

## ES/NFI Cluster: Shelter and Settlement Guidelines for COVID -19

### Introduction

The purpose of this document is to support partners in ensuring their planning and implementation of shelter and settlement responses minimises the transmission and /or impact of covid -19. It should be read in conjunction with WHO, IASC and UNHCR guidance notes. The Global Shelter Cluster also has a dedicated page with resources from other agencies and countries for reference. <https://www.sheltercluster.org/response/covid-19-and-shelter>

### Specific objectives

1. Mitigate and reduce transmission risks through appropriate management of physical space.
2. Provide clear and unequivocal messages focusing on what people can do to reduce risk or which actions to take if they think they may have COVID-19.
3. Identify specific protection measures for at-risk groups such as older persons, persons living with HIV/AIDS, persons with cardiovascular disease or weak immune systems etc.
4. Adapt existing ES/NFI programmes to better serve at-risk groups.

### Considerations for Shelter and Settlement

- In accordance with WHO guidelines, quarantined or self-isolated persons should have safe and dignified access to an adequately ventilated single rooms, with dedicated toilet, hand hygiene and washing facilities. If this cannot be achieved in the household's current housing arrangement, specific facilities should set-up for this purpose, to the extent possible.
- ES-NFI Cluster will continue all its core lifesaving activities to address needs induced by conflict and natural disasters while simultaneously prioritizing populations with covid -19 related chronic and acute vulnerabilities including – poor shelter, residing in overcrowded settlements, poor health, income/expenditures, age within sectoral responses.
- Emergency shelter and settlement intervention need to be closely linked and integrated with the public health response. In particular, the cluster should work closely with the Protection Cluster, Food Security and Agriculture Cluster, Education, WASH and Health cluster during needs assessments, targeting and selection of beneficiaries, coordination and distribution of ES and NFI items and in the design of the joint winterization response 2020.
- In locations where people live in high occupancy per shelter, attempts to reduce density by providing extended, partitioned, or upgraded living conditions are essential to increase the covered living space. Additional shelter and housing may be provided for identified cases requiring isolation where self-isolation in an existing dwelling is impossible – working with health and protections colleagues to ensure that isolation does not deprive people of family support and coping mechanisms or exacerbate stigmatization.
- Transitional shelter approaches should incorporate transportation costs as beneficiaries are expected to travel long distances to source for the needed construction materials; and a cash for work component, to help families cover their needs and cope economically while focusing on the construction. Partner Staff are expected to adhere to social distancing practices, safety standards, and hygiene practices during site visits, and training sessions.
- In many situations, lengthy international procurement is unlikely to be the best option due to import and global supply chain challenges, and timeliness of response. When selecting shelter approaches, local solutions should be prioritized, that are quick to implement using labour-based methods and cash, plus local material purchases, encouraging local economic stimulus. However, be aware not to encourage options that put people at risk by having to take additional measures to source materials from markets, engage in extended social contact, etc. See if material delivery options exist, bulk purchase and distributions, etc. – assess all options before deciding on a shelter implementation method.
- Failure to improve shelter conditions particularly for those in who are newly displaced, or residing in informal settlements, means that people will be left to live in substandard shelter, in overcrowded settlements, risking their lives, and at heightened risk of widespread transmission of COVID-19. These conditions are ripe for virus transmission.
- Due to the impact of covid-19 on livelihoods, over 1.3 million people will not have access to heating / fuel and able to cope with the winter, leaving them extremely vulnerable to rain, snow, and freezing temperatures. Household's may be pushed to employ negative coping mechanisms which often have serious protection implications for children such as forced labor and early marriages.
- It is recommended to establish a rapid response team (including shelter staff) that can handle suspected cases and activate protection and isolation measures, as well as coordinate with local authorities.
- Continued innovative approaches which encourage partners to 'stay and deliver' need to be closely linked to sustained and unfettered humanitarian access, adequate and predictable resourcing from donors, and the ability to retain necessary staff in areas where the needs are the greatest.



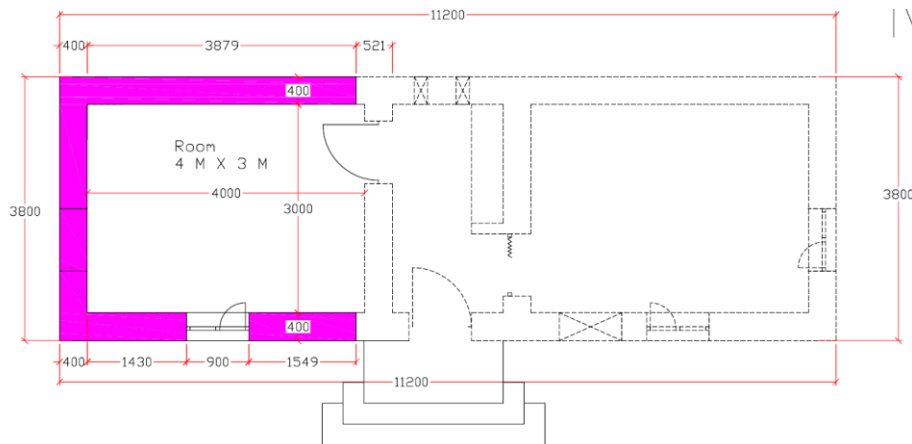
- The spread of COVID-19 may affect the ability of humanitarians to go to the field and respond – including undertaking assessments, inability to conduct focus group discussions, training, delayed distribution, and effective post-distribution monitoring.
- Delays in delivery of core relief items to affected regions may be experienced due to movement restrictions / border closures, as well as other factors including conflict and natural disasters. While, immediate response will rely on existing and pre-positioned stocks, this may result in normal programming in existing response locations being compromised.

