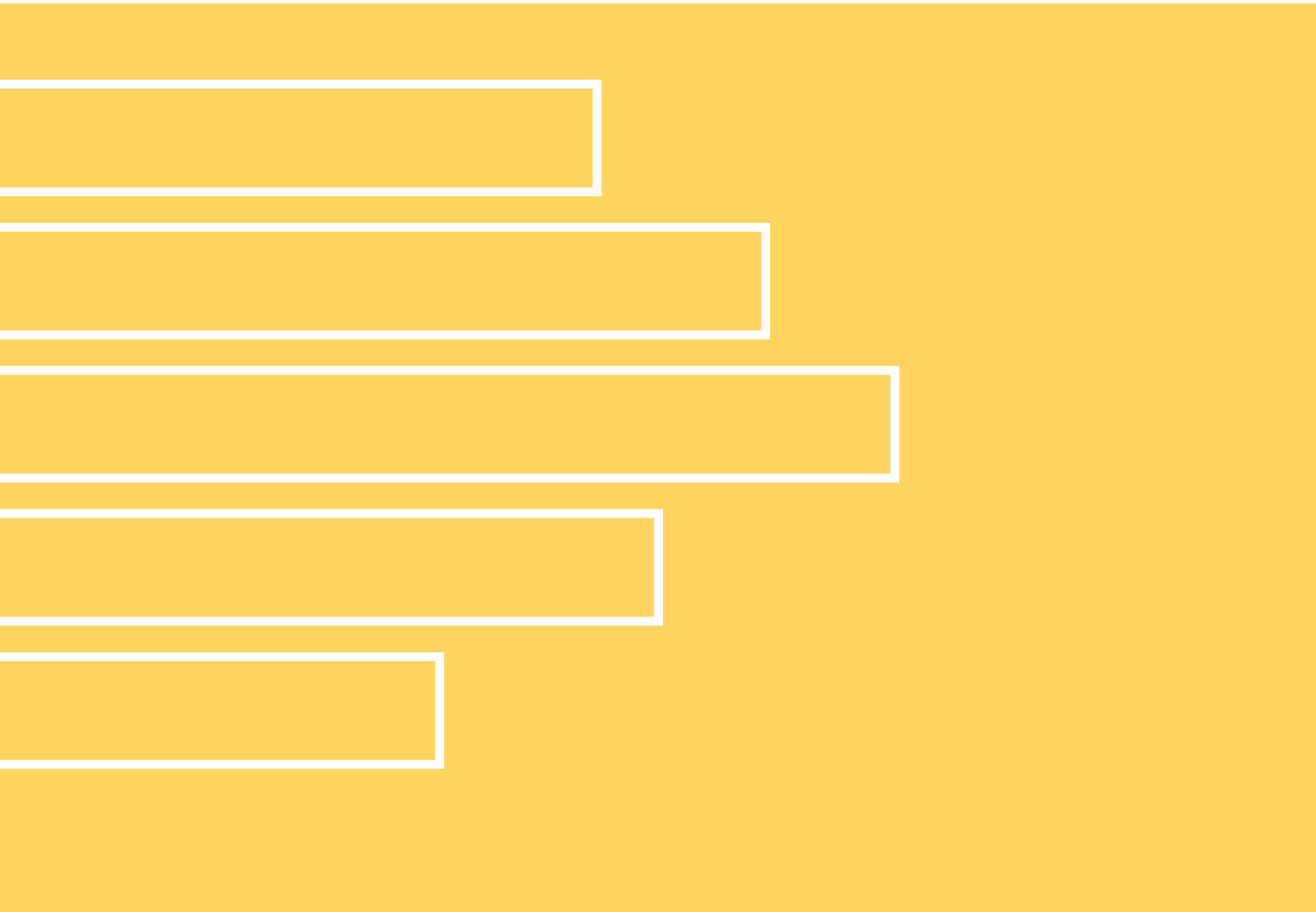AHOP **INSIGHTS**

Coordinating action: lessons from early COVID-19 response in five African countries

December 2021

Coordinating action: lessons from early COVID-19 responses in five African countries

Suggested citation

Cataloguing-in-Publication (CIP) data

Sales, rights and licensing

Third-party materials

General disclaimers

About AHOP

The African Health Observatory - Platform on Health Systems and Policies (AHOP) is a regional partnership that promotes evidence-informed policy-making. AHOP, which is hosted by the WHO Regional Office for Africa through the integrated African Health Observatory, is a network of centres of excellence from across the continent leveraging existing national and regional collaborations. The current partner National Centres are the College of Health Sciences, Addis Ababa University, Ethiopia; KEMRI Wellcome Trust, Kenya; Health Policy Research Group, University of Nigeria; School of Public Health, University of Rwanda; and Institut Pasteur de Dakar, Senegal. AHOP draws support from a technical consortium that includes the European Observatory on Health Systems and Policies, the London School of Economics and Political Science and the Bill & Melinda Gates Foundation.

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AHOP Insights:

The "AHOP Insights" series draws upon the reflections of AHOP Partners and the wider evidence base. We explore themes that are of importance to the African Region, often applying a comparative lens to interrogate issues and learn from diverse approaches. The series aims to capture current concepts, experiences and solutions to the ever-changing health systems and policy environment.

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An early review of this document was provided by colleagues at the European Observatory on Health Systems and Policies and the Bill & Melinda Gates Foundation.

Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
AFTCOR	Africa Task Force for Novel Coronavirus
AHOP	African Health Observatory - Platform on Health Systems and Policies
AU	African Union
CDC	Centers for Disease Control and Prevention of the United States
CNGE	National Epidemic Management Committee (Senegal)
COUSP/PHEOC	Public Health Emergency Operations Centre (Senegal, Ethiopia)
DFID	Department for International Development of the United Kingdom
EAC	East African Community
EPHI	Ethiopian Public Health Institute
EU	European Union
IPD	Institut Pasteur de Dakar (Senegal)
MoH	Ministry of Health
MoHSA	Ministry of Health and Social Action (Senegal)
NCDC	Nigeria Centre for Disease Control
NDRMC	National Disaster Risk Management Commission (Ethiopia)
NEPRCC	National Epidemic Preparedness and Response Coordination Committee (Rwanda)
NERC	National Emergency Response Committee on Coronavirus (Kenya)
NPHCDA	National Primary Health Care Development Agency (Nigeria)
PTF COVID-19	Presidential Task Force on COVID-19 (Nigeria)
RBC	Rwanda Biomedical Centre
REC	Regional economic community
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization

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Key messages

Early in the COVID-19 pandemic, the five AHOP countries, namely Ethiopia, Kenya, Nigeria, Rwanda and Senegal, recognized that the response to the pandemic had to go beyond health, and efforts were made to integrate action on health with responses across the education, economy, trade and culture sectors.

The governments of AHOP countries responded strongly to the COVID-19 pandemic, setting up task forces, command posts and coordination committees to take on specific roles and responsibilities. This meant that their ministries of health did not solely take on the burden or responsibility for pandemic health outcomes and could draw on wide expertise, resources and capacity.

New structures brought together stakeholders from across and beyond the governments. These multisectoral and multistakeholder responses led to greater flexibility, inclusivity and reach, but they also presented challenges such as duplication of activities and disconnect among stakeholders at national and subnational levels or between public and private efforts.

The specialized structures and multisectoral responses were often driven by the highest echelons of governance. It remains to be seen if these structures will continue to be effective in the medium to long term and with vaccination strategies dominating the discourse.

There are opportunities to institutionalize a multisectoral and multistakeholder approach for the future of health systems.

