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Evaluation And Management Of Patients With Possible Covid-19

Protocol For Emergency Department Evaluation And Management Of Patients With Possible Covid-19

Covid-19 And Health Care Facilities
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Signature Sheet

Minister of Health

Permanent Secretary

Chief Medical Officer

Health Disaster Coordinator

Director

National Emergency Management Organization
Preamble

Infectious disease emergencies are circumstances caused by biological agents, including organisms such as bacteria, viruses or toxins with the potential for significant illness or death in the population. The Infectious Disease Emergencies Response Plan may be used in situations that include naturally occurring outbreaks (e.g., measles, mumps, meningococcal disease), emerging infectious diseases (e.g., SARS, pandemic influenza), radiological and nuclear events and or bioterrorism.

- **The Structure:** The core part of the plan provides guidance to all components of the response and is divided into modules, or chapters, that are based on the mode of transmission of the disease such as the respiratory infections, haemoragric fevers, vector-borne diseases, water borne diseases primarily to organize the plan in a systematic and structured manner. The use of modules provides responders with the information they need in short segments so they do not need to read the entire plan to begin implementation and allows for flexibility in response by allowing only required components to be activated without disrupting the flow of the plan. Each module has clear information on their purpose, implementation approach, staffing needs, reporting, and available resources.

- **Situation Specific Annexes:** The Annexes are designed to supplement the Core Plan with specific guidance on how to respond to particular events. The content in each Annex should be used in tandem with the general information in the Core Plan.

- **Appendices:** The Appendices contain reference material to assist in the response. Examples of appendix items include maps, pre-written Health Alerts, protocols, forms, reference materials, and equipment instructions.

The Plan defines the response levels and the corresponding command structures to be set up at each response level. A three tier response level, which is adopted from the national influenza pandemic and outbreak preparedness and response plan is used.

The Plan aims to provide a framework of response system for agreed and coordinated efforts amongst different government departments and organizations with an aim to reduce the mortality
and morbidity of SVG population due to Public Health Events. It also serves as a tool for clear communication of the level of risk with the public.

The Plan includes the following key features

A three-tier response trigger system with each level representing a graded risk of Public Health Event activities and outcomes affecting SVG and its health impact on the community.

The Plan includes three response levels – Alert, Serious and Emergency. These response levels are based on risk assessment of Public Health threats that may affect SVG and its health impact on the population.

**AIM**

- Actively seek all cases of Ebola Virus Disease (PHE)
- Identify all suspected cases of and track all their contacts
- Reduce the risk of transmission of all infectious diseases and or contaminants in health facilities and the general community

**Figure 1: Aim**
The Legal Framework

As with all Ministries under the Public Service the Ministry of Health, Wellness and the Environment takes authority from the National Disaster Response Plan on the authority of Emergency Powers Act (45) (1970) and the Nation Disaster (Relief) Act (1947).

The following lists the legislative framework under which this plan operates:

The Public Health act of 1977:

I. Part IV and V addresses communicable diseases

II. Part IX and X addresses Port Health and food and water safety

III. Part XI addresses management of dead bodies
IV. Essential Services Act

V. National Emergency and Disaster Management Act #15, 2006 (June 1)

In addition to the above St. Vincent and the Grenadines also abide by International agreements namely; International Health Regulations (2005), International Atomic Energy Agency, International Maritime Organizations, International Federation of Red Cross and Red Crescent Societies among others.
Response Triggers

Figure 2: The CMO activates all plans or direct stand down of all response levels.

- **Alert Response Level**: Immediate health impact by Public Health Event is Low, Signs of Public Health Event outside of SVG, Risk of causing human infection in SVG is Low, WHO recommendation to maintain global alert for the Public Health Event.

- **Serious Response Level**: Risk of health impact by Public Health Event is Moderate, Confirmed human cases in countries with frequent trade and travel to SVG.

- **Emergency Response Level**: Risk of health impact by Public Health Event are High and Imminent, High risk of human infection with the Public Health Event in SVG, Public Health Event may maybe widespread, There are imported cases of the Public Health Event, There is evidence of one case in country, There is local transmission, Imminent risk of community level outbreaks and the event can be declared Public Health Emergency by the Minister of Health on the advise of the CMO.

**Response Triggers**

The response triggers will be evaluated and escalated or deescalate after completion of a risk assessment and more information becomes available.
Command Structure

The Surveillance committee will provide advice to the Health Emergency Operation Centre which is principally the same members of the National Health Services Sub Committee (Appendix A1) activation of the health response is by the CMO or by Unified Command with the Director of NEMO.
Overall Structure, System and Roles and Responsibilities

Organizational Structure

The MoHWE has as its chief technical head the Chief Medical Officer. The permanent Secretary is the chief accounting officer, with the Honourable Minister of Health, Wellness and the Environment having overall responsibility for policy and political direction.

The National Surveillance Committee

The national Surveillance Committee (NSC) is chaired by the national epidemiologist and its composition is guided by various entities involved in national public health response and surveillance as outlined by the International Health Regulations IHR. During emergency periods, the NSC will be chaired by the Chief Medical Officer, with the Medical Officer of Health serving as deputy chair. This is to allow for the highest level of decision making regarding advising the government and to allow the national epidemiologist to focus on defining the epidemic as it unfolds.

The National Surveillance Committee (NSC) will have direct responsibilities for the following:

- Provide expert advice to the MoHWE
- Ongoing surveillance and the development of early warning systems
- Develop guidance on public health measures to be applied
- Offer advice for the clinical management of cases
- Scoping the regional and international arena
- Advice on quarantine and other social distancing measures

National Emergency Management Organization (NEMO)

NEMO has the overall responsibility for national disaster coordination and response in St. Vincent and the Grenadines. The responsibility of NEMO will include the following:
• National coordination of the emergency response to all threats to Public Health
• Convoking meetings of the National Emergency Council, National Emergency Committee and managing the National Emergency Operation Center
• Mobilization of both human and financial resources in the event of a Public Health Event

The Health Emergency Operating Centre (HEOC)

The HEOC has a Director of Operations who for outbreaks is the CMO and comprises all health stakeholders relevant to the national health response in the any public health threat or declaration of a pandemic in St. Vincent and the Grenadines. The responsibilities of the HEOC includes the following:

• Advise NEMO on the activation of the N EOC in the event of a pandemic in St. Vincent and the Grenadines
• The chair of the HEOC will be the representative of the MoHWE on the NEC
• Make necessary arrangements for the management of patients when and if existing capacity is exceeded
• Develop national plans for the allocation of health resources in the event of a pandemic, including but not limited to human resources, personal protective equipment and essential drugs and supplies needed for the national pandemic response
• Develop, implement and update national health disaster plan.

Finance

The ministry of Health, Wellness and the Environment has the overall responsibility for the funding of this response plan. Financing will be done through three modalities:

• Each programme within the MoHWE with responsibilities for implementation of this plan will mobilize its budgeted resources to do so.
• A contingency fund will be allocated to the MoHWE by the ministry of finance in the event of a Public Health Event in St. Vincent and the Grenadines.
• NEMO, through the National mechanism will coordinated assistance and support, locally, regionally and internationally.

Standing down

Once activated, the National Health Multihazard Plan and the National Disaster Management and Response Plans would be deactivated on the recommendation of the chair of the National Health Services Sub Committee to the director of NEMO. The scientific basis for this decision will be provided by the NSC.

Review of the plan

The National Health Multihazard Plan and Highly Infectious Diseases Plans will be reviewed every two years or as otherwise deemed necessary by the National Health Services Sub Committee. Reviewing of the plan will be the responsibility of the NSC, and other relevant agencies. There will be annual simulation exercises aimed at testing health’s preparedness and response plan to all public health threats. After each simulation, recommendations on improvements will be made and the plan adjusted to reflect these changes.
Public Health Response Measures

Impact on health and social services

- The impact of a pandemic of any infectious disease on the health and social services is likely to be intense, sustained and national with all services becoming quickly overwhelmed as a result of:
  - the increased demand for care by affected patients and its complications
  - burden added by bereavement and anxiety
  - the need for high dependency care
  - logistical problems due to disruption of supplies, transport and utilities
  - delays in dealing with other medical conditions
  - the medium and long term effects of the pandemic on the national economy

- Innovative approaches will be needed for many aspects including staffing, triaging patients and coping with patients needing more intensive care than is normally available.
- There will also be pressure on mortuary facilities.

Absence from work

- Absence from work will depend on the age specific attack rates. Even if working age persons are spared, there will be absenteeism resulting from persons needing to take time off to care for sick family members or for compliance with quarantine and or isolation measures.
- Accelerated transmission may occur in the work place resulting in staff being infected during a narrower time frame than within the general population, so social distancing methodologies may be required such as shift systems or staggered times of work.
- In the absence of vaccination, high exposure populations like health care workers will have higher absenteeism. This may be compounded by fear among varying categories of health care workers.
- The skill mix required in some occupations like health care, education and construction may limit the redeployment of staff.
Impact on other services

- In the absence of effective and timely interventions, all other services will be affected through staff sickness. This includes first responders (fire, police), and other essential services (utilities, food production, education, transportation).
- Death registration services and funeral home services may have increased workloads and may trigger the employment of non-traditional methods for interment.

Impact on travel

Travel restrictions will be activated on the advise from the NSC to the National Health Sub Committee.

- Travel will be impacted through:
  - any explicit restrictions or advice on travel to and from St. Vincent and the Grenadines
  - public gatherings as a public policy
  - people opting not to travel
  - availability of fuel and transport for workers

Travel restrictions and screening of passengers on entry to SVG will have only limited impact on the arrival of the pandemic.

Public, political and media concern

On advise from the NEOC the communication committee will be mandated to address the issues such as;

- There will numerous public and political concerns during the pandemic
- Press interest, the need for information and coverage will be intense
- Being able to manage persons’ concerns and fears will be key in the response to the pandemic
- Interest will extend to national and mass gatherings (carnival, nine mornings, and sporting events).
The extent to which interventions might ameliorate the impact

- Vaccination with a vaccine specially formulated against the pandemic strain will achieve the greatest reduction in illness, and mitigate the impact on the health sector and other services. This vaccine is not expected to be made available until 6 to 8 months after the first wave of the pandemic. In any event, it is unlikely that such vaccine will be available for use in SVG immediately upon its production. SVG will endeavour to explore non-traditional avenues for accessing vaccines.

- With minimal stockpiles of antivirals in SVG, their use will be limited. More so, the amount of antiviral required to prevent people from getting the disease is prohibitive, and a treatment strategy is the only reliable option.
The Plan: Key elements

The contingency plan is built around key headings:

- Leadership, organization and co-ordination: chain of command
- Communications
  - strategic and operational communication and advice
  - professional information and guidance
  - communications with the public and media
- Surveillance, information gathering, situation reporting and risk assessment
- The public health response: measures to reduce the health impact
  - Vaccination
  - Immunization strategy
  - Antiviral agents and their use
  - Other public health control measures
- The health service response
  - investigation and management of cases and contacts
  - infection control
  - organization and reinforcement of the health services
- The civil contingency response: reducing societal disruption
- Workforce, education and training
- Research, legal and indemnity issues

Leadership, organization and co-ordination: the chain of command

Strong national leadership, a good command and control structure and co-ordination will be required for an effective response to all Public Health Events. The National Emergency Management Organization (NEMO) is the lead agency. Command and control will be guided by structures outlined in the National disaster management Act. Having NEMO as the lead agency will allow the Ministry of Health and the Environment to be fully devoted to hands-on practical response issues.
Communications

Effective communication provides the backbone for an effective and coordinated response. The Ministry of Health, Wellness and the Environment is the lead agency for the production of a comprehensive communication strategy. It must be noted that even in the presence of a comprehensive communication strategy, rumors and misinformation will be prevalent, and that the media may sometimes make reports before they can be verified by official channels. All in all, the need for timely, consistent and accurate information and advice to different groups must be met in a timely manner.

Strategic and operational communications and advice

Strategic and operational communications will involve NEMO, through the NEOC, and all partners taking part in the response including regional and international agencies. NEMO will activate the NEOC, which will become the hub for strategic and operational communications. Once a pandemic has been declared, the Agency for Public Information will convene regular briefings and allow for information to the public.

Professional information and guidance

Regular information bulletins to health professionals will be issued by the Ministry of Health based on relevant and up to date information from WHO and other international and regional sources (CDC, CARPHA, PAHO). Clinical guidance and public health advice will also be issued by the MoHWE.

Communications with the public and the media

Public

Although formal research has not been conducted, it is assumed that present awareness of Public Health Events is low. Risk communication, both before and during a pandemic, is a key element of the response. Emphasis in the inter-pandemic period will be on the uncertainties surrounding the pandemic, advice on measures to reduce personal risk and the limitations of the national response (vaccine provision, antiviral
Clear, active engagement of the population will be a priority throughout a pandemic through, for example:

- Readily accessible, easy to understand and regularly updated information and advice
- In addition to information disseminated directly to the public, key points on health related advice will be provided by the MoHWE
- Mechanism for feedback on public concerns
- Sharing advice of expert groups with the public
- Working on and with the media to promulgate public health messages.

Media

The central coordination of media communication will be led by NEMO, supported by the API.

Surveillance, information gathering, situation reporting and risk assessment will continue to be done by MOHWE.

Timely, up to date surveillance and other information will be needed to provide evidence based risk assessment at all levels, and provide policy advice and inform decision making processes.

Information needs during the pandemic will be more demanding than routine surveillance or any monitoring system presently provided for. A key factor during the inter-pandemic period is to understand the data requirements of the various actors at different stages of a pandemic so that, as far as possible, they may be fulfilled on time. This may put additional burden on data provision, collection, analysis and dissemination. It is important that persons needing surveillance data be informed of the possible constraints in providing it.
Surveillance in SVG

- Monitor the prevalent viruses and diseases (through syndromic surveillance)
- Identify, with the assistance of regional expert facilities, a novel virus if it were to present.
- Identify clusters of unusual respiratory illnesses that may be caused by a new virus
- Monitor the spread of a new virus and define its epidemiology
- Provide information on significant outbreaks
- Monitor deaths
- Monitor utilization and effectiveness of any interventions, including adverse effects
- Coordinate with animal health surveillance to determine presence of new viruses in animals and assess the risk of cross species transmission
- It is recognized that the objectives of surveillance will change as the pandemic evolves. The different phases will trigger enhancements such as closer monitoring of some population subsets, or changes in emphasis. Flexibility will therefore be promoted and maintained.

Actions to improve surveillance

- Maintain alertness among clinicians and other health care providers to recognize and report unusual disease activities. Although influenza is a common condition, increased cases of influenza or outbreaks linked to zoonotic pathogens must be immediately reported.
- Increase coverage and frequency of reporting from all health care professionals
- Include monitoring for long term sequelae from pandemic type pathogens
- Establish a case information system that links cases with laboratory data

Microbiology and virology

Laboratory confirmed diagnoses will inform the characteristics of the virus which is important for surveillance. Although the capability for viral isolates is not available in SVG, there are links with regional laboratories (CARPHA, CDC). Not withstanding, it is necessary that the national laboratory aims to:
• Maintain reagents for routine diagnostic tests
• Ensure surge capacity in virology at reference level in the event of an outbreak
• Ensure surge capacity for bacteriological diagnosis for complications of influenza
• Ensure laboratory staff protection and compliance with bio-safety requirements
The public health response: measures to reduce the health impact

The public health response covers the population measures to be employed. It also refers to field investigations and feedback from suspected outbreaks using appropriate protocols. Public health measures are either pharmacological (vaccines, antivirals) or non pharmacological (personal hygiene, social distancing).

Immunization

Internationally, during the inter-pandemic period, vaccines used forms the basis for influenza prevention. Since scientists have been able to predict the most likely strain to be circulating in any given year, vaccine production and use has been available globally. It must be noted that seasonal vaccines will not be effective against a pandemic strain virus, since it is impossible to predict with any certainty when a pandemic will appear. In the event that a pandemic strain vaccine becomes available, it will be insufficient to satisfy global needs, and as such it is unlikely that SVG will have access to vaccines. There are three scenarios in the public health strategy regarding vaccines:

1. No vaccines available
2. Vaccines available in limited supply
3. Vaccines widely available

It is unlikely that SVG will be involved in direct vaccine development. SVG may contribute by way of providing viral samples which may be used in the development of a pandemic strain vaccine. In the event of a Public Health Event vaccine becoming widely available, the immunization infrastructure must be maintained and be equipped to deal with the increased demand for vaccination. Monitoring of adverse effects from vaccination will form an integral part of the immunization strategy.
Immunization strategy

A tried approach to immunization will be used, with different population groups being vaccinated depending on the availability of vaccine. In the context of limited vaccine supply, because of the risk faced by health care workers, they will be given precedence over all other groups followed by essential services providers. In general the immunization strategy aims to achieve the following:

- Protect health care workers who are at risk. Apart from being essential to health care, they are at greater risk of acquiring infection.
- Prevent illness and absence among workers required to keep essential services going
- Prevent serious illness among vulnerable groups (define vulnerable groups)
- Reduce the spread of infection in situations where it might spread rapidly (MHC, LPH, prisons, nursing homes)
- Reduce spread by those most likely to transmit the virus, eg children
- Prevent illness in the general population.

Vaccines will be purchased through the PAHO revolving fund by the MoHWE. They will be stored at Central Medical Stores with the appropriate security. Detailed operational guidance for the delivery of vaccines could only be finalized once details such as vaccine formulation, schedule and doses are known. It is generally expected that vaccination will take place at the workplace, schools, and community health centers. Non-nursing personnel may be asked to take part in the administration of vaccines, eg dental practitioners, community health Aides.

