

ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency preparedness and response flagship programmes



#3

QUARTERLY
REPORT

OCTOBER
2022



World Health
Organization



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WHO AFRO'S RESPONSE
TO GRADE 2 AND 3
EVENTS IN THE
REGION



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Acronyms

AAR	After Action Review
Africa CDC	Africa Centers for Disease Control and Prevention
AKI	Acute Kidney Injury
AOP	Annual Operational Plan
AVoHC	African Volunteers Health Corps
AVoHC-SURGE	African Volunteers Health Corps-Strengthening and Utilizing Response Groups for Emergencies
CAR	Central African Republic
CBS	Case-based Surveillance
CDC	Centre for Disease Control
CFE	Contingency Fund for Emergencies
CFR	Case Fatality Rate
COVID-19	Coronavirus Disease 2019
DRC	Democratic Republic of Congo
EBS	Event-based Surveillance
EIOS	Epidemic Intelligence from Open Sources
EMT	Emergency Medical Technicians
EPR	Emergency Preparedness and Response
EVD	Ebola Virus Disease
EWARS	Early Warning, Alert and Response System
EYE	Eliminate Yellow Fever Epidemics
FCV	Fragile Conflict and Vulnerable Settings
GBV	Gender-based Violence
GHOA	Greater Horn of Africa
GIS	Geospatial Information System
GPW 13	World Health Organization's Thirteenth Global Programme of Work
HCW	Health Care Worker
HeRAMS	Health Resource and Health Services Assessment
IBS	Indicator-based Surveillance
ICAP	International Centre for AIDS Care and Treatment Program
ICU	Intensive Care Unit

IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMS	Incident Management System
IMST	Incident Management Support Team
IPC	Infection Prevention and Control
IT	Information Technology
JEE	Joint External Evaluations
KPI	Key Performance Indicators
MEAL	Monitoring, Evaluation, Accountability and Learning
MHNT	Mobile Health and Nutrition Units
MHPSS	Mental Health and Psychosocial Support
MHRP	Multi-Hazard Response Plan
MOH	Ministry of Health
NAPHS	National Action Plan for Public Health Security
NFP	National Focal Person
NGO	Non-governmental Organization
OCV	Oral Cholera Vaccines
OSL	Operations Support and Logistics
PHEIC	Public Health Event of International Concern
PHEOC	Public Health Emergency Operations Centre
PPE	Personal Protective Equipment
PROSE	Promoting Resilience of systems for emergencies
Q3	Quarter 3
Q4	Quarter 4
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
SAM	Severe Acute Malnutrition
STAR	Strategic Tool for Assessing Risks
SURGE	Strengthening and Utilizing Response Groups for Emergencies
SVD	Sudan Ebola Virus Disease

TASS	Transforming African Surveillance Systems
UHPR	Universal Health and Preparedness Review
UN	United Nations
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
UPHR	Universal Health and Preparedness Review
USAID	United States Agency for International Development
USD	United States Dollar
WAHO	West African Health Organization
WASH	Water, Sanitation, Health and Hygiene
WCO	WHO Country Offices
WHO	World Health Organization
WHO AFRO	WHO Regional Office for Africa
WHO EMRO	WHO Regional office for the Eastern Mediterranean
YF	Yellow Fever

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Message from the Regional Director







The World Health Organization Regional Office for Africa (WHO AFRO) continues to enhance its support to Member States enabling them to prepare for, detect and respond to public health emergencies. This is being accomplished through its flagship programmes – PROSE, TASS, and SURGE designed to capacitate Member States and build robust emergency preparedness and response (EPR) systems in Africa. During the third quarter (Q3) of 2022, an increased number of **new, emerging, and re-emerging diseases continued to plague the continent** as evidenced by significantly higher numbers of Grade 2 and 3 events¹ compared to Quarter 2. The re-emergence of Rift Valley Fever in Mauritania, Polio in Botswana, and Ebola in Uganda against the backdrop of ongoing epidemics such as Mpox and Marburg Virus has accentuated the importance of health emergency response as the first step in protecting lives and livelihoods. Ongoing protracted conflicts as well as failed rains attributable to climate change have led to food insecurity, which not only threatens health directly, but also interrupts health-seeking behaviour such as vaccination. The situation compounds with the occurrence of outbreaks such as measles. Regardless, WHO AFRO has continued to support Member States by mobilizing human, technical and material resources to respond to these events.

Collaboration is key to successfully building strong EPR systems in Africa. One such effort of working together has been made by **Africa CDC, WHO AFRO and EMRO**, who have partnered to build on complementarities towards protecting vulnerable populations against public health emergencies through coordination in i) oversight and strategy decisions that shape the vision and approach of the collaboration; ii) implementation of decisions that shape the rollout of activities at the regional and country levels; and iii) decisions on cross-cutting issues such as resource mobilization, monitoring, evaluation, accountability and learning as well as communication. Additionally, a partnership framework and governance structure has been established to guide collaborative efforts under the Joint Emergency Preparedness and Response Action Plan (JEAP).

The PROSE (Promoting Resilience of Systems for Emergencies) flagship has witnessed momentum under the pillar of evidence-based plans, policies and legislation and workforce development. Countries under the Dakar and Nairobi Hubs were inducted into the phase 1 roll-out plan targeting a total of 10 countries (Benin, Congo, Cote d’Ivoire, Ghana, Sierra Leone, Rwanda, South



Dr Matshidiso Moeti
Regional Director, WHO AFRO

Category	Collaboration area
Technical areas	 Workforce development
	 Surveillance including diagnostics and genome sequencing
	 Response readiness, and coordination
	 Country assessment in the preparedness context
Partnership building area	 Logistics, supply chain and stockpiling
	 Institutional strengthening and coordinaton

Africa, South Sudan, Tanzania, and Zambia). The Dakar Hub has completed the process of recruitment of consultants to support the implementation of PROSE in five (5) countries. The Strategic Toolkit for Assessing Risk (STAR) was used to conduct risk assessment in South Sudan, Zambia, Rwanda, South Africa and Tanzania to identify high-risk hazards and events of concern. In Benin, Congo, Cote d’Ivoire, Sierra Leone and Ghana, the assessments using the STAR toolkit are ongoing. Country profiles are being prepared for all the assessed countries. Preparedness plans are also being developed for an improved, coordinated response to these infectious diseases during emergencies.

1 Further information on grading can be found here- <https://www.who.int/emergencies/grading>

Further, 153 National Focal Points (NFPs) and International Health Regulations (IHR) stakeholders from six countries (Namibia, South Africa, Liberia, Guinea, Mali and Zimbabwe) were onboarded and trained through a series of workshops from July to September. In collaboration with the Johns Hopkins University, a competency model was developed along with the finalization of the IHR NFP competency framework that defines the knowledge, skills and behaviour imperative for a designated IHR NFP to function optimally.

Transforming African Surveillance Systems (TASS) flagship has made notable progress in Integrated Disease Surveillance and Response (IDSR) implementation, improving data management systems and analytics capacity. This quarter, there was a selection of 14 countries for implementation of the TASS program. Niger, Togo, Botswana, Nigeria, Mauritania, CAR, Chad, Congo, Rwanda, Kenya, and Uganda were selected in alignment with implementation of SURGE phase 1 and 2 in these countries. Madagascar, Namibia, and Lesotho were also added for TASS acceleration.

A series of three workshops were organized for **assessment and training to boost the electronic version of the IDSR and the information systems in the WHO African Region** in general. The Johannesburg workshop brought together 12 English and Lusophone speaking WHO African Region Member States. While the Kigali workshop brought in delegations from 14 English-speaking AFRO member countries, the third workshop in Côte d'Ivoire was for French speaking countries in Abidjan, with delegates from 17 countries. During the workshops, country representatives were introduced to the electronic version of the IDSR and reviewed architecture of currently used data management and information systems. One of the outcomes of the workshops was country-specific remediation plans to address identified bottlenecks towards strengthening IDSR.

The architecture of the electronic IDSR has been put in place to help streamline the process of data collation across countries. This will enhance data flow and leverage eIDSR to create a holistic picture of three aspects: Case-based surveillance (CBS) reporting; Event-based Surveillance (EBS) reporting and Indicator-based surveillance (IBS) reporting. TASS has advanced the use of public health intelligence tools to pick up signals from media articles, conduct verification confirmation, and risk assessment grading as part of Event-based surveillance (EBS).

Strengthening and Utilizing Response Groups for Emergencies (SURGE) flagship continues to illustrate the value of a rapid response mechanism and role of data in remedial action. This is evident from faster detection of and response to more grade 2 and 3 events in Q3. The weekly bulletin at the close of quarter 3 reported a total of 5 grade 3 events, 23 grade 2 events and 2 grade 1 events. A case in point was the dangers of unregulated products that became markedly clear after the loss of children in Gambia due to kidney failure,

following administration of poorly manufactured medications. This highlighted the need to create and maintain a highly dynamic and robust emergency response system that can cater to a diverse range of health emergencies. A case of Ebola virus was confirmed in DRC after the patient had already died. As a response, 182 contacts were line listed, 200 contacts were ring vaccinated and the outbreak was contained within 4 weeks with no secondary cases. In Uganda, an outbreak of the Sudan Ebola virus was responded to. There were 50 cases and 25 deaths by end of Q3 with response activities still ongoing.

The Regional Emergency Hub in Nairobi, Kenya that was launched last quarter, made gains in Quarter 3 with pre-positioning of stockpile supplies worth \$1,013,665. Since the operationalization of this hub, lead-time for outbound delivery for supplies has reduced from an average of 18 days to under 4 days. Further, with respect to the Senegal Hub, the Government of Senegal has allocated 5 hectares of land near the International Airport, Diass, and donated a building that is now currently under renovation and will act as a temporary office space for the Dakar Hub.

During this quarter, an extensive process was established for **screening and recruiting an additional 162 Emergency Experts** – 52 allocated for deployment in Mauritania, 53 for Niger and 57 for Togo. With the help of partners such as US CDC, efforts are ongoing to create the Emergency Expert's database with capability to depict deployment status and availability of the experts to respond to in-country events. A soft launch of the dashboard is planned for Quarter 4.

In this quarter, scoping missions were conducted in the Central African Republic, Namibia, Rwanda, Congo, and the Democratic Republic of the Congo. **Phased implementation of the SURGE flagship programme continues to enable key learnings to be implemented in the new countries being onboarded.** Emerging lessons learnt from governments, partners, and WHO across five phase 1 countries (Botswana, Mauritania, Niger, Nigeria and Togo) include fostering country ownership, collaborating with partners at every stage, developing an effective project management system, and creating a comprehensive training programme and platforms for sharing knowledge.

Finally, I would like to thank all respective teams, partners, and stakeholders for their relentless effort towards achieving WHO set goals. Continuous engagement and collaboration are key in achieving the set objectives and I am very happy to see the collaborative effort and teamwork of the 3 flagship programmes. As we move into the last quarter in 2022, **WHO AFRO will continue to actively collaborate with all actors across the region.**

We will ensure that our initiatives reach those who need them the most and that public health emergencies are proactively prevented, accurately detected, and adequately addressed for the good health and well-being of all people in the region.

