



COVID-19 PANDEMIC RESPONSE
IN THE EASTERN MEDITERRANEAN REGION

PROGRESS REPORT OF
THE INCIDENT MANAGEMENT SUPPORT TEAM

2021



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SARS-CoV-2 next generation sequencing in Abu Dhabi, United Arab Emirates, December 2021.

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Cover photo 2:

Isolation facility in De Martino Hospital, Mogadishu, Somalia, September 2021.

© WHO Somalia

Cover photo 3:

Medical supplies arrive in Kabul, Afghanistan, January 2022.

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Cover photo 4:

Mass vaccination campaign site in Baghdad, Iraq, November 2021.

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Special thanks to the IMST secretariat, including Abdinasir Abubakar, Victoria Bélorgeot and Lubna Al Ariqi, for facilitating the work of the IMST; to Muneera Al-Mahdli and Injy ElKashef for assisting in the development of this report; and to Mohamed Alfatesh for designing the report.

Abbreviations and acronyms

ABHR	alcohol-based hand rub
AMC	Advance Market Commitment
COVAX	COVID-19 Vaccines Global Access
CSO	civil society organization
ELISA	enzyme-linked immunosorbent assay
ePHERM	Electronic Public Health Emergency Response Management software
FCV	fragile, conflict-affected and vulnerable
ICU	intensive care unit
IFRC	International Federation of Red Cross and Red Crescent Societies
IMST	Incident Management Support Team (for COVID-19)
IPC	infection prevention and control
PCR	polymerase chain reaction
PHEOC	Public Health Emergency Operations Centre
RCCE	risk communication and community engagement
SAGE	Strategic Advisory Group of Experts on Immunization
SPRP	Strategic Preparedness and Response Plan
UHC	universal health coverage
UHC-PBP	universal health coverage-priority benefits package
UNICEF	United Nations Children's Fund
VOC	variant of concern
WHO	World Health Organization

Foreword from the Regional Director



Dr Ahmed Al-Mandhari
WHO Regional Director for the
Eastern Mediterranean

As the second year of the COVID-19 pandemic came to an end, WHO's regional IMST for COVID-19 and the countries in WHO's Eastern Mediterranean Region remained in full response mode to battle the virus. By the end of 2021, COVID-19 had infected over 17 million people across the Region and claimed more than 316 000 lives.

Even before COVID-19, countries in the Region were plagued by emergencies. In 2021, WHO responded to urgent health needs as a result of the insecurity due to the political transition in Afghanistan and demonstrations in Sudan. With so many competing health response priorities, several countries facing emergencies lagged behind in achieving the global COVID-19 vaccination targets set by WHO to vaccinate 40% of the populations of every country by the end of 2021. While vaccine supply was sufficient, challenges in vaccine roll-out included lack of high-level political commitment, insecurity, weak health systems, logistical challenges and limited engagement with communities to enable them to access vaccination.

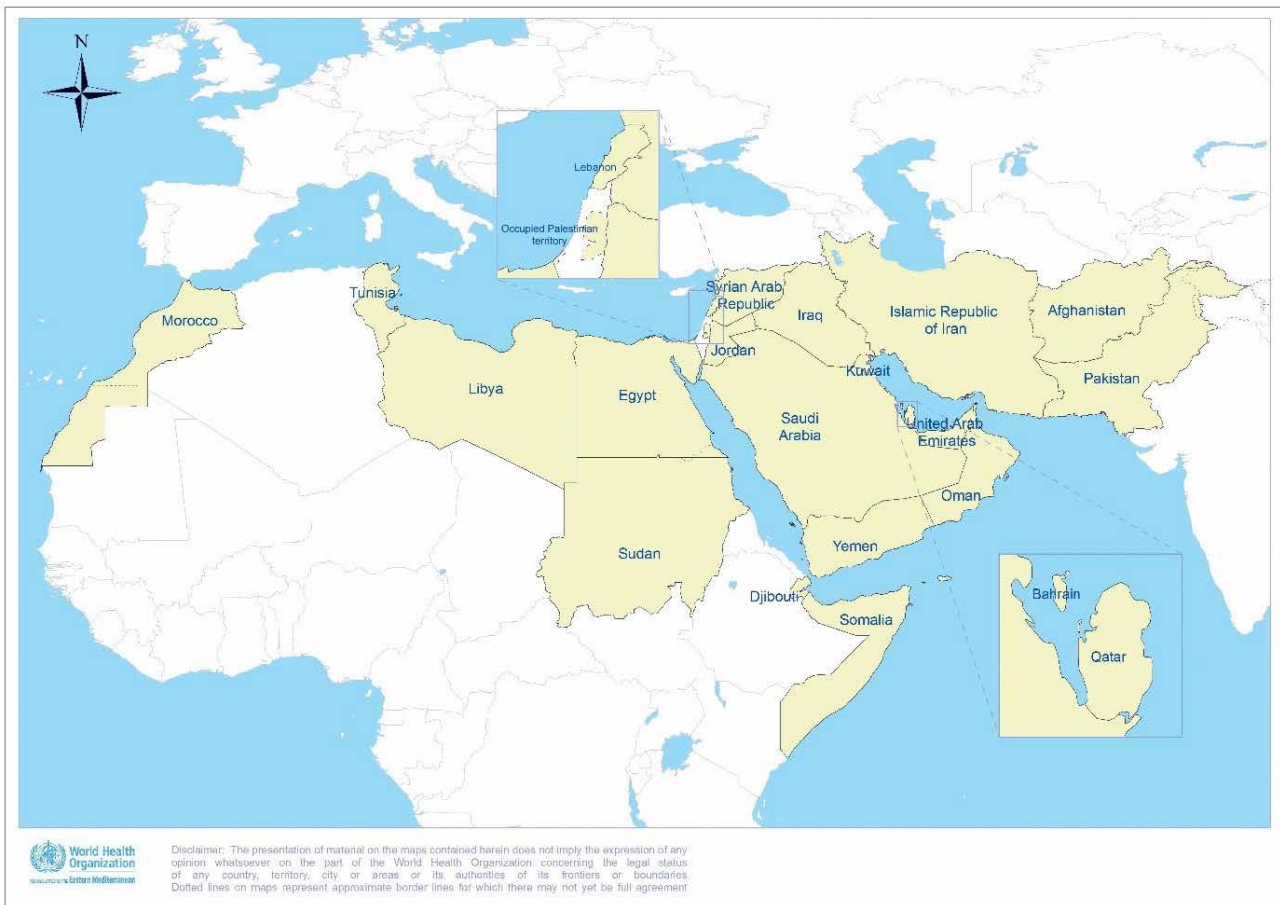
In December 2021, the emergence of the Omicron variant of concern threatened to set back progress and placed populations at increased risk, resulting in an increase in numbers of cases across the Region. Coupled with vaccine inequity, vaccine hesitancy, and low levels of adherence to public health and social measures, the Omicron variant gave the virus an opportunity to forge ahead. By the end of 2021, 14 countries in the Region had officially reported detecting the Omicron variant, and a dramatic increase in cases was observed in the first week of January 2022 compared to the last week of December 2021.

Across the Region, we saw varying levels of public adoption of the COVID-19 personal preventive measures, largely guided by the broader public health and social measures applied by each country. Growing signs of COVID-19 fatigue were observed among the public, as well as concerns about the rapidly spreading Omicron variant and confusion about the effectiveness of available vaccines or booster doses against the new variant. We thus expanded our engagement of communities in the COVID-19 response, including community health workers and the media.

Supporting frontline health care workers remained a key priority, as their role is critical in ensuring access to treatment for COVID-19 as well as for other essential health services, including for maternal and child health, mental health and chronic diseases. A key area of focus is ensuring health system resilience, so that populations with medical conditions other than COVID-19 are not deprived of life-saving health care services.

As we prepare for a third year of responding to COVID-19, we are aware that no single country or agency can end this pandemic alone. Over the past two years, we have seen repeatedly that we can only succeed if we work together with all stakeholders at all levels, including communities and civil societies. This is our vision in the Region, to ensure "Health for All by All".

WHO's Eastern Mediterranean Region





WHO's Eastern Mediterranean Region comprises
21 Member States and one territory:

Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, the occupied Palestinian territory, Qatar, Saudi Arabia, Somalia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

In the Eastern Mediterranean Region, as of 31 December 2021


 **8**
countries
in fragile and
conflict-affected situations¹

 **6**
countries
with less than 10% COVID-19
vaccination coverage
(fully vaccinated population)

 **31**
major outbreaks
other than COVID-19 in
11 countries

¹ Classification of fragile and conflict-affected situations [website]. Washington, DC: World Bank; 2022 (<https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/harmonized-list-of-fragile-situations>).

IMST progress in 2021: key figures



US\$
250.3
million

mobilized
for the COVID-19 response
in the Region

103



21

COVID-19 missions
conducted

countries
visited by IMST missions



95

direct communications
with the regional Ministerial
Group on COVID-19



43

partners
brought together as a
regional network



111

regional IMST meetings
held



300

interviews
by regional spokespersons



24

**regional media
press briefings**
hosted



36

videos
developed for the public



174

social media cards
and infographics developed



6

Facebook live sessions
streamed with the Regional
Director and experts

Over



11 million

people reached
by 687 Twitter posts



Over **20 million** US\$

in COVID-19 supplies dispatched from the regional logistics hub to all 6 WHO regions.



1.5 million
COVID-19 tests



10.4 million
masks



21.8 million
gloves



960 000
respirator masks



130 000
face shields

15

countries

have domestic genome sequencing capacity to detect SARS-CoV-2 variants of concern



3

regional laboratories identified for genome sequencing



22

countries rolled out COVID-19 vaccines



16

countries supported

by WHO in receiving medical oxygen and biomedical equipment and supplies



22

countries participated in COVAX



21

countries received vaccine doses from COVAX

318 million

COVID-19 vaccine doses allocated to countries through COVAX



180 million

COVID-19 vaccine doses shipped to countries through COVAX



Over

50 000

health care workers received ICU/critical care training, by WHO or cascade training



4

fragile, conflict-affected and vulnerable (FCV) developed their first national IPC guidelines



2450

health care workers received IPC training

INTRODUCTION

Evolution of the COVID-19 pandemic in 2021


Over
17
million
COVID-19 cases
reported

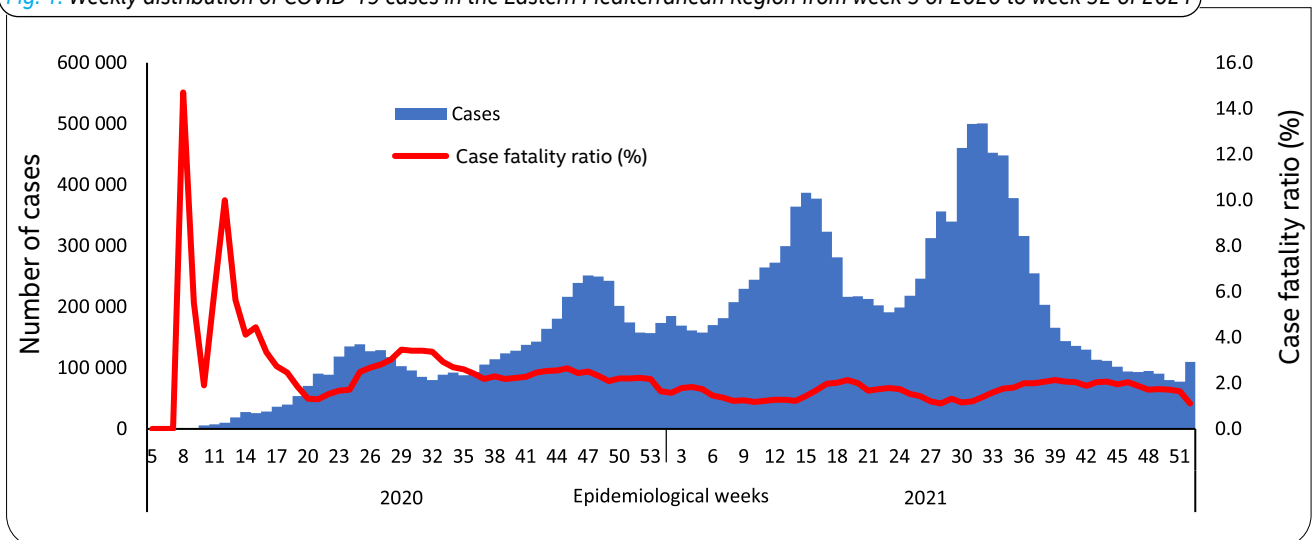

Over
316 000
deaths reported


From the start of the COVID-19 pandemic to 31 December 2021, over 291 million COVID-19 cases and 5.4 million associated deaths were reported globally. Of these cases, 5.9% were reported from WHO's Eastern Mediterranean Region. The first cases of COVID-19 in the Region were reported by the United Arab Emirates on 29 January 2020 among travellers coming from Wuhan, China. Nearly two years later, as of 31 December 2021, countries of the Region had reported a total of 17 203 559 cases and 316,176 associated deaths (a case fatality ratio of 1.8%).

