2. The Strategic Preparedness and Response Plan for COVID-19 in the African Region:

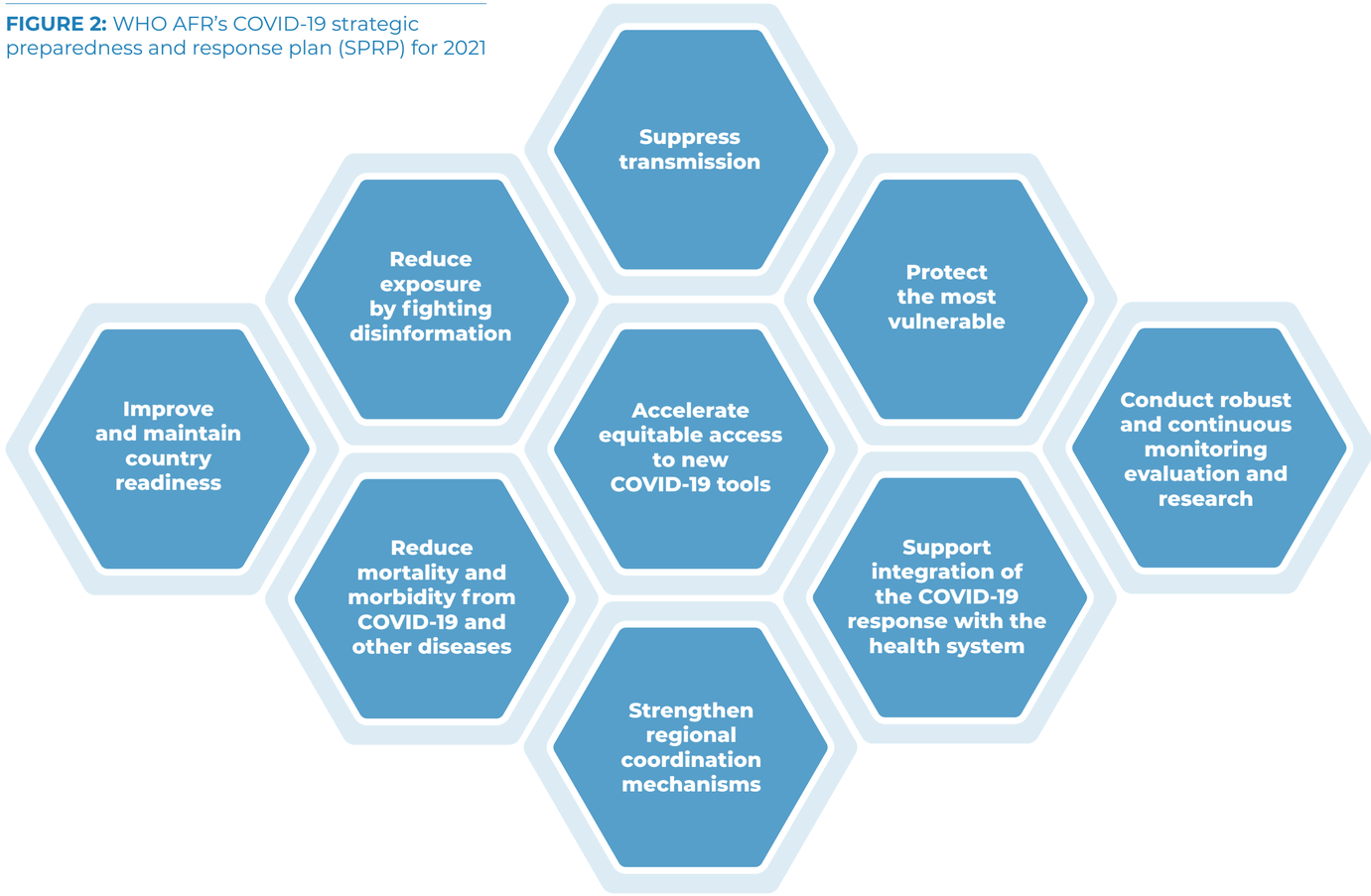
Structure and Coordination

- **2.1 The Response**
- **2.2 Deploying resources responsibly and strategically**
- **2.3 Expert deployment, training and building capacities**
- **2.4 Risk communication and community engagement**
- **2.5 Tackling the global infodemic**
- **2.6 External communications**
- **2.7 Procurement and supply chain**
- **2.8 Testing and laboratory capacity**
- **2.9 Points of entry, surveillance and geographic information systems**
- **2.10 Vaccination**
- **2.11 Health service continuity and case management**
- **2.12 Integrated action and innovations for health**

2.1 The Response

WHO AFR's COVID-19 **Strategic Preparedness and Response Plan** (SPRP) for 2021 is designed based on the 'whole of organization approach.' Guided by a coordination structure and 11 technical pillars, an information network attached to its global presence, 47 country offices in Africa, and strong partnerships, it builds upon the experience of the first year of the COVID-19 global pandemic response and management, and previous epidemics or pandemics.

FIGURE 2: WHO AFR's COVID-19 strategic preparedness and response plan (SPRP) for 2021



From the field

Addressing multiple crises in Mozambique
(a first person account)

The COVID-19 crisis hit Mozambique at a moment when we were still recovering from two deadly cyclones that struck the country in early 2019. As part of the Emergency Preparedness and Response Cluster, we were the first on the ground and I was particularly impressed by the efficiency and professionalism of the three levels of the Organization to provide timely support to the country. I really felt proud to be part of the Organization. By the time the COVID-19 pandemic was declared, I had a sense of what an emergency mode meant, but I was far from imagining the level of stress we were about to deal with, especially at the WHO country office. The recurrence of emergencies (floods, cholera outbreaks, drought, and cyclones, among many others) often directs our attention to humanitarian needs rather than preparedness. This could partly explain why we are sometimes perceived as an organization that typically reacts to, instead of preventing events and preparing to mount an adequate response.

Fortunately, this perception did not last, and the role of the WHO Country Office leadership was instrumental in supporting the country and partners to define the contours of the COVID-19 preparedness and response.

Despite many challenges at the beginning, our ability to catalyse collective action by different actors in-country emerged stronger, and we got over the hurdle of the first year of the crisis. Notwithstanding our best efforts, a combination of factors, led by popular fatigue leading to poor adherence to public health and social measures, has brought us to the brink of a third wave. The Delta variant has also come down hard in southern Africa, making the virus much stronger and its spread easier. However, I remain confident that lessons from previous waves, coupled with a renewed determination on the part of the country's authorities, will be fundamental to curb virus transmission, with a focus on activities tailored to the lowest demographic level.

As one famous Prime Minister said, 'never let a good crisis go to waste.' It is my hope that the COVID-19 crisis will spur us in the right direction and initiate a real conversation on how to improve our health system.

Sinésia Lucinda João Sitão
Infectious Hazard Management Officer
WHO-Mozambique

WHO / Mozambique – Country Office

2.2 Deploying resources responsibly and strategically

Resource mobilization focused during the last six months on securing funds for oxygen production and equipment procurement, distribution and maintenance, vaccination procurement, preparedness and roll-out, improved case management and critical care capacities, expanded PCR and antigen testing, surveillance, community engagement, research and innovation, and information management. As this report goes to press, there has been an overwhelming surge in response to Africa's appeal for the equitable global distribution of vaccines, and several major donors have promised to match Africa's needs. But while vaccines supplies have been secured, covering the cost of undertaking the vaccination roll-out, estimated at US$ 5.00 for every US$ 1.00 spent on a vaccine dose remains a challenge.

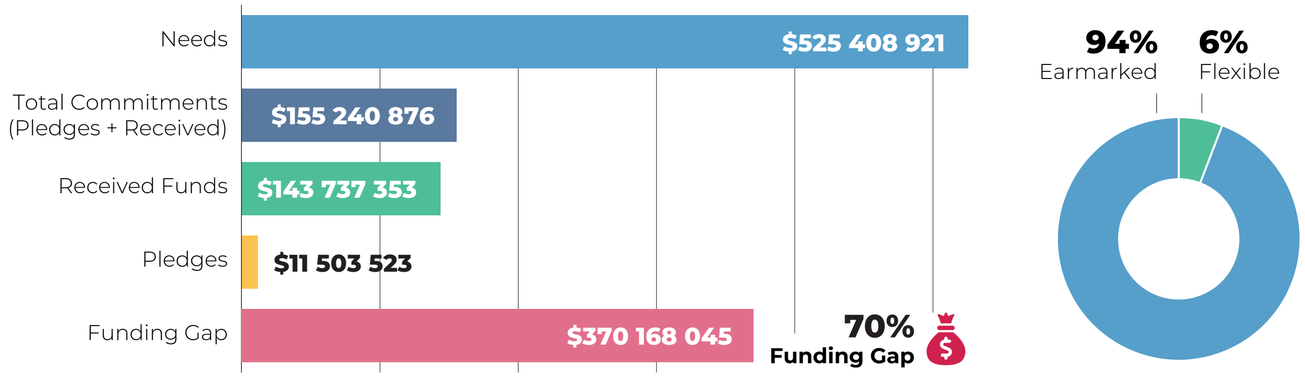
Income and expenditure

To allow WHO to build on gains from 2020 and continue supporting countries to combat the COVID-19 pandemic, a total of US$ 525.4 million was proposed as the estimated required total for the implementation of the WHO African Region SPRP 2021. This is in addition to Member State bids for national action plans and strategic preparedness and response plans. As of the end of July 2021, the total funding committed to the 2021 SPRP was US$ 155.2 million. This represents 27% of all the grants received, of which 94% is earmarked. A 70% funding gap remains.

"As the world continues to deal with the COVID-19 pandemic and its aftermath, WHO's role in the coordination and provision of technical expertise continues to be crucial, in view of sharing information and ensuring an efficient response. DG ECHO remains committed to supporting WHO in its efforts to deliver assistance to the most vulnerable, faced with the COVID-19 pandemic on top of existing humanitarian crises. In 2020, out of the total of €70.5 million allocated to WHO, €8.35 million was allocated to African countries and €30 million specifically for preventing, containing and mitigating the spread of COVID-19 in fragile States in Asia and Africa. In 2021, until July, DG ECHO has allocated € 7.7 million to WHO, for projects in African countries."

