Interim Guidance on Managing Relief Camps/Shelters During Emergencies Within the Context of COVID-19 Pandemic.

MEGHALAYA STATE DISASTER MANAGEMENT AUTHORITY
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INTERIM GUIDANCE ON MANAGING RELIEF CAMPS/SHELTERS DURING EMERGENCIES WITHIN THE CONTEXT OF THE COVID-19 PANDEMIC

INTRODUCTION:

Meghalaya is a multi-hazard prone state with high susceptibility to disasters. The COVID-19 pandemic further exacerbates the vulnerabilities of communities, by affecting the communities' ability to have adequate access to essential services and means to sustain livelihood. It is within the interest of all to develop, plan and implement an urgent and effective response to the pandemic as well as any concurrent disaster that may arise in the near future. In this light, the guiding document is shaped to address the changing needs of existing relief camps management protocols and procedures to accommodate provisions for prevention and management of COVID-19. In addition, to the guidelines on *Minimum Standards of Relief* provided by the National Disaster Management Authority which are to be strictly followed, District Disaster Management Authorities are recommended to adopt strategies for prevention and management of COVID-19.

People living in shelters and camps are vulnerable to COVID -19 partly because of the health risks associated with movement/displacement and overcrowding which can be further intensified by modalities of services/ assistance provision which often involves large crowds. While adaptations of site plans may not be a feasible option considering the resource needs; however, maximising site planning for better distancing among residents and crowd management, adherence to infection and control protocols and standards laid down by the Ministry of Health & Family Welfare, Government of India and the Government of Meghalaya, strong risk communication and community engagement and a good surveillance system for early detection of cases can have a significant impact on COVID -19 transmission and spread within the camp setting.

Considering the dynamic situation of COVID-19 prevalence and penetration, conditions vary from community to community, disaster camp managers need to coordinate and seek inputs from the state and their district health officials for information specific to their location. Shelters with fewer than 50 residents should be prioritised over larger shelters. Large congregate shelters should be a last resort, for better social distancing. Buildings /spaces already identified by the Government of Meghalaya for institutional quarantine, are not advised to be used as relief shelters.

RECCOMENDATIONS:

Following are the recommendations for disaster managers, shelter staff and volunteers in planning, operationalisation and management of relief camps/ shelters, with an aim to reduce the possibility of transmission of COVID-19 among camp residents, staff, and volunteers:

I. **Triage and entry assessment**:

Formal assessment/triage should be conducted on evacuees to identify people with symptoms that indicate they might have the COVID-19 disease. They should be conducted by a healthcare professional on-site or designated, trained shelter worker. A separate area should be designated to screen evacuees with adequate handwashing stations and evacuees should be provided with face masks. Staffs that are checking the evacuee's temperature should use a system that creates a physical barrier between the evacuee and the screener. Screeners should stand behind a physical barrier, such as a glass or plastic window or partition that can protect the staff member's face from respiratory droplets that may be produced if the person sneezes, coughs, or talks. If social distancing or barrier/partition controls cannot be put in place during screening, screeners should use PPE (i.e., facemask, eye protection [goggles or disposable face shield that fully covers the front and sides of the face], a single pair of disposable gloves) when within 6 feet of an evacuee. However, given PPE shortages, training requirements, and because PPE alone is less effective than a barrier, staff should try to use a barrier whenever possible. Thorough cleaning and disinfection of the area every 4-6 hours is recommended.

If the evacuee is found to be exhibiting symptoms of COVID-19, notify responsible authorities and direct the individual to an isolation room if available, or an available space in the camp/shelters designated for symptomatic persons. Clear instructions must be given to the individual that if his/her symptoms (breathing difficulty) worsen, he/she should notify someone immediately and that he/she should not leave their room or symptomatic area except to use the bathroom and that to wearing a mask.

II. **Screening, monitoring and isolation**:

Shelters should monitor and record possible COVID-19 cases and perform periodic assessments of all shelter policies and procedures related to lowering transmission on COVID-19 (e.g. isolation area, social distancing, meal service, cleaning, disinfection). Case numbers should be shared with local public health officials daily to alert them of increasing numbers. Screen all people entering the shelter (residents, staff, volunteers, and visitors) for signs of COVID-19 at entry to emergency shelters. Staff and volunteers, who screen positive for COVID-19 symptoms should be sent home immediately, or as advised by the health authorities. If staff or volunteers are also residents of the shelter, they should be directed to an isolation area.

