

While implementing public health measures to reduce transmission of COVID-19, such as restrictions of movement, childcare and school closures, and quarantine and isolation of suspected and confirmed cases, it is important to anticipate and address risks and vulnerabilities for already vulnerable groups, including women, children, people living with disabilities, and people of different sexual orientation or gender identity.<sup>1</sup> Measures taken for reducing transmission, may increase risks of and vulnerability to gender-based violence, violence at home, and negative coping measures such as child marriage and child labour.<sup>2</sup> These measures may also increase the likelihood of children being separated from their families – which negatively affects both physical and psychological wellbeing of these children.

This document provides interim guidance for child protection and health actors in the context of quarantine and isolation measures to mitigate related child protection risks, minimize family separation and promote family unity and social cohesion. Actions require multi-sector collaboration and contextualization, taking into account national laws and guidelines related to child protection and health, and the public health measures for COVID-19 control that are in place in the country.

## A. Quarantine and isolation measures and their impacts on family separation<sup>3</sup>

Quarantine and isolation are measures that restrict people's movement in order to slow transmission of a contagious disease. ***Quarantine*** is the separation or restriction of activities of persons who are not ill but who may have been exposed to an infectious agent or disease, to monitor their symptoms and promote early detection of cases. Quarantine is different from ***isolation***, which is the separation of ill or infected people from others to prevent the spread of infection or contamination.<sup>4</sup> Because of how the coronavirus is transmitted, if one person in a household is ill, other household members are at risk of exposure to the virus. Quarantine and isolation measures include:

### ***1. Home-based isolation and quarantine***

A person in home-based quarantine should stay home and not interact with other family members at home unless their family members are also in quarantine.

A person in isolation should also stay at home. Isolated persons should stay in a separate room from other family members at home and if possible, use a separate bathroom. If a separate bathroom is not available, it should be cleaned each time after the ill person uses it. WHO has produced detailed guidance on [home care for patients with COVID-19 presenting with mild symptoms and management of their contacts](#), and [advice for the public](#).<sup>5</sup> Confirmed cases of COVID-19 who are in isolation require focused clinical care in collaboration with medical personnel.

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<sup>1</sup> See, [Thematic Reports of the UN Secretary-General on COVID-19](#), including on mental health, human rights, debt, socio-economic impacts, disability, elders, children, women; and Inter Agency Standing Committee, Interim Guidance, Public Health and Social Measures for COVID-19 Preparedness and Response in Low Capacity and Humanitarian Settings.

<sup>2</sup> See, e.g. Alliance for Child Protection in Humanitarian Action, [Technical Note: COVID-19 and Child Labour](#).

<sup>3</sup> More information on the types of quarantine can be found at: [Guidance Note: Protection of Children During Infectious Disease Outbreaks](#), Alliance for Child Protection in Humanitarian Action (ACPHA).

<sup>4</sup> See, WHO Guidance, [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#), pg. 1

<sup>5</sup> See also CDC information about [what a person should do if sick](#) or [caring for someone who is sick at home](#).

## **2. Facility-based isolation and quarantine**

Facility-based quarantine occurs outside the home in a place dedicated to quarantining individuals. Facilities of this kind are generally run by health authorities or other government entities. Families or members of a group may be quarantined together. Beyond individuals or families, quarantine measures may be imposed on whole villages or communities and while often less individually restrictive, they may still have significant effects.

Facility-based isolation also occurs outside the home in a place dedicated for such a purpose and run either by health authorities or other government entities and allows for close monitoring of the health of individuals and mitigation of health-related risks, as well as provision of necessary clinical care.

## **3. Community-level quarantine and mobility restrictions**

Community-level containment measures restrict people's movement within a community, town, city, state or other administrative unit. They may limit non-essential movement, impose curfews, close child-care, schools and certain businesses, including limitations on availability of essential protection, health and civil registration services, including birth registration.

## **4. Zone (or area)-based quarantine**

Zone-based measures prohibit travel between communities, towns, cities, states or even nations by prohibiting certain forms of travel, closing routes, borders or others similar actions and may be imposed without notice.

