World Health Organization

ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency preparedness and response flagship initiatives

2022
ANNUAL REPORT

Table of **Contents**

Acronyms

Africa CDC	Africa Centres for Disease Control and Prevention
AVoHC	African Volunteers Health Corps
CAR	Central African Republic
CDC	Centers for Disease Control and Prevention
CFE	Contingency Fund for Emergencies
CFR	Case Fatality Rate
COVAX	COVID-19 Vaccines Global Access
COVID	Coronavirus Disease
CVC	Core Voluntary Contributions
DRC	Democratic Republic of the Congo
EAC	East African Community
EIOS	Epidemic Intelligence from Open Sources
EMP	Emergency Preparedness
EMRO	WHO Regional Office for the Eastern Mediterranean
EOC	Emergency Operations Centre
EOCNET	Emergency Operations Centre Network
EPR	Emergency Preparedness and Response
FAO	Food and Agriculture Organization of the United Nations
FCV	Fragile, Conflict-affected and Vulnerable Setting
GHoA	Greater Horn of Africa

GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GPW13	World Health Organization's Thirteenth General Programme of Work
HCW	Health Care Worker
HPIS	Health Programming and Information Services
ICAP	International Center for AIDS Care and Treatment Program
IDSR	Integrated Disease Surveillance and Response
IEHK	Interagency Emergency Health Kits
IHR	International Health Regulations
IMS	Incident Management System
JEAP	Joint EPR Action Plan
MEAL	Monitoring, Evaluation, Accountability, and Learning
MHNT	Mobile Health and Nutrition Teams
MHPSS	Mental Health and Psychosocial Support
MHRP	Multi-Hazard Response Plan
NAPHS	National Action Plan for Health Security
NBW	National Bridging Workshops
NFP	National Focal Person
NGO	Non-Governmental Organization
OCV	Oral Cholera Vaccine
OSL	Operations Support and Logistics

PHE	Public Health Event
PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operations Centre
PPE	Personal Protective Equipment
PROSE	Promoting Resilience of Systems for Emergencies
PRSEAH	Preventing and Responding to Sexual Exploitation, Abuse and Harassment
PVS	Performance of Veterinary Services
Q1	Quarter 1
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
RCCE	Risk Communication and Community Engagement
RO	Regional Office
RRT	Rapid Response Team
RTA	Road Traffic Accident
RUTF	Ready-to-use Therapeutic Food
SAM	Severe Acute Malnutrition
SARS	Severe Acute Respiratory Syndrome
SPAR	State Party Self-Assessment Annual Report
STAR	Strategic Tool for Assessing Risks
SURGE	Strengthening and Utilizing Response Groups for Emergencies

TASS	Transforming African Surveillance Systems
TWG	Technical Working Group
UN	United Nations
US	United States
USD	United States Dollar
VCS	Voluntary Contributions Specified
WAHO	West African Health Organization
WASH	Water, Sanitation and Hygiene
WCO	World Health Organization Country Office
WHE	World Health Emergencies
WHO	World Health Organization
WOAH	World Organization for Animal Health

List of **figures**

List of **tables**

WHO initiative to strengthen regional Ebola cross-border collaborations.

Dr Matshidiso Moeti
Regional Director, WHO AFRO

Message from the **Regional Director**

> WHO is establishing Regional Emergency Hubs in Kenya, Senegal, and South Africa. At the end of 2022, WHO AFRO was monitoring 155 health events in the region, up from 133 at the beginning of the year.

With over 100 major public health emergencies affecting millions of people each year, [1] sub-Saharan Africa remains uniquely vulnerable to epidemics and humanitarian crises. The past year presented serious challenges for Africa and African health systems.

By the end of 2022, the WHO African Region (AFRO) was monitoring 155 health events, up from 133 at the beginning of the year.[2] The COVID-19 pandemic continued to expose critical vulnerabilities in the region's health infrastructure and logistical systems, especially around vaccination, while aggravating the harm caused by other major health crises. Meanwhile, escalating violence and displacement in multiple countries strained some of the region's most fragile health systems, and outbreaks of Ebola, cholera, and yellow fever intensified pressure on emergency preparedness and response capabilities.

A protracted drought and multiple conflicts have affected over 10 million people in Eastern Africa and the Sahel, exacerbating health challenges in some of the continent's most remote and underserved areas. WHO AFRO supported the humanitarian response by establishing subnational clusters, deploying more than 70 international experts, organizing trainings on infectious disease surveillance and outbreak management, and delivering primary health services to displaced populations. WHO also responded to outbreaks of Ebola in Uganda and DRC, Marburg virus in Ghana, and cholera in six countries including Malawi. During the year, WHO AFRO deployed hundreds of staff and disbursed almost US$650 million in funding to address health emergencies in Member States. WHO supplied a combination of urgent medical assistance and long-term institutional support designed to mitigate the impact of health crises while building robust and resilient health systems across the continent.

While most countries have now lifted their emergency measures, the COVID-19 pandemic continued in 2022,[3] with about 1.7 million additional cases and 20,000 deaths reported in the AFRO region. WHO continued to support vaccination efforts through the COVID-19 Vaccines Global Access (COVAX) facility.

1 "WHO Health Emergencies Programme | WHO | Regional Office for Africa," accessed March 5, 2023, https://www.afro.who.int/about-us/programmes-clusters/who-health-emergencies-programme.

2 "WHO Weekly Bulletin on Outbreaks and Other Emergencies," Jan 2022 and Jan 2023. https://apps.who.int/iris/bitstream/handle/10665/365512/OEW01-261222010123.pdf?sequence=1&isAllowed=y
https://apps.who.int/iris/bitstream/handle/10665/350967/OEW01-271202012022.pdf

3 https://www.un.org/africarenewal/magazine/february-2022/africa-track-control-covid-19-pandemic-2022

$650million
in funding disbursed to address health emergencies in Member States.

Capitalizing on the momentum generated by these efforts, WHO AFRO helped Member States restart their vaccination campaigns for yellow fever and strengthen mpox surveillance and testing capacity. Integrated Disease Surveillance and Response mechanisms are helping to detect epidemics earlier, and outbreak reporting by Member States has significantly improved.

To address the extraordinary challenges facing the region, WHO AFRO has transformed its Emergency Preparedness and Response (EPR) cluster by consolidating all initiatives currently being implemented across the 47 countries of the AFRO region.

Informed by extensive stakeholder consultations and lessons learned during the pandemic, Member State health ministers endorsed an ambitious eight-year Regional Strategy for Health Security and Emergencies 2022–2030 at the 72nd Regional Committee meeting held in Lomé, Togo in August 2022.[4] By adopting the strategy, Member States agreed to reach key targets for strengthening their emergency preparedness and response capabilities by 2030. The WHO AFRO EPR cluster is working with Member States to operationalise this strategy by implementing three flagship initiatives and establishing regional emergency hubs.

To implement these flagships efficiently and advance its broader mission, the EPR cluster launched a thorough review of its own capabilities and identified priority areas for capacity-building. The objective of this review is to transform EPR into a fit-for-purpose cluster supported by continual improvements in monitoring, evaluation, accountability, and learning systems. WHO is also establishing Regional Emergency Hubs in Kenya, Senegal, and South Africa.

The progress achieved by WHO in 2022 would not have been possible without the active engagement of Member States and partners. Because disease threats do not stop at national borders, WHO AFRO forged a partnership with the WHO Regional Office for the Eastern Mediterranean (EMRO) and the Africa Centres for Disease Control and Prevention (Africa CDC) to build transnational emergency preparedness and response capabilities and improve continent-wide health security. Productive collaboration with national governments remains essential to our work, and we look forward to strengthening our partnerships in 2023 and beyond.

4 WHO AFRO, 2022. https://www.afro.who.int/news/african-health-ministers-adopt-new-regional-strategy-transform-health-security
WHO Regional Committee for Africa "Regional Strategy for Health Security and Emergencies" 2022. https://www.afro.who.int/sites/default/files/2022-08/AFR-RC72-8%20Regional%20strategy%20for%20health%20security%20and%20emergencies%202022-2030%20.pdf

Introduction

Major interlocking health emergencies increased in scale during 2022. The year began with the emergence of a new COVID-19 variant, Omicron, amid persistently low worldwide vaccination rates. WHO and its partner organizations, including Africa CDC, immediately ramped up vaccine supply through the COVAX initiative to enhance vaccine uptake among Member States. By December, the continent had delivered a billion doses of the vaccine.

As the year progressed, declining COVID-19 case rates enabled countries to ease their emergency containment measures, though the shock of the pandemic has left lasting socioeconomic scarring. The COVID-19 response efforts are ongoing, and the improving emergency preparedness and response architecture continues to bridge gaps in access to vaccines, health facilities, and medical products across the continent.

Throughout the year, the region faced other emergencies, including outbreaks of wild poliovirus, Ebola virus, Marburg virus, cholera, mpox, and yellow fever. Yellow fever outbreaks were reported in 12 countries in the region,[5] eight of which have experienced continued transmission since 2021,[6] while four reported confirmed cases only in 2022.[7]

5 Cameroon, Central African Republic (CAR), Chad, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Ghana, Kenya, Niger, Nigeria, Republic of Congo, Sierra Leone, and Uganda

6 Cameroon, CAR, Chad, Côte d'Ivoire, DRC, Ghana, Nigeria, and the Republic of Congo

7 Kenya, Niger, Sierra Leone, and Uganda

Ebola outbreaks were reported in the Democratic Republic of the Congo (DRC) and Uganda, while Ghana reported a Marburg virus outbreak, and six countries[8] reported outbreaks of cholera.

Mpox cases have steadily declined since October 2022, and WHO has continued to strengthen regional surveillance and laboratory capacity, including genomic surveillance in the affected countries. Of the 13 countries that reported mpox outbreaks between January and December 2022, Nigeria (61.8%), DRC (22.7%), and Ghana (9.5%), collectively accounted for 94.0% of confirmed cases. Rift Valley fever re-emerged in Mauritania, polio outbreaks were reported in more than 10 countries, and a measles outbreak affected the Sahel region. Surveillance cells have been established in DRC, while epidemiological investigations in remote health districts are ongoing in Central African Republic (CAR) and Ethiopia.

Communities across the Greater Horn of Africa (GHoA) region continue to suffer from conflict, instability, and a drought-induced increase in food insecurity. Rising rates of malnutrition and continued population displacement are exacerbating health risks and increasing the need for care in some of the world's most fragile and underserved areas. WHO and its partners both within and outside the health sector have launched a coordinated response effort designed to mitigate the damage caused by hunger and conflict that includes providing sexual and reproductive health services, treating chronic infectious diseases such as tuberculosis and HIV, and providing mental health services for people at high risk of violence and distress. Meanwhile, WHO continued to build the capacity of Member States to address recurrent outbreaks of endemic diseases like cholera, measles, and malaria. Improving surveillance systems for communicable diseases is crucial to this effort, as health authorities must be able to quickly identify and respond to new outbreaks. Over US$ 40 million was disbursed from the WHO Contingency Fund for Emergencies (CFE) to finance initial response activities in the AFRO region in 2022.

Sub-Saharan Africa continues to endure a disproportionate share of the world's health emergencies and humanitarian crises. The coronavirus pandemic highlighted key weaknesses in the readiness of the region's EPR systems, the development of its health workforce, and the capacity of its emergency supply logistics. To address these challenges, Member States approved an eight-year strategic plan in August 2022. To support the operationalization of the strategic plan, WHO AFRO is implementing three flagship initiatives: Promoting Resilience of Systems for Emergencies (PROSE), Transforming African Surveillance Systems (TASS), and Strengthening and Utilizing Response Groups for Emergencies (SURGE). The implementation of the strategic plan and the three flagships is guided by the WHO's 13th General Programme of Work (GPW13), which aims to ensure that an additional one billion people are better protected from health emergencies by 2025. Beyond their specific programmatic objectives, PROSE, TASS, and SURGE are designed to also advance Sustainable Development Goal 3, "Good Health and Well-Being." The three flagships were developed in collaboration with 30 ministers from 15 African governments, as well as technical experts and partners from across the continent, who helped define priority actions and formulate a scorecard to monitor results.

In close collaboration with Member States, WHO AFRO implemented these flagship initiatives throughout 2022—signing formal agreements with governments, forging institutional partnerships, and securing additional resources—while simultaneously responding to disease outbreaks and public health emergencies across the African Region. The three flagships advance complementary objectives and are guided by the One Health approach, which recognizes the inherent interdependence of human, animal, and environmental health.

8 Malawi, DRC, Nigeria, Kenya, Mozambique and Ethiopia

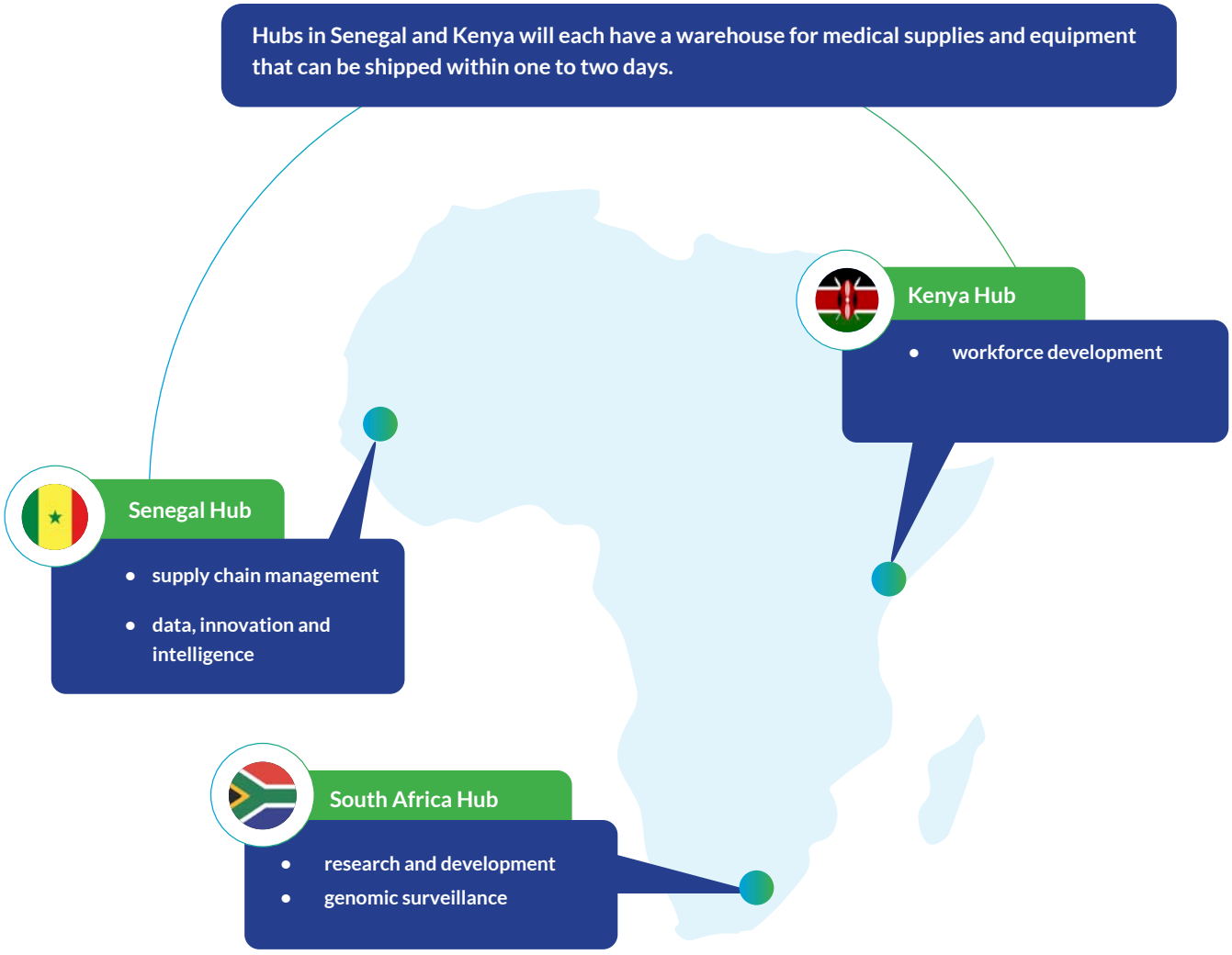
During 2021, as the COVID-19 pandemic highlighted the inadequacy of existing mechanisms for coordinating an emergency health response across countries and distributing essential medical supplies, WHO AFRO redoubled its efforts to build emergency-response capacity at the subregional level.