**Preventive emergency shelter solutions within household' current arrangement:**

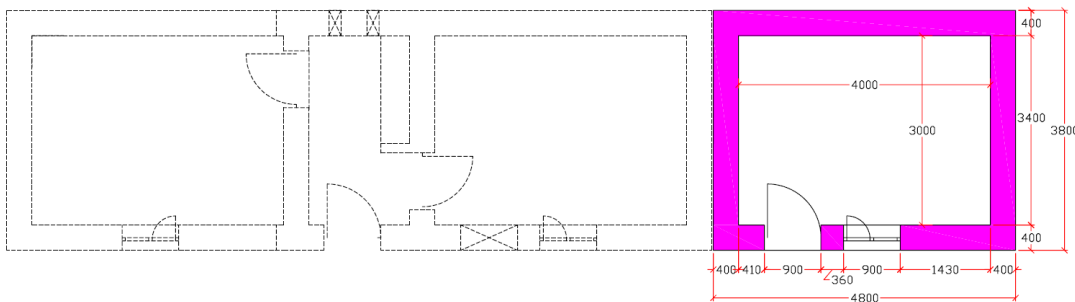
At this stage, the cluster shall mitigate the risk of transmission through preventive activities including:

- Risk Communication and Community Engagement:** This includes hygiene promotion messages, awareness raising and evidence-based sensitization on COVID-19 intensively addressed to the communities, i.e. what to do if a person has symptoms, and the premise of quarantine/ self-isolation and social distancing.
- Provision of extension kits (one room extension):** This aims to increase the covered living space available and reduce overcrowding particularly for at risk populations residing in poor shelter in informal and informal settlements. This response should target population with vulnerabilities that aggravate risk of transmitting covid -19 including age, comorbidities, lack of income, populations residing in IDP sites with highest needs, districts in high risk provinces of return, and lack /limited access to health and wash facilities. This constitutes of providing an extension to the main house to reduce overcrowding either by extending one room to two or from two room to three rooms. Three design packages are suggested reflecting various local building technologies across the country, namely Type-A (Room with Chawka Brick Ceiling) ; Type B (Room shelter Khar Wood Ceiling) and Type C ( Room with C Brick Vault Ceiling). The designs incorporate necessary disaster risk reduction and resilience elements into the design. Each of the three shelter sizes is complimented by a correlating BoQ and design specifications. That said, the BoQ and plans act as guidelines for the beneficiary to understand what is achievable given the resources provided. Design should be developed according to the land available and beneficiary preference. **The unit cost for each design ranges from USD 850 – 960.** At risk households should also be provided with NFIs to reduce sharing of items and promote safe handling practices.

*Floor Plan (1 room to 2 room)*



*Floor Plan (2 room to 3 room)*



- c. Rental Support:** This modality will be instrumental to those who, due to restrictions, have lost the capacity to generate sufficient income to cover their basic needs (rent, food, and others). CfR should be provided to very vulnerable at-risk households intended at ensuring their access to safe shelter for a limited period. It aims to minimize the effects of negative coping strategies and reinforce the safety and dignity of vulnerable families. It should seek to both provide adequate shelter and ensure security of tenure for affected persons. An exit strategy must be planned prior to commencing implementation. Referral pathways linking CfR initiatives to government-led and other development programs or transition to Bai Wafa type tenures of security arrangement may be key components of the exit strategy. In all cases the target population must be informed of the duration of the planned initiative and made aware of supporting programs and services that are available to enable beneficiaries to independently meet their longer-term shelter needs. A monthly CfR amount will be determined depending on the average cost of single rental unit and considerations such as individual vulnerability, household financial capacity protection concerns etc. **The value of one month of CfR assistance for ESNFI cluster is set at minimum of \$75 USD per family and assistance should run for a period of least 3 months.** Extension from the first instalment up to 12 months as a transitional shelter solution will be based on updated data on the needs of the household, the improvement or deterioration of the household's situation, covid -19 spread, – and within funding possibilities of the partner. At risk households should also be provided with NFIs to reduce sharing of items and promote safe handling practices.

#### **Winterized facilities support**

The COVID-19 pandemic is a threat not just to people's physical wellbeing but also their economic wellbeing. Large numbers of people are expected to be adversely affected by loss of livelihoods due to the economic consequences of the pandemic. Therefore, the cluster will also expand its winterization program targeting more vulnerable people with heating /fuel support to help them cope with the upcoming winter season. At risk household should be prioritised with winter support to reduce use of waste for heating / fuel and their exposure to respiratory infections likely toacerbate risks associated with covid-19. It should be noted that a comprehensive winterization strategy must consider a range of measures to ensure that PoC are adequately protected from the cold including adequate shelter, heating, NFIs, and winterized facilities.

