REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

Coronavirus Disease 2019 (COVID-2019) Health Strategic Preparedness and Response Plan

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Lebanon

10 March 2020

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I. Purpose of the Document

This document has been developed to establish a national plan of action to scale up preparedness and response capacities in Lebanon for prevention, early detection, and rapid response to coronavirus disease 2019 (COVID-19) as required under the International Health Regulations (IHR 2005). Using the WHO global 2019 Novel Coronavirus Strategic Preparedness and Response Plan as the foundation, this plan was developed for Lebanon.

II. Background, PHEIC declaration and Situation Analysis

Coronaviruses are zoonotic viruses that circulate amongst animals. Some have been identified in humans, causing illness ranging from mild symptoms to severe illness.

On 31 December 2019, WHO was alerted to several cases of pneumonia of unknown origin in Wuhan City, Hubei Province of China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a new virus as the cause of the pneumonia cluster. The new virus is a coronavirus, belonging to the same family of viruses that cause the common cold, as well as viruses that cause Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). This new virus is currently referred to as the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

Since the first cases were reported, WHO has been working with Chinese authorities and global experts to learn more about the virus, including source of infection, how it spreads, severity, high-risk groups, how best to treat patients, and what countries can do to prepare for and respond to the situation or to the epidemic.

The Emergency Committee on the COVID-19 under the International Health Regulations (IHR 2005) was first convened on 22-23 January, and subsequently reconvened on 30 January 2020. The Director General of WHO declared the COVID-19 outbreak to be a public health emergency of international concern (PHEIC) after the second meeting. The Emergency Committee has provided recommendations to WHO, to the People's Republic of China, to all countries, and to the global community, on measures to control this outbreak. The Committee believes that it is still possible to interrupt virus spread, provided that countries establish strong measures to detect disease early, isolate and treat cases, trace contacts, and promote social distancing measures commensurate with risk.

As of 1 March 2020, the total number of reported confirmed cases of COVID-19 stood at 87,161 cases reported from 60 countries and 2980 associated deaths (CFR 3.4%). Of the total number of confirmed cases, 79,968 were reported from China, 3,736 from Republic of Korea, 1,128 from Italy, and 593 from Iran. The number of confirmed/suspected cases and affected countries continues to rise.

Most cases of COVID-19 are mild in nature, but some have progressed to severe illness and death. Human-to-human transmission has been confirmed in many of the affected countries. There is not enough information about the epidemiological profile of COVID-19 to draw definitive conclusions about the full clinical features of disease, the intensity of the human-to-human transmission, and the original source of the outbreak. However, WHO is working closely with affected countries to compile more epidemiological data to answer the unknown questions.

Given high volumes of domestic and international travel both to and from affected countries and the observed human to human transmission, it is not unexpected that new confirmed cases will continue to appear in other areas and countries. With the information currently available for the novel coronavirus, WHO advises that measures to limit the risk of exportation or importation of the disease should be implemented without unnecessary restrictions of international traffic and trade.

CoVID 19 is transmitted by droplet, from an infected person. It can remain infective up to several days on inert material. The main mode of prevention remains: distancing at least 1.5 meters from an infected person, frequent hand hygiene and cough etiquette practices. Based on the current data, one person infects on average 4 persons, and the mortality is around 3%

a. Situation in the WHO Eastern Mediterranean Region

Regional health system context

Almost two-thirds of the Region's countries are experiencing directly or indirectly complex emergencies, with fragile health systems, weak disease surveillance, poor response capacities, and a sub-optimal level of public health preparedness – all factors making them particularly vulnerable to any emerging infectious diseases. Major religious mass gatherings are taking place in the region which pose unique risks to public health security.

Detecting and responding to emerging infectious diseases have become an important public health priority for Eastern Mediterranean Region. Majority of the countries in the region have adequate influenza and other respiratory disease surveillance system through extended network of sentinel sites. 20 out of the 22 countries in the region have functioning reference laboratories with the ability to detect and confirm seasonal influenza virus, MERS-CoV and other high threat pathogens. Furthermore, all countries in the region have trained national multidisciplinary rapid response teams for timely investigation and response to any public health threat. Countries with complex emergencies in the region have functioning early warning surveillance system with the ability to detect epidemic-prone diseases. Therefore, its important to leverage the existing respiratory disease surveillance and laboratory capacities for the current surveillance and investigation and response to COVID-19 outbreak.

