-19.

The purpose of this document is to provide guidance on how home isolation for people who may have been exposed to the virus³ can be achieved in an overcrowded setting. It also provides advice on how this can

¹ Concept note on transferring returnees from the borders to the provinces. MORR, MOPH, MOT (March, 2020)

² Overcrowding is defined as a situation in which a person is living in a space that is less than 4.5m² per person. Overcrowded settings can be in urban and semi-urban areas and host a diverse population, including IDPs, returnees, refugees and host communities.

³ For case definitions please see Annex 1

be done for returnees arriving in a community who are being instructed to self-isolate away from others⁴. It will focus on informal settlements, displacement sites, and shelters with many occupants or with few/single rooms.

This guidance aims to support an efficient response and guide decision-makers on the best available options in the Afghanistan context. It also aims to explain alternatives to the establishment of quarantine camps or sites at borders.

2 Home-isolation in overcrowded settings

Home isolation measures can apply to people who may have COVID-19 but are asymptomatic and need to be isolated as a preventative measure. It can also apply to people who are confirmed to have the virus and have mild symptoms that require isolation in their homes rather than in a health facility.⁵ It may also apply to people who have recently returned to Afghanistan from other countries--particularly countries with a high number of people confirmed to have the virus and where contact with COVID-19 is assumed.

People who are isolating preventatively—such as those who have recently returned to Afghanistan--and those who are asymptomatic should not be mixed with people who are confirmed to have the virus in isolation facilities as this may lead to healthy people getting sick. Keeping groups of people in confined spaces in a pandemic situation is not best practice and the experience in other countries has demonstrated that this increases the risk of the virus spreading.

Who should self-isolate:

Individuals identified by trained COVID surveillance teams:

Individuals who need to self-isolate will be identified by trained surveillance teams based on the most updated WHO case definitions. Surveillance teams will follow the national referral pathway for case identification. Additionally, individuals who feel they may have COVID-19 symptoms can also reach out through MoPH-staffed hotlines to seek medical attention, access testing, and receive tailored guidance⁶.

People recently returning from neighbouring countries:

For those returning to Afghanistan from neighboring countries, individuals who are confirmed **asymptomatic** during medical screening at border points⁷ but who may have come into contact (during cross-border travel or within the community) with people who have the virus, should follow current MoPH guidance to self-isolate at home and seek medical treatment if they develop symptoms.

The humanitarian community does not support the establishment of camps to isolate people returning to Afghanistan. The establishment of camps is not in line with current Government of Afghanistan recommendation⁸ or global best practice and has proven an ineffective tool in other contexts. The concentration of individuals in such confined environments increases the risk of disease spread.

*Although the humanitarian community acknowledges the difficulties for some families to practice self-isolation in family environments, the guiding principle of 'do no harm' makes **self-isolation at home the preferred way to quarantine people at risk of contracting the virus, developing symptoms and/or further spreading the virus.***

People who have had contact with confirmed COVID-19 patients:

⁴ The Government of Afghanistan currently advises those with a history of travel in the last 20 days with no signs and symptoms to self-isolate within their residences. (National Emergency Response Plan for Coronavirus, updated 24 March 2020)

⁵ Current Government of Afghanistan protocol is for all confirmed cases to isolate and receive treatment within dedicated health facilities. Should the number of confirmed cases extend beyond current health facility capacity, home isolation for those with mild symptoms and no underlying conditions can be considered.

⁶ Please see Annex 2 for provincial contacts

⁷ For best practice health screening and triage, please see Annex 3

⁸ Concept note on transferring returnees from the borders to the provinces. MORR, MOPH, MOT (March, 2020)

WHO recommends that “**contacts**” of patients with laboratory-confirmed COVID-19 should be quarantined for 14 days from the last time they were exposed to the patient.⁹

For the purpose of implementing self-isolation, a **contact** is a person who is involved in any of the following activities during the period 2 days before and up to 14 days after the onset of symptoms in the confirmed patient:

- Having face-to-face contact with a COVID-19 patient within 1 meter and for >15 minutes;
- Providing direct care for patients with COVID-19 disease without using proper personal protective equipment;
- Staying in the same close environment as a COVID-19 patient (including sharing a workplace, classroom or household or being at the same gathering) for any amount of time;
- Travelling in close proximity to (that is, within 1m separation from) a COVID-19 patient in any kind of transport;
- and other situations, as indicated by local risk assessments.

