



**Progress Report for the Implementation of the  
COVID 19 Response Plan  
WHO Tanzania Country Office**

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The WHO Country Office response plan has supported the country to reduce the burden associated with the health threats associated with COVID-19 in terms of mortality and morbidity reduction, hospitalization and demand for health care goods and services; maintaining essential services, protecting vulnerable groups (such as women, girls and children) and minimizing health, economic and social impacts in the long term. We express our gratitude to all those who supported the development and implementation of the plan, including our WHO sub-regional, regional and head Quarters colleagues.

## Acronyms

AFRO	Africa Regional Office
AMREF	African Medical and Research Foundation
BMF	Benjamin Mkapa Foundation
CDC	Centers for Disease Control
CHWs	Community Health Workers
CIF	Case Investigation Forms
CORPs	Community Owned Resource Persons
DFID	Department for International Development
EAC	East African Community
ETU	Emergency Treatment Unit
EVD	Ebola Virus Disease
FAQ	Frequently Asked Questions
FELTP	Field Epidemiology and Laboratory Training Program
HAI	Health Associated Infections
HCWM	Health Care Waste Management
HIDTU	Highly Infectious Disease Treatment Units
HMT	Health Management Teams
IHR	International Health Regulations
IOM	International Organization for Migration
IPCAT2	Infection Prevention and Control Assessment Tool 2
IPC	Infection Prevention and Control
KAP	Knowledge Attitude and Practice
KJPH+	Kigoma Joint Programme for Health plus
MOH	Ministry of Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MUHAS	Muhimbili University of Health and Allied Sciences
NHLQATC	National Health Laboratory and Quality Assurance and Training Centre
NIMR	National Institute for Medical Research
NTF	National Task Force
PHEOC	Public Health Emergency Operations Center
PHIEC	Public Health Emergency of International Concern
POE	Points of Entry
PCR	Polymerase chain reaction
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
PORALG	President's Office for Regional Administration and Local Government
RHMTs	Regional Health Management Teams

RRT	Rapid Response Teams
SOPs	Standard Operating Procedures
TMDA	Tanzania Medicine and Drug Authority
ToTs	Trainer of Trainers
UNICEF	United Nations Children’s Fund
	United Nation High Commissioner for Refugees
UNHCR	
USAID	United States Agency for International Development
	Water Sanitation and Hygiene
WASH	
WCO	WHO Country Office
WHO	World Health Organization

## 1. Executive Summary

The WHO Country Office COVID-19 Response plan was developed to support the preparedness and response activities of COVID-19 in the United Republic of Tanzania. The strategic measures to contain the pandemic was based on the following pillars in line with the International Health Regulations (IHR): coordination, surveillance, Infection Prevention and Control (IPC) and WASH, Risk Communication and Community Engagement (RCCE), case management and laboratory sampling and testing and logistics. Surge teams were mobilized and deployed from the WHO Regional Office in Africa in the areas highlighted above including incident management. All interventions were in support of the prioritized activities as laid down in the national preparedness and response plan for COVID-19 response.

The principle of 'Leaving No One Behind' and social and gender inclusion was applied throughout the six-month period to ensure an intersectional gender-responsive approach to this crisis and the ensuing recovery measures in future. The technical support focused on strengthening capacities of both right-holders and duty bearers at the national level and at the sub-national level.

WHO continued to collaborate with partners to support the Government to ensure the employment of appropriate policies for containment of the outbreak in line with the WHO generic guidelines on COVID-19. Some of the major activities that took place during this period included: the reactivation of the national task force (NTF) for coordination, cascading relevant trainings in the districts, review of the new isolation policy and treatment facilities, adaptation of the SOPs and continued prepositioning of the required supplies.

The report records major strides made in all the emergency pillars. It also points out challenges observed and areas wanting improvement. Rapid Response Teams (RRTs) from several regions in mainland Tanzania and Zanzibar were oriented on event-based surveillance, contact tracing and follow-up and Integrated Disease Surveillance and Reporting (IDSR). Standard Operating Procedures (SOPs) for case and contact identification, active case search, contact tracing and follow-up and alert management are among the tools developed. Capacity building and mentorship of different target groups in the area of surveillance was a major area addressed in the COVID-19 response. This included orientation of surveillance officers and clinicians on surveillance contact tracing of COVID-19. Field Epidemiology and Laboratory Training Program (FELTP) graduates and residents were deployed to support COVID-19 this activity in several regions in the country. The WHO Country Office facilitated Cross border surveillance and coordination meetings among the East African Community countries to develop joint operational procedures. One of the challenges observed in surveillance was the non-availability of detailed data related to the pandemic from the national authorities to enable an in-depth analysis which would inform strategic response plans.

Using a phased approach, over 900 laboratory practitioners from 21 regions in mainland Tanzania were trained on hands on training techniques for collection of COVID-19 samples, packaging, transformation as per International Air Travel Association (IATA) regulations amongst other aspects such as biosafety and biosecurity issues including Infection Prevention and Control (IPC). Several reagents and supplies for enabling COVID-19 testing were donated to the National Health Laboratory and Quality Assurance and Training Centre (NHLQATC). These include a PCR machine, RNA extraction kits, master mix, primers and probes amongst others. In Zanzibar, The Country Office has facilitated the installation of a high throughput Abbott automation system at the referral hospital – Mnazi Mmoja. In terms of challenges, optimal collaboration with the NHLQATC in the laboratory pillar has been lacking.

The WCO facilitated the development of public awareness messages on COVID-19. Multiple fronts were covered including mode of transmission, signs and symptoms, treatment seeking behavior, comorbidities, preventive measures, mental health and stigma. It is estimated that around 312 radio stations and 130 television channels across the country have been broadcasting public awareness messages against COVID-19 with about 2 radio and 1 television broadcasts being disseminated daily. One radio broadcast is estimated to reach 450,000 listeners while a television broadcast reaches 210,000 viewers at a time. Dissemination was nationwide through mainstream media, social media, mobile van and mobile phones. This translated into increased community awareness and practice on protective behaviours against COVID-19. Journalists, being a key vehicle for disseminating information to the public were trained on how the media could help to combat COVID-19 by tackling misinformation and promoting advice by the health authorities. This led to wide broadcasting of COVID prevention messages reaching approximately 4 million people in Zanzibar and Kigoma.

The National Call Centre, also known as “Afya Call Centre”, with the capacity to respond to 1,000 calls at any one time and connected to 5,000 other satellite Call Centers from regions and districts, was launched on 8<sup>th</sup> May 2020 by the Honorable Minister of Health with the aim to strengthen sensitization, health education, and provision of health advice on various health related issues including COVID-19. WHO has contributed to the operations of the Call Centre through providing technical responses to the compiled COVID-19 Frequently Asked Questions (FAQs). One of the challenges observed in the rea of RCCE was the lack of regular information on-sub-national activities in the regions and districts which would inform the national team to provide targeted technical support. Another observation made was the delay in the approval of messages developed and mixed messaging from the high level national authorities on various issues proved to be a major constraint. This has compromised the implementation of public health measures.

The WCO facilitated an assessment of the readiness to effectively triage, isolate and treat COVID-19 patients taking all IPC precautions into account in 141 health facilities in mainland Tanzania and Zanzibar. The major gap observed was the lack of IPC focal persons or



committees, non-functional triage points, lack of isolation rooms, absence of SOPs and posters, poor waste segregation and lack of monitoring and resuscitation equipment for patients with respiratory symptoms. Mentorship on Case management and IPC was done after the assessment directed to the gaps identified. Assessment of IPC core components at national level was also conducted using the nationally developed tools as well as WHO's Instruction for the national infection prevention and control assessment tool – 2 (IPCAT-2) standardized tool. The other critical assessment conducted by the pillar was on oxygen supply for facilities managing COVID-19 patients. A rapid assessment was conducted of the capacity for production, distribution and use of oxygen across all the regions in mainland.

In terms of strengthening the surge capacity, WHO provided technical and financial support for the conversion of two halls of the Saba Saba Trade Fair in Dar es Salaam into COVID 19 surge facilities with the capacity of 550 beds. The facility was refurbished and handed over to the Ministry of Health.

Some of the challenges observed in case management and IPC included lack of PPEs and other essential equipment and supplies for standard precaution, which impairs the care of the patients and staff safety, inadequate number of trained staff to be able to effectively provide care for EVD and COVID, inadequate capacity for screening triaging and isolation in most of the health facilities. Cascade mentorship is needed to cover all the facilities, limited capacity in terms of skills, knowledge, equipment and supplies in supporting critical care. This includes limited production, distribution and use of Oxygen.

The WCO supported mainland Tanzania and Zanzibar to purchase various equipment, laboratory reagents, medicines and medical supplies in order to effectively manage the COVID-19 response. The range included ventilators, hand sanitizers, masks, laboratory kits and reagents to mention a few. Furthermore, an ambulance was purchased to facilitate COVID-19 surveillance activities such as the rapid transfer of suspects to the health facilities. Capacity building of pharmaceutical and logistic staff was also carried out on the management of essential medicines and health products during emergencies.

The major challenges in the logistics pillar were the delays from local and some international suppliers as they were unable to supply all items within the agreed time , global challenges on air freight and access to medicines and health products due to global lockdown from March to July 2020 and inadequate funding to support all the supplies needed and other logistics and operational activities.

## **2. COVID-19 Background**

Following the outbreak of COVID 19 in WUHAN in the Peoples Republic of China in December 2019, WHO classified Tanzania as one of the four countries in East Africa that were at high risk for importation of the disease given the close interaction and flow of people between China and Tanzania. A standard package of readiness activities was instituted for the country, this was reflected in the WHO Country Office (WCO) six-month COVID 19 preparedness and response plan developed in January 2020 and later transformed into a response plan in March 2020. The package of readiness includes among others; coordination, surveillance, laboratory, case management and IPC, risk communication and community engagement (RCCE) and Logistics.

