FSM COVID-19 Response Framework

COVID-19 CONTINGENCY PLAN FOR FEDERATED STATES OF MICRONESIA

Last Updated: April 3, 2020

1 This Plan

As a "Whole of Government" response, this Plan guides the work the Federated States of Micronesia (FSM) is carrying out to mitigate the impact excepted from COVID-19. In addition, this Plan is to assist members of the FSM President's COVID-19 Task Force and members of the Department of Health and Social Affairs Incident Command System in supporting the FSM states to have the capacities and resources in responding to COVID-19. After all, the FSM States have the mandates of providing direct healthcare, maintaining and operating healthcare hospitals, facilities, and clinics, and ensuring that the needed health workforce is available.

The response plan uses a flexible, scaled approach which guides the activities at the National and State level to minimize the impact of COVID-19 on the FSM population. Public health responses will change depending on the 'Readiness Condition' – Condition 5: 'All clear', Condition 4: Zero cases but COVID-19 threat exists, Condition 3: 1-10 cases, Condition 2: >10-100 cases, Condition 1: >100 cases (widespread transmission on main island, Condition 1b: >100 cases (widespread transmission throughout FSM/State).

The Plan describes in detail the different response measures that will be implemented throughout the outbreak and recovery.

Condition 4: Zero cases but COVID-19 threat exists
• Establish ICS health structure and link with Disaster Taskforce • Open COVID-19 Command Centre. Daily DEOC meetings. Weekly situation report (sitrep) • Set up a triage screening station, included signs at Emergency Room and outpatients • Identify alternative locations for routine outpatient care. Establish 1st wave medical care team (RNs/MDs) for COVID-19 patients. Consider how to surge hospital staff. • Ensure adequate resources and training – IPC, human resources, medical supplies • Implement risk communication, focusing on awareness and prevention • Continue routine surveillance, POE, establish SARI screening, develop daily sitrep template • Identify and establish isolation and quarantine facilities, and plan how to manage these • Support POE activities around travel restrictions
Condition 3: 1-10 cases (FIRST CASES)
• Daily meeting of DEOC. Daily sitrep to stakeholders • Ensure separate triage area at hospital or open COVID-19 clinic. Activate 1st wave of RNs/MDs • IMMEDIATELY start contact tracing (Day 1, first suspected case) – close and casual contacts • Quarantine or self-isolation of contacts of suspected cases • Strengthen risk communication activities, focusing on social distancing, hand and respiratory hygiene, addressing rumors and misinformation, partnership with all sectors • Continue surveillance activities (routine ILI, SARI surveillance, numbers hospitalized, confirmed cases, numbers in quarantine/self-isolation). Test those meeting case definition • Mitigate transmission through social distancing measures – consider telemedicine, school closures, reduced social activities, limit sporting events, limit church gatherings etc. • Build more hand-washing stations at hospital, clinics, schools, main town, villages
Condition 2: >10-100 cases
• Daily meeting of DEOC team. Daily situation report to stakeholders • Cease contact tracing if more than 10 cases or 100 close contacts. • Consider ceasing mandated quarantine and encourage self-isolation/home quarantine • Cease POE screening • Strengthen social distancing measures. Sick people should not go to work • Risk communication and outreach - focus on what we know/don't know/what we're doing/what you can do, social distancing, home quarantine, hand and respiratory hygiene • Open overflow areas/tents in hospital for ill cases. Activate 2nd wave of RNs/MDs. Employ student nurses for surge. Use alternative venues for routine outpatient care. Implement telemedicine • Mildly sick people should not be hospitalized. Consider cohorting mildly sick people in external venue (i.e. gymnasium) or home-based care • Surveillance – routine ILI, report on suspected and confirmed cases, SARI cases, severe cases, deaths (hospital and community), sick HCW. Test those meeting case definition • Repurpose staff from other government departments to help with response
Condition 1: >100 cases
• Daily meeting of DEOC team. Daily then weekly sitreps if outbreak continues >2 months • Continue social distancing strategies • Cease quarantine • Encourage self-isolation/homecare of mildly sick patients • Focus risk communication on reassurance, self-help measures, social distancing • Review hospital capacity. Consider opening additional overflow areas/tents in hospital. Use alternative venues for routine outpatient care and medication resupplies • Surveillance – routine ILI, cases meeting clinical definition, SARI cases, severe cases, deaths (hospital and community), sick HCW. Test all SARI cases and commence sentinel testing • Plan for return to business-as-usual

Table of Contents

2 BACKGROUND

2.1 Country profile

The Federated States of Micronesia (FSM) is a sovereign nation with a Compact of Free Association with the United States Government that went into effect in 1986. The national capital is Palikir located in Pohnpei State. In 1991, FSM became a member of the United Nations.

FSM is made up of 607 small islands in the Western Pacific about 2,500 miles southwest of Hawaii and northeast of Australia. Though the country's total land mass is about 271 sq. miles, it spans over one million sq. miles of the Pacific Ocean. It is divided into 4 States: Kosrae (from the east), Pohnpei, Chuuk and Yap (to west). Each State, except Kosrae, has groups of outer islands and atolls. There are more eight languages spoken in the country; however, English is spoken and understood by many and is used as working language in the government. According to the latest FSM Census, the population in 2010 was 102,843. Absent a 2020 Census and based on past projection, the population of the FSM in 2020 is 115,023.[1]

2.2 COVID-19

Coronaviruses are a large family of viruses which may cause illness in animals or humans. In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The most recently discovered coronavirus causes coronavirus disease COVID-19.

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. The outbreak was declared a Public Health Emergency of International Concern on 30 January 2020.

2.3 Purpose

The purpose of this document is to:

- provide a standardized framework for FSM (National and States) in its response to the COVID-19.
- provide technical information and guidance for coordinated efforts of all levels in Government in collaboration with stakeholders to minimize the impact of COVID-19; in terms of serious illness or overall deaths, and to minimize social disruption and economic losses.
- assist States and health care systems with preparedness and response planning at different phases of the COVID-19 outbreak in order to ensure optimal medical care and to maintain

[1] UN Department of Economics and Social Affairs Population Dynamics, *World Population Prospects, 2019*: https://population.un.org/wpp/.

continuity in provision of other essential community services.

This contingency plan outlines the strategies to manage a flexible, scalable and proportionate health system response, with appropriate and timely interventions and allocation of resources to protect the community by minimizing the morbidity and mortality from COVID-19.

2.4 Related policies and plans

The COVID-19 contingency plan is an operational plan, operating within the nation's existing disaster management framework and legislation (listed below).

The plan should be read in conjunction with the following policies, guidance and legislation:

- All Hazard Response and Recovery: Public Health Base Plan, 2017 –outlines the legislative authority for the Secretary of health and Social Affairs to protect, maintain and improve the health of the public. The Plan establishes the organizational framework for the activation and management of department activities in response to incidents or events having public health, or health care implications, or that threaten the continuation of the department's services. The Plan also describes the capabilities and resources available to FSM DHSA to address various public health hazards that arise following emergency incidents and disasters, and for threats to the department's business continuity.
- Federated States of Micronesia National Disaster Management Plan, 2016 – this plan outlines the national coordination mechanisms and legislative arrangements for any national disaster, including pandemics. The Department of Health and Social Affairs is the lead agency for health emergency.
- Federated States of Micronesia Nationwide Integrated Disaster Risk Management and Climate Change Policy (2013) – this policy provides guidance on disaster responses using a multi-hazard risk-management approach.

2.5 Roles and responsibilities

The National Government's role are to:

- determine, maintain and implement national policies, legislation and broad national strategies in close consultation with State Governments
- maintain national capabilities to deal with COVID-19
- coordinate international border health activities and immigration matters
- ensure provision of nationally consistent guidance for health professionals
- coordinate the national public information strategy
- facilitate provision of support to States
- as far as possible, maintain government services
- deliver government payments
- work with States to maintain essential services and other support services, and

- Maintain links to the international agencies such as the UN Joint Presence Office in the Country and the specialized UN agencies such as World Health Organization (WHO), UNICEF, UNDP, UNFPA, etc.
- Coordinate bilateral support and assistance.

The FSM Department of Health and Social Affairs (DHSA) is the national health agency, and its primary functions are to provide guidance and support to FSM State Health Services, and act as a conduit to regional and International health partners.

Each State has its own local government, which provides all services such as health, education, public safety, roads and power infrastructure.

2.6 Assumptions

- Everyone is susceptible to COVID-19 infection, though children appear to be less affected.
- Those with co-morbidities, including diabetes and hypertension, may have more severe outcomes following infection.
- There are no treatments or vaccines currently available.
- Social distancing measures are effective in slowing transmission of COVID-19.

2.7 Target audience

The target audience for the FSM COVID-19 contingency plan is primarily those in the health sector including the national and state level. The plan may also provide useful guidance to non-health sector agencies involved in COVID-19 response.

3 COVID-19 RESPONSE

The COVID-19 contingency response plan is based on a staged approach depending on number of cases and likely impact at the national and state level.

