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

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Contents

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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
UNHCR	United Nation High Commissioner for Refugees
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
WCO	WHO Country Office
WHO	World Health Organization

1. Executive Summary

The second WHO Country Office COVID-19 Response plan covering July – December 2021 was developed to support the preparedness and response activities of COVID-19 in the United Republic of Tanzania covering the same period.

Similar to the first report, we document the strategic measures that were taken to contain the pandemic 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.
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.

The report records a wide range of interventions implemented both in mainland Tanzania and the island of Zanzibar. It also points out challenges observed and areas which require improvement.
In the area of coordination, the capacity of health personnel was strengthened in IMS at the national and sub-national level in Zanzibar. Technical support was also availed to the Zanzibar Health Research Institute (ZAHRI) and the ministry of health in Zanzibar to conduct an epidemiological survey to assess the compliance of the communities to the public health and social measures that were adopted in Zanzibar during the COVID-19 pandemic. The islands were also enabled to adapt the WHO/AFRO IDSR – 3rd edition, technical guidelines followed by a stakeholder's validation meeting. The adaptation of these guidelines was followed by a ToT training and cascade orientation at the subnational level.
In mainland Tanzania, capacity building of health personnel from the PHEOC at the sub national level from five regions was provided on public health emergency management and PHEOC operations. Similarly, the SOPs for PHEOCs were reviewed to accommodate the new developments from the generic WHO guidelines. The major challenge in coordination was the lack of clear guidance from the national authorities with regards to the involvement of stakeholders in supporting the response at the sub national level. The non-functionality of the National Task Force (NTF) meetings during this period was a major hurdle in the response during this second period.

In the area of surveillance, the organization provided technical support to the region in Arusha at the height of the pandemic to contain it. In this regard, the region in collaboration and with technical support from WHO put forward a plan to decentralize the response to the lower levels so that the communities were more engaged and were able to participate in preventive actions. Furthermore, all the facilities were capacitated to provide real time support, care and prevention of the disease under close coordination of the Council Health Management Teams (CHMTs). The organization provided technical support in the orientation of 294 health care workers (HCWs) in Dar es Salaam region from five municipals (Temeke, Ubungo, Kinondoni, Ilala and Kigamboni) in the detection of cases using standard case definitions for

COVID-19, ILI/SARI sentinel surveillance and its linkages with COVID-19 (influenza site HFs only) and assessing the performance of eIDSR.

The WCO facilitated supportive supervision in the implementation of IDSR and onsite mentorship to strengthen the region in Lindi which was one of the poorest performing regions in the implementation of IDSR in the country. Technical teams from WHO and MoH carried out a ToTs of 70 targeted PoE staff from 7 entry points in Mbeya, Songwe, Rukwa and Katavi regions.

The joint supervision team at the POE made practical recommendations to the POEs which would enable the POEs in handling emerging and re-emerging infections more effectively in both mainland Tanzania and Zanzibar.

The organization facilitated the Ministry of Health, Zanzibar to hold a four-day training with key community health volunteers (CHVs) from North B district and West B districts on community -based surveillance (CBS).

The organization supported the Kigoma region to strengthen the IDSR reporting system, outbreak investigation and follow up in the refugee camps through capacity building of health information teams (HIT), health information team supervisors and health promotors working in the refugee camps. Following the establishment of community transmission of SARS-NCOV-19 in Kigoma and the escalating of COVID-19 alerts, WHO in collaboration with Kigoma RHMT built the capacity of laboratory personnel on specimen collection, packaging and transportation.

The major challenge observed in the surveillance pillar is the lack of transparency in information sharing by both ministries of health (Tanzania mainland and Zanzibar). To date, no data has been shared to enable detailed epidemiological analysis to guide planning of appropriate response activities. This in turn affected all surveillance response activities. There is still limited involvement of other stakeholders including partners in conducting COVID-19 case field investigation that makes it difficult to elucidate the type of variant of the COVID-19 virus circulating in the country.

On the laboratory front; the organization supported the training of Mnazi Mmoja laboratory staff on how to handle biological materials suspected to contain different biosafety containment levels, bio risk management thereafter guided the biosafety committee team to conduct laboratory risk assessment and recommend mitigation measures as part of assuring safety and security of COVID-19 testing processes in Zanzibar. In an endeavour to sustain the quality of the laboratory testing; WHO supported Mnazi Mmoja laboratory to have an inter laboratory comparison scheme for SARS-CoV-2 testing with NPHL of Mainland Tanzania whereas an MOU between the two laboratories was endorsed.

A major challenge in the laboratory pillar is the lack of laboratory data sharing from the ministry of health including number of travelers or patients tested and results. However, WHO and other partners are continuing with advocacy efforts to persuade the Government to share data. Another challenge is the stock-out of laboratory reagents that repeatedly led to disruption of services in Zanzibar.

In terms of RCCE, a lot of ground was covered. For example, in collaboration with the Port Health experts, WHO contributed to the development of messages to be strategically positioned at points of entry targeting travelers and long-distance truck drivers. These messages have been packaged in standalone banners and positioned in various points of entry in the country. Continued public awareness activities contributed to increased awareness as evidenced by the second Knowledge Attitude and Practice (KAP) study conducted in Mainland indicating that 99.8% (n=1818) of individuals were aware about COVID-19.

Through WHO's advocacy efforts, the Ministry of Health recruited 24 new staff to strengthen capacity of the Health Promotion unit to effectively implement planned RCCE activities. WHO played a key role in the orientation of the staff on the role of RCCE during public health emergencies; the Zanzibar RCCE response plan and basic principles of RCCE. With technical support from WHO, the Health Promotion team oriented 25 health care providers on the basic elements of psychological first aid that can be provided to individuals and families affected by the COVID-19 pandemic.

One of the challenges observed in the RCCE pillar is the persistent delays in the approval of messages developed and mixed messaging from the high-level national authorities. This has contributed to the complacency of the public in general in practising safety precautions, which in turn poses a challenge for the RCCE teams to sustain and scale up RCCE interventions.

Under the case management pillar there are a number of steps that have been taken. For example, after the adoption of home care for mild and moderate cases for both Zanzibar and the mainland, the number of patients who were being attended in the designated centers was drastically reduced and therefore there was a significantly decongestion of patients. The decline in number of patients minimized the need for surge capacity. It was decided by the MOH that the Saba Saba facility would remain on standby in the event where there was a surge in incidence of COVID-19 confirmed cases. The policy of decentralizing COVID-19 response and care including home-based care for mild cases commenced in the districts and there was an urgent need to ensure that all districts had the capacity to initiate and effectively roll out this strategy.

Previous assessments conducted in the district health facilities indicated major gaps which include screening, triaging and isolation of patients. These necessitated the need to effectively utilize reference working tools such as SOPs, algorithms, flow charts and job aides to maintain best practices in managing COVID-19 cases. In this regard, WCO continued supporting the Ministry of Health in building capacity of front-line health workers through training, mentorship and supportive supervision to effectively screen, triage and isolate patients. Similarly, the pillar continued with the development/adaptation of tools and key performance indicators (KPIs) to gauge health facilities' readiness in terms of IPC/WASH infrastructure, standards, and practices.

Furthermore, WHO supported the development of the training materials on advanced IPC with facilitators and participants' guides were developed; while existing materials on basic and intermediate level were reviewed and repackaged. For ensuring sustainability, it is recommended that IPC modules be incorporated into the training curricula at pre-graduate, post-graduate and in services training levels. In view of this, Muhimbili university of Health and Allied Sciences (MUHAS) and Ministry of Health are working on integrating some of the IPC materials into the training curricula. The plan is that all students

be oriented on IPC issues before they get into clinical rotation, and clinical instructors and staff should supervise the practice to ensure adherence and safety.

Assessment of oxygen supply and critical care for both mainland and Zanzibar was commissioned, with the aim of identifying opportunities and existing gaps. Comprehensive reports and plans were developed, identifying immediate, and long term needs. The two reports have been submitted to MOH and now been used to mobilize resources.

The Case Management and IPC Pillar has produced some detailed proposals and plans that were included or referred to in the version 2 Response plan – for example, the five year proposal on strengthening IPC in health facilities, the oxygen scale-up plan, and the critical care training plan. One of the challenges observed in this pillar is that several COVID-19 treatment centers have been decommissioned and as such, in the event of a surge in confirmed cases, effective infection control measures can be compromised. In the majority of the facilities, there are inconsistent IPC practices among HCWs and patients. Inconsistent use of masks, poor practices in hand hygiene, and inadequate waste segregation and disposal remain a significant challenge in most health facilities.

The logistics pillar procured various medical equipment including; laboratory test kits and reagents, PPEs including face shields, goggles, gowns, respiratory masks, surgical masks etc. Also procured were medicines and biomedical equipment e.g. oxygen concentrators and other supplies.
A total of US$ 1,164,000 was mobilized between July and December 2020 for COVID 19 response and utilization as at 31st December 2020 was 72%.

2. COVID-19 Background

The United Republic of Tanzania reported the first case of COVID - 19 on 16th March 2020 as an imported case that was detected in Arusha region. The outbreak has progressively increased to affect several regions in Tanzania Mainland as well as Zanzibar. As of 29th April 2020, a total of 509 confirmed cases and 21 deaths have been reported from 24 out of 26 regions in Tanzania Mainland and both islands of Zanzibar. Currently Community transmission has been observed in all regions-Tanzania Mainland , as well as Zanzibar and similar transmission scenario may be observed in other parts of the country. The geographical location of the country promotes high cross border interaction for trade and other socio-cultural activities. The weak health system and existing gaps in capacity for public health emergency response as observed during ongoing response calls for a need of more efforts to support the country to enhance response interventions at this transmission scenario. It is against this back drop that the WHO Country Office (WCO) developed an updated COVID-19 response plan to reflect the current context in the country for a period of six months from June to December 2020.

The Government of United Republic of Tanzania and partners have been implementing COVID-19 response activities since March 2020. However, there are still major gaps in the various key response technical areas that must be addressed in order to scale up respective measures at national and subnational level to ensure adequate response to promptly manage the outbreak. The progress report for the implementation of the first six months of the WCO COVID response plan is available.[1]

WHO currently has classified the risk of COVID – 19 transmissions globally as very high. During initial phases of the outbreak, the risk to Tanzania was aggravated by the huge number of tourists in URT and this necessitated the categorization of URT as priority 1 in AFRO. In the period of the past 6 months a several initiatives have been put in place initially for preparedness and later for response with much of the emphasis in 6 regions - Dar es Salaam, Mwanza, Arusha, Kilimanjaro, Mbeya and Dodoma that were identified as having higher risk due to presence of international points of entry (PoE) and economic activities that promotes more interaction of people. However, the current situation where 24 out of 26 regions in Mainland and Zanzibar have been reporting cases, the risk of transmission has increased to all regions in the country. Likewise, given the geographical area of the country that has been affected, weak health system in most of the regions coupled with limited resources to address all response interventions comprehensively, the COVID – 19 risks in Tanzania stands to be very high throughout the country. However, effects of this outbreak may also be increased by the disruption in socio- economic activities especially traffic and trade due to the geographical location of Tanzania and being a tourist destination especially for Zanzibar with travelers from all over the world.

The reports from ongoing response interventions in the regions where cases have been reported shows that there are significant gaps in all technical areas including response coordination whereby decentralization of response activities from national level is still limited. There is inadequate personal protective equipment and as well as limited IPC practices including triage and screening in health facilities. Despite having

[1] WHO Country Office, Tanzania. 2020. Progress report for the implementation of the COVID-19 response plan – January – June 2020, Dar-es-Salaam, Tanzania

designated isolation facilities in every district in the country there is a big gap in critical care facilities throughout the country. Surveillance activities are limited by inadequate technical capacity, human resource as well as limitations in event - based surveillance.
This report covers the activities that the WCO conducted to support the United Republic of Tanzania to address the gaps observed in the first plan from June – December 2020.

