2.11 Health service continuity and case management

Experience from past epidemics shows that disruptions in health care systems result in a significant number of indirect deaths. For example, during the 2014–2016 Ebola epidemic in West Africa, more deaths were attributed to disruptions in malaria, tuberculosis (TB), HIV, maternal and child health (MCH) services than from Ebola infection. Significant disruptions in health care services have also been observed and predicted in the current pandemic. To better understand the extent of disruptions to essential health services caused by the COVID-19 pandemic, in early 2021, WHO launched the second round of the National pulse survey on continuity of essential health services during the COVID-19 pandemic. The findings showed that health services remained interrupted in 37 countries, even when virus infection numbers were waning. The survey also provided critical insight from country key informants into the extent of the impact of the COVID-19 pandemic on essential health services across the life course, the reasons for those disruptions, and how countries continuously adapt strategies and approaches to maintain service delivery.

FIGURE 12: Evolution of reasons for service disruptions from 2020 to March 2021

Disruptions due to insufficient staff availability

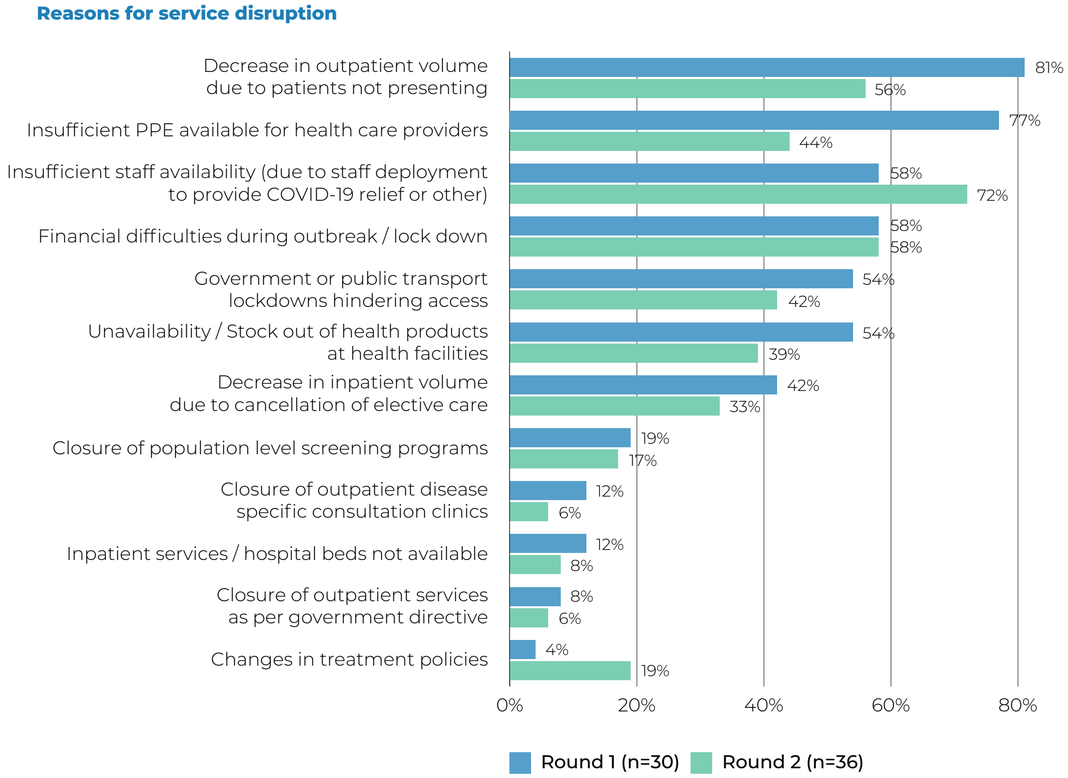
have increased from 58% to 72% of countries since 2020

Disruptions due to insufficient availability and stocks of PPE and other health products

have decreased substantially (77 to 44%)

No change in the number of countries reporting financial difficulties

to access to services during the COVID-19 pandemic (58%)



Note: *represents global findings from all countries that participated in either rounds 1 or 2 of survey*
Denominator: *does not include "Not applicable" or "Do not know" responses.*

Based on various levels of implementation of non-pharmaceutical intervention measures, Africa's early response to the COVID-19 pandemic saved lives. However, the measures restricting social contact and movement of people – several of which had been interrupted at the time of writing this report –, as well as the fear of visiting health care facilities, greatly affected health care services for non-COVID-19 conditions. In addition to reallocation of resources such as health care personnel and diagnostic equipment to effectively combat the pandemic, shortage of medical supplies arising from disruption in supply chains further compounded the impact of COVID-19 on the treatment of other health conditions. As Africa settled into the reality of a protracted COVID-19 situation, several outbreaks of other diseases such as EVD, typhoid, cholera, and pneumonic plague also occurred.