Key Highlights



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Additional Scoping Missions

were conducted in Namibia, Rwanda, Democratic Republic of Congo, Central African Republic and Congo under SURGE flagship



Stockpile worth ~\$1 M

available in the Nairobi Hub that includes personal protective equipment, cold chain reagents, medical emergency kits, Ebola kits and medical trauma kits

162

emergency experts recruited under the SURGE flagship



360+

participants in webinars for National Focal Persons under the PROSE flagship



PROSE regional webinar

was held to introduce the roll out plan for the implementation of PROSE in countries under Dakar and Nairobi hubs



10

priority countries finalized for implementation of PROSE priority package



12

priority countries finalized for TASS implementation given the gaps in the execution of the Integrated Disease Surveillance and Response (IDSR) strategy



Contingency plan

was prepared for Ebola, Cholera and Mpox to better respond to emergencies



58 experts were deployed to 25 countries and working in partnership with 79 in-country staff to manage graded events



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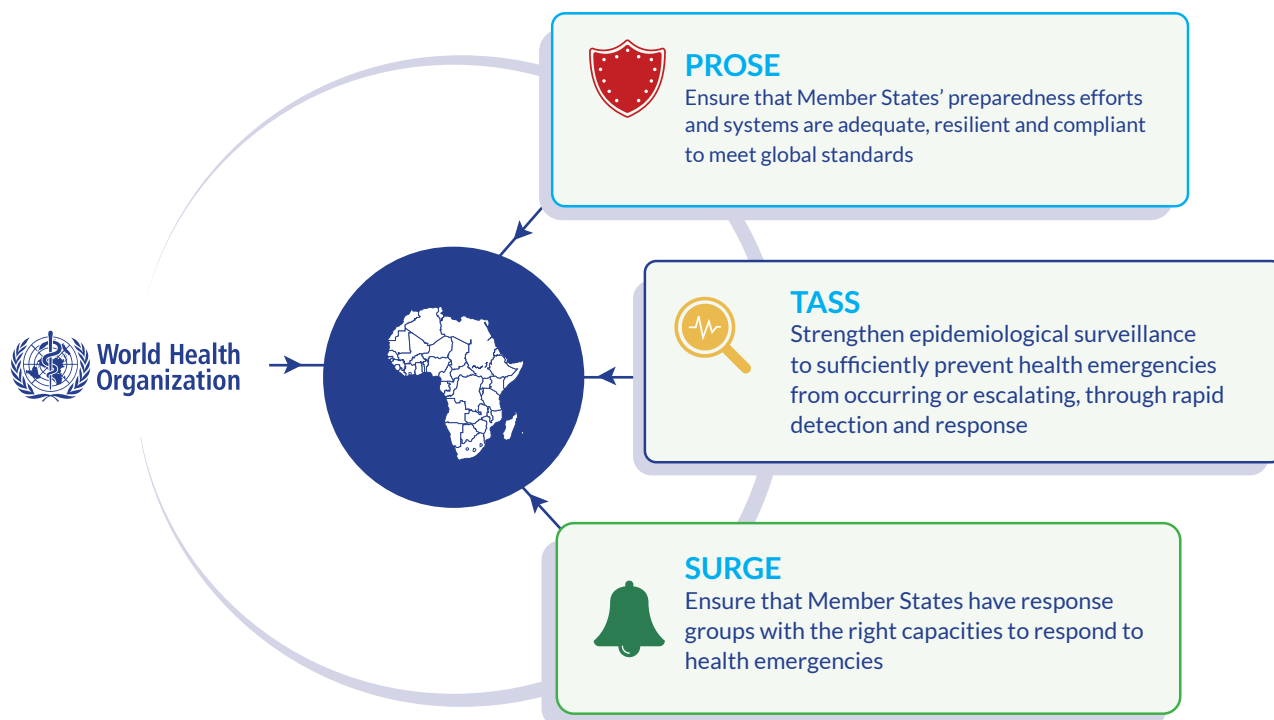
ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency preparedness and response flagship programmes



Introduction

The third quarter of 2022 was characterized by an increase in the number of events that the World Health Organization (WHO) had to respond to in the African region. WHO AFRO, with support from its various partners, continued to support Member States in response to new emergency health events and protracted events, building on foundational work done by the emergency preparedness and response (EPR) cluster since January 2022. Six grade 2 events, which was an increase from four(4) grade 2 events in Q2, and two (2) grade 3 events were reported in Q3.





The first Marburg virus disease outbreak in Ghana was reported in July that had a case fatality rate (CFR) of 67% by the time it was declared over in September. The Democratic Republic of Congo (DRC) reported an Ebola virus outbreak in North Kivu region which started in August 2022 and a Sudan Ebola virus (SVD) outbreak was ongoing in Uganda at the end of the quarter. The number of countries affected by Yellow Fever (YF) in parts of East, West and Central Africa increased from 10 in Q2 to 12 in Q3. The ongoing COVID-19 pandemic showed a steady decline in cases in most African region countries, but response activities have continued to be strengthened. The Mpox outbreak was declared a public health event of international concern (PHEIC) as it continued to spread in African countries and other WHO regions with new modes of transmission. In addition to these diseases, drought and hunger in the Greater Horn of Africa (GHOA) and humanitarian crises in the Sahel as well as Northern Ethiopia have continued to be public health challenges requiring response activities in the region in Q3. Technical, operational, and financial support was provided to Member States to prepare, detect and timeously respond to public health events.

Objective of WHO EPR Cluster

With the aim of contributing to 1 billion people being protected from health emergencies, the EPR Cluster's flagship programmes continue efforts within WHO AFRO Member States to ensure that they are better prepared for, can detect and assess, and rapidly respond to public health emergencies.

A coordinated multi-sectoral approach remains key to public health systems that respond effectively to public health emergencies. WHO, in collaboration with stakeholders, has developed a strategic framework to prepare for all emergencies that threaten people's health worldwide². Partnership established between Africa CDC, WHO AFRO, and the WHO Regional Office for the Eastern Mediterranean (EMRO) have made significant progress in responding to notable technical areas, namely, workforce development, surveillance including diagnostics, and genome sequencing, response readiness and coordination, country assessment in preparedness context, logistics supply chain and stockpiling as well as in institutional strengthening and coordination.

This report presents progress made in the WHO EPR cluster to achieve the set targets in quarter 3 (**July-September 2022**). The report highlights progress made by Member States towards implementation of the flagships and collaborative initiatives being undertaken by WHO AFRO to enable Member States to prevent, detect and respond to public health events in the region while sharing lessons learnt throughout the process.



The Flagship programmes

The three (3) flagship programmes established in January 2022 have contributed towards building the capacity of member states through implementation of identified and agreed upon pillars per flagship.

The aim of these programmes is:

- to support member states in preparation and prevention of disease outbreaks and health emergencies
- to promptly detect, speedily report, and confirm outbreaks
- to strengthen and sustain their capacity to promptly respond to and recover from the negative effects of outbreaks and health emergencies

Promoting Resilience of Systems for Emergencies (PROSE) Flagship

The PROSE flagship highlights key learnings taken from 10 priority countries selected under Dakar hub and Nairobi hubs. The flagship continued its implementation phase started in Q2 with main activities including review of National Action Plan for

Health Security (NAPHS) and development of Annual Operational Plans (AOPs) in six (6) countries. Countries utilized the Strategic Tool for Assessing Risk (STAR) to develop their risk profiles and season risk calendars as well as update their Multi-hazard Risk Plans (MHRPs). Progress on roll out of Health Workforce Development to ensure human resources availability for implementing International Health Regulations (IHR) core capacity requirements is highlighted. National Focal Persons (NFPs) from six (6) countries were onboarded on IHR and NAPHS implementation.

Transforming Africa Surveillance Systems (TASS) Flagship

Activities in the TASS flagship supported 14 countries for Integrated Disease Surveillance and Response (IDSR) implementation. A diagnostic exercise to understand the IDSR landscape focusing on the tools and systems used in Member States was done and key gaps and potential approaches to address the gaps were identified together with the Member States. Adjustments to national IDSR plans was done to reflect the evolving local contexts while simultaneously encouraging national prioritization of, and investment in IDSR capabilities.

Incomplete and untimely reporting is still being experienced at both the country and regional level and digitization of reporting systems is a key activity in efforts to improve real time visibility into events happening in countries. Implementation of electronic IDSR was initiated and development of the architecture to streamline data collection and analysis across Member States is underway. Work has already begun in rolling out the rest of the flagship pillars namely Data and Information Management, Workforce Development, Advocacy, and Policy Dialogue for Sustainable and Predictable Funding through implementation of multiple advocacy strategies and policy dialogues.

Strengthening and Utilizing Response Groups for Emergencies (SURGE) Flagship

Updates on the SURGE flagship focus on notable progress made by member states in timely and effective deployment of emergency supplies and human resources as well as transportation, procurement, and distribution of supplies at national and subnational levels. Scoping missions managed to be conducted in five (5) countries with plans to conduct scoping missions in nine (9) other countries in Q4 already in motion. Additional emergency responders totaling 162 across Mauritania, Niger and Togo were recruited in the quarter towards the target of building a multidisciplinary team of 3000 emergency responders in the African region. Operationalization or strengthening of Public Health Emergency Operations Centre (PHEOCs) in select Member States was a key area of focus for the flagship in Q3. Capacitation of the EPR hubs in Nairobi and Dakar to support rapid deployment of resources in emergency responses continued to be pursued in the quarter with the target of ensuring that emergencies are responded to within 24 to 48 hours.

To achieve this, WHO AFRO has partnered with national governments to enable them to take center stage in securing seed funding, resources, train and track emergency experts' utilization as well as build structures to protect vulnerable populations and strengthen patient outcomes using a partnership framework that informs detection and response to emergencies. WHO AFRO has deployed complementary efforts to promote accountability and collaborative approaches.

Since its onset, the EPR flagship project saw the development of highly skilled country teams with capacity to respond to events and coordinate a rapid response to minimize their negative impacts and effects on health systems and health outcomes for people.

The report wraps up with updates of ongoing humanitarian events and response with particular emphasis on the Marburg outbreak, Ebola Virus, Monkeypox, Sudan Ebola, Acute Kidney Injury, multi-country Yellow Fever. Q3 saw the acceleration of response to the new, emerging and re-emerging diseases being experienced in Africa.

Some key lessons coming out of the experience in Q3 across the flagships include the undeniable benefits of multisectoral partnerships and coordination of efforts across the 3 flagships to leverage existing synergistic opportunities for maximization of resources and potentially increased impact in the Member States.





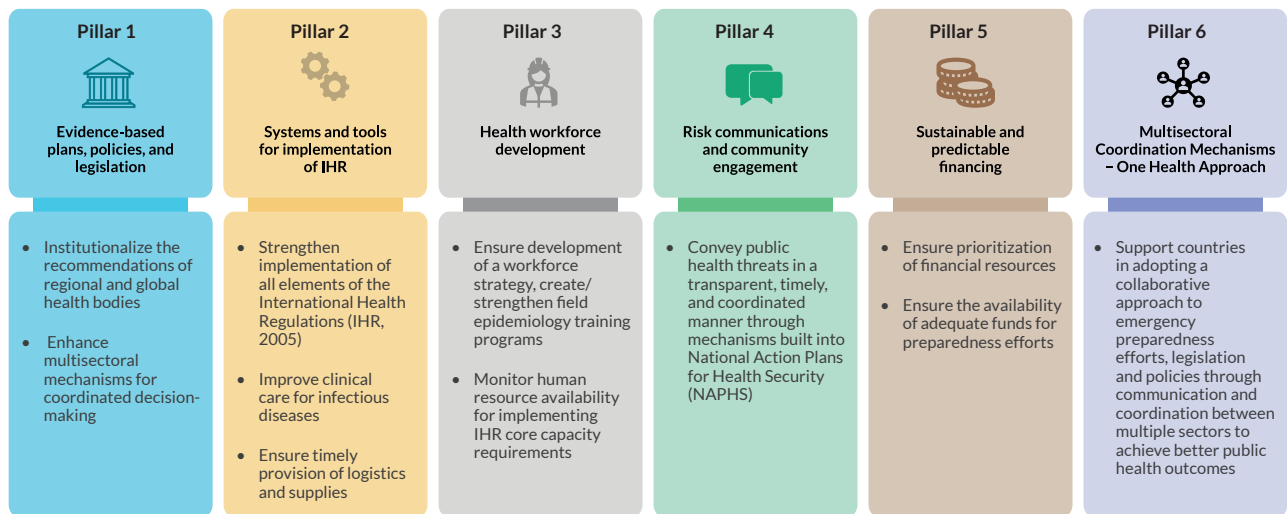
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Quarter 3 progress - all flagships

A. PROSE

Since the last quarter, there has been a continuous and sustained focus on pillar 2 with additional momentum being gained on pillar 3 and pillar 4 of this flagship (see figure 1). Activities under the PROSE flagship looked to deepen the engagements with priority countries, including others (based on countries expressing their interest and also due to ensuing needs as they respond to public health events) and building on the wins from Q2 across pillars. Specifically, in Q3, 10 countries were prioritized for the implementation of PROSE packages.

