

Annual Report of the Regional Director on the work of WHO in the African Region



2021-2022

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Designed in Brazzaville

THEME

Saving lives through sustaining the response to COVID-19 and other emergencies, delivering essential health services, managing determinants of health, mainstreaming research and innovation and sustained implementation of the Transformation Agenda of the WHO Secretariat in the African Region.

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FOREWORD

Following a year during which most of WHO's work took place in an intense and very difficult phase of the pandemic, compounded by severe vaccine shortages and delivery constraints, the Organization is supporting Member States in the African Region to translate the invaluable lessons learnt into solutions that will help build resilient health systems and health security into the future.

While doing the essential work to help capacitate countries to restore health services, livelihoods and economies, we still face the critical task of raising COVID-19 vaccination to adequate levels, especially among vulnerable groups, to catch up with the rest of the world.

As we share this report on our work for the period from 1 July 2021 to 30 June 2022, I would like to emphasize that the inspired leadership, action, innovation and creativity ignited by our collective response to the pandemic is what will now be carried forward, as part of building back better into the future.

More than ever, the COVID-19 pandemic illustrated the close intersections between health emergencies, communicable and noncommunicable diseases, peace and resilient health systems. It also revealed the depth of global inequities that negatively impacted Africa's access to the critical tools needed to mount a pandemic response.

Throughout the review period, the Secretariat worked tirelessly with pandemic response partners, governments and communities. We proudly supported the exemplary and robust leadership displayed by Africa's Heads of State, dedicated ministers of health and other national stakeholders. Their transformative leadership translated into action to ensure the next health threat finds the continent better prepared and more self-sufficient, with strong continental institutions.

There is still much hard work ahead to recover from the pandemic-related disruptions to health service delivery and access. This presents the opportunity to incorporate some of the innovations adopted to sustain services at the height of the pandemic, to stretch the reach of services into the future.

Going forward, the priority of strengthening primary health care to advance countries towards Universal Health Coverage (UHC) will require the same determination that Africa's leaders displayed in the pandemic response. Deliberate and intentional focus is also needed for countries and communities experiencing protracted conflicts that are fuelling humanitarian crises. This is where the most severe negative health outcomes are being recorded.

The new 2022 WHO report which revealed that healthy life expectancy in the African Region has increased by an average 10 years per person since 2019, from 46 to 56 years, reflects the improvements in many critical health care sectors. Yet, much progress is still needed to reach the Sustainable Development Goals (SDGs) by 2030. This will require increased and more sustainable investment towards strengthening health systems, enabling communities to lead healthy lives, and addressing the social and economic determinants of health.

I thank our Member States and partners for their continued support for the 2030 global health sector strategies, which I believe provide a solid foundation from which to recover from the setbacks, while ensuring we are better prepared for the next health shock.

Dr Matshidiso Moeti

World Health Organization
Regional Director for Africa



Executive summary

The COVID-19 pandemic was the major factor that defined the work of the WHO Secretariat in the African Region during the period between 1 July 2021 and 30 June 2022. Despite challenges, we used the lessons learnt during the period to not only sustain the response, but also to address other health priorities and define future strategies.

Although the predictions that the Region would be hard hit with high morbidity and mortality were not borne out, we did record close to 9 million cases and 172 546 deaths during the period. Despite shortages of supplies, most notably vaccines, especially during the third wave that affected the whole globe, we were at the forefront together with other partners, including the Africa Centres for Disease Control (Africa CDC), to support Member States in sustaining the response and saving lives.

Simultaneously, the Secretariat continued to provide support to Member States to respond to ongoing public health emergencies and prepare for future ones; sustain delivery of essential health services; manage determinants of health guided by data and research; and mainstream innovation. The work on reforming the Secretariat to better respond to the needs of Member States continues to be of importance.

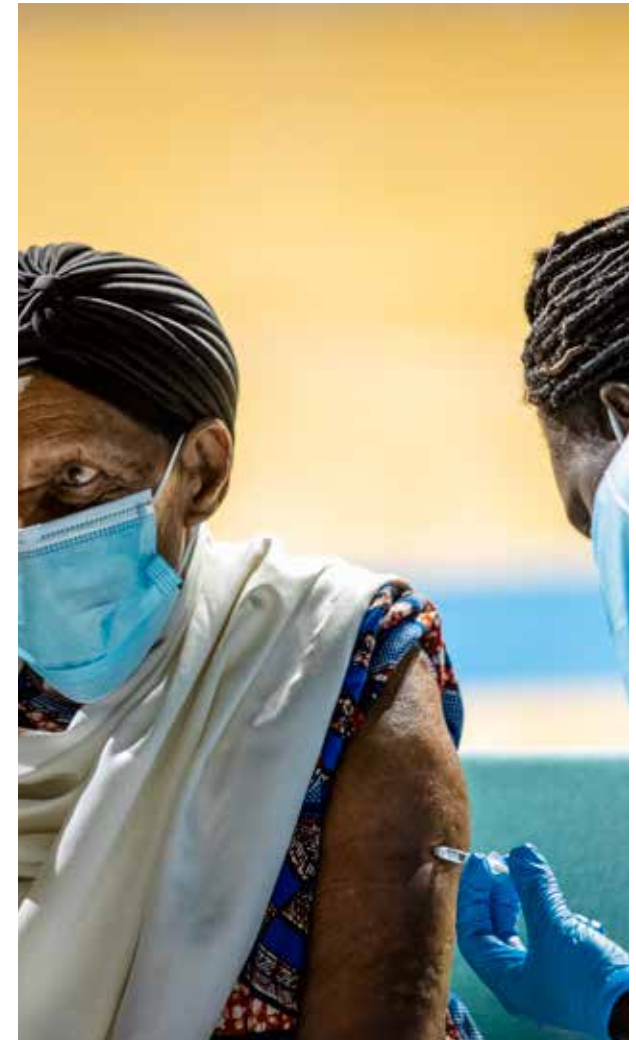
The Secretariat's transformation work focused on strengthening WHO country offices to better respond to country priorities; consolidating and expanding the leadership programme; driving progress towards gender parity, while creating an inclusive and respectful work environment; strengthening partnerships and communicating effectively; and enforcing accountability, efficiency and transparency.

The successful implementation of the functional reviews has improved the capacity of country offices to create partnerships and mobilize resources at country level. The creation of Multicountry Assignment Teams (MCATs) now brings high-calibre technical expertise closer to countries, to facilitate engagement with national agencies and technical partners on a more continuous basis.

The Regional Pathways to Leadership for Health Transformation blended programme has been consolidated, and has especially targeted women, who currently constitute 48% of alumni. It has now been extended to Member States, as they requested during the Seventieth session of the Regional Committee in 2020. It has also been adopted by other WHO regions. The capacity to prevent sexual exploitation, abuse and harassment (PRSEAH), and create a respectful work environment, has been enhanced at all levels. A full-time Ombudsman and a Regional PRSEAH Coordinator have been appointed, and are working with PRSEAH experts and focal points in countries.

Administrative key performance indicators (KPIs) have been progressively improved to accurately measure the Secretariat's performance and management decisions, to improve efficiency, accountability and transparency. The disbursement mechanisms that country offices use for payments to final beneficiaries, which were previously made in cash, were also digitized. Efforts to strengthen the supply chain resulted in savings of approximately US\$ 1.6 million.

Over the past year, the WHO Regional Office for Africa has strengthened its communications capabilities and worked intensively to transform its digital communication platforms.



As a result, social media following grew by 140 000 in the first four months of 2022, contributing to a total 3.83 million followers across the Regional Office's social media pages on Facebook, Twitter and Instagram.¹

The Secretariat supported Member States to improve the early detection of COVID-19 cases through the use of antigen rapid diagnostic tests (Ag-RDT), increased “test and trace”, and SARS-CoV-2 polymerase chain reaction (PCR) testing capacities. The COVID-19 sequencing laboratory network contributed to improving genomic surveillance in the WHO African Region, with a sixfold increase in the number of sequences performed, compared to the previous year. To facilitate diagnosis and treatment, millions of items of personal protective equipment (PPE) and laboratory test kits, as well as thousands of oxygen concentrators, were procured and shipped. In addition, support was provided to improve the capacity of countries in terms of supply chain mechanisms, and capacities to assess locally manufactured medical supplies, and evaluate local manufacturing companies. More than 60 000 health care workers (HCWs) were trained to manage critical and severe patients.

COVID-19 vaccination is an important component of the pandemic control strategy. Despite inequitable vaccine supply, WHO adopted a global strategy in October 2021 to vaccinate 40% of total populations by the end of 2021, and 70% by mid-2022. Vaccine donations were mobilized from the United States Government and Team Europe, among others, through the COVID-19 Vaccines Global Access (COVAX) Facility. By 30 June 2022, a total of 623 million vaccine doses had been administered in the African Region, with 16% of the population fully vaccinated.

The Regional Office continued to closely monitor other threats arising from epidemic- and pandemic-prone diseases, resulting in early detection and effective responses to outbreaks in the Region. WHO supported the response to 45 acute emergencies between July 2021 and June 2022. These ranged from outbreaks of measles, cholera, Ebola and Marburg virus diseases and yellow fever, to flooding, droughts and fires. In all these acute cases, WHO's Incident Management System (IMS) was activated within 48 hours, catalysing WHO emergency procedures and activities to support the management of the response. The Region's certified polio-free status was threatened by the detection of cases of wild poliovirus type 1 (WPV1) in Malawi and Mozambique linked to a strain from Pakistan, circulating in 2019. The Secretariat is working with partners to contain the WPV1 importation and prevent it from establishing a local spread, while simultaneously responding to ongoing circulating vaccine-derived poliovirus outbreaks.

To guide future efforts, a new Regional strategy for health security and emergencies 2022–2030 has been developed for adoption by the Seventy-second session of the WHO Regional Committee for Africa in August 2022.

A key negative impact of the pandemic was the diversion of health system resources that disrupted the delivery of essential health services. It also exposed the weaknesses and vulnerability of national health systems. The Secretariat worked with partners to support Member States in addressing these challenges. The strategic actions to mitigate disruptions and revive the delivery of essential health services, as well as guide system



¹ At the end of 2021, WHO AFRO's social media following stood at a total of 3.69 million

recovery and improve resilience, were informed by data from evaluations including pulse surveys. In the first-round pulse survey, covering 30 countries in the African Region, partial or complete disruptions were reported on 54% of the 25 tracer service indicators assessed. Response measures targeted the causes of disruptions identified in the surveys, and included enhancing community communications, investing in surge commodities, rapid training and job aids for new roles, and provision of home-based care where appropriate.

WHO developed and disseminated guidelines on maintaining sexual, reproductive, maternal, newborn, child and adolescent health (SRMNAH) service delivery, and provision of services for noncommunicable diseases (NCDs), mental health, malaria, neglected tropical diseases (NTDs), and HIV, among others. The Secretariat facilitated the adoption of

COVID-19-compliant service delivery models and supported capacity building for health workers, to improve the quality and coverage of essential health services.

The Secretariat has stepped up its efforts to strengthen laboratory systems and diagnostics, not only for surveillance during epidemics and pandemics, but also to contribute to national health systems for routine care services. By March 2022, a total of 1000 laboratories in all Member States had scaled up their capacity to perform PCR tests for better detection of epidemic- and pandemic-prone diseases. More than 225 laboratories participated in COVID-19 external quality assurance (EQA) exercises. Sequencing networks were established in the Region, including two specialized laboratories in South Africa and one in Nigeria, along with seven regional reference laboratories in the Democratic

Republic of the Congo (DRC), Gabon, Ghana, Kenya, Morocco, Senegal, South Africa and Uganda.

The pandemic has demonstrated the urgent need to accelerate innovations in the Region for service delivery, to improve efficiencies and contribute to making the Region self-sufficient in medical products and technologies. The Secretariat increased its interventions to promote innovation in the Region. The work done included documenting and disseminating over 1000 new or modifications of existing technologies in the context of COVID-19, more than 120 of which have been piloted or adopted by Member States.

The WHO Secretariat has embarked on an innovative project that seeks to digitize health campaigns in Benin, DRC, Kenya and Nigeria, and enabled 18 innovators to make progress



in upscaling their innovations. The Regional Office has supported Member States to develop capacity for technology transfer and manufacturing, including the launch of an mRNA hub in South Africa. The African Vaccine Regulatory Forum (AVAREF), which had been in existence before the pandemic, was pivoted to strengthen the institutional capacity of regulatory authorities and ethics committees to support the response to the pandemic.

WHO, together with its collaborating centres and strategic partners including the European and Developing Countries Clinical Trials Partnership (EDCTP), Tackling Infections to Benefit Africa (TIBA), the African Academy of Sciences (AAS) and the Africa Centres for Disease Control, has supported countries to conduct clinical trials, sequencing, and development of COVID-19 countermeasures.

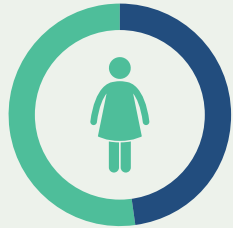
To curb the growing threat of antimicrobial resistance (AMR), the Regional Office supported 38 countries to develop national action plans (NAPs) and implement actions to address AMR in the context of the One Health approach. A total of 33 African Region countries are conducting AMR surveillance using the Global Antimicrobial Surveillance System (GLASS).

The COVID-19 pandemic has exacerbated inequities and reaffirmed the importance of acting on the social, economic and environmental determinants of health. The Secretariat has continued to work with Member States and partners to address these determinants, including collaborations with UNICEF, WaterAid and Oxfam, to promote the global initiative for hand hygiene for all (HH4A) in the Region. WHO and other UN agencies worked with 11 countries in the Region to develop intersectoral road maps and advocate for high-level commitments to the prevention and treatment of child wasting. WHO is also supporting Member States to accelerate implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC).

The key lesson during this period is that the pandemic has exposed the vulnerabilities in national health systems. Addressing these vulnerabilities requires extensive work to engage sectors beyond health.

Moving forward, the Secretariat will work with partners to support Member States to improve health system resilience, using innovative approaches. These efforts will require joint mobilization of resources with Member States.

“
Addressing these vulnerabilities requires extensive work to engage sectors beyond health.



48%

of alumni are women in The Regional Pathways to Leadership for Health Transformation blended programme



3.83 MILLION

followers on Facebook, Twitter, and Instagram



60 000 HCWS
trained to manage
critical and severe
patients

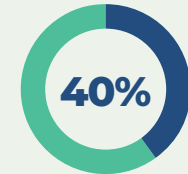


**45 GRADED
EMERGENCIES**

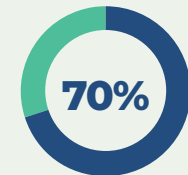
between July 2021
and June 2022

VACCINATION TARGETS

October 2021:



Mid-2022



33

**AFRICAN REGION
COUNTRIES**

are conducting AMR
surveillance using the
Global Antimicrobial
Surveillance System
(GLASS)




623 MILLION
vaccine doses
administered



**1000
LABORATORIES**
scaled up their capacity
to perform PCR tests



18
innovators
supported

1000 
NEW OR MODIFIED
technologies in the
context of COVID-19



**11
COUNTRIES**

developed intersectoral road maps
and advocate for the prevention
and treatment of child wasting



**38
COUNTRIES**

supported to develop NAPs
and implement actions to
address AMR

2021

Timeline of key events in the WHO African Region: 1 July 2021-30 June 2022

1 JULY

5.7 million COVID-19 cases and 146 298 deaths reported on the African continent, including 4.17 million cases and 98 300 deaths in the WHO African Region.

7 JULY

Zimbabwe launches the first typhoid conjugate vaccination campaign in the African Region and targets around 6 million children between nine months and 15 years.

29 JULY

Following months of a near-halt, COVID-19 vaccine shipments to Africa begin to rapidly ramp up from multiple sources.

9 AUGUST

The first case of Marburg, a viral disease in the same family as Ebola, detected in Guinea.

1 OCTOBER

WHO and partner organizations step up genomic sequencing in Africa, reinforcing a regional hub in South Africa as well as a 12-laboratory network to boost COVID-19 response in the continent.

30 SEPTEMBER

Only a third of the continent's 54 nations have fully vaccinated 10% of their people against COVID-19.

7 SEPTEMBER

The Democratic Republic of the Congo declares an outbreak of meningitis in the north-eastern Tshopo Province.

6 OCTOBER

WHO recommends the RTS,S vaccine - the world's first vaccine against malaria - for wider use. Ghana, Kenya and Malawi played a pivotal role in this effort, providing the evidence after immunizing more than 800 000 children in a pilot programme.

8 OCTOBER

Ebola outbreak in North Kivu in the Democratic Republic of Congo declared over just two months later.

14 OCTOBER

WHO in Africa launches an initiative to enhance community screening for COVID-19 in eight countries, aiming to reach more than 7 million people with rapid diagnostic tests.

2 DECEMBER

Botswana becomes the first high-burden country to be certified by WHO for achieving an important milestone on the path to eliminating MTCT, achieving "silver tier" status, which moves the country closer to eliminating mother-to-child HIV transmission by lowering the rate to under 5%.

28 NOVEMBER

Botswana and South Africa detect the Omicron variant. WHO calls for science-based control measures as countries impose travel bans due to concerns over Omicron.

6 DECEMBER

WHO launches a three-week online campaign targeting 30 million African women aged 16 - 35 years with sexual health information and education.

7 DECEMBER

Africa reduces new infections and nearly halves AIDS-related deaths, but ending AIDS as a public health threat by 2030 is unlikely.

16 DECEMBER

Health authorities declare the Ebola outbreak in DRC's North Kivu Province over. It was the country's second outbreak in 2021, and the 13th recorded to date.

DECEMBER

Seychelles and Mauritius become the first countries on the African continent to reach the 70% COVID-19 vaccination target.

2022

JANUARY

Africa records 10 million COVID-19 cases including 7.6 million in the WHO African Region.

17 FEBRUARY

Wild poliovirus type 1 is detected in Malawi.

23 APRIL

Ebola outbreak declared in Mbandaka, Democratic Republic of the Congo.

APRIL

Rwanda and Uganda eliminate human African trypanosomiasis as a public health problem, after Cote d'Ivoire and Togo in 2020.

18 MAY

Outbreak of wild poliovirus type 1 is declared in Mozambique.

28 MAY

Togo eliminates trachoma as a public health problem, becoming the fourth country on the continent to be validated by WHO.

30 JUNE

Nearly 194 million people have been fully vaccinated (17% of the Region's population), up from 135 million (10%) in January 2022. More than 12.5 million cases and 256 041 deaths reported to date on the continent, including 9.1 million cases and 173 589 in the Region.

INTRODUCTION

This report covers the work of the Secretariat for the reporting period, highlighting the key achievements, challenges, and strategic focus for the coming year.

The report is presented in six chapters, the first of which highlights the consolidation of the Transformation Agenda to make the Secretariat more responsive and accountable.

Chapter 1 highlights the implementation of a country-focus approach to strengthen the capacity of country offices to ultimately achieve greater impact.

It also highlights the progress made in leadership transformation, which is being extended to other WHO regions and to Member States, and covers our continuing work to strengthen management and accountability in respect of human and material resources, including procurement.

Lastly, the chapter presents the progress made in partnerships and communication, especially in relation to COVID-19.

Chapter 2 is dedicated to the Secretariat's work in the prevention, detection and response to emergencies, beginning with highlights of the progress made against COVID-19. This includes pandemic control, and the status of COVID-19 vaccination in the Region.

The chapter then discusses other areas of work on emergencies, covering the response to acute and protracted emergencies, and the support provided to Member States to build their capacities for preparedness and response to future emergencies.

The chapter closes by highlighting the polio eradication initiative in the Region, including efforts to contain the WPV 1 importation and the response to circulating vaccine-derived poliovirus outbreaks.

Chapter 3 discusses the impact of the COVID-19 pandemic on national health systems, especially the consequent disruptions to access and uptake of essential health services, and the Secretariat's response in supporting Member States to restore these services.

It highlights the Secretariat's contribution to boosting national leadership and coordination to address the challenges, with a special focus on better use of emerging technologies, and local manufacturing of medicines and vaccines.

This chapter also discusses strategic actions implemented in the context of COVID-19 to enhance service delivery coverage and quality for priority populations, including pregnant women, newborns, children and adolescents, as well as older people.

It closes with an overview of health interventions to advance coverage for priority communicable and noncommunicable diseases, highlighting the use of data to guide the targeting of communicable disease interventions to enhance efficiency and impact.

Chapter 4 focuses on the response to the growing concern over the spread of antimicrobial resistance (AMR), highlighting WHO's involvement in multiple strategic, technical and financial interventions, including the distribution of digital awareness materials that reached over one million people.



This section of the report also underlines the importance of laboratory and diagnostic capacities in countries for health care management surveillance, and managing epidemics and pandemics. It details the Regional Office's support and investment towards strengthening such capacity, including relevant specialist in-country training.

Further, this chapter emphasizes the widespread innovations sparked by the pandemic, and the Regional Office's support for creators to upscale their inventions, including examples of successful outcomes.

It closes with an overview of the important progress towards local manufacturing and the evolving regulatory landscape on the continent, detailing WHO's support for individual countries and the development of the all-important African Medicines Agency (AMA).

Chapter 5 concentrates on WHO's contributions to tackling the social, economic and environmental determinants of health and reducing the health equity gap, which has been significantly exacerbated by the COVID-19 pandemic.

It highlights WHO's contributions and support in respect of environmental health risks in the context of climate change, multisectoral action to promote healthy lifestyles, overcoming malnutrition and ensuring food security, and reducing risk factors for NCDs.

As such, there is a special focus on tobacco control, including examples of WHO interventions to support farmers to shift away from tobacco farming to food production, as well as on reducing the harmful use of alcohol, and regulating the food environment to promote healthy diets and reduce the incidence of obesity.

Chapter 6 provides an overview of the many challenges still besetting the African Region as it seeks to sustain the response to COVID-19 and other epidemics, while securing the uninterrupted delivery of essential health services, and making the necessary preparation for future shocks.

It highlights some of the lessons learnt from the pandemic, emphasizing the power of committed leadership and partnerships, as well as of technology and analytics, along with the importance of capacitating communities to play a central role in disease control and health emergencies.

Finally, the **conclusion** closes the report with a short summary of the key takeaways, including the need to accelerate efforts towards achieving resilient health systems in Member States, cemented in a primary health care approach, as a basis for securing equitable health for all Africans.

There is also a timeline featuring priority events and incidents that guided WHO's work in the African Region over the review period.





CHAPTER 1: CONSOLIDATING THE TRANSFORMATION OF THE SECRETARIAT FOR EFFECTIVE SUPPORT TO MEMBER STATES

The COVID-19 pandemic has reinforced the relevance of WHO Regional Office in Africa's Transformation Agenda, and its alignment with the global WHO transformation efforts to ensure the Organization is fit for purpose to effectively fulfil its mandate and address priorities, as agreed with Member States, in a dynamic global health environment.

The pandemic experience over the past two years has shown that rapid change is both necessary and possible for WHO in the African Region which, despite the disruptions of the pandemic, recorded significant progress in implementing country functional review recommendations, promoting gender parity and addressing sexual exploitation, abuse and harassment, while fostering an inclusive and respectful work environment.²

² The number of WHO AFRO female team Leads, heads of country offices and directors increased by 6.6% from 24.2% in 2020 to 30.8% by the beginning of 2022

1.1 FOCUS ON STRENGTHENING COUNTRY OFFICES TO DELIVER BETTER

The Secretariat's work has continued to prioritize implementation of the country-focus approach for greater and sustained impact; quality results and value for money; broader engagement with Member States and partners; more effective communication of its work; and accountability for resources and compliance. The country-focus approach is aimed at strengthening individual and institutional efficiency, accountability for results and responsiveness, while bringing timely and high-quality technical support closer to countries.

Action in response to the outcomes of the functional reviews is central to achieving the GPW 13 vision of delivering measurable impact at country level. As such, the human resource focus during the reporting period was aimed at assisting budget centres to identify and prioritize staff needs across country offices and Regional Office clusters. The functional reviews of all country offices in the Region have now been completed, and the implementation of their outcomes is well under way, as highlighted in Figure 1 below.

1.1.1 IMPROVED CAPACITY FOR PARTNERSHIPS, RESOURCE MOBILIZATION AND TECHNICAL SUPPORT

Capacities for strengthening partnerships, mobilization of resources and programme management were reinforced. New functional competencies were established to strengthen WHO leadership functions at country level. These included the appointment of deputy WHO representatives in two country offices³; 35 Policy, Planning and Coordination experts; 40 Programme Management Officers; and 33 External Relations

and Communications officers. These new functions are already showing a return on investment, working in coordination with the Regional Office and headquarters to maintain funding from mature partnerships, and to develop funding streams from new sources and mechanisms through international development banks, the private sector, philanthropic donors, and bilateral and multilateral partners.

