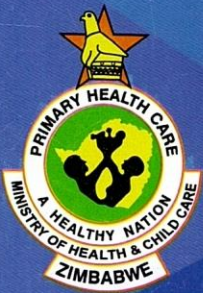


ZIMBABWE EBOLA VIRUS DISEASE PREPAREDNESS AND RESPONSE PLAN



MINISTRY OF
HEALTH AND CHILD CARE
2014



World Health
Organization



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MINISTRY OF HEALTH AND CHILD CARE
2014



Foreword

The Ebola Virus Disease (EVD) which was first reported in West Africa in March, 2014, has seen cases and deaths increasing, with a cumulative figure of 6553 cases and 3083 deaths (CFR 47%) as of 23 September, 2014. Nigeria has had an outbreak caused by an imported case, and this has led to 20 cases and 8 deaths being reported, and Senegal with 1 case and no death. There is also another outbreak in Congo DRC which is not linked to the current outbreak in West Africa.

This outbreak is threatening regional and global security. Despite the great effort being made by individual countries and various agencies, including WHO, the outbreak has continued to spread unabated, posing a threat to neighboring countries and to the region as a whole. This has prompted Zimbabwe to respond by putting in place this National Ebola Virus Disease (EVD) Preparedness and Response Plan.

The development of this plan by my Ministry is critical to the country's preparedness given the global threat of the current situation in West Africa. Zimbabwe has never experienced any Viral Hemorrhagic Fever (VHF) outbreak in the past and is not yet affected by the current EVD outbreak raging in West Africa. This plan will prepare and guide the country in the event that we experience cases of EDV.

This plan is targeted at all levels of the health delivery system including partners and the community. It spells out what needs to be done at each level from the community to national, which resources are required and how they will be mobilised and utilised. There is need to strengthen coordination mechanisms and put in place procedures, institutional capacities including budgets, skilled personnel, communication strategies that can reduce the risks of the introduction and spread of EVD in Zimbabwe.

This plan focuses on the following thematic areas: surveillance and case detection including port health and laboratory confirmation, case management, infection prevention and control, social mobilization, coordination and logistics. This document is dynamic in that its focus may be adapted according to the prevailing situation at that particular moment. It will be operational for a period of between 6 to 9 months starting from September 2014.

I am confident that my Ministry with the support of partners and stakeholders will achieve the objectives of this plan.



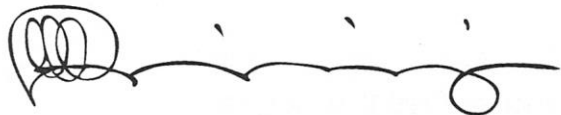
Brigadier General (Dr) Gerald Gwinji

Secretary for Health and Child Care

Promulgation

The Ministry of Health and Child Care Ebola Virus Disease preparedness and response Plan dated September 2014 is hereby approved this day of2014 as the official plan providing a framework within which the Ebola Virus Disease emergency will be responded to. Implementation of response activities during emergencies shall be done in accordance with this plan and standard Operational Procedures as outlined by the MoHCC standard procedures.

Approved



Brigadier General Dr. G. Gwinji

Secretary for Health and Child Care

Acknowledgements

The Zimbabwe Ebola Viral Disease Preparedness and Response Plan was developed by the Ministry of Health and Child Care, Local Authorities and Non-Governmental Organizations with support from the World Health Organization. The invaluable support from the ten members which initiated the draft document cannot be over emphasized.

The plan was finalized by a select group of Ministry of Health and Child Welfare staff from national, provincial, district levels consisting of EDC, Environmental Health, Laboratory Services and Department of Pharmacy Services, City of Harare Health Department, City of Kadoma Health department, Department of Civil protection, MSF Belgium, and the World Health Organization. MOHCC therefore acknowledges the contribution of the following:

<p>MOHCC</p> <p>Dr. Isaac Phiri - Deputy Director EDC - MoHCC</p> <p>Mr. Victor Nyamandi - Deputy Director Environmental Health and Food Safety</p> <p>Mr. Samuel Tsoka - Deputy Director Health Promotion</p> <p>Ms. Tariro Muganhiri - Port Health Manager</p> <p>Dr. Sekesai Zinyowera - NMRL Coordinator</p> <p>Mr. Andrew Tarupiwa - Laboratory Scientist</p> <p>Ms. Millicent Chinembiri - Pharmacist</p> <p>Mr. L. Manyanye - District Environmental Health Officer</p> <p>Ms. Nikkie Dube - Health Promotion Officer Parirenyatwa Group of Hospitals</p> <p>Mrs. M. S. Magarira - Health Promotion Harare Hospital</p> <p>Ms. Tendai Gudza - Public Health Intern</p> <p>Mr. Daniel Chirundu - Director of Health Kadoma City</p> <p>Dr. K.P.E. Masunda - City of Harare Health Department</p>	<p>Department of Civil Protection</p> <p>Mr. Lameck Betera</p> <p>Mr. Nyoni - Department of Civil Protection</p> <hr/> <p>Z.D.F</p> <p>Col. Tafirenyika</p> <hr/> <p>M.S.F</p> <p>Mr. S. Mapuranga</p> <hr/> <p>W.H.O</p> <p>Mr. Stephen Maphosa - NPO/ODM</p>
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This plan would have not been successful without the contribution and guidance of the following:

1. Dr. P. Manangazira - Director EDC
2. Dr. D. G. Dhlakama - A/Principal Director Preventive Services
3. Dr. S. Zizhou - PMD Mashonaland East Province
4. Dr. R. Mudyiradima - PMD Masvingo Province
5. Mr. G. T. Mangwadu - Director Environmental Health
6. Mr. D. Mangwanya - Director Pharmacy Services
7. Dr. D. Okello - WHO Representative Zimbabwe Country Office

Editorial:

Dr. I. Phiri - MOHCC
Mr. V.K. Nyamandi - MOHCC
Mr. S. Maphosa - WHO
Mr. Daniel Chirundu - Kadoma City Health

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Executive Summary

The Ebola virus Disease (EVD) which was first reported in West Africa in March, 2014, has seen cases and deaths increasing, with a cumulative figure of 6553 cases and 3083 deaths (CFR 47%) as of 23 September, 2013. Nigeria has had an outbreak caused by an imported case, and this has led to 20 cases and 8 deaths being reported, and Senegal with 1 case and no death. There is also another outbreak in Congo DRC which is not linked to the current outbreak in West Africa.

This outbreak is threatening regional and global security. Despite the great effort being made by individual countries and various agencies, including WHO, the outbreak has continued to spread unabated, posing a threat to neighboring countries and to the region as a whole. This has prompted Zimbabwe to respond by putting in place this National Ebola virus disease (EVD) Preparedness and Response Plan.

The Zimbabwe national Ebola virus disease (EVD) Preparedness plan focuses on the following thematic areas: case management; surveillance; port health; laboratory confirmation; health promotion; infection control; coordination and logistics. The International Health Regulations (IHR) 2005 is critical in how international travel will be controlled. In this regard, this Ebola EPR plan will be guided by the IHR (2005) framework, particularly in areas relating to surveillance, screening of travellers, quarantine, reporting, notification, verification, response and collaboration.

At the time this preparedness plan was developed, MOHCC had already embarked on various activities in preparing various institutions, health workers and stakeholders on how to respond in the event of the introduction of any possible suspected EVD cases into Zimbabwe. Sensitization and orientation of health workers in the major health institutions was already ongoing. The national Rapid Response Team was conducting orientation sessions for port health officers and stakeholders at points of entry. Three institutions were designated as isolation and treatment centres in the country (Wilkins Infectious Diseases Hospital in Harare, Thorngrove Infectious Diseases Hospital in Bulawayo and Gweru Infectious Diseases Hospital). PPEs were distributed at strategic places, although a lot more need to be purchased. A gap analysis had already been carried out, and the strengths identified in the country were: a robust surveillance system; a good and effective coordination mechanism; adequate health staff; a good communication system. Gaps included lack of expertise and capacity among health staff and facilities in dealing with an Ebola outbreak situation as the country has not experienced any outbreak in the past; inadequate port health officers, including capacity and equipment; logistics and financial resources.

Coordination of preparedness and response activities would be through the Inter Agency Coordination Committee on Health (IACCH). The Directorate of Epidemiology and Disease Control in the Ministry of Health and Child Care (MOHCC) chairs the meetings, and WHO is the secretariat. The National Rapid Response Team (NRRT) will lead the response activities and carry out the task of capacity building. The National Health Emergency Operation Centre (NHEOC) was established in the Department of Epidemiology and Disease Control, and is responsible for providing real time health information for action during disease outbreaks. The RRTs will be replicated at provincial and district levels. The main partners will include local authorities, local NGOs, the private sector, local communities, other government departments, WHO and other UN Agencies. The Civil Protection Department will activate Civil Protection Committees at all levels.

Samples for the confirmation of Ebola cases will be sent to the NICD Laboratory in South Africa as it is a level 4 laboratory mandated by WHO with required capacity to deal with biohazards samples. Triple packaging will be used to package and transport the laboratory samples. Laboratory scientists and other health workers will be trained on infection control.. Transportation has been arranged with the World Courier.

