ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency preparedness and response flagship programmes

#1
QUARTERLY REPORT

MAY 2022

World Health Organization

Table of **Contents**

World Health Organization

ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency preparedness and response flagship programmes

Acronyms

Africa CDC	Africa Centres for Disease Control and Prevention
AVoHC	African Health Volunteers Corps
BMGF	Bill and Melinda Gates Foundation
COVID-19	Coronavirus Disease 2019
EMRO	World Health Organization Regional Office for the Eastern Mediterranean
EPR	Emergency Preparedness and Response
GBV	Gender-Based violence (GBV)
GPW 13	World Health Organization's 13th Global Programme of Work
HEPR	Health Emergency Preparedness and Response
HR	Human resource
IDSR	Integrated Disease Surveillance and Response
IPC	Infection Prevention and Control (IPC)
M	Million
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NAPHS	National Action Plan for Public Health Security
PSEA	Protection from Sexual Exploitation and Abuse
PHEOC	Public Health Emergency Operations Center
PROSE	Promoting Resilience of Systems for Emergencies
RCCE	Risk Communications and Community Engagement
RRT	Rapid Response Teams
SOP	Standard Operating Procedure
SURGE	Strengthening and Utilizing Response Groups for Emergencies
TASS	Transforming African Surveillance Systems
TOR	Terms of Reference
USD	United States Dollar
WASH	Water, Sanitation, Health and Hygiene (WASH)
WHE	World Health Emergencies Programme
WHO	World Health Organization
WHO AFRO	World Health Organization Regional Office for Africa

Table of **figures**

Message from the **Regional Director**

Dr Matshidiso Moeti
Regional Director, WHO AFRO

Building the capacity of member states to adequately prevent, prepare for, detect, and rapidly respond to health emergencies is more critical now than ever. This is even more so in the African region where over a hundred emergencies occur each year adding to the unprecedented strain brought by two years of COVID-19 on public health systems and on society at large.

The World Health Organization Regional Office for Africa (WHO AFRO), in accordance with recommendations from various WHO committees[1], has developed three flagship programmes to support Member States in the African region to prepare for, detect and respond to public health emergencies. The programmes are the following:

1. Promoting Resilience of Systems for Emergencies (PROSE)
2. Transforming African Surveillance Systems (TASS)
3. Strengthening and Utilizing Response Groups for Emergencies (SURGE)

They are the result of extensive consultations with more than 30 African government ministers, technical actors, partners across the continent as well as regional institutions such as the Africa Centres for Disease Control and Prevention (Africa CDC), whose contributions have shaped the priority activities. They build on efforts made by multiple actors over the past decades to build strong EPR systems in Africa.

So far, implementation has been led by WHO AFRO's Emergency Preparedness and Response (EPR) Cluster; however, this is changing. In the coming weeks and months, we will work with our partner, Africa CDC, and with our colleagues within WHO's Regional Office for the Eastern Mediterranean (EMRO) and the World Health Emergencies (WHE) Programme in Geneva to implement all three flagships under a common umbrella covering not only the AFRO region, but the entire African continent.

Since early 2022, our teams have endeavoured to roll out the

1 Independent Panel on Pandemic Preparedness and Response (IPPPR), the IHR Review Committee and the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme

flagships focusing on SURGE. They have been working closely with colleagues at the headquarter level and in WHO Country offices to sign formal agreements with governments, co-create roadmaps, crystallize critical partnerships, secure resources all while responding to the various disease outbreaks and public health emergencies across the continent. We are grateful for their service.

In terms of progress, implementation has begun in five (5) countries (Bostwana, Mauritania, Niger, Nigeria, and Togo) and plans are underway to expand to twelve (12) more by December 2022. These countries include Angola, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Kenya, Namibia, Rwanda, Tanzania, Uganda, Ethiopia, and, Senegal. This initial set of countries were selected for early implementation based on criteria including the willingness of the country government to implement the programmes, their willingness to contribute, the human resource capacity of the WHO country offices to coordinate the programmes, and the strength of the capacity of the Ministry of health in these countries to support implementation. This year, we are on course to develop a 1,000 of the 3,000 emergency experts and elite responders we aim to have on the continent when at full scale. This first annual cohort will be for the initial set of seventeen (17) countries we are targeting in 2022. Selected from various line ministries through a competitive process, they will be trained using a world class emergency preparedness and response curriculum developed by WHO teams and partners. All the experts will be certified and integrated into the emergency expert database we are establishing for the continent. The certification and integration processes are currently being defined. Each emergency expert team will be equipped with the means of transportation, as well the minimum package of supplies and equipment to respond to any outbreak in their country. WHO is providing vehicles in this initial phase and making a seed investment of USD 1 in each country to jumpstart activities. The hope is that this will spur investements from other partners and from the government in the short and medium term. Moreover, we are working with governments to make sure that the much-needed Public Health Emergency Operations Centers (PHEOCs) have the legal mandate, appropriate anchoring, plans and procedures, human and material resources as well as the infrastructure needed to become the host of emergency expert teams and to spearhead emergency preparedness and response activities. Although the EPR Cluster is taking the lead, the work under the flagships will be executed using all of WHO's capabilities at the global, regional, and particularly, the country level. Overall, we are invigorated by the enthusiasm and efforts being deployed by governments to make sure the flagships are set for success.

So far, they have committed to lead 80% of the activities at the country level and have assigned senior technical officers for implementation. Moreover, among the countries hosting our upcoming sub-regional hubs (Kenya, Senegal, and South Africa), the governments of Senegal and Kenya have offered land for us to establish our centers of excellence. The hubs are the places where the EPR Cluster is moving most of its staff currently sitting in the regional office in Brazzaville as part of its fit for purpose initiative, which aims to ensure that we have the capabilities, the capacity and the adequate organizational design to deliver on the flagships.

As for the centers of excellence, they will be part of the sub-regional hubs, and will support the flagships. With support from the WHO Academy, the centers will take on a variety of sub-regional activities including workforce development; logistics and stockpiling; data, innovation and intelligence; research and development; and genomic surveillance.

All this shows the extent of the momentum that is building around the flagships and the opportunity they represent to unlock existing systemic challenges and develop African-driven solutions that address regional, national, and local needs. As we take stock of our progress from the past quarter, we are keen for feedback from partners, Member States, and colleagues to ensure that the flagships deliver the impact we all seek through our work: to ensure that people in the African region are better protected from public health emergencies.

Dr Matshidiso Moeti
Regional Director, WHO AFRO

Key **Highlights**

30+

African government ministers consulted to design the flagships and to define the pillars and priority activities

An unprecedented **partnership**

with **Africa CDC, WHE/HQ, WHO AFRO, BMGF** and **WHO EMRO** to jointly implement the flagships in all countries in Africa over the next five years

Scoping missions carried out in **5 of 17** countries selected for the initial implementation phase

Of the 5 countries:

03 have signed **MOUs** with **WHO** and the others finalizing their documents

04 have validated their **Roadmaps;** the remaining roadmap is being finalized

05 have appointed senior officers at the highest level of government to **spearhead activities**

USD1m

WHO is providing USD 1m in seed funding to each country, to jumpstart activities and attract other investments

In commitment to WHO, national governments have allocated **5 and 12 hectares** of land, in **Senegal and Kenya**, respectively

A total of **120 vehicles** have been shipped across **15 countries**

4/5

countries are on track to complete phase 1 of the training of their emergency experts by the end of June 2022.

All participating countries have identified a **warehouse to stock medical supplies and equipment, while 40%** have identified priority medical supplies to be procured

1000

Activities are on track to train 1,000 emergency experts in 2022 out of the **3000+ planned** for the continent and to create a database to track their utilization and availability

Introduction

The health and economic impacts of the COVID-19 pandemic highlighted pre-existing challenges and weaknesses facing health Emergency Preparedness and Response (EPR) and health security in African countries. Globally, the African region reports the heaviest burden of public health emergencies with more than a hundred public health events taking place annually[2], causing damage to health and economic systems in its countries.

These public health emergencies have catastrophic effects as they overwhelm already-weak health systems, interrupt essential health services and fuel socio-economic disruption. The COVID-19 pandemic was no exception; it exposed the weaknesses in the health emergency preparedness and response systems in the African region all the while compounding the damage done by other public health events in Africa. The scale of the pandemic laid bare key challenges plaguing the health emergency preparedness and response systems in the African region, especially around the following:

- **Implementation of international health guidelines and frameworks**: Countries in the African region still struggle to implement frameworks related to health emergency preparedness and response. This creates barriers to the implementation of public health interventions.

- **EPR workforce challenges**: Less than 10% of countries in the African Region have optimal and sustainable human resources to prepare for, detect and respond to public health risks and emergencies[3]. This challenge puts a strain on the existing workforce to the point of overwhelming the entire system, especially during large-scale health emergencies. To compound the issue, the existing workforce have limited technical health emergency know-how, especially within Rapid Response Teams.

