



COVID-19 Response for Africa - monthly bulletin

Situation and Response actions in the African Region

Issue 9



DRC, in central Congo. Teams testing for COVID-19 and human African trypanosomiasis-@WHO AFRO

COVID-19 Epidemiological Situation and Response actions in Africa
November 2022

In this issue:

- [Epidemiological update for the COVID-19 pandemic in the WHO African region](#)
- [Theme of the month: **Community Based Response Initiative, Research, and the Fellowship programme:**](#)
- **CBRI Country experience:** - Cameroon integrates CBRI initiative to respond to other diseases
 - Lessons from Liberia: How CBRI has tripled testing, increased vaccination
 - Community Health workers (CHWs) encourage social and health system links in Botswana
- [Update on COVID-19: response in the region](#)
- [Key Performance Indicators in the WHO African region – what has changed?](#)



African Region

FOREWORD

Dear Colleagues,

Africa has witnessed during the past four weeks its lowest level of incident COVID-19 cases since the onset of the pandemic. Combined, the emergence of new variants of concern in Europe, Latin America and Asia, and increased cross-border circulation during the festive season pose a real risk of a new surge, underscoring the criticality of maintaining vigilance. For these reasons, WHO is encouraging Member States in Africa to maintain critical levels of surveillance and response in the region.

Because public health emergencies begin and end in the community, engagement within and with communities has been central to our achievements in tackling COVID-19. The WHO African Region Office COVID-19 incident management system team (WHO AFRO IMST) in September 2021 launched a community-based Response Initiative (CBRI), initially focused on conducting antigen rapid diagnostic testing in hotspot communities. This began in eight countries but was quickly extended to a total 21 Member States, with an expanded scope for provision of IPC kits, home-based care and vaccination.

CBRI multiplies frontline public health services by the community health worker, narrowing the connection between people in communities and neighbourhoods to the health facilities. It directly integrates personnel across the healthcare chain in the COVID-19 response, improving both testing and case identification, referrals for serious cases, and home care capacities, while addressing other potential crises.

While continuing to respond to the pandemic, together, countries, WHO and partners are engaged in reaching vaccination targets, but also in absorbing COVID-19 response practices to support other public health emergencies. With help from all pillars engaged in the AFRO COVID-19 Community-based Response Initiative, we are giving an added push to advocacy actions, reinforcing lifesaving social behavior transformative practices especially during the upcoming festive season.

I invite you to read more about this in the following pages.

Cordially yours and I wish you all a happy end of the year in good health,

Abdou Salam Gueye, Regional Emergency Director

1 Epidemiological update for COVID-19 in the WHO African region

As of 29 November 2022, 12.4 million COVID-19 cases, 257,118 deaths (CFR: 2.1%), and 11.5 million recoveries (93.3% of the cases) were registered on the African continent. The WHO African Region accounts for 71.5% (8.8 million) cases and 67.6% of deaths (173,792) of this total. In the previous week, the number of COVID-19 cases reported in Africa increased by 18.1% - from 9,825 to 11,605 - when compared to the preceding week. This was the fourth consecutive week of increasing incidence of new cases. Nevertheless, the COVID-19 pandemic remains under control in the region. Generally, the continent is witnessing a low incidence of new cases, not seen since the start of the pandemic. Equally, hospitalizations, ICU admissions and deaths have remained exceedingly low, even in countries experiencing a surge in case numbers. Countries are starting to plan for a transition towards more long-term surveillance strategies while maintaining capacities for early detection to bring evolving situations under control. The COVID-19 Incident Management Support Team (IMST) encourages countries to continue monitoring the pandemic situation using subnational-level early warning systems, which are demonstrably effective. For a more comprehensive global picture, please see <https://covid19.who.int>.

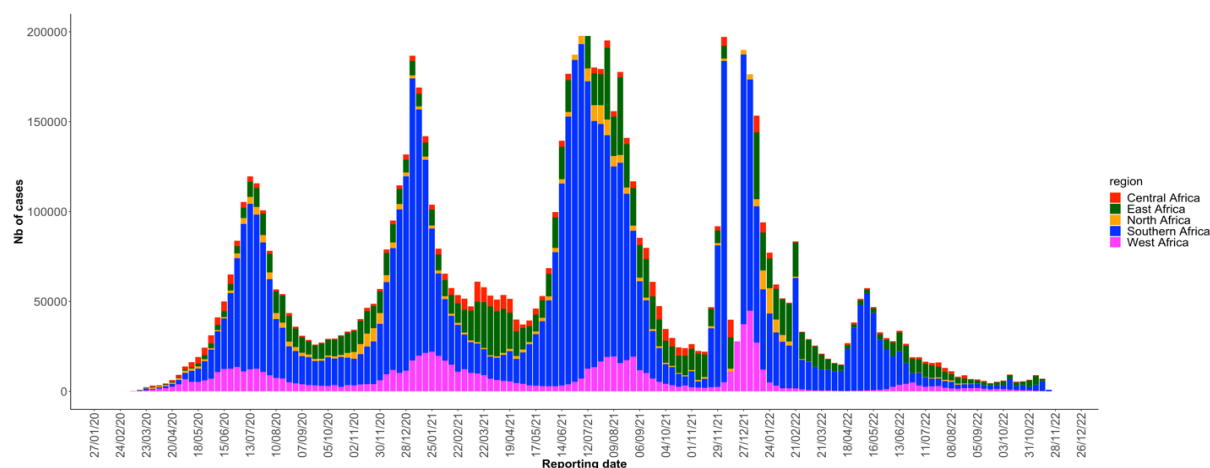


Figure 1 Weekly trend of COVID-19 cases in the WHO African region as of 28 November 2022 (Data source: <https://covid19.who.int/>)

2 Updates on the response to countries under Situations of Concern (SOC)

According to our classification, COVID-19 resurgence has not occurred for the past four weeks on the continent. Cabo Verde, the Democratic Republic of the Congo (DRC), Kenya, Madagascar, Mauritius, and South Africa were on alert in November and are being closely monitored for potential response support. While fewer cases and deaths continue to be reported this year compared to 2020 and 2021, the pandemic is not yet over, and vigilance remains necessary. Countries are encouraged to sustain continuous monitoring.

3 Theme of the month: Community Based Response Initiative, Research, and the Fellowship programme

A regional meeting conducted from 9 to 11 November in Brazzaville, in collaboration with countries and the WHO AFRO COVID-19 IMST shared CBRI lessons and results with a view towards its expanded rollout.

WHO AFRO developed the CBRI to bolster countries' capacities to improve detection and response to the COVID-19 pandemic in hotspot areas. Initially implemented in September 2021 in eight countries, the Initiative has expanded to 21 countries: Democratic Republic of Congo, Burundi, Cameroon, Congo, Cote d'Ivoire, Guinea-Bissau, Mozambique, Senegal, Zambia, Botswana, Cameroon, Comoros, Eswatini, Guinea, Liberia, Mali, Namibia, Niger, South Africa, Zambia and Zimbabwe.

CBRI applies a combination of key strategies such as active case finding, testing using antigen rapid diagnostic tests (Ag-RDT), home-based isolation and care (HBIC), provision of community infection prevention and control (IPC) kits, assessing hotspot communities for compliance to public health and safety measures (PHSM), and implementing risk communication and community engagement (RCCE) actions to improve prevention and response. CBRI has also encouraged genomic sequencing (GS) of positive samples, and increased vaccination in communities witnessing vaccine hesitancy.



Participants listening to CBRI country presentations during the regional workshop- WHO/Marriane Tabi

While the experience gained from the Initiative confirmed that public health and social measures remain a key aspect of disease control, additional technical, logistical, and operational capacities have enabled Member States to boost and sustain pandemic response efforts.

As a result of CBRI, 279,848 Ag-RDT tests were performed, representing 94.6% of expected tests and 43.6% of all tests performed in the implementing districts covered by the Initiative, resulting in 6,877 cases detected, 40.2 % of the total number of cases.

Additionally, IPC materials were distributed to 39,002 high-risk contacts, and at least 1.2 million people received information on COVID-19 risk factors and prevention measures, such as vaccination, hand washing and case management options. In addition to CBRI, the AFRO team continues to support other emergencies, which may occur in the districts covered by the project.

Given the current low COVID-19 incidence observed and the consequent lifting of several COVID-19 response social measures, CBRI contributes between 50 – 90 % of all testing in some hotspot districts and at country level, such as in the Republic of Congo. Every two weeks, the 21 countries

implementing the Initiative meet to share field experiences on how to improve service delivery, with 496 personnel trained at the field level.



