WHO-EM/CSR/291/E

# COVID-19 strategic preparedness and response plan

## Strengthening the collective response and accelerating readiness in the Eastern Mediterranean Region

July 2020 edition


World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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## 1. PURPOSE OF THE DOCUMENT

This document has been developed by the WHO Regional Office for the Eastern Mediterranean to establish a regional plan of action to support countries in rapidly scaling up capacities for prevention, early detection and response to coronavirus disease 2019 (COVID-19). The plan summarizes the main public health measures that WHO will support and prioritize in order to facilitate an effective response in countries. This is an update to the first regional plan (of February 2020) and reflects the everchanging COVID-19 situation in the Region: as outbreaks have persisted, there is a need to revisit the strategic response to strengthen support to affected countries. This document is aligned with the WHO global strategic preparedness and response plan (of 3 February 2020) as well as the global strategy update (of 14 April 2020), with appropriate adaptations to the regional context.

In consideration of the health and humanitarian challenges facing the Region even prior to the COVID-19 pandemic, the Regional Office developed *WHO's strategy for the Eastern Mediterranean Region, 2020–2023: turning Vision 2023 into action*. *Vision 2023* pledges the Organization to work towards health for all, by all, so that everyone in the Eastern Mediterranean Region can enjoy a better quality of life. Strategic planning for addressing health emergencies, including comprehensive preparedness and effective response, is one of four priorities highlighted in *Vision 2023* and its accompanying strategy. The proposed goal, objectives and activities under the updated COVID-19 preparedness and response plan are aligned with the regional strategy and *Vision 2023,* as well as WHO's Thirteenth General Programme of Work, 2019–2023 (GPW 13).

## 2. GLOBAL SITUATION

On 31 December 2019, WHO was alerted to several cases of pneumonia of unknown origin in Wuhan, Hubei province, China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a new type of coronavirus as the cause of the pneumonia cluster. The novel coronavirus belongs to the same family of coronaviruses that cause illnesses ranging from the common cold to more severe diseases such as Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS). The illness caused by this novel coronavirus is referred to as coronavirus disease 2019 (COVID-19).

The Director-General of WHO declared the 2019 coronavirus outbreak to be a public health emergency of international concern (PHEIC) on 30 January 2020, after the second meeting of the Emergency Committee under the International Health Regulations (IHR) (2005). On 11 March 2020, COVID-19 was characterized as a pandemic. On 30 April 2020, the Director-General convened the third meeting of the IHR (2005) Emergency Committee and declared that the outbreak of COVID-19 continued to constitute a PHEIC.

Since the first cases were reported, WHO has been working with experts around the world to learn more about the virus including the source of infection, modes of transmission, disease severity, high-risk groups, levels of immunity, evidence-based treatments and outbreak containment. Furthermore, WHO has been working with countries to better prepare for and respond to COVID-

19 outbreaks within and across their borders, and continues to provide guidance to countries, health care workers and the general public regarding measures to control the pandemic.

Since March 2020, most countries in the world have been implementing social measures such as strict lockdowns, travel restrictions and other public health measures to limit the spread of COVID-19. Other common strategies implemented in countries as part of community mitigation measures include intensification of case detection, contact tracing, isolation and quarantine. Some countries have succeeded in limiting transmission, while others are experiencing rapid spread of the virus and high caseloads. As of 11 July 2020, the total number of reported confirmed cases of COVID-19 stood at 12 322 395 worldwide, with 556 355 associated deaths (case fatality rate: 4.5%). Globally, 218 countries and territories (and one conveyance/ship) are affected and the number of confirmed/suspected cases and affected countries continues to rise. The Americas are most affected with 6 397 230 cases, followed by Europe with 2 888 850, and then the Eastern Mediterranean Region with 1 255 977 cases. In all WHO regions, countries are now starting to ease their lockdown measures. Most are doing so by employing phased strategies in order to assess the impact of easing restrictions on the number of COVID-19 cases, although transition strategies vary widely overall and are generally not informed by public health indicators.

## 3. SITUATION IN THE EASTERN MEDITERRANEAN REGION

### 3.1 Context

The WHO Eastern Mediterranean Region comprises 22 Member States in Asia and Africa. Many of these countries are directly or indirectly impacted by complex humanitarian emergencies, and more than 40% of people in need of humanitarian assistance globally are located in the Region. Fragile health systems have led to suboptimal disease surveillance and preparedness and response capacities, making the countries of the Region particularly vulnerable to the emergence and rapid transmission of novel pathogens.

During recent weeks and months, alongside ongoing violent conflict, countries in the Region have continued to experience outbreaks of communicable diseases such as chikungunya, dengue, diphtheria, cholera, Crimean-Congo haemorrhagic fever, MERS-CoV and Rift Valley fever, in addition to COVID-19.

### 3.2 Humanitarian settings and vulnerable groups

In the Eastern Mediterranean Region, nine of the 22 Member States are impacted by humanitarian emergencies, many of which are the result of armed conflict, political instability or insecurity, or natural disasters. These emergencies have significantly weakened or disrupted health systems. Refugees, internally displaced persons (IDPs) and returnees constitute a sizeable population in the Region. The Region is home to 43% of those in need of humanitarian assistance globally and is the source of 64% of the world's refugees. The Region is also home to approximately one third of the world's IDPs. These populations are especially vulnerable due to poor living conditions, and many remain marginalized with limited access to needed quality health care. In addition, those who are able to access health services often face financial hardship. In the context of COVID-19 and the rapid spread of the virus, refugees, IDPs and

populations in need in emergency countries, especially those in besieged areas, are experiencing volatility and increased risk.

If COVID-19 cases are detected in fragile and vulnerable settings, the risk of rapid transmission and poor outcomes is amplified by people's inability to adhere to physical distancing measures and other recommended comprehensive public health measures due to suboptimal living conditions, lack of access to basic services (including water, sanitation, proper shelter, electricity and sufficient food) and overcrowding. Furthermore, due to the disruption of health services, population access to quality health services may be limited or not possible, including limitations in proper laboratory diagnostic capacities, personal protection equipment (PPE) and infection prevention and control (IPC) measures, as well as inadequately equipped health facilities.

### 3.3 Migrant workers

There are 46 million professional and low-income labour migrants in the Region, and many migrant workers face a distinct risk for contracting COVID-19. Migrants often lack social or economic support, and migrants work informally or in low paying temporary positions with varying access to health services and varied coverage schemes. Still others are serving as health care workers on the front line, caring for COVID-19 patients. Those who live in cramped housing or dormitories and those who work in crowded worksites also face higher risk. In the Region, migrant workers have been one of the most affected vulnerable groups during the COVID-19 pandemic. Many migrant workers have lost their jobs due to the pandemic and subsequent economic slowdown, and many were stranded in the countries where they were employed due to travel restrictions. Given their living and working conditions, migrant workers find it difficult to maintain social distancing and proper hygiene in order to minimise the risk of contracting infection. As a result, COVID-19 has spread to migrant dormitories in some countries of the Region and affected thousands of migrant workers. WHO has been working with Member States and other partners to protect migrant workers, ensure the availability of basic health care services and promote specific prevention measures to reduce the risk of infection.

