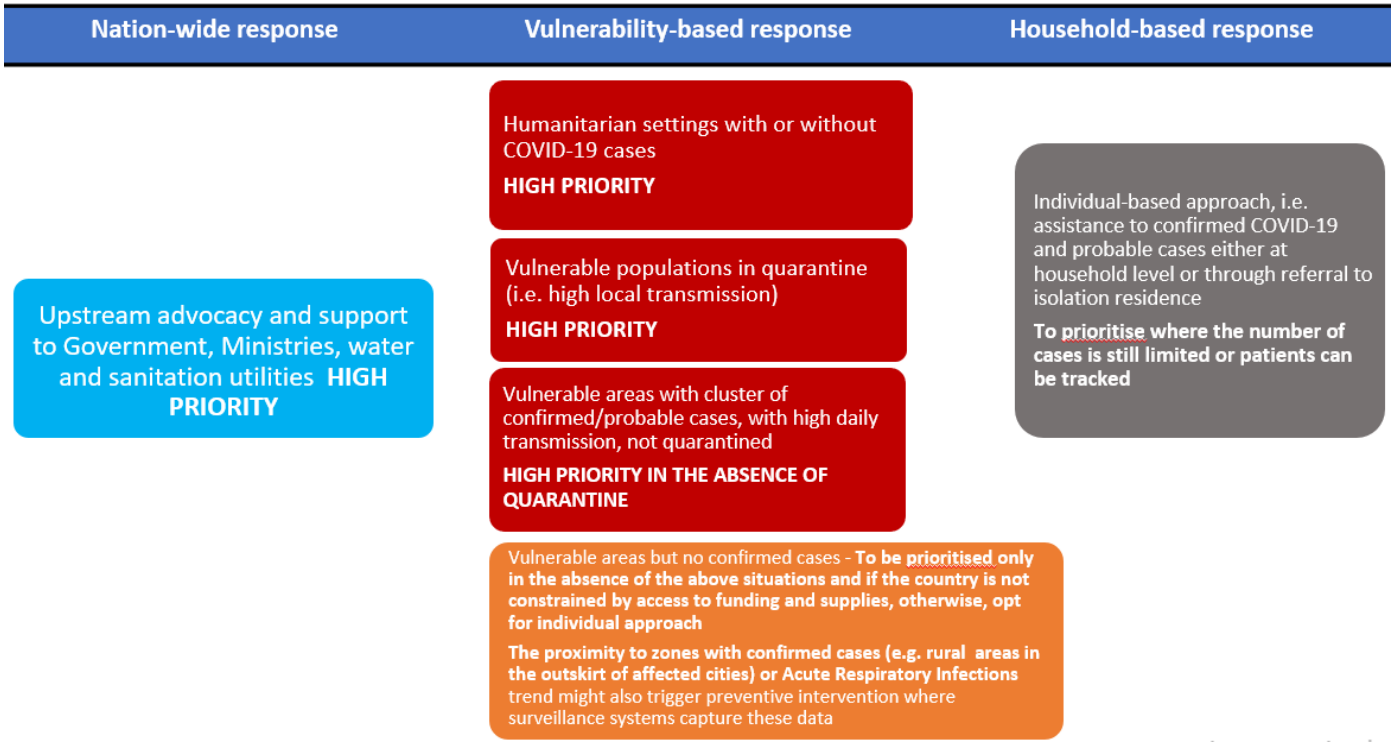
COVID-19 Preparedness and Emergency Response

WASH and Infection Prevention and Control (IPC) Measures in Households, Communities and Public spaces

Recommendations for the prioritization of activities

With a widespread disease in regions and many countries, prioritizing WASH-IPC interventions in communities is a complicated task. Every country is facing different situations requiring adapted responses. We propose here some recommendations on how to build a prioritization strategy at country level. We do not follow exactly the WHO language in terms of country scenario (sporadic cases, cluster of cases, community transmission) because the proposed framework applies to simultaneous contexts within countries. We organize the prioritization around three main categories of targets: nation-wide, vulnerable areas and settings, individual and households.



To narrow down the targeting of vulnerability-based responses, we consider key vulnerabilities to help the prioritization of interventions:

- High population density (urban slums and other informal settlements, including camps and shelters)
- Precarious or shared housing (incl. shared toilets)
- Limited access to water and limited handwashing practices (zones with existing WASH programs aiming to increase access)
- Poverty level (data from MICS, DHS, social safety net programs database etc.)
- Low access to quality health services
- Low access to information (e.g. rural areas)
- Relying on public transport

It will not be always possible to get all these data, and sometimes vulnerable neighborhoods (e.g. slums) are already known, but the triangulation of several of these criteria may help narrow down the identification of at risk zones, both for the disease and its secondary impacts. The most difficult remains after that: delimiting the zones. This may be easier in rural areas than in urban areas. If a zoning is required to prepare an intervention (e.g. blanket support to households to access hygiene products, through in-kind distribution or cash-transfer), it must be carefully planned with local authorities, community representatives, informal leaders or influencers, on the basis of past similar experiences if any, accompanied by a good communication to the public to explain the intervention rationale and objective. In cities, such zoning can be done at the lowest level possible, using administrative boundaries (urban zoning codes) or community-agreed houses blocks boundaries. Once the limits are defined, you can undertake a more exhaustive assessment of the WASH situation to tailor the intervention.