Advice on how to isolate¹⁰:

If directed to self-isolate at home, people isolating in a household with several other people should take precautionary measures to keep themselves separated. This is especially important for households with members who are elderly or chronically ill.

Isolated people should not leave the house for **14 days**. During this time, the isolated person(s) will be dependent on other household members to meet their basic needs, such as providing them with food or removing any waste.

The ability of individuals and families to self-isolate at home will depend on the type of house and/or shelter where they live. In general terms, to achieve isolation in a home setting, a separate ventilated bedroom is recommended where the self-isolated individual can recover without sharing an immediate space with others. In accordance with WHO guidelines:

- Self-isolated people should have safe and dignified access to an adequately ventilated single rooms, with dedicated toilet, hand hygiene and washing facilities.
- Household members should stay in a different room, or if that is not possible, maintain a distance of at least 1 metre from one another.
- The number of caregivers should be limited and visitors should not be allowed until the person in self-isolation has completed 14 full days of isolation.
- The isolated person should use dedicated linen and eating utensils; these items should be cleaned with soap and water after use and not shared.
- Surfaces that are frequently touched should be cleaned and disinfected after use by the isolated person, including bathroom and toilet surfaces.
- Household members should avoid other types of exposure to items from the isolated individual's immediate environment (eating utensils, dishes, cups, towels, bedding, etc).
- Parents/caregivers and children who might have been exposed to COVID-19 should be quarantined/isolated together. Men and women who are not closely related should be quarantined/isolated separately.

To the extent possible, home-isolation in informal settlements, IDP sites or other overcrowded settings should follow WHO's standard guidance on how to self-isolate, provided above¹¹.

⁹ WHO: Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19). Interim guidance, March 2020.

¹⁰ The following assumes individuals and families have shelters in which they can self-isolate. People who are displaced or who are homeless and being directed to self-isolate will need additional support to access suitable shelter—whether that be through the provision of an emergency tent, rental support, or accommodation at a collective shelter center.

¹¹ [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

If a dedicated self-isolation space cannot be achieved in the household's current housing arrangement, shelter modifications should be made. This includes extending, partitioning or otherwise changing living conditions to increase the amount of covered living space available. Any modification should be done in line with Shelter, Health and WASH Cluster guidance to ensure alignment with construction and hygiene standards.¹²

If modification of the existing shelter is not feasible, alternative housing arrangements, such as temporarily relocating some family members to the home of a relative, should be explored. If neither modification nor temporary alternative accommodation are viable options, specific facilities will be needed for this purpose. Ideally, local authorities, together with affected communities, should explore the use and repurposing of existing buildings within/near the site. This option is most applicable in urban areas where hotels, hostels are available. Alternative facilities can also include separate tents or refugee housing units (RHU) for individuals or families. To the extent possible, negotiation for additional space for potential self-isolation needs to be carried out as part of preparedness, ahead of home-isolation orders being given.

Additional Considerations:

Throughout the process of isolation, specific considerations will need to be adopted for persons with specific needs (i.e. older persons without caregivers, unaccompanied and/or separated children, persons with disabilities, people with mental health issues, child-headed households and breastfed babies)¹³. In case of home-isolation by an individual presenting specific needs living with family members, it is recommended that only one relative only addresses their needs on a daily basis to minimize contact and risk of transmission to a larger number of people. The caregiver in charge of persons with specific needs must take appropriate mitigation measures to reduce cross-contamination across the household, and strictly observe the above-mentioned guidelines as if they were in home isolation themselves. For persons with specific needs living on their own (for instance children-headed households living on their own or caring for younger siblings, or people with mental health issues living on their own), if no relative lives closely enough to care for them, it is recommended that a designated member of the community takes on the role of caregiver, and applies the same principles in their own home, in order to reduce the possibility to transmit the virus to their own relatives. Designated caregivers must act in their own households as if they were also under home isolation principles, for the entire duration of the care provided to vulnerable individuals in other households.