19 countries in the WHO AFRO region are currently enrolled in the COVID-19 community response initiative /Marriane Tabi

CBRI Country Experiences-Cameroon, Botswana, Liberia

Cameroon integrates experiences from COVID-19 CBRI initiative to respond to other diseases



WHO AFRO developed the CBRI to bolster the efforts of countries in the region to improve detection and response to the COVID-19 pandemic in hotspot areas -@WHO AFRO

CBRI was introduced in Cameroon at a time when the country was dealing with multiple outbreaks including cholera and Monkey Pox (M-pox) in COVID-19 hotspots.

A cholera outbreak in March 2022 with at least 300 cases documented in one week in Cameroon's Southwest region, posed an additional burden to the health system, which was still actively responding to the 4th wave of COVID-19. The country had also recently declared an outbreak of Mpox in its Southwest and Central regions. CBRI presented a solution for combining advocacy and surveillance efforts to respond to multiple health threats.

CBRI highlighted and bridged gaps in both human and cash resources required for managing multiple outbreaks. In hotspot areas witnessing considerable challenges in detection and response, these gaps pose added pressure on health systems. With CBRI, Cameroon's health partners leveraged teams composed of epidemiologists, laboratory technicians, surveillance focal points in health facilities, nurses, and community health workers (CHWs) to strengthen surveillance and community response to COVID-19, and to support cholera and Mpox surveillance and treatment in the most affected health districts.



Health district actors and WHO's commitment in engaging communities through sensitization, has been key in the project's successful implementation in countries -@WHO AFRO

Achievements in Cameroon

CBRI helped to increase response efficiency by combining advocacy and surveillance efforts in a context of multiple health threats. Additionally, it encouraged increased partner collaboration, which was instrumental in supporting the entire response cycle, from prevention to case detection to treatment.

Of the 31,373-antigen rapid diagnostic tests (Ag-RDTs) targeted in the COVID-19 CBRI in Cameroon, 41,545 tests were performed, above the testing target. Of the total, 746 people tested positive, and 705 cases were evaluated, with 95 receiving a further referral to a treatment unit. Another 700 samples were collected for genomic sequencing. At least 125,500 people participated in awareness activities, and 250 of 235 targeted communities were evaluated with the WHO IPC scorecard assessment tool.

Cameroon witnessed over the last four weeks of October an increase in the number of people vaccinated and tested, attributed to CBRI-prompted active case finding. CBRI also encouraged home-based isolation and care (HBIC) and provision of community IPC kits. Equally, it has helped to assess

hotspot communities for adherence to public health and social measures with enhanced RCCE activities.

Showcasing the utility of integrated disease management, 1,105 alerts on cholera were received from CBRI implementing districts, which carried out 832 tests - 562 positive for *Vibrio Cholerae* bacterium. Integrating resources meant increased spending and personnel efficiencies, a welcome development in resource-limited health settings; because of monitoring visits by CBRI health personnel to communities, 1,079 households and 138 health district centres were sanitized.

With the outbreak of Mpox, health stakeholders harmonized surveillance, response and key performance indicators for that pathogen, integrating them into the CBRI data collection tool. Implementing districts are expected in the weeks ahead to receive training in data gathering, followed by data analysis.

Determinants of the country's successful implementation of the CBRI project include the commitment of health district actors, together with continued funding and technical support from WHO. A second phase of the project is scheduled for the coming months, targeting two additional districts for three months.¹



Lessons from Liberia: CBRI has compelled more testing and increased vaccination

After launching its COVID-19 vaccination programme in March 2021, Liberia's coverage of fully vaccinated people stagnated at less than 30%. A low-risk perception of the pandemic and a decline in cases had contributed to discontinuing public health and social measures but resumed in hotspot districts when the country joined in July 2022 WHO AFRO's CBRI programme.

¹ CBRI received preliminary support from the WHO Ethics Review Committee, its further expansion will be subject to more thorough review to ensure compliance with the organization's ethical criteria.

Out of 15 counties in Liberia, Nimba and Montserrado counties were selected for initial CBRI implementation. The two counties make up about 45.5% of the country's population of five million, with Montserrado being in the country's capital Monrovia. In its turn, Nimba is considered a strategic location to implement the initiative, because it borders Sierra Leone, Guinea, and Côte d'Ivoire, a hotspot for easy cross-border transmission of COVID-19.

For the response, Liberia has been incorporating lessons from its experience with Ebola Virus Disease (EVD), such as strong political buy-in, collaboration and community engagement. Identifying community influencers who worked closely with mobile health teams and local leaders at the county level has been critical. Working in close collaboration with the technical health pillars, influencers chosen among community leadership helped mobilize people for vaccination, while CBRI teams provided information on prevention measures, conducted testing, undertook contact tracing, and linked those who needed care to treatment centres.

People who tested positive and were asymptomatic or had mild symptoms received bespoke home-based care (HBC), with regular visitation by health workers and community influencers. This aspect of the response was critical in reducing pressure on facilities witnessing multiple health conditions. It also provided a personal touch, which reassured people and helped to increase their disposition to turn up for testing. Moreover, with a perspective of receiving good aftercare both at home and at health facilities, people were better prepared to accept the news of potentially positive test results. Directly resulting from the CBRI presence, between July and the end of October Liberia tested 60,877 people for COVID-19 - 233 positive -, representing three times the initial testing target. Cumulatively, between 1 January and 31 October, the country recorded 1,205 cases of COVID-19.

“Without this project, these 233 cases could have remained undetected. And if you don't detect, you cannot undertake timely isolation, which is critical in preventing the transmission chain,” explained Dr Mandy Julius, Team Lead for health emergencies at WHO Liberia.

CBRI also pushed Liberia's vaccination coverage over the 70% mark, with a total of 9,975 people vaccinated during the project implementation period, making it one of three countries in the WHO African region to reach that target alongside Seychelles and Mauritius. Liberia plans to integrate the CBRI approach to manage other public health interventions and expand it beyond the two pilot counties.



WHO supported Liberia's CBRI response efforts by training teams on how to engage communities in Liberia-@WHO AFRO

Lessons from Botswana: Community Health workers encourage social and health system links in Botswana

In Botswana, the inclusion of community health workers (CHWs) in CBRI boosted collaboration between communities and health systems in the pandemic response. Already busy with prevention and referral work surrounding routine disease management and outbreaks, CBRI trainings doubled the impact of CHWs actions within both social and clinical settings.



Genomics Sequencing is a major part of the CBRI project. Here, is the team charge with genomic assessment at the Manguzi hospital in Kwazulu Natal, South Africa. The team also supports cross border surveillance-@WHO AFRO

For most people in Africa, the first point of contact in primary care are community health workers. These are often members of communities who work on a quasi-volunteer basis at the grassroots level in both rural and urban settings on the continent, visiting households door-to-door to encourage vaccination, promote prenatal care, and refer those presenting symptoms to health facilities.

Participants from Botswana said CBRI served to complement and enhance the country's active CHW base. Characterised by tremendous gaps in the number of health care personnel available in the country, CHWs are a key aspect of Botswana's universal health care goals and architecture. In this context, CBRI provided COVID-19-specific training to 105 CHWs in 12 facilities in three of 27 health districts on case finding in the community, community testing, caring and follow up of cases in home-based isolation, in addition to IPC kit distribution. Working from June to September with the Ministry of Health and WHO, the CHWs were exposed to all aspects of the COVID-19 response, from surveillance to laboratories, case management, infection prevention and control, and risk communication and community engagement.

Armed with skills to detect symptoms and refer those at risk to appropriate diagnosis, because of the CBRI training, CHWs are now able to combine skills in COVID-10 detection, integrating the newly acquired knowledge to monitoring for other diseases, such as HIV, Ebola virus disease, diarrhea, and respiratory pathogens besides SARS-COV-2, among others. During CBRI implementation, the CHWs responded to a seasonal diarrhea outbreak together with the COVID-19 response work, an example of integrated emergency response.

CBRI also addressed the COVID-19 *Infodemic*. For example, all three CBRI implementing hotspot districts had been hard hit by false rumors, myths, and misconceptions about the disease. CBRI-trained CHWs to work within communities to dispel myths and reduce vaccine hesitancy during RCCE campaigns, IPC kit distribution, and active case monitoring, both at home and in health facilities.

As a result of CBRI, COVID-19 detection increased in the implementing districts, with 355 cases detected among 1,125 COVID-19 rapid tests; 203 cases and high-risk contacts were reached with IPC kits. Moreover, it was reported that CBRI witnessed a reduction in the number of brought-in-dead (BID), because of early case detection and continuous monitoring.

