INTER-CLUSTER COORDINATION GROUP (ICCG) MYANMAR

Interim Operational Guidance for COVID-19 Quarantine and Isolation in IDP Camp Settings in Myanmar
Revised 12 May 2020

Purpose: This interim operational guidance aims to clarify a number of concepts around quarantine and isolation and lay out risks and recommendations for the humanitarian community to consider. This second version builds on the interim guidance issued by the ICCG on 16 April 2020. The guidance recognizes and builds on broader guidelines and policies on COVID-19 from the Ministry of Health and Sports (MoHS), WHO and other technical and advisory bodies at the global, regional and national levels. Key reference documents are cited throughout and a list is included as part of Annex 1. The document will be updated as the situation evolves and in line with possible revisions to national policies and strategies and any new or revised global guidance that may be forthcoming. In addition, the ICCG will try to capture and circulate practices and strategies for home quarantine and isolation from other humanitarian settings. As a guiding principle, humanitarian interventions at different isolation or quarantine facilities should adhere at a minimum to ICCG guidance on a do no harm approach (available here).

Terminology:

- **Quarantine** of persons is the restriction of activities of or the separation of persons who are not ill but who may have been exposed to an infectious agent or disease, with the objective of monitoring their symptoms and ensuring the early detection of cases. For COVID-19 in Myanmar, this has often included individuals returning from countries or traveling from certain areas within Myanmar where there has been local transmission, as well as contacts of suspect or confirmed cases.
- **Isolation** is the separation of ill or infected persons from others to prevent the spread of infection or contamination. In Myanmar, all individuals fitting the COVID-19 case definition are isolated at designated government health facilities.

Background: WHO emphasizes the early identification of cases and their contacts, the isolation of suspected and confirmed cases and the quarantine of contacts.[1] All suspect cases according to the WHO case definition should be tested.

[1] Per WHO interim guidance, *Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19)*, "The quarantine of persons is the restriction of activities of or the separation of persons who are not ill but who may been exposed to an infectious agent or disease, with the objective of monitoring their symptoms and ensuring the early detection of cases. Quarantine is different from isolation, which is the separation of ill or infected persons from others to prevent the spread of infection or contamination."

In Myanmar, numerous requests from various government entities at state and union levels have been made to humanitarian actors to support different types of COVID-19 isolation or quarantine facilities, often with a lack of clarity on the exact purpose of the facility in question.

The current MoHS policy is for all suspected and confirmed COVID-19 cases to be isolated and managed at designated health facilities.[2] This may evolve as the transmission scenario changes in Myanmar. Additionally, the Ministry of Social Welfare, Relief and Resettlement (MoSWRR) Action Plan on COVID-19 response in IDP camps refers to the establishment of quarantine centres and to persons having come in contact with symptomatic persons being placed "under quarantine if necessary." At this time, Rakhine State Government is also identifying community infrastructure for use across the state. Additionally, government designated quarantine facilities in the vicinity of and within some IDP camps have identified by the Rakhine State Government, while the COVID-19 Task Team in Sittwe is collaborating with state government for potential use for quarantine. In Kachin and Shan state, UN agencies have been requested by state counterparts to help map infrastructure for possible use for IDP and non-IDP settings.

The following is a summary of the WHO case definition for COVID-19. Please review the complete guidance for details.

- **"Suspect case"** is a person with acute respiratory illness or symptomatic AND a specified condition on (1) history of travel to or residence in a location reporting community transmission of COVID-19 disease, (3) contact with a confirmed case or (3) severe clinical presentation in the absence of an alternative diagnosis.
- **"Probable case"** is a "suspect case" for whom testing for the COVID-19 virus is inconclusive or testing could not be performed for any reason.
- **"Confirmed case"** is a person with laboratory confirmation of COVID-19 infection, *irrespective* of clinical signs and symptoms.
- **"Contact"** is a person who experienced an exposure during the 2 days before and the 14 days after the onset of symptoms of a **probable** or **confirmed** case. If a contact develops acute respiratory illness, the person then falls under the definition of a "**suspect case'**

In Myanmar, individuals meeting the below criteria are also currently being quarantined although they do not fall within the WHO case definition:

- A returning migrant or any other person who:
    - Does not have any acute respiratory illness, AND
    - Has history of travel to or residence in a location reporting community transmission of COVID-19 disease

Use of Masks:

[2] Waibagi Specialist Hospital, Mandalay General Hospital (Kantawnadi Hospital) and Nay Pyi Taw General Hospital (1000-Bed) for international ports of entry for PUI cases. All State and Regional level Hospitals and Children Hospitals. Myit Kyi Nar General Hospital, Lashio General Hospital, Muse District Hospital, Keng Tong General Hospital and Sao San Tun General Hospital for POEs.

