Summary national Strategic Preparedness & Response Plan

for Health in support of COVID-19 in Uzbekistan

COVID-19 in Uzbekistan

The present document is a short summary of the National Health Strategic Preparedness & Response Plan (SPRP), prepared by WHO Uzbekistan in consultation with the Ministry of Health. The national SPRP was issued on 19 March and updated on 6 April. The SPRP outlines the immediate health priorities, with a specific focus on suppressing transmission of the virus and ensuring health systems are capacitated to respond in Uzbekistan This document has been complemented with advice form WHO on Transitioning go the 'New Normal'. and as well suggests guidance to the transition to the new normal.

Context

Worldwide the outbreak of COVID-19 has affected more than 4 million people and has cost more than 300,000 deaths so far. The socio-economic consequences are still not foreseeable but is hitting the world economy and destroys the livelihood of many small and middle enterprises.

Governments all over are working tirelessly to contain the damage as much as possible with continuation of strict physical distancing, thorough testing and contact tracing and isolation for infected persons, quarantine for contacts as well as with mobilizing all possible health care workers and volunteers or even the military to contain the outbreak.

Easily accessible financial support must be provided to families and companies who struggle most because of the outbreak. In Uzbekistan that should also include families of the 10% of Uzbeks working abroad, as labour migrants.

Strategies to prevent a worst-case scenario

Uzbekistan has a population of almost 34 million people, where the majority is younger than 35 years of age. The Government, with the Ministry of Health in the lead, has been pro-active and started COVID-19 preparedness already as of half January 2020.

The worst case scenario is based on estimations from other countries and applies when no efforts and or measurements are put in place at all by a Government. The Uzbek Government has put in place many preventive measurements and as well has made efforts to increase and improve hospital readiness.

The Government estimates, as a worst case scenario, that 10 % of the population will be infected. From those, maximum 40 % will need hospitalization and from those hospitalized, 5 % will need specialized Intensive Care Unit support.

The following areas should be considered by the Uzbek Government and are in line with WHO recommendations and based on best practice internationally.

i. ***National and international coordination*** **works well and needs to be continued in a transparent and trusted way.** The MoH is a leading member of the two national Commissions (Special Republican Commission covering the health response and the National Anti-Crisis Commission covering the socio-economic response). The Commissions are working in close collaboration with WHO and the wider UN Country Team and other partners in health, as well as donors and multilateral development banks. Coordination inside the health system is well defined and WHO recommendations are implemented.

ii. ***Emergency Risk Communications.*** **Most important for the Government is to keep the trust and compliance of the population** through honest, transparent and frequent situation updates.

- A daily public update on trustworthy COVID 19 figures on national and oblast level by state mass media with indication of local hot-spots coupled with reminders on physical distancing, frequent hand-washing, wearing masks in public and at home (if caring for a sick or if the person is ill) and self-observing symptoms including self-quarantine.
- Implementation and adaptation of the risk communication plan developed by the UN jointly with the MoH and the Government.
- Compliance to lockdown and physical distancing/hygiene measures must be encouraged by Government, health care personnel, public influencers, religious leaders, celebrities, Red Crescent volunteers and by the public themselves. Police should be deployed to enforce compliance in case of violations, in accordance with national law and international human rights obligations.
- Restrictions on public life (closure of schools and shops, businesses etc.) must be continued till the infection rate is visibly going down over several days. Restrictions should be constantly explained and encouraged by state media and the Government.
- The Government must announce and broadly implement measures how to support businesses and workforces during and after the COVID 19 lockdown financially and socio-economically.

iii. ***Surveillance and case investigations*** **play a major role in identifying COVID 19 infected persons** and their contacts and thus 'containment of the outbreak'.

