ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Quarterly Emergency Preparedness and Response Report

#3 QUARTERLY REPORT | SEPTEMBER 2023

World Health Organization

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Acronyms

AAR	After Action Review
AFRO	World Health Organization's Regional Office for Africa
AfDB	African Development Bank
ALIMA	The Alliance for International Medical Action
AMR	Antimicrobial Resistance
APIX	Agency for the Promotion of Investments and Major Works
BCP	Business Continuity Plan
CADRI	Capacity for Disaster Reduction Initiative
CAR	Central African Republic
CCC	Command Center Coordination
CDC	Centers for Disease Control and Prevention
CERF	Central Emergency Response Fund
CFE	Contingency Fund for Emergencies
CFR	Case Fatality Rate
CHAI	Clinton Health Access Initiative
COVID	Coronavirus Disease
DAT	Diphtheria Antitoxin
DRC	Democratic Republic of the Congo
EAC	East African Community
ECCAS	Economic Community of Central African States
EIB	European Investment Bank
EMRO	World Health Organization Eastern Mediterranean Regional Office

EMT	Emergency Medical Team
EPR	Emergency Preparedness and Response
ERF	Emergency Response Framework
FCV	Fragile, Conflict-affected, and Vulnerable
GHoA	Greater Horn of Africa
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GOARN	Global Outbreak Alert and Response Network
GPW13	World Health Organization's Thirteenth General Programme of Work
HDRM	Hospital Disaster Risk Management
HNO	Humanitarian Needs Overview
HQ	Headquarters
HRP	Humanitarian Response Plan
IAR	Intra-Action Review
IASC	United Nation's Inter-agency Standing Committee
ICG	International Coordinating Group
ICRC	International Committee of the Red Cross
IDSR	Integrated Disease Surveillance and Response
IEHK	Interagency Emergency Health Kits
IHR	International Health Regulations
IMS	Incident Management System
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IPCAF	Infection Prevention and Control Assessment Framework

JEE	Joint External Evaluation
JOR	Joint Operational Review
JPA	Joint Plan of Action
JRA	Joint Risk Assessment
LTRA	Long-term Risk Assessment
MCOH	One Health Multisectoral Tool
MDA	Muscular Dystrophy Association
MHNT	Mobile Health and Nutrition Team
MHPS	Mental Health and Psychosocial Support
MHPSS	Mental Health and Psychosocial Support
MINUSMA	United Nations Multidimensional Integrated Stabilization Mission
MOH	Ministry of Health
MSF	Médecins Sans Frontières
NAPHS	National Action Plan for Health Security
NBW	National Bridging Workshop
NCP	National Cholera Plans
NHEROP	National Health Emergency Response Operations Plan
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
OH	One Health
OSL	Operations Support and Logistics
PAMI	Priority Areas for Multisectoral Interventions
PHEOC	Public Health Emergency Operations Center
PHSA	Public Health Situation Analyses

PPE	Personal Protective Equipment
PRSEAH	Prevention and Response to Sexual Abuse and Harassment
PSEAH	Prevention of Sexual Exploitation, Abuse, and Harassment
Q1	Quarter One
Q2	Quarter Two
Q3	Quarter Three
Q4	Quarter Four
RCCE	Risk Communication and Community Engagement
RDT	Rapid Diagnostic Test
RED	Regional Emergency Director
REDISSE	Regional Disease Surveillance Systems Enhancement
REPREP	Response Preparedness
RIT	Readiness Intelligence Tool
RRA	Rapid Risk Assessments
RRT	Rapid Response Team
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender-Based Violence
SOMARS	Surveillance Outbreak Response and Analysis System
SOP	Standard Operating Procedure
SPAR	State Party Annual Report
STAR	Strategic Tool for Assessing Risks
SURGE	Strengthening and Utilizing Response Groups for Emergencies
TESK	Trauma Emergency Test Kits
TOT	Training-of-Trainers

