MINISTRY OF HEALTH DEVELOPMENT

REPUBLIC OF SOMALILAND

NATIONAL COVID-19 PREPAREDNESS AND RESPONSE PLAN

April - December 2020

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Foreword

The President of Republic of Somaliland initiated national preparedness activities early March 2020 in response to the new emerging CoVID-19. The Ministry of Health Development (MoHD) has led the entire preparation measures. In swift response to the outbreak, the government of Somaliland took early preventive measures even before the disease became a global pandemic.

The Government of Somaliland put in place swift response measures including the deployment of medical teams to all entry points of the country such as airports, seaports and land borders. In the first instance, the Somaliland Government established a National COVID-19 Preparedness and Prevention committee led by the Vice President. Through this whole of government approach, the committee decreed the establishment of quarantine site for suspected cases, the formation of an incident management system, temporary suspension of land borders restricted to non-essential crossings, ordering closure of schools, restricting mass gathering and advising on social distancing measures. Additionally, the Government initiated comprehensive risk communication strategies and community engagement approaches which involves and empowers communities and citizens to implement a set of interventions that can prevent the spread of the disease and eventually bring under control the on-going outbreak.

Somaliland has experienced multiple hazards including frequent droughts, cyclones and disease outbreaks that have all contributed to the displacement of thousands where access to health services is limited. This makes our response operations for COVID-19 more complex and difficult. Given the fragility of our health system and the limited capacity to adequately respond to and effectively prevent a potential spread of COVID-19 in the Somaliland, we hereby appeal to our international partners for their urgent support with the technical expertise and medical resources needed for the implementation and execution of our COVID-19 National Preparedness and Response Plan.

The National COVID-19 Response Plan, as detailed in the attached document, is aimed at guiding all national and international partners with standardized, integrated and informed interventions. The implementation of the national response and preparedness plan is expected to strengthen the coordination, early detection, confirmation, containment and control measures to mitigateagainst the spread of the corona virus disease. It considers key response measures including the establishment of command & control center, rapid response teams; strengthening national laboratories, case Investigation; contact tracing; risk communication and community engagement; Infection prevention and control; case management; operational support and logistics; maintaining essential health services and provision of psychosocial support. An adequately supported strategy, aims to reduce COVID-19 associated morbidities and mortalities while maintaining the delivery of essential health services.

I therefore call upon all partners to align their efforts and expertise with the attached National Response Plan detailing the investment and support needed to assist the Somaliland Government implement and scale up adequate emergency preparedness and response efforts, to be better able to contain an outbreak, ensure the novel coronavirus does not overwhelm our health system and keep the Somaliland population safe.

Hon. Omar Abdillahi Ali

Minister of Health Development

Republic of Somaliland

Acknowledgement

The COVID-19 National Emergency Preparedness and Response Plan have been developed by the Somaliland Ministry of Health Development. The Ministry of Health acknowledges the contribution of different government ministries, UN agencies and all partners in the health sector who have contributed immensely to the development of this plan. I also would like to acknowledge the Department of Policy, Planning & Strategic Information on leading on the development of this plan.

Dr. Mohamed Abdi Hergeye

Director General

Ministry of Health Development

Republic of Somaliland

Executive Summary

The coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The novel coronavirus is a new strain that has not been previously identified in humans and was first detected during an investigation into an outbreak in the city of Wuhan, China.

In December 2019, WHO was notified of an outbreak caused by a Novel Corona Virus (COVID-19) in a population in Wuhan City, Hubei Province of the People's Republic of China. The disease has spread rapidly to countries and territories around the world as well as in conveyance vessels in different continents.

Although COVID-19 is newly discovered and a lot about the disease is still unknown, a case definition was developed by WHO and has been put to use across all affected countries. Human to human transmission is known to be primarily through droplet particles from infected individuals and by contact with, and transfer from contaminated materials and surfaces. The WHO and its partners are conducting research aimed at understanding the epidemiology and clinical manifestations of this new virus. There are ongoing global efforts to develop vaccines alongside exploration of treatment options including re-purposing of existing drugs are entering clinical trials stage.

