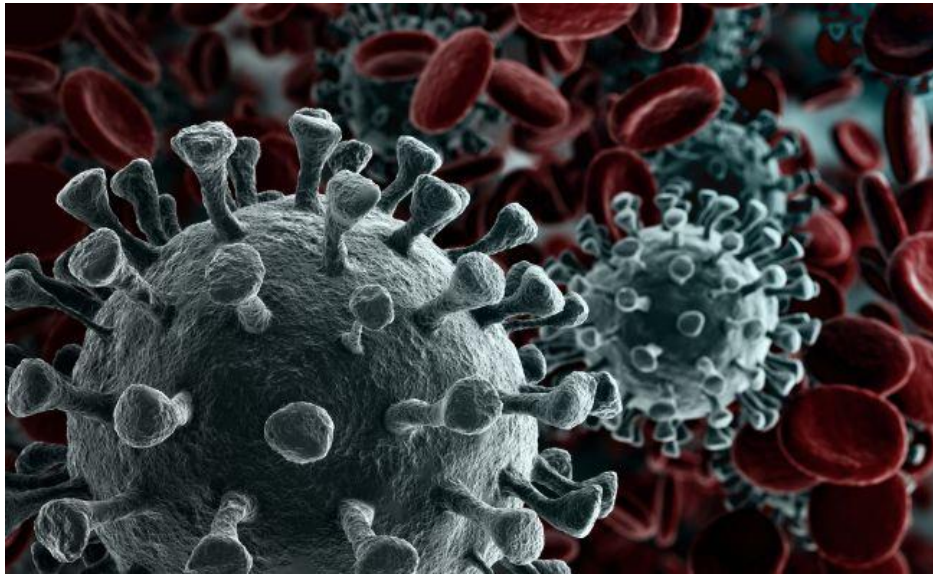




ZIMBABWE PREPAREDNESS AND RESPONSE PLAN



CORONAVIRUS DISEASE 2019 (COVID-19)



MINISTRY OF HEALTH AND CHILD CARE

March 2020

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FOREWORD

On 30th January 2020, the Director General of the World Health Organization declared the outbreak of the coronavirus disease 2019 (COVID-19) in January 2020 a Public Health Emergency of International Concern (PHEIC).

The Government of Zimbabwe through the Ministry of Health and Child Care (MOHCC) immediately instituted actions to enhance the status of preparedness and capacity to respond to the COVID-19 outbreak. A team of senior Government officials led by the Hon Minister of Health and Child Care undertook an assessment of preparedness at the major points of entry into Zimbabwe as well as in hospitals designated as the main isolation facilities in the country. Inter-ministerial meetings to discuss priority actions to ensure that Zimbabwe is well prepared to respond to this outbreak were convened. These meetings brought together stakeholders from Government ministries, agencies, departments; private sector partners; civil society; academia and professional associations; technical and donor partners and the media. At the technical level, MOHCC convened meetings of the Interagency Coordination Committee on Health (IAACH) and Epidemic Preparedness and Response (EPR) Task Force.

The findings of the assessment activities as well as the deliberations from the above meetings guided the development of this national preparedness and response plan for coronavirus disease 2019 (COVID-19). We also reviewed the Zimbabwe Preparedness and Response Plan for Pandemic Influenza A H1N1 (June 2009). Between November-December 2019, MOHCC with the support of WHO and other partners conducted assessment and simulation exercises to enhance Zimbabwe's core capacities under the International Health Regulations (2005). These included the Public Health Emergency Operations Centre simulation exercise (Dec 2019), Ebola Virus Disease simulation exercise (Dec 2019) and after-action review of the 2018/2019 Cholera outbreak in Zimbabwe (Dec 2019). The relevant recommendations from these important activities have been included in the preparation of the national preparedness and response plan to COVID-19

The overall goal of Zimbabwe's nation preparedness and response plan is to minimize morbidity and mortality of COVID-19 in Zimbabwe and associated adverse socio-economic impact in a manner that would strengthen national core capacities under IHR (2005) and contribute to overall health system strengthening. It is very urgent that priority activities in this plan are implemented rapidly and effectively starting with the highest risk areas and then extending to ensure that every community in Zimbabwe is adequately protected. This will require a whole-of-government and whole-of-society approach.

The Ministry of Health and Child Care looks forward to working very closely with stake-holders from across Government, private sector, civil society, academia, professional associations, private-not-for profit sector, community-based organizations, religious leaders, traditional leaders, international organizations in the very crucial next few weeks and months.

Dr Obadiah MOYO

Honorable Minister

MINISTRY OF HEALTH AND CHILD CARE

ACKNOWLEDGEMENTS

The Ministry of Health and Child Care extends gratitude and appreciation to all individuals and representatives of Government ministries, civil society, NGOs, private sector, development partners, academia, professional associations who made contributions to the development of this plan.

We are particularly grateful to all those who participated in the inter-ministerial meetings on COVID-19 convened by the Honorable Minister of Health in February and early March 2020, Inter-agency Coordination Committee on Health (IAACH) and Epidemic Preparedness and Response Task Force meetings. Several national professional organizations conducted symposiums and workshops on preparedness for COVID-19 and the recommendations from these important activities were also fed into the preparation of this plan. We are very grateful to you all.

Front-line health workers including port health workers at points of entry, staff of designated isolation centers as well as rapid response teams in several parts of the country are already implementing several priority activities included in this plan. We are very grateful to you.

Initial funding to support implementation of this plan has been provided by the Government of Zimbabwe. We are also grateful to several partners from private sector, NGOs as well as from members of the international community who are already providing technical, financial and logistical support that is already supporting implementation of key activities in the plan.

The rapid and full-scale implementation of all priority activities in this plan will require additional technical, financial and logistical resources from all stakeholders.

Ensuring safety of all front-line health workers to ensure that they can continue delivering essential health services while at the same time implementing priority actions to prevent and/or contain COVID-19 is a very high priority in this plan. The Ministry of Health and Child Care is especially grateful to all stakeholders and partners who are supporting this key priority.

Dr Agnes MAHOMVA

Permanent Secretary

MINISTRY OF HEALTH AND CHILD CARE

1. Background

1.1. Overview of COVID-19 outbreak

On 31 December 2019, WHO received a report of a cluster of pneumonia patients in Wuhan City, Hubei Province of China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a novel (new) coronavirus as the cause of the pneumonia. The virus was named 2019-nCoV, later renamed COVID-19.

WHO Director General convened meetings of the International Health Regulations (2005) Emergency Committee on the outbreak of novel coronavirus (n-CoV) on the 23rd and 30th January 2020. Following the recommendation of the IHR (2005) Emergency Committee, WHO Declared the outbreak a Public Health Emergency of International Concern on the 30th January 2020. In line with recommendations issued by the IHR (2005) Emergency Committee, all countries were urged to prepare for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of further human-to-human transmission of the virus. All countries were urged to share full data with WHO. The committee did not recommend any travel or trade restriction based on the epidemiological information available at the time.

The IHR (2005) emergency committee recommended to the global committee to continue to demonstrate solidarity and cooperation, in compliance with article 44 of the IHR (2005), particularly in supporting the identification of the source of the new virus, its potential for human-to-human transmission and research for developing necessary treatment. The global community was urged to provide support to low- and middle-income countries to enable their response to the outbreak as well as to facilitate access to diagnostics, potential vaccines and therapeutics.

