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# Report on the Strategic Response to COVID-19 in the WHO African Region

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February – December 2020



**World Health  
Organization**

REGIONAL OFFICE FOR

**Africa**

**Report on the Strategic Response to COVID-19 in the WHO African Region**  
**February to December, 2020**

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# Contents

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<b>Foreword</b>	<b>XI</b>
Director-General World Health Organization	XI
Regional Director for Africa World Health Organization	XIII
<b>Executive Summary</b>	<b>XIV</b>
<b>Introduction</b>	<b>1</b>
<b>Response Strategy</b>	<b>8</b>
Strengthening surveillance, rapid response and case investigation to control the spread of COVID-19	10
Cross-border collaboration and measures to reduce the risk of importation of COVID-19	11
Improving laboratories in Africa to test for COVID-19 and beyond	13
Treating, Isolating and Caring for COVID-19 patients in Africa	18
Continuing essential health services during COVID-19	20
Preventing COVID-19 infection among health workers and patients	24
Preventing and containing COVID-19 by communicating effectively, engaging communities and transmitting risks	30
Delivering essential supplies and equipment amid massive global disruptions	32
External Communication	38
Advancing research, innovations and vaccines to combat COVID-19	39
Providing essential Personnel to support countries and save lives	42
<b>Milestones achieved since the onset of the pandemic</b>	<b>43</b>
<b>Heroes of COVID-19</b>	<b>44</b>
<b>Lessons learnt and emerging challenges</b>	<b>48</b>
<b>Partners in saving lives and protecting communities</b>	<b>49</b>
<b>Financial Overview</b>	<b>53</b>
<b>The Way Forward: Building back better</b>	<b>57</b>



**Now more than ever, we  
need a healthier world.  
Now more than ever, we  
need a safer world.  
Now more than ever, we  
need a fairer world.”**

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**Dr Tedros Adhanom Ghebreyesus**  
Director-General  
World Health Organization

# Foreword



The COVID-19 pandemic has changed the world we live in, with more than 114 million cases and 2.5 million deaths reported as of the time of writing. In many communities, schools and businesses closed for months, causing significant hardship, particularly for the most vulnerable people.

The pandemic has highlighted a surprising paradox: some of the wealthiest countries, with the most advanced medical technology, have been hardest hit, while many countries in Africa have fared relatively well, thanks in part to their experience in applying basic public health tools to prevent and respond to outbreaks of infectious disease.

The lesson is clear: investments in public health functions are essential, especially primary health care, which is the first line of defence against health emergencies, and the foundation of universal health coverage.

The pandemic has triggered the fastest and most wide-reaching response to a global emergency in generations. This report shows that, under WHO leadership, the response in the African Region has been swift and unparalleled, with the mobilization of science, a search for solutions, and commitment to come together in solidarity to defeat this virus.

We have seen individual and collective acts of kindness and generosity, and support to health workers to keep them safe while caring for patients. Billions of people are playing their part to keep themselves and others safe, through physical distancing, avoiding crowds, wearing masks and practicing hand hygiene. The effective use of proven public health measures like surveillance, testing, isolation, supported quarantine and quality care have enabled many countries to prevent or control widespread transmission.

In addition to these proven public health tools, diagnostics give us the ability to detect the COVID-19 virus, oxygen and dexamethasone give us the ability to treat it, and vaccines are now giving us an extra tool to prevent it.

WHO and our partners in the ACT Accelerator have worked day and night for equitable access to these tools for communities in Africa and other parts of the world. This isn't just a moral imperative; it's also an economic and strategic imperative. We will not end the pandemic anywhere until we end it everywhere.

Bringing this pandemic to an end and improving health outcomes requires an all-of-society effort and I thank the governments, partners and communities in the WHO African Region for your sustained support.

Working together, we can build a healthier, safer, and fairer world, for all of us.

**Dr Tedros Adhanom Ghebreyesus**

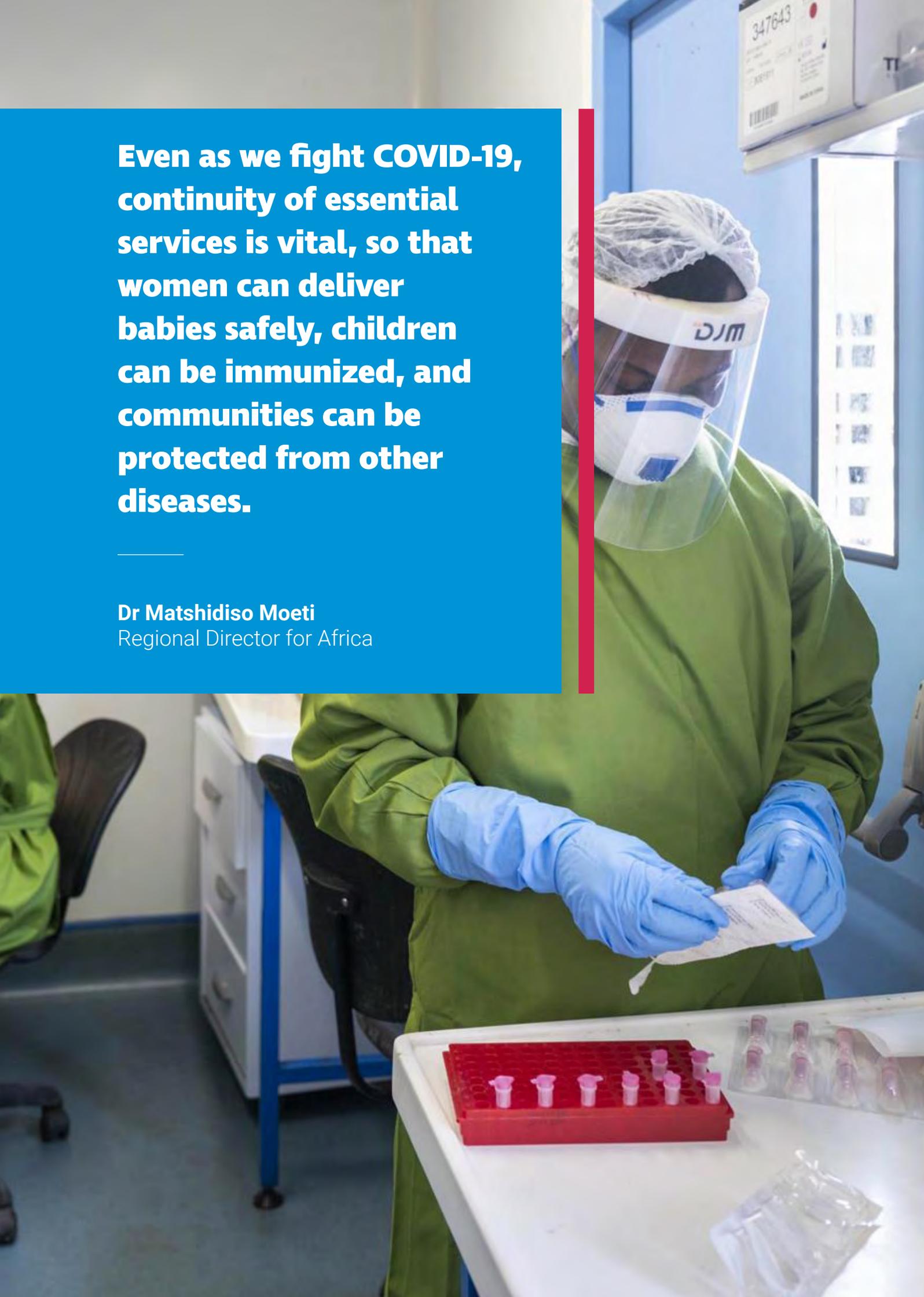
Director-General

World Health Organization

**Even as we fight COVID-19, continuity of essential services is vital, so that women can deliver babies safely, children can be immunized, and communities can be protected from other diseases.**

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**Dr Matshidiso Moeti**  
Regional Director for Africa



# Foreword

The COVID-19 pandemic is taking a tremendous toll on lives and livelihoods globally, including in the WHO African Region. As we publish this report in February 2021, more than 3 million cases have been reported on the African continent and 79 000 lives have been lost. Cases and deaths in Africa account for around 3.5% of the global total. The strong leadership of African governments, the fortitude and perseverance of communities, and the contributions of partners have been vital in slowing the spread of COVID-19 in Africa.

This report highlights the results achieved in responding to the pandemic in the WHO African Region, in line with the Strategic Preparedness and Response Plan (SPRP) elaborated in February 2020. Progress in surveillance, cross-border collaboration, testing, infection prevention and control, treatment and the continuity of essential health services are shared, as well as best practices in Member States, emerging challenges and lessons learnt, which will inform our collective response going forward.

Since the onset of the pandemic, WHO has repurposed more than 1286 staff, deployed over 446 international experts, supported the training of over 200 000 health workers, and provided essential supplies to all 47 Member States of the African Region.

The valuable financial, material and technical support of partners has enabled the African Region to mount an unprecedented multipronged response. The need remains for sustained predictable and flexible funding, to ensure that WHO country offices are able to fulfil their role as the closest advisers to ministries of health and that the Regional Office is equipped to provide strategic and technical backstopping, guidance and coordination.

We know that this pandemic is far from over. The Region faces severe challenges, including ensuring timely access to COVID-19 vaccines, tackling the severe socioeconomic impact of COVID-19 on already vulnerable populations, strengthening fragile health systems, providing improved testing equipment, and combating the increasing number of health-care worker infections by ensuring continuous access to sufficient personal protective equipment.

We also know that COVID-19 is one of many challenges facing African countries and that a comprehensive approach is needed to build resilience and realize sustainable development – strengthening health systems, empowering and engaging communities, and addressing the social determinants of health. By working together in these areas, with solidarity and equity, we can defeat COVID-19 and improve well-being in the African Region.

**Dr Matshidiso Moeti**

Regional Director for Africa  
World Health Organization

*19 March 2021*



# Executive Summary

## Strategic Response to COVID-19 in the WHO/AFRO

Since the first imported case of COVID-19 was reported in the WHO African Region in February 2020, responses of varying adequacy have been provided by all the countries in the Region with the coordinated support of the Regional Office and all the partners. The COVID-19 pandemic has affected, albeit to varying magnitudes, all the 47 countries of the Region, inducing significant socioeconomic impacts.

By the end of 2020, the African continent reported cases surpassing the two million mark, including around 300 000 active cases. Countries' response capacities have been strengthened to contain and suppress the COVID-19 outbreak in the Region.

In February 2020, WHO/AFRO published the COVID-19 Strategic Preparedness and Response Plan (SPRP). The SPRP was updated on 4 May 2020. The SPRP set out one goal: "To ensure that ALL countries in the WHO African Region establish and sustain the response capacities and capabilities at national and subnational levels to contain the spread and mitigate the impact of the COVID-19 pandemic". The SPRP has five strategic objectives for tackling the spread and limiting the harm caused by the disease, namely: (1) Strengthen the existing regional coordination mechanisms for strategic, technical, and operational support to countries in collaboration with regional, subregional, national and international partners; (2) Scale up country readiness and response interventions to contain and mitigate COVID-19 and support continuity of routine health services; (3) Strengthen public awareness through an integrated risk communication and community engagement approach to COVID-19 including a psychosocial component in all 47 Member States; (4) Accelerate support for a clear and transparent process to set research and innovation priorities to fast-track and scale up research, development, and the equitable availability of candidate therapeutics, vaccines, and diagnostics; and (5) Conduct robust and continuous monitoring and evaluation of response capacities using key performance indicators (KPIs) in ALL countries.

**From the onset of the pandemic, WHO's leadership and coordination role with UN agencies, the African Union (AU) and the regional economic communities (RECs), the UN Economic Commission for Africa (UNECA) and other partners has been strengthened both at regional and country levels to ensure coherence, alignment and complementarity of actions.**

Based on the findings from the Member State self-assessment and the key priorities identified by the WHO Secretariat to meet the strategic objectives, WHO has undertaken numerous actions focusing on capacity building and operational support through 12 intervention pillars namely: Coordination, planning and monitoring; Surveillance, rapid response teams and case investigation; Points of entry (PoEs); National laboratory system; Case management; Continuity of health services; WASH and infection prevention and control; Risk communication and community engagement (RCCE); Operational support and logistics (including supply management); External communication; Research, innovations and vaccines; Human resources to support countries, including capacity building and policy guidance, and strategic partnerships.

From the onset of the pandemic, WHO's leadership and coordination role with UN agencies, the African Union (AU) and the regional economic communities (RECs), the UN Economic Commission for Africa (UNECA) and other partners has been strengthened both at regional and country levels to ensure coherence, alignment and complementarity of actions. At the Regional Office, WHO activated a COVID-19 incident management support team (IMST) to provide operational and technical support to countries and national incident management systems and teams. All 47 countries have developed response plans and put in place high-level mechanisms to coordinate the response at national and subnational levels. In addition, all countries have been supported to adapt

guidelines, recommendations and tools developed by WHO, including the monitoring and evaluation framework, for continuous adaptation of the response based on lessons learnt and tracking of key essential indicators.

In terms of information sharing, WHO continues to produce weekly bulletins and situation analysis reports (SITREPS), as well as providing weekly epidemiological updates on COVID-19 through the United



Nations Economic Commission for Africa (UNECA) coordination platform, which brings together Member States and partners to address/adjust bottlenecks in the COVID-19 response. WHO AFRO developed and disseminated 34 editions of external situation reports and 288 editions of daily situation reports to monitor the evolution of the COVID-19 outbreak in the Region, including an interactive dashboard (accessible via the portal of the African Health Observatory at [\[LINK\]](#) or [\[LINK\]](#)) for real-time monitoring of the pandemic in the Region. As a result of WHO AFRO's support, 26 countries in the Region are using several tools to boost their contact tracing programmes, including GO.Data, EWARS and Outbreak Toolkit for better data management.

Over 300 technical staff have been deployed to the countries in technical areas such as surveillance, coordination, treatment, infection prevention and control and testing. Moreover, more than 53 COVID-19 capacity building webinars have been conducted covering diverse topics such as IPC, IDSR, IMS, nutrition, MHSPs, case management, laboratory and modes of transmission. These webinars reached diverse health care workers such as nurses, doctors, etc.

A total of 26 countries in the WHO African Region implemented partial or nationwide lockdowns, while 44 countries closed their borders. Of these, 39 countries continued to allow in cargo, humanitarian and emergency flights. WHO developed and provided guidance on the management of ill travellers at international airports and seaports, controlling the spread of COVID-19 at ground crossings, managing

COVID-19 cases in aviation and outbreaks on board ships. At the same time, technical capacity has been strengthened in several countries for points of entry staff. As a measure to mitigate the risk of the epidemic spreading through countries' points of entry, almost all of them have set up screening procedures (through testing or the obligation to present valid test results) at airports and seaports

Even before the first case of COVID-19 was detected on the African continent, WHO began preparing its Member States and mobilizing national and regional laboratory systems and testing capacities. By the end of June, all countries in the Region could test for COVID-19 by PCR. Twenty international laboratory experts were deployed to 13 countries<sup>1</sup>. The WHO Laboratory Community of Practice has hosted 14 webinars on topics related to COVID-19 testing, attracting 600 participants from over 28 countries. Two global external quality assurance exercises were launched with 227 participating laboratories from all 47 countries. With the support of WHO and partners, 39 countries have successfully decentralized testing, with over 790 COVID-19 testing laboratories operational in the Region. Working closely with all the partners, over 8.2 million testing commodities including 5.4 million tests and extraction kits and 2.8 million sample collection supplies have been shipped to countries in the Region. WHO has also launched the COVID-19 network of genome sequencing laboratories. The network includes three specialized labs in South Africa and Nigeria and nine regional labs covering the needs of all Member States of the African Region.

COVID-19 has placed a huge stress on already strained health systems in the African Region. WHO deployed case management experts and provided extensive technical guidance and distance training on clinical care of COVID-19 patients to more than 12 000 medical doctors and 44 000 nurses in 47 countries. WHO has helped increase the number of oxygen plants in the Region from 68 to 101, and the number of oxygen concentrators from 2 600 to 5 100. Moreover, WHO has procured 79 320 134 PPE materials to reduce the risk of workplace exposure for health care workers.

In addition to the direct mortality caused by COVID-19, efforts by already weak health systems to contain the virus have stretched the health workforce and led to disturbing disruptions in the delivery of other essential health and social services. To guide its support to countries, WHO conducted two rapid assessments to analyse service disruption. On average, countries reported partial or severe/complete disruptions to 54% of the 25 assessed health services. Disruptions were caused by a combination of demand and supply-side factors, which included patients not presenting (81%) and insufficient personal protective equipment for health care workers (77%). However, it is noteworthy that 53% of the countries from the Region defined the essential health services to be maintained during the COVID-19 pandemic.

**Even before the first case of COVID-19 was detected on the African continent, WHO began preparing its Member States and mobilizing national and regional laboratory systems and testing capacities.**

WHO has further provided support to identify the health services most affected by the pandemic, training, technical expertise, as well as guidance and tools to scale up the delivery of essential services. Guidelines were developed by WHO, covering all the major NCDs. WHO has also set up monitoring systems with 22 African countries to track service delivery data in around 4800 health facilities.

Infection prevention and control (IPC) is critical to combating COVID-19, by containing the spread of the virus within health care facilities, as well as preventing transmission of the infection to health care workers and among patients. An assessment of IPC/WASH national programmes and implementation of IPC measures in 1967 health facilities in 28 countries showed a mean IPC performance score of 66%. WHO deployed at least one IPC expert each to 22 countries, recruited local experts for 25 countries, while 6495 health workers were trained as master trainers, and

<sup>1</sup> Ethiopia, Chad, Mauritania, Botswana, Equatorial Guinea, Gambia, Sao Tome and Principe, Comoros, Lesotho, Zimbabwe, Rwanda, Congo and Tanzania.

over 200 000 trained – virtually and face-to-face – in basic IPC strategies. IPC guidelines and protocols were disseminated to all 47 countries, including on the local production of WHO-recommended alcohol-based hand rub.

With COVID-19, a new pathogen that soon became a pandemic, risk communication and community engagement (RCCE) was crucial in clearing confusion, avoiding misunderstandings, building trust in the response, increasing the probability that health advice was followed, and minimizing and managing rumours that undermined the responses and could lead to further spread of the disease. All 47 countries have been supported in developing and implementing risk communication and community engagement plans. Over 10 645 participants in 16 countries have been trained on the WHO RCCE 5-Step Package for the Region. In West and Central Africa, 15 countries conducted research for a better understanding of the contexts, identified effective communication channels, influencers and/or credible leaders, tools and approaches that fit with communities' expectancies and address their worries.

The COVID-19 outbreak has led to an acute shortage of materials, systems, personnel, life-saving medical commodities and equipment needed to respond rapidly to alleviate suffering among Africa's populations. To ensure market access for low and middle-income countries, WHO and partners created a UN COVID-19 Supply Chain System, which serves alongside the WHO procurement system to respond to 897 requests totalling US\$ 88.5 million from all 47 countries in the Region. Therefore, WHO and other partners (such as the Global Fund/GDF/UNICEF/UNDP/UNITAID-CHAI) provided 3 096 040 sample collection kits, 9 153 386 test kits (manual PCR) and a range of PPE items including 1 417 410 face shields, 9 739 165 gloves, 165 170 goggles, 1 351 067 gowns, 51 783 950 medical masks and 2 207 430 respirators. WHO also called for humanitarian corridors and Solidarity Flights, to ensure enhanced, equitable access to essential supplies across every country in the African Region. Meanwhile, 450 participants from 33 countries attended the health logistics webinars on SARI facilities, waste management and ventilation.

COVID-19 has dramatically shaken up health communication; the WHO Regional Office for Africa has scaled up information provision through regular media briefings and increased social media and website content production. The nearly 30 press conferences held, and 30 press releases issued, as well as the over 600 interviews conducted with WHO experts have also helped to dispel misinformation and ensure factual reporting. The proliferation of misinformation and disinformation on social media has been a real challenge for the response, and WHO in the African Region is setting up an Infodemic Response Alliance to collectively manage the infodemic.

In different geographic and resource settings, COVID-19 has generated demand for innovation and a transformative approach to address the extraordinary challenges posed by the virus. WHO has worked closely with partners including Africa CDC to support countries with standard protocols to generate critical evidence to design country-specific pandemic responses. WHO AFRO spearheaded spotlight events including hackathon and innovation webinars to harness innovations that



could be deployed for the COVID-19 response in the Region. The COVID-19 pandemic has galvanized the development of more than 120 health technology innovations that have been piloted or adopted on the continent. WHO has unearthed innovations that are being rolled out at country level such as VaxiGlobal (fighting against fake COVID-19 certificates), mSafari (a contact tracing tool) and NextGenCovAI (real-time test results). WHO has put in place a multistakeholder African COVID-19 Vaccine Readiness and Delivery Taskforce to coordinate regional efforts in this area, with the support of partners.

To support countries' response to COVID-19, international emergency medical teams (EMTs) were dispatched to 16 African countries. Additionally, WHO has repurposed over 1286 staff to support COVID-19 efforts at regional and country levels, and more than 446 international experts were deployed to 45 countries in the Region. A regional EMT training centre was also established in Addis Ababa to scale up the implementation of national EMTs for the COVID-19 response.

The WHO Regional Office for Africa has worked closely with over 100 partners on outbreak preparedness and response in the Region. The COVID-19 pandemic has demonstrated that partnerships and international solidarity are vital to save lives and overcome the devastating socioeconomic impacts of this virus. Partnerships with UN agencies include the WHO and World Food Programme (WFP)-led partnership, which in collaboration with national governments and the AU supported the establishment of humanitarian air corridors for the transportation of expert equipment in response to the pandemic. Partners including the African Development Bank, the World Bank, Germany, the European Civil Protection and Humanitarian Aid Operations (ECHO), the United Kingdom and China among others, together with foundations, multilateral organizations and the private sector, have contributed to the procurement and delivery of essential medical supplies and equipment to 47 countries.

The Region faces severe challenges in responding to the COVID-19 pandemic, including the highest rates of HIV/AIDS, tuberculosis (TB) and malaria in the world, as well as poverty and fragile health systems. This is compounded by the presence of millions of internally displaced persons (IDPs), refugees and other groups affected by protracted humanitarian crises in several countries, floods, locust invasions and other emergencies, including the Ebola outbreak in the Democratic Republic of the Congo, seasonal peaks of malaria, measles epidemics, cholera, and malnutrition.

Several countries such as Nigeria, Mauritius, Ethiopia, Cameroon and others have developed good practices in monitoring and managing points of entry and building an effective national laboratory system in the fight against COVID-19. All countries can now diagnose COVID-19, averaging 167.4 tests per 10 000 population. WHO has worked with partners to provide training to some 200 000 health workers.

Despite these encouraging results, the scale of the challenge is huge. A lot more needs to be done, and more speedily, as the pandemic continues to accelerate across the African Region. The strong and determined leadership of African Heads of State continues to be vital in prioritizing actions to address the socioeconomic impacts of COVID-19 through concerted efforts to save lives and protect livelihoods. With the current evolution of the pandemic, the partners in the Region will need greater collaboration to strengthen their efforts on access to vaccines. Indeed, the COVAX facility is working with the WHO coordinated ACT Accelerator to ensure that global solidarity and equity prevail in the global fight against the pandemic. We need to prepare for regulatory approvals of vaccines, delivery strategies for priority groups and much needed sustainable, flexible and predictable funding to sustain these efforts. WHO in the African Region will continue to support countries, particularly "hot spot" or high-risk countries by mobilizing surge support and repurposing staff to the most affected countries.

# Introduction

The WHO African Region remains one of the least affected by the COVID-19 pandemic, accounting for 2.3% (1 856 571) of cumulative reported cases, and 2.3% (41 505) of cumulative deaths globally (case fatality ratio, 2.2%) The Region observed a sustained decline in case incidence as from mid-July 2020, but since the end of September 2020, it has known a continuous increase and it is currently facing the same level of case incidence as during the first peak. All the 47 countries in the Region are experiencing cases on their soil. Most of them are currently facing community transmission (42), including eight countries with high incidence and one country with uncontrolled incidence (South Africa).

The top five countries (South Africa, Ethiopia, Algeria, Kenya and Nigeria) account for 77% of total cases and 85% of total deaths. As of 29 December 2020, a total of 1 545 452 (83%) case-patients reported from all 47 countries in the Region had recovered, with Gabon (98.4%) and Côte d'Ivoire (98.3%) experiencing the highest recovery rate, and Uganda (33.4%) and Niger (48.5%) the lowest, which could be attributed to these countries underreporting recoveries. As with other regions, deaths have occurred primarily among older people with pre-existing conditions such as cardiovascular disease, diabetes and chronic respiratory diseases. Infections among health workers have been gradually increasing, and account for 66 954 (3.6%) infections reported in 42 countries.



