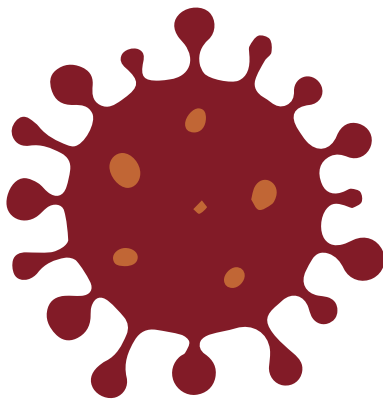


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**A COMPARATIVE ANALYSIS OF COVID-19
MITIGATION MEASURES IN TIBA COUNTRIES, A
CASE FOR DEVELOPMENT OF MULTI DIMENSIONAL
STRATEGIES FOR RESOURCE CHALLENGED
COUNTRIES**

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EXECUTIVE SUMMARY

The paper is a desk research-based analysis of the 9 TIBA countries' response to the outbreak of the Coronavirus (COVID-19). The TIBA countries under analysis are Botswana, Ghana, Kenya, Rwanda, South Africa, Sudan, Tanzania, Uganda and Zimbabwe. It provides a brief background of the pandemic that started as a localized outbreak in Wuhan China and has swept over the world bringing with it global multi-dimensional challenges. The paper discusses the various Public Health Measures that the TIBA countries implemented. The paper studies the response of the TIBA countries to the COVID-19 outbreak from the time the outbreak was declared a Public Health Emergency of international concern on 30 January 2020 to the 18th of May 2020 when the study ended.

The desk-based review utilized data collection methods including the review of published electronic and grey literature, TIBA governments public health measures, global and continental COVID-19 guidelines, best practices of successful mitigations of past outbreaks in Africa and the review of social media content to identify key themes, attitudes and belief systems prevailing in each country. However, the desk review has some limitations, including publication bias and difficulties in addressing generalizability owing to the different contexts of the countries that are reviewed.

The paper provides a comparative analysis of the TIBA countries response to COVID-19 based on the World Health Organization's Non-Pharmaceutical Interventions (NPIs) guidance as part of a multidimensional response.

The paper notes the challenges of public health measures in TIBA countries. These challenges include social distancing difficulties in high density residential areas and informal settlements. The challenge of water access is discussed in the context of handwashing being a key tool for limiting infections. The paper notes the challenge of lockdowns in a context where up to 66% of citizens depend on informal trading. It notes the increased vulnerability of some sections of the community during enforcement of public health measures and argues for the implementation of social safety nets. It notes the difficulties TIBA countries had with access to personal protective equipment (PPEs) and observes how some countries such as Kenya and Ghana promoted local production of PPEs to overcome the global shortages.

The paper considers the lessons learned from the mitigation of the 2014 Ebola outbreak and concludes by making recommendations on NPI implementation going forward. Recommendations include strengthening community engagement and communication strategies to mobilize communities and investment in bio medical research to enable production of test kits that will enhance mass testing.

The report encourages regional and international solidarity to help TIBA countries implement public health measures especially with economic and equipment support.



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CHAPTER 1: BACKGROUND TO THE NOVEL CORONAVIRUS OUTBREAK IN TIBA COUNTRIES

1.1 Background

The novel Coronavirus (Sars-Cov-2) also called COVID-19, a pandemic that started as a localised outbreak in Wuhan China has swept over the world bringing with it global multi-dimensional challenges. The Pandemic has been noted to have three defining characteristics: firstly, explosive speed and scale. Secondly it is notable for its severity as overall 20% of cases are severe or critical, with a crude clinical case fatality rate currently of over 3%, increasing in older age groups and in those with certain underlying conditions. Thirdly for the societal and economic disruptions it causes, the shocks to health and social care systems and the severity of measures taken to control transmission that have had broad and deep socio-economic consequences.¹ The World Health Organisation (WHO) notes that 'where there has been early action and implementation of comprehensive public health measures – such as rapid case identification, rapid testing and isolation of cases, comprehensive contact tracing and quarantine of contacts – countries and subnational regions have suppressed the spread of COVID-19 below the threshold at which health systems become unable to prevent excess mortality. Countries that have been able to reduce transmission and bring outbreaks under control have maintained the ability to deliver quality clinical care, and minimize secondary mortality due to other causes through the continued safe delivery of essential health services.'²

1.2 COVID-19 in Africa

The first African case of the Coronavirus was confirmed in Egypt on 14 February 2020. In a display of the speed with which the virus spreads, by 7 April, 52 African countries had reported cases. By 18th May 2020 More than 70% of the reported deaths were taking place in only five countries: Algeria, Egypt, Nigeria, South Africa and Sudan³. The anticipated challenges the virus presented to Africa, a continent with generally weak health systems,⁴ brought about warnings from WHO. The United Nations (UN) health agency cited a new study⁵ by its regional office in Brazzaville which found that between 83,000 and 190,000 could die and 29 to 44 million be infected during the period. WHO Director-General Tedros Adhanom Ghebreyesus has warned that Africa is highly likely to be the next hotspot as the world continues to be gripped by the novel Coronavirus. Despite the enormity of the crisis caused by the COVID-19 pandemic, African countries in general and TIBA countries in particular could draw from the experience of successfully mitigating past Ebola outbreaks.

In response to the COVID-19 outbreak, TIBA countries implemented various Public Health Measures that are the subject of this study.

1.3 Methodology

The paper is based on desk research of the 9 TIBA countries' response to the COVID-19 outbreak.

1 WHO 14 April 2020, COVID-19 strategy update [www.who.int › docs › covid-strategy-update-14april2020](http://www.who.int/docs/default-source/covid-19-strategy-update-14april2020)

2 WHO 14 April 2020, COVID-19 strategy update [www.who.int › docs › covid-strategy-update-14april2020](http://www.who.int/docs/default-source/covid-19-strategy-update-14april2020)

3 <https://www.afro.who.int/news/COVID-19-cases-top-10-000-africa>

4 <https://www.afro.who.int/news/COVID-19-cases-top-10-000-africa>

5 World Health Organization Africa New WHO estimates: Up to 190 000 people could die of COVID-19 in Africa if not controlled 07 May 2020 <https://www.afro.who.int/news/new-who-estimates-190-000-people-could-die-COVID-19-africa-if-not-controlled>



1.3.1 Data collection

The desk-based review used the following data collection methods:

- Desk review of published electronic and grey literature – Synthesizing existing global and local literature, review of scholarly and policy literature relevant to TIBA countries
- Review of current TIBA Governments COVID-19 public health measures - review of statutory instruments, provisions for public health and existing legislation supporting COVID-19 mitigation
- Review of global guidelines - Review of World Health Organisation, UN, Africa CDC, Afro -WHO guidelines and protocols for COVID-19 and their implementation
- Review of best practice, case studies of successful mitigation of previous epidemic outbreaks in Africa
- Review of social media - Analysis, of content of social media using Twitter, Facebook, WhatsApp and YouTube. Social media traffic will help identify key themes, attitudes, belief systems emerging in the public discourse on COVID-19 situations in each country. It will help understand citizen attitude towards mitigation policies and understanding of the disease itself.

As the COVID-19 outbreak in Africa is an emerging and rapidly evolving issue, much of the TIBA country responses were determined from public announcements and media reports. Triangulation was used to determine veracity of media reports to minimise inaccuracy and exaggeration.

1.4 Study period

The paper studies the response of the TIBA countries to the COVID-19 outbreak from the time the outbreak was declared a Public Health Emergency of International Concern on 30 January 2020 to the 18th of May 2020 when the study ended.

1.5 Limitations of study

The desk review had some limitations, including publication bias and difficulties in addressing generalizability owing to the different contexts of the countries that were reviewed. Economic, social and cultural differences between different countries and regions will influence their implementation of non-pharmaceutical public health measures. According to WHO guidelines ‘the implementation of non-pharmaceutical initiatives should be flexible depending on the local or national situation (or both).⁶

1.6 International public health guidelines for COVID-19 mitigation

Various regional and international guidelines were promulgated by the World Health Organisation and the Africa Centre for Disease Control (Africa CDC) to assist The African response to COVID-19. The African Union Joint Continental Strategy for COVID-19, has set a goal of ‘Preventing severe illness and death from COVID-19 infection in Member States and minimizing social disruption and economic consequences of COVID-19 outbreaks. The AU strategy notes that:

‘In Africa, the primary strategy for COVID-19 will be to limit transmission and minimize harm. Tactics to

⁶ Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza; 2019. Licence: CC BY-NC-SA 3.0 IGO.

achieve this include rapid diagnosis and isolation of infected persons, quarantine of people who had close contact with an infected person, and social distancing within the general population.’

1.7 Non pharmaceutical framework of study

WHO in their guidance entitled ‘Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza’ states that ‘non-pharmaceutical interventions (NPIs) also known as non-pharmacological interventions, include all measures or actions, other than the use of vaccines or medicines, that can be implemented to slow the spread of influenza in a population’.⁷

WHO guidelines advise that NPIs outside of health care settings usually focus on:

- Reducing transmission by personal protective or environmental measures - Personal measures that reduce the risk of person-to person transmission, such as hand washing, physical distancing, and respiratory etiquette. Measures to ensure the protection of health workers and vulnerable groups, such as through the provision of correct personal protective equipment.
- Reducing the spread in the community - Community-level measures to reduce contact between individuals, such as the suspension of mass gatherings, the closure of non-essential places of work and educational establishments and reduced public transport.
- Limiting the international spread - Measures to reduce the risk of importation or reintroduction of the virus from high-transmission areas, such as limits on national and international travel, enhanced screening and quarantine.
- Improving risk communication with the public’.⁸

This paper considers an effective strategy for COVID-19 mitigation in TIBA countries as one that in addition to WHO prescribed NPIs, creates social safety nets that ensures wellbeing of citizens during the implementation of measures. The paper thus looks for a multi-dimensional approach to COVID-19 mitigation among TIBA countries using the WHO guidelines as a framework by adding socio economic impact cushioning measures and the COVID-19 essential element of testing.

1.8 Scope of study

This paper will discuss the NPIs implemented by TIBA countries and assess the key themes for the multi-dimensional elements in the public health measures that have emerged. It will carry out a comparative analysis of TIBA country responses to the COVID-19 outbreak which will include the challenges countries have faced in implementing mitigation strategies. It will consider lessons learned from mitigation of the 2014 Ebola outbreak and conclude by making recommendations on NPI implementation going forward.

7 Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza; 2019. Licence: CC BY-NC-SA 3.0 IGO.

8 Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza; 2019. Licence: CC BY-NC-SA 3.0 IGO.



CHAPTER 2: A COMPARATIVE ANALYSIS OF NPI IMPLEMENTATION TOWARDS COVID-19 MITIGATION IN TIBA COUNTRIES

A comparative analysis of TIBA countries NPI implementation was conducted through scrutiny of the public health measures implemented in each country. A detailed account of the 9 TIBA countries is available in annex 1 of this report.

2.1 Reducing Community Spread

All the TIBA countries enacted public health measures to reduce the possibility of mass infections and did not delay in implementing NPIs to contain the virus or reduce spread. Zimbabwe, South Africa, Botswana, and Rwanda all declared nationwide lockdowns after COVID-19 was confirmed in Egypt on 14 February 2020. Lockdown measures included banning of all mass gatherings, closure of schools, closure of places of worship, closure of restaurants, the banning of sport and leisure activities and shutdown of markets. Kenya, Sudan and Ghana opted for partial lockdowns targeting infection hotspots and use of curfews to restrict people movement. Tanzania did not implement any lockdowns but opted for a strategy of restricting public gatherings.

TIBA countries started relaxing lockdowns during the month of May. Rwanda, South Africa, Botswana and Zimbabwe all allowed partial return to work, slightly easing lockdown conditions to allow takeaways to open and some outdoor exercise to be allowed. Kenya allowed restaurants to resume operations but only under tight measures, including testing catering staff and implementing social-distancing measures.

2.2 Hygiene and personal protection measures

WHO guidelines label hygiene and personal protection as environmental factors in the virus mitigation strategies. COVID-19 mitigation measures in all TIBA countries have included a drive on personal hygiene promotion particularly handwashing. Sudan, Rwanda and Kenya moved to make handwashing water available in public spaces through portable handwashing facilities. South Africa, recognizing the challenge of access to water, delivered 11 000 water storage tanks and 1000 water tankers to communities lacking access. Ghana took the step of providing water to communities with access to water challenges. A great amount of innovation was shown by communities across TIBA countries in creating variations of the 'Veronica Bucket' to facilitate hygienic hand washing. Some of the community handwashing innovators in Kenya were given national awards for their inventions. Personal protection equipment, especially face masks and gloves, is globally recognized as a key weapon for reducing the virus spread. TIBA countries all promoted the use of personal protection equipment, in most cases the use of facemasks became mandatory in public. However TIBA countries quickly faced the challenge of restricted global supply chains due to demand. Some of the TIBA countries responded to this challenge by encouraging local companies to produce PPE. For example, with International Finance Corporation (IFC) support, Kenyan company Hela Clothing shifted its Kenyan manufacturing facility from making men's underwear to making masks. Hela produced 10 million face masks in Kenya in April and May, 90% of which were standard three-ply surgical masks, with the remaining 10% being reusable fabric masks.⁹ Countries with limited resources for PPE manufacturing such as Sudan and

⁹ Mary-Jean MoyoTania Lozansky | May 19, 2020 Working with Africa's apparel makers to produce personal protective equipment <https://blogs.worldbank.org/nasikiliza/working-africas-apparel-makers-produce-personal-protective-equipment>

Zimbabwe encouraged private sector, tertiary institutions, community and international donor mobilization to plug the gaps in PPE supply. Sudanese people chose to rely upon “nafeer” - a Sudanese social tradition that comes from an Arabic word meaning “a call to mobilise”. In response to the lack of PPE, for example, volunteers formed the ‘Be Safe initiative’ to raise funds to enable factories to produce protective clothing and face-guards for medical staff.¹⁰

2.3 Improving risk communication

TIBA countries all embraced the key role communication plays in helping citizens better understand and respond to the COVID-19 outbreak. Communication methods have included daily briefings by state officials, use of radio and television for sending official public health messages and the use of social media through official accounts. Innovation in public communication has seen some countries such as South Africa develop Apps that citizens can download. Partnerships with mobile phone companies has allowed TIBA countries to send messages directly to the mobile phone users. The embracing of technology in public health messaging saw Rwanda utilize drones fitted with megaphones sent to spread messages in neighbourhoods. This combining of traditional media methods with digital media, social media and incorporating emerging technologies has helped communities embrace the public health messages. In Ghana for example in the absence of security forces, communities have self-mobilized in some areas to ensure the upholding of the President’s directives on COVID-19 public health measures.¹¹

2.4 Limiting International Spread

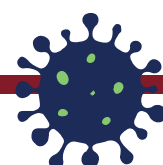
TIBA countries responded to the movement of the virus across borders by implementing measures that included closure of ports of entry except for returning residents and cargo. International flights were stopped except for essential travel such as in Sudan where international relief flights could continue and Zimbabwe where international flights still landed in Harare. Returning residents and flight crews were subjected to rigorous screening on arrival and 14-day quarantines.