Figure 1: The pillars of the PROSE flagship programme and the focus areas for quarter 3



Highlights



More than **820 members** participated in the PROSE regional webinar held on 9 August 2022 to introduce the PROSE roll out plan.



An integrated scoping mission for PROSE/TASS/SURGE was conducted in four (4) countries. Outcome of the scoping mission included the development of roadmaps to implement PROSE priority core packages.



WHO AFRO assumed chairmanship of a regional interagency quadripartite platform that aims to advance collaborations in human and animal health, agriculture, and environment to tackle zoonotic disease outbreaks and climate-related emergencies. The four agencies are the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Health Organization (WHO), and the World Organisation for Animal Health.



Updates on pillar 2- Evidence Based Plans, Policies and Legislation

A total of 10 countries (five countries each within the Dakar and Nairobi hubs) have now been prioritized for the phase 1 implementation of PROSE. Prioritization was based on the availability of data that determined the burden of emergencies, risk identification, development of the National Action Plan on Health Security (NAPHS) and inclination of member states.

Figure 2. Phase 1 priority countries for PROSE implementation



Phase 1 Priority Countries

Dakar Hub

Benin	Congo	Cote d'Ivoire	Ghana	Sierra Leone
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Nairobi Hub

South Sudan	Tanzania	South Africa	Zambia	Rwanda
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In Q3, a total of six (6) countries - Benin, Congo, Uganda, Botswana, Lesotho, and Cameroon - reviewed their National Action Plan for Health Security (NAPHS) and developed their Annual Operational Plans. This is a prerequisite for developing an investment case to assess the newly established Pandemic Fund. Through the NAPHS - a country owned, multi-year, planning process - countries can plan and define accountabilities towards the accelerated implementation of International Health Regulations (IHR 2005) Core capacities based on critical gaps identified during prior Joint External Evaluation (JEE) reviews. In Congo and Sierra Leone, WHO received a letter of intent signed by the Minister of Health, requesting the conduct of the Universal Health and Preparedness Review (UHPR). UHPR is a Member States-driven intergovernmental consultative process that offers a cooperative platform to build mutual trust, transparency, and accountability to strengthen national capacities for pandemic preparedness, universal health coverage and ensure healthier populations. As prescribed by the IHR monitoring and evaluation framework (IHR MEF) Cameroon, South Sudan and Namibia completed After Action Reviews (AARs) for various responses to public health events. In Namibia, the AAR was for response to the Hepatitis E outbreak. Simulation exercises were also conducted in three countries -Tanzania, Senegal and Burkina Faso - to refine, update and test preparedness and response plans to varied public health events.

Updates on pillar 3 - Implementation of Systems and Tools for the Implementation of IHR

In Q3, Zambia, Tanzania, South Africa and Madagascar completed their risk assessment using the Strategic Tool for Assessing Risks (STAR). The STAR offers easy-to-use toolkit a to rapidly conduct public health risk assessment for planning and prioritization of health emergency preparedness and disaster risk management activities. Five (5) countries - Zambia, South Africa, Tanzania, Mozambique and South Sudan updated hazard risk profiles and seasonal risk calendars that informed national multi-hazard plans to address high risk infectious diseases/events.

Highlights



Within the scope of the IHR monitoring and evaluation framework, **simulation exercises were conducted in three (3) countries** - Tanzania, Senegal, and Burkina Faso. Also, after-action reviews were conducted in three (3) countries - Namibia, South Sudan and Cameroon.



Thirty-nine countries have assessed and strengthened their readiness capacities to respond to potential Mpox outbreak.



An additional six (6) countries neighbouring Uganda - Burundi, Congo, Kenya, Rwanda, South Sudan and Tanzania, have also strengthened their capacities to respond to any potential SVD outbreak.



Five (5) countries updated their hazard risk profiles and seasonal risk calendars. This has informed the development of national multi-hazards plans to address these identified high-risk infectious diseases.

Zambia used the STAR tool to assess 25 different types of hazards. Eleven (11) of these were prioritized as either high risk or very high-risk hazards. Contingency plans were developed for Mpox and the contingency plan for Cholera was updated. A risk calendar and risk matrix were subsequently developed to support response planning. In addition, key actions for readiness were agreed on for implementation in line with their readiness capacities. These were used to update country's Multi Hazard Response Plan (MHRP). A MHRP sets out the structures that a country must have in place and to be activated when an emergency or a major health risk is detected. South Sudan, South Africa and Rwanda also developed the contingency plan for Mpox and Ebola, and subsequently corrective actions were taken to close the identified gaps.

Highlights



Six (6) countries - Benin, Congo, Uganda, Botswana, Lesotho and Cameroon - reviewed their National Action Plan for Health Security (NAPHS) and have subsequently developed their Annual Operational Plans. Development of the NAPHS is a pre-requisites for countries to assess funds from the newly established Pandemic Fund.

Updates on pillar 4 - Workforce Development

In Q3, trainings and workshops for the development of workforce focused on the onboarding of IHR National Focal Points (NFP) on IHR and NAPHS implementation. Delegates from six (6) countries (Namibia, South Africa, Liberia, Guinea, Mali, and Zimbabwe) participated in the IHR National Focal Points (NFP) onboarding. In Liberia, there were 22 participants including four (4) NFPs, and members from MOH and In Guinea, there were 30 participants including the NFP and other IHR implementation stakeholders.

Also, four (4) webinars on IHR were conducted by AFRO between July and October with a total of 367 participants. Participants included NFPs, IHR implementation stakeholders and WHO country office staff. The topics covered during the webinar included: functions of NFPs and their roles, operational readiness, dynamic implementation, follow-up of National Action Plans for Health Security (NAPHS), One Health and enhancing multisectoral and multidisciplinary coordination. Post webinar feedback revealed incremental knowledge gain on the various aspects of the topics covered.

WHO AFRO also took initiative to collaborate with Johns Hopkins University to initiate the design and development of the IHR NFP Competency Framework. These will enable a tailored learning pathways to guide the functions and roles of NFPs in the implementation of the IHR.

In September, WHO AFRO conducted workshop in Lusaka Zambia on the development and implementation of evidence based NAPHS including the development of Annual Operational Plans (AOP) preparation. A total 51 officers (WCO staff and MOH NAPHS implementation officers) participated in the workshop.

Highlights



A total of **153 NFPs and IHR Stakeholders** from six (6) countries (Namibia, South Africa, Liberia, Guinea, Mali, and Zimbabwe) were onboarded on IHR NFP training.



Four (4) webinars on the IHR were conducted between July and October. A total of 367 IHR stakeholders, and WHO office staff participated from Member States.



A total of 150 inter-disciplinary professionals from 47 countries in Africa were trained on methods for managing Simulation Exercises, After-action and Intra-Action reviews. This will test the functionality of their existing preparedness and response capacities and plans.

Through these workshops, countries are being capacitated to lead these processes, implement multisectoral accountability approaches for tracking NAPHS/AOP implementation with a view to strengthening IHR core capacities.



PROSE Progress - Dakar Hub and Nairobi Hub

In Q3, there was progress across core operational areas – budgeting and recruitment - for the accelerated implementation of the PROSE flagship. The Dakar Hub completed the recruitment of two (2) consultants to support the implementation of PROSE in five countries - Benin, Congo, Ghana, Sierra Leone, and Cote d'Ivoire. In the Nairobi hub, the recruitment of consultants is ongoing and will be completed by next quarter. To enable coordination and communication across francophone countries with AFRO, a panel of French-speaking emergency preparedness experts was established.

The PROSE regional webinar was held on August 9, 2022, to introduce the PROSE roll out plan and priority package to the countries and hubs. More than 820 members were part of the webinar.

Figure 3. Activity-wise updates on the Dakar hub and Nairobi hubs

Status of activities for PROSE implementation in Q3	Dakar Hub	Nairobi Hub
Designation of points at Hub level	●	●
Start of the recruitment process for an international consultant to manage the PROSE project	●	○
Organization of virtual briefing meetings of each PROSE project focal point at WCO level	●	●
Development of a budgeted PROSE rollout plan for the 10 countries from both hubs	●	●
Establishment of a roster of French-speaking experts in emergency preparedness	○	NA
Carrying out priority activities in 10 countries from Dakar and Nairobi hub	○	○

● Completed ○ Ongoing

Figure 4: Activity-wise updates on PROSE priority package

Activities	Benin	Congo	Cote d'Ivoire	Sierra Leone	Ghana	Zambia	South Sudan	Rwanda	South Africa	Tanzania
STAR						●			●	●
Risk calendar / Country profile						●	○	●	●	●
NAHPS and AOP	●	●					●	●	●	○
UHPR		○		○		○				
MHRP						●		●	●	●
JEE										●
Simulation exercise							●	●	●	●

● Completed ○ Ongoing ● Planned

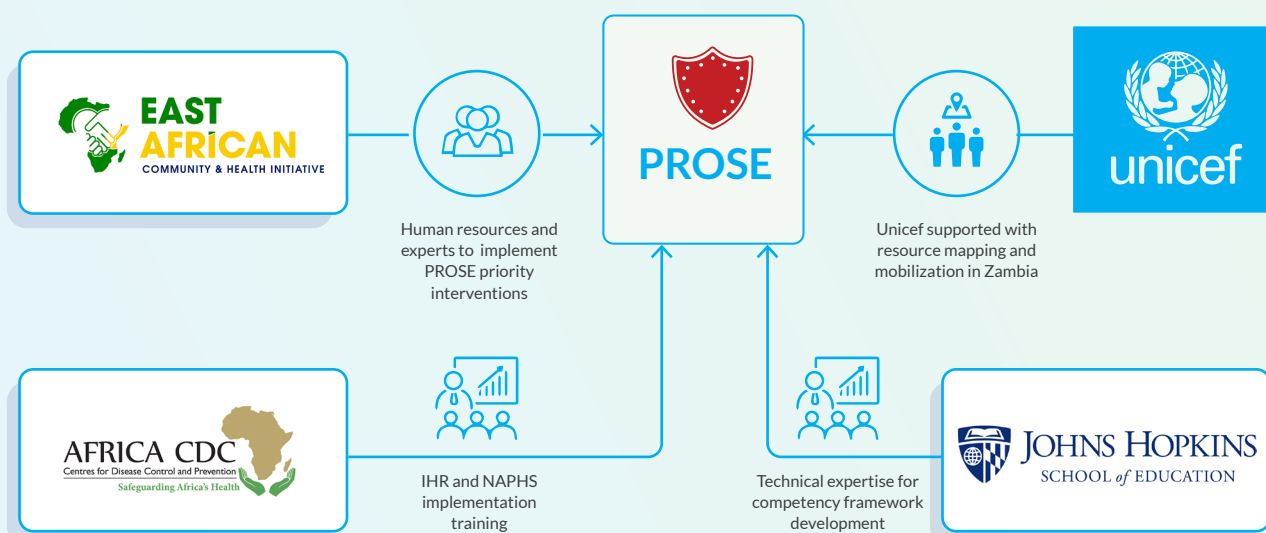
Note: The activities listed in Figure 4, vary for each country as they are at different levels of implementation.

There was progress with the implementation of the PROSE packages in the 10-priority phase 1 countries. Countries like (Zambia, South Africa, and Tanzania) completed their risk assessment using the STAR, and at varied levels of subsequently creating their risk profiles and developing their contingency plans. The NAPHS reviews were conducted in Congo and Benin and simulation exercise was conducted in Tanzania. In Congo, Sierra Leone, Zambia and Rwanda, PROSE supported the initiation of UHPR.

Other than above activities, in Benin, two workshops were conducted for the training in risk communication and community engagement in Grand-Popo, from 20 to 23 September 2022 and in Parakou from 27 to 30 September 2022. Also, in Côte d'Ivoire, national training guide elaboration was done for the health promotion actors. In Ghana, national bridging workshop on Rabies was conducted to support the country strengthening Rabies preparedness through one health approach.