Figure 1: Cumulative reported cases in countries of the WHO African Region

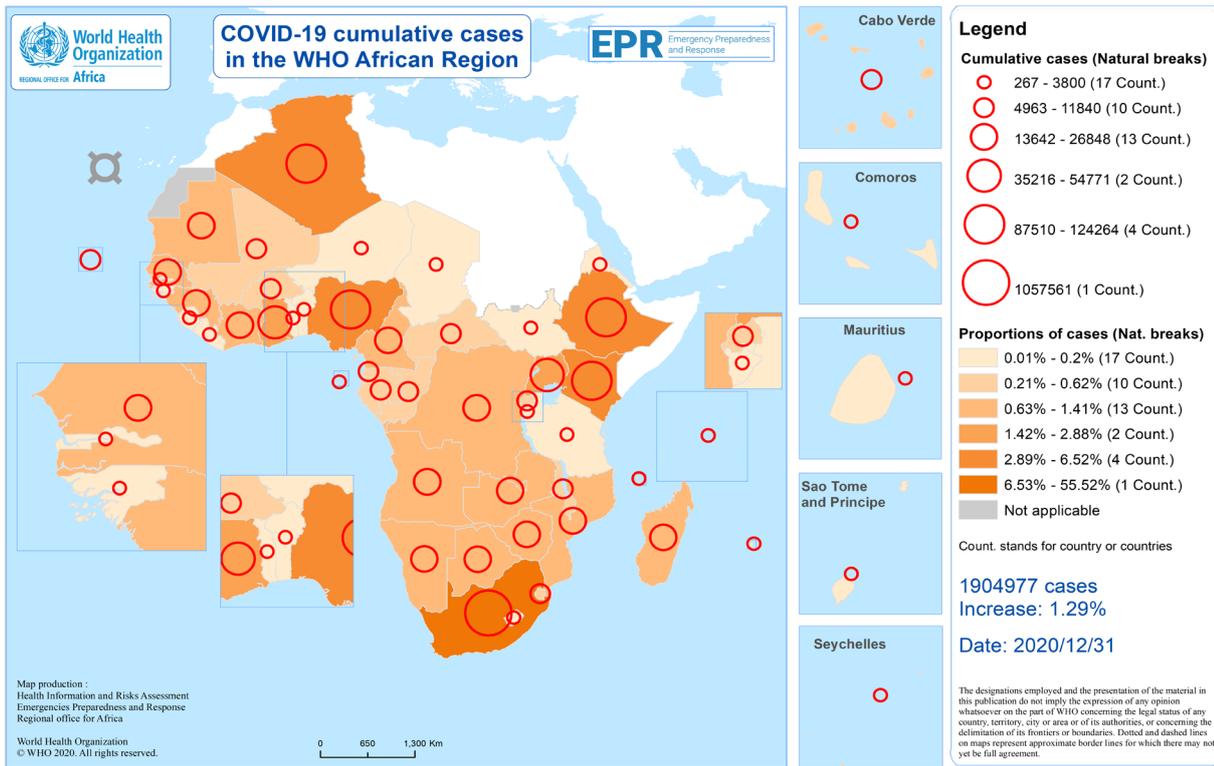


Figure 2: Cumulative attack rates per country of the WHO African Region

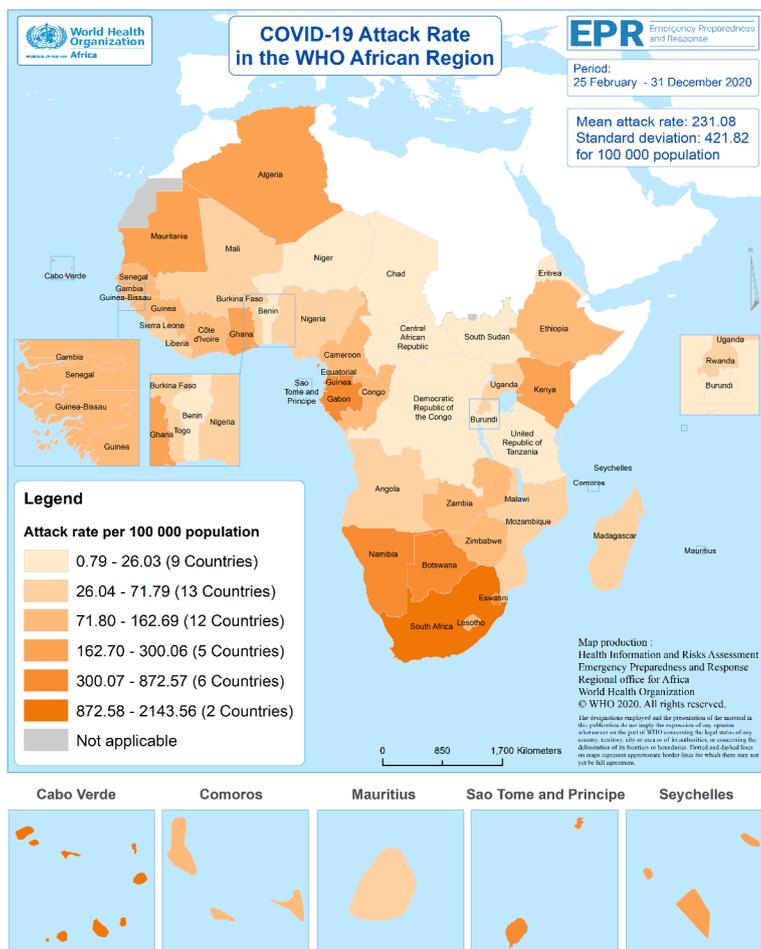
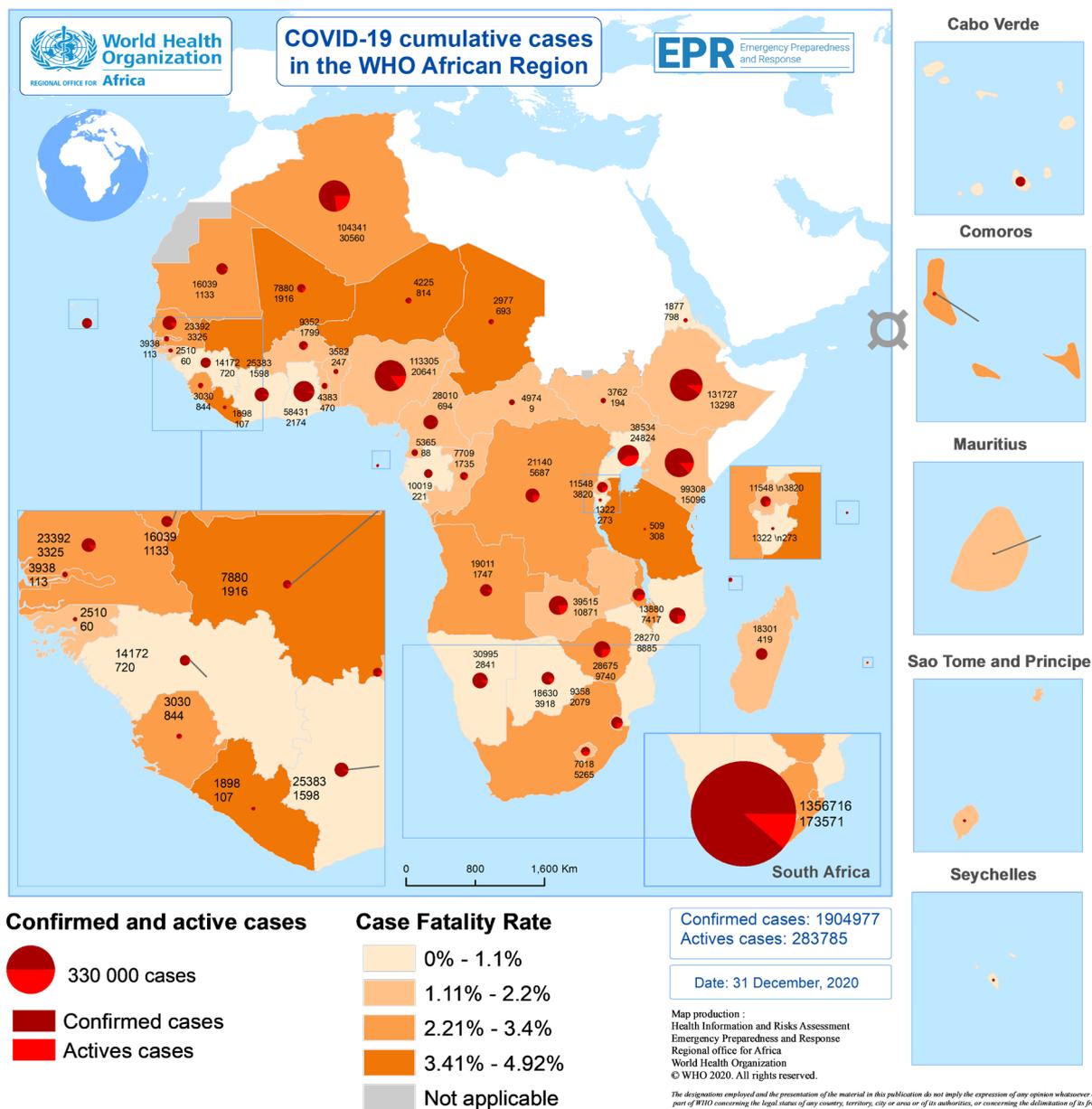


Figure 3: Cumulative reported cases/deaths per 100 000 population in countries of the WHO African Region



COVID-19 continues to devastate health systems, economies, livelihoods and sociocultural activities, threatening to reverse development gains and economic growth prospects in the Region. The pandemic has had major impacts on already fragile and overburdened health systems, constraining their capacity to continue delivering essential health services. In addition to COVID-19, countries in the Region face the highest global rates of HIV/AIDS, tuberculosis (TB) and malaria, as well as other health emergencies including the Ebola outbreak in the Democratic Republic of the Congo, Chikungunya in Chad, seasonal peaks of malaria, measles epidemics, yellow fever, cholera and malnutrition.

Measures needed to curb the pandemic, including national lockdowns, curfews, closure of borders and schools, restrictions on trade, travel and mass gatherings and the scale down of public services and economic activities have had devastating effects on the socioeconomic fabric of communities throughout the Region, with millions of people facing the risk of falling into extreme poverty. According to the World Bank, with the informal sector, a major source of income and employment in sub-Saharan Africa

being one of the hardest-hit by the pandemic, the Region is forecast to move into recession for the first time in more than 25 years and experience an increase in the proportion of people in extreme poverty for the first time in two decades.<sup>2</sup>



- 47 countries have **closed and re-opened schools,**
- 43 countries have **applied international travel restrictions** (closed and re-opened borders),
- 4 countries have **never applied international travel restrictions,**
- 26 countries have **imposed lockdowns** (nationwide lockdowns, 14 countries and partial lockdowns, 12 countries),
- 30 countries have **imposed a curfew,**

- 37 countries have **closed restaurants and bars,**
- 35 countries have **suspended religious activities,**
- 32 countries have **imposed a 14-day quarantine,**
- 29 countries have **officially suspended sporting activities/events,**
- 47 countries **require the use of face masks,**
- 44 countries require a **PCR test 3-5 days before return travel to the country of departure.**

<sup>2</sup> COVID-19 Economic Impact: Sub-Saharan Africa, International Finance Corporation, September 2020

The response to the pandemic is further compounded by poverty, floods and locust invasions and protracted humanitarian crises in several countries,<sup>3</sup> leading to millions of internally displaced persons (IDPs) and refugees. Despite these many challenges, progress has been achieved in several areas and there are reasons for hope and optimism.

## Preventing transmission and reducing deaths

**“Nigeria recognizes the strong role WHO has played in coordinating the global response to the COVID-19 pandemic, in especially challenging circumstances. Nigeria is grateful for the strong collaboration and support from WHO at the global, regional and country levels in strengthening the country’s response activities”**

**Dr Chikwe Ihekweazu**

Director General of Nigeria Centre for Disease Control (NCDC)

WHO has been at the forefront of efforts by a wide array of partners to support countries in the African Region to adequately plan, finance and implement their response to COVID-19.

In January 2020, even before the World Health Organization declared the COVID-19 outbreak a pandemic on 11 March 2020, WHO classified countries into three priority groups<sup>4</sup> using criteria which included high international traffic to and from affected countries, and reports of IHR core capacities. This was instrumental in determining rapid and effective support to

countries when the first few cases of COVID-19 reached the Region, notably all countries classified under priority 1 by WHO.

As part of the global WHO response, a Regional Strategic Preparedness and Response Plan (SPRP) was developed in February 2020 and updated in May 2020, to build capacity and support countries to establish and sustain their response capabilities at national and subnational levels to interrupt and contain the transmission of COVID-19 and reduce deaths in the Region. Strategic areas of engagement included coordination and operational support, scaling up country preparedness and response activities, continuity of essential health services, research, innovation and vaccines, and communication.

The strategies were based on gaps identified through COVID-19 readiness assessments conducted by countries in February 2020 with the support of WHO and partners, as well as key priorities necessary to meet the strategic objectives. At the beginning of the pandemic, the regional preparedness and readiness levels of countries in the Region was 66%<sup>5</sup>.



1. Coordination, Planning and Monitoring
2. Surveillance, rapid response teams and case investigation
3. Points of entry (PoE)
4. National laboratory systems
5. Case management
6. Continuity of health services
7. Wash and infection prevention and control
8. Risk communications and community engagement (RCCE)
9. Operational support and logistics (incl. supply management)
10. External communication
11. Research, innovations and vaccines
12. Human resources to support countries

<sup>3</sup> Burkina Faso, Cameroon, Central African Republic, Democratic Republic of the Congo, Ethiopia, Mali, Niger, Nigeria, South Sudan

<sup>4</sup> Priority 1: Algeria, Angola, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Ethiopia, Kenya, Mauritius, Nigeria, South Africa, United Republic of Tanzania, Uganda and Zambia; Priority 2: Chad, Eritrea, Equatorial Guinea, Gabon, Guinea, Madagascar, Mali, Mauritania, Mozambique, Rwanda, Senegal, Seychelles, Togo and Zimbabwe; Priority 3: Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic (CAR), Comoros, Eswatini, Gambia, Guinea-Bissau, Lesotho, Liberia, Malawi, Namibia, Niger, Sao Tome and Principe, Senegal, Sierra Leone and South Sudan

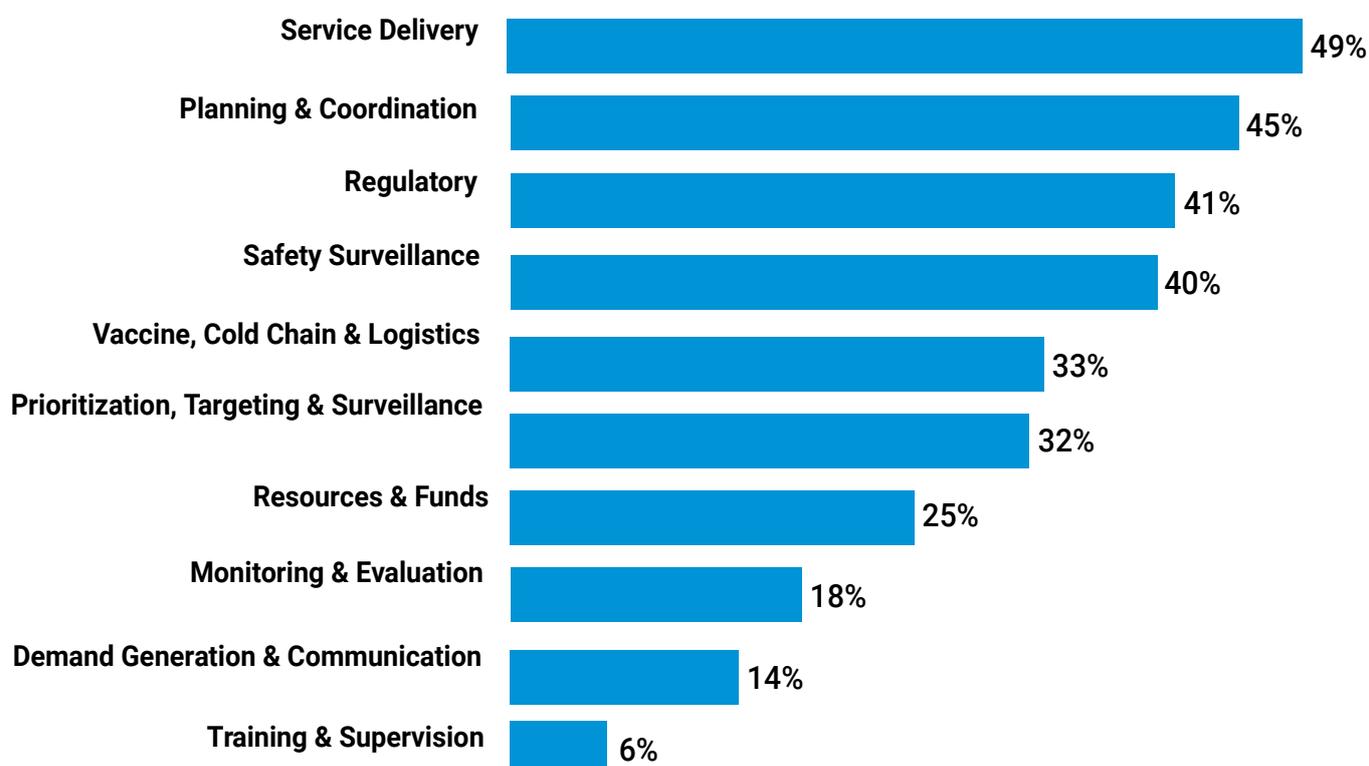
<sup>5</sup> 70% for PoEs, 53% for RRT, 65% for preparedness, 71% for laboratory, 75% for RCCE, 58% for IPC, 79% for coordination and 82% for logistics.

Since then, much progress has been made, particularly in capital cities, the sites of the first cases of the virus. By March, the regional readiness status rose to 77% and 80% by June. The self-assessments and gap filling conducted before the outbreak was reported, and more than 200 experts deployed to enhance readiness capacities throughout the WHO African Region were instrumental in helping countries quickly transition from readiness to response as soon as the first imported cases were detected.

Self-assessment on vaccine introduction readiness from 45 of 47 countries in the WHO African Region showed weighted readiness for the Region at 36%. Adaptation of training, monitoring and demand generation tools lowers the total score because these tools are still being finalized for adaptation. However, these are activities that will be ramped up towards introduction of the vaccine. Demand generation too is lagging behind, and this is expected to remain as such until countries are aware of which particular vaccine they will receive.

The figure below illustrates the readiness of countries in the Region per vaccine pillar as monitored by the Vaccine Introduction Readiness tool (VIRAT).

*Figure 4. Pourcentage de préparation régionale par pilier*



## Coordination, Planning and Monitoring

The development of a comprehensive strategic preparedness and response plan (SPRP) even before the first case of COVID-19 was reported in the Region served as a good guiding mechanism for WHO and partners. The gaps identified in countries at the beginning of the pandemic mandated strong partnerships to speed up country-level readiness, and ability to manage a challenging regional public health emergency.

Emergency partner coordination meetings held in Nairobi and Dakar at the onset of the pandemic led to the development of a joint regional partners' preparedness and response plan, which included targeted and tailored support to all countries in the WHO African Region, coordinated by the hubs in Dakar and Nairobi.

The SPRP was updated in May 2020, building on lessons learnt in the first three months of implementation of the response, to ensure continuity of essential health services and comprehensive interventions by countries to mitigate and contain the pandemic through establishment and sustainment of capacities at all levels and in all strategic areas of the health system. A comprehensive monitoring and evaluation framework was developed to support the monitoring of the SPRP using key performance indicators (KPIs) collected daily, weekly, monthly or quarterly and reported in an online platform by intervention area. Capacities increased substantially in all areas in all countries by end the of December compared to January-February 2020. Data sharing by countries remains a challenge for regular monitoring of the response and will require further engagement of countries in 2021 to address issues they may experience in this critical area.



WHO activated a COVID-19 incident management support system (IMST) to provide operational and technical support to countries in all aspects of the response, and national incident management systems and emergency operations centres were established as well as high-level multisectoral task forces under the leadership of Heads of State, which implemented all-of-society and all-of-government approaches, in line with WHO guidance..

WHO's leadership and coordination role with the African Union (AU) and the regional economic communities (RECs), the UN Economic Commission for Africa (UNECA), sister UN agencies and other partners at regional and country levels, has facilitated coherence, alignment and complementarity of actions in our support to countries. Coordination has been strengthened through various mechanisms. WHO and the Africa CDC have particularly reinforced collaboration on key joint priorities, ensuring synergies in the provision of technical support to countries. The WHO Director-General attends meetings of the African Union Heads of State Action Committee on COVID-19 and actively engages with African Union Special Envoys for COVID-19 response (who include the Director of Africa CDC), tasked among other things with mobilizing resources to support the response in the Region. The WHO Regional Director for Africa and the Director of Africa CDC co-chair monthly meetings of the Africa COVID-19 Task Force (AFTCOR) Steering Committee, providing technical leadership to the COVID-19 response of the African Union.

**“From the onset of COVID-19 on the continent, the African Union and leaders from all 55 AU Member States demonstrated harmonized, proactive leadership by endorsing the Africa Joint Continental Strategy for COVID-19 early on. Tantamount to the Africa Joint Continental Strategy is communication, coordination, collaboration, and cooperation among Member States. Our close partnership with the WHO Regional Office for Africa (WHO AFRO) has been critical in our collective response efforts to the pandemic on the continent.”**

**Dr John Nkengasong**  
Director of the Africa CDC

# Response Strategy

Coordination between WHO and the Africa CDC has been further bolstered through the establishment of technical working groups, providing guidance documents, SOPs and other technical expertise and training in surveillance, infection prevention and control, risk communication and community engagement, case management, laboratory, supply chain, knowledge management, and operational research. Since early in the pandemic, WHO and the Africa CDC have published the “Joint COVID-19 Scientific and Public Health Policy Update”, a weekly brief of information on public health policy changes and developments in scientific knowledge to support evidence-based response by Member States.

WHO has provided weekly epidemiological updates on COVID-19 to the UNECA coordination platform, which brings together Member States and partners to address bottlenecks in the COVID-19 response. Other coordination mechanisms include weekly meetings of the UN Regional Directors, monthly meetings of the steering committee of the Harmonization for Health in Africa (HHA) initiative to discuss joint actions, as well as monthly partner briefings.

**“As the pandemic spread towards Africa, it was clear that we were facing a challenge never witnessed in our generation. That this was not just a health crisis, but also a social, economic, and potentially political crisis was evident. And for this reason, going it alone without solidarity, while not knowing how it will continue to manifest and when it will end was never an option. Therefore, we are so proud of how Africa has responded. From the outset, the instincts of community mobilisation and drawing the strengths of partnerships kicked in. Many purpose-driven coalitions focusing on specific issues such as medical supplies, finance and debt issues, food security, cross-border trade issues, vaccines, remittances, among others were set up by partners. The effectiveness of these coalitions, which have played a big part in easing the blow of the pandemic would not have been possible without WHO, faithfully partnering through the ECA COVID-19 Coordination meetings, which have been taking place on a weekly basis for the last seven months; sharing information and guidance. Decision making and advocacy have been effective with the voice and expertise of everyone being brought to bear through partnership.”**

**Dr Vera Songwe**  
Executive Secretary, UN ECA

WHO developed and disseminated several COVID-19 guidance documents and tools to be adapted by countries and which are highlighted throughout this Report. These include considerations for implementing and adjusting public health and social measures in the context of COVID-19, key public health recommendations to countries for conducting elections in the context of COVID-19, the Framework on COVID-19 Information Sharing-Within East and Southern Africa (ESA). Over 37 webinar sessions with 12 500 participants have been held to build the capacity of national and subnational level staff in all countries in the Region.



### Best Practices

#### **THE ROLE AND IMPACT OF INCIDENT MANAGEMENT TEAM IN THE ONGOING COVID-19 RESPONSE IN MPUMALANGA PROVINCE, SOUTH AFRICA, (JUNE–OCTOBER 2020)**

Mpumalanga, one of the nine provinces, first reported a COVID-19 case on 11 March 2020. By mid-June 2020 cases gradually increased peaking towards end July – early August 2020. With the guidance of the National Department of Health (NDoH), Mpumalanga province supported by partners, implemented a range of response measures which led to a slowing of the incidence. Prior to the spread of the pandemic in the province, a coordination structure to respond to the outbreak was established at the provincial department of health. Additionally, the different sectors in the province including the department of health constituted the Provincial COVID-19 Coordination Committee (PCCC) which is co-chaired by the Department of Cooperative Governance and Traditional Affairs (CoGTA) as well as South African Police Services (SAPS) meet three days per week to discuss ongoing multi-sectoral interventions to mitigate the impact of COVID-19 in the province. The absence of a documented Incident Management Team (IMT) structure with clear roles and responsibilities, especially at district and lower levels was identified as a major bottleneck that impacted coordination and effectiveness of the provincial COVID-19 response.

