
[‘CAPPHE’]

In

Israel, Jordan, & West Bank
This report ‘Common Action Plan for use in the Event of a Public Health Emergency’ is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this report are the sole responsibility of Search for Common Ground and do not necessarily reflect the views of USAID or the United States Government.
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ACKNOWLEDGEMENTS

This *Common Action Plan for Use in the Event of a Public Health Emergency (CAPPHE) in Israel, Jordan and the Palestinian Authority* has been created for use by the respective Health Ministries to ensure an immediate joint response in times of a potential and/or actual public health emergency in the region. The manual is based on knowledge shared and contacts developed during an eighteen month intensive project, the Regional Cooperate Health Initiative, is a USAID funded CMM grant managed by the Jerusalem office of Search for Common Ground (SFCG), a veteran international non-governmental organization with expertise in the field of conflict transformation ([www.sfcg.org](http://www.sfcg.org)). The project engaged Palestinian, Jordanian and Israeli senior health professionals and laboratory technicians in a process of knowledge enrichment, skills development and interaction in order to mitigate a lack of coordination and harmonization on biosafety and biosecurity standards exacerbated by the Arab-Israeli conflict.

The long list of acknowledgements attests to the highly cooperative nature of this initiative. We gratefully thank the following people and organizations without whom the project would not have reached its successful conclusion:

- The wholehearted and active engagement of the participants in the project - Israelis, Palestinians and Jordanians alike - who demonstrated a willingness to step beyond conflict and dedicate scarce time resources for the benefit of their peoples.
- The board of the Middle East Consortium on Infectious Disease Surveillance (MECIDS) comprising leading Jordanian, Palestinian and Israeli public health professionals ([www.mecidsnetwork.org](http://www.mecidsnetwork.org)) for their guidance and active participation with special thanks to MECIDS past chairman, Professor Alex Leventhal, present chairman, Dr Mohammad Abdallat, and Executive Officer, Sari Husseini
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• Arab World for Research and Development (AWRAD) for its external evaluation of the project.

Our hope is that Israeli, Palestinian and Jordanian health officials will use this manual both nationally and cooperatively for the wellbeing of their societies.

Search for Common Ground, Jerusalem
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<tr>
<th>Acronym</th>
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<td>BSL-3</td>
<td>Biological Safety Level 3</td>
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<td>FFP-3</td>
<td>Protective Filtering Face Pieces Class 3</td>
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<td>International Health Regulations</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>The Middle East Consortium on Infectious Disease Surveillance</td>
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<td>MERS- CoV</td>
<td>Middle East Respiratory Syndrome Coronavirus</td>
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<td>PESTLE</td>
<td>Political, Environmental, Sociological Technical, Legal &amp; Economical</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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FORWARD

Infectious disease outbreaks always begin somewhere local. Sick animals, a feverish child, something that is not quite right health-wise, alert people and communities. From this local beginning, infectious diseases can grow rapidly across borders, communities and countries. Countries, therefore, need to work closely together to detect problems early and to respond quickly. Collaboration, both formal and informal, has turned out to be critical in halting the spread of infectious diseases. This need, for fast, cross-border information sharing and collaboration in a trusted environment, has been the rationale behind the creation of multi-country regional infectious disease surveillance and response networks. One of the original networks, on which others have subsequently been modelled, is the Middle East Consortium on Infectious Disease Surveillance (MECIDS) created in 2003 by the international non-governmental organisation, Search for Common Ground. Regional infectious disease surveillance networks have provided a platform for quick and informal sharing of information, frequent communication and trusted collaboration with other networks. They aim to detect outbreaks earlier, respond faster, coordinate and recover smoothly and build a smarter legacy.

Managing well the early stages of an infectious disease outbreak is the most effective way to influence its future course. For this reason, early detection has become the narrative of infectious disease management and surveillance for the prevention of epidemics.

The key to effective and sensitive management of infectious outbreaks across sectors is early communication, particularly during the initial period of uncertainty when all the facts are not yet known. This communication requires mutual trust already developed as a result of prior regular meetings and scientific exchanges. Once the trust is in place, principles and rules for early communication can be developed and implemented. This CAPPHE, built on the lessons learned from a table top exercise to prevent the spread of an infectious disease outbreak across Israel, Jordan and the West Bank, held in Cyprus in November 2016, advances cooperation significantly.
INTRODUCTION
To enable Jordan, Israel and the West Bank to adequately respond to a public health emergency on behalf of their respective populations, it is necessary to reinforce the existing public health frameworks, both within and between the respective nations.

