UNITED NATIONS
UZBEKISTAN

World Health Organization

COVID-19

NATIONAL STRATEGIC PREPAREDNESS & RESPONSE PLAN FOR HEALTH

2020 report

CONTENTS

ABBREVIATIONS

AFP	Acute Flaccid Paralysis
ARI	Acute Respiratory Infection
COVID-19	Acute respiratory infectious disease caused by a coronavirus (2019-nCoV)
ECDC	European Centre for Disease Prevention and Control
EOC	Emergency Operations Centre
EPI	Expanded Program on Immunization
GISRS	Global Influenza Surveillance and Response System
IAR	Intra-Action Review
IEC	Information, Education and Communication
ILI	Influenza-Like Illnesses
IRC	Independent Review Committee
JEE	Joint External Evaluation
MMR	Measles, Mumps, and Rubella
MR	Measles and Rubella
PCV	Pneumococcal Conjugate Vaccine
PHEIC	Public Health Emergency of International Concern
SARI	Severe Acute Respiratory Infection
SIAs	Supplemental Immunization Activities
SPRP	Strategic Preparedness and Response Plan
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

INTRODUCTION

On 30 January 2020, the WHO Director General declared the 2019-nCoV (COVID-19) outbreak to be a public health emergency of international concern (PHEIC) following the recommendations of the Emergency Committee under the International Health Regulations (IHR 2005). On 11 March, the WHO declared the outbreak a global pandemic. To build global solidarity, the Committee felt that a global coordinated effort was needed to enhance preparedness in regions of the world that may need additional support. A national Strategic Preparedness and Response Plan (SPRP) was developed for Uzbekistan, in collaboration with WHO and other partners, to provide guidance on managing the response to COVID-19. The national SPRP was issued on 19 March and updated on 6 April and outlines the immediate priorities to suppress transmission of the virus and to support health systems to respond to the pandemic.

This report, produced under the technical leadership of WHO Uzbekistan and in consultation with the Ministry of Health, serves to summarize progress against the SPRP under the ten pillars of the SPRP, and concludes with a summary of cross cutting issues and priorities for 2021.

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PILLAR 1:
Country-level coordination, planning, and monitoring

COVID-19 national plan

On 11 March 2020, the World Health Organization (WHO) made the exceptional assessment that COVID-19, the disease caused by the novel coronavirus, should be characterized as a pandemic. The development of the COVID-19 Strategic Preparedness and Response Plan for Uzbekistan began at this time.

The SPRP was discussed and agreed with the Ministry of Health and all development partners and was updated regularly. In addition, the National Action Plan for the implementation of International Health Regulations (IHR 2005) was approved by the Ministry of Health in January 2020; the country is moving forward with its implementation despite the pandemic.

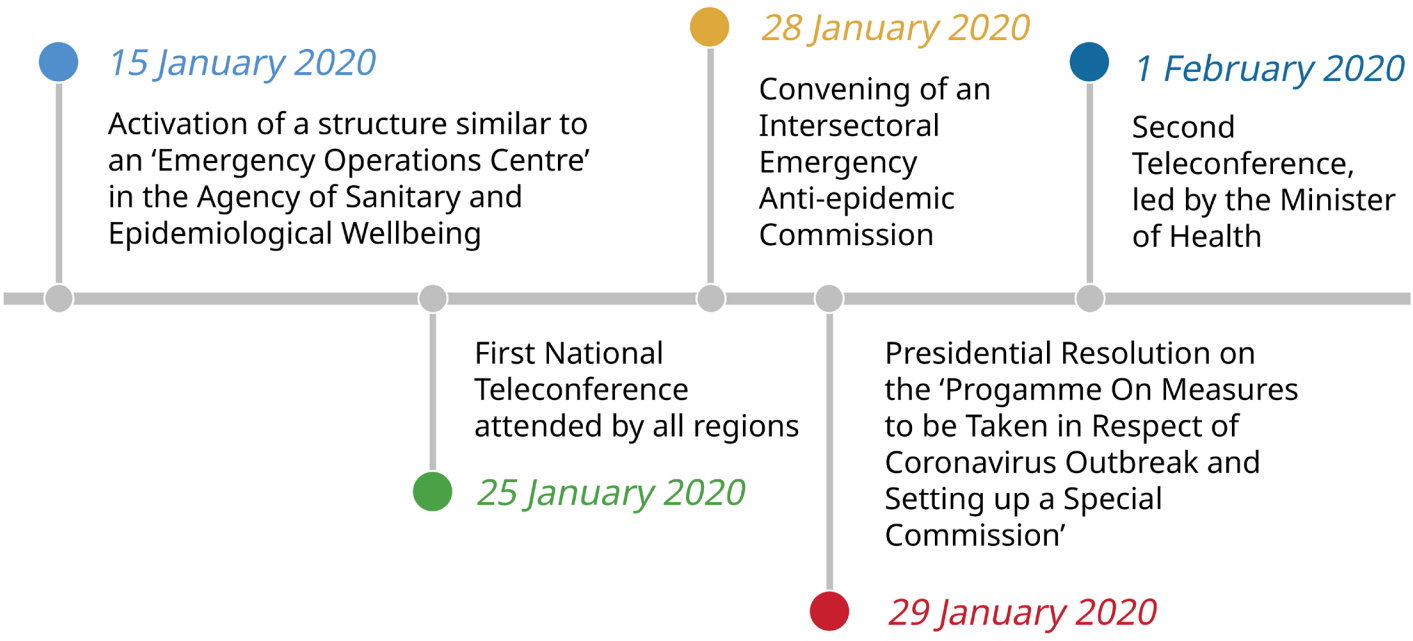
Multi-sectoral coordination mechanism for COVID-19 preparedness and response

In support of the Government and to ensure close development partner coordination, WHO chaired a COVID-19 Health Working Group under the auspices of the UN-chaired Crisis Management Team. An associated Health Procurement Task Force was co-chaired by UNDP and ADB.

In early 2020, the Government of Uzbekistan began its response efforts to the outbreak of COVID-19. The measures taken are presented in Picture 1.

WHO provided daily support to the Government of Uzbekistan by sharing all technical guidance and offering advice during technical meetings, jointly analyzing actions taken and recommending further urgent actions to ensure public health security.

Picture 1. Sequence of early national response measures



Mass gathering events affected by COVID-19 (cancelled, postponed, suspended or reopened in a post-crisis scenario), as a result of a Risk Assessment exercise

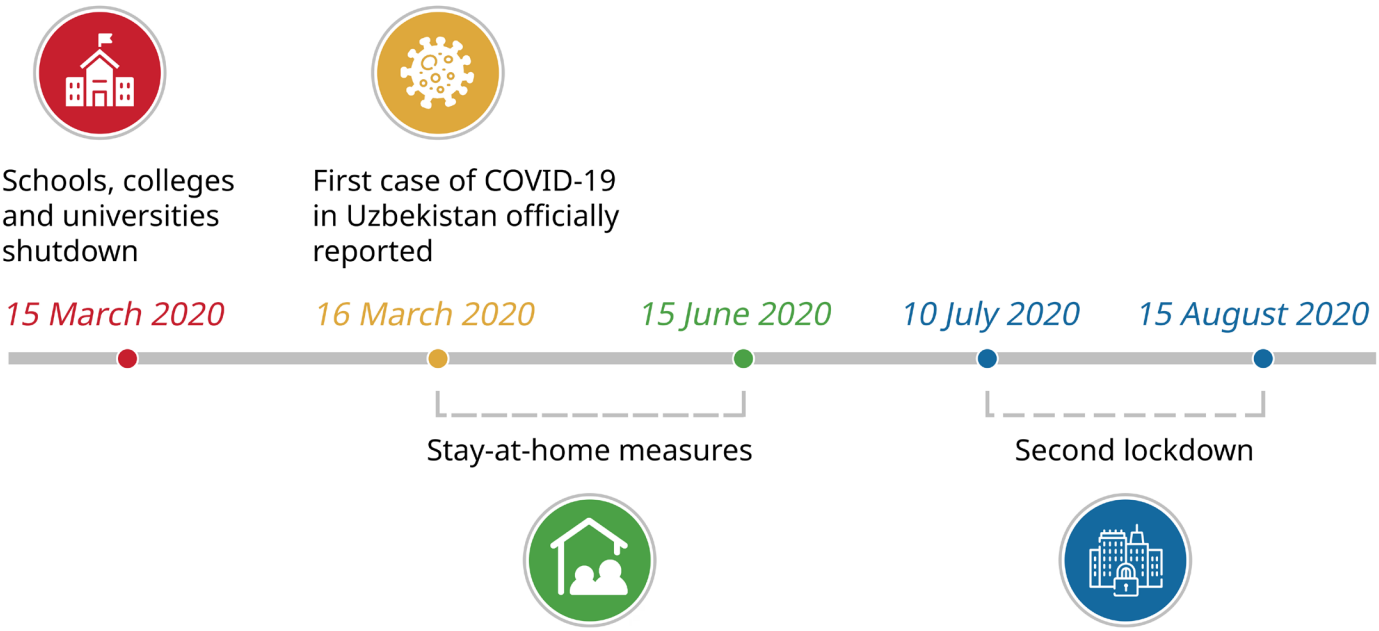
By mid-March 2020, Europe became the epicenter of COVID-19 infection and a similar impact was soon after observed in Central Asia. Along with other Central Asian countries, Uzbekistan experienced a nation-wide interruption to services. By 15 March, schools, colleges and universities were shut down and a state of emergency was declared on 16 March, after the first case of COVID-19 in Uzbekistan was officially reported the previous day.