The COVID-19 pandemic exposed the weaknesses in the health emergency preparedness and response systems in the African region

Countries in the African region lack sustainable and predictable financing, relying largely on international funding

2 Impouma, B., Roelens, M., Williams, G., Flahault, A., Codeço, C., Moussana, Farham, B., Hamblion, E., Mboussou, F., Keiser, O. (2020). Measuring Timeliness of Outbreak Response in the World Health Organization African Region, 2017–2019. Emerging Infectious Diseases, 26(11), 2555-564. https://wwwnc.cdc.gov/eid/article/26/11/19-1766_article. [Accessed 6 Dec. 2021].

3 WHO Health Emergency Programme, Joint external evaluation of the International Health Regulation (2005) capacities: current status and lessons learnt in the WHO African region, 2019.

- **Limited availability of emergency supplies**: The lack of logistics hubs within the African region limits the availability of emergency supplies and stockpiles and exacerbates response time. Currently, the region relies on logistics support from WHO's central logistics hub and from other agencies. Within this framework, it can take up to 20 days before countries receive supplies compared to necessary rapid response time of 24 to 48 hours.

- **Financing of EPR work**: With limited capacity to mobilize resources domestically, countries in the African region lack sustainable and predictable financing, relying largely on international funding. This challenge contributes to, and reinforces, all other challenges related to EPR in the region.

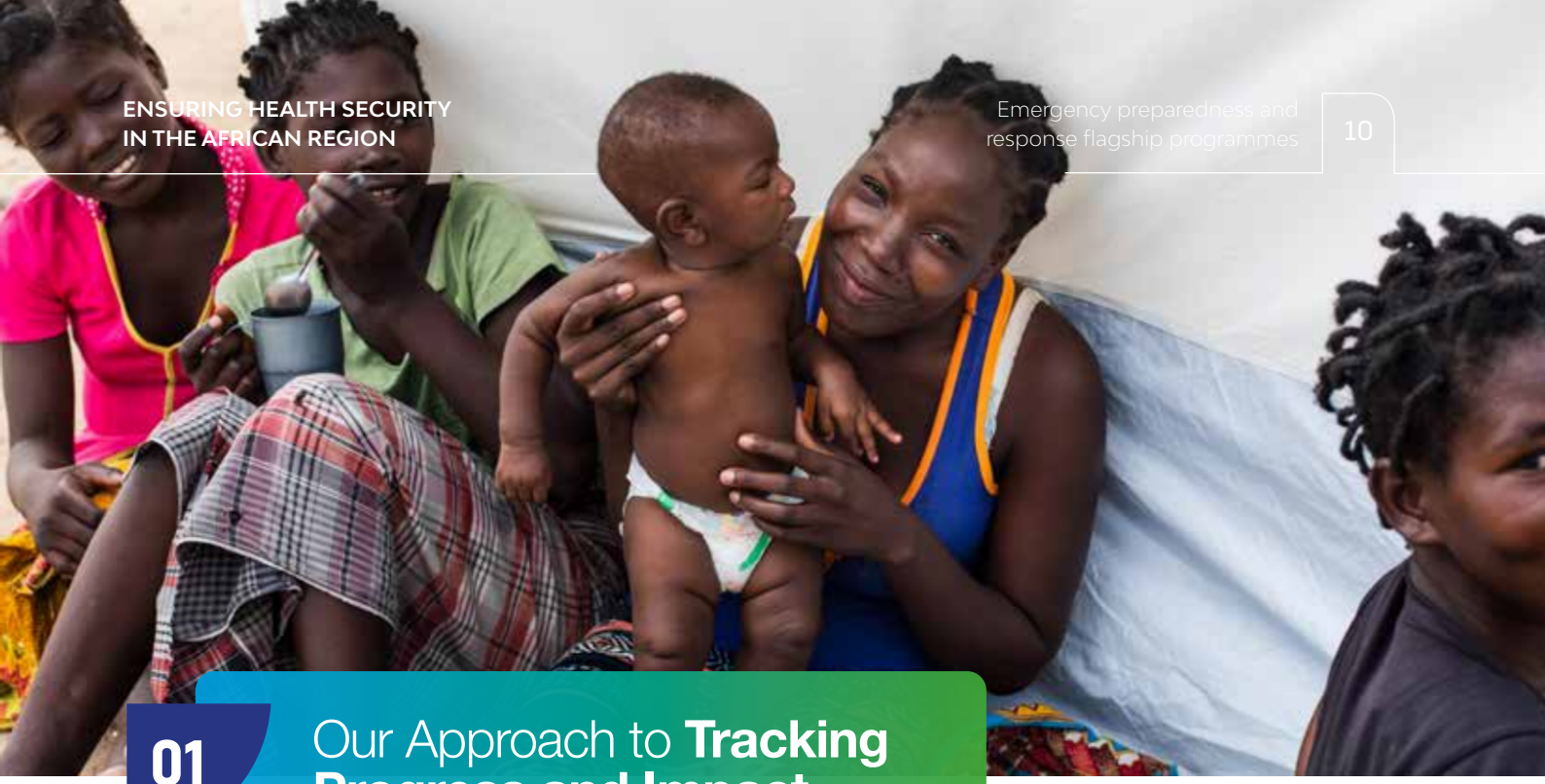
To address these challenges and improve health security in the African region, the WHO AFRO EPR Cluster launched three flagship programmes in early 2022. The overarching goal of the flagship programmes is to promote health security in the African Region and contribute to the achievement of the Sustainable Development Goal 3 - "ensure healthy lives and promote well-being for all at all ages." The programmes align with, and aim to contribute to, achieving the outcome area two of WHO's Thirteenth Global Programme of Work (GPW 13) which is to ensure that one billion more people are better protected from health emergencies. More concretely, the objectives of the flagships are to support Member States to prepare for and prevent disease outbreaks and health emergencies; promptly detect, speedily report, and confirm outbreaks; strengthen and sustain their capacity to promptly respond to, and recover from, the negative effects of outbreaks and health emergencies.

The three flagship programmes are *Promoting Resilience of Systems for Emergencies (PROSE), Transforming African Surveillance Systems (TASS), and Strengthening and Utilizing Response Groups for Emergencies (SURGE).*

These flagship programmes have already begun work in selected countries, making substantial progress on their plans for the year 2022. With the Africa CDC as a key partner, we have engaged in extensive consultations with various stakeholders and Member States to expand to more countries in 2022. The ambition is to eventually expand to the entire African continent; consultations have already begun with our colleagues from the WHO Regional Office for the Eastern Mediterranean (EMRO) to build strategic alignment and make sure the entire continent is covered.

This document provides an overview of the progress the flagship programmes have made to date to achieve the impact outlined in the theory of change for the programmes, measured against the plan for the year 2022. The document focuses on the SURGE flagship which is being implemented in five countries selected for quarter 1 and highlights key learnings from those countries, WHO, partners and from the EPR ecosystem. This first quarterly report reflects the work conducted by the WHO's EPR Cluster mainly. The following ones will report on the joint implementation that will unfold under the Africa CDC, EMRO, and WHO AFRO partnership. Through these quarterly reports we seek to provide visibility to key stakeholders including partners, donors, and Member States, and to hold ourselves accountable to the impact we seek.

> The overarching goal of the flagship programmes is to promote health security in the African Region and contribute to the achievement of the Sustainable Development Goal 3 - **"ensure healthy lives and promote well-being for all at all ages."**



01 Our Approach to **Tracking Progress and Impact**

Our theory of change reflects the impact that our three flagship programmes are seeking to achieve in the African region, in line with WHO's Thirteenth General Programme of Work (GPW 13). GPW 13 defines WHO's strategy for the five-year period, 2019-2023, which focuses on triple billion targets to achieve measurable impacts on people's health at the country level. The triple billion targets have three main outcome areas outlined in Figure 1 below.

