ACHAP 10TH BIENNIAL CONFERENCE

REPORT

11-15TH JULY 2022,
SAINTE FAMILLE HOTEL,
KIGALI, RWANDA.

THEME: CHRISTIAN HEALTH ASSOCIATIONS IN PANDEMICS:THE CASE OF COVID-19

AFRICA CHA PLATFORM

EXECUTIVE SUMMARY

The 10th biennial conference was held in Sainte Famille hotel, Kigali, Rwanda, from 11th-15th July 2022 under the theme ; Christian health associations in pandemics: The case of Covid-19. The conference was hosted by ACHAP's in-country partner BUFMAR.

The thematic areas covered by the conference were pandemic preparedness, pandemic response and recovery, communication and advocacy, and collaboration and partnership.
The methodology employed during the conference was plenary discussions and breakout sessions which included questions and answers from the participants and the panelists.

The main highlights of the conference were: 1. the official opening prayer and reflection by archbishop of Rwanda, Antoine Cardinal Kambanda, 2. keynote addresses by; the honorable Minister of Health of Rwanda, a representative of Africa CDC, and the BUFMAR Director General, 3. the Call to Action session chaired by the ACHAP board chair.

The delegation at the ACHAP 10th Biennial Conference.

LIST OF ABBREVIATIONS

ABBREVIATIONS.	IN FULL
ACHAP	Africa Christian Health Associations Platform
BUFMAR	Bureau des Formations Médicales Agrées du Rwanda
CHA	Christian Health Association
CHVs	Community Health Volunteers
FBOs	Faith Based Organizations
IPC	Infection Prevention Control
IEC	Information Education Communication
RH	Reproductive Health
HRH	Human Resources for health
ERP	Emergency Response Participation
ICU	Intensive Care Unit
FP	Family planning
MOH	Ministry of health

ARRIVAL DAY: MONDAY 11TH JULY 2022.

Registration and hotel check-in was done by the participants assisted by the ACHAP conference planning committee.
Preparatory meetings for moderators, facilitators and rapporteurs were held in the course of the day, and thereafter, an interdenominational service in remembrance of health workers who died of was conducted at the St. Paul Chapel.

DAY ONE: TUESDAY,12TH JULY 2022.

The conference started with a devotion and prayer from Rebecca Waugh of IMA World health.

Rebecca Waugh delivering the opening sermon.

Rebecca read the Bible from the book of Mathew, with a message to reflect on three words;
Grateful- that despite the challenges of COVID and the losses the pandemic presented, we have been able to gather as a family of faith at the conference,
Joyful- that out joy is independent of external circumstances, and is part of our inheritance and birthright as children of God,
Generous- that in God's economy, generosity expands us. We are alive because God expanded his generosity. Our coming together will be a time of learning, praying and personal refreshment; by opening up to others, we prompt people to open up to God.

BREAKAWAY SESSIONS.

This activity was facilitated by Dr. James Mukabi of ACHAP.

WORKSHOP ONE: HEALTH SERVICE DELIVERY IN PANDEMICS.

SPONSORED BY USAID'S ACHAP AFYA PROJECT.

MODERATOR

DR. JOSEPHINE BALATI- CSSC

PRESENTERS

DAVID BALIKITENDA- UPMB
ROSE ODENY- CHAK
WINNIE NYABENGE- ACHAP AFYA
JANET KOMAGUM- UCMB
ALISON AMONGIN- UCMB

Dr. Josephine Balati leading the workshop.

The COVID-19 pandemic has caused significant disruption in the continuity of health services. The biggest disruptions were seen in health routine immunization, facility-based services for non-communicable diseases, antenatal care, family planning and contraception, as well as HIV/TB care and treatment services.
In Nigeria, OPD attendance dropped by 13%, fully immunized-one year dropped by 16%,and ANC attendance by 15% between 2019 and 2020.

The participants were then divided into three groups.
The session was guided by the following questions:

1. What health systems strengthening measures did CHAs/ other partners put in place to ensure that delivery of key health services was not hampered by the COVID 19 pandemic?
2. What worked well in ensuring continuity in delivery of health services during the pandemic? Please describe any existing collaborations/ partnerships with government/ other partners that facilitated this.
3. What innovative measures did CHAs/ other partners use to ensure continuity of health services delivery?
4. What key health systems challenges did CHAs/ other partners experience in delivering health services during the pandemic and how did they mitigate them?
5. Were there any unique experiences from previous pandemics (such as ebola) that helped CHAs/ other partners to cope well with the COVID 19 pandemic?
6. What key lessons or best practices can be shared on providing health services during pandemics?

GROUP ONE PRESENTATION.

1)What health systems strengthening measures did CHAs/ other partners put in place to ensure that delivery of key health services was not hampered by the COVID 19 pandemic?

•Collaboration between internal and external stakeholders, including government, religious leaders, and community members to support service delivery.
•The supply chain system allowed medicines to reach facilities through last mile delivery and bimonthly ordering cycles by health facilities.
•The VHTs/ CHWs supported movement of drugs for chronic patients.
•Capacity enhancement for religious leaders, health workers and the CHWs
•Development and electronic transmission of IEC materials.
•Virtual trainings and support supervision was conducted by the secretariat team to the field teams using smartphone applications.
•Tele-help was introduced in some countries.

2)What worked well in ensuring continuity in delivery of health services during the pandemic? Please describe any existing collaborations/ partnerships with government/ other partners that facilitated this.

•Leadership from facilities; religious leaders were part of the district and regional taskforces to ensure continuity of service delivery.
•Some countries created national task forces to complement government efforts towards decision making.
•Virtual requisition of health and medical supplies.
•Some organisations sought movement permits for technical teams to access field locations during the COVID-related lockdowns (UPMB).
• MOUs with FBO health facilities to support government COVID-19 services.
•Some facilities received PPEs, WASH equipment, and training.

3)What innovative measures did CHAs/ other partners use to ensure continuity of health services delivery?

•The use of technology such as teleconferencing.
•Use of CHWs to extend services to household level.
•Increased training and support CHWs to enable continuity of services.

4)What key health systems challenges did CHAs/ other partners experience in delivering health services during the pandemic and how did they mitigate them?

•Poor internet connectivity.
•Inadequate number of health workers; the shift system affected working hours, some workers fell ill, and some were not willing to work during the height of the pandemic due to fear and uncertainty.
•Inadequate medical supplies.
•Reduction in number of patient contact or flow at facility.
•Change in behavior especially adhering to government-mandated SOPs.
•Infection control was a relatively new practice to the health workers.
•Some of the donated equipment was not in working condition, while others could not be used at lower level facilities due to insufficient infrastructure (e.g. electricity).

5)Were there any unique experiences from previous pandemics (such as Ebola) that helped CHAs/ other partners to cope well with the COVID 19 pandemic?

•The facilities that had experience with Ebola were better prepared in terms of WASH compared to those that had not had previous pandemic experience.
•The facilities that had lost staff to Ebola took COVID 19 more seriously.

6)What key lessons or best practices can be shared on providing health services during pandemics?
•A reactive other than proactive approach to management of COVID 19 eg use of PPEs, social distancing, WASH practices.
•COVID 19 was politically addressed, which impacted public behaviour change.
•Involvement of community structures and stakeholders such as religious leaders and VHTs in the management of COVID 19.
•Involvement of community structures in IPC/WASH activations and health promotions.

GROUP TWO PRESENTATION.

1) What health systems strengthening measures did CHAs/ other partners put in place to ensure that delivery of key health services was not hampered by the COVID 19 pandemic?
•Training of community and religious leaders to make sure a wide reach (Malawi).
•Capacity building for CHWs and improvement of IPC(infection prevention control) measures and infrastructure to equip hospitals to run smoothly even beyond COVID .
•VHTs supported advocacy and community delivery of medical supplies and PPEs.
•Following WHO guidelines and providing hospital with budgets to buy stock up.
•Encouraging COVID 19 vaccine uptake.
•Availability of resources (advocates) to provide IPC guidelines to the communities.

2)What worked well in ensuring continuity in delivery of health services during the pandemic? Please describe any existing collaborations/ partnerships with government/ other partners that facilitated this.
•National taskforces were formed to share and organise resources.
•Partnerships between government and sponsors to reduce financial burdens on healthcare facilities.
•Donations to equip ICUs and tackle supply chain interruptions.
•Exporting learnings from previous pandemic experiences eg Ebola.
•Investment in workforce development and capacity building.

3)What innovative measures did CHAs/ other partners use to ensure continuity of health services delivery?
•Creation of isolation centers, and restriction of movement in some parts of the hospitals and healthcare facilities to control infections.
•Leveraging social media, radio talks, and TV shows to reach wider populations with COVID related messages.
•Home visits by CHVs.
•Traffic control was done to ensure smooth movement.
•Key messaging webinars in different languages.

4)What key health systems challenges did CHAs/ other partners experience in delivering health services during the pandemic and how did they mitigate them?
•Shortage of funding, infrastructure and resources.
•Hesitancy and misconceptions towards PPEs and barrier measures.
•Lack of oxygen in healthcare facilities.
•Lack cooperation with government disorganisation (Burundi, Tanzania).
•Misleading information on social media.

5) Were there any unique experiences from previous pandemics (such as Ebola) that helped CHAs/ other partners to cope well with the COVID 19 pandemic?
•Lesson from Ebola and HIV helped facilities to prepare in terms of IPC and community engagement towards COVID-19 more seriously.
•Involvement of community leadership in mobilisation and dialogue.

•Fighting stigma by involving credible sources of information such as religious leaders.

6)What key lessons or best practices can be shared on providing health services during pandemics?
•Reactive other than proactive approach so as to be able to manage any future pandemics.
•Putting more effort toward effective collaboration between governments and communities.
•Putting the stories and experiences of African countries at the forefront, so Africa is not left behind in global collaboration.
•Prioritising mental health and addressing problems as they arise.

GROUP THREE PRESENTATION.

