STANDARD OPERATING PROCEDURES FOR PREPAREDNESS, DETECTION AND RESPONSE TO A CORONAVIRUS (2019-NCOV) OUTBREAK IN SOUTH AFRICA

National Department of Health
Directorate: Communicable Diseases
30 January 2020
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**Abbreviations**

<table>
<thead>
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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CDC</td>
<td>Communicable Disease Control</td>
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<tr>
<td>CIF</td>
<td>Case investigation form</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NHLS</td>
<td>National Health Laboratory Service</td>
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<td>NICD</td>
<td>National Institute for Communicable Diseases</td>
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<td>PHO</td>
<td>Port Health Official/s</td>
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<td>PHS</td>
<td>Port Health Service</td>
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<td>PoE</td>
<td>Port/s of Entry</td>
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1. Purpose of the document

This document outlines the standard operating procedures for detection and response to case/s of suspected novel coronavirus disease (2019-nCoV) in South Africa. The content of this document should inform provincial preparedness plans.

2. References and links

2.1 Guidelines and policies


2.2 Useful links


South Africa has released case definitions and precautionary measures for 2019-nCoV which can be found on: http://www.nicd.ac.za/novel-coronavirus-outbreak-in-wuhan-city-hubei-province-of-china/


3. Background

On 31 December 2019, the World Health Organization (WHO) China Country Office was informed of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province of China. On 7 January 2020, the causative pathogen was identified as a novel coronavirus (2019-nCoV). The majority of these cases were linked to a seafood, poultry and live wildlife market in Wuhan City, suggesting that the novel coronavirus has a possible animal origin. According to WHO, as of 29 January 2020, 6065 cases have been reported globally; 5997 cases and 132 deaths were reported in China; 68 cases were reported from outside China (in 15 countries). It should be noted that the number of cases is increasing; for the latest update refer to https://www.who.int/emergencies/diseases/novel-coronavirus-2019. The incubation period is currently estimated to be up to 14 days.

Coronaviruses belong to a large family of viruses causing a wide spectrum of illness, ranging from very mild to severe. Some cause illness in people; numerous other coronaviruses circulate among animals, including camels and some bat species. Rarely, some animal coronaviruses can evolve to cause illness in people. Sometimes coronaviruses may develop the ability to spread from person to person, for example the Middle East respiratory syndrome coronavirus (MERS-CoV), first reported from Saudi Arabia in 2012, and the severe acute respiratory syndrome coronavirus (SARS-CoV), first recognized in China in 2002.
A WHO Emergency Committee meeting was convened on Wednesday, 22 January 2020 by the WHO Director-General under the International Health Regulations (IHR2005) regarding the outbreak of novel 2019-nCoV in the People’s Republic of China. The WHO Expert Committee acknowledged that developments in China are concerning, noted the country’s intense efforts to investigate and contain the outbreak, but concluded that at this stage, a Public Health Emergency of International Concern (PHEIC) would not be declared. As infected travellers may appear in any country (to date, cases have been reported in Japan, Republic of Korea, Vietnam, Singapore, Australia, Malaysia, Cambodia, Thailand, Nepal, Sri Lanka, USA, Canada, France, Germany, United Arab Emirates, Hong Kong, Taiwan, and Macau) the committee recommended that all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread of 2019-nCoV infection, and to share full data with WHO.

It should be noted that as of 29 January 2020, no cases of 2019-nCoV have been reported in South Africa. The National Institute for Communicable Diseases (NICD) is closely monitoring the situation, and will test patients that satisfy the criteria for suspected cases, bearing in mind that it is influenza season in the northern hemisphere and the expected respiratory tract infections are common.
4. Process flow for detection of and response to suspected 2019-nCoV cases

The overarching process flow for the detection and response of 2019-nCoV is provided in Figure 1. The roles and responsibilities of the different stakeholders are also depicted in Figure 1 and Figure 2.

It is strongly recommended that these flow charts are used in conjunction with National Guidelines on Epidemic Preparedness and Response (2010).

All provinces should develop province-specific standard operating procedures for preparedness, detection and response which would include province-specific adaptation of the process flow depicted in this document.

<table>
<thead>
<tr>
<th>Province</th>
<th>Designated Hospital</th>
<th>Designated Referral Hospital</th>
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<tr>
<td>Western Cape</td>
<td>Tygerberg Hospital</td>
<td>Tygerberg Hospital</td>
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DETECTION AND REPORTING OF SUSPECTED 2019-nCoV CASE
- The case definition must be strictly adhered to (Annexure 1: 2019-nCoV case definition, Annexure 2: EVD CIF).
- **Public/private health facility:** If a suspected case is identified (e.g. at the Emergency Centre) – isolate the case in a suitable room/unit for assessment, applyIPC measures. Contact the Infectious Disease Specialist and/or NICD hotline (Figure 2).
- **Port of Entry (airport, land port, harbour):** Port Health Official should consult with NICD (hotline) on whether case fits the case definition. EMS will be contacted for the management and transport of the passenger/patient to health facility. (Figure 2) (Annexure 3, 4).

TRANSPORT AND/OR REFERAL OF SUSPECTED 2019-nCoV CASE TO HOSPITAL
- Referral from Port Health (airport, land port, harbour) and public or private facility must be discussed with the Infectious Disease Specialist/NICD, EMS practitioner, local CDC Coordinator and Port Health.
- Referral from non-designated hospital: Decide on retaining patient at hospital (facility where case presented) or whether to transfer to designated facility
- Forward list of contacts to the Provincial CDC e.g. relatives, cohorts and other contacts (ambulance, laboratory, cleaning staff) of patient/s under observation. (Annexure 3).

