

COVID-19 Outbreak Preparedness and Response Operations

in IDP Camps

19th April 2020

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Objective

In order to ensure that adequate preparedness measures are put in place by humanitarian aid organizations to respond to potential confirmed cases (mild/moderate¹) of COVID-19 in IDP camps in the conflict-affected governorates in Iraq, should the Ministry of Health's capacity to manage cases in hospitals be overwhelmed due to a rising caseload, the Iraq Health Cluster jointly with the Shelter Cluster have drafted this document. It is intended to provide guidance to partners in the field so that they are able to quarantine/isolate confirmed cases within the premises of camps, utilizing available resources in the best - and especially fastest - manner. The document has been reviewed by the Strategic Advisory Group of the Health Cluster and CCCM, Protection, Food Security and WASH clusters and has been endorsed.

In line with the Iraq Country Strategic Preparedness and Response Plan Against COVID-19, the main aims of this document are to:

- Limit human-to-human transmission, including reducing secondary infections among close contacts and healthcare workers, preventing transmission amplification events, and preventing further spread from Iraq;
- Identify, isolate, and care for patients early, including providing optimized care for infected patients; and referring them to higher level healthcare when required;
- Communicate critical risk and event information to all communities, and counter misinformation;
- Minimize social and economic impact through multisectoral partnerships.

This document is developed using technical input from the *Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings*² and *Key Considerations for Selecting Health Infrastructure for the Response to COVID 19*³ in addition to other technical guidance documents developed by WHO and referenced accordingly.

The existing capacity of partners (Health/WASH/CCCM/Food Security/Shelter and NFI) should be built upon in addressing the issue of establishing quarantine and isolation areas to manage travel/contact cases (for quarantine) or mild/moderate cases of COVID-19 (for isolation) that may present in IDP camps. Taking this into account, different stages are presented below, where one or more situations may fit individual camps in different governorates.

Based on the Health Scenario Planning document ([Annex 1](#)), **quarantine areas shall be set up in IDP camps but already planned for a partial or full use as isolation facility, would the cases become overwhelming**

¹ Uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnea, nasal congestion, or headache. Rarely, patients may also present with diarrhoea, nausea, and vomiting. (<https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf>)

² Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings (jointly developed by IFRC, IOM, UNHCR and WHO) <https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp>

³ Key Considerations for Selecting Health Infrastructure for the Response to COVID 19:

https://www.sheltercluster.org/sites/default/files/docs/unhcr_selection_health_infrastructure_covid19_20200401.pdf

and health structures unable to cope. **Principles of IPC (Infection Prevention and Control) would be the same for both use as quarantine and isolation facility of those areas.** Hence, throughout the document, reference is made to Quarantine / Isolation (Q/I) areas.

The guidance intends to provide indication for an optimal establishment and management of Q/I areas. Nonetheless, land availability, site topography, resources availability, community acceptance, etc. may vary on a case by case basis and be less than recommended in the document. Hence, relevant partners shall seek advice from their respective clusters, to ensure alternative solutions are identified.

Community engagement

Ahead of the preparation of Q/I areas, communities should be consulted in all preparedness efforts especially the process that will be followed if a person needs to be quarantined inside the Q/I area, or if a suspected case is identified such as testing and isolation. This consultation and information dissemination should be conducted jointly by the camp management/CCCM and Health partner. Ensure to consider the different concerns of men who may be quarantined individually, women especially if individual quarantine might be required, and families, for undertaking quarantine and isolation. This may require ensuring separation within the facility for individual men and women and families. Engagement with all individuals in quarantine/isolation over their personal perception of safety must continue throughout.

Information should be provided through different channels ahead of time, jointly by CCCM and Health, and community buy-in should be sought ahead of implementation. If time allows, visiting the Q/I area by IDPs ahead of its opening can be considered, to allow people familiarizing with it and to avoid fear around type of facilities and protocols that will be put in place.