Regional epidemiological context

The epidemiology of the region is constantly changing. As of march 1 2020, 11 countries in the WHO Eastern Mediterranean Region (EMR) have reported COVID-19 cases. A total of 1,122 laboratory confirmed cases, of which 978 are from Iran, have been reported in the EMR.. All death in the region totaling 54, have been reported from Iran.

Due to the global nature of travel, it is expected that further cases of COVID-19 may appear in other countries in the Region. EMRO dashboard can be accessed on:

https://app.powerbi.com/view?r=eyJrIjoiN2ExNWI3ZGQtZDk3My00YzE2LWFjYmQtNGMwZjk0OWQ1MjFhIiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9

Number of countries in the region have taken steps to repatriate their citizens from Wuhan or other cities affected by the outbreak, and those repatriated nationals were isolated for 14 days. WHO/EMRO has developed an interim guidance to countries for evacuation and quarantine of travelers returning from China. Thus far, WHO recommends no restrictions on travel and trade while some countries in the Region decided to take restrictive measures at Points of Entries, including suspension of flight coming from/to China, South Korea, Italy, and Iran. Such restrictive legal enforcements are currently considered and decided by each state.

III. COVID-19 Risk Analysis

a. Overall Risks

As of 28 February, WHO assessed the COVID-19 risk to be very high for China, very high at the regional level, and very high at the global level.
Sitrep: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200228-sitrep-39-covid-19.pdf?sfvrsn=5bbf3e7d_2

Overall Risk		
China	**Regional**	**Global**
Very High	Very High	Very High

This assessment takes into consideration:

- ***High likelihood of further spread:*** Human-to-human transmission, including transmission within healthcare settings, has been confirmed within Wuhan and cities outside of China. The outbreak continues to grow within China at a rapid rate. In addition, 7193 confirmed cases have been

reported by 59 countries outside China as of 1 March 2020. Local transmission has been confirmed in many countries other than China.

- ***Potential impact on human health:*** The virus can cause severe illness and death. However, many uncertainties remain, including the full extent of the current outbreak within China, and the full clinical spectrum of illness.
- ***Effectiveness of current preparedness and response measures:*** Until now, countries that have reported an imported case have demonstrated efficient and effective disease surveillance and response measures. Many countries that are yet to report a case have also demonstrated effective surveillance measures to date, through rapid testing and isolation of suspected cases. However, of great concern are countries that are less prepared to detect and respond to an imported case.

b. **Risk Analysis in Lebanon**

Lebanon has been strengthening and maintaining its national capacities required under the International Health Regulations (IHR 2005). Lebanon has conducted the Joint External Evaluation (JEE) and developed national action plans for health security to meet their core capacity requirements under the IHR. The following JEE technical areas were used for measuring capacity; (1) IHR coordination, (2) Infection prevention and control, (3) Laboratory and Biosecurity / Biosafety, (4) Surveillance, (5) Reporting, (6) Preparedness, (7) Emergency Response, (8) Risk Communications, and (9) Points of Entry. All the countries of the region scored between 2/5 and 5/5. Lebanon preparedness and readiness relatively good, scoring 4/5.

Lebanon's geographic location makes it a busy hub for travel to and from all the world. Although it does not have direct flights with China, the initial epicenter for the outbreak, it does have direct fights to most regional countries, and to all Europe. Based on the epidemiologic data, the first case of COVID 19 was imported to Lebanon through travelers coming back from Iran/ Qom, believed to be the epicenter in Iran. The first case was confirmed on 21 February 2020; a Lebanese women who was aboard a plane coming from Iran. Until March 1, 2020: A total of 231 people were tested at RHUH, with results being 221 negatives and 10 positives. 8 of the COVID-19 cases had travel history to Qom city in Iran, while 2 had direct contact with persons who have been to Iran. Local transmission is confirmed but remains limited to these 2 cases.

Taking into consideration the mode of transmission, the risk of exposure, the readiness of the health system, as well as the likelihood and the severity of the impact of a local outbreak, the risk of local transmission and spanning outbreak in Lebanon is high.

