INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN

VENEZUELA

Second iteration: 10 April 2020

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Overview and response to date

Note: Since the first iteration of this Plan, there has been an increase in the number of people returning to Venezuela, mainly crossing by land from Colombia. This situation requires specific response from the point of view of epidemiological control and establishing adequate temporary accommodation and protection conditions, as reflected in this second edition.

• On 13 March, two cases of the novel coronavirus SARS-CoV-2 (COVID-19) were confirmed in Venezuela. On the same day, the Government decreed a State of Emergency\(^1\) permitting it to take extraordinary measures to manage the situation. As of 10 April, 175 cases of COVID-19 have been confirmed by the authorities in Caracas and in 21 states in the country, and nine deaths have been reported.

• On 17 March, the Government of Venezuela requested the support of the United Nations (UN) in Venezuela to fight the spread of COVID-19 at the national level and to address the possible social and economic consequences of the measures implemented to control the outbreak.

\(^1\) Via Decree published on Extraordinary Official Gazette No. 6519, dated 13 March. The Decree will be in force for 30 days, renewable for the same period, until it is considered that the outbreak is adequately contained.
To date, efforts to prepare and respond to the COVID-19 outbreak include:

- PAHO/WHO's support, in collaboration with the Ministry of the People's Power for Health (MPPS), in developing the National Coronavirus Prevention and Control Plan. The Plan, in line with the World Health Organization's global guidelines, has five components: a) strengthen the epidemiological surveillance and laboratory services; b) sanitary control at points of entry; c) implementation of the sanitary protocol for clinical-epidemiological management of suspected and confirmed cases; d) communication and community engagement; and e) identification and strengthening of the sentinel sites (centros centinelas).

- The Government preventive measures to control the spread of COVID-19 include:
  - Preventive social quarantine across the national territory as of 17 March, with closure of borders between the states, except for the food distribution supply chain, health and sanitary services, police and military security, transportation, electricity, gas, fuel, solid waste management and telecommunications.
  - Suspension of all work activities except for social service activities and those of immediate need (food distribution, health, safety and transport services).
  - Suspension of educational activities at all levels since 16 March.
  - Suspension of commercial and private flights from Europe, Colombia, the Dominican Republic and Panama from 15 March for 30 days, and domestic flights excluding cargo and postal flights.
  - Mandatory use of face masks on public transportation such as the metro and railways and from 22 March, in all public areas.
  - Establishment of 46 hospitals and sentinel centres in all states and collaboration with Member States such as China, Russia and Cuba, for the provision of supplies and medicines, technical cooperation and human resources support. As of 1 April, a total of 23,000 hospital beds and 1,200 Intensive Care Unit (ICU) beds have been prepared to receive COVID-19 cases, and 52,000 PCR tests and one million rapid tests have been made available.
  - The launch of a COVID-19 screening survey through the Patria System to strengthen the epidemiological surveillance of COVID-19. As of 6 April, 17,202,618 people had reportedly responded to the survey, enabling the prioritization of the deployment of 14,000 workers to conduct screenings of 98,269 people (as of 31 March, 54,248 screenings had been conducted). This tool seeks to track the evolution of the outbreak in the country, in order to adapt the response.
  - A communication campaign to provide key information to the population on preventive measures, evolution of the virus and actions required to prevent the spread of COVID-19.

- As part of the initial response, PAHO/WHO delivered 2,000 diagnostic kits, 150,000 masks, 200 personal protection equipment (PPE) kits, and seven hygiene kits to the four sentinel centres in Caracas. PAHO/WHO is also providing technical cooperation to the authorities on a regular basis on epidemiological surveillance, infection control, laboratory screening, and case management. On 8 April, UNICEF has facilitated the arrival of 90 tons of supplies, including PPE kits and other essential medical and water, sanitation and hygiene (WASH) supplies.
- PAHO/WHO and UNICEF have also jointly focused on supporting water supply and sanitation and hygiene measures in hospitals, health centres, airports and other establishments and institutions.
- Efforts by the humanitarian community also include risk communication for the prevention of COVID-19, with the development of standard contents and dissemination planning.
- The humanitarian community is working to mitigate the impact of the pandemic on pre-existing humanitarian needs and to maintain critical activities finding new approaches, in line with global Inter-Agency Standing Committee (IASC) guidelines.

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2 On 16 March, the measures took effect first in the Capital District and the states of Apure, Cojedes, La Guaira, Miranda, Tachira and Zulia.
3 MPPS, Current Situation Bolivarian Republic of Venezuela, 1 April 2020.
COVID-19 risks analysis

In the context of a global pandemic, Venezuela is vulnerable to the effects of COVID-19. Based on the ongoing needs analysis in the context of humanitarian operations, there is a need to consider the following risks:

- A regional context with an increasing number of cases, including all neighbouring countries (Brazil and Colombia in particular), whose long borders with Venezuela continue to see people cross using irregular routes.
- Limitations in the health system capacity to respond to a severe pandemic, due to shortages of basic supplies (protective equipment for health workers, biomedical equipment, drugs and medical supplies) and lack of training on their usage; shortcomings in basic WASH services; reduced capacity to prevent and control infections; lack of specialized human resources to treat complicated cases, besides the non-specialized human resources that support them; insufficient functionality of critical services such as emergencies, pre-hospital care, and insufficient beds and care personnel in intermediate and intensive care units.
- Limited access to adequate water and sanitation services, PPE kits and cleaning and hygiene materials, in public spaces, critical services and the households of the most vulnerable. These limitations are an obstacle to preventing the spread of COVID-19, accentuated by the impact of the preventive measures on the movement of hygiene products between municipalities and states.
- Due to the high level of economic vulnerability of the population, preventive measures, especially the “social quarantine”, cannot be fully complied with. The population, for example, in poor neighbourhoods, must go out to work daily to access to goods and services and to generate income to cover basic needs such as food. Without access to a regular income, families dependent on the informal economy further deplete their already limited savings.
- Special attention needs to be paid to the situation of miners in the states of Bolivar and Amazonas, an area endemic with malaria and dengue, where COVID-19 could spread quickly. The significant movement of people to cities with better access to goods and services and/or towards the border areas require a particular focus, since these movements increase the risk of COVID-19 exposure for vulnerable populations, including those living in overcrowded conditions and unsanitary accommodations.
- Some of the population faces difficulties in access health care services due to several factors, including poor transport coverage, lack of fuel and lack of economic resources. These circumstances especially affect the most vulnerable and isolated populations (including the elderly, children at risk, people with disabilities and indigenous communities).
- Limitations for the humanitarian response include lack of funding, limited operational capacity, the absence of a registration mechanism for international NGOs and the absence of the World Food Programme (WFP). Other challenges for humanitarian access include difficulties in accessing fuel, mobility in the context of “social quarantine” and, in some areas, for security reasons (such as in border or mining areas).
- Mitigating sanctions would allow for a larger allocation of resources to treat and prevent the outbreak, according to the UN High Commissioner for Human Rights who also added that “humanitarian exemptions to sanctions measures should be given broad and practical effect, with prompt, flexible authorization for essential medical equipment and supplies”. In the Venezuelan context, it is particularly important to increase the possibilities for importing fuel and/or diluents for its production in order to alleviate the shortage of petrol as a major obstacle to humanitarian access. The High Commissioner also pointed out that the countries under sanctions must adopt measures that provide national and international organizations with the necessary guarantees to carry out their humanitarian activities without interference.
- The return of Venezuelans from Colombia, Ecuador, Peru and other countries since mid-March requires particular consideration to ensure appropriate implementation of sanitary measures, including epidemiological surveillance of COVID-19 for at least 15 days and, where necessary, the provision of safe and adequate temporary shelter. The National and State level Governments have requested assistance in responding to the needs of this population and have designated facilities as temporary accommodation centres. On 7 April, the Ministry of People’s Power for Foreign Affairs submitted a formal request for assistance to the UN Resident Coordinator/Humanitarian Coordinator to support the response.
Scenarios

WHO identified four COVID-19 transmission scenarios:

1. Countries with no cases (No cases);
2. Countries with 1 or more cases, imported or locally detected (Sporadic cases);
3. Countries experiencing cases clusters in time, geographic location and/or common exposure (Clusters of cases);
4. Countries experiencing larger outbreaks of local transmission (Community transmission).