A critical part of the communication strategy is to inform the public of the reasons for vaccination and or why vaccines cannot be administered to all. There will also be a need to address public concerns about possible adverse effects from a pandemic strain vaccine.
Antiviral agents and their use

The only other major counter measure against infectious diseases is the use of antivirals drugs. They will be used in both the presence and absence of vaccination. If antivirals are indeed effective against a pandemic strain as with seasonal influenza, they will reduce significantly the number of hospitalizations and deaths in the event of a pandemic. If they become available, they will be procured by the CMS, and distributed through public pharmacies. Selected privately owned pharmacies will be asked to participate, with the requisite monitoring elements in place.

Other public health control measures

Public health measures such as social distancing, in the presence or absence of medical measures, are helpful in limiting the spread of influenza. The following public health measures will be employed:

International travel

With diseases being highly infectious, restriction of international travel will only seek to delay or at best reduce the transmission of the disease, but may still be deemed useful and include:

- Travel advice on travel to and from affected countries
- Health information for existing and returning passengers
- Health screening at sea and airports.

National travel

Restriction of travel within communities will also be considered as disease surges and the risks are assessed. This is also a useful consideration for travel to and from the Grenadine Islands. Restricting travel will affect the spread of the disease from one community to the next.
Mass gatherings

- Decisions to restrict mass gatherings must also be a consideration and as such size and duration of such gatherings must be factored in.
- Closing schools must also be considered depending on the disease surge levels as it has ripple effects on other services, the workforce etc
- The legal basis for the restriction of mass gathering is covered by the Public Health Act.

Personal and respiratory hygiene (Appendix)

People can limit the risk of catching or spreading infection during a pandemic by:

- covering nose and mouth when coughing or sneezing in the cuff of the arm
- disposing of dirty tissue promptly and carefully by bagging and binning
- avoiding non-essential travel from home and avoiding large crowds whenever possible
- maintaining good basic hygiene like hand washing with soap and running water
- cleaning hard surfaces frequently using regular cleaning agents
- making sure children follow these advice

If you believe that you have contracted an infectious disease you should: (Appendix)

- call your healthcare provider, do not show up at the clinic or hospital
- stay at home
- take medicines as prescribed or advised by health care provider
- drink plenty of fluids
- stay in contact with health care provider
The Health Service Response

The health service will provide coordinated local arrangements for safe and efficient clinical management of cases, suspected cases, and their contacts in the primary and secondary care settings. Maintaining services in the face of unprecedented demand will present a huge challenge to the health care system. All Health personnel (public and private) also have a role in providing support for the public health response, placing even greater strain on the national health services.

Investigation and management of cases and contacts (Appendix)

The public will require clear guidance on who should present to health facilities, who should have home care, and how. The MoHWE will provide the necessary information to the public on the provision of health care services. The management of patients will be based on internationally developed and accepted guidelines, with specific guidelines for age groups, and care settings. Efficient mechanisms for the supply of antivirals in a timely manner (within 48 hours of onset of symptoms) must be developed by health care facilities. There will be a system for monitoring adverse effects from the use of antivirals (pharmacovigilence).

Infection control (Appendix)

Infection control guidance has been developed and circulated to all health care facilities, along with the requisite training.

Organization and reinforcement of health services

Operational guidance for the management of a large number of patients on a scale that will overwhelm the health care services has been developed.
Some the key decisions in this plan includes:

- Provision of staff protective equipment
- Establishment of Flu or Triage clinics
- Protocols for holding suspected cases at a facility
- Protocols for admission and discharged
- How to maintain care for home quarantine or Isolation
- Logistics for the maintaining of supplies (pharmaceutical and equipment)
- Cancellation or reorganization of routine health centers activities
- Management of dead bodies (Appendix)
- The interfacing between the Community Health Services, Hospital Services, and the other departments in health and the private sector as the disease level surges and the national system become overwhelmed.

The civil contingency response: reducing societal disruption

While this plan focuses on the health services response, other government agencies are required to play an active part in the national response. Additionally, businesses will be required to develop contingency plans in the event of a pandemic, considering the implications for their functions. The extent of these contingency plans should include:

- Maintenance of essential services such as emergency (fire), transport, food production and distribution, utilities and communications
- Management of mass causalities
- Maintenance of public order and security
Workforce, education and training

All organizations will need to consider the implications for continued operations in the context of staff absence (sickness or caring for family) and increased demand for services in some cases. This will include:

- Establishing minimum staffing levels
- Identifying who are essential staff
- Redeploying of staff carryout functions not performed
- Ensuring a system for vetting additional staff and/or volunteers
- Accommodations for persons who will remain at the workplace between shifts.

The educational and training needs of regular and drafted staff will be important. New staff, as well as volunteers, will have to be trained not only on their individual and specific tasks, but also how to mitigate against becoming infected with influenza. Staff will also require moral and psychological support during what will be an extremely difficult time.

Essential preparatory work, research, and legal issues

The work during the inter-pandemic period will focus primarily on improving preparedness. These will include setting a research agenda, strengthening present public health infrastructure (surveillance, outbreak investigation), reviewing and updating the legislative framework for public health interventions and identifying gaps and challenges in the response.
Disease Surge-Level by Level Actions

**Level 1: 0-1 case**
- Surveillance, control, ports, airports and public health
- COVID-19 training
- IPC training, organization
- Establishment of flu clinic
- Establish taskforce
- Lab response capacity
- Develop COVID-19 MOMA/IMO/MSDC and all of health
- Nemo-advice/collaborate
- Develop psycho team

**Level 2: More than 1 Cases**
- Strengthen port surveillance
- Develop forms for aircraft yachts
- Agency collaboration, immigration, AIA and customs
- Community response team
- Hospital response team
- Referral/transfer response team
- Waste management
- Activation of mobile systems protocol
- VRDs to institutionalized chronic care support (PPP)
- Outpatient clinics
- PCR testing
- Identify surge capacity
- Psychosocial support
- Social distancing

**Level 3: Localized/cluster**
- Surveillance ports, contact tracking
- Social support to community
- Implement hospitalward COVID-19 plan
- Increase PCR testing, implementation of rapid testing, enforce coordinating community quarantine measures
- Social distancing
- Independent quarantine facility
- Independent isolation facility
- Implement medication regimen
- Sensitization/awareness
  - Food supplies
  - Essential services
  - Mask etiquette
- Community shutdown

**Level 4: Community Spread**
- National shut down
- NBAC authority mechanism
  - COVID-19
  - Emergency care
  - Chronic care
- Surveillance ports, public health
- Monitoring of vulnerable groups
- National response capacities
- Capacity isolation
RESPONSE LEVEL ACTIONS

Public health response

At the **Alert Response Level**, the following response measures will be implemented:

- Surveillance Committee will actively collaborate with relevant stakeholders, PAHO CARPHA and other health authorities to formulate the case definitions for local surveillance.
- View any new surveillance definitions issued by WHO and modify local surveillance activities and communicate with relevant stakeholders.
- Collaborate with relevant stakeholders to implement travel restrictions on persons from Liberia, Guinea and Sierra Leone and to request Negative PCR test for Ebola from persons traveling from Nigeria.
- Exchange information on EVD with the health authorities as appropriate on a timely basis.
- Liaise with WHO and international health authorities to monitor the global spread and impact of EVD.
- Implement active surveillance at port of entries.
- Identify and prepare quarantine centers.
- Conduct epidemiological investigation of suspected cases of EVD and put contacts or other potentially exposed persons under medical surveillance as appropriate.
- Seek Support from CARPHA and WHO to enhance capacity in laboratory.
- Liaise between the CARPHA and National Laboratory.
- Strengthen liaison with WHO and overseas counterparts to obtain updated information.
- Issue guidelines and health advice to relevant sectors and the general public.
- Update healthcare workers’ knowledge on infection control measures for EVD.
- Identify staff as member of response team.
- Conduct extra training for members of the response team.
- Mobilize psychosocial team.
- Develop a psychosocial plan.
- Identify suitable transportation.
- Arrange briefings for government departments and other relevant sectors on the infection control guidelines and the proper use of personal protective equipment (PPE).
- Review and promulgate enhanced infection control measures where necessary.
- Formulate clinical management guidelines and SOPs on EVD.
- Review stock of PPE.
- Identify and prepare isolation center.
Port health measures

- Enhance dissemination of health message to travellers (e.g., inflight broadcast, distribution of leaflets, promulgating travel health news on its website and using posters).
- Assess travellers with fever or other symptoms of the infection at border control points.
- Identify travellers from affected countries/areas and enhance health education or surveillance of these travellers if necessary.
- Refer suspected cases to response team further management.
- Closely follow the latest situation overseas and WHO’s recommendation on port health measures.
- Keep the immigration and control points stakeholders updated of the disease situation.

Communication Measures

- Keep local stakeholders and the general public informed of latest developments.
- Disseminate information and step up health advice to public through various means including press releases, pamphlets, announcements in the public interest, website, and incorporate health messages in ongoing health education activities.
- Maintain close liaison with overseas healthcare authorities and WHO to obtain latest information and expert advice.
- Provide materials to inform healthcare professionals, private hospitals and the public of the latest situation.
Serious Response Level Actions

**SERIOUS RESPONSE LEVEL**
At the Serious Response Level, the following response measures will be implemented.

**Surveillance**
- Notify WHO in accordance with International Health Regulations (2005) when and if an imported or local cases is detected
- Further enhance surveillance activities, including zero reporting from the public and private hospitals on EVD
- Liaise with private hospitals to step up surveillance and reporting of EVD, and give advice on infection control based on guidelines
- Ensure timely monitoring of cases and contacts
- Closely monitor the risk assessment and advice from WHO and overseas situation for the possibility of sustained human to human transmission

**Investigation and control measures**
- Conduct epidemiological investigation and contact tracing, put close contacts of confirmed cases of EVD under quarantine / medical surveillance; and other contacts under medical surveillance
- Liaise with the Police to provide security if necessary
- Liaise with WHO and overseas authorities for further analysis and discuss on diagnostic development as appropriate
- Review stock of PPE and whether more stringent standard of PPE is required for frontline staff directly involved in the care of patients of EVD, as appropriate
- Enhance and / or review infection control measures according to the latest knowledge on the transmission route of EVD
- Consider setting up designated clinics and protocol for triaging patients with relevant symptoms at primary care level
- Isolate and treat confirmed cases in designated hospitals
- Update / revise clinical guidelines on management and related admission criteria for various specialties
- Reduce non-urgent and non-emergency services where necessary
- Liaise with WHO and relevant experts on the latest development and recommendations on the use of vaccines and / or medication
- Review and modify existing port health measures and enact legislation, where necessary, in light of WHO’s latest guidelines
- Assist retrieval of flight manifests from airlines to facilitate tracing of flight contacts
- Keep in view WHO’s latest recommendations on port health measures
- Public communication will be strengthened MOHWE will set up a telephone hotline as required
- MOHWE will conduct regular briefings to the press and Cabinet
- Deploy psychosocial team
- Activate psychosocial plan
Emergency Response Level Actions

At the Emergency Response Level, the following response measures will be implemented:

- Monitor daily the number of detections of cases of Ebola virus
- Adjust surveillance mechanisms with reference to the latest recommendation(s) of the WHO
- Conduct epidemiological studies to look into community sources and mode of transmission
- Seek advice from Attorney General, when necessary, on the legal authorities for implementation of enhanced measures and on acquiring emergency public health power to enable enforcement of the control measures
- Closely liaise with relevant parties on the need to remove residents from affected premises to quarantine center(s) and arrange with related departments accordingly if such decision is made
- Further re-organize or reduce non-urgent services to meet the surge in workload due to EVD
- Reprioritize their non-urgent and non-essential services
- Screen Passengers for elevated body temperature
- Continue public education on use of PPE and practices
- Prepare and disseminate material to provide clear guidance on extra preventive measures to be taken
- Ensure proper management of medical waste

Monitor daily number of patients seen at Accident & Emergency Departments and other health facility due to relevant symptoms

Assess the state of disease spread and potential for pandemicity jointly with WHO and relevant experts, where appropriate

Thoroughly investigate any suspected community sources

Collect epidemiological data

Mobilize the capacity of isolation beds and management of confirmed and suspected cases. Mobilize District hospitals /wards to increase capacity to treat acute cases

Review and promulgate updated guidelines and protocols on diagnosis, treatment and admission criteria

Liaise with WHO and relevant experts on the latest development and recommendations on the use of vaccines and /or medication

Communication) Provide daily updates of the course of the epidemic and MOHWE response plans and actions

Continue to educate the public regarding relevant symptoms and when and how to seek medical attention or treatment

Liaise with funeral Homes and other stake holders for immediate and proper disposal of dead bodies
The actions to be taken at Emergency Response Level will be reviewed by the National Health Services Sub Committee and the relevant Taskforce, and the strategy revised as appropriate to ensure the most efficient use of health resources. If the situation evolves to epidemic with multiple community outbreaks and a high attack rate in the population, containment strategies may become no longer effective in stopping disease spread. There may be a heavy burden of excessive morbidity and mortality overwhelming the healthcare system; a shortage of medical supplies; and disrupted district wide infrastructures (including transportation, utilities, and public safety). The purpose of emergency response at this stage will be to slow down progression of the epidemic and minimize the loss of human lives, in order to buy time for the production of an effective vaccine or medicine against infectious diseases and all other public health threats, specifically; surveillance activities will be limited to essential elements. Case investigation and quarantine measures will be scaled accordingly.
Viral hemorrhagic fevers (VHF) refer to a group of illnesses that are caused by several distinct families of viruses. In general, the term “viral hemorrhagic fever” is used to describe a severe multisystem syndrome (multisystem in that multiple organ systems in the body are affected). Characteristically, the overall vascular system is damaged, and the body’s ability to regulate itself is impaired. These symptoms are often accompanied by hemorrhage (bleeding); however, the bleeding is itself rarely life-threatening. While some types of hemorrhagic fever viruses can cause relatively mild illnesses, many of these viruses cause severe, life-threatening disease.

(Center for Disease Control and Prevention, 2014)
Ebola Preparedness and Response
Introduction

Ebola is a deadly virus originating in parts of Africa. It is classified as a hemorrhagic fever, putting it in the same category as Marburg fever, Lassa fever, and Dengue fever. There are four varieties, named after their country of origin. Ebola Zaire, Ebola Cote d'Ivoire, and Ebola Sudan are all known to cause serious illness in human beings. Ebola Reston does not appear to cause illness in people.

The virus may be transmitted through bodily fluids such as blood and secretions. Well-established vectors for infection include handling other primates infected with Ebola, contact with infected corpses during funeral services, and touching infected patients without exercising proper caution. It is thought that the disease may be transferred through airborne particles, but so far there are no proven cases of this method of infection. Health care workers are particularly susceptible to infection during an outbreak, particularly in the nations in which Ebola has so far occurred.

There is currently no proven vaccine to prevent EVD nor approved medication to treat patients. Nevertheless, MOHWE will liaise with the World Health Organization (WHO) and relevant experts on the latest development on vaccine and recommendations on medical treatment for EVD.

To ensure that the MOHWE is equipped with the core capacities to prevent, detect, characterize and respond quickly, efficiently and in a coordinated manner to threats in order to reduce mortality and morbidity, this document sets out the preparedness and response plan of the MOHWE. This plan is an annex of the National Health Multihazard Plan.

Whether to activate this preparedness and response plan depends on a comprehensive risk assessment based on the following general key factors:

- clinical severity of the illness such as its clinical course and any serious consequences leading to hospitalizations and deaths;
- transmissibility of the infection, and the capability of sustaining community level outbreaks;
- geographical spread of the EVD in humans or animals, such as the global distribution of affected areas, the volume of trade and travel between the affected areas and SVG;
- vulnerability of the population; difference in attack rates or risk of serious consequences;
- availability of preventive measures, such as vaccine, and availability of treatments;
- impact on healthcare infrastructure in SVG of and transmission in healthcare settings;
- Recommendations by international and regional health authorities.

Case definition
**Person Under Investigation (PUI)** A person who has both consistent symptoms and risk factors as follows:

1. Clinical criteria, which includes fever of greater than 38.6 degrees Celsius or 101.5 degrees Fahrenheit, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; AND

2. Epidemiologic risk factors within the past 21 days before the onset of symptoms, such as contact with blood or other body fluids or human remains of a patient known to have or suspected to have EVD; residence in—or travel to—an area where EVD transmission is active*; or direct handling of bats or non-human primates from disease-endemic areas.

**Probable Case** A person under investigation whose epidemiologic risk factors include high or low risk exposure(s)

**Confirmed Case** A case with laboratory-confirmed diagnostic evidence of Ebola virus infection

**Exposure Risk Levels**

Levels of exposure risk are defined as follows:

**High risk exposures**

A high risk exposure includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of an EVD patient
- Direct skin contact with, or exposure to blood or body fluids of, an EVD patient without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring*

**Low risk exposures**

A low risk exposure includes any of the following

- Household contact with an EVD patient
- Other close contact with EVD patients in health care facilities or community settings.

**Close contact** is defined as being within approximately 3 feet (1 meter) of an EVD patient or within the patient’s room or care area for a prolonged period of time (e.g., health care personnel,
household members) while not wearing recommended personal protective equipment (i.e.,
standard, droplet, and contact precautions; or having direct brief contact (e.g., shaking hands) with
an EVD patient while not wearing recommended personal protective equipment.

- Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact

**No known exposure** having been in a country in which an EVD outbreak occurred within the past 21 days and having had any high or low risk exposures

**Public Health Observation** means that people are monitored by the public health authority for 21 days after the last known potential exposure to ensure immediate action is taken in the event that symptoms of EVD develop.

**Condition al release** People on conditional release self-monitor temperature twice daily and report to the public health authority.

**Controlled movement**: control movement requires that people notify the public health authority of their intended travel for 21 days after their last known exposure to EVD. These individuals should not be allowed to travel by commercial conveyances. Local use of public transport should be discussed with public health authority. If travel is approved, the individual should have timely access to health care facilities if symptoms develop.