### 3.4 Effects on health systems

COVID-19 adds a new layer of burden to health systems in the Region, from those weakened by humanitarian emergencies and political instability to even well-established systems. The tremendous impact of COVID-19 is exceeding national and local health system capacities in affected countries, which could jeopardize routine service delivery and undermine other health priorities.

Health care workers are at the forefront of the response to the COVID-19 pandemic and are at increased risk of infection due to suboptimal preparedness capacities of health systems. Rapidly increasing numbers of COVID-19 cases and hospital admissions result in shortages of health workers in general and particularly in certain specialties, such as intensive care unit (ICU) physicians and nurses, infectious diseases specialists and pulmonologists. The increased workload leads to long working hours, psychological distress, fatigue, occupational burnout and, in some cases, physical and psychological violence. The current shortage of PPE increases the risk of health care-associated infection significantly further. The acute onset of the epidemic also resulted in a lack of adequate training as well as shortages of equipment (e.g. ventilators) and supplies to enable health workers to provide adequate care to their patients.

## 3.5 Maintaining essential health services

Maintaining essential health services must also be a priority at this time, as even the most robust health systems are struggling due to the impact of COVID-19. Although health systems and health workforces are being strained by the pandemic, efforts should be made to mitigate the effects of COVID-19 on essential services. Essential services have already been impacted in the Region, with almost all countries reporting some disruptions in services and, in many cases, those countries facing conflict or humanitarian emergencies are reporting near total disruption of essential health services. While some routine care or elective procedures can be postponed, disruption of essential health services can lead to increased morbidity and mortality due to illnesses other than COVID-19. Thus, countries need to make concerted efforts to continue provision of essential services while responding to the COVID-19 pandemic.

## 3.6 Societal and economic effects

Public health emergencies such as COVID-19 can exacerbate societal inequalities due to age, gender, disability, education and wealth. Governments, therefore, should take steps to ensure that public health measures adhere to human rights principles and incorporate the protection of at-risk and vulnerable groups.

In the Eastern Mediterranean Region, the proportion of people living below the poverty line (i.e. on less than US$ 1.90 per day) is above 25% *(1)*. Over 100 million people (15% of the population) live with some form of disability *(1)*. The Region is home to 12 million refugees *(2)*, 13 million IDPs *(3)*, and 46 million low-income labour migrants *(4)*. Individuals and communities may no longer be able to work and access the labour market, especially in light of public health measures such as physical distancing and closure of businesses deemed to be non-essential. People in prisons and other detention centres are likely to be more vulnerable to COVID-19 than the general population due to prolonged periods spent in crowded and confined conditions. Labour migrants also face an increased risk due to similarly crowded living conditions.

Pandemics and outbreaks can have differential impacts on women and men due to differing risks of exposure, susceptibility and other social determinants of health *(5)*. Thus, a gender-lens is a critical aspect in decision-making on COVID-19 response. Preliminary analysis of data from the Region from 30 May 2020 shows higher morbidity and mortality rates among men than women (male to female ratio: 3.7:1.0 and 2.1:1.0, respectively). However, since only 25% of reported cases in the Region have demographic information, interpretations of gender differences are made with caution. Better and more complete reporting by sex and age are required to understand the key differences and disparities. Violence against women has been known to increase during emergencies, and restrictions on movement in order to contain the spread of COVID-19 may place survivors of domestic violence at increased risk. Initial data from two countries in the Region indicate an increase in cases of domestic violence of 50–60%, based on survivors' calls for help to women's organization hotlines *(6)*. Thus, response to violence against women is an essential service within the COVID-19 response. It is also critical to maintain the availability and accessibility of sexual and reproductive health services as part of the essential package of health services, as experience shows that these services are often scaled back during epidemics.

Globally, 70% of workers in the health and social sectors are women. In the Region, half of reported cases of COVID-19 among health care workers are women. Equitable access to training on IPC measures, PPE and essential products for hygiene and sanitation, as well as to psychosocial support, is critical. In addition, sociocultural expectations and constructs often place unpaid caregiving roles on women. These additional responsibilities place women at higher risk from COVID-19 and its impacts, which should be recognized and incorporated in national response measures *(5, 7)*.

A whole-of-government, whole-of-society approach is required to contain the pandemic and to alleviate the social and economic effects of COVID-19 *(8)*. National preparedness and response plans for COVID-19 need to address the societal impacts of the pandemic alongside its health impacts. This could include direct provision of resources to support workers and households, health and unemployment insurance, scale-up of social protection and safety nets, and support to businesses to prevent bankruptcies and job losses *(9)*. To protect the most vulnerable people, consideration should be given to providing financial support for informal workers, protection of income from lay-offs and sick leave for formal workers, protection of housing stability for affected families (i.e. suspension of mortgages and rent payments, and safe and adequate shelter for the homeless), food security (i.e. access to and distribution of food) and access to safe water and sanitation services. Innovative hygiene measures are already being implemented globally such as the installation of handwashing stations at the entrances to public buildings, offices and public transportation to support individuals and communities to adhere to hand hygiene recommendations *(10)*.

## 4. EPIDEMIOLOGICAL SITUATION IN THE REGION

### 4.1 Evolution of the COVID-19 epidemic in the Region

After the first cluster of cases was reported in Wuhan, China in December 2019, the United Arab Emirates reported its first laboratory-confirmed cases on 29 January 2020. On 14 February, Egypt reported its first confirmed COVID-19 case, a contact of a confirmed case with history of travel to China. While cases in the United Arab Emirates and Egypt continued to be reported, the Islamic Republic of Iran reported its first two cases of COVID-19 in Qom on 19 February 2020. Within two days (21 February), Lebanon reported its first confirmed case who had travelled back from Qom. On 24 February, Afghanistan, Bahrain, Iraq, Kuwait and Oman reported their first confirmed cases – all had travelled to the Islamic Republic of Iran. Subsequently Pakistan, Qatar, Saudi Arabia and United Arab Emirates reported cases, which also had travel history to the Islamic Republic of Iran. Globally, the Islamic Republic of Iran became the second epicentre of the COVID-19 outbreak after China, up until 13 March 2020 when Italy surpassed it for the number of cases *(11)*. While the initial cases reported in the Region were detected among travellers, or were linked to travellers, the risk of travel-related transmission was largely mitigated through wide applications of strict border closures and restrictions in international air travel. Subsequently, COVID-19 country epidemics passed the containment phase as the Region moved to experience local transmission patterns and spread in communities.