The percentage of overdue reports to partners was reduced to 4% of all reports, in comparison to the 13.5% previously. WHO is therefore fostering partner trust by showcasing a high level of accountability through consistent, quality, and timely reporting to partners, which used to be a major source of concern to them. An increase of over 8% has also been achieved for resources available to the African Region for the 2020–2021 biennium (over US\$ 1.78 billion) compared to the previous biennium (2018–2019, with resources at over US\$ 1.64 billion). Over US\$ 580 million was raised for the COVID-19 response in the biennium 2020–2021, over 40% (US\$ 246 million) of which was raised at country level. The strengthened country offices are also demonstrating increased collaboration and interaction with stakeholders.

The increased engagement with non-State actors has broadened the partner base, including the establishment of emerging partnerships with the private sector, nongovernmental organizations and professional associations, in line with the Framework of engagement with non-State actors (FENSA). This enhanced engagement is increasing the impact of interventions at country level, as well as improving partner synchronization in response to government priorities. At the heart of the process of engaging with these non-State actors (NSAs) are due diligence and risk assessment, which were consistently conducted to preserve the integrity of the Organization.

The FENSA implementation rate increased significantly in the 2020–2021 biennium to 171 NSAs engaged, against 62 in the previous biennium, thus tripling the volume of partnerships with NSAs in the Region. This results from the identification of FENSA focal points in country offices, as well as the training of country offices on the procedure for engagement with NSAs.

In order to build on these gains, WHO continues to seek flexible and predictable funding from Member States and NSAs that share its goals and values of fostering health equity through sustainable financing. In respect of discussions on sustainable financing by governing bodies, the Regional Office effectively supported Member States whose participation was crucial to reaching the agreement to increase assessed contributions to an aspirational 50% of the base budget by 2028–2029.

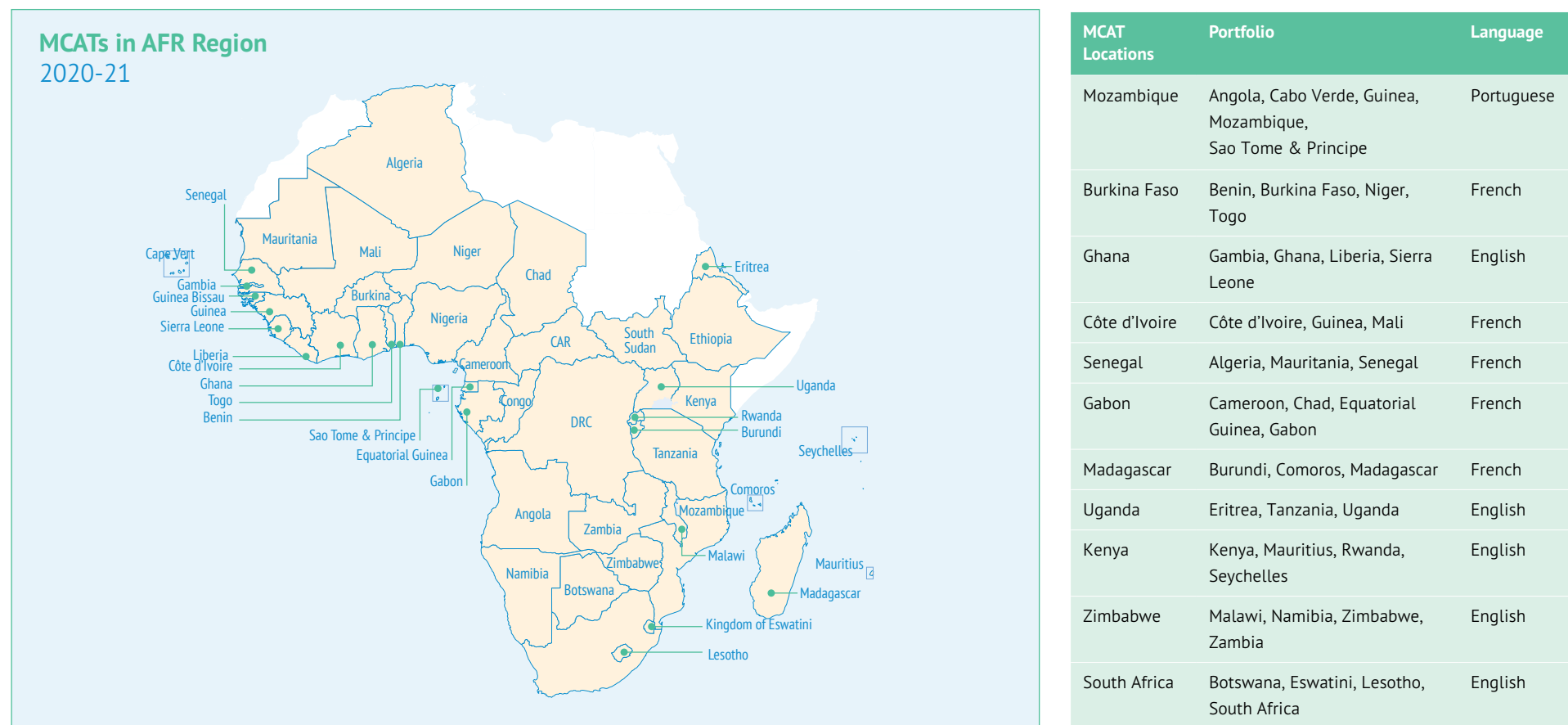
To bring timely, high-quality technical support closer to Member States, the three Inter-country Support Teams (ISTs)⁴ were repurposed into 11 Multicountry Assignment Teams (MCATs). These comprise experts tasked with scaling up technical support in three cross-cutting and eight priority health areas that drive the disproportionate morbidity and mortality rates⁵ in the Region. The MCATs, a joint enterprise working across WHO country office clusters, and guided at regional level by the MCAT coordination team, has begun operations. The additional higher-calibre technical experts will cover a smaller number of countries compared to the former IST arrangement, thereby providing more in-depth, dedicated support. Supporting fewer countries will facilitate engagement with national teams and technical agencies on a more continuous basis, to implement programmatic priorities. The MCATs have the potential to generate value for money in the African Region by doing more, and better, with less. As technical expertise is shared between countries with similar profiles, the MCAT mechanism promotes experience-sharing, integration of work, and implementation of holistic approaches.

3 Ethiopia and Nigeria, while the appointment for the Democratic Republic of the Congo is in process

4 To effectively decentralize the technical functions of the Regional Office, ISTs were established in three locations – Harare, Libreville and Ouagadougou – to work with country offices in East and Southern, Central and West Africa respectively.

5 HIV, TB and hepatitis, tropical and vector-borne diseases, NCD prevention and control, health financing, nutrition, RMNCAH, diagnostics and laboratory services and service delivery systems

Figure 1. WHO Multi-country Assignment Team distribution in the African Region



IMPROVED CAPACITY FOR PARTNERSHIPS, RESOURCE MOBILIZATION AND TECHNICAL SUPPORT

+ FUNCTIONAL COMPETENCIES



02

of the four big
country offices
get deputy WHO
representatives



40

Programme
management
officers



35

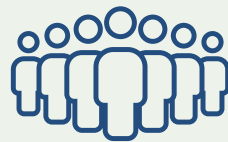
Policy,
planning and
coordination
experts



33

External
relations and
communications
officers

+ WHO LEADERSHIP



171 NON-STATE
ACTORS

engaged in the
2020-2021 biennium

3 INTERCOUNTRY
SUPPORT TEAMS (ISTS)



11 MULTICOUNTRY
ASSIGNMENT TEAMS

US\$ 580 MILLION
raised for the COVID-19
response

**US\$ 246
MILLION**

of which raised
at country level

1.2 STRENGTHENING CHANGE MANAGEMENT PROCESSES AND LEADERSHIP

The growing demand from Member States for strengthening of leadership and change management competencies prompted WHO to expand the Pathways to Leadership for Health Transformation blended programme, piloted in the Republic of Congo, to over 100 senior health ministry officials in Ghana⁶, Lesotho and Niger. Those trained are already applying their newly acquired skills in strengths-based leadership and systems thinking to lead COVID-19 recovery efforts, and address core health challenges in their respective countries.

The WHO in the African Region Transformation Agenda continues to be widely recognized as having influenced the global WHO transformation, with its initiatives being adapted across other WHO regions and WHO headquarters. This includes the country functional review process, the programmatic key performance indicator framework in WHO EMRO and WHO SEARO, as well as the participation of 23 WHO EURO senior staff in the AFRO Region's Pathways to Leadership Programme in November 2021. A second WHO EURO cohort is planned for October 2022, and the programme is now a career development component of the global transformation programme.

Two Regional Programme Meetings were also hosted virtually in 2021 and 2022 for all WHO Representatives in the African Region. These provided an opportunity for high-level reviews of GPW 13 progress in countries, while equipping representatives with knowledge and skills to support WHO's strategic engagement and collaboration with Member States, in UN reform and UN country programming, in the context of the 2030 Agenda for Sustainable Development.

“

The WHO in the African Region Transformation Agenda continues to be widely recognized as having influenced the global WHO transformation, with its initiatives being adapted across other WHO regions and WHO headquarters.

STRENGTHENING CHANGE MANAGEMENT PROCESS AND LEADERSHIP



THE PATHWAYS TO LEADERSHIP
FOR HEALTH TRANSFORMATION
BLENDED PROGRAMME,
PILOTED TO OVER 100
senior health ministry officials.

ADAPTATION OF:



Country Functional
Review Process



Programmatic key performance
indicator in WHO EMRO and WHO
SEARO



23 WHO EURO senior staff
participated in the Africa Region's
Pathways to Leadership Programme

⁶ Two cohorts were conducted in Ghana

1.3 Women's empowerment and prevention of sexual exploitation, abuse and harassment (PRSEAH):

As part of conscious efforts to achieve gender parity at senior level, a second Pathways to Leadership programme was launched, exclusively for female staff, during the last quarter of 2021. This increased the percentage of female staff among the 200 programme alumni from 38% to 48% (96), who are now equipped with the requisite leadership and managerial competencies to take on leadership roles within WHO.

The subsequent launch of the WHO Africa Women in Leadership Speaker Series amplified these leadership development efforts. Participant feedback following the three sessions conducted between November 2021 and April 2022 revealed increased confidence levels among female staff, and a growing sense of belonging.

With greater emphasis on putting people at the centre of the Transformation Agenda, aligning with global WHO reform in terms of team-level ownership and accountable leadership, these concerted diversity, equity and inclusion efforts have continued to improve the Secretariat's performance in ensuring gender parity, and a respectful and fair workplace. One notable achievement was reaching the target of recruiting 100 UN Volunteers in the African Region, set by the Africa Young Women Health Champions Initiative (AWHC). This was launched in 2020, in partnership with the United Nations Volunteers (UNV) programme, to attract young talented professionals, especially women.

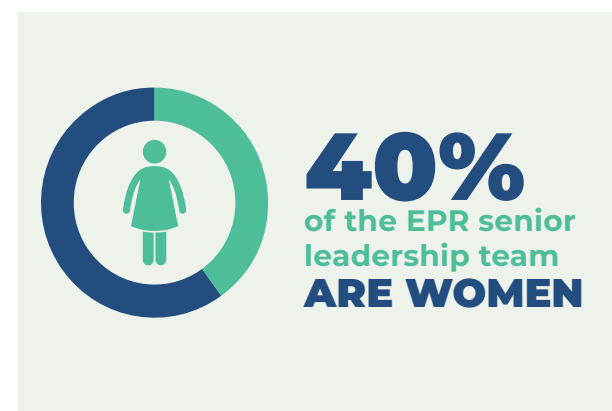
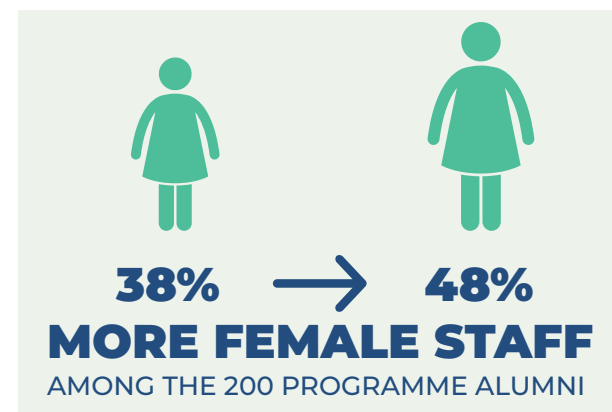
The Secretariat's commitment to living the WHO values and upholding the highest ethical standards was institutionalized through concrete systemic measures, including the recruitment of a full-time Ombudsman and a Regional Coordinator to lead the Region's efforts in preventing and

responding to PRSEAH. Recognizing that increasing the number of women in emergency response teams is a critical first step towards addressing PRSEAH in such settings, women now constitute 40% of the Region's Emergency Preparedness and Response (EPR) senior leadership team, and a female Regional Emergency Response Manager now oversees all graded emergencies. The team was entirely male just one year ago.

PRSEAH capacity has been enhanced at country level, with each country office having a PRSEAH focal point as well as an alternate, in order to provide first-level support in cases of SEAH. All staff have had the opportunity to undergo training in PRSEAH, and each WHO team is presently required to identify one performance objective related to PRSEAH for assessment in the staff annual performance review process.

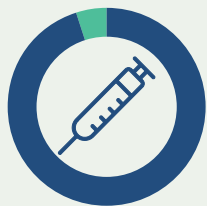
A PRSEAH technical expert has also been included in all WHO emergency response surge teams, and all WHO surge staff as well as ministry of health counterparts are required to sign a code of conduct, acknowledging awareness of the prohibition of sexual misconduct, and their duty to report any suspected cases.

“
These actions have resulted in a growing “speak up” culture within WHO, with more staff, consultants and partners aware of their rights, and empowered to report and prevent all forms of SEAH.



1.4 IMPROVING STAFF WELFARE BY PROMOTING WORK-LIFE BALANCE, INCLUDING SUPPORTING STAFF TO OVERCOME THE COVID-19 CHALLENGE

The agility and resilience of the WHO workforce in the face of the COVID-19 pandemic has highlighted the importance of promoting workplace mental health, and a healthy working environment, to ensure a healthy work-life balance. To this end, stress counselling and psychological services were, and continue to be made available to staff and their dependants across the Region. The Secretariat also contributed to setting up services for COVID-19 testing, including the procurement of antigenic, serological and PCR testing equipment and kits, and for follow-up medical care for positive cases and their contacts. Vaccination posts were set up, mainly at the Regional Office and in some country offices, resulting in the achievement of staff vaccination coverage rates of over 95%. Provisions for flexible working arrangements are also in place to support staff to enable remote working as the Organization adopts new ways of working.



95%
staff vaccination
coverage during
2021 - 2022



1.5 DRIVE TOWARDS INCREASING EFFICIENCY

1.5.1 FINANCIAL MANAGEMENT IMPROVEMENTS

The implementation of an efficient imprest account replenishment system allows for programme-related funds to be transferred to country office accounts in less than 24 hours. The disbursement mechanisms that country offices use for payments to final beneficiaries, which were previously made in cash, have also been digitized. The Region maintained a 95% “A rating” for all 215 imprest accounts, reflecting a substantial improvement in financial management at country level.

To counter the interruption by the pandemic of inspections of activities funded through direct financial cooperation, direct implementation and grant letters of agreement, pre-checks of requisitions were intensified and served as a first line of quality assurance. The number of purchase orders

with outstanding reports exceeding 180 days was reduced to a minimum level of between five and 14 days.

In 2021, five internal audits⁷ were conducted in the African Region. The audit of the General Management Cluster in the Regional Office was completed in November 2021, with concrete steps taken to accelerate implementation of the recommendations. The Compliance Unit has also resumed its compliance and administrative reviews of country offices⁸ to improve governance, oversight and internal control. Furthermore, a road map to review and strengthen the Secretariat’s anti-fraud and anti-corruption policy architecture, tools and risk assessments, was also created. An Organization-wide cross-functional working group was established with the aim of producing a WHO anti-fraud and anti-corruption handbook and updated policy, to serve as a reference for all WHO staff and implementing partners. Specifically, the handbook will promote a culture of integrity and accountability, by providing guidance on how to prevent, detect and report fraud and corruption within WHO.

“
An Organization-wide cross-functional working group was established with the aim of producing a WHO anti-fraud and anti-corruption handbook and updated policy, to serve as a reference for all WHO staff and implementing partners.”

DRIVE TOWARDS INCREASING EFFICIENCY



95% “A RATING”
for all 215 imprest accounts

Reports
exceeding 180 days
WERE REDUCED TO A
MINIMUM LEVEL OF
5-14 DAYS

⁷ Angola, Gabon, General Management Cluster, Nigeria, Zimbabwe

⁸ Côte d’Ivoire, DRC, Ghana, Mali, Mauritania, Mozambique, Niger, Uganda

1.5.2 IMPROVING PROCUREMENT PRACTICES

Efforts to strengthen the supply chain, by proactively securing long-term pricing for goods and services, and renewing supplier contracts or concluding new ones through open and broad competition processes, resulted in savings of approximately US\$ 1.6 million. Even though most transactions were handled through emergency processing due to the pandemic during the reporting period, a cumulative total of US\$ 3.7 million has been saved over the past three years (2019–2021).

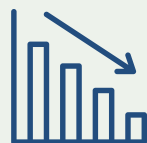
Regular renewal of long-term agreements (LTAs), through competitive bidding after four consecutive years of assignment, resulted in a 50% reduction, from US\$ 1.4 million to US\$ 0.7 million, in spending on operational recurrent services/consumables compared to the previous biennium. Pursuing more competitive options through newly established companies saw a 70% decrease in costs across two bienniums, from US\$ 0.6 million to US\$ 0.2 million – from the traditional contracts in 2020–2021 to the improved ones in 2022–2023.

Efforts by WHO country offices to advocate for the waiving or recovery of the cost of their premises with Member States is contributing to increased cost savings, with the potential for further economizing across the Region. In Côte d'Ivoire, for example, the annual cost recovered amounted to US\$ 103 000, which is being redirected to address health priorities in that country.

IMPROVING PROCUREMENT PRACTICES



US\$ 3.7 MILLION
saved between 2019 – 2021



70% DECREASE
in costs across two
bienniums





1.5.3 ENFORCING ACCOUNTABILITY AND TRANSPARENCY THROUGH KEY PERFORMANCE INDICATORS (KPIs) AND DASHBOARDS

As part of the managerial reforms of the Transformation Agenda, the Secretariat initiated the use of administrative KPIs in 2015 in order to track progress, demonstrate results, and inform corrective actions for improved service delivery. The administrative KPIs have since been progressively improved to strengthen internal accountability and transparency, and to measure regional and country office performance in specific areas. These include travel, human resources, financial management, procurement, asset management, health and safety, and security. Regular monitoring and reporting on the managerial KPIs by all budget centres has contributed to timely delivery of goods and services, ethical practices, and a culture of accountability for Member States' investment in WHO in the African Region. Corresponding performance monitoring dashboards have been created to facilitate real-time access to administrative KPI reports for course correction, where necessary, and continuous improvement.

1.6 GALVANIZING PARTNERSHIPS AND COMMUNICATIONS FOR EFFECTIVE DELIVERY

The work of the Secretariat requires collaboration with other stakeholders for effective support to Member States. The building of partnerships is facilitated by strong communication. The Secretariat sustained and strengthened existing partnerships and built new ones during the reporting period, accompanied by a strong focus on corporate communication.

The Secretariat strengthened partnerships with traditional partners, as well as with governments, including those of Canada, China, Germany, Norway, the United Kingdom, the United States, the Bill & Melinda Gates Foundation, the

European Commission, Rotary International, the African Development Bank and the World Bank. This contributed to strengthening the Organization's coordination role in the COVID-19 response and other key interventions, effectively addressing challenges and achieving life-saving results.

Strategic dialogues and leadership meetings with key partners successfully identified multiple streams of collaborative work, which included the response to COVID-19. The Regional Office also organized 16 partner briefings to showcase and coordinate its efforts to mitigate the public health and socioeconomic impacts of COVID-19 at national and subnational levels. The briefing agendas included regular updates on vaccine roll-out in the African Region, as well as new projects focused on genomic surveillance, community engagement, and partner coordination. As a result, further deep dives on strategic technical discussions with partners took place, resulting in the signing of memoranda of understanding (MOUs) and the development of joint sustainable workplans.

Partnership was strengthened among the Harmonization for Health in Africa (HHA) regional offices through the new framework to enhance collaboration, and increase impact at country level, during the period 2022–2023. A fruitful dialogue was held among HHA regional directors in April 2022, during their 12th annual meeting, on how to leverage the lessons learnt from the COVID-19 pandemic in the African Region for building more resilient health systems.

In view of strengthening partner coordination and collaboration at country level, coordination and harmonization challenges were analysed in 39 countries, and solutions identified through a mapping carried out in November 2021. WHO also worked closely with the Africa Centres for Disease Control and Prevention (Africa CDC), through the Africa Taskforce for Coronavirus (AFTCOR), the African Vaccine Delivery Alliance (AVDA) and the African COVID-19 Vaccine Readiness and Deployment Taskforce (ACREDT), to support coordination of the pandemic response.

A central tenet of the COVID-19 response in the Region has been to ensure access to timely, credible and trusted public health information. The African Infodemic Response Alliance (AIRA), launched by the WHO Regional Office for Africa in 2020 to coordinate actions and pool resources to combat health misinformation, now has 15 members,⁹ up from 13 in 2020. The Alliance has worked with members to provide infodemic management support over the past year, training 650 people in social media listening and infodemic management in 21 countries¹⁰ in the African Region.

The Regional Office has strengthened its communications capabilities and worked intensively to transform its digital communication platforms. As a result, social media following grew by 140 000 in the first four months of 2022,¹¹ contributing to a total 3.83 million across the Regional Office's social media pages on Facebook, Twitter and Instagram.

The Region's COVID-19 social content hub, Viral Facts Africa, produced and disseminated over 100 multilingual pieces of COVID-19-related digital content, generating over 95 million views. To advocate for key issues such as vaccine equity, 44 virtual press conferences and 572 media interviews were conducted, and 73 press releases disseminated over the past year. This effort resulted in regional spokespeople being quoted 15 109 times in published media, or an average of 1200 times every month. This was double the baseline figure of 600.

9 UNICEF, UNESCO, UNGlobalPulse, Verified, International Federation of Red Cross and Red Crescent Societies, US Centers for Disease Control and Prevention, Africa CDC, Gavi, the Vaccine Alliance, AfricaCheck, Pesacheck, GhanaFact, Agence France Presse FactCheck, Dubawa, Meedan

10 Angola, Benin, Burundi, Cabo Verde, Comoros, Côte d'Ivoire, DRC, Eswatini, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Niger, Nigeria, Sao Tome and Principe, South Africa, South Sudan, Togo

11 At the end of 2021, WHO AFRO's social media following stood at a total of 3.69 million

GALVANIZING PARTNERSHIPS AND COMMUNICATIONS FOR EFFECTIVE DELIVERY



15 MEMBERS

in The African Infodemic Response Alliance (AIRA), up from 13 in 2020



650 PEOPLE TRAINED

in social media and infodemic management listening



44

virtual press conferences held



572

media interviews conducted



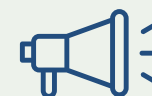
73

press releases issued



16 PARTNER BRIEFINGS

to mitigate the public health and socioeconomic impacts of COVID-19



15 109 TIMES

spokespeople were quoted in published media, an average of 1200 times every month



CHAPTER 2: SUSTAINING THE RESPONSE TO THE COVID-19 PANDEMIC AND PREVENTING, DETECTING, AND RESPONDING TO OTHER HEALTH EMERGENCIES

In the context of the ongoing COVID-19 pandemic, the African Region responded to multiple public health emergencies (PHEs). The Secretariat supported Member States in preventing, preparing for, detecting and responding to PHEs, including COVID-19. The increased COVID-19 variants resulted in the third and fourth waves of the pandemic, with an upsurge of mild to moderate cases. There was, in contrast, a reduction in severe cases, with increased population immunity despite the low vaccination coverage due to inequitable distribution and low vaccine uptake by populations.

Besides the COVID-19 pandemic, the Region is prone to health and humanitarian emergencies that originate from the human-animal-environmental interface, as well as climate-related events (prolonged droughts, food insecurity, destructive floods, volcanic eruptions and cyclones). A total of 130 new public health events were reported between 1 July 2021 and 30 June 2022, with 86.2% of them being infectious disease outbreaks, including circulating vaccine-derived poliovirus type 2 (cVDPV2) and wild poliovirus outbreaks. The Region also experienced several protracted humanitarian crises resulting in mass refugee migration, internal population displacements and cross-border movements, which provide opportunities for further spread of infectious diseases.