WHO embarked on deploying a technical team in the province since mid-June which was later built on by additional surge team members to reinforce the response. The priority was to reinforce the coordination for COVID-19 response. Emphasis was laid on the importance of an Incident Management Team (IMT) structure with clear roles and responsibilities at provincial level. The IMT was introduced at district and subdistrict levels clarifying the roles and responsibilities of pillar leads, frequency of meetings, reporting and issue tracking. The provincial COVID-19 Rapid Response Team (RRT) was established with clear roles and responsibilities for targeted district and subdistrict

support. Periodic supportive field visits were carried out by the provincial RRT and WHO team to the high-case-load districts and hot spot subdistricts with particular emphasis on IMT to ensure designation of focal points for each of the COVID-19 pillars (work streams) including coordination. Each of the visits (happening fortnightly) is concluded by a reprioritized district/subdistrict action plan with ongoing support. A Municipal Manager was included in the district COVID-19 response team and had a great role in addressing identified key issues and service delivery in collaboration with other sectors (water and sanitation, social development, education, and the private sector, such as mines). Partner organization contribution was also significant in addressing specific gaps such as data management, contact tracing and part of the provincial RRT. As a result, there were regular IMT meetings with documentation of minutes and issues as well as action points; improved plans following field visits by the provincial RRT team at each level, routinized provincial COVID-19 Situation Reports developed and disseminated. Resource mobilization and ownership was enhanced particularly by the municipal managers.

Providing standard Terms of Reference, Standard Operating Procedures and Guidelines and opportunities for experience sharing helped to build local capacity. The buy-in of the decision-makers like the Municipal Managers, heads of department and engagement of other sectors are promising to sustain the practice. The rest of the districts adopted the IMT system with varying degrees of implementation indicating its scalability in a timely manner. This IMT structure is not meant to specifically address COVID-19 in Mpumalanga; the same structure can be replicated in other geographic areas as well as for other emergencies and public health events.



**“WHO is providing a timely technical support closer to the warfront at the right time by sharing global and other province perspectives and up-to-date evidence that influence decision-making at local context”**

**L/Gen. BM Zama, Provincial commissioner**  
 Provincial COVID-19 Coordination Committee (PCCC) Chair, South Africa

**“As a partially rural province where limited support from academia and different health partners exist, WHO contribution is duly acknowledged for their ongoing contribution to the COVID-19 response in the Province.”**

**Ms DC Mdluli**  
 Chief Director PHC Services Provincial IMT lead  
 Mpumalanga Province, South Africa



## Strengthening surveillance, rapid response and case investigation to control the spread of COVID-19

WHO AFRO has continued to work closely with countries to strengthen COVID-19 surveillance, with the primary objectives of rapidly finding, testing, isolating and managing suspected cases, identifying and quarantining close contacts of confirmed cases, and monitoring the evolution of the disease over time.



Since the onset of the COVID-19 outbreak, WHO AFRO has undertaken a regular detailed epidemiological analysis, which has yielded a deeper understanding of the dynamics of the outbreak and informed critical decision-making and public health actions. AFRO developed and disseminated 34 editions of external situation reports and 288 editions of daily situation reports to monitor the evolution of the COVID-19 outbreak in the Region.

WHO AFRO developed a COVID-19 data collection and analysis tool which was disseminated to all Member States with accompanying user guides. Twenty-six countries in the Region are using new data management tools to boost their contact tracing as a result of WHO AFRO’s support for the roll-out

of outbreak data management tools such as GO.Data, EWARS and Outbreak Toolkit. An interactive WHO AFRO geographic information system (GIS) dashboard was also developed to visualize up-to-date COVID-19 outbreak data and information on the Region's 47 countries, including a snapshot of the situation on the African continent and worldwide [\[LINK\]](#). Over 900 epidemiologists, surveillance staff and public health officers from ministries of health, partner organizations and WHO country offices were trained on topics including COVID-19 surveillance in the context of IDSR; implementation of contact tracing for COVID-19, and an alert management system for COVID-19.

As the Region faces a new resurgence (since early October 2020) of the pandemic, WHO can never stress enough the need for countries to provide better, timely and more accurate COVID-19 outbreak data, to enable improved response from enhanced epidemiological analysis and understanding of COVID-19 in the Region as mandated under the International Health Regulations (IHR 2005). With the recent emergence in the African Region of new COVID-19 variants which seem to have higher transmissibility, WHO also calls on countries to boost capacity for laboratory surveillance, including genomic sequencing and analysis through the African genome sequencing laboratory network to detect any new mutations and strengthen the efforts to curb the pandemic.

## Cross-border collaboration and measures to reduce the risk of importation of COVID-19

**“We implemented bold and stringent measures, including the immediate closure of borders as soon as the first cases were detected. The assistance of WHO was instrumental throughout”**

**H.E Pravind Kumar Jugnauth**  
Prime Minister of Mauritius

Leveraging capacities built from previous outbreaks such as Ebola, countries in the WHO African Region managed to delay the importation of COVID-19 cases by swiftly implementing interventions at points of entry (PoEs).

At the beginning of the pandemic, 26 countries in the Region put in place partial or nationwide lockdowns, and 44 countries closed their borders. Of these, 39 allowed in cargo, as well as humanitarian and emergency flights. All countries in the Region have continuously conducted entry screening at airports. As the movement of goods and people within and between countries continued even during the restrictions, and countries began to

ease lockdowns and limitations on movement and transportation, screening at seaports and ground crossings intensified, leading to the detection of cases of COVID-19 particularly among truck drivers. Member States were supported in implementing PoE public health emergency response plans.



WHO and partners including the International Organization for Migration (IOM), and the International Civil Aviation Organization (ICAO), the International Air Travel Association (IATA), UNICEF and the Africa CDC among others, enhanced multisectoral coordination and collaboration to mitigate the risk of importation of COVID-19, by strengthening IHR capacities, training national person-

nel on PoE screening, infection prevention and control, isolation and follow-up of ill travellers and risk communication at PoEs. A harmonized strategy for POE surveillance, laboratory testing, and transnational response to COVID-19 for cross-border truck drivers was implemented, as were harmonized sub-regional essential IPC services and interventions for truck drivers within the East African Community.

WHO developed and provided guidance on the management of ill travellers at international airports and seaports controlling the spread of COVID-19 at ground crossings, managing COVID-19 cases in aviation and outbreaks on board ships [\[LINK\]](#). Throughout the pandemic, regional economic communities and WHO have been working with Member States to develop and disseminate cross-border guidelines and standard operating procedures to handle movement of cargo within the Region. Key among them are the East African Community (EAC), the Southern African Development Community (SADC) and the Intergovernmental Authority on Development (IGAD). A best practice in this area is the development by the EAC and partners of a Regional Electronic Cargo and Driver Tracking System (RECDTS) to monitor truck drivers and movement of cargo in that region. The system was piloted in Uganda, Kenya and Rwanda, and subsequently launched in all EAC Member States. Designed as a mobile telephone application, the RECDTS has enabled the issuing of EAC COVID-19 digital certificates which are mutually recognized by Partner States, eliminating the need for multiple testing and alleviating congestion at East African border crossing points. SADC has also finalized its Corridor Trip Movement System (CTMS), which is being piloted before wider dissemination for use.

#### Best Practices

31 December 2020

### INFORMATION EXCHANGE BETWEEN SOUTH SUDAN AND UGANDA ON TESTING OF TRUCK DRIVERS

The Port Health on both sides of the border worked in collaboration throughout the response and there was and continues to be regular and timely sharing of surveillance related information, especially through tracking of drivers sampled and confirmed SARS-CoV-2 positive. This also includes contact tracing and follow up. Members of the COVID-19 response teams from both sides resorted to adopt convenient communication channels such as emails, phone calls and even created a WhatsApp group for prompt sharing of information requiring immediate and swift action.

Cross-border coordination meetings are conducted on a regularly basis, these discuss several cross-cutting COVID-19 response issues including those relating to truck drivers. Recommendations from those meetings are generated and proposed to the COVID-19 task force to mitigate outstanding issues. An example is the non-recognition of test

certificates (results) from the Nimule (border town) PCR lab by Ugandan authorities. This has been put to rest through mutual dialogue.

Harmonized testing of truckers crossing the border: Truck drivers presenting with valid certificates from both sides are authorized and deemed valid without necessity of swabbing and testing. This reflects trust between the two authorities regarding testing and validation of results. In addition, the majority of the truckers adhere to the directives to test first before travelling or crossing the border and abide by other preventive health measures. This came after an observed increased positivity rate in samples collected from this yet vulnerable group and the need to protect the hundreds of frontline workers at the border crossing point including Border Police, Immigration personnel, customs and clearance agents, amongst others.

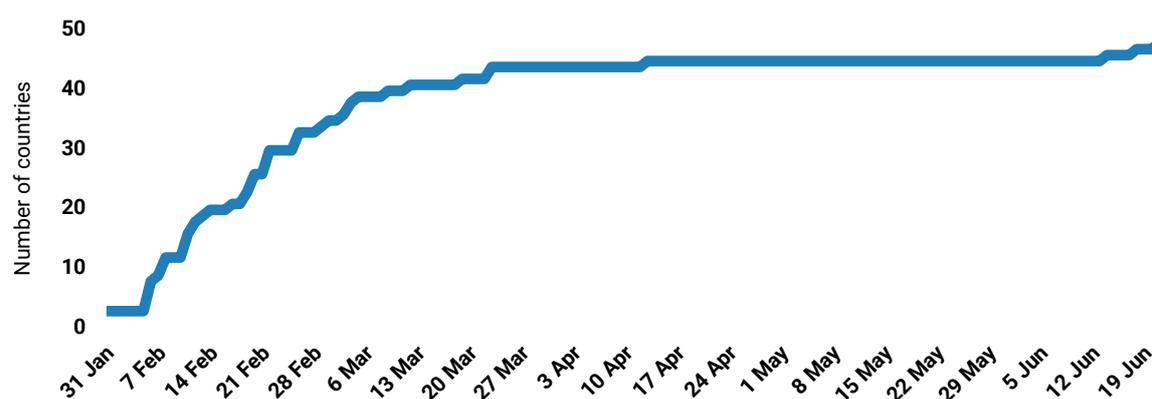
Despite the progress observed in COVID-19 preparedness and response at PoEs, several challenges need to be addressed: porous borders and existence of secondary and tertiary crossing points between countries often used by travellers to bypass official PoEs remain a challenge, as do inadequate implementation of COVID-19 preventive measures, especially physical distancing and shortage of staff and funding for interventions at PoEs. WHO and partners also supported countries facing shortages of appropriate infrastructure and resources to manage suspected cases. As the risk of a resurgence or second wave looms over the Region, WHO will continue to mitigate the risk of re-importation by enhancing capacities and interventions at PoEs, particularly at subnational levels.



## Improving laboratories in Africa to test for COVID-19 and beyond

Testing is one of the major tools for containing outbreaks and fighting COVID-19. Even before the first case of COVID-19 was detected on the African continent, WHO began preparing its Member States and mobilizing the influenza laboratory network to ensure that as many countries as possible in the WHO African Region were able to test for COVID-19 by PCR. With WHO's support, when the first case of COVID-19 was detected in the Region in February 2020, sixty-four per cent (30/47) of countries were already able to test for COVID-19. That figure increased to over 90% in March, and by the end of June, all countries in the Region could test for COVID-19 by PCR.

Figure 5: Number of laboratories testing for COVID-19



Twenty international laboratory experts were deployed to 13 countries<sup>6</sup>, enabling countries with no PCR capacity before the pandemic to have functioning molecular laboratories with the capacity to perform PCR for COVID-19 and other pathogens in the future. The laboratory support team at the WHO Regional Office was expanded and laboratory experts drawn from regional networks including the AMR, HIV-1, Tuberculosis (TB), Influenza and Polio laboratory networks, to provide quality support to countries.

The pandemic has resulted in a dynamic landscape where technical training needs and methods have had to be adapted to suit the situation. The WHO Laboratory Community of Practice (CoP) was launched in May 2020. Since its inception, the CoP has hosted 14 webinars on topics related to COVID-19 testing, attracting 600 participants from over 28 countries. Topics which attracted strong interest included Antigen-detection in the diagnosis of COVID-19 using rapid tests; Oral fluid alternative to COVID-19 diagnostics; SARS-CoV-2 infections: duration of infectiousness and reinfections; Sequencing SARS-CoV-2 to inform public health measures; Landscape of COVID-19 antigen-based RDTs and considerations for use; Biosafety guidelines for handling COVID-19 specimens.

In order to maintain the quality of results reported from countries, WHO has launched two global external quality assurance exercises. The first, completed in July, attracted 46 participating laboratories from 39 countries. Ninety-six per cent (44/46) of the laboratories achieved the benchmark score of 100%. In the second exercise, 181 laboratories at subnational level are participating from all 47 countries.

### EXAMPLES OF COUNTRY SUCCESSES TO SCALE-UP COVID-19 TESTING LABS

- Nigeria 1 lab in March to 59 in September 2020
- Ethiopia: 1 lab in March to 45 by August 2020
- Kenya: 1 lab in March to 38 by October 2020
- Uganda: 1 lab in March to 13 by October 2020
- Sierra Leone: 1 lab in March to 5 by September 2020
- Cameroon: 1 lab in March to 8 by July 2020

A key strategy has been to support countries decentralize testing to local or district levels as an enabler for rapid detection, contact tracing and to mitigate the impact of COVID-19 beyond the national level. With the support of WHO and partners, 39 countries have successfully decentralized testing, with over 790 COVID-19 testing laboratories operational in the Region. In Ethiopia, COVID-19 testing labs increased from one lab in March to 45 by August. In Nigeria, the number of labs testing for COVID-19 rose from one in March to a phenomenal 59 September

2020, while in Sierra Leone, the number was raised from one to five in the same time period. Uganda has continued to increase its testing labs, from one to 13 by October, and Kenya from one to 38. To quickly scale up decentralization, several countries repurposed part of the robust 4150 GeneXpert machines network in the WHO African Region for COVID-19 testing.

The COVID-19 pandemic has presented major challenges for laboratory testing. The pressure on the global supply chain, where demand for testing commodities has continually exceeded supply, was unprecedented, translating into stock shortages and impacting the fair and equitable distribution to Member States of commodities in short supply. The supply chain pressures were compounded by logistical challenges associated with reduced air traffic and border closures, all of which hampered efforts to ramp up widespread testing in the Region. Together with partners, WHO has continued to progressively address these issues in an integrated manner, and to date, over **8.2 million** testing commodities including **5.4 million** test and extraction kits and **2.8 million** sample collection supplies - with a total value of **US\$ 27.9** - have been shipped to countries in the Region.

WHO has produced guidance for countries on key laboratory and testing topics such as decentralization of testing [\[LINK\]](#).

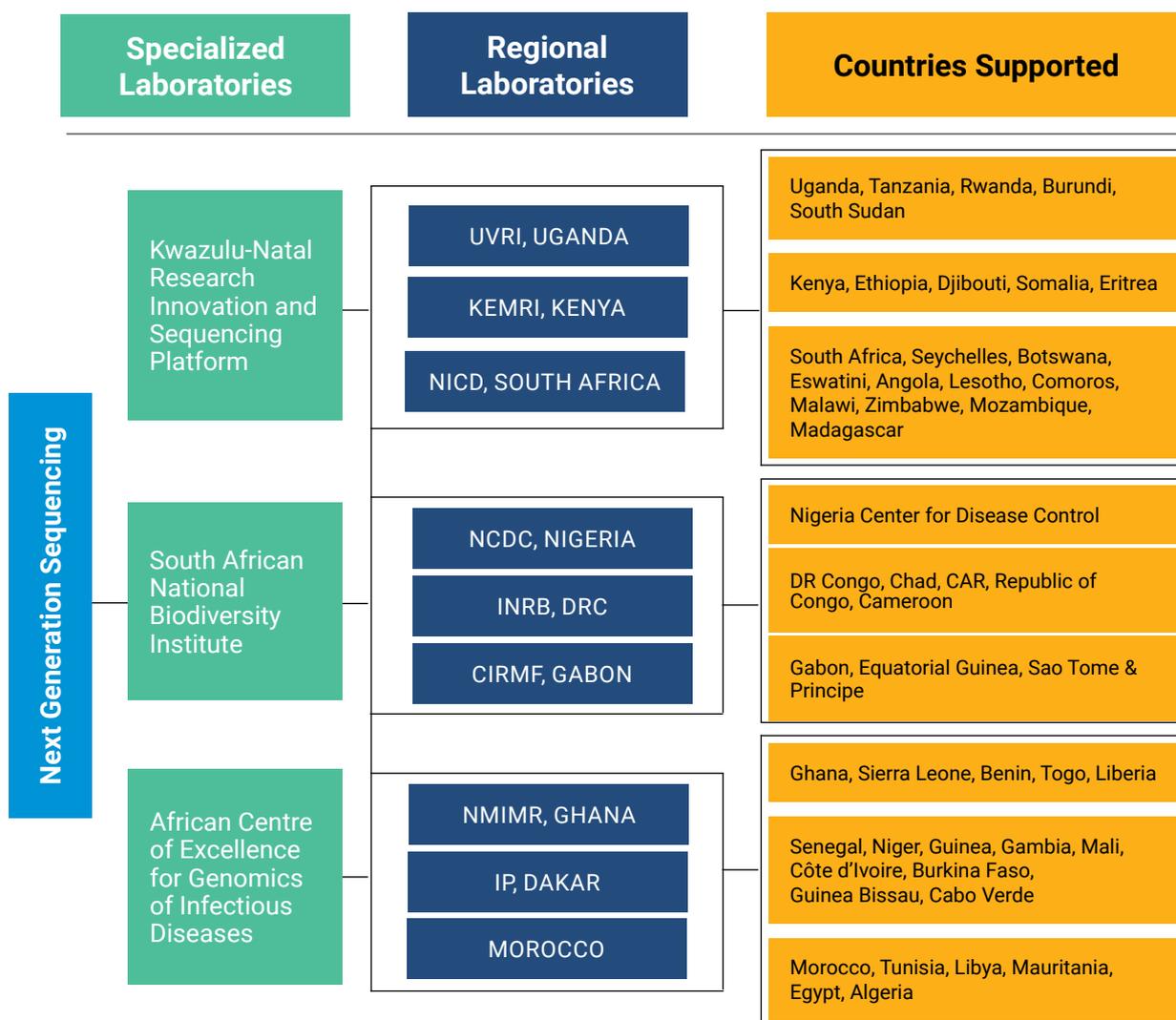
<sup>6</sup> Ethiopia, Chad, Mauritania, Botswana, Equatorial Guinea, Gambia, Sao Tome and Principe, Comoros, Lesotho, Zimbabwe, Rwanda, Congo and Tanzania.

By December 2020, a total of 5233 COVID-19 genome sequences had been submitted to the GISAID sequence database from Africa, representing just 2% of all genomes in the database. To increase this number, AFRO, in collaboration with Africa CDC has initiated a Regional Sequencing Laboratory Network for COVID-19 and Emerging Pathogens. The network, launched in October 2020, aims to expand the sequencing capacity in the WHO African and East Mediterranean Regions, by introducing next generation sequencing (NGS) in laboratories in these Regions. The network includes three specialized labs in South Africa and Nigeria and nine regional labs covering the needs of all African Region Member States (Fig. 6).

**“We would like to recognize and thank WHO for the continued support and particularly with the efforts to scaling up testing in Uganda. The Ministry of Health and the National Health Laboratory Services remains committed to working collaboratively with WHO”**

**Dr Henry Mwebesa**  
 Director General, Health Services Ministry of Health Uganda

Figure 6: COVID-19 Sequencing Laboratory Tiers



**Regional Laboratories**

- UVRI - Uganda Virus Research Institute
- KEMRI - Kenya Medical Research Institute
- NICD - national institute for communicable diseases
- NCDC Nigeria- Nigerian Center for Disease Control
- INRB, DRC- National Institute of Biomedical Research, DRC
- CIRMF, Gabon - Centre International de Recherches Médicales de Franceville
- NMMR, Ghana, Noguchi Memorial Institute for Medical Research, Ghana
- IPD - Institut Pasteur de Dakar Foundation

Strong coordination and collaboration between WHO and key regional partners such as the Africa CDC, FIND, CHAI, ASLM, NICD, UNICEF, IOM, as well as subregional communities including the EAC, SADC, IGAD and the West African Health Organization (WAHO) have enabled countries to receive support for COVID-19 testing, including the supply of reagents and consumables, training, guidance documents and cross-border testing initiatives and approaches.

While significant efforts have been made by national governments to improve COVID-19 testing, with more than 18 million PCR tests performed since the onset of the pandemic and recent testing rising from a cumulative 142.1 tests per 10 000 people in 47 assessed countries on 26 November to 167.4 per 10 000 people by December 2020, the level is still low. More and better testing is vital to fighting COVID-19 both before we have effective therapeutics and vaccines, and when we have them.

The roll-out in the Region of new, WHO-approved COVID-19 antigen-based rapid diagnostic tests to complement the gold-standard PCR tests, has significantly boosted testing capacity and is proving a game changer in the continent’s fight against COVID-19, as they help to meet the huge testing needs. WHO has provided Member States with interim guidance on the use of these tests, supported the development of testing strategies and facilitated the training of laboratorians on the quality and safe use of antigen RDTs for COVID-19 testing. By the end of December 2020, more than 850 laboratorians had been trained in the countries on COVID-19 antigen RDT use.

Best Practices

**RWANDA, A MODEL FOR RAPID SCALE UP**

Rwanda continues to be a beacon for expanding and increasing access to testing. As with other countries in the Region, Rwanda was initially only carrying out tests in one laboratory at the national level. Recognizing that testing is an important tool to contain and control COVID-19, the country rapidly decentralized COVID-19 testing to the subnational level, expanding testing from two to 13 laboratories, thus enabling 100% coverage and access to testing in the country. COVID-19 testing was established and is operational in all five regions of Rwanda.

Notably, this network of laboratories has meant that samples can reach a laboratory within six hours of collection and results returned within 48 hours.

Critical to this success has been the effective use of supply forecasting to guard against stock-outs, and the integrated e-Lab information management system (e-LIMS), which allows for the rapid

dissemination of information and communication of results so that public health interventions can be rapidly implemented.

*Figure 7: COVID-19 testing laboratory capacity in Rwanda March-November 2020*

**Total Laboratories: 12**

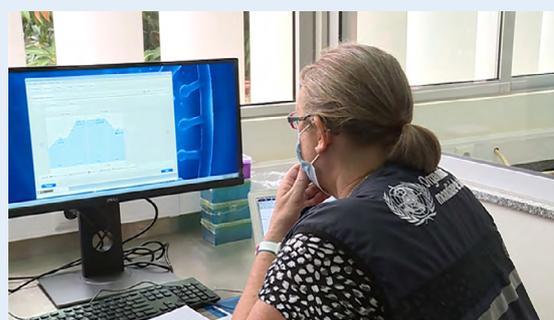
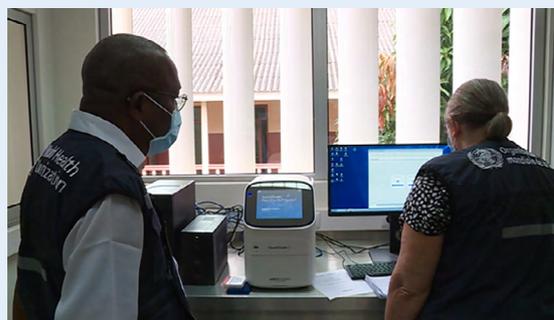


## Best Practices

**A STEP FORWARD FOR SAO TOME AND PRINCIPE**

A joint external evaluation (JEE) conducted in Sao Tome and Principe in May 2019 showed that the country's level of preparedness in relation to the IHR (2005) indicators was low in most areas including PCR laboratory capacities, which proved the biggest challenge to the country at the onset of the outbreak. Prior to the COVID-19 pandemic, Sao Tome and Principe did not have laboratory systems for performing real-time PCR, which is the gold standard for the detection of COVID-19. Identified as a priority for rapid capacity building by WHO in February 2020, between March and July 2020, the laboratory infrastructure in the country was reassigned, equipment procured and delivered, staff trained in molecular techniques and a laboratory with the capacity to use molecular methods to detect pathogens instituted in Sao Tome and Principe.