Key collaborations and partnerships made during PROSE implementation

WHO AFRO commenced key partnerships and collaborations to accelerate the implementation of PROSE priority packages. These collaborations included areas on resource mobilization, support for trainings on IHR and implementation of the NAPHS. The East African Community Health Initiative provided needed human resources and experts to implement PROSE priority interventions, while UNICEF supported resource mapping and mobilization in Zambia. Through ongoing work and collaboration with the Africa CDC, support was provided for the trainings on IHR and NAPHS implementation. The Johns Hopkins University provided technical expertise for the development of the competency framework for the IHR stakeholders and finalization of NFP framework.



Reflections and learnings

As the flagship is being implemented, key lessons are emerging:

Structured implementation cycle of PROSE priority package:
The design of the priority packages for the Member States does not include a schedule to implement the various components of the package or activities. As such, implementation and sequencing of the suite of packages and related activities in various Member States should be done per country context and needs.

Coordinated efforts for roll out of flagships in Member States:
The Member States are receiving support on multiple fronts from the EPR cluster. It would be useful for the flagships to coordinate activities (such as visits for scoping mission) in the Member States for ease of implementation at the country level.

“ ...introducing priority package with a plan of action gets better results. Initially the roll out activities were not implemented in a planned manner. ”

“ ...activities of all flagships should be planned for coordinated implementation at the country level. ”

Allan, Mpairwe
PROSE, Nairobi hub

“ the PROSE package does not include a schedule of activities. We have prioritized activities following country needs after operational analysis. ”

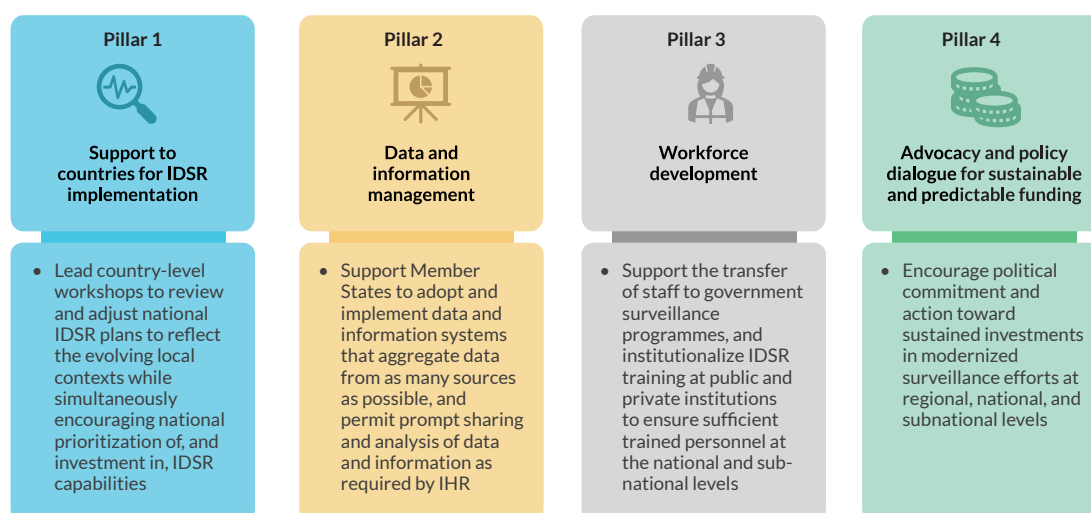
Diallo, Amadou Bailo
PROSE, Dakar hub

B. TASS



This quarter, the Transforming African Surveillance Systems (TASS) flagship project has continued to focus efforts on supporting Member States for IDSR implementation, while it has initiated work foundational to the other pillars.

Figure 5: The pillars of the TASS flagship programme



Focus for Q3 - Pillar 1 – Support to countries for IDSR implementation

Under TASS Acceleration activity, the flagship, in consultation with the Member States, finalized the countries for implementation of the programme. For TASS Acceleration phase I, 10 initial countries were selected based on participation in SURGE phase I and SURGE phase II. Four (4) of the five (5) SURGE phase I countries; Niger, Togo, Botswana, Mauritania and five (5) of the 12 SURGE phase II countries; CAR, Chad, Congo, Kenya, and Uganda were selected. Madagascar was also selected for TASS acceleration phase 1. For TASS Acceleration phase II: 10 countries to be funded through the Canadian project: DRC, Senegal, Cote d'Ivoire, Tanzania, Mozambique, Ghana, Malawi, Cameroon, Gambia, as well as Rwanda (from SURGE II) and Nigeria (from SURGE I) were included. Two (2) additional countries with a TASS acceleration work plan reviewed (Namibia, Lesotho) as well as the remaining SURGE II countries (Angola, Ethiopia, and Namibia) will be considered for TASS acceleration phase III.

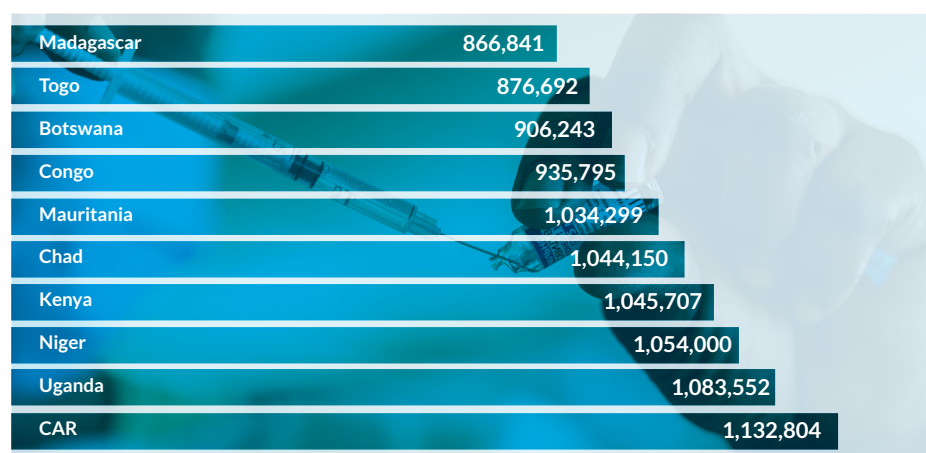
Six (6) countries have received 50% of their budget (since September 2022), while two additional country proposals have been received from CAR and Botswana. Further, Rwanda and Chad are in progress of submitting their proposals.

Table 1: TASS Acceleration budget

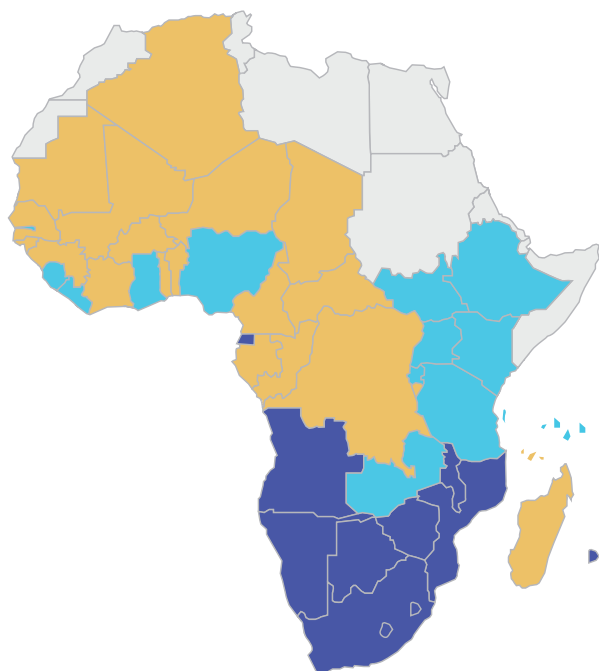
TOTAL TASS ACCELERATION BUDGET

 **9.98m**
USD

 **10** African
countries



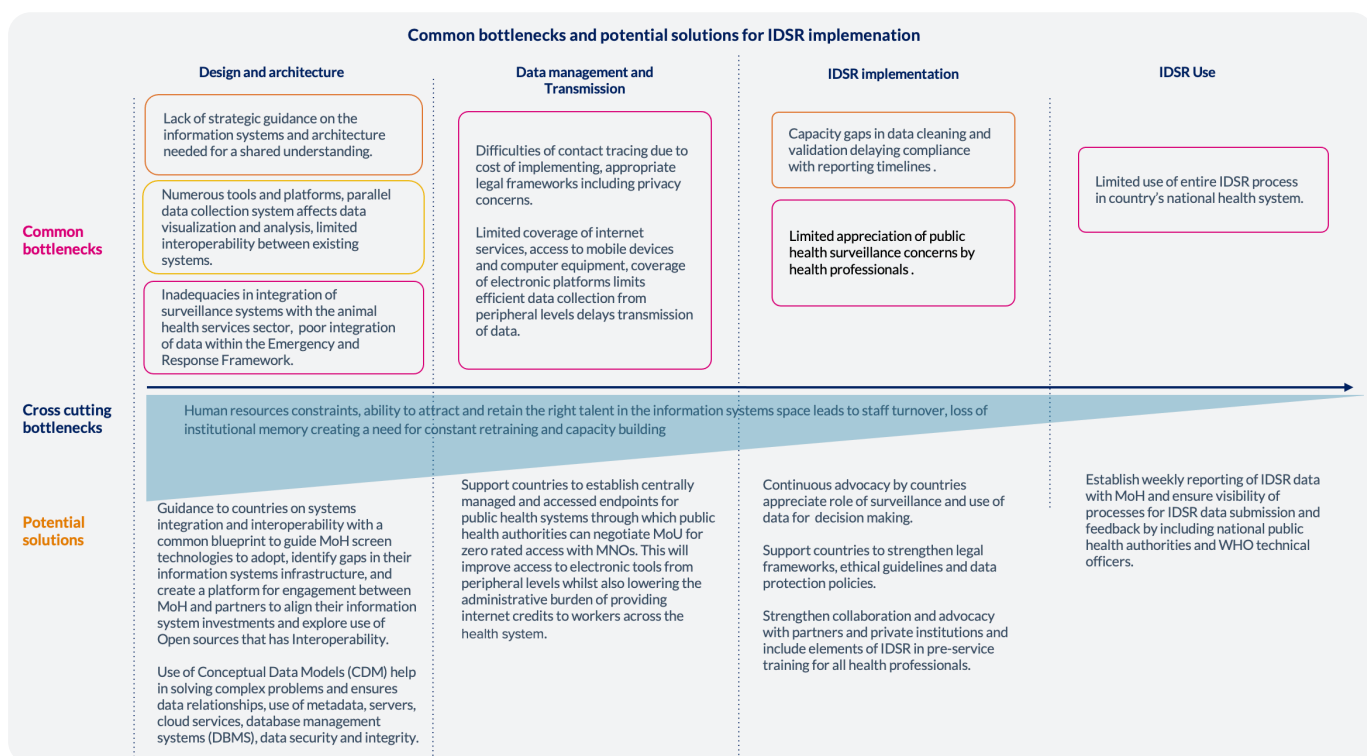
TASS accelerated IDSR implementation through three regional workshops (September 2022) and a series of webinars aimed to rapidly scale up IDSR implementation, improve data management systems and analytics capacity, strengthen diagnostics capacity at all levels, improve systems for monitoring and evaluation of IDSR performance at all levels as well as enhance advocacy and coordination of IDSR activities including One Health surveillance activities.



WORKSHOP ONE Location: Abidjan	18 Member States attended: Algeria, Benin, Burkina Faso, Burundi, Cameroon, Chad, Central African Republic, DR Congo, Comoros, Côte d'Ivoire, Gabon, Guinea, Madagascar, Mali, Mauritania, Niger, Senegal, and Togo.
WORKSHOP TWO Location: Kigali	14 Member States attended: Ethiopia, The Gambia, Ghana, Kenya, Liberia, Nigeria, Rwanda, Sierra Leone, Seychelles, South Sudan, Uganda, Tanzania, Zanzibar, and Zambia.
WORKSHOP THREE Location: Johannesburg	12 Member States attended: Angola, Botswana, Cabo Verde, Equatorial Guinea, Eswatini, Malawi, Lesotho, Mauritius, Mozambique, Namibia, South Africa and Zimbabwe.