This section of the report provides an update on the evolution of the response to the COVID-19 pandemic in the Region, including COVID-19 vaccination. It also provides updates on the response to other public health emergencies, including the wild poliovirus type 1 (WPV1) importation and cVDPV2 outbreaks.

WHO COVID-19 RESPONSE



130 NEW

public health events
between 1 July 2021
and 30 June 2022



86.2% OF THEM

being infectious
disease outbreaks

including circulating vaccine-derived poliovirus
type 2 (cVDPV2) and wild poliovirus outbreaks

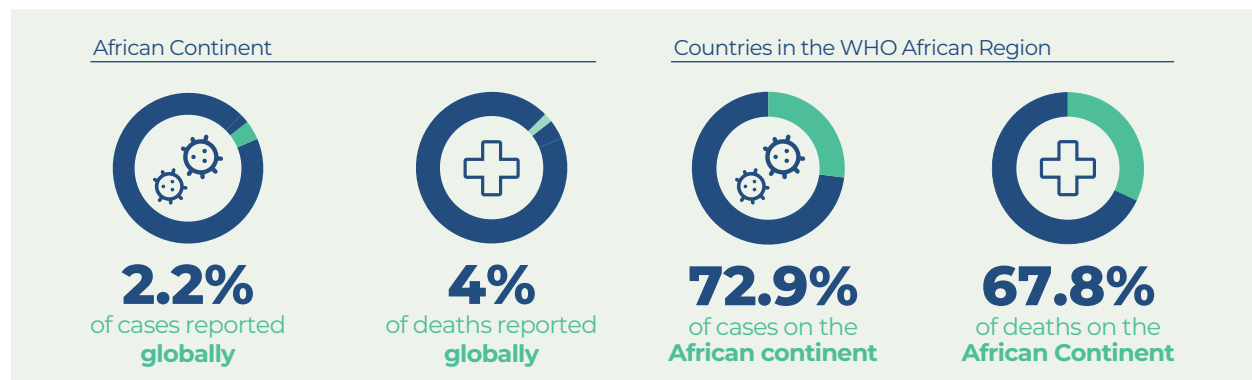
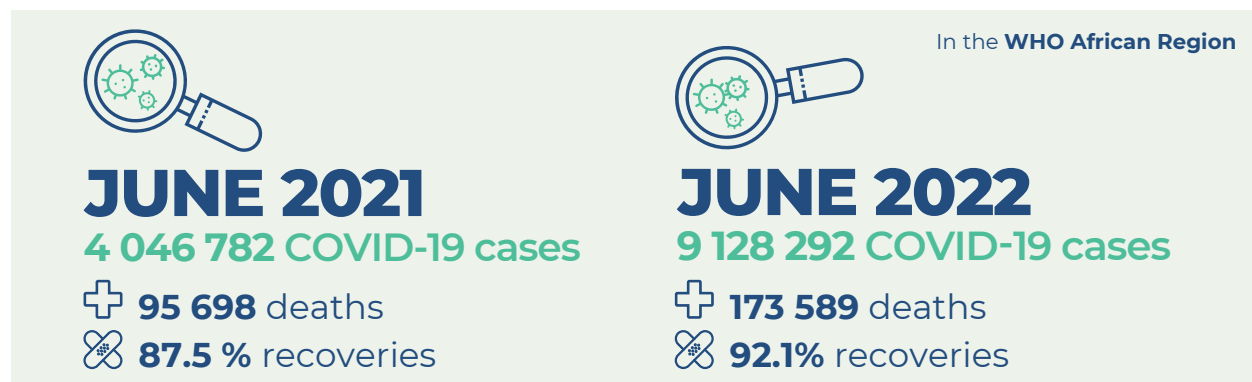


2.1 UPDATE ON THE COVID-19 PANDEMIC IN THE AFRICAN REGION

It has been nearly 30 months since the COVID-19 pandemic began in the WHO African Region, when the first cases were reported in Algeria on 25 February 2020. Over the past year, we have seen a significant improvement in the epidemiological evolution of COVID-19 in the WHO African Region. A substantial increase in the number of cases and deaths was seen during the period under review, with the number of cases increasing from 4 046 782 on 30 June 2021, to 9 128 292 by the end of June 2022 (a 126% increase). The number of deaths surged from 95 698 on 30 June 2021, to 173 589 by the end of June 2022 (an 81% increase), while recoveries increased from 87.5% of cases on 30 June 2021, to 92.1% on 30 June 2022.

By the end of the review period, the African continent had recorded a cumulative 12 514 721 COVID-19 cases, 256 041 deaths (case fatality ratio of 2.1%), and 11 680 406 recoveries. Africa accounted for 2.2% of cases reported globally (544.5 million) and 4% of deaths (6.3 million). Countries in the WHO African Region accounted for 72.9% of cases (9.1 million), and 67.8% of deaths (173 589) on the African continent.

COVID-19 UPDATE





The reduction in cases and deaths seen over the final two months of the review period is a result of substantive efforts by Member States (with support from WHO and partners) to continue implementing response measures, in line with the WHO Strategic Preparedness and Response Plan, and their respective COVID-19 national preparedness and response plans.

The early detection of upsurges in cases has been bolstered by the widespread use of antigen rapid diagnostic tests (Ag-RDT) in all countries, coupled with increased “test and trace” and SARS-CoV-2 polymerase chain reaction (PCR) testing capacities. The enhancement of the community-based surveillance initiative using Ag-RDT, which is a cost-effective and easy-to-use diagnostic tool, helped augment COVID-19 case detection. The initiative has contributed to a 40% increase in testing capacity in the participating countries, and intends to reach more than 7 million people with rapid diagnostic tests by next year.

The COVID-19 sequencing laboratory network launched in September 2020 has also contributed to improving genomic surveillance in the WHO African Region, with a sixfold increase in the number of sequences performed compared to the baseline target. For example, South Africa established a tracking system and a set of resurgence indicators that significantly boosted early detection. This was enabled by a functional and well-connected network of public and private laboratories, with an established level of sequencing capacity that helped detect “abnormalities” in some collected samples – leading to the identification of the Omicron variant.

Investment in reinforcing the capacities and resources of laboratories (both public and private), supported by an “empowering” and enabling environment, has proved to be key for countries to monitor and detect public health threats. Additionally, South Africa’s well-established genomic surveillance, which utilizes both human and wastewater samples, has created an effective early warning system.

In strengthening capacities for key functions, WHO, with support from partners, trained over 200 000 experts in diverse specialties (case management, infection prevention and control, laboratory science, risk communication, etc.) using virtual platforms and onsite hands-on health facility-based platforms. These resources are being leveraged to support the response in countries. Worthy of note is the collaboration with the ECHO Group, which enabled virtual trainings and webinars for over 150 000 front-line experts across the 47 Member States, at national and subnational levels. Case management capacity, which was non-existent at the onset of the pandemic, given its novel nature, has now been greatly increased, with a pool of over 1000 COVID-19 case management experts across the countries of the Region.

In addition, WHO facilitated the procurement and shipment of 144 million items of personal protective equipment (PPE), 95 million laboratory test kits, 1760 monitors, 6921 oxygen concentrators, and 429 ventilators to support the response. A regional stockpile of 700 oxygen concentrators, 3100 oxygen cylinders and 595 pulse oximeters has been created, and is ready for shipping to countries on request. Additionally, given the increased oxygen demand (an estimated 1.3 million COVID-19 patients needing oxygen) since the pandemic began, oxygen plants on the continent increased from 68 to 115, and oxygen concentrators from 2600 to 6671. This was achieved through the efforts of partners and WHO, through the United Nations (UN) platform (including 1517 that were shipped from the WHO African Region stockpile). WHO supplied and distributed 1517 oxygen concentrators and 10 874 cylinders to Member States in the past two months of the review period.

Overall, 15 countries were also supported towards manufacturing, delivering, and maintaining oxygen plants, and where such plants have been established, oxygen costs have been reduced by 40%. A series of capacity-building activities have been initiated to improve the management of oxygen systems.



As part of operations support and logistics (OSL) and response improvement strategies, the Secretariat provided support to revamp the capacity of countries' supply chain mechanisms, through an assessment of sourcing and the use of locally manufactured medical supplies. WHO is currently working with Member States and partners to evaluate local manufacturing companies.

In all countries of the Region, more than 60 000 health care workers (HCWs) were trained in the management of critical and severe patients, indications of rational use of oxygen and other therapeutics, and monitoring of home-based and isolation care (HBIC). WHO supported countries in the African Region to access the therapeutics platform, and procure the recommended therapeutics for COVID-19 treatment. As of May 2022, thirty-four per cent of countries in the Region were using these recommended therapeutics to treat patients.

The infection prevention and control (IPC) component of the response has improved significantly, through capacity

building and provision of guidelines on IPC interventions targeting all 47 countries, in the context of the COVID-19 resurgence. Risk communication and community engagement (RCCE) activities were notably enhanced, through social mobilization and sensitization that sought to promote compliance with public health and social measures (PHSMs), and vaccine uptake. This was achieved through capacity building thanks to partnerships with at least 13 civil society organizations (CSOs). Furthermore, strategic partnerships have been established with social media companies and mobile network providers to disseminate key health messages. For instance, a partnership with Facebook and MTN reached at least 15 million Facebook users and 10 million mobile subscribers in the first half of 2022. These partners engaged with civil society, the private sector and local community structures, such as women's and youth groups, traditional, political and religious leaders, influencers, and other trusted people at the community level. Additionally, the capacity of over 6000 health care workers was strengthened in the WHO African Region.

Similarly, WHO and Member States are scaling up research activities, notably through sero-surveillance and operational research. The aim is to better understand the dynamics of the COVID-19 pandemic and post-COVID-19 syndrome within the African Region, and to generate evidence to inform operational planning, and understand vaccine effectiveness. A community-based response initiative in hotspot districts improved active case finding through testing, genomic sequencing, home-based isolation and care, provision of community IPC kits, assessment of priority communities for compliance with public health and safety measures, vaccination and RCCE.

At the onset of the pandemic, most modelling predictions suggested that the African Region would be hard hit in terms of morbidity and mortality, but those predictions were not borne out. Several factors may have contributed to the low burden of disease on the continent, including demographic characteristics (a young population in the majority of countries); differences in case identification

and death detection capacity; and possible pre-existing immunity from other coronavirus infections.¹² Other findings have indicated that the observed numbers are due to underestimates of the true magnitude of the pandemic, resulting from weak surveillance systems. There were also components of early institution of restrictions of movement, and better compliance with lockdown measures in the early stages of the pandemic, rapid repurposing of outbreak response systems to manage the pandemic, and less resistance to vaccination mandates. Also, the previous experience of Member States and partners, notably WHO in the African Region, in managing outbreaks and other public health emergencies, contributed to the level of readiness and response to the pandemic.

There have been variations in the estimates of cases and deaths across the continent. A WHO study¹³ showed that by December 2021, fifty-four per cent of the population had immunity against COVID-19, with 439 000 deaths (compared to 155 248 reported) over 2020–2021. A total 55% of cases occurred in 2020, and 45% in 2021, while 81% of all deaths occurred in 2021. This was likely due to the severity of Delta and other variants. While the Region recorded a similar number of infections to the rest of the world, there were significantly fewer deaths. A WHO assessment showed that only 14.2% of COVID-19 infections – or one in seven – were being detected in Africa,¹⁴ plausibly because of the use of different case definitions and testing strategies, or different methods of counting cases (for example, mild cases not being tested or counted); different ways of handling time lags; differing quality of care or interventions being introduced at different stages of the illness; and the variation of patient profiles (for example, age, gender, ethnicity and underlying comorbidities) between countries in the Region.

Nonetheless, four distinct waves have seen successively higher peaks, mostly driven by highly transmissible variants of the SARS-CoV-2 virus. The Delta variant, in particular, was responsible for a very distinct wave between May and September 2021, leading to public health capacities in many African countries being rapidly overwhelmed. At the time, there were reports of shortages of intensive care unit bed capacity and oxygen supply in many countries including Algeria, Malawi, Namibia and Uganda. Most countries began reporting existing capacities becoming overwhelmed at CFRs of about 2%.

Similarly, the Omicron variant, first reported in November 2021 and responsible for the fourth wave, caused a rapid surge in case numbers. While it was more virulent and has caused significantly more infections than the other variants of concern (VOCs), its negative impact on public health systems was less severe compared to previous waves. For the first time since the onset of the pandemic, the fourth wave was characterized by an epidemiological profile where the surge in cases did not result in a commensurate increase in hospitalizations and deaths. The average CFR during the fourth wave was low (0.7%), compared to the Delta variant-driven third wave (2.4%), the Beta variant-driven second wave (2.7%), and the first wave attributed to the spread of the wild SARS-CoV-2 virus, when capacities in several countries were lacking (2.5%). Further information on progress made in improving the laboratory capacity to detect new SARS-CoV-2 variants is summarized in section 4.2 on strengthening regional diagnostic and laboratory systems.

In spite of the observed improvement in the epidemiological evolution of COVID-19, there are still concerns that need to be addressed. For instance, WHO raised concerns when

nearly half of all African countries halted contact tracing in early 2022, stressing that this intervention, along with robust testing, forms the backbone of any pandemic response. Without this critical information, tracking the spread of the virus is difficult, as is identifying emerging new variants. By May 2022, about half of all African countries were no longer doing any kind of contact tracing, even though WHO recommends prioritized contact tracing for high-risk contacts in the health care setting and nursing homes, and for patients with comorbidities.

Additionally, the evolution of the pandemic in distinct waves has made it difficult for countries to maintain compliance with preventive measures, resulting in clusters of cases in families, schools, workplaces and closed settings, and leading to the circulation of new VOCs, especially the Delta and Omicron variants.

12 Ngoy N, Oyugi B, Ouma PO, et al. Coordination mechanisms for COVID-19 in the WHO Regional office for Africa. *BMC Health Services Research*. 2022;22(1):1-17

13 Cabore JW, Karamagi HC, Kipruto HK, et al. COVID-19 in the 47 countries of the WHO African region: a modelling analysis of past trends and future patterns. *The Lancet Global Health*. 2022

14 <https://www.afro.who.int/news/six-seven-covid-19-infections-go-undetected-africa>

WHO COVID-19 RESPONSE



144 MILLION

items of personal protective
equipment (PPE)

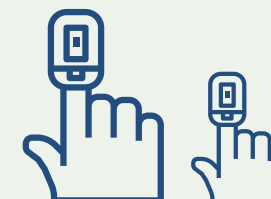


95 MILLION

laboratory test kits



1760 monitors



**REGIONAL
STOCKPILE**

of oxygen
concentrators,
oxygen cylinders and
pulse oximeters



429 ventilators



**6921 oxygen
concentrators**



**14 474
oxygen cylinders**



**15
COUNTRIES**

supported towards
manufacturing,
delivering, and
maintaining
oxygen plants



60 000 HCWs

trained in the management
of critical and severe patients



47 COUNTRIES

trained in infection
prevention and control



6000 HCWs

trained in IPC in the
WHO African Region



**40%
INCREASE**

in testing capacity
in the participating
countries



150 000 FRONT-LINE EXPERTS
benefited from **virtual trainings** and
webinars provided through collaboration
BETWEEN **WHO** AND THE **ECHO GROUP**

2.1.1 COVID-19 VACCINATION:

During the first half of the year in review, global vaccine inequity remained a major stumbling block for the WHO response to the pandemic in Africa, heightened by the increasingly severe third and fourth waves. In October 2021, WHO adopted a strategy to vaccinate 40% of the total population in countries by the end of 2021, and 70% by mid-2022.

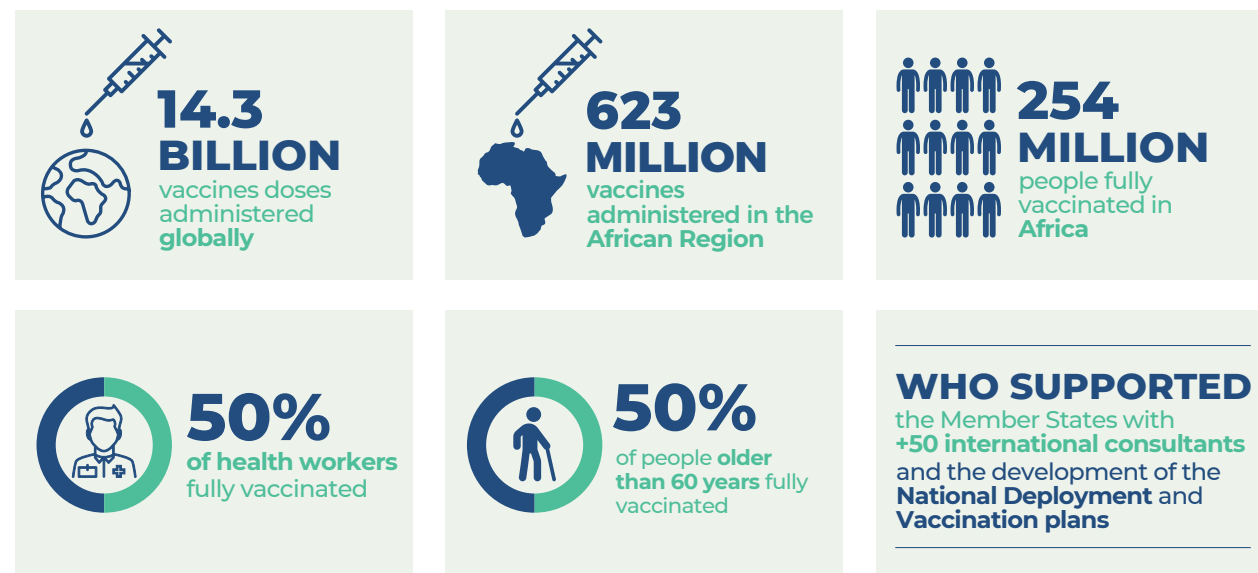
WHO support to Member States in the African Region included recruitment of over 50 international consultants who were deployed to countries, and support for the development of National Deployment and Vaccination Plans, microplanning, logistics, and planning and implementation of vaccination. Support was provided to countries to access vaccines, including through donations from the US Government and Team Europe, among others, using the COVID-19 Vaccines Global Access (COVAX) Facility.

In January 2022, sixty additional experts were deployed to 20 priority countries¹⁵, with the aim of strengthening in-country COVID-19 vaccination partnership coordination, in order to improve government ownership and oversight.

By 30 June 2022, of the 14.3 billion vaccine doses administered globally, 5% thereof (623 million) had been administered in the African Region. This included a total of 15.6 million booster doses, contributing to 254 million fully vaccinated people in Africa (19% of the population), and 181 million in the WHO African Region (16% of the population). While targets remained unmet for high priority groups such as health workers and people with comorbidities and older adults, a WHO study in 31 African countries in June 2022 revealed that the number of fully vaccinated health workers increased from 33% to 50% between January and June 2022. For people older than 60 years, the number increased during the same period from 10% to 50%. By the end of June 2022, two countries¹⁶ in the WHO African Region had achieved the target of fully vaccinating 70% of their populations.

This achievement was the result of significant efforts to boost COVID-19 vaccine uptake in Africa by multipartner country support teams (WHO, Gavi, UNICEF, Africa CDC, the US Centers for Disease Control, the World Bank, and others) that were deployed to support the 20 priority countries to urgently increase vaccine absorption. Early lessons from this work include the fact that mass vaccination campaigns, coupled with strong national leadership and community engagement, are key enablers for countries to reach large numbers of people quickly. Strong partner coordination and adequate funding for operational costs were critical elements for success. Significant availability of flexible funding from donors to countries also greatly influenced the increase in coverage in the Region.

COVID-19 VACCINATIONS BY 30 JUNE 2022



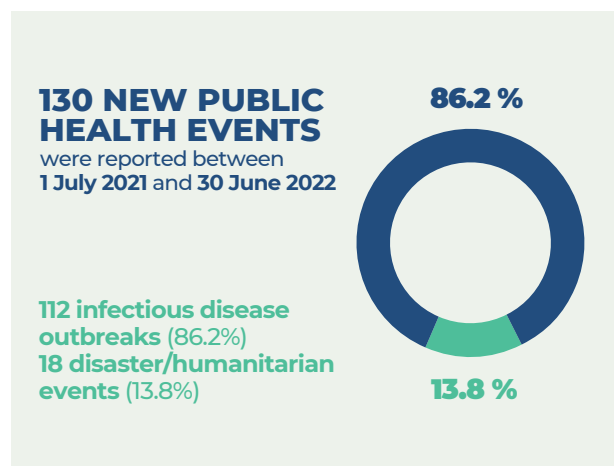
¹⁵ Angola, Burkina Faso, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea-Bissau, Kenya, Madagascar, Mali, Mozambique, Nigeria, Senegal, South Sudan, Uganda, United Republic of Tanzania, Zambia

¹⁶ Mauritius, Seychelles

2.2 PREPAREDNESS FOR, DETECTION OF, AND RESPONSE TO PUBLIC HEALTH EMERGENCIES

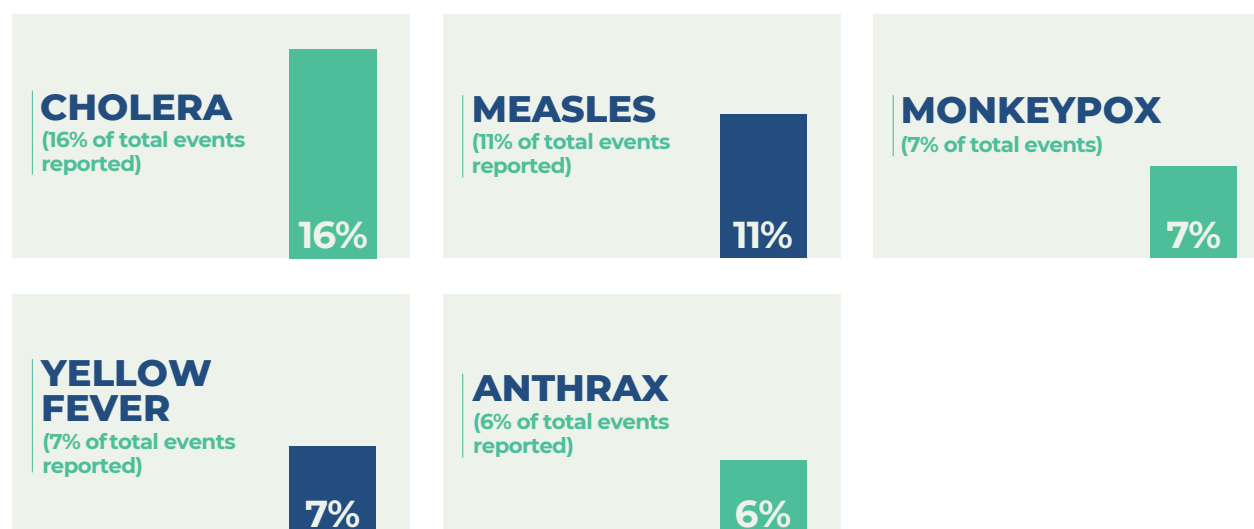
In addition to supporting Member States to respond to the COVID-19 pandemic, the Secretariat continued to closely monitor threats arising from epidemic- and pandemic-prone diseases, and strengthen the implementation of the Integrated Disease Surveillance and Response (IDSR) strategy, which resulted in early detection and effective response to outbreaks in the Region.

Through its field presence in each of the 47 Member States, and the roll-out of the Epidemic Intelligence from Open Sources (EIOS) platform as part of effective IDSR implementation, a total of 130 new public health events were reported between 1 July 2021 and 30 June 2022, with 86.2% (n=112) being infectious disease outbreaks, and 13.8% (n=18) disaster/humanitarian events. In addition to these, 12 humanitarian crises were reported/responded to, all of which were graded events.



The top five acute public health events reported were cholera (16% of total events reported) in 21 countries; measles (11% of total events reported); monkeypox (7% of total events); yellow fever (7% of total events reported); and anthrax (6% of total events reported). Cholera outbreaks were reported in 21 Member States.¹⁷ During the review period, 151 607 cases and 4291 deaths were reported (CFR 2.8%), with 73% of cases and 84% deaths from Nigeria alone. Thirty-seven deaths (CFR 10%) resulted from 200 confirmed and 200 probable cases of yellow fever, with the consequent response resulting in the vaccination of 2.5 million people in three countries.¹⁸ A total of 16 international and national experts were deployed to Member States, with 128 experts trained in yellow fever outbreak investigation and response, final classification algorithm, and preparation of International Coordinating Group (ICG) on Vaccine Provision requests for vaccines.