The establishment of this lab with the technical and financial support of WHO has represented a great step forward for Sao Tome and Principe, enabling the country to be self-reliant in terms of its capacity to detect COVID-19 as well as other pathogens in-country.



## Treating, Isolating and Caring for COVID-19 patients in Africa

Weak health systems in the African Region have been severely taxed by the COVID-19 outbreak. The Region has limited ICU and treatment centres, as well as inadequate numbers of trained health professionals in critical care services to effectively address not only this pandemic, but future health emergencies. Crucial supplies of medical oxygen, ventilators and personal protective equipment (PPE) have been insufficient to meet the demands of large numbers of patients requiring critical clinical care.

Front-line health workers, disproportionately women who are highly represented in the most affected cadres – nurses and midwives – have saved thousands of lives under the most challenging circumstances, and often at the cost of their own. A total of 87 638 health workers in the Region have been infected with COVID-19 since the start of the pandemic, and the numbers continue to rise amid a lack of full understanding of the drivers of infection among health workers. Inadequate information on clinical characterization, treatment, supportive care, post COVID-19 syndrome and special populations pose additional challenges to the effective management of COVID-19 patients in the Region.

To help countries address these challenges, WHO deployed case management experts to several countries in the Region and provided extensive technical guidance and large-scale on-site and distance training on all aspects of clinical care for COVID-19 patients to more than 12 000 medical doctors and 44 000 nurses in 47 countries. WHO has supported 15 countries in oxygen production and delivery, and<sup>7</sup> procurement of ambulances to facilitate the referral of patients to treatment centres. WHO support has helped increase the number of oxygen plants in the Region from 68 to 101, and the number of oxygen concentrators from 2600 to 5100. The number of COVID-19 designated beds for severely or critically ill COVID-19 patients has increased from 14 000 to 43 000, close to the estimated needs for 1 million cases. WHO has procured 79 320 134 PPE materials, including 66 945 892 delivered and 12 374 242 to be delivered worth US\$ 26 899 512 to reduce the risk of workplace exposure for health care workers.

Partnerships with the Africa CDC have been developed in training, joint development of guidelines and organization of joint webinars on clinical management of cases. Together with the Africa CDC and the Africa Academy of Sciences, joint operational research on clinical care for COVID-19 patients has been conducted. In collaboration with the West African College of Nurses (WACN), WHO has trained nurses on topics including COVID-19 clinical care, infection prevention and control, case detection and reporting, mental health and psychosocial support.

Despite these advances, countries need a lot more support to be able to ensure appropriate treatment facilities, sufficient trained health workforce and adequate medical supplies to treat COVID-19 patients and build resilience to meet future health emergencies.

**“I would like to acknowledge the critical role played by our health workers in the COVID-19 response in Ethiopia. Without their commitment and support, we would not have been able to wage a strong national response to COVID-19. Yet again, this pandemic has shown us that there is no health and security without health workers. As they work tirelessly to protect us, we must do all within our means to appreciate and protect them. I am thankful to WHO for their continued help and support”**

**H.E. Dr Dereje Duguma**  
State Minister of Health, Ethiopia

<sup>7</sup> Sao Tome and Principe, Sierra Leone, Comoros, Benin, and Togo

Best Practices

31 December 2020

## EMERGENCY MEDICAL TEAM (EMT) FOR COVID-19 IN GUINEA-BISSAU

Guinea-Bissau's health system lacks the adequate equipment, human resources and capacity for surveillance, diagnosis and treatment of several health issues. There is one doctor for every 5964 inhabitants and one nurse for every 1223 inhabitants (Multiple Indicator Cluster Survey, 2014). The country has no intensive care unit (ICU) specialist, no fully equipped ICU bed, nor continuous oxygen reserves for severe patients. There is also limited medicines, imaging and electrocardiogram services, particularly in the main public hospital in Bissau, the Simão Mendes National Hospital (SMNH). The other 10 regions, outside Bissau region, have small COVID-19 treatment centres with no oxygen reserves. Following the initial COVID-19 cases recorded, cases spiraled to more than 1000 in less than three weeks and a paradigm shift from local to community transmission was noted in Bissau region. It is against this backdrop that the Government of Guinea-Bissau requested for an EMT from WHO in April 2020 and by the end of May, a team of five experts that comprised of an infectious diseases doctor, a pneumologist, an anesthesiologist and two nurses was received in the country. The delay in bringing in international experts was mainly due to the challenge in getting Portuguese-speaking experts, and COVID-19 travel restrictions.

WHO and partners procured a lot of equipment and consumables to support the response, particularly

in improving case management for patients with severe acute respiratory infections. Ventilators, monitors, blood gas analyzers arrived in the country, most of which the health care workers (HCWs) did not fully understand how to operate as they had not used them at all in their clinical routine. The EMT provided technical assistance in creating national protocols for treatment of COVID-19 and provided training for appropriate prescription of corticoids, anti-aggregates, insulin and for hydro-electronic imbalances and antibiotic usage, when indicated. WHO helped in setting up the triage tent and circuits, facilitated technical meetings, organized wards and provided daily coaching on patient admissions and management. Wards for suspected and confirmed cases are now identified, patients' beds numbered, hand sanitizers provided in the corridors, and safety boxes correctly placed.

A number of challenges persist, such as limited oxygen supplies to cater for the high demand for oxygen for COVID-19 patients and/or the needs in the regions for filling oxygen cylinders as the epidemic evolves; limited electricity; lack and/or limited availability of other key COVID-19 case management equipment such as ultrasound machine(s), lumbar puncture and thoracic drainage equipment, CT scan, and accessories for ventilators, among others.

**“WHO has trained more than 450 HCWs in case management, IPC, oxygen-therapy, non-invasive ventilation (NIV), thoracic ultrasound, blood gas analyzer sample collection and its interpretations, and sedation for NIV usage which is really applaudable”**

**Dr. Jamila Lemuela do N. N. Bathy**

Clinical Director Cumura Hospital

## Continuing essential health services during COVID-19

Although many countries in the Region have been spared catastrophic direct mortality rates caused by the COVID-19 pandemic, the knock-on effects of the virus on health outcomes in the Region have been felt widely, and risk having long-lasting repercussions on the health gains made over the last decade. Several indicators were developed by WHO to monitor health service disruption in the Region, including for service delivery, reproductive, maternal, newborn and child health (RMNCH), malaria, HIV/TB, NCDs and immunization. The indicators have been used to inform rapid assessments conducted in several countries to help guide WHO support and decision-makers in ascertaining the extent of service disruptions, defining national mitigation strategies, and ensuring better targeting of financial and human resources. Preliminary findings suggest that COVID-19 has severely impacted other essential health and social



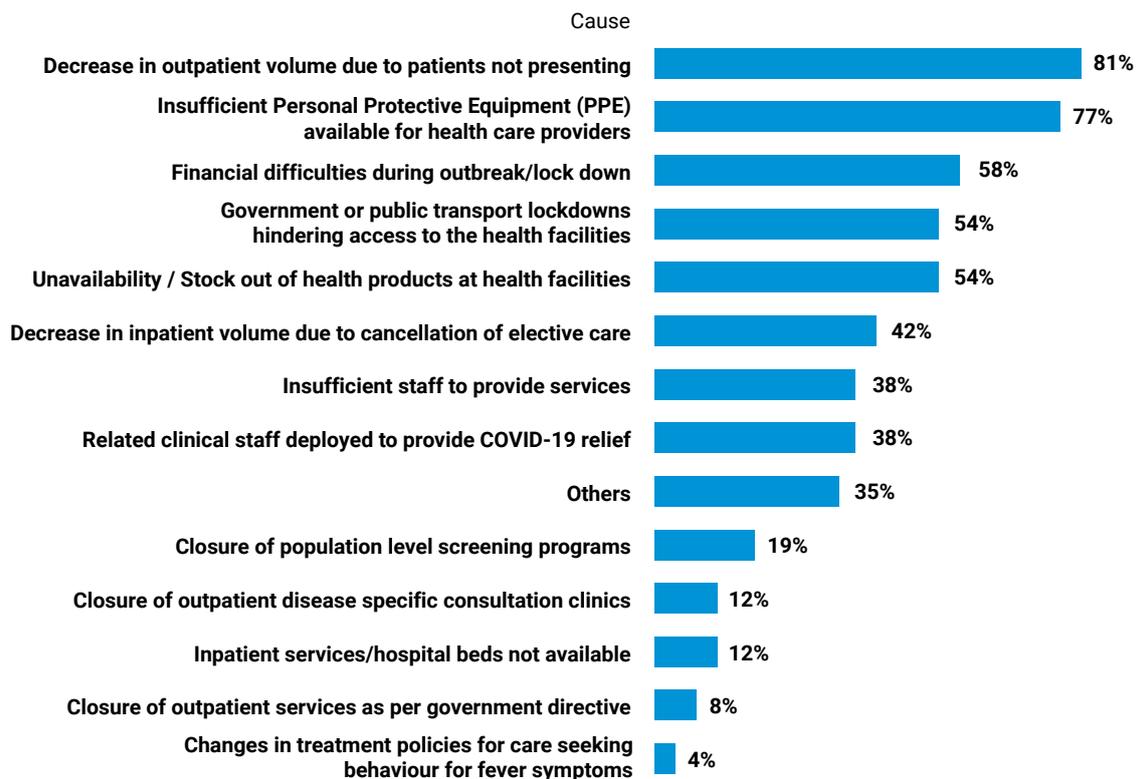
services, with indicators revealing a sharp decline in the uptake of services such as outpatient consultations, skilled birth attendance and malaria treatment in 2020, compared to 2018 and 2019. These services were especially impacted between May and July, when many countries in the Region imposed total or partial restrictions on movement as well as other public health measures to contain the spread of the virus. On average, countries reported partial or severe/complete disruptions to 54% of the 25 assessed health services.

The most frequently disrupted services included routine immunization services, both outreach (72%) and facility-based (63%); family planning and contraception (67%); antenatal care (67%); and treatment for mental health disorders (67%). COVID-19 has also had severe consequences in terms of the disruption of food systems. Initial estimates by UNICEF and WFP suggest that acute malnutrition has increased by 19% to 25% across the Region, while overall hospital admissions for severe acute malnutrition have dropped by 5% in relation to the same period in 2019.

The repurposing of health facilities and the health workforce to COVID-19 case management, increased absenteeism among health workers due to concerns over contamination, insecurity and lack of appropriate PPE, as well as fear by patients of visiting health facilities have compounded disruptions in already weak health systems. Other factors which have affected the continuity of health services in the Region include floods, internal displacements, protracted conflicts and other outbreaks of epidemic-prone diseases such as the cholera outbreaks in Ethiopia, Kenya and Uganda, measles in Angola, Ethiopia, Kenya, Mozambique, South Sudan and Somalia and yellow fever in South Sudan and Uganda to mention a few.

## Impacts of Essential Health Services

Figure 6: Main causes for disruption in AFRO (n=26)



**45%** Missed or delayed health care services

(among those requiring services)\*

**28%** Difficulty accessing medications

% Much More Difficult (among those requiring services)\*

\* Base = missed, delayed, skipped or been unable to complete health care visits

Q21. Have you or any other person in your household delayed, skipped or been unable to complete health care visits since the COVID-19 crisis?

Q24. Has the COVID-19 crisis made it more difficult to obtain medications you need for you or your household or has it had no impact? If you do not need medications, please say so.

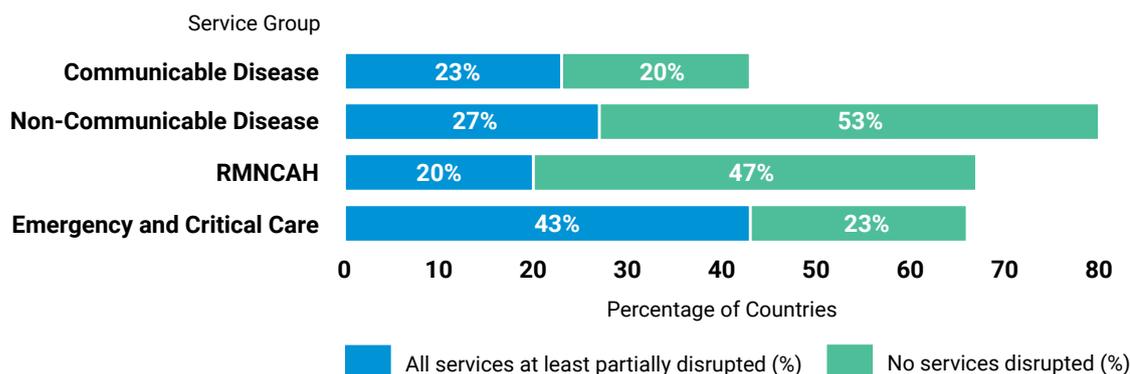
Q41. Do you have any longstanding illness or health problem?

Q22. Why have you or another person in your household delayed, skipped or been unable to complete health care visits since the COVID-19 crisis?

Q23. And do you mind if I ask what those delayed, missed or not completed health care visits were for?

"Responses should be interpreted within the context of a country's prevalence of health issues and the population's typical frequency of accessing specific types of health services."

Figure 7: Percentage of countries reporting disruptions across entire service groups (n=30)



From the onset of the pandemic, WHO has continuously advocated for and supported its Member States to ensure that the continuity of essential health care remains a priority. WHO African countries have developed and implemented plans to ensure continuation of essential health services based on WHO operational guidelines for maintaining essential health services in the context of the COVID-19 pandemic. It is noteworthy that 53% of the countries from the WHO African Region defined the essential health services to be maintained during the COVID-19 pandemic.

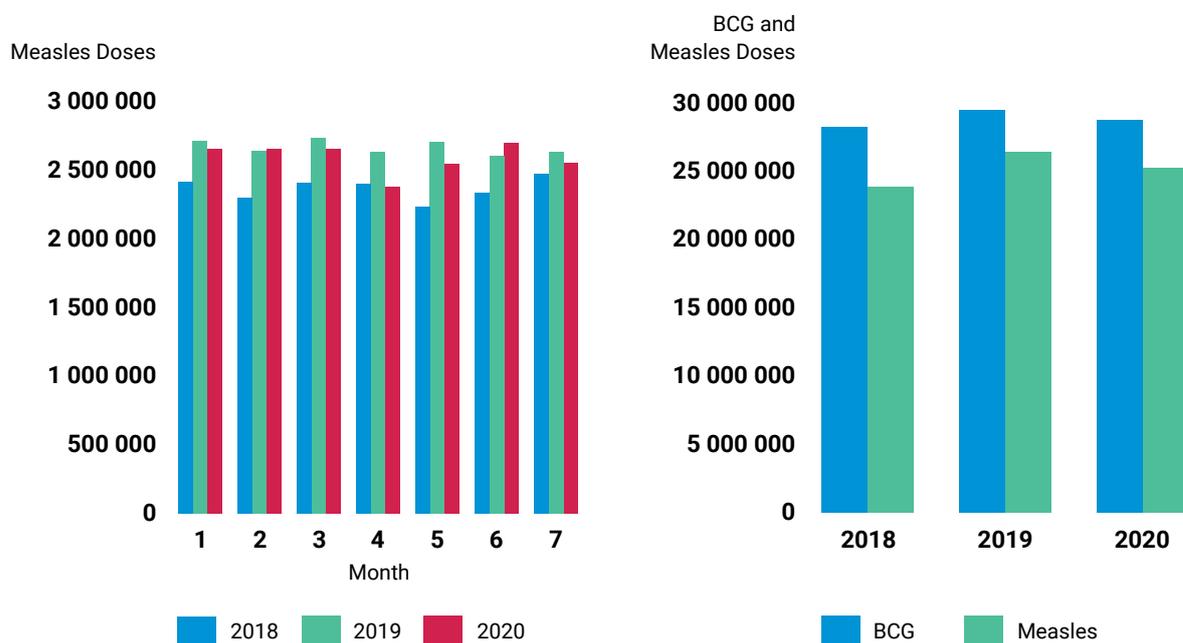


With the support of WHO, most of the countries have been taking measures to overcome disruptions to health services such as mass immunization campaigns which were postponed at the beginning of the pandemic. In South Africa, for instance, there has been an improvement in the immunization coverage (by all antigens) since May 2020, following a decline in routine immunization coverage (all antigens) in April 2020 during the nationwide lockdown in the country. Similarly, in Ghana, immunizations have increased steadily since June 2020. WHO provided technical and

financial assistance to the Ghana Ministry of Health to support the continuity of service provision for mothers and children.

Fig 8: A brief focus on immunization

**1 million children missed their 1st dose of measles in the first 7 months of 2020 compared to the same period in 2019**



Member States have been supported to develop alternative approaches to service delivery, including telemedicine to replace in-person consultations.

WHO has further provided support to identify the health services most affected by the pandemic, training, technical expertise, as well as guidance and tools to scale up the delivery of essential services. Guidelines for health workers and the general population were developed by WHO, covering all the major NCDs, including cardiovascular disease, diabetes, cancer, chronic respiratory diseases, mental health, sickle cell disease, oral and eye health. These have enabled countries to identify interventions to strengthen NCD service availability and provision during the pandemic. WHO and partners issued guidance for infant and young child feeding (IYCF) [\[LINK\]](#), as well as services for the prevention and treatment of wasting [\[LINK\]](#), and vitamin A supplementation [\[LINK\]](#). WHO has continuously advised on the safe provision of essential health services and assisted countries to address stock-outs of essential medical products. WHO has also set up monitoring systems with 22 African countries to track data on service delivery in some 4800 health facilities with the target of timely detection of disruptions in access and uptake of essential services.

The vast majority of countries in the Region implemented triaging to identify priorities, and 64% put in place novel supply chain and/or dispensing approaches for medicines to overcome service interruptions. Measures were also put in place to enable the free movement of health workers and ambulances during lockdowns. Governments worked closely with WHO, other UN agencies and the private sector to ensure the continuity of essential health services even during these periods.

The Ebola outbreak has shown that deaths from other preventable causes surpassed the total number of deaths from Ebola, and the vulnerability of children and women increased with the breakdown of protection mechanisms during the crisis. Learning from this and other outbreaks, it is imperative that governments, partners and communities continue to strive to achieve the optimal balance between fighting the COVID-19 pandemic and ensuring that health systems are able to provide equitable and affordable access to essential service delivery, in order to protect the hard-won gains made in improving access to care and health outcomes in the Region.

**“I urge all countries to not lose focus on their gains made in health as they adapt to tackle this new threat. We saw with the Ebola virus disease outbreak in West Africa that we lost more people to malaria, for instance than we lost to the Ebola outbreak. Let us not repeat that with COVID-19.”**

**Dr Matshidiso Moeti**

WHO Regional Director for Africa



Best Practices

2 December 2020

## OVER 3.3 MILLION CHILDREN VACCINATED IN CHAD IN LARGE-SCALE POLIO CAMPAIGN

**N'Djamena** – More than 3.3 million children have been vaccinated against polio in Chad in a just concluded immunization drive, one of the largest of its kind in the African Region this year, as campaigns that were halted in March 2020 due to the COVID-19 pandemic resume.

While Africa was declared free of the wild poliovirus in August 2020, another form of polio continues to infect children: circulating vaccine-derived poliovirus, or cVDPV. This type of polio is rare and

can only occur in areas where not enough children are immunized, which means that the only way to stop its spread is through immunization. The current outbreak in Chad was first detected in February 2020 but immunizations were halted due to COVID-19. This pause in response activities led to the spread of the virus across 36 districts in the country, paralyzing more than 80 children and even leading to cases in neighbouring Sudan and the Central African Republic. For more information follow this [\[LINK\]](#).

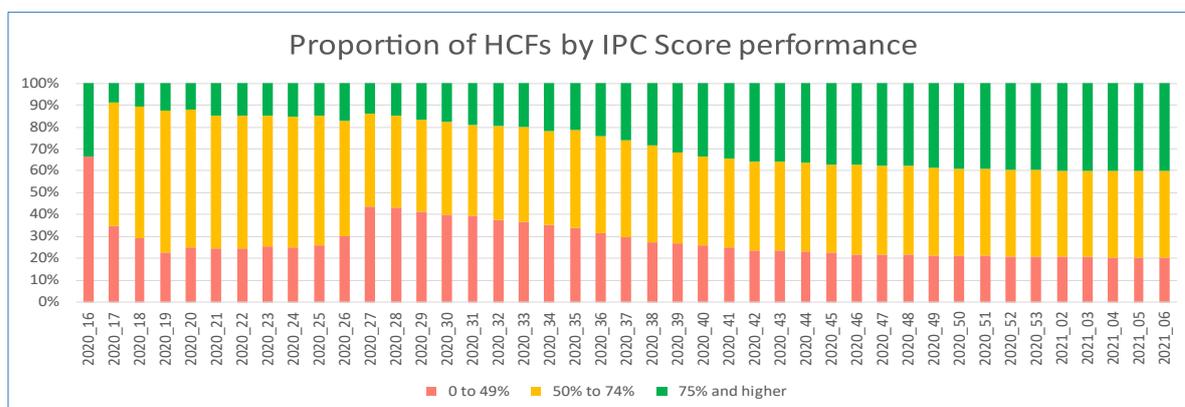


## Preventing COVID-19 infection among health workers and patients

Infection prevention and control (IPC) is a critical and integral component of protecting health care workers and patients by reducing the transmission of COVID-19 and containing the spread of the virus in health care facilities. Global shortages of PPE in the Region led to insufficiently robust IPC practices in health care facilities, compounded by the lack of staff awareness and institutionalization of IPC approaches. In the DRC for example, after 305 health workers were infected, investigations showed that roughly 35% were not wearing PPE while caring for patients and 80% were not trained in basic IPC

approaches. An assessment of IPC/WASH national programmes and implementation of IPC measures in 1967 health facilities in 28 countries, showed a mean IPC performance score of 66%. Isolation capacity and PPE had average scores of 50% and 55% respectively; hand hygiene and health facility-based surveillance, 76% and 62%; and sanitation and water supply, 82% and 75%.

**Figure 9: Proportion of health facilities with IPC performance scores per epidemiologic week (n=1967). We can clearly see how the proportion of health facility with a score above 75% is increasing and those ones with a score below 50% is decreasing.**



WHO has provided extensive technical support to help countries improve IPC capacities in health care facilities and key public gathering areas. Despite the challenges encountered during lockdowns and border closures in deploying experts to countries and training the large numbers of health care workers needed to overcome shortages of trained professionals in IPC, WHO deployed at least one IPC expert each to 22 countries, recruited local experts for 25 countries, and reinforced coordination by experts in AFRO and the two subregional hubs in Dakar and Nairobi. Over 6495 health workers were trained as master trainers, and over 200 000 others trained – virtually and face-to-face – in basic IPC: patient-triage strategies, screening measures, quarantine practices for infected or suspected patients, standard precautions (hand hygiene, respiratory etiquette, cleaning and disinfection of the environment) and transmission-based precautions. IPC guidelines and protocols were disseminated to all 47 countries, including on the local production of WHO recommended hand rub, COVID-19 management in hotels, and establishing and implementing IPC measures in camps for refugee and IDPs and urban slums. Essential IPC equipment and supplies (including PPE) have been delivered to all 47 countries in the Region.

**“IPC is not just a COVID-19 thing. It needs to be entrenched in the health care system and it should be part of the normal standard of care. People need to be aware, trained, retrained and reminded.”**

**Professor Bola Olayinka**

Nigerian leading expert in infection prevention and control

Partnerships have been pivotal in implementing IPC activities in Member States. IPC/WASH partner working groups were established for East and Southern Africa, West and Central Africa. Training of trainers was conducted in 11 countries in collaboration with RESOLVE and the West African College of Nurses, and joint guidelines on IPC in the community developed with UNICEF. To evaluate the effectiveness of health worker safety measures, WHO is researching the risk factors for infection in health workers exposed to COVID-19 patients. Research is also being conducted

to understand the behaviour of health workers associated with COVID-19 in the community.

Despite the achievements in countries, significant challenges remain in the implementation of comprehensive IPC programmes and activities throughout the Region. Many countries implemented IPC measures in health systems for the first time during the pandemic and will need continued support to establish and sustain comprehensive IPC programmes and approaches which contribute to better, safer health services for people and communities, well after the end of COVID-19.

Evidence-based and consistently applied safe water, sanitation and waste management and hygiene (WASH) practices in communities, homes, schools, market places, and health care facilities are vital to the safety of health workers, patients and populations, particularly during disease outbreaks. Despite the importance of these key interventions in protecting against COVID-19 infection, the provision of these services remains grossly under-prioritized. Co-ordination and sustained investments in this area are urgently needed to protect people and communities and to help prevent human-to-human transmission of the COVID-19 virus as well as ensure improved public health outcomes in the Region.