1)What health systems strengthening measures did CHAs/ other partners put in place to ensure that delivery of key health services was not hampered by the COVID 19 pandemic?

- Strong coordination at country level.
- Community engagement.
- Early preparation for future emergencies.
- Collaboration with international bodies like CDC.
- Establishments of COVID care centers.

2)What worked well in ensuring continuity in delivery of health services during the pandemic? Please describe any existing collaborations/ partnerships with government/ other partners that facilitated this.

- Engagement of religious leaders.
- Private sector engagement.
- Capacity building and engagement of community health workers.
- Collaborations with the government.

3)What innovative measures did CHAs/ other partners use to ensure continuity of health services delivery?
•Online training of CHWs.

- Adaptation of local manufacturing of healthcare products and PPEs.
- Engagement of community health workers.
- Engagement of religious health facilities.

4)What key health systems challenges did CHAs/ other partners experience in delivering health services during the pandemic and how did they mitigate them?

- Very little understanding of COVID due to insufficient messaging and circulating misinformation.
- Limited financial resources.
- Mental health issues arising from the effects of the pandemic (Loss of livelihood, illness, separation, death, etc).
- Lack of essential health commodities.
- Other health services such as reproductive health were ignored.

5)Were there any unique experiences from previous pandemics (such as ebola) that helped CHAs/ other partners to cope well with the COVID 19 pandemic?

- Learnings from Ebola were employed during the COVID pandemic such as pre-planning for pandemics.

6)What key lessons or best practices can be shared on providing health services during pandemics?

- Revision of health policies, acts and laws.
- Multi sectoral approach.
- Develop of preparedness plans.

- Development of basic structures at each level of service delivery.
- Learning from countries with more advanced healthcare systems.
- Defining a clear mandate for every health institution.
- Community engagement.
- Compiling of lessons learnt into reference documents.
- Need to standardise and simplify messaging.
- Involvement of religious leaders in the development of information communication materials.

WORKSHOP TWO: FAITH IN PANDEMICS.

This workshop explored faith leaders' experiences related to overcoming COVID-19 misinformation/disinformation, vaccine confidence, vaccine equity, lessons learnt in the pandemic, and future pandemic preparedness.

MODERATOR
DENNIS CHERIAN- IMA WORLD HEALTH.

PRESENTERS
DOUG FOUNTAIN- IMA WORLD HEALTH
DR. CHIDZWERE NZOU- ZACH
DR. MWAI MAKOKA- WCC
JOSÉ QUINTAS- CARITAS ANGOLA
REV. JANE NG'ANG'A- EPN

Workshop two in progress

SUMMARY OF PRESENTATIONS .

REV. JANE NG'ANG'A.

EPN partnered with manufacturing plant suppliers, churches and individuals to disseminate COVID vaccines, provided training to local faith leaders and health workers to prepare for vaccination, engaged faith leaders in COVID vaccine advocacy and training, and organised a survey to gauge the knowledge of faith leaders on the pandemic.

Survey Case Study; Burundi- The focus on Burundi was to highlight the challenges and address misconceptions about the COVID-19 vaccine, necessitated by low vaccine uptake in the country. The outcomes were as follows; 155 responders believed the vaccine didn't work and chose not to get vaccinated; 35 believed in it and were open to vaccination; 117 responders cited inaccessibility in districts since the vaccines were only available in cities.

A Call to Action was drafted from a series of vaccine advocacy webinars- faith leaders committed to encourage knowledge about COVID-19 status, provide care to orphans and vulnerable people, advocate for vaccine uptake on national and regional levels, spearhead deliberations on using lessons from Ebola for future pandemic preparedness, display the call to action in their places of worship, and continuous training on advocacy.

DOUG FOUNTAIN.

FBOs are strategically important as they take up a substantial share of health facilities, and create supply through multiple community based programmes. CCIH, under the USAID Momentum programme, engaged local faith actors (LFAs) in COVID-19 immunisation in 4 countries; Ghana, Sierra leone, Indonesia, and Uganda.

Key findings from this initiative were that: public vaccination by top religious representatives has a positive effect in highly religious settings, social media disinformation–at times from LFAs is both a threat and an opportunity for clear messaging, LFAs are insufficiently engaged and supported, which poses a gap as vaccine supply increases.

The programme outlined 4 themes for engaging LFAs : Strengthen support through theological and scientific analysis and sensitive dialogue, Strengthen collaboration among LFAs and state and civil society actors, Leverage faith-based infrastructure to increase acceptance, uptake, and delivery, and Provide technical support and tools to LFAs.

The importance of translating information for non science audiences and into local languages to enable people to use it was also noted during this initiative.

JOSÉ QUINTAS.

The pandemic broke out at a time when Angola was experiencing hunger and drought. Initiatives to combat the two disasters were combined; Caritas Angola focused on raising national awareness and training faith leaders and private sector officials on advocacy. They set up provincial committees under the FLAME initiative, which assisted in equitable distribution of foodstuff and commodities, mosquito nets, and face masks, and Part of the training was also vocational; community members were trained on tailoring of face masks to reduce costs and generate some income during the tough economic times presented by the pandemic. Religious leaders were involved in vaccine advocacy to inspire confidence and subsequent uptake in their communities.

DR. CHIDZWERE NZOU.

Community posts were formed following the Circle of Hope model in Zambia, and strategically placed in highly populated areas such as marketplaces. To date, there are 7 community posts; the first one was introduced in September 2020 and the latest one in June 2022.

The benefits of this initiative were; Reducing congestion at public health clinics, community posts brought services closer to people, and the impact of lockdowns was mitigated. This also led to demand creation among faith leaders as heads of Christian denominations were engaged at the inception of the community initiative. They participated in sensitisation in local churches and selection of faith community champions.

QUESTION AND ANSWER SESSION

QUESTIONS.

1) How did faith leaders respond to COVID-19 vaccination programmes in various countries, and how could it have been done faster?
2) What was done to prepare against future pandemics?
3) What strategies are in place to reach out to faith leaders spreading contradicting messages about the vaccine?
4) Is there a clear difference between working together and being used?

ANSWERS.

•In some countries religious leaders have stronger influence than the government. Church leaders should remain at the forefront to enforce regulations and encourage faster vaccine uptake.
•There is still some uncertainty around sustainability in terms of funding after termination of vaccination programmes.
•Use of media to encourage the youth, communicate guidelines, and debunk misinformation, and collaborating with governments.
•Setting clear lines of communication to persuade and sensitise people.
•Starting early and staying proactive to prepare for the future, mobilise global networks and help each other by sharing information.
•Drawing strategic plans for IPC.
•Relationships between governments and churches should be balanced, with clear stipulations of their interactions to ensure that each stakeholder remains independent while working together.

WORKSHOP THREE: COMMUNITY INVOLVEMENT: ADAPTATION AND RESILIENCE IN PANDEMICS.

MODERATOR
FLORENCE BULL

PRESENTERS
DR. ALEX MUHEREZA- ACHAP
DR. GODFREY KWAY
DR. DAN MUGISHA
EVELYN GATHURU- CHAK

Workshop three presenters

DR. ALEX MUHEREZA ON KANGAROO MOTHER CARE DURING THE COVID-19 PANDEMIC.

Community engagement:
1)VHT support was employed to track preterm babies and keep track of their condition.
2) Contribution by community gate keepers to identify preterm babies and provide health assistance to alleviate their risk of death.
Challenges to care of preterm babies during the pandemic: Premature discharge from health facilities due to limited space, limited access to referral services due to COVID-related restrictions of movement, high risk of infant mortality due to hypothermia, undernutrition, infections, and limited technology for comprehensive care.

DR. GODFREY KWAY ON GOVERNMENT AND COMMUNITY PARTNERSHIPS FOR COVID VACCINES.

Tanzania has had high risk of infection due to cultural events, open ports and tourism, with 35,768 COVID 19 infections in the past week.
An information pamphlet was designed in order to guide faith leaders and their communities on the coronavirus and the vaccine. 'Mother mentors', who had been earlier engaged to sensitize communities on HIV treatments, were used to steer campaigns on uptake of the COVID-19 vaccine. As a result, 14% of the eligible population on the mainland and 20% of the eligible population in Zanzibar have received the vaccine. Further assistance to this cause will be requested from the government.

Government efforts on Vaccination

- Printing and distribution of 13,300 SBCC toolkits.
- Demand creation initiative under global fund support in November 2021.

- **Best approaches**
- House to house meetings in Arusha.
- Outreach services in Pwani.
- Each patient sensitised and vaccinated in Mwanza.

Challenges

- Accessibility, especially in rural areas.
- Misconceptions about COVID-19.
- Short shelf life of COVID-19 vaccines.
- Preference of the vaccine brand offering a single shot.

Lessons learned

•Sound leadership is very important during COVID-19.
•Coordination and supervision in communities should be prioritised.
•Use of technology to orient facilitators saves time and overall cost.
•Sharing of knowledge and resources is highly important.

Conclusion

Even with the wealth of information gathered from around the world, there are still people who are concerned about the vaccine and have refused to get vaccinated. Those concerns will have to be addressed to inspire confidence in the vaccine. Also, the use of existing structures and sharing of resources has proven the best bet against COVID-19 and any future pandemics.

EVELYN GATHURU ON FAMILY PLANNING DURING THE COVID-19 PANDEMIC.

An increase in adolescent pregnancies was observed during COVID-19 lockdowns. People were not willing to go to healthcare facilities as they feared getting COVID-19 and those infected were stigmatized. Non-essential services were halted, placing Family Planning was at the bottom of the priority list.
To address the situation:

- Secure family planning had to be listed as an essential service.
- Working with community-own resource persons was prioritized.
- Third-party trainings were conducted under COVID guidelines.
- COVID co-messaging was integrated in training and service delivery.
- PPEs were distributed.
- Faith leaders were trained to disseminate proper information.
- Outreaches were conducted to provide the services to those who could not reach the service providers.
- In total 60,816 clients got access to family planning services through 590 integrated outreaches.

