Findings of Focus Group Discussions on COVID-19 related stigma and Quarantine Centers
November 2020

Key findings

The below points reflect opinions expressed by Focus Group Discussion (FGD) participants in multiple locations across NWS. See section 4 (page 3) for a detailed readout of FGDs as well as analysis.

Perceptions on COVID-19, infected individuals, and humanitarian engagement

- Messaging via news and social media strongly and consistently emphasized the dangers of COVID-19 infection, resulting in fear of the virus and the people who might be carrying the virus. This may have been unintentionally reinforced by messaging and measures from de facto authorities and humanitarian partners strongly focused on need to adopt precautionary measures.

- **Negative and derogatory language around COVID-19 and the risk of infection has developed among the community,** this contributes to stigmatization of individuals dealing with/potentially infected with COVID-19. For example, people infected with the virus were frequently referred to using the term “M’coren” which carries a pejorative connotation. This terminology was frequently used by participants during the sessions.

- **Community support systems are weakening** with specific impact on older people and households least able to cope in their situation of prolonged internal displacement such as female headed households, households without access to humanitarian assistance, and households without livelihoods and income.

- **A negative perception of health workers and health facilities** is increasing, highlighting the complex and difficult operating environment in relation to the health response. Both health workers and facilities were referred to as “spreaders” of the virus. Concerningly, some participants expressed a lack of trust in capacities of healthcare workers. Nevertheless, health staff still perceived as one of the most reliable sources of information on prevention and response to COVID-19.

- Similarly, a **negative perception of persons seen as at elevated risk of infection such as older persons and persons with disabilities** exists. Participants indicated hesitation, especially amongst men, to assist / engage with people potentially infected as well as with individuals seen as at elevated risk. This is linked by some participants to a gradual reduction in willingness to support others in relation to COVID-19.

- Participants indicated it was not uncommon for people to **hide COVID-19 symptoms.**
  - Women hide symptoms to avoid social stigma and exclusion from the community as well as to prevent stress and/or tension within the household.
  - Men hide symptoms to avoid income loss, avoid quarantine and/or isolation due to long treatment, and community reactions (stigma).
**Perceptions of Quarantine Centers**

- Overall – after explanation of purposes and objectives – FGD participants demonstrated a **positive attitude towards the establishment of / concept of quarantine centers** that would contribute to the control of the spread of the virus; however, hesitation was expressed related to **risk of income loss, shame and stigma** especially in the case of women and girls after being discharged, and **family separation**, specifically children left behind alone with no care arrangements if parents are quarantined.

- In this light, there was **common agreement that children should not enter quarantine without accompanying parents/caregivers** – it was made clear that the community will not accept this. Interruption of education in case children are placed in quarantine was also raised as a concern.

- Similarly, participants agreed that **women and girls would need to be accompanied** by husbands and other caregivers to mitigate stigmatization, shame, and spread of rumours.

- Participants living in IDP sites were inclined to **support the idea of quarantine centers inside camps given the challenges for self-isolation in tents**. Participants living in non-camp locations in contrast agreed that home isolation is a better setting, especially when considering associated stigma.

- **A lack of a basic understanding of the structure, available services, and type of medical care provided in the quarantine centers** (i.e. what to expect in quarantine) was evident amongst participants (despite a brief introduction to the rationale for and concept of quarantine centers at the outset of the FGDs).
  - Participants in one FGD in Idleb expressed a belief that the centers would in fact contribute to spreading the virus rather preventing given the act of “closing up” people in one place. Others in the same session argued that centers would be effective to combat spreading the virus in case sick/suspected individuals are temporarily separated from the community to limit their interactions. People on both sides of the argument agreed to possess insufficient knowledge on the quarantine process and ways of working in such centers and that this is required.