MEDICAL MANAGEMENT AND LABORATORY INVESTIGATIONS
- Isolate the patient and apply infection precautions in accordance with site-specific standard operating procedures for this purpose
- Clinical and laboratory verification of diagnosis: discuss with pathologist/NICD Hotline about diagnostic specimens and transport to the NHLS/NICD. Clinician to complete the case investigation form (CIF) (Annexure 2: 2019-nCoV CIF) and co-submit with specimens to NHLS/NICD. Guidelines for the collection and submission of specimens to NHLS/NICD available on NICD website: www.nicd.ac.za
- Manage case according to national guidelines: available on NICD website: www.nicd.ac.za

MEDICAL MANAGEMENT AND LABORATORY INVESTIGATIONS
- Finalize reporting and do GAP analysis for responses to the case.
- Perform mitigation of any shortcomings identified during case management (Annexure 7: CDC Report format)

MULTI-DISCIPLINARY PUBLIC HEALTH RESPONSE
- Provincial CDC responsible for coordination of response including: Convening of an outbreak control committee if necessitated by the circumstances (with sub-committees). (Figure 2)
- Trace and place case contacts under observation e.g. family or cohorts in collaboration with local authorities (district municipalities). Annexure 3).
- Collate information and share reports with key stakeholders.
- Handling of mortal remains of 2019-nCoV case must be in accordance with guidelines (Annexure 6).
- Efficient and transparent communication with the media (press release/briefs) must be provided
- Writing of reports e.g. daily updates, preliminary and final (Annexure 7: CDC Report format).

Contacts and details:
- **Consultant on call for Infectious Diseases**
  - NICD Hotline 082-883-9920
  - National Health Operations Centre 012-395-9636/37
- **National and Provincial CDC**
  - Provincial Port Health
  - EMS
  - See Annexure 11 for contacts

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Figure 1: Process flow for the detection and response to a suspected EVD case.
Clinician suspects a case of EVD/VHF at health facility
• Communicates this information to site-specific contacts (as per site-specific procedure) and NICD Hotline

Infection control nurse
• Immediately notifies District Level
• Immediately fills in a notification form

Local Laboratory
• Liaise with NHLS/NICD for EVD/VHF specific investigations
• Perform routine blood testing as per protocol for suspected VHF cases

District Outbreak Response Team Chairperson
• Immediately notifies Province
• Captures notification on an electronic system

District Outbreak Response Team
• Surveillance
• Environmental Health/Port Health
• Health promotion, School Health
• Communicable Disease Control
• Animal Health
• Local laboratories
• Other sectors

Provincial Outbreak Response Team Chairperson
• Immediately notifies National Level

Provincial Outbreak Response Team
• Environmental Health/Port Health
• Surveillance
• Health promotion, School Health
• Communicable Disease Control
• Laboratory
• Animal Health
• Other Sectors

National Outbreak Response Team Chairperson
• Immediately notifies WHO Level

National Multi-sectoral Outbreak Response Team (MNORT)
• Surveillance
• Environmental Health/Port Health
• Health promotion, School Health
• Communicable Disease Control
• Laboratory/NICD
• Animal Health, and other sectors

National Institute for Communicable Diseases (NICD)

Feedback
• Community
• Ports of Entry

Figure 2: Flow of information for suspected EVD case notification and response.
5. Annexures

Annexure 1: 2019 nCoV case definition

2019-nCoV Quick Reference for Health Workers

27 January 2020

Background: On the 31st December 2019, the World Health Organization (WHO) China country office reported a cluster of pneumonia cases in Wuhan City, Hubei Province of China. A novel coronavirus (2019-nCoV) has been confirmed as the causative virus. Other cities in China as well as countries outside of China including, Japan, Italy, United States of America and Thailand have also reported cases. Most cases to date have links to Wuhan but person-person spread has been described.

Clinical presentation and management of suspected cases
The main clinical signs and symptoms are fever and cough with a few patients presenting with difficulty in breathing and bilateral infiltrates on chest X-rays. Lymphopaenia may be present. Treatment is supportive.

Clinical and epidemiological criteria for Person Under Investigation (PUI)

Severe Illness
Fever (≥38°C) and cough with pneumonia or Acute Respiratory Distress Syndrome (ARDS) (clinical/ radiological) requiring admission AND any of

1. A documented travel history to Wuhan, Hubei Province, China within 14 days before symptom onset; or
2. Close physical contact with a confirmed patient with 2019-nCoV while he/she is symptomatic*; or
3. Patient is a healthcare worker who was exposed to patients with severe acute respiratory infections unless another aetiology has been identified to explain the clinical presentation

or

Illness of any severity
A person with acute respiratory illness (ARI) of any degree of severity AND who within 14 days of onset of illness had been exposed to the following:

1. Close physical contact with a confirmed patient with 2019-nCoV while he/she is symptomatic*; or
2. Healthcare facility in a country where hospital-associated 2019-nCoV infections have been reported; or
3. Any direct contact with animal source in countries where 2019-nCoV is known or where human infections have occurred (due to the animal source remaining undetermined, guidance for this point will be updated)**; or
4. A documented travel history to Wuhan, Hubei Province, China within 14 days of symptom onset; and had visited an animal market in Wuhan City

*Close contact is defined as: healthcare-associated exposure, including providing direct care for nCoV patients, working with healthcare workers infected with nCoV, visiting patients or staying in the same-close environment of a nCoV patient. This could also be defined as a healthcare worker working together in close proximity, sharing the same classroom environment with a nCoV patient, travelling together with nCoV patient in any kind of conveyance or living in the same household as a nCoV patient. ** To be added once/If animal source is identified as a source of infection.

Infection control
1. Early detection is key - healthcare workers should maintain a high level of clinical suspicion
2. Patients should be asked to wear a surgical mask as soon as they are identified and evaluated in a private room
3. Isolate PUI (ideally an airborne infection isolation room if available)
4. Use appropriate infection control for PUI
   a. Adequate standard precautions for all patients
   b. Add contact and droplet precautions for all patients
   c. Apply airborne precautions (eg N95 mask) and eye protection must be used when performing aerosol-generating procedures
   d. If available, airborne precautions can be used at all times
   e. Limit movement of patient (e.g. use designated portable X-ray equipment)

Specimen collection for 2019-nCoV
Collect appropriate samples. Lower respiratory tract samples are preferred because the lower respiratory tract is the primary site of infection.