To support capacity building on COVID 19 preparedness, WHO repurposed the country office team to provide technical advice in key pillars. Surge teams were mobilized and deployed from the Regional Office in Africa in the areas highlighted above including incident management. All interventions were in support of the prioritized activities as laid down in the national preparedness and response plan which was reviewed in January 2020 to cover a period of six months from January – June 2020.

During this period several districts were prioritized for strengthening preparedness. Significant progress has been made since the commencement of the implementation of activities. Key among the achievements include constitution and training of Rapid Response Teams (RRTs) on COVID 19 management; review of training materials and training of key staff in various areas of readiness. Training of trainers took place centrally with the aim of cascading this to high risk districts. Procurement and facilitating the availability of the required COVID 19 supplies were undertaken with support from various partners. To improve monitoring of the cases, WHO deployed staff to the Public Health Emergency Operations Center (PHEOC) and worked hand in hand with the PHEOC manager. The standard operating procedures (SOPs) for the response have been finalized and will be disseminated as soon as senior management clears the draft. WHO continues to collaborate with partners to support the Government to ensure appropriate policies for containment of the outbreak are employed by supporting resumption of the national task force (NTF) for coordination, cascading the relevant trainings in the districts, review of the new isolation policy and treatment facilities, adaptation of the SOPs and continue prepositioning the required supplies. The logistics team worked with the MOH to constitute mobile Emergency Treatment Units (ETUs) for deployment anywhere in the country when required.

### 3. Implementation progress

#### 3.1 Pillar: Coordination and Leadership

##### 3.1.1 Strategic Planning and Management

The Coordination and Leadership pillar is responsible for overall management of the COVID19 response and provides strategic leadership and day-to-day oversight and management of the response. To guide the management of the COVID-19 response, WHO provided technical guidance to the Ministry of Health in the development of the National COVID – 19 Contingency Plan and a 72 Hours response plan for COVID – 19.



COVID—19 Response Incident Manager at WHO Tanzania, Dr. Grace Saguti presenting at the first National Task Force Meeting convened by the Ministry of Health, Community Development, Gender, Elderly and Children, after Tanzania reported the first case of COVID-19, March 2020

##### 3.1.2 Mentorship and training

The WCO facilitated the training of ToTs for the National Rapid Response Teams (RRT) trainers for containment of COVID – 19 from the 17<sup>th</sup> – 21<sup>st</sup> February 2020. This included the development of tools for RRTs; terms of reference and rapid risk assessment tool. The number of regions in which the TOTs took place were 4 (Mbeya, Kilimanjaro, Arusha and Mwanza) where four teams of five officers per council were trained at regional level (a total of 20 officers) to conduct cascade training in the regions. Subsequently, the trainings were conducted in these four regions whereby 80 staff (20 from each region) were trained between 24<sup>th</sup> February and 10<sup>th</sup> March 2020. These were regional health management teams (RHMT), Point of entry officers, regional and council surveillance officers, laboratory experts and clinicians and logisticians from respective regions and councils. Rapid Response Teams (RRTs) are a key component of the

response coordination at all levels. The trained RRTs in respective regions and councils have been useful for the preparedness and response to assist coordination as well as technical capacity for rapid investigation and response. The focus of this training was also to have TOTs to build more teams and enhance capacity building for responders in other technical areas.

### 3.1.3 Situation analysis and support supervision



COVID—19 Response preparedness assessment in Kilimanjaro, March 2020

To better understand the situation in the field, supportive supervision visits were jointly organized by the MOH and WHO from the 17th - 28th February 2020 in five regions ; Dar es salaam, Mbeya, Kilimanjaro, Arusha and Mwanza focusing on the RHMTs to assess and guide them on emergency coordination, management of POE located in their regions, case management and readiness in Infection prevention and Control (IPC). The teams also assessed health facilities for availability of isolation and treatment facilities of COVID – 19 cases. Among the regions visited, Dar es salaam, Mwanza and Kilimanjaro were the only ones which had appropriate standard isolation facilities. In addition, the gaps in appropriate equipment and supplies for the response were established. It was observed that all regions had a shortage of Personal Protective Equipment (PPE). Infection prevention and control practices in health facilities and at POE were also found to be limited.



Participants follow presentations during of assessment of preparedness of COVID-19 in Mwanza region, initially identified as one the six high risk regions for possible importation of cases March 2020

### 3.1.4 Table top simulation

Technical support was provided for a simulation exercise through the adaptation of a Table-Top exercise. This entailed adaptation of the facilitators guide and participants guide and exercise scenarios. The exercise plan was developed, and an Exercise Management Team was established as a first and important step for conducting simulation exercises at national level. This task was conducted in Dar es salaam from the 12th to 13th March 2020.

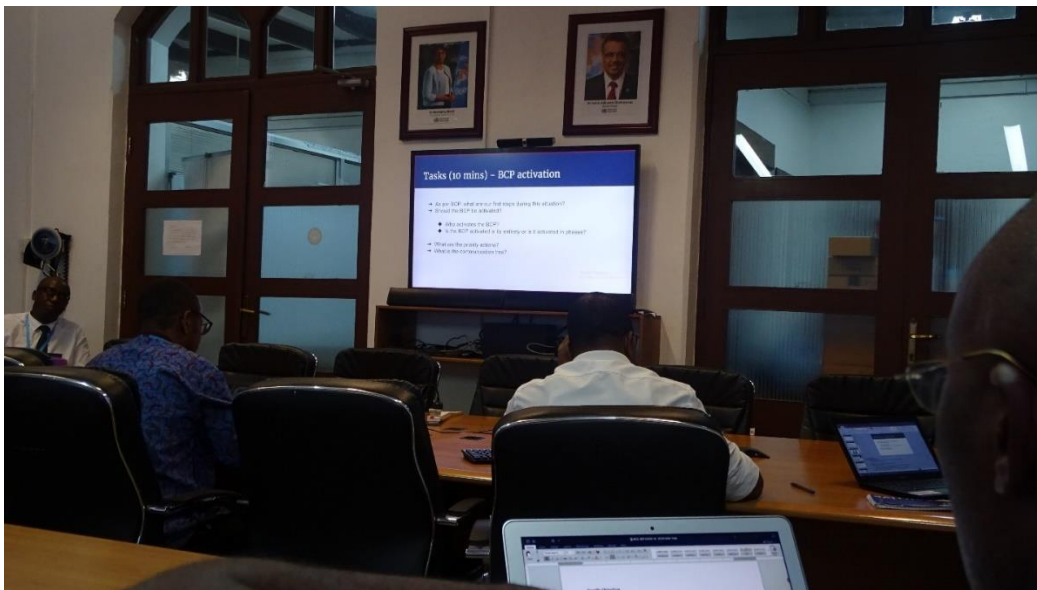


Table-top simulation exercise for Rapid Response Teams in Kilimanjaro, Arusha, Mwanza and Mbeya , March 2020

At the regional level tabletop simulation exercises were conducted by participants of the RRT training in all the 4 regions of Kilimanjaro, Arusha, Mwanza and Mbeya that were covered in RRT training. The scenario used was adapted from WHO Tabletop simulation exercise scenario

for COVID–19 covering coordination, surveillance, infection prevention and control, case management, risk communication and coordination of the response. These exercises were supervised by National trainers.

### **3.1.5 Response to the first COVID 19 case**

In response to the first case of COVID – 19 that occurred in Arusha on the 16<sup>th</sup> March 2020, WHO deployed 3 technical staff for 10 days to support the initiation of the response and conduct case investigation of this first case. The team strengthened the regional coordination, case investigation and initiated all technical response interventions. It also assisted in the development of the Arusha Regional COVID – 19 response plan, key SOPs for surveillance and response that were later adapted at national level as national SOPs.



WHO Emergency Response staff and MOHCDGEC staff inspecting a construction of COVID—19 treatment centre at Mount Meru Regional Hospital in Arusha, March 2020

### **3.1.6 Strengthening the human resource capacity**

The WCO also invested in strengthening the human resource capacity for the response. The office recruited a technical expert for one month in February 2020 as the Incident Manager to support the coordination of preparedness activities. It further deployed six consultants beginning February 2020 to date to support the response. The expertise deployed include; a surveillance officer (1), a laboratory technologist (1) clinical/case management experts (2) and infection prevention and control experts (2), and WHO staff within the office that have been supporting the implementation of activities related to the containment of the outbreak in Tanga, Dar es salaam, Mwanza, Lindi, Arusha, Kilimanjaro, Pwani and Zanzibar for an average of 10 days to a maximum of 2 weeks. Two Surge staff supported Tanga region for 6 weeks to enhance surveillance and to slow transmission. Five staff were deployed to and stationed at Zanzibar to

support surveillance, Case management, IPC and Coordination for a 3-month period. Additional 6 staff were deployed to Zanzibar on 31 May to support coordination, case management and IPC and Surveillance.

### **3.1.7 Establishment of a new Public Health Emergency Operating Centre (PHEOC)**

The Country office facilitated the establishment of a fully equipped and functioning new PHEOC at the National Institute for Medical Research (NIMR), Dar es Salaam. A WHO officer was deployed to provide technical support at the PHEOC. The officer's responsibility was to assist in liaising with partners on information collection, and to provide support in documentation and in data management. The PHEOC was supported to operate in full activation or level III to enable coordination of stakeholders' involvement in response, resource mobilization and tracking and coordination of information by addressing all mechanisms of timely and accurate information gathering, analysis, sharing and feedback. Also, to organize different sectors, agencies that are involved in response to link with the Government at all levels to enable collaborative planning and monitoring of resources and interventions and to facilitate timely decisions making.