TOP FIVE ACUTE PUBLIC HEALTH EVENTS REPORTED, JUNE 2021-JUNE 2022



17 Benin, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

18 Cameroon, Chad, Ghana

Of the total of 701 events reported globally during the reporting period, only 88 were graded. The African Region accounted for 67% (n= 58) of all graded emergencies worldwide. WHO supported the response to 45 acute emergencies between July 2021 and June 2022. These ranged from outbreaks of Ebola and Marburg virus diseases, cholera, and yellow fever, to flooding, droughts and fires. In all these acute events, WHO's Incident Management System (IMS), a coordination mechanism, was activated within 48 hours, catalysing WHO emergency procedures and activities to support the management of the response. Close to 1000 experts, comprising staff and consultants, were rapidly deployed, repurposed or recruited to fill critical IMS functions at country level.

In response to multicountry PHEs (cholera, yellow fever and the Sahel crisis), WHO established command centres for cholera response in Lomé (Togo), for yellow fever in Ouagadougou (Burkina Faso), and for the Sahel crisis in Dakar (Senegal). These command centres strengthened coordination by Member States and partners to the response.

WHO also deployed over 100 experts in 11 Member States¹⁹ to strengthen preparedness and response to cholera outbreaks; completed cholera hotspot analyses in 10 Member States²⁰ to inform prevention and response strategies; and supported the development of cholera elimination plans in five Member States²¹ to bring the total to 11 Member States²² with national cholera elimination plans, in accordance with GTFCC guidance. WHO also jointly

facilitated, with the West African Health Organisation (WAHO) and UNICEF, four cross-border collaboration meetings for West African countries; mobilized US\$ 13 million; and trained 120 national and partner organization experts in 13 Member States²³ on cholera readiness. Meanwhile, preventive and reactive campaigns in eight Member States²⁴ resulted in the vaccination of 13 million people from a total 31.9 million vaccines shipped to 10 Member States.²⁵ Outbreaks were brought under control in 14 Member States²⁶ by the end of June 2022.

With increased ownership and national expertise, WHO supported the response to two Ebola outbreaks in the DRC (North Kivu and Equateur Provinces), including the timely delivery of diagnostics, vaccines and treatment to facilitate the vaccination of over 3600 high-risk contacts. While the response to outbreaks has been swift, community compliance with preventive measures, and the early seeking of treatment, still pose a challenge. Cases presenting late to health facilities contribute to a high case fatality ratio.

To ensure a coordinated response to humanitarian emergencies, national health clusters were activated in 12 countries²⁷ to bring together operational partners.

Among the responses to humanitarian crises, the Secretariat mounted a regional response to the Sahel crisis and drought in the Horn of Africa. In the Sahel, an estimated 33.2 million people in six Member States²⁸ needed humanitarian assistance in the first half of 2022, including more than

14 million people experiencing food insecurity at crisis and emergency levels. WHO classified the emergency as a grade 2 public health emergency in March 2022. Contingency Fund for Emergencies (CFE) funding of US\$ 8.3 million was provided to support the WHO response, and a dedicated response coordination team of at least 11 experts (staff and consultants) established in Dakar (Senegal). Through the deployment of emergency health kits and provision of essential health services, over 3.6 million people were reached as of 30 June 2022.



WHO mounted a regional response to the Sahel crisis and drought in the Horn of Africa. In the Sahel, an estimated 33.2 million in six Member States needed humanitarian assistance in the first half of 2022, including more than 14 million people experiencing food insecurity at crisis and emergency levels.

19 Benin, Burundi, DRC, Ethiopia, Kenya, Nigeria, Sierra Leone, South Sudan, United Republic of Tanzania, Zambia, Zimbabwe

20 Benin, Burkina Faso, Cameroon, Chad, Ghana, Mali, Niger, Nigeria, Senegal, South Sudan

21 Benin, Burundi, Nigeria, Sierra Leone, South Sudan

22 Benin, Burundi, DRC, Ethiopia, Kenya, Nigeria, Sierra Leone, South Sudan, United Republic of Tanzania, Zambia, Zimbabwe

23 Benin, Burundi, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, DRC, Mali, Niger, Senegal, Togo

24 Cameroon, DRC, Ethiopia, Niger, Nigeria, South Sudan, Uganda, United Republic of Tanzania

25 Cameroon, DRC, Ethiopia, Malawi, Niger, Nigeria, South Sudan, Uganda, United Republic of Tanzania, Zambia

26 Benin, Burkina Faso, Burundi, Côte d'Ivoire, Ethiopia, Ghana, Mali, Niger, Nigeria, Uganda, Rwanda, Togo, Zambia, Zimbabwe

27 Burkina Faso, Chad, Cameroon, CAR, DRC, Ethiopia, Mali, Madagascar, Mozambique, Nigeria, South Sudan, Niger

28 Burkina Faso, Cameroon, Chad, Mali, Niger, Nigeria

In the Horn of Africa, seven countries were impacted by drought, including Ethiopia, Kenya, South Sudan and Uganda in the African Region, with more than 80 million people threatened with severe food insecurity. These countries were contending with the absence of rains for the fourth consecutive season, making this one of the worst droughts in modern history. WHO classified the drought as a grade 3 public health emergency in May 2022, and established a joint incident management system for the African and Eastern Mediterranean Regions, covering all affected countries. A CFE amount of US\$ 16.5 million was approved to support the WHO response.

Emergency health kits worth more than US\$ 500 000 were subsequently distributed to Member States to strengthen the response. These actions ensured that a population of 2 million affected people received essential health care services, including interventions in respect of trauma care, emergency reproductive health assistance, HIV/AIDS, routine immunizations and mass vaccination campaigns, nutrition screening and referrals/treatment, and support for survivors of gender-based violence.

The delivery of 104 tons of medical supplies, drugs and equipment worth nearly US\$ 1 million to 18 countries²⁹ for preparedness and response to acute health emergencies enhanced rapid response team interventions, improved case management at facility level, and enabled the establishment of severe acute respiratory infections (SARI) treatment centres, screening points and community facilities. These treatment centres enhanced care for COVID-19 patients

and the working conditions of health workers. The provision of 3219 beds to support patient care at COVID-19, Ebola and multi-disease treatment centres in 15³⁰ Member States contributed to the reduction of suffering, and saved lives.

Comprehensive assessments of 23 new and ongoing complex humanitarian crises were conducted, and findings documented in 16 editions of Public Health Situation Analysis. Health Resources Availability Monitoring System (HERAMS) assessments were also conducted in seven Member States³¹ experiencing humanitarian crises, to provide core information on essential health resources and services to enhance planning and delivery of humanitarian assistance.

To identify and address gaps in national plans, the Secretariat supported countries to conduct simulation exercises based on health emergency risk mapping. During the review period, six simulation exercises were conducted in five Member States,³² nine Member States³³ conducted full COVID-19 intra-action reviews (IARs), while 28³⁴ conducted the vaccine-specific IAR. Two IARs of the UN Supply Portal identified gaps in coordination at country level, and lack of visibility and predictability of order status and lead times. Recommendations to address these gaps were initiated, including strengthening coordination at country level through the provision of guidance and tools to support senior managers at country level. Ebola virus disease (EVD) readiness assessments were undertaken in 2021 in high-risk West African Member States, resulting in heightened preparedness that enabled the timely detection of EVD, Lassa fever and Marburg virus disease (the first ever in West Africa) in Guinea.



29 Benin, Burkina Faso, Cameroon, Central African Republic, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Equatorial Guinea, Madagascar, Malawi, Mozambique, Niger, Sierra Leone, Togo, United Republic of Tanzania, Zambia, Zimbabwe

30 Burkina Faso, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gambia, Ghana, Malawi, Mauritius, Nigeria, Sao Tome and Principe, Sierra Leone, Seychelles, United Republic of Tanzania

31 Burkina Faso, Central African Republic, Ethiopia, Mali, Mozambique, Nigeria, Zimbabwe

32 Cameroon, Central African Republic, Guinea-Bissau, Mali, United Republic of Tanzania

33 Benin, Cameroon, Chad, Democratic Republic of the Congo, Madagascar, Mali, Sao Tome and Principe, Seychelles, United Republic of Tanzania

34 Burkina Faso, Cameroon, Central African Republic, Chad, Congo, DRC, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Namibia, Niger, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

Several health emergency information products were produced and widely disseminated to enhance timely monitoring of health emergencies in the Region, and inform public health decisions and actions. Thirty-six editions of the Weekly Bulletin on Outbreaks and Other Emergencies were developed and disseminated to over 7000 subscribers, with onward webcasting to the WHO website and other media platforms. The Weekly Bulletin is a one-stop reference hub for up-to-date and comprehensive information on all public health events in the Region. It has become a key resource for partners and stakeholders, and serves as the Region's contribution to global public health surveillance.

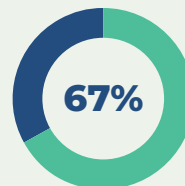
Available statistics showed that the publication has reached an average of 5000 persons per week with average page view of about 1300 per week. The number of citations referencing WHO manuscripts published on COVID-19 and other events in the Region continue to increase.

Ten peer-reviewed scientific papers were published, seven of which focused on characterizing the COVID-19 pandemic in the Region, while three described surveillance business processes. Additionally, 18 editions of the Event Information Site were developed and disseminated through a secure site for national International Health Regulations (IHR) focal points, while 15 editions of Disease Outbreak News were produced for the public. These publications contained essential updates and guidance to enhance detection and response capacities. Available statistics show that these publications are reaching on average 500 people every week, with an average page view of about 1300 per week.

EMERGENCIES/OUTBREAKS REPORTED JUNE 2021-JUNE 2022

Between July 2021
and June 2022

**701 EVENTS
REPORTED
GLOBALLY**



in the
African
Region

+100 EXPERTS

in 11 Member States to
strengthen preparedness
and response to

CHOLERA OUTBREAKS



104 TONS

of medical supplies delivered
to 18 countries for preparedness
and response to acute

HEALTH EMERGENCIES



2.3 STRATEGIC PRIORITIES IN THE COMING YEARS

Following the reports of the IHR Review Committees on the H1N1-2009 pandemic³⁵, the West Africa Ebola Outbreak and Response³⁶, and the functioning of the “International Health Regulations” during the COVID-19 pandemic, which underlined deficiencies in country IHR core capacities as critical factors in exacerbating health emergencies, a number of global commitments were made to address these gaps. These include the involvement of WHO and the Food and Agriculture Organization of the United Nations (FAO) in the Global Health Security Agenda (GHSA)^{37,38} launched in 2014; the Global Preparedness Monitoring Board (GPMB) established in 2018 and comprising high-level independent experts supported by WHO as its Secretariat, for high-level advocacy for preparedness strengthening; the establishment of an Intergovernmental Negotiating Body (INB)³⁹ to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, with a view to adoption under Article 19, or under other provisions of the WHO Constitution as may be deemed appropriate; and the G7 Pact for Pandemic Readiness,⁴⁰ to strengthen global pandemic readiness. These commitments call on Member States to strengthen IHR core capacities.

To guide future efforts, a new Regional strategy for health security and emergencies 2022–2030 has been developed for adoption by the Seventy-second session of the WHO Regional Committee for Africa in August 2022. The strategy is anchored on three flagship initiatives: Promoting Resilience of Systems for Emergencies (PROSE), Transforming Africa’s Surveillance Systems (TASS), and Strengthening and Using Response Groups for Emergencies (SURGE).

“
The Regional strategy for health security and emergencies 2022–2030 is anchored on three flagship initiatives: Promoting Resilience of Systems for Emergencies (PROSE), Transforming Africa’s Surveillance Systems (TASS), and Strengthening and Using Response Groups for Emergencies (SURGE).

2.4 POLIO IN THE WHO AFRICAN REGION: ADVANCES AND CHALLENGES

The polio-free status of the Region, as certified in 2021, was threatened by the detection of wild poliovirus type 1 (WPV1) in Malawi and Mozambique in February and May 2022 respectively. Genetic sequencing indicated that the Malawi and Mozambique cases were linked to a strain from Pakistan, circulating in 2019.

Tellingly, there had been no supplementary immunization campaigns in Malawi and surrounding countries with the bivalent oral polio vaccine, which prevents wild poliovirus type 1, in at least a decade. While an imported case does not impact the Region’s certified status as free of indigenous wild poliovirus, these cases clearly demonstrate that polio anywhere is a threat everywhere, and that continued support is needed to achieve eradication. This underlines the importance of Member States achieving and maintaining optimal immunization coverage and sensitive surveillance to protect children from this preventable disease.

The Secretariat is working with partners to contain the WPV1 importation and prevent it from establishing a local spread. These coordinated responses are happening in the context of ongoing circulating vaccine-derived poliovirus outbreaks (cVDPV, also known as variant poliovirus), as well as the COVID-19 pandemic. While working to stop the transmission of polio and achieve the goal of eradication, WHO is also building on the polio legacy by transitioning the

35 WHO, Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, World Health Organization, 2011 (A64/10)

36 WHO, Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, World Health Organization, 2016 (A69/21)

37 WHO’s work in health emergencies: Strengthening preparedness and Response in Health emergencies – Implementation of the International Health Regulations (2005), World Health Organization, 2021(A74/9)

38 The Global Health Security Agenda (GHSA). (<https://ghsagenda.org/about-the-ghsa/>), accessed 10 June 2022)

39 Decision WHASS2.5, The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response. In: Second special session of the World Health Assembly, Geneva, 29 November – 1 December 2021. Part I: Decisions. Geneva, World Health Organization, 2021 (WHASS2/2021/REC/1)

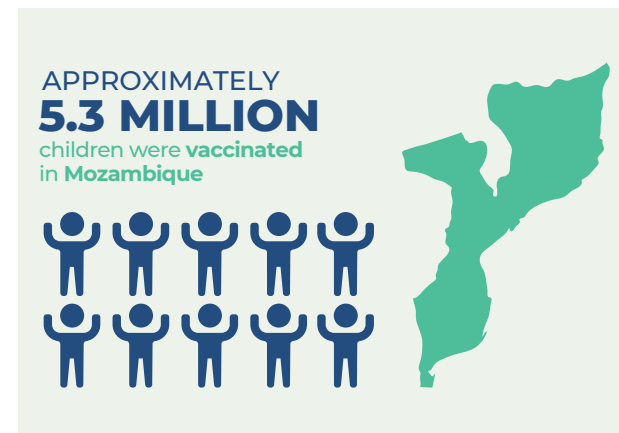
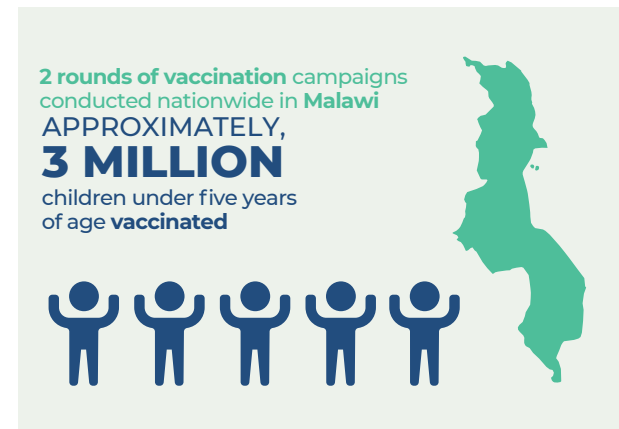
40 G7 Pact for Pandemic Readiness: Concept Note and Health Minister Communiqué. (<https://reliefweb.int/report/world/g7-pact-pandemic-readiness-concept-note-20-may-2022> and <https://www.g7germany.de/resource/blob/974430/2042058/5651daa321517b089cdccaffd1e37a1/2022-05-20-g7-health-ministers-communicue-data.pdf?download=1>, accessed 10 June 2022)

polio structures and assets to support other public health priorities, including routine immunization, surveillance and outbreak response, in an integrated manner.

WHO RESPONSE TO THE WILD POLIOVIRUS TYPE 1 (WPV1) IMPORTATION

WHO's Polio Eradication Programme, in collaboration with Member States and Global Polio Eradication Initiative (GPEI) partners, responded rapidly by deploying a team within 48 hours of the outbreak of WPV1 to Malawi and neighbouring countries deemed to be at high risk, to prevent further spread of the disease. Two rounds of vaccination campaigns were conducted nationwide in Malawi between March and April 2022, reaching approximately 3 million children under five years of age (102% administrative coverage). Mozambique also participated in the coordinated, multicountry campaigns, vaccinating approximately 5.3 million children (111% administrative coverage). In all WPV1 countries, more children were reached than the original target populations, leading to administrative coverage exceeding 100%.⁴¹ Despite high administrative coverage for both campaign rounds, only Tanzania's first round, out of the four countries responding to WPV1, met the target of 80% of districts which passed lot quality assurance surveys (LQAS) independent campaign assessments of quality. This indicator highlights the additional efforts required to ensure high-quality campaigns, which is critical for halting poliovirus transmission, according to the polio guidelines.

The GPEI is actively supporting neighbouring countries⁴² to strengthen disease surveillance, including expanding environmental and acute flaccid paralysis surveillance, and prepare for a further two rounds of polio vaccination campaigns, focusing on improving the quality. Coordinated efforts across Malawi, Mozambique, the United Republic of Tanzania, Zambia and Zimbabwe are aiming to reach 23 million children under the age of five in July 2022.



41 In Malawi 2 975 652 children were reached and the target based on population estimates was 2 922 175. In Mozambique the target population was revised between rounds from 4.2 million to 4.8 million and still over 5.3 million children were reached. Target populations are based on census data which are often extrapolated, leading to an underestimation of the denominator

42 Malawi, Mozambique, United Republic of Tanzania, Zambia, Zimbabwe

RESPONDING TO OUTBREAKS OF CIRCULATING VACCINE-DERIVED POLIOVIRUS (CVDPV)

Between July 2021 and June 2022, more than 400 cVDPV2 cases were reported in nine Member States.⁴³ Response activities supported by WHO and partners resulted in the vaccination of over 142 million children under five years of age during the same time period. The African Region has also taken the global lead in preparedness, introduction and roll-out of the novel oral polio vaccine type 2 (nOPV2), which has been successfully used in 18 African Member States,⁴⁴ with no evidence of seeding of new outbreaks. In this challenging context, WHO recently announced the successful closure of 32 outbreaks at the end of the first quarter of 2022. However, there are ongoing outbreaks, suspected and confirmed, affecting 18 Member States that require the highest level of political commitment to finish the job.⁴⁵

Several contributory factors to the surge in polio outbreaks were identified. These included declining immunity to the type 2 virus among young children, inadequate routine immunization coverage, regional migration patterns, and low-quality immunization campaigns. The COVID-19 pandemic led to a four-month suspension in 2020 of polio campaigns in the majority of Member States. This pause, coupled with related disruptions to routine immunization, led to tens of millions of children not receiving polio vaccines. Additionally, the scaled-down funding for the polio programme exacerbated the already substantial burden on overextended Member States, notably impacting surveillance activities.

POLIO TRANSITION

The polio programme was able to quickly pivot to support the emerging needs of the COVID-19 pandemic response and vaccine roll-out in Africa. In 2021, sixty-one per cent of the polio workforce spent more than 50% of their time on the COVID-19 response and vaccine roll-out. In addition, the polio network continues to support routine immunization strengthening and response to other outbreaks and health emergencies. In line with this cross-cutting capacity established by polio, WHO is continuing its support for the transition of essential functions supported by polio, to greater public health systems. This includes integrating transitioned personnel and leveraging their expertise to enhance multi-disease surveillance and emergency response (Integrated Disease Surveillance and Response) capacities, with a focus on vaccine-preventable disease surveillance.

The Secretariat successfully advocated for additional resources, through the GPEI, for 10 polio high-risk countries⁴⁶, along with a phased approach to the polio transition to integrated functions, which began in 2022. The Secretariat also plans to engage diverse donor agencies, through donor round tables, to raise awareness and resources to address country-specific gaps identified in polio transition plans. Country missions will continue, with progress reports on implementation of transition initiatives compiled, as a basis from which to continue advocating for much-needed outstanding resources.

In 2022, the polio programme's priorities include curtailing outbreaks of wild and variant poliovirus; enhancing acute flaccid paralysis and environmental surveillance; strengthening laboratory sequencing capacity for timely confirmation of cases; sustaining human resource capacity for "last mile efforts"; and applying technology and innovations to improve programme performance. With activities accelerating following the relaxation of COVID-19 restrictions, WHO and partners are poised to ramp up vaccination campaigns, while leveraging technology and innovative solutions to increase campaign impact and surveillance sensitivity. WHO, our partners and Member States, are all committed to halting all forms of polio worldwide.



In 2021, 61% of the polio workforce spent more than 50% of their time on the COVID-19 response and vaccine roll-out. In addition, the polio network continues to support routine immunization strengthening and response to other outbreaks and health emergencies.

43 Cameroon, Congo, DRC, Ethiopia, Guinea-Bissau, Mozambique, Niger, Nigeria, Senegal

44 Benin, Cameroon, CAR, Chad, Congo, Cote d'Ivoire, DRC, Ethiopia, Gambia, Guinea Bissau, Liberia, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Uganda

45 Benin, Cameroon, CAR, Chad, Côte d'Ivoire, DRC, Eritrea, Ghana, Guinea, Madagascar, Malawi, Mauritania, Mozambique, Niger, Togo, United Republic of Tanzania, Zambia, Zimbabwe

46 Angola, Cameroon, Chad, DRC, Ethiopia, Guinea, Kenya, Niger, Nigeria, South Sudan

FEATURE: RAMPING UP COVID-19 VACCINATION IN HARD-TO-REACH COMMUNITIES IN KENYA⁴⁷

“It takes a lot of commitment and resources to vaccinate people living in sparsely populated regions,” says Dr Adam Haji, a WHO medical officer in Kenya. “It is not enough to send them messages; it must be accompanied by a lot of hard work, like driving many kilometres on bad roads to get people vaccinated.”

Lilian Anyango, who lives in poverty in Kisumu County in western Kenya was one of the grateful recipients, after fearing not the myths circulating about the harm the new COVID-19 vaccine could cause, but rather that she would miss out.

In February 2022, WHO supported Kenya’s Ministry of Health with technical and financial support to ramp up COVID-19 vaccination in 11 of the country’s 47 counties with some of the lowest vaccination coverage.

Outreach campaigns were launched in different locations where beneficiaries could be reached, including markets, bus parks and other social settings. Women and youth groups, motorcycle taxi drivers and religious leaders were also engaged to help, along with an association of people living with disabilities and an organization of street families.

In Wajir County in northern Kenya, the campaign delivered messages that were relayed via community radio to reach nomadic herder communities, and vaccination teams set up vaccination stations at watering points. During one campaign in December 2021, all churches and places of worship were used as vaccination posts.

Kenya was able to surpass its target of vaccinating 10 million people by the end of December 2021, with as many as 3 million Kenyans inoculated in the last months of the year alone.



⁴⁷ <https://www.afro.who.int/countries/kenya/news/ramping-covid-19-vaccination-among-kenyas-hard-reach-communities>



CHAPTER 3: SUSTAINING THE DELIVERY OF ESSENTIAL HEALTH SERVICES

The pandemic not only directly caused disability and death, but also diverted human, infrastructural, and financial resources from the health sector, disrupting the delivery of essential health services. It exposed prevailing vulnerabilities in national health systems, reinforcing the nexus between health security and optimally functional health systems, emphasizing the need for concurrent investment in both.

The WHO Global pulse survey conducted an assessment of the impacts of the COVID-19 pandemic on health systems, measured by the magnitude of service disruptions. Three rounds of the pulse survey were conducted: third quarter of 2020, first quarter of 2021, and fourth quarter of 2021. Other programme-level surveys conducted within the period of the pandemic closely mirrored the findings of the Global pulse survey, which received responses from key informants across various levels of national health systems in participating countries across the various rounds, on the status as well as the degree of service disruptions based on selected tracer services and thresholds of disruption.

A report on Maternal and Child health service utilization in 8 countries⁴⁸ indicated disruptions in uptake of Maternal, Newborn and Child Health Services (RMNCH). Further studies which showed disruptions in service utilization as a result of Covid were facility-level studies in 12 countries.

48 Shapira G, Ahmed T, Drouard SHP, et al. Disruptions in maternal and child health service utilization during COVID-19: analysis from eight sub-Saharan African countries. *Health Policy and Planning*. 2021 Aug;36(7):1140-1151. DOI: 10.1093/heapol/czab064. PMID: 34146394; PMCID: PMC8344431.

Information from these from frontline assessment⁴⁹ (48), similarly showed significant disruptions in RMNCH and communicable disease services. The pulse surveys and other evaluations provided critical insights into the impact of the COVID-19 pandemic on essential health services, the challenges faced by national health systems, and strategic actions taken by countries to mitigate the disruptions, revive the delivery of essential health services, and build back better. The results of the pulse surveys enabled coordinated and evidence-based support to Member States by WHO, as well as regional and global partners.