4 Update on pillar response actions

4.1. Coordination

WHO AFRO launched in November a three-month fellowship programme to address challenges in capacity in addressing public health emergencies in Africa confirmed by the COVID-19 pandemic. The Fellowship will support 15 aspirational master's degree students, PhD fellows, and emergency public health managers and leaders to advance skills and competencies for strategizing, managing and leading public health emergencies. A call was issued early in November on the WHO AFRO website and social media pages, with a 20 November 2022 deadline. Fifteen individuals will be selected among 1,599 applicants.

4.2. Case Management

During the month of November, WHO AFRO attended a global meeting on case management to discuss allocation and uptake of COVID-19 therapeutics for quarter four (Q4) of 2022. Some 527,112 allocations of Molnupiravir were made available to Zimbabwe, Togo, Rwanda, Namibia, Lesotho, Eswatini, Ethiopia, Kenya, Ghana, Cameroun, Mali, Ivory coast, Burkina Faso, and Mozambique.

Ghana and Ivory Coast confirmed allocations for Q4 of 504 and 2,592 doses, respectively. Ghana and Lesotho were offered 5,670 and 420 doses of Tocilizumab, respectively. However, these countries have yet to confirm the allocation. Another 320,832 doses of Nirmaltrevir-Ritonavir (Paxlovid) have been offered to Ethiopia, Ghana, Ivory Coast, Mozambique, Senegal, Malawi, Rwanda, Botswana, and Lesotho. Scheduled allocations will continue in the foreseeable future, in addition to stockpiling of drugs for the event of a surge.

From 8 to 11 November an inter-regional training on the WHO Emergency Care Toolkit was held in Nairobi; and an Emergency Medical Team (EMT) induction training was held in Mauritania, to introduce the country's emergency medical team members to teamwork during an emergency. The EMT induction training provided participants with knowledge on quality clinical care services to populations affected by public health emergencies, and provided the opportunity for in-depth discussion on development, implementation, and capacity building of an EMT in Mauritania.



Group picture with the WHO country WR in Mauritania and the Minister of public health -@WHO AFRO

Challenges	Ongoing Response Actions
Some countries reporting a surge in COVID-19 cases despite the general downturn.	Continue clinical/ hospital surveillance to monitor COVID - 19 trends in Member states.

4.3. Laboratory

As COVID-19 testing decreases, even as countries remain on alert, sustaining laboratory capacities built during the pandemic is a priority. The actual number of tests conducted in Africa as a result of increased capacity supported by WHO, increased to 85.6m as of 11 December 2022, against 67.9m at the beginning of 2022. However, overall testing for SARS CoV-2 continues to decline in the region, with a mean of 4 tests/10000 and a median of 1.2 tests/10000 compared to a mean of 17.6 and median of 5.9 tests/10000 in the beginning of the year.

70% of WHO AFRO's 47 countries are testing below 5 tests per 10,000 population and the majority of countries have a positivity rate of less than 5%. Exceptions are noted to this data. For example, in the space of three months, Cabo Verde, Ghana, and South Africa sustained positivity rates of above 10% for six weeks consecutively.

Over 30 countries have integrated SARS CoV-2 into influenza sentinel surveillance and are reporting data to the global platforms. A total 40,052 COVID-19 sequences have been generated by countries in the West and Central African Regions of which 33,626 have been submitted to GISAID. West African countries sequences submissions on the GISAID platform this year increased by 96%, while Central Africa recorded a 52% increase when compared to the same period last year. However, sequencing output from the region has plateaued due to decreased testing.

A guidance framework is being prepared for countries on SARS CoV-2 testing beyond the response. Laboratory capacities are also deployed to the WHO COVID-19 Community Surveillance Project through distribution of Ag-RDT from stockpiles, and collating Strengths Weaknesses Opportunities and Threats analyses resulting from country visits to formulate a regional landscape of collective gaps and challenges to enable targeted support.

Challenges	Ongoing Response Actions
Difficulties in sustaining laboratory capacities built during COVID-19 in this transition phase.	Development of testing guidance which transcends the transition.
Delayed approval from country Ministries of Health and response of experts to support country visits.	Strict follow-up with virtual calls for countries to be visited to provide technical support.



4.4. Points of Entry (PoE)

During this reporting period, PoE team advised integration of cross border collaboration in CBRI project design. The number of countries requiring evidence of COVID-19 vaccination for international travel has reduced. Meanwhile, efforts are underway to strengthen PoE capacities in countries, given the potential for undiagnosed disease incidence in a context of lower testing rates, in addition to increased inter-continental mobility during the festive season.

Challenges	Ongoing Response Actions
Preliminary to the transition period activities, effective planning for sustainable capacity building of member countries' PoEs is not yet accomplished.	Collaboration with partners and Member States to collect existing secondary data and conducting where necessary assessments to obtain primary data and prioritise needs.

4.5. Risk Communication and Community Engagement

Appropriation and dissemination of results of qualitative studies conducted in the DRC and the Republic of Congo to enhance RCCE interventions continued, with emphasis on COVID-19 vaccine uptake. An action plan was developed to promote COVID-19 vaccination, rapid screening tests and public health and social measures.

An RCCE Regional survey conducted among WHO Country Office (WCO) RCCE focal points investigated the status on relaxation of and compliance with PHSM, in addition to RCCE challenges.

In the weeks ahead, plans are underway for developing a regional RCCE strategy and support for the Promoting Resilience of Systems for Emergencies (PROSE) flagship initiative in 10 priority countries.

Challenges	Ongoing Response Actions
General perception that COVID-19 is low leading to relaxation of public health measures in countries.	RCCE has been aligning COVID-19 key messages with the current low incidence situation of the COVID-19 pandemic in the region.



RCCE is considered key element for CBRI scale up. Providing strategic guidance to participants in a November CBRI meeting, RCCE specialists highlighted how to incorporate risk communication and cultural norms in implementation of the Initiative. WHO/Marriane Tabi

4.6. Africa Infodemic Response Alliance (AIRA)

The main rumours identified by AIRA this month through social media listening were on the Sudan virus disease. Although social media conversations on COVID-19 have reduced, AIRA continues to

monitor trends and prepare documentation in case of any possible *infodemic*. National *infodemic* management response initiatives have also received advice, in collaboration with the ministries of health. In November, 11 African women influencers shared social media messages promoting facts on COVID-19 in Guinea.

During the previous four weeks, technical support was provided to 23 countries in the WHO African Region and five *infodemic* management consultants were mentored.

Challenges	Ongoing Response Actions
Online rumours and misinformation on COVID-19 and Sudan Virus disease.	Develop a robust information flow which answers questions on SVD/COVID-19 from the public in real-time.

4.7. Information Management

The WHO County Office (WCO) and MoH in The Gambia were supported to develop a research protocol to ascertain the most likely cause of Acute Kidney Injury (AKI) among children in the Gambia, given other potential causes of AKI, in addition to adulterated medicines. Data collection and analysis of COVID-19 response Key Performance Indicator data from Member States for October were completed.

Issue 8 of the Monthly COVID-19 Response Bulletin was released on 11 November 2022. It recapitulated information on the proposed interim guidance to Member States in the transition of the COVID-19 response from acute response to recovery. It also contained information on the Fellowship programme for building capacity in managing public health emergencies, scheduled to be piloted in the coming months.

Challenges	Ongoing Response Actions
Very low documentation of best practices and lessons learnt in the COVID-19 response.	A plan to hold a Scientific writing workshop early next year to support countries to write up their work.



During the three-day regional CBRI meeting, the team presented the Monitoring and Evaluation Framework for the CBRI project as well as other data issues like collection, quality, analysis and visualization- WHO/Marriane Tabi

4.8. Infection Prevention and Control

In November, IPC standards and transmission-based precautions in health facilities were enhanced, as recommended in the global IPC strategy, even as countries are transitioning out of the acute phase of the pandemic. Priority has been given to ensure country compliance with WHO technical recommendations, tools, and strategies. IPC carried out an awareness and capacity building webinar with Ministry of Health and IPC stakeholders in preparation for the development of the five-year strategic plan for Benin, Zambia and Mozambique.

Burkina Faso and Ivory Coast were supported in the implementation of the community IPC scorecard tool. Support was rendered through the revision of the concept note and preparation of the implementation at national level.

Challenges	Ongoing Response Actions
Inadequate qualified human resources in member states that are dedicated to the implementation of IPC interventions.	Advocate for the recruitment of human resources to support and strengthen IPC in countries.