Stay-at-home measures were quickly applied and extended until 15 June. These measures had an impact on health service provision, including immunization services. In the initial days of the pandemic, the Government of Uzbekistan reoriented health service providers to respond to the pandemic. A second lockdown took place from 10 July until 15 August, further affecting health service delivery.

Throughout this time, WHO provided support to the Government of Uzbekistan on a daily basis in response to the declared PHEIC, by sharing all technical guidance and providing advice during technical meetings, jointly analyzing immediate actions and recommending which actions needed to be swiftly taken to ensure public and global health security.

As of January 2021, public health measures are being lifted due to a steady decline in the number of COVID-19 cases, although it is expected that further restrictions could be decreed based on the epidemiological situation.

Picture 2. Sequence of national response measures (continued)



PILLAR 2:
Risk Communication and Community Engagement (RCCE)

Capacity-building training for press officers

From 11 to 13 March, WHO, UNICEF, UNFPA and the UN Information Office, in partnership with the Ministry of Health (MoH), conducted a two-day training on effective communication in emergency situations for regional MOH branch 30 press secretaries and for communication staff from medical organizations across Uzbekistan. The training covered a wide range of topics including working with public opinion and combatting misinformation, developing clear and transparent messages about protective measures, community engagement, engaging trusted influencers, and how to find reliable sources of information for delivery of messages to the public.

Since March 2020, the UN Communication Group (UNCG) has developed over 361,600 posters, infographics and brochures in Uzbek, Russian, English and Karakalpak languages and Braille and have disseminated them across Uzbekistan to raise awareness on COVID-19. For example, in cooperation with the 'Yuksalish' movement, the Ministry of Internal Affairs and the National Guards of Uzbekistan, COVID-19 posters were distributed in food stores, including big retail stores such as Korzinka and Macro, pharmacies, bazaars and major government agencies.

Over 156 social media posts and 31 videos in Uzbek and Russian were developed and disseminated on various social media platforms. These covered such topics as: physical distancing, hygiene, healthy lifestyle and mental stress; information for school administrations and teachers on protection measures; recommendations on wearing masks for children with disabilities, autoimmune diseases, and cancer; and how to take care of a family member who has COVID-19.

Three Public Service Announcements on protection measures for the public and the media were produced jointly with the Ministry of Health. The UN Communication Group, with the help of the UNICEF U-report platform, surveyed over 11,000 young people in Uzbekistan to better understand the effectiveness of public information campaigns on COVID-19 and to identify the additional information needs of young people.

Picture 4. #WearAMask campaign

In August, the United Nations Communication Group launched the #WearAMask campaign in Uzbekistan to urge everyone to help break the chains of COVID-19 transmission by wearing a mask, physical distancing, regularly washing hands, avoiding crowds, and oral hygiene. The campaign has received over 483 photographs and six videos from across Uzbekistan. Photographs and videos of the campaign are regularly posted on UN social media platforms and some posts can be viewed via Twitter or Facebook[1].

As part of the UN75 campaign, the United Nations Communication Group conducted six dialogues which were attended by 240 participants from across Uzbekistan, including students, experts, bloggers, lawyers and representatives of civil society organizations. These dialogues focused on the importance of continuing to share credible information, practicing physical distancing, regular hygiene and a healthy lifestyle during COVID-19, as well as spreading kindness.

1 See https://bit.ly/3m1msrh and https://bit.ly/3kZRKO2

Picture 3. Pillar 2 in numbers.

Two-day training on effective communication in emergency situations

361,600 posters, infographics and brochures in Uzbek, Russian, English and Karakalpak languages

Over **156** social media posts and **31** videos in Uzbek and Russian

Over **11,000** young people in Uzbekistan surveyed on the effectiveness of public information campaigns on COVID-19

Over **483** photographs and six videos from across Uzbekistan in #WearAMask campaign

Six dialogues with **240** participants from across Uzbekistan on healthy lifestyle during COVID-19

Photo | UN Uzbekistan Communication Office

PILLAR 3:
Surveillance, rapid response teams, and case investigation

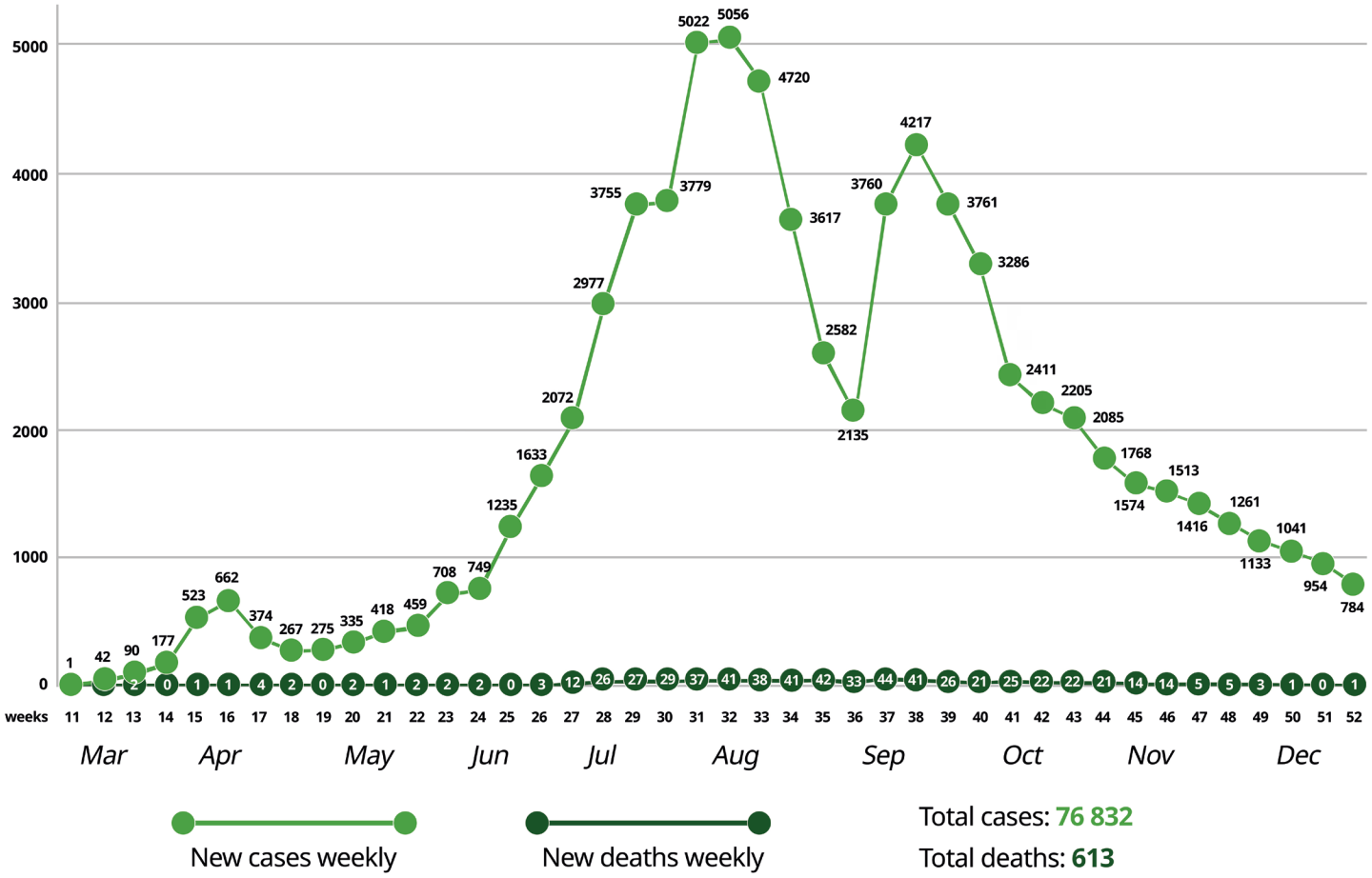
COVID-19 dynamics in Uzbekistan

From May to June 2020, WHO organized a number of sessions on predictive tools (Essential Supply Tool, Health Workforce Estimator and Adapt Surge Planning Support Tool), which were developed by WHO to support countries to forecast the supplies, healthcare workforce and space needed for the COVID-19 response. The sessions were attended by specialists from the Ministries of Health, Finance, Economy and Industry, and members of the COVID-19 Procurement Task Force led by the Ministry of Investments and Foreign Trade. In addition to further demonstrate the tools, practical exercises using real-time data provided by the MoH were conducted.