### 4.2 Current situation in the Region (as of 11 July 2020)

An alarming milestone was reached on 28 June 2020 when WHO confirmed more than 1 million cases of COVID-19 in the Eastern Mediterranean Region. By the end of June 2020, the graph of

daily reported cases in the Region had progressed to a peak, but now appears to be stabilizing at about 10% of global reported cases (Fig. 1). Although the overall regional trend of reported cases and deaths, as of 11 July 2020, appears to have stabilized and is even decreasing, at individual country level there is a mixed picture being observed: for example, Lebanon, Libya, Morocco, Palestine and the Syrian Arab Republic report an increasing number of cases; Jordan, Oman and Kuwait show decreases in cases and stabilization in deaths; Afghanistan, Bahrain, Egypt, Iraq, Jordan, Pakistan, Qatar and Saudi Arabia show either plateauing, stabilization or decreasing reports of cases; the Islamic Republic of Iran, Lebanon, Morocco, Tunisia and the United Arab Emirates show new resurgence in reported cases after an initial dip; while mixed pictures, or uncertain data, are noted in the other Member States (Fig. 2). As noted, an overall regional plateau and stabilization of caseloads has been seen from epi week 25 onward, with the Islamic Republic of Iran representing 20% of the regional burden of cases, Pakistan 19%, Saudi Arabia 18%, Egypt 8%, Iraq 7%, Oman 5%, Kuwait 4% and United Arab Emirates 4%.

The Eastern Mediterranean Region has the third highest number of cases and third highest number of deaths among WHO regions. Based on WHO data on 11 July 2020, 10:00 CET, the Eastern Mediterranean Region has reported 1 255 977 cases, representing 10.2% of 12 322 395 global cases reported by 218 countries/areas/territories worldwide to date. The countries most affected in the Region as of 11 July 2020 are the Islamic Republic of Iran (252 720 cases, 2262 deaths), Pakistan (246 351 cases, 2755 deaths), Saudi Arabia (226 486 cases, 3159 deaths) and Qatar (102 630 cases, 520 deaths). All of the countries affected by complex emergencies have recorded cases and deaths, and the COVID-19 pandemic will likely exacerbate the existing humanitarian crises in these countries.

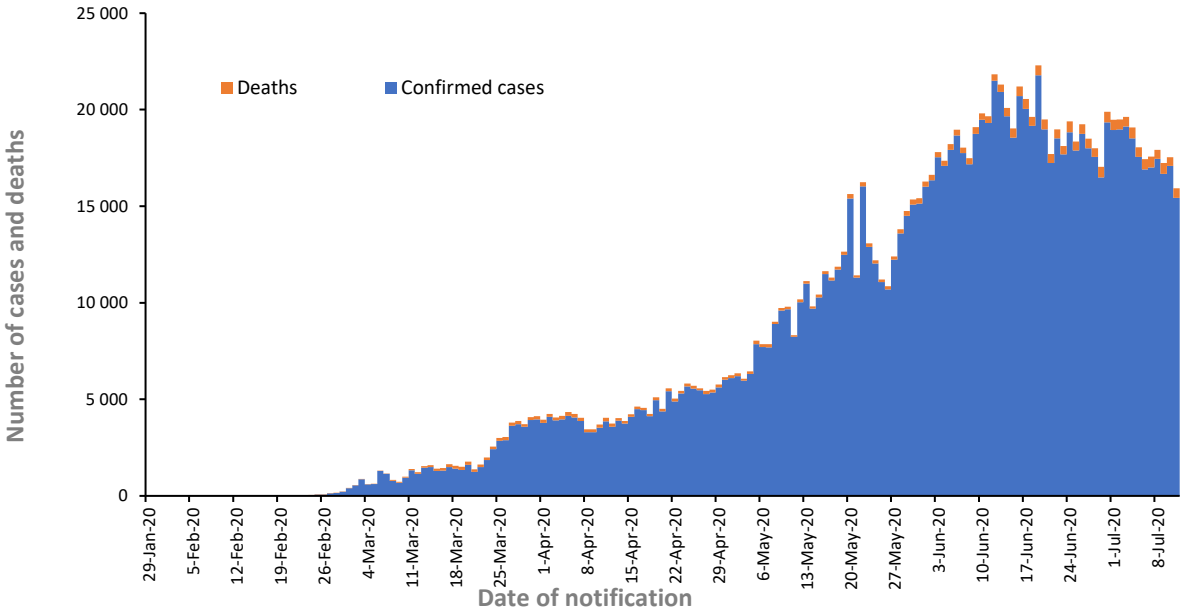


**Fig. 1. Daily distribution of cases and deaths in the Region, 11 July 2020**

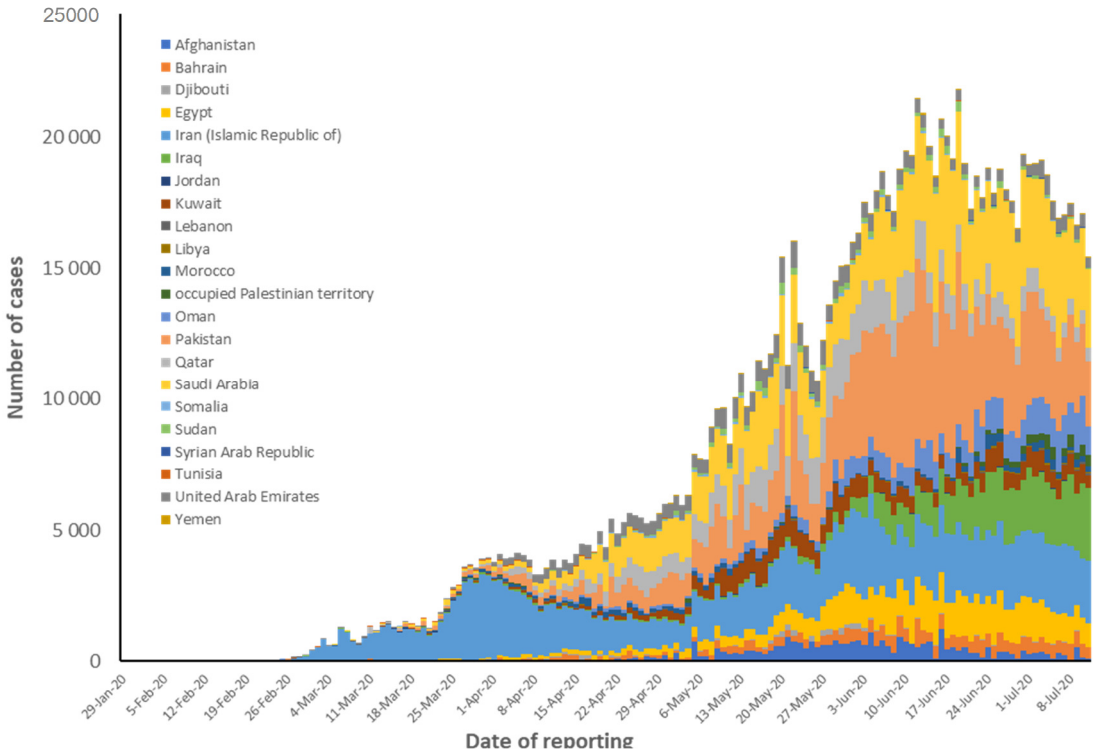


**Fig. 2. Daily distribution of cases in countries of the Region, 11 July 2020**

Many countries in the Region have already started to ease restrictions, lift lockdowns and even make plans to resume air travel. This being done largely in response to increasing economic pressures, but nevertheless increases the risk of a resurgence of travel-related cases along with ongoing community transmission. The risk of further spread of COVID-19 in Member States of the Region is still considered high. Daily reports of COVID-19 cases continue to escalate, even in those countries with strong health system capacities according to previous IHR (2005) assessments and joint external evaluations. Implemented public health measures have successfully slowed the spread of infection in some countries, however others continue to record higher caseloads. It has always been unclear to what extent the restrictions and public health measures were being implemented, even though they are now largely being lifted. For example, Gulf Cooperation Council (GCC) countries are still reporting higher numbers of laboratory-confirmed cases despite the implementation of strict lockdowns and other public health measures. The outbreak in GCC countries has also spread to migrant workers, and the health authorities are employing aggressive mass laboratory testing to target migrants or expats working in these countries.