“
An average of 47% of the region experienced disruption of services during the COVID-19 pandemic.”

3.1 IMPACT OF THE COVID-19 PANDEMIC ON ESSENTIAL HEALTH SERVICES

Member States of the WHO African Region reported significant impacts of the COVID-19 pandemic on national health systems, with resultant disruptions in access to, and uptake of essential health services over the last 28 months of the pandemic in the Region. The third quarter of 2020, six months following the onset of the pandemic in the Region, recorded the highest degree of reported service disruptions, with the same pattern replicated across other WHO regions.

According to the pulse survey, partial or complete disruptions were reported on 54% of the 25 tracer indicators of service coverage assessed in the first round in more than two thirds of countries. Ninety-five per cent of the 40 responding countries in the second round still reported varying degrees of disruption in 63 service indicators assessed, with only about 38% of the countries reporting severe or total disruption in at least half of the services assessed. By the third round, 91% (39 of 43) countries reported some extent of disruption in at least one essential health service of the 66 tracer indicators of the services assessed. The regional average disruption of services stood at 47% of services.

Some of the service categories reportedly disrupted were scheduled and unscheduled primary care services such as outpatient consultations, secondary care services such as elective surgeries, as well as rehabilitative and palliative care. Comparatively, there has been a decrease in the percentage of countries reporting different degrees of service disruptions, as well as the number of reported disrupted services and the magnitude of disruptions across the three rounds of the pulse survey. The table below shows a comparative analysis of the numbers and degrees of service disruptions across the rounds of the survey.

	Q3 2020 (Round 1) 30 Countries, 25 services	Q1 2021 (Round 2) 40 countries, 63 services	Q4 2021 (Round 3) 43 countries, 66 tracer services
Average disruption	62%	44%	47%
75 - 100% disruption	49%	6%	17%
50 - 74% disruption	17%	51%	34%
25 - 49% disruption	17%	17%	17%
Less than 25% disruption	9%	20%	26%
No disruption	9%	6%	6%

49 Tracking Universal Health Coverage in the WHO African Region, 2022. WHO | Regional Office for Africa. <https://www.afro.who.int/publications/tracking-universal-health-coverage-who-african-region-2022>. Published 2022. Accessed August 13, 2022.

The reasons for service disruptions included a combination of demand and supply-side factors. The main reasons cited included, among others, population fear of contracting COVID-19 in health facilities; movement restrictions implemented by governments as a measure to contain transmission in the early phases of the pandemic; and health workforce shortages in health facilities. Of these, only health workforce-related challenges were still reported in the last round of the survey in the fourth quarter of 2021.

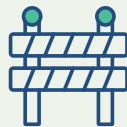
THE REASONS FOR SERVICE DISRUPTIONS INCLUDED A COMBINATION OF DEMAND AND SUPPLY-SIDE FACTORS

POPULATION FEAR OF
CONTRACTING COVID-19
in health facilities

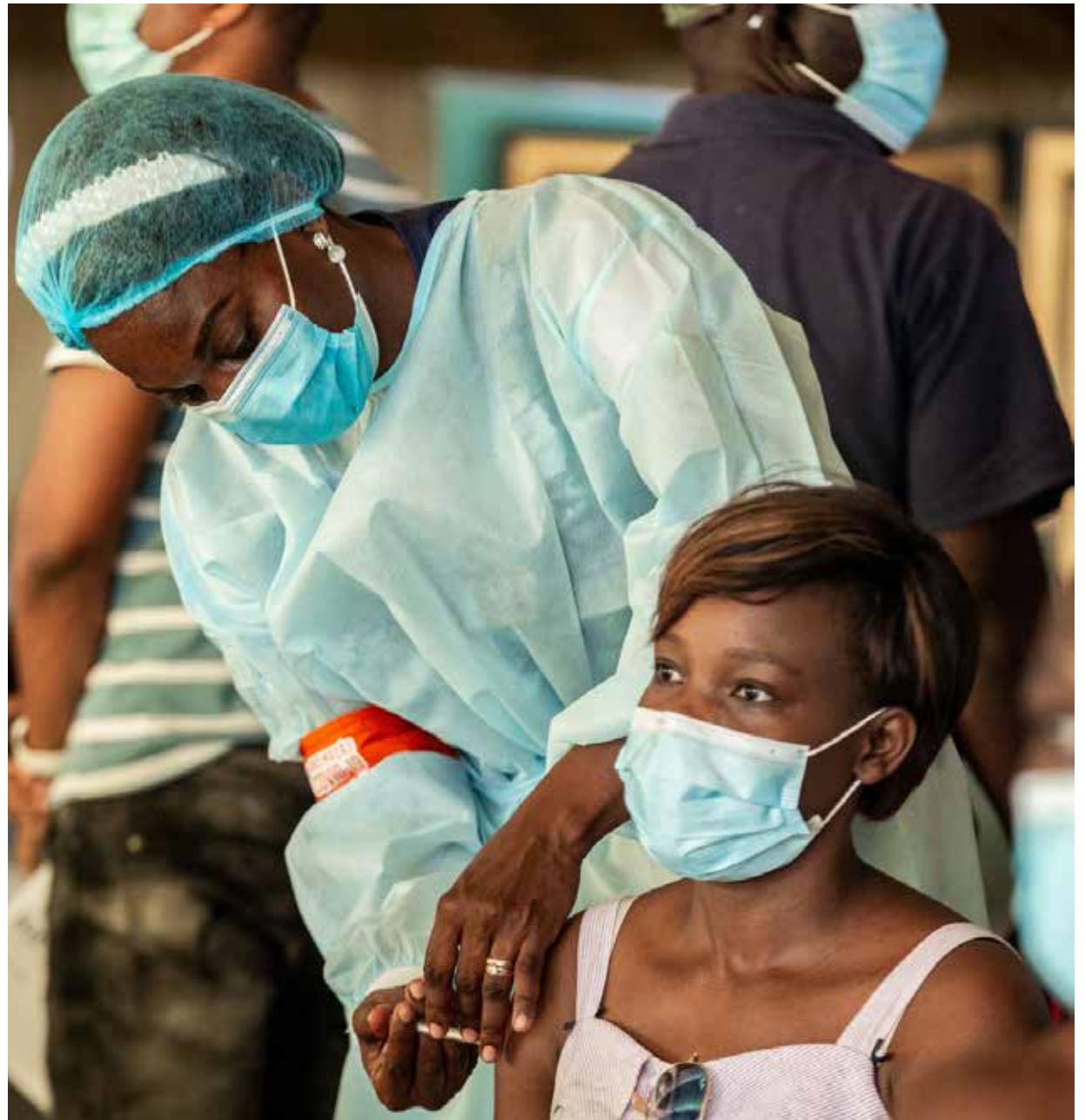


MOVEMENT RESTRICTIONS

IMPLEMENTED BY GOVERNMENTS AS PUBLIC HEALTH AND SOCIAL MEASURES to **contain transmission** in the early phases of the pandemic



HEALTH WORKFORCE
shortages in health facilities



African Region countries have made substantial progress towards reducing COVID-19-related disruptions to the delivery of essential health services. For family planning services, reported disruptions dropped by 39 percentage points (80%), from 71% in Quarter 3 of 2020, to 32% in Quarter 4 of 2021.

There were also substantial drops in the proportion of countries reporting COVID-19-related disruptions to the delivery of antenatal care (by 34 percentage points); to sexual, reproductive, maternal, newborn, child and adolescent health services (by 30 percentage points); and to sick child services (by 28 percentage points). These results reflect far fewer pandemic-related disruptions to the delivery of essential services in Quarter 4 of 2021, compared to Quarter 3 of 2020, but this pace will need to be maintained to fully restore service levels, and advance countries towards achieving Universal Health Coverage.

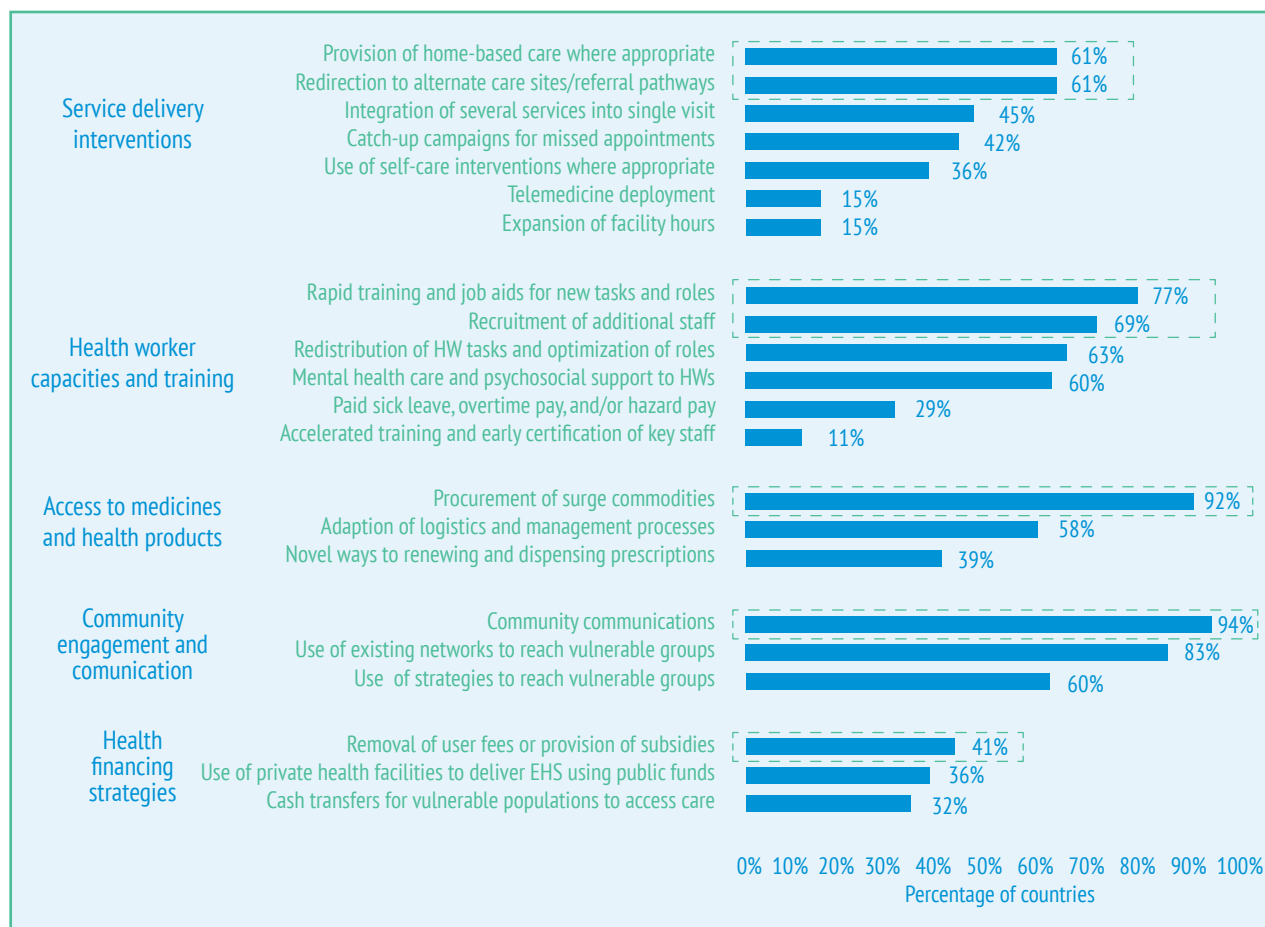
PROPORTION OF COUNTRIES REPORTING DISRUPTIONS TO THE DELIVERY OF ESSENTIAL SERVICES BETWEEN Q3 OF 2020 AND Q4 OF 2021

	Third quarter 2020		Fourth quarter 2021		Absolute difference (A-B) (% points)	% Rate of reduction ($\text{Log}_n(B/A) \times 100$)
	Percent (A)	Number of countries surveyed	Percent (B)	Number of countries surveyed		
Family planning	71	21	32	28	39	-80
Antenatal care	71	21	37	27	34	-65
Sexual, reproductive, maternal, newborn, child and adolescent health care	64	22	34	27	30	-63
Sick child services	64	22	36	25	28	-58
Communicable diseases	63	17	38	26	25	-51
Facility-based births	50	22	32	28	18	-45
Rehabilitation and palliative care	67	18	46	26	21	-38
Cancer care	55	31	38	28	17	-37
Mental, neurological and substance use disorders	67	17	50	19	17	-29
Immunization	68	22	59	32	9	-14
Nutrition services	64	22	52	27	12	-21

3.2 STRATEGIC ACTIONS TO MITIGATE THE IMPACT OF COVID-19 ON THE DELIVERY OF ESSENTIAL HEALTH SERVICES

The results of the pulse surveys guided discussions within the COVID-19 Taskforce and partner briefings in different countries, and the subsequent design of mitigation measures. These mitigation measures taken by countries included enhancing community communications (94% of countries); investing in surge commodities (92%); rapid training and job aids for new roles (77%); and provision of home-based care, where appropriate (61%), as shown in the Figure 2.

FIGURE 2: PERCENTAGE OF COUNTRIES IMPLEMENTING MITIGATION AND RECOVERY ACTIONS (N=38) AS OF 30 JUNE 2022



3.2.1 PEOPLE-CENTRED ADAPTATION OF HEALTH SERVICE GOVERNANCE AND SERVICE DELIVERY PLATFORMS AND STRATEGIES

Efforts launched early in the pandemic towards mitigating the impact of COVID-19 on service provision were sustained during the review period. These included adapted guidance and support, health service delivery models, and health worker capacity building. These were anchored on improved leadership and the use of data for action.

WHO provided guidance and support on sustaining essential health services during the COVID-19 pandemic. The WHO guidelines on maintaining sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) service delivery during COVID-19 were disseminated, and 21 countries⁵⁰ supported to adapt them. WHO in the African Region, UN Population Fund (UNFPA) and UNICEF worked with the World Continuing Education Alliance⁵¹ to build the capacity of midwives and nurses, using a digital learning platform.

Furthermore, WHO developed and disseminated guides targeting the general population and health care workers in response to significant pandemic-related disruptions to the provision of NCD and mental health services.⁵² These included strategies and approaches to ensure continuity, prevent nosocomial and health worker infection at health facilities, and provide critical mental health and psychosocial support (MHPSS). Other examples included the implementation of guidance on malaria⁵³, the distribution of three neglected tropical diseases (NTDs) guidance documents focused on

safely maintaining NTD interventions in the context of the pandemic; and the utilization of a virtual support platform to interact with country managers and stakeholders.

The result of this strategic guidance was sustained delivery of programme- and disease-specific services and interventions, averting expected levels of reversal of disease control gains. For example, although WHO and partners had projected, under a worst-case scenario, a doubling of malaria deaths in sub-Saharan Africa during the pandemic, the 2021 world malaria report documented only an estimated 12% increase in deaths in the Region between 2019 and 2020. The worst-case scenario of malaria deaths projected by WHO was averted through appropriate guidance, and countries mounting an urgent and sustained response.

Health service delivery models were adapted with the aim of ensuring continuity of essential health services during the pandemic. For instance, facility-based delivery of health services was adapted to ensure strict compliance with COVID-19 public health measures, by both health workers and their clients. Home-based delivery of essential health services was adopted by many Member States.

Special strategies were implemented in the area of routine immunization. Seven other countries⁵⁴ were supported to implement the “Identify, Reach, Monitor, Measure and Advocate” (IRMMA) framework for reducing the number of “zero-dose” children and missed communities. In the same vein, nine countries⁵⁵ were supported to implement strategies for reducing the number of under-immunized children.



50 Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, DRC, Gabon, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Nigeria, Senegal, Sierra Leone, Togo, Zambia, Zimbabwe

51 A technology company

52 [COVID-19 - QUESTIONS AND ANSWERS ON COVID-19 - All Documents \(sharepoint.com\)](https://www.who.int/publications/m/item/covid-19-questions-and-answers-on-covid-19-all-documents)

53 Tailoring of malaria interventions in the context of COVID-19 (<https://www.who.int/publications/m/item/tailoring-malaria-interventions-in-the-covid-19-response>)

54 Burundi, Cameroon, Central African Republic, Chad, Congo, DRC, Sao Tome and Principe

55 Burundi, Cameroon, Chad, Equatorial Guinea, Gabon, Sao Tome and Principe, Kenya, Uganda, Zimbabwe

Health worker capacity was also strengthened to improve the quality and coverage of essential health services. With a view to strengthening the health workforce, WHO published the State of the Health Workforce in the African Region 2021⁵⁶, a regional guide for determining staffing norms and standards for health facilities, and regional threshold densities for attaining UHC. In furtherance of home-based health service delivery, front-line health workers were prioritized for training, vaccination and supply of PPEs and other commodities. Systems were put in place for making surge commodities available, so averting massive disruptions in the supply management system in Member States. Between February 2021 and March 2022, training on maternal and perinatal death surveillance and response, medical certification of cause of death, and labour care guidance was delivered to 56 900 nurses and midwives. This provided the foundation for improving information and care for mothers and babies. It is expected that there will be better assigning of standardized cause of death for maternal and perinatal cases, which will guide appropriate response measures. Additionally, more than 3150 health care workers were trained on noma and in the continuity of essential oral health services, using digital technologies and platforms.

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WHO published the State of the Health Workforce in the African Region 2021, a regional guide for determining staffing norms and standards for health facilities, and regional threshold densities for attaining UHC.

56 900 NURSES AND MIDWIVES TRAINED

on **maternal and perinatal death surveillance and response, medical certification of cause of death, and labour care guidance** in the Region.



⁵⁶ <https://apps.who.int/iris/bitstream/handle/10665/348855/9789290234555-eng.pdf?sequence=1&isAllowed=y>



Investment in improved leadership and coordination. Nine countries⁵⁷ were assisted to revise their national health policies and legal frameworks to support a stronger commitment to accommodate emerging technologies and local manufacturing of medicines and vaccines. Twenty-one countries⁵⁸ were supported to revise their national health strategic plans (NHSPs) to enable them to prioritize the COVID-19 response, while maintaining uninterrupted essential health service delivery. This included strategies to improve sector coordination to advance countries towards integrated health service delivery, improved community engagement, and identifying needs for effective resource mobilization.

Improved use of data for action was central. The Regional Office has enhanced its health intelligence focus to make information available for decision-making. In November 2021, available data and statistics underwent a verification process, involving ministries of health and national statistics offices from all African Region countries. Analyses were conducted to generate Member State-specific information.

To improve efficient and accurate collection and reporting of mortality data, five countries⁵⁹ were supported to deploy the electronic tool for medical certification of cause of death. Four other countries⁶⁰ received training to implement

International Classification of Diseases (ICD)-compliant medical cause-of-death certification. Eswatini was supported to develop a civil registration and vital statistics (CRVS) strategic plan, and six other countries⁶¹ to update from ICD-10 to ICD-11. These efforts are expected to assist countries to establish systems for collection, transmission and analysis of mortality data, thereby allowing for updated mortality patterns to guide interventions and response measures.

57 Burkina Faso, Côte d'Ivoire, Eritrea, Gabon, Ghana, Kenya, Uganda, Senegal, South Africa

58 Benin (MTR), Burkina Faso, Botswana (MTR), Congo, Côte d'Ivoire, Eritrea, Eswatini (MTR), Ethiopia, Ghana, Mauritania, Niger, Nigeria (HRH), Senegal (CH Plan), Togo (HWF), Zimbabwe, ongoing in Algeria, Cameroon, Gambia, Malawi, Rwanda (MTR), United Republic of Tanzania

59 Botswana, Kenya, Mauritania, Namibia, Uganda

60 Burundi, DRC, Gabon, Mauritania

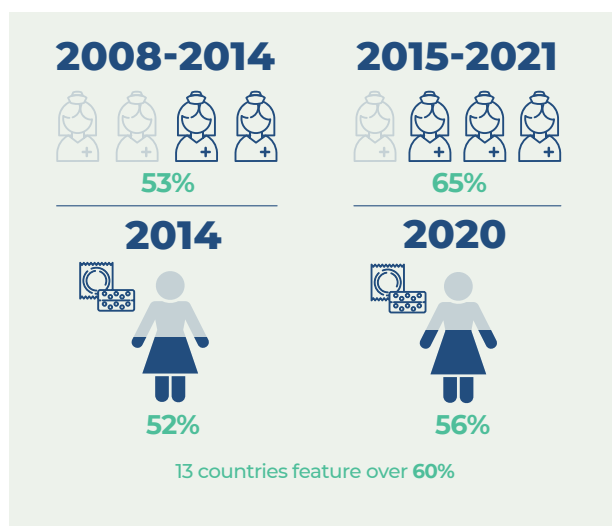
61 Eswatini, Ghana, Kenya, Namibia, United Republic of Tanzania, Uganda

3.2.2 ADVANCING PROVISION OF ESSENTIAL SERVICES TO TARGETED POPULATIONS

Enhancing service delivery coverage and quality for priority populations was the central focus of investments during the review period.

Service delivery for women. Strategic actions were taken to enhance access to quality essential health services for improved health across the life course, as part of efforts to attain UHC. Skilled birth attendance in the African Region increased from 53% (2008–2014) to 65% (2015–2021).⁶²

IMPROVED SERVICE DELIVERY FOR WOMEN



The proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods in the African Region increased from 52% in 2014 to 56% in 2020⁶³, with 13 countries⁶⁴ having a performance of more than 60%.

Service delivery for children. To enhance multisectoral coordination and partnerships for child health, WHO partnered with the African Union (AU) to incorporate early childhood development (ECD) into its Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA-plus). Building on the guidance on standards for improving the quality of care for children and young adolescents, and standards for improving the quality of care for small and sick newborns, 17 countries⁶⁵ were assisted to conduct facility-based paediatric death audits (PDA) and mortality reviews. Subsequently, nine countries⁶⁶ have adapted and integrated the standards and the PDA guidelines into their existing structures and processes.

Service delivery for adolescents. Pursuant to the WHO Africa's Adolescent Health Flagship Programme, an evaluation of the Eastern and Southern Africa Commitment on Education, Health and Well-being of Adolescents and Young People was conducted. The outcome resulted in a recommitment in December 2021, endorsed by Ministers of Education, Health, Gender and Youth from East and Southern Africa. In addition, 10 countries⁶⁷ were supported to establish an accreditation system for adolescent- and youth-friendly services, capacitating national authorities to assess 7910 health facilities. This resulted in 5532 of the health facilities being certified as adolescent- and youth-friendly.

Service delivery to older persons. To address the health and social implications of the rapidly growing older population in the African Region, African ministers of health endorsed a regional framework for implementing the priority actions of the Global plan of action for the decade of healthy ageing 2021-2030. In 2021, the Secretariat assessed the progress made in implementing the healthy ageing priority interventions. On average, 85% of countries received guidance in integrated care for older persons; 57% put in place a mechanism or developed a national strategy on healthy ageing; 40% have national focal points dedicated to healthy ageing; 40% have established or designated multidisciplinary coordination committees; 23% have established or are putting in place long-term care policies; while 11% have started on processes to create age-friendly environments.

Some efforts and practices in countries made a significant difference in older people's lives during the COVID-19 pandemic. In the countries where government ministries collaborated with relevant stakeholders to address the specific needs of older people, they continued to receive pensions during the pandemic to mitigate the economic impact of COVID-19. Likewise, countries with existing social protection for older people were better equipped in their response.

62 UNICEF WHO joint global dataset on skilled attendance at birth (compiled in WHO Global Health Observatory)

63 UN DESA Population Division, Estimates of Family Planning indicators 2021 (compiled in WHO Global Health Observatory)

64 Algeria, Cabo Verde, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Namibia, Rwanda, South Africa, Zambia, Zimbabwe

65 Botswana, Burkina Faso, Central African Republic, Côte d'Ivoire, Eswatini, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

66 Ethiopia, Ghana, Kenya, Nigeria, Rwanda, Sierra Leone, United Republic of Tanzania, Uganda, Zambia

67 Cameroon, Côte d'Ivoire, DRC, Ethiopia, Malawi, Mozambique, Nigeria, Sierra Leone, South Africa, Zimbabwe

3.2.3 HEALTH INTERVENTIONS TO ADVANCE EXPANDED COVERAGE FOR PRIORITY COMMUNICABLE AND NONCOMMUNICABLE DISEASES

During the year under review, disease control investments focused on sustaining the gains of the last two decades. For that purpose, the use of data was mainstreamed in guiding the targeting of communicable disease interventions, so enhancing efficiency and impact.