Introduction

In early 2020 countries across the globe were forced to act fast and organize themselves in response to the newly identified SARS-CoV-2 virus which causes COVID-19.

Over a year and a half on, five National Centres from the African Health Observatory - Platform on Health Systems and Policies (AHOP), based in **Ethiopia**, **Kenya**, **Nigeria**, **Rwanda** and **Senegal**, reflect on how their national responses were coordinated and the extent to which these responses have evolved as COVID-19 continues to pose a serious health threat (Figure 1). Regional reflections and cross-cutting insights are shared.

Fig. 1: WHO African Region daily confirmed cases of COVID-19 (January 2020 to July 2021)
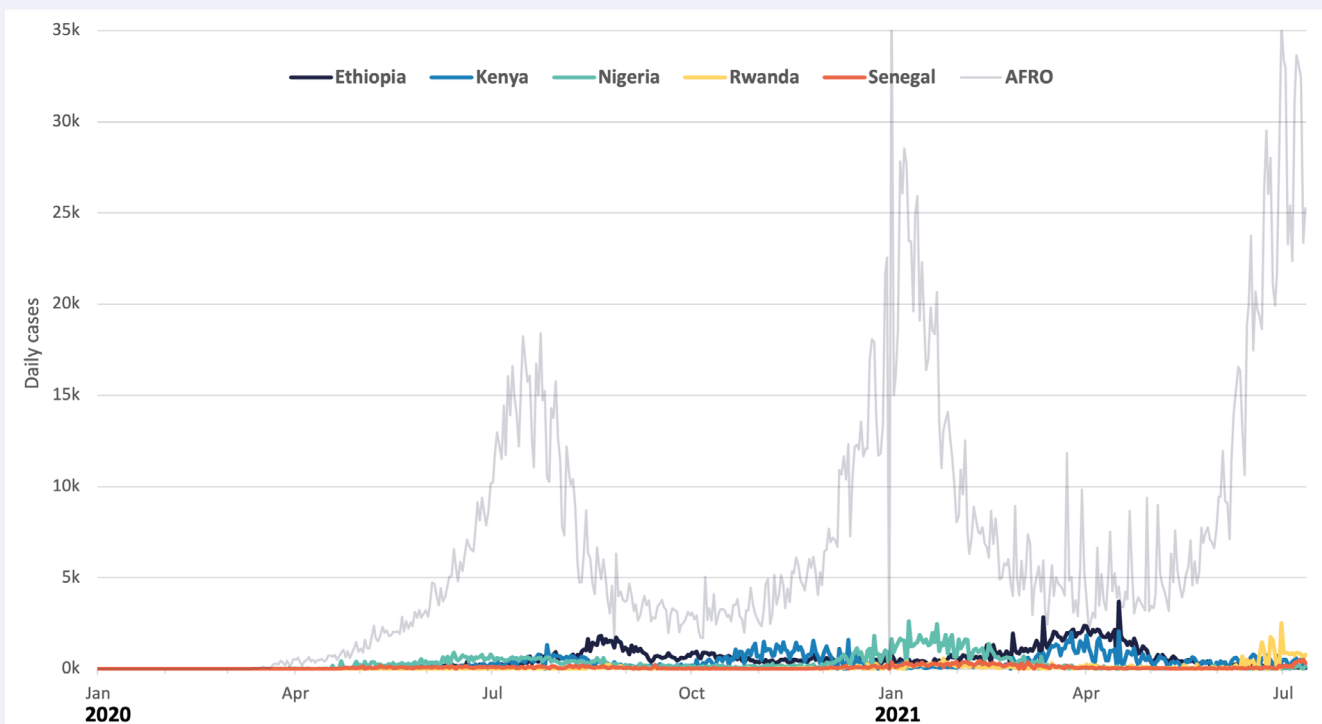
Source: AFRO Dashboard (https://who.maps.arcgis.com/apps/dashboards/0c9b3a8b68d0437a8cf28581e9c063a9, accessed 2 August 2021)

Ethiopia

From the outset, the Ethiopian government took the lead in coordinating the COVID-19 response efforts at the national and local levels.

At the national level, the response was coordinated by the National Disaster Risk Management Commission (NDRMC), an interministerial group first convened in March 2020. Additional oversight and follow-up were provided by the Prime Minister. The Commission was formed specifically to coordinate the pandemic response and formulate emergency legislation. It had no direct link with primary health care structures.

> "
> The Ethiopian COVID-19 response was an example of consultative policy-making in a country where the policy-making culture remains predominantly vertical

As a member of NDRMC, the Ministry of Health (MoH) provided technical guidance to the cross-sectoral nationwide response efforts. Along with the MoH, the Ministry of Peace was mandated to handle and operate quarantine centres. Several teams reported to the Minister of Health, including a task force, a response director, a scientific thinktank, the Ethiopian Public Health Institute (EPHI) and the Public Health Emergency Operations Centre. All these structures were involved in the response with specific yet overlapping roles and functions. Some of the structures and teams supporting the COVID-19 response efforts were newly created while others predated the pandemic. The mechanisms to coordinate and streamline their work or to distinguish between new and pre-existing functions remain ill defined. Similarly, the roles and partnership arrangements are unclear for the other key health stakeholders including United Nations agencies, USAID, DFID, the EU and other donors, as well as the implementing partners, universities and the private sector, none of which is visible in the COVID-19 response implementation arrangement frameworks (Figure 2).