Countries of the Region have shown mixed patterns of resurgence, decreases, increases or stabilization of reported COVID-19 cases throughout 2021, with two waves observed in 2021 regionally: the first with its peak in week 15 (starting on 11 April) with 387 375 new confirmed cases and 5553 deaths, and the second starting in week 24 (13 June) (Fig.1). COVID-19 cases increased sharply from the last week of July 2021 and reached a peak (501 055 cases and 6998 deaths) in week 32 (starting on 8 August). A similar pattern was observed in the trend of COVID-19 deaths (Fig. 2). In descending order, the Islamic Republic of Iran, Tunisia, Pakistan, Egypt and Iraq reported the highest numbers of deaths in 2021.


A gradual decrease in the number of confirmed cases was subsequently observed until week 51 of 2021 but was followed by a sharp increase observed from week 52 due to the circulation of the Omicron variant of concern (VOC), leading to an unprecedented surge of cases in early 2022.

Fig. 1. Weekly distribution of COVID-19 cases in the Eastern Mediterranean Region from week 5 of 2020 to week 52 of 2021




Over
294
million
PCR tests
conducted

Despite 38% of the Region's population having received at least one dose of COVID-19 vaccine as of 31 December 2021, vaccination coverage in low-income countries (Afghanistan, Somalia, Sudan, Syrian Arab Republic and Yemen) was 7% on average, whereas it averaged 76% for high-income countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates). Six countries in the Region had not yet reached 10% vaccination coverage (fully vaccinated) (Afghanistan, Djibouti, Somalia, Sudan, Syrian Arab Republic and Yemen).


538 million
 COVID-19 vaccines administered in the Region


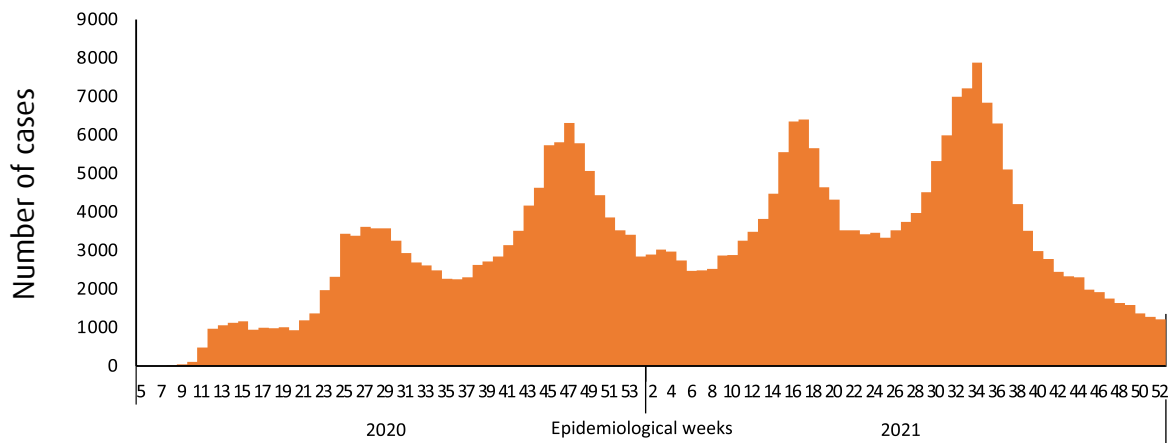

30%
 of the Region's population fully vaccinated

Fig. 2. Weekly distribution of COVID-19 associated deaths in the Eastern Mediterranean Region from week 5 of 2020 to week 52 of 2021



© WHO Regional Office for the Eastern Mediterranean

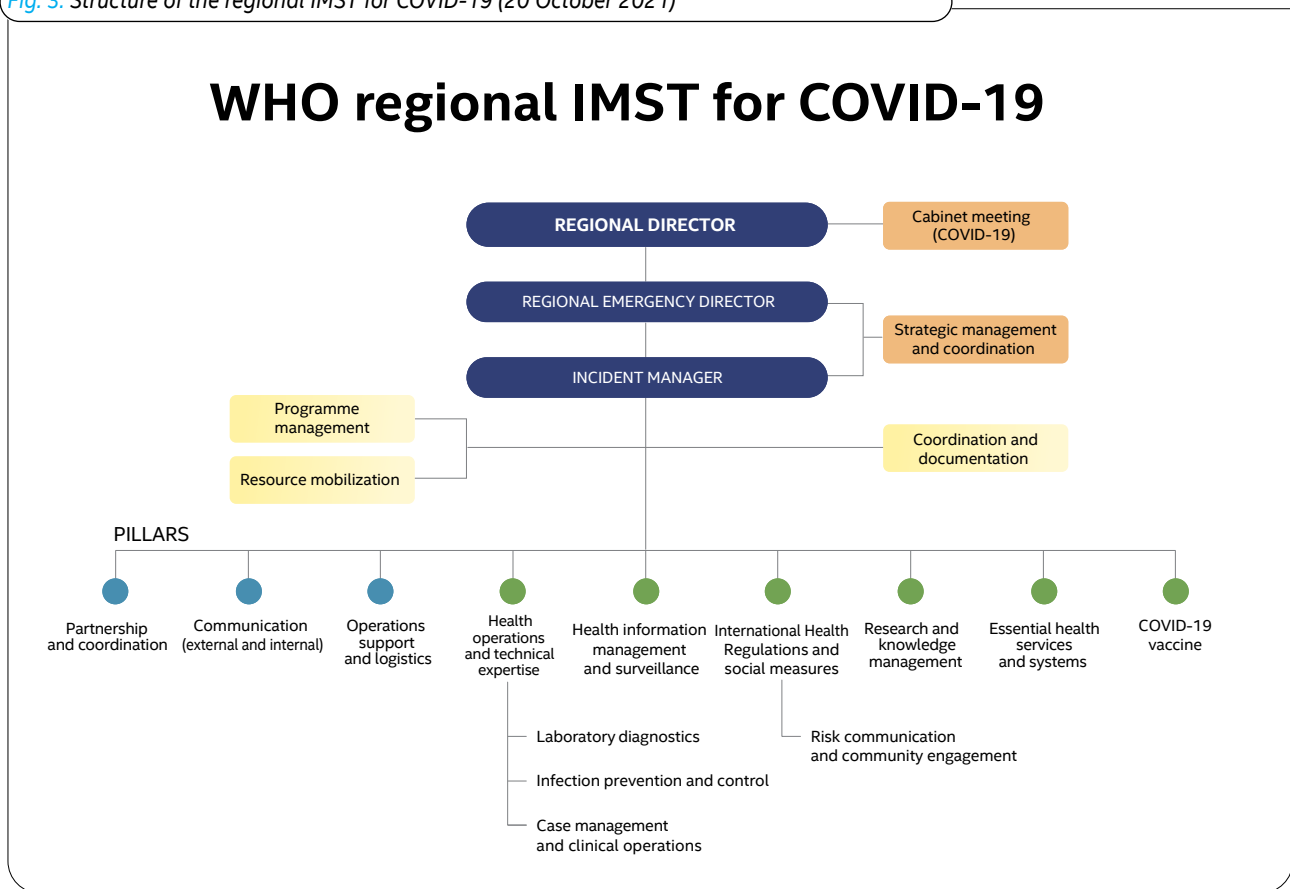
Dashboards in the National Health Command Center in Riyadh, Saudi Arabia, during the visit by the WHO mission, 18 October 2021

Regional IMST for COVID-19

The WHO Regional Office for the Eastern Mediterranean formally activated the IMST for COVID-19 on 22 January 2020 to coordinate efforts to prepare for and respond to COVID-19 in the Region. Since its establishment, the IMST has served as the main regional coordination structure for the COVID-19 response. Linking the WHO headquarters-level IMST to WHO country offices, the regional IMST enables a streamlined response both regionally and through country

support. The IMST's main roles include coordination, leadership, communication, strategic and technical guidance, surveillance, capacity-building, logistics, and research and innovation. Led by the Incident Manager, the IMST is composed of nine pillars, which are key technical and operational groups working together for increased regional collaboration, timely response and country support. There are also four sub-pillars and three cross-cutting support functions (Fig. 3).

Fig. 3. Structure of the regional IMST for COVID-19 (20 October 2021)



This report highlights the IMST's key achievements at the regional and country levels in 2021. IMST activities have been documented progressively in the six-month IMST progress report¹ and the 2020 IMST progress report². Regional goals and objectives have been published in the regional COVID-19

strategic preparedness and response plans (SPRPs)³ to accelerate readiness, strengthen the collective response and sustain an effective response to end the acute phase of the pandemic and transition to recovery.

¹ COVID-19 pandemic response in the Eastern Mediterranean Region, progress report of the incident management support team, January–July 2020. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/handle/10665/334319>).

² COVID-19 pandemic response in the Eastern Mediterranean Region: 2020 progress report of the Incident Management Support Team. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/9789290226765-eng.pdf>).

³ Coronavirus disease 2019 (COVID-19) strategic preparedness and response plan: accelerating readiness in the Eastern Mediterranean Region: February 2020. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/handle/10665/331950>); COVID-19 strategic preparedness and response plan: strengthening the collective response and accelerating readiness in the Eastern Mediterranean Region: July 2020 edition. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/handle/10665/333943>); COVID-19 strategic preparedness and response plan: reinforcing the collective readiness and response in the WHO Eastern Mediterranean Region, 2021 edition. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/WHOEMCSR383Eeng.pdf?ua=1&ua=1&ua=1>); COVID-19 strategic preparedness and response plan: sustaining an effective response to end the acute phase of the pandemic and transitioning to recovery in WHO's Eastern Mediterranean Region, 2022 edition. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (<https://applications.emro.who.int/docs/WHOEMCSR513E-eng.pdf?ua=1>).

IMST HIGHLIGHTS IN 2021


DRIVING EQUITABLE VACCINE DELIVERY AND VACCINATION COVERAGE

Tackling COVID-19 vaccination inequities

COVID-19 vaccination was rolled out in the Region as early as 2020, with Bahrain starting immunization of its population in November 2020. Thanks to the COVID-19 Vaccines Global Access (COVAX) initiative – launched by WHO and its partners Gavi, the Vaccine Alliance and the Coalition for Epidemic Preparedness Innovations (CEPI), and with key delivery partner the United Nations Children's Fund (UNICEF) – by 21 April 2021 all 22 countries and territories of the Region had introduced COVID-19 vaccination due to the unprecedented speed in vaccine development and deployment. WHO supported each country in vaccinating its population following the Strategic Advisory Group of Experts on Immunization (SAGE) prioritization road map towards achieving the global coverage targets. However, significant inequity in access and coverage were observed. These inequities were at first caused by global vaccine supply constraints due to hoarding of vaccines by high-income countries and export bans by some manufacturing countries. They were then compounded by weak health system capacities to deliver vaccines as well as vaccine hesitancy resulting from fear, misinformation and rumours.

Through a comprehensive review of access to vaccines, deployment efforts and COVID-19 vaccine use in the Region, WHO identified bottlenecks and developed recommendations to reduce inequities. WHO analysed and compiled reported data on: the numbers of vaccine products that were issued an emergency use authorization by national regulatory authorities in each country; the numbers of vaccine doses allocated and delivered by COVAX; the numbers of vaccine doses received bilaterally; the numbers of vaccine doses produced locally; the dates of vaccination initiation; vaccine usage rates; and vaccination coverage rates. A regional survey assessed vaccine acceptance. A results chain approach was then implemented, with WHO country offices in the Region reporting to the Regional Office regarding key challenges identified to be addressed.

Thanks to this analysis, vaccines made available to countries were used effectively within their shelf life. Significant regulatory work successfully led to emergency use authorizations that opened the door for the use of new vaccines over a short period of time. Also, following an initial shortage of vaccines in early 2021, COVAX allocated and delivered significantly larger numbers of doses to Advance Market Commitment (AMC) countries by the end of 2021.