IV. Preparedness and response interventions based on Transmission Scenarios

Through this plan, the MOH will closely work with the relevant authorities and other partners to build strong capacity to prevent, prepare, detect and respond to any potential COVID-19 outbreak. This plan will address the existing capacity gaps related to the prevention, preparedness, detection and response for emerging infectious diseases.

The overall goal of the national preparedness and response plan is to strengthen surveillance and response for COVID-19 infection to early detect any imported case, rapidly contain local transmission and mitigate the health impact of the outbreak in Lebanon.

WHO has defined 4 transmission scenarios for COVID-19:
1. Countries with no cases (No Cases);
2. Countries with 1 or more cases, imported or locally detected (Sporadic Cases);
3. Countries experiencing cases clusters in time, geographic location and/or common exposure (Clusters of cases);
4. Countries experiencing larger outbreaks of local transmission (Community transmission).

I. Preparedness Measures for Scenario 1

The main measures that were implemented in Lebanon before the 21st of February when no COVID-19 cases were detected yet included:

- Awareness raising activities, development and dissemination of IEC material
- Intensive dissemination of risk communication and community engagement messages
- Screening at POEs of travellers coming from outbreak countries
- Ensuring a functional surveillance system with clear SOPs for case detection and confirmation

II. Outbreak Containment Measures for Scenarios 2 and 3

The transmission scenario that we are currently witnessing remains contained. The cases reported have been imported by exposure from a country with local transmission or through contact with infected household member.

The main measures to be taken include:

- Intensive risk communication and community engagement
- At POE, screening travellers coming from outbreak countries
- Ensuring a functional surveillance system with clear SOPs for case detection and confirmation
- Ensuring patient care and quarantine facilities with clear SOPs for patient referral
- Ensuring adequate reference diagnostic lab capacity, with standard safety and quality SOPs.
- Provision of PPEs at health facility level
- National coordination mechanisms established
- Assessment of capacities and gaps for potential local spread and outbreak explosion

III. Outbreak Mitigation Measures for Scenario 4

In case of an outbreak and based on the current available epidemiological data, the following is estimated: for a population of 6 million, approximately 600 thousand persons (10%) will contract symptomatic infection, over a period of 2-3 months. Of these cases, 90,000 (15%) will seek healthcare, out of which 18,000 (20%) would require hospital admission and 2,700 (3%) would be admitted to the intensive care unit. The death toll is estimated at a maximum of 1,800, 2% of those seeking healthcare. A pandemic that lasts eight weeks and has an attack rate of 10% will require at its peaks (4th and 5th week), to use 61% of the ICUs in all the Lebanese territories and around 36% of the hospital beds.

- Awareness raising activities should continue and be reinforced
- Surveillance activities should be maintained
- Risk communication and community engagement activities should continue
- IPC programs should be rigorously implemented especially in all hospitals and health facilities
- Designation of additional referral hospitals
- Development of new SOPs for patient diagnosis and referral and home care
- Develop protocols for quarantine (self-quarantine, isolation canters etc)
- Ensure sufficient stock of PPEs with focus on the health care workers
- Support referral laboratories by MOPH and partners with the needed testing kits and PPEs.

V. Areas of work and priority actions

i. Partnership and coordination

a. Establishment of the national COVID19 Task Force to mobilize resources and monitor country level activities to facilitate coordination with relevant ministries

b. Strengthen multi-sectoral coordination, as well as coordination with WHO local office, by sharing updated information and contingency planning
c. Conduct quick mapping of human resource needs for the implementation of the national plan
d. Set up and activate Emergency Operation Centers (EOC) at national and sub-national levels to better coordinate the response
e. Coordination of activities of all health and relevant non-health partners
f. Establish and maintain the COVID19 national platform for national data collection, provide appropriate support or guidance, and closed-loop communication of answers in timely manner
g. Coordinate between relevant stakeholders (including the National CD Committee) to support priority research activities in order to close knowledge gaps

ii. Points of Entry and IHR (2005)