COVID-19 Readiness Condition[2] (COV-CON)
Condition 5: 'All clear'
Condition 4: Zero cases but COVID-19 threat exists

[2] The FSM COVID-19 Readiness Conditions alignment with the WHO transmission scenarios

FSM COVID-19 Readiness Conditions	**WHO transmission scenarios**
Cov-Con 4: Zero Cases	Countries with no cases (*No Cases*)
Cov-Con 3: 1-10 Cases	Countries with 1 or more cases, imported or locally detected (*Sporadic Cases*)
Cov-Con 2: >10-100 Cases	Countries experiencing cases clusters in time, geographic location and/or common exposure (*Clusters of Cases*)
Cov-Con 1: 100 Cases	Countries experiencing larger outbreaks of local transmission (*Community Transmission*)

Reference:World Health Organization (2020): Investing in Sustainable Capacities for Health Security Preparedness in the Context of COVID-19, 20 March 2020

Condition 3: 1-10 cases
Condition 2: >10-100 cases
Condition 1: >100 cases (widespread transmission on main island)
Condition 1b: >100 cases (widespread transmission throughout FSM/State)

The national government will support COVID-19 responses across FSM through the eight response pillars recommended by WHO[3], which will include:

3.1 Whole of government response

- Working across government to effectively manage the COVID-19 response
- Country-level coordination, planning, and monitoring
- Establish Incident Management System and open Emergency Operations Center

3.2 Risk communication and community engagement

- Implement national risk-communication and community engagement plan for COVID-19

3.3 Surveillance

- Ensure detection, verification, reporting and aggregation of cases
- Enhance existing surveillance systems to enable monitoring of COVID-19
- Investigate cases and conduct contact tracing
- Provide robust and timely epidemiological data and report through COVID-19 situation reports

3.4 Points of entry

- Travel restrictions
- Point of Entry measures

3.5 Laboratory measures

- Ensure specimen collection, management, storage and transport are functional

3.6 Infection prevention and control

- Implementation of existing infection prevention and control guidance for droplet and contact precautions including the appropriate use of personal protective equipment (PPE)
- Assess IPC needs and carry out IPC training
- Implement triage and early detection

[3]*Reference:World Health Organization (2020): Investing in Sustainable Capacities for Health Security Preparedness in the Context of COVID-19, 20 March 2020*

- Develop a plan to manage PPE supply and distribution

3.7 Case management

- Isolation and cohorting of patients
- Appropriate and ethical medical treatment
- Managing patient flow in hospitals
- Limiting hospital visitors
- Management of cases by a single team
- Surge including staff and increasing bed capacity
- Good communication and staff education.

3.8 Operational support and logistics

- Review supply chain control and management
- Prepare a budget and ensure and appropriate procurement mechanisms through partners and donors
- Prepare staff surge capacity and deployment mechanisms
- Identify critical/priority essential services

4 COV-CON4: ZEROCASES

COV-CON 4: Zero cases			
Trigger:			
No-cases identified on island; external threat identified			
Assumptions:			
• The disease represents a real risk to the health and safety (infectivity/severity) • Travel restrictions and Points of Entry screening may help delay the introduction of the virus to FSM, but cannot bring the risk of introduction to zero • There are preparedness activities that FSM can do now to limit the impact of the virus on the country when it arrives			
Mission Goals:			
1) Prevent/delay of introduction 2) Prepare for introduction			
Objectives/activities by goal:		Assigned to:	Date Completed:
Prevent/delay introduction	1. Travel restrictions a. Follow FSM National Requirements		
	2. Ports of Entry (PoE) screening a. Implement PoE as mandated by National Government Post-travel detection		

	3. Post-Travel Detection a. Encourage traveler awareness of COVID symptoms and how to engage the healthcare system safely ☐ Provide traveler health alert notifications to all in-bound passengers with information on how to contact the health department if they have symptoms of COVID-19 b. Ensure provider awareness of case definition (Person Under Investigation <PUI> criteria) ☐ Provide weekly update at Hospital CME on current PUI criteria c. Establish clear process for PUI reporting ☐ Develop flowchart of PUI reporting to all healthcare providers for posting in clinics		
Prepare for Introduction	1. Planning ☐ Develop Contingency-based planning for COVID-19 in FSM ☐ Develop COVID Treatment Center plans for IPC and clinical guidelines ☐ Develop Quarantine plan for contacts of first initial cases identified on FSM ☐ Government agencies identify essential activities, and non-essential activities that could be interrupted during the emergency		
	2. Exercise plans with AAR ☐ Exercise plans for PoE screening and PUI identification		
	3. Emergency management (Utilize ICS to coordinate Task force and DHS activities) ☐ Create organizational chart, task monitoring and reporting processes, operational period/battle rhythm		
	4. Risk communications: ☐ Create/streamline community messaging i. Communication objectives: 1. Everyday actions to prevent the spread of respiratory illness 2. What to do if you think you have COVID-19 3. Awareness of the COV-CON and what actions will be taken at each readiness condition 4. Awareness of isolation versus quarantine 5. Municipalities to start developing quarantine plans for their communities 6. Prepare for possible situation when families would need to 'shelter- at-home' (stay at home for ~ 14 days): For instance, stocking up on food, water, and prescription medications		

	5. Improve Infection Prevention and Control (IPC) at the hospital ☐ Refine patient triage and workflow to reduce risk of infection of other patients and staff i. Early identification of infectious visit patients by medical records ii. Provision of surgical mask for any patient with fever, cough, or difficulty breathing iii. Separation of ill patients from well-visit patients in waiting area iv. Establishment of separate examination/treatment areas for infectious patients from other patients (especially nebulization therapy) v. Limiting the nurses/providers who evaluate infectious patients		
	☐ Consider modifications of hospital environment for infection control i. For example, install plexiglass as barrier for initial presentation/triage, install windows in isolation room doors to allow for visual assessment of patient without the need for PPE		
	☐ Plan for cohort COVID patients at the dorm, and plan to cohort management staff (one doctor, limited nurses) to reduce exposure and PPE requirements		
	☐ Procure PPE and management supplies i. Submit orders for N95 respirators, gowns, gloves, face shields, goggles, surgical masks		
	☐ Expand/renovate hospital isolation rooms i. Target initial COVID patients to stay only in rooms in the dorm area ii. Insert small windows into all isolation room doors to allow for visual assessment of patient without having to open/enter the isolation room iii. Renovate two rooms for isolation. They do not need to be Airborne Infection Isolation Rooms (AIIR). Also, renovation should be done quickly, and not impact the use of the other rooms, incase COVID patients are detected before renovation is complete.		
	☐ Develop Emergency Medical Services Protocols for patients with Severe Acute Respiratory Illness i. Develop transportation protocols using CDC guidance for EMS ii. Develop Emergency Room management protocols for someone with Severe Acute Respiratory Illness (including what IPC to use, how to limit the number of staff exposed, and post treatment decontamination/disinfection)		

	6. Neighboring island preparedness ☐ Pre-deploy medical supplies and PPE to States as appropriate i. O2, pulse oximeter, IV, PPE (but note, majority of PPE should remain in FSM, including all N95 respirators at this point) ☐ Arrange supply-run to the neighboring islands to restock islands for possible long-term 'sequestration.' Option for people to also choose to move to neighboring islands to for duration of the impending COVID-19 Pandemic		
	7. Develop public health contact tracing team ☐ Create and train team who will perform the initial contact tracing of contacts of COVID-19 cases. This includes establishing a definition for close contact requiring quarantine (might use CDC definitions of close contact and the exposure risk assessments)		

5 COV-CON 3: 1-10 CASES

COV-CON 3: 1-10 cases			
Trigger:			
• 1-10 suspected or confirmed cases			
Assumptions:			
• Only recent introduction of the virus with limited spread. • Opportunity exists to interrupt transmission with contact tracing and quarantine. • Hospital isolation capability not yet exceeded.			
Mission Goals:			
1) Identify and mitigate local transmission 2) Prevent/delay additional introduction			
Objectives/activities by goal:		Assigned to:	Date Completed:
Identify and mitigate local transmission	1. Rapidly detect and isolate cases a. Ensure that cases are reported immediately upon first contact with health system ☐ Maintain/refine the COVID-PUI reporting process ☐ Ensure that the community understands the symptoms and risk factors for COVID-19 (i.e. travel) and how/why to quickly report for care b. Case immediately isolated in Hospital isolation room ☐ Ensure strict IPC 2. Quickly conduct contact tracing a. Public health contact tracing to quickly identify contacts and evaluate their risk based on the CDC close contacts and risk assessment 3. Implement quarantine of contacts a. Contacts considered medium to high risk are quarantined for 14 from last exposure in community or government quarantine facility (note there is an option for home quarantine with monitoring, but this may not be as effective in the home-settings of FSM. Discussion should be made if FSM would allow tourists to quarantine in a hotel) 4. Prevent infection from occurring in healthcare settings ☐ Ensure appropriate IPC as described above ☐ Continue to refine/improve IPC options in the hospital 5. Prevent introduction to neighboring States and islands ☐ Consider placing neighboring States or islands in 'Sequestration,' stop all travel to the neighboring islands		
Prevent/delay additional introduction	6. Maintain travel restrictions a. Follow FSM National Requirements		
	7. Maintain/refine Ports of Entry (PoE) screening a. Implement PoE as mandated by National Government Post-travel detection		

	8. Continue Post-Travel Detection a. Encourage traveler awareness of COVID symptoms and how to engage the healthcare system safely • Provide traveler health alert notifications to all in-bound passengers with information on how to contact the health department if they have symptoms of COVID-19 b. Ensure provider awareness of case definition (Person Under Investigation <PUI> criteria) • Provide weekly update at Hospital CME on current PUI criteria c. Establish clear process for PUI reporting • Develop flowchart of PUI reporting to all healthcare providers for posting in clinics		

6 COV-CON 2: >10-100 CASES

COV-CON 2: >10-100 cases

Trigger:

Any of the following
1) >10-100 suspected or confirmed COVID-19 cases
2) Hospital isolation capacity overwhelmed
3) President or Governor's choice

Assumptions:

- Transmission of the virus is now established on FSM.
- Isolation and quarantine are unlikely to stop transmission but can slow the spread of the illness.
- Hospital isolation capacity is exceeded, making the ability to safely manage COVID-19 patients impossible
- Need to shift COVID management to site away from hospital to prevent hospital-associated infections and allowing for continued service delivery.