Venezuela is transitioning from phase 3 to phase 4. The last reported cases are probably local and resulting from community transmission. As of 31 March, most cases are in Greater Caracas, a region with a higher population density, although cases have been already reported in 20 states. Border areas such as Zulia, Táchira, Apure and Bolívar face high risks since all neighbouring countries already report COVID-19 cases and people continue to cross the borders using irregular routes despite movement restrictions.

Impact on pre-existing humanitarian needs

The potential outbreak and the preventive measures implemented by the authorities to limit the transmission of the virus may have an impact on the already existing humanitarian situation in the country and exacerbate people’s vulnerabilities.4 Venezuela is not exempt from the dilemma between adopting rigorous measures to contain the transmission of the virus or preserving the socio-economic status quo. While measures have been taken to mitigate the most severe effects of the measures5, it is important to seek ways to maintain and expand humanitarian operations under the Humanitarian Response Plan (HRP) to support the most vulnerable populations.

If the virus spreads, it will immediately impact the health system as it did in countries in Asia, Europe and North America. Although the country has COVID-19 diagnostic kits, PCR tests are geographically concentrated near the capital. Also, the increase in the number of suspected cases will require higher capacity to analyse the results and this may reduce the available stock. Severe cases requiring hospitalization will test the health system’s capacity in light of the interruptions in water and electricity supplies, shortages of medicines and medical supplies, the emigration of health professionals and the operational capacity in intermediate and intensive care units. An exponential increase in cases could quickly overload the operational capacity of services. Another concern is the limited capacity of morgue services in hospitals and forensic facilities to respond to an increase in deaths; inadequate disposal of bodies could result in a health crisis within the pandemic.

The reallocation of funds to meet the immediate needs relating to COVID-19 may constrain other critical health services, such as access to sexual and reproductive health care for women and adolescents, leaving them at high risk of sexually transmitted diseases, unwanted pregnancies and unsafe abortions, and without access to health and menstrual hygiene kits. For pregnant women this can increase the chances of unsafe delivery and death. The reallocation of funds can also affect emergency services, mental health care and support and protection and gender-based violence services.

The COVID-19 outbreak and the preventive measures to contain it will likely exacerbate the economic downturn that Venezuela had faced in the last six years. There had been a significant drop in oil prices in recent months, economic inactivity has increased, and household demand is likely to fall in the context of ‘social quarantine’ and loss of income. The functioning of the supply chain for essential commodities such as food, medicines and hygiene products is also challenging. In a situation of high demand and movement restrictions, there could be shortages and price increases of basic cleaning and personal hygiene products.

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4 The Global Humanitarian Overview was launched on 4 December, with a section on Venezuela. Recent reports can also be found at humanitarianresponse.info
5 Labour immobility was decreed from 23 March to 31 December 2020, labour immobility was decreed. Also, a special plan was stipulated to continue with the payment of the payroll for companies and businesses; complementary bonuses to the payroll and an investment program for the agricultural sector. Lease payments were suspended for six months and measures were taken to restructure business and personal credit (Decrees 4.167, 4.168 and 4.169 of 23 March).
(bottled/tanker water, soap/disinfectant gel, cleaning products). After a few days of preventive measures, prices of basic products (such as rice, pasta and flour) had risen in some areas. Also, if rural workers no longer have access to fuel, food production could be reduced. A decrease in imports and the disruption of international food supply chains could also affect domestic production. While the economic protection measures decreed by the Government are an initial step to mitigate the effects, it is important to monitor and address the needs of the most vulnerable groups.

The preventive measures implemented in the country (quarantine, border closures, access limitations and suspension of work activities) have an impact on livelihoods and coping mechanisms. In a social quarantine, the most vulnerable people living on a day-to-day basis may lose income opportunities, limiting their purchasing capacity and consequently reducing food security and the capacity to meet other basic needs. A reduction in remittances can be expected, given the partial paralysis of economies in countries in the region with high numbers of Venezuelan migrants and refugees. Under these circumstances, affected people are likely to recur more frequently to negative coping mechanisms, such as the reduction in food consumption, sale of assets and/or debt, particularly for the most vulnerable groups, such as women and adolescent heads of household engaged in the informal economy. This may lead to a higher risk getting sick with COVID-19.

The quarantine may reduce access to water, sanitation and environmental services for the most vulnerable households. There are risks of interruptions in bottled water/tank truck supply in some sectors are expected, as well as delays or suspension of garbage collection services, which could worsen inadequate hygiene habits. The functioning and maintenance of WASH systems and infrastructure are impacted by the decrease in operational personnel, supply chain constraints for essential water and wastewater treatment products, disruption of power supply, and limitations in water supply services. As a result, there are specific risks for health facilities, detention centres, and other institutions and establishments.

The preventive closure of schools since 16 March affects approximately 6.8 million students now relying on alternative educational options. This situation increases the risk of school desertion and disruption of social services for the most vulnerable population because educational facilities often serve for cross-sectoral interventions, including child protection and food security. The Ministry of People's Power for Education has adopted measures for distance learning and the continuation of school meals until the end of this academic year. When alternative educational resources are not widely available or used, the reopening of schools will require compensatory measures to ensure that students can catch up.

Measures to control COVID-19 can also affect people on the move through the suspension of flights and social quarantine throughout national territory. The decision of all neighbouring countries to close their borders with Venezuela, as they will will reduce people’s ability to move and put them at risk of being stranded without being able to reach their destination. The closure of borders with Colombia and Brazil also affects people receiving medicines and medical treatment on the other side of the border, for example, people with HIV/AIDS and people with non-transmissible diseases, although some people are being allowed to enter Colombia for medical treatment on exceptional circumstances. These closures constrain the continuation of small-scale cross-border subsistence commerce. The closure of official border crossings has resulted in the use of informal crossings (trochas) becoming more frequent and more expensive (from an average of 3,000 pesos (US$0.9) to 50,000 pesos ($12). The use of informal crossings makes epidemiological surveillance at points of entry impossible. People using these crossings to enter Venezuela also face challenges in terms of ensuring health protocols, including maintaining a period of isolation, while attempting to return to their places of origin.

Since mid-March, there has been an increase in the number of Venezuelans entering from Colombia. Between 40,000 and 60,000 persons have been reported to have returned since the closing of the borders, including pendular movements. Most have entered Venezuela through Tachira, with smaller entries through Zulia, Apure and Bolívar. As quarantine measures are extended in Colombia, Ecuador, Peru and other countries, more Venezuelans are expected to return. Temporary accommodation spaces for the returnees to complete their health quarantine in the border municipalities has become a critical challenge. In addition to the implementation of health measures to prevent transmission chains associated with returnees, it is important to respond to the basic needs and guarantee the rights of people on the move.

The COVID-19 outbreak might especially affect women, as they represent most of the health system workforce and are often responsible for hygiene and cleaning jobs, which could increase their exposure and risk to the virus. Women often take care of ill people, the elderly and children who are currently at home due to the preventive social quarantine and the suspension of schools. Women working in both informal and domestic economies also risk losing the income required to support their households. These multiple responsibilities and changes in domestic dynamics can increase the risk of gender-based violence, domestic violence and forced prostitution, resulting in anxiety and stress.

In addition to women, domestic violence can affect children and adolescents in dysfunctional families. Quarantine measures can also create tensions that can turn into emotional or physical violence in dysfunctional families, and increase the risks of abuse, exploitation and negligence. Children can be exposed to high levels of stress and trauma during an important stage of their development. Therefore, it is important to provide the tools and support to both parents and children to manage daily stress, and to strengthen violence prevention and response modalities.

Households, as well as health and humanitarian personnel, will be exposed to stress that can increase anxiety levels, requiring mental health care and psychosocial support. Quarantine measures bring negative psychological effects, including confusion, anger, burn-out, disaffection, anxiety, impaired performance and resistance to work, and may even lead to post-traumatic stress disorder and depression. Many of the symptoms are related to fears of being infected, frustration, boredom, lack of supplies or information, financial losses and stigma.