4.9. Operational Support and Logistics (OSL)

In November, all procurement related to the \$US 5 million allocated fund for stockpiling orders was finalised and delivery is ongoing. This includes personal protective equipment (PPE), biomedical equipment, emergency kits & and medicines. In cross-pillar collaboration with the case management, OSL has reinforced ICU units in 10 countries, with supply of hospital equipment. Additionally, procurement is ongoing with local suppliers in Nairobi.

In the month ahead, plans are underway to monitor the stock level of essential commodities at country level, working with IPC to prepare PPE distribution plan, fast track countries’ procurement

requests in collaboration with WHO AFRO supply chain focal point, and follow-up the shipment of supplies through the United Nations portal.

Challenges	Ongoing Response Actions
COVID--19 and EMT supplies still under shipment due to the slow process of the pre-alert system in countries.	Fast track Equatorial Guinea PSA plant procurement and contract signature for Cameroun.



During the month, OSL commissioned PSA plant (9m3/h at Liberia, Bomi hospital, on 8 November 2022. This is the second PSA plant, provided by WHO in the country -@WHOAFRO

4.10. Update on COVID-19 Vaccination

There has been marked improvement in the vaccination performance of countries following the mass vaccination campaign carried out with support from the AFRO SURGE team. The Zambia mass vaccination campaign contributed an additional 1.9 million people who have completed the primary series, while the Niger campaign witnessed over 1.2 million people completing the primary series. A mass vaccination campaign was conducted from 18 to 27 November 2022 in Cameroon, with support from WHO AFRO which resulted in some two million people vaccinated.

Four in-country missions were conducted between September and November to support countries on vaccination data management and adjusting population size estimates for high priority groups. During these missions, rapid assessment of existing data systems was completed for 20 countries.

In the month ahead, there are plans to continue to follow up with countries still waiting for data systems assessment, and support for countries which have conducted the assessment to develop operational plans to address identified gaps and challenges. Follow up is also planned for countries with disbursed funds to assess, provide guidance and strategize on timely fund utilization.

Challenges	Ongoing Response Actions
Vaccine hesitancy and low risk perception of the pandemic in most countries.	Continue vaccination campaigns in targeted countries and communities.
Competing priorities including response to outbreaks – Ebola, Polio, Yellow Fever	Discussions with countries on the possibility of integrating COVID-19 with other interventions

5 Update on Key Performance Indicators for the 2022 COVID-19 SPRP in WHO AFRO

KPI reporting levels remained high in October with all but one country reporting. Of these, 70% submitted the reports on time. This narrative covers 46 countries that reported, excluding Eritrea. (Figure 2) However, the number of reporting countries per KPI varies. The overall weighted performance for WHO AFR in October was 87%. Overall performance per country ranged from 58% to 94%. (Figure 3) A trend analysis of the KPIs from June through October is provided in Figure 24.

Regarding coordination of the response, 39/46 countries reported at least 70% of key response pillar functions filled by dedicated experts at WCOs with an average of 90% positions filled. This has been consistent since July 2022. (Figure 4) Conducting joint review meetings to assess response operations is a key recommendation to maintain response momentum. In October 32 countries reported implementing most recommendations made from joint review meetings compared to 20 the previous month. Several countries - Congo, Malawi, Madagascar, South Sudan, Guinea-Bissau, Zambia, Kenya, Côte d'Ivoire, Benin, Comoros, Eswatini, Gabon, Lesotho, Niger, Nigeria, São Tomé & Príncipe and the United Republic of Tanzania improved performance on this KPI from less than 70% to 70% or more (October) of recommendations implemented. (Figure 5) Utilization of allocated funds for the response ranges from 30 to 96% and 36 countries of 46 countries utilized at least 50% of the funds allocated. (Figure 6)

To deconstruct rumours and myths related to COVID-19, RCCE activities are essential. The number of AFR countries that completed at least 70% of planned RCCE activities, decreased from 30 (September) to 26 (October). Activities scheduled in Burundi, Mauritius and São Tomé & Príncipe were not completed. (Figure 7)

Member States continue to do surveillance for COVID-19. In October, 38 of 45 WHO AFR countries reported receiving prompt surveillance data at the district or regional level (Figure 8), a slight decline from September. Likewise, 34 of 44 countries reported monitoring of hospitalization of COVID-19 cases. (Figure 9)

Although many countries are now phasing out all COVID-19 preventive measures at PoEs, basic International Health Regulations for international travel are being maintained. In October 22 of 43 WHO AFR countries reported to have facilities that provide medical services and/or diagnostics at PoEs as was reported in the previous month. (Figure 10)

Genomic surveillance is on the decline. The number of countries performing genomic sequencing reduced from 30 in September to 21 in October. (Figure 11) In October, laboratories performed efficiently with an average PCR testing turnaround time of 21 hours. In addition, for the first time since April, all WHO AFR countries performed PCR testing within 48 hours. (Figure 12) The testing rate has steadily declined from an average of 3 tests per 10,000 population per week in August to 1 test per 10,000 population per week in October. (Figure 13)

Efforts to improve infection prevention and control are ongoing. In October, 18/46 countries reported 70% and above of their facilities attaining an IPC score of 75% or higher - using the IPC scorecard. However, the situation in 13 countries, remained below expectation, with scores below the 75% IPC scorecard threshold. In Ghana, Comoros, Eswatini and Zimbabwe, the assessment was not made. (Figure 14) 12/40 countries in October reported a national performance of personnel protection of 70 and above on a scale of 0 to 100. (Figure 15)

Seventeen countries reported ICU admissions for COVID-19, with an average case fatality rate of 8%. (Figure 16) Standardizing ICU care for management of severe and critical Covid-19 cases has been a priority during the response. In October, 23/41 countries presented adequate or required ICU standards. (Figure 17) Enough equipment and supplies were available in ICUs for the treatment of severe and critical COVID-19 cases in 32 countries, a significant increase compared to 24 countries in September. (Figure 18)

Effective disease management and response depends on supply chain efficiency, with many factors affecting this operation, such as weather conditions, conflict, manufacturing delays, and oscillating fuel costs, among others affecting contractual arrangements. 32/37 countries received timely requested quantities of PPEs, testing kits or medical equipment in October. (Figure 19)

Essential services are gradually recovering in countries. Compared to 2019, in 17/29 countries more infants survived after receiving the first dose of measles vaccine. (Figure 20)

Despite some hiccups, COVID-19 vaccination has been ongoing in WHO AFR. In October, the percentage of doses administered out of the number of doses received varied from 3% in Burundi to 100% in Zimbabwe. 15/46 WHO AFR countries, administered at least 70% of the received doses, e.g. Botswana administered 92% of the received doses. These countries are South Sudan, Ethiopia, Malawi, Zambia, Guinea, Niger, Cabo Verde, Nigeria, Côte d'Ivoire, United Republic of Tanzania, South Africa, Gambia, Botswana, Rwanda and Eswatini. Burundi, Republic of Congo, and Madagascar administered fewer than 31% of the doses received. (Figure 21) Seychelles, Liberia, and Mauritius, fully vaccinated at least 70% of the population, with Seychelles reportedly reaching 87% of the population. (Figure 22)

Research and innovation activities to support the response remain below expectation. Notable exception are Rwanda, Uganda, Zambia, Zimbabwe, Cameroon, Côte d'Ivoire, Eswatini, Sierra Leone, Benin, DRC, Liberia, Algeria, which performed well on this indicator. (Figure 23)