All continents of the world have now reported confirmed COVID-19 cases. As of 16 March 2020, a total of 169,387 cases had been reported from 148 countries. China accounts for 48% of all the cases reported globally (81,020 cases)¹.

1.2. Overview of Zimbabwe's 2020 National Preparedness and Response Plan for COVID-19

The Government of Zimbabwe through the Ministry of Health and Child Care took immediate action to enhanced preparedness to respond to COVID-19 outbreak. The first actions were taken on 24 January 2020 in response to the recommendations of the 23 January 2020 IHR (2005) Emergency Committee meeting. These activities included the development of a national preparedness and response plan for COVID-19.

The overall goal of Zimbabwe's national preparedness and response plan is to minimize morbidity and mortality resulting from COVID-19 and associated adverse socio-economic impact in Zimbabwe while strengthening national core capacities under IHR (2005). The plan includes prevention, containment and mitigation strategies in line with the different COVID-19 transmission scenarios. The implementation of the priority activities in this plan are expected to contribute to overall health systems strengthening.

¹ Johns Hopkins University Coronavirus Resource Center-Accessed 16 March 2020

The national preparedness and response plan for COVID has 8 pillars, aligned to WHO's global 2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan (Feb 2020)²;

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

The process of developing Zimbabwe's 2020 national preparedness and response plan for COVID-19 was informed by the following activities:

- i. Deliberations and recommendations from inter-ministerial meeting on COVID-19 preparedness convened by the Honorable Minister of Health and Child Care (MOHCC) in February-March 2020;
- ii. Deliberations and recommendations from meetings of the Inter-Agency Coordination Committee on Health (IACCH) and the National Emergency Preparedness and Response (EPR) Task Force in January-February 2020;
- iii. Assessments of status of preparedness of major Points of Entry (POEs) as well as major isolation health facilities in the country, Feb 2020;
- iv. Deliberations from workshops convened by several professional organizations including the Zimbabwe College of Primary Care Physicians, Zimbabwe College of Public Health Physicians; the Urban Councils Association of Zimbabwe (UCAZ) in response to the COVID-19 in February 2020
- v. A review of the Zimbabwe Preparedness and Response Plan for Pandemic Influenza A H1N1 (June 2009).
- vi. A review of recommendations from recent assessment and simulation exercises to enhance Zimbabwe's IHR (2005) core capacities including Public Health Emergency Operations Centre simulation exercise (Dec 2019), Ebola Virus Disease simulation exercise (December 2019) and report of after action review of the 2018/2019 Cholera outbreak in Zimbabwe (December 2019).
- vii. Review of the report of the national consultation convened by the Ministry of Health and Child Care on the implementation of the 2018 Public Health Act (August 2019)
- viii. Review of status of Zimbabwe's core capacities under IHR (2005) including most recent state party self-assessment annual reporting tools (2019 and 2018) as well as report of Joint External Evaluation (2017)
- ix. Review of WHO guidance documents on preparedness and response to COVID-19 outbreak including the WHO-China Joint Mission on COVID-19

² WHO (February 2020). 2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan

2. Situation Analysis

2.1. COVID-19 outbreak Globally

On 11th March 2020, WHO Director General declared that the COVID-19 outbreak was a pandemic. Two reasons contributed to this declaration:

- The speed and scale of transmission of COVID-19. As at that time (11 March 2020), a total of 125,000 cases had been reported to WHO from 118 countries and territories. In a 2-week period the number of cases reported outside China had increased 13-fold.
- The fact that several countries had not heeded to recommendations of WHO to scale up preparedness and response capacities.

It was emphasized that the COVID-19 pandemic was controllable if countries adopted a comprehensive approach tailored to their circumstances, striking a fine balance between protecting health, preventing economic and social disruptions and respecting human rights.

All WHO member states were encouraged to adopt a four-pronged strategy:

- i. Enhanced preparedness and readiness
- ii. Strengthen capacity for detection, prevention and treatment
- iii. Strengthen capacity to reduce and suppress transmission
- iv. Strengthen capacity for innovation and improvement

The number of confirmed COVID-19 cases reported to WHO continue to rise. The number of new countries reporting confirmed COVID-19 cases also continues to rise. As of 16 March 2020, a total of 169,387 cases had been reported from 148 countries. China accounts for 48% of all the cases reported globally (81,020 cases)³.

2.2. COVID-19 situation in the African Region

As of 16 March 2020, twenty-five countries in the African continent had reported a total of 353 confirmed COVID-19 cases⁴. Most of the cases in the African continent followed importations from Europe and North America.

Several regional and sub-regional meetings of Ministers of Health have been convened at the level of the African Union as well as at the level of the Regional Economic Commissions. The resolutions of these meetings have been in line with guidance from the WHO and the Africa CDC to enhance level of preparedness for COVID-19.

³ Johns Hopkins University Coronavirus Resource Center-Accessed 16 March 2020

⁴ Algeria (48 cases), Burkina Faso (7 cases), Cameroon (4 cases), Central Africa Republic (1 case), Congo (1 case), Cote D'Ivoire (1 case), Democratic Republic of Congo (1 case), Egypt (126 cases), Ethiopia (4 cases), Eswatini (1 case), Equatorial Guinea (1 case), Gabon (1 case), Ghana (6 cases), Guinea (1 case), Kenya (3 cases), Mauritania (1 case), Morocco (28 cases), Namibia (2 cases), Nigeria (2 cases), Rwanda (5 cases), Senegal (24 cases), Seychelles (3 cases), South Africa (61 cases), Togo (1 case) and Tunisia (20 cases).

2.3. COVID-19 situation in Zimbabwe

As of 14th March 2020, Zimbabwe had no confirmed COVID-19 case. A total of seven travelers that met the case definition of suspect case had been investigated. All these cases had negative laboratory results for COVID-19.

Several key preparedness activities have been implemented in response to the COVID-19 outbreak globally, in the African region.

The Government of Zimbabwe through the Ministry of Health and Child Care (MOHCC) has led the development of a first draft of national preparedness and response plan for COVID-19. As of 6th March 2020, Government of Zimbabwe has provided ZWL\$2 Million to the MOHCC for implementation of the National Covid-19 Preparedness and Response Plan. Priority was given to provinces to conduct self-readiness assessments of their Points of Entry (PoE) and isolation facilities and strengthen sensitization and training of districts on COVID-19 as well as procurement of personal protective equipment.

The Honorable Minister of Health and Child Care has convened 2 Inter-ministerial meetings to review and identify priority activities for preparedness to COVID-19. These meetings, held on 5th February 2020 and 2nd March 2020 respectively brought together key stakeholders from Government, private sector, academia, development partners and the media. The key issues covered during the most recent meeting held on 2nd March 2020 included:

- i. There were no confirmed cases of COVID-19 in Zimbabwe;
- ii. The national and sub-national Rapid Response Teams (RRTs) have been activated;
- iii. Capacity building of Health care workers and port health staff to screen, detect and manage suspects is ongoing.
- iv. Laboratory capacity to detect the virus is available locally, with a similar facility for out of country verification at the NICD in South Africa;
- v. Screening of travelers entering the country through major entry points is ongoing;
- vi. Facilities for isolation of suspected cases have been set up at Wilkins Infectious Disease Hospitals in Harare, and Thorngrove Infectious Disease Hospital in Bulawayo. MOHCC is in the process of strategically setting up other isolation centers in Mutate, Masvingo, Kadoma and Gweru.