In its early days, the pandemic response implementation in Ethiopia appeared vertical, with important stakeholders outside the government omitted. **As in many countries across the region, the approach taken diverted resources committed to health system functions and essential services to the pandemic response, jeopardizing the continuity of routine health care.** After the initial phase of the outbreak, efforts were made to learn from the measures implemented hitherto in order to improve future responses. NDRMC undertook a series of visits and consultations with actors at the grassroots to understand the challenges and to revise the approaches accordingly. This consultation process, alongside informal advocacy efforts conducted via the media, resulted in new provisions 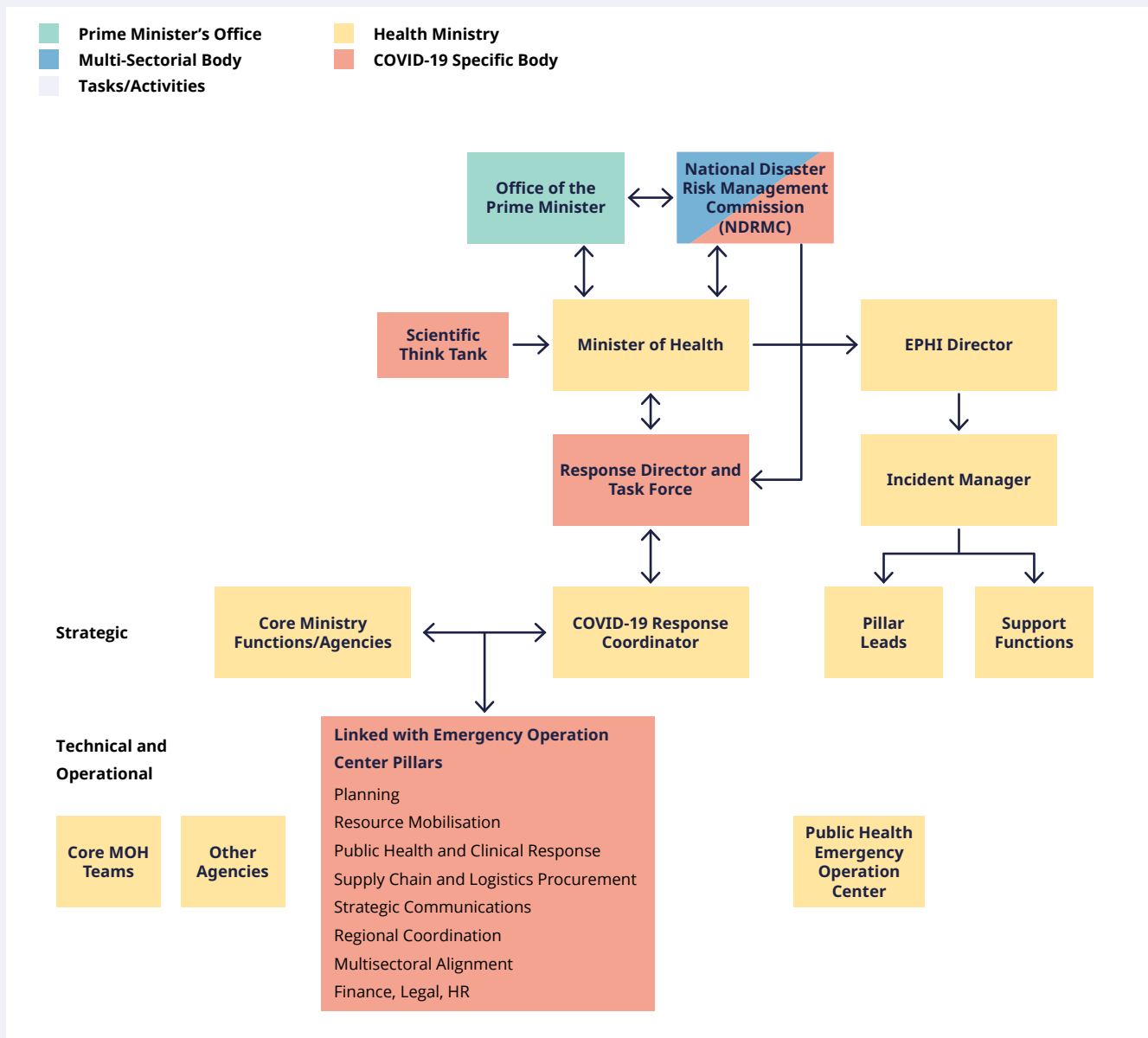for opening private COVID-19 treatment centres and the expansion of testing centres. This was a rare example of consultative policy-making in a country where the policy-making culture remains predominantly vertical.

Fig. 2: Overview of the Ethiopian COVID-19 response

Source: Presentation by the Minister of Health Dr Lia Tadesse

Kenya

Kenya adopted a whole-of-government approach in the coordination of the COVID-19 response activities (Figure 3).

In January 2020, to facilitate decision-making the government published its National 2019 Novel Coronavirus Contingency Plan,[1] which provided guidance on COVID-19 preparedness and response and detailed the roles and responsibilities of government bodies. On 28 February 2020, the president instituted the National Emergency Response Committee on Coronavirus (NERC) through an executive order. NERC was formed after the Inter-Ministerial Disaster Coordinating Committee was disbanded and drew its membership from several ministries. It is chaired by the Cabinet Secretary of Health and it still continues to be responsible for coordinating Kenya's preparedness for and response to COVID-19.

Fig. 3: Overview of Kenya's COVID-19 response
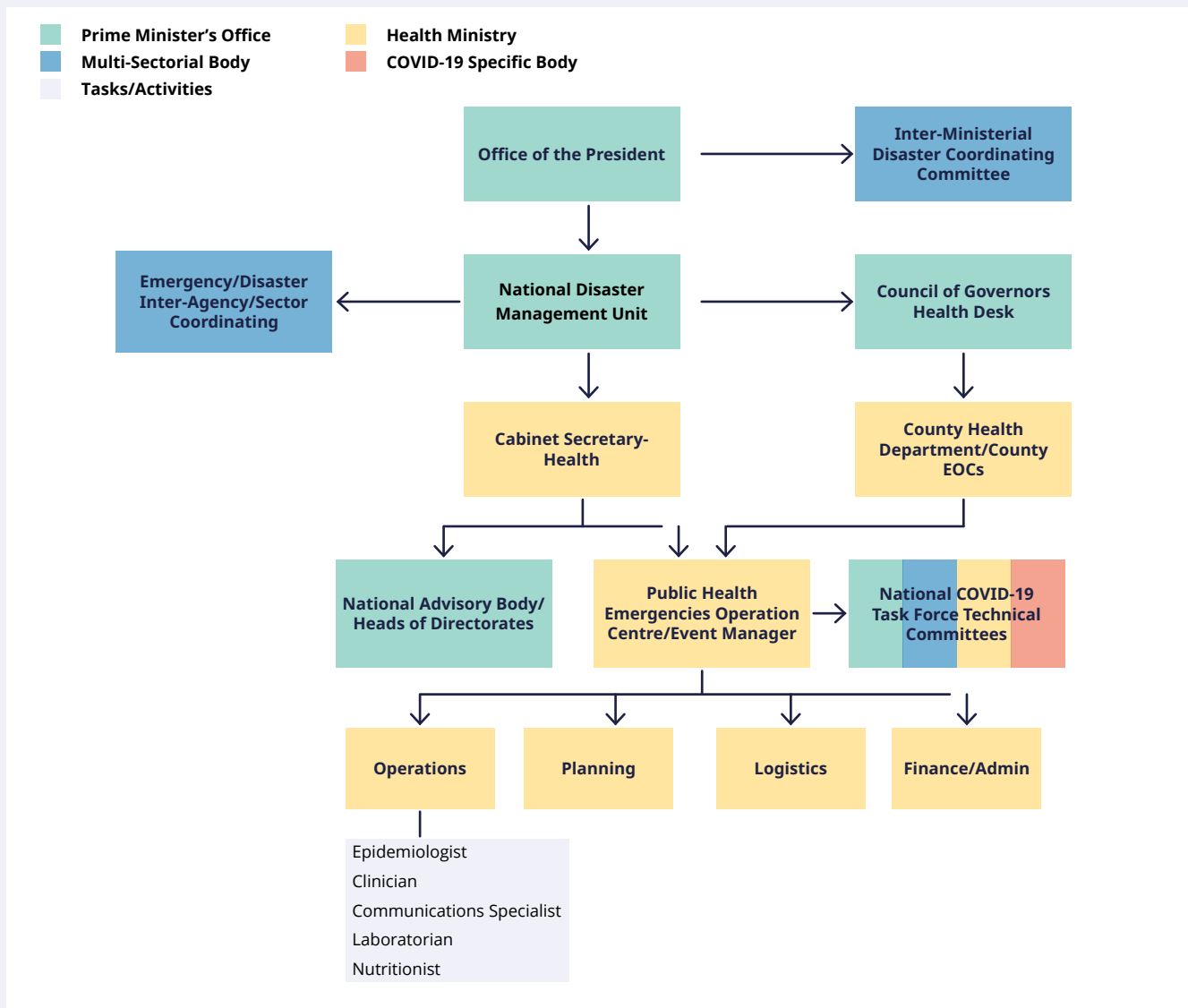
Note: On 28 February 2020, the President instituted the National Emergency Response Committee (NERC) on COVID-19 through an Executive Order. NERC was formed after the Inter-Ministerial Disaster Coordinating Committee was disbanded.