**Recommendations**

**Three immediate actions** that would contribute to increasing voluntary entry into quarantine centers across NWS are:

1) **maintenance of family unity in quarantine (or at least accompaniment of those who require so),**
2) **financial support to compensate for loss of income,** and
3) **sustained and clear messaging on quarantine centers’ rationale and functioning as well as on supportive approaches to COVID-19.**

Detailed recommendations from community members expressed during the FGDs are noted in Section 7 (pages 7-8). Recommendations from the Protection Cluster to humanitarian partners, building on feedback from FGD participants and discussions within the Protection Cluster, are provided in Annex 1 (pages 10-11) of this note.
1. Background and purpose of organizing FGDs on stigma and quarantine

In an environment of rapidly increasing numbers of confirmed COVID-19 cases in NWS, with specific concerns about a rise in cases in overcrowded living settings of IDPs – currently 1.4 Million IDPs are reported to live in IDP sites according to the CCCM Cluster – as well as about challenges to self/home quarantine, the humanitarian community under guidance of the Health Cluster is establishing dedicated quarantine centers. These centers are planned to host contacts of COVID-19 positive individuals as well as asymptomatic COVID-19 for 10 to 14 days aiming to reduce the spread of the virus. From a public health point of view, these centers are deemed to be an essential measure to combat COVID-19 and their proper functioning is in the interest of the population in NWS. However, despite large-scale and consistent efforts to improve knowledge and awareness among the community on COVID-19 and precautionary measures, concerns exist regarding the willingness (and in some cases ability) for individuals to voluntarily enter quarantine upon referral by relevant health workers/facilities.

Protection Monitoring through the Protection Monitoring Task Force of the Protection Cluster, the IRC July-August Protection Monitoring Report, consultations with Protection Cluster partners, as well as evidence from other countries indicates that dynamics related to stigma towards individuals perceived to carry the virus may result in people to reject entry into quarantine centers, avoid seeking health care when falling ill, and even hide symptoms. Moreover, findings highlight that in the context of COVID-19 in NWS healthcare staff face bullying, women experience increased stress due to pressure to keep their family safe and living environments clean, and that an additional reason for people to hide COVID-19 symptoms is a fear for loss of livelihoods.

The Protection Cluster with the support of protection partners and on behalf of the Quarantine Centers TF conducted a series of focus group discussion (FGDs) to better understand:

- community perspectives on the concept of quarantine in a dedicated center, including concerns related to stigma and community reaction/perceptions,
- to seek suggestions on how to address these concerns to improve effectiveness of the centers,
- to build on exiting capacities within the community to promote positive health care seeking behaviors,

This brief report based on the FGD outcomes aims to develop a contextual understanding of issues related to stigma and of of measures that would need to be taken to improve the willingness of the community to access such quarantine centers. Thereby the report aims to contribute to better planning of the centers, in line with protection mainstreaming and accountability to affected populations principles.

2. Methodology

The Protection Cluster developed the FGD guiding protocol and circulated within the Quarantine Centers TF for inputs for further clarity and elaboration on the centers’ purpose, procedures, and services to ensure facilitators are well positioned to conduct and informed and targeted discussion and sessions yield relevant outputs.

In mid-October 2020, an online training was facilitated by the Protection Cluster for field staff who would conduct the FGDs in NWS. The training was conducted in Arabic with tools also translated into Arabic (FGD questionnaire, protocol, and consent form).
In total, twenty-eight FGD sessions were organized in camps and urban settings in Aleppo and Idleb. These locations were selected to correspond with planned locations of quarantine centers. Ca. 140 community representatives (70 female and 70 male), including adolescents and persons with disabilities, participated in the sessions. FGDs lasted for around 60-90 minutes each and included participants representing displaced populations and on occasion host communities in NWS.

Bilateral engagement with staff participating in the FGDs has been conducted to validate findings and seek further suggestions on stigma, quarantine, and communication with communities.