The risk of infection spreading between countries in the Region is well documented, with most countries having received cases from other affected countries (both within and outside the Region). The public health measures employed in many countries of the Region were designed to allow a window of opportunity for health ministries to enhance and escalate response capacities for case detection, testing and isolation. However, the lifting of the interventions is not being done gradually and could result in a new resurgence of cases in the coming weeks.

# 5. NATIONAL STRATEGIES FOR CONTAINMENT OF COVID-19

## 5.1 Case finding, testing and isolation

Detecting and responding to COVID-19 is now the most important public health priority for all countries in the Eastern Mediterranean Region. All countries have put in place mechanisms of varying degrees of effectiveness to enhance their surveillance systems for early detection, isolation and laboratory confirmation of suspected cases. National COVID-19 surveillance guidelines and laboratory testing guidelines have been developed and are closely aligned with or adapted from WHO guidelines *(12,13).* However, standard case definitions and testing strategies vary from one country to another, and this will impact detection and confirmation of cases. Some countries have implemented case definitions requiring multiple clinical, laboratory and imaging characteristics in order to be considered a suspected case, while others have implemented broad-based testing of asymptomatic contacts or large proportions of random asymptomatic individuals in the community.

WHO has outlined surveillance strategies for COVID-19 that can be adapted for implementation at national level within countries of the Region *(12)*. The aim of COVID-19 surveillance is to provide the needed information to monitor the impact of COVID-19, and in turn, guide public health actions to limit the spread of disease. Recommended strategies focus on expanding surveillance activities to primary care level, conducting hospital-based surveillance, enhancing surveillance in high-risk groups and combining COVID-19 surveillance with existing respiratory disease surveillance systems, as well as implementing cluster investigations, active case finding and contact tracing.

Effective contact tracing is vital in controlling outbreaks of COVID-19 and is achieved through identification, assessment and management of people who have been exposed to the virus. Active case finding and contact tracing remain ever important as countries initiate down-scaling of restriction measures. WHO is conducting primer webinars for countries on contact tracing, as well as making detailed training materials available for country rapid response teams and contact tracing teams.

Screening through temperature checks and travel history questionnaires at points of entry (PoE) has been heavily implemented, and most of the initial cases in the Region were detected due to PoE-focused surveillance strategies. WHO is working with countries in the Region to enhance active surveillance and screening at PoE in accordance to IHR (2005) requirements.

Several countries in the Region have reported enhancing their event-based surveillance system for respiratory diseases through strengthening efforts to capture rumours or through use of call-in hotlines for reporting, as well as collecting reports from social media, newspapers and communities. Some countries have enhanced COVID-19 surveillance and active case finding through existing influenza-like illness (ILI) or severe acute respiratory infection (SARI) surveillance systems. Countries undergoing complex emergencies have continued to adapt their early warning surveillance systems to detect and respond to COVID-19; adaptations include surveillance officers using unexpected unusual events to report suspected COVID-19 cases, or adding COVID-19 as a separate condition in the respiratory diseases category for immediate and

weekly reporting. As many countries in the Region scaled up their COVID-19 surveillance, the existing polio surveillance structure and resources were leveraged to support COVID-19 response activities, while maintaining the core functionality of polio surveillance. In some countries (Afghanistan, Pakistan, Somalia, Yemen and others), polio staff have been fully engaged with: case detection and reporting; case investigation, sample collection and contact training; risk communication and material development; and training of health workers and sensitizing frontline health workers. Furthermore, the polio programme contributes to the overall coordination and management of the COVID-19 pandemic response and the surveillance data management.

In terms of laboratory capacity, all 22 Member States of the Region now have functioning national laboratories with the ability to detect and confirm COVID-19 virus, seasonal influenza viruses, MERS-CoV and other high-threat pathogens. However, these national reference laboratories still require ongoing additional support to improve and sustain diagnostic capacity, biosecurity and biosafety, and specimen transportation. In addition, there is a need for further expansion of laboratories at the subnational level. Countries with complex emergencies and weak health systems continue to need additional support to enhance epidemiological and virological surveillance for emerging infectious diseases. WHO has made concerted efforts to establish and expand testing capacities in countries with complex emergencies, such as the Syrian Arab Republic and Yemen.

WHO recommends that all laboratory-confirmed cases should be isolated in health facilities. In situations where isolation in a facility is not possible, WHO has issued guidance on home isolation for confirmed mild or asymptomatic cases *(14)*. Quarantining of contacts can be in the home or in dedicated facilities. Countries in the Region have employed different isolation and quarantine strategies. For example, GCC countries have dedicated temporary facilities that are being used for quarantine of asymptomatic individuals (e.g. contacts), and Egypt has likewise repurposed hotels. Pakistan has moved towards quarantine at home rather than repurposed facilities. Many countries have found upkeep of repurposed facilities to be difficult and have also recommended quarantining at home. Many GCC countries continue to admit all laboratory-confirmed cases to health care facilities, while other countries do not have this capacity and have recommended isolation of mild cases at home.

## 5.2 Transmission scenarios

National strategies should be tailored to the different transmission scenarios as they develop: whether there are no cases, sporadic cases (having one or more cases that are imported or locally detected), clusters of cases (clustered in time, geographic location, and/or common exposure), or community transmission (experiencing large outbreaks of local transmission). WHO recommends countries should self-assess and report on a weekly basis national admin level 0 and subnational admin level 1 transmission scenarios based on currently available information. If this information is not available, WHO conducts the assessment and validates findings with respective countries.

Initial cases reported in the Region were imported cases; however, the situation has changed over time, with countries exhibiting patterns of local transmission, clusters of cases and widespread community transmission. Some countries with ongoing community transmission, or at high risk of community transmission, have implemented comprehensive public health measures in an effort to return to a steady state of low-level transmission or no transmission. These measures

include limiting international and national travel, limiting population movement (especially to reduce exposure of vulnerable and high-risk groups), curfews, school closures, and closure of businesses with high risks of exposure, as well as increased contact tracing, isolation of symptomatic cases, enhanced community awareness and increased laboratory testing.

### 5.3 Reporting

Despite well-meaning efforts, constraints have been noted regarding timely notification of suspect, confirmed and probable cases to the Regional Office. In addition, one of the most significant challenges is the provision of detailed case-based reports on COVID-19 through the Eastern Mediterranean Flu Network (EMFLU) platform. Data received by the Regional Office are often of varying quality and are usually not received in a timely manner. Daily reporting through national IHR focal points continues to improve; however, additional work is done by the Regional Office to scan other data sources to fill in data gaps in received reports.