The workshops introduced electronic version of the IDSR to the countries and reviewed the current architecture of data management information systems. Delegates from countries participating in the workshops identified common bottlenecks towards strengthening IDSR. Based on the gaps identified from the Member States survey conducted in quarter 2 and the discussions during the workshop, specific country needs were further galvanized through consultative process culminating to country-specific remediation plans to strengthen IDSR implementation. Illustrative examples and solutions are presented in Figure 6.


Figure 6: IDSR Gaps and Solutions Examples



The countries were inducted on practical approaches to weekly data reports, data validation exercise, simulation exercise on the architecture and needs of the information system in an emergency, including thresholds, contact tracing, data hosting, use of GIS tools and data analysis and visualization.

Country-wise progress on IDSR implementation activities

DEMOCRATIC REPUBLIC OF CONGO




Democratic Republic of Congo began preparatory activities of scaling up IDSR by creating media visibility for the cascade training to be conducted, and drawing up the list of supplies, reagents, and consumables for the lab investigation towards strengthening diagnostics, and genomic sequencing needs were drawn up in collaboration with the national public health laboratory.

KENYA



Kenya began scaling of IDSR through National Training of Trainers (ToT) workshop for 45 participants designed to support onboarding of the Kenya Ministry of Health to the Epidemic Intelligence from Open Sources (EIOS) Global Initiative for strengthening Event-based Surveillance and Response. Kenya partnered with Africa CDC, Washington State University, USAID Kenya/ East Africa -Health IT Project, ICAP, GIS. The workshop illustrated that there is an opportunity for stronger, integrated surveillance systems in Kenya enabling quicker detection and action to prevent / timely respond to outbreaks. Finally, knowledge exchange through sharing valuable experiences, requirements and lessons learned would prove invaluable to drive IHR, resulting in better coordination of preparedness for and response to priority diseases, conditions, and events by the MOH structures (both national and devolved structures) working in collaboration with relevant programs and stakeholders.

MAURITANIA



In Mauritania, discussions were held with the Health and Development Training Institute (ISED) in Dakar for the training of national trainers on tools for collecting and analyzing epidemiological surveillance data (ODK, POWER BI, EpiInfo). The consultations include the Director of ISED, Director of Epidemiological Surveillance of the Ministry of Health of Mauritania and three (3) members of WCO Mauritania. There was also ongoing discussion with ICAP-Columbia University for collaboration on monitoring and evaluation of TASS project activities in Mauritania.

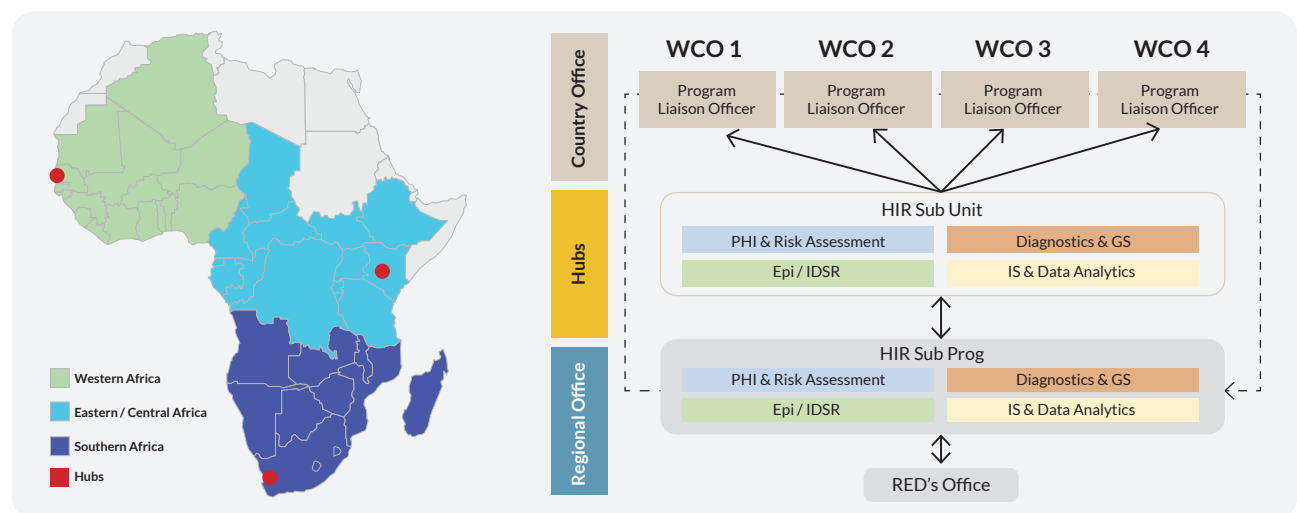
TOGO



In Togo, preparation has been done to support production of IDSR training materials and tools with other activities being planned in November and December.

IDSR data analysis and data use

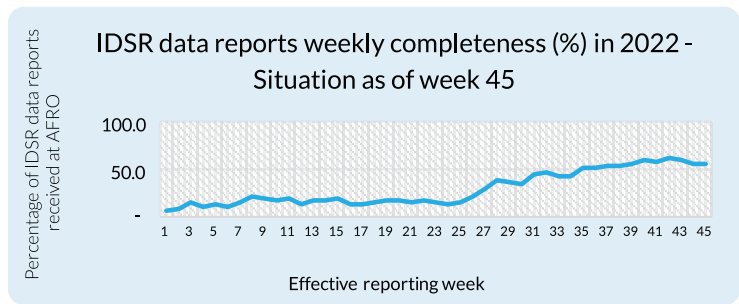
Figure 7: Country-wise structure for eIDSR implementation



Implementation of the electronic IDSR has been initiated with the designing of data architecture to help streamline the process of data collation across countries. It is envisaged that this will enhance flow and leverage eIDSR to create a holistic picture of three aspects: Case-Based reporting System (CBS); Event-Based reporting System (EBS) and Indicator-Based System (IBS). Inclusion of the ten countries, plus Nigeria, targeted in Year 1 to benefit from the budgeted amount. The structure of the arrangement is presented in Figure 7.

Continued weekly review, threshold analysis and feedback to countries and tracking of completeness and timeliness of monitoring of data from countries. Figure 8 shows the number of reports received. The flagship plans on ultimately receiving 45 IDSR weekly data reports, excluding Algeria and South Africa which are not implementing IDSR, corresponding to WHO AFRO Member States that are implementing the third edition of IDSR. In terms of completeness, Figure 9 shows an increasing trend of completeness over time.

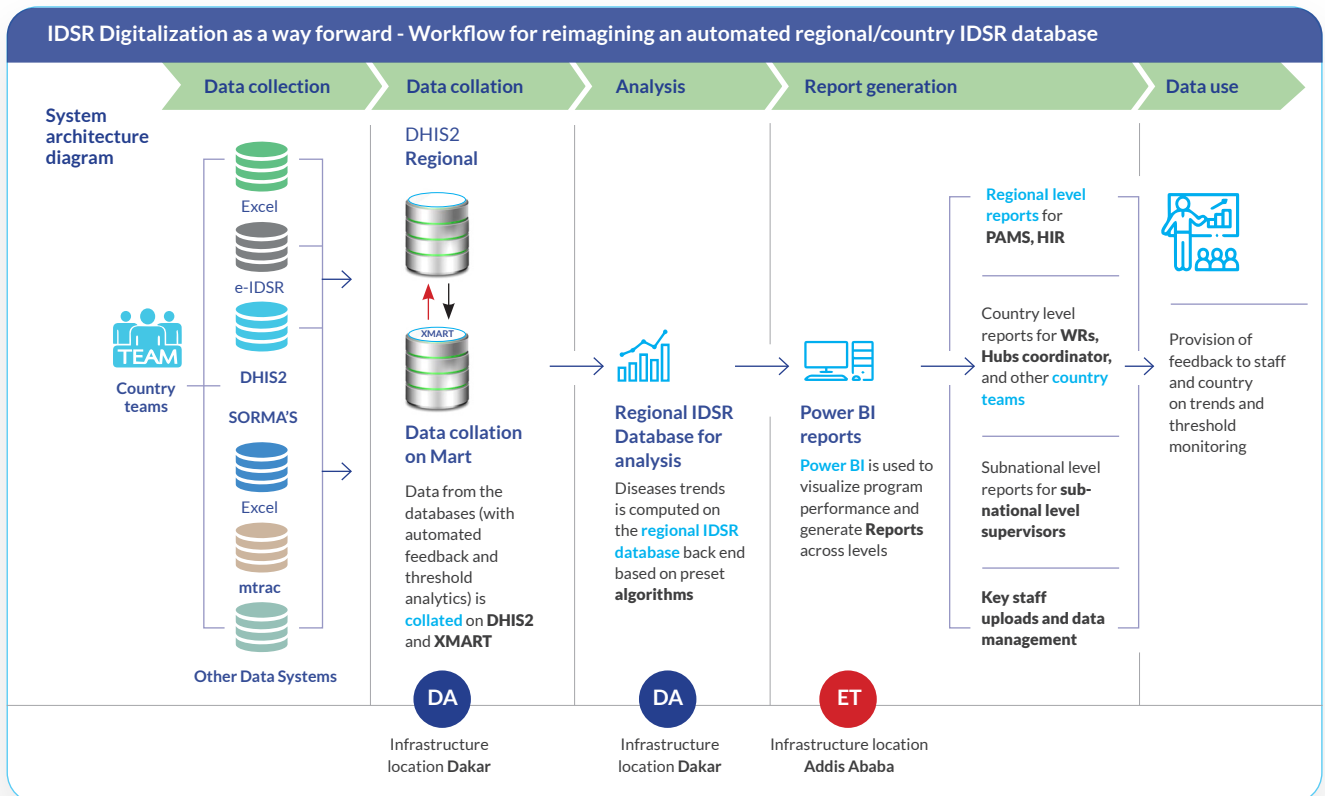
Figure 8: IDSR weekly reports completeness rate as of week 45, 2022



Pillar 2: Data management and digitization

TASS is working towards the implementation of AFRO-centralized surveillance data management and knowledge management platform. All countries conduct validation of IDSR data before publication and sharing.

Figure 9: WHO AFRO's centralized data and knowledge management platform



Additionally, TASS has initiated several advocacy strategies and policy dialogue for sustainable and predictable funding. Full implementation of activities under this pillar is scheduled for next year. Meanwhile, the programme has developed a 9.9 Million USD proposal to accelerate IDSR in 10 focus countries, and a 2 Million USD proposal to integrate IDSR with vaccination for five (5) countries.

There has been progress made to accelerate catalytic efforts towards generating more funds to support various activities. For example, proposals have been developed for EWARS deployment, EIOS rollout, electronic tools deployment for community-based surveillance, situation room infrastructure for countries, which have been shared with partners. The two proposals are for Strengthening Disease Surveillance & Epidemic Intelligence; and Integration of IDSR and Vaccination. These efforts are geared towards creating a momentum for implementation of various activities under TASS with the broader vision of continuous advocacy for countries to streamline the activities in their national plans and ensure resources are available for implementation.

C. SURGE



The SURGE implementation continues in full swing with scoping missions undertaken for Central African Republic, Namibia, Rwanda, Congo and DRC. Further, the scoping missions for Angola, Kenya, Senegal, Ethiopia, Chad, Tanzania, and Uganda are planned for the next quarter. The outbreak of Ebola (reported in September 2022) has led to delaying the scoping mission in Uganda due to which this year, all countries but one will have SURGE implemented.

