

Technical WASH Guidance for COVID-19 Preparedness and Response

Key points

- Frequent and proper hand hygiene is one of the most important measures that can be used to prevent infection with the COVID-19 virus. WASH practitioners should work to enable more frequent and regular hand hygiene by increasing access to soap, increasing access to handwashing facilities, and using proven behaviour change techniques.
- Existing guidance on safe management of drinking-water and sanitation services applies to the COVID-19 outbreak. Extra measures are not needed. Disinfection will facilitate more rapid die-off of virus in water supplies.
- Many co-benefits, from other WASH related diseases, are realized by safely managing water sanitation services and good hygiene practices.

COVID-19

- **Symptoms:** Most common are fever, tiredness, and dry cough. Less common are aches, nasal congestion, runny nose, sore throat or diarrhea (2-10%). Symptoms appear 2-10 days after infection.
- **Transmission:** two main routes are respiratory (e.g. droplets from coughing or sneezing) and contact (e.g. surfaces that have been contaminated with droplets).
- **Environmental Survival:** Survival on surfaces (2 hours – 9 days), depends on surface, temperature, relative humidity, and specific strain. Inactivation in minutes using common disinfectants (70% ethanol or 0.5% sodium hypochlorite).
- **Protection:** The most effective way is frequent handwash, cover your cough with the bend of elbow or tissue and practice “social distancing” - at least 2 meters (6 feet) from people.

Drinking-water and sanitation services

- No evidence that the COVID-19 virus is found in drinking-water, surface waters or groundwater.
- Some recent Dutch evidence (KWR Water) that COVID-19 is present in wastewater although this is not believed to be a major transmission route.

As always:

- Maintain FRC of ≥ 0.5 mg/l after at least 30 minutes contact time; storage containers must be regularly cleaned.
- Where there is no off-site treatment for faecal sludge, in-situ treatment can be done with 10% lime slurry.

- Clean communal toilets, bathrooms, and showers with detergent and 0.5% sodium hypochlorite at least once a day; Use PPE (Personal Protective Equipment) while cleaning and practice hand hygiene before and after removing PPE. Clean reusable PPEs with disinfectant. Sterilize¹ then safely dispose of greywater or water from washing PPE, surfaces and floors.

Hand Hygiene

- **Handwashing Stations:** should be located at homes, schools and public spaces (e.g. markets, places of worship, transportation centers). Water and soap should be available within 5m of toilets and at entrance and exit of all public spaces.
- **Critical Times:** regular handwashing should occur: after sneezing and coughing, after touching surfaces in public spaces, before preparing food, before and after eating, after using the toilet or changing a child’s diaper, and after touching animals⁷.
 - i. Soap and water for 40–60 seconds using the appropriate technique⁸.
 - ii. Alcohol-based hand-rub (60-80% ethanol or isopropyl alcohol): 20–30 seconds using the appropriate technique⁹ (essential for health care facilities). How to produce hand-rub¹⁰.
 - iii. Chlorine solution (0.05%) as a last resort; 20-30 seconds using hand-rub technique⁹.
- **Water points:** ideally pedal-operated taps or devices with sensors to minimize hand contact. Where standard taps are in use, ensure taps are regularly disinfected; if possible provide paper towels to use when opening/closing taps.

Hygiene Promotion and Behavior Change

- **Objective:** reducing exposure through adequate personal and interpersonal practices (e.g. hand hygiene, coughing and sneezing etiquette, social distancing, etc).
- **Common Pitfalls:** Too much focus on one-way messages without listening to the perspective of different groups; too much focus on designing promotional materials (posters and leaflets) before understanding the problem properly; too much focus on personal hygiene and not enough on operation and maintenance. Make sure vulnerable groups are involved and targeted⁴.
- **NFI:** soap (250 g/p/month personal hygiene; 200 g/p/month laundry; 250 g/p/month menstrual hygiene and 250 g/p/month additional COVID-19 handwashing); water storage containers, washing basins, other general hygiene items e.g. menstrual hygiene management materials.

Health Care Facilities:

- WASH Services:** Safe water in adequate quantity and sanitation services at all times. Regular cleaning of facilities. Staff and patients should have separate toilets; where possible COVID-19 patients should have own toilets ¹².

- Environmental Cleaning:** floors, surfaces and touch points and linen; Regular cleaning and disinfection of toilets, bathrooms and showers; PPE used by cleaners. 70% Ethyl alcohol to disinfect reusable dedicated equipment (e.g. thermometers) between uses; Sodium hypochlorite (0.5%) for disinfection of surfaces ¹¹.