2.3.1 Coordination

Rapid Response Teams have been activated in all the Provinces, districts and cities. The RRTs meet on a regular basis to monitor implementation of COVID-19 preparedness and response activities including surveillance of travelers from COVID-19 affected countries. The Honorable Minister of Health and Child Care addressed Parliament and Senate on COVID 19 as part of awareness creation and risk communication on COVID-19. Two Inter-Ministerial meetings and two Inter-Agency Coordination Committees on Health (IACCH) meetings have been convened since the declaration of COVID-19 as a Public Health Emergency of International Concern.

2.3.2 Points of Entry and Surveillance

Screening of travelers arriving from countries with confirmed COVID-19 cases commenced on the 24th of January 2020. As of 11 March 2020, a total of 9,505 travelers arriving from China and other countries with

confirmed COVID-19 cases were screened at the major points of entry into Zimbabwe. Seven (7) travelers had symptoms on arrival in Zimbabwe these were referred to Wilkins Hospital for isolation and subsequent testing. All these cases subsequently tested negative and were discharged.

2.3.4 Laboratory

A total of 7 suspected cases were tested using Polymerase Chain Reaction (PCR) at the National Microbiology Reference Laboratory, (NMRL). All samples tested negative. Quality control samples are sent to the South African National Institute of Communicable Diseases (NICD). To date all samples tested at NICD have been negative. The country has three sets of primers from AU-CDC, China and WHO. One scientist received training on COVID-19 testing at the National Institute of Communicable Diseases in South Africa. The country is in the process of acquiring Rapid Diagnostic Tests, (RDTs) for COVID-19 for use at Points of entry.

2.3.5 Case Management and Infection Prevention and Control (IPC)

Isolation hospitals have been designated at Wilkins Infectious Diseases Hospital, and Thorngrove Infectious Diseases Hospitals in Harare and Bulawayo respectively. In addition to the above, MOHCC has identified Kadoma, Mutare, Masvingo and Gweru as sites targeted for setting up isolation centres to be used for testing and treatment of COVID-19 cases.

Wilkins Hospital admitted seven travelers from China (3), Bahrain (1), Thailand (1) and Dubai (1). PCR tests were done for the seven suspects and they all tested negative.

As part of building capacity of MOHCC staff on case management and Infection Prevention and Control for COVID-19, the Government seconded 4 MOHCC staff members as well as staff from local authorities to attend training conducted by the Africa Centers for Disease Control (Africa CDC), WHO and other partners.

On the 2nd of March 2020, Bulawayo City Council held a sensitization meeting which was attended by 28 health care workers drawn from the health facilities within the city. The health care workers had an opportunity to familiarize themselves with the Thorngrove Infectious Diseases Hospital which the major isolation centers in the southern part of the country. A drill on doffing and donning PPEs was also done.

Between 9th-14th March 2020, MOHCC with financial support from Government and partners conducted a meeting to capacitate health workers on the eight pillars of COVID-19 preparedness and response.

The private sector has also played a pivotal role in COVID 19 through mobilization of resources and sensitization of health care workers.

2.3.6 Rapid Response Teams

All the Provincial and city RRTs have been activated for COVID 19 and these also assist in surveillance of travelers from COVID-19 affected countries. The membership of the RRTs are in line Integrated Disease Surveillance and Response (IDSR) national guidelines. These are closely aligned to the eight pillars of COVID-19 preparedness and response.

2.3.7 Risk Communication

A Risk Communication strategy for COVID-19 has been developed. The strategy incorporated standard messages for dissemination to key stakeholders, population groups and the entire nation.

3. Goal and Objectives

3.1. Goal

The overall goal of Zimbabwe's national preparedness and response plan is to minimize morbidity and mortality resulting from COVID-19 and associated adverse socio-economic impact in Zimbabwe while strengthening national core capacities under IHR (2005). The plan includes prevention, containment and mitigation strategies in line with the different COVID-19 transmission scenarios. The implementation of the priority activities in this plan are expected to contribute to overall health systems strengthening.

3.2. Specific Objectives

- a) To coordinate, plan and monitor an effective multisectoral response to Covid-19
- b) To enhance surveillance at all levels to enable early detection and response
- c) To strengthen case management and infection prevention and control practices at health facilities and the community
- d) To support the implementation of risk communication and community engagement strategies
- e) To provide operational/logistics support and supply management and maintain adequate stocks, equipment and supplies for COVID-19 preparedness and response activities.
- f) To enhance the provision of adequate safe water and sanitation for the covid-19 response

3.3. Lessons from the global response to COVID-19

Important lessons in responding to this outbreak were documented by the WHO-China Joint mission on COVID-19 conducted during the period 16-24 February 2020. All countries are advised to plan for different scenarios, first case, first cluster of cases and first evidence of community transmission.

It is important to plan for both containment and mitigation measures in responding to COVID-19. Containment measures are the activities that are aimed at interrupting transmission. These activities include timely detection of cases, isolation of cases and contact tracing and follow up.

Mitigation measures are taken when there is widespread transmission of the virus and countries focus on reducing the impact of the virus by treating patients, encouraging research and development of vaccines and doing everything to reduce the impact on society including on the health system.

The main recommendations of the WHO-China joint mission were as follows:

3.3.1. Countries with imported cases and/or outbreaks of COVID 19

- i. Immediately activate the highest level of national Response management protocols to ensure the all-of-government and all-of-society approach needed to contain COVID-19 with non-pharmaceutical public health measures;
- ii. Prioritize active, exhaustive case finding and immediate testing and isolation, painstaking contact tracing and rigorous quarantine of close contacts;
- iii. Fully educate the public on the seriousness of COVID-19 and their role in preventing its spread;
- iv. Immediately expand surveillance to detect COVID-19 transmission chains by testing all patients with atypical pneumonia, conducting screening in some patients with upper respiratory illness

and/or recent COVID-19 exposure and adding testing for the COVID-19 virus to existing surveillance systems (eg sentinel systems for influenza-like illness and SARI);

- v. Conduct multi-sector scenario planning and simulations for the deployment of even more stringent measures to interrupt transmission chains as needed eg the suspension of large-scale gatherings, closure of schools and work-places.

3.3.2. Uninfected countries

- i. Prepare to immediately activate the highest level of emergency response mechanisms to trigger the all-of-Government and all-of-society approach that is essential for the early containment of a COVID-19 outbreak;
- ii. Rapidly test the country's national preparedness plan in light of new knowledge on the effectiveness of non-pharmaceutical measures against COVID-19; incorporate rapid detection, largescale case isolation and respiratory support capacities, rigorous contact tracing and management in national COVID-19 readiness and response plans and capacities;
- iii. Immediately enhance surveillance for COVID-19 as rapid detection is crucial to containing spread; consider testing all patients with atypical pneumonia for COVID-19 virus and adding testing for the virus to existing influenza surveillance systems;
- iv. Begin to enforce rigorous application of infection prevention and control measures in all health facilities especially in emergency departments and outpatient clinics as this is where COVID-19 will enter the health system
- v. Rapidly assess the general populations understanding of COVID-19, adjust health promotion materials and activities accordingly and engage clinical champions to communicate with the media.