UAE	United Arab Emirates
UHPR	Universal Health and Preparedness Review
ULC	WHO AFRO's Universal Health Coverage/Life Course Cluster
UN	United Nations
UNDOS	United Nations Department of Operational Support
UNDSS	United Nations Department for Safety and Security
UNFPA	United Nations Population Fund
UNHAS	United Nations Humanitarian Air Service
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNISS	The United Nations Integrated Strategy for the Sahel
US	United States
VDPV	Vaccine-derived Poliovirus
WASH	Water, Sanitation, and Hygiene
WFD	Workforce Development
WFP	World Food Programme
WHO	World Health Organization

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Message from the **Regional Emergency Director (RED)**

Dr Abdou Salam Gueye
Regional Emergency Director, WHO AFRO

During the third quarter (Q3) of 2023, the WHO African Region's longstanding efforts to strengthen emergency preparedness and response (EPR) capacity across the region contributed to the swift and effective containment of infectious disease outbreaks.

Of the 24 new public health events reported during the quarter, over half were detected within seven days of onset, reflecting the improved weekly reporting of Integrated Disease Surveillance and Response (IDSR) data by the Member States.

The WHO African Region responded to diphtheria and cholera outbreaks by mobilizing resources and deploying essential medical supplies and personnel to the affected areas. A rapid and comprehensive response to the cholera outbreak was followed by a significant decline in cases and deaths across the region, and Malawi declared an end to its cholera public health emergency during the quarter. WHO African Region team efficiently managed the large-scale deployment of supplies needed for the diphtheria outbreak, actively coordinated the delivery of emergency health kits and other supplies in response to the Sudan crisis, and continued to operationalize the regional emergency hubs, which will play a vital role in strengthening health security and emergency preparedness across the AFRO region.

The initiatives of the WHO African Region extended beyond immediate emergency response to building long-term capacity and infrastructure. Over 600 healthcare workers and community leaders were trained in response techniques, particularly in South Africa, which faced its largest cholera outbreak in over a decade during Q3.

The ongoing process of establishing regional emergency hubs in Kenya and Senegal involved high-level meetings and collaborations with various governments and international partners, reflecting a strategic approach to strengthening the resilience of health systems.

The achievements realized this quarter were made possible through close collaboration with various stakeholders, including the Member States, international partners, and local communities. Resource mobilization and advocacy were especially critical priorities during the quarter. Despite significant resource constraints, the WHO African Region's efforts to rapidly detect and respond to public health emergencies, effectively manage disease outbreaks, enhance logistics and supply-chain capabilities, build human capital, and foster collaboration have significantly contributed to improving health outcomes and emergency preparedness across the region.

Introduction

Across Sub-Saharan Africa, a series of escalating environmental, political, and climate-related crises has underscored the critical need for robust and proactive regional strategies to support emergency preparedness and response to multidimensional health threats. Collaboration with national governments and international partners is increasingly vital to address complex health challenges in a context marked by conflict and violence, population displacement, and environmental distress. With underdeveloped infrastructure and limited public services, local authorities often struggle to implement effective emergency response efforts, particularly in remote areas and among vulnerable communities. The WHO African Region remains committed to strengthening local capacities and pioneering agile and efficient approaches to operational and logistical challenges. During Q3, the WHO African Region continued to focus on building systemic resilience and enhancing the crisis-management capabilities of Member States, with a focus on early detection and rapid response.

Emergency Response

Strengthening the health emergency workforce

As part of the Strengthening and Utilizing Response Groups for Emergencies (SURGE) flagship initiative, the WHO African Region continues to develop the capacity of Member States to respond to emergencies by investing in their emergency workforce. The initiative has been expanded to 17 countries, with over 1,400 responders trained. Seven countries have already deployed their workforces locally and/or internationally, and the SURGE initiative is on track to achieving its goal of having over 3,000 emergency responders ready to be deployed in 24-48 hours.