**Quarantine**: This is used to separate and restrict the movement of persons exposed to a communicable disease who don’t have symptoms for the purpose of monitoring. At this time it is not recommended that asymptomatic patients be quarantined.

**Isolation** refers to the precautions that are taken to prevent the spread of an infectious agent from an infected or colonized patient to susceptible persons. **Purpose** Isolation practices are designed to minimize the transmission of infection, using current understanding of the way infections can transmit. Isolation should be done in a user friendly, well-accepted, inexpensive way that interferes as little as possible with patient care, minimizes patient discomfort, and avoids unnecessary use.

Isolation practices can include placement in a private room, the use of protective barriers such as masks, gowns and gloves, a special emphasis on hand washing (which is always very important), and special handling of contaminated articles.

**HCP** refers to Health Care Personnel

**PPE** refers to Personal Protective Equipment
### Outcome 1: The immediate risks to the health of affected populations are reduced

#### Output 1.1: The Port of Entries surveillance is enhanced

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<td>Conduct rapid assessment to describe the current Risk in order to ensure that all activities of the chain of transmission are identified and measures to prevent future infections are implemented</td>
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<td>Reproduce and disseminate guidance and tools for surveillance</td>
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<td>Train Health workers on Infection Control and the use of PPEs</td>
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<td>Procure sprayers and chlorine for disinfection purposes</td>
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<td>Establish case definition</td>
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<td>Deploy PH Nurses and PH officers to support surveillance at port of entries</td>
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<td>Organize the active search for suspected cases and contacts suspected cases of EHF</td>
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<td>Enumerate all the contacts and place them under daily</td>
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surveillance for 21 days in order to detect the possible onset of fever

Train immigration officers at port of entries in Surveillance of travellers

Monitor and report on activities carried out

**Output 1.2: Increased public awareness about EHF disease (signs and symptoms, transmission risk factors, actions for suspected cases, its prevention and control measures)**

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<th>Activities planned</th>
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<tr>
<td>Train health care workers on EHF signs and symptoms, prevention measures and referral mechanisms as well as personal protection.</td>
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<td>Develop key messages</td>
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<td>Produce and disseminate context-specific Information, Education and Communication (IEC) materials, including leaflets and posters</td>
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<td>Conduct health promotion campaigns through, community sensitization and media</td>
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### Out Put 1.3 Management of suspected cases and contacts

### Output 1.4: Safe management of dead bodies from isolation centres

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<tr>
<td>Train volunteers and funeral home workers in proper utilization of appropriate PPE in isolation centres and handling of dead bodies</td>
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<td>Ensure secure burial of corpses</td>
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<td>Ensure proper waste management</td>
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### Output 1.5: psychosocial support to Health workers / families affected by Ebola.

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<td>Mobilize psychosocial team</td>
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<td>Development of a psychosocial plan</td>
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<td>Provide psychosocial services</td>
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### Resource Management

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<td>Weekly Report on the disease</td>
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<td>Update the Ministry of Health, Ministry of National Security, Cabinet on the outbreak other stake holders</td>
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Composition of the Taskforce

Chief Medical Officer – Chair
Medical Officer of Health – Deputy Chair
Director of NEMO – Secretary
Health Disaster Coordinator
Epidemiologist
Chief Health Promotion Officer
PS Ministry of Tourism
PS Ministry of National Security
Commissioner of Police /Nominee
Chief Immigration Officer/Nominee
Chief Engineer/Nominee
General Manager CWSA/Nominee
Director of Airports
CEO Port Authority
Director Agency for Public Information
Trade Union Representative
Infectious Disease Specialist
MOHWE Representative
Chief Veterinary Officer
Chief Laboratory Technologist
Appendices

Composition Of The National Surveillance Committee

Health Disaster Coordinator
Chief Medical Officer – Chair
Medical Officer of Health – Deputy Chair
Epidemiologist
Director
Chief Nursing Officer
Chief Laboratory Technologist
Chief Health Promotion Officer
Surveillance Officer
Infectious Disease Specialist
Infection Control
Senior Nursing Officer Community
<table>
<thead>
<tr>
<th>Subcommittee</th>
<th>Composition</th>
<th>Functions</th>
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</table>
| Communications                      | API – Lead<br>Health Promotion Unit<br>Health Information Unit<br>Telecommunications Companies | 1. To design and carry out public education campaigns about the prevention of and response to Ebola, aimed at increasing the preparedness of specific target groups and to decrease fear in the population in general.  
2. |
| Infection Control and Training      | Dr. Jose Davy – Lead<br>MCMH Infection Control Unit<br>SVGCC DNE<br>Trade Union Representative | 1. To develop protocols for all groups of stakeholders and all types of facilities most at risk of exposure to Ebola virus.  
2. To train a cadre of professionals from different specialties to train healthcare workers and other groups, e.g. security forces, taxi drivers and hotel workers, in the areas of biosafety, including the use of personal protective equipment.  
3. To work with other subcommittees and agencies to ensure that all protocols are adhered to  
4. |
| Surveillance                        | Port Health – Mr. Neri James – Lead<br>Immigration, Airport Authority, Port Authority, Community Nursing, MOHWE Surveillance Committee, Ministry of Tourism, SVGHTA, Taxi Drivers Association | 1. To develop and implement mechanisms to ensure that sufficient, efficient and effective surveillance is established and maintained at designated ports of entry to prevent the entry of the Ebola virus unto SVG.  
2. To identify designated areas at all ports of entry where persons suspected of being infected with the Ebola virus may be temporarily quarantined.  
3. |
<table>
<thead>
<tr>
<th>Isolation Facility Establishment</th>
<th>Chief Engineer – Lead Physical Planning, CWSA, Infection Control, Environmental Health, CNO</th>
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<tr>
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<td>1. To determine and establish the most appropriate option for an isolation facility for the management of Ebola virus patients for SVG.</td>
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<td>2. To identify a facility for the immediate use if necessary.</td>
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<td>3. To upgrade the current isolation rooms at the MCMH for non-Ebola use</td>
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<td>4. To identify quarantine rooms at all health facilities and ports of entry working in collaboration with the surveillance committee.</td>
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<td>Bio hazardous Material Management</td>
<td>CWSA – Lead Infection Control, MCMH Laboratory, Environmental Health</td>
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<td>1. To advise on and develop protocols to manage the collection and disposal of materials, samples and waste generated in the care of Ebola virus patients.</td>
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<td></td>
<td>2. To advise on and develop protocols and capacity for the management of deceased Ebola virus patients.</td>
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<tr>
<td>Security</td>
<td>Ministry of National Security-Lead Immigration, RSVG Police Force,</td>
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<td>1. Advise on general and specific security matters as it relates to nationals, visitors, and persons under various forms of public health surveillance, quarantine and isolation.</td>
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<td>2. To provide security or supervise the provision of security for patients and workers dealing with Ebola virus infected patients.</td>
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<td>3. To advise on and implement border security aimed at preventing the importation of the Ebola virus.</td>
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<td>4. To identify a rapid response Ebola security team that will be trained to provide specialized security functions relative to Ebola infection suspect or confirmed cases.</td>
</tr>
<tr>
<td>Clinical management team</td>
<td>SNO MCMH – Lead CNO, Infection Control MCMH, Dr. Davy, Medical Director, SVGMA, SVG Nurses Association</td>
</tr>
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</table>
SCREENING SUSPECTED PATIENTS FOR EBOLA VIRUS DISEASE (EVD) IN HEALTHCARE FACILITIES

STANDARD OPERATING PROCEDURE

Currently, the Ebola Virus Disease (EVD) outbreak in West Africa is predominantly in Guinea, Sierra Leone, Liberia and Nigeria. However, all countries are at risk, particularly those in that region. The risk for St. Vincent and the Grenadines according to CARPHA remains low.

The virus is transmitted through direct contact with contaminated body fluids. Usually this is in the case of very close contact, family members, and health care workers delivering close direct care, some funeral ritual observances. For this reason, maintaining proper distance and hygiene is essential.

Screen-isolate-notify

Screen/ triage individuals

- Conduct the interview from a respectful distance of 1-2 meters.
- No extra personal protective equipment is required when interviewing the patient if this distance is maintained. It is acceptable should you wish to wear gloves.
- If the patient is vomiting, bleeding, or having diarrhea at the visit, they should be moved immediately to a separate area and PPE should be used (gown, gloves, mask, goggles or face shield, and shoe covers)

1. Interview the patient

- Ask about these symptoms: fever, vomiting, diarrhea, bleeding (at mucous membranes or in stool), headaches, muscle aches, joint aches, weakness
- Be mindful that most people with fever will not have EVD, even from affected areas. When in doubt, confer with a physician on how to proceed.
- If a temperature must be taken, do so carefully with gloves and without touching the patient.

2. Ask about these exposures:

- The patient has visited an affected area within the past 3 weeks OR has had contact with an ill individual who had visited an affected area within 3 weeks of becoming ill.
- Close contact with a confirmed case of EVD
- Close contact with a person who died, if the person who died (from a febrile illness or unexplained cause) had visited an affected area within 3 weeks of becoming ill
- Participated in a funeral service within 3 weeks of having a fever where the funeral was held in an affected area; Or
- had been in an affected within 3 weeks of becoming ill

3. **Determine if a patient has possible Ebola Virus Disease:**

Anysymptoms + anyexposure

- If the patient does not meet these criteria, but the staff remains suspicious for EVD, seek consultation with a physician. The response team is available for consultation.
- Perform hand hygiene immediately after seeing the patient. Clean your hands with soap and water, alcohol-based hand rub, or chlorine solution 0.05%.

**ISOLATE patients with suspected Ebola Virus Disease.**

- Have the patient move immediately to an area isolated from other patients and staff
- The Emergency response team must be notify immediately
- Make arrangement for transportation of patient to isolation site
- The patient should not be in contact with any persons, including clinical staff, until the ambulance team arrives
- Should the patient be critically ill and the health care team on site must administer care (barrier PPE is essential): Gown, gloves, mask, and eye coverings are essential, Shoe or boot covers and head cover is optional
- If the patient had active vomiting, diarrhea or bleeding, secure the soiled area so that it is separate from any persons. You can place a chair, tape, or other object to block access to the soiled area
- All soiled linen and clothing must be placed in Biohazard bag for immediate disposal and area must be thoroughly decontaminated.
- Vehicle transporting the patient must be decontaminated immediately after with chlorine bleach
- NOTIFY the relevant health authorities CMO, MOH,
GUIDANCE FOR MANAGING SUSPECTED CASE OF EBOLA VIRUS DISEASE

For any suspected cases of Ebola Virus Disease, please contact: (Mon-Fri 8: AM - 4: PM)

Department of wellness Disease Prevention and Management: 784-451-2489
Community Nursing Primary Health care: 784-485-6133
Public Health: 784-456-1991

Weekends and after 4: PM

A suspected case of Ebola Virus Disease (EVD) is a patient with both:

1. **Clinical criteria:** Fever (T> 38.6°C or 101.5 F) and additional symptoms such as severe
   Headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage
   AND

2. **Epidemiologic risk factors** within the past 3 weeks before the onset of symptoms such as:
   a. Contact with blood or other body fluids of a patient known to have or suspected to have EVD
   b. Residence in—or travel to—an area where EVD transmission is active

**Infection Control Measures**

1. **Isolation:** Patient will be placed in a private room; duration of precautions will be assessed on
   a case-by-case basis in conjunction with public health authorities

2. **Hand hygiene** must be performed before room entry and immediately after removal of PPE.

3. **Personal protective equipment (PPE):** All persons entering the room should wear at
   minimum: Gloves, Gown (fluid-resistant or impermeable); if anticipate significant exposure to
   bodily fluids, use coveralls, Eye protection (goggles or face shield) –one time use only, N-95
   mask or PAPR/ CAPR

   Additional PPE may be required in certain situations (e.g. copious amounts of blood, other body
   fluids, vomit, or feces present in the environment or if performing aerosol generating
   procedures): Double gloving, Disposable shoe covers Leg coverings (full body suit) if anticipate
   significant exposure to bodily fluids
4. Patient care equipment

- Dedicated medical equipment (e.g. stethoscopes) should be used for provision of patient care.
- Ideally disposable equipment should be used; all non-disposable equipment should be cleaned and disinfected according to manufacturer’s instructions and hospital policies.

5. Patient care considerations

- Limit phlebotomy, procedures, and laboratory testing to the minimum necessary for patient care
- Avoid aerosol-generating procedures when possible
- Limit HCP only to those essential for patient care
- Maintain a log of persons entering the patient’s room

6. Environmental cleaning/ control

- Hospitality service employees performing environmental cleaning and disinfection should wear recommended PPE as described above (including additional PPE) if needed.
- Follow standard procedures, per hospital policy and manufacturers’ instructions for cleaning and/or disinfection of environmental surfaces and equipment, textiles and laundry, food utensils and laundry

7. Occupational health considerations

- Maintain a log of all HCP entering the patient’s room

Management of exposed HCP:

- If HCP is symptomatic he/she should stay at home from work/ immediately stop working, notify supervisor.
- If HCP is asymptomatic he/she should be monitored for fever and other symptom twice daily for 21 days after last known exposure; this will be done in an effort to assess the need for work exclusion on a case-by-case basis in conjunction with public health authorities

8. Visitor monitoring

- Restrict all visitors into the patient’s room; may consider exceptions on a case-by case basis.
Maintain a log of all visitors entering the patient’s room.

Visitors should be: Screened daily for symptoms before entering.

Educated and assessed for ability to comply with precautions

Restricted to the patient room and an immediately adjacent waiting area.

**Laboratory Specimen Handling/ Processing**

- **Labeling/ Containment**: All samples from a suspected or confirmed case should be labeled and contained immediately within a clear plastic biohazard bag. Please clearly label the specimen and biohazard bag with “Ebola” to alert laboratory staff.

- **Transport**: All samples should be hand carried to the lab to avoid risk of contamination or exposure through use of the pneumatic tube or dumbwaiter system.
SAFE DONNING AND DOFFING OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

**Donning PPE**

**Gown**

Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back. Fasten in back at neck and waist.

**Mask or Respirator**

Secure ties or elastic band at middle of head and neck. Fit flexible band to Nose Bridge, fit snug to face and below chin. Fit-check respirator.

**Goggles/Face shield**

Put on face and adjust to fit.

**Gloves**

Use non-sterile for isolation. Select according to hand size. Extend to cover wrist of isolation gown.

**SAFE WORK PRACTICES**

- Keep hands away from face
- Work from clean to dirty
- Limit surfaces touched
- Change when torn or heavily contaminated
- Perform hand hygiene

**REMOVING PPE**

Remove PPE at doorway before leaving patient room or in anteroom.

**Gloves**

Outside of gloves are contaminated!

- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist

**Goggles/Face Shield**

Outside of goggles and face shield are contaminated!

- To remove, handle by “clean “head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

**Gown**

Gown front and sleeves are contaminated!

- Unfasten neck, then waist ties
- Remove gown using a peeling motion; pull gown from each shoulder toward the same hand
- Gown will turn inside out Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle

**Mask OR Respirator**

Front of mask/respirator is contaminated – DO NOT TOUCH!

- Grasp ONLY bottom then top ties/elastics and remove
- Discard in waste container

**HAND HYGIENE**

Perform hand hygiene immediately after removing all PPE!
1. **Before the arrival of the plane/Vessel**
   - For planes/vessels arriving from countries with confirmed/suspected EVD, the Port Health Officer calls and confirms from the crew if there are passengers that show symptoms consistent with EVD case definition.
   - If there are passengers that show symptoms consistent with EVD the emergency response team should be mobilized immediately.
   - Possible evacuation routes should be enforced immediately.
   - Lines and routes of exit of the passengers from the plane/vessel should allow for the observation of individual traveler.
   - Should symptoms be evident, the screening form must be completed.
   - Alert security for crowd management.
   - Alert other staff and airport workers to limit their presence in key transit areas to minimum.

2. **Managing passengers exiting the airplane/Vessel**
   - Passengers disembarking the plane/vessel should be moved through guided passages that allow observation by Port Health officers.
   - Security officers should be in this area to supplement the extraction of the symptomatic passengers for completion of the form and physical observation.
   - Security must be present to expedite evacuation/isolation of the worst cases or uncooperative travelers.
   - **Safe and secure holding areas with capacity for temporarily quarantine must be present at the airport**
   - Response team must be contacted.
   - Staff assigned to work at Isolation site must also be informed.

**Screen-isolate-notify**

3. **Screen/ triage individuals**
• Conduct the interview from a respectful distance of 1-2 meters.
• No extra personal protective equipment is required when interviewing the patient if this distance is maintained.
• If the patient is vomiting, bleeding, or having diarrhea at the visit, they should be moved immediately to a separate area and PPE should be used (gown, gloves, mask, goggles or face shield, and shoe covers)

**Interview the passenger**

• Ask about these symptoms: fever, vomiting, diarrhea, bleeding (at mucous membranes or in stool), headaches, muscle aches, joint aches, weakness
• Be mindful that most people with fever will not have EVD, even from affected areas. When in doubt, confer with a physician on how to proceed.
• If a temperature must be taken, do so carefully with gloves and without touching the patient.

Ask about these exposures:

• The passenger has visited an affected area within the past 3 weeks OR has had contact with an ill individual who had visited an affected area within 3 weeks of becoming ill
• Close contact with a confirmed case of EVD
• Close contact with a person who died, if the person who died (from a febrile illness or unexplained cause) had visited an affected area within 3 weeks of becoming ill
• Participated in a funeral service within 3 weeks of having a fever where the funeral was held in an affected area; or
• If the passenger had been in an affected area within 3 weeks of becoming ill
• Determine if a passenger has possible Ebola Virus Disease:

Any symptoms + any exposure

• If the passenger does not meet these criteria, but the port health staff remains suspicious for EVD, seek consultation with a physician. The response team is also available for consultation.
• Perform hand hygiene immediately after seeing the passenger. Clean your hands with soap and water, alcohol-based hand rub, or chlorine solution 0.05%.