Maria Bernardez Ercilla
Acting Head of the Regional Office for East and Southern Africa
European Commission Directorate-General for European Civil Protection and Humanitarian Aid Operations

FIGURE 3: Funding overview (as of 31 July 2021)



Since the onset of the pandemic, a total of US$ 479.3 million has been committed – US$ 11.5 million in pledges and US$ 143.7 million received in 2021 – for the COVID-19 response in the WHO African Region. As of 31 July 2021, a total spending rate of 74% had been realized. The target areas of intervention and implementation aligned with the funds earmarking is as follows:

FIGURE 4: Targeted specific areas of interventions/implementation (as at 31 July 2021)

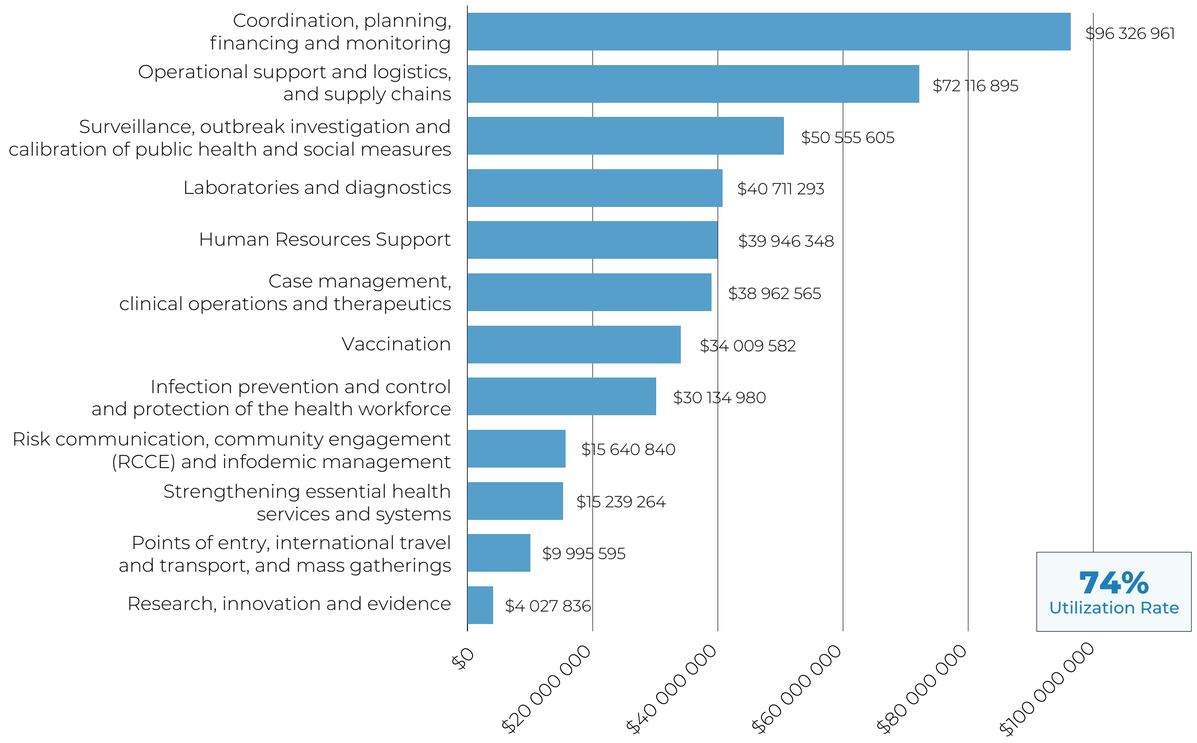


TABLE 1: Contributions received from partners (as of 31 July 2021)

Type of Organization	Donor	Amount Received (US$)	%
Member State	Germany	50 568 566	81%
	Canada	49 940 814	
	United States	3 005 000	
	Norway	3 098 059	
	Denmark	1 411 614	
	Comoros	1 356 625	
	Japan	1 315 026	
	Isle of Man	1 118 881	
	Mali	1 106 717	
	Ireland	936 454	
	Mauritania	533 169	
	France	528 517	
	Netherlands	475 900	
	Lesotho	162 912	
	Cameroon	125 418	
		115 683 672	
UN Agency	United Nations Development Programme	8 091 682	9%
	United Nations Office for the Coordination of Humanitarian Affairs	1 999 541	
	International Organization for Migration	718 205	
	UNDP Multi-Partner Trust Fund	717 912	
	International Organization for Migration	306 985	
	United Nations	139 697	
	United Nations Population Fund	111 400	
		12 085 423	
Intergovernmental Organizations	GAVI Alliance	7 579 525	6%
	European Union	1 194 743	
		8 774 268	
Multilateral Development Finance Institution	African Development Bank	2 806 752	3%
	Islamic Development Bank	1 344 633	
	International Development Association	400 000	
		4 551 385	
Non-state Actors	Vital Strategies	1 174 500	1%
	Foundation for Innovative New Diagnostics	245 726	
	Task Force for Global Health	219 000	
	King Salman Humanitarian Aid & Relief Center	165 000	
	Veolia Environment Foundation	112 591	
		1 916 817	
	Grand Total	**143 011 564**	**100%**

As the pandemic lifespan stretched, funding and implementing partners understood the need to increase country capacities in resource mobilization, and to introduce greater flexibility in funding cycles towards strategic positioning of resources. In effect, while the quick turnaround for COVID-19 resource mobilization had initially been appropriate, during this second year of the pandemic, WHO-AFR provided guidance for countries to request the right funding, for the right programme. This was especially true given the rapidly changing epidemiological situation, which required greater flexibility from funding bodies in addition to strong accountability mechanisms.

For example, WHO-AFR worked with countries to support applications to a US$ 7.5 billion COVID-19 dedicated portfolio created by the Global Fund to fight HIV/AIDS, Malaria, and Tuberculosis. To this end, the Brazzaville team, with colleagues in 47 country offices and the subregional hubs in Dakar, Libreville, Harare, Nairobi and Ouagadougou, conducted broadscale (trainings, guidance) and tailored (individual outreach, application review, funding) interventions for government partners. WHO-AFR worked with the Global Fund to adapt programmatic criteria, within widened funding submission windows. The strong coordination during the past semester between WHO-AFR and Global Fund led to more robust submissions surrounding surveillance; national testing strategies; end-to-end supply systems; and health systems strengthening, some of which had been absent, underrepresented, or not aligned with WHO guidance.

Notwithstanding challenges, across Africa, countries activated resources in a relatively similar manner, with considerable focus on enhancing testing capacities for critical care and for social behaviour change communication. Spending capacity was directly proportional to the availability of goods and services, that is, difficult access to reliable oxygen supplies or unavailability of qualified personnel, limited background infrastructure as a base for the installation of COVID-19 treatment centres, among so many others. WHO is grateful to, and acknowledges partners and contributors for their continued support. We are committed to making sure our income is used efficiently, effectively, and responsibly, making every cent count.

"The COVID-19 pandemic is a threat to everyone. Since the onset of the pandemic, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) strongly engaged in response and preparedness measures across the African continent and beyond. To provide essential pandemic response services to the Tanzanian people, GIZ partnered with WHO as a strong, reliable and knowledgeable organisation. GIZ is looking forward to further supporting the Tanzanian government together with WHO and other development partners to provide coordinated and effective response as the COVID-19 pandemic and its aftermath can only be overcome with globally Joined forces."

Dr. Mike Falke
Country Director GIZ Tanzania and EAC

TABLE 2: Global Fund (GF) – 2021 COVID-19 Response Mechanism (C19RM) – Regional Progress

Approved funding estimated at $744 049 920

Status	# Countries	Countries
Fast-track		
Approved	20	Benin, Burundi, Chad, DRC, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Multicountry Southern Africa, Nigeria, Rwanda, Senegal, Tanzania – Mainland, Togo, Zambia, Zimbabwe
Submitted	4	Eswatini, Liberia, Mauritania, Niger
Full-funding		
Approved	5	Angola, Gambia, Ghana, Malawi, Uganda
Submitted	37	Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, CAR, Chad, Cote d'Ivoire, Comoros, DRC, Eswatini, Ethiopia, Gabon, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Mali, Mauritania, Maurtitius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & P., Senegal, Sierra Leone, South Sudan, South Africa, Tanzania – Mainland, Tanzania – Zanzibar, Togo, Zambia, Zimbabwe
Not yet submitted	2	Benin, Congo
Confirmation to come	1	Eritrea

TABLE 3: Global Fund (GF) – 2021 COVID-19 Response Mechanism (C19RM) – Regional progress, approved funding