- Respiratory samples - Combined nasopharyngeal and oropharyngeal swab in ambulatory patients and sputum (if produced) and/or tracheal aspirate or bronchoalveolar lavage in patients with more severe respiratory disease.
- Serum for serological testing - acute and convalescent samples may be submitted in addition to respiratory samples. Respiratory samples are the primary method if diagnosis.
- Use universal/viral transport medium for swabs; sterile container for sputum and aspirates; clotted blood container for serum see page 2 for instructions for collecting swabs.

A single negative test result, especially if from upper respiratory tract specimen, does not exclude infection. Repeat sampling and testing of lower respiratory tract samples is recommended for case with severe disease or in whom 2019-nCoV is strongly suspected.
COLLECTION OF NASO/OROPHARYNGEAL SWABS FOR DETECTION OF RESPIRATORY VIRUSES:

Respiratory viruses are best isolated from material that contains infected cells and secretions. Therefore, swabs should aim to brush cells and secretions off the mucous membranes of the upper respiratory tract. Good specimen quality (i.e. containing sufficient cells and secretions), appropriate packaging and transport (i.e. to keep virus viable/detectable) is essential. Please discuss plans to collect samples with doctor on call before collecting sample at NICD hotline - 0828839920

Step 1: Equipment and materials
1. Specimen submission form and case investigation form
2. Nasopharyngeal (NP) and oropharyngeal (OP) flocked swab
3. Tube containing universal transport medium (UTM)
4. Tongue depressor
5. Gloves
6. N95 mask (fit tested)
7. Biohazard bag for disposal of non-sharp materials
8. Tissue for patient to wipe nose after sample collection
9. Cooler box and cooled ice packs
10. Ziploc plastic specimen bag

Step 2: Record keeping
1. Complete the specimen submission form and case investigation form (available on NICD website)
2. Place the specimen submission form into a ziplock bag
3. Label the tube of universal transport media (UTM) with the patient's name and date of birth

Step 3: Collection of nasopharyngeal swab (NPS)
1. Don a pair of gloves, and an N95 respirator, making sure the respirator has a good fit. Open a sterile flocked swab at the plastic shaft
2. Ask the patient to tilt his/her head back. Estimate the distance from the patient’s nose to the ear: This is how far the swab should be inserted
3. Gently insert swab into the nostril and back (not upwards) to the nasopharynx until a slight resistance is met
4. Rotate swab 2-3 times and hold in place for 2-3 seconds
5. If resistance is met remove and try another nostril
6. Slowly withdraw swab and without touching it, put it into a UTM
7. Break plastic shaft at the break point line and close the tube

Step 4: Collection of oropharyngeal swab (OPS)
1. Keeping the same pair of gloves on, and holding the UTM with the nasopharyngeal swab in, take a second flocked swab and open it at the plastic shaft
2. Ask the patient to tilt their head back and open mouth wide
3. Hold the tongue down with a tongue depressor
4. Have the patient say “aaah” to elevate the uvula
5. Swab each tonsil first, then the posterior pharynx in a “figure 8” movement
6. Avoid swabbing the soft palate and do not touch the tongue with the swab tip as this procedure can induce the gag reflex.
7. Place the swab into the same UTM tube with the NPS already in and break off the shaft at the break point line
8. Tightly close the tube
9. Place the closed tube with two swabs in the Ziploc
10. Remove gloves and N95 mask
11. Wash hands with soap and water

Diagram: How to collect a nasopharyngeal swab (left) and oropharyngeal swab (right)

Step 5: Transport of specimens
1. Ensure the cooler box and ice packs stay at 2-8°C
2. Transport to CRDM, NICD on same day as collection
3. Mark: Suspected Novel coronavirus, CRDM
4. NHL5/NICD, Centre for Respiratory Disease and Meningitis (CRDM) Lower North Wing, SAW building 1 Modderfontein Rd, Sandringham, Johannesburg, 2131
5. NHL5 laboratories use usual overnight regional courier service
6. Private laboratories/clinics organise shipment via Marken [NHL5 account] or World couriers [WHO shipment fund]

Step 6: Contact details for assistance with sample transport
1. Linda de Gouveia lingad@nicd.ac.za (011-555-0327) or
2. Amelia Buys ameliab@nicd.ac.za (011-386-6373) or
3. Cardia Fourie cardiaf@nicd.ac.za (011-386-6373)
Annexure 2: 2019-nCoV case investigation form (CIF)
Annexure 3

Contact tracing

- A contact line list (see form below) should be completed for each suspected case at time of sample collection and completion of the CIF by the facility infection control focal point, attending clinician or designated port health officer. If the form cannot be completed at this time, the district or provincial CDC will complete the form when notified to the case. A copy of this form should be submitted to ncov@nicd.ac.za

- Only details of close contacts will be collected on the contact line list. A close contact is defined as healthcare-associated exposure, including providing direct care for nCoV patients, working with healthcare workers infected with nCoV, visiting patients or staying in the same close environment of a nCoV patient. This could also be defined as a healthcare worker working together in close proximity, sharing the same classroom environment with a nCoV patient, traveling together with nCoV patient in any kind of conveyance or living in the same household as a nCoV patient.

- If laboratory testing confirms 2019-nCoV infection, the contact line list will be utilised to call each contact to complete the contact monitoring form (see form below). If any contact is found to be symptomatic, procedures will be followed for a suspected case.

- Contacts who do not have symptoms at time of the call, are to be monitored telephonically for 14 days by CDC or NICD call centre personnel post last exposure to the confirmed case.

- Monitoring of contacts may switch from telephonic monitoring to self-monitoring dependant on the number of contacts to be followed up.

- Contacts under monitoring should be advised to:
  - Avoid unnecessary social contact
  - Avoid travel
  - Remain reachable for monitoring

- Should a contact develop symptoms, a health care worker will visit the patient in their home to collect a specimen and to complete the required documentation. If a healthcare worker is not available, the patient will be requested to visit their nearest healthcare facility to have a specimen collected.