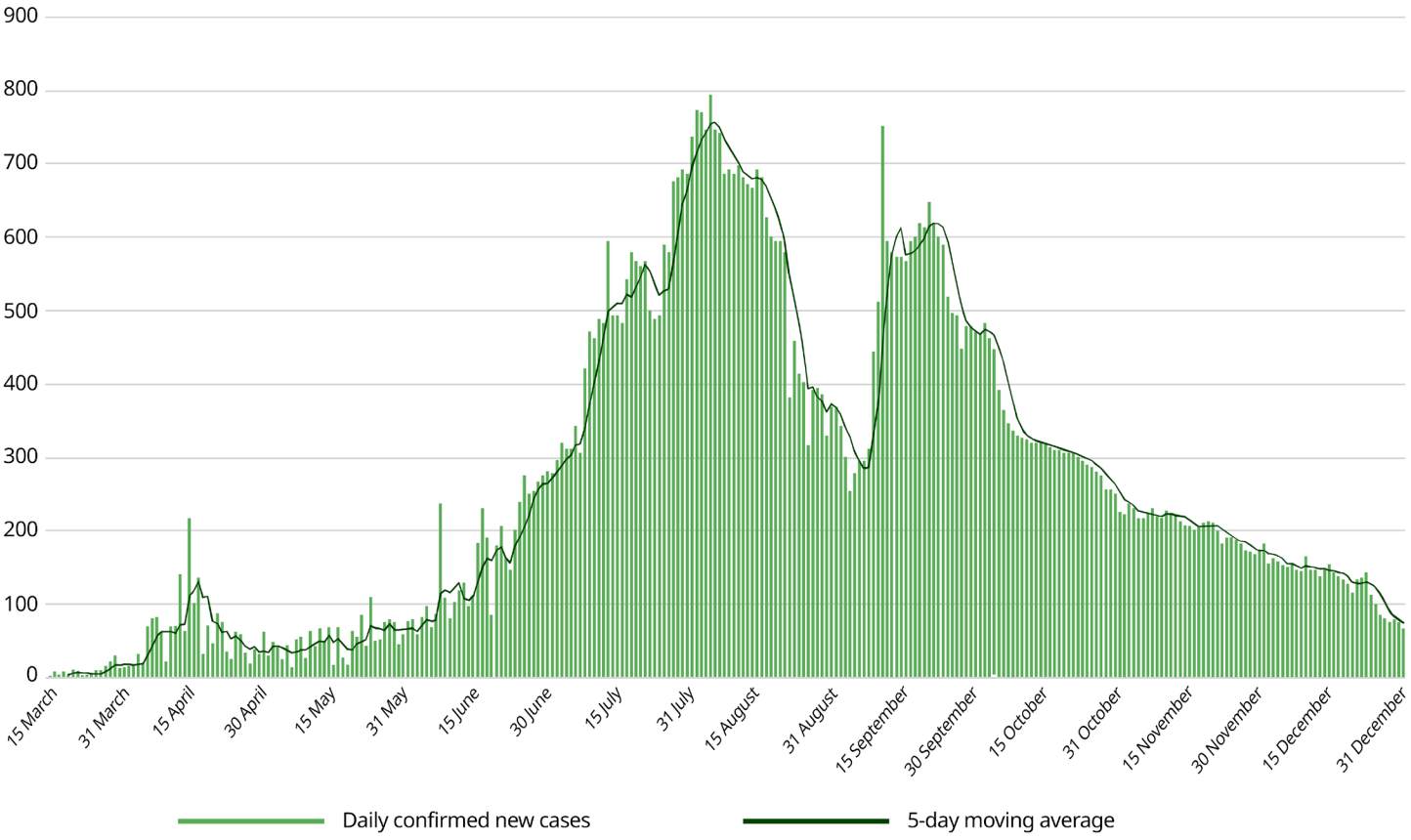
In August 2020, WHO organized a session on International Classification of Diseases (ICD-10) coding and certification of death due to COVID-19. The session was attended by more than 100 participants from all over Uzbekistan. The MoH provided very positive feedback on the session, mentioning that many specialists from the regions found it very useful. The MoH requested similar sessions on coding and certification of disease due to COVID-19.

Disaggregation by gender and age is not available for epidemiological data on new detected cases and deaths.

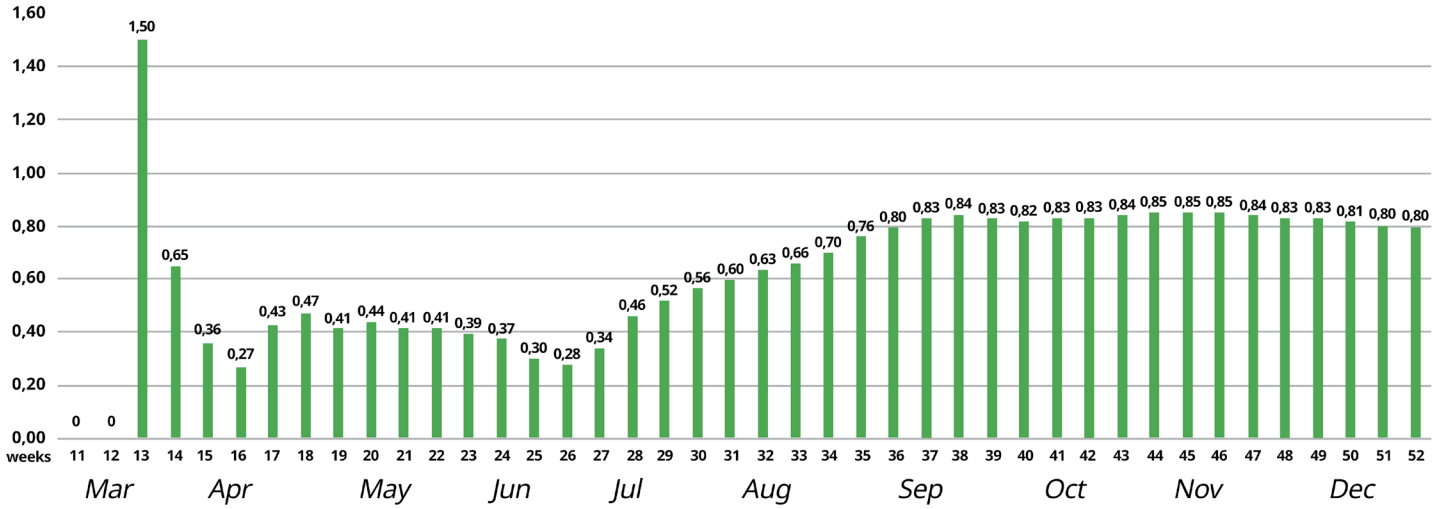
Picture 5. Weekly number of new cases and new deaths, March to December 2020



Picture 6. Confirmed new cases and 5-day moving average



Picture 7. Weekly case fatality rate, March to December 2020



Note: The case fatality rate (or ratio) indicates the number of total deaths over the number of confirmed/diagnosed cases of disease. For more information, see https://www.who.int/news-room/commentaries/detail/estimating-mortality-from-covid-19

Testing for COVID-19 and reporting routinely through established sentinel or non-sentinel influenza-like illness (ILI), severe acute respiratory infection (SARI), acute respiratory infection (ARI) surveillance systems such as the Global Influenza Surveillance and Response System (GISRS) or another WHO platform

Following recommendations from the GISRS, in the framework of the Pandemic Influenza Preparedness Framework (PIP), and with support from USAID, WHO Regional Office for Europe and WHO Country Office in Uzbekistan, the MoH and Sanitary and Epidemiology Welfare and Public Health Service of the Republic of Uzbekistan issued the first Weekly National Influenza Bulletin[2]. It is now publicly available in two languages, Russian and Uzbek. It is anticipated that regular data sharing will enhance understanding of the public health burden caused by influenza and SARS-CoV-2 viruses. It is hope that data sharing will broaden insight into the biology of these viruses and their antigenic diversity, reinforce the necessity for systematic surveillance of global viruses' circulation and result in an appropriate timely response to seasonal and pandemic influenza and other respiratory viruses, such as SARS-CoV2.

2 http://ssv.uz/ru/menu/informatsionnye-bjulleteni

PILLAR 4:
Points of entry, international travel, and transport

Designated points of entry and public health emergency contingency plan

Initial emphasis was put on hospital readiness and on preparing the country's total of 53 entry points. There are nine points of entry 'designated to WHO by the Government of Uzbekistan' (IHR terminology). When the first case of COVID-19 was recorded in the country on 16 March 2020, measures were put in place to register each person coming into the country, but proper travel tracking of those persons has proved to be a challenge as many people do not stay in one location. Therefore, permanent support is being provided by WHO to the Government through regular webinars that focus on the quarantine and isolation of patients, as well as introducing self-isolation for contacts, asymptomatic and mild casesof COVID-19. The JEE, which is currently being prepared jointly by the Government of Uzbekistan and WHO, will provide a detailed situation analysis at points of entry and will give an opportunity to the Government to further strengthen its capacity at airports and border crossings.

PILLAR 5:
National laboratories

COVID-19 laboratory test capacity

At present, 70 laboratories around the country perform NAAT testing for SARS-CoV-2, with the number of tested samples ranging from 32-42,000 a day. WHO, in line with a joint WHO/KFW project, has started the procurement process of Xpert Xpress SARS-CoV-2 cartridges to strengthen Uzbekistan's capacity for COVID-19 detection. The test leverages the design principles of cartridge technology, in which multiple areas of the viral genome are targeted. The test can provide rapid detection of the current coronavirus SARS-CoV-2 (COVID-19) in 30 minutes with minimal hands-on time to prepare the sample.