Success of the quarantine and isolation areas will rely on community compliance. Establishment of the areas and compliance of individuals in undertaking quarantine and isolation should be framed as an *individual responsibility, to support the wider health of the community*. Stigmatization of individuals undertaking quarantine or isolation may easily arise, and should be addressed through repeated community information campaigns on how COVID-19 is transmitted including on asymptomatic infection, the principle of quarantine to keep people safe, and that after undertaking quarantine for 14 days there is usually no longer a risk of COVID-19 transmission, unless there is a re-infection, which is not so common.

Technical guidance for the establishment of Quarantine / Isolation areas

Selection of the most appropriate space to establish a quarantine/isolation area, as near as feasible to the health facility in the camp, should be guided by the Health partner, with CCCM partner advising on space availability and feasibility, in appropriate consultation with local authorities. Design of the space should reflect the below requirements, guided by the Health partner in consultation with the supporting partners (CCCM, Shelter, WASH).

Set up tents equaling 1%⁴ of the camp population in a location away from the main camp. The distance should be at least 100 meters away (or what is feasible in the specific camp, based on available space), fenced by chicken mesh or plastic wire (if not available, then plastic sheeting) to discourage movement between the camp and the isolation area. A portion of the fence shall be provided with Plexiglas as “visit corner” of the Q/I areas.

The location to set up Q/I areas shall ensure that run-off water does not flow from the Q/I area onto the camp or any nearby host community. If that is not possible, consider digging trenches around each tent and the Q/I area to allow runoff water to flow toward the external perimeter of the camp.

Wind direction needs to be monitored, especially to avoid it blowing from the Q/I area toward the rest of the camp.

MoMD or WASH partners should spray the location with 0.5% bleach solution before setting up the tents.

Guarded entry/exit points need to be provided, so as to discourage people forcing in/out of the areas, while considering the risk for contamination while accessing the different areas (check the [Annex 2](#) for a sample layout). Entry/exit points shall be provided for:

- One for the entrance of cases (entering the quarantine/isolation period)
- One for the discharge of cases (having completed the quarantine/isolation period)
- One for staff and supplies vehicles
- One for the waste collection area

Clear demarcation needs to be made inside the Q/I area, to separate different parts: area where staff will move, temporarily store material, change (if applicable), etc. will not be accessible to cases (check the [Annex 2](#) for a sample layout).

Set up emergency shelter (tunnel tent, UNHCR tent or RHUs), each to house a single individual. The tents should be at a distance of at least 2.5 meters from one another, so as to respect ventilation across tents, as well as minimize the risk of fire incidents. Proper ventilation should be ensured by setting up the tents in the general direction of the wind.

WASH facilities (toilets and showers) shall be provided for the use of quarantine/isolation areas. They need to be separated for women and men, lit at night, on a ratio of 1:20. Consider the need for refilling water tanks and desludging of cesspits when placing them – preferably near to each other, and near the perimeter of the areas. A laundry area shall be provided, for the regular wash of blankets and clothes – this can be combined with the hand washing points near the showers.

A dedicated zone for logistic purposes shall be foreseen (check the [Annex 2](#) for a sample layout). Space for health personnel may also be considered in this zone, especially for the purpose of serving Isolation area, and if this is far from the camp PHCC – or the camp does not have a PHCC. In such case working tents

⁴ Currently, the global attack rate is 0.02%. If we estimate the number of infected to be 10-fold higher, it will be 0.2%. Therefore, we could prepare for 1% Attack Rate, among whom 0.8% would have mild/moderate symptoms while all of them would not be sick at the same time. The cases can be divided into 6-8 hospitalization cycles (each on average of 14 days) with the maximum caseload occurring during the middle of the cycle; this will equal 0.1% of the population.

should be made available for a minimum number of clinical, para-clinical and support staff. Each tent should be able to accommodate a minimum of 4 individuals with changing, resting and storage facilities, toilets and washrooms. Two such tents would be sufficient, one for doctors and nurses and the other for helpers and guards. These tents should be stocked with necessary supplies (case management supplies, food, toiletries and stationery) and infection prevention facilities.