The EPR cluster has since worked closely with Member State governments to support the decentralization of emergency management and enable an efficient response to protracted multi-country health crises.

WHO is also establishing Regional Emergency Hubs in Kenya, Senegal, and South Africa. Serving as centres of excellence, these hubs aim to train 3,000 African responders in the multidisciplinary technical competencies necessary for effective emergency management. Each hub would have a specialized function to leverage countries' comparative advantage. The Senegal hub will include a specific focus on supply chain, data, innovation and intelligence; the Kenya hub will focus on workforce development; and the South Africa hub will work on research and development and genomic surveillance. As such, each hub would act as a nerve centre for African expertise in its respective area and facilitate cross-country learning.

In addition, the Kenya and Senegal hubs will each have a warehouse to stock medical supplies and equipment that can be shipped within one to two days, significantly reducing WHO AFRO's response time in supporting Member States during emergencies.

Figure 1: The Regional Hubs and their roles



Response to graded emergencies

During 2022, a surge in disease outbreaks combined with escalating humanitarian crises, drove a sharp increase in the number of monitored events and graded health emergencies. Drawing on lessons learned during the pandemic, the EPR cluster responded by adopting a more collaborative and decentralized approach to supporting Member States. The hubs played a critical role in enabling the rapid deployment of physical and human resources.

Over the year, the number of events being monitored by WHO AFRO and its partners rose from 133 to 155, including 134 disease outbreaks and 21 humanitarian situations. WHO responded to outbreaks of Ebola virus in DRC and Uganda; yellow fever in 12 countries across Eastern, Western, and Central Africa; Marburg virus in Ghana; acute kidney injury in The Gambia; and cholera in six countries—all of which were grade 2 or grade 3 health emergencies. WHO also responded to two public health emergencies of international concern (PHEICs), mpox and COVID-19.

The lasting effects of the pandemic, coupled with ongoing violence and instability, climate shocks, and rising global food prices, contributed to a significant increase in protracted humanitarian crises across Africa. Several existing emergencies also dragged on, deepening their negative impact.

The severe drought in the GHoA and the conflicts in northern Ethiopia and South Sudan were both re-graded from protracted 2 to protracted 3, indicating a long-term state of crisis.

With support from Member States and international partners, WHO AFRO provided technical, operational, and financial assistance to address these and other graded emergencies. Multilevel Incident Management Systems (IMS) were activated, Emergency Operation Centres (EOCs) were established, and US$40 million was disbursed from the Contingency Fund for Emergencies (CFE). A total of 245 experts, including WHO EPR staff, national and international consultants, and UN volunteers, were deployed to affected countries, where cluster coordination and training in case management provided timely support to at-risk communities.

The newly operationalized Kenya Hub proved instrumental in addressing the surge in graded emergencies. The Nairobi warehouse stockpiled over US$1 million in personal protective equipment (PPE), cold-chain reagents, emergency medical kits, specialized Ebola kits, and medical trauma kits. At the end of the year, an additional US$3.3 million in supplies was en route from Dubai. In total, WHO AFRO has stockpiled US$4 million in emergency supplies and processed 58 outbound shipments to support emergency response efforts in 25 countries across Africa. As a result of improved logistics, the average outbound lead time for shipping supplies has fallen from three weeks to just three days.

In parallel, WHO's Risk Communication and Community Engagement (RCCE) team worked closely with health ministries to develop appropriate messaging and outreach efforts to counter emerging outbreaks and mitigate the damage caused. The RCCE team conducted awareness-raising campaigns in response to the Ebola outbreaks in Uganda and DRC. The team also developed and shared outreach guidelines for mpox as well as information and education materials in most of the affected countries while providing continued support to reduce the spread of COVID-19.

ACHIEVEMENTS

The progress made in response to PHEs during the year included:

- **The reduction of the length of outbreaks** (for example, the 14th Ebola virus outbreak in DRC lasted 10 weeks compared to the 13th outbreak which lasted 18 weeks)
- **The establishment of the warehouse in Nairobi that is contributing to increased efficiency in deployment of critical supplies from the stockpile within 24-72 hours**
- **The containment of the Ebola virus in Uganda without spreading into neighboring countries**
- **In addition to Africa CDC, WHO AFRO developed partnerships with the Global Outbreak Alert and Response Network (GOARN), National Emergency Medical Teams, as well as national and international NGOs to have a robust response to the multiple events occurring in the region**

CHALLENGES

Progress was made during the year, however, some factors that hindered response include:

- **The limited and overstretched human resources in the AFRO region faced multiple simultaneous emergencies, which hindered the effectiveness of their response**
- **Partners did not consistently coordinate their support**
- **Limited funding constrained the response effort for other graded events**

PRIORITIES FOR THE NEXT YEAR

Enhance and consolidate the partnership between the WHO and other partners, to support the Member States in rapidly responding to public health events and protecting their populations

Strengthen the collaboration between WHO AFRO and countries for the surveillance of public health events for early detection

During 2022, WHO monitored and responded to the following major outbreaks:

COVID-19

In January 2020, the WHO declared COVID-19 a PHEIC, although the AFRO region did not confirm its first case until February. By the end of 2022, the region had reported almost nine million confirmed cases and 174,158 COVID-19-related deaths. All 47 Member States have reported COVID-19 cases, with South Africa, Ethiopia, Kenya, Zambia, and Botswana reporting the most cases during 2022. The WHO and its partner organizations continued to catalyse vaccine uptake through the COVAX facility, and a declining number of cases allowed governments to ease emergency measures during the year. By December 2022, the continent had received one billion vaccine doses, but less than 30% of the population was fully vaccinated.

EBOLA VIRUS IN UGANDA

In September 2020, an outbreak of the Sudan strain of the Ebola virus was declared in Uganda. In 2022, the country reported 164 Ebola cases—of which 142 were laboratory-confirmed and another 22 were probable—and 77 deaths. WHO deployed 133 experts to Uganda and supported the Ministry of Health in training and deploying 80 epidemiologists and 48 clinicians, all of whom were Ugandan nationals. A total of US$10.5 million was disbursed as part of this effort, including US$3 million to support emergency preparedness in neighbouring countries. WHO delivered 15,000 units of PPE and 60 pallets of infection prevention and control equipment and other medical supplies. Due to the response activities supported by WHO AFRO and its partners, by December 2022 the number of reported Ebola cases had sharply decreased.

CHOLERA IN MALAWI

A cholera outbreak in Malawi started in March 2022. By late December, a total of 15,064 cases and 470 deaths had been confirmed. As the outbreak expanded in the north of the country, affecting 29 districts in the last three months of the year, the government declared a public health emergency. WHO deployed 13 technical officers to Malawi and disbursed US$5 million in funding from the CFE. The team launched an oral cholera vaccination campaign that reached 2.4 million people, achieving an 86.3% coverage rate. WHO also supported other aspects of the response effort, including water-quality monitoring, surveillance, case management, and the provision of supplies.

MPOX

In 2022, 13 African countries reported 1,124 confirmed mpox cases and 16 deaths. Mpox was declared a PHEIC in July, and the outbreaks in African countries were rated a grade 3 emergency. Nigeria, DRC, and Ghana reported the largest numbers of confirmed cases. WHO headquarters staff and the AFRO team conducted joint missions to these countries to bolster the response effort and advocate for more active engagement by national health ministries and other stakeholders. A total of US$960,000 was disbursed to support the response, and 39,540 laboratory test kits were delivered to the affected countries. Enhanced surveillance collaboration between WHO and the national health authorities was a key element of the mpox response.

MULTICOUNTRY YELLOW FEVER

In 2022, WHO AFRO recorded 455 confirmed yellow fever cases and 40 deaths across Cameroon, Chad, CAR, Republic of Congo, Côte d'Ivoire, DRC, Ghana, Niger, Nigeria, Uganda, Kenya, and Gabon. To manage the epidemic, WHO supported the resumption of national vaccination campaigns, which reached about four million at-risk individuals. In addition, seven requests for emergency vaccine distribution by the Interagency Coordination Committee were approved, and WHO and its partners directly vaccinated 50 million people across the affected countries. WHO also deployed 16 consultants and four Incident Management Support Teams and trained 51 people from 10 countries in yellow fever surveillance, outbreak investigation, and response techniques. By December 2022, the number of countries still reporting yellow fever outbreaks had fallen from 12 to five, and the risk level for yellow fever was downgraded to moderate.

MARBURG VIRUS IN GHANA

In June 2022, WHO recorded a Marburg virus outbreak in Ghana. Although just three cases and two deaths had been reported, the outbreak was registered as a grade 2 emergency due to the high lethality of the virus. In collaboration with its partners, WHO AFRO provided US$300,000 in financial support, supplied PPE to local health facilities, and deployed 15 national employees and two international specialists. Due to the swift and effective response by WHO and its partners, the government declared the Marburg outbreak over in mid-September, just eight weeks after it began.

ACUTE KIDNEY INJURY IN THE GAMBIA

On 1 August 2022, the Epidemic and Disease Control Unit of the Gambian Ministry of Health reported an unusual increase in the incidence of acute kidney injury detected at the country's main tertiary hospital. A total of 127 cases were reported, of which 82 were confirmed, and 70 deaths were attributed to acute kidney injury. Most cases occurred in children under the age of two. WHO responded by deploying an emergency medical team from Senegal to The Gambia to support clinical case management with a focus on nephrology care. WHO also deployed seven experts to lead the response, scaled up surveillance, and organized a mass recall of the contaminated cough syrups determined to be associated with the outbreak. The response included measures to strengthen regulatory oversight by building the capacity of the national Medicine Control Agency. WHO AFRO provided US$470,000 in financial assistance and delivered 10,000 doses of paracetamol for clinical care. The last confirmed case was identified on 5 October 2022, and surveillance and response activities were still ongoing at the end of the year.

EBOLA RESURGENCE IN DRC

On 16 August 2022, the DRC announced its 15th outbreak of the Zaire strain of the Ebola virus since 1976, confirming a single case after death. WHO offered immediate assistance by activating incident management teams in Kinshasa and Beni, supplying 1,000 doses of the Ervebo vaccine, and mobilizing US$300,000 in financial support, which enabled the authorities to contain the outbreak within four weeks.

Table 1: WHO OSL Support for Response Activities

Disease and Country	Funding mobilized	Personnel deployed	Vaccines and other materials provided
Marburg in Ghana	$300,000	15 country staff and 2 international experts	Personal protective equipment (PPE)
Ebola (EVD) in DRC	$300,000	RRT IMS	1000 doses of Ervebo vaccine supplied
Acute kidney injury in the Gambia	$470,000	7 international experts 8 emergency medical technician for clinical care.	10,000 doses of paracetamol
Ebola virus in Uganda	$10.5 million	133 international experts 1000 health workers 1155 infection prevention and control professionals	8 Ebola kits, 1920 Sudan Ebola virus polymerase chain reaction test kits 15,000 units of PPE, 60 pallets of infection prevention and control equipment and other medical supplies
Cholera in Malawi	$495 471	5 experts	1.5 million oral cholera vaccine (OCV) doses
Drought and Food Insecurity in the Greater Horn of Africa		70 international experts	
Multi-country Yellow Fever			107.5 million vaccine doses
The Humanitarian Crises in Northern Ethiopia		54 mobile health and nutrition teams (MHNTs), 470 RRT 426 health care works for severe acute malnutrition (HCW-SAM) 26 health care workers for gender-based violence (HCW-GBV) 50 nutrition surveillance experts	700 measles vaccine doses, 1 million OCV doses
Humanitarian Crises in the Sahel	$424,031		

CHOLERA RESPONSE IN NIGER: AUGUST - SEPTEMBER 2022

On 1 September 2022, the Regional Public Health Directorate (Direction Régionale de la Santé Publique, DRSP) of Maradi, Niger reported 10 suspected cases of cholera, including three positive cases confirmed through rapid diagnostic tests. Further testing identified the virus as Vibrio Cholerae O1 Ogawa. By 4 September 2022, 14 suspected cases had been reported, with seven testing positive for cholera. WHO deployed 15 personnel to the affected region and activated expert responders. A SURGE team was deployed, which included the SURGE Coordinator, three epidemiologists, two case management physicians, two PCI/WASH experts, two communicators, two laboratory technicians for the mobile laboratory, and four drivers. The outbreak was declared over on 28 September 2022, and no deaths were reported.

Multiple factors contributed to the success of the response effort. The SURGE team was deployed within 48 hours of being notified of the first three cases. The team had received six weeks of training based on assessments of previous response efforts. The mobile laboratory deployed by the two laboratory focal points of the SURGE team enabled onsite diagnosis and allowed the team to train local laboratory technicians in diagnosing cholera, cutting the diagnosis time from three weeks to 48 hours. The implementation of a ring strategy allowed the team to circumscribe the epidemic. The team received regular updates on the regional security situation. The team collaborated efficiently with the national authorities, various NGOs active in the health sector, and the WHO mission team.

Humanitarian Crises

Humanitarian crises continued to magnify health risks across the region by increasing rates of malnutrition and infectious diseases while disrupting access to health services.

DROUGHT AND FOOD INSECURITY IN THE GHOA

The GHOA suffered its fifth consecutive drought in 2022, the worst in more than 40 years. As crops failed and food prices rose, 46 million people faced food insecurity across Ethiopia, Somalia, Kenya, South Sudan, Sudan, Djibouti, and Uganda. By the end of the year, 26% of the population was experiencing a grade 3 crisis. Working closely with regional governments, WHO and its partners established four health clusters and more than 45 subnational clusters, deployed more than 70 international experts, and conducted trainings in treating severe acute malnutrition, infectious disease surveillance, and the prevention of sexual exploitation, harassment, and abuse.

NORTHERN ETHIOPIA CONFLICT

The conflict in northern Ethiopia began in late 2020 and is now a grade 3 active protracted crisis. Over 13 million people need assistance, and more than 2.8 million have been displaced. Crowded camps and settlements for refugees and internally displaced persons increase the risk of outbreaks of infectious diseases, including malaria, measles, acute respiratory tract infections, and cholera. WHO AFRO and its partners deployed 54 Mobile Health and Nutrition Teams to provide access to primary and essential healthcare in remote and underserved areas. The teams treated malaria and diarrheal diseases and vaccinated more than 7,000 children against measles; 470 individuals were trained in rapid response to disease outbreaks; 400 health workers were trained in managing severe acute malnutrition; 120 health workers were trained in preventing gender-based violence; and 268 health workers were trained in mental health and psychosocial support.

SOUTH SUDAN HUMANITARIAN CRISIS

Since achieving independence from Sudan in 2011, South Sudan has endured a series of overlapping conflicts that have displaced four million people and left more than seven million in need of humanitarian assistance. This crisis is a longstanding WHO priority. WHO AFRO supported the establishment of 11 health facilities, both fixed and mobile, which provide primary healthcare and bolster efforts to control outbreaks of measles, hepatitis E, cholera, and other infectious diseases. WHO AFRO continues to mitigate the risk of cholera through water, sanitation and hygiene (WASH) interventions, and has administered one million doses of oral cholera vaccines (OCV) in the country.