3. Community perceptions on COVID 19-pandemic and individuals who contracted the illness

Feelings and thoughts of fear, anxiety, deep concern, panic, pity, and necessity to avoid people infected with the virus were highlighted in all FGD sessions regardless the profile, gender, living situation, or location of participants. However, participants also demonstrated sufficient understanding about self-protection and preventive measures including concepts of “isolation” and “physical distance” while indicating not all community members were fully committed to adhering to preventive measures. Religious leaders/figures, healthcare staff, humanitarian frontline staff working with the community for longer periods, local authorities and councils (especially in FGDs in northern Aleppo) were pointed out as trustworthy information sources by participants.

Male participants were observed to use more negative and strong language regarding individuals carrying the virus. The term “M’Coren” was mentioned often, carrying a pejorative connotation. Individual statements were also recorded that refer to COVID-19 positive individuals as “damned” with the disease or being “virus bombs”. One participant, referred to the virus as media propaganda.

During female FGDs, language of pity, compassion, and prayers to support infected individuals was accompanied with strong expressions of fear and anxiety for themselves and family members. Women participants underlined the necessity of family support to infected individuals. In female FGDs, it was also indicated that preventive measures such as isolation or self-quarantine would be most helpful to control the spread of the disease, reflecting awareness of urgency of such measures.

Persons with disabilities expressed concerns on being spotlighted on social media to their community which would bring shame in case of quarantine or diagnosed as COVID-19 positive. Moreover, participants demonstrated sympathy, caring, and supporting approach toward individuals infected with the virus. Participants highlighted the need to help and encourage infected persons to improve self-care, to seek medical care and mental support instead of holding them responsible and assigning blame.

In general, participants expressed the opinion that people infected with COVID-19 or who might be at risk due to interaction with positive cases should be able to come forward and seek medical assistance for themselves, also to avoid infecting others by hiding symptoms. However, the majority stated they have never come across a COVID-19 positive case; they ascribed this to the impression that people rather hide symptoms, fearing shame and stigma, rather than seek support. Participants also expressed the belief that once persons were infected with COVID-19 and would seek care, this could not be kept confidential in the community.

---

1 Al Bab, Afrine, Jarablus in Aleppo and Harim-Dana, Atma, Quh Kafar, Lousen and Maaret Mesrin in Idleb.
2 In other Protection Cluster monitoring, persons with disabilities have expressed frustration with humanitarian partners about being photographed and thus ‘used’ without permission. At all times, but especially in the context of COVID-19, this is to be avoided.
4. Gendered impact of COVID-19 and stigma

Women participants reported to be under pressure due to community expectations to protect their family members, including children and older people, from COVID-19; an infection would be directly ascribed to a lack of cleanliness of the house and surroundings for which women are deemed to be responsible. This pressure leads to increased stress and potential further impacts in case family members contract the virus. Household dynamics are reported to be influenced negatively by these dynamics and perceptions as well as due to the effects of COVID-19 transmission prevention measures and the impacts of lack/loss of livelihoods due to the economic downturn in NWS.³

Both male and female participants reported a fear of disgrace if women are infected by the virus given that it may imply the women or girl in question has been in unsafe environments. According to participants, this would result in the women and her family being ashamed, socially excluded and/or bullied, and could even lead to the women being rejected by the spouse in extreme cases.

Men reported hesitations to self-identify and seek care when showing COVID-19 symptoms out of feelings of shame, but more importantly the need to provide an income for the family. Moreover, men reported to feel responsible for the safety of the family and therefore indicated that many men, especially those living in IDP sites which are often deemed insecure, would prioritize staying with the family over entering quarantine (with some participants suggesting that this would even impact seeking longer term healthcare).

Women reported to tend to hide symptoms of common colds or (most likely) regular flu due to fear of being exposed in the community. They also conceal these symptoms to their family members. A female participant stated that women would conceal illness due to fear of being blamed by their husbands.

