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

Information Document

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ANNEXES

BACKGROUND

1. All Member States of the World Health Organization (WHO) African Region are at risk of health emergencies[1] with over 100 public health events notified to WHO every year. The top five outbreaks in 2019 and 2020 included COVID-19, measles, circulating vaccine-derived poliovirus (cVDPV), cholera and yellow fever (Annex 3). These emergencies impact all sectors including the economy, as well as lives and livelihoods. Improving investment in health emergency preparedness through compliance with the International Health Regulations (IHR, 2005) is crucial for mitigating these risks.

2. The IHR (2005) is a legal instrument which obliges all States Parties to build and sustain core public health capacities to prevent, prepare for, promptly detect and rapidly respond to health emergencies.[2] Despite the significant progress made, the Region still lags behind in the implementation of the IHR (2005).

3. Member States adopted the Regional strategy for health security and emergencies (2016-2020)[3] at the Sixty-sixth session of the Regional Committee. The aim of the strategy is to contribute to the reduction of morbidity, mortality, disability and socioeconomic disruptions due to outbreaks and other health emergencies in the WHO African Region.

4. The Sixty-sixth session of the Regional Committee requested the Regional Director to report every two years on progress made in implementing the regional strategy. This is the second and final progress report.

PROGRESS MADE/ACTION TAKEN

To strengthen and sustain the capacity of all Member States to prepare for and prevent health emergencies (Annex 1):

5. **Legislation, laws, regulations, frameworks, and policies:** Ten Member States[4] have the required IHR capacity for this technical area. This falls short of the target of all Member States having built this capacity by 2020 (Annex 1).

6. **Financing to support IHR implementation:** Ten Member States[5] mobilized adequate financing for IHR implementation. This falls far short of the target requiring all Member States to allocate enough domestic resources by 2020.

7. **Joint external evaluation (JEE):** The target was for 80% of Member States to have conducted a JEE by 2018. This target was surpassed; by the end of 2020, all Member States, except Algeria, had conducted a JEE of IHR core capacities.

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1 World Health Organization. 2017. Mapping the risk and distribution of epidemics in the WHO African Region: a technical report. (https://apps.who.int/iris/handle/10665/206560, accessed 5 March 2021)

2 World Health Organization. 2016. International Health Regulations, Third Edition. (https://www.who.int/publications/i/item/9789241580496, accessed 5 March 2021)

3 World Health Organization. 2016. Regional strategy for health security and emergencies, 2016–2020, Document AF. 2016. (http://www.who.int/iris/handle/10665/252834, accessed 15 February 2021)

4 Algeria, Cabo Verde, Ethiopia, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania

5 Algeria, Cabo Verde, Ethiopia, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania

8. **Outbreak and disaster risk analysis and mapping:** Risk profiling and mapping was conducted in 39 Member States (83%),[6] surpassing the 80% target. Additionally, in 2016, a comprehensive regional epidemic risk assessment and mapping was conducted for all epidemics reported in the Region between 1970 and 2016.

9. **National action plans for health security (NAPHS):** By the end of 2020, thirty-one Member States (66%)[7] had developed and costed their NAPHS following the JEE, representing 67% of all Member States that conducted a JEE.

10. **IHR annual reporting:** From 2017 to 2020, all 47 Member States submitted their IHR annual reports, a commendable increase from 20 in 2015. However, to date, no African country has all the required IHR capacities (Annex 2).

11. **Regional health workforce and expert networks:** A regional workforce consisting of over 6000 experts was set up in 2018 and expanded in 2020. In addition, IHR and JEE expert rosters exist with close to 1500 multidisciplinary experts.

To strengthen and sustain the capacity of all Member States to promptly detect, speedily report and confirm outbreaks (Annex 1)

12. **Implementing Integrated Disease Surveillance and Response (IDSR):** By the end of 2020, all Member States, except Algeria, were implementing IDSR. However, only 21 of them (45%) were implementing IDSR with at least 90% coverage at subnational level. A revised regional IDSR strategy for 2020–2030 was endorsed at the Sixty-ninth Regional Committee and revised IDSR technical guidelines were developed.

13. **Functional national laboratory system and network:** Twenty (43%) Member States[8] have the required IHR capacity for this technical area. This falls short of the target of 37 Member States (80%) by 2020.