- d. Winterized tent facilities:** The tent in its standard form is suitable for external temperatures falling to +5 degrees C with heating to maintain an internal temperature > +13 degrees C. Winterized family tents should not be used as winter shelter in locations where the prevailing external temperature falls below -5 degrees C or where extreme wind will increase the impact of minus temperatures. The use of winterized tents as family shelters in locations where winter external temperatures are maintained above -5 degrees C should only be considered in situations of acute need. Where the use of tents is considered unavoidable to preserve life and due to limited availability of other options, the following additional measures are required.
1. Wind Loading – Stringent monitoring of tent set-up is required to ensure that all mud flaps are adequately buried or weighted with sandbags and all guy ropes are correctly positioned and tensioned. Regular additional monitoring is required to ensure that guy ropes are re-tensioned as required.
  2. Surface Water – Raise the ground area by a minimum of 120mm with either gravel sub-base or an individual concrete plinth. This will help to prevent the ingress of surface water and provide a dry surface onto which additional floor insulation may be added - polystyrene sheets or foam mats. Drainage channels around tent plots to divert surface water will be necessary.
  3. Snow & Rain – The addition of a plastic sheet to cover the tent and fixed to the existing guy lines will provide further protection from possible water ingress through the roof caused by heavy and persistent rain or melting snow on the roof of a heated unit. Regular clearing of snow from tent roofs and surrounding areas will be essential to maintaining the structure.
  4. Winterization Kit – A winter kit constituting of the following should be provided: Insulation sleeping mats (depends on HH size), one (1) liner and one (1) partition, one (1) heat resistant floor panel (for positioning a solid/liquid fueled stove); one (1) heat resistant sleeve (for stove chimney to pass through the tent wall). The later items are provided to allow solid fuel or liquid fuel stoves to be used inside the tent and should be considered redundant where a bottled gas or electric heating is available.
- e. Heating / Fuel Support:** All shelter types, including existing structures, will require a heating strategy for utilization during the winter. The response should consider the availability of heating options, associated fuel supply and the safety of the shelter occupants. Consideration on the risk of fire should be made with appropriate safety information campaigns, maintained safe occupancy levels, adequate and maintained means of escape and provision of safety equipment (e.g. fire extinguishers) where appropriate. Exposed liquid and solid fuel heating appliances should not be used in regions where safer alternative heating materials are widely available and accepted. Where existing heating systems are deemed inadequate, supplementary heating may be provided through the provision of individual electric room heaters or bottled gas units subject to being certified as safe for indoor use and in the case of bottled gas heaters with additional safety features. **The value of 3 months heating / fuel assistance is set at \$200 USD per family adequate purchase of a gas cylinder, and 180 kgs of firewood or LPG.**

- f. **Personal Insulation:** In cold climates, with temperatures below freezing, people will die within one day without adequate protection from the elements. In addition, rain and wind increase heat transfer away from the body. Therefore, survival is often dependent upon prioritizing the distribution of NFIs to best provide thermal comfort. Adequate personal insulation for individuals is essential to preserve body core temperature. Retained personal insulation may include appropriate winter clothing that can be worn to schools. It should be considered that possibility of catch classes in the winter season means that school age going children will require warm clothes to maintain thermal comfort in heated classrooms. **The value of winter clothing kit is set at \$65 USD per family by the Afghanistan Shelter Cluster.**

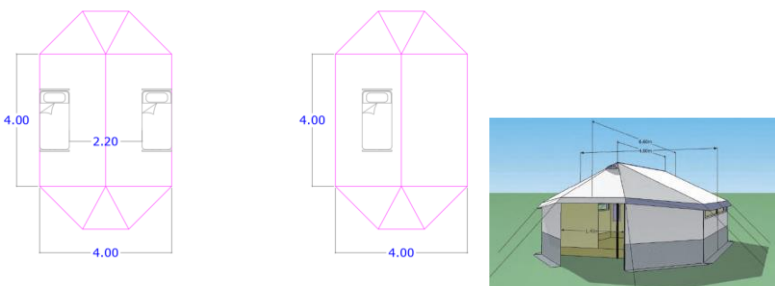
#### **Response emergency shelter solutions within household' current arrangement**

Self-isolation is considered applicable where there is existing capacity within the household in which suspected or confirmed individuals can achieve quarantine or isolation. This capacity is determined by the availability of vacant rooms, tents or housing units within the plot or shelter unit. The ability of individuals and families to isolate themselves will depend on the type of house and/or shelter where they live. If this cannot be achieved at the household's current housing arrangement, minor modifications to current shelters can be implemented. If the existing shelter does not support modification or cannot accommodate the number of individuals needing to self-isolate, specific facilities such as tents, refugee housing units (RHU) can be set-up for this purpose. At risk households should also be provided with NFIs to reduce sharing of items and promote safe handling practices. The ability to provide this support will be limited by staff capacity, ability of individuals or community members to do it themselves, contextual situation, and funding levels. The proposed support will be based on a standardized assessment and is likely to include.

1. Provision of shelter items to create partitions if required/ feasible.
2. Provision of doors and door frames, if not present between the isolation room and rest of the shelter.
3. Provision of a temporary toilet (if feasible) or advice/ guidance on the allocation of an existing toilet to be used exclusively by the suspected case.
4. Installation of a handwashing facility nearby the latrine (if not already present).
5. Provision of a suitable amount of soap and disinfection products to permit regular cleaning of the isolation room and other areas of the tent.
6. Provision of PPE materials in accordance with WHO guidelines.
7. Connection of the isolation room directly to the existing water tank (if feasible).