Following medical screening, residents should be grouped as "not sick," "sick," and "requires immediate medical attention."

Table 1: Grouping of camp residents and actions to be taken

Sl No.	Category	Action to be taken
1.	Not sick	Advise the resident on cough etiquette and hand washing.
2.	Sick	Provide a cloth face covering if available, and if the person can tolerate it.[1] Advise the resident on cough etiquette and hand washing. Direct the resident to an isolation area in the shelter or at another location, according to a predesignated plan.
3.	Requires immediate medical attention	Call 108 for transport and tell the operator this is a probable case of COVID-19.

Emergency shelters should not exclude people who are having symptoms or test positive for COVID-19 unless they do not have the capacity to adequately isolate residents with COVID-19.

Isolation area: The shelter should have a designated isolation area for potentially infectious individuals. Choose an area that is physically separated from the rest of the shelter by walls on all sides and a door. A building or area outside or near the actual shelter can be used and may be the best choice for isolation area placement. If such an area does not exist and cannot be made inside the shelter, an isolation area can be created using plastic or other barrier material. Makeshift walls that are floor to ceiling (if feasible) should be created, and isolation signs or posters should be placed near the entrance to the isolation area to indicate that individuals should not enter the area without appropriate personal protective equipment. Shelter staff providing medical care to residents with suspected or confirmed COVID-19 where close contact (within 6 feet) cannot be avoided, should at a minimum, wear eye protection (goggles or face shield), an N95 or higher-level respirator (or a facemask if respirators are not available or staff are not fit tested), disposable gown, and disposable gloves. Shelter staff who enter the isolation area for reasons other than providing medical care (e.g. delivering meals or other items) should wear N95 masks (or a facemask if respirators are not available or staff are not fit tested).

Limit crossover of shelter staff between the isolation unit and the rest of the shelter occupants. Assign dedicated shelter staff (e.g., healthcare workers when available, housekeeping, custodial) to provide care for potentially infectious individuals and

[1]NOTE: Cloth face coverings should not be placed on babies or children younger than 2 years of age or anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the covering without assistance.

restrict these staff from working with non-infectious individuals in the shelter. Dedicate an entrance(s) or passageway(s) for infectious individuals when feasible. This promotes separation as well as the ability to triage those who have been working with potentially infectious patients.

Isolation areas should be well-ventilated. At least 6 feet of distance should be maintained between residents in isolation areas. Cots should be placed at least 6 feet apart with temporary barriers between them. Bathroom facilities should be near the isolation area and separate from bathrooms used by well residents.

The decision to discontinue isolation and reintegrate the COVID-19 recovered/cured with the general residents of the shelters as well as approvals for resuming duties of recovered shelter staff should be made by health authorities. Provisions should be made for strict adherence of health protocols.

People who need extra precautions: People at higher risk for severe illness from COVID-19 may include: people 65 years or older. Persons of any age with serious underlying medical conditions including chronic lung disease, serious heart conditions, and diabetes. Higher risk shelter residents should be prioritized for COVID-19 testing and personal protective equipment if resources are available but limited. Some staff and volunteers may be at higher risk for severe illness. Plan for alternative staffing resources to replace high risk staff and volunteers during the COVID-19 pandemic. Consider pre-deployment of additional workers and mental health personnel to shelters.