FIGURE 13: Strategies to restore and adapt service delivery

More than half countries

report using community communications (64%) and staff recruitment (53%) to overcome service disruptions

42% of countries

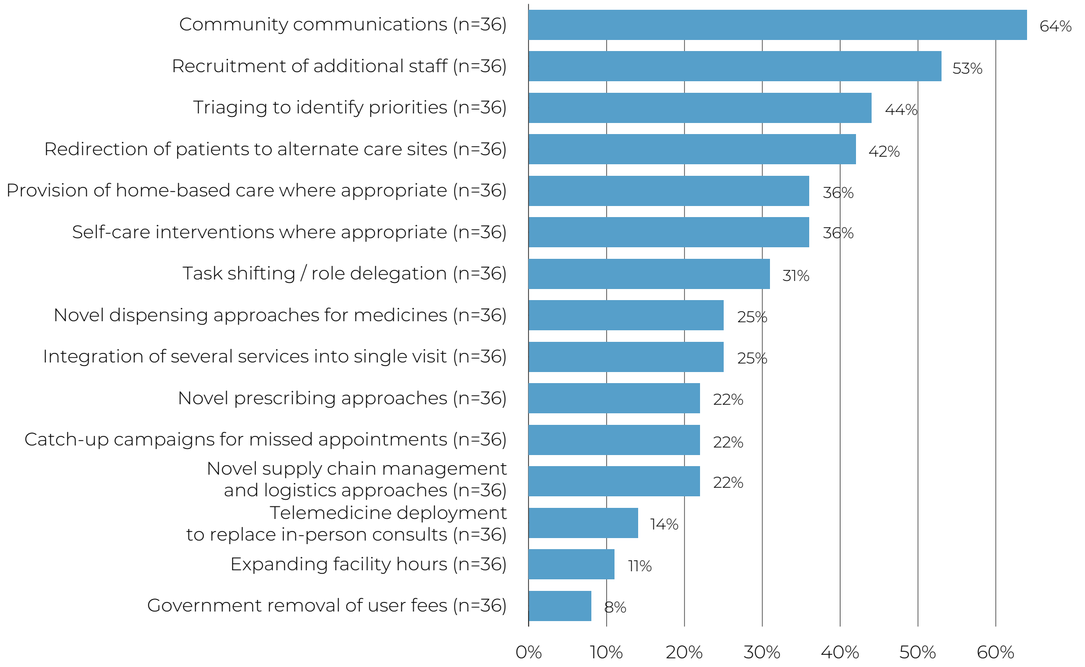
have redirected patients to alternative care sites

36% of countries

have provided home-based care where appropriate

22% of countries

have conducted campaigns for measles to catch up



Denominator: *does not include "Not applicable" or "Do not know" responses. Working draft for internal use –onolyt for circulation*

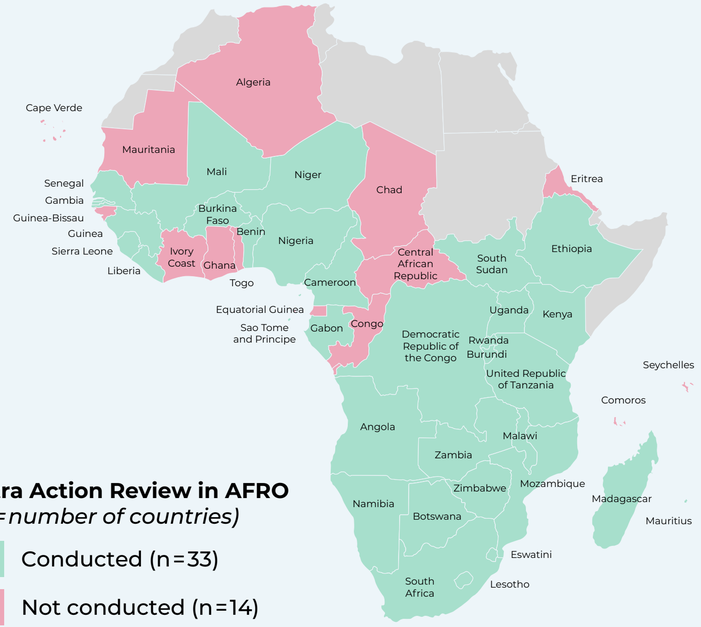
The most serious impediment to any plausible solution to tackle the crisis is the key issue of the chronic shortage of qualified personnel. Across the continent, at any given time, hospitals are short of qualified staff by at least 60%. In many countries, health practitioners live a constant cycle of playing catch-up. COVID-19 has thrown into stark relief the challenges of achieving health security on the continent and reliance on alternative and home-based care as a solution to overcome service disruptions. However, at the end of the reporting period, disruptions persist, even if countries have largely reopened their economies.