Wearing a medical mask[3] is one of the prevention measures that can limit the spread of certain respiratory viral diseases, including COVID-19. **The use of a mask alone is insufficient to provide an adequate level of protection, and other measures should also be adopted.** Whether or not masks are used, maximum compliance with hand hygiene and other infection prevention and control measures is critical to prevent human-to-human transmission of COVID-19.[4] **Medical masks and respirators must be prioritized for health care workers. In the case of quarantine facilities, regular surgical or cloth masks could be used to help reduce transmission of the disease.**

Facilities for persons without acute respiratory illness (sometimes referred to as cohort quarantine facilities):

Contact cases, as well as asymptomatic individuals without acute respiratory illness but with history of travel to or residence in a location reporting community transmission of COVID-19 disease, may be put in cohort quarantine facilities when home quarantine is not feasible or applicable due to government policy**.** Contacts are separated and monitored during a recommended period of time (21 days facility quarantine plus 7-day home quarantine as per current Myanmar MoHS policy). If a person develops symptoms and becomes a suspect case, immediate referral to a designated COVID-19 hospital (or a community treatment/isolation facility, depending on MoHS policy and feasibility at the time) is required. Therefore, health monitoring is a critical component of all types of quarantine.

The MoSWRR Action Plan for COVID-19 preparedness and response in IDP camps indicates that some form of quarantine capacity in IDP camps may be requested for persons who have been in contact with a probable or confirmed case. In addition, depending on capacity and resources, it may become necessary to consider options for home-based quarantine arrangements in parallel, at least in camps in which appropriate cohorted facilities cannot be established or are not able to be managed properly. Resources such as adequate food, water, hygiene provisions and other basic necessities, and a MoHS-led system to monitor the health of quarantined persons and refer those who develop symptoms is key. If quarantine facilities are not well managed, there could be increased risk of infection among individuals quarantined within them, particularly if suspected cases are not detected and referred out in a timely fashion.

Government and community-based facilities are also being established by Government of Myanmar primarily to ensure quarantine for non-symptomatic individuals (largely migrants but also prisoners and refugees) returning from countries or locations within Myanmar with active transmission. These are a form of cohorted quarantine facilities, albeit intended for a broader category of persons (all non-symptomatic persons returning from countries with active transmission) than the quarantine facilities in IDP camps outlined in the MoSWRR Action Plan

[3] In this document medical masks are defined as surgical or procedure masks that are flat or pleated (some are shaped like cups); they are tested according to a set of standardized test methods (ASTM F2100, EN 14683, or equivalent) that aim to balance high filtration, adequate breathability and optionally, fluid penetration resistance affixed to the head with straps.

[4] https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak

(i.e. contacts of symptomatic persons). Numerous community-level quarantine facilities are being established throughout Myanmar to accommodate returning migrant workers, for periods that have recently been extended to 21 days plus 7 days of home quarantine, many in situations in which support for basic assistance is likely to be required.

Requests to provide assistance to persons living at these types of cohorted quarantine facilities in collaboration with the government are being considered by various humanitarian agencies. Government of Myanmar guidance is available here on the management of community-based quarantine facilities. Additionally, the Gender in Humanitarian Action Workstream and PSEA Network issued guidelines on gender considerations for cohorted quarantine centers,[5] and Key Considerations for Children and Their Caregivers During Quarantine, Isolation and Hospitalization Due to COVID-19 are also available.