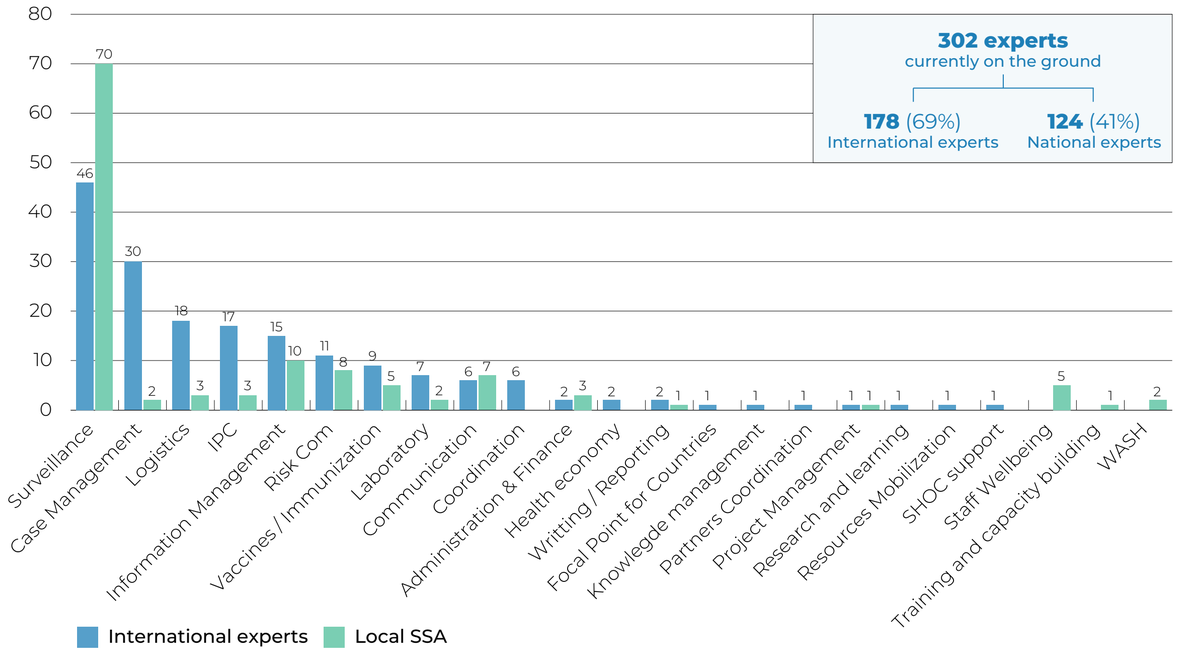
Country	FT or FF	Estimated Amount Approved (USD)
Angola	Full-funding	20 650 086
Benin	Fast-track	7 811 238
Burundi	Fast-track	1 336 336
Chad	Fast-track	9 710 281
DRC	Fast-track	23 217 172
Ethiopia	Fast-track	30 683 553
Gambia	Fast-track	3 682 162
Gambia	Full-funding	9 290 458
Ghana	Fast-track	17 002 204
Ghana	Full-funding	39 032 780
Kenya	Fast-track	31 148 545
Madagascar	Fast-track	6 500 000
Malawi	Fast-track	25 587 781
Malawi	Full-funding	128 293 942
Mali	Fast-track	13 412 379
Mozambique	Fast-track	7 832 808
Multicountry Southern Africa	Fast-track	254 235
Nigeria	Fast-track	66 794 825
Rwanda	Fast-track	14 262 101
Senegal	Fast-track	5 759 229
Tanzania (United Republic)	Fast-track	39 837 553
Togo	Fast-track	7 069 515
Uganda	Full-funding	173 700 579
Zambia	Fast-track	23 643 352
Zimbabwe	Fast-track	37 536 806
Total estimated approved		**744 049 920**

2.3 Expert deployment, training and building capacities

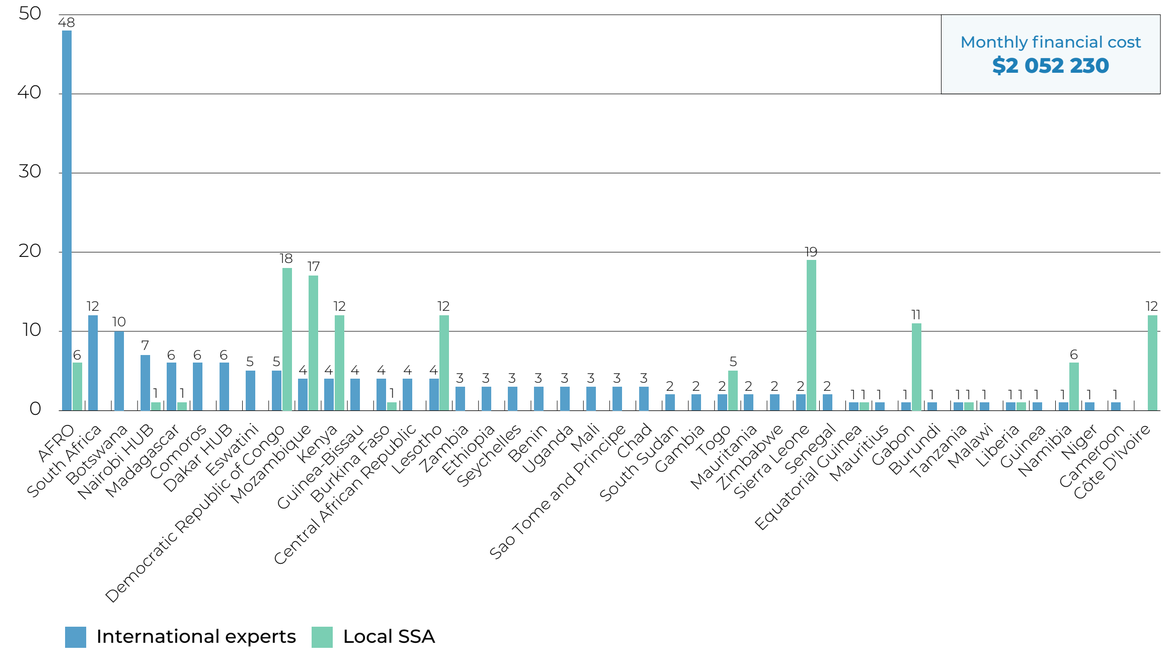
Knowing that the control of outbreaks can be won or lost at the local level, from 1 February to 31 July, WHO-AFR continued to deploy COVID-19 response workers to cities and towns, where close community contact implies greater risk of contamination from the virus.

FIGURE 5+6: Cumulative deployments data – Number of experts

Breakdown per area of expertise



Breakdown per country



"The United States remains a long-standing development partner for the people of Zimbabwe and our COVID-19 response now exceeds US$23.3 million. We are working tirelessly alongside our development partners to help Zimbabwe maintain critical health and humanitarian assistance activities during the COVID-19 pandemic. Our partnerships, including our support to and collaboration with WHO, and the steps we continue to take to combat COVID-19 in Zimbabwe demonstrate the United States' ongoing commitment to supporting the people of Zimbabwe through this crisis and beyond."

Anne G. Murphy
USAID Health Office Director

45 Countries

received training for **200 000 health workers** on infection prevention and control, border control, treatment, logistics, laboratory testing and risk communication.

A sample breakdown follows:

15 Countries

were targeted with training procurement and supply chain practices for oxygen and other medical supplies.

8 Countries

Guinea, Mali, Sierra Leone, Liberia, Ghana, Togo, Guinea Bissau and Senegal – benefitted from five workshops on capacity building at points of entry and strengthening cross-border collaboration. These workshops contributed to the development of joint action plans between the neighbouring countries.

23 Countries

in West and Central Africa received training on points of entry and surveillance training, with participants including border police, ministries of health, public health officials, environmental health, immigration and customs.

47 Countries

and **345 000 community health workers** received training on COVID-19 symptoms, referral and psycho-social support.

40 Countries

were represented in a **briefing for 50 Information Managers**, on 22 July, where HIV/TB focal points shared their experience with COVID-19 focal points on Global Fund implementation.

45 Countries

and **255 000 local leaders and influencers** were engaged in COVID-19 awareness and training.

2.4 Risk communication and community engagement

The greatest lesson learnt on communication from the first year of the pandemic is that public health bodies must communicate early, strategically, and persistently to curb the spread of the virus, with strong support from community health. Educated and empowered communities play a vital role in preventing transmission of COVID-19, and community health workers are a gateway to good health. WHO-AFR fully absorbed this lesson in implementing the SPRP 2021. Working with UNICEF, AFENET, civil society and national public health agencies, community health workers and influencers received training on contact tracing, with keen attention to symptomatic contact referral, ahead of patient transfer to designated isolation facilities. As part of its partnership with community health, WHO facilitated procurement of reporting and monitoring forms, pens, digital thermometers, and alcohol-based rub solutions. Several important survey and training mechanisms were provided to inform risk communication strategies and for understanding drivers of non-adherence to public health measures:

Survey and training mechanisms to inform risk communication strategies

5 **Knowledge Attitudes and Practices (KAP)** in Uganda, South Sudan, Ethiopia, and Namibia, with results pending in mid-July for Kenya, Tanzania, Eswatini, Lesotho

3 **Online and offline Social Listening & Community feedback platforms** (with AIRA and UNICEF) fed: a monthly joint report, designed to summarize, and recommend actions

14 **Social Science Evidence in Health Emergencies** by Collective service trainings conducted

15 **Behavioural observations** using participatory mapping and community dialog methodologies

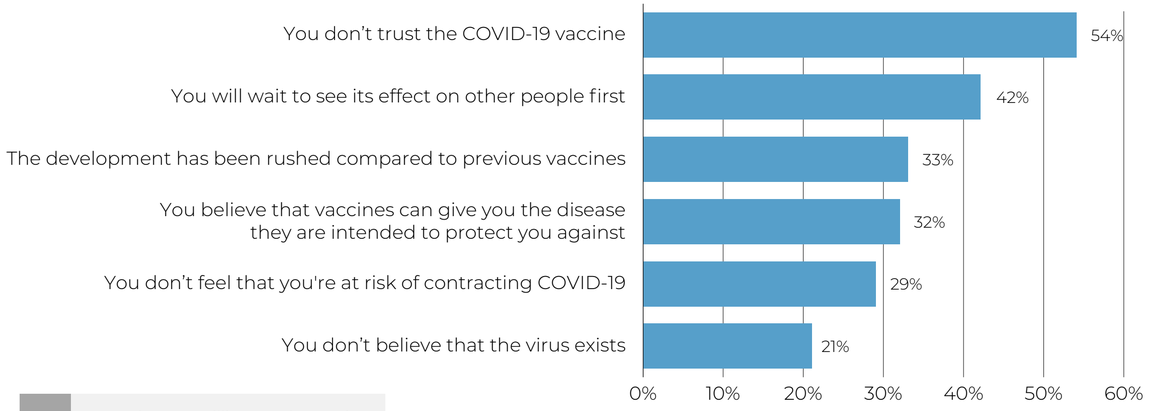
Online peer learning-communication hubs shared best practice in community prevention measures, such as alphabetical order entry in supermarkets, shock media, and youth-led public information campaigns, among others.