Figure 1: WHO's Thirteenth General Programme of Work (GPW 13) 2019-2023

The triple billion targets seek to ensure that by 2023:

1

One billion

more people are benefiting from universal health coverage

2

One billion

more people are better protected from health emergencies

3

One billion

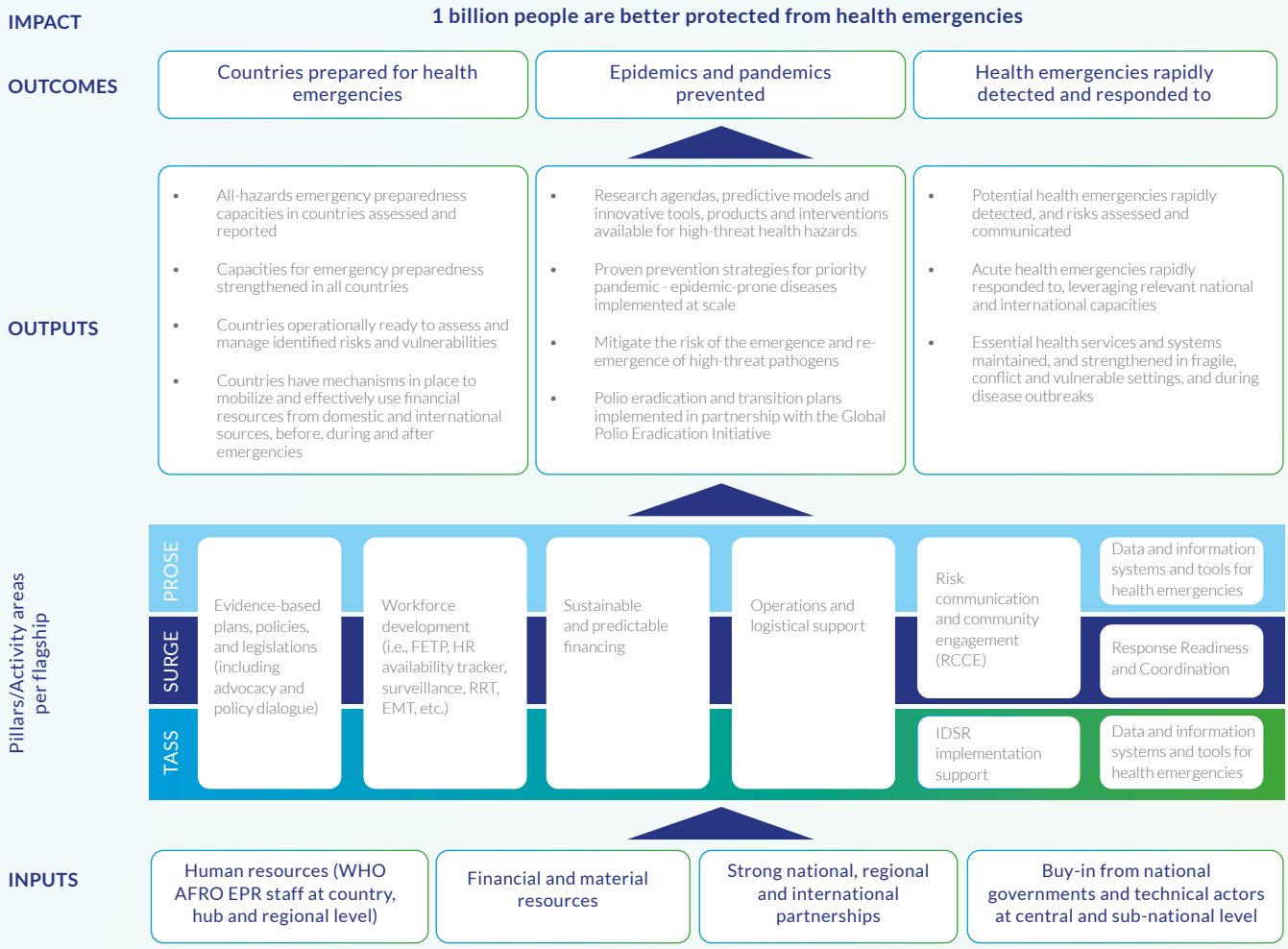
more people are enjoying better health and well-being

Focus of the flagships

The results framework for the flagship programmes is the extension of the second outcome area of GPW 13 in the African region. Thus, the impact of the flagships will contribute to ensuring that 1 billion people are better protected from health emergencies across the globe, with a focus on countries within the African region.

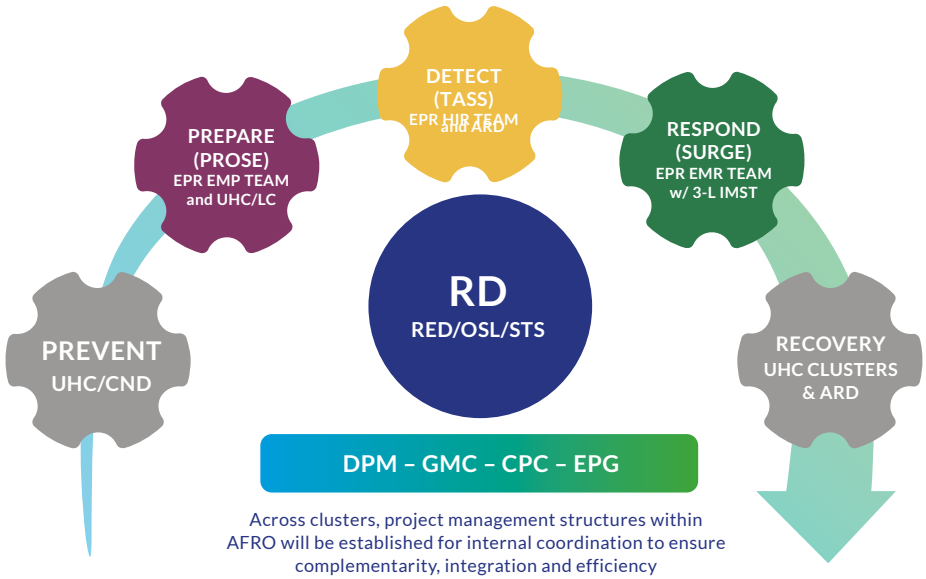
The impact of the flagships will be achieved through mutually reinforcing outcomes and outputs that each flagship programme will work distinctly towards. To contribute towards better protecting 1 billion people from health emergencies, the flagship programmes have three outcome areas– countries are prepared for health emergencies (preparedness), epidemics and pandemics are prevented (prevention), and health emergencies are rapidly detected and responded to (detection and response). Each of these outcomes has outputs that will help us measure progress periodically to ensure that we are consistently working towards our goal. Figure 2 below summarizes our theory of change and shows the linkage between our work at the regional and national level and WHO's overall strategy in the EPR sector.

Figure 2: Theory of change for the flagships



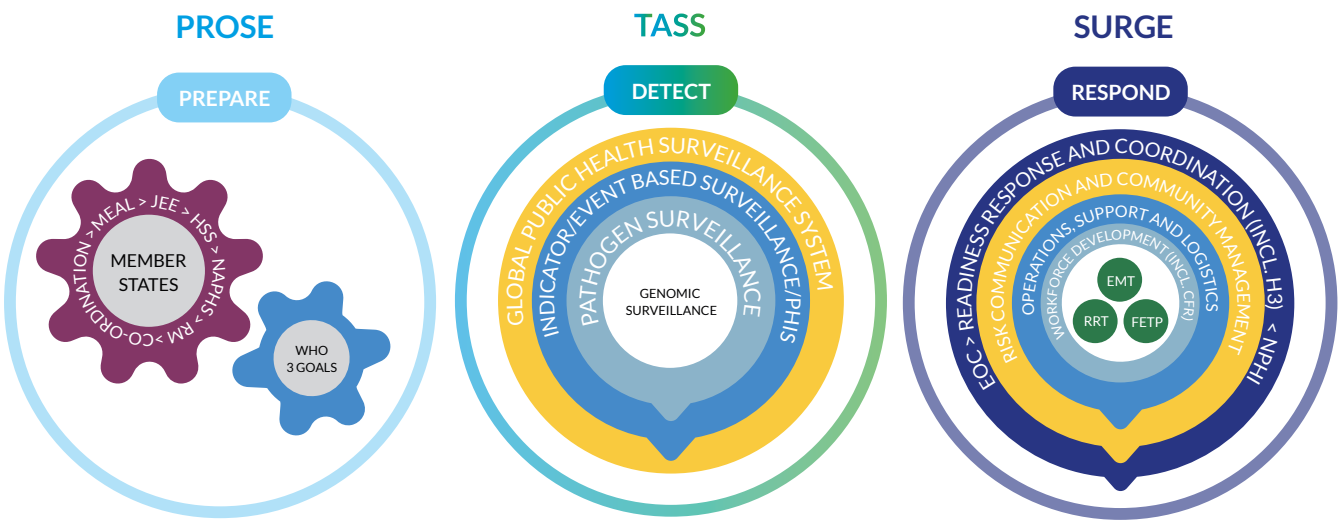
As a regional organization, we recognize the need for a systemic approach to solving challenges in the public health sector. That is why, we are considering the entire lifecycle of emergencies. We will leverage the strengths of all WHO AFRO Clusters in order to cover the entire lifecycle of emergencies. Figure 3 below shows how different parts of WHO AFRO will complement each other and build on existing synergies in order to prevent, prepare for, detect, respond to, and recover from public health emergencies.

Figure 3 : Role of the clusters in the WHO region in the emergency lifecycle



To achieve the outcomes and outputs outlined in the theory of change mentioned above, each flagship programme will undertake a set of activities grouped under specific pillars. Most activities planned under the flagships will be cross-cutting with some exceptions. We are conscious that the implementation of these activities, especially the cross-cutting ones, will require a tight coordination between programme teams, partners, and Members States to ensure that countries are optimally served. These include the development of evidence-based policies; plans and legislation in the EPR sector; workforce development; sustainable and predictable financing; operations and logistics support; risk communication and community engagement (RCCE); and data and information systems. Figure 4 below illustrates the types of activities each flagship with cover and how they integrate with the existing frameworks in the EPR sector.