Non-medical management of Quarantine / Isolation areas

Gender considerations must be taken into account when establishing the area and moving individuals in, ideally, through consultation with the community (Women's Committee, as well as male leaders). For example, tents of single men should be separated from those of individual women or families. Individual women or families should be consulted, as far as is possible, on the location that they feel safest in – for example, close to guarded entrances, or in well-lit areas.

[WASH] Ensure that WASH facilities are disinfected using 0.5% bleach spray⁵ after every use. WASH and CCCM partners should collaborate to find a camp specific plan to ensure regular cleaning/disinfection: volunteers among individuals referred to quarantine areas would be the preferred modality. Alternatively, cleaners paid through incentives and hired among the camp population can be considered. Training and PPE should be provided⁶, so as to minimize secondary infections.

Ensure sufficient supply of soap and clean water, for drinking, bathing and disinfection, basic cooking⁷. In addition, and only if clean water and soap are not available in sufficient quantities, provide each tent with alcohol-based (at least 62-71%) hand sanitizers to be used frequently, even when hands are not visibly soiled.

Mandatory disinfection of hands and shoes of all people entering/exiting the Q/I shall be put in place, with the use of 0.5% bleach spray. Same applies to medical staff entering/exiting each tent when visiting cases/patients. Medical and other logistical staff wearing disposable gloves would not need to sanitize these, in order to preserve the integrity of the gloves. However, the gloves must be safely disposed as soon as used.

Every time a case is discharged from Q/I areas, disinfection of the vacated tent can be done by spraying 0.5% bleach solution (or 70% alcohol, although not readily available and costly) on surfaces and materials that cannot be washed with detergent and water. Remaining items, including blankets and other NFIs, can be washed thoroughly in water and detergent. If the numbers are low, Camp Management could provide new NFI sets, if available.

⁵ To make a 0.5% dilute solution of chlorine from 5% concentrated liquid household bleach = [5.0%/0.5%] -1 = 10-1 = 9 parts of water; hence add one part of concentrated bleach to nine parts of water. Note that such solution may bleach clothes, hence use of gumboots is HIGHLY RECOMMENDED for aid workers.

⁶ Initial ToT can be provided by health partners if not too stretched. WASH partners will also be the back-up on this task

⁷ The SPHERE handbook, 2018 edition: <https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf>

Solid waste collection shall happen regularly and based on usual protocols, while dedicated staff shall wear PPE.

[NFI] Each tent should be provided with basic NFI set (blanket, mattress, etc.) and each individual provided with appropriate hygiene kit items. Shelter and NFI cluster has included cooking stove as part of the NFI that shall be provided in Q/I areas

[Food security] There will be a need to ensure that individuals who are in the quarantine/isolation areas have sufficient access to food, and rely on families sharing existing rations (either delivered in-kind by MoMD, or through the cash-based assistance delivered by Food Security partners). It is preferable that individuals in the Q/I area cook their meals. Special attention will need to be provided to people who are unwell, hence unable to cook for themselves. In such circumstances their families can be allowed to deliver them meals through aid workers, that will wear Personal Protective Equipment (regular surgical masks and disposable gloves). The food parcel should be left at the door of the tent to minimize contact with the patient, to be collected by the patient after the distributor has left. Masks and gloves should be disposed as soon as distribution is complete in the isolation area, using the standard procedures.⁸

Yet, provision of hot/wet meals while possibly preferable, comes with significant logistical issues. Ready-to-eat rations could be an alternative.

In terms of nutrition, nothing specific is recommended, since these are either healthy persons requiring simple quarantine period, or they are patients with flu-like symptoms. An increased intake of fluids is recommended, in the form of water, juices, etc.

[Protection/MHPSS] Provide individual tents with any feasible entertainment facilities to prevent boredom, depression and any other psychological issue. Radios can be provided, as well as PSS and Learning kits for children. No visit inside the tents in the Q/I area shall be allowed, so as to minimize the risk of virus transmission. Phone contact with relatives shall be the preferred way to maintain contact with the family. If necessary, Protection partners should coordinate with CCCM & Health over feasibility of visiting arrangements, and how to support these. Potential support of MHPSS specialists shall be considered, to both facilitate maintaining family contacts while respecting safety measures when “meeting” relatives.