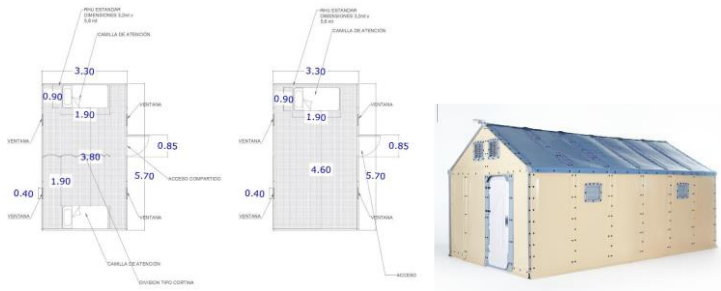
**Shelter Modification:** A guidance note should be provided to the household/caregiver of the suspected case detailing practical tips on how to undertake minor shelter modifications, reduce density by providing partitions, modifications (doors and frames), and retro fitting the current shelter. Modifications will include the partition of existing rooms, the provision of separate of toilet/ bathroom as appropriate, and provision of NFI kit to minimize sharing of core relief items. The cost of the modification should be tailored to the design of the house. **The standard costing for shelter repair estimated as USD 300 may be applied for planning purpose.** The BOQ for shelter modification should include – a set of tools, supply & fix plaster boards / plywood / hardboard 1.2m x 2.4m depending on most available material), timber for wooden frame, metal struts, door and window for ventilation. Alternatively, where this option is not practical, and the household has access to land, emergency shelter solutions may be provided, including:

**Emergency shelter kit (tents):** Persons at risk may be provided with an emergency shelter kit including (tents and 2 pc of plastic tarpaulin). Isolation of a maximum of two persons per tent is recommended. For ventilation, it will be necessary to keep the 'doors' closed and ensure that the windows on the wall and ridge are open to promote negative pressure ventilation. At risk households should also be provided with NFIs to reduce sharing of items and promote safe handling practices.



**Prefabricated Units:** This includes assembled units such as RHUs, containers etc. A maximum of two people per unit is recommended. There will be factors that make it difficult to comply with this recommendation, such as the need

for a patient to be accompanied or the lack of beds for the population in need. As a last resort, one bed should be added per RHU, reaching a maximum of 3 patients per unit.



### Considerations for selecting emergency shelter solutions at household level for the response to COVID 19

Typology	Individual Isolation	Key considerations
<b>Tents</b>	Yes	Designed for family or individual use for accommodation purposes. Will not perform against continued cleaning and disinfection requirements, nor provide adequate head space for medical visits, equipment. Currently available and prepositioned. Expensive modality for a 14day response. Quick to set up and respond. They are not made of rigid material, security (for valuables) may be inadequate.
<b>RHU</b>	No	Not recommended as individual family shelter for isolation purposes. Expensive modality for a 14day response. Quick to set up and respond. Cleaning and disinfection options easier due to rigid walling and impervious plastic construction. Possibility of re use
<b>Shelter modification kits</b>	Yes	Use of local materials Beneficiary driven Construction and set up may take longer than required. Single room dwellings provide limited options for partitioning etc.
<b>Shelter Extension Kits</b>	Yes	Preventative measure. Addresses long term recovery needs while mitigating again covid -19 Beneficiary driven Incorporate a cash for work component, reducing vulnerabilities, providing beneficiaries with a source of income while at the same time supporting recovery.
<b>Rental Support</b>	Yes	Both preventative and response measure. Addresses long term recovery needs while mitigating again covid -19 Beneficiary driven

### Emergency shelter solutions outside household' current arrangement

This option is considered applicable where the household does not have enough vacant rooms, tents, or housing units or access to land to achieve the quarantining or isolation of suspected or confirmed cases. As such, a dedicated temporary 'facility' is constructed, or an existing building is repurposed with proximity to the household residence to permit quarantining or isolation of suspected or confirmed cases. These options include:

- a. **Re purpose existing buildings:** Local authorities, together with affected communities, partners should explore the use and repurposing of existing buildings within/near the site. The team should map available capacities for the facilities located near government hospitals, health centers and have these buildings available for use for COVID-19.  
Renting functioning hotel structures is proposed. This option is most applicable in urban areas where hotels, hostels are available. These are ideal spaces for providing accommodation since they minimize the risks of contagion associated with COVID-19 as well as reducing the protection risks inherent in collective accommodations. The local authorities in coordination with shelter and WASH clusters shall be required to assess the suitability of the structures for occupancy and determine the need for minor rehabilitation works (if



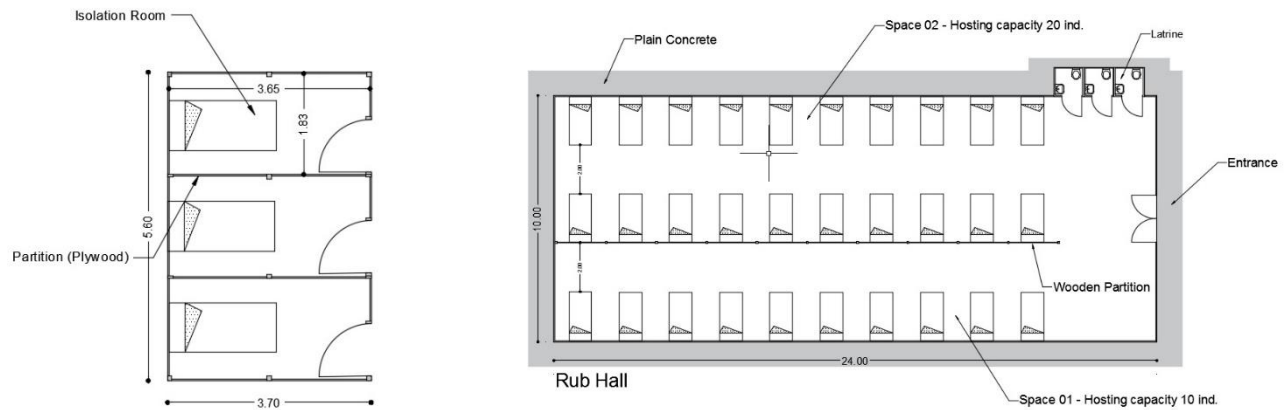
any). Appropriate accommodation meeting space requirements and structures in good condition must be chosen as they will not require major adaptations, since it would be very difficult to have construction contractors in the current context of restrictions on free movement.