- The CDC should inform the healthcare facility of the incoming patient in order for the healthcare facility to use appropriate IPC measures.
2019-nCoV CONTACT LINE LIST
Complete a contact line list for every case under investigation and every confirmed case.

<table>
<thead>
<tr>
<th>Details of case under investigation/confirmed case</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICD Identifier</td>
</tr>
<tr>
<td>Surname</td>
</tr>
</tbody>
</table>

For cases who travelled long-distance (>2 hours in public transport) in the past 14 days

<table>
<thead>
<tr>
<th>Air/bus line</th>
<th>Flight/bus #</th>
<th>Seat #</th>
</tr>
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</table>

Details of health official completing this form

<table>
<thead>
<tr>
<th>Surname</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>Facility name</td>
</tr>
<tr>
<td>Email address</td>
<td>Telephone number</td>
</tr>
</tbody>
</table>

Today’s date DD/MM/YYYY

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### Details of contacts

*Close contact* is defined as: healthcare-associated exposure, including providing direct care for nCoV patients, working with healthcare workers infected with nCoV, visiting patients or staying in the same close environment of a nCoV patient. This could also be defined as a healthcare worker working together in close proximity, sharing the same classroom environment with a nCoV patient, traveling together with nCoV patient in any kind of conveyance or living in the same household as a nCoV patient. **Healthcare worker.**

<table>
<thead>
<tr>
<th>Surname</th>
<th>First name(s)</th>
<th>Sex (M/F)</th>
<th>Age (Y)</th>
<th>Relation to case</th>
<th>Date of last contact with case DD/MM/YYYY</th>
<th>Place of last contact with case (Provide name and address)</th>
<th>Residential address (for next month)</th>
<th>Phone number(s), separate by semicolon</th>
<th>Alternate contact person and phone detail</th>
<th>HCW**? (Y/N) if yes, facility name</th>
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### Details of contact of case under investigation/confirmed case

<table>
<thead>
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<th>Date of contact</th>
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<td>Name</td>
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<td>Date of birth</td>
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</tr>
<tr>
<td>Physical address</td>
<td>District</td>
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</tr>
<tr>
<td>House number</td>
<td>Street</td>
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</tr>
<tr>
<td>Contact number</td>
<td>Alternative number</td>
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### Details of health official completing this form

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<th>Name</th>
<th>Role</th>
<th>Facility name</th>
<th>Date completing form</th>
<th>DD/MM/YYYY</th>
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<tr>
<td>Email address</td>
<td>Telephone number</td>
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### Physical address

**Province**

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### Next of Kin

**Province**

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### Instructions for completion

Mark “Y” if symptom present and “N” if not. If any first five symptoms are present collect a combined nasopharyngeal and oropharyngeal swab.

Refer to 2019-nCoV Quick Guide (link) for additional details.

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### Notes

- **Contact**
- **Complete for each contact of confirmed case**

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Page 13 of 27
Annexure 4:
Standard operating procedure for the management of suspected communicable disease at the points of entry and transportation to a designated hospital

1. INTRODUCTION

Port Health Service (PHS) is defined as the first line of defence to protect the citizens of South Africa and visitors against the health risks associated with cross border movement of people, conveyances, baggage, cargo shipments and other imported consignments. It is thus vital for all points of entry to be on the alert and prepared to respond to a possible importation of a communicable disease, whether intentional or unintentional.

The following standard operating procedures detail measures that must be implemented by port health officials in preventing and responding to a suspected case of EVD.

2. SCREENING MEASURES

a) Port Health Officials (PHO) must monitor all arriving conveyances from the affected countries and increase surveillance measures.

b) Upon arrival of the conveyance, Port Health Officials must collect and verify the health documentation and interview the crew member/operator to determine if there is any sick passenger on board.

c) In addition to the routine interview of crew members/operators, Port Health Officials must ask crew members questions specific to signs and symptoms of 2019-nCoV.

d) If PHO is certain that there are no sick passengers on board and all health requirements have been met, the passengers may be allowed to disembark.

e) All arriving travellers must be channelled through the thermal scanning processes.

f) Travellers found to have elevated temperature must be escorted to the Port Health clinic where available, for further examination and must be interviewed to determine their travel history.

g) Where Port Health Clinic is not available, Port Health must interview the traveller with elevated temperature to determine their travel history, record the details of the traveller and if required transfer the traveller to the nearest health facility.

h) Travellers presenting with any one of these symptoms; fever, headache, joint and muscle aches, sore throat, and weakness, diarrhoea, vomiting, stomach pain and have travelled to the affected countries must be isolated and arrangements be made for transportation of the traveller to the nearest designated health facility (see table below) for further management.

<table>
<thead>
<tr>
<th>Province</th>
<th>Designated Hospital</th>
<th>Designated Referral Hospital</th>
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<tr>
<td>Western Cape</td>
<td>Tygerberg Hospital</td>
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3. IN THE EVENT OF A SUSPECTED CASE

3.1 Prior to arrival of conveyance

a) If traveller presents with symptoms related to a communicable disease while on board a conveyance;
   ▪ In case of airport/sea port the tower/captain will inform Operations/Agent who must inform PHO of the ill passenger,
   ▪ In case of land port, PHO will be informed on arrival of the conveyance at the port.

b) Suspected case is moved to an isolated area on the conveyance, if sufficient space is available.

c) Nurse or Port Health Officials must contact the NICD to confirm whether the symptoms conform to 2019-nCoV case definition;

d) Based on the information provided, Port Health must notify and make arrangements with the designated health facilities and ambulance for transportation of the ill traveller.

e) Port Health must then notify the relevant Provincial Communicable Disease Control Coordinator.