¹² For guidance on options for modification or establishment of shelters to meet WHO and Shelter and WASH Cluster guidance, please see Annexes 4 and 5

¹³ For guidance on further support for those undergoing self-isolation at home please see Annex 5

Annex 1

Case Definitions

The WHO developed case definitions for suspected, probable and confirmed cases of COVID-19¹⁴ .

Suspected Case:

- A. 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. 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.

Probable Case:

- A. A suspect case for whom testing for COVID-19 is inconclusive.
OR
- B. A suspect case for whom testing could not be performed for any reason.

Confirmed Case:

- A. A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms. Confirmatory tests include positive serology in paired serum samples.

¹⁴ [https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov))

Annex 2: Provincial COVID focal points



وزارت صحت عامه

هموطنان گرامی!

اگر تب، سرفه، ریزش و نفس تنگی دارید و اخیرا از کشور ایران به خصوص از شهر قم و کشور چین برگشته اید یا از نزدیک با کسانی که از ایران و چین برگشته اند به تماس شده اید، هرچه زودتر با این شماره ها به تماس شوید تا تیم های صحتی وزارت صحت عامه شما را همکاری نماید.

۰۷۹۳۴۵۵۵۱۵	دوکتور محمد نعیم "رحیمی"	سمنگان	۰۷۷۳۰۳۶۵۹۰	دوکتور الله محمد "نوری"	کابل
۰۷۹۹۲۲۹۶۸۰	دوکتور غلام خالص "قادری"	جوزجان	۰۷۴۴۴۵۴۱۸۵	دوکتور جان محمد "کوهستانی"	کاپیسا
۰۷۸۶۳۰۵۷۴۴	دوکتور محمد هارون "صدری"	سرپل	۰۷۰۰۰۳۷۵۱۰	دوکتور صلی الله "نامری"	لوگر
۰۷۹۶۱۲۴۶۲۸	دوکتور همایون "آهی"	فاریاب	۰۷۰۴۹۶۹۰۴۲	دوکتور سکندر "یعقوبی"	پنجشیر
۰۷۹۹۰۹۷۵۶۳	دوکتور محمد شریف	پکتیا	۰۷۷۰۰۲۲۲۶	دوکتور کریم "حیبی"	بامیان
۰۷۹۸۲۷۲۹۵۰	دوکتور مومن خان	پکتیکا	۰۷۷۵۶۵۵۰۷۹	دوکتور حیدر علی "امیری"	دایکندی
۰۷۹۹۷۹۵۸۱۱	دوکتور عبدالهادی "امیری"	غزنی	۰۷۹۹۲۲۹۱۲۹	دوکتور محب الله "شیاب"	پروان
۰۷۷۵۰۶۸۰۴۷	دوکتور نصیب الله	خوست	۰۷۷۱۰۵۰۶۰۷	دوکتور "رووفی"	وردک
۰۷۰۳۰۰۹۰۰۸	دوکتور محمد سرور "فیروزی"	کندهار	۰۷۷۵۳۵۸۴۹۳	دوکتور اجیر الرحمان "الکوزی"	ننګرهار
۰۷۹۷۴۸۰۴۶	دوکتور سید نور آقا	ارزگان	۰۷۷۲۴۵۶۱۹	دوکتور محمود "ریاض"	کټ
۰۷۰۷۴۱۴۲۴۰	دوکتور احمد خان	هلمند	۰۷۰۰۶۰۸۲۹۱	دوکتور محمد صدیق "سمسور"	لغمان
۰۷۰۰۳۵۷۹۲۸	دوکتور گل محمد	زابل	۰۷۰۴۹۸۳۶۴۹	دوکتور نظام الدین	نورستان
۰۷۰۸۵۰۰۷۰۶	دوکتور شیبیا "رحمانی"	نیمروز	۰۷۰۴۰۰۵۶۵۷	دوکتور محمد شریف	بغلان
۰۷۹۴۶۱۱۲۸۰	دوکتور احمد امیر "لزاد"	هرات	۰۷۹۷۹۰۱۴۰۳	دوکتور محمد صابر "خاشی"	بدخشان
۰۷۹۹۶۱۵۰۸۴	دوکتور محمد جواد "میرزایی"	فراه	۰۷۹۵۲۱۲۰۸۰	دوکتور محمد محسن	کنډز
۰۷۹۹۵۲۷۰۹۹	دوکتور عبدالحلیم "قادری"	بادغیس	۰۷۰۰۲۱۴۴۵۵	دوکتور حمیدالله "امید"	تخار
۰۷۹۷۲۴۹۷۲۷	دوکتور محمد ناظم "فضل"	غور	۰۷۹۵۵۱۹۹۸۸	دوکتور امین الله "شیرپور"	بلخ