For cases in the Q/I area that need MHPSS: if staff is not allowed/refuse to meet the cases personally because of lack of PPE or other reasons, consultations might happen over the phone (if the IDPs have phones) or through alternative modalities to be explored. The MHPSS component of IDPs in Q/I areas is a must since IDPs are already in a stressful situation/trauma due to conditions in camps. PSS services shall also be offered to family members of those in quarantine/isolation to support them in coping with the situation.

[Protection/GBV] An increase in domestic violence cases due to forced stay/movement restrictions has already been recorded. Hence, minimizing risks of ‘domestic violence’ for GBV survivors shall be carefully

⁸ Adapted from *Recommendations for adjusting food distribution Standard Operating Procedures in the context of the COVID-19 outbreak*: https://reliefweb.int/sites/reliefweb.int/files/resources/20200319_covid_sop_food_assistance.pdf

considered. Should a GBV survivor and the perpetrator both be in need of quarantine, they should be separated and benefit each from an individual tent.

[CCCM] Guards shall be deployed at the entrances/exit of the Q/I area, so as to ensure no movement in/out⁹ with the exception of humanitarian partners that provide health, food, WASH and other basic daily assistance. Appropriate arrangement should be made with camp security, to ensure that the area is secured in the same way as the rest of the camp. Guards should be trained on COVID-19 self-protection measures and provided with appropriate PPE and access to handwashing stations.

CCCM to establish with Protection and Health the feasibility of a protocol for enabling visitors (in the dedicated area, and with at least 1 meter distancing), and the responsibility for supervision of this. person remains inside the Q/I area while the visitor stays outside the fence. Plexiglas shall be installed on that part of the fence. Visiting hours need to be established and clearly communicated to the IDP community. Visiting time shall be limited to 10 min/day, maintaining the minimum security distance of one meter (two large steps). Queuing shall be avoided as much as possible, and always maintaining the minimum security distance (two large steps). Privacy considerations must be made too

Specialized health care

Health care of Quarantine cases

The health partner in the camp should monitor the travel/contacts/suspected cases regularly (once a day) during the quarantine period, using the standard precautionary/protective measures to prevent the health workers from contracting any potential infection. The health partner should assess the health status of every individual and ensure continued treatment for those with chronic conditions. Specimens should be collected from any of the individuals exhibiting signs/symptoms of COVID-19 infection (flu-like symptoms) and sent to the laboratory for testing. Should a test turn out positive, that individual should either be referred to a government health facility (preferred) or immediately isolated in the Isolation area. The rest of the individuals would need to be quarantined for 14 days, based on the “contact” definition¹⁰, after one of their members tested positive for COVID-19 infection. Hence, it is crucial that people in the quarantine

⁹ A note that implementation of movement restrictions relies on community compliance. While CCCM partners will provide guards for the Q/I areas, the guards should NOT place themselves at physical risk at any time during their duties, or physically intervene in any situation. Any violations of the movement restriction into the quarantine area should be noted and reported to the camp management team and health partner.

¹⁰ Based on WHO Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts, page 3 (<https://drive.google.com/file/d/1H3cCTqAngQ0D-JBsEnQplAxQUbwSgg8T/view>):

“A **contact** is a person who is involved in any of the following from 2 days before and up to 14 days after the onset of symptoms in the 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 with (that is, within 1 m separation from) a COVID-19 patient in any kind of conveyance; • and other situations, as indicated by local risk assessments”

areas are reminded to respect social distancing, respiratory and hygiene practices to limit the spread of the disease, if they present any symptom and/or turn to be positive.

Individuals not showing any signs/symptoms of the infection after the quarantine period may be allowed to resume their previous lifestyle within the camp.