4. ISOLATE passengers with suspected Ebola Virus Disease.
- Have the passenger move immediately to an area isolated from other passengers and staff, such as a quarantine room.
- The passenger should not be in contact with any persons, until the response team arrives.
- Should the passenger be critically ill, the port health team on site must administer care. Barrier PPE is essential: Gown, gloves, mask, and eye coverings are essential. Shoe or boot covers and head cover is optional.

**These items must available on site**

- If the passenger has active vomiting, diarrhea or bleeding, secure the soiled area so that it is separate from other persons. All soiled linen and clothing must be placed in Biohazard bag for immediate disposal and area must be thoroughly decontaminated.
Appendices

SOP Contact Tracing Investigation for Ebola

Contact tracing is the identification and diagnosis of persons who may have come into contact with an infected person.

The goal is to

- Identify individuals who had close contact with an infectious person
- Identify appropriate control measures
- Facilitate early diagnosis
- Prevent spread

Categories to be traced

- Close contacts of a Probable Case whose epidemiologic risk factors include high or low risk exposure(s)
- Close contacts of a Confirmed Case with laboratory-confirmed diagnostic evidence of Ebola virus infection

Contact tracing must be carefully planned and undertaken by a team of public health trained personnel, with experience in clinical assessment, specimen collection, infection control and field epidemiology

A team leader must be designated

The goal of the contact tracing team is to obtain information on the clinical and epidemiological patterns of transmission ensure confidentiality and maintain public calm

Procedure

The team should collect all material necessary (PPE Hand sanitizers, Bleach, note pad, pens, sample collection kits and transport media if recommended)

- All close contact of confirm probable cases should be identified
- Contact tracing efforts should be focus on persons who had close unprotected contact with the infected case during the period of communicability
- Information from flight manifest and other pertinent identification document on close contacts should be collected
- Information about close contact can be obtain through interview of patient/client, family members, workplace, or others with knowledge about patients/clients recent activities and travel.
- All close contact should be listed in contact line listing form base on the nature and duration of contact, categories the contact into
- Close contact- those who have risk exposure, include being in less than three meter, having cared for, lived with, or having direct contact with the body secretions, fluid and/or excretions of case).
- Social contact- All types of contacts who do not fit the definition of close contact.

**NB** Close contact should be place under quarantine and social or active surveillance

- Interview the contacts case for clinical and exposure history, travel history- include detail route of travel dates of departure and arrival, vehicles used and flight number
- Place of stay after onset including temporary residence such as hotels
- Date if illness on set
- Symptom
- Hospital and clinic attended for medical advice
- Pre – existing condition
- House hold contacts other contact at work, school and community setting.

If several cases are report, determine linkage between cases and see if they are infected from a common source.

- Conduct environmental assessment. Determine and rectify any possible environment risk factor
- Conduct health educational sessions

**Surveillance period:**

- Will last until twenty one days counting from last contact with the index case.
- In case contact met with case during the surveillance period against advice, the surveillance period should be extended accordingly.
- Contact should be reminded to remain vigilant against infectious disease and maintain good personal and environmental hygiene after completion of surveillance.
- All close contact should be asked to take their temperature at least twice daily.
- Public Health Personnel will monitor via telephone and home visit daily for twenty one days to assess for development of symptoms.
- Contacts will be transferred immediately to isolation center if he/she develop signs of EVD (infection control measures must be used)
- The Chief Medical Officer Medical Officer of Health Epidemiologist and Focal point for communicable disease should be notify immediately
- Daily update must be provided to CMO, MOH Epidemiologist and Focal Point Communicable Disease
This alert is to inform you of the Ebola virus outbreak in West Africa and measures you can take to minimize your risk of contracting the disease.

Ebola Virus Disease is a severe, often fatal illness.

WHO IS AT RISK TO EBOLA VIRUS DISEASE?

- Persons who have travelled to areas
- Persons who have come into contact with the blood or body fluids from someone who is sick with Ebola or has died from the disease.
- Persons who have been in contact with other persons coming from a country affected by the Ebola Virus

TRANSMISSION:

- The virus is spread from person to person through direct contact with blood or body fluids such as sweat, urine, faeces, saliva and semen.

SYMPTOMS:

- Fever
- Sore throat
- Nausea
- Intense weakness
- Vomiting
- Tiredness
- Headache
- Diarrhea
- Bleeding
- Muscle pain
- Coughing

PREVENTION:

- Wash hands frequently with soap and clean water or use alcohol based hand sanitizers.
- Avoid direct contact with blood and body fluids (sweat, urine and faeces, saliva and semen) of other persons.

If you have recently traveled to any of the affected countries and develop any of the above or suspect that you have come in contact with someone infected with Ebola, remain at home and call your health care provider immediately.
Ministry of Health, Wellness and the Environment

St. Vincent and the Grenadines

Ebola Surveillance Form

Ministry of Health Wellness and the Environment is currently conducting routine surveillance checks to heighten awareness with regards to the emergence of the Ebola virus.

Please take a few minutes to answer the following questions

Name: __________________________________________________________________
Age: ___________    Sex: ( ) Male   ( ) Female
Address while in St. Vincent: _______________________________________________
Contact Number(s): __________  _____________________
Flight #: ____________________

Have you been to any of the following countries within the last four (4) weeks?

- Liberia: Yes [ ] No [ ]
- Sierra Leone: Yes [ ] No [ ]
- Guinea: Yes [ ] No [ ]
- Nigeria: Yes [ ] No [ ]
- Other Countries: Yes [ ] No [ ] Where: __________________________

Have you any of the following symptoms?

- Fever: Yes [ ] No [ ]
- Severe headache: Yes [ ] No [ ]
- Muscle pain: Yes [ ] No [ ]
- Vomitting: Yes [ ] No [ ]
- Diarrhea: Yes [ ] No [ ]
- Abdominal pain: Yes [ ] No [ ]
- Skin rash: Yes [ ] No [ ]
- Bleeding: Yes [ ] No [ ]
- Fainting episodes: Yes [ ] No [ ]
- Fatigue: Yes [ ] No [ ]
- Sore throat: Yes [ ] No [ ]
- Loss of appetite: Yes [ ] No [ ]
• Red eyes

Have you had contact with anyone known to have or suspected to have Ebola Virus Disease (EVD)?

Yes [  ] No [  ]

Have you been in contact with blood or other fluids of anyone known to have or suspected to have EVD?

Yes [  ] No [  ]

• If you are coming from any of the above mentioned countries

(A) Have you handled bats, rodents or primates? Yes (  ) No (  )

(B) Were you medically evaluated by a doctor before leaving that country? Yes (  ) No (  )

If yes, what was the result of the medical evaluation?________________________

If you have visited any country with an Ebola outbreak, you should:

1. Monitor your health for any of the above signs and symptoms for 21 days.
2. Limit your contact with other people.
3. Seek medical care immediately if you develop any of the signs and symptoms.
4. Contact the Accident & Emergency Department at telephone number 1-784-456-1955.

Thank You

FOR OFFICIAL USE ONLY!

Suspected case: Yes [  ] No [  ]

Action taken

Isolation: Yes [  ] No [  ]

Cleared: Yes [  ] No [  ]

Comments: _________________________________________________________________

_______________________________________________________________

Public Health Official Name: ____________________________________________
RESPIRATORY INFECTIONS

[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

[Cite your source here.]
COVID-19 Response Plan
Introduction

On 31 December 2019, WHO was alerted to a cluster of pneumonia patients in Wuhan City, Hubei Province of China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a novel (new) coronavirus as the cause of the pneumonia. The proposed interim name of the virus is 2019-nCoV.

Coronavirus disease (COVID-19) is a communicable disease caused by a newly discovered coronavirus. A pneumonia of unknown cause was detected in Wuhan, China and first reported to the WHO on 31 December 2019. The causative agent, now known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), belongs to a family of coronaviruses previously implicated in Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) outbreaks. Coronaviruses 229E, NL63, OC43, and HKU1 cause infection in humans while other coronaviruses such as SARS-CoV, SARS-CoV-2 and MERS-CoV infect animals and can be transmitted to humans.

Most people, about 80%, of those infected with SARS-CoV-2 experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying morbidity like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

The virus is spread mainly through droplets of saliva or discharge from the nose when an infected person coughs or sneezes. Proper hand hygiene, cough etiquette and social distancing are some public health measures used to prevent the spread of COVID-19 disease. Containment of exposed persons, testing, and isolation of positive cases are other measures shown to slow down transmission of the disease.

There are currently no specific vaccines or treatments for COVID-19. However, there are many ongoing clinical trials evaluating potential treatments. WHO will continue to provide updated information as soon as clinical findings become available.

The Ministry of Health, Wellness and the Environment has identified that the key elements to a successful response within the Disaster Management and Risk Reduction Frameworks are:

- **Risk Assessment - Early Detection** - risk identification, sampling, packaging and transportation, testing, waste management, psychosocial support
- **Response and Preparedness - Containment** - contact tracing, quarantine, isolation, clinical management, infection control
- **Governance - Management** - Joint or Unified Command and Control of the Event - coordination of supplies and resources, information management and reporting, enforcement of non-pharmacological or non-public health measures such as social distancing, hand hygiene, flu etiquette, reorganization and progressive expansion of the
health services with an aim to reduce the mortality and morbidity of SVG population. It also serves as a tool for clear communication of the level of risk with the public.

The plan is built around the eight pillars focused on the major areas of the public health preparedness and response: (i) Country-level coordination, (ii) Points of entry (iii) Surveillance, rapid-response teams, and case investigation (iv) National laboratories (v) Case management (vi) Risk communication and community engagement, (vii) Infection prevention and control IPC, (viii) Operational support and Logistics

**Aim:**

- **Actively detect and contain all active cases of COVID-19**
- **Detect all suspected cases of COVID-19 and tract their contacts**
- **Reduce the risk of transmission of COVID-19 in health facilities and the general public**
Case Definitions

Suspect Case A.

A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.

OR B.

A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;

OR C.

A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A.

A suspect case for whom testing for the COVID-19 virus is inconclusive. Inconclusive being the result of the test reported by the laboratory.

OR

B.

A suspect case for whom testing could not be performed for any reason.

Confirmed case:

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;

2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment; OR 4. Other situations as indicated by local risk assessments.

**Note:** for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.
Non Pharmacological Management Of COVID-19

1. As a general rule do NOT touch or shake hands with anyone as hands may be contaminated.

2. Avoid touching environmental surfaces as they may be contaminated (railings, doorknobs etc.) If you do remember to wash your hands or use hand sanitizer.

3. Wash hands frequently with soap and water or use alcohol-based hand sanitizer.

4. Do NOT allow persons who are known or appear to be sick (especially with cough) to enter your taxi or minibus.

5. Should someone display symptoms of COVID-19 (fever, dry cough, shortness of breath etc) while being transported, park and exit the vehicle. Call the COVID-19 hotline at 534-4325 for assistance.

**PHYSICAL DISTANCING** Avoid overcrowding or mass gatherings such as sporting events, carnival.

Practice flu, cough etiquette.
COVID-19: What People With Diabetes And Hypertension Should Know

1. Avoid close contact with people who are sick
2. Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
3. If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
4. To the extent possible, avoid touching high-touch surfaces in public places—elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
5. Avoid touching your face, nose, eyes, etc.
6. Clean and disinfect your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones)
7. Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
8. Keep a supply of medications (including vitamins and supplements.)
9. In case of being quarantined, get extra refills on your prescriptions so you do not have to leave the house
COVID-19: What Kidney Patients Should Know

1. If you are a dialysis patient, your underlying health condition(s) can put you at a higher risk of becoming seriously ill from COVID-19.
2. You must keep going to treatment.
3. Be in constant communication with your dialysis center.
4. Know the signs of COVID-19 infection and be honest.
5. Try to get a supply of medicines and foods.
6. Follow the recommendations for hygiene and social distancing.
7. Wash your hands often with soap and water for 20 seconds or use alcohol-based hand sanitizer. (Sing “Happy Birthday” to yourself twice while washing your hands—that will ensure you’ve washed them long enough.)
8. Avoid touching your eyes, nose or mouth with unwashed hands.
9. Stay at least 6 feet away from anyone who has respiratory symptoms such as a cough or sneezing.
10. Stay home if you feel sick or have cold-like or flu-like symptoms including a fever, cough, sore throat, headache or body aches.
11. Cover your coughs and sneezes with a tissue, then throw used tissue into the trash.
12. Clean and disinfect any objects and surfaces that you touch frequently.
13. It is important that people taking immuno-suppressants or other medications do not make any changes unless advised to do so by their renal unit.
Disease Surge Level by Level Actions

**Level 1: 0-1 case**
- Surveillance, control ports, airports and public health
- COVID-19 training
- IPC - Training, organization
- Establishment of flu clinic
  - Establish task force
  - Lab response capacity
    - Develop COVID-19 MCM, MMDC and all of health
    - Nemo-advice/collaborate
    - Develop psychoteam

**Level 2: More than 1 Cases**
- Strengthen port surveillance
- Develop forms for aircraft yachts
- Agency collaboration, immigration, AIA and customs
- Community response team
- Hospital response team
- Referral/transfer response team
- Waste management
- Activation of mobile systems protocol
- Visit to institutionalized alternative chronic care support (ICCPS)
- Outpatient Clinics
- PCR testing
- Identify surge capacity
  - Psychosocial support
  - Social Distancing

**Level 3: Localized/cluster**
- Surveillance ports, contact tracing
  - Social support to community
  - Implement hospital and COVID-19 plan
  - Increase PCR testing, implementation of rapid testing
  - Enforce coordinating community quarantine measures
  - Social distancing
  - Independent quarantine facility
  - Implement medication regimen
- Sensitization/awareness
  - Food supplies
  - Essential services
  - Hand etiquettes
  - Community shut down

**Level 4: Community Spread**
- National shut down
- NEMO authority mechanism
  - COVID-19
  - Emergency care
  - Chronic care
- Surveillance ports, public health
- Monitoring of vulnerable groups
- National response capacities
- Capacities: isolation
At the **Alert Response Level**, the following response measures will be implemented:

1. **Surveillance Committee** will actively collaborate with relevant stakeholders, PAHO CARPHA and other health authorities to formulate the case definitions for local surveillance.
2. View any new surveillance definitions issued by WHO and modify local surveillance activities and communicate with relevant stakeholders.
3. Collaborate with relevant stakeholders to implement travel restrictions on persons from Liberia, Guinea and Sierra Leone and to request Negative PCR test for Ebola from persons traveling from Nigeria.
4. Exchange information on EVD with the health authorities as appropriate on a timely basis.
5. Liaise with WHO and international health authorities to monitor the global spread and impact of EVD.
6. Implement active surveillance at port of entries
7. Identify and prepare quarantine centers.
8. Conduct epidemiological investigation of suspected cases of EVD and put contacts or other potentially exposed persons under medical surveillance as appropriate.
9. Seek Support from CARPHA and WHO to enhance capacity in laboratory.
10. Liaise between the CARPHA and National Laboratory.
11. Strengthen liaison with WHO and overseas counterparts to obtain updated information.
12. Issue guidelines and health advice to relevant sectors and the general public.
13. Update healthcare workers' knowledge on infection control measures for EVD
14. Conduct extra training for members of the response team
15. Arrange briefings for government departments and other relevant sectors on the infection control guidelines and the proper use of personal protective equipment (PPE).
16. Review and promulgate enhanced infection control measures where necessary
17. Review stock of PPE
18. Formulate clinical management guidelines and SOPs on EVD
19. Identify and prepare isolation center.
**Respiratory Infections**

**Port Health Measures**

- Enhance dissemination of health message to travellers (e.g. inflight broadcast, distribution of leaflets, promulgating travel health news on its website and using posters).
- Assess travellers with fever or other symptoms of the infection at border control points.
- Identify travellers from affected countries / areas and enhance health education or surveillance of these travellers if necessary.
- Refer suspected cases to response team further management.
- Closely follow the latest situation overseas and WHO’s recommendation on port health measures.
- Keep the immigration and control points stakeholders updated of the disease situation.

**Communication**

- Keep local stakeholders and the general public informed of latest developments.
- Disseminate information and step up health advice to public through various means including press releases, pamphlets, announcements in the public interest, website, and incorporate health messages in ongoing health education activities.
- Maintain close liaison with overseas healthcare authorities and WHO to obtain latest information and expert advice.
- Provide materials to inform health care professionals, private hospitals and the public of the latest situation.
### Serious Response Level Actions

**SERIOUS RESPONSE LEVEL**
At the Serious Response Level, the following response measures will be implemented.

- **Surveillance**
  - Notify WHO in accordance with International Health Regulations (2005) when and if an imported or local cases is detected.
  - Further enhance surveillance activities, including zero reporting from the public and private hospitals on EVD.
  - Liaise with private hospitals to step up surveillance and reporting of EVD, and give advice on infection control based on guidelines.
  - Ensure timely monitoring of cases and contacts.
  - Closely monitor the risk assessment and advice from WHO and overseas situation for the possibility of sustained human-to-human transmission.