Women are considered as main duty bearers for taking care of all family members as well as work around the house such as cooking, cleaning, childcare, etc. Their absence for a prolonged period if quarantined would form basis for serious domestic issues according to FGD participants.

Moreover, perceptions from communities related to women having been away from the home for a prolonged period, especially when unaccompanied by her spouse or parents, was clearly expressed as being of concern by FGD participants. Stigma affecting women in such situations would go beyond COVID-19 and has cultural roots.

5. Concerns and perceptions specifically regarding quarantine centers and potential barriers to voluntarily access to such centers

Discussions with male participants revealed deep concerns due to misperceptions about isolation/quarantine centers in general. For some participants, such centers were described as “prisons” or locations where in fact “a person would contract the virus, suffer in detention, and die slowly”. However, some participants

³ In the context of the COVID-19 outbreak in NWS, the GBV sub-cluster reports a significant increase in GBV incidence.
expressed positive thoughts on the effectiveness of the centers to decrease the spread of virus within the community.

A key issue raised by male participants on multiple occasions during discussions in multiple FGDs was related to concerns over possible loss of income if men were to enter quarantine for extended periods. It was evident from the discussion that men tend to think the quarantine period would be lengthy and unnecessary. Participants also associated the establishment of a quarantine center in a specific area to a future spread of the virus in that location.

Male and female participants agreed that it is better to be isolated in the house, apartment, or accommodation rather than a quarantine center where it is expected that admitted people would be separated from their families. Self-isolation would also reduce issues around confidentiality and fears of exposure to community stigma/blame. Moreover, concerns were expressed around capacities of the healthcare system – affected by years of war – and ensuing poor quality of services.

A female participant indicated that she believed that due to fear of shame families would rather ‘let their daughters be sick and at risk of dying than to go to an isolation treatment center’. Nevertheless, other female participants still saw the idea of quarantine/isolation centers for cases suspected to be infected with the virus as a useful and helpful approach in limiting the its spread; however, this was caveated with remarks that certain conditions and requirements would need to be met. Requirements mentioned were: assistance and support, proximity to the IDP site/residential location, and possibility for family contact or unity, especially in cases involving children, women, and persons with disabilities.

Fears of psychological distress due to being alone while in quarantine and due to shame after being discharged were frequently mentioned by participants.

Persons with disabilities expressed that the quarantine/isolation center idea is not harmful, but – on the contrary – beneficial as it reduces the risk of infection within the community. However, it was still underlined that quarantine centers might not be efficiently equipped to host persons with disabilities, especially if the person fully depends on family support for daily activities. Some persons with disabilities shared similar misperceptions of the centers and their purpose, also expressing that quarantine in centers would be unnecessary confinement causing shame and mental harm. Finally, they indicated that having more medical centers in their areas was positive given the general lack of fully equipped medical facilities.⁴

A lack of understanding about the functioning of the centers, procedures, and reasons for persons to require to enter quarantine (i.e. when should one go into quarantine) was evident in all FGDs. Such lack of understanding leads to misperceptions and potential rumors which results in fear of centers and a reluctance to enter centers, especially when combined with existing gender norms and cultural practices.

⁴ Protection monitoring has also identified increased hesitation among persons with disabilities and older persons to seek regular healthcare due to fears of infection with COVID-19 and community perceptions.
6. Community recommendations to humanitarian partners on removing barriers to access to isolation/quarantine centers

**Information provision and community engagement**

- **Increase engagement with the community through trusted channels** to disseminate accurate information and have conversations on:
  - the aim of quarantine
  - who needs to quarantine, how identified and referred
  - quarantine procedures and potential treatment
  - conditions in the centers, approach to family unity
  - available services in the centers and support to those in quarantine
  - quarantine (and healthcare) to be free of charge

- **Involve and mobilize trusted community figures or institutions in these engagements** and in information dissemination – this would persuade people regarding admission to the centers, also with the help of the family members. Religious leaders, health staff, humanitarian frontline staff working with the community for long periods, and de facto local authorities and councils were pointed out as trustworthy entities by participants.