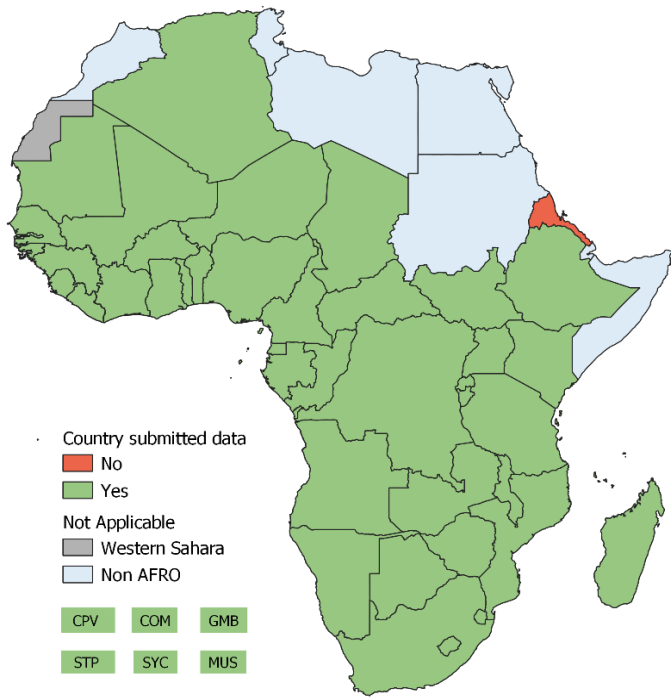


Figure 2: Completeness of reporting

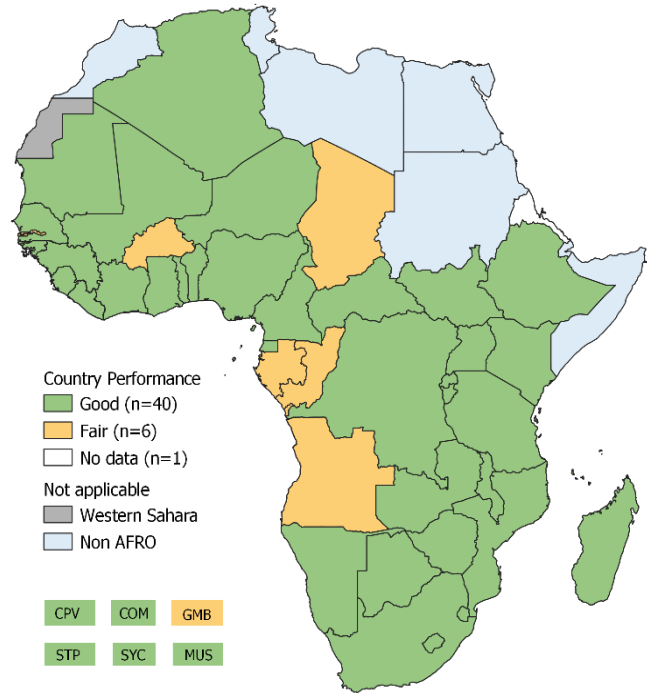


Figure 3: Overall performance

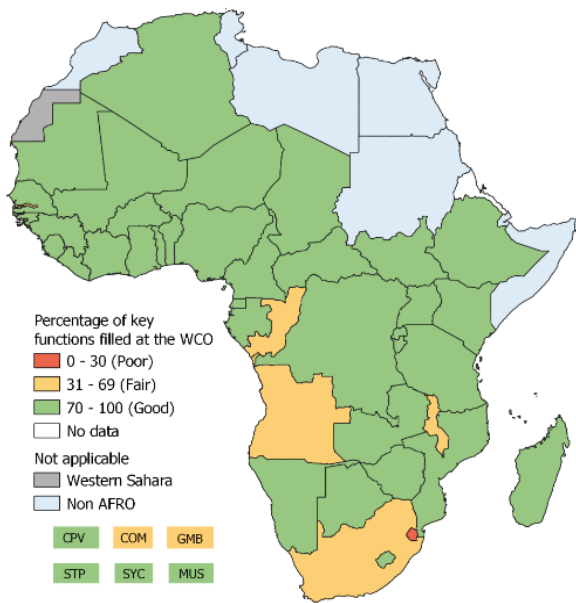


Figure 4: Key functions at WCO

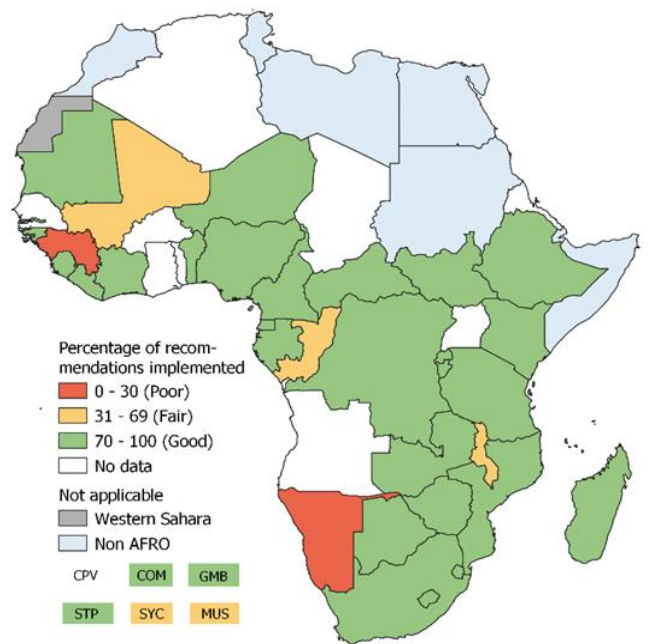


Figure 5: implementation of recommendations from joint review meetings

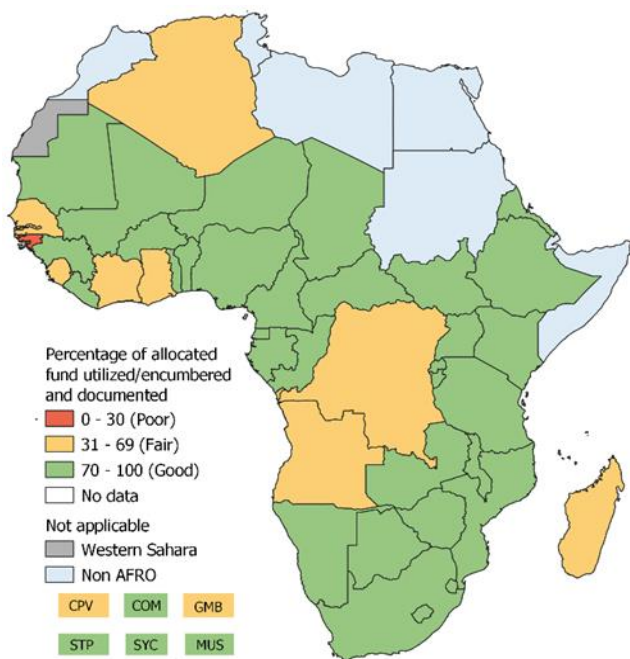


Figure 6: Utilization of allocated funding to support the response

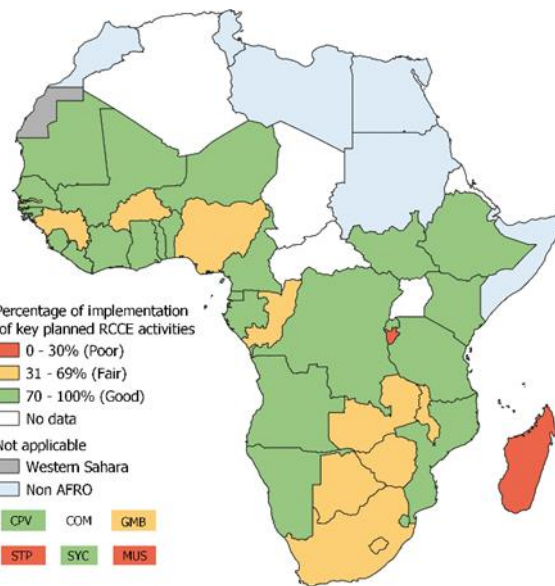


Figure 7 RCCE activities implementation

