COVID-19 Strategic Preparedness and Response Plan

OPERATIONAL PLANNING GUIDELINES TO SUPPORT COUNTRY PREPAREDNESS AND RESPONSE.......................................

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INTRODUCTION

On 30 January 2020, the Director-General of WHO declared the coronavirus disease 2019 (COVID-19) outbreak a public health emergency of international concern (PHEIC) under the International Health Regulations (IHR 2005), following advice from the IHR Emergency Committee. On 4 February 2020, the Director-General of WHO briefed the Secretary-General of the United Nations and requested the activation of the United Nations crisis management policy to establish a Crisis Management Team (CMT) to coordinate the UN system-wide scale up to assist countries prepare for and respond to COVID-19.

On 6 February 2020 UN Development Coordination Office (UNDCO) hosted a call with WHO to brief all Resident Coordinators and UN Country Teams (UNCTs) to provide updates on the COVID-19 epidemiological situation and introduce the COVID-19 Strategic Preparedness and Response Plan (SPRP),[1] emphasizing the importance of responding to the crisis as "One UN."

The primary objective of the international response to the COVID-19 outbreak remains stopping the human-to-human transmission of the virus, and caring for those affected. WHO is calling all partners to use this unique window of opportunity to act immediately to assist all countries to rapidly detect, diagnose, and prevent the further spread of the virus. This guidance document outlines the measures to be taken at country level to contain the virus, and will be updated with further guidance if the epidemiological situation changes.

COVID-19 preparedness and response planning

The SPRP outlines the public health measures that need to be taken to support countries to prepare for and respond to COVID-19. It can be used to rapidly adapt National Action Plans for Health Security (NAPHS) and Pandemic Influenza Preparedness Plans (PIPP) to COVID-19, taking what we have learned so far about the virus and translating that knowledge into strategic action that can guide the efforts of all national and international partners to support national governments.

Based on an initial assessment of country risk and vulnerability, the SPRP estimates the resource requirements to support countries to prepare for and respond to COVID-19. In many cases, national governments will be well placed to implement these measures with minimal support. In other cases, partners may be best placed to implement measures where there is a gap in capacity, either on a national or subnational level, in support of national governments. A detailed gap and needs analysis will need to be conducted in each affected country to develop a COVID-19 Country Preparedness and Response Plan (CPRP) and resource requirements in support of national governments. These CPRPs will need to be monitored using indicators based on those set out in the SPRP, and adapted as the situation evolves.

It should be noted that the costs outlined in the SPRP cover public health measures taken in support of national preparedness and response and do not include the broader measures required to mitigate the social and economic consequences of COVID-19 or ensure business continuity of partner organizations. Plans to ensure the continuity of essential services and mitigate social and economic impacts will need to be developed in parallel to the scaling up of the public health preparedness and response measures.

1 https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf

Purpose of the planning guidelines

The purpose of this document is to provide a practical guide for the UNCTs and partners to develop a CPRP to immediately support national governments to prepare for and respond to COVID-19. The initial CPRP should be developed for a 3-month period from 1 February to 30 April in alignment with the SPRP. Subsequent CPRPs will be developed based on the evolving situation and needs.

This guide outlines the priority steps and actions to be included in the CPRP across the major areas of the public health preparedness and response:

- Country-level coordination, planning, and monitoring;
- Risk communication and community engagement;
- Surveillance, rapid-response teams, and case investigation;
- Points of entry;
- National laboratories;
- Infection prevention and control;
- Case management;
- Operations support and logistics.

This guide does not supersede existing national guidance and plans. Rather, this guide should be used to rapidly adapt existing relevant national plans, including NAPHS and PIPPs, and focus the support of the international community. The UN and its partners will implement the adapted preparedness and response activities outlined in the CPRP to ensure that the best support possible is provided to national authorities and communities affected by COVID-19. All technical guidance documents are available by topic from the WHO COVID-19 website.[2]

Next steps

Using this guide, the immediate next steps for Resident Coordinators and UNCTs are:

- Appoint a COVID-19 lead within the UNCT to coordinate and oversee the development of the CPRP;
- Engage with national authorities and UNCT/Humanitarian Country Team (HCT) to identify appropriate coordination mechanism including health cluster /sector and key technical/operational partners at country level;
- Map existing preparedness and response capacity and identify key gaps based on the actions outlined in this document;
- Engage with national authorities and key technical/operational partners to assign roles and responsibilities to address key gaps to be addressed by the CPRP;
- Engage with local donors and existing programmes to mobilize resources and capacities to implement CPRP;[3]
- Establish monitoring mechanisms based on key performance indicators in the SPRP, track progress, and review performance to adjust the CPRP as needed;
- Conduct regular operational reviews and adjust the CPRP as required.