"The Embassy of Demark in Uganda is proud to partner with the WHO Country Office and does acknowledge the good collaboration WHO has, not only with the donor partners but most significantly with the Ministry of Health and district health offices. The pivotal role which WHO plays in supporting the Government to provide a national response to COVID 19 has significantly helped in containing the spread and management of COVID-19 in Uganda."

H.E. Nicolaj A. Hejberg Petersen
Ambassador, Royal Danish Embassy, Kampala, Uganda.

FIGURE 7: KAP study – Reasons for vaccine hesitancy

What would be your reasons for not taking a COVID-19 vaccine?



Base N=103; those unwilling to take vaccine

Note: *Base too small to break down by demographics*

From the field

Partner voice – In Kenya, Women take action against COVID-19

When the COVID-19 pandemic hit Kenya, Ugenya Sub County in Siaya County came into the national limelight by a video clip, which went viral, capturing the first ever COVID-19 death burial, in accordance with stringent COVID-19 regulations. This scared many people at the time, including families in the area and members of the Duuma women group, which I lead.

Fortunately, we saw an opportunity to help our community better when we attended a meeting organized by WHO-Kenya, where the local leadership was sensitized and engaged towards the virus, and what we could do to stop its spread. The meeting enabled local sub-county leadership – political, social, and administrative – to reflect on COVID-19 in the sub county and the need to further appreciate the problem at hand and commit to some action.

Although this meeting was held last October, this year we resolved to take action and approached WHO to engage further on how to reach women, so that we could learn and participate in COVID-19 prevention and control. I then mobilized and organized a meeting in June with 15 women, representing 7 women's groups. Here, we recognized that as women we could play a key role in influencing members of our households to observe COVID-19 containment measures, like ensuring we have hand washing stations at home, and reminding our families and communities to carry and wear face masks as they leave home. Since then, the four women's groups that I lead have continued to support each other through table banking, but to also to ensure sustained COVID-19 health measures.

Most members of the four women's groups have hand washing stations in their homes and remind their families and neighbours about all measures. We no longer hold our regular meeting, to minimize gatherings. We also avoid attending funeral gatherings. Our groups use tailored re-useable face masks, to match our individual group uniforms. We thank God that our efforts to sustain safety measures have shown some results – to date we have not reported any unfortunate severe disease or death due to COVID-19 among our members.

Marie Awuor
Chair of DUUMA women's group,
Maendeleo ya Wanawake Organization,
Ugenya, Siaya County

Duuma Women's Group / Ugenya, Siaya County, Kenya

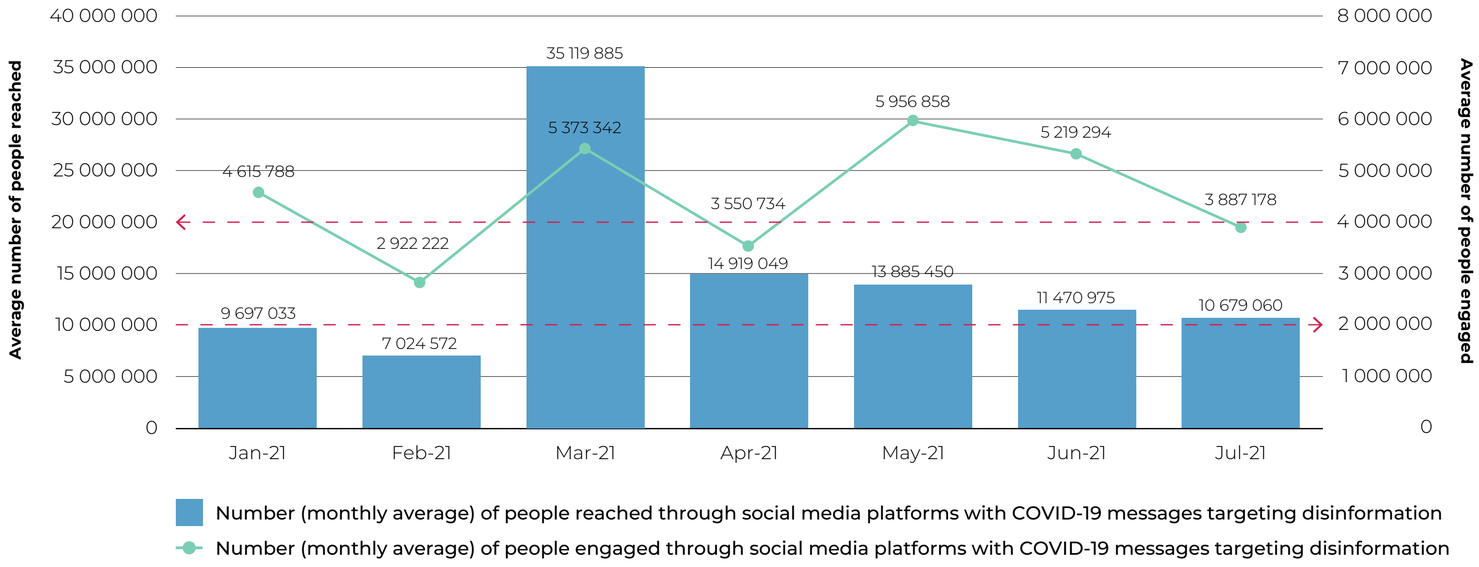
2.5 Tackling the global infodemic

The word blend “infodemic” (information plus epidemic) reflects the outsized effect that new information technologies have had on contemporary health communication. Although the word blend is relatively new, the association between epidemics and misinformation is not. Accordingly, from the beginning of the pandemic, COVID-19 has been a clear target of false or poorly backgrounded or incomplete public information, contributing to considerable confusion among policy-makers and the public alike.

WHO-AFR measured key words and other indicators via media and social media monitoring tools to inform a wider strategy for improving information quality on key COVID-19 related issues: vaccine side effects, use of face masks, and use of non-approved medications, among others. On a similar note, Viral Facts, a public-facing brand launched in March, dedicated to positive reinforcement of virus and response-related information, conducts a weekly report based on a triage of, and response to misinformation. This interactive activity, which stems from the December 2020 Africa Infodemic Response Alliance (AIRA), relies on input from a once-a-week social listening trends report, also started in March. To ensure partner engagement and relevance, a periodic satisfaction survey of this weekly report found that 85% of respondents rated the report between 8 and 10 points, with 10 being the highest possible grade.

To tackle the infodemic crisis, WHO-AFR conducted trainings for 20 communications professionals in 10 countries, with a multiplier effect, and eight countries were set up with infodemic management systems. On the academic front, WHO-AFR conducted two qualitative studies, in partnership with two universities in Southern and East Africa, designed to measure the impact of specific infodemic content.

FIGURE 8: Number of people reached and engaged through social media platforms with COVID-19 messages targeting disinformation



2.6 External communications

The pace of global and regional interest in the COVID-19 situation in Africa picked up from January 2021, in proportion to the onset of the third wave of the virus, the expansion of its more aggressive variants, and discrepancies in, and reliability of vaccine access, further threatening the lives of millions. Urgent outreach and advocacy through mass and social media put additional pressure on world leaders to commit resources, medical supplies, equipment and personnel to the fight against COVID-19 on the continent.

545M
people reached with social media content

48%
engagement rate

35 000

300 000
English-language followers growth (Jan–Jul 2021)

400 000
French-language followers growth (Jan–Jul 2021)

6 500x
published quotes by AFRO spokespersons on major news outlets such as the BBC, the New York Times, RFI, Le Monde, East African, and the Daily Nation, among others

11
COVID-19 newsletters on vaccine and general topics, mostly targeting national health authorities and partners

100M
people reached through AIRA's multi-lingual video productions

85 English
62 Fench
8 Portuguese
3 Swahili

16.5M
monthly reach

45%
engagement rate

2.7 Procurement and supply chain

To identify and ensure procurement and distribution of goods in the right quantity, at a high quality and in a timely manner, WHO-AFR worked strategically with countries and suppliers to scale up quality medical oxygen access, essential in the treatment of COVID-19. Working in close coordination, biomedical specialists and technical staff in operations support and logistics, case management, health system continuity, and quality control and procurement, consolidated technical specifications for oxygen (O^2), while also ascertaining the status of oxygen plants. While some of this work had already begun in the first quarter of the year, following an intra-action review (IAR) of the United Nations supply portal, the resurgence of the crisis forced both a speed-up and scale-up of actions. For example, with 26 non-operable oxygen plants in Africa, the team developed a protocol for service, repair, and maintenance, along with an O^2 needs and gaps calculation tool. This tool enables countries to keep track of needs and related expenditures to ensure supply and investment sustainability.

While the frenetic pace to secure supplies witnessed in the first year of the pandemic had somewhat slowed during the first quarter of this SPRP, the WHO-AFR team encountered new challenges. On the supply side, price inflation and variations among countries and suppliers added to market complexity. For example, the price of a 240 cubic feet cylinder of oxygen to treat an adult for roughly a day, may range from US$ 23 in Kenya to US$ 112 in Guinea; in some cases, the price of oxygen has more than doubled. These prices are beyond the reach of most public health

Oxygen saves lives

Used to treat hypoxemia at all levels of the health care system, oxygen (O^2) is required for the treatment of acute respiratory illnesses such as severe pneumonia, chronic pulmonary diseases, emergencies, and cardiovascular diseases, as well as for surgeries. A plan for a regional stockpile of cylinders and oxygen is being developed, to be hosted at the WHO regional warehouse in China, with three potential sub-hubs in Africa.

Additionally, on the basis of a memorandum of understanding between AFRO, UNITAID and the Clinton Health Access Initiative (CHAI), ACT-Accelerator partners signed agreements with international medical gas companies in the private sector, providing a pathway to increasing access to medical oxygen in low- and middle-income countries during the COVID-19 pandemic. This collaboration with industry aims to overcome fundamental issues such as unstable funding commitments and insufficient infrastructure, all of which have limited the availability of medical oxygen.