3.3.3. The Public

- i. Recognize that COVID-19 is a new and concerning disease but that outbreaks can be managed with the right response and that the vast majority of infected people will recover
- ii. Begin to adopt and rigorously practice the most important preventive measures for COVID-19 by frequent hand washing and always covering your mouth and nose when sneezing or coughing;
- iii. Continually update yourself on COVID-19 and its signs and symptoms because the strategies and response activities will constantly improve as new information on the disease is accumulating every day
- iv. Be prepared to actively support a response to COVID-19 in a variety of ways including the adoption of more stringent social distancing practices and helping the high-risk elderly population.

3.3.4. The international community

- i. Recognize that true solidarity and collaboration is essential between nations to tackle the common threat that COVID-19 represents
- ii. Rapidly share information as required under IHR (2005)
- iii. Recognize the rapidly changing risk profile of COVID-19 affected countries and continually monitor outbreak trends and control capacities to reassess any additional health measures that may significantly interfere with international travel and trade.

Planning Scenarios

There are 3 strategic priorities for enhancing preparedness and response capacities for COVID-19 and these are:

- Slow and stop transmission, prevent outbreaks and delay spread
- Provide optimized care for all patients, especially the seriously ill
- Minimize the impact of the epidemic on health systems, social services and economic activity

Four transmission scenarios for COVID-19 have been identified:

- Scenario 1: No cases of confirmed COVID-19: A country has no confirmed COVID-19 cases
- Scenario 2: Sporadic cases: A country has one or more cases, imported or locally detected
- Scenario 3: Cluster of cases: A country experiencing clusters in time, geographic location and/or common exposure
- Scenario 4: Community transmission: A country experiencing larger outbreaks of local transmission.

The critical preparedness, readiness and response actions for each transmission scenario is summarized below:

3.4. No cases

In this transmission scenario, the country has not reported any confirmed COVID-19 cases.

4.1.1. Aim: Stop transmission and prevent spread

4.1.2. Emergency response mechanism: Activate emergency response mechanisms

4.1.3. Risk communication and public engagement: Educate and actively communicate with the public through appropriate risk communication and community engagement channels

4.1.4. Case Finding, contact tracing and management: Conduct active case finding, contact tracing and monitoring; quarantine of contacts and isolation of cases

4.1.5 Surveillance: Consider testing for COVID-19 using existing respiratory disease surveillance systems and hospital-based surveillance

4.1.6. Public Health measures: Promote hand hygiene, respiratory etiquette, social distancing

4.1.7. Laboratory testing: Test suspect cases per WHO case definition, contacts of confirmed cases; test patients identified through respiratory disease surveillance

4.1.8. Case management: Prepare to treat patients. Ready hospitals for potential surge. Promote self-initiated isolation of people with mild respiratory symptoms to reduce the burden on the health system

4.1.9. Infection prevention and control: Train staff in infection prevention and control and clinical management for COVID-19. Prepare for surge in health care facility needs including respiratory support and PPE

4.1.10. Societal response: Develop all-of-society and business continuity plans

3.5. Sporadic cases

In this transmission scenario, the country has one or more cases, imported or locally acquired.

4.2.1. Aim: Stop transmission and prevent spread

4.2.2. Emergency response mechanism: Enhance emergency response mechanisms

4.2.3. Risk communication and public engagement: Educate and actively communicate with the public through appropriate risk communication and community engagement channels

4.2.4. Case Finding, contact tracing and management: Enhance active case finding, contact tracing and monitoring; quarantine of contacts and isolation of cases

4.2.5. Surveillance: Implement COVID-19 surveillance using existing respiratory disease surveillance systems and hospital-based surveillance

4.2.6. Public Health measures: Promote hand hygiene, respiratory etiquette, social distancing

4.2.7. Laboratory testing: Test suspect cases per WHO case definition, contacts of confirmed cases; test patients identified through respiratory disease surveillance

4.2.8. Case management: Treat patients. Ready hospitals for potential surge. Promote self-initiated isolation of people with mild respiratory symptoms to reduce the burden on the health system

4.2.9. Infection prevention and control: Train staff in infection prevention and control and clinical management for COVID-19. Prepare for surge in health care facility needs including respiratory support and PPE

4.2.10. Societal response: Implement all-of-society, repurpose Government (as per degree of the Office of the President and Cabinet) and ready business continuity plans

3.6. Clusters of cases

In this transmission scenario, the country has cases of local transmission, most of which can be lined to chains of transmission.

4.3.1. Aim: Stop transmission and prevent spread

4.3.2. Emergency response mechanism: Scale up emergency response mechanisms

4.3.3. Risk communication and public engagement: Educate and actively communicate with the public through appropriate risk communication and community engagement channels

4.3.4. Case Finding, contact tracing and management: Intensify active case finding, contact tracing and monitoring; quarantine of contacts and isolation of cases

4.3.5. Surveillance: Expand COVID-19 surveillance using existing respiratory disease surveillance systems and hospital-based surveillance

4.3.6. Public Health measures: Promote hand hygiene, respiratory etiquette, social distancing

4.3.7. Laboratory testing: Test suspect cases per WHO case definition, contacts of confirmed cases; test patients identified through respiratory disease surveillance

4.3.8. Case management: Treat patients. Ready hospitals for potential surge. Enhance triage procedures; activate surge plans for health facilities-designate referral hospitals, defer elective procedures. Promote self-initiated isolation of people with mild respiratory symptoms to reduce the burden on the health system

4.3.9. Infection prevention and control: Train staff in infection prevention and control and clinical management for COVID-19. Advocate for home care for mild cases if health systems are overwhelmed and identify referral systems for high risk groups.

4.3.10. Societal response: Implement all-of-society resilience, repurpose Government and business continuity and community services plans

3.7. Community Transmission

In this transmission scenario, the country has large outbreaks and is unable to relate confirmed cases through chains of transmission for many cases or by increasing positive tests through sentinel sampling (routine systematic testing of respiratory samples from established laboratories).

4.4.1. Aim: Slow transmission, reduce case numbers, end community outbreaks

4.4.2. Emergency response mechanism: Scale up emergency response mechanisms

4.4.3. Risk communication and public engagement: Educate and actively communicate with the public through appropriate risk communication and community engagement channels

4.4.4. Case Finding, contact tracing and management: Continue contact tracing where possible especially in newly infected areas; quarantine of contacts and isolation of cases; apply self-initiated isolation for symptomatic individuals

4.4.5. Surveillance: Adapt existing surveillance systems to monitor disease activity eg through sentinel sites

4.4.6. Public Health measures: Promote hand hygiene, respiratory etiquette, social distancing

4.4.7. Laboratory testing: Test suspect cases per WHO case definition, test patients identified through respiratory disease surveillance. If testing capacity is overwhelmed, prioritize testing in health care settings and vulnerable groups. In closed settings test only the first symptomatic suspect cases.

4.4.8. Case management: Prioritize care and activate triage procedures. Scale up surge plans for health facilities (designate referral hospitals, defer elective procedures). Implement self-initiated isolation of people with mild respiratory symptoms to reduce the burden on the health system

4.4.9. Infection prevention and control: Re-train staff in infection prevention and control and clinical management for COVID-19. Implement health facilities surge plan.

4.4.10. Societal response: Implement all-of-society resilience, repurpose Government and business continuity and community services plans

4. Priority Activities

4.1. Pillar 1: Coordination, planning and monitoring

National public health emergency coordination mechanisms at national and the appropriate sub-national levels should be activated with engagement of relevant multisectoral actors from relevant Government ministries, regulatory authorities; nongovernmental organizations; private sector; civil society; academia and development partners amongst others.