Mission Goals:

1) Maximize use of limited resources
2) Slow transmission in the community
3) Care for cases of COVID-19
4) Prevent infections occurring in healthcare settings
5) Maintain services for other urgent health conditions at hospitals
6) Prevent spread to neighboring States or islands

Objectives/activities by goal:		Assigned to:	Date Completed:
Maximize use of limited resources	1. Stop PoE screening		
Slow transmission in the community	1. School closure a. School closure will be important in slowing the spread on the island, however students must refrain from non-essential travel 2. Social gatherings/meetings canceled or postponed ☐ Cancelation of government sponsored meetings/gatherings ☐ Postponement/modification of church gatherings ☐ Postponement of other gatherings		

	3. Encourage social distancing (limit non-essential travel around island) a. Could include enforcement of limited travel by the Police 4. Immediate implementation of COVID-19 treatment center (may be at hospital) ☐ Activate plans to stand-up COVID treatment Center 5. All cases of respiratory illness evaluated at COVID Treatment Center ☐ Inform public and all EMS services of all respiratory infections, regardless of severity t be seen at the COVID Center 6. Regardless of severity all COVID cases are isolated at the COVID Treatment Center a. This is to help limit/slow further spread within the community 7. Shift of non-urgent services (NCD/well baby/prenatal) out of the hospital to alternative sites if possible a. To help maximize resources to provide well-patient care, while the hospital takes urgent/emergent care and the COVID Treatment Center focuses on all COVID patients 8. Quarantine of close contacts for 14 days occurring at community managed sites or ECEs a. Community quarantine sites set-up for each state providing twice daily monitoring b. Once a person in quarantine is found to have symptoms, they are referred to the COVID Treatment Center for evaluation 9. Stop all travel to neighboring islands, but allow medevac flights		

7 COV-CON 1: >100 CASES 'WIDESPREAD TRANSMISSION IN ONE STATE OR MAIN ISLAND

COV-CON 1: >100 cases 'Widespread Transmission in one State or main island

Trigger:

Any of the following

1) More than 100 cases or widespread transmission occurring in one or more FSM States
2) President or Governor's Choice

Assumptions:

- Widespread transmission now occurring in FSM.
- Efforts to slow transmission using strict isolation and quarantine are no longer worthwhile.
- Priority shifts to managing severe cases, home isolation, social distancing.

Mission Goals:

1) Shift focus to management of severe cases
2) Reprioritize resources away from quarantine activities
3) Mandate social distancing
4) Continue to prevent spread to neighbor States and islands

Objectives/activities by goal:		Assigned to:	Date Completed:
Shift focus to management of severe cases	1. Based on current census at COVID Treatment Center, consider shifting to home isolation and management of mild cases (out of COVID Treatment Center)		
Reprioritize resources away from quarantine activities	1. Stop quarantine activities (all persons currently in quarantine allowed to leave)		
Mandate social distancing	1. Shutdown non-essential government activities and release non-essential staff 2. Encourage Families to 'shelter-at-home' (Stay at home unless illness or needs for necessities are required) 3. Police to enforce only essential travel in FSM Main Island 4. Continue to limit travel to neighboring islands (but allow for medevac flights) 5. If urgent need: consider cargo-only run with skeleton crew and no interaction between crew and island (but only if people are starving in the islands; this seems it would be high-risk for the neighboring islands)		

8 COV-CON 1: >100 CASES 'WIDESPREAD TRANSMISSION THROUGHOUT FSM'

COV-CON 1B: >100 cases 'Widespread Transmission throughout FSM'

Trigger:

Any of the following

1) More than 100 cases or widespread transmission throughout the States
2) President or Governor's Choice

Assumptions:

- Transmission is now occurring in most States.
- Once a neighboring state or island has cases, travel between that state or island and other States can be reinstated.

Mission Goals:

1) Continue management of severe cases
2) Support neighboring States and islands in managing cases
3) Continue self-isolation and social distancing efforts to slow spread

Objectives/activities by goal:		Assigned to:	Date Completed:
Continue management of severe cases	1. Continue the COVID Treatment Center for severe cases		
Support neighboring islands in managing cases	1. Evaluated on a case-by-case basis: medevac of severe cases to FSM (consider current census/capability at COVID Treatment Center; ability to decontaminate plane; severity and prognosis of the case; treatment success rate of severe cases at COVID Treatment Center) 2. Re-instate travel to neighboring islands if they have identified cases		
Continue isolation and social distancing efforts to slow spread	1. Continue 'shelter at home' 2. Continue operation of only essential government functions 3. Continue to school closure		

9 Recovery and return to normal

Thirty days after the last case is confirmed, FSM will return to COV-CON 5 and the State of Emergency declaration will be lifted. An After-Action Review will be undertaken by all key stakeholders to assess the response and the lessons learned.

Annex I: Budget

LINE ITEMS	National	Pohnpei	Chuuk	Kosrae	Yap	Subtotal
Department of Health and Social Affairs/State DHS						
Administration	63,000	90,000	150,000	60,000	80,000	443,000
Leadership and Coordination	10,000	15,000	20,000	12,000	13,000	70,000
Overtime/Hazardous	50,000	600,000	1,000,000	200,000	400,000	2,250,000
Surveillance and Early Detection	80,000	80,000	80,000	80,000	80,000	400,000
Case Management & Training	5,000	50,000	50,000	40,000	40,000	185,000
Pharmaceuticals	-	1,000,000	1,200,000	700,000	800,000	3,700,000
Medical equipment (Portable x-ray, GeneXpert, ventilators, BioFire, etc.)	-	1,000,000	1,000,000	1,000,000	1,000,000	4,000,000
PoE Screening & Triage	10,000	230,000	300,000	150,000	170,000	860,000
Isolation Facility	5,000	350,000	400,000	170,000	180,000	1,105,000
PPE's	250,000	500,000	700,000	300,000	400,000	2,150,000
Infection Control &Training	10,000	50,000	50,000	50,000	50,000	210,000
Contact Tracing & Training	20,000	300,000	400,000	100,000	200,000	1,020,000
Risk Communication	10,000	20,000	30,000	10,000	20,000	90,000
Set up quarantine facility	600,000	80,000	100,000	40,000	60,000	880,000
Support for Affected Travelers	500,000	-	-	-	-	500,000
Lab testing	20,000	52,000	67,000	43,000	50,000	232,000
Sub Total	1,633,000	4,417,000	5,547,000	2,955,000	3,543,000	$18,095,000.00
Department of Justice						
Fuel	500,000					$500,000.00
Communication	12,000					$12,000.00
Overtime/Hazardous	1,500,000					$1,500,000.00
Sub Total	2,012,000	-	-	-	-	$2,012,000.00
Department of Finance and Administration						
Overtime/Hazardous	100,000					100,000.00
Fuel	8,000					8,000.00
Communication	5,000					5,000.00
Sub Total	113,000	-	-	-	-	$113,000.00
Department of Foreign Affairs						

Overtime/Hazardous	50,000					50,000.00
Fuel	8,000					8,000.00
Communication	5,000					5,000.00
Sub Total	63,000	-	-	-	-	$63,000.00
Department of Education						
Overtime/Hazardous	50,000					50,000.00
Fuel	8,000					8,000.00
Communication	5,000					5,000.00
Sub Total	63,000	-	-	-	-	$63,000.00
Department of Resources and Development (R&D)						
Overtime	50,000					50,000.00
Fuel	8,000					8,000.00
Communication	5,000					5,000.00
Sub Total	63,000	-	-	-	-	$63,000.00
Department of DECCEM						
Overtime	15,000					
Fuel	5,000					
Communication	5,000					
Water catchment	-	175,000	235,000	35,000	55,000	500,000
OCE	15,000					
Sub Total	40,000					
Department of TC&I						
Overtime/Hazardous	50,000					50,000.00
Fuel	250,000					250,000.00
Communication	20,000					20,000.00
Sub Total	320,000	-	-	-	-	$320,000.00
GRAND TOTAL	4,267,000	4,592,000	5,782,000	2,990,000	3,598,000	**$20,729,000.00**
% of allocation	20.1	21.6	27.2	14.1	17.0	

Annex II: Surveillance

The Surveillance Annex describes the various elements of the COVID-19 surveillance system in FSM. The surveillance system is scalable, with various elements being added or deleted depending on the COV-CON alert level.