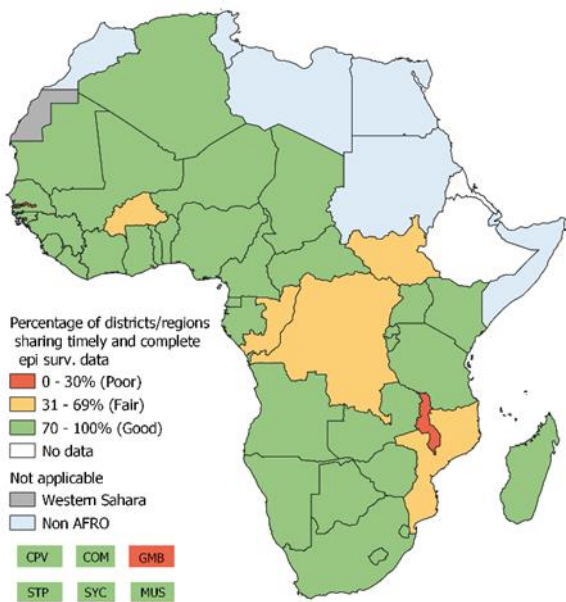


Figure 8: Reporting of surveillance data

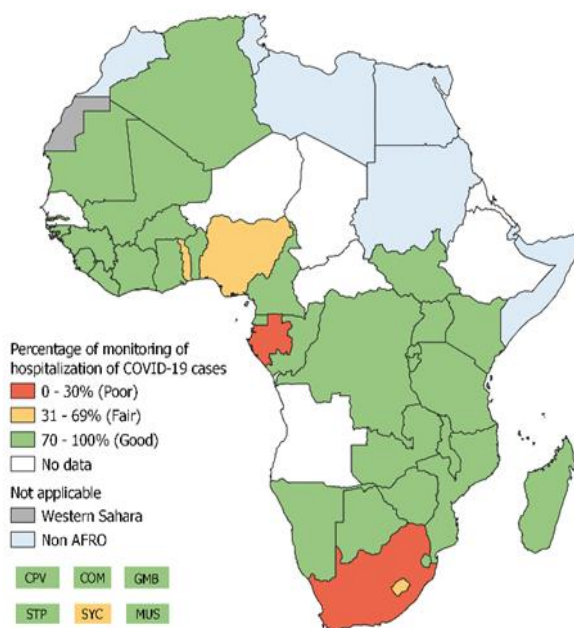


Figure 9: Monitoring of hospitalized cases

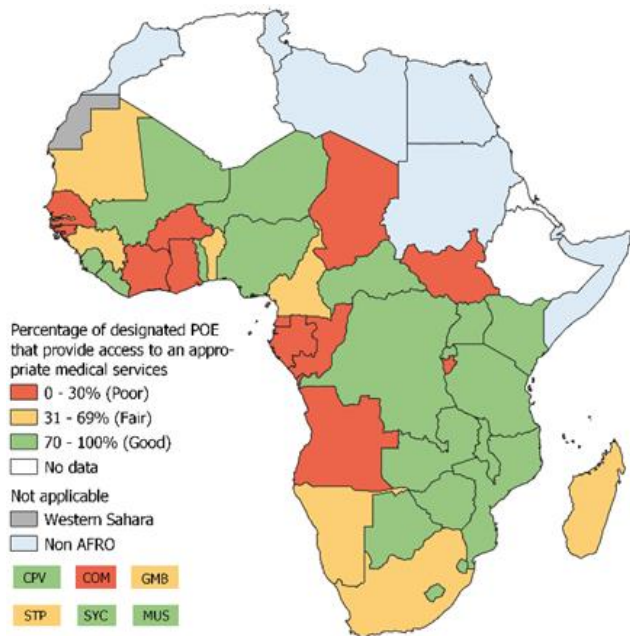


Figure 10: Medical access at PoEs

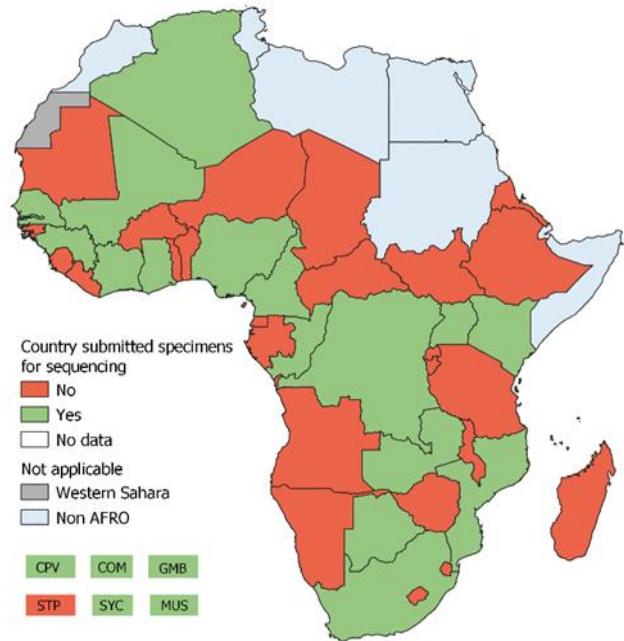


Figure 11: Genomic sequencing

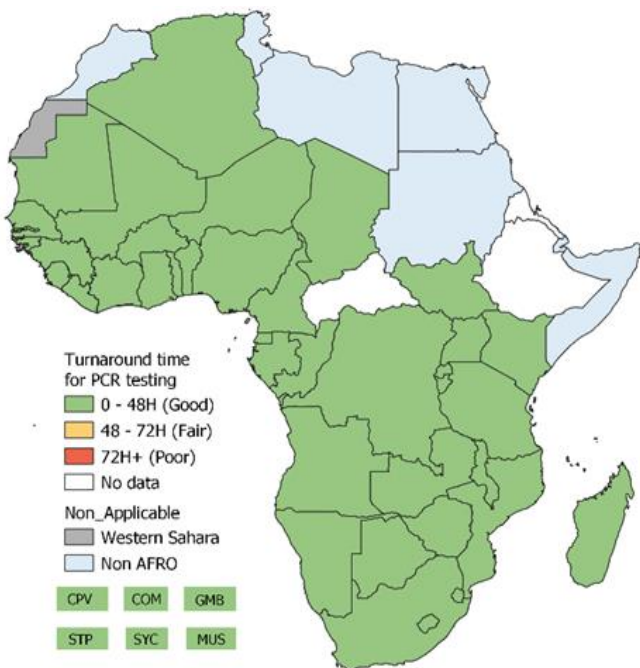


Figure 12: Turnaround time for PCR testing

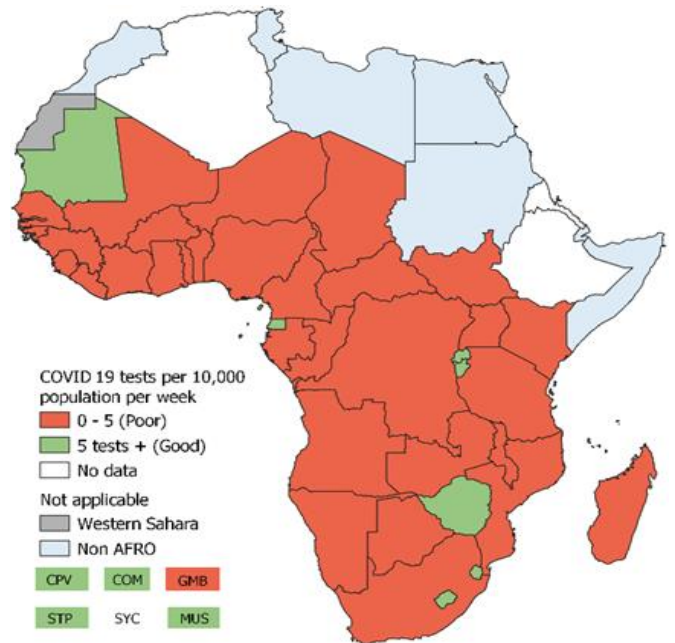


Figure 13: COVID-19 testing

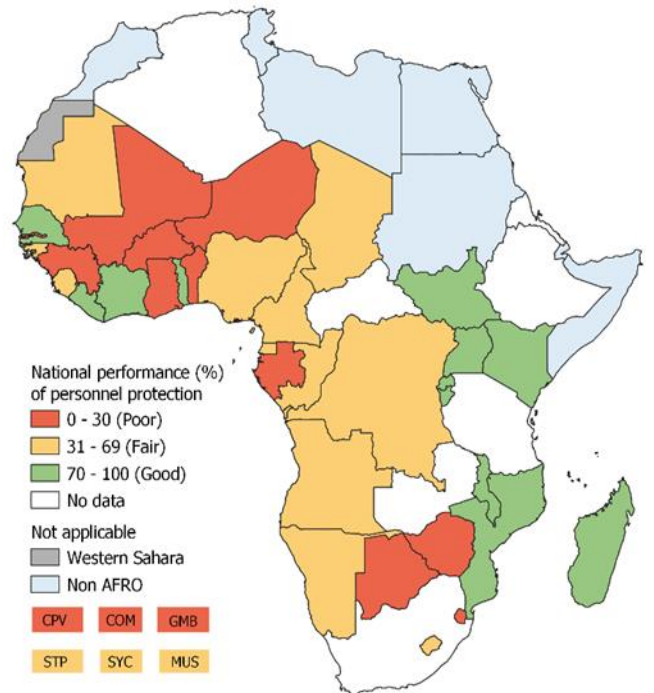
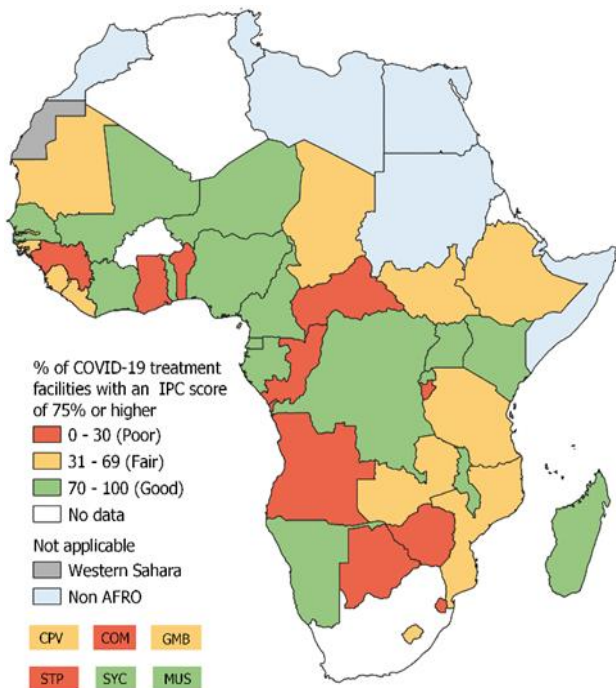