The priority activities to be implemented by the multisectoral coordination mechanism at **national level** include:

- i. Development of national COVID-19 preparedness and response plan and budget. This could be done by updating existing pandemic influenza preparedness plan;
- ii. Conduct initial capacity assessment and risk analysis including mapping of vulnerable populations
- iii. Develop a monitoring and evaluation mechanism and use this to assess the impact of planned activities
- iv. Establish an incident management system in line with Zimbabwe Standard Operating Procedures (SOPs) for activating and deactivating the Public Health Operations Center (PHEOC)
- v. Identify, train and designate spokespersons
- vi. Ensure regular coordination meetings with key stakeholders from relevant government ministries, private sector, development partners, civil society, academia
- vii. Review regulatory requirements and legal basis for all potential public health measures in line with Public Health Act 2018 and other relevant legislation
- viii. Monitor the implementation of the national COVID-19 preparedness and response plan and produce regular situation reports
- ix. Conduct after-action reviews in accordance with IHR (2005)
- x. Document lessons learned and incorporate these into updated national emergency preparedness and response plan/National Action Plan on Health Security as well as National Health Strategic Plan

The priority activities to be implemented by the multisectoral mechanisms at **provincial level** include:

- i. Review and update provincial emergency preparedness and response plans to incorporate appropriate priority actions from the national COVID-19 preparedness and response plan and budget.
- ii. Conduct initial capacity assessment and risk analysis at provincial and district level. This should include mapping of vulnerable populations
- iii. Develop a monitoring and evaluation mechanism and use this to assess the impact of planned activities at provincial and district level
- iv. Activate the Provincial Emergency Preparedness and response coordination mechanisms and ensure regular meetings.
- v. Ensure regular coordination meetings with key stakeholders from relevant government ministries, private sector, development partners, civil society, academia
- vi. Monitor the implementation of the provincial COVID-19 preparedness and response plan and produce regular situation reports

- vii. Document lessons learned from implementation of updated provincial emergency preparedness and response plans.

4.2. Pillar 2: Risk Communication and community engagement

Communication is essential in providing information to the public that will equip them with stronger coping mechanisms for COVID-19. Risk communication is the real-time exchange of information and advice between authorities and experts and the people and communities who are at risk. Accurate information provided early and often and in language and channels that people use and trust will enable communities to understand the health risks they face and take the action required to protect themselves and others. It is crucial to communicate what is known about COVID-19, what is unknown, what is being done and actions that are being taken on a regular basis by relevant authorities and stakeholders. Preparedness and response activities should be conducted in a participatory, community-based manner.

The Ministry of Health and Child Care (MOHCC) has developed a risk communication and community engagement preparedness, readiness response plan to COVID-19 (February 2020) with the following objectives:

- i. Provide timely communication about COVID-19 to the general population
- ii. Engage community influences, networks and stakeholders in the prevention and control of COVID-19
- iii. Provide risk communication messages on COVID-19 to health service providers at all levels including at points of entry
- iv. Support relevant authorities to build and maintain public trust about efforts to prevent, control and respond to COVID-19

The strategic approaches of the risk communication and communication engagement preparedness, readiness response plan to COVID-19 (February 2020) include:

- i. Strengthening coordination
- ii. Situation and communication analysis
- iii. Building capacities of communities
- iv. Community engagement, social mobilization and advocacy
- v. Individual and house household level (behavior change communication)

Stakeholders at high-risk for COVID-19 identified in the risk communication and communication engagement preparedness, readiness response plan to COVID-19 (February 2020) include:

- i. People moving across borders
- ii. People working at POE
- iii. Business Persons engaged in cross border trading
- iv. Workers in health care settings including traditional healers, personnel in pharmacies
- v. Persons with underlying medical conditions, their family members and immediate contacts

Priority activities for risk communication and communication engagement include:

- i. Conduct rapid behavioral assessment to understand target audience perceptions, concerns, influencers and preferred communication channels;

- ii. Prepare local messages and pre-test through participatory process, specifically targeting key stakeholders and at-risk groups
- iii. Identify trusted community groups (local influencers, community leaders, religious leaders, health workers, community volunteers, local networks such as women's groups, youth groups, business groups, traditional leaders, traditional healers)
- iv. Finalize clearance processes for timely dissemination of messages and materials including in local languages and adopted to appropriate communication channels
- v. Engage with existing public health and community-based networks, media, local NGOs, schools, local authorities, relevant Government line ministries, private sector etc....
- vi. Establish and utilize hotlines and other 2-way communication channels such as radio talk shows, U report/rural WASH report and appropriate social media channels
- vii. Establish large scale community engagement for social and behavioral change approaches to ensure preventive community and individual health and hygiene practice surveys and community dialogues
- viii. Establish community information and feedback mechanisms
- ix. Ensure changes to community engagement approaches are based on evidence and needs and are culturally appropriate and empathetic

4.3. Pillar 3: Surveillance, rapid response and case investigation

In Zimbabwe which is yet to confirm COVID-19, the main objective of surveillance is the rapid detection of imported cases, comprehensive and rapid contact tracing and case identification. The objectives of surveillance change in relation to the transmission scenarios (see section 4). Robust COVID-19 surveillance data are essential to guide the appropriate and proportionate public health response actions.

Priority actions at **national level** include:

- i. Disseminate case definitions in line with WHO guidance and investigation protocols to health care workers in both public sector and private sector health facilities;
- ii. Enhance indicator-based surveillance for influenza-like illness (ILI) and severe acute respiratory infections (SARI)
- iii. Activate active case finding and event-based surveillance for COVID-19
- iv. Assess gaps in active case finding and event-based surveillance systems
- v. Develop surveillance tools to enable monitoring of COVID-19 transmission including developing standardized protocols for contact tracing and monitoring
- vi. Put in place standard mechanism in line with Zimbabwe SOPs for activation and deactivation of PHEOC to regularly review surveillance case definitions and public health interventions based on surveillance findings.
- vii. Enhance laboratory capacity to confirm COVID-19 cases
- viii. Establish reporting formats and channels to share surveillance data including reports of all alerts and suspect cases, contacts monitored...etc.
- ix. Actively monitor and report disease trends, impacts
- x. Train and equip rapid-response teams to investigate cases all alerts and clusters and contact tracing
- xi. Conduct regular analysis of epidemiological surveillance and laboratory data

- xii. Establish regular mechanism to share surveillance analysis with decision makers and stakeholders at all levels in the country and with international partners in line with IHR (2005)

Priority actions at **provincial level** include:

- i. Disseminate case definitions approved by national level to all public sector and private sector health facilities in the province
- ii. Train relevant health workers to conduct active case finding and event-based surveillance for influenza-like illness and severe acute respiratory infections (SARI) using nationally approved surveillance tools and standardized protocols for contact tracing and monitoring
- iii. Train and equip rapid-response teams to investigate cases all alerts and clusters and contact tracing
- iv. Assess gaps in active case finding and event-based surveillance systems at provincial and district level
- v. Establish a provincial surveillance working group to regularly review surveillance data collected from the province, conduct regularly analysis and share with stakeholders in the province and at national level
- vi. Monitoring compliance of province with national reporting formats and channels to share surveillance data including daily reporting of all alerts and suspect cases, contacts monitored...etc.