Recommendations:

1) IDPs should be consulted on possible establishment of quarantine facilities in camps, and on possible self-quarantine strategies.
2) **Cohort quarantine spaces, particularly for individuals returning to IDP sites from locations with local transmission, should be outside of IDP camps** to reduce the risk of introduction of the virus inside of camps, and ensure access for health care workers to monitor and refer individuals in these facilities elsewhere if they show symptoms. Quarantine facilities may be established inside camps for contacts of confirmed cases from within camps if access to facilities outside the camp is limited (due to lack of transport, movement restrictions, etc.) and if home-based quarantine is not an option due to government policy or inadequate conditions in the home.
3) Contacts of confirmed cases and individuals with travel history (returning refugees or migrants) should be quarantined in separate facilities to reduce the risk of exposure to each group.
4) Although **current government policy requires the quarantine of all contacts of suspected and confirmed cases within facilities identified by the government**, these may quickly reach capacity in the event of transmission within densely populated camps and **strategies to support home quarantine within camps should be developed as a preparedness measure**. (See Annex 3 on MoHS guidance on home quarantine for assistance with the identification of measures that may be applied to camp settings.)
5) Minimum standards on health, shelter, gender, protection and WASH should be considered for all types of quarantine facilities.[6]
6) Schools, temporary learning centers and other education institutions should not be used for quarantine or isolation facilities, except as a last resort. If educational buildings are used for quarantine or isolation, plans for maintenance, repairs, disinfection and waste management must be considered from the planning stage to restore the buildings to their original function as soon as possible.

[5] Guidance produced by UNFPA and UN Women, available on ICCG shared folder
[6] Checklist for assessing, planning and managing isolation and shielding centres from a gender-specific protection perspective & Global WASH Cluster Guidance

7) Packages of assistance for individuals during the duration of quarantine and upon release should be standardized.[7]
8) Rubb Halls or other large tent like structures may be procured as part of a "no regrets" approach to ensure preparedness for space for quarantine facilities, noting land issues and infrastructure needs may make this unfeasible in some contexts.[8] WASH guidelines for quarantine centers should be adhered to the extent possible.[9]

Facilities for suspect and confirmed cases (sometimes referred to as cohort isolation or treatment facilities):

Isolation is an important measure to avoid transmission of infection from ill or infected persons to others. Applying this to the case definitions, "isolation" is appropriately used for "suspect case" and "confirmed case" only. As stated above, current MoHS policy is that all suspected cases are referred to and tested at designated isolation/treatment facilities. Furthermore, the current MoSWRR Action Plan does not provide for either community treatment/isolation facility or home isolation in camps; the Action Plan refers to the establishment of "quarantine centres" only.

Approaches to isolation of COVID-19 cases has varied around the world and has often been based on severity of symptoms and capacity of a given health care system. General principles and evidence follow this hierarchy:

1. isolation of confirmed cases is ideally done in designated health facilities if capacity allows;
2. isolate and treat in designated community facilities (tents/structures) if not;
3. isolate at home when conditions at home allow, while continuing to push for isolation at designated facilities.

Depending on how the situation evolves, quarantine facilities originally intended for those without acute respiratory illness may be requested to isolate suspected or confirmed cases with mild and moderate symptoms if MoHS policy changes due to insufficient space at designated treatment facilities. In this case, people under quarantine should me moved to a separate location to avoid mixing individuals quarantined with suspect, probable or confirmed cases. Partners may be requested to repurpose other types infrastructure for isolation. These cohort isolation facilities should be designed only if treatment facilities are over capacity and cannot

[7] See Core Migrants Group Standardized Package of Assistance. This may be different for contacts of confirmed cases who have access to other types of assistance. In this case the package will conform with CCCM guidelines

[8] Patients with fever and medical personnel in full PPEs will easily suffocate if the interior temperature is not adequate. Sometimes natural ventilation is not sufficient. Military grade tents are usually of very good quality and ventilation features are better. The size of the tents is dependent on need. The bigger it is, the more land, the more personnel to manage. Multiple units but smaller, perhaps 10 patients max, may be ideal. The height of the tents is very important for this hot climate. According to publications from ICRC, the recommended minimum height is 2.4m.