3.2 Once the conveyance has arrived at the Point of Entry

a) Port Health Officials must board the conveyance, together with the clinical personnel and ensure entrance to the conveyance is secured and no person enters or leaves the conveyance.

b) Port Health Officials must obtain and confirm the following information from the crew member:
   ▪ number of cases,
   ▪ signs and symptoms;
   ▪ vector control measures, where required and
   ▪ collect and verify the required health documentation and passenger list;

ca) Port Health Officials must brief the passengers that there is a possible case of 2019-nCoV on board, calm them and provide the necessary health information, including, reporting to the nearest health facility and inform the health worker of their travel history should they experience any symptoms;

d) Port Health Officials must identify the contacts and allow all passengers except the sick passenger and contacts to disembark;

e) Sick passenger may then be escorted from the aircraft and transported to the designated health facility (see section 5 below: Medical Evacuation Procedure);

f) Passenger locator cards and health information must be handed out to the contacts and inform them that they will be contacted for monitoring purposes;

gh) Contacts may then be allowed to disembark and channelled through thermal screening processes.

i) Port Health must hand over passenger list and close contact details to Provincial Communicable Disease Control Coordinator for further monitoring;

j) The ground handling and cleaning company of the conveyance operators should be notified at the same time so that preparations can be made for appropriate cleaning and/or disinfection of the conveyance after passengers have disembarked; if required;

k) Port Health Officials must monitor the entire cleaning and/or disinfection process.

4. MANAGEMENT OF INTENTIONAL TRANSPORTATION OF A SICK PASSENGER INTO SOUTH AFRICA/CONFIRMED CASE

a) Conveyance operators or medical companies transporting patients to South Africa for medical attention by commercial flight, charter flight or road ambulances must notify PHO beforehand utilising notification Form AC1 and include the medical history of the patient.

b) Form AC2 must be completed by the medical crew for information on the symptoms of the patient.

c) For patients arriving from the affected countries, Port Health must consult with the NICD and the Chief Director: Environmental Health & Port Health Services before a decision is taken to approve or disapprove the transportation of the patient.

d) If approval to transport the patient is granted, Port Health Officials must issue Form PH1 to the applicant.
e) In instances where a patient develops symptoms related to a communicable disease before or during transportation, the AC2 form must be completed and handed over to the PHO upon arrival at the airport.

f) Port Health Officials and Port Health Nurse must assess the patient upon arrival and inform the hospital receiving the patient of the condition.

g) All information related to the passenger must be communicated to the Provincial CDC to conduct a follow-up on the case.

h) Port Health Official or Port Health Nurse must follow up with the hospital to receive an update prior to closing the file.

5. MEDICAL EVACUATION PROCEDURE


1.1 Suspected/Confirmed 2019-nCoV medical evacuation procedure

- The provincial EMS manager must be contacted when an ambulance is requested to transfer a suspected or confirmed 2019-nCoV patient to and from a designated/referral hospital. (Annexure 8: Provincial EMS Managers’ contact details)
- The Provincial CDC must be informed prior to EMS medical evacuation of any suspected/confirmed 2019-nCoV patient.
- Driver must not have any contact with patient and must act as liaison
- Ideally two trained EMS specialized response team personnel must accompany patient.
- Hand hygiene must be observed before and after every contact with patient.
- Don correct PPE.
- Focus of care is supportive and maintaining existing treatment. No invasive procedures should be done in transit. (No sharps to be used)
- Keep contact with designated referral hospital. Determine and communicate an estimated time of arrival (ETA) and report an update on patient’s condition, as hospital needs to prepare: - isolation ward needs to be prepared, staff need to don PPE, security needs to clear public and staff from entrance and route.
- When arriving at hospital, the patient is to be kept inside ambulance until hospital indicates that the patient is allowed to enter.
- Provincial CDC must be informed after every 2019-nCoV transfer; crew must be placed on 14-day contact list and must submit temperature readings twice a day.

1.2 Unsuspected 2019-nCoV EMS medical evacuation procedure

- Normal call out to a home or healthcare facility and/or after transporting has commenced, a suspicion for a possible 2019-nCoV case is raised.
- Immediately contact and report to Provincial CDC who will assist in advice and decision on where to take patient.
- Driver must not have any contact with patient and must act as liaison.
- Hand hygiene must be observed before and after every contact with patient.
- EMS personnel must Don correct PPE.
- Focus of care is supportive and maintaining existing treatment. No invasive procedures should be done in transit. (No sharps to be used)
- Keep contact with designated referral hospital. Determine and communicate an estimated time of arrival (ETA) and report an update on patient’s condition, as hospital needs to prepare: - isolation ward needs to be prepared, staff need to don PPE, security needs to clear public and staff from entrance and route.
- When arriving at hospital, the patient is to be kept inside ambulance until hospital indicates that the patient is allowed to enter.
• Provincial CDC must be informed after every 2019-nCoV transfer, crew must be placed on 14-day contact list and must submit temperature readings twice a day.

1.3 Medical evacuation procedure of 2019-nCoV patient to and from a Healthcare facility

• When arriving at the healthcare facility, the patient and clinical team will remain inside the ambulance or isolation ward. The driver will liaise with healthcare staff and only after the indication from healthcare staff has been given that they are ready to receive/transfer the patient, can the patient be taken to/from the ambulance/isolation ward.
• Driver must ensure that healthcare facility is ready to receive or transfer the patient and that public are cleared from entrance and route that patient will be moved along.
• During the movement of the patient, ensure that all spills are immediately cleaned and decontaminated on the route that patient was moved.

1.4 Cleaning and decontamination

• Crew decontaminating the ambulance should wear correct PPE.
• During or after transport of a 2019-nCoV patient, vomitus, blood and other spillages should be flooded with disinfectant, namely chlorine solution with a concentration of 5000 ppm (0.5%) or 20x30g sachets of Biocide D Extra/10L water, covered with paper towels or absorbent material and left for at least 30 minutes before cleaning.
• Never use high pressure jet spray inside confined space of ambulance.
• Physical material like blood and vomitus must first be cleaned up and removed before terminal cleaning can start.
• All surfaces should be wiped down and washed at least two times, with 500 ppm (0.05%) chlorine solution. Vehicle is ready to use again immediately after cleaning.
• Containers with secretions, excretions and other waste products such as vomitus and blood should be flooded with a copious amount of disinfectant, namely chlorine solution with a concentration of 5000 ppm (0.5%) or 20x30g sachets of Biocide D Extra/10L water, for at least 30 minutes.
• All items leaving the ambulance should be enclosed and sealed in adequate layers of appropriate bags to prevent leakage. The outer surfaces of the bags should be wiped with chlorine disinfectant at a concentration of 0.05% (500 ppm) and labelled as bio hazardous. Disposable equipment should be disposed of by incineration (as per normal Health Care Waste Management (HCWM) Regulation Act 59, 2008), non-disposable equipment can be washed and disinfected (Autoclaved).
• If sharps bin, for any reason, was used it needs to be wiped down and placed inside plastic bag. Bag is wiped again and placed inside double red bag and sealed in waste box that should then be clearly marked as containing sharps.