برای دریافت معلومات بیشتر به شماره رایگان ۱۶۶

مرکز معلومات صحتی وزارت صحت عامه در تماس شوید!

Annex 3: Screening and Triage

All individuals entering Afghanistan, regardless of the entry point, should undergo medical screening (temperature checking and detection of other COVID-19 symptoms), as best practice to identify potential COVID-19 patients for isolation and medical attention. Immediate isolation should only be conducted for individuals presenting symptoms of COVID-19 and not more than one person should be put per room/tent, either in temporarily set-up isolation wards at the borders, or in public health facilities.

To avoid cross-contamination, confirmed and unconfirmed cases should never be isolated in the same space. Repeated testing over extended periods of time in isolation facilities should be terminated as soon as individuals test negative, in order to minimise exposure to potentially infected individuals.

The use of prisons, juvenile rehabilitation centres and other facilities hosting people deprived of their liberty should not be used as last resort isolation wards, because social distancing and other health measures cannot be effectively enforced in such locations. Those already being detained in such facilities are at particular risk and robust hygiene arrangements, as well as swift action in the event of confirmed cases are essential to protecting other detainees.

During medical screening at border points, people confirmed asymptomatic for COVID -19 but who are presumed to have come into contact with people who have COVID-19 (through conditions of travel for instance) should be instructed to self-isolate at home, in line with current MoPH guidance.

Periodic monitoring visits of trained and adequately equipped community health workers (including dedicated surveillance teams, BPHS and EPHS implementing agencies, and other health providers) to check on the health of the quarantined individuals is recommended, although this may not be possible across Afghanistan given the health infrastructure and security constraints. Such an approach is the best way of containing the spread of the virus, facilitating necessary referrals and relocating patients to dedicated hospitals for testing if they develop symptoms.

Annex 3: Shelter Options

Density is a key factor for transmission pathways. The ability of individuals and families to isolate themselves will depend on the type of house and/or shelter where they live. 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.

If this cannot be achieved at the household's current housing arrangement, minor modifications to current shelters can be implemented. If the existing shelter does not support modification or cannot accommodate the number of individuals needing to self-isolate, specific facilities such as tents, refugee housing units (RHU) can be set-up for this purpose. At risk households should also be provided with NFIs to reduce sharing of items and promote safe handling practices.

The practical options for housing high-risk community members in overcrowded areas, particularly in IDP settlements, have been defined at three levels: at **household/family**-level, **site**-level and at **community**-level.

At household/family level:

A guidance note will be provided to the household/caregiver of the suspected case detailing practical tips on how to undertake minor shelter modifications, reduce density by providing extensions, partitions, modifications (doors and frames), and retro fitting to upgrade living conditions. Alternatively, where this option is not practical, and the household has access to land, emergency shelter solutions may be provided, including additional plastic tarpaulins, shelter extension kits, tents, refugee housing units, thus increasing the amount of covered living space available.

At site level:

In cases where the household does not have enough vacant rooms, tents, or land to achieve quarantine or isolation, alternative shelter solutions, or relocation of vulnerable people should be explored. This would only apply in cases where home-isolation is not possible.

Option 1:

Ideally, local authorities, together with affected communities, should explore the use and repurposing of existing buildings within/near the site. This option is most applicable in urban areas where hotels, hostels are available. The surveillance team should map available capacities for the facilities located near government hospitals, health centers and have these buildings available for use for COVID-19. It is recommended that these facilities have access to individual WASH facilities. This approach helps negate the constraints in displacement sites around land availability, overcrowding, inadequate WASH facilities, and risks of transmission due to tents being used to isolate multiple individuals etc.