Although children and adolescents do not belong to the highest risk age group for COVID-19, homeless children and those in shelters are at a higher risk of infection. Those involved in informal work and supporting household income may be affected by the impact of social quarantine and have a reduced access to essential goods and services. Children in care of the elderly may suffer a deterioration in their living conditions and nutritional status if these elderly people, most vulnerable to COVID-19, become ill or die. Children and adolescents from indigenous populations and those with disabilities may not have access to adequate and appropriate information and may not be able to protect themselves from the COVID-19 or access the measures to mitigate the impact of quarantine measures.

Vulnerable groups

- Elderly people, including child carers
- People at risk due to underlying medical conditions, such as diabetes, cardiovascular disease, chronic respiratory disease, cancer or HIV
- Healthcare workers
- People with limited access to water, sanitation and hygiene
- People on the move, including returnees, those living in overcrowded conditions and insalubrious housing, those who are homeless and those living in border areas carrying out pendular crossings
- People in detention centres, including preventive detention centres where they depend on family members for food (who cannot move due the social quarantine)
- Children at risk (in care institutions, those who are homeless, and heads of households)
- Indigenous communities with limited access to the health system
- People suffering from food insecurity
- People with disabilities
- Vulnerable women (caregivers of ill people, cleaners, heads of household who have lost or reduced their income due to quarantine measures)
- Population in long-term care facilities such as nursing and care homes for the elderly
- Low-income families with high out-of-pocket health expenditures for essential medicines and supplies
Objectives of the Intersectoral Preparedness and Response Plan

The objective of the Intersectoral Preparedness and Response Plan is to help reduce vulnerabilities and prevent high levels of morbidity and mortality associated with the COVID-19 pandemic.

To achieve this, humanitarian organizations will provide coordinated support to the response of relevant authorities and focus on priority activities and essential programs with special emphasis on health and WASH, to reduce the risk of in-hospital infections. This Plan is aligned with the National COVID-19 Prevention and Control Plan, which aims to: i) reduce and stop transmission, prevent outbreaks and slow down the spread; ii) provide optimized assistance to all patients, with special consideration for the severely ill; and iii) minimize the impact on the health system, social services and economic activity. The MPPS has designated 46 hospitals for COVID-19 assistance in all 24 states; these require support to ensure the functionality of key services, including medical supplies and infrastructure, including WASH.

The Plan includes the following specific objectives:

- Strengthen the capacity of the health system for early detection and patient care and to reduce the spread of the virus.
- Strengthen the capacity of the health system for infection prevention and control (IPC) in health facilities and prioritized communities.
- Provide timely and adequate information to the population on prevention and control of the virus.
- Provide multi-sectoral assistance and ensure safe and decent conditions in temporary accommodation centres for the most vulnerable returnees and reduce the risk of people on the move being a vector for the spread of the virus.
- Ensure a coordinated and timely response at the national and sub-national levels and across sectors.
- Ensure the continuity of other key programmes under the Humanitarian Response Plan and mitigate the impact that the preventive measures may have on the most vulnerable population.

Prioritization Strategy

The Plan remains valid for the rest of the year, with a multi-phase strategy:

- During the first phase (first three months), the Plan focuses on strengthening the response capacity in 16 of the 46 prioritized hospitals and sentinel sites located in the areas of Greater Caracas (Capital District, Miranda, La Guaira), in the border areas of Tachira, Zulia, Apure and Bolívar and in three additional states (Anzoátegui, Lara and Falcon). Some of these hospitals will be supported with comprehensive health, WASH and IPC interventions, and others with partial programme interventions. This geographic prioritization focuses on areas with the highest population density, the highest number of reported cases, the highest risk of exposure, and areas with immediate operational capacity of humanitarian organizations. Some interventions will also address capacity-building for outpatient primary health care in prioritised states.
- WASH Interventions in the most vulnerable communities will be aligned with the same geographical prioritization of hospitals and sentinel sites in 10 states with a focus on urban areas, areas with higher population density, and areas with limited access to safe water. An estimated 511,000 people are expected to be reached with WASH assistance in communities.
- Risk communication and community engagement activities are focused on the 10 states prioritized for health and WASH, although some activities, such as dissemination through social networks and the media, will have national coverage.
  - In the border areas, which are already prioritized, the increase of returnees requires dedicated
attention to mitigate the additional pressure for host municipalities. The response will focus on supporting health and WASH interventions, support for temporary accommodation and distribution of food and basic goods, as well as protection services (legal advice, gender-based violence prevention and care, and addressing the needs of unaccompanied or separated children). The states of Tachira and Zulia report the largest flows of returnees, although the states of Apure and Bolivar have also been affected. Partners will aim to provide a comprehensive response in priority temporary shelters, in accordance with the number of returnees accommodated and the critical needs identified in these centres in collaboration with the authorities.

- **During a second phase**, the prioritization will be reviewed based on the evolution of the epidemiological situation. The response and the number of hospitals supported with a comprehensive health and WASH package might be wider. The impact on multi-sectoral humanitarian needs will also be monitored, in order to re-prioritize the humanitarian response if necessary, including if food and nutritional security decreases, and if critical protection and psychosocial support services need to be strengthened.

The financial requirement for the implementation of the Intersectoral Plan has been estimated at **$72.1 million**, including the components of health, WASH and risk communication and community engagement. It also incorporates the multi-sectoral response to returnees included in the component relating to the points of entry, with a focus on temporary accommodation centres. The cost for other key activities is included in the Humanitarian Response Plan (see annex for details on financial requirements).

### List of the 16 hospitals and sentinel sites prioritized for the first phase of the response

<table>
<thead>
<tr>
<th>State</th>
<th>Municipality</th>
<th>Location</th>
<th>Name of hospital / sentinel site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anzoategui</td>
<td>Simon Rodríguez</td>
<td>El Tigre</td>
<td>Dr. Felipe Guevara Rojas General Hospital</td>
</tr>
<tr>
<td>Anzoategui</td>
<td>Aragua</td>
<td>Barcelona</td>
<td>Dr. Luis Razetti Hospital</td>
</tr>
<tr>
<td>Apure</td>
<td>San Fernando</td>
<td>San Fernando de Apure</td>
<td>Dr. Pablo Acosta Ortiz General Hospital</td>
</tr>
<tr>
<td>Bolivar</td>
<td>Gran Sabana</td>
<td>Gran Sabana</td>
<td>Rosario Vera Zurita Hospital</td>
</tr>
<tr>
<td>Bolivar</td>
<td>Heres</td>
<td>Bolivar City</td>
<td>Ruiz y Paez University Hospital Complex</td>
</tr>
<tr>
<td>Capital District</td>
<td>Libertador</td>
<td>Lidice</td>
<td>Dr. Miguel Perez Carreño (IVSS) Hospital</td>
</tr>
<tr>
<td>Capital District</td>
<td>Libertador</td>
<td>Universitary City</td>
<td>University Clinical Hospital /Rafael Rangel National Institute of Hygiene</td>
</tr>
<tr>
<td>Falcon</td>
<td>Miranda</td>
<td>Coro</td>
<td>Dr. Alfredo Van Grieken University Hospital</td>
</tr>
<tr>
<td>La Guaira</td>
<td>La Guaira</td>
<td>Macuto</td>
<td>Dr. Jose Maria Vargas (dependent on the Venezuelan Institute of Social Security) Hospital</td>
</tr>
<tr>
<td>Lara</td>
<td>Simon Planas</td>
<td>Simon Planas</td>
<td>Dr. Armando Velasquez Mago General Hospital</td>
</tr>
<tr>
<td>Miranda</td>
<td>Lander</td>
<td>Valles del Tuy</td>
<td>Simon Bolivar Hospital</td>
</tr>
<tr>
<td>Miranda</td>
<td>Sucre</td>
<td>El Llanito, Petare</td>
<td>Domingo Luciani Hospital</td>
</tr>
<tr>
<td>Miranda</td>
<td>Sucre</td>
<td>Petare</td>
<td>Ana Francisca Perez de Leon II Hospital</td>
</tr>
<tr>
<td>Táchira</td>
<td>San Cristobal</td>
<td>San Cristobal</td>
<td>University Hospital of San Cristobal</td>
</tr>
<tr>
<td>Zulia</td>
<td>Maracaibo</td>
<td>Maracaibo</td>
<td>University Hospital of Maracaibo</td>
</tr>
</tbody>
</table>
## Component 1: Risk communication and community engagement