HUMANITARIAN CRISIS IN THE SAHEL

Six countries in the Sahel region are facing a grade 2 crisis: Burkina Faso, Chad, Cameroon, Mali, Niger, and Nigeria. Violence and instability have displaced more than seven million people. WHO has provided an integrated health and nutrition services package to over eight million vulnerable people out of a target population of 10 million. WHO conducted a joint evaluation workshop with government representatives from the affected countries, donors, and partners to assess the impact of a dedicated response team established to improve health security in the region. By the end of 2022, WHO had disbursed US$424,031 from the CFE to support the incident management team in the country offices and hubs.

NIGER: PROVIDING HIGH-QUALITY HEALTH SERVICES IN INSECURE AREAS

The WHO country office in Niger has collaborated with the local NGO, Action for Well-Being (Action pour le Bien-Être), to support national health authorities operating in insecure areas. The NGO, which has an excellent knowledge of the local context and the trust of the population, organized mobile clinics in six health districts of Tahoua and Tillabéry. Two mobile clinics were organized each month to provide curative care, vaccinations, and reproductive health services. The initiative reached over 100,000 people, including 70,000 internally displaced persons and 30,000 indigenous people. More than 300 community outreach specialists were deployed to help health workers raise awareness and monitor diseases with epidemic potential. The initiative also helped rehabilitate six health centres associated with the mobile clinics.

WHO AFRO and Africa CDC collaboratively planned the first round of interventions. Twenty countries were prioritized for interventions.

Emergency Preparedness and Response Flagship Initiatives

A. Promoting Resilience of Systems for Emergencies (PROSE)

In early 2022, an initial set of priority countries was selected to participate in the PROSE flagship. At the Emergency Preparedness Unit's retreat held during 22-25 March 2022, the development of the PROSE flagship was finalized, and WHO AFRO and Africa CDC collaboratively planned the first round of interventions. At the end of the retreat, 20 countries were prioritized for AFRO interventions[9] and three for EMRO interventions.[10]

Prioritization criteria for PROSE priority countries

01 Risk of public health emergencies

02 Fragility and violence

03 Average International Health Regulations (IHR) score

04 Government commitment

05 Geographic location

06 WHO language balance

07 The presence of an Africa CDC collaboration centre

08 Human resources at the WHO country office

09 The technical capacity and resources of the local authorities

10 Experience with National Action Plans for Health Security (NAPHS) and other strategic plans for the health sector

11 Small island status

12 Experience responding to public health emergencies

On 9 August 2022, over 820 staff and partner representatives participated in a regional webinar to introduce the PROSE rollout plan and priority intervention package to the countries and hubs.

9 Angola, Benin, Botswana, Cape Verde, DRC, Republic of Congo, Central Africa Republic, Côte d'Ivoire, Ethiopia, Gabon, Ghana, Kenya, Mozambique, Seychelles, Sierra Leone, Liberia, South Africa, South Sudan, Tanzania, and Zambia

10 Libya, Somalia, and Sudan

Progress Update

During 2022, progress was achieved across all six PROSE pillars. Especially significant gains were registered under Pillar 3, while gains under Pillar 5 were relatively modest. In addition to pillar-specific achievements, the Kenya hub was established, and important progress was made toward operationalizing the Senegal hub.

Figure 2: The Six Pillars of the PROSE Flagship

1. Multisectoral coordination mechanisms - One Health approach	2. Evidence-based plans, policies and legislation	3. Systems and tools for implementation of IHR	4. Health workforce development	5. Risk communication and community engagement	6. Sustainable and predictable financing
• Support countries in adopting a collaborative approach to emergency preparedness efforts, legislation and policies through communication and coordination between multiple sectors to achieve better public health outcomes	• Institutionalize the recommendations of regional and global health bodies • Enhance multisectoral mechanisms for coordinated decision-making	• Strengthen implementation of all elements of the International Health Regulations (IHR, 2005) • Improve clinical care for infectious diseases • Ensure timely provision of logistics and supplies	• Ensure development of a workforce strategy, create/strengthen field epidemiology training programmes • Monitor human resource availability for implementing IHR core capacity requirements	• Convey public health threats in a transparent, timely, and coordinated manner through mechanisms built into National Action Plans for Health Security (NAPHS)	• Ensure prioritization of financial resources • Ensure the availability of adequate funds for preparedness efforts

Pillar 1: Multisectoral Coordination Mechanisms - One Health Approach

One Health is an integrated approach to improving the health of humans, animals, and the environment. The approach integrates efforts to enhance nutrition, water safety, food safety, zoonotic disease control, pollution management, and antimicrobial resistance. This approach is the cornerstone of the International Health Regulations - Performance of Veterinary Services National Bridging Workshops (IHR-PVS NBW) and other initiatives set forth in the Tripartite Zoonoses Guides.[11]

11 https://www.who.int/initiatives/tripartite-zoonosis-guide

Joint roadmaps for implementing the One Health approach were developed during IHR-PVS NBW in consultation with 21 countries to more effectively address zoonotic diseases and other health events occurring at the interface of humans, animals, and the environment. Cameroon, Ethiopia, Guinea, Kenya, Tanzania, Uganda, Liberia, Nigeria, Senegal, and Sierra Leone received assistance in human resource management and finance management to operationalize the One Health strategy.

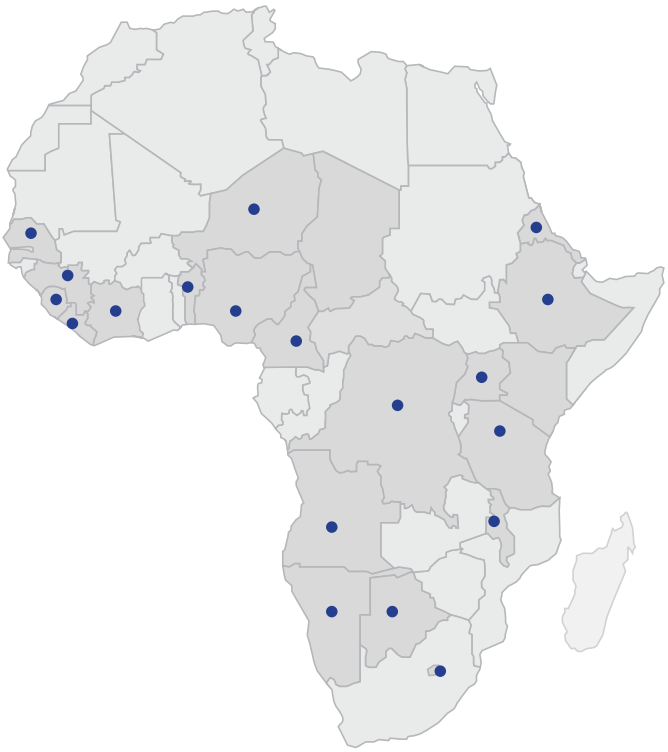
Between 22-24 November, an IHR-PVS NBW was held in Ghana. The three-day event brought together 50-80 participants from the animal health services and public health sectors. The workshop's goal was to enhance collaboration between animal and human health experts to combat zoonotic diseases in line with the One Health approach. WHO facilitated the IHR-PVS NBW, and WHO AFRO worked closely with health authorities in Zambia and Ghana to adopt the One Health approach.

Pillar 2: Evidence-Based Plans, Policies, and Legislation

NAPHS are country-owned multiyear plans for building the capacity to implement International Health Regulations (IHR 2005). The NAPHS are based on critical gaps identified during prior Joint External Evaluation reviews.[12] With technical support from WHO AFRO, about 19 countries[13] reviewed their NAPHS and developed Annual Operational Plans to guide their investment cases and priority actions.

Pillar 3: Systems and Tools for Implementing IHR

The Strategic Tool for Assessing Risks (STAR) is an analytical instrument designed to support health emergency preparedness and disaster risk management. Malawi, Tanzania, DRC, Zambia, South Africa, Madagascar, Rwanda, and Eswatini completed their STAR assessments during 2022, and Eswatini, South Africa, Tanzania, Zambia, and Rwanda updated their risk calendars in line with the assessment results.



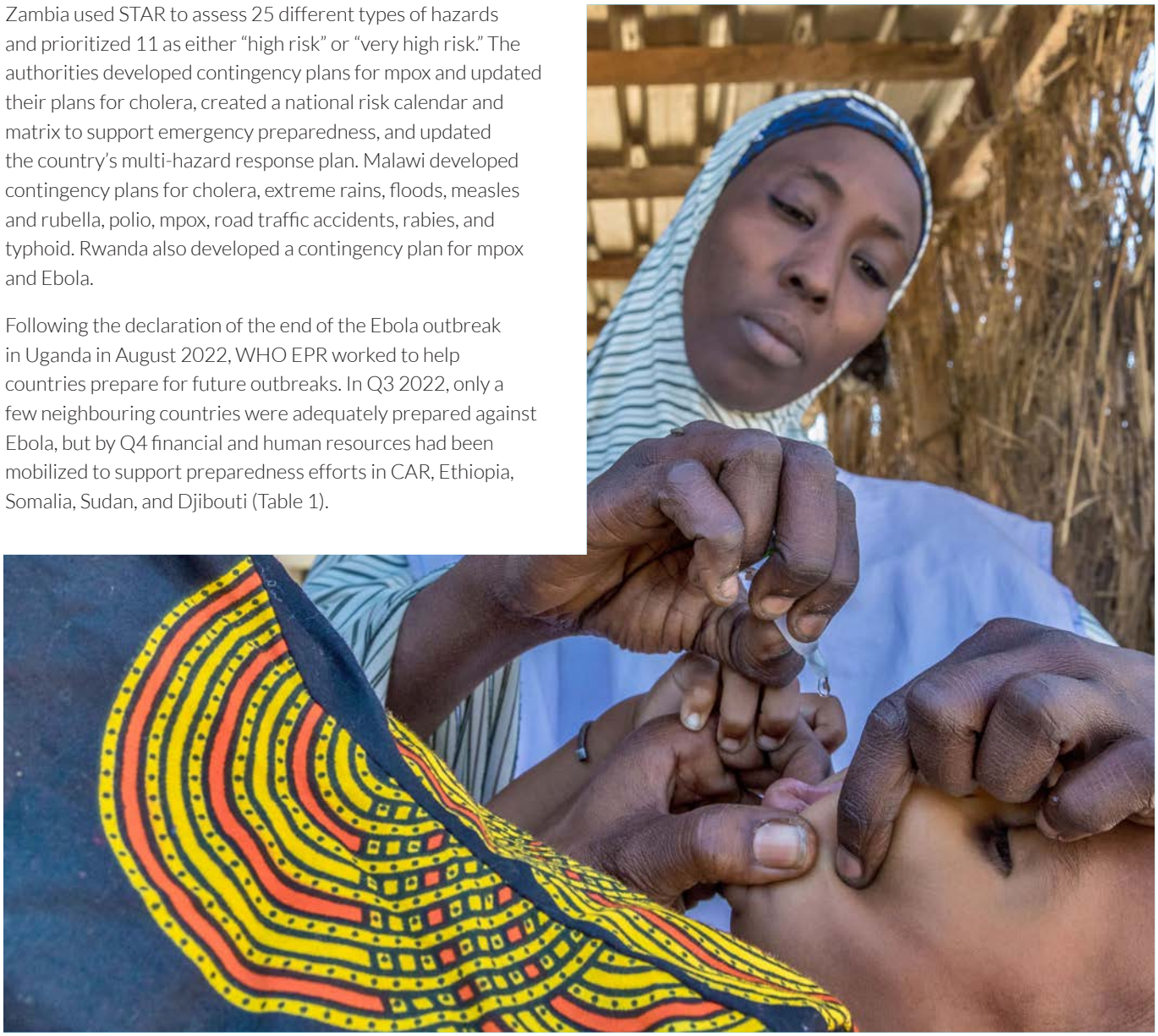
19 countries that reviewed their NAPHS: Senegal, Guinea, Nigeria, Benin, Uganda, Tanzania, Cameroon, Congo, Angola, Namibia, Botswana, Malawi, Ethiopia, Burkina Faso, Sierra Leone, Liberia, Côte d'Ivoire, Eritrea, and Lesotho

12 https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/national-action-plan-for-health-security

13 Senegal, Guinea, Nigeria, Benin, Uganda, Tanzania, Cameroon, Congo, Angola, Namibia, Botswana, Malawi, Ethiopia, Burkina Faso, Sierra Leone, Liberia, Côte d'Ivoire, Eritrea, and Lesotho

Zambia used STAR to assess 25 different types of hazards and prioritized 11 as either "high risk" or "very high risk." The authorities developed contingency plans for mpox and updated their plans for cholera, created a national risk calendar and matrix to support emergency preparedness, and updated the country's multi-hazard response plan. Malawi developed contingency plans for cholera, extreme rains, floods, measles and rubella, polio, mpox, road traffic accidents, rabies, and typhoid. Rwanda also developed a contingency plan for mpox and Ebola.

Following the declaration of the end of the Ebola outbreak in Uganda in August 2022, WHO EPR worked to help countries prepare for future outbreaks. In Q3 2022, only a few neighbouring countries were adequately prepared against Ebola, but by Q4 financial and human resources had been mobilized to support preparedness efforts in CAR, Ethiopia, Somalia, Sudan, and Djibouti (Table 1).



Pillar 4: Workforce Development

Human resources are crucial to public health emergency preparedness, and recruitment and training are vital components of the PROSE flagship.

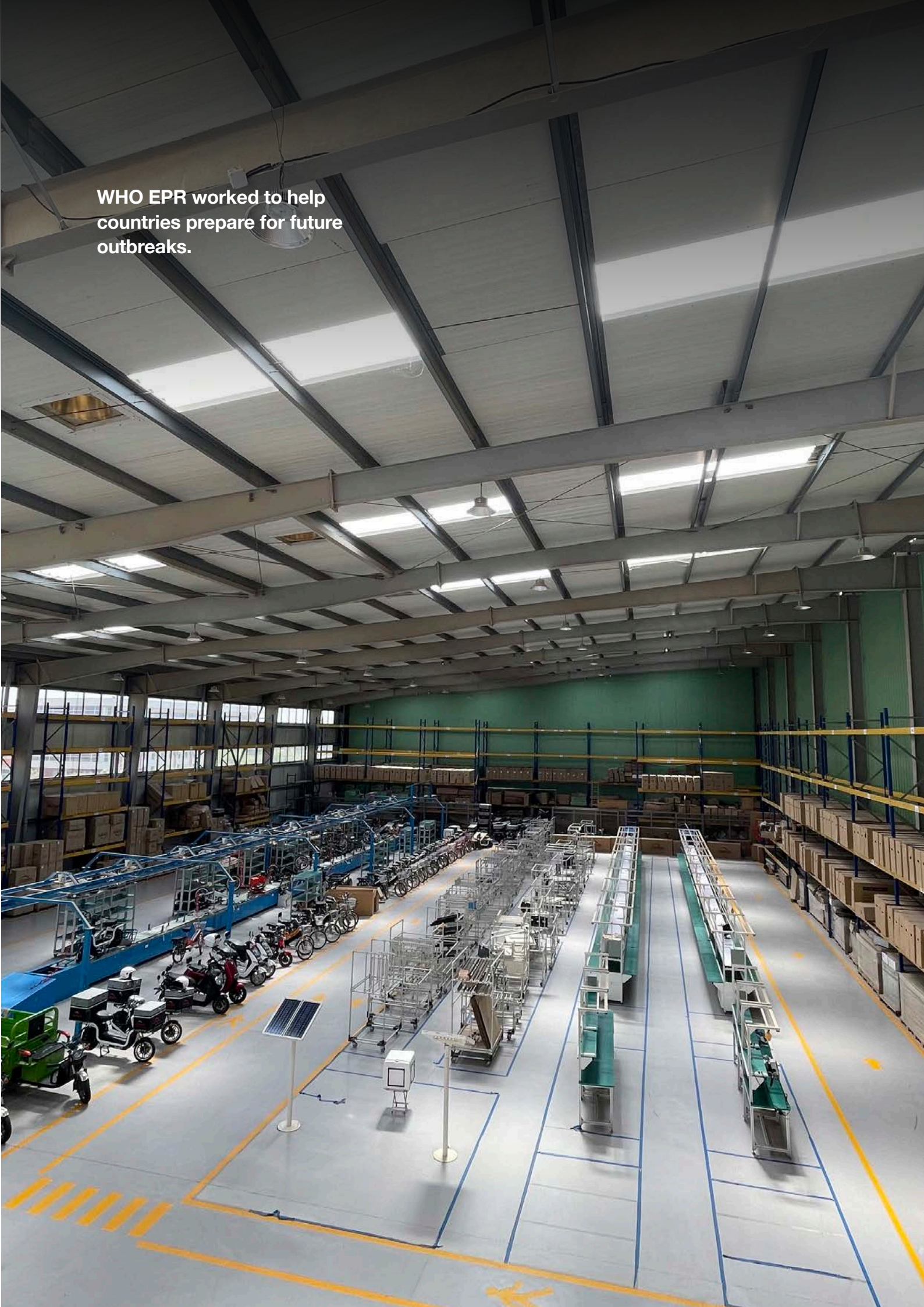
In 2022, the EPR cluster onboarded 153 national focal persons (NFPs) and trained IHR stakeholders from Namibia, South Africa, Liberia, Guinea, Mali, and Zimbabwe.