2.5 Socio-economic measures

TIBA countries recognized the hardships that COVID-19 mitigation measures would bring to their citizens. In recognition of this, the countries implemented socio economic measures to cushion the impact of public health measures. These measures included creation of budgetary lines for social relief grants and economic relief as seen for example, in South Africa, Zimbabwe, Botswana and Kenya where financial support in the form of cash grants was given to vulnerable persons. Ghana went further to absorb the energy bills of vulnerable persons. Other TIBA countries including Rwanda and Sudan distributed food packs to the vulnerable. Companies affected by COVID-19 lockdowns were given a helping hand such as in Botswana where the state created a facility to pay the salaries of employees from companies closed during COVID-19. These socio-economic measures were necessary to restrict the immediate and long-term impacts of COVID-19 mitigation. They went a long way in creating social safety nets for their citizens despite the limitations inevitably faced by low- and middle-income countries.

10 Kholood Khair How ‘nafeer’ can help Sudan out of its Coronavirus crisis <https://www.aljazeera.com/indepth/opinion/nafeer-sudan-Coronavirus-crisis-200601135252128.html>

11 Vida Duti Silver linings of the COVID-19 crisis in Ghana Country director | IRC Ghana <https://www.ircwash.org/blog/silver-linings-COVID-19-crisis-ghana>



2.6 Testing and Contact Tracing

The World Health Organisation director-general Tedros Adhanom has rightly stated that countries fighting the Coronavirus should “test, test, and test”.¹² TIBA countries faced a challenge in the capacity to carry out mass testing. At the start of the Pandemic, Kenya had 2 testing laboratories, Botswana was sending tests to South Africa, and Zimbabwe was depending on one national reference laboratory. TIBA countries had to find ways of quickly enhancing testing. Ghana rolled out a pool testing method and by 7 May had tested 100 000 people. South Africa quickly grew its national testing capacity to 50 000 tests per day though actual tests carried out were lower. Sudan, through a partnership with WHO increased its testing capacity from 30 tests per day to 600 tests per day. Nevertheless, serious limitations remain, and international solidarity is required to increase the testing capacity.

Contact tracing which is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission, was evident in the containment strategy of several TIBA countries. As part of a comprehensive strategy, case identification, isolation, testing, contact tracing and quarantine, are critical activities to reduce transmission and control the epidemic. Since the Coronavirus disease spreads from person-to-person through droplet and contact transmission, to control the spread of COVID-19, interventions need to break the chains of human-to-human transmission, ensuring that the number of new cases generated by each confirmed case is maintained below 1 (effective reproduction number < 1).¹³ Contact tracing for COVID-19 requires identifying persons who may have been exposed to COVID-19 and following them up daily for 14 days from the last point of exposure.

Zimbabwe utilized contract tracing to identify persons who were in contact with the country’s first official case in the town of Victoria Falls. South African supermarkets have been manually capturing the details of shoppers to aid with contact tracing. Cape Town’s Orangezicht City Farm Market has introduced a simple system: shoppers have to give their name and phone number before entering. Employees enter the data on a paper list. This to ensure that if a visitor to the market falls ill, everyone else who was there with him is contacted, so that they can isolate themselves and the virus does not spread any further.¹⁴ In South Africa, Scientists at the University of Cape Town have developed a Coronavirus tracing app for emerging markets — designed to help prevent the spread of COVID-19. The involvement of communities in developing contact tracing methods is encouraged by WHO guidelines that state ‘critical elements of the implementation of contact tracing are community engagement and public support; careful planning and consideration of local contexts, communities, and cultures; a workforce of trained contact tracers and supervisors; logistics support to contact tracing teams; and a system to collate, compile, and analyse data in real-time.’¹⁵

In Tanzania temperature reading was done at boarder posts where movements of people and goods continued throughout the pandemic because Tanzania did not implement a lockdown. Suspected cases were put under

12 Hermione Dace Mass Community Testing Is Crucial to the COVID-19 Response: Here’s How We Get There Tony Blair Institute for Global Change 4 April 2020 <https://institute.global/policy/mass-community-testing-crucial-COVID-19-response-heres-how-we-get-there>

13 WHO, Contact tracing in the context of COVID-19, Interim guidance 10 May 2020 <https://www.who.int/publications/i/item/contact-tracing-in-the-context-of-COVID-19>

14 South African app aims to slow spread of COVID-19 in developing nations <https://www.dw.com/en/south-african-app-aims-to-slow-spread-of-COVID-19-in-developing-nations/a-53447346>

15 WHO, Contact tracing in the context of COVID-19 , Interim guidance 10 May 2020 <https://www.who.int/publications/i/item/contact-tracing-in-the-context-of-COVID-19>

quarantine in facilities located in boarder regions or were sent back to their home countries. Boarder testing was specifically critical to truck drivers because of their frequent movements across boarders shipping goods. Some had to cross multiple boarders weekly. For example, trucks from Dar es Salaam Tanzania usually pass through Kenya and Uganda before arriving in Kigali Rwanda, and others pass through Zambia and Zimbabwe to get to South Africa and DRC, etc. In May 2020 the Tanzanian boarders with Zambia, Kenya and Uganda were temporarily closed and strategies were developed to ensure safety.^{16 17} Some of the challenges faced by drivers in implementing these strategies were also addresses in bilateral meetings under the EAC leadership. For example, the EAC delegation held discussions with truck drivers at the border between Uganda and Tanzania in a bid to assess the challenges encountered when crossing it. During the meeting, dissatisfaction was voiced with how new measures to combat the spread of the coronavirus had been implemented¹⁸.

Regarding laboratory testing and contact tracing, the Tanzanian government used dedicated teams of health workers and other government officials to trace contacts. Toll free lines were also established for members of the public to report cases and even help in contact tracing. Laboratory testing was done by one national laboratory located in the capital city Dar es Salaam which made shipping of samples challenging and costly. In May 2020, the president ordered an investigation of the laboratory over suspicion of misconduct and since then testing and reporting of cases in the Tanzania mainland has become less public. In May 13th, 2020, the ministry of health released figures that showed a total number of samples taken in Zanzibar standing at 197, where 451 contacts were being followed up and 329 contacts had been traced. The statement showed that there were 296 people in quarantine, and 394 had been releases from quarantine.

2.7 Regional initiatives

Apart from national strategies and measures, individual TIBA countries also benefitted from different regional efforts and actions put in place which were considered critical in responding to COVID-19. Specifically they helped contain the spread of the virus and mitigate its social and economic impacts on different regions. Five regional bodies are discussed in this paper, those are: The East African Community (EAC); the Southern African Development Community (SADC); the Economic Community of West African States (ECOWAS); the Common Market for Eastern and Southern Africa (COMESA); and the Africa Union (AU).

2.7.1 The East African Community (EAC)

In April 2020, the East African Community (EAC) which has 6 members including Kenya, Rwanda, South Sudan, Tanzania and Uganda. established guidelines to facilitate the movement of goods and services during the COVID-19 pandemic. The guidelines promoted mandatory COVID-19 testing of truck drivers to tackle the trans-border spread of the disease while minimising disruptions to cross border trade. On 12 May, regional heads of states also met via teleconference and deliberated on the regional approach to the COVID-19 pandemic. This had been initiated by the ministers responsible for health, trade transport and EAC affairs. In their communique¹⁹, the heads of states decided to adopt a harmonised system for certifying and sharing COVID-19 test results, as well as a regional COVID-19 response plan that compliments the partner states'

16 <https://www.theeastafrican.co.ke/business/Zambia-Tanzania-border-closure/2560-5551244-ti4rqj/index.html>

17 <https://policynetwork.org/opinions/blogs/cross-border-issues-and-pandemic-containment-in-east-africa/>

18 <http://repository.eac.int/handle/11671/2058>

19 <https://www.eac.int/communique/1725-communique%C3%A9-heads-of-state-consultative-meeting-of-the-east-african-community>



national COVID-19 response plans. They also deliberated towards adopting an EAC digital surveillance and tracking system for drivers and crew on COVID-19 for immediate use by partner states.

2.7.2 Southern African Development Community (SADC)

The Southern African Development Community is an economic entity, that includes political and security cooperation of 16 countries including Tanzania, South Africa and Zimbabwe. In addition to the measures put in place by the three TIBA countries who are also members of SADC, they were also benefiting from the regional measures put in place by SADC, thought to be critical to containing the spread of COVID-19 and to mitigating its regional social and economic impacts. Those actions include: (i) strengthening disaster risk management; (ii) coordinating and monitoring the implementation of the SADC Protocol on Health, utilizing the SADC Pooled Procurement Services for pharmaceuticals and medical supplies; (iii) adopting regional Guidelines on Harmonisation and Facilitation of Cross Border Transport Operations across the Region during the COVID-19; (iv) mobilising regional support towards containment and mitigation of the socio-economic impact of COVID-19; and (v) partnering with the United Nations Educational, Scientific and Cultural Organization (UNESCO) to ensure continuity of education and learning programmes.

2.7.3 The Economic Community of West African States (ECOWAS)

ECOWAS is a 15-member regional block including Ghana with the goal of creating a borderless region where the population has access to its abundant resources and is able to exploit them as part of sustainable environment. During the COVID-19 pandemic, the ECOWAS commission implemented decisions made by the heads of states to strengthen cooperation among member states in research, training and experience sharing in health matters in general and in the fight against COVID-19 in particular. An ECOWAS committee of experts met to ensure the implementation of guidelines for the harmonization and facilitation of Cross Border Trade and Transportation in the region, to facilitate the creation of contract tracing hotlines and case reporting by communities in the member states. It also aims to provide support in accessing supplies necessary to fight COVID-19. For example, the commission distributed 30,500 diagnostic test kits, 10,000 Personal Protective Equipment and 740,000 prescription tablets (Chloroquine and Azithromycin) to member states²⁰

The Commission used a multi institutional approach to strike a balance between the health and the economic well-being of the citizens of ECOWAS member states while achieving desired synergy in handling the COVID-19 pandemic²¹ The role of the team also included to identify appropriate corridors for trade and the transport of commercial and humanitarian goods. They proposed measures to ensure these corridors remain open for medical supplies and personnel in the short medium term while ensuring continuity in community trade, transport, free movement and cross-border businesses in the medium to long term. ECOWAS also supported member states in accessing supplies necessary to fight COVID-19. For example, they supplied 30,500 diagnostic test kits, 10,000 Personal Protective Equipment and 740,000 prescription tablets (Chloroquine and Azithromycin) to Member States²² In addition, WAHO began providing technical and financial support to member states in the coordination and training of health personnel and in the provision of diagnostic test kits and critical medical supplies.

20 <https://www.ecowas.int/covid-19/ecowas-support-member-states-against-covid-19/>

21 <https://www.ecowas.int/ecowas-committee-of-experts-meet-on-ease-of-trade-during-covid-19-period/>

22 <https://www.ecowas.int/covid-19/ecowas-support-member-states-against-covid-19/>

2.7.4 Common Market for Eastern and Southern Africa (COMESA)

COMESA which has 21 Member States including Kenya, Rwanda, Sudan, Uganda and Zimbabwe adopted a Common Guideline for Safe Trade during COVID-19. The Guideline provides measures and practices to be applied across the region covering various sectors. This includes facilitating cross-border movement of relief goods and essential supplies, cross-border freight transport operations, air transport and the movement of goods in-land. It also includes the regulation and control of trucks and vehicles, aircrafts and vessels carrying essential goods and services as well as support by customs and revenue authorities to sustain existing supply chains. COMESA also provided regular updates on the COVID-19 situation in the region, including on preventive measures as well as measures to facilitate trade.

2.7.5 Africa Union

The African Union (AU) through the Africa Centres for Disease Control (Africa CDC), is a specialised institution for disease control. It put in place continental measures to help member states contain the spread and the potential impact of COVID-19. Africa CDC established an Africa Task Force for Novel Corona Virus (AFTCOR) to put in place preparedness and response measures against the pandemic. AU also issued a Joint Continental Strategy on COVID-19 to: (i) ensure synergy and maximize the utilization of valuable resources and avoid duplication; (ii) promote evidence-based public health practices surveillance, prevention, diagnosis, treatment and control of COVID-19; (iii) disseminate information on the necessary measures to contain the pandemic; (iv) mobilise resources to strengthen the response to the pandemic (AU has established a COVID-19 response fund); (v) strengthen testing capacities and training capabilities in Member States; and (vi) facilitate the distribution and procurement of key medical equipment.

The extent of the implementation and effect of the different guidelines developed under the different regional bodies, and the support provided to individual countries is unknown. However, the above discussion shows that there are important areas such as cross boarder trader, movement of people and goods during the pandemic and joint procurement or manufacturing of PPE and medical supplies that require collaboration between and among governments.