### Situation
- Risk communication and community engagement are vital aspects to share information about COVID-19: what is and what is not yet known, as well as ongoing and recommended actions. Preparedness and response activities should be implemented in a coordinated, inclusive and community-based way, with continuous feedback from the community to detect and respond to concerns, rumours and misinformation.
- The use of television, radio, social media and SMS text messaging is quite widespread in Venezuela. Social media networks provide an opportunity to ensure information flow during confinement, but they also could be used to spread rumours and/or unverified sources, affecting the reputation of organizations and increasing the risk of COVID-19 transmission.
- The communication strategy developed by the Interagency Communications Taskforce on COVID-19 includes joint, transparent and consistent messages disseminated via reliable communication channels, using community networks and key influencers and/or local leaders. The messages will be translated into indigenous languages and adapted to the most vulnerable and sensitive groups.
- The efforts focus on empowering affected communities by establishing communication systems with feedback mechanisms to listen to their information needs and respond accordingly.
- It is important to diversify information dissemination tools to include groups that may lack access to or knowledge of new technologies, including the elderly, the homeless, children, people in detention centres, and isolated indigenous communities. Messages will be adapted to their needs using different communication channels: community radios, SMS, focal groups discussions, etc.

### Key actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and implement an information and education campaign that includes protective measures at personal and family levels; preventing infection; protective measures for pregnant women and warning signs; how to manage stress during quarantine (mental health, solidarity, no-violence, caregiving for the elderly and children); advice and alternatives on what to do at home with your children, including protection (psychosocial)</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Rapid assessment to understand the targeted audience, their knowledge, perceptions, concerns, influencers and preferred communication means</td>
<td>UNICEF, Caritas</td>
<td>1st to 2nd month</td>
</tr>
<tr>
<td>Identify, collaborate and strengthen the communication capacities of trusted community networks, community radios, religious leaders and local influencers (community networks and radios)</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Design the processes for the authorization and dissemination of messages and materials, and establish relevant communication channels</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Develop and disseminate key messages under one voice</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Strengthen national capacities on COVID-19 risk communication (targeting communities, communicators, media, scientific societies and health care providers and decision makers)</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Strengthen communication modalities with communities / accountability systems to affected communities</td>
<td>UNICEF, Caritas and Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Disseminate country context-appropriate key messages and information products agreed by the Communication Taskforce, in line with the prevention guidelines</td>
<td>Clusters</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Identify gaps (products/IECs) and report to the Communication Taskforce</td>
<td>Clusters</td>
<td>1st month</td>
</tr>
<tr>
<td>Identify hard-to-reach groups, and report to the Communication Taskforce to find appropriate channels</td>
<td>Clusters, Caritas</td>
<td>1st month</td>
</tr>
<tr>
<td>Provide a technical focal point for areas of IPC, WASH and Protection</td>
<td>Health, WASH and Protection Clusters</td>
<td>1st month</td>
</tr>
<tr>
<td>Provide technical support with trainings/training materials on infection prevention and control/ WASH for public space guards</td>
<td>Health and WASH Clusters</td>
<td>1st to 2nd month</td>
</tr>
</tbody>
</table>
Component 2: Epidemiological surveillance and laboratory services

Situation

- As described above, the health system in Venezuela faces limitations in its ability to undertake all required actions.
- These limitations have affected the delivery of priority public health services, including the epidemiological surveillance and communication activities of the National Epidemiological Surveillance System and the Network of Public Health Laboratories, required to prevent and reduce the impact of transmissible diseases.
- The National Epidemiological Surveillance System faces challenges in the implementation of diagnostic technologies and technical-scientific innovations to enable early, continuing, and systematic detection of COVID-19 cases and management of cases and the epidemiological situation.

Key actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide technical support to the MPPS and other actors to strengthen the National Epidemiological Surveillance System capacities on detection, report and investigation of COVID-19 suspected cases, ensuring data breakdown by sex, age, pregnancy and lactant women, disabilities, indigenous population</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Support the MPPS and the scientific community in the development of technical documents for surveillance and laboratory screening of COVID-19 and disseminate them to the Health Cluster and communities</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Support the MPPS in strengthen the operational capacities of the epidemiology services for COVID-19 outbreak control (rapid response units)</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Provide technical support to the MPPS to strengthen functional capacities of the epidemiology services for COVID-19 analysis and monitoring</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Strengthening the capacity of the national referral laboratory and support decentralization to 4 states of the country on COVID-19 laboratory screening</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Support the MPPS and other actors in the implementation of community-based epidemiological surveillance</td>
<td>Health Cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
</tbody>
</table>
Component 3: Points of entry

**Situation**

- At the international airport, flights from Europe, Colombia, the Dominican Republic and Panama, as well as domestic flights are suspended for 30 days. Only cargo flights are allowed, which significantly reduces the need for entry controls. Aruba, Bonaire and Curaçao maintain an indefinite maritime and air border closure. Trinidad and Tobago have implemented entry restriction measures, with mandatory quarantine for foreign persons.
- In areas bordering Colombia, the closure of border crossings affects pendular movements to access basic goods and services. This group of people faces the deterioration of their physical and mental well-being and their living conditions. For example, an estimated of 700 people with HIV receive antiretroviral drugs in Cucuta.
- A positive development in terms of points of entry was the 16 March announcement by the Presidents of Colombia and Venezuela that, with coordination support from WHO/PAHO, a dialogue was initiated between the countries’ Ministries of Health to share information and articulate case management. The President of Colombia also announced initiatives with the Government of Tachira and the National Assembly.
- The situation at the border crossing between Venezuela (Santa Elena de Uairén) and Brazil (Pacaraima) is constantly progressing towards increasing restrictions. As of 18 March, the border allows the crossing only for supplies and food cargo and is entirely closed to people.
- Land borders (seven official border crossings) between Colombia and Venezuela had been closed since 14 March following an order by the Colombian Government. Reports show that Colombian authorities allowed some people to cross from Venezuela to Colombia, for medical reasons, and also allowed Venezuelans to return to Venezuela. Despite the border closures, there has been a significant increase in the number of people crossing the border since mid-March. It is estimated that in the coming weeks more people will return across the western border, and the flow will continue at this scale or a little higher, mainly via Tachira and Zulia, although returns are reported also via Apure and Bolivar. In these two states, taking into consideration the volume of crossings, the response capacity is stronger, mainly from local authorities, with occasional support from the UN and partners. The high number of returnees crossing into Tachira and Zulia requires stronger support from the UN and partners to assist the returnees and prevent them from being a possible vector in the transmission of COVID-19. If the response is not timely, existing protection and health risks could result in social tensions with the host communities and in their final destinations. The response for the returnees is focused on assisting them at the points of entry and during quarantine for cases that are negative and/or asymptomatic. Positive cases will require further monitoring and medical attention at sentinel sites and/or hospitals in the border states.

**Key actions**

**At points of entry**

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide technical guidance on preparedness for timely detection of suspected cases and contacts of confirmed cases in line with the International Health Regulations at points of entry (sea, air and land)</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
</tbody>
</table>

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Footnote: 7 The Presidency of the Republic of Colombia reported on 6 April that “these spaces [corridors] have already been opened in special cases, being noteworthy the voluntary return of Venezuelan to their country, crossing the Simón Bolívar Bridge in Villa del Rosario (Norte de Santander). (Balance general, Epidemia of COVID-19, 6 April 2020).
### INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN

**Promote information-sharing and binational dialogue between the Ministries of Health of Venezuela and Colombia as established in the RSI-2005, to enable information analysis, strengthening binational health services and coordinating health response for COVID-19**