With increasing numbers of cases, local authorities are reporting time constraints and limited resources to be able to provide detailed data in a timely manner. Thus, the Regional Office has initiated collection of weekly aggregated data as well as case-based reporting in order to try to improve data sharing. The Regional Office continues to engage WHO country offices and ministries of health to address unavailable, incomplete or delayed data sharing, as timely and complete data sharing will facilitate the Regional Office's support to countries as well as national, regional and global understanding of epidemiology and COVID-19 clinical disease.

### 5.4 Clinical management

To date, there are no specific medications approved to treat COVID-19, and only supportive care is available. Likewise, there is currently no vaccine to protect people from COVID-19 virus. There is emerging evidence from affected countries that some medications such as remdesivir and dexamethasone may have the potential to treat the symptoms of COVID-19; however, further large-scale studies and randomized control trials are needed to determine if these treatments are safe before potential treatments and vaccines become available.

Efforts to develop treatments and vaccines are collectively supported by the WHO Research and Development Blueprint platform as well as the Regional Office's research department, clinical management team and experts in the regional Incident Management Support Team (IMST) for COVID-19. One example is WHO's Solidarity trial, a clinical randomized controlled trial which has been launched to evaluate the efficacy and safety of investigational therapeutic agents against local standard of care for the treatment of hospitalized patients with COVID-19. Enrolment into the Solidarity trial is through a nation-based registry led by the government. Several countries in the Region have joined and others are in the process of joining the trial to further global understanding of possible therapeutics for COVID-19.

The Regional Office has worked closely with countries to provide technical support on clinical management for COVID-19, including comprehensive guidance for clinical care in various settings. The Regional Office provides support in reviewing national clinical algorithms and continues to emphasize the importance of using repurposed therapeutic agents as part of randomized control

trials. Dissemination of information related to newly defined clinical case definitions, such as multisystem inflammatory syndrome in children and adolescents, is also provided.

Regional capacity in clinical management of the disease is being scaled up through multiple approaches and ongoing efforts. One aspect is addressing the acute and drastic shortage of essential supplies including PPE, diagnostics, and medical equipment and supplies for clinical management. The Regional Office is scaling up such supplies through the COVID-19 supply chain system, including provision of oxygen concentrators and other biomedical supplies and equipment. Another significant component is to enhance the capacity of clinicians, nurses and co-medicals to manage ICU/severe COVID-19 patients. In this regard, due to limited ability to travel, WHO has provided online clinical management trainings to countries in the Region and is preparing to provide on-site skill set trainings for ICU care through collaboration with local and external entities. The Regional Office is also engaging key clinicians in each country to establish a network of clinicians caring for patients with COVID-19.

### 5.5 Public health and social measures

Public health and social measures are readily available and acceptable measures for all countries of the Region, and public health experts recommend rigorous and routine implementation of these critical interventions in responding to the pandemic. WHO recommends implementation of public health measures for COVID-19 response in accordance with the epidemiological context, including personal measures, physical and social distancing measures, movement measures, and special protection measures *(15)*. As discussed above, many countries in the Region have implemented comprehensive public health measures to curb the spread of COVID-19. In countries experiencing community transmission or at risk for development of community transmission, emphasis should be placed on the following:

- personal measures, including hand washing and proper respiratory etiquette;
- physical distancing measures, including suspension of mass gatherings and closure of non-essential businesses and institutions;
- movement measures, including limiting travel (national or international) and implementing screening and quarantine protocols;
- special protection measures, including shelter in place for the elderly and protection of closed settings such as prisons.

Implementing these measures requires a multi-pronged approach and consideration of the local context. Furthermore, strong risk communication and community engagement efforts are required to achieve sustainable behaviour change in many of these priority areas.

The lifting of public health and social measures has posed challenges around the Region and the world. The risks and benefits of lifting the measures must be considered, and there is no single formula that can be applied to every country. Without careful planning and in the absence of scaled-up public health and clinical care capacities, premature lifting of physical distancing measures is likely to lead to an uncontrolled resurgence in COVID-19 transmission and an amplified second wave of cases. Although many countries are pursuing gradual steps to loosen lockdown restrictions in order to revive a battered economy, some countries have since

experienced a resurgence of new cases and deaths and been forced to reintroduce localized restrictions. Furthermore, compliance or adherence of the general public to preventive measures, such as social distancing or lockdowns, is a major challenge. WHO has been advising countries to follow recommendations to adjust public health and social measures that will slow down transmission and reduce mortality associated with COVID-19. WHO recommends countries to improve the scale, quality and monitoring of aforementioned priority public health interventions to limit the transmission of infection, as many of these interventions have been implemented using varying strategies. Given the implications on health and other sectors, monitoring the impact of these interventions is of utmost importance.

### 5.6 Research and knowledge sharing

Research and innovation are essential components of the COVID-19 pandemic response. The WHO Research and Development Blueprint outlines priority areas for this work, namely further clinical understanding of the disease as well as development of vaccines, therapeutics and diagnostics. WHO is collaborating with global partners in all these areas including concerted efforts to share virological data, accelerate vaccine development and to identify therapeutic agents via the global WHO Solidarity trial.

WHO has identified and announced key research areas for COVID-19, which include additional regionally and nationally relevant research questions that will enable better understanding of the disease epidemiology in the Region, assess the feasibility and implementation effectiveness of public health and social measures and document national experiences for use by others. In addition, a series of standard studies based on WHO Unity Studies protocols are being supported at national level in several countries of the Region. Research evidence is assessed and presented in a way that supports evidence-based decision-making, including through WHO platforms for knowledge management and sharing. WHO is committed to continued coordination and collaboration with partners around the world in order to make swift progress with larger studies rather than small, isolated studies occurring in silos. These collaborations cover all key areas of research and innovation (e.g. digital health, as well as outbreak investigation and clinical management).

## 6. PREPAREDNESS AND RESPONSE STRATEGY FOR COVID-19

### 6.1 Goal

The overarching goal is for all countries to control the pandemic by slowing down transmission and reducing mortality associated with COVID-19.

### 6.2 Regional strategic objectives

- Mobilize all sectors and communities to ensure that every sector of government and society takes ownership of and participates in the response.
- Control sporadic cases and clusters and prevent community transmission by rapidly finding and isolating all cases, providing them with appropriate care, and tracing, quarantining and supporting all contacts.

- Suppress community transmission through context-appropriate IPC measures, physical distancing measures, and appropriate and proportionate public health and social measures (personal measures, movement measures, physical distancing measures, and special protection measures)
- Reduce mortality by providing appropriate clinical care for those affected by COVID-19, and by ensuring the continuity of essential health and social services.

