Ministerie van Volksgezondheid

FIGHTING COVID-19 TOGETHER

A COMPREHENSIVE NATIONAL PREPAREDNESS AND RESPONSE PLAN FOR COVID-19 IN SURINAME

• Virginia Asin-Oostburg MD, MPH, BPhT

6-5-2020

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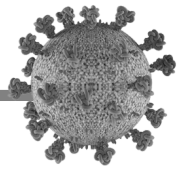

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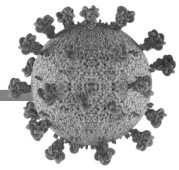

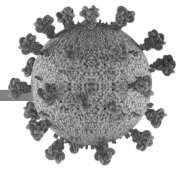

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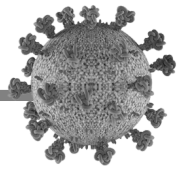

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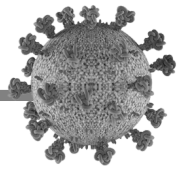

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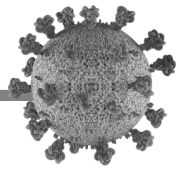

List of Annexes (provided in a separate document)

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Annex 2: Draft SOP EOC structure and operations

Annex 3: Risk Communication and Community Engagement COVID-19 IN SURINAME, version: 07, May 2020

Annex 4: Draft Standard Operating Procedures (SOP) COVID 19, version 24 February 2020;

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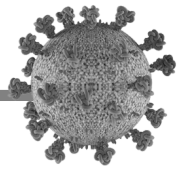

ACKNOWLEDGEMENT

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First and foremost, and on behalf of the Government of Suriname, I wish to thank the Director of Health, Dr. Cleopatra Jessurun, for her leadership in the development of such an important planning document for Suriname, and Ms. Diana Pinto Masis, Health Lead Specialist for the IDB, for supervising the development process on behalf of the MOH and the IDB, and the close collaboration with the Consultant, Dr. Virginia Asin-Oostburg.

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1. Ms Yldis Pollack-Beighle, Minister of Foreign Affairs and staff members:
    a. Mr Carl Lijong
    b. Ms Jacqueline Warso
2. Ms Lilian Ferrier, Minister of Education Science and Culture
3. Mr Rabin Parmisser, Minister of Agriculture, Husbandry and Fishery
4. Mr Stephen Tsang, Minister of Trade, Industry and Tourism
5. Mr Soeharto Moestadja, Minister of Labor and
    a. Mr. Glenn Piroe, Deputy Director Judicial Affairs, Ministry of Labor
6. Ms. Angela Salmo, Director Social Affairs, Ministry of Social Affairs and Housing

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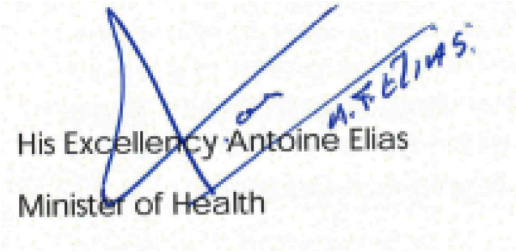
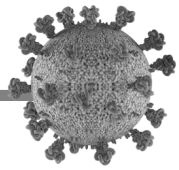
Last but not least, I thank the Consultant, Dr. Virginia Asin Oostburg, for her unwavering commitment to produce a plan that is widely supported by experts, politicians and all sectors of society and is tailored to the Suriname situation.





PREAMBLE

The Government of the Republic of Suriname,

Recognizing that the COVID-19 pandemic, primarily started as a health crisis and further expanded with negative socio-economic effects, has presented difficult challenges for the global community to overcome,

Acknowledging that the current national ad hoc measures to stop the further spread of COVID-19 and prevent mass outbreak beyond control, require a structural and integral approach,

Aware that the ad hoc measures that are mainly aimed at safeguarding individuals against COVID-19 as to prevent a mass outbreak, have negative socio-economic consequences for society as a whole,

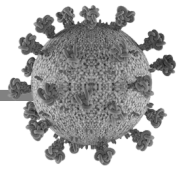
Determined to develop and implement a "COVID-19 National Preparedness and Response Plan" to effectively contribute to the process of eliminating or reducing risk to manageable proportions of the COVID-19 pandemic, in good coordination and harmonization with all crucial sectors,

Bearing in mind that the COVID-19 pandemic, even though evolved to a global economic crisis, must be tackled primarily at the root from a medical point of view, hence the initiative to draft the 1st "COVID-19 National Preparedness and Response Plan" from a perspective of Public Health,

Encouraging all government Institutions responsible for the vulnerable and crucial sectors, to draft their own "Preparedness and Response Plan" in conformity with the "COVID-19 National Preparedness and Response Plan". It is of paramount importance that the Government of the Republic of Suriname, through all its relevant Departments and Institutes, adopt all possible measures to protect its citizens and safeguard all vulnerable and crucial sectors of society against disastrous socio-economic effects,

Further recognizing that the COVID-19 Pandemic has presented difficult challenges to sister nations and also affected the dynamics of geopolitics,

Convinced that Suriname can also be of service to the global community, in particular the direct region, with a "National Preparedness and Response Plan" aimed at strengthening and further developing its production sectors related to food security and –safety, among others. Considering at all times the harmonization of our policies with the rest of the region.



Foreword Director of Health, Drs. Cleopatra Jessurun

We can't live this way forever. We all want to get back to some semblance of normality – whether that's seeing our friends and family, getting back to work or school, or just being able to spend our free time in the way we want to.

This document sets out the steps that will take us there. It doesn't have all the answers and it doesn't set exact timescales. That's because we are still learning about the virus. We will have to move carefully and gradually to ensure we keep it under control and develop the best ways of doing so.

Too many people have lost their lives to this disease already, around the world. We cannot risk a COVID-19 outbreak here, in Suriname – most importantly because that would mean many deaths, and also because it would mean another lockdown.

In the past weeks we have seen what the hard work of the Ministry of Health and it partners has achieved, with a very low case load of COVID-19 and only one death.

We know that a lockdown and the measures taken by the National COVID-19 Management Team are doing harm of its own. They are causing loneliness and social isolation, deepening inequalities and damaging the economy.

None of us want these to last any longer than they have to.

So we are setting out the phases by which we will aim to ease these measures. They are gradual and incremental and will be matched with careful monitoring of the virus. We may, at times, need to hit the brakes on easing. However, it may also be that we are able to ease restrictions faster than we initially thought that we could.

The biggest single factor in all of this will be how well we continue to observe advice designed to control the virus. Continued hand washing, cough hygiene and physical distancing will be essential - so too will compliance with our test, trace, quarantine and isolate and treat system.

This will mean that our workplaces, our social hangouts and public transport will look different from normal – we have to get used to things being different and it is going to be that way for a while.

Unfortunately, in some ways, easing the measures will also be more complicated than the present situation – with the trade-off that we will be able to do more. Our messages will

necessarily become more complicated as we begin to ease lockdown measures, recognizing that every decision we take as individuals will have an impact on our collective wellbeing.

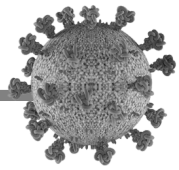
As we move through the different phases of easing it is incumbent on us to give you clear guidance on what that will mean for you. We will also give notice as to when changes are happening so people have time to prepare.

The COVID-19 crisis is both complex and uncertain. The Ministry of Health is sharing this plan, based on our current understanding about the epidemic, about the broader consequences of the crisis for our health, our economy and society, and about how our responses are mitigating the impacts of the crisis. Both the epidemic and our understanding continue to develop and so we too will continue to develop our plans, to share them, and seek expert and societal views on how they might be improved. We may not get everything in this complex and uncertain crisis right the first time, but we will continue to listen and to do everything we can to improve our responses.

The way we make progress more quickly is by being open about where we are controlling the virus and sticking closely to the rules that are in place at the time, by continuing to work together to suppress the virus further and restore a way of life in Suriname that is as close to normal as possible.

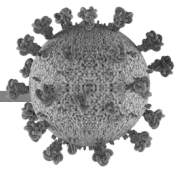
Cleopatra Jessurun,

Director of the Ministry of Health



LIST OF ACRONYMS

ARI	Acute Respiratory Infection
AZP	Academic Hospital Paramaribo
BGVS	Medicine Supply Company Suriname
BOG	Bureau of Public Health
BVS	Bankers Association Suriname
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CDB	Caribbean Development Bank
CL	Central Laboratory
COVID-19	Coronavirus Diseases 2019
CSO	Civil Society Organization
DC	District Commissioner
DKZ	Diaconessen Hospital
DNV	Directorate National Security
EOC	Emergency Operating Center
GOS	Government of Suriname
HCF	Health Care Facilities
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standard Committee
IDB	Inter-American Development Bank
IHR	International Health Regulations
ILI	Influenze Like Illness
IPC	Infection Prevention Control
IsDB	Islamic Development Bank
KKF	Chamber of Commerce
LH	s Lands Hospital
M&E	Monitoring and Evaluation
MH	Military Hospital
MHPSS	Mental Health and Psycho-Social Support
MM	Medical Mission
MMC	Mungra Medical Hospital
MML	Molecular Microbiology Laboratory
MoH	Ministry of Health
NAPHS	National Action Plans for Health Security
NC-19MT	National COVI-19 Management Team
NCCR	National Coordinating Center for Disaster Management
NCD	Non Communicable Diseases
NGO	Non-Governmental Organization
NII	National Information Institute
NIS	National Indoor Stadium
GZA	Health Care Assistant
NPHRT	National Public Health Response Team
PAHO	Pan American Health Organization
PCS	Psychiatric Center Suriname
PHC	Primary Health Care
PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operating Center
PIPP	Pandemic Influenza Preparedness Plans
POE	Points of Entry
PPE	Personal Protective Equipment
PR	Public Relation
RCCE	Risk Communication and Community Engagement
RGD	Regional Health Services
RRT	Rapid Response Team
SARI	Severe Acute Respiratory Infection
SOP	Standard Operating Procedure
SoZaVo	Ministry of Social Affairs and Housing
SurVAM	Suriname Association for Insurance Companies
SVZ	Sint Vincentius Hospital
SZF	State Health Fund
TB	Tuberculose
UN	United Nations
VES	Association of Economists Suriname
VMS	Association for Medical Practitioners
VP	Vice President
VSB	Association for Surinamese Entrepreneurs
WASH	Water Sanitation and Hygiene
WHO	World Health Organization



EXECUTIVE SUMMARY

The republic of Suriname on the North East coast of South America has a population of about 600,000 with a median age of 32 years. Most people live in the coastal area and there is a large hinterland with about 50,000 inhabitants (Figure 2 and 3).

There are 1.2 doctors per 1,000 inhabitants and in 2016 the health expenditure per capita was USD 362. From 2014 basis health insurance is mandatory for all residents.

In Suriname the first COVID-19 patient was tested positive on 13 March 2020. From 13 March 2020 up to April 16, 2020), 10 persons have tested positive[1]. After a period of zero active cases, around the elections of May 25th end the week thereafter, 4 new cases were diagnosed.

The World Health Organization (WHO) has identified four scenarios for the COVID infections based on the number of cases diagnosed. Suriname classifies for the scenario "sporadic cases".

The guiding principles in the comprehensive National Strategic Preparedness and Response to the COVID-19 pandemic are to;

- Slow and stop transmission, prevent outbreaks, and delay spread.
- Provide optimized care for all patients, especially the seriously ill
- Minimize and mitigate the impact of the epidemic on the Surinamese health systems, social services, and economic activity.

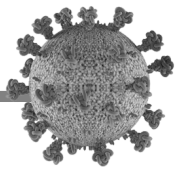
The Government of Suriname immediately activated the response team at the buro of public health of the Ministry of Health and the National Coordinating Center for Disaster Management to respond to this pandemic.

The government of Suriname has taken clear measures to respond to the COVID pandemic;

- Closing of all schools
- Closing of all borders
- Closing of the international airport
- Physical distancing
- A curfew from 20.00 – 06.00 hrs.
- Mandatory government quarantine for repatriated citizens
- Contact tracing of all diagnosed cases
- Partial lockdown

Suriname has several advantages in the response to the COVID-19 pandemic, that are;

- A relative early and decisive response
- A young population



- Not having a dense population

The challenges for Suriname are;

- Protection of the large hinterland
- Monitoring the large border rivers in the East and West
- Upcoming elections on May 25th, 2020

In the response there has been constant contact with regional and international health agencies (CARPHA, CDEMA, PAHO) as well as International development partners (IDB, IsDB, CDB).

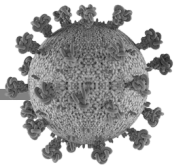
The National partners in the response to the COVID-19 are (Table 3);

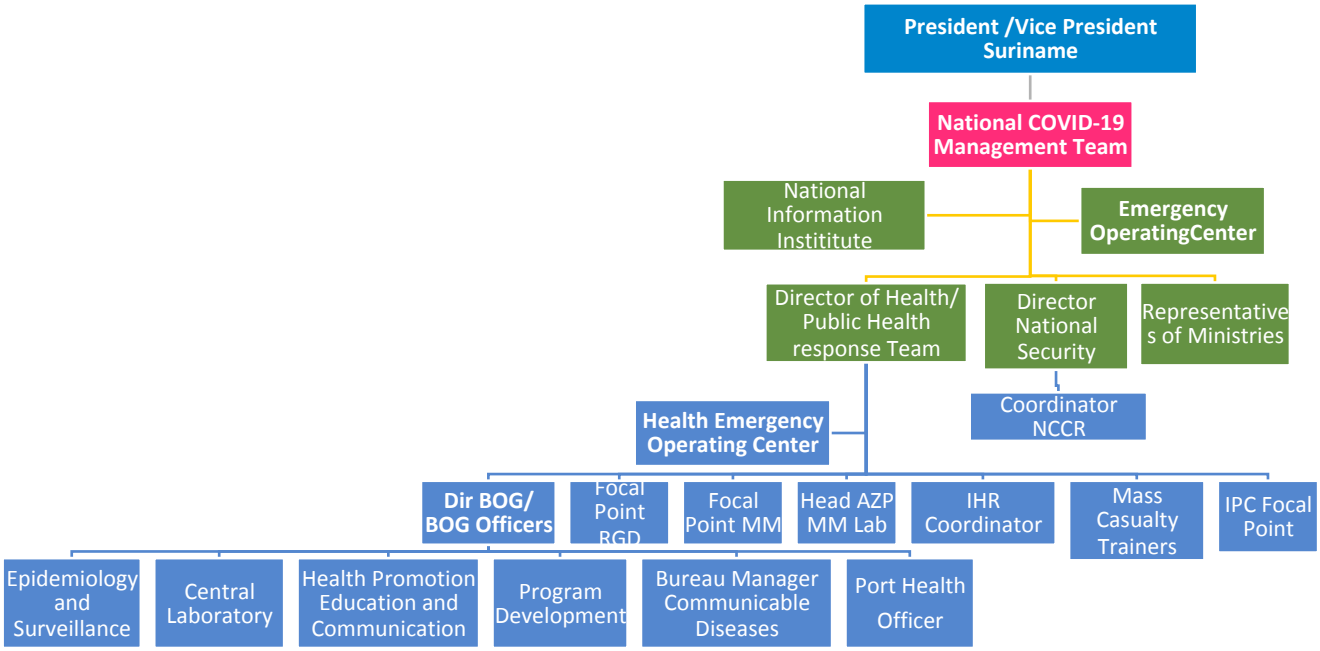
- The Ministry of Health
- The Public Health Response Team
- The Cabinet of the President/Vice President
- The National COVID-19 Management Team
- The Directorate of National Security
- The National Coordinating Center for Disaster Management

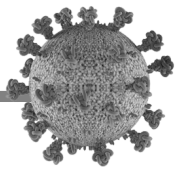
All health services providers, primary and secondary care, were involved in the preparedness and response to the COVID-19 pandemic (Table 4) and their responsibilities identified (Table 7).

The cabinet of the President and Vice President, and all Ministries were each assigned responsibilities in the COVID-19 response (Table 6).

The Command structure for the National Response to the COVID pandemic is given below.




President /Vice President Suriname
National COVID-19 Management Team
National Information Instititute
Emergency OperatingCenter
Director of Health/ Public Health response Team
Director National Security
Representatives of Ministries
Coordinator NCCR
Health Emergency Operating Center
Dir BOG/ BOG Officers
Focal Point RGD
Focal Point MM
Head AZP MM Lab
IHR Coordinator
Mass Casualty Trainers
IPC Focal Point
Epidemiology and Surveillance
Central Laboratory
Health Promotion Education and Communication
Program Development
Bureau Manager Communicable Diseases
Port Health Officer



The WHO has identified 9 pillars around which a preparedness and response can be developed. Suriname has used these 9 pillars and applied it to the scenarios of no cases, sporadic cases, clusters of cases and community transmission.

These nine pillars of the WHO are;

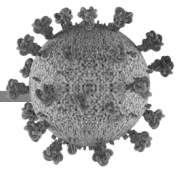
Pillar 1: Country-level coordination, planning, and monitoring
Pillar 2: Risk communication and community engagement
Pillar 3: Surveillance, rapid response teams, and case investigation
Pillar 4: Points of entry
Pillar 5: National Laboratories
Pillar 6: Infection prevention and control
Pillar 7: Case management
Pillar 8: Operational support and logistics
Pillar 9: Maintaining essential health services during an outbreak

The key actions in each pillar and the activities for each pillar in each scenario are presented in Table 11 and 12.

Special attention should be given to psychological support during the epidemic, especially for the health workers, diagnosed patients and quarantined people.

The specific government's role in the COVID-19 response with estimated budget is presented in Table 13. The total non-health estimated budget for the COVID-19 response is estimated on SRD 910 million.

The needs assessment for Personal Protection Equipment (PPE) is presented in a separate report. The total estimated budget for PPE for 3 months is USD 4,759,995.00, including estimated USD 666,700 needed for 3 months for logistics and operational support of the pandemic response.



CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The interventions and policy decisions taken by the Government of Suriname (GOS), and the cooperation of the population has resulted in an early containment of the COVID-pandemic in Suriname. Alertness is required as a few new cases have presented after having been an active COVID free country for a month.

Suriname needs to prepare for the potential outbreak of new cases that can lead to clusters of cases in the country. Especially, the monitoring of the Border Rivers on the East and West are of importance, and the illegal entry through boats (so called schoeners) from Brazil. The neighboring countries to Suriname, French Guyana, Guyana and Brazil all are worse off regarding COVID-19 cases.

Recommendations

1. Suriname should use the momentum to put measures in place to prepare for an eventual second wave of COVID-19, decide on preparing for clusters of cases. In that case the PPE purchase for this situation, Situation II (see PPE document) should be procured.

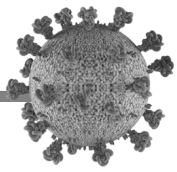
2. Given the diagnosis of several new cases in the end of May it is recommended to continue the current interventions taken by the GOS till the end of June.

3. Further activate and prepare all stakeholders and reserve the required budget for the Ministries to fulfill their described responsibilities.

4. Formalize the organizational structure of the COVID-response to that for all public health emergencies and update the following plans;
    a. National Pandemic Influenza Readiness Plan
    b. Health Disaster Plan
    c. National Disaster Plan

5. Formalize an effective communication and reporting structure in the COVID response and facilitate the hiring required key personnel.

6. Response to COVID-19 pandemic is proving to be a test on efficiency and effectiveness of the health system and of collaboration and cooperation with other health and non-health sectors, partners and stakeholders on national, regional and international level. It has proven the need for the health in all sectors policy and has



identified required strengthening of the Ministry of Health, Bureau of Public Health (BOG).

7. Following this preparedness and response plan there is need for a detailed implementation plan with protocols, guidelines, instructions and Standard Operating Procedures (SOPs).

8. Confirm the support from Regional and International organizations for technical support, training and readiness assessment.

9. Develop a strategy for a step by step release of the lockdown and opening of the borders, depending on;
    a. COVID-19 is endemic and contained
    b. The pandemic is declared over
    c. Availability of vaccinations
    d. Early Warning Systems (EWS) are effective in monitoring the disease and in picking up "signals" across the globe.

10. Develop, set up and institutionalize a "COVID-19 National Early Warning System" (COVID-19-NEWS) for National Risk Reduction and Case Importation. In collaboration with CARICOM this can be expanded to a CARICOM-EWS. This item can be proposed at the next CARICOM health ministers and Council for Human and Social Development meeting.

11. Provide psycho-social support during and after the COVID pandemic.

12. Prepare outlines for a post pandemic (COVID-19) recovery period.


Suriname to
ns in the Americas
No Smoking

Background

Demographics

The Republic of Suriname is a country on the northeastern coast of South America is bordered by the Atlantic Ocean to the north, French Guiana to the east, Guyana to the west and Brazil to the south. At just under 165,000 square kilometers, it is the smallest sovereign state in South America.

Area: 63,251 sq mile
Total population: 597,927 (Juli 2018)
Median age (years): 32.47
Annual population growth: 1,18%
Literacy rate ≥ 15 years: 95%
Population under 15 years: 26%
Population over 60 years: 12%
Life expectancy Male: 71.02 years
Life expectancy Female: 75.88years

Source: PAHO core indicators 2019, Bureau of Statistics Suriname, Epidemiology (Bureau of Public Health)

Suriname has a population of approximately 597,927, most of whom live on the country's north coast, in and around the capital and largest city, Paramaribo.