## **Impacts of quarantine and isolation measures on children and their families**

Isolation and quarantine may result in family separation when either a caregiver or child is placed in a facility while the other remains at home, when they are placed outside the home in different facilities, or when measures, such a travel restrictions, are imposed and family members cannot reunite until restrictions are lifted. Children who are left alone or are without adequate nurturing care and supervision at home due to illness of the primary caregiver or who are isolated or quarantined in a facility are at increased risk of violence, sexual exploitation, abuse, and neglect. This is particularly true for younger children, as well as children with special needs.<sup>6</sup> These public health containment measures also can limit access of vulnerable families to critical social services.

Facilities dedicated to quarantine and isolation may not have adequately considered, mitigated or responded to non-health vulnerabilities, risks and special needs of individuals, including protection-related concerns that may arise for families both inside and outside facilities. In many countries, health care providers are required to screen for and report domestic violence or other protection related risks, and make appropriate referrals for medical and social interventions. These legal and professional obligations continue during the pandemic. In addition, inadequate safeguards and health care workers who are not sufficiently trained or equipped to deal with social and protection issues or to provide developmentally appropriate, nurturing and protective care for children while they are in quarantine, may also increase the risk of sexual exploitation, abuse, and neglect of children while they are in a facility. There is also a risk of prolonged (or even permanent) family separation if caregivers are placed in different quarantine or isolation facilities from their children, or if children are moved during quarantine without proper documentation and regular communication.

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<sup>6</sup> See, e.g. Bick, J., Zhu, T., Stamoulis, C., Fox, N. A., Zeanah, C., & Nelson, C. A. (2015). Effect of Early Institutionalization and Foster Care on Long-term White Matter Development. *JAMA Pediatrics*, 169(3), 211 and Smith, N. & Harrell, S., Sexual Abuse of Children with Disabilities: A National Snapshot, Issue Brief, March 2013.

## B. Recommendations to Prevent Family Separation

When implementing quarantine and isolation policies, ***authorities should take steps that minimize family separation and promote family unity.***

WHO recommends that laboratory confirmed and suspected COVID-19 cases be isolated to contain virus transmission and that contacts of patients with confirmed cases be quarantined for 14 days after their last contact with the patient. While all confirmed cases of severe COVID-19 illness are recommended to be isolated in a designated facility, this may not be possible or advisable for cases of mild or moderate COVID due to capacity limitations (space, health workers, supplies etc.) and the burden on health care systems. In addition, isolation of individuals with mild or moderate illness is also not always advisable because of protection considerations for children and other vulnerable individuals.<sup>7</sup> These considerations also apply to quarantine of unconfirmed but suspected COVID or individuals who have had known contacts with confirmed COVID cases.

The location of isolation will depend on the established COVID-19 care pathway and can be done at a health facility, community facility or at home. The decision of location should be made on a case-by-case basis and will depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and conditions at home, including the presence of vulnerable persons in the household. For patients at high risk for deterioration, isolation in hospital is preferred.<sup>8</sup>

Overall, ***policies and individual decisions should allow home-based quarantine or isolation of children and caregivers based on a holistic assessment in which the child's best interests is a primary consideration.*** The decision to separate a child from his or her caregiver when applying any specific containment or care measures should be based not only on medical factors such as possible outcomes of infection for the child or caregiver, but also on the possible consequences of family separation on the child.

In consultation with a health care provider, the caregiver, and the child, a holistic assessment should be conducted with an ***aim to keep children together with their caregivers wherever possible, and to identify an alternate healthy family member as caregiver, or someone who is familiar to the child and his or her family where it is not possible.*** Factors to consider include medical, familial, and psychosocial factors such as the patient's clinical condition, medical risk factors, home environment – including access to health care (including communication and transport), nutrition, access to water, sanitation and hygiene services, safety and protection concerns, isolation capacities, as well as high-risk individuals at home. Due to the negative and possibly long-term consequences of even a short period of family separation, additional non-medical factors must also be weighed carefully, including the availability and safety of suitable kinship, child-specific,<sup>9</sup> or other family-based alternative care that is nurturing and familiar to the child, the age and developmental stage of the child, the location of any siblings, the child's attachments, any special needs of the child, the ability to maintain family contact and other routines after separation, among other factors.

This means that if a caregiver or child is a confirmed or suspected case of COVID, no one solution should be universally applied. Depending on a consideration of all factors, it can be in the child's best interest for the caregiver and child to isolate or quarantine together at home while following recommended clinical care and [infection prevention and control measures](#). In such cases, the caregiver

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<sup>7</sup> [Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic](#), page 15.