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 (Annex 1)

14. **Public health emergency operations centre (PHEOC) and incident management system (IMS) functioning according to minimum common standards:** By 2020, thirty-nine Member States (82%) had established PHEOCs. Of these, 27[9] were functional, 12[10] were in the process of becoming functional and six[11] were at the establishment stage. This exceeds the 80% target by 2020.

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6 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, CAR, Chad, Comoros, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

7 Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Malawi, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Uganda, Sierra Leone, South Sudan, Tanzania (plus another specific NAPHS in Zanzibar), Zambia and Zimbabwe.

8 Angola, Burkina Faso, Burundi, Cabo Verde, Central African Republic, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Guinea, Lesotho, Mali, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania

9 Burkina Faso, Cameroon, Côte d'Ivoire, Eswatini, Ethiopia, Gambia, Guinea, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Seychelles, Uganda, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

15. **Multilevel and multifaceted risk communication strategy:** Fifteen (32%) Member States[12] have the required IHR capacity for this technical area. This falls short of the target of 42 Member States (90%) by 2020.

16. **Adequate health workforce:** Thirteen (28%) Member States[13] have the required IHR capacity for this technical area. This falls short of the target of 37 countries (80%) by 2020.

17. The main challenges that impacted the implementation of this strategy include the COVID-19 pandemic (resource allocation, response activities, etc.), inadequate funding and implementation of NAPHS, and the huge number of health emergencies reported every year with weak health systems.

NEXT STEPS

Member States should:

18. Invest more in emergency preparedness and fast track the implementation of the IHR – build and sustain the required capacities (Annex 2).

19. Build resilient health systems that can cope with the shock of health emergencies.

20. Leverage the COVID-19 outbreak to strengthen the systems for emergency preparedness including the use of innovative approaches to build back better.

The WHO Secretariat and partners should:

21. Learn from recent outbreaks such as COVID-19 and Ebola virus disease and urgently develop a revised strategy for emergency preparedness and response, 2022–2030, focusing on how to build resilient health systems.

22. Develop a strategy to mobilize human and financial resources for its implementation.

23. Strengthen the regional platform for implementing the One Health approach by improving the involvement of the animal and environmental sectors in health emergency preparedness and response.

24. The Regional Committee reviewed this progress report and endorsed the next steps.

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[10] Angola, Benin, Burundi, Central African Republic, Congo, Democratic Republic of Congo, Ghana, Guinea-Bissau, Lesotho, Mali, Mauritius, Niger.

[11] Botswana, Cabo Verde, Eritrea, Equatorial Guinea, Gabon, Sao Tome and Principe.

[12] Angola, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Mauritius, Mozambique, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leon, South Africa, Uganda, United Republic of Tanzania