On 30th January 2020, WHO declared COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC) and advised all countries to establish measures aimed at early detection, confirmation, prevention and control of this diseases to interrupt the chain of transmission. It was subsequently declared as a pandemic on 11th March 2020 following the spread to all continents and evidence of local transmission in many of affected countries. Major milestones have been achieved in interrupting local transmission in China, and in other countries. Somaliland is keen to learn and adopt experiences from China and other countries affected by the disease in combating the virus.

The National Plan was developed following a thorough needs assessment of Somaliland’s current national capacities and in alignment with WHOs' Strategic Preparedness and Response Plan guidelines. It is built on risk assessment findings, known epidemiological information and control measures in addition to the existing capacities for epidemic preparedness and response in Somaliland. The National Plan has been developed to cover a period of nine (9) months, beginning March 2020. It will be reviewed in the course of implementation depending on how COVID-19 evolves globally, regionally and locally in Somaliland.

The goal of the National Plan is to prevent, rapidly detect and effectively respond to COVID-19 outbreak to reduce morbidity and mortality in the country.

The National Plan covers the following key intervention areas with some elements of each area considered as high priority.

- National level coordination, planning & operations
- Risk communications and community engagement
- Surveillance, Rapid Response Teams & Case Investigation
- Points of entry
- National Laboratory for quality and timely diagnostic services
- Case management
- Infection prevention and control
- Logistics and supply management
- Psychosocial support

This National Plan was developed in consideration of the status of health care system and existing infrastructure in Somaliland, and the need to build the country's resilience given the chronic nature of emergencies that the country faces.

The international community, health partners, UN agencies and the national government are requested to contribute to the implementation of this plan. This will enable the Ministry of Health Development to prevent, detect and respond to COVID-19 pandemic. The National Plan is estimated to cost a sum of $15,205,000 for the first 6 months as the following table shows.

This budget for Health Emergency Plan for Covid-19 is flexible depending on different seniors and changes of the situations

	National level coordination, planning & operations	**$2,010,000**
2	Risk communications and community engagement	**$1,330,000**
3	Surveillance, Rapid Response Teams & Case Investigation	**$900,000**
4	Points of entry	**$1,225,000**
5	National Laboratory for quality and timely diagnostic services	**$700,000**
6	Case management	**$3,790,000**
7	Infection prevention and control	**$1,600,000**
8	Logistics and supply management	**$2,900,000**
9	Psychosocial support	**$750,000**
	GRAND TOTAL IN U$	**$15,205,000**

Background

The Republic of Somaliland, the former British Somaliland Protectorate, got its independence on 26 June 1960 to establish the independent State of Somaliland. Then on the 1st of July 1960 the state of Somaliland jointed voluntarily Somalia, the former Italian colony. The Union did not work, and the Republic of Somaliland reclaimed its independence in 1991 after the collapse of the former government of Republic of Somalia. Somaliland is bordered by Ethiopia, Djibouti, Somalia, and the Gulf of Aden. Since independence, Somaliland has committed itself to state building process in a relatively secure and peaceful environment. Since the beginning of the 1990s and thereafter, Somaliland has seen remarkable progress on many fronts: not least a unique reconciliation process, the creation and implementation of functioning governance and judiciary system, and a democratization process that has led to free and fair elections and a multiparty legislative system.

The Somaliland population is young and has become more urbanized over the past few decades. However, there is still a significant proportion of Somaliland's population living in rural areas as agro-pastoralists and nomadic pastoralists.

Health Care System in Somaliland

The Somaliland health system is designed to ensure effective interventions to be made available at each of the four tiers of the health care system – health posts (Primary Health Unit [PHU]), Health Centres, Referral Health Centres/District Hospitals, and Regional Hospitals.

Table 1: Demographic and Health Indicators

Indicator	Baseline (2012)	Current Status (2017 H)	Vision 2021 Target
1. Population		3,833,483	
2. Life expectancy (years)	51	64.5	66
3. Population Growth rate (%)	3	3.2	3.2
4. Women fertility rate	7-8	6.2	6.4
5. Infant mortality rate (/1000)	72	85	70
6. U5 Mortality Rate (/1000)	90	50	50.1
7. MMR (/100.000)	1044	732	400
8. Neonatal Mortality (/1000)	35-48	40	35
9. HIV/AIDS prevalence rate (%)	0.5-1.5	o.6	0.5
10. Health Workers per population ratio		4.38/10,000	910,000