Figure 4: Illustrative framework of the flagships



To execute the activities outlined in the workplans for the flagships, key inputs such as complementary partnerships, buy-in from multi-sectoral stakeholders as well as human and financial resources are needed. WHO AFRO has already identified and begun work with some partners, including the Africa Centres for Disease Control and Prevention (Africa CDC), to have a consolidated strategy for preparedness, detection, and response. We are also constantly working with our colleagues within WHE HQ to make sure all activities on the ground are within the scope of the new global architecture for health emergency preparedness and response (HEPR). Recognizing the need for buy-in from national governments and actors at the central and sub-national levels, all our stakeholder engagements will ensure that the various levels have an active role. Regarding resource mobilization, we will make initial investments to jump-start activities, but expect engagement from national governments and partners for activities to reach scale and realize their potential.

In doing this work, we acknowledge that some factors are outside of our sphere of control or influence. The stable political, environmental, and socio-economic conditions in countries, continued investments by partners at the country level in other public health emergency preparedness and response, and commitment from stakeholders at all levels are three assumption areas that underline the overall coherence of the theory of change.

To keep ourselves accountable to our stakeholders and ensure that we are making progress towards our goal, we have defined key performance indicators that we will track on a quarterly basis. The performance indicators reflect the result of discussions with partners and national governments on how we hold each other accountable and learn from the collective body of our work. Figure 5 shows the non-exhaustive list of performance indicators covering pillars of the SURGE flagship programme.

We will continue to refine the indicators and strengthen our monitoring and evaluation capabilities. In addition, we will produce quarterly and annual reports to keep all stakeholders informed of our progress, challenges, and opportunities, and to share our learnings. While the quarterly reports focus on progress towards implementation, the annual reports will be specific to GPW 13 output indicators and will present the opportunity for us to take stock of the progress towards our outcomes and outputs and the overall impact defined under the strategic plan for 2019-2023 that we are operationalizing.

The performance indicators reflect the result of discussions with partners and national governments on how we hold each other accountable and learn from the collective body of our work

Figure 5: List of indicators to track implementation for the SURGE programme (not exhaustive)

Overall programme management

1. Number of countries where scoping missions and baseline assessments have taken place
2. Number of governments that gave their formal approval for the flagships through signed MOUs
3. Number of countries where a roadmap has been developed with a budget and an implementation plan
4. Number of countries where a programme coordinator has been designated in addition to EPR staff and WHO Country Office staff
5. Number of countries where implementation has already started

Workforce development

1. Percentage of countries where phase 1 SURGE training activities have been completed
2. Percentage of target people identified who completed both phases 1 and 2 of the SURGE training
3. Percentage of trained personnel (by gender) who are registered on the SURGE E-database for response activities in each country
4. Emergency expert team breakdown by line ministry
5. Average number of days spent per month by emergency expert team members on response activities

Response readiness and coordination

1. Percentage of target countries where the PHEOC has a legal mandate
2. Number of countries where the PHEOC has the appropriate anchoring (dependent on context)
3. Percentage of required key plans and procedures (for emergency preparedness and response) developed and validated in each country
4. Percentage of public emergencies for which the PHEOC has been activated
5. Extent to which multisectoral health emergency or humanitarian coordination platforms are functional

Operations and logistical support

1. Percentage of emergency expert teams with adequate transport means
2. Adequacy of storage conditions of medical products and supplies at country level
3. Timeliness of the deployment of supplies from hubs for each country
4. Adequacy of WHO's stock levels (in the hubs) relative to needs for each country

Risk Communication and Community Engagement (RCCE)

1. Number of countries where multisectoral RCCE focal points have been nominated at both national and subnational level
2. Number of countries where 5-year RCCE plans have been developed
3. Number of outbreaks for which RCCE activities have been conducted
4. Percentage of target countrieswhere monitoring and evaluation activities have been conducted for RCCE activities

02 Plan for 2022 – Spotlight on SURGE

For 2022, each flagship programme has outlined plans that are aligned to their 5-year strategic objectives to support the African region in emergency preparedness and response. The 5-year goal is to rollout all three flagships to the entire African continent in collaboration with Africa CDC and WHO EMRO. Eventually, the ambition is to make these a bi-continental programme covering countries in EMRO. For 2022, we are targeting an initial set of 17 countries where all three flagships will be rolled out. More specifically, for PROSE, the goal for 2022 is to determine a clear roadmap with each of the 17 countries in collaboration with our partners and begin implementation under each of the five pillars defined. For TASS, the goal is to assess the needs of the targeted countries, define implementation modalities and provide laboratory strengthening services. As for SURGE, this is where we are putting the most effort because of the immediate need to make sure countries have the workforce, operations and logistics support, along with the coordination mechanism needed to stop the next pandemic. As such, the plan for 2022 is to launch the programme in all seventeen countries. Figure 6 provides a summary of the high-level plans for each flagship programme for the year 2022[4].

Figure 6: Overview of the 2022 plan for each EPR flagship programme

Focus of the Q1 report

PROSE

The programme is currently in the preparation phase. The following high-level activities are planned:

- **Development of overarching program roadmap with budgeted activities and timeline:** Following consultations with Africa CDC, and new guidance from WHE HQ, prioritize key activities for the next two years
- **Scoping missions:** Conduct scoping missions in the initial set of countries and identify synergies with ongoing SURGE programme activities
- **Implementation of priority activities from partner consultations:** Begin implementation of the flagships in the initial set of countries while focusing on the priority activities identified with Africa CDC, WHE HQ, and Member States

TASS

The programme is currently in the preparation phase. The following high-level activities are planned:

- **Initial assessments of countries:** Revise tools to be used for country assessments following final country selection for programme rollout
- **Extensive Member State and partner consultations:** Engage with Member States and partners together to help assess and validate country needs, while aligning with other programme areas on the initial set of countries
- **Proposal development:** Develop proposals for laboratory strengthening with Africa CDC and a blueprint for surveillance with the World Bank, in line with the Bank's REDISSE project building on the MOU that already exists between the two institutions

SURGE

The programme has launched in a set of five initial countries. The next steps include the following:

- **Implementation of programme activities:** Provide support to various country teams leveraging regional and global partnerships, expertise within WHO and beyond to ensure success across the different programme pillars
- **Programme scale up:** Conduct scoping missions to the remaining 12 SURGE countries and begin implementation learnings from the first set of countries; mobilize resources to enable scale up of activities
- **Programme monitoring and facilitation of learning across countries:** Monitor progress in each country and facilitate sharing of lessons learned, challenges and opportunities across countries

Yet to be launched

Launched (in 5 countries)

In each SURGE country, we aim to ensure that they have human and material resources, as well as an efficient and cohesive coordination mechanism needed to tackle any disease outbreak or emergency. Across the 17 countries, we will train 1,000 elite workforce, provide a transport fleet of 8 vehicles per country, put in place the minimum stock needed to tackle the priority diseases, set up or strengthen national public health emergency operations centers, and strengthen risk communication and community engagement. To achieve this, we have structured our work around four main pillars.

Pillar 1 - Workforce Development

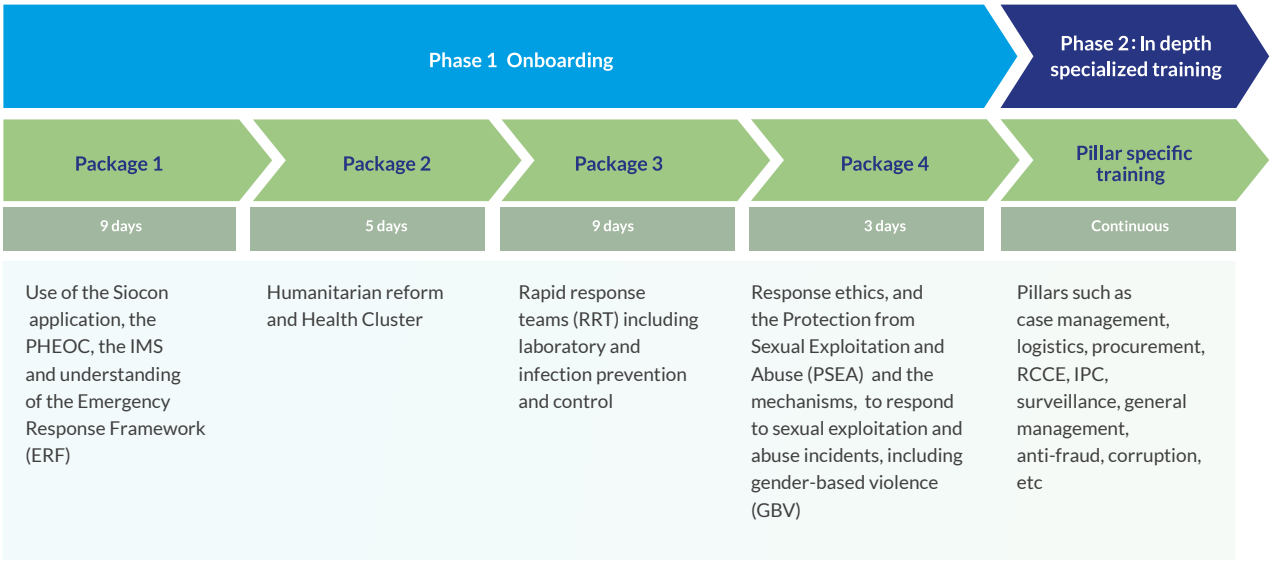
The goal of this pillar is to ensure the availability of a dedicated, well-trained, and ready-for-deployment multidisciplinary health emergency expert teams at the national and sub-national levels to enable quicker initial mobilization of high-caliber African responders (within 24 hours) and a shorter response time to emergencies.