A WHO and international experts' mission were conducted from 10 September to 15 October during which 16 laboratories were assessed on their capacity and capability to test SARS-CoV-2. Eight laboratories were assessed for their sample referral system. It was found that the basic requirements of quality management systems, such as SOPs, verification of tests and competency assessments were not implemented. None of the biosafety cabinets installed had been checked by a certified specialist. Risk assessments had not been performed and storage temperatures were not being checked. At regional and district levels, sampling needed urgent improvement, and laboratories lacked systems to trace transported samples as well as acceptance and rejection criteria. To further support the implementation of these gaps WHO conducted training courses for national and regional lab specialists on assessment using the WHO Laboratory Assessment Tool, and provided a training of trainers on laboratory quality management systems, and training of national mentors.

The COVID-19 response project funded by the Asian Development Bank (ADB) and Asian Infrastructure Investment Bank (AIIB) will help enhance the capacity of laboratories under ASEW. Further support to ASEW was provided through the development of a national testing strategy for COVID-19. The draft of the national testing strategy was presented and discussed with the Director of the ASEW.

Scoring on the External Quality Assessment Project (EQAP)

The National Public Health Laboratory which performs functions of the National Influenza Center (NIC), and the National Reference Laboratory for measles, polio and rubella took part in WHO's External Quality Assessment Project for both influenza and COVID-19, providing 100 per cent correct results.

PILLAR 6:
Infection Prevention and Control

National IPC programme and Water, Sanitation and Hygiene (WASH) standards within all health care facilities

A national training programme on IPC was developed by WHO and offered to the MoH in English, Russian and Uzbek. As part of the case management portfolio, the IPC curriculum was updated for resuscitators and health care staff in intensive care units. To support IPC efforts, development partners supported the Government of Uzbekistan with personal protective equipment (PPE) for health workers, including goggles, respirators, boot covers and coveralls.

Furthermore, within the framework of the Project 'Health System Strengthening in immunization service (HSS)', WHO training courses for immunization service providers (ISPs) on 'Safe Immunization' and a course for Primary Health Care (PHC) unit managers on 'Organizing an immunization service on PHC' have been extended by adding an additional training day dedicated to providing information on infection and prevention control in the light of COVID-19.

Number of health workers trained in IPC (monthly, weekly)

Between September and December 2020, a total of 1,213 health care workers were trained on 'COVID-19 case management' with topics dedicated to IPC. In addition, 90 health care managers from different regions were trained remotely on 'Infection prevention and control in the context of COVID-19'.

Focal point for IPC training

As part of the project 'Extension for Community Healthcare Outcomes' (ECHO), the University of New Mexico, together with the US Centers for Disease Control and Prevention (CDC) and WHO, organized 15 global webinars on IPC in the context of COVID-19. Various IPC topics were presented and discussed during the webinar series, to which WHO Country Office has regularly invited IPC experts, faculty of medical institutes and medical workers from Uzbekistan. Furthermore, WHO, in collaboration with the MoH and the Tashkent Institute of Postgraduate Education, is organizing regular IPC trainings for general staff and health managers in all regions to strengthen the knowledge of regional health care staff. By the end of December 2020, health care staff in Andijan, Bukhara, Jizzakh, Kashkadarya, Navoi, Namangan and Samarkand regions and in the Republic of Karakalpakstan had taken part in training on 'Infection prevention and control in the context of COVID-19'.

1,213 health care workers
were trained on 'COVID-19 case management'

90 health care managers
were trained remotely on
'Infection prevention and control
in the context of COVID-19'

PILLAR 7:
Case management

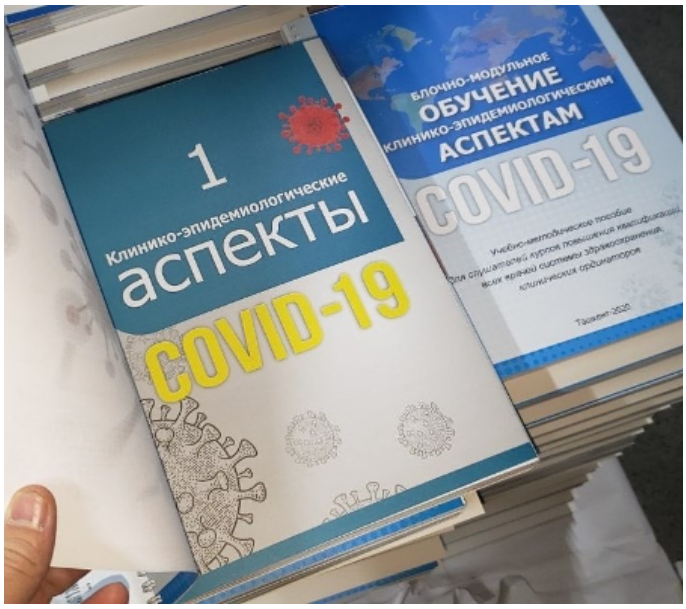
Clinical referral system in place to care for COVID-19 cases

Uzbekistan, as many other countries, applied different treatment options and issued several clinical guidelines for treatment of patients with COVID-19. From the beginning of the outbreak, WHO provided regular support to the Ministry of Health with case management, commenting on draft clinical protocols and guiding the establishment of new standards of patient care. All updated and newly published guidance was shared with the MoH via a national roster of International Health Regulations (IHR) experts, telegram channels and other available mechanisms.

To confront the misinformation and misapplication of WHO guidance, WHO CO worked on a press release against the usage of Remdesivir in the treatment of patients with COVID-19[3].

Nine clinical online sessions were organized by WHO CO and WHO RO for Europe for clinical experts in the country. Following the WHO recommendations on clinical management of patients with COVID-19, a new training programme was developed by the Institute of Postgraduate Medical Education in collaboration with the WHO Regional Office for Europe and WHO Country Office in Uzbekistan. Within the nationalization process of these new treatment protocols and their further integration into national training curricula, a 36-hour training programme for post-graduates with a focus on the management of patients in intensive care units was adopted by the MoH. The training programme provides a system approach to case management, highlights the importance of infection prevention and control for health care practitioners, sets up new standards of care, emphasizes the importance of pandemic preparedness and ethics during the pandemic, and provides best management practices for patients in ICUs. It is anticipated that the programme will be launched in January 2021. Training packages in Russian, Uzbek and English language are being printed now.

Picture 7. Training packages on case management



Percentage of confirmed hospitalized COVID 19 cases who have been discharged

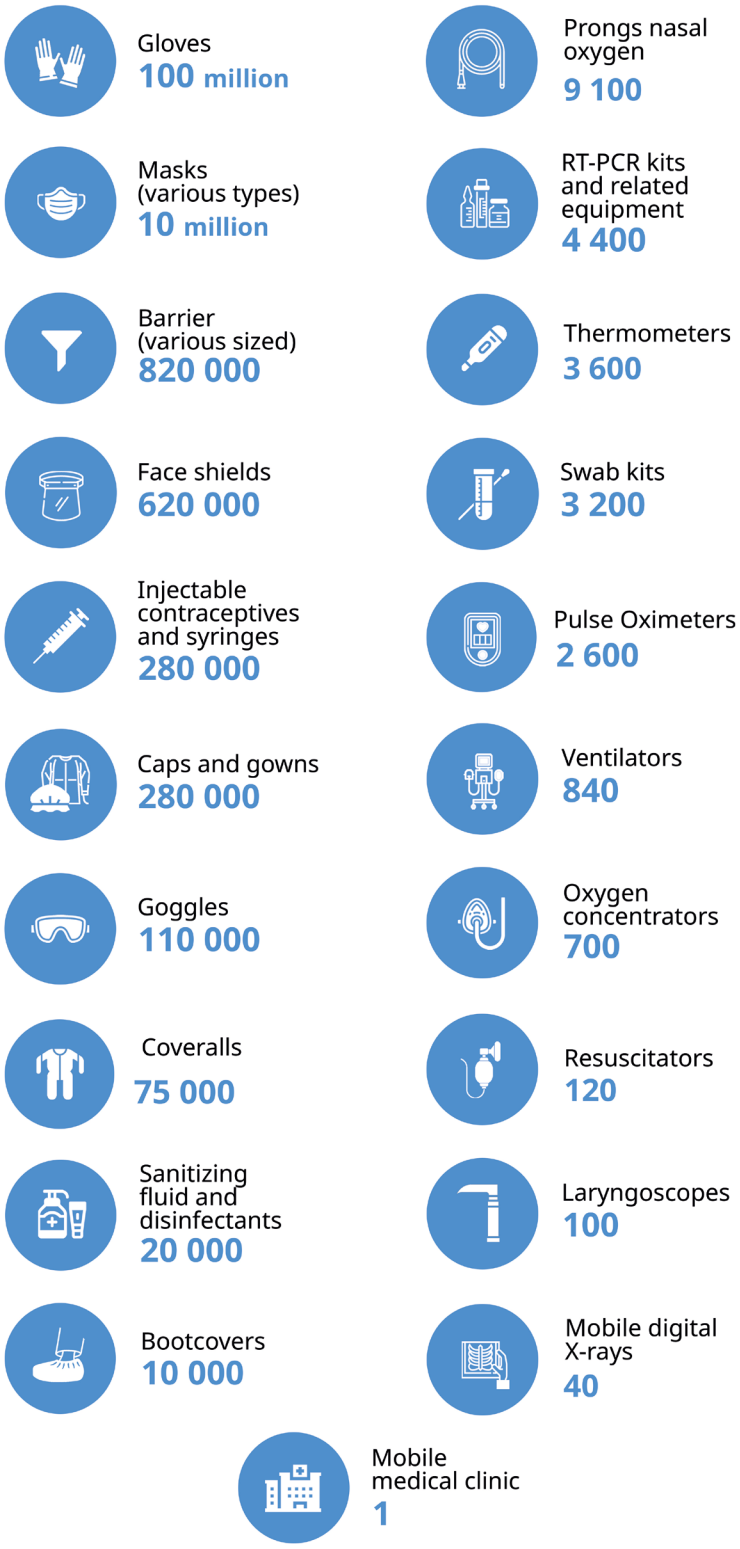
As of 31 December 2020, among the total number of infected patients with COVID-19 (77,126), 75,112 people recovered, representing a recovery rate of 97.4 per cent[4].