### Best Practices

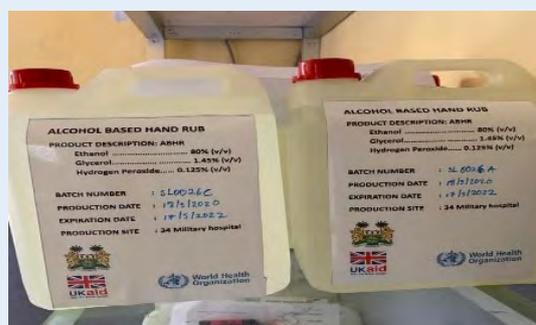
September 2020

## PRODUCTION OF ALCOHOL-BASED HAND RUB IN SIERRA LEONE

With the interruption of air and sea traffic to the country, Sierra Leone experienced critical shortages of PPE at the onset of the pandemic. With DFID support, in May 2020, WHO provided technical support to the Ministry of Health and Sanitation (MoHS) to restart local production of alcohol-based hand rub (ABHR). With the country producing over 400 liters of the solution per day, public hospitals and health facilities in Sierra Leone are no longer dependent on imported hand rub.

Production is ongoing at 34 Military Hospital in Freetown (supported by DFID) and Bo Government Hospital in Bo District, Southern Province (supported by GIZ and World Bank). As at December 2020 A total of 29 720 litres have been produced and delivered to central medical stores for distribution to health facilities. The estimated cost of locally produced hand rub is between US\$ 2 and US\$ 3 per 500mls compared to US\$ 10 for foreign imports.

The ABHR production initiative was initially launched in 2019 with funding from US CDC and AfDB. WHO trained 24 pharmacists and nurses from eight of the country's 16 districts to start the first local production of alcohol-based hand rub. Although the production process was interrupted due to lack of funding, the need for IPC as part of the COVID-19 response made ABHR production a WHO priority to mitigate the risk of health worker infection and enhance patient safety.



Best Practices

10 September 2020

## COMBATTING HEALTH WORKER INFECTIONS IN NIGERIA

**Kaduna** – When Dr Mark Anthony makes his weekly rounds in Kaduna State, from public hospitals to private facilities, he is encouraged to see health workers protecting themselves, attending to patients with the right protective gear and performing the necessary hand hygiene. It gives him hope that the battle against COVID-19 will be won in his country.

In late March, Dr Anthony, the Kaduna State Health Ministry Infection Prevention and Control lead, benefitted from a WHO-supported training on infection prevention and control measures, which has since been held across all six geopolitical zones of Nigeria.

Dr Anthony has helped to train as many as 4000 health workers in Kaduna and across the northwest region on infection prevention and control, including the appropriate use of personal protective equipment, respiratory and hand hygiene.

The State now has some of the highest numbers of health workers trained, and this also cascades down to the non-medical staff.

Dr Anthony has helped to train as many as 4000 health workers in Kaduna and across the northwest region on infection prevention and control, including the appropriate use of personal protective equipment, respiratory and hand hygiene. The State now has some of the highest numbers of health workers trained, and this also cascades down to the non-medical staff.

Infection prevention and control is a key tenet of the response to COVID-19. So far Nigeria has recorded more than 52 000 infections, including in 2175 health workers. In April, just a month into the outbreak in Nigeria, Kaduna state recorded some of the highest levels of health worker infections, with 30 health care staff infected [\[LINK\]](#)



Best Practices

9 August 2020

## ESTABLISHING FLU/FEVER CLINICS AND COVID-19 TESTING CENTRES FOR TRIAGE OF SYMPTOMATIC PATIENTS IN MAURITIUS

Each regional hospital had a dedicated pathway for flu and fever at the beginning of the response as a form of triage to curb the risks of transmission from suspected cases. The medical teams concerned were trained on the pathway and a protocol was established for it. To respond to the growing number of confirmed cases and strengthen IPC, a detached fever/flu clinic for COVID-19, referred to as COVID-19 testing centre was built in each regional hospital.

The WHO Country Office liaised with WHO AFRO and WHO Headquarters to develop the design of the infrastructure which was based on the WHO model of severe acute respiratory infections treatment centres. The construction was ensured by the Ministry of National Infrastructure and Community Development with funding from the Government, the WHO Country Office, UNDP and the private sector. Between 24 March and 9 August 2020, the flu/fever clinics and the COVID-19 testing centres welcomed 23 352 patients and was key in preventing the propagation of COVID-19 from suspected cases to health personnel and other patients. .



COVID-19 testing centre – Source: WCO



Isolation room in the centre – Source: WCO

**“From the beginning of the pandemic itself, we had the flu clinics in each of the hospitals where patients coming with symptoms such as fever were directed to and the flu clinics were then shifted in separate facilities in refurbished containers, known COVID-19 testing centres, which are more conducive to receive patients.”**

**Dr Ori**

Nigerian leading expert in infection prevention and control

Best Practices

30 December 2020

## ADOPTION OF STRINGENT IPC MEASURES FOR FOOD AND ESSENTIAL SUPPLY SHOPPING IN MAURITIUS

The sudden lockdown caused a lot of panic among Mauritians. The prevalent fear of disrupted food and essential goods supply created a rush towards markets and supermarkets. These counteractive behaviours increased the risk of COVID-19 transmission. By 24 March 2020, Mauritius experienced a sharp rise in the number of COVID-19 cases. Many cases did not adhere to the infection prevention and control guidelines recommended island-wide. The Government therefore took the bold decision of closing all commercial activities, namely all supermarkets, shops and bakeries till 31 March 2020. The High-Level Committee on COVID-19 worked in collaboration with the Mauritius Chamber of Commerce and the Association of Retailers to devise the IPC measures to be implemented during food and essential supply shopping. All supermarkets and corner shops eventually reopened on 2 April 2020 with a series of positive measures to prevent overcrowding in premises and prevent the spread of COVID-19.

Supermarkets opened six days a week and Mauritians were only allowed to shop twice a week in alphabetical order using family names: "A to F" on Mondays and Thursdays, "G to N" on Tuesdays and Fridays, and O to Z on Wednesdays and Saturdays. One person per household was allowed to shop for 30 minutes and the wearing of protective

masks was compulsory. Customers had to bring an identification document which was verified at the entrance of the supermarkets. The elderly were dissuaded from shopping, while younger adults of the family were encouraged to do so. A special morning slot from 09:00 am to 10:00 was created for elderly persons who had to shop for themselves.

Physical distancing was key, and all supermarkets and shops placed markings on the ground to indicate the recommended 1 m of physical distancing throughout shopping. Protective barriers were installed at the checkout tills to protect both the staff and the customers. Staff also wore gloves, protective visors and masks at all times. Shoppers could only use trolleys which were sanitized by supermarkets staff after each use. Hand sanitizers were offered upon entry into the premises and shoppers were advised to avoid touching surfaces and products that they were not buying. Mauritians were only allowed to acquire essential foodstuffs in specific aisles. Special one-way pathways were designed in the shopping premises to avoid excessive movement and facilitate the respect of the 1 m precautionary distance between shoppers. These very strict and novel measures contributed immensely in helping the population to shop safely while avoiding transmission of the virus.

### Ken Arian

Senior Adviser, Prime Minister's Office

**"I think that we are the only country in the world which have taken the measures of people going to supermarkets in alphabetical order while respecting sanitary measures such as physical distancing and wearing of masks inside of the supermarkets."**

### Ken Arian

Senior Adviser, Prime Minister's Office

## Preventing and containing COVID-19 by communicating effectively, engaging communities and transmitting risks

One of the most valuable public health interventions to help save lives during major public health events is to communicate proactively and effectively with communities to promote involvement and ensure the success of crucial measures designed to break the chain of transmission. Effective risk communication and community engagement (RCCE) in the Region has proven crucial in clearing confusion, countering misinformation, dispelling misunderstandings and building trust in the response to a new pathogen that quickly evolved into a pandemic, helping to increase compliance with health advice such as handwashing, wearing masks and physical distancing, and minimizing and managing rumours that undermine responses and can lead to further spread of the disease.

**“Community involvement is crucial to the success of preventive measures such as handwashing, wearing masks and physical distancing”**

**Dr Dansan Atim**

Senior Medical Officer Surveillance Division  
Ministry of Health of Uganda

Since the onset of the pandemic, WHO has proactively established a community of practice to coordinate RCCE efforts in countries, through strengthened collaboration with the Africa CDC, UNICEF, the International Federation of Red Cross and Red Crescent Societies (IFRC), NGOs and other organizations. Between March and July 2020, all countries in the African Region had communicated COVID-19 prevention and preparedness messages to their populations, supported by WHO to produce radio messages, TV spots and set up call centres to inform members of the public about the risks of COVID-19 and how to protect themselves from the virus. Over the same period, the proportion of countries that had implemented a community engagement plan rose from 57% to 62%. All 47 countries have been supported in developing and implementing risk communication and community engagement plans based on technical guidance by WHO, which includes general risk communication guidance [\[Link\]](#), guidance for physical and social distancing [\[Link\]](#), asymptomatic, pre-symptomatic and mild signs and symptoms of COVID-19 [\[Link\]](#), addressing NCD risk factors in the context of COVID-19 [\[Link\]](#), and safe practices during Ramadan [\[Link\]](#).



Fact sheets on COVID-19 have been produced and disseminated, covering topics such as COVID-19 stigma and discrimination [\[Link\]](#), treatments and vaccines and COVID-19 mistrust, denial and disbelief.

**“Promoting access to correct information and battling misinformation contributes to a better participation of the population in the response to this unprecedented pandemic”**

**Dr Djamila Cabral**  
WHO Representative for Angola

Over 10 645 participants in 16 countries have been trained on the WHO RCCE 5-Step Package for the Region.

The potential of community involvement in the COVID-19 response has not been fully exploited. As communities increasingly experience “compliance fatigue”, and rumours and misinformation are still spreading, it is imperative that WHO and partners continue to support countries to empha-

size risk communication and strengthen the role of community and religious leaders as well as community health workers, to effectively engage communities in preventing infection and transmission to protect individuals, curb the spread of the virus and save lives. The use of social science research results available in countries is key to building an effective risk communication and community engagement strategy.

**“To roll out a vaccine effectively across countries in Africa, it is critical that communities are engaged and understand the need for vaccination...it is important to already start working with communities to prepare the way for one of the largest vaccination campaigns Africa has ever experienced.”**

**Dr Richard Mihigo**  
Programme Area Manager, Immunization and Vaccine Development  
WHO Regional Office for Africa.

Best Practices

3 December 2020

## BATTLING COVID-19 RUMOURS AND HOAXES IN ANGOLA

**Luanda** –“COVID-19 doesn’t kill anybody in Angola as we are immune due to malaria,” so goes one of the myriad falsehoods about the pandemic in the southern African country. Misinformation and rumours have constantly cast a pall on the fight against COVID-19. In July, the World Health

Organization (WHO) office in Angola and the Ministry of Health set up the COVID-19 Alliance – a system to fight the surge of potentially harmful misinformation shared mostly online. For more information click on this [\[LINK\]](#).

Best Practices

31 December 2020

## A SAFE MAGAL RELIGIOUS PILGRIMAGE IN TOUBA, SENEGAL

In Senegal, a rapid socio-anthropological study carried out in August and September 2020 two months before the Grand Magal 2020 helped reduce the risk of COVID-19 transmission at this major religious annual gathering. The Grand Magal, is described as "... largest religious event in Senegal, the sub-region and one of the largest in Africa or even the world...(ii) that drains between 4 and 5 million visitors every year in the holy city of Touba, epicentre of the Sufi brotherhood of the Mourides." (Cheik SOKHNA et alii ; Le « miracle » sanitaire du Magal ou Etude de l'impact du Magal de Touba 2020 dans l'évolution du Covid-19 au Sénégal, nov 2020).

In the context of COVID-19 pandemic, such an event presents a high risk of contamination. As a prelude to this religious event WHO supported the Ministry of Health and Social Action (MSAS) to carry out the rapid research that provided RCCE approaches, material and messages in order to strengthen the adherence of pilgrims to preventive measures. Due to this study, partners joint efforts and support national authorities to develop and implement a comprehensive action plan. The Magal pilgrimage took place from 5-6 of October 2020. Before, during and after the event, the risk of transmission was significantly mitigated thanks to the contextualized RCCE approach.

## Delivering essential supplies and equipment amid massive global disruptions

The COVID-19 outbreak has led to an unprecedented global demand for, and acute shortage of materials and life-saving medical supplies such as personal protective equipment (PPE), diagnostic and clinical care products, which are needed to alleviate suffering and reduce loss of life in the WHO African Region. Travel restrictions imposed by countries at the onset of the pandemic exacerbated international market constraints, severely hampering the supply of essential medical commodities and equipment to countries in the Region. To ensure market access for low and middle-income countries, WHO and partners created a UN COVID-19 Supply Chain System, providing a channel for these countries to request critical and potentially life-saving health care supplies. For that purpose, several major and significant logistic mechanisms have been established to support the supply system, such as:

- implementation of an online Supply Portal combined with a free-to-user air service in partnership with WFP.
- implementation of WHO humanitarian corridors and Solidarity Flights
- implementation of regional logistic platforms and coordination mechanisms with partners such as A-CDC, AU, WFP, UNICEF by fostering coordination and complementarities among main stakeholders.
- strengthening of supply and logistics capacities at country level through the deployment of experts and by conducting trainings and remote technical support.

The UN COVID-19 Supply Portal as it is known, is a purpose-built tool which facilitates requests and purchases of critical supplies from national authorities and implementing partners through a centralized approach, allocating quality-assured essential supplies at affordable prices to countries, based on country capacity and assessed vulnerability, and the gap between country needs and available supplies.

Launched in May 2020, the UN Supply Portal and the WHO procurement system have delivered personal protective equipment, biomedical equipment, and diagnostic supplies in response to 897 requests totalling US\$ 88.5 million to all 47 countries in the Region. As of 31 December 2020, the following items have been procured and shipped to the WHO African Region. The figures below represent diagnostic items that have been provided by WHO and other partners (such as the Global Fund/GDF/UNICEF/UNDP/UNITAID-CHAI). The PPE items listed below have been procured and delivered by WHO alone to support the African Region.

Collaboration between WHO and the Africa CDC has been enhanced to avoid duplications and strengthen complementarities between this system and a similar AU platform. Although requests to the Supply Portal decreased by 66.1% between July and September 2020, they increased significantly by 133.3% in October compared to September, reaching a total value of US\$ 10 million in October alone (Figure 13 and 14).

Between November and December, the countries of the Region did not express significant needs, which translates into a 79% reduction of orders on the UN Supply Portal.

### KEY FIGURES (31 DECEMBER 2020)

Figures below represents Diagnostics items that have been provided by WHO and other partners (such as Global Fund/GDF/UNICEF/UNDP/UNITAID-CHAI).

- Sample Collection Kits 3 096 040
- Tests (Manual PCR) 9 153 386

The PPE items listed below have been procured and delivered by only WHO to support the African Region.

 Face Shields 1 417 410

 Gloves 9 739 165

 Goggles 165 170

 Gowns 1 351 067

 Medical Masks 51 783 950

 Respirators 2 207 430

 Sample Collection Kits 3 096 040

 Test kits (Manual PCR) 9 153 386

Figure 10: Number of requests submitted in the UN supply Portal between May and December 2020

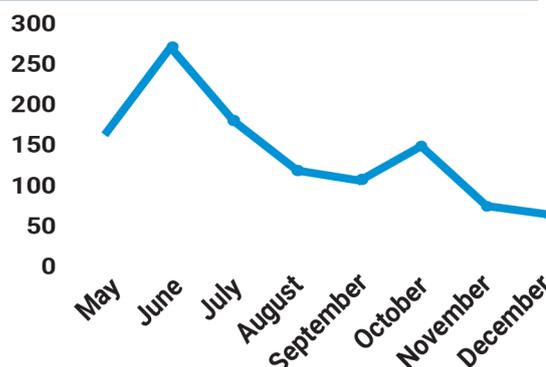
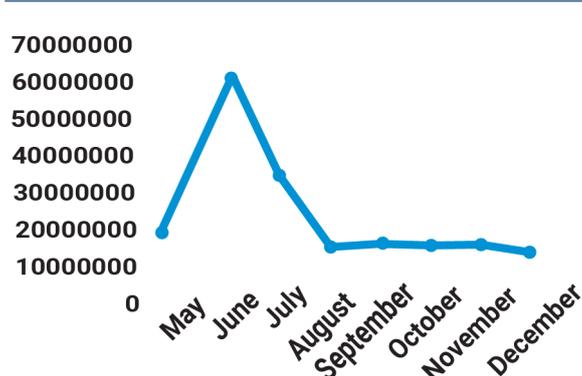


Figure 11: Value of requests submitted in the UN supply Portal between May and December 2020



WHO also called for humanitarian corridors and Solidarity Flights, to ensure enhanced, equitable access to essential supplies across every country in the African Region. In collaboration with national governments, WFP, the AU, Africa CDC, and the Jack Ma Foundation, WHO organized “Solidarity Flights” that delivered 1 million facial masks, gloves, other personal protective equipment for case management of 30 000 patients, ventilators, 20 000 laboratory test kits and other essential medical supplies to 52 African countries. With the support of the Government of Korea, 548 064 PCR tests and extraction kits were delivered to 24 African countries.



Holistic support (technical, operational and training) has been provided to set up new COVID-19 treatment centres and to repurpose existing facilities into laboratories, community facilities for mild and moderate cases, screening, testing areas and points of entry. A total of 27 health facilities have been supported, including 11 new structures with a total of 3097 COVID-19 beds. A total of 450 participants from MoHs and partners, representing 33 countries across the Region, attended the health logistics webinars on SARI facilities, waste management and ventilation (Fig. 15).

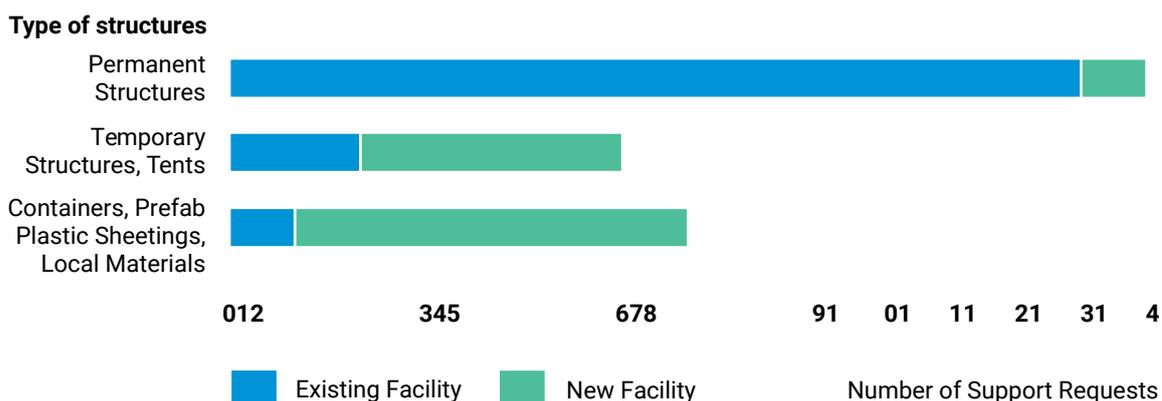
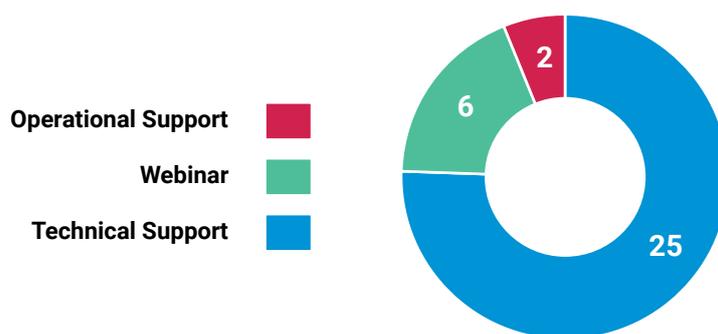
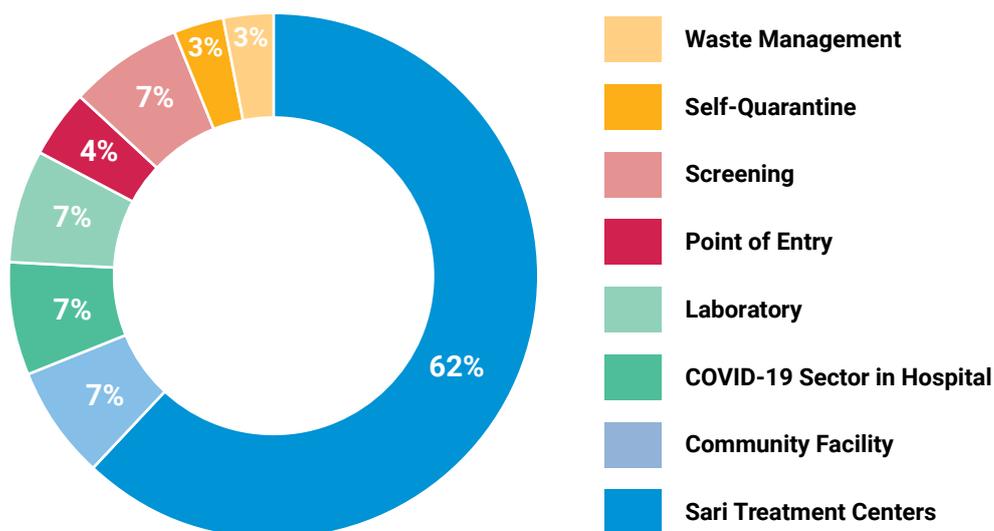
### Best Practices

## OPERATIONAL SUPPORT AND LOGISTICS IN ETHIOPIA

- Stock shift from other programmes (maternal and child health, Ebola) which guaranteed medicines and medical supplies in country.
- Local production capacity increased, ensuring the availability of hand sanitizers and face masks.
- Simplified custom clearance system at Bole Airport for COVID-19 donations.
- Ensured medical equipment (mechanical ventilators, ICU beds) are installed and maintained at local level.
- Maintenance of oxygen plants in government and private health facilities.
- Emergency supply warehouse was built and permanent emergency supply chain (ESC) warehouse managers hired.
- Resources from WFP were mobilized for six months which supported the running of the COVID-19 treatment centers in order to provide quality health services.
- Served as a major reception and distribution hub for COVID-19 supplies (IPC, laboratory, etc.) for other African countries.

Ensured adequate and timely availability of logistics required to mount effective outbreak response in the country and other African countries.

Figure 12: OSL Health Logistics - Achievements



Technical recommendations have been provided by WHO to its Member States in the Region for the development of a system to manage the proper collection and storage of expired and used GeneXpert cartridges and lysis vials used in COVID-19 rapid diagnostic tests. Over 100 participants have been trained and incinerators mapped in 47 countries. WHO has also implemented a Stock Management Tool to support countries in the management of their stock, including essential items related to COVID-19 activities. Two technical tool orientation webinars drawing 100 participants from ministries of health and WHO have been organized. Additional training sessions were undertaken at country level.

## Best Practices

## OPERATIONAL SUPPORT AND LOGISTICS: WHO SUPPORT FOR HUMANITARIAN CORRIDOR FLIGHT OPERATIONS IN ADDIS ABABA, ETHIOPIA

COVID-19 pandemic lockdown measures endorsed by most governments in the Region saw several borders closed, flights cancelled, and commercial flights grounded, hampering deliveries of essential medical equipment and supplies to countries. WHO called for humanitarian corridors and Solidarity Flights, ensuring enhanced, equitable access to essential supplies across every country in the African Region. Solidarity was key, through collaborating in the effort among countries and organizations to overcome the fragmented supply chain. Ethiopian Airlines was identified as one of the few airlines that remained operative with adequate fleet, storage capacities and negative cold chain; which explains the decision to purposively select Addis Ababa as a central hub to receive all cargo from different parts of the world and forward them to countries in the African Region

The overall objective of the major airlift operations in Addis Ababa was to enhance part of the wider UN supply chain effort in delivering essential supplies in the Region. This objective enhanced mitigation of shortage risks in the face of soaring essential

supplies demand. Thus, the need for WHO and WFP Ethiopia to coordinate and facilitate shipping of essential supplies to targeted COVID-19 affected countries.

### Overview of flights

- 1st round Alibaba/Jack-Ma round Alibaba/Jack-Ma PPE Donation to 50 countries
- Donation Solidarity Flight WHO PPE cargo from Dubai hub for 30 African countries and The Jack Ma PPE and laboratory kits donation round two for 50 countries
- Korea donation distributed total of 548 064 PCR tests and Extraction kits to 24 African countries

### Support for difficult-to-reach countries:

- Comoros Island and Eritrea supported, GSC Shipping and facilitated last leg shipping to reach countries.