DURING Q3, OVER

30 technical experts

were deployed to support different functions of the Incident Management System (IMS) and strengthened the response to:

- Cholera
- Diphtheria
- Bacterial intestinal infections
- Humanitarian crises in Chad and DRC

WHO African Region is using the Global Outbreak Alert and Response Network (GOARN) to deploy trained AVoHC-SURGE (Africa CDC's African Health Volunteers Corps merged with WHO's Strengthening and Utilizing Response Groups for Emergencies) members to support response activities outside their home countries. Altogether, 16 Member States have registered with the GOARN to receive or deploy AVoHC-SURGE members. The GOARN and standby partners also facilitated the deployment of non-AVoHC-SURGE member health specialists to address the cholera outbreaks in Cameroon and DRC, the diphtheria outbreaks in Nigeria and Niger, the humanitarian crisis in DRC, a multi-country yellow fever outbreak, the impact of the Sahel Crisis, and the ongoing drought in the Horn of Africa.

In collaboration with Africa CDC and East African Community (EAC), WHO African Region staff successfully completed a scoping mission in Uganda, where they met with the Minister of Health and other stakeholders. A two-year costed roadmap was drafted, and emergency-management stakeholders were sensitized. For the period under review, WHO and Africa CDC staff continued to train an additional 338 identified AVoHC-SURGE members as core responders in CAR, DRC, and Senegal. During Q3, seven countries[1] utilized AVoHC-SURGE members to investigate and respond to outbreaks of cholera, circulating vaccine-derived poliovirus (cVDPV), road accidents, dengue fever, measles, humanitarian crises, mpox, and bacterial intestinal infections. Six WHO African Region Triple-E members were deployed to support the regional response to cholera, diphtheria, bacterial intestinal infections, and humanitarian crises.

1 Ethiopia, Kenya, Niger, Tanzania, Chad, DRC, and the Republic of Congo

During Q3, the WHO African Region collaborated with 57 strategic health operational partners, including national and international nongovernmental and civil society organizations. Stand-by partners played a crucial role in bolstering the delivery of health services by deploying key technical experts in various countries.

Close collaboration between the WHO African Region, Member States, and other partners played a pivotal role in the response to the cholera outbreak in Ethiopia, Mozambique, and DRC and to the Sudan crisis in Chad, Ethiopia, and South Sudan. The WHO African Region worked closely with the Africa Centres for Disease Control and Response (Africa CDC) to reinforce operational partnerships developed through the SURGE initiative. In Q3, the WHO African Region collaborated with Save the Children, ALIMA, MSF, UNHCR, OCHA, ICRC, UNFPA, and UNICEF to support SURGE onboarding training in Ethiopia, Senegal, and CAR.

Some health workforce deployments in Q2 continued throughout Q3, and new deployments were also made in Q3 to support response activities. In Q3, Malawi continued to benefit from the deployments of a partner coordinator, a WASH specialist, and an information management officer, which were done in Q2. A Q2 deployment of a health cluster coordinator in Chad was also continued in Q3. In Q3, a specialist in the prevention of sexual exploitation, abuse, and harassment (PSEAH) was deployed to Cameroon. A health cluster coordinator was deployed in Mozambique to support the coordination of health-related activities in the region while in DRC, a specialist in mental health was deployed to address mental health concerns within a complex emergency context.

The SURGE initiative faced funding constraints, and human resources were inadequate to implement the emergency response work plan. To compensate, resources were mobilized through the Economic Community of Central African States (ECCAS) partner.

The World Bank, through the REDISSE IV Project, has been providing support to the health sector in ECCAS countries, and additional funds are being mobilized through partnerships with the governments of Canada and the United Kingdom. Funding also posed a serious challenge for various response efforts, prompting WHO African Region staff to mobilize resources at all levels of the organization, including the WHO country offices, regional offices, and headquarters.