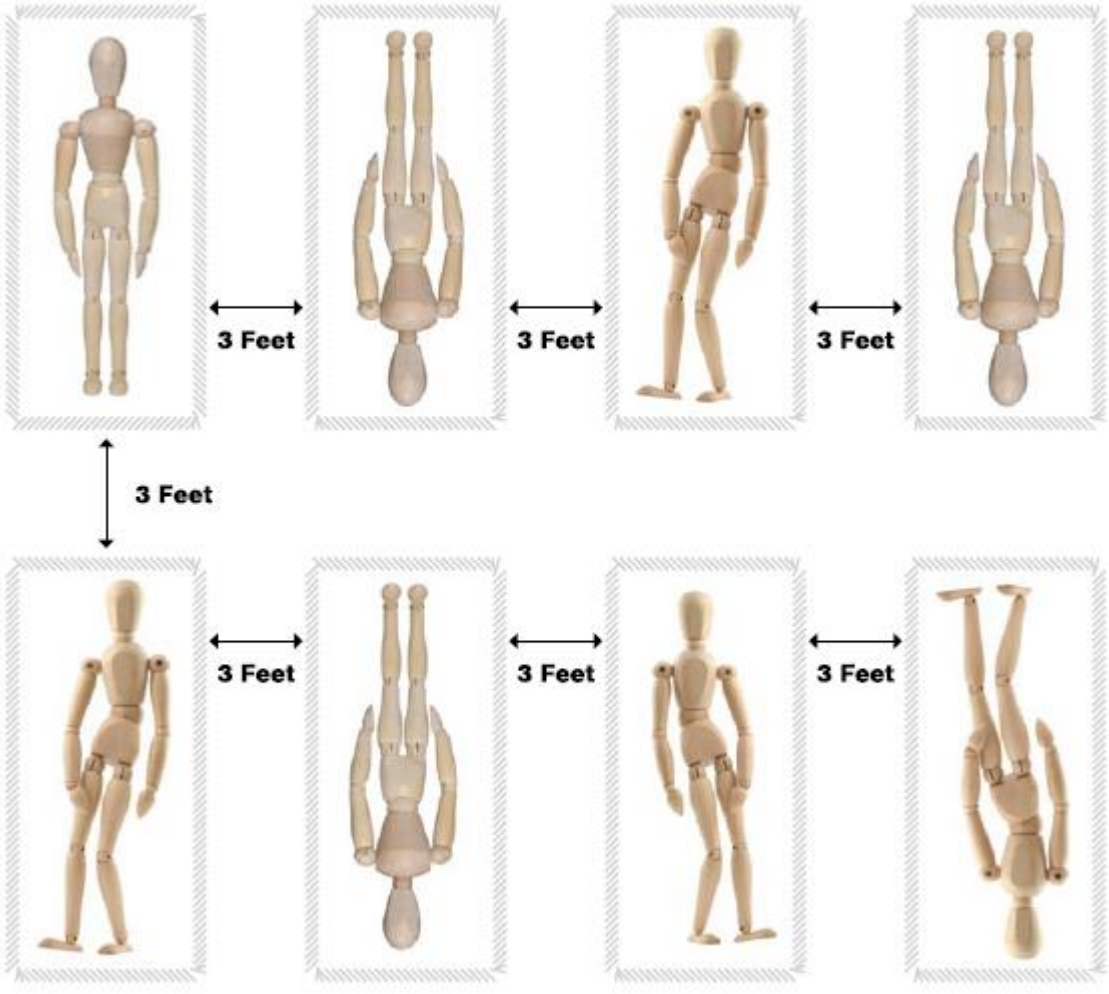
III. **Information in all common areas of the shelter:**

Post signage throughout the facility on: common symptoms of COVID-19 and the importance of wearing a cloth face covering, the need to follow frequent handwashing and proper respiratory etiquette, coping with stress. Residents should be informed to report symptoms to shelter staff if they feel ill. IEC on how to wear and remove PPE should be available to staff and reminders to wash their hands with soap and water after touching someone who is sick or handling a sick person's personal effects, used tissues, or laundry. Ensure signage is understandable for non-English speaking persons and those with low literacy. Make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or with low vision.

IV**. Social Distancing**

When possible, families (especially those with small children) should be placed together within a shelter, in individual rooms or in separate areas of the facility. Shelter facility should be large enough to provide space for distancing among residents. Arrange all sleeping areas (including cots) so that individuals are separated by putting a minimum of 3 feet between individual sleeping areas (or cots) to prevent the spread of infections. In addition, sheltered individuals should be instructed to sleep head to toe.

Figure 1: Cot or Sleeping area configuration to reduce the risk of disease spread



Source: *Infection Prevention and Control for Shelters During Disasters.* Association for Professionals in Infection Control and Epidemiology, 2007/2008 Emergency Preparedness Committee. Appendix G.

Identify and notify emergency shelters in advance with capacity of accommodation according to population density of villages and urban settlements to earmark space for social distancing. For flood prone areas, emergency shelters may be identified in highland areas. It is also important to take into account the measures to ensure social distancing during evacuation procedures and transit to emergency shelters, keeping in mind the additional needs of persons with disabilities, unaccompanied children, the aged and other people with special needs.