2.8 Promoting preventive natural therapies

Tanzania adopted some non-pharmaceutical therapeutic measures to prevent the spread of COVID-19. These included strategies to boost immunity though emphasizing consumption of certain types of foods like ginger, garlic, vegetables and some commercial nutritional therapies developed through research e.g. COVIDOL. Steaming was also promoted using natural herbs²³. Though, controversial, Tanzania formalized these strategies and were promoted by the president, parliament and government officials, as a means to reduce the risk of contracting the disease. They were promoted through government radio, TV and Whatsapp messages and public speeches. The government also used these measures to mitigate public fear of the disease. In May 2020, the Tanzania government procured a therapy by the name 'COVID-Organics' developed by the Malagasy Institute of Applied Research in Madagascar and launched by the Madagascan President²⁴.

23 <https://www.voanews.com/covid-19-pandemic/herbal-cures-covid-19-spreading-tanzania-despite-no-evidence-they-work>

24 <https://www.newscientist.com/article/2243669-no-evidence-madagascar-cure-for-covid-19-works-says-who/>



In a press released on 6th May 2020²⁵, ECOWAS denied the approval of the (COVID-Organics CVO) by member states. However, the press clarified that ECOWAS was working with some of the traditional medicine centres in the ECOWAS region to find a cure. WHO and Africa CDC explained that COVIDOL from Tanzania and COVID-Organics had not been approved by WHO. Generally, the role of traditional knowledge in managing COVID-19 symptoms became very visible in most African countries and institutions responsible for conducting traditional medicine research also received more attention from the African governments.

25 https://www.ecowas.int/wp-content/uploads/2020/05/Press-Release-COVID-19-ECOWAS-Commission-and-WAHO-Refute-Endorsement-on-CVO_060520-page-001.jpg

CHAPTER 3: CONTEXTUAL CHALLENGES TO COVID-19 PUBLIC HEALTH MEASURES AND RECOMMENDATIONS FOR TIBA COUNTRIES.

TIBA countries as shown in the previous section, were prompt in implementing Public Health measures in line with WHO NPIs. However, there were challenges that emerged especially due to the TIBA countries being low- and middle-income countries. Some of the challenges that have emerged are in the ability of citizens to social distance in crowded living conditions, the ability for citizens to implement hygiene recommendations such as washing of hands in scenarios where potable water is unreliable or not available, and scenarios where a significant proportion of the population work as informal traders, market traders or vendors. These and other challenges that emerged in TIBA country COVID-19 mitigation measures, are discussed with recommendations on possible adaptations and changes to enhance the efficacy of the necessary measures.

3.1 Reducing community spread, the challenge of social distancing and self-isolation in urban crowded living

Overcrowding in urban areas, slum dwellings and the challenge of inadequate rural housing made the public health measure of social distancing incredibly challenging for some citizens in TIBA countries.

A study of housing conditions in sub-Saharan Africa conducted in 2015, showed that 47% of Sub-Saharan Africans in urban areas and 82% in rural areas live in unimproved housing.²⁶ The study considered unimproved housing to have at least one of four characteristics: (1) unimproved water supply (as defined by the World Health Organisation Joint Monitoring Programme (WHO-JMP1)); (2) unimproved sanitation (as defined by WHO-JMP1), (3) more than three people per bedroom and (4) house made of natural or unfinished material. Good sanitation is key in combatting COVID-19 and the report found that almost half of urban populations and over 80% of rural populations did not have access to improved water and sanitation. 'An improved drinking water source is considered one that adequately protects the source from outside contamination particularly faecal matter, whilst an improved sanitation facility is one that hygienically separates human excreta from human contact'

The unintended effect of COVID-19 shutdowns and lockdowns in informal settlements of Africa, was to bring out people in crowds of thousands to look for food, increasing the risk of COVID-19 spread significantly. In Zimbabwe where food shortages emerged recently, long queues formed outside supermarkets, again showing little regard for social distancing by residents. An equally troubling incident occurred in the informal settlement of Mooiplas outside Pretoria South Africa where a two-and-a-half-mile queue for food parcels developed with no regard for social distancing. A stampede as food parcels were distributed in the informal settlement of Kibera in Nairobi Kenya further illustrated the challenges that public health measures had brought to residents of overcrowded informal settlements.

Any socio-cultural related challenge? For example, the importance of religion/going to places of worship, inability to stock food (no financial or refrigeration capacity), inability to order food online, etc. Food markets

26 Lucy S. Tusting- Mapping changes in housing in sub-Saharan Africa from 2000 to 2015 *Nature*. 2019; 568(7752): 391–394. Published online 2019 Mar 27. doi: 10.1038/s41586-019-1050-5



are usually congested (hard to keep distance).

3.1.1 The challenge of lockdowns in the context of informal employment-based livelihoods

The International Labour Organization estimates that more than 66% of total employment in Sub-Saharan African is in the informal sector. A large informal sector often adds to city congestion, through informal vending and transport services, and does not contribute to city revenue. On the other hand, the informal sector provides crucial livelihoods to the most vulnerable of the urban poor²⁷.

According to a 2014 study by the International Labour Organisation (ILO), nearly eight out of ten employed persons in Sub-Saharan Africa were in vulnerable forms of employment. Accordingly, the vulnerable employment rate was estimated at 76.6 per cent in 2014²⁸.

An IMF report of 2018 on shadow economies indicated that Zimbabwe's share of the informal economy stands at 60.7 percent of GDP which is ranked third globally, indicating the high levels of informality in the country.²⁹ This is a development that has implications for the spread of COVID-19 and its overall impact as there exists many informal economy workers in the streets trying to make a living in the context of high levels of poverty.³⁰ The informal sector thrives in Kenyan rural and urban centres. According to 2015 estimates there were 11.8 million people employed in the informal economy, against 2.4 million working in the formal sector. By 2018 the informal sector accounted for 83.6% of total employment.³¹

The impact of a lockdown is keenly felt by the large proportion of Africans in the informal sector and vulnerable employment. Lockdowns and closure of markets deprive market and informal traders of any income, threatening livelihoods in communities that generally live from hand to mouth. "Economic recession and deteriorating livelihoods mean impoverishment, malnutrition, worsened access to routine health services, and that in turn all means lives lost as well," says Dr Francesco Checchi, a professor of epidemiology at the London School of Hygiene and Tropical Medicine.

Regarding the remaining 34% of the people in Sub-Saharan Africa who according to ILO are employed in the formal sector, COVID-19 also posed challenges. Working from home in most parts of Africa including teaching and studying is challenging because of poor internet access, power shortages and homes are too crowded to provide sufficient or effective working space, etc.

3.1.2 Recommendations

3.1.2.1 Options beyond total lockdown

China, Europe and North America all adopted much the same epidemic control policy: lockdown. Many

27 <https://blogs.worldbank.org/africacan/understanding-the-informal-economy-in-african-cities-recent-evidence-from-greater-kampala>

28 http://www.ilo.org/africa/whats-new/WCMS_377286/lang--en/index.html

29 Leandro Medina and Friedrich Schneider, "Shadow Economies Around the World: What Did We Learn Over the Last 20 Years?" IMF, January, 24, 2018, <https://www.imf.org/en/Publications/WP/Issues/2018/01/25/Shadow-Economies-Around-the-World-What-Did-We-Learn-Over-the-Last-20-Years-45583> (accessed May, 17, 2020)

30 David Mhlanga and Emmanuel Ndhlovu, "Socio-economic Implications of the COVID-19 Pandemic on Smallholder Livelihoods in Zimbabwe," *Pre Prints*, April, 13, 2020,

31 <https://theconversation.com/how-the-COVID-19-pandemic-will-affect-informal-workers-insights-from-kenya-134151>

African governments followed suit, but in general, lockdowns may be simply unworkable in the continent. Thus, there is need for an African-based lockdown and social distancing model that will specifically suit the citizen. This is mainly because a significant proportion of Africans have to work daily in the streets to earn a living. Countries like Tanzania where a total lockdown was not imposed present the opportunity to analyse and weigh options African countries may consider when faced by such a pandemic. Specifically, African governments need to understand what it takes to strike a balance between protecting livelihoods and promoting public health during pandemics

Ghana, Kenya and Sudan have explored local variants of lockdown, curfews, isolation, movement restriction, contact tracing and quarantine. Kenya utilized localized lockdown measures targeting hotspots in cities such as Mombasa and Nairobi. These may work better than nationwide shutdowns imposed by resource challenged countries like Zimbabwe. It can be argued that African countries should not close their fresh produce markets or people will starve. Instead, through consultation, market goers can readily work out how to reduce the risks of transmission, through measures such as better hygiene, crowd control, and physical barriers such as polythene sheeting at point of sale. The Orangezicht City Farm Market in Cape Town that was partially opened and implemented contact tracing provides an example of innovations that can be employed to ensure some level of operation by informal traders is carried out within the context of public health measures to reduce community spread.

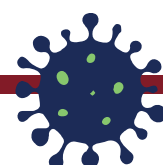
3.1.2.2 Persuasion not coercion; humane enforcement of lockdowns

In almost all the TIBA countries, the military was deployed to police the enforcement of lockdowns and curfews. It is recommended that TIBA countries develop robust communication strategies that help people understand the COVID-19 Pandemic and the measures required to combat it. Unleashing the army may send a wrong message to citizens and create animosity towards the state rather than a determination to overcome the virus. In Ghana once communities understood the importance of public health messages, reports emerged of communities enforcing the measures without need for police or military presence. Coherent public messages from trusted sources go a long way in instilling confidence in the mitigation measures countries need to take to mitigate COVID-19.

3.1.2.3 Protecting vulnerable people and groups during lockdowns

In the enforcement of lockdowns, TIBA countries are reminded to consider vulnerable people. The World Health Organization Guidelines suggest that countries should, 'identify and equitably protect vulnerable subpopulations at risk of poorer outcomes and identify partners who may be able to reach out to these people. This includes considering the likely impact of the pandemic and public health measures on mental health and introducing safeguards, as well as the continued provision of essential social services.'³² The gender dimension is also an important factor in considering mitigation measures. Poverty in Africa is said to have 'the face of a woman' meaning women and their young children are often disproportionately the victims of poverty related problems. There is need for gender mainstreaming of the mitigation measures to take into account the plight of various societal groups especially women, who in the African context have to look for basic necessities like water in public boreholes in congested environs where there is very little or nothing they

32 WHO Critical preparedness, readiness and response actions for COVID-19 <https://www.who.int/publications/i/item/critical-preparedness-readiness-and-response-actions-for-COVID-19>



can do to protect themselves from getting infected. It is women who have to find food to feed their families meaning its women who are likely to suffer the most when insensitive lockdowns and curfews are imposed. Social media videos emerged in Zimbabwe where community workers talked of the vulnerability of underage girls, who to avoid starvation during lockdown were selling sex for as little as fifty United States dollar cents just to raise enough money for a single meal. Social safety nets should be developed to look after disabled persons, vulnerable girls and women during lockdowns. A tragic consequence of the lockdowns in South Africa was the two-fold increase in domestic violence cases. More than 120,000 victims rang the national helpline for abused women and children in the first three weeks after the lockdown started on March 27; double the usual volume of calls. “The country battles another deadly epidemic of gender-based violence,” the Daily Maverick newspaper warned as it became clear the virus had hit South Africa hard. Lockdown without social safety nets is a convener of social ills.

During pandemics African government need put in place mechanisms to ensure that health care remain accessible to non-Covid-19 cases. Literature shows that during pandemics access to maternal health care and treatment of other diseases like Malaria, diabetes and HIV/AIDS etc. become difficult. Some countries like Nigeria reported delayed immunization of newborn babies and lack of space and time to care for non covid-19 cases³³. This situation is exacerbated by the general low investment in health care by many African governments.

3.1.2.4 Recommendation

Vulnerable groups such as the disabled, women in domestic violence situations and orphans should be given support during lockdowns. Support should include psychosocial support, food or financial support packages aimed at reducing the vulnerability of these groups. The World Health Organization advises countries to create policies for COVID-19 mitigation that ‘ensure that due consideration is given to maintaining good mental wellbeing’. African governments must enact policies that recognize that for successful bio medical outputs, investment is required in provision of resources and facilities towards the softer outcomes of wellbeing, social safety and good mental health.

3.1.3 Training and deployment of community health workers

The COVID-19 scenario may be like the Ebola outbreaks of 2014 or the HIV AIDS epidemic that required innovation in healthcare provision and saw the employment of Community Health Workers (CHWs) as frontline staff. The importance of community health workers is greater now than ever. For many people in remote and rural regions of sub-Saharan African more generally, they will be the first - and possibly only - line of defence against Coronavirus. Increasing ownership of low-cost smartphones and cellular coverage has also enabled community health workers to connect with each other remotely to share best practices, up-to-date policy changes, and messages of encouragement - something which is especially important at this time. By accessing the World Health Organization’s WhatsApp group, community health workers have also been able to access timely and accurate information which they have relayed to local community members in order to dispel unfounded rumours or misinformation that is being spread at a time of heightened anxiety.

The key is in informing communities through an army of social workers, community health workers and community leaders of the threat brought by the virus and the measures required to combat it.

33 <https://africanarguments.org/2020/04/14/how-covid-19-lockdowns-affect-healthcare-of-non-covid-cases/>

The table below shows the potential role of community health workers in fighting COVID-19

Prevention	<ul style="list-style-type: none"> i. Organize and carry out social information campaigns to promote social distancing and advocate for timely policies. ii. Encourage strategies in their neighbourhoods and online to promote mental and physical health and resilience. iii. Deliver food and medications to the elderly, poor, immigrants, and other vulnerable residents. iv. Check on vulnerable people such as child headed households, disabled, chronically unwell v. Make masks at home, and donate them to supplement the stock of personal protective equipment at local hospitals.
Detection	<ul style="list-style-type: none"> i. Learn the signs and symptoms of COVID-19, and help staff hotlines run by hospitals and public health departments to answer questions from the public. ii. Refer possible COVID-19 patients to their nearest testing centre, and organize transportation. iii. To ensure effective contact tracing there is need for integrated surveillance, decentralized management of multidisciplinary teams, comprehensive protocols, and community-led strategies
Response	<ul style="list-style-type: none"> i. Call people with COVID-19 who are in self-isolation with mild symptoms, and monitor them for worsening symptoms. ii. Provide moral support and organize food deliveries for people with COVID-19 at home. iii. With nurse supervision, monitor patients for worsening symptoms and support rapid referral of people who require hospitalization. iv. With public health officers, support contact tracing, symptom reporting, and monitoring of contacts of COVID-19 patients to ensure access to testing and treatment for people who develop signs and symptoms. v. Help hospitals and non-profits raise funds for the most vulnerable.