Strengthening PHEOC

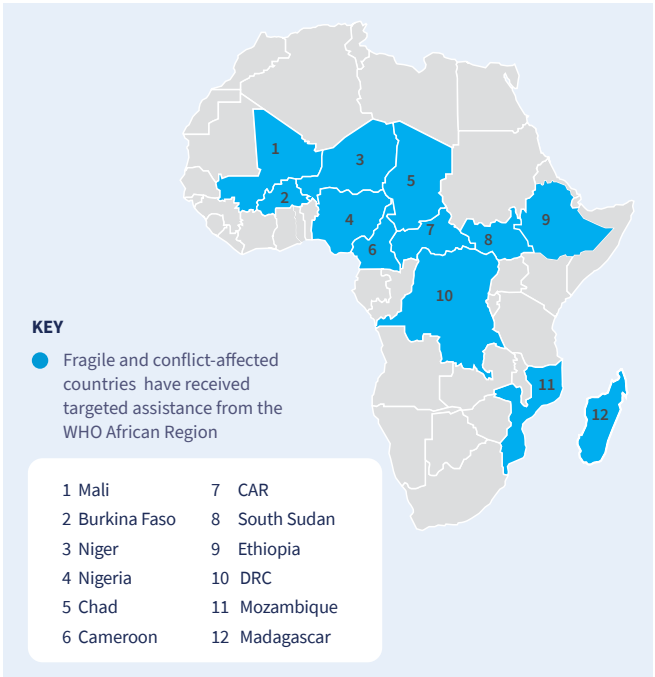
WHO AFRO, in collaboration with EMRO, Africa CDC, and other partners, conducted a Regional TOT on PHEOC and trained 37 national experts. The training included public health emergency management, PHEOC operations and management, Incident Management System (IMS), policy, plans, and procedures development, designing and conducting simulation exercises, and preparing after-action reviews. Furthermore, in collaboration with partners, the WHO African Region organized an Africa PHEOC Network monthly webinar series to facilitate the exchange of experiences and best practices among PHEOCs in African Member States and create a community of practice. WHO AFRO provided technical assistance to six Member States (Chad, Republic of Congo, Central African Republic, Democratic Republic of the Congo, Mauritius, and Equatorial Guinea) focused on strengthening public health emergency management capabilities through capacity assessments, development of implementation plans, legal frameworks, handbooks, and operational Standard Operating Procedures (SOPs). Additionally, WHO AFRO, in partnership with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), rolled out ePHEM software in Burkina Faso, Mali, Togo, Sierra Leone, and Liberia to enhance public health emergency information management and decision-making. WHO AFRO also supported Mali in conducting country-level training on simulation exercises and functional exercises to test PHEOC capacities and plans. Furthermore, WHO AFRO conducted capacity assessments and published a scientific article entitled “Public health emergency operations centers in Africa: a cross-sectional study assessing the implementation status of core components and areas for improvement, December 2021”.

Essential health services and systems maintained and strengthened in fragile, conflict-affected, and vulnerable settings

During Q3, the WHO African Region launched several interventions to strengthen health systems and respond to emergencies in fragile, conflict-affected, and vulnerable (FCV) settings and countries facing humanitarian crises. The WHO African Region recruited and deployed health cluster coordinators, who were instrumental in effectively managing health-related activities in countries

experiencing complex emergencies. WHO African Region also facilitated the deployment of information management officers to support health clusters in FCV countries such as Niger, CAR, DRC, Burkina Faso, Chad, South Sudan, and Mozambique.

WHO African Region also actively assisted in preparing Humanitarian Needs Overviews (HNOs) and Humanitarian Response Plans (HRPs), ensuring that comprehensive assessments would serve as the basis for developing robust response strategies.



Twelve fragile and conflict-affected countries[2] have received targeted assistance from the WHO African Region to strengthen health cluster coordination and response mechanisms.

WHO African Region supported assessments of the impact of attacks on healthcare facilities to inform a strategy for developing more resilient health systems. These assessments were conducted in collaboration with health clusters, ministries of health, and national universities. They included behavioral-change studies in Nigeria's Adamawa State and evaluations of interventions in DRC, Cameroon, South Sudan, CAR, Niger, Ethiopia, and Mozambique.