All health partners in the camp should work in a coordinated manner to disseminate health messages on practicing personal hygiene measures, prevention of panic and stigmatization of persons that have been referred to Q/I areas.

Health care of Isolation cases

The health partner in the camp should monitor the cases (through regular six-hourly visits by the clinical management team) following standard case management guidelines and using the standard precautionary measures.¹¹ The cases should be provided with the necessary medicines and supplements, including mental health support. This should continue for at least 14 days. The health partner should also ensure adequate management of underlying conditions such as diabetes or hypertension including continuation of treatment.

Once the patient has tested negative for COVID-19 infection by laboratory confirmation, he/she may be introduced/re-introduced into the main camp.

All health partners in the camp should work in a coordinated manner to disseminate health messages on practicing personal hygiene measures, prevention of panic and stigmatization of persons that have been referred to Q/I areas.

Case management under different situations

Situation A: Quarantine of persons with travel history

Communities should be made aware of procedures relating to new arrivals / individuals returning to the camp who have traveled within and between governorates. Camp management teams should ensure that all new arrivals are also informed about the procedures before they enter the camp.

Camps that accept new arrivals/returning individuals should establish facilities to allow for these individuals to be kept under quarantine for 14 days before being introduced into the camp, on the condition that they do not show signs/symptoms of flu-like disease or COVID-19¹². During the quarantine period, since it is unknown whether the person may be positive, he/she shall spend most of the time inside

¹¹ *Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected:*

[https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125)

¹² Kindly follow the guidelines set out in the *Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings* document (<https://interagencystandingcommittee.org/other/interim-guidance-scaling-covid-19-outbreak-readiness-and-response-operations-camps-and-camp>) under *Section IV: Individual Health Screening*

the assigned tent, and exit for the only use of WASH facilities, or to attend a “visit” to relatives through the visit corner. The person shall also respect all measures of social distancing.

As mentioned under [Non-medical management of Quarantine / Isolation areas](#), it is preferable to have separate tents for these new arrivals/returnees.

Movement of people under quarantine should be minimized to the maximum. Entertainment facilities, according to available resources, should be provided in the tents.

WASH facilities and food distribution should be conducted as outlined under [Non-medical management of Quarantine / Isolation areas](#).

The health partner in the camp should monitor the quarantines individuals once a day, similar to the guidance in [Health care of Quarantine cases](#). If any person starts showing signs of flu-like illness, specimens need to be collected from this person and, if laboratory tests confirm COVID-19 infection, the individual should preferably be transferred to a government health facility

Situation B: Quarantine of family members/contacts of suspected & confirmed COVID-19 cases

Any family members or close contacts of a suspected/confirmed case of COVID-19 should be quarantined for a minimum of 14 days (incubation period of the virus).

Contacts of cases may be initially quarantined inside the Quarantine area. The health partner in the camp should adopt the protocols presented under the [Health care of Quarantine cases](#).

Once Quarantine area capacity is exceeded, people can quarantine within their residences in the camp, as long as standard measures of precaution are practiced. This should be accomplished as follows:

- Quarantine the contacts in a family tent within the camp. If the family can already separate the case in another tent they have, the suspected/confirmed case shall use that. Where possible, at-risk family members¹³ should be separated.
- Minimize movement of the contacts in the camp as much as possible. Provide tents with any feasible entertainment facilities to prevent boredom, depression and any other psychological issue.

Use of WASH facilities and daily soap and water allowance should be as under [Non-medical management of Quarantine / Isolation areas](#).

Food distribution should be conducted as per the guidelines set out in *Recommendations for adjusting food distribution Standard Operating Procedures in the context of the COVID-19 outbreak* (https://reliefweb.int/sites/reliefweb.int/files/resources/20200319_covid_sop_food_assistance.pdf)

Situation C: Isolation of mild/moderate cases of confirmed COVID-19 cases

¹³ Persons above 60 and/or those suffering from chronic, non-communicable diseases

This situation is a guidance on management of such people identified as confirmed cases of COVID-19, subsequent to laboratory confirmation of specimen testing, who are not able to be referred and managed in the public health facilities pre-identified by the Directorate of Health (DoH) in that particular governorate due to overload of cases or those that do not require additional medical care/interventions.