22 
countries
have rolled out
COVID-19 vaccines

8 
priority countries
targeted in biweekly
country support
team calls



COVID-19 vaccination centre in De Martino Public Hospital, Mogadishu, Somalia, during the WHO mission on 27 September 2021 – Somalia is one of six countries in the Region with vaccination coverage under 10% (fully vaccinated population)

Reaching the global vaccination coverage targets in Morocco

Low- and lower-middle-income countries benefit from COVAX under the AMC mechanism, receiving vaccines for 20% of their population without any cost. Among the 11 AMC countries in the Region, Morocco is one of two to have reached the global target of fully vaccinating at least 40% of its population by the end of 2021, Tunisia being the other country. As of 31 December 2021, Morocco had achieved the highest vaccination coverage (61% of the population being fully vaccinated) among all AMC countries in the Region. Based on WHO's continuous monitoring of vaccination progress, Morocco is on track to achieve 70% vaccination coverage (population fully vaccinated) by the end of June 2022.

Morocco's success in this area is rooted in political ownership at the highest level. In January 2021, King Mohammed VI led by example by being the first to receive the COVID-19 vaccine in Morocco, doing so on national television. As early as 2020, the

country had a clear deployment plan with defined roles and responsibilities for government offices and ministries. Strong leadership – with the Minister of Health chairing the National Steering Committee that brings together other ministries and government departments – allowed for a whole-of-government approach.

The Ministry of Interior played a central role in the vaccine roll-out – for example, through developing a national database for vaccination registration; community mobilization to register for vaccination (i.e. through a network of community mobilizers going house to house); vaccination follow-up; and establishing and managing vaccination sites (i.e. by ensuring sufficient human resources for the organization of vaccination sites). Additional vaccination sites were established in the existing offices of other ministries and government departments (e.g. the training centres of the Ministry of Education) and ran late and on weekends. Ongoing well-planned social mobilization activities were broadcast through different media channels including television and radio, and successfully increased vaccine demand.

WHO provided guidance to align Morocco's vaccination strategy with the SAGE road map to prioritize vaccination of certain target groups, and coordinated vaccine allocation and delivery with COVAX accordingly. WHO also supported Morocco in developing a proposal to receive technical assistance from COVAX, shared policy guidance on different vaccine products, and supported emergency use authorization by the national regulatory authority for local vaccine use. The country's release of adequate domestic resources to secure vaccines from multiple sources, including through COVAX, ensured continuous vaccine availability. Participating in a large-scale phase 3 trial for the Sinopharm COVID-19 vaccine also enabled the country to secure a large number of doses from the manufacturer at an early stage and helped build trust around this vaccine among national experts.



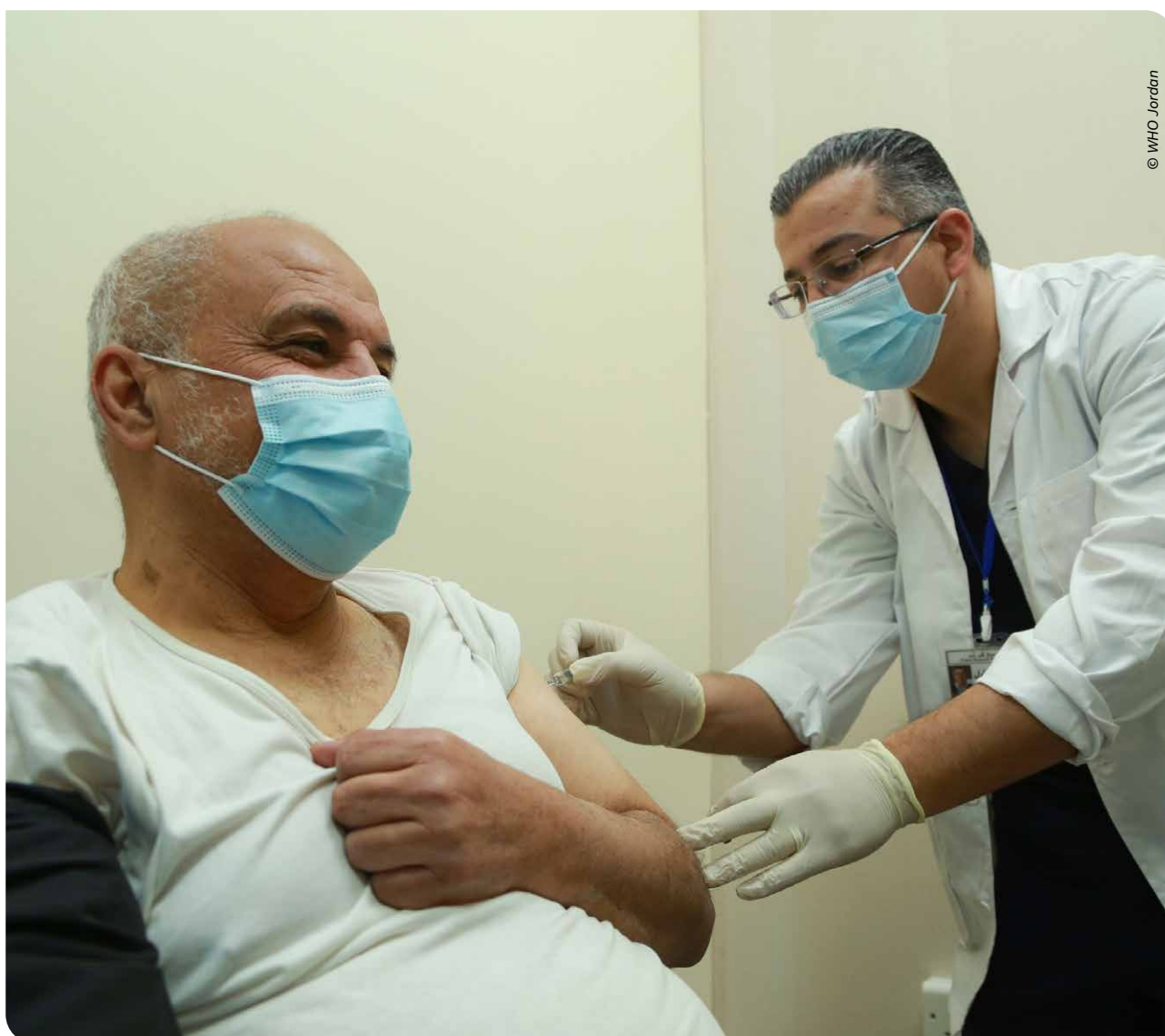
WHO Morocco staff member receiving the COVID-19 vaccine in Rabat, Morocco, 12 May 2021

Utilizing online platforms to roll out COVID-19 vaccines in Jordan

In March 2021, WHO's Regional Office for the Eastern Mediterranean conducted a mission to Jordan to review the country's COVID-19 response. It expanded a standard intra-action review to cover 11 key areas of the response and identify best practices, challenges and lessons learned through desk reviews, interviews with key informants, group discussions and field visits. During the mission, the development and use of a vaccination registration dashboard was highlighted as a successful example of coordination. In early 2021, Jordan had quickly rolled out COVID-19 vaccines thanks to its online vaccination registration dashboard/platform, which was created to monitor daily registrations and vaccinations. The Coronavirus Crisis Cell, established for COVID-19-related decision-making with members from the Ministry of Health, regulates and manages the vaccination process, including

vaccine distribution and the registration platform. Thanks to this platform, Jordan had the capacity to make and complete 28 000 appointments daily as early as March 2021, expanding to 100 000 daily appointments by July 2021.

In the first phase of vaccination, priority groups included health care workers, essential staff, people over 60 years of age and those with comorbidities. To encourage vaccination, an "open day" prioritizing health care workers in all vaccination sites was organized in late March, enabling them to be vaccinated without appointments. Since mid-July 2021, individuals have been able to register for vaccination directly in health care centres. The COVID-19 vaccination strategy in Jordan has been praised for being inclusive of all individuals, including migrants and refugees.



© WHO Jordan

The early phases of COVID-19 vaccination in Jordan prioritized older people and those with underlying health conditions, January 2021

SUPPLYING THE REGION WITH LIFE-SAVING COMMODITIES



Over
US\$ **20**
million

in COVID-19 supplies dispatched from the regional logistics hub to all 6 WHO regions.



Exponentially expanding logistical support to the Region and beyond

The demand for health supplies drastically increased in 2020 with the beginning of the COVID-19 pandemic and this demand continued in 2021. WHO's logistics hub in Dubai, United Arab Emirates, the largest WHO repository of medical equipment and supplies in the world, managed this exponential increase, fulfilling 545 orders in 2021, a 60% increase compared to 2020 (Fig. 4). In 2021, the WHO logistics hub in Dubai received US\$ 44.6 million in health supplies and managed an inventory valued at US\$ 60 million. By successfully dispatching personal protective equipment and biomedical supplies – providing critical consolidation, inventory management and distribution services – WHO underscored the value of maintaining a readily available supply of priority commodities and the capability to rotate the inventory to respond to evolving needs.

Since the beginning of the pandemic, WHO's logistics hub in Dubai has dispatched US\$ 102 million in health supplies to 129 countries globally, delivering over 5000 metric tonnes of supplies in over 800 shipments. The main recipients of these shipments were Afghanistan, Libya, Sudan, Syrian Arab Republic and Yemen, countries facing complex emergencies. Through the hub, WHO often became the main source of supply of health commodities when airports or other ports of entry were closed. It achieved this by coordinating charter flights, collaborating with WHO country offices to prioritize the most critical items, and providing vital infrastructure and management support. WHO's logistics hub also supported the availability of critical medicines and supplies to avoid stock-outs and maintain essential health services.

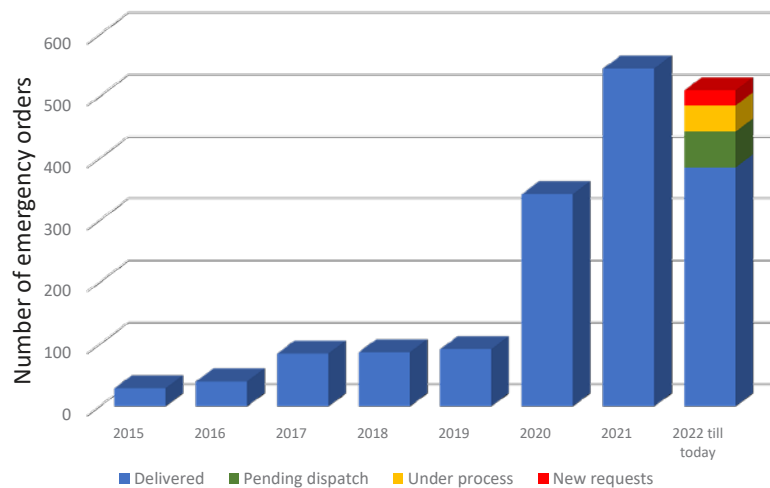


Fig. 4. Dubai logistics hub requests status by year, 2015–2021



Over
US\$ 2
million

delivered in cold-chain shipments of laboratory reagents to more than 50 countries in support of Unity Studies



US\$
45.1
million

dispatched in health supplies across all six WHO regions

including over



US\$
20
million

in COVID-19 supplies



US\$
5.8
million

delivered in laboratory reagents to maintain surveillance and detection activities across WHO regions

WHO logistics hub in Dubai airlifting its largest single shipment of humanitarian cargo from Dubai International Airport to Addis Ababa, Ethiopia, to address the urgent needs of 150 000 people, September 2021



© WHO



237

COVID-19-related orders fulfilled



30

charter flights coordinated

Ensuring the uninterrupted supply of health commodities during Afghanistan's acute emergency



The first

shipment of health supplies to Afghanistan during the August 2021 acute emergency was delivered by WHO



US\$
2.8 million

in health supplies delivered to Afghanistan



The first shipment of medical supplies landing in Kabul, Afghanistan, after the transition of governance, 30 August 2021

Amid outbreaks of COVID-19 and other infectious diseases such as measles and cholera, and prolonged crises leading to a weakened health system, Afghanistan experienced a significant escalation of violent conflict in mid-2021. All points of entry into Afghanistan closed during a transition of governance in August 2021, limiting the importation of life-saving health commodities and leading to the depletion of local health supplies during a period of increased demand. To ensure the provision of essential medicines and supplies, WHO established an air bridge between Dubai, United Arab Emirates and Kabul, Afghanistan. The air bridge enabled the uninterrupted provision of emergency supplies and essential health supplies such as trauma and emergency surgery kits.

The WHO logistics hub in Dubai was the first to deliver health supplies to Afghanistan during the acute emergency, through a charter flight from Dubai to Mazar-i-Sharif in August 2021.