a. Establishment of multi-sector POE contingency plans and establishment of referral protocols from POE to designated health facilities
b. Provide guidance regarding issues of travel and trade based on current public health advice
c. Coordinate provision of needed technical support for related IHR capacities
d. Provide and update overview of global traffic/trends in regard to COVID-19 and the EMR, as well as specific capacities at PoE
e. Share technical guidance related to IHR capacities
f. Provide targeted technical support/assessment to specific PoE (Beirut Rafic Hariri International Airport, Sea ports, and Border Crossing Points)
g. Organize trainings for health and non-health authorities at POEs

iii. Health Information Management

a. Disseminate standard case definitions, case investigation and follow up for active surveillance of COVID-19 to all surveillance sites (Health Facilities, Lebanese Order of Physicians, Syndicate of Hospitals, Order of Nursing…)
b. Collect daily information relevant to COVID-19 through social media, local newspapers, community (event-based surveillance)
c. Establish active case finding
d. Ensure that national surveillance system covers laboratories, health facilities in public and private sector, points of entry, and other relevant health providers with a direct line of communication with the national IHR Focal point
e. Ensure timely notification of confirmed and probable cases to WHO (within 24 hours of identification), as well as reporting of suspected cases of COVID-19 preferably through EMFLU or using WHO interim case reporting form.
f. Enhance/establish existing acute respiration infection surveillance system, as needed, including indicator-based surveillance, event-based surveillance, and sentinel surveillance
g. Develop dashboards, repositories and situation reports (as needed)
h. Provide information required to guide all aspects of the operations – including communications, risk and needs assessment, priority setting, planning, information management, health operations and health logistics
i. Produce and disseminate daily briefing and weekly updates to all levels

iv. Case management

a. Ensure healthcare service continuity (facilities, personnel, medicines, supplies, medical devices) and surge plans including establishment of a referral system to designated hospitals.
b. Provide case management technical expertise and guidance to health facilities in Lebanon
c. Provide trainings on healthcare/ambulatory teams in the management of COVID-19 cases, Infection control, PPE donning and doffing …
d. Facilitate implementation of international/WHO protocols for research/clinical trials at country level if there are opportunities

v. Infection Prevention and Control (IPC)

a. Provide IPC technical expertise and guidance to Health facilities when needed, particularly regarding triage, early recognition, standard precautions, isolation procedures, and referral mechanisms in line

with WHO guidelines

b. Organize refresher trainings on IPC and capacity building for all health facilities

vi. Rapid Response Teams (RRTs)

a. Establish multidisciplinary rapid response teams (RRTs) and ensure the RRTs are in place at national and subnational levels
b. Ensure the mechanism of activation and deployment of national RRTs is in place
c. Conduct refresher trainings among national RRT teams in case management, specimen collection and transport, contact tracing, decontamination, investigation, social mobilization and safe and dignified burials.
d. Ensure RRTs are trained and equipped to investigate suspected cases, especially regarding the provision of appropriate investigation protocols and case definitions, systems for contact tracing, and surveillance mechanisms as outlined
e. Coordinate with WHO local office for collaboration on outbreak investigation and response
f. Organize field-based simulation exercise to ensure the functionality of RRTs.

vii. Laboratory diagnostics

a. Establish and sustain laboratory confirmatory capacity for COVID-19 (at RHUH and other designated hospitals at mohafaza level)
b. Adapt and disseminate SOPs for specimen collection, management and transportation for COVID-19 diagnostic testing
c. Strengthen national diagnostic capacity through in-service training and mentoring among lab technicians.
d. Ensure availability of testing kits and other essential supplies at the national reference laboratory at RHUH and at laboratories of designated hospitals at mohafaza level.
e. Build capacity for collection, storage and transportation of samples and establish a process for shipment of specimens to international reference laboratories when needed.
f. Establish surge plans in to be used in times of increased testing demands

viii. Risk communication and community engagement

a. Develop and implement national emergency risk communication and community engagement strategies for COVID-19
b. Identify and designate media spokesperson(s) at the national level and organize regular interviews with traditional and non-traditional media organizations
c. Ensure timely and credible information is made available to the public, health professionals and other key audiences in appropriate formats through different accessible platforms addressing different audiences including the general public
d. Disseminate press releases regularly highlighting the latest situation and national response
e. Hold press briefings to raise media awareness on the latest situation, address media queries and ensure media are aware of correct facts and information.
f. Reinforce national rumour and misinformation detection and management mechanisms
g. Update regularly the covid-19 page of the MOH website
h. Develop and disseminate Information, education and communication materials in coordination with concerned stakeholders (UN agencies, NGOs, Scientific Communities, Syndicates etc)