WHO African Region's efforts have significantly contributed to maintaining and strengthening essential health services and systems in FCV settings. During Q3, the WHO African Region helped coordinate EPR efforts in FCV countries, scale up surveillance systems, improve access to quality essential health services, enhance WASH conditions, deploy qualified health staff, and ensure access to essential medicines and health supplies.

WHO African Region continues to work on promoting sexual and reproductive health rights in FCV settings and has raised over

US$ 600,000

in collaboration with WHO AFRO's Universal Health Coverage/Life Course (ULC) cluster

2 Mali, Burkina Faso, Niger, Nigeria, Chad, Cameroon, CAR, South Sudan, Ethiopia, DRC, Mozambique and Madagascar

This fund will be used to implement key interventions targeting workforce capabilities, data management, and the availability of sexual and reproductive health services in FCV countries.

During the reporting period, the WHO African Region encountered several challenges that affected the implementation of its health emergency detection and response interventions. These included inadequate funding and human resources, limited diphtheria vaccine availability, coordination challenges with WASH-sector partners during the cholera response, and the complexity of responding to recurrent and multiple disease outbreaks. Specific mitigation measures were adopted to address each of these issues.

Continued instability and seasonal environmental hazards led to an increase in displaced persons and prolonged humanitarian responses. These challenges were addressed through sustained coordination and oversight for event responses and collaboration with the Health Information and Risk Analysis Unit, which enabled the design of data-driven humanitarian response plans. The challenge of recurrent and multiple disease outbreaks was tackled by scaling up surveillance systems for early detection and instituting a timely and coordinated outbreak response. Developing resilient essential health packages for FCV countries and promoting the humanitarian development/peace nexus approach strengthened the WHO African Region's response to complex events by emphasizing the role of case management, the provision of essential medicines and medical supplies, and RCCE in FCV responses.

Figure 1: Emergency Response Highlights

RESPONDED TO
24 **NEW PUBLIC HEALTH EVENTS BETWEEN JULY AND SEPTEMBER 2023**

71 Events in total since January 2023

CONDUCTED
06 **RRAS, AND TWO LTRAS DURING Q3**

MAKING **023** RRAS AND **02** LTRAS **FOR THE YEAR SO FAR**

RAISED OVER US$ 600,000
in collaboration with the ULC cluster to implement **key interventions targeting workforce capabilities, data management, and the availability of sexual and reproductive health services** in FCV countries

MONITORED 148 PUBLIC HEALTH EVENTS
AND RESPONDED TO 16 GRADED EMERGENCIES
including new outbreaks of diphtheria and bacterial gastrointestinal infections

THE CHOLERA REGIONAL INCIDENT MANAGEMENT SUPPORT TEAM
ORGANIZED THREE-PART WEBINARS
on cholera surveillance, testing, and confirmation. The webinars were held on

31 AUG	07 SEP	14 SEP
400 PARTICIPANTS FROM 59 COUNTRIES	326 PARTICIPANTS FROM 61 COUNTRIES	315 PARTICIPANTS FROM 62 COUNTRIES

MOBILIZED
US$ 5,619,181
to finance the implementation of humanitarian response plans in FCV countries, and an additional **US$ 500,000 has been pledged**

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

In line with the 2022-2030 Regional Strategy for Health Security and Emergencies[3], the WHO African Region continued to help Member States build their capacity to respond to public health emergencies rapidly. As of 30 September, 148 public health events were being monitored across the region, of which 16 were graded emergencies requiring operational support from the WHO African Region.

In Q3, the WHO African Region responded to 16 graded public health events, of which eight were acute and eight were protracted. The eight acute events included four grade 3 events, two grade 2 events, and one grade 1 event. Four new graded emergencies were added in Q3, including diphtheria outbreaks in Nigeria, Niger, and Guinea and a bacterial gastrointestinal infection in the Republic of Congo. The two major events—the crises caused by Cyclone Cheneso in Madagascar and Cyclone Freddy in Malawi, Mozambique, and Madagascar—were closed during the quarter after a successful response.