Lessons learnt

- The simplest solution is the most effective.
- It is important to fact-check and provide the right information.
- Healthcare workers should work with county health departments and community gatekeepers to bring services closer to the people.
- Family planning should always be listed as an essential service.
- Integration of COVID-19 messaging in service delivery is important to dispel fears.
- During a pandemic, activities should be adapted to the situation rather than halted.

DR. DAN MUGISHA ON TB AND COVID.

Screening for TB was integrated into COVID screenings. Great improvement in TB case findings was attributed to:

- Improved access to TB screening and care services as a result of making these services accessible to the community.
- Greater community mobilization towards TB awareness and treatment.

Lessons learnt

- Making services readily available to the community, engaging community and religious leaders, and training health workers really important are important towards the cause of TB.

What could be done differently

- Strengthening health service delivery in communities.
- Proper training and information to healthcare workers.
- Ensuring sustainability of healthcare projects, training, and infrastructure.
- Lessons on how to address FP amongst religious communities using scriptural arguments, since medical and scientific arguments are seen to challenge faith.

QUESTION & ANSWER SESSION.

QUESTIONS

1) In what ways were communities affected by COVID-19 and how did communities adapt to minimize the impact of corona virus?

- Communities were affected in many different ways such as; loss of employment, increase of gender-based violence and teenage pregnancies as a result of the lockdowns, hunger due to food shortages, and increased poverty.
- Through the preachings of faith leaders, the communities would receive the necessary messages and information about COVID-19 and vaccine uptake.
- In Kenya, adaptation was driven by trust in the government and the measures put in place.
- In Rwanda, food provision was done for financially unstable families. Moreover, counseling was provided by community agencies to inspire hope amongst people.
- In Cameroon, daily updates were given to the public to keep them informed. Community agents kept delivering messages to help people adapt to new ways of living.
- In Malawi, amidst the presidential campaign the opposing parties had a different story to tell about COVID. One party was in denial about COVID-19, declaring that it doesn't exist while to the other side, COVID-19 was indeed very real. The former party won the election; however as COVID-19 started claiming lives, they changed their views about the pandemic, which confused the public. People from the villages in Malawi thought COVID-19 infected urban people, until people closer to them started dying of COVID.

- In CAR, churches were closed. Social distancing and wearing of masks were among the guidelines being used by the government against COVID. Church offerings were collected from homes and fed back into the church. Finally, a prayer by the president of the republic restored hope and tranquility in the population.

2)Share experiences of how information and disinformation affected your communities during COVID-19.

- Leadership played a critical role in spreading information to the public about vaccine uptake. When people in top leadership positions set an example by getting vaccinated, the public became more inclined to accepting the vaccine.
- There was a lot of misinformation about the vaccine and its side effects (e.g., religious belief that it was the mark of the beast, it supposedly destroys the natural immunity of African people, etc.). Confusion about which brand of vaccine was better also led to delay of uptake. Faith leaders were interviewed publicly to dispel the false rumors. Some, however, still believe the rumors and are still hesitant about getting vaccinated.

3)What are some of the factors that facilitated quicker recovery from the effect of the pandemic?

- Use of local and natural remedies such as ginger, turmeric, garlic and herbal tea to speed recovery from COVID infection and boost the immune system for those who were not infected.
- Easing of COVID barrier measures such as lockdowns as the cases reduced.
- Continuous encouragement in order to create hope.

4)Based on the lessons learnt, in what ways can communities build more resilience to better handle future health crises?

- Have an emergency plan/protocol in place because a pandemic will almost always be unprecedented.
- In future emergencies, healthcare workers have to be mindful of the way the engage with communities. It would be better to start with informing local communities and build upwards.
- Documentation of lessons learnt for reference in the event of another pandemic.
- A pandemic should not take the focus away from all the other issues happening in the community/country. Sooner or later those issues will be exacerbated by the pandemic.
- Advising and counseling families about making their homes a safe place for young people and helping them build healthy relationships to curb gender-based violence.

FIELD VISITS

The participants were divided into three groups to visit the following health facilities;
Group One: **Nyarugenge District Hospital**- led by Dennis Kinyoki.
Group Two: **Cor Unum Health Care Centre**- led by Dr. Alex Muhereza.
Group Three: **Nyamata Hospital**- led by Dr. James Mukabi.

Group 1 at Nyarugenge District Hospital

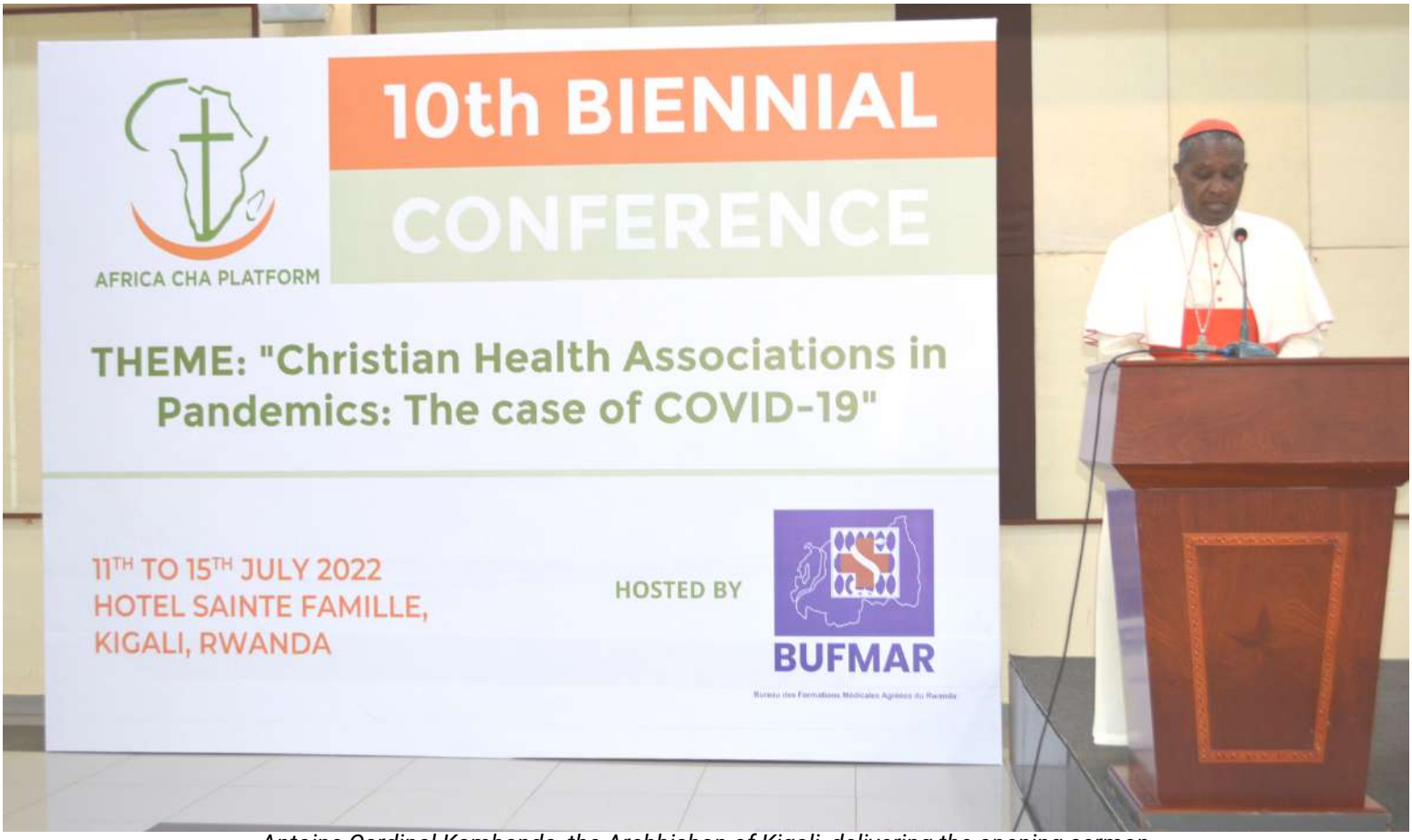
Nyamata District Hospital

DAY TWO: WEDNESDAY, 13TH JULY 2022.

The session started with remarks from the ACHAP coordinator, Nkatha Njeru, who gave an overview of the conference and welcomed the guests and participants.

ARCHBISHOP OF KIGALI, ANTOINE CARDINAL KAMBANDA.

The opening prayer and morning reflection was conducted by His Eminence, the Archbishop of Kigali, Antoine Cardinal Kambanda.
The theme of the sermon from the book of Peter was healing through Jesus Christ:
Diseases bind us; they prevent us from serving and accessing the Lord and others. Physical diseases always have an underlying spiritual condition. We need to welcome Jesus in our hearts and lives so spiritual and physical healing can begin.
May the lord enlighten us to find His will and strengthen us to do His will.



Antoine Cardinal Kambanda, the Archbishop of Kigali, delivering the opening sermon

PETER YEBOAH, ACHAP BOARD CHAIR.

The board chair gave an overview of ACHAP being a continental Christian Health Organization and outlined its core values;

- Christ-centeredness
- Transparency and accountability
- Inclusivity and diversity
- Innovation
- Professionalism
- Partnerships

explained the rationale behind the theme of the conference;

- Awareness of the role of FBOs and how they responded to the pandemic,
- Pandemic preparedness requiring global partnership,
- Recognition of the distinct roles of CHAs in pandemic response and management

the objectives of the conference;

- To share ongoing documented experiences, challenges and lessons learnt,
- To highlight better accountability and transparent mechanisms in use of resources,
- For FBOs to learn systems and coordinated methods of resource mobilisation towards strengthening community resilience,
- To influence partnerships, and
- Advocate for co-creation amongst CHAs.

And the main expectations;

- Networking and strengthening of FBO partnerships,
- Enhancing social relations beyond health,
- Building spiritual solidarity guided by generosity ,gratitude and joy,
- Uniting ACHAP's partners.

Highlights.