- Step up significantly communication for the public about first contact strategy via call centres, online platforms, and/or physical approach.
- Detection, testing, contact tracing and quarantine/hospitalisation need to be carried out faster by experienced personnel (training is ongoing).
- A national electronic system must be implemented to improve speed and quality of detection and managing of COVID cases, including training, (requested under the SPRP) that connects all health care facilities, laboratories and hospitals in real time.
- Increase the number and capacities of Rapid Response Teams in all oblasts and connect them to the electronic system via tablets.
- To strictly test only suspected cases and their contacts, in order to rationally use available tests.
- Test kits must be available in all oblasts, down to villages, and trained sample takers arrange the correct transport of samples to the next designated laboratory.
- WHO-approved tests should be provided widely to increase the number of tested persons.
- Medical personnel and the tested person should receive test results on the same day or latest the day after sample taking to quickly be further managed.
- Organize and expand services for home care for COVID-19 patients, with the possibility to get information/advice over a hot line and how to protect the care giver and the rest of the family from infection.
- The Government must make sure that enough and adequately staffed and equipped additional isolation and quarantine facilities are available. Food catering and psycho-social support need to

be available at the facilities. For mental health reasons and to ensure continued contact with families and relatives, persons isolated and or put in quarantine should be given access to their mobile phones, devices and provided with internet access.
    - A positive tested person should be isolated (either in a hospital, in an assigned isolation facility and or at home);
    - A contact should be put in quarantine (either a designated quarantine facility, such as a school, hotel, stadium, sanatorium etc) or put at home -quarantine.
- Expand the number of designated hospitals through a surge plan in both public and private sectors.
- Expand beyond designated hospitals into alternative designated public and private facilities if needed e.g. tents, hotels to be transformed into hospitals.

iv. ***Point of entries*** **are still mainly closed and should remain closed or strictly controlled by medical personnel if reopened**. Distribution of public health advocacy material, temperature scanning and mandatory filling in of health declaration forms for each traveller must be performed.

- A 14-day obligatory quarantine of all travellers from abroad (hotel, home, special quarantine facilities) to continue to be implemented.
- Suspected cases should have specialised transport at the PoE to hospitals or quarantine facilities.

v. ***Laboratory staff*** **in all 14 provinces received training in working with PCR machines on testing for COVID 19.**

- Availability and rational use of test kits is paramount to contain the spread of COVID 19.
- All designated laboratories in all provinces have several PCR machines (200 requested in SPRP) and can use them for COVID 19 testing.
- Designated labs must work in shifts 24/7 to provide and report trustworthy results still the same day in an electronic way.
- The purchase of additional PCR machines under the SPRP will increase the speed and the number of possible tests.
- Other laboratories, including private laboratories, might be involved in COVID testing if need be.
- MoH must ensure that tests and the needed reagents are available to allow a throughout testing at all areas of the country at any time.
- The four mobile laboratories with integrated PCR machines (requested in the SPRP) will be stationed in remote areas or in hotspots to ease the load on designated laboratories.

vi. ***Infection prevention control*** **is the key requirement to a successful containment of the highly infectious disease and to keep health care workers able to work.**

- MoH should ensure that enough PPE are available for medical personnel working with COVID 19 patients but also for all other health care workers in any facility and at all levels of the system and nationwide. Regardless of the services the clinic is providing (including all non-COVID clinics), any health worker should have access to enough and quality PPE.
- PPE must be made available to caregivers of infected people at home
- Protect other potential first contact health system entry points with PPE, assuming not all people will follow advice.
- For all health care workers of all clinics nationwide, personnel should regularly review how to use PPE, under what circumstances this needs to be used, and how to report shortages.
- Ensure enough PPE availability and training for all isolation and quarantine facilities

vii. ***Case management*** in a worst-case scenario with an overwhelming COVID 19 patient load requires establishment of make-shift hospitals staffed with additional medical personnel from less affected oblasts and surge personnel and equipment requested in the SPRP (oxygen devices and ventilators).

- Define places or buildings where additional hospitals can be set up.
- Refine the staff surge plan and train other health care workers on COVID specifics, incl. infection control.
- Do not use drugs for malaria, or HIV, or steroids or ARI to treat COVID 19 patients, as there is no proven benefit and can eventually do harm and worsen the condition.
- Consider ethical questions on who receives ventilators and who not.
- Prioritize the purchase of oxygen devises and lung ventilators as per SPRP.
- In the event hospitals become overloaded, reduce the number of persons that have access to hospitals, namely non-urgent patients, students, medical representatives, patient visitors, etc.
- Anticipate and address mental health needs of the health workforce

viii. ***Essential health services*** **must continue for the most urgent acute patients and the chronically ill,** not to increase the mortality rate further.