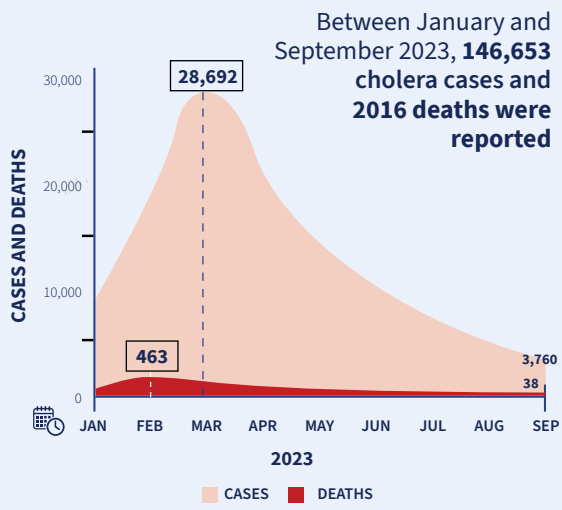
3 https://www.afro.who.int/sites/default/files/2022-07/AFR-RC72-8%20Regional%20strategy%20for%20health%20security%20and%20emergencies%202022-2030%20.pdf

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

1 Multi-country cholera outbreak

WHO African Region continued to support the cholera response in the affected countries[4]. A grade review completed on 21 September retained the grade 3 status of the multi-country outbreak until March 2024. During Q3, 13 countries were still reporting active cholera transmission. However, outbreaks were contained in Eswatini, South Sudan, the Republic of Congo, and South Africa, where the final cases were reported in April, May, June, and August, respectively. Outbreaks in Zambia and Tanzania were previously contained, but new cases were reported during Q3. Of all reported cases, 60% were in the Central and Eastern African subregions, with Cameroon, Ethiopia, and DRC accounting for about 76% of cases reported in the last epidemiological week of Q3. While the cholera outbreak continued to evolve, sustained support from the WHO African Region contributed to a continued decline in cases across the region. Between January and September 2023, 146,653 cholera cases were reported.

The reported cases peaked in March at 28,692, then began to decline in April and reached a low of 3,760 in September. A total of 2,016 deaths were recorded between January and September 2023.



60% were in the **Central and Eastern African subregions, with Cameroon, Ethiopia, and DRC accounting for about 76%** of cases reported in the last epidemiological week of Q3

4 Ethiopia, Burundi, Cameroon, DRC, Mozambique, Zambia, Malawi, Nigeria, Zimbabwe, South Africa, South Sudan, Tanzania, Uganda, and Kenya

February had the highest number of reported deaths at 463, but by September, the number of reported deaths had fallen to 38.

THE INTERNATIONAL COORDINATING GROUP (ICG) PROVIDED

12.9 million **DOSES OF ORAL CHOLERA VACCINE (OCV)**

WHICH WERE USED TO VACCINATE OVER 12 MILLION PEOPLE IN:

KENYA · MALAWI · DRC · MOZAMBIQUE

CAMEROON · TANZANIA · ZIMBABWE · ZAMBIA

114,254 KG OF CHOLERA-RELATED SUPPLIES WORTH

US$ 854,933

WERE SUPPLIED TO 13 COUNTRIES

THESE COMMODITIES INCLUDED

1,190 RAPID DIAGNOSTIC TESTS (RDT) KITS

18 LABORATORY KITS TO ANALYSE 1800 SAMPLES

THE WHO AFRICAN REGION DEPLOYED

A TOTAL OF 119 SURGE EXPERTS

88 MALAWI · **08** KENYA · **05** ESWATINI

05 MOZAMBIQUE · **05** ETHIOPIA · **08** SOUTH AFRICA

When an outbreak at a religious site in Amhara drove a spike in cholera transmission in Ethiopia, the WHO African Region supported the rapid expansion of the response effort, including the establishment of treatment centers, IPC systems, and RCCE.