3. Implementation progress

3.1 Pillar: Coordination and Leadership

3.1.1 Capacity building of Trainer of Trainers for the Incident Management System at the district level for Ebola Viral Disease and COVID-19 preparedness and response

The WCO continued to support technical capacity in the area of EVD preparedness and COVID-19 response activities. The training of trainers and the district Incident Management System (IMS) trainings were designed to equip the participants with the required skills for effective coordination of any public health emergencies and outbreaks including EVD and COVID-19.

WHO participated and facilitated training of trainers of Incident Managers from 14th to 17th September 2020. This training included twenty-five participants at national level from Unguja and Pemba.

In supporting the MOH decentralization of preparedness and response activities, WHO participated and facilitated IMS training at the district level, a total of forty-seven participants benefit from the training which was conducted in Unguja at Abla hotel conference hall from 24th – 27th September 2020 and a total of thirty participants were trained from 5th – 8th October 2020. The CDC IMS training package was used to deliver the training.

WHO Coordination officer facilitating a session during IMS training, September 2020

3.1.2 Capacity building of Public Health Emergency and Operation Centre staff on the incident management system and related operations in five regions

To improve the capacity of PHEOC staff from the subnational level in public health emergency management, WCO through the Health Systems resilience building Japanese Grant, supported training on the incident management system (IMS) and PHEOC operations of 15 staff from the 5 subnational PHEOCs in Tanzania Mainland. Three staff from each of the regional PHEOCs were trained from 5th to 9th October 2020 in Dar-es-salaam. The regions that benefited included Dar es salaam, Mbeya, Kigoma, Kagera and Mwanza. These were the 5 regions that had already established PHEOCs. The training aimed at enabling the staff from the newly established PHEOCs to effectively support the coordination of COVID 19 response activities and other public health emergencies preparedness and response including communication and information management pertaining to public health emergency management in the respective regions. The staff trained were also equipped with skills and tools for orienting other health workers and stakeholders on IMS and emergency management in their respective regions.

This training was preceded by a 3 days' work session from 28th to 30th September 2020 to develop the training package to be used to deliver the training. The draft training package was piloted during that training which allowed for inputs from the trainees and the trainers on how to improve the package before using it to roll out the training to other regions.

3.1.3 Review of national Public Health Emergency Operation Centre – Standard Operating Procedures

To improve operationalization of National PHEOC for Tanzania Mainland Ministry of Health to continue supporting COVID 19 response and other public health emergencies, WHO supported the MOH to review the national the Standard Operating Procedures (SOPs) for PHEOC of 2016, so as to update them and accommodate new developments including linkages with already established subnational PHEOCs. The SOP was reviewed in a 5 days' workshop from 23rd to 27th September 2020 in Dar-es-salaam involving a team of experts from ministry of health, PORALG, Prime Minister's office Disaster Management Department and representatives from subnational PHEOCs. The WCO provided technical support in this activity. A draft of the reviewed SOP is currently at the approval stage by the MOH leadership. The SOP will also be adapted at the subnational PHEOC.

3.1.4 Facilitation of an epidemiological survey in compliance with Public Health and Social Measures for the Zanzibar Health Research Institute (ZAHRI) and Zanzibar Ministry of Health to interrupt COVID-19 transmission

WHO participated and supported the Zanzibar Health Research Institute (ZAHRI) and Zanzibar Ministry of Health to conduct an epidemiological survey in compliance with Public Health and Social Measures to interrupt COVID-19 Transmission in Zanzibar. The purpose of this cross-sectional study was to assess the compliance of public health and social measures that were adopted in Zanzibar for interruption of transmission of COVID-19 by the communities. WHO supported orientation of the research protocol to the research team, a total of twenty research assistants and supervisors were oriented on the research protocol in Unguja on 10th September 2020 and 13 research assistants and supervisors from Pemba were oriented on 16th September 2020 . The findings from this survey have been useful in assisting public health experts to guide the public on practices to adopt in order to prevent COVID-19 infection.

Research team and participants in a Focus Group Discussion (FGD) – youth (men) in urban district, September 2020

3.1.5 Development of operational plan for COVID -19 response plan II

In the month of August 2020 WHO supported the MOH to conduct a 3 days work session to develop an operational plan for COVID 19 response plan version 2 of July 2020. The working session which took place in Dar-es-salaam from 20th to 21st August 2020involved technical officers from the MOH and development partners. The output of the session was an operational plan that identifies activities by priority to be implemented in 3 phases; short term July to October, medium term November to February, and long-term March to June 2021. This plan has enabled focusing on interventions that were included in the main response plan which is currently being implemented.

3.1.6 Challenges

Coordination of response was hampered by difficulties faced in implementing activities outlined in the comprehensive national COVID – 19 response plan that clearly states the response strategies to be followed by the country at all levels of implementation. 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 contributed to inadequate stakeholders' engagement from planning to implementation of interventions.

3.1.7 Way forward

To strengthen coordination and leadership in the implementation of the response activities, the pillar proposes continuous engagement of the Government through the MOHCDGEC and PORALG to achieve joint planning of interventions, develop comprehensive response plans for national and regional levels. In addition, sharing of these documents with all stakeholders and partners is essential for timely implementation of interventions.

3.2 Pillar: Surveillance, laboratory support and Points of Entry

3.2.1 Support the Response of COVID-19 outbreak in Arusha Region

The WCO provided support to the Arusha region to strengthen leadership, surveillance, , commitment of health care workers and community engagement in responding to COVID-19 epidemic which led an up-surge of few cases. Important factors that led to the successful control of the disease in Arusha region are outlined.

At the height of the epidemic in March – June 2020, the region had 10 designated COVID-19 isolation centers but in the second half of the year 2020, these centers were vacant. Despite these successes, the region was keen to remain free of COVID-19 disease and completely halt the transmission from any remnant cases. In this regard, the region in collaboration and with technical support from WHO prepared a plan to decentralize the response to the lower levels to further engage the communities and ensure that they are able to participate in preventive actions. Furthermore, all the facilities were capacitated to provide real time support, care and prevention of the disease under close coordination of the Council Health Management Teams (CHMTs).

In the implementation of the Plan, using the national guidelines, WCO provided technical support to the Arusha region from 7th to 25th June 2020 in the COVID-19 response. The support included training of 140 community health care workers from Arusha City Councils and 17 supervisors. The training covered contact tracing, COVID-19 prevention aspects, elements of home isolation and addressing stigma and family support in relations to COVID-19. In each training session, 10-15 CHWs were trained with strict adherence to physical distancing. Following the training, the CHWs supported community responses in their catchment areas integrating community response with their routine HIV activities in the community.

Furthermore, coaching was done for all seven CHMTs on the national packages for prevention, care and support of COVID-19 and delivery of essential health services of TB, HIV, RCH, NCD and how to care for the old/senior citizens in the context of COVID-19. Coaching was done through visiting selected facilities in each district, the regional health teams formed three teams, each team was allocated two districts except one team which was allocated three districts. In each district, the teams spent 3-4 days to demonstrate capacity building approaches to CHMTs and elements to monitor during supervision visits. A total of 100 CHMTs members were coached and 18 Health facilities were visited in the region.

A team of supervisors from WHO, Arusha region, Karatu District Council and facilitation of CHWs in one of the sessions, June 2020

3.2.2 Adaptation and validation of WHO/AFRO IDSR guidelines – 3rd edition to strengthen surveillance and response of public health events including COVID-19 in Zanzibar

The country office supported Zanzibar to adapt the WHO/AFRO IDSR – 3rd edition, technical guidelines which was followed by a stakeholder's validation meeting from 5th to 23rd July 2020 in Unguja-Zanzibar. The new adapted guidelines enabled Zanzibar to align with Africa's Regional Strategy for Health Security and Emergencies (2016-2020) enabling Zanzibar to strengthen prevention, detection and response to public health events. The new guidelines provide opportunities to strengthen surveillance with the emphasis in strengthening event and community-based surveillance. It also provided an opportunity to establish and strengthen the electronic surveillance system through the information, communication and technology unit in Zanzibar. The adaptation task force constituted of 29 experts from WHO, CDC, UNICEF, the Ministry of Heath Zanzibar and mainland Tanzania. The WHO adaptation checklist was used. The meeting to validate the new guidelines was attended by 24 stakeholders mainly from the MoH Zanzibar representing various programmes implementing IDSR and partners including WHO, UNICEF and CDC amongst others.

Adaptation task force participated in the adaptation of Zanzibar 3rd Edition IDSR Guidelines, July 2020

3.2.3 Facilitation of Trainer of Trainers on the IDSR Guidelines (3rd edition) and cascade training at the subnational level to strengthen surveillance and response in public health events including COVID-19

Facilitators and IDSR Zanzibar ToTs August 2020
Guidelines, July 2020

The organization supported the Training of Trainers (ToT) in Zanzibar on the 3rd edition of the IDSR guidelines which was conducted from 24th to 28th August 2020. The training was preceded with a facilitators meeting to adapt the training materials and preparation of the training program. The training was attended by 33 surveillance officers from the MOH and all districts in Unguja and Pemba. The ToT were used to cascade the training of new guidelines at the sub-national level in all districts and health facilities. In Pemba a total of 95 heath facilities were trained on the new IDSR guidelines and in Unguja 67 community-based surveillance focal persons were trained in two districts (North B and West B).
A group of facilitators and participants during the ToT training is observed in the picture on the left.

3.2.4 Orientation of health care workers in the detection of cases using standard case definitions for COVID-19, influenza like illness and severe acute respiratory infections (ILI/SARI) Sentinel Surveillance in the region of Dar-es-Salaam

In order to detect and respond effectively to the COVID-19 epidemic, the following were implemented: strengthening detection rate at the facility level through mentorship and training of HCWs, strengthening and expanding ILI/SARI sentinel sites at selected health facilities, use of CHWs in detection of cases and follow up of contacts and establishment of event-based surveillance at the drug dispensing outlets.

The organization provided technical support in the orientation of 294 HCWs in Dar es Salaam region from five (5) municipals (Temeke, Ubungo, Kinondoni, Ilala and Kigamboni) in the detection of cases using standard case definitions for COVID-19, ILI/SARI sentinel surveillance and its linkages with COVID-19 (Influenza site HFs only) and assessing the performance of eIDSR.

3.2.5 Support supervision and onsite mentorship on IDSR reporting public health events including COVID-19 in Lindi Region

The WCO supported supportive supervision on the implementation of IDSR and onsite mentorship to strengthen the region in Lindi. This was conducted in three districts (Nachingwea DC, lindi DC and Kilwa DC) from 23rd to 28th August 2020. The objective of the supervision and mentorship was to strengthen all functions of surveillance in these districts, the three districts were selected because they showed inadequate performance in reporting on IDSR, compared to other districts in Lindi. This led to the region being one of the poorest performers in the country. A team of regional supervisors including the Regional Medical Officer conducted supportive supervision in the three districts in which 37 CHMTs members were oriented from Kilwa DC-15, Nachingwea DC-12 and Lind DC-10. A total of 29 heath facilities were visited and supervised including Kilwa-9, Nachingwea-12 and Lindi-8.

A total of 136 (Kilwa DC-60, Nachingwea DC-42 and Lindi DC -34) health care workers were mentored in various functions of surveillance including detection, reporting, analysis, and investigation and confirmation of suspected cases and responding to outbreaks. Furthermore, data quality audits were conducted in the districts and health facilities visited. Some challenges observed included inconsistency of data between the data recorded in the health facilities registers and districts, and some facilities not analyzing and reporting data at both heath facilities and districts. New heath facility reporting officers were oriented on surveillance functions. The performance of the reporting rate of the supervised districts improved after mentorship.