<sup>8</sup> World Health Organization, [Clinical Management of COVID-19](#), pp. 12-13.

<sup>9</sup> E.g. care by a non-kinship trusted adult known to the family and child.

should also be instructed on how to monitor the child's and his or her own health and on how to maintain communication with a health care provider during the home care period.<sup>10</sup> If possible, for quarantined individuals, community-based health workers should check on the child and caregiver's health, including to determine if the caregiver can continue to care for the child, while maintaining clinical care in consultation with a health care provider for individuals in isolation.

Any household member who is elderly or has underlying health conditions is at high risk of poor outcomes if infected with the coronavirus and should ideally prevent all exposure to confirmed or suspected infected household members or others, including by quarantining in a separate household. All household members who have had contact with a family member with confirmed or suspected COVID, whether they have symptoms or not, should quarantine and, at a minimum, maintain good hand and respiratory hygiene, disinfect frequently touched surfaces, undertake appropriate waste management, and practice physical distancing from other household members.

In situations where a caregiver is symptomatic, another capable household member should be considered as an alternate caregiver even when the ill caregiver is being [cared for in the home](#).

However, the situation of newborns and lactating mothers requires additional special considerations, as close contact and early exclusive breast feeding are important to help a baby to thrive. "Studies have consistently shown a lower risk of children developing severe symptoms or critical illness from COVID-19 infection compared to adults."<sup>11</sup> in addition, the risk of COVID-19 infection in infants is low and typically mild or asymptomatic. In contrast, "the consequences of not breastfeeding or separation of mother and child can be significant...[and] it appears that COVID-19 in infants and children represents a much lower risk to survival and health than the other infections and conditions that breastfeeding is protective against. This protection is especially important when health and other community services are themselves under pressure."<sup>12</sup> Accordingly women with COVID-19 should be supported to safely breastfeed, hold her newborn skin-to-skin, and share a room with her baby. Women with COVID-19 can breastfeed if they wish to, and if too unwell can be supported to safely provide the baby with breast milk.<sup>13</sup>

Any caregiver who is symptomatic but still caring for children, including breastfeeding mothers, should practice respiratory hygiene, including during feeding (for example, use of a medical mask when near a child if the mother has respiratory symptoms), perform hand hygiene before and after contact with the child, and routinely clean and disinfect surfaces with which she has been in contact.<sup>14</sup>

If a caregiver is unable to continue providing care and there is no other household member available and able to care for the child or children:

1. The child should be quarantined within a household (nearby where possible), under the care of an extended family member or a trusted family friend who is at low-risk of poor health outcomes if infected, who has been identified by the caregiver, and who is willing and able to temporarily care for the child while maintaining the child in quarantine.

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<sup>10</sup> See, World Health Organization, [Interim guidance: Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts](#).

<sup>11</sup> [Epidemiology, Spectrum and Impact of COVID-19 on Children, Adolescents and Pregnant Women](#), (UNICEF/International Pediatric Association), pg. 4.

<sup>12</sup> World Health Organization, [Clinical management of COVID-19](#), pg. 43.

<sup>13</sup> World Health Organization, [Clinical management of COVID-19](#), pp 42-44.

<sup>14</sup> World Health Organization, [Clinical management of COVID-19](#), at pg.44.

2. Only if there is no other alternative should the child be placed into temporary alternative care, preferably family-based rather than facility-based quarantine, with a caregiver who is at low risk of poor health outcomes and who is able to provide nurturing, responsive care for the child. Efforts should be made to place children in alternative care families who are as close as possible to the child's place of residence or to the place where the caregiver is being treated. For more information on alternative care measures, please refer to: [Protection of Children during the COVID-19 Pandemic: Children and Alternative Care Immediate Response Measures](#) and [COVID-19 Guidance for Interim Care Centers](#).
3. If separated, wherever possible and consistent with the child's best interests, contact between the child and his or her family should be maintained regularly (daily is ideal) and reunification should be as swift as possible. Communication means (e.g. mobile phone cards) should be made available, where feasible.
4. Where a caregiver is separated from his or her child due to movement restrictions, authorities should swiftly issue documents that grant permission for any travel necessary to facilitate reunification or establishment of arrangements for the safe care of the child.