FIRST PRIORITY: DO NO HARM = always assess the potential unintended effects of the selected interventions, people have their own perception and understanding of public health interventions.

Nation-wide response

Priority	Coverage	Activities
High priority upstream national advocacy in countries with lock-down strategies affecting the most vulnerable groups	National coverage through WASH sector policy adaptation (E.g. LAC initiative) and large scale RCCE	Support existing government coordination mechanisms, update and support creation of exhaustive service providers contact list where needed. Large-scale assistance to the population with a specific advocacy for vulnerable areas and groups, affected by service disruption (VAT waiving, water billing postponed, no disconnection from & reconnection to water and sanitation services, free daily volume of water for most vulnerable households, advocacy to national electricity providers to keep supplying water and sanitation utilities, support to water and sanitation utilities for service continuity, support to hygiene and IPC supplies production, subsidized soap, inclusion of WASH supplies and service in social safety net program, national HWWS campaign, no disconnection from electric grid and internet to ensure access to information)

Vulnerability-based response – Humanitarian settings

Priority	Coverage	Activities
High priority, sustain humanitarian WASH services	Populations relying on humanitarian assistance, particularly children on the move and their family (refugees, IDPs, migrants)	Ensure availability and access to water meets the required needs for enhanced hand washing and hygiene practices
		Increase availability of handwashing facilities and soap in camp-like settings, ensure households have soap to wash hands at home and IPC items to protect themselves (kit distribution or cash-transfer where markets functionality and mobility allow it)
		Ensure access to tailored information about prevention measures against COVID-19

Vulnerability-based response – General population

Priority	Coverage	Preliminary steps	Activities	Monitoring
High priority, ensure adequate WASH and IPC measures in vulnerable areas put in quarantine (assumed	Vulnerable areas/ neighborhoods in quarantine	Ahead of quarantine in either zones, discuss with local authorities and areas' representative to agree on WASH services continuity strategy	Support water & sanitation utilities/systems for service continuity in quarantined areas (logistic, financial, supplies), or deliver water in quarantined areas with pre-existing constrained access through alternative systems (Eg. trucks), increase storage where needed, ensuring social distancing between users of public tap-stands	Remote monitoring through key informants and households SMS/Phone/Inte

widespread community transmission)		Identify key informants and hygiene promotion relays prior to "quarantinization"	Blanket distribution of IPC kits (min. soap, commercial liquid chlorine, IEC materials, consider including handwashing system, cloth masks[1]) to all households in small quarantined areas with vulnerable population (incl. cash-transfer if market accessible), or Provide IPC kits to health care facilities to be delivered to probable and confirmed households, or Support vulnerable households in quarantined areas preferably based on existing social safety net list or humanitarian cash-transfer programs, including an IPC kit (single-headed female HH; marginalized HH, HH with elderlies or persons with underlying health conditions, HH with HIV AIDS, etc.)	rnet-based questionnaire
		Rapid assessment of WASH supplies & services availability/accessibility		
		Identify social institutions (childcare center, orphanages, social and nursing homes for homeless, elderlies, people with disabilities etc.), assess IPC conditions; in complex urban settings, this can be an entry point to liaise with local representatives	Ensure hand hygiene, water in sufficient quantity and access to cleaning and disinfection materials for collective vulnerable sites; provide necessary briefing to institutions' personnel	
		In quarantined areas, identify public spaces most frequented (if let open during quarantine)	Install & run (through area-based volunteers) handwashing station in public places of quarantined areas still accessible to people, ensuring social distancing between users	
			Ensure access to tailored information about prevention measures against COVID-19, considering potential constraints to access information through telecommunication and internet; training on hygiene promotion techniques for water & sanitation utilities staff or informal workers still active in quarantined areas	
High priority, ensure vulnerable areas with clusters of confirmed cases have access to WASH services	Zones (incl. rural areas) with clusters of confirmed cases and known vulnerabilities, not quarantined	Identify neighborhood boundaries with local representatives and existing administrative maps in order to target interventions at the lowest level possible	Advocate to utilities to prioritise water distribution in areas with limited water access, to not disconnect defaulters or reconnecting past defaulters; advocate and support continuity of services for both water and sanitation interventions; training utilities staff on hygiene promotion messaging is an opportunity	Remote or on-site monitoring through key informants and households SMS/Phone/Internet-based questionnaire. If personnel deployed in areas, ensure they are informed and
		Rapid assessment of WASH supplies & services availability/accessibility	Increase the volume of water delivered daily through support to water utilities for increase production & distribution, piped systems quick repairs or alternative systems (water-trucking, temporary additional storage installation)	
		Identify key informants and hygiene promotion relays.	Support market, commercial areas, commuting and key transit points to improve sanitary conditions and reduce transmission risks, incl. installation and operation of handwashing stations (ensuring social distance between users), make available mask for	