## Best Practices

**COVID-19 SUPPLY PORTAL IN MALAWI****Factors contributing to the successful utilization of the COVID-19 Supply Portal (CSP) in Malawi include:**

- Ease of use of CSP complemented by availability of training documents and videos on the WHO site.
- Availability of information on how to access the COVID-19 Supply Portal.
- UNICEF designated the Supply Chain Coordinator, given that it procures most of the COVID-19 supplies on behalf of the MoH.
- Validated supply needs consolidated under the national action plan by the Supply Chain Coordinator in consultation with national authorities, UN Country Team, the Resident/Humanitarian Coordinators, and other partners.
- Country's supply needs informed by the National Action Plan and the COVID-19 Essential Products Quantification exercise report in consultation with the National Response Team (NRT).
- Awareness raising and explanation of CSP functionality to key stakeholders including the Health Donor Group (HDG), UN Procurement working group, Humanitarian Country Team (HCT), Logistics cluster group, Covid-19 Health Supplies and Logistics Committee and the Drugs and medical supplies technical working group.
- MoH chair of the national CSP task force technical working group to ensure country ownership, while the diverse membership enables experts on supply chain to review country requests.
- Technical issues channeled to WHO through the global service helpdesk and addressed within 24-48 hours.
- Efficient two-pronged approach for submission and approval of requests through the CSP.
- Majority of orders validated within 24-48 hours.



## External Communication

COVID-19 has dramatically shaken up health communication. Getting the right message across is – and continues to be – one of the most challenging aspects of responding to this pandemic not just in Africa, but the world over. There has been a huge rise in demand for, as well as an overabundance of information, given the novelty of the virus. The fast-evolving knowledge about the pandemic has meant consistently keeping pace with events and developments to provide up-to-date, accurate information while dispelling misleading claims.

The communications unit is also keeping Member States and partners informed about the latest developments, guidelines and best practices through weekly newsletters. The COVID-19 newsletter has recorded an average open rate of more than 50% including forwarded messages. Since February 2020, the communications unit has produced more than 20 impact stories, including photo essays highlighting the support WHO provides to countries and the COVID-19 response by governments in the Region.

**“In health emergencies, misinformation can kill and ensure diseases continue to spread. People need proven, science-based facts to make informed decisions about their health and wellbeing, and a glut of information – an infodemic – with misinformation in the mix makes it hard to know what is right and real.”**

**Dr Matshidiso Moeti**  
WHO Regional Director for Africa



Communication support to country communications officers has also been stepped up. The unit has worked with countries to increase social media presence by sharing and helping to create content as well as setting up accounts. Regional Francophone Twitter and Facebook accounts were started earlier this year, and social videos shared on the Facebook page often get around 200 000 to 400 000 views with some reaching over one million views.

The proliferation of misinformation and disinformation on social media has been a real challenge for the response. This so-called infodemic has led to dangerous false claims of cures and prevention circulating on social media.

**“Africa can only beat the COVID-19 pandemic and other disease outbreaks by relying on trusted information that is based on insights scientists bring to the conversation. To fight misinformation and mischaracterization, public health experts must work with the community and media consistently and continuously. This is the value that the Africa Infodemic Response Alliance partnership brings to the collective of responses in the continent.”**

**Dr John Nkengasong**

Director, Africa Centres for Disease Control and Prevention (Africa CDC).

To combat this, WHO in the African Region is setting up an Infodemic Response Alliance to collectively manage the infodemic – this alliance includes institutional as well as media partners. WHO is working on setting up a brand identity called Viral Facts, which will then counter misinformation and provide correct information.

Best Practices

3 December 2020

## LANDMARK ALLIANCE LAUNCHES IN AFRICA TO FIGHT COVID-19 MISINFORMATION

The World Health Organization (WHO) today launched a new alliance, the Africa Infodemic Response Alliance (AIRA), to coordinate actions and pool resources in combating

misinformation around the COVID-19 pandemic and other health emergencies in Africa. For more information click on this [\[LINK\]](#)

## Advancing research, innovations and vaccines to combat COVID-19

Improving our response to the ongoing COVID-19 Pandemic in the WHO Africa Region required innovation, new information and research and development (R&D). Responding to the pandemic required a multisectoral approach, guided by critical knowledge on the diverse dimensions of the disease. With a pressing need for diagnostic tests that can produce rapid, accurate results at scale in different geographic and resource settings, COVID-19 generated demand for research, innovations and a transformative approach to address the extraordinary challenges posed by the virus.

**“COVID-19 is one of the most serious health challenges in a generation, but it is also an opportunity to drive forward innovation, ingenuity and entrepreneurship in life-saving health technologies,”**

**Dr Matshidiso Moeti,**

WHO Regional Director for Africa.

WHO has worked closely with partners including Africa CDC to support countries with standard protocols, policy briefs and guidance for investigation of various aspects of COVID-19, which enabled countries to generate critical evidence to design country-

specific pandemic responses. With direct financial, technical and material support from WHO, 16 countries have since implemented at least one of the WHO standard protocols. A few other countries are supported by partners like Institut Pasteur; BMGF, US CDC and Africa CDC, among others. As early as February 2020, a multisectoral collaboration between WHO, the Institut Pasteur and five francophone African countries<sup>8</sup>, implemented synchronized COVID-19 sero-epidemiology studies of 1000 health workers, adapting the WHO UNITY protocol for health workers. The use of sero-epidemiology studies to grasp the true magnitude of the COVID-19 pandemic has expanded in the Region with countries like Kenya and South Africa using this methodology to better understand the prevalence of the disease and manage outbreaks.

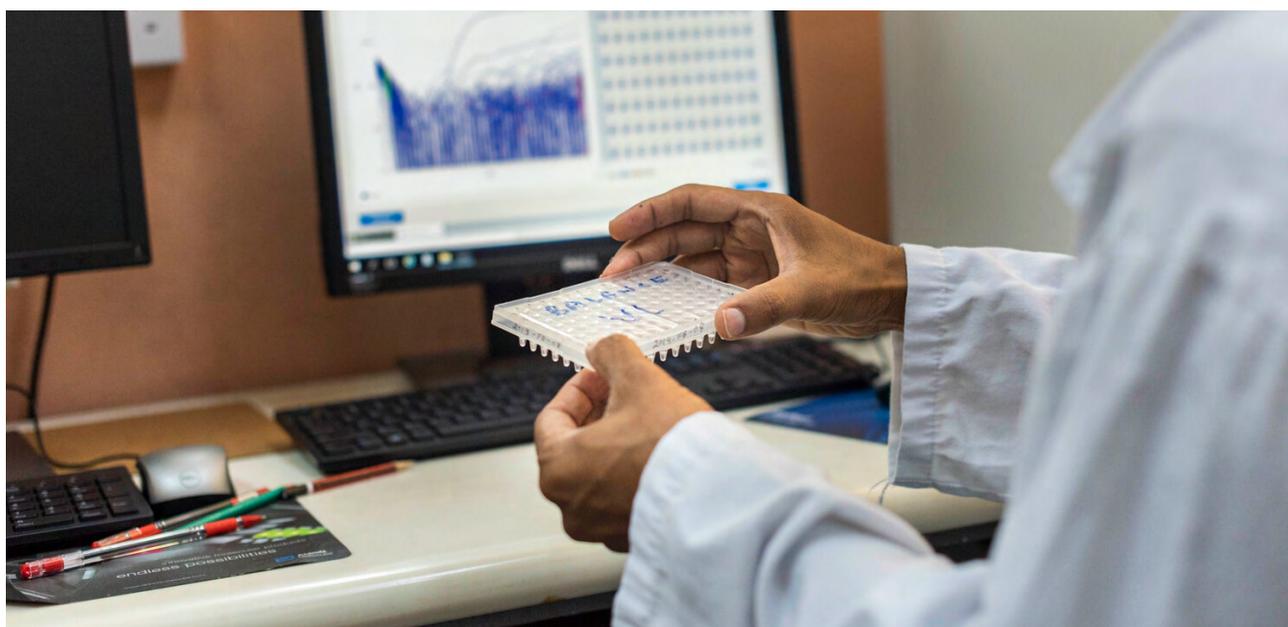
WHO has funded the implementation of country COVID-19 studies, supported country participation in the Global Therapeutic Trial, and the development of standard protocols for scientific evaluation of traditional remedies in the Region.

**“We extend our appreciation to AFRO for the level of financial and technical support provided to Liberia for the implementation of the First Few Cases (FFX) study. Through the support provide by AFRO, we have been able to complete the investigation of the 600 enrolled participants across 10 of the 15 counties in Liberia.”**

**Yealue Kwuakuan, COVID-19 Response Incident Officer,**  
WHO Liberia

The COVID-19 pandemic has galvanized the development of more than 120 health technology innovations that have been piloted or adopted on the continent. The recent study by WHO AFRO revealed that out of 1000 new or modifications of existing technologies that have been developed worldwide to target different areas of the COVID-19 response, Africa accounts for 12.8% of the innovations. The response areas include surveillance, contact tracing, community engagement, treatment, laboratory systems and infection, prevention and control. In Africa, 57.8% of the technologies were ICT-driven, 25% were based on 3D printing and 10.9% were robotics. The ICT-based innovations include WhatsApp Chatbots in South Af-

rica, self-diagnostic tools in Angola, contact tracing apps in Ghana and Kenya and mobile health information tools in Nigeria. The countries with the most innovations were South Africa (13%), Kenya (10%), Nigeria (8%) and Rwanda (6%).



<sup>8</sup> Burkina Faso, Cameroon, Central African Republic, Niger, Madagascar

In March 2020, WHO AFRO spearheaded spotlight events that included hackathon and innovation webinars to harness innovations that could be deployed to combat COVID-19 in the Region. Through these initiatives, WHO has unearthed innovations that are being rolled out at country level. For instance,

WHO AFRO is supporting the roll-out of VaxiGlobal, which is an innovation aimed at fighting against fake COVID-19 certificates being presented at various points of entry in Southern Africa; mSafari, which is a contact tracing tool that makes it possible to identify contacts of an infected person using public transport in Kenya; and NextGenCovAI, which is an integrated platform used in Uganda to provide real-time results for patients tested for COVID-19 at various testing centres.

Despite some exciting achievements in research and innovation in response to the COVID-19 pandemic, dependence on external funding and the low priority allocated to these critical areas in many countries has resulted in a deficit of scientific communities empowered to drive research and innovation as part of the response in most countries in the Region.

Through the UN Supply Portal, WHO is supporting countries to replenish test kits and other commodities. This area of access to new technologies, which also includes future vaccines and treatments, is one in which international solidarity remains absolutely vital.

**“Our collective advocacy is needed to ensure the equitable distribution of the vaccine to the Region. Equity and solidarity must be at the forefront of the discussions on vaccine availability and delivery.**

**Dr Matshidiso Moeti**  
WHO Regional Director for Africa

WHO has put in place a multistakeholder African COVID-19 Vaccine Readiness and Delivery Taskforce to coordinate regional efforts in this area, with partners including UNICEF, Gavi, the Vaccine Alliance, Africa CDC, the World Bank, IFRC, Sabin Institute, and various NGOs, academic and research institutions, among others. .

National multistakeholder task forces for coordination and planning, building on the experience gained from the introduction of other new vaccines (Ebola, conjugate meningitis, polio, etc.), need to develop national plans, identify and prioritize target populations, provide for

supply chain and waste management as well as needed infrastructure, and strategically use RCCE to combat misinformation and prepare for vaccine acceptance and uptake. Synergies need to be created with the African Union initiative (African Vaccine Acquisition Task Team and the COVAX facility), while opportunities also need to be explored to revitalize other essential health services. Underlying these efforts is the urgent need to secure significant additional financing to ensure the vaccination of at least 60% of the population in the Region, including from domestic resources and the private sector.

Best Practices

3 September 2020

## **AFRICAN COUNTRIES ENGAGING IN GROUND-BREAKING COVID-19 VACCINE INITIATIVE**

Brazzaville-Through COVAX, vaccines that have passed regulatory approval or WHO prequalification will be delivered equally to all participating countries, proportional to their populations. Health workers and other

vulnerable populations will be prioritized and then vaccine availability will expand to cover additional priority populations in participating countries. For more information click on this [\[LINK\]](#).

## Providing essential Personnel to support countries and save lives

Despite the initial challenges in deploying experts to countries due to flight restrictions, traveller quarantines and landing authorizations in most of the countries in the Region, international emergency medical teams (EMTs) were dispatched to 16 African countries.<sup>9</sup> WHO guided Member States on activating and coordinating EMTs for COVID-19 response and provided support to set up the necessary protocols and procedures for countries to request EMT support. WHO further implemented innovative digital solutions and remote working to overcome challenges posed by international travel restrictions. More than 200 international experts were deployed to 45 countries in the Region to support response efforts, including training of front-line health workers and response staff in technical areas including surveillance, coordination, treatment, infection prevention and control and testing. A Regional EMT training centre was also established in Addis Ababa to scale up the implementation of national EMTs for COVID-19 response. Additionally, WHO has repurposed over 1286 staff to support COVID-19 efforts at regional and country levels.



WHO-funded surge teams of health experts, with key expertise in areas ranging from epidemiology and procurement, to community mobilization and health education, were further deployed to South Africa, to strengthen its COVID-19 response.

**“WHO will greatly bolster our efforts as we have seen how effective their interventions have been in countries.”**

**HE Dr Zweli Mkhize**  
Minister of Health of South Africa

Efforts in this area have been closely coordinated with the health agencies of the regional economic communities, and health networks including the West African Network of Excellence for Tuberculosis, AIDS and Malaria (WANETAM), the Network of National Institutes of Public Health of the Community of Portuguese-speaking Countries (RINSP-CPLP), the African Field Epidemiology Network (AFENET), and the International Association of National Public Health Institutes (IANPHI).

Increased funding is needed as the pandemic evolves and beyond, to scale up the essential personnel required to maintain critical functions in countries, particularly at subnational levels.

Best Practices

5 August 2020

### WORLD HEALTH ORGANIZATION SURGE TEAM TO ARRIVE IN SOUTH AFRICA

Brazzaville/Geneva/Johannesburg- WHO will be deploying 43 experts from various fields to support the COVID-19 outbreak response management. The first 17 health experts will arrive today and include key expertise in

epidemiology, surveillance, case management, infection prevention and control, procurement, as well as community mobilization and health education. For more information, follow this [\[LINK\]](#).

<sup>9</sup> Algeria, Cameroon, DRC, Zambia, Burkina Faso, Chad, Congo, Ethiopia, Ghana, Madagascar, Nigeria, Sao Tome and Principe, South Africa, South Sudan, Zimbabwe, Senegal.

# Milestones achieved since the onset of the pandemic

2020	
Coronavirus outbreak declared a public health emergency of international concern by the WHO Director-General	<b>30 JANUARY</b>
First confirmed case of COVID-19 in the WHO African Region.	<b>14 FEBRUARY</b>
42 Labs in the WHO African Region have the capacity to test for SARS-CoV-2 by RT PCR.	<b>25 FEBRUARY</b>
COVID-19 cases in Africa exceed 10 000.	<b>11 MARCH</b>
African regulatory agencies to speed up review of COVID-19 clinical trials.	<b>24 MARCH</b>
First ever virtual World Health Assembly convened, endorsing a resolution on the COVID-19 response, with consideration of other items suspended until later in the year	<b>1 APRIL</b>
WHO advocates for equitable access to COVID-19 vaccine.	<b>7 APRIL</b>
WHO and Africa CDC launch expert committee for COVID-19 traditional medicine research.	<b>14 APRIL</b>
1 000 000 COVID-19 cases and 25 374 deaths in the WHO African Region.	<b>20 APRIL</b>
Launch of the COVID-19 network of genome sequencing laboratories.	<b>1 MAY</b>
More than 1.5 million COVID-19 cases and 37 072 deaths in the WHO African Region.	<b>18–19 MAY</b>
	<b>22 MAY</b>
	<b>1 JUNE</b>
	<b>9 JULY</b>
	<b>14 JULY</b>
	<b>22 JULY</b>
	<b>23 JULY</b>
	<b>23 AUGUST</b>
	<b>3 SEPTEMBER</b>
	<b>10 SEPTEMBER</b>
	<b>19 SEPTEMBER</b>
	<b>1 DECEMBER</b>
	<b>1 DECEMBER</b>

# Heroes of COVID-19

Millions of people across the African Region and the world have been affected by the COVID-19 pandemic; not only those who lost their lives to the virus, but those who survived and the many whose livelihoods, education, safety, and numerous other socioeconomic realities were changed as a result of COVID-19. As we mourn the victims and collectively come together to care for the survivors and rebuild the socioeconomic fabric of the Region, we honour and thank the countless men and women: health workers, laboratory technicians, virologists, researchers, and community leaders among others, who selflessly fought the battle against COVID-19. These are some of the Heroes of the COVID-19 response:



**“We have very stringent rules. We strictly follow them while using the personal protective equipment or handling samples, making sure we don’t put ourselves at risk. Without the protective equipment, we wouldn’t be able to do our job.”**

**Dr Benbetka Chahrazed**  
Virologist, Algeria

<https://www.afro.who.int/news/algerias-main-lab-anchors-covid-19-response>

**“Our workload has greatly increased. I have spent many nights here to help make the laboratory capable of detecting COVID-19. We spent many hours communicating partners to obtain reagents, supplies and equipment.”**

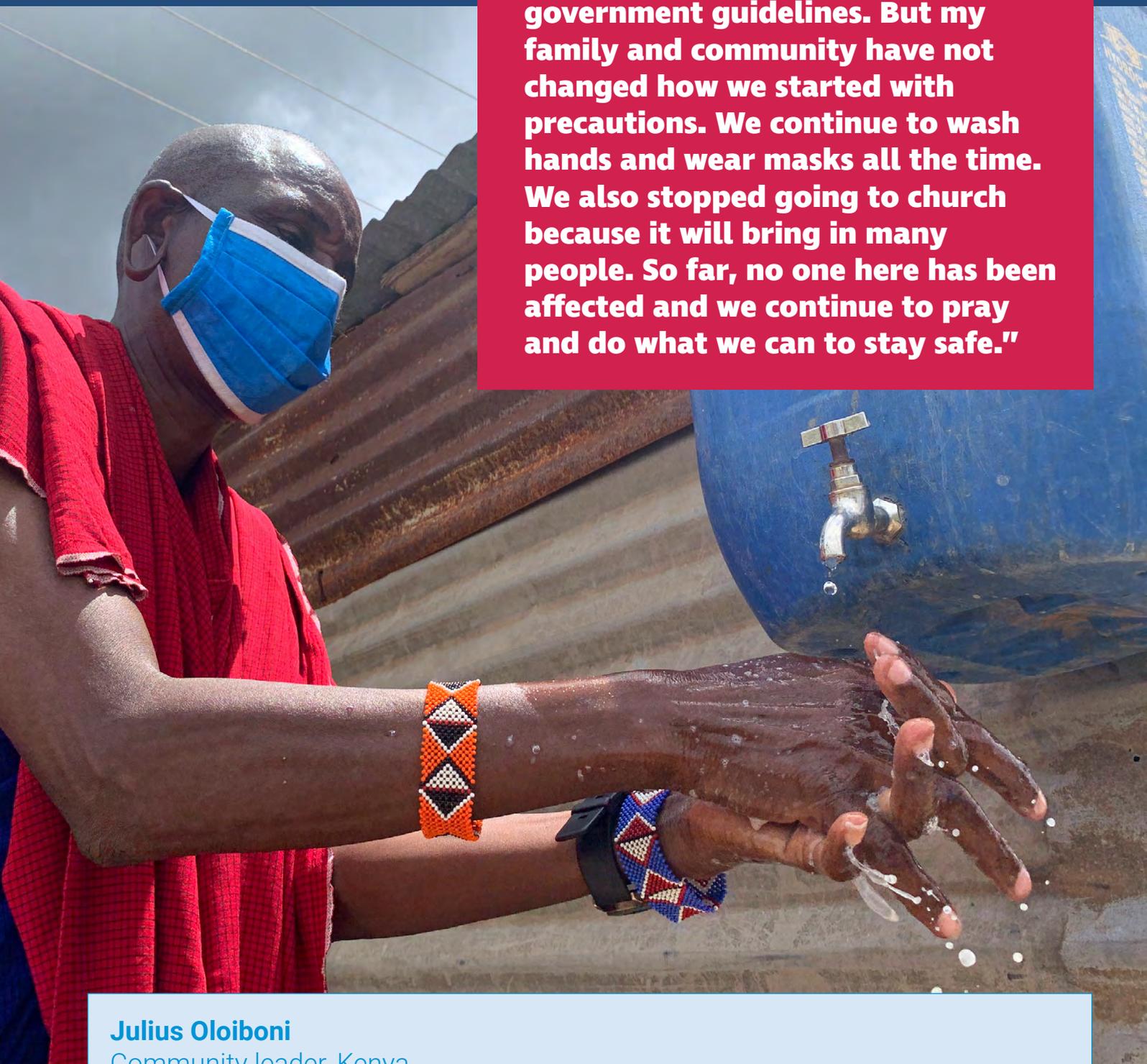


**Adamu Tayachew**

Researcher, Laboratory technician, Ethiopia

[Scaling up coronavirus outbreak readiness in Ethiopia | WHO | Regional Office for Africa](#)

**“The situation has changed a lot. The virus is everywhere. We are shocked that the numbers keep increasing. We are shocked that there are people disregarding government guidelines. But my family and community have not changed how we started with precautions. We continue to wash hands and wear masks all the time. We also stopped going to church because it will bring in many people. So far, no one here has been affected and we continue to pray and do what we can to stay safe.”**



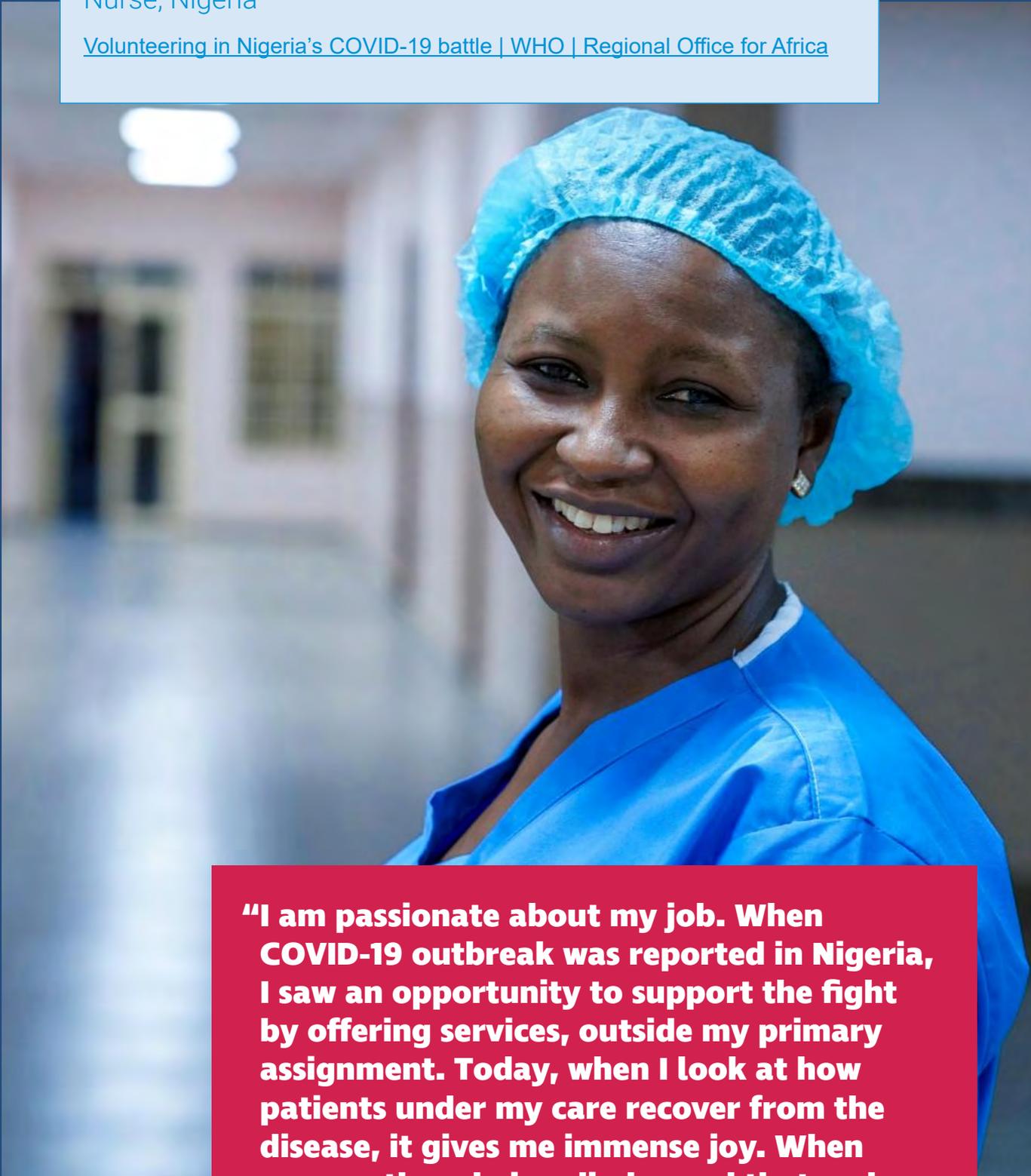
### **Julius Oloiboni**

Community leader, Kenya

[Kenyan communities taking the lead in curbing COVID-19 spread | WHO | Regional Office for Africa](#)

**Tsaimu Juliana**

Nurse, Nigeria

[Volunteering in Nigeria's COVID-19 battle | WHO | Regional Office for Africa](#)

**"I am passionate about my job. When COVID-19 outbreak was reported in Nigeria, I saw an opportunity to support the fight by offering services, outside my primary assignment. Today, when I look at how patients under my care recover from the disease, it gives me immense joy. When you see them being discharged that makes me even happier because the joy of every health personnel is to see his or her patient recover and discharged in good health."**

# Lessons learnt and emerging challenges

Significant progress has been made in the response to the COVID-19 pandemic in African countries over the past year. Many governments were quick to impose lockdowns, establish border screenings, restrict international travel and implement other key public health and social measures even before the first case was imported into Africa. This not only helped to flatten the epidemic curve, but also helped countries to buy time to establish readiness capacity for case management such as isolation facilities. Most countries demonstrated strong government commitment at the highest level, with the President or Prime minister heading the multisectoral response task force, which has facilitated quick and decisive action. Moreover, from the outset, most countries adopted a “whole-of-government and whole-of-society approach to the COVID-19 pandemic response with the involvement of all key sectors. Importantly, most countries decentralized the response to the provincial, district and subdistrict levels. Further, most countries ensured good coordination and collaboration between the various government departments. Planning and decision-making were guided by locally available data and global best practices.