3 https://uzbekistan.un.org/ru/102986-gruppa-po-razrabotke-rekomendaciy-voz-ne-rekomenduet-ispolzovat-remdesivir-pri-covid-19

4 https://coronavirus.uz

PILLAR 8:
Operational support and Logistics

Picture 8. Overview of procurement between March and December 2020, through the following agencies and organizations: ADB, UNAIDS, UNDP, UNFPA, UNICEF, UNODC, WHO



As of January 2021, WHO has delivered USD 9.6 million worth of biomedicals, diagnostics, laboratory supplies, personal protective equipment and visibility materials to Uzbekistan[5]. Shipments continue to arrive.

As of October 2020, UNICEF had delivered USD 1.71 million worth of medical equipment, laboratory supplies, personal protective equipment (PPE) and disinfection materials to Uzbekistan.

Since October 2020, UNOPS has been supporting the Government of Uzbekistan with a KOICA-funded project that will eventually channel at least USD 3.5 million in support of the MoH's response to the COVID-19 global pandemic.

5 https://uzbekistan.un.org/en/105345-world-health-organization-delivered-humanitarian-supplies-amount-almost-9-million-republic,

https://uzbekistan.un.org/ru/105345-vsemirnaya-organizaciya-zdravookhraneniya-v-2020-godu-postavila-v-respubliku-uzbekistan

PILLAR 9:
Maintaining essential health services and systems

COVID-19 has seriously affected the health systems of all countries, including Uzbekistan, and underscored the importance of strengthening human resource capacity and national essential health services. These services include prevention and treatment of communicable diseases, immunization, antenatal care, child and adolescent health, non-communicable diseases, mental health, safe health services through implementing triage and infection prevention, ensuring access to PPE in all health institutions, informing the community, and providing timely diagnostics, medicine and vaccines.

DTP3 vaccination coverage in children under 12 months of age

Monitoring the coverage of key childhood vaccination coverage can provide insights on the impact of COVID-19 on the health system's capacity to maintain routine health services.

During the stay-at-home period, DTP1 and DTP3 vaccine implementation decreased, but as the measures were lifted in mid-summer, numbers started to increase. A comparison with figures from the year 2019 indicates that the impact of COVID-19 on DTP has been minimal and the country is on its way to recovering its previous vaccination rates. It should be noted that historically, during the summer months, immunization services are used more intensively due to the geographic conditions of the country. Therefore, the impact of COVID-19 since the spring of 2020 has been small, with a growing trend in doses administered in later months. However, the impact is higher in bigger cities in terms of DTP dose administration (e.g. in Tashkent city, Tashkent region, and Samarkand).

Essential health services during COVID-19

Core essential services to be maintained during the COVID-19 pandemic include:

- Immunization services;
- Reproductive health services including care during pregnancy and childbirth;
- Essential maternal and child health services during COVID-19;
- Essential services for adolescent health and children and adolescents living with HIV
- Vaccine controlled and vaccine preventable diseases

Further activities conducted under the essential health services pillar include:

- Capacity-building for providers of essential health services
- Safe school re-opening

Impact of COVID-19 on general immunization

The preliminary impact of COVID-19 on immunization services in Uzbekistan was assessed by WHO via a mapping exercise in April 2020. At that time, immunization services were undisrupted and remained ongoing, no vaccine stock-outs were reported, and Vaccine Preventable Disease (VPD) surveillance continued. Some immunization staff, at the

national level only, had been repurposed to the COVID-19 response. A systematic analysis of the impact of the pandemic on essential health services showed that, during the stay-home period, DTP1 and DTP3 vaccine implementation decreased, but as the measures lifted in mid-summer the numbers started to increase. Comparison of figures from year 2019 indicate that the impact of Covid-19 on DTP has been minimal and the country is on its way to recovery.

Uzbekistan officially recorded its first case of COVID-19 in March 2020 and stay-at-home measures were promptly introduced. COVID-19 case progression was relatively low in Uzbekistan in the beginning, which meant that health service provision continued with minimal disruption. COVID-caseloads peaked from June 2020 onwards, particularly in the southern regions of the country where population density is high. In cities and regions such as Tashkent, Bukhara and Samarkand, some health service provision point operations were suspended. This coincided with an increase in vaccine demands as the weather improved (the majority of vaccine administration happens in summer months). As a result, immunization services had to be mobilized and a significant portion of immunization sessions were conducted in communities as opposed to health centres. For example, in Tashkent, out of 68 service points, 30 were closed, which meant that immunization sessions had to be organized directly in community. Community level immunization services were also provided in Bukhara, Kagan, and Karakul districts.

COVID-19 also had an impact on the human resources of health services. Many qualified personnel were assigned to the COVID-19 response, which led to untrained health personnel being assigned to immunization service provision. Some HSS and other The Vaccine Alliance (GAVI) funding was reprogrammed for UNICEF to procure much-needed PPE for service providers, particularly for immunization sessions at the community level. PPE procurement was completed in June, and immunization services were subsequently performed at large scale, either at the community level or in health service points that had not been suspended. As a result of these efforts, immunization coverage remained high.

UNICEF provided extensive support to ASEW to plan delivery, actively negotiate a delivery plan with the UNICEF Supply Division (SD) and calculate cold chain capacity to avoid overloading. All vaccines arrived in the country safely and were stored in appropriate conditions. During the summer period, the country received an annual stock of almost all vaccines.

In terms of vaccine stocks, the major issue has been transportation. Some vaccine arrivals were delayed due to COVID-19 and the discontinuation of international flights. From May 2020, however, vaccines started to arrive. Major delays were experienced particularly for Hep B and Measles, Mumps, and Rubella (MMR). For the Hep B vaccine, the Expanded Programme on Immunization (EPI) reallocated vaccines between regions as needed to ensure availability. Pneumococcal conjugate vaccine (PCV) arrived in November. Adequate vaccine stocks in the country ensured that no programme interruptions occurred.

Reproductive health services including care during pregnancy and childbirth

The Interim National Clinical Guideline for the Management of COVID-19 in Pregnancy, Delivery and the Postpartum Period (two editions) was developed with technical support from WHO CO and UNFPA including three training modules in Uzbek, Russian and Karakalpak. The guideline was printed in Russian (2,000 copies) and Uzbek (8,000 copies) and disseminated among national providers by UNFPA. On 26 May, a national webinar was conducted, led by the MoH and WHO, with about 35 participants.

The National Guideline on Managing COVID-19 in Children was developed, including five training modules in Uzbek, Russian and Karakalpak by local experts with the assistance of WHO Country Office and based on WHO recommendations. The guideline was printed by WHO (300 copies) and UNICEF (300 copies). On 24 April and 6 May 2020, two national webinars were conducted for national specialists and for the Capacity-Building Group with about 150 participants in total.

Essential maternal and child health services during COVID-19

To ensure essential maternal and child health service, UNICEF procured and distributed PPE (masks, gloves, etc.) for 4,000 health providers in four perinatal and pediatric hospitals.

In order to better respond to COVID-19 and build health care facilities (HCFs) back better, UNICEF is working with the MoH to conduct a self-assessment on WASH in HCFs to understand the current WASH situation in maternity hospitals, pediatric centres and primary health care facilities. The preliminary results show that most district level HCFs and PHC level facilities do not meet basic requirements for WASH or for IPC.

The second edition of the national guideline on 'Management of children with COVID-19' has been drafted and is currently in the MoH approval process. WHO CO will further support the National Working Group with the printing and publishing of about 2,500 copies in Uzbek and Russian.

Essential services for adolescent health and children and adolescents living with HIV

UNICEF developed key messages for children and adolescents living with HIV based on WHO's Q&A on COVID-19, HIV and antiretrovirals, and disseminated these materials via social media. UNICEF disseminated recommendations for adolescents and young people (including adolescents living with HIV) to promote good mental health and community support.

Vaccine controlled and preventable diseases

During the 2019-2020 influenza season, the country had stopped testing for influenza or reporting influenza data to the joint WHO-ECDC electronic platform (TESSY). Publication of the influenza bulletin as well as WHO recognition of the National Influenza Center (NIC) are still suspended.

