Annex 3

LIBERIA OPERATIONAL PLAN FOR ACCELERATED RESPONSE TO RE-OCCURRENCE OF EBOLA EPIDEMIC

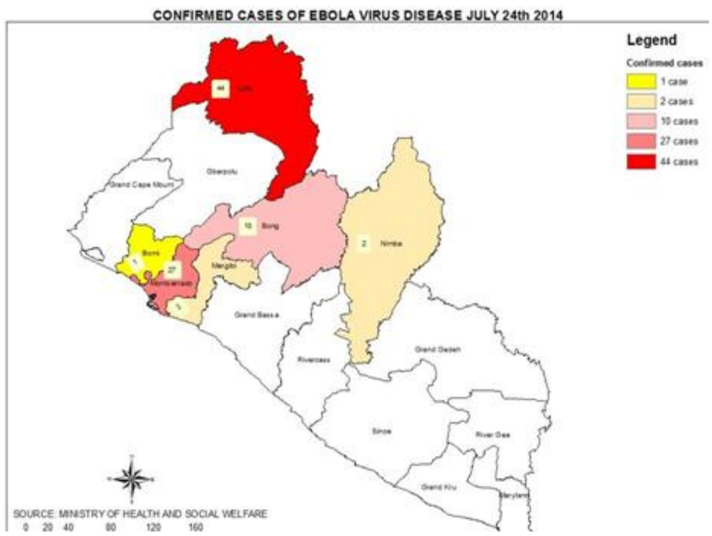
GOVERNMENT OF LIBERIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

July – December 2014

1. Introduction

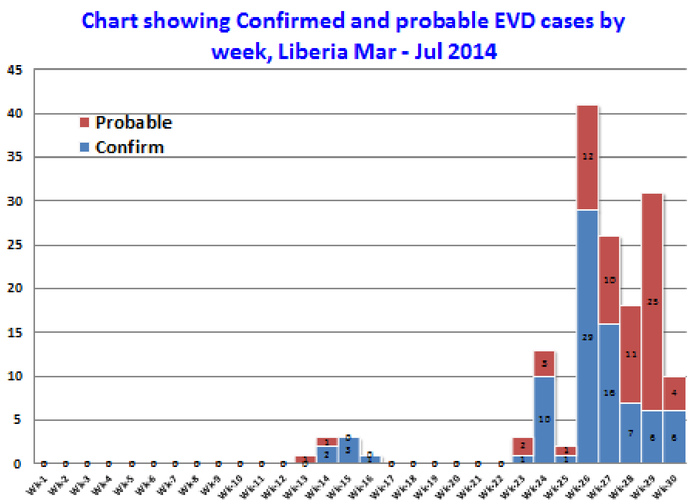
Following the confirmation of Ebola Virus Disease (EVD) outbreak in Guinea, the Ministry of Health and Social Welfare (MOHSW) has recorded two episodes of EVD epidemics in less than six months.

The first epidemic began on 22 March and ended in April, 2014 and mainly affected two counties. The last case was confirmed on 10 April, 2014. Cumulatively, six cases were confirmed positive of the virus and all died at the time, (Case Fatality Rate [CFR] of 100%).



On 25 May 2014, the Ministry received an investigation report of what became the index case of the second wave of EVD epidemic (probable case with no sample collected) from Lofa County. The alleged case was a female, Liberian and married to a Sierra Leonean. She was admitted on 23 May, discharged against medical advice on 25 May and died six hours later. The corpse was prepared and taken to Sierra Leone by six family members. Both episodes of the epidemic were cross border importation with the first wave of the epidemic imported from Guinea.