Source: HSSP II

Figure 1: Health system structure

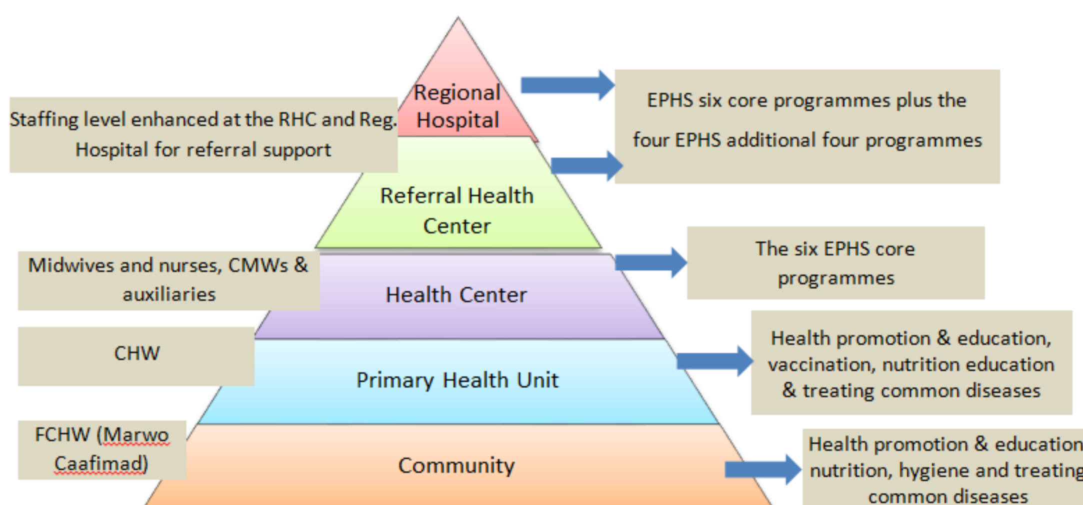

Table 2: Number of Public Health Facilities

Hospitals	Health Centers	Referral Health Centres	Primary Health Units	Total
24	230	15	159	428

Source: HSSPII

Table 3: Qualified Health workface working in the Ministry of health development. Private Health workforce is not included.

SN	Qualifications	Total
1	Doctors	129
2	Q/Nurses	914
3	Qualified Midwives	448
4	Pharmacists	26
5	Anesthesia	23
6	Data management Staff	15
7	Laboratory Technician	94
8	Radiology/Xray	28
	Total	**1677**

Source: HSSP II

Risk level of COVID-19 to Somaliland

The World Health Organization (WHO) rated Somaliland as at risk for CoVID-19 spread based on risk profile and capacity of the country to respond to a potential outbreak. The fragile health system in Somaliland is marked by decades of limited investment, underfunding, and lack of qualified staff, infrastructure, equipment medicines and supplies. The surveillance system does not cover the entire country and is structurally weak with long delays between alert and confirmation of an outbreak.

The points of entry (PoE) in the country have limited equipment and are insufficiently staffed. Across all regions of the country, there is a lack of treatment centres, isolation units, intensive care units, infection control material, medicines and medical supplies and adequately trained staff to address quickly spreading COVID-19 outbreak. Therefore, the Somaliland population is at high risk of COVID-19 infection and fast spread to all regions of the country. In a fragile country with a weak health system and capacity for risk management and preparedness may put us in a situation where we can be more vulnerable to external shocks like this pandemic. The greatest social impact of COVID-19 is the public health.

As an oral society there are cultural and religious norms which depend on communal gatherings in Mosques, tea shops, cafes etc. which represent a high risk to the population which we need to mitigate against and a huge challenge for social distancing.

Current situation

Since the outbreak of COVID-19 and its dramatic spread all over the globe the Government of Somaliland has undertaken the following preparatory activities to prevent and mitigate against the virus:

- Established a temporary isolation and screen centre at the airport
- Established a National COVID-19 Preparedness and Response Committee – an inter-ministerial with a secretariat linking the technical committee and other government agencies
- Established a MOHD technical committee
- Established GoSL emergency fund
- Trained and deployed 75 health worker to 11 points of entry – screening all arrivals
- Started Risk communication activities – with a national campaign launched by the Vise President
- Developed the National COVID-19 Preparedness and Response Plan
- Established 8 treatment centres around the country
- Trained case management team in Hargeisa
- Started quarantining all arrivals

There are two confirmed cases and several suspected who have either had contact with the confirmed cases or are cases showing signs and symptoms of COVID-19 who arrived in the country from affected areas through one of the key points of entry. The suspected cases have been promptly traced and recognized and isolated. The Ministry of Health Development is requesting support of its partners to respond to this situation.

