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# PROGRESS REPORT ON THE IMPLEMENTATION OF THE REGIONAL STRATEGY FOR HEALTH SECURITY AND EMERGENCIES 2016–2020

**Information Document**

## CONTENTS



## ANNEXES

## BACKGROUND

1. The World Health Organization (WHO) African Region contends with more than one hundred public health emergencies annually.[1] Many of these emergencies can be mitigated through proven public health interventions and strong health systems, but the health systems in most Member States remain inadequate.

2. In May 2005, the Fifty-eighth session of the World Health Assembly adopted the International Health Regulations-IHR (2005) and 196 Member States committed to implementing the IHR.[2] Establishing critical public health functions is a sovereign responsibility of Member States, but the means of fulfilling that responsibility are global. The IHR (2005) constitute the essential vehicle for that action. The West Africa Ebola crisis (2013–2016) highlighted major challenges in the application of the IHR.

3. In 2016, at the Sixty-sixth session of the Regional Committee, Member States adopted the Regional strategy for health security and emergencies 2016–2020.[3] The strategy stipulates bold targets for all Member States (Annex 1).

4. This document is submitted in compliance with the request of the Sixty-sixth session of Regional Committee that the Regional Director should report every two years on progress made in implementing the regional strategy. This is the first report covering the period 2016–2018.

## PROGRESS MADE/ACTIONS TAKEN

5. Member States are commended for their great commitment in assessing their IHR capacities. However, major gaps and challenges have been observed.

6. **Legislation, laws, regulations, frameworks, and policies:** Only six Member States have the required IHR capacities for this technical area. This falls short of the 2018 target which requires all Member States to have these capacities (Annex 1).

7. **Financing to support IHR implementation:** All Member States committed to mobilize adequate resources for IHR implementation by 2018. However, only six Member States have mobilized adequate resources. Inadequate domestic financial resources constitute a major challenge.

8. **Joint external evaluation (JEE):** Member States are commended for embracing the JEE, a voluntary component of the IHR monitoring and evaluation framework. By 2018, thirty-eight Member States (81%) had conducted a JEE, surpassing the 2018 target of 80% of Member States.

9. **Outbreak and disaster risk analysis and mapping:** A comprehensive regional epidemics risk assessment and mapping was conducted for the period 1970-2016. Further, 33 Member States (71%) conducted risk profiling and mapping.

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1 World Health Organization, Health Emergencies Programme in the African Region: Annual Report 2016. Regional Office for Africa. http://www.afro.who.int/fr/node/8317 (Accessed on 28 October, 2018).

2 World Health Organization. International Health Regulations (2005), Third Edition. http://apps.who.int/iris/bitstream/10665/246107/1/9789241580496-eng.pdf?ua=1 (Accessed January 14, 2019).

3 World Health Organization. Resolution: Regional strategy for health security and emergencies 2016–2020, http://www.who.int/iris/handle/10665/252834 (accessed on 18 January 2019.

10. **Development of national action plans for health security (NAPHS):** By 2018, twenty-one Member States[4] had completed their NAPHS 11[5] had initiated the planning process. By the end of 2019, all 38 Member States (over 80%) that have conducted the JEE will have completed their NAPHS.

11. **Availability of the IHR capacities:** In 2017 and 2018 all 47 Member States submitted their IHR annual reports compared to only 22 Member States in 2016. Worryingly, no Member State had all the required IHR capacities (Annex 2). It is therefore unlikely that the 2020 target of 80% of Member States will be achieved.

12. **Regional health workforce:** A multidisciplinary regional workforce has been set up by the WHO Secretariat and partners. The regional workforce has been instrumental in responding to major outbreaks.

13. **Integrated Disease Surveillance and Response (IDSR):** By 2018, forty-four Member States (94%) were implementing the IDSR strategy. However, only 19 Member States (40%) were implementing IDSR with 90% national coverage. The 2020 target of 90% of Member States may be missed.

14. **Functional national laboratory system:** Thirteen Member States (27%) have the required IHR capacities for this technical area (Annex 2). The target for 2020 is 37 Member States (80%). Unless corrective measures are instituted, the Region is unlikely to achieve the 2020 target.

15. **Functional public health emergency operation centres (PHEOCs):** By 2018, twenty-three Member States (49%) had established PHEOCs. Of these, 14[6] were fully functional, nine[7] were in the process of becoming fully functional and 11[8] were at the establishment stage. The Region is on course to achieve the target of 80% by 2020.

16. **Multilevel and multifaceted risk communication strategies:** Thirteen Member States (27%) have the required IHR capacity for this technical area. The target for 2020 is 42 Member States (90%). Unless corrective measures are instituted, the Region is unlikely to achieve the 2020 target.

17. **Adequate health resources:** Twenty-three Member States (49%) have the required IHR capacity for this technical area. The target for 2020 is 37 countries (80%). The Region is on course to achieve the target of 80% Member States by 2020.

18. **IHR-Performance of Veterinary Services (PVS) national bridging workshops:** Nine Member States have conducted IHR-PVS bridging workshops. For the first time, experts from human, animal, environmental and other sectors met to address public health events, using the "One Health Approach".