Throughout 2021, the WHO logistics hub delivered US\$ 2.8 million-worth of prepositioned and internationally procured health supplies to Afghanistan, through 30 charter flights coordinated by WHO and Global Shipping, to support the COVID-19 response and other ongoing emergencies. The logistics operations for Afghanistan were among the largest and most complex in 2021 for the WHO logistics hub in Dubai, as between 65% and 75% of WHO-donated health supplies arriving in Afghanistan in 2021 were delivered by the hub.

The WHO logistics hub in Dubai worked closely with WHO Afghanistan to prioritize the most critical items needed based on the country's evolving needs, and supported the reception, inspection and consolidation of supplies. This successful coordination at multiple levels of the Organization continued to position WHO at the forefront of the health emergency response.

BUILDING KNOWLEDGE AND SKILLS IN THE REGION



National and facility-level IPC structures established or updated in

5
countries



Priority IPC practices assessed in

54 health facilities
in **5**

countries (Afghanistan Iraq, Libya, occupied Palestinian territory, Tunisia)

Enhancing genomic surveillance through the regional sequencing strategy

7
countries

received WHO support to sequence abroad and strengthen local sequencing capacity using MiniOn technology

15
countries

have domestic genome sequencing capacity to detect SARS-CoV-2 VOCs

7

countries

confirmed and monitored SARS-CoV-2 variant circulation through WHO support to sequence abroad

Laboratory technicians from seven complex-emergency countries receiving WHO training on SARS-CoV-2 next-generation sequencing in Abu Dhabi, United Arab Emirates, December 2021



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3

regional reference laboratories

identified for genome sequencing



14

national laboratory technicians trained on SARS-CoV-2 next generation sequencing in

7

complex-emergency countries

(Afghanistan, Iraq, Lebanon, Libya, Sudan, Syrian Arab Republic, Yemen)

Eleven countries of the Region developed capacity for SARS-CoV-2 next-generation sequencing in public health laboratories during the first year of the COVID-19 pandemic. This number grew to 15 in 2021, although there were varying capacities.

Record levels of SARS-CoV-2 circulation in the Region due to the Omicron VOC, as well as the risk of emergence of new VOCs, meant that developing domestic genome sequencing capacity has been a priority for all countries. Therefore, a two-pronged regional sequencing strategy was established by WHO.

1. In partnership with the United Kingdom Health Security Agency, through the New Variant Assessment Platform, three regional reference laboratories were identified for sequencing (in Morocco, Oman and United Arab Emirates) in 2021, and a regional sequencing laboratory network is being established. Allowing smooth coordination with international and regional networks, these laboratories will build and/or support the sequencing capacity of other countries in need of technical assistance, aiming to support the whole Region.
2. To build sequencing capacity in countries experiencing complex emergencies that lack such capacity (Afghanistan, Iraq, Lebanon, Libya, Somalia, Sudan, Syrian Arab Republic and Yemen), WHO procured sequencing equipment, conducted a regional training for 14 national laboratory technicians from seven complex-emergency countries, and provided mentorships. Shipping of the equipment is underway and sequencing is set to begin in the seven countries in 2022.

Building SARS-CoV-2 laboratory testing from scratch in Somalia

392 282

suspected COVID-19 cases

tested between 16 March 2020 and 1 January 2022

10

public and private laboratories

with PCR testing capacity

4

laboratories

are establishing SARS-CoV-2 genome sequencing capacity



A laboratory technician conducting PCR testing at the National Public Health Reference Laboratory in Mogadishu, Somalia, 26 September 2021

Amid protracted conflicts, a fragmented political situation, regular humanitarian emergencies and recent infectious disease outbreaks, responding effectively to COVID-19 in Somalia was a significant challenge. At the beginning of the COVID-19 pandemic, Somalia had no polymerase chain reaction (PCR) testing capacity. WHO supported the establishment of PCR testing by providing equipment, testing kits, and personal protective equipment for laboratory staff, and by deploying experts to Hargeisa and Garowe for training on molecular testing. WHO Somalia is currently working on establishing PCR capacity in the national laboratories of six States within Somalia.

In addition, WHO Somalia developed a protocol for SARS-CoV-2 antigen rapid diagnostic tests, alongside

laboratory training provided to health care workers. These tests were deployed across the country, expanding access to testing to populations who previously had none.

Despite limited resources and a fragile health system, the implementation of key initiatives led to stronger health services for improved health beyond the COVID-19 response. The progress in laboratory diagnostics presented an opportunity to leverage the PCR laboratory network to detect and respond to other epidemic-prone diseases in the country. With the support of WHO Somalia, the federal Ministry of Health established influenza-like illness and severe acute respiratory infection surveillance in the country's three reference laboratories, and can now test for influenza, dengue and other diseases.

Supporting countries and territories of the Region to develop national IPC guidelines

16

countries

developed national IPC guidelines, all within the last five years including 5 countries in 2021

7

countries

benefited from review and/or update of their national COVID-19 guidelines

4

FCV countries

developed their first national IPC guidelines

IPC surge mission visiting the Al Kuwait isolation centre in Sana'a, Yemen, December 2021



Evidence-based national IPC guidelines are the fundamental building blocks to scale up IPC programmes in any given country. In the context of the COVID-19 pandemic, and considering SARS-CoV-2's modes of transmission, comprehensive national IPC guidelines became an absolute necessity.

Before 2021, 11 countries in the Region had national IPC guidelines. In order to support the development of guidelines in the 11 remaining countries and territories, national technical guideline development groups were assembled, based on WHO technical advice, in Afghanistan, Iraq, Libya, occupied Palestinian territory and Tunisia, with members representing various IPC technical specialties from the health ministries and academia. A first draft of the guidelines developed by the groups was

reviewed by WHO IPC regional and global experts. A consensus meeting with WHO and national stakeholders was then conducted to approve the final draft, which WHO reviewed to ensure alignment with WHO guidelines and standards.

Following a series of meetings and policy dialogues, Afghanistan, Iraq, Libya, occupied Palestinian territory and Tunisia successfully developed their first national IPC guidelines, marking a momentous and unprecedented public health achievement. The guidelines are being disseminated for hospital implementation, with support from WHO, to serve as a practical reference for national IPC standards and as a resource for the development of IPC training materials. WHO is providing support to the six remaining countries without national IPC guidelines for their development.

Bridging the IPC gap in Yemen by manufacturing disinfection products locally

Eight years of ongoing conflict in Yemen have taken a toll on the country's health system, particularly regarding health facility infrastructure, service quality and supply availability. A series of disease outbreaks in recent years, including cholera and diphtheria, has further exacerbated the burden on the country's fragile health system. With the emergence of COVID-19, the essential IPC practice of hand hygiene to prevent the spread of SARS-CoV-2 in health care settings was impeded by a shortage of soap, clean water and alcohol-based hand rub (ABHR) in most health facilities. To address this, WHO initiated support to produce ABHR locally in health care settings.

Al-Gumhori Teaching Hospital, a 600-bed tertiary facility in Sana'a, was one of 12 hospitals prioritized by the Ministry of Public Health and Population to enhance IPC implementation, focusing on improving hand hygiene compliance, as it is among the largest hospitals in Yemen. Due to the extreme shortage of hand hygiene supplies in the hospital and local market, WHO supported the hospital's IPC team and leadership to secure the raw materials needed to manufacture disinfection products within the hospital. The hospital's IPC team designated a location within the hospital to produce ABHR, detergents and disinfectants, relying on WHO's formula for correct concentrations and dilution. The disinfection products that are manufactured supply all hospital departments.

WHO developed hand hygiene standard operating



Pharmaceutical laboratory locally producing ABHR, Al-Gumhori Teaching Hospital, Sana'a, Yemen, December 2021.

procedures and trainings; created and distributed information, education and communication materials including posters and workplace reminders; and shared technical guidance throughout the development of this initiative. Thanks to the sustained efforts of the hospital's leadership and IPC team, and with the support of WHO, the hand hygiene multimodal interventions were successfully implemented with on-site staff refresher training in different hospital departments. Hand hygiene compliance among health care workers is being monitored using the WHO hand hygiene observation tool.

Developing critical care capacity in fragile and conflict-affected situations



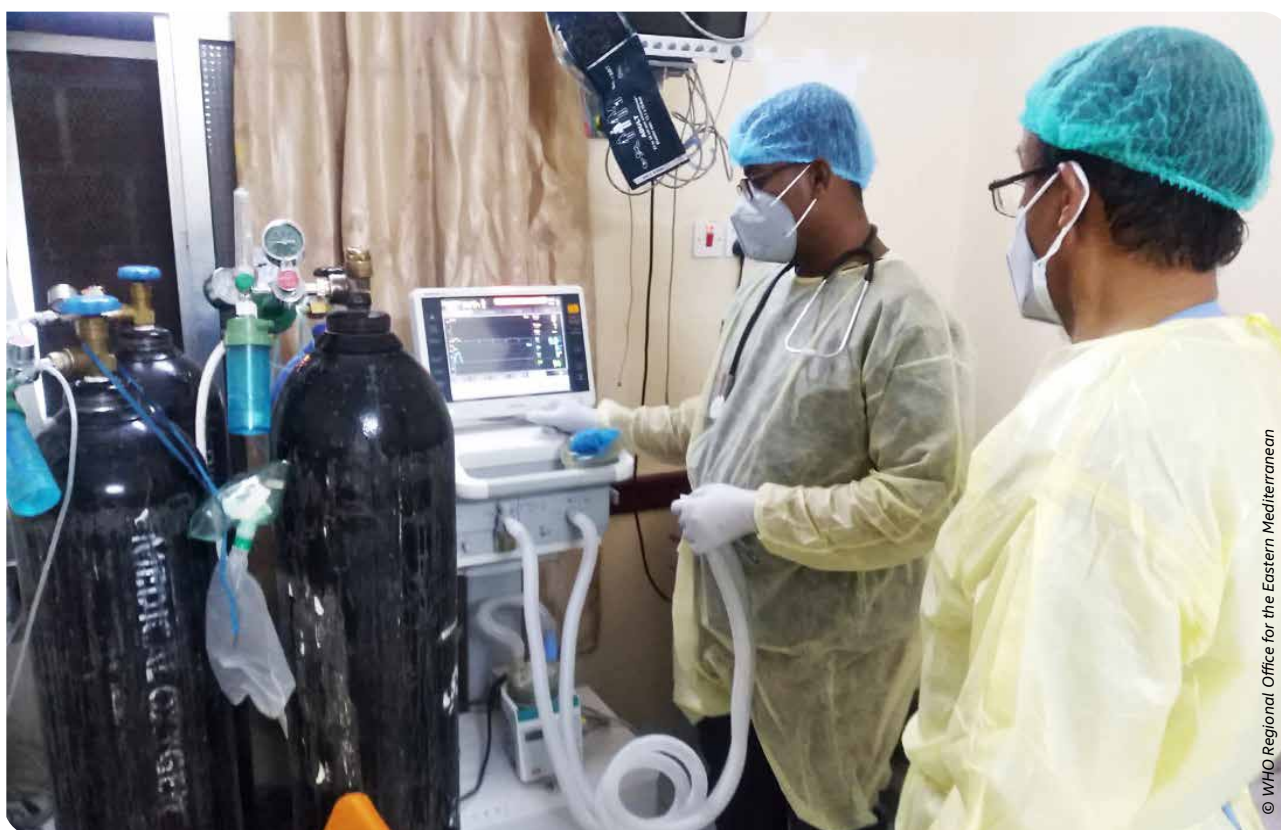
Over

50 000

health care workers received ICU/critical care training, by WHO or cascade training

Prior to the COVID-19 pandemic, most resource-limited countries or countries in fragile and conflict-affected situations in the Region had little or no intensive care unit (ICU)/critical care capacity. In the early days of the COVID-19 pandemic in 2020, countries of the Region started procuring and receiving mechanical ventilators and other biomedical equipment to treat COVID-19 cases. However, inappropriate use of such equipment and insufficient compliance with the WHO treatment protocol persisted, leading to high case fatality ratios in such settings, with COVID-19 mortality post-ICU admission nearing 100% in some countries. To tackle this, WHO worked on building ICU/critical care capacity and improving frontline health care workers' life-saving skills, as well as bridging such surge response to longer term capacity-building through different modalities according to local contexts and needs.

WHO developed introductory training packages on ICU/critical care and the use of biomedical equipment, and rolled them out differently based on the local context and needs. For instance, Yemen, which had almost no ICU/critical care capacity in its public sector prior to the pandemic, greatly benefited from WHO's support in this area, with 1259 health care workers participating in an in-person training of trainers on ICU/critical care for COVID-19. WHO is currently working with Yemen to establish a longer term nationally certified ICU/critical care training programme, moving beyond the COVID-19 pandemic to merge the surge response with sustainable capacity-building. Iraq, the occupied Palestinian territory and Somalia also received in-person ICU/critical care training, as did Afghanistan, where 7834 health care workers participated.