If the hotel structures are conceived as a model of response for affected population, it is recommended that authorities take responsibility for site and case management with support from humanitarian actors. The authorities and partner would work together on exit strategies so that after 14 days of quarantine, beneficiaries could leave their accommodation in safety and dignity. In this regard, a specific protocol should be developed to address key issues such as: possibility of moving to another place/back home, access to emergency health care and/or assistance programmes within the framework of their conditions and/or limitations. A CBI could be considered to ensure access to accommodation and food after the quarantine while promoting the exiting from hotels. The success of this model will depend on substantial leadership and coordination among relevant parties. It will be helpful to create a multi-functional working group or committee between the authorities, who will manage the emergency sites; the health authorities, who will define the protocols and ensure medical assistance; and partners, donors, who will fund the rental and the food during expenses during the 14-day quarantine, as well as facilitate and accompany the process as much as possible.

It is imperative that site management and handling of protection cases is ensured. Specific measures for the protection of children and the prevention of gender-based violence should be considered, as well as the appropriate referral of beneficiaries to other protection services that may be required, particularly in the case of child protection, including the situation of unaccompanied or separated children, or the needs of survivors of sexual and gender-based violence.

- b. Temporary Standalone facility:** In situations where renting a hotel is not viable, the feasibility of establishing a standalone facility should be explored. As such, upon identification of this need, the authorities will be consulted to identify a suitable location where a dedicated facility is to be constructed or identified to permit quarantining or isolation of suspected or confirmed cases. This facility may will be implemented through the construction of a temporary facility based on standardized design options, as outlined below, erection of a rub hall or a sequence of prefabricated structures. **It is recommended as much as possible to ensure support is provided within existing health facilities.**

The design shall be modified by the partner with support, if necessary, from the cluster coordination team. Modifications to the design are expected to be required in accordance with space availability, ground conditions, health protocol, community preference, specific needs (disability) number of suspected or confirmed cases, and number of projected suspected or confirmed (i.e. design capacity). The facility would be temporary in nature and local materials should be used for construction (timber, plywood, plastic sheeting, etc.). The local authorities, shelter and WASH cluster will be responsible for the technical assessment of the proposed lands for the installation of a rub hall and/or prefabricated structures. It is recommended that the facility is managed by the local authorities with support from humanitarian actors. However, if this is not feasible health partners (or non-health partners with health partner support) should be identified to manage the facilities. In cases where the facility is used for confirmed cases, it is important to note that its main function is not to deliver health care. *The “tenants” would only exhibit mild symptoms, not need hospital care and if housing arrangements would have allowed, they would have been advised to stay in their own homes without any medical assistance.* A certain level of monitoring would however be recommended to identify cases whose condition is deteriorating and need transfer to a hospital. Physical separation between individuals should be provided to ensure the safety and dignity of those being accommodated. Specific measures should be considered for children and lactating mothers. Non-Food Items will be provided based on identified needs



Some additional measures include creation of reception and access control spaces; creation of isolation and/or evacuation areas where the person suspected or confirmed to have the virus can be located while the health response protocol is activated; avoid overcrowding (more than 3.5 m<sup>2</sup> per person, guarantee a minimum social distance of 1.5 meters); Ensure natural ventilation of the spaces; Provide isolation spaces for possible COVID-19 carriers until they receive adequate health care and are relocated for isolation/detection/health care. Support will be based on a standardized assessment, to include.

- 1- Site assessment to determine appropriate location for the establishment of temporary facility.
- 2- Adjustment to the standard temporary facility layout (design), if required.
- 3- Site preparation and construction of temporary facility, if required.
- 4- Identification of an outdoor play/ relax area designated for suspected or confirmed cases (especially children) if space permits.
- 5- Installation of temporary toilets (one per 15 people maximum, separated by gender).
- 6- Installation of handwashing facilities adjacent to toilets, regularly supplied with soap.
- 7- Water tank installation with connection to the temporary facility and handwashing facilities.
- 8- Provision of safe water and desludging services (services providers should be trained on IPC and provided with prevention equipment).
- 9- The WASH cluster will provide soap, chlorine, disinfectant products, awareness sessions, safe water, and desludging services and public handwashing facility.
- 10- The caregiver will be required to ensure the cleaning and disinfection of isolation rooms, latrines, and hand washing facilities, after each use, especially when shared between suspected cases.