The EOC is also useful in facilitating the NTF meetings and NTF sub committee meetings. Two National task force meetings took place in February and March 2020 and three coordination meetings in April and May 2020.



The National Emergency Operation Centre in Tanzania participating in a cross border simulation with other EOCs in Africa, March 2020

In Zanzibar, WHO supported four officials of the PHEOC for a study tour in Dodoma to acquaint them with the operations of PHEOC. The main objective of the trip was to share PHEOC experiences among the PHEOC staff in Tanzania Mainland and Zanzibar. The main



WHO Liaison Officer in Zanzibar, Dr Ghirmay Andemichael, donating, on behalf of WHO, PHEOC equipment and office materials to MoH Director General, Dr Jamala Taib, March 2020

accomplishment of the peer visit was the acquisition of knowledge and skills on PHEOC operations. Coincidentally, the Zanzibar PHEOC team also participated in the simulation drills conducted by WHO AFRO region for 15 countries. They equally attended the Ebola national task force meeting during the peer visit. Some recorded challenges during the peer visit include limited time to conduct all the planned activities and competing priorities by the PHEOC Dodoma.

To further support the operationalization of the PHEOC, WHO procured office equipment and information technology (IT) equipment to facilitate digitalization of information and communication and data sharing. Office equipment procured include office tables, conference tables, and office seats/chairs while IT equipment are In-Focus monitors, laptops and desktop computers. These materials were handed over to the Ministry of Health.

### **3.1.8 Challenges**

Coordination of response was hampered by the absence of a comprehensive National COVID – 19 response plan that clearly states the response strategies to be followed by the country at all levels of implementation. The MOH only availed the detailed response budget to WHO and partners. This has led to the lack of a common understanding on the response strategies, limited partners and stakeholders’ engagement in activity planning and implementation. Also, there has been no clear guidance on the involvement of stakeholders in supporting the response interventions in the regions where the actual response is implemented. The absence of regular coordination meetings as well as National Task Force meetings has contributed to less stakeholders’ engagement from planning to implementation of interventions.

In Zanzibar, the dilapidated PHEOC office location poses enormous challenge to the operations of the PHEOC. Although, the MoH allocated an office space for PHEOC, the equipment that WHO procured and donated to MoH cannot be installed due to the derelict nature of the building. The MoH has reached out to various partners to renovate the PHEOC building but the



partners are yet to respond favourably. Just recently, there are indications that the Global Fund will fund the renovation of the PHEOC.

### 3.1.9 Way forward

Continuous engagement of the Government through the MOHCDGEC and PORALG to achieve joint planning of response interventions, develop comprehensive response plans for national and regional levels and subsequently sharing of these documents with all stakeholders and partners is essential for timely implementation of intervention.

The MoH in Zanzibar should intensify efforts to convince partners to renovate the PHEOC office site for a better coordinated emergency response to any public health event.

Figure 1 shows intervention regions where technical support was provided specifically under the coordination pillar.



Figure 1. Regions specifically supported by the Coordination Pillar

## **3.2 Pillar: Surveillance, laboratory support and Points of Entry**

### **3.2.1 Review and updating of training materials**

Existing training materials for the preparedness of Ebola Virus Disease (EVD) in the country were reviewed to accommodate information on COVID 19. This was done during a four days' workshop in Arusha conducted from 18<sup>th</sup> - 21<sup>st</sup> February 2020. Participants to the workshop included staff from MoH, Airport and Sea Authority, Presidents Office for Regional Administration and Local Government (PORALG) and Tanzania Field Epidemiology and Laboratory Training Program (FELTP). The training materials are being updated regularly following updates from the WHO Headquarters and used by the MoH in all regions in responding to COVID-19.

### **3.2.2 Conducting of training for Rapid Response Teams and Surveillance Officers**

A total of 80 members of the RRTs, and 265 surveillance officers from both private and government health facilities were trained utilizing the revised training materials. The participants were drawn from Mwanza, Arusha, Mbeya, Kilimanjaro, Dar es Salaam, Pwani and Dodoma regions. Furthermore, 150 district and health facility-based surveillance officers, IDSR focal persons and contact tracing focal persons were oriented on event -based surveillance, contact tracing and follow up, IDSR reporting, and supervising the community health workers in their respective areas of work.

In Zanzibar, a total of 68 RRT members and 181 surveillance officers were trained. These training participants were selected from both public and private health facilities. The trainings and the dates are listed below:

- a. District training of 42 RRT members in Unguja from 24<sup>th</sup> – 26<sup>th</sup> February 2020
- b. District training of 26 RRT members in Pemba from 6<sup>th</sup> – 10<sup>th</sup> January 2020
- c. Training of 39 PoE health workers in Unguja from 28<sup>th</sup> – 29<sup>th</sup> February 2020
- d. Training of 70 community health volunteers on contact tracing from 24<sup>th</sup> – 26<sup>th</sup> February 2020
- e. Training of 33 districts' surveillance officers, districts' data managers, districts' medical officers in 7 districts in Unguja and healthcare workers from health facilities from 21<sup>st</sup> – 22<sup>nd</sup> February 2020.
- f. National contact tracing training of trainers for 39 health workers from Unguja and Pemba from 18<sup>th</sup> – 20<sup>th</sup> February 2020.

### **3.2.3 Development of Standard Operating Procedures**

Standard Operating Procedures for case and contact identification, active case search, contact tracing and follow up and alert management amongst others were developed in addition to development of training materials and translation into Swahili. These are; community case definition of COVID-19 for CHWs use (Swahili version) and SOPs/guidance for the self-

isolation/quarantine for a COVID-19 contact. An orientation package for surveillance and contact tracing materials of COVID-19 cases were also developed.

#### **3.2.4 Printing and dissemination of surveillance tools**

WHO printed and disseminated EVD and COVID-19 standard case definitions and other surveillance tools (SOP on alert management, contact tracing tools, daily follow up forms, line-listing forms, daily summary report form) and case investigation forms (CIF). A total of 436,550 contact tracing forms, standard case definitions and 600 booklets of the CIF were distributed to all health facilities in Mainland through the MoH, while 113,150 contact tracing forms, standard case definitions and 150 booklets of the CIF were printed specifically for Zanzibar. The standard case definitions are for screening and detection of suspected COVID-19 cases in health facilities, communities and POE while the contact tracing tools are for reporting (line list of contacts with details and follow up) on contacts.

The PoE documents are specifically for enlightenment and screening of passengers at the PoE. The PoE screening and risk assessment forms, ring cards, PoE Core capacities, PoE COVID-19 screening algorithm, PoE capacity requirements for responding to potential Public Health Emergency of International Concern (PHEIC) and PoE event notification form were printed and distributed to all PoE (Airports, Sea ports and ground crossings) through the MoH.

#### **3.2.5 Capacity Building on Contact Tracing**

At all district and community levels, orientation of surveillance officers, clinicians and community health workers (CHWs) (which had been identified by the respective authorities) on contact tracing on COVID-19 was conducted. One hundred and sixty-six (166) health officers were trained as trainer of trainers (ToT) for Community Health Workers. These later trained 612 CHWs in Dar es Salaam with the support of the Benjamin Mkapa Foundation (BMF) through UNICEF funding. Some of these trainers also trained 100 community owned resource persons (CORPS) in Tanga with financial support from AMREF and CDC. The trainings took place between 6<sup>th</sup> - 16<sup>th</sup> May 2020. The 612 CHWs are under the supervision of health officers and FELTP graduates/residents that were deployed in Dar es Salaam to support COVID-19 surveillance. The 100 CORPS trained in Tanga were deployed in Tanga City Council, Mkinga DC, Korogwe DC and Korogwe under the supervision of regional and district health teams.



A session of orientation for CHWs on COVID—19 in Dar es Salaam in April 2020

### **3.2.6 Human Resources deployment at regional level for enhanced surveillance**

Twenty –seven (27) FELTP graduates/ residents were deployed during the period May to June 2020 in 13 regions (Dar es Salaam, Morogoro, Mtwara, Katavi, Rukwa, Tabora, Singida, Shinyanga Geita, Kilimanjaro, Iringa, Iringa and Dodoma), to support surveillance and contact tracing. As at 5<sup>th</sup> June 2020, 14,588 contacts had been listed and reported since the beginning of outbreak on the 16<sup>th</sup> March 2020: 12,721 Tanzania Mainland and 1,867 Zanzibar. RRTs are composed of WHO, MoH and regional health staff.

### **3.2.7 Recruitment of epidemiologists to increase country human resource for surveillance**

Three Epidemiologists were recruited in March 2020, for six months; 2 in Tanzania Mainland and 1 in Zanzibar. They have been supporting capacity building on surveillance, RRT and were involved in investigation of cases and contacts in collaboration with the MOH, CDC and PATH. Shortlisting for recruitment of surge staff to support surveillance activities which include contact tracing in 28 regions including Zanzibar and Pemba was in progress at the time of reporting.

### **3.2.8 Strengthening of capacity for Points of Entry**

Mentoring and on-job training was conducted in seven (7) points most at risk PoE (Julius Nyerere International Airport, Dar es Salaam Sea Port, Tanga Sea Port, Horohoro, Holili, Tarakea, Namanga, and Kilimanjaro International Airport) between 5<sup>th</sup> to 18<sup>th</sup> April 2020, during which 334 (53 were POE Health Officers and 281 POE staff) were trained. The main objective was to ensure appropriate implementation of port health activities, including entry and exit screening, IPC practices, use of standard case definition to detect suspected cases and active observation of upper respiratory infection symptoms, appropriate data capture, data management and response to public health events of international concern. A cumulative total of 5,160 passengers were followed up by Ministry of Health surveillance for 14 days.