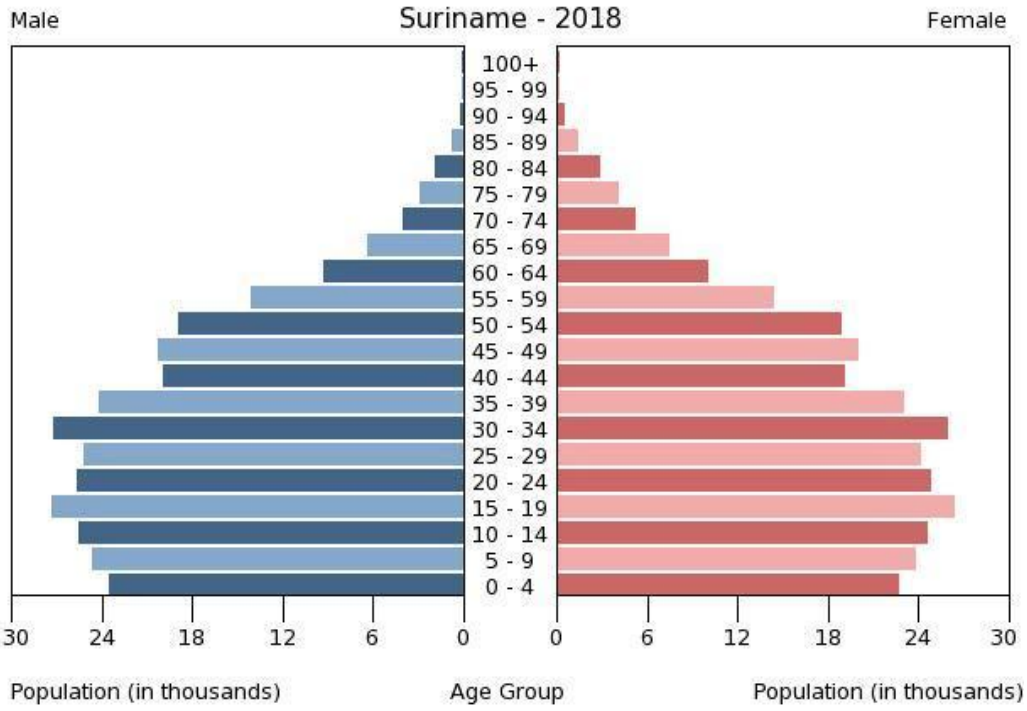
Table 1: Age structure of the population of Suriname in 2018

Source: Bureau of Statistics Suriname

Age group	Percentage	Male / Female distribution
0-14 years:	24.11%	(male 73,466 /female 70,704)
15-24 years:	17.36%	(male 52,876 /female 50,913)
25-54 years:	44.42%	(male 135,282 /female 130,327)
55-64 years:	7.94%	(male 23,377 /female 24,085)
65 years and over:	6.17%	(male 16,019 /female 20,878)

The population pyramid below (Figure 1) shows the 2018 population distribution based on the age structure shown in Table 1.

Figure 1: Population distribution 2018[2]



From 2000 to 2018 Suriname has increased in population from 431.303 in 2000 to 597.927 in 2018, with an increase in average age in the same period from 28.71 in 2000 to 32.47 in 2018. See Figure 2 and 3, (Source: Bureau of Statistics Suriname).

[2] Source: PAHO core indicators 2019, Bureau of Statistics Suriname, Epidemiology (Bureau of Public Health)

Figure 2: Population growth 2000 - 2018

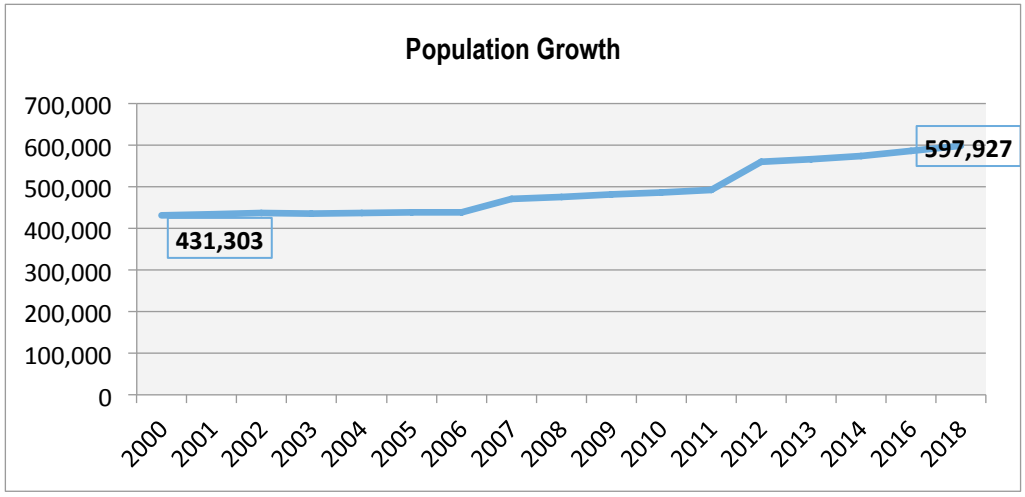
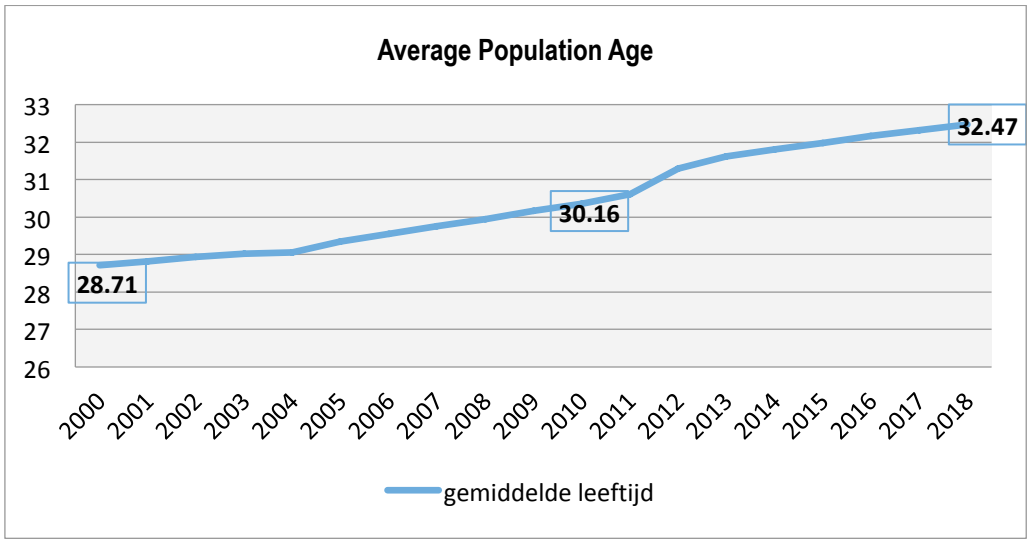


Figure 3: Average age of the population



The Health System in Suriname

Primary Health Care delivery in Suriname is organized around geographical areas Paramaribo, the Capital City of Suriname, the Coastal area and the Hinterland. Health care services are provided by Public and Private Health Care Providers. The Medical Mission (MM) with 51 clinics and the Regional Health Service (RGD) with 63 clinics, deliver public health care in respectively the Hinterland and the Coastal area while the majority of private primary health care providers are located in and around Paramaribo.

Secondary and Tertiary care is provided by 5 hospitals in Paramaribo and 3 Hospitals in the Districts Wanica, Nickerie (western border) and Marowijne (eastern border).

The Paramaribo hospitals are:

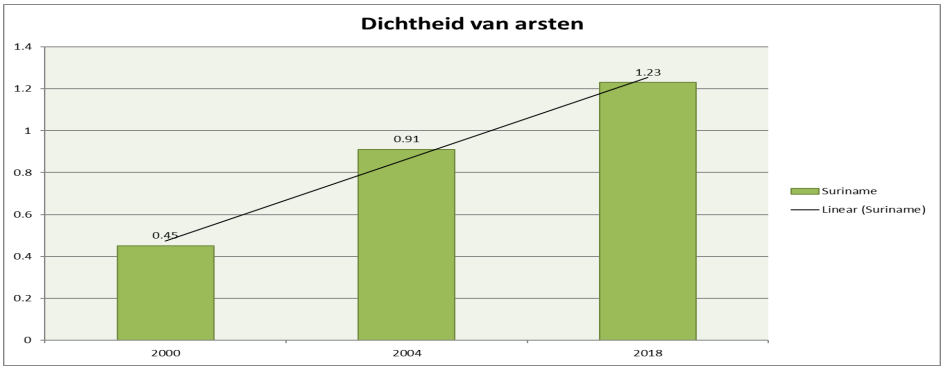
1) Academic Hospital Paramaribo (AZP) - public
2) s Lands Hospital (LH) - public
3) Sint Vincentius Hospital (SVZ) - private
4) Diaconessen Hospital (DKZ) - private
5) Military Hospital (MH)

The 3 other hospitals are respectively (all public):

1) Wanica Hospital;
2) Mungra Medical Center (MMC)
3) The Marwina Hospital.

Primary, Secondary and Tertiary care is mainly provided by Doctors (including medical specialists), Nurses and Midwives. The Medical Mission also works with Health Care Assistants (GZA) at the clinics in the Hinterland. Figure 4 below shows the increase in the ratio of the number of doctors per 1.000 population in Suriname from 2000 to 2018 from 0.45 in 2000 to 1.23 (that is 1.23 doctors per 1.000 population). According to the WHO estimates, on average 2.3 health care worker (doctors, nurses and midwives) per 1.000 population is sufficient to cover primary care needs.

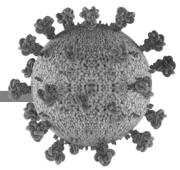
Figure 4: Density of Doctors per 1,000 population



Cost of Healthcare and Health Insurance

Legislation on Basic Health Insurance (from 9 October 2014) makes it mandatory that every resident of Suriname must be insured. Under the constitution all residents of Suriname have the right to health care. Expatriates legally residing in Suriname also have the right to health care.

The 2018 Suriname Health Accounts 2016 Statistical Report presented the analysis of the estimated amount and flow of health spending in the Suriname health system. In addition to



estimating general health expenditures, this analysis also looked closely at spending on priority diseases such as HIV and non-communicable diseases, and the sustainability of financing in light of the National Basic Health Insurance Law passed in 2014.

Total health expenditure (THE) in Suriname in 2016 amounted to SRD 1,249,855,860 (USD 202,471,385), of which 99% was spent on health goods and services consumed within the year of the Health Accounts analysis. The balance of 1% was for capital investments, which includes infrastructure and equipment. Table 2 provides an overview of "Key Health Financing Figures" for 2016.

Table 2: Key health financing data 2016

Indicator	**2016 (SRD)**	**2016 (USD)**
Total population	558,368	-
Nominal GDP	20,420,222,000	3,307,989,956
THE	1,249,855,860	202,471,385
Total current health expenditure	1,238,322,730	200,603,066
Total capital health expenditure	11,533,130	1,868,318
THE per capita	2,238	362
THE as a percentage of GDP	6%	-
Total government health expenditure	675,755,160	109,469,489
Current government health expenditure	672,804,950	108,991,568
Capital government health expenditure	2,950,210	477,921
Total general government expenditure	4,714,900,000	852,162,643
Government health spending as a percentage of GDP	3.3%	
Government health expenditure as % of general government expenditure	13%	-
Who funds health? Key financing sources (%THE)		
Government	54%	
Households	33%	
Other	13%	
Who manages health resources? Key financing agents (% THE)		
SZF	37%	
Households	22%	
Commercial Insurance Companies	22%	
Government	18%	
NGOs	1%	
Corporations	<1%	
Where are health funds spent? Key health care providers (% THE)		
Hospitals	38%	
Clinics	34%	
Pharmacies	13%	
Laboratories and Diagnostic Imaging	7%	
Administrators	5%	
Other	3%	
Providers Abroad	1%	
What types of health care are consumed? Key health functions (% THE)		
Curative Care	68%	
Pharmaceuticals	13%	
Laboratory and Diagnostic Imaging	7%	
Preventive Care	6%	
Administration and Governance	5%	

Other	1%

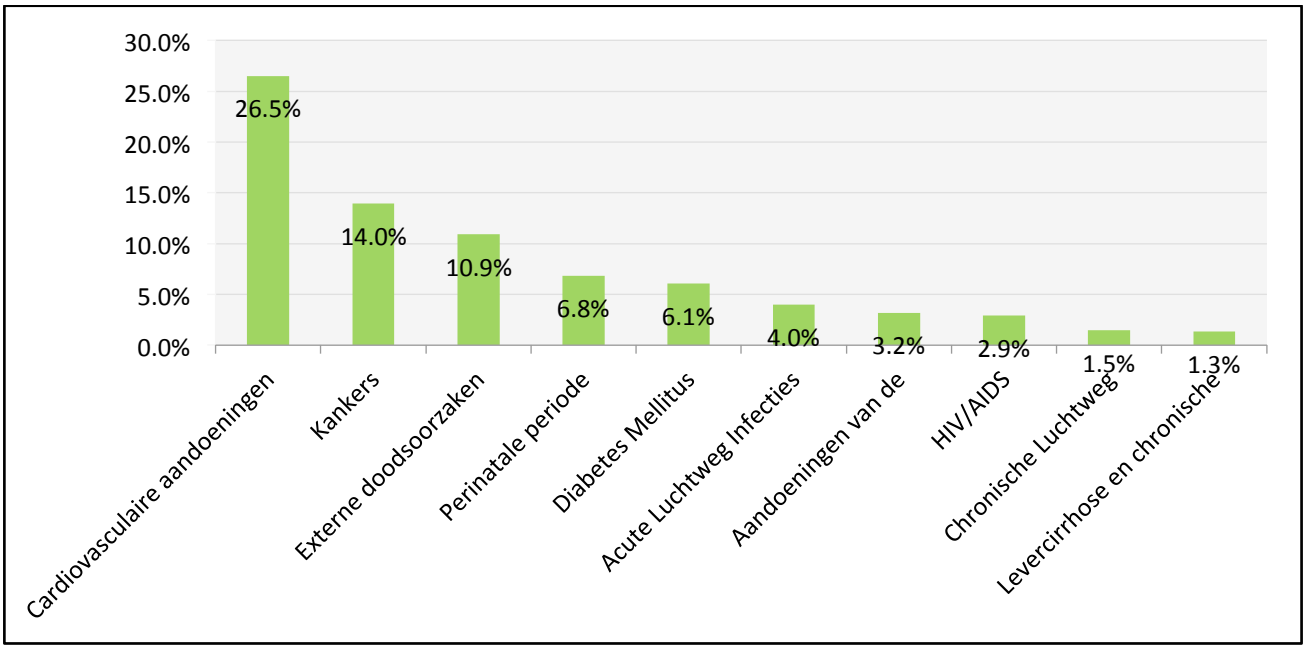
Source: Suriname Ministry of Health. September 2018. *Suriname 2016 Health Accounts Report*. Paramaribo, Suriname.

Three types of **health-care financing** cover the cost of care for the people in Suriname:

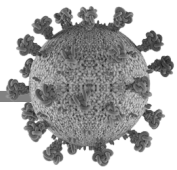
1) The State Health Fund (SZF) covers 60% of the population, civil servants and their family members
2) The Ministry of Social Affairs (SoZaVo) pays premium for the poor which is on average 20% of the population
3) Private insurance companies cover the remaining 20% of the population.
4) Out of pocket expenses
5) Government responsibilities such as public health programs

The latest mortality data published by the Bureau of Public Health (BOG) in 2014, shows that the main causes of death are attributed to chronic diseases with more than 45% of deaths due to preventable chronic Non-Communicable Diseases (NCD) such as cardiovascular diseases (26.4%), Cancer (14.0%) and Diabetes Mellitus (6.1%). The list of 10 main causes of death also included 4% of persons dying of acute respiratory infections due to bacterial or viral infections, Figure 5.

Figure 5: Causes of Death 2013[3]



[3] Source: Causes of death Buro of Public Health (BOG), 2014



Introduction Pandemics and COVID-19

The COVID-19 Pandemic[4]

An outbreak is the occurrence of disease cases in excess of what's normally expected, according to the World Health Organization. **An epidemic** is more than a normal number cases of an illness, specific health-related behavior or other health-related events in a community or region.

A pandemic is defined as the "worldwide spread" of a new disease.

The last pandemic reported in the world was the H1N1 flu pandemic in 2009, which killed hundreds of thousands globally.

Three criteria must be met for a pandemic to occur:

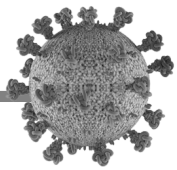
1. A new virus emerges to which humans have little or no immunity.
2. The new virus must be virulent enough to cause disease in humans; and
3. The new virus must have the capacity to spread efficiently from person to person.

COVID-19 the disease

An outbreak of a novel Corona virus causing severe acute respiratory illness was first reported in Wuhan City, Hubei Province, China since December 21, 2019. As of 20 May 2020, a total of 4 789 205 cases are confirmed in more than 180 countries and 200 territories, including 26 cruise ships with 318 789 deaths. The virus has not been previously identified and there is still little known about it, including its origin. On 30th January 2020, the World Health Organization (WHO) declared the 2019-nCoV outbreak in Wuhan, China, as a Public Health Emergency of International Concern (PHEIC). The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (abbreviated "COVID-19"). Whilst most cases were initially from China, in just four months the virus has rapidly spread to over 180 countries. There is evidence of human-to-human transmission among cases both in and outside of Wuhan City, China and internationally.

The first case in the Americas was confirmed in the USA on 20 January 2020 and Brazil reported the first case for Latin America and the Caribbean on 26 February 2020. Since then, COVID-19 has spread to all 54 countries and territories in the Americas[5]. According to the Pan American Health Organization (PAHO), as of 15 April 2020 (14:00 EST) an additional 31,558 cases and 2,986 deaths were reported in the past 24 hours in the Region of the Americas, – representing a 5% (cases) and 11% (deaths) relative increase compared to the previous day. The majority of the new cases (25,802 cases) and deaths (2,395) continue to be reported from the United States of America[6]. On 13 March 2020 Suriname recorded its first COVID-19 positive case.

[4] https://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/
[5] https://www.paho.org/en/documents/covid-19-pahowho-response-report-3-13-april-2020
[6] https://www.paho.org/en/topics/coronavirus-infections/coronavirus-disease-covid-19



COVID-19 in Suriname

In Suriname the first COVID-19 patient was tested positive on 13 March 2020. From 13 March 2020 up to April 16, 2020), 10 persons have tested positive[7]. After a period of zero active cases, around the elections of May 25th end the week thereafter, 4 new cases were diagnosed.

Public health practices and lessons from several countries have demonstrated that COVID-19 transmission from one person to another can be slowed or stopped providing that countries have time to prepare for the arrival and potential spread of COVID-19: to ready emergency response systems; to increase capacity to detect cases through widespread testing; provide care for patients; to ensure hospitals have the space, supplies, and necessary personnel; and to develop life-saving medical interventions. Suriname is taking all necessary measures to prevent importation of cases, reduce or halt local spread and to avoid the health system becoming overwhelmed as a result of seriously ill patients with COVID-19.

In anticipation of the National COVID-19 Preparedness and Response plan, and to support Suriname in rapid decision making, a "**National Critical Operational actions matrix for Preparedness, Readiness and Response COVID-19 – SURINAME"**, was adapted from the WHO interim guidance document entitled 'Critical preparedness, readiness and response actions for COVID-19'. The document provided regularly updated links to WHO guidance materials and the full list of WHO technical guidance available for COVID-19 and provided updated recommendations. Where national guidance documents were not available yet, WHO and/or CDC documents were adopted as the Standard for Suriname.

National characteristics regarding the COVID-19 pandemic for Suriname;

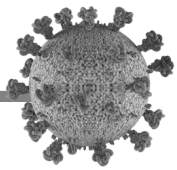
- A very low number of diagnosed people (10) that had not increased in more than 4 weeks. With a sudden addition of 4 cases at the end of May.
- A country that is not densely populated.
- A relatively young population.
- Timely taken initial measures by the government, e.g. closing of the borders, physical distancing, closing of the international air space, a curfew (20.00-06.00 hrs.) and closing of the schools.
- Suriname has a limited overall capacity to respond to such a pandemic and the health system does not have the capacity to handle a COVID-19 epidemic in the country. Therefore, early and assertive measures should be taken.

Aim, Goals, Objectives and Guiding Principles

The **Comprehensive National Strategic Preparedness and Response Plan** for COVID-19 aims to:

- Slow and stop transmission, prevent outbreaks, and delay spread
- Provide optimized care for all patients, especially the seriously ill

[7] https://covid-19.sr/



- Minimize and mitigate the impact of the epidemic on the Surinamese health systems, social services, and economic activity.

The aim of the Plan is also to provide guidance for the **integrated response** to the COVID-19 outbreak in Suriname, and to provide guidance for the development of National and Facility-level preparedness and response plans and Standard Operational Procedures.

The primary focus of the response must be the testing, rapid identification, and contact tracing, and treatment of patients with serious and severe COVID‑19, and the sheltering of individuals at the highest risk of poor outcomes. The plan also aims to provide guidance for a **phased transition** from widespread transmission to a steady state of low-level or no transmission and highlights the coordinated support required on a regional and national level to meet and overcome challenges of COVID-19.

A renewed focus on large-scale public health capacities must be implemented with urgency.

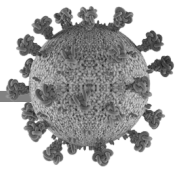
The overarching goal is to control the pandemic by slowing down the transmission and reducing mortality associated with COVID‑19.

The main objective of the plan is to guide the Country's response to stop cases from becoming clusters and clusters from becoming explosive outbreaks and to put in place, the capacities for testing and diagnosis, isolation, contact tracing and quarantine while engaging all stakeholders in the response.

The objective of the plan is to guide activities to increase the level of preparedness, alert and response to identify, manage, and care for patients with COVID-19 based on different public health scenarios, recognizing the geography and demography of the Country (hard to reach hinterland) and uncontrollable borders especially in the east and the south. Different scenarios anticipate that the "one-size-fits-all" approach would not work to managing cases and outbreaks of COVID-19 and that responses must be tailored to meet the local situation in Suriname.