To facilitate decision-making during time of illness, families should plan for and obtain agreement in advance for the care of any children, in case the caregiver becomes ill and deteriorates such that he or she is temporarily unable to provide safe care.

### C. Key Child Protection Considerations to Promote or Restore Family Unity

When putting in place policies and practices to minimize family separation and promote family unity, a human-rights based approach should be used.<sup>15</sup> Specifically,

1. Children have special protections under the Convention on the Rights of the Child, including [rights to life, survival and development](#).
2. In all decisions involving children, ***the best interest of the child is a primary consideration***. This includes decisions made about an individual child or groups of children by authorities of all kinds, including health officials, law enforcement, social and child welfare authorities, border and immigration authorities, justice officials, and executive and legislative bodies. It applies to decisions regarding the child's placement, care and support during quarantine.
3. ***Maintenance of family unity, including family contact must be prioritized*** when establishing and implementing policies and public health and social measures to contain COVID-19, as the right to be cared for by family is a key right of the child.<sup>16</sup> Family separation should be a last resort, for the shortest possible time and swift reunification should be prioritized.
4. If a child requires emergency alternative care due to the inability of a caregiver to continue caring for their child, ***kinship and family-based care are the preferred options*** and, if not immediately available, should be actively pursued from the first day of the separation of the child from his or her caregiver, with a safe transfer as soon as possible. States must recognize the right of parents and guardians to make decisions about their children.

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<sup>15</sup> See, UNICEF, [COVID-19 and the impact on children's rights: the imperative for a human rights-based approach](#).

<sup>16</sup> United Nations Convention on the Rights of the Child, Article 9.

5. When determining a child's best interests, ***the child's views should be considered***. Input from the affected child should be obtained consistent with his or her age and capacities.
6. As complex as the situation may be, ***the principle of "Do No Harm" should prevail***. Specific measures should be taken for children's care in line with their ages, gender and abilities. Children with disabilities will require specific support. Any placement should be one that minimizes the risk of harm not only to a child or caregiver's health due to COVID-19, but to the child's development and well-being due to protection related risks.
7. In any facility, ***safety and protection of individuals, including children, is paramount***, including not only safety from infection but from violence, exploitation, abuse or neglect. A strict child safeguarding policy and code of conduct must be in place. Every person who will come in contact with children, including health personnel, should be trained on the content of the policy and code and their obligations to follow them and report any breaches.
8. Responses should ***enhance the safety, dignity and rights of people, including children***. Assistance should avoid exposing them to harm, be provided based on need and without discrimination, assist people to recover from the effects of actual or threatened violence, coercion or deliberate deprivation, and support people to fulfil their rights.<sup>17</sup>

#### **D. Preparatory Actions to Prevent and Respond to Family Separation**

To maintain family unity and minimize risks of family separation while also preparing for situations in which family separation may occur, child protection practitioners should work with health actors to coordinate the following actions.

1. Develop an emergency plan that is multi-sectoral, including material or financial support for families required to isolate or quarantine and for families providing alternative care for children, assistance to families in planning advance directives for any possible caregiver illness, and provide necessary training, that describes the role and responsibilities of key stakeholders, including community structures, community level protection actors, and social service and child welfare workforce, as well as communication and reporting channels.
2. Select locations and design facilities, services and information to be accessible and disability inclusive. Doing so at the planning and design phase will result in lower overall costs associated with such measures.
3. Develop and disseminate messages to families through trusted sources that encourage them to identify alternative kinship or other family-based care for children in case caregivers become incapacitated or are otherwise unable to care for children.
4. Support community protection focal points and caseworkers to prepare families to create alternative care plans that identify, in advance of an emergency, who should temporarily care for their child(ren) if their primary caregiver becomes ill with COVID-19. In devising these plans, the child's views should be considered. Children living with primary caregivers who are elderly, disabled, or have underlying health conditions are particularly at risk of family separation due to caregiver illness and should be prioritized.

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<sup>17</sup> The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, Protection Principles, [https://handbook.spherestandards.org/en/sphere/#ch004\\_002](https://handbook.spherestandards.org/en/sphere/#ch004_002).