WHO AFRO conducted four webinars on IHR between July and October. The 367 participants included NFPs, IHR implementation stakeholders, and WHO country office staff.

Topics covered included NFP functions, operational readiness, programme implementation, NAPHS follow-up, the One Health approach, and multisectoral and multidisciplinary coordination.

Table 2: IHR and NFP trainings by countries

Country	Participants	Training period
Liberia	22 Participants	Q3
Guinea	30 Participants	Q3
Mali	15 Participants	Q4
Zimbabwe	40 Participants	Q4
Namibia and South Africa	46 Participants	Q2



WHO EPR worked to help countries prepare for future outbreaks.

Table 3: List of AFRO IHR webinars

Topics covered	Participants	Training period
Role of NFPs and the identification of IHR stakeholders	137 Participants	Q3
Mandatory functions of NFPs	56 Participants	Q3
One Health: Enhancing multisectoral and multidisciplinary coordination, including non-traditional sectors	54 Participants	Q3
Operational readiness and NAPHS implementation and follow-up	100 Participants	Q4

WHO AFRO also collaborated with Johns Hopkins University to design and develop the IHR NFP Competency Framework, which sets forth the functions and roles of NFPs in implementing the IHR. In September, WHO AFRO conducted a workshop in Lusaka, Zambia on developing and implementing evidence based NAPHS and Annual Operation Plans. The workshop's 51 participants included staff from WCO and the Ministry of Health, who learned new multisectoral accountability approaches for tracking the implementation of strategic plans.

Pillar 5: RCCE

During 2022, the RCCE team supported various preparedness activities, including the training of national stakeholders involved in RCCE and the development of RCCE roadmaps. WHO AFRO created a database of relevant national and subnational actors, including media outlets, and engaged stakeholders in RCCE activities before, during, and after emergencies. The RCCE team was instrumental in raising awareness of the importance both of general and disease specific EPR. The team supported the development of the regional RCCE strategy and national RCCE plans in Ethiopia, Kenya, and Namibia. WHO AFRO also helped 15 high- and medium-risk countries accelerate the implementation of global anti-meningitis initiatives by supporting the development of national strategic plans.

Pillar 6: Sustainable and Predictable Financing

Under this pillar, WHO supported the health authorities of Central African Republic in developing an investment case for the Pandemic Fund. The financial resources from the fund will address critical gaps in emergency preparedness and response within the context of a broader primary healthcare agenda.

PROSE: Progress in Senegal and Kenya Hubs

In Q3 and Q4 2022, WHO achieved important progress in implementing PROSE priority interventions and activities. WHO AFRO and the Government of Kenya jointly launched an Emergency Hub in Kenya, the first of its kind in the region. Efforts are now underway to operationalize the Hubs in Senegal and South Africa. With support from the WHO Academy, these hubs will focus on workforce development, logistics and supply-chain management, data collection and reporting, research and development, and genomic surveillance. Consultants were recruited to support these efforts, a roster of French-speaking experts in emergency preparedness was developed, and orientation workshops were held, including a workshop for 33 French-speaking experts held in Thiès, Senegal between 7-11 November 2022. The Thiès workshop trained participants in using tailored strategies and tools to bolster emergency preparedness in Western and Central Africa.

Figure 3: The Implementation of PROSE Priority Activities

Activities	Benin	Congo	Côte d'ivoire	Sierra Leone	Zambia	South Sudan	Rwanda	South Africa	Tanzania
STAR		●			●			●	●
Risk calendar / Country profile					●	○	●	●	●
NAPHS and Annual Operational Plans	●	●	●	●	●	●	●	●	●
Joint External Evaluation									●
Simulation exercise						●	●		

● Completed ○ Ongoing ● Planned

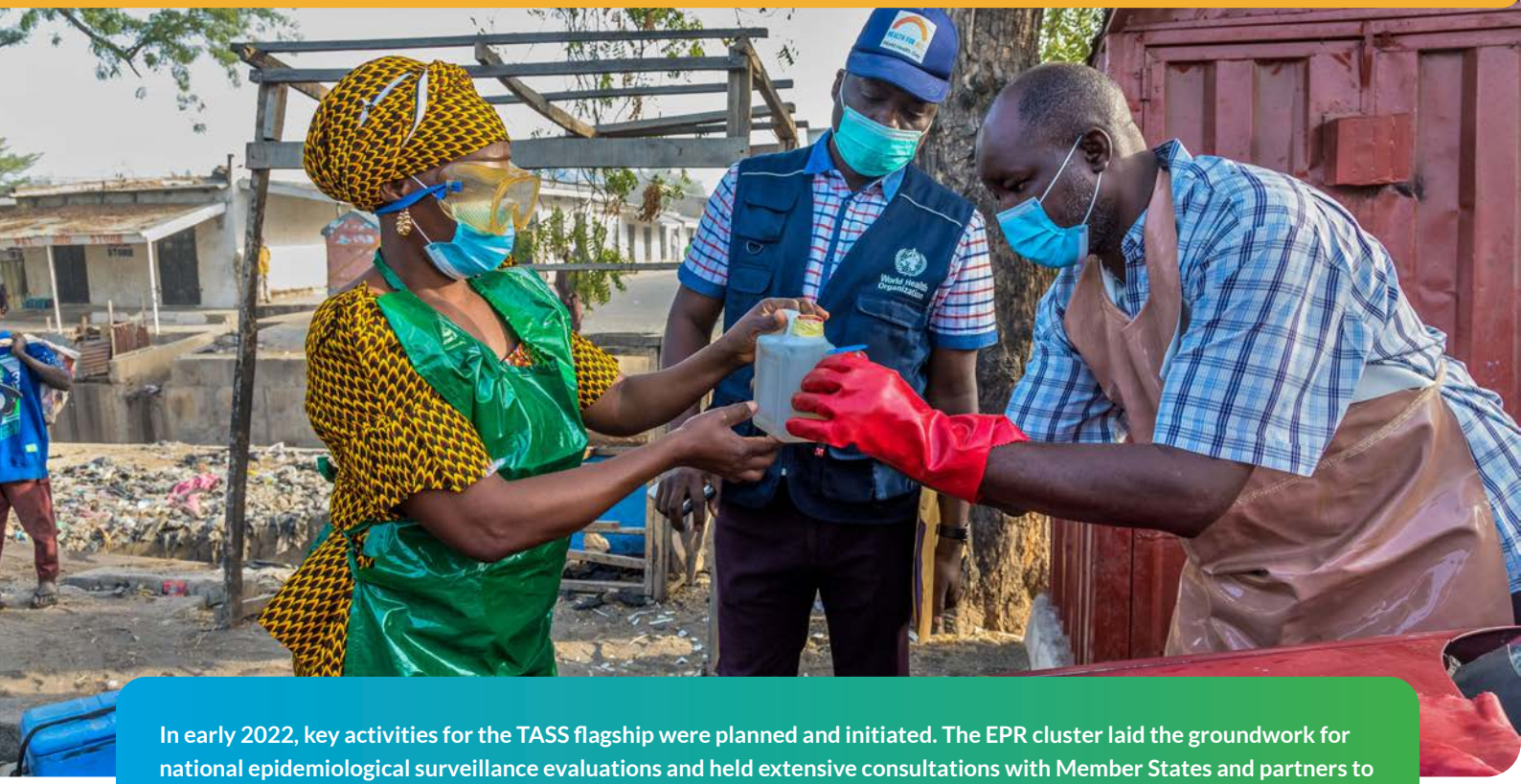
LESSONS LEARNED

One of the key lessons learnt during the implementation of the PROSE flagship is that activities must be sequenced according to the context and needs of each Member State and implemented on a clear timetable. **In addition, efforts to operationalize the RCCE teams require stronger coordination, and WHO will more closely monitor these activities going forward.** Member States are receiving support on multiple fronts from the EPR cluster, and the three flagships can improve implementation at the country level by coordinating scoping missions and other activities.

> “...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.”
>
> **Dr. Allan Mpairwe**
> **PROSE, Kenya hub**

> “...the PROSE package does not include a schedule of activities. We have prioritized activities following country needs after operational analysis.”
>
> **Dr. Diallo Amadou Bailo**
> **PROSE, Senegal hub**

B. Transforming African Surveillance Systems (TASS)



In early 2022, key activities for the TASS flagship were planned and initiated. The EPR cluster laid the groundwork for national epidemiological surveillance evaluations and held extensive consultations with Member States and partners to confirm country needs and align interventions. In May, WHO AFRO conducted a rapid needs assessment of Integrated Disease Surveillance and Response (IDSR) capabilities in the Member States via a questionnaire covering planning methods, instruments, processes, and reporting procedures. The assessment revealed significant gaps in IDSR capacity.

Workplans for accelerating TASS implementation were developed in collaboration with Member State representatives during a virtual webinar held at the end of June. These plans were implemented in three phases over the course of the year. Ten countries were selected to participate in the first phase of TASS acceleration based on their participation in SURGE phases I and II[14], while 15 were selected for the second phase based on either their inclusion in the Canadian Fund project, their participation in SURGE II, or a favourable review of their acceleration workplan[15].

In September, regional workshops held in Abidjan, Kigali, and Johannesburg helped swiftly scale up the implementation of IDSR-related activities. The workshops focused on data management and analytics, diagnostics capacity, monitoring and evaluation, and coordinating IDSR operations, including One Health surveillance efforts.

The transition from paper-based surveillance to electronic surveillance is crucial to improve IDSR capabilities, and Member States received support to develop and deploy electronic systems.

During 2022, the EPR Cluster continued to support the implementation of a centralized data-collection and knowledge-management platform for the AFRO region. In Q4, the team partnered with the Kenyan Ministry of Health to deliver a workshop on the Epidemic Intelligence from Open Sources (EIOS) initiative[16]. Seven Member States started using EIOS in 2022[17], and the workshop contributed to a significant improvement in the reporting of IDSR data via the centralized platform. The best practices shared through the workshop enabled the Kenyan health authorities to scale up their event-based reporting system and IDSR strategies.

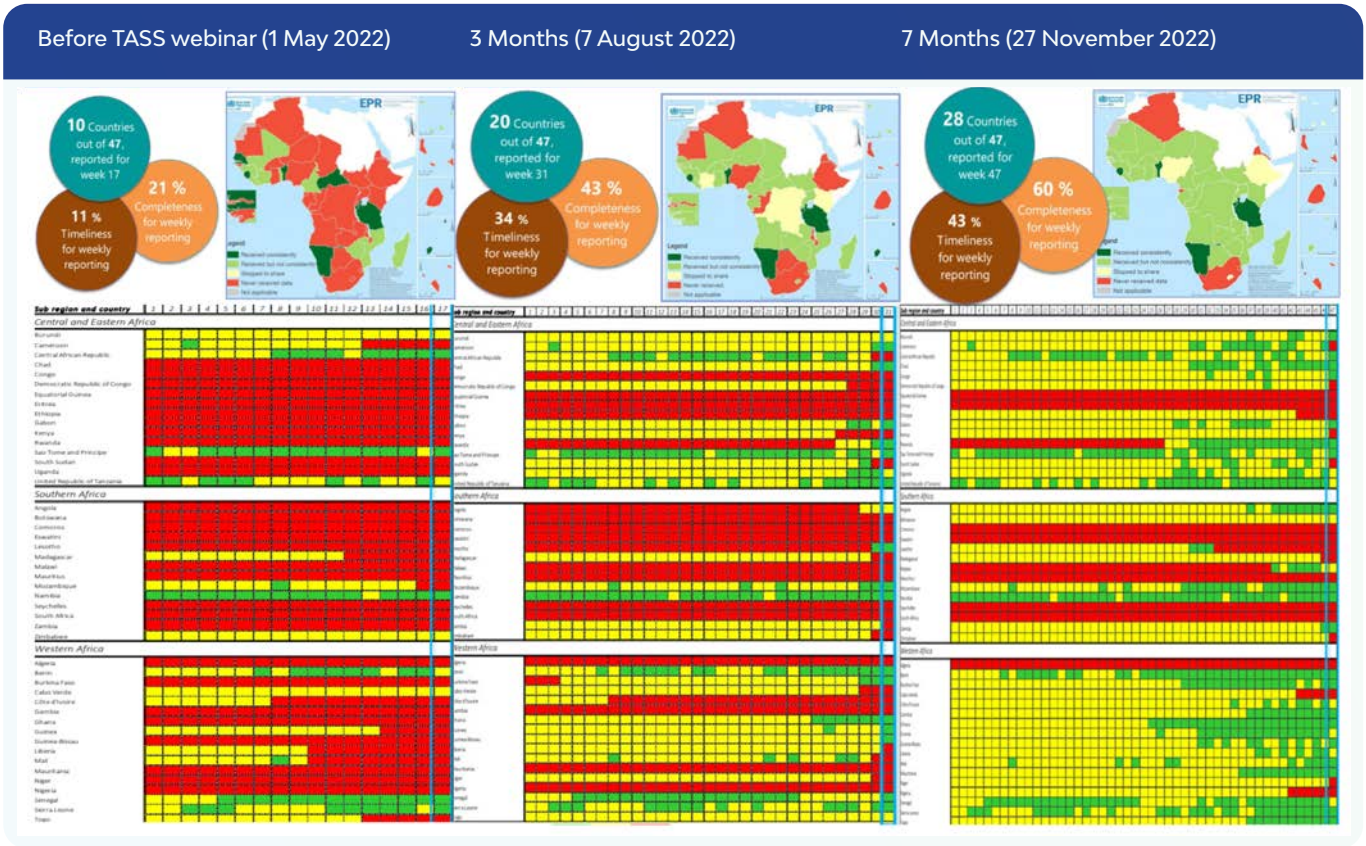
14 Niger, Togo, Botswana, Mauritania, Central African Republic, Chad, Republic of Congo, Kenya, and Uganda

15 DRC, Senegal, Côte d'Ivoire, Tanzania, Mozambique, Ghana, Malawi, Cameroon, The Gambia, Nigeria, Rwanda, Namibia, Lesotho, Angola, and Ethiopia

16 EIOS is a multistakeholder collaboration launched in 2017.

17 DRC, Kenya, Mali, Seychelles, Tanzania, Togo, and Zambia

Figure 4: Improved reporting from the beginning of 2022



Key Events

IDSR survey

A survey was conducted in May 2022 to assess the status of IDSR in the region and inform strategic planning. The survey contained a structured self-assessment questionnaire that was shared with the Member States. The questionnaire covered various areas of IDSR, including planning, tools and processes, and reporting.