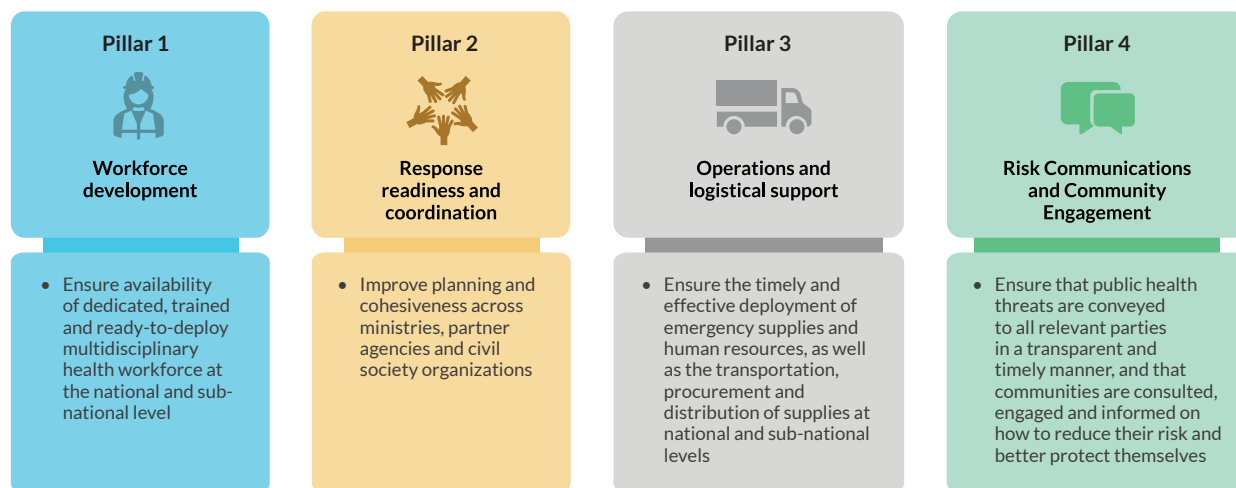
Figure 10: SURGE country wise scoping missions plan

Countries covered in the Scoping Mission Plan		
By mid-August	By 1st week of October	By 1st week of November
<ul style="list-style-type: none"> • Congo • DRC • Namibia 	<ul style="list-style-type: none"> • CAR • Kenya • Senegal • Ethiopia 	<ul style="list-style-type: none"> • Chad • Rwanda • Tanzania

Africa CDC has been instrumental in the planning and preparation of the scoping missions. During the scoping missions, areas of collaboration were explored with an array of stakeholders. For instance, in Namibia, partnerships were forged with Ministry of Agriculture, Ministry of Information, academic institutions, the military, and the private sector for information exchange and joint use of resources to respond to emergencies.

This section of the report covers key updates on pillars of SURGE with a focus on operations and logistical support.

Figure 11: Pillars of the SURGE Flagship



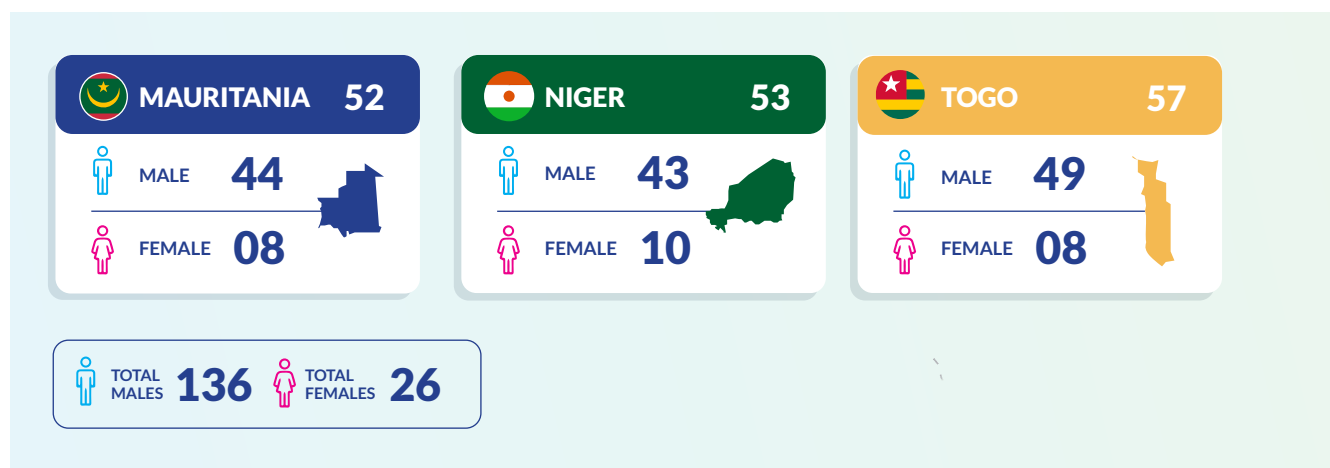
Pillar 1: Workforce Development

The pillar aims at rapid mobilization of high-caliber African responders to shorten the response time to emergencies. The target is effective deployment within the first 24-48 hours by creating a multidisciplinary team of 3,000 African ‘Emergency Responders’ ready for deployment across national and sub-national levels.

Recruitment process:

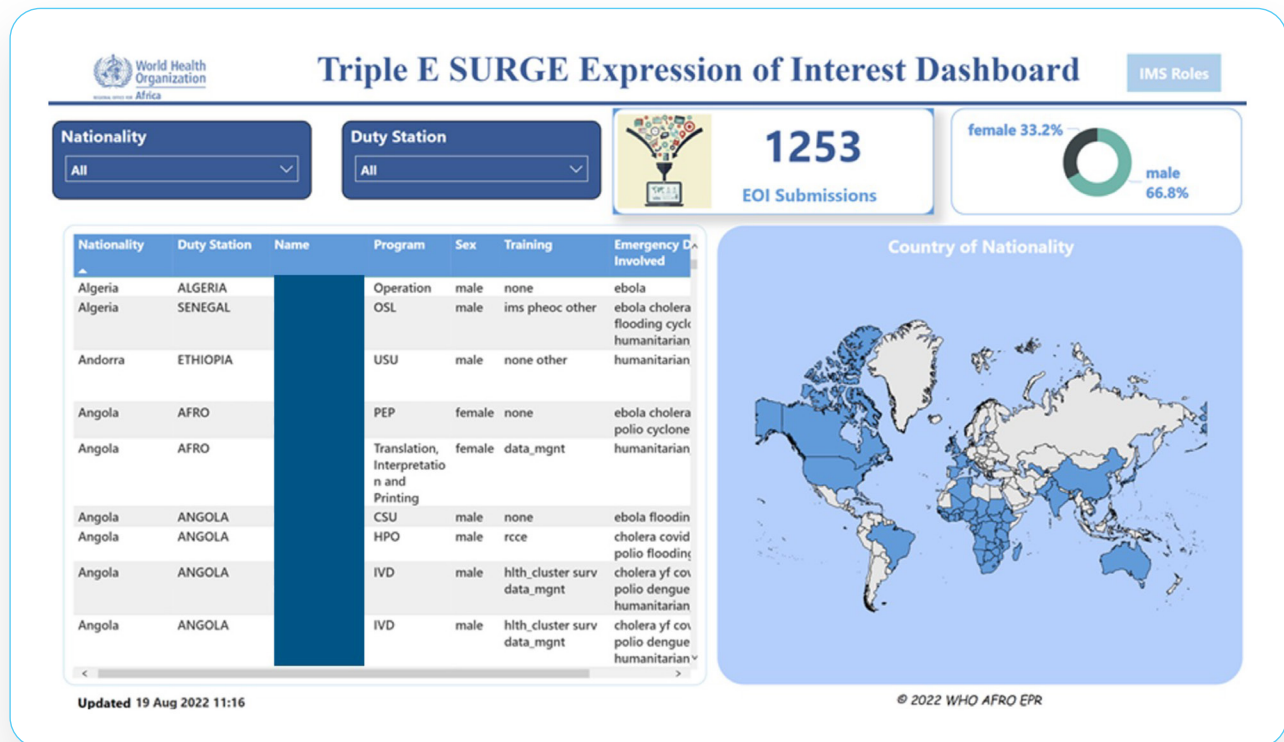


Quarter 3 witnessed additional recruitment of 162 emergency responders of which 16% are female.



In order to recruit emergency responders from the WHO internal workforce, an expression of interest was released. **1,253 people expressed interest, and the selection of 250 will be made in the next quarter.**

Figure 12: Triple E SURGE Expression of Interest Dashboard



Quarter 3 also saw progress in training as the content for the Module 5 training, which focuses on external communication, was developed. This module includes training experts on how to engage with media including media houses and press releases, and how to create audio visuals for better external communication. Also, 53 experts from Niger have so far been trained on this module. Experts from other countries are expected to get trained in the coming quarters.

Pillar 2: Response Readiness and coordination

This pillar aims to establish Public Health Emergency Operations Centers (PHEOCs) as a unique coordination point for the health emergency management as recommended by the International Health Regulation (IHR 2005). The core activities of this pillar aim to set up or cement the national mandate and coordination capacity of PHEOCs, which function as a unique coordination point for the management of all emergency preparedness and response work in each country.

Establishment of PHEOCs continues to be an intensive process with varied levels of progress across the different countries and the activities under this flagship primarily afford technical support.

The extent of progress in Q3 in the response readiness and coordination pillar is detailed below:

- WHO AFRO in partnership with EMRO, Africa CDC, WAHO and other key partners, developed a five-year PHEOC strategic plan 2022–2026, targeting 90% of the Member States to have functional PHEOCs, to ensure effective readiness and response coordination.
- In efforts to implement the Regional strategic plan at country level, 30 countries were supported to develop national PHEOC implementation plan to strengthen their PHEOC for effective readiness and response coordination.
- Provided technical support to Botswana, Benin, Burundi, Chad, Ghana, Mauritania, and Niger to operationalize / strengthen their PHEOC. The support included development of legal framework, different plans, and procedures; training to the PHEOC routine staff and surge staff on emergency management including Incident management system (IMS); and conducting simulation exercise to test systems, skills and capacities.

Pillar 3: Operations, Support and Logistics

The pillar focuses on facilitating prompt and effective deployment of emergency supplies and human resources. It targets an average deployment time to countries of 24-48 hours, down from 20 days currently. Activities under this pillar strengthen transportation, procurement, and distribution networks at regional, national, and sub-national levels. This replaces a reliance on WHO's central logistics hub.

According to the plan, at the country level, priorities include equipping emergency responders with an 8-vehicle fleet, designing warehouse facilities where required, optimizing storage infrastructure to hold two weeks of supplies, and procuring USD 350,000 of supplies.

Partnerships and Collaboration with Governments, UN Agencies and other stakeholders have been crucial in operationalization of the hubs. Against the overwhelming support received in Quarter 2 from the Kenyan government and the Government of Senegal, the flagship has continued to pursue mutually beneficial partnerships and structures to enable optimization of its activities. A prime example is the mutual recognition of the UN Secretariat and UN entities' contracts that improves logistical capacity by allowing for suppliers and vendors recognized by other UN agencies to be leveraged for service provision. This cuts down the time it would take to source and onboard new suppliers and vendors specifically for the flagship programs.

Africa CDC and the EPR flagship are also jointly developing training material for capacity building to strengthen human resources for emergency supply chain management. This is through identifying the key learnings from past emergencies that can be used to improve supply chains knowledge, promote adoption of industry best practices, and human resource deployment and enhance the effectiveness of coordination mechanisms in times of crises, through well-trained technical and operational staff.



Well-coordinated regional distribution is fundamental for successful emergency response. A critical element of this is adequate stockpiles that can be rapidly dispatched in the event of an emergency.



Nairobi Hub Warehouse

Current stockpile supplies worth **\$1,013,665**

Including:



PERSONAL PROTECTIVE EQUIPMENTS



EBOLA KITS



MEDICAL EMERGENCY KITS



MEDICAL TRAUMA KITS



This stockpile is warehoused in a facility that was secured in September and was critical in **achieving readiness to ship in 24-72 hours achieved in the Uganda Ebola response and the Rwanda Ebola preparedness.**



In addition to the stockpile available in the warehouses in Nairobi and Dakar, there is currently **cargo worth \$ 3,275,392 in transit to Nairobi and another stockpile in Dubai.**

For effective health emergency response, health products and technologies must be adequate in terms of supply and quality and so the value of strategic sourcing cannot be overstated. To achieve this, activities in Q3 have focused on building a network of reliable suppliers through discussions with Kenyan Pharmaceutical Manufacturers Association, agreements reached with Afro Quality Assurance team to conduct joint evaluations, and discussions with Africa CDC to gain access to their vendor database.