5. Establish protocols that prioritize family unity and children's best interests when making determinations about quarantine and isolation of caregivers and children, and that result in separation of children from their families only as a last resort.
6. Coordinate with health actors to establish a standard operating procedure (SOP) for registration and confidential data collection systems for when children or caregivers are admitted for quarantine, isolation or treatment, including details of the child's name, family name(s), date of birth, and place of origin or current residence, address, or home location, the names and contact information of the child's primary caregivers, and names and contact details of other family members who could provide alternative care if needed. If no family members are nearby or have contact details available, the name of a trusted neighbor or friend should be sought. Such SOPs should include data protection and data sharing protocols timely agreed and endorsed by both health and protection actors.
7. Train and provide necessary resources and support to clinical health care workers so that they can provide developmentally appropriate nurturing and protective care to any children being treated in the health care facility or accompanying their caregiver. Plan for provision of age-appropriate toys and other activities and psychosocial support services. Additionally, ensure health workers are trained on infection prevention and control (e.g. using personal protective equipment (PPE) and environmental cleaning).
8. For every isolation, quarantine, or treatment center, assign a social worker or designate and train a health center staff member (at least one per facility per shift) as the emergency focal point for child protection issues that may arise. The designated staff should be trained on child protection and liaise with the primary staff members responsible for child protection case management in the facility.
9. Recruit and train families who are at lower risk of poor outcomes from infection, without underlying health conditions, and with sufficient space in their homes to become trained foster or alternative care families who can be mobilized to temporarily provide nurturing care for children who may be separated from their families. Conduct and update mappings for such caregiver networks.
10. Referral pathways and service mapping for children, including child protection case management and family tracing and reunification, should be developed or adapted and disseminated widely, ensuring safe, accessible entry points.
11. Establish procedures to support remote or virtual contact between children and caregivers who are physically separated due to quarantine, isolation or treatment. This could include safe options for visiting (if proper precautions are in place), electronic media such as Skype, telephone or WhatsApp, or the exchange of letters, photos or videos. Maintaining contact can help children remain connected with their families and allow caregivers to provide nurture and care even if it is through virtual means. This connection can help reduce anxiety or stress that children may experience if they are not in touch with their caregivers.

12. Provide social workers and other essential workers with targeted safe childcare, mental health and psychosocial and other services to lessen the burden and potential separation risk for those families and support their safety and wellness.<sup>18</sup>
13. Reduce the risk of stigma and rejection of children by establishing, as early as possible, engagement and communities sensitization to [reduce any stigma or discrimination](#) that children may face as a result of COVID-19. Information should be in a format that is easily understandable (i.e.: orally, simple printed materials, or graphic materials) that explains the authorized messages regarding COVID-19 recovery. Information about a child's health status should be provided to caregivers upon the child's placement or return.

#### **E. Actions to Promote Family Unity if a Child is Admitted to a Facility**

While in most cases children should be allowed to isolate, quarantine or be treated for COVID-19 at home, there may be a few instances where a child must be admitted to a facility and additional steps can be taken to promote family unity and contact.

1. If a child must be isolated, quarantined, or treated in a facility rather than at home, all efforts should be made to allow a caregiver or other adult family member who is familiar to the child to accompany the child.
2. In cases the child must be transferred alone to a facility and where that facility is far away from the families' places of residence, appropriate temporary accommodation should be available for caregivers whose children have been admitted.
3. Before separating the child from his or her family, all the child's details and those of their family must be documented (see section D. 6, above) and without exception, must be transferred with the child anytime she or he is moved to a new location. The child's family should receive regular (daily if possible) updates on the child's condition and whereabouts.
4. If a child is removed for isolation, quarantine, or treatment, he or she should be transferred to a location that is as close as possible to the family. The family should be informed where the child will be placed and be informed in advance of any transfer to a new location.
5. Unless it is a medical or other emergency, health actors or other authorities implementing public health measures should contact child protection actors before separating a child from his or her family to support appropriate care and contact arrangements during separation, and take any other actions that may be required under law, such as notifying the court in the case of non-consent of the parent.
6. Upon admission of a separated or unaccompanied child, the health actor must immediately act consistent with standard operating procedures including by referring the child to the child protection focal point in the facility for documentation and case management, including where necessary, immediate initiation of active tracing of the child's family.
7. Any isolation, quarantine, or treatment center that anticipates hosting children, particularly those without caregivers, must identify and train sufficient care staff or other volunteers so that children can be safe, protected and receive appropriate responsive care and stimulation. Arrangements should be appropriate based on the age of the children involved, and the

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<sup>18</sup> Alliance for Child Protection in Humanitarian Action, [Social Service Workforce Safety and Wellness During the COVID-19 Response: Recommended Actions](#).

capacity of health and child protection actors and care staff. Arrangements should comply with relevant national legal frameworks or where there are none, with an established policy including child safeguarding.