Sources: Executive Order No. 2 of 2020, National Emergency Response Committee on Coronavirus; Issues at State House, 28 February 2020. (https://www.health.go.ke/wp-content/uploads/2020/06/Executive-Order-No-2-of-2020_National-Emergency-Response-Committee-on-Coronavirus-28.2.20.pdf, accessed 2 August 2021)

The World Bank. Kenya COVID-19 Emergency Response Project (P173820) (http://documents.worldbank.org/curated/en/146211585062143296/pdf/Project-Information-Document-KENYA-COVID-19-EMERGENCY-RESPONSE-PROJECT-P173820.pdf, accessed 2 August 2021)

ThinkWell Strategic Purchasing for Primary Health Care. (2020). COVID-19 Summary Update for Kenya. Washington, DC: ThinkWell.

While NERC provides overall oversight of the contingency plan, the National COVID-19 Task Force Technical Committee leads its implementation. The task force is led jointly by the Presidency and MoH and includes members from MoH and other government agencies, the United Nations, development partners, NGOs and civil society organizations and the private sector, which is represented through the Kenya Private Sector Health Association and the Kenya Healthcare Federation.

> **"**
> **Kenya soon recognized the need to utilize routine data in both responding to the pandemic and as a lever for guiding decision-making**

The task force has the mandate to review the evolving threat posed by the COVID-19 outbreak. In addition, it can coordinate and mobilize technical advice and financial resources to the Ministry of Health and other ministries on appropriate measures. It was subdivided into different subcommittees that included resource mobilization; public health emergency operations; media, communications and call centres; case management and capacity building for health workers; laboratories for sample handling and testing; facility preparedness; human resources for health; and mental health and psychological support. Inevitably, as the pandemic evolved, the bulk of the contingency planning, coordination and response fell on the task force, while NERC retained the mandate for high-level policy-making.[2]

Regionally, the East African Community (EAC) launched a COVID-19 response plan that focused on building regional capacity to support partner States in surveillance, monitoring and coordination of preparedness and response to the pandemic; research and development; and resource mobilization.[3] However, coordination efforts in the subregion have been hampered by the differing approaches adopted across the EAC countries.

The implementation and coordination of the task force's action points were carried out within the MoH departmental structure, which included the Director General's Office and the Public Health Emergency Operations Centre. Owing to the decentralized nature of Kenya's governance structure, coordination with the county governments was critical in the pandemic response. MoH provided daily situation reports through the Cabinet Secretary, the chief administrative secretaries and the Director General. These efforts evolved to achieve two main goals: consistent messaging and communication to the general public and partners and development of a mechanism for feeding evidence into response decision-making. They additionally helped to insulate technical decision-makers from the political pressure associated with the COVID-19 response.

The Presidency also established the Task Force to Marshal Funds for Coronavirus Response. This body comprised a multisectoral membership drawn from the private, development and public sectors. The national government and the county governments, which were represented through the Council of Governors, organized the Virtual Pandemic Response Summit Presidency that launched the Task Force to Marshal Funds for Coronavirus Response. This strategy was premised on five pillars: boosting private sector activity; policy, legislative and institutional reform; strengthening county governments' preparedness and response to pandemics and disasters; enhancing information and communication technology capacity for business continuity; and investing in human resource development. The counties'

COVID-19 Social Economic Reengineering and Recovery Strategy was anchored in the United Nations Development Programme's common themes that emphasize the protection of health services and systems; the scale-up of social protection, job protection and support of the most vulnerable productive sectors; cohesion and community resilience; and strategies that are 'greener' and 'bluer', while taking advantage of innovation and technology.

The national coordination efforts worked as planned up to a point. Clarity around the roles and responsibilities of the various stakeholders was at times lacking, for example for the development and technical partners, donors and corporate organizations. The roles and responsibilities of the subnational-level actors varied in responding to the crisis and taking direction from the national level. The national government does not have direct control over what the counties seek to engage in or the partnership coordination mechanisms between them. Some counties are doing better than others in innovating and responding to the crisis, resulting in calls to strengthen intergovernmental coordination across the counties. Synergizing private and public sector activities and information sharing has also been a challenge, despite the private sector's involvement in NERC.[4]

Experience in Kenya to date suggests a need for better and more transparent communication and better public engagement instead of the current operating modes that are often ad hoc, fragmented and selective, and better coordination between subnational and national level governance structures. There is also a need to continue the renewed focus on and utilization of routine data in both responding to the pandemic and as a lever for guiding decision-making and exposing gaps in the health system. The utility of digital and other virtual platforms for data collection and dissemination and for engagement has also been highlighted by recent experience, suggesting there is value in strengthening and sustaining these activities beyond the pandemic. Finally, indications are that the whole-of-government approach should not stop with the pandemic but could usefully continue to guide multisectoral collaborations.

Nigeria

The COVID-19 emergency has required a multisectoral response beyond the Ministry of Health, which traditionally was responsible for addressing Nigerian health needs.

The Presidential Task Force on COVID-19 (PTF COVID-19) was established by President Muhammadu Buhari on 9 March 2020. This task force and MoH together have led the coordination of COVID-19 activities across the country (Figure 4). The membership of the task force includes the Secretary to the Federal Government; an appointed National Director of the Committee; the Director General of the Nigeria Centre for Disease Control (NCDC); the Ministers of Health, the Interior, Humanitarian Affairs and Disaster Management/Social Services, Information, Education, and Environment; the Director General of State Services; and the WHO Acting Country Representative.[5]

Fig. 4: The COVID-19 national multisectoral response team in Nigeria
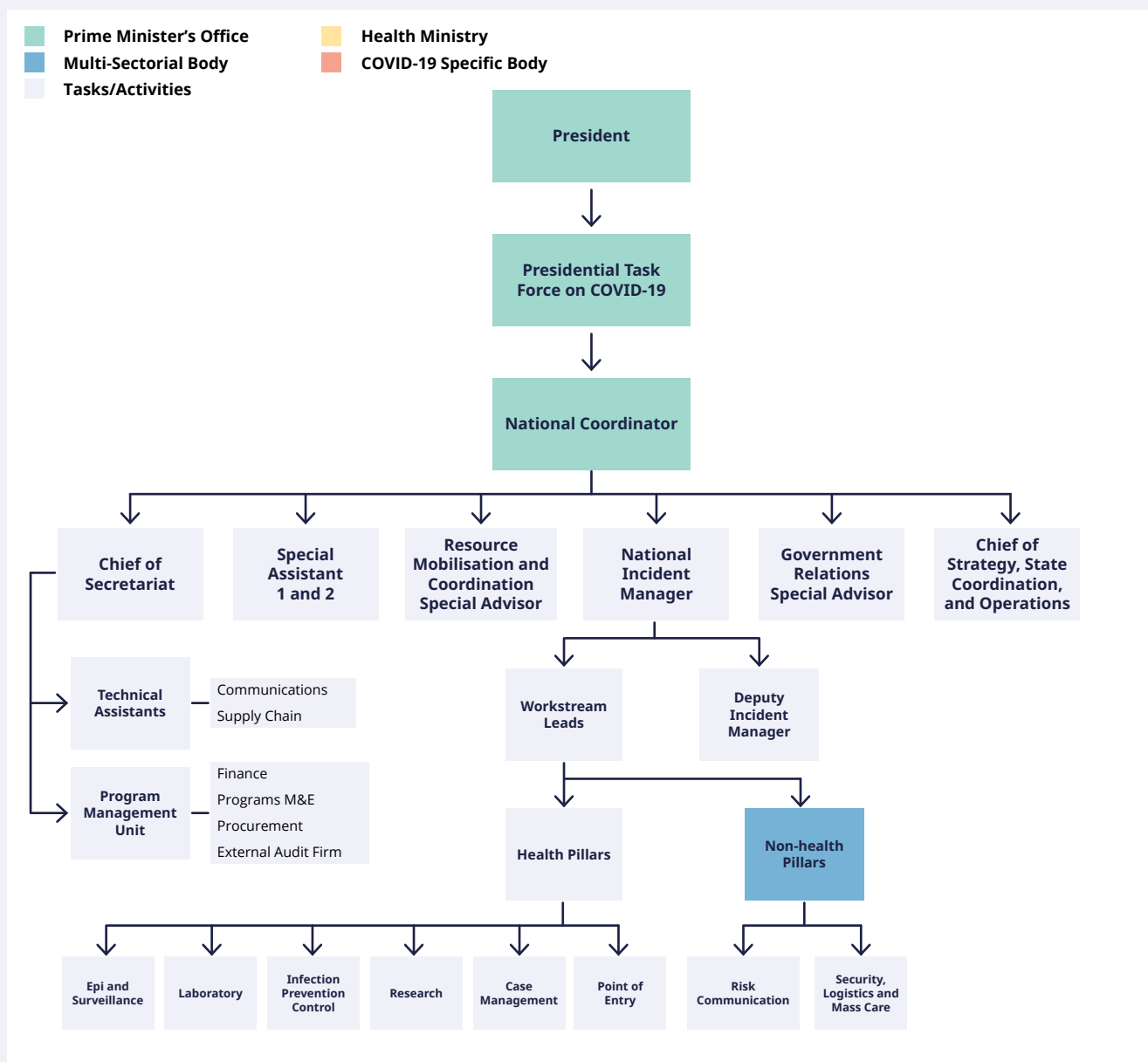
Note: On 31 March 2021 the Presidential Task Force on COVID-19 was converted into the Presidential Steering Committee on COVID-19.
Source: National COVID-19 Pandemic Multisectoral Response Plan Version #: 1 Released 18 May 2020