- **Female to female interaction** is also deemed important to overcome gender barriers and discuss gender specific issues.

- **Use verbal communication and allow for questions and dialogue** in engagement with communities as this is deemed more effective in generating trust and confidence in messaging by participants. For persons with disabilities, **diverse communication methods** should be available. **Face to face interaction** was also suggested to be effective specifically to reach all community groups including illiterate individuals and people living in remote areas with no access to television or internet.

- To strengthen this, **regular and continuous – in contrast with occasional and ad hoc – community engagement is required**, taking into account feedback of different community segments on the perceptions and efficiency of the centers; this would be most effectively conducted by humanitarian partners operating centers or having been operating for an extended period in proximity to future locations of quarantine centers. Expressed reasonable recommendations and concerns need to be acted upon to build trust. Some participants also expressed willingness to continue to be engaged in discussions on quarantine centers and their functioning as well as the community’s perceptions of quarantine – this should be built upon.

- Participants (as well as protection partners) recommend to make efforts to **shift the tone of messaging on COVID-19 towards a more positive message related to ways of supporting community and family members in difficult times** rather than continuously emphasizing dangers of the virus (contributed to by media messaging).

- Some participants also suggested **continuation of good practices such as mass media awareness raising campaigns** on COVID-19 prevention and precautionary measures as well as treatment procedures – including on the function of quarantine centers – through trustworthy media outlets and humanitarian frontline workers. Rumors spread through ill-considered media campaigns and word of mouth about
unpreparedness of quarantine centers and lack of services should be prevented through ways suggested above to increase community awareness and acceptance.

- Participants suggested to further increase the distribution of face masks and sterilizers in conjunction with community engagement.

**Quarantine centers**

- ** Provision of subsistence assistance to quarantined individuals**, including potential incentives or cash assistance, to encourage self-identification and ensure that the family is financially supported in times of loss of income during the quarantine period was deemed essential by nearly all participants.
- Participants strongly indicated that **family separation due to quarantine would result in a reluctance or unwillingness to enter quarantine centers voluntarily**. According to participants, facilities and procedures would need to be designed to accommodate full families to ensure take up.
- Children in quarantine centers should **access education** to avoid disruption according to participants.
- **Specific considerations and provision of services for persons with specific needs** are to be provided in quarantine centers. Participants specifically mentioned older people and persons with disabilities and serious medical conditions. When required, these individuals should be allowed to be accompanied by their primary caregiver. Protection partners are also concerned for unaccompanied and separated children that would need to quarantine.
- Moreover, specific attention and respect to the community’s cultural practices are to be embodied in the design of **gender segregated (WASH) facilities and effective communication channels** between quarantined individuals and their relatives who remain outside.
- Participants indicate that to increase confidence in quarantine procedures and centers, they are to be fully equipped and managed by trained and qualified staff that take into consideration cultural norms and various needs of individuals. This also implies strong measures to maintain confidentiality.
- **Provision of free transportation** for individuals for admission to and after discharge from quarantine centers was also mentioned by some participants as a need.
- **Quarantine centers or zones within IDP sites are supported** by participants given that this implies a degree of proximity to the location of residence.
- Some participants also emphasized that follow up **engagement with individuals and families after quarantine** can contribute to community support (and normalization/countering of stigma and prevent ‘out casting’); this was reinforced by protection partners. However, this is to be approached on a case by case basis given potential concerns related to confidentiality and stigma. **Informed consent** would need to be provided.