[9] WASH in confined spaces (quarantine & isolation centres, prisons) if requested by Government

- Ensure provisions of WASH services (water and sanitation facilities construction)
- Installation of handwashing facilities and provision of soap and water
- Support material provision for cleaning and disinfection of facilities with 0.1% chlorine solution
- Distribution of hygiene items including MHM
- Coordinate with other sectors to ensure provision of basic services (food, health) and mainstream protection

manage all mild and moderate cases. WHO advises that in this scenario, management of all mild and low- to moderate risk patients with confirmed disease should be done in designated community facilities (e.g. stadium, gymnasium, hotel or tent) with access to rapid health advice (i.e. via adjacent dedicated COVID-19 health post, telemedicine) or at home according to the national or subnational capacity and context. Mild, moderate and severe patients should be separated from each other to mitigate the risks of increased infection. The MoHS may request humanitarian partners to directly manage **mild to moderate cases** at their supported treatment centers if government designated hospitals and health staff are at full capacity, as outlined in the HRP addendum contingency plan. If a patient develops symptoms that may correspond to severe disease or complications, the facility should ensure rapid referral to a pre-identified hospital. Guidelines for community treatment facilities are available here. As a preparedness measure, health cluster partners are preparing for the deployment of (or repurposing of existing) infrastructure to serve as treatment facilities. These facilities will be located nearby but not inside of IDP camps.

In addition, in the event of transmission of COVID-19 within camp settings, **the capacity of any nearby cohorted facility (whether for quarantine or isolation purposes) is likely to be overwhelmed by need, thereby necessitating alternative strategies involving self-isolation within the family home and even in settings with overcrowded living conditions**, in consultation with the healthcare provider (Annex. 2 for self-isolation at home). This should focus on protecting family members and adjacent families to all possible extents with defined measures such as the use of surgical masks by the patient and increased hygiene practice by everyone. In this scenario, humanitarian actors should also continue to advocate and support a return to facility-based isolation over time, while minimizing risk posed by home isolation in crowded camp settings.

Recommendations:

1) **Site specific and community-based risk assessments** can help identify factors that may influence transmission scenarios and related response required including its urgency, magnitude, design and critical control measures where responders must prioritize resources depending on key areas and high-risk populations. IASC guidance includes an adoptable rapid risk assessment framework where the pathogen, exposure of the population and contextual factors are taken into consideration.[10] An emergency plan for each setting needs to be developed derived from the national MoHS strategy and should balance the potential benefits of strict outbreak control measures with the socio-economic and protection consequences.

2) **Community treatment/isolation facilities are currently not recommended for inside camp settings.** The need for dedicated, specialized management as well as clear physical separation from local communities makes the development of community treatment/isolation facilities inside of camps high-risk. In cases where referral of confirmed cases outside of camps is challenging due to movement restrictions or

[8] https://interagencystandingcommittee.org/system/files/2020-05/IASC%20Interim%20Guidance%20on%20Public%20Health%20and%20Social%20Measures%20for%20COVID-19%20Preparedness%20and%20Response%20Operations%20in%20Low%20Capacity%20and%20Humanitarian%20Settings.pdf

additional requirements placed on IDPs (e.g. travel authorizations or police escorts), **camp based treatment facilities should only be considered on a case by case basis** and discussed further at the ICCG or COVID-19 Task Team at the state level, and in consultation with the Government. Humanitarian partners are preparing to deploy additional treatment/isolation facilities or repurpose existing infrastructure as per recommendation number four, to be located nearby camps but not inside.

3) **Partners may consider supporting "fever clinics"**, supervised by Township Medical Officers, to receive patients that have acute respiratory symptoms so that they do not go to normal primary health care centers. These can reduce the burden on and ensure timely referral to designated facilities, as well as reduce nosocomial infections (infections acquired at a health facility) at primary health care facilities serving IDPs, protecting both health care workers and other patients seeking routine care.[11]

4) As a contingency, health cluster partners as part of the HRP addendum are preparing for the **deployment of field isolation/treatment centers in case designated facilities are overburdened**. These facilities should be nearby but not inside of IDP sites for ease of access. Clear referral pathways from IDP sites to field isolation/treatment facilities and onto designated facilities for more severe cases is key. Minimum standards on gender and protection should be considered for all types of isolation facilities[12] as well as WHO guidance on their management.[13]