The work under the pillar brings together WHO and Africa CDC to support African governments, to strengthen and integrate Africa's health emergency workforce by establishing a cadre of 3,000+ African emergency experts and responders. Each country on the African continent will have one integrated team of emergency experts, apart from countries that are considerably large and/or have high complexity emergency operations: Nigeria (3 teams), Ethiopia (3 teams), DRC (3 teams), Madagascar (2 teams). Overall, we will establish ~61 teams consisting of ~50 people, totaling a workforce of 3,000+ elite African responders, with the support of administrative and technical staff from WHO and Africa CDC. Wherever possible, the project will make use of existing regional, national, and sub-national emergency response structures.

The work under this pillar will build upon the African Health Volunteers Corps (AVoHC), a network of African volunteer medical and public health professionals established by the African Union to support emergency response to disease outbreaks in Africa. AVoHC was created by the Assembly of African Union Heads of State and Government during their 25th Ordinary Session in Johannesburg, South Africa, in June 2015. AVoHC brings a mandate from the highest levels of government along with an extensive database of approximately 900 experts, 200 of which have been deployed so far – which will lay the foundation for the work under this pillar.

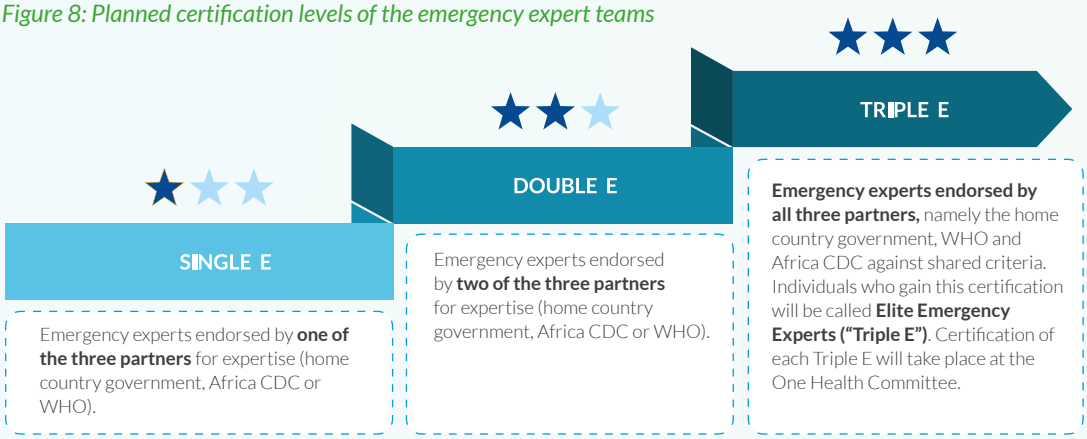
In terms of the content of the training, it draws from best practices identified over the past years in terms of emergency preparedness, detection, and response. The training in the initial set of countries will be conducted in two phases described in Figure 7 below. The training will cover general as well as in-depth, specialized and sector-specific content. Both the process and content will be further refined based on the learnings and feedback of participants, staff, and partners.

Figure 7: High-level training programme for the emergency expert teams



Respecting that WHO, Africa CDC and governments may have distinct criteria for recognizing emergency expertise, there will be credentialing by three levels as indicated in Figure 8 below.

Figure 8: Planned certification levels of the emergency expert teams



The emergency expert teams will be composed of laboratory experts, epidemiologists, anthropologists, entomologists, veterinarians, data managers, as well as experts from other sectors such as field logistics and coordination; infection prevention and control (IPC); risk communications, community engagement; gender-based violence; water, sanitation, health and hygiene (WASH), nutrition; finance and administration; and mental health and psychosocial support. They will include individuals who are part of existing rosters (e.g., AVoHC roster, WHO AFRO roster, government rosters, FETP rosters), which will be integrated as much as possible to maximize efficiency. This approach will enable response efforts to tap into a wide pool of talent efficiently while also recognizing and elevating highly experienced leaders.

Furthermore, all emergency expert team members will receive various resources and benefits. They will have access to in-person and virtual learning programmes, in varied formats – digital, lecture and simulation-based training to ensure up-to-date and consistent knowledge of response actions in an emergency. Apart from the civil servant positions they hold, they will receive an additional contract with the government to serve as experts and be available for rapid deployment when surge capacity is needed within the sub-region. Advance arrangements will be made to ease deployment– this will include ensuring experts have up-to-date vaccinations, passports, visas and completion of WHO travel and safety training. Expert teams in the WHO African Region will be supported by the sub-regional Hubs and Centers of Excellence.

The general plan for 2022, under this pillar will be to establish the emergency expert teams in the 17 initial set of countries selected for implementation. To do this, we have established a generic process illustrated in Figure 9, which will be adapted based on the country context. This process has been carefully designed to ensure legitimacy for the emergency expert teams to respond to emergency HR needs at the country level, to ensure transparency and rigor in the selection of candidates, and to build on the best available knowledge to date on public health emergency response.

Figure 9: Generic process for establishing emergency expert teams

Pillar 2 - Response Readiness and Coordination

For this pillar, the aim to create a unique coordination point for the management of all emergency preparedness and response activities, namely Public Health Emergency Operations Centers (PHEOC) or equivalent institutions which are a requirement of the 2005 International Health Regulations.

The work under this pillar will involve establishing a governance mechanism and the legal framework for the PHEOC in each country, developing plans and procedures, putting in place the infrastructure for minimum operational readiness, and establishing rigorous training programmes linked with the workforce development pillar. Additional work linked to this pillar will include joint advocacy and policy dialogue with global, regional, and local partners to establish the minimum resources, particularly staff, required to operate the PHEOCs at all times. This is where the partnership with Africa CDC and WHO is crucial. We will join our voices and resources to advocate and implement jointly and bring awareness at the highest decision-making spheres and at technical levels to create better coherence and cohesiveness in response readiness and coordination. While this work is underway, WHO will continue to work with the national government to conduct regular country capacity and risk assessments, strengthen country readiness through simulation exercises involving various line ministries, foster exchange of best practices and experiences among PHEOCs or relevant institutions through regional network of PHEOCs. The activities planned for this year will establish the foundation for institutions fit for response coordination. The next years will build on this foundational work. Figure 10 below outlines the generic activities we plan to undertake in each country over the next months to ensure better response readiness and coordination.

Figure 10: Generic list of activities under the response readiness and coordination pillar for 2022

Governance and legal framework

- Conduct assessment of PHEOCs in countries – capacity, readiness, operationalization, equipment, etc.
- Map existing laws and regulations on public health emergency management and on PHEOCs
- Revise the decree establishing the PHEOC (based on the context) to improve its anchoring
- Conduct high-level advocacies for the PHEOC to become the coordination center for the management of public health emergencies
- Revitalize or set up the steering committee to provide strategic guidance and oversee the operationalization of the PHEOC

Plans and procedures

- Conduct a baseline assessment of checklists and readiness plans; and assess gaps in planning
- Evaluate/update emergency management procedures (coordination, operation, logistics, communication, resource mobilization, etc.)
- Update key response plans such as multi-hazard preparedness and response plan, risk assessments, etc.
- Develop/update SOPs for activation, deactivation, notification, reporting, engagement and coordination requirements between disaster management, law enforcement, national security agencies, and other sectoral agencies
- Put in place streamlined procedures for deploying emergency expert teams and managing emergency funds

Infrastructure, material and human resources

- Appoint focal points for other sectors such as environment, livestock, army health services, social actions, etc.
- Identify a physical location for the PHEOC with adequate space to accommodate routine and surge staff
- Define information and communication technology requirement for the PHEOC and equip it with the necessary ICT/telecommunication facility
- Operationalize emergency expert team database and track their utilization and retention

Training, information and data systems and operationalization

- Establish a training and simulation exercise plan to enable regular capacity building of response personnel
- Conduct regular risk assessments to identify potential public health hazards
- Put in place a system / mechanism for required data and information to systematically flow to PHEOC from different departments, sectors and agencies and integrate in a central information system
- Set up a system to facilitate communication and information monitoring

Pillar 3 - Operations Support and Logistics

The objective under this pillar is to ensure the timely and effective deployment of emergency supplies and human resources, as well as the transportation, procurement, and distribution of supplies at regional, national and sub-national levels. In 2022, our immediate focus will be that the trained emergency expert teams have means of transportation, access to medical supplies and equipment, and that those resources be adequately and responsibly managed. More concretely, we will provide training to selected logistics officers from the countries, help the countries review their storage capabilities, and make recommendations on how to optimize the use of existing infrastructure to store two weeks' worth of supplies, provide design for warehouse facilities where needed, provide USD350,000 to USD400,000 worth of supplies which will be stored at WHO's sub-regional logistics hubs and subsequently distributed when and as needed. This will help avoid expiry of sensitive stocks should we send the supplies to the countries and no needs occur. The ultimate end goal is to reduce the average time it takes for medical supplies and equipment to reach countries from 20 days to 24-48 hours.