Courtesy of World Economic Forum ³⁴

3.2 Hygiene and personal protection

3.2.1 The challenge of handwashing in communities with poor access to water

According to a 2019 WHO JMP report³⁵, 42% of Ghanaians have limited access to handwashing facilities and 17% have no access at all. Even among the 42%, it is unclear how many practice handwashing on a regular basis. The speed with which temporary handwashing facilities are being delivered to healthcare centres, public institutions and public places is itself clear evidence of historic weaknesses in the subregion water, sanitation and hygiene (WASH) system. There are approximately 2.5 million slum dwellers in about 200 settlements in Nairobi, Kenya, representing 60% of the Nairobi population and occupying just 6% of the land. Kibera houses about 250,000 of these people. It is the biggest slum in Africa and one of the biggest in the

34 World Economic Forum <https://www.weforum.org/agenda/2020/03/retraining-unemployed-fight-COVID-19/>

35 Progress on household drinking water, sanitation and hygiene 2000-2017. Special focus on inequalities. New York: United Nations Children's Fund (UNICEF) and World Health Organization, 2019



world. Until recently, Kibera had no water and it had to be collected from the Nairobi dam. The dam water is not clean and causes typhoid and cholera. Now there are two mains water pipes into Kibera, one from the municipal council and one from the World Bank. Residents collect water at Ksh3 per 20 litres.

Similar challenges exist in rural areas. In some rural areas such as in Binga in Zimbabwe, women have to travel 6 kilometres to collect water. Enforcing social distancing at these water points is also a challenge, as a single water point may be servicing up to 250 households. Poor Living standards mean that Africans from such countries have to prioritize drinking water over hygiene. Thousands of women and children might spend eight to nine hours and all night in queues at crowded boreholes or narrow water wells to get water and that may not be safe.³⁶ Without supplementary water provision, the most basic and effective COVID-19 mitigation strategies will fall flat. The message of social distancing, hand washing, and hygiene will fall on the deaf ears of communities that have for decades struggled with basic access to clean water.

3.2.1.1 Recommendations

Several TIBA countries recognized the need for a quick intervention in providing portable water and handwashing systems in crowded places. South Africa rolled out water tanks and water trucks to areas without potable water. This is an example of interventions that will help communities practice the required hygiene measures such as handwashing. It is recommended that TIBA countries provide clean water for washing and drinking during the COVID-19 pandemic to ensure that public health measures are effective.

3.2.2 Provision of Personal protection equipment

Africa's health systems are already overstretched. COVID-19 demands an emergency response at scale and that begins with governments. African hospitals need testing kits, basic materials for hygiene, personal protective equipment for the professional health workers, and ventilators. There is a global shortage of all of these and a scramble among developed countries to get their own supplies, relegating Africa to the back of the queue.

3.2.2.1 Recommendations

At the onset of the Pandemic in Africa, Governments such as Kenya, Ghana, Sudan and Zimbabwe encouraged private sector players, universities and citizens to explore ways of producing crucial PPE locally. As a result one factory in Kenya was able to produce 10 million face masks in just over a month. Universities in Zimbabwe started producing hand sanitizer and soap and Sudanese groups started working on essential equipment production. COVID-19 is likely to be around for a long time and this requires countries to enhance their capacity for home grown solutions.

3.3 Improving risk communication

3.3.1 Public perceptions, mistrust, stigma and myths

One of the challenges Africa faces is managing distrust, fear, and stigma associated with the disease and the accompanying health response. For reference, such distrust has been a major impediment to treating the

³⁶ Human Rights Watch, "Zimbabwe: Unsafe Water Raises COVID-19 Risks: Severe Water, Sanitation Crisis Undermines Pandemic Fight,"

recent Ebola outbreaks in West Africa and the Democratic Republic of Congo, with reports of attacks against healthcare workers. Violence is already starting to hinder the Coronavirus response. For instance, in Abidjan, the commercial capital of Côte d'Ivoire, residents of the crowded Yopougon residential district destroyed a testing facility that was being constructed, fearing that it posed a risk to nearby homes.

Stigmatization of the ill is another core challenge rooted in distrust and suspicion. Sufferers of Ebola and HIV/AIDS have been heavily stigmatized across the continent. Individuals may be reluctant to undergo testing if they fear ostracization or other reprisals from their communities. Just as HIV/AIDS was dubbed the “white man’s disease,” the Coronavirus pandemic has spurred suspicion and mistrust, initially against East Asians, but increasingly against Europeans and Americans. The presence of foreign health and aid workers in communities where distrust exists will spark fear and play on pre-existing tensions. Therefore, security considerations will have to be integrated into the broader response—adding another layer of cost and complexity.

3.3.2 Social media, ally or foe?

Social media has proven to be both an ally and a foe in mitigating COVID-19. As panic still prevails in African countries, we should all beware of ‘infodemic’ which may hamper the efforts to fight against the virus. Currently, there has been a lot of misinformation and contradicting facts that are posted especially through the social media networks. South Africa is the top country to be talking about Coronavirus on social media (27.23%), as South African citizens have also been making use of online forums and message boards to have social conversations about COVID-19. Rounding up the top three countries talking about the Coronavirus are Ghana (3.54%) and Zimbabwe (2.92%). Data from a social media sentiment analysis indicates that the consensus around Coronavirus is progressively negative around the world, with 83% of social media mentions on ‘Coronavirus’ being negative in March. These feelings are attributed to the virus’s impact on stock markets, working environments, restrictions put in place, the sickness and ill-health of citizens around the world, fatality rates and countries being on lockdown. The preponderance of fake news in social media has been one of the barriers to effective social response to COVID-19. Fieldwork on this study was conducted by Ipsos³⁷ with results based on 1,101 interviews with adults aged 18+ in Khartoum Sudan. showed that over one in two (56%) believe that ‘hot climate prevents the spread of the virus’, and even higher proportions believe that you can prevent it by drinking lemon and Vitamin C (67%). One in three Sudanese believe that it can be cured with garlic (32%) and one in four believe Africans ‘cannot get it’ (23%). The United Nations recognized the dangers of social media misinformation in Sudan that it issued a statement saying ‘As Coronavirus (COVID-19) spreads globally, the Federal Ministry of Health (FMoH), United Nations in Sudan and other partners are calling for members of the public to share facts, verified health advice, and official information to help combat the disease. Misinformation, rumours and myths can be as deadly as COVID-19. During a pandemic, sharing accurate information – and stopping the spread of misinformation – can save lives. We call on all Sudanese to do their part, and spread facts not fear in the fight against COVID-19. Combating fake or misleading information about the virus is an individual and collective responsibility.’³⁸

Social media can be harnessed by governments for public messaging as Rwanda, Botswana, South Africa

37 Responding to COVID-19: Highlights of a Survey in Sudan https://www.ipsos.com/sites/default/files/ct/publication/documents/2020-05/sudan_report_0.pdf

38 United Nations Sudan Sudan: Spread facts, not fear, in the fight against COVID-19 01/04/2020 <https://sudan.un.org/en/39632-sudan-spread-facts-not-fear-fight-against-COVID-19>



have done. But the challenge is in stopping social media contaminating crucial public health messages about COVID-19, with myths and fabrications that do nothing more than endanger citizens.

3.3.3 Recommendations: Developing robust communication strategies

Effective communication strategies will minimize the reach and impact of ‘fake news and social media-based disinformation’. A transparent and credible public information strategy is likely to be the best way to minimize unwarranted panic and, indeed to mobilize the public as a partner in controlling the disease outbreak’, and reduce the economic costs of panicked behaviour.

In most of the TIBA countries reviewed, Social Media has been observed as a key vehicle of information dissemination even though data costs could be very high and marginalise the poor and vulnerable. In rural communities with low internet connectivity, usage of WhatsApp has been very high throughout the TIBA countries, followed by Twitter, Facebook and YouTube. Consequently, rather than totally shunning away from these platforms there is a strong need for governments within the TIBA countries to take an active role in disseminating validated information about COVID-19 using these sources, considering the high risk of misinformation on COVID-19 currently underway in these digital platforms. Monitoring, analytics, and measuring of social media activity is key to assessing opinions of relevant stakeholders and make relevant changes to mitigation policies. This can allow governments to pick up emerging issues that could be potentially destructive to policy initiatives such as in Tanzania and Zimbabwe which had frequent questioning of government policies within these platforms.

3.4 Limiting international spread

Whilst all TIBA countries acted swiftly to close borders to limit the international spread of the disease, challenges emerged among the millions of migrants and refugees.

³⁹Africa houses four of the world’s six largest refugee camps (in Uganda, Kenya, Tanzania and Ethiopia). These camps are ideal spaces for transmission of the Coronavirus. They are overcrowded and lack adequate water, sanitation and hygiene facilities. Many inhabitants have fled war or strife and have compromised immune systems as a result of malnutrition, high stress and other co morbidities. Healthcare facilities are basic; mechanical ventilators and intensive care beds are very rare. In these settings, social distancing or isolation will be extremely difficult.⁴⁰ Kakuma and Dadaab refugee camps in Kenya together accommodate 411,000 refugees (194 000 and 217 000 respectively). Movement between Kakuma, Dadaab and Nairobi was suspended in response to COVID-19. South Africa and its neighbour Botswana faced the challenge of migrants stuck on either side of their borders during the lockdown. With no work to do and source of income, hundreds of migrants in Botswana opted for voluntary deportations to their countries of origin, a substantial number heading back to Zimbabwe where they were housed in quarantine facilities. In South Africa, more than 7000 migrants were stuck at Beitbridge border post when lockdown commenced. Special arrangements between South Africa and Zimbabwe had to be made to allow them to cross the border. Migrants caused the increase on Coronavirus cases in Zimbabwe. Uganda too saw a large proportion of positive cases from truck drivers tested at border posts. The movement of people across borders has presented a challenge in

³⁹ Aimée-Noël Mbiyozo, “COVID-19 responses in Africa must include migrants and refugees,” ReliefWeb, April, 8, 2020, <https://reliefweb.int/report/world/COVID-19-responses-africa-must-include-migrants-and-refugees> (accessed May 17, 2020)

⁴⁰ Aimée-Noël Mbiyozo, “COVID-19 responses in Africa must include migrants and refugees,” ReliefWeb

COVID-19 containment. Mass movements of people escaping lockdowns across Africa may have contributed to the spread of the virus across the continent. The movement of unregulated and undocumented migrants across borders also presents a huge problem that undermines virus containment measures carried out by TIBA countries.

3.4.1 Recommendations

What may work is strict screening and testing at high frequency border posts and the availability of quarantine facilities for arrivals who test positive. African countries must seek inter Africa cooperation in handling issues of migrant labour, trade, sharing key lessons learned and success methodologies. Importantly Africa must attempt to work as a unit. The fact that poor mitigation in one country will through people movement, still export the disease to other African countries who have better mitigation, requires Africa wide cooperation. It is recommended that rather than putting thousands at risk of infection through mass deportations, African States create a health emergencies social fund that will help states with large migrant populations, better support and protect migrants during epidemics and pandemics.

Humanitarian agencies may have to be called upon to assist in the care of displaced persons. In their responses, governments should consider the possible unintended consequences of measures like border closures on migrant populations and cross border informal traders. Refugee camps and detention centres must urgently be protected and provided with adequate hygiene and health facilities to prevent catastrophic outbreaks. Governments should ensure that prevention, testing and treatment is available to all, regardless of nationality or immigration status.

3.5 Socio economic challenges

The case of Cape Flats ward councillor Bongani Ngcani who was quoted by News24 as saying: “A man told me: ‘I would rather die of COVID-19 than of hunger’” illustrates the challenge of a COVID-19 mitigation strategy based on lockdown in resource stretched countries. Alex de Waal argues that African countries cannot close its fresh produce markets as part of the pandemic mitigation or people will starve.⁴¹ But market goers can readily work out how to reduce the risks of transmission, through measures such as better hygiene, crowd control, and physical barriers such as polythene sheeting at point of sale. The reality is that, not many low- and middle-income countries can afford mass handouts. Approximately 46% of Ugandans do not make any savings, according to 2019 statistics from the central bank. Of the remaining 54% that put aside money for future use, most of their savings go towards affording household consumption. For instance, about 37% primarily save to meet recurrent expenses such as food and education, while 26% save for emergencies like illness. As Innocent Anguyo a graduate of Development Management from the London School of Economics and Political Science (LSE) notes, ‘the main fear bugging most Ugandans is not the virus, but rather the isolation measures that have significantly disrupted people’s means to make an income. For that reason, people continue to brave the streets to work. For instance, street vendors continue scurrying to the windows of vehicles in traffic lights and jams. Without masks, they bark the prices of their merchandises to the motorists, who, petrified by a prospect of contact, swiftly raise their windows, fearing the street could become the epicentre within Uganda. These vendors cannot afford to isolate at home, or should I say

41 BBC, “Coronavirus: Why lockdowns may not be the answer in Africa,” BBC, April, 15, 2020, <https://www.bbc.com/news/world-africa-52268320> (accessed May, 17, 2020)



the verandas of commercial buildings, unless they want to starve to death. The street is their workplace, livelihood and home.⁴²

3.5.1 Recommendations

Several TIBA countries have rolled out economic and social support measures that include food handouts, social welfare pay-outs, and financial bailouts for companies. These measures need to be sustained for the duration of the public health measures especially the lockdowns.