The national surveillance systems are weak and with limited capacity to detect and respond rapidly to the outbreak, and links to the national Laboratory. The suspected cases are handed over to the health authorities and transferred to an isolation or treatment centers. There may be approximately 220 contacts (passengers on the plane and airport staff) that will be followed up for fourteen days.

There is some disruption in the national socio-economic structure as well as concern in the population in the urban area. The health promotion teams have started their risk communication messages to the public to avoid misinformation.

The emergency coordination structure is active with limited HR and operational support for effective coordination.

Objectives

The main objective of the COVID 19 Preparedness and Response Plan is to support the Government of Somaliland's efforts to prevent, rapidly detect and effectively respond to COVID-19 outbreak to reduce associated morbidity and mortality in Somaliland. The National Preparedness and Response Plan (NPRP) outlines the key measures to be taken at national level to contain the virus and will be updated with further guidance if the epidemiological situation changes. The National plan also conforms with "operational planning guidelines to support country preparedness and response" by WHO HQ issued on 12 February 2020.

Specific objectives

- To support early detection, prevention and control of COVID-19 outbreak in Somaliland
- To contribute to the reduction in morbidity and mortality associated with COVI-19 outbreaks in Somaliland
- To enhance coordination and leadership for the preparedness and response to COVID-19 outbreak
- To enhance national capacity to promptly detect cases early, manage cases and contacts and institute response activities
- Limit human to human transmission of COVID-19 cases through enhancing case detection and implementation of standard Infection Prevention and control practices
- To provide timely information and key messages to the general public about COVID-19 prevention and control interventions at community level
- To provide psychosocial care to affected health care workers and communities
- To mitigate the socio-economic impact of the outbreak

The emergency coordination structure will be activated with required staff for operations and coordination. The response will be coordinated from the office of the President with support from donors, UN and other partners.

Scenario Modeling

Using the calculation attack rate for China, which has managed to put the pandemic under control, where a total of 81,416 cases had been reported by 20 March 2020 in a population of 1.3 billion people, about 6,500 people could be affected in Somaliland (see below). This is calculated on the assumption that the health system capacity in Somaliland is not up to the standard of China and 4-10 times more people could be affected.

Assumption:

One person can infect 2.5 persons

Cases can be doubling in 5.2 days

Cases can increase to eight fold in two weeks' time

According to a study done by WHO Collaborating Center for Infectious Disease Modelling for Somaliland, majority of the patients who require hospitalization and critical care are above 60 years.

Table 4: The age factor in morbidity & mortality

Age group	% symptomatic cases requiring hospitalization	% hospitalized cases requiring critical care	Infection Fatality ratio
0-14 years	0.1-0.3%	5%	0.002-0.006%
15-24 years	0.4-1.2%	5%	0.007-0.3%
25-54 years	1.3-10.2%	5.1-12.2%	0.4-0.6%
55-64	10.3-16.4%	12.3-27.4%	0.7-2.2%
65+	16.5%-27.3%	27.5-70.9%	2.3-10%

Source: WHO

Pillars for Preparedness and Response

The National COVID-19 National Preparedness & Response Plan has components to support the preparedness phase, response phase and early recovery phases. The plan puts emphases on the establishment of coordination structures, in which response systems and capacities must be in place before the disaster phase.

Somaliland is considered to be at high risk due to the Hargeisa international airport, Berbera seaport and multiple land border crossings with Ethiopia, Djibouti and Somalia. During the initial outbreak, outpatient attendance for fevers will increase. This surge could be met only by a concerted effort between the Ministry of health and international partners.