In-person meetings like this one offer an opportunity to strengthen FBOs and their response to pandemics; that they leverage their credibility, networks, infrastructure, and dedicated health professionals to mobilise communities to respond to pandemics.
ACHAP members were all involved in COVID-related activities, and have played an important role in building vaccine acceptance in various areas. Alongside COVID, there is need to ensure continuity of essential health services.
A five-year strategic plan will be launched at this conference to guide ACHAP's activities towards attaining the SDGs.

KEYNOTE ADDRESS: AG DIRECTOR AFRICA CDC, DR. AHMED OGWELL OUMA.

The speech was delivered by a representative of Africa CDC, Dr. Patrick Chanda, who gave a brief history of CDC, response to pandemics in Africa, and the role of faith-based health systems as perceived by Africa CDC.

Keynote speaker, Dr. Patrick Chanda.

Highlights.

Africa CDC has worked with partners to develop information and strategies to respond to various pandemics over the years; Ebola, Polio, Cholera, Yellow fever and most recently COVID-19.
Through the Saving Lives and Livelihoods Program, Africa CDC aims to build capacity for pandemic response and accelerate COVID-19 vaccination programs in African Union member states.

They have leveraged faith actors to influence communities, resulting in an increase in uptake of vaccines. Each stakeholder brings their unique abilities to control public health threats.

Africa CDC believes that investment in leadership programs, decentralizing of institutions, and capacity building and partnership of implementing partners are key to strengthening governance and building resilient communities, and that strengthening the health center on the African continent is essential towards achieving the 70% population vaccination target.
There is need to continue to push for change as faith actors; We need to work together and speak to each other to mobilise our communities when pandemics hit.

OFFICIAL OPENING ADDRESS BY DR. DANIEL NGAMIJE, MINISTER OF HEALTH, RWANDA.

The Rwandese Minister of Health, Dr. Ngamije Daniel, began by thanking ACHAP for choosing Kigali and BUFMAR for accepting to host the conference.

Highlights.

Strategies used in Rwanda when COVID-19 appeared.

- Investment in innovation using technologies such as drones, GPS tracking and electronic bracelets for contact tracing during the lockdowns,
- Local manufacturing of face masks and sanitizer,
- Shift from systematic isolation centers to home-based care to future-proof the system,
- Recruitment of additional staff in healthcare facilities,
- New mobile treatment centres,
- Increasing intensive care units and vaccine storage capacity,
- Acquisition of an oxygen plant,
- Engagement in vaccine production through partners,
- Community engagement,
- Sound political leadership.

Dr. Daniel Ngamije delivering the opening address.

Achievements.

- 70% of the population in Rwanda is fully vaccinated.
- Joint experiences were documented for future reference.

HOST ADDRESS BY MONIQUE GAHONGAYIRE, DIRECTOR GENERAL, BUFMAR.

Monique began by thanking the Archbishop and the Minister of Health for supporting BUFMAR in Rwanda and attending the conference, and welcoming the conference participants.

Highlights.

BUFMAR has 154 health facilities, including 17 hospitals and 137 health centers working throughout Rwanda with a mission to contribute to the well-being of the Rwandan population by providing quality health services. Its vision is to be a strategic representative of member churches in managing government partnerships in the field of health.

Monique Gahongayire, DG BUFMAR.

The BUFMAR team is grateful to the ACHAP secretariat for choosing Rwanda to host the conference, and assures a stronger partnership and continued collaboration with ACHAP.

CLOSING REMARKS BY PETER YEBOAH.

The ACHAP board chair thanked all participants for attending the conference and listening attentively to the remarks from the honorable guests, reiterated the takeaway messages from each guest speaker, and the Archbishop's reflections on Christ centeredness.

PLENARY SESSION ONE: FBO HEALTH SYSTEM AND FAITH ACTORS IN EMERGENCIES; BUILDING RESILIENCE.

MODERATOR

DR. SAMUEL MWENDA- CHAK

PANELISTS

DR.PATRICK CHANDA- AFRICA CDC
PETER YEBOAH- CHAG
DR. EDWARD- MOH RWANDA
VUYELWA CHITIMBIRE- ZACH

Faith-based health service providers are key players in providing health care services during pandemic at both local, national and regional level. They have been at the forefront of pandemic response in Africa and have applied lessons learnt to COVID-19 response efforts. They have uniquely engaged local communities and governments, and leveraged their reach and trust at country level to provide preventative and curative services to mitigate the impact of the pandemic.
The panel will explore the role FBO health system have played in the recent health pandemics in Africa as well as existing opportunities to enhance their roles.

HOW RWANDA ENGAGED FBOS IN COVID-19, DR. EDWARD.

The preparations to handle Ebola and other pandemics could not leave out FBOs. Their response teams were trained and their facilities made ready for use during outbreaks.
During COVID-19 faith-based facilities such as churches were used to reach the community with information about transitions, prevention measures, as well as vaccines. They were also involved in sanitization of public facilities.
FBOs were the first to visit and help the community during COVID-19 lockdowns by providing food, counseling, and social support. They were also essential in dispelling misconceptions about COVID through church radio stations.
FBO workers were trained in testing and monitoring of COVID-19 cases. The church-based organization health facilities made good use of community agents to reach out to people by conducting daily home visits.

LESSONS LEARNT FROM PREVIOUS PANDEMICS, DR. PATRICK CHANDA.

- Faith based service providers were key players in providing healthcare services during pandemics such as HIV, Ebola, Cholera, and most recently, COVID-19.
- The key lessons included community engagement in response to pandemics, employing a multi sectoral approach, leveraging partnerships with governments and other key actors, and identifying and building the capacity of local organizations.
- FBO's were at the forefront of vaccine advocacy, and led by example, which was encouraging to communities.

There remains a need for continuous streaming of information, and more training institutions and health organizations.

WHAT WORKED WELL IN PARTNERSHIP BETWEEN FBOS,SERVICE PROVIDERS AND GOVERNMENT, PETER YEBOAH.

FBOs gained recognition and respect due to their timely response and contribution to health organizations during the pandemic.
Most African countries did not receive aid from western countries, which inspired self-reliance and subsequent domestic resource mobilization.
FBO partnership with government was also strengthened; Leadership for COVID-19 response at government and local levels complimented each other.
FBOs need join the government in lobbying and advocacy by Signing MOUs with their respective ministries of health, use data as the basis of allocating commodities for COVID-19, and continuously demonstrate their relevance and ability to offer solutions and influence agenda setting.

CHALLENGES FACED BY FBOs IN COVID RESPONSE AND MITIGATION MEASURES TO ADDRESS THE CHALLENGES, VUYELWA CHITIMBIRE.

Pertinent challenges presented by COVID were: Difficulties in building resilience as most countries were caught unaware and unprepared, economic difficulties, insufficient information about COVID, lack of resources, equipment, and technical know-how to address the pandemic, supply chain interruptions that affected supply of medication, advocacy towards the COVID-19 vaccine, and low leadership competencies.
To mitigate these challenges, COVID-19 messaging was streamlined by consolidation of information, FBOs leveraged their partnerships and demanded inclusion of faith leaders, and a review of policies, laws and acts was sparked.

DR. SAMUEL MWENDA.

The community is the measuring instrument of faith actors' performance.
We have to strengthen ACHAP on a national, regional and sub regional level by reinforcing the relationship and involvement with governments, thus enabling ACHAP to help communities all over the continent during times of health crisis.
Organizations have collected so much data and information from the pandemic that should be compiled to produce a solid document that can be used by FBOs and governments to mobilize structures, and create protocols and guidelines to be used in the event of another pandemic.

CRITICAL LESSONS LEARNT AND BEST PRACTICES-ALL PANELISTS.

- Involvement of key stakeholders and formation of new partnerships is key in pandemic response.
- ACHAP need to leverage available systems, infrastructure and networks in member countries.
- Ensure documentation of learnings from COVID and Ebola for future reference.
- Continuous use of data for decision-making with contribution from FBOs.
- Good leadership is essential.
- Continuous affirmation of the role of FBOs.

PLENARY SESSION TWO: FBOs PARTNERSHIP TO ENHANCE EFFECTVE RESPONSE AT COUNTRY, REGIONAL AND GLOBAL LEVEL.

MODERATOR
DR. MWAI MAKOKA- WCC

PANELISTS

DENNIS CHERIAN- IMA
DOUG FOUNTAIN- CCIH
CARINA DINKEL- DIFÄM
BETH GIKONYO- CHAK

Objectives of the session:
1) Share experiences from partners supporting FBOs and ACHAP.
2) Document collaborations of partners and government along the timelines of COVID-19.
3) Highlight key challenges faced.
4) Document best practices and lessons learnt.

CARINA DINKEL.

In some countries, governments rely on the church and FBOs for provision of services and procurement of commodities as evidenced by the fact that Christian health facilities remained open while government operations closed during the COVID pandemic. This highlights the important role FBOs play in health programming.

BETH GIKONYO

pandemic response programme was focused on the impact of COVID to the community; the goal was not to leave any patient behind. The programme was implemented using a population health model, drawing lessons from NCD programming in Ghana and Chad. FBOs played a key role alongside the government in ensuring access to services.
Religious leaders are trusted by their communities, thus FBOs remain critical partners in making a difference in communities .
FBO's helped ease restrictions on movement by drafting letters to the government to allow people to travel for programme activities, and made significant donations COVID19 to help their communities.

DOUG FOUNTAIN

CCIH was focused on local partnerships; in Ghana, CCIH worked on material Christian health asset mapping, leveraging partnerships with ACHAP, CHAG, The Dalton Foundation, WCC, and the CCIH (secretariat). There were 8331 health assets with 1276 hospitals, 6497 health centers, 287 community health programs, 341 health training institutions, and 39 drug supply organizations.
A challenge made apparent by this effort was the ability to guide programmes effectively, given the scope of work and COVID- necessitated restrictions.

QUESTIONS AND ANSWERS.

QUESTIONS.