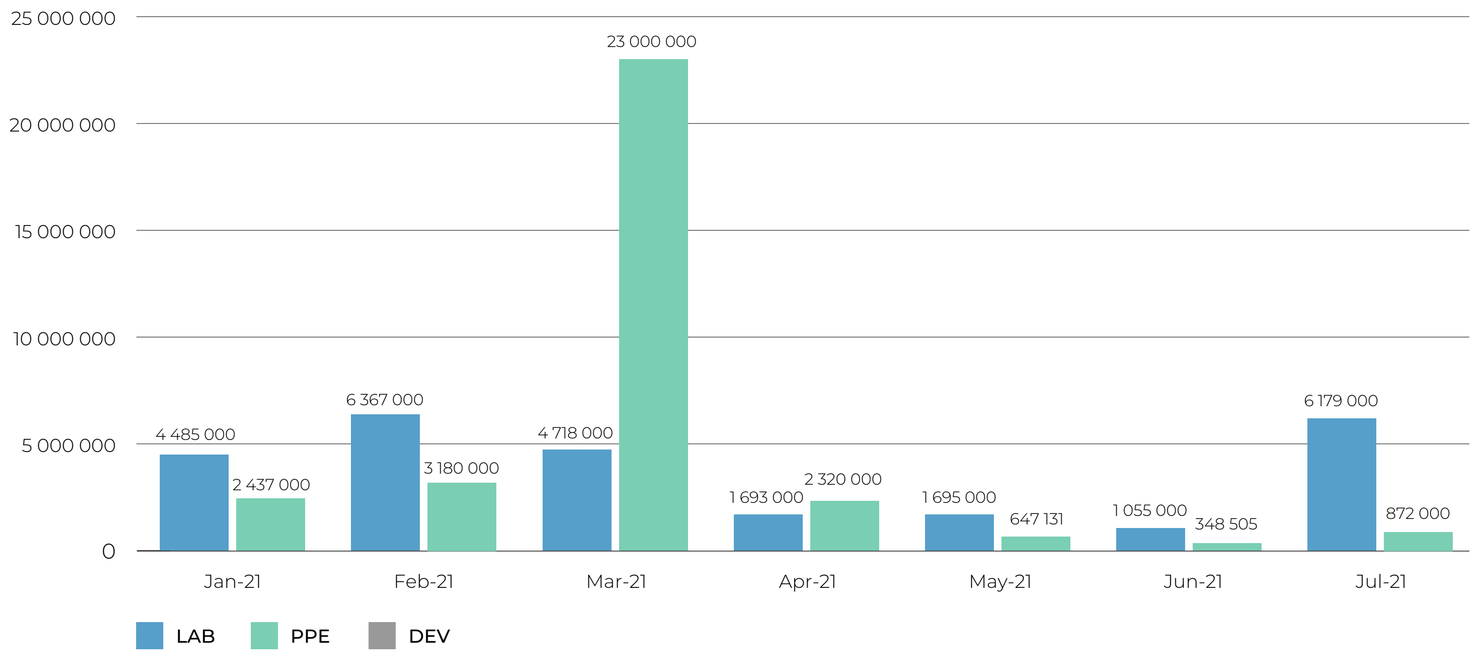
Under the agreements signed with the private sector, companies commit to work with ACT-A global health partners to facilitate equitable access to increased oxygen needs, as a consequence of the COVID-19 pandemic. ACT-A, a global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines, was launched at the end of April 2020. It brings together governments, scientists, businesses, civil society, and philanthropists and global health organizations (the Bill & Melinda Gates Foundation, CEPI, FIND, Gavi, The Global Fund, UNITAID, the Wellcome Trust, the World Bank, and WHO). Following the launch of the ACT-Accelerator, UNICEF and PAHO became delivery partners for COVAX, its vaccines pillar.

WHO / Hargeisa General Hospital

facilities across sub-Saharan Africa and make oxygen one of the most expensive treatments in the Region's health systems. Procuring oxygen in different countries is also complicated by often incompatible oxygen cylinders, and the absence of, or incomplete protocols regarding equipment safety and even treatment dosages.

Moreover, as borders open for trade, and suppliers overcome production constraints, numerous challenges remain. Because oxygen (O^2) is an explosive, full cylinders of the gas may not be distributed by air, meaning longer lead times. Even working double-time, O^2 suppliers – particularly international – require four to six weeks for delivery. This is time a waiting patient cannot afford. To tackle this issue, WHO-AFR developed a proposal for bulk procurement of oxygen cylinders from international suppliers – with an estimated lead time of 40 days –, which includes local maintenance service agreements. That should also contribute to mitigate WHO-AFR's difficulties in hiring biomedical engineers and technicians, who are essential personnel in medical oxygen treatment management.

FIGURE 9: OSL WHO-AFR supplies breakdown



Operation Support and Logistics
AFRO supplies 2021

$169.3M

For diagnostics:

21.3M
items have been ordered including

15M
Rapid antigen tests

1M
GeneXperts

3.7M
PCR tests

1.6M
Sample collection kits

32.4M
PPEs items have been ordered

31.6k
items devices including

539
Oxygen concentrators

412
Ventilators

392
Patient monitors

4.8k
Pulse oximeters and other accessories

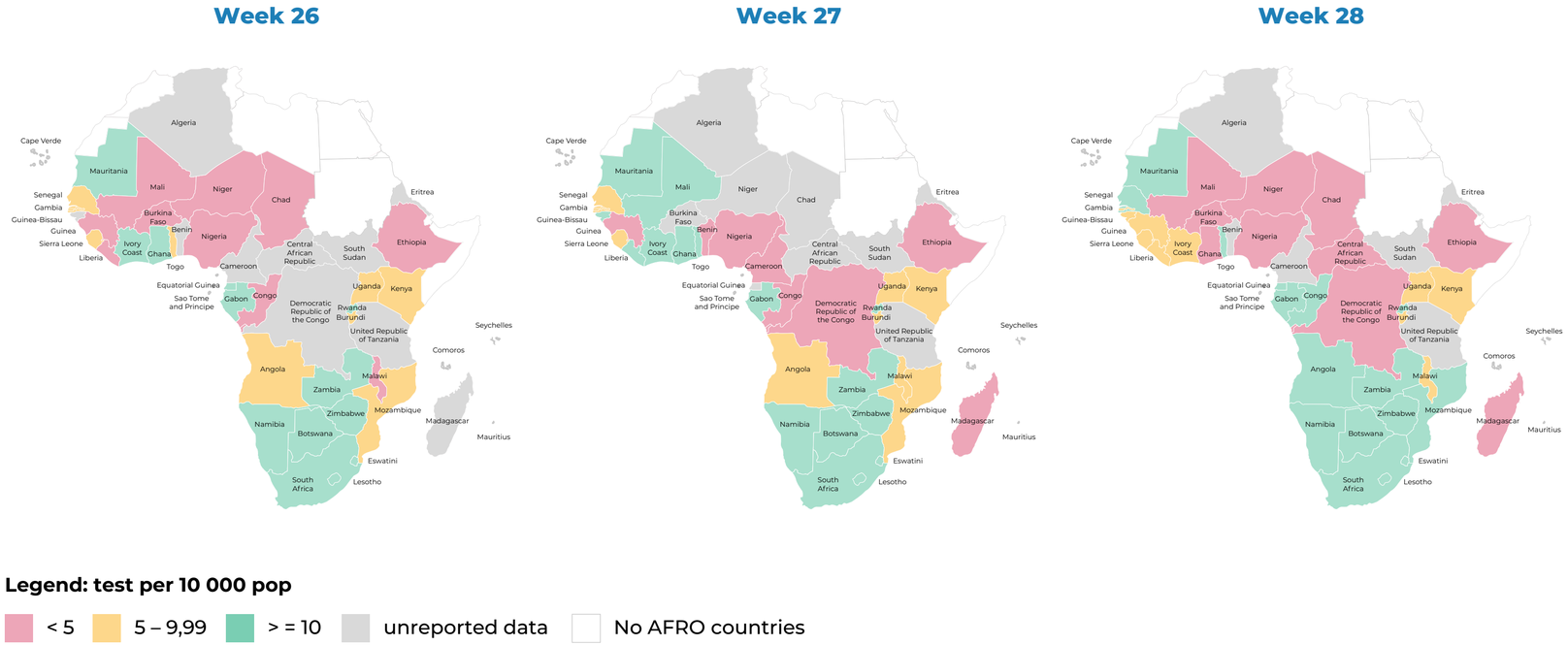
2.8 Testing and laboratory capacity

Testing for pathogens plays a role in case detection, patient isolation, contact tracing and quarantine, the key elements to breaking COVID-19 transmission chains. Nucleic acid amplification tests (NAATs), which are considered the gold standard, continue to be used for detecting SARS-CoV-2 in populations. However, in 2021 we have witnessed an increase in the use of antigen-detecting rapid diagnostic tests (Ag-RDT) to complement PCR testing in the Region.

In the WHO African Region over 27 million laboratory tests were performed in the first half of 2021, accounting for almost 50% of all tests (58 million) performed since the beginning of the pandemic. The African Region, like others, has experienced waves of the pandemic with cases periodically rising and falling. In the first six months of 2021, several countries experienced a third wave of COVID-19. Based on data up to June 30, testing increased to meet the demand generated by this third wave, with 16 countries testing within the >10/10 000 population universal benchmark for testing. This meant a 45% increase in the number of countries in January 2021 that had attained this benchmark, with 50% of these countries having low positivity rates (<5%).