Hands-on training in Al-Amal isolation centre, Aden, Yemen, February 2021

© WHO Regional Office for the Eastern Mediterranean

Establishing COVID-19 case management capacity in the occupied Palestinian territory

Given that COVID-19 mortality following hospital admission neared 100% in some FCV countries at the beginning of the pandemic, WHO prioritized capacity-building in case management and clinical operations early on. In 2021, WHO continued such efforts by procuring supplies, conducting training and providing technical support.

Since the beginning of the pandemic, WHO has supported the occupied Palestinian territory's COVID-19 response amid the complex emergency context. WHO provided 60 ICU beds, 124 ventilators and 150 oxygen concentrators to the occupied Palestinian territory in 2020 and 2021.

In the occupied Palestinian territory, WHO supported the training of doctors and nurses on intensive care management of COVID-19 patients, including patient assessment and monitoring, airway management and mechanical ventilation, and IPC measures. Lectures and practical trainings were conducted separately for doctors and nurses over three weeks and one month, respectively, followed by mentoring in hospital settings. Upon their return to their hospitals, training participants have continuously cascaded the WHO training and extended their skills and knowledge to the wider network of health care professionals.



WHO training ICU/critical care nurses in the Gaza Strip, March 2021



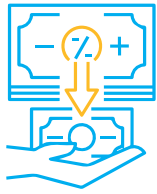
Nearly

1000

health care workers

in the occupied Palestinian territory have received WHO training on ICU and case management since the beginning of the COVID-19 pandemic

SUPPORTING IMPLEMENTATION OF EVIDENCE-BASED PUBLIC HEALTH AND SOCIAL MEASURES



US\$
772 000



provided in financial support

for **10** civil society organizations (CSOs) and **8** countries to involve CSOs in national and local COVID-19 responses



10

regional webinars

held on RCCE



530

people trained

through **118** trainings and webinars in the areas of International Health Regulations (IHR,2005) monitoring and evaluation, points of entry, travel measures, mass gatherings, operational readiness and One Health



45

meetings

held to support WHO country offices

Strengthening Watch and Alert modes for Sudan's Public Health Emergency

Operations Centre to strengthen rapid and informed response

Sudan is experiencing multiple emergencies: in addition to COVID-19, the country faces other disease outbreaks such as dengue, malaria, cholera and chikungunya; natural hazards such as floods and droughts; and armed conflict. Despite the urgent need for data collection to generate an early response in such a humanitarian context, the data collected were rarely used to guide response actions. The country has many functional yet fragmented surveillance systems and reporting sources but faces delays in the sharing of data – which are often unverified and incomplete – with unclear reporting lines.

To achieve one streamlined hub of information

and coordination, WHO supported Sudan's Public Health Emergency Operations Centre (PHEOC) to establish an official "Watch" team. A PHEOC serves as a coordination structure for the preparation for, response to and recovery from public health emergencies, and typically operates in three modes: Watch, Alert and Response.¹ To establish the Watch team, WHO provided support to draft terms of reference and standard operating procedures, and to train the team. WHO also provided its PHEOC Electronic Public Health Emergency Response Management (ePHERM) software to document and manage signals and alerts. Once implemented, the Watch team were able to streamline signals and alerts produced by various

¹ Handbook for public health emergency operations center operations and management. Brazzaville: WHO Regional Office for Africa; 2021 (https://www.afro.who.int/sites/default/files/2021-03/AFRO_PHEOC-Handbook.pdf).

information sources and surveillance systems, such as indicator-based and community-based surveillance systems, social media, call centres, and other sectors and partners. The Watch team now operates the system by registering detected signals and alerts into ePHERM, where they are systematically sorted, verified and reviewed daily by a technical committee. The technical committee is composed of experts from different departments, who make technical recommendations to act on each signal and alert received. On the same day, the policy group – the decision-making authority

within the Federal Ministry of Health – reviews the technical recommendations and plans the corresponding response actions.

Throughout the COVID-19 pandemic, the system made it possible to identify clusters of cases and deaths, to estimate vaccine hesitancy among the population through avenues such as data collection from call centres and open media sources, and to detect outbreaks of other infectious diseases. With the recent civil unrest in Sudan and the fragility of the health system, ePHERM was the primary source of information for the PHEOC and leadership.

In 2020 and 2021



171

raw signals
detected by Sudan's
PHEOC



105

signals selected
for verification and
follow-up



17

signals designated
as "events"



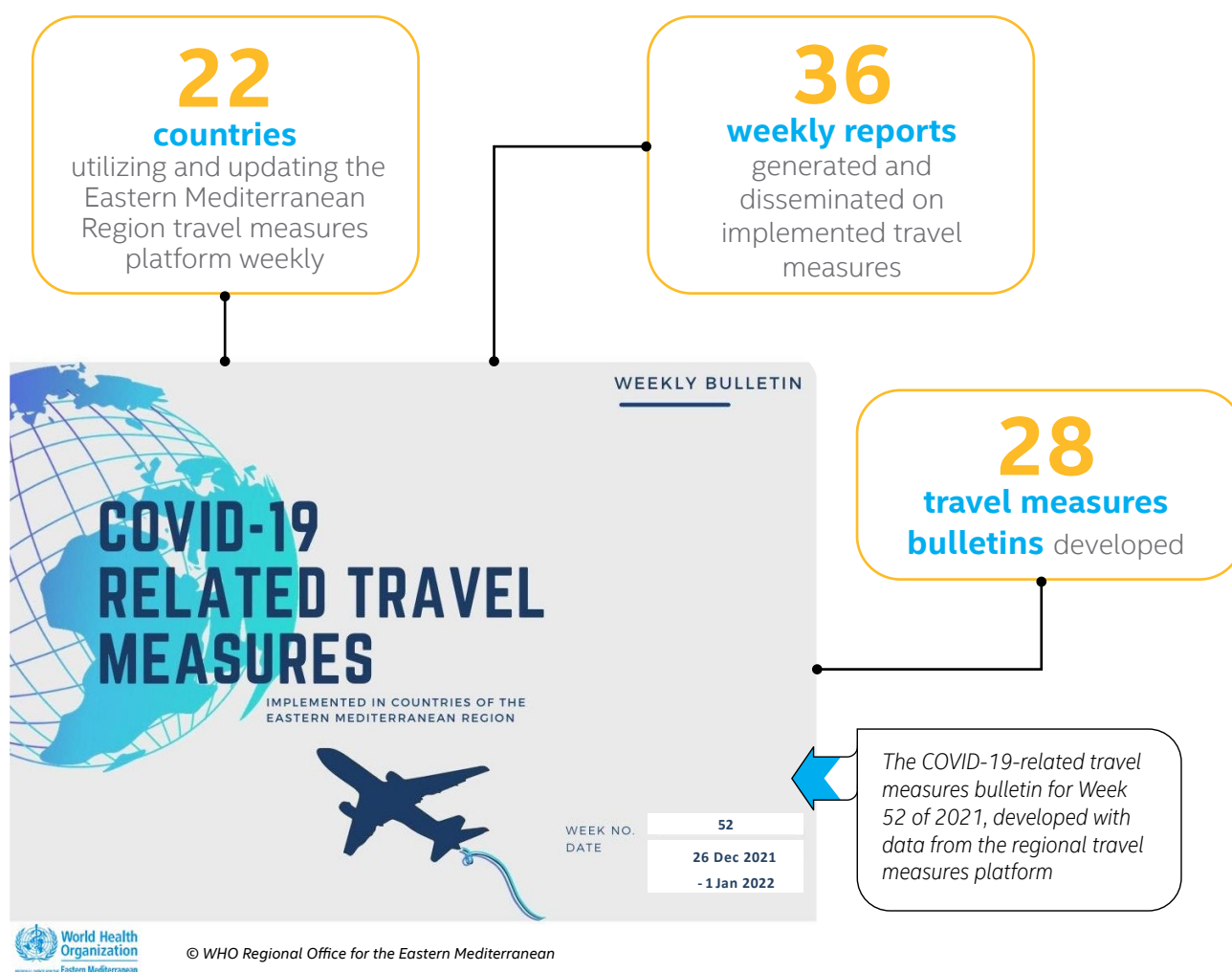
Public Health Emergency Operations Centre, Khartoum, Sudan, 2021

Facilitating coordinated reporting through the regional travel measures platform

In response to the COVID-19 pandemic and the circulation of variants, countries of the Region implemented various mitigation measures. Despite Article 43 of the IHR (2005) requiring reporting, justification and review¹ of these measures, discrepancies and challenges in reporting and cataloguing were observed. Therefore, WHO developed a unique and tailored digital solution facilitating compliance with reporting requirements: the Eastern Mediterranean Region travel measures platform. The online platform includes a map of implemented measures and a dashboard with related epidemiological updates.

Initially developed in November 2020 using the District Health Information Systems 2 software, the travel measures platform was upgraded in April 2021 by transitioning to an in-house solution,

custom designed for the collection of regional data. National IHR focal points enter data weekly on screening, quarantine, testing, vaccination and other restrictions, as per IHR (2005) obligations. They have access to regional updates in real time, fostering transparency and accountability, and facilitating timely exchange of information between countries from official sources. In addition to facilitating coordinated reporting in a previously fractured landscape, the platform enables WHO to communicate travel measures – including testing, quarantine and vaccination requirements – to countries for a coordinated regional COVID-19 response. Furthermore, the generation of timely and accurate metrics strategically guides health policy planning.



¹Statement on the fifth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic [website]. Geneva: World Health Organization; 2020 [https://www.who.int/news/item/30-10-2020-statement-on-the-fifth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/30-10-2020-statement-on-the-fifth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic)

Capturing behavioural insights to inform evidence-based RCCE interventions for the COVID-19 response



Feedback from
more than
27 000
respondents
captured through
KAP survey

Understanding the complex factors that influence and impact people's decisions and actions has been at the forefront of the COVID-19 response. Identifying and addressing the barriers and drivers that affect individual behaviours became increasingly important as health authorities struggled to ensure that public health and social measures were understood by, acceptable to and actionable by the population.

In the Region, the systematic collection and use of behavioural insights was established as one of the four core pillars guiding WHO's RCCE response to COVID-19. Building on this strategic approach in 2021, WHO and UNICEF conducted a knowledge, attitudes and practices (KAP) survey, enabling the capture of insights from individuals across the Region on COVID-19, public health and social measures, and COVID-19 vaccines. By capturing feedback from 23 countries/territories in the WHO Eastern Mediterranean Region and/or the UNICEF Middle East and North Africa region, results of the two-time survey have enabled WHO and UNICEF to support countries in implementing evidence-based, tailored interventions to increase adherence to public health and social measures, and to build COVID-19 vaccine demand and address related barriers.



WHO Libya supports the efforts made by the Ministry of Health and the National Centre for Disease Control to spread health awareness about COVID-19 prevention measures, April 2021

TAKING ACTION THROUGH PUBLIC HEALTH INTELLIGENCE

Modelling for enhanced decision-making

In March 2020, to support evidence-based decision-making and respond to inquiries from countries of the Region during the COVID-19 pandemic, WHO's Regional Office established a modelling support team. The team developed a participatory scenario-based modelling approach, exploring country-specific scenarios to provide insights on the estimated timing of peaks of COVID-19 cases as well as the epidemiological outcomes under different public health and social measures and vaccination scenarios.

The scenario-based approach provided a framework to understand complex dynamics, with results translated into actionable public health decisions, responding to decision-makers' queries, enhancing data sharing, and building trust, ownership and support between WHO and policy-makers. A wide range of stakeholders – from health ministries, academia, and national and international organizations – were engaged in all stages of the modelling process and promoted modelling results.

Several countries/territories used the modelling results to inform decision-making in 2020 and 2021. Examples include decision-making on schools reopening in Lebanon and occupied Palestinian territory; enforcing fines related to mask-wearing in Egypt; and the gradual release of lockdown measures in Tunisia. In Jordan, the results guided decisions on the relaxation or reinstating of public health and social measures, and the models explored the potential impact of the circulation of the Alpha VOC. His Excellency the Minister of Health of Jordan conveyed the benefits of extending some control measures during a media interview, a decision that was informed by the modelling results.