PTF COVID-19's remit was to support the National Emergency Operations Centre at NCDC and other relevant ministries and government agencies; coordinate effective policy and programmatic responses as well as preparedness across the centre and states; partner with and guide state-designed actions to contain the virus; ensure public engagement; engage in and sustain bilateral and multilateral relationships with international organizations and bodies; and advise on funding and utilization of the other resources needed.

PTF COVID-19 gave daily updates to Nigerian media representatives and citizens on the efforts being made to contain the virus and addressed concerns and questions. NCDC also provided daily updates on its progress in setting up testing laboratories and treatment centres across Nigeria. Reports from NCDC and the task force groups at the state level assisted PTF COVID-19 in constantly engaging Nigerians on the evolving trends of the disease. Fake news and misinformation made the coordination of clear communication products essential. The communication efforts were led by NCDC, the Ministry of Information, the National Orientation Agency and mainstream media.

> "
> **State responses across Nigeria were varied and not always aligned with that of the federal government**

Responses on COVID-19 were varied across the 36 Nigerian states and the capital territory and not all were aligned with that of the federal government. Some states played down the seriousness of the threat of the pandemic and in some instances deliberately misreported COVID-19 cases.[6]

The autonomous nature of the state system in Nigeria meant that coordination of state actions by the federal government was always going to be a challenge. In May 2020 the federal government initiated investigations on state spending on the coronavirus outbreak.[7] But the federal government itself has been accused of corruption and weak accountability, which has led civil society organizations to question government's efforts to hold states accountable.

Public distrust in the government has not abated with the pandemic, as many see COVID-19 as offering the opportunity for government and top public officials to embezzle public funds. The alleged hoarding of private sector-donated palliatives resulted in frenzied looting of property during the End SARS protests. This distrust is largely rooted in the widespread scepticism about the COVID-19 situation across the country.[8]

Even as the pandemic progressed, no coordinated attempts were made to revamp primary health care. Instead, the federal government slashed the Basic Healthcare Provision Fund, the country's primary health care fund, by close to 50% while revising budgetary allocations to match the economic realities posed by COVID-19 and falling oil prices.[9] Health workers were forced to embark on strikes over lack of personal protective equipment, poor working conditions, inadequate welfare and lack of recompense for the risks they faced. Hundreds of them were infected with COVID-19 and many lost their lives working on the frontline. Many in the profession have chosen to emigrate.

The impact of COVID-19 and its targeted responses were varied across the different areas of the health system. Psychosocial services, including psychologists, counsellors and social workers, were forgotten in the coordinated responses to the pandemic. Nongovernmental organizations, international bodies – specifically UNICEF and the World Food Programme – and professional associations like the

Nigerian Psychological Association and the Association of Medical Social Workers of Nigeria were involved in efforts to bridge the gap and mitigate the psychosocial effects of the pandemic.[10]

Although PTF COVID-19 still gathers information from NCDC and the various COVID-19 task forces in the states, emerging studies indicate that responses and risk communication have been largely vertical and non-inclusive with limited public engagement.[11] On 17 January 2021 the Director General of NCDC acknowledged via Twitter that there was a lot more to do to build resilient and sustainable subnational health security.[12]

To improve safety compliance, in January 2021 the president signed into law the Coronavirus Disease (COVID-19) Health Protection Regulations 2021.[13] Its impact so far has been limited. Safety protocols are blatantly flouted in public spaces and there are reports that hand washing and sanitization facilities have been abandoned or are non-functional, there is disregard for social distancing and face coverings are used only to clear checkpoints.[14] Testing centres have grown to about 144 in the country, but equity in testing has been elusive. A lack of accountability has characterized resource allocation with the PTF COVID-19 resource tracker no longer functional.

Recognizing the undetermined nature of the longevity of the COVID-19 pandemic, the government dissolved PTF COVID-19 when its mandate expired on 31 March 2021 and replaced it with the Presidential Steering Committee on COVID-19. This committee has almost the same composition as its predecessor, its technical and administrative structure is limited and its mandate will run out on 31 December 2021.

The National Primary Health Care Development Agency (NPHCDA) coordinates the distribution of vaccines. As of June 2021 about 4 million doses of the AstraZeneca vaccine had been received from COVAX, of which close to 90% were administered,[15] implying that about 3.5 million persons in Nigeria had been vaccinated with that vaccine shipment. While this might be a success story for NPHCDA and COVAX, for Nigeria it translates into only about 1.5% of the population.

Rwanda

Rwanda's COVID-19 response takes a multisectoral, multipartner approach.

The Prime Minister's Office, working through the National Epidemic Preparedness and Response Coordination Committee (NEPRCC), is in charge of COVID-19 response activities. Shortly before the first COVID-19 case was detected in Rwanda in March 2020, the government set up a COVID-19 Incident Management System Coordination Structure comprising the COVID-19 National Steering Committee and a COVID-19 Joint Task Force Committee. Both structures are responsible for implementing the national COVID-19 preparedness and response plan and reporting back to NEPRCC. Since March 2020 the COVID-19 Joint Task Force Committee has worked with expert advisory teams from MoH, the Ministry of Defence, the Ministry of Finance and Economic Planning, the Ministry of Internal Security and the Ministry of Local Government and in collaboration with health-focused international organizations to manage the COVID-19 response. Response activities have been implemented through the COVID-19 National Incident Management System Coordination Structure (Figure 5).

