



Ministry of Health and Child Care

In partnership with

Zimbabwe Evidence Informed Policy Network

Mandatory COVID-19 Related Institutional Quarantine for Returning Residents in Zimbabwe

A Rapid Response Brief

To establish recommended duration of mandatory institutional quarantine and other requirements for the mandatory quarantine of returning residents for effective prevention and control of COVID-19, in Zimbabwe and other low resource settings.

Background

Coronaviruses have always been part of the human and animal pathogens ecosystem. At the end of 2019, a novel coronavirus was identified as the cause of a cluster of pneumonia cases in Wuhan, a city in the Hubei Province of China. It rapidly spread, resulting in a global pandemic. The disease is designated COVID-19, which stands for coronavirus disease 2019. The virus that causes COVID-19 is designated severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2); previously, it was referred to as 2019-nCoV. Understanding of COVID-19 is evolving rapidly. Interim guidance has been issued by the World Health Organization and by the United States Centers for Disease Control and Prevention.

The World Health Organisation (WHO) declared COVID-19 a Public Health Emergency of International Concern (PHEIC) on the 30th January 2020, and on 11 March 2020 declared it a pandemic. The outbreak has continued to increase exponentially particularly in northern countries and states are considering options to prevent introduction of the disease to new areas, or to reduce human-to-human transmission in areas where the virus is already circulating (WHO, 2020). Several public health measures have been put in place in tackling the epidemic, key among them is quarantine, which involves the restriction of movement, or separation from the rest of the population, of healthy persons who may have been exposed to the virus, with the objective of monitoring their symptoms and ensuring early detection of cases. Minimising and stopping the spread of COVID-19 also requires finding and testing all suspected cases so that confirmed cases are promptly and effectively isolated and receive appropriate care, and the close contacts of all confirmed cases are rapidly identified so that they can be quarantined and medically monitored for at least the duration of the incubation period of the disease. WHO has stated that quarantine should be implemented as part of a comprehensive package of public health response and containment measures and, in accordance with Article 3 of the International Health Regulations (2005), be fully respectful of the dignity, human rights and fundamental freedoms of persons.

In Zimbabwe, the government has initiated medical mandatory quarantine in designated centres for all returning citizens as part of surveillance of COVID-19 for effective infection prevention and control. The quarantine of persons is the restriction of activities of or the separation of persons who are not ill but who may have been exposed to an infectious agent or disease, with the objective of monitoring their symptoms and ensuring the early detection of disease. Quarantine is different from isolation, which is the separation of ill or infected persons from others to prevent the spread of infection or contamination.

COVID-19 was first reported in Zimbabwe on the 21st of March 2020. By 22 April the number of cases had risen to 28, with 15 of them attributed to local transmission of the infection, and 13 being imported cases. The Government of Zimbabwe has put in place a whole-of-Government, whole-of-society national COVID-19 response effort. The national response is being overseen by an Inter-Ministerial Task Force that is chaired by Honorable Vice President KC Mohadi. On 17 March 2020, His Excellency the President of Zimbabwe declared a state of national disaster to ensure effective national response to COVID-19 pandemic. On 19th March 2020, His Excellency the President of Zimbabwe launched the National COVID-19 preparedness and response plan.

On 27th March, His Excellency the President of Zimbabwe announced the implementation of a 21-day total lockdown in the country covering the period 30 March 2020 to 19 April 2020. This has since been extended for 14 days to the 3rd of May 2020. This measure was instituted to promote social distancing. Statutory Instrument 83 of 2020, the Public Health (COVID-19 Prevention, containment and treatment) National Lockdown Order was promulgated and came into force on 28 March, 2020 followed by Statutory Instrument 93 of 2020, Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (Amendment) Order, 2020 (No.3).

Statutory Instrument 83 of 2020 provides for the quarantine of returning residents in any place for a period of 21 days. Since then some returning residents have been quarantined in various parts of the country. The 21 days was set based on observations in Zimbabwe where some people developed COVID-19 well-after 14 days of exposure to a case. The World Health Organisation recommends that contacts of patients with

laboratory-confirmed COVID-19 be quarantined for 14 days from the last time they were exposed to the patient.

Questions have been asked from many sectors why Zimbabwe has set duration of the mandatory quarantine at 21 days, and not the WHO-recommended 14 days. It is against this background that the ERA Zimbabwe platform (ERAZ) was requested to conduct rapid evidence synthesis and develop a rapid response brief to inform the Ministry of Health and Child Care on the recommended duration of the quarantine as the country develops its national guidelines for COVID-19 institutional quarantine.

Aim

To establish recommended duration of mandatory institutional quarantine and other requirements for exposed returning residents for effective infection prevention and control of COVID-19, in low resource settings?

Objectives

- To establish the recommended duration for mandatory institutional quarantine
- To inform Guidelines and Standard Operating Procedures for institutional and self-quarantine

Methodology

A search strategy was developed to gather the evidence to answer the question, “*What is the recommended duration of mandatory institutional quarantine for returning residents exposed to infectious disease for effective infection prevention and control of COVID-19, in low resource settings?*”? The understanding of COVID-19 is still evolving since the initial cases of the novel coronavirus were identified in China, in 2019. The PICO approach was used to identify the key elements of the question and the scope was widened to include other previous but similar pandemics as given in the table below (See search strategy in attached protocol). A total of two hundred and thirty-three records were identified through database searching and two additional records were identified from the Centre for Disease Control and World Health Organisation repository. Duplicated records were identified and eliminated. The exclusion and inclusion criteria was used for the screening process, fifty-six were identified to be eligible. The reason for exclusion included year of publication, settings and locations for the study, papers in English language were considered. A total of 22 studies were included in the review. (See Prisma table in attached protocol).

Recommended Considerations

- The decision to implement quarantine should take into account its effectiveness and should be used not only to directly prevent possible asymptomatic infections but also to screen out potentially infective persons and thus prevent secondary or even tertiary infections. Quarantine should be followed with prompt case detection. This requires testing of all returning residents even those not exhibiting symptoms. Quarantining is thus most successful in settings where detection of cases is prompt, contacts can be traced within a short time frame with prompt issuance of quarantine.
- Continuous follow up and testing after period of being quarantined is necessary following evidence that incubation period may be longer than 14 days. Evidence has also shown that if one gets COVID-19 through ingestion the incubation period is longer. Given resource constraints in accessing test kits, the quarantine may be prolonged to reduce the cost of follow up testing and given some evidence that incubation can be up to more than 14 days. A minimum of 21 days of quarantine have a success of detecting cases at 98.3%. So Zimbabwe should continue with 21 days of quarantine.
- Evaluation of potential sites for institutional quarantine is important for preparedness and planning, which identifies facilities, staffing, training and reporting and recording mechanisms. The facilities should make every possible effort to quarantine persons individually.

- Personal protective equipment (PPE) in quarantine institutions should be provided for both quarantined persons and Staff who have close contact with quarantined individuals. Where feasible, PPE must be based on local supply, feasibility, and safety within the scope of duties and activities.
- Psychosocial support should be provided to quarantined persons before, during and after the quarantined persons.
- There should be national guidelines for both institutional and self-quarantine. These should inform information kits that must be distributed to every individual who will be quarantined
- Quarantine can be done at the cost of returning citizens. Self-quarantine will require strict surveillance for adherence to quarantine guidelines.

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