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and support for the preparation of arrival spaces (tents, mobile warehouses, handwashing and hydration points, distribution of hygiene kits, and others) and awareness-raising for frontline staff</td>
<td>PAHO/WHO, Shelter, Energy and NFI, WASH Cluster (PAHO/WHO, UNHCR, UNICEF, OIM)</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Enhancing health services, triage, patient routes in the border areas. Implementation of screening rapid tests, advice for the installation of field hospitals and emergency medical teams</td>
<td>Health Cluster/PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Monitor the situation of vulnerable persons in transit in border areas (persons with COVID-19 requiring immediate treatment, gender-based violence victims, and unaccompanied or separated children), and refer identified cases to available care routes</td>
<td>PAHO/WHO / Protection Cluster and AoRs/UNHCR/UNICEF/UNFPA</td>
<td>1st month</td>
</tr>
<tr>
<td>Support to the coordination of the return process, and logistics and techniques for the transport of returnees from the point of entry to the temporary accommodation centres and to their places of origin.</td>
<td>IOM/UNHCR</td>
<td>1st month</td>
</tr>
</tbody>
</table>

**In temporary accommodation spaces**

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of accommodation centres and shelter management. Specific actions comprise of provision and installation of tents, mobile warehouses or temporary accommodation units, establishing hand washing and hydration points, water supply, rehabilitation of existing sanitary toilets or installation of chemical toilets and support for solid waste management</td>
<td>Shelter, Energy and NFI Cluster/ WASH Cluster/ UNHCR/UNICEF/IOM</td>
<td>1st month</td>
</tr>
<tr>
<td>Training on shelter management, IPC at shelter sites, and technical advice on implementing sanitation and hygiene measures to help prevent and protect from infection</td>
<td>Shelter, Energy and NFI Cluster/ WASH Cluster/UNICEF/PAHO/WHO/UNHCR</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Distribution of essential supplies (jerrycans, buckets, filters, mosquito nets, mats, blankets, sun lamps, soap, pots, charcoal, hygiene and cleaning kits, dignity kits, and others).</td>
<td>Shelter, Energy and NFI Cluster/ UNHCR/UNICEF and partners</td>
<td>1st month</td>
</tr>
<tr>
<td>Distribution of prepared meals/food kits.</td>
<td>Food Security Cluster/IOM</td>
<td>1st month</td>
</tr>
</tbody>
</table>

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8 Those tested positive in rapid screening will be isolated in separate locations and, if they require medical attention, they will be moved to sentinel sites or hospitals in the area, for a humanitarian response.
<table>
<thead>
<tr>
<th>INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with communities, messages on COVID-19 risk, psychosocial support and prevention of violence, discrimination or stigmatization, counselling on general, reproductive and sexual health</td>
</tr>
<tr>
<td>Identify cases of protection and assistance to vulnerable people, including children and at risk, separated and unaccompanied children. Support to safe spaces for the response to gender-based violence</td>
</tr>
<tr>
<td>Psychosocial support</td>
</tr>
</tbody>
</table>
## Component 4: Infection Prevention and Control and Case Management

### Situation
- In the last few years, there have been assessments on the conditions of health facilities in Venezuela, showing reduced capacity in service provision and limited operational conditions, particularly regarding continued access to electricity, drinking water and cleaning supplies to ensure adequate sanitation.
- In general, the lack of adequate medical equipment for treatment, insufficient trained personnel (at multiple levels, including pre-hospital), and limited referral systems in the country may limit access to timely life-saving assistance.
- Case management requires that health personnel have a good understanding of what a COVID-19 suspected case is and can provide an appropriate response. High caseloads will strain staff, facilities, and supplies.
- Other challenges to reducing person-to-person transmission in health care facilities include the low availability of appropriate PPE kits and cleaning supplies.
- Activities to limit person-to-person transmission are also essential to protect health workers at all levels and reduce the risk of clusters of cases in health facilities.
- Efforts to limit the spread transmission are also essential to protect health care personnel at all levels and reduce mass cases in health care facilities.
- Health care facilities and services should be reorganized focusing on better segregation and isolation to enable patient flow and reduce nosocomial infections.
- A total of 46 referral hospitals have been designated in Venezuela for COVID-19 cases (out of the network of 294 hospitals on the national level). Early response will be essential to save lives, including the establishment of pre-hospital response systems, directing patients to intensive care units in the designated COVID-19 hospitals with adequate medical equipment and sufficient trained personnel.
- Prevention and control of infections in health facilities should focus on critical services in hospitals, including emergency services, therapy or intensive care, delivery rooms, operating theatres among others.
- Beyond health facilities, infection prevention and control are also implemented at the community/household level, with a focus on the most vulnerable groups.

### Key actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify and monitor IPC/WASH needs in designated hospitals, and distribute activities</td>
<td>WASH and Health Clusters</td>
<td>1st to 3rd / ongoing</td>
</tr>
<tr>
<td>Establish monitoring modalities for current and planned IPC/WASH activities/supplies at prioritized hospitals</td>
<td>WASH and Health Clusters</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Strengthen pre-hospital and hospital management of suspected and confirmed COVID-19 patients at the national and sub-national levels (pre-hospital transport, pre-triage, triage -respiratory-, emergency care, intermediate care and intensive care)</td>
<td>Health Cluster</td>
<td>2nd to 3rd</td>
</tr>
<tr>
<td>Create isolated spaces for COVID-19 suspected or confirmed cases of women in labour and new-borns</td>
<td>Health Cluster</td>
<td>1st to 3rd</td>
</tr>
<tr>
<td>Strengthen capacities for in-hospital infection prevention and control</td>
<td>WASH and Health Clusters</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Strengthen epidemiological surveillance of in-hospital infections</td>
<td>Health Cluster</td>
<td>2nd to 3rd</td>
</tr>
</tbody>
</table>
### INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN

<table>
<thead>
<tr>
<th>Activity</th>
<th>Sector(s)</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train health personnel on IPC and clinical case management, including specific protocols for pregnant women</td>
<td>WASH and Health Clusters</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Provide emotional support to health staff to cope with the situation with psychological support tools for both health staff and group leaders/managers</td>
<td>Working group on mental health and psychosocial support</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td><strong>In communities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue and/or increase activities to support water distribution in unserved sectors, and provision of supplies/equipment for the maintenance and treatment of water systems and wastewater</td>
<td>WASH Cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Technical support and supplies (where feasible) on IPC for the personnel working in public spaces and services</td>
<td>WASH Cluster (with PAHO) / Shelter, Energy and NFI Cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Technical support / guidelines for safe conditions on prevention and case management in public spaces and services</td>
<td>Health Cluster / WASH / Protection / Shelter, Energy and NFI Cluster</td>
<td>1st to 3rd month / ad hoc</td>
</tr>
<tr>
<td>Support early detection of cases in the nearest communities by providing training to health personnel, PPE kits and improving patient transfer capacity</td>
<td>PAHO/WHO, Health Cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td><strong>In households with confirmed/suspected cases, or in vulnerable households in quarantine</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical support/supplies (where feasible) in the provision of safe water, cleaning and hygiene items, and appropriate PPE kits to vulnerable households in quarantine, with confirmed/suspected cases</td>
<td>WASH (with PAHO) / Shelter, Energy and NFI Cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Technical support / guidelines for safe conditions for prevention and case management of COVID-19 in households, collective housing, detention centres, nursing and care homes for the elderly or in special conditions (children, people with disabilities, gender-based violence victims, etc.)</td>
<td>Health Cluster / WASH / Protection Cluster and AoRs / Shelter, Energy and NFI Cluster</td>
<td>1st to 3rd month / ad hoc</td>
</tr>
</tbody>
</table>
Component 5: Coordination

Coordination structures and responsibilities

- At the national level, the Government created the Presidential Commission for COVID-19 Monitoring, Control and Prevention. Members of the Humanitarian Country Team and clusters maintain regular contact with relevant authorities from the Ministries of People's Power for Health, Education, Interior, Justice and Peace, Defence and Women and Gender Equality, among others.

- The UN system and the humanitarian community, under the leadership of the Resident Coordinator/Humanitarian Coordinator (RC/HC), designated PAHO/WHO as the focal point for the COVID-19 response.

- The Humanitarian Country Team agreed to use existing humanitarian coordination structures at the national and local levels, according to the following guidelines:
  - The Humanitarian Country Team is responsible for strategic decision-making and compliance of guidelines for humanitarian organizations.
  - The Inter-Cluster Coordination Group is responsible for the inter-sectoral coordination.
  - The clusters are responsible for sectoral coordination and development of sectoral guidelines. The Hospitals and Essential Services sub-group (Health Cluster) is responsible for the coordination of WASH and health interventions in hospitals and sentinel sites.
  - Field Coordination Centres and Clusters at the sub-national level are responsible for monitoring, information dissemination and coordination at sub-national level.