Innovation allows for the optimization of resources and leapfrogging of adequate technological requirements for improved health outcomes in health emergency settings. Innovating compact, mobile, essential services and equipment that can be repurposed as needed allows for agility and rapid deployment in emergency settings. In Q3, procurement processes have been ongoing for Mobile Intensive Care Units, Mobile Labs and Warehouse in a box.



Mobile ICU in a box (Interior and Exterior)

In the coming months, the areas of priority include roll out of the pilot project to facilitate entry of goods from the WHO hubs into Member States with the Africa CDC as well as identification of a list of vendor managed inventory.

Another key priority is to initiate the Push inventory system in key locations. This will optimize for emergency preparedness and response as well as strategic sourcing through engagement with the private sector. Key activities planned for the next quarter include the East Africa Humanitarian Seminar (9–11 December 2022) as well as the joint business seminar with the governments of Kenya, Morocco, Tunisia, Egypt, South Africa and UNECA.

Pillar 4: Risk communication and community engagements (RCCE)

In Quarter 3, the RCCE program has supported ministries of health in development of key messaging in response to outbreaks. Of note has been the involvement of the RCCE WHO experts in the Ebola outbreaks in both DRC and Uganda.



There are plans for an RCCE strategy meeting in the coming quarter. At this meeting, an RCCE workplan and associated M&E framework will be developed to guide the activities of this pillar going forward.



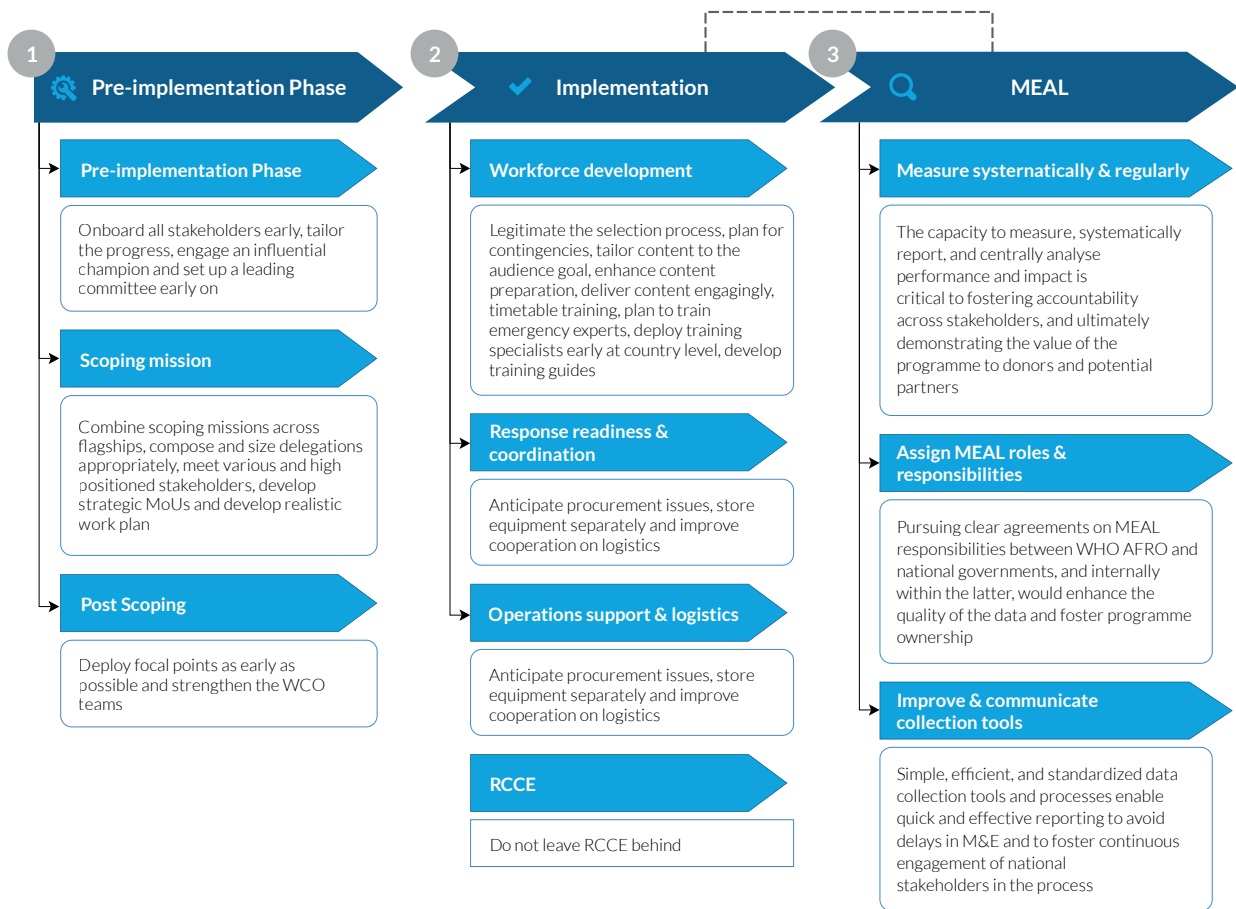
Reflections and learnings:

A publication, “Emerging lessons from the rollout of the AVOHC-SURGE flagship programme from governments, partners, and WHO across five countries” was released in August 2022.

The report brings to light the challenges observed and best practices developed while deploying the programme in phase 1 countries. It was developed through a qualitative research method based on the contributions of WHO staff, country stakeholders, and local financial and technical partners. The lessons are captured against the three (3) stages of flagship rollout in each country.



Figure 13: Emerging lessons from roll out of the AVOHC-SURGE across the 3 stages



Key Lessons

- 1 During the pre-implementation phase, **WHO AFRO and WHO Country Offices (WCOs) deployed tremendous efforts to onboard stakeholders as early as possible, and with as many government players and partners as possible.** This outreach encouraged interest and further participation in adapting the initiative to countries and take ownership.
- 2 Once committed to the flagship, influential champions (often ministers of health) **coordinated the creation of in-country steering committees and project management tools.** Focal points were also essential to kick start the initiative but sustaining this momentum after they left has become a key challenge in some countries.
- 3 While implementing the workforce development pillar, which is the main focus to date, **stakeholders applauded the transparent selection of emergency responders, the quality of training facilitators, and training delivery.**
- 4 Availability of other funding from different donors and bilateral partners such as the World Bank, USAID-CDC, African Development Bank need to be discussed with countries during scoping mission. These additional funds received by countries can complement resources mobilized under the flagship initiative.
- 5 Improvements in audience engagement, detailed orientation, gender inclusivity and cultural sensitivity, pedagogy, and organization could further enhance learning outcomes. Importantly, coordination mechanisms for the deployment of the Experts reportedly lacked clarity from the outset.
- 6 For logistics, the acquisition of vehicles was smooth, **but some countries struggled to prioritize the medical kits to procure, find adequate storage, and develop clear procedures to use the resources.**
- 7 **Partnership has been key in rolling out of the training modules by bringing non-state actors, NGOs and other UN agencies** to support the implementation of training modules both within the country and from different health emergency networks.
- 8 On RCCE, **countries are yet to invest significantly in this pillar.** RCCE progress is stalling against the established work plan.
- 9 Regarding MEAL, **most countries have established monitoring committees to supervise programme performance and tackle roadblocks.** However, key performance indicators (KPIs) and MEAL roles and responsibilities are not yet well established.

Action points recommended

Make the flagship ready for action in the first wave of countries, particularly in supporting the response to any new public health outbreaks. This requires developing a concrete action plan for the next phase of the implementation, that is meaningfully tailored to countries' contexts, needs and challenges. In the medium term, WHO AFRO will need to update the flagship's strategy to pave the way for scale-up while consolidating the country-level implementation activities with the other two flagships.

Boost the capacity of WHO AFRO at regional and country levels to ensure the sustainability and success of AVoHC-SURGE and other flagships. Capacity can be built by strengthening EPR teams at the regional and national levels and leveraging other WHO project areas and clusters.

Elevate the engagement of all stakeholders involved in the flagships. Notably, WHO AFRO should continue to foster and deepen country ownership over the programme. The report recommends that WHO AFRO should also embrace SURGE and other flagships, namely TASS and PROSE, as opportunities to create a consortium of technical and financial partners working on EPR in the African region.





02

WHO AFRO's response to
Grade 2 and 3 events



World Health
Organization

ENSURING HEALTH
SECURITY IN THE
AFRICAN REGION

Emergency preparedness
and response flagship
programmes

Response to Grade 2 and 3 events

WHO AFRO, in collaboration with its partners, continued to support Member States to detect, assess, and rapidly respond to new health events while sustaining response to other protracted emergencies.

In the third quarter of 2022, five new grade 2 and one protracted grade 2 event were reported. They include the Marburg outbreak in Ghana, Ebola outbreak in Beni DRC, the Sudan Ebola virus outbreak in Uganda, Acute Kidney Injury (AKI) due to unknown cause affecting children in the Gambia and the yellow fever outbreaks in nine countries. There was one public health event of international concern (PHEIC) – Mpx. In addition to the ongoing COVID-19 pandemic, there were two grade 3 humanitarian events in the region - the food insecurity in the greater horn of Africa and Madagascar, and the humanitarian crises in the Sahel, Northern Ethiopia, South Sudan, Mozambique, and DRC which required continued financial, technical, and operational support. WHO provided both operational and technical assistance to Member States to ensure that robust responses to emergencies were established within 72 hours. Table 1 summarizes events responded to in quarter 3 - both new and ongoing events. Ten grading calls were conducted jointly with WHO headquarters - six (6) for new events and four (4) to review grade or close existing events. Four major events (EVD, Marburg, Mpx, and SVD) were added and countries

Key Highlights

USD 2,530,000 was used to support **25 countries across Africa** to manage various events over this period

58 experts deployed to the 25 countries and working in partnership with 79 in country staff to manage the events

43 countries supported to have sequencing capacity for COVID-19

were supported to initiate a comprehensive response which included the activation of incident management teams, development and implementation of response plans as well as the scale up of other essential operations. The response to floods in Madagascar and South Sudan was closed in this quarter.

Response to new events

Marburg outbreak in Ghana

Date: 7 July 2022
Cases: 3 cases, 2 Deaths
Status: Contained in 8 weeks

\$ 300,000 utilized

PPE supplied

15 Country staff and 02 International experts deployed

Acute Kidney Injury (unknown cause) in the Gambia

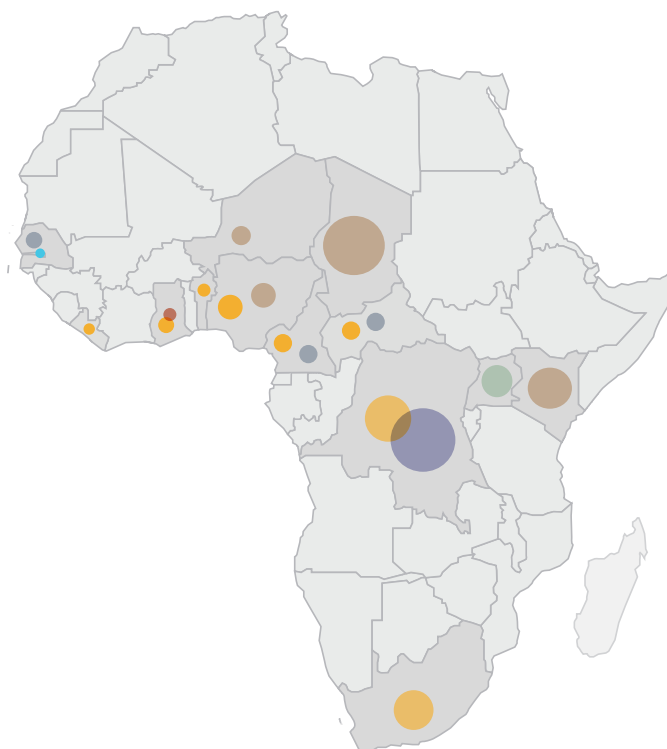
Date: 23 September 2022
Cases: 75 cases, 50 deaths
Status: Emergency Medical team from Senegal were deployed to Gambia to support clinical management of the cases with focus on nephrology care.