COVID-19 Key WASH Activities for Refugee Settings

The following are key WASH preparedness and response activities developed in alignment with the WHO Technical guidance¹ for COVID-19 and Strategic Preparedness and Response Plan² which describes an eight pillar approach. Below are those pillars directly relevant to WASH.

Pillar 1 - Coordination, planning and monitoring

- Ensure refugee WASH needs are fully represented in WASH COVID-19 Preparedness and Response Plans and multi-sectoral COVID-19 Preparedness and Response Plans (CPRPs).
- Undertake COVID-19 refugee WASH coordination and planning with WASH partners to maximise WASH service business continuity and ensure a clear division of labour, reduction of duplication of effort, and maximum predictability. These plans should ensure business continuity of WASH services by:
 - Supporting national / local WASH providers and partners, to ensure refugees continue to receive services.
 - Ensure there are enough quantities (pre-positioning) of essential WASH supplies e.g. fuel, chemicals, backup generators, spare parts, and soap to cover the next three months.
 - Identifying essential WASH staff (pump operators, technicians, service crews, waste management staff) and providing them with handwashing supplies and personal protective equipment (e.g. protective outer wear, gloves, boots, goggles / face shield, mask).
 - Identification of backup WASH staff and provide job training (if required) to ensure critical job redundancy.

Pillar 2 - Risk communication and community engagement

- Train and work with community-based protection outreach workers, community health workers, and hygiene promoters to promote approved MoH risk-based messages on healthy behaviours, social distancing, and hand-washing using low interpersonal transmission risk methods (e.g. social media, radio, television, text, loudspeaker). Engage community using low interpersonal risk methods (e.g. hotlines, group chat).
- Ensure that handwashing stations with soap and water are available in all public places.
- Distribute WASH NFIs via non-contact methods ³. Relax requirement for distribution monitoring with signatures.
- Prioritise limited WASH interventions and supplies to “green zones” containing vulnerable households or vulnerable groups in isolation. Conduct distribution through non-contact methods ³.
- Adapt communal WASH facilities with social distancing measures so that services can be accessed safely:
 - Increasing operation times to reduce queuing (e.g. increasing pumping to ensure 24-hour availability).
 - Installing additional temporary facilities to reduce queuing (e.g. water points, communal toilets).
 - Regular disinfection of common contact surfaces (e.g. door handles and taps) with 0.5% chlorine solution.
 - Marking social distance intervals on/near infrastructure (communal water points and toilets).
 - Communicating importance of social distancing when using communal services.
- Suspend household surveys.

Pillar 4 - Points of entry

- Ensure if new arrivals are required to quarantine, that population densities are reduced, and full WASH services are available.

Pillar 6 - Support to infection prevention control in healthcare facilities

- Under the leadership of Health, provide support to healthcare facilities including assessment, design and implementation, and monitoring of water, excreta management, medical waste management interventions.

FURTHER INFORMATION AND REFERENCES

¹ WHO and UNICEF (2020), *Water, Sanitation, Hygiene and Waste Management for COVID-19 Technical Brief*. [LINK](#)

² WHO (2020), *COVID-19 Strategic Preparedness and Response Plan Operational Planning Guidelines*. [LINK](#)

³ IASC and WFP (2020) *Interim Recommendations for Adjusting Food Distribution Standard Operating Procedures In the Context of the COVID-19 Outbreak*. [LINK](#)

⁴ IASC, OCHA and WHO (2020), *COVID-19: How to Include Marginalized and Vulnerable People in Risk Communication and Community Engagement*. [LINK](#)

⁵ UNHCR (2017), *Hygiene Promotion Guidelines*. [LINK](#)

⁶ WASH'Em (2020), *Handwashing with Soap – Our Best Defence Against Coronavirus*. [LINK](#)

⁷ WHO (2019), *Five Critical Moments for Hand Hygiene*. [LINK](#)

⁸ WHO (2019), *How to Handwash Poster*. [LINK](#)

⁹ WHO (2019), *How to Handrub Poster*. [LINK](#)

¹⁰ WHO (2019), *Guide to Local Production: WHO Recommended Handrub Formulations*. [LINK](#)

¹¹ CDC (2019), *Best Practices for Environmental Cleaning in Healthcare Facilities in Resource Limited Settings*. [LINK](#)

¹² UNHCR (2020), *WASH and Energy checklist for Healthcare Facilities*, UNHCR, Geneva. [LINK](#)

¹³ UNHCR (2020), *COVID-19 WASH Resources for Refugee Settings*, UNHCR, Geneva. [LINK](#)

¹⁴ WASH Cluster (2020), *Key Covid-19 WASH Guidance*. [LINK](#)