# COVID-19 Ukraine WASH Cluster Response Strategy

**FINAL VERSION – 25/3/20**

## Introduction to the strategy

The WASH Cluster Response Strategy for COVID-19 in Ukraine focuses on the two conflict affected areas of eastern Ukraine (Donetsk and Luhansk) also including areas not controlled by the Government of Ukraine. Water Sanitation and Hygiene (WASH) activities are based on a planned response to a number of “clusters” of COVID-19 cases but could easily be expanded to incorporate a wider area, in future. Due to the need to act quickly, the assumed time period covered by activities and budget detailed, below, is **three months**, but with additional consideration of an appropriate recovery period until the end of 2020.

Participating WASH agencies are requested to consider provision of holistic WASH support for a complete geographical cluster, to simplify logistical approaches and potential access issues. Where a partner can provide a significant input, but not necessarily a holistic one, they must commit to coordinating with the WASH Cluster and relative ministry(s) or local leadership.

This strategy should be read in conjunction with Annex 1 (detailed implementation description), Annex 2 (Logical Framework) and Annex 3 (a response budget estimate).

## Background

The first COVID-19 case in Ukraine was detected on 3 March in the western oblast of Chernivtsi. As of 25 March, there were 113 laboratory confirmed COVID-19 cases, including four deaths, with many suspected cases currently being processed.[[1]](#footnote-1) The number of cases confirmed reflects only those that have passed screening test and then confirmed by laboratory test, therefore the actual number of cases is expected to be higher.

Eastern Ukraine has been affected by six years of armed conflict and with weakened health systems and an ageing population, and could now be disproportionately affected during the ongoing COVID-19 pandemic. In the conflict-affected oblasts, Donetsk and Luhansk, there is an abnormally high proportion of elderly people (36 per cent of total population), particularly in isolated settlements.

Access to adequate healthcare services and emergency medical care in Donetsk and Luhanska oblasts, particularly in the area close to the ’contact line’, remains challenging for people of all ages. This is due to high associated costs of medicines and travel, lack of specialised medical personnel, long distances from commercial and service centres, and limited availability of public transport, as well as restricted freedom of movement through military checkpoints.

From a water, sanitation and hygiene (WASH) perspective, in Government-Controlled Areas (GCA) of Luhansk and Donetsk Oblast, 51% of people already need help with either water supply (31%), sanitation (26%) or hygiene (14%). In the same area 70% of households use centralized water supplies and 50% are using them as their single source of water. The rest of the population use smaller decentralised systems (often established at the level of a group of villages), shared boreholes and private wells. The level of need (51%) rises to 68% for people living within 20km of the contact line, 86% for people living in rural areas, and 66% of households with disabled people need WASH assistance, well above the average value.

Of households in GCA areas that use centralized drinking water, close to the contact line (within 20 km) 28% receive water on a schedule compared to 11% who live further away. Also, within the 20 km zone, 24% of households experienced a cut longer than one week in the previous 12 months, compared to 3% who live further form the Line of Contact (LoC). It is noteworthy that, as recently as February 2020, stoppages of treated water supply occurred in Luhansk Oblast due to historic and more recent debts accrued by water utility companies, for electricity: the companies have struggled to operate in a conflict zone. In Donetsk region the water company Voda Donbasa, which serves 3.8 million people continues to face the threat of water stoppages due to historic electricity debts, exacerbated by national energy market reforms which failed to take into account the reality of the eastern conflict areas.

Many health facilities, schools and other public institutions lack reliable water supply, or have insufficient toilets. At household level only 1% report lack of access to hygiene materials, this figure rises to 5% within 5km of the line of contact.

Conditions in Non-Government Controlled Areas (NGCA) are comparable with the GCA side, however needs are more homogenous and less directly concentrated towards the line of contact. Water company staff are currently finding it difficult to cross the line of contact and will need some advocacy support to make sure provision of clean water can be continued.

At the time of writing all schools in Ukraine are closed, there are no regular-scheduled international flights in and out of the country, and Entry Exit Checkpoints into NGCA areas are closed to all apart from the movement of humanitarian goods and personnel (and that may change rapidly). Water infrastructure continues to be shelled in spite of the outbreak.