It is generally acknowledged that the International Health Regulations [IHR] are not sufficiently enforced and in some instances have not been translated into appropriate national capacity building. National and international public health capacities and responses need to be organised and emboldened in five essential areas:

- Surveillance of disease and monitoring of trends
- Thorough investigation of acute health events irrespective of origin
- Public health and clinical laboratory support to public health needs
- Intervention and operational research
- Training in risk assessment, communication and diagnostic support

AIMS
The aims of this CAPPHE is to provide the participating countries with a framework for:

1. An agreed policy for communication and collaboration especially with regard to the essential need for decision making in a period of uncertainty;
2. A list of all contacts necessary for the implementation of this policy;
3. The relevant roles and responsibilities of decision makers and technical/scientific experts;
4. The sources of technical/scientific advice;
5. Risk communication and risk management;
6. The realisation that important decisions will have to be made, even in the early period of uncertainty when few facts are available;
7. The methods of communication and directory of communication;
8. Coordination of a national and international response and which international organisations to inform;
9. **The role of MECIDS.**

In summary the CAPPHE will provide the necessary arrangements for the national and international response to an outbreak of an infectious disease that is anticipated to disrupt normal activities; give rise to significant difficulties for healthcare staff to respond to it, and/or place an extreme burden on resource allocation. Outbreaks of infectious diseases are intrinsically unpredictable. Therefore any plans for responding to future outbreaks need to be flexible and adaptable for a wide range of scenarios not just the “reasonable worse case”. During outbreaks, the assumptions on which to base the response will be necessarily updated in light of emerging evidence about the range of likely scenarios at any given time.

**COMMUNICATION PRINCIPLES**

A layered approach is needed for sensitive information sharing as follows:

- Routine call/distribution of sensitive information among network members with an agreed frequency;
- Informal/ad hoc calls to alert and discuss incidents and outbreaks.

The MECIDS framework allows for informal sharing of sensitive information among network members. Members commit not to forward, publish or quote information, but can use it for their own decisions.

This network of communication and information sharing is based on trust. To build such trust, people need to meet regularly in order to get to know one another professionally and personally and build a sound working relationship.

Each country is expected to determine the primary method of communication within and between the countries concerned. The primary method of communication between countries at times of infectious disease outbreaks will be through teleconferences. As a result, each country is expected to have teleconference arrangements already in place for communication use within and between countries.
NOTIFICATION, ACTIVATION AND ESCALATION

Indications for action in any of the three countries can be coupled with impact levels, namely:

- Initial
- Low
- Moderate
- High

The response can then take the form of a series of phases, namely:

- Detection and assessment
- Treatment
- Escalation
- Recovery

These incorporate indications for moving from one phase to another. The phases are not numbered as they are not linear, may not follow in a strict order, and may possibly move back and forth or jump phases. In addition, there may not be a clear determination between phases, especially when considering regional variations and comparisons.

RESPONSE PHASES [TRAFFIC LIGHTS]

This ‘traffic lights’ framework aligns functions and processes required to support the response to the public health emergency. As mentioned above, the phases are designed to be flexible and countries can choose which phase it is in to best reflect national circumstances.
1. **DETECTION**
   - A trigger by one country
   - Increase of surveillance
   - Development of diagnostics
   - Phase may be short depending on the speed of spread and impact on the population

2. **ASSESSMENT**
   - Collection and analysis of clinical and epidemiological information on the first few cases to estimate potential impact and severity in the country concerned.
   - Advice on reducing community transmission and infection risks e.g. self-isolation.
   - Advice on treatment and prophylaxis
   - Triggers assessed regarding move to the next phase

3. **TREATMENT**
   - Treatment of individual and population.
   - Health response enhanced to deal with increasing number of cases as required to meet local/national pressures.
   - Continued surveillance of cases.
   - Review plans of possible future requirements in the event of escalation.

4. **ESCALATION**
   - International spread between the three countries. This may already have happened in the *Green* and *Amber* phases.
   - Escalation of surge management arrangements in health care.
   - Prioritisation and triage of service deliveries to maintain essential services.
   - De-escalation of response measures as situation improves.

Once the situation has improved and the danger has passed, countries can move out of the ‘traffic light’ phases into a recovery phase:
5. **RECOVERY**

- Normalisation of services.
- Restoration of “business as usual” services.
- Post-incident reviews.
- Management of the return to normality in a sustainable way.

**NOTE:** Communication between the neighbouring countries needs to occur at all stages of the response phases. Each country is to maintain accurate notes of decisions/actions taken at all meetings/teleconferences.