The health partner in the camp should adopt the protocols presented under the [Health care of Isolation cases](#).

If it is not possible to set up individual tents per person, the option to set-up treatment units, where multiple people could be managed, according to WHO standards¹⁴, should be explored. The WHO guideline on establishment of Severe Acute Respiratory Infections Treatment Centre should be shared with the Health, CCCM and WASH teams at the camps¹⁵.

Situation D: Management of COVID-19 cases from camps before utilizing camp capacity OR when Isolation areas in camps reach/exceed their capacity

Health partners plan to support the enhancement of the capacity of secondary health facilities pre-identified by the DoH at district level in term of supplies, medical equipment, PPEs, training, laboratory capacity, referral services and technical guidelines, while it should be agreed with the DoH that they will run the facilities. Confirmed COVID-19 cases should be managed in these facilities/isolation units as a first step before the isolation areas in camps can be fallen back on as a reserve.

In addition, in order to ensure that both the referral hospitals and the isolation areas in camps are not overwhelmed by an increasing caseload of COVID-19 patients, health partners need to establish isolation units adjacent to the referral hospitals in the different governorates. In order to avoid creating a parallel system and to evade difficulties in handover of the services, these isolation units should be run by the DoH, while temporary support (tentatively, for a period of 3 months) in terms of equipment and supplies can be provided by health partners.

Management of family separation and other cases requiring specific considerations

Specific considerations need to be made when the quarantine/isolation protocol would imply family separation.

Children could be left unaccompanied (without appropriate parental care) when a parent or caregiver is taken into quarantine/isolation. At this point the unaccompanied child(ren) should be referred to the Child

¹⁴ *Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected - Interim guidance – 13 March 2020:* <https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf>

¹⁵ *Severe Acute Respiratory Infections Treatment Centre - Practical manual to set up and manage a SARI treatment centre and a SARI screening facility in health care facilities:* https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwjuv5yX6uDoAhWBTX0KHZ7yAa4QFjAAegQIAxAB&url=https%3A%2F%2Fapps.who.int%2Firis%2Frest%2Fbitstreams%2F1273270%2Fretrieve&usg=AOvVaw1aLs_tRiXivXP9C1wJQoXp

Protection actor in the camp, and the case managed in line with the *Alternative Care Guidance for the COVID-19 Situation*¹⁶. Children in this situation are most likely to need interim alternative care arrangements until their caregiver has recovered and they can be reunited. This may require coordinated support from Camp Management, Shelter/NFI and Food Security actors. Communication between the child(ren) and parent/caregiver also needs to be facilitated including confirmation of methods (e.g. safe options for visiting - if proper precautions are in place, phone calls, etc.)