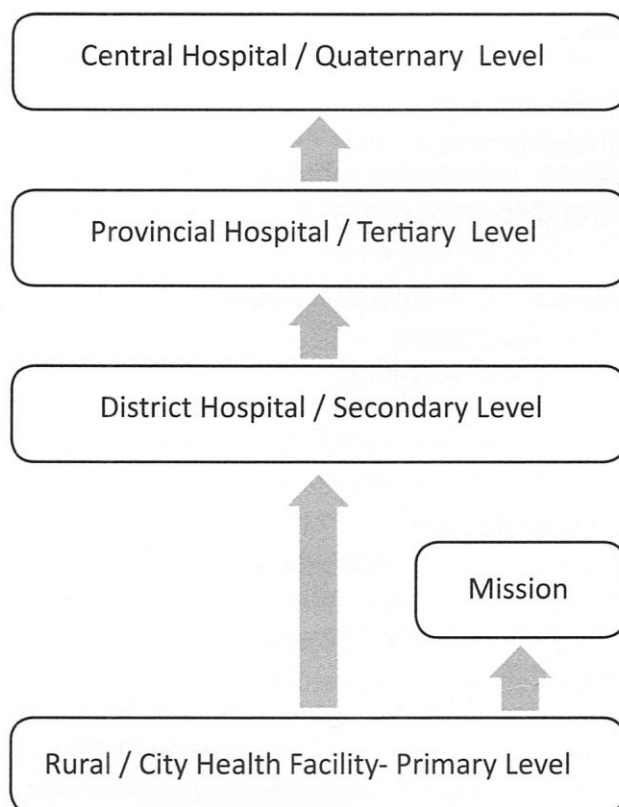
This plan will be effective for a period of 6-9 months (September, 2014 to April, 2015).

List of Acronyms

AEFI	Adverse Effects Following Immunization
BDBV	Bundibugyo Ebola Virus
CAAZ	Civil Aviation Authority of Zimbabwe
CFR	Case fatality Rate
CMED	Central Mechanical Equipment Department
DHE	District Health Executive
DHIS	District Health Information System
DPS	Director of Pharmacy Services
DRC	Democratic Republic of Congo
EBOV	Zaire Ebola Virus
EDTA	Ethylenediaminetetraacetic acid
ELISA	Enzyme-linked Immunosorbent Assay
EVD	Ebola Virus Disease
GoZ	Government of Zimbabwe
HW	Health Worker
IACCH	Inter-Agency Coordination Committee on Health
IATA	International Air Travel Association
IEC	Information Education Communication
KABP	Knowledge Attitude behaviour Practice
LA	Local Authority
MOF	Ministry of Finance
MoHCC	Ministry of Health and Child Care
MoLGNH	Ministry of Local Government and National Housing
NHEOC	National Health Emergency Operation Centre
NICD	National Institute for Communicable Diseases
NMRL	National Microbiology Reference Laboratory
OPD	Out Patient Department
PHE	Provincial Health Executive
PPE	Personal Protection Equipment
RDNS	Rapid Disease Notification System
RESTV	Reston Ebola Virus
SADC	Southern African Development Community
SOP	Standard Operating Procedure
SUDV	Sudan Ebola Virus
TAFV	Tai Forest Ebola Virus
TAT	Turn Around Time
UN	United nations
ZDF	Zimbabwe Defence Forces
ZPS	Zimbabwe Prison Services
ZRP	Zimbabwe Republic Police

1. Background Information

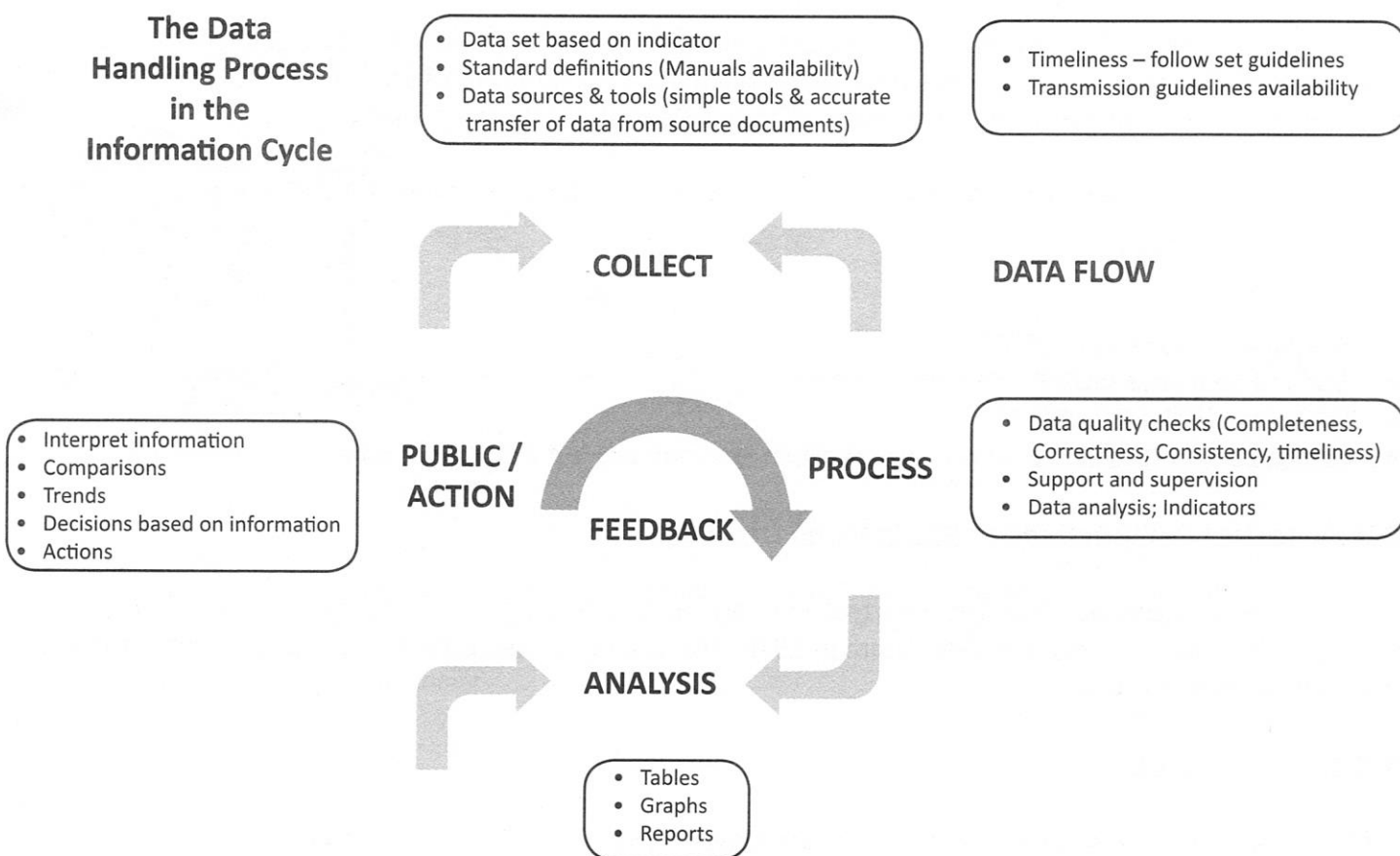
Zimbabwe is a landlocked country bordered by Mozambique on the east, South Africa to the south, Botswana to the west and Zambia to the north and northwest. The 2007 population of Zimbabwe is estimated at 13.1 million people. The country has experienced varying emergencies and disasters in the past which ranged from natural to man-made disasters and disease outbreaks. The country has 8 rural provinces, 2 city provinces and 63 administrative districts. Health delivery system is administered at 4 levels i.e. health facility, district and provincial hospital as well as central hospital level. The table below illustrates these levels of care:



1.1 Existing Surveillance System

Zimbabwe has an integrated disease surveillance system with information flow from the community and health facility transmitted to the district, province and national levels using the District Health Information System (DHIS). The table below shows activities done at each level

1.2 The Information Cycle Diagram



The following are priority Diseases, Conditions and Events of Public Health Importance in Zimbabwe which require immediate reporting:

- Acute haemorrhagic fever syndrome (Ebola Virus Disease, Marburg Fever, RVF)
Acute Flaccid Paralysis (AFP)
- Smallpox
- Cholera
- Yellow fever
- Adverse Events Following Immunization (AEFI)
 - Anthrax
 - Typhoid fever
 - Diarrhoea with blood (Shigella dysenteria)
 - Hepatitis A
 - Human Influenza due to new subtype
 - Maternal death
 - Measles
 - Meningococcal meningitis
 - Neonatal tetanus
 - Plague
 - Rabies (confirmed cases)
 - SARI
 - SARS
- Any other public health event of international concern
- Infectious
 - zoonotic diseases
 - food borne, chemical
 - radio nuclear or due to an unknown conditions

2. Definition of ebola virus disease

2.1 Introduction

Ebola virus disease (EVD), formerly known as Ebola hemorrhagic fever is a severe acute viral illness, often fatal in humans. EVD is caused by the Ebola virus, which belongs to the family of viruses called Filoviridae (Filovirus). EVD outbreaks occur primarily in very remote villages in Central Africa, near tropical rainforests.