Figure 11: Generic list of activities per country under the operations support and logistics pillar in 2022

Equip emergency expert teams with transport means

- Acquire vehicles for transport of emergency expert teams to tackle diseases outbreaks and other emergencies
- Identify parking area for the fleet of public health emergency response vehicles
- Identify and secure with WFP, the military services, and other partners, means of transportation in addition to the team-dedicated fleet

Set up or improve warehousing

- Build, rent or optimize warehousing space dedicated to the storage of medical supplies and equipment for response
- Operationalize WHO EPR logistics hubs in the African region

Identify and acquire priority medical supplies

- Identify priority products to be stocked based on the epidemiological profile of the country and purchase basic stock
- Assess gaps relative to existing national stocks

Develop or optimize inventory system and distributions plan

- Set up or improve inventory management tools , systems, and procedures
- Develop distribution plans based on priorities defined nationally

Ensure adequate human and material resource management

- Develop procedures for deployments of emergency expert teams
- Develop procedures for the maintenance and use of transport means for emergency expert teams

Promote responsible waste management

- Identify key actors and initiatives relative to waste management in the emergency sector
- Update the plan for the management of waste from emergencies response activities and support its implementation

Pillar 4 - Risk Communications and Community Engagement (RCCE)

The objective of this pillar to ensure that public health threats are conveyed to all relevant parties in a transparent and timely manner and that communities are consulted, engaged, and informed on how to reduce their risk and better protect themselves[5]. In 2022, our focus will be to create cohesiveness in terms of RCCE at the national and sub-national levels to maximize the impact of ongoing efforts. We will do this by mapping all essential actors at national and sub-national such as media and key civil society actors in the RCCE sector, create a database and engage them consistently in RCCE activities before, during and after emergencies. We will also develop standardized training modules and manuals, conduct periodic trainings especially for media and community leaders, build global, regional and local partnerships, and foster standardized monitoring and evaluation practices. In all our work around RCCE, we will promote a multi-sectoral approach, innovation, and alignment across partners.

Figure 12: Generic list of activities per country under the RCCE pillar for 2022

Assess current RCCE capacity

- Conduct baseline assessments and in-depth social studies on RCCE at the national and sub-national levels
- Map existing RCCE action plans, partners, and initiatives
- Map key media actors to engage in times of emergency preparedness and response activities
- Engage key national RCCE institutions in the public and private sector to align on a common vision

Promote multi-sectoral coordination

- Identify and appoint focal points at sub-national level and across sectors
- Promote joint advocacy among partners around common issues
- Implement joint multisectoral coordination meetings on RCCE
- Strengthen coordination with other response pillars and sectors

Strengthen collaboration with local stakeholders and actors

- Identify and engage with stakeholders (NGOs, community associations) at sub-national level who engage in response activities
- Establish and maintain relationships with these stakeholders through periodic interactions
- Create a database of these partners and collaboratee with them to carry out response activities when needed

Develop integrated RCCE plans, SOPs, and tools

- Develop RCCE strategic plans, national RCCE frameworks and training manuals for RCCE
- Identify and build linkages between existing initiative and actors
- Conduct technical working meetings for the development and validation of tools with the communities
- Ensure that proven strategies for community engagement are integrated in RCCE strategic plans

Support implementation activities

- Provide communication materials on a need basis
- Strengthen media engagement through media trainings for spokespersons and media houses, periodic media briefings and information sharing as needed
- Support the development tools such as rapid surveys
- Provide capacity building activities on a need basis to fill gaps and evaluate the effectiveness of these activities

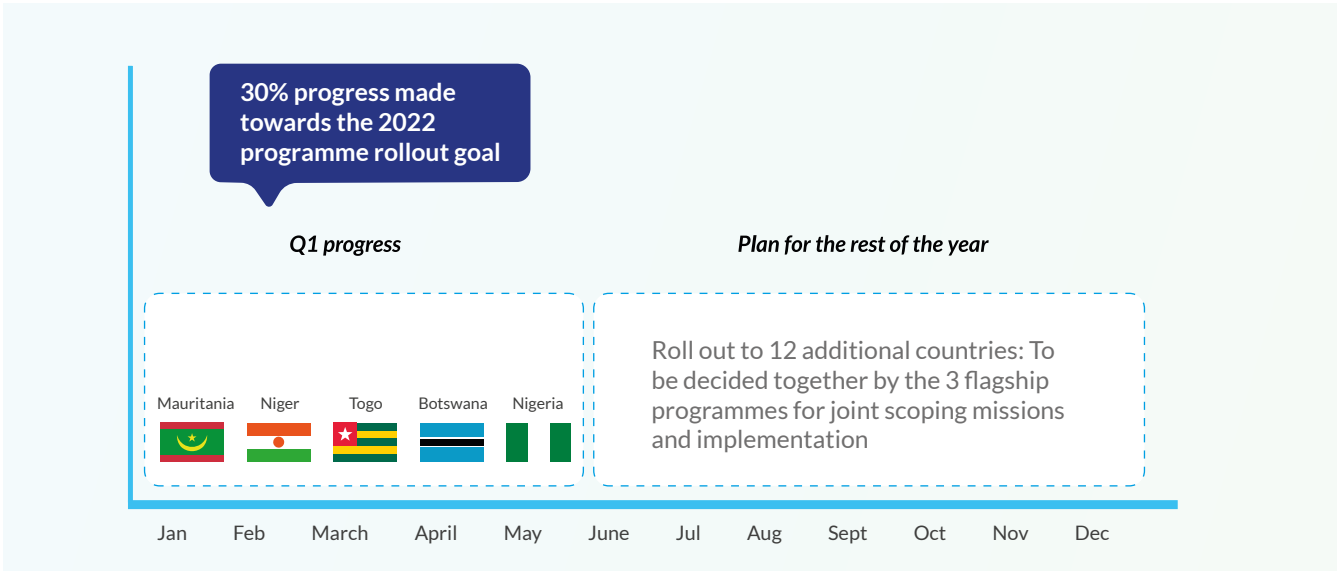
Improve monitoring and evaluation within RCCE

- Develop a standardized indicators, data collection and reporting tools
- Improve mechanism for managing rumors and info-demic
- Monitor the implementation of activities through a digitalized platform
- Document best practices and learnings