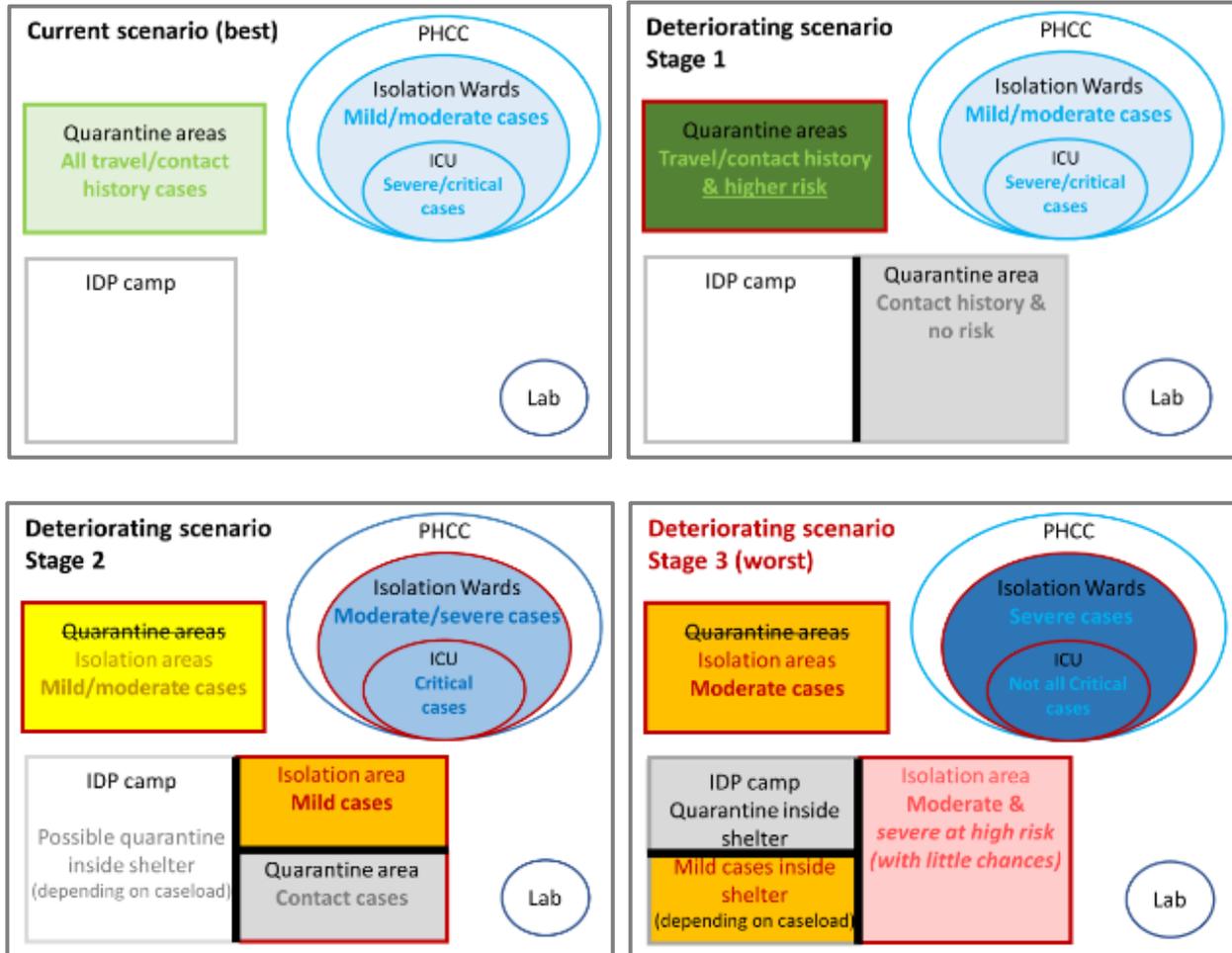
If the patient who needs to be isolated is a child, elderly or a person with a disability, the primary caregiver can join the patient in quarantine/isolation even if not COVID-19 positive. The caregiver must follow the guidelines of the facility and cannot leave until the case has completely recovered and tested negative for COVID-19 and the caretaker is also confirmed as not having COVID-19.

If the child is alone in the quarantine/isolation area, for some reason unaccompanied by the primary caregiver, then this case should be referred to the Child Protection actor in the camp who will support the health actor to identify an age-appropriate solution for alternative care, and who will monitor the care arrangement and the child's wellbeing until the child is reunified with their primary caregiver.

Furthermore, a woman/girl alone may also be at risk, as well as persons with specific needs. Specialized protection actors need to be consulted, so as to ensure the best arrangement for those cases, including for caregivers and service providers following up on these cases.