There are 5 distinct species of Ebola virus of which 4 of the strains can cause severe illness in humans and animals. These are:

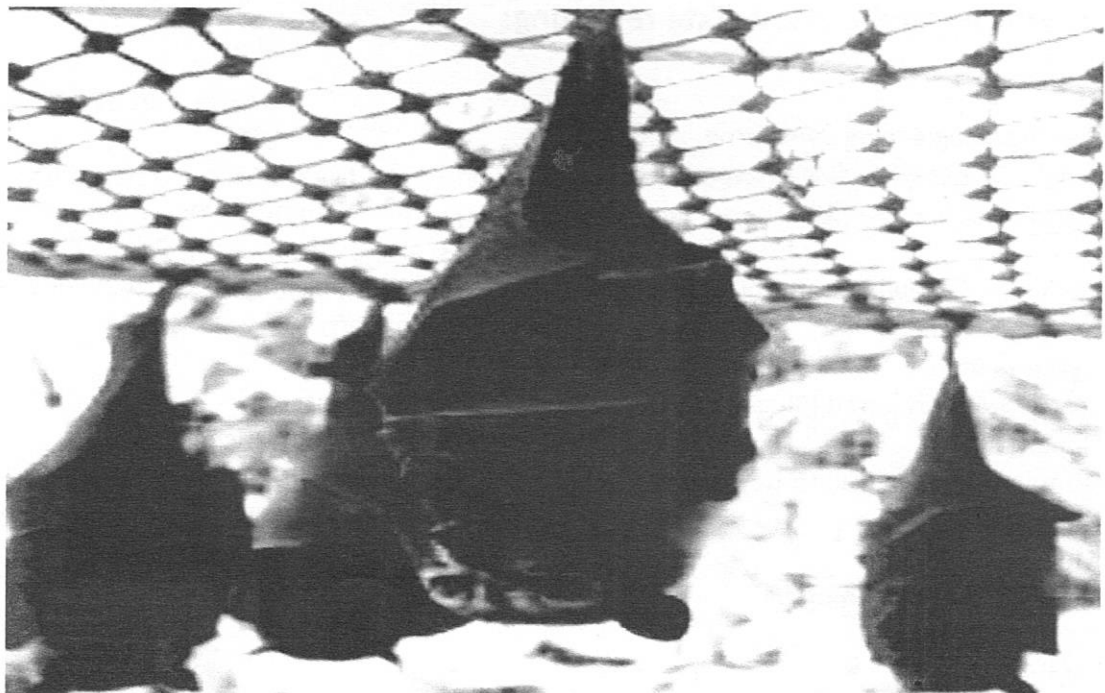
- Zaire Ebola virus (EBOV)
- Bundibugyo Ebola virus (BDBV)
- Sudan Ebola virus (SUDV),
- Taï Forest Ebola virus (TAFV)
- Reston Ebola virus (RESTV) which causes diseases in animals but no cases in humans.

2.2 Historical Perspectives of Ebola Virus Disease

The first human outbreaks were first reported simultaneously, in Northern Zaire at a place known Yambuku (now DRC) and in Sudan, at a place named Nzara in 1976. The virus is named after the Ebola River, where the virus was first isolated in the DRC.

2.3 Natural Hosts

EVD is a zoonotic disease which means a disease transmitted from animals to humans. Fruit bats, particularly species of the genus *Hypsignathus monstrosus*, *Epomops franqueti* and *Myonycteris torquata*, are considered possible natural hosts for Ebola virus. As a result, the geographic distribution of Ebola viruses may overlap with the range of the fruit bats. Humans can be infected by other humans if they come in contact with body fluids from an infected person or contaminated objects from infected persons or when “butchering” wild animals.

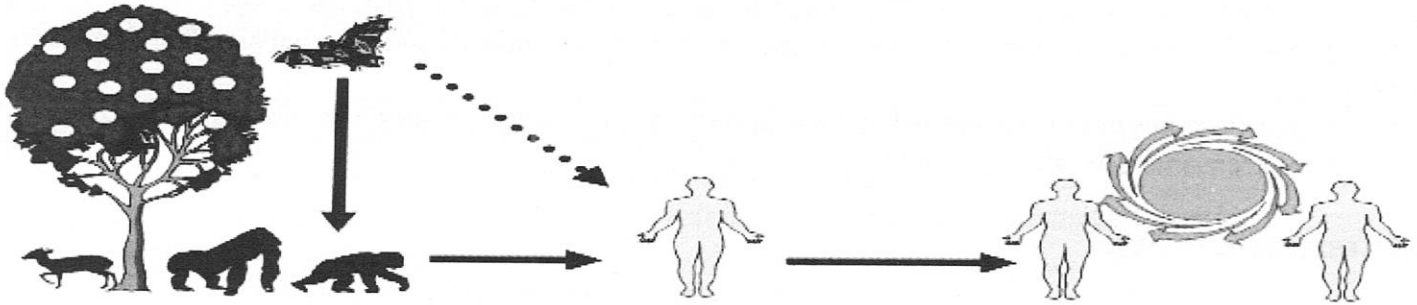


Fruit bat natural host of Ebola virus.

The illustration below explains the hypothesis of Ebola virus transmission at the human animal-interface

1. Virus Reservoir: Fruit Bats

The virus maintains itself in fruit bats. The bats spread the virus during migration



2. Epizootic in primates

3. Primary human infection

4. Epizootic in primates

Infected fruit bats enter in direct or indirect contact with other animals and pass on the infection, sometimes causing large scale epidemics in gorillas, chimpanzees and other monkeys or mammals (e.g forest antelopes).

Humans are infected either through direct contact with infected bats (rare event), or through handling infected dead or sick animals found in the forest (more frequent). Secondary human - to - human transmission occurs through direct contact with the blood, secretions, organs or other body fluids of infected persons. High transmission risk when providing direct patient care or handling dead bodies (funerals).

2.4 Past Outbreaks

Several Ebola outbreaks have happened in the past, which have resulted in extremely high case fatality (deaths) of up 90% of infected individuals. The table below shows the year, country, the type of Ebola virus species involved, number of people affected and deaths from these outbreak.

Year	Country	Ebola virus species	Cases	Deaths	Case fatality
2012	Democratic Republic of Congo	Bundibugyo	57	29	51%
2012	Uganda	Sudan	7	4	57%
2012	Uganda	Sudan	24	17	71%
2011	Uganda	Sudan	1	1	100%
2008	Democratic Republic of Congo	Zaire	32	14	44%
2007	Uganda	Bundibugyo	149	37	25%
2007	Democratic Republic of Congo	Zaire	264	187	71%
2005	Congo	Zaire	12	10	83%
2004	Sudan	Sudan	17	7	41%
2003 (Nov-Dec)	Congo	Zaire	35	29	83%
2003 (Jan-Apr)	Congo	Zaire	143	128	90%
2001-2002	Congo	Zaire	59	44	75%
2001-2002	Gabon	Zaire	65	53	82%
2000	Uganda	Sudan	425	224	53%
1996	South Africa (ex-Gabon)	Zaire	1	1	100%
1996 (Jul-Dec)	Gabon	Zaire	60	45	75%
1996 (Jan-Apr)	Gabon	Zaire	31	21	68%
1995	Democratic Republic of Congo	Zaire	315	254	81%
1994	Cote d'Ivoire	Tai Forest	1	0	0%
1994	Gabon	Zaire	52	31	60%
1979	Sudan	Sudan	34	22	65%
1977	Democratic Republic of Congo	Zaire	1	1	100%
1976	Sudan	Sudan	284	151	53%
1976	Democratic Republic of Congo	Zaire	318	280	88%

2.5 Common Clinical and Laboratory Features of Ebola Virus Disease (EVD)

The Ebola virus Disease affects multiple organ systems in the body. Most symptoms can appear between 2 to 21 days after infection, which is the incubation period for the disease. Early symptoms include sudden onset of fever $\geq 38^{\circ}\text{C}$, body weakness, muscle pain, headaches and a sore throat. These symptoms mimic many other diseases including malaria, typhoid fever, meningitis, Influenza and many others. Some patients develop rash, red eyes, hiccups, chest pains and difficulty in breathing and swallowing. In the advanced stage patients develop vomiting, diarrhea, impaired kidney and liver function and ultimately internal and external bleeding from all the orifices.

The laboratory features of the disease include: leucopenia early in the early stages, thrombocytopenia, elevated amylase and transaminases and signs of DIC.

2.6 Treatment of EVD

There is no cure for Ebola Virus Disease (EVD) or a vaccine. In the past EVD outbreaks up to 90% of cases that had contracted the disease have resulted in death. The current outbreak in West Africa a case fatality of close to 55% has been recorded probably due to early treatment seeking. Treatment of EVD patients hinges on isolation of the affected people so that they don't transmit the disease to others. Most care of the patient is limited to supportive therapy through balancing the patient's fluids and electrolytes, maintaining their oxygen status, maintaining normal blood pressure, transfusion to those who need it and treating any complicating bacterial infections.

2.7 Transmission of EVD

The Ebola filovirus is extremely infectious but moderately contagious. Infectious, because a small amount can cause disease, moderately contagious, because the virus is not transmitted through air droplets. Persons can only transmit the disease when they start to exhibit the symptoms of the disease. The viral load and infectiousness of their body fluids (i.e. blood, vomits, and excreta) increases as their health condition deteriorates. Women are more at risk as they often care for the sick at home.

Ebola virus is introduced into the human population through close contact with the blood, secretions, or other bodily fluids and organs of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead in the rainforest. Ebola then spreads in the community through human-to-human transmission, with infection resulting from direct contact (through broken skin or mucous membranes with blood) the blood, secretions, or other bodily fluids and organs of infected people.

