Ebola virus disease preparedness strengthening team

Guinea-Bissau country visit

12–20 November 2014

World Health Organization

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Executive summary

Guinea-Bissau is small a country on the west coast of Africa with an area of 36 125 km² and a population of 1 664 000.[1]The country has borders to the north with Senegal and to the east and south with Guinea, with the Atlantic Ocean on the west.

Guinea-Bissau has had several outbreaks of infectious diseases, including cholera, measles and meningitis, and sporadic human and animal cases of anthrax have been reported during the past 10 years. Malaria, tuberculosis and cholera are the main health concerns. In 2010, cases of avian influenza were reported in the Biombo region.

The country has never experienced an outbreak of Ebola virus disease (EVD), but, owing to the proximity to Guinea and population mobility, the Ministry of Public Health, in collaboration with cooperation partners, launched a contingency plan in March 2014 for the prevention of and response to a possible outbreak of EVD in the country. The Ministry also created an emergency task force to prepare an emergency plan for a possible outbreak, which meets every week to assess the situation with partners and to discuss next steps.

All regional health authorities are on the alert to identify suspected cases of the disease and identify isolation sites if needed, and regional officers have surveyed the stocks of medications and available resources. All partners are mobilized and are ready to work on prevention and response in the case of an outbreak. In September 2014, because of the increase in the number of Ebola cases in neighbouring countries, the Prime Minister created a high-level coordination team composed of the rapporteurs of all subcommittees and all relevant actors. The Prime Minister has appointed a High Commissioner to coordinate the response and to act as the political liaison among all ministries and, importantly, to supervise donor funds.

Social mobilization campaigns have been conducted on radio, television and newspapers to raise the awareness of the population about the risks of EVD, with support from UNICEF.

All passengers arriving at the international airport terminal are screened, and several public places in Bissau are equipped for hand hygiene with chlorinated water or alcohol-based hand-rub, including hotels, restaurants, the WHO Country Office and public buildings.

As the main objective of the mission was to determine whether the country met the conditions outlined in the consolidated checklist for EVD preparedness, the team first met at the WHO Country Office in Bissau to discuss the objectives and expected results of the visit with the WHO Representative,Dr Kossi Akla Ayigan, and his team.

The main concern for Guinea-Bissau is lack of laboratory capacity to diagnose Ebola virus. The National Public Health Laboratory does not have the required biosafety or biosecurity level or the human or structural resources to diagnose EVD. The country has not yet established a formal agreement with the Institut Pasteur in Dakar for laboratory diagnosis of EVD and has not identified carriers that could transport samples by air; it is still exploring the possibility of transporting samples by road (over 800 km).

Médecins sans Frontières (MSF) has renovated an entire ward at the National Hospital as an Ebola treatment centre, if needed, and has trained six medical doctors and two nurse technicians for the rapid response team.

Thus, although Guinea-Bissau has a fragile health system, it has already implemented a number of Ebola preparedness activities during the past 10 months. Partners are active in supporting the Ministry of Health in its efforts.

[1] World Health Statistics (2014)

The main activities to be conducted are:

- Laboratory diagnosis: As the Institut Pasteur in Dakar is currently the best option for laboratory diagnosis of EVD, it is essential that the Ministry of Health, through the National Institute of Health, establish a formal agreement with the Institut Pasteur.
- Transport of samples: The authorities should urgently identify the fastest, safest route (by air or road) for transportation of samples for testing in Dakar.
- Train gravediggers in safe, dignified burials.
- Train and develop social communication in border areas, especially for the early detection of cases.
- Strengthen overall implementation of prevention measures in all public places and private health facilities. Ensure that the correct definition of suspected and confirmed EVD cases is understood by all health professionals and the general public.
- Define the roles and responsibilities of the Ministry of Health, United Nations agencies and partners.
- Monitor all actions already in place.

Introduction

Guinea-Bissau is small a country on the west coast of Africa with an area of 36 125 km² and a population of 1 664 000.[1] On the Human Development Index,[2] Guinea-Bissau is ranked 177th place out of 187 countries. The country has borders to the north with Senegal and to the east and south with Guinea, with the Atlantic Ocean to the west. Guinea-Bissau is a member of the African Union, the United Nations, the Economic Community of West African States, the West African Economic and Monetary Union, the Organization of Islamic Cooperation, the Community of Sahel–Saharan States and the Community of Portuguese-speaking Countries.

Guinea-Bissau is divided into eight regions: Bafatá, Biombo, Bolama-Bijagos, Cacheu, Gabu, Oio and Tombali Quínara. The regions are divided into 36 sectors plus an autonomous sector, the capital city of Bissau. The health sector is divided into 11 health regions, including Bissau; and the 11 health regions are divided into 114 health zones, the level closest to communities. However, over 40% of the population still lives 5 km from the nearest primary health care facility.

Guinea-Bissau has five main ethnic groups and more than 20 native languages, but Portuguese is the only official language. About 45% of the population live in urban areas, and 50–80% of the population claims to be Muslim. About 42% of the population is under 15 years of age, the life expectancy for men is 53 years and that for women 56 years, and 55% of the population is literate.[3] Access to the Internet is enjoyed by 2.8% of the population, and there are 63 cell phones per 100 people.

Guinea-Bissau has had several outbreaks of infectious diseases, including cholera, measles and meningitis. Sporadic human and animal cases of anthrax have been reported during the past 10 years. Malaria, tuberculosis and cholera are the main health concerns. According to information provided in the contingency plan, cases of influenza A (H1N1) were reported in the Biombo region in 2010. The country has never experienced an outbreak of EVD; however, because of its proximity to Guinea and population mobility, the Ministry of Public Health, in collaboration with national stakeholders and international partners, launched, contingency plan in March 2014 for the prevention of and response to a possible outbreak of EVD in the country. The Ministry of Public Health has also created an emergency task force with partners to prepare an emergency plan for a possible EVD outbreak. Five sub-committees were created (to discuss surveillance, logistics, coordination, clinical issues, social mobilization and communication). Each sub-committee meets every week to assess the situation with partners and to discuss the next steps.

All regional health authorities are on the alert to identify suspected cases of the disease and identify isolation sites if needed, and regional officers have surveyed the stocks of medications and available resources. Because of the increase in the number of EVD cases in neighbouring countries during September 2014, the Prime Minister created a high-level coordination team composed of the rapporteurs of all subcommittees and all relevant actors. The Prime Minister has also appointed a high commissioner to coordinate the response to EVD and to serve as the political liaison among all ministries and, importantly, to supervise donor funds.

All partners are mobilized and ready to work on the prevention of and response to a possible EVD outbreak.

[1] World Health Statistics (2014)
[2] United Nations Development Programme (2013)

Map No. 4063 Rev. 4 UNITED NATIONS
June 2012

Department of Field Support
Cartographic Section

WHO missions to assess countries' preparedness for an EVD outbreak

In October 2014, WHO prepared a "consolidated Ebola virus disease preparedness checklist" in response to the unprecedented scale of EVD in West Africa. WHO identified four groups of countries for effective implementation of preparedness:

1. Guinea-Bissau, Mali, Senegal and Cote d'Ivoire, which directly border currently affected countries
2. Benin, Burkina Faso, Cameroon, the Central African Republic, the Democratic Republic of the Congo, the Gambia, Ghana, Mauritania, Nigeria, Togo and South Sudan, for various reasons
3. All other countries in Africa
4. Countries in other regions.

WHO considered that, with adequate preparation, a case entering one of these countries could be contained before a large outbreak occurred.

WHO is coordinating the deployment of international "preparedness strengthening teams" to help unaffected countries build on their existing preparedness and planning. The team visits will support countries in ensuring their operational readiness for EVD to the greatest degree possible. The teams are part of a larger group of activities to prepare all countries for the potential introduction of EVD.

Team members

- Regina Ungerer (team leader), ePORTUGUESe Programme, WHO Headquarters, Switzerland
- Ana Paula Coutinho Rehse (team leader, Infection Prevention and Control), WHO Regional Office for Europe, Denmark
- Yacoub Ahmedou, WHO Regional Office for Africa, Congo
- Abdou Moha, WHO Regional Office for Africa, WHO Country Office, Mozambique
- Manuela Gonzalez, United Nations Office for the Coordination of Humanitarian Affairs, Senegal
- Paulo Campos (rapid response team), National Institute of Medical Emergencies, Portugal
- Rodolfo Soares (anthropologist, safe burials), Portugal
- Renata Rodrigues Santos (psychologist, social mobilization), Brazil
- Igor Damiani (molecular biologist, laboratory), Brazil
- Jessica Marcinkevage (epidemiologist), Centers for Disease Control and Prevention (CDC), United States of America
- Amelia Maria Kasper (epidemiologist), CDC, United States of America

Objectives

The main objective of this mission was to assess the level of preparedness of Guinea-Bissau in respect of the WHO consolidated checklist. The checklist helps countries to assess and test their level of readiness it is being used to identify concrete action to be taken and where countries will require support from partners. The checklist was prepared by a number of international and national institutions, including WHO, the United Nations Office for the Coordination of Humanitarian Affairs and CDC. It lists 10 key components and tasks for both countries and the international community that should be completed within 30, 60 and 90 days from the date of issue of the list, with minimal requirements for equipment, material and human resources.