Table 1: FSM COVID-19 surveillance system

READINESS CONDITION	SURVEILLANCE SYSTEM	REPORTING	TRIGGERS	COVID19 TESTING
COV-CON 5: 'All clear'	Existing systems – ILI -routine reporting and influenza testing	Weekly syndromic data		Nil
COV-CON 4: Zero cases but COVID-19 threat exists	Existing systems - ILI POE screening - daily SARI screening – to be implemented *Case definitions updated*	Weekly syndromic data Numbers/percentage screened Numbers/percentage secondary screening	Threshold exceeded – further investigation/ enhanced surveillance/ commence lab testing	*Assuming limited testing availability* Meets PUI definition IF EpiNet investigation indicates suspicion of potential COVID19 cases Unusual ILI clusters – test ONE case in cluster All SARI cases that meet the case definition
COV-CON 3: 1-10 suspected or confirmed cases	Existing systems – ILI – daily reporting POE screening - daily SARI screening - weekly Contact tracing - daily *Case definitions updated*	POE Numbers/percentage screened Numbers/percentage secondary screening Numbers in quarantine Numbers in home isolation Numbers in isolation Numbers contact tracing Daily situation report	Commencing: Any PUI or Condition 3 (First Few initial cases) Ceasing: Non-epi linked cases in the community	*Assuming limited testing availability* Meets PUI definition Unusual ILI clusters – test ONE case in cluster All SARI cases

COV-CON 2: >10-100 suspected or confirmed cases	COVID-19 surveillance – daily reporting Existing systems – ILI – normal reporting schedule *Case definitions updated*	Suspected cases Lab confirmed cases Numbers hospitalized -deaths -recovered COVID-19 deaths in the community (verbal autopsy) Mild cases in the home (self-isolation) Daily situation report	Commencing: First suspected case – PUI using current case definition	*Assuming limited testing availability* Testing of PUIs Testing all SARI cases
COV-CON: >100 cases or widespread transmission in one State or the main island	COVID-19 surveillance Existing systems – ILI – normal reporting schedule SARI screening COVID-19 sentinel testing and diagnosis by clinical suspicion *Case definitions updated*	- suspected cases - lab confirmed cases - numbers hospitalized - deaths, recovered - mild cases in the home (self-isolation) -HCW cases -COVID-19 deaths in the community (verbal autopsy) Clinical suspicion (syndromic) Proportion positive % (epi curve) Daily and then weekly situation reporting	Continuing Ceasing: No reported cases for 14 days Lab capacity exceeded and widespread community transmission	*Depends on availability of testing kits and laboratory capacity* If available: -test all suspected cases -test all SARI cases until capacity is no longer available THEN move to sentinel testing First five cases of ILI presenting to Outpatients on a Monday morning are swabbed (should be scheduled with flights)
COV-CON 1b: Widespread Transmission throughout FSM	COVID-19 surveillance Existing systems – ILI – normal reporting schedule COVID-19 sentinel	Reporting - by clinical suspicion - numbers hospitalized - deaths, recovered - mild cases in the home (self-isolation) -HCW cases Clinical suspicion (syndromic) -COVID-19 deaths in the community (verbal autopsy)	Continuing Ceasing: No reported cases for 28 days (2 incubation periods) Lab capacity	*Depends on availability of testing kits and laboratory capacity* If available: -test all suspected cases -test all SARI cases until capacity is

	testing *Case definitions updated*	Proportion positive % (epi curve) Daily and then weekly situation reporting	exceeded and widespread community transmission	no longer available THEN move to sentinel testing First five cases of ILI presenting to Outpatients on a Monday morning are swabbed (should be scheduled with flights)

ASSUMPTIONS

- COVID-19 surveillance systems will change throughout the outbreak
- Limited laboratory testing will be available early in the outbreak
- Laboratory testing will be overwhelmed once there is widespread community transmission. Numbers will then be determined through syndromic surveillance (SARI), based on clinical suspicion and through sentinel testing

SCREENING AT POE

Implemented during containment phase (Condition 4).

Data

- Numbers/percentage screened
- Numbers/percentage secondary screening
- PUI – current case definition
- Reported daily in the states. National reporting weekly

Trigger for ceasing

- Non-epi linked cases in the community

SYNDROMIC ILI SURVEILLANCE

Implemented throughout the outbreak. Used for trends, early warning.

Existing surveillance system

- ILI[4]

[4]PSSS case definition

Influenza-like illness (ILI)	Sudden onset of fever*, PLUS: cough and/or sore throat	Influenza; other viral or bacterial respiratory infections

- Currently reported weekly
- Thresholds would be looked at on a weekly basis by FSM and by the States

Enhanced surveillance

- Further investigation at state level – Epinet teams. Alert national surveillance team. Use existing SOPs – to conduct investigation. Line listing. Start sampling and testing if required.

SARI surveillance

Implemented from Condition 4 and continues throughout the outbreak. Once COVID-19 surveillance is implemented, SARI surveillance becomes part of the COVID-19 surveillance system.

- Engage hospital doctors to report on SARI cases. *Include in EHR system where possible.*
- The surveillance officer will call hospital re numbers of SARI cases daily
- Zero reporting
- Daily reporting
- Reporting to national surveillance on a weekly basis
- SARI case definition[5]
- Condition 4: weekly reporting. Condition 3 and below: Daily reporting

Data

- Numbers of SARI cases
- % of COVID-19 positive SARI cases

COVID-19 surveillance

Based on SARI surveillance (severe cases), suspected cases, confirmed laboratory cases, HCW surveillance, deaths (hospital and community)

Trigger

- First suspected case – PUI using current case definition

System

Forms

- COVID-19 case forms. Includes a laboratory section. To be developed.

SARI surveillance

---

* Fever is defined as 38 ºC / 100.4 ºF or higher. If no thermometer is available, fever or chills reported by the patient or the caregiver are also acceptable.

[5]**SARI case definition**

An acute respiratory infection with:

- history of fever or measured fever of ≥ 38 C°;
- and cough;
- with onset within the last 10 days;
- and requires hospitalization.

- SARI surveillance (see above) – **change to daily reporting when COVID-19 surveillance implemented**

Laboratory testing

- Laboratory sample results – FSM surveillance section has access and will manually extract data (Lisa). State labs have access.

HCW surveillance

- Infection control nurse/quality assurance person – report to local surveillance officer and manually added to line list.

Deaths

- Reporting of deaths/deaths certification – family report to the hospital, verbal autopsy.

COVID sentinel surveillance (laboratory sampling)

- First five cases of ILI presenting to Outpatients on a Monday morning are swabbed (should be scheduled with flights)
- Report by proportion positive % (positive cases/all cases tested) – requires negative test results

DATA

Line list produced in excel format. Demographic, clinical, laboratory etc. States would complete the line list and then send to National surveillance team.

- Numbers of
    - confirmed cases
    - suspected cases
- Hospitalized cases
    - Numbers of SARI cases
    - % of COVID-19 positive SARI cases (number of confirmed SARI cases/number of tested SARI cases)
    - Hospitalized confirmed COVID-19 cases
    - COVID-19 severe hospitalized cases
- numbers of hospitalized confirmed cases/severe hospitalized confirmed cases[6] (includes critical cases) – provides a proportion (%)
- numbers/proportions cleared of infection

CASE DEFINITIONS

Case definitions will change by Condition Level and latest information

- ILI
- PUI
- Suspected
- Probable
- Confirmed

[6]Severe cases with dyspnea, respiratoryfrequency ≥30/minute, blood oxygen saturation ≤93%, PaO2/FiO2 ratio <300, and/or lunginfiltrates >50% of the lung field within 24-48 hours OR critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure).
Reference: Joint WHO-China commission report page 12

- Clinical suspicion – diagnosis by clinician
- SARI
- Clearance of a confirmed case – to be determined – likely to be:
    - No symptoms for 3 days
    - Clear x-ray
    - (2 negative tests if available)

Annex III. COVID-19 and Vulnerable Population Mitigation Plan

Background:

The COVID-19 has been determined to be a pandemic and a Public Health emergency of international concern and represents a considerable threat to health systems and economies globally. Those at **highest risk** for developing severe complications and of deaths from Covid-19 are:

- Elderly and people over 60 years of age,
- Co-morbidities or (NCDs) such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease, cancer, etc.
- Mentally Ill Clients
- People with Disability (PWD)

In China, the case fatality rate of COVID-19 patients with cardiovascular disease was 13.2%, while it was 9.2% for those with diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer. The proportion of death among COVID-19 patients with no co-morbidities was 1.4%. As such globally, advice is to protect high-risk groups from exposure to COVID-19, using measures that focus on social distancing and avoiding areas of high-risk of exposure to the COVID-19 virus. Currently in small pacific island states, individuals who require regular medications are generally required to undergo a consultation with a health practitioner and get a prescription refill monthly at the clinics, which is often located at a centralized major health facility. The frequent visits at these health facilities, which are often busy runs counter to recommendations for social distancing and avoiding high-risk locations and increases the risk of exposure of these individuals to the COVID-19 virus.