**Considerations for selecting emergency shelter solutions at community level for the response to COVID 19**

Typology	Non-Clinical Functions	Screening Facility	Treatment Facility	Key considerations
RHU	Yes	Maybe	Maybe	Maintain social distance and short duration for waiting areas and non-clinical functions. Cleaning and disinfection options easier due to rigid walling and impervious plastic construction.
UNICEF Multipurpose tents hospital	Yes	Maybe	Maybe	Individual partitioning may help mitigate infection transmission risk, but the greater risk is that co-location of vulnerable, suspect, and confirmed cases may increase infection spread.
Large tents (MSF, etc) (100 PE with PVC partitions)	Yes	Maybe	Maybe	Greater risk of virus co location. For treatment and screening facilities, partition, heating, ventilation, and air conditioning (HVAC) system should be considered. No safe distance for patients has been established for such facilities.
Rub Halls (56, 120, 320m <sup>2</sup> ) or similar (100% PVC)				

Repurposing existing buildings	Yes	Yes	Yes	Can include community halls and other structures with proximity to health centre, access, and ventilation. Avoid usage of schools where possible. Ensure adequate WASH facilities are available and health provision is easily accessible.
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1. *Non Clinical functions include dispensary, medical storage, medical staff offices, etc. – in such usage, where people are utilizing the space for work functions, maintain adequate ventilation and social distancing – limit for work purpose to 1 staff for continued usage, for occasional usage higher capacity may be acceptable so long as staff are not less than 2 meters in proximity for at least 15 minutes duration.*
2. *Consult with health staff for categorization of patients – for confirmed cases, can be co-located with 2m spacing between beds refer to WHO guidance.*
3. *Large tents, even those designed for medical functions may not be suitable for COVID-19 as they are not designed for individual isolation but rather for general medical treatment. Where they have mechanical ventilation capacity and ability for individual isolation, they may be appropriate. Generally, they should perform well in regard to cleaning and disinfection requirements.*
4. *Rub Halls are not recommended for COVID 19 related usage as they cannot provide isolation capacity. Individual partitioning may help mitigate infection transmission risk, but the greater risk is that co-location of vulnerable, suspect, and confirmed cases may increase infection spread. The decision to use Rub Halls is more dependent on the diagnostic capacity to make sure that cohorts are not co-located. No safe distance for patients has been established for such facilities – individual isolation where possible is the primary recommendation. For treatment and screening facilities, heating, ventilation, and air conditioning (HVAC) system should be considered.*

### Annex 1: Special considerations for vulnerable and at-risk groups

Criteria	Inclusion criteria	Risk-mitigations / Assumptions
<b>Older persons</b>	60 years old and above	<ul style="list-style-type: none"> <li>- The following measures should be considered when there are older persons in shelters, reception centers and hotels:</li> <li>- Information should be provided in multiple formats and in local languages to address the barriers that older persons often face related to literacy, language, and disability.               <ol style="list-style-type: none"> <li>1. These include access to alcohol-based hand sanitizers when access to water is scarce, access to social support and essential supplies for older persons in quarantine or self-isolation and a proportionate and nondiscriminatory approach to restrictions on freedom of movement.</li> <li>2. If possible, staff should check the body temperature of older residents in the morning and afternoon.</li> <li>3. Staff should be aware of the mental health and well-being of older persons. Showing affection can help relieve anxiety.</li> <li>4. Older residents and staff should be well fed.</li> </ol> </li> <li>- Facilities should be kept warm and spaces should be regularly ventilated.</li> <li>- Staff should try to maintain the normal schedule and daily routine of older residents.</li> <li>- If possible, staff should organize or facilitate online contact between older residents and their family and friends.</li> </ul>
<b>Persons Living with HIV/AIDS</b>	May have a suppressed immune system.	<ul style="list-style-type: none"> <li>- Ensure that reliable and confidential communication channels exist and prevention and mitigation messages and recommendations on COVID-19 reach people with HIV/AIDS.</li> <li>- It is essential that people living with HIV do not interrupt ARV treatment to ensure 100% adherence due to movement restrictions.</li> <li>- Disseminate key messages about non-discrimination towards people of concern living with HIV during this pandemic.</li> <li>- Map and share contacts of organizations working in the field of HIV/AIDS or networks of PLHIV so that they can coordinate with them directly or through phone calls and seek support if necessary (e.g., special deliveries of medications to their place of residence or designated collection points that are not overcrowded).</li> <li>- Share secure telephone numbers of specialized organizations so that affected PLHIV can voice their concerns while the outbreak persists and have access to regular psychosocial support.</li> </ul>





<b>Persons with Disabilities</b>	Including (sensory, intellectual, cognitive, and psychosocial disabilities)	<ul style="list-style-type: none"> <li>- Consult regularly with persons with disabilities to understand their barrier to assistance in the current context.</li> <li>- Information and key messages should be tailored to the needs of all persons of interest with disabilities (including sensory, intellectual, cognitive, and psychosocial disabilities)</li> <li>- Identify potential barriers to access services: mobility limitations, physical and health accessibility, and communication barriers, among others.</li> <li>- Continue close coordination and communication with specialized networks and organizations working on the protection of persons with disabilities at the national level.</li> </ul>
<b>Children, Adolescents and Families</b>	Under 18 years	<ul style="list-style-type: none"> <li>- Design simple messages to reassure them and help parents or other caregivers respond positively to emotional needs of children.</li> <li>- Key child-friendly messages about COVID-19, including on hand washing, hygiene, and social distancing.</li> <li>- Provide recreational and learning activities for children in isolation</li> <li>- Provide children and adolescents in shelters with items to support their hygiene, health, and well-being while in care, e.g. soap, hand sanitizer, educational materials, and recreational supplies such as sports equipment, games, or puzzles.</li> <li>- If caregivers become ill, work with them to outline and identify alternative care solutions that may be needed if they become ill, are quarantined, hospitalized, or worse.</li> </ul>
<b>NCDs</b>	Hypertension; diabetes. Cardiovascular disease. Chronic respiratory diseases	Include hypertension; diabetes; cardiovascular disease. Chronic respiratory diseases (e.g. COPD, asthma); chronic kidney disease; cancer (leukemia, lymphoma, myeloma OR currently or recently on chemotherapy treatment for any cancer type)
<b>TB</b>	Recent diagnosis of tuberculosis disease AND/OR currently undergoing treatment for tuberculosis	Active or latent tuberculosis may increase susceptibility to COVID-19 and disease severity
<b>Pregnancy</b>	Pregnant women identified as acutely malnourished	To date, there is no evidence that pregnancy increases the risk of severe outcomes from COVID-19 (6). However, pregnant women suffering from acute malnutrition may be particularly vulnerable to severe COVID-19 disease.
<b>Other immunodeficiency conditions</b>	Severe immunodeficiency diseases	To date, there is no evidence of association on immunodeficiency and severe outcomes from COVID-19. However, people having immunodeficiency conditions or on immunosuppressive treatment are known to be more susceptible to infections. Therefore, we suggest including people having immune deficiency conditions, until evidence becomes available.
<b>Other chronic infections</b>	Hepatitis B infection Hepatitis C infection	To date, there is no evidence of association between chronic infectious diseases such as hepatitis B or hepatitis C and severe outcomes from COVID-19. However, these diseases impair organ function and may thus complicate COVID-19 progression.
<b>Covid-19 (+ve) cases</b>	Persons who tested positive for covid-19	Persons who have symptoms of covid 019 including cough, temperature above 37.5 degrees and / or persons who have received confirmed positive covid -19 test.