3.6 Testing

As a key element of the COVID-19 response strategy, mass testing of citizens is required. This presents challenges in the African context of supplies and deployment. Getting test kits to and through remote villages and densely-packed, often unplanned, informal settlements in urban areas poses a major hurdle. In almost half the TIBA countries, the rainy season is about to start or has already arrived, making many dirt roads difficult or impassable and rendering many rural communities inaccessible. Flooding in East Africa has resulted in communities getting cut off or large numbers of people becoming internally displaced. Urban areas will prove difficult to access, as informal urban settlements pose their own unique challenges. Slums are not only densely populated, but are mostly unmapped, so administering mass testing in a systematic way will be extremely challenging. In the sprawling slum of Kibera in Nairobi for example, no government clinics, hospitals or facilities exist. Residents usually lack physical addresses and records of who lives where and how many people live in each place of residence. The lack of reliable census records will prove to be a key constraint that will undermine data collection and coordination.

The testing capacity of TIBA countries has been hindered by shortage of equipment and testing facilities.

COVID-19 demands an emergency response at scale and that should be pioneered by governments. Africa's health systems are already overstretched, African hospitals need testing kits, basic materials for hygiene, personal protective equipment for the professional health workers, and equipment for assisted breathing. The COVID-19 pandemic saw countries around the world competing for ever dwindling medical supplies. This left the poorer TIBA countries unable to compete with richer countries in procuring test kits, ventilators, personal protection equipment and other bio medical equipment. While countries like Israel, the UK, Australia, the United States and China among others swiftly commissioned scientific researches towards vaccines and treatment drugs for the COVID-19 Virus, African countries under review made no significant step towards that kind of research but were rather absorbed in trying to source basic equipment for treatment of COVID-19, an exercise that became near impossible due to escalation of prices amidst the global shortages caused by worldwide demand.

3.6.1 Recommendations: Investment in biomedical research and equipment

Makerere University in Uganda became a torchbearer for TIBA Countries by developing a rapid testing kit for COVID-19⁴³. The STDS-Agx (swab tube dipstick agglutination) COVID-19 test kit developed by Makerere University's team can produce results in a minute or two, compared to the four-to-six hours it takes to get

42 <https://blogs.lse.ac.uk/africaatlse/2020/04/09/kampala-epidemic-un-ugandan-society-in-times-COVID-19/>

43 Richard Wetaya April 13, 2020 Cornell Alliance for Science <https://allianceforscience.cornell.edu/blog/2020/04/ugandan-scientists-develop-quick-low-cost-covid-19-test-kits>

results from the German and Chinese kits now in wide use. “Everyone is running to the market and the variance in economic prowess means poor countries like those in sub-Saharan Africa are left with nothing. We must innovate around these shortages to fight the pandemic” Dr Misaki Wayengera the lead researcher said. Further South, in Zimbabwe, TIBA partnered with the government of Zimbabwe to strengthen the country response to COVID-19 including research on the efficacy of rapid serology tests.

For the effective long-term mitigation of the COVID-19 pandemic in Africa, mass testing needs to be rolled out. The need for quick and low-cost tests is immediate and immense. With a population of over one billion, Africa may need fifteen million test kits over the next three months, says Africa Centre for Disease Control and Prevention (CDC) Director John Nkengasong⁴⁴. African Governments must invest in home grown solutions such as the test kits being developed by the Makerere University. If the Makerere University team could produce a viable test on a miniscule research budget of just USD\$22,000, the possibilities become endless should Africa through its governments and inter-governmental agencies such as Africa CDC, create a research and innovation fund as part of the emergency response. Such a fund would help create cheap solutions to emergency health equipment. TIBA countries should promote investment in production of personal protective equipment and other medical equipment required for the long-term mitigation of COVID-19.

3.7 Other challenges and observations

3.7.1 Environmental factors

The COVID-19 outbreak could not have arrived in East Africa at a worse time. The region has been battling a locust problem that threatens an already precarious food security situation. WFP chief David Beasley warned of the “hunger pandemic” that could occur as food insecurity worsens in the shadow of the Coronavirus pandemic. Famines “of biblical proportion loom”, he said. Furthermore, the COVID-19 lockdown in Sudan has prevented locust experts from traveling and visiting sites across the country⁴⁵. “There is no doubt that the Coronavirus has impacted the locust operation – we could have been much more successful now, but at least Sudan can cope with the situation, taking all the precautionary measures for saving lives of the locust technicians,” he says, referring to the locust specialists who are of vital importance in protecting food sources.⁴⁶

Sudan is in a precarious position as the transitional government deals with soaring inflation, high unemployment and a food shortage, but battling infectious COVID-19 could prove all the more challenging, according to Michele Bachelet, UN high commissioner for human rights. “The idea of the perfect storm is overused, but in this context, it actually may be apt because of this interlocking between political problems, healthcare problems, economic problems, and food problems,” says Harry Verhoeven, senior advisor for the European Institute of Peace (EIP), a Brussels-based non-profit foundation.⁴⁷

Floods in East Africa as the rainy season started in April just as the countries implemented public health measures against COVID-19 became and added challenge. Kenya, Uganda, Rwanda were greatly affected

44 Global solidarity collapses over access to coronavirus testing kits and vaccines, says Africa CDC director <https://africanbusinessmagazine.com/interviews/global-solidarity-collapses-over-access-to-coronavirus-testing-kits-and-vaccines-says-africa-cdc-director>

45 <http://www.rfi.fr/en/africa/20200501-COVID-19-could-push-sudan-into-perfect-storm-of-ill-health-sanctions-darfur-crisis>.

46 <http://www.rfi.fr/en/africa/20200501-COVID-19-could-push-sudan-into-perfect-storm-of-ill-health-sanctions-darfur-crisis>.

47 <http://www.rfi.fr/en/africa/20200501-COVID-19-could-push-sudan-into-perfect-storm-of-ill-health-sanctions-darfur-crisis>.



with some communities in the Great Lakes region being cut off by rising waters.⁴⁸

TIBA countries are battling environmentally related challenges such as widespread locusts, severe droughts, intense tropical cyclones which are just but a few examples of the complex Sub-Saharan Africa context in which TIBA countries are implementing mitigation measures. There is a need for disaster relief funds that cover not only COVID-19 mitigation but also environmental disasters. As TIBA countries struggle to get test kits, PPE and drinking water to their citizens, they will need international support to deal with the crosswinds of environmental disasters.

3.7.2 The need for international solidarity

Both Sudan and Zimbabwe were exempted from IMF COVID-19 debt relief which most TIBA countries benefited from as the two countries are under sanctions. Failure by the Government of Zimbabwe to unlock financing opportunities from the traditional financing institutions such as IMF is likely to aggravate the economic crises in the country and worsen the social plight of its citizens. This has hindered the two countries ability to implement a multi-dimensional COVID-19 mitigation strategy.

3.7.3 Inter African health Peer monitoring systems

The Abuja declaration alongside the Addis agreement of 2012⁴⁹, create a roadmap for a continent-wide commitment to disease mitigation that should be built upon to develop similar agreements on COVID-19 and any future pandemics. For the development of a continent wide COVID-19 mitigation strategy, cooperation among African Countries towards an effective knowledge sharing and collaborative capacity building framework is required. The Africa Union needs to consider health as a security matter and set up a fund for a continental epidemic's surveillance and solidarity mechanism.

Importantly African countries can develop shared mitigation strategies, create health emergencies funding pots, create platforms for shared learning and hold each other accountable for the implementation of effective health policies and mitigation measures. Development partners can then help by creating African health policy implementation and review teams that will constantly lobby for implementation of effective health policies and review of policies in times of emergencies such as the COVID-19 pandemic.

The biggest resource in Africa has often been said to be its human capital. In the fight against COVID-19, Africa's strength remains its people. Once they understand the scale of the COVID-19 problem and the mitigation measures required, Africans will use their cultural strengths and innovations to develop localized mitigation measures that complement the States' effort and result in far positive outcomes. The fight against COVID-19 will be won through a tripartite partnership drawing in international development partners for external support, State Governments for nationwide support and the African people for adoption, adaptation and implementation of context specific mitigation measures.

48 Eastern Africa Region: Floods and Locust Outbreak Snapshot (May 2020) Source OCHA Posted 12 May 2020 Originally published 11 May 2020

49 UNAIDS Abuja +12 Shaping the future of health in Africa

CHAPTER 4: COMBATTING COVID-19 IN LOW-AND MIDDLE-INCOME AFRICAN COUNTRIES, LESSONS LEARNED FROM THE 2014 EBOLA OUTBREAK

The African continent has a lot of relevant experience in tackling epidemics. Valuable lessons were learned from the Ebola outbreak of 2014 that gave the continent institutional experience for effecting containment and treatment of the disease in a way that has positive health and wellbeing outcomes. Africa was able to demonstrate the development of mitigation measures that are home grown and effective. This analysis of reports on the Ebola outbreak mitigation measures and lessons learned can inform COVID-19 mitigation strategies in Africa. It fits into the multi-dimensional NPIs discussed in this report as recommended by WHO and adapted to the TIBA countries.

4.1 Measures that Enabled African Countries to Successfully Combat the Ebola Virus

Nigeria and other West African countries effective Ebola mitigation: A Case Study

The Royal College of Physicians in their document entitled ‘Ebola virus disease epidemic in West Africa: lessons learned and issues arising from West African countries’ observed that When the epidemic entered Nigeria, there were fears that the large population of Lagos, poor health systems, Nigerian cultures and doctors’ strikes would fuel the epidemic and make Nigeria a worse case than other African nations. However, with just 20 cases and eight deaths, Nigeria (20 October 2014) and Senegal (17 October 2014) were declared Ebola free by the WHO.

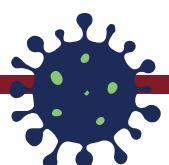
4.1.1 Prompt response

As soon as the first case of the disease was confirmed, the Federal Ministry of Health (FMOH), the Nigerian Center for Disease Control (NCDC) and the Nigeria Field Epidemiology and Laboratory Training Program (NFEFTP) were mobilized to investigate, manage and control the epidemic, with support from the Lagos State Government. The emergency response was supported by an existing Emergency operations Centre and International Medical Supplies structure for polio eradication, Nigerian trainees and graduates of a CDC Field Epidemiology Training Program, and CDC response officials. This reactive and prompt response enabled them to track, quarantine and manage case contacts in Lagos. The International Medical Supplies response established an Emergency Trauma Unit within 2 weeks, trained approximately 2,000 Ebola caregivers, identified approximately 890 contacts, and completed 19,000 contact tracing home visits.

4.1.2 Preparedness and prior experience

The Centre for Disease Control (CDC) notes that by the time of the 2014 Ebola outbreak, Africa had developed systems for combatting Ebola from lessons learned in the 1976 Ebola outbreak in Zaire (now Democratic Republic of Congo).⁵⁰ Nigeria success in combating Ebola Virus can also be attributed to the prior establishment

50 Cordelia E. M. Coltart, Benjamin Lindsey, Isaac Ghinai, Anne M. Johnson, and David L. Heymann, “The Ebola outbreak, 2013–2016: old lessons for new epidemics,” *Philosophical Transaction, Royal Society London*, 372(1721), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5394636/>



of the Integrated Disease Surveillance and Response Program in 1998, the NFIETP in 2008, and NCDC in 2012, as well as the responsiveness of the Lagos State Ministry of Health. Previous Nigerian experience in the management of Lassa Fever, another viral hemorrhagic infection, also helped ‘nip the epidemic in the bud’

4.1.3 Contact Tracing

Contact tracing commenced in Lagos and extended to Port Harcourt and Enugu as the outbreak continued to spread. A total of 899 contacts were traced. Contact tracing enhanced immediate identification of symptomatic contacts, some of whom eventually became cases. Contact tracing could be challenging in urban cities. However, use of electronic technology, adequate logistics, and highly skilled personnel enhanced the tracing of contacts to facilitate the successful containment of the outbreak. Even though, contact tracing could not be successfully implemented in the initial stages of the 2014 outbreak, the disease was contained later on and most of the subsequent new chains of eruption of disease were prevented due to the implementation of contact tracing in all the affected regions. This massive success could be achieved because the international stakeholders succeeded in achieving the community involvement. Available evidence suggests that contact tracing played a significant role in containing the epidemics of EVD in heterogeneous settings.⁵¹ A major credit for the success of contact tracing goes into the strategy which was adopted to communicate the appropriate message, and the psycho-social support offered to the members of the community. The policy makers took appropriate steps to ensure involvement of the community and negate stigma by engaging and educating community leaders about the signs and symptoms of the EVD, its mode of transmission, and steps needed to contain the infection in the community; fostering linkages with religious centres to deliver accurate message to the community; creating awareness among the general population using different modes of mass media communication; offering psychosocial support to constructively deal with the fear associated with EVD; and educating the media to publicise only important issues and at the same time respect the confidentiality for cases and contacts.⁵²

4.1.4 Minimizing social interactions

The resumption of a new school term was delayed, and the duration of national camping programs was shortened, for example, National Youth Service Corps. This enabled Nigeria to keep the virus at bay completely, thereby, nullifying the mathematical models by averting hundreds of thousands of new cases. Although it was predicted that without drastic improvements in control measures, the numbers of cases and deaths from EVD would increase from hundreds to thousands per week, this prediction failed to materialize. This underlines the importance of public health measures that reduce community spread.

4.1.5 Cultural awareness and Communication strategy

As part of the control measures in Nigeria, there was a massive mobilization, awareness creation and sensitization of the populace to the dangers, signs and symptoms of EVD, and acceptable practices within and outside the health institutions. In addition, hand washing was emphasized and use of sanitizers publicized.

One study of communities in Liberia during the Ebola outbreak found a preference for “higher-order,”

51 Patel U, Pharr JR, Ihesiaba C, Oduenyi FU, Hunt AT, Patel D, et al. Ebola outbreak in Nigeria: Increasing ebola knowledge of volunteer health advisors. *Glob J Health Sci.* 2015;8(1):46199.