- Continuity of hospital beds, specialised doctor and nurse services, essential drugs and monitored home care for (non-COVID-19) acute or chronic patients need to be available, including for persons in closed institutions, people with limited mobility, and persons in quarantine locations.
- Import of drugs and devices needs to be continued without delay
- Essential other programmes and services need to continue as usual: immunization programme, TB and HIV programme, drug and alcohol dependency programmes , maternity and paediatric services and dental care.

Strategy to transition to the 'New Normal'

Managing the transition phase effectively will depend on finding the best equilibrium between modulating restrictive large-scale public health interventions and keeping disease transmission under control by strengthening core public health interventions, such as identifying, isolating, testing and caring for all cases, and tracing and quarantining all contacts together with personal protective measures (hand hygiene and respiratory etiquette) and individual physical distancing (>1 metre distance).

To ease large-scale public health restrictive measures, WHO recommends considering the following six conditions:

i. Evidence shows that COVID-19 transmission is controlled.
ii. Sufficient public health and health system capacities are in place to identify, isolate, test and treat all cases, and to trace and quarantine contacts.
iii. Outbreak risks are minimized in high-vulnerability settings, such as long-term care facilities (i.e. nursing homes, rehabilitative and mental health centres) and congregate settings.
iv. Preventive measures are established in workplaces, with physical distancing, handwashing facilities and respiratory etiquette in place, and potentially thermal monitoring.
v. Manage the risk of exporting and importing cases from communities with high-risk of transmission.
vi. Communities have a voice, are informed, engaged and participatory in the transition.

Measures must be eased in an incremental, step-wise manner leaving sufficient time (around 2 weeks) to elapse for the true impact of the easing to become fully visible. The time interval between relaxation of two measures depends largely on the quality of the surveillance system and capacity to measure the effect.

Transition is likely to be a bidirectional process and countries must be ready to constantly monitor, adjust, move forward and quickly reverse processes depending on the disease transmission patterns and how they change as a result of the shifts in restrictive measures as well as the manner in which people react to the easing of the restrictions. It is extremely important to emphasize that in practice, risk will depend very much on people's interactions, behaviour and cultural or living arrangements. There is no "copy and paste" solution from one country to another.

Due consideration should be given to progressive easing**.** When deciding which measures should be reversed first, modelling suggests that lower risk activities could include use of public spaces and people allowed out of the home but still keeping a physical distance (>1 metre distance) while higher risk activities could include reopening of bars and restaurants, schools, non-essential retail and some small gatherings. Informed by a risk assessment at national, subnational or even community levels, progressive modulation of measures could be around geographical segmentation starting first in areas of lower population density (rural vs. urban, or small cities vs. large cities), age segmentation (younger people returning to work earlier than older people) or workplace segmentation (with workplaces where physical distancing can be observed more easily opening earlier).

Attention should be given to avoid crowding in public areas; for example, transport and transportation hubs.

Until a vaccine is made available, individual physical distancing (e.g. >1 metre distance), hand hygiene and respiratory etiquette by all the population and public hygiene measures must continue to play an important role, even as large-scale restrictive measures are adjusted.

If the use of medical masks is promoted among the population, it is of paramount importance to ensure access to masks for the health workforce first. In addition, it is important for individuals to be aware of the proper use of masks and that their use does not replace the need for individual physical distancing (>1 metre distance) and personal protective measures (hand hygiene and respiratory etiquette) as these measures remain the backbone interventions to interrupt transmission.

Reversal of "shielding" measures are more likely to lead to disease resurgence with serious consequences in vulnerable populations. Easing of these measures should be given additional consideration to determine the conditions at which to ease such interventions.

The impact that easing different measures may have on potential disease transmission remains very uncertain. Carefully monitoring the reproductive factor (Rt) in real time will be essential. While it is recommended that this is below <1 (declining rate of new cases) to ease largescale physical distancing measures, it is useful to recall that the Rt is only as accurate, valid and reliable as the epidemiological data that feeds into it. Usually, the Rt is based upon reported case numbers, which can change due to other variables such as testing practice and health care seeking behaviour. More importantly, it should only be one of several indicators that countries use to evaluate disease transmission patterns. Effects of modulation of measures are likely to have a time delay of around 14 days.