Also included as annexes to aid planning and monitoring are:

- Key performance indicators to monitor the implementation of the COVID-19 SPRP;
- Estimated resource requirements for a cluster of transmission of up to 100 cases, including the essential supplies, critical technical and operational support, as well as training and incentives for national workforces.

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2 WHO Novel Coronavirus (COVID-19) technical guidance web page, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

3 When local resources cannot be mobilized, UNCT members will be encouraged to send queries and requests for support to through their respective existing headquarters support channels. The CMT will coordinate requests for support between agencies, bringing these to the attention of the UN senior management for action.

PILLARS

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Pillar 1: Country-level coordination, planning, and monitoring

National public health emergency management mechanisms should be activated with engagement of relevant ministries such as health, education, travel and tourism, public works, environment, social protection, and agriculture, to provide coordinated management of COVID-19 preparedness and response. NAPHS and PIPPs, if available, should also be adapted to address COVID-19.

Step	Actions to be taken
1	☐ Activate multi-sectoral, multi-partner coordination mechanisms to support preparedness and response
	☐ Engage with national authorities and key partners to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response, or preferably adapt, where available, an existing *Influenza Pandemic Preparedness Plan*
	☐ Conduct initial capacity assessment and risk analysis, including mapping of vulnerable populations
	☐ Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures
2	☐ Establish an incident management team, including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available
	☐ Identify, train, and designate spokespeople
	☐ Engage with local donors and existing programmes to mobilize/allocate resources and capacities to implement operational plan
	☐ Review regulatory requirements and legal basis of all potential public health measures
	☐ Monitor implementation of CPRP based on key performance indicators in SPRP and produce regular situation report
3	☐ Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary
	☐ Conduct after action reviews in accordance with IHR (2005) as required
	☐ Use COVID-19 outbreak to test/learn from existing plans, systems and lesson-learning exercises to inform future preparedness and response activities

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Pillar 2: Risk communication and community engagement

It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumours and misinformation. Changes in preparedness and response interventions should be announced and explained ahead of time, and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust.

Step	Actions to be taken
1	☐ Implement national risk-communication and community engagement plan for COVID-19, including details of anticipated public health measures (use the existing procedures for pandemic influenza if available)
	☐ Conduct rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels
	☐ Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups
	☐ Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)
2	☐ Establish and utilize clearance processes for timely dissemination of messages and materials in local languages and adopt relevant communication channels
	☐ Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication
	☐ Utilize two-way 'channels' for community and public information sharing such as hotlines (text and talk), responsive social media such as U-Report where available, and radio shows, with systems to detect and rapidly respond to and counter misinformation
	☐ Establish large scale community engagement for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations
3	☐ Systematically establish community information and feedback mechanisms including through: social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations
	☐ Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathic.
	☐ Document lessons learned to inform future preparedness and response activities

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Pillar 3: Surveillance, rapid response teams, and case investigation

In countries with high-risk of imported cases or local transmission, surveillance objectives will focus on rapid detection of imported cases, comprehensive and rapid contact tracing, and case identification. In a scenario in which sustained community transmission has been detected, objectives will expand to include monitoring the geographical spread of the virus, transmission intensity, disease trends, characterization of virologic features, and the assessment of impacts on healthcare services. In some countries, surveillance priorities will differ at subnational levels. Robust COVID-19 surveillance data are essential to calibrate appropriate and proportionate public health measures.

Step	Actions to be taken
1	☐ Disseminate case definition in line with WHO guidance and investigation protocols to healthcare workers (public and private sectors)
	☐ Activate active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI)
	☐ Assess gaps in active case finding and event-based surveillance systems
2	☐ Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19
	☐ Undertake case-based reporting to WHO within 24 hours under IHR (2005)
	☐ Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children
	☐ Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours
3	☐ Provide robust and timely epidemiological and social science data analysis to continuously inform risk assessment and support operational decision making for the response
	☐ Test the existing system and plan through actual experience and/or table-top or simulation exercises, and document findings to inform future preparedness and response activities
	☐ Produce weekly epidemiological and social science reports and disseminate to all levels and international partners

Pillar 4: Points of entry

Efforts and resources at points of entry (POEs) should focus on supporting surveillance and risk communication activities.