2.8 Most Common Transmission Settings

2.8.1 Health-care setting

Most health care workers get infected while caring for EVD patients or due to close contact with patients when infection control precautions are not strictly adhered to. Health care workers get infected while doffing (removing) the personal protective equipment (PPE).

2.8.2 Family settings

Family members who care for sick relatives especially women who are at high risk of contracting the EBV disease. There is also a possibility of sexual transmission as convalescent men can still transmit the virus through their semen for up to 7 weeks after recovery from the illness.

2.8.3 Burial Ceremonies

Some cultural and religious practices in some communities in which mourners and burial undertakers have direct contact with the body of the deceased through the washing and handling of the corpse can lead to them contracting the disease. In some traditions and beliefs in some tribes in Africa, widows of deceased individuals are required to kiss or lie beside the deceased putting them at high risk of contracting the disease.

2.9 Prevention and Control of EVD

Several ways and settings can be applied in the prevention and control of Ebola. Effective prevention and control hinges on early diagnosis and reporting of suspect cases. This calls for increased awareness among the community and high index of suspicion among health care workers, effective epidemiological surveillance and contact identification and follow up as well as early referral for treatment and laboratory testing.

2.9.1 Controlling EVD infection in health-care settings

Health care workers need to use appropriate infection control precautions and procedures when handling any suspected EVD patients. They need to have a high index of suspicion for early diagnosis; use appropriate personal protective equipment (PPE) in attending to EVD cases and specimen taken from the cases should be handled with relevant care.

2.9.2 Reducing the risk of EVD infection in the Community

There is need to reduce wild life to human interface by avoiding hunting and consumption of bush meat, reduce human to human transmission in the community and avoid risky cultural and religious practices that enhance viral transmission e.g. care for sick, dead and unsafe funeral practices.

2.9.3 Current Ebola Outbreak in West Africa

WHO notified Ebola Virus Disease (EVD) in Guinea on 13 March 2014 then Liberia on 31 March 2014 and Sierra Leone on 26 May 2014. It is believed that the first EVD cases started in early December in Guinea. A case has since been reported in Nigeria and Senegal. The cases and deaths have been increasing, with a cumulative figure of 6553 cases and 3083 deaths (CFR 47%) as of 23 September, 2014. Nigeria has had an outbreak caused by an imported case through air travel, and this has led to 20 cases and 8 deaths being reported, while in Senegal 1 case and no death have been reported.

There is an EVD outbreak in Democratic Republic of Congo (DRC) in Equator Province which is not linked to the current outbreak in West Africa.

For the first time 3 countries in West Africa were affected at the same time affecting people in towns and cities, in densely populated areas. There has been cross border transmission in the 3 countries as they share common borders, areas of conflict and political instability in the recent past, in poor marginalized and traumatized communities with women and children being most affected.

The 3 countries affected have an inefficient healthcare system with poor level of health workers training. It's the first occurrence of Ebola in West Africa so there is no institutional memory on how to manage the disease. There is a high level of resistance to the Ebola outbreak response in some affected communities with strong traditional practice of care for the dead involving direct contact with corpse during burials. All these factors have made it difficult to effectively control the outbreak.

Drastic measures have been taken to avoid further spread of the disease in West Africa. These include closing of borders, restricting movement of people with quarantine of entire communities in some affected countries and

declaration of the state of emergency in the affected countries. WHO declared EVD a Public Health Emergency on International Concern (PHEIC).

3. Zimbabwe Ebola Virus Disease Preparedness and Response Plan

3.1 The problem Statement

Zimbabwe recognizes that there is a risk, though still low at the moment that there could be a case/cases of Ebola Virus Disease occurring in the country due to the rapid movement and displacement of people globally. The EVD outbreak unfolding in the West African countries has been increasing in cases and deaths with no sign of abating. It would therefore, be prudent that Zimbabwe puts in place a preparedness and response plan.

3.2 Situation Analysis

3.2.1 Capacity Assessment within MOHCC and other Departments

A capacity assessment done for Zimbabwe as a country showed that there is the following as strengths:

- Port Health services are established at all major points of entry
- PPEs have been prepositioned at several points of entry and isolation facilities
- Well-established and efficient surveillance system is in place at National, Provincial, District and Health facility level
- Human resources are available at all levels
- More isolation facilities have been identified throughout the country
- Good coordination mechanism is in place through the IACCH
- Communities in Zimbabwe are generally literate to grasp health education

3.4 Gaps noted within the MOHCC and other Departments

- Lack of technical capacity and expertise among health staff for EVD in health facilities and points of entry in areas of EVD surveillance and response, case management and infection control
- Inadequate financial resources for EVD preparedness and response
- Lack of awareness among the stakeholders including the community for EVD

3.5 Activities done so far

1. The National Rapid Response Team (RRT) was activated and is coordinating EVD activities in the country through the Inter Agency Coordination Committee on Health (IACCH).
2. The NHEOC is obtaining real time information on EVD.
3. An inter- ministerial taskforce on Ebla was activated.
4. The assessment of the country's capacity to deal with EVD in the event that we have a case was done.
5. Sensitization, orientation and training of health workers and other stakeholders is ongoing.
6. Isolation facilities have been identified.
7. Resource mobilization for Ebola Virus Disease from government is ongoing.
8. Pre - positioning of PPEs at major airports, ground ports of entry and other isolation facilities has been done.
9. Drills of EVD and practice in donning and doffing of PPEs is being practised.

4. Aim of the plan

4.1 Introduction

The EVD plan endeavors to provide a framework for preparedness and response to the threat of Ebola virus disease in Zimbabwe. The procedures outlined are geared towards minimizing the number of cases and deaths from the disease.

The International Health Regulations (2005)

The Ebola outbreaks in West Africa provide a strong opportunity for Zimbabwe as a country to put more effort towards building core capacities towards implementation of the International Health Regulations (2005).

The purpose and scope of the IHR (2005) are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” In this regard, this Ebola EPR plan will be guided by the IHR (2005) framework, particularly in areas relating to surveillance, screening of travellers, quarantine, reporting, notification, verification, response and collaboration.

On the 5th of September, 2014, SADC ministers of health held a special summit on Ebola in Victoria Falls, and the need to implement the IHR International Health Regulations (2005) was one of the major recommendations that the ministers agreed on. The ministers came up with a communiqué where they adopted a common Regional Position on travel of persons and trucks / commercial vehicle from EBOLA affected countries. See Annex 1

4.2 Broad objective

The broad objective of this plan is to provide a guideline on EVD preparedness and response in the event that cases of EVD are introduced in Zimbabwe.

4.2.1 Plan objectives

- To put in place an EVD alert and preparedness plan in the country
- To outline the interventions for the detection, prevention and control of Ebola virus disease in Zimbabwe
- To strengthen Ebola virus disease surveillance at community, health facility and major points of entry in Zimbabwe
- To put in place infection prevention and control (IPC) protocols in order to prevent the spread of the disease to health care workers
- To outline logistical requirements for EVD preparedness and response

5. Scope of the EVD plan

The plan covers the following 7 thematic areas: Public Health Surveillance and Case Detection, laboratory surveillance and diagnosis, infection control and prevention, case management, social mobilization, logistics and supplies and coordination

5.1 Public Health Surveillance and case detection

The objective of surveillance is for early detection of cases. Travelers from the affected countries are screened and monitored for a period of 21 days while still residing in Zimbabwe. On arrival every traveler shall complete a medical surveillance form. All suspected cases shall be isolated at designated isolation facility at the point of entry pending transfer to a treatment centre.

5.2 The travellers from the affected countries

The travelers are monitored on a daily basis to see if they develop signs and symptoms of the disease for a period of up to 21 days. This follow up is done by trained health workers and among other things; thermometers will be used to monitor their body temperature. The travelers shall be educated on the signs and symptoms of the disease, and will be provided with contact phone numbers of focal persons in their areas to call in the event of them developing symptoms.

5.3 Cases or Suspected cases of EVD

Cases or Suspected cases of EVD shall be isolated to appropriately designated isolation facilities at or near the points of their detection. The cases or suspected cases are reported through the rapid disease notification system (RDNS) to the higher office immediately. All rumours reported by the public shall be investigated immediately by Rapid Response Teams at that level and shall inform the higher level using the reporting system.

5.3.1 The composition of Rapid Response Team

The rapid response team for EVD disease investigation shall consists of an epidemiologist or team leader, clinician, laboratory scientist/technician, health promotion officer, infection control officer, environmental health officer/technician, veterinary officer data manager, logistician and others that can be co-opted to suite the local settings.

The duties of this team is to investigate any rumors or reports of EVD and institute initial control measures at that level.

Refer to SOP on Ebola document

6. EVD laboratory surveillance and Diagnosis

6.1 The role of laboratory in EVD surveillance and diagnosis

The role of the laboratory is to timeously collect the appropriate sample from a suspected EVD for confirmation. The laboratory personnel are to ensure that an appropriate specimen has been collected and transported to the designated reference laboratory in NICD in South Africa. Results will be transmitted back to the National level of the Ministry of Health and Child Care authorities.

7. Logistics and Supplies for EVD

Medicines and medical supplies needed to manage a total of 100 initial patients are to be stored at the designated treatment centers. The bulk of the stocks will be kept at NatPharm Harare and Bulawayo regional stores and each of the treatment facilities will order as and when required.

8. Case Management

The EVD cases will be treated in properly designated treatment centers in Harare, Gweru, Bulawayo, Hwange, and Beitbridge. Each point of entry in the country will have isolation facilities where patients will be held pending referral to the treatment centers using properly designed ambulances.