Reference documents are listed, such as guidelines, training manuals and guidance notes, to help technical experts to implement the action required for each key component, described in the table below.

Component	What this component is	Why it should be in place and ready
Overall coordination	Clarification of the roles and responsibilities of national authorities and international partners in preparedness activities, with a shared set of objectives	Will minimize duplication of effort and ensure the maximum effect of limited resources
Rapid response team	A group of experienced experts who are on stand-by and can reach any part of the country within 24 hours. They will help to contain or stop an outbreak early on, investigate the first case(s), support epidemiological surveillance and contact-tracing, provide health care, engage with the community and carry out infection, prevention and control measures.	As countries do not know in which geographical area a first case will emerge, a fully operational rapid response team is critical in order to act immediately once a suspected case is reported. They will be an initial stabilizing resource in the earliest phase of an outbreak.
Public awareness and community engagement	Promoting understanding of EVD in at-risk communities and addressing stigma that might hamper EVD emergency health care and effective surveillance. The community plays a crucial role in the response.	In affected countries, health centres have been attacked by frightened people, and false rumours about the disease have been spread.
Infection prevention and control	Development of optimum infection prevention and control capacity; support to health facilities to ensure safe working conditions; and public awareness and community engagement	In the epidemic in West Africa, 5–6% of health care workers have been infected. Infection prevention and control and safe working conditions are critical for delivering emergency health care.
Case management (a) Ebola treatment centre	Development or conversion of existing facilities into fully operational EVD treatment centres for 15 patients, including physical infrastructure and the capacity of staff to manage EVD cases	The lack of functional treatment centres at the beginning of an outbreak can result in a small outbreak getting out of control. Therefore, there should be at least one fully operational facility before a first case occurs in order to contain an outbreak early on.
Case management (b) Safe burials	Ensuring safe burial with due regard to local customs and religion with safe handling to prevent transmission of Ebola virus to communities	Unsafe burial of EVD victims has caused infection of communities and is one of the main risk factors.

Component	What this component is	Why it should be in place and ready
Contact tracing	Identification and tracking of the chain of transmission within the first 72 h of a report of a confirmed, probable or suspected case	Rapid contact-tracing and immediate monitoring are essential to stop or limit transmission to other people.
Laboratory	Ensuring that samples are taken safely and transported to laboratories that can analyse them rapidly	Rapid confirmation of cases is crucial to contain an outbreak, trace contacts and provide emergency health care.
Capacity at points of entry	Preparing points of entry to deal with a case of EVD crossing the border, including preparation of facilities and increasing staff capacity	Effective, targeted screening at points of entry will help to prevent cross-border transport of infection.

Overview

A week-long mission was conducted to assess the level of preparedness of Guinea-Bissau for a case of EVD in the country. The team met first in the WHO Country Office in Bissau to discuss the objectives and expected results of the mission with Dr Kossi Akla Ayigan (WHO Representative) and his team. They were keen to host the mission, as they have the responsibility to lead a response to EVD, in addition to their core functions at country level.

According to the WHO Representative, the country needs support to meet the expectations for Ebola preparedness, and the mission should be an opportunity for strengthening their preparedness, not only for Ebola but to build capacity and strengthen the health system to deal with this and other possible outbreaks.

Nevertheless, a contingency plan was developed in March 2014 and is being adapted accordingly.

The Minister of Health has created a task force that meets two or three times a week to assess the situation and to discuss future steps.

The Prime Minister has appointed a high commissioner to coordinate the response to EVD and to serve as the political liaison between all ministries and, importantly, to supervise donor funds.

A number of awareness campaigns for EVD prevention and control are being broadcast on the radio and television and in newspapers, supported by UNICEF.

The airport is performing temperature screening on all passengers.

WHO Representative Aygan Kossi Akla and Minister of Health, Dr Valentina Mendes

President of the National Institute of Health, Dr Plácido Cardoso

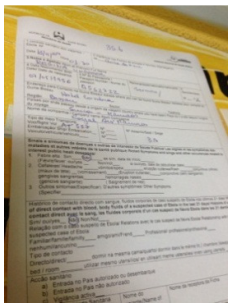
Screening at the airport

At the airport, before entering the terminal, all passengers must clean their hands with chlorinated water, undertake an electronic temperature check and fill in a form, which is then sent to the surveillance team at the National Institute of Public Health.

There are points for hand hygiene with chlorinated water or alcohol-based hand-rub in several public places (hotels, restaurants, the WHO Country Office, public buildings).

Hand-washing with chlorinated water

Temperature checking



Surveillance form

Meeting with partners

The team met several times with partners and organizations working in the country to clarify their roles and responsibilities and the support they give to the Ministry of Health for EVD preparedness.

During the meeting with the United Nations Resident Coordinator, Dr Maria do Valle Ribeiro, and representatives of other United Nations agencies working in Guinea-Bissau (UNICEF, the High Commission for Refugees, the Population Fund, the Office for Coordination of Humanitarian Affairs, the Integrated Peace-building Office in Guinea-Bissau), CDC and the European Union, the United Nations Resident Coordinator reported that an inter-ministerial meeting is held every week with the Prime Minister, United Nations agencies, partners and foreign missions to discuss the latest developments and designate roles.

UNICEF Representative, United Nations Resident Coodinator and WHO Representative

Discussion of the consolidated checklist

Coordinated by WHO, the checklist was discussed extensively with the Ministry of Health, the National Institute of Health, partners and members of the mission. Participants were separated into four groups according to their expertise. The results of the discussions were presented to the Ministry of Health and United Nations organizations and will be issued as a document to support implementation by the Ministry of Health and partners in 30, 60, 90 days and beyond. The list is given in Annex 1.

Coordination group

Rapid response team, epidemiological surveillance and laboratory group

Cases management, points of entry and infection control group

Public awareness and community engagement and safe and dignified burials group

Table-top exercise

The EVD table-top exercise is a simulation package with a progressive scenario to enable participants to consider the potential impact of an outbreak in terms of existing plans, procedures and capacities. The aim of the exercise is to strengthen national readiness for the virus through facilitated group discussions. The aim is to identify gaps and therefore strengthen preparedness. It is not a test of a country's preparedness.

The objectives of the simulation were to:

- share information on progress in the preparation and response measures against EVD;
- identify areas of interdependence between health professionals and their interaction with other sectors;
- identify lines of accountability, roles and responsibilities;
- review operational management of a suspected case of EVD;
- ensure that arrangements for notification, coordination and internal communications are in place before and after confirmation of a case;
- validate aspects of personal protection and other logistics (e.g. disinfection, burial) and the management of suspected cases of contamination before and after laboratory confirmation;
- review the requirements of public health laboratories, coordination and funding; and
- review public and media communications, and strengthen team-building for managing an emergency response.

This exercise should improve national preparedness measures as a whole, not only for EVD.