This plan along with the objectives described herein provide the focus of actions the FSM States will address in their out-reach activities to their respective populations. While the focus is on those individuals with NCD conditions, disability and other conditions that might necessitate their ability to access the mainstream services, the providers are to ensure the special needs of this vulnerable population are being met and addressed. The need for culturally and gender-based appropriate and sensitive care or services is underscored throughout this document.

GOAL: TO PROTECT THE HEALTH OF HIGH-RISK INDIVIDUALS

Objective 1: to reduce the exposure of individuals with NCDs, elderly, mentally ill, and PWD's to the COVID-19 virus

Action	Description	Inputs	Person Responsible /Partners	Timeline
SITUATION: NO CONFIRMED COVID CASE				
Reduce case load at regular follow-up clinics to avoid crowding	The number of patient appointment is reduced to 10 -15 patients per day (spread throughout the day) by adding one or two regular clinic days per week; priority will be given to those elderly with high CVD risk. However, patients will be asked to phone in for triage before visiting the clinic. Appropriate spacing in waiting room should be used. These clinics should include NCD's, antenatal, immunization, family planning, mental clinics, and other regularly scheduled clinics such as TB and HD clinics.	Staff to be assigned to the clinic during the additional regular scheduled clinic days. Health staff should pay attention to their own health and not cover the clinic if they feel even slightly unwell. Telephone facility	Clinic manager in consultation with Director of Medical Services& Chief of Public health	Immediate
Decentralize clinical services to peripheral health facilities	Basic NCD services such as blood pressure and blood glucose monitoring, foot inspection and dispensing of maintenance medications will be delivered at the lowest level of the health system, i.e. the village clinic/nurse aide stations - Assess capacity at the peripheral facilities and address gaps, including emergency procurement of equipment and supplies as needed	Directive to implement decentralization Orient health workers on the directive and on infection control. Essential basic medical equipment/supplies	Director of Medical Services	Immediate
Provision of longer-term prescriptions to patients	2-3-month supply of maintenance medications will be provided to chronic clients to reduce the number of visits to the health facility for refills - Assess stock levels at peripheral facilities and at central supplies/pharmacy; if current stocks are	Ensure pharmaceuticals in enough quantities to cover number of registered patients	CHC's, Dispensary Managers, and NCD Manager in consultation with Chief Pharmacist	Immediate

	insufficient, initiate emergency procurement			
Establish remote consultation options	Set-up communication options for remote consultation (phone-in, SMS, etc.) for NCD patients (and potentially for other issues) to reduce the need for patients to visit facilities if feeling unwell (NCD-related), or for check-up Consider scheduled mobile clinics or clinic without walls.	Telephone facility Information dissemination regarding remote consultation in collaboration with community leaders/officials	Clinic managers in collaboration with Incident Management Committee Chairman as well as community leaders.	Immediate
SITUATION: CONFIRMED COVID-19 CASE				
Aside from the above actions, further decentralization with consideration of establishing alternative service delivery points	If cases of COVID-19 increase significantly and stress health services considerably, then a further expansion of the prescribing rights of nurses should be considered and utilized, along with mobilizing partners such as private providers/agencies, community volunteers/groups to serve as alternative service delivery points for NCD services.	Develop partnership with private providers/agencies, community volunteers/groups, and solicit their support to this plan. Ensure they adhere to strict hygiene practices and ensure any staff/volunteers involved are well.	Chief of Medical Services in collaboration with Chief of Public Health	Establishing partnerships - immediate Use of alternative service delivery points - whether need arises
Decentralized other services for the elderly through interagency collaborations	Minimize elderly aggregation such as social security gathering for checks and work with other local agencies such as banks or municipal government handing out checks to local elderly residents.	Volunteers/groups and solicit their support to this plan.	Incident Command and required agencies	Immediate

Objective 2: to reduce the vulnerability of individuals with NCDs or co-morbidities (who are immune-compromised) to the COVID-19

Action	Description	Inputs	Person Responsible /Partners	Timeline
Control risk factors of	Clinic managers in conjunction with providers need to review	Directive to frontline health	Clinic Manager in collaboration	Immediate

registered individuals in the regularly scheduled clinics	and update health status including CVD risk of registered individuals with NCDs and provide maintenance medications and actions to minimize frequent clinic visits. Provide lifestyle advice and advice on strict adherence to medications for better control of risk factors and NCDs and give advice on managing issues such as foot wound or possible hypoglycemia. Update immunization status by providing required vaccination.	workers Orient health workers on the directive Maintenance drugs	with Director of Medical Services	
Educate on basic personal protection	Provide information on the following to patients and assess their level of understanding: - Individuals with NCDs if infected with COVID-19 are at increased risk of severe symptoms and death; they need to control their risk factors by continue taking their medications and adhere to lifestyle advice - They need to secure a long-term supply of maintenance medications - They may consider identifying place to stay, where they can have own room so they may better protect themself. - They need to practice these preventive measures o Frequent proper handwashing o Social distancing or avoid large gatherings and crowds o Keep at least 1-2 meters of distance from a person with respiratory symptoms. Respiratory hygiene o Avoiding touching eyes, nose and mouth	Development and reproduction of customized posters/flyers on preventive measures for discussion and distribution to patients (standard messages) Information dissemination through broadcasts & other channels	NCD Manager	Immediate

Objective 3: to identify and resolve the challenges and issues encountered in implementing the mitigation plan

Action	Description	Inputs	Person Responsible /Partners	Timeline
Monitoring of NCD services during the COVID-19 response	Periodically assess the adequacy and quality of services provided to individuals with NCDs, plan to address challenges and resolve issues. Provide feedback to the Incident Management Committee and seek support as necessary	Monitoring checklist and feedback form Orient frontline health workers on the use of the tool	NCD Manager in collaboration with Director of Medical Services	Immediate

Annex IV. Decentralization of Clinical Services

Background:

Health resources and services in the FSM tend to be concentrated around the central state hospital/public health department facilities while those for communities in outlying areas on the main islands and in outer islands are much more limited and inconsistent. Standards are needed to guide improvement of health services and health status in these outlying areas.

The need to decentralize services during the COVID19 pandemic is essential to minimize spread of the virus thus critical to utilize services in the peripheral sites. Just as imperative, these peripheral sites must meet the standards. Below is a standardized monitoring tool to ensure these dispensaries met the overall standard score.

FSM HC-Dispensary Standards Monitoring Tool
(See footnotes for details about definitions and how to measure items)

Domains	Elements to consider		How to measure				Notes
			Disp Records	Central DHS office recs	Direct observation	Interview	
Facility	Walls, floors roof all good[1]	Y/N			X		
	On-site radio (or Phone)[2]	Y/N			X		
	Electricity[3]	Y/N			X		
	Water Supply[4]	Y/N			X		
	Washbasin or Sink[5]	Y/N			X		
	Toilet in good condition[6]	Y/N			X		
	Lights[7]	Y/N			X		
	Secure storage (meds, etc.)[8]	Y/N			X		
	At least 1 private exam room						

Essentials	Essential Meds (list)[9] Instruments Supplies (list)[10]	Y/N Y/N			X X		
Staff credentials & availability	-Health Assistant must meet minimum credentials[11] -Staff available most days at disp[12] -Staff available after hours when needed[13]	Y/N Y/N Y/N		X		X X	
Cleanliness & Infection control	Washbasin/Sink clean Used sharps in safe container→ disposed of safely when full Toilet area clean Exam rooms/office clean/no evidence rats, mice roaches Outside of building clean[14]	Y/N Y/N Y/N Y/N Y/N			X X X X X		
Reporting	<u>Radio Reports</u> - Weekly Reporting in by Radio[15] - CD report is included each wk[16] - Births, deaths report is included each week	Y/N Y/N Y/N		X X X			
	<u>Record of patients seen</u> - Line list of all patients seen in clinic (or SOAP note in individual patient charts)[17]<u>Patient Registries</u> are kept for the following conditions:[18] 1) NCD patients 2) Prenatal patients 3) Family planning clients	Y/N Y/N Y/N Y/N Y/N Y/N Y/N	X X X				

	4) Homebound patients 5) VIA-Breast Ca screened patients NCD Patient individual records[19]						
Service delivery	Routine hours of operation[20] After hours service when needed[21] School program[22] Vit A/deworming[23] PEN NCD Care Delivery[24] Growth monitoring of <5yo[25] Family Planning[26] Pregnancy care[27] VIA or PAP screening delivery[28]	Y/N Y/N Y/N Y/N Y/N Y/N Y/N Y/N Y/N	 X X X X X		X	X X X	Interview with Chief or Mayor on-site Interview with Chief or Mayor on-site
Support visits	At least 4 visits in past 12 months (must include immunizations as well as supplies)	Y/N		X29			
Community health	Community Profile Posted in Dispensary[30]	Y/N			X		
Community engagement	-Health council is in place[31] -Community engagement by Health Assistant is strong[32] -Community Satisfied[33]	Y/N Y/N Y/N				X X X	

 # Items meeting Standards: _____/43 Items Total [35 items (80%) needed to meet overall standard]

Essential supplies List for FSM Health Centers- Dispensaries

Testing Equipment

- BP Cuff (pediatric and adult)
- Glucose meter & strips
- Adult scale
- Infant scale
- Hemoglobin meter & test strips
- Pregnancy tests
- Syphilis Rapid Test
- Urine dipsticks
- Large swabs and vinegar (for VIA testing) or PAP supplies