RHMT Member conduct meeting with CHMT during supportive supervision and orientation Mentorship on IDSR at Lindi DC, Lindi Region – August 2020

3.2.6 Support Supervision and mentorship at Point of Entries to strengthen the surveillance of public health events in Mbeya, Songwe, Rukwa and Katavi

Technical teams from WHO and MoH carried out a ToTs of 70 targeted PoE staff from 7 entry points in Mbeya, Songwe, Rukwa and Katavi regions. Staff were trained and given training materials to ensure that once they go back to their PoE stations, they would conduct mentorship in their respective areas of work. This aimed to improve implementation of port health activities and to ensure that all PoE staff from other government departments including immigration, customs and security agencies are well trained on WASH/IPC practices for enhanced COVID-19 and EVD preparedness and response at all PoE's.

Among the challenges identified were; inadequate port health staff where only 48% are currently available, inadequate capacity of port heath staff in HID prevention skills, inadequate disinfecting materials (chlorine and sanitizers) at most POEs (chlorine was mentioned to be available at only 1 out of 6 POEs), difficulties in practicing temporary isolation due to the absence of temporary or permanent structure, frequently changing travel advisory guidance for entry and exit screening and inadequate PPEs in all the POEs visited.

Screening at Point of Entry in Katavi, November 2020

The supervision team recommended to the MoH to assign more staff at the points of entry responsible for handling health issues and capacity building for the POE staff to ensure that the country is ready to respond to HIDs. The team pointed out the need for the manager of the port health services and zonal coordinator to have a standard capacity building plan for capacity improvement. The supervision team also recommended that the POE zonal coordinator to closely supervise and monitor preventive actions of HID (social distancing, IPC/WASH, isolation, mask wearing), the MOH to set aside funding towards the provision of a temporary or semi-permanent isolation in order to minimize the probability of infection before the cases are confirmed. They also emphasized that clarification on travel advisory is

required for staff to effectively promote, continuity of assessment on population movement and connectivity across the respective borders.

Supervisors and mentees during supportive supervision and mentorship in Songwe Airport November 2020

3.2.7 Capacity building of front line Field Epidemiology and Laboratory Training Programme (FELTP) Human and Animal Surveillance Officers on the IDSR guidelines – 3rd edition

The WCO provided technical support in the first workshop of 11 cohort trainings. The workshop was conducted in Bagamoyo Town, and Pwani Region from 8th – 14th November 2020. This training included twenty-one (21) participants from the health sector and twenty (20) participants from the zoonotic section of the health sector, with representation from all the 18 districts of Morogoro and Pwani regions. The CDC curriculum and materials for frontline courses in epidemiology were used for in class sessions this included; introduction to principles of disease surveillance, case investigation summary statistics and basic report writing.

3.2.8 Development of Event Based Surveillance Standard Operation Procedures for the operationalization of Event based Surveillance of Public health events including COVID-19

The organization provided technical facilitation in a working session of five days aimed at reviewing SOPs for the implementation of Event based Surveillance (EBS) in the country. This session was conducted at the NIMR conference-Dar es Salaam from 8th to 15th November 2020, the participants were from the MoHCDGEC.

During this workshop, existing EBS guidelines were amended to reflect the new adopted Tanzania mainland IDSR guidelines and the proposed SOP content. The SOP layout and contents was agreed upon members. For proper implementation of the SOPs, it was proposed to develop some job aid for smooth operations of EBS procedures. The proposed job aids included: a check list for media scanning, triaging and verification tool and risk assessment tool.

3..2.9 Orientation of Council Heath Management Teams from Morogoro on the IDSR guidelines, 3rd edition in order to strengthen surveillance and response in public heath events including COVID-19

Technical support was provided in the orientation, advocacy and sensitization of Morogoro Regional Heath Management Team (RHMT) and its nine (9) Council Heath Management Teams (CHMTs) on the IDSR guidelines, 3rd edition. The event was coordinated by MoHCDGEC . The workshop was held in Morogoro from 25th to 27th November 2020.

A total of 90 participants attended the sessions, the participants comprised of 9 RHMT members and 9 CHMT members from each of the 9 Morogoro District Councils (Morogoro MC, Morogoro DC, Gairo DC, Mlimba DC, Ifakara DC, Kilosa DC, Ulanga DC, Malinyi DC and Mvomero DC). The participants were the supervisors of different programs implementing IDSR at regional and district level which include, surveillance officers (IDSR FPs), laboratory technicians, Immunization and Vaccine Officers, Reproductive and Child heath coordinators, Neglected tropical diseases coordinators, Heath Information Management System Coordinators, Malaria Focal persons, TB and Leprosy coordinators and AIDS coordinators. The sessions were also attended by Districts Medical Officers and Acting District Medical Officers from 9 Morogoro District councils.

3.2.10 Technical presentation on COVID-19 at the 37th Tanzania Public Health Association Annual Conference, Arusha, Tanzania

The Organization was among the technical and financial supporters of the 37th Tanzania Public Health Scientific Conference held in Arusha from 6th to 11th Dec 2020. The conference aimed to inform the Government of the United Republic of Tanzania and other stakeholders of the most evidence- based approaches to mitigate epidemics in future.

The conference's main theme was *'Emerging and Re-emerging Infectious Diseases: Risks, Impacts, preparedness and responses.'* The subthemes were; (i) emerging and re-emerging infectious diseases, (ii) social determinants of infectious diseases of epidemic potential, (iii)the intersection of non-communicable Disease and infectious disease epidemics and (iv) strengthening health systems and improving capacity to respond to epidemics. The conference attracted more than 150 participants from different institutions and organizations in the country; the conference was officiated by the One Health Coordinator, from the Prime Minister's Office.

At the conference, the WHO team shared an overview of the COVID-19 pandemic in the country including the chronology of events since the first case was confirmed in the country. The spread of COVID-19, public health measures undertaken such as personal hygiene, social distancing, closure of schools and colleges; and Infection and Prevention Control (IPC). Furthermore, analysis of effect of COVID-19 pandemic in Tanzania on immunization services were shared with minimal effect found, except for Human Papilloma Virus Vaccine (HPV) where there was significant decline as a result of school closure.

A surveillance scientific article on the rapid adoption of digitalization on health services in Africa to curb the effect of COVID-19 disruption was among three presentations presented by WHO in the conference.

3.2.11 Updating the Integrated Diseases, Surveillance and Response (IDSR) tools to correspond to new updates of the 3rd Edition IDSR guidelines and incorporate COVID-19 in mainland Tanzania

A workshop was conducted to update IDSR tools to correspond with new updates of the 3rd edition IDSR guidelines including additions of new conditions and diseases including COVID-19. The MoH Tanzania mainland in collaboration with WHO organized a three-day working session from 21st to 23rd December 2020 to update the e-IDSR booklet, define event-based signals, review standard case definitions, signal register and also the revision of the IDSR training modules. This activity was accomplished by a team of surveillance experts mainly from MoH and WHO. The output of this working session included the developed/revised documents; e-IDSR reporting booklets/registers, pre-defined event-based signals, standard case definitions for priority modifiable diseases which include COVID-19, alert register at various levels and revised IDSR training materials. The documents (IDSR booklet, standard case based surveillance (CSCD), event based surveillance (EBS) SOPs for operationalization of EBS)were reviewed and submitted for printing.

3.2.12 Support Printing of IDSR Guidelines and other tools which include COVID-19

The WCO facilitated the printing of the Zanzibar adopted IDSR 3rd edition IDSR guidelines and alert registers for dissemination to districts and health facilities which include COVID-19. A total 1,600 copies of Zanzibar 3rd edition IDSR Guidelines booklets and alert registers.

3.2.13 Stakeholders sensitization meeting to enhance surveillance and response to public health events using IDSR 3rd edition guidelines in Zanzibar

Facilitation was provided to public and private stakeholders (31 from Pemba and 45 from Unguja), to sensitize them on surveillance and response to public health events using the IDSR 3rd edition guidelines. The meeting was conducted on the 16th October in Pemba and 20th October 2020 in Unguja. The contents included: new key updates from the Zanzibar IDSR guidelines, 3rd edition, overview of IDSR, preparedness and response to outbreak and risk communication and community engagement. This was followed up with discussions and way forward towards achievements in the implementation of the guideline from the national to the community level.

3.2.14 Supportive supervision and mentorship at points of entry in Zanzibar to enhance surveillance of public health events including COVID-19

Zanzibar strengthened their surveillance system especially at the point of entries. In developing and implementing this effectively, the Ministry of Health in collaboration with WHO conducted supportive supervision and mentorship at all points of entry in Unguja and Pemba. The aim was to capacitate the PoE staff and strengthen the surveillance system for early detection of public health events which include COVID-19. Observation, interviews and discussion using standardized checklist was used during supervision. Seven points of entries were supervised and mentored; in Pemba these were; Mkoani, Wesha, Wete seaports and Pemba airport. While in Unguja these included; Malindi, Mkokotoni seaports and Amani Abeid Karume International airport. The supervision was conducted in Unguja from 10th to 13th November 2020 and Pemba: 22nd to 27th November 2020.The checklist focused on the following areas of supervision and mentorship: diseases surveillance, waste management, vector control, Inspection program, occupational health, medical and first aid services, emergency services, health promotion.

Preventive messages against COVID-19 at Points of Entry, Zanzibar, November 2020

3.2.15 Community health volunteers (CHV) on community base surveillance (CBS) in Zanzibar to strength community-based surveillance of public health events including COVID-19

The organization supported the Ministry of Health, Zanzibar to hold a four-day training with key community health volunteers (CHVs) from North B district and West B districts on community based surveillance (CBS). This training was conducted from 21st – 22nd October 2020, for a total of 31 CHVs from North B district and from 23- 24 October 2020 for 36 CHVs from West B district. The training covered the following topics; introduction of CBS, responsibilities of CHVs, identification of cases of priority diseases, concept of rumors of diseases and event, provision of health information about cases/rumors of diseases and referral of patients, diagnosis, monitoring and confirmation of suspected epidemics.

Orientation of community health workers on case- based surveillance, October 2020, Zanzibar

3.2.16 Training of Facility IDSR Focal Persons on IDSR 3rd Edition technical guidelines in Pemba to enhance the surveillance of public health events including COVID-19

The Ministry of Health Zanzibar in collaboration with WHO conducted training of the IDSR focal persons in Pemba to enhance health care workers knowledge and skills on the implementation of the new 3rd IDSR guideline. WHO held a four-day training with key Community health volunteers from North B district and West B district on Community Based Surveillance. This training took place from the 21st – 22nd October 2020 where 31 CHVs from North B district were oriented and from 23rd – 24th October 2020 where 36 CHVs from West B district were oriented. A total of 95 healthcare workers were trained, the training was divided in three (3) sessions to ensure adherence to social distancing and other IPC measures. The method of facilitation used included, presentations, group works and plenary discussions.

3.2.17. Strengthening surveillance and response for COVID -19, EVD and other outbreak prone health events in the refugee camps – Kigoma

The organization supported the Kigoma region to strengthen the IDSR reporting system, outbreak investigation and follow up in the refugee camps through capacity building of health information teams (HIT), health information team supervisors and health promotors working in the refugee camps. Seventy-six (76) surveillance officers were trained including, 32 HIT members, 24 HIT supervisors, 14 healthcare workers and 6 coordinators from Nyarugusu, Nduta and Mtendeli refugee camps were trained. Aggregation by camp; thirty-two (32) were from Nyarugusu refugees camp, 16 from Nduta refugee camp and 28 from Mtendeli refugee camp. These surveillance officers managed to rapidly detect, report and manage epidemics alerts and rumours at community level. This was observed through joint supportive supervision conducted by UNHCR, Kigoma RHMT and MOHA and through the district IDSR system.