Regional IDSR workshops

To strengthen IDSR in Member States and accelerate the adoption of electronic IDSR systems in the AFRO region, a series of workshops was held in the first half of 2022 to review the current data-management architecture. Led by WHO AFRO, the webinars included a briefing on the TASS flagship, an update on epidemiological surveillance and detection efforts in the African region, a presentation of the results of the rapid IDSR assessment, and an analysis of IDSR data between 2019 and 2022.

The team described the experiences of Sierra Leone, Nigeria, South Sudan, and Uganda in implementing new IDSR methodologies and presented an overview of the upcoming activities and objectives of TASS. This process enabled the WHO AFRO team to identify bottlenecks to strengthening IDSR and One Health surveillance initiatives. The webinar highlighted the need for greater coordination between WHO AFRO and the Member States on IDSR reporting, as well as the importance of forming partnerships and mobilizing funding to improve IDSR at the country level. Workshops were held in Abidjan, Kigali, and Johannesburg with participants from 44 member states[18].

Key Progress

The TASS flagship continued to concentrate on supporting the implementation of IDSR systems by Member States. As a result, most of the progress achieved during the period fell under Pillars 1 and 2, while Pillars 3 and 4 will be the focus of subsequent TASS implementation phases.

18 The Abidjan workshop included representatives from Algeria, Benin, Burkina Faso, Burundi, Cameron, Chad, Central African Republic, DRC, Comoros, Côte d'Ivoire, Gabon, Guinea, Madagascar, Mali, Mauritania, Niger, Senegal, and Togo. The Kigali workshop included representatives from Ethiopia, The Gambia, Ghana, Kenya, Liberia, Nigeria, Rwanda, Sierra Leone, Seychelles, South Sudan, Uganda, Tanzania, and Zambia. The Johannesburg workshop included representatives from Angola, Botswana, Cape Verde, Equatorial Guinea, Eswatini, Malawi, Lesotho, Mauritius, Mozambique, Namibia, South Africa, and Zimbabwe.

Figure 5: The Four Pillars of the TASS Flagship

1. Support to countries for IDSR implementation

- Lead country-level workshops to review and adjust national IDSR plans to reflect the evolving local contexts while simultaneously encouraging national prioritization of, and investment in, IDSR capabilities

2. Data and information management

- Support Member States to adopt and implement data and information systems that aggregate data from as many sources as possible, and permit prompt sharing and analysis of data and information as required by IHR

3. Workforce development

- Support the transfer of staff to government surveillance programmes, and institutionalize IDSR training at public and private institutions to ensure sufficient trained personnel at the national and subnational levels

4. Advocacy and policy dialogue for sustainable and predictable funding

- Encourage political commitment and action toward sustained investments in modernized surveillance efforts at regional, national, and subnational levels

Pillar 1: Support to countries for IDSR implementation

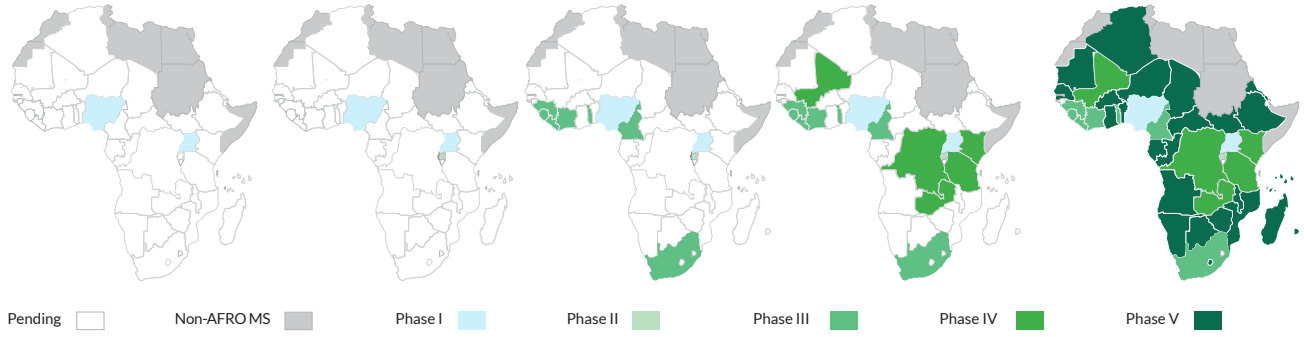
Although most African countries have some form of IDSR system, technological upgrades and other improvements are critical to combat modern disease risks. In 2022, TASS activities emphasized countries' ownership of their IDSR plans and focused on aligning IDSR systems with countries' self-defined strategic objectives. WHO AFRO worked with 12 countries to develop or update their IDSR plans, while the EPR cluster disseminated IDSR training materials and tools in 10 countries and conducted training-of-trainers (ToT) at the national and subnational levels.

IDSR workshops and complementary activities were implemented in Niger, Togo, Botswana, Mauritania, Central African Republic, Chad, Republic of Congo, Kenya, Uganda, and Madagascar. In Kenya, WHO AFRO trained a pool of expert trainers on IDSR and motivated the Ministry of Health to strengthen event-based surveillance and response by embracing the EIOS initiative.

Pillar 2: Data management and digitization

During 2022, WHO AFRO continued to expand participation in the EIOS initiative to strengthen public health intelligence, risk assessment, and genomic surveillance in the Member States. The EIOS initiative is a global collaboration between WHO and a wide range of public health stakeholders. It provides open-source information designed to enable users to create a comprehensive system for integrating the rapid detection, verification, assessment, and communication of public health risks and threats in line with the One Health approach.

Figure 6: EIOS Implementation Progress



2019	2020	2021	2022	2023
2 MEMBER STATES	1 MEMBER STATE	7 MEMBER STATES	7 MEMBER STATES	22 MEMBER STATES
NIGERIA | UGANDA	RWANDA	CAMEROON | COTE D'IVOIRE GUINEA | LIBERIA | SENEGAL SIERRA LEONE | SOUTH AFRICA	DRC | KENYA | MALI | SEYCHELLES TANZANIA | TOGO | ZAMBIA	NIGER | BOTSWANA | MAURITANIA CAR | CHAD | CONGO | MADAGASCAR SENEGAL | MOZAMBIQUE | GHANA NAMIBIA | ETHIOPIA | BENIN ALGERIA | SOUTH SUDAN | GABON MALAWI | GAMBIA | LESOTHO ANGOLA | BURKINA FASO | ZIMBABWE

COMPLETED — ONGOING / PLANNED

A total of 72 Health District managers and 55 One Health providers participated in the training

WHO AFRO organized a workshop in Kenya to share knowledge and experience with EIOS. The workshop strengthened collaboration between the Ministry of Health and other stakeholders for better coordination, preparation, and response to diseases and events. The workshop also increased awareness of the importance of EIOS for the public health intelligence framework and early warning and detection. Following the workshop, the Kenyan Ministry of Health strengthened its event-based surveillance and IDSR capacity while stepping up the implementation of the IHR 2005. The health authorities are currently working to operationalize the Kenyan EIOS community platform.

In Niger, WHO AFRO trained national officials in strengthening IDSR systems and implementing the IHR 2005. In line with the One Health approach, participants included staff from the Ministry of Environment, the Ministry of Education, and the Ministry of Water and Sanitation. A total of 72 Health District managers and 55 One Health providers participated in the training. Additional specialized training was provided to laboratory officers on the genomic surveillance and confirmation of SARS-CoV2 and related pathogens. Following the trainings, data sets and equipment were provided to public and private health facilities.

In Togo, WHO AFRO helped build data-management and analytics capabilities by providing an online surveillance tool for focal points, laboratory, and data managers. WHO AFRO also worked with the local health authorities to utilize a threshold analysis to assess diseases with epidemic potential. To facilitate early warning, WHO AFRO developed a bridge between Togo's digital health information system and national telecommunications operators.

Moreover, the implementation of IDSR systems has helped streamline the data-collation process and improve case-based, event-based, and indicator-based reporting systems across participating countries. WHO AFRO is currently holding discussions with Columbia University's International Center for AIDS Care and Treatment Program (ICAP) to explore the potential for collaborative monitoring and evaluation of IDSR programming and other TASS activities.

C. Strengthening and Utilizing Response Groups for Emergencies (SURGE)

A review of Joint External Evaluations conducted in 2019 revealed that only four African countries had adequate capacity to deploy emergency human resources swiftly and at scale.

Moreover, two of Africa's three logistical hubs were outside the continent, inhibiting access to priority medical supplies and slowing emergency response efforts. Unclear decision-making processes and inefficient procurement systems compounded these challenges, while limited technical knowledge among rapid response teams (RRTs) hindered their ability to participate in large-scale emergency operations. A lack of consistent long-term funding exacerbated these challenges. The COVID-19 pandemic exposed these vulnerabilities while weakening African health systems and depleting their scarce resources.

Figure 7: Findings of the 2019 Joint External Evaluation

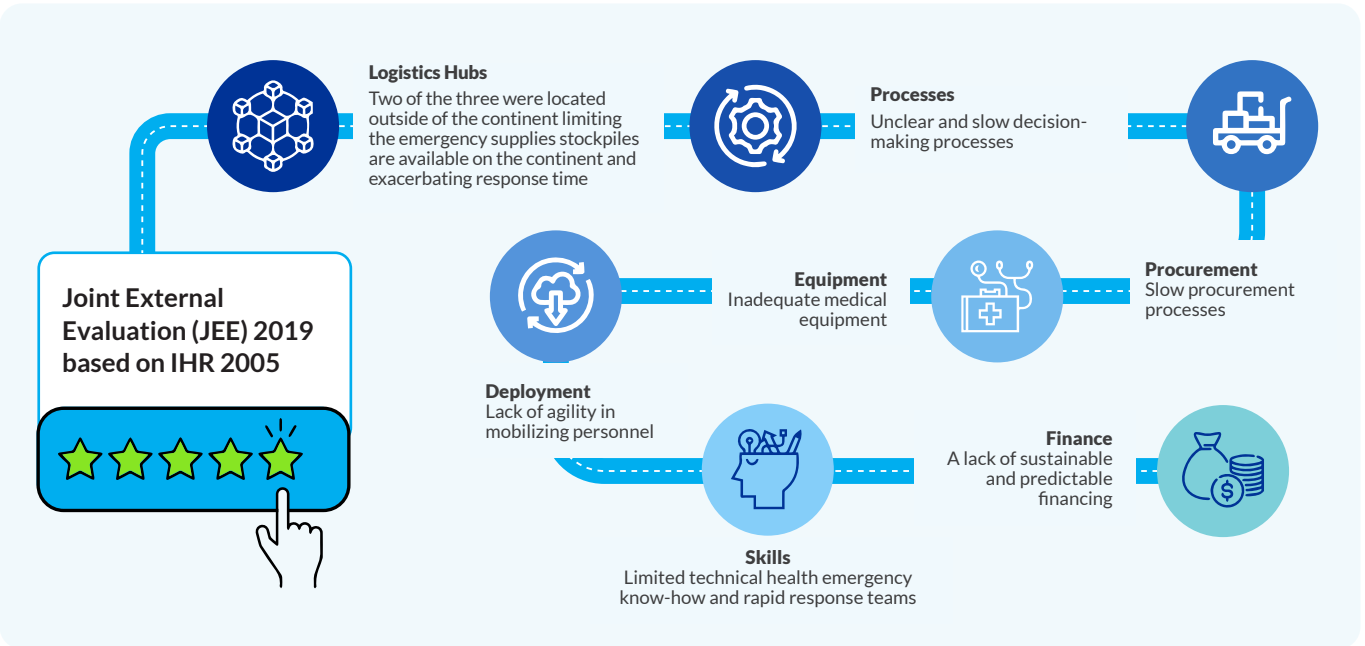
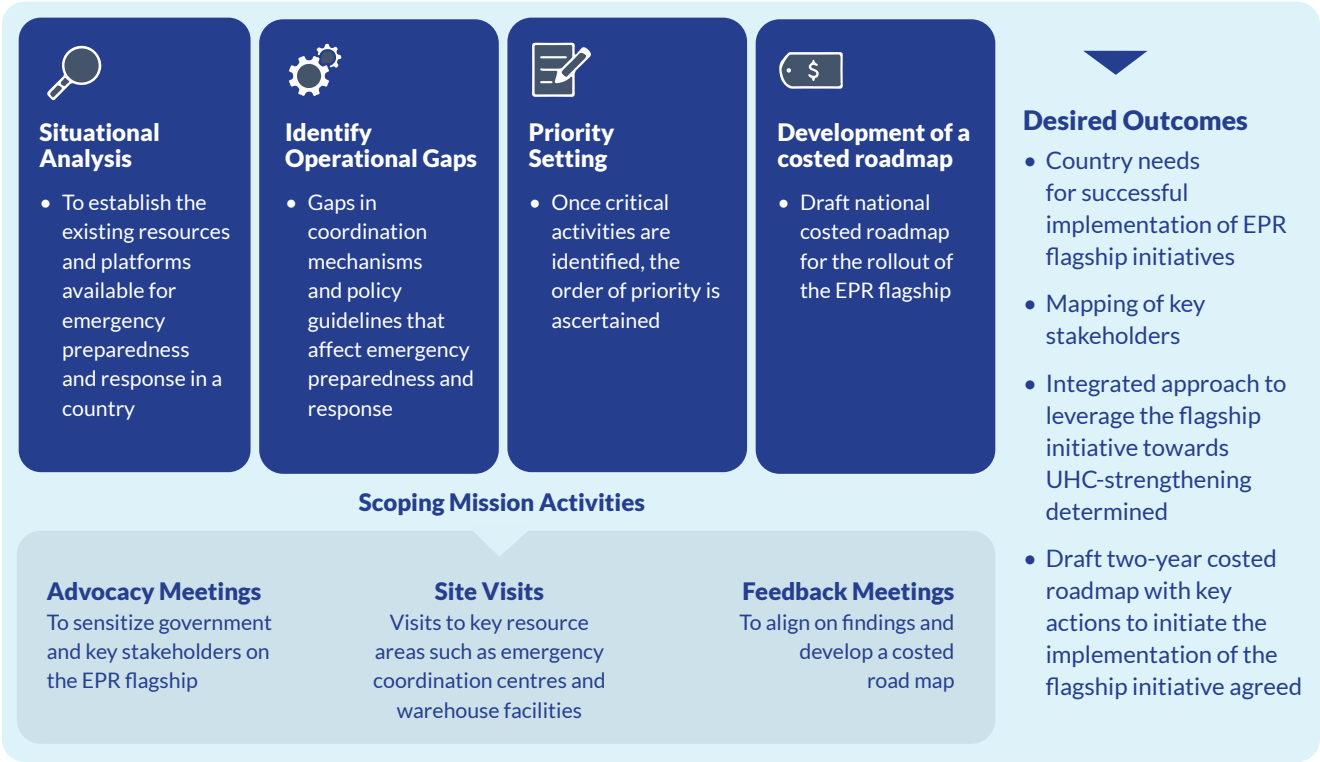
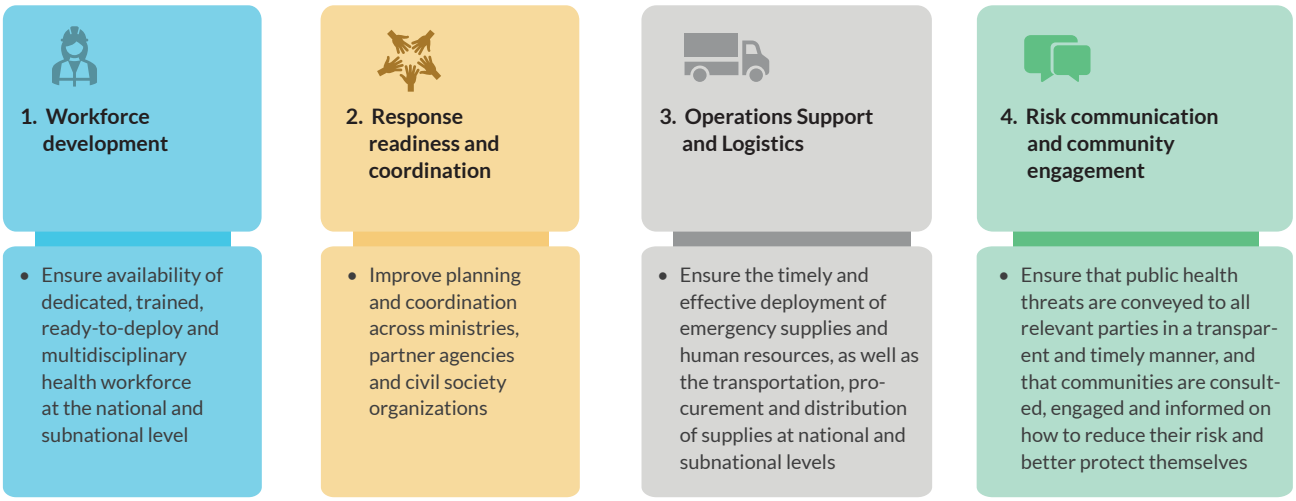