Main mission findings

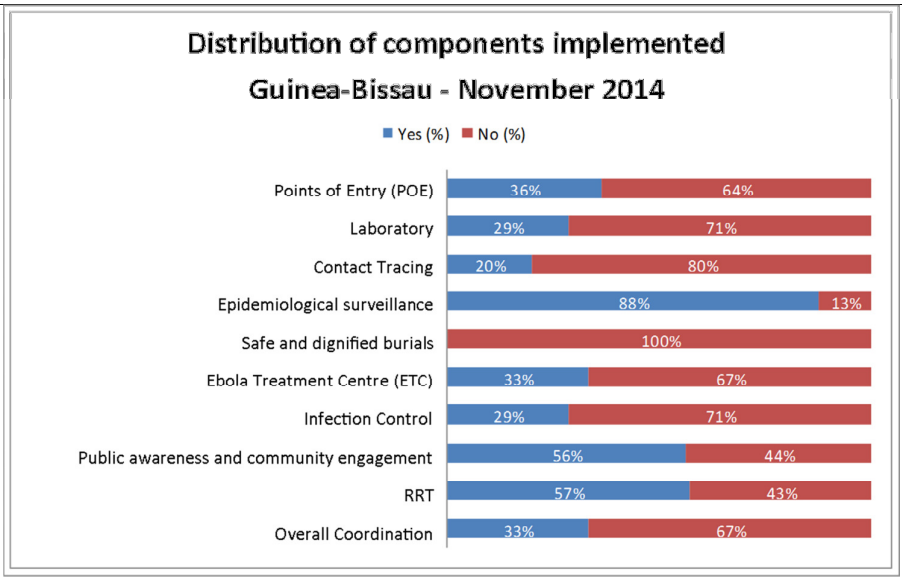
Component	Main mission findings
Overall coordination	Since March, the country has had a contingency plan for EVD. The Ministry of Health has created a technical task force to coordinate preparedness for EVD, by adapting the former emergency and epidemiological committee into the Technical Task Force Group. The Prime Minister has appointed a high commissioner for EVD as politically coordinator among all ministries and to supervise donor funds. The National Institute of Health is the focal point for the International Health Regulations (2005). The National Institute of Health can serve as an emergency operational centre, working 24 hours per day, 7 days a week. It needs only to organize the staff.
Rapid response team	MSF has trained six medical doctors and two nurse technicians for the rapid response team.
Public awareness and community engagement	A number of awareness campaigns on EVD prevention and control are being broadcast on the radio and television and in newspapers. Religious and community leaders will be involved in awareness-raising. UNICEF has been responsible for social mobilization. It has sponsored local artists and shows to raise awareness about the disease.
Infection prevention and control	Numerous hand hygiene points are available in most public places.
Case management (a) Ebola treatment centre	MSF has renovated a ward at the National Hospital for used as an Ebola treatment centre. Key structural aspects such as electricity and hospital beds were not available on the day of the visit. MSF is confident, however, that the centre could be activated if needed. A new incinerator and an autoclave are available but have not yet been installed. A small drum-incinerator has been donated and installed by MSF for the high-risk area in the Ebola treatment centre. The eight health professionals trained by MSF will be responsible for the treatment centre. Sufficient quantities of personal protective equipment are available at the Hospital, the WHO Country Office, the MSF office and the Ministry of Health. During the influenza pandemic in 2009, 5000 kits were donated by WHO, which were distributed to the 11 health districts and leading stakeholders, including the National Hospital and the National Institute of Health. UNICEF has helped to distribute the kits to high-risk areas (Gabu, Tombali and Quinara).
Case management (b) Safe burials	None of the activities for ensuring safe, dignified burials has been initiated. Most burials are conducted by family members. There are 194 body bags available for safe burials, 144 donated by the Government of China and 50 by MSF.
Epidemiological surveillance	Two hotlines for information and notification are available 24 h/ 24 h (Orange and MTN providers). The National Institute of Health also has a line for notification, but it operates only during working hours (Monday–Friday, 08:00–17:00). Hotline operators must be trained.

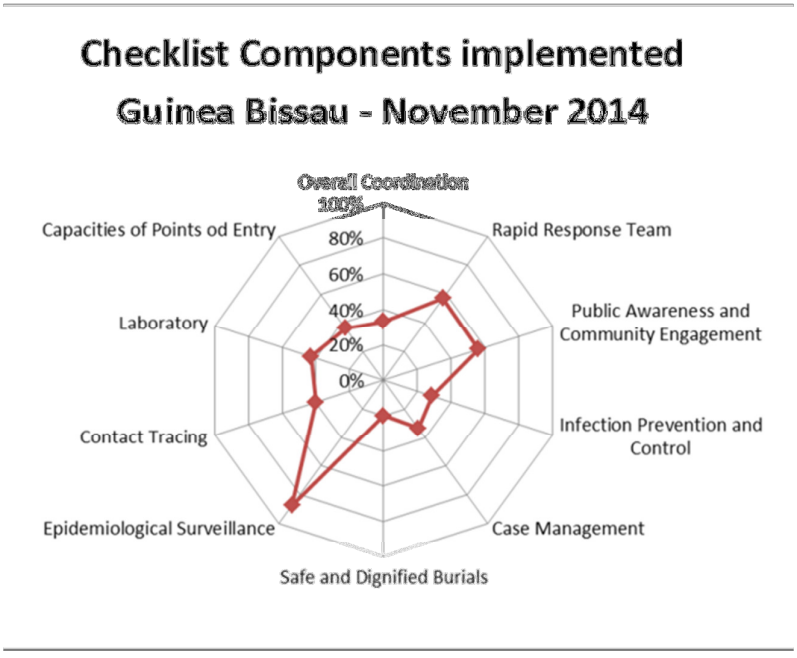
Component	Main mission findings
Contact tracing	According to the WHO Country Office in Bissau, by 19 November 2014, four rumours had been reported. The possible cases were assessed by MSF, INASA and the Autonomous Sector of Bissau as they fulfilled the criteria for further investigation (travellers from Guinea and from within the country with a variety of symptoms). The cases were isolated and put under observation in the absence of epidemiological criteria, as they had entered Guinea-Bissau from neighbouring Guinea, even though the borders were closed. Clinical specimens were not collected for further EVD testing, as the cases did not fulfill the criteria for suspected cases. All were discharged on the basis of clinical judgement: one patient had laboratory confirmation of malaria, one of gastric ulcer with vomiting and blood and one with fever followed by a miscarriage.
Laboratory	As of 19 November, Guinea-Bissau did not have local capacity to diagnose EVD. The National Public Health Laboratory has not yet formalized an agreement with the Institut Pasteur in Dakar for EVD diagnosis, although agreements for laboratory confirmation of cholera and poliovirus are in place. The situation is known to concerned health authorities and partners. On 3 December 2014, the Director of the National Institute of Health contacted the Institut Pasteur in Dakar to discuss the possibility of sending samples from suspected cases. The National Public Health Laboratory is not equipped to diagnose EVD. Technicians must be trained and the infrastructure of the laboratory improved, including purchasing reagents. Portugal has offered to support the training of one laboratory technician in shipping biological samples from 24 November (for details of the course, see Annex 2). Shipment of EVD samples by air cannot be guaranteed by local air carriers. During the mission, national authorities were exploring options for transporting samples by road, a 12–15-h drive. Agreements and clearance with border authorities in both Senegal and Guinea-Bissau remain to be discussed. After the mission, CDC located a chartered flight company that would agree to transport EVD samples from Bissau to Dakar, if necessary. This would costs about US$ 3000. The Ministry of Health and the National Institute of Health will explore this option. The WHO Country Office has supported renovation of two vehicles for transporting samples and is also securing financial resources for fuel and per diem for drivers, if necessary. Four off-road vehicles are available for transporting patients with EVD, one at the Ministry of Health, one at the National Institute of Health (commandeered by WHO), one at the border with Guinea and one with MSF.
Capacity at points of entry	48 ground borders with Guinea were closed in early August 2014, following the advice of the Prime Minister of Guinea-Bissau. Local communities living near the border are since reported to be suffering from financial and social disruption. At the airport, before entering the terminal, all passengers must wash their hands with chlorinated water solution, have their body temperature measured with an infrared scan and fill in a surveillance form. The results of the body temperature testing and the surveillance form are evaluated on site and then sent to the surveillance team at the National Institute of Public Health. The Minister of Health has decided to open one humanitarian and one commercial corridor; however, no dates have been set. According to the WHO Country Office, on 9 December 2014, the Government authorized the opening of three border areas with Guinea: two in the Gabu region and one in the Quínara region, where all visitors are screened.

Identified priorities

Component	Identified priorities
Overall coordination	▪ Define the responsibilities of the Government, partners, United Nations agencies, nongovernmental organizations and civil society as soon as possible. ▪ Establish clear protocols for receiving international aid, and make sure that strategies are in place and coordinated by the Government, United Nations agencies, donors, nongovernmental organizations, etc. ▪ The relations between the Government and partners should be strengthened, so that all know their roles and responsibilities. ▪ The leadership of the task force committee and its actions and recommendations must be recognized and adopted.
Rapid response team	▪ Full implementation of the key tasks on the preparedness checklist
Public awareness and community engagement	▪ Ensure that all messages to the community are clear and validated by the Ministry of Health to avoid misconceptions and misunderstanding. ▪ Strengthen and develop social communication, especially in border areas. ▪ Strengthen communication strategies between civil society, religious leaders, traditional healers and the Government.
Infection prevention and control	▪ Full implementation of the key tasks on the preparedness checklist
Case management (a) Ebola treatment centre	▪ Monitor safety messages for technicians.
Case management (b) Safe and dignified burials	▪ Provide training to people responsible for burials. So far, no training has been given. ▪ Operational procedures for safe, dignified burials should be translated into Portuguese. They are being revised in the ePORTUGUESe Programme. ▪ Map and identify all resources and who is doing what.
Epidemiological surveillance	▪ Definitions of suspected and confirmed EVD cases must be available in all regions, at points of care, in health units and in border areas. ▪ Full implementation of the key tasks on the preparedness checklist
Contact tracing	▪ Full implementation of the key tasks on the preparedness checklist ▪ Health technicians in the regions must be trained in contact tracing, if necessary.
Laboratory	▪ According to the *WHO guideline Laboratory guidance for the diagnosis of Ebola virus disease*, the first 25 positive and the first 50 negative specimens detected in a country without a recognized national reference of viral haemorrhagic fever laboratory should be sent to a WHO collaborating centre for secondary confirmation. Similarly, in countries with a national viral haemorrhagic fever reference laboratory, the initial positive cases should also be sent to a WHO collaborating centre for confirmation. If the results are concordant, the laboratory results reported by the national reference laboratory would be accepted by WHO. ▪ More health professionals (not only laboratory technicians) should be trained to prepare, fill in and sign forms for samples to be sent to Dakar, if necessary, according to IATA rules for infectious samples class A (UN2814). To date, only two professionals are qualified to do so. ▪ The Minister of Health, the Minister of Transportation and the Minister of Immigration should contact their counterparts in Senegal to guarantee safe passage of samples. ▪ A simulation exercise should be run to identify gaps in transport of samples from various parts of the country to make sure that all the necessary safety measures are in place and being followed. This must be well coordinated and the population well informed to avoid panic. ▪ Monitor all actions already in place.
Capacity at points of entry	▪ Full implementation of the key tasks on the preparedness checklist