Since then Ebola virus disease has continued to spread in the country with nearly 50% (seven counties) of the 15 counties affected. The affected counties often referred to as response counties include Bomi, Bong, Grand Gedeh, Margibi, Montserrado, Lofa and Nimba, while at risk counties referred as alert counties are now six and they include: Grand cape Mount, Gbarpolu, Grand Bassa, Rivercess, Sinoe and River Gee. As of 24 July 2014, the cumulative number of cases recorded from both waves of the epidemic is 296 with 147 deaths (CRF = 62%). Already 39 cases have been recorded among health workers with 17 deaths (CFR = 43.6%).



The Ministry of health in collaboration with partners successfully responded to the first wave of the epidemic and there are concerted efforts to interrupt the current wave of the epidemic.

From onset of the epidemic, a multi-disciplinary National Task Force (NTF) chaired by the Minister of Health and Social Welfare was re-activated in March 2014 to ensure effective coordination of the response efforts. The NTF meets on a daily basis to review the epidemic situation and provide guidance to the field teams. Similarly, the affected counties are being supported to establish a similar Task Force to enhance planning, implementation and monitoring of the epidemic response operations at the local level.

2. Current response and challenges

The Ministry with support of partners has continued to respond to the current wave of the epidemic. Response activities are being implemented in all affected counties.

On 23 July 2014 the Minster of Health and Social Welfare recommended review of the NTF to make it smaller and more functional for decision making. The technical working groups were also reviewed and consolidated into five sub-committees which include: Incident Management System (IMS) to manage all aspects of the response and coordinating with all technical sub-committees as well as County task force in all affected counties; Case management, Infection Control and Psycho-social support, Epidemiology and Laboratory, Social mobilization, Media and Communication, and Logistics and security.

On 26 July 2014, the President of the Republic, Madam Ellen Johnson Sirleaf declared the EVD epidemic as national health emergency and established National Task Force to be chaired by her and co-chaired by the Minister of Internal Affairs, and inclusive of major stakeholders.

With support of partners, the following actions were also undertaken:
1. National technical staff deployed to support county efforts in the affected and at risk counties;
2. Technical and in-kind support from partners to support the Ministry of Health based on comparative advantages and expertise;
3. More than twenty technical assistants from partners have arrived in the country to support the Ministry of health, though they are yet to reposition themselves to support the affected counties in a more coordinated manner;
4. Emergency medical supplies, including PPE kits mobilized and sent to response counties;
5. Health workers in Montserrado and Lofa trained on case management and infection prevention and control;
6. Treatment centers scaled up to accommodate increasing number of suspected, probable and confirmed cases;
7. Case investigation, line listing and contact tracing, and laboratory confirmation on-going; and
8. Daily situation update produced and disseminated via emails to partners among others

Despite this progress, there are operational gaps/challenges that affect scope and quality of the response both at the urban and rural areas. These include among others:

- Weak capacity for case detection due to increasing number of cases and late follow up;
- Inadequate investigation teams due to increasing number of cases and deaths in the communities in the urban areas as well as in the affected counties;
- Contacts are not systematically followed and often line listing not completed timely. Most of the contacts are either lost to follow up or not captured in the tracking system;
- Weak data management affecting data classification, analysis and interpretation making it difficult to have an informed epidemiological situation;
- Slow burial of dead bodies either confirmed or suspected of Ebola. This has the potential for further exposure of people at the community level;
- Limited participation of senior health workers and managers in public and private health facilities in training sessions organized on Ebola;
- Increasing pockets of resistance and denial in both rural and urban areas which call for reviewing of messages targeting resistance and denial;
- High exposure of health workers and nosocomial infection as a result of weak infection control measures, inadequate universal precaution practices and probably inadequate medical supplies and protective equipment;
- Outbreak coordination at the central level has been structured but the same arrangements are required at the county level;
- The health system is weak to cope with the spreading epidemic. Already health workers are abandoning patients that could result into more community deaths;
- Lack of experience among health workers and capacity of rapid response.