Figure 8: SURGE Scoping Missions



In 2022, WHO AFRO conducted scoping missions in 15 of the 17 targeted countries. A planned scoping mission in Uganda was delayed due to the Ebola virus outbreak, while a mission in Angola was also delayed. Both missions have been rescheduled for 2023. Among the 15 countries where the missions were completed, WHO provided seed funding to launch the government-led implementation of SURGE. Africa CDC assisted with mission planning and participated in one of the missions.

Figure 9: The Four Pillars of the SURGE Flagship Programme



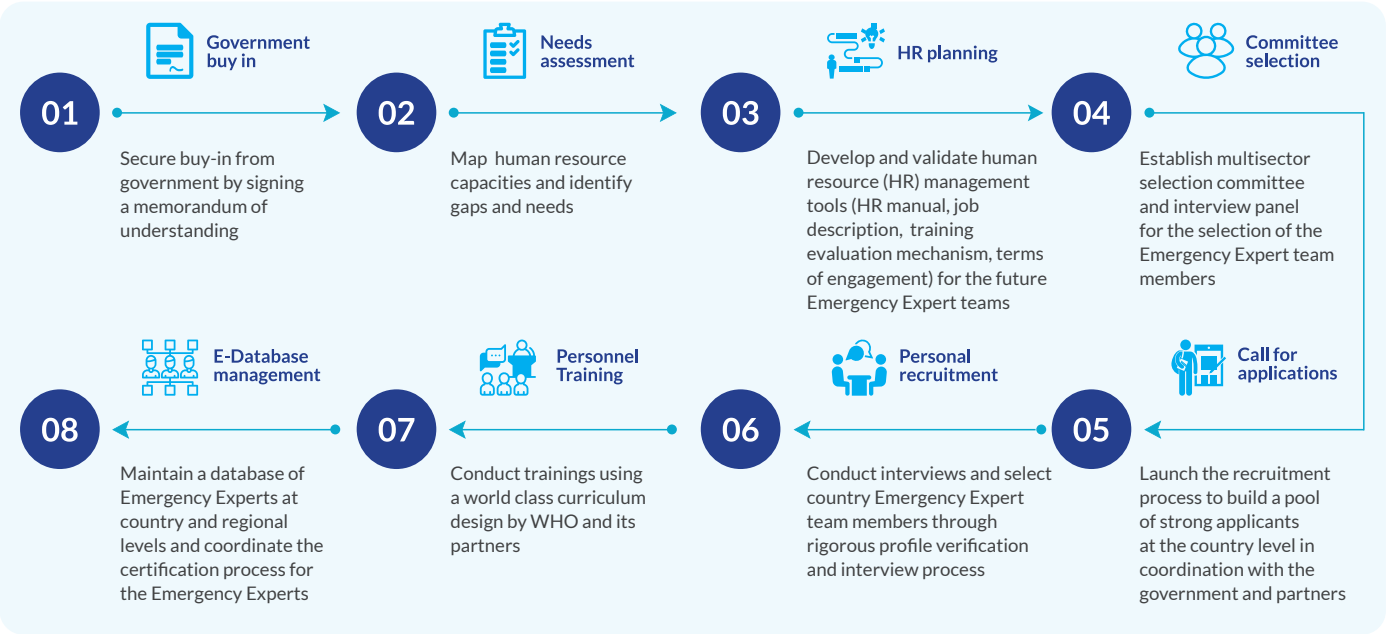
Pillar 1: Workforce Development

Emergency Responders

The SURGE flagship works closely with Africa CDC on AVoHC-SURGE which is Strengthening and Utilizing Response Groups for Emergencies (SURGE) integrated with Africa CDC's program, African Health Volunteers Corps (AVoHC). This work focuses on training and equipping national-level cadres of multidisciplinary African responders known as AVoHC-SURGE, who can be rapidly mobilized and deployed during emergencies. With support from the US CDC, the regional office developed an online platform for Member States to manage AVoHC-SURGE responders.

The platform currently includes 349 staff from six countries and 250 Triple-E-qualified responders. Activities under this pillar are implemented through an eight-step process (Figure 10).

Figure 10: Activities under Pillar 1, Workforce Development



Participating governments identified 50 national responders in each country where scoping missions were conducted—except Nigeria, which warranted 80 responders due to its size and population. WHO also recruited 250 emergency responders from its internal workforce.

Responders were trained on core aspects of emergency preparedness and response, including:

(i) incident management systems and the management and operation of Public Health Emergency Operations Centres (PHEOCs);
(ii) humanitarian situations and health cluster coordination;
(iii) participation in Rapid Response Teams (RRTs);
(iv) addressing sexual exploitation, abuse, and gender-based violence; and
(v) media communications.

Workforce Database

A workforce database is currently being developed. Once completed, its dashboard feature will provide real-time information on the availability of emergency responders, which will allow for rapid deployment in the event of a crisis.

Pillar 2: Response Readiness and Coordination

PHEOCs

WHO AFRO is working to establish Public Health Emergency Operations Centres (PHEOCs) in all WHO AFRO member countries and build their capacity. A PHEOC is a hub for coordinating EPR. Each PHEOC utilizes an Incident Management System (IMS) to allow experts from multiple sectors to align their emergency response activities in a structured manner while communicating and sharing data in real time to enable evidence-based decision-making. PHEOCs also support capacity-building, acting as training centres for emergency management. Thirty-nine PHEOCs are operational in the AFRO region, with the latest additions being in Niger and Equatorial Guinea[20].

During 2022, WHO AFRO continued to develop the governance arrangements and legal framework for the PHEOCs. The team formulated standard operating procedures, continued to invest in the necessary infrastructure for minimum operational readiness and established rigorous training programmes. WHO and its partners continue to engage in joint advocacy and policy dialogue with Africa CDC and other global, regional, and local stakeholders to ensure that the PHEOCs have sufficient resources to operate continuously.

During 2023, WHO AFRO will continue to work with the national governments to conduct regular country capacity and risk assessments, perform simulation exercises, and foster the exchange of the best practices through the region wide PHEOC network.

Regional Simulation Exercise

In collaboration with Africa CDC and the African Emergency Operations Centre (Africa EOC) network, WHO AFRO conducted a regional simulation exercise to test Ebola preparedness and response from 6 to 7 December 2022. Thirty-six countries participated in the exercise, which simulated an Ebola outbreak arising during a humanitarian crisis. WHO AFRO used the exercise to test its risk-assessment methodology, grade-level determinations, emergency alert and response procedures, communications processes, and emergency-management policies, plans, and systems. The exercise revealed that multi-hazard preparedness and response plans should specify decision-making, information-management, and stakeholder-engagement procedures, as well as systems for cross-border PHEOC-to-PHEOC communications. The WHO AFRO team is currently preparing a full report on the exercise, which should be ready during Q1 2023.

African EOC Network website

The African EOC Network was established in November 2015 by the WHO Regional Office for Africa in coordination with the WHO Health Emergencies Programme. The network is a regional platform for collaborating and sharing information on public health emergency management. In 2022, the EOC Network developed a dedicated website for the African Regional PHEOC Network (AFR-PHEOC-NET), which is set to launch in Q1 2023. The website will enable communication, information-sharing, and the exchange of best practices among PHEOCs across the region.[19]

The site is:

https://pheocnet.afro.who.int/

Scan to visit

19 https://pheocnet.afro.who.int/

20 Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Côte d'Ivoire, The Democratic Republic of Congo, Ethiopia, Equatorial Guinea, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Republic of Congo, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

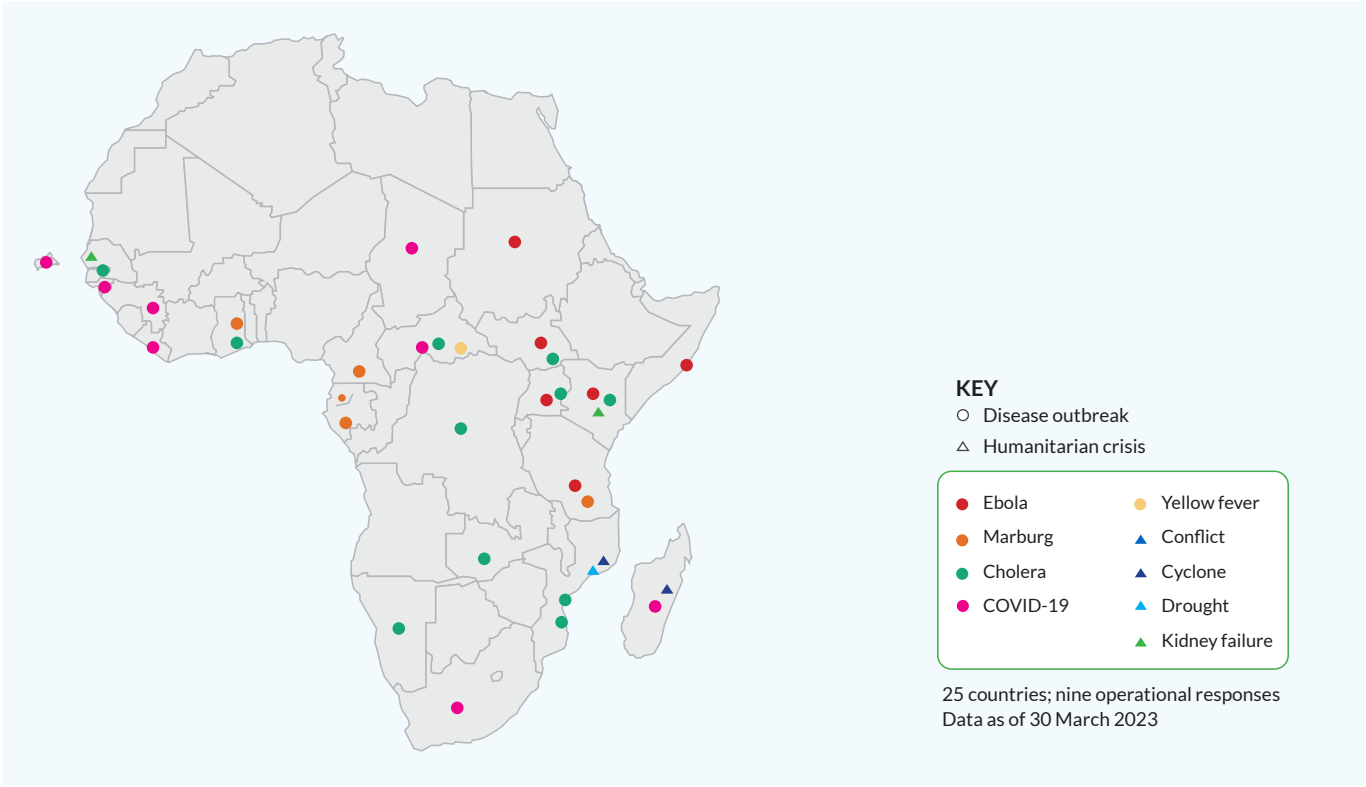
Pillar 3: Operations Support and Logistics (OSL)

OSL support to the Member States

In 2022, WHO AFRO shipped supplies to 46 African countries in response to outbreaks of cholera, Ebola, Marburg virus, COVID-19, Rift Valley fever, and yellow fever. WHO AFRO dispatched interagency emergency health kits (IEHKs) from the Kenya hub to Central African Republic, Mozambique, and Kenya. The IEHKs are designed to meet priority health needs when emergencies disrupt routine health services. Each IEHK contains medical supplies that can serve a population of 10,000 for three months.

In addition, the Kenya hub dispatched emergency nutritional supplements to drought-affected areas. The OSL team continued to support the effort against COVID-19, dispatching rapid tests to Guinea-Bissau, Guinea, Liberia, Gabon, Madagascar, Cape Verde, Chad, and South Africa. To bolster EPR capacity at the national level, WHO AFRO equipped emergency responders in each participating country with an eight-vehicle fleet, established warehouse facilities as necessary, ensured that storage infrastructure could hold at least two weeks of supplies, and procured US$350,000 worth of supplies. At the end of 2022, marked progress in key OSL indicators was observed across all participating countries (Table 5).

Figure 11: OSL Support to Member States



The team coordinated campaigns during health emergencies such as the Ebola outbreak in Uganda. WHO AFRO also supported the countries most affected by mpox.

Table 4: Status of Key OSL Indicators across countries

Country	1. Status of equipping emergency expert teams with transport means	2. Status of improvement or setup for warehousing	3. Identification of priority medical supplies for immediate procurement	4. Procurement of priority medical supplies
Chad	Eight vehicles delivered to WHO. Handover not yet done - under process (MoU not yet signed)	MoH under consultation with partners	Quantification ongoing	Procurement not yet initiated
Ethiopia	Eight vehicles are being delivered from the supplier to Ethiopia WCO	Resource mobilization to be launched	Quantification to be initiated	Procurement not yet initiated
Kenya	Eight vehicles delivered to WHO and handed over to MoH	Resource mobilization ongoing	MoH to provide the quantification through WCO	Procurement initiated by AFRO/OSL
Senegal	Eight vehicles not yet delivered	MoH under consultation with partners	Quantification ongoing	Procurement not yet initiated
Tanzania Mainland	Eight vehicles delivered to WHO and handed over to MoH	Central medical store needs to be extended and resource mobilization to be launched	Quantification to be initiated by MoH	Procurement not yet initiated
Zanzibar	Six vehicles not yet delivered	Resource mobilization ongoing	MoH provided the quantification through WCO	Procurement initiated by AFRO/OSL
Angola	Eight vehicles delivered to WHO and handed over to MoH	Resources mobilization ongoing	MoH provided the quantification through WCO	Procurement initiated by AFRO/OSL
Uganda	Eight vehicles delivered to WHO and are being used for Ebola response	Resources mobilization ongoing	MoH provided the quantification through WCO	Procurement initiated by AFRO/OSL
Botswana	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	Quantification submitted to AFRO OSL Team	Procurement ongoing
Mauritania	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	Quantification submitted to AFRO OSL Team	Procurement ongoing
Niger	Eight vehicles delivered to WHO and handed over to MoH on May 2022	Warehousing identified (WHO and ONPPC)	Quantification submitted to AFRO OSL Team	Procurement ongoing
Nigeria	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	Quantification submitted to AFRO OSL Team	Procurement ongoing
Togo	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	Quantification submitted to AFRO OSL Team	Procurement ongoing
Central African Republic	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	MoH provided the quantification through WCO	Procurement ongoing/ initiated by AFRO/OSL
Congo	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	Quantification submitted to AFRO OSL Team	Procurement not yet initiated
Dem. Rep. Congo	Eight vehicles delivered to WHO and handed over to MoH	Budget available, Resource mobilization ongoing	MoH provided the quantification through WCO	Procurement ongoing/ initiated by AFRO/OSL
Namibia	Eight vehicles delivered to WHO and not yet handed over to MoH	Resource mobilization ongoing	quantification to be shared by MoH through WCO	Not yet initiated
Rwanda	Eight vehicles delivered to WHO. Handover not yet done - under process (MoU not yet signed)	Warehousing identified (MoH)	Quantification ongoing	Procurement not yet initiated

Pillar 4: Risk Communication and Community Engagement (RCCE):

In 2022, RCCE efforts focused on ensuring integrated and consistent communications at the national and subnational levels. WHO AFRO directly supported health ministries in developing their messaging strategies in response to outbreaks.