## Annex 2 Guidance note - Construction site safety recommendations

*Partners overseeing construction sites operating during the COVID-19 pandemic should ensure all possible steps are taken to protect their workforce and to minimize the spread of the infection. This annex does not encompass all aspects of health and safety and should be seen as a complement of standard health and safety policy in place for all construction projects, rather than a standalone document.*

- Encourage beneficiaries to engage workers from within the community and discourage engaging laborers from external communities.
- Plan construction phases avoiding large group of workers and unnecessary overlap of labourers. It is suggested to establish shifts to be also applied for break, lunch and pray time.
- Basic Personal Protective Equipment (PPE) related to construction safety such as gloves should be provided to workers depending on the tasks they are assigned to. In addition, each worker should be provided with two or more reusable masks (not surgical/medical graded masks).
- Additional hand washing stations including provision of clean water and soap, together with cleaning and disinfection products may be required for construction sites opened prior to the outbreak. For new construction site, plan, and budget provision of these items.
- Preferably, every worker should be provided with a basic set of tools needed for the tasks they are assigned to. Using of the same tool by multiple workers should be avoided. If tools are shared or stored for later use by another person, they need to be disinfected/cleaned.
- For large construction projects, if possible, prior to starting construction work coordinate with Health partners to check the site and ensure appropriate measures are adopted.
- All laborers should receive orientation on the health and safety measures to apply in each site.
- Prevention messages should be printed and clearly displayed on site. Consider providing an additional printed copy of the key prevention messages for all workers to disseminate in their families (and communities).
- Workers should be clearly informed on protocols to follow in case they or their family members get sick.
- Workers should be requested to maintain physical distance of 2 meters (6') from others as much as possible and to adhere to the other suggested practices for infection prevention and control, in particular:
  - Wash your hands regularly with clean water and soap for at least 20 seconds or clean them with a hand sanitizer.
  - Avoid touching eyes, nose, and mouth with unwashed hands.
  - When coughing or sneezing, cover mouth with tissue and throw it into closed bin immediately. If you do not have a tissue, cough, or sneeze into your flexed elbow.
  - Do not spit.
  - Wear masks where activities need proximity.
- Workers should not greet each other with handshakes or embraces at any point during the day.
- If workers are operating in an area where sick or suspected infected people are currently or recently transited (in the previous 3 days), they should wear mask and disposable gloves at all times; If masks are not available, workers should be encouraged to prepare handmade ones using household items or clothes materials;
- Ensure toilets in the construction site are cleaned regularly.
- Ensure family contacts are known – in case of emergency.
- Only essential (beneficiaries, workers, supervisors, and managers) should be allowed on site.
- Programme/monitoring visits should be reduced to the minimum and should be planned when few workers are on site (i.e. lunch or prayer time).
- Body temperature should be measured for all persons entering the site.
- Discourage engagement of sick laborers and advise them to seek medical attention. Anyone falling in one of the following categories should not be allowed on site:
  - Has a family member suspected COVID-19 patient living in the same household or self-isolating, or if s/he has got in close contact with a confirmed COVID-19 patient in the previous two weeks. S/he should not report on site and self-quarantining at home for two weeks.
  - Is showing one or more symptoms related to COVID-19 (high temperature, new persistent cough, shortness of breath). S/he should not report on site, stay home and self-isolate or seek medical care in case of severe symptoms.
  - Is a vulnerable person (by virtue of age, clinical/health condition, or others above)
- Workers should be encouraged to reach the site using individual modes of transportation and avoid public transport when possible.
- Meetings on site should always be avoided. Instruction to workers should be given in open spaces and maintaining physical distance.
- If construction activities happen in an enclosed space, the site should be ventilated as much as possible, for example leaving doors and windows open during the working day.



- Due to potential sudden access restrictions, all materials and equipment should be carefully and safely stored before leaving the site at the end of every day.
- When receiving and unloading goods and construction materials, workers should always keep distance from the drivers. When possible, drivers should remain in their vehicles. If drivers must unload the goods for safety reasons, they should do so without the help of the workers, and they should wash or clean their hands before and after. Any contact between deliverers and receivers should be avoided. It is recommended that everyone needing to sign paperwork have their own pen or wash their hands after.