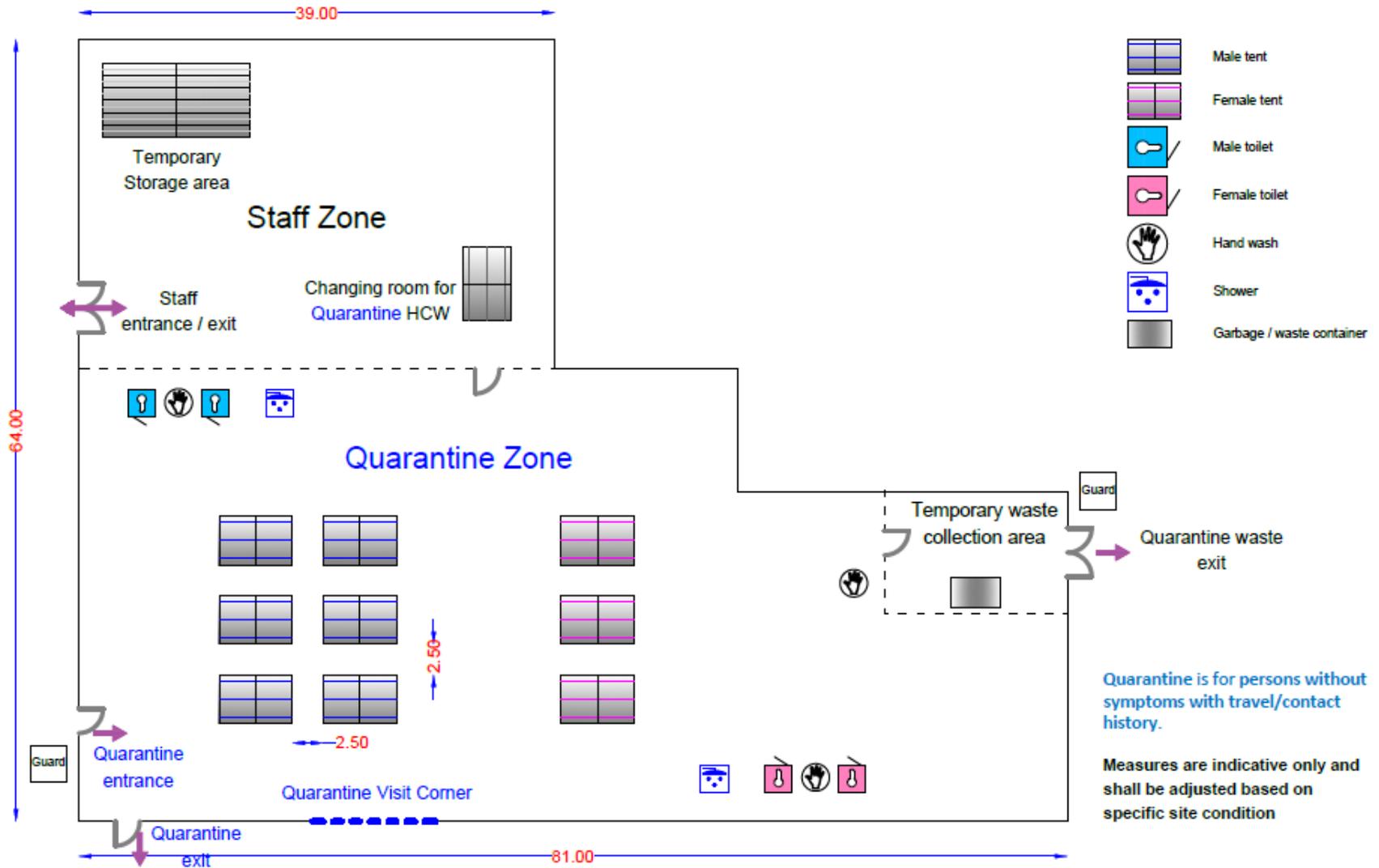
¹⁶ *The Alternative Care Guidance for the COVID-19 Situation* has been produced by the Iraq Child Protection Case Management Working Group:
<https://reliefweb.int/report/iraq/uacalternative-care-guidance-covid-19-situation-iraq-child-protection-sub-cluster-enar>

Annex 1 – Health scenario planning



Annex 2 – Sample of plan lay-out for Quarantine and Isolation areas

Sample of plan lay-out for Quarantine area



Sample of plan lay-out for Quarantine and Isolation area