Clinic Equipment

- Fetoscope or Doppler
- OB Wheel
- Medical eligibility wheel for FP
- PEN items: BMI and Risk Assessment Charts
- IMCI Reference Charts
- STI Syndromic management Reference Charts
- Tape measure
- Stethoscope
- Otoscope
- IV fluid bags, tubes, needles
- Syringes & needles
- Dressing cart with tape, gauze, betadine, NSS, gloves
- Laceration Sets (Scalpels, Forceps, Needle Holders, Gauze, Syringe, Lidocaine, Tape, Sutures)
- OB Pack (Scissors, Cord clamp/tie, Drapes, …
- Neonatal ambu bag
- Stove and pot for sterilization (or autoclave)
- Nebulizer machine & tubing

Patient Charting & Other Forms

- Child Road to Health Cards
- Death and birth forms
- Monthly report forms
- Logbook with line list of patient visits

Logbook Registries* for:

- NCD patients
- Family Planning Patients
- Cervical cancer screening patients
- Homebound patients in catchment area
- Prenatal patients
- Child vaccination log

*(*Note: no need for logbooks if electronic med records or electronic registry able to provide info for patients in these categories)*

- NCD individual patient cards, take-home booklets or individual patient charts

Supplies for Patients

- Condoms

Cleaning Supplies

- Chlorine bleach
- Isopropyl alcohol
- Broom
- Bucket
- Mop
- Brush
- Soap

Total = _____ item in stock/45 total items

Essential Meds for FSM Health Centers & Dispensaries

CLASS	DRUG	STRENGTH/DOSAGE
Analgesics NSAID	Acetaminophen Acetylsalicylic Acid (ASA) Diclofenac (or Ibuprofen or Naproxen)	Suspension: 160 mg/5 ml, 80 mg/ml Tablet: 325 mg, 500 mg Tablet: 81mg, 325 mg Tablet
Anesthetics	Lidocaine	Injectable: 2% vial
Anti-anginal	Nitroglycerine	Tablet (sub-lingual) 0.4mg
Antacids/Anti-reflux	Aluminum hydroxide Omeprazole	Tablet: 500 mg Solution: 200 mg/5 ml Tablet: 20mg
Antibiotics	Amoxicillin Cloxacillin Co-trimoxazole Gentamycin Neomycin/Bacitracin Sulfa meth/Trimethoprim Ampicillin Gentamycin	Capsule: 250 mg, 500 mg Suspension: 125 mg/5 ml Capsule: 250 mg500 mg Suspension: 125mg/5 ml Tablets: 80 mg 160 mg Suspension: 40 mg/5 ml Ophthalmic drops Ear drops Ointment Tablet: 800/160 mg Suspension: 200/40 mg/5 ml Injectable: 1 Gm vial Injectable: 80 mg/2ml vial
Anti-convulsive	Carbamazepine	Tablet: 200 mg
	Diazepam	Injectable: 10mg/2 ml vial
Anti-emetics/anti-nausea	Promethazine	Tablet: 25 mg Syrup: 12.5mg/ml
Anti-fungal	Griseofulvin	Tablet: 500 mg
Anti-gout	Allopurinol Colchicine	Tablet: 300 mg Capsule: 0.6 mg
Allergy	Diphenhydramine Epinephrine	Suspension: 12.5 mg/5 ml Tablet: 25 mg 1:1000
Anti-hypertensives	Hydralazine HCTZ Atenolol Captopril (or lisinopril or enalapril)	Injection: 10mg/mL Tablet: 25mg Tablet: 50 mg Tablet: 25 mg
Corticosteroids	Prednisone	Tablet: 5 mg
Anti-parasitic	Lindane (scabies, lice) Mebendazole (or Albendazole) Metronidazole	Lotion, shampoo Tablet: 100 mg Tablet: 250 mg Suspension: 125 mg/5 ml
Contraceptives	Oral Contraceptive Pills Depo-Provera	Injectable 150mg
Bronchodilators	Salbutamol Albuterol soln (for nebulizer)	Suspension: 2 mg/L Tablet: 4 mg Single dose units or dropper
Corticosteroids	Betamethasone Cream	1%
Diuretics	Furosemide	Tablet: 20 mg
Hypoglycemics	Glucophage (metformin) Glipizide (or glyburide or glimipramide)	Tablet: 500 mg Tablet: 5 mg

Physiologic solutions (colloidal, buffer, etc.)	☐ ORS ☐ 0.9 NS (normal saline) ☐ D5LR	Sachet Intravenous Intravenous
Vitamins/Minerals	☐ Vitamin K ☐ Vitamin A ☐ Ferrous sulfate with Folate	Injection: 0.5mg/mL Capjel: 200,000 Tablet: 300mg
Anti-Cholesterol	☐ Simvastatin (or other statin)	Tablet: 20mg
Uterine contraction inducer	☐ Pitocin	Injection:10 units/mL

Total= _____ items in stock/47 total items

Annex V. Covid-19 Community Outreach Package

Summary

A comprehensive Covid-19 Community Outreach Package (COV-COP) has been planned in alignment with the Pohnpei State COVID-19 Response Framework and the Pohnpei State COVID-19 Risk Communication Subcommittee Plan. The activity is a cross-sectoral effort, led by the Department of Public Health (DPH) in close collaboration with the Department of Education (DOE), WHO, UNICEF, Micronesia Red Cross Society (MRC), and other local partners.

COV-COP consists of two phases. Phase 1 will include a series of community microplanning workshops in each of the six Pohnpei municipalities. The participants will include the traditional community leaders, as well as local schoolteachers and the municipal government. The purpose of the workshop is to empower the community leaders to strengthen the community-based preparedness for Covid-19. It will involve education, as well as creation of community micro plan, which will specify the actions the community can take to reduce the impact of Covid-19.

Phase 2 will include a house-to-house outreach, aiming to cover 70% of the estimated 5000 households on Pohnpei Main Island. The activity will be undertaken by teams of 3-4, with representatives from the DPH, DOE and MRC. The teams will provide education on Covid-19, hand washing and social distancing, as well as distribute soaps and information materials. In order to ensure consistency of messages, all teams have received training and a set of supportive documents to guide them during the home visits. The details can be found below.

Historical background

Pohnpei State has a strong experience of conducting community outreach activities, both on a municipal as well as an individual household level. DPH has extensive experience in conducting comprehensive community health outreach activities, which have been preceded by micro-planning workshops with the community leaders. This experience, in combination with a good working relationship with the community leaders, can allow for the workshops to be organized within a very tight planning timeline.

Additionally, members of the DPH and DOE have an experience of conducting house-to-house outreach within the communities. DOE has already conducted one round of Covid-19 outreach, during which they have delivered communication materials and provided soaps. COV-COP builds on this previous activity, ensuring consistency of messaging and filling in the gaps not previously addressed.

Strategy details

COV-COP is a comprehensive program which aims to support the communities both directly, through Phase 2, as well as indirectly, by working with the community leaders in Phase 1.

<u>Phase 1</u>

In order to avoid overcrowding and to promote social distancing, the microplanning workshop within each municipality has been divided into smaller workshops, for a group of 10 chiefs each. The

workshops will take place simultaneously within one municipality and will be facilitated by a member of DPH, with support from DOE and partners. All six municipalities will be covered one by one over a period of one week.

The microplanning workshop has two main purposes. The first one is to educate and empower the community leaders on how to reduce the spread and impact of Covid-19. The second purpose is to work together with the leaders and identify community-specific risks, as well as actions which the community can take to mitigate them. Examples of actions can include creating a local Covid-19 information network; identifying potential quarantine areas within the community; implementing strategies to protect the elderly and other vulnerable groups; designing further behavioural change activities to address culturally sensitive risks.

At the end of the microplanning workshops, the proposed action plans will be collected, together with an allocated budget, and submitted to partner agencies for support. The chiefs will also be notified about the Phase 2 outreach and asked to promote the activities within their communities.

Phase 2

The house-to-house outreach will begin immediately after Phase 1. It will be conducted by 30 teams of 3-4 members each, led by a representative from either DPH, DOE or MRC. The teams will be allocated specific areas and provided with materials to distribute within the households, aiming to reach 10 houses per day. The communities will be notified about the outreach teams by their village chiefs, as well as over a radio announcement.

All team leaders have received comprehensive training, as well as supporting materials to help deliver a standardised message across the whole population. The training agenda, as well as the draft supporting materials, can be found below. The teams will undergo a second refresher training prior to their deployment, as well as receive a complete set of all materials which is currently under final revision. The teams will participate in daily briefing and debriefing sessions, in order to ensure a high quality and coverage of households, as well as safety and wellbeing of the teams themselves. Phase 2 outreach is scheduled to take 4-5 weeks.