"Sweden remains committed to supporting the UN system and WHO to address this pandemic through a well-coordinated, innovative and effective COVID-19 response in the African Region. In particular, to mitigate the impact on essential health services, including sexual and reproductive health services. Through guidance and the promotion of cross-country exchange on self-care SRHR guidelines for example, WHO is showing new ways to build more resilient health systems."

Dag Sundelin
Head of Sweden's regional SRHR-Team for Africa

AFRO COVID-19 Intra-Action Reviews 2020–2021

- ✓ **Globally 59 countries have conducted IARs**
- ✓ **AFRO leading (56%) in conducting IARs globally**
  - **33 AFRO countries (70.2%) have conducted IARs covering several response pillars**
  - **Only 14 countries have not conducted IARs in AFRO**
  - **10 countries have conducted vaccine IARs in Africa**
- ✓ **Mixed method utilized; online and physical**



Intra Action Review in AFRO
(n = number of countries)

Conducted (n = 33)

Not conducted (n = 14)

Utilization of IAR findings

- Updating of COVID-19 response plan / SRPs
- Development of resurgence plan
- Used for resource mobilization & advocacy to governments & partners
- Country follow up teams monitoring implementation of IAR recommendations
- Several manuscripts published for global lessons sharing
- 2 Hubs compiled pillar specific findings and actions
  - presented to partners & used for resource mobilization
  - used the information to provide technical guidance to MS
  - revised guidelines and SOPs

Guidance to countries

- Initial IARs targeted all response pillars and National level
- Current IARs targeting;
  - 2nd / 3rd IAR for all pillars esp. during resurgence
  - Sub-national level
  - Vaccine pillar
  - Pillars missed during initial IARs

Key ask

AFRO to provide seed funds for implementation of strategic IAR recommendations at country level

Achieving case management optimization

Both case management and critical care capacities received enhanced attention during the reporting period. WHO-AFR has followed an ongoing concerted strategy to preposition oxygen supplies and build case management and critical care capacities in COVID-19 treatment. Moreover, in a study completed in July and conducted with partners, the African COVID-19 Critical Care Outcomes Study (ACCCOS), examined countries undergoing resurgence; the findings will partially guide the continued response.

Patient care and clinical outcomes for patients with COVID-19 infection admitted to African high-care or intensive care units

ACCCOS
African Covid-19 Critical Care Outcomes Study

Prospective observational cohort study
64 hospitals | 10 African countries | 3 140 patients

48.2%
mortality in critically ill patients with COVID-19 in Africa

11 to 23 excess deaths per 100 patients compared to the global average

Insufficient critical care resources may have been associated with increased mortality

Only 1 in 2 critical care referrals were admitted Access to interventions were between 7 and 14 times less than required

Risk factors associated with mortality include:

- HIV / AIDS
- Diabetes
- Chronic liver disease
- Kidney disease
- Increasing age
- Severity of organ dysfunction at admission

Steroid therapy was associated with survival

Female sex was not associated with mortality or survival

Quick SOFA coud be used as a triage tool in low resource environments

The African COVID-19 Critical Care Outcomes Study (ACCCOS) Investigators. Lancet 2021; 397: 1885-94

Several health care system factors affect the capacity to treat patients adequately

Inadequate oxygen capacity – shortage of equipment such as ventilators, O^2 concentrators, and monitors

Weak HBIC in place – no clear protocols for their management.

Inadequate critical care capacity of health workers

Poor triage and screening facilities

Overwhelmed treatment facilities with limited beds for critical and severely ill patients. Facilities are repurposed but not adequately equipped

Inadequate patient triage among hospitalized patients

Late referral problems

Lack of clear referral pathway, causing delay in transport of patients to more advance centres

Viral factors also cause confusion in how to treat patients. This is the case with the high transmission incidence of the Delta variant, while a few countries have begun to report the incidence of additional – Alpha and Beta – variants.