During the stay-at-home period, vaccine administration decreased, but as measures were lifted in mid-summer, numbers started to increase. Similar trends in measles and rubella (MR) and acute flaccid paralysis (AFP) case surveillance have been observed and case reporting increased in the summer months for MR and AFP.

Measles surveillance data is available from the national case-based surveillance system. Uzbekistan also presents annual updates on the status of measles and rubella elimination to the European regional commission

for certification, and reports case-based information to the European Centralized Information System for Infectious Diseases (CISID).

Surveillance sensitivity and geographic representativeness is well beyond the targets (see table below), predominantly due to a low rate of suspected cases within specimens collected for laboratory investigation. Laboratory investigation of suspected measles and rubella cases is performed in the only national laboratory accredited by WHO, in Tashkent.

Measles surveillance sensitivity and representativeness

Surveillance sensitivity*

2015	**0.11**
2016	**0.25**
2017	**0.5**
2018	**0.4**
2019	**1.05**

Geographic representativeness**

2015	**0.0**
2016	**0.0**
2017	**0.0**
2018	**7.1%**
2019	**14.3%**

* Rate of discarded cases: The rate of suspected measles or rubella cases investigated and discarded as non-measles or non-rubella cases using laboratory testing in a proficient laboratory and/or epidemiological linkage to another confirmed disease. (Target >2/100 000 population)

** Representativeness of reporting discarded cases: Percentage of subnational administrative territories (e.g. at the province level or its administrative equivalent) reporting the rate of discarded cases >2/100 000 population per year. Target >80%)

During the first and second quarter of 2020, the case-based MR surveillance system detected a relative increase in measles cases in all regions of Uzbekistan. However, there was a marked decrease in the rate of case confirmation using laboratory or epidemiological linkage. Increased reliance on clinical case confirmation suggests reduced capacity of the surveillance system to conduct high-quality case investigation. In response to this outbreak, in June 2020, Uzbekistan conducted nationwide supplemental immunization activities (SIA) with mono MCV (Measles containing vaccine). Thanks to this and also as a positive side effect of the enhanced hygienic measures and closure of all public childcare institutions, the number of measles cases in the third and fourth quarters significantly decreased.

Capacity-building for providers of essential health services

To improve the quality of online training and distance learning for health care providers of essential maternal, newborn and child health services including immunization during and after COVID-19, UNICEF has procured and installed 51 sets of web-conferencing equipment for national and regional perinatal, pediatric and sanitary-epidemiological service centres. These health care facilities are connected to a network for online cooperation and virtual learning during and after COVID-19. It is expected that online training on COVID-19 management and control will provide equitable, convenient and effective access to standardized, up-to-date information on best practices, and fill the gaps in the current training resources. At least 1,500 health professionals across the country will be able to access online training for free by the end of 2020.

UNICEF also distributed 22 tablets to 13 primary health care facilities in Tashkent, Khorezm and Surkhhadarya to ensure that health care providers can participate in distance learning and supervision activities. UNICEF is advocating and providing the Government with technical support for the development of a nutrition strategy and action plan.

UNICEF has equipped training rooms with web-conferencing equipment and broadband internet connection in Kungrad, Beruniy, Nukus city, and in the Karakalpak Republican Perinatal Centers and Karakalpak Medical Institute. This will enhance their capacity for uninterrupted in-service professional development of the healthcare workforce, and online cooperation with other medical facilities in the region. It is expected that at least 200 health professionals will benefit from these training resources by the end of 2020. By the end of October, 60 healthcare workers improved their skills on supportive supervision of perinatal services and perinatal audit. Broadband internet connection and HD web cameras allow national trainers to routinely hold consultations with target facilities as part of a supportive supervision process.

Safe school re-opening

UNICEF, jointly with WHO and the IFRC, has been supporting the Government to address a variety of areas. Support was given to the Ministries of Health and Public Education to support safe school operations, firstly through the development of safe school guidelines, and secondly by analyzing WASH data to identify the gaps in WASH infrastructure in the country and help schools plan for how to compensating for them. UNICEF and WHO supported the Government to develop national health regulations and guidelines on safe school operations to equip children and staff with health messaging about COVID-19, prepare staff in schools for re-opening, and to quickly respond to evolving health and safety requirements.

A guideline on safe schools re-opening has been developed in consultation with experts from both the health and education sectors. There are around 9,800 general secondary schools in Uzbekistan. UNICEF has supported the Government to print around 20,000 copies of the guidelines on safe school operations in Russian and Uzbek for distribution among administrative, pedagogical and technical staff. UNICEF and WHO supported the Government to develop a range of posters in Uzbek, Russian and Karakalpak to accompany the guidelines.

PILLAR 10:
Vaccination

As COVID-19 vaccines receive approval through WHO PQ process (and/or EUL) and national regulatory authorities, countries will need to be prepared for their introduction and deployment. This is a complex process involving early planning, regulation, communications, training, logistics, legal, infrastructure, operations and other areas which must be reviewed and prepared to ensure successful and timely distribution of vaccines. This process should be based on WHO fair and equitable access and allocation framework and following guidance issued by WHO Strategic Advisory Group of Experts on Immunization (SAGE).

Countries are recommended to develop end-to end national immunizations plans based on readiness assessment tools (VIRAT/VRAF 2.0) to monitor the progress on implementing the national deployment and vaccination plan (NDVP) for COVID-19. These documents help structure the process to be prepared to introduce a COVID-19 vaccine(s) into their national immunization programme, and to monitor, manage and communicate safety issues, once available and approved for use. This preparation process will include technical assistance from WHO in order to ensure a safe, secure, and effective deployment.

Successful implementation of mass vaccination campaigns is challenging in fragile settings and coverage, as has been seen with other antigens in many emergency settings, may be less than optimal. Large scale programmes and funding bring important opportunities but also risks of further fragmenting health systems.

The phases and actions outlined below are adapted from the COVID-19 vaccine introduction readiness assessment tool, referred to as the VIRAT/VRAF 2.0, and the NDVP guidance document to support countries in their vaccine planning and implementation processes.

National action plan priorities

Phase 1: Coordinate and plan vaccine introduction

- Establish a National Coordinating Committee (NCC) (or engage an existing committee) for COVID-19 vaccine introduction with terms of reference, roles and responsibilities and regular meetings, including relevant sub technical working groups.

- Develop a National Deployment and Vaccination Plan (NDVP) with inputs from relevant bodies and in line with WHO guidance and SAGE recommendations, including COVID-19 vaccine program costs (vaccine and supplies, operating costs, HR and capital costs).

- Identify and plan a national vaccine access/ procurement approach (e.g., COVAX Facility, bilateral purchase agreement, procurement through UN agency, self-procurement), ensuring that the procurement plan and purchasing strategy includes vaccines, ancillary supplies, and Personal Protective Equipment (PPE).

- Review epidemiological data and define target populations that will be prioritized for access to vaccines, estimate their numbers, and develop a delivery strategy for reaching these populations. Ensure that the data related with underlying health conditions are captured in the health information system to help planning the vaccination for pop. at risk for severe COVID-19.

- Support the adoption of efficient and expedited regulatory pathways for approval and regulatory oversight of COVID-19 vaccines (i.e., emergency use authorization, exceptional approval/ approval mechanism based on reliance/ recognition, abbreviated procedure, fast track, etc.), including risk-based pharmacovigilance and post marketing surveillance of products.

- Assess required logistic procedures as well as dry storage and cold chain capacity and infrastructure needs at all levels with regards to the COVID-19 vaccines characteristics and develop a plan to fill the identified supply and logistics gaps.

- Review and address specific training requirements of the involved staff for vaccination and reporting events.

- Ensure any necessary policies or mechanisms (including legislation) are updated or in place to enable the indemnification of vaccine manufacturers against any losses they may incur from the deployment and use of COVID-19 vaccines.

- Establish compensation schemes if there are unintended health consequences as result of vaccines, including no-fault liability funds, and ensure that associated policies are in place.

- Brief key ministries, National Immunization Technical Advisory Groups (NITAG), stakeholders and partners about COVID-19 vaccine introduction and their expected roles. Inform regularly & disseminate global and regional guidance (i.e., SAGE) with NITAGs and Regional Immunization Technical Advisory Groups (RITAG) and support NITAG working groups on COVID-19 vaccines.

- Ensure NITAG and associated working groups, or the equivalent, are established and resourced to enable a policy recommendation/advice on the use of COVID-19 vaccines.

- Ensure a safety coordinating committee is in place.

- Include COVID vaccine program costs (vaccine, operating costs, HR and capital costs) in government budgetary and/ or planning documents approved by the appropriate authority; in addition, include appropriation or allocation (from Ministry of Finance or Ministry of Treasury) in the cash planning as an additional means to ensure that financing is indeed readily available.

Phase 1: In FCV and humanitarian settings:

- Agree context-specific vaccination strategies in fragile settings – including appropriately prioritized/sequenced public health goals (for example, protecting health workers and vulnerable groups) and potential wider goals/impact (for example enabling lifting of social/economic restrictions)

- Identify and reach high-risk individuals, the elderly, those with exacerbating underlying conditions, and health care workers (in private and public sectors), including in areas not under government control, as well as those in areas under government control who may be excluded or not covered by the public health system (e.g., detainees, migrants and refugees, and stigmatized populations

- Prioritize available vaccine stocks appropriately, globally and within countries, based on risks and vulnerabilities so that populations are reached progressively on basis of need.