## Global and national response strategy

Globally and in Ukraine, the government and health response will focus on eight pillars of activity:

* Pillar 1: Country-level coordination, planning, and monitoring
* Pillar 2: Risk communication and community engagement
* Pillar 3: Surveillance, rapid response teams, and case investigation
* Pillar 4: Points of entry
* Pillar 5: National laboratories
* Pillar 6: Infection prevention and control
* Pillar 7: Case management
* Pillar 8: Operational support and logistics

In Ukraine the WASH cluster will look to provide support to Pillar 2 and Pillar 6.

## WASH response

### COVID-19 virus survival in the environment

Although not completed on COVID-19 itself studies of surrogate human coronaviruses show that the following can facilitate the die-off of similar viruses:

* Heat
* High and low pH
* Sunlight
* common disinfectants (e.g. chlorine).

For similar viruses, effective inactivation can be achieved in 1 minute using 70% ethanol or a sodium hypochlorite solution. Water with 0.5% residual chlorine (relatively weak) is recommended as sufficient for drinking, washing hands, as well as for cleaning all areas. Nevertheless that chlorine residual is often not present at the far end of large water networks, and in fact the national standard implies a level of between 0.3 mg / L and 0.5 mg / L.

### Assumptions

In this response strategy WASH agencies have made use of the following assumptions:

1. Firstly, regular humanitarian WASH programming (outside of COVID-19 response) should continue, and in any case is also likely to contribute to the COVID-19 response.
2. Secondly, where possible, WASH response partners will focus on clusters of cases within specific geographical areas. Each cluster is assumed to cover roughly half of a raion, or around 400 square Km (20 km by 20 km), and to contain an at-risk population of around 200,000 people. Further assumptions about the nature and infrastructure within each cluster area are listed in Annex 2, the logical framework. However, where an organisation has existing programming, for example within a number of health centres, they will be encouraged to continue to strengthen WASH activities in support of those healthcare facilities, rather than expecting a different agency to take over. Coordination would be necessary with other agencies that may be completing a community-level response in the same area.
3. This response plan is priced for eight clusters of cases (eight raions) within two regions (oblasts) of eastern Ukraine, on both sides of the line of contact: in Non-Government Controlled Areas (NGCA) approaches may be more simplified and in Government Controlled Areas (GCA) the response will focus on locations where humanitarian WASH partners are already operating. However, activities listed for each cluster could easily be scaled up to reach a wider geographical area, or even at national level.
4. Access to affected communities, for WASH partners agencies, is assumed. However this remains a risk and it is assumed that the situation will allow a relaxing of isolation/ quarantine in April to allow for response or special measures will facilitate movement of response partners.
5. Availability of essential supplies such as hygiene items, or (to a lesser extent) PPE or on the local markets is assumed, in Ukraine.

### Priority Actions for WASH Agencies (first three months)

For each cluster of cases either a single or group of agencies will consider the following activities.

**A) Pillar 2 actions addressing risk communication and community engagement**

* A.1) WASH Partners will conduct a COVID-19 public information risk communication campaign, covering basic information on COVID-19 to educate the public on how COVID-19 is transmitted, how to identify symptoms, where to go and what to do if they are sick, and to dispel misinformation.
* A.2) Hygiene promotion messages and how to protect themselves and others, including the use of extensive handwashing and the use of hand sanitizers at the level of clusters of cases.

Risk communication and community engagement campaigns will be conducted through existing humanitarian networks currently operational in eastern Ukraine: at EECPs, in social institutions, schools, Feldsher Points (FAPS) and health centres etc., as well as through social networks and mass media.

**B) Pillar 6 actions supporting Infection Prevention and Control**

* B.1) Provide Infection Prevention and Control (IPC) assistance to health facilities, including the installation of additional handwashing points, distribution of soap and cleaning materials and support to waste management, consideration of the provision of PPE for non-medical staff. Water supply and improvements (source reliability, volume, quality and storage), where feasible.
* B.2) Support community-level hygiene through continuity of water supply, the facilitation of additional hygiene, handwashing and psychosocial messaging at community level and the installation of additional handwashing facilities with soap at public places, including government offices, food shops marketplaces, etc.
* B.3) IPC assistance to schools, old people’s homes, orphanages, and other public institutions, including water supply improvements (reliability of source, volume of water, quality and storage, installation of additional handwashing points, and distribution of soap and cleaning materials.