Fig. 5: The Rwanda COVID-19 National Incident Management System Coordination Structure
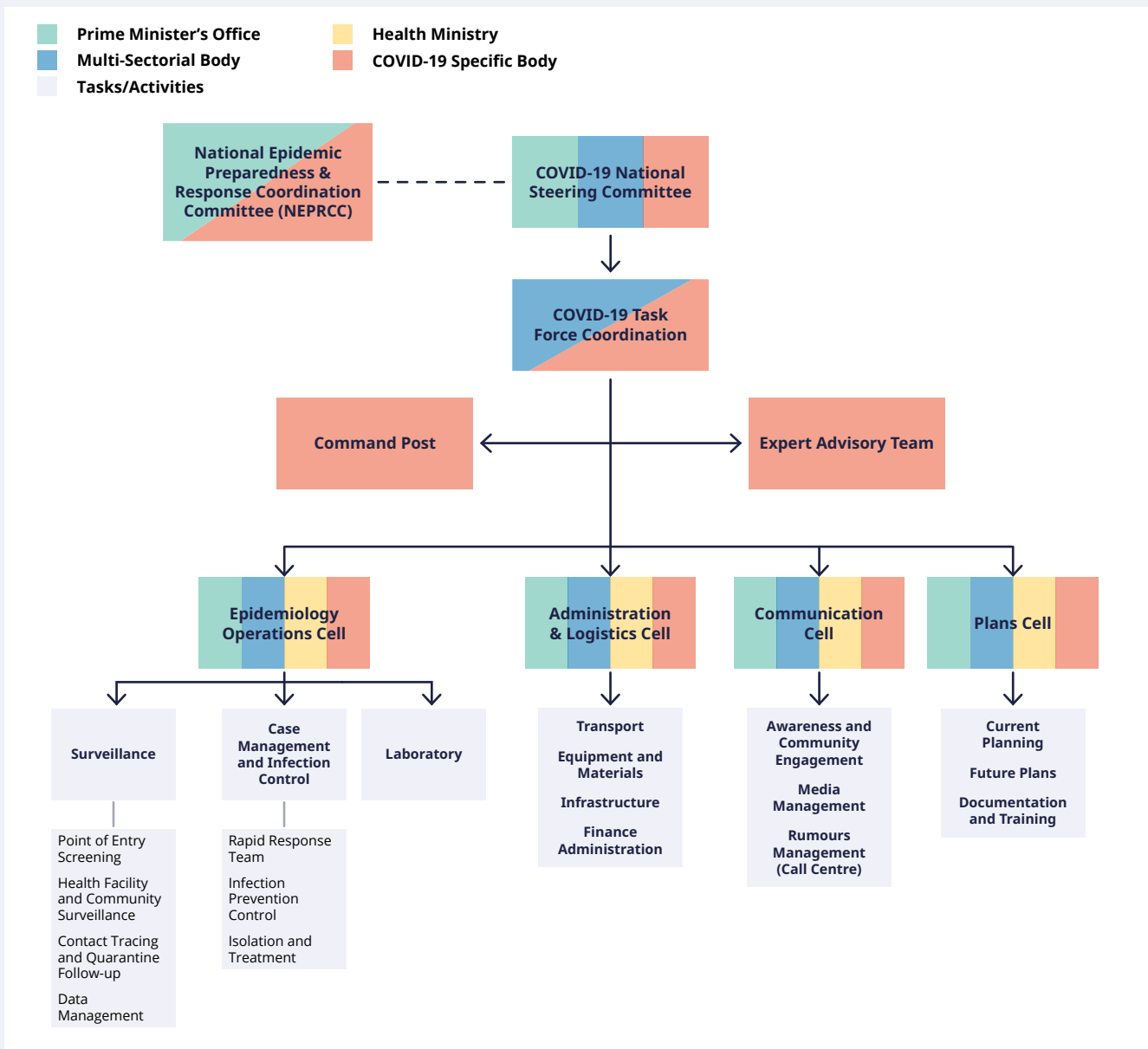
The Rwanda Biomedical Centre (RBC) has been a key implementation agency in the response to COVID-19 and it collaborated with MoH to develop the initial six-month National COVID-19 Preparedness and Response Plan.[16] This plan divided the country's response into four phases: pre-epidemic; sporadic cases involving limited numbers of imported cases from affected countries; single clusters of cases stemming from local transmission in a district, sector or village; and community transmission involving more than one cluster.

At the decentralized level, each district set up a command post that ensured effective surveillance dealing with contact tracing, screening and reporting; case management and infection control; and administration and logistics. These command posts made daily reports to the National COVID-19 task force.

> " **The legacy of previous Ebola outbreaks is clear to see in the infrastructure of Rwanda's pandemic response**

At the community level, Rwanda utilized youth volunteers, who are commonly found in towns and cities. They were tasked with ensuring that COVID-19 prevention guidelines were adhered to in public gathering places like bus parks and bus stations, churches, meeting places and business areas. Community health workers at the village level were assigned the responsibility of visiting homes to identify people with symptoms of COVID-19 and refer them for testing.

The response in each of Rwanda's 30 districts has been led by the district mayors, who coordinate interventions for all aspects of infection control.[17] The legacy of the past Ebola outbreaks is clear to see in the infrastructure of Rwanda's pandemic response.[18] For example, the strategies used during those outbreaks in developing the national preparedness plan, training health workers, equipping health facilities, establishing dedicated treatment centres, conducting simulation exercises, educating the public, and extensively screening visitors at national points of entry have served as a strong foundation for the COVID-19 response.[19]

Key multilateral organizations such as UNICEF also played a role in combating the downstream effects of the pandemic. UNICEF is supporting the Government of Rwanda to mitigate the secondary effects of COVID-19 on children and families, including providing remote learning opportunities for children and personal protective equipment for community health workers.[20]

The Rwandan government has been praised for the flexibility of its health system and its use of creative strategies during the COVID-19 response. Such strategies have included remote case identification and the use of a toll-free hotline, a national WhatsApp number, drones for information dissemination and robots for temperature screening at airports and patient monitoring in hospitals. But even **more important, the basic principles, that is, the bricks and mortar of public health responses, have been adhered to**.

As the pandemic has continued, Rwanda's response coordination efforts have been tested. It is becoming increasingly challenging to conduct the level of COVID-19 testing required with the onset of a third wave. With the large number of patients, there are growing infrastructural, supplies and human resources needs, bringing with them the associated financial challenges.

Senegal

The COVID-19 response in Senegal is led by the government through the Ministry of Health and Social Action (MoHSA).

Following the identification of the first case of the disease on 2 March 2020, MoHSA activated the Public Health Emergency Operations Centre (COUSP) created in 2014, notified WHO's International Health Regulations focal point and launched a National Epidemic Management Committee (CNGE). This committee comprises field epidemiologists and representatives from laboratories, treatment centres, police services and COUSP. Both COUSP and CNGE existed prior to the COVID-19 outbreak to coordinate the response to major national public health emergencies. Throughout the COVID-19 pandemic, the Senegalese response has been multidisciplinary and multisectoral.

COUSP has been coordinating the day-to-day operations of the response. Together, COUSP and CNGE oversee the defining of the emergency measures to be implemented; coordinate the action of the different actors involved in the COVID-19 response; supervise field operations, serving as the liaison between emergency response actors and the Minister of Health and Social Action at large; and ensure the epidemiological monitoring of the pandemic.

MoHSA is the primary source of COVID-19-related data. It provides daily updates on the numbers of tests performed, new cases, cases per region, recoveries, total cases and deaths, the total of the people vaccinated, and the positivity rate.

Since the beginning of the outbreak, the Senegalese Government has issued daily reports on cases and the overall outbreak progression, holding daily meetings of the operational coordination group, as well as coordinating the National Epidemic Management Committee and the Regional Epidemic Management Committee, which meets periodically at the regional level. The government approved the response plan and is committed to putting the necessary resources into the response.