ix. Operations support and logistics

a. Consolidate requests and share with the PMO's national committee for quantification and prioritization
b. Survey for IPC and Laboratory Reagent stocks available and identify gaps
c. Develop a list of items needed for resupply or procurement (National and subnational, POE…)

x. Programme Management

a. Allocate funds for the execution of the National plan in collaboration with WHO country office
b. Manage and support financial allocation for all operating costs

c. Support fast track procurement requests

V. Operationalizing the plan

Implementation of this plan will require significant and extensive coordination and collaboration which includes but is not limited to national technical meetings, and workshops between health authorities and other partners and ministries.

VI. Monitoring and evaluation

Monitoring and evaluation of the national preparedness and response will be conducted at regular intervals by the MOH. **Key performance and impact indicators can be used to monitor and evaluate the implementation of the planned activities**, as well as to assess the overall performance of the programme, derive evidence & lessons learnt to correct and adjust the program and operations. A progress report will be generated and shared regularly with the national committee highlighting the progress and level of operational readiness, the strengths, weakness, gaps and recommendations on how to address the challenges.

Monitoring framework

Type	Indicator	Target containment scenario	Target mitigation scenario
Point of entry and IHR	Number of POE that have capacity to detect suspected/confirmed cases	3	0
	Number of POE that have isolation	4	0
Health Information Management	% of HCF where surveillance guidelines are disseminated to healthcare workers including private sector	100%	100%
Case management	Public designated hospitals to treat COVID-19 cases	1	5
	%Nb of Hospitals where case management were disseminated	100%	100%
Infection Prevention and Control	% of acute healthcare facilities with triage capacity	50%%	100%
	% of acute healthcare facilities with isolation capacity	5%	100%
Rapid Response Teams	Nb trained multidisciplinary rapid response teams at mohafaza level	4	4
	% of hospitals that have adequate supplies including PPEs	100%	100%
	% of alerts have been verified and investigated within 48 hours	100%	100%
Laboratory diagnostics	Nb of laboratory that can provide results within 72 hours	1?	5
	Number of national reference laboratories with capacity to test COVID-19	1	1
	Number of national laboratories with trained laboratory technicians on COVID-19 testing	1	5

	Number of national reference laboratories reporting virological data through EMFLU or FluNet	1	5
Risk communication and community engagement	Presence of health communication plan that was updated according to the new situation	1	1
	frequency of media interviews and press release in different languages	daily	Weekly
Operations support and logistics	Number of hospitals experiencing stock-outs of critical items	0	0
	Number of labs receiving IPC medical supplies and laboratory reagents in response to COVID-19	1	5
Programme Management	% of surge deployment resources from the external and internal rosters of experts	0%	TBD

VII. Timeline

Timeline

Areas of work	Activities	Timeline
1. Partnership and Coordination	a. Establishment of a National COVID19 technical committee to mobilize resources and monitor country level activities to facilitate coordination with relevant authorities, ministries and WHO country office b. Strengthen multi-sectoral coordination, by sharing updated information and contingency planning for joint actions c. Coordinate and collaborate with WHO country office to cover gaps in preparedness and response as the outbreak evolves in order to complete and implement the national preparedness and response plan for COVID-19 d. Conduct quick mapping of human resource needs for the implementation of the national plan e. Set up and activate Emergency Operation Centers (EOC) at national and sub-national levels to better coordinate the response f. Support and guide the coordination of activities of all health and relevant non-health partners g. Establish and maintain the national platform to provide appropriate support or guidance, and closed-loop communication of answers in timely manner h. Coordinate between relevant stakeholders to support priority research activities in order to close knowledge gaps	Ongoing
2. Point of entry (PoE) and IHR	a. Provide technical expertise to inform operations for IHR and PoE issues, including guidance on establishing multi-sector PoE contingency plans and establishment of referral protocols from PoE to designated health facilities b. Provide guidance regarding issues of travel and trade based on current public health advice and in alignment with global strategy c. Coordinate provision of needed technical support for related IHR capacities d. Provide and update overview of global traffic/trends in regards to COVID-19, as well as specific capacities at PoE e. Share technical guidance related to IHR capacities f. Provide targeted technical support/assessment to specific PoE	Feb - April