Strategic objectives

• **Mobilize** all sectors and communities to ensure that every sector of government and society takes ownership of and participates in the response and in preventing cases through hand hygiene, respiratory etiquette and individual‑level physical distancing.
• **Control** sporadic cases and clusters and prevent community transmission by rapidly finding and isolating all cases, providing them with appropriate care, and tracing, quarantining, and supporting all contacts.
• **Suppress** community transmission through context‑appropriate infection prevention and control measures, population level physical distancing measures, and appropriate and proportionate restrictions on non‑essential domestic and international travel.
• **Reduce** mortality by providing appropriate clinical care for those affected by COVID‑19, ensuring the continuity of essential health and social services, and protecting frontline workers and vulnerable populations.
• **Introduce and Implement** safe and effective vaccines and therapeutics that can be delivered at scale and that are accessible based on need.



Guiding Principles

Speed, scale, and equity must be our guiding principles.

- **Speed**, because of the explosive nature of the virus it means that every day lost in implementing effective response capacities and behaviors costs lives;
- **Scale**, because everyone in society has a part to play in building the capacities required to control this pandemic; and
- **Equity**, because everyone is at risk until the virus is controlled everywhere in the world: collective resources must be directed to where there is greatest risk.

COVID‑19 is a truly global/national crisis:
The only way to overcome it is together, in global/national solidarity.

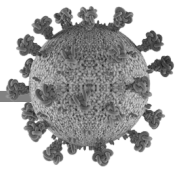
Governance, Coordination, Stakeholders and Partners

It is important that the Government has a defined mechanism for coordination of its response to the COVID-19 pandemic. The National COVID-19 Preparedness and Response Plan (The Plan) is the primary mechanism for coordination of the Ministry of Health's response to a Public Health Emergency of National Concern, and will guide the national pandemic response. The Public Health response is supplemented by the National Plan for Pandemic Influenza Readiness which is an integral part of the National Emergency Response Plan.

The Plan defines the Ministry of Health's roles and responsibilities for the sector-specific response, and provides the structure and mechanisms for effective coordination with other government sectors, local, and tribal authorities, the private sector, and non-governmental organizations (NGOs).

The COVID-19 Pandemic will present unique challenges to the coordination of the national response:

- First and foremost, the types of support that the Government will provide to the Nation are of a different kind and character than the response to communities damaged by natural disasters (e.g. flooding)
- Second, although the situation seems to have stabilized in Suriname, the pandemic is still very much evolving with increased numbers of infected persons in our bordering countries Guyana, French Guyana and Brazil. At the same time, it is already clear that unless a vaccine is produced, distributed and given to the population, COVID-19 outbreaks will occur in waves in any one locale, remaining a realistic threat to Suriname and will continue to have a national impact that could last for many months (even up to two years).
- Finally, the COVID-19 pandemic is a public health and medical emergency that will have sustained and profound consequences for the operation of critical infrastructure, the mobility of people and freight, and the economy on macro – and micro level. Health and medical considerations will affect foreign policy, international trade and travel, domestic disease containment efforts, continuity of operations within the Government, and many other aspects of the national response.



The National COVID-19 Preparedness and Response Plan stipulates mechanisms for coordination of the national response. Strong leadership, mutual understanding of roles and responsibilities and clear communication channels are fundamental principles for a harmonized response. Day-to-day situational monitoring should occur through the Health Emergency Operation Center (H-EOC) per instructions from the Director of Health through guidance from the Public Health Response Team. Strategic policy development, management and coordination of the pandemic response on the national level, should be accomplished through the National COVID-19 Management Team, chaired by the Vice President.

Sustaining these mechanisms for several months to over a year will present unique challenges with maintaining human resources and care providers needed for the different areas of intervention and secured financing for the funding of the emergency operation. To prevail against COVID-19, we need an approach that unites in common cause every individual and community, every business and non-profit, every department of every government, every non-governmental organization, every international organization, and every regional and global governance body, to harness their collective capacity into collective action.

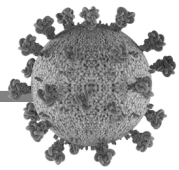
International and Regional coordination

International organizations and befriended Nations play a significant role in supporting the country to plan, finance and implement their response. International and Regional (Public Health) Authorities such as CARPHA and CDEMA, should provide real-time information on the evolving epidemiology and risks; support in timely access to essential supplies, medicines and equipment; the latest technical guidance and best practices; rapidly accessible and deployable technical expertise, access to an emergency health workforce and medical teams; and equitable access to newly developed vaccines, therapeutics, diagnostics and other innovations, as well as complementary socio-economic measures, including material and protection assistance. Particular attention and support will be required in areas with low-capacity settings ill-equipped to cope with COVID-19 due to vulnerable health systems and workforces that are in need of support of national and international organizations and donors, United nations (UN) e.g. World Health Organizations, WHO and Pan American Health Organization, PAHO), International Development Partners (World Bank. Inter-American Development Bank (IDB), Islamic Development Bank (IsDB), Caribbean Development Bank (CDB) and Non-Governmental Organizations (NGO) partners. This global pandemic requires intensified collaboration beyond the health sector on bi-lateral, regional and multi-lateral level.

National Coordination

Disaster control, guided by the National Plan Pandemic Preparedness[8], is organized along the lines of the government structure, thereby observing the legislative task and authority of each department.

[8] Nationaal plan pandemische influenza paraatheid (National plan pandemic influenza readiness), 2003.



The National Plan Pandemic Preparedness, is an integral part of the National Disaster Control Plan coordinated by the National Coordinating Center for Emergency Response (NCCR) in

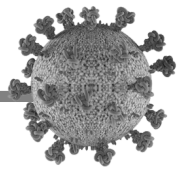
Suriname, established per Decree in May 2003. **The National COVID-19 Preparedness and Response plan builds on this National Plan Pandemic Influenza Preparedness.**

During a pandemic response, the Ministry of Health is the lead agency coordinating the national health response to manage the crisis. This will be led by the Director of Health with Technical Support from the Director of the BOG and assistance from the **Public Health Response Team** (referred to in the National Plan Pandemic Influenza Preparedness as Disaster Committee Health). The Ministry of Health has responsibility for the coordination of the health response to the COVID-19 pandemic, including surveillance, international liaison with health and public health agencies, and coordination of nationwide vaccination campaign (when the COVID-19 vaccine becomes available) i.e. procurement and funding, vaccine allocation, management and infrastructure.

In collaboration with other stakeholders at the regional and local levels, responsibilities of the Ministry of Health also include, distribution of health plans to all organizations that may be involved in the pandemic response, liaison with these partners on an ongoing basis, planning and executing simulation exercises, and advising decision makers.

The Ministry of Health, Suriname derives its legislative tasks from article 21 of the Decree of 10 October 1991, (S.B. 1991 no. 58), (S.B. 2002 no. 16), "Task Description Government Departments"[9] and the International Health Regulations (IHR)[10]. This binding instrument of international law entered into force on 15 June 2007. The stated purpose and scope of the IHR are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."

[9] http://dna.sr/wetgeving/surinaamse-wetten/geldende-teksten-tm-2005/grondwet-suriname/
[10] WHO-IHR_International Health Regulations 2005



COVID-19 National Response Structure

The strategic objectives for the national response structure are to:

- Establish leadership and clear communication channels
- Strengthen capacities to manage the health risks from all hazards including covid-19;
- Embed comprehensive emergency risk management in the health sector;
- Enable and promote multi-sectoral linkage and integration across the whole of government and whole of society.

This guidance therefore must align closely with structures already in place in government and in the country and underscores the need for appropriate and timely readiness and needs assessments for evidence-based decision-making at national, regional and local levels.

The national response is activated through an established response mechanism that follows the **BOG threat levels of infectious diseases** (annex 8) is in line with the WHO pandemic scenarios and follows a phased approach:

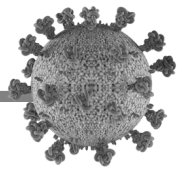
- Phase 1: No threats
- Phase 2: Alert but no positive tested COVID-19 cases in the country
- Phase 3: Public Health Emergency of National Concern and positive tested COVID-19 cases in the country.

Phase 1 and 2 correspond with the WHO scenario "no cases". Phase 3 corresponds with the WHO scenarios "sporadic cases", "clusters of cases", "community transmission".

Phase 1: No threats (WHO scenario "no cases")
Based on the legally established responsibility of the Ministry of Health, the BOG has derived authority to monitor the public health of Suriname. The BOG is the leading authority for the fight against infectious diseases specifically and continuous improvement of the public health in general for the people living in Suriname.

The BOG is the central coordinating unit for the national infectious disease surveillance system.
During phase 1, the "no threat" phase, the sentinel surveillance system for SARI/ILI picks up severe acute respiratory syndrome cases. The Epidemiology unit at the BOG follows standard operating procedures, reports, within 24 hours, to the PAHO-WHO and monitors the testing and follow up of cases.

Moving from one response phase to the next is initiated by specific triggers. Triggers for a response can be from an internal or external alert. Internal triggers can be: 1) unexpected results; 2) increases in a trend; 3) changes in reporting. External triggers can come from alerts from regional or international public health authorities such as CARPHA and PAHO-WHO, as was the case with SARS, MERS and currently with the COVID-19 pandemic. In case of a national or international alert, the Director of Health is immediately notified and on standby



to activate phase 2. In the case of SARS-CoV-2 infection, the COVID-19 outbreak alert in Wuhan, triggered the Suriname response on 10 January 2020 which activated phase 2.

Phase 2: Alert but no positive tested COVID-19 cases in the country (WHO scenario "no cases").

Based on the level of emergency, the Director of Health activates phase 2 and scales up the response. Leadership for the response is now at the level of the Ministry of Health, led by the Director of Health with technical assistance from the BOG and supported by a team of public health experts, the "Public Health Response Team", representing partners in the health sector (for details of the Public Health Response Team, see section below on "Stakeholders and Partners".

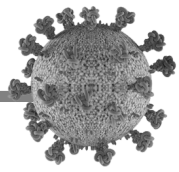
When phase two is activated, the Director of Health informs the Minister of Health of the emergency and regularly updates the Minister on the actions taken and the measures implemented. The Minister of Health subsequently notifies the President/Vice President and the Council of Ministers of the emergency. The Minister of Health regularly provides update during the meetings of the Council of Ministers and advices on standby to escalate the response to the National level.

Simultaneously the Director of Health notifies the NCCR of the emergency, activates the communication channels with DNV, who then activates the NCCR. Bi-directional communication is maintained for close collaboration with the Coordinator NCCR and to keep each other updated on the progress of the emergency and interventions being prepared.

The documents "Nationaal Plan Pandemische Influenza Paraatheid (2009), "Preventie en Beheersing van Rampen in de Sector Volksgezondheid"[11] and the "National Disaster Management Program" describe the functions, roles and responsibilities of all actors involved in disaster response in Suriname. The Director of Health leads the Health Sector in the National Program and the National Disaster Management Program is coordinated by the Coordinator NCCR.

When the situation evolves to positive tested COVID-19 cases in Suriname the emergency is escalated to a "National Emergency of Public Health Concern" and phase 3 is activated.

[11] Titles translated in English: "Plan Pandemic Influenza Readiness" and "Prevention and Management of Disasters in the Health Sector"



Phase 3: Public Health Emergency of National Concern and positive tested COVID-19 cases in the country.

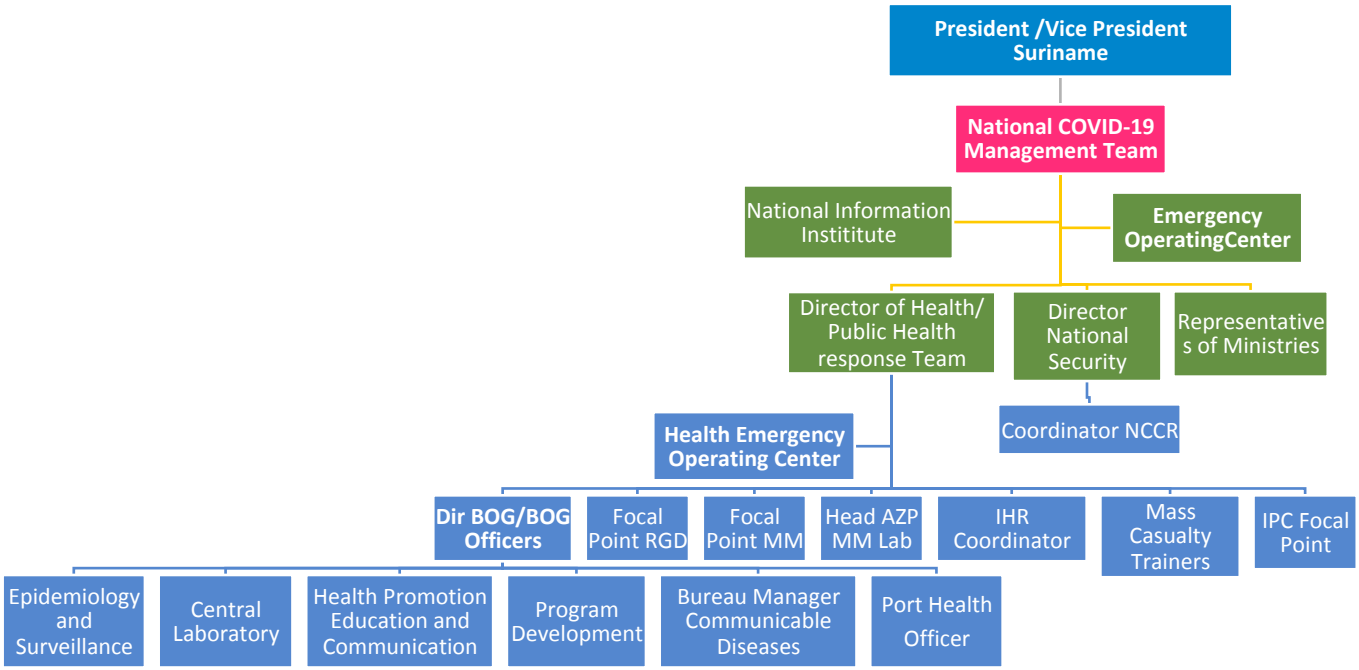
The President of Suriname, per advice of the Minister of Health, activates phase 3, (WHO scenario "sporadic cases; clusters of cases; community transmission) and scales up the response.

Leadership for the response is now escalated up to the level of the Cabinet of the President/Vice President, led by the Vice President of Suriname, assisted by the National Information Institute (NII) and in close collaboration with the "National COVID-19 Management Team", consisting of the Director of Health, the Director National Security, the Coordinator NCCR and the Ministers of the different Ministries or their designates (for details of the National COVID-19 Management Team, see section below on "Stakeholders and Partners".

The daily operation of the national response is managed and monitored by the NCCR through the Emergency Operating Center (EOC). The National Information Institute (NII) functions as the central coordinating unit for communication with the Public. The role, responsibility and function of the NCCR in a Pandemic, are described in the National Plan Pandemic Influenza Preparedness which is an integral part of the National Disaster Management Program, coordinated by the NCCR.

Figure 6 shows the functional structure for an organized transparent and harmonized response to the pandemic during phase 3. It is of paramount importance that every actor in the response agrees with the structure and that all actors adhere to the structure and comply with established communication channels (see pillars 1 and 2).

Figure 6: Command Structure for the National Response



When gradually the level of emergency decreases the country consecutively moves from response to post-response and recovery and to "no alert" phase. The above described command structure simultaneously escalates back from phase 3 – phase 2 – phase 1.

New waves and/or new alerts can again trigger the response process.

Stakeholders and Partners

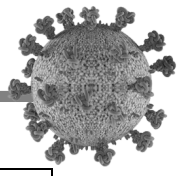
A coordinated response to pandemic COVID-19 requires collective infrastructures, response capacities and coordinated activities that will permit the national (health) authorities and their representatives to anticipate problems, monitor for adverse outcomes and respond to minimize the impact of pandemic COVID-19 within their jurisdictions. The levels of key groups with their respective roles and responsibilities in managing the pandemic are as follows:

National Level:

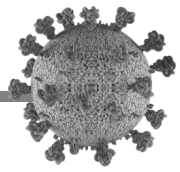
Table 3 presents an overview of **key stakeholders on the National level** involved in the preparedness and response to the COVID-19 outbreak.

Table 3: Key stakeholders on National level to COVID-19 pandemic

Institution	Assigned Responsibility	Profile
Ministry of Health	Minister of	Health Sector Lead with overall responsibility for supervision of the



	Health	management and coordination of the preparedness and response to COVID-19 outbreak
Public Health Response Team (PHRT)	Director of Health	The Public Health Response Team comprises members of the Ministry of Health with varying backgrounds, and focuses on all aspects of Pandemic COVID-19 Plan including coordination, disease prevention and control, and case management. The Team closely collaborates with the NCCR.
Cabinet of the President/Vice President	President or Vice President	Highest authority of the country with ultimate legislative responsibility for the health and safety of the population. In the event of a pandemic (or outbreak) that is very severe, the Cabinet of the President will participate actively in a leadership position. Addresses and informs Parliament on interventions and measures of National importance. The Vice President Chair and Coordinator of the Council of Ministers
National COVID-19 Management Team (NC-19MT)	President or Vice President	This forum is an **Inter-Ministerial Committee**, and comprises representatives from other stakeholders and relevant agencies involved in responding to the outbreak. The NC-19MT is the main platform to co-ordinate inter-ministerial actions/responses to deal with the outbreak. It is anticipated that NC-19MT will report directly to the President/Vice President, at such time when NC-19MT is asked to consult on a real, actual or perceived threat of pandemic COVID-19. The mandate of the NC-19MT includes providing advice, expertise and recommendations, liaison and other activities associated with the pre-pandemic, pandemic and post-pandemic phases to support the health and safety mandates of all orders of government. NC-19MT will also provide advice, assistance and expertise concerning the development, maintenance, testing and evaluation of the National COVID-19 Preparedness and Response Plan.
Directorate National Security (DNV)	Director DNV	Highest authority of DNV responsible for guaranteeing the safety and security of the people of Suriname. In coordination with Ministry of Health, DNV will play a vital role in crisis management at different level. DNV is responsible for ensuring Inter-Ministerial coordination at the national level through the NC-19MT and activation of the National Coordinating Center for Disaster (NCCR).
National Coordinating Center for Disaster Management (NCCR)	Coordinator NCCR	Officer highest in rank responsible for coordination of disaster response, preparedness and mitigation of calamities, the aftermath, but also taking measures and applying interventions to prevent disasters to minimize the effects of a disaster.
National Information Institute (NII)	Head NII	Central point for government information and communication of the information to the public. Provides direction and coordinates government information and dissemination of government policies.



Ministry of Health:

Ministry of Health is the lead agency coordinating the national health response to manage the crisis. This will be led by the Director of Health with Technical Support from the Director of the BOG. The Ministry of Health has responsibility for the nationwide coordination of the pandemic COVID-19 health response, including surveillance, international liaison with health agencies, and coordination of the vaccine (when it becomes available) response (i.e. infrastructure procurement, vaccine allocation, management and funding). In collaboration with other stakeholders at the regional and local levels, responsibilities also include, distribution of health plans to all organizations that may be involved in the pandemic response, liaison with these partners on an ongoing basis, planning and executing simulation exercises, and advising decision makers.

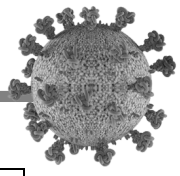
Several providers deliver health care in Suriname. Table 4 gives an overview of the providers at each level of care.

Table 4: Health services providers in Suriname

Primary Health Care providers:	
1) Regional Health Services	Public clinics providing service to persons living in the coastal districts of Suriname
2) Medical Mission,	Providing primary health care to persons living in the hinterlands of Suriname
3) Private Primary Care providers,	Coordinated through the Association of Medical Doctors
4) Non-allied Private Primary Care providers	
Secondary and Tertiary Care is provided by the public and private hospitals:	
Public Hospitals:	**Private Hospitals:**
a. Academic Hospital Paramaribo b. 's Lands Hospital c. Military Hospital d. Mungra Medical Center, Nickerie e. Wanica Hospital	a. Diaconessen Hospital b. Sint Vincentius Hospital
All Stakeholders at every level of care must develop, adjust or enhance existing SOPs for case finding, contact tracing and monitoring; quarantine of contacts and isolation in line with the National Plans.	

Table 5: presents an overview of key stakeholders in the Health System in Suriname, responsible for preparedness and response

Institution	**Assigned Responsibility**	**Profile**
Ministry of Health	Director of Health	High level health manger with overall knowledge of the government health system and authority to delegate
Bureau of Public Health	Director Bureau of Public Health	High level health manger with overall knowledge of the public health system and authority to delegate
Primary	Director Regional Health Services	High level primary care manager with overall



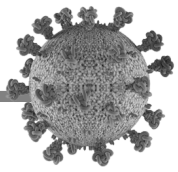
Health Care		knowledge of the health care system, specific knowledge of primary care, the role of primary care within the health system and authority to delegate
	Director Medical Mission	
	Association for Medical Practitioners (VMS)	Chair or Representative of the Association
	Association of Nurses	
	Association of Midwives	
Hospital care	Dir. and Medical Director of Hospitals:	
	1. Academic Hospital	High level hospital manger with overall knowledge of the health care system, specific knowledge of hospital care, the role of hospital care within the health system and authority to delegate
	2. Sint Vicentius Hospital	
	3. Diaconessen Hospital	
	4. Military Hospital	
	5. Wanica Hospital	
	6. Mungra Medical Center	
	7. Marwina Hospital	

Non-Health and Non-Traditional Stakeholders/Partners

In anticipation of a multi-dimensional crisis due to the COVID-19 pandemic a whole of government approach to the response is warranted. To protect live and livelihood different ministries/agencies are advised to have a crisis group within their respective ministries/agencies to respond to the COVID-19 pandemic/outbreak.