- **Investigation and control measures**
  - Conduct epidemiological investigation and contact tracing, put close contacts of confirmed cases of EVD under quarantine / medical surveillance, and other contacts under medical surveillance.
  - Liaise with the Police to provide security if necessary.
  - Liaise with WHO and overseas authorities for further analysis and discuss on diagnostic development as appropriate.
  - Review stock of PPE and whether more stringent standard of PPE is required for frontline staff directly involved in the care of patients of EVD, as appropriate.
  - Enhance and / or review infection control measures according to the latest knowledge on the transmission route of EVD.
  - Consider setting up designated clinics and protocol for triaging patients with relevant symptoms at primary care level.
  - Isolate and treat confirmed cases in designated hospitals.
  - Update / revise clinical guidelines on management and related admission criteria for various specialties.
  - Reduce non-urgent and non-emergency services where necessary.
  - Liaise with WHO and relevant experts on the latest development and recommendations on the use of vaccines and / or medication.
  - Review and modify existing port health measures and enact legislation, where necessary, in light of WHO’s latest guidelines.
  - Assist retrieval of flight manifests from airlines to facilitate tracing of flight contacts.
  - Keep in view WHO’s latest recommendations on port health measures.
  - Public communication will be strengthened. MOHWE will set up a telephone hotline as required.
  - MOHWE will conduct regular briefings to the press and Cabinet.
  - Deploy psychosocial team.
  - Activate psychosocial plan.
Emergency Response Level Actions

At the Emergency Response Level, the following response measures will be implemented:

- Monitor daily the number of detections of cases of Ebola virus
- Adjust surveillance mechanisms with reference to the latest recommendation(s) of the WHO
- Conduct epidemiological studies to look into community sources and mode of transmission
- Seek advice from Attorney General, when necessary, on the legal authorities for implementation of enhanced measures and on acquiring emergency public health power to enable enforcement of the control measures
- Closely liaise with relevant parties on the need to remove residents from affected premises to quarantine center(s) and arrange with related departments accordingly if such decision is made
- Further re-organize or reduce non-urgent services to meet the surge in workload due to EVD
- Reprioritize their non-urgent and non-essential services
- Screen Passengers for elevated body temperature
- Continue public education on use of PPE and practices
- Prepare and disseminate material to provide clear guidance on extra preventive measures to be taken
- Monitor daily number of patients seen at Accident & Emergency Departments and other health facility due to relevant symptoms
- Assess the state of disease spread and potential for pandemics jointly with WHO and relevant experts, where appropriate
- Thoroughly investigate any suspected community sources
- Collect epidemiological data
- Mobilize the capacity of isolation beds and management of confirmed and suspected cases. Mobilize District hospitals / wards to increase capacity to treat acute cases
- Review and promulgate updated guidelines and protocols on diagnosis, treatment and admission criteria
- Liaise with WHO and relevant experts on the latest development and recommendations on the use of vaccines and / or medication
- Communication) Provide daily updates of the course of the epidemic and MOHWE response plans and actions
- Continue to educate the public regarding relevant symptoms and when and how to seek medical attention or treatment
- Liaise with funeral homes and other stakeholders for immediate and proper disposal of dead bodies
- Ensure proper management of medical waste
Flu Clinic Flow Chart

PATIENT ARRIVES AT CLINIC WITH COUGH, FEVER AND SHORTNESS OF BREATH. DIRECTED TO FLU DESK

PATIENT SCREENED
Nurse checks: temperature, ask about cough and difficulty breathing, ask about last 14 days travel history, records blood pressure and oxygen saturation. Nurse will wear a mask for screening.

SUSPECTED COVID-19
(COUGH, HIGH FEVER, SHORTNESS OF BREATH AND TRAVEL HISTORY)

REFER TO DMO/HNS/FNP

DMO/HNS/FNP ASSESSMENT
(SUSPECTED)

NOTIFY MOH/HDC

HEALTH TEAM NOTIFIED FOR COLLECTION OF SAMPLES

SAMPLES COLLECTED SENT TO LAB

DMO/FNP further assess and treat

DMO/HNS/FNP ASSESSMENT
(NOT SUSPECTED)

DMO/FNP further assess and treat

NON-SUSPECTED CASE
(FEVER, NO SHORTNESS OF BREATH, NO COUGH AND NO TRAVEL HISTORY)

DMO/FNP further assess and treat
Evaluation and Management of Patients with Possible COVID-19

Flu-like symptoms on question – Private/District Clinic

1. **Identify the exposure history**
   Has the patient lived in or traveled to a country where COVID-19 is present or been in contact with a confirmed case of COVID-19 in the last fourteen (14) days?

   - **YE**
   - **N**

   Continue with usual triage and assessment.

2. **Identify signs and symptoms**
   - Fever (subjective or >100.4 F or 38 C)
   - Cough, difficulty breathing, Diarrhea

   - **YE**

   A. Continue with triage
   B. Notify Public Health
   C. Monitor at home upon discharge for 14 days after known COVID-19 exposure

3. **Refer patient to Milton Cato Memorial Hospital**
   Call prior to sending patient.

4. **Further Evaluation and Management**
   - b. Complete history and physical examination
   - c. Erect IV fluids
   - d. Collect Nasopharyngeal and Oropharyngeal swabs and send to Laboratory
   - e. Use only dedicated/preferable disposable equipment

5. **Decontamination of surfaces**
   - a. Disinfect using 10% bleach
   - b. Ensure that during the decontamination process you are wearing household latex gloves, plastic impermeable aprons and face mask.
   - c. Place all contaminated waste in a biohazard bag or garbage bag and burn the contents
   - d. Leave environmental surfaces to air dry
   - e. Room can be opened after 12 hours of decontamination
Protocol for Emergency Department Evaluation and Management of Patients with Possible COVID-19

1. Identify the exposure history
Has the patient lived in or traveled to a country where COVID-19 is present or been in contact with a confirmed case of COVID-19 in the last fourteen (14) days?

   YE → Continue with usual triage and assessment.
   NO → 2. Identify signs and symptoms

2. Identify signs and symptoms
Fever (subjective or >100.4 F or 38 C)
Cough, difficulty breathing, Diarrhea

   YE → 3. Isolate Patient
In Waiting Room 2/Retro-fitted Container.
PPE to be worn by healthcare provider

   NO → 4. Inform
   a. Triage nurse to immediately inform on duty physician who will then place PPE and assess the patients’ clinical status.
   b. The physician is responsible for informing the response team if COVID-19 is suspected

   A. Continue with triage
   B. Notify Public Health
   C. Monitor at home upon discharge for 14 days after known COVID-19 exposure

3. Isolate Patient
In Waiting Room 2/Retro-fitted Container.
PPE to be worn by healthcare provider

4. Further Evaluation and Management
   f. Complete history and physical examination
   g. Erect IV fluids
   h. Collect Nasopharyngeal and Oropharyngeal swabs and send to Laboratory
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   d. Leave environmental surfaces to air dry
   e. Room can be opened after 12 hours of decontamination
## COVID-19 and Health Care Facilities

<table>
<thead>
<tr>
<th>Component</th>
<th>Recommendation</th>
<th>Comments</th>
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</table>
| **Patient Placement**         | • Single patient room (containing a private bathroom) with the door closed  
• Facilities should maintain a log of all persons entering the patient's room                                                                                                                                                                                                                                                                          | • Consider posting personnel at the patient’s door to ensure appropriate and consistent use of PPE by all persons entering the patient room                                                                                                                                                               |
| **Personal Protective Equipment (PPE)** | • All persons entering the patient room should wear at least:  
  o Gloves  
  o Gown (fluid resistant or impermeable)  
  o Eye protection (goggles or face shield)  
  o Facemask  
• Additional PPE might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment), including but not limited to:  
  o Double gloving  
  o Disposable shoe covers  
  o Leg coverings                                                                                                                                                                                                                                               | • Recommended PPE should be worn by HCP upon entry into patient rooms or care areas. Upon exit from the patient room or care area, PPE should be carefully removed without contaminating one’s eyes, mucous membranes, or clothing with potentially infectious materials, and either  
  o Discarded, or  
  o For re-useable PPE, cleaned and disinfected according to the manufacturer's reprocessing instructions and hospital policies.  
  • Instructions for donning and removing PPE have been published  
  • Hand hygiene should be performed immediately after removal of PPE                                                                                                                                                                                                |
| **Patient Care Equipment**    | • Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of patient care                                                                                                                                                                                                                                  |                                                                                                                                                                                                                               |
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and hospital policies

<table>
<thead>
<tr>
<th>Patient Care Considerations</th>
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<tbody>
<tr>
<td>- Limit the use of needles and other sharps as much as possible</td>
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<tr>
<td>- Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care</td>
</tr>
<tr>
<td>- All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers</td>
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<table>
<thead>
<tr>
<th>Aerosol Generating Procedures (AGPs)</th>
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</thead>
<tbody>
<tr>
<td>- Avoid AGPs for 2019-nCoV patients.</td>
</tr>
<tr>
<td>- If performing AGPs, use a combination of measures to reduce exposures from aerosol-generating procedures when performed on 2019-nCoV patients.</td>
</tr>
<tr>
<td>- Visitors should not be present during aerosol-generating procedures.</td>
</tr>
<tr>
<td>- Limiting the number of HCP present during the procedure to only those essential for patient-care and support.</td>
</tr>
<tr>
<td>- Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room (AIIR) when feasible. Room doors should be kept closed during the procedure.</td>
</tr>
<tr>
<td>- Although there are limited data available to definitively define a list of AGPs, procedures that are usually included are Bi-level Positive Airway Pressure (BiPAP), bronchoscopy, sputum induction, intubation and extubation, and open suctioning of airways.</td>
</tr>
<tr>
<td>- Because of the potential risk to individuals reprocessing reusable respirators, disposable filtering face piece respirators are preferred.</td>
</tr>
</tbody>
</table>
procedure except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure.

- HCP should wear gloves, a gown, disposable shoe covers, and either a face shield that fully covers the front and sides of the face or goggles, and respiratory protection that is at least as protective as a NIOSH certified fit-tested N95 filtering face piece respirator or higher (e.g., powered air purifying respiratory or elastomeric respirator) during aerosol generating procedures.
- Conduct environmental surface cleaning following procedures (see section below on environmental infection control).
- If re-usable equipment or PPE (e.g. Powered air purifying respirator, elastomeric respirator, etc.) are used, they should be cleaned and disinfected according to manufacturer instructions and hospital policies.
- Collection and handling of soiled re-usable respirators must be done by trained individuals using PPE as described above for routine patient care.

**Hand Hygiene**

- HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material,
- Hand hygiene in healthcare settings can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap
and before putting on and upon removal of PPE, including gloves.
- Healthcare facilities should ensure that supplies for performing hand hygiene are available.

and water, not alcohol-based hand rubs.

| Environmental Infection Control | Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is paramount, as blood, sweat, emesis, feces and other body secretions represent potentially infectious materials.
- HCP performing environmental cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (shoe and leg coverings, etc.) if needed.
- Face protection (face shield or facemask with goggles) should be worn when performing tasks such as liquid waste disposal that can generate splashes.
- Follow standard procedures, per hospital policy and manufacturers' instructions, for cleaning and/or disinfection of:
  - Environmental surfaces and equipment
  - Textiles and laundry
  - Food utensils and dishware
  
  - Use EPA-registered hospital disinfectants to disinfect hard non-porous surfaces.
  - Follow label instructions for use.
  - Searchable EPA website of registered products.
  - For additional information on Environmental Infection Control, see the Guideline for Environmental Infection Control in Healthcare Facilities [PDF - 249 pages].

| Safe Injection practices | Facilities should follow safe injection practices as specified under Standard Precautions.

|  | Any injection equipment or parenteral medication container that enters the patient treatment area should be |
### Duration of Infection Control Precautions
- Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.
- Factors that should be considered include, but are not limited to: presence of symptoms related to 2019-nCoV, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridium difficile*) and available laboratory information.

### Monitoring and Management of Potentially Exposed Personnel
- Facilities should develop policies for monitoring and management of potentially exposed HCP.
- Facilities should develop sick leave policies for HCP that are non-punitive, flexible and consistent with public health guidance.
  - Ensure that all HCP, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.
- Persons with respiratory exposures to excretions from a patient with suspected 2019-nCoV should:
  - Stop working and immediately
- HCP who develop sudden onset of acute respiratory distress after an unprotected exposure (i.e. not wearing recommended PPE at the time of exposure to a patient with 2019-nCoV should...
- Not report to work or should immediately stop working
- Notify their supervisor
- Seek prompt medical evaluation and testing
- Notify local and state health departments
- Comply with work exclusion until they are deemed no longer infectious to others

- For asymptomatic HCP who had an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact) to a patient with 2019-nCoV
  - Should receive medical evaluation and follow-up care including fever monitoring twice daily for 7 days after the last known exposure.
  - Hospitals should consider policies ensuring twice daily contact with exposed personnel to discuss potential symptoms and document fever checks
  - May continue to work while receiving twice daily fever checks, based upon hospital policy and discussion with local, state, and federal public health authorities.

<table>
<thead>
<tr>
<th>Monitoring, Management, and Training of Visitors</th>
<th>Avoid entry of visitors into the patient’s room</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Exceptions may be considered on a case by case basis for</td>
<td>o Visitors who have been in contact with the 2019-nCoV patient before and during hospitalization are a possible</td>
</tr>
<tr>
<td>those who are essential for the patient's wellbeing.</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>• Establish procedures for monitoring managing and training visitors.</td>
<td></td>
</tr>
<tr>
<td>• Visits should be scheduled and controlled to allow for:</td>
<td></td>
</tr>
<tr>
<td>o Screening for 2019-nCoV (e.g., fever and other symptoms) before entering or upon arrival to the hospital</td>
<td></td>
</tr>
<tr>
<td>o Evaluating risk to the health of the visitor and ability to comply with precautions</td>
<td></td>
</tr>
<tr>
<td>o Providing instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE according to the current facility policy while in the patient's room</td>
<td></td>
</tr>
<tr>
<td>o Visitor movement within the facility should be restricted to the patient care area and an immediately adjacent waiting area.</td>
<td></td>
</tr>
</tbody>
</table>

source of 2019-nCoV for other patients, visitors, and staff.
What to do if you suspect COVID-19

1. Isolate patient in Kingstown clinic, Isolation Pod or Female Medical Ward
2. Inform Consultant on call and Dr Davy.
3. Perform Swab for PCR testing for confirmation of COVID19 (Please note that rapid testing is reserved for patients in convalescent period. For patients with more than 7 days of symptoms Rapid testing may be performed along with PCR.)
4. Patients may not be discharged if he or she is clinically stable.
5. If rapid test was ordered; await results prior to discharging patients.
6. Patients should be given instructions for home care and isolation upon discharge
7. Inform Community Health Teams prior to discharge of the patients so that home assessment may be done, and contact tracing can be performed.
Criteria for COVID-19 Testing

Testing for Single Case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness of breath), AND with no other etiology that fully explains the clinical presentation AND

A history of travel to or residence in a country/area or territory reporting local transmission (See situation report) of COVID-19 disease during the 14 days prior to symptom onset.

OR

B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID19 case (see definition of contact) in the last 14 days prior to onset of symptoms.

OR

C. A patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness breath) AND requiring hospitalization AND with no other etiology that fully explains the clinical presentation.

Also

D. Test contacts of a positive COVID19 case using PCR method

Patients will also require the following laboratory tests
CBC with differential, routine urinalysis, biochemistry (LFT, UCE, CK-MB), PT/PTT, arteria, LDH, and CRP.

Testing at the first sign of Local Transmission & Community Transmission

Person with no travel history or no contact with COVID19 positive patient

Screen all symptomatic patients with IgG/IgM method use PCR for confirmation

Test contacts of a positive COVID19 case using PCR method

?? When do stop routine samples.... To be answered by policy makers
Proposed Sampling strategy Interpretation of Results

<table>
<thead>
<tr>
<th>Method of Detection for SARS-CoV-02</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT- PCR</td>
<td>RDT (IgM/IgG)</td>
</tr>
<tr>
<td>Positive</td>
<td>Positive</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive (false negative RDT)</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative (false positive RDT)</td>
</tr>
<tr>
<td>Negative</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Contact tracing starts on confirmation of a case

- Suspect Case
- RDT 7 days post onset of symptoms
  - PCR Test
    - Ideally 5 days of symptoms
    - PCR Negative
      - Complete quarantine, Retest with RDT at the end of 34
    - PCR Positive
      - Clinical Management of case
        - Clinically Unwell
          - RDT Positive
            - Released
          - RDT Negative
            - RDT test 14 days after contact
              - RDT Positive
                - Released
            - RDT Negative
              - RDT Negative

- RDT
  - RDT Positive
    - Released
  - RDT Negative
    - RDT Negative
Scaling up Screening for COVID-19

Screen all persons meeting the following criteria

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease (e.g. cough, shortness of breath), AND with no other etiology that fully explains the clinical presentation AND

A history of travel to or residence in a country/area or territory reporting local transmission (See situation report) of COVID-19 disease during the 14 days prior to symptom onset.

OR

B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID19 case (see definition of contact) in the last 14 days prior to onset of symptoms.

OR

C. A patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness breath) AND requiring hospitalization AND with no other etiology that fully explains the clinical presentation.

Test using a PCR method for all of the above

Also

D. Test close contacts of a positive COVID19 case using PCR test method. Test should not be done earlier than five days after exposure. If an exposed person, who has had negative PCR test, becomes symptomatic before the end of the 14 days quarantine period, the PCR test will be repeated.

E. Person with no travel history or no contact with a COVID19 positive patient but presents with atypical Pneumonia and /or flu like symptoms in clusters, in the absence of evidence of community transmission, will be screened using PCR testing.

F. Immunoglobulin methods/ Rapid test would be used to screen persons in the convalescent period or for persons presenting with 7-12 days of symptoms.
Please note

Definition of contact: A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case: 1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes; 2. Direct physical contact with a probable or confirmed case; 3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment; OR 4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.
Admission Criteria to a Health Facility for COVID-19

Any suspect or confirmed case of COVID-19 with one or more of the following:

- **Pneumonia**
  - Adult with pneumonia but no signs of severe pneumonia and no need for supplemental oxygen.
  - Child with non-severe pneumonia who has cough or difficulty breathing + fast breathing: fast breathing (in breaths/min): < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40, and no signs of severe pneumonia
  - Adolescent or adult: fever or suspected respiratory infection, plus one of the following: respiratory rate > 30 breaths/min; severe respiratory distress; or SpO2 ≤ 93% on room air

- **Acute Respiratory Distress Syndrome**
  - Onset 1 week of a known clinical insult or new or worsening respiratory symptoms.
  - Chest imaging (radiograph, CT scan, or lung ultrasound): bilateral opacities, not fully explained by volume overload, lobar or lung collapse, or nodules. Origin of pulmonary infiltrates: respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g. echocardiography) to exclude hydrostatic cause of infiltrates/oedema if no risk factor present.