5) Although current government policy requires the isolation of all suspect and confirmed cases (mild, moderate & severe) within designated health facilities, any upswing in transmission could stretch this available capacity and create a need to revise the approach to the isolation of mild and moderate cases (attack rates for crowded camp settings, dependent also on mitigation measures in place, are estimated to be very high[14], quickly overwhelming planned capacity to isolate all suspect/confirmed cases). As a preparedness measure, **the preparation of home isolation strategies for mild and moderate cases within camps is encouraged**. During any period of home isolation partners should continue to work with health authorities to expand isolation facility capacity and revert back to facility isolation whenever possible. With reference to Annex 2: Self Isolation for suspected or confirmed cases with mild symptoms (WHO), practical steps partners can take to prepare for this scenario include:

    a. Ensure sufficient and suitable PPE prioritized for patients and designated caregivers.
    b. Developing protocols for disposal of infectious waste.

[11] In line with MoHS Guidelines on Fever Clinics
[12] Checklist for assessing, planning and managing isolation and shielding centres from a gender-specific protection perspective
[13] Tents are used for SARI treatment centers, specifications here:https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre
[14] MoHS/WHO estimates for Myanmar country wide is an attack rate of 20%. However, estimates from Global Health Cluster: If with no baseline information, **worst case scenario attack rate** is calculated at **70%** if with no mitigation measures (i.e. 70% of camp population will get sick if there are no public health measures in place. Current applied **attack rate to other places is at 50%.** However, if we have mitigation measures in place, then 50% attack rate is unlikely to be reached. As an example in Cox's Bazar, current IDP population of 1 million people, it will not be feasible to isolate 500,000 people.

c. Ensuring sufficient stocks of soap and water.
d. Possible designation of separate toilets and HW stations with regular cleaning protocols.
e. Procurement of NFIs – extra linen, separate utensils, bedding.

6) Procurement of any tent like structures or repurposing of other infrastructure for treatment/isolation facilities should be in line with WHO guidance.[15]

Green zone or transmission shielded areas: The designation of a "green zone" or a transmission-shielded area to protect high-risk populations may be considered in humanitarian settings. However, the risk of introduction of the virus into such green zones needs to be extremely carefully evaluated. If such risk can be mitigated through strict measures and tight monitoring for at risk individuals, their caretakers and visitors, as well as their environment, this approach may be considered. Furthermore, community acceptance of this approach is critical and must be gained in advance of any separation of high-risk individuals. An emergency plan to respond to the virus introduction needs to be developed for each green zone. Practical guidance on the implementation of this concept can be found here.

Recommendation: While community feedback is being sought by various organizations on the feasibility of this approach in Myanmar in particularly high-risk settings (e.g. camps with the most complex access to health care services), **"green zones" should only be considered on an exceptional basis**, with a concrete plan in place to manage risk.

Further Considerations for Humanitarian Partners

- Be consistent and clear when communicating what we are doing and for what purpose. A cohorted quarantine facility for returning migrants or refugees and contacts in the vicinity of an IDP camp is vastly different from a community treatment facility for suspect or confirmed cases in terms of purpose and required human, financial and physical resources.
- Humanitarian partners should not establish facilities unless they are capable of sustaining the appropriate level of services and protection to patients, as well as ensure duty of care for personnel at the facility.
- Priorities:
    1. Focus on prevention, including Risk Communication and Community Engagement and other Infection Prevention and Control activities.
    2. Work with MoHS to strengthen surveillance, case investigation and response activities, including adherence to MoHS guidelines for surveillance for non-health actors.
    3. Continue to adjust delivery modalities for lifesaving activities to reduce risk of exposure to beneficiaries, in line with Interim IASC Guidance.
    4. Strengthen capacity at designated hospitals for management of moderate and severe cases.

[15] Tents are used even in the components of the SARI treatment centers, specifications here:https://www.who.int/publications-detail/severe-acute-respiratory-infections-treatment-centre

Annex 1: Key Related Documents

- MoHS guidance on management of community-based quarantine centers (v2.0)
- MoHS Guidance on Home Quarantine (self-monitoring)
- MoHS Fever Clinic Guidance
- Protection and gender considerations checklist for quarantine centers (Myanmar Gender in Humanitarian Action Workstream and PSEA Network)
- Global Wash Cluster Technical Guidance Note #2
- WHO Severe Acute Respiratory Infections Treatment Centre manual
- WHO Home care guidance for patients with COVID-19 presenting with mild symptoms and management of their contacts (home isolation)
- WHO interim guidance on the use of masks in the context of COVID-19, 6 April 2020
- WHO Operational considerations for case management of COVID-19 in health facility and community
- IASC Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness in Low Resource and Humanitarian Settings
- Core Migrants Group (Myanmar) Standardized Package of Assistance for Community Based Quarantine Centers
  Key Considerations for Children and Their Caregivers During Quarantine, Isolation and Hospitalization Due to COVID-19