35
rounds

of modelling analyses
conducted for 11
countries



Orientation of Field Epidemiology Training Programme fellows on regional COVID-19 surveillance in WHO's Regional Office in Cairo, Egypt, October 2021

Monitoring the circulation of the Omicron VOC in Jordan for tailored interventions

After WHO designated the SARS-CoV-2 Omicron variant as a VOC on 27 November 2021, Jordan successfully responded to and mitigated the surge in COVID-19 cases induced by this highly transmissible variant. Concerted efforts from all stakeholders, including the private sector, enabled testing capacities to be significantly enhanced, doubling the number of tests performed from an average of 200 000 tests weekly in the third quarter of 2021 to around 400 000 tests weekly by the end of 2021. To ensure optimal catchment, testing was conducted in a wide range of locations, including drive-through clinics, parks and malls.

Thanks to substantial investment in sequencing capacity and related equipment, Jordan is among the 15 countries in the Region with domestic genome sequencing capacity to detect SARS-CoV-2 VOCs, enabling the country to detect VOCs in a timely manner and to adapt response measures accordingly. By late 2021, Jordan had reported the detection of all five SARS-CoV-2 VOCs (Alpha, Beta, Gamma, Delta and Omicron). Although Jordan has not developed a unified national strategy, private laboratories, the Central Public Health Laboratory, the Royal Medical Services and the University of Jordan took part in genome sequencing, and all stakeholders directed efforts towards ensuring adequate representation in terms of the samples and populations tested. Strong leadership and coordination were ensured at the highest levels, as the Ministry of Health and the National Center for Security and Crisis Management collected, analysed and disseminated data for action.

Jordan shared data on COVID-19 alerts, hospitalization and ICU bed occupation indicators, and other epidemiological indicators, with all stakeholders to facilitate the capture of the evolving COVID-19 situation in real time. Furthermore, WHO has been highly involved in strengthening genome sequencing capacities by convening stakeholders (i.e. the main national laboratories, including health ministry, military, private sector and veterinary laboratories) and by establishing the genome consortium to develop and implement a national strategy to optimize genome sequencing, which will benefit the health system and future health emergencies beyond COVID-19.



400 000

tests

conducted weekly
in Jordan by
the end of 2021



Preparation for genome sequencing at the Central Public Health Laboratory, in Amman, Jordan, March 2022

Putting strong data collection, management and analysis at the core of Saudi Arabia's COVID-19 response

From the beginning of the pandemic, the COVID-19 response was recognized as a national priority in Saudi Arabia, with sustained commitment from the highest levels of authority in the country. Strong governance, intersectoral coordination and health information management led to evidence-based decision-making. Experts from WHO's Regional Office witnessed Saudi Arabia's strong surveillance system during a comprehensive technical mission in October 2021 to review the national and subnational response to COVID-19.

Saudi Arabia is currently undergoing transformation in many sectors, including the health sector, as it works towards its national strategy for Vision 2030. Amid this transformation, the country was able to successfully respond to the COVID-19 pandemic, building on its experience with Middle East respiratory syndrome, which it has been tackling since 2012.

Saudi Arabia leveraged existing systems from that response, including those for surveillance, laboratory diagnostics, IPC, RCCE and clinical management.

Effective digital innovation led to the development of mobile applications for the COVID-19 response, including applications for self-reporting, mass testing, making appointments, reporting vaccine side-effects, contact tracing and accessing public places. All health providers contribute to the surveillance system, leading to large amounts of data being available in real time. Data are displayed on dashboards in the Ministry of Health's National Health Command Center, and extracted data are then displayed on the Ministry's public COVID-19 dashboard. Strong data analysis and the commitment of all information providers to share data in real time have enabled the use of data for decision-making, such as for the downsizing of Hajj and suspension of Umrah.



©WHO Regional Office for the Eastern Mediterranean

One of the seven dashboards observed during WHO's visit to the National Health Command Center in Riyadh, Saudi Arabia, 18 October 2021

PARTNERING AND COMMUNICATING FOR IMPACT



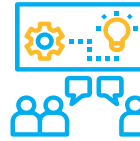
43

partners
brought together as a regional network



26

biweekly situation reports
published¹



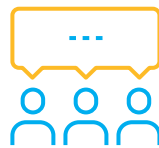
95

direct communications
with the regional Ministerial Group on COVID-19



300

interviews
by regional spokespersons



24

meetings
held by the COVAX RCCE Demand Generation Working Group



24

regional media press briefings
hosted



Over
5 million

visits to the COVID-19 website, accounting for **40%** of all visits to WHO's regional website



36

videos
developed for the public



24

sets of Q&As and myth busters
developed



174

social media cards and infographics
developed

Over
11 million

people reached
by **687** Twitter posts



6

Facebook live sessions
streamed with the Regional Director and experts

Over
64 000

people reached
by **115** Instagram posts

¹COVID-19 situation reports [website]. Cairo: WHO Regional Office for the Eastern Mediterranean (<http://www.emro.who.int/health-topics/corona-virus/situation-reports.html>).

Sustaining the longest running IMST for continuous support to countries



111

regional IMST meetings held



44

global IMST meetings attended



103

COVID-19 field missions conducted

The WHO Regional Office formally activated the IMST on 22 January 2020 to coordinate and prioritize efforts for preparedness and response to COVID-19, and to act as the link between global, regional and country responses. The IMST successfully developed regional preparedness and response strategies to guide the COVID-19 response, while documenting the progress and successes of the response across the Region. Since its establishment, the IMST has served as the main regional coordination structure for the COVID-19 response. Although the Incident Management System had previously been used by WHO to respond to acute emergencies, the IMST for COVID-19 has been the most integrated and longest running coordination structure of this kind, now

activated for over two years.

The technical pillars composing the IMST have enabled a comprehensive regional response while ensuring a country focus for tailored support and impact. The engagement of the Regional Director, both with the IMST and with key decision-makers, has ensured continuous action and support for the response in the Region. The IMST for COVID-19 has been an effective regional interdepartmental coordination mechanism, bringing together 400 technical and support staff under the leadership of the Regional Director, who has continuously advocated for the active participation of all Regional Office departments in the COVID-19 response and its coordination mechanism.

Hanano Hospital, visited during the WHO mission to Dhusamareb, Somalia, 28 September 2021



21

countries visited in person by IMST mission members

400

Regional Office and country office staff involved in IMST meetings and activities

Deploying the regional external communications strategy to boost vaccination efforts

As COVID-19 vaccines were rolled out in the Region, timely and accurate communications to present the facts on vaccine development and to address rumours, misinformation and vaccine hesitancy were crucial. WHO developed an external communications strategy for COVID-19 vaccination both regionally and to guide countries and streamline communications to various external audiences.

External communications on vaccines were delivered through a multi-pronged approach. To ensure senior management, internal spokespersons and WHO country offices were updated on WHO's public position about COVID-19 vaccines, internal talking points and briefing notes were shared on messaging related to vaccine research, development and safety, as well as WHO Emergency Use Listing Procedure approved vaccines.

To address misinformation and update the public on new developments, a new section on vaccines was created on WHO's COVID-19 website. Sets of questions and answers, myth busters, social media cards, infographics and weekly news updates were regularly published online, alongside video interviews with technical officers. WHO strengthened its partnership with Facebook in relation to COVID-19 through the launch of several campaigns containing targeted messaging on vaccination for specific audiences across the Region, including the impact of vaccination on fertility and pregnancy/unborn children.



Over
19 million
people

reached by Facebook posts on WHO guidance on vaccination of children and youth



WHO's partnership with Facebook against COVID-19 was strengthened with the launch of several campaigns containing targeted messaging about vaccines for specific audiences across the Region

Tackling misinformation by training key actors in Iraq

In partnership with Al Jazeera Media Institute, the Regional Office and WHO country office in Iraq trained 80 journalists and Ministry of Health communications focal points, from all governorates of the country.

The workshop, held in Baghdad over two 3-day rounds in December 2021, marked the first time that journalists and Ministry focal points came together to discuss common challenges and solutions. WHO technical experts updated participants on communicable and noncommunicable diseases, mental health, maternal and child health, and COVID-19 to ensure that they had access to the latest information on public health issues that were relevant in Iraq.

Al Jazeera Media Institute facilitators trained journalists on research and interview skills and techniques to verify the credibility of information before publishing. In practical sessions and simulation exercises, participants were taught to address rumours and misinformation by using the influence they already have. Ministry of Health focal points were reminded of their role in ensuring the availability of accurate and relevant information to both the media and the public, and in collaborating with journalists to ensure correct information is disseminated widely and in a timely manner.

For a longer term impact, an information sharing and fact-checking network was established with participants for more effective collaboration on information sharing and verification.



80

**journalists and
Ministry of Health
focal points**
trained in Iraq



Iraq concludes the first-of-its-kind workshop for journalists and Ministry of Health communications focal points on public health information sharing and verification in Baghdad, Iraq, December 2021

Scaling up vaccination through COVAX

22

countries of the Region

had introduced COVID-19 vaccination by 21 April 2021



22

countries

of the Region participated in COVAX



21

countries

received vaccine doses through COVAX

318

million

COVID-19 vaccine doses

allocated to countries of the Region through COVAX



180

million

COVID-19 vaccine doses

shipped to countries of the Region through COVAX

The occupied Palestinian territory transferring its first shipment of 37 440 Pfizer doses and 24 000 AstraZeneca doses of COVID-19 vaccines, received through COVAX as part of the first wave of COVID-19 vaccine allocation, to health ministry storage facilities in the West Bank and Gaza Strip, 22 March 2021

In the Region, significant discrepancies in routine vaccination coverage already existed between countries prior to the COVID-19 pandemic. High-income countries led research and development of COVID-19 vaccines globally, and when vaccines became available in late 2020, these countries had the capacity to purchase large quantities.

Gavi, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO launched COVAX, the vaccine pillar of the Access to COVID-19 Tools Accelerator, in April 2020. Alongside key delivery partner UNICEF, COVAX aims to accelerate the development and manufacture of COVID-19 vaccines and to guarantee fair and equitable access for every country in the world.

The WHO Regional Office was involved every step of the way, monitoring vaccine allocation rounds, COVAX dose-sharing announcements, vaccine doses received, vaccine consumption and progress in vaccination. WHO established a regional working group for COVID-19 vaccine deployment, co-chaired by UNICEF and involving numerous different United Nations and international partners. The working group coordinates and monitors country support for COVID-19 vaccine deployment. Several sub-working groups were also established with relevant partner agencies on various thematic areas.

Of the 22 countries/territories of the Region, 11 high- and upper-middle-income countries self-finance their vaccine procurement, while 11 lower-middle-income and low-income countries are AMC countries, benefiting from official development assistance to fund their vaccine supply.

Following an initial shortage of vaccines in early 2021, COVAX managed to improve supply, especially for AMC countries, in late 2021, with 85% of the total doses delivered by COVAX being delivered to AMC countries.

As vaccination coverage remains uneven within the Region and countries, additional efforts are needed to procure vaccines through COVAX or other mechanisms, and vaccine donations should be centralized through COVAX to ensure equity.



© WHO occupied Palestinian territory

Aligning RCCE efforts with partners for a stronger and coordinated response

Within the Eastern Mediterranean Region, a strong partnership has long been established between WHO, the International Federation of Red Cross and Red Crescent Societies (IFRC) and UNICEF. In 2020, this partnership was wholeheartedly strengthened in response to the detection of and response to COVID-19, bringing together the three agencies to form a solid, united partnership that leveraged the collective capacities of the respective agencies to support national efforts and a regional response to COVID-19.

To ensure the continued close coordination between the three agencies and other key stakeholders, a Regional RCCE Interagency Working Group for the Eastern Mediterranean Region/Middle East and North Africa was established and a regional RCCE guiding framework was developed.¹ This framework set forth the strategic approach for COVID-19 RCCE response in the Region and guided partner efforts throughout 2021, ensuring there were common priorities and a common vision among the three respective agencies. Through this working group, other partners and actors joined the response effort, including regional United Nations partner agencies, CSOs, faith-based partners, the media and academia.

Furthermore, WHO increased its partnerships at the local, national and regional levels with CSOs, faith-based organizations and others in joint efforts to respond to the needs of specific vulnerable groups, including refugees and migrants, persons living with HIV and drug addiction, and marginalized groups.

 **24**
WHO, IFRC and UNICEF
interagency meetings
held



© WHO Libya

WHO, IFRC and UNICEF RCCE facilitators joining forces to roll out the RCCE training of trainers, targeting community health workers from the Ministry of Health, staff from the National Center for Disease Control and volunteers from the Libyan Red Crescent, to support COVID-19 vaccine acceptance in Tripoli, Libya, December 2021

¹Regional guiding framework for risk communication and community engagement for the COVID-19 response in the Eastern Mediterranean Region/Middle East and North Africa. December 2020. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/WHOEMIHR015E-eng.pdf?ua=1>).