The government of Suriname constitutes Departments combined in the following Ministries:

a. Ministry of Labor
b. Ministry of Home Affairs
c. Ministry of Foreign Affairs
d. Ministry of Defense
e. Ministry of Finance
f. Ministry of Trade, Industry and Tourism
g. Ministry of Justice and Police
h. Ministry of Agriculture, Husbandry and Fisheries
i. Ministry of Natural Resources
j. Ministry of Education, Science and Culture
k. Ministry of Public Works, Transport and Communication
l. Ministry of Spatial Planning, Land and Forest Management
m. Ministry of Regional Development
n. Ministry of Sports and Youth Affairs
o. Ministry of Social Affairs and Housing

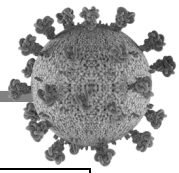


p. Ministry of Health

The Ministries within the Government of Suriname derive their legislative tasks from article 21 of the Decree of 10 October 1991, (S.B. 1991 no. 58), (S.B. 2002 no. 16), "Task Description Government Departments".

Table 6: gives an overview of the assigned responsibilities and the profile of the non-health sector and non-traditional stakeholders in the response to COVID-19.

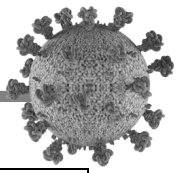
Institution	Assigned Responsibility	Profile
Government		
Cabinet of the President	President Highest authority of the Land	• Leadership; Empathy; Trust; Transparency; Openness in Policy; Example in word and deed; • Addresses the public on important interventions and measures to safeguard life and livelihood; Informs Parliament on emergency and policy decisions to address the urgency
Cabinet of the Vice President	Vice President Deputizes in absence of President; Chair of the Council of Ministers	• Chairs the Council of Ministers; • Leads and coordinates translation of policy interventions and measures in Council of Minister; • Takes policy decisions to ensure appropriate prepared and response; • Monitors progress on implementation and facilitates accelerated decision making;
Labor	Minister/Director Highest designated authority with overall responsibility for supervision of the Labor Market both Public and Private and authority to delegate	• The Ministry of Labor has the responsibility in general to protect workers and promote workers' rights, promote harmonious labor relations between workers and employers, promote social dialogue and tripartite consultations, prevent and mitigate conflict, develop the employability of young persons, women and workers by technical and vocational education and training and entrepreneurship trainings, and to give advice to employers and workers on the most efficient ways to implement the labor legislation. • Coordinates with colleague Ministers for comprehensive and integrated approach to implementation of Labor related interventions.
Foreign Affairs	Minister/Director Highest designated authority with overall responsibility to formulate and implement the foreign policy according to the instructions as set out by the President.	• As such the Ministry is responsible for building and maintaining the relations with friendly nations, regional and multilateral organizations.
Home Affairs	Minister/Director Highest designated authority responsible for effective and efficient functioning of the public sector e.g. through development, implementation, sustaining and maintaining the Human Resource policy of the Government.	• Monitors the Rule of Law (checks and balances) • Guarding the principles of Human Rights and Good Governance (leave no one behind); • Lead Ministry for the coordination of the national response to disasters and emergencies of national concern (NCCR)
Trade and	Minister/Director	• To maintain public confidence in the economy so that



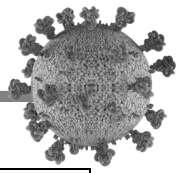
Industry	Highest designated authority to protect the economy to safeguard life and livelihood.	economic activities and a level of normalcy can continue. • Guarding cost of living to ensure consumers have access to affordable most basic necessities of live; • Security measures for persons that survive on a daily income in collaboration with Ministry of Social Affairs;
Tourism	Minister/Director Highest designated authority to protect all aspects of the tourism industry: hotels, restaurants, and destinations,"	• Working with Travel Agents; Tour Operators; Hotels and Restaurants to formulate strategies and plans to support the sector to adhere to and comply with policy interventions and measures; • Formulate plans and strategies with sector partners and stakeholders to ensure protection of tourists/visitors during and after the COVID-19 Pandemic. • Works in close collaboration with Transport Department and other relevant departments.
Agriculture, Husbandry and Fisheries	Minister/Director Highest designated authority with overall responsibility for policies and interventions on food safety and food security and authority to delegate	• Focus of Ministry in this context is on the Agriculture sector; • Formulate policy to build a sustainable agriculture policy with focus on food safety, food security and access to food for all[12]; • Contributes to the economic development of the country
Education	Minister/Director Highest designated authority with overall responsibility for school continuation at all levels	• Develops innovative initiatives and policies to minimize discontinuation of education at all levels and introduction of digital platforms during the pandemic. • Collaborates with School Leaders to implement alternatives to education (distance learning/face-to-face in compliance with physical distancing requirements[13]) • Collaborates with partner Ministry of Communication to provide internet as a public good to all in every corner of the country;
Public Works and Transportation	Minister/Director Highest designated authority with overall responsibility and decision-making authority for infrastructure; public transportation, waste management and sanitation	• Readiness of isolation and quarantine locations in the community including waste management. • To ensure the provision of essential services of potable water and electricity. • To formulate plans to ensure availability and continuity of air, land and sea transportation services critical to the economy. • Coordinates communication of instructions and measures to persons working in public transportation (bus/boat/taxi).
Communication	Minister/Director Highest designated authority with overall responsibility and decision-making authority in charge of all forms of communication	• Designs and implements policies to provide internet as a public good to all in every corner of the country; • To formulate public communications policies and plans

[12] Ministry of Agriculture, Husbandry and Fishery, Support Interventions for COVID-19 for the Agriculture Sector, May 2020

[13] 3-days school weeks for 3rd to 6th grade with longer school hours and children spread over all available classes
2-days school weeks for kindergarten to 2nd grade with longer school hours and children spread over all available classes



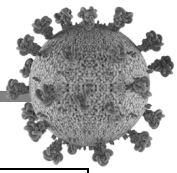
	(radio, telephone, digital)	to manage information flow to all citizens in an appropriate, acceptable, efficient and timely manner; • Provides Internet, electronic mail, electronic services to business and government especially during the time of crisis to ensure effective and efficient communication with all people of Suriname in every corner of the country • Fosters and maintains close collaboration and partnerships with the Ministries of Health, Education and Regional Development
Regional Development (RD)	Minister/Director Highest designated authority for the implementation of the decentralization policy with coordination and supervision responsibility of Districts Commissariats	• Support from District Commissioners (DCs) for the implementation of COVID_19 interventions and measures (tourists not allowed in resorts; bus owners to transport 1/3 of the normal number of passengers) • Communication with Local Authorities to support Central Government policies and promote compliance from villagers; • Screening of persons that have to travel to villages; • Use of community radios to communicate with all tribes in all tribal languages
Social Affairs and Public Housing (SoZaVo)	Minister/Director Highest designated authority with overall responsibility and decision-making authority for general social well-being, in particular social care and well-being for the elderly, persons with a disability and children/youth through a social provisions scheme, social support and assistance and housing.	• *Social provisions plan and Housing plan to support vulnerable and indigent populations affected by the COVID-19 Pandemic:* o Define and implement policy to persons in need of psychosocial support, in collaboration with Ministry of Health and relevant Experts (Psychologists, Social Workers and Special Experts); o Establish and manage a network of psychosocial support experts and related partners and stakeholders o Temporary cash assistance to targeted populations namely households with children o Housing Fund to target the population who has no housing and who cannot pay rent; o Support the transfer of houses from the Housing foundation (of the Ministry) to long-term residents, for small repairs and housing improvement
Justice and Police	Chief of Police Authority to enforce and maintain law and order.	• Participates in the National COVID-19 Management Team • Close collaboration with DNV and NCCR • Monitoring compliance to lock down and public physical distancing interventions and measures related to the COVID-19 response; • Monitoring compliance to curfew instated by the President
Defense	Minister/Commander National Defense Force Highest designated authority in charge of	• Support to the Police upon request in monitoring compliance to interventions and measures related to the



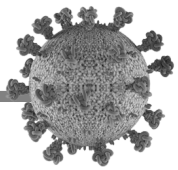
	protecting sovereignty and independence of the country and the National Defense Force.	COVID-19 response; • Guarding and surveilling borders of the country to protect against importation of COVID-19; • Assistance to NCCR in prevention and mitigation of the COVID-19 emergency
Finance	Minister/Director Highest designated authority in charge of guarding revenues and expenses of the country with responsibility for financial, monetary and fiscal policy including investment policy. Authority to expedite process for availability and disbursement of funds;	• Secure and mobilize emergency funds to finance the preparedness and response operation by ring fencing a budget for emergency response; • Mobilize funds through expedited process for disbursement of funds; • Collaboration and negotiation with International Donors and International Development Partners to mobilize and channel funds to Suriname in collaboration with Ministry of Foreign Affairs

Institution	**Assigned Responsibility**	**Profile**
Other		
Parliament of Suriname	Members	Legislative support
Private Sector *VES (Association of Economists) *SurVAM Society of Suriname Insurance Companies *BVS Bankers Association Suriname *VSB Association of Entrepreneurs	Chairs	**Private Sector Businesses**[14] • Key partner and stakeholder in the response • Understanding the pandemic planning context offers business contingency planners a practical framework in which to develop and execute plans. • Knowing government roles, responsibilities, and authorities enables planners to obtain answers rapidly for many basic planning questions, such as: * What is the threat (e.g., spread, duration, virulence) to businesses, the community, and the nation? * Where will it appear first, and how will we know when it does? * When will it begin affecting businesses? * How will government help to inform and support the business community? * How will it affect businesses and those that depend on the business community? * How can the business community help to support the business sector, the community and our nation? **Important for Businesses** • Having a structured institutionalized collaboration mechanism between government and the business sector. A good relationship finds its foundation in leadership, respect, mutual understanding and communication. Only on that foundation parties will be able to build and establish mutual understanding, which is paramount in a good relationship. Relationship should work toward building bridges so that when disaster hits and the emergency is here, the emergency response should automatically flow from the good relationship. Response should build on the good relationship and use already existing communication channels.

[14] HHS_USA_cikrpandemicinfluenzaguide



		• Health departments at all levels of government are working to protect the nation, its businesses, and citizens from the COVID-19 pandemic. Knowing what these groups can do and are doing, and monitoring with them the evolving pandemic threat, will ensure that business has the most accurate information and maximum preparation time. • Similarly, knowing what other government departments can and will do, and then collaborating with them to provide necessary support during a pandemic, helps define the external operational parameters and networks within which business must plan for during the preparedness, response, and recovery phases.
Civil Society Organization (CSO) *Service Clubs *Faith Based Organizations *Youth Organizations *Community Organizations *Thematic NGOs *Sports organizations *Journalists (media)	Presidents Religious leaders Chairs Directors	Strategic Objectives: 1. Increase knowledge about COVID-19 and NCDs 2. Promote and support mobilization of funds for access to, and consumption of, healthy foods 3. Promote and support mobilization of funds for access to essential medicines and treatments for affected people 4. Promote good mental and physical health 5. Engage young people as key players and Youth Ambassadors in the COVID-19 response
		Suggested strategies to achieve the five objectives: 1. Information dissemination; 2. Strengthening of CSO communication networks for information and experience sharing; 3. High-level advocacy targeting policymakers; and 4. Leveraging partnerships with critical regional and global public health institutions.



Starting point for Suriname

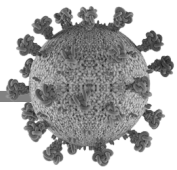
The development of the Plan is occurring simultaneously with the response to the COVID-19 pandemic which has led to a need for an accelerated development of the Plan.

The overview below summarizes the actions taken by the Ministry of Health from the moment COVID-19 was recognized as a Public Health Emergency of International Concern and declared a Pandemic.

Health system response Suriname to the COVID-19 pandemic

The development of the National Plan happens simultaneous with the response to the COVID-19 pandemic. The overview below summarizes the actions taken by the Ministry of Health from the moment COVID-19 was recognized as a Public Health Emergency of International Concern and declared a Pandemic.

- January 10 COVID-19 National Management Team reactivated and members added
- January 15 SOP drafted. Establishment 178 hotline with the Bureau of Public Health.
- Note: SOP were updated January 27, Feb 11 and Feb 25
- January 23 first guidelines from Caribbean Public Health Agency (CARPHA) shared and first virtual ZOOM meeting regarding Novel Coronavirus. Exchange of information with CARPHA continues until today. Port Health entry screening instituted and form developed for passengers to be completed on arrival regarding their health
- January 24 first training for caregivers. Inventory and needs assessment for 1st line and 2nd line PPE
- January 25 VG receives clinical management and public health advice on COVID-19, from local experts. Designated facilities for COVID-19 patients are identified after consultation with all hospitals
- January 26 first distribution of materials to a number of healthcare institutions and first press release. Ministry of Health (MOH) drafts a concept Coronavirus action plan
- January 27 meeting with external partners; Ministry of Financial Affairs, Ministry of Public Works and Transport, Ministry of Justice and Police and the National Coordination Centre for Emergency Response (NCCR) for an integrated approach
- January 29 step-up communications to counter balance the increase in fake news. 1st posters for awareness in collaboration with the PAHO/WHO Country Office. First reporting of questionable COVID-19 cases. After swift Quick Response Team, most were classified as fake
- January 30 collaboration with immigration services in the border districts. 1st line receives guidelines
- January 31 RT-PCR testing starts at AZP. First ship is inspected by QRT. First press conference is held. MOH establishes Facebook page, with the Bureau of Public Health (BOG)
- Feb 1 awareness campaign Minister of Health with Youth ambassadors
- Feb 2 awareness posters for the schools. Drafting of first travel advice and restrictions



- Feb 4 information session and training for International Airport staff, and other external partners. Private sector information picks up. MOH VG looks at quarantine facilities options
- Feb 5 BOG receives test kits from PAHO/WHO and the first test is deployed at the Central Laboratory
- Feb 6 pool of caregivers established for Personal Protective Equipment (PPE) training and deployment identification. Health alert card is issued to passengers at the airport
- 10 Feb finalization of agreements between hospital directors with regard to designation and materials. Agreement with medical specialists
- 11 Feb awareness programs homes for the elderly and institutions for people with disabilities
- Feb 13 awareness for day-care centers and schools
- Feb 14 first COVID-19 situation report from Suriname. To come out weekly
- 18 Feb Hospital Readiness Assessment for COVID-19 in collaboration with PAHO
- 24 Feb establishment of MOH travel advice management team
- Feb 26 presentation crisis team plan of action and readiness COVID-19
- Feb 27 presentation MOH COVID-19 Plan of Action in Parliament
- Feb 28 awareness posters distributed to ministries and 1st billboards. Request MOH to Cuba for healthcare providers (doctors and nurses) to support COVID-19 clinical work
- March 1 meeting CARICOM heads of states Barbados
- March 3 first text messages via Telesur (Telephone Company Suriname) with BOG tips. Upgrading control room 178
- March 5 live broadcast Government Television Station (GOV.TV) "Everything about COVID-19"
- March 7 MOH instructional film for stakeholders, featuring the MOH plan, use of masks and frequently asked questions
- March 10 MOH information session on COVID-19, for the Board of Ministers and an information session for the Diplomatic Corps
- March 11 revised MOH travel advice management team
- March 13 first positive case of COVID-19 Suriname

The actions taken by the MOH during the period 10 January and 13 March 2020 covered the entire country (coastal area and hinterland). Table 7 presents an overview of the respective health care providers, the RGD, Medical Mission and Private Clinics, involved in the response actions during the above described period.

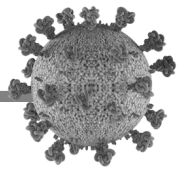


Table 7: Responsibilities for Health care providers in the response to COVID-19

Coastal Area	Hinterland	Private Clinics
The Regional Health Service (RGD) as the main provider of public primary health care in the coastal area participates in the National Public Health Response Team and is assigned 4 key functions in the COVID-19 response: 1. **The Gate keeper function**, using the flu-triage procedures for a quick screening to separate suspect cases from regular patients; 2. **Ambulance transportation and First Responder** to assist in transportation of COVID-19 suspect cases for further diagnosis, testing and treatment; 3. **Transportation of COVID-19 related persons for repatriation flights to Suriname**; **4. Surge capacity provider** for the temporary use of registered nurses **in the Wanica Hospital** **Hospitals** Academic Hospital, Vincentius Hospital, Wanica Hospital to prepare ICU readiness and explore expansion possibilities for ICU capacity.	The **Medical Mission** as the main provider of public primary health care in the hinterland participates in the National Public Health Response Team. Because of the geographical vastness of its catchment area and its population mostly living in hard to reach locations, the MM relies on health care assistants to deliver primary health care in settlements and tribal and indigenous communities, through the use of standardized protocols and supervised by doctors. The MM's network of policlinics reaches from the capital (where it's operating center is located) to the eastern, southern and western border of Suriname. As the only provider of healthcare services in the hinterland it also serves as a focal point for other specialized services to the populations in the hinterland. The network of MM policlinics is the eyes and ears of the national alertness for covid-19 in the hinterland. MM facilitates and implements contact tracing and active case detection, as well as informs local communities about national intervention measures and works with them on how to implement those measures. MM clinics also implement monitoring of villages and settlement's quarantine and isolation.	**Primary Health Care in the coastal area** is supplemented by private clinics. The Chair of the Association of Medical Doctors Suriname (VMS) or a designated physician coordinates the communication between the Ministry of Health and the Private Health Care providers. The VMS works closely with the Medical Team of the Ministry of Health in the development of patient management and treatment protocols and algorithms.

National Pandemic Readiness

The **National COVID-19 Preparedness and Response plan** builds on the **National Pandemic Preparedness Plan**, takes into account the WHO pillars that provide the foundation for Preparedness and Response and is in line with the WHO COVID-19 interim guidelines and the WHO guidance on topics related to pandemic influenza and public health emergency planning. Table 8 presents the pillars of the WHO for COVID response.

Table 8: The WHO Pillars that provide the foundation for Preparedness and Response

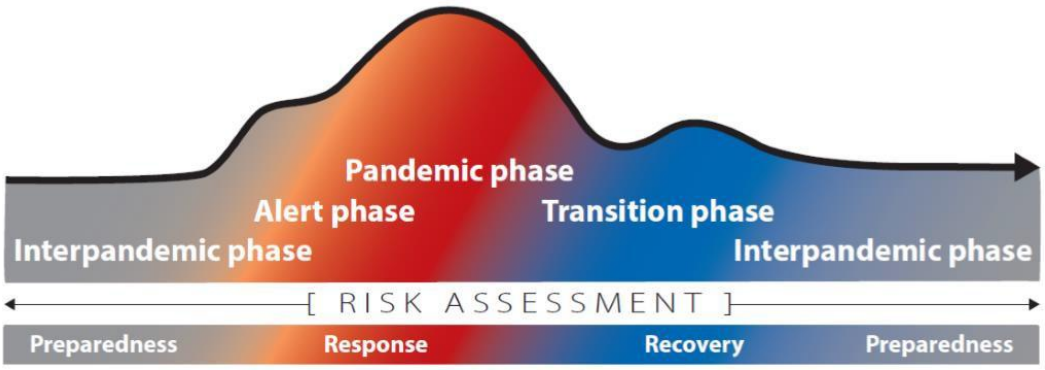
PUBLIC HEALTH	Pillar 1: Country-level coordination, planning, and monitoring
	Pillar 2: Risk communication and community engagement
	Pillar 3: Surveillance, rapid response teams, and case investigation
	Pillar 4: Points of entry
	Pillar 5: National Laboratories
	Pillar 6: Infection prevention and control
	Pillar 7: Case management
	Pillar 8: Operational support and logistics
	Pillar 9: Maintaining essential health services during an outbreak

We have to go after the virus, find it, deal with it before it deals with us!

Stages of Pandemic disease and response strategies

The WHO recognizes phases, inter-pandemic, alert, pandemic and transition, to describe the spread of the new influenza subtype around the world, taking account of the disease it causes (Figure 7).
These pandemic phases correlate with the pandemic stages preparedness, response and recovery.

Figure 7: Stages of a pandemic



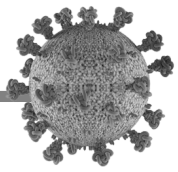
Legislatively, The Ministry of Health and the BOG have the responsibility to develop plans to respond to health emergencies. In response to the COVID-19 pandemic, the BOG developed a color-coded scheme for threats of infectious diseases in Suriname (Table 9) based on pandemic stages preparedness, response and recovery to guide interventions and actions according to the level of alert.

Table 9: Color coded scheme for threats of infectious disease in Suriname

Stage	Color	Level of alert	
Preparedness	Green	No threat/No reported cases	WHO scenarios
	Yellow	Alert phase/No reported cases	
Response	Orange	Sporadic cases/Clusters	
	Red	Community transmission	
	Purple	Community transmission	
Recovery	Blue	Post-response/No Reported cases	
Preparedness	Green	No threat/No reported cases	

Pandemic Transmission Scenarios

Suriname should increase the level of preparedness, alert and response to identify, manage, and care for new cases of COVID-19 and should prepare to respond to different public health scenarios, recognizing that there is no one-size-fits-all approach to managing cases and outbreaks of COVID-19. Suriname should assess its risk and rapidly implement the necessary measures at the appropriate scale to reduce both COVID-19 transmission and



economic, public and social impacts. WHO has defined four transmission scenarios for COVID-19: 1) no cases; 2) sporadic cases; 3) clusters of cases; 4) community transmission, (Table 10).

Table 10: WHO transmission scenarios.