Besides infrastructural and other issues of a genomic nature, case management is profoundly associated with patient behaviour. In many cases, patients reach health facilities at a point where treatment becomes more difficult. Albeit a routine practice in many African settings, where patients prefer to consult traditional medicine providers, or simply are unable to reach a health facility due to difficulties finding or paying for transport, in the case of COVID-19, denial, fear, and misconceptions surrounding the virus have been specifically mentioned. In some countries, the high prevalence of comorbidities such as diabetes and hypertension has also been a reason for relatively high death rates. Finally, low vaccine uptake has been mentioned as a strong contributing factor to the continued incidence of severe cases of the virus.

Engagement of regional operational partners

Nairobi Hub
(23 countries)

Dakar Hub
(24 countries)

- Mapping of operational partners presence and actions in the region
- Regular interactions with partners for identifying key issues, challenges and opportunities of COVID-19 response actions

WHO AFRO
Brazzaville

- Regular identification and sharing operational gaps highlighted by the main response pillars with partners
- Ongoing identification of funding opportunities with RM sub-pillar

Clinical case management and IPC | **Operational research** | **Community-based response interventions** | **Specific response actions in humanitarian settings**

Ongoing main support to AFRO IMST response pillars

Clinical Case Management

- Current 3rd wave: engagement of Global and Regional Emergency Medical Teams
- Current: ALIMA (DRC), Polish Team (Uganda), UK Med (Namibia and Botswana), South Africa
- Upcoming: Team Rubicon (Uganda), UK Med in Zimbabwe, ALIMA in other countries of West Africa (TBC)
- In addition to the direct response operation in countries, development of National and or local based EMTs capacities

Strategies implemented by countries

Expansion of oxygen access including, installation of oxygen plants, procurement of oxygen concentrators, cylinders and their accessories

Training of Health workers to support critical care and early identification and treatment of patients with co-morbidities

Improve Home Based Isolation and Care (HBIC) by training Community Health Volunteers (CHV), Health Care Workers (HCW) and providing referral pathways to treatment centres

Setting up non-traditional treatment centres such as stadiums to aid decongestion of facilities

Development and adaptation of guidelines which are used as job aids / Standard Operating Procedure (SOP) to support clinical care practices

Support provided by AFRO

Funding provided to countries to support trainings, supervisions and monitoring in treatment facilities

Ongoing webinar on case management experience sharing to enable countries compare notes and possibly adapt good practices

Collaboration with institutions (AFEM, CCSOSA) to train clinicians on critical care

Recruitment of two biomeds to support oxygen needs in countries

Expanded studies on how to implement effective home-based care programming

The impact of COVID-19 on older people in the African Region

With the burden of COVID-19 severity lying squarely on vulnerable communities, in a study on ageing populations in Africa finalized in May, conducted by WHO-AFR, rapidly ageing populations, and the associated incidence of noncommunicable diseases (NCDs) demonstrably left many countries ill-prepared to respond directly to older people's needs during the pandemic. Not only were health systems in most countries unprepared for COVID-19, but the lack of critical care resources has impacted older people, who are most likely to require such care. High among older people in the Region, case fatality rates and excess mortality rates have been difficult to assess, given low testing rates and poor-quality data. In this regard, COVID-19's impact on older people has likely been underestimated.

On the economic front, COVID-19 has also brought several far-reaching issues to the fore. Already vulnerable to poverty, in 22% of countries in the WHO African Region, older people actively participate in the informal labour market. However, the inability of working older adults to earn an income during lockdowns, and the need to continue physical distancing, increased poverty rates and food insecurity. Without access to social protection, dependence on younger people for financial security also increased, a particular challenge given disruptions in both remittances and younger household earner incomes during the pandemic.

Cultural habits surrounding interaction with elders or grandparents, and even decision-making routinely attributed to older people suffered a dramatic change. As services and forms of social interaction have increasingly gone online, older people – many with limited access to technology – were left isolated and challenged in terms of accessing resources, services, and human contact, an essential ingredient in a healthy ageing process. Indeed, societal ageism and abuse of older people has increased in the Region over the period of the COVID-19 pandemic, with longer term implications for how older people are perceived and included in economic and social life, and efforts to "build back better" after COVID-19. Countries where existing networks of older persons' organizations, or other community-based networks were strong, were better able to reach older people in terms of targeted and appropriate messaging and provision. Older people were also prioritized during vaccination roll-outs, when they occurred. But vaccination programmes in the Region have lagged behind other regions due to budgetary and logistical challenges, and a large proportion of older people remain unvaccinated.

WHO / Dalia Lourenco