Annex 2: Self Isolation for suspected or confirmed cases with mild symptoms (WHO) [16]

*Note MoHS policy is currently for all suspect and confirmed cases, regardless of severity of symptoms, to be referred to a gov't designated facility. General guidance from WHO is included below as part of forward planning

For those presenting with mild illness, hospitalization may not be possible because of the burden on the health care system, or required unless there is concern about rapid deterioration. If there are patients with only mild illness, providing care at home may be considered, as long as they can be followed up and cared for by family members. Home care may also be considered when inpatient care is unavailable or unsafe (e.g. capacity is limited, and resources are unable to meet the demand for health care services).

Home care for patients with suspected COVID-19 who present with mild symptoms. Patients and household members should be educated about personal hygiene, basic IPC measures, and how to care as safely as possible for the person suspected of having COVID19 to prevent the infection from spreading to household contacts. The patient and household members should be provided with ongoing support and education, and monitoring should continue for the duration of home care. Household members should adhere to the following recommendations.

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

- Place the patient in a well-ventilated single room (i.e. with open windows and an open door).

- Limit the movement of the patient in the house and minimize shared space. Ensure that shared spaces (e.g. kitchen, bathroom) are well ventilated (keep windows open).

- Household members should stay in a different room or, if that is not possible, maintain a distance of at least 2 metres from the ill person (e.g. sleep in a separate bed).

- Limit the number of caregivers. Ideally, assign one person who is in good health and has no underlying chronic or immunocompromising conditions.

- Visitors should not be allowed until the patient has completely recovered and has no signs or symptoms of COVID-19.

- Perform hand hygiene before and after any type of contact with patients or their immediate environment.

- Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty. If hands are not visibly dirty, an alcohol-based hand rub can be used. For visibly dirty hands, use soap and water.

- When washing hands with soap and water, it is preferable to use disposable paper towels to dry hands. If these are not available, use clean cloth towels and replace them frequently.

- To contain respiratory secretions, a medical mask should be provided to the patient and worn as much as possible, and changed daily. Individuals who cannot tolerate a medical mask should use rigorous respiratory hygiene; that is, the mouth and nose should be covered with a disposable paper tissue when coughing or sneezing. Materials used to cover the mouth and nose should be discarded or cleaned appropriately after use (e.g. wash handkerchiefs using regular soap or detergent and water).

- Caregivers should wear a medical mask that covers their mouth and nose when in the same room as the patient. Masks should not be touched or handled during use. If the mask gets wet or dirty from secretions, it must be replaced immediately with a new clean, dry mask.

- Remove the mask using the appropriate technique – that is, do not touch the front, but instead untie it. Discard the mask immediately after use and perform hand hygiene.

- Avoid direct contact with body fluids, particularly oral or respiratory secretions, and stool. Use disposable gloves and a mask when providing oral or respiratory care and

when handling stool, urine, and other waste. Perform hand hygiene before and after removing gloves and the mask.

- Do not reuse masks or gloves that are designed for single-use

- Use dedicated linen and eating utensils for the patient; these items should be cleaned with soap and water after use and may be re-used instead of being discarded.

- Daily clean and disinfect surfaces that are frequently touched in the room where the patient is being cared for, such as bedside tables, bedframes, and other bedroom furniture. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.1% sodium hypochlorite (i.e. equivalent to 1000 ppm) should be applied.

- Clean and disinfect bathroom and toilet surfaces at least once daily. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.1% sodium hypochlorite should be applied.

- Clean the patient's clothes, bed linen, and bath and hand towels using regular laundry soap with common household detergent, and dry thoroughly. Place contaminated linen into a laundry bag. Do not shake soiled laundry and avoid contaminated materials coming into contact with skin and clothes.