WHO African Region also worked with health authorities in Uganda and South Africa to assess their readiness and establish additional response measures, which enabled them to contain their outbreaks within 60 days. Malawi and Mozambique, which accounted for the largest share of cholera cases and deaths, also achieved significant progress during Q3. In Malawi, the accelerated integrated community interventions implemented with support from the WHO African Region and partner organizations helped reduce case rates from over 1,000 per day between January and May to fewer than 100 per month between July and September. On 16 August, Malawi's government declared that the cholera outbreak was no longer a public health emergency.

After Action Reviews (AARs) and supportive supervisory visits revealed that limited knowledge and skills had hindered the response to the cholera outbreak. To address this gap, the Cholera Regional Incident Management support team organized a three-part series of webinars on cholera surveillance, testing, and confirmation. The webinars were held on 31 August (400 participants from 59 countries), 7 September (326 participants from 61 countries), and 14 September (315 participants from 62 countries).

Lack of funding, suboptimal coordination, and other challenges threatened the success of the cholera response. Due to limited funding for regional and global cholera response plans, the effort relied heavily on CFE resources. National health authorities also deprioritized the cholera response, which weakened multisectoral collaboration, data reporting, and overall preparedness during the pre-cholera season. The limited laboratory capacities of Member States also delayed outbreak confirmation. An inadequate global supply of vaccines and cholera kits further hindered the response, and the rising frequency of climate-related disasters such as floods, drought, and Cyclones posed a serious long-term challenge. The mitigation strategy to some of these challenges included high-level advocacy with Member States to invest in WASH, allocation of resources for cholera response, and active engagement with WASH partners at the regional and global levels.

SPOTLIGHT

STOPPING CHOLERA: HOW SOUTH AFRICA CONTAINED AN OUTBREAK **IN 60 DAYS**

BACKGROUND

During 2023, South Africa reported a second cluster of cholera cases in Gauteng Province. Local transmission was established after cases were reported in 17 of 52 districts in the provinces of Gauteng, Free State, Mpumalanga, North-West, and Limpopo. By 31 July, a total of 1,380 cases had been reported, 199 of which were laboratory-confirmed, along with 47 deaths, indicating a CFR of 3.4%. By mid-year, the cholera outbreak had become the country's largest in over a decade. The National Department of Health, the Provincial Departments of Health, and the Provincial Departments of Water and Sanitation, in collaboration with WHO, UNICEF, Médecins Sans Frontières (MSF), the Clinton Health Access Initiative (CHAI), and other partners, mounted a strong collaborative response effort.

ACTIVITIES

WHO African Region deployed a team of 10 experts to South Africa to assist with coordination, RCCE, epidemiology and surveillance, IPC/WASH, and case management. This deployment was supported by funding for field-level operations. The establishment of a robust surveillance system was crucial in identifying and monitoring cholera cases, allowing for early detection and rapid response. Efforts were made to ensure prompt access to medical care, including the provision of oral rehydration solutions, antibiotics, and other essential medical supplies. This approach significantly contributed to the effective management of patients and helped reduce mortality rates.

WHO African Region supported RCCE initiatives to educate the public about cholera. Information campaigns focused on increasing awareness of cholera transmission, symptoms, and preventive measures. At the same time, community engagement efforts emphasized the importance of proper hygiene practices, access to safe water sources, and sanitation measures to curb the spread of the disease. Actions were taken to improve WASH service quality, promote proper sanitation practices, and ensure the provision of potable water in affected regions. Data was critical in containing the outbreak, as accurate and timely reporting enabled the health authorities and their partners to make evidence-based decisions. The WHO African Region supported training of over 600 healthcare workers and community leaders across eight provinces, which equipped them with the necessary skills to respond effectively to the cholera outbreak and other health issues.