V**. Food services:**

The minimum estimated nutritional requirements as per the National Disaster Management Authority guidelines is 2400 kCal per person per day and 1700 kCal per per day for children. The estimates may be useful for planning of general rations; they

can further be adjusted to fit the context. People with specific nutrient needs may require supplementary food in addition to any general ration. This includes children aged 6-59 months, older people, persons with disabilities, people living with HIV/AIDS, and pregnant and breastfeeding women. Provisions for supplementary food needs should be taken into account during planning and operations. On-site feeding is usually undertaken when people do not have means to cook for themselves, in such scenario, serve pre-packaged meals or individual meals dispensed by food service workers.

Food service workers should wear gloves and cloth face coverings during meal preparation and service. Maintain a minimum of 3 feet of distance between people of different households at mealtimes using increased table spacing and staggered mealtimes. Clean and disinfect the area between meal service times. Encourage staff and shelter residents to not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people. Serve using disposable silverware, cups, and plates, if available. If these items are not disposable, the food contact surface should be protected from contamination and cleaned and disinfected after each use. Provide handwashing stations and soap with disposable towels or alcohol-based hand or use prior to entering food lines. Residents should wear cloth face coverings while in the food line. Position shelter staff at handwashing stations to promote proper handwashing and to monitor for signs of illness. Staff should wear cloth face coverings. Implement illness screening, including fever monitoring, of residents entering the food distribution area.

- Temperature of 100.4 F or above is considered a fever.
- Staff and volunteers who are symptomatic should leave the facility as soon as possible. Residents who are symptomatic should be directed to the isolation area.
- Increase monitoring for symptoms among close contacts of people who become symptomatic.

When planning rations, consult with community and food supply authorities to take account the local needs and availability of supplies. Whenever there is a change in rations, share information with the entire community as early as possible. Locate distribution and delivery points where they are accessible, safe and most convenient for recipients/ residents. Provide recipients with advance details of the distribution plan and schedule, the quality and quantity of food ration. Instruct recipients to maintain 3metre distance from each other throughout the distribution process. Cordoned off (with a rope or tape) a 1-2-meter radius around the desk at the collection point if possible. Ensure that there are clearly marked entrance and exit points (accessible to people with disabilities) in the distribution area.

VI. **Water and sanitation and hygiene (WASH):**

Recommendations for water, sanitation and hygiene measures in relief camp settings are important for providing adequate care for residents and protecting residents,

staffing and volunteers from infection risks. The following WASH related actions are particularly important:

- engaging in frequent hand hygiene using appropriate techniques;
- providing sufficient and safe water;
- implementing regular environmental cleaning and disinfection practices;
- safely managing and disposal of shelter waste.

All shelters should establish hand hygiene programmes. Map and provide hand washing stations at key locations with safe water, soap or alcohol rub. Minimum one station for every ten residents.

Figure 2: Handwashing station

Increase water quantities and adapt chlorine solutions for safe water (0.5 mg/l free residual chlorine). Ensure that minimum of 15 litres per person per day is available to residents to cater to their needs (drinking water and food, hygiene practices and basic cooking). If feasible, identify shelters where toilets can be provided to each family. However, if communal toilets are to be used limit the number of people using the facilities, maximum one toilet per twenty residents (separated for men, women, children, and shelter staff). Ensure that planning the following minimum requirements is taken into consideration. Communal toilets: 1-2 litres per day for hand washing, 2-8 litres per cubicle per day for toilet cleaning, 20-4- litres per day for conventional flushing toilets connected to a sewer, 3-4 litres per user per day for pour -flush toilets, 1-2 litres per person per day for anal washing. Provide commode chairs and bucket toilets for those facing mobility barriers. Determine any extra precautions needed for cleaning, decommissioning and desludging excreta facilities and equipment (for example chlorine solution for cleaning, treatment with quicklime or chlorine).