> "
> **Throughout the pandemic, the Senegalese response has been multidisciplinary and multisectorial.**

Multiple stakeholders and partners were involved in the COVID-19 response, notably WHO, the West African Health Organization, CDC, UNICEF, USAID, the Senegalese Red Cross and the Alliance for International Medical Action.[21] Other stakeholders were involved in providing diagnostic services such as the Institut Pasteur de Dakar (IPD), which catered for 80% of the diagnostic tests conducted nationally, and other public and private labs. IPD increased testing capacity substantially through developing 10 new mobile testing sites distributed across 10 regions.

The National Agency for Statistics and Demography, Doctors without Borders, the International Organization for Migration, PATH, World Vision, the World Bank, the Clinton Health Access Initiative, USAID and the United Nations Population Fund have provided additional technical support.

At the beginning of the pandemic, the government called for a contribution from the Senegalese population to boost the funds available to fight COVID-19. Many individuals and private companies contributed financially to the response. Businesses have contributed also in communication on, and reinforcement of the public health measures put in place.[22]

Fig. 6: Operational Structure of the the Senegalese National Epidemic Management Committee
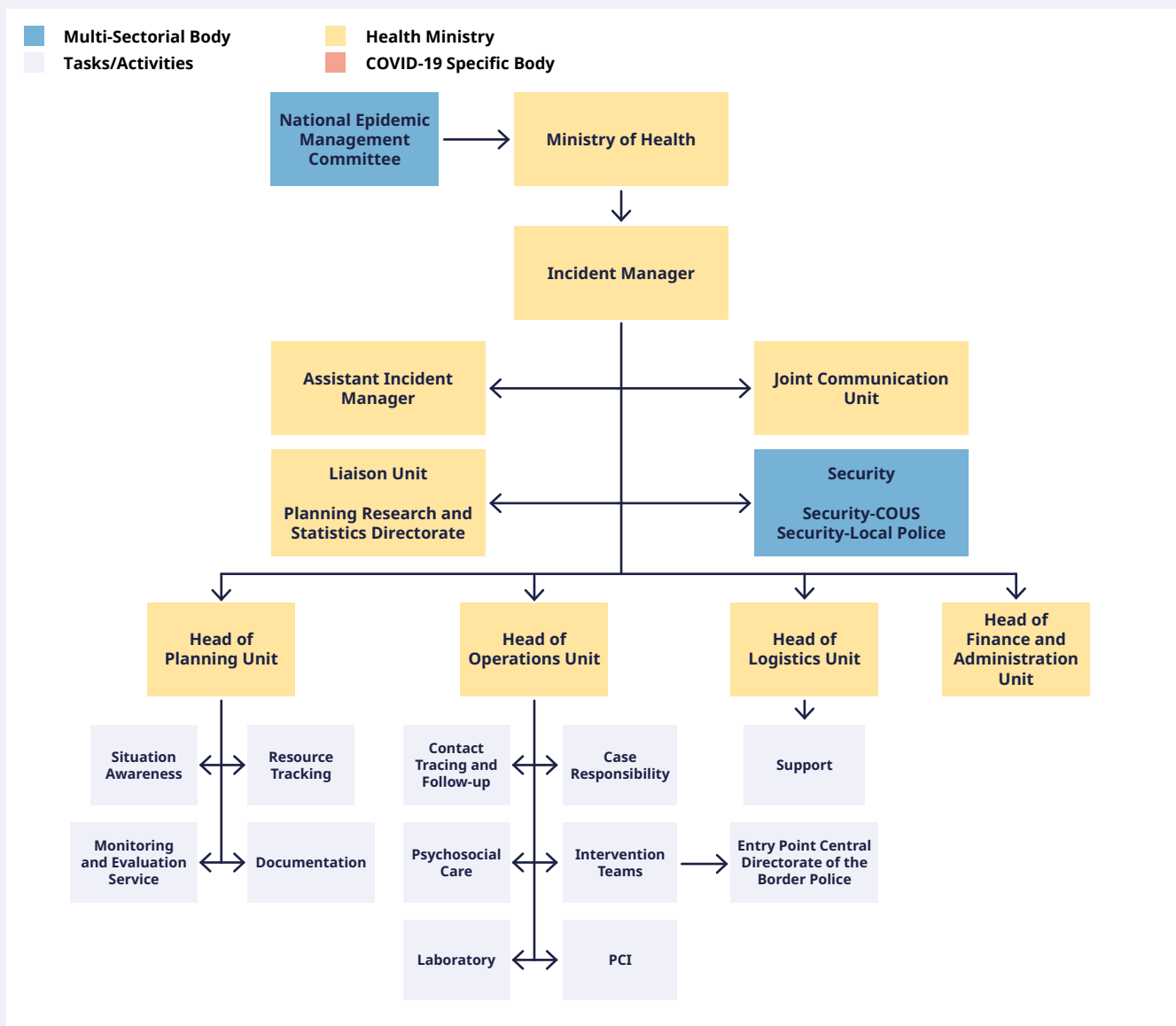
Note: COUSP is activated through the CNGE structure. A representative of COUSP sits in all of the units listed in the CNGE structure set out here.

Source: Ministère de la santé et de l'Action Sociale.(2019) Guide technique national pour la surveillance intégrée de la maladie et la riposte 2019 (MSAS) (https://sante.gouv.sn/sites/default/files/gudie%20national%20de%20la%20surveillance_1.pdf, accessed 4 August 2021)

Ministère de la santé et de l'Action Sociale.(2020) Riposte à l'épidémie du nouveau coronavirus COVID-19, Sénégal Rapport de situation n°2 du 9 mars 2020 (https://www.sante.gouv.sn/sites/default/files/SITREP%202%20Covid-19%2009-03-2020.pdf, accessed 4 August 2021)

As Senegal continues to battle the COVID-19 pandemic, the **original structures and coordinating bodies established for the response remain influential, although as the pandemic evolves some of them have seen their activities reduced while others have become more dominant**. Both the National Education and Information for Health Service and the Risk Communication and Community Engagement Services have seen demand for their services fluctuate substantially. The delivery of the first vaccine doses has seen different technical commissions emerging to manage the development of national vaccination plans.[23]

The Senegalese coordinated COVID-19 response approach extends beyond its borders to the regional level. Its health minister was among the health ministers from the West African subregion who participated in the emergency regional meeting in Bamako, Mali, on 14 February 2020 for discussion on the preparations for the response to the COVID-19 outbreak.[24] In addition, a virtual extraordinary summit of Heads of State of the ECOWAS region was held on 23 April 2020, where President Muhammadu Buhari of Nigeria was elected as coordinator of future efforts targeted at COVID-19 elimination.[25]

Regional coordination: past and present

Since the onset of the COVID-19 pandemic, regional leadership and coordination have been central to the pandemic response.

Regional players, including WHO, United Nations agencies – notably UNECA – the African Union and the regional economic communities (RECs) have actively sought to strengthen COVID-19 response coordination at both the regional and country levels to promote alignment and complementarity of action. WHO established a COVID-19 incident management system to provide operational and technical support to countries and national incident management systems teams. All 47 countries in the WHO African Region have developed response plans and put in place functional mechanisms to coordinate the response at national and subnational levels.[26] WHO has provided weekly epidemiological updates on COVID-19 to the UNECA coordination platform, which brings together Member States and partners to address and adjust to bottlenecks in the COVID-19 response.