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4 Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Namibia, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Uganda.

5 Botswana, Democratic Republic of the Congo, Eswatini, Seychelles, The Gambia, Guinea, Rwanda, South Africa, South Sudan, Zambia, Zimbabwe.

6 Cameroon, Côte d'Ivoire, Ethiopia, Guinea, Kenya, Liberia, Mauritania, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Uganda, United Republic of Tanzania.

7 Central African Republic, Democratic Republic of the Congo, The Gambia, Guinea-Bissau, Mali, South Sudan, Togo, Benin, Zambia.

8 Botswana, Burundi, Burkina Faso, Congo, Gabon, Ghana, Madgascar, Mozambique, Namibia, Niger, Zimbabwe.

**NEXT STEPS**

19. All Member States should:

(a) Urgently address the gaps noted above by strengthening their national public health capabilities, infrastructure, and processes in line with the IHR;

(b) Conduct a baseline JEE by 2019, and those that did so in 2016 and 2017 should conduct a repeat JEE by 2020;

(c) Urgently develop and implement their NAPHS to establish the required IHR capacities. This will require political commitment at the highest level to mobilize adequate domestic and external financing;

(d) Establish a PHEOC with a clearly defined legal mandate. Importantly, PHOECs should be incorporated into the health sector organizational structures and adequately resourced.

20. The WHO Secretariat and Partners should:

(a) Provide technical and financial support for implementation of the NAPHS and the IDSR strategy;

(b) Document progress in NAPHS and IDSR implementation and support evaluations in Member States.

21. The Regional Committee reviewed the progress report and approved the next steps.

## Annex 1: Progress against milestones and targets of the Regional strategy for health security and emergencies 2016–2020

| Milestones and Targets | Progress made |
|---|---|
| ***To strengthen and sustain the capacity of all Member States to prevent outbreaks and other health emergencies.*** | |
| (a) All Member States have legislation, laws, regulations, frameworks, and policies to support IHR and DRM implementation by 2018. | Only 6 Member States achieved the target |
| (b) All Member States have budget lines and allocated domestic resources to support IHR implementation by 2018. | Only 6 Member States achieved the target |
| (c) At least 80%, of Member States have organized a joint external evaluation (JEE) of IHR core capacities by 2018 with WHO Regional coordination support. | Thirty-eight (38) Member States (81%) achieved the target. |
| (d) At least 80%, of Member States will have conducted outbreak and disaster risk analysis and mapping in a multisectoral approach, by 2018. | Thirty-three (33) Member States (71%) achieved the target |
| (e) At least 80% of Member States have all-hazards preparedness plans that are tested and resourced, by 2018. | Twenty-one (21) Member States (47%) achieved the target and 11 (23%) were in the process.<br>By end of 2019, over 80% of Member States will have achieved the target |
| (f) At least, 80% of the Member States will have the minimum IHR core capacities by 2020 | By 2018, no Member State has all the required IHR capacities.<br>The 2020 target is not likely to be achieved. |
| (g) A regional health workforce developed in collaboration with partners, including the Africa CDC by 2017. | A multidisciplinary regional workforce has been set up. |
| ***To strengthen and sustain the capacity of all the Member States to promptly detect, speedily report and confirm outbreaks.*** | |
| (a) Over 90%, of Member States are implementing IDSR including event-based surveillance systems with at least 90% country coverage by 2020. | By 2018, forty-four Member States (94%) were implementing IDSR.<br>Only 19 (40%) Member States were implementing IDSR with 90% national coverage. |
| (b) At least 80% of Member States have a functional national laboratory system and network as described in the joint external evaluation (JEE) tool by 2020.[9] | By 2018, Only 13 Member States (27%) had achieved the target |
| ***To strengthen and sustain the capacity of all Member States to promptly respond to and recover from the negative effects of outbreaks and health emergencies.*** | |
| (a) At least 80% of Member States have a public health emergency operation centre (EOC) functioning according to minimum common standards by 2020. | By 2018, twenty-three Member States (49%) had established PHEOCs;<br>• Fourteen were fully functional;<br>• Nine were in the process of becoming fully functional<br>• Eleven were at the establishment stage. |
| (b) At least 80% of Member States have a public health emergency operation centre (EOC) functioning according to minimum common standards by 2020. | By 2018, twenty-three Member States (49%) had established PHEOCs;<br>• Fourteen were fully functional;<br>• Nine were in the process of becoming fully functional<br>• Eleven were at the establishment stage. |
| (c) Over 90% of Member States have a multilevel and multifaceted risk communication strategy for real-time exchange of information, by 2020. | By 2018, only 13 Member States (27%) had achieved the target |
| (d) Over 80% of Member States will have an adequate health workforce to respond to outbreaks and health emergencies as stipulated in the JEE tool by 2020. | By 2018, twenty-three Member States (49%) had achieved the target. |

[9] World Health Organization. Joint External Evaluation tool (JEET), IHR (2005). http://apps.who.int/iris/bitstream/10665/204368/1/9789241510172_eng.pdf (accessed on 17 April 2016).

**Annex 2: Number of countries in each IHR technical capacity, 2018**