4.4. Pillar 4: Points of Entry

Points of entry are airports and land crossing of international entry and exit of travelers, cargo and conveyances. To slow down international spread of COVID-19, staff and infrastructure at points of entry must be prepared to detect and manage ill people and to refer them to public health services safely. Under the IHR (2005), countries have designated key points of entry at which to strengthen and maintain capacities to prevent, prepare for and respond to public health risks. Activities at ports of entry should support surveillance and risk communication activities.

Travel restrictions should be evaluated against evidence-based assessments of potential effectiveness and impact on communities and livelihoods. The most recent WHO recommendations for international travel in relation to the COVID-19 outbreak were issued on 29 Feb 2020.

Priority activities at **national level** include

- i. Develop a points of entry public health emergency plan
- ii. Develop points of entry Standard Operating Procedures for staff at all points of entry
- iii. Develop capacity building plan for all staff at points of entry
- iv. Regularly review WHO recommendations for international traffic in line with evolving evidence and national risk assessment.
- v. Monitor the implementation of the points of entry public health emergency plan and SOPs
- vi. Conduct periodic assessment of all points of entry to assess isolation facilities and other capacities to manage ill passengers and to safely transport them to designated health facilities
- vii. Prepare appropriate risk communication messages for travelers, staff and crew. Ensure that messages are translated and communicated in appropriate languages.

Priority activities at **Points of Entry** include

- i. Ensure that all relevant staff are sensitized on the nationally approved points of entry public health emergency plan
- ii. Establish facilities to safely assess and isolate travelers or staff with influenza symptoms or signs. These facilities could be onsite at the POE or could be offsite in liaison with local public health authorities
- iii. Train all relevant POE staff on the Standard Operating Procedures for use at all points of entry
- iv. Submit data and other information using nationally approved tools and templates to provincial and national level in compliance with national POE SOPs
- v. Conduct period assessment of all points of entry to assess isolation facilities and other capacities to manage ill passengers and to safely transport them to designated health facilities
- vi. Prepare appropriate risk communication messages for travelers, staff and crew. Ensure that messages are translated and communicated in appropriate languages.

4.5. Pillar 5: National laboratory system

To quickly confirm COVID-19, it is essential to have access to laboratories that have the capacity for COVID-19 diagnostic capacity. The National Medical Reference Laboratory (NMRL) in Harare now has this capacity. There is also established close communication with the Regional Reference Laboratory at the National Institutes for Communicable Diseases (NICD) in South Africa.

Priority activities include

- i. Adopting and disseminating SOPs (as part of disease outbreak investigation protocols) for specimen collection, management and transportation for COVID-19 diagnostic testing
- ii. Identify hazards and conduct a biosafety risk assessment at NMRL and other laboratories that may be considered for COVID-19 diagnostic capacity soon
- iii. Adopt standardized systems for molecular testing, supported by assured access to reagents and kits
- iv. Capacitate National Virology Laboratory and Mpilo Central Laboratory to carry out COVID-19 testing
- v. Ensure specimen collection, management and referral network and procedures are functional
- vi. Share genetic sequence data and virus materials according to established protocols for COVID-19
- vii. Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis
- viii. Develop and implement surge plans to manage increased demand for testing
- ix. Monitor and evaluate diagnostics, data quality and staff performance and incorporate findings into strategic review of national laboratory plan
- x. Develop a quality assurance mechanism for point-of-care testing including quality indicators.

4.6. Pillar 6: Infection prevention and control

Transmission of pathogens responsible for acute respiratory disease such as COVID-19 is through droplets and contact with contaminated materials and surfaces. Infection prevent and control (IPC) practices in communities and health facilities should be reviewed and enhanced to prepare for treatment of patients with COVID-19 and to prevent transmission to staff, patients, visitors and community members.

Priority activities include:

- i. Review and update national IPC guidelines, protocols and SOPs. These should include patient referral pathways, identification of IPC focal points, guidance for IPC measures and referral systems from public places such as schools, markets, public transportation as well as from communities, households and family practices.
- ii. Assessment of IPC capacity at all levels of healthcare system including public, private and traditional practices and pharmacies.
- iii. Assess IPC capacity in public places and community spaces where risk of communication is considered high
- iv. Develop and implement plan for monitoring of health care personnel exposed to suspect and confirmed COVID-19 for respiratory illness
- v. Develop a plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity
- vi. Engage trained staff to implement IPC activities with priorities identified based on risk assessment and local care seeking behavior
- vii. Record, investigate and report all cases of healthcare-associated infections
- viii. Review, update and disseminate IPC guidelines for home and community-level care providers
- ix. Implement triage, early detection and infectious source controls, administrative controls and engineering controls
- x. Support access to Water and Sanitation for Hygiene (WASH) services in public places and community spaces most at risk
- xi. Monitor IPC and WASH implementation in selected healthcare facilities and public spaces using Infection Prevention and Control assessment framework, hand hygiene compliance observation tools and WASH Facilities improvement Tool
- xii. Provide prioritized tailored support to health facilities based on IPC risk assessment and local-care seeking patterns, including for supplies, human resources and training.
- xiii. Conduct training to address any skills and performance deficits.

4.7. Pillar 7: Case Management

Adequate provisions should be made for the delivery of appropriate clinical management of severe acute respiratory infections due to COVID-19 in health care facilities as well as home care for patients with mild disease and contacts.

Depending on which transmission scenario a country is in (see section 4), there may be high volume of cases that may present to health care facilities putting already overstretched facilities and staff under pressure. To limit the pressure of additional cases on the health care system, appropriate guidance should be given regarding the management of mild cases in isolation.

Delivery of essential health services for non COVID-19 related conditions should be kept functional. This is especially important for the most vulnerable populations (elderly, patients with chronic illness like HIV and non-communicable diseases, pregnant and lactating mothers and children. This will reduce case fatality. Provisions should be made to ensure that People living with HIV/AIDS and other vulnerable populations do not need to visit health facilities at the same time as the time of COVID-19 surge and thereby get exposed to higher risk.

Priority actions

- i. Map vulnerable populations, public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities (e.g. schools, community centers, military barracks....etc) that may be used to provide treatment.
- ii. Assess intensive care unit capacity in all major cities and provinces
- iii. Continuously assess the burden on local health system and capacity to safely deliver primary health care services
- iv. Review case management protocols, standards and regulatory frameworks to ensure quality of care and safety of care
- v. Ensure that guidance is made available for self-care of patients with mild COVID-19 symptoms, including guidance on when referral to health care facilities is recommended
- vi. Train and refresh medical/ambulatory teams in the management of severe acute respiratory illnesses and COVID-19 specific protocols
- vii. Establish dedicated and equipped teams and ambulances to transport suspect and confirmed cases
- viii. Establish referral mechanisms for severe cases with co-morbidities
- ix. Provide comprehensive medical, nutritional and psychosocial care for COVID-19 patients and care-providers
- x. Assess diagnostics, therapeutics and vaccines for compassionate use
- xi. Evaluate implementation and effectiveness of case management procedures and protocols
- xii. Support hospitals to develop/update their business continuity plans.
- xiii. Develop/strengthen institutional arrangements with private-health care actors to coordinate health service delivery
- xiv. Establish financing mechanisms for COVID-19 specific health services and other essential health services
- xv. Identify indicators, information sources and reporting formats to report on the status of essential health service delivery
- xvi. Conduct rapid assessments to understand the needs for patients with chronic illnesses including PLHIV to document information needs, medication on hand, ability of people to access service support through telephone or through community networks.
- xvii. Accelerate full implementation of WHO HIV Treatment Guidelines for multi-month dispensing (MMD) ensuring PLHIV have sufficient medications on hand.