Step	Actions to be taken
1	☐ Develop and implement a points of entry public health emergency plan
2	☐ Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s)
	☐ Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities
	☐ Communicate information about COVID-19 to travellers
3	☐ Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate

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Pillar 5: National laboratories

Countries should prepare laboratory capacity to manage large-scale testing for COVID-19 — either domestically, or through arrangements with international reference laboratories. If COVID-19 testing capacity does not exist at national level, samples should be sent to a regional or international reference laboratory with appropriate capacity. In the event of widespread community transmission, surge plans should be activated to manage the increased volume of samples from suspected cases. WHO can provide support to access relevant reference laboratories, protocols, reagents, and supplies.

| Step	Actions to be taken
1	☐ Establish access to a designated international COVID-19 reference laboratory
	☐ Adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing
	☐ Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks
	☐ Adopt standardized systems for molecular testing, supported by assured access to reagents and kits
2	☐ Ensure specimen collection, management, and referral network and procedures are functional
	☐ Share genetic sequence data and virus materials according to established protocols for COVID-19
	☐ Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis
	☐ Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission
3	☐ Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned
	☐ Develop a quality assurance mechanism for point-of-care testing, including quality indicators

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Pillar 6: Infection prevention and control

Infection prevention and control (IPC) practices in communities and health facilities should be reviewed and enhanced to prepare for treatment of patients with COVID-19, and prevent transmission to staff, all patients/visitors and in the community.

Step	Actions to be taken
1	☐ Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices and pharmacies. Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations
	☐ Assess IPC capacity in public places and community spaces where risk of communtiy transmission is considered high
	☐ Review and update existing national IPC guidance: health guidance should include defined patient-referral pathway including an IPC focal point, in collaboration with case management. Community guidance should include specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport as well as community, household, and family practices
	☐ Develop and implement a plan for monitoring of healthcare personnel exposed to confirmed cases of COVID-19 for respiratory illness
	☐ Develop a national plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity (numbers and competence)
2	☐ Engage trained staff with authority and technical expertise to implement IPC activities, prioritizing based on risk assessment and local care-seeking patterns
	☐ Record, report, and investigate all cases of healthcare-associated infections
	☐ Disseminate IPC guidance for home and community care providers
	☐ Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette
	☐ Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk
3	☐ Monitor IPC and WASH implementation in selected healthcare facilities and public spaces using the Infection Prevention and Control Assessment Framework, the Hand Hygiene Self-Assessment Framework, hand hygiene compliance observation tools, and the WASH Facilities Improvement Tool
	☐ Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources, training
	☐ Carry out training to address any skills and performance deficits
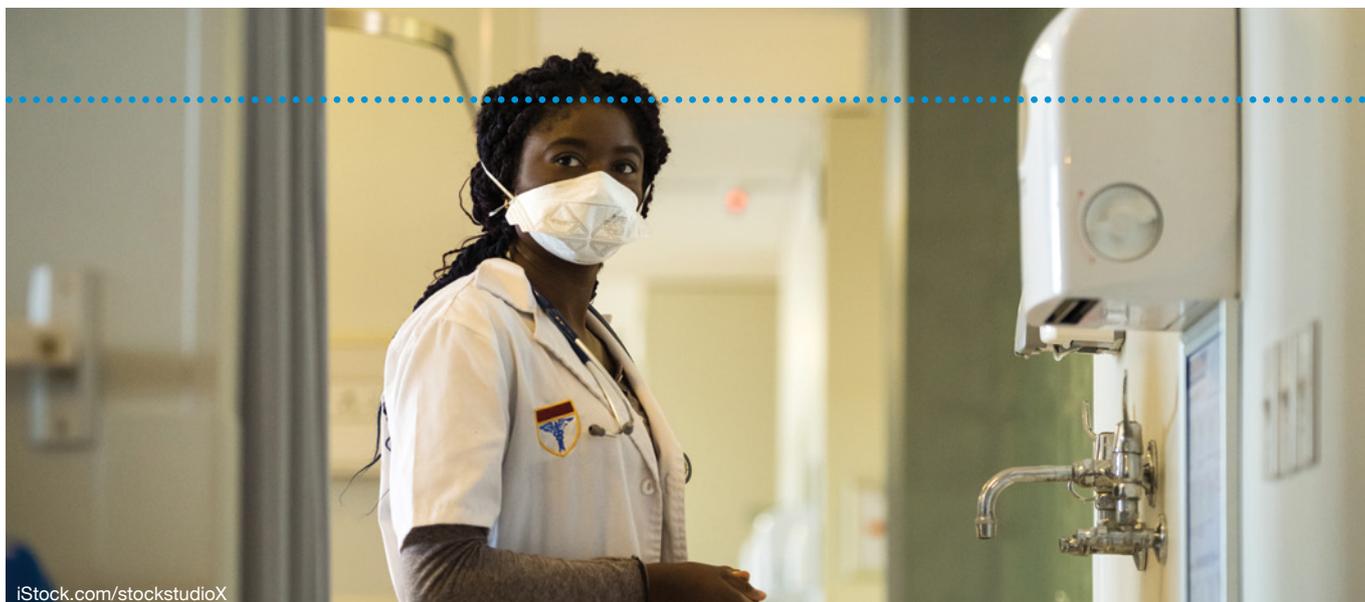
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Pillar 7: Case management