The health information team demonstrating surveillance forms for COVID-19 at Nyarugusu refugee camp, September 2020

3.2.18 Building capacity of community in Kigoma region to conduct community-based surveillance activities

The organization supported the Kigoma region to conduct community- based surveillance for 151 community mobilizers which included; community influential people, traditional healers, spiritualists, religion leaders, community-based arts groups and community-based organizations in the region.

As these community groups are mostly contacted when a community member gets sick, the groups were capacitated on COVID-19 and Ebola risks and preventive measures. Emphasis was given on their role to report to health authorities if anyone from their clients and the community seems to have signs and symptoms suggestive of COVID-19 or Ebola. Subsequently, the number of epidemic alerts and rumours reported to the region have increased since this capacity building exercise..

Facilitation session of a community influencers training at Nyamyusi village, July 2020

3.2.19 Building capacity of district surveillance officers and health facility-based surveillance officers on Integrated Diseases Surveillance System 3rd edition guidelines in Kigoma region

The Organization supported the training of 170 district IDSR focal persons, health facilities-based IDSR focal persons and surveillance focal person from eight local government authorities (LGAs) to use COVID-19 and Ebola case definitions, completing case investigation forms, reporting and contact tracing and follow up. Other areas covered were; IDSR reporting, responding to alerts and rumours, reporting of clustered cases, identifying contacts and follow, recording and reporting to the responsible authorities. The participants from LGAs were selected from amongst at risk villages and town centres and are the ones who on daily basis update the reportable health events including EVD and COVID-19 through IDSR system from the field.

3.2.20 Capacity Building of district Laboratory technician on specimen collection, packaging and transportation

Following the establishment of community transmission of COVID-19 in Kigoma and the escalation of alerts, WHO in collaboration with Kigoma RHMT built the capacity of 32 laboratory personnel, 4 from each council, on specimen collection, packaging and transportation. These included district laboratory technologists, laboratory managers, laboratory technicians and laboratory attendants for facilities that had no laboratory technicians from all the district councils in the region.

Practical sessions on infectious specimen collection at Kakonko Health Center, July 2020

The capacity building focused on sample collection, packaging of infectious specimens and substances, transportation and bio-risk management, emphasis was given on packaging the specimen according to regulations of the International Air Transportation Association (IATA) and shipment and documentation for COVID-19. These laboratory personnel were then used as mentors of other personnel which are at health facilities and designated highly infectious treatment units which were not involved during the initial training.

3.2.21 Challenges in surveillance

Lack of transparency in information sharing by both Ministries of Health (Tanzania mainland and Zanzibar) has been the major challenge. To date, no data has been shared to enable detailed epidemiological analysis to guide planning of appropriate response activities. The last official reports from the Government to WHO were on 29 April and 7 May 2020 for Tanzania mainland and Zanzibar respectively. There is still limited involvement of other stakeholders including partners in conducting COVID-19 case field investigation. The lack of transparency in data sharing has also made it difficult to elucidate the type of COVID-19 variant circulating in the country.

3.2.22 Recommendations on surveillance

The pillar recommends, enhanced high level advocacy of the surveillance data sharing and partners involvement is surveillance response activities . This will enable Tanzania to collaborate in planning and sharing of information, including organizing regular meetings, collaborative planning with partners and engendering synergy and complementarity for effective implementation. Such planning will also attract the appropriate technical and financial support.

3.2.23 Laboratory services

The WHO continuously supported the country to strengthen capacity of laboratories in sample collection, packaging, biosafety management and transportation centrally to the National Public Health Laboratory (NPHL) for testing. The training was conducted in five (5) phases: phases 1-3 were conducted in April-June 2020 covering 151 councils in 21 regions in the country. In these phases a total of 906 laboratory technicians from 6 selected health facilities in each council were trained. Phase four (4) was conducted on 6th – 17th July 2020 in Zanzibar covering all 11districts of Pemba and Unguja Islands. Phase five (5) of the training was conducted in the councils of Ruvuma, Rukwa and Katavi regions. For the reporting period of July to December where phase 4 and 5 was conducted an overall a total of 177 laboratory technicians were trained. The trained laboratory practitioners joined the council rapid response teams (RRT) and hence improved the quality and number of suspected COVID-19 samples collected. Figure xx is a map showing twenty (20) regions in mainland Tanzania and five regions in island of Pemba and Unguja of Zanzibar that were supported by WHO.

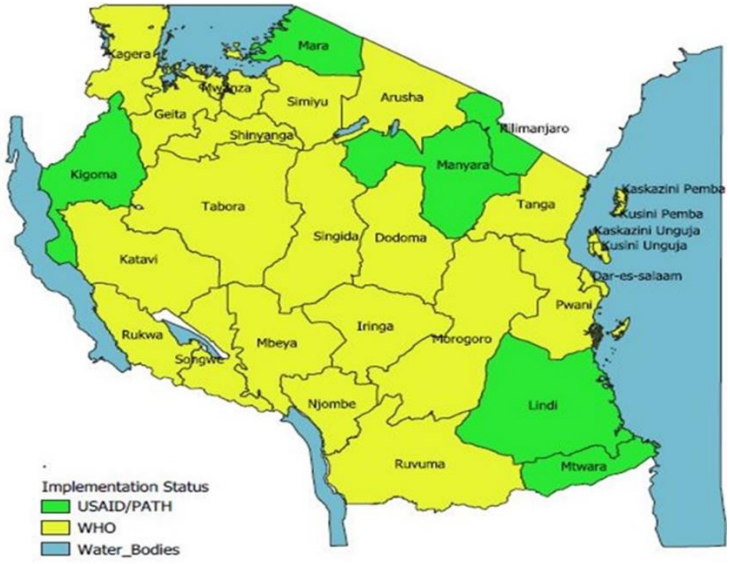

Figure 1. Sample collection and bio-risk management

The Laboratory unit also supported the NPHL in reviewing and updating SOPs, job aids, protocols and other tools for successful sample management and quality assurance monitoring activities of COVID-19. WHO also provided technical guidance on the use SARS-CoV-2 rapid diagnostic tests. These documents will be printed, disseminated and distributed to all health acilities in the country. The process to evaluate the SARS-CoV-2 RDTs is underway.

The organization's support extended to build the capacity of the Zanzibar laboratory personnel in the Zanzibar Laboratory to test COVID19 at Mnazi Mmoja hospital where the high throughput Abbott automation system was installed in November 2020.

The organization trained laboratory staff from Mnazi Mmoja on how to handle biological materials suspected to contain different biosafety containment levels and bio risk management. The technical team from WHO also guided the biosafety committee team to conduct laboratory risk assessment and recommended mitigation measures as part of assuring safety and security of COVID-19 testing processes in Zanzibar. WHO's capacity building also included competency assessments for laboratory staff, development of verification protocol for SARS-CoV-2 laboratory testing, internal quality control indicators and quality assurance plan, to ensure high quality in testing COVID 19 attained and sustained. Additionally, as part of sustaining quality testing; WHO supported Mnazi Mmoja laboratory to have an inter laboratory comparison scheme for SARS-CoV-2 testing with NPHL of Mainland Tanzania whereas an MOU between the two laboratories was endorsed.

Subsequently, WHO supported the NPHL to adopt and deploy the use of high throughput SARS-CoV-2 testing platforms including the Abbott m2000, Roche C6800 automated systems and the new Biorad CFX96 PCR machines donated by the Swiss Development Corporation (SDC) through Ifakara Health Institute (IHI). WHO has also continuously supported the procurement of reagents and supplies through the UN supply portal and other WHO mechanism to sustain the testing. The laboratory supplies and reagents that were procured included RNA extractions kits, master mix and enzymes, detection kits,

primers and probes and 50 triple packaging materials to both Mainland and Zanzibar. WHO has placed more orders for reagents and supplies as requested by the Mnazi Mmoja hospital and NPHL.

In order to further strengthen the laboratory activities in emerging and re-emerging infections in both mainland and Zanzibar the following activities were undertaken;

- The Organization supported the MOH Zanzibar to establish another laboratory to test for COVID-19 and other highly infectious diseases at the Binguni Infectious Disease Institute. The process has been initiated and requirements have been listed for purchasing
- The Country Office coordinated and facilitated a one-month training program for ten (10) laboratory scientists in the country on the use of the mobile laboratories; all of them are on standby ready to be deployed in any part of the country when need arises
- The Organization in collaboration with IHI supported the MoH Zanzibar to develop the COVID-19 seroprevalence survey protocol – currently the proposal is being finalized and the approval process from the ethical committee of the research authority is underway. Once approved sensitization and advocacy to the MOH will be done.
- Supported the NPHL in the decentralization of COVID-19 sample collection sites identification, assessments and certification – the overall oversight remains at the MOHCDGEC and WHO continues to provide technical assistance including participation in supportive supervision visits
- WHO collaborated with the NPHL in the development and deployment of the COVID-19 testing online booking – the system has been launched and travelers are encouraged to use the platform and this is envisaged to improve laboratory services

3.2.24 Challenges in Laboratory support

Challenges encountered during this reporting period include lack of laboratory data sharing including number of travelers or patients tested and results. However, WHO and other partners are continuing with advocacy efforts to persuade the Government to share data.
Delays in delivery of reagents continue to be observed due to logistical arrangements where all the reagents need to be cleared in mainland Tanzania by the Tanzania Medicine and Drug Authority (TMDA). For those equipment and supplies which are not yet registered for use by the TMDA, the clearance takes a much longer period.

3.2.25. Way forward in Laboratory support

There is a need to continue advocating for coordinated efforts to support building the capacity in COVID-19 testing including decentralization and mobilization of more resources for procurement of reagents and supplies.

3.3 Pillar: Risk Communication and Community Engagement

3.3.1 Review of existing public awareness messages and dissemination of printed materials

To support continued community sensitization at subnational level, WHO supported the Ministry of Health to transport printed materials - 178,500 posters and 210,000 leaflets – to 26 Regions in the mainland. These materials were distributed to more than 3.8 million people across the country. Print materials have been useful in complementing other channels of communication such as radio, television, social media and newspapers.

In collaboration with partners, WHO provided technical guidance in the review of existing public awareness messages to align with the prevalent response direction. A total of 59 products (banners, posters, social media jingles and video and radio spots) were reviewed and redesigned. These products have not yet been endorsed for dissemination.

In collaboration with the Port health experts, WHO contributed to the development of messages to be strategically positioned at points of entry targeting travelers and long-distance truck drivers. Messages were pretested in select air and seaports before finalization and printing. These messages have been packaged in standalone banners and positioned in various points of entry in the country.

Team of experts developing risk communication and community engagement messages to address COVID-19,, August 2021

3.3.2 Knowledge Attitude and Practice Study on Community Perceptions on COVID-19

Periodic Knowledge, Attitude and Practice (KAP) studies have been conducted to explore changes in Knowledge, Attitude and Practices of the community towards COVID-19 and re-align Risk Communication and Community Engagement strategies based on the findings.

Since the beginning of the response in March 2020, two KAP studies were conducted showing an increased level of community awareness towards the pandemic. From KAP 1, the findings reveal that 99.8% (n=1818) of individuals were aware of COVID-19 with no difference in the level of awareness

between males and females. During this reporting period, a second KAP study was conducted indicating that the level of awareness was equally very high, with only 4 and 6 respondents in KAP 1 and KAP 2 respectively were not aware of COVID-19. Overall, there is notable improvement in the proportion of individuals with comprehensive knowledge of COVID-19 ranging from 34.1% (n=482) during KAP-1 to 47.6% (n=669) during KAP-2. From the two KAP studies, almost 96.5% of all respondents reported the need for more information on COVID-19, where the majority indicated the need for more information on how to prevent and receive updates on COVID-19 in the country in KAP 1 and in KAP 2 the majority of individuals would need more information on signs, symptoms and prevention. The preferred sources of COVID-19 information were radio with 69.2% in KAP 1 and 84.0% in KAP 2 followed by television with 60.4% in KAP 1 and 68.1% in KAP 2, and mobile phone with 60.2% in KAP 1 and 44.2% in KAP 2. RCCE partners in collaboration with the Ministry of Health will continue to administer KAP studies and other community assessments in addition to community feedback mechanisms in place in order to best re-align communication strategies towards COVID-19 response.