8. Child protection actors or care staff assigned to isolation, quarantine or treatment centers should be provided with information and training on global and national guidance on how to protect themselves and others from infection, and the role of personal protective equipment needed to minimize their risk, as well as access to such equipment.<sup>19 20</sup>
  - o When a confirmed COVID-19 child is isolated, medical masks should be worn instead of the fabric masks by both the child and care giver when physical distancing is not possible, with following age specific advice:
    - i. Care givers should maintain a distance of at least 1 meter when possible, and wear medical mask when physical distancing is not possible; As much as possible individuals with underlying medical conditions or over 60 that are at increased risk of severe illness from COVID-19 should not be designated as the caretaker during the time of isolation.
    - ii. Advice for children in different age groups:
      - Children under 5 in isolation need not wear mask<sup>21</sup>
      - Children 6 to 11 years of age should wear masks if they are able to follow instructions and wear a mask AND if appropriate and continuous adult supervision is possible AND physical distancing cannot be maintained.
      - Children over 12 should wear masks if distancing cannot be maintained as per adult recommendations for isolation.
  - o When a child is in quarantine, there is no need to wear masks even when the child is in quarantine with the family/ care giver.
9. Consistent with established mechanisms, a means of communication between children and their families should be provided and should be free of charge. Communication should be as often as possible, and frequency should be agreed upon between the family and caseworker.
10. To address the mental health and psychosocial and other effects of the disease and related containment measures, including quarantine or isolation, facilities should develop and provide

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<sup>19</sup> World Health Organization, [Rational use of personal protective equipment for coronavirus disease \(COVID-19\) and considerations during severe shortages](#).

<sup>20</sup> See also, [Advice on the use of masks for children in the community in the context of COVID-19](#), (UNICEF/WHO).

<sup>21</sup> *In some countries, guidance and policies recommend a different and lower age cut-off for mask use. It is recognized that children may reach developmental milestones at different ages and children five years of age and under may have the dexterity needed to manage a mask. Based on the do no harm approach, if the lower age cut-off of two or three years of age is to be used for recommending mask use for children, appropriate and consistent supervision, including direct line of sight supervision by a competent adult and compliance need to be ensured, especially if mask wearing is expected for an extended period of time. This is both to ensure correct use of the mask and to prevent any potential harm associated with mask wearing to the child. Children with severe cognitive or respiratory impairments who have difficulties tolerating a mask should, under no circumstances, be required to wear masks. [Advice on the use of masks for children in the community in the context of COVID-19](#), (UNICEF/WHO)*

access to mental health and psychosocial support services,<sup>22</sup> education, and other stimulating and nurturing support for children and caregivers consistent with their ages and abilities.

11. Health actors should be trained on Psychological First Aid, basic MHPSS provision and recognition of signs of distress, and use of referral pathways.

#### **F. Actions to Promote Family Unity if a Primary Caregiver is Admitted to a Facility**

1. Before separating the child from his or her family, all the child's details and those of their family must be documented (see section D. 6, above).
2. If an ill caregiver being admitted is accompanied by a child, information about the child and his or her family should be gathered at the point of admission and child protection staff should be immediately notified and assigned to the case. In consultation with the caregiver and the child, authorities should make necessary care arrangements to identify and transfer any children to the care of a responsible trusted adult who has been identified by the caregiver. Details regarding the handover of child, including when, where and to whom the handover was made (including contact details) should be documented.
3. If an adult is admitted to a facility alone, inquiry should be made about the presence of children at home and if any, their location and the care arrangements in place. If alone, child protection staff should be immediately notified and assigned to check in on children, monitor their safety, health and wellbeing, make necessary care arrangements, and report back to the caregiver.
4. Children whose caregivers are undergoing treatment should be informed about where their caregivers are and, if appropriate, their caregiver's health status. Where possible, contact should be maintained (see section E.9 above).