4.8. Pillar 8: Logistics, Procurement and Supply Management

Logistical arrangement to support preparedness and response operations are critical to ensure that this plan is effectively implemented. Priority activities in this regard include

- i. Map available resources and supply systems in health and other sectors.
- ii. Conduct in-country inventory of supplies based on WHO's Disease commodity package (DCP) and COVID-19 patient kit
- iii. Procure PPEs, IPC commodities, diagnostic equipment and reagents, essential medicines and other sundries for COVID-19 preparedness and response
- iv. Develop a central stock reserve for COVID-19 case management
- v. Review supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies including COVID-19 DCP and patient kit reserve in country
- vi. Review procurement processes (including importation and customs) for medical and other essential supplies
- vii. Encourage local sourcing of some essential supplies that are locally produced to ensure sustainability
- viii. Assess the capacity of the local market to meet increased demand for medical and other essential supplies
- ix. Prepare staff surge capacity and deployment mechanisms
- x. Identify and support critical functions that must continue during a widespread outbreak of COVID-19

5. Budget

5.1. Budget Summary (for 12-month period starting March 2020)

Line Item	Cost (USD)
1. Coordination, planning and monitoring	1,424,100.00
2. Risk Communication and community engagement	1,098,500.00
3. Surveillance, rapid response and case investigation (including POE)	4,159,890.00
4. Points of Entry	112,440.00
5. National laboratory system	3,119,454.00
6. Infection prevention and control	238,850.00
7. Case management	4,090,540.00
8. Logistics, procurement and supply management	12,144,606.00
Total	26,388,380

6. Monitoring and Evaluation

The following key performance indicators are proposed to monitor the implementation of this plan⁵:

Pillar	Key performance indicator	Target
Coordination, planning and monitoring	<ul style="list-style-type: none"> National Public Health Emergency Operations Center activated National preparedness plan finalized and endorsed National coordination meetings held weekly % of provinces with weekly EPR coordination meetings held weekly 	NPHEOC Activated Plan finalized Weekly meetings 100%
Risk communication and Community Engagement (RCCE)	<ul style="list-style-type: none"> Risk communication and community engagement s plan finalized and endorsed National RCCE coordination meetings held weekly % of provinces implementing priority RCCE activities 	Plan finalized Weekly meetings 100%
Surveillance	<ul style="list-style-type: none"> Updated surveillance SOPs and tools % provinces implementing priority surveillance activities 	SOPs finalized 100%
Points of Entry	<ul style="list-style-type: none"> Updated POE protocols, SOPs and tools % POEs implementing priority activities 	SOPs finalized 100%
National laboratory system	<ul style="list-style-type: none"> Updated laboratory SOPs and tools % Labs implementing priority activities No of laboratories with COVID-19 testing capacity 	SOPs finalized 100%
Infection prevention and control (IPC)	<ul style="list-style-type: none"> Updated IPC SOPs and tools % provinces implementing priority IPC activities 	SOPs finalized 100%
Case management	<ul style="list-style-type: none"> Updated case management SOPs and tools % health facilities implementing priority case management activities 	SOPs finalized 100%
Logistics	<ul style="list-style-type: none"> Updated logistics SOPs and tools % provinces implementing priority logistics activities % of PPEs, IPC commodities, diagnostic equipment and supplies, essential medicines and other sundries procured 	SOPs finalized 100%

⁵ More indicators to measure the **quality** of implementation of priority activities will be identified by the thematic groups and will complement this list.

7. Roles and Responsibilities

The implementation of the national preparedness and response plan required the active involvement of wide range of stake-holders from wide range of sectors and all levels of society.

Entity	Roles and Responsibilities
Government Ministries, departments, agencies including regulatory authorities	<ul style="list-style-type: none"> • Develop/update and disseminate policy guidelines, Standard Operating Procedures (SOPs), technical guidelines • Activate, lead and monitor Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Ensure compliance with appropriate national legal and regulatory provisions • Provide technical, financial and logistical resources to support the implementation of national COVID-19 plan
Private Sector	<ul style="list-style-type: none"> • Actively participate in Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Identify opportunities to provide technical, financial and logistical resources to support the implementation of national COVID-19 plan • Support efforts to scale up the implementation of the different thematic areas according to the comparative advantage of each industry eg the telecommunications industry could support risk communication and community engagement strategies.
Professional associations and academia	<ul style="list-style-type: none"> • Actively participate in Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Provide technical resources to support the implementation of national COVID-19 plan • Support research and capacity building activities
Civil Society, Community based organizations and communities	<ul style="list-style-type: none"> • Actively participate in Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Provide technical resources to support the implementation of national COVID-19 plan • Support research and capacity building activities
Media	<ul style="list-style-type: none"> • Provide technical, logistical and financial resources to support scaling up of risk communication and community engagement activities • Support efforts to provide reliable, authentic information and messages.

Entity	Roles and Responsibilities
Development Partners, UN Agencies, International Community	<ul style="list-style-type: none"> • Actively participate in and support Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Identify opportunities to provide technical, financial and logistical resources to support the implementation of national COVID-19 plan • Support efforts to scale up the implementation of the different thematic areas according to the comparative advantage of each partner agency
Non-Governmental Organizations (NGOs)	<ul style="list-style-type: none"> • Actively participate in and support Emergency Preparedness and Response multi-sectoral coordination mechanisms at national and sub-national level • Identify opportunities to provide technical, financial and logistical resources to support the implementation of national COVID-19 plan • Support efforts to scale up the implementation of the different thematic areas according to the comparative advantage of each partner agency

8. Annexes

1.1 Budget

9. Proposed Time-line of Priority Activities, March-May 2020

9.1. Proposed Time-line of Priority Activities, March-May 2020

10.1.1 Coordination, Planning and Monitoring

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Finalize national COVID-19 preparedness and response plan	x	x										
2. Conduct capacity assessments and risk analysis			x	x								
3. Finalize monitoring and evaluation mechanism for COVID-19 preparedness		x	x									
4. Activate the National Public Health Emergency Operations Center (NPHEOC)		x										
5. Identify, train and designate COVID-19 response spokesperson			x									
6. Ensure at least once weekly meetings of activated NPHEOC structures			x	x	x	x	x	x	x	x	x	x
7. Support all provinces to finalize the provincial preparedness and readiness plans			x	x								
8. Ensure at least once weekly meetings of activated provincial coordination structures				x	x	x	x	x	x	x	x	x
9. Review legal and regulatory requirements for potential public health actions				x	x							
10. Produce situation reports and other monitoring reports as required	x	x	x	x	x	x	x	x	x	x	x	x
11. Conduct periodic operational and reviews as required				x			x					x
12. Implement resource mobilization activities ⁶	x	x	x	x	x	x	x	x	x	x	x	x

⁶ Resources to be mobilized will be in the form of technical, financial, logistical/material resources. As this is whole-of-Government, whole-of-society plan, all entities including Government, private sector, international community, communities, individuals, philanthropic organizations...etc. will be approached to support the funding and implementation of activities included in this plan.