**COMMAND AND CONTROL**

This section entails the day to day management of the public health threat. This CAPPHE cannot be prescriptive and anticipates that each country has the necessary plans, with appropriate names of those in command and control, in place.

During the course of an emergency response, it is necessary to schedule daily information exchange calls between the three countries.

If the event expands and involves media and international bodies, a joint control centre is advised. This will be important to provide cohesive and transparent media communications.

**MEDIA LEAD**

There is a need to identify a national lead who will work across borders and coordinate media requests. In the presence of 24 hour news coverage both nationally and internationally, messages must be consistent and in line with the relevant national communication messages and strategy. Appropriate specialists are likely to be called upon to provide the necessary expert opinion to the media and to contribute to the communication strategy.

**COMMUNICATION STRATEGY**

A national and international communication strategy is to be devised to ensure consistency of messaging and the avoidance of duplication across countries. This will include, but is not limited to:

- Centralisation and coordination of media requests
- Localisation of national messages
Communications to the public with especial consideration given to “hard to reach” communities
Communications across the health and social care community
Communications with regional and national/international bodies
Communications with multi-agency partners
Timeliness and accuracy of information
An understanding that honesty is the best policy
Management of public and partners’ expectations
Specialist advice and information for particular settings across sectors.
Recruitment of key stakeholders for the development of messaging and cascading information
Pooling of communications resources
Arrangements for “out of hours” communications - vital in these days of “News 24”

CAPACITY AND PATIENT PATHWAYS
The key principles in guiding patient care are:-

- Maximal care given to people even when resources are stretched
- Plans are consistent with the overall aim of processing and maintaining essential health care services
- Incremental changes to services and clinical standards reflecting changes in local demand and the resources available.
- Changes are consistent with established ethical principles
- Consideration given to sharing a patient care facilities if event is large

It is essential to take a whole-systems approach that encompasses primary, community and secondary care. In addition, plans must support strategic objectives at each stage of the public health emergency.

INFECTION PREVENTION AND CONTROL
Each of the three countries has the necessary infection control arrangements in place which are to be considered under the following headings. Each country is to fill in information under these
headings as necessary, depending on equipment, availability and resources. Information for each country has been provided in Annex 1

1. Core principles of containment and infection control.

2. Placement of patients within the hospital
   a. Single patient isolation
   b. Designated ‘infection’ wards/cohort areas

3. Hand hygiene

4. Personal Protective Equipment (PPE) for staff
   a. Schedule of PPE to be worn by staff
   b. Gloves
   c. Plastic aprons
   d. Surgical gowns
   e. Eye protection
   f. Surgical masks
   g. Protective Filtering Face Pieces 3 (FFP3) [conforming to European Standards EN 149 1 2001]
   h. Procedure for putting on PPE
   i. Procedure for taking off PPE

5. Clothing & uniform

6. Equipment

7. Linen

8. Waste

9. Environmental cleaning

10. Specimens
11. Transfers to other departments or hospitals
12. Operating theatres
13. Visitors
14. Discharging patients
16. Staff eating and drinking
17. Outbreak monitoring

RECOVERY

Recovery is defined as the process of rebuilding, restoring and rehabilitating communities following an emergency, but it is more than simply the replacement of what has been destroyed and the rehabilitation of those affected.

The recovery phase needs to begin at the earliest opportunity following the onset of an emergency, running in tandem with the response to the emergency. It continues until the disruption has been rectified, demands on services have returned to normal levels, and the needs of those affected [directly or indirectly] have been met. Whilst the response phase to an emergency can be relatively short, the recovery phase may last for months, years or even decades.

RECOVERY PRINCIPLES

The principles of recovering from emergencies are:

- Recovery is an enabling and supportive process, which allows individuals, families and communities to attain a proper level of functioning through the provision of information, specialist services and resources.

- Effective recovery requires the establishment of planning and management systems which are accepted and understood by recovery agencies, the community and armed forces [if deployed].
Recovery management systems are more effective when they recognise the complex, dynamic and protracted nature of recovery processes and the changing needs of affected individuals, families and groups within the community over time.

Recovery management is most effective when agencies involved in human welfare have a major role in all levels of decision-making which may influence the wellbeing and recovery of the affected community.

Recovery uses tools to identify priorities [according to the acrostic PESTLE – Political, Environmental, Sociological, Technical, Legal and Economical].

RECOVERY FORMAT
Once the emergency has peaked and areas can be closed down the following is required:

- A hot debrief within 12-24 hours.
- A recovery action plan, if required, dependent upon the length of the emergency.
- A cold debrief within 2-4 weeks to inform the post-incident Board report and identify organisational learning.