#### **G. Procedures in Quarantine and Isolation Facilities**

Set up of facilities to provide quarantine or isolation for children who do not require hospital care for COVID-19 should comply with WHO guidance.<sup>23</sup> Persons who are quarantined or isolated must be provided with health care; financial, social and psychosocial support; and items to meet basic needs, including food, water, and other essentials. The needs of vulnerable populations should be prioritized.

Standard Operating Procedures (SOPs) for care and protection of children in quarantine facilities should consider the roles that can be played by health providers, child protection and GBV actors, and key actors from other sectors such as those who provide food and non-food items. SOPs should consider situational specifics and concerns, as well as applicable national laws and guidelines.

The SOP for protection of children should at least include: 1) roles and responsibilities of each actor; 2) clear referral procedures between health and child protection actors for child protection issues including unaccompanied children; 3) minimum care package for children in quarantine centers, including psychosocial support, access to education and other services for children in the centers and provision of food and other NFIs; 4) child safeguarding measures, including for [protection from sexual exploitation and abuse](#); 5) age- and gender-appropriate nurturing care arrangements; and 6) child friendly reporting and complaint mechanisms. While written for interim care centers, Save the Children's guidance on [Child Safe Programming and Safeguarding in Interim Care Centres](#) may be

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<sup>22</sup> IASC Reference Group on Mental Health and Psychosocial Support, [Interim Briefing Note addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#).

<sup>23</sup> [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#)

useful along with the ICRC's recommendations for [Prevention and Response to Sexual and Gender-Based Violence in COVID-19 Quarantine Facilities](#).

## H. Resources

Author	Resource
World Health Organization	<a href="#">Medical Q &amp; A on COVID-19</a>
World Health Organization	<a href="#">Clinical management of COVID-19</a>
World Health Organization	<a href="#">Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19)</a>
World Health Organization	<a href="#">Infection Prevention and Control during Health Care when novel coronavirus (nCoV) infection is suspected</a>
World Health Organization	COVID-19 technical guidance for <a href="#">schools</a> and <a href="#">workplaces</a>
Inter-Agency Standing Committee (IASC)	<a href="#">Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response in Low Capacity and Humanitarian Settings</a>
Alliance for Child Protection in Humanitarian Action (The Alliance)	Child Protection <a href="#">resources on COVID-19</a> including technical notes, podcasts, webinar recordings, digests and COVID-19 forum. <a href="#">Technical Note: Protection of Children during the COVID-19 Pandemic</a> and its annexes on: 1) Child Protection Case Management; 2) Alternative Care; 3) Social Services Workforce Safety and Wellness; 4) Working with Communities; 5) Protecting Children from Violence in the Home; 6) Child Labour; 7) Children Deprived of their liberty; 8) Child Helplines; and 9) Children Associated with Armed Forces or Armed Groups;
Alliance for Child Protection in Humanitarian Action	<a href="#">Guidance Note: Protection of Children During Infections Disease Outbreaks</a>
Save the Children	<a href="#">COVID-19 Guidance for Interim Care Centres</a>
International Committee for the Red Cross	<a href="#">Prevention and Response to Sexual and Gender-Based Violence in COVID-19 Quarantine Facilities</a>
Inter-Agency Standing Committee (IASC)	<a href="#">Interim Technical Note: Protection of Sexual Exploitation and Abuse (PSEA) during the COVID-19 Response</a>
IASC, MHPSS Reference Group	<a href="#">Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak</a>
UNICEF, IFRC, World Health Organization	<a href="#">Communicating with children, families and communities to prevent social stigma</a>
Child Protection Area of Responsibility	Child Protection <a href="#">Resource Menu for COVID-19</a>
GBV Area of Responsibility	GBV <a href="#">Tools and Resources for COVID-19</a>
Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, IASC and Global Protection Cluster	<ul style="list-style-type: none"> <li>• <a href="#">Identifying and Mitigating Gender-based Violence Risks with the COVID-19 Response</a></li> <li>• <a href="#">Resources</a> for GBVIMS and Remote GBV Case Management to support COVID-19 Response</li> </ul>
Nurturing Care for Early Childhood Development	<a href="#">Resources on nurturing care</a> during the COVID-19 pandemic

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