Working documents, templates, workshop agendas

COVID-19 Community Outreach
Training Workshop

Time	Activity
Phase 2 training (house to house outreach)	
9:00-9:30	COVID-19: What is it and how can we stop it?
9:30-10:00	Overview of Phase 1 and 2 activities
10:00-10:30	Live simulation of the outreach activity
10:30-11:00	Q&A + coffee
11:00-11:15	Explanation of data collection
11:15-12:15	Group practice (groups of 3, rotate through the roles)
12:15-12:30	Assigning of team members, roles, dates
12:30-13:00	Lunch break
Phase 1 training (municipal workshops)	
13:00-13:30	Overview of the microplanning workshop
13:30-14:30	Shortened simulation of the microplanning
14:30-15:00	Assigning of team members, roles, dates

Covid-19 Community Outreach

Phase 1 microplanning workshop

draft agenda

Objectives:

1. Empower the community leaders to protect their communities
2. Provide information on covid-19 and infection control training
3. Identify community-specific risks and mitigation measures
4. Plan community-based activities (with focal points, timelines, budget)

Date/Time	Activity
9:00-9:30	Covid-19: what is it and how can we stop it? (presentation)
9:30-10:00	Q&A
10:00-10:30	Coffee break & handwashing practice
10:30-12:30	Community risks and how to reduce them (group discussion)
12:30-13:30	Lunch break & handwashing practice
13:30-15:00	Defining the community action plan (group activity)

Reducing the risk in the communities

Group discussion

[Municipality name]

Discussion facilitation: [name]

Writing on the flipcharts: [name]

Taking notes: [name]

Purpose:

1. Identify the risks in the community
2. Identify ways to mitigate the risks

Risks: *[the table is prefilled with examples]*	**How community can mitigate the risk:**
People who need to self-isolate - how can they buy groceries / medicine	
Infecting elderly family members	
Sharing sakau	
Stigmatization of the sick	
Spreading of misinformation and panic	
People will not want to self-isolate	

Developing the Community Action Plan

Group activity

[Municipality name]

Activity facilitation: [name]

Writing on the flipcharts: [name]

Taking notes: [name]

Purpose:

1. Fill in the activity plan
2. Identify community champions

List of Activities

Objective: Prevent covid-19 transmission in the communities

Activity	Person responsible	Timing (start date, duration, frequency)	Budget (purpose, USD)	Other notes
Distributing information in the community...				
Identifying community champions...				
Total budget				

.....

Minimum number of households visited per day: 10

Average duration of each visit: 20 minutes + transport time

Team size: 2-4 persons

Equipment per team:

- ✓ Car with petrol, car provided by: .....
- ✓ Flipchart presentation
- ✓ Bucket (for demonstration purposes)
- ✓ Soaps (x2 per household)
- ✓ Leaflets (x1 set per household)
- ✓ Lunch (NOT provided)

Roles and responsibilities

Team leader (L): ..... Phone number: .....

Member 1 (M1): ..... Phone number: .....

Member 2 (M2): ..... Phone number: .....

Member 3 (M3): ..... Phone number: .....

	L	M1	M2	M3
Ensure the team departs on time with all the necessary equipment				
Plan the route & drive the car				
Conduct the presentation				
Conduct the handwashing activity				
Conduct the social distancing activity				
Demonstrate the bucket assembly				
Update AKVO				

Household activity (20 minutes)

1. Group introduction & purpose of visit
2. Flipchart presentation (see talking points)
3. Handwashing activity
4. Social distancing activity
5. Bucket assembly
6. Give 2 soaps and 1 set of leaflets
7. Update data on AKVO

Annex VI. Needed Supplies List

PPE	UNIT OF ORDER	UNFILLED ORDER QTY 3/20/20	NOTES/COMMENTS
EXAM GLOVES, SMALL	100S	830	
EXAM GLOVES, MEDIUM	100S	140	
EXAM GLOVES, LARGE	100S	2360	
SURGICAL GLOVES, 6.5	100S	360	
SURGICAL GLOVES, 7	100S	580	
SURGICAL GLOVES, 7.5	100S	1220	
SURGICAL GLOVES, 8	100S	980	
FACE MASKS	PK OF 50	7221	
N-95 MASKS	PK OF 20	500	
FACE SHIELDS	PK OF 10	500	
SURGICAL GOWN , S	EACH	1500	
SURGICAL GOWN , M	PK 30	1500	
SURGICAL GOWN , L	PK 30	1500	
SURGICAL GOWN , XL	PK 30	1500	
GOGGLES	EACH	30	
ISOLATION GOWN, FLUID RESISTANT , REGULAR	PK 30	1500	
ISOLATION GOWN, FLUID RESISTANT , 2XL	PK 30	1500	
ISOLATION GOWN, FLUID RESISTANT , XL	PK 30	1500	
TYVEK COVERALLS		0	
SHOE COVERS			
NON PHARMA			
ALCOHOL SWABS	PK OF 100	2175	
ANGIO CATHETERS 22G	PK OF 100	335	
ANGIO CATHETERS 24G	PK OF 100	340	
IV HEPLOCK	EACH	2300	
IV HEPLOCK, LUER LOCK	EACH	10000	
IV SETS 15 DROPS	EACH	8500	
IV SETS 20 DROPS	EACH	3480	
VOLUMETRIC INFUSION SET 60 GTTS/ML	EACH		
MEDICINE CUPS	PK OF 100	44900	
METRISET	EACH	6100	
NEEDLES 18G	PK OF 100	11990	

NEEDLES 19G	PK OF 100	12000	
NEDDLES 20G	PK OF 100	13000	
NEEDLES 21G	PK OF 100	12990	
NEEDLES 22G	PK OF 100	18000	
NEEDLES 23 G	PK OF 100	19990	
NEEDLES 25G	PK OF 100	19990	
SYRINGE 1ML	PK OF 100	20985	
SYRINGE 3 ML	PK OF 100	20895	
SYRINGE 5 ML	PK OF 100	23960	
SYRINGE 10ML	PK OF 100	14995	
NEBULIZER SETS	EACH	6120	
OXYGEN CANNULAS, INFANT	EACH	6000	
OXYGEN CANNULAS, PEDIA	EACH	6000	
OXYGEN CANNULAS, ADULT	EACH	6200	
SURGICAL TAPE	1" ROLL, PK 12	212	
SURGICAL TAPE	2" ROLL, PK 6	492	
SURGICAL TAPE	3" ROLL , PK 4	286	
4 X 4 GUAZE	PK 200	3220	
2 X 2 GUAZE	PK 200	2600	
CONFORMING GUAZE 2"	PK 200	2780	
CONFORMING GUAZE 4"	PK 200	3580	
ISO PROPYL ALCOHOL	70%, 500ML	3579	
LIQUID HAND SOAP		3300	
CLOROX DISINFECTING WIPES		11000	
HAND SANITIZER	8OZ BOTTLE	50000	
4 OZ. STERILE SPECIMEN CONTAINER	CS/100	4000	
THERMOMETERS, INFRA RED, NO TOUCH		40	
PHARMA			
ACETOMINOPHEN	80MG/0.8 DROPS	1000	
ACETOMINOPHEN	100MG/ML DROPS	2932	
ACETOMINOPHEN	160MG/ ML ELIXIR	4580	
ACETOMINOPHEN	250MG/ 5ML ELIXIR	2020	
ACETOMINOPHEN	150MG/ML INJECTION	7500	
ACETOMINOPHEN	120MG SUSPENSION , PK OF 12	584	
ACETOMINOPHEN	650MG SUSPENSION , PK OF 12	412	
ACETOMINOPHEN	325 MG TABS/CAPS, PACK OF 1000	118	
ACETOMINOPHEN	500MG TABS , PACK OF 1000	287	
ALBUTEROL	2MG/5ML ORAL SOLUTION	920	

ALBUTEROL	4MG TAB	33	
ALBUTEROL	NEBULIZER SOLUTION , BX OF 25	1200	
ALBUTEROL	MDI	2800	
AMINOPHYLLINE INJECTION		900	
AMLODIPINE 10MG	10MG	1000	
AMLODIPINE 5MG	5MG	1000	
AMOXICILLIN	125MG/5ML SUSPENSION	3200	
AMOXICILLIN	250MG/5 ML SUSPENSION	4405	
AMOXICILLIN	250 MG CAPS	118	
AMOXICILLIN	500 MG CAPS	289	
AMPICILLIN	1G INJECTION	15800	
ANTIBIOTICS			
ASPIRIN	81MG, PK OF 100	500	
ASPIRIN	325 MG TABS, PK OF 1000	15	
ATORVASTATIN 10MG	10MG	5000	
ATORVASTATIN 20MG	20MG	1000	
AUGMENTIN	250MG/5ML SUSP	1082	
AUGMENTIN	500/125 MG TABS	402	
AUGMENTIN	250/125 MG TABS	121	
AZITHROMYCIN	200MG/5ML SUSPENSION	294	
AZITHROMYCIN	500 MG TABS , PK OF 3	807	
AZITHROMYCIN	INJECTION, AMPOULE	200	
BECLOMETHASONE	MDI	1100	
CAPTOPRIL 25MG	25MG	2500	
CARBOCISTEINE	250MG/5 ML SYRUP	100	
CEFACLOR	125 MG/5 ML SUSPENSION	644	
CEFACLOR	250 MG CAPS, PK OF 500	32	
CEFAZOLIN	1G INJECTION	3300	
CEFEPIME INJECTION	1G INJECTION	1000	
CEFOXITIN	1G INJECTION	1300	
CEFTRIAXONE	1G INJECTION	5500	
CEPHALEXIN	250 MG CAPS , PK OF 500	52	
CEPHALEXIN	500 MG CAPS , PK OF 500	166	
CEPHALEXIN	250MG/5 ML SUSPENSION	2758	
CHLORAMPHENICOL	125 MG/ 5 ML SUSPENSION	644	
CHLORAMPHENICOL	250 MG CAPS, PK OF 500	62	
CHLORAMPHENICOL	1G INJECTION	3350	
CHLOROQUINE	200MG, PK OF 100	22	
CICLESONIDE INHALER		50	
CIPROFLOXACIN	250MG, PK OF 100	50	