WHO mission assessing and mentoring to strengthen surveillance at points of entry, April 2020

### **3.2.9 Cross Border Initiatives**

WHO Facilitated cross border surveillance and coordination meetings among East Africa Community (EAC) countries (Uganda, Kenya, Rwanda, South Sudan, Rwanda and Burundi) to develop joint operational procedures especially ground crossing. Not less than 3 staff which included 2 consultants participated in two regional cross-border surveillance meetings, with participants from six countries (Uganda, South Sudan, Kenya, Rwanda, Burundi and Tanzania) to discuss the surveillance approach to COVID-19 in line with requirements of IHR (2005) for Member States and to share information on events within their borders through the IHR National Focal Point. This is to prevent or minimize the risk of cross-border transmission of COVID-19 by the truck drivers. A framework on COVID-19 information sharing with East and Southern Africa member states was developed, in addition a harmonized strategy for POE surveillance and laboratory testing of COVID-19 cross border truck drivers was developed. The framework and the strategy have been shared with the national authority for adaptation and implementation.

### **3.2.10 Challenges in surveillance**

Lack of transparency in information sharing by both Ministries of Health (Tanzania Mainland and Zanzibar) has been a challenge. To date, no data has been shared to enable detailed epidemiological analysis to guide planning of appropriate response activities. In addition, the turn-around time from sample collection to laboratory results could take a week due to centralization of laboratory testing facilities. This in turn affected contact identification for follow up, hence leading to rapid spread of infection especially in Dar es Salaam and Zanzibar.

Although, the Ministry of Health acknowledged community transmission in Dar es Salaam and Zanzibar the source of infection of most of the cases cannot be established. To date, the government has not shared the situation reports on cases from 29 April and 7 May 2020 for Tanzania mainland and Zanzibar respectively.

The total number of confirmed and officially reported COVID-19 cases in the United Republic of Tanzania remains at 509 with the majority of cases in Dar es Salaam (374) and Zanzibar (134) despite ongoing transmission. There is also limited involvement of other stakeholders including partners in conducting COVID-19 case field investigation that made it difficult to know the type of transmission scenario in different regions to inform the strategy to be adopted. Furthermore, surveillance and contact tracing activities implementation was slow to begin due to delayed approval from the Government in Dar es Salaam and in lack of sharing of line list of cases and contacts on COVID-19.

In Zanzibar, other challenges included inadequate logistics support at points of entry (inappropriate walk-through thermal scanners, computers, printers and photocopy machines), undue delay in approving SOPs and other guidelines and inadequate number of trained community health volunteers (CHVs).

### **3.2.11 Recommendations on surveillance**

The country should continuously be engaged to sustain the decentralization of the response activities especially surveillance and case investigation at sub national levels to enable rapid detection of cases, identification of contact for follow-up to enable breaking of COVID-19 human to human transmission. High level advocacy to enable Tanzania to collaborate in planning and sharing of information, including organizing regular meetings to plan with partners for appropriate support is also called for.

Partners should accelerate their procurement processes to ensure that adequate logistics support is available for the MoH to respond to the ongoing COVID-19 outbreak. Additionally, Ministry of Health has a duty to approve all developed guidelines and tools timely to guide the COVID-19 response operations in the field. Figure 2 shows where technical support was provided specifically through the surveillance pillar.



Figure 2. Regions supported by the Surveillance Pillar

### 3.3 Pillar: Laboratory

A total of 906 laboratory practitioners from 151 councils of 21 (out of 26) regions namely Pwani, Dar es salaam, Mwanza, Arusha, Tanga, Dodoma, Morogoro, Kagera, Geita, Tabora, Singida, Simiyu, Shinyanga, Iringa, Njombe, Mbeya, Songwe, Kilimanjaro, Manyara, Mara and Kigoma were trained. The training was conducted in phases; Phase 1 from April 20- May 9, 2020 and Phase 2 was conducted from 18<sup>th</sup> to 30<sup>th</sup> May 2020 and Phase 3 was conducted from 15<sup>th</sup> to 27<sup>th</sup> June 2020. The training increased the knowledge of the participants, improved skills through hands-on training method for collection of COVID-19 samples, packaging and transportation as per IATA regulation. The training also covered biosafety and biosecurity issues including IPC. The trained laboratory practitioners joined the councils' rapid response teams (RRT) and hence improved the quality and number of sample collection of suspected COVID-19 cases. Two more phases are planned to complete all the regions in both mainland and Zanzibar.



Laboratory technician participate in a training on how to safely collect and transport COVID—19 Samples, April 2020

The WHO Country Office provided technical guidance and mentorship to the MOH through the National Health Laboratory Quality Assurance and Training Centre (NHLQATC). WHO's support the NHLQATC included donation of supplies and reagents for ABI7500 PCR, RNA extraction kits, Master Mix (Enzymes), Primers and Probes, Triple Packaging Materials, Nasopharyngeal and Oropharyngeal swabs, Viral Transport Medium, N95 Masks and other consumables. The reagents provided would suffice to test more than 2000 samples. More reagents and supplies procured are in the pipelines and will be delivered continuously as they arrive to country.



WHO's support extended to build Zanzibar Laboratory capacity to test COVID19 at Mnazi Mmoja hospital where the installation of a high throughput Abbott automation system is underway. Plan to secure some startup reagents for initial dry runs has been arranged and fast tracked. WHO has placed more orders for reagents and supplies through the UN supply portal to sustain the testing until proper procurement plan is institutionalized in Zanzibar MoH. WHO is coordinating partners support as part of streamlining efforts towards COVID19 response in Zanzibar including Pemba. These partners include CDC and SDC.

### 3.3.1 Challenges in Laboratory support

Collaboration with NHLQATC continues to be partial in several aspects including inconsistent participation of Government staff in lab pillar meetings, reluctance in reviewing and inputting on draft testing strategy, delays in endorsing contract for recruitment of molecular laboratory scientists. For Zanzibar specifically, there is lack of coordination with partners to streamline efforts in procurement of reagents and supplies. Delays in delivery of reagents were observed due to heavy global demand and logistical arrangements where all the reagents need to be cleared in mainland which takes longer especially for those which are not yet registered for use by the Tanzania Medicine and Drug Authority (TMDA).

### 3.3.2 Way forward in Laboratory support

There is a need to continue advocating for coordinated efforts to support COVID-19 testing capacity building including decentralization and mobilization of more resources for procurement of reagents and supplies. MOH should adopt and institutionalize WHO recommended testing strategies, protocols and methods. Figure 3 shows where technical support was provided by the Laboratory pillar.

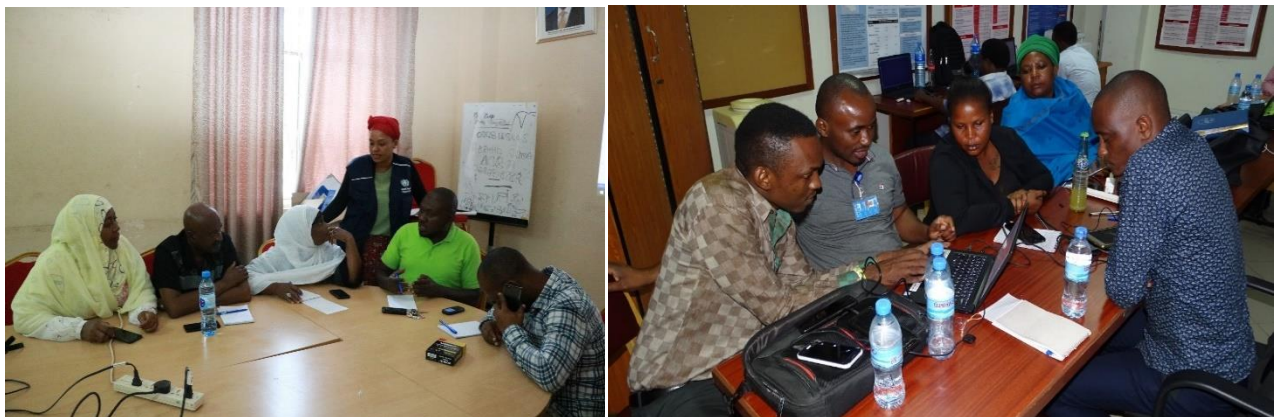


Figure 3. Regions supported by the Laboratory Pillar

### **3.4 Pillar: Risk communication, social mobilization and community engagement and Psychosocial support**

#### **3.4.1 Development of Public awareness messages and training materials on COVID-19**

In collaboration with partners, WHO provided technical guidance in the development of public awareness messages covering a range of issues including mode of transmission, signs and symptoms, seeking treatment, comorbidities, prevention measures, mental health and stigma. Target audiences for these messages included the general public, people with special needs, children, journalists and faith leaders. Messages were packaged into social media banners, brochures, posters, banners, mobile messages, audio and video clips. Dissemination was nationwide through mainstream media (Radio and TV sessions), social media, mobile van and mobile phones. It is estimated that around 312 radio stations and 130 television channels across the country have been broadcasting public awareness messages against COVID-19 with about two radio and one television broadcasts being disseminated daily. One radio broadcast is estimated to reach 450,000 listeners while a television broadcast reaches 210,000 viewers at a time.



WHO, MOH Zanzibar and MOHCDGEC in mainland Tanzania and partners develop risk communication and community engagement messages, April 2020

WHO and partners provided advise, information, experiences and technical support towards the development of RCCE training tools and guidance. The following packages were developed; training packages for media, influential leaders, community health workers, health promotion coordinators and social welfare personnel. Once these training tools are endorsed by MOH, they



Live radio programme were also used to make the communities aware of COVID—19, April 2020

will be disseminated for use by the Regional and District RCCE personnel and partners. As for public awareness the following materials were printed and distributed; 10,000 posters; and 20,000 brochures to communities in Dar es Salaam Region that were distributed by community volunteers. Two hundred (200) pull-up banners with prevention messages were positioned in the various points of entry as a strategic area with a lot of movement of people. One thousand flash disks were uploaded with audio and video clips and distributed to all regions to be aired in public transportation and health facility settings. .