Areas of work	Activities	Timeline
3. Surveillance and reporting systems	a. Disseminate standard case definitions, case investigation and follow up for active surveillance of COVID-19 to all surveillance sites b. Collect daily information relevant to COVID-19 through social media, local newspapers, community (event-based surveillance) c. Establish active case finding d. Ensure national surveillance systems cover laboratory, private sector, points of entry, and other relevant health providers with direct line of communication with the national IHR Focal point e. Ensure timely notification of confirmed and probable cases to WHO (within 24 hours of identification), as well as reporting of suspected cases of COVID-19 preferably through EMFLU or in using WHO interim case reporting form. f. Enhance/establish existing acute respiration infection surveillance system, as needed, including indicator-based surveillance, event-based surveillance, and sentinel surveillance g. Keep national and subnational country levels informed on the evolution of the outbreak in the region h. Develop dashboards, repositories and situation reports i. Provide information required to guide all aspects of the operations – including communications, risk and needs assessment, priority setting, planning, information management, health operations and health logistics j. Monitor available research, knowledge and product development to inform the operations k. Produce and disseminate daily briefing and weekly updates to national and subnational levels	Ongoing
4. Case Management	a. Ensure healthcare service continuity (facilities, personnel, medicines, supplies, medical devices) and surge plans including establishment of a referral system b. Provide case management technical expertise and guidance to health facilities c. Provide trainings on healthcare/ambulatory teams in the management of COVID-19 cases d. Coordinate with stakeholders (National CD Committee) to address unknown about clinical characterization, challenges in clinical care and collaboration to innovate and problem solve together e. Facilitate implementation of international/WHO protocols for research/clinical trials at country level if there are opportunities	Ongoing
5. Infection Prevention and Control (IPC)	a. Provide IPC technical training and guidance to Health facilities when needed, particularly regarding triage, early recognition, standard precautions, isolation procedures, and referral mechanisms in line with WHO guidelines b. Share up-to-date interim WHO IPC guidance documents with HC professionals c. Provide IPC training and capacity building if at national and subnational levels if needed d. Strengthen triage and isolation capacity in referral hospital(s)	February- April

Areas of work	Activities	Timeline
6. Rapid Response Teams (RRTs)	a. Coordinate with Mohafaza and caza physicians to activate/reactivate the multidisciplinary rapid response teams (RRTs) and ensure the RRTs are in place at national and subnational levels b. Ensure the mechanism of activation and deployment of national RRTs is in place c. Conduct refresher trainings among national RRT teams in case management, specimen collection and transport, contact tracing, decontamination, investigation, social mobilization and safe and dignified burials. d. Provide technical guidance to ensure RRTs are trained and equipped to investigate suspected cases, especially regarding the provision of appropriate investigation protocols and case definitions, systems for contact tracing, and surveillance mechanisms as outlined e. Coordinate with WHO country office for any international collaboration on outbreak investigation and response f. Organize field-based simulation exercise to ensure the functionality of RRTs.	March-May
7. Laboratory diagnostics	a. Support reference lab to establish and sustain laboratory confirmatory capacity for COVID-19 b. Adapt and disseminate SOPs for specimen collection, management and transportation for COVID-19 diagnostic testing c. Provide technical assistance to strengthen national diagnostic capacity through in-service training and mentoring among lab technicians. d. Ensure availability of testing kits and other essential supplies in national reference laboratories. e. Establish access to a designated international COVID-19 reference laboratories f. Build capacity for collection, storage and transportation of samples and establish a process for shipment of specimens to international reference laboratories until national capacity can be established. g. Establish surge plans in to be used in times of increased testing demands	Ongoing
8. Risk communication and community engagement	a. Provide support to develop and implement national emergency risk communication and community engagement strategies and/or action plans for COVID-19 b. Identify and designate media spokesperson(s) at national and subnational levels and organize regular interviews with traditional and non-traditional media organizations c. Support timely and credible information is made available to the public, health professionals and other key audiences in appropriate formats through different accessible platforms addressing different audiences including vulnerable populations d. Disseminate press releases regularly highlighting the latest situation and national response e. Hold press briefings to raise media awareness on the latest situation, address media queries and ensure media are aware of correct facts and information. f. Reinforce national and subnational rumour and misinformation detection and management mechanisms g. Update regularly the nCoV info and the MOPH website	Ongoing