Healthcare facilities should prepare for large increases in the number of suspected cases of COVID-19. Staff should be familiar with the suspected COVID-19 case definition, and able to deliver the appropriate care pathway. Patients with, or at risk of, severe illness should be given priority over mild cases. A high volume of cases will put staff, facilities and supplies under pressure. Guidance should be made available on how to manage mild cases in self-isolation, when appropriate. Plans to provide business continuity and provision of other essential healthcare services should be reviewed. Special considerations and programmes should be implemented for vulnerable populations (elderly, patients with chronic diseases, pregnant and lactating women, and children).

Step	Actions to be taken
1	☐ Map vulnerable populations and public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities that may be used to provide treatment
	☐ Identify Intensive Care Unit capacity
	☐ Continuously assess burden on local health system, and capacity to safely deliver primary healthcare services
	☐ Ensure that guidance is made available for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is recommended
2	☐ Disseminate regularly updated information, train, and refresh medical/ambulatory teams in the management of severe acute respiratory infections and COVID-19-specific protocols based on international standards and WHO clinical guidance; set up triage and screening areas at all healthcare facilities
	☐ Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity
	☐ Ensure comprehensive medical, nutritional, and psycho-social care for those with COVID-19
	☐ Participate in clinical expert network to aid in the clinical characterization of COVID-19 infection, address challenges in clinical care, and foster global collaboration (optional based on country capacity)
3	☐ Prepare to assess diagnostics, therapeutics, and vaccines for compassionate use, clinical trials, regulatory approval, market authorization, and/or post-market surveillance, as appropriate
	☐ Adopt international R&D blueprint guidance and WHO protocols for special studies (companionate use, Monitored Emergency Use of Unregistered and Investigational Interventions) to investigate additional epidemiological, virologic, and clinical characteristics; designate a clinical trial or study sponsor
	☐ Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, immunocompromised), and adjust guidance and/or address implementation gaps as necessary

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Pillar 8: Operational support and logistics

Logistical arrangements to support incident management and operations should be reviewed.
Expedited procedures may be required in key areas (e.g. surge staff deployments, procurement of essential supplies, staff payments).

Step	Actions to be taken
1	☐ Map available resources and supply systems in health and other sectors; conduct in-country inventory review of supplies based on WHO's a) Disease Commodity Package (DCP) and b) COVID-19 patient kit, and develop a central stock reserve for COVID-19 case management
2	☐ Review supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies, including COVID-19 DCP and patient kit reserve in-country
	☐ Review procurement processes (including importation and customs) for medical and other essential supplies, and encourage local sourcing to ensure sustainbility
	☐ Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms
	☐ Prepare staff surge capacity and deployment mechanisms; health advisories (guidelines and SOPs); pre- and post-deployment package (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support, including peer support groups) to ensure staff well-being
3	☐ Identify and support critical functions that must continue during a widespread outbreak of COVID-19 (e.g. water and sanitation; fuel and energy; food; telecommunications/internet; finance; law and order; education; and transportation), necessary resources, and essential workforce