MIDDLE EAST CONSORTIUM ON INFECTIOUS DISEASE SURVEILLANCE [MECIDS]
Since it was founded in 2003, MECIDS has been dedicated to monitoring, preventing, and responding to health risks in Jordan, Palestine and Israel. MECIDS also conducts regular multinational training courses for regional health workers, giving them a chance to meet each other while honing their professional skills. Its vision is to promote long term health, stability and security in the region.

At its core, MECIDS serves as a framework through which the participating country health sectors share information about disease patterns and coordinate swift cross-border responses in the event of an outbreak. Biosafety and biosecurity, food-borne illnesses, avian influenza,
Middle East respiratory syndrome, coronavirus [MERS-CoV] and leishmaniasis – a disabling and disfiguring disease transmitted by sand flies – are the primary health concerns monitored by MECIDS.

With its administrative secretariat in Jerusalem and its scientific secretariat in Amman, MECIDS is able to connect and collaborate with a wide range of regional academic institutions, national centres for disease control, and health ministries.

LABORATORY ASPECTS

In the Middle East, the lack of reliable and quality laboratory diagnostic capability compromises patient care, especially if there is a local perception that laboratory diagnostic testing is not helpful. Consideration is therefore needed to develop fully integrated national and international laboratory plans and strategies that would include a comprehensive laboratory quality management system. This system would be applicable for regional, national and international laboratories responsible for the health and security of their peoples and would include the surveillance of emerging and re-emerging infections, to enable swift identification of outbreaks.

Though some consensus documents and standards exist, no international standards exist. The World Health Organisation’s [WHO] Guidance for Development of National Laboratory Strategic Plans document is recognised as a useful starting point. This can be regarded as the closest approximation to guidelines for developing a ‘roadmap’ to be used by national leaders to develop a consensus plan. Laboratory planning often concentrates on the science and technologies of the diagnostic service, while ignoring [at its peril] the supply chain, information technology, maintenance and other support services. This becomes a serious issue in low resource environments and can result in service interruption, especially in the face of an outbreak situation. Key reagents can go out of stock, critical equipment such as biosafety cabinets, fridges and freezers, autoclaves and air handling systems cannot be serviced. These considerations are especially critical at a biosafety level (BSL) 3 containment level laboratory. Work undertaken by MECIDS on the laboratory diagnosis of salmonella species and MERS CoV is to be applauded and it is recommended that further work such as this be undertaken, for other laboratory investigations. The introduction of an international compatible IT system between the laboratories of the three countries should be explored. It is advisable that frequent meetings/workshops involving scientific/technical communities from each country be held. In the face of an emerging public health crisis there is a need for a facility for countries so they can take up surge capacity if other nations find difficulty in meeting diagnostic demands.
## Communication

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# Israeli Ministry of Health Israeli Ministry of Agriculture

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Annexes

Annex 1
Definition of Infection Control-related Terms

**Standard Precautions**
Standard precautions are infection prevention and control practices that apply to all patients regardless of diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions and excretions, except sweat, regardless of whether they contain visible blood, non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions include: respiratory hygiene/cough etiquette; hand hygiene before and after caring for a patient; use of gloves (clean, non-sterile gloves are adequate); use of masks, eye protection, face shields and gowns (a clean, non-sterile gown is adequate) when splashes or sprays of blood, body fluids, secretions or excretions are possible; cleaning of patient-care equipment, the patient’s physical environment and soiled linen; and precautions to reduce the possibility of health care worker exposure to blood borne pathogens. Private rooms are generally not necessary but may be considered for patients who contaminate the environment or cannot maintain appropriate hygiene. Reusable dishes and eating utensils are washed and sanitized in a manner that renders them safe for reuse (e.g., in a dishwasher with recommended water temperature). Linen and laundry are washed and dried according to routine standards and procedures.

**Hand Hygiene**
Hand hygiene is a general term that applies to any of the following: 1) handwashing with plain (non-antimicrobial) soap and water; 2) antiseptic handwash (washing hands with water and soap containing an antiseptic agent); or 3) antiseptic hand rub (waterless antiseptic product, most often alcohol-based, rubbed on all surfaces of hands). Hand hygiene is to be performed before and after contact with patients, after contact with contaminated items and immediately after removing gloves. Hands are to be washed with soap and water when visibly dirty or soiled with blood or other body fluids, contaminated with proteinaceous material, exposed to spores (e.g., Bacillus species or Clostridium difficile), suspected or proven, before eating and after using a restroom. It is essential health care personnel always perform hand hygiene between patient contacts and after removing personal protective equipment (PPE). Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents and is an essential element of standard precautions.