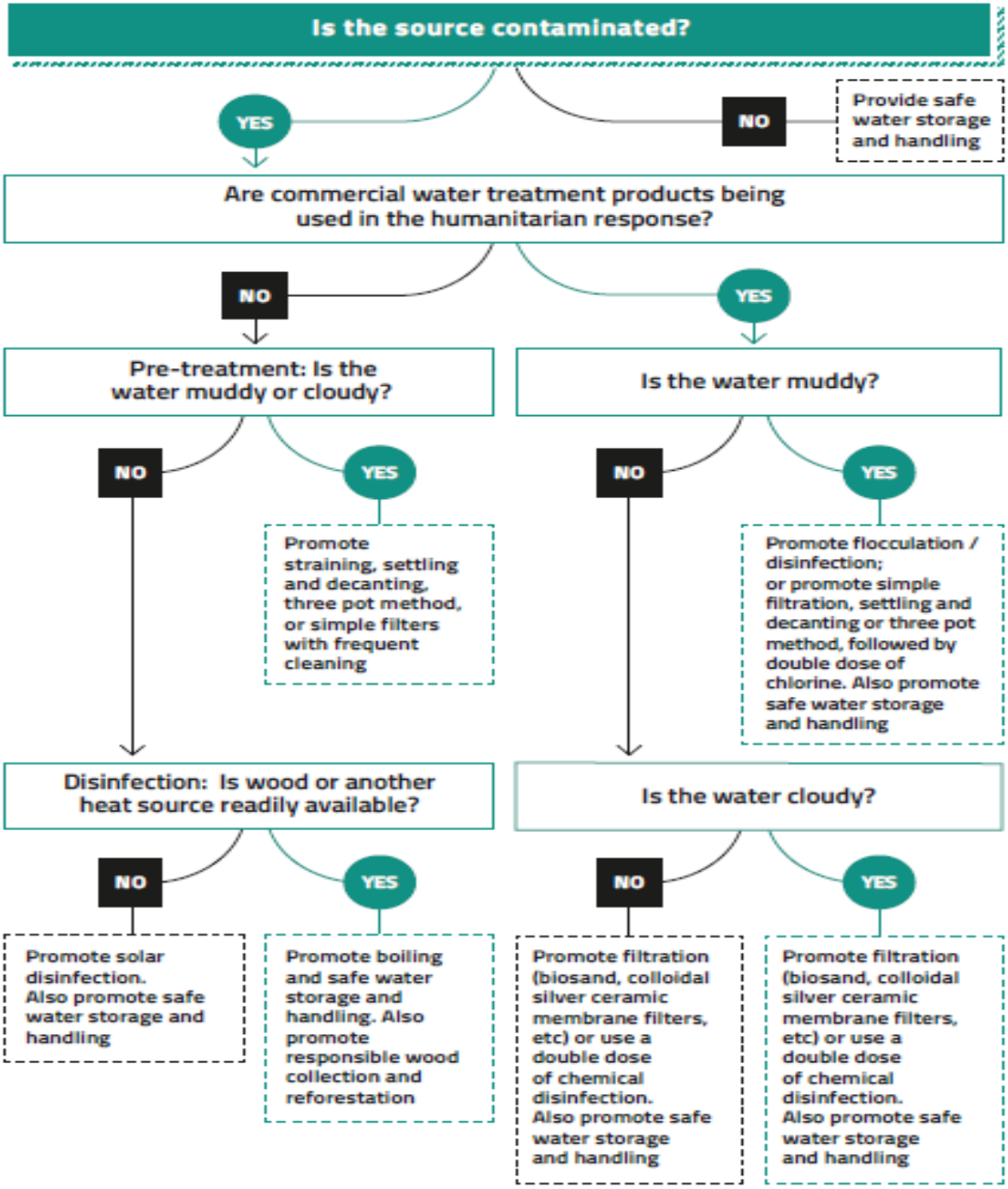
Figure 3: Communal toilets

Ensure at least 72-hour water supply (and storage) per camp is available for emergencies. If tap water is unavailable in camp, ensure that the nearest water collection point is not more than 500 metres from camp site.

Water decontamination: Several measures can improve water safety, starting with protecting the source water; treating water at the point of distribution, collection or consumption; and ensuring that treated water is safely stored at camp sites in regularly cleaned and covered containers. Such measures can be effectively planned, implemented and monitored using water safety plans provided by the water utility stakeholders such as the PHE department, MUDA etc.

Water should be treated with residual disinfectants such as chlorine if there is significant risk of source or post-delivery decontamination. Use the household water treatment and storage decision tree as a water treatment approach.

Figure 4: Household water treatment and storage decision tree



Source: Adapted from IFRC (2008) Household water treatment and safe storage in emergencies manual.