- **Patients with co-morbidities such as Diabetes, Hypertension and Heart Disease**

- **Persons with Sepsis**
  - Adults: life-threatening organ dysfunction caused by
    a) Dysregulated host response to suspected or proven infection.
    b) Signs of organ dysfunction include: altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output (5, 20), fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate, or hyperbilirubinemia.
  - Children: suspected or proven infection and ≥ 2 age-based systemic inflammatory response syndrome criteria, of which one must be abnormal temperature or white blood cell count.

- **Persons with Septic Shock**
- **Full term pregnancy**
- **Persons requiring mechanical ventilation**
Clinical Management of COVID-19

**Identify signs and symptoms**

**Clinical Features**
- Fever (100.4 F or 38 C)
- Difficulty breathing
- Radiological evidence - bilateral lung infiltrates

**Isolation**
- Ensure that all patients suspected of COVID-19 are managed in isolation in single rooms
- Only allow members of the care team to enter isolation rooms
- Ensure the use of Personal Protective Equipment at all times

**Diagnosis**
- Nasopharyngeal swab

**Treatment**
Currently there is no approved treatment for 2019-nCoV
Symptomatic treatment is recommended. Special attention must be paid to possible complications and infections

<table>
<thead>
<tr>
<th>SIGN/SYMPOTM</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Paracetamol, avoid NSAIDs</td>
</tr>
<tr>
<td>Pain</td>
<td>Paracetamol if mild, Morphine is severe</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>O2 at 5L, evaluate for pneumonia or CCF and treat</td>
</tr>
<tr>
<td>Vomiting, diarrhea</td>
<td>ORS if mild, IV fluids if dehydration. For vomiting give Chlorpromazine 25-50mg IV q 6hrs or Metoclopramide 10mg IV q8hrs for adults. Promethazine is recommended for children</td>
</tr>
<tr>
<td>Heartburn</td>
<td>Omeprazole for adults and children over 10 yrs</td>
</tr>
<tr>
<td>Convulsions</td>
<td>Diazepam for active seizures/ Phenobarbital for control 10mg/kg</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>D 50% 25-50ml in adults/ 5mg/kg in children</td>
</tr>
<tr>
<td>Aggression</td>
<td>Haldol in adult</td>
</tr>
<tr>
<td>SHOCK</td>
<td>IV fluids/ Dobutamine/ Dopamine</td>
</tr>
</tbody>
</table>
Management of Mild Covid-19 Disease/ Home Care

Criteria for Home care

- Patient must have mild form of the disease (Patients uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnea, nasal congestion, or headache. Rarely, patients may also present with diarrhea, nausea, and vomiting)
- Patients > 80 years of years must be cared for in a health care facility
- Persons with Diabetes, HIV patients not virally suppressed, Hypertension and Cardiovascular disease must be cared for in a health care facility

Diagnosing COVID-19

A member if health team will take nasopharyngeal and oropharyngeal swabs which would be sent for laboratory confirmation.

The patient will be placed in single room isolation at home while awaiting results.

Once daily visits will be made to ascertain clinical condition

Patient will have telephone access to health team

Treatment

- Managed at home under quarantine for 14 days
- Will be visited by health team daily for temperature checks and evaluation of symptoms
- Paracetamol for fevers and pain
- Oral hydration
**Pneumonia**

- Adult with pneumonia but no signs of severe pneumonia and no need for supplemental oxygen.
- Child with non-severe pneumonia who has cough or difficulty breathing + fast breathing: fast breathing (in breaths/min): < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40, and no signs of severe pneumonia.

Give empiric antimicrobials to treat all likely pathogens causing SARI and sepsis as soon as possible, within 1 hour of initial assessment.

Empiric therapy should be de-escalated on the basis of microbiology results and clinical judgment.

**Severe Pneumonia**

- Adolescent or adult: fever or suspected respiratory infection, plus one of the following: respiratory rate > 30 breaths/min; severe respiratory distress; or SpO2 ≤ 93% on room air (adapted from 14).

- Child with cough or difficulty in breathing, plus at least one of the following: central cyanosis or SpO2 < 90%; severe respiratory distress (e.g. grunting, very severe chest in drawing); signs of pneumonia with a general danger sign: inability to breastfeed or drink, lethargy or unconsciousness, or convulsions (15). Other signs of pneumonia may be present: chest in drawing, fast breathing (in breaths/min): < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40 (16). While the diagnosis is made on clinical grounds; chest imaging may identify or exclude some pulmonary complications.

Treat as non-ventilated ARDS.

Add Lopinavir/ritonavir (200mg/50mg) 2 tablets POBID in adults. Children <15kg ½ tab BID, 15-35kg 1tab BID.

**ARDS**

Onset 1 week of a known clinical insult or new or worsening respiratory symptoms. Chest imaging (radiograph, CT scan, or lung ultrasound): bilateral opacities, not fully explained by volume overload, lobar or lung collapse, or nodules. Origin of pulmonary infiltrates: respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g. echocardiography) to exclude hydrostatic cause of infiltrates/oedema if no risk factor present. Oxygenation impairment in adults:

- Mild ARDS: 200 mmHg < PaO2/FiO2a ≤ 300 mmHg (with PEEP or CPAP ≥ 5 cmH2O, or non-ventilated)
Appendix

• Moderate ARDS: $100 \text{ mmHg} < \text{PaO}_2/\text{FiO}_2 \leq 200 \text{ mmHg}$ (with PEEP $\geq 5 \text{ cmH}_2\text{O}$, or non-ventilated)

• Severe ARDS: $\text{PaO}_2/\text{FiO}_2 \leq 100 \text{ mmHg}$ (with PEEP $\geq 5 \text{ cmH}_2\text{O}$, or non-ventilated)

• When $\text{PaO}_2$ is not available, $\text{SpO}_2/\text{FiO}_2 \leq 315$ suggests ARDS (including in non-ventilated patients). Oxygenation impairment in children: note $\text{OI} = \text{Oxygenation Index}$ and $\text{OSI} = \text{Oxygenation Index using SpO}_2$. Use $\text{PaO}_2$-based metric when available. If $\text{PaO}_2$ not available, wean $\text{FiO}_2$ to maintain $\text{SpO}_2 \leq 97\%$ to calculate OSI or $\text{SpO}_2/\text{FiO}_2$ ratio:

• Bi-level (NIV or CPAP) $\geq 5 \text{ cmH}_2\text{O}$ via full face mask: $\text{PaO}_2/\text{FiO}_2 \leq 300 \text{ mmHg}$ or $\text{SpO}_2/\text{FiO}_2 \leq 264$

• Mild ARDS (invasively ventilated): $4 \leq \text{OI} < 8$ or $5 \leq \text{OSI} < 7.5$

• Moderate ARDS (invasively ventilated): $8 \leq \text{OI} < 16$ or $7.5 \leq \text{OSI} < 12.3$ Severe ARDS (invasively ventilated): $\text{OI} \geq 16$ or $\text{OSI} \geq 12.3$.

Implement mechanical ventilation using lower tidal volumes ($4–8 \text{ mL/kg predicted body weight, PBW}$) and lower inspiratory pressures (plateau pressure $< 30 \text{ cmH}_2\text{O}$)

In adult patients with severe ARDS, prone ventilation for 12–16 hours per day is recommended. Use a conservative fluid management strategy for ARDS patients without tissue hypo perfusion.

**Sepsis**

Adults: life-threatening organ dysfunction caused by

a) Dysregulated host response to suspected or proven infection.

b) Signs of organ dysfunction include: altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output ($5, 20$), fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate, or hyperbilirubinemia.

Children: suspected or proven infection and $\geq 2$ age-based systemic inflammatory response syndrome criteria, of which one must be abnormal temperature or white blood cell count.

First line treatment- Ampicillin and Gentamicin

Second line- Amikacin

Third line- Piperacillin/Tazobactam

**Septic Shock**

Children: suspected or proven infection and $\geq 2$ age-based systemic inflammatory response syndrome criteria, of which one must be abnormal temperature or white blood cell count.
Appendix

Adults: persisting hypotension despite volume resuscitation, requiring vasopressors to maintain MAP \( \geq 65 \) mmHg and serum lactate level > 2 mmol/L.

Children: any hypotension (SBP < 5th centile or > 2 SD below normal for age) or two or three of the following: altered mental state; tachycardia or bradycardia (HR < 90 bpm or > 160 bpm in infants and HR < 70 bpm or > 150 bpm in children); prolonged capillary refill (> 2 sec) or feeble pulse; tachypnoea; mottled or cool skin or petechial or purpuric rash; increased lactate; oliguria; hyperthermia or hypothermia

In resuscitation for septic shock in adults, give 250–500 mL crystalloid fluid as rapid bolus in first 15–30 minutes and reassess for signs of fluid overload after each bolus.

In resuscitation from septic shock in children, give 10–20 mL/kg crystalloid fluid as a bolus in the first 30–60 minutes and reassess for signs of fluid after each bolus.

In adults, administer vasopressors when shock persists during or after fluid resuscitation. The initial blood pressure target is MAP \( \geq 65 \) mmHg in adults and improvement of markers of perfusion.

In children administer vasopressors if: 1. Signs of shock such as altered mental state; bradycardia or tachycardia (HR < 90 bpm or > 160 bpm in infants and HR < 70 bpm or > 150 bpm in children); prolonged capillary refill (> 2 seconds) or feeble pulses; tachypnea; mottled or cool skin or petechial or purpuric rash; increased lactate; oliguria persists after two repeat boluses; or 2. Age-appropriate blood pressure targets are not achieved; or 3. Signs of fluid overload are apparent

If signs of poor perfusion and cardiac dysfunction persist despite achieving MAP target with fluids and vasopressors, consider an inotrope such as dobutamine
Prevention of complications

Anticipated outcome

Interventions

**Reduce days of invasive mechanical ventilation**

- Use weaning protocols that include daily assessment for readiness to breathe spontaneously
- Minimize continuous or intermittent sedation, targeting specific titration endpoints (light sedation unless contraindicated) or with daily interruption of continuous sedative infusions

Reduce incidence of ventilator-associated pneumonia

- Oral intubation is preferable to nasal intubation in adolescents and adults
- Keep patient in semi-recumbent position (head of bed elevation 30–45º)
- Use a closed suctioning system; periodically drain and discard condensate in tubing
- Use a new ventilator circuit for each patient; once patient is ventilated, change circuit if it is soiled or damaged, but not routinely
- Change heat moisture exchanger when it malfunctions, when soiled, or every 5–7 days

**Reduce incidence of venous thromboembolism**

- Use pharmacological prophylaxis (low molecular-weight heparin [preferred if available] or heparin 5000 units subcutaneously twice daily) in adolescents and adults without contraindications. For those with contraindications, use mechanical prophylaxis (intermittent pneumatic compression devices)

Reduce incidence of catheter-related bloodstream infection

- Use a checklist with completion verified by a real-time observer as reminder of each step needed for sterile insertion and as a daily reminder to remove catheter if no longer needed
- Turn patient every 2 hours
- Give early enteral nutrition (within 24–48 hours of admission)
- Administer histamine-2 receptor blockers or proton-pump inhibitors in patients with risk factors for GI bleeding. Risk factors for GI bleeding include mechanical ventilation for ≥ 48 hours, coagulopathy, renal replacement therapy, liver disease, multiple comorbidities, and higher organ failure score
- Actively mobilize the patient early in the course of illness when safe to do so
COVID-19 Pregnancy and Breastfeeding

To date, there are limited data on clinical presentation and perinatal outcomes after COVID-19 during pregnancy or the puerperium. There is no evidence that pregnant women present with different signs or symptoms or are at higher risk of severe illness. So far, there is no evidence on mother-to-child transmission when infection manifests in the third trimester, based on negative samples from amniotic fluid, cord blood, vaginal discharge, neonatal throat swabs or breastfeeding. Similarly, evidence of increased severe maternal or neonatal outcomes is uncertain, and limited to infection in the third trimester, with some cases of premature rupture of membranes, fetal distress, and preterm birth reported.

Pregnant women with suspected, probable, or confirmed COVID-19, including women who may need to spend time in isolation, should have access to woman-centred, respectful skilled care, including obstetric, fetal medicine and neonatal care, as well as mental health and psychosocial support, with readiness to care for maternal and neonatal complications.

Mode of birth should be individualized based on obstetric indications and the woman’s preferences. WHO recommends that caesarean section should ideally be undertaken only when medically justified.

Infants born to mothers with suspected, probable, or confirmed COVID-19 should be fed according to standard infant feeding guidelines, while applying necessary precautions for IPC (hand washing and use of a medical mask).

Breastfeeding should be initiated within 1 hour of birth. Exclusive breastfeeding should continue for 6 months with timely introduction of adequate, safe and properly fed complementary foods at age 6 months.

Mothers and infants should be enabled to remain together and practice skin-to-skin contact.
QUARANTINE GUIDELINES FOR STAFF EXPOSED TO COVID19

If a person comes into direct contact with a suspect or confirmed case of COVID19 while not wearing personal protective equipment; he/she shall be placed under quarantine.

In the case of receiving a negative result for the suspect case; quarantine shall be discontinued.

In the case of exposure to a positive case; quarantine is for 14 days at home in a single room with daily temperature checks and monitoring for respiratory symptoms such as dry cough and shortness of breath.

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes

2. Direct physical contact with a probable or confirmed case

3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment

OR

4. Other situations as indicated by local risk assessments.
Discharge Criteria for Confirmed COVID-19

Patients meeting the following criteria can be discharged:

- Afebrile for >3 days
- Improved respiratory symptoms
- Pulmonary imaging shows obvious absorption of inflammation
- Nucleic acid tests negative for respiratory tract pathogen twice consecutively (sampling interval ≥ 24 hours). CARPHA recommends a swab at day 14 and another at day 21.
- For symptomatic patients after the resolution of symptoms, samples should be collected at least seven days after the onset or after > 3 days without fever.
- For asymptomatic SARS-CoV-2-infected persons, the tests to document virus clearance should be taken at a minimum of 14 days after the initial positive test.

After discharge, patients are recommended to continue 14 days of isolation management and health monitoring, wear a mask, live in a single room with good ventilation, reduce close contact with family members, eat separately, keep hands clean and avoid outdoor activities. It is recommended that discharged patients should have follow-up visits after 2 and 4 weeks.
CARE FOR YOURSELF

- Monitor your symptoms as instructed by your healthcare provider
- Take paracetamol for fever.
- Do not take Advil or Ibuprofen.
- If your symptoms get worse immediately call your healthcare provider or the COVID-19 Hotline at telephone number 5344325
- Get some rest, eat a balanced diet and stay in touch with others through communication devices

Limit Contact with Others:

- Do not leave home. Do not go to work, school, other publics areas
- Do not use public transportation
- Arrange to have groceries delivered to you
- Stay in a separate room and if possible and use a separate bathroom from others if possible your home
- If you have to be in contact with others, stay 3 feet apart, wear a mask and keep your interactions short
- Avoid contact with the elderly, persons with chronic diseases and pets

Cleaning high touch surfaces and items

- At least once daily, clean and disinfect surfaces you touch often e.g. toilets, tables, doorknobs, phones, TV remotes
- Do not share personal items such as toothbrushes, bed linen, utensils or electronics
- Use regular household disinfectants or diluted bleach to disinfect
- For items that cannot be cleaned, discard in a plastic lined bin
- Put lid of toilet down before flushing

KEEP YOUR HANDS CLEAN

- Wash your hands often with soap and water and dry with a paper towel
- You can also use an alcohol based hand sanitizer
- Avoid touching your eyes, nose and mouth with your unwashed hands.
- Cough or sneeze into a tissue or the cuff of your elbow
Cleaning/Disinfection of an Ambulance after transporting a Suspect/Confirmed case of COVID-19

- Put on personal protective equipment (PPE)...see below
- Remove all equipment and supplies from the ambulance
- Spray disinfectant on all inner surfaces, doors and trollies with bleach solution (one-part water 9 parts bleach). For surfaces where bleach can not to use; use 70% alcohol for surfaces were bleach can’t be used.
- Dry surfaces using disposable towels
- Ensure that the cab/ fronts seats are also cleaned
- If there are spills (blood and or body fluid) use spill kit if available or place absorbable cloth/paper on spill for a few minutes before removing.
- Collect and place all waste in red disposal/garbage bags
- Let surfaces dry for 30 minutes
- Reload equipment into ambulance
ORDER OF DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

**NB:** All males who are wearing socks must roll them down; place your pants foot into the socks then pull them back up

1. Remove all jewellery (watches, rings, earrings etc). If you have long hair secure it behind your head
2. Perform hand hygiene
3. Put on inner gloves
4. Boot covers
5. Put on coverall and zip up
6. Respirator
7. Eye protection (goggles)
8. Pull up hood of coverall over the head
9. Put on outer gloves

ORDER OF DOFFING PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. Perform hand hygiene
2. Unzip coverall
3. Remove outer gloves
4. Take hood off by rolling it back unto itself
5. Place hands behind your back and remove coverall rolling downwards inside out
6. Remove boot covers
7. Place contaminated PPE and boot covers into a biohazard waste disposal bag
8. Perform hand hygiene
9. Remove inner gloves
10. Put on a new pair of gloves
11. Remove eye protection (goggles)
12. Remove respirator/ N95
13. Remove gloves
14. Perform hand hygiene
Psychosocial Support for COVID-19 – Community Response Team

Psychosocial support and care in the face of a pandemic is extremely vital in preserving and addressing the emotional and social needs of the infected and affected by COVID-19. Psychosocial support includes:

1. Psychological First Aid
2. Counselling
3. Social services
4. Integration into society for those in isolation/quarantined
5. Addressing Stigma and Discrimination
6. Disseminating information to the public and development of messages

The activation of this mechanism also includes first responders inclusive of nurses, doctors, immigration officers, police officers and other providers who have been directly involved in Covid-19 care services. This algorithm outlines the process for mental health and social support for children and adults who are either in quarantine and or isolation.