1. What did you do/ are you doing and why?
2. What were the main outcomes, experiences, and lessons learnt?
3. Provide strategic recommendations for handling pandemics or wide scale medical emergencies vis-à-vis Christian health actors in Africa. Please provide practical suggestions in implementing the recommendations.

ANSWERS

DENNIS CHERIAN

- FBOs have a lot to offer, and should streamline communication with each other.
- Engage more faith actors in case of pandemics.
- More focus training health workers.
- Have a strategy that articulates issues for targeted programming.

CARINA DINKEL

- FBOs have credibility at national levels.
- Faith actors should put more efforts and passion in community.
- More support should be channeled to organisations that want to get involved in health.
- FBOs should use their platforms to join forces with their governments.
- ACHAP to continue supporting FBOs that have difficulties engaging with governments.

DOUG FOUNTAIN

- As faith actors in health, we are part of the church and all share one word; Christian.
- Scope, Scale, Impact; we often tell the story of impact, forgetting scale and scope.
- It is important to conduct extensive research so as to address the real issues on the ground.
- There is need for FBOs to strengthen advocacy.

BETH GIKONYO

- Private public partnerships; FBOs should support private services, working with the government and community.
- COVID presented an opportunity for FBOs to assert their role on community level.
- Even with a pandemic, programmes cannot be silent about other diseases, particularly NCDs (diabetes, asthma, HIV).
- Churches are becoming more involved in vaccine advocacy, which is improving vaccination rates in countries.

DR. MWAI MAKOKA

- Facilities should be equipped to run more efficiently.
- Reorienting Christian health actors
- CHAs should be supported with training and capacity building to handle health matters in their communities.
- Sharpen advocacy by using media visibility to raise awareness.

Strategic recommendations for handling pandemics or wide scale medical emergencies vis-à-vis Christian health actors in Africa.

- Proper articulation of CHAs' stories.
- Orienting and re-orienting health care providers.
- Self-reliance; Internal fundraising for African countries.
- Increasing visibility; FBOs need to know what other FBOs are doing, and join forces for a wider reach.
- Support both CHAs and church (Christian) radio stations.
- Build relationships with governments.
- Enhance the software of building trust and legitimacy.
- Build an ecosystem that serves the needs of the community.
- Strengthen primary service healthcare.
- ·Engage with non-medical actors.eg media.
- Increase research.
- Support struggling CHAs to draft MOUs with their governments.
- Proper documentation of programmes.

BREAKOUT SESSION ONE: EMERGENCY PREPAREDNESS: LESSONS LEARNT FROM COVID-19 AND PREVIOUS PANDEMICS.

MODERATOR

DR.TONNY TUMWESIGYE- UPMB

PRESENTERS

PATRICIA KAMARA- CHAL
FLORENCE BULL- CHASL
ELLED MWENYEKONDE- CHAM
KONGYU EMMANUEL- CBCHS
ALICE MUHIMPUNDU- WORLD VISION RWANDA.

In some areas, FBOs and their facilities were the only available source of health services. The session will explore the following questions.

1. How were FBOs structures affected by COVID-19?
2. How did FBOs adapt various facets of the health system to survive through the pandemic, challenges faced and lessons learnt?

PATRICIA KAMARA.

After the Ebola outbreak in Liberia in 2016, a national action plan was developed to prevent and prepare for future outbreaks.
Before the COVID-19 outbreak, CHAL distributed IPC supplies to all 73 members and provided supplies to the ministry of health.
During COVID-19, DPF were introduces in 34 health facilities, and solar lights were installed in five health facilities. They strengthened the SALT approach (Stimulate, Appreciate, Listen and Transfer). CHAL partnered with county health teams to conduct IPC audits.
Liberia's success was influenced by: A unified health coordination system, strong partnerships, integrated disease surveillance and response systems, and a strong and functional reporting system.

Lessons learnt.
•Pandemic response requires swift, flexible and adequate funding.
•Response requires interventions beyond the critical level.
•Economic impact of the virus will last longer after the virus is eradicated.

FLORENCE BULL.

Various emergencies have stressed the health system in Sierra Leonne: Decades civil war that ended in the 2000s, mudslides in 2017, Ebola outbreak from 2013 to 2016, and COVID from 2020 to date.
In preparation for COVID response, the country set up a national coordination control and command structure, activated an emergency operation center to level 2, heightened disease surveillance, and enforced mandatory quarantine of persons coming from high prevalence areas.
The challenges faced were poor influx of patient for services due to fear and restriction of movement, and poor access to COVID-19 vaccine and training opportunities for CHASL member health facilities.
In response to these, the country began planning for adaptive service reconfiguration, inclusion of local leaders and community structures, reasonable restriction of movement, and provision of social protection and support
CHASL worked in line with government policies and plans, reactivated IPC structures, streamlined screening and triaging at facility entry points to quickly identify cases, installed fully functional isolation units in all member health facilities, and ensured prompt information sharing on COVID-19 within the network.

Recommendations for building resilience during epidemics and moving forward.
•Investigating diagnostic surveillance structures.
•Protect essential health services during outbreaks.
•Strong leadership and commitment at all levels.

ELLED MWENYEKONDE.

Malawi never went into due to politics. A significant number of healthcare workers contracted COVID and some lives were lost
Pandemic response activities were implemented using national framework.
CHAM was strategically aligned with the ministry of health to champion coordination, leadership, resource mobilization, capacity building for clinical care and treatment, and case management.
Resources were mobilized from donors and partners both in cash and in kind, and trainings targeted specific districts.
The main challenges encountered were lack of PPEs during the first wave as the supply chain was overwhelmed, communities shunned health services for fear of being tested for COVID, medical insurance did not cover COVID case management, restricted referrals as survival chances were thought slim.
Lessons learnt and recommendations; emergency preparedness is essential, hospitals need to be well capacitated, healthcare workers need to be motivated to work as frontline soldiers in pandemics, there is need to strengthen partnerships and coordination across all levels, healthcare facilities should invest in sustainable oxygen supply, plans, guidelines and strategies should be revised regularly to include emerging issues, More ETUs in preparation for subsequent waves of COVID.

ALICE MUHIMPUNDU.

During the pandemic, World Vision built permanent hand washing facilities in schools, hospitals, health centers, churches and near refugee camps, donated food for families with under 5 children, and distributed masks, gloves, thermo-flashes and hygiene kits.
Lessons learnt from COVID are that FBOs are potential influencers in pandemic response, FBOs and followers have financial capacities to respond to emergencies, and that partnerships are essential for success.

KONGYU EMMANUEL.

Challenges that arose in Cameroon due to COVID; limited staff which posed a challenge in managing work shifts and patient load, low income which affected the running of health facilities, and restriction on meetings and movement.
CBCHS adapted to these by; supplying larger consignments of drugs to last longer, conveying daily reminders on prevention to both patients and staff, ensuring regular supply of PPEs and water, increasing the number of hand hygiene points, and placing workers on rotation until others returned from isolation
In case of future pandemics, there is an absolute need for outbreak response readiness within the church and its institutions, and increased collaborations with MOH and other partners to ensure buffer stock of medical supplies and consumables. Christians should also be educated on the influence of religious teachings on health care.

BREAKOUT SESSION TWO: HEALTH WORKFORCE IN EMERGENCIES.

MODERATOR
MICHAEL IDAH- CHAN

PRESENTERS
DR. JAMES DUAH- CHAG
DR. CHIDZWERE NZOU- ZACH
DAVID DEE KPANGBALA- CHAL
ADAM MACHALILA- CSSC
JANE NG'ANG'A- EPN

Health workforce issues and challenges in Africa contribute to slow response to pandemics. Health workers are critical in planning, service delivery, supervision, coordination, and evaluation of health pandemics. The availability of trained health workers is key to improving health outcomes.
The session explored strategies and mechanisms to increase, maintain and protect human resources for health (HRH), to assure their availability, training, protection, welfare, remuneration, and financing during pandemics.

DR. JAMES DUAH

When CHAG facilities admitted their first COVID patients, it became evident that new knowledge and feasible interventions in case management and surveillance were required, which would shift attention from basic treatment.
The facilities had adequate commodities such as PPE, medicines, and equipment to deal with COVID. However, there were gaps in coordination, assessment of each facility's situation, reporting to CHAG HQ, and a recorded overuse of church health services since the government suspended all services expect emergencies.
CHAG began training of available staff in critical areas; IPC, case management, testing/diagnostics, contact tracing, RCCE, and psychosocial support training to support affected families.
Health workers were motivated by tax waivers, and 50% additional allowance for frontline workers. Key challenges encountered were some facility staff were infected before training, threat of closure of some CHAG hospitals, high demand for PPES, and non- commitment to insurance packages for affected staff.

Lessons learnt from CHAG's response focused on continuous training, putting mechanisms and structures in place for quick and effective response, the importance of taking early proactive measures, and creating trust within communities.

ADAM MACHALILA.

At the advent of COVID in Tanzania, there were measures put it place to handle cases. CSSC received training support and equipment from partners (DIFAEM, USAID, MISEREOR, IMA World Health).
Church owned facilities experienced challenges such as, knowledge gaps, shortage of IPC- competent personnel, and psychosocial distress. To mitigate these challenges, CSSC began training of healthcare workers in IPC, COVID case management and COVID vaccines.
As a result, knowledge gain increased by 26% , performance of IPC practices increased by 37%, The cascading training model enabled to capacitate over 5000 health worker and narrowed the knowledge gap, and more than 200 health facilities were capacitated with essential equipment for COVID management.

DAVID DEE KPANGBALA.

CHAL employed techniques that worked in previous pandemics; Continuous capacity building, introduction of home-based case management, reinstating retired health workers for support, and compensation for overworked staff. Interventions also included in-service training, introduction of a drug revolving program for over 35 member facilities, and improvement of existing infrastructure.

DR. CHIDZWERE NZOU.