Essential Hygiene items: All residents should have access to the minimum quantity of essential hygiene items which include: two water containers per family, if running water is not available in the shelter; 250 grams of soap for bathing per person per month; 200 grams of soap for laundry per person per month; soap and water at handwashing stations; diapers and nappies, oral hygiene products. Apart from these other minimum supplies for menstrual hygiene and adult hygiene include: a dedicated container for soaking cloths and storing pads/ cloths and ropes and pegs for drying. Either absorbent cotton material, disposable pads or reusable sanitary pads as preferred by the resident; underwear; extra soap; additional water containers. The aged may also require adult diapers apart from bed pan and urinal bottles. Bleach or similar disinfectant cleaning products should also be available to residents as part of the hygiene kits. For distribution of essential hygiene supplies /kits, locate distribution and delivery points where they are accessible, safe and most convenient for recipients/ residents. Provide recipients with advance details of the distribution plan and schedule. Instruct residents to maintain 3 metre distance from each other throughout the distribution process. Cordoned off (with a rope or tape) a 1-2-meter radius around the desk at the collection point if possible. Ensure that there are clearly marked entrance and exit points (accessible to people with disabilities) in the distribution area.

Figure 5: Social distancing at distribution site

Cleaning and disinfection: The risk of exposure to cleaning staff is inherently low. Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash. Solid waste (trash) such as tissues, food items, and drinking containers should be considered as potentially “infectious waste.” Waste receptacles with non-removable, no-touch lids, should be placed a reasonable distance away from any populated areas. Place a handwashing station or hand sanitizers

alcohol next to any waste bins. Disinfect the lids and handles of receptacles on a regular basis. Outdoor waste receptacles should be covered with lids. Areas and items that are visibly soiled should be cleaned immediately. All common areas should be cleaned and disinfected every 6 hours or minimum thrice daily with a focus on frequently touched surfaces like tables, doorknobs, light switches, handles, desks, toilets, faucets, and sinks. Currently, the World Health Organisation recommends using: 70% ethyl alcohol to disinfect small surface areas and equipment between uses, such as reusable dedicated equipment (for example, thermometers); and sodium hypochlorite at 0.1% (1000 ppm) for disinfecting surfaces. Linens (such as bed sheets and towels), eating utensils, and dishes belonging to those who are sick do not need to be cleaned separately, but they should not be shared without having been thoroughly washed. Wash linens using laundry soap and dry properly rinsed linens in the sun. Staff should wash their hands with soap and water or use hand sanitizer immediately after handling dirty laundry or used eating utensils and dishes. Bathing areas should be cleaned daily and as necessary. Regular household soap or detergent should be used for cleaning first and then, after rinsing, regular household disinfectant containing 0.1%sodium hypochlorite (that is, equivalent to 1000 ppm or 1-parthousehold bleach with 5% sodium hypochlorite to 50 parts water) should be applied.

Figure 6: Sanitization of food-contact surfaces.

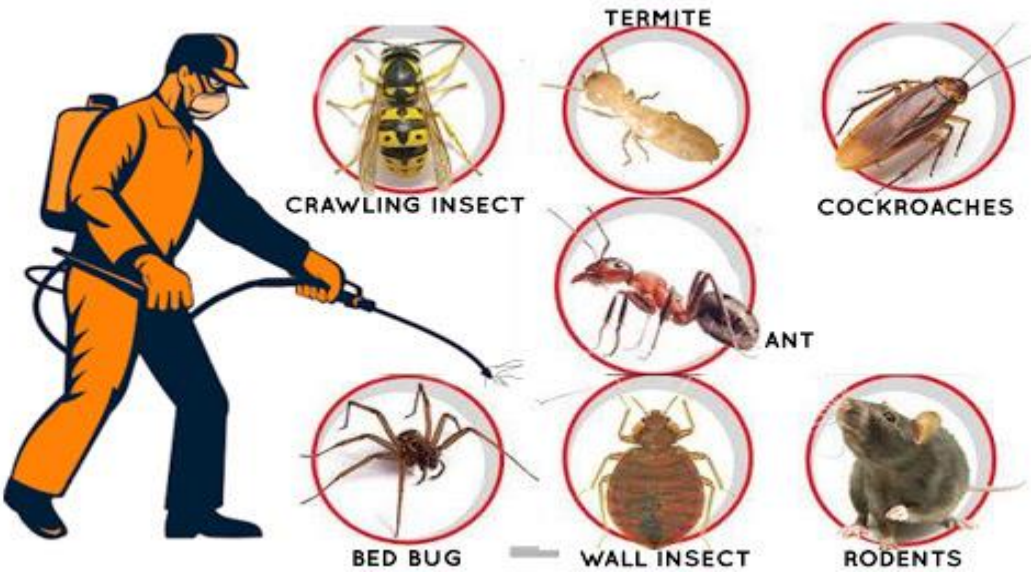
Food preparation areas should be cleaned after each meal and as needed between food preparation tasks. Dining areas should be cleaned after each meal if food is provided in a cafeteria style service. Living and sleeping areas should be cleaned at-least weekly and more often if necessary, traffic flow patterns and use will determine the frequency these areas should be cleaned. Waste generated in general section of the shelters or camps can be classified as non-hazardous and should be disposed in strong black bags and closed completely before collection and disposal by municipal waste services. Medical/First aid or triage areas should be cleaned daily and as necessary. Frequency and level of cleaning and disinfection will be determined by the healthcare services being provided. Isolation area should be cleaned daily, upon individual transfer to a medical facility or move to another part of the shelter, and as necessary. All waste produced isolation wing of the shelters is considered to be infectious and should be collected safely in clearly marked lined containers. Shelters should prepare for proper disposal of barrier equipment such as gowns, gloves, respirators/masks and waste from the isolation section of the shelters. These wastes should be treated, preferably on-site, and then safely disposed. The World Health Organisation recommends that utility gloves or heavy-duty, reusable plastic aprons are cleaned with soap and water, and then decontaminated with 0.5% sodium hypochlorite solution each time they are used.