WHO and the AU-based Africa Centres for Disease Control and Prevention (Africa CDC) have worked particularly closely on key joint priorities, ensuring synergies in the provision of technical support to the countries. The WHO Director General attends meetings of the AU Heads of State Action Committee on COVID-19 and actively engages with AU special envoys for COVID-19, who include the Director of Africa CDC, and who are tasked with among other things the mobilization of resources to support the response in the region. The WHO Regional Director for Africa and the Director of Africa CDC co-chair monthly meetings of the Africa Task Force for Novel Coronavirus (AFTCOR) Steering Committee, joined by the African Partner Outbreak Response Alliance and the deans of African universities' medical faculties.

Within AFTCOR, six bilateral working groups were set up (see Box 1), based on the key prevention and response pillars[27] wand with a plan for weekly active engagement to enable the exchange of information and development of joint products. WHO and Africa CDC publish a weekly information brief – the "Joint COVID-19 Scientific and Public Health Policy Update" – providing Member States with information on developments in public health policy and in scientific knowledge to inform decision-making. Bi-weekly regional coordination meetings are also held with major donors to support resource mobilization, alignment and accountability.

Box 1: The Six AFTCOR working groups

Working group

1. **Surveillance, including screening at points of entry**

2. **Infection prevention and control in health care facilities**

3. **Clinical management of persons with severe COVID-19 infection**

4. **Laboratory diagnosis and subtyping**

5. **Risk communications**

6. **Supply chain and stockpiling medical commodities**

Source: https://au.int/sites/default/files/documents/38264-doc-africa_joint_continental_strategy_for_covid-19_outbreak.pdf

As the pandemic has evolved, regional partners have shifted their focus to vaccine access. In addition to bilateral procurement efforts, all 54 countries on the continent have expressed interest in COVAX, the global initiative co-led by the Coalition for Epidemic Preparedness Innovations, Gavi and WHO. Dr Matshidiso Moeti, the WHO Regional Director for Africa, supports the initiative, seeing it as an opportunity to ensure that African countries do not get left at the bottom of the list for access to COVID-19 vaccines and are able to go beyond the continent to collaborate with other governments and manufacturers globally. COVAX aims to deliver 600 million vaccine doses to 41 sub-Saharan countries, for the equivalent of about 20% of their population, by the end of 2021. As of mid-July 2021, only 3.2% of the continent's population had received one vaccination dose and 1.4% both doses.[28]

African leaders have expressed their commitment to securing an effective vaccine for their populations through the Consortium for COVID-19 Vaccine Clinical Trials led by the AU. Close collaboration among Africa CDC, WHO and the African Vaccine Regulatory Forum, plus other relevant stakeholders, is supporting countries to strengthen their capacity to adopt and scale up a vaccine for COVID-19. To ensure that vaccines are transported and stored adequately to remain effective, WHO, Gavi, UNICEF and other partners are working with countries to help them prepare to receive vaccines by identifying existing cold chain equipment and storage capacity and providing technical support to countries to ensure that they are ready to receive and manage vaccines.

> "
> **As the pandemic has evolved, regional partners have shifted their focus to vaccine access**

Vaccines will play a crucial role in managing the pandemic and preventing the next one. As such, **global health actors in the region are not just focusing their efforts on vaccine access through the current international donor-led efforts but also on securing the long-term sustainability of African vaccine manufacturing and knowledge transfer.[29]** Recently, the pharmaceutical giants Pfizer and BioNTech have committed to work with the South African Biovac Institute to manufacture vaccines in Cape Town from 2022, aiming for annual production of more than 100 million doses.[30]

Given this renewed focus on an Africa that is more self-reliant, eschewing old models of charity in global health, it will be interesting to see whether structural legacies from the COVID-19 pandemic will help or hinder progress. The multistakeholder and multisectoral approaches of governments to stem the progression of the coronavirus at national, regional and global levels have been crucial. How they will remain or evolve to re-engineer the health systems on which they were built remains to be seen.

Cross-cutting themes: what can we learn from AHOP experiences?

The COVID-19 pandemic appeared suddenly and evolved rapidly; as such, every country needed to respond robustly or risk confronting uncontrolled transmission of the virus.

The countries did not fare equally as subsequent waves of the virus took their toll on their populations. The differences in the immediate and downstream consequences rest, in part, on the decisions made during the early days of the outbreak. Responses across AHOP countries show commonalities and differences, reflecting individual countries' capacities, approaches to collective decision-making and public health legacies in dealing with external health threats.

1. Specialized response structures

Governments in AHOP countries responded strongly to the pandemic and often through specialized structures that had not existed previously. Task forces, command posts and coordination committees emerged, all with specific roles and responsibilities and a more prevalent focus on working together than is common in traditional governance structures. Expertise from specialized agencies was called upon to coordinate and implement different branches of the pandemic response, from testing and diagnostics to case management and health communications. Suddenly, MoH was not the sole entity with the burden or responsibility for pandemic health outcomes; it was empowered to draw on wider expertise, resources and implementation capacity of other government agencies and structures at both national and local levels.

2. Multisectoral, multistakeholder approaches

A key characteristic of the specialized structures used in the COVID-19 response was their multistakeholder nature, bringing together actors from across and beyond the government and from varied sectors to combat the pandemic. The greater flexibility, inclusivity and reach this approach offered in comparison to the traditional structures have been referenced repeatedly. Also highlighted was the need for robust coordination and oversight of the diverse actors and structures to avoid duplication of activities and for effective response implementation. Across many of the countries a disconnect among the stakeholders was seen, especially between national and subnational levels or public and private efforts, undermining the effectiveness of the multisectoral, multistakeholder responses.

3. High-level leadership

The AHOP countries' experience suggests that specialized structures and multisectoral responses were often overseen by the highest echelons of governance within the countries. The governments were able to mobilize an unprecedented level of resources to direct to the pandemic response. The multistakeholder approaches also helped to engage additional external actors, many of which were previously not under government purview.

4. Country experiences

In Ethiopia, a traditionally vertical policy and decision-making process evolved to take into account lessons learnt from grassroots actors for their implementation in policy. Kenya used a whole-of-government approach that if sustained beyond the pandemic could be harnessed for re-engineering the health system through a more frictionless relationship between national and subnational governance structures. Senegal took advantage of historical disease management structures and quickly adapted them in combating COVID-19. These innovative advances at times came into direct conflict with historical governance systems within the countries. For example, Nigeria's whole-of-government approach often posed accountability and public trustworthiness questions, while Rwanda's more centralized approach raised questions of inclusivity and the role of the wider pool of stakeholders.

Where to next?

Over a year and a half into the pandemic, many of the structures and actors mobilized for the response are still needed. But as priorities move away from containment and coordination towards vaccine roll-outs and long-term strategies, it will be telling to see whether the newly established structures will help or hinder national and regional efforts.

The outcomes of the COVID-19 response in the AHOP countries suggests the existence of an opportunity to institutionalize a multisectoral and multistakeholder approach for the future of health systems. Time will tell if the leadership and political will seen during the pandemic to bolster ministries of health will last or if the superstructures created will ultimately lead to inefficiencies and loss of sight of the goal of improving health outcomes.

In every crisis there is an opportunity. COVID-19 threatened and in some instances overwhelmed health systems globally. The opportunity in the COVID-19 pandemic allows critical reflection on what is needed to secure the long-term viability of each and every health system. The lessons from the AHOP countries suggest that future health systems should operate with the support of the central government and draw on resources from a wide range of actors, including those outside the traditional health system. They also suggest that further learning and reflection are needed to improve coordination and communication among multilevel, multisectoral and multistakeholder partners.

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