The WHO Regional Office for Africa developed models based on the African and country context to project caseloads. While the caseloads from all models invariably overestimated the case numbers, the models helped the Region and the countries to forecast the requirements for hospitalization and case management, such as intensive care unit (ICU) and high dependency unit (HDU) beds and capacity to deliver high-flow oxygen for severe and critical cases. To augment the COVID-19 response, in early August 2020, when humanitarian flights were authorized, WHO deployed multidisciplinary surge teams to hot spot countries such as South Africa to support them in key areas of the response. Indeed from the early days of the pandemic, WHO has played an active role in supporting countries in the Region in their preparedness and response efforts, with Member States reporting improved capacity to respond to the virus in critical intervention pillars, including leadership and coordination, incident management systems, surveillance and contact tracing, rapid response teams, laboratory capacity, case management, infection prevention and control, risk communication and community engagement and logistics and supply chain management.

Since the onset of the pandemic, preventive, diagnostic and treatment measures have been strengthened. All countries can now diagnose COVID-19, averaging 167.4 tests per 10 000 population. Production of oxygen, critical for severely ill COVID-19 patients, has also increased significantly, and WHO has worked with partners to provide technical support, training and essential medical supplies including the delivery of more than 9.15 million testing kits and the training of close to 200 000 health workers using a virtual platform in collaboration with diverse partners. WHO has also supported the development of research and innovations to tackle the virus and set up an online information portal on emerging COVID-19 innovations

**“With strong commitment and action at all levels, we can achieve our shared goals and make health a reality for all people in the African Region.”**

**Dr Matshidiso Moeti**  
WHO Regional Director for Africa

Despite these encouraging best practices and lessons learnt, many challenges remain, which WHO will strive to overcome with countries and partners. First, the COVID-19 pandemic continues to be viewed by some as a public health containment challenge, which hampers a multisectoral response and compliance with PHSMs. Second, striking a balance between responding to the COVID-19 pandemic, while maintaining essential health services, especially in the face of increasing health worker infections, is a major challenge. Third, ensuring physical and social distancing and implementing non-pharmaceutical

interventions (NPIs) in informal settlements is challenging. Fourth, timely information flow from the sub-national or national level has been inadequate, thereby undermining efficiency and productivity. Fifth, managing competing interests between preserving life and livelihoods and sustaining the economy is a delicate balancing act. Sixth, tracking deaths occurring outside health care settings and hospitals remains a major challenge and this has been further impacted by underreporting, knowledge gaps, and the changing case definitions, testing strategies, testing capacity which inevitably affects data analysis and interpretation.

In addition, response supplies such as PPE, laboratory test kits and other essential medical supplies continue to be inadequate for increasing needs, and WHO is supporting replenishment in collaboration with other UN agencies and the African Union. Efforts need to be made in supporting countries to decentralize preparedness to subnational levels, as well as bolster research and innovation. Resource mobilization needs to be stepped up at regional and country level, to ensure increased, flexible and sustainable funding for response efforts, particularly at subnational level, as well as for PoEs, IPC, WASH, research and innovations. WHO will also continue to work with countries to sustain the delivery of essential health services which have suffered disturbing disruptions throughout the pandemic.

Furthermore, with the emergence of new COVID-19 variants of concern which could have an impact on the spread of transmission or clinical severity as well as the selection of vaccines or therapeutics and diagnostic tools, African countries need additional resources to facilitate the scaling up of genomic surveillance that meets the needs of the Region, using the established regional sequencing laboratory network.

Finally, most countries in Africa, in line with WHO's guidance, have started defining their priority groups for vaccination. A key challenge is that vaccine supplies will be limited for some time. Groups at highest risk are scheduled to be vaccinated first, including front-line health and social-care workers, older people, those with comorbidities like diabetes and hypertension. We need to overcome the supply and access bottleneck for vaccines so that more vaccines can be made available and expanded to lower-risk groups. Countries will also need to overcome delivery challenges such as ensuring robust cold chain capacities and vaccination in densely populated areas where physical distancing is more challenging, and transmission tends to be higher..

## Partners in saving lives and protecting communities

**“The African Development Bank responded swiftly to the pandemic by launching a \$10 billion crisis response facility to support African countries to address immediate fiscal challenges. The Bank also launched a \$3 billion Fight Covid-19 social bond on the global capital market, the largest USD-denominated social bond ever in world history. The Bank strongly supported WHO as the executing agency for support to sub regional organizations in Africa with \$48 million. The Bank also provided \$26 million to the Africa Centres for Disease Control. Together, let's form partnerships to overcome this pandemic everywhere and in Africa. ”**

**Mr Akinwumi Adesina**  
President, African Development Bank

The COVID-19 pandemic has demonstrated that partnerships and international solidarity are vital to save lives and overcome the devastating socio-economic impacts of this virus. WHO has worked with a wide range of partners to provide countries with authoritative, real-time, and evidence-based information on the evolving epidemiology and risks of COVID-19; expedite access to essential supplies, medicines and equipment; deliver technical guidance and expertise; and disseminate best practices in all 47 countries in the WHO African Region.

Partnerships with UN agencies include the WHO and WFP-led partnership which, in collaboration with national governments, the AU, Africa CDC and the

Jack Ma Foundation, delivered life-saving personal protective equipment (PPE) and other medical and essential supplies to front-line health workers in 52 countries of the Africa continent, including the 47 WHO Member States of the Region. WHO has also partnered with other international organizations, professional associations, academic and training institutions, WHO collaborating centres and NGOs to establish coordination and operational mechanisms and scale up country preparedness and response.

The solidarity of our funding partners expressed through contributions of over US\$ 331.8 million from 57 donors has been vital to ensuring that WHO in the African Region was able to deliver on its mandate to support countries to contain the spread of COVID-19 in the Region. The initial estimated resource envelope of US\$ 455 010 113 was based on country needs for the health component of the response up to the end of 2020, aligned with the SPRP. WHO remains grateful for the unwavering support of partners, which has enabled achievements in key areas of the COVID-19 response. At the time of reporting, 71% of funds received has been utilized.

WHO is particularly appreciative of donors who provided fully flexible funding, allowing us to maximize the efficiency and effectiveness of our response by rapidly directing resources to where they are needed the most. WHO AFRO is also extremely grateful to all the partners who have made in-kind contributions of personal protective equipment (PPE), testing kits, motorcycles, tablets and other equipment essential to the early response efforts.



Partners including the African Development Bank, the World Bank, Germany, ECHO, the United Kingdom and China among others, have together with foundations, multilateral organizations and the private sector contributed to the procurement and delivery of essential medical supplies and equipment to 47 countries; the scale-up of public health measures in the Region and laboratory capacities in more than 35 countries; and the deployment of experts including rapid response teams to reinforce national capacity to respond to the pandemic in all 47 countries. Critical funding has also helped to ensure the continuity of essential health services during COVID-19, including routine immunization and maternal and childcare.

**“WHO and WHO-AFRO are critical players in ensuring a coordinated, broad-reaching COVID-19 response across the African Region. The Gates Foundation has a long history of supporting WHO and its regional affiliates, and now more than ever the world needs a strong, effective, and fully funded WHO to ensure that it can deliver on its mandate to improve health for all people. ”**

**Dr Chris Elias**

President of the Global Development Division  
Bill & Melinda Gates Foundation

**“The Conrad N. Hilton Foundation is pleased to support WHO to help ensure a rapid, African-led, collaborative, and equitable response to COVID-19 in the African Region that continues to mitigate the public health and socio-economic impact of the pandemic.”**

**Peter Laugharn**

President, Conrad N. Hilton Foundation

Despite these successes, the road ahead is still long and arduous. We count on the continued support of our partners to provide fully flexible and predictable resources which will enable WHO to quickly respond, in collaboration with partners, to gaps and programmatic needs in the response not only to COVID-19, but also to the impact of the pandemic on health systems and health outcomes in the Region.

## Best Practices

31 December 2020

### UGANDA MOBILIZES RESOURCES FROM IN-COUNTRY PARTNERS

WHO and partners have worked together on the COVID-19 response in Uganda. Together, Uganda has put in place measures to find, isolate, test, treat and trace COVID-19 cases and intensify community engagement interventions in its effort towards stopping the outbreak in the communities. The COVID-19 response in Uganda has been further enhanced by a strong partnership between the Government, WHO and partners including the donor community.

Locally, financial support of more than US\$ 10 million has been mobilized from partners

including CDC, DANIDA, GAVI, Irish Aid, KOICA, and UK AID. In addition, financial support has also been received from the Republic of Azerbaijan, People’s Republic of China, Germany, Japan, Norway, and Sweden through their contribution to the Global and Regional funding. With this, WHO has managed to support the government in the different aspects of the outbreak including case management, laboratory management, logistics and transport, community engagement, surveillance, and psychosocial support, amongst others.

**“Collaborations with partners such as the World Health Organization is crucial to combat not only the COVID-19 pandemic, but also other historic and emerging health challenges. With its long standing commitment to the Sub-Saharan African Region, Novartis reaffirms its unwavering commitment to supporting a rapid, coordinated and effective response to COVID-19.”**

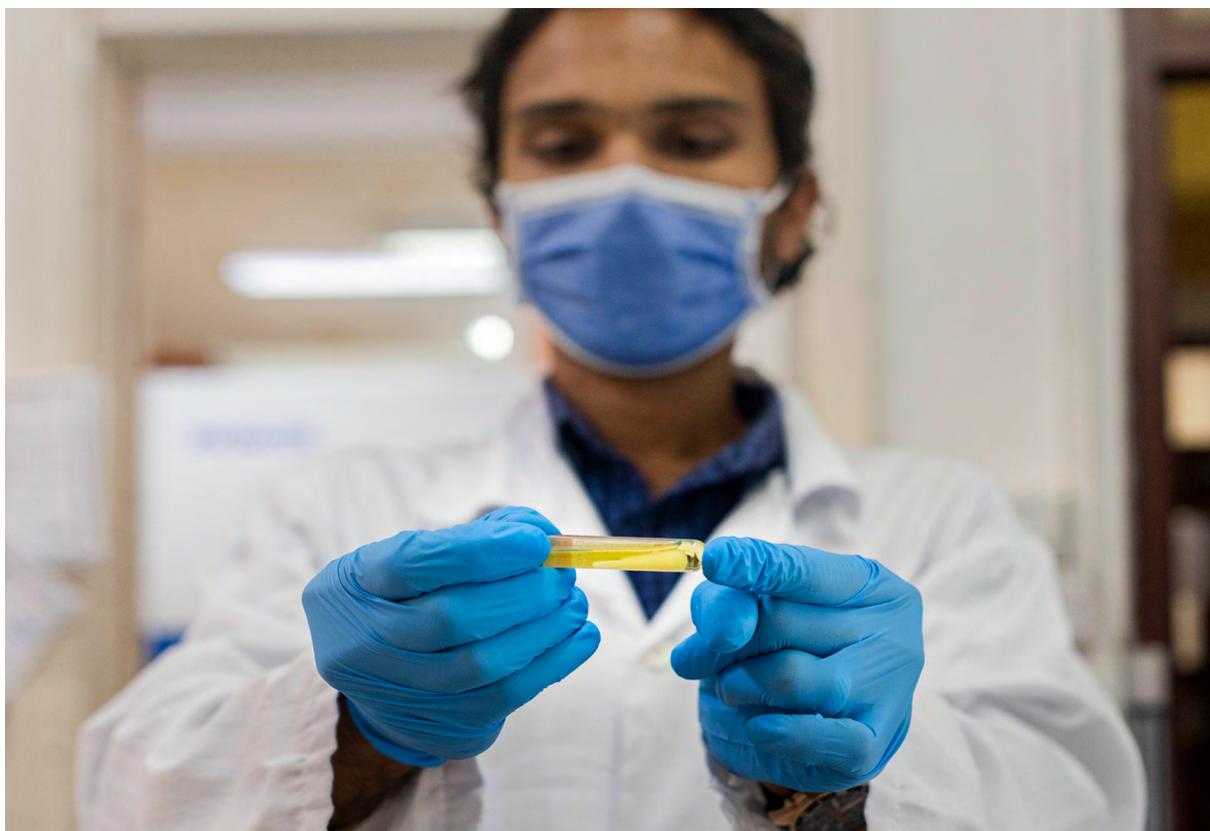
**Vas Narasimhan**

Chief Executive Officer, Novartis

**“In the heart of the COVID-19 pandemic, WHO’s role on coordination and provision of technical expertise and guidance is crucial to allow sharing of information and efficient response. DG ECHO remains committed to supporting WHO to deliver assistance to the most vulnerable communities in areas stricken by humanitarian crisis: In 2020, DG ECHO awarded €30 million to WHO, to prevent, contain and mitigate the spreading of COVID-19 in fragile states in Asia and Africa.”**

**Sophie Whitney**

Acting Head of Regional Office for Africa  
European Commission Directorate-General for  
European Civil Protection and Humanitarian Aid  
Operations



# Financial Overview

Figure 13: Financial Contributions from Partners (as at 31 December 2020)

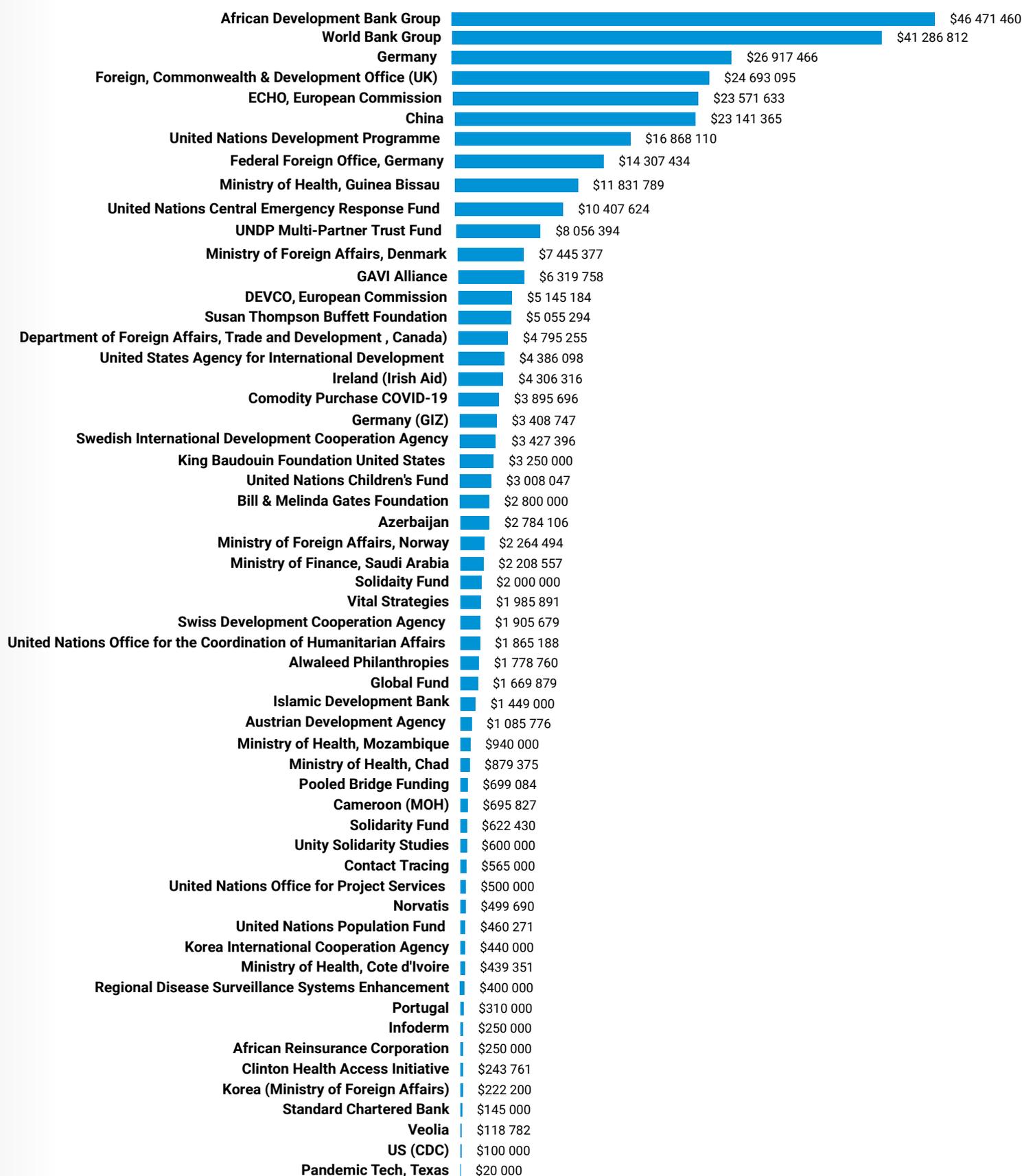


Figure 14: Funding Overview (as at 31 December 2020)

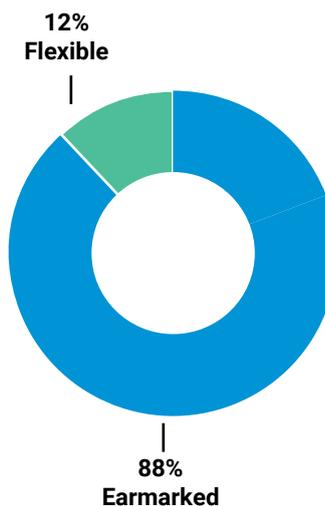
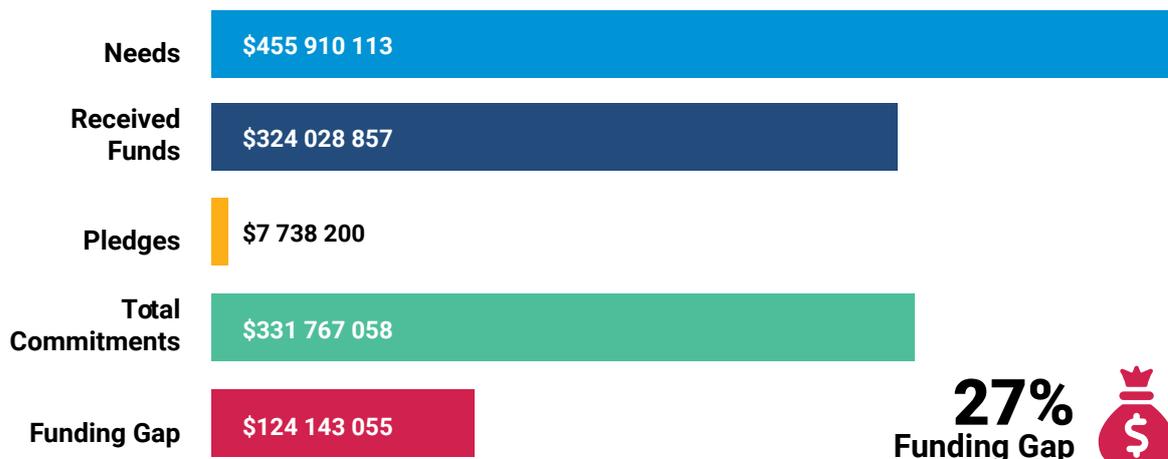


Figure 15: Financial contributions (US\$) by pillar (as at 31 December 2020)

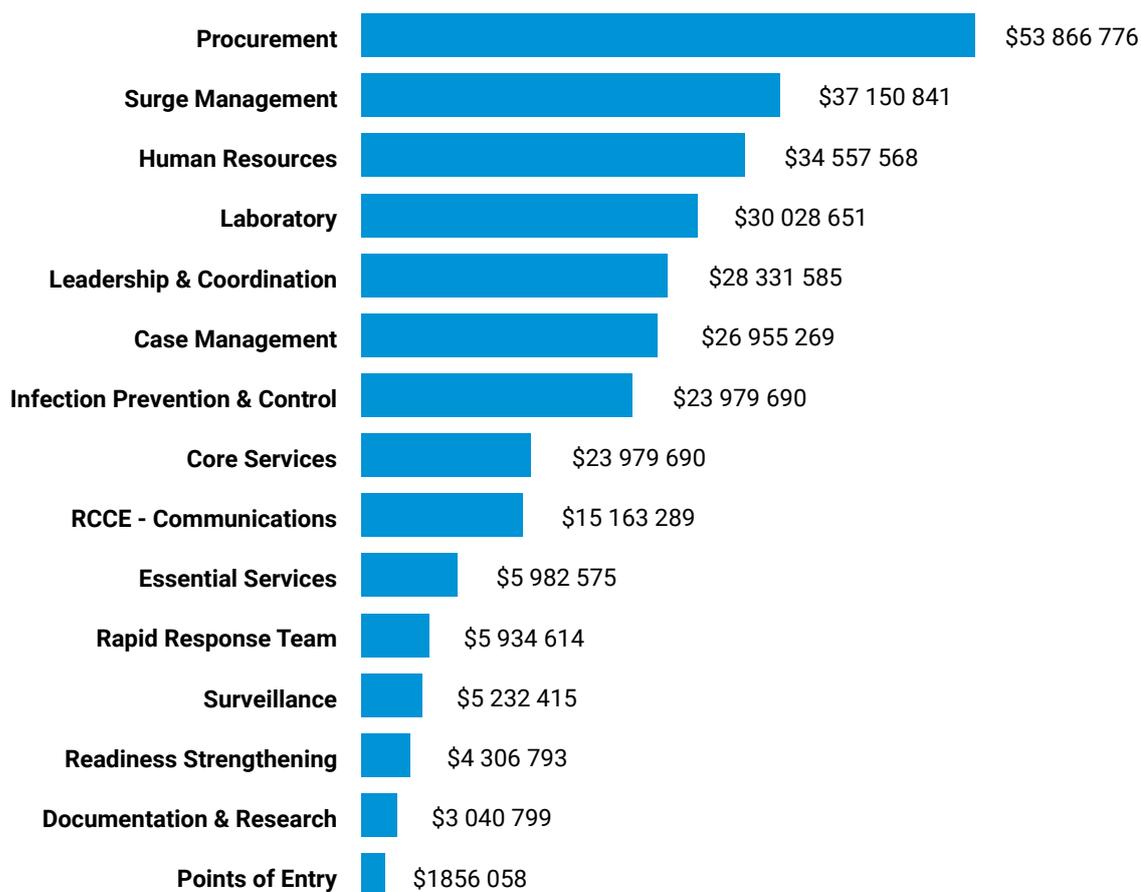
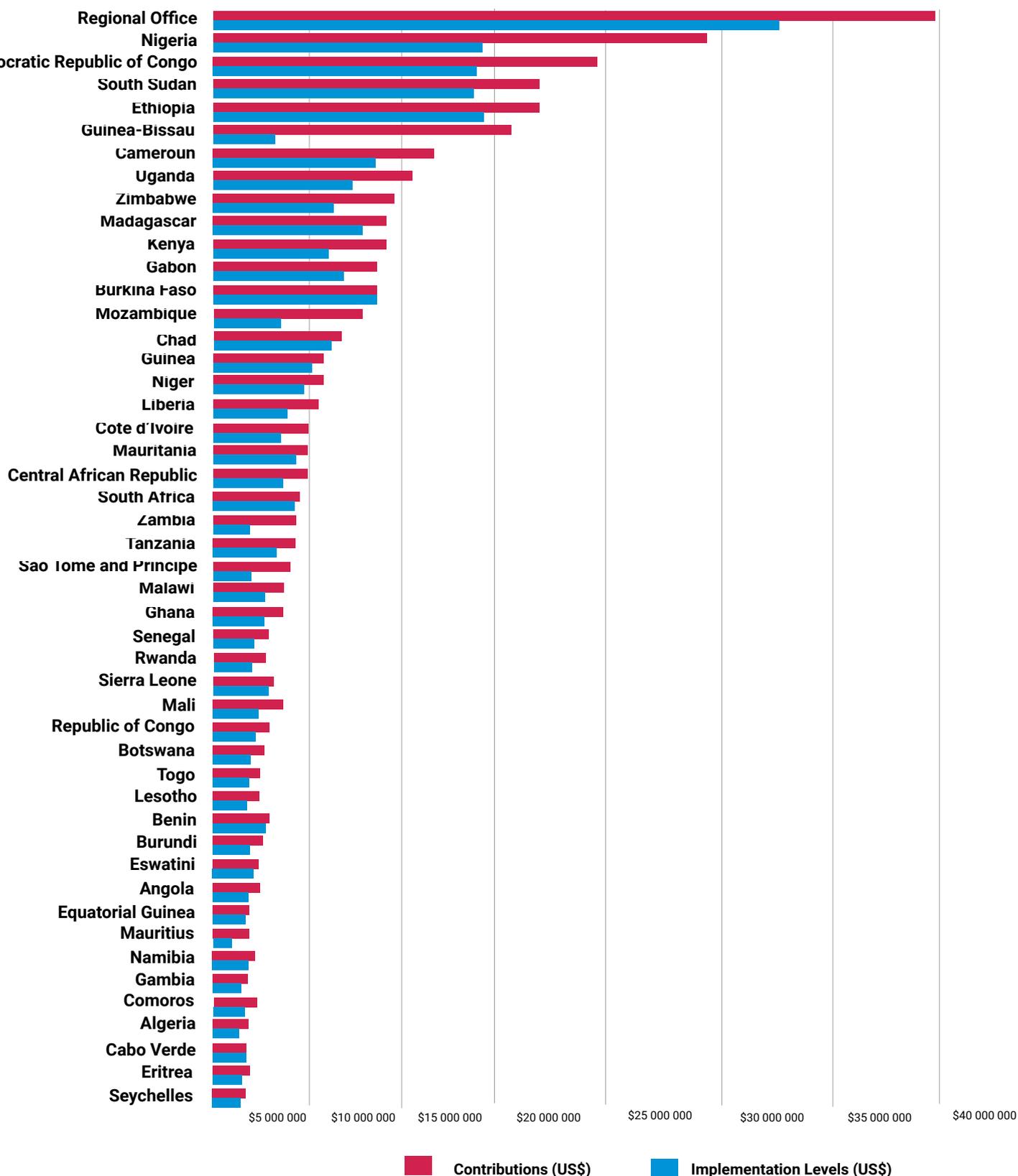