COVID-19 pandemic exposed gaps around preparedness and quick response. It became clear that every organisation should have adequate personnel, and for HRH protection, services that cannot be safely offered should be paused, workers should wear masks all day at work, transportation arranged for workers unnecessary movement should be limited.
Health workers were trained on IPC, and introduced to skills for increasing resilience such as avoiding unhealthy coping mechanisms (alcohol, smoking), taking short breaks, and promoting physical exercise for wellness and good mental health.

QUESTIONS AND ANSWERS SESSION.

QUESTIONS

1) To everyone: During pre-service training what do you wish your health workers knew before pandemic?
2) To Dr. James: How did CHAG and the government compromise?
3) To Dr. James: What safe methods of training were used to not take away health workers from their jobs?
4) To Adam: How did it go without any political support?
5) To David Dee: Did you notice how the pandemic affected older people, and why bring back retired personnel?
6) How did they compensate Overworked staff?
7) How do you train your health workers in case of pandemics?

ANSWERS

1) ERP (Emergency Response Preparation).
2) CHAG engaged facilities virtually and provided support for continuation of services.
3) Training was done during the periods where there were areas not yet affected by COVID-19 in Ghana.
4) The former government regime did not support COVID vaccination until the new president took over and sought good advice about vaccination, which was then cascaded to health workers.
5) Retired workers were very experienced; CHAL knew the consequences and decided to bring them on board, ensuring that the retired workers were highly protected.
6) They had support financial from international partners.
7) They have a curriculum for nurses that encompasses IPC.
8) Rwanda borrowed learnings from Ebola. Most first responders had been trained, thus when COVID hit they were prepared to deal with it.
9) FBOs working with the ministry of health to sensitize the community on prevention and transmission.
10) FBOs provided support by donating food to people who could not leave their homes.
11) FBOs helped address misconceptions about COVID.
12) Rwanda has community health workers at lower levels who help when needed.
13) FBO facilities and staff played an important role through their response reactivity,
14) FBOs helped in vaccine uptake training.
15) Partnerships at community, national and regional level.
16) FBOs had the capacity to continue providing services when the government stopped.
17) Data sharing on COVID-19 is essential.
18) Having private & public partnership and other platforms to join forces
19) Media visibility to raise awareness.
20) Orientation of Christian health workers.
21) Working with non-medical health workers.
22) Supporting CHA'S
23) Advocacy.

BREAKOUT SESSION THREE: GENDER AND YOUTH PERSPECTIVES IN PANDEMICS.

MODERATOR
DR. RICHARD NECI- EPN

PRESENTERS
DR.ALEX MUHEREZA- ACHAP
DR.DAN MUGISHA- UPMB
JANET OPOTA- UCMB
BETTY MURERWA- WORLD VISION

Gender inequality and gender-based violence increased because of the pandemic. In addition, due to closure of the schools, many young people dropped out of school and were exposed to various health risks.

DR. ALEX MUHEREZA.

GENDER AND COVID 19.
Gender is a critical determinant of health outcomes.
Gender refers to "the array of socially constructed roles and relationships, personality traits, attitudes, behaviors, values, relative power and influence that society ascribes to the two sexes on a differential basis. It includes norms, roles and responsibilities, decisions making, access to resources, adoption of behaviors, and participation in society.
Gender inequality- power imbalance - is everywhere, and is linked to poverty, ethnicity and socio-cultural practices; a good example being the Mwenye syndrome observed in Kilifi County in Kenya.
From risk of exposure and biological susceptibility to infection to the social and economic implications, individuals' experiences are likely to vary according to their biological and gender characteristics and their interaction with other social determinants. The following were the effects of COVID-19.

- Increased risk of severe disease and death among men.
- Increased violence against women and children during lockdowns.
- Reduced access to sexual and reproductive health and rights for women and girls.
- Increased teenage pregnancy.
- Mental health challenges.
- Men being more likely to externalize their difficulties such as through anger, alcohol/substance abuse, and increased risk taking.
- Women who are more likely to internalize had signs and symptoms associated with anxiety and depression.
- Increased separation and divorce due to tension within homes during the lockdowns, with no means of escape.
- Negative emotional health consequences to boys through their disrupted boyhood, stressful home events, fear, and lost education as a result of the lockdowns.
- Boys finding it difficult to process stressful experiences and to express their emotions.

DR DAN MUGISHA.

The COVID-19 pandemic has impacted all aspects of life in Uganda, resulting in school closures, loss of jobs, and disruptions of access to health and social services.
UNICEF reported a one out of ten-school dropout rate due to COVID. Economic hardship led to increased school tuition fees and subsequent further drop out (an estimated 30% by the National Planning Authority). With the closure of schools, the youth, especially adolescent girls and young women were exposed to sexual and gender-based violence, leading to high teenage pregnancy rates in the country; According to UNFPA, a 17% spike in teenage pregnancies was observed in Uganda between the onset of lockdown in March 2020 and June 2021. A total of 354,736 teenage pregnancies were registered in 2020, and 196,499 in the first six months of 2021.

Interventions by FBOs.

- Sensitization and advocacy took center stage to bring awareness to the effects of COVID, lockdowns, and social and economic decline in communities.
- Efforts toward improving access to services working with implementing partners and government sectors (Health, Youth and gender, education). Services included HIV and pregnancy prevention.
- Mitigation and management of SGBV.
- Improved access to and uptake of Family Planning services.
- Economic empowerment services.
- Support for OVCs.
- Support towards returning to school, even for young pregnant mothers.

Challenges.

- Challenges reaching clients due to travel restrictions and relocation of target populations to places convenient for their survival. This led to significant lack of follow up.
- Effects of COVID on the health work force and the health system: loss of staff through death and attrition, stigma, difficulty travelling to work, and facility challenges for PNFPs to sustain salaries for health workers
- Initial breakdown of community health structures due to fear and stigma, travel restrictions, and economic hardships.
- Rise in cost of implementation affecting coverage of services.
- Challenges in documenting access to services as recipients were advised to seek medical services at facilities closest to their residence
- Youth champions and treatment peers were initially unavailable following the lockdowns and the need to observe COVID SOPs and service provision guidelines.
- Closure of some of the CSOs, FBOs, and organizations that partnered with UPMB affecting effective service provision.
- COVID-19 related surge in unmet needs in HIV prevention, FP and SGBV services due to lockdowns.

Lessons learnt.

- The importance of community structures in sustaining health services in emergencies.
- Preparedness is critical in responding to a crisis of this magnitude.
- Concerted effort through multi-sectoral engagement is vital in addressing gender-based violence.
- • Faith leaders play a pivotal role in addressing community challenges and remain an untapped resource.

JANET OPOTA.

How COVID 19 affected youths in Uganda.

- Increase in teenage pregnancy rates.
- Limited access to FP services for youths due to movement restrictions and unfriendly care in facilities.
- Low skilled birth attendance due to challenges of affordability.

ACHAP-Afya Youth-led initiatives.

- Trained 60 Youth peers.
- Community based distribution of FP.
- Trained 294 Village Health Teams to continue providing services.

Challenges faced in delivering youth-focused services.

- Restrictions on gathering affected proper selection, number of peers trained, referrals, community reach by peers, and accessibility of reproductive health services.
- Limited access to services due to distant health service centers, stock-out of some FP commodities, and overloaded healthcare workers.
- Poverty: some parents forced young girls into marriage to ease their financial constraints.

Lessons Learnt.

- Provision of adolescent delivery kits promotes ANC attendance and safe delivery for adolescent mothers.
- Integration of services is crucial in enhancing programme sustainability during the pandemic by increasing the number of service points accessible to the vulnerable.
- Engagement of FBOs enhances health services outcomes.
- Strengthening reproductive health services for the youth through their peers and paying special attention to adolescent girls is important in ensuring their health and safety.

BETTY MURERWA.

The goal of World Vision's response programme was to improve the utilization and quality of RMNCH and malaria services in a sustainable manner.

Components of the program.
Component one;
Patient Voice Program/PVP and b) Citizen Voice and Action/CVA

Component two;
Saving for transformation

Key concepts.
Sex
Biological aspects of an individual as determined by their anatomy.

Gender
Refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men.

Challenges faced in delivering gender and youth-focused services.

- COVID-related restrictions such as prohibition of community gathering and meetings.
- Limited scope of work and budget.
- Barriers to understanding of gender.
- Gender Based Violence.
- The burden of care and unpaid work.
- Loss of income vs household level consumption.

Ways in which youths were affected by COVID in Rwanda.

- Mental health challenges.
- High school dropout rate, sexual exploitation for money, unwanted pregnancies, and drug abuse.
- Loss of friendship, loss of entertainment and recreational activities, and limited individual freedom.
- Loss of jobs.
- Barriers to access services; lack of information on Adolescent Sexual and Reproductive Health services lack of youth-friendly services, stigma, prejudice and judgmental attitude from health care providers, lack of confidentiality etc.
- Fear of stigma from being seen entering a clinic, which may be especially intimidating for young women for whom it is less culturally acceptable to be sexually active before marriage.
- Curfews posed a problem for young people who were in school, working or had limited mobility during service delivery hours.

Youth-led initiatives that were implemented by CHAs/FBO to address these challenges.

- Strengthened and supported Adolescent Sexual and Reproductive Health services and youth corner services.
- Supported youth score card meetings and encouraged their participation and feedback on quality of healthcare.
- 1,118 youth including 467 teenage mothers are supported by *Ingobyi* through S4T groups and income generating activities.
- World Vision Rwanda initiated the Ultra Poor Graduation/UPG model and supported 4041 (2267 girls and 1774 boys) youth headed households.
- Cash transfer to youth (95 USD each) for productive assets of their choice.
- 1386 young people received vocational and life skills training and received graduation kits.

The role of faith actors in mitigating gender-based violence during the pandemic.

- Faith based health facilities and their staff supported in treatment and isolation centers.
- Worked with One-stop centers for GBV management.
- Supported with food distribution, hygiene materials, PPEs, and financial support.
- Provided safe spaces for vaccination campaigns.
- Provided sensitization messages and teachings via TV and radio stations to overcome fear.
- Supported people to access health care services.
- Installed handwashing facilities and posters with COVID prevention messages.
- Helped in identifying the most vulnerable families and individuals for support.
- Showed good partnership with government to support people in need.