**7. Conclusion**

FGD findings show that communities living in NWS, specifically IDP sites, are greatly worried due to the perceived rapid spread of the virus. Camp and informal settlement residents were observed to be more welcoming to the idea of quarantine centers given that it’s almost impossible for individuals to self/home quarantine in camp environment while sharing a living space and WASH facilities as well. Quarantine closer to the location of residence, such as in quarantine zones in IDP sites, was received as a positive option.
In general, almost all participants agreed to have very little knowledge on the quarantine process and the existence of plans for quarantine centers while misperceptions on quarantine and COVID-19 related treatment are rife. Their knowledge is mainly obtained through informal sources and rumors which has contributed to increased anxiety and misperceptions. Increased and continuous engagement and information dissemination by trusted sources directly within communities on procedures and protocols, family unity (or means to preserve contact), available services, culturally appropriate set up, and the provision of assistance in relation to quarantine centers should be prioritized to contribute to combating stigma and promote willingness to adhere to public health protocols, including seeking care and entering into isolation/quarantine. In the FGDs in Idleb, participants suggested that health/medical staff, imams and humanitarian workers who have been in interaction with the community for years would be considered as most trusted sources of information on quarantine/isolation centers and procedures in relation to COVID-19. In Aleppo, participants also referred to de facto authorities and local councils as trusted source of information on COVID-19 related matters.

Following from remarks of FGD participants, provision of psychosocial support and mental health support is to be prioritized for individuals admitted to the centers, as well as their families, to ease psychological pressures, promote coping with stress, empower individuals and families to deal with stigma and shame while also stimulating supportive attitudes, and overcome barriers for reintegration in the community following discharge. Further, special considerations should be in place to ensure a child friendly environment quarantine centers – minimum arrangements such as education, psychosocial support, extracurricular activities, protection services, and contact with family/primary care givers are advised to be considered.

It was quite evident in FGDs in all locations that female participants are more supportive of the idea of quarantine centers as part of the public health response compared to male participants who more frequently opposed the concept of quarantine in a center, regularly describing such centers as prisons and underlining issues such as income loss, community stigma and shame (including for family), and possible neglect of husband and children if women would be admitted to isolation/quarantine centers.

Female participants (as well as male participants) indicated that women and girls would face severe barriers to entering quarantine centers due to fears of stigma and rumours as well as a reluctance on behalf of husbands to separate from their wives and/or daughters. The FGDs showed that willingness to enter quarantine is low for women and children, older people, persons with disabilities, and other people in need of support without any form of accompaniment.

Three immediate actions that would contribute to increasing voluntary entry into quarantine centers across NWS are: 1) maintenance of family unity in quarantine (or at least accompaniment of those who require so), 2) financial support to compensate for loss of income, and 3) sustained and clear messaging on quarantine centers’ rationale and functioning as well as on supportive approaches to COVID-19.

Finally, in the context of COVID-19 in NWS, maintaining confidentiality is nearly impossible while stigma is deemed to be one of the main barriers for willingness to seek healthcare and enter quarantine. A whole of system approach is required to take up the highly complex effort to shift narratives in NWS around COVID-19.
Annex 1. – List of Protection Cluster recommendations to humanitarian actors in relation to quarantine centers, aiming to increase acceptance and improve perceptions