Surveillance was scaled up and mass recall of the contaminated syrups were conducted in all regions

\$ 470,000 utilized

10,000 doses of Paracetamol

7 experts deployed to lead the response and 8 EMTs for clinical care



Mpx response in nine African Countries

Date: 23 July 2022
Status: Surveillance technical guidelines and reporting tools were developed and disseminated to all countries to facilitate case detection, reporting, investigations, management, contact tracing and follow-up.

\$ 960,000 utilized

39,540 Laboratory test kits

Ebola virus disease Resurgence in Beni, North Kivu in DRC

Date: 16 August 2022, DRC announced the 15th outbreak of EVD since 1976
Cases: 1 EVD case after death
Status: Contained in 4 weeks

\$ 300,000 utilized

1000 doses of Ervebo Vaccine

WHO repurposed staff and activated incident management teams in Kinshasa and in Beni

Multi-country Yellow fever response

Countries: 12
Status: To date, an estimated 4 million at-risk people have been protected through reactive vaccination campaigns

Seven requests to the Inter-agency Coordinating Group for emergency vaccine provision were approved

16 consultants-4 in YF-IMST and 12 in countries

Sudan Ebola Virus outbreak in Uganda

Date: 20 September 2022
Cases: 50 SVD cases, 25 deaths.
Status: Ongoing

\$ 500,000 utilized

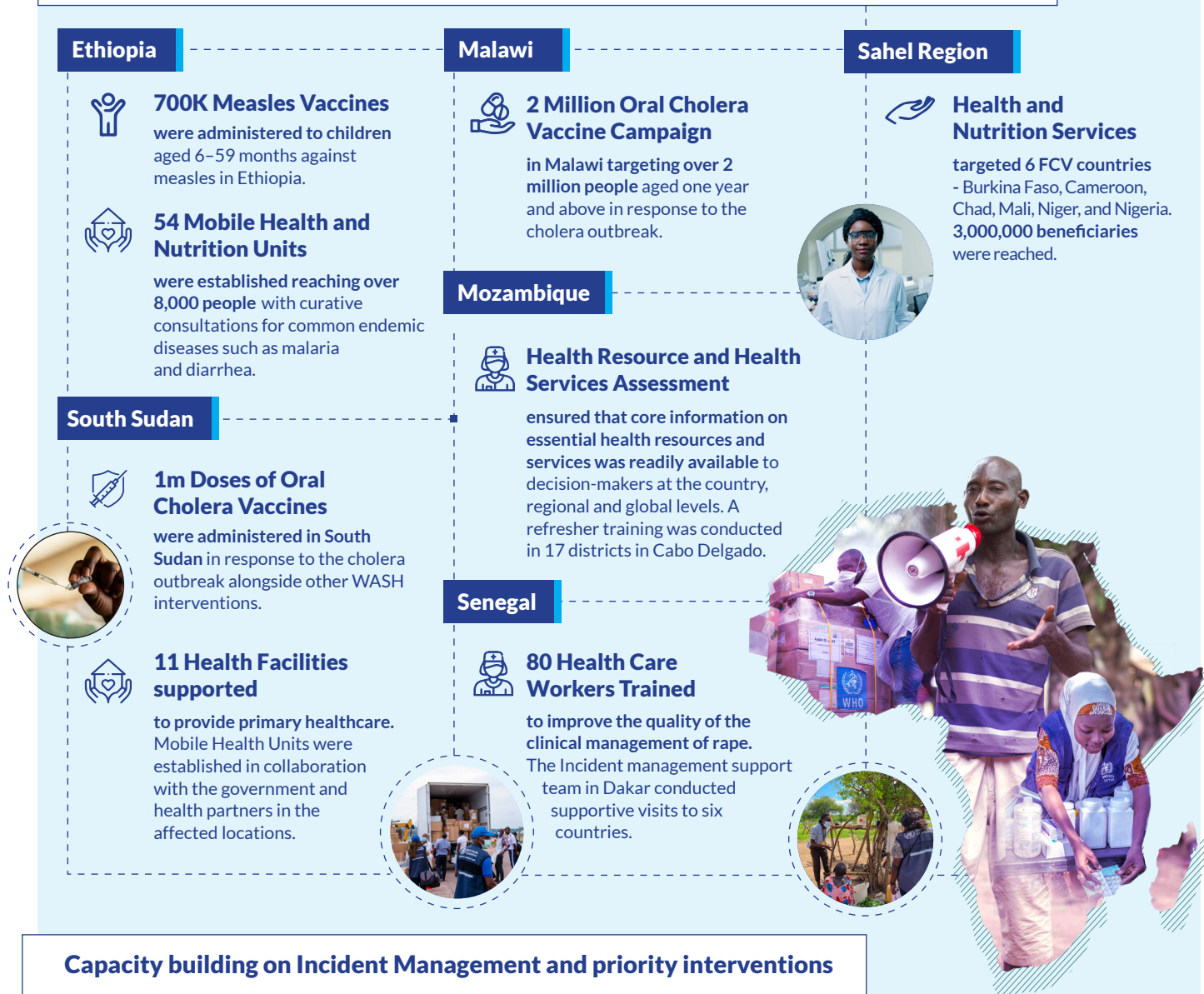
14 tons or PPE and IPC supplies delivered

33 personnel from WHO and 44 clinicians from MoH

Response to ongoing Humanitarian Events

Access to essential health services is always hampered in humanitarian settings by several factors. To ensure affected populations have access to much-needed health services, Ethiopia and South Sudan were technically and operationally supported to establish Mobile Health and Nutrition Units (MHNTs).

Technical and operational support was provided to respond to various disease outbreaks



Capacity building on Incident Management and priority interventions

As part of the capacity building of HCWs, the **Ethiopia country office** was supported to train:

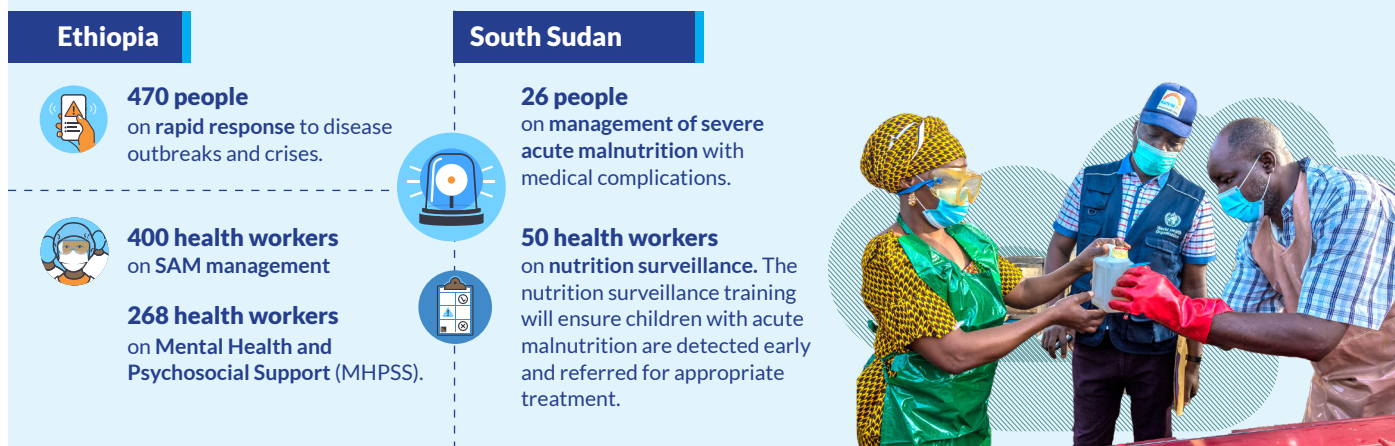


Table 2: Summary of events during quarter 3

Event	Grade	Date Graded	Countries affected	Nature of event	Status of event
Marburg	2	16 July 2022	Ghana	First viral hemorrhagic fever outbreak in decades due to Marburg Virus detected in Urban Ashanti region. Three cases including two (2) deaths (CFR = 67%) was confirmed. A total of 198 contacts were identified and followed up in the three regions affected (Ashanti, Savannah, and Western).	End of outbreak declared by Government on 16 September 2022 Closure time: 8 weeks
Ebola (EVD)	2	23 August 2022	DRC	Recurrent Ebola outbreak in Beni, North Kivu province in DRC. The same area had a large Ebola outbreak in 2018-2019. With a large population of survivors coupled with insecurity, inaccessibility, mass displacement, a weak health system and rising hostility towards the UN. Only one case was confirmed and died. 182 contacts were listed and followed up and over 200 contacts and contacts of contacts were vaccinated.	End of outbreak declared by Government on 28 September 2022 Closure time: 8 weeks
Ebola (SVD)	2	21 September 2022	Uganda	Ebola Disease due to the Sudan Ebola Virus was confirmed in the Central Uganda District of Mubende. It was preceded by a cluster of 6 community deaths. The outbreak was the 7th Ebola outbreak in the country, the 4th due to the Sudan Ebola virus species and the first in over a decade. As of 28 September 2022, a total of 50 SVD cases (31 confirmed and 19 probable) were reported. The cumulative number of deaths was 25 with a CFR of 50%.	Active
Acute Kidney Injury	2	23 September 2022	Gambia	Acute Kidney Injury outbreak, following the confirmation of 75 cases and 54 deaths (CFR=65%) in children under 5 years of age in six (6) out of seven (7) health regions in The Gambia. Toxicology tests done on the medicines taken by the children revealed the presence of ethylene glycol and diethylene glycol in two out of 9 syrups respectively. Affected drugs were recalled. Multi-sectoral investigations ongoing.	Active
Yellow fever	2	10 February 2022	Cameroon, Chad, CAR, Rep of Congo, Cote d'Ivoire, DRC, Ghana, Niger, Nigeria, Uganda, Kenya and Gabon	By the end of the third quarter, five (5) countries (Chad, CAR, Cameroon, Kenya, Niger) had acute responses ongoing, and seven countries (Ghana, Uganda, DRC, Congo, Cote d'Ivoire, Nigeria and Gabon) had no acute response but had epidemiological situations requiring close monitoring.	Active-Protracted
Humanitarian Crises in the Sahel	2	19 November 2020	Burkina Faso, Northern Cameroon, Chad, Niger, Northeast Nigeria, and Mali	Recurrent acute events within a protracted and underfunded humanitarian landscape, including violence, volatility, displacement, and socio-economic factors that challenge healthcare delivery.	Active-Protracted
Mpox	PHEIC	23 July 2022	DRC, Nigeria, Cameroon, Ghana, Liberia, Congo, South Africa, CAR and Benin and 83 Member States from other WHO regions.	The Multi-country Mpox outbreak was declared a public health event of international concern on 23 July because the outbreak was spreading around the world rapidly, through new modes of transmission, about which too little is understood.	Active
Drought and food insecurity in the Horn of Africa	3	20 May 2022	Ethiopia, Somalia, Kenya, South Sudan, Sudan, Djibouti, and Uganda	The worst drought in more than 40 years in the GHOA - fourth consecutive failed rainy season. Multiple and overlapping shocks along the region: a combination of extreme weather (drought and flooding), conflicts, crop pests, macroeconomic challenges, increasing food prices (accelerated by the Ukraine crisis), and effects of the COVID-19 pandemic.	Active-Protracted
The humanitarian crisis in Northern Ethiopia	3	19 December 2020	Ethiopia	Complex Humanitarian crisis due to armed conflict, with displacements (internally and externally), inaccessibility and upsurge in Malaria, Measles, and a rupture in the Supply chain of medications for Tuberculosis and other chronic medical conditions.	Active-Protracted