1.5 Handling of Health care waste

• As per normal HCWM Regulation, ensure that waste is safely stored until the health care waste management company can pick it up. Ensure that the company knows and acknowledges that waste was generated by suspected or confirmed 2019-nCoV case.
• All bags, bins and boxes must be adequately sealed, as not to leak any fluids, and must be wiped down with 0.05% chlorine solution before being stored or removed.

1.6 Handling of Suspected or Confirmed 2019-nCoV case mortal remains.

• If patient dies in transit, the EMS Provincial coordinator and Provincial CDC must be notified. A decision on where to take the corpse must be communicated to the ambulance crew.
• Provincial Environmental Health must be informed.
• Under no circumstances will the corpse be removed from ambulance other than at assigned facility that was communicated to ambulance crew.
• The corpse must be placed in double body bags that are fluid leak proof. The bags must be wiped down with a 0.05% chlorine solution before leaving the ambulance.
• The removal of a suspected 2019-nCoV corpse must be done under the directive of Environmental Health
Annexure 5.1:
Flow diagram depicting the approach to an imported possible/suspected or confirmed case of infectious disease at PoE

Suspected Case from an Incoming Conveyance

Patient or other passengers informs flight attendant who informs conveyance operator
Crew moves suspected patient to isolated area
Suspected patient is given a facemask to put on

Tower/Agent informs Port Health Officer (PHO)

PHO informs NICD of suspected case

PHO contacts emergency medical Services (EMS) and designated hospital for patient referral

Port Health Officer notifies Provincial Communicable Disease Control Coordinator (CDC)

Upon arrival of conveyance, PHO facilitates assessment of passenger and contacts on the conveyance prior to their disembarkation

PHO identifies all close contacts, facilitates completion of passenger locator cards and allows contacts to disembark

CDC coordinator monitors contacts utilising information provided by port health

Where cleaning and/or disinfection is required, PHO must inform the cleaning/ground handling company and monitor the process

Confirmed Case/Intentional transportation

Evacuation/airline Company informs PHO prior to transfer of case

PHO informs NICD and the Regional Port Health Director about the request and takes a decision

Following acceptance, PHO communicates decision to medical company

Upon arrival of conveyance, PHO and Nurse must assess the patient and inform receiving hospital

PHO must communicate passenger information to Provincial Communicable Disease Control
Annexure 5.2:

The flow diagram depicts the process flow for the management of a suspected or possible case from a country/area reporting outbreak of contagious infectious disease.

**Incoming Vessel**
- Patient or other passengers informs captain/crew
- Crew moves suspected patient to isolated area
- Captain reports illness to Harbour

**Incoming Road/Rail**
- Traveller informs driver/port health on arrival

**Captain or clearing agent informs Port Health Officer (PHO)**
- PHO contacts Emergency Medical Services (EMS) and designated hospital for patient referral and notifies Provincial/District CDC

**PHO facilitates assessment of passenger and contacts on the vessel prior to their departure from the harbour**

**CDC coordinator monitors contacts utilising information provided by port health**

**If close contacts develop signs and symptoms, refer to designated health facility**

**Where cleaning and/or disinfection is required, PHO must inform the cleaning/handling company and monitor the process**
Annexure 6: Guidelines for the safe handling of human remains of confirmed/suspected 2019-nCoV case and Repatriation of Human Remains of a Person Who Died of Confirmed/Suspected 2019-nCoV

- The human remains of a person who has died of a confirmed 2019-nCoV should be cremated.
- Where cremation is not possible, the repatriation of human remains who died of confirmed/suspected 2019-nCoV must be conducted in line with the Regulations Relating to the Management of Human Remains (Regulation 363 of 22 May 2013).
- A formal request for an import/export permit issued by the Director-General: Health must be made by the Department of International Relations and Cooperation (DIRCO) or through the embassies, prior to importation/exportation of the human remains.
- Once a permit has been issued by the Director-General, the human remains may be transported.
- The human remains must not be embalmed and shall be transported under the following precautions:
  - Be placed in leak proof triple body bag and in a non-transparent sealed coffin,
  - The first two body bags must be transparent and sealed and the third body bag non-transparent and not sealed
  - After the body has been placed in the triple body bag, the remains must be placed in a non-transparent coffin which is lined with 5cm saw dust to prevent any potential leakages.
- The import/export permit, death certificate and written declaration by an institution responsible for packaging the human remains that transportation of human remains will not constitute a health hazard must accompany the human remains at all times.
- No person must open the coffin or remove the human remains after they have been sealed without prior approval from an Environmental Health Practitioner.

In the case of importation;

- Environmental Health Practitioner at a point of entry must inform forensic pathology of the arrival of the human remains for transportation to a mortuary of the designated hospital.
- Environmental Health Practitioner at a point of entry must monitor the removal of the remains from the conveyance to the forensic pathology vehicle.
- Environmental Health Practitioner at a Municipal level must monitor the handling of the human remains after arrival at the designated mortuary.