- Gloves and protective clothing (e.g. plastic aprons) should be used when cleaning surfaces or handling clothing or linen soiled with body fluids. Depending on the context, either utility or single-use gloves can be used.

- After use, utility gloves should be cleaned with soap and water and decontaminated with 0.1% sodium hypochlorite solution. Single-use gloves (e.g. nitrile or latex) should be discarded after each use. Perform hand hygiene before putting on and after removing gloves.

- Gloves, masks, and other waste generated during home care should be placed into a waste bin with a lid in the patient's room before disposing of it as infectious waste. The onus of disposal of infectious waste resides with the local sanitary authority.

- Avoid other types of exposure to contaminated items from the patient's immediate environment (e.g. do not share toothbrushes, cigarettes, eating utensils, dishes, drinks, towels, washcloths, or bed linen).

- When HCWs provide home care, they should perform a risk assessment to select the appropriate personal protective equipment and follow the recommendations for droplet and contact precautions.

Annex 3: Home Quarantine (Self Monitoring)

Self-monitoring (or self-quarantine) at home can be recommended for people returning from areas affected by COVID-19, people who have been in contact with suspected or confirmed COVID-19 cases. **For IDP settings, this guidance is intended for contact cases resulting from any confirmed or suspected cases within the camp, while quarantine for returning individuals with travel history is highly recommended to be OUTSIDE of IDP sites**

The Ministry of Health and Sports has issued the below guidance for self-quarantine:

(1) Must stay in a separate room at home up to 28 days after home arrival. Be careful that asymptomatic infected person can spread COVID-19 to other household members during quarantine period.

(2) Maintain good ventilation, open the windows as much as possible.

(3) Must maintain physical distance at least 2 meters (6 ft.) away from other household members and must not consume foods together.

(4) Should use separate bathrooms as much as possible. If there is need to share bathrooms, clean used water-tap handles and doorknobs with 1:50 Hypochlorite Solution (1,000ppm). (To get 1:50 Hypochlorite Solution (1,000 ppm), mix 4 teaspoonfuls of 5% bleaching powder into 1 liter of water.)

(5) Must not allow any home visitor. Instead of accepting home visitors, use mobile phones or internet for communication.

(6) Must totally avoid any crowded place. Please strictly follow this important point.

(7) Practice frequent handwashing with soap and water at least 20 seconds. Use hand sanitizers with at least 60% alcohol, if soap and water is not available. (Practice proper handwashing after sneezing, coughing, before and after touching commonly used objects, before and after eating)

(8) Avoid touching eyes, nose and mouth with unwashed hands.

(9) Must fully cover mouth and nose with surgical mask whenever talking with other household members.

(10) Must use disposable tissues fully covering nose and mouth during coughing or sneezing. Always discard used facemasks, tissues and gloves in a closed bin followed by proper handwashing.

(11) Use personal utensils, bed linens and clothes separately. Used utensils, bed linens and clothes should be washed thoroughly using washing machine. Before washing, put these materials up to 30 minutes in a solution containing 1 time 1:50 Hypochlorite Solution (1,000ppm) and 20 times of water.

(12) Check body temperature twice a day if possible. Wear a surgical mask and inform designated health center or fever center if there is any symptom such as fever, cough, difficulty in breathing, sore throat, body aches and pain, and other flu-like symptoms.

Family/Household members of quarantined persons must abide by the following instructions:

(1) Prepare a separate room for person under home quarantine.

(2) Provide specific utensils, plates, cups and towels for personal use.

(3) Must maintain physical distance at least 2 meters (6 ft.) away from person under quarantine and must not consume foods together.

(4) Practice frequent handwashing with soap and water at least 20 seconds. Hand sanitizers with at least 60% alcohol can be used if soap and water is not available. (Practice handwashing after sneezing, coughing, before and after touching objects, before and after eating). All household member must avoid any crowded place as much as possible.

(5) Make sure that person under home quarantine must not go outside and stay at home.

(6) Regularly inform health status of person under home quarantine to the designated health center and provide psychological support as much as possible.

(7) Inform designated health center or nearest fever center if there is any development of symptoms such as fever, cough, difficulty in breathing, sore throat, body aches and pain, and other flu like symptoms in person under home quarantine.

(8) Cooperate and support basic health service professionals whenever they come to do disease control procedures at home.