### **Annex 3: Recommendations for isolation in shelter/home**

***Quarantine** of persons is the restriction of activities or separation of persons who are not ill, but who may be exposed to an infectious agent or disease, with the objective of monitoring symptoms and early detection of cases.*

***Isolation** is the separation of ill or infected persons from others, to prevent the spread of infection or contamination.*

- Patients and households self-isolating at home should be educated about personal hygiene, basic IPC measures, and how to care as safely as possible for persons suspected of having COVID-19 to prevent the infection from spreading to shelter contacts.
- Ideally, patient should be placed in a single room with exclusive bathroom, but if that is not possible, beds should be placed at least 1.5 m apart, and bathroom must be disinfected every time it is used it.
- 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).
- If and where feasible, a communication link with health care provider or public health personnel, or both, should be established for the duration of the home isolation period, that is, until the patient's symptoms have completely resolved.
- Strict follow-up of medical indications, and appropriate medical treatment for existing conditions.
- Other shelter residents must settle in different spaces; if this is not possible, they must maintain a social distance (at least 1.5 m) from the persons quarantined.
- Permanent use of surgical masks by those with symptoms.
- Perform hand hygiene frequently, particularly after contact with respiratory secretions, before eating and after using the toilet. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub.
- Use of disposable materials for serving food.
- Do not share personal hygiene or food items with other inhabitants of the shelter.
- If required, use disposable tissues, and dispose them in plastic bags and handle waste separately. This must be labelled.
- Implement hand washing routines with soap and water.
- The patient's clothing, sheets and dirty towels must be separated, and hand washed with soap and water. Dirty clothing should not be shaken and should not come into direct contact with the skin.
- The person handling these residues around the patient must have protective equipment such as a mask and gloves.
- Conduct family training on hygiene measures, prevention, and elimination of waste to avoid contagion.
- All isolated patients to undergo daily medical monitoring by telephone. If during this follow-up any severity criteria are detected, the patient should be referred to the hospital designated by the health authority.

### **Annex 4: Management of cleaning and disinfection in home isolation**

- Clean and disinfect frequently touched surfaces such as bedside tables, bedframes, and other bedroom furniture daily with regular household disinfectant containing a diluted bleach solution (1-part bleach to 99 parts water). For surfaces that do not tolerate bleach, 70% ethanol can be used.
- Clean and disinfect bathroom and toilet surfaces at least once daily with regular household disinfectant containing a diluted bleach solution (1 part bleach to 99 parts water); if the bathroom/toilet is of common use by all the residents of the collective site, it must be cleaned and disinfected after each use.
- Hands should be washed before and after cleaning and disinfection, and gloves should also be used.
- Clean clothes, bedclothes, bath, and hand towels, etc. used by the patient using regular laundry soap and water at 60–90 °C with common laundry detergent and dry thoroughly.
- Cleaning personnel should wear disposable gloves when cleaning or handling surfaces, clothing or linen soiled with body fluids and should perform hand hygiene before and after removing gloves.
- Depending on the context, household cleaning gloves or disposable gloves can be used. In the first case, after use the gloves should be washed with soap and water and decontaminated with a 0.5% sodium hypochlorite solution. Disposable gloves (e.g. nitrile or latex) should be discarded after use.



- An exclusive pedal container must be used in the environment or patient room for opening, with a lid and a black bag, which, once it reaches its  $\frac{3}{4}$  filling or capacity parts, must be closed before leaving the room and be put in a second bag.
- The waste generated by the patient, should be as shortest time as possible with other waste from the house.

#### **Annex 5: Family isolation**

- Seek social distancing for 14 days.
- Shelter with good ventilation.
- Avoid visits from other people to the place of isolation.
- Cleaning and disinfection of the isolation area should be carried out daily with the usual disinfectants.
- Perform hand washing with water, soap, and clean and exclusive-use towels.
- Items used for the care of people will be for exclusive use.
- Waste must be handled in a differentiated manner (separate bags and cans).
- Do not attend any mass events.
- Monitoring should take place daily for 14 days.
- It is possible to use the same bathroom in case of not having the capacity to individualize them, and in given circumstances it should be disinfected after each use.

#### **Annex 6: Rational use of personal protective equipment (PPE)**

*PPE includes gloves, medical masks, goggles or a face shield, and gowns, as well as specific procedures, respirators (i.e., N95 or FFP2 standard or equivalent) and aprons.*

- Based on the available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The people most at risk of infection are those who are in close contact with a COVID-19 patient or who care for COVID-19 patients.
- PAHO/WHO recommends the use of PPE to health personnel, to personnel who work in health facilities where COVID-19 patients are cared for, to the COVID-19 patients and to the personnel who care for them. For others, it is recommended to reinforce the social distance of 1.5 m, frequent hand washing with soap or alcohol-based hand sanitizer and not touching your eyes, nose, or mouth.
- ES/NFI partners that maintain direct contact with persons of concern during their assistance activities should increase the personal protection measures for front line personnel by equipping staff with reusable or medical masks as applicable, provision of gloves, and hygiene items.
- Partner staff should take precautions to protect themselves and beneficiaries through frequent hygiene measures such as washing hands with soap and water for at least 20 seconds and using an alcohol-based hand sanitizer. It is also recommended to change clothes when entering shelters to avoid introducing contaminated items from the street.