In the case of exportation;

- The human remains must be transported from the mortuary of a designated hospital to the point of entry by Forensic Pathology in consultation with the embassy of which the deceased holds residence.
- Environmental Health Practitioner at a Municipal level must monitor the handling of the human remains at the designated mortuary.
- Environmental Health Practitioner at a point of entry must monitor the removal of the human remains from the forensic pathology vehicle to the conveyance.
Management (handling, movement, storage and burial) of human remains of a person who died of 2019-nCoV

- Handling of the Human Remains must be strictly monitored by **Environmental Health Practitioners** throughout the process.
- Human remains shall be placed in a leak proof triple body bag both first two bags shall be transparent and sealed while the third one shall be non-transparent and unsealed.
- After the body has been placed in the triple body bag, the remains must be placed in a non-transparent coffin.
- The human remains must be transported in a manner that is in compliant with the provisions of the Regulations Relating to the Management of Human Remains.
- The Human remains are considered contagious and should be kept only in designated health facilities’ mortuaries.
- Human Remains can only be transferred from one designated facility to another designated facility or from such to a cemetery or crematorium.
- Under no circumstances shall the human remains be directly handled, whether for aesthetic, hygiene preparations, cultural or religious reasons.
- The human remains may not be embalmed or viewed by breaking the seals of first two bags but by opening the third bag.
- Where it is feasible and acceptable to family culture and/or religion, it is strongly recommended that the remains be cremated.
- In all cases, remains should not be kept in households for vigil or any purpose but be kept in designated health facility mortuary premises and directly transported from designated health facility mortuary straight to place of burial or cremation or the home on the day of burial/cremation.
- The body should be buried in a sufficiently deep grave to prevent access by rodents and carnivores.

- Human remains shall be placed in a triple body bag both first two bags shall be transparent and sealed while the third one shall be non-transparent and unsealed zip-up body bag with handles and appropriate BIOHARZARD warning tag written "hazard Group 4 Pathogens" before transporting to designated health facility mortuary.
Annexure 7: Communicable Disease Outbreak Report format

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<th>LOCATION</th>
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Executive summary

I. Introduction:
- Background
- Reasons for investigation (public health significance, threshold met, etc.)
- Investigation and outbreak preparedness

II. Methods:
- Dates of investigation
- Site(s) of investigation (health care facilities, villages, other)
- Case finding (indicate what was done regarding case finding, e.g., register review, contact investigation, alerting other health facilities, other)
- Lab specimen collection
- Description of response and intervention (include dates)
- Data management

III. Results:
- Date and location of first known (index) case
- Date and health facility where first case was seen by the health care system
- Results of additional case finding
- Lab analysis and results
- With text, describe key features of results of time, place, and person analysis
- For detailed results by time (epi curve), place (map), and person characteristics (tables) and line lists
- Results of response and evidence of impact

IV. Self-evaluation of the timeliness and quality of preparedness, outbreak detection, investigation, and response

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<td>Were treatment protocols available to health workers?</td>
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<td>Does the district epidemic management committee regularly meet as part of epidemic preparedness?</td>
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<td>Interval between onset of index case (or occurrence of an unusual cluster at the community level) [date 1] to arrival of first outbreak case at the health facility [date 2] (Target: &lt;3 days)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Interval between initial outbreak case seen at the health facility (or date of outbreak threshold crossing at the health facility) [date 1] and reporting to the district health team [date 2] (Target: within 24 hours)

Cumulative interval between onset of index case (or occurrence of an unusual cluster at the community or health facility) [date 1] to notification to the district [date 2] (Target: <7 days)

### Outbreak investigation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Were case forms and line lists completed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were laboratory specimens taken (if required)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval between notification of district [date 1] and district field investigation conducted [date 2] (Target: within 48 hours)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Interval between sending specimens to the lab [date 1] and receipt of results by the district [date 2] (Target: 3-7 days, depending on type of test)</td>
<td></td>
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</table>

### Outbreak response:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval between notification of outbreak to district [date 1] and concrete response by the district [date 2] (Target: within 48 hours of notification)</td>
<td></td>
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</tbody>
</table>

### Evaluation and Feedback:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval between end of the outbreak [date 1] and finalization of outbreak report with case forms/line list sent to national level [date 2] (Target: 2 weeks)</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the outbreak management committee meet to review investigation results?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was feedback given to health facilities and community?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### V. Evaluation of other aspects of the response:

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........................................................................................................................................................................................................................................................................................................

### VI. Interpretations, discussion, and conclusions:

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........................................................................................................................................................................................................................................................................................................

### VII. Recommended public health actions:

Comment on following levels: community, health facility, district, partners, provincial, and national

........................................................................................................................................................................................................................................................................................................

........................................................................................................................................................................................................................................................................................................

District Epidemic Committee Chairperson:

Name: _____________________________________________________

Signature: ___________________________________________________

Date report completed: ________________________________________
# Annexure 8: Contact list

## Provincial CDC, NICD Epis, NICD Hotline, Lab, Designated hospitals, Provincial Port Health, Provincial EMS

<table>
<thead>
<tr>
<th>Institution/Province</th>
<th>Name</th>
<th>Email address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Department of Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicable Disease Control</td>
<td>Tsakani Furumele</td>
<td><a href="mailto:Tsakani.Furumele@health.gov.za">Tsakani.Furumele@health.gov.za</a></td>
<td>012 395 8096 / 0824199686</td>
</tr>
<tr>
<td>Malaria, Vector-borne and Zoonotic Diseases</td>
<td>Devanand Moonasar, Wayne Ramkrishna</td>
<td><a href="mailto:Patric.Moonasar@health.gov.za">Patric.Moonasar@health.gov.za</a>, <a href="mailto:Wayne.Ramkrishna@health.gov.za">Wayne.Ramkrishna@health.gov.za</a></td>
<td>082 578 3107, 082 317 4687</td>
</tr>
<tr>
<td>Port Health</td>
<td>Funeka Bongweni</td>
<td><a href="mailto:Funeka.Bongweni@health.gov.za">Funeka.Bongweni@health.gov.za</a></td>
<td>012 395 9728 / 0609930107</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>Murdoch Ramathuba</td>
<td><a href="mailto:Murdoch.Ramathuba@health.gov.za">Murdoch.Ramathuba@health.gov.za</a></td>
<td>012 395 8518 / 0814150093</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Keneilwe Modise</td>
<td><a href="mailto:Keneilwe.Modise@health.gov.za">Keneilwe.Modise@health.gov.za</a></td>
<td>012 395 8257 / 0829648888</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>Ronel Steinhobel</td>
<td><a href="mailto:Ronel.Steinhobel@health.gov.za">Ronel.Steinhobel@health.gov.za</a></td>
<td>012 395 9198 / 0836275661</td>
</tr>
</tbody>
</table>