Areas of work	Activities	Timeline
	h. Conduct regional traditional and social media surveillance for listening and understanding perception of target audience and provide technical support to subnational levels i. Develop and disseminate Information, education and communication materials	
9. Operations support and logistics	National Level a. Consolidate requests and share for quantification and prioritization b. Survey for IPC and Laboratory Reagent stocks available and identify gaps c. Develop a list of items needed for resupply or procurement Subnational a. Receive, inspect, consolidate, kit, and dispatch emergency medical supplies b. Report on available supplies and dispatches completed c. Liaise with the central level to monitor and report on global supply availability and forecast (request for new supplies) d. Monitors and reports on supply chain disruptions or blockages	Ongoing
10. Programme Management	a. Support referral hospitals with resource allocation and management b. Ensure budget monitoring of the allocated funds with WHO country office and the National nCov technical and ministerial committees c. Manage and support financial allocation for all operating costs d. Support the surge deployment resources from the private sector and public sector rosters of experts e. Support fast track procurement request for national and subnational health facilities	Ongoing

Annexes

Annex 1_surveillance documents and forms in attached zipped folder:

- Case Definition
- Hospital Reporting Form
- Specimen collection
- Laboratory request form
- Call center
- Caller form
- Patient and data flow
- The First Few X (FFX) Cases and contact investigation protocol
- Household transmission investigation protocol

Annex 2_laboratory documents and forms in attached zipped folder:

- Receiving and processing samples suspected for COVID-19
- Instructions of donning and removing of PPEs using gown
- Instructions on donning and doffing of PPEs using coverall
- Real time RT PCR
- Receiving and processing samples suspected for COVID-19
- Sequence of donning PPE audit checklist
- Sequence of removing PPE audit checklist
- Sequence of removing PPE using coverall audit checklist
- Specimen collection and handling guidelines of suspected novel coronavirus
- Recommendations for sample transportation
- Waste management of contaminated materials
- Reception of samples suspected of novel coronavirus

Annex 3_Self Isolation guidelines

English	Arabic
Self-Isolation **Upon your return from an affected country, or in case you had close contact with a suspected or confirmed COVID-19 case, you need to self-isolate for 14 days even if you do not have any symptoms** **From the airport to your house:** • Wear a facemask before you exit the plane • Do not hug and kiss any of your friends or family receiving you at the airport • Use a private car to drive home • One of the plane passengers should drive the car • Leave car windows open • Go directly to your house or to the place where you will self-isolate **At your house:** • Stay home; in your room, your apartment, or your house. Do not go to work, classes, athletic events, or other religious or social gatherings until 14 days after the date of your departure from the affected country. • Stay in a well-ventilated room with a window that can be opened, separate from other people in your home. Keep the door closed • Ask friends, family members or delivery services to carry out errands for you – such as getting groceries, medications or other shopping • Wash your hands. This should be done often and thoroughly with soap and water, for at least 20 seconds, rinse and dry thoroughly. Avoid touching your eyes, nose, and mouth with unwashed hands. • Do not invite or allow visitors to enter. If it urgent to speak to someone who is not a member of your household, do this over the phone. • It is important that you separate yourself from other people in your home and if you share facilities like toilets and bathrooms, regular cleaning will be required. • Ensure you use separate towels from other household members, both for drying yourself after bathing or showering and for hand hygiene purposes. • Do not share drinking glasses, towels, eating utensils, bedding, or any other items until you are no longer asked to self-isolate. • All waste that has been in contact with the individual, including used tissues, and masks if used, should be put in a plastic rubbish bag and tied when full. The plastic bag should then be placed in a second bin bag and tied.	**العزل المنزلي** **في حال العودة من أحد الأماكن الموبوءة من دون عوارض يجب إتباع هذه التعليمات لمدة 14 يوم** **الإنتقال إلى المنزل:** **منذ لحظة الوصول إلى مطار بيروت الدولي:** • **استعمال القناع الجديد من لحظة الخروج من الطائرة.** • **عدم الاختلاط أو تقبيل أوالسلام على الأهل والمستقبلين.** • **الصعود في سيارة خاصة.** • **يقود السيارة أحد القادمين على متن الطائرة.** • **ترك نوافذ السيارة مفتوحة.** • **التوجه مباشرة إلى المنزل أو مكان العزل الفردي.** **العزل في المنزل:** • **البقاء في المنزل لمدة 14 يوماً، وعدم الذهاب إلى العمل أو المدرسة أو الأماكن العامة الأخرى أو المناسبات الاجتماعية.** • **يجب البقاء في غرفة جيدة التهوئة مع نافذة يمكن أن تكون مفتوحة، منفصلة عن الآخرين في المنزل.** • **لشراء طعام أو دواء - أطلب من الأصدقاء أو أفراد الأسرة أو السائقين توصيل المواد عند باب منزلك أو غرفتك.** • **إغسل يديك كثيراً باستخدام الصابون والماء لمدة 20 ثانية على الأقل.** • **يجب أن لا تدعو الزوار.** • **يجب أن يكون لديك حمام أو مرحاض منفصل.** • **يجب وضع نفاياتك في كيس من القمامة البلاستيكية، ثم ربطها في كيس آخر.** • **لا تشارك الأكواب أو أدوات الأكل أو المناشف أو أغطية السرير.**