52 Shrivastava SR, Shrivastava PS, Ramasamy J. Public health strategies to ensure optimal community participation in the Ebola outbreak in West-Africa. *J Res Med Sci.* 2015;20(3):318–319.

practical information and training that communities are desperate for such as “how do I manage a family of children, including infants and toddlers, in quarantine?” rather than information about the disease itself⁵³. It was shown that households prefer practical information about risk factors, and most importantly ways in which they can reduce risks. What they preferred was practical information about risk factors for Ebola transmission and, crucially, how to reduce risks when caring for the sick and burying the dead, as well as the material resources necessary to put this advice into practice⁵⁴. These observations are useful in developing effective communication strategies for the current COVID-19 Pandemic in Africa.

The cultural dimension in messaging cannot be overstated. Research by JN Anoko on villages in the Forest region of Guinea where health workers had been attacked shows that public health messaging should make sure communication about the disease is ‘rooted in a consideration of local circumstances, knowledge and the enhancement of regional cultures’. It emphasizes the importance of understanding customs and cultures, and how Ebola responses may be understood in relation to local power dynamics. Following the violence against health workers implementing Ebola control measures, a new communications strategy was developed. Trusted intermediaries and appropriate stakeholders were identified, and complaints were heard at a communication workshop, from which messages on Ebola were developed collaboratively⁵⁵. Improving risk communication is one of the NPIs that WHO considers crucial in COVID-19 mitigation and this may help mobilize communities to support public health measures as was witnessed with the Ebola outbreak.

4.1.6 Non reliance on coercion and forced quarantine

Asking communities to take part in designing and enforcing their own control policies proved to be more effective than reliance on state coercion and forced quarantines. In the Ebola epidemic, when the Liberian government ordered the army to impose isolation on West Point in the capital, Monrovia, in 2014, it discovered within a few days that the lockdown was so unpopular as to be unfeasible. It did not stop transmission either. The government shifted focus to local community leaders to come up with measures that are relevant to their localities. This strategy proved to be more effective, than the lockdown which was infeasible and had proven to be unpopular. Evaluations and lessons learned papers argue that quarantine should be as consensual as possible. For example, an ACAPS paper found that ‘community-led self-imposed quarantine was considered by all sources interviewed to be the most important factor deciding the success of a quarantine’⁵⁶ This helps minimize human rights violations, and makes quarantine more effective, and less likely to breed mistrust.

4.1.7 Livelihoods protection

Several programs supported livelihoods during the Ebola outbreak including UNDP. Welt Hunger Hilfe programs worked to help re-start agriculture in Ebola-affected districts of Sierra Leone. This included cash transfers to help resume farming or business for 684 Ebola virus disease (EVD)-affected households and

53 Blakey, S. M., Reuman, L., Jacoby, R. J., & Abramowitz, J. S. (2015). Tracing “Fearbola”: Examining the psychological predictors of anxious responding to the Ebola virus. *Cognitive Therapy and Research*, 39, 816-825. doi:10.1007/s10608-015-9701-9

54 Clare Chandler, James Fairhead, Ann Kelly, Melissa Leach, Frederick Martineau, Esther Mokuwa, et al, Ebola: limitations of correcting misinformation. Published: December 18, 2014 DOI: [https://doi.org/10.1016/S0140-6736\(14\)62382-5](https://doi.org/10.1016/S0140-6736(14)62382-5)

55 Julienne N. Anoko, Communication with rebellious communities during an outbreak of Ebola Virus Disease in Guinea: an anthropological approach, 2014 Ebola Response Anthropology Platform

56 ACAPS, 2015. Ebola Outbreak, Sierra Leone: Communication: Challenges And Good Practices. ACAPS Ebola project: December 2015. [online] pp.1-16. Available at: <https://www.acaps.org/special-report/ebola-outbreak-sierra-leone-communication-challenges-and-good-practices>



the establishment of seed banks in 68 communities affected by quarantines. An Irish Aid-funded project implemented by Action Against Hunger provided cash transfers and help with vegetable farming in Moyamba district between May 2015 and May 2016. The transfers were seen to lead to increases in ‘income and diet diversification’.⁵⁷

Reflection on the effective mitigation of the Ebola outbreak, carries good lessons that can inform the public health measures used in the COVID-19 mitigation efforts. The Ebola response to a large extent mirrored the WHO NPI guidelines. This case study has influenced the recommendations put forward in previous chapters for TIBA countries to consider in the implementation of NPIs.

57 Dumas T, Mitigating the Impact of the Ebola Virus Disease on the Most Vulnerable Households Through an Integrated Food and Nutrition Security Intervention in the District of Moyamba, Sierra Leone published 25/05/2016 <https://www.alnap.org/help-library/mitigating-the-impact-of-the-ebola-virus-disease-on-the-most-vulnerable-households>

CONCLUSION: DYNAMISM REQUIRED IN COVID-19 MITIGATION AMONG TIBA COUNTRIES

Having discussed the challenges and opportunities facing TIBA countries in the face of a rapidly developing COVID-19 situation the following summarizes what countries can do going forward:

WHO guidelines are emphatic on the need for public health measures to consider speed, scale, and equity as guiding principles. Speed, because the explosive nature of the virus means every day lost in implementing effective response capacities and behaviors costs lives; scale, because everyone in society has a part to play in building the capacities required to control this pandemic; and equity, because everyone is at risk until the virus is controlled everywhere in the world: collective resources must be directed to where there is greatest risk. COVID-19 is a truly global crisis: the only way to overcome it is together, in global solidarity.

For countries that have introduced widespread physical distancing measures and population-level movement restrictions, there is an urgent need to plan for a phased transition away from such restrictions in a manner that will enable the sustainable suppression of transmission at a low-level whilst enabling the resumption of some parts of economic and social life, prioritized by carefully balancing socio-economic benefit and epidemiological risk. Without careful planning, and in the absence of scaled up public health and clinical care capacities, the 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.

The recommendations from the report are as follows:

- Reducing community spread – The use of lockdowns, curfews and other restrictive measures to stop community spread require flexibility in application of methods. More localized lockdowns may be better received by citizens than countrywide lockdowns. Persuasion should be used more than coercion in implementing lockdowns. Care should be taken not to cut the lifeline of market-based traders and informal traders by shutting down their sources of livelihoods without social support. Social safety nets must be created to support vulnerable community members. Consultations should be carried out with communities in high density areas, slums and informal settlements to help them design social distancing measures appropriate for their context.
- Hygiene and personal protection – TIBA countries should promote local production of PPEs, hand sanitizers and soaps to ensure the hygiene aspects of public health measures are effective. Provision of clean water is key in ensuring the handwashing message is implemented. Innovations by communities to create handwashing devices should be supported.
- Limiting international spread – TIBA countries should strengthen measures to screen international travelers and provide quarantine facilities for those determined to be requiring it. Attention should be paid to migrants and refugees who may be hardest hit during lockdowns. Social support packages should extend to these groups to ensure they adhere to public health measures.
- Testing and contact tracing – TIBA countries should work with international partners to develop testing capacity. Initiatives to enhance contact tracing through Apps and digital technologies should be encouraged.



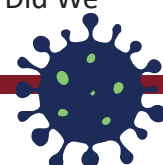
- Improving risk communication – Communication is a key tool in the fight against COVID-19. TIBA countries should refine their communications strategies to reach geographically and culturally diverse communities.
- Socio- economic support – TIBA countries should continue the socio-economic support measures extended to residents to cushion the impact of COVID-19.
- International solidarity and regional mechanisms are important approaches to be encouraged for enhancing the capacity to mitigate the pandemic

Finally, as the COVID-19 pandemic continues to be a rapidly evolving situation, TIBA countries are encouraged to embrace a Dynamic Sustainability Framework (DSF)⁵⁸. The DSF framework embraces the expectation that change is constant and thus the success of an intervention to be sustained over time lies in the measured, negotiated, and reciprocal fit of an intervention within a practice setting and the practice setting within the larger ecological system. The DSF suggests that optimal fit requires that characteristics of the intervention, practice setting, and ecological system be consistently tracked, using valid, reliable and relevant measures, and expects that interventions, settings and the ecological system should change over time, particularly where data can suggest improvements for each. TIBA countries should keep exploring ways to improve outcomes of public health measures just as Africa did with the 2014 Ebola outbreak.

58 David A Chambers , Russell E Glasgow & Kurt C Stange, The dynamic sustainability framework: addressing the paradox of sustainment amid ongoing change , Implementation Science volume 8, Article number: 117 (2013)

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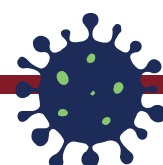
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TIBA Countries' Non Pharmaceutical Public Health measures in response to COVID-19

WHO guidelines state that 'Non Pharmaceutical Interventions (NPIs) outside of healthcare settings usually focus on reducing transmission by personal protective or environmental measures (e.g. hand hygiene); reducing the spread in the community (e.g. isolating and treating patients, closing schools and cancelling mass gatherings); limiting the international spread (e.g. traveller screening); and improving risk communication with the public.' The essential elements of these decisions are personal protective measures, environmental measures, social distancing measures, travel-related measures and risk communication.⁵⁹

The response of TIBA countries is summarised below using the essential elements of the WHO guidelines. In addition, the dimension of testing, socio economic support measures and social safety nets is added to help determine the multi-dimensional aspects on the NPIs. Testing is a key intervention in supporting the objective of reducing community spread as it helps with targeted isolation and quarantine of infected persons. Socio economic measures are key in cushioning the social impact of mitigation measures whilst social safety nets are crucial in ensuring the well-being of citizens during mitigation measures.

59 WHO Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza; 2019. Licence: CC BY-NC-SA 3.0 IGO.



Botswana

The first 3 COVID-19 cases in Botswana were announced on 30th March 2020.



President Masisi of Botswana, under the Emergency Powers Act (Cap.22.04), published regulations on the 2nd of April 2020 requiring all non-essential workers to remain home for 3 weeks. From 22 April 2020, Botswana declared a 28-day lockdown with restriction of movements within the country in a bid to reduce the spread of COVID-19.

As of May 10, there were 23 COVID-19 cases with 12 recoveries, 10 active cases and one death.

WHO Guideline	Botswana NPIs
Reducing community spread	<ul style="list-style-type: none"> • Mandatory social distancing • Prohibition of non-essential movement of people within Botswana. • 28-day lockdown closure of schools and ban on gatherings • Movement was only allowed for essential services employees and only those with movement permits issued by the government. • Rapid identification of suspected cases increased • self-isolation was promoted • Contact tracing and follow-ups of suspected cases who had been in contact with individuals with a positive diagnosis were carried out.
Hygiene and personal protection	<ul style="list-style-type: none"> • Promotion of handwashing was made prominent in public health promotion. • Use of Personal Protection equipment such as face masks and gloves by all frontline staff and public officials was instituted.
Improving risk communication	<ul style="list-style-type: none"> • The Ministry of Health raised awareness of COVID-19 through the media (television and radio), posters and pamphlets. • Media was used for promoting good personal hygiene through regular hand washing and social distancing to prevent and reduce the spread of the coronavirus. • Botswana also used social media with some official government statements issued on twitter.

Limiting international spread	<ul style="list-style-type: none"> • Travellers from or recently transiting through specified high risk countries were prohibited entry into Botswana except returning residents. • Mandatory quarantine for returning residents was imposed, • Visa issuance was suspended. • At ports of entry, all people arriving into Botswana went through temperature screening. This screening protocol was implemented by the Ministry of Health and Wellness. • In order to further strengthen this effort of preventing imported cases, some local ports of entry (mainly borders) are closed with only major borders operating.
Multidimensional Measures	
Socio-Economic measures	<ul style="list-style-type: none"> • The Government established a COVID-19 Pandemic Relief Fund of 2 billion Pula. • To stabilize businesses, Government Guaranteed Loans of up to Pula 25 million per borrower for tax compliant businesses. • Reduction in bank rate, waiver of penalties, rescheduling of loan repayments was gazetted. • A COVID-19 Wage Support Scheme to provide financial support to employees in various sectors who become technically unemployed on a temporary basis due to the impact of the Coronavirus was implemented. • Wage subsidies for businesses registered for tax, regardless of whether they owed tax were introduced. Qualifying businesses would access wage subsidies of up to P 2 500 per month per citizen employee for the months of April, May and June 2020.
Testing	<ul style="list-style-type: none"> • Botswana announced its own capacity to carry out COVID-19 testing after setting up its own National Health Laboratory in March 2020. • A strict testing regime for truck drivers applied at the country's borders that remained open for cargo and returning residents



Ghana



The first COVID-19 cases were confirmed in Ghana on 12 March 2020.

The President of Ghana Akuffo-Addo, established an inter-ministerial committee and prepared a coronavirus response programme to achieve five key objectives:

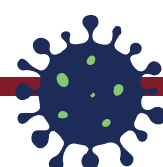
limit and stop the importation of the virus; contain its spread; provide adequate care for the sick; limit the impact of the virus on social and economic life; and, inspire the expansion of domestic capabilities whilst deepening self-reliance. A further directive was given to the Minister of Health to exercise his powers, under section 169 of the Public Health Act, 2012 (Act 851).

On the 7th of May Ghana had recorded 3091 positive cases out of 137,924 tests, with 303 recoveries and 18 deaths.

