**WHO AFGHANISTAN EMERGENCY RESPONSE PLAN to COVID-19**

**Phase 2**

**17 March 2020**

**SITUATION ANALYSIS**

On 31 December 2019, a cluster of pneumonia of unknown etiology was reported in Wuhan City, Hubei Province of China. On 9 January 2020 [Chinese authorities reported in the media](http://www.xinhuanet.com/politics/2020-01/09/c_1125438971.htm) that the cause of this viral pneumonia was identified as a new type of coronavirus. On 30 January 2020, WHO declared COVID-19 as a Public Health Emergency of International Concern (PHIEC). The epidemic rapidly expanded in China followed by multiple hotspots all over the world (Iran, South Korea, and a number of European countries). On the 11th March, 2020, WHO declared COVID-19 a pandemic.

As of 16 March 2020, there are 168,019 cases of COVID-19 with 6,610 associated deaths from 148 countries. Iran reported 1,053 new confirmed cases on 16 March with a cumulative number increased to 14,991 including 853 deaths with a Case Fatality Rate of 5.7%.

On 17 March, Afghanistan reported 22 confirmed case with the first case being reported on 24 February. Afghanistan, bordering Iran, is at high risk for the COVID-19 epidemic, exacerbated by intense trade and a large Afghan population ling and working within Iran. Ove the last weeks, on average, 7 to 8,000 returnees crossed the Iran-Afghanistan border through Islam Qala alone. Yesterday, it recorded the highest number at 9,552 returnees.

Looking to the rapidly spreading nature of the virus and the challenged capacities of the health system in Afghanistan, there is an urgent need for enhanced multi-sectoral preparedness, operational readiness and response capacities to limit the spread of COVID-19, to help implement the most effective measures in controlling disease transmission: early detection, early isolation and treatment, contact tracing and risk communication and community engagement.

**Public Health Risk and Preparedness**

Sharing a large border with Iran with frequent and substantial population movements, puts Afghanistan on high risk to having a significant impact due to COVID-19. With up to 20,000 returnees per day of from Iran through formal and informal crossings, it is important to ensure that early detection, isolation and contact tracing of suspected cases will be carried out in order to limit community transmission of COVID-19 not only in the Western provinces of Herat, Farah, and Nimroz, as well as along the migration routes to the rest of the country.

The Ministry of Public Health in collaboration with WHO and partners has implemented preparedness and some containment measures since late January 2019 ( Phase 1) . The National Emergency Committee and Health Cluster regularly convene, including five technical committees working on 1) coordination and preparedness, 2) surveillance and detections, 3) case management and health services, 4) operation and logistics and 5) risk communication and community engagement.

A national isolation center with a capacity of 100 beds (with possible upgrading to 200 beds) and regional and provincial isolation centers with total capacity of 991 beds are in place as part of contingency plan. Four major airports with international flights and all ground crossings are staffed and equipped for screening of travelers with focus to those arriving from global hotspots. The Central Public Health Lab (CPHL) with the support from WHO is currently able to perform diagnostic tests for COVID-19.

WHO has procured and delivered medical equipment & supplies, and supported training of healthcare workers, laboratory support, risk communication, normative support, staffing as well as published Daily Updates with OCHA, and weekly Sitreps.

Currently the government is developing and implementing a multi-sectoral operational plan on COVID-19 Complimentary to this, the UN have also developed multi-sectoral COVID-19 response plan through the humanitarian cluster system under UN Country Preparedness and Response (CPRP). The WB COVID-19 facility with government is planning their inputs in the overall COVID-19 response.

WHO and the Health Cluster are implementing the Phase 1 plan, which mainly focuses on preparedness and containment.

This Phase 2 Emergency Plan on COVID 19 will focus on preparedness, containment and mitigation.

**GOAL**

To help prevent and limit the spread of COVID-19 in Afghanistan, and reduce the related morbidity and mortality due to COVID-19

**Specific Objective**

* To assist the Government of Afghanistan in the implementation of the multi-sectoral response plan with a focus on early detection, early isolation and treatment, contact tracing, risk communication and community engagement, and additional support measures when needed.