Figure 14: Infection Prevention and Control performance

Figure 15: National performance of personnel protection

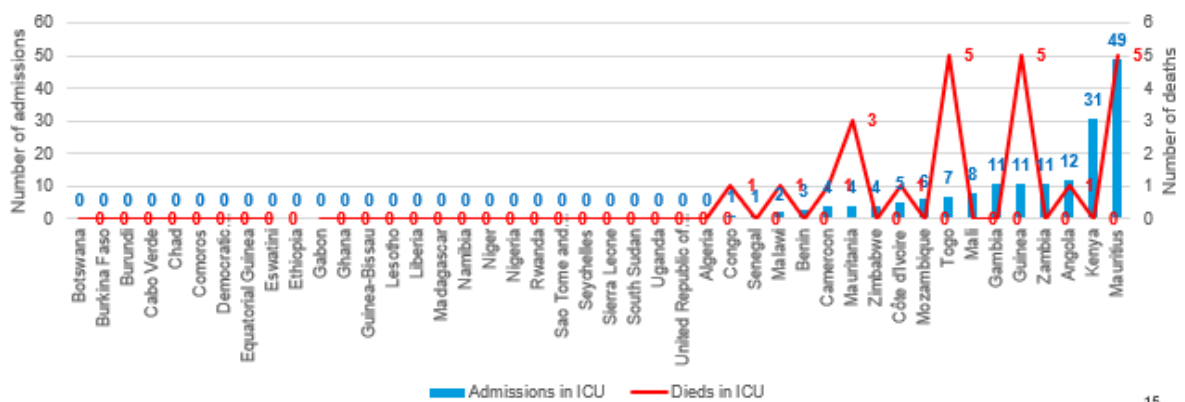


Figure 16: ICU admissions and deaths

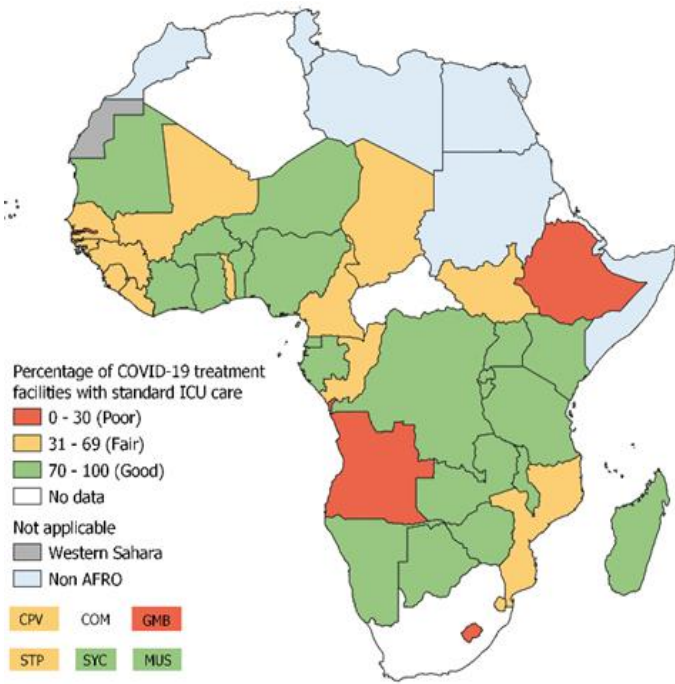


Figure 17: COVID-19 treatment facilities with standard ICU care

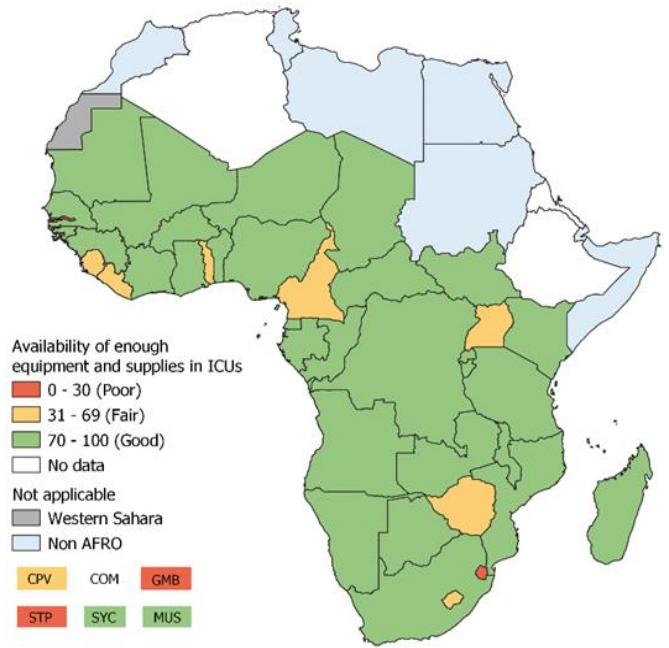


Figure 18: Availability of equipment and supplies in ICU

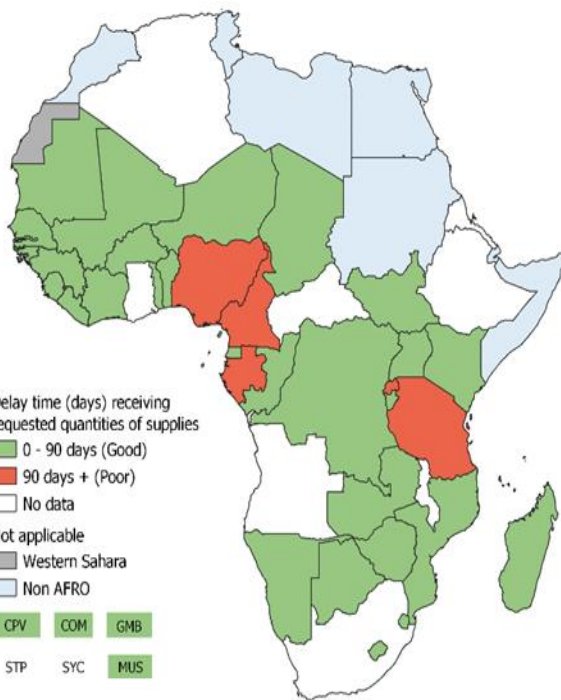


Figure 19: Delivery time of supplies for the response

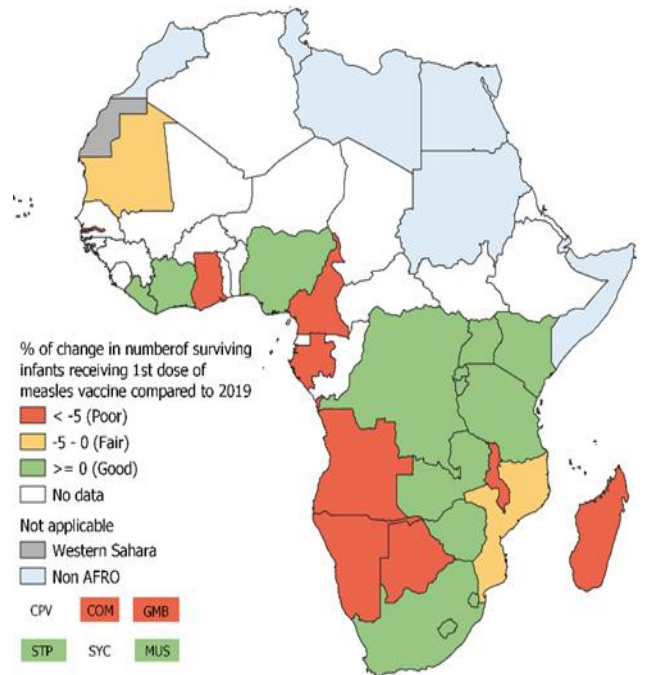