ANNEXES

Annex 1: Key Performance Indicators

Category	Indicator	Target	Rationale for Use
Epidemiology situation	Number of countries with cases	N/A	Basic epidemiological data to understand the scale and evaluate risk of the event. Further analyses and stratification: • Number of confirmed cases worldwide • Number of countries with local transmission • Number of countries with imported cases • % of countries in which there are cases that were not directly associated with travel to areas affected by community spread • % of alerts, suspects or confirmed cases detected at Points of Entry • % deaths reported among reported cases
	% of cases who are healthcare workers	TBD	Useful to strengthen IPC over time. Data might be available if online reporting platforms for data sharing are established. Some caution should be exercised when interpreting data, as some HCWs also be at high risk of community transmission.
Global response – Program management	% CPRP budget funded	80%	Helps to assess the financial support to the global response as per the CPRP.
	% of funds received for the CPRP implemented	100%	Helps to assess the level of implementation of the global response as per the CPRP.
Global response – Supply	Country requesting PPE has received stockpiles	N/A	Focuses on capacity to deploy supplies to countries during the event.
Global response – R&D	Country if eligible is enrolled in clinical trials	N/A	Focuses on country collaboration and can serve to advocate for acceptance of multi-site clinical trials in countries where it was not feasible during the outbreak.
Country readiness – Capacity	Preparedness index & Operational readiness index (Using 18 different indicators from SPAR)	Level 1: <=30 Level 2: <=50% Level 3: <=70% Level 4: <=90% Level 5: > 90%	Demonstrates the level of preparedness and operational readiness based on the implementation of IHR capacities. Indicators are based on objective assessments, not on functional evaluation. Findings should be triangulated with other instruments such as AAR and SimEx.
	Country has activated their public health Emergency Operations Centre or a coordination mechanism for the COVID-19 event	100%	Indicates health system preparedness to manage the event.
	Country has prepared a referral system to care for COVID-19 patients	TBD	Addresses health system readiness. Countries should have designated hospitals for patients.

Annex 1: Key Performance Indicators (continued)

Category	Indicator	Target	Rationale for Use
Country – Surveillance and rapid detection	Country has reported the first COVID-19 case to WHO within 24 hours of confirmation as per IHR requirements	100%	Gauges extent of global collaboration/information-sharing, which is essential to facilitate global risk management.
	For the first 10 suspected cases in a country, percentage of laboratory results available within 72 hours	TBD	Reflects system capacity to rapidly establish testing capacity or access/connect to a laboratory that can test for COVID-19. Can be the basis for longer-term system strengthening.
IPC & Biosafety	% of acute healthcare facilities with triage capacity	80%	In the context of COVID-19, the healthcare facility should have the infrastructure, as well as the standard operating procedures (questionnaires).
	% of acute healthcare facilities with isolation capacity	80%	Isolation capacity: defined as availability of single rooms and/or areas for cohorting. Appropriately equipped with PPE for contact and droplet precautions.
Country – Risk communication and community engagement	Country has reported to have contextualized their risk communication and community engagement strategies	>80%	A reporting mechanism needs to be set up to enable data collection for this potential indicator.
	Number of individuals reached with tailored information (frequency) (% of those that took action — changed course)	TBD	This measure focuses on alternative channels to reach individuals and decision makers in different sectors — travel and tourism, food and agriculture, healthcare workers and business.

ANNEX

Annex 2: Estimated resource requirement to prepare for and respond to cluster of local transmission of up to 100 cases

Expenditure Type	Item Name	Unit Cost (US$)	Quantity	Total (US$)
Country-level coordination				
Setup Cost				
Supplies – International	Satellite communications	12 000	5	60 000
Total				**60 000**
Monthly Cost				
Incentive Payment	Incident management national	800	20	16 000
Service Contract	Car 4x4 (rental)	3000	21	63 000
	Fuel for Car	250	84	21 000
	Mobile phone credit	421	70	29 470
	Office space rental	3500	7	24 500
Staff – International	Incident management international	24 000	4	96 000
Training	Incident management training	800	20	16 000
Total				**265 970**
Risk communications and community engagement				
Monthly Cost				
Incentive Payment	Risk communications national	600	20	12 000
Service Contract	Car 4x4 (rental)	3000	7	21 000
	Communications cost	1500	7	10 500
	Fuel for Car	250	56	14 000
	Risk communication local media	10 000	7	70 000
Staff – International	Risk communication international	24 000	4	96 000
Training	Risk communications training	600	20	12 000
Total				**235 500**