**Priorities UNDER 8 pillars for COVID-19 phase 2 Response:**

1. **COUNTRY‐LEVEL COORDINATION AND RESPONSE PLANNING**

* Support coordination and leadership structures at the national and sub-national levels.
* Technical support to updating National Emergency Response Plan to COVID-19.

1. **RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (Accountability to Affected Population)**

* Support risk communication interventions to help ensure that clear communication messaging on COVID-19 is widely available to all communities and all Afghans
* Support production and dissemination of Information Education Communication (IEC) materials for raising public awareness
* Technical guidance and dissemination of WHO guidelines on COVID-19 including case definition and case management to health facilities are available to BPHS and EPHS implementing partner, Private Health Sector, surveillance teams etc.
* Advocacy and guidance on additional support measures including limitation of mass- gatherings, temporary closure of institutions, schools, universities, restaurants, and other and other places where people gather in large numbers, travel restriction, and its related enforcement.

1. **SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION**

* Enhance surveillance system for early detection, isolation, and confirmation of suspected cases.
* Ensure rapid detection and confirmation of the suspected cases for immediate isolation and treatment of confirmed cases.
* Support rapid response teams and provide technical guidance at all levels.
* Ensure guidelines and SOPs and contact tracing and follow up forms available with the teams.
* Ensure availability of stockpiles of PPEs and consumables for surveillance and diagnostic and case management facilities.

1. **POINTS OF ENTRY**

* Support of health and other teams for screening at the Points of Entry (PoE) on ground crossings and airports.
* Provide essential risk communication and information to all travelers at all POE
* Implementation of health measures in transit and encashment centers for travelers.

1. **LABORATORIES**

* Support the expansion of diagnostic facilities for COVID-19 confirmatory testing at the national and sub-national levels.
* Provide technical guidance to Central Public Health Laboratories (CPHL) and sub-national laboratories on SOPs and training.

1. **INFECTION PREVENTION AND CONTROL (IPC)**

* Support IPC at identified health facilities, isolation centers and designated POE
* IPC training of health workers, support staff, cleaners, ambulance staff in designated health facilities and isolation centers.
* Ensure availability of stockpiles of PPEs and consumables

1. **CASE MANAGEMENT**

* Support and equip Isolation wards/ICUs in the designated national, regional and provincial hospitals.
* Ensure availability of stockpiles of PPEs and consumables

1. **OPERATIONAL SUPPORT AND LOGISTICS**

* Provide national and international technical assistance.
* Facilitate procurement of essential supplies and equipment, and essential drugs.

**PHASE 1 RESPONSE – Preparedness and CONTAINMENT-planned budget 3.5 Million usd Starting MID January**

WHO Afghanistan immediately allocated medical supplies & equipment and PPEs from existing stocks to Herat and Kabul Hospitals and other health facilities. WHO re-prioritized more than $1 million USD for initial, ongoing and planned interventions and activities, while additional resources were mobilized from USAID, ECHO and the Afghanistan Humanitarian Fund (to be received soon), totaling $3.2 Million USD.

Phase 1 response focuses on Pillars relating to Country Level Coordination and Response Planning, Risk Communication and Community Engagement, Surveillance, rapid response teams, and case investigation and Points of Entry with some support going toward Infection Prevention Control and Case Management. Phase 1 activities are complementary to the Ministry of Public Health *Emergency Response plan for n-CoV 2019.* An Interim Response Report for Phase 1 is available.

**PHASE 2: PREPAREDNESS, CONTAINMENT AND MITIGATION**

Under Phase 2, WHO will continue to focus on the 8 pillars with emphasis on Risk Communication and Community Engagement, Surveillance, Rapid Response and Case investigation and Infection Prevention Control. The polio teams and volunteers are mobilized to engage in nation-wide surveillance, contact tracing and risk communication effort. The WHO Health Emergencies will coordinate with the Health Systems Program to integrate the humanitarian and development response toward building more resilience health systems.