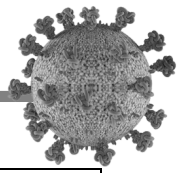
WHO Transmission scenario for COVID-19* *Considerations for mitigating and expanding public health measures will be included in the scenario analysis.				
	No Cases	**Sporadic Cases**	**Clusters of Cases**	**Community Transmission**
Transmission Scenario	No reported Cases	One or more case, imported or locally acquired	Most cases of local transmission linked to chains of transmission	Outbreaks with the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories
Aim	Stop transmission and prevent spread	Stop transmission and prevent spread	Stop transmission and prevent spread	Slow transmission, reduce case numbers, end community outbreaks

Suriname could experience **one or more of these scenarios at the same time at different levels and in different locations** and should adjust and tailor their approach to the local context.

The following section is a description of key actions per pillar and per WHO scenario based on an ideal situation (Table 11). This section is developed by Technical Officers of the Pan American Health Organization (PAHO) and UN Regional Coordinator. It is advised by the IDB and PAHO to follow the WHO pillars and actions coming out of each pillar per scenario.

Table 11: COVID-19 Key Actions following the WHO pillars

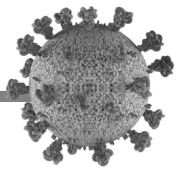
Pillar 1: Country-level coordination, planning, and monitoring	National public health emergency management mechanisms should be activated with engagement of relevant ministries such as health, education, travel and tourism, public works, environment, social protection, and agriculture, to provide coordinated management of COVID-19 preparedness and response. National Action Plans for Health Security (NAPHS) and Pandemic Influenza Preparedness Plans (PIPP), if available, should also be adapted to address COVID-19.
Pillar 2: Risk communication and community engagement	It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumors and misinformation. Changes in preparedness and response interventions



	should be announced and explained ahead of time and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust.
Pillar 3: Surveillance, rapid response teams, and case investigation	In countries with high-risk of imported cases or local transmission, surveillance objectives will focus on rapid detection of imported cases, comprehensive and rapid contact tracing, and case identification. In a scenario in which sustained community transmission has been detected, objectives will change to monitoring the geographical spread of the virus, transmission intensity, disease trends, characterization of virology features, and the assessment of impacts on health-care services. In some countries, surveillance priorities will differ at subnational levels. Robust COVID-19 surveillance data are essential to calibrate appropriate and proportionate public health measures.
Pillar 4: Points of entry	Efforts and resources at points of entry (POEs) should focus on supporting surveillance and risk communication activities.
Pillar 5: National laboratories	Countries should prepare laboratory capacity to manage large-scale testing for COVID-19 – either domestically, or through arrangements with international reference laboratories. If COVID-19 testing capacity does not exist at national level, samples should be sent to a regional or international reference laboratory with appropriate capacity. In the event of widespread community transmission, surge plans should be activated to manage the increased volume of samples from suspected cases. WHO can provide support to access relevant reference laboratories, protocols, reagents, and supplies.
Pillar 6: Infection prevention and control	Infection prevention and control (IPC) practices in communities and health facilities should be reviewed and enhanced to prepare for treatment of patients infected with COVID-19, and prevent transmission to staff, all patients/visitors and in the community.
Pillar 7: Case management	Healthcare facilities should prepare for an influx of COVID-19 cases while still maintaining provision of health services including for non-communicable diseases, surgeries, and potential concomitant emergencies (e.g. measles, influenza, etc). Triage systems will be needed to prioritize treatment for severe and high-risk patients and to manage demands on staff, facilities, and supplies. Special considerations and program should be implemented for vulnerable populations (elderly, patients with chronic diseases, pregnant and lactating women and children).
Pillar 8: Operational support and logistics	Logistical arrangements to support incident management and operations should be reviewed. Expedited procedures may be required in key areas (e.g. surge staff deployments, procurement of essential supplies, staff payments).
Pillar 9: Maintaining essential health services during an outbreak	When health systems are overwhelmed, both direct mortality from an outbreak and indirect mortality from vaccine-preventable and treatable conditions increase dramatically. Countries will need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse.

Considerations when implementing this section

A. Refer to the PAHO and WHO websites for the most up to date country and technical guidance on Covid-19:
   - https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance
   - https://www.paho.org/en/topics/coronavirus-infections
   - https://www.paho.org/en/technical-documents-coronavirus-disease-covid-19

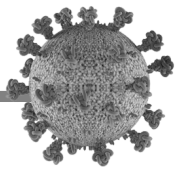


B. While responding to the current pandemic, the Public Health Response Team develops and adjusts manuals, guidelines, algorithms and standard operating procedures to guide and direct the response, guided by WHO instructions as they become available.

C. Whilst these documents are already in use, they are not properly branded yet, still in draft and compiled in three basic documents. These drafts are included as annexes to the Plan:
   - Annex 4: Standard Operating Procedures (SOP) COVID 19, version 24 February 2020;
   - Annex 5:COVID 19 protocols (Richtlijnen voor de verschillende disciplines van het Ministerie van Volksgezondheid bij COVID – 19)
   - Annex 6: Compilation operational guidance documents for response to COVID-19 I Dutch

D. When planning to operationalize the actions consider the following for implementation:
   - Some actions might not be applicable to the Suriname situation:
     - Assess how to modify the action and tailor to the country reality;
   - Some actions might not fully align with the current country situation:
     - Identify and assess gaps and shortcomings and decide how to bridge or fill the gaps and how to handle shortcomings;
   - Some actions might not be under the jurisdiction and authority of the Health Sector:
     - Collaborate with the responsible authority and actively participate in committees or implementing bodies

E. **Review this section every time there is a covid-19 threat.** Regardless of the frequency of review of the National Plan, consider the following instructions:
   - Review and assess each action per row and per scenario;
   - Assess if this action is still in line with the tasks, roles and responsibility of the identified responsible party, function, program or service;
     - If not, identify the correct responsible person, communicate and confirm the responsibility;
     - Assign and confirm the responsible person;
   - Assess if the function, program or service is fully equipped to successfully undertake the action;
     - If not, identify what is lacking and advise how to provide in the need (human resources, technical staff, means and materials, transport, information systems, communication);
     - Identify structural permanent solutions and what can be dealt with on an "ad-hoc" basis within a specific time frame;
     - When "ad-hoc", develop a plan to manage "ad-hoc" solutions.



- Reaffirm the collaborating partner ministries/departments
- Provide an estimated budget per pillar with budget lines and where possible an indicative amount.

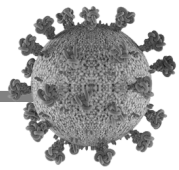


Table 12: Activities for each WHO pillar for sporadic cases, clusters of cases and community transmission

<table>
<tr><th colspan="4">PILLAR 1: COUNTRY-LEVEL COORDINATION, PLANNING AND MONITORING</th></tr>
<tr><th>No Cases</th><th>Sporadic Cases</th><th>Clusters of Cases</th><th>Community Transmission</th></tr>
<tr><td>• Activate the Emergency Response Mechanism* by activating a Public Health Response Team to be the designated technical and implementing committee in coordinating the COVID-19 response across Suriname. It must be a multi-sectoral, multi-partner coordinating mechanism that collectively develops new or updates existing SOPs and action plans and implements, provides collaborative input on the country-specific operational plan and reports to the high-level National COVID-19 Management Team.
• Assign the Health Response and Preparedness Committee (established in August 2019) to review of the “National Plan Pandemic Influenza Readiness” (Annex 1), update and adjust accordingly to guide the COVID-19 response
Responsible Party: Director of Health

• Reaffirm National Leadership, organizational structure and communication lines for the National Management of the COVID-19 Pandemic
• Provide guidance on, and prepare for activation and functioning of the National COVID-19 Management Team
• Prepare to activate the Emergency Operating Center (EOC)
Responsible Party: Minister of Health</td><td>Declare Health Emergency of National Concern

DNV and NCCR response mechanism activated

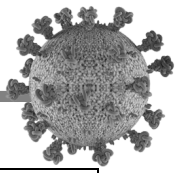
Responsible Party: VP per advice of Minister of Health</td><td>Introduce nationwide measures to detect, isolate, test, quarantine and protect

Responsible party: President/Vice-President</td><td>Introduce nationwide measures to detect, isolate, test, quarantine and protect

Responsible party: President/Vice-President</td></tr>
<tr><td colspan="3">● Public Health Response team fully activated and in implementation mode.
● Health EOC operational
● Execute daily meetings chaired by HEOC coordinator (reporting to Director of Health).
● Continually assess additional human resources needs in case of:
○ a) Movement into another transmission scenario
○ b) Repatriation flights
○ c) Unforeseen infrastructural / medical emergencies.

● National COVID-19 Management team fully activated and in management mode.
○ Activate the EOC
○ Execute Daily Meetings chaired by Cabinet of VP.

Responsible party: President/Vice President</td></tr>
<tr><td>○ Appoint designated PHEOC (Annex 2) daily coordinator (recommendation: Health Disaster Coordinator, who would then report to Director of Health)
○ Activate Health Emergency Operating Center (PHEOC) *. PHEOC is a subset of the National Response Team.
Responsible Party: Director of Health designates Health Disaster Coordinator</td><td colspan="3">○ Continually assess additional human resources and other needs to maintain PHEOC operation
Responsible Party: PHEOC daily coordinator</td></tr>
<tr><td>○ Designate an EOC daily coordinator in</td><td colspan="3">○ EOC fully operational</td></tr>
</table>



charge of liaising across teams (the Public Health Response Team and the National COVID-19 Management Team), ensuring the implementation of the emergency operational plan. ○ The coordinator functions as the common denominator in charge of streamlining communication between key focal points and reports to the Vice President. **Responsibility Party:** President/Vice President	○ Conduct daily meetings with partners and stakeholders ○ Prepare and Organize daily press briefings ○ Conduct weekly operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary **Responsible Party:** EOC daily coordinator
• Engage with national authorities and key partners to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response, or preferably adapt, where available, an existing Influenza Pandemic Preparedness Plan **Responsible Party:** Vice President and Council of Ministers (engage Ministerial Planning Units with support from the National Planning Bureau in collaboration with the National COVID-19 Management Team) • NCCR shall utilize this COVID-19 Preparedness Response and Plan to support its operation and logistical plan • NCCR together with the BOG shall test the plans, protocols, and operational procedures by organizing and doing drills and simulation exercises **Responsible Party:** NCCR and BOG	Implement country-specific operational plan and schedule monthly evaluation.

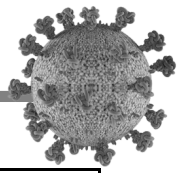
Reorganization, recruitment, and training of health workers

Key actions:

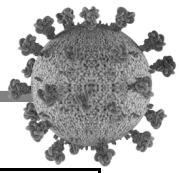
- Conduct a mapping of available health workers (Public, private and NGO sector) arranging where possible by specialization and competency
- Develop a plan with inter-professional teams for case investigation, contact tracing and case management at district level, within primary health care and hospital settings
- Identify and develop tools that would streamline training of health care workers in various topics depending on the area of work (ideally, accessible online)
- Develop one web-based knowledge management platform for Suriname health care workers to access all national SOPs, guidance documents, technical strategies, flow charts and related communications materials.
- Develop facility-level human resource for health plans to monitor allocation of health workers vs cases in facilities; the redistribution of workers; shifts and rest periods for workers; and psychosocial support.

Responsible Party: Director of BOG in collaboration with Social Affairs, Red Cross, key NGOs, private sector and civil society organizations, with technical support from PAHO

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission

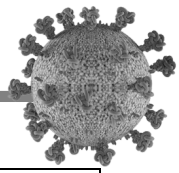


● Conduct a mapping of availability, needs and gaps in health workforce capacity by utilizing available information (registries, databases) on human resources for health in the country. ● Develop plan to establish and equip (vehicle and ambulance) District Rapid Response Teams (one team per district) ● Establish a centralized roster or database of all available health workforce according to level of care at the appropriate level (national or district) and designating a function for updating contact information and potential health care service capacity of all people willing and capable to serve. ● Use recent graduates awaiting internship and students in their final undergraduate year (professional practice or social service) as support personnel in community activities, home visits, patient orientation, data collection, and general examinations.	● Develop a plan for the recruitment of additional health workers to function as temporary health workforce surge capacity and to cover essential health care services. ● Implement and operationalize District Rapid Response Teams ● Activate the recruitment and training of additional health workers and assign them to health facilities equipped with sufficient PPE.	● Deploy District Rapid Response Team if necessary ● Develop a plan for the reorganization and role distribution of health workforce including: ● Moving staff temporarily from non-affected or less-affected areas of the country to other areas where they are most needed. ● Redistributing of personnel from one area of the health facility to another or to other functions where they are most needed. ● Develop facility-level plans that coordinate shifts of health workers to ensure adequate coverage and allow sufficient downtime for overworked personnel. ● Establish a mechanism to provide psychological support for health workers which could include: dedicated hotline; flexible work schedules and distributed workload; childcare and other support options; buddy system to provide basic emotional support.	● Deploy District Rapid Response Team if necessary ● Activate the plan for the reorganization and role distribution of health personnel including task shifting and allocate to COVID-19 facilities and other facilities to maintain essential services. ● Implement protocols and systems for the management and monitoring of suspected and confirmed cases among the human resources involved in the COVID-19 response. ● Develop a system of reporting of incidents and symptoms by health workers through a blame-free environment and support as needed (psychosocial, financial, sick leave, other). ● Establish protocols to assure safe return to work of health workers following



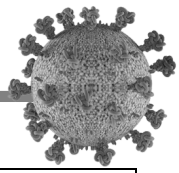
			quarantine or sick leave.

○ Conduct initial capacity assessment of facilities (hospitals, laboratories, primary care facilities) and health care workers (doctors, nurses, laboratory technicians etc.) and risk analysis, including identification and mapping of at-risk populations and vulnerable populations	○ Continuous assessment and risk analysis, including identification and mapping of at-risk populations and vulnerable populations
○ Strengthen M&E unit at BOG to develop a COVID-19 M&E plan and indicator framework; ○ Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures; ○ Train and Support data providers in developing M&E plans and indicator frameworks (health/behavior/social) **Responsible Party:** M&E unit at the BOG ○ Identify COVID-19 M&E indicators to include in the Health National Strategic Plan **Responsible Party**: Ministerial Planning Unit at MOH and M&E Unit at BOG	Continuously assess and analyze number of cases, geographical location, contact history and compliance to measures to identify trends for targeted interventions and adjusting of public health measures **Responsible party:** Head Epidemiology and Surveillance in close collaboration with M&E Unit BOG
○ Designate a focal point for resource mobilization and to capture the comprehensive needs list. ○ Utilize WHO forecasting model as a supporting tool. ○ Develop a needs list with budget for supplies and equipment needed for the different scenarios. Disaggregate as much as possible to source of funding (government; loans; grants; donor funding) in line with the National COVID-19 Preparedness and Response plan ○ Identify and maintain list of local donors ○ Do Gaps analysis and engage in preliminary donor conversations. ○ Develop Resource Mobilization Strategy ○ Set up a mechanism to coordinate and centralize donor funding and ensure ongoing dialogue with local donors **Responsible parties:** Ministerial Planning Unit with Deputy Director Finance and Human Resources under supervision of Director of Health – MOH in close collaboration with Ministry of Finance and Ministry of	○ Continuously monitor mechanism to coordinate and centralize donor funding, monitor equitable distribution and ensure ongoing dialogue with donors ○ Continue to engage with local donors and existing programs on a bi-weekly basis for ongoing mobilization /allocation of resources and capacities to implement operational plan. **Responsible party:** Resource Mobilization Focal Point



Foreign Affairs	

***A Health Emergency Operations Centre (HEOC) is the central location from which health personnel convene for the coordination and direction of operational information and resources for strategic management of public health events and emergencies. It provides staff support to commanding officers in making decisions and coordinating responses to emergency incidents. It is usually a physical place where personnel can assemble, and response activities can be managed. (see annex SOP PHEOC)**		
Functions Health Emergency Response Mechanism	**Designate**	**Name delegated Officer**
Health Emergency Operating Center (HEOC)	Director of Health	Cleopatra Jessurun
Daily Coordinator PHEOC	Health Disaster Manager	Adjai Ramadhin
Risk Communication and public engagement		Victoria Morpurgo; Melissa Benn
Case finding, contact tracing and management	Rapid Response Team	Melissa Benn; Herman Jintie; Pedro Roep; Radjesh Ori; Jerry Slijngaard
Surveillance	Head Epidemiology and Surveillance BOG	Radjesh Ori
Public Health measures	Director BOG	Minouche Bromet; Mirelva Pinas
Infection Prevention and Control (IPC)	National IPC Coordinator	Kathleen Jharie
Laboratory testing	Head Central Lab and Head Lab AZP	Merill Wongsokarijo and Peter van Keulen
Case management strategy	Medical Team	Stephen Vreden; Fauwzia Poese
Case management recommendations by case severity and risk factors	Team Internist	Stephen Vreden
Technical Support to the PHEOC	PAHO	Astrid van Sauer
Societal response	Psychologist's et.al.	(Victoria)
Surge for resources. Human Resources, Needs for material and equipment; Training and Technical Support		



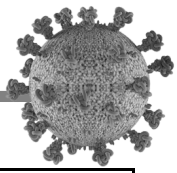
PILLAR 2: RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

This section focusses on risk communication, community engagement and impact monitoring

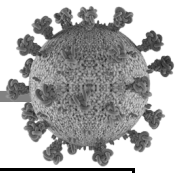
Key actions

- Develop national COVID-19 Risk Communication and Community Engagement plan based on different scenarios (Sporadic cases, Clusters of cases, Community transmissions)
- List all relevant groups, with an emphasis on vulnerable populations and identify most effective communication channels
- Ensure timely and culturally sensitive distribution of information to all peoples in the country to make them self-sufficient in displaying desired behavior, and to increase mutual social control
- Establish the main national source for trusted reliable and accurate information
- Engage all potential partners and stakeholders that can support the effective and efficient communication with the public
- Continually document lessons learned to inform future preparedness and response activities

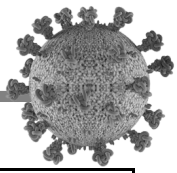
No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
○ Develop and Implement National Risk-Communication and Community Engagement (RCCE) Plan for COVID-19 **(Annex 3)** to prepare to communicate rapidly, regularly and transparently with the population. ○ Development must take into account anticipated public health measures based on existing guidelines to prevent the spread of diseases with flu like symptoms ○ Review regulatory requirements and legal basis of all potential public health measures ○ Ensure that the Plan distinguishes key Partners and Stakeholders, different audiences, key communication messages, spokes persons and mechanisms according to the country's state of transmission, i.e. No Cases, Sporadic Cases, Cluster Cases, Community Transmission **Responsible Party:** Director of Health in collaboration with BOG ○ Establish the main national management team as the principal and most trusted source of information to manage the "Infodemic" around COVID-19 by:	○ Adapt risk communication and prevention guidelines as new knowledge about the disease becomes available and government regulation to contain the spread are implemented. ○ Continue risk communication ○ Continue to manage the infodemic ○ Initiate communication on government regulations ○ Continue to provide relevant and timely information ○ Maintain the established communication mechanisms ○ Adapt frequency of providing information	○ Adapt risk communication and prevention guidelines as new knowledge about the disease becomes available and government regulation to contain the spread are implemented. ○ Initiate Crisis Communication, with a strong emphasis on government ○ Continue to provide relevant and timely information ○ Continue to manage the infodemic ○ Maintain the established communication mechanisms ○ Adapt frequency of providing information regulations	○ Adapt risk communication and prevention guidelines as new knowledge about the disease becomes available and government regulation to contain the spread are implemented. ○ Continue crisis communication with regular updates on the situation ○ Continue to increase the communication of government regulations ○ Continue to provide relevant and timely information ○ Continue to manage the infodemic ○ Maintain the established communication mechanisms ○ Adapt frequency of providing information



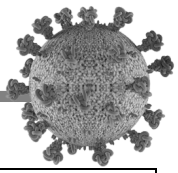
o Providing relevant and accurate information timely and routinely o Creating an identifiable brand o Developing a central and accessible outlet with up to date information • Developing a consistent communication mechanism • **Responsible party:** National Information Institute (NII) under supervision of the Vice President in collaboration with Ministry of Health ○ Initiate Risk Communication through relevant channels **Responsible Party:** Director of BOG			
Identify and train and designated spokes people ○ **Responsible Party**: Director of Health	○ Minister/ director of Health designated as spokesperson for health sector ○ **Responsible Party**: National COVID-19 Management Team	○ Minister/ director of Health designated as spokesperson for health sector. ○ **Responsible Party**: National COVID-19 Management Team	○ Minister/ director of Health designated as spokesperson for health sector ○ **Responsible Party**: National COVID-19 Management Team
○ Describe type, form and frequency of formal communication between partners and stakeholders ○ Document minutes of each (evaluation) meeting **Responsible Party:** National Response Team, National COVID-19 Management Team	○ Document minutes of each (evaluation) meeting **Responsible Party:** National Response Team, National COVID-19 Management Team	○ Document minutes of each (evaluation) meeting **Responsible Party:** National Response Team, National COVID-19 Management Team	○ Prepare for after-action reviews in accordance with IHR (2005) once community transmission passes. ○ Collect documentation / minutes of each (evaluation) meeting. **Responsible Party:** National Response Team, National COVID-19 Management Team