03 Quarter 1 Progress – Focus on the SURGE Flagship

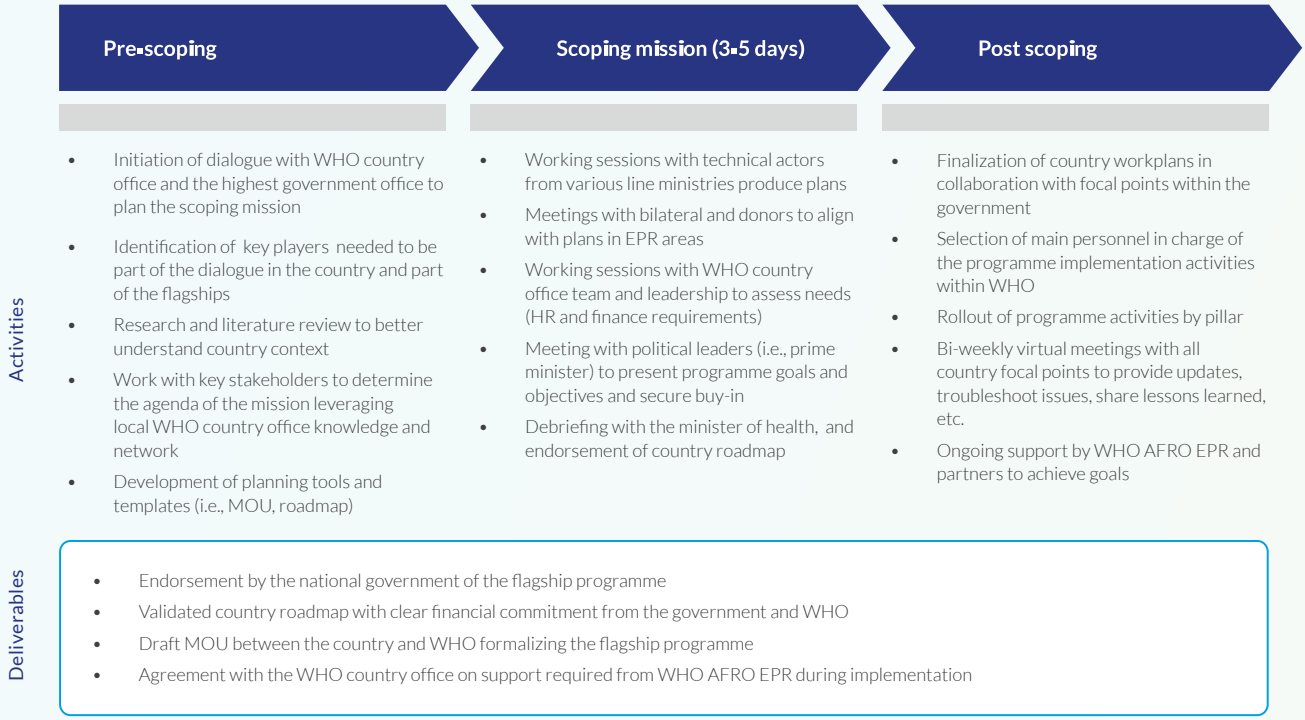
In the last quarter of 2021, WHO, in consultation with its partners, set the ambitious goal of launching the SURGE flagship in seventeen (17) countries. So, far we are on track. As of mid-May 2022, scoping missions have been conducted in all five (5) countries - Botswana, Mauritania, Niger, Nigeria, and Togo- and implementation has already begun in four (4) countries except for Nigeria where operational details are being defined. The five (5) countries were selected for early implementation based on a set of criteria including willingness of the country government to implement the programmes, their willingness to contribute, the human resource capacity of the WHO country offices to coordinate the programmes and the strength of the capacity of the Ministry of health in these countries to support implementation. Following a similar selection process, in consultation with Africa CDC and WHO EMRO, the programmes will expand to 12 additional countries before the end of the year by leveraging the experience of the SURGE programme.

Figure 13: Extent of progress towards 2022 programme rollout goals



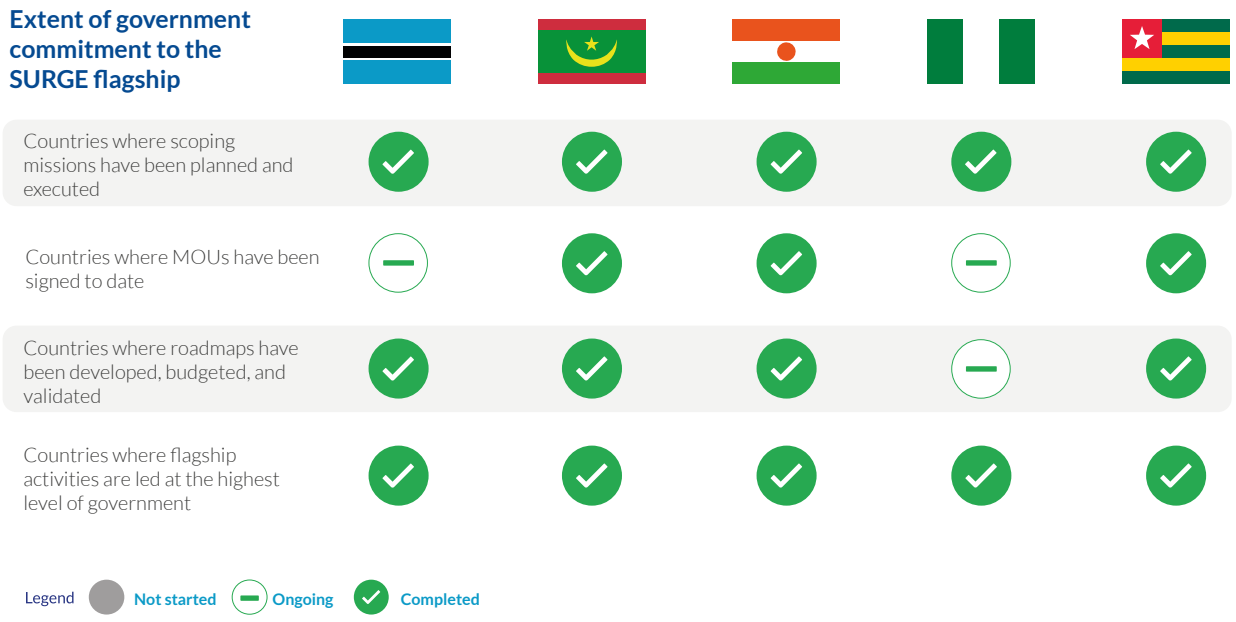
From January to May 2022, together with WHO country offices, we prepared and executed the scoping missions mentioned in all five countries to secure country commitment, develop a clear budgeted roadmap grounded in National public health security (NAPHS), and agree on implementation modalities. The discussions and stakeholder engagement focused particularly on SURGE; however, the other programmes were presented as well. In the coming months, our ambition is to conduct a similar engagement in twelve (12) other countries in collaboration with Africa CDC and WHO EMRO. Figure 14 , shows the detailed pre-scoping, scoping, and post-scoping activities that were conducted to roll out the flagships in each country.

Figure 14: Detailed activities of programme introduction at country level



In each of the five initial countries, there has been strong commitment from the government materialized by the validation of roadmaps, the signing of a memorandum of understanding (MOU) between the Minister of health (representing the government) and the WHO Country Representative, and the appointment of senior technical officers to lead implementation. Additionally, we are witnessing a paradigm shift, as member states are taking the lead in planning and executing the activities, allowing for substantial progress in some of the key pillars of the flagships.

Figure 15: Extent of government commitment to the SURGE flagship

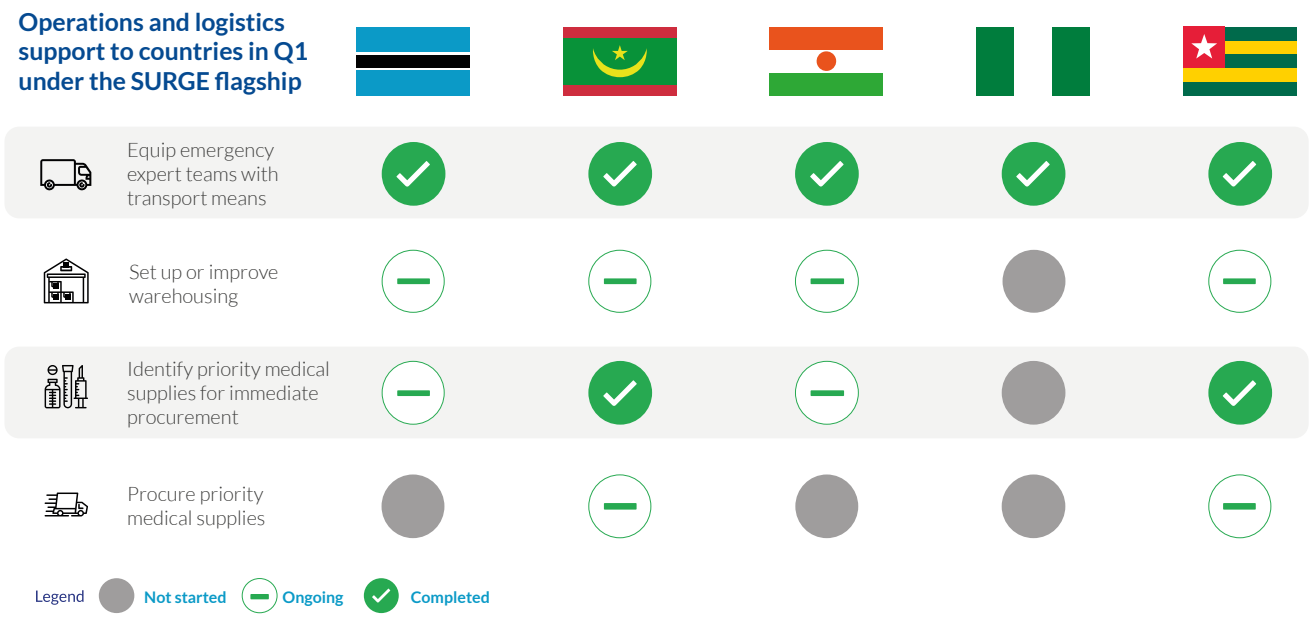


In terms of resource commitments, WHO is providing USD 1 M in seed funding to each country to jump-start activities in the roadmap with the expectation that this will generate more investments from the government and other partners to fill the funding gap. Governments are also committing resources in the form of staff, land, buildings, and budget to ensure that the acvitities agreed in the roadmaps are adequately executed.