## Timeline: Initial response (3 months) versus recovery period (to end 2020)

The initial phase of the response is expected to be immediate, with activities needing to be implemented and completed within a three months period. Therefore the majority of work ix expected to be completed by established organisations (NGOs, and UN agencies) that already have field presence, with ongoing programmes that can be redirected ad augmented by additional funding.

**Highest priority** is suggested to implement activities A.1 (Risk Communication) and A.2 (Community involvement and hygiene promotion), along with B.2 (Community Level hygiene and IPC, which complements soft approaches) with some actual physical water supply and sanitation components. These activities should start immediately, closely followed by B.1 (support to Health Facilities) and B.3 (support to other institutions)

In the period from July to December 2020 recovery activities are expected, which are not yet budgeted in this response plan, focusing much more of assisting schools to reopen widely, and re-establishing previous humanitarian WASH responses as set out on the Humanitarian Response Plan 2020.

## Coordination

Actions should be implemented at all time in coordination with the WASH Cluster, but also having coordinated with the Health cluster and Ministry of Health (MoH) teams as well as each Oblast authorities or local leadership.

### Budget Estimation

The total budget required for the WASH response to COVID-19 in the eastern conflict affected area of Ukraine is around 5.4 million USD for three months (April to June 2020). See also Annex 3, the Response Budget Estimate

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| --- | --- | --- |
| **Actions** | **Per cluster of cases**  **(USD)** | **Response total**  **(USD)** |
| A.1 Risk Communication |  | \* 300,000 |
| A.2 Community Engagement | 10,000 | 80,000 |
| B.1 IPC / WASH at health facilities | 61,000 | 488,000 |
| B.2 Community-level hygiene and IPC | 245,000 | \*\* 2,060,000 |
| B.3 IPC / WASH assistance to schools and other institutions | 76,000 | \*\*\* 658,000 |
| **Subtotal (Programme Costs)** | **392,000** | **3,586,000** |
| Estimated Non Project Costs (33% of Total) | 193,075 | 1,766,239 |
| **Total** | **585,075** | **5,352,239** |

\* This is national total estimate for Risk Communication by WASH actors irrespective of the number of locations where humanitarian agencies operate.

\*\* Figure includes 100,000 USD for improved water access and handwashing at five EECPs.

\*\*\* Figure includes 50,000 nationally for work in collective centres for IDPs from the ECA.

## Advocacy

WASH agencies note that any response to stop the COVID-19 is dependent on access to the affected areas where there are geographic clusters of cases, and continuity of water supply. Therefore, the WASH Cluster urges influential donors, embassies and government counterparts to address the following:

* Continuity of water supply should be guaranteed through government action to eliminate the threat of electricity cuts to water suppliers in the eastern conflict area, for the duration of the COVID-19 outbreak.
* All aggressive actions and/or accidental targeting of water- and sewerage-related infrastructure must cease, with all sides guaranteeing the safety of both the infrastructure itself and the workers who operate in those locations.
* Specific access to outbreak areas and clusters of cases should be granted to humanitarian WASH actors by means of showing a special identification, or otherwise.
* Water company staff should be allowed to move freely to complete their work. In particular to cross the Line of Contact in the ECA, for work reasons.

## Additional Resources

Some excellent additional resources are available online from the Global WASH Cluster: <https://docs.google.com/document/d/1YXrH8kQn8NGJOXOkpdxW-stsTsxM9L0PSRyMPkhNnOc/edit>

# Annex 1 - Detailed Implementation

## A.1 – Risk communication

WASH agencies will participate alongside health and communications colleagues to deliver the key messages which normal members of the public need to understand in order to react to the COVID-19 outbreak. Key messages include:

* basic information on how COVID-19 is transmitted;
* how to identify symptoms;
* where to go and what to do if they are sick;
* hygiene messages such as handwashing;
* dispelling misinformation.