CIPROFLOXACIN	500MG, PK OF 100	134	
CLARITHROMYCIN	250MG, PK OF 100	100	
CLINDAMYCIN	250MG, PK OF 100	60	
CLOPIDOGREL 75MG	75MG	1000	
CO-TRIMOXAZOLE	200MG/40MG/5 ML SUSPENSION	2512	
CO-TRIMOXAZOLE	SS TABS	68	
CO-TRIMOXAZOLE	DS TABS	97	
DEXTROMETHORPAN COUGH SYRUP		5700	
DEXTROSE 5%	INJECTION	270	
DEXTROSE 5%	WITH 0.45% SODIUM CHLORIDE	490	
DEXTROSE 5%	WITH 0.9%	510	
DEXTROSE 5%	IN LACTATED RINGER'S INJECTION , CASE OF 12	520	
DEXTROSE 50%	PK OF 12	3145	
DIGOXIN 0.125MG	0.125MG	1000	
DIGOXIN 0.25MG	0.25MG	1000	
DIPHENHYDRAMINE	12.5 MG/ 5 ML ELIXIR	2348	
DIPHENHYDRAMINE	25MG CAP, PK OF 1000	24	
DIPHENHYDRAMINE	50 MG CAP	13	
DOXYCYCLINE	100MG, PK OF 100	50	
ENALAPRIL 10MG	10MG	1000	
ENALAPRIL 5MG	5MG	1000	
ERYTHROMYCIN	200 MG/5ML SUSP	1370	
ERYTHROMYCIN	250MG TAB	53	
FUROSEMIDE	20MG/ML INJECTION	4000	
FUROSEMIDE	10MG/ML ORAL SOLUTION	220	
FUROSEMIDE	40MG TABS	40	
FUROSEMIDE 20MG	20MG	1500	
FUROSEMIDE 40MG	40MG	1500	
GENTAMICIN	INJECTION	6500	
GLIBENCLAMIDE 5MG	5MG	25000	
GLICLAZIDE 80MG	80MG	4500	
GLIPIZIDE 10MG	10MG	2500	
GLIPIZIDE 5MG	5MG	5000	
GUAIFENESIN COUGH SYRUP		7740	
HYDROCHLOROTHIAZIDE 25MG	25MG	5000	
HYDROCORTISONE	100MG INJECTION	3200	
IBUBROFEN	100 MG/5M SUSP	746	
IBUBROFEN	400MG TAB	134	
IBUBROFEN	600MG TAB	120	

IBUBROFEN	800MG TAB	60	
INSULIN 70/30	70/30	1000	
INSULIN N	N	500	
INSULIN R	R	500	
IPRATROPIUM	NEBULIZER SOLUTION , PK OF 25	450	
ISOSORBIDE DINITRATE 10MG	10MG	1100	
ISOSORBIDE MONONITRATE 30MG	30MG	5000	
LACTATED RINGER'S INJECTION	PK OF 12	510	
LEVOFLOXACIN	500MG, PK OF 100	20	
LISINOPRIL 10MG	10MG	5000	
LISINOPRIL 5MG	5MG	5000	
LOSARTAN 50MG	50MG	5000	
MEROPENEM	1G INJECTION	1400	
METAPROTERENOL	10MG/5ML SYRUP	234	
METFORMIN 500MG	500MG	10000	
METHYLPREDNISOLONE SODIUM SUCCINATE INJECTON	40MG	200	
METRONIDAZOLE	125MG/5 ML SUSP	1170	
METRONIDAZOLE	INJECTION	9100	
NAFICILLIN	1G INJECTION	1000	
NAPROXEN	250 MG, PK OF 500	62	
NAPROXEN	500MG TAB , PK OF 500	90	
NITROGLYCERIN 0.4MG	0.4MG SL	5000	
PENICILLIN G	INJECTION	30700	
PENICILLIN VK	125MG/5 ML SUSPENSION	346	
PENICILLIN VK	250 MG TAB	20	
PREDNISOLONE	5MG TAB, PK OF 1000	115	
PREDNISOLONE	20MG TAB, PK OF 1000	39	
PREDNISONE	5MG/ML ORAL LIQUID	150	
PSEUDOEPHEDRINE	30MG/5ML ELIXIR	300	
PSEUDOEPHEDRINE	30MG, PK OF 500	46	
PSEUDOEPHEDRINE	60 MG TAB , PK OF 500	71	
SODIUM CHLORIDE 0.9%	500ML, PK OF 24	645	
SODIUM CHLORIDE 0.9%	1L, PK OF 12	1130	
SPIRONOLACTONE 25MG	25MG	5000	
TETRACYCLINE	250MG, BX OF 100	50	
THEOPHYLLINE	30MG, PK OF 100	5	
VACOMYCIN	1G	1500	
WARFARIN 2MG	2MG	2000	
WARFARIN 5MG	5MG	2000	

WATER FOR INJECTION	20ML, PK OF 12	450	
ISO ROOM EQUIPMENT			
HEART MONITOR : SPO2, PULSE, ECG, TEMP, BLOOD PRESSURE	EACH	8	
CO2 CAPNOGRAPHY MACHINE	EACH	8	
SPO2 PROBES (FINGER CLIPS)	EACH	40	
PULSE OXIMETER	EACH	40	
FLOW SPLITTER FOR OXYGEN SUPPLY	EACH	40	
FLOW METER, THORBE TUBE	EACH	20	
HUMIDIFIER, NON HEATED	EACH	12	
NASAL PRONGS	EACH	100	
OXYGEN CONCENTRATOR	EACH	10	
OXYGEN MASK WITH RESERVOIR, ADULT	EACH	1120	
VENTURI MASK	EACH	100	
LARYNGOSCOPE BLADES: 0,1,2,3,4**	EACH	20	
ENDOTRACHEAL TUBE	EACH	100	
12MONTHS: UNCUFFED TUBE 4.0**	EACH	10	
12 MONTHS: CUFFED TUBE 3.5**	EACH	10	
2 YRS: UNCUFFED TUBE 4.5**	EACH	10	
2YRS: CUFFED TUBE 4.0**	EACH	10	
4YRS: UNCUFFED TUBE 5.0**	EACH	10	
4 YRS: CUFFED TUBE 4.5**	EACH	10	
6-8 YRS: CUFFED TUBE 5.0**	EACH	10	
ADULT FEMALE: CUFFED TUBE 6.5-7.5**	EACH	100	
ADULT MALE: CUFFED TUBE 7.5-10.0**	EACH	100	
ENDOTRACHEAL TUBE INTRODUCER, BOUGIE	EACH	5	
ENDOTRACHEAL TUBE INTRODUCER, STYLET	EACH	100	
COLORIMETRIC END TIDAL CO2 DETECTOR	EACH	5	
RESUSCITATOR ADULT	EACH	12	
RESUSCITATOR, CHILD	EACH	12	
OROPHARYNGEAL AIRWAY, GUEDEL, STERILE	EACH	40	
NASOPHARYNGEAL AIRWAY	EACH	40	
NEBULIZER COMPRESSOR	EACH	4	
CG4+ CARTRIDGES FOR I-STAT BLOOD GASES…OR OTHER MEANS TO SIMPLY MEASURE BLOOD GASES: NB MOST LABS HAVE I-STAT DEVICES)	PK OF 25	4	

INFRA RED THERMOMETER	EACH	0	
KING AIRWAY TUBE , SIZE 4 KLTSD424	EACH	20	
KING AIRWAY TUBE, SIZE 5, KLTSD425	EACH	10	
OXYGEN CYLINDERS	EACH	300	
PORTABLE VENTILATORS, EPV200	EACH	12, FOR REVIEW	
STATIONARY VENTILATORS, HAMILTON (MODEL TO BE CONFIRMED)	EACH	20	
EQUIPMENT			
PORTABLE X RAY	EACH	0	ORDER PLACED WITH CHEMSTREET
SYSMEX XN 550	EACH	0	ORDER ON HOLD WITH MEDPHARM
SYSMEX XN 450	EACH	0	ORDER ON HOLD WITH MEDPHARM
RENOVATION TO POHNPEI ISOLATION UNIT		1	FOR APPROVAL (AES QUOTE + 129K)
BIOFIRE	EACH	3	REVIEW NEED IN LIGHT OF COVID MAY BE ABLE TO BE PERFORMED ON GENEXPERT
BIOFIRE PANELS		8 (2)	REVIEW NEED IN LIGHT OF COVID MAY BE ABLE TO BE PERFORMED ON GENEXPERT
PORTABLE SUCTION MACHINE	EACH	30	15 ON ORDER FOR YAP
BLOOD GAS ANALYZER	EACH	4	