Checklist components in graphics





Photographs

WHO materials brought to the country to be distributed to health centres and units

WHO Representative Kossi Akla Ayigan

Meeting with partners at the WHO Country Office

Meeting with the United Nations Resident Coordinator

Meeting with the Minister of Health

Meeting with the Minister of Health

Training exercise in using personal protective equipment

Border region of Gabu (east of the country)

National Public Health Laboratory

Meeting at the National Institute of Health

Ebola treatment centre renovated by MSF

Incinerator to be installed

WHO Country Office

Debriefing with the WHO Representative and officials from the Ministry of Health

Annex 1. Consolidated checklist for Ebola virus disease preparedness

1. Overall coordination

Task	Implementation status	Responsible	Comments	Quick off date
1.1.1. Implementation of a multisectoral and functional High-level Emergency & epidemic committees / Ebola Task Force (ETF) at the national and subnational / district levels.	In progress	Ministry of Health	Task partially implemented. Goal: 30 days for implementation. ETF at National level is operational. At regional level is necessary to reactivate outbreak committees.	01/12/2014
1.1.2. Pre-existent Emergency Committee transformed into ETF	In progress	Ministry of Health	Task not implemented. Goal: 30 days for implementation. Minister of Health is responsible for convening the meeting with Region Governors. At regional level is necessary to reactivate outbreak committees.	01/12/2014
1.1.3. Membership to the Committee / ETF at national and in “at risk” districts level reviewed and updated	In progress	Minister of Health and Region Governors	Task partially implemented. Goal: 30 days for implementation. There is a ToR in place for the national and regional multisectoral committees. Sharing of documents with all partners.	01/12/2014
1.1.4. Membership to the sub-Committee / ETF with focal points and a clear mandate	In progress	Minister of Health	Task partially implemented. Goal: 30 days for implementation. There is a ToR in place for the national and regional multisectoral committees. Sharing of documents with all partners.	01/12/2014

1.1.5. Existence of clear TOR of Committee / ETF	Complete	Minister of Health	Task fully implemented. Goal: regular revision of ToR as needed	continuous
1.1.6. Mechanisms are in place for coordinating donor support at the country level	In progress	High-Commissioner for Ebola Coordination	Task partially implemented. Goal: 30 days for implementation. Need clear ToR for the work of the High-Commissioner (currently under discussion).	01/12/2014
1.1.7. Review of current policy and legislative frameworks to ensure that ETF and committtees are empowered	In progress	Prime Minister	Task partially implemented. Goal: 30 days for implementation. There is a Health Emergency Declaration in place.	01/12/2014
1.1.8. Contingency or emergency plans exist and are fully budgeted for fund identification	In progress	World Bank African Development Bank	Task partially implemented. Goal: 30 days for implementation. Contingency plan is budgeted but not totally covered. Total Budget: US$ 1,785.942. According to WHO, only some of the activities in the contingency plan is budgeted. For example: The ETC was not included in the plan, as this activity is being fully covered by MSF. WB has made US$ 250,000 available to the Ministry of Health and US$ 500.000 to WHO.African Development Bank has offered US$ 124.000 to the MINSAP to be used for the Contingency Plan. Budget gap: US$ 1,000.000.	01/12/2014
1.2.1. Establish EOC/IMS personnel at the subnational / district level for localized EOC/IMS coordination and management	In progress	Ministry of Health and Emergency Management Team	Task partially implemented. Goal: 30 days for implementation. Some Professionals have received training. ToR should be adapted for team capacity building. (Technical Committee).	01/12/2014

1.2.2. Identify, train and designate Incident Manager and Operations Manager who is empowered to take operational decisions	In progress	Ministry of Health and Dr Cristovão Manjuba	Task partially implemented. Goal: 30 days for implementation. Dr Cristovão Manjuba (Director of Communicable Diseases Programme) to be appointed as the Ebola Incident Manager.	01/12/2014
1.2.3. Clearly assign communication responsibilities to specific EOC/IMS roles	In progress	Director General Dr Nicolau Almeida	Task partially implemented. Goal: 30 days for implementation. Communications with the media (radio, TV and newspaper) are made by the Director General. Communications with the High Commissioner will be made by the Director General. All messages and information on EBOLA should be agreed, reviewed and validated by the Technical Committee before disseminated.	01/12/2014
1.2.4. Develop plans for communication channels within EOC/IMS and between EOC/IMS, partners and the public	In progress	Ministry of Health INASA	Task partially implemented. Goal: 30 days for implementation. Campaigns on radio, TV, newspapers and Public awareness and community engagement already in place.	01/12/2014
1.2.5. Established procedures for command & control, coordination mechanisms, clearance of key technical and information products	In progress	Ministry of Health INASA	Task partially implemented. Goal: 30 days for implementation. There is no assessment and evaluation of the information collected. There is need to follow up on all measures.	01/12/2014
1.2.6. Test coordination and operations through table top exercises and drills	Awaiting	Ministry of Health with the support from partners	Task not implemented. Goal: 30 days for implementation.	01/12/2014
1.2.7. Identify a physical location for the EOC	Awaiting	INASA	Task not implemented. Goal: 30 days for implementation. National Institute of Health is the natural choice.	01/12/2014

2. Rapid response team

Task	Implementation status	Responsible	Comments	Quick off date
2.1. Identify and assign team leader(s) and multidisciplinary members under the framework of the EOC/IMS	In progress	MINSAP and MSF	Task partially implemented. Goal: 30 days for implementation. There are 6 out of 11 teams needed	01/12/2014
2.2. Ensure that there is a rapid communication system in place to alert the RRT	In progress	MINSAP	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
2.3. Train all clinical staff on the RRT in case management using international standards and the use of a mock ETC	In progress	MSF	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
2.4. Train the RRTs on sampling procedures for suspect EVD cases and on the transport of category A pathogens	In progress	MSF	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
2.5. Train the subnational RRT in surveillance and contact tracing	Awaiting	CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
2.6. Map potential health facilities at the district level that are ready to receive suspect EVD cases	Awaiting	MINSAP	Task not implemented. Goal: 30 days for implementation.	01/12/2014
2.7. In the absence of an EVD case in the country after 60 days, conduct at least one simulation exercise to maintain the capacity of the RRTs to respond quickly	Awaiting	MINSAP	Task not implemented. Goal: 30 days for implementation.	01/12/2014

3. Public awareness and community engagement

Task	Implementation status	Responsible	Comments	Quick off date
3.1. Develop or adapt, review, translate into local languages and disseminate targeted messages for media, health care workers, local and traditional leaders, churches, schools, traditional healers and other community stakeholders	In progress	INASA (Estevão da Silva e Jean Pierre Mendes Umpeça) UNICEF	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.2. Identify and engage influential/key actors/mobilisers, such as religious leaders, politicians, traditional healers, and media in urban and rural areas.	In progress	INASA (Estevão da Silva)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.3. Map out public communication capacities and expertise within health and other sectors	In progress	INASA (Jean Pierre Mendes Umpeça)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.4. Identify and establish mechanisms for engagement with national networks for social mobilization	In progress	Director of the Multimedia Communication Centre do (Malamane e Mohammed Djicó)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.5. Identify established functional communication coordination mechanism involving all government sectors and other stakeholders (including civil society organisations and communities).	In progress	INASA (Estevão da Silva)	Task partially implemented. Goal: 30 days for implementation. Difficulty to meet partners for sub-committee meetings	01/12/2014
3.6. Establish coordination mechanism for engaging with the community (involving the traditional leaders, relevant sectors in a bottom-up approach)	Awaiting	INASA President Dr Plácido Cardoso	Task not implemented. Goal: 30 days for implementation. Plans exists but lack resources and transportation to reach remote areas	01/12/2014
3.7. Establish coordination mechanism for engaging with partners (e.g. NGOs).	In progress	INASA (Estevão da Silva)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014