STRATEGIC PILLARS

Pillar 1: National coordination, planning, and operations

The Government of Somaliland will establish a health emergency management mechanism at National and Regional levels that will actively engage with relevant ministries such as health, finance, education, religious affairs and interior ministry, to provide coordinated management of COVID-19 preparedness and response. The President has established a National COVID-19 Preparedness and Response Committee which is inter-ministerial with a secretariat linking the technical committee and other government agencies

The implementation of this strategy requires a whole government approach led by the Ministry of Health Development to combat the threat faced by the nation from COVID-19. The Ministry of Health Development will work closely with the National COVID -19 response committees to ensure that the response is holistic and multi-sectoral in approach. The Ministry of Health Development will also engage and work with all local and international partners, religious groups, private and business entities and community groups.

The national incident Management Team will provide guidance and leadership to all partners who will be supporting implementation of the COVID -19 SRP. The Ministry of Health Development will

also coordinate regional health management teams to ensure that a common and coherent coordination is in place which will enable smooth implementation at all levels.

STEP	ACTION - THE MINISTRY WILL:
1	Establish a multi-sectoral, multi-partner coordination mechanisms to support preparedness and response
	Develop national preparedness and response plan and engage with all government agencies, donors, key partners and existing programs to support resource requirements for COVID-19 preparedness and response
	Conduct mapping of vulnerable populations and capacity assessment and risk analysis
2	Establish a national incident management team and regional rapid response teams with designated staff for deployment when required
	Establish a national public health emergency operation centre
	Review regulatory requirements and legal basis of all potential public health measures
	Monitor implementation of National Preparedness & Response Plan (NPRP) based on key performance indicators and produce regular situation report
3	Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary
	Conduct reviews in accordance with International Health Regulations (IHR, 2005) to learn from existing plans and systems for the benefit of future preparedness and response activities

Pillar 2: Risk communication and community engagement

The Somaliland Government has instigated a risk communication and community engagement intervention very early with;

- Temporary suspension of land borders restricted to non-essential crossings
- Ordering closure of schools
- Restricting mass gathering
- Putting the key messages on all mobile ringtones
- Closing of washing areas at mosques
- Advising on social distancing measures
- Requesting anyone who feels unwell or had contact with confirmed cases to stay at home
- Setting up a toll free number for the public to call for advice and information

It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumors and misinformation.

Changes in preparedness and response interventions will be announced and explained by the national COVID-19 committee ahead of time with a community perspective. Responsive, empathic, transparent and consistent messaging in Somali through trusted channels of communication, using community-based networks and key influencers will be utilized by the Ministry of Health Development.

STEP	ACTION – THE MINISTRY WILL:
1	Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures (use the existing procedures for pandemic out brakes)
	Conduct rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels
	Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups
	Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)
2	Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels
	Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication
	Utilize two-way 'channels' for community and public information sharing such as hotlines (text and talk), responsive social media such as U-Report where available, and radio shows, with systems to detect and rapidly respond to and counter misinformation
	Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations
3	Establish community information and feedback mechanisms including: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations
	Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic.
	Document lessons learned to inform future preparedness and response activities

Pillar 3: Surveillance, rapid response teams, and case investigation

The Ministry of Health Development has developed tools for collecting data of suspected cases. Rapid response teams are deployed for case investigation. There's daily report produced to inform decision makers and MOHD have developed a District Health Information System (DHIS2) tracking & mapping system. As a country with a high-risk of imported cases or local transmission, surveillance objectives will focus on rapid detection of imported cases, comprehensive and rapid contact tracing, and case identification.

In a scenario in which sustained community transmission has been detected, objectives will expand to include monitoring the geographical spread of the virus, transmission intensity, disease trends, characterization of virologic features, and the assessment of impacts on healthcare services. Robust COVID-19 surveillance data are essential to calibrate appropriate and proportionate public health measures. The Ministry aims to strengthen the surveillance system and to prepare more capacitated and well equipped rapid response teams with the means to conduct effective case investigation.