## Areas of work and priority activities for COVID-19 preparedness and response (February–December 2020)

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| **Leadership, partnership and coordination** | **Leadership**<br>1. Strengthen the regional Incident Support Management Team (IMST) to monitor country-level activities, facilitate coordination with counterpart IMSTs in WHO headquarters and country offices, and mobilize resources.<br>2. Maintain and strengthen the country support teams to provide the required technical assistance to enhance the response and facilitate communication between WHO country offices and IMST technical pillars.<br>3. Work with WHO country offices, through the country support teams, to activate national public health emergency management mechanisms including planning, operations, logistics and finance, in cooperation with partners.<br>4. Conduct joint operational review/after action review to assess WHO's progress, working together with partners, in implementing country preparedness response plans.<br>5. Conduct regular risk assessments using a standard methodology and with the participation of relevant sectors to balance the risks of introducing, adapting and lifting public health and social measures.<br>**Partnership and coordination**<br>1. Strengthen and support multisectoral, multi-partner coordination mechanisms with international and regional health partners, stakeholders, donors and national IHR focal points to ensure a whole-of-government approach to country preparedness and response to COVID-19, with particular focus on graded emergencies and fragile and vulnerable settings in the Region.<br>2. Strengthen the network of partners at regional level to ensure coordination of preparedness and response at regional and country levels, including United Nations organizations, nongovernmental organizations, academia, donors, observers and other stakeholders.<br>3. Coordinate and collaborate with international and national partners (including local nongovernmental organizations, academia, donors and the International Federation of Red Cross and Red Crescent Societies) through available coordination structures including the Global Outbreak Alert and Response Network (GOARN), emergency medical teams, WHO standby partners, country health clusters and the Global Health Cluster to cover gaps in preparedness and response.<br>4. Support the mainstreaming of cross-cutting issues in the preparedness and response to COVID-19 to ensure that planning, implementation, and monitoring and evaluation are gender-responsive, human rights-based and equity-oriented through the development of tools and policy briefs. | All countries | 660 480 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| **Epidemiology, outbreak investigation and health information** | 1. Develop regional mathematical and economic COVID-19 models, and support countries in running the regional models or validating their national models.<br>2. Detect and monitor COVID-19 cases through media scanning including daily aggregation of information relevant to COVID-19 from government websites, social media, local newspapers and the community.<br>3. Monitor the effectiveness of response and control measures, including management of the COVID-19 monitoring and evaluation framework by the Regional Office.<br>4. Ensure comprehensive data analysis and interpretation of EMFLU data, including information dissemination and support to country support teams in analysing the epidemiological data for action.<br>5. Support health ministry and WHO country office to collect and analyse data, and communicate results of the analysis through dashboards, situation reports, etc.<br>6. Develop a geospatial database to conduct in-depth data analysis.<br>7. Support improvement of case finding using case definitions, event-based surveillance, and influenza-like illness (ILI) and severe acute respiratory infection (SARI) surveillance.<br>8. Enhance existing SARI and ILI surveillance to enable monitoring of COVID-19 transmission at the community level and improve testing of SARI and ILI cases.<br>9. Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring of COVID-19.<br>10. Procure and ensure availability of sufficient quantities of personal protective equipment (PPE) and disinfectant materials for rapid response teams and contact tracing teams.<br>11. Train and equip multidisciplinary rapid (community) response teams to immediately investigate cases and clusters, scale up case management and conduct isolation of cases, contact tracing and quarantine of contacts.<br>12. Provide financial support to identify/deploy (national) local experts to support outbreak response and contact tracing activities. | All countries | 2 238 084 |
| **Laboratory diagnostics** | 1. Support all countries in the Region to sustain and increase capacity for laboratory confirmation of COVID-19, in line with WHO's laboratory testing guidance for COVID-19 in suspected human cases.<br>2. Strengthen laboratory workforce capacity for COVID-19 diagnostics by providing technical assistance and training of relevant laboratory staff, if needed, including in biosafety and biosecurity.<br>3. Ensure that testing is strategically and geographically decentralized in countries, where possible, to support rapid detection. | All countries | 892 437 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| | 4. Support the external quality control programme for COVID-19 and advocate for the participation of all active national and subregional laboratories.<br>5. Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into a strategic review of national laboratory plans and share lessons learned.<br>6. Facilitate sharing of COVID-19 positive specimens to WHO collaborating centres for genetic sequencing, and share data and virus materials through GISAID.<br>7. Ensure availability of materials in nationally designated laboratories for specimen collection and safe transportation, including testing kits and other essential reagents, consumables and equipment.<br>8. Procure and distribute field laboratory sample collection kits and other essential laboratory consumables (sample collection materials, viral transport media, triple packaging boxes) for rapid response teams. | | |
| **Infection prevention and control (IPC)** | 1. Provide technical support to WHO country offices and national IPC and COVID-19 focal points with regard to standard precautions, triage, isolation capacities and other IPC measures, as needed.<br>2. Ensure implementation of surveillance of infections among health care workers in countries with health care-associated infections. | Afghanistan, Iran (Islamic Republic of), Iraq, Libya, Morocco, Pakistan, Somalia, Sudan and Tunisia | 972 038 |
| **Case management and isolation** | 1. Provide trainings to health care/ambulatory teams in management of COVID-19 cases.<br>2. Provide training and capacity-building to clinicians, co-medicals and nurses in management of COVID-19.<br>3. Develop a training package for co-medicals and nurses on the use of ICU devices and critical care of COVID-19 patients.<br>4. Facilitate implementation of international/WHO protocols for research and clinical trials at country level, where opportunities exist.<br>5. Identify oxygen capacity and mechanical ventilation capacity in countries.<br>6. Support the establishment of screening and triage areas at all health care facilities, and increase screening capacities in the community.<br>7. Support isolation centres/health facilities to assess their management capacities for COVID-19 and to develop their response plans.<br>8. Provide technical support for pre-hospital assessment and planning during the COVID-19 pandemic. | Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, Pakistan, Palestine, Somalia, Sudan, Syrian Arab Republic, Yemen | 1 278 735 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| **Operations support and logistics** | 1. Recruit or maintain staff/experts to assist with quantifying and validating country supply requests.<br>2. Conduct technical missions on logistics to support development of medical supply plans.<br>3. Facilitate the procurement processes for medical and other essential supplies (including importation and customs) and encourage local sourcing of high-quality products to increase timeliness and accessibility of supplies.<br>4. Enhance the capacity of the Dubai Hub to monitor and report staff costs.<br>5. Develop the monitoring and reporting tools for deployment of medical supplies, including disruptions and blockages to the global supply chain.<br>6. Support the Dubai Hub in communication/infographics and reporting.<br>7. Establish a dedicated warehousing and kitting area to facilitate rapid deployment of supplies.<br>8. Develop and implement a mobile application to monitor and track COVID-19 logistics/supplies operations.<br>9. Facilitate charter flight arrangements for deployment and return of rapid response teams. | All countries | 2 450 000 |