Figure 16: Financial contributions and implementation (US\$) by budget centre (as at 31 December 2020)



# The Way Forward: Building back better



The number of new infections and deaths due to COVID-19 in the African Region continues to increase at a fairly rapid pace. Particularly concerning for the Region is the emergence of new variants of SARS-CoV-2 which are associated with an increase in the number of cases due to their high transmissibility. COVID-19 also continues to negatively affect the lives and livelihoods of individuals and communities across the Region, making it difficult for the Region to achieve the Sustainable Development Goals. It is also important to note that individuals and societies have increasingly become apathetic about behaviours that are needed to combat COVID-19, with practices such as social distancing, wearing of face masks and handwashing increasingly less adhered to than in the early months of the pandemic. Vaccines against SARS-Cov-2 have now become available, but the African Region has lagged far behind in accessing them. Greater efforts are therefore needed to combat the pandemic and mitigate its impacts. None of these challenges can be addressed in isolation. They are deeply intertwined and require an integrated response. Importantly, greater focus should be put on approaches for strengthening health systems to enable countries prevent, detect and respond to health emergencies with greater efficiency and effectiveness.

WHO must be equipped with predictable, flexible, and sustained financing that enables the Organization to have the robust structures and capacities that are needed to fulfil its core functions to effectively support integrated health systems strengthening, including preventing, detecting, and responding to health emergencies. These funds will enable WHO to cover unheeded gaps, while aligning with the priorities set out in the approved programme budget with no limitations on the type of activity, location or programme budget outcomes and outputs. Partner support was pivotal in the response to COVID-19, and WHO must continue to convene partners and leverage their support for an effective response to the COVID-19 pandemic.

## **1. Strengthening country level coordination:**

In the recent past, countries of the African Region moved swiftly to establish functional public health emergency operations centres (PHEOCs) to serve as the nerve centre for coordination of information and resources for emergency management. When COVID-19 hit Africa, the PHEOCs across countries were rapidly activated and played a pivotal role in successfully coordinating whole-of-government responses to COVID-19. The centres brought multisectoral/multiagency actors into a single national response system, namely the incident management system. Moving ahead, countries need to strengthen their multisectoral/multiagency coordination mechanisms at all levels, with more emphasis at subnational levels. Likewise, enhancing coordination, communication and information flow between the strategic, operational and tactical levels (national and subnational PHEOCs) of the response system is crucial. Besides, it is imperative to clearly define roles and responsibilities of each response level and each actor involved in the response, with their activities in the national response plan effectively monitored.

Coordinating health partners in public health emergencies is one of the key functions of WHO. It is also a commitment that WHO has undertaken globally through the Inter-Agency Standing Committee (IASC) and institutionally through the Emergency Management Framework. As Africa was recording its first case of COVID-19 in late February 2020, WHO country offices established coordination mechanisms by activating the incident management system (IMS) which has pillars in various health operations and technical expertise. These IMS structures worked with nationally established coordination committees to engage partners and obtain their commitment to the operationalization of country emergency preparedness and response plans. Effective operationalization and implementation of country plans required strengthening and coordinating partners, assessing country operational needs and priorities, mapping capacities, providing the required technical support to countries, monitoring progress and informing the development of country-specific strategic and operational approaches.

This kind of structure rallied partners to contribute jointly to the COVID-19 response in a coordinated effective, efficient, timely, predictable and evidence-based manner. Intra-action reviews at the subregional level revealed a desire by partners to continue using this coordination mechanism in the management of other public health emergencies. A strong coordination system ensures efficiency and accountability of all stakeholders in responding to public health emergencies when they occur. It ensures easier and faster mobilization of resources and provides a baseline on which a response can be built. Importantly, it also ensures that partners receive information in a timely manner, building the trust partners have in WHO as a leader in health emergency management. Continued investment in strengthening partner and health cluster coordination in countries is a worthwhile endeavour.

## 2. Enhancing surveillance particularly in the context of the emerging threat of the new variants of SARS-CoV-2

Surveillance remains a critical component of the COVID-19 response. The scaling up of in-country public health capacities to promptly identify possible cases through contact tracing and active case searches

**“The emergence of new COVID-19 variants is common. However, those with higher speed of transmission or potentially increased pathogenicity are very concerning. Investigations are underway to comprehensively understand the behaviour of the new mutant virus and steer response accordingly.”**

**Dr Matshidiso Moeti**  
WHO Regional Director for Africa

and to speedily conduct confirmatory tests, with rapid turnover of results, is essential to curbing the further spread of the disease. These activities, however, need to be aligned with the reality in different cities, districts and countries while maintaining access to essential health services in the context of a continuing COVID-19 pandemic. The role of surveillance is even more critical with the emergence of new SARS-CoV-2 variants being reported in some countries in the Region. Countries in the African Region should be supported to scale up genomic surveillance and subsequent analysis of sequencing data through proper capacitation and strengthening of the network of laboratories. This will help to rapidly detect any new mutations and any

changes in the behaviour of the variants already circulating, including their transmissibility, virulence, or antigenicity.

## 3. Strengthening capacities at major points of entry (PoEs)

Existing PoE capacities which were built during previous outbreaks, especially the Ebola outbreak, played a critical role in delaying the importation of COVID-19 cases in the WHO African Region. It is therefore important to continue to strengthen IHR capacities for response to public health emergencies of international concern (PHEIC) and routine capacities at PoEs in line with the IHR (2005) requirement to limit the international spread of infectious diseases. Furthermore, cross-border collaboration between Member States or regional economic communities such as ECOWAS, SADC, EAC, among others, should be enhanced and used for information sharing, international contact tracing and harmonization of PoE interventions across international borders to facilitate travel and movement of goods and services. Countries should leverage the ongoing COVID-19 response to enhance and sustain their IHR (2005) core capacities, building on the experience gained from the COVID-19 outbreak response to strengthen their capacity to prevent, detect and respond to health emergencies and be better prepared for future responses to pandemics and other health emergencies.

## 4. Strengthening the national laboratory system (NLS)

A national laboratory system with capacity for timely, accurate and safe detection of SARS-CoV-2 is critical for the appropriate management of the COVID-19 pandemic. Countries should be supported to enhance their national laboratory capacities and services through tailored support for laboratory infrastructure, training of laboratory workers and provision of laboratory equipment, supplies and reagents. In this regard, the ongoing efforts to increase national capacities for PCR testing will be further complemented with the availability of rapid antigen detection tests (Ag-RDTs), targeting capacity building at all levels of the health system and facilitating decentralization of testing to encompass remote areas. Countries in the African Region should be supported through the expansion of the existing regional laboratory networks to ramp up genomic surveillance to detect new SARS-CoV-2 variants that may impact transmissibility, pathogenicity or virulence, and the provision of vaccines, therapeutics and diagnostic

## 5. Enhancing risk communication and community engagement (RCCE)

Countries should be supported in establishing an enabling environment that facilitates healthy choices at community and household level through the correct use of face masks, handwashing and other non-pharmaceutical measures, and vaccination of targeted populations. Additionally, subnational levels will be supported to collect and analyse social, financial and environmental indicators of barriers to health-promoting behaviours. The importance of building trust at all levels must be inculcated by all technical teams and politicians.

Countries must be supported to ensure strong collaboration among key response partners with clear coordination structures; improve on activity planning, documentation and reporting of activities, experiences and best practices; and promote the involvement of national and local leadership in influencing positive behaviour change.

A system of involving communities in disease prevention and health promotion needs to be encouraged. Community involvement should include planning, implementing and evaluating health and wellness issues.

Furthermore, systems must be put in place at national and subnational levels to actively and continuously monitor misinformation and disinformation both on COVID-19 infection and COVID-19 vaccines. A system should be established for providing timely, regular facts and information to the public to guide informed decision-making. The importance of building trust must be inculcated by technical teams and politicians at all levels.

## 6. Building the capacity for rapid response teams (RRTs) at national and subnational levels

Rapid response teams (RRTs) are a unique resource that can rapidly respond to public health concerns, anywhere in a country. Since 2015, WHO has developed several training modules that are available to countries to facilitate the set-up, training and management of RRTs, including modules on all-hazard, Ebola and COVID-19 RRT training. RRT online training modules are also being used. Epidemic-prone diseases in the African Region would have devastating impacts if WHO and partners do not support national governments to contain outbreaks. WHO, its partners and public health agencies worldwide have learnt many lessons from emergency response, one of which is that we need a readily available group of public health responders who can be deployed to investigate events and control diseases from the moment we detect them. In-country RRTs increase efficiency and effectiveness, while enhancing emergency response capability by filling key positions in the field when emergencies occur. This improves health security by increasing countries' ability to quickly respond to health threats and grow a stronger national emergency workforce. The role of RRT at both national and subnational levels is even more important with the emergence of new SARS-CoV-2 variants being reported in some countries in the Region and the circulation of the virus in the communities. Countries in the African Region should be supported to manage RRTs at national and subnational levels through proper capacitation and strengthening of the RRT knowledge network. This will help to improve the response to COVID-19 and contain the virus.

## 7. Advancing research and innovations to combat COVID-19

Improving our response to the ongoing COVID-19 pandemic in Africa requires regularly updated information, constant innovation and considerable support for research and development (R&D) on priorities that respond to African realities. Thus, shaping research and innovations to stimulate the

generation, translation and dissemination of valuable knowledge in the battle against the unprecedented COVID-19 pandemic in the Region remains a priority for the Region. Efforts continue to be made to achieve this outcome.

The regional strategy for scaling up health innovations provides a timely opportunity to strengthen innovation ecosystems to accelerate progress. Renewed, reinvigorated and innovative approaches to encourage and motivate communities grappling with fatigue to continue to observe public health measures, particularly considering the easing of restrictions, need to be aligned with national realities. The emergence of several innovations in e-commerce, telehealth, e-learning and virtual meetings has made life easier, while limiting the spread of the pandemic.

In line with the WHO's core function of shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge, a shortlist of priorities, reflecting six key priority areas where in-depth scientific knowledge is needed for Africa to stay ahead of the outbreak has been developed in consultation with key stakeholders in the Region. These include transmission dynamics of COVID-19, epidemiology and surveillance; diagnostics; clinical characterization of cases; drug and vaccine clinical trials (including traditional medicines; modelling impact of COVID-19 on the health systems; and social science and policy research. These will define our focus moving forward.

## 8. Preparing health systems for COVID-19 vaccine introduction

A vaccine is needed urgently to control the pandemic. Nonetheless, it is clear that the vaccine will not fix the root causes of vulnerabilities. A vaccine cannot address the global under-investment in essential public health functions and resilient health systems, nor the urgent need for a "One Health" approach that encompasses the health of humans, animals and the planet we share.

The COVAX facility represents the vaccines pillar of the Access to COVID-19 Tools (ACT) accelerator, a global collaboration established to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. The ACT's goal is to reduce COVID-19 mortality and severe disease through accelerated development, equitable allocation and scaled-up delivery of 2 billion doses of vaccines by the end of 2021. We expect the first vaccine doses to be delivered in the first quarter of 2021, with volumes increasing to more significant levels in the second half and continuing to increase over the course of the next two years. It is anticipated that countries in our Region will receive approximately 595 million doses of COVID-19 vaccines by the end of 2021 through the COVAX facility. Four countries in the African Region have embarked on the roll-out of vaccines.

Collective coordination and advocacy are required to ensure that the principles of solidarity and equity remain at the forefront in the months ahead. In order to expedite decision-making on vaccine allocation, it is essential that Member States expedite the development of national deployment and vaccination plans for COVID-19 vaccines (NDVP). These plans should include key elements as outlined in the NDVP

**"A vaccine is needed urgently to control the pandemic. But as you know, it will not fix the vulnerabilities at its roots. A vaccine cannot address the global under-investment in essential public health functions and resilient health systems, nor the urgent need for a "One Health" approach that encompasses the health of humans, animals and the planet we share. There is no vaccine for poverty, hunger, climate change or inequality. None of these challenges can be addressed in isolation. They are deeply intertwined – and so must be our response."**

**Dr Tedros Ghebreyesus,**  
WHO Director-General

guidance document including prioritization of target groups for vaccination, the vaccination strategy and site(s), logistics and cold chain management plans; ensuring availability of sufficient ancillary materials (e.g. syringes, PPE); training plan; safety monitoring, management and reporting process, including the capacity to manage any cases of anaphylaxis at vaccination sites. These NDVPs should also be costed, funding gaps identified and plans developed to address these gaps in financing during the roll-out of vaccines; while plans should also be prepared to address any gaps in financing during the early roll-out of vaccines.

## **9. Increasing support for treating, isolating and caring for COVID-19 patients in Africa**

The pandemic has stretched fragile health care systems to their limits, exposing the inadequacy and weakness of treatment facilities, especially critical care capacity to handle patients with severe and critical disease. Member States need to be supported to expand high dependency and intensive care capacity in countries by leveraging partnerships to ensure that patients receive quality care. Building case management capacity in countries, through mapping of specialists and sub-specialists in-country, as well as partnerships with academic institutions, professional societies and the private sector will be key in sustainable skills transfer to non-specialists and increased skilled human resource capacity in case management. AFRO can provide support by working with partners to fund academic institutions, and setting up skills and simulation labs, where clinicians can acquire high-acuity specialized skills, which can then be utilized in their institutions. There is a need to develop innovative clinical experience sharing, where clinicians across the continent have a platform to interact with each other on clinical management of challenging cases through telemedicine grand rounds and real-time clinical consultations, imparting knowledge and skills to countries with insufficient skilled human resources.

## **10. Increasing support to ensure continuity of services during COVID-19 and systems strengthening**

According to available data from surveys and routine health information systems, access and utilization of essential health services has fallen during the COVID-19 pandemic. For example, in the African Region, compared to the same period in 2019 (January to August), in 2020, more than 1.3 million children under the age of one year missed their first dose of measles vaccine. WHO has been providing technical support to Member States to ensure continuation of essential health services during the COVID-19 pandemic. By addressing priorities beyond COVID-19 such as communicable and noncommunicable diseases (HIV/AIDS, TB, malaria, diabetes, high blood pressure, malnutrition, mental health), maternal and child health including immunization, water, sanitation and hygiene, Member States will be accelerating the implementation of the Operational Framework for Primary Health Care (PHC) that was recently adopted at the Seventy-third World Health Assembly held in November 2020. It provides core strategic and operational levers to transform vision into concrete actions.

In terms of best practice, the effort by countries of the Region to maintain access to essential health services while dealing with the COVID-19 pandemic will contribute to reducing the impact of health service disruption across the Region and improve the resilience of health systems. This will enhance preparedness for future threats in order to accelerate progress toward universal health coverage.

WHO continues to be committed to sustaining gains in health by using integrated people-centred approaches with a strong focus on equity. Mitigating the socioeconomic impacts of COVID-19, including ensuring access to essential health services must be an essential focus to avoid a reversal of hard-won gains made over the years in health and development. Despite the heavy toll that COVID-19 has exacted on the lives, livelihoods and health of people in our Region, the lessons learnt in dealing with

this pandemic and other health emergencies provide a unique opportunity to ensure that preparedness is integrated at every level of the health system, and that we build resilient health systems which provide quality health care regardless of the context and contribute to protect people along the life course. Thus, Member States in the Region are now better prepared to reduce the impact of COVID-19 on the provision and utilization of essential health services than they were at the beginning of the pandemic.

## **11. Strengthening the logistics, procurement and supply chain management systems**

One of the key lessons learnt from the current pandemic is that going individually to the international market to procure and negotiate appropriate prices for supplies can be extremely difficult, even impossible for low-income countries. The closure of borders and lockdowns in countries placed export restrictions on priority medical products including laboratory reagents and medicines, thus potentially creating tensions and stock-outs in distribution channels. In addition, transport and export restrictions increased lead times and exposed countries to stock-outs which seriously affected access to quality-assured medical products and health technologies.

Procuring and supplying essential crisis supplies is still a challenge for most countries, even those with high resource availability. To address supply-side issues related to the pandemic, COVID-19 commodities are obtained through pooled procurement, at the lowest prices, while ensuring adherence to the appropriate quality assurance policy, under the United Nations supply portal. However, there is a need to rethink the current service delivery model for procurement and supply in Africa to address emergency situations. Service delivery must prioritize needs and be tailored to the context of the African Region, which relies mostly on international importations, in a context of scarce local production.

There is also a need to foster competency-based accreditation of national supply chain personnel and scale up the training of the country workforce with the aim of expanding the skill set of existing personnel in procurement and supply management. Lastly, pre-positioned stock with relevancy to the pandemic and epidemic situations are vital to ensuring adequate and timely access to resources that the continent needs. Boosting oxygen production capacity is critical to addressing the existing deficit which has been compounded by the pandemic. Member States will need to prioritize the assessment and forecasting of their oxygen needs to manage respiratory infections and other conditions requiring oxygen therapy. Ensuring availability of the appropriate oxygen delivery interface for clinical use will help expedite the use of oxygen. AFRO can provide technical assistance to Member States, guiding them through the process of evaluating, planning, procuring and training to ensure a sustainable transfer of skills. The pandemic has also revealed the existing gap in terms of capacity for equipment maintenance. Member States will need to be given substantial support for the systematic computerization of equipment management and the strengthening of skills in equipment maintenance.

## **12. Supporting countries to strengthen their national health information system**

One key lesson that WHO learnt during the COVID-19 pandemic was the paucity of health data in the African Region. Particularly concerning was the lack of data on mortality with proper medical certification and classification of cause of death. Tools for medical certification and classification of cause of death, as well as for classification of diseases, are available. Within the broader context of strengthening the national health information system, WHO should put greater effort on supporting countries to establish sustainable systems for generating disease and cause of death information both from health care facilities and communities. Central to this effort is support to countries for the implementation and roll-out of the WHO International classification of Diseases (which is now in its eleventh revision (ICD 11)) and medical certification of cause of death.

Use of information for decision-making remains critical for an effective response to the COVID-19 pandemic. WHO should support countries to track their readiness/preparedness, progress and performance and generate information to support decision-making. WHO should continue to provide technical support and training to countries for regular monitoring and evaluation of countries' readiness and progress and performance regarding the COVID-19 response. WHO tools to help Member States monitor the continuation of essential health services on a monthly basis are under development and will be available shortly.

### **13. Addressing the high levels of harmful misinformation and disinformation around COVID-19 (both the disease and the vaccine)**

WHO is not only fighting a pandemic but an infodemic where misinformation as well as disinformation is circulating widely. Based on social media analysis performed by the UN Global Pulse team in the Office of the Secretary-General, vaccines were mentioned over 600 000 times in the 47 countries of the WHO African Region between 1 December and 7 February. In addition, there is fake news and advice on treatments and prevention which is being shared by traditional and social media platforms. To address this tsunami of harmful misinformation and disinformation, WHO is conducting a wide range of activities including regular press conferences and technical briefings with reporters, as well as disseminating newsletters to crucial decision-makers such as ministers of health and providing talking points to country offices. WHO is producing a range of videos including expert interviews and health promotion messages which encourage good health-seeking behaviours, and sharing them with country offices to disseminate widely. It is also conducting advocacy campaigns to encourage target groups such as young people to adopt healthy behaviours.

This will be critical to addressing vaccine hesitancy, particularly among health workers and challenges such as vaccine denial among health workers and religious leadership. Through the Africa Infodemic Response Alliance (AIRA), WHO will continue coordinating the regional infodemic response and research efforts to provide timely and strategic responses at regional and country levels. At country level, WHO will continue supporting efforts to drive vaccine demand generation and prepare risk communication approaches to maintain confidence in vaccines through providing engaging communication products which appeal to the target populations and which can be disseminated on a range of media channels including social media, radio, television and newspapers.

### **14. Strategic technical partnerships**

In addition to pre-existing partner engagement platforms, other technical partner engagement platforms have been established by almost all the AFRO IMST COVID-19 response pillars and subpillars. Based on a survey conducted in November 2020, around 15 partner engagement platforms engaging more than 60 global and regional technical, financial and strategic partners were identified. Based on these observations, it will be important to reinforce the coordination of these different platforms to reduce the duplication and lines of communication and engagement of different partners involved in the response to the COVID-19 pandemic in the Region. The reinforcement of interactions between these platforms, combined with the enhancement of WHO's presence in the different subregional and regional organizations such as the AU, ECOWAS, SADC, will increase the visibility and the positioning of the WHO Regional Office in the definition, planning and roll-out of major public orientations and directives in the response to the pandemic in the Region. Additional efforts in supporting and reinforcing partner coordination functions in WCOs with dedicated and qualified partner coordination experts can constitute significant value addition for reinforcing the quality and effectiveness of WHO actions in Member States.

## 15. Predictable, sustainable and flexible financing

In the recent past, the demand for WHO to address deep-rooted health system issues while responding to health emergencies in the African Region has increased at an exponential rate. While partner support has been pivotal in the response to COVID-19, there is an urgent need for greater flexible, predictable and sustainable (medium to long term) funding to enable the Organization to cover unheeded gaps, while aligning it with the priorities set out in the approved programme budget with no limitations on the type of activity, location or programme budget outcomes and outputs. This will enable WHO to have the robust structures and capacities it needs to fulfil its core functions to effectively support integrated health systems strengthening, including preventing, detecting, and responding to disease outbreaks. Additionally, flexible funds will allow for full alignment with priorities and ensure flexibility in shifting funds towards underfunded priority areas and away from areas that benefit from other sources of funding, as well as promote timely implementation of activities in response to the changing public health environment.





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