Option 2:

In situations where Option 1 is not available, the feasibility of establishing a standalone facility within the site should be explored. The size of the proposed facility will be guided by the current and projected number of individuals who need to self-isolate. A dedicated temporary facility should be constructed within the boundary of the IDP site or overcrowded shelter (space permitting) for those who have been directed to self-isolate. Local materials should be used for construction (timber, plywood, plastic sheeting, etc.). The facility would be temporary in nature, made of wood and plastic sheeting. Physical separation between individuals should be provided to ensure the safety and dignity of those being accommodated. Specific measures should be considered for children and lactating mothers. Alternatively, where the use of the shelter materials cited above is not feasible, modular refugee housing units (RHUs) can also be installed (space permitting). While large tents--even those designed for medical functions--may not be suitable for COVID-19 as they are not designed for individual isolation, in cases where they have mechanical ventilation capacity and ability for individual isolation, they may also be appropriate.

At community level:

All attempts should be made to find a solution within the periphery of the existing settlement. Where there is no capacity within the settlement to facilitate the isolation of a significant number of people, a dedicated facility should be constructed or found at provincial level to permit isolation of those who may have been exposed to the COVID-19 virus. Upon identification of this need, a location where most people are located/likely to live should be identified in coordination with local authorities. *This should only apply in cases where home isolation is not possible, and if resources in health facilities do not allow.*

Option 1:

This facility may be implemented through the re-occupation of existing buildings including stadiums, gymnasiums, hotels, hostels, setting up a sequence of prefabricated structures, refugee housing units and as a last resort the erection of rubb halls and large multi-purpose tents etc. In the case of existing buildings, the local authorities, as well as health, shelter and WASH actors should assess the suitability of the structures for occupancy and determine the need for minor rehabilitation works (if any). It is recommended that the facilities are managed by the local authorities with support from humanitarian actors.

Rubb halls, large multipurpose tents are not recommended for COVID 19 related usage as they cannot provide isolation capacity¹⁵. Individual partitioning may help mitigate infection transmission risk, but the greater risk is that co-location of vulnerable, suspect and confirmed cases may increase infection spread. **The decision to use these facilities is more dependent on the diagnostic capacity to make sure that cohorts are not co-located.** No safe distance for patients has been established for such facilities and thus individual isolation where possible is the primary recommendation. Set up and design of these facilities should be done in consultation with health authorities, WHO, WASH partners to identify adequate spacings for categorization of patients and minimize possible co-location. For use as treatment and screening facilities, individual partitioning, heating, ventilation, and air conditioning (HVAC) system should be provided.

For all options, local solutions that are quick to implement, use labour-based methods and cash for local material purchases, and encourage local economic stimulus should be prioritised. However, solutions should minimise options that put people at risk by having to take additional measures to source materials from markets, engage in extended social contact, etc.

¹⁵ Large tents, even those designed for medical functions may not be suitable for COVID-19 as they are not designed for individual isolation but rather for general medical treatment. Where they have mechanical ventilation capacity and ability for individual isolation, they may be appropriate. Generally, they should perform well in regard to cleaning and disinfection requirements.

Annex 4: WASH Considerations

For COVID-19, WASH standards should follow guidance as per below:

- Water, sanitation, hygiene, and waste management for the COVID-19 virus - Interim guidance (WHO/UNICEF – March 2020);
- Sphere standards and the Coronavirus response - Applying humanitarian standards to fight COVID-19 (Sphere – March 2020);
- Afghanistan National Guidelines for WASH in Emergency (ANGWE) (WASH Cluster and Ministry of Rural Rehabilitation and Development (MRRD) – January 2018)

Level 0 (No suspected or confirmed case) Specific WASH Guidance

- COVID-19 specific hygiene promotion training to can be found at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/online-training>
- COVID-19 Information, Education and Communication (IEC) materials can be found on-line: <https://www.humanitarianresponse.info/en/operations/afghanistan/health/documents/publication-date/2020?search=COVID-19%20Poster1>

Level 1 (Household level self-Isolation at Home) Specific WASH Guidance

The quantity of water available to people self-isolating at home should be increased from 15 to 50 l/person/day to promote disinfection, washing and cleaning. Elderly and people with compromised immune systems should be prioritised. Handwashing facilities should be installed, if possible, at the main entry, and other common places, and regularly provided with soap and/or chlorinated water.