**Respiratory Hygiene/Cough Etiquette**
Respiratory hygiene/cough etiquette is a combination of measures designed to minimize the transmission of respiratory pathogens via droplet or airborne routes in health care settings. The components of respiratory hygiene/cough etiquette are: 1) covering the mouth and nose when
coughing or sneezing; 2) using tissues to contain respiratory secretions with prompt disposal into
the nearest waste receptacle after use; 3) performing hand hygiene (e.g., handwashing with non-
antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having
contact with respiratory secretions and contaminated objects/materials; 4) offering a mask to
persons who are
coughing to decrease contamination of the surrounding environment; and 5) turning the head
away from others and maintaining spatial separation, ideally greater than 3 feet, when coughing.
Respiratory hygiene/cough etiquette should be used with any person (e.g., patients and
accompanying family members or friends) with signs of a cold or other respiratory infection (e.g.,
cough, congestion, rhinorrhea and increased production of respiratory secretions) who enters
any health care facility. Health care facilities should post visual alerts (in appropriate languages)
at the entrance to outpatient treatment areas (e.g., emergency departments, physician offices,
outpatient clinics) instructing patients and persons who accompany them (e.g., family, friends)
to inform health care personnel of symptoms of a respiratory infection when they first register
for care and to practice respiratory hygiene/cough etiquette. When space and chair availability
permit, coughing persons should be encouraged to sit at least 3 feet away from others in common
waiting areas.

Droplet Precautions
In addition to standard precautions, droplet precautions are intended to reduce the risk of
droplet transmission of infectious agents from close respiratory or mucous membrane contact
(e.g., less than 3 feet) with large-particle respiratory droplets (larger than 5 µm in size).
Respiratory droplets can be generated by the patient during coughing, sneezing, talking or the
performance of cough-inducing procedures. Because droplets do not remain suspended in the
air, special air handling and ventilation are not required to prevent droplet transmission; single-
patient rooms are preferred. Health care personnel and visitors wear gloves and masks
(respirators are not necessary) when entering a patient’s room. A mask should be worn once,
changed when moist and then discarded. Upon touching or discarding a used mask, hand
hygiene is to be performed. During procedures that may generate small particles of respiratory
secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), health
care personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 or other
appropriate particulate respirator. When a single-patient room is not available, pandemic
influenza patients may be cohorted (e.g., place the patient in a room with other patients who
have active pandemic influenza infection but no other infection) with spatial separation of
patients (e.g., greater than 3 feet between beds in multi-patient rooms). In general, wearing eye
protection (e.g., goggles) or a face shield for routine contact with pandemic influenza patients is
not necessary, but should be worn as recommended for standard precautions. If transport or
movement of the patient from the room is necessary, the patient is to wear a surgical mask that
covers the mouth and nose, if possible.
**Contact Precautions**
In addition to standard precautions, contact precautions are intended to reduce the risk of epidemiologically important microorganisms by direct (e.g., hand or skin-to-skin contact) or indirect (e.g., touching environmental surfaces or patient-care items) contact. Single-patient rooms are preferred and health care personnel and visitors wear gown and gloves for all interactions that may involve contact with the patient or the patient’s environment. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for their use may need to be established. When a single-patient room is not available, pandemic influenza patients may be cohorted (e.g., place the patient in a room with other patients who have active pandemic influenza infection but no other infection) with spatial separation of patients (e.g., greater than 3 feet between beds in multi-patient rooms). When possible, dedicate the use of noncritical patient-care equipment to a single patient or cohort of patients to avoid sharing between patients. If use of common equipment or items is unavoidable, they must be adequately cleaned and disinfected before use for another patient. Rooms of patients on contact precautions are given cleaning priority with a focus on frequent cleaning (e.g., at least daily) and disinfection of high touch surfaces (e.g., bed rails, bedside commodes, faucet handles, doorknobs, carts, charts) and equipment in the immediate vicinity of the patient.

**Airborne Precautions**
In addition to standard precautions, airborne precautions are used for the care of patients known or suspected to be infected with pathogens transmitted by airborne droplet nuclei (small-particle residue [5 µm or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and can be dispersed widely by air currents within a room or over a long distance). Use of an airborne infection isolation (AIIP) room with the door closed is required to prevent airborne transmission. An AIIP room is a single-patient room equipped with special air handling and ventilation capacity (e.g., negative air pressure).