| **Risk communication and community engagement (RCCE)** | 1. Continue technical support to countries to implement national emergency RCCE strategies and/or action plans for COVID-19, and regularly monitor their implementation.<br>2. Continue disseminating timely and credible information to the public, health authorities, decision-makers, health professionals and other key audiences, including vulnerable populations, using appropriate formats and accessible platforms.<br>3. Prepare locally adapted messages and pre-test them through a participatory process, specifically targeting key stakeholders and at-risk groups.<br>4. Continue developing and disseminating RCCE materials on COVID-19 and support countries in the translation, adaptation and production of these materials for local use, including materials developed by WHO headquarters and other WHO regions, as well as by other departments within the Regional Office.<br>5. Expand the engagement of regional and national key influencers in communicating evidence-based messages to broader audiences.<br>6. Increase coordination for RCCE through the subregional task force to improve alignment with other United Nations organizations and regional and international agencies.<br>7. Compile interpersonal counselling and community engagement modules along with remote training platforms to provide countries with high-quality technical support (including virtual workshops) for planning, delivery and monitoring. | All countries | 857 964 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| | 8. Collaborate with faith leaders for community engagement and empowerment through the Islamic Advisory Group and other faith-based organizations in coordination with WHO headquarters and UNICEF.<br>9. Establish and integrate regional and national social sciences interventions to further improve behaviour change including surveys, focus groups and secondary data collection.<br>10. Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.).<br>11. Support countries to conduct knowledge, attitudes and practice studies to inform behaviour change interventions.<br>12. Develop and publish COVID-19 risk communication materials in various languages/dialects for the use of IDPs, refugees, migrants and returnees. | | |
| **Points of entry (PoE) and IHR (2005)** | 1. Provide technical expertise to inform operations for PoE, including direct technical assessment and targeted assistance for specific PoE capacities concerning the management of ill travellers.<br>2. Provide guidance to countries on IHR (2005) issues related to travel and trade based on current public health advice, and in alignment with WHO's global COVID-19 strategy.<br>3. Enhance regional PoE capacities under IHR (2005) obligations in the light of gaps revealed by COVID-19, including management of cases aboard ships.<br>4. Enhance proficiency of national focal points in IHR (2005) competence.<br>5. Provide support and technical guidance to country emergency operation centres (EOCs) at national and subnational levels to better coordinate the COVID-19 response.<br>6. Development community working environment for the public health EOC (PHEOC) in collaboration with regional and international partners (WHO Regional Office for Africa, Public Health England, the Centers for Disease Control and Prevention (CDC), Africa CDC), including an online platform (weekly webinar sessions and daily back-office support) to bring experts and PHEOC staff at health ministries together to share experiences and build capacities.<br>7. Provide a software solution (Public Health Emergency Response Management software) for managing COVID-19 emergencies and appropriate technical support.<br>8. Provide and coordinate technical expertise to guide countries on social distancing measures and mass gathering using a risk assessment approach.<br>9. Provide countries with the technical assistance to plan for mass gatherings in anticipation of the easing of social distancing measures using risk assessment tools. | Afghanistan, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Pakistan, Qatar, Sudan, Syrian Arab Republic, Tunisia | 974 575 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| **Mental health and psychosocial support (MHPSS)** | 1. Develop COVID-19-related MHPSS information and messages (on positive coping, self-help, social connectedness, etc.) in accessible formats, and distribute through social media and other channels.<br>2. Set up 24/7 helplines for MHPSS support using tools such as psychosocial first aid (PFA) and Problem Management Plus (PM+), and provide information on available services and coping strategies.<br>3. Build capacity of multidisciplinary teams to ensure continuity of MHPSS services through remote means including for people in isolation/quarantine.<br>4. Strengthen the capacity of the regional technical unit by recruiting dedicated staff. | All countries | 183 063 |
| **Working in fragile and vulnerable settings** | 1. Develop and conduct a modular training programme on the inclusion of refugee and migrant health within advocacy for progress towards universal health coverage in the context of COVID-19.<br>2. Develop a tool to assess the response to COVID-19 by WHO and health partners in the context of IDPs, refugees, migrants and returnees.<br>3. Develop thematic analytic reports on the health of IDPs, refugees, migrants and returnees in the context of COVID-19 (including themes such as temporary contractual workers, mental health and best practices).<br>4. Develop a regional report on the lessons learned from the response to COVID-19 in the context of conflict, IDPs, refugees, migrants and returnees.<br>5. Develop a website on IDPs, refugees, migrants and returnees to disseminate publications. | Targeted counties hosting refugees and migrants | 181 469 |
| **Early recovery/health systems strengthening** | 1. Evaluate the ongoing health system response to COVID-19 to document country experiences and lessons learned (including tools development, country assessments and regional synthesis).<br>2. Provide technical cooperation to countries in support of health systems recovery from COVID-19, including developing a recovery toolkit, establishing a training programme and building capacities.<br>3. Review health budgetary mechanisms towards increased investment in essential public health functions in the context of COVID-19 (review of selected countries' budgetary processes in response to and recovery from COVID-19; policy brief on options for financing essential public health functions).<br>4. Provide technical cooperation and support to countries to enhance hospital readiness for response to COVID-19, including assessment, capacity-building, national consultants and documentation.<br>5. Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways (including assessment tool, implementation guide and technical cooperation). | All countries | 1 198 185 |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| | 6. Develop thematic analytic reports on health systems response to COVID-19, including in fragile and vulnerable settings (including themes such as governance, quality, equity, efficiency, workforce and the humanitarian-development-peace nexus). | | |
| | 7. Support the documentation of success stories and lessons learned from health system response to the COVID-19 pandemic at regional and country levels, including in fragile and vulnerable settings. | | |
| | 8. Assess and document the socioeconomic impact of COVID-19 in the Region, including assessment tool, national consultants, documentation and dissemination. | | |
| **Research/knowledge management** | 1. Support COVID-19 innovation based on a regional call related to priority areas, to create a platform to identify and share the best innovative practices in the Region as well as support 1-2 innovations per country through an evaluation system. | All countries | 881 598 |
| | 2. Support priority COVID-19 research in countries through an open call for research proposals; key proposals linked to the announced regional priority topics that meet research and ethical requirements will be supported. | | |
| | 3. Provide operational, technical and data acquisition support to the WHO Unity Studies in Member States; focus will be on serosurveys, but may include all categories of Unity Studies based on country needs. | | |
| | 4. Develop a regional COVID-19 Health System Response Monitor platform, to generate a monitoring report on COVID-19 response in countries, in collaboration between the WHO Eastern Mediterranean Regional Health Observatory and other WHO observatories. | | |
| | 5. Assess and support national COVID-19 evidence-informed policy-making processes, assessing and supporting national decision-making processes, and how these were affected by COVID-19 pandemic, especially in evidence-informed decision making during a pandemic. | | |
| **Programme planning and management, and administration/finance** | 1. Support countries to complete and implement their national COVID-19 preparedness and response plans, including estimated resource requirements (human, financial, supplies, etc.). | All countries | 1 807 337 |
| | 2. Facilitate the recruitment and deployment of technical staff to support the COVID-19 response at regional and country levels. | | |
| | 3. Support fast-track procurement requests for WHO country offices and Regional Office units. | | |
| | 4. Support countries with outbreak/crisis response workplan planning, programme management and monitoring, in line with the regional and country COVID-19 preparedness and response plans. | | |
| | 5. Conduct joint operational review/after action review to assess progress in implementing the regional COVID-19preparedness and response plan. | | |
| | 6. Support countries and Regional Office units with resource allocation and management. | | |