3.8. Draw up a roster with clear roles and responsibilities for internal and external communications and spokespersons.	Awaiting	INASA (Estevão da Silva e Jean Pierre Mendes Umpeça)	Task not implemented. Goal: 30 days for implementation. These two professionals were designated to the task but their responsibilities are not clear	01/12/2014
3.9. Establish functional and timely procedures for review, validation and clearance of information products	In progress	INASA (Estevão da Silva)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.10. Identify and train spokespersons and communication team and provide with talking points as needed	Awaiting	INASA (Estevão da Silva)	Task not implemented. Goal: 30 days for implementation. Teams were identified. At the beginning of November 2014, there was a capacity building training for the high risk regions (those neighbouring Guinea). Still 6 health regions to be trained. National: Coordination Committee of Social Mobilization (Estevão da Silva e Jean Pierre Mendes Umpeça) The Associated Regional Directors are the focal points for social mobilization. At local level, the health areas are the responsible for social mobilization.	01/12/2014
3.11. Develop a comprehensive strategy, plan and budget for engaging with the media and public (including a scaled-up approach)	In progress	INASA UNICEF WHO	Task partially implemented. Goal: 30 days for implementation. Strategy already approved, however financial resources still need to be allocated. UNICEF is leading radio Ebola campaigns and messages. WHO collaborates with the local radios. Some radios have agreed to give 30 days minutes of air for campaign. However, more broadcast time is required.	01/12/2014
3.12. Establish a system for rumour monitoring, investigation and response	Awaiting	INASA (Estevão da Silva e Jean Pierre Mendes Umpeça)	Task not implemented. Goal: 30 days for implementation. Need to improve structure to increase coverage.	01/12/2014

3.13. Establish a plan for reviewing, revising and monitoring impact of communication strategy	Awaiting	INASA UNICEF	Task not implemented. Goal: 60 days for implementation. There is a plan. NGO Palmerinha has an agreement with UNCIEF to assess, follow up and monitor the impact of communication.	01/01/2015
3.14. Identify critical communication networks and plan for the use of materials in appropriate languages (TV, radio, social media, SMS, story tellers, theatre, and other appropriate communication means)	In progress	INASA (Estevão da Silva)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
3.15. Establish media monitoring mechanisms with appropriate tools	Awaiting	INASA UNICEF	Task not implemented. Goal: 60 days for implementation.	01/01/2015
3.16. Map psychological and social assistance capacity and train teams to assist those affected by Ebola.	Awaiting	Ministry of Health (Nedilé & Red Cross) Francisco Mendes e Ione	Task not implemented. Goal: 30 days for implementation. The Red Cross has a contingency plan that includes the psychosocial aspects of the teams who are in the process of training. MINSAP will be responsible for identifying teams within the public health sector. MINSAP and Red Cross will disseminate a list to the communication sub-commission (Estevão da Silva).	01/12/2014

4. Infection prevention and control

Task	Implementation status	Responsible	Comments	Quick off date
4.1. Provide health facilities with basic hygiene, sanitation, disinfection, protective equipment and posters. Priority should be given to hospitals; then health centres in high risk areas (started in 30 days and to cover priority districts in 60 days)	In progress	Subcommittee CCIH (Comissão de controle de infecção hospitalar)	Task partially implemented. Goal: 15 days for implementation.	01/12/2014
4.2. Increase the general awareness about hygiene and how to effectively implement infection prevention and control (started in 30 days and completed in 60 days for priority districts)	Awaiting	Subcommittee CCIH (Comissão de controle de infecção hospitalar)	Task not implemented. Goal: 30 days for implementation.	01/12/2014
4.3. Identify health facilities for setting up basic isolation units (2 beds) for suspected cases in all major hospitals and all border points (ideally regional and district hospitals).	Awaiting	Subcommittee CCIH (Comissão de controle de infecção hospitalar)	Task not implemented.Goal: 15 days for implementation.	01/12/2014
4.4. Equip and adequately train health care workers including environmental health personnel, cleaners etc. on IPC measures, including waste management, with priority for those at first contact with patients and at basic isolation unit.	Awaiting	Subcommittee CCIH (Comissão de controle de infecção hospitalar)	Task not implemented. Goal: 60 days for implementation.	01/01/2015
4.5. Establish a compensation and benefits package for health care workers (HCWs) for: remuneration and motivation for high-risk assignment; in case of infection and death	Awaiting	Trade union of medical doctors and nurses	Task not implemented.Goal: 30 days for implementation.	01/12/2014
4.6. Map availability of hospital supplies	In progress	Subcommittee of logistics	Task partially implemented. Goal: 7 days for implementation.	01/12/2014
4.7. Introduce good practices of Infection Prevention and Control	Awaiting	Subcommittee CCIH (Comissão de controle de infecção hospitalar)	Task not implemented. Goal: 60 days for implementation.	01/01/2015

5(a) Case management: Ebola treatment centre

Task	Implementation status	Responsible	Comments	Quick off date
5.1. Set up at least one facility with trained staff, adequate supplies, ready to provide care to a patient or cluster of patients with suspected EVD. This facility should cater for 15 patients initially	Complete	Subcommittee for general practitioner MSF	Task fully implemented. MSF has renovated an entire ward of the National Hospital to be used as a ETC. However, it needs to be finalized and needs a power generator.	01/12/2014
5.2 Identify double cabin vehicle to be used as ambulances in the regions	Awaiting	Subcommittee for general practitioner MSF	Task not implemented. Goal: 7 days for implementation. URGENT	01/12/2014
5.3 Equip and adequately train ambulance teams to transport suspect EVD cases	Complete	Subcommittee for general practitioner MSF	Task fully implemented. Goal: continuous training of staff. MSF has trained 6 medical doctors and 2 hygiene and sanitation technicians to be RRT and transport of EVD cases	01/12/2014
5.4. Identify health facilities at district level that can be turned into an ETC at short notice. (map facilities that have running water, sanitation, bathroom nearby and incinerator).Have protective equipment; disinfection supplies and awareness posters.	Awaiting	Subcommittee for general practitioner MSF	Task not implemented. Goal: 30 days for implementation.	01/12/2014
5.5. Identify health facilities at local level that can be turned into an ETC at short notice. (map facilities that have running water, sanitation, bathroom nearby and incinerator). Have protective equipment; disinfection supplies and awareness posters.	Awaiting	Subcommittee for general practitioner MSF	Task not implemented. Goal: 30 days for implementation.	01/12/2014
5.6. Train trainers at the Subcommittee for general practitioner to help build capacity of the teams trained by the MSF	Awaiting	MSF	Task not implemented. Goal: 30 days for implementation.	01/12/2014

5(b) Case management: Safe, dignified burials

Task	Implementation status	Responsible	Comments	Quick off date
5.b.1. Develop SOPs for safe burials and decontamination	Awaiting	Dr Isis Julieta Pina Ferreira Gomes Ferreira (Outbreak control)	Task not implemented. Goal: 30 days for implementation.	01/12/2014
5.b.2 Identify appropriate secured burial ground with agreement of the community	Awaiting	It was suggested that the Red Cross could be responsible	Task not implemented. Goal: 30 days for implementation. It is necessary to identify land, plan according different scenarios, to cover all eventualities in a country with more than 30 days ethnic groups (Muslins, Christians and animists. The current idea is to build a new cemetery in Bissau for Ebola cases. If Ebola is to enter Guinea-Bissau, most likely it will be in the border with Guinea. Therefore, it is necessary to discuss with the near communities to identify areas for possible victims.	01/12/2014
5.b.3 Equip and adequately train burial teams (8 people).	Awaiting	It was suggested the Red Cross and PROMETRA (Promotio of Tradition Medicine)	Task not implemented. Goal: 30 days for implementation. Red Cross claims that already takes this into consideration in its contingency plan. However, other users of the plan seem to disagree	01/12/2014
5.b.4. Ensure that a dedicated transportation process is in place to bury human remains safely and dignified	Awaiting	INASA	Task not implemented. Goal: 30 days for implementation. A proposal exists to purchase a funerary vehicle. However it is important to define what is a "safe transportation" of a Ebola dead patient. It is not recommended as a safe practice to put a coffin in the back of a car.	01/12/2014
5.b.5 Ensure burials teams have access to support services such as drivers, grave diggers, and potential security support during the burial process	Awaiting	Subcommittee of logistics (Mrs Olga Campos)	Task not implemented. Goal: 30 days for implementation.	01/12/2014