PIONEERING INNOVATION AND RESEARCH IN THE REGION



491

people trained

on research and knowledge management in relation to COVID-19



22

meetings and webinars

conducted on research and knowledge management in relation to COVID-19



96

meetings

held individually with countries on research and knowledge management in relation to COVID-19

Building knowledge on SARS-CoV-2 through seroprevalence studies

13

countries

supported by WHO in conducting 17 rounds of seroprevalence studies

Since the beginning of the COVID-19 pandemic, WHO has applied epidemiological methods extensively to monitor SARS-CoV-2 spread and epidemiological trends, calculate attack rates, and determine disease severity. Among these methods, seroprevalence studies tested population immunogenicity by measuring antibody levels (immunoglobulin G and immunoglobulin M) using rapid antibody tests and/or serological enzyme-linked immunosorbent assay (ELISA) tests, with or without PCR tests.

WHO developed and shared standardized age and sex population-based seroprevalence study resources with countries globally. Starting in June 2020, WHO provided technical guidance, laboratory resources and field teams to support the implementation of seroprevalence studies in 13 countries in the Region, with three countries conducting two to three rounds. In order to standardize the data-collection methods used, WHO provided technical support to these countries by developing standard operating procedures and indicators for field data collection and monitoring, to ensure the effective use of resources provided.

Between June 2020 and December 2021, study results showed an increase in the prevalence of antibody levels from under 1% at the start of the period to up to 70% by late 2021. These results enabled WHO to identify the frequency of occurrence of asymptomatic disease and recurrence of infection, can be used to identify priority populations for vaccine distribution, and enabled the interpretation of the impact of public health and social measures on epidemiological trends. This was the case in Jordan where seroprevalence study results (low population immunogenicity) were used in modelling and informed the decision to strengthen the implementation of public health and social measures at the beginning of the pandemic, and to decrease in late 2021 when the measured population immunogenicity reached 70%. Seroprevalence studies remain a key epidemiological method to monitor population immunity levels after vaccine introduction and to track the impact of new SARS-CoV-2 variants. They are also beneficial as an additional testing and surveillance method as they often comprise PCR testing.

865

ELISA kits

for seroprevalence studies delivered to 9 countries



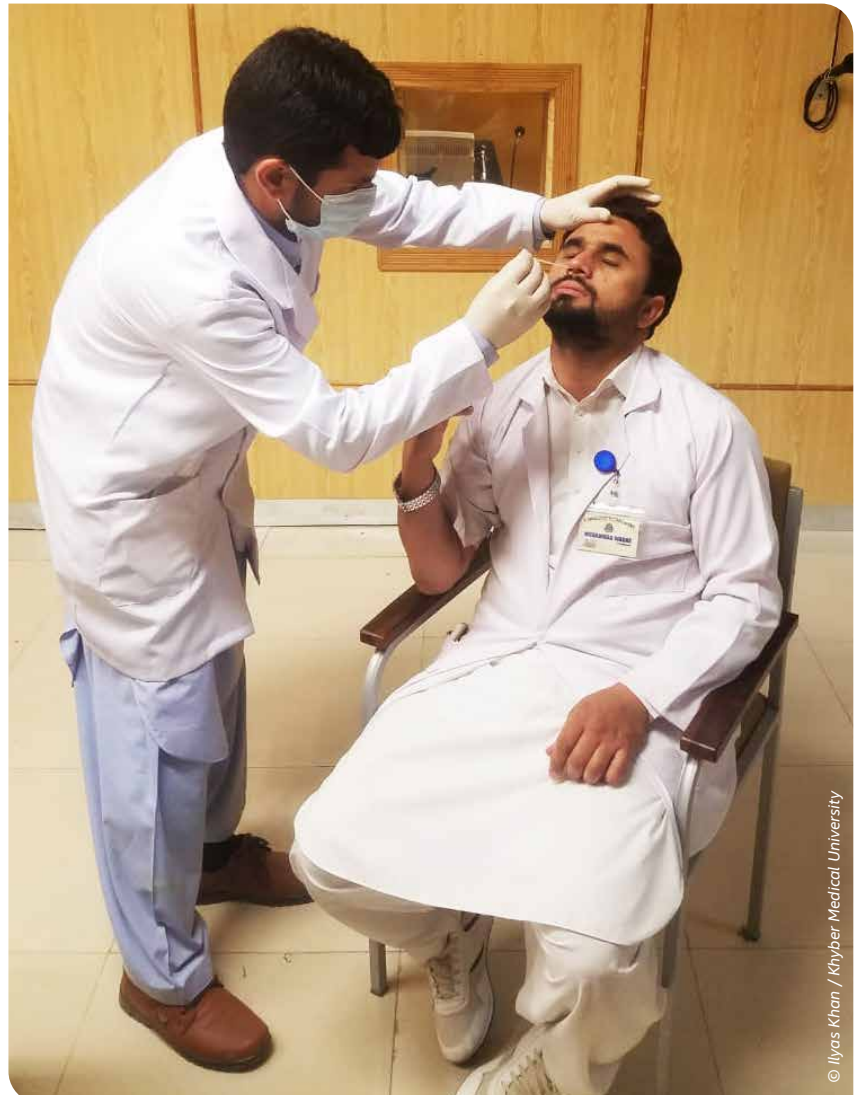
Seroprevalence study conducted with WHO support in Aden, Yemen, January 2021

Supporting Pakistan to evaluate COVID-19 vaccine effectiveness among a cohort of health care workers

Given the importance of real-world data in determining COVID-19 vaccine effectiveness, several countries in the Region – for example, Kuwait, Morocco, Qatar and the United Arab Emirates – conducted vaccine effectiveness studies in 2021. To expand such efforts, WHO formed a multidisciplinary technical team in September 2021 to oversee and support the implementation of large-scale COVID-19 vaccine effectiveness studies in countries as part of a regional study. The objective of this study was to establish a regional network to measure vaccine effectiveness against specific outcomes in various target populations, over time and for different vaccine products used in the Region, through standardized study designs and methodologies. To this end, WHO defined the minimum criteria required for countries to conduct COVID-19 vaccine effectiveness studies in line with WHO protocols, established a central data entry platform to collect and aggregate validated data from national study sites, and held training sessions for all countries in the Region. From the countries that expressed interest in the regional COVID-19 vaccine effectiveness study, four (Egypt, Islamic Republic of Iran, Jordan and Pakistan) were selected to participate based on their technical proposals, which were in line with WHO protocols, target group sizes and variety of vaccine products. The

4
countries supported
by WHO to initiate vaccine
effectiveness studies

study will later be extended to include additional countries. Among the selected countries, Pakistan was the first to receive WHO support towards the implementation of its vaccine effectiveness study in December 2021. The study aims to measure the effectiveness of various inactivated and viral vector-based COVID-19 vaccines against symptomatic infection among a cohort of 1627 health care workers from three teaching hospitals affiliated to Khyber Medical University, Peshawar. Over 90% of the participants have now been recruited, with samples collected from over 60% of these individuals, and the preparations for study initiation are ongoing. Evidence from these vaccine effectiveness studies is subsequently expected to inform evidence-based policy-making for immunization programmes across the Region.



Nasopharyngeal swab collection as part of the health care worker vaccine effectiveness study at Saidu Teaching Hospital, Swat, Pakistan, 21 April 2021

© Ilyas Khan / Khyber Medical University

Saving lives in Somalia through a multidimensional initiative to scale up medical oxygen

9

countries

received technical biomedical support, including recruitment and financial support of 15 national biomedical engineers

From 26 to 30 September 2021, six experts from the WHO Regional Office travelled to Somalia, with six additional colleagues connecting virtually, to review the national and subnational COVID-19 response. The mission covered nine priority areas of the response, expanding a typical intra-action review. Through the review of key documents, stakeholder interviews and field visits, lessons learned were identified and recommendations were shared with the health ministry to strengthen the COVID-19 response. During visits to several ICUs, critical care units and hospitals, the WHO mission team witnessed significant improvements regarding oxygen scale-up, benefiting health beyond the COVID-19 response.

When the Region was first struck by COVID-19, many countries suffered from critical shortages of medical oxygen and biomedical devices. WHO therefore procured related equipment and supplies, provided technical

support, and strengthened local human resources with biomedical engineers, training, maintenance, repairs and planning. To overcome the lack of baseline oxygen data at national levels, WHO created the regional Live Oxygen Platform, the first data platform showing oxygen production capacity and oxygen requirements in real time, to identify gaps in the timely procurement of oxygen and biomedical supplies and related technical support.

Somalia is one of the countries that has greatly benefited from such multidimensional support in oxygen scale-up. Long-term crises, including decades of conflict, war, political instability and natural disasters such as recurrent droughts and floods, have led to reduced investments in health and social services and a weak and fragmented health system. Before the COVID-19 pandemic, only 20% of Somalia's public hospitals had at least one medical oxygen source, despite it being an essential medicine. When this critical gap was exacerbated by COVID-19, WHO quickly procured medical oxygen, oxygen cylinders, other oxygen accessories, and pressure swing adsorption oxygen plants. WHO and partners also supported the introduction of innovative solar-powered oxygen concentrators and provided biomedical technical support.

In a low-resource setting such as Somalia, with frequent power outages and referral challenges, the uninterrupted and timely oxygen supply available from the pressure swing adsorption plant and solar-powered systems can be life-saving for patients requiring oxygen treatment and already benefits many patients beyond COVID-19. Such interventions during the acute phase of the COVID-19 response have transformed a COVID-19 surge response measure into sustainable health system development.



18

countries participated
in the WHO regional Live
Oxygen Platform



16

countries supported
by WHO in receiving medical
oxygen and biomedical
equipment and supplies



© WHO Regional Office for the Eastern Mediterranean

Neonatal patient having benefited from oxygen therapy during WHO's visit to Hanano Hospital, Dhusamareb, Somalia, 28 September 2021

INTEGRATING THE COVID-19 RESPONSE FOR SYSTEM BUILDING

Deploying the priority benefits package during the COVID-19 pandemic



Dr Kahtan Al-Sahbi, WHO health and knowledge management officer, presenting the key achievements of the minimum service package implemented in Yemen over the last five years, with Dr Adham Abdel-Moneim, WHO Representative in Yemen, and the Deputy Minister of Public Health and Population, Aden, Yemen, 17 May 2022

Even before the COVID-19 pandemic, developing and implementing a universal health coverage-priority benefits package (UHC-PBP) in each country was a regional priority for WHO. A UHC-PBP is a set of publicly financed, evidence-informed, prioritized, individual, population-based and intersectoral interventions defined through a deliberative process that accounts for people's health needs, the country's economic reality, and societal preferences.

The UHC-PBP rests on two key components: health services and programmes, which include promotive, preventive, curative, rehabilitative and palliative interventions that respond to people's health needs; and intersectoral actions and fiscal

policies, which relate to actions in other sectors with impacts on health, such as promoting physical activity, subsidizing beneficial commodities or taxing harmful products. Before the COVID-19 pandemic, some countries and territories of the Region – such as Afghanistan, Egypt, Islamic Republic of Iran, occupied Palestinian territory, Saudi Arabia, Somalia and Yemen – had already developed UHC-PBPs.

Achieving universal health coverage (UHC) is one of the targets set in the Sustainable Development Goals, and was reaffirmed at the United Nations General Assembly High Level Meeting on UHC in 2019. During the COVID-19 pandemic, implementing UHC-PBPs became even more urgent as overwhelmed

health systems and supply shortages led to populations struggling to access diagnostics, therapeutics and vaccines. Therefore, in 2021, WHO prepared a set of key considerations for developing a UHC-PBP through an evidence-based review process, compiling them in a guidance document to be finalized and shared with countries of the Region. The document, tailored specifically to the Region, supports countries in developing or reviewing their UHC-PBP by outlining the necessary steps in this endeavour, such as stakeholder analyses and engagement, review of the burden of diseases, and identification of priority interventions. Yemen has followed the key considerations to review its national minimum service package, equivalent to the UHC-PBP, with WHO support to select the services included in this package. To push this initiative further, WHO is preparing tailored programmes for the development of UHC-PBPs in complex-emergency countries. WHO is currently providing support to Jordan, Libya, Syrian Arab Republic and Yemen in developing or reviewing their UHC-PBPs.

4

countries

receiving ongoing WHO support to develop or review UHC-PBPs

Assessing the continuity of essential health services in Bahrain

Almost every country in the world has witnessed a disruption of health services during the COVID-19 pandemic. To better understand the extent of these disruptions, WHO rolled out three rounds of the pulse survey, covering between 129 and 159 countries per round. The survey supports a rapid assessment of the impact of the COVID-19 pandemic on health systems and essential health services across the life course. The findings provide immediate insights from key informants on country experience, the extent of disruptions to a set of tracer services, the reasons behind the disruptions, and existing mitigation strategies.