Awareness Campaigns

During 2022, the team coordinated campaigns during health emergencies such as the Ebola outbreak in Uganda. WHO AFRO also supported the countries most affected by mpox—Nigeria, DRC, Ghana, and Liberia—by formulating RCCE guidelines to monitor country-level preparedness and response capabilities and by developing and disseminating mpox information, education, and communication materials. The team continues to provide technical support for risk communications to the Incident Management Support Team for mpox.

Figure 12: WHO Awareness Campaign on Mpox in Nigeria

RCCE Training

In Q4 2022, WHO AFRO conducted trainings in participatory monitoring and online evaluation systems in Gabon. The training targeted 33 participants from the government and civil society. As part of the training, a description of RCCE activities in Gabon was published online. The RCCE team also supported Cameroon, Gabon, Kenya, and Senegal in documenting their response activities to the COVID-19 pandemic. WHO AFRO assisted other countries in identifying factors associated with infection rates and strengthening their RCCE-related response activities. Participating countries revised their RCCE strategies to address the identified challenges. High-level administrative and political engagement was vital to COVID-19 RCCE in Kenya and Senegal, and findings from the experience of both countries have been documented.

Development of Country Roadmaps and RCCE Strategy

The RCCE team also supported health authorities in Ethiopia, Kenya, and Namibia to develop RCCE plans. Missions were conducted to better understand the country context and identify strengths, gaps, and opportunities to accelerate progress. A workshop to guide the development of the Regional RCCE Strategy was held from 13 to 16 December 2022 in Brazzaville. Members of the regional office, two hubs, and eight country offices participated in the workshop, which successfully identified key objectives and developed overarching strategy frameworks.

UGANDA: THE PIVOTAL ROLE OF CONTACT TRACERS AND VILLAGE HEALTH TEAMS IN COMBATTING EBOLA

Members of the Contact Tracing and RCCE team conduct community outreach in Uganda's Madudu - Mubende District

On 20 September 2022, an Ebola outbreak prompted Uganda's government to declare a state of emergency. With support from WHO and its partners, the Ugandan Ministry of Health trained and deployed around 300 contact tracers, who played a critical role in curbing the spread of the virus. Every contact tracer worked with 10 village health workers and volunteers trained in disease surveillance. Recruited by communities, village health teams helped build trust and overcome fears among responders.

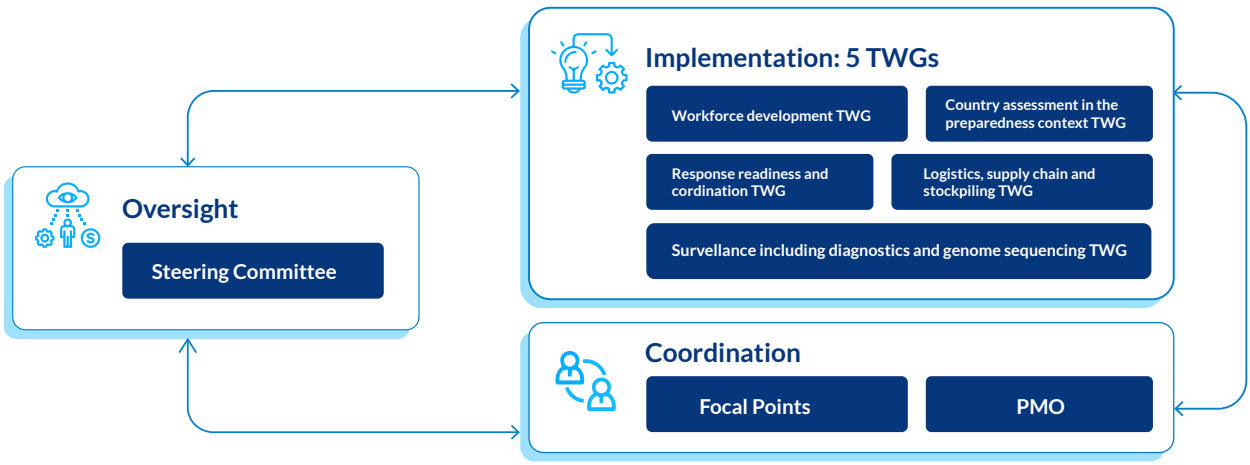
Since the start of the epidemic, the Ministry of Health has trained over 1,200 village health team members with support from WHO AFRO and its partners. Contact tracing improved quickly, with follow-up rates rising from 25% to nearly 94% by mid-October. WHO and its partners also provided four Ebola kits to Mubende Regional Hospital and redeployed 108 technical staff to assist with case management, risk communication, community engagement, and laboratory testing.

> "I work closely with the investigation unit. Once they record a confirmed case of Ebola, my team and I go to the field to follow up with the patient's contacts to ensure that they are symptom-free and then we remain on alert to identify and report symptoms should they develop.
> ...since I have been involved in the Ebola response, I feel like I am saving lives. I have learned that if all contacts are identified and treated, the disease will disappear. That's what motivates me every day."
>
> **Nyangoma Kirrungi, Contact Tracer**

Partnerships and Collaboration

Many of the direst health risks facing Africa are preventable or controllable, but only if proven public health interventions are implemented effectively. Collaboration is key to successfully build strong EPR systems in Africa. One such collaborative effort of working together has been made by Africa CDC, WHO AFRO and EMRO under the Joint Emergency Preparedness and Response Action Plan (JEAP) initiative. The partnership builds on complementarities towards protecting vulnerable populations against public health emergencies. A steering committee provides high-level oversight, while five technical working groups ensure effective implementation (Figure 23). Financial and technical assistance from the Bill & Melinda Gates Foundation has also been a key element of the JEAP initiative.

Figure 13: JEAP Organizational Structure



Legend:
PMO - Project Management Office
TWG - Technical Working Group

In collaboration with Africa CDC and WHO EMRO, WHO AFRO has adopted five priorities for the JEAP initiative for strengthening EPR systems across the continent:

- Workforce development
- Surveillance, including diagnostics and genome sequencing
- Response preparedness and coordination
- Country-level readiness assessments
- Logistics, supply chains, and stockpiles

Africa CDC remains an invaluable partner. Africa CDC has played a key role in establishing PHEOCs; conducting regional simulation exercises; supporting the development of the EPR flagship programs and defining their objectives; and identifying and training regional emergency responders. The continued support of Africa CDC, as well as other partners in the COVAX initiative, was vital to the COVID-19 response activities implemented during the year. The West African Health Organization (WAHO) also played a key role in developing the strategic plan for operationalizing and expanding PHEOCs in the region.

WHO continues to work closely with the Food and Agriculture Organization of the United Nations (FAO) and World Organisation for Animal Health (WOAH) to integrate interventions in animal, environmental, and human health in line with the One Health approach. Multisectoral collaboration was especially critical to strengthen the preparedness of Zambia and Ghana against zoonotic disease threats. Partnerships with *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ) and the East African Community (EAC) Secretariat established as part of the One Health approach were crucial to the simulation exercises. EAC also provided critical human resources to assist with the implementation of the PROSE flagship activities. Finally, the US CDC has provided vital assistance to build up the regional EPR workforce, training health workers from 19 countries in genomic sequencing and financing the development of the emergency-responders database.

Additional collaborative activities include joint learning events, cross-institutional capacity-building, and joint evaluations. In parallel, partnerships with the East, Central, and Southern Africa Health Community (ECSA-HC) and Resolve to Save Lives are supporting the implementation of the PROSE flagship.

Budget Execution

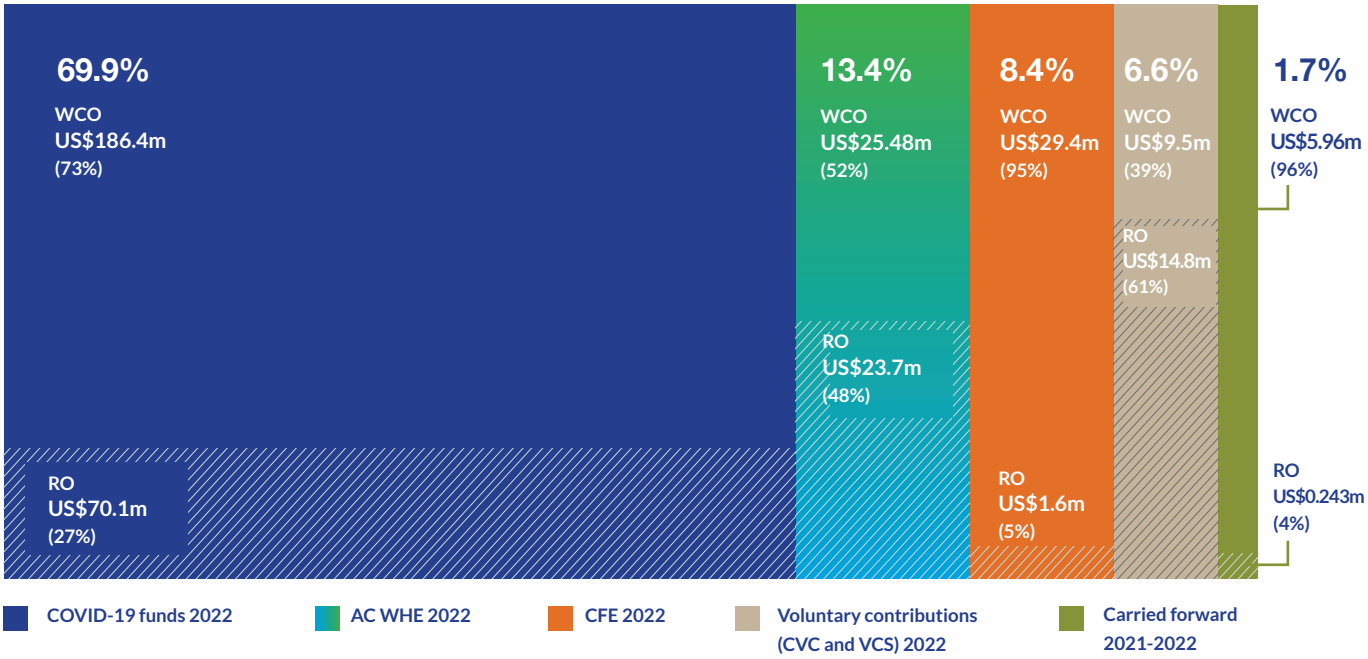
Distribution and Utilization of Funds

In 2022, a net amount of US$367 million was available (excluding the APHEF funding) to WHO country offices (WCOs) and regional office (RO). This amount included carried-forward funds, COVID-19 funds, Assessed Contributions for World Health Emergencies (AC WHE), Core Voluntary Contributions (CVC), Voluntary Contributions Specified (VCS), and Contingency Fund for Emergencies (CFE) funding. COVID-19 funds accounted for about 70% of the total, followed by Assessed Contributions for World Health Emergencies at about 13%. The voluntary contributions (CVC and VCS) and the Contingency Fund for Emergencies together accounted for about 7%. Carried-forward funding made up the smallest share of total funding at 1.7% (Figure 14).

Figure 14: Net amount available for WCOs and RO

The allocation of funds to WHO country offices and regional offices varied by funding source. Of the nearly US$257 million in COVID-19 funding, 73% was allocated to WHO country offices, while regional offices received the remaining 27%. Just over US$49 million in AC WHE funding was divided almost equally, with WHO country offices receiving 52% and regional offices 48%. A full 95% of the US$31 million in CFE funding was distributed to the WHO country offices, with regional offices receiving 5%. Regional office received 61% of the US$24 million in voluntary contributions (CVC and VCS), while WHO country offices received 39%.

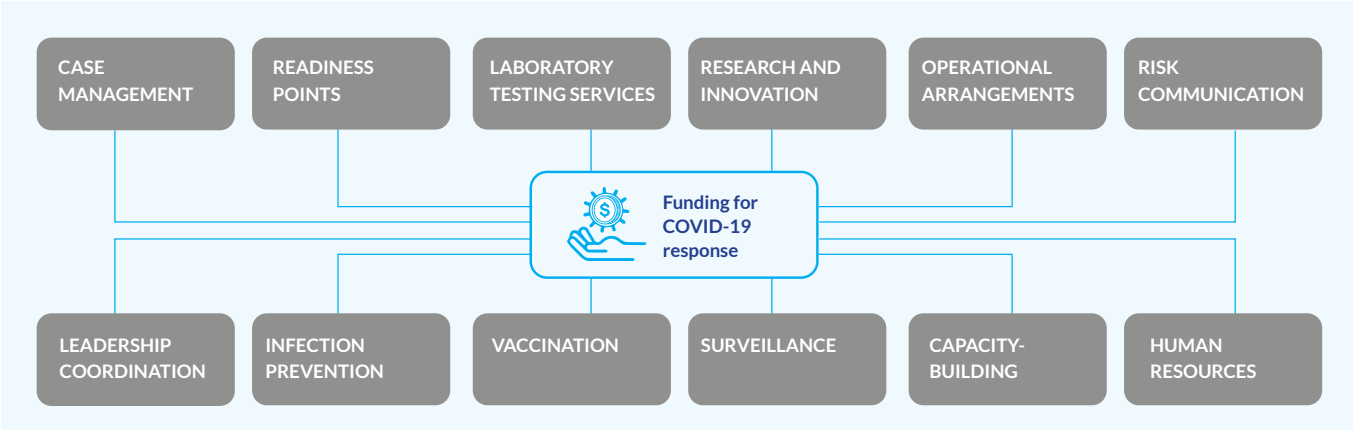
Figure 15: Allocation to WHO Country Offices and Regional Offices for each of the fund types



Of the total funds distributed to the WCOs, Ethiopia received the largest share at 6.2%, while Algeria received the smallest share at 0.2%.

In 2022, WHO has an overall utilization rate of 67% (excluding the APHEF funding). WHO regional office (RO) has a utilization rate of 65% and the utilization rate of the WHO country office stood at 70%.

COVID-19 Fund Allocation and Execution by Pillar



Amongst these pillars, human resources received the third-largest allocation at US$10.1 million and had the highest execution rate at 98%. The vaccination pillar received the largest allocation at US$17.8 million, but its execution rate was just 85%.

Looking Ahead

In 2023, the EPR cluster will prioritize the following activities to advance the strategic objectives of its flagship initiatives.