6. Epidemiological surveillance

Task	Implementation status	Responsible	Comments	Quick off date
6.1. Establish a 24/7 hotline with escalation facilities with medically trained staff.	In progress	To be defined by INASA (Responsible + substitute)	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.2. Train the hotline staff on case identification and management of communication with potential cases.	In progress	MINSAP – Dr Cristovão Manjuba + substitute	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.3. Provide guidance (case definition and investigation forms to all sub-national / district levels and healthcare facilities);, standard case definitions to all countries).	In progress	MINSAP and WHO	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.4. Provide training on the case definition and investigation for all health workers in the country.	In progress	MINSAP and partners	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.5. Test existing Surveillance/IDSR systems for Ebola, identify gaps and start implementation of corrective actions where necessary.	In progress	INASA	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.6. Establish immediate lines of reporting for suspect cases, clear responsibility for such actions.	In progress	INASA	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
6.7. Identify human resources for community surveillance (community HCWs, Red Cross/Crescent volunteers, NGOs, healer, leaders etc.)	Awaiting	MINSAP and partners	Task not implemented. Goal: 30 days for implementation.	01/12/2014
6.8. Disseminate simplified case-definitions for community use	In progress	MINSAP, WHO and UNICEF	Task partially implemented. Goal: 60 days for implementation.	01/01/2015

7. Contact tracing

Task	Implementation status	Responsible	Comments	Quick off date
7.1. Train the teams at both national and subnational / district levels including on contact tracing and data management (with a ToT strategy).	In progress	MINSAP, INASA e CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
7.2. Provide UNMEER with list of required equipment and materials for contact tracing at National and sub-national levels.	In progress	MINSAP, INASA e CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
7.3. Train staff at district level on contact tracing.	In progress	MINSAP, INASA e CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
7.4. Train staff at sub district and community level on contact tracing.	In progress	MINSAP, INASA e CDC	Task partially implemented. Goal: 60 days for implementation.	01/01/2015
7.5 Develop a plan to guarantee data quality.	In progress	MINSAP, INASA e CDC	Task partially implemented. Goal: 90 days for implementation.	01/02/2015

8. Laboratory

Task	Implementation status	Responsible	Comments	Quick off date
8.2. Stand-by arrangements and agreements with WHO Collaborating Centres for confirmatory testing in place.	Awaiting	MINSAP, INASA and WHO	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014
8.3. Stand-by arrangements and agreements with relevant air-lines to ship samples from suspected cases to WHO collaborating Centres in place.	Awaiting	MINSAP, INASA and WHO	Task not implemented. Goal: 30 days for implementation.	01/12/2014
8.4. Availability of resources to facilitate transportation and shipment of specimens.	In progress	MINSAP, WHO and CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
8.5. Existence of protocol for: - Sample collection; - Referral and shipment of specimens from suspect EVD cases to designated laboratory for confirmation at national and sub-national public health laboratories.	In progress	MINSAP, WHO and CDC	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
8.6. Laboratory personnel trained on procedures for specimen collection, packaging, labelling, referral & shipment, including handling of infectious substances.	Awaiting	MINSAP, WHO and CDC	Task not implemented. Goal: 30 days for implementation.	01/12/2014
8.7 Build Capacity of the molecular virology laboratory at LNSP/INASA to diagnose Ebola samples. Have mobile laboratory available.	Awaiting	MINSAP, INASA, WHO, CDC and others	Task not implemented. Goal: 90 days for implementation.	01/02/2015

9. Capacity at points of entry

Task	Implementation status	Responsible	Comments	Quick off date
9.1. Ensure that a health emergency contingency plan is in place at high risk PoE (ports, airports, and ground crossings).	Complete	IHR Focal Point	Task fully implemented. Goal: revise and update plan as needed	continuous
9.2. Deliver identified supplies (9 PPE full sets at each PoE medical equipment to survey cases; 3 Infrared hand held thermometers, 1 scanner, 2 observation room/ 2 Health facilities and supplies for safe isolation and observation of suspect cases if possible separation room, if not, a separated area. Depending on the geographical location, 1 Ambulance to PoEs. Every PoE needs to have either a separation room of a dedicated area for holding suspected cases	In progress	IHR Focal Point	Task partially implemented. Goal: 30 days for implementation.	01/12/2014
9.3. Identify PoE teams to cover 24/7, to assist travellers and ensure correct isolation if required, including through a “holding” centre/area for any suspect cases.	In progress	IHR Focal Point	Task partially implemented. Goal: 30 days for implementation. PoE team for airport is identified and operational. PoE team for ground crossing needs to be identified and trained.	01/12/2014
9.4. Review and test current communication system between health authorities and conveyance operators at PoE, and national health surveillance system	Awaiting	IHR Focal Point	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014
9.5. Use standard operating procedures to identify, manage and direct the POE suspects patients to designated hospitals / isolation facilities.	Complete	IHR Focal Point	Task fully implemented. Goal: revise and update SoPs as needed	continuous

9.6. Use standard operating procedures to implement exit case tracing in the case of a confirmed outbreak of Ebola virus disease	Awaiting	IHR Focal Point	Task not implemented. Goal: 30 days for implementation.	01/12/2014
9.7. Build capacity of health technicians on the procedures if a case of Ebola is identified. (material for training already available).	Awaiting	IHR Focal Point	Task not implemented. Goal: 15 days for implementation.	01/12/2014
9.8. Identify contact person for each entry point of ground borders with Guinea.	Awaiting	High Commissioner	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014
9.9. Establish a coordination mechanism between officials at PoE (border control officer, immigration, tourism, etc.)	Awaiting	IHR Focal Point	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014
9.10. Identify facilities to ensure 24/7 coverage in PoE	Awaiting	High Commissioner	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014
9.11. Map stock of supplies and equipment in PoE	Awaiting	IHR Focal Point	Task not implemented. Goal: 7 days for implementation. Urgent	01/12/2014

Annex 2. Capacity-building programme in transport of infectious substances offered by Portugal for laboratory technicians

Transporte de Substâncias Infecciosas

Programa

data: 24 e 25 de novembro de 2014 | local: INSA, IP, em Lisboa.

Enquadramento e objetivos	O transporte de substâncias infecciosas é estritamente regulado por normas da Organização das Nações Unidas e exige que os remetentes tenham uma formação adequada. Com o objetivo de assegurar nos remetentes/transportadores de substâncias infecciosas as competências necessárias para o envio destas amostras, o Departamento de Doenças Infecciosas do INSA irá realizar uma ação de formação dedicada à temática "Transporte de Substâncias Infecciosas". O curso é desenvolvido de acordo com o modelo da OMS, dividido em módulos direcionados à classificação, documentação, marcação, rotulagem e embalagem de substâncias infecciosas e à preparação de envios que requeiram o uso de gelo seco. Terão também a oportunidade de praticar a embalagem e o preenchimento da documentação para o embarque. No fim do curso irá ser realizada uma sessão de esclarecimentos especificamente para enviar amostras para o diagnóstico do vírus ébola e outros agentes de grupo de risco 4.
Destinatários:	Remetentes/transportadores de substâncias infecciosas e técnicos que necessitem de realizar o envio de amostras de substâncias infecciosas.
Formador(es):	Ana Pelerito, Rita Cordeiro, Isabel Carvalho e Sofia Núncio
Nº de participantes:	Inscrições limitadas a 25 pessoas. A ação só se realizará com o mínimo de 10 formandos.
Programa Dia 24	09:00 *Abertura e entrega da documentação* 09:15 Introdução. Regras gerais. *Questionário de diagnóstico. Sofia Núncio* 10:15 *Pausa.* 10:30 Módulo 1 - Termos utilizados no transporte de substâncias infecciosas. *Quiz 1. Rita Cordeiro* 12:00 *Almoço livre* 13:30 Módulo 2- Categorização e identificação de substâncias infecciosas. *Quiz 2. Rita Cordeiro* 15:00 *Pausa* 15:15 Módulo 3 - Embalagem de substâncias infecciosas. *Quiz 3. Ana Pelerito*
Dia 25	09:00 Módulo 4 - Marcação de embalagens. *Quiz 4. Isabel Carvalho* 10:15 *Pausa* 10:30 Módulo 5 - Transporte de substâncias infeciosas com gelo seco. *Quiz 5. Isabel Carvalho* 12:00 *Almoço livre.* 13:30 Módulo 6 – Documentação para o transporte de substâncias infecciosas. *Quiz 6. Isabel Carvalho* 15:00 *Pausa* 15:15 Revisões. Avaliação final. *Sofia Núncio* 16:30 Sessão de esclarecimento para envio de amostras para diagnóstico do vírus ébola 17:30 Conclusões e encerramento do curso.

duração: 14 horas | preço da inscrição: €300 (os inscritos no curso "Biossegurança em laboratórios de nível 2 e 3" apenas pagam €100) | data limite de inscrição: 29 de novembro