WHO Guideline	Ghana NPI
Reducing Community spread	<ul style="list-style-type: none"> • A ban on social gatherings and closure of all educational institutions for four weeks commenced on Sunday, March 15. • After the three weeks restrictions were eased, although measures against public gatherings, and the closure of schools and borders, remained in place • A partial lockdown was imposed on COVID-19 infection “hotspots” of Greater Accra (including the sprawling township of Kasoa); Greater Kumasi; and Tema.
Hygiene and personal protection	<ul style="list-style-type: none"> • The Government encouraged the textile and fashion industry to diversify production to personal protective equipment (PPEs) • The President announced on 9th April, that Government will absorb water bills for all Ghanaians for April, May and June and provided water tanker services to vulnerable communities • Ordinary Ghanaians created alternatives to the “Veronica bucket”, the popular hand washing apparatus. • Temporary hand washing facilities were delivered to healthcare centres, public institutions and public places • Significant progress was made in solar powered and manually paddled devices that aim at eliminating contamination during handwashing and the Ghana Standards Authority speedily moved to test and approve some of these innovations.⁶⁰

60 Vida Duti Silver linings of the COVID-19 crisis in Ghana Country director | IRC Ghana <https://www.ircwash.org/blog/silver-linings-COVID-19-crisis-ghana>

<p>Improving risk communication</p>	<ul style="list-style-type: none"> • Government machinery for combating the disease was fully activated: all sub national structures (Metropolitan, Municipal and District Assemblies (MMDAs)) were directed to form cross-sectoral committees and to prepare emergency response plans. • The President held meetings with Christian and Muslim leaders to pray for the nation; traditional authorities to rally the people; leadership of political parties to rally their supporters; the medical association and scientists to strategize on combating the disease. The President regularly addressed the nation on disease mitigation measures.
<p>Limiting international spread</p>	<ul style="list-style-type: none"> • The President placed additional stringent restrictions on travel by ordering the closure of Ghana’s land, sea, and air borders to human traffic effective midnight, 22 March 2020 • The measure also affected international commercial flights, which were not operating during the border-closure period. • Citizens returning from abroad and foreign nationals with Ghanaian residence permits were subjected to a 14-day mandatory quarantine period if they showed symptoms of the virus.
<p>Multidimensional measures</p>	
<p>Socio economic measures</p>	<ul style="list-style-type: none"> • The President established a COVID-19 Fund, to be managed by an independent board of trustees to receive contributions and donations from the public to assist in the welfare of the needy and the vulnerable. He donated three months of his own salary. • He announced a GH¢1.2 billion Coronavirus Alleviation Programme to support households and businesses. • GH¢280 million was allocated to provide food to the vulnerable and to cater for water bills for all Ghanaians for three months, April, May and June. • Half the assistance (GH¢600 million) was extended to micro-, small- and medium-scale businesses. • Government fully absorbed electricity bills for the poorest of the poor. For all other consumers, residential and commercial, the Government absorbed 50% from April to June. • GH¢323 million was allocated towards health practitioners as frontline combatants for their unrelenting efforts in the face of very limited resources.



Testing	<ul style="list-style-type: none">• Ghana adopted “pool testing” of samples. In this method, one test kit is used to test 10 samples combined. A positive result resulted in the testing of entire batch individually to identify the infected sample.• Ghana was the first country in Africa to use medical drones to deliver COVID-19 samples directly to laboratories.• By the 7th of May 2020, Ghana had managed to trace 120,000 people, and 100,000 people from that group had been tested.
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Kenya

The first COVID-19 case in Kenya was confirmed on 13 March 2020.

On 28th Feb 2020, the National Emergency Response Committee was established through an executive order No.2 of 2020. The Kenyan

Government through the Ministry of Health has put several measures in place to safeguard public health and safety including but not limited to a multi-agency approach to deal with the threat of COVID-19.



WHO Guideline	Kenya NPI
Reducing Community spread	<ul style="list-style-type: none"> • Kenya opted against a full COVID-19 lockdown enforcing partial and targeted lockdowns. • The government reacted to the COVID-19 cases in Kenya by imposing a dusk-to-dawn indefinite curfew and restrictions during the day excepting only critical and essential service providers. • Additional travel restrictions came on 6 April, with partial lockdowns of four counties with the highest infection rates, that is, Nairobi, Mombasa, Kilifi and Kwale, except for transportation of food supplies and other cargo. • On Friday, March 27, a nationwide overnight curfew went into effect between the hours of 19:00 to 05:00 (local time) to prevent further spread of COVID-19
Hygiene and personal protection	<ul style="list-style-type: none"> • The use of facemasks, the washing of hands in public places and before boarding public transport were made compulsory • Kenya was quick to harness private sector capacity to produce Personal Protection Equipment (PPE) for COVID-19 mitigation. The Ministry of Health announced on April 14, 2020 that Mass Production of Personal Protective Equipment (PPE's) was to be rolled out at Export Processing Zones Authority Kenya's Shona Ltd after compliance certification. • The Kenyan government recognised innovators creating hands-free public handwashing facilities.
Improving risk communication	<ul style="list-style-type: none"> • The Government of Kenya continued to engage the public with a comprehensive communication campaign including • COVID-19 daily briefings and press statements • Posters, mainstream and social media • Situational reports



Limiting international spread	<ul style="list-style-type: none"> • President Uhuru Kenyatta announced on Sunday, March 15, that foreign nationals traveling to Kenya from any country with confirmed cases of coronavirus disease (COVID-19) would be prohibited from entering. • Kenyan citizens and foreigners with valid residence permits were exempted from the entry ban, that took effect on Tuesday, March 17 2020 • All travellers that entered the country within the last 14 days prior to announcement were to self-quarantine. • All international flights to and from Kenya were suspended at 23:59 on Wednesday, March 25. Only cargo flights were allowed to operate but crew were to follow strict regulations. • The land border between Kenya and Uganda was closed.
Multidimensional measures	
Socio economic measures	<ul style="list-style-type: none"> • The Treasury tabled a supplementary budget. • Within it, Ksh10 billion was slated for distribution to the elderly and vulnerable through Kenya’s relatively well-developed cash transfer system, • While a new budget line for COVID-19 response was allocated Ksh3.9 billion. In total, the Treasury says it allocated Ksh40.3 billion for pandemic-related expenditures. • 25th March 2020, a stimulus package was announced to address the impact of corona virus on the economy. It included a 100 per cent tax relief for individuals with a gross income of up to Ksh24, 000. Income tax was reduced from 30 per cent to 25 per cent, Value Added Tax from 16 per cent to 14 per cent • While the orphans, the elderly and other vulnerable members of the society were allocated a Ksh10 billion welfare package.
Testing	<ul style="list-style-type: none"> • Kenya Initially started with 2 testing labs in Nairobi and this was increased to 20 labs in 10 counties. • By 1 May 2020, Kenya was testing more than 1400 people per day • By 1 May , 21 702 tests had been conducted • An expanded targeted testing program was implemented⁶¹

61 COVID 19 Pandemic Situation Update 01/05/20 <https://www.health.go.ke/wp-content/uploads/2020/05/MOH-PRESENTATION-1ST-MAY-2020.pdf>

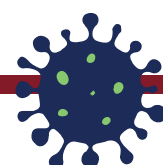
Rwanda

The first positive case of COVID-19 was confirmed on March 8 2020.

The President Kagame led government, through the office of the Prime Minister Edouard Ngirente implemented a nationwide shutdown that took effect on midnight March 21 and was subsequently extended to April.



WHO Guideline	Rwanda NPI
Reducing Community spread	<ul style="list-style-type: none">• Banned “unnecessary” movements including for exercise• Shut schools and places of worship• Banned travel between cities and districts• Requirements for citizens to practice social distancing• Closed all non-essential businesses only allowing those providing essential services such as medical care, telecommunications, security, and banking to operate.
Hygiene and personal protection	<ul style="list-style-type: none">• The measures also encouraged the use of mobile money and online banking whenever possible• The Ministry, through official statements released daily via social media, continually advised Rwandans to wash their hands regularly and maintain a physical distance of at least one meter from other people.• Rwanda’s Ministry of Health established public hand washing stations in the bus park of the nation’s capital.
Improving risk communication	<ul style="list-style-type: none">• The ministry utilizes media for communicating with the citizens on COVID-19 measures• Social media is used for daily messages• Rwanda has used drones fitted with megaphones to communicate COVID-19 mitigation measures in neighbourhoods



<p>Limiting international spread</p>	<ul style="list-style-type: none"> • Before closure announcement all border posts—which represent high-risk exposure areas—were manned by trained officials with fever scanners, • All border posts were closed on 21/03/2020 except for cargo and returning Rwandan residents who were to undergo a 14 day quarantine • the suspension of all commercial flights to and from Rwanda for thirty days and indefinite suspension of domestic travel between cities and districts • ongoing tracing and testing process subjected to those that travelled into the country from countries that had COVID-19 cases • Several hotels in and around Kigali have been turned into quarantine centres and the government picks up the tab for those staying at the hotels.
<p>Multidimensional measures</p>	
<p>Socio economic measures</p>	<ul style="list-style-type: none"> • On March 17, to mitigate the possibility of price gouging during this shutdown period, the government implemented fixed prices on food across the nation. • The government rolled out a food distribution scheme as a way of providing for the most vulnerable people in the society starting with the urban poor who are unable to work and have no garden to get food from during the lockdown. • On 5 April, a statement from the office of the prime minister announced that senior government officials had agreed to forfeit their April salary as a contribution to the funds needed in the fight against COVID-19.
<p>Testing</p>	<ul style="list-style-type: none"> • By 8 April, Rwanda was conducting more than 700 tests per day • In the month of April alone more than 15 000 tests were conducted • A strategy of targeted and random mass testing was rolled out by the Rwanda Biomedical Centre targeting 1000 tests a day ⁶²

62 Mass COVID-19 tests begin as Rwanda readies for end of lockdown Saturday April 25 2020 <https://www.theeastafrikan.co.ke/news/ea/Mass-Covid19-tests-begin-as-Rwanda-readies-for-end-of-lockdown/4552908-5534212-vilf4fz/index.html>

South Africa

The first confirmed case of COVID-19 was reported in South Africa on 5 March 2020. On March 15, 2020 the president of South Africa, Cyril Ramaphosa declared a state of disaster under the Disaster

Management Act 57 of 2002, as a preventative measure. Ramaphosa outlined a three part strategy to further deal with the threat of the pandemic to the people and the economy during the extended lockdown. Firstly, an intensified public health response to slow down and reduce infections. Secondly, a comprehensive package of economic support measures to assist businesses and individuals affected by the pandemic. Thirdly, a programme of increased social support to protect poor and vulnerable households.



WHO Guidelines	South Africa NPIs
Reducing community spread	<p>On Monday, March 23, 2020, President Ramaphosa announced a nationwide total lockdown that commenced on Friday the 27th of March 2020. The conditions of the lockdown included:</p> <ul style="list-style-type: none"> • bans on mass gatherings of more than 50 people • cancellation of large events, such as sporting events, concerts • closure of schools • The South African measures were some of the strictest in Africa with bans on sale of cigarettes and alcohol • Promotion of social distancing. The President announced that the virus required social distancing and no handshakes or hugs.
Hygiene and personal protection	<ul style="list-style-type: none"> • The promotion of social distancing was promulgated. Handshakes or hugs were also banned. • Handwashing, use of soap and hand sanitisers encouraged
Limiting international spread	<ul style="list-style-type: none"> • The president announced sweeping measures to contain the spread of COVID-19, including travel restrictions on foreigners from hard-hit countries • More than 72 ports of entry were closed. • Borders were closed and only returning residents were allowed in, albeit subject to quarantine.
Improving risk communication	<ul style="list-style-type: none"> • The government keeps the nation abreast almost with daily announcements on the number of COVID-19 infections and fatalities. • The government also partnered with the local network providers such as MTN, Vodacom and Telkom to send citizens messages that encouraged them to stay home, wash hands with soap or sanitisers. • A national Sexual and Gender Based Violence (SGBV) hotline has been promoted to improve GBV reporting rates during lockdown.



Multidimensional measures

Socioeconomic measures	<ul style="list-style-type: none"> • Government delivered over 11,000 water storage tanks to communities in need across the country with 1,000 water tankers being provided for the delivery of water. • Homeless people have been accommodated in 154 shelters across the country. • R400 million set aside by government for Social Relief of Distress grants and many other forms of relief. • The Unemployment Insurance Fund of R40 billion was set aside to help employees who were unable to work, as part of the effort to prevent jobs losses. • A comprehensive package of economic support measures to assist businesses and individuals affected by the pandemic was launched. • A programme of increased social support to protect poor and vulnerable households was announced.
Testing	<p>Ramaphosa said the health response strategy was</p> <ul style="list-style-type: none"> • to screen in communities and test people in hospitals, clinics and mobile clinics, • To isolate those who are infected, and to care for those who are ill in health facilities. • By 11 April 2020 South Africa had conducted around 60,000 tests Community health workers (CHWs) were deployed for home visits throughout the country. In the first three weeks of April, 28 000 CHWs screened 900 000 people, and referred 11 000 for COVID-19 testing. South Africa was testing at a rate of nearly 5,000 a day.⁶³ • The full national public testing capacity is 50 000 tests a day.⁶⁴ • Community health workers (CHWs) were deployed for home visits throughout the country. In the first three weeks of April, 28 000 Community Health Workers screened 900 000 people, and referred 11 000 for COVID-19 testing.⁶⁵

63 Mike Onyiego, "How the spread of coronavirus is testing Africa," BBC Africa, April, 11, 2020, <https://www.bbc.com/news/world-africa-52230991>

64 BMJ 2020; 369 doi: <https://doi.org/10.1136/bmj.m1623> (Published 24 April 2020) BMJ 2020;369:m1623

65 BMJ 2020; 369 doi: <https://doi.org/10.1136/bmj.m1623> (Published 24 April 2020) BMJ 2020;369:m1623

Sudan

The first COVID-19 case in Sudan was reported on 13th March 2020.

Sudan imposed a lockdown on April 18 2020. Sudan’s Health Minister, Dr Akram Ali Al-Toum, said that the comprehensive ban aims to reduce the chances of spread of the novel coronavirus disease. Early in March, the ruling cabinet of ministers and the Sovereign Council formed the “High Committee for Health Emergencies” to coordinate governmental and non-governmental efforts for combating COVID-19. As at 8 May 2020, Sudan had 930 cases and 52 deaths with 92 recovered.