| **Provincial Communicable Disease Control Directorate** | | | |
| Eastern Cape | Thomas Dlamini, Nosiphiwo Mgobo | thomas.dlamini@echealth.gov.za, Nosiphiwo.Mgobo@echealth.gov.za | 083 378 0189, 060 579 9027 |
| Free State | Dikeledi Baleni, Babsy Nyokong | balenid@fshealth.gov.za, nyokongb@fshealth.gov.za | 083 757 8217, 082 463 7499 |
| Gauteng | Chika Asomugha, Caroline Kesebilwe | Chika.Asomugha@gauteng.gov.za, Caroline.kesebilwe@gauteng.gov.za | 082 330 1490, 083 490 8165 |
| KwaZulu-Natal | Premi Govender | premi.govender@kznhealth.gov.za | 071 609 2505 |
| Limpopo | Marlene Freda, Ngobeni Mashudu P. Mudau | Marlene.Ngobeni@dhspd.limpopo.gov.za, Prudence.Mudau@dhspd.limpopo.gov.za | 079 491 1909, 071 678 3864 |
| Mpumalanga | Mandla Zwane, Hluphi Mpangane | MandlaZw@mpuhealth.gov.za, hluphim@mpuhealth.gov.za | 082 229 8893, 076 522 8511 / 013 766 3411 |
| North West | Chiseldah Lebeko | clebeko@nwpg.gov.za | 082 421 7985 |
| Northern Cape | Gloria Hottie | hottieg@webmail.co.za | 072 391 3345 / 053 830 0529 |
| Western Cape | Charlene Jacobs | Charlene.Jacobs@westerncape.gov.za | 072 356 5146 / 021 483 9964 |

| **Port Health and Environmental Health** | | | |
| Central Region (Gauteng, Free-State, Northern Cape) | Funeka Bongweni | Funeka.Bongweni@health.gov.za | 012 395 9728, 060 993 0107 |
| Northern Region (Limpopo, Mpumalanga, North West) | Ockert Jacobs | Ockert.Jacobs@health.gov.za | 012 395 9417 / 082 372 0556 |
| Coastal Region (KwaZulu Natal, Northern Cape, Western Cape) | Antoinette Hargreaves | Antoinette.Hargreaves@health.gov.za | 031 301 0381, 083 460 0935 |

| **Emergency Medical Services (EMS)** | | | |

| **National Institute for Communicable Diseases (NICD)** | | | |
| Hotline (24-hours) | Doctor-on-call | | 082 883 9920 |
| Outbreak Response Unit | Ann Mathews | annm@nicd.ac.za | 066 0463581 |
| Laboratory | Jacqueline Weyer, Kerrigan McCarthy | jacquelinew@nicd.ac.za, kerriganm@nicd.ac.za | 082 903 9131, 0798717278 |

<p>| <strong>Designated Hospitals</strong> | | | |
| Eastern Cape: | | | 041 405 2255 |</p>
<table>
<thead>
<tr>
<th>Region</th>
<th>Hospital</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Free State</td>
<td>Livingston Hospital</td>
<td>051 405 1911</td>
</tr>
<tr>
<td></td>
<td>Pelonomi Hospital</td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>Charlotte Maxeke Hospital</td>
<td>011 717 1000</td>
</tr>
<tr>
<td></td>
<td>Greys Hospital</td>
<td></td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td></td>
<td>033 897 3000</td>
</tr>
<tr>
<td></td>
<td>Greys Hospital</td>
<td></td>
</tr>
<tr>
<td>Limpopo</td>
<td>Polokwane Hospital</td>
<td>015 287 5000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>Rob Ferreira Hospital</td>
<td>013 741 6100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>Klerksdorp Hospital</td>
<td>018 406 4600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Cape</td>
<td>Kimberley Hospital</td>
<td>053 802 9111</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Cape</td>
<td>Tygerberg Hospital</td>
<td>021 938 5454</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Provincial EMS Managers

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Contact Details</th>
<th>Contact Persons</th>
</tr>
</thead>
</table>
| NDOH: EMS & Disaster Medicine Directorate | 012 395 9636 / 081 324 4555 012395 9636 / 073 571 6392 | Mr Raveen Naidoo (Director)  
Mr Ahmed Bham (EMS Ops Manager – Disaster Medicine) |
| Gauteng                   | 011 564 2211 / 072 433 7450 011 564 2021 | Mr. J.P. Von Benecke  
Mr Kgati Malebane (Director EMS) |
| Western cape              | 012 937 0300 082 568 6489 / 021 948 9908 | Mr. Arthur van Heerden  
Dr S De Vries (Director EMS) |
| Kwazulu Nata             | 0834571242 083 501 1955 / 033 846 7237 | Mr M Mabaso  
Ms B Zungu (Director EMS) |
| Free State                | 0609856082 082 659 1600 / 051 408 1855 | Mr R Ruiters (Provincial EMS Ops Manager)  
Dr Joe Khoali (Director EMS) |
| North West                | 082 335 6034 / 018 473 0324 | Mr B Redlinghys (Director EMS) |
| Limpopo                   | 082 040 5494 082 440 0802 / 015 295 2999 | Mr F Masegela  
Dr Clive Sibanda (Director EMS) |
| Northern Cape             | 053 802 2280 / 053 831 1954/5 083 335 6034 / 053 831 2884 | Mr R. Dreyer  
Mr M Ntintelo (Director EMS) |
| Mpumalanga                | 013 753 2288/ 082 907 3256 013 766 3302 / 082 828 6223 | Mr. Scosh Mkhonto  
Mr Zungu (Director EMS) |
| Eastern cape              | 060 572 9172 / 060 572 9172 | Mr AK Munilili (Director EMS) |