Respiratory protection (e.g., NIOSH-approved N95 or higher respirators) is worn by susceptible persons when entering the room. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance and training. If transport or movement of the patient from the room is necessary, the patient is to wear a surgical mask that covers the mouth and nose, if possible.

In the event of an outbreak or exposure where large numbers of patients require Airborne Precautions, consult MOH Division of Infectious Diseases to determine the safety of cohorting patients together based on clinical diagnosis in areas with the lowest risk of airborne transmission.

**Personal Protective Equipment (PPE)**
Personal protective equipment is a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields and gowns. Respirators (e.g., N95 or other appropriate
particulate respirator) should be used within the context of a respiratory protection program that includes fit-testing, medical clearance and training.
Annex 2:

Infection Control and Personal Protective Equipment (PPE), Jordan and the West bank

Infection control practices for pandemic influenza involve the application of standard and droplet precautions during patient care in health care settings (e.g., hospitals, nursing homes, outpatient offices, emergency transport vehicles).

Infection control guidelines, include recommendations for isolation precautions to prevent transmission of microorganisms and the type(s) of PPE to be worn to reduce the risk of exposure to microorganisms.

Local health departments have primary authority to implement and to enforce infection control measures for their citizens. Whenever a dangerously contagious or infectious disease becomes or threatens to become epidemic, Ministry Of Health (MOH) may enforce additional measures as it deems necessary to protect the public health.

Concept of Operations

The Pandemic Influenza Plan will provide the framework for guidance on infection control measures for health care settings, including:

- Assigning and activating the Triage area in health care centre
- Isolation of infectious patients in private rooms or cohort units
- Selection and use of PPE
- Hand hygiene and safe work practices
- Cleaning and disinfection of environmental surfaces
- Handling of laboratory specimens
- Post-mortem-care
- Restricting visitors
- Educating patients and health care staff
- Cohorting health care workers assigned to an outbreak unit
- Screening of persons entering the health care facility who may be infected with pandemic influenza
- Detection and control of nosocomial transmission of pandemic influenza

Settings where persons with pandemic influenza might seek and receive health care services (e.g., hospitals, emergency departments, outpatient facilities, residential care facilities and homes) should implement basic infection control principles to prevent the spread of pandemic influenza. Basic infection control principles include:

1) Limit contact between infected and non-infected persons through:
a) Isolation precautions (i.e., standard precautions, droplet precautions, contact precautions and airborne precautions, as indicated).

b) Measures which promote spatial separation in common areas (e.g., sit or stand as far away as possible – at least 6 feet – from potentially infectious persons).

2) Exposure control by reducing the potential for exposure to the pandemic influenza virus by persons caring for influenza patients in health care settings. Persons caring for infectious patients should:
   a) Wear a mask for close contact with infectious patients.
   b) Use contact and airborne precautions, including the use of fit-tested N95 respirators (or greater respiratory protection) and eye protection, when appropriate.
   c) Wear gloves (gown if necessary) for contact with respiratory secretions.
   d) Perform hand hygiene after contact with infectious patients.

3) Control source by containing respiratory secretions:
   a) Instruct persons who have “flu-like” symptoms to use respiratory hygiene/cough etiquette (“Cover Your Cough”).
   b) Promote use of masks by symptomatic persons in common areas (e.g., waiting rooms in physician offices or hospital emergency departments) or when being transported (e.g., in emergency vehicles).

MOH will provide guidance on adapting infection control practices to specific health care settings, including:

• Nursing homes and other residential facilities
• Pre-hospital care (emergency medical services [EMS])
• Medical offices and other ambulatory care settings
• During the provision of professional home health care services
• During the care of pandemic influenza patients in the home or in alternative care sites (e.g., schools, auditoriums, conference centres, hotels)

MOH will provide recommendations for infection control in schools, work places and community settings.

All support agencies will provide services as indicated in other plans developed under referenced authorities in support of this annex.

Annex 3

Israel:

Appendix B: Laboratory Diagnosis of Influenza A/H1N1 2009
Foundations and Rules:

The laboratory diagnosis of people suspected to be infected with swine flu of 2009 A/H1N1 is conducted in a qualified laboratory (Tal-Hashomer or Hadassah). The final verification of positive results shall take place in reference laboratories of the World Health Organization (WHO) in the event of no other instructions.

The laboratory diagnosis is conducted according to the following rules:

1. Swine flu of 2009 A/H1N1 tests are conducted only for patients according to section 5 f’ in the CEO returns (inpatients with hard cases, biopsy sentinel lymph nodes, testing of cancer clusters).