Annex 4_ Interventions Implemented So Far in Lebanon

	What is already done	In progress	Partners to MOPH
coordination	-a National Crisis Multi- Ministerial committee is established -National inter- ministerial crisis Task force is established -a standing National Infectious Diseases Committee is activated -the MOPH IHR team activated	-More active engagement of non-health stakeholders (Crisis response funding, self-quarantine monitoring, points of Entry screening)	WHO, UNCT, OCHA, DRM
Points of entry	-Written SOPs for travelers screening -Updated travelers screening form -Awareness roll ups and brochures -PPEs for airport and land crossing health and security staff -PM decision regarding measures at Airport -Surged additional staff for screening travelers (9 RNs by WHO, 3 MDs volunteers) -Repurposed 23 RNs (UNICEF)for land crossings -Training Land crossing health and security staff	-Stock piling of PPEs for all POE -More political commitment for implementation of prevention measures	WHO, Unicef, ministry of public works, academic institutions, professional orders
surveillance	-Case definitions updated	-Logistics support (drivers for coordination in all mohafazas of surveillance activities)	WHO, heath societies: infectious diseases,

	-Team trained and equipped -Call center activated -Case investigation SOPs updated -Contact tracing and referral SOPs updated -FFX invetsigation	-Human resources for call center, and patient and contact tracing and investigation -PPEs	epidemiology, pulmonary; academic institutions, professional orders and syndicates
Diagnosis and treatment	-Reference Lab at RHUH fully and safely equipped for testing -4 isolation rooms, 128 beds dedicated, additional 64 beds under preparation at RHUH -Stock of PPEs for one month at RHUH -Guidelines for testing, referral, case management and IPC disseminated to all health professionals, and to UN medical team (ESCWA and UNIFIL) -assessment of 5 public hospitals for potential patient referral	-Securing sufficient quantities of reagents and primers and lab supplies at reference lab -Update all hospitals contingency plans -Designate and upgrade referral hospitals in each mohafaza -Clarify role of private sector in crisis response and case management -ensure a national contingency stock of advanced PPEs for hospital case management	WHO, heath societies: infectious diseases, epidemiology, pulmonary; academic institutions, professional orders and syndicates
Risk communication	-Awareness brochures for general public and travelers -TV radio and social media interviews -Daily sitrep by WHO, periodical preparedness briefs -Sensitization meeting to Scientific societies at order of physicians -Community volunteers (NGOs and LEMSIC) for	-Media support staff at MOPH for daily communication and updates -More community sensitization and active engagement	WHO, UNICEF, UNCT, RCO, Media, ministry of Information, DRM.

	awareness raising		