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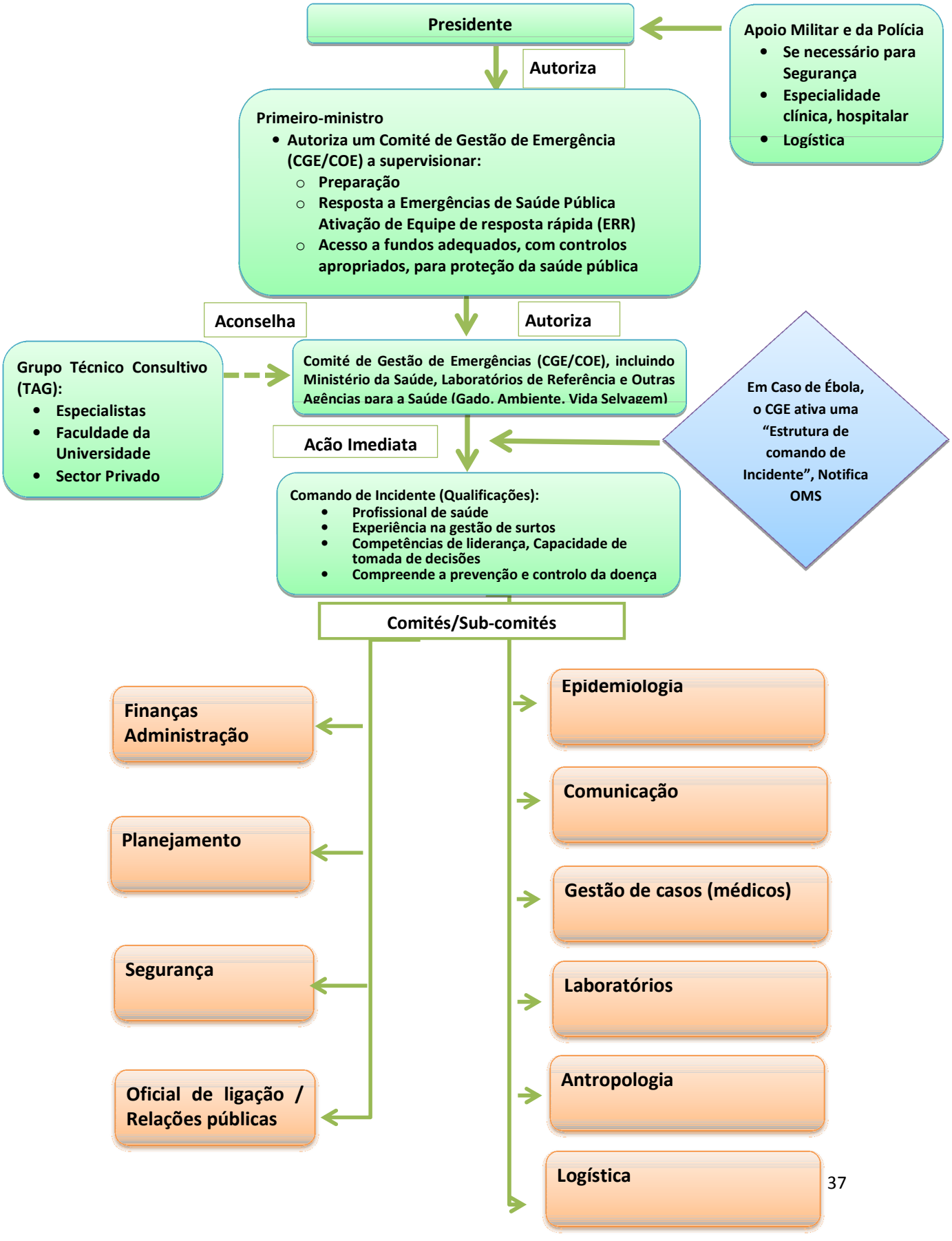
Annex 3. Estrutura de Comando de Incidentes e Comité de Gestão de



Annex 4. National preparedness plan

REPUBLIQUE DE LA GUINÉE-BISSAU
MINISTERE DE LA SANTÉ PUBLIQUE
Direção Geral de Prevenção e Promoção de Saúde

Direction de Services des Maladies Transmissibles et Non Transmissibles

Comité National Multi-sectoriel de Gestion des Épidémies et Catastrophes

Plan de prévention et de réponse à l'Epidémie de la maladie à Ebola (Mai à Décembre 2014)

Bissau, 26 Mai 2014

Introduction

La République de Guinée-Bissau est située sur la côte ouest du continent africain. Le pays possède des frontières au nord avec la République du Sénégal, à l'est et au sud-est avec la République de Guinée et l'océan Atlantique à l'Ouest. Du point de vue administratif, la Guinée-Bissau est divisée en 8 régions : Bafatá, Biombo, Bolama-Bijagós, Cacheu, Gabu, Oio, Quínara et Tombali. Les régions sont subdivisées en 36 secteurs et un secteur autonome (ville de Bissau), capitale politique, économique et administratif du pays. La carte sanitaire se présente avec 11 régions sanitaires, y compris le secteur autonome de Bissau. 11 régions sanitaires ont été divisées en 114 zones sanitaires (niveau le plus proche aux communautés), définis sur la base de critères géographiques, couvrant une population comprise entre 5 000 et 12 000 habitants. Plus de 40 % de la population vit encore, à une distance supérieure à 5 km, structures de prestation de soins de santé primaires, plus proche.

La Guinée-Bissau a subi plusieurs épidémies de maladies/contagieuse au cours des années, à savoir : choléra, rougeole, méningites et charbon. En 2010, il y a des cas notifiés de l'influenza aviaire dans la région de Biombo. Les régions transfrontalières et la communication aérienne avec la République de Guinée Conakry, notamment, Quinara, Tombali, Gabu, Bolama-Bijagós et SAB respectivement constituent des zones d`entrée et potentiel de propagation de maladies.

Récemment, le pays a été tenu au courant de l'existence d'une fièvre hémorragique épidémique du virus Ebola en cours depuis février dans la République voisine de Guinée-Conakry. On sait que la maladie est virale et à l'origine de taux de létalité élevé et a été enregistrée pour la première fois en 1976 dans la République démocratique du Congo (anciennement Zaire).

Le pays n'a jamais connu l'épidémie de fièvre hémorragique à virus Ebola et en raison de la situation géographique et la mobilité des personnes, le ministère de la santé publique en collaboration avec ses partenaires traditionnels de la coopération a lancé la préparation d'un plan de prévention et de réponse à une possible propagation de l'épidémie dans le pays, une plan qui couvre la période de mai à décembre de l'année en cours (2014).

Réponse Nationale:

Compte tenu de la situation actuelle, le MSP a convoqué une réunion technique avec ses partenaires pour la préparation des stratégies possibles de prévention de cette épidémie qui figureront dans le plan d'urgence. Aussi toutes les directions régionales ont été informées de l'existence de l'épidémie de fièvre hémorragique à virus Ebola en Guinée-Conakry et il été donc demandé aux responsables sanitaires d'identifier les sites possibles pour l'isolement des cas suspects de la maladie. Outre ces directives, les directions régionales ont également procédé à la mise à jour la liste des stocks de médicaments et des intrants disponibles.

Partenaires impliqués:

Tous les partenaires au développement sanitaire en Guinée Bissau ont été sensibilisés et sont intéressés à appuyer dans la prévention et de réponse à une éventuelle épidémie du virus Ebola dans le pays.

Population vulnérable ou à risque :

Toute la population résidente et notamment des régions frontalières avec la République voisine de Guinée-Conakry sont à risque. Les scénarios pour les sources possibles de contamination les plus probables sont l'entrée du virus par des points d'entrée dans les zones frontalières, campements des

pécheurs dans les régions de Quinara,Tombali, Bijagós et ville de Bissau par le biais de l'aéroport de Bissau.

Objectif général:

Prévenir et répondre à temps et efficacement à une éventuelle épidémie de fièvre hémorragique à virus Ebola dans le pays.

Objectifs spécifiques:

1 – Réactiver et opérationnaliser les épidémies, les comités de gestion à tous les niveaux en améliorant la coordination des activités.

2 – Renforcer les capacités techniques des équipes pour répondre efficacement à la prise en charge de la maladie à Virus Ebola et réduire la mortalité et la morbidité liées à cette maladie.

3 – Pré positionner des médicaments et équipements médicaux pour l'organisation d'une préparation et d'une réponse adéquate aux cas notifiés.

4 – Fournir des mesures de bonne pratique d'hygiène y compris lavage des mains auprès des ménages pour réduire le risque de contamination des les maladies (Ébola et autres. Choléra, etc).

5 – Créer des conditions favorables pour la collecte et le transport des échantillons.