3.3.3 Using mainstream and social media to promote COVID-19 safety precautions

The Organization supported Radio Joy FM in the Kigoma region to broadcast COVID-19 safety precautions for a period of 1 month. Radio Joy FM is a local radio station that has coverage in Kigoma and Katavi regions extending to DRC and Burundi. A total of 21 recorded and live radio programs were broadcasted on a wide range of topics related to COVID-19, EVD and Cholera prevention. Approximately 4 million people were reached contributing to improved hand hygiene practices in public places such as marketplaces, places of worship, bus stops and schools.
In Zanzibar, WHO worked closely with the Health Promotion Unit to host a 1-hour interactive sessions in local radio and TV stations in Unguja. A wide range of topics including the socioeconomic impacts of COVID-19, prevention measures targeting the hospitality and tourism industry as well as safety precautions in schools were discussed.

In the same vein, the WHO Country Office has continued to respond to media enquiries and compiles daily media monitoring reports to inform response efforts. The office also uses its website and social media platforms to share updates on COVID trends globally and regionally, prevention messages and best practices.

3.3.4 Capacity building of the Ministry of Health – Health Promotion Unit to enhance leadership and coordination roles

In collaboration with partners, WHO contributed to the development of the TORs and SOPs to guide the implementation of RCCE interventions during public health emergencies in Zanzibar. The TORs for the RCCE subcommittee and message review committee were developed and have been endorsed for use. Additionally, SOPs for implementing various RCCE interventions at national and subnational level were defined. The SOPs aim to guide risk communication and community engagement frontline responders working at various levels (national, district and community) to develop, implement and monitor RCCE interventions during health emergencies. Key elements covered in the SOPs include; steps for conducting community engagement, addressing uncertainty, managing rumors and misinformation, principles for message development and effective communication, and media engagement. In the mainland, support

was provided to develop SOPs for the Afya Call Centre to guide call center agents on day to day operations.

Through WHO's advocacy efforts, the Ministry of Health recruited 24 new staff to strengthen capacity of the Health Promotion unit to effectively implement planned RCCE activities. WHO played a key role in the orientation of the staff on the role of RCCE during public health emergencies; the Zanzibar RCCE response plan and basic principles of RCCE.

3.3.5 Supporting Afya Call Centre operations

The National Call Centre continued to operate receiving on average about 60,000 calls a day. During this period, WHO supported 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 rumors and design messages with correct information.

3.3.6 Engagement of faith leaders in promoting public health measures

WHO facilitated dialogues between the RCCE team and Islamic leaders in Zanzibar through a series of meetings under the leadership of the Zanzibar's Mufti. Five (5) meetings were organized involving 21 influential Imams and Sheikhs; Priests and Pastors. In all the sessions, the faith leaders were oriented on the COVID-19 safety precautions and how they can play a role in promoting these measures in the places of worship. As a result of this engagement, compliance to safety precautions was observed in churches and mosques for several months.

Promoting public health messages on the response - influential Imams and Sheikhs; Priests and Pastors, August 2020

3.3.7 Capacity building to health care providers on Mental health and Psychosocial Support

With technical support from WHO, the Health Promotion team oriented 25 health care providers on the basic elements of psychological first aid that can be provided to individuals and families affected by the COVID-19 pandemic. Frontline workers were oriented on how addressing mental health and psychosocial considerations is key to stopping transmission and preventing the risk of long-term repercussion on the population's wellbeing and capacity to cope with adversity.

3.3.8 Providing mentorship to district RCCE personnel to implement risk communication and community engagement interventions

In collaboration with partners, the Organization conducted joint mentorship and supportive supervision missions in all 11 districts in Zanzibar. During the mission, the national team supported the district personnel to develop district RCCE micro plans and assemble district RCCE teams for effective implementation of RCCE response activities. District teams were also oriented on basic RCCE principles and concepts including best practices, challenges were discussed, and recommendations made for improvement including the need to mobilize and deploy resources to strengthen RCCE response at subnational level.

3.3.9 Community mobilization activities in collaboration with partners

WHO participated in a number of joint community mobilization activities organized in partnership with the Tanzania Red Cross Society and Health Promotion team. Activities included visits to a total of 44 schools and 15 health facilities with the aim of promoting hand hygiene, masking and social distancing. During these visits, discussions were held with teachers and school barazas on how proposed measures can be implemented including ensuring hand washing facilities are installed in the school and health facility settings. During these visits,106,048 posters and 237,000 leaflets were distributed and posted on health facility and school walls.

In commemorating, the 2020 Global Hand Washing Day, the health promotion team with support from WHO conducted community sensitization activities through the use of mobile vans visiting all 11 districts in Kigoma to promote and demonstrate correct handwashing practices in schools and communities. During these visits 5000 posters and 12000 brochures were distributed in schools and communities. On the 14th and 15th October 2020, the Minister of Health and Deputy Minister for Health launched the campaign through press conferences raising awareness on the benefits of hand hygiene and calling on government institutions to ensure that hand washing facilities are installed and maintained. Members from communities in Pemba, 15 media houses and 150 community health volunteers participated in both events.

Distribution of public health messages on the response, August 2020

3.3.10 Capacity building and Deployment of Community Health Volunteers

The organization provided technical guidance in the orientation of 121 CHVs recruited by the Health Promotion unit and deployed in 4 Pemba Districts and 3 Unguja Districts. The CHVs distributed in 98 schools and selected markets, 400 posters and 600 brochures on COVID-19 prevention. In the mainland, WHO contributed to the development of a comprehensive training package for CHWs. This training guide is currently under review for endorsement.

3.3.11 Promotion and engagement of Kigoma Community on preparedness and responding to EVD outbreak, COVID-19 and other epidemics

The Organization facilitated broadcast COVID-19, EVD and other outbreak prone diseases preventive and control messages through radio Joy FM which is widely listened in Kigoma region .The broadcast covers Kigoma Municipal, Kigoma District, Buhigwe District, Uvinza, part of Kasulu TC and Kasulu DC, it also, extends its coverage to Mishamo in Katavi, Kalemie in DRC and Nyanzalac in Burundi. A total of 21 recorded and live programs including regular radio spots have been aired out. About 90% of Kigoma community have been reached including communities from nearby countries DRC and Burundi. The community has gained knowledge in the facts regarding COVID-19, EVD, Cholera and other epidemics in Kigoma region and therefore dispelling the wrong myths attached to emerging and re-emerging infections.

3.3.12 Engagement of local technical expertise

One RCCE expert was recruited to support the implementation of the RCCE response plan in Zanzibar. Through this engagement, the capacity of the health promotion section in Zanzibar and subnational RCCE personnel have been strengthened as outlined in the achievements above.

3.3.13 Challenges

Delays in the approval of messages developed and mixed messaging from the high-level national authorities has contributed to general public complacency in practising safety precautions, posing a challenge for the RCCE teams to sustain and scale up RCCE interventions.
Limited information on on-going RCCE activities in the regions and districts which would inform the national team to provide targeted technical support.

3.3.14 Way forward

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.

3.4 Pillar: Case Management and Infection Prevention and Control (IPC)

3.4.1. Situation analysis

Tanzania adopted a strategy of decentralized care to support the management of COVID-19 patients. This initiative tends to strengthen district health facilities to be able to identify and temporarily isolate, follow and treat mild cases during home care. In the mainland, all hospitals were required to designate isolation units for highly infectious diseases, including COVID-19. While in Zanzibar, the MOH and WHO designated 2 centers to manage COVID-19 confirmed patients. The treatment center at Kidimni, Unguja, initially reserved 20 beds for severe and critical cases in addition to being equipped with a cardiac monitor and a ventilator.

To manage moderate and critical cases, the pillar strongly advocated for repurposing of facilities and equipping them with the necessary equipment. In view of this, WHO supported the MOH in renovating and repurposing a facility in the Saba-Saba fair trade grounds in Dar es Salaam. The facility had a capacity to receive 500-800 patients.

After the adoption of home care for mild and moderate cases for both Zanzibar and the mainland, the number of patients who were being attended in the designated centers was drastically reduced and therefore there was significant decongestion of patients. The decline in number of patients minimized the need for surge capacity. It was decided by the MOH that the Saba Saba facility would remain on standby in the event there was a surge in incidence of COVID-19 confirmed cases. As the number of cases decreased and decentralized care started, most designated facilities were decommissioned and few like Kidimni and Mlongaliza remained temporarily closed but on standby.

In both the mainland and Zanzibar, it was reported that the number of patients seeking care, especially with COVID symptoms, had rapidly declined during the reporting period. There was also a general complacency on screening patients for COVID, in most of the facilities visited. Due to the sensitivity surrounding data, patients on home care were not easily accessed and most patients were not followed up. In general, the interventions and support for patients on home isolation were very minimal.

Misinformation and wrong perceptions around COVID-19 contributed to poor compliance in IPC practices. The upcoming general elections in the country were also changing the narratives around COVID-19 mitigation measures. Despite the above challenges on the ground, the pillar continued to provide technical guidance and assistance through capacity building, development and review of guidelines and SOPs, planning of equipment and supplies, and others.

3.4.2 Strengthening capacity of health facilities

The policy of decentralizing COVID-19 response and care including home-based care for mild cases commenced in the districts and there was an urgent need to ensure that all districts had the capacity to initiate and effectively roll out this strategy. If the districts were not supported to initiate implementation of the policy, there would be a greater risk for nosocomial and community transmission from both health facilities and home care. As such, WHO fully supported the process by mentoring the CHMTs and

identifying and making isolation facilities ready while ensuring prepositioning of adequate PPEs and medical supplies. In Zanzibar, most CHMTs were new and required mentorship from the national level.

In Zanzibar, 33 COVID-19 facilities were designated to collect samples and follow up mild and moderate cases on home isolation. The pillar identified and made 30 beds ready in 24 facilities. These were the facilities that met IPC criteria such as adequate space, ventilation, toilet facility and doffing PPE. Flow charts on referral of suspects for sample collection were made available. All facilities were oriented to screen patients presenting with COVID-19 symptoms; and if they met the case definition, they should be referred to specific designated facilities to provide sample and for follow up or subsequent referral to treatment center based on their severity of illness.

3.4.3 Training, mentorship and supportive supervision

Previous assessments conducted in the district health facilities indicated major gaps which included screening, triaging and isolation of patients. These necessitated the need to effectively utilize reference working tools such as SOPs, algorithms, flow charts and job aides to maintain best practices in managing COVID-19 cases. In this regard, WCO continued supporting the Ministry of Health in building capacity of front-line health workers through training, mentorship and supportive supervision to effectively screen, triage and isolate patients.

In the mainland, in collaboration with USAID and MUHAS, the pillar supported the MOH in conducting an advanced IPC control training of IPC leaders from national and facility levels in Dar es Salaam. Thirty-five (35) IPC focal points and Quality Improvement teams represented from 12 RRHs were trained as trainers. Similarly, training of trainers (TOTs) on general IPC for 36 participants (13 IPC focal persons, 13 Quality Improvement focal persons, and 10 matrons and maternity ward attendants) was provided by WCO in collaboration with MEDIPEACE.

With financial and technical support from WHO, on-site mentorship and supportive supervision on COVID-19 management and IPC was rolled out to 5 zones covering a total of 15 regions. These are: central (Dodoma, Manyara and Singida); Northern (Arusha, Tanga, and Kilimanjaro) Southern highlands (Mbeya, Songwe and Iringa); Eastern (Dar es Salaam, Pwani, and Morogoro) and Western (Tabora, Kigoma and Katavi). A total of 830 health workers from the 15 regions received training on screening, triaging and critical care (Dodoma, 84; Manyara, 53; Singida, 84; Arusha, 35; Tanga, 57; Kilimanjaro, 64; Mbeya, 50; Songwe, 54; Iringa, 53; Dar es Salaam, 56; Pwani, 37; Morogoro, 41; Tabora, 52; Kigoma, 55; and Katavi, 53).