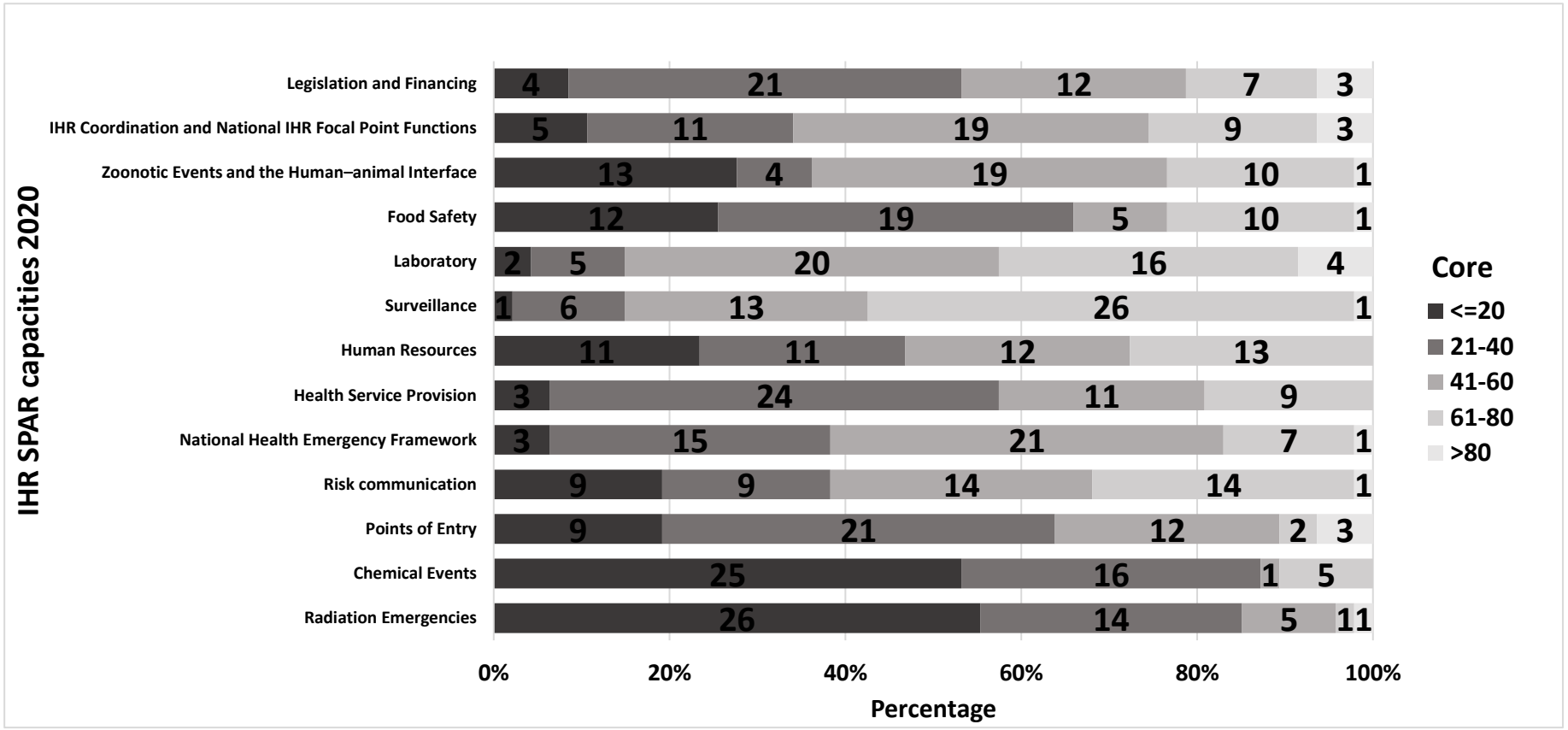
[13] Algeria, Burkina Faso, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Malawi, Mozambique, Namibia, Rwanda, Senegal, Togo, Uganda.

Annex 1: Progress against milestones and targets of the Regional strategy for health security, 2016-2020

Milestones and Targets	Progress Made
To strengthen and sustain the capacity of all the 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 10 Member States have the required IHR capacities for this technical area.
(b) All Member States have budget lines and allocated domestic resources to support IHR implementation by 2018.	Only 10 Member States reported to have mobilized adequate financing to support IHR implementation.
(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.	46 Member States (98%) had conducted a JEE by the end of 2020, surpassing 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.	Risk profiling and mapping was carried out in 39 Member States (83%). In addition, a comprehensive regional epidemic risk assessment and mapping was conducted in 2016 for all epidemics reported in Africa between 1970 and 2016.
(e) At least 80%, of Member States have all-hazards preparedness plans that are tested and resourced by 2018.	31 Member States (66%) had costed their NAPHS. This falls short of the target
(f) At least 80% of Member States will have the minimum IHR core capacities, by 2020	In 2017, 2018, 2019 and 2020, all 47 Member States submitted their IHR annual reports compared to 20 and 22 Member States in 2015 and 2016 respectively. No African country has attained the required IHR capacities (Annex 2).
(g) A regional health workforce developed in collaboration with partners, including the Africa CDC, by 2017.	A regional workforce has been set up. The regional workforce has been instrumental in responding to recent outbreaks in the Region.
To strengthen and sustain the capacity of all 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 the end of 2020, Member States (98%) were implementing IDSR. However, only 21 (45%) Member States were implementing IDSR with at least 90% coverage at subnational level.

Milestones and Targets	Progress Made
(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.	20 Member States (>43%) have the required IHR capacity for this technical area by 2020 (Annex 2).
To strengthen and sustain the capacity of all the 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.	41 Member States (87%) had established PHEOCs by 2020. Of these, 28 were fully functional, 13 were in the process of becoming fully functional and 4 were at the establishment stage.
(b) Over 90% of Member States have a multi-level and multi-faceted risk communication strategy for real-time exchange of information, by 2020.	15 Member States (32%) have the required IHR capacity for this technical area (Annex 2).
(c) 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.	13 Member States (28%) have the required IHR capacity for this technical area

Annex 2: Number of countries in each IHR technical capacity, 2020 (State Parties Annual Report)



Annex 3: Top 10 outbreaks in 2019 and 2020 in the WHO African Region