Figure 7: Greywater or water from washing PPE

In terms of disposal of greywater or water from washing PPE, surfaces and floors, if greywater includes disinfectant used in prior cleaning, it does not need to be chlorinated or treated again. However, it is important that such water is disposed of in drains connected to a septic system, a sewer or in a soak-away pit. If greywater is disposed of in a soak away pit, the pit should be fenced off within the health facility grounds to prevent tampering and to avoid possible exposure in the case of overflow.

Toys: In shelters, toys will be present, shared, and exchanged. While toys are an important tool for distraction, entertainment, and development, they have the potential to spread disease. Shelters should have a designated play area for children. Children and parents/guardians should perform hand hygiene before entering and when leaving the common play area. Communal toys should be cleaned at least daily and when obviously soiled. Small toys may be wiped with a 70% alcohol swab and allowed to air dry. Rinsing with water is not necessary. Toys that will not be damaged by immersion should be cleaned using soap and water left to dry thoroughly before next use. Children with symptoms of COVID-19 should not be allowed in common play areas until they are no longer symptomatic or considered non-contagious as per a medical professional. The toy of any child who is visibly ill, or suspected of having an infectious disease, should remain with that child while they are ill. Toys used by ill children must be thoroughly cleaned and disinfected before sharing with other children. Follow the same procedures to clean and disinfect toys for an infected/ill child that you would cleaning/disinfecting the toys of a non-infected/well-appearing child. Any toy that cannot be cleaned and disinfected should remain the sole property of that child, including being sent with the child when leaving the shelter.
A summary of the cleaning activities for each shelter area should be developed and provided to the person assigned to clean that particular area.

Figure 8: Pest Control



Pest control: Following a disaster, there will likely be an increase in insects and other pests in or around the shelter. Rain and high-water levels, such as after a cyclone or flood, may lead to an increase in the numbers of mosquitoes and other pests. Pest control should be included in the community disaster plan for shelters. Recommendations for pest management include: eliminate food sources for pests. Eliminate areas for nests, burrows, or breeding grounds. Evaluate inside and outside

of shelter for potential entrances for vermin, such as windows with torn or missing screens, doors propped open, standing water, etc and seal/eliminate any potential problem areas.

Plan for a significant increase in supplies including mask, gowns and gloves, cloth face covering, water and other fluids for hydration, food supplements, utensils and silverware, soap, hand sanitizers, sanitary products, bed linens/blankets, disinfectants and cleaning supplies, material to be used as barriers, over the counter medications etc.

VII**. Essential healthcare:**

Essential healthcare addresses the major causes of mortality and morbidity in disaster affected population. Coordinate with health authorities to agree on services to prioritise, when and where. It is vital to ensure a continuum of care for people with pre-existing health conditions, the elderly, pregnant and breastfeeding mothers and children needing vaccinations who are evacuated to relief camps or shelters. Protocol developed by health authorities need to be followed in the management of chronic conditions, vaccinations and immunisations and other essential health services.