Each zone was visited by a team of experts with skills in IPC, basic case management and critical care. A total of 20 Referral hospitals, 15 District Hospitals, 3 Health/Medical centres, and 1 treatment facility were covered. The purpose was to build capacity of the regional team with the view of cascading to all other district hospitals and selected Health centres. During the visit, facility assessments were done using WHO's standard tools to identify critical gaps in screening, triaging, and critical care; taking the opportunity to also review the lessons learnt. The team provided two days training on effective screening and triaging, essential critical care, and IPC to staff in each of the facilities visited, followed with mentorship and supportive supervision. The nature of the training and area of focus was mainly based on

the assessment and discussion with team prior to the training. The supportive supervision visit was used as an opportunity to orient RHMTs and CHMTs on the just finalized National Response Plan. Half-day session was carried out with the 9 RHMTs and 9 CHMTs members highlighting the key components of the plan. It was agreed that RHMT will cascade orientation to the remaining districts with the aim of reviewing and updating their own regional and district plans. The training, mentorship and supportive supervision was an integrated activity with a focus on building capacity of the front-line health care workers in critical and general management of COVID-19 and mitigating gaps that were identified from previous mentorship programs.

Discussions of public health experts on the response, August 2020

In Zanzibar, supportive supervision and mentorship was completed in 84 facilities reaching a total of 1,346 HCWs. The health workers were represented from COVID designated (facilities assigned to pick up samples, follow up and monitor mild/moderate cases under home isolation) and Non-COVID facilities that continue with delivering essential health services, but are expected to identify and refer suspects of COVID-19. During the mentorship and supportive supervision, an IPC focal person was identified and mentored on general IPC measures to reduce risks of infections in the facilities. A total of 104 IPC focal persons have been mentored and trained extensively on standard and transmission-based IPC precautions; and 46 Health workers assigned to COVID treatment centers were trained on critical care. Some of the facilities did not have designated IPC focal points and were supported to identify one person who would be dedicated for IPC. In the referral hospitals, a team comprising 4-5 members constituted the IPC team. In Tanzania mainland, IPC focal points/IPC committees had already been identified in all health facilities; however, in most cases they were not active as they did not have clear ToRs and were also overwhelmed with other duties. The pillar has supported in reactivating the focal points/committees by providing clear ToRs and mentorship to boost their skills and confidence in management of COVID-19 patients.

3.4.4 Development/adaptation of assessment tools and indicators

The pillar has continued with development/adaptation of tools and key performance indicators (KPIs) to gauge health facilities' readiness in terms of IPC/WASH infrastructure, standards, and practices. Using these tools, 30 health facilities in 8 regions have been assessed on core thematic areas of IPC; and their readiness to triage and isolate COVID-19 patients has been evaluated. IPC KPI assessment data was shared with AFRO and is made available on AFRO's dashboard. Tools to support mentorship and supervision have also been developed and were used to mentor front line health care workers. In collaboration with Clear Consortium, WCO supported MOH in reviewing various WASH data collection tools. In addition, the pillar provided technical assistance in facilitating a 2-day workshop in Dar es Salaam where a team of 18 IPC staff from Ministry of Health reviewed IPC indicators and tools for Monitoring & Evaluation of IPC implementation at the national level. Supportive supervision in IPC and Case Management was conducted in 264 health facilities in 12 regions; WCO technically supported in development of the tools used for the supervision.

3.4.5 Development/adaptation of training materials, guidelines, and SOPs

With support from WCO, training materials on advanced IPC with facilitators and participants' guides were developed; while existing materials on basic and intermediate level were reviewed and repackaged. For ensuring sustainability, it is recommended that IPC modules be incorporated into the training curricula at pre-graduate, post-graduate and in services training levels. In view of this, Muhimbili University of Health and Allied Sciences (MUHAS) and Ministry of Health are working on integrating some of the IPC materials into the training curricula. The plan is that all students be oriented on IPC issues before they get into clinical rotation, and clinical instructors and staff should supervise the practice to ensure adherence and safety.

Technical support has been provided to review SOPs on Case Management and general IPC. In total, the pillar has contributed in the review of 27 SOPs in case management and IPC; of which five (5) were translated into Swahili. The SOPs were endorsed by the CMO and are being disseminated to the facilities all over the country. It has been noted that some facilities are yet to receive printed copies of the SOPs, although most of the facilities have already got at least a copy each. Electronic copies of the SOPs are being widely shared for use. Distribution of previously printed IPC guidelines (with support from WHO) was also completed.

3.4.6 Strengthening emergency, critical care and Oxygen Supply

The virtual capacity building on critical care continued and by December 2020, a total 912 had received training. The sessions were later combined with training with IPC with technical support from WHO. Assessment of oxygen supply and critical care for both mainland and Zanzibar was commissioned, with the aim of identifying opportunities and existing gaps. Comprehensive reports and plans were developed, identifying immediate, and long-term needs. The two reports have been submitted to MOH and are now been used to mobilize resources.

3.4.7 Water Sanitation and Hygiene (WASH)

Four (4) days training on web-based WASH - Facility Improvement Tool (FIT) was provided for 105 health staff represented from 23 councils, 13 health centers, and 69 dispensaries in Kigoma with support from WCO. The participants were mentored on various aspect of WASH FIT. This training simplified WASH data collection through imbedding the adopted indicators into a mobile application and enabling easy data monitoring and reporting.

The pillar continues to support in planning for procurement of critical supplies in IPC/WASH. In view of this, 32 Hatch chlorine testers were procured. 24 have been donated to Kigoma rural water supply authority (RUWASA) and 12 to Zanzibar water authority (ZAWA) to enable them to regularly monitor and report Free Residual Chlorine (FRC) level to the national level.

WCO participated in an annual Conference on Environmental Health and Sanitation that took place in Dodoma from Dec. 15-18, 2020. The conference reviewed performance; identified bottlenecks and suggested means of addressing the challenges that face the sub-sector. The conference included technical meetings and various exhibitions. The conference was conducted under the theme "Gender consideration – A Pillar for Sustainable Sanitation and Hygiene".

3.4.8 Engagement with technical partners

The Case Management and IPC Pillar has produced some detailed proposals and plans that were included or referred to in the version 2 Response plan – for example, the five year proposal on strengthening IPC in health facilities, the oxygen Scale-Up Plan, and the Critical Care Training Plan. The 5-year proposal was developed in partnership with MOH, PO-RALG, UNICEF, and AMREF. Oxygen scale-up plan was developed following the assessment reports done in health facilities in Tanzania mainland. Some of the activities have been accommodated in the second version of the National COVID-19 Response Plan. These include procurement and installation of at least 8 oxygen production plants in the strategic zones (Zonal and Regional Referral Hospitals) in the mainland. A budget line was also worked out to revive the zonal workshops for medical equipment repair and maintenance. Similarly, draft concept note was also developed for scaling-up oxygen production, supply, and use in Zanzibar. In addition to the above, contributions for proposal write up for resource mobilization were made by the pillar. Proposals submitted to UN COVID-19 socio- economic appeal, the GIZ, the Japanese embassy, can be mentioned as examples.

In partnership with MOH, MTaPs (USAID), and MUHAS, the pillar conducted an internal evaluation to assess IPC implementation at country level. The assessment was conducted using WHO's standard tool for assessing IPC at national level. From the assessment, gaps were identified in prevention of health care associated infections. In view of this, the pillar in partnership with the MOH, developed a concept note for conducting ToTs on prevention of health care associated infections to regional quality improvement focal persons and IPC focal persons to be rolled out in six regions in Tanzania mainland. The activity also includes cascading mentorship to lower levels and conducting supportive supervision in selected facilities. In partnership with USAID, the pillar also provided technical assistance to MOH in integrating the IPC indicators into national IPC Monitoring and Evaluation Plan.

The pillar continues to actively participate and contribute in the weekly AFRO organized webinars as well as the weekly regional in-depth meetings with national IPC focal points from Eastern and Southern Africa region (ESAR). These were important platforms for sharing experiences, identifying common gaps and developing strategies and plans to strengthen IPC/WASH at the level of health care facilities, POEs and the community. Key deliverables from those discussions include the development of risk assessment tools for school re-opening, and development of tools required to gauge country's progress in implementation of IPC in the context of COVID-19.

The pillar continues to provide partners with appropriate guidance on COVID-19 operational readiness activities as appropriate. In this regard, in response to a request from UNDP and UNICEF, WCO provided guidance on decontamination of offices following staff return and this support was also provided to the hired cleaning agencies. The pillar also continues to work closely with RCCE in promoting advocacy messages for COVID-19 prevention. This includes crafting appropriate messages to the community, including messages on proper hand hygiene, respiratory hygiene, and social distancing; and also addressing misconceptions, rumors and misinformation from social media.

3.4.9 Capacity building on case management and IPC in Kigoma region

For continuum of COVID-19 patients care and establishment of health facility-based surveillance of COVID-19 and EVD, WHO supported Kigoma region to train 16 clinicians, nurses and facility based IDSR focal persons on health facility-based surveillance, triaging of patients and responding to alerts in the health facilities and community. A perspective of community contact tracing and follow up was emphasized during the training. This training has enabled the clients' segregation practices upon use of clients triaging system at health facilities in Kigoma region.

3.4.10 Gaps/challenges

Tanzania has not reported COVID-19 cases to WHO since the 29 April 2020. As a result, the pillar has no updated data on COVID-19 cases and deaths; this has created difficulties in identifying and providing the required support to the Ministry. Several COVID-19 treatment centers have been decommissioned and as such, in the event of a surge in cases, effective infection control measures can be compromised. In the majority of the facilities, there are inconsistent IPC practices among HCWs and patients. Inconsistent use of masks, poor practices in hand hygiene, and inadequate waste segregation and disposal remain a significant challenge in most health facilities. Incoherent information from authorities and lack of proper guidance and support resulted into staff not been able to enforce the required measures. Delay in distributing guidelines and tools also posed a significant challenge. Guidelines had been developed/ adapted but a large portion of them were yet to be disseminated. Non-adherence to national guidelines on rational and proper use of masks in health care and non-health care settings was also noted widely. The pillar coordination was not adequate with very infrequent subcommittee meetings and later complete lack of the meetings. Another challenge was shortage of PPEs especially at facility level in the Mainland.