- Further coordination structures involved are:
  - The UN Country Team.
  - The Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group to define joint messages for different audiences, including communication with communities, and disseminating reliable and updated information for the prevention and control of COVID-19. For media requests, it was agreed that all requests should be redirected to the PAHO/WHO focal point on communication (Sabina Rodriguez: rodrigusab@paho.org).
  - National NGO Forum.
  - International NGO Forum.

Key actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the authorities to prepare and monitor the National COVID-19 Prevention and Control Plan</td>
<td>PAHO/WHO</td>
<td>First month</td>
</tr>
<tr>
<td>Provide technical support to the Emergency Operational Committee (at national and state levels) and to CENAGRED (National Commission for Risk and Disaster Management) to coordinate the COVID-19 response</td>
<td>PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Strengthen the Hospitals and Essential Services sub-group (Health Cluster)</td>
<td>Health cluster</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Capacities and risk analysis assessments, with identification of vulnerable populations</td>
<td>OCHA, Clusters Coordinators</td>
<td>First month</td>
</tr>
<tr>
<td>Develop a cross-sectoral plan focused on complementary support by humanitarian organizations to the authorities’ efforts</td>
<td>OCHA, Clusters Coordinators</td>
<td>First month</td>
</tr>
<tr>
<td>Continuously monitor the evolution of humanitarian needs and the impact on humanitarian response</td>
<td>OCHA, Clusters Coordinators</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Create a working group led by the HC to review the progress of the efforts on a regular basis</td>
<td>HC, PAHO/WHO, UNICEF, Deputy HC/OCHA</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Mobilize resources and establish regular communication with donors</td>
<td>OCHA</td>
<td>2nd to 3rd month</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Ensure coordination with the competent authorities</td>
<td>RC/HC, Deputy HC, PAHO/WHO</td>
<td>1st to 3rd month / ongoing</td>
</tr>
<tr>
<td>Monitor the implementation of the cross-sectoral plan and produce periodic situation reports</td>
<td>OCHA, Clusters Coordinators</td>
<td>2nd to 3rd month</td>
</tr>
<tr>
<td>Identify spokespersons</td>
<td>Interagency Communications Taskforce on COVID-19 (UN System) and Humanitarian Communication Group</td>
<td>First month</td>
</tr>
<tr>
<td>Lessons learnt / After Action Review</td>
<td>OCHA, Clusters Coordinators</td>
<td>After the response</td>
</tr>
</tbody>
</table>
Component 6: Adaptation and continuity of humanitarian operations and humanitarian access

Situation

- The measures taken to prevent the spread of COVID-19, including distance measures and social quarantine, have created **challenges for the continuity of humanitarian operations**. The UN has activated plans to ensure the continuity of operations with remote working modalities and essential personnel continuing to work from the office. Some humanitarian actors in the field have suspended operations to minimize the spread of infection to staff and beneficiaries. Other organizations report continuity of activities but face logistical and access challenges due to the 'social quarantine'. An increased number of checkpoints to cross different jurisdictions restrict the movements of these organizations. Humanitarian organizations seek a balance between the need to prevent the transmission of the outbreak and the spread to staff and/or beneficiaries and responding to people’s humanitarian needs. Consequently, it focuses on sustaining life-saving humanitarian operations.

- Countrywide challenges to access fuel are a general concern. In Zulia, all regular petrol distribution is suspended and restricted to health and safety authorities. The suspension of regular petrol distribution in Tachira, announced on 15 March, has affected the operational capacity of humanitarian organizations, access to essential services for the population, and the capacity of rural producers to distribute food.

- Inputs for the distribution of prepared meals are already becoming more expensive.

- Reduced movement and activity may impact people’s access to information and accountability to affected populations.

- The closure of international points of entry has an impact on the arrival of humanitarian aid. Ports, warehouses and customs agents are operating on a more limited basis and with reduced staff. This may lead to delays in the processes that permit entrance of medicines and essential supplies. International staff from several organizations that support the implementation of the Humanitarian Response Plan, are facing difficulties due to flight cancellations from most countries of origin. The principle of staying and continuing assistance applies. However, some humanitarian personnel are in the country with expired or nearly expired visas, and this will affect their legal status in Venezuela (exceptions are being negotiated with the authorities). In order not to lose capacity in the humanitarian response, the aim is to avoid humanitarian workers having to leave the country without being able to return. The absence of a registration procedure for international NGOs under national legislation limits their capacity to respond since, without legal status in the country as an international organization, they cannot easily import goods and obtain working visas for international staff. Special agreements are being negotiated between the authorities and international NGOs to allow their presence legally and facilitate their work.

- The situation may result in increased stress for humanitarian staff, especially health workers and teams interacting with patients.

In this context, given the vulnerability of the population and the potential increase in humanitarian needs, it is important to ensure humanitarian presence and that critical humanitarian activities can continue while maintaining social distance. Also, humanitarian efforts must be prioritized and focus on the continuity of life-saving activities, particularly health and WASH. Ways to sustain these critical activities while limiting the spread of the virus and protecting humanitarian actors and beneficiaries must be explored. Infection prevention and control measures and the implementation of essential activities will increase the cost of the projects.

Solutions to mitigate the impact of the preventive measures on humanitarian activities:

- Negotiate movement permits (*salvoconductos*) for humanitarian organizations to be able to move and to enable cargo transport by land. As of 31 March, the COVID-19 the Presidential Commission had issued over 250 *salvoconductos*.

- Make progress in the discussions to ensure access to fuel through the *salvoconductos*.

- Find solutions for international NGO staff to remain and continue operating in the country.

- Find solutions to regularize the situation of international NGOs in the country.

- Support importation of supplies required to meet the objectives of the Plan.

Key actions
**INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN**

<table>
<thead>
<tr>
<th>Action</th>
<th>Humanitarian actors responsible for supporting the response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define, update and disseminate PAHO/WHO guidelines to humanitarian actors</td>
<td>PAHO/WHO</td>
</tr>
<tr>
<td>Define, update and disseminate sectoral guidelines for the reorganization/prioritization of activities</td>
<td>Clusters coordinators</td>
</tr>
<tr>
<td>Monitor and advocate for humanitarian access and the facilitation of the movement for humanitarian organisations and transport companies</td>
<td>OCHA</td>
</tr>
<tr>
<td>Provide psychological support to humanitarian actors</td>
<td>UNDSS, Working group on mental health and psychosocial support</td>
</tr>
<tr>
<td>Monitor the safety conditions for humanitarian actors</td>
<td>UNDSS</td>
</tr>
</tbody>
</table>

**Guidelines for humanitarian activities**

In the new context, it is important to find solutions and to reorganize humanitarian activities to limit the spread of the virus, to prioritize operations to contribute the prevention and response on COVID-19 and to mitigate the impact of the preventive measures. Returnees to Venezuela are especially vulnerable to COVID-19, partly because of their mobility. During quarantine they will be accommodated in temporary collective shelters, with high concentrations of people and shared sanitary facilities that may present challenges in maintaining the recommended social distance, in addition to the protection risks inherent to this type of accommodation. Returnees have restricted mobility during quarantine and will need assistance to cover their basic needs during this period.

**Cluster** | **Guidelines for partners on continuing action / reorganizing activities** |
---|---|
**GENERAL** | • Cease all activities that involve gathering people, including training and awareness-raising in communities.  
  • Reorganise meetings using remote modalities  
  • Disseminate / know PAHO/WHO guidelines:  
    o Procedures on how to assist suspected or confirmed COVID-19 cases in humanitarian workers  
    o General recommendations for the prevention of COVID-19 in offices  
    o General recommendations for the prevention of COVID-19 in communities |
LOGISTICS

- Develop a strategy to anticipate possible delays and disruptions in the supply chain especially at the international level and evaluate potential alternatives.
- Assess the capacity of national suppliers to anticipate possible supply shortages and explore alternative plans for the acquisition of essential supplies in operational areas.
- Develop standard operating procedures for the use of salvoconductos and guidelines to manage and transport humanitarian cargo.
- Identify humanitarian stocks in the country and prioritize areas of intervention.
- Prepare contingency plans for possible disruptions in distribution chains associated to preventive measures (e.g. transport of cargo near the delivery area/assisted communities, warehouse renting in the field, negotiate with suppliers on working modalities and guarantee salvoconductos for vehicles transporting and distributing humanitarian supplies).
- Assure that providers respect hygiene rules for the transport and storage of humanitarian supplies and consider measures recommended by PAHO for cargo handling:
  - Face masks and gloves are not required when handling cargo coming from affected countries.
  - Gloves must be used to protect from mechanical damages, e.g. in the case of rough surfaces.
  - Using gloves does not replace frequent hand cleaning and hygiene measures.
  - In case of disinfection of supplies or pallets, regular equipment is recommended, with no additional PPE kits required.