○ List all relevant groups and define and identify vulnerable populations based on knowledge of the disease and its prevalence within different populations. ○ Conduct rapid behavior assessment for all relevant groups, based on guidelines to prevent the spread of the disease, which will: ○ Provide a better understanding of the key target audiences, perceptions and concerns ○ Identify most effective communications channels and foster strategic partnerships to reach every individual in every corner of the country ○ Identify relevant organizations and individuals and trusted community groups who can serve as influencers and assist in communicating the desired behavior **Responsible Party:** BOG – collaboration between relevant units (Family and Community Health/ Program Development	○ Adapt vulnerable groups list based on prevalence of the disease. ○ Continue scouting for and engaging potential influencers	○ Adapt vulnerable groups list based on prevalence of the disease. ○ Continue scouting for and engaging potential influencers	○ Adapt vulnerable groups list based on prevalence of the disease. ○ Continue scouting for and engaging potential influencers
○ Prepare culturally aware messages using available information and pre-existing messages from reputable sources (PAHO, WHO) and adapt to the local context. ○ Identify and contract translators for local context ○ Pre-test all messaging through a participatory process, specifically targeting key stakeholders and vulnerable groups. ○ Identify or establish the correct clearance process for timely dissemination of messages and materials ○ Translate messages to languages in line with the target audience and the distribution channel ○ Disseminate message through identified media channels **in a timely fashion** **Responsible Party:** Director BOG in close collaboration with Director MOH	○ Increase frequency of message dissemination. ○ Adapt messages to adhere to updated guidelines	○ Increase frequency of message dissemination. ○ Adapt messages to adhere to updated guidelines ○ Establish large scale community engagement for social and behavior change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations	○ Increase frequency of message dissemination. ○ Adapt messages to adhere to updated guidelines ○ Establish large scale community engagement for social and behavior change approaches to ensure preventive community and individual health and hygiene practices in line with the national public health containment recommendations



○ Partner with media channels to broaden the reach of messaging ○ Provide covid-19 risk communication training to the media ○ Engage with existing public health and community-based networks, the private sector, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors to broaden the reach of messaging **Responsible Party:** Director BOG in close collaboration with Director MOH	○ Maintain the relationship with the media through regular, scheduled check-ins ○ Ensure public health and community-based networks have up to date information through regular, scheduled check-ins	○ Maintain the relationship with the media ○ Ensure public health and community-based networks have up to date information	○ Maintain the relationship with the media ○ Ensure public health and community-based networks have up to date information
○ Use two-way 'channels' for information sharing such as hotlines (text and talk), responsive social media such as U-Report in country where it exists, radio and health worker feedback to detect and rapidly respond to and counter misinformation and provide evidence-based information	○ Systematically establish community information and feedback mechanisms including through social media monitoring; community perceptions, knowledge, attitude and practice surveys; and direct dialogues and consultations	○ Maintain established feedback mechanisms	○ Document lessons learned to inform future preparedness and response activities



PILLAR 3: SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

Surveillance and case detection

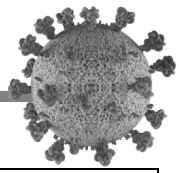
This section focuses on early detection, contact tracing and monitoring, quarantine and management of contacts

Key actions:

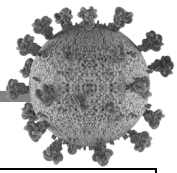
- Strengthen active case finding by strengthening the surveillance system
- Contact tracing of confirmed, probable or suspect COVID-19 cases
- Quarantine of exposed persons such as contacts and repatriated or immigrated persons
- Identify, Train and expand Rapid Response Teams for all regions to support PHEOC

(Annex 4 – 5 – 6)

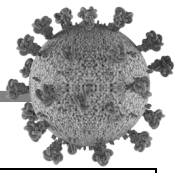
No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
MOH reviews, adapts and translates WHO case definitions and investigation protocols where appropriate; develop and disseminate through an established section on the MOH website to all clinicians (facilitated by the NPHRT) at every level of care. **Responsible party:** Director of MOH	MOH reviews and adapts *updated* WHO case definitions and investigation SOP where appropriate; update the MOH website accordingly and communicate changes when needed. **Responsible party:** Director of MOH	MOH reviews and adapts *updated* WHO case definitions and investigation SOP where appropriate; update the MOH website accordingly and communicate changes when needed. **Responsible party:** Director of MOH	MOH reviews and adapts *updated* WHO case definitions and investigation SOP where appropriate; update the MOH website accordingly and communicate changes when needed. **Responsible party:** Director of MOH
Activate and expand active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI) by: ● Assess sentinel sites and consider expanding with key RGD clinics (Albina, Latour and Nickerie) ● Identify measures to enhance event-based surveillance e.g. by utilizing the hotline/**control room**. Expansion based on a weekly assessment of the amount of daily calls. (adjust for consultative calls) ● **Implement port of entry** screening by training responsible authorities in entry screening including	● Expand control room capacity based on the weekly assessment. ● **Maintain and strengthen Port of entry** screening ● Monitor ILI and SARI cases on weekly basis to evaluate changes in trend and test additionally for COVID-19 if testing capacity is sufficient ● **Implement data base** for documentation of COVID-19 cases ● Set up a health system for early identification and management of suspect COVID-19 cases and ARI/ILI patients by improving triage capacity and data reporting system	● Expand control room capacity based on the weekly assessment. ● **Maintain Port of entry screening and implement Port of exit** screening ● Monitor ILI and SARI cases on weekly basis to evaluate changes in trend and test additionally for COVID-19 ● Expand COVID-19 surveillance by using/adapting ILI and SARI surveillance to routinely include COVID-19 ● Adapt data system to include all sources of	● Expand control room capacity based on the weekly assessment ● **Maintain Port of entry and exit** screening ● Enhance ILI and SARI surveillance to routinely include COVID-19. ● Adapt data system to include all sources of (suspect or contacts) COVID-19 cases at HC facilities and other identified (testing) facilities ● Maintain engagement with **external partners** for heightened surveillance and reporting from risk areas ● Enhance surveillance and testing of HCW working



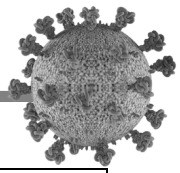
screening form ● **Monitor existing surveillance systems** for ILI and SARI cases on weekly basis to evaluate changes in trend ● **Identify and Implement COVID-19 data system** to capture all suspect cases at the epidemiology unit at the BOG with data forms ● Identify **quarantine** facilities (identification by NCCR and approval of location by MOH) and develop quarantine SOP including facility requirements and guidelines for early detection of cases ● Assess gaps in active case finding and event based surveillance systems (ARI) routinely to modify surveillance strategies **Responsible Party:** Epidemiology unit (BOG)	(such as flu clinics) ● Identify mechanisms to enhance surveillance and testing of HCW working with COVID-19 ● Assess gaps in active case finding and event based surveillance systems (ARI) routinely to modify surveillance strategies	(suspect or contacts) COVID-19 cases such as the flu clinics and high risk areas ● Identify **risk areas** for heightened case detection and investigation and **engage external partners** such as community leaders, Malaria Program, Red cross etc. in surveillance and reporting ● Strengthen guidelines to enhance surveillance and testing of HCW working with COVID-19 ● Assess gaps in active case finding and event based surveillance systems (ARI) routinely to modify surveillance strategies	with COVID-19 ● Implement guidelines for home isolation for mild symptomatic cases. ● Assess gaps in active case finding and event based surveillance systems (ARI) routinely to modify surveillance strategies
● Identify, train, equip and deploy rapid-response team members and their specific roles in COVID-19 response at the district level to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours**.** RRT to report to the BOG/EPI ● Develop SOPs for RRTs functions and identify and train team members in its use. At least 18 RRTs to be identified ● RRT to consist of at least 4 persons: one health officer (responsible for the intake), one police officer, one representative from NCCR and one representative from the respective District Commissariat.	● Increase RRT capacity to include teams in Nickerie, Marowijne, *Para* and Paramaribo as required. ● Engage Medical Mission and RGD for identification and training of additional RRT in the interior and other areas. ● Implement and enhance contact tracing and monitoring capacity at the Epi unit	● Increase RRT capacity as needed ● Intensify case finding, contact tracing, monitoring, quarantine of contacts of cases by increasing the number of teams at Epi unit	● Increase RRT capacity if necessary ● Continue active case finding, continue contact tracing where possible, especially in newly infected areas and monitoring of isolation and quarantine of contacts, and isolation of cases



● Identify the team for COVID-19 case investigation and contact tracing utilizing forms and strategies provided by PAHO/WHO. **Responsible Party:** Epidemiology unit (BOG)			
● Undertake case-based reporting to WHO within 24 hours under IHR (2005) ● Implement data system to capture all suspect COVID-19 cases at the epidemiology unit at the BOG with data forms and improve case reporting to PAHO/WHO/IHR ● Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children ● Actively communicate with focal points at sources/HCF (hospitals, quarantine) to report routinely case status with identified forms to the BOG/epi unit **Responsible Party:** IHR Coordinator with cooperation of Epidemiology unit (BOG)	● Undertake case-based reporting to WHO within 24 hours under IHR (2005) for new cases ● Submit cumulative data in line listing format to IHR at least once weekly ● Use PHEOC structure to improve information flow and data sharing ● Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children ● Intensify communication with focal points at sources/HCF (hospitals, quarantine) to report routinely case status with identified forms to the BOG/epi unit	● Undertake case-based reporting to WHO within 24 hours under IHR (2005) for new cases ● Submit cumulative data in line listing format to IHR at least twice weekly ● Use PHEOC structure to improve information flow and data sharing ● Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children ● Intensify communication with focal points at sources/HCF (hospitals, quarantine) to report routinely case status with identified forms to the BOG/epi unit	● Undertake case-based reporting to WHO within 24 hours under IHR (2005) for new cases ● Maintain Influenza surveillance system to report COVID-19 incidence to IHR ● Use PHEOC structure to improve information flow and data sharing ● Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children ● Intensify communication with focal points at sources/HCF (hospitals, quarantine) to report routinely case status with identified forms to the BOG/epi unit



	Produce weekly epidemiological and social science reports and disseminate to all levels and international partners to enhance Risk assessment and decision making **Responsible Party:** Epi Unit and PHEOC coordinator	Produce weekly epidemiological and social science reports and disseminate to all levels and international partners to enhance Risk assessment and decision making **Responsible Party:** Epi Unit and PHEOC coordinator	Produce weekly epidemiological and social science reports and disseminate to all levels and international partners to enhance Risk assessment and decision making **Responsible Party:** Epi Unit and PHEOC coordinator
After action reviews ● Test the existing system and plan through actual experience and/or table-top or simulation exercises, and document findings to inform future preparedness and response activities ● Use documentation on meetings (minutes), assess gaps in surveillance, contact tracing, isolation and quarantine and RRT functioning with the PHEOC team. ● Hold all-round evaluation meetings with partners in surveillance to identify gaps in systems (including reporting) ● Revise plans, SOPs and training material where needed to improve future response with identified gaps **Responsible Party: HEOC**			



PILLAR 4: POINTS OF ENTRY (FOR LAND, SEA AND AIR BORDERS)

Strengthening surveillance and risk communication at Points of entry

Key actions:

- Point of entry screening
- Risk communication for travelers
- Triage and isolation of ill passengers (suspect COVID-19 cases)

There is a multi-sectoral national port health committee (PHC). The task of the committee is to maintain readiness at air – sea and land borders by organizing annual policy meeting with managers of relevant ministries and private organizations involved in air – sea and land borders. Other tasks are to advice the Minister of Health on matters concerning development of the national port health program; support the development of port health programs in the border districts and collaboration with other ministries and international organizations for continuous improvement of the national port health program.

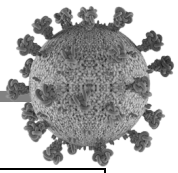
The committee is chaired by Ms. Stephanie Cheuk A Lam (BOG). Members of the committee are representatives of Ministry of Public Works, Transport and Communication; Ministry of Agriculture, Husbandry and Fishery; Ministry of Health; Maritime Authority Suriname; "Havenbeheer"; Customs; Airport Authority; Police Force, sections Maritime Police and Military Police.

Responsible party: Each entity represented in the PHC is responsible for the implementation of actions as described below. ***The Port Health Committee reports to the Minister of Health.***

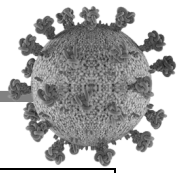
No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
○ Develop/adapt and implement a points of entry public health emergency plan to include preparedness and response mechanisms for COVID-19 ○ Identify all direct partners, such as immigration, in preparedness and response and provide awareness sessions and training sessions in IPC ○ Train and equip designated Port Health team in COVID-19 SOPs and IPC for case detection, isolation, reporting, documentation and transport[15] procedures for ill passengers. ○ Collaboration with the Coast Guard for screening of crew members of ships at Sea ○ Activate preparedness	○ Implement and strengthen entry screening ○ Periodic updates to and information sharing from all direct partners at points of entry: *Immigration Officers* *NCCR* *Police* *Coast Guard* *Port Authorities* *RGD and* *Medical Mission* ○ Deploy and maintain operations of Port Health team at all points of entry	○ Implement and strengthen entry and exit screening ○ Periodic updates to all direct partners at points of entry ○ Maintain operations of Port Health team at all points of entry	○ Implement and strengthen entry and exit screening ○ Periodic updates to all direct partners at points of entry ○ Maintain operations of Port Health team at all points of entry

[15] Transportation carried out by RGD for suspect cases and high risk persons identified by NCCR

mechanisms for heightened surveillance/screening for entry			
o Prepare rapid health assessment for the identification of triage and isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities for case management.	o Maintain use of and staffing for triage and isolation areas o Ongoing assessment of adequacy of triage and isolation areas	o Maintain use of and staffing for triage and isolation areas o Ongoing assessment of adequacy of triage and isolation areas	o Maintain use of and staffing for triage and isolation areas o Ongoing assessment of adequacy of triage and isolation areas
o Communicate information about COVID-19 to travelers o Risk communication involving all relevant partners to enhance early case finding at point of entry	o Risk communication to enhance early case finding at point of entry	o Risk communication to enhance early case finding at point of entry	o Risk communication to enhance early case finding at point of entry
	o Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust response plans as appropriate o Regular, for example bi-weekly, evaluation meetings with PHU to adapt response mechanisms o Evaluation session with direct partners to identify gaps in emergency plans	o Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust response plans as appropriate o Regular, for example bi-weekly, evaluation meetings with PHU to adapt response mechanisms o Evaluation session with direct partners to identify gaps in emergency plans	o Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust response plans as appropriate o Regular, for example bi-weekly, evaluation meetings with PHU to adapt response mechanisms o Evaluation session with direct partners to identify gaps in emergency plans
Points of Entry Response Actions - Staff trained, PPE provided, designated physical space for assessment - Protocols and referral pathways established and persons tested according to national case definition - Signage and communications materials for preventive measures with contact info for BOG MOH communicates and	Implement plan o In addition to the participation in the National COVID-19 Response Team, communication with Foreign Affairs and Corps Diplomatique (Guyana; French Guyana; Brazil) and instate regular (weekly) meetings chaired	Implement plan o Intensify communication with Foreign Affairs and Corps Diplomatique and instate regular meetings	Implement plan o Intensify communication with Foreign Affairs and Corps Diplomatique and instate regular meetings



shares guidelines for quarantine of persons. Guidelines should include entry of persons at every border into Suriname Develop repatriation strategic plan in collaboration with NCCR, Port Health, Foreign Affairs, Corps Diplomatic, Airlines and Airport Authorities; ○ Oversee and support development of guidelines and standard operation procedures for each stakeholder from the point of departure to arrival in the home country (formal and informal borders)			



PILLAR 5: NATIONAL LABORATORIES

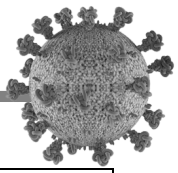
Strengthen the laboratory capacity to support diagnosis and surveillance for COVID-19
This section will focus on enhancing testing capacity

Key actions:
- Capacity building at the national reference laboratory (Central Laboratory-BOG) for detection of SARS-CoV2
- Identification of testing areas such as Flu clinics and border areas
- Enhancing testing capacity to.

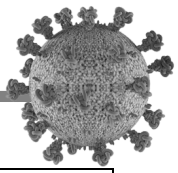
Responsible party: Head Central Laboratory-BOG and Head Microbiology Laboratory AZP

(Annex 7)

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
○ Capacity building to establish and maintain access to a designated international SARS-CoV2 reference laboratory ○ Identify and support additional testing sites for SARS-CoV2 using molecular systems to strengthen broadened testing strategy **Responsible party:** Director of Health in close collaboration with Head Central Laboratory with support from PAHO and CARPHA	○ PCR testing at The Central Laboratory (CL) using open Molecular technology (CL has capacity for testing maximally 80 samples/day) ○ Inclusion of MML-AZP using PCR testing (AZP has capacity for testing maximally 50 samples/day) ○ Maintain testing capacity for minimum of 50 samples a day (total maximum capacity is 130 samples/day). *(Nationwide in total 4 GeneXpert machines available)*	○ Ongoing PCR testing by CL and MML using open molecular technology ○ Mapping available alternate molecular methodologies to increase testing capacity i.e. closed molecular system like GeneXpert. ○ Consider expanding testing sites in keeping with available technology and risk assessment ○ Increase COVID-19 cartridges for the GeneXpert to maintain testing capacity for a minimum of 150-200 samples a day	● Use of closed and open molecular systems for PCR testing. ● Consideration of other testing modalities such as rapid Antigen tests if available for sero-prevalence studies ● Consider use of Antibody testing for population prevalence studies ● maintain testing capacity for a minimum of 100 samples a day in keeping with epidemiological principles (see pillars 1 and 3)
○ Review, adapt and disseminate existing SOPs (as part of disease outbreak investigation protocols) for all testing facilities, for specimen collection, management, and transportation for SARS-CoV2 diagnostic testing	○ Implement SOP for sample collection at all designated testing facilities. RGD Nurses and Rapid Response Team are trained and competent in taking swabs according to the SOPs ○ testing algorithm implemented at CL and	○ Implement SOP for sample collection at all designated testing facilities ○ Revise and adapt the national algorithm for laboratory testing to first prioritize ruling out SARS-CoV2 ○ Develop SOP	○ Implement SOP for sample collection at all designated testing facilities ○ Revise and adapt the national algorithm for laboratory testing to first prioritize ruling out SARS-CoV2 ○ Develop SOPs for sample collection and



○ Develop a national algorithm for laboratory testing for SARS-CoV2 **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	MML, to first rule out Influenza (*SARI/ILI samples will also be tested on COVID-19*).	for rapid testing procedures	transportation with use of rapid test kits. ○ develop algorithms for use of rapid test kits in terms of location of testing, interpretation of results and confirmatory methods ○ train persons in use of rapid test kits and algorithms.
○ Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks ○ Identify hazards and perform biosafety risk assessment for every testing facility ○ Adapt biosafety measures and include in SOPs of designated laboratories ○ laboratories to have a level 2 BSL ○ Central Laboratory designated at the National Influenza Center (NIC) **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	○ Maintain biosafety measures identified; adapt and include in SOPs where necessary	○ Maintain biosafety measures in line with SOP and BSL 2	○ Maintain biosafety measures in line with SOP and BSL 2
○ Laboratories to ensure access to sufficient reagents, supplies including PPEs according to the needs ○ Identify suppliers for test kits and supplies **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	○ Ensure availability of test kits and supplies for additional testing facilities *(due to global shortage of PPEs, test kits and viral transport medium, timely ordering is important)*	○ Ensure availability of test kits and supplies for additional testing facilities *(due to global shortage of PPEs, test kits and viral transport medium, timely ordering is important)*	○ Ensure availability of test kits and supplies for additional testing facilities *(due to global shortage of PPEs, test kits and viral transport medium, timely ordering is important)*
○ Share virus materials with regional reference laboratory (CDC) for sequencing according to established protocols for COVID-19 **Responsible party:** Head	○ Share virus materials for first 10 confirmed cases with (regional) reference laboratory	○ Share virus materials for confirmed cases with regional reference laboratory as required	○ Share virus materials for confirmed cases with regional reference laboratory as required



Central Laboratory-BOG			
○ Discuss and identify databases to link laboratory data with key epidemiological data for timely data analysis **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	○ utilize established databases to link laboratory data with key epidemiological data for timely data analysis *(implement COVID-19 GO DATA database)*	○ utilize established databases to link laboratory data with key epidemiological data for timely data analysis *(COVID-19 GO DATA database)*	○ utilize established databases to link laboratory data with key epidemiological data for timely data analysis *(COVID-19 GO DATA database)*
○ Use existing criteria to monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	○ Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned ○ Recruit three (3) additional Lab technicians to support monitoring and evaluation	○ Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned	○ Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned
○ Discuss guidelines and mechanisms for use of rapid test kits once made available **Responsible party:** Head Central Laboratory-BOG and Head Microbiology Laboratory AZP	○ Guidelines finalized	○ If consideration to be given to use rapid test kits, when available develop mechanism to validate sensitivity and specificity of the test kits in the population	○ implement use of rapid test kits as guided by national response

PILLAR 6: INFECTION PREVENTION AND CONTROL

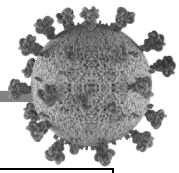
Strengthen Infection Prevention and Control measures implementation in HCF, High risk facilities and community

Key actions:

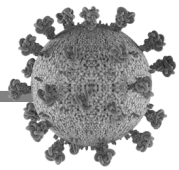
- Identify and routinely Assess IPC capacity in key areas
- Adapt/develop IPC measures for key areas
- Increase IPC capacity in Health Care Workers
- Implement and assess IPC measures

(Annex 4 – 5 – 6)