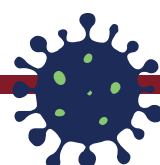


WHO Guideline	Sudan NPIs
Reducing Community spread	<ul style="list-style-type: none"> On 13 April, the Sudanese government announced a lockdown of the state of Khartoum effective from 18 April 2020 and took other measures to confront the pandemic. The closure of all schools and universities was announced. Public gatherings including mosques in Khartoum State were banned.
Hygiene and personal protection	<ul style="list-style-type: none"> Portable handwashing stations were set up in Khartoum State in partnership with the IOM (International Organization for Migration) The use of PPE was encouraged. Soap and sanitisers were distributed in prisons of Khartoum State. Infection control supplies such as soap, water tanks, hand sanitizer, water purification supplies were dispatched to states. The International Organization for Migration (IOM) set up 20 portable handwashing facilities accessible to homeless persons in seven locations in Khartoum State. This initiative was developed in coordination with the Khartoum State Ministry of Social Development (SMoSD) and Sudan Ministry of Health (SMoH)



Improving risk communication	<ul style="list-style-type: none"> • COVID-19 information and updates were released daily and disseminated through the media and information centre at the FMOH.(Federal Ministry of Health) • The minister of health himself and sometimes the minister of media and information made appeals and important announcements and gave details of the instructions to follow. • Basic information and tips on COVID-19 were sent to over 13.5 million mobile phone subscribers daily. • Government owned and private television and radio stations were giving primetime air slots to raise public awareness on COVID-19 with a reach estimated at 60% of the population of Sudan (approximately 24 million people).
Limiting international spread	<ul style="list-style-type: none"> • The Federal Ministry of Health (FMOH) began to screen passengers arriving in Sudan through different ports and to gather their information. • On 12 March, the government started to tighten the procedures for entry to Sudan from affected countries. • On 16 March the Security and Defense Council in Sudan announced a state of health emergency, with the government closing all airports, land and sea border crossings, except for flights carrying aid, technical and humanitarian support and pre-scheduled freight. • On 20 April the Sudan Civil Aviation Authority (CAA) issued a decision to extend the closure of Sudanese airports for international and domestic flights until 20 May 2020
Multidimensional measures	
Socio economic measures	The ministry of labour and social welfare (the federal and Khartoum state) was tasked with food distribution and social support for poor families during the total lockdown. They identified 600,000 families in need in Khartoum state and started delivering a basket containing 11 essential food and household items to each of them.
Testing	<ul style="list-style-type: none"> • FMOH worked with WHO to increase testing capacity by setting up additional laboratories to increase the overall capacity to 600 tests per day from 30 tests a day that was capacity in April. • Around 400 tests were being done per day.
Reducing community spread	Sudan imposed a lockdown on April 18, 2020.
Hygiene and personal protection	Health ministry sources said the country has about 300-400 beds ready for patients

Reducing transmission by personal protection	Social distancing is being promoted as prevention measure.
Improving risk communication	<ul style="list-style-type: none"> • Strict preventive guidelines were announced for the public to follow • Government encouraged the public to immediately report any suspected cases during the lockdown. • The government warned that anyone who will be caught violating the lockdown directives will be prosecuted. • COVID-19 information and updates are being released daily and disseminated through the media and information centre at the FMoH. The minister of health himself and sometimes the minister of media and information make appeals and important announcements and give details of the instructions to follow.



Tanzania

The first COVID-19 case was reported in Tanzania on 16 March 2020.

The President Magufuli led Tanzanian government developed a COVID-19 Response Plan, with the support of the World Health Organization. The plan seeks to increase laboratory testing, surveillance and contact tracing and through isolating and caring for those infected to slow the advance of this highly contagious disease.



WHO Guidelines	Tanzania NPI measures
Reducing community spread	<ul style="list-style-type: none"> • Prime Minister Kassim Majaliwa shut down all primary and secondary schools, colleges and other institutions of higher learning for one month to help curb the spread of the virus. • The government also banned mass public gatherings • Citizens were encouraged not to leave home unless for essential services
Hygiene and personal protection	<ul style="list-style-type: none"> • Tanzania did not opt for strict lockdown measures although mass gatherings like funerals and weddings were banned. • Sporting events were closed. • Prisons were closed to visitors. • There was an immediate implementation of SADC pooled procurement services (SPSS) BY Tanzania medical stores department (MSD) to enable availability of drugs and medical devices at affordable prices
Limiting international spread	<ul style="list-style-type: none"> • Travel restrictions were put in place on 23 March 2020. • All flights have been cancelled. • The government through the Ministry of Health, Community Development, Gender, Elderly and Children imposed a mandatory quarantine at the first International Point of Entry in Tanzania for all travellers from countries which are most affected by the COVID-19 pandemic. The quarantine was for a period of 14 days at government designated facilities. The travellers bear the quarantine costs.
Improving risk communication	<ul style="list-style-type: none"> • The country seemed to prioritize public education on such things as sanitation, washing of hands and social distancing. • Public information Hotlines for enquiries and updates were established

Multidimensional Measures

Socioeconomic measures	<ul style="list-style-type: none">• To stop profiteering caused by the COVID-19 outbreak, Tanzania's Fair Competition Authority warned manufactures and retailers against hiking prices of goods.• Handwashing facilities were put in public places and markets remained open.
Testing	<ul style="list-style-type: none">• A total of 652 tests were administered at time of the report.• The announcement of test results was halted.



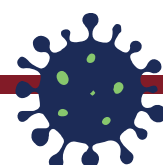
Uganda

Uganda confirmed its first COVID-19 case on 21 March 2020. On 11 February Dr Jane Ruth Aceng, the Minister of Health, issued a statement rallying Public Health Workers (PHWs) and the country to stay vigilant due to the COVID-19 pandemic. Uganda's COVID-19 control legal measures were announced by the President then published as legal instruments by the Minister of Health under the Public Health Act. A lockdown was announced on 31 March 2020.



WHO Guidelines	Uganda NPI measures
Reducing community spread	<ul style="list-style-type: none"> • Schools and universities were closed, and mass gatherings were suspended. • Public transportation was banned. • Markets were restricted to selling foodstuffs whilst arcades and shopping malls were shut. • A 14-day 7pm curfew was announced prohibiting movement of people. • Closures of salons, garages and lodges, and a freeze on private car use were instituted. • Market vendors and factory workers were ordered to temporarily relocate to live on the premises of their workplaces. • Vital institutions such as banks, funeral homes, garbage collection companies, water and electricity distributors, the roads maintenance agency and the tax collection authority were directed to encamp their crucial staff or obtain special exemption from a high-level district official. • The security forces were deployed to enforce the lockdown measures. • President Yoweri Museveni partially lifted the national lockdown, allowing a few businesses to operate from 6 May.
Hygiene and personal protection	<ul style="list-style-type: none"> • Social distancing, hand washing and non-contact greetings were promoted to reduce chances of infection by the public. • Wearing of masks was made mandatory.

Limiting international spread	<ul style="list-style-type: none"> • Screening of passengers entering the airports was carried out • Borders and the airport remained closed since 20 March. • International travellers were banned from entering Uganda from 23 March 2020 • Information sheets with telephone numbers of medical officers were developed and handed out to travellers at Entebbe International Airport. • Public Health Workers were drafted into surveillance teams tracking returnees from abroad.
Improving risk communication	<ul style="list-style-type: none"> • The President addressed the nation giving regular updates on the COVID-19 situation • Use of radio, television and social media was made for official communication. • Posters were made available for downloading from the ministry of health website • Press statements were released regularly with details of numbers of infected persons and tests conducted.
Multidimensional Measures	
Socioeconomic measures	<ul style="list-style-type: none"> • Uganda’s government began to distribute food items like maize flour, beans and salt to vulnerable people in Kampala and its suburban areas. • Sick people received extra food including sugar and powdered milk. • The national Persons with Specific Needs Sub Working Group (PSN SWG) analysed the specific impact of the COVID-19 crisis and related containment measures on Persons with Specific Needs, with a specific focus on persons with disabilities and older persons.
Testing	<ul style="list-style-type: none"> • According to the Ministry of Health (MoH). Fifty-five people had recovered, with no deaths registered by the end date of this report. A total of 61,460 samples were tested by the Uganda Virus Research Institute as of 11 May 2020. • By 4 May up to 2246 tests per day were conducted • The Uganda Virus Research Institute (UVRI), the country’s only COVID-19 test centre, was re-equipped and restocked.



Zimbabwe

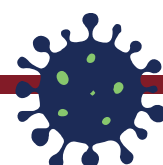
On 21 March 2020 Zimbabwe reported its first COVID-19 case. The President of Zimbabwe, declared the pandemic a national disaster and announced a nationwide lockdown effective from 30th March 2020. A COVID-19 National Preparedness and Response Plan was subsequently launched.



WHO Guidelines	Zimbabwe NPIs
Reducing community spread	<ul style="list-style-type: none"> Public events were cancelled, schools and tertiary institutions eventually closed early. Social distancing continues to be promoted while gatherings of more than 50 people were banned. All schools were closed.
Hygiene and personal protection	<ul style="list-style-type: none"> The wearing of masks in public was made mandatory. The government disinfected hotspot areas like markets and restructured the stalls to promote social distancing Handwashing and social distancing were promulgated as prevention strategies.
Limiting international spread	<ul style="list-style-type: none"> Zimbabwe's borders were closed to all human traffic except for returning nationals and permit holders. Borders remained open for cargo. Screening checks were conducted on travellers, including thermal scans and review of travel history within the previous 14 days. All arrivals were subjected to strict screening procedures including arduous enforcement of a 21-day quarantine at government designated quarantine.
Improving risk communication	<ul style="list-style-type: none"> The Government of Zimbabwe continued to engage the public with a comprehensive communication campaign including: <ul style="list-style-type: none"> COVID-19 daily briefings and press statements Posters, mainstream and social media Situational reports Toll free lines were promoted to enable easy communication and reporting.

Multidimensional Measures

<p>Socioeconomic measures</p>	<ul style="list-style-type: none"> • The government introduced a COVID-19 stimulus package which was pegged at ZW\$18 billion or US\$720 million. • The government introduced a food grant of ZW\$2.4 billion for the rest of the year. • As much as ZW\$500 million was set aside to support the tourism sector, while ZW\$1 billion was allocated towards mining. • ZW\$3 billion went towards manufacturing to alleviate shocks in the business sector. • Over 2 million people received food or cash assistance in April. Distributions were delayed due to the implementation of COVID-19 protection measures. • Government committed to provide assistance of ZW\$200 to vulnerable families. This move targeted especially the elderly in the country.
<p>Testing</p>	<ul style="list-style-type: none"> • By 10 May, Zimbabwe had 36 positive cases including 9 recoveries and 4 deaths. • 11664 rapid screening tests and 9872 PCR diagnostic tests have been conducted cumulatively until 10 May. • Testing was decentralized to the different provinces including Bulawayo.

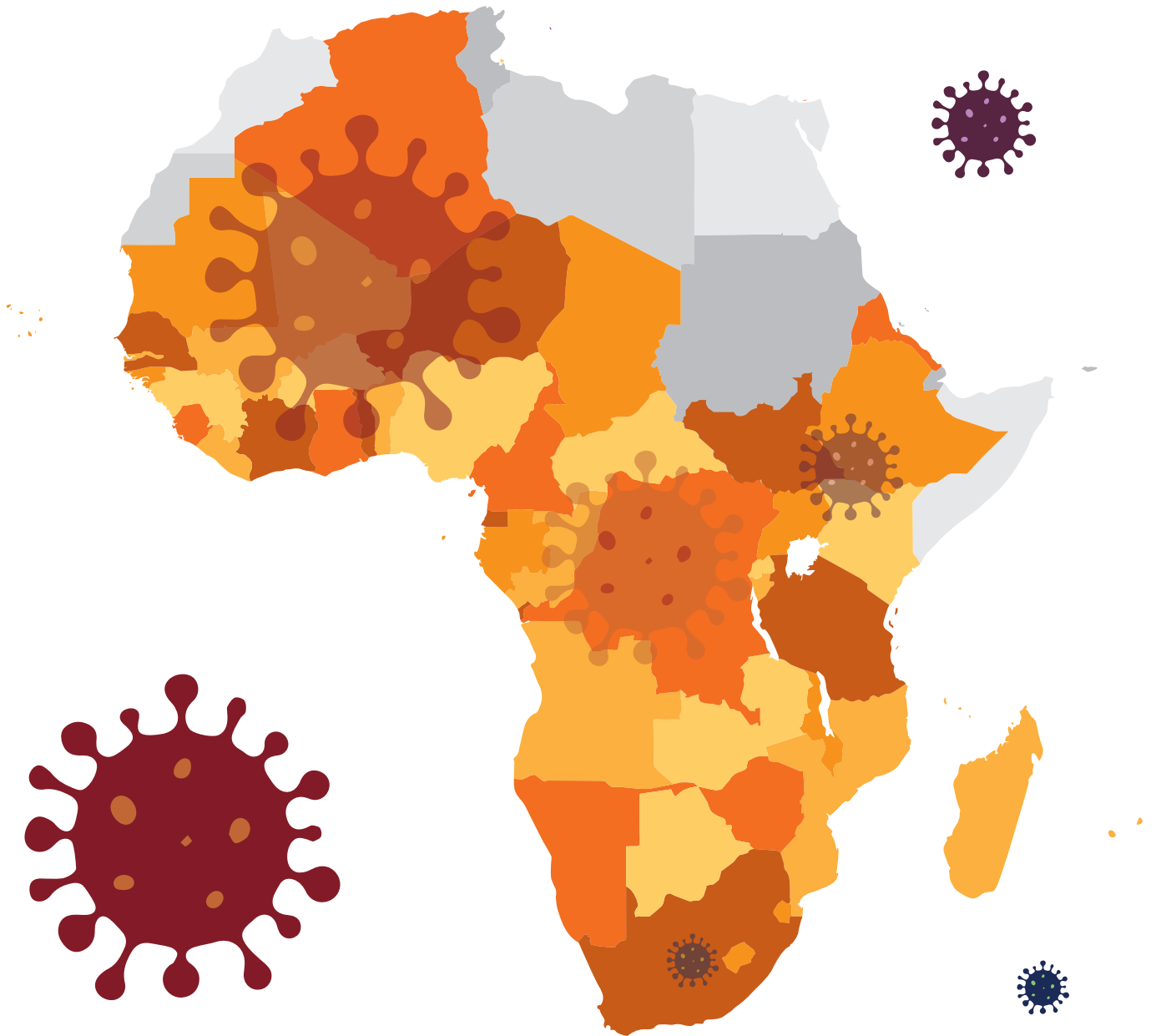


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