There is an online list of **Information Education Communication (IEC) materials**, maintained by UNICEF, The WASH Cluster, URCS and WHO, available at:

Add the link here

It is anticipated that most risk communication activities will be implemented at large scale via mass media, TV, radio, social media. However more imaginative actions would strengthen the approach, such as making use of “apps” for smart phones or making a cartoon series for children’s consumption. Implementing agencies are encouraged to be imaginative in combining different ways of spreading messages. Insertion of risk messaging into distance (online) schooling could also be considered.

## A.2 – Community involvement and hygiene promotion

The use of messaging alone (A.1) is not considered to be efficient in affecting behaviour change in populations. Therefore, it is important to balance Risk Communication through mass media with more direct community involvement, so that greater discussion of the issue can be lead to changes in behaviour. At community level additional discussions around the risks of COVID-19 will be dependent on access to communities and must be balanced by social distancing measures.

Messages would be very similar to the Risk Communications component (A.1), but with a more hands-on approach, and greater inclusion of hand washing and practical hygiene messages or demonstrations.

Modalities of implementation will include:

* Door to door discussions;
* Theatre performances to small groups of people standing well apart form each other (both the audience and the venue would need careful organisation);
* Establishing community volunteers to spread messages safely;
* Talking to people in queues at banks, pharmacies or food shops;
* Drawing competitions for children;
* Including suitable leaflets within any distributed materials;
* Phone calls to people living in an affected area (for example a quiz that people can enter ad maybe win a prize).

There are many options for implementing effective community engagement, and once again the WASH cluster recommends being as imaginative as possible so that messages stick in people’s minds.

## B.1 – IPC and WASH support for health facilities

Poor WASH and IPC lead to health acquired infections, transmission of diseases from health facilities to communities and increased use of antibiotics and exacerbate outbreak and spread of infections- in this case- COVID- 19. On the contrary, effective IPC reduces hospital-acquired infections by at least 30% (WHO 2016)[[2]](#footnote-2).

WASH agencies will provide Infection Prevention and Control (IPC) assistance to health facilities, because without such assistance some facilities may struggle to maintain adequate hygiene, and it is possible the key Ukrainian medical staff may be reluctant or may even refuse to work.

Likely interventions include:

* Undertake a quick assessment;
* Distribution of soap and cleaning materials. This is the most basic and straightforward approach to assist existing medical facilities, and should be implemented immediately. Sufficient materials for at least three months should be included. Suitable “kit” lists for health faculties are being developed by the WASH Cluster in UIkraine and are available upon enquiry;
* Installation of additional handwashing points using plastic hand washing stations, provision of soap and agreeing with staff how they will be filled with water daily. Again, this is a rapidly achievable activity.
* Water supply improvements will make sure basic cleaning, not to mention handwashing can continue. A range of approaches will be considered including improving the source reliability (does a well need work to increase the volume or cleanliness of water? Can a pipe be repaired to make piped water more available?). Installation of water storage so that additional chlorination of general water supply to to 0.5 mg / L residual chlorine can be implemented; training of staff to test water quality and provision of “Pool Testers”. In extreme cases water may need to be delivered by truck to key medical facilities.
* Provision of some 0.5% hypochlorite solution for cleaning purposes and training on how to mix and store this cleaning solution.
* Support to medical waste management Solid waste management. HCF infectious waste volumes will increase because of higher generation of personal protective equipment (PPEs) such as gloves, face and nose masks, water-proof protective gowns, rubber boots, rubber apron, and other contaminated materials including paper tissues. To reduce waste volumes, it is advisable to use reusable plastic PPEs that can be cleaned and disinfected with 0.5% chlorine solution. Proper collection, storage, transfer, treatment and final disposal of infectious waste from healthcare facilities and COVID -19 treatment units is key. Ensure IPC protocols are in place in health care facilities, implemented and monitored effectively (waste collection, segregation waste storage, treatment and final disposal, incinerators/autoclaves, sprayers). Key actions might include:
  + to make sure suitable bins (pedal bins or bins with swing lids) are available with liners;
  + color-coded waste segregation bins according to the 3- bin system (infectious waste, sharps and general waste);
  + waste record keeping is important to understand how much waste is generated;
  + storage location need to be cleared to cater for large volumes, transport mechanism in decontaminated trucks and final disposal arrangements through incineration;
  + construction of burn pits and burning with the aid of fuel drops such as kerosene could be used, in the absence of incinerators.
  + Training waste handlers and sanitation crew on Infection Prevention and Control (IPC) measures.
* Ensure that sewage from the facility is going somewhere sensible;
* Support to cleaning staff: consideration of the provision of PPE for non-medical staff. WHO recommends the following level of personal protective equipment for cleaners at healthcare facilities[[3]](#footnote-3):
  + Medical mask
  + Gown
  + Heavy duty gloves
  + Eye protection (if risk of
  + splash from organic material
  + or chemicals).
  + Boots or closed work shoes