Phase 2: Ensure regulatory preparedness

- Approval, importation, and release.

  Ensure the national regulatory authority or other concerned authority has clarified the regulatory requirements, and documents needed for regulatory approvals of COVID-19 vaccines and related supplies.

- Ensure that regulatory procedures are in place for import permit of COVID-19 vaccines and related supplies, and identify the requirements and documents needed to import COVID-19 vaccines and related supplies, including for taxes and tariffs.

- Confirm to WHO the existence of an expedited import approval from appropriate authorities. Timelines and maximum number of days should be mentioned. (expected timeline: maximum 5 working days.

- Ensure COVID-19 vaccines can be released (lot release) in less than two days by reviewing the summary lot protocol only (testing is not required). Identify the requirements and documents needed for national regulatory authority (NRA) lot release for COVID-19 vaccines. Timelines and maximum number of days for lot release/waiver process should be mentioned.

Phase 2: Optimize service delivery

- Update protocols for infection prevention and control measures including adequate personal protection equipment to minimize exposure risk during immunization sessions.

- Identify potential COVID-19 vaccine delivery strategies and outreach strategies leveraging both vaccination platforms and non-vaccination delivery approaches to best reach identified target group.

- Ensure vaccination supports re-establishment of other essential health services, without excessively diverting resources such that services are further disrupted.

Phase 2: Plan training and supervision

- Develop a training plan at all levels to prepare for COVID-19 vaccine introduction, including adaptation of training materials, and identification of key training partners and training methods (in-person or virtual).

- Ensure availability of plans to safeguard the security of staff (e.g., during an emergency or major campaign) as well as security at the central and/or regional storage facilities and for transit of products.

  Adapt supportive supervision tools and develop plans for visits at all levels.

- Conduct one of the published COVID-19 vaccine table top simulation exercises to test and enhance the planning assumptions of the NDVP in WHO course on Simulation Exercise Management.

Phase 2: Put in place monitoring and evaluation systems

- Develop or adapt existing surveillance and monitoring frameworks with a set of recommended indicators (coverage, acceptability, disease surveillance, etc.) for COVID-19 vaccine, including gathering information from facilities and contractors participating in vaccine delivery, and ensuring necessary human resource capacity is in place.

- Develop or adapt necessary paper-based and/or electronic monitoring tools and appropriate institutional arrangements (e.g., vaccination cards/certificates, facility-based nominal registers, etc.) to monitor progress and coverage among different at-risk categories and facilitate vaccine delivery and timely reporting.

- Produce and distribute monitoring tools to eligible vaccination providers, develop, test and roll-out any changes to electronic systems, provide training for use of these tools and processes to traditional and new providers.

Phase 2: Prepare cold chain, logistics & infrastructure

- Update and implement systems and protocols for tracking and monitoring the stock management and distribution of vaccines and key supplies through the Government's existing Vaccine Logistics Management and Information System (VLMIS), including operating procedures to reflect the characteristics of COVID-19 vaccines (i.e., vial size, vaccine vial monitor (VVM), etc.)

- Create a distribution strategy, including mapping the potential port(s) of entry, points of storage (stores) and stocking, and fallback facilities in the country with their respective cold chain storage (2-8C, -20C, -60/70C) and transportation capacity for vaccines and ancillary products, and ensure necessary human resource capacity is in place.

- Map and develop plan to provide for infrastructure needs, including for energy (primary and back-up power, especially in cold chain), information technology/ communications (including internet connectivity) and water.
- Plan and procure waste management supplies and equipment for appropriate implementation of waste management protocols.

Phase 2: Establish or reinforce vaccine safety surveillance systems

- Ensure guidelines, documented procedures and tools for planning and conducting vaccine pharmacovigilance activities (i.e., adverse events following immunization (AEFI) reporting, investigation, causality assessment, risk communication and response), have been developed and disseminated to surveillance facilities/sites.
- Establish the reporting forms and procedures among the EPI and NRA to share safety information and decision making.
- Stimulate and focus passive surveillance on groups and events according to available safety information (consider risk management plans).
- Plan active surveillance of specific COVID-19 vaccine related adverse events. If this is not possible, develop provisions that allow reliance on active surveillance data, decisions, and information from other countries or regional or international bodies.
- Expedite appropriate representation, well defined terms of reference and training the AEFI committee to review COVID-19 Vaccine safety data (e.g., causality assessment of serious AEFI, clusters of AEFI, emerging safety concerns, etc.).
- Identify provisions that require manufacturers to implement risk management plans and collect and report COVID-19 vaccine safety data to the NRA.
- Define roles and responsibilities and establish a coordination mechanism between relevant stakeholders (NRA, Expanded Programme on Immunization (EPI), MAH, Ministry of Health, WHO and others) for exchange of COVID-19 Vaccine safety information, including relevant data systems and information flow.
- Identify and secure channels of data sharing mechanisms to share COVID-19 vaccine safety data and findings with relevant regional and international partners.

Phase 2: Manage demand and engage communities

- Design and distribute a social mobilization and engagement strategy/demand plan and information awareness program (including advocacy, communications, social mobilization, risk and safety comms, community engagement, and training) to generate confidence, acceptance, and demand for COVID-19 vaccines.
- Engage healthcare workers as a strong part of the solution with their triple role of vaccine receivers, vaccine providers and influencers of people's vaccine acceptance and uptake.
- Evaluate anti vaccination feelings and strength of infodemic in population and communicate appropriately to counter impact of both.
- Develop key messages and materials for public communications and advocacy, in alignment with demand plan.
- Address vaccine hesitancy, misinformation, and other demand-side issues.

Phase 3: Initiate and evaluate vaccine deployment process

- Continue monitoring of vaccine implementation, including coverage and data monitoring.
- Ensure post-market surveillance studies are operational and ongoing, including reporting of temperature excursions that may occurred as well as quality or safety deviations if found.
- Update the National Deployment and Vaccination Plan (NDVP) or similar strategy document with input from relevant bodies and in line with WHO guidance and SAGE recommendations, incorporating new information vaccine profiles, etc.
- Conduct post-introduction evaluation (PIE) 6 months following introduction.
- Conduct an Intra-Action Review (IAR) for vaccination during the COVID-19 response for course correction and improvement.

Global and regional support

Support to ongoing national action plans

- The COVID-19 Intra-Action Review (IAR), which was developed to guide countries to conduct periodic reviews of their national and subnational COVID-19 response, will be adapted to include vaccination.

- The Vaccine Readiness Assessment Tool (VIRAT) has been developed with support from WHO and UNICEF Country Offices for use by Ministries of Health, and enables countries to monitor their own readiness against key criteria. In November 2020, the WHO Vaccine Country Readiness and Delivery workstream released guidance on developing a national deployment and vaccination plan (NDVP) for COVID-19 vaccines. This guidance is intended to help countries develop their detailed plan for COVID-19 vaccine introduction. A key portfolio of trainings, briefs and simulation exercise is available from OpenWHO to help country programs and health care workers in the preparation for vaccine roll-out. In 2021 this intensive planning will be put into action in countries through direct technical support, coordination of the large partnership, monitoring, evaluation, and revision of the normative guidance and tools as adjustments are needed.

Support to accelerate equitable access to new COVID tools

- WHO's Strategic Advisory Group of Experts on Immunization (SAGE) will continue to review all available information on vaccine candidates that have reported phase 3 data. On the basis of these deliberations SAGE will formulate policy recommendations on how these vaccines can be best deployed in different contexts, and the steps that must be taken to ensure we are able to follow-up with the recipients of all new vaccines in order to better understand safety and long-term efficacy, and the impact that different vaccines might have on the dynamics of transmission, and therefore on the effectiveness of other public health and social measures.

Research and innovation priorities

- The Solidarity Vaccine Trial will be launched in 2021 and holds the promise to ensure that as many of the 200 vaccine candidates still in development have the best chance of success. Its aims is to evaluate efficiently and rapidly (within 3–6 months of each vaccine's introduction into the study) the efficacy of multiple vaccines, helping to ensure that weakly effective vaccines are not deployed. High enrolment rates facilitated by flexible trial design and hundreds of study sites in high-incidence locations will yield results on short-term efficacy for each vaccine within just a few months of including that vaccine. Preparations are complete to initiate the trial in two countries in at least 15 trial sites with an anticipated enrolment rate of 200 patients per site per week.

- WHO is leading normative guidance on research and development, including target product profiles for vaccines, defining animal models and lab assays, core protocols for clinical trials, maintaining a landscape document of all vaccines in development, and convening manufacturers and experts to guide vaccine development.