2. Samples of swine flu diagnoses are sent cooled and must arrive at the laboratory within a maximum of 48 hours from the time of receipt.

3. The samples are sent to the laboratory as instructed by the Department of Laboratory procedures:

"Registering and labelling of samples " (action No. CL11004 (2), report 7/2004), transferred and packaged according to the safety instructions, "a security procedure concerning the transfer of infectious biological materials and samples for medical laboratory diagnosis" (serial number: SF-51-001/5) in a triple package with the test name registered on the exterior and labelled with the biological biohazard sign.

B. Reporting the results of laboratory tests.

Appendix B 1
Instructions for receiving and sending diagnoses samples of swine flu of 2009 A/H1N1

General Instructions:
1. Samples must be sent only in cases that meet the definition of a suspected case of flu 2009 A/H1N1 and constitute an indication of the sample, as defined in item 5 of CEO returns.
2. The laboratory is to be contacted before sending the samples and coordination must take place for the receipt and dispatch of samples.
3. Samples are packaged according to the Ministry of Health instructions of samples' type "biological hazard" by the triple packaging principle: enter sample into a preliminary container with a hermetic closure. The container is placed in a standard package with a screw cap provided by the department for emergencies. The package is to be filled with an absorbent material in case of spillage. More than one sample can be inserted inside the package. Insert the package with the sample container inside a box with Styrofoam and ice for cooling and with extra absorbent material. The package is to be closed with thick tape on all sides. The package exterior must be labelled "biological hazard" and "swine flu". Labels are to be provided by the department for emergencies.
4. Hermetic closure of the sample containers is to be secured and fixed inside the package in order to prevent the sample material from spilling at the time of transfer.
5. The patient's name, identification number and sample material must be registered on each preliminary container (test tube, etc.) individually.
6. Reference forms: a reference form must be attached to each sample (Appendix 3 below) in which all the details have been filled. The forms should be put in sealed nylon bag and inserted into the Styrofoam box.
7. Samples must be sent to the lab immediately after receiving them. The samples have to be fresh and stored in refrigeration (4-8 Celsius) immediately upon receipt and until they arrive to the laboratory.
8. No freezing of samples!

Instruction for receiving samples:
1. The samples for prevention and discovery of an infection are to be taken from the throat and nasal swabs only.
2. No nose-mouth swabs are to be taken because there is a risk of infection in doing so.
3. Swabs are to be taken from throat and nose by a medical swab placed inside a virologic tool (bought test tubes or ones provided by the laboratory can be used). After inserting the swab inside the tube, break the tip of the applicator and close the tube. It recommended to use three swabs (in the right nostril, left nostril and throat) from a single patient to a single tube. You can use a store VIROCULT tube type. In this case, you can send a test tube for each swab. It is strictly forbidden to use a bacterial tool or send a dry swab.
4. Blood for serology: patients from whom swabs has been taken for diagnosis, a 5-10 ml must be collected inside a chemical sterile test tube during the critical stage of illness and two weeks later. Syringes can be sent after the separation. 
Please keep the swabs cool. No freezing of samples.

There is no need to inform the lab when sending the samples or to set a date for their arrival with the laboratory staff.

Phone numbers for clarifications and questions in the laboratories:

Tal Hashomer Laboratory:
National Center for Influenza: 03-530-2455
Dr. Michal Mandelbaum - Director of the National Center for Influenza: 054-200-2058
Prof. Ella Mendelson - Director of Virology Laboratory: 03-530-2421 052-666-6770
Prof. Zehava Grossman- Deputy Director of Virology Laboratory: 050-624-2639

Hadassah Laboratory:
Secretariat - 02-6778-570
Laboratory - 02-677824, 02-6776546

State of Israel
Ministry of Health
Public Health Services
Department of Epidemiology
Reference Form for a virology test/investigation form of influenza A/H1N1
See detailed instructions for taking samples from a patient suspected of swine flu 2009 A/H1N1. Patient’s name, identification number and sample material must be registered on the test tube. Re-sampling must be made taken in case of a lack of diagnosis.