Step 1: Routed referral from Covid-19 Hotline (emotional disturbances, issues affecting sleep, coping problems, self harm/suicidal ideation, tearfulness, death)

Step 2: The calls according to need is routed using the already installed process, there are several practitioners assigned to general populations.

- Anya Abbott: 433-8499
- Jerwayne Laidlow: 495-2956
- Shunnell Nedd: 531-0027

Step 3: At the end of every call, the call and a general summary will be logged by practitioner

Each professional understands the sensitivity of this process and is committed to professionalism and confidentiality. Each practitioner is to sign a confidentiality contract. Follow up maybe scheduled and organized with practitioner and caller via telephone until advised to meet face to face if this is needed.

NB: Anyone who has active suicidal/homicidal ideations will be referred to the appropriate channels; from group member to group leader Roselle Solomon to named taskforce liaison for intervention.
Protocol

The general template for introducing ourselves at the beginning of a call: Good morning/afternoon/evening. My name is _______ and I'm an aid in the Ministry of Health, Wellness and the Environment. How can I help you?

Conversations should flow naturally so that the caller does not feel interrogated or screened however questions can be asked inclusive of: 1. How are you sleeping? 2. How is your appetite? 3. Are you feeling down, depressed or hopeless? 4. Do you feel nervous, anxious or on edge? 5. Is it hard for you to stop or control your worry? 6. Do you find yourself being irritable or easily annoyed? 7. Do you have any thoughts to hurt yourself or others? 8. Are you hearing or seeing anything that others cannot hear or see?

General Psychological First Aid (PFA) approach, give caller a listening ear then link with resources. Information that needs to be documented in the log book: • Date of call • Time of call • Telephone number of the caller • Name of caller • Address of caller • Query (what did they call about) • Response (given by you)

Team information

NAME EMIAL ADDRESS TELEPHONE #

1. Anya Abbott a-k-p-jacobs@hotmail.com 433-8499
2. Jerwayne Laidlow jerwayne.laidlow@gmail.com 495-2956
3. Ellica Matthews ellicamatthews@gmail.com 454-8811
4. Shunnell Nedd shanyy@msn.com 531-0027
5. Roselle Solomon rtksolomon@gmail.com 497-3893
6. Odelia Thomas odelia.thomas@gmail.com 492- 5080
Confidentiality Agreement

This agreement is between

______________________________________
Name of party

And

The Ministry of Health, Wellness and the Environment

I hereby agree that I will maintain professionalism, sensitivity and confidentiality regarding caller information. In the event that a caller identifies any thoughts of self harm, suicidal and homicidal ideation this information will be directed to the relevant authorities.

Volunteer/Practitioner: ____________________________

Signature

Witness: ____________________________
Protocol for Hotels and Guest Houses Suspicion of COVID-19

1. Identify signs and symptoms

If the guest has visited or lived in a country where Ebola is present or come into contact with someone diagnosed with 2019-nCoV and has any of the following:

- Fever (subjective or > 100.4 F or 38 C)
- Difficulty breathing
- Headache, weakness, muscle pain, abdominal pain, vomiting, diarrhea, hemorrhaging

2. Isolate

Place the guest in his previously assigned room and ensure that isolation is maintained at all times.

If the guest is accompanied with asymptomatic guest, assign them another room

Notify the staff to have no contact with the guest at this time

3. Inform the Authorities

Please call 4561955 or 4561185 Ext 120 for further instructions and transport to health care setting

Do not attempt transport the guest

4. Decontamination

Follow the instructions for decontamination of the room once the guest is removed

Do not assign a guest until 12 hrs post decontamination has been completed

CHECKLIST

1 bottle    Hand sanitizer
1 bottle    Antimicrobial liquid soap
6 rolls    Paper towels
6    Absorbent disposable cleaning cloth
1 box    Disposable gloves
1 pack    Small/Medium garbage bags
1 gallon    Bleach
            Spray can/bottle
            N95 Mask
            Impermeable apron/gown
# HOME CARE FOR THE ELDERLY

1. **Protection**  
   If you have fever, cough, and any other respiratory symptoms, do not visit the elderly.  
   If you live in the same house wear a face covering or mask and avoid close contact.

2. **Medication**  
   Ensure that the elderly have adequate supply of his or her routine medications (e.g. for diabetes and hypertension).

<table>
<thead>
<tr>
<th>3. If the elderly person is ill, be sure to contact his or her doctor or the nearest health centre. Information can also be accessed by calling the COVID-19 hotline at 5344325.</th>
<th>4. If the elderly person is ill but does not require hospitalization; ensure that the ill person gets plenty of rest, stays hydrated and eats nutritious foods.</th>
</tr>
</thead>
</table>
| 5. Wear a medical mask when in the same room with an ill person. Do not touch the mask or the face during use and discard it afterwards. | 6. Frequently clean hands with soap or water or alcohol based sanitizers  
   - Before or after and during food preparation  
   - Before eating  
   - After using the toilet  
   - Before and after contact with the ill person and his or her surroundings |
| 7. Use dedicated dishes, cups, eating utensils, towels and bedlinens for the ill person. Wash dishes, cups, eating utensils, towels and bedlinens used by the ill person with soap and water. Use disposable utensils if possible. | 8. Identify frequently touched surfaces by the ill person and clean and disinfect them at least 3 times daily. |
| 9. Assign a separate bathroom for the sick person if possible. If not ensure that it is cleaned properly with bleach (1 part bleach, 9 parts water) Ensure that the lid of the toilet is covered before flushing to avoid backsplash | 10. Call your health care provider immediately if the person worsens or experiences shortness of breath or any other complications. |
COVID-19 and Long-term Care (geriatric) Facilities

1. **Minimize the chances of exposure**

   Face mask or coverings should be worn by all health care providers and visitors within the facility. Temperature checks and routine questions about respiratory symptoms are recommended. Anyone with fever and respiratory symptoms should not be allowed to enter. New admissions to the facility should arrive in face covering or be given one upon arrival.

2. **Adhere to standard and transmission-based precaution**

   Adhere to proper Hand Hygiene Practices

   Use of personal protective equipment if there is a suspect or confirmed case of COVID19.

3. **Patient placement**

   If hospitalization is not necessary patient can be managed within the facility. Minimize the transfer out of room. Place in single room if possible. Do not allow mixing with other persons. Assign one health care provider to this person if possible. Use disposable cutlery if possible. Use dedicated equipment where possible, sanitize with 70% alcohol if to be shared. Patient should wear face mask at all times. Healthcare worker must wear PPE on entering the patient’s room.

4. **Taking precautions when performing aerosol generation procedures**

   An N95 mask must be worn by health care worker when performing aerosol generating procedures (nebulization, suction, etc). Limit personnel within the room. Clean surfaces with bleach (one part bleach and 9 parts water) after the procedures.

5. **Managing visitor movement and access within the facility**

   Limit visitors to the facility to only those essential for the patient’s physical or emotional well-being and care (e.g., care partners). Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets. Limit points of entry to the facility and visitation hours to allow screening of all potential visitors. Actively assess all visitors for fever and COVID-19 symptoms upon entry to the facility. If fever or COVID-19 symptoms are present, the visitor should not be allowed entry into the facility.

6. **Manage and monitor health care personnel**

   As part of routine practice, HCP should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
• HCP should be reminded to stay home when they are ill.
• If HCP develop fever (T≥100.0°F) or symptoms consistent with COVID-19* while at work they should keep their cloth face covering or facemask on, inform their supervisor, and leave the workplace.

7. **Train and educate health care personnel**

Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and the environment during the process of removing such equipment.

8. **Implement environmental infection control measures**

Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product’s label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.

9. **Establish internal reporting and reports to public health**

Communicate and collaborate with public health authorities. Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP. Communicate information about patients with known or suspected COVID-19 to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.
Interim Guidance For Her Majesty's Prisons Re: COVID-19

This document provides short-term guidance for the HER MAJESTY'S PRISON in St. Vincent and the Grenadines during the global pandemic of COVID-19. This guidance is to facilitate the continued operations of the HMPs in a manner that will ensure the health and safety of incarcerated persons and staff. Revisions to this document may be provided as more information becomes available. The guidelines may be further adapted to suit the current staffing, prison population, physical space, resources and other facility conditions.

1. SCREENING OF STAFF: Enhanced health screening of staff should be implemented when community transmission of COVID-19 is sustained in the population. Such screening includes self-reporting of symptoms and temperature checks.

2. SOCIAL VISITS: Social visits should be suspended for a period of 30 days, at which time the suspension may be reevaluated. To ensure inmates maintain social ties, the HMP may allow for additional inmate telephone communications.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons’ physical health and the health of the general public. However, visitation is important to maintain mental health. If visitation is suspended, HMP should explore alternative ways for incarcerated/detained persons to communicate (e.g. teleconferencing) with their families, friends, and other visitors in a way that is not financially burdensome for them.

3. LEGAL VISITS: Access to legal counsel remains a paramount requirement in the HMP but like social visiting, the HMP is mitigating the risk of exposure created by external visitors. As such, while in general, legal visits will be suspended for 30 days, case-by-case accommodation will be accomplished at the local level and confidential legal calls will be allowed in order to ensure inmates maintain access to counsel. Attorneys seeking an in-person visit with their client or a confidential call should contact [relevant authority HMP]. If approved for an in-person visit, the attorney will need to undergo screening using the same procedures as staff.

4. INMATE MOVEMENT: All inmate facility transfers will be suspended for 30 days, at which time the suspension will be reevaluated. Admission of new inmates will continue.

5. CONTRACTORS: Access to HMP facilities should be restricted to those performing essential services (e.g. medical or mental health care) or those who perform necessary maintenance. Persons granted access should be screened using the same procedures as staff prior to entry.
6. SCREENING OF INMATES:

- All newly-arriving inmates are being should be screened for COVID-19 exposure risk factors and symptoms.
- Asymptomatic inmates with exposure risk factors should be quarantined.
- Symptomatic inmates with exposure risk factors should be isolated in a single room. The Ministry of Health, Wellness and the Environment should then be immediately consulted for testing for COVID-19.

7. MODIFIED OPERATIONS: The HMP should implement social distancing and limit group gatherings. These includes but is not limited to staggered meal times, recreation etc.

8. INFORMATION SHARING: Symptoms of COVID-19 and hand hygiene instructions should be shared with all staff and facility inmates. Signage may be posted. Ensure that signage is understandable for those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision. Specifically:

- Incarcerated persons should be reminded of importance of immediately reporting symptoms to staff

- Staff should stay at home when sick; if symptoms develop while on duty, self-isolate and immediately contact the health authorities to determine whether they need to be evaluated and tested.

9. STAFFING: Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.

  - Allow staff to work from home when possible, within the scope of their duties.
  - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
  - Consider offering revised duties to staff who are at higher risk of severe illness with COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes.
Communicate with the public about any changes to facility operations, including visitation programs.

10. **CLEAN AND DISINFECT:**

Ensure that sufficient stocks of hygiene supplies and cleaning supplies are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility. Supplies include:

- Tissues
- Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
- Hand drying supplies
- Alcohol-based hand sanitizer containing at least 70% alcohol (where permissible based on security restrictions)
- Cleaning supplies

Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.

Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).

Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).

Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day. Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures. These measures may prevent spread of COVID-19 if introduced.

- Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding
Implement lawful alternatives to in-person court appearances where permissible.

- Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.
  - Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
- Practice good [cough etiquette](https://www.cdc.gov/coronavirus/2019-ncov/php/cough-sneeze.html): Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
- Practice good [hand hygiene](https://www.cdc.gov/coronavirus/2019-ncov/php/hand-washing.html): Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Avoid touching your eyes, nose, or mouth without cleaning your hands first.
- Avoid sharing eating utensils, dishes, and cups.

Avoid non-essential physical contact.
Protocol For Taxi/ Minibus Management Of COVID-19

1. As a general rule do NOT touch or shake hands with anyone as hands may be contaminated.
2. Avoid touching environmental surfaces as they may be contaminated (railings, doorknobs etc.) If you do remember to wash your hands or use hand sanitizer.
3. Wash hands frequently with soap and water or use alcohol-based hand sanitizer.
4. Do NOT allow persons who are known or appear to be sick (especially with cough) to enter your taxi or minibus.
5. Should someone display symptoms of COVID-19 (fever, dry cough, shortness of breath etc) while being transported, park and exit the vehicle. Call the COVID-19 hotline at 534-4325 for assistance.
6. Use single use nitrile or latex disposable gloves to clean infectious waste like (vomit, feces, blood).
7. Disinfect taxi or minibus with 10% bleach by wiping all surfaces.
8. Place contaminated waste in a sturdy garbage bag for disposal.
9. Once you have cleaned the surfaces of your vehicle, allow them to air dry before use.
PHYSICAL DISTANCING

Avoid overcrowding of the motor vehicle by implementing the following measures:

a. Only allow passengers to sit in alternate rows at the windows (economically feasible with larger vehicles)

b. More trips throughout the day coordinated with identified employers
CHECKLIST OF ITEMS NEEDED FOR CLEANING AND DISINFECTING

✓ 1 bottle hand sanitizer (1 liter)
✓ 1 medium sized bottle antimicrobial liquid soap
✓ 6 rolls paper towels
✓ 6 absorbent disposable cleaning cloths
✓ 1 box single use disposable nitrile or latex gloves
✓ 1 pack small - medium sized garbage bags or biohazard bags
✓ 1 gallon bleach
✓ spray can/ bottles

PLEASE NOTE

• To clean and disinfect use 1 part bleach to 9 parts water
• If you have transported an ill person, clean the vehicle and do not use for 12 hours
Waste Management COVID-19

Steps in managing waste material

1. Place infectious waste in red bags (if unavailable label bag with biohazard sign). On the outside of the bag pour bleach solution (one part bleach, four parts water). Place in another biohazard bag prior to collection.

2. Place sharps in sharp containers. Use containers until 2/3 full. Replace.

3. Soiled linen should be washed with bleach as fecal material contains the virus.

Out-Fit of Waste-Handler

The diagram above indicates the personal protective equipment needed for Auxiliary Staff to handle medical waste. An N95 mask is usually worn when discarding infectious waste. If N95 mask are unavailable a surgical mask can be worn.

Although not shown in diagram; googles should be worn.

At no time should bags be opened

Place in location for solid waste removal.
PAHO/WHO GUIDANCE ON MANAGEMENT OF DEAD BODIES

Dead body management in the context of the novel coronavirus (COVID-19)
(Interim recommendations, March 18, 2020)

Objective

• Management of dead bodies in the context of the COVID-19
  ➢ Packing and transfer of the body from the isolation room/ward/other setting to a mortuary, crematorium or burial
• Ensure that mortuary staff and the burial team apply standard precautions at all times (i.e. perform hand hygiene, environmental cleaning) including appropriate use of PPE; long sleeved gown, gloves and facial protection if there is a risk of splashes from the patient's body fluids or secretions onto the body or face of the staff member.

* Updated information on the 2019-nCoV can be obtained at:

Aerosol-generating procedures (AGP): it includes the following procedures: positive pressure ventilation (BiPAP and CPAP), endotracheal intubation, airway suction, high frequency oscillatory ventilation, tracheostomy, chest physiotherapy, nebulizer treatment, sputum induction, bronchoscopy, and necropsies.

For the most update information available for infection prevention and control for the 2019-nCoV, please refer to https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance.

2

• Body bags are not necessary for packing the body. Wrap the body in cloth or any other tissue for transfer and remove it as soon as possible to the mortuary area.
• Keep both handling and movement of the body at minimum.
• PPE requirements for transport team (if change of team from the team doing packing of the body) include gloves and gown/apron.
• No special vehicle is required.
Mortuary care

• When preparation of the deceased (e.g. cleaning of body, tidying of hair, trimming of nails and shaving) wear appropriate PPE (gloves, gown, mask, eye protection – Table 1). Mortuary staff and funeral directors must be advised of the biohazard risk.

• Apply principles of cultural sensitivity. If the family of the patient wishes to view the body after its removal from the isolation room or related area, they may be allowed to do so with following standard precautions at all times, hand hygiene. Give the family clear instructions not to touch or kiss the body.

• Embalming is not recommended.

• Cleaning should be conducted in accordance with manufacturer’s instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).

Burial

• Decedents with COVID-19 can be buried or cremated.

• Check local requirements that may dictate the handling and disposition of the remains of individuals who have died of COVID-19.

Autopsy including engineering and environmental controls

• Safety procedures for deceased individuals infected with an acute respiratory illness (ARI), including COVID-19, should be consistent with those used for any autopsy procedure. In general, the known hazards of work in the autopsy room seem to arise from contact with infectious materials and, particularly, with splashes onto body surfaces of health-care workers rather than from inhalation of infectious material. However, if a patient with COVID19 died during the infectious period, the lungs and other organs may still contain live virus, and additional respiratory protection (N-95 or equivalent respirators) is needed during procedures that generate small-particle aerosols (e.g. use of power saws and washing of intestines). Therefore, postmortem examinations of patients with COVID-19 deserve special caution. (5)

• Ensure that safety measures are in place when performing postmortem examinations and collection of samples for microbiologic analyses. Engage a minimum number of staff in the procedure, and perform only if: o an adequately ventilated room suitable for the procedure is available. o appropriate PPE is available; scrub suit, surgical mask or if AGP particulate
respirator or N95 mask, long sleeved fluid-resistant gown, gloves (either two pairs or one pair autopsy gloves) and face shield (preferably) or goggles, boots.