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
o Use the IPC committee to assess IPC capacity at all levels of the healthcare system, including public, private, traditional practices and pharmacies, using the WHO IPC and WASH tools. (Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations) o Train Rapid Response Teams in IPC (see pillar 3) **Responsible party:** Director MOH in close collaboration with IPC committee	o Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for visitors and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette o Monitor IPC and WASH implementation using existing WHO frameworks and tools	o Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for visitors and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette o Monitor IPC and WASH implementation using existing WHO frameworks and tools	o Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for visitors and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette o Monitor IPC and WASH implementation using existing WHO frameworks and tools
● Use the IPC committee in collaboration with other stakeholders to assess IPC capacity in public places and community spaces where risk of community transmission is considered high for example in institutions like schools and elderly care homes and prisons. **Responsible party:** Director MOH in close collaboration with IPC committee	o Implement and closely monitor IPC measures in health facilities and other high risk areas	o Enhance IPC measures in health facilities, public areas and community places	o Enhance IPC measures in health facilities, public areas and community places
● Review and update existing national IPC guidelines,	o Adapt IPC measures when	o Adapt IPC measures when applicable	o Adapt IPC measures when applicable



including defined patient-referral pathways and specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport as well as community, household, and family practices and train stakeholders in its use and make available online through MOH or national COVID-19 website. **Responsible party:** National IPC Coordinator supported by IPC committee	applicable after routine assessment and following evidence based developments. ○ Adapt and disseminate IPC guidance materials	after routine assessment and following evidence based developments. ○ Heightened dissemination and use of IPC guidance focusing on risk areas ○ Disseminate and monitor implementation of specific IPC guidance for home and community care providers	after routine assessment and following evidence based developments. ○ Heightened dissemination and use of IPC guidance focusing on risk areas ○ Disseminate and monitor implementation of specific IPC guidance for home and community care providers
● Develop a national plan to manage procurement and donations of PPE (stockpile, distribution) according to priority needs. **Responsible party:** Ministerial Planning Unit (MPU) MOH and BGVS	○ routinely assess PPE stock management and procure supplies according to needs	○ routinely assess PPE stock management and procure supplies according to needs	○ routinely assess PPE stock management and procure supplies according to needs
○ Identify and mobilize trained staff with authority and technical expertise to implement IPC activities at vulnerable health facilities, prioritizing based on risk assessment and local care seeking patterns **Responsible party:** National IPC Coordinator supported by IPC committee	○ Enhance IPC measures at high risk areas and health care facilities and identify IPC human resource surge capacity (numbers and competence) by training additional staff	○ Based on routine risk and needs assessment enhance IPC measures at high risk areas and health care facilities and identify IPC human resource surge capacity (numbers and competence) by training additional staff ○ Enhance IPC measures and activities focusing on vulnerable populations, at risk communities.	○ Based on routine risk and needs assessment enhance IPC measures at high risk areas and health care facilities and identify IPC human resource surge capacity (numbers and competence) by training additional staff ○ Enhance IPC measures and activities focusing on vulnerable populations, at risk communities.
○ Provide/adapt guidelines for WASH for the public and private sector **Responsible party:** National IPC Coordinator supported by IPC committee	○ Enhance and monitor WASH services in high risk areas supported by focal points/community leaders	● Support access to WASH services in public places and community spaces most at risk and monitor implementation	● Support access to WASH services in public places and community spaces most at risk and monitor implementation



PILLAR 7: CASE MANAGEMENT

This pillar looks at the following areas of focus:

1. **Strengthen the basic health care team at the first level of care**
2. **Centralized Bed Management Mechanism**
3. **Separate flows for triage, care, and diagnostic testing of patients with respiratory symptoms suggestive of COVID-19**
4. **Strengthening of home care – Telehealth**
5. **Reorganization, recruitment, and training of health workers**

1. Strengthen the basic health care team at the first level of care

This area focuses on the role of the RGD, Medical Mission, the private sector, pharmacies, and other health actors in the first level of care.

Key actions:

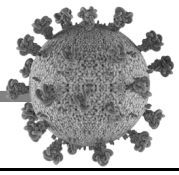
- Train inter-sectoral teams at 80% of primary health centers (PHC) across RGD, Medical Mission and the private sector in infection prevention and control; triage and referral flows for COVID-19
- Develop and disseminate clinic guidelines to ensure that essential services are maintained in the PHC – 'clinic days' – while adhering to social distancing and IPC.
- Utilize telemedicine options to conduct remote consultations between doctors and suspect patients where feasible for pre-triage or follow-up care.
- Monitor supply of medicines and other essential supplies at clinic level and ensure no stock-outs
- Establish strong referral links between RGD, Medical Mission and the private sector clinics with designated COVID-19 facilities to ensure smooth admission of suspect patients and efficient ambulance transfer.

Responsible party: Director of Health supported in collaboration with Primary Care Providers, Directors of designated Hospitals and Medical Specialists (Infection and Intensive Care specialists)

(Annex 4 – 5 – 6)

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
● Develop plan with Regional authorities for emergency use of community facilities (RGD/MM/District Commissariats) for potential surge. ● Identify facilities across districts in case of surge ● Assess capacity of community facilities and identify needs for equipment, materials, human resources and supplies. ● Map vulnerable (at risk[16]) groups in each district and assign	Continue to provide services to patients at community health clinics which include: ○ Rapid identification of cases within at-risk group with comorbidities ○ Continued consultations with patients needing essential services at the primary health level – HIV, TB, Malaria, Maternal and Child Health including vaccination programs, Reproductive health and family planning services. ○ Continue monitoring and dispensing medicines to patients	○ Develop a system at the clinic to ensure pre-triage of patients with respiratory symptoms. Provide staff conducting pre-triage with adequate personal protective equipment and infection control measures ○ Rapid identification of cases within at-risk group with comorbidities ○ Activate the SOPs to ensure fluid communication and coordination of patient transfers including the management teams in the	● Activate plan for emergency use of community facilities ● Activate a plan to involve the RGD, Medical Mission and other non-governmental partners support monitoring and follow-up of persons at-risk and/or patients hospitalized at home. ● Expand the referral flow between case investigation, contact tracing and case management to support sentinel surveillance and

[16] At-risk populations include populations older than 65; populations with preexisting conditions such as cancer, immune-compromised hypertension, diabetes, chronic lung, kidney and heart disease.



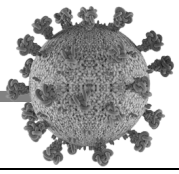
clinics for each catchment area. Ensure that these clinics are equipped and staff trained in IPC. ● Develop individual and community education materials on self-care, prevention measures, isolation, and quarantine to provide to all patients during community health talks, walk-in visits and through signage at all RGD, Medical Mission and private sector clinics, pharmacies and health posts. Include also, distribution of these materials to NGOs for vulnerable groups.	with chronic conditions (HIV, acute hypertension, etc.) and those receiving home-based hospital care. Provide these patients with no less than 3 months' supply of medicines where possible. ○ Prepare implementation of plan for emergency use of community facilities	Hospital, Medical Mission, NCCR or private sector as needed. ○ Implement plan for emergency use of community facilities	investigation in communities, homes and quarantine on a larger scale. ● Rapid identification of cases within at-risk group with comorbidities ● Develop national contingency plans for medical transport in the event of a surge in cases. Consider using an advanced mobile fleet staffed with a physician and adequate personnel for transfers of critical patients. ● Establish a COVID-19 specific early alert centers (911-type emergency coordination centers) to improve transfer times and the referral of critical patients.
● Develop protocols for the management of at-risk populations diagnosed with COVID-19 ● Develop algorithms treatment guidelines and protocols for management and treatment of patients at all points of access to the health system	● Implement protocols and use algorithms for management and treatment of at-risk populations diagnosed with COVID-19	Implement protocols and use algorithms for management and treatment of at-risk populations diagnosed with COVID-19	● Implement protocols for management of at-risk populations diagnosed with COVID-19

2. Centralized Bed Management Mechanism

Referral of patients, especially critical care patients, require the coordination of all the private and public hospitals in Suriname to ensure timely access to hospital beds. At the hospital level in Suriname, the hospital bed monitor is the Nursing Director in each hospital.

Key actions:

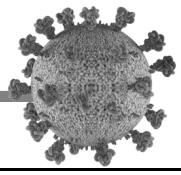
○ Designate hospital(s) solely for the management of patients with COVID-19 and monitor its bed capacity (including for critical care)
○ Identify needed physical, equipment and human resource surge capacity for the designated hospital and put in place.
○ Equip hospital bed monitors (Nursing Directors in Suriname) with tools to monitor bed allocations using electronic solutions if necessary.
○ Designate hospital/s for managing emergencies, patients with chronic conditions and other non-respiratory acute diseases, and high-risk pregnancies and childbirth
○ Utilize findings from hospital readiness assessments to determine the bed allocation plans in isolation facilities, wards, dedicated



hospitals and health facilities for other essential services
- Develop tools for assessing complexity of patients (COVID-19 plus other comorbidities) and separate beds to match patient complexity
- Develop tools for management of beds according to patient cohorts
- Develop plans for COVID-19 case management sites that are in non-hospital community or alternative settings

Responsible parties: Directors of Health of COVID-19 designated Hospitals (Wanica Hospital, AZP and SVZ)

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
• MOH and National Response Team identify designated COVID-19 facilities (hospitals and policlinics)	● Ensure adequate provision of medication, supplies and equipment for management of at-risk populations with comorbidities	● Ensure adequate provision of medication, supplies and equipment for management of at-risk populations with comorbidities	● Ensure adequate provision of medication, supplies and equipment for management of at-risk populations with comorbidities
● Identify and Prepare Intensive Care Unit capacity to accommodate expected critical cases each scenario	● Intensive Care Unit ready for patient admittance ● Execute steps to upgrade capacity in facilities where upgrade of medium-care beds in preparation of cluster cases and / or community transmission.	● Expand ICU for patient admittance ● Assess Academic Hospital ICU capacity and identify expansion plan of ICU ward (from 15 to 24) ● Prepare to operationalize field hospitals.	● Expand ICU for patient admittance ● Operationalize field hospitals.
○ MOH or PHEOC establishes a centralized bed management mechanism. This mechanism should maintain records on the inventory, occupancy, and movement of hospital beds. ○ Identify in each community options for setting up of community facilities with basic equipment and human resources	○ Bed management mechanism is maintained and used to inform the PHEOC on availability of beds.	○ The centralized bed management mechanism is activated, in accordance with established protocols, to respond to increased demand for beds and transfers in conjunction with RGD or other clinics at the primary health care level	○ The centralized bed management provides alerts to the MOH or PHEOC on the need for surge capacity via field hospitals or community-based case management.
● Utilize hospital readiness assessments to understand bed allocations, ward allocations, health worker allocations, discharge criteria and possible adjustments that could be made to create efficiencies in managing	● Develop a plan for bed management in the designated COVID-19 hospital using more flexible bed management by looking at *complexity* to ensure that each patient is admitted to the right ward or service based on their condition, thus	● Develop a plan to implement bed allocation based on four levels of complexity among patients at the designated COVID-19 facility: 1. Basic care bed units – Type D beds	● Implement bed allocation by complexity in designated facilities. ● Implement bed conversion at other hospitals ● Implement non-hospital SARI sites for patient managements



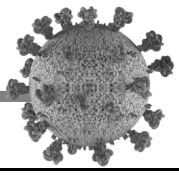
patients.	providing timely, quality care and avoiding long (sometimes unnecessary) stays in ICU beds.	2. Intermediate care bed units – Type C beds 3. Critical patient units – Type A and B beds a. Intermediate care units – type B beds b. Critical care units – type A beds ● Develop a plan to consider *bed conversion* at other hospitals in Suriname and negotiate with other hospitals for the hospitalization of pre-discharge patients who cannot be at home, are pregnant, have dengue or urinary tract infections, need dialysis, pregnant women with obstetric risk etc.	

3. Separate flows for triage, care, and diagnostic testing of patients with respiratory symptoms suggestive of COVID-19

Key actions:

- ○ Hospital-level readiness assessments to be conducted and results reviewed routinely to ensure advancement towards a more prepared facility
- ○ Emergency rooms, designate isolation spaces and flow of patients to wards and other parts of hospital pre-identified and marked
- ○ Staff trained in COVID-specific triage, SOP for case management based on national guidelines.

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
• Conduct hospital preparedness assessments to identify gaps to be addressed.	○ Implement any recommendations from hospital readiness assessments and ensure: ○ Separate isolation space in the emergency room from the general emergency room, with very clearly marked patient flow routes. ○ Separate the waiting and outpatient areas for symptomatic respiratory patients (who should	○ Designate hospital isolation wards in order to determine, through the bed manager, where COVID-19 patients should be hospitalized, and avoiding transfers of such patients to other parts of the hospital, which could increase the risk of contagion for other patients and for health personnel.	○ Implement isolation by cohorts – based on severity of patients, types of illness or other specific parameters.



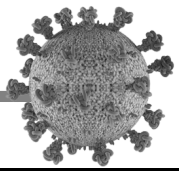
	wear masks) from those for patients being treated for other pathologies. ○ Ensure the availability of trained and protected personnel to triage and identify the level of risk and type of care required by each person.		

Strengthening of home care – Telehealth

Key actions:

- ○ Identify the specific consultations for which telehealth will be the right solution
- ○ Implement telehealth technology at dedicated sites and train medical staff to conduct remote consultations
- ○ Document case information and upload into centralized COVID-19 patient management files
- ○ Develop and implement clear referral protocol for any telehealth consultations that lead to suspect cases needing testing

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
● Continuously assess burden on local health system, and capacity to safely deliver primary health care services` ● Develop protocol to provide guidance for self-care of patients with mild COVID-19 symptoms ● Disseminate guidance to health providers and telehealth consultants on the management of severe acute respiratory infections and COVID-19-specific protocols based on international standards and WHO clinical guidance	• Monitor compliance to self-care protocols ● Continuously review update guidance protocol based on updated case definition and disseminate to health providers and telehealth consultants.	○ Monitor compliance to self-care protocols ○ Continuously review update guidance protocol based on updated case definition and disseminate to health providers and telehealth consultants. ○ Establish a call system connecting patients with the nearest first level of care center. ○ Use information and communication media for telehealth sessions to manage these patients remotely. ○ Ensure that referral flows are established following telehealth consultations and patients can receive follow-up services at first level of care or at hospitals as needed.	• Monitor compliance to self-care protocols • Continuously review update guidance protocol based on updated case definition and disseminate to health providers and telehealth consultants. Expand telehealth services to include home-based management of mild cases by: ○ Developing a protocol for health care workers to follow including checklists and SOPs ○ Link with network of ambulances and hospitals for referral in case patients require hospitalization ○ Develop relationships with private sector telecommunications companies to facilitate telehealth at no expense to



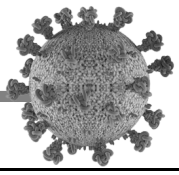
			patients and through use of low-tech solutions.

Reorganization, recruitment, and training of health workers

Key actions:

- Conduct a mapping of available health workers (Public, private and NGO sector) arranging where possible by specialization and competency
- Develop a plan with inter-professional teams for case investigation, contact tracing and case management at district level, within primary health care and hospital settings
- Identify and develop tools that would streamline training of health care workers in various topics depending on the area of work (ideally, accessible online)
- Develop one web-based knowledge management platform for Suriname health care workers to access all national SOPs, guidance documents, technical strategies, flow charts and related communications materials.
- Develop facility-level human resource for health plans to monitor allocation of health workers vs cases in facilities; the redistribution of workers; shifts and rest periods for workers; and psychosocial support.

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
● Conduct a mapping of availability, needs and gaps in health workforce capacity by utilizing available information (registries, databases) on human resources for health in the country. ● Develop plan to establish and equip (vehicle and ambulance) District Rapid Response Teams (one team per district) ● Establish a centralized roster or database of all available health workforce according to level of care at the appropriate level (national or district) and designating a function for updating contact information and potential health care service capacity of all people willing and capable to serve. ● Use recent graduates awaiting internship and students in their final undergraduate year (professional practice or social service) as support personnel in community activities, home visits, patient orientation, data	○ Develop a plan for the recruitment of additional health workers to function as temporary health workforce surge capacity and to cover essential health care services. ○ Implement and operationalize District Rapid Response Teams ○ Activate the recruitment and training of additional health workers and assign them to health facilities equipped with sufficient PPE.	○ Deploy District Rapid Response Team if necessary ○ Develop a plan for the reorganization and role distribution of health workforce including: ○ Moving staff temporarily from non-affected or less-affected areas of the country to other areas where they are most needed. ○ Redistributing of personnel from one area of the health facility to another or to other functions where they are most needed. ○ Develop facility-level plans that coordinate shifts of health workers to ensure adequate coverage and allow sufficient downtime for overworked personnel. ○ Establish a mechanism to provide psychological support for health workers which could include: dedicated hotline;	○ Deploy District Rapid Response Team if necessary ○ Activate the plan for the reorganization and role distribution of health personnel including task shifting and allocate to COVID-19 facilities and other facilities to maintain essential services. ○ Implement protocols and systems for the management and monitoring of suspected and confirmed cases among the human resources involved in the COVID-19 response. ○ Develop a system of reporting of incidents and symptoms by health workers through a blame-free environment and support as needed (psychosocial, financial, sick leave, other). ○ Establish protocols to assure safe return to work of health workers following quarantine or sick leave.



collection, and general examinations.		flexible work schedules and distributed workload; childcare and other support options; buddy system to provide basic emotional support.	

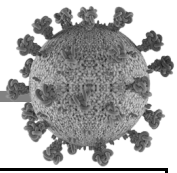
PILLAR 8: OPERATIONAL SUPPORT AND LOGISTICS

Guarantee supply management for the operation of health facilities at all levels to respond to COVID-19 and to maintain essential health services

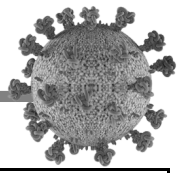
Key Actions:

- Develop National COVID-19 Needs List with Essential Medical Supplies and Equipment based on changing case-transmission scenarios
- Form partnerships with private sector and NGOs to agree on needed supplies, pooled procurement and equitable distribution plans
- Strengthen national, district and health-facility logistics management information systems to enhance accountability for donated and procured emergency supplies
- Develop a governance framework and technical committee for the selection, procurement and use of medicines, medical supplies and equipment that are new to the Suriname market, utilizing guidance from stringent regulatory authorities
- Monitor supplies at all levels of care and create alerts for fast depletion of essential medicines.
- Ensure blood supply availability for use by hospitals and activate emergency blood management when needed.

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
○ Reinstate the Procurement unit at the Ministry of Health to coordinate partners network to agree on needed supplies, pooled procurement and equitable distribution plans ○ Designate the Medicine Supply Company Suriname (BGVS) as the central coordinating unit for supply chain management and distribution of COVID-19 pharmaceuticals and non-pharmaceuticals and upgrade existing information system ○ Develop distribution plans for each scenario in line with emergency use of community facilities in Districts	○ Monitor the supply of stock and identify the critical products that can run out in the country due to transport or production issues or lack of suppliers. ○ Jointly with the public service networks, drug regulatory authorities, and United Nations agencies, coordinate efforts to facilitate the procurement and transport of the needed products. ○ Implement the list of essential drugs and supplies necessary for patient care and the protection of health workers, based on the level of care and infection control. ○ Review and evaluate the	○ Establish at the national or institutional levels drug distribution or dispensing systems in specific health centers for patients with chronic conditions or in need of special drug therapies (e.g., patients with hypertension or heart or lung disease; people with HIV, diabetes, tuberculosis, kidney failure, etc.). These facilities should establish the necessary distribution procedures and controls to dispense the drugs and not expose these patients to risks of infection.	○ Open satellite pharmacies with continuous schedules in emergency or special services to serve COVID-19 patients, offering a defined stock of drugs and supplies based on established protocols. ○ Special attention should be given to the blood supply and its availability in all hospitals ○ At the national, regional, or local level, as appropriate, activate the emergency blood management plan to: permanently monitor the availability of blood and components on a daily



(see pillar 7) ○ Develop a National Needs List to include essential medical supplies and equipment and begin local and international procurement. Items include: 1. Provide personal protective equipment (PPE) to all exposed health personnel, including health students and all pertinent staff. Quantify the needs (per health worker per day for at least 3 months). 2. Basic hygiene supplies for all staff and patients, cleaning and maintenance of facilities, adhering to infection control standards and procedures. 3. Drugs and clinical supplies for managing cases of COVID-19 and other pathologies. 4. Equipment and supplies for the conversion of beds, reorganization of primary care, home hospitalization, and hospitals. 5. Repair and maintenance services for the equipment in use, including support services such as radiology, respirators in disuse that can be salvaged. 6. Continuity of basic supply services to maintain the autonomy of hospital systems such as water, oxygen networks, electricity, climate control, negative pressure systems, exhaust fans, etc. **Responsible party:** Director of	inventories of useful drugs and medical supplies in central, regional, and local warehouses, identifying those at risk of stock-outs (<3 months of inventory), or drugs or supplies with zero stocks that are critical to patient care, the protection of health workers, and infection control. ○ Estimate needs, including drugs and supplies in transit, and resupply facilities in the service network. ○ Develop a list of suppliers that meet the quality and eligibility criteria established in the country's regulations and investigate product availability, waiting periods, and estimated prices. ○ The Registration Inspectorate should develop emergency procedures for priority registration and licensing of vital goods for the emergency that are not marketed in the country. ○ Establish a technical committee to support emergency procurement to ensure quality, timeliness, and control of processes. This committee will acquire drugs and supplies through donation or purchase. ○ Monthly report Dir BGVS to Dir MOH **Responsible party:** Director BGVS	○ Create a periodic distribution plan/map for inputs and drugs vital to the COVID-19 response, establishing the minimum stocks at the various levels; minimum stocks of 6 months at the central level, 3 months at the intermediate level, and 2 months at the services level are recommended. ○ When inventory management information systems are deficient, make a push distribution, calculated in the central services, with a focus on maintaining the minimum stocks. ○ Weekly report Dir BGVS to Dir MOH **Responsible party:** Director BGVS	basis; activate networks and reference centers with greater capacity to collect/process blood, including collection by apheresis; mobilize blood from areas where the virus is not circulating or where blood is widely available; and shift blood drives to areas with no viral circulation, avoiding the congregation of donors. ○ Finally, continue distributing information about the importance of ongoing donation, given the needs of patients who chronically require transfusions, such as transplant recipients or leukemia or cancer patients. ○ Weekly report Dir BGVS to Dir MOH **Responsible party:** Director BGVS

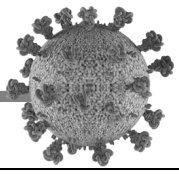


Health in close collaboration with Director BGVS			

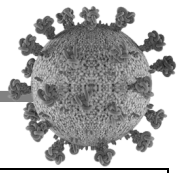
PILLAR 9: MAINTAINING ESSENTIAL HEALTH SERVICES DURING AN OUTBREAK

Responsible party: Director of Health/Daily coordinator HEOC

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
Establish a Coordination Mechanism to monitor the provision of essential health services during the pandemic which includes Hospital Medical Directors, RGD and Medical Mission, BGVS, Laboratory teams, Blood bank, Radiology among other related teams.	Utilize health service delivery data at national and facility-levels to assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways	Develop a plan to establish 24-hour acute care services at designated first-level hospital emergency units or primary health care facilities with emergency service capacity. Ensure public awareness of any such changes and of when they are activated.	Actively monitor all health service delivery data to ensure that essential health services are being provided in accordance with national plans. Utilize other health information systems to monitor surveillance data to respond to other outbreaks and emergencies. Monitor the national data on the inventory of medicines and medical devices to avoid stock outs, and for coordination of re-distribution of supplies.
Identify a National List of Essential services in Suriname that will be maintained. These services should include at a minimum: Prevention and treatment services for HIV, TB, Malaria and other communicable diseases; Services related to Reproductive health, Maternal and Child Health including antenatal care, delivery, postnatal care, vaccination for babies and children among others; Care of vulnerable populations, such as young infants and older adults;	Create a roadmap for progressive and phased reduction of health services by identifying routine and elective services that can be delayed or relocated to non-affected areas; by establishing triggers/thresholds that activate a prioritization process and phased reallocation of health care workers towards essential services; and by establishing effective and clearly communicated patient flow (screening, triage, and targeted referral) at all levels	Establish outreach mechanisms using community health workers, community volunteers, non-governmental organizations and other such mechanisms as needed to ensure delivery of essential services Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control	



Provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions; Continuity of critical inpatient therapies; Auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services.			