ANNEX

Annex 2: Estimated resource requirement to prepare for and respond to cluster of local transmission of up to 100 cases (continued)

Expenditure Type	Item Name	Unit Cost (US$)	Quantity	Total (US$)
Surveillance				
Monthly Cost				
Incentive Payment	Surveillance national	800	40	32 000
Service Contract	Car 4x4 (rental)	3000	21	63 000
	Fuel for Car	250	84	21 000
Staff – International	Surveillance international	24 000	8	192 000
Training	Surveillance training	800	40	32 000
Total				**340 000**
Case investigation and rapid response				
Monthly Cost				
Incentive Payment	Contact tracer	600	50	30 000
Service Contract	Car 4X4 rental	3000	14	42 000
	Credit for phone	10	105	1 050
	Fuel for Car	250	56	14 000
Staff – International	RRT international	24 000	20	480 000
	RRT national	800	4	3200
Training	Contact tracer training	600	50	30 000
Total				**600 250**
Points of entry				
Setup Cost				
Supplies – International	POE – setup equipment	9000	14	126 000
Total				**126 000**
Monthly Cost				
Incentive Payment	POE national	800	10	8000
Service Contract	Communications and IT	4167	7	29 169
Staff – International	POE international	24 000	2	48 000
Training	POE training	800	10	8000
Total				**93 169**

Annex 2: Estimated resource requirement to prepare for and respond to cluster of local transmission of up to 100 cases (continued)

Expenditure Type	Item Name	Unit Cost (US$)	Quantity	Total (US$)
National laboratory system				
Setup Cost				
Supplies – International	Lab equipment	43 750	5	218 750
Total				**218 750**
Monthly Cost				
Incentive Payment	Laboratories national	800	10	8000
Staff – International	Laboratories international	24 000	1	24 000
Supplies – International	Lab – consumable kit	4750	10	47 500
Supplies – Local	Lab – sample transport kit	50	200	10 000
	Lab – stationery	250	7	1750
Training	Laboratories training	800	10	8000
Total				**99 250**
Case management				
Setup Cost				
Equipment	Case management – setup kit	35 300	10	353 000
Supplies – International	Case management – medical equipment	690 000	1	690 000
Total				**1 043 000**
Monthly Cost				
Incentive Payment	Doctor national	1200	28	33 600
	Nurse national	600	140	84 000
	Support staff national	300	210	63 000
Staff – International	Case management international	24 000	4	96 000
Supplies – International	Case management – medicines	60 000	1	60 000
	Case management – PPE	6500	10	65 000
Training	Doctor training	1200	28	33 600
	Nurse training	600	140	84 000
	Support staff training	300	210	63 000
Total				**582 200**

Annex 2: Estimated resource requirement to prepare for and respond to cluster of local transmission of up to 100 cases (continued)

Expenditure Type	Item Name	Unit Cost (US$)	Quantity	Total (US$)
Infection prevention and control				
Monthly Cost				
Incentive Payment	IPC national	800	40	32 000
Service Contract	Car 4x4 (rental)	3 000	14	42 000
	Fuel for Car	250	56	14 000
Staff – International	IPC international	24 000	4	96 000
Supplies – International	IPC – PPE	22 770	10	227 700
Training	IPC training	800	40	32 000
Total				**443 700**
Logistics and supply management				
Setup Cost				
Supplies – Local	Logistics – setup equipment	5 000	4	20 000
Total				**20 000**
Monthly Cost				
Incentive Payment	Logs national	600	20	12 000
Service Contract	Car 4x4 (rental)	3 000	21	63 000
	Fuel for Car	250	84	21 000
	Security company (warehouse)	3 000	7	21 000
Staff – International	Logs international	24 000	4	96 000
Training	Logs training	600	20	12 000
Total				**225 000**

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