Organization name - HMO: Clalit\ Meuhedet\ Leumit \ Maccabi \ Hospital Health Bureau\ IDF \ Other
Clinic Address [hospital \ Health Bureau ________________________________]

Demographic details:
First Name, Last Name _____________ Identification Number \ Passport Number

Date of birth ____________ Gender: Male \ Female Soldier: Yes \ No
Day Month Year
Address (city, street, house number) ________________________________
Phone ___________ _______________ Cell phone

Clinical details: date of disease start ____________
Day Month Year

Reason for sampling

☐ inpatients with a respiratory severe difficult disease, for an ambiguous reason
☐ part of a cancer cluster
☐ another, specify

Clinical details (circle the desired option)
Risk group: chronic lung disease\ chronic and significant heart disease\ immunodeficiency (e.g., cancer patients or patients on steroids) \ diabetes or gastrointestinal disease \ chronic kidney disease \ ill haemoglobin \ neurological disease \ pregnancy \ morbid obesity \ aspirin treatment (up to age 19) \ Other: Specify ________________________________

Severe symptoms:
Adult: tachypnea \ pneumonia \ oxygen desaturation \ aggravation of a basic disease \ neurological change \ Other: Specify ________________________________
Youth: tachypnea \ hypothermia \ low blood pressure \ cyanosis \ pallor \ respiratory effort \ stethoscope findings \ oxygen desaturation \ neurological disease \ reduced functioning \ lack of drinking \ vomiting \ Other: Specify ____________________

Hospitalized Yes ___ No ___ if yes, in the intensive care unit Yes ___ No ___
Date of hospitalization ______________
                        Day Month Year

Epidemiological details:
Have visited/ visiting any educational framework (kindergarten/ dorms / school / summer camp / Youth Camp / Higher Education organization)? Yes No ___ if yes, please write name and address __________

Sample material _______ date of receiving sample ____________
                        Day Month Year

Test results: positive ___ negative___

Details of test sender:

Physician at the clinic \ contact at the hospital ______ phone of HMO clinic ______
Cell phone of physician \ contact at the hospital ______
Fax number of the clinic \ hospital: ______________

Appendix B 3: instructions for protection and safety of workers in laboratories that deal with samples of flu patients with A/H1N1 2009
According to the information available today, only the samples taken from the respiratory tract are samples proved contagious. For samples of blood and other body fluids, there is no proof they are contagious.

**Treating samples not taken from respiratory system:**

In general, all workers in all laboratories have to consider every patient sample as potentially infectious from a certain infectious agent. Thus, they must use personal protective tools that include surgical gowns with long sleeves, and gloves should be changed several times during the day. Standard safety instructions appear in the guide to safety procedures in the medical laboratories of the Department of laboratories in the Ministry of Health and in the website of the American CDC: http://www.cdc.gov/OD/ohs/biosfty/bmbl5/bmbl5toc.htm

Blood samples, syringes and urine should be treated according to the standard procedure, while highlighting the following means of protection:

1. Consistent cleaning and disinfecting of work surfaces, tools and equipment regularly. In the case of sample spillage, two pairs of gloves must be worn. Thereafter one must cover the spilled liquid with bleach (hypochlorite concentration of 3500-5000 ppm - 1:10 dilution of home liquid bleach), wait for ten minutes and then wipe the surface. Dispose the waste in accordance with local procedures concerning hazardous waste.

2. Make sure every action which is likely to produce aerosol must be conducted using the appropriate devices according to biosafety level 2 (BSL2) requirements which every laboratory receiving biomaterial should follow. For example, samples from patients must be by centrifuges of the "biological hazard" type. If test tubes need to be manually opened, it is advisable to keep the pipes untouched for five minutes after centrifugation and before opening them.

**Treating samples originating in the respiratory system:**

The transfer of respiratory samples from one location to another within the hospital is done by a multiplied packaging with a hard upper section (transparent plastic package with a screw cap or a Styrofoam container) and in addition a "biological hazard" label.

The sender or assistant nurse who is transferring the sample will be instructed on the risks associated with exposure of the sample and the required treatment of its spillage (see below).

Samples that are taken from the respiratory tract and transferred to microbiological or virological laboratories are treated according to procedures for treating infectious samples to BSL-2 augmented instructions. Meaning:

1. Opening of the samples and working with them shall occur only inside the biological hazard hood (Biosafety cabinet Class II, at the least) until the stage in which the sample is chemically installed and is not infectious.
2. Protection of laboratory worker includes surgical gown and gloves, in addition to the face and mouth masks of N95 type and protection goggles suitable for each worker.

3. Access to the working room, incubators, refrigerators and freezers that store samples or containers containing a virus, is limited only to authorized staff.

4. In case of spillage, all the surrounding people must distance themselves, protect themselves as required, and spillage must be covered by liquid bleach (hypochlorite concentration of 3500-5000 ppm - 1:10 dilution of home liquid bleach). After waiting for ten minutes, wipe the surface. Dispose the waste in accordance with local procedures concerning hazardous waste.