School age children read COVID—19 poster on wall in Dar es Salaam , April 2020

### **3.4.2 Knowledge Attitude and Practice Study on Community Perceptions on COVID-19**

As a result of the wide dissemination of messages, there was increased community awareness and practice on protective behaviors against COVID-19. This was substantiated by a Knowledge Attitude and Practice (KAP) study conducted in Mainland whose preliminary findings indicate that 99.8% (n=1818) of individuals were aware about COVID-19 and the top three sources of information mentioned by the majority were radio by 84.5% (n=1536), television 77.2% (n=1403) and social media by 32.1% (n=584). The findings also showed that television, social media and printable materials were statistically significant sources of information for most urban dwellers than individuals from rural areas. On the contrary, community health workers were the major source of information for the majority of the rural population. Except for Dar es Salaam and Arusha where the main source of information for Covid-19 awareness was television, the rest of the regions used radios.



Information, Education and communication materials were distributed widely in the community. In the photo, distribution of brochures at Tandale in Dar es Salaam April 2020

### **3.4.3 Capacity building for Journalists in the COVID-19 response**

Fifty (50) journalists from print, digital (radio and TV) and social media platforms in Kigoma and Zanzibar were trained. The training covered a range of topics including: Basics on COVID-19, how the media can help to combat COVID-19 by tackling misinformation and promoting advice by the health authorities. This led to wide broadcasting of COVID prevention messages reaching approximately 4 million people in Zanzibar and Kigoma. Because of this engagement, media houses also offered free airtime for health experts to host live and recorded sessions to educate the public on COVID-19. A total of two sessions were held daily by each media house

cumulating to three thousand (3,000) sessions covered by 50 media companies during this reporting period.

WHO Country Office has been responding to media enquiries and compiles daily media monitoring reports to inform response efforts. The office also uses its website and social media account to share updates on COVID trends globally and regionally, prevention messages and best practices.

#### **3.4.4 Community feedback and rumour tracking tool**

WHO provided technical expertise in the development of community feedback and rumor tracking tools, tool for capturing RCCE activities at district level, reporting forms and guide for data collection. These tools were pretested in 5 Regions and once endorsed, they will be deployed to all Regions.

#### **3.4.5 Call Centre Operations**

The National Call Centre, also known as “Afya Call Centre”, with the capacity to respond to 1,000 calls at any one time and connected to 5,000 other satellite Call Centers from regions and districts, was launched on 8<sup>th</sup> May 2020 by the Honorable Minister of Health with the aim to strengthen sensitization, health education, and provision of health advice on various health related issues including COVID-19. The Call Centre operates 24 hours a day and about 90 operators (majority volunteers) serve the call centers, in 8 hourly shifts (30 operators per shift). To date the Call Centre has been receiving on average about 60,000 calls a day. WHO has contributed to the operations of the Call Centre through providing technical responses to the compiled COVID-19 Frequently Asked Questions (FAQs). In addition, through media monitoring and call center reports, technical guidance has been provided to dispel a number of myths including: every fever is COVID-19, drinking alcohol protects against COVID-19, COVID-19 cannot be transmitted in areas with hot and humid climates, eating garlic protects against COVID-19 and having black skin protects against COVID-19.

#### **3.4.6 Capacity building of community leaders**

Thirty-four (34) Health Promotion Coordinators were oriented in Mainland and 247 community leaders in Zanzibar on COVID-19. This has contributed to increased community participation and acceptance of public health measures. RCCE supportive mission was organized in 5 regions (Dar es Salaam, Arusha, Mwanza, Kigoma and Kagera) to build capacity of RCCE personnel at subnational level in RCCE microplanning and community engagement approaches. Furthermore, 153 Community Health workers (CHWs) were oriented on COVID-19 on the general aspect of COVID-19 risks, information to communicate to the communities to reduce human to human transmission and distribute the IEC materials to the communities in Kigoma region.

### **3.4.7 Capacity building of Journalists and other potential groups**

Twenty-eight journalists from various media houses operating in Kigoma were oriented on their roles and responsibilities to the public in delivering and communicating the correct messages related to COVID-19 pandemic and Ebola outbreak threat. A total of 33 airport staff, 15 taxi drivers and 12 business men were sensitized at the Airport. Live program radio sessions were conducted through Radio Joy FM. The radio coverage was in more than 4 districts and approximately 150 audience were sensitized at Kigoma Bus stand on COVID-19 risks and preventive measures.

### **3.4.8 Engagement of Technical Expertise**

Two RCCE experts were recruited in the WCO and have provided technical advice and guidance towards the implementation of the RCCE response plan. They have also built the capacity of the national and regional RCCE personnel. The products of their work have been outlined above.

### **3.4.9 Challenges in Risk communication, social mobilization and community engagement**

There has been lack of regular information on on-going RCCE activities in the regions and districts which would inform the national team to provide targeted technical support. Due to lack of a psychosocial expert to guide and support implementation of psychosocial support (PSS) response initiatives, this was not achieved. Delay in the approval of messages developed and mixed messaging from the high level national authorities on various issues was a major challenge and has contributed to confusion compromising the implementation of public health measures.

### **3.4.10 Way forward**

The WHO Country Office is exploring local recruitment of a psychosocial support expert to support PSS activities. The WHO Country Office is also planning to recruit additional local RCCE experts to be deployed in regions and districts for capacity building to intensify public awareness activities at community level.

Through various engagements with high level leadership and decision-making platforms, WHO will continue with advocacy for harmonization and consistency of messaging on public health measures in place to respond to COVID-19.

## **3.5 Pillar: Case Management and Infection Prevention and Control (IPC)**

### **3.5.1 Assessment of gaps**

One hundred twenty-four (124) health facilities in 22 regions of Mainland Tanzania and seventeen (17) health facilities in Unguja, Zanzibar, were assessed to gauge their readiness to effectively triage, isolate and treat COVID-19 patients taking all IPC precautions into account. The assessments were conducted using the “kobo scorecard,” which is WHO’s standard rapid field assessment tool. The tool evaluates 12 core thematic areas to calculate the IPC scores: availability of IPC focal point and hygiene committee at facility level; availability of hand hygiene stations; availability and use of PPE; triage; isolation capacity; waste segregation; waste elimination; staff capacity building; mechanism for reporting of suspected cases; sterilization; bio-cleaning of patient's environment; and level of exposure of health care workers to COVID-19 virus.

The average score value for the assessed facilities in Tanzania Mainland was 56% and for Zanzibar was 42.8%. The overall score values ranged from 26% to 97%. The assessed facilities included government and private owned hospitals and health centers. The biggest gaps were noted is the lack of IPC focal persons or committees, non-functional triage points, lack of isolation rooms, absence of SOPs and posters, poor waste segregation and lack of monitoring and resuscitative equipment for patients with respiratory symptoms. Mentorship on case management and IPC was done after the assessment directed to the gaps identified.

Assessment of IPC core components at national level was also conducted using the nationally developed tools as well as WHO’s Instruction for Infection Prevention and Control Assessment tool (IPCAT-2). The (IPCAT-2) identifies six (6) core components for assessment. These are IPC programs, IPC guidelines, IPC education and training; healthcare associated Infections (HAI) surveillance; multimodal strategies; and monitoring and auditing of IPC practices. The calculated national average score was 64%; with critical gap in HAI surveillance and coordination (41%). A good performance score of 81% was obtained in development of the guidelines.

The other critical assessment conducted by the pillar was on oxygen supply for facilities managing COVID-19 patients. A rapid assessment was conducted to assess the capacity for production, distribution and use of oxygen across all the regions in mainland. The team visited 8 regions and conducted on site mentorship and further assessment of hospital based and private oxygen plants and status of oxygen supply. The facilities visited benefited directly from immediate repairs, particularly for oxygen concentrators. An assessment tool adapted from WHO regional tool was distributed to all facilities through reproductive and child health coordinators to evaluate the availability and use of oxygen and other critical care equipment at subnational level. Reports are being compiled and the final report is expected to inform actions to be taken. An investment strategy for oxygen scale-up is being finalized.

### **3.5.2 Mentorship and Training**

About 4,935 health workers and support staff from 162 facilities in 24 regions of Tanzania mainland have been trained and mentored on site by WHO teams. The remaining two regions in Tanzania mainland, Simiyu and Geita had been supported by other partners. All mentorships were preceded by facility assessments to identify critical gaps for intervention. From the assessments conducted, a number of cross cutting issues/gaps were identified, and actions were taken immediately by the mentors/trainers to address most of those gaps. In times where the gaps could not be addressed on site, they were communicated to the responsible officers for further action and follow up.

WHO in collaboration with partners provided financial and technical support to the Ministry of Health to develop capacity of health care workers at all levels. In this regard, several trainings, both physical as well as virtual, were organized and supported by WHO. To enable effective training, WHO also supported the development and review of standard training materials. Training package for COVID-19 was developed in such a way that it integrates aspects of case management and IPC. The adoption of this integrated package enabled the trainers to run joint programs in IPC and case management; and to effectively utilize the mobilize resources. A total of 1095 trainers from the 22 regions in Tanzania mainland were trained using the same training package; and were deployed to cascade training to lower government owned and private facilities. The trainers included Health Management Teams (HMTs), doctors, nurses, lab personnel, environmental officers, pharmacists, college and university tutors, and microbiologists.

Similarly, in Zanzibar, 108 health workers from Unguja and Pemba were trained on basic case management and IPC. The training was for clinicians and nurses selected to man the isolation facilities.. The trained teams were used by the regions to conduct cascade training to all districts and relevant health facilities, such as regional referral and isolation facilities. Trainings covered, among others, design and set up of HDTUs; set up of make shift isolation facilities, standard and transmission-based IPC precautions; preparation and use of antiseptics; setting up standard hand hygiene stations, advice on rational use of PPE including masks and respirators, and decontamination.