For instance, through the setting up of ESPEN, data was used to prioritize communities for mass drug administration. Targeting specific neglected tropical diseases (NTDs) has resulted in remarkable progress as four countries⁶⁸ were validated for the elimination of human African trypanosomiasis (HAT). All countries, except for Comoros, have eradicated leprosy as a public health problem. Gambia and Ghana were validated for the elimination of trachoma, while Malawi and Togo were validated for the elimination of lymphatic filariasis as a public health problem. Togo has submitted its trachoma elimination dossier for validation.

The use of data has also become the norm in malaria elimination. Stratification of the malaria burden and tailoring of interventions were mainstreamed in the 10 high burden to high impact (HBHI) countries⁶⁹ of the Region. The countries were supported by WHO to prioritize districts, adopt problem-solving approaches in defining a package of interventions for each stratum of districts, and target them appropriately. This was the major factor that contributed to averting the predicted COVID-19 related reversal of the malaria gains of the 2005–2015 decade.

The disruptions during COVID-19, which included other contextual challenges such as flooding and conflict, resulted in an estimated 47 000 more global deaths from malaria in 2020 than in 2019. This was much lower than the projected doubling of malaria deaths, according to the worst-case scenario for COVID-19-related service disruptions. Most Member States maintained the majority of malaria services, and the SADC Malaria Elimination 8 initiative, the East African Community's Great Lakes Malaria Initiative and WAHO's Sahel Malaria initiative still undertook cross-border coordination activities.

In response to the flattening of malaria incidence and mortality reduction (ongoing since 2015), the Rethinking Malaria process was initiated in collaboration with partners, and included the convening of selected African social and public health thought leaders to assess the situation and advise on the way forward.

In the same vein, access to HIV interventions was relatively sustained, with HIV testing and treatment coverage showing improvement. The proportion of people living with HIV who know their status improved from 87% in 2019 to 89% in 2020 in East and Southern Africa, which have the highest HIV prevalence in the Region, and from 69% in 2019 to 77% in 2020 in West Africa. Likewise, the proportion of people living with HIV who are receiving antiretroviral therapy improved from 73% in 2019 to 77% in 2020 in East and Southern Africa, and from 61% in 2019 to 73% in 2020 in West Africa, as a result of the WHO-led West and Central Africa catch-up initiative.

While this level of coverage for testing and treatment missed the 90% target for 2020, it is nonetheless encouraging. Further improvement is expected in the next few years as there is now universal use of differentiated service models, as well as optimized treatment using more efficacious and tolerable regimens. Combination prevention interventions are being deployed, including antiretroviral medicines used as pre-exposure prophylaxis (PrEP), voluntary male medical circumcision (VMMC), behaviour change interventions targeting reductions in the number of sexual partners, and increased treatment of people living with HIV to reduce viral load and prevent onward transmission.

Progress towards elimination of mother-to-child transmission (MTCT) of HIV included up to 90% of pregnant women living with HIV in many East and Southern African countries of the Region being reached with PMTCT services. Botswana became the first high-burden country to be certified by WHO for achieving an important milestone on the path to eliminating MTCT, namely the “silver tier” status, which moves the country closer to elimination. Nine other countries⁷⁰ are close to achieving the milestones of an HIV MTCT rate of less than 5% and new paediatric HIV infections due to MTCT of less than 50 per 100 000 live births.

68 Benin, Equatorial Guinea, Rwanda, Uganda

69 Burkina Faso, Cameroon, DRC, Ghana, Mali, Mozambique, Niger, Nigeria, Uganda, United Republic of Tanzania

70 Botswana, Cabo Verde, Eswatini, Namibia, Malawi, Rwanda, Seychelles, Uganda, Zimbabwe

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Botswana became the first high-burden country to be certified by WHO for achieving an important milestone on the path to eliminating MTCT, namely the “silver tier” status, which moves the country closer to elimination.



The burden of sexually transmitted infections (STIs) remains high, with about 374 million curable STIs acquired every year globally, 91 million of them in Africa. Antimicrobial resistance (AMR) to the last-line treatment of *Neisseria gonorrhoeae* has been documented in a few African countries. There is ongoing implementation of the Enhanced Gonococcal Antimicrobial Surveillance Programme (EGASP) in five countries.⁷¹ South Africa has a functional system to monitor AMR to gonorrhoea. Eight countries⁷² updated their national STI case management guidelines towards eliminating MTCT of syphilis. South Sudan is modelling STI integration into primary health care.

To address inequitable access to cancer prevention and control, WHO implemented three major global cancer initiatives⁷³ to sustain and accelerate the elimination of cervical cancer as a public health problem in the Region, and to improve childhood cancer survival rates through the implementation of the Global Initiative for Childhood Cancer (GICC). By the end of the review period, 11 countries⁷⁴ had been supported to switch to the recommended high-performance screening test for cervical cancer. Kenya was implementing a community-based HPV test using community health workers, and Liberia had established the first public sector cervical cancer screening and

breast cancer early detection clinics, with WHO support. Under the Global Initiative for Childhood Cancer (GICC), Zambia and Ghana developed country-specific treatment guidelines and established hospital-based paediatric registries. The Director-General's Special Initiative for Mental Health was implemented in two Member States.⁷⁵ Kenya, Uganda and Zimbabwe developed mental health investment cases in partnership with the UN Interagency Task Force on Noncommunicable Diseases (NCDs). In addition, three countries⁷⁶ implemented the Quality Rights initiative, which aims to ensure that mental health care is anchored in human rights, and is recovery-oriented.

71 Cote d'Ivoire, Malawi, South Africa, Uganda, Zimbabwe

72 Botswana, Cameroon, Eswatini, Ethiopia, Ghana, Kenya, Rwanda, Sierra Leone

73 WHO Global initiative for Childhood cancer (GICC) <https://www.who.int/docs/default-source/documents/health-topics/cancer/who-childhood-cancer-overview-booklet.pdf>: Cervical Cancer Elimination Initiative <https://www.who.int/initiatives/cervical-cancer-elimination-initiative> and The Global Breast Cancer Initiative- https://cdn.who.int/media/docs/default-source/documents/health-topics/cancer/the-global-breast-cancer-initiative.pdf?sfvrsn=b1192ada_18&download=true

74 Botswana, Burkina Faso, Cote d'Ivoire, Kenya, Malawi, Rwanda, Senegal, South Africa, Uganda, Zambia

75 Ghana, Zimbabwe

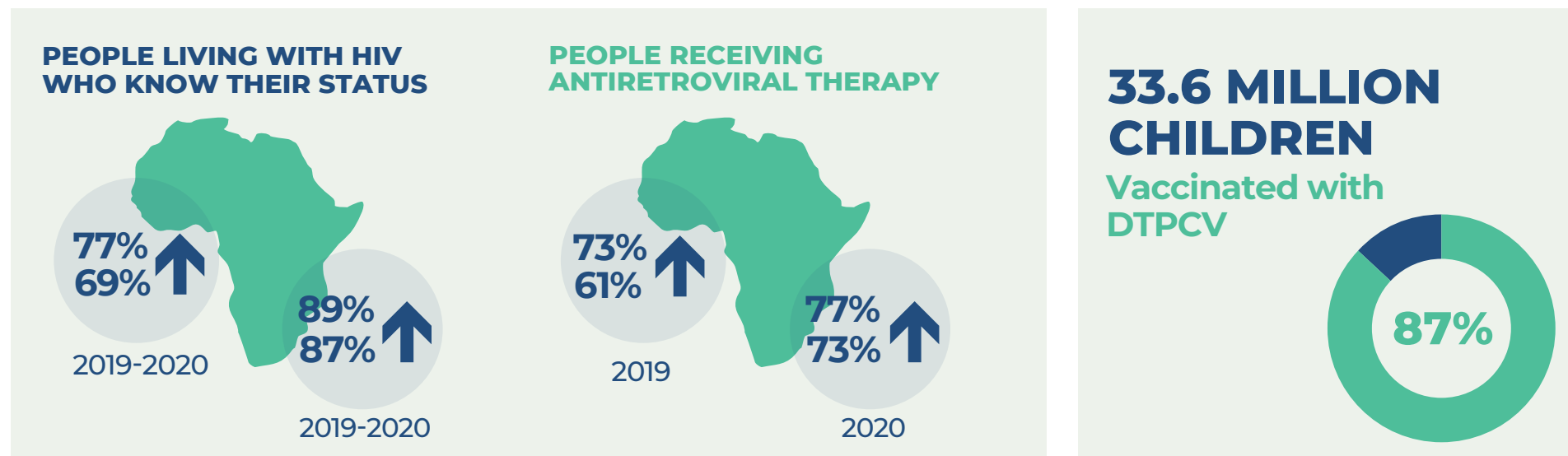
76 Ghana, Kenya, Zimbabwe

Uganda became the first country globally to implement the SAFER Initiative⁷⁷, using the road map developed in 2021. Mental health and psychosocial support was provided in three countries⁷⁸ in response to grade 3 humanitarian crises, and to all countries in response to COVID-19. Three countries⁷⁹ integrated mental health into NCD multisectoral plans to increase service coverage at primary health care level.

During the reporting period, routine immunization focused on sustaining the gains made, although the targets were not fully achieved. In 2021, out of a total target population of 38.4 million in the Region, 33.6 million children received the three doses of DTPCV (diphtheria, tetanus, pertussis-containing vaccine), achieving coverage of 87%. Also, 32.1 million children received the first dose of the measles

vaccine, a coverage of 84%, which is below the target of 90% for all antigens. The result is a 2.5% increase in the number of under-immunized children in the Region, from 2 137 810 in 2020, to 2 192 274 in 2021, although 18 countries⁸⁰ reported a reduction in the number of under-immunized children. (See the Figure 3.)

HEALTH INTERVENTIONS TO ADVANCE EXPANDED COVERAGE FOR PRIORITY COMMUNICABLE AND NONCOMMUNICABLE DISEASES



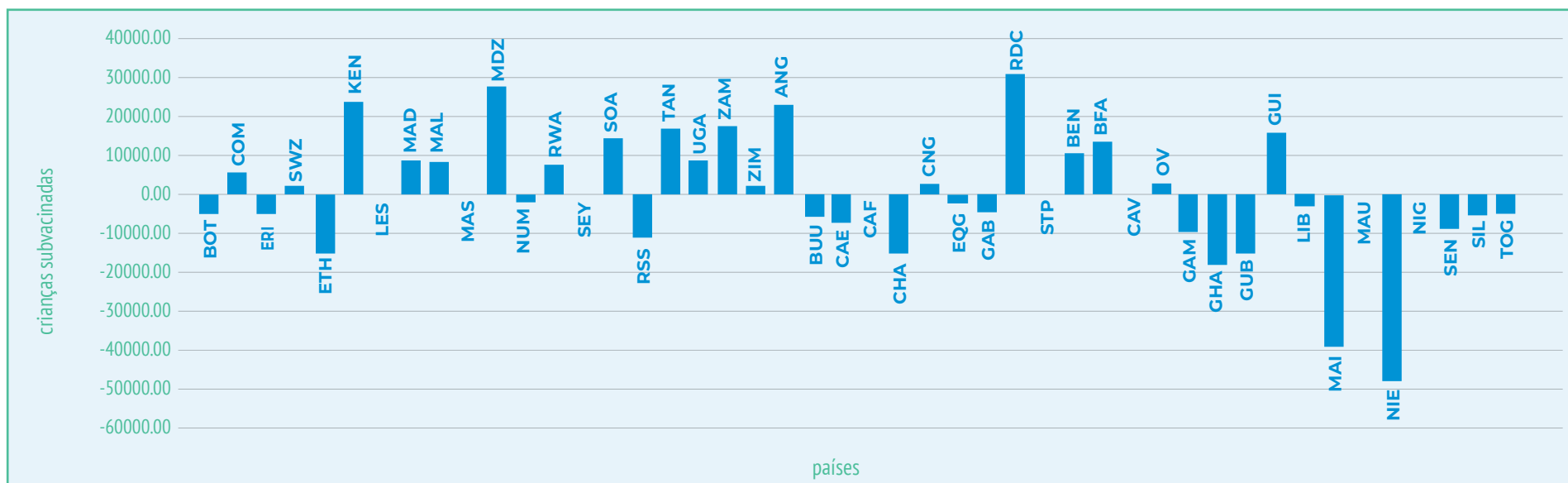
⁷⁷ <https://www.who.int/initiatives/SAFER>

⁷⁸ Ethiopia, North East Nigeria, South Sudan

⁷⁹ Ethiopia, Ghana, Nigeria

⁸⁰ Botswana, Burundi, Central African Republic, Chad, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Liberia, Mauritania, Mauritius, Nigeria, Namibia, Sao Tome and Principe, Senegal, South Sudan, Togo

FIGURE 3: EVOLUTION OF UNDER-IMMUNIZED CHILDREN IN COUNTRIES OF THE WHO AFRICAN REGION IN 2021



The underperformance of national immunization systems in the Region during the period under review is generally attributed to the service delivery disruptions associated with the COVID-19 pandemic, especially the shift in focus and resources to rolling out COVID-19 vaccination. In addition to supporting routine immunization in the Region with normative guidance and training materials adapted to ensure compliance with COVID-19 protocols, similar support was provided for measles mass vaccination campaigns in 11 countries.⁸¹ The result was that over 100% of the targeted 14 210 898 children were reached with life-saving vaccines.

“
Measles mass vaccination campaigns in 11 countries resulted in 14 210 898 targeted children being reached with life-saving vaccines.”

The RTS,S malaria vaccine pilot implementation continued in Ghana, Kenya and Malawi. In October 2021, WHO recommended wider use of the vaccine among children starting from 5 months of age, in moderate- to high-transmission settings. This recommendation was made official through the WHO position paper published on 4 March 2022. The position paper detailed the recommendation that the vaccine be used for the prevention of *Plasmodium falciparum* malaria in children living in regions with moderate to high malaria transmission, as defined by WHO, and should be provided in a four-dose schedule in children from 5 months of age. Subsequently, the WHO guidelines for malaria were updated to include the vaccine as one of the tools to fight the disease, and WHO received the manufacturer’s dossier for prequalification of the vaccine.

81 Botswana, Cameroon, Chad, Comoros, Cote d’Ivoire, Eswatini, Kenya, Niger, Nigeria, Senegal, South Sudan

Following the WHO recommendation for wider use, the Gavi Board met in December 2021 and approved the establishment of the malaria vaccine programme at Gavi. The Board approved an initial investment of US\$ 155.7 million for the programme during the period 2022–2025. In addition, the funding for the expansion of the vaccine into comparator areas of the pilot programme was secured from GiveWell and Open Philanthropies (about US\$ 5 million). The three pilot countries,⁸² which started administration in 2019, have started developing plans for this expansion.

Plans are under way to introduce the vaccine more broadly, after about 23⁸³ countries outside of the pilot programme expressed interest in introducing RTS'S. However, limited supply remains problematic at an estimated 15 million doses per year during the short to medium term (4–6 years), against the need for an estimated 80 million to 100 million doses per year at a steady rate.

Consequently, a framework was developed to guide allocation of the limited supply of the vaccine to countries. The framework will ensure equitable and fair of the limited vaccine supply to eligible countries. Also, guidelines have been developed to enable countries to apply for support from the Gavi malaria vaccine programme. A series of workshops are ongoing to support countries to prepare their proposals for submission to Gavi.

FEATURE: FIGHT TO END MOTHER-TO-CHILD TRANSMISSION OF HIV IN GUINEA⁸⁴

It is thanks to WHO-supported differentiated antiretroviral delivery models for stable HIV patients with suppressed viral loads that Rama, a Guinean mother, has seen her second child grow to the age of 13 years, in excellent health, and living an HIV-free life.

She did not know her status when she gave birth to her first child, but “in the case of my second child, the doctor explained that it was entirely possible to have a healthy, HIV-negative child if one takes the medicine faithfully”.

They are the face of Guinea’s fight to end mother-to-child transmission of HIV, with WHO supporting the Government to accelerate HIV elimination and boost paediatric HIV treatment.

With WHO’s guidance, Guinea has developed the ‘R3M’ (third-month appointment) and ‘R6M’ (sixth-month appointment) differentiated antiretroviral delivery models. The strategies are designed to maintain treatment, while lowering costs, reducing provider workload, and improving service quality.

In the three years to 2021, Guinea increased the number of PMTCT centres at which pregnant women and their children are offered free antiretroviral medication, from 357 to 487.

A 2021 report by the country’s National AIDS and Hepatitis Prevention Programme indicates that of 2252 children tested for HIV between 1 January and 31 December 2021, ninety-three per cent tested negative – up from 91% in 2020.

“At the centres, people living with HIV are treated following WHO recommendations, aimed at guaranteeing essential aspects such as the quality of screening tests, viral load and surveillance,” says Dr Casimir Manengu, acting WHO Representative in Guinea.

“Each time I look at him, I’m amazed,” says Rama.

82 Kenya, Ghana, and Malawi

83 Angola, Benin, Burundi, Burkina Faso, Cameroon, Central African Republic, Côte d’Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Guinea, Guinea-Bissau, Liberia, Madagascar, Mali, Mozambique, Niger, Nigeria, Sierra Leone, South Sudan, Togo, Uganda, Zambia, Zimbabwe

84 <https://www.afro.who.int/countries/guinea/news/guinea-fight-end-mother-child-hiv-transmission>



CHAPTER 4:
**COMBATING
ANTIMICROBIAL
RESISTANCE,
DEVELOPING REGIONAL
DIAGNOSTIC AND
LABORATORY SYSTEMS,
AND INNOVATION FOR
HEALTH IMPACT**



4.1 COMBATING ANTIMICROBIAL RESISTANCE (AMR)

Antimicrobial resistance (AMR), which currently accounts for more than 700 000 deaths annually, is a global threat that stands to negatively impact the overall development of our Member States if nothing is done. AMR threatens the existing medicines supply chain that is essential for treating diseases responsible for the high disease burden, and has the capacity to push up mortality and high cost of management in Africa.

The AMR programme in the Regional Office is guided by six key strategic areas: surveillance systems including laboratory capacity; infection prevention and control (IPC); optimizing the use of antimicrobial medicines; AMR awareness and education; research capacity for evidence-based policies and practices; and multisectoral coordination and partnership. An investment case for AMR action has argued that investment in AMR stands to yield some of the greatest benefits with regard to the Sustainable Development Goals. Furthermore, costed and budgeted AMR national plans increase the possibility for effective resource mobilization and sustainable interventions for long-term impact.

Over the past five years, there has been a notable increase in the number of countries that have developed NAPs and are implementing AMR actions. As of June 2022, eighty-one per cent of countries in the African Region had developed such NAPs, in line with the One Health approach. Seven⁸⁵ countries developed and approved their multisectoral national AMR plans, bringing the total number of countries with endorsed plans to 29. Five countries⁸⁶ were supported to submit proposals to the Multipartner Trust Fund and received up to US\$ 1 million each to support implementation of NAP activities in the human, animal and environmental sectors. A costing and budgeting tool for AMR NAPs, which was successfully piloted in Sierra Leone, was officially launched for use by the whole Region.⁸⁷

WHO, in collaboration with FAO and the World Organisation for Animal Health (OIE), supported 41 countries to undertake Tripartite AMR Country Self-Assessments (TrACSS) to monitor the progress of NAP implementation. This served as the basis for an updated regional report and country profiles on the status of AMR plans in the health sector in the Region. AMR/use surveillance has expanded significantly. To date, a total of 33 African Region countries⁸⁸ are enrolled in the Global AMR and Use Surveillance System (GLASS).

85 Eritrea, Eswatini, Namibia, Rwanda, Senegal, Togo, Uganda

86 Ethiopia, Ghana, Kenya, Senegal, Zimbabwe

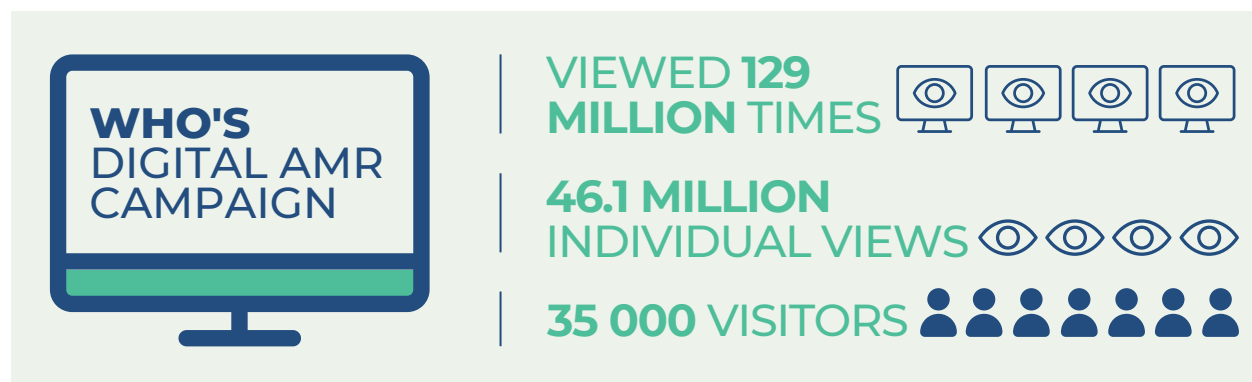
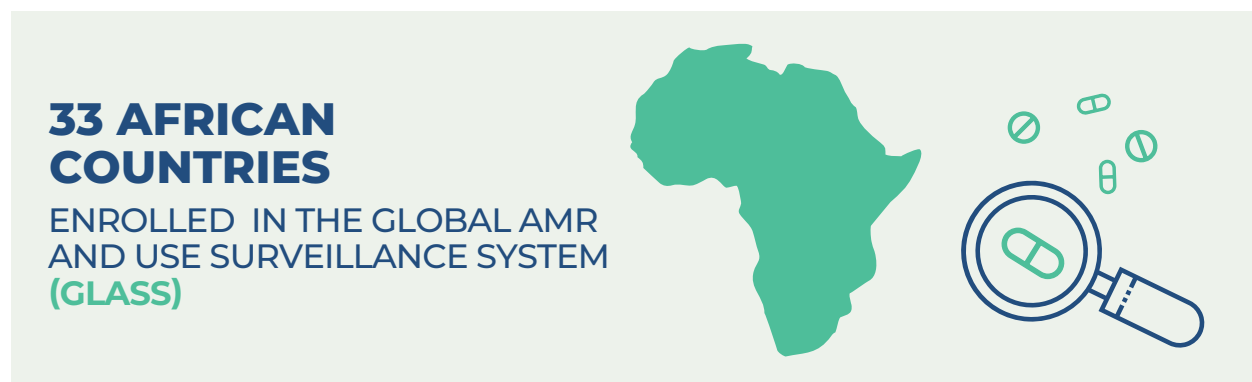
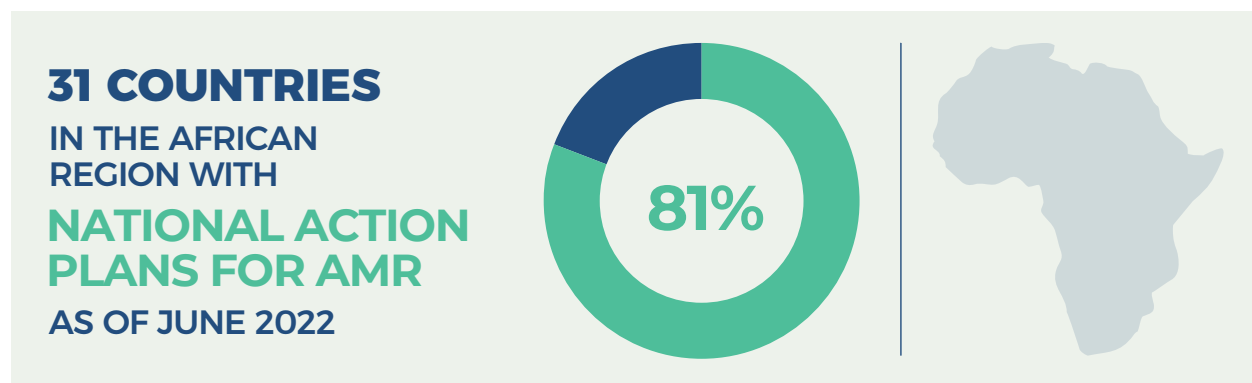
87 [Webinar: Launch of the WHO Costing and Budgeting Tool for National Action Plans on Antimicrobial Resistance & Lessons Learned from Africa](#)

88 Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

Awareness, education and understanding of AMR is central to behaviour change, and our approach to handling antimicrobials within our communities. To enhance awareness and understanding of AMR, the third continental World Antimicrobial Awareness Week⁸⁹ (WAAW), themed “AMR governance: Preventing AMR is our shared responsibility”, was observed at continental level with partners of the Quadripartite (FAO, OIE, WHO and the UN Environment Programme) and AU/Africa CDC. Five countries⁹⁰ were supported to develop context-based AMR awareness materials and campaigns during the WAAW 2021. Within the same period, WHO completed the roll-out of its digital AMR campaign, which was viewed over 129 million times and received over 46.1 million individual views, with the AMR campaign website⁹¹ receiving over 35 000 visitors.