The following matrix gives the various thematic areas, and each thematic area has objectives, the activities to be carried out, target group, the inputs required, output and outcome indicators expected, the cost of activities, what the responsible organization is, the time frame for achieving that objective as well as the means of verification that the objective and its activities have been met.

(A) SURVEILLANCE GOAL AND OBJECTIVES

Surveillance Goal: To strengthen early detection and response to an Ebola Virus Disease (EVD) outbreak in Zimbabwe									
Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To prevent the introduction of EVD from other countries	Capacity building of Port Health Staff in Outbreak detection	Port Health Staff, PHEs and DHES	Training materials Guidelines Modules Stationery Allowances, Fuel Conferencing	233 port health staff trained 10 PHES trained 15 DHE trained	EVD Outbreak detected	\$90768.00 ¹	MoHCC	September 2014 to May 2015	Training Reports

¹Training Covers 233 officers @ \$75.00 per person per day by 3days. Fuel and transport \$7575, Conferencing-\$23368 and Stationery-\$2000.00. facilitators 6 facilitators covering 3 training sessions for 4 days for each session@ \$75 per day.

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To prevent the introduction of EVD from other countries	Sensitization of stakeholders at Points of Entry on medical screening of passengers	Border agencies Stakeholders at points of entry	Training materials Allowances, Fuel	400 stakeholders sensitized	Informed Stakeholders at Ports of Entry	\$15,000,00 ²	MoHCC	September 2014 to May 2015	Sensitization reports
	Screening and documentation of travelers at ports of entry	Port Health Staff	Infrared thermo-scanners and thermometers, Airtime, Communication Devices, Surveillance forms	100% travelers entering Zimbabwe screened	Suspect EVD cases detected % of clients placed on medical surveillance	\$36,500,00 ³	MoHCC	September 2014 to May 2015	Screening reports

² This will cover allowances for a team of 10 people for 15 days, fuels and transports to Ports of Entry and materials used in the sensitization.

³ This covers 100 IR thermometers 44 laptops

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To prevent the introduction of EVD from other countries	Medical Surveillance of travelers from EVD affected areas for 21 days	Travelers from EVD affected areas	6000 Digital thermometers, Airtime, Fuel for medical surveillance, internet services at points of entry. Allowances for health and community teams	Number of travellers from EDV affected countries placed on medical surveillance	% of travelers from EVD affected areas medically monitored for 21 days	\$120,000.00	MoHCC	September 2014 to May 2015	Medical Surveillance reports
	Create additional 202 post for Port Health Officer	Health workers	202 posts created	Number of posts created	No of posts filled	\$1,212,000.00	MoHCC	January 2014	Posts Filled
To strengthen existing disease surveillance systems (continued)	Adaption and distribution of data collection tools	PHE/DHE/ HF	Stationery	Data collection Tools developed	Proper documentation of surveillance activities	\$10, 000.00	MoHCC		Completed surveillance forms

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To strengthen existing disease surveillance systems (continued)	Orientation of Rapid response Teams on EVD ⁴	10 PHE teams 56 DHES 8 LA Health Depts. 5 ZD Forces Teams	Abridged training modules, Fuel Allowances	89 Rapid Response Teams retrained	EDV rumors and cases investigated within 24 hours	\$110,000.00	MoHCC		Training Reports
	Training of HC, OPD staff on Case Definition and recognition of EVD tools	Train staff at OPDs and Health Centers	Cases Definition EVD Training modules	3200 OPD staff trained	EVD diagnosed competently	\$32,000.00 ⁶	MoHCC (DHE) ZDF (health) ZPS ZRP	Sept 2014 to May 2015	Availability of case definitions % Cases correctly diagnosed

⁴ In case of a fully fledged outbreak of EVD. The district RRTs will be transformed in to Mobile Epidemiologic Teams that will investigate cases, do active case finding among others.
⁵ This covers stationary, allowances for 89 RR Teams at provincial, district and armed forces levels. 56 IR thermometers for mobile teams are also included. When districts train they are urged to include uniformed forces in their areas of jurisdiction as well.
⁶ Training will be done on site by DHES and hospital executives- case definitions to be posted in all OPDs and consultation rooms

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To strengthen existing disease surveillance systems (continued)	Weekly Collection and transmission of data	Health Information Practitioners	Weekly surveillance forms, Internet	90 Health Information officers trained	EVD data Adequately captured and recorded	\$32,940.00 ⁷	MoHCC and partners	Sept 2014 to May 2015	Weekly surveillance Reports
To establish community surveillance systems at grassroots level	Establish and Training of community teams ⁸	Community Leaders	Community Disease surveillance tools	Community surveillance teams set up ⁹	Case Investigation Reporting of Rumors	\$137,000.00 ¹⁰	MoHCC ZDF ZRP ZPS	Sept 2014 to May 2015	Training reports Surveillance Team Reports
To establish immediate lines of reporting for suspected cases	Establishment national and district call centers	National and Provincial level staff	2 hot lines National and 2 at each Province Human resources	Call centers set up	Functional call centers	\$50,000.00	MoHCC National Health Trust	Nov 2014	Call Centre reports
	Train hotline staff management	National and Provincial level staff	Training materials	210 hotline operators trained	Number of cases and rumor received through hot line	\$75,600.00 ¹¹	MoHCC		

Total Surveillance = \$1,921,808.00

⁷ On the job training by DHEs
⁸ The teams will be trained on EDV recognition, follow up of cases, education of community on EDV, reporting cases to RRT and Health Centre. Training to be done by HC staff with DHE staff.
⁹ The community response teams will be trained by DHEs Uniformed forces and Local Authorities. These will be community members. The target is to have at least a critical mass of trained community members in high-risk areas. These will be activated when there is need
¹⁰ This will cover training of 50 teams in high-risk areas and allowances for their community activities @\$3.00 per day for 90 days.
¹¹ Two day trainings in the 2 regions....No of sessions to be decided later.

(B) CASE MANAGEMENT

Goal									
Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To establish 100 case management teams in Zimbabwe by 30 October 2014	Identification and setting up of Case management teams members	Central, Provincial & District Hospitals, Local Authorities ZRP, ZDF ZPS	Case management modules	100 case teams ¹² set up	Quality care management provided to EVD patients	\$400,000.00 ¹³	MoHCW ZDF ZPS ZRP LA	31 October (National team on study by.)	Lists of Case management teams
	Case management drills at health institutions	Central, Provincial & District Hospitals, Local Authorities ZRP, ZDF ZPS	PPE Procedure Manuals Transport Facilitators Air time	1872 Case management drills done in 6 months	Cases properly and efficiently managed	\$50,000.00 ¹⁴	DHES LA ZPS ZRP ZDF	October-April	Drill Reports

¹² Each team will have 10 members (Nurses, Doc, Caterers, EHOs, Nurse Aides, Cleaners etc)

¹³ The country will be divided into 2 regions North and South. There will be 2 teams of trainers who will train teams in the 2 regions. The training will be of 5 days duration covering EVD outbreak management, case management RRT Surveillance etc.

¹⁴ Cost covers 3 sets of PPE for drills and \$500 per institutions for the 6 months

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To identify and equip EVD Isolation Units at Ports of entry	Designate isolation facilities at points of entry	Port Health Authority LA	Beds Bedding Materials Disinfectants IR thermometers	11 isolation units designated at points of entry	General population protected	\$50,000.00	MoHCC	by 20 October 2014	Reports on Isolation unit establishment
To identify and equip EVD Treatment Units	Establish static Isolation Units at Harare, Bulawayo, Gweru, Mutare	Harare, Bulawayo, Gweru, Mutare Local authorities	Repairs Maintenance	4 Static treatment centers set up	Cases well managed	\$300,000.00 Incinerator, car bag equipment and renovation	MoHCC and partners LA	by 30 October 2014	Purpose made EVD treatment units set up
To capacitate provinces and Uniformed forces to deploy mobile treatment units	Provide expertise and materials to set up mobile treatment centers	Provincial Medical Directorates ZDF Medical Corps	Training Materials for Treatment center set Up	10 Provinces and ZDF equipped to set up field treatment units	Cases well managed	\$100,000.00	MoHCC Partners	by 30 October 2014	Reports on availability of materials and competency to set up.

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To standardize EVD management	Develop Standard operational procedures for EVD Management	Central, Provincial & District Hospitals, Local Authorities ZRP, ZDF ZPS	Stationery, Printing Orientation Workshops	Develop Institution Specific SOP on PPE, Burial and Corpse Management, Disinfection, Case Management and Communication Strategy	Standardized way of EDV management	\$112,000.00 ¹⁵	MoHCC	By 30 October 2014	Availability of SOP at Institutions
	Equip and adequately train ambulance teams to transport suspected EVD cases	Ambulance Services in Central, Provincial & District Hospitals, Local Authorities ZRP, ZDF ZPS	Stationery, Printing and orientation workshop, Ambulances	Training of Ambulance crews	98 teams of 3 members each trained ¹⁶	173,250.00 ¹⁷	MoHCC	By 30 November 2014	Training Reports

¹⁵ Each Unit to be allocated \$2000.00 to develop SOPs.

¹⁶ Each team will have 3 crew members. Target is to train a team for each district, defences forces units and local authorities.

¹⁷ Three day training of 294 cadres plus trainers @\$175 per day.