**Information provision and community engagement**

- **Increase and standardize consistent qualitative and meaningful in-person engagement** with the community through trusted channels, both to provide information and seek feedback (ensuring feedback is acted upon and these actions are communicated to community members).
- **Use verbal communication and face to face interaction** as much as possible with considerations to COVID-19 measures, this allows for clarification questions and is the most widely trusted way of information dissemination; continue the distribution of face masks and sterilizers in conjunction with community engagement to serve as entry point.
- **Disseminate accurate information** on quarantine centers and their purposes, processes and ways of working, and services available in centers.
  - the aim of quarantine
  - who needs to quarantine, how identified and referred
  - quarantine procedures and potential treatment
  - conditions in the centers, approach to family unity
  - available services in the centers and support to those in quarantine
  - quarantine (and healthcare) to be free of charge
- **Shift the tone of messaging on COVID-19 towards a more positive messages** on ways of support to community and family members affected by the virus and use positive support messages designed to combat stigma around COVID-19 through community key figures, implement community mobilization programming (applying community-based protection methodologies) to stimulate community support mechanisms.
- **Involve and mobilize trusted community figures** or institutions in communications with the community. Religious leaders, health staff, humanitarian frontline staff working with the community for long periods, and de facto local authorities and councils were pointed out as trustworthy entities by the community.
- **Ensure diverse communication methods**, such as the use of posters with high contrast pictures which describe the information and assistive communication devices such as whiteboards for written live communication, are available for persons with specific needs, persons with disabilities, older people, illiterate individuals, and people living in remote areas with no access to television or internet.
- **Combat the spread of rumours and misinformation** through this consistent engagement with the community and by ensuring updated messages that include latest information are available to all humanitarian partners (and conduct information / training sessions to humanitarian partners).
- **In addition to in-person engagement, continue mass media awareness raising campaigns on COVID-19 prevention and precautionary measures as well as treatment procedures** – including on the function of quarantine centers – while also including messaging to stimulate community support mechanisms.
Procedures, assistance, and services while in quarantine centers

- **Ensure family unity** given the barriers to voluntary quarantine in centers separation causes; when this is unfeasible, allow for accompaniment of children, women, persons with disabilities, and others that would be supported and/or protected through such an arrangement.

- **Provide financial support** to individuals identified as having to enter quarantine to reduce barriers to self-identification and ensure that the family is financially supported in times of loss of income during the quarantine period.

- **Specific considerations and provision of services for persons with specific needs** must be provided in the center. Older people, persons with disabilities, and persons with serious medical conditions must have access to medication, assistive devices as well as individualized care and assistance from their primary care giver.

- **Ensure measures and protocols are in place that aim to maintain confidentiality.** Follow-up after quarantine should require informed consent.

- **Provision of free transportation** for individuals for admission to and after discharge from quarantine centers.

- **Provision of MHPSS counselling** for those who require support during quarantine, especially in relation to potential increased stress, either via telephone or – preferably – in person. Ensure proactive information provision to individuals on availability of counselling or – preferably – conduct intake conversations between MHPSS counsellors and individuals entering quarantine.

- **Center management staff to be trained on protection principles and basics** such as identification of individuals with specific protection concerns and protection sensitive and safe referrals; referral pathways to be agreed-upon.

- **Specialized protection services** to be available, especially for unaccompanied and separated children to guarantee wellbeing and address urgent protection concerns.

- **Gender segregated facilities** (WASH and temporary accommodation) to be provided.

- **Provide effective communication channels** between quarantined individuals and their relatives outside the centers, this supports wellbeing while it also aims to indirectly combat misinformation.

- **As above, meaningful engagement with individuals and communities** to be conducted to ensure consistent engagement with communities within the catchment area of each quarantine center, as well as with individuals inside quarantine. Feedback should be provided

- **Conduct follow-up with those exiting quarantine centers**, including through community mobilization and group-based PSS sessions to stimulate community support networks by combating negative perceptions.
Annex 2. Protection Cluster reference documents

*Relevant Protection Cluster guidance (NWS)*

Protection Considerations on Community-Based Treatment Centers

Respect for confidentiality and responsible messaging during COVID-19

Protection Cluster recommendations on criticalities of protection activities during COVID-19

GBV service provision during COVID-19
- [https://drive.google.com/drive/folders/1HzeNBR3hITmHhpy3Yf_WCLv9f94cL-pb?usp=sharing](https://drive.google.com/drive/folders/1HzeNBR3hITmHhpy3Yf_WCLv9f94cL-pb?usp=sharing) – GBV SC COVID-19 detailed guidance documents and information materials

Child Protection Case Management during COVID-19

Child Protection Emergency Case Fund guidance note

Protection Cluster Inclusion of Persons with Disabilities TWG COVID-19 guidance

*Relevant guidance (Global)*