Capacity building activities included providing strategic, technical and financial support to four countries.⁹² For instance, WHO finalized the review of Benin’s AMR Surveillance plan; provided technical and financial support to Nigeria for the implementation of AMS activities; and supported Comoros, the DRC and Togo with training. Interventions to optimize the use of antimicrobials are critical to safeguarding their long-term effectiveness. To this end, an AMR guidance document and aide memoire were piloted in Zambia and Uganda, with the aim of mainstreaming AMR stewardship into manufacturing and medical product regulatory inspections.

COMBATING ANTIMICROBIAL RESISTANCE (AMR)



89 [Directors of Africa Regional Institutions for the Continental World Antimicrobial Awareness Week 2021 - Preventing Antimicrobial Resistance \(AMR\) is Our Shared Responsibility](#)

90 Burkina Faso, Burundi, Cameroon, Zambia, Zimbabwe

91 [AMR campaign website](#)

92 Benin, Burundi, DRC, Mali



4.2 STRENGTHENING REGIONAL DIAGNOSTIC AND LABORATORY SYSTEMS

The Secretariat stepped up its efforts to strengthen laboratory systems and diagnostics, not only for surveillance during epidemics and pandemics, but also to contribute to the delivery of routine care services by national health systems.

The COVID-19 pandemic placed unprecedented pressure on health systems, highlighting the critical role of laboratories and laboratory testing. Deficiencies in laboratory capacity have resulted in ambitious programmes to invest in strengthening diagnostic laboratory services for clinical care, emergencies and research. Laboratory capacity for the detection and prevention of, and response to epidemic- and

pandemic-prone diseases, was significantly strengthened at regional and national levels. For example, during the early part of 2020, only two laboratories in the Region had the capacity to diagnose COVID-19. By March 2022, a total of 1000 laboratories in all Member States had the capacity to do so, as well as to perform PCR tests for better detection of other epidemic- and pandemic-prone diseases.

To maintain the quality of detection, more than 225 laboratories participated in COVID-19 external quality assurance (EQA) exercises. Sequencing networks were also established in the Region, including three specialized laboratories in South Africa (two) and Nigeria, and regional reference laboratories in DRC, Gabon, Ghana, Kenya, Morocco, Senegal, South Africa and Uganda. They are supporting laboratories in their respective subregions to sequence COVID-19 genomes and to establish DNA sequencing. The WHO Secretariat is also supporting countries to implement laboratory quality control systems

and biosafety and biosecurity measures, to ensure adequate systems for referral and transport of infectious specimens to collaborating centres.

Laboratory capacity was also strengthened for detecting other events, such as malaria, yellow fever and cholera. Strengthening laboratory sequencing capacity for timely confirmation of cases was also identified as one of the key strategic approaches for the polio ramp down. It also contributed to the detection and response to multicountry cholera and yellow fever outbreaks reported in the Region during the period under review.

The capacity to detect new SARS-CoV-2 variants has improved over the course of the pandemic, from only 12 countries having laboratories able to sequence viral genomes at the onset of COVID-19, to 37 presently. The goal has been to support the

remaining countries to develop in-country genomic sequencing capacity, and optimize sampling strategies to improve the detection and surveillance of SARS-CoV-2 variants.

These enhanced diagnostic and laboratory services strengthened Member States' capacity to forecast their requirements for medicines, laboratory reagents and biomedical equipment for the COVID-19 response, to maintain essential health service delivery, and to monitor supply and demand.

To foster harmonization of medical device management, 90 participants from the African Region received training on medical devices based on the African Medical Devices Forum (AMDF) guidelines on medical devices, including in vitro diagnostics. Following the publication of the third WHO model list of essential in-vitro diagnostics,⁹³ 60 participants from Member States were trained in October 2021 in evidence-based selection of essential in vitro diagnostics, priority medical devices and assistive technology to accelerate progress towards UHC.

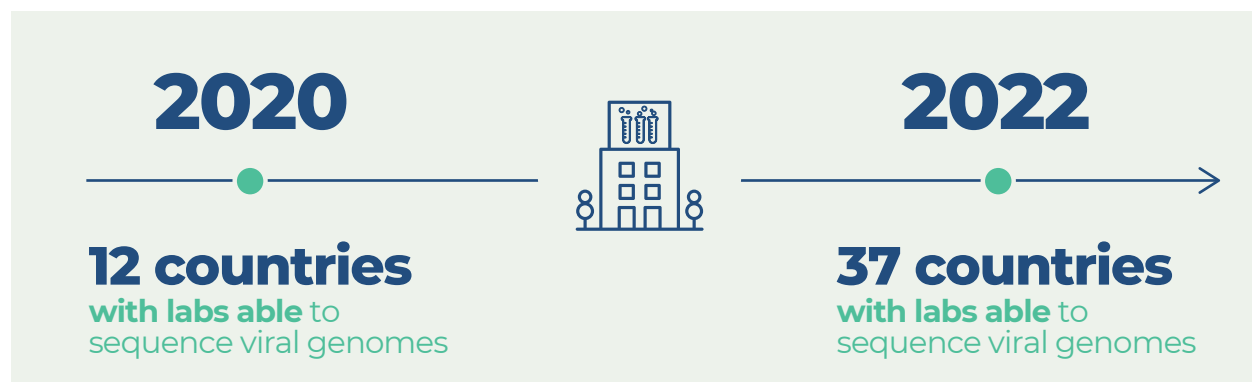
In collaboration with OIE and FAO, WHO launched the first Global Laboratory Leadership Programme (GLLP), which trained 25 laboratory leaders from five⁹⁴ Central African countries. The aim is to foster and mentor current and emerging laboratory leaders to build, strengthen and sustain national laboratory systems.

Collaborating centres and laboratory networks in Member States have played an important role in strengthening public health. During the reporting period, a Collaborating Centre for Microbial and Antimicrobial Resistance was designated at the University of Witwatersrand, South Africa, and collaboration was established with Institut Pasteur Dakar in Senegal. Collaborating arrangements were also concluded with sequencing laboratories in East, Southern and West Africa.

⁹³ [Third WHO model list of essential in-vitro diagnostics](#)

⁹⁴ Central African Republic, Chad, Congo, DRC, Gabon

STRENGTHENING REGIONAL DIAGNOSTIC AND LABORATORY SYSTEMS



4.3 INNOVATION FOR TRANSFORMATION OF HEALTH SYSTEMS

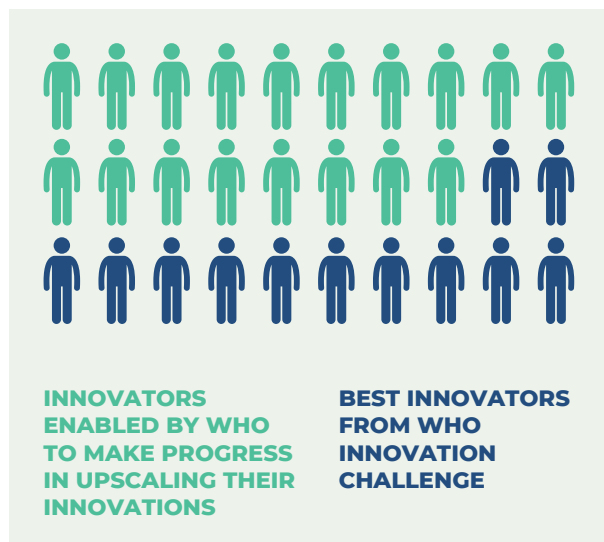
4.3.1 TECHNOLOGY AND DIGITAL INNOVATION

The Regional strategy for scaling up health innovations and the Framework for implementing the Global strategy on digital health in the WHO African Region, adopted by Member States, guide the work of the Regional Office in this specific area. Innovation in health has become a key driver in transforming health care delivery to meet the dynamic landscape of public health needs, with the COVID-19 pandemic galvanizing the development of innovative and digital solutions to guide the response.

The WHO Secretariat has undertaken several initiatives aimed at capacitating countries to strengthen their health innovation ecosystems, to make them more responsive to the innovation needs of the African Region. The Secretariat supported Botswana to develop an integrated and robust platform to coordinate the partnership-driven scale-up of locally relevant health innovations for sustainable impact. The platform will be replicated in other countries according to their innovation scaling needs.

The Secretariat also conducted a study of over 1000 new or modifications of existing technologies targeting different areas of the COVID-19 response, which was shared with countries for either adoption or adaptation to their contexts. More than 120 health technology innovations have since been piloted or adopted by Member States. These included tools for data and information management, contact tracing, self-screening, chatbots, telehealth services, risk assessments, and commodity deliveries, among others.

Another 2021 study, profiling the 30 best innovators from the WHO Innovation Challenge, revealed that support from WHO enabled 18 innovators to make progress in upscaling their innovations, with notable impact. For instance, Vaxiglobal, a start-up in Zimbabwe, developed a COVID-19 test verification system currently used in that country at all points of entry. This has contributed to curtailing fake COVID-19 test certificates.



ERQ MA'ED Media and Mental Health, a social enterprise company from Ethiopia, developed an integrated mental wellness social innovation to address issues of family conflict, violence, abuse. The visibility provided by WHO unlocked the demand for ERQ MA'ED services, resulting in over 20 000 calls per annum across the country. The innovation has since received global recognition and is currently enjoying financial support from various partners, including USAID and Care International.

TrueSpec Africa is a company founded by a young innovator from Cameroon, which developed a technology that uses artificial intelligence to enable hospitals, pharmacies, pharmaceutical laboratories and quality control centres to detect counterfeit drugs. The innovator's technology has since been scaled up in Cameroon, Côte d'Ivoire, DRC and Nigeria, leading to his recognition and inclusion in Forbes Africa's 30 UNDER 30 Class of 2022.

Leveraging innovation contributed significantly to improving programme delivery at country level. For instance, geographic information system (GIS) technology was at the centre of eliminating polio in the African Region. The digital track-and-trace system was also developed to track tobacco products in line with the provisions of Article 8 of the Protocol to eliminate illicit trade in tobacco products. The use of handheld electronic devices for STEPS data collection in connection with the STEPS online data management platform (eSTEPS) was also leveraged to improve NCD surveillance, with positive impacts for real-time decision-making and corrective action in field work. WHO supported four countries⁹⁵ to complete STEPwise approach to NCD risk factor surveillance (STEPS) field work, with the results expected to contribute to better planning of NCD programmes going forward. An oral health policy brief on the continuity of essential oral health services during the COVID-19 pandemic in the Region was also developed and disseminated.⁹⁶

It therefore remains important for countries to create an enabling environment to foster development and adoption of local innovations in a sustainable way. This calls for creative, favourable policies and incentive mechanisms that will attract further investments in innovation.

⁹⁵ Burkina Faso, Cabo, Verde, Niger, Sao Tome and Principe

⁹⁶ <https://www.afro.who.int/publications/continuity-essential-oral-health-services-during-covid-19-pandemic-who-african-region>

4.3.2 INNOVATION FOR PRODUCT DEVELOPMENT

Over the past two years, many governments of African Region Member States and the AU have shown strong political commitment, and made strategic investments towards enhancing local vaccine and medicine manufacturing capacity in Africa. They set up the Pharmaceutical Manufacturing Plan for Africa (PMPA), the African Medicines Agency (AMA), and the Partnerships for African Vaccine Manufacturing (PAVM). The PAVM was launched in April 2021, with the goal of seeing 60% of the continent's vaccine needs manufactured in Africa by 2040.

In 2021, WHO launched the global mRNA technology transfer hub in Cape Town, following large-scale vaccine purchases by wealthy countries, and companies prioritizing sales to governments that could pay the highest price. This pushed low- and middle-income countries to the back of the queue for COVID-19 vaccines. The aim of the hub is to help low- and middle-income countries manufacture mRNA vaccines at scale, and according to international standards. Six African countries⁹⁷ will be the first on the continent to receive the technology needed to produce mRNA vaccines.

The Secretariat supported the vaccine and medicine manufacturing effort on the continent notably through the setting up of the African Vaccine Regulatory Forum (AVAREF). The aim is to strengthen the institutional capacity of regulatory authorities and ethics committees, through collaboration and work sharing, while recognizing national ownership of African countries that seek to build their capacity, and to promote harmonization of practices in support of oversight of clinical trials. AVAREF has demonstrated its value in strengthening regulatory and ethics reviews, promoting harmonized standards and approaches, and accelerating the review of clinical trials for vaccines of high public health impact against meningitis, tuberculosis, malaria, Ebola virus disease and COVID-19, among others. It has also shed light

on the growing complexity of biomedical research, which calls for increased cooperation among partners, including donors, researchers, product developers, regulators and the medical ethics community.

Despite the progress made over the past two years, major challenges remain. In many cases, locally produced vaccines are much more expensive than imported products, and addressing this will require financial and technical support to local manufacturers. The low maturity level of Africa's regulatory systems is another challenge, with only Ghana, Nigeria and the United Republic of Tanzania reaching WHO regulatory system maturity level 3. AVAREF support for strengthening regulation in Member States will be needed, in collaboration with the AMA.

Other challenges include the low level of development of pharmaceutical systems; the persistence of the illicit pharmaceutical market in some countries, which constitutes a major threat to the development of the local industry; and the international presence and expansion of the global industry. There will be a need for continental consultations on the threats of the illicit pharmaceutical trade to the viability of local vaccine manufacturing in Africa.

Lack of prioritization and insufficient investment in research and development is another challenge. This calls for support for the development of an African platform for coordination of health products and innovations towards self-sufficiency, including ensuring appropriate investment in research and development in Africa.

In supporting local production in Africa, the target is to ensure availability and access of quality, safe and efficacious vaccines and other medical products. To this end, the Secretariat will work with Member States and partners to implement strategic actions to improve cost competitiveness of locally-produced vaccines, and the low maturity level

of regulatory systems. Other focus areas will include strategic actions to address the low level of development of pharmaceutical systems, and the low prioritization and insufficient investment in research and development.

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The Secretariat will work with Member States and partners to implement strategic actions to improve cost competitiveness of locally-produced vaccines, and the low maturity level of regulatory systems.

⁹⁷ Egypt, Kenya, Nigeria, Senegal, South Africa, Tunisia



4.4 RESEARCH FOR IMPACT

Research provides a platform for exchange of evidence and best practices for driving programmes and interventions. The research programme is important in providing strategic guidance and support for research to inform WHO's health agenda.

WHO, together with its collaborating centres and strategic partners such as the European and Developing Countries Clinical Trials Partnership (EDCTP), Tackling Infections to Benefit Africa (TIBA), the African Academy of Sciences (AAS) and Africa CDC, has supported countries to conduct clinical trials and sequencing, and to develop COVID-19 countermeasures. Notable breakthroughs were seen in the response to malaria and neglected tropical diseases (NTDs). WHO has supported the development of research skills among young African scientists on the continent through partnership with the Hideyo Noguchi Africa Prize.

To optimize understanding of the COVID-19 pandemic, WHO developed generic research protocols for key areas to facilitate accelerated research.⁹⁸ These include epidemiology, transmission dynamics, clinical characterization of cases, drug and vaccine clinical trials,⁹⁹ and social and behavioural insights. With 134 studies planned in 35 countries on Unity-aligned sero-epidemiological studies, over 84 studies across 28 countries have since been conducted. The preliminary data showed an increase from 65% to 77% of people with SARS-CoV-2 antibodies from the third to the fourth quarter of 2021.

UNITY-ALIGNED SERO-EPIDEMIOLOGICAL STUDIES



GOAL
134 STUDIES IN
35 COUNTRIES

ACCOMPLISHED
84 STUDIES IN
28 COUNTRIES

**PEOPLE WITH
SARS-COV-2 ANTIBODIES
INCREASE FROM 65% TO 77%
FROM THE THIRD TO THE
FOURTH QUARTER OF 2021**



More than 20 other countries¹⁰⁰ have implemented at least one of the WHO standardized protocols for understanding COVID-19 transmission and behaviours. A meta-analysis of seroprevalence surveys in the Region also identified 54 studies, 42 of which were published papers. A number of these studies are expected to be published in a special issue of the Pan African Medical Journal by the third quarter of 2022. In addition, a Lancet Commission Paper on lessons learnt from the 2014–2016 Ebola virus disease epidemic in West Africa and the COVID-19 pandemic in the WHO African Region for strengthening health security and UHC is expected to be published. These papers have significant potential to be used to shape health policies going forward, given that by documenting lessons learnt from responding to previous outbreaks, they provide critical guidance on what worked, and what did not, in diverse scenarios.

⁹⁸ <https://www.afro.who.int/publications/social-and-behavioural-insights-covid-19-data-collection-tool-africa>

⁹⁹ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/early-investigations>

¹⁰⁰ Algeria, Angola, Botswana, Burkina Faso, Cameroon, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, São Tomé and Príncipe, Senegal, Sierra Leone, South Africa, South Sudan, Tanzania, Togo, Uganda, Zambia, Zimbabwe

The challenge that still confronts the Region is the lack of strong research, development and innovation stewardship. This is exacerbated by the lack of incentives, ownership, and low indigenous funding due to the non-prioritization of research and innovation. The prevailing situation provides a window of opportunity for building strong research capacity-strengthening initiatives that respond to regional health needs.

The Secretariat will step up its efforts to promote a culture of research and innovation in the Region, through the convening of an annual African research round table that will bring together all stakeholders involved in research in Africa, and develop a collaboration framework to guide engagement with stakeholders that will define the road map for research in Africa.

In an attempt to promote inclusive research, WHO aims to launch an African Women in Science dialogue to develop the agenda for women scientists in Africa, as well as intensify engagement with the African diaspora on potential research collaboration.

The Secretariat will also establish a collaborative network of scientists from research institutes, universities and innovation hubs, including global partnerships, to address capacity gaps in research and development, and manufacturing, on the continent. Additionally, it will broker promising pipelines of health research and development for products developed on the continent to accelerate local manufacturing, through partnering with established value chain actors; strengthen local innovation and manufacturing ecosystems to accelerate health impact; and promote multisectoral, transdisciplinary, social science, health systems, implementation and operational research.

FEATURE: CONGO APPLIES COVID-19 GENOME SEQUENCING SKILLS TO OTHER DISEASES¹⁰¹

Two years after the start of COVID-19, the Republic of Congo began applying its genomic sequencing capacities developed during the pandemic to fight other pathogens, like those responsible for malaria, tuberculosis or diarrhoeal diseases in young children.

“Strengthening genomic sequencing capacities contributes to the empowerment of countries to conduct disease surveillance and improve patient care – and therefore to the fight against epidemics,” says Dr Lucien Manga, WHO Representative in Congo, adding that WHO supported Congo’s National Public Health Laboratory with both training and equipment.

Not only does the country now produce its own genomic sequences of the virus that causes COVID-19, but the Congolese Foundation for Medical Research (FCRM) has also established a sequencing protocol to describe the genes in staphylococcus responsible for the bacteria’s resistance to antibiotics. This will make it possible to adapt treatment to circumvent this resistance.

“The development of genomic sequencing in Congo has highlighted the importance of research, and of having molecular biology laboratories and trained personnel, to effectively fight against diseases,” says Foundation President Professor Francine Ntoumi.

A similar approach will be applied to a battery of parasites responsible for widespread diseases in Congo.

WHO is now supporting a Foundation project to strengthen national capacity to conduct clinical trials, with the aim of preparing the country to introduce new COVID-19 treatments.

“By making it possible to know which variants are in circulation, sequencing allows for a precise response and for optimizing the use of resources, which is essential for countries with limited resources,” says Dr Gilbert Ndziessi, technical coordinator of Congo’s National COVID-19 Response Committee.

101 <https://www.afro.who.int/countries/congo/news/congo-applies-covid-19-genomic-sequencing-skills-other-diseases>



CHAPTER 5: TACKLING THE SOCIAL, ECONOMIC AND ENVIRONMENTAL DETERMINANTS OF HEALTH

The Secretariat has continued to work with Member States and partners to address health issues associated with social, economic and environmental conditions. Indeed, the COVID-19 pandemic has exacerbated inequities and reaffirmed the importance of acting on the social, economic and environmental determinants of health in order to ensure no one is left behind, as countries embark on rebuilding economies and livelihoods.

If the underlying causes of disease and injury are not addressed through preventive and promotive health interventions, households and health care systems in the Region will remain challenged under a costly and rapidly increasing burden of noncommunicable diseases and environmental disasters.

The workstreams dedicated to making populations healthier under the WHO Thirteenth General Programme of Work (GPW 13) offer entry points for intersectoral engagement to achieve three outcomes. These are: creating safe and equitable societies by addressing multiple determinants of health; reducing risk factors through multisectoral action; and creating healthy settings using the Health in All Policies approach. This area of WHO's work, although under-resourced, is fundamental to protecting the health and well-being of populations.

5.1 ADDRESSING ENVIRONMENTAL HEALTH RISKS AND PROACTIVELY ADAPTING TO CLIMATE CHANGE

Nearly a quarter of all deaths in Africa are due to environmental causes linked to climate change, access to safe drinking water, sanitation and hygiene services, soil and air pollution, vector control, and management of chemicals and waste.¹⁰²

The year 2021 was important because health was on the agenda of the United Nations Framework Convention on Climate Change (UNFCCC) for the first time. Seven African countries¹⁰³ that participated in the 26th Conference of Parties (COP26) in November 2021, and 12 others,¹⁰⁴ have made high-level commitments to building climate-resilient and sustainable low-carbon health systems. To facilitate the translation of these commitments into action, in June 2022 the Secretariat, in partnership with the Agha Khan Development Network, trained ministry of health and WHO staff from 24 countries¹⁰⁵ on calculating the carbon footprint in health care facilities.

The important linkage between climate change and health is also evident in the emerging opportunities for the health sector to access climate funds. With the Secretariat's support, Ethiopia, Mauritius, Sierra Leone and the United Republic of Tanzania submitted climate change and health proposals to the Green Climate Fund Readiness scheme. The Mauritius proposal has successfully passed all three rounds of the

review process, and is poised to receive financial support of about US\$ 430 000. The Sierra Leone proposal has reached the third round of comments, while the Ethiopian and Tanzanian proposals have just begun the review process.

The Global Joint WHO/UNICEF water, sanitation and hygiene (WASH) report,¹⁰⁶ published in March 2022, revealed that basic drinking water coverage in sub-Saharan Africa in 2020 stood at 69%, sanitation at 42%, and hygiene access at 37%. To support the drastic acceleration required for the Region to meet the SDG WASH targets, WHO is collaborating with UNICEF, WaterAid and Oxfam to promote the global initiative for hand hygiene for all (HH4A) in the Region. Individual country profiles to inform future decision-making and progress on the SDG targets will be developed for the countries¹⁰⁷ participating in the initiative, due to be concluded in September 2022.

Additionally, WHO is conducting the Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) surveys, in which 43 countries¹⁰⁸ from the African Region are participating. The report will be published in December 2022. The surveys may be able to capture whether hand hygiene interventions included in the COVID-19 response are showing sustained results.



The important linkage between climate change and health is also evident in the emerging opportunities for the health sector to access climate funds.

102 WHO Preventing disease through healthy environments: assessment of the burden of disease from environmental risks, Geneva, World Health Organization, 2018

103 Cabo Verde, Central African Republic, Kenya, Madagascar, Malawi, Sao Tome and Principe, Togo

104 Côte d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Mauritania, Mozambique, Nigeria, Rwanda, Sierra Leone, Uganda, United Republic of Tanzania

105 Algeria, Burkina Faso, Botswana, Cabo Verde, Central African Republic, Côte d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania

106 <https://www.unicef.org/documents/progress-drinking-water-sanitation-and-hygiene-africa-2000-2020-5-years-sdgs>

107 Burkina Faso, Ethiopia, Kenya, Nigeria, Rwanda

108 Non participating countries are Algeria, Angola, Equatorial Guinea and Eswatini

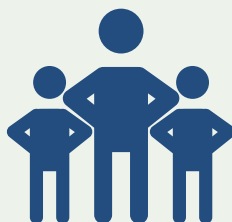
5.2 PROMOTING HEALTH AND ADDRESSING DETERMINANTS

Several Member States are taking steps towards implementing the Health in All Policies (HiAP) framework, using the HiAP Global Guidelines. Following an orientation workshop for 16 policy-makers from governments and civil society, the United Republic of Tanzania is implementing an integrated, sector-wide approach to address the determinants of health. Burundi and the United Republic of Tanzania launched reports on the assessment of intersectoral action to address social determinants of health (SDH) towards achieving the SDGs. In addition, multisectoral actions to promote healthy lifestyles, healthy ageing and physical activity were implemented in 20 countries.¹⁰⁹

WHO, along with its collaborating centre at the University of Pretoria, South Africa, conducted implementation research to explore how the COVID-19 pandemic impacted health and social inequities among vulnerable groups. These findings were published¹¹⁰, and are guiding the initiation of similar studies by other institutions in the Region.¹¹¹ The main findings will inform efforts to build operational research capacity, leveraging lessons learnt on addressing health inequities among marginalized groups such as the homeless, migrants, women, children and older people.