STEP	ACTION – THE MINISTRY WILL:
1	Disseminate case definition in line with WHO guidance and investigation protocols to healthcare workers (public and private sectors)
	Activate active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI)

	Assess gaps in active case finding and event-based surveillance systems
2	Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19
	Undertake case-based reporting to WHO within 24 hours under IHR (2005)
	Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio and high-risk groups
	Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours
3	Provide robust and timely epidemiological and social science data analysis to continuously inform risk assessment and support operational decision making for the response
	Test the existing system and plan through actual experience or simulation exercises, and document findings to inform future preparedness and response activities
	Produce weekly epidemiological reports and disseminate to all levels and international partners

Pillar 4: Points of Entry

The Ministry of Health Development trained 75 health workers and deployed them to key points of entry around the country. Its's important to provide enough resources to points of entry (POEs) with focus on supporting surveillance and risk communication activities. These POEs currently have limited HR, supplies and logistics. There are 4 critical main entry points including Hargeisa International Airport, Togwajale border crossing, Port of Berbera, and Lawyacaddo. The remaining are secondary points (Buhoodle crossing in Togdheer, Tuka-raq border crossing in Sool and Sanag border corssing). All entry points will undergo a risk assessment. There are huge gaps in equipment, HR, PPEs and supervision support.

STEP	ACTION – THE MINISTRY WILL:
1	Develop and implement a points of entry public health emergency plan
2	Disseminate latest disease information, standard operating procedures and equip and train staff in appropriate actions to manage ill passenger(s)
	Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities
	Communicate information about COVID-19 to travellers
3	Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate

Pillar 5: National laboratories

The Ministry of Health Development has limited laboratory capacity to manage large-scale testing for COVID-19 and requires the establishment of national reference laboratories. Until the Ministry builds adequate COVID-19 testing capacity at national level, samples will be sent to a regional or international reference laboratory with appropriate capacity. In the event of widespread community transmission, we require support to manage the increase in sample collections from suspected cases. We will request all partners to provide support to establish a reference laboratory with appropriate training, guidelines, protocols, reagents, and supplies to response to COVID-19.

STEP	ACTION – THE MINISTRY WILL:
1	Establish a designated international COVID-19 reference laboratory
	Adopt and disseminate standard operating procedures (as part of disease outbreak

	investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing
	Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks
	Adopt standardized systems for molecular testing, supported by assured access to reagents & kits
2	Ensure specimen collection, management, and referral network and procedures are functional
	Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis
	Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission
3	Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned
	Develop a quality assurance mechanism for point-of-care testing, including quality indicators

Pillar 6: Infection prevention and control

The Ministry has instigated Infection prevention and control (IPC) practices in communities and health facilities to prevent COVID-19 transmission. The Ministry is working with all local authorities on Infection prevention and control at community and household level. We require support to review and enhance our IPC system, prepare for better treatment of patients with COVID-19, and prevent transmission to staff, as well as patients/visitors in the community.

STEP	ACTION – THE MINISTRY WILL:
1	Provide sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations
	Assess IPC capacity in public places and community spaces where risk of community transmission is considered high
	Review and update existing national IPC guidance and provide community guidance which should include specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport as well as community, household, and family practices
	Establish a mechanism for monitoring healthcare personnel exposed to confirmed cases of COVID-19 for respiratory illness and development a plan to support them
	Develop a national plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity (numbers and competence)
2	Engage trained staff with key personal with technical expertise to implement IPC activities, prioritizing based on risk assessment
	Establish a mechanism to record, report, and investigate all cases associated infections
	Develop and distribute IPC guidance to communities with a focus of on most vulnerable
	Implement early detection triage, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette
	Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk
3	Monitor IPC and WASH implementation in healthcare facilities and public spaces using the Infection Prevention and Control Assessment Framework.
	Provide prioritized tailored support to health facilities based on IPC risk assessment.
	Carry out training to address any skills and performance deficits

Pillar 7: Case management

The Ministry has prepared 8 treatment centers all over the country and has trained a limited number of health workers in preparation for case management. Healthcare facilities are prepared in each region to address any increase in the number COVID-19 cases at the regional level. Staff have been training to be familiar with COVID-19 case definition, and able to deliver the appropriate care pathway.

Patients with, or at risk of, severe illness will be given priority over mild cases. Guidance will be made available to frontline staff on how to manage mild cases in self-isolation. The Ministry will provide special considerations for vulnerable populations (elderly, patients with chronic diseases, pregnant and lactating women, and children). There's huge gaps in support for case management teams and PPEs to ensure their safety while undertaking their duties.