(C) INFECTION CONTROL

Infection Control Goal: To prevention infection among health workers and clients									
Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To train 5 trainers in 10 provinces and 6 central hospitals, 8 provincial hospitals ¹⁸ , partners, Uniformed Forces ¹⁹ and 8 major councils ²⁰ in EVD Infection control.	Training of trainers	Health Workers (All Categories)	200 trainers of trainers (ToT) Equipment IES Material Handbooks	Conduct 6 training sessions of 3 days duration	180 trainers trained	\$180,030.00	MOHCC (National) and Partners	29 September 7 th October 2014	Training Reports
To cascade training to grassroots level	Training of operative health workers	Grass root Health workers	200 trainers Equipment IES Material Handbooks	Conduct 56 training sessions	8000 Health Cadres trained ²³	\$32,000.00	MoHCC		Training Reports

¹⁸ Central & Provincial Hospital and : Medical Nursing (Infection Control) Administration, Health Promotion, Public Relations, Domestic Services ZDF, ZPCS, CIO ZRP

²⁰ Major Councils – Harare Bulawayo Mutare, Bindura, Kadoma, Chinhoyi, Gweru and Kwe-kwe- (5 people each)

²¹ Provincial level- 5 Cadres (Nursing, Medical, Environment, Administration, Health Promotion, Laboratory)

²² Trainers- Infection Specialist, Case Management, Environmental Health, Logistic and Supplies, Epidemiologist (5 for each group)

²³ District Uniformed 100 cadres per brigade (500) ZRP= 100 ZPS= 100 Councils- 800

²⁴ Sets to be distributed as follows 300 sets per Isolation Unit, 100 sets for laboratory 9kits each for Ports of Entry among others

²⁵ Each team to have 8 people 4 burial persons 2 to disinfect 1 security and 1 driver. Provincial teams trained first and will cascade the training.

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To ensure 50 sites have adequate and appropriate PPE for EDV management by 7th October 2014	Purchase and Pre position 2834 ^{2A} sets Personal Protective Equipment at 50 sites.	Head Office -1000 10 provinces and 6 central hospitals, 8 provincial hospitals, partners, Uniformed Forces and 8 major councils	PPE Setss	Distribute PPE to 50 sites	2834 PPE sets prepositioned at 50 sites	\$249,989.00	MoHCC and Partners	To be done by 7th October 2014	Distribution reports

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To prevent EDV transmission due to burial practices	Promotion of Community Infection (Prevent Transmission of EVD in Communities)	Councils Traditional leaders Private Cemetery	Directive from Ministers Burial Space by local authorities	Directive issued to councils Burial space availed by councils	5 grave reserves by each local authority	\$56,000.00	MoHCW MoLGNH Councils	By 3rd of October	Burial space availed
Promotion of Community Infection (Prevent Transmission of EVD in Communities)	Training of community burial groups	Funeral parlors, Churches, Red Cross, Grave yard Attendants Knapsack	PPE Training, Body bags, Disinfectants, Loose tools	110 ³⁵ Community burial groups set up and trained	Burial done with dignity	\$137,200.00 ²⁶	MOHCW and partners	By 17 October	Reports

(D) LABORATORY CONFIRMATION

Laboratory: To confirm diagnosis of suspected EVD									
Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To confirm diagnosis of suspected EVD	Training on collection, storage and transportation of samples	Laboratory scientists and clinicians	Conferencing Accommodation Allowances Fuel	Laboratory scientists and clinicians capacitated	Evidence based patient management	\$40,000.00	MoHCC	September to May 2015	Training Reports Lab. Reports
	Transportation of Samples to NMRL	Treatment Centres	Fuel, Servicing, accommodation and allowances	Number of samples received at NMRL	Number of samples submitted to NICD	\$30,000.00	MoHCC	September to May 2015	
	Transportation of Samples to NICD	NMRL	Testing of samples to South Africa	Number of samples tested	Results of samples provided	\$1,000,000.00	MoHCC	September to May 2015	
	Purchase of Lab Reagents	NMRL				\$50,000.00	MoHCC	September to May 2015	
	Purchase Chemistry Analyser	NMRL	Procure a chemistry analyzer			\$120,000.00	MoHCC	September to May 2015	
	Renovation and Refurbishing of level 3 laboratory to identify Ebola Virus					\$2,800,000.00	MoHCC	September to May 2015	
	Training of 4 Lab Staff in testing infectious material				Competent Lab staff	\$8,000.00	MoHCC	September to May 2015	

Subtotal cost = \$4,048,000.00

(E) HEALTH PROMOTION AND SOCIAL MOBILIZATION

Health Promotion and Social Mobilization									
Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To sensitize and orient stakeholders on the prevention and control of Ebola Virus Disease	80 Orientation meetings 80 Sensitization meetings	Government departments Private Sector, National, Provincial and District Civil Protection Committees,	Human, financial, material resources, Transport, Stationary	80 Number of meetings held, 80 Number of orientation meetings held	Improved knowledge on EVD	\$416, 000.00 ²⁷	MoHCC	29 September 7th October 2014	Reports
To produce and disseminate IEC materials for healthcare workers and the general population on Ebola Virus Disease	Produce and distribute IEC material Produce and Radio, TV Shows, Produce job aids for health workers	Partners Health workers, Other sectors, General population	Human, financial, material resources, Transport, Stationary	Availability of IEC material, Number of IEC material produced and distributed	Increased awareness and Adoption of prevention behaviors and practices	\$54, 600.00 ²⁹	MoHCC	29 September 7th October 2014	Productions Available
To mobilize communities for the prevention and control of Ebola Virus Disease	Road shows, SMSs Distribution of posters, flyers, billboards & other IEC materials, Perceptions Beliefs assessment, Dramas	Community (rural, peri-urban and urban), General population	Human, financial, material resources, Transport, Stationary	Percentage of community mobilized	Increased awareness Improve knowledge, behaviors and practices	\$116, 600.00 ³⁰	MoHCC	29 September 7th October 2014	Community mobilization reports
To orient and sensitize media on Ebola Virus Disease prevention and control	Provide updates to media, Press conferences, Press release, Breakfast meetings	Media houses, Journalists	Human, financial, material resources, Transport, Stationary	2 media houses and journalists sensitized, Number of press articles presented	Improved media reporting on Ebola Virus Disease	\$20, 000.00 ³¹	MoHCC		Report of media sensitization
Monitoring and Evaluation of interventions	Communication Coordination Documentation KAPB assessment	Community Health workers, Media, Other stakeholders	Human, financial, material resources, Transport, Stationary	Increased level of knowledge and awareness	Change in attitudes, behaviours and practice Improved knowledge	\$30, 000.00 ³²	MoHCC	29 September 7th October 2014	

²⁸ To include case definition, patients management charts etc.

³¹ 2 media workshops Venue + refreshments for press conferences and press briefings

³² Follow-up meetings and documentation: \$30 000

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
To promote collaboration and coordination activities for preparedness of Ebola Virus Disease	Hold 12 IACCH meetings, 6 National Civil Protection Committee Meetings (Department of Civil Protection)	MOHCC, Other Ministries, UN Agencies, Non- Governmental Organizations, Civil Protection	Transport, Refreshments, Stationery, Communication (phone / cell phone calls)	Number of agencies, sectors, ministries, NGOs involved in the collaboration.	Well informed agencies, sectors, ministries, NGOs	\$ 34,475.00 ³³	MoHCC	September 2014 to May 2015	Minutes of meetings
	12 National Taskforce meetings (monthly), 4 Zoonotic sub-committee meetings (monthly) Establish National Health Emergency Operation Centre (NHEOC)			Number of taskforce meetings held Number of zoonotic sub-committee meetings held	Well-coordinated activities	\$137,200.00 ²⁶			

Subtotal= \$671,675.00

(F) LOGISTICS AND SUPPLIES

Specific Objective	Activities	Target Audience	Input	Output Indicator	Outcome Indicator	Cost	Responsible Organization	Time Frame	Means of Verification
	Procure Laboratory equipment			25 Vehicles Sources		\$1,000,000.00 ³⁴	MOHCC	October 2014	
To ensure availability of adequate resources for preparedness and response to a possible outbreak / outbreak of Ebola	Procurement of disinfectants and medicines			Medicines and Disinfectants Procured		\$450,000.00			Financial Reports
Provision of EPR staff allowances			Funds		Outbreak adequately prepared for and responded	\$1,600,000	MOHCC		Audited Accounts
	Procurement of communication equipments					\$50,000.00			

Subtotal = \$3,100,000.00
Total Budget = \$9,601,045.00

³⁴ Not Clear how this figure was arrived at!!!

Zimbabwe Government Contribution to the Preparedness and Response Plan

As has been mentioned in this plan, MOHCC and WHO had already started conducting activities through orientation of health staff, port health officers and stakeholders in Ebola Preparedness and Response. The orientation was done for major health institutions and Points of Entry (Airports and ground crossing). There are adequate human resources in the health sector, although there is need for capacity building in case management, infection control and surveillance. Some of the logistics like ambulance services are also available.