10.1.2 Risk Communication and Community Engagement (RCCE)

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Review, update and confirm membership of RCCE thematic technical group	x	x										
2. Conduct at least once weekly meeting of RCCE thematic technical group	x	x	x	x	x	x	x	x	x	x	x	x
3. Prepare, pre-test and finalize local messages	x	x										
4. Establish clearance processes for messages including in local languages		x										
5. Produce and disseminate IEC materials			x	x	x	x	x	x	x	x	x	x
6. Identify trusted influencers and networks to disseminate key messages	x	x	x									
7. Establishment of hotline ⁷			x									
8. Sensitization of key influencers and leaders			x	x	x	x	x	x	x	x	x	x
9. Sensitization of schools and education sector			x	x	x	x	x	x	x	x	x	x
10. Identify dissemination channels for key messages	x	x										
11. Media training			x	x	x							
12. Training of community-based organizations			x	x	x							
13. Disseminate key messages through road shows, community dialogues			x	x	x	x	x	x	x	x	x	x
14. Training of private sector, industry leaders			x	x	x							
15. Establishment of health promotion website			x	x	x							
16. Establish and use community feedback mechanisms			x	x	x	x	x	x	x	x	x	x

⁷ Support from private sector telecommunications industry

10.1.3 Surveillance, rapid response and case investigation

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Disseminate case definitions to public and private sector facilities	x	x	x	x								
2. Develop SOPs for surveillance for influenza like illness, SARI		x	x									
3. Activate active case finding and event-based surveillance systems		x	x	x	x	x	x	x	x	x	x	x
4. Review, update and confirm membership of surveillance thematic technical group		x	x									
5. At least once weekly meetings of surveillance thematic group			x	x	x	x	x	x	x	x	x	x
6. Refresher training of RRTs and front-line health workers		x	x									
7. Provide investigation supplies and operational support for RRTs		x	x	x								
8. Conduct regular (at least once weekly) risk assessment, surveillance data analysis		x	x	x	x	x	x	x	x	x	x	x
9. Conduct periodic assessment of surveillance performance and quality				x				x				x
10. Provide regular surveillance updates to policy makers at all levels		x	x	x	x	x	x	x	x	x	x	x

10.1.4 Points of Entry

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Conduct assessment of capacities and facilities at all POEs	x	x	X									
2. Develop SOPs for use at all points of entry		x	X									
3. Train/sensitize all POE staff on national SOPs	x	x	x	X								
4. Establish capacities for isolation and referral for ill travelers at all POEs	X	x	x	x								
5. Prepare and disseminate risk communication messages at all POEs	x	x	x	x	x	x	x	x	x	x	x	X
6. Review POE SOPs in line with regular risk assessments		x	x	x	x	x	x	x	x	x	x	x
7. Review, update and confirm membership of POE thematic technical group		x	X									
8. At least once weekly meetings of POE thematic technical group			x	x	x	x	x	x	x	x	x	x

10.1.5 National Laboratory Systems

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Review, update and confirm membership of Laboratory thematic technical group		x	X									
2. At least once weekly meetings of laboratory thematic technical group			x	x	x	x	x	x	x	x	x	x
3. Develop SOPs for specimen collection, management and transportation		X	x									
4. Conduct biosafety risk assessment			x	x	X							
5. Conduct refresher training of key staff			x	x	x	x	x					
6. Adopt standardized systems for molecular testing		x	x									
7. Expand testing capacity to National Virology laboratory and Mpilo Central Hospital			x	x	x	x	x	x				
8. Monitor specimen collection, management and referral network			x	x	x	x	x	x	x	x	x	x
9. Develop and implement plans to link lab data with epid data		X	x									
10. Develop and implement surge plans to manage increased demand for testing				x	x	x	x	x	x	x	x	x
11. Monitor and evaluate diagnostics, data quality and staff performance				x	x	x	x	x	x	x	x	x
12. Develop and implement quality assurance mechanisms				x	x	x	x	x	x	x	x	x

10.1.6 Infection Prevention and Control (IPC)

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Review, update and confirm membership of IPC thematic technical group		x	X									
2. At least once weekly meetings of IPC thematic technical group			x	x	x	x	x	x	x	x	x	x
3. Develop SOPs for IPC		X	x									
4. Conduct IPC capacity assessment in health care settings			x	x	x							
5. Conduct IPC capacity assessment in community settings			x	x	x	x	x	x	x	x	x	x
6. Conduct refresher training of key staff			x	x	x	x	x	x	x	x	x	x
7. Develop and implement plan to monitor PPE stocks			x	x	x	x	x	x	x	x	x	x
8. Develop and implement monitoring plan for health workers exposed to COVID-19			x	x	x	x	x	x	x	x	x	x
9. Report, investigate and report all health care associated COVID-19 infections			x	x	x	x	x	x	x	x	x	x
10. Enhance access to WASH at health facilities, in public places			x	x	x	x	x	x	x	x	x	x
11. Monitor IPC and WASH implementation in health care facilities			x	x	x	x	x	x	x	x	x	x
12. Provide prioritized support to health facilities based on IPC risk assessment			x	x	x	x	x	x	x	x	x	x
13. Prepare weekly monitoring reports on IPC			x	x	x	x	x	x	x	x	x	x

10.1.7 Case Management and continuity of essential health services

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Review, update and confirm membership of case management thematic group		x	X									
2. At least once weekly meetings of case management thematic technical group			x	x	x	x	x	x	x	x	x	x
3. Develop SOPs for case management		X	x									
4. Map out all public and private sector health care facilities nation-wide			x	x	x							
5. Conduct rapid case management capacity assessment at all hospitals nation-wide			x	x	x	x	x	x	x	x	x	x
6. Design SOPs to rapidly monitor burden on health system and capacity to respond			x	x	x	x	x	x	x	x	x	x
7. Conduct refresher training of key staff-ambulance teams, front-line health workers			x	x	x	x	x	x	x	x	x	x
8. Establish referral mechanisms for patients with co-morbidities			x	x	x	x	x	x	x	x	x	x
9. Support hospitals to develop business continuity plans			x	x	x	x	x	x	x	x	x	x
10. Strengthen public-private institutional arrangements for service delivery			x	x	x	x	x	x	x	x	x	x
11. Develop financing mechanisms for staff, supplies and sundries			x	x	x	x	x	x	x	x	x	x
12. Monitor continuity of essential services including for patients with chronic illnesses			x	x	x	x	x	x	x	x	x	x

10.1.8 Logistics, Procurement and Supply Management

Priority Activities	March 2020				April 2020				May 2020			
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4
1. Review, update and confirm membership of Logistics thematic technical group		x	X									
2. At least once weekly meetings of logistics thematic technical group			x	x	x	x	x	x	x	x	x	x
3. Develop SOPs for logistics, procurement and supply management		X	x									
4. Conduct rapid mapping of available resources and supply systems			x	x	x							
5. Conduct in-country inventory of supplies based on WHO commodity package			x	x	x	x	x	x	x	x	x	x
6. Develop central stock reserve of essential supplies, medicines			x	x	x	x	x	x	x	x	x	x
7. Review supply chain control and management systems			x	x	x	x	x	x	x	x	x	x
8. Review procurement processes for medical and other essential supplies			x	x	x	x	x	x	x	x	x	x
9. Identify local sources of essential supplies			x	x	x	x	x	x	x	x	x	x
10. Assess the capacity of local market to meet increased demand for essential supplies			x	x	x	x	x	x	x	x	x	x
11. Develop plans for staff surge capacity and deployment mechanisms			x	x	x	x	x	x	x	x	x	x
12. Identify critical functions that should continue during widespread outbreak			x	x	x	x	x	x	x	x	x	x