STEP	ACTION – THE MINISTRY WILL
1	Map vulnerable and at risk populations
	Establish 6 treatment centers with Intensive Care Unit
	Assess burden on local health system, and capacity to safely continue to deliver primary healthcare services
	Ensure that guidance is made available for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is recommended
	Establish 6 isolation centers
	Identify alternative facilities that may be used to provide treatment both public and private health facilities
2	Provide updated information, train, and refresh medical/ambulatory teams in the management of severe acute respiratory infections and COVID-19-specific protocols
	Establish a dedicated referral mechanisms with equipped ambulances and teams to transport suspected and confirmed cases, and for severe cases
	Link technical teams with clinical expert network to aid in the clinical characterization of COVID-19 infection, address challenges in clinical care, and foster global
	Evaluate implementation and effectiveness of case management procedures and protocols and adjust guidance and/or address implementation gaps as necessary

Pillar 8: Logistics and supply management

The Ministry is coordinating supplies and equipment and ensuring the equitable distributions to all regions. Logistical arrangements to support incident management and operations will be reviewed. Expedited procedures may be required in key areas (e.g. staff deployment, procurement of essential supplies, staff payment).

There's limited capacity in the Logistic Management Information System (LMIS) system of the ministry which is critical in the logistics and supply management. There is a shortage of key supplies and equipment in response for COVID-19 including PPEs, ICU equipment and rapid testing kits.

STEP	ACTION – THE MINISTRY WILL:
1	Map available resources and supply; conduct in-country inventory review of supplies based on COVID-19 patient kit, and develop a central stock reserve for COVID-19 case management
2	Review supply chain control and management system - essential supplies, including COVID-19 and patient kit reserve in-country

	Review procurement processes, importation and customs procedures for medical and other essential supplies, and encourage local sourcing to ensure sustainability
	Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms
	Prepare staff surge capacity and deployment mechanisms; health advisories (guidelines and SOPs); pre- and post-deployment package (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support, including peer support groups) to ensure staff well-being
3	Identify and support critical functions that must continue during a widespread outbreak of COVID-19 (e.g. water and sanitation; fuel and energy; food; telecommunications/internet; finance; law and order; education; and transportation), necessary resources, and essential workforce

Pillar 9: Psychosocial Support

It is critical that we provide psychosocial support in these challenging times to our population. Emergencies are always stressful, but specific stressors particular to COVID-19 outbreak affect the population and health care givers. There is a huge phobia of people infected by COVID-19 which need to be effectively alleviated. The ministry in collaboration other ministries including Ministry of Religious affairs, Ministry of Social Services will provide culturally and religiously appropriate services to mitigate stress and provide psychosocial support.

STEP	ACTION –THE MINISTRY WILL:
1	Enhance critical inter-sectoral referral pathways to ensure that children and families with other concerns (such as protection, survival needs, etc.) or more severe distress may access needed services promptly.
	Train and building capacity in appropriate Mental Health and Psychosocial Support (MHPSS) approaches in emergencies and provision of MHPSS in the context of COVID-19.
	Ensure that people with mental health continue to access medication and support during the outbreak, both in the community as well as in institutions.
	Respect the right to informed consent at all times throughout treatment for people with mental health and substance abuse disorders on an equal basis with all other people.
	People who develop symptoms of COVID-19 during a stay in an inpatient mental health facility should receive the same level of good quality treatment and support as all other people.
	Prepare health advisories (guidelines and SOPs); pre- and post-deployment package (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support, including peer support groups) to ensure staff well-being
3	Develop procedures to minimize risk of infection of COVID-19 and protocols for responding to individuals who may have become infected.

Monitoring and evaluation

To monitor progress and achievements of the implementation of activities while measuring the performance in different pillars, performance indicators will be tracked Key which can be refined during the operational planning. The baseline and target for each of the indicators, source of data, and frequency of collection will be defined and included in the results framework of the operational planning. Evaluation will be conducted when COVID-19 will be prevented based on the indicators of the pillars achievement.