Figure 20: Surviving infants receiving 1st dose of measles vaccine

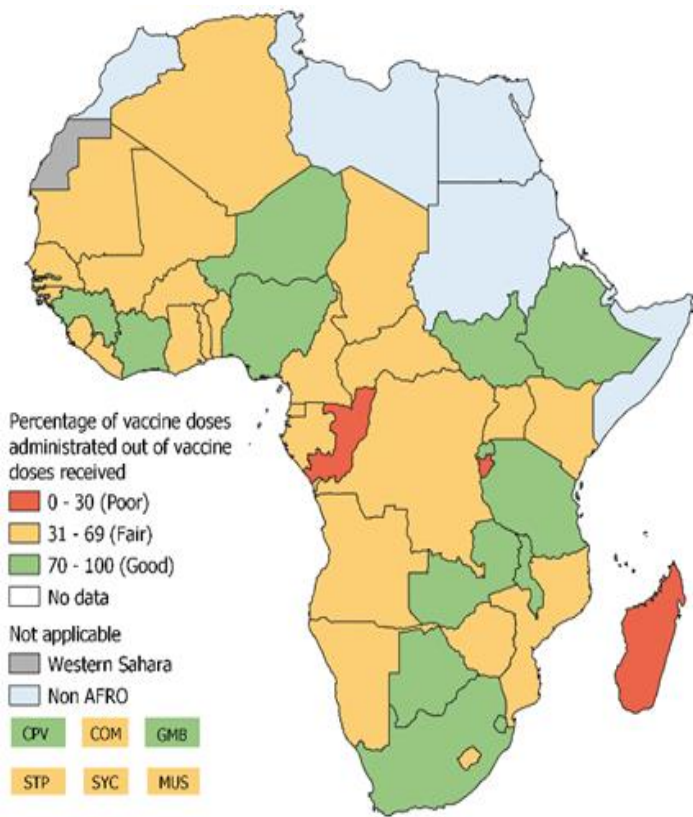


Figure 21: COVID-19 vaccine doses administered out of those received

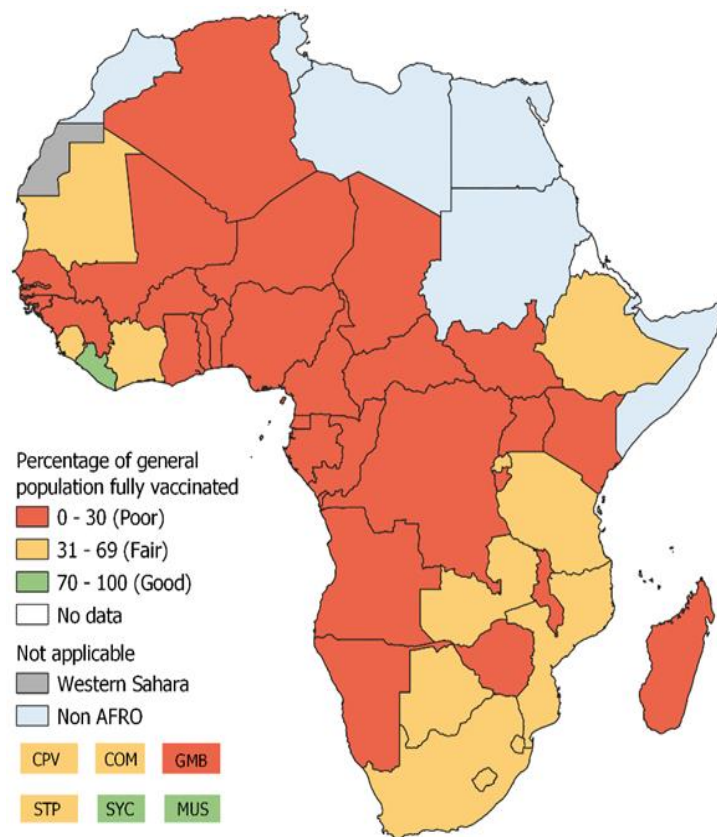


Figure 22: General population fully vaccinated

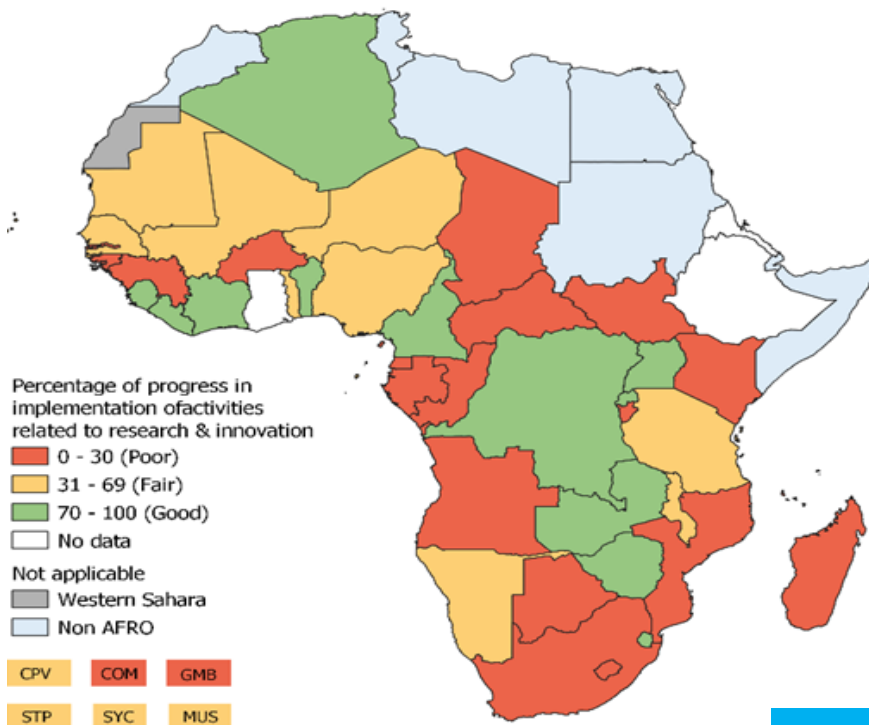


Figure 23: Implementation of research activities

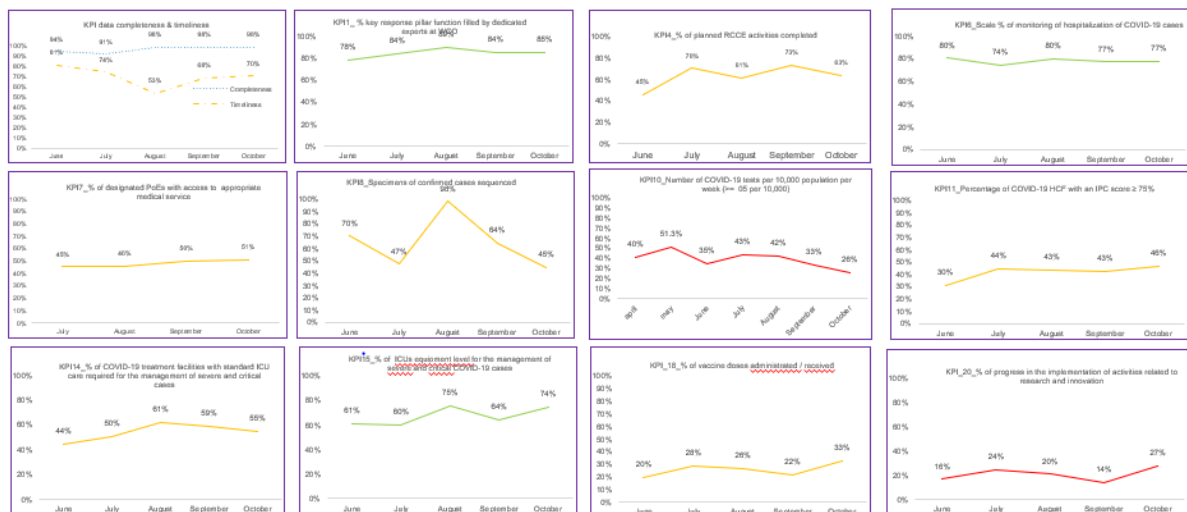


Figure 24: Trend analysis of WHO AFRO COVID-19 response KPIs from June to October 2022

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