Lessons Learnt from COVID to ensure continuous integration of gender perspectives during crises.

- Preparedness, adaptation, and response in times of pandemics and outbreaks.
- Integration of gender perspective and youth programs in their faith-based activities to support against GBV.
- Consistently pursue effective programs and strategies to support youth.
- Encourage peer to peer group teaching and programs empowering women and youth towards resilience and against economic shocks.
- RMNCH-related components like family planning should be part of the teachings in women's and youth forums.

BREAKOUT SESSION FOUR: COVID-19 RESPONSE IN FRANCOPHONE COUNTRIES.

The session covered experiences, challenges and lessons learnt.

MODERATOR

DR. NDILTA DJEKADOUM- AEST, CHAD.

PRESENTERS

DR. HABIMANA JEAN BAPTISTE- NEMBA HOSPITAL, RWANDA
DR. GOUMOU EMMANUEL- RECOSAC GUINEA.
BAMBA MAMADOU- ICPH, CÔTE D'IVOIRE
PST LANDISON TRIOMPHE- FKJM, MADAGASCAR
JULIEN BASILE GOUNOUMAN- ASSOMESCA, REPUBLIC OF CENTRAL AFRICA

DR. HABIMANA JEAN BAPTISTE

Director General of Nemba Catholic Hospital located in Diocese of Ruhengeri, a member of BUFMAR.
The hospital was established in 1974.The first case of COVID -19 was confirmed in Nemba District Hospital on July 2020.

Interventions against COVID by Nemba Hospital.

- Training of different stakeholders (Staff of Hospital and health centers, Community health workers, Youth volunteers, teachers etc.
- Identifying infection hotspots and increase community mobilisation.
- Bi-monthly mass testing to identify COVID cases and keep them in home-based care as recommended by RBC to decrease the spread of infections.
- Increased awareness of Community health workers on preventive measures and case management.
- Supply of medical equipment's such as pulse oximeters and PPEs in collaboration with RBC, ACHAP, and BUFMAR.
- Strengthening community sensitisation on COVID 19 preventive measures by reaching hotspots and rural areas with the support of ACHAP and BUFMAR.
- COVID Vaccination activities.
- Severe cases were hospitalized in isolation blocks, and maternity isolation blocks were well equipped with materials related to labour and newborn management.
- Asymptomatic and mild symptom cases were referred for home-based care.

Challenges.

- Some people were not complying with COVID prevention measures.
- Some staff were affected by COVID, resulting in a shortage of staff during the period.
- Sometimes the staff and CHWs were overloaded.
- Financial limitations.
- Management of cases was difficult when majority of family members were affected.

DR. GOUMOU EMMANUEL.

In 2016, after the Ebola epidemic, the Ministry of Health of Guinea organized an open forum and recommended grouping of denominational health facilities into a Christian and Muslim network to strengthening the health system. This initiative was supported by DIFAEM and CRS. A consultative general meeting of the umbrella organization was held on October 29, 2016, where RECOSAC-G was formed.
During the COVID pandemic, lessons drawn from Ebola were employed for response.
RECOSAC-G noted certain challenges; health facility personnel were afraid of interacting with patients and vice versa, increase in the prices of drugs and consumables affected supply, additional budget constraints due to the purchase of PPEs, and reduction in health facility attendance.

With support from their partner, DIFÄM, RECOSAC launched a community COVID-19 response project to address specific issues:

- Maintaining attendance/use of services in health facilities.
- Continued service delivery.
- Maintaining access to drugs and consumables.
- Integrating the fight against COVID into the daily activities package of health facilities.

Lessons learnt.

- The DIFÄM and RESOSAC-G partnership has been the foundation of success in the fight against COVID.
- Provision of health worker salaries was an important component in the implementation of the project.
- Public awareness is key to managing pandemics.
- Capacity building of stakeholders is important to help reduce mistrust and fear.
- The involvement of community health workers and community leaders has increased.
- Coverage of health training is essential for visibility.
- Valuing the contribution of community actors to the health of populations encourages them to act.
- The introduction and use of NICT s has made it possible to circumvent certain obstacles to groupings.
- Multidisciplinary approaches work in responding to pandemics.

BAMBA MAMADOU.

ICPH is a coordination structure of Baptist health centress and NGOs which aims to: Set up a national coordination framework for the management of Baptist health structures, create a framework for consultation between the various managers of the structures to guarantee the quality of medical services, capitalize on the contribution experiences of Baptist health centres in public health action, and mobilise innovative partnerships for the promotion of Baptist health centres.
During the COVID crisis, it was noted that health centers lacked blood for transfusion needs, and private health structures were not taken into account in the State Response plan.

Intervention Strategies.

ICPH supported the Baptist Medico-Social Center of Torgokaha to write a proposal titled "Strengthening the resilience of the health system in the face of COVID 19 in the commune of Korhogo". This proposal was selected by the EU for their Mobilizing Funds to Strengthen Community Resilience project, an initiative to fund the activities of civil society organizations.

Lessons Learnt.

- Faith-based structures are considered credible and highly trusted by communities.
- The State must ensure that the vaccine supply chain is made more fluid: several shortages of one or all of the vaccines have often demotivated the populations.
- National coverage of COVID response is 45%; therefore it is important to continuously identify encumbering factors and unmet needs.
- Setting up a dedicated team for COVID vaccination is essential.
- The ministry of health needs to channel more efforts towards vaccination, as Côte d'Ivoire is slated to host the African Cup of Nations.
- The more marginalized rural areas have lower vaccination rates. To carry out vaccination in rural areas, the Ministry relies on Rural Health Centers, which are often understaffed.

PST LANDISON TRIOMPHE

COVID-19 was first detected in Madagascar in March 2020. The government responded quickly with numerous protective measures, including the cancellation of all meetings of more than 10 people. This included all religious services. Since the start of the pandemic in Madagascar, FJKM has been active in the fight against COVID-19.
The General Assembly of FJKM, during its meeting in August 2021, voted that the National Committee for the Fight against AIDS (KPMS) join the efforts of FJKM to fight against epidemics, including COVID.
At the start of the crisis, FJKM organized visits to treatment centers and hospitals. Afterwards, pastors and laypeople were trained to visit and pray with COVID patients and their families.
In January 2021, recognizing the importance of this ministry, the President of Madagascar publicly invited the church to get involved in visitation and encouragement of COVID patients and their families as well as health personnel.

FKJM's intervention activities.

- Educating pastors, community leaders, and the population on COVID prevention and care.
- Training and equipping those who interact closest with COVID patients and their families to support them.
- Equipping seminary students and FJKM headquarters with IPC materials.
- Promoting and organising vaccination sessions.
- Supporting patients and families impacted by COVID.
- Sensitising marginalised populations to health measures against pandemics and other diseases (cholera, plague, etc.)
- Supporting families who lost their income due to confinement and other effects of COVID.
- Producing educational materials on COVID-19 (e.g. flyers and posters).
- Sharing educational messages about COVID-19 via FJKM radio and television stations.
- Training of seminary students on COVID.
- Visiting COVID patients in hospitals and their homes and providing psychological support to their families.
- Organising weekly meetings with slum-dwelling children to share a community meal so as to establish a good relationship of trust.
- Home visits to vulnerable people to raise awareness of diseases linked to poor hygiene.
- Educating parents about the different vaccines.

Common misconceptions in Madagascar.

- The vaccines contained a "nano-chip".
- The population could protect themselves from COVID just by taking natural foods (ginger, garlic, lemon, cinnamon, etc) as well as medicinal plants.
- Only God can protect people from any disease including COVID, therefore vaccines are unnecessary.
- The vaccines were financed, even manufactured by secret organizations that want to control the world. Vaccination was only a means used by the government , like any other project, to acquire funding.

Lessons learnt

- God wants to take care of his people.
- When servants of God commit to a a cause, God leads them to the path of success.
- The government can trust the church to lead community intervention.
- Christians need to show themselves as the salt of the earth and the light of the earth when crises arise.
- The COVID pandemic can be overcome through belief and commitment.

JULIEN BASILE GOUNOUMAN

Association Des Œuvres Médicales des Eglises Pour La Santé En Centrafrique (ASSOMESCA) was formed in 1989 with a purpose was to promote the health of the population in the spirit of the Gospel, and a mission was to promote collaboration between the medical work of the Churches with a view to the realization of the PNDS. During the COVID pandemic, ASSOMESCA worked to enforce barrier measures at service level and disseminate information on government measures, held a national day of fasting and prayer with the involvement of the President of the Republic, and sought to address mental health challenges in the public that were brought about by the pandemic and its effects.

In response to government measures, churches:

- Established weekly family worship programs and collection of tithes and offerings.
- Organised periodic sessions of fasting and prayer.
- Circulated messages via social media.
- Made hygiene materials available to public.
- Trained health workers in faith-based structures and provided PPEs.
- Trained pharmacy managers on proper use of PPEs.
- Got involved in recycling.
- Supplied hospitals and health centres with oxygen concentrators and drugs (Paracetamol, Zinc and Azithromycin).

In terms of vaccination: The Ministry of Health has ensured full management with a limited stock of COVID-vaccines. Initial rollout targeted key groups starting with state and private health personnel.

Challenges faced.

- Reluctance and/or refusal of vaccination.
- Gradual abandonment of good practices.
- Less involvement of faith-based structures in the activities carried out by the ministry of health.

Lesson Learnt.

Involvement of religious leaders at the level of the community is key in getting the public to cooperate.

FIELD VISIT

After the breakout sessions, the entire delegation visited the Kigali Genocide Memorial. A donation was made to the memorial in ACHAP's name. and thereafter a flower ceremony was held at the gravesite.

Visit and flower ceremony at the Kigali Genocide Memorial

DAY THREE: THURSDAY 14TH JULY 2022.

Opening prayer and morning reflection was led by Dr. Djékadoum Ndilta.