Résultats attendus pour l'objectif spécifique 1

I- Les comités de gestion des épidémies réactivés et fonctionnels à tous les niveaux.

Résultats attendus pour l`objectif spécifique 2

I – Les capacités des techniciens de santé dans la surveillance et la prise en charge clinique des cas sont renforcées.

Résultats attendus pour l'objectif spécifique 3

I – Les sites de l'isolement des cas suspects équipés adéquatement à tous les niveaux et y compris les points d'entrée.

Résultats attendus pour l'objectif spécifique 4

I - La connaissance des populations sur l'épidémie d'Ebola est renforcée.

5 **- Résultats attendus pour l'objectif spécifique 5**

I – Les conditions pour la collecte et le transport des échantillons sont créés.

Stratégies pour l'objectif spécifique 1

Réactiver et opérationnaliser les comités de gestion des épidémies à tous les niveaux en améliorant la coordination des activités.

A – Coordination des comités de gestion des épidémies pour le monitorage de l'évolution de la situation hebdomadaire d'épidémie, la communication et la concertation quotidienne entre les différents niveaux.

B- Mobilisation et gestion des ressources à différents niveaux.

Stratégies pour l'objectif spécifique 2

Renforcer la capacité des techniciens de santé à répondre efficacement à une éventuelle épidémie pour réduire la mortalité et la morbidité attribuée à cette maladie.

A – Disposer des techniciens de santé ayant de très bonnes connaissances sur la détection précoce et la notification des cas.

Stratégies pour objectif spécifique 3

Fournir des mesures de prévention et des conditions de service appropriées pour la prise en charge adéquate des cas suspects.

A – Renforcement et équipement des points d'entrée pour la détection et la prise en charge des cas suspects possibles.

B - Fournir aux structures de santé des outils de surveillance et de gestion de cas cliniques.

Stratégias pour objectif spécifique 4

Promouvoir l'adoption de bonnes pratiques d'hygiène, y compris le lavage des mains auprés des familles afin de réduire le risque de contamination par d'autres maladies infectieuses (Ebola, choléra, etc.)

A – Renforcement des capacités des acteurs (personnels de santé, les professionnels des médias, chefs religieux et traditionnels, volontaires communautaires (ASC).

B – Sensibilisation des populations à adopter les meilleures pratiques d'hygiène individuelle et collective et prévenir ainsi la maladie.

Stratégies pour objectif spécifique 5

Créer des conditions propices à la collecte et le transport des échantillons.

A – Renforcement des capacités techniques pour la collecte, le conditionement et le transport des échantillons.

Activités relatives à l'objectif spécifique 1

- Organiser des réunions du Comité de gestion à tous les niveaux
- Organiser des supervisions à tous les niveaux
- Soutenir les équipes régionales de la santé par le biais de missions techniques ad hoc

- Doter l`INASA des fonds pour le transport d'échantillons de DRS à LNSP

Activités relatives à l'objectif spécifique 2

- Former les professionnels de la santé, les agents de santé communautaire et volontaires des ONG.
- Soutenir la reproduction des supports de formation, manuels, dépliants, cartes, etc.
- Organiser des réunions techniques transfrontalières.

Activités relatives à l'objectif spécifique 3

- Acheter et pré-positioner les matériels médicaux et autres intrants.
- Soutenir en moyen logistique les activités des régions et assurer la maintenance

Activités relatives à l'objectif spécifique 4

- Produire des supports de communication (spots, affiches et dépliants)
- Organiser l'orientation de sessions courtes au niveau des aires sanitaires à l'intention des ONG, des animateurs des radios et des chefs traditionnels et religieux.
- Effectuer des missions de suivi et de supervision.

Activités relatives à l'objectif spécifique 5

- Achat des matériels & équipements pour le laboratoire
- Adapter les règles de procédure standard

Suivi et évaluation

Le suivi et l'évaluation des actions programmées se fera sur une base hebdomadaire pendant les réunions du Comité régional de gestion des épidémies comme instance identique de coordination au niveau régional. Les rapports de mise en œuvre de ce plan doivent reposer sur les indicateurs inclus dans ce tableau.

Résultats attendus	Indicateurs
Les comités de gestion des épidémies réactivées et fonctionnelles à tous les niveaux	% des comités de gestion des épidémies réactivées et fonctionnelles
Capacités des techniciens de santé dans la prise en charge clinique des cas et de la surveillance renforcée	% des techniciens de santé formés
Les sites d'isolement des cas suspects équipés adéquatement à tous les niveaux et y compris les points d'entrée	% des sites d'isolement des cas/suspects équipés de manière adéquate

La connaissance des populations au sujet de l'épidémie d'Ebola renforcée	Nombre des séances de sensibilisation organisées
Conditions pour la collecte et le transport des échantillons créées	% d'échantillons reçus dans des conditions acceptables au LNSP

RÉSUMÉ DU PLAN

Résultats attendus	Stratégies	XOF	USD
Les comités de gestion des épidémies réactivés et fonctionnels à tous les niveaux	Coordination des comités de gestion des épidémies pour le monitorage de l'évolution de la situation hebdomadaire d'épidémie, la communication et la concertation quotidienne entre les différents niveaux	28 398 960	57 957
	Evaluation du niveau de préparation et la réponse du pays et des districts pour identifier les gaps et les combler	13 152 000	26 841
	Mobilisation et gestion des ressources à différents niveaux	23 896 000	48 767
Les capacités des relais communautaires dans la surveillance active et le suivi des contacts est renforcé	Disposer des relais communautaires ayant de très bonnes connaissances sur la détection précoce et la notification des cas	17 991 600	36 718
Les capacités des techniciens de santé dans la surveillance active et le suivi des contacts est renforcé	Disposer des techniciens de santé ayant de très bonnes connaissances sur la détection précoce et la notification des cas	16 280 000	33 224
	Production et dotation des guides techniques (définitions de suspect, probable confirmé, normes de biosécurité, etc…)	9 249 000	18 876
	Supervisions formatives	30 856 440	62 972
	Documentation de la surveillance/investigations	42 200 000	88 163
	Dotations de moyens pour le dépistage aux points d'entrée	72 480 000	147 918
Les sites d'isolement des cas suspects équipés adéquatement à tous les niveaux et y compris les points d'entrée	Renforcement et équipement des points d'entrée pour la détection et la prise en charge des cas suspects possibles	49 164 000	100 335
	Dotation d'outils de biosécurité et de gestion de cas cliniques aux structures de santé.	151 327 200	308 831

Les structures de soins publiques et privés en conformité avec les normes de contrôle de l'infection (biosécurité)	Supervision régulière sur l'adoption des normes de biosécurité dans tous les structures de soins (publiques et privées)	27 769 320	56 672
Les mesures de bonnes pratiques d'hygiène y compris lavage des mains auprès des ménages pour réduire le risque de contamination des maladies dérivées des mains souillés (Ebola, choléra, autres diarrhées, etc) rendus disponibles pour les communautés	Fourniture de kits d'hygiène et d'outils pour le lavage des mains	55 937 500	114 158
Le transport des cas suspects vers les centres d'isolement et les funérailles des cas probables et confirmés est sécurisé et assuré logistiquement	Assurance des kits de désinfection dans tous les moyens de transport pour les malades, pour le personnel, et pour l'enterrement sécurisé	12 015 634	24 522
Les besoins en logistique sont satisfaits.	Quantification des besoins de chaque service/commission	149 013 520	304 109
	Approvisionnement régulier	0	0
Les conditions de travail sont assurées aux différentes équipes/services/commissions	Contractualisation des services y inclus l'assistance technique	100 400 000	204 898
	Transportation d'échantillons	8 300 000	16 939
	Maintien du réseau de communication interne aux acteurs et coordination	6 000 000	12 245
La connaissance des populations sur l'épidémie d'Ebola est renforcée	Renforcement des capacités des acteurs (personnels de santé, les professionnels des médias, chefs religieux et traditionnels, volontaires communautaires (ASC).	17 991 600	36 718
	Sensibilisation des populations à adopter les meilleures pratiques d'hygiène individuelle et collective et prévenir ainsi la maladie	28 485	58 133
	Participation et leadership des communautés dans les activités planification et sensibilisation à base communautaire	8 995 800	18 359

Le personnel laborantin est formé sur la collecte et transport d'échantillons en respectant toute procédure sécuritaire	Formation sur les capacités techniques pour la collecte, le conditionnement et le transport des échantillons	2 952 000	6 024
Les moyens nécessaires pour maintenir le lien fonctionnel avec l'IPD sont disponibles	Evaluation des possibilités d'accueil d'un laboratoire mobile	6576 000	13 420
	Planification de ressources humaines pour l'application des tests en laboratoire mobile	p.m.	0
	TOTAL	**880 431 574**	**1 796 799,13**