| Area of work | Activities | Priority countries | Budget (US$) |
|---|---|---|---|
| | 7. Ensure budget monitoring of the allocated funds with WHO country offices and financial and programme reporting. | | |
| | 8. Ensure programme planning, monitoring and reporting in line with the Operational Guidelines 2020–2021 for COVID-19 activities. | | |
| | 9. Support the surge deployment resources from the external and internal rosters of experts and GOARN experts. | | |
| **Resource mobilization and grant management** | 1. Engage donors in the Region to support regional and country-level measures to prevent and control the spread of COVID-19. | All countries | 1 039 796 |
| | 2. Support WHO country offices in their resource mobilization efforts at country level. | | |
| | 3. Manage grants effectively. | | |
| **Communications** | 1. Hold press briefings to inform media, address media queries and ensure media are aware of correct facts and information. | All countries | 547 309 |
| | 2. Produce weekly epidemiological and social reports and disseminate to all levels and international partners. | | |
| | 3. Conduct surveillance on traditional and social media to respond to rumours and misinformation, while providing technical support to countries in these activities. | | |
| | | | **Total budget US$ 15 000 000** |

# 7. OPERATIONALIZING THE PLAN

## 7.1 Monitoring and evaluation framework

The regional COVID-19 monitoring and evaluation framework aims to assess performance of preparedness and response activities through provision of regular data analysis, which will be conducted at regular intervals by the Regional Office. The regional COVID-19 monitoring and evaluation framework is aligned with the WHO global monitoring and evaluation framework, which has been developed to assess COVID-19 preparedness and response at the global level.

Selected key performance indicators will be used to monitor and evaluate the implementation of planned activities and respective outputs, as well as to assess the overall performance of the preparedness and response plan. Thus, data obtained will allow for derivation of evidence, identification of gaps, and lessons learned in order to adjust preparedness and response activities and operations. The main objectives are:

- monitoring of COVID-19 response activities at the regional and country levels through regular data analysis;
- supporting informed and participatory decision-making regarding activities and interventions for technical support to the countries in the Region;
- supporting transparent resource allocation to the countries in the Region;
- documenting evidence for operational reviews/after action reviews and lessons learned to support the programming cycle.

The regional IMST will regularly review progress on the implementation of the plan and its impact using the agreed set of indicators. A progress report will be generated and shared regularly by the monitoring and evaluation working group with senior management and involved technical units. This will highlight the progress and level of operational readiness, as well as strengths, weaknesses, gaps and recommendations on how to address any challenges and ensure timely follow-up actions to a coordinated emergency preparedness and response.

## Regional monitoring and evaluation framework

| Area of work | Indicator | Target |
|---|---|---|
| **Coordination and partnership** | Number of countries with activated/functional public health emergency operations centre or equivalent | 22 |
| | Number of countries with a functional multisectoral, multi-partner coordination mechanism for COVID-19 preparedness and response | 22 |
| | Number of countries with national COVID-19 preparedness and response plan | 22 |
| **Points of entry (PoE) and IHR (2005)** | Number of countries that produce and distribute COVID-19 information for both travellers and staff working at PoE facilities and conveyances | 22 |
| | Number of countries that have PoE with capacity to implement additional measures for entry/exit screening, according to emergency need | 22 |
| **Surveillance** | Number of countries with COVID-19 event-based surveillance | 22 |
| | Number of new confirmed cases in health care workers | |
| | Number of countries that reported the first COVID-19 case to WHO within 24 hours of confirmation as per IHR (2005) requirement | 22 |
| **Case management** | Number of countries that have a clinical referral system in place to care for COVID-19 cases | 22 |
| | Number of countries with designated hospitals to treat COVID-19 patients | 22 |
| | Number of health care workers trained in case management of COVID-19 cases | |
| | Number of countries that agreed to participate in the WHO Solidarity trial and have started the trial | |
| **Infection prevention and control (IPC)** | Number of countries with IPC focal points assigned at national and facility level | 22 |
| | Number of countries with IPC guidance disseminated to health care facilities at all levels | 22 |
| | Percentage of COVID-19 health care facilities with triage capacity | |
| | Percentage of acute health care facilities with isolation capacity | |
| | Number of health care workers trained in IPC in the previous week | |
| | Number of countries with national occupational health and safety plans/programmes for health workers | 22 |
| **Rapid response teams** | Number of countries with trained multidisciplinary rapid response teams | 22 |
| **Laboratory diagnostics** | Number of countries with laboratory results available within 24 hours of testing | 22 |
| | Number of countries with COVID-19 laboratory testing capacity | 22 |
| | Number of countries participating in external quality assessment programme (EQAP) | 22 |
| | Percentage of countries scoring 100% in EQAP | |
| **Risk communication and community engagement (RCCE)** | Number of countries that have implemented COVID-19 RCCE strategies | 22 |
| | Number of regional/country media interviews conducted and press releases delivered | |
| | Number of countries adapting and disseminating WHO information, education and communication materials | |
| | Number of countries that communicated COVID-19 prevention and preparedness messages to the population | 22 |
| **Operations support and logistics** | Number of countries requesting PPE that have received the supplies | 22 |
| | Number of countries experiencing stock-outs of critical items | 0 |
| **Programme management** | Percentage of surge deployment resources from the external and internal rosters of experts and GOARN experts | |
| | Percentage of national COVID-19 preparedness and response plan budget that is funded | |

## 7.2 Tentative budget summary for 11 months (February–December 2020)

The budget activities will be carried out by the regional IMST for COVID-19 response, which is organized under pillars and sub-pillars (as listed below).

| # of the pillar | Name of the pillar | Total (US$) |
|---|---|---|
| 1 | Leadership | 338 206 |
| 1.1 | Partner coordination | 322 274 |
| 1.2 | Surveillance and epidemiological analysis | 2 238 094 |
| 1.3 | Health operations | |
| 1.3.1 | Risk communication and community engagement | 857 964 |
| 1.3.2 | Laboratories | 892 437 |
| 1.3.3 | Clinical management | 1 278 735 |
| 1.3.4 | Infection prevention and control | 972 038 |
| 1.3.5 | Essential health services | 1 198 185 |
| 1.3.6 | IHR, travel and trade | 974 575 |
| 1.3.7 | Working in fragile and vulnerable settings | 181 469 |
| 1.3.8 | Mental health and psychosocial support | 183 063 |
| 1.4 | Logistics and supply chain | 1 807 337 |
| 1.5 | Programme management | 272 302 |
| 1.5.1 | Planning, monitoring and evaluation | 169 103 |
| 1.5.2 | Finance, budget and grant management | 338 206 |
| 1.5.3 | Human resources and administration | 338 206 |
| 1.6 | External relations | |
| 1.6.1 | Resource mobilization | 1 039 796 |
| 1.6.2 | Communications | 547 309 |
| 1.7 | Research and innovation | 881 598 |
| 1.8 | Staff health and safety | 169 103 |
| | **Total** | **US$ 15 000 000** |

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