Mental health and psychosocial care among adults, adolescents and children also needs to be prioritised. Set up a cross-sectoral technical group for mental health and psychosocial care services. Conduct a needs assessment, keeping in mind that mental conditions may be pre-existing, induced by crisis or both. Work with community members including marginalised groups to strengthen community self-help and social support. Orient staff and volunteers on how to offer psychosocial first aid. Train staff in detection and brief interventions, harm reduction and management of withdrawals related to substance abuse.

NOTES:

Notes for the District Disaster Management Authorities (DDMAs)

A. Priority list of actions:

I. Map, assess, identify gaps and prioritize planned activities in consultation with all stakeholders.

II. Assess the demographics of the camp population against the high-risk groups i.e. older persons, those with pre-existing medical conditions, who are affected by COVID19 more seriously than others.

III. Map available services and referral pathway, ensuring all field staff and communities have access to relevant contacts and information.

IV. Discuss with service providers and local authorities on contingency planning, possibilities of identifying additional land, and on scaling up WASH and health services in the camp sites, especially for high risk populations.

B. Do's and Don'ts:

I. Community Engagement, Communication and Mobilization:

Engage communities in assessing risks, information dissemination, reporting mechanism, planning and implementing mitigation measures. Work with relevant sectors to agree on key messages as well as contextualized and translated IEC material, check with health department to ensure uniformity of messaging.

Do: establish block and zone focal points, set up monitoring teams, as well as those who will be checking up on the vulnerable / high risk population - provide training on COVID-19 and key messages.

Do: Set up hand washing committees dedicated to training and monitoring and peer pressure to other camp residents to ensure regular handwashing – linked to WASH and need for rapid increase in supply and hand washing stations at all possible points of concern.

Information Dissemination: At all levels, share situation updates, local health contingency plans, risks and prevention measures, and site-level planning process and progress, as well as emergency contacts and procedures. Monitor and actively counter negative rumours or misinformation that may harm individuals or groups living within the camps

Do: utilize diversified methods to spread messaging, such as IEC materials and radio announcements rather than door to door or mass campaigns.

Do: tell camp/shelter residents what to expect if they are feeling sick.

II. Referral mechanism:

Do: make sure that contacts and referral pathways are clearly communicated to all camp population and partners and made publicly available in the camps and surrounding areas.

III. Site improvements:

Handwashing/Bathing sites assess the number of existing locations and increase options for regular handwashing, especially at camp entrances and at communal facilities and gathering points. Work with WASH and Health colleagues to assess whether chlorine solutions, soap or alcohol options may improve the overall effectiveness of the process.

Do: consider increased cleaning/ hygiene measures (including garbage bins) for communal facilities. Ensure that cleaning staff use appropriate PPE.

IV. Movement in and out of camps:

Movements in and out of camps and their regulations must be discussed with the authorities. Consider:

- Improve monitoring at entry points, including hand-washing station
- Assess priority needs that will require camp population to go outside – e.g. for food, medical referral, etc.
- Visitors should be minimized or restricted during the preventative quarantine period New arrivals to the camp may require additional screening procedures, such as isolation prior to entry, etc. which should be discussed with health cluster/actors in country for recommendations.
- Ensure easily understandable IEC materials are visible and explained to people as they enter.

V. Distribution of essential supplies:

Consider the following when planning distributions and activities in sites, make sure that these measures do not adversely impact of scale of activities, reduce coverage and leave people without assistance:

Do: prioritize lifesaving distributions.

Do: Where feasible, plan for smaller-group distribution that avoid large crowds and minimize the queuing time - keeping in mind that this will mean more number and frequencies of distributions. Consider distribution of tokens with pre-allocated time slot ahead of distribution.

Do Not: merge distributions or provide too many large items at the same time since this will require more family members to turn up.

Do: identify or advocate for larger space to conduct distribution and reduce crowding, where possible and practical, maintain social distancing between distribution staff and those collecting items.

Do: ensure well equipped handwashing facilities are in place throughout the distributions (enough soap and water).

Do: Involve hygiene promotion workers to disseminate health messages during distributions.

VI. Stockpiling and prepositioning of supplies:

Do: ensure enough stocks of soap and buckets with taps for handwashing stations. Consider stocking laundry soap or other personal hygiene materials and tools for cleaning, as well as stocks of chlorine, staying mindful of chlorine storage and expiry dates.

Do: Consider stock of required PPE for health workers in the sites.

Do: list potential items required for camp improvement, maintenance, etc. and collect quotes and identify suppliers ahead of time.

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