Budget Summary

Thematic Areas and Activities	Cost (USD)
SURVEILLANCE	
Capacity building for port health staff	\$ 90 768.00
Sensitization of stakeholders at points of entry	\$ 15 000.00
Screening and documentation of travelers at points of entry	\$ 36 500.00
Medical surveillance of travelers from EVD affected countries	\$ 120 000.00
Adaptation and distribution of data collection tools	\$ 10 000.00
Orientation of Rapid Response Teams at all levels	\$ 110 000.00
Training of Health Care staff on case definitions and recognition of EVD cases	\$ 32 000.00
Weekly collection and transmission of surveillance data	\$ 32 940.00
Creation of 202 posts for Port Health Staff	\$ 1 212 000.00
Establishment of community surveillance systems at grass root level	\$ 150 000.00
Establishing a hotline	\$ 50 000.00
SUB -TOTAL	\$ 1, 921 808.00
CASE MANAGEMENT	
Setting up of case management teams	\$ 400 000.00
EVD emergency drills/ Case management	\$ 50 000.00
Designation and equipping of isolation facilities at POEs	\$ 50 000
Identify and equip EVD treatments units	\$ 300 000.00
Capacitate uniformed forces	\$ 100 000.00
Standardize EVD management	\$ 112 000.00
Provide expertise and equipment for mobile clinics	\$ 100 000.00
Equip and adequately train ambulance crews	\$ 173 250.00
SUB -TOTAL	\$ 1 185 250.00
COORDINATION	
Holding IACCH, National Taskforce, Zoonotic sub-committee and Civil Protection meetings at all levels.	\$ 34 475.00
HEALTH PROMOTION	
Orientation and sensitization meetings	\$ 416 000.00
Production and distribution of materials	\$ 54 600.00
Road shows, drama, radio messages	\$ 116 600.00
Media updates, press conferences, breakfast meetings	\$ 20 000.00
Communication, documentation, KAPB, Assessments.	\$ 30 000.00
SUB-TOTAL	\$ 637 200.00

INFECTION CONTROL

Training of trainers in infection control (TOT) in infection control	\$ 180 030.00
Cascade training to lower levels	\$ 32 000.00
Purchasing and prepositioning of PPEs	\$ 240 989.00
Designation of burial places	\$ 56 000.00
Training of burial groups	\$ 137 200.00

SUB-TOTAL **\$ 646 219.00**

LABORATORY

Purchase of laboratory commodities – Triple packaging, outer packaging UN2841 boxes	\$ 40 000.00
Training on collection, storage and transportation of EVD samples	\$ 30 000.00
Purchase of laboratory reagents	\$ 50 000.00
Refurbishment of National Microbiology Reference Laboratory (NMRL)	\$ 2 800 000.00
Costing per test at NICD SA (US\$2 000/test x 500 tests)	\$ 1 000 000.00
Purchasing of chemistry analyzer for initial monitoring of EVD	\$ 120 000.00

SUB TOTAL **\$ 4 048 000.00**

LOGISTICS

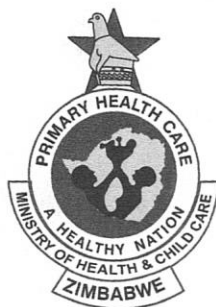
Procurement of 25 service vehicles and ambulances	\$ 1 000 000.00
Provision of allowance for health care workers	\$ 1 600 000.00
Procurement of disinfectants and medical supplies	\$ 450 000.00
Procurement of communication equipment	\$ 50 000.00

SUB TOTAL **\$ 3 100 00.00**

GRAND TOTAL **\$ 11 572 952.00**



SUMMARY EBOLA PREPAREDNESS AND RESPONSE PLAN



MINISTRY OF HEALTH AND CHILD CARE
SEPTEMBER 2014



The Aim of the Ebola Virus Disease (EVD) Preparedness and Response Plan

The EVD plan endeavors to provide a framework for preparedness and response to the threat of Ebola virus disease in Zimbabwe. The procedures outlined are geared towards minimizing the number of cases and deaths from the disease

The Broad Objective of the Ebola Virus Disease (EVD) Preparedness and Response Plan

The broad objective of this EVD plan is to provide a guideline on preparedness and response in the event that cases of EVD are introduced in the country

The purpose of this Ebola Virus Disease (EVD) Preparedness and Response Plan is to guide the country

The purpose of this Ebola Virus Disease (EVD) preparedness and response plan is to guide the country in terms of resource mobilization, stakeholders' involvement, health workers' response in the event of an EVD outbreak in Zimbabwe

The Scope of the plan

The Scope of the EVD plan covers the following main areas:

- surveillance
- case detection,
- laboratory services,
- infection control and prevention,
- case management,
- social mobilization,
- logistics and supplies and
- coordination

Thematic area 1: Ebola Viral Disease Surveillance and Case detection

Total Budget - \$1,897.868.00

Objectives for thematic area 1

To prevent the introduction of EVD into the country

- The objective aims at building capacities of Port Health Staff at the point of entry, provincial and district level, clinicians at all 4 levels of care and the community surveillance teams in disease and outbreak detection. Resources are required for drafting guidelines, modules, training materials, stationery, allowances, fuel, and conferences venue at an estimated budget of **\$85,368.00**. If achieved, this objective will strengthen early detection of EVD cases and avert its introduction into country.
- Four Hundred (400) stakeholders at Points of Entry are sensitized on medical screening of travelers/passengers in the initial stage of the plan. Material resources required are training materials, allowances and Fuel at an estimated cost of **\$15,000.00**. This will result in informed Stakeholders at Ports of Entry.
- Port health staff and clinicians are to be equipped with surveillance gadgets for screening and documentation of travelers passing through points of entry. Resources required are infra-red thermo scanners and thermometers, airtime, communication devices, surveillance forms at an estimated cost of **\$36,500.00**.

- Medical Surveillance and monitoring of each and every traveller from the EVD affected areas will be monitored for 21 days. Resources required include allowances for health and community teams, fuel for surveillance vehicles, 6000 disposable digital thermometers, airtime, and internet services at port of entry. The estimated budget is **\$120, 000**. If implemented, travellers from EVD affected areas will be medically monitored for 21 days.

To strengthen existing disease surveillance systems

- This objective endeavours to adapt and distribute data collection tools by all levels of health care. Data collection Tools need to be developed to ensure proper documentation of surveillance activities. A budget of **\$10 000.00** is required.
- Orientation of Rapid response Teams on EVD at all levels will be targeted. Training modules will be developed and health workers at the provincial, district, local authority and the Uniformed Forces will be orientated at a total cost of **\$110,000.00**.
- 3,200 OPD staff from selected primary health centres and referral hospitals will be targeted for training on case detection and recognition at an estimated cost of **\$32,000.00**. This cost will cover the allowances for trainers, the cost of hiring the venue, fuel, bus fares for the participants and lunch allowances. This will result in correct diagnosis of EVD.
- 90 Health information officers from all the provinces will be orientated on collection, compilation, analysis and transmission of surveillance data. For this a budget of **\$32,940.00** is needed. This cost will cover conference facility, fuel, busfare and allowances.
- Creation of additional 202 Posts of Port Health Staff (Environmental practitioners including an establishment of supporting clinicians/nurses at all points of entry). Presently, the establishment for Port Health Staff is 33. Need to lobby for these posts. Cost will depend on posts created. **\$1,212.000.00**

To establish community surveillance systems at grassroots level

- The aim is to establish and train community disease surveillance teams from among community leaders, village health workers and school health coordinators. This will strengthen case Investigation and reporting of rumors (whistle blowing). Disease surveillance tools will be developed and trainings will be done. A budget is **\$150, 000.00** is required.

To establish immediate lines of reporting for suspected cases

- Two hotlines (Toll free) at national level and 2 at each province total of lines 22lines: Total budget of **\$50,000.00** is needed.

Thematic area 2: Case Management

Total Cost \$1,185,250.00

Objectives for thematic area 2

To establish case management teams in Zimbabwe by December 2014

- This objective aims at Identification and setting up of Case management teams at Central, Provincial and District Hospitals as well as at the points of entry, Local Authorities and uniformed forces. Case management modules will be required to provide standardized training's. A budget of \$400,000.00 is required.

To enhance the competency of HW on EVD case management

- The objective focuses on conducting EVD drills and simulations at health institutions at Central, Provincial and District Hospitals, Local Authorities and in the uniformed forces health facilities. PPEs, Procedure Manuals, Transport, Facilitators and Air time will be needed so that cases will be properly and efficiently managed. A budget of **\$50,000.00** is required.

To identify and equip EVD Isolation Units at Ports of entry

- This objective intends to designate 11 isolation facilities at points of entry and hospitals. Port Health Authority and Local authorities will require Beds, Bedding Materials, Disinfectants, medicines and thermo detectors. A budget of **\$50,000.00**.

To identify and equip EVD Treatment Units

- The objective focuses on establishing 4 static Isolation Units at Wilkins Infectious Diseases Hospital in Harare, Thorngrove in Bulawayo, in Gweru and Mutare. This will guarantee that cases are well managed. Repairs, maintenance and purchasing of 4 incinerators amounting to **\$300,000.00** is needed to ensure the 4 Static treatment centres are set up.

To capacitate provinces and Uniformed forces in the deployment in mobile treatment units

- Focus is on the 10 Provinces and ZDF to be equipped to set up field treatment units. There is need for provision of expertise and materials to set up mobile treatment centers. Training materials, tents and equipment is required for setting up treatment centers by Provincial Medical Directorates and ZDF Medical Corps at a cost of **\$100 000.00**. This will ensure cases are well managed.

To standardize EVD management

- Emphasis is on developing Institution Specific SOP on:-PPE, Patient Flow, Burial and Corpse Management, Disinfection, Case Management. Central, Provincial & District Hospitals, Local Authorities, ZRP, ZDF and ZPS will be used to develop standardized SOPs on EDV management. A budget of **\$112 000.00** is needed.