The commitment from national governments to have reliable emergency expert teams has been materialized further through the recent allocation of land from the governments of Senegal (5 ha) and Kenya (12 ha) for WHO to build facilities for our hubs and centers of excellence. The hubs will host the centers of excellence which in turn will be the locus of a variety of sub-regional activities including logistics, workforce development, research and development, genomic surveillance and data, innovation and intelligence, the advancement of IDSR as well as logistics, supply chain, and stockpiling. In addition, they will also be the places where most of WHO's EPR Cluster staff will be stationed so that they are ready to deploy to countries they are meant to serve. Overall, there is strong momentum around the flagships and the EPR Cluster is reorganizing to be up to the challenge. The momentum is already generating encouraging results in the key pillars.

In terms of the 2022 plan for workforce development explained in the previous section, Figure 16 below shows the progress made on the process for establishing the African emergency expert teams in the five countries:

Figure 16: Extent of progress towards establishing the emergency expert teams in the five (5) countries for Q1



In terms of the 2022 plan for operation support and logistics, activities are on track to make sure that emergency expert teams are ready to be deployed with the adequate supplies and equipment. A total of 120 vehicles have been shipped to 15 countries with an allocation of 8 vehicles per country. Countries have identified dedicated parking space for the fleet and procedures for deployment and maintenance are being developed. Also, all participating countries have identified a site for warehousing to stock medical supplies and equipment and 40% of them have already identified priority medical supplies and equipment to be procured and stocked for response to emergencies.

Figure 17: Operations and logistics support provided to countries in quarter 1, 2022

Assess existing capacities and needs	**3** out of 5 countries have assessed their human resource capacities and needs and have developed a plan to fill gaps. The remaining countries have commenced the process and are on track to complete it by June 2022.
Develop and validate SURGE HR tools	**3** out of 5 countries have developed human resource tools for the emergency expert teams including manuals, job descriptions and terms of reference (TORs), training evaluation mechanisms as well as terms of engagement, ahead of recruitment.
Establish multisector selection committee and interview panel	**3** out of 5 countries have established a multisector selection committee and an interview panel to handle the interview and selection of candidates for the emergency expert teams.
Launch recruitment process for SURGE positions	**2** out of 5 countries have launched the recruitment process (i.e., call for applicants) for the emergency expert positions, while the remaining countries are on track to launch the process by the end of May 2022.
Select candidates following interviews	**2** out of 5 countries have completed the recruitment process and have selected the candidates for training. The remaining countries hope to finalize the selection of candidates by early June 2022.
Conduct trainings using a world class curriculum design WHO experts and partners	**4** out of 5 countries are on track to complete phase 1 of the trainings for the selected emergency expert team members by the end of June 2022. 2 countries are planning to organize phase 1 of their trainings by the end of May 2022.
Set up and maintain a database of experts certified to the SURGE program	**2** countries plan to start with this following a successful training process. The database will be a centralized, regional system and will show by country the function, gender, location, and area of expertise of emergency experts available for deployment. It can be used by WHO, Africa CDC, ministries and partners when emergencies are declared. The SURGE programme team aims to have this database ready and functioning by the end of Q2.

The next steps are to improve the identified spaces for storage of medical and ensure they meet industry standards. In countries, where priority supplies have been identified, we are working to make them available in the shortest time possible. Over the next month, the operations support and logistics team of the EPR Cluster will work with country teams and other partners to provide training on logistics and operations (stock management, software license purchase, etc.) and help set quality standards for warehouse management. In the meantime, WHO will stock sensible medical products in warehouses in Dakar and Nairobi for expedient deployment.

In countries where implementation is taking place, WHO's teams and national technical actors have begun consultations with decision-makers to either revise or adopt a legal decree creating the PHEOC

In terms of the 2022 plan for response readiness and coordination, progress has been slower, although this is to be expected because of the institution building character of the work. Nevertheless, there is traction within government and among partners to build up their PHEOCs to create a sustainable institution that can serve as the unique referral point for public health emergency management. In countries where implementation is taking place, WHO's teams and national technical actors have begun consultations with decision-makers to either revise or adopt a legal decree creating the PHEOC. In some countries (i.e., Mauritania and Togo) we are working with decision-makers to raise the anchoring of the PHEOC while in others such as in Botswana where the anchoring is in the president's office, we are trying to ensure that the anchoring allows for more accessibility to technical actors of the ministries. In terms of physical infrastructure, we are using the workforce development as an opportunity to fully equip training rooms with IT and communication equipment so that they can be utilized by PHEOC teams for both operations coordination during emergencies and for trainings. Also, in our efforts to build the workforce, strengthen logistics, and RCCE, our teams work closely with the national PHEOCs to ensure that they are at the forefront of inter-agency and multisectoral coordination. In parallel, we are working with technical staff within the PHEOC and with other national institutions to develop plans and standard operating procedures (SOPs), leveraging what has already been done for other emergencies so that full operationalization of the PHEOC is not delayed. Further progress under this pillar will require a collective effort from all the partners who have invested over the past decade to bring PHEOCs to fruition.

As for the progress in RCCE activities, our work has mostly been opportunistic. The ambition is to create a common multisectoral strategy which is implemented at national and sub-national levels through a system of multi-sectoral focal points. An initial part of this is identifying the key actors who need to be engaged consistently during all phases of emergencies and engage them regularly. The country teams have already begun identifying the key stakeholders including public institutions in charge of communication and key players in the media. They have also started identifying focal points at national and sub-national levels leveraging the One Health platforms and will work with them over the coming months to identify gaps, build synergies between initiatives, provide regular trainings using the workforce development infrastructure, and develop a long-term strategy.

04 Emerging **Learnings**

The key learnings from our work so far are around the timing of the flagships, the importance of country ownership and the licence from the government to implement, and the crucial need for some form of singularity in how regional players interface with countries.

Figure 18: Emerging learnings from Q1, 2022

The timing of the flagships:

The most frequent feedback received from the ecosystem of actors over the past months is that the arrival of the flagships is timely. As COVID-19 and other emergencies have stretched routine health systems, governments and partners are realizing the need for strengthening public health emergency systems. This increased attention to system building in EPR has resulted in commitments from governments to ensure the flagships succeed.

Country ownership and license to implement flagships:

Country ownership and the right mandate at regional, national as well as sub-national level are key ingredients for a successful and sustainable implementation. For this reason, we are presenting the flagships to Members States at the seventy-second session of the WHO Regional Committee for Africa taking place from August 22nd to August 26th, 2022. It is also the reason why we insist on having co-created roadmaps with national governments, local partners, and on the signing of an MOUs between the highest decision makers in the country and WHO country representatives. This ensures that both governments and WHO are held accountable for the success of the programmes.

Building an interconnected and trackable EPR workforce:

As we conceptualized the SURGE flagship and its workforce development pillar, one of the critical questions our teams wrestled with is how we develop an elite workforce at the country level, track their utilization, and ensure that they stay in the system to deliver the impact that's expected. Among the many solutions that emerged, we prioritized the development of a regional database of elite EPR workforce which will collect data on the trained teams from recruitment, training, to deployments. This database is being developed and will be piloted with emergency expert teams. It will allow WHO, ministries and partners to see the pool of elite workforce available by country, function, gender, location, and area of expertise, and make decisions on deployments when emergencies are declared. Through this initiative, we will not only build the elite EPR workforce that Africa needs, but we will also be able to create a network of highly trained individuals, from multiple sectors and disciplines, and track how they evolve in their organizations. Consequently, we can make sure that EPR systems survive the departure of individuals and that there is discipline to the way workforce development is organized on the continent.

Realtime knowledge sharing and peer learning:

As we progress with implementation at the country level, we realized the crucial need for real time, peer learning, and knowledge sharing across countries to unlock similar challenges and generate innovative solutions. To ensure that there is cross-pollination across countries, we have instituted regular meetings between country teams to discuss the progress of their activities, brainstorm around challenges and diversify potential solutions. We plan to expand this approach to knowledge sharing and peer learning across thematic areas where multiple actors are trying to achieve the same objectives. This includes, for instance, the establishment and operationalization of PHEOCs, strategies to achieve higher retention rates within country emergency expert teams or the development of functional and efficient supply chains for public health emergencies. As an organization, we are building our Monitoring and Evaluation, and Learning capacity so that we could organize more learning events and develop knowledge products tailored to the flagships.

Singularity in strategic planning and implementation with key regional players:

As a regional organization, we ensure that our work is complementary with that of other actors in the EPR space. As we conceptualized the flagships and sought feedback from the ecosystem, we realized that we needed to go beyond just strategic planning and have a singular interface at the country with other regional actors such as Africa CDC who has a similar reach and positioning as an organization. The benefits of such partnerships are tremendous as it ensures mutually reinforcing and complementarity approaches in delivering support to countries. This is the reason why we are actively working with Africa CDC to build a single strategy and approach for the continent and combine our activities on the ground in each of the preparedness, detection, and response areas. We will actively seek out other partnerships at regional or sub-regional level to ensure that there is no duplication of efforts at country level, and that together we build strong and sustainable public emergency preparedness and response systems.

World Health Organization