Level 2 (Community Level Isolation) Specific Guidance

Similar to the services provided to the person self-isolating in Level 1, WASH actors will need to strongly coordinate with Shelter actors to ensure that any temporary isolation facility takes into consideration the guidance on WASH facilities for persons with specific needs (PWSN) and Persons with Disabilities (PwD), and is equipped with:

- temporary toilets (one per 15 people maximum, separated by gender) regularly cleaned and disinfected;
- handwashing facilities adjacent to toilets, regularly supplied with soap or/alcohol-based hand rub or/chlorinated water (0.05%);
- Water tanks with connection to the temporary facility and handwashing facilities where practical and feasible;
- Sufficient and safe water and desludging services if needed (services providers should be trained on infection prevention and control (IPC) and provided with prevention equipment)
- A suitable amount of soap and disinfection products in support of the Health actor, if agreed, to facilitate regular cleaning and disinfection of the isolation room and other areas of the tent.

Outcome	Standards indicators before COVID-19	New Standards indicators level 0	Standards indicators level 1
At risk populations have immediate access to adequate safe water, hygiene and sanitation through life saving activities	Safe water supply: <ul style="list-style-type: none"> • Minimum of 15 litres per person; • <10 CFU/100ml at point of delivery (unchlorinated water); • ≥0.2–0.5mg/l FRC (chlorinated water); • Turbidity of less than 5 NTU. 	Safe water supply: <ul style="list-style-type: none"> • Minimum of 15 litres per person; • 0 CFU/100ml at point of delivery (unchlorinated water); • ≥0.5-1mg/l FRC (chlorinated water); • Turbidity of less than 5 NTU. 	Safe water supply: <ul style="list-style-type: none"> • Minimum of 15 litres per person; • 0 CFU/100ml at point of delivery (unchlorinated water); • ≥0.5-1mg/l FRC (chlorinated water) • Turbidity of less than 5 NTU. Direct connection of the isolated rooms to the water tanks as far as

			possible where practical and feasible.
	<p>Shared toilets:</p> <ul style="list-style-type: none"> • Minimum 1 per 20 people; • Safety and security especially for women and girls, children, older people and persons with disabilities. 	<p>+ Individual toilets' option:</p> <ul style="list-style-type: none"> • 1 safe latrines/toilets per family (construction/rehabilitation); • Safety and security especially for women and girls, children, older people and persons with disabilities; • Equipment and tools available to facilitate regular maintenance of a hygienic environment through waste minimisation, collection & disposal. 	<p>Individual toilets:</p> <ul style="list-style-type: none"> • 1 safe latrines/toilets per family (construction/rehabilitation); • Safety and security especially for women and girls, children, older people and persons with disabilities; • Equipment and tools available to facilitate regular maintenance of a hygienic environment through waste minimisation, collection & disposal. • Construction or allocation of a dedicated toilet for each isolation room, with a handwashing facility, in collaboration with shelter partner.
	<p>Hygiene promotion:</p> <ul style="list-style-type: none"> • 2 water containers per household (10–20 litres; one for collection, one for storage); • 250 grams of soap for bathing per person per month; • 200 grams of soap for laundry per person per month; • Soap and water at a handwashing station (one station per shared toilet or one per household); • Potty, scoop or nappies to dispose of children's faeces. 	<p>Hygiene promotion:</p> <ul style="list-style-type: none"> • 2 water containers per household (10–20 litres; one for collection, one for storage); • 250 grams of soap for bathing per person per month; • 200 grams of soap for laundry per person per month; • Soap and water at a handwashing station (one station per shared toilet or one per household); and • Potty, scoop or nappies to dispose of children's faeces; • All public handwashing stations have soap or alcohol rub (or 0.05 per cent chlorine solution). 	<p>Hygiene promotion:</p> <ul style="list-style-type: none"> • 2 water containers per household (10–20 litres; one for collection, one for storage); • 250 grams of soap for bathing per person per month; • 200 grams of soap for laundry per person per month; • Soap and water at a handwashing station (one station per shared toilet or one per household); and • Potty, scoop or nappies to dispose of children's faeces; • All public handwashing stations have soap or alcohol rub (or 0.05 per cent chlorine solution); • Distribution of one WASH Hygiene Kit per Household with explanation on IPC measures and their importance.