Among countries of the Region, Bahrain stood out as reporting very little health service disruption throughout the pandemic, never exceeding 5% of services disrupted. In the pulse survey's first¹ (May–July 2020) and second² (January–March 2021) rounds, Bahrain reported that none of its health services were disrupted. In the third round³ (November–December 2021), only one of 50 tracer essential health services was disrupted, but some disruption was reported in sexual, reproductive, maternal, newborn and adolescent health, and communicable disease-related services. Following a short suspension of outpatient and community-based services as well as mobile clinics in the beginning of the COVID-19 pandemic, all service delivery platforms were back to functioning as usual by the end of 2021.

21 and 17

countries

participated in the first and second rounds, respectively, of the global pulse survey in 2021

¹Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1).

²Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January–March 2021. Interim report 22 April 2021. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2021.1).

³Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021: Interim report, 7 February 2022. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1).

This success in maintaining health services during the pandemic in Bahrain is credited to well-structured governance, decentralized decision-making and investments in health (i.e. infrastructure, digital technologies, workforce capacity). The country had defined national essential health services prior to the COVID-19 pandemic and a clear list of services to maintain during the pandemic. The country also has a health system recovery plan, with allocated

funding to maintain essential health services during COVID-19. COVID-19-related data – such as those on service continuity, comorbidities, health inequalities and misinformation – are continuously tracked. To maintain essential health services, Bahrain extended facilities' working hours, provided home-based care, deployed telemedicine, encouraged self-care interventions and launched catch-up campaigns for missed appointments.



Visit to intensive care units and isolation facilities near the Salmaniya Medical Complex in Manama, Bahrain, established to ensure the continuity of essential health services in the main hospital, during the WHO mission to Bahrain on 7 November 2021

Responding to the impact of COVID-19 on mental health in the Syrian Arab Republic

In the Syrian Arab Republic, approximately one in every 10 Syrians live with a mild to moderate mental health condition.¹ The impact of long-term exposure to conflict, coupled with the stress, anxiety and uncertainty brought about by the COVID-19 pandemic, has caused a critical health threat for Syrian communities and families. In response to the needs of the community, the WHO Country Office in the Syrian Arab Republic, in close collaboration with local Al-Tal and Al-Qutayfah nongovernmental organizations in Rural Damascus, launched the “My Hero is You” campaign, which aimed to engage with children, addressing their fears and concerns about COVID-19.

With the aim of empowering affected families to better detect and respond to the mental health needs of children, the campaign involved the development of a child mental health book and the delivery of psychological support sessions to parents, caregivers and health educators. These sessions aided in equipping trusted adults with the capacity to build children’s coping skills to manage stress induced by the pandemic. Following the success of the initiative in Rural Damascus, WHO replicated this initiative in three other governorates in 2021 to reach thousands of parents and children in need of mental health support.

5000
children
and
2000
parents
reached by the “My Hero is You” mental health campaign in Rural Damascus



Volunteer for a charity based in Al-Qutayfah in Rural Damascus, Syrian Arab Republic, during the My Hero is You campaign to help children cope with COVID-19-related stress, June 2021

¹WHO in Syria: mental health [website]. Cairo: WHO Regional Office for the Eastern Mediterranean (<http://www.emro.who.int/syria/priority-areas/mental-health.html>).

MOBILIZING RESOURCES FOR AN EFFECTIVE RESPONSE



US\$
250.3
million

mobilized for
the COVID-19 response
in the Region

In the compound housing Afghan evacuees hosted by Qatar, WHO Director-General, Dr Tedros Adhanom Ghebreyesus (not pictured), and WHO Regional Director for the Eastern Mediterranean, Dr Ahmed Al-Mandhari (right), meet with health workers mobilized for immunization, mental health support, paediatric care, maternity and newborn services, and other essential care, in Doha, Qatar, September 2021



© WHO / Inas Hamam

Utilizing funds effectively for enhanced programme management



In 2021, WHO implemented close to US\$ 298.4 million on COVID-19-related operations (97% at the country level and 3% at the regional level) in the Region. WHO's regional Programme Management team provided a broad range of support to WHO country offices in the Region in identifying solutions to maximize the use of funds at the regional and country office levels and ensure the smooth implementation of the global¹ and regional² COVID-19 SPRPs in alignment with donor agreement requirements.

The team recommended options for the allocation of flexible funds to the Regional Office and country offices

¹COVID-19 strategic preparedness and response plan. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/WHO-WHE-2021.02>).

² COVID-19 strategic preparedness and response plan: reinforcing the collective readiness and response in the WHO Eastern Mediterranean Region, 2021 edition. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/WHOEMCSR383E-eng.pdf?ua=1&ua=1&ua=1>).

in consultation with senior WHO management, and for solving emerging bottlenecks impacting timely programmatic implementation, such as in relation to human resources, and planning and operations. Weekly financial analyses on fund utilization and implementation were conducted. Furthermore, WHO facilitated activities delivered through the COVID-19 Partners Platform¹.

Most of the utilized funds were directed towards COVID-19 vaccine deployment (19%), the

maintenance of essential health services (19%), and case management and clinical operations (17%). The regional Programme Management team provided support to the 22 countries and territories of the Region for the development of national deployment and vaccination plans for COVID-19 vaccines. The team also continuously assisted in the procurement of COVID-19 therapeutics for countries across the Region.



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WHO procured 34.6 tonnes of life-saving health supplies and airlifted them to Kabul, Afghanistan, in January 2022 – these supplies were to treat 150 000 people in need of medical care for three months

¹ Partners Platform for health in emergencies [website]. Geneva: World Health Organization (<https://partnersplatform.who.int/en/>).

Key lessons learned to leverage the COVID-19 response in 2022



Partnership and coordination

- Ensuring regular information sharing with partners is crucial to identify opportunities and any gaps in the regional COVID-19 response.
- Strong commitment from the highest levels of political leadership, recognizing the COVID-19 response as a national priority, is a key success factor in the coordination of a whole-of-government and whole-of-society response.



Communications (external and internal)

- Aligning high-level advocacy goals with communications efforts at Regional Office, country office and health ministry levels, with the collaboration of the highest levels of WHO and national management, is vital for an effective response.
- Training country communications officers plays a central role in advancing the COVID-19 response at country and community levels.



Operations support and logistics

- Facilitating the consolidation, prioritization and scheduling of deliveries through solid demand and distribution planning can enable increased precision of the health emergency response.
- Pre-positioning health supplies in a timely manner is critical to mitigate potential stockouts of essential supplies for the COVID-19 response.



International Health Regulations (IHR 2005) and social measures

- Developing national policies and legislation is essential to guide and enforce the implementation of public health and social measures and enhance compliance to the IHR (2005) at the country level.
- Institutionalized multisectoral coordination is key in the implementation of well-coordinated public health and social measures.



Infection prevention and control (IPC)

- An effective IPC response to COVID-19 requires leadership commitment and true partnership by bringing together different agencies, experts, donors and national authorities to plan and operationalize the IPC programme.
- Protecting the health workforce requires the implementation of sound national surveillance systems for detection, management and optimal treatment of infected health care workers.



Risk communication and community engagement (RCCE)

- Increasing community participation in the COVID-19 response through community engagement and social mobilization campaigns has been key in the majority of countries.
- Accommodating social media in public communications strategies for listening, information-sharing and addressing rumours is crucial given the impact of misinformation, disinformation and rumours on people's behaviours and overall responses.



Laboratory diagnostics

- Leveraging molecular testing for SARS-CoV-2 to diagnose other high-threat pathogens is required in countries with complex emergencies.
- Integrating, digitalizing and aligning testing strategies with surveillance systems, nationally and subnationally, has contributed to the success of the COVID-19 response in many countries.



Essential health systems and services

- The universal health coverage priority benefits package (UHC-PBP) has not been widely accepted and implemented in the Region due to weak health systems and lack of involvement of key partners.
- The COVID-19 response has provided the opportunity to fast-track "building back better" and building more resilient health systems in the Region.



Case management and clinical operations

- Investing in and building critical care capacity in priority countries can save lives.
- Tackling the inequity in access to medical drugs, oxygen and biomedical supplies has contributed to minimizing the burden on health systems.



Resource mobilization

- Countries should continue to highlight the urgent funding needs for the COVID-19 response, while also showcasing the importance of preparedness, health systems strengthening and the continuity of essential health service delivery.



Research and knowledge management

- Ensuring the use of appropriate evidence from research and available data is essential during emergency response for timely decision-making.
- Countries investing in research and innovation in support of the COVID-19 response has resulted in the conduct of large-scale trials and vaccine effectiveness studies in the Region.



COVID-19 vaccine

- Improving vaccine delivery systems, especially for those most at risk such as refugees, migrants and people living in FCV settings, using integrated people-centred approaches, will maximize the impact of vaccination.
- Despite challenges, COVAX has achieved its intended goal of fair and timely vaccine distribution to priority countries.



Health information management and surveillance

- There is a need to invest in solid national health information management and integrated disease surveillance systems that are flexible enough to detect new events to allow for timely decision-making.
- Political willingness to share data is crucial for sustaining the monitoring of diseases and response activities, and to feed into global knowledge on new diseases.



Programme management

- Increasing and sustaining adequate capacity in programme management for emergencies, including dedicated and trained staff, is critical both at regional and country levels.

Priority actions in 2022

With the experience and lessons learned from 2020 and 2021, the WHO Regional Office developed the 2022 edition of the COVID-19 SPRP for the Region, its fourth edition.¹ The 2022 SPRP aims to continue guiding the regional public health response to end the acute phase of the pandemic and transition to

recovery in the Region. It sets the goal and objectives that will guide the response in 2022, and the priority actions that WHO will undertake to sustain, strengthen, adapt and transition the COVID-19 response.

Strategic preparedness and response plan for COVID-19 in the Eastern Mediterranean Region in 2022



Accelerate efforts to end the acute phase of the COVID-19 pandemic with an integrated, sustained and comprehensive response, while building the foundations for better preparedness and health systems recovery and resilience



WHO mission meeting community health care workers in Garowe, Somalia, 29 September 2021

¹COVID-19 strategic preparedness and response plan: sustaining an effective response to end the acute phase of the pandemic and transitioning to recovery in WHO's Eastern Mediterranean Region, 2022 edition. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (<https://apps.who.int/iris/handle/10665/354369>).



REGIONAL STRATEGIC OBJECTIVES

1. Leadership, coordination and political investment



Increase or maintain strong political commitment, leadership, coordination and partnership within and among countries and partners to sustain an effective and integrated whole-of-government and whole-of-society COVID-19 response and minimize the impact of the pandemic.

2. Surveillance and laboratory diagnostics



Expand, enhance and integrate surveillance, testing and genome sequencing capacities to detect emerging SARS-CoV-2 variants early, monitor variant circulation, and generate reliable and comprehensive data analyses for decision-making. Fully integrate SARS-CoV-2 surveillance into existing influenza and other respiratory disease surveillance, such as GISRS+, to better contribute to the regional strategy for integrated disease surveillance.

3. Vaccination



Accelerate COVID-19 vaccination to reach coverage targets set to reduce the impact of the pandemic in terms of severe disease, hospitalization, death and the emergence of new variants, by prioritizing the most vulnerable, especially in countries with low coverage. Leverage efforts and investments in COVID-19 vaccination to strengthen routine immunization programmes and immunization systems overall.

4. Public health and social measures



Implement feasible and effective public health and social measures informed by regular situational assessments to mitigate transmission of SARS-CoV-2, prevent clusters among vulnerable populations and reduce the risk of new SARS-CoV-2 VOCs emerging.

5. Risk communication and community engagement



Renew efforts to strengthen risk communication and community engagement and empowerment, and address misinformation, through consistent social listening and community feedback.

6. Clinical care and the protection of health workers



Reduce severe disease and mortality by ensuring quality COVID-19 care (especially for at-risk groups), improving critical care and intensive care unit capacities, strengthening, protecting and supporting the health workforce, ensuring the availability of medical oxygen and other essential supplies, and continuing research on COVID-19 therapeutics.

7. Health systems and essential services



Strengthen health systems resilience, including through the Health Systems and Response Connector (HSRC) to improve access to COVID-19 tools, sustain an effective COVID-19 response, enhance country readiness, strengthen workforce capacities and primary health care, and build stronger and resilient systems, while ensuring the continuity of all essential health services.

8. Access to essential tools



Accelerate and promote equitable access to and distribution of new COVID-19 diagnostics, therapeutics and vaccines, and explore opportunities to expand the regional production of these tools.