Summary of the Budget

PILLARS FOR PREPAREDNESS AND RESPONSE	SUMMARY OF BUDGET
National level coordination, planning & operation	$2,010,000
Risk communications and community engagement	$1,330,000
Surveillance, Rapid Response Teams & Case Investigation	$900,000
Points of entry	$1,225,000
National Laboratory for quality and timely diagnostic services	$700,000
Case management	$3,790,000
Infection prevention and control	$1,600,000
Logistics and supply management	$2,900,000
Psychosocial support	$750,000
TOTAL	**$15,205,000**

Detailed budget per strategic Pillar

NATIONAL COORDINATION, PLANNING & OPERATIONS	
Expenditure Type	**Total (US$)**
Develop and establish national and regional plan	60,000
Establish national and regional multi-sectoral preparedness COVID-19 committees	300,000
Supervision for national & regional team	250,000
Preparedness training for frontline staff	300,000
Resources mobilisation activities in support of response	100,000
Establish Emergency Operation Centre (EOCs) and Incident Management System	500,000
Conduct risk and capacity assessment	100,000
Operational support (HR and operations costs)	400,000
TOTAL	**2,010,000**

RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT	
Expenditure Type	**Total (US$)**
Develop Risk communications and community engagement plan	30,000
Community engagement activities	300,000

Equipment for virtual communication - VTC, screens, laptops, tablets and cameras	150,000
Training and deployment of key personal for community engagement	400,000
Key messages - development, translation, printing, dissemination of IEC materials	250,000
Monitoring & evaluation of risk communication activities	200000
TOTAL	**1,330,000**

SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION	
Expenditure Type	**Total (US$)**
Expand EWARN to all facilities	150,000
Strengthen surveillance system for COVID-19	200,000
Training and deployment of Rapid response Teams at regional and district level	250,000
Establish community based surveillance system	150,000
EstablishDHIS2 COVID-19 Tracker - Digital Data Package	75,000
Monitoring & supervision of surveillance activities	75,000
TOTAL	**900,000**

POINTS OF ENTRY	
Expenditure Type	**Total (US$)**
Establish screening mechanisms at all point of entry	125,000
Capacity assessment of all points of entry	75,000
Establish quarantine facilities at key points of entry	250,000
Training, equipping and deployment of health workers at all points of entry	500,000
Training, equipping and deployment of ambulance teams for suspected cases	150,000
Data collection tools for points of entry	50,000
Monitoring & supervision of points of entry activities	75,000
TOTAL	**1,225,000**

NATIONAL LABORATORY SYSTEM	
Expenditure Type	**Total (US$)**
Strengthening laboratory capacity to detect & confirm COVID-19 cases	500,000
Collection, packaging and transportation of samples	150,000
Monitoring & supervision of data quality, diagnostics and performance	50,000

TOTAL	700,000

CASE MANAGEMENT	
Expenditure Type	**Total (US$)**
Establish and equip 6 isolation centers	400,000
Establish and equip 6 treatment centers with ICU capacity	1,500,000
Establish oxygen plant in each region	690,000
Review and adapt global case management protocols and guidelines	50,000
Case management training	300,000
Translation, printing & distribution of treatment guidelines	50,000
Establishing & equipping a dedicated national ambulance service	500,000
Monitoring & supervision of the effective implementation of case management	300,000
TOTAL	**3,790,000**

INFECTION PREVENTION AND CONTROL	
Expenditure Type	**Total (US$)**
Assessment of health facilities & PoE for IPC requirements for COVID-19	100,000
Review, translate & distribution of SOPs for IPCs in health facilities	50,000
Personal Protective Equipment (PPE) for frontline health workers	200,000
Training for health worker on IPC guidelines	500,000
Decontamination supplies and equipment	250,000
Water, sanitation and hygiene services for most at risk public buildings and community spaces	500,000
TOTAL	**1,600,000**

LOGISTICS AND SUPPLY MANAGEMENT	
Expenditure Type	**Total (US$)**
Strengthen national logistics and management system	100,000
Procure medicine, supplies, consumables and distribute for case management	1,500,000
Procure test kits, reagents and materials	300,000

Procure supplies for infection, prevention and control measures	750,000
Service Contract	
Monitoring & supervision of the effectiveness of PMS services	250,000
TOTAL	**2,900,000**

PSYCHOSOCIAL SUPPORT	
Expenditure Type	**Total (US$)**
Introduction of integrated stress management system	250,000
Training for health workers to provide psychosocial services	300,000
Monitoring & supervision of the effectiveness of psychosocial services	200,000
TOTAL	**750,000**