Annex 5: Additional Considerations for supporting self-isolated individuals, families and communities

Government and humanitarian partners supporting people to self-isolate at home should ensure adequate individual and community resources are provided so that those in isolation are not socially, financially, or otherwise punished for complying with home-isolation directives. Particular consideration must be given to vulnerable individuals including children, the elderly, and people with disabilities.

Prioritise safety and dignity, and avoid harm

- Proposed locations for any additional isolation facilities should be identified as early as possible and take into account the need to mitigate the risks of social tension, stigma, physical attacks, threats to safety including risks related to the environment, and the risks of eviction (proximity to main roads and security installations).
- Measures proposed should never put community members at further harm, including members of HH where one member may have been exposed to the virus, those providing assistance during the period of isolation including relatives, caretakers, healthcare workers or humanitarians.
- Ensure that all shelter and wash facilities established/rehabilitated for isolation do not present safety risks, especially for children, people with disabilities, and the elderly.
- Clear SOPs for management of provisional or temporary isolation areas should be developed. Given the fears many have about being exposed to COVID-19, it will be critical to ensure that people involved in the management of any provisional or temporary isolation facilities, and caretakers are well trained on infection control and provided with the necessary PPE and training on how to use and dispose these.
- Training and the provision of equipment for the possible caretakers should be prioritised, with specific attention paid to women who are the most common caretakers.

Share information and ensure communication

- In close coordination with the Risk Communication and Community Engagement (RCCE) working group, actors supporting isolated individuals should remain updated with rapidly changing information on COVID-19 and ensure that updated, accurate and adapted information reaches men, women, girls and boys of diverse backgrounds.
- Those carrying out community outreach should prioritise the most at risk, especially older persons, people with disabilities and people with pre-existing or underlying medical conditions such as asthma, diabetes and heart disease.

Support persons with specific needs

- People with disabilities and older people without caregivers may not be able to care for themselves or access services while in self-isolation. Additional measures to reach people with disabilities and older people through adapted communication means should be planned (see above).
- If caregivers need to be moved into isolation/quarantine, plans must be made to ensure continued support for people with disabilities. In such situations, community-based structures, groups, volunteers, networks and leaders in the community can be useful partners in communicating and providing mental health and psycho-social support (MHPSS) and other needed support.
- Planned distribution of assistance to support people in isolation should ensure that people in need, including female headed households, older persons and persons with disability, have equal and timely access to assistance.

Ensure the protection of children

- Every effort should be made to ensure that parents/caregivers and children who may have been exposed to COVID-19 can remain together. In cases where parent/caregivers and their children have divergent diagnoses, they should only be separated when all alternative means to remain united have been exhausted and separation is deemed in the best interest of the child.
- Ensure unaccompanied and separated children (UASCs) particularly and their caregivers receive necessary support and that the same measures are in place to avoid separation.

- In case parents/caregivers need to go into temporary self-isolation facilities, child protection agencies should be 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, measures must be in place to ensure that an alternative caretaker is trained in caring for children.

Prevent instances of sexual and gender-based violence

- 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/rub hall/shelters. Additional measures should be put in place to safeguard these areas from abuse or violence.
- Ensure that survivors who are directed to self-isolate are being followed-up on by SGBV case management agencies regularly (by phone), to ensure that they are not facing additional protection risks.

Mental health and psychosocial support (MHPSS)

- Staff in direct contact (including over the phone) with communities should be trained on Psychological First Aid.
- Precautions should be taken to ensure that people with mental health and substance abuse disorders are able to continue to access medication and support during if they are required to self-isolate, both in the community as well as in institutions.

Community participation and support

- Outreach through community and religious leaders should be done to prevent stigmatisation and marginalisation of self-isolating individuals/households from the onset, as well as support re-integrating survivors back into the community.
- Where possible, community and relevant protection actors should be engaged to identify community caregivers who can support people with specific needs, including persons with disabilities, older persons and unaccompanied and separated children.