The recent Emergency Use Listing of antigen-detecting rapid diagnostic tests in late 2020 provided the Region with a simple, low-cost device to rapidly scale up testing. Although the uptake has been slow, by November 2020, WHO-AFR and partners had delivered over 22 million

FIGURE 10: Percentage of countries performing at least 10 tests per 10 000 population during the last three weeks of 2021



Ag-RDTs. Ten countries – Angola, Burundi, Cabo Verde, Cameroon, Congo, Democratic Republic of the Congo, Gambia, Mauritius, Nigeria, Zimbabwe – have rolled out the use of Ag-RDT, and have regularly provided report testing data to WHO AFRO. In Zimbabwe, Ag-RDTs became the mainstay of testing for SARS-CoV-2 during the second wave of the pandemic (December 2020 to March 2021). Their expanded use helped increase the country's testing capacity nearly four-fold, which proved crucial for containing the resurgence. In the Democratic Republic of the Congo, Ag-RDTs have been distributed to five provinces and 15 districts, effectively enabling testing to be conducted in hard-to-reach locations with limited infrastructure. To further promote the use of Ag-RDT, WHO-AFR has delivered training to 37 countries in three languages reaching more than 700 end users. Training efforts are scheduled to continue, with a focus on small group-focused hands-on or virtual training to optimize the training experience. As the use of Ag-RDT in the Region builds momentum, WHO-AFR in conjunction with partners is working with policy-makers and stakeholders to expand their use and enable comprehensive testing in Africa.

TABLE 4: Testing data for the First Semester till 30 June 2021

Country	# Tests	% Pos	Average weekly test / 10 000	Country	# Tests	% Pos	Average weekly test / 10 000
Algeria	N/A	N/A	N/A	Liberia	62 695	3,2	5,2
Angola	336 083	6,3	4,3	Madagascar	113 808	21,5	1,7
Benin	224 550	2,2	7,7	Malawi	180 243	16,4	3,9
Botswana	741 267	7,3	131,3	Mali	158 695	4,6	3,3
Burkina Faso	104 283	6,5	2,1	Mauritania	210 096	3,1	18,8
Burundi	281 306	1,6	9,9	Mauritius	57 330	2,4	18,8
Cabo Verde	137 009	14,9	102,7	Mozambique	318 363	18,1	4,2
Cameroon	1 092 460	5,0	17,1	Namibia	313 055	21,1	51,3
C.A.R	21 757	28,0	1,9	Niger	54 447	4,0	0,9
Chad	64 147	4,4	1,6	Nigeria	21 718 543	0,4	43,9
Comoros	28 719	11,0	13,8	Rwanda	891 176	3,4	28,7
Congo	94 770	5,8	7,2	STP	8 370	16,1	15,9
Côte d'Ivoire	446 965	5,8	7,1	Senegal	288 369	8,2	7,2
DRC	96 037	23,5	0,4	Seychelles*	71 426	20,1	282,0
EQG	79 239	4,3	23,5	Sierra Leone	120 862	2,3	6,3
Eritrea	N/A	N/A	N/A	South Africa	6 303 620	14,5	44,3
Ethiopia	1 056 812	14,4	3,8	South Sudan	69 043	10,5	2,6
Gabon	502 262	3,1	94,0	Eswatini	143 472	6,7	51,5
Gambia	47 761	4,8	8,2	Togo	269 053	1,7	13,5
Ghana	586 412	7,0	7,9	Uganda	560 250	7,9	5,1
Guinea	168 335	5,9	5,3	Tanzania	N/A	N/A	N/A
Guinea-Bissau	35 744	3,9	7,6	Zambia	1 243 267	10,8	28,2
Kenya	894 752	9,8	6,9	Zimbabwe	412 120	8,7	11,6
Lesotho	75 915	10,6	14,8	**TOTAL**	**40 684 888**	**5,2**	**15,1**

** Data for weeks 1 to 25 of year 2021*

Identifying and tackling COVID-19 variants

The identification in late 2020 of SARS-CoV-2 viruses with enhanced transmissibility, underpinned WHO-AFR's increased commitment to accelerate genomic surveillance in the Region. Enhanced regional capacity for virus genome sequencing has been instrumental in determining the incidence of COVID-19 variants of concern (VOC) in countries, information that is used to inform public health responses to COVID-19. At the end of 2020, WHO-AFR and Africa CDC launched a network of 12 Regional Sequencing Laboratories to support countries with limited capacity to characterize circulating viruses. By June 2021 the network had genetically characterized nearly 8000 viruses from the Region, a 1.75-fold increase when compared to a similar time frame in late 2020. To ensure continuity of service, WHO-AFR supports countries to ship samples to Sequencing Network laboratories, provides Network laboratories with supplies, technical guidance, and financial support. WHO-AFR is also supporting the introduction of PCR screening for VOC to complement genetic sequencing, and to ensure rapid identification of circulating VOC.

WHO / Blink Media – Nana Kofi Acquah

2.9 Points of entry, surveillance and geographic information systems

AFRO invested in increasing the Region's capacity to use integrated hybrid techniques of remote sensing, GPS, GIS, and information management to map the spatial variation of surveillance towards pandemic control and management, to verify the incidence of the disease among social groups and geographic areas, to quantify supply needs, and to gauge distances and distribution times.

Engaging neighbouring countries to undertake joint strategies for epidemic surveillance and control was a primary goal for WHO-AFR. The WHO AFRO Dakar hub – in partnership with the Economic Community of West African States (ECOWAS) and AFENET and CDC Atlanta – undertook five dialogue sessions and trainings for authorities in cross-border situations in Ghana, Nigeria, Togo, Benin, Senegal, Guinea Bissau, Gambia, Sierra Leone and Mali.

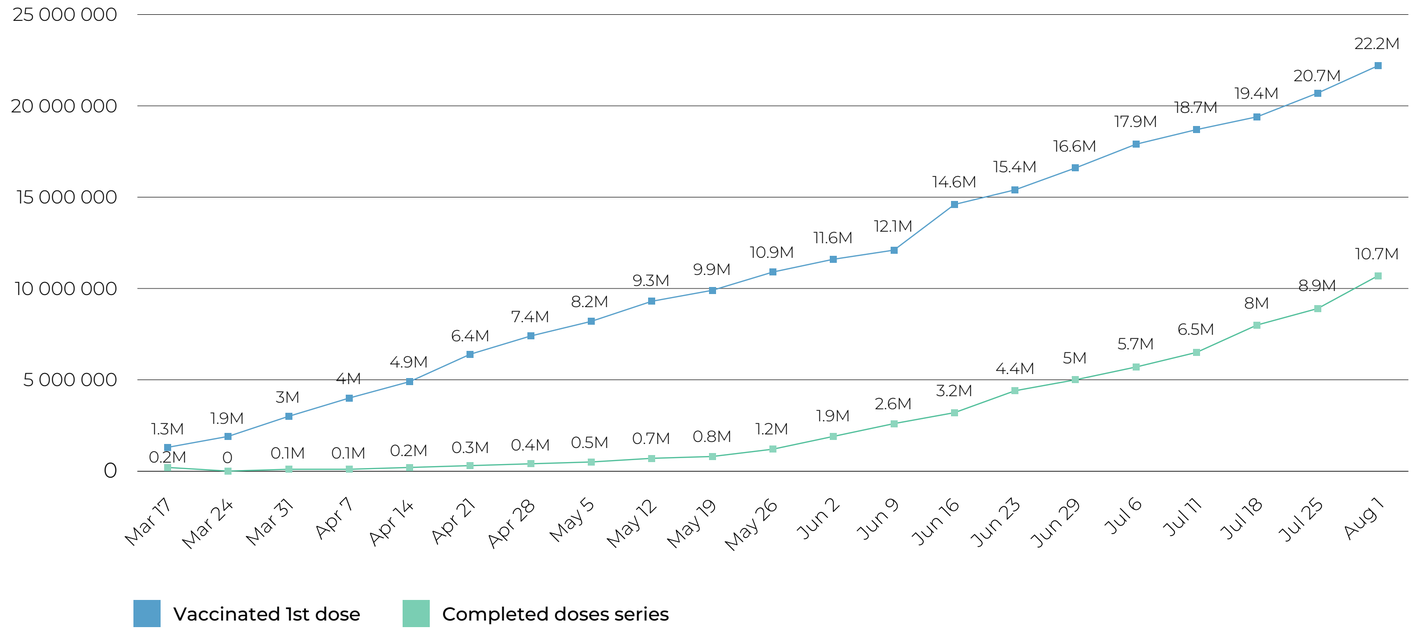
Cross-border surveillance is a key issue in disease management in the African context, primarily because traditional cross-border migration implies cultural or seasonal population movements, which may have no relationship with national boundaries or official borders. Utilizing the recent experience with Ebola virus disease, the enhanced dialogue during the past semester served to reinforce information and messaging, and harmonize practices, such as acceptance of PCR or antigen tests, procedures, and practices for officers at points of entry, contact tracing, and information to focal points. In addition, WHO engaged with organizations such as the Food and Agriculture Organization of the United Nations (FAO) to ensure transhumance groups – seasonal migration of pastoral communities – were mobilized about both human and animal health and safety measures, to avoid a spillover human to animal effect, which could further compromise food security.

2.10 Vaccination

At the cusp of a mass vaccination roll-out, with support and guidance from WHO, at least 40 African countries started vaccination planning before sufficient COVID-19 vaccines became available. Despite advocacy on the part of WHO and its partners in public health, a regional vaccination roll-out during the first six months of the year fell short of expectations. However, some countries made use of WHO's COVID-19 Vaccine Country Readiness Assessment Tool, and managed to vaccinate priority populations such as the elderly, health care workers and those suffering from preconditions. Despite the vaccine supply crunch, seven countries, including Equatorial Guinea, Mauritius, Morocco, and Seychelles had reached by end July vaccination rates significantly above the continental average. In addition, about 30 countries have used more than three quarters of the vaccines received.

To reach at least 40% of the population by year-end, WHO-AFR and its partners estimate that 780 million vaccines would be required for Africa. Encouragingly, whereas only 245 000 doses were supplied to just six countries in June, by July commitments to improve vaccine access and distribution began to materialize. By the end of the reporting period, 3.8 million vaccine doses were delivered to 13 countries through the COVAX Facility, bringing the total doses delivered to the continent to 82 million. These recently delivered vaccines are part of 60 million doses COVAX has allocated to 49 African countries, scheduled for delivery between July and September. However, with associated costs – distribution, personnel, logistics, and equipment hovering at US$ 5.00 for every US$ 1.00 spent on a

FIGURE 11: WHO African Region – Weekly trends of vaccine uptake per dose



vaccine –, at the time of writing this report, funding for the entire vaccination effort on the continent had not yet been resolved.