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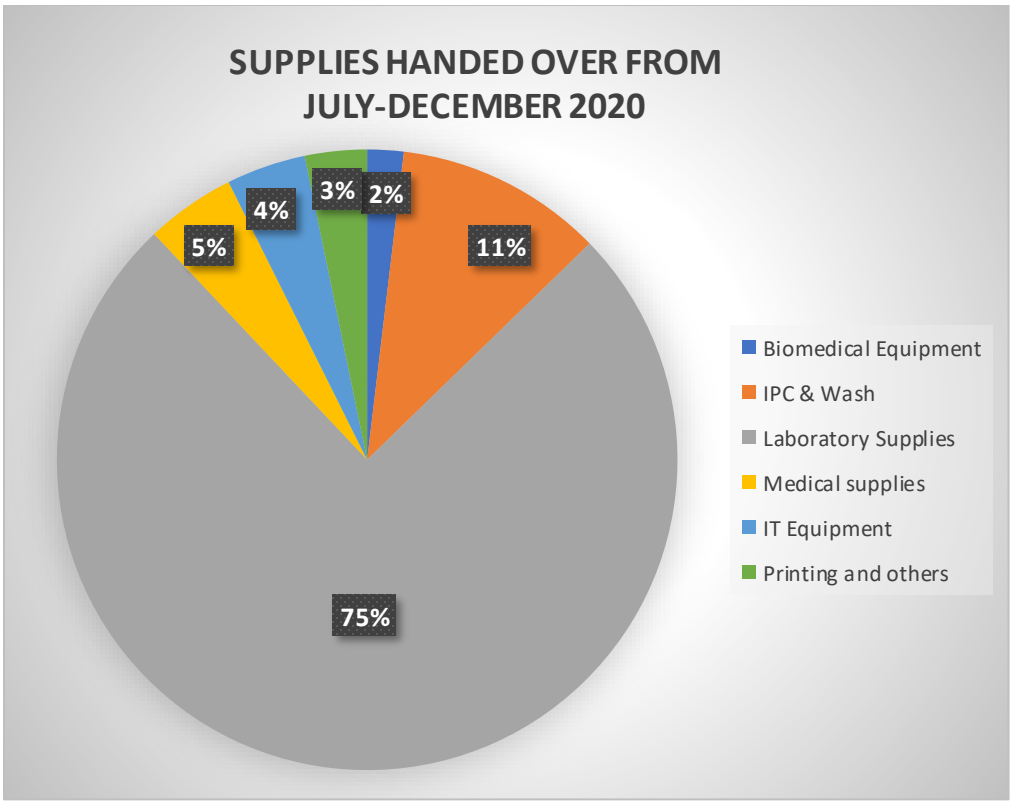
3.4.11 Way forward

High level advocacy targeted at political leaders is needed on transparency of data and adherence to public health measures. Continued high level advocacy and political engagement can bring about changes in mind set and result in improved outcomes. Politicians need to be continuously sensitized so as to realize that on COVID-19 is a threat to all nations in the world, including Tanzania.

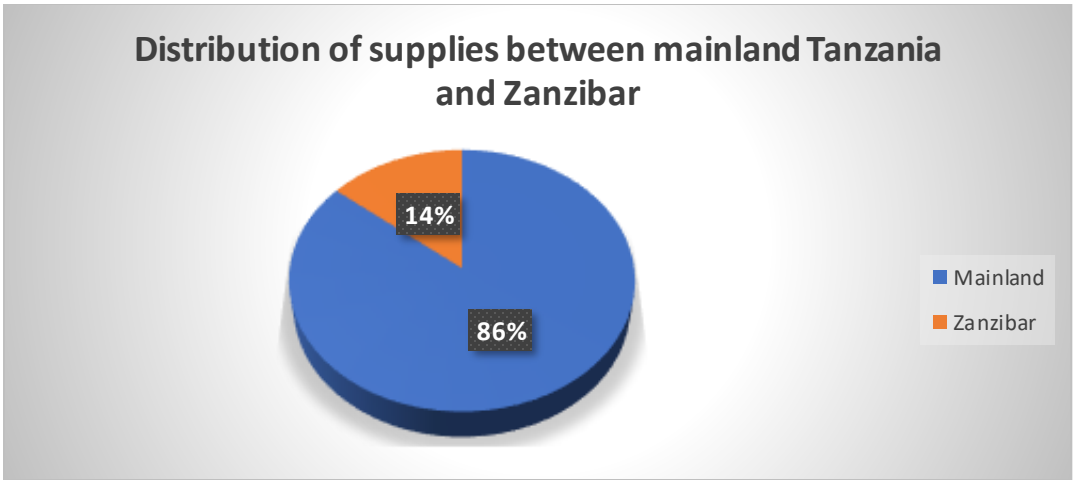
3.5 Pillar: Logistics and operations

3.5.1 Procurement of medicines, equipment, laboratory reagents and medical supplies

Various medical equipment were procured including; laboratory test kits and reagents, PPEs including face shields, goggles, gowns, respiratory masks, surgical masks etc. Also procured were medicines, biomedical equipment e.g. oxygen concentrators and other supplies. All the procurement and handing over done in the reporting period are worth Tshs 3,514,953,430.93 equivalent to USD 1,528,240.62 and are categorized as follows:



Out of these, products worth 495,093,247.95 were handed over to the MOH in Zanzibar.



(For the list of items and quantities see Annex 1).

Most of the items were officially handed over to the Ministries of Health in mainland and Zanzibar for subsequent distribution to health facilities for use. The laboratory supplies were handed over to the National Reference Laboratory as well as the Mnazi Mmoja Hospital laboratory in Zanzibar.

Dr Andermichael handing over equipment, medical supplies, reagents, medicines to the MOH in Zanzibar
23 October 2020

3.5.2 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.

3.5.3 Printing of Guidelines and other 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 Local Procurement Committee (LPC) to ensure following of efficient procurement procedures as per requirements in emergencies. Therefore, organized printing of guidelines, RCCE materials and other technical documents as requested by the other pillars of the response.

3.5.4 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, WHO worked with other partners to support the review of the National Donations Guidelines to reflect on current MOH requirements as well as inclusion of equipment and other medical supplies. The office continued to use the COVID-19 Supply Portal particularly for the procurement of laboratory reagents and kits as well as PPE materials.

3.5.5 Challenges: Logistic pillar pleaser respond

Delays in getting authorization letters from the MOH for the Tanzania Medicines and Medical Devices Agency to issue import permit for equipment and supplies for COVID-19. The MOHCDGEC refusal to receive unsolicited donations especially for COVID-19 in these times of emergency. Global challenges on air freight and access to medicines and health products due to global lockdown from March to December 2020. Delays in charging the cost of items procured through the portal.

3.5.6 Way Forward

Continuous dialogue with both ministries of health on the importance of rapid clearance of the equipment and supplies for COVID-19 which include life saving supplies and medicines for the population affected with the pandemic.

3.6 Finance and Administration

A total of **US$ 1,164,000** was mobilized between July and December 2020 for COVID 19 response and utilization as at 31st December 2020 was **72%.** Expenditures were reviewed to ensure compliance with donor requirements, budget lines and best value of money. Response support funds were mainly used as follows:

Table 1. Distribution of funds in the COVID-19 response

Activity	Amount	% age
513-Contractual Serv, General & SSA	237,725	28%
519-General Op. Costs & travel	177,880	21%
527-Direct Implementations	298,829	36%
555-Procurement – Medical supplies and Equipment	124,814	15%
Total	**839,248**	**100%**

Four donor reports were completed and submitted. Currently, two Final Certified Financial Statements are in process and at approval stage.

3.6.1 Challenges

1 Inadequate funding to support all the supplies needed and other logistics and operational activities.

2 Low utilization rate of mobilized funds because of slow pace of implementation of the Ministry of Health

3.6.2 Way forward

1. Intensify advocacy for more resource mobilization to enable support all logistics and operations activities.
2. Continue to review the country`s needs with respect to supplies and proactive follow-up with the MOH for timely implementation of activities and disbursement of funds.

4. Conclusion

The experience gained from the first six months of implementing the COVID-19 response plan enabled more focused and strategic implementation Similar to the first half of 2020 report on the support provided by the WHO to the national authorities in responding to the COVID-19 pandemic, there have been a variety of interventions that were implemented with the provision of both financial and technical support. Continuous dialogue with bilateral partners to solicit for funding to enable the implementation of the emergency plans in each pillar bore fruit.

In the coordination pillar, a major emphasis was placed in strengthening the sub-national level in public health emergency management. The training aimed at enabling the staff from the newly established PHEOCs to effectively support the coordination of COVID 19 response activities and other public health emergencies preparedness and response including communication and information management pertaining to public health emergency management in the respective regions. The staff trained were also equipped with skills and tools for orienting other health workers and stakeholders on IMS and emergency management in their respective regions. The WCO supported the MOH to develop a second operational plan of COVID -19. WHO also participated and supported the Zanzibar Health Research Institute (ZAHRI) and Zanzibar Ministry of Health to conduct an epidemiological survey in compliance with Public Health and Social Measures to interrupt COVID-19 Transmission in Zanzibar.
In the surveillance front, the country office supported Zanzibar to adapt the WHO/AFRO IDSR – 3rd edition, technical guidelines which was followed by a stakeholder's validation meeting. Using a decentralized system, the WCO supported the Arusha region to strengthen leadership in emergency and response of infectious diseases, surveillance, commitment of health care workers and community engagement. Furthermore, the WCO supported the national authorities in various techniques to detect and respond effectively to the COVID-19 epidemic including strengthening the detection rate at the facility level through mentorship and training of health care workers, strengthening and expanding ILI/SARI sentinel sites at selected health facilities, engaging CHWs in the detection of cases and follow up of contacts and establishment of event-based surveillance at the drug dispensing outlets. The surveillance pillar was also present in the refugee camps to provide the necessary guidance in surveillance of infectious diseases. The organization supported the Kigoma region to strengthen the IDSR reporting system, outbreak investigation and follow up in the refugee camps through capacity building of health information teams (HIT), health information team supervisors and health promotors working in the refugee camps.
In the laboratory pillar, the WHO continuously supported the country to strengthen capacity of laboratories in sample collection, packaging, biosafety management and transportation centrally to the National Public Health Laboratory (NPHL) for testing. Subsequently, WHO supported the NPHL to adopt and deploy the use of high throughput SARS-CoV-2 testing platforms including the Abbott m2000, Roche C6800 automated systems and the new Biorad CFX96 PCR machines donated by the Swiss Development Corporation (SDC) through Ifakara Health Institute (IHI). WHO has also continuously supported the procurement of reagents and supplies through the UN supply portal and other WHO mechanism to sustain the testing. The laboratory supplies and reagents that were procured included RNA extractions kits, master mix and enzymes, detection kits,

In the RCCE pillar the WHO in collaboration with partners provided technical guidance in the review of existing public awareness messages to align with the prevalent response direction. In collaboration with the Port health experts, WHO contributed to the development of messages to be strategically positioned at points of entry targeting travelers and long-distance truck drivers. Messages were pretested in select air and seaports before finalization and printing. These messages have been packaged in standalone banners and positioned in various points of entry in the country. Furthermore, the Organization conducted joint mentorship and supportive supervision missions in all 11 districts in Zanzibar. During the mission, the national team supported the district personnel to develop district RCCE micro plans and assemble district RCCE teams for effective implementation of RCCE response activities.

In the case management pillar, the policy of decentralizing COVID-19 response and care including home-based care for mild cases commenced in the districts and there was an urgent need to ensure that all districts had the capacity to initiate and effectively roll out this strategy. If the districts were not supported to initiate implementation of the policy, there would be a greater risk for nosocomial and community transmission from both health facilities and home care. As such, WHO fully supported the process by mentoring the CHMTs and identifying and making isolation facilities ready while ensuring prepositioning of adequate PPEs and medical supplies. In Zanzibar, most CHMTs were new and required mentorship from the national level. In the mainland, in collaboration with USAID and MUHAS, the pillar supported the MOH in conducting an advanced IPC control training of IPC leaders from national and facility levels in Dar es Salaam. The pillar has continued with development/adaptation of tools and key performance indicators (KPIs) to gauge health facilities' readiness in terms of IPC/WASH infrastructure, standards, and practices. The pillar continues to provide partners with appropriate guidance on COVID-19 operational readiness activities as appropriate. In this regard, in response to a request from UNDP and UNICEF, WCO provided guidance on decontamination of offices following staff return and this support was also provided to the hired cleaning agencies.
In the logistics and operations area, the 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, WHO worked with other partners to support the review of the National Donations Guidelines to reflect on current MOH requirements as well as inclusion of equipment and other medical supplies. The office continued to use the COVID-19 Supply Portal particularly for the procurement of laboratory reagents and kits as well as PPE materials.

The WCO managed to mobilize a total of **US$ 2,469,000** between July and December 2020 for COVID 19 response and the utilization as of 31st December 2020 was **72%.** Expenditures were reviewed to ensure compliance with donor requirements, budget lines and best value of money.