WASH

Priority actions:

- WASH/IPC in health centres.
- Continuous water tanker distribution in unserved areas.
- Continuity of activities to improve access to safe water in unserved sectors.
- Continuity of supplies / equipment for water disinfection and continuation of service.
- Promote personal hygiene practices, water treatment and storage, hygiene and IPC, for households and public spaces, using pre-existing tools that minimize the risk of propagation.
- Technical/material support (if viable) WASH/IPC for public spaces/services.
- Support the following households with hygiene kits/IPC:
  - With COVID-19 cases or group of cases in quarantine (if applicable).
  - Vulnerable households.

General guidelines for activities:


Specific guidelines:

In collaboration with other relevant clusters, the WASH Cluster will contribute to the development of guidelines to integrate IPC and other clusters’ key activities into WASH.
**INTERSECTORAL COVID-19 PREPAREDNESS AND RESPONSE PLAN**

**SHELTER, ENERGY AND NFI**

**Immediate actions:**

- Standardize protocols for hygiene and the observance in temporary shelters. Improve hygiene conditions and protocols for people in transit who have limited resources and stay overnight in temporary shelters.
- According to the cluster coordination functions, map active temporary shelters and those in the process of being established by different actors (including the Government), including designated spaces for quarantine to improve the coordination between the different actors.
- Adapt kits for people on the move with specific needs and shelter kits to respond to the COVID-19 outbreak, observing the Sphere standards and including IPC kits with face masks.
- Liaise with the relevant government authorities to build and maintain safe shelters located in border areas, especially for people on the move and returnees.
- Adapt the shelters located in border areas and other key locations to provide safe housing for people in need for extended periods and provide medium-term solutions for people affected by the COVID-19 outbreak who cannot move to another state due to the quarantine and other preventive measures.
- Distribute solar lamps and propose secondary sources of energy generation for health centres in remote areas without regular access to the national grid.
- Distribute hygiene kits to temporary shelters, to nursing and care homes for the elderly (including masks and gloves) and to outpatient clinics. In coordination with the Health Cluster, develop guidelines for nursing and care homes for the elderly.

**EDUCATION**

In response to the COVID-19 outbreak in the country, the education authorities decided to continue the rest of the school year through distance learning, as a preventive measure. In order to guarantee the right to education, the Ministry of the People's Power for Education (MPPE) has rescheduled activities with the Programme "Every Family, One School", switching all regular activities to non-attendance mode to ensure the continuity of services. ⁹

In the same way, the cluster has also prioritized activities according to three strategic pillars for emergency management and response: continuity of learning, preparedness, and return to school.

The first pillar - **continuity of learning** - plans immediate activities to ensure the continuity of learning for children in the country. The priority areas are:

- Support the continuity of learning and distance learning using modalities that ensure access for all children in equal conditions with self-directed accompanied pedagogical sessions, complemented with open educational tools to use during recreational time and provide individual educational materials.
- Ensure communication and dissemination of key messages on the importance of home schooling, prevention and coping with disease, protection, positive discipline, and health and hygiene using traditional and non-conventional resources.
- Support families and strengthen their capacities to address mental health and psychosocial support during the emergency, based on recreational methods disseminated within the population.
- Protect the most vulnerable by continuing school feeding programmes during

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⁹ [http://me.gob.ve/index.php/item-web/2-uncategorised/6637-cada-familia-una-escuela](http://me.gob.ve/index.php/item-web/2-uncategorised/6637-cada-familia-una-escuela)
the emergency, according to prevention and protection standards.

The second pillar - preparedness - focuses on activities to prepare school institutions for the return to school. The priority areas are:

- Support teaching capacities to implement distance learning modalities with quality and relevance, provide tools for self-care and competences for full welcome when returning to school.
- Coordinate contingency plans which include COVID-19 and return to school at the national and local levels to ensure children and adolescents remain at school.

The third pillar - return to school - involves activities to restore the system and enable an appropriate reception of children in schools. The priority areas are:

- Support the schools with learning resources to ensure a friendly and motivating reception for the children when they return to school.
- Support teachers and other educators with permanency and development allowances to ensure continuity and required capacities for the reopening of schools.

During these three interconnected phases, the direct and continuing technical assistance to the MPPE, as well as the programme "Every Family a School" (development and distribution of educational materials, planning and monitoring), will ensure the sustainability of the response. Likewise, intersectoral activities with WASH (distribution of hygiene kits, raising awareness and school infrastructure assessments before the return), Food Security (protocols for food distribution) and Protection (monitoring children diagnosed with COVID-19, psycho-social support, monitoring isolated children and GBV prevention after quarantine), and others, will ensure a comprehensive response.

Immediate actions:

- Mapping capacities for educational response to COVID-19
- Webinar: Alternatives for educational continuity in the face of the preventive closure of schools, 26 March 2020, Venezuela
- Webinar: Mental Health and Psychosocial Support (SMAPS): joint actions towards COVID-19, Venezuela

NUTRITION

The health services, including primary health care, ensure a nutrition strategy. The priority responses are to prevent the spread of infection among vulnerable groups (pregnant women, infants and children under 5) and to minimize the impact of COVID-19 on the nutritional status of vulnerable groups. Sessions with families to identify malnutrition cases have been suspended.

- Support the dissemination of messages to the population to prevent transmission and promote hygiene through the media and social networks.
- Prioritize hospitals and outpatient clinics at the state level to refer acutely malnourished children and ensure monitoring of moderate and severe acute malnutrition treatments.
- Ensure nutritional supplies are provided through partners for the treatment and monitoring of moderate and severe acute malnutrition.
- Support the health system for the assistance and management of moderate and severe acute malnutrition cases and support partners that provide screening, treatment and monitoring services for cases of malnutrition.
- Prevent and mitigate the secondary impacts of COVID-19: organize sessions with communities for the active scanning for acute malnutrition cases, after

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11 https://www.humanitarianresponse.info/fr/operations/venezuela/document/sistematizaci%C3%B3n-seminario-virtual-alternativas-para-lacontinuidad
12 https://www.youtube.com/watch?v=qZxq27SBApK
the infection prevention phase.

- Continue to strengthen health workers’ capacities regarding infants and young children feeding practices, after the phase of protection against COVID-19 exposure.

**PROTECTION**

- Coordinate with institutional counterparts to ensure response for vulnerable groups and the mitigation of protection risks.
- Provide essential protection services and urgent humanitarian assistance to the most vulnerable populations, including monitoring and reporting of, and response, to cases that impact the protection of people.
- Provide hotlines for counselling on protection in coordination with institutions.
- Develop key messages, guidelines and other material for awareness-raising, information and trainings - including the provision of specialized protection services, individual counselling and emergency humanitarian assistance during quarantine - for the most vulnerable populations and for humanitarian actors exposed to the COVID-19 transmission, in cooperation with national authorities and the UN Communications Group, if necessary.
- Support other clusters with technical assistance with the development of guides and other products as needed.
- Raise awareness against stigma and discrimination. Disseminate information products on COVID-19 prevention and procedures to follow in the event of suspected cases, adapted to the local context and prioritized communities, including radio campaigns and the use of social media.
- Monitor the impact on protection risks disaggregated by gender, age and disabilities, including discrimination in access to services, with a focus on border areas and communities. Identification of strategies for risk mitigation in collaboration with other clusters.
- Create, together with the Health Cluster, a working group on mental health and psychosocial support, to identify the needs in this area, develop products in coordination with the Communications Taskforce, and identify assistance modalities.