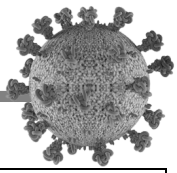
PSYCHOSOCIAL CARE

(based on The IASC[17] Guidelines for MHPSS[18] in Emergency Settings)

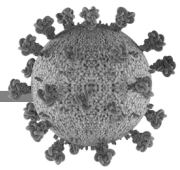
Responsible party:
Ministry of Social Affairs with technical assistance from expert groups and in close collaboration with MOH

No Cases	Sporadic Cases	Clusters of Cases	Community Transmission
○ Establish multi stakeholder team to coordinate Mental Health and Psycho Social Support (MHPSS). **Responsible Party: Ministry of Social Affairs in collaboration with Mental Health Focal Point BOG and Psychiatric Center Suriname (PCS)** ○ Conduct a rapid assessment of the context and of culturally specific MHPSS issues, needs and available re-sources, including training needs and capacity gaps across the spectrum of care. **Responsible Party: Ministry of Social Affairs in collaboration with Mental Health Focal Point BOG and Psychiatric Center Suriname (PCS)** ○ Establish a MHPSS strategy for COVID-19 cases, survivors, contacts (particularly those in isolation), family members, frontline workers and the broader community, with special attention to the needs of special or/and vulnerable groups (e.g. children, older adults, pregnant and lactating women, people at risk of and exposed to gender-based violence and people with disabilities. **Responsible Party: Ministry of Social Affairs in collaboration with Mental Health**	○ Establish helpline for those quarantine and relatives of infected persons. ○ Activate communication strategy ○ Develop activity toolkits that parents, teachers and families can use with their children in isolation, including messages on preventing the spread of the disease such as hand washing games & rhymes ○ Establish opportunities for the bereaved to mourn in a way that does not compromise public health strategies to reduce the spread of COVID-19 but reflects the traditions and rituals of the community ○ Establish measures to reduce the negative impact of social isolation in quarantine sites. Communication with family and friends outside of the site, as well as measures that promote autonomy (e.g. choice in daily activities) should be facilitated and promoted	○ Expand helpline (for total population) ○ Crosscutting activities as mentioned below	○ Crosscutting activities as mentioned below

[17] Inter-Agency Standard Committee - IASC
[18] Mental Health and Psycho-Social Support – MHPSS



Coordination BOG and Psychiatric Center Suriname (PCS) o Train all frontline workers including non-health workers in quarantine sites, on essential psychosocial care principles, psychological first aid and how to make referrals when needed. Online trainings might be used if it is not possible to bring staff together due to infection risks **Responsible Party: Ministry of Social Affairs in collaboration with Mental Health Coordination BOG and Psychiatric Center Suriname (PCS)**			
• Cross cutting activities	• Ensure that a functioning referral pathway for persons with mental health conditions is activated between all sectors involved, (including health, protection and gender-based violence), and that all actors operating in the response are aware and use such a system • Ensure that accurate information about COVID-19 is readily available and accessible to frontline workers, patients infected with COVID-19, as well as community members. Information should include evidence-based practice for preventing transmission, how to seek out healthcare support, as well as messages to promote psychosocial well-being • Integrate mental health and psychosocial considerations into all response activities. Consider and address obstacles to women's and girls' access to psychosocial support services, especially those subject to violence or who may be at risk of violence. • Provide all workers responding to the COVID-19 outbreak with access to sources of psychosocial support • Establish and implement monitoring, evaluation, accountability and learning mechanisms to measure effective MHPSS activities.		



Estimating the needs for the National Response to the COVID-19 pandemic

Surprised by the COVID-19 pandemic, the national budget of Suriname was not prepared to cover the expenses to respond to the crisis. Yet, funds are needed to coordinate the response; to be able to detect, test, isolate, treat and quarantine people; provide optimized care for infected patients; communicate critical risk and event information to all communities and counter misinformation and to minimize social and economic impacts through multi-sectoral interventions.

Budgets should be available to cover critical needs, pay for essential services, provide financial support to vulnerable groups impacted by the crisis and to protect and provide support to the private sector to prevent them for losing their business and prevent lay-offs due to loss of income.

Health Sector needs

The document **"Comprehensive Needs list preparedness and response for COVID-19"** describes in detail the needs for execution of the actions according to the pillars, based on the implementation of the recommended interventions. The corresponding budget for the health sector for a period of three months is estimated at **US$ 4,759,995.00.** The comprehensive needs list is linked to the "**National COVID-19 Preparedness and Response Plan**" and is an integral part of the Plan.

In the strategy to estimate the needs for the national response for the health sector the following distinction is made:

- Administrative, Operational and Logistical support looking at three categories of needs: 1) staffing; 2) investment; 3) operational costs;
- To develop the needs list for medical care, case finding, identification and management, several projections have been developed based on the reality of the country guided by the WHO Essential Supplies Forecasting tool for COVID-19.

For a detailed overview of the total needs for the health sector national response to the COVID-19 pandemic, reference is made to the document **"Comprehensive Needs list preparedness and response for COVID-19".**

Non-Health Sector needs

Roughly **SRD 910,000,000.00** is the estimated need for the Non-Health sector to cover expenses for covid-19 crisis interventions from the departments Social Affairs, Housing, Education, Agriculture, Trade and Industry.

The total need for crisis intervention for a period of six months for Education, Social Affairs, Housing, Agriculture, Trade and Industry is estimated at SRD 910,000,000.00 (nine hundred and ten million Surinamese Dollars). Estimated budgetary needs per department for a period of six (6) months for response intervention are mentioned for ministries, where available. The follow up project to develop COVID-19 Response Plans for each Ministry should further detail the respective needs lists with budgets of all ministry.

Table 13 presents an overview of Government's role in COVID-19 response and estimated need for selected departments.

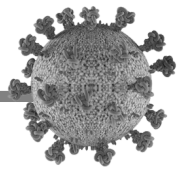
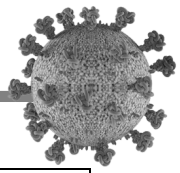
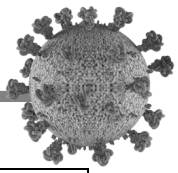


Table 13: Government's role in the COVID-19 response

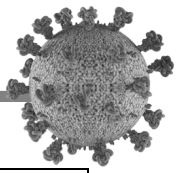
Department	Role in COVID-19 response	Needs for intervention
Cabinet of the Vice President	• Chairs the National CIVID-19 Management Team; • Holds frequent (weekly and if needed daily) meetings with Council of ministers to keep them updated and informed about the covid-19 situation and for accelerated procedures for decision making; • Carries out an assessment of the urgent needs of all ministries to respond to the covid-19 crisis; • Collaborates with the Minister of Finance to secure emergency funds to cover urgent needs of the population at large; Coordinates with the Minister of Finance the fair distribution of the funds per ministry	•
Finance	• Financial impact assessment to estimate economic impact on each Ministries Based on assessments: Financial intervention measures: • Emergency Fund • Implementation of Tax-support measures Establishing an Emergency Fund to support private and social sector (See Social Affairs and Housing)	**Total estimated budget SRD 910,000,000.00** **SRD 400.000.000,00** (Social Affairs including **SRD 50.000.000,00** for Housing construction fund) and **SRD 300.000.000,00** for production sector (See Min Trade, Industry and Tourism) **SRD 30,000,000.00** for Education
Social Affairs and Public Housing (SoZaVo)	COVID-19 Social Provisions as part of the Emergency Fund: • Development of a Cash Assistance Support Package COVID-19 for vulnerable groups o Elderly o Persons with a disability o Households with children o Low income households or Households without income o Persons who lost income due to COVID-19 measures • Persons in need of housing or housing improvements and long-term residents of the Housing foundation houses. Inventory of vulnerable groups is ongoing. Monthly allowance for each specific category calculated and announced, and will also evaluated monthly.	Total estimated budget SRD 400,000,000.00
Education	The Ministry developed a plan for "crisis intervention and future perspectives" for the education sector. The plan was developed in close collaboration with colleague ministers from the Caribbean with technical and financial support from UNICEF. During special Education-COHSOD meetings interventions were discussed and decisions taken to ensure harmonization based on solidarity principles. • The key principle of the plan is that no student may suffer the consequences of the covid-19 crisis	The budget to cover the overall cost for implementation of the crisis intervention plan will include different sources of funding: • Government budget • Emergency Fund Support from International Donor/Development Partners



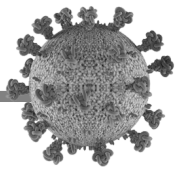
	• The plan is constructed in close collaboration with Ministers of Education from the CARICOM; • The plan takes into consideration mainstreaming the school year with the Region and Internationally; • The plan focusses on innovation and technology to increase the reach of quality education for all in Suriname The plan was presented to and approved by the Council of Ministers.	
Trade and Industry	COVID-19 triggered accelerated response to policy interventions being planned. A document is being put together "Policy vision HIT (Handel Industrie en Toerisme" with subtitle: Challenges and Opportunities from the COVID-19 Pandemic. •Networks have been mobilized to protect consumers, businesses, distributers, importers and exporters. •Close collaboration with Min Finance to secure funding for importation of essential goods and pharmaceutical etc. •Introduction of new policy visions on stimulating and promoting local production in close collaboration with Min Agriculture, Husbandry and Fishery •Close collaboration with local airlines to protect from bankruptcy and repositioning to serve the Region •Production fund established to support local companies to increase local production of food and goods to replace importation of food and basic goods.	Estimated budget SRD 300.000.000,00 **Aim:** 1. Acute impact relief 2. Financing sustainable development goals **Objectives:** o Economic resilience, o Diversification of the economy o Reduce dependency on importation of goods
Tourism	• Development and implementation of Tourism and HORECA sector specific safety and security measure to prevent transmission of the coronavirus SARS-CoV2 in Suriname • Monitoring of adherence to measures	No specific budget announced by Min Finance
Agriculture, Husbandry and Fisheries	Policy vision for the Ministry is that the COVID-19 Pandemic provides an opportunity for the sector reform: "COVID-19, the Vehicle for Structural Transformation" • Development and implementation of short term (6 months) interventions such as: • Setting up of hydroponic systems; • Planting in buckets and on racks • Creating vegetable gardens and planting of occulated fruit trees Although focus is on agriculture, attention is also given to: • Livestock farming such as chickens, ducks and small kettle; • Information to, Education of and Training session for target audiences; • Provision of plant material • Collaboration with producers of agriculture products to supply goods locally in close collaboration with Ministry of HIT • Collaboration with exporters to monitor export of fruits and vegetables For more detail, reference is made to the Policy Paper of the Ministry	Total estimated budget for the emergency interventions is SRD 130.000.000,00. SRD 30.000.000,00 for small loans with an annual interest of 3% and a grace period of 12 months. SRD 100.000.000,00 for purchasing of food for food packages for vulnerable groups



	"Husbandry and Fishery, Support Interventions for COVID-19 for the Agriculture Sector, May 2020".	
Labor	• To develop and implement strategies to advise workers and employers on: o Issues regarding payment of wages o Occupational safety and health in the workplace; o Labor legislation • Promote and encourage dialogue on the level on the enterprise with regard to safety issues on the workplace and survival strategies to be discussed and agreed upon between workers and employers. • Prepare for "Start-up assistance" (Standard Labor Ministry program, crucial and relevant to empower workers and promote their entering back on the labor market), in case of a dismissal boom because of COVID-19 in the future, technical and vocational training for drop-outs and the unemployed and SME-business • Develop strategy to assist employers by granting wages subsidies, to temper unemployment via non-termination conditions attached to this assistance. o Non-termination condition would facilitate the Dismissal Board and block termination and force employers and workers to engage in survival dialogues and workplace Covid-19 agreements; ***Caution with strategy to assist unemployed workers due to Covid-19. Could boost a boom of unemployed workers in the unemployment benefit scheme. If the benefit is significant, it could hamper the willingness of workers to return to the labor market, thus negatively influencing the economic recovery and the unemployment figures.***	No specific budget announced by Min Finance
Foreign Affairs	• Information flow from the government of Suriname to the International Community; • Channeling of information through Diplomatic Missions to the people of the represented countries living in Suriname and Representatives of international organizations residing in Suriname; • Channeling of information received from friendly nations, regional and international organizations to relevant national authorities; • Channeling information and providing support through Surinamese embassies and consulates to nationals abroad; • Coordination and centralization of international collaboration and cooperation; Coordinating international and Diplomatic support as may be required to respond to the COVID-19 pandemic, in collaboration with MoH.	No specific budget announced by Min Finance
Home Affairs	• Development and implementation of COVID-19 transmission prevention protocols and procedures for 25 May 2020, Election Day Suriname; o Adjustment of election locations and procedures to adhere to hand washing hygiene instructions o Set up of election locations in compliance with physical distancing	No specific budget announced by Min Finance



	instructions	
Regional Development (RD)	• Reinforcing of communication channels between District Commissioners and Local/Traditional (Tribal) Authorities; • Intensify collaboration Min. RD with District Commissioners and Local/Traditional (Tribal) Authorities to streamline and harmonize adherence to nationwide COVID-19 intervention measures	No specific budget announced by Min Finance
Justice and Police	***Needs for support in maintaining law and order and border patrol is included in the document "A Comprehensive Needs list for COVID-19 Preparedness and Response"***	
Defense		



Post Pandemic/Recovery[19] from COVID-19 Pandemic

It is still difficult to pinpoint exactly when the recovery would start with any degree of accuracy. The data from previous pandemics indicates that recovery can occur quickly if a pandemic is well contained and public fears can be put at ease[20]. The post-pandemic phase starts when the containment has been reached and the WHO has declared that global containment of the pandemic has been achieved.

Lessons from previous pandemics teach us that in the post-pandemic period, cases and outbreaks due to the SARS-CoV-2 virus are expected to continue to occur. In addition, it is most likely that for some period of time, elderly persons, persons that are immuno-compromised and persons with underlying chronic conditions such as Diabetes and Cardiovascular diseases, will continue to be affected disproportionately by severe disease from COVID-18. It is impossible to predict if these at risk groups will remain at higher risk over the long term for severe disease or whether and when this will change.

Given this picture, it will remain important for people to continue to take prudent steps to protect themselves. Actions to generally reduce risks of COVID-19 infection, such as through hand and respiratory hygiene and use of COVID-19 vaccine (when it becomes available) will also reduce the risks from COVID-19 infection specifically.

At the time the post-pandemic/recovery phase is reached, plans must be in place, interventions must have been prepared and budgets must have been secured to successfully carry out all actions for the post-pandemic phase, full recovery and return to "normal".

It is important to note that intervention actions in all pandemic phases must include recovery related actions to protect as much as possible lives and livelihood and minimize negative human, social and economic impacts of COVID-19 and ensure full recovery with the least damage.

The pandemic is not yet contained and the public cannot be put at ease yet. After successfully managing the first wave from 13 March to 25 May 2020 (election day), the COVID-19 situation in Suriname is drastically and rapidly worsening. Suriname is now experiencing the second wave of a COVID-19 outbreak. This second wave started after election day with increasing numbers of persons testing positive for COVID-19. As of 5 June 2020, 82 persons have already tested positive. It can be expected that in the coming days more cases will follow. An extensive community transmission needs to be taken into account.

From the start of the pandemic up to the 5th of June 2020, 1175 persons have been tested for COVID-19 of which 82 have tested positive. To date ten (10) are declared fully recovered after testing negative twice for COVID-19 and one succumbed to the complications of COVID-19 (Table 14).

[19] https://www.who.int/influenza/resources/documents/pandemic_guidance_04_2009/en/
[20] https://www.hospitalitynet.org/opinion/4098030.html

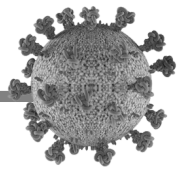


Table 14: COVID-19 cases in Suriname (up to May 5th, 2020)

Number of persons tested	Number of persons tested positive	Number of persons hospitalized or in government monitored isolation	Number of persons in ICU	Number of persons needing ventilation	Number of persons recovered	Number of deaths
1175	82	82	7	3	10	1

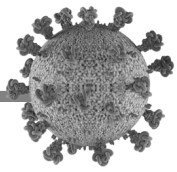
Paraphrasing the United Nations Secretary-General António Guterres, ***"Post-wave/pandemic and recovery from this crisis must be done with a strong focus on building more equal, inclusive and sustainable economies and societies that are more resilient in the face of pandemics, climate change, and the many other global challenges we face. What we need now is solidarity. With solidarity we can defeat the virus and build a better world.".***

Post event-recovery activities involve actions with assigned responsible persons or parties to ensure restoration. They include activities that should continue until the declaration of the end of the pandemic and the pre-pandemic status is restored such as:

- Dismantling of alternative care sites;
- Phasing out of alternate care workers;
- Commencement of new services that may be required to address impact of the pandemic;
- Review, evaluate and take measures to:
    - Improve or enhance their respective roles of all directly and indirectly involved in the preparedness and response, following the conclusion of the COVID-19 pandemic;
    - Increase and upgrade the pandemic COVID-19 response capacity;
    - Develop and agenda for collaborative research activities;
- Post-pandemic studies to assist in evaluations of the pandemic COVID-19 response capacity including, any medical, scientific and technical aspects; and submitting to all relevant stakeholders a report together with its recommendations for future pandemics
- Re-designing fiscal and monetary policies able to support the direct provision of resources to support workers and households, the provision of health and unemployment insurance, scaled up social protection, and support to businesses to prevent bankruptcies and massive job losses.

Given the extend and the duration of the pandemic, the uncertainties surrounding management and treatment and the severity of the disease, it can be expected that many people have been affected in a variety of ways. Some may have lost a friend or relative, suffer from fatigue or have financial losses as a result of the interruption of business.

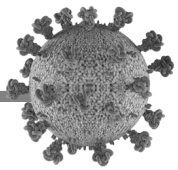
The Government and other authorities should ensure that these concerns are addressed and that plans are developed to support the rebuilding of the society and to prevent repeating of mistakes and ad-hoc decision making during the first wave. Table 15 presents a checklist



for interventions in the post pandemic / recovery period. Table 15 presents a checklist for interventions in the post pandemic / recovery period.

Table 15: Checklist of interventions to be addressed in the post pandemic/recovery period

Carry out After Action Review with support from PAHO and assess response impact
Address impacts from first wave COVID-19 related illness and death and prepare for next pandemic wave(s)
Use M&E indicator framework to evaluate the response and draft and submit Monitoring and Evaluation report (after the wave/post-pandemic)
Develop a multi-sectoral plan to ensure the quick revitalization of the country after the wave / pandemic
Develop a strategy to implement recommendations for improvement coming out of After Action Review and M&E report
Develop essential services recovery plans for their service or organization
Designate a responsible person or establish a committee with the responsibility to provide social and psychological support to affected families and companies? (Anticipate occurrence of Post-Traumatic Stress Syndrome)
Develop a plan to overcome impact of skilled worker and essential material shortage and competition
Define responsibilities for social, psychological and practical support to affected families and companies. If needed, organize training and education for personnel involved.
Assess how existing community groups (religious groups/churches, sports groups) can contribute to rebuilding the society. Identify contact persons within these groups.
Put a mechanism in place to assess economic losses and to provide financial support to affected groups
Establish a multi-sector committee including the private and business sector to develop criteria for affected groups in need for after pandemic recovery financial support from government and seek ways to ensure availability of funds.
Develop a plan to maintain public and media relations



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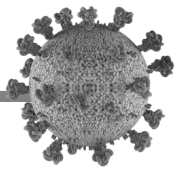

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