To equip and adequately train ambulance teams to transport EVD cases

- Ambulance at central provincial and district hospitals to adequately transport suspected EVD to referral facilities. A total budget of **\$173,250.00** is required.

Thematic area 3: Infection Control

Total Cost - \$640,220.00

Objectives for thematic area 3

To put in place procedures on EVD infection prevention and control (IPC)

Personal Protective Equipment (PPE), IEC Material, and Handbooks will be mobilized at a budget of \$180 030.00 to enable each health facility to have IPC procedures and expertise in place. Over 500 health workers will be targeted.

To cascade IPC to grassroots level

- All provinces have infection control training teams to cascade the training to their health facilities. A total of 8000 health workers in all the country's hospitals will be trained in infection control and prevention at an estimated cost of **\$32.00.00.00** which will cover the provincial and districts trainings of trainers.

To ensure 50 sites have adequate and appropriate PPE for EDV management

- 2340 sets of Personal Protective Equipment will be purchased and Pre-position at 50 sites distributed at all levels of care. A total budget of **\$240,890.00** is estimated.

To prevent EDV transmission in burial settings

- Burial Space for EDV victims will be purchased and reserved throughout the country. A budget of **\$56.000.00** is required.

To Prevent Transmission of EVD in Communities

- Training and equipping 110 community burial groups. The objective targets Funeral parlors, Churches, NGOs, Grave yard Attendants and sprayers. Inputs include PPE, Training, Body bags, disinfectants and tools. A total budget of **\$137 200.00** is needed.

Thematic area 4: Laboratory Confirmation

Estimated Cost - \$4,048,000.00

Objectives of thematic area 4

To confirm diagnosis of suspected EVD

- Purchase of laboratory commodities, that includes triple packaging, laboratory reagents, carry out renovations of level 3 laboratory at NMRL, pay costs for to have tests at NICD in SA (US\$2 000/test x 500 tests) Training of 4 laboratory scientists in testing infectious material.
- Health care workers will be trained in collection, storage and transportation of Ebola virus samples. This training will capacitate laboratory scientists and clinicians.
- Upgrading of laboratory to level for Ebola Virus confirmation
- A total of **\$4,048.000.00**

Thematic area 5: Health Promotion and Social Mobilization including communication strategy

Total Cost - \$637 200

Objectives of thematic area 5

To sensitize and orient stakeholders on the prevention and control of Ebola Virus Disease

- This objective seeks to have 80 orientation and sensitization meetings conducted to Government departments, Private Sector, National, Provincial and District Civil Protection Committees and Partners. Resources required include Human, financial, material resources Transport, conferences and Stationery. A total cost of **\$416, 000.00** is required.

To produce and disseminate IEC materials for healthcare workers and the general population on Ebola Virus

- The Ministry would like to produce and distribute IEC materials, job aids for health workers, Radio and TV Shows. . This activity will target health workers, other sectors and the general population. The aim is to have an increased awareness and adoption of prevention behaviors/ practices Human and financial, material resources, transport, and stationery will be required at an estimated cost of **\$54, 600.00**.

To mobilize communities for the prevention and control of Ebola Virus Disease

- This objective seeks to increased awareness Improve knowledge, behaviors and practices, among Community (rural, peri-urban and urban) and general population through road shows SMSs, distribution of posters, flyers, billboards and other IEC materials, perceptions Beliefs assessment and dramas. A total estimated budget of **\$116 600.00** is required.

To orient and sensitize media on Ebola Virus Disease prevention and control

- The country seeks to improve media reporting on Ebola Virus Disease through involvement of media houses and journalists by providing updates to media, press conferences, press release, and breakfast meetings. Human, Financial, Material resources and Stationery will be required at an estimated cost of **\$20,000.00**

To monitor and evaluate EVD interventions

- The objective endeavors to Increase level of knowledge and awareness on EVD among community health workers, media, and stakeholders. This will in turn achieve Change in attitudes, behaviours and practice improved in EVD preparedness. Resources required include Human, Financial, Material resources, Transport and Stationery. An estimated budget of **\$30, 000.00** is required.

Thematic area 6: Coordination

Total Cost \$34,475.00

Objectives of thematic area 6

To promote collaboration and coordination activities for preparedness of Ebola Virus Disease

- This objective targets to have agencies, other sectors, ministries and NGOs well informed on EVD. Activities planned include holding of 12 IACCH meetings, 6 National Civil Protection Committee Meetings (Department of Civil Protection), 12 National Taskforce meetings (monthly), four Zoonotic sub- committee meetings (quarterly), and establish National Health Emergency Operation Centre (NHEOC). Resources required include Transport, Refreshments, Stationery, and Communication (phone/ cell phone calls) at an estimated cost of **\$34.475.00**

Thematic area 7: Logistics and Supplies

Objectives of thematic area 7

Total Cost - \$3,100.000.00

To ensure availability of adequate resources for preparedness and response to a possible outbreak/ outbreak of Ebola

- Medicines and supplies for EVD will need to be procured and proportioned to the provinces and points entry in the event that we have cases.

- To procure ambulances and services vehicles
- A total of **\$1,000,000.00** is needed for procurement of 25 vehicles for field operations and ambulances. 11 vehicles are planned for PoE, 2 Vehicles for EDC, 2 for Port Health operations at national level, 2 for laboratory services, 3 ambulances and 5 for local authorities.
- To provide allowances for health workers in Ebola Treatment Centers (ETC)
- In the event that a case of Ebola is introduced into the country and estimating that about 10 more cases will emanate from that case a total of **\$1,600,000.00** will be required for staff allowance in Ebola treatment centers and for contact tracing.

To procure medicines and supplies for EVD

- A total of **\$450,000.00** is required for the procurement of medicines and supplies for EVD
- To procure communication equipment
- There is need to procure communication equipment for National Emergency Operation Centre , Port Health Authorities and the ETC such as computers, laptops, tablets, mobile handsets and internet service for PoE's. A total of **\$50,000.00** is required.

Budget Summary

Thematic Areas and Activities	Cost (USD)
SURVEILLANCE	
Capacity building for port health staff	\$ 90 768.00
Sensitization of stakeholders at points of entry	\$ 15,000.00
Screening and documentation of travelers at points of entry	\$ 36,500.00
Medical surveillance of travelers from EVD affected countries	\$ 120,000.00
Adaptation and distribution of data collection tools	\$ 10,000.00
Orientation of Rapid Response Teams at all levels	\$ 110,000.00
Training of Health Care staff on case definitions and recognition of EVD cases	\$ 32,000.00
Weekly collection and transmission of surveillance data	\$ 32,940.00
Creation of 202 posts for Port Health Staff	\$ 1, 212. 000.00
Establishment of community surveillance systems at grass root level	\$ 150,000.00
Establishing a hotline	\$ 50 ,000.00
SUB-TOTAL	\$ 1, 921.808.00
CASE MANAGEMENT	
Setting up of case management teams	\$ 400,000.00
EVD emergency drills/ Case management	\$ 50,000.00
Designation and equipping of isolation facilities at POEs	\$ 50, 000
Identify and equip EVD treatments units	\$ 300,000.00
Capacitate uniformed forces	\$ 100,000.00
Standardize EVD management	\$ 112,000.00
Provide expertise and equipment for mobile clinics	\$ 100,000.00
Equip and adequately train ambulance crews	\$ 173,250.00
SUB-TOTAL	\$ 1 ,185.250.00

COORDINATION

Holding IACCH, National Taskforce, Zoonotic sub-committee and Civil Protection meetings at all levels. \$ 34,475.00

HEALTH PROMOTION

Orientation and sensitization meetings \$ 416,000.00
Production and distribution of materials \$ 54,600.00
Road shows, drama, radio messages \$ 116,600.00
Media updates, press conferences, breakfast meetings \$ 20,000.00
Communication, documentation, KAPB, Assessments. \$ 30,000.00

SUB-TOTAL \$ 637,200.00

INFECTION CONTROL

Training of trainers in infection control (TOT) in infection control \$ 180,030.00
Cascade training to lower levels \$ 32,000.00
Purchasing and prepositioning of PPEs \$ 240,989.00
Designation of burial places \$ 56,000.00
Training of burial groups \$ 137,200.00

SUB-TOTAL \$ 646,219.00

LABORATORY

Purchase of laboratory commodities – Triple packaging, outer packaging UN2841 boxes \$ 40,000.00
Training on collection, storage and transportation of EVD samples \$ 8,000.00
Purchase of laboratory reagents \$ 50,000.00
Refurbishment of National Microbiology Reference Laboratory (NMRL) (level 3 to elements of level 4 for EVD confirmation) \$ 2, 800,000.00
Costing per test at NICD SA (US\$2 000/test x 500 tests) \$ 1,000,000.00
Purchasing of chemistry analyzer for initial monitoring of EVD \$ 120,000.00

SUB TOTAL \$ 4,048,000.00

LOGISTICS

Procurement of 25 service vehicles and ambulances \$ 1,000,000.00
Provision of allowance for health care workers \$ 1,600,000.00
Procurement of disinfectants and medical supplies \$ 450,000.00
Procurement of communication equipment \$ 50,000.00

SUB TOTAL \$ 3,100,000.00

GRAND TOTAL \$ 11,572,952.00