This level of PPE for cleaners applies for

* + Entering the room of COVID-19 patients (to clean).
  + Cleaning a consultation room after and between consultations with patients with respiratory symptoms.
  + Cleaning the area where people with fever are being screened.
  + Cleaning isolation area
  + Cleaning (an ambulance or other vehicle) after and between transport of patients with suspected COVID-19 disease to the referral healthcare facility.

More thorough technical approaches are described within: “WASH and Infection Prevention and Control (IPC) in Health care facilities (HCF) Guidance Note, UNICEF, 10 March 2020”: <https://drive.google.com/file/d/1CTgRmGsnqOSo82m7XRt9arrcI-LxhjQU/view>

## B.2 – Community-level hygiene and IPC

As a rapid intervention the facilitation of additional hygiene, handwashing and psychosocial messaging at community level will be enhanced by making sure that additional handwashing facilities with soap are installed in public places, not usually considered as public institutions for example:

* Food shops;
* Pharmacies;
* Banks;
* Market places; and
* Government offices

Standardised kits are under development and are available from the WASH cluster in Ukraine upon enquiry. As well as institutional level kits, some distribution of hygiene kits at individual or family level is also anticipated, targeting primarily areas where several cases have been reported.

If possible and if needed, WASH agencies will also support adequate hygiene level within the communities through ensuring continuity of water supply, without which all discussion of hand washing is clearly impossible.

Linked to hygiene in public places, specific WASH agencies will work at Entry Exit Checkpoints (EECPs) to increase volumes of water available and to install additional handwashing locations with soap.

## B.3 – IPC and WASH support to schools and other institutions

WASH Agencies will provide Infection Prevention and Control (IPC) assistance to schools, old people’s homes, orphanages, and other public institutions, including water supply improvements (focusing on the reliability of source, volume of water, quality and storage), installation of additional handwashing points, and distribution of soap and cleaning materials.

Methodology would be similar to that used at health facilities, but with a greater focus on simplicity of intervention, mainly through the provision of adequate quantities of cleaning materials. Standardised kits are under development and are available from the WASH cluster in Ukraine upon enquiry.

In each cluster of cases (or each raion) it is assumed that a WASH agency will work in at least 28 locations, for example:

* 15 schools
* 5 old people's homes
* 4 child-focused institutions
* 4 market places

However, these numbers of locations remain flexible and must be approximated for each raion.

Cleaners within these institutions will not be expected to wear Personal Protective Equipment (PPE) unless specific guidance comes from the Government. Instead, cleaners will be trained regarding IPC, and regarding social distancing techniques, and handwashing, that will help them to avoid infection. Cleaners will be encouraged to implement additional disinfection of surfaces around such facilities, using a hypochlorite (bleach) solution or using alcohol.

Further recommendations of how to strengthen WASH and IPC in schools is given in “COVID-19 Emergency Preparedness and Response - WASH and Infection Prevention and Control Measures in Schools, UNICEF, 15 March 2020”. <https://drive.google.com/file/d/1yLfoQjTDGRfL6cVm6prRgMBR4yTEvn-G/view>

1. Updated information from the Ministry of Health (MoH) can be found at: <https://moz.gov.ua/article/news/operativna-informacija-pro-poshirennja-koronavirusnoi-infekcii-2019-ncov-> [↑](#footnote-ref-1)
2. COVID-19 Emergency Response: WASH and Infection Prevention and Control (IPC) in Health care facilities (HCF) Guidance Note, UNICEF, 10 March 2020 (available here) [↑](#footnote-ref-2)
3. Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19), WHO, Interim Guidance 27 February 2020. [↑](#footnote-ref-3)