Promoting Resilience of Systems for Emergencies

a. Leveraging funding from the Pandemic Fund to support implementation of NAPHS in the region.

b. Hosting the first ever WHO-inter parliamentary union high-level conference on strengthening health security preparedness.

Transforming African Surveillance Systems

a. Supporting the digitalization of the Regional Surveillance Data System and IDSR implementation in Member States.

b. Development of a Regional Emergency Data Management and visualization platform interconnected with Members States' routine surveillance platforms (this includes starting to set up the data centre in the Senegal hub).

c. Improving data analysis and the use of IDSR routine data at Member State, regional office and hub levels to optimize early detection of public health events through routine data

d. Scaling up Event-Based Surveillance and Public health Intelligence systems and use at country level (rollout out of EIOS to 22 additional countries in 2023).

e. Scaling up the implementation of TASS to improve IDSR use.

Strengthening and Utilizing Response Groups for Emergencies

a. Identifying, training, and equipping 1,000 additional AVoHC-SURGE responders.

b. Scaling up SURGE to 15 additional countries.

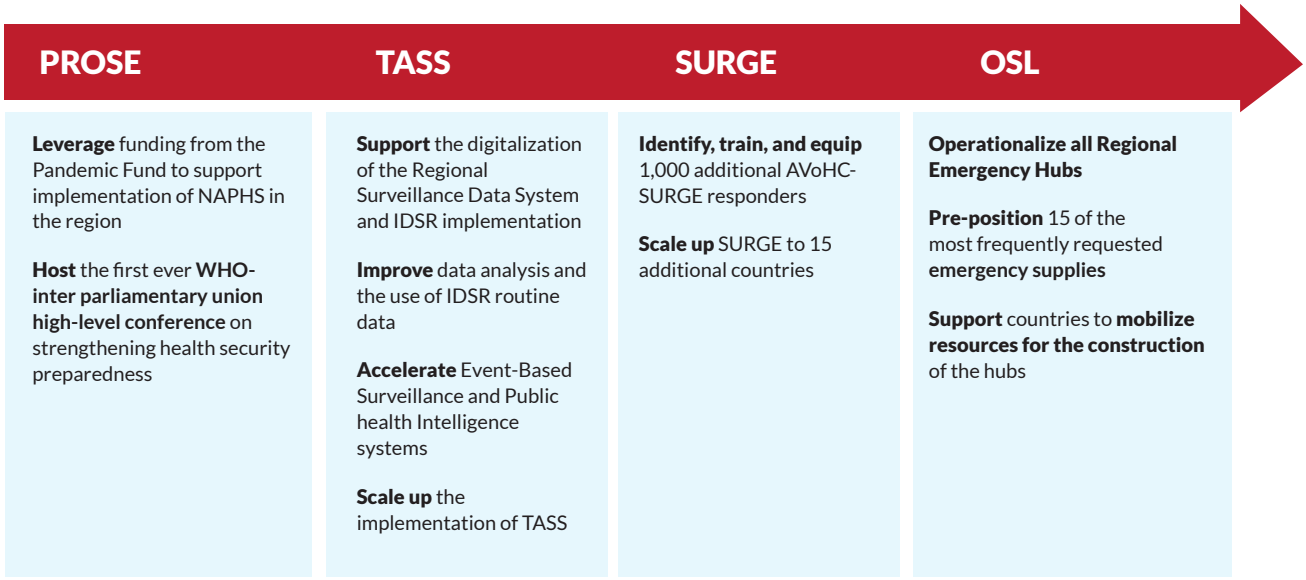
Operations Support and Logistics

a. Operationalization of all three EPR Regional Emergency Hubs and maintaining the KPI of reaching communities with emergency supplies within 48 hours.

b. Pre-positioning of 15 of the most frequently requested emergency supplies.

c. Supporting countries to mobilize resources for the construction of the hubs.

Figure 17: EPR Cluster Focus Areas for 2023



The Kenya Hub will also oversee various sub-regional activities in Eastern Africa, including maintaining medical and logistical supplies stockpiles and stationing WHO staff to ensure quick deployment during emergencies.

Annex 1: Summary of Graded Health Events in 2022

Event	Grade	Date Graded	Countries affected	Nature of event	Status of event
Ebola	2	21 September 2022, regraded on 8 October	Uganda	An Ebola outbreak was declared on 20 September 2022, and the situation was upgraded to a grade 3 emergency in October. However, transmission slowed, and 164 cases and 77 deaths were reported (39% CFR)	**Active**
Cholera	2	25 December 2022	Malawi	A cholera outbreak in Malawi began in March 2022 and was declared a public health emergency on 5 December 2022. The outbreak expanded to 29 districts, leading to a cumulative case count of 15,064 and 470 deaths (3% CFR)	**Active**
Mpox	3 (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 affected 13 countries and was declared an international public health emergency on 23 July 2022. The three countries with the highest number of confirmed cases are Nigeria, DRC, and Ghana. At the end of 2022, there were 1,219 confirmed cases and 16 deaths (1.3% CFR)	**Active**
Yellow fever	2	30 November 2021	Cameroon, Chad, Central African Republic, Côte d'Ivoire, DRC, Ghana, Niger, Nigeria, Uganda, Kenya and Gabon	A yellow fever outbreak started in late 20211 and spread to 12 countries. By December 2022, the number of countries with an active outbreak had fallen to five, with cumulative cases and deaths of 455 and 40, respectively (11% CFR).	**Active**
Drought and food insecurity in the GHOA	3	20 May 2022	Ethiopia, Somalia, Kenya, South Sudan, Sudan, Djibouti, and Uganda	The GHOA is experiencing its fifth consecutive drought in Q4 2022, with more than 46 million people affected by food insecurity. This is the GHOA's worst drought in more than 40 years, with 26% of the population currently classified as experiencing a crisis.	**Active-Protracted**
Humanitarian Crisis in South Sudan	protracted 3	December 2013	South Sudan	The humanitarian crisis in South Sudan has remained one of the key priorities for WHO spanning protracted years of pre and post independence conflicts The current health related humanitarian burden is 5.5 Million with WHO providing resilient essential health and nutrition services to all age groups for both acute and protracted events.With persistent disease outbreaks , intermittent peripheral community clashes, and economic challenges, South Sudan is also classified with the World bank and prioritized by WHO AFRO as fragile , conflicted and vulnerable country. WHO continues to support the humanitarian response, despite difficult circumstances and inadequate financial resources.	**Active-Protracted**
Humanitarian Crises in the Sahel	3	10 February 2022	Burkina Faso, Northern Cameroon, Chad, Niger, Northeast Nigeria, and Mali	This crisis has affected six countries and displaced over 7 million people. While WHO continues to support the response efforts, the region faces many challenges like insecurity, violence, and displacement that threaten access to care and essential services delivery.	**Active-Protracted**
Conflict in Northern Ethiopia	3	19 November 2020	Ethiopia	An armed conflict has caused widespread displacement affecting 13 million people. The crisis has contributed to a surge in malaria and measles while adversely affecting the delivery of essential medical services and disrupting the supply chain of medications for tuberculosis and other chronic medical conditions.	**Active-Protracted**

Annex 2: Member States Discuss the Global Architecture for Health Emergency Preparedness, Response, and Resilience at the 75th World Health Assembly

At the 75th World Health Assembly, Member States reviewed the status of Africa's emergency preparedness, and response architecture as part of an effort to strengthen global health security and expand the role of global partnerships in the African health sector, with support from the Bill & Melinda Gates Foundation, WHO AFRO and EMRO, Africa CDC, and others.

The Director-General committed to developing new proposals for building the capacity of health systems, expanding financing mechanisms, and improving governance at the regional, national, and international levels. The participants highlighted the need to prioritize equity, cooperation, and sustainable financing under the "One Health" approach.

In addition to bolstering pandemic preparedness, the recently created Pandemic Fund will enhance the response to other health emergencies,

Dr. Tedros' Re-election

The Member States of the WHO re-elected Dr. Tedros Adhanom Ghebreyesus to serve a second five-year term as Director-General. WGH welcomes his commitment towards equal representation of women in decision-making and leadership at the highest level of the WHO.

including the growing threat posed by antimicrobial resistance. Participants at the World Health Assembly emphasized that the capabilities and partnerships developed during the response to COVID-19 will contribute to achieving this ambitious agenda and that collaboration during crises strengthens the bonds between global health partners. During the COVID-19 pandemic, WHO implemented innovative new mechanisms to fill critical gaps in response capacity, and these initiatives can be adapted and mainstreamed into the health systems of Member States and partners.

The Director-General formulated ten proposals for strengthening health governance, systems, and financing, and for promoting equity, inclusion, and coherence. These proposals are described below:

Governance

1. **Establish a Global Health Emergency Council** to complement the Standing Committee of the Executive Board and a main committee on emergencies at the World Health Assembly.
2. **Make targeted amendments** to the International Health Regulations (2005).
3. **Scale up universal health and preparedness reviews** and strengthen independent monitoring.

Systems

4. **Build the capacity of emergency health workers**.
5. **Promote a coordinated response to health emergencies** by adopting standardized approaches for strategic planning, financing, operations and monitoring.
6. **Expand partnerships and strengthen networks for a whole-of-society approach** to collaborative surveillance, community protection, safe and scalable care, access to medical countermeasures, and emergency coordination.

Finance

7. **Enhance coordination** between financial and health-sector officials.
8. **Fully finance the Pandemic Fund** to provide catalytic and gap-filling funding.
9. **Expand the funds available for rapidly scalable and sustainable emergency response**, including risk financing to support the rapid development of medical countermeasures.

Equity, Inclusion and Coherence

10. **Consolidate WHO's place at the centre of the global emergency** health preparedness and response architecture.

Annex 3: The 72nd Regional Committee Meeting (AFR/RC72/1) in August 2022

In her opening statement, the WHO Regional Director for Africa, Dr. Matshidiso Moeti praised the President of Togo for leading a COVID-19 response effort that created opportunities for inclusive socioeconomic innovation. The Regional Director noted an impressive reform project in the transportation sector that has positioned Togo as a significant West African aviation hub, as well as efforts to promote digital development.

Dr Tedros and Dr Moeti at the 72nd Regional Committee Meeting

Dr. Moeti also expressed her appreciation to the vice-chairpersons of the 71st session of the Regional Committee for Africa, the Honourable Minister of Health of Botswana and the former Minister of Health of São Tomé and Príncipe, whose leadership greatly facilitated the discussions of the governing body and other events throughout the year. Dr. Moeti deplored the pandemic's impact on development, with 22 million jobs lost and 30 million people in Africa pushed into extreme poverty in 2021, and made an impassioned case for prioritizing investments in the health sector. She noted that equity is a critical factor in health outcomes, both in Africa and worldwide. Despite the progress made in COVID-19 vaccination in the first half of 2022, eight of the 20 priority countries still have coverage rates under 10%, highlighting the need for increased efforts to ensure that Africa's coverage catches up with that of the rest of the world.

The Regional Strategy for Health Security and Emergencies 2022-2030 was presented by the Secretariat and adopted by all 47 health ministers. The strategy highlights the heavy toll that health emergencies, including those caused or exacerbated by climate change, inflict on African health systems and economies. The devastating effects of COVID-19 require building resilient health systems capable of providing quality health care, while coping with health emergencies. Implementing the regional strategy for health security and emergencies 2022-2030 should help reduce the average time to contain outbreaks. The strategy incorporates lessons learned from the pandemic and emphasizes building responsive and resilient health systems to effectively manage health emergencies while ensuring the continuity of essential health services.

The strategy called on the Member States to: (a) actively commit political will and provide technical leadership to its implementation; (b) mobilize domestic and external resources and ensure sustainable financing; (c) provide adequate human and logistic resources; (d) review and make available the necessary structures, health system components, and tools required at national and subnational levels; (e) raise the profile of the One Health approach and strengthen coordination mechanisms; (f) conduct needs assessments and build capacity at the national and decentralized levels; (g) work towards meeting the targets set out in the strategy by 2030; (h) monitor, evaluate and periodically review progress.

The strategy also called on the WHO Secretariat and its partners to: (a) continue to coordinate and provide leadership for health emergency preparedness and response in the African Region; (b) continue to support Member States during health emergencies as per WHO's constitutional mandate; (c) disseminate recommendations from global and regional reviews; (d) disseminate technical guidelines, guidance, and review recommendations to support the implementation of the strategy, (e) provide technical and financial support to Member States to develop evidence-led plans that are regularly monitored and evaluated; (f) ensure that the regional pool of trainers is operational and serves as a platform for coordinated action to cascade country-level training; (g) provide support to countries to strengthen IHR capacities and facilitate synergy and complementarity in partnerships for IHR implementation; (h) establish regional teams of experts to build country capacities; (i) coordinate and mobilize partners and other actors to implement the strategy and achieve its objectives; and (j) implement the supranational actions stipulated in the strategy.

Annex 4: The ground-breaking launch of the Kenya Regional Emergency Hub in July 2022

Then-President of Kenya Uhuru Kenyatta and WHO Director-General Dr. Tedros shake hands at the groundbreaking ceremony for the WHO Emergency Hub in Nairobi

The former President of Kenya, H. E. Uhuru Kenyatta, the Director-General of WHO, Dr. Tedros Adhanom Ghebreyesus, and the WHO Regional Director for Africa, Dr. Matshidiso Moeti attended the groundbreaking ceremony for the Kenya Centre of Excellence and the Emergency Hub.

The hub will maintain medical and logistical supply stockpiles and station WHO staff to ensure quick deployment during emergencies. Its operations will also complement Kenya's domestic emergency response capabilities, which include local manufacturing capacity, as well as health research and surveillance of emerging health challenges.

> "The Centre of Excellence and the Emergency Hub builds on Kenya's global health security leadership and will lead to an empowered Africa which can contain outbreaks and other emergencies rapidly."
> said former **Kenyan Minister of Health, Sen. Mutahi Kagwe.**

The hub will be fundamental to WHO Africa's flagship initiatives in health security, which aim to ensure that one billion people are better protected from health emergencies by the end of 2025. Former President Kenyatta allocated 30 acres of land (valued at US $25.4 million) and committed US$5 million to the construction of the hub. The allocated land is near the Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH).

> "I thank the Government of Kenya for its leadership and generosity in supporting the Emergency Hub. The Hub will improve the capacity of African countries to prepare, detect and respond to health emergencies, support resilient health systems, and strengthen the regional and global health architecture."
> said **Dr Tedros.**

Annex 5: Launching Quarterly Emergency Preparedness and Response Partner Webinars - August 2022

In August 2022, at the 72nd Regional Committee Meeting in Lomé, Togo, African health ministers endorsed a new Regional Strategy for Health Security and Emergencies 2022–2030. By adopting the strategy, the Member States agreed to reach 12 targets by 2030, which will strengthen their capacity to address health emergencies.

The WHO AFRO EPR cluster is working with Member States to operationalise this strategy by implementing three flagship initiatives. To enhance accountability and encourage stronger collaboration in the implementation of the flagships, WHO AFRO will be convening partners to launch the flagship quarterly progress reports. The webinars will provide a platform for WHO, Member States, and partners to discuss progress and co-create solutions to bottlenecks. The webinars are instrumental in strengthening accountability, dissemination of lessons learned during implementation of the three flagships, and in exchanging ideas among key actors in emergency response. The inaugural partners' call was held in August 2022.

The mandate for the quarterly partner webinars is to:

- Enable dialogue on progress, learnings, and areas for partner support in advancing the new regional strategy through the flagship initiatives.
- Launch Quarterly Progress Reports on the flagship initiatives.
- Discuss other priority topics related to health emergencies in Africa, including WHO AFRO's response to urgent emergencies.

World Health Organization