To increase Africa's capacity to address vaccine shortfalls more efficiently, WHO and its partners have advocated for domestic production of the COVID-19 vaccine, and a patent waiver for vaccines. As a result of these efforts, and following a loan from the United States, South Africa – the country with the largest number of cases on the continent – began vaccine production in June 2021. This initiative aims to produce 400 million doses of COVID-19 vaccines for the African market, which are set to be distributed by 2022. COVAX has also sealed deals with Sinopharm and Sinovac to supply 32.5 million vaccine doses to Africa. Allocated during the last week of July, these doses are scheduled for delivery as soon as countries are ready to receive them.

From the vaccination frontline

Ghana, the first African country to receive vaccines through the COVAX Facility, reached over 470 000 people in areas of highest prevalence of COVID-19 cases in just 20 days. This included some 60% of its first-phase target population, and around 90% of all health care workers. Ghana's strategy was to 'pre-list' populations through mapping, screening, and scheduling appointments for vaccinations in advance. Such a strategy was instrumental to the world's most rapid and well-targeted COVID-19 vaccination roll-outs. Strong logistical preparations and coordination were key to reaching people in remote areas in the country. To vaccinate elderly people living in hard-to-reach communities, Ghana's mobile vaccination teams received strong backing from community mobilizers.

In a similar manner, Angola's electronic pre-registration system helped ensure the right people were vaccinated and that they were aware of where and when to get the vaccine. SMS messaging, email confirmations and QR codes for on-site verification have also proven useful in preparing to deliver second doses, as well as collecting data to monitor the safety of vaccines. Angola vaccinated 70 000 people from priority groups across the country, half of whom were health care workers. In addition, the country invested in cold chain logistics and storage facilities to ensure that all COVID-19 vaccines, including those which must be stored in ultra-cold temperatures, will remain usable.

Mauritius, Rwanda and Seychelles, all of which had held wide-ranging vaccine roll-out simulation exercises in advance, achieved a strong rate of vaccination by the end of July. With support from WHO AFRO, several countries had conducted simulation exercises by mid-July, most possessing strong regulatory and safety procedures. This support enabled countries to secure personal protective equipment (PPE) for vaccination teams which made infection prevention a key part of the vaccine roll-out, in addition to training and supervision of the teams for safe vaccination delivery.

WHO / Blink Media – Nana Kofi Acquah

Ten steps to prepare for COVID-19 vaccine rollout in Africa

The World Health Organization (WHO), UNICEF and Gavi, the Vaccine Alliance, from the beginning of the year have been working with countries to shore up readiness using a 10-point assessment tool including:

- **Planning and coordination**
- **Training and supervision**
- **Resources and funding**
- **Monitoring and evaluation**
- **Vaccine regulation**
- **Vaccine cold chain and logistics**
- **Prioritization**
- **Safety and surveillance**
- **Service delivery**
- **Demand generation and communication**

Falsified vaccines

WHO-AFR deployed specialists, conducted trainings, and workshops in at least 40 countries to address weak regulatory systems, and to curb the expansion of falsified and substandard drugs and vaccines, along with false information and marketing. Countries took part in infodemic management and social listening exercises. A communication guide to explain the efficacy and safety of the Chinese manufactured Sinopharm and Sinovac was widely disseminated, to dispel misinformation regarding the alleged poor quality of those vaccines, as compared to other market brands.

From the field

What are the main challenges for Africa's COVID-19 vaccine roll-out?

COVID-19 vaccines are just one part of the response, but vaccine supply constraints pose a serious threat to the health and welfare of people on the African continent.

I would like to amplify the call from WHO to those countries that have already vaccinated their high-risk populations to share their excess doses. Many African countries are struggling and we cannot afford to wait until late 2022 to only protect our high-risk groups. Let us remember the world is interconnected, and that if Africa lags behind, there will be implications for the rest of the world.

The unpredictability of supplies demands an agile approach to the vaccine roll-out from us, and our teams are on high alert to assist countries around the clock. More delays in vaccinations will only exacerbate the emergence of new variants of the virus.

Having said that, if it hadn't been for the COVAX Facility, many African countries wouldn't even have the small number of doses they have received so far.

Dr Messeret Shibeshi
Immunization Officer

WHO

How COVAX Works:

COVAX is a partnership between the World Health Organization (WHO) and two international groups – Gavi, the Vaccine Alliance and the Coalition for Epidemic Preparedness Innovations (CEPI) – which aims to send vaccines to developing countries, with UNICEF as the main logistics partner. Most COVAX funding comes from high-income countries and organizations such as the Bill & Melinda Gates Foundation. At the summit of the G7 industrial nations in May, leaders announced a contribution of 850 million doses to the scheme. Another important collective vaccine initiative is the African Union's African Vaccine Acquisition Trust (AVAT). It is managed by Africa CDC, and in July UNICEF signed an agreement with Janssen Pharmaceutica NV to supply up to 220 million doses of the J&J single-dose vaccine to all 55 Member States of the African Union (AU) by the end of 2022. Some 35 million doses are to be delivered by the end of this year. Several African countries have purchased vaccines, or have negotiated bilateral vaccine donations from producing nations.

OCHA Sudan

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

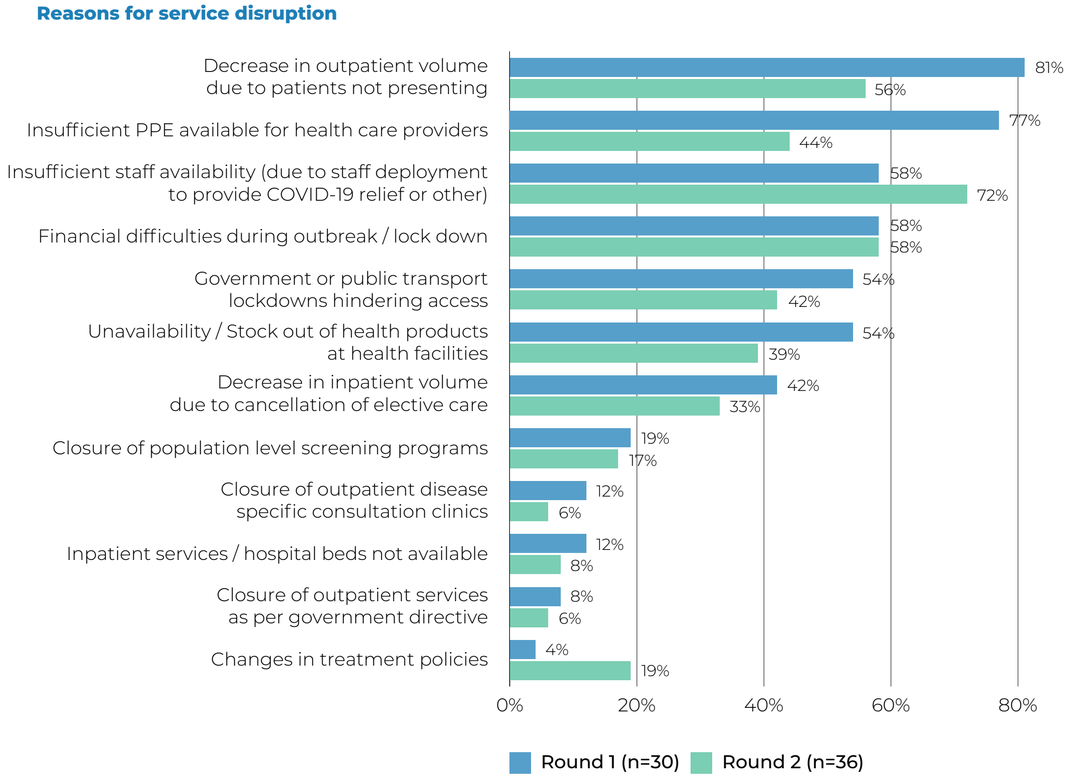
have increased from 58% to 72% of countries since 2020

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

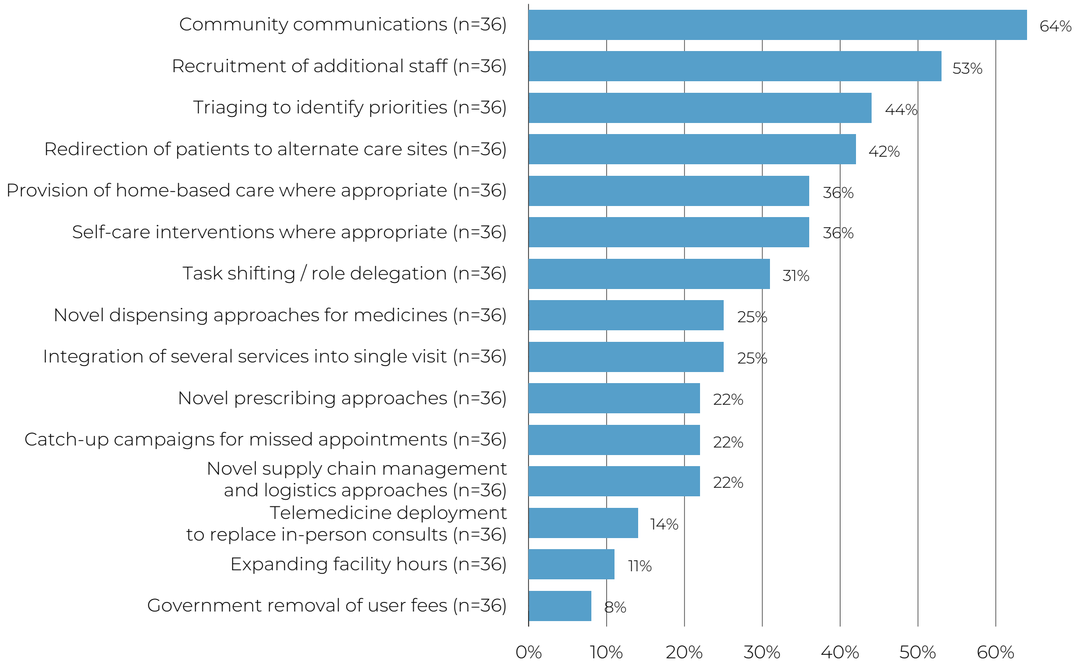
have redirected patients to alternative care sites