Mentorship of health workers in one of the isolation facilities in Mererani, Arusha, May 2020

### **3.5.3 Supportive supervision**

National and regional teams, including multi-disciplinary RRTs, were tasked to conduct supportive supervision to facilities to identify critical gaps and provide onsite support for improvement. The IPC team played critical role in leading advocacy measures at all levels. At the national level, the team advocated for an increased budget from the Government and additional funds from partners to improve IPC at national level. Improved funding would enable the pillar to address several of the gaps identified in the gaps/challenges section.

The teams deployed for supportive supervision ensured that IPC committees were formed in each of the facilities visited; IPC guidelines/SOPs/standards were accessible in each facility; and standard hand washing stations were installed at all strategic positions. The IPC team continued to advocate for mandatory use of masks and observing physical distancing by all health workers when they are always operating within health care settings. The supportive supervision and mentorship improved the confidence and skills of health care workers assigned to the isolation and treatment facilities to receive, admit and manage COVID 19 patients.

#### **3.5.4 Strengthening the surge capacity**

WHO provided technical and financial support for the conversion of two halls of the Saba Saba Trade Fair in Dar es Salaam into COVID 19 surge facilities with the capacity of 550 beds. The facility was refurbished and handed over to the Ministry of Health.

WHO supported the establishment of seven (7) functional designated isolation and treatment units for COVID-19 suspects and confirmed cases. In addition, WHO supported designing the isolation and treatment center for UN-staff presenting with mild symptoms. Twenty-six (26) frontline health workers from IOM were capacitated in all areas of case management and IPC/WASH to work on this center. Furthermore, WHO gave financial and technical support to build the capacity of 160 health workers at designated highly infectious diseases treatment units. The focus was on ICU management and critical care of COVID-19 patients.

The Region Health Management Team (RHMT) in Kigoma in collaboration with UNHCR and WHO assessed adherence to COVID-19 preventive measures in the process of preparing Burundians convoy for voluntary repatriation. All the three camps, Mtendeli, Nduta and Nyarugusu were covered; The focus was on Infection Prevention and Control/Water Sanitation and Hygiene (IPC/WASH) and Case Management.

#### **3.5.5 Development and dissemination of guidelines, standard operation procedures, job aids, standards and protocols**

WHO supported the printing of twenty thousand copies of IPC guidelines. Over 3000 IPC guidelines were disseminated to health facilities in the country. But this has not been adequate as in Tanzania mainland alone, there are close to 9400 health facilities. Twenty-one (21) SOPs to support IPC and Case management were developed in collaboration with UNICEF and USAID implementing partners. In view of the evolving policy decisions four of the SOPs: rational use of PPE, safe and dignified burial, case management and home isolation were revised.

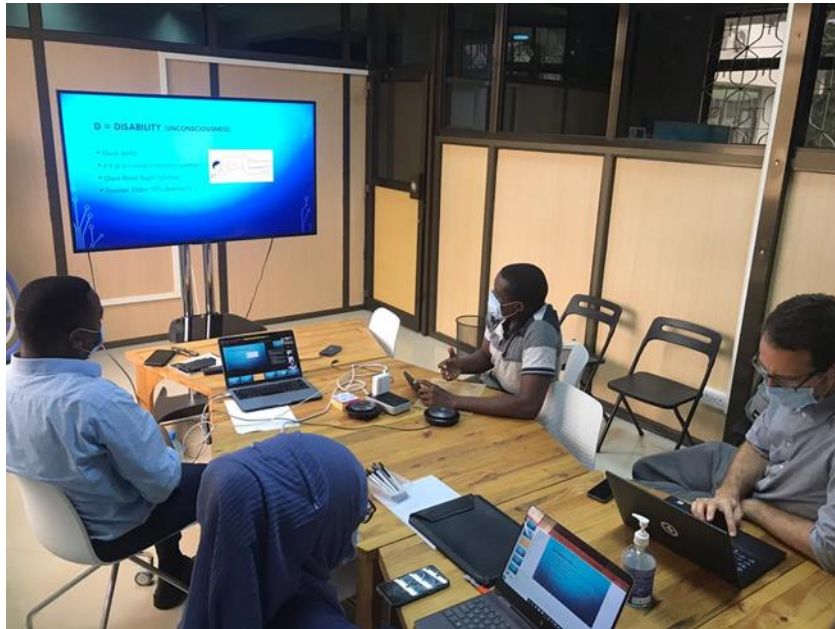
Printing of the 20,000 copies of SOPs on rational use of PPE has been completed and dispatched to all facilities in the 26 regions. All possible channels, including email and social medial platform have been used to disseminate the SOPs.

#### **3.5.6 Capacity building for health workers**

Training of regional teams on basic case management and IPC was done for 463 health workers from Unguja, Pemba, Arusha, Kilimanjaro, Dodoma, Songwe, Pwani, Rukwa, Mbeya and Morogoro for clinicians and Nurses selected to man isolation facilities... The trained teams were subsequently used by regions to conduct cascade training to all districts and relevant health facilities including regional referral and isolation facilities.

With the spread of COVID-19 in Tanzania and elsewhere, WHO has been recommending minimizing physical meetings and trainings. In line with this, MOH in collaboration with WHO, MUHAS and

Gradian Health Systems facilitated a series of weekly virtual trainings in IPC and critical care. The trainings, which covered a variety of topics on IPC and critical care, took place in the months of April-May and were run twice per week for 2 hours per session. A total of 967 clinicians and individuals dealing with health-related projects benefited from these sessions. While most participants were from Dar es Salaam and the other regions in Tanzania, some actually participated from neighboring countries of Burundi, Kenya, and Rwanda.



Virtual training for management of critical COVID—19 cases organized by Muhimbili University of Health and Allied Sciences, April 2020

In Zanzibar, the critical care and IPC trainings remained the same; instructor led and interactive. A total of 48 participants were trained i.e. 24 each from Unguja and Pemba.

Eight Anesthesiologists and emergency physicians from the mainland regions and Zanzibar have been trained as trainers in order to ensure sustainability. The trainers subsequently supported the ongoing weekly central training sessions in 4 of their own respective regions.

In Dar es Salaam, a 5-days training on setting up and decommissioning of mobile ETUs was conducted. With a total of 36 participants - 28 from MoHCDGEC; 3 from MoH Zanzibar; and 5 from Red Cross were trained. The training included simulation exercises and donning and doffing practical sessions to ensure mastery of competencies. The profile of trainees included medical doctors, pharmacists, nurses, Civil engineers, and logisticians.

WHO trained MOH staff from Mainland and Zanzibar in two sessions on: Setting up of a mobile ETU from 19 to 22 February 2020 and from 24 to 27 February 2020. The training included simulation exercises and donning and doffing practical sessions to ensure competencies of the

staff. The profile of participants included civil engineers, logisticians, pharmacists, nurses, and doctors. The participants were 36 in total, 31 from MoH mainland, 5 from Red Cross and 3 from MoH Zanzibar.



A health worker practicing donning personal protective gear at a COVID—19 surveillance training, in March 2020

### **3.5.7 Water Sanitation and Hygiene (WASH)**

Three hundred forty-six (346) health workers from Tanzania mainland and fifty six (56) health workers from Zanzibar received refresher training on aspects of WASH in the context of health care facilities and management of wastes.

As part of strengthening COVID-19 preparedness and response in the country, WHO, through the Kigoma Joint Program Health plus (KJPH+), provided financial and technical support to the Kigoma region to build capacity of healthcare workers working at various facilities including maternity wards, pediatric wards, medical laboratories and incinerators/burning chambers/ mortuaries on WASH and Health Care Waste Management (HCWM) standards so as to mitigate infectious risks posed by improper practices.



In the wake of widespread knowledge and public alert on COVID—19 communities installed handwashing points at homes and businesses, March 2020

A total of 95 health care workers from the districts of Uvinza, Kasulu, Kibondo, Buhigwe, Kigoma and Kakonko were trained in IPC. The trainings were conducted in Kasulu and Kibondo districts from 29<sup>th</sup> January 2020 to 5<sup>th</sup> February 2020 and were facilitated by experts from WHO, MoHCDGE and , Kigoma RHMT. The trainings helped strengthen IPC at facility levels.



Infection Prevention and Control training in session in Zanzibar, March 2020.

Orientation of burial teams was conducted for Six-seven (67) participants (64 from all 4 districts in Pemba and 3 national RRT members in Unguja)..

### **3.5.8 Purchase of equipment and supplies for case management**

Two (2) ventilators, 4 patient monitors, 4 Oxygen concentrators, 2 portable ultrasound machines, 2 portable X-ray machines, 4 pulse oximeters, 4 ECG machines, 75 glucometers, and 4 infusion pumps were procured to support critical care at Mloganzila and Amana Isolation Facilities. Furthermore, procurement of 2 I-stat machines and cartridges to support critically ill COVID-19 patients at Amana hospital and Mloganzila was done and equipment already in use in the two facilities.

A total of 500 bottles of test kits for determining disinfectant concentration in health facilities were procured by WHO and distributed to all high-risk regions. Procurement of 36 digital chlorine testers for Free Residual Chlorine testing are being done internationally for Tanzania mainland and Zanzibar. The gadgets are expected to be delivered in a month's time.

### **3.5.9 Engagement of Technical Experts**

Three international experts were hired: two IPC and one for case management for the Dar-es-Salaam and Zanzibar WHO offices. Locally two staff have been seconded from International Organization for Migration (IOM) to support IPC and Case Management, one based in Dar Es Salaam and the other based in Kigoma to support refugee camps and host communities. One international expert in critical care was hired as a consultant. Thirty-one (31) IPC and 33 case management experts have been shortlisted to support all the regions. The process awaits approval by the Government and will depend on the availability of funds so that these experts can be deployed.