At the community level, there are persistent issues around:

- Denial, mistrust and rejection of proposed public health interventions arising from misinterpretation of the cause of the new disease
- High exposure to Ebola virus in the community through household care and customary burial procedures. This has resulted in a high level of community deaths leading to panic and anxiety.
- Fear of the disease by frontline health workers leading to either lack of care for patients or suboptimal implementation of protective measures.
- Close community ties and movement within and across borders has led to difficulties in tracing and following up of contacts for the three countries.
- Suspected cases and contacts running away from follow up making it difficult to carry out effective contact tracing as well as facilitating further spread of the disease to other communities and counties
- Some prayer houses and spiritual healing centers are being used by suspected patients, and further spreading the disease
- Myths and beliefs about the disease

With the unprecedented scale of the epidemic, the WHO Regional Office for Africa convened a two-day emergency ministerial meeting on EVD outbreak in Accra, Ghana. The meeting brought together ministers of health and key stakeholders to obtain consensus on the optimal way of interrupting the on-going EVD transmission in West Africa. Outcome of the meeting was a strategy reflecting the discussions, identified actions and best practices from previous Ebola virus outbreaks.

Goals of the strategy

The goals of the strategy are to:
1. Stop transmission of Ebola virus in the affected countries through scaling up effective, evidence-based outbreak control measures;
2. Prevent the spread EVD to the neighboring at-risk counties through strengthening epidemic preparedness and response measures.

Pillars of the strategy

The strategy addresses three major pillars:
1. Immediate outbreak response interventions
2. Enhance coordination and collaboration
3. Scaling-up of human and financial resources mobilization

Key interventions under the three pillars focus on urgent or immediate actions to be implemented by the three affected countries (Guinea, Liberia and Sierra Leone) to contain the epidemic.

Counties bordering the above affected counties are considered at risk and are urged to implement preparedness actions.
Based on agreed commitments from the governments represented in the Accra meeting, countries were required to develop and align their national operational plans along the agreed Accra framework.

It is against this background that the NTF commissioned review of the national operational plan, aligning it to the Accra strategy.

1. Initial process of reviewing the operational plan commenced in the Ministry of Health through the technical sub-committees with each sub-committee working separately along the following corresponding thematic areas: Coordination, finance and Logistics
2. Epidemiology and Laboratory
3. Case management, infection control and psychosocial support
4. Social Mobilization, media and communication

The technical sub-committees comprised of government agencies, UN agencies, bilateral partners, and non-governmental organizations.

The activities prioritized in the plan categorize the counties into two: affected or response counties and at-risk or alert counties; and they are developed based on the thematic areas. The plan was reviewed and costed by WHO.

As part of the consultative process, the plan will be shared again with all stakeholders to get their consensus and endorsement by the Ministry of Health and Social Welfare.

Majority of activities in the plan will be implemented at county and district levels with overall coordination, resource mobilization and monitoring at the central level.

The plan covers a period of six months commencing from July to December 2014.

The overall goal of the plan is to reduce morbidity and mortality due to Ebola virus disease and interrupt its transmission in the country.

Specifically, the objectives are to:

1. Ensure effective coordination of the outbreak response activities at all levels;
2. Strengthen early detection, investigation, reporting, active surveillance and diagnostic capacity;
3. Institute prompt and effective case management and psychosocial support;
4. Create public awareness about EVD, the risk factors for its transmission, its prevention and control among the people.

3. Budget

Estimated budget for response to the epidemic of Ebola virus haemorrhagic fever over six months (July to December 2014)

Thematic area	Amount (USD)	Pledged (USD)	Gap (USD)
Coordination, finance and logistics	6,941,190.00	897,600.00	6,043,590.00
Epidemiology and laboratory	2,268,860.00	1,775,299.00	493,561.00
Case management and infection prevention and control; Psychosocial support	10,296,260.00	1,966,466.00	8,329,794.00
Social mobilization/ Public Information	1,924,680.00	1,546,465.00	378,215.00
Total (USD)	**21,430,990.00**	**6,185,830.00**	**15,245,160.00**