With financial support from the Swiss Agency for Development and Cooperation, Douala in Cameroon is one of five cities¹¹² participating in the global Urban Governance Health and Wellbeing project. As part of the initiative, city leaders and influencers were trained in urban leadership, following which Douala developed a draft City Action Plan involving over 300 partners and stakeholders.

The main objective of the project is to enhance the engagement of urban leaders and authorities, and strengthen civic engagement for better health and well-being in urban settings. To further expand the network of participating cities, the priority areas of work and indicators of the project were extended and disseminated, with cities across the Region invited to join the healthy cities movement. In response, four mayors¹¹³ of African cities took part in the 10th Global Conference on Health Promotion and the Expo Dubai in April 2022, which resulted in the launch of the Geneva Charter for Wellbeing.



As a part of the
Urban Governance initiative
city leaders and influencers **were trained in urban leadership**
following a draft City Action Plan involving
OVER 300
partners and stakeholders



109 Angola, Burundi, Burkina Faso, Cabo Verde, Cameroon, Congo, Comoros, DRC, Gabon, Ghana, Guinea, Kenya, Mauritius, Mozambique, Nigeria, South Africa, Senegal, United Republic of Tanzania, Togo and Uganda

110 <https://www.up.ac.za/who-cc>

111 Benin, Namibia, Senegal, Sudan, Zambia

112 Bogota, Douala, Khulna (Bangladesh), Mexico, Tunis

113 Douala, Freetown, Kampala, Tunis

The mayors of Brazzaville (Congo), Douala (Cameroon), Freetown (Sierra Leone), Gaborone (Botswana) and Lusaka (Zambia) engaged in the first African Mayors Dialogue on Urban Governance for Health and Wellbeing in the post-COVID-19 era, jointly organized by WHO in the African Region and UN-Habitat. This was followed in May 2022 by a joint session on Quality Urbanization and Health for All in intermediary cities in Africa, also jointly organized by WHO in the African Region and UN-Habitat, during the 9th Africities Summit in 2022.

The interest in cities is motivated by Africa's rapidly growing and largely unplanned urbanization. By 2050, more than 60% of the continent's population will live in cities. The existing socioeconomic gaps and other inequalities will likely increase and exacerbate social exclusion, risky behaviours, uncertain livelihoods, and the lack of basic amenities and services. Working with municipal governments has the advantage of bringing together multiple sectors to work with communities living in close proximity.

To facilitate understanding of the factors influencing community behaviour change in the context of COVID-19, a Social and Behavioural Insights data collection tool¹¹⁴ was developed and tested in Nigeria and Zambia. The resulting case studies will be used to inform capacity building and interventions in the other 45 African Region countries. The Secretariat collaborated with civil society organizations to develop approaches that facilitate context-appropriate risk communication on COVID-19, and sustainable community engagement in hard-to-reach areas.

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114 <https://www.afro.who.int/publications/social-and-behavioural-insights-covid-19-data-collection-tool-africa> (available in English, French and Portuguese)

5.3 OVERCOMING MALNUTRITION AND ENSURING FOOD SAFETY

To address the perennial challenge of data for monitoring progress on national and global nutrition targets, WHO, in collaboration with UNICEF, is supporting four countries¹¹⁵ to strengthen their routine nutrition information systems, towards improved nutrition data quality and utilization. The Secretariat is building a library of resources to promote healthy diets, the latest addition being a document highlighting the nutritional benefits of African traditional leafy vegetables.¹¹⁶

Capacity to respond effectively to food safety emergencies was built and maintained through the International Food Safety Authorities Network (INFOSAN). WHO, the INFOSAN Secretariat and FAO conducted joint trainings in Cameroon and Senegal, thereby strengthening linkages among 50 regulatory authorities. Emergency simulation exercises in 14 countries contributed to better understanding of food safety emergency response mechanisms, and improved preparedness.¹¹⁷

Food safety campaigns in Burkina Faso led to the enrolment of 300 school-aged children and food handlers in “nutrition clubs for the promotion of food safety and healthy diets”. In Senegal, the healthy food market initiative, piloted in 2020 at the Marché de Grand Dakar, led to the construction of 40 model food stalls promoting safe food-handling practices, compliant with sanitary and hygiene requirements. A total 1600 households benefited from food safety campaigns. In addition, 180 actors were trained, using the Codex Code of Practice, on how to minimize aflatoxins in the processing of groundnuts, cereals, fish and fishery products, and in the handling of meat and vegetables.

In Guinea, 22 Codex-aligned national food standards were drafted, while Sierra Leone developed national food safety guidelines. In Côte d’Ivoire, over 100 stakeholders, comprising regulators, producers, processors, and civil society, were sensitized on Codex, and oriented on fruit and vegetable standards to improve its use.



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300 school-aged children and food handlers in “nutrition clubs for the promotion of food safety and healthy diets”

115 Côte d’Ivoire, Ethiopia, Uganda, Zambia

116 <https://apps.who.int/iris/handle/10665/353365>

117 Algeria, Burundi, Cabo Verde, Chad, Eswatini, Ethiopia, Guinea, Liberia, Mauritania, Mozambique, Niger, Senegal, Togo, United Republic of Tanzania

5.4 REDUCING TOBACCO USE AND OTHER RISK FACTORS FOR NONCOMMUNICABLE DISEASES

5.4.1 TOBACCO CONTROL

To accelerate implementation of the WHO FCTC, WHO support for Member States saw Botswana enact a comprehensive tobacco control law; Côte d'Ivoire adopted decrees on large graphic health warnings on tobacco packages; Mauritania implemented graphic health warnings covering 70% of principal display areas; Togo adopted a digital track-and-trace system for tobacco products, in line with the provisions of Article 8 of the Protocol to eliminate illicit trade in tobacco products; and Ghana ratified the Protocol. This brought to 21 the number of African parties¹¹⁸ to the Protocol.

WHO also supported Madagascar to leverage resources from earmarked tobacco tax revenues to build a national centre for tobacco cessation and treatment of tobacco dependence, while supporting other UHC initiatives. Ethiopia was assisted to adopt a directive for full implementation of the key measures for tobacco control, including protection from industry interference.

FEATURE: SWITCHING FROM TOBACCO TO BEANS¹¹⁹

WHO, in partnership with FAO and the World Food Programme (WFP), is supporting farmers in Migori, Kenya, to make the shift away from tobacco, to producing alternative crops. Migori County was selected because it is one of the subregions with the highest number of tobacco farmers. The project, Tobacco Free Farms, launched in March 2022, aims to become a model for the implementation of Article 17 and 18 of the WHO FCTC (Alternative livelihoods and protection of the environment).

The three UN agencies are collaborating with the Government of Kenya and farmer communities, which are the direct beneficiaries. These communities are organized into Farmer Service Centres (FSCs) – organized groups of farmers who collectively source farm-related and other services. They are assisted by the Farm to Market Alliance (FtMA), farmer groups that identify markets for produce and negotiate prices for various value chains. FAO and the Ministry of Agriculture provide training for farmers, as well as extension services.

The training focuses on, among other things, good agronomy practices and sensitization to the health impacts of tobacco growing. Farmers were supported with nearly four tons of seeds and other requirements, resulting in 370 acres of farmland previously dedicated to tobacco growing now used to grow red beans (Nyota). Its high iron content, and consequent higher nutritional value, makes this bean a preferred choice for procurement by WFP.

So far, 330 farmers have switched to growing these beans, with the first harvest yielding more than 200 metric tons. Some were purchased by WFP, and others consumed locally by households.

The project seeks to reach more than 1000 farmers by the end of 2022.



118 Benin, Burkina Faso, Cabo Verde, Chad, Comoros, Congo, Cote d'Ivoire, Eswatini, Gabon, Gambia, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritius, Niger, Nigeria, Senegal, Seychelles, Togo

119 <https://www.afro.who.int/countries/kenya/news/launch-tobacco-free-farms-kenya>



5.4.2 ALCOHOL USE

At the height of the COVID-19 pandemic, a decrease in drunk driving-related road accidents was observed in countries¹²⁰ that had adopted policies and regulations to restrict alcohol sales and distribution, in line with WHO technical guidance. Currently, Liberia, Rwanda and Sao Tome and Principe are developing policies to reduce the harmful use of alcohol, implementing the WHO SAFER technical package.¹²¹ Uganda was supported to develop a multi-agency and multisectoral road map to implement prioritized SAFER interventions.

5.4.3 PROMOTING HEALTHY DIETS AND PHYSICAL ACTIVITY

Regulating the food environment forms part of efforts to promote healthy diets and reduce the risk of obesity. Kenya, Uganda and the United Republic of Tanzania are involved in the Global Regulatory and Fiscal Capacity Building Programme (RECAP), supported by multiple partners,¹²² which aims to strengthen national capacities for the development and implementation of regulatory and fiscal measures. In collaboration with partners, WHO provides technical support towards achieving the goals of the project.

The three countries have made progress in adopting nutrient profile modelling and food labelling standards, as a prelude to establishing regulations for the marketing of food and non-alcoholic beverages.

WHO also provided technical support to help Burkina Faso, Mali and Sierra Leone align their national nutrition labelling policies with the regional strategy and Codex standards, while strengthening nutrition labelling regulations with a view to reducing risk factors for diet-related NCDs. Côte d'Ivoire and South Sudan were assisted to carry out awareness-raising activities promoting healthy eating behaviours among young populations.

The Secretariat developed and disseminated an advocacy brief for promoting physical activity¹²³ to policy-makers and organizations, to promote healthier lifestyles in the Region. Cabo Verde adopted the WHO guidelines on physical activity and sedentary behaviour,¹²⁴ boosting awareness of the benefits of physical activity among policy-makers and health workers. The country also mounted a multimedia campaign to disseminate the guidelines and promote an active lifestyle. Ghana is conducting an assessment of walking and cycling in Accra to gather evidence on the economic benefits of investing in walking and cycling, for health and environmental outcomes.

120 Botswana, Eswatini, Kenya, Lesotho, Namibia, South Africa, Zimbabwe

121 <https://www.who.int/publications/i/item/the-safer-technical-package>

122 International Development Law Organization, International Development Research Centre, Swiss Agency for Development and Cooperation and OPEC Fund for International Development

123 <https://www.afro.who.int/publications/promotiong-physical-activity-african-region> (available in English, French and Portuguese)

124 <https://www.who.int/publications/i/item/9789240015128>



5.5 RAISING AWARENESS ON VIOLENCE AGAINST CHILDREN, ROAD SAFETY AND REHABILITATION

Violence against children and adolescents, including neglect and abuse, carries life-long and costly emotional, social and economic consequences. The African Region has the second highest rate of child homicide, accounting for 27% of global homicides among persons younger than 17 years. Following the adoption of the Seventy-fourth World Health Assembly resolution on ending violence against children through health systems strengthening and multisector approaches, 32 Member States¹²⁵ participated in a meeting to examine the Regional report¹²⁶ on preventing violence against children 2020, and to determine how to implement the resolution.

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The African Region has the second highest rate of child homicide, accounting for 27% of global homicides among persons younger than 17 years.

In collaboration with the Ministries of Health of Côte d'Ivoire and Uganda, over 100 health care workers received training on strategies to end violence against children, resulting in better recognition of, and response to, maltreatment of children.

Madagascar developed a new National Road Safety Strategic Plan 2020–2029, that will align country-level action with the implementation of the Second Decade of Action for Road Safety 2021–2030. WHO collaborated with the Senegalese Red Cross to sensitize and capacitate over 3000 road users, including school-aged children, motorists and opinion leaders, on first response.

WHO also provided financial and technical support to Senegal to improve the quality of road traffic fatalities data. Furthermore, WHO's leadership and technical support enabled the Government of Senegal to create the Agency

125 Algeria, Burkina Faso, Burundi, Cabo Verde, Chad, Comoros, Congo, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, South Sudan, Uganda, United Republic of Tanzania, Togo, Zambia, Zimbabwe

126 <https://www.afro.who.int/publications/preventing-violence-against-children-2020>



Nationale de Sécurité Routière (ANASER) in November 2021. This will enhance Senegal's commitment to implementing the WHO Global plan for the Decade of Action for Road Safety 2021–2030.

Rwanda developed a strategic plan for rehabilitation, while five other countries¹²⁷ finalized the situation assessment step to advance their own plans. Burkina Faso and Ethiopia are in the process of integrating rehabilitation data into the DHIS2 health information management system. WHO collaborated with the Health Systems Strengthening Accelerator¹²⁸ to conduct three virtual workshops to help advance rehabilitation health financing capacity among policy-makers in 13 Member States.¹²⁹

One major challenge encountered during the review period was the slowdown in the implementation of prevention strategies in many countries due to the COVID-19 pandemic. Other challenges included weak legislative frameworks and enforcement of laws; understaffing in the Region and at country level; industry interference; ineffective intersectoral integration; limited and unpredictable funding; scarcity of data; inadequate governance and coordination among sectors; political instability; and shifts in country priorities.

The adage that “health is invisible until it’s not there” may explain why more resources are invested in treating than in preventing disease. And yet success in making a billion people healthier must begin with preserving the health of a billion individuals.

The Secretariat will continue to work with Member States in defining and delivering evidence-informed interventions to address determinants of health (economic, environmental, social and structural); to support adaptation and implementation of technical packages to promote health and reduce the risk of diseases; and to collaborate with governments and partners towards creating sustainable, healthy settings for African populations.

To overcome the resource limitations that hamper promotive and preventive health care, the Secretariat will catalyse partnerships with agencies and institutions allied with other sectors, and provide rationales for the inclusion of health content in existing initiatives, so fostering person-centred development for health and well-being. These efforts will be focused at the country level.

With its accumulated experience in resource mobilization from non-health sectors (including the Codex Trust Fund for food safety and the Green Climate Fund for climate change and health), the Secretariat will continue to identify opportunities and support Member States to develop and submit grant proposals. In this regard, ministries of health will need to facilitate intersectoral collaboration at country level, and demonstrate leadership in advancing the Health in All Policies agenda.

127 Burkina Faso, Burundi, Guinea-Bissau, Seychelles, Zambia

128 <https://www.acceleratehss.org/about/>

129 Benin, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Rwanda, South Africa, Togo, United Republic of Tanzania, Zambia



CHAPTER 6: CHALLENGES, LESSONS LEARNT AND WAY FORWARD

One major challenge encountered during the review period was the slowdown in the implementation of well-being and health care provision strategies in many countries due to the COVID-19 pandemic. Most staff of the Secretariat and government counterparts were repurposed to the COVID-19 response, and senior-level decisions were also delayed due to the shift in the focus of senior officials to the response. This limited engagement time for other health issues.

Another key challenge is chronic understaffing in the Regional and country offices, coupled with increased demands from the COVID-19 response, and to address the weaknesses in health systems that were exposed by the pandemic. Attempts at improving staffing capacities in countries, including through the MCATs, are further compounded by insufficient financial resources and earmarking of the available resources by donors.



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One major challenge encountered during the review period was the slowdown in the implementation of well-being and health care provision strategies in many countries due to the COVID-19 pandemic.

Another challenge was the lack of prioritization of certain programmes by Member States, which was reflected in their underfunding, including at the Secretariat level. Notable among these are cross-cutting programmes such as health research, health information, laboratory capacity, antimicrobial resistance, addressing determinants of health, and health promotion. Yet, these are necessary areas if the Region is to attain health for all.

A specific challenge linked to the pandemic response is its evolving nature in distinct waves that created complacency in the implementation of response measures. Coupled with low vaccination coverage, this facilitated the circulation of new VOCs, leading to new waves. The halting or relaxation of robust testing deprives the Secretariat and Member States of the critical information needed to track the spread of the virus, and identify emerging new variants.

The major lesson learnt is that strong national leadership, along with broad partnerships for health at national, regional, and global levels, were the key catalytic factors that propelled the response. These, however, were not sufficient without the engagement of beneficiary communities, and the use of innovative approaches to facilitate delivery and use of services.

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One key lesson from the pandemic, for Africa and the world, is that countries need to urgently invest in addressing foundational health system gaps, and essential public health service delivery.

Experience from the COVID-19 response has shown that all programmes are linked at the health system level, and that individual programme gains can easily be reversed if the system is challenged, as evidenced by the reversal of achievements in disease control programmes. It has also shown that the health sector requires inputs from

other sectors to succeed, yet there is inadequate capacity in the African Region in both the ministries of health and the WHO country offices to effectively engage these other sectors. Although it worked for COVID-19 due to the nature of the pandemic that necessitated leadership at the highest levels of government, such mobilization may prove challenging going forward.

The urgent priority is to bring the COVID-19 pandemic to an end by increasing vaccination rates as fast as possible. Simultaneously, lost ground must be recovered on the journey towards the achievement of UHC for all Africans, no matter where they live. Working closely with a broad range of partners, WHO will focus on supporting Member States to improve health systems resilience, powered by continuous innovation to withstand all forms of public health threats.

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To ensure health security, the Secretariat will support Member States to increase and improve their efforts to build, strengthen and maintain the capacities required under the IHR (2005), in accordance with the recommendations of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR). Member States and partners will be supported to implement the new Regional strategy for health security and emergencies 2022–2030, to be adopted by the Seventy-second Regional Committee.

As WHO supports Member States to identify innovative ways of increasing domestic investments in health, the Secretariat will also focus on strategies to facilitate more efficient use of resources. Fragmented implementation of programmes is a major cause of investment inefficiencies, and integration is one of the strategic approaches for achieving more with available resources, so creating value for money.



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In 2022, the polio programme’s priorities are curtailing outbreaks of wild and variant poliovirus, enhancing acute flaccid paralysis and environmental surveillance, strengthening laboratory sequencing capacity for timely confirmation of cases, sustaining human resource capacity for “last mile efforts”, and applying technology and innovations to improve programme performance.

Moving forward, the Secretariat will support the delivery of integrated data-driven people-centred health services, achieving delivery of comprehensive services to each person entering the health system through different health service delivery platforms, with a focus on primary health care.

The polio infrastructure and network are proven resources for integrated public health, as evidenced by COVID-19. In 2022, the polio programme’s priorities are curtailing outbreaks of wild and variant poliovirus, enhancing acute flaccid paralysis and environmental surveillance, strengthening laboratory sequencing capacity for timely confirmation of cases, sustaining human resource capacity for “last mile efforts”, and applying technology and innovations to improve programme performance. The Secretariat also plans to

engage diverse donor agencies, through donor round tables, to raise awareness and resources to address country-specific gaps identified in polio transition plans.

The Secretariat will continue to play a leadership role in building momentum and delivering support to Member States for the adaptation and implementation of technical packages to address the determinants of health.

The Secretariat will accelerate, consolidate and institutionalize those aspects of the Transformation Agenda that will make the Organization more fit for purpose, and responsive to the rapidly changing needs of its Member States, and better aligned across its three levels.



CONCLUSION

Within the context of chronic understaffing of the Regional Office for Africa and its country offices, coupled with the increased demands imposed by the response to the COVID-19 pandemic and the challenges inherent in the work itself, WHO in the African Region remained fully committed to our Member States, and is continuing to reorganize its country offices and teams to ensure they are fit-for-purpose. “Sustainable financing for WHO remains a major challenge, however; this has been acknowledged as problematic by Member States, and is the subject of discussion at the global level, reflected in the establishment in June 2020 of the Sustainable Finance Working Group”.

In fulfilling its mandate to prioritize and promote equity, inclusive governance, and data science, WHO has proved

to be a powerful voice for equitable access to health care generally, and for tools to fight COVID-19 specifically. The pandemic context spurred a continent-wide drive to accelerate local production of key public health tools and technology transfer for self-sufficiency, with the Secretariat providing support at regional and country levels to advance progress in all aspects, especially in the regulatory arena.

Earlier this year, WHO formulated a plan with five interconnected priorities, including prevention of noncommunicable diseases, a focus on primary health care, preparing for health and humanitarian emergencies, investing in research innovation and technology, and strengthening WHO as a whole.

This provides a road map for a unified approach to drive change towards achieving the health-related Sustainable Development Goals (SDGs), and ultimately improving the health and well-being of all people, regardless of where they live.

Going forward, the Secretariat will be guided by these five carefully curated priority areas as it strengthens support for Member States towards more robust pandemic preparedness, leveraging interventions such as surge missions and specialist hubs. There will also be a renewed focus on building more resilient health systems, boosting health promotion and prevention, and improving health care delivery and access to services, through an emphasis on primary health care.



ANNEXES: CASE STUDIES

STRENGTHENING OF SUBNATIONAL UNITS WITH A FOCUS ON DISTRICT HEALTH TEAMS

More than 20 years after the districts were established in Côte d'Ivoire (in 1994), provision of high-quality services still eluded the system. Following engagements at the WHO-convened Health Sector Directors' Policy and Planning regional meeting in 2018, the MoH and partners agreed on the need to revamp the districts as the central strategy to accelerate movement towards UHC in the country where WHO was called on to support the process.

Following a review of the operability of districts, it was agreed that enhancing managerial competencies was a critical starting point. A modular-based training programme was developed, with WHO providing the technical and financial support for their completion. These were adapted from modules from Burkina Faso, and 13 modules selected following a workshop from 15 June to 20 June 2020 that involved 31 participants from the Ministry of Health (General Directorate of Health, central directorates, public health institutes, regional directorates), the National Health Insurance Fund, and technical and financial partners (WHO, UNICEF, MSH, UCP-World Bank, World Bank).

With WHO support, the first training sessions on health district management were held on 9–14 August 2021, bringing together 32 district medical officers and utilizing the 13 training modules adapted. The process of revamping the districts so far has led to managerial training modules with a pool of trainers to support the roll-out. Thirty-two district leaders have so far been given guidance, thereby improving their understanding of managerial roles and responsibilities. As a result, the districts are better able to identify their priorities and engage more effectively with partners and communities. Supported districts are now on track towards attaining their UHC targets. The country is planning to extend the programme to all 113 health districts over the next two years, with the financial support of the World Bank through a five-year comprehensive plan of action.

WHO has supported the follow-up process, at the regional and country levels. A joint mission (MoH, WHO/AFRO and country office) comprising different technical capacities was conducted between 5 June and 12 June 2022 to assess the alignment of the Country Office to support MoH priorities. Specifically, the WCO in Côte d'Ivoire seized the opportunity to fast-track the implementation of targeted, innovative, high-impact interventions aimed at strengthening subnational health systems to optimize health outcomes.





STRENGTHENING OF THE DISTRICT HEALTH SYSTEM IN CONGO

The Republic of Congo has been grappling with stagnant health outcomes over the past years. This has been the result, inter alia, of limited investments in primary health care, leading to underutilization of primary health care facilities by the population. The 2018 National Health Policy, together with the National Development Plan 2018–2022, outlined the need to address this situation through an enhanced district approach. To facilitate the process, WHO together with the MoH set up a joint operational strategy for revitalizing 12 health districts out of the 52 existing in the country, in the first phase, with the goal of expanding progressively to the remaining 40 districts. In the first phase, work focused on building operational health areas (the subdistrict level) – with the stated result of improving the supply and demand of essential services through improving local governance.

The focus of the effort was on improving the functionality of the health committees coordinating each of the country's 12 health districts. Enhanced supportive supervision missions using comprehensive tools were conducted to each health district by joint WHO/MoH teams. Better use of locally mobilized funds (from cost sharing) was supported, with savings used to fund operational gaps, such as payment of health volunteers, purchase of fuel for outreach/vaccinations, and purchasing of medicines and basic equipment. WHO also contracted three NGOs, which focused on sensitizing the population in the 12 health districts on appropriate care practice. After two years of programme implementation, progress was more than encouraging. The health care facilities regained the confidence of the community; the service utilization rates increased, resulting in turn in improved antenatal care and immunization coverage rates among other benefits. These improvements in district functioning were crucial in the response to

COVID-19, particularly in making available infrastructure, staff and medicines to patients, including pregnant women.

Several lessons were learnt in this process. First, the need to decentralize WHO support directly to districts was crucial. Strengthening of public health capacity at the district level improves accountability and results. Second, a common pool of funds was used for the process, pooling resources from multiple programmes towards the district-strengthening initiative. Third, the presence of strong national-level (MoH) support for decentralization was an essential lever in making possible the deliverables. The national-level support strengthens and improves sustainability of the achievements, in this case ensuring actions are implemented to address bottlenecks relating to: (i) the health workforce: redeployment, motivation and retention; (ii) health financing; and (iii) accountability.

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