### **3.5.10 Challenges**

- Lack of PPEs and other essential equipment and supplies for standard precaution, which impairs the care of the patients and staff safety.
- Inadequate number of trained staff to be able to effectively provide care for EVD and COVID
- Inadequate capacity for screening triaging and isolation in most of the health facilities. Cascade mentorship is needed to cover all the facilities
- Inadequate capacity in terms of skills, knowledge, equipment and supplies in supporting critical care. This include limited production, distribution and use of Oxygen.
- The decentralization concept of COVID-19 care policy has not been well grasped by the districts in Zanzibar. Mentorship and supervisory visits need to be done soon and more frequently to optimize care.

- Poor waste collection, segregation and disposal practices. Increasing waste collection bins and installation of machines for making bin liners at facilities will contribute to improved and safe waste management;
- Inadequate number and quality of isolation facilities in the country. Establishment of isolation facility in each council of each region is critical;  
Delayed availability of PPEs from the local and international markets. The country is proposing building capacity for local production of PPEs at MNH, Bugando, Mwananyamala, Amana, Ruangwa and Morogoro RRH.

### 3.5.11 Way forward

- Conduct rapid cascade mentorship and supportive supervision to be able build capacity of the district to provide effective care for EVD and COVID. This will include identification and support to facilities to provide decentralized care.
- Consolidate assessment reports for basic care, critical and Oxygen supply for effective planning and resource mobilization.
- Provide adequate PPEs and training for Standard precaution in all facilities in order to ensure adherence to IPC measures.
- Print and distribute to all facilities Standard Operating procedures, Job Aides and information leaflets for IPC and Case Management

Figure 4 shows regions which the IPC and case management provided technical support



Figure 4. Regions supported by the Case Management and Infection Prevention and Control Pillar

### 3.6 Pillar: Logistics

#### 3.6.1 Procurement of medicines, equipment, laboratory reagents and medical supplies

Various medical equipment and supplies were procured including; ventilators, hand sanitizers, laboratory test kits and reagents, medicines, etc. In addition, emergency purchases of ICT equipment and furniture for setting up EOCs both in Mainland and Zanzibar was done. Procurement was done mostly internationally but some items such as the ICT equipment and furniture, medical equipment and some supplies including masks and sanitizers were procured locally. During the same period, procurement of an ambulance for COVID-19 for a quick transfer of patients to health facilities was done. All the procurement done in the period are worth USD 442,569. (The list of items and quantities are annexed in this report). The items were officially handed over to the Ministries of Health in Mainland and Zanzibar for subsequent distribution to the regions and districts for use. The laboratory supplies were handed over to the National Reference Laboratory.



WHO Tanzania received and procured equipment, medical supplies, reagents, medicines and subsequently donated to the United Republic of Tanzania, April 2020-





Participants of a training on setting up a mobile treatment unit practicing how to pitch the tent for the unit, March 2020

### **3.6.2 Capacity Building of Staff**

WHO also trained about 20 pharmaceutical and logistics staff from 17-19 March 2020 from the MOH on management of essential medicines and health products during emergencies.

Participants were also informed of the availability of the Tanzania Emergency Supplies and Commodities Guideline (TESCOG) which has been developed by the MOH in collaboration with partners. The guideline has now been printed by the Ministry and disseminated to the regions for use.

### **3.6.3 Deployment of Teams**

In order to strengthen regional and districts emergency preparedness and response activities, WHO has deployed staff and Consultants from the Africa Regional Office (AFRO), WCO as well as from the MOH. The support to the various teams deployed in the regions and districts included transportation, subsistence allowances, and internet connectivity.

### **3.6.4 Printing of Guidelines, SOPs and Technical documents**

The Logistics pillar also worked with all the other pillars in ensuring quick procurement of services such as printing of various documents related to the pandemic. In this regard, the pillar worked in close collaboration with the Procurement Committee to ensure efficient procurement procedures as per requirements in emergencies. Therefore, organized printing of guidelines, SOPs, RCCE materials and other technical documents requested by the other pillars of the response.

### **3.6.5 Working with other Partners**

WCO worked closely with other Development Partners and UN Agencies to support the two ministries of health in ensuring access to quality essential medicines, medical equipment, laboratory reagents and other health products. Through the Logistics Technical Committee, forecasting of essential COVID-19 supplies was done using the WHO quantification tool. Partners then worked together to procure supplies according to the requirements. With the advent of the COVID-19 Supply Portal, partners accessed it particularly for the procurement of laboratory reagents and kits as well as face masks which were affordable and of assured quality.

### **3.6.6 Support to Building of Treatment Centres**

WHO also facilitated the renovation, procurement process and procedures towards conversion of the Saba Saba Trade Fair into a treatment center by engaging a contractor and supervising the renovation work and installation of new wash rooms.

### **3.6.7 Human resources for logistics**

The office is currently in the process of recruiting two logisticians.: one for Zanzibar and another one for Mainland.

### **3.6.8 Challenges**

- Delays from local and some international suppliers as they were unable to supply all items within the agreed time
- Global challenges on air freight and access to medicines and health products due to global lockdown from March to July 2020
- Shortages of PPEs especially at facility levels
- Overpricing of various supplies in the local market
- Inadequate funding to support all the supplies needed and other logistics and operational activities.

### **3.6.9 Way forward**

- Continue to work with other pillars to advocate for more resource mobilization to enable support all logistics and operations activities.
- Continue to review the country`s needs with respect to supplies and support the MOHs as requested

## 4. Conclusion

Extensive technical and financial support to the national authorities in response to the COVID-19 pandemic has been provided by the WCO as outlined in this report.

Coordination of the response was central to ensuring the smooth implementation of the operational plans under each pillar. Resource mobilization was a central theme that ran throughout the response ensuring funding was available to meet the needs in each pillar and in so doing meet the goal of the reduction of human to human transmission of the virus. A fully equipped PHEOC in Dar-es-Salaam and in Zanzibar strengthened the coordination of the response.

As the generic WHO guidelines for the response unfolded in the different technical areas; they were adapted by the WCO in collaboration with the national expert teams and health development partners to the Tanzanian context. The core capacity of the WCO was strengthened through the deployment of surge teams from the WHO Regional office for Africa.

COVID-19 being a novel viral infection, the WCO facilitated the delivery of appropriate public awareness messages through multiple fronts. This was substantiated by a KAP survey conducted by the research institutions where awareness of the pandemic by the population was at 99.8%. In the rural population the CHWs were the source of the information.

The six-month implementation of the different packages per pillar geared towards flattening the curve of the epidemic has been a test of resilience of the WCO to respond to a novel pandemic. This has not been without a few challenges as detailed in the report. However, these provided a spring board for the WCO and the surge team from AFRO to think strategically in the best way forward to solve these challenges. Nonetheless as the pandemic continues to unfold, there are several *grey* areas and therefore not all solutions were readily at hand. There is a steep learning curve for all public health specialist when addressing a novel pandemic as the one we are facing now.

## Annex

### I List of Equipment and supplies procured for the COVID-19 Response in respective pillars

#### Coordination

Class/Group	Item Description	Qty Ordered
Audio Visual	Digital SLR with 18 Megapixel, LCD, screen 3 with memory card of SD, SDHC/SDXC minimum of 32GB, Preferable SONY	1
Audio Visual	Television- Flat Screen 55" with, Television wall stand twist and tilt, and accessories e.g. External Speakers, Preferable - Samsung, Sony	3
Audio Visual	Television- Flat Screen 55" with, Television wall stand twist and tilt, and accessories e.g. External Speakers, Preferable - Samsung, Sony	1
Communications	Samsung A2 Core Dual Sim 16GB	2
Communications	Wireless Conference Phone – GSM, Type Konftel 300M 3G/4G GSM	1
Communications	MONDOPAD INFOCUS 57", Touch sensitive with built-in	1
Furniture	Conference /Visitors Chairs PU Metal Frame	40
Furniture	Office Desk with Drawers size 150x75x75	5
Furniture	Conference table oval shape for 30 seaters	1
Furniture	Steel cupboard 2 doors model Globe GB 18SC	4
IT EQUIPMENT	Computer - Dell DESKTOP series, i7, 16GB Ram,500GB Win10	4
IT EQUIPMENT	Computer - Dell LAPTOP series, i7 14" Screen,16GB ram500GB, Win10	4
IT EQUIPMENT	APC Smart-UPS - SMT1500,1 Year Warranty	4
IT EQUIPMENT	Digital SLR with 18 Megapixel, LCD, screen 3 with memory card of SD, SDHC/SDXC minimum of 32GB, Preferable SONY	1
IT EQUIPMENT	Samsung A2 Core Dual Sim 16GB	2
IT EQUIPMENT	Wireless Conference Phone – GSM, Type Konftel 300M 3G/4G GSM	1
IT EQUIPMENT	EPSON projector 3200 with accessories 1 set Bulb	2
IT EQUIPMENT	RICO COPIER MP 3055 MFP Black, and white, with accessories 2 spare Toners	1
IT EQUIPMENT	HP Color LaserJet Enterprise MFP, M700 series dtn, with accessories 2 set of Tonners	
IT Equipment	Computer - Dell series, i7, 16GB Ram,500GB Win10	4
IT Equipment	APC Smart-UPS - SMT1500,1 Year Warranty	4