There were some challenges experienced during this period of the implementation of the COVID-19 response plan. A few are cited below.
The major challenge observed in the coordination pillar was the absence of regular National Task Force and coordination meetings by the national authorities which contributed to inadequate stakeholders' engagement from planning to the implementation of interventions.

One of the greatest challenges that this pillar faced was the lack of transparency in information sharing by both Ministries of Health (Tanzania mainland and Zanzibar) where to date, no data has been shared to enable detailed epidemiological analysis to guide planning of appropriate response activities.
Challenge - Challenges encountered during this reporting period include lack of laboratory data sharing including number of travelers or patients tested and results. However, WHO and other partners are continuing with advocacy efforts to persuade the Government to share data.
Delays in the approval of messages developed and mixed messaging from the high-level national authorities has contributed to general public complacency in practising safety precautions, posing a challenge for the RCCE teams to sustain and scale up RCCE interventions.
Limited information on on-going RCCE activities in the regions and districts which would inform the national team to provide targeted technical support. Tanzania has not reported COVID-19 cases to WHO since the 29 April 2020. As a result, the pillar has no updated data on COVID-19 cases and deaths; this has created difficulties in identifying and providing the required support to the Ministry. Several COVID-19 treatment centers have been decommissioned and as such, in the event of a surge in cases, effective infection control measures can be compromised.
Challenges - Delays in getting authorization letters from the MOH for the Tanzania Medicines and Medical Devices Agency to issue import permit for equipment and supplies for COVID-19. The MOHCDGEC refusal to receive unsolicited donations especially for COVID-19 in these times of emergency. Global challenges on air freight and access to medicines and health products due to global lockdown from March to December 2020.
We propose the way forward to these challenges. To strengthen coordination and leadership in the implementation of the response activities, the pillar proposes continuous engagement of the Government through the MOHCDGEC and PORALG to achieve joint planning of interventions, develop comprehensive response plans for national and regional levels. In addition, sharing of these documents with all stakeholders and partners is essential for timely implementation of interventions.
Recommendation - The pillar recommends, enhanced high level advocacy of the surveillance data sharing and partners involvement is surveillance response activities . This will enable Tanzania to collaborate in planning and sharing of information, including organizing regular meetings, collaborative planning with partners and engendering synergy and complementarity for effective implementation. Such planning will also attract the appropriate technical and financial support. There is a need to continue advocating for coordinated efforts to support building the capacity in COVID-19 testing including decentralization and mobilization of more resources for procurement of reagents and supplies. 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. High level advocacy targeted at political leaders is needed on transparency of data and adherence to public health measures. Continued high level advocacy and political engagement can bring about changes in mind set and result in improved outcomes. Politicians need to be continuously sensitized so as to realize that on COVID-19 is a threat to all nations in the world, including Tanzania. Continuous dialogue with both ministries of health on the importance of rapid clearance of the equipment and supplies for COVID-19 which include life saving supplies and medicines for the population affected with the pandemic. The support that the country team received from WHO/AFRO and the new updates on the pandemic was indispensable to the gains that were made during the reporting period.

Annex 1: Medicines and health products procured between July – December 2020 by the WHO Country Office

BIOMEDICAL EQUIPMENT				
Item Description	**Quantity Ordered**	**Total in TZS**	**Status of shipment**	**Date Received**
Oxygen Concentrator (canta, V8-WN-NS), 8L/mm, w/acc	30	66,573,599.77	Delivered to MOH ZNZ	13 -10 - 20
TOTAL		**66,573,599.77**		
IPC & WASH				
Chlorine (DPD NO. 1+NO. 3) Comparator starter pack, 50 tablets +Disc	24	3,233,331.84	Delivered to Kigoma	13 -10 - 20
Chlorine (DPD NO. 1+NO. 3) Comparator starter pack, 50 tablets +Disc	12	1,616,665.92	Delivered to MOH ZNZ	13 -10 - 20
Face MASK Disposable 3ply P/50	20 Boxes	900,000.00	Delivered to MOH ZNZ	27-07-20
Plastic Aprons	90	90,000.00	Delivered to MOH ZNZ	15 -09- 20
150PCK/2000PCS - DISPOSABLE MEDICAL MASK	300,000	271,206,000.00	Delivered to MOH ZNZ	20/10/2020
25,000PCS - 25PACK/1000PCS - RESPIRATORY MASK KN95	25,000	103,815,082.26	Delivered to MOH ZNZ	7/10/2020
TOTAL		**380,861,080.02**		
IT EQUIPMENT				
MONDOPAD INFOCUS 57", Touch sensitive with built-in	1	32,890,000.00	Delivered to MOHCDGEC	17 -8-20
Wi-Fi and modem With minimum of 5, people, 10 MBPS	1	46,000,000.00	Recived Not handedover	17 -08-20
Apple MAC Book Laptops	3	17,988,750.00	Delivered to MOHCDGEC	26 - 08 - 20

MS Office	3	2,159,062.50	Delivered to MOHCDGEC	26 - 08 - 20
Lawrence iFinder GO Waterproof, Hiking GPS	2	700,000.00	Delivered to MOH ZNZ	23 - 8 -20
ArcGIS for Desktop with basic level,license 5	4	12,688,000.00	Delivered to MOH ZNZ	23 - 8 -20
MONDOPAD INFOCUS 57",Touch sensitive with built-in	1	32,890,000.00	Delivered to MOH ZNZ	23 - 8 -20
TOTAL		**145,315,812.50**		
LABORATORY SUPPLIES				
Serbe Cov - E-Gene	20	6,440,000.00	Delivered to NHLQATC	30 - 07 - 20
Wuhan CovRdRp Gene	4	736,000.00	Delivered to NHLQATC	30 - 07 - 20
QIAamp Viral RNA Min Kit	10	23,161,000.00	Delivered to NHLQATC	17 -08 - 20
Disposable sampling kit (60 tests/box, 17 set nuclei Acid extraction kit (box 1or2) 4set magnetic stand	490	81,779,040.00	Delivered to NHLQATC	26-08-20
Real time fluorescent RT-PCR kit for detecting 2019 -Ncov	588	681,492,000.00	Delivered to NHLQATC	26-08-20
Nuclear Acid extraction kit	17	51,070,176.00	Delivered to NHLQATC	26-08-20
Nuclear Acid extraction kit	17	51,070,176.00	Delivered to NHLQATC	26-08-20
Magnetic Stand	4	695,400.00	Delivered to NHLQATC	26-08-20
Disposable sampling kit (50 tests/box)	683	94,991,640.00	Delivered to NHLQATC	8/10/2020
Nuclear Acid extraction kit	20	60,082,560.00	Delivered to NHLQATC	8/10/2020

Magnetic Stand	3	521,550.00	Delivered to NHLQATC	8/10/2020
Real time fluorescent RT-PCR kit for detecting 2019 -Ncov	683	791,597,000.00	Delivered to NHLQATC	8/10/2020
Nuclear Acid extraction kit	20	60,082,560.00	Delivered to NHLQATC	8/10/2020
SD Biosensor Standard M Ncov Real -time detection kit	275	542,622,938.00	Delivered to NHLQATC	31/10/20
SD Biosensor Standard M SPIN -X Viral RNA Extraction kit	264	123,198,176.64	Delivered to NHLQATC	31/10/20
Insulated PU-Box, 10 L/40mm for UN2814, Class 6.2, cat.Shipment+5 cool packs	10	1,656,000.00	Delivered to MSD	6/8/2020
Insulated PU-Box, 10 L/40mm for UN3373, Class 6.2, cat.Shipment+5 cool packs	10	1,242,000.00	Delivered to MSD	6/8/2020
Disposable Sampler	6000	29,206,800.00	Delivered to NHLQATC	17 -07 -20
Insulated PU-Box, 10 L/40mm for UN3373, Class 6.2, cat.Shipment+5 cool packs	40	5,099,600.00	Delivered to NHLQATC	7/9/2020
Disposable Sampler	6000	28,980,000.00	Delivered to NHLQATC	17 -08-20
Superscript III Platinum. One step Quantitative RT-PCR	2	7,226,600.00	Delivered to NHLQATC	26-08-20
Electronic Temperature indicator Libro CD, SHIPMENT ,-95/+50C	1	185,058.00	Delivered to NHLQATC	26-08-20
Insulated PU-Box, 10 L/40mm for UN3373, Class 6.2, cat.Shipment+5 cool packs	10	1,274,900.00	Delivered to MOH ZNZ	8/9/2020
TOTAL		**2,644,411,174.64**		
MEDICAL SUPPLIES				
Waste bins	75	1,350,000.00	Delivered to MSD	6/8/2020
Waste bags (red color)	150	150,000.00	Delivered to MSD	6/8/2020

Cotton wool 500g	75	750,000.00	Delivered to MSD	6/8/2020
Disposable syringes 2cc	75	862,500.00	Delivered to MSD	6/8/2020
Disposable syringes 10cc	75	1,575,000.00	Delivered to MSD	6/8/2020
Disposable syringes 5cc	75	877,500.00	Delivered to MSD	6/8/2020
Alcohol swabs	38	80,864.00	Delivered to MSD	6/8/2020
PAEDIATRIC NEBULIZER MASK	1,200	4,800,000.00	Delivered to MSD	6/8/2020
Hospital Bed sheets	800	14,400,000.00	Delivered to MSD	6/8/2020
Absobet Gause	100	3,850,000.00	Delivered to MSD	6/8/2020
ADULT NEBULIZER MASK	1,000	4,000,000.00	Delivered to MSD	6/8/2020
Oxygen face mask	200	1,200,000.00	Delivered to MSD	6/8/2020
Pulse Oximeters	75	7,500,000.00	Delivered to MSD	6/8/2020
Drip stand	25	2,000,000.00	Delivered to MSD	2/7/2020
ON call plus machine	75	1,875,000.00	Delivered to MSD	6/8/2020
ON call strips 50's	60	1,560,000.00	Delivered to MSD	6/8/2020
Nebulizer compressor Essential C101	75	675,000.00	Delivered to MSD	6/8/2020
Infussion Pump	11	38,500,000.00	Delivered to MSD	6/8/2020
Full Flow Bed with steel head	14	7,700,000.00	Delivered to MSD	6/8/2020

Humani Insulini Medicine	4500	69,308,200.00	Delivered to MSD	8/10/2020
Drip Stand	15	1,200,000.00	Delivered to WHO /MOH ZNZ	27-07-20
TOTAL		**164,214,064.00**		
PRINTING				
A4 Case Investigation Forms	200	1,000,000.00	Delivered to MSD	6/8/2020
Contact Listing Form - Swahili	16000	640,000.00	Delivered to MSD	6/8/2020
A4 Contact Daily Follow up Form	17800	516,200.00	Delivered to MSD	6/8/2020
A4 Daily summary report	12000	540,000.00	Delivered to MSD	6/8/2020
Case Definition Corona	7500	862,500.00	Delivered to MSD	6/8/2020
National Infection Prevention and control Guidelines for Health care Services in Tanzania	10,000	62,660,000.00	Delivered to MSD	6/8/2020
STD Operation Procedures (SOP) on use of PPE	20,000	9,500,000.00	Delivered to MSD	6/8/2020
Roll UP banners	198	23,760,000.00	Delivered to MSD	6/8/2020
TOTAL		**99,478,700.00**		
OTHERS				
Multipurpose Tents 42 M2	2	6,900,000.00	Delivered to MSD	6/8/2020
Multipurpose Tents 24 M2	2	5,060,000.00	Delivered to MSD	6/8/2020

Perimeters, PP, Net 1mx50m	6	276,000.00	Delivered to WHO /MOH ZNZ	23 - -8 -20
Sheeting, Plastic 4x60m+Bands	6	1,863,000.00	Delivered to WHO /MOH ZNZ	23 - -8 -20
TOTAL		**14,099,000.00**		
OVERALL TOTAL			**3,514,953,430.93**	