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*

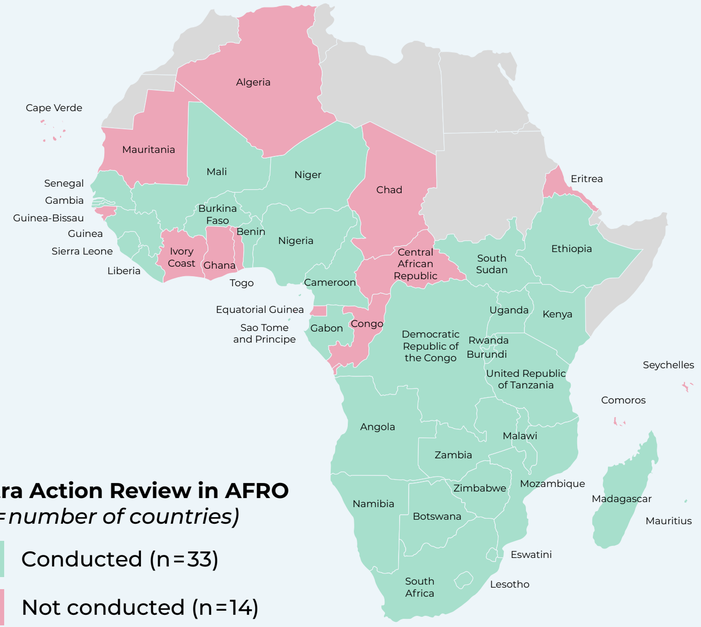
The most serious impediment to any plausible solution to tackle the crisis is the key issue of the chronic shortage of qualified personnel. Across the continent, at any given time, hospitals are short of qualified staff by at least 60%. In many countries, health practitioners live a constant cycle of 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

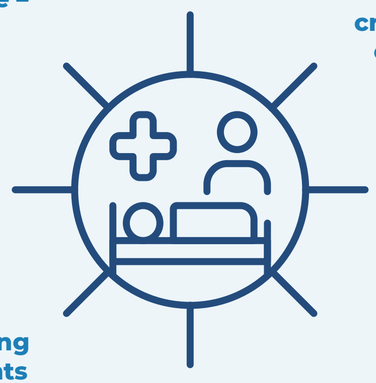
The African COVID-19 Critical Care Outcomes Study (ACCCOS) Investigators. Lancet 2021; 397: 1885-94

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.

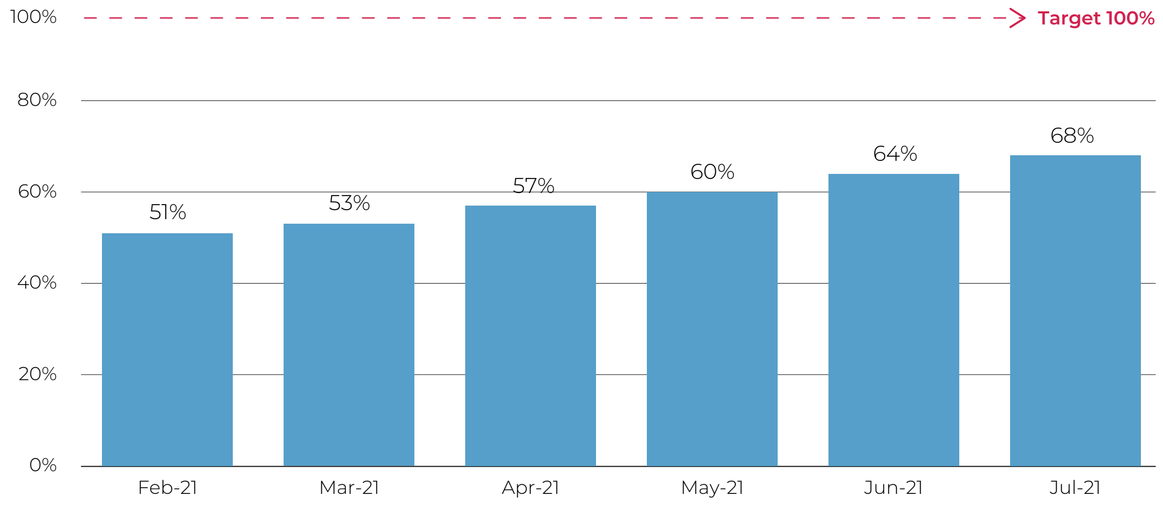
WHO / Dalia Lourenco

2.12 Integrated action and innovations for health

In cross-cutting areas such as innovation, digital health, research, laboratories, health information, primary health care and antimicrobial resistance, WHO-AFR continued to provide integrated support across technical programme areas. Among achievements, a database of more than 1000 technological innovations for COVID-19 was created to improve access to information on new approaches and tools. Intra-action reviews (IARs) were conducted in 20 countries; they constituted a collective learning exercise based on shared experiences and challenges and bottleneck recognition, which informed the updating of response plans and strengthened response structures.

Capacity to diagnose COVID-19 reached all 47 countries in the Region early in the year, with South Africa and Senegal having been the only countries able to do so at the start of the pandemic. With the support of WHO-AFR, four additional countries introduced polymerase chain reaction testing for the first time. Along with reliable antigen-detecting rapid diagnostic tests and effective access to easy-to-use tools, countries have been urged to scale up testing. Also, on laboratory-related innovation, WHO-AFR and Africa CDC, working in collaboration, launched the COVID-19 network of genome sequencing laboratories, and support is being provided to rapidly expand genetic surveillance capacities across the continent.

FIGURE 14: Percentage of countries that have conducted at least one intra-action review (IAR) or equivalent country-level review of COVID-19 response



On a related note, improving data and information management on the continent has been at the top of AFRO's priority activities. To better monitor health service disruptions and utilization by communities during the pandemic, a regional dashboard was created, and is being used by 27 countries, reflecting data from almost 7000 health facilities. Highlighted over the past year, gaps in mortality surveillance and civil registration and vital statistics are being addressed through the development of road maps, training and integrating the use of electronic medical certificates for cause of death. Along similar lines, under WHO AFRO guidance, Kenya, Namibia and Rwanda started preparations to introduce digital health platforms as part of strengthening information systems. Digital solutions were also found in other countries, with a new mobile application for case referral introduced in South Sudan.

At the reporting and academic level, the African Advisory Committee for Health Research and Development (AACHRD) supported young scientists from 20 countries to develop scientific papers related to universal health coverage and the Sustainable Development Goals. WHO AFRO also co-drafted and contributed information to at least 10 academic journals and medical trade articles, in addition to WHO-produced white papers.

Manufacturing medical products in the African Region

At a Forum convened by WHO from 21 to 25 June, decision-makers from government, academia, the international community, and research institutions discussed local production and technology transfer for national pharmaceutical and vaccines production. Participants were led in the discussions by Algeria, Ghana, Kenya, Rwanda, Ethiopia, Nigeria, Senegal and South Africa, which have already embarked on setting up capacities to manufacture vaccines.

The Forum responded to Africa's stark reality, where imports account for 70% to 90% of all medicines consumed, with tremendous implications on the capacity of people – and national health systems – to afford even the most basic medications. With countries unable to source, procure and dispense lifesaving oxygen (O^2) to patients, followed by dire shortages of vaccines on the entire continent, COVID-19 renewed Africa's commitment to reduce the continent's dependence on imported medical products.

Simultaneously, the discussion tackled a constant witnessed on the continent of fake – and often cheaper – or illegal medications. This calls for more robust regulatory systems, quality control and internationally standardized medicine manufacturing, in line with the African Union's Pharmaceuticals Manufacturing Plan for Africa. Together with the United Nations Economic Commission for Africa (ECA) and the United Nations Industrial Organization (UNIDO), WHO supports regulatory system strengthening to ensure better quality and prices for medicines bought and sold in Africa. Better regulations create an enabling environment for the domestic pharmaceutical industry and curb trafficking in falsified or dangerous medications, a marked issue during the COVID-19 crisis.

WHO / Booming – Carlos Cesar

From the field

Tracking progress of COVID-19 intra-action review recommendations in Sierra Leone

COVID-19 is a protracted pandemic that is likely to remain with us for quite some time despite the recent gains in vaccination. For this reason, countries will need to periodically assess the situation to determine whether to scale up the response in case of resurgence or scale it down if the situation is under control. One strategy to assist with this determination is conducting intra-action reviews (IAR).

In Sierra Leone, WHO supported the first COVID-19 IAR in September 2020. It was about the fifth country globally and the second in Africa to have done so. The main goal of the IAR was to generate sufficient information on critical issues affecting the COVID-19 response that would guide the government on strategies to sustain the gains and improve on the outcome of the response. The following six main thematic technical coordinating structures were reviewed: National Coordination, Surveillance, Laboratory, Case Management, Risk Communication and Community Engagement and Food and Nutrition. Several recommendations were generated from each pillar and prioritized as immediate, medium term or long term.

A committee was formed to follow up on the implementation of the IAR recommendations. The WHO Country Office in Sierra Leone, in communication with AFRO, plays a key role in supporting the committee in tracking this implementation. Accordingly, WHO in March supported the Government to convene a six-month stakeholders' implementation progress assessment of surveillance, laboratory and case management, with varying degrees of progress reported. Out of eight surveillance recommendations, 13% had been fully implemented, 75% were ongoing and 13% had not started. Out of 16 laboratory recommendations, 94% were ongoing and 6% had not started. Out of 12 recommendations for case management, 17% had been completed, 33% were ongoing, while 50% had not started.

WHO continues to support the Government of Sierra Leone in tracking implementation of the IAR recommendations, documenting best practices and using the lessons learnt in tackling future COVID-19 resurgences.

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