Relevant guidance documents:

- Welcome WHO page to ACT-Accelerator partnership
- Welcome WHO page to COVID-19 vaccine country readiness and delivery
- COVID-19 Vaccine Introduction Readiness Assessment Tool
- Behavioral considerations for acceptance and uptake of COVID-19 vaccines
- Guidance on developing a national deployment and vaccination plan (NDVP) for COVID-19 vaccines
- COVID-19 vaccine introduction readiness assessment tool
- Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines

CROSS-CUTTING ISSUES AND PRIORITIES FOR 2021

Intra-Action Review (IAR)

Uzbekistan is one of the first countries in Central Asia to have conducted an Intra-Action Review (IAR), lead by the Robert Koch Institute (Germany) and WHO Regional Office for Europe and its Country Office in Uzbekistan. The IAR emphasized the importance of continuing national and international support focused on enhancing human resources (in Public Health, laboratory and infectious diseases) and ensuring the use of real-time monitoring tools to support the management of Public Health Essential Operations and Health Care Capacity.

International Health regulations (IHR) and Joint External Evaluation (JEE)

Under the International Health Regulations (IHR) and due to the declaration of COVID-19 as a Public Health Event of International Concern, the Republic of Uzbekistan has put in place extensive mechanisms to prevent, detect and respond to the pandemic. The Government has made enormous efforts to ensure the sustainability of the health system and the recovery of society, focusing on adequate public health and social measures. Throughout the ongoing pandemic and its socio-economic impact, there is an evident need to reinforce human capacity to detect new cases, test suspected and exposed cases, trace contacts and ensure the adequate treatment of vulnerable patients, reducing the time for people who have recovered to reintegrate back into society.

Despite the pandemic, the country submitted its State Party Annual Reporting to WHO (e-spar) in October 2020 and is preparing for Joint External Evaluation (JEE) of the implementation in 2021. As of January 2021, the JEE working group on self-assessment has conducted three working group meetings and discussed progress and gaps. This will allow for the systematic assessment of all aspects of emergency preparedness and response and will result in a National Action Plan on preparedness and response, aimed at enhancing national health system capacity and the overall management of health services.

Priorities for 2021

Health Supply Chain assessment

An assessment of the Health Supply Chain was conducted jointly with WHO, UNICEF and UNFPA. It is expected to identify performance and capacity gaps, and develop an action plan for strengthening the procurement and supply system considering the current pressure on supply chains.

COVID-19 vaccine

WHO and UNICEF are providing support and technical assistance to the MoH regarding the country's readiness for the roll-out of a COVID-vaccine. This includes assessing cold chain infrastructure needs, community engagement gaps and other requirements for the successful roll-out of COVID-tools, including vaccines. As per recommendations of the WHO, in December 2020, the country established a National Technical Working group for the introduction of the COVID-vaccine and submitted its vaccine application form to COVAX. As per the Roadmap of the SAGE (Strategic Advisory Group of Experts on immunization) Uzbekistan decided tovaccinate 20 per cent of its population in 2021.

Software for data collection, analysis and presentation

WHO does not endorse the use of any specific software for controlling COVID-19 but rather offers available technical solutions to countries for their consideration and provides technical support for existing in-country platforms whenever possible. The COVID-19 (or any other information) system may include tools for data collection, data analysis and data presentation (dashboard). In general, these tools can be implemented as part of the same software or independently as different software programs. For the latter, it is recommended to have proper integration between the tools to assure a more valid, timely and effective information system.

In April 2020, WHO Country Office conducted a review of two existing pieces of software and provided recommendations for potential use in Uzbekistan as per a request from the Minister of Health. These pieces of software were ESRI ArcGIS and DHIS2. The details of the tools are as follows:

• ArcGIS is now widely used by several organizations including the WHO HQ, some regional offices and John Hopkins University. It is mainly used for data presentation and some data analysis. The following provide links to some examples of dashboards and tools:

• WHO Novel Coronavirus Situation Dashboard: https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd

• Center for Systems Science and Engineering (CSSE) by John Hopkins University: https://coronavirus.jhu.edu/map.html

• COVID Outbreak in Italy - World Food Program Emergency Division: http://unwfp.maps.arcgis.com/apps/opsdashboard/index.html#/4f74fc222b7041cd9cc3c52e62af1b8c

• COVID-19 in Republic Moldova: http://gismoldova.maps.arcgis.com/apps/opsdashboard/index.html#/d274da857ed345efa66e1fbc959b021b

• UN ECA Outbreak Status Map for Africa: https://ecageoinfo.maps.arcgis.com /apps/opsdashboard/index.html#/b959be51c0014845ad44142bce1b68fe

• ArcGIS has a compact data presentation tool (dashboard). If Uzbekistan is interested only in data presentation, then this can provide a solution. The template for ArcGIS Hub Coronavirus Response is provided by ESRI at no cost, but free access to ArcGIS online is provided only for six months. It is not clear if ESRI offers free of charge technical support for implementation, capacity building and maintenance so some additional costs should be considered.

• The DHIS2 (District Health Information Software 2) tool has been developed by a team from Oslo University (a Collaborative Center for WHO). The tool is mainly designed for collecting and reporting data (both individual and aggregate) with the possibility of implementation at all levels (from primary health care to central) or at a limited number of levels depending on the country's choice. It also has a presentation tool and some analysis tools. It can be implemented only forinternal use with predefined access measures at each level. More than ten countries have been using it. The following provides a quick demonstration link - https://covid.dhis2.org/

(registration is needed first to be able to view it). The offer for this tool includes free of charge software, implementation at all levels and capacity-building.

If Uzbekistan is interested in a data collection, reporting and presentation system at no cost, this could be a good solution. An additional advantage for DHIS2 for Uzbekistan is that there are plans to use this tool for a Tuberculosis information system in the future, so investment in COVID-19 will contribute to the strengthening of HIS in general.

WASH and Maternal, Newborn and Child Health (MNCH)

Urgent actions are required to incorporate WASH into the national COVID-19 response and funding plans and satisfy the immediate need for hygiene products, disinfectants and PPE for all facilities providing essential maternal, newborn and child health (MNCH) care. Median actions are to include WASH into the health care budget as a separate budget line of health facilities, to support the MoH to develop a WASH monitoring system and a continuous improvement plan by using the WHO/UNICEF WASH FIT tool. Long-term actions are to support intersectoral cooperation to improve WASH in HCFs, support the Government to plan financial and human resources for cross-sectoral WASH improvement activities and to develop and implement a quality health care framework that includes accountability mechanisms and engaging communities to demand quality health care.

Sixth Meeting of the Emergency Committee

On 14 January 2021, the sixth meeting of the Emergency Committee convened by the WHO Director-General under International Health Regulations (2005) (IHR) regarding the coronavirus disease (COVID-19) took place in WHO HQ in Geneva. The recommendations of the Emergency Committee, which are now available in all UN languages[6] were shared with the national roster of experts in the Ministry of Health.

The following recommendations were issued for State Parties:

1. SARS-CoV-2 Variants

Increase molecular testing and genetic sequencing, and share sequences and meta-data with WHO and through publicly accessible databases to enhance global understanding of the virus' evolution and to inform response efforts.

Support coordinated global research efforts to better understand critical unknowns about SARS-CoV-2 specific mutations and variants.

2. COVID-19 Vaccines

Engage in technology transfer to accelerate global production and deployment of COVID-19 vaccines and ancillary supplies. Prepare for COVID-19 vaccine introduction and post-introduction evaluation using guidance, tools, and trainings for national/subnational focal points and health workers developed by the Access to COVID-19 Tools (ACT) Accelerator's Country Readiness and Delivery workstream.

As necessary and appropriate, incorporate the private sector into COVID-19 vaccine planning and introduction to supplement existing service provision and vaccination capacity.

Encourage and facilitate vaccine acceptance and uptake by providing credible information on vaccine safety and the benefits of vaccination to address concerns.

3. Health Measures in Relation to International Traffic

At the present time, do not introduce requirements of proof of vaccination or immunity for international travel as a condition of entry as there are still critical unknowns regarding the efficacy of vaccination in reducing transmission and limited availability of vaccines. Proof of vaccination should not exempt international travelers from complying with other travel risk reduction measures.

Implement coordinated, time-limited, risk-based, and evidence-based approaches for health measures in relation to international traffic in line with WHO guidance and IHR provisions. Careful consideration should be given to when and if travel bans should or should not be used as tools to reduce spread. Such decisions should be based on the best available evidence.

Share information with WHO on the effects of health measures in minimizing transmission of SARS-CoV-2 during international travel to inform WHO's development of evidence-based guidance.

4. Evidence-Based Response Strategies

Refine evidence-based strategies according to WHO guidance to control the spread of SARS-CoV-2 using appropriate public health and social measures, including strategies that address pandemic fatigue.

5. Surveillance

Increase investment in surveillance and sequencing capacities to detect and report early emergence of variants and assess abrupt changes in transmission or disease severity to increase understanding of the evolution of the pandemic.
Utilize the WHO SARS-CoV-2 global laboratory network, leverage the Global Influenza Surveillance and Response System (GISRS) and other laboratory networks for timely reporting and sharing of samples; support other State Parties, where needed, for timely sequencing of SARS-CoV-2 virus specimens.

6. Strengthening Health Systems

Continue to strengthen public health infrastructure, system capacities, and functions for COVID-19 response and to enhance universal health coverage.

6 https://www.who.int/news/item/15-01-2021-statement-on-the-sixth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic

COVID-19
National Strategic Preparedness & Response Plan for Health
2020 report

Uzbekistan
2020