PROPOSED AREAS OF INTERVENTIONS in PHASE 2:

|  |  |  |  |
| --- | --- | --- | --- |
| S/N | Areas of intervention | Estimated cost (US$) | Urgent Need (US$) |
| 1 | **COUNTRY‐LEVEL COORDINATION AND RESPONSE PLANNING** | | |
| 1.1 | Support coordination and leadership structures at national and sub-national levels | 400,000 | 200,000 |
| 2 | **RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (AAP)** | | |
| 2.1 | Conduct risk communication campaigns to public using national media (TV and radio) | 600,000 | 400,000 |
| 2.2 | Develop, print and distribute brochures and leaflets to various target groups | 400,000 | 200,000 |
| 2.3 | Infrastructure (tents, information centres) at focal areas for distribution of communication material – Link to Pillar 4 | 800,000 | 400,000 |
| 2.4 | Technical assistance to support Communication with Communities (CwC) and Accountability to Affected Population (AAP) for six months | 400,000 | 200,000 |
| 3 | **SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION** | | |
| 3.1 | Train focal points of all surveillance sites on  case definitions, case investigation and follow up for active surveillance | 100,000 | 100,000 |
| 3.2 | Train private health care providers on case definitions, case investigation and follow up for active surveillance | 400,000 | 200,000 |
| 3.3 | Enhance influenza surveillance system at the sentinel sites | 200,000 | 100,000 |
| 3.4 | Surveillance, contact tracing, risk communication/health information, support through the Polio teams and volunteers | 2,000,000 | 500,000 |
| 3.5 | Train rapid response teams (RRT) at the national and sub-national levels | 200,000 | 50,000 |
| 3.6 | Operations cost of the rapid response team (transport and other running cost for case finding, investigation, contact tracing and monitoring | 800,000 | 300,000 |
| 4 | **POINTS OF ENTRY** | | |
| 4.1 | Train relevant stakeholders on public health emergency contingency plan at points of entry | 200,000 | 100,000 |
| 4.2 | Hire staff at 10 PoEs to provide risk communication/ health information, early detect, investigate and manage ill passenger (screening of passengers) | 800,000 | 200,000 |
| 4.3 | Procure required equipment for screening passengers (infrared thermometers, advanced fever detectors, etc.) | 300,000 | 100,000 |
| 4.4 | Operation/running cost of the Health teams at the PoE | 150,000 | 150,000 |
|  | PPEs refer to Line 6.2 | 0 | 0 |
| 4.5 | Support adequate ambulance services for the transportation of the suspected case to the designated hospitals and facilities | 150,000 | 100,000 |
| 5 | **NATIONAL LABORATORIES** | | |
| 5.1 | Procure specimen collection, packaging and transportation supplies | 300,000 | 300,000 |
| 5.2 | Train Lab staff on proper specimen collection and handling | 200,000 | 200,000 |
| 5.3 | Procure PCR, reagents and consumables for upgrading 10 reference national and regional laboratories and diagnostic kits | 1,500,000 | 1,000,000 |
| 5.4 | Rehabilitate and upgrade 10 national and regional reference laboratories | 800,000 | 800,000 |
| 6 | **Enhance national and healthcare facility Infection Prevention and Control** | | |
| 6.1 | Print and disseminate existing IPC protocols | 100,000 | 100,000 |
| 6.2 | Procure Infection Prevention and Control supplies and Personal Protective Equipment | 1,600,000 | 780,000 |
| 6.3 | Training of medical and support staff on Infection Prevention and Control in the hospitals | 500,000 | 300,000 |
| 6.4 | Technical assistance on monitoring implementation of IPC | 200,000 | 200,000 |
| 6.5 | Hire and recruit essential non-medical staff for relevant IPC | 200,000 | 100,000 |
| 7 | **Case Management** | | |
| 7.1 | Support ICU and isolation facilities at national and sub-national level including procurement of medical and non-medical equipment | 3,000,000 | 1,000,000 |
| 7.2 | Support specific hospital/facilities for isolation/ICU quarantine facilities | 1,000,000 | 500,000 |
| 7.3 | provisions for consumables PPEs, N95 masks, surgical masks, gloves, coveralls, | 1,000,000 | 400,000 |
| 7.4 | Procurement of essential medicines | 1,000,000 | 400,000 |
| 7.5 | Training of medical staff on Case Management | 500,000 | 200,000 |
| 8 | OPERATIONAL SUPPORT AND LOGISTICS | | |
| 8.1 | Logistician for 6 months | 200,000 | 200,000 |
| 8.2 | National public health officers (x4) | 200,000 | 200,000 |
|  | **Total cost** | **20,200,000** | **10,180,000** |

**TIMEFRAME: One Year**