- Placement of PPE: put on PPE in antechamber room (before entering autopsy room) and remove in designated dress out room.
- Perform autopsies in an adequately ventilated room, i.e. at least natural ventilation with at least 160L/s/person air flow or negative pressure rooms with at least 12 air changes per hour (ACH) and controlled direction of air flow when using mechanical ventilation. (6)

3

- Minimize AGP in the autopsy room (e.g. during lung excision) avoiding the use of power saws whenever possible o avoiding splashes when removing, handling or washing organs, especially lung tissue and the intestines; and o using exhaust ventilation to contain aerosols and reduce the volume of aerosols released into the ambient air environment; exhaust systems around the autopsy table should direct air and aerosols away from health-care workers performing the procedure (e.g. exhaust downward).
- For reduction of AGP during autopsy, it should be considered: o use containment devices whenever possible (e.g. biosafety cabinets for the handling and examination of smaller specimens). o use vacuum shrouds for oscillating saws. o do not use high-pressure water sprays. o if opening intestines, do it under water.

Environmental Cleaning

- Human coronaviruses can remain infectious on inanimate surfaces for up to 9 days. Surface disinfection with 0.1% sodium hypochlorite or 62 – 71% ethanol significantly reduces coronavirus infectivity on surfaces within 1 min exposure time. It is expected a similar effect against the SARS-CoV-2. (7)
- Chlorine should be diluted to 0.1% (1000 ppm) daily and be keep it out of sunlight. Clean all surfaces by: o wearing appropriate PPE. o removing any spill/body fluids with absorbent (paper) towels then dispose of them immediately as infectious waste. o cleaning surfaces with water and detergent. o applying chlorine 0.1% or other disinfectant standardized by the health-care facility – if sodium hypochlorite solution is used wet the surface with the solution and allow at
least 10 minutes contact time or rinsing the area with clean water to remove the disinfectant residue (if required).

4

Personal protective equipment – Summary
Table 1 presents a summary of the use of personal protective equipment§ according to the procedure related to the mortuary management of COVID-19.
Table 1 – Use of personal protective equipment according to the procedure related to the mortuary management of COVID-19.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Hand hygiene</th>
<th>Gloves</th>
<th>Surgical Mask</th>
<th>Respirator (N-95 or similar)</th>
<th>Long sleeved impermeable gown</th>
<th>Facial protection(*)</th>
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</thead>
<tbody>
<tr>
<td>Managing the body inside the isolation room</td>
<td>√</td>
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<td>√</td>
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<tr>
<td>Removal of the body from the isolation room or similar area</td>
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<td>√</td>
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<td>√</td>
<td>√</td>
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<tr>
<td>Mortuary care</td>
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<td>√</td>
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<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Necropsies (*) – face shield preferred</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<td>√</td>
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</tbody>
</table>

Table 2 presents a summary of the required equipment for mortuary management of COVID-19.
Table 2 – Technical specifications for personal protective equipment for procedures related to the mortuary management of COVID-19.

Equipment Details

Hand hygiene

- Alcohol based hand rub
- running water
Appendix

- liquid plain soap for hand hygiene
- disposable towel for hand drying (paper or tissue)

Personal protective equipment

- Gloves
- waterproof plastic apron
- long sleeve gowns
- anti-fog goggles
- face shield
- N95 respirator or surgical mask
- Waste management and environmental cleaning
- Disposal bag for bio-hazardous waste
- Soap and water or detergent
- disinfectant for surfaces – hypochlorite solution 0.1% (1000 ppm)

§ For the technical specifications of PPE, please refer to Requirements and technical specifications of personal protective equipment (PPE) for the novel coronavirus (2019-ncov) in healthcare settings.
PORT HEALTH SCREENING TOOL

1. Name
   ___________________________________________________________________

2. Identification Number
   ________________________________________________

3. General Appearance
   ___________________________________________________________________

4. Date of Birth
   ____________________________________________

5. Age
   ___________________________________________________________________

6. Country of Birth
   ________________________________________________

7. Address in St. Vincent and the Grenadines
   ________________________________________________

8. Last known place of residence (full address)
   ________________________________________________

9. List of countries visited on this trip
   ________________________________________________

10. Have you been in contact with any person known to be ill with nCoV?
    ________________

11. Have you been in contact with any person with flu-like symptoms?
    ________________

12. Do you currently feel ill?
    ___________________________________________________________________

13. Do you currently have a cough?
    ___________________________________________________________________

14. Do you currently have shortness of breath?
    ___________________________________________________________________

15. Do you have a runny nose?
    ___________________________________________________________________

16. Temperature
    ________________________________________________

17. Conclusion
    ________________________________________________
I ____________________________ of ____________________________, as a result of the global pandemic, Covid-19, UNDERTAKE to quarantine myself at my own expense at a home/hotel/other appropriate premises as set out below:

Type of location (home, hotel, etc.) __________________________________________
Address ________________________________________________________________
Telephone number __________________________________________________________

I will quarantine myself for a period of 14 days from today’s date. I understand that this self-quarantine is MANDATORY. I further understand that any breach of this undertaking will result in appropriate action under the Laws of Saint Vincent and the Grenadines.

I have/have not, in the last 14 days, been in contact with any person known to have Covid-19. I do/do not have symptoms of Covid-19 (flu-like symptoms, fever, cough, diarrhoea etc.).

For Nationals of Saint Vincent and the Grenadines:

I hereby surrender my Saint Vincent and the Grenadines passport number ________________, which is the property of the Government of Saint Vincent and the Grenadines. This passport will be returned to me upon compliance with the 14-day quarantine and all health protocols during the 14-day period.

For Nationals of Other Countries:

As a condition of entry, I hereby surrender my passport number ___________________ issued by the Government of _________________________________. This passport will be returned to me upon compliance with the 14-day quarantine and all health protocols during the 14-day period.

I certify that my statements are true to the best of my knowledge, information and belief.

Dated March 28, 2020

__________________________
Print Name

__________________________
Signature
This form is to obtain important information from aircrafts entering St. Vincent and the Grenadines on any possible exposure or symptoms of reportable communicable diseases. This form must be presented with aircraft health declaration form for port of entry.

Date..............................

1. Name of Owner/Operator of Aircraft .................................................................
2. Marks of Nationality and Registration .................................................................
3. Origin of Flight (Routing) ....................................................................................
4. Flight arriving from (include all places en route) ..................................................
5. Flight Number ....................................................................................................
6. No. of Crew on Board .........................................................................................
7. No. of Passengers on Board ...............................................................................  
8. Next Port of Disembarkation ..............................................................................

Declaration of Health
Name and number of persons on board with signs and symptoms of coronavirus disease or other flu-like illness (a fever 38 °C or greater, a cough and shortness of breath), as well as such cases disembarked during a previous stop.
9. No. of passengers or crew with Chinese passports ........................................
10. No. of passengers or crew with signs and symptoms of coronavirus disease (fever, cough, shortness of breath) .................................................................
11. No. of passengers or crew with travel history to China in the past fourteen (14) days............................

<table>
<thead>
<tr>
<th>Name of Passenger</th>
<th>Seat Number</th>
<th>Signs/Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Use attachment overleaf for additional information)

Signature..........................................................  Date..............................
  Authorized Agent/Pilot-in-Command

Signature..........................................................  Date..............................
  Port Health Officer/Health Professional
<table>
<thead>
<tr>
<th>Name of Passenger</th>
<th>Seat Number</th>
<th>Signs/Symptoms</th>
</tr>
</thead>
</table>
This form is to obtain important information from captains of vessels entering St. Vincent and the Grenadines on any possible exposure or symptoms of reportable communicable diseases. The data received through this form will be treated confidentially.

Date DD/MM/YYYY

Please answer all questions

<table>
<thead>
<tr>
<th>Passenger Information</th>
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<tbody>
<tr>
<td>1. Number of Passengers on board</td>
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</table>

<table>
<thead>
<tr>
<th>Journey Information</th>
</tr>
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<tbody>
<tr>
<td>2. What countries have you visited in the last 14 days?</td>
</tr>
</tbody>
</table>

Please keep your ticket and boarding passes.

<table>
<thead>
<tr>
<th>Health Information</th>
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<tbody>
<tr>
<td>3. Have any of the passengers on board had a fever anytime during the last 14 days?</td>
</tr>
<tr>
<td>4. Do any passengers currently feel ill?</td>
</tr>
<tr>
<td>5. Currently do any passengers on board have any of the following?</td>
</tr>
<tr>
<td>• Cough</td>
</tr>
<tr>
<td>• Fever</td>
</tr>
<tr>
<td>• Shortness of Breath</td>
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<tr>
<td>6. Next Port of Call</td>
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</table>

<table>
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</tr>
<tr>
<td>• Shortness of Breath</td>
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<tr>
<td>12. Next Port of Call</td>
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</table>
NATIONAL EMERGENCY MANAGEMENT ORGANISATION (NEMO)  
MINISTRY OF NATIONAL SECURITY  
ST. VINCENT AND THE GRENADINES  
WEST INDIES  
Tel: 784-456-2975, Fax: 784-457-1691, Email: nemosvgeoc@gmail.com or nemosvg@gov.vc

COVID-19 TASKFORCE

PROTOCOL FOR THE QUARANTINE OF YACHT OCCUPANTS ON AN ISLAND RESORT IN  
ST. VINCENT AND THE GRENADINES

AIM: The safe quarantine of all persons who travel to St. Vincent and the Grenadines for a period of 14 days to reduce the risk of the importation and subsequent transmission of a highly infectious disease (COVID-19) in St. Vincent and the Grenadines.

OBJECTIVES:

1. Determine the nationality of each traveler.
2. Establish the status of exposure to COVID-19 of each traveler.
3. Establish the physical appropriateness of the site of quarantine.
4. Establish the capacity of the coordinating organization to provide the necessary resources for all of the travelers/persons to be quarantined.
5. Establish the process of monitoring of the persons quarantined by the Port Health Officers of the Ministry of Health, Wellness and the Environment.
6. Establish the process of monitoring of the vessel by the Royal St. Vincent and the Grenadines Police Force, Coast Guard Service.

INFORMATION REQUIRED FOR EACH PERSON TO BE QUARANTINED:
1. Full name, date of birth, passport number.
2. Travel history of person for the preceding 14 days.
3. Certificate of Health issued by the National Health Authority of the country of departure including:
   a. their exposure to any highly infectious disease (COVID-19) positive or suspected case,
   b. any objective screening for any highly infectious disease (COVID-19) (name, date and facility).

INFORMATION REQUIRED ON THE PROPOSED SITE OF QUARANTINE:

1. Name of the proposed site of 14-21 days of quarantine.
2. Contact number of the Manager/CEO of the proposed site.
3. Details of the capacity of the proposed site including:
   a. Number of self-contained rooms
   b. Housekeeping facilities
   c. Kitchen facilities
   d. Communications facilities
   e. Security facilities
   f. Transportation facilities.

INFORMATION REQUIRED ON THE SUPPORTING ORGANIZATION:

1. Name, address, contact information and description of the supporting organization.
2. Arrangements for the provision of supplies including food sufficient for 21 days.
3. Arrangements for the provision of housekeeping services.
4. Arrangements for the provision of waste disposal.

PROCESS FOR MONITORING BY THE PORT HEALTH OFFICERS OF THE PERSONS QUARANTINED:

1. A court order for quarantine for 14 days in the first instance will be issued to all arriving persons.
2. Any breach of the quarantine order will result in prosecution.
3. The Captain of the vessel will be required to maintain a log of the temperature and general health of each person.
4. The Captain of the vessel will be responsible for ensuring that there is no unauthorized contact between the travelers and persons not listed as travelers.

5. The Captain of the vessel will ensure that no travelers leave the island resort during the 14 day quarantine process.

6. The Port Health Officer assigned to monitor the travelers in quarantine will make contact with the Captain on a daily basis and will make random visits to inspect the logs and to determine the general health of the travelers.

7. The RSVGPF Coast Guard Service will ensure that the vessel has no unauthorized contact with any other vessel.

8. Successful completion of quarantine will be determined by the Port Health Officer after consultation with the Medical Officer of Health.

COVID-19 TASK FORCE

PROTOCOL FOR THE REPATRIATION OF VINCENTIAN CREWPERSONS

AIM: The safe repatriation of Vincentian nationals in a manner that reduces the risk of the importation and subsequent transmission of COVID-19 in St. Vincent and the Grenadines.

OBJECTIVES:

1. Establish the nationality of the returning individual.
2. Establish the status of exposure of the returning individual to COVID-19.
3. Establish the appropriateness of the site of quarantine.

CONDITIONS AND INFORMATION REQUIRED FOR THE REPATRIATION OF VINCENTIAN CREWPERSONS:

1. Total number of persons to be repatriated
2. Mode of arrival (boat, plane)
3. Full name, date of birth, passport number, contact number and address in departing country.
4. Certificate of Health issued by the National Health Authority of the country of departure including:
   c. details of person’s current health status,
   d. their exposure to any COVID-19 positive or suspected cases,
   e. any objective screening for COVID-19 (name, date and facility).
5. Address of the proposed site of 14-21 days of quarantine.
6. Contact number of person residing where the person proposes to stay in SVG or who can facilitate the inspection of the proposed quarantine site.
7. Commitment of repatriating company or individual to pay for the accommodation of those persons without an appropriate quarantine site.
8. The repatriating company to secure an alternate site approved by the Ministry of Health, Wellness and the Environment.

PROCESS ON ARRIVAL:

1. Disembarking Protocol (by sea):
   a. Vessel will berth at the Cruise Ship Terminal Kingstown
   b. Disembarkment will be in groups of 10 (or more if possible)
   c. Hand hygiene will be enforced
   d. Photo identification is required for ALL seamen.
   e. Area for screening will be sanitized after each group is screened
   f. Screening will include probing for symptoms and temperature check
   g. Persons going to government facility will be boarded on agreed transport to await departure

2. Disembarking Protocol (by air)
   a. All passengers will be screened before entering the arrivals area
   b. Screening will include probing for symptoms and temperature check
   c. Persons with adequate home facilities for quarantine will allowed to leave.
   d. Persons going to government facility will be boarded on agreed transport to await departure

COVID-19 TASKFORCE

PROTOCOL FOR THE REPATRIATION OF VINCENTIANS RESIDING IN FOREIGN COUNTRIES

AIM: The safe repatriation of Vincentian nationals in a manner that reduces the risk of the importation and subsequent transmission of COVID-19 in St. Vincent and the Grenadines.

OBJECTIVES:

4. Establish the nationality of the returning individual.
5. Establish the status of exposure to COVID-19 of the returning individual.
6. Establish the appropriateness of the site of quarantine.

INFORMATION REQUIRED FOR EACH PERSON TO BE REPATRIATED:

4. Full name, date of birth, passport number, contact number and address in departing country.
5. Certificate of Health issued by the National Health Authority of the country of departure including:
a. details of person’s current health status,
b. their exposure to any COVID-19 positive or suspected cases,
c. any objective screening for COVID-19 (name, date and facility).

6. Address of the proposed site of 14-21 days of quarantine.

7. Contact number of person residing where the person proposes to stay in SVG or who can facilitate the inspection of the proposed quarantine site.

8. Commitment of repatriating company or individual to pay for the accommodation (room and meals) of those persons without an appropriate quarantine site.

9. The repatriating company to secure an alternate site approved by the Ministry of Health, Wellness and the Environment.

10. The repatriating company to provide security if necessary at an approved alternate site.

PROCESS ON ARRIVAL:

3. Disembarking Protocol (by sea):
   a. Vessel will berth at the Cruise Ship Terminal Kingstown
   b. Disembarkment will be in groups of 10 (or more if possible)
   c. Hand hygiene will be enforced
   d. Photo identification is required for ALL seamen.
   e. Area for screening will be sanitized after each group is screened
   f. Screening will include probing for symptoms and temperature check
   g. Persons going to government facility will be boarded on agreed transport to await departure

4. Disembarking Protocol (by air)
   a. All passengers will be screened before entering the arrivals area
   b. Screening will include probing for symptoms and temperature check
   c. Persons with adequate home facilities for quarantine will be allowed to leave.
   d. Persons going to government facility will be boarded on agreed transport to await departure

CONDITIONS OF QUARANTINE IN ST. VINCENT AND THE GRENADINES:

1. A court order for quarantine for 14 days will be issued to all arriving persons.
2. Any breach of the quarantine order will result in prosecution.

# DIRECTORY

<table>
<thead>
<tr>
<th>Personnel/Department</th>
<th>Telephone #</th>
<th>Alternative #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Medical Officer</td>
<td>1-784-493-9796</td>
<td></td>
</tr>
<tr>
<td>Permanente Secretary of Health</td>
<td>1-784-485-6904</td>
<td>1-784-532-0670</td>
</tr>
<tr>
<td>Medical Officer of Health</td>
<td>1-784-494-1035</td>
<td>1-784-61991</td>
</tr>
<tr>
<td>Health Disaster Coordinator</td>
<td>1-784-453-2351</td>
<td>1-784-527-0365</td>
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<tr>
<td>Epidemiologist</td>
<td>1-784-593-6805</td>
<td>1-784-72</td>
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<tr>
<td>Focal Point for Communicable Disease</td>
<td>1-784-497-7425</td>
<td>1784-451-2489</td>
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<tr>
<td>Medical Director</td>
<td>1784-456-1185</td>
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<tr>
<td>Chief Health Promotion Officer</td>
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<tr>
<td>Chief Environmental Officer</td>
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<td>Accident and Emergency</td>
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<td>Public Health</td>
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<tr>
<td>Chief Nursing Officer</td>
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<tr>
<td>Senior Medical Officer</td>
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<tr>
<td>Senior Nursing Officer CNS</td>
<td>1-784-485-6133</td>
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<tr>
<td>Senior Nursing Officer MCMH</td>
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<tr>
<td>Hospital Administrator</td>
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<td>Chief Immigration officer</td>
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