Dr. Ndilta delivering the opening sermon

PLENARY SESSION 3: COMMUNICATION AND ADVOCACY IN PANDEMICS: THE ROLE OF FBOS.

MODERATOR
VUYELWA CHITIMBIRE- ZACH

PRESENTERS
JAMES MWESIGWA- UPMB
MARIE MUKABATSINDA- IRH
ALICE MUHIMPUNDU- WORLD VISION RWANDA
CARINA DINKEL- DIFÄM
REBECCA WAUGH- IMA WORLD HEALTH

Religious leaders, FBOs and faith communities at all levels are considered important stakeholders who have played a key role in health emergency preparedness and response, and COVID-19 has magnified this role. The session will answer the following questions:

1. How did the CHAs engage and coordinate with the respective governments in developing and rolling out health messages, buy-in from leadership/gatekeepers, and understanding of their operations?
2. What strategies have been put in place to ensure continuous and strengthened collaborations with respective governments and other partners?
3. What has been the role of media- print, radio, social media, interpersonal communication, and interfaith networks in the surveillance of misinformation and disinformation, and dispelling myths about COVID-19 prevention and vaccination?
4. What has been the role of faith leaders in advocating for vaccine equity, access, and uptake? Participants will also share their experience of vaccine hesitancy and how it has been countered through targeted advocacy and SBC. Are there CHAs that developed sermon guides, toolkits, and advocacy packages?

JAMES MWESIGWA

UPMB COVID-19 RISK MANAGEMENT.

UPMB addressed key issues towards safer programming; staff safety, telecommuting, social distancing, higher risk of infection in the workplace, extremely vulnerable populations, staff health and staffing levels, premise access and travel, on-site infections, business continuity, cyber security, and information and risk communication.
They used two methods to analyse and deal with the pandemic: The RCA (Root cause analysis) method and the FMEA(Imagine harm, guess cause, change harm) method.
Infection Prevention and Staff Safety.
Unsafe workplaces were seen to increase risk of infection among workers. Initial measures put in place to decongest workplaces were 1. Reallocating staff function to ease telecommuting, and 2. Requesting workers to stay home if they had any COVID-related symptoms.

Cyber security

As people entered lockdown, they were more reliant on internet and digital communication. An arising risk was the rise in ransomware as people took advantage of this situation. The government sought to address these threats by sending mass warnings to workers.

Risk communication

The pandemic threatened communication with clients and suppliers, and to mitigate that, people engaged more in networking trade and were able to communicate virtually.

Business continuity

The pandemic threatened the existence of businesses and their ability to deliver services. To deal with that, businesses appointed COVID-19 risk management teams, and the government devised business recovery plans.

Workplace social distancing

To enforce social distancing, workplaces redesigned their layouts to ensure minimal interaction, and put up warning signages and markings around their premises.

Challenges

- Inadherence to safety measures.
- Insufficient ICT infrastructure.
- Poor internet connectivity in rural areas.
- Psycho-social challenges to the population.

Achievements

- Workplace infections were reduced.
- Not a single person was hospitalized/ death occurred at UPMB workplaces.
- UPMB developed a document on working safely during COVID-19.
- Cost savings on UPMB medical insurance scheme.

Conclusions

- FMA provides cost effective alternative models to help epidemic control.
- FMA supports innovation implementing strategies designed as solutions to local problem.
- Cyber security is still an issue that needs to be dealt with.

MARIE MUKABATSINDA.

FAMILY PLANNING AND COVID 19.

COVID-19 disrupted access to family planning around the world; Supply chain disruptions resulted in commodity stock-outs, and movement in and out of the country was highly restricted.
To ensure continuity of the FP programme in Nigeria and Rwanda while protecting health workers, IRH focused on virtual trainings, reducing group sizes where in-person interaction was necessary, emphasis on the fertility awareness method which does not require supplies, and conducting follow ups on phone.
The programme targeted couples in Rwanda and newly married couples and new parents in Nigeria. It was implemented through two main strategies: System approach to build capacity, supply of materials and raising awareness, and engaging religious leaders to spread FAM messages.
Working with religious leaders was based on the fact that they have a large influence on their communities, have reputable connections, and shared common goals.
Faith based organizations and health facilities were best positioned to expand access to FP. Involving religious leaders as champions of FP proved an important step in creating a supportive environment.

Lessons learnt.

- Religious leaders played a key role in system strengthening during COVID and make important contributions in FP service delivery.
- Engagement of religious leaders during COVID pandemic led to effective advocacy and increased collaboration with governments.
- Combining transformative masculinity approach with FAM was successful in addressing gender norms.

CARINA DINKEL.

CHAS AND FAITH ACTORS COMMUNICATION & ADVOCACY DURING THE PANDEMIC.

DIFAEM supported COVID programmes for 62 partner organizations in 26 countries through two small project activity funds including lobbying and advocacy, emergency relief, and provision of goods.
Communication strategies were aimed at fighting the infodemic through webinars, surveys among participants to reveal needs, and development of starter formats through regional WhatsApp groups.Focus on communication led to a a huge multiplier effect; information was readily available to share, community sensitization was made easier, and correct information was cascaded from healthcare workers.

Lessons learnt

- Low-key access to information for low income countries was very important.
- WHO publications/format are often too elaborate, and it is important to have the information summarized for the benefit of the target audiences
- Francophone countries are often at a disadvantage in terms of access to information.

ALICE MUHIMPUNDU

PROTECTION COMMUNICATION AND ADVOCACY DURING COVID-19

The key areas of focus of the child protection programme were education, health and nutrition, resilience and livelihoods, and child protection, addressing three cross cutting themes: Local partnerships, faith and development, and advocacy.
Child protection intervention is aimed at protecting children from abuse, exploitation, trafficking and violence. During the pandemic, programming focused on child protection and advocacy, positive parenting, and celebrating families. 700 radio talk shows were conducted with government leaders, faith leaders and civil society organizations at the national and community levels, 80000 Christian storybooks were distributed to over 4913 children, and feedback was circulated through phone calls and SMS.
As a result, 48102 child protection needs were identified, and 10873 child protection needs were reported to relevant authorities.

REBECCA WAUGH.

IMA 3-MONTH EMERGENCY RESPONSE PROGRAMME

Programme communication was focused on 3 audiences; Health workers, faith leaders, community members. In December 2021, IMA worked to highlight vaccine response, and show importance of working with faith leaders. In collaboration with ACHAP, IMA will continue to partner with organizations to help people understand pandemic preparedness and the significance of media.

QUESTION AND ANSWERS.

QUESTIONS.

1. Why is it important to involve stakeholders like the government to be able to commute and fight pandemics?
2. How engaged are religious leaders in addressing social norms?
3. What policy change can be effective to improve relationship between partners?
4. How can the importance and effectiveness of CHAs be catalyzed in Africa?

ANSWERS.

1. CHAs outside of UPMB are small, and without the help of the government the gap between UPMB facilities and other facilities will continue to grow.
2. Religious leaders approve/support the idea of debunking social norms, and they are using their platform to advocate for uptake of Family Planning.
3. During the pandemic, governments recognized the work of FBOs, and more and more began to partner with them.
4. CHAs can employ influential strategies, increase their social media visibility, and work closer together to on communication.

COMMUNICATION AND ADVOCACY: KEY MESSAGES.

- Governments should be involved in communication during pandemics and engage the media to counter misinformation. CHAs need to strengthen their relationships with their respective governments.
- Engagement of non-medical actors is important to cushion health systems that get overwhelmed by pandemics.
- Engagement of religious leaders is important in the design and implementation of health projects.
- Social media is a powerful tool for advocacy when used correctly. Healthcare workers should strive to be conversant with newer social media platforms.
- CHAs need more access to solid data and support from organizations like Africa CDC to validate information.
- ACHAP needs to do more to reinforce the capacity of its members.
- FBOs need to be continuously engaged in system strengthening and policy making.
- Health workers need to be trained and presented with opportunities to engage with the media.
- Every organisation needs to have dedicated communication personnel.
- Child protection has to be a priority during pandemics.
- CHAs need to develop more innovative methods of communication such as virtual tools to adapt to challenges brought about by lockdowns.
- Documentation of programmes is important as publications make a good reference tool for future health emergencies.

PLENARY SESSION 4: SUPPLY CHAIN SYSTEMS AND HEALTH TECHNOLOGIES IN PANDEMICS.

MODERATOR.
DR. NDILTA DJÉKADOUM- AEST

PRESENTERS.
TITUS MUNENE- MEDS
ERNEST RWAGASANA- BUFMAR
DR.RICHARD NECI- EPN
DR.BILDARD BAGUMA- JMS

KEY MESSAGES ON SUPPLY CHAIN MANAGEMENT DURING PANDEMICS.

- Strong and flexible leadership and government support are essential.
- DSOs need to explore more health care financing models and partnerships for sustainability.
- Early preparedness is understated.
- DSOs need to leverage technology to establish proper methods of communication.
- Every organization needs a sound disaster management plan.
- DSOs could explore partnerships with micro finance institutions and negotiate with health insurance companies for reimbursement to increase people's access to medications.
- Health organizations should form more strategic alliances with international actors, governments, and the private sector.
- DSOs need to continue complementing government efforts to provide commodities during pandemics, e.g., by donating sanitizers.
- Development of sustainable systems is key to surviving pandemics.
- Continuous knowledge sharing is important to learn from other organizations and draw lessons from their experiences.
- Monitoring of products from unknown sources is very important for quality assurance. DSOs need to invest in laboratories to develop tools for monitoring the quality of drugs.
- Countries would increase their purchasing power if they develop regional procurement levels.
- Standardization of medical supplies is essential.
- Governments need to invest in local production e.g., manufacturing of sanitizers to be able to cater to needs without relying on aid.

CALL TO ACTION

The Call to Action for uptake of COVID-19 Vaccination document is herein embedded:

Call to Action: Uptake of COVID-19 Vaccination In Africa

Appel à l'Action: Adoption de la Vaccination COVID-19 en Afrique