**HEALTH**

**Specific actions for humanitarian organizations:**

- Establish general recommendations for the prevention of COVID-19 in offices.
- Establish a continuous communication channel with Health Cluster partners (chat) as a platform to share official information and to clarify doubts about prevention, screening and treatment of COVID-19.
- Ensure strategies for coping with work-related stress resulting from long working hours.
- Ensure and standardize basic protection equipment for all employees at the headquarters and field offices.
- Ensure water, hygiene and sanitation supplies for essential personnel, particularly in workplaces.
- Ensure basic sanitation conditions in health facilities.
- Define the minimum requirements for essential personnel that must remain in workplaces for long periods of time.
- Identify health facilities to refer workers in case they are infected with COVID-19.

**Priorities for the continuity of operations:**

- Reorganize health care services giving priority to critical services.
- Prioritize hospitals for COVID-19 assistance.
- Establish hotlines for the population to address questions, report cases, etc.
• Negotiate with donors to extend the deadlines for implementation of operations and reporting.
• Adjust project activities to strengthen COVID-19 response.

Priority activities for the cluster:
• Purchase, distribute and/or deliver equipment, supplies, medicines, personal protection equipment to hospitals and outpatient clinics for suspected, probable and confirmed COVID-19 cases.
• Develop and/or distribute and/or publish information on COVID-19 for travellers, health employees and/or communities
• Strengthen staff capacities for the prevention, detection and management of COVID-19 cases.
• Strengthen community capacities on health promotion, COVID-19 prevention and case assistance.
• Assist with suspected, probable and confirmed COVID-19 cases (general medicine, specialized medicine, nursing, mental and psychosocial health, nutrition, therapeutic support)
• Strengthen information systems and epidemiological surveillance (including operational capacity of the Infections Committees)
• Monitor trends, needs, availability of services, and implementation of protocols in communities and health facilities

FOOD SECURITY
• Continue food distribution programmes in schools, hospitals and canteens, avoiding high concentrations of people.
  o Delivery of take away meals
  o Distribution of meals to small decentralized groups.
  o Converting some of the prepared meals distribution into non-prepared meals.
  o Transfer part of food distribution programmes to cash transfer programmes, based on the re-assessment of the basic food basket and according to developments in the situation.
• Continue cash transfer programmes and food support to families.
• Accompany partners with food supply in operational areas.
• National mapping of food supplies to reduce the risk of price increases due to shortages in specific locations.
• Use remote communication means for training on food security, nutrition and food production.
ANNEXES

Monitoring
The Intersectoral Plan will be monitored using KoBo Toolbox, where critical cluster activities have been included: https://ee.humanitarianresponse.info/x/#bEz1a9Qz. Bi-weekly reporting will be requested for the preparation of the situation report.

Financial Requirements
The methodology to estimate the cost of the Plan is based on the health, WASH, risk communication and community engagement activities.

- Health costs are based on an average cost estimate for the acquisition and maintenance of equipment, supplies, drugs, consumables and other essential items, for pre-hospital assistance, pre-triage, triage, recovery rooms, emergency, intermediate and intensive care, training and logistics.
- Costs for epidemiological surveillance and laboratory services include human resources, logistics, supplies, reactive, laboratory and PPE kits, and training.
- Costs for WASH/IPC interventions in hospitals are estimated on an average cost for WASH/IPC interventions in hospitals, including water supply (wells, restorations, pumps, tanks, etc.) and essential services (water storage, handwashing points and supplies, restoration of toilets, cleaning products and supplies and products for waste segregation).
- Costs for WASH interventions in communities are estimated on an average cost for the WASH package per beneficiary. The number of beneficiaries has been identified based on the number of people in need for WASH living in urban areas (with higher population density) for the ten prioritized states, and the operational response capacity based on the HRP 2020 objectives. The targeted population is approximately 510,000 people.
- Costs for communication activities are based on estimates to implement key actions (design and printing of communication products, production and dissemination of radio spots, sending SMS, distribution and transportation of supplies, translation to indigenous languages, etc.), with a focus on vulnerable populations in the priority areas defined by WASH and Health Clusters, considering that some of the activities will reach a national coverage (campaigns using social media, and others).
- The costs for the support of the temporary accommodation centres were calculated on the basis of an average cost of rehabilitation of the priority centres, the average cost of assistance per person for 15 days of quarantine in the temporary accommodation centres, including food, basic items and WASH/IPC, and the cost of maintenance of the centre. During the first phase, estimates show the need to support the rehabilitation of 23 priority temporary accommodation centres (18 centres with minor rehabilitations, and five centres with major rehabilitations, based on an assessment of existing capacity), and to assist 20,000 people during a first phase.

Costs for other key activities are included in the HRP. Under this scenario, the reorganization of some activities already foreseen in the HRP and cross-cutting activities for infection prevention and control included in the clusters’ projects will probably increase the costs. This will ensure a responsible implementation of key activities (including waste management, distribution of cleaning products, training on IPC, distribution of PPE kits, hygiene promotion, handwashing points, etc.).

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<thead>
<tr>
<th>Concept</th>
<th>Cost (USD)</th>
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<tr>
<td>Epidemiological surveillance and laboratory services</td>
<td>9.350.000</td>
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<td>Health interventions in 14 prioritized hospitals</td>
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<td>WASH/IPC interventions in 16 prioritized hospitals</td>
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<td>Risk communication and community engagement</td>
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<td>Shelter - rehabilitation in 23 temporary accommodation centres</td>
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<td>Shelter / WASH / Food security - support in temporary accommodation centres for 20,000 people over 15 days</td>
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<td>Technical and logistical support</td>
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<td><strong>TOTAL</strong></td>
<td><strong>72.100.000</strong></td>
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Useful links

All available communication products from reliable sources can be found at:
- Two folders containing protocols and technical documents shared by the Ministry of the People’s Power for Health: https://drive.google.com/drive/folders/1_u1iHDwyvC7gcNVo1sIRQw9_GXpYMFDc9
- Information products and social media: https://drive.google.com/drive/folders/1oBbYw3KGg-k8W4K68yC2b2aqg5occNHJ
- PAHO website: www.paho.org/coronavirus
- Trello Board with COVID-19 official communication products: https://trello.com/b/snT6vSCu/covid-19

List of 46 hospitals and sentinel sites

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<th>Nº</th>
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<th>HEALTH FACILITY</th>
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<td>PTO. AYACUCHO</td>
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<tr>
<td>7</td>
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<td>LAMAS MUNICIPALITY</td>
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<td>GRAN SABANA</td>
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<td>SAN CARLOS</td>
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<td>12</td>
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<td>III</td>
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<td>O</td>
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<td>GUARICO</td>
<td>ISRAEL RANUAREZ BALZA</td>
<td>III</td>
<td>S.J. DE LOS MORROS</td>
</tr>
</tbody>
</table>
### List of temporary accommodation centres

At the national level, not all the temporary accommodation centres for returnees have been yet identified. A total of 71 temporary accommodation centres have been mapped in seven states (Amazonas, Apure, Bolivar, Carabobo, Sucre, Tachira and Zulia) with a total capacity for 3,664 people.

This mapping is regularly updated and can be consulted at the following link: [http://unhcr.maps.arcgis.com/apps/opsdashboard/index.html#/697aae3a1f8f4ff5ce4c5d7761fabd1](http://unhcr.maps.arcgis.com/apps/opsdashboard/index.html#/697aae3a1f8f4ff5ce4c5d7761fabd1)
# Key contacts

## VENEZUELA - COUNTRY HUMANITARIAN COORDINATION CONTACTS

<table>
<thead>
<tr>
<th>Coordination</th>
<th>WASH</th>
<th>Health</th>
<th>Shelter, Energy and NFI</th>
<th>Nutrition</th>
<th>Logistics</th>
</tr>
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<tbody>
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<td><strong>Henry Renna</strong>&lt;br&gt; <a href="mailto:educacion.van@redum.org">educacion.van@redum.org</a>&lt;br&gt; +58 997640196 (WA)</td>
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<td><strong>Dominique de Juriew</strong>&lt;br&gt; <a href="mailto:dejuriew@unicef.org">dejuriew@unicef.org</a>&lt;br&gt; +58 4149235586</td>
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