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
IT Equipment	Computer - Dell series, i7 14" Screen,16GB ram500GB, Win10	4
IT Equipment	EPSON EB-S05 with accessories 1 set Bulb	2
IT Equipment	ArcGIS for Desktop with basic level, license 5	1
IT Equipment	Low lense iFinder GO Waterproof, Hiking GPS	2
IT Equipment	MONDOPAD INFOCUS 57", Touch sensitive with built-in	1
IT Equipment	ArcGIS for Desktop with basic level, license 5	1
IT Equipment	Lowrence iFinder GO Waterproof, Hiking GPS	2
IT Equipment	Yealink ZVC830 Zoom Rooms Video, Conferencing System with Zoom, application License	2
IT Equipment	Wi-Fi and modem with minimum of 5, people,10 MBPS	1
Office Machines	RICO COPIER MP 3055 MFP Black, and white, with accessories 2, spare Toners	1
Office Machines	HP Color LaserJet Enterprise MFP, M700 series dtn, with accessories 2 set of Tonners	1
White Board	White Board 150cm * 100cm	1

### **Laboratory**

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
Lab Reagents	Serbe Cov - E-Gene	6
Lab Reagents	Wuhan CovRdRp Gene	1
Lab Reagents	QIAamp Viral RNA Min Kit	2
Lab Reagents	SS111 1-STEP QRT-PCR 500	1
Lab Reagents	Mini Sigma Virocul! Screw Vial, lml Virocult, Foam Swab. 8PACK/125	8
Lab Reagents	Viro Transport Media	300
Lab Reagents	Swabs	3000
Lab Reagents	Tagpath - Step Multiplex	1
lab staff use	Mask N95	500
Lab supplies	Tripple packaging 1.5ltr	4
Lab supplies	Superscript III Platinum.One step Qauntitive RT-PCR	2
Lab supplies	Electronoc Temperature indicator Libro CD, SHIPMENT , -95/+50C	1
Lab supplies	Triple Packaging, Insulated PU-Box for UN3373	50
Lab supplies	Triple Packaging, Insulated PU-Box for Biological substances	50

Lab supplies	EX- Freeze 600 cool pack 600g-15x38x160mm melting point -22c	250
Tubes for VTM	Sterile Tube for VTM 4mls	6300
Printing Materials	A4 Sample Request form	3000

### IPC/WASH

Class/Group	Item Description	Qty Ordered
PPE	Surgical Mask, non-sterile, earloop,3ply, 370 Boxes/ Pack 50	18,500
PPE	Mask Respirator FFP2 3 boxes/50	150
PPE	Examination Gloves 7 boxes/pack 100 - S	700
PPE	Examination Gloves 7 boxes/pack 100 - M	700
PPE	Examination Gloves 7 boxes/pack 100 - L	700
PPE	Examination Gloves 17boxes/pack 100 - XL	1700
PPE	Isolation Gown M	120
PPE	Isolation Gown L	180
PPE	Isolation Gown XL	200
PPE	Safety Goggles Clear	50
PPE	Face Shields	350
PPE	Apron Protection, Plastic, reusable	480
PPE	Face shield, Fog-resistance full face length	40
PPE	Coverall, Protection, Cat iii, Type M	72
PPE	Bleach Gallon/5Ltrs	4 Gallon/5Ltrs
PPE	Hand sanitizers	10
PPE	Gum Boots	12
PPE	Waste bags	500
PPE	Long sleeve Apron	55
PPE	Surgical Mask, non-sterile, earloop,3ply, 140 Boxes/ Pack 50	7,000
PPE	Mask Respirator FFP2 1 boxes/50	50
PPE	Examination Gloves 3 boxes/pack 100 - S	300
PPE	Examination Gloves 3 boxes/pack 100 - M	300
PPE	Examination Gloves 3 boxes/pack 100 - L	300

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
PPE	Examination Gloves 3 boxes/pack 100 - XL	300
PPE	Isolation Gown M	30
PPE	Isolation Gown L	20
PPE	Isolation Gown XL	50
PPE	Safety Goggles Clear	30
PPE	Face Shields	100
Wash Supplies	Hand wash soap	5
Wash Supplies	Rubber Squeezer	60
Wash Supplies	Hand sanitizer	50
Wash Supplies	Soap (Powder) – Bag of 15kgs Each	2 Bags
Wash Supplies	Bucket with Tap – 20 Litres	6
Wash Supplies	Spraying Machine for Spray (10-16Litres)	20
Wash Supplies	Colour Code Dustbin	50
Wash Supplies	Colour Coded Wastebag (Pieces)	500
Wash Supplies	Door Mate (Carpet type) Eac	25
Wash Supplies	Door Mate (Rubber type) Eac	20
Wash Supplies	Mop (Standard Size), Each	60
Wash Supplies	Bucket (10 Litres), Each	35
Wash Supplies	Bucket (20 Litres), Each	50
Wash Supplies	Examination Beds/Steel, Each	2
Wash Supplies	IV Stand/Drip Stand Powder Coated, Each	9
Wash Supplies	S.steel 3 Shelves Trolley	1
Wash Supplies	S Steel 2 Shelves Trolley	1
Wash Supplies	Gum boot Size 41	1
Wash Supplies	Examination Gloves; Box	box/50
Wash Supplies	Ngt Feeding Tube	100
Wash Supplies	Absorbent gauze 90 cmx100 Yard; Rolls	100
Med. Supplies	Waste bins	75
Water test	Kit WATA Test	400

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
Water test	KIT Wata test	100

### Case management

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
ECG	ELECTROCARDIOGRAPH (R12 Beneheart)	2
ECG	Rolling Stand for R12	2
Gauze Rolls	Gauze Rolls	14
Hospital Bed	Hospital Patient bed	7
I -START ANALYZER	I- START ANALYZER IMMUNO READ EQUIPMENT with I start printer, Electronic simulator, Rechargeable battery, Battery charge 9V	2
Istat	I -START ANALYZER IMMUNO READY (With accessories)	2
Istat	CG4-Cartridge 25s	2
Istat	Cartridge Chemo	2
Med. Supplies	Waste bags (red color)	150
Med. Supplies	Cotton wool 500g	75
Med. Supplies	Disposable syringes 2cc	75
Med. Supplies	Disposable syringes 10cc	75
Med. Supplies	Disposable syringes 5cc	75
Med. Supplies	Alcohol swabs	75
Med. Supplies	PAEDIATRIC NEBULIZER MASK	1,200
Med. Supplies	Drip stand	80
Med. Supplies	Hospital Bed sheets	800
Med. Supplies	Absorbent Gauze	100
Med. Supplies	ADULT NEBULIZER MASK	1,000
Med. Supplies	Oxygen face mask	200
Med. Supplies	Pulse Oximeters	75
Medical Equip	ON call plus machine	75
Medical Equip	ON call strips 50's	60
Medical Equip	Nebulizer compressor Essential C101	75



<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
Medical Equip	Infusion Pump	11
Medical Equip	Full Flow Bed with steel head	14
Medical Oyxgen	OXYGEN CYLINDERS 8.5M3	90
Medical Oyxgen	PORTABLE OXYGEN CYLINDERS 1.36M3	20
Medical Oyxgen	MEDICAL THERAPY SET (Medical regulator, humidity, flomiter, niple, nut and adult musk)	15
Medical Oyxgen	Cylinder Deposit paid	110
Medical Oyxgen	Annual Cylinder Rent	110
Patient Monitor	Patient Monitors	4
Patient Monitors	MONITOR PATIENT, EPM Series	2
Ultrasound	ULTRASOUND Machine E2. (With accessories)	2
Ultrasound	ULTRASOUND Trolley for E2	2
Ventilators	VENTILATOR (SynoVent E3)	2
Posters	A2 Size Corona Algorithin	200
Posters	A3 case Ebola Virus	2000
	CG 4 Catridges 25's (2 pack/25	50
	Catridge, Chem8+25's (2 pack/25	50
mackintosh rolls	Mackintosh rolls	80

### **Surveillance**

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
Forms	A4 Contact Listing Form	2000
Forms	A4 Daily Contact Follow up Form	10,000
Forms	A4 Summary Field Teams	5000
Forms	A3 Questionnaire Secondary Screening	11000
Forms	A4 Mpango wa ufuatiliaji	1000
Forms	A3 Guidance for the self-Isolation/Quarantine	1000
Forms	A4 Port Health Event Notification forms	11,000
Forms	A4 Daily Contact Follow up Form	3,000
Forms	A4 Contact Listing Form	1000

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
POE	Thermometer infrared	60
POE	Thermometer infrared	20
Posters	A2 Point Of entry Core Capacities	100,000
Printing Materials	A4 Contact Daily Follow up Form	20000
Printing Materials	Contact Listing Form - Swahili	5000
Printing Materials	A4 POE Surveillance forms - English	10,000
Printing Materials	A4 POE Surveillance forms - Swahili	50000
Printing Materials	A4 POE New Surveillance form	20000
Posters	A3 6 Case definition	12000
Posters	A4 Case Investigation Forms	200
Printing Materials	A4 Case Investigation Forms	400
Printing Materials	Contact Listing Form - Swahili	20000
Printing Materials	A4 Contact Daily Follow up Form	100000
Printing Materials	A4 Daily summary report	15000
Printing Materials	Case Definition Corona	10000
Printing Materials	A4 Case Investigation Forms	150
Printing Materials	A4 Daily summary report	5000

### **RCCE**

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
Furniture	Recliner Single Sofa Set for Call Center Office	1

### **Logistics**

<b>Class/Group</b>	<b>Item Description</b>	<b>Qty Ordered</b>
IT Equipment	15 Laptops for staff use to enable Staff to work at Home	15
Tents	Multipurpose Tents 42 M2	2
Tents	Multipurpose Tents 24 M2	2
Tents	Multipurpose Tents 42 M2	2
Tents	Multipurpose Tents 24 M2	2

Tents	Multipurpose Tents 42 M2	2
Tents	Multipurpose Tent 24 M2	2