[1] All other items which might not be in direct relation with COVID prevention must be clearly justified (Eg. household loss of income might impede them to purchase water purification tablets which in many regions is key to ensure water safety)

			vendors, availability of clean toilets, trash bins distribution and waste collection	comply with protection measures
		Identify and reinforce local community representatives, leaders/influencers, or religious leaders, in COVID-19 hygiene related messaging	In small clusters, well delimited, with a majority of vulnerable households (e.g. slums), provide a basic IPC kits for all, either through in-kind distribution, or Cash-transfer where market is working, or Provide IPC kits to health care facilities to be delivered to probable and confirmed households	
		Identify vulnerable collectives sites (childcare centers, orphanages, homeless, elderlies/disabled residences etc.)	Ensure hand hygiene, water in sufficient quantity and access to cleaning and disinfection materials for collective vulnerable sites	
		Identify public spaces most frequented	Support sanitation workers (particularly informal workers dealing with raw fecal sludge and solid waste management)), ensuring workers protection & service continuity	
			Where schools are open or will re-open, either entirely or partially to provide meal to pupils, engage teachers and pupils on hygiene preventive practices, ensure availability of hand hygiene facilities and soap, water in sufficient quantity and access to cleaning and disinfection materials; ensure accompanying teaching staff in the application of safe infection prevention protocols	
To prioritize in the absence of cluster of confirmed cases if national surveillance system is able to detect ARI trends	Zones (incl. rural areas) with sporadic cases or increased Acute Respiratory Infections cases informed by surveillance data and known vulnerabilities	Same as above	Same as above, except for households targeting due to the absence of quarantine or small clusters of confirmed cases. Refer to households targeted approach below	
To be prioritised only in the absence of the above situations and if the country is not constrained by access to funding and supplies, otherwise, opt for individual based approach	Zones (incl. rural areas) with known vulnerabilities but no confirmed cases, no ARI increase	Identify key informants and hygiene promotion relays as preparedness and prevention measures.	Refer to population wide approaches applied to vulnerable neighborhood, peri-urban areas or rural zones	
		Identify neighborhoods/peri-urban/villages with most vulnerabilities and their limits	As a minimum: promote hand hygiene by increasing availability of hand washing facilities in public places, commercial building, schools, collective vulnerable sites (childcare centers/orphanages, homeless/elderlies/disabled residences etc.), promote protective practices with C4D/RCCE.	
		Identify and reinforce local community representatives, leaders/influencers, or religious leaders, in COVID-19 hygiene related messaging		
		Rapid assessment of WASH supplies & services availability/accessibility		

Individual or household-based approach (can be coupled with an area vulnerability approach)

Priority	Coverage	Preliminary steps	Activities	Monitoring
Approach to prioritise where the number of cases is still limited and patients can be tracked. Actual COVID-19 trend must be confirmed by an analysis of ARIs trend and associated mortality rates, or mortality rate of people with underlying health conditions, confirming that the disease is not widespread. This could applied either at the beginning of the outbreak in countries where it is only starting or during the epidemic tail-end phase to accelerate the end of transmission.	Suspected cases of COVID-19 not requiring hospitalization (likely in quarantined area and clusters of cases) Confirmed cases via laboratory testing where available	Have access to surveillance data or suspected cases directly from healthcare facilities. Upon the sick person or family consent, undertake a quick evaluation of the patient ability to maintain self-isolation home.	Targeted assistance to suspected and confirmed cases may include: - support household in establishing self-isolation procedure at home - ensure hand washing facility is available at home, demonstrate cleaning and disinfecting often-touched surface - deliver at least (in-kind or cash approach) soap, bucket with tap/support (if needed) or hand-sanitizers, commercial bleach, IEC materials - where relevant (decision to be taken in coordination with MoH and relevant partners), provide adequate cloth mask to the family with instructions on use, reuse and safe disposal Alternatively, according to local health authorities strategies, and provided no forced isolation occurs (each person should volunteer for isolation), when suspected and confirmed cases with mild-symptoms are referred to an isolation residence (e.g. requisitioned hotel, equipped commercial building etc.), ensure provision of safe water, adequate hand washing commodities, provision of IPC materials and training where needed, sanitation services.	Remote monitoring through households SMS, Phone, Internet-based questionnaire. Via contact follow-up teams in charge of monitoring of cases stayed at home. Nurses in isolation residences.