Results

These efforts effectively halted the spread of cholera in South Africa. Despite the initial rapid increase in confirmed cases, **the outbreak was ultimately contained within 60 days**

Lessons learned from evaluations of the outbreak and the response effort **emphasized the urgency of strengthening the national healthcare system**, improving sanitation facilities, and building Member States' capacity to handle future health crises better

WHO case management experts conducting on-the-job training and mentorship on the management of cholera cases with staff of Kanana Community Health Center

2 Diphtheria outbreak – Nigeria, Niger, and Guinea

Diphtheria cases began rising rapidly in July 2023, and during Q3, the outbreak was reclassified from a grade 1 to a grade 2 public health emergency affecting Nigeria, Niger, and Guinea.

Nigeria registered the largest number of reported cases, with 14,482 (88.4% of the total), followed by Niger with 1,331 cases (8.1%) and Guinea with 576 cases (3.5%). The case fatality rate was 3.8% in Nigeria, 4.8% in Niger, and 10% in Guinea. WHO African Region is supporting efforts among the affected countries to strengthen response coordination, improve case identification and testing, procure, and administer and distribute antibiotics and diphtheria antitoxin (DAT), and accelerate catch-up vaccinations. To support the countries, five international experts were deployed, who supported field operations, vaccination campaigns and surveillance and case management in Nigeria.

In Nigeria, a reactive vaccination campaign has reached 1,089,495 children. All three phases of the campaign have been completed in Kano State, and the first phase has been completed in Katsina, Bauchi, Yobe, and Kaduna States. Preparations for new rounds of the vaccination in other affected states are ongoing.

In Niger, three teams organized as part of the SURGE flagship were deployed to investigate and manage the epidemic in the Matameye, Abala, and Torodi regions. A vaccination campaign was launched, targeting people under the age of 30 in the two epicenters of Amsoudou and Kantché. To date, a total of 19,683 people in Amsoudou and 32,809 people in Kantché have been vaccinated.

The health authorities in Guinea deployed investigation teams to affected areas in the Kankan region in collaboration with the local health facilities. The WHO African Region assisted these efforts through enhanced surveillance, including active case identification, community mobilization, and case management. Supplies were provided to support the response, and resources from the Contingency Fund for Emergencies (CFE) were disbursed to all three countries (Table 1).

Insufficient funds and an inadequate supply of vaccine doses complicated the response to the multi-country diphtheria outbreak. So far, 14,192 vials of DAT that can treat 5000 patients with severe form of Diphtheria have been procured for distribution with Nigeria being allocated 90% (12,800 vials). However, the global shortage of DAT is slowing the inflow of additional doses of this life-saving drug. Moreover, the low vaccination rates in the affected countries pose a serious challenge, as Nigeria alone will require an estimated 13 million doses of the diphtheria vaccine. Mitigation efforts hinged on collaborations with UNICEF and Gavi, as well as the coordination of global vaccine and DAT procurement through headquarters. The resurgence of diphtheria highlights the urgency of scaling up vaccination coverage to the recommended 85% in all countries in the region, strengthening response efforts in the affected countries, and fast-tracking the procurement of laboratory supplies for diphtheria.

Total of **19,683 people in Amsoudou and 32,809 in Kantche** have been **vaccinated**

The WHO African Region **assisted these efforts through enhanced surveillance, including active case identification, community mobilization, and case management**

Table 1: Diphtheria Antitoxin (DAT) Provided and Funding Disbursed in Response to the Multi-Country Diphtheria Outbreak in Q3

Country	DAT vials in Q3	Amount Disbursed (US$) in Q3
Nigeria	none	650,000
Niger	750 vials	450,000
Guinea	642 vials	380,000

Diphtheria Reactive Immunization Campaign, Damturu, Nigeria

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

3 Drought and food insecurity – Greater Horn of Africa region

A protracted regional drought has contributed to widespread food insecurity, resulting in an ongoing Grade 3 emergency since 20 May 2022. The affected countries include Djibouti, Kenya, Ethiopia, Somalia, Sudan, South Sudan, and Uganda.

61 million people were acutely food insecure in the quarter of which an estimated 11.5 million developed acute malnutrition. Admission trends for severe acute malnutrition continue to increase in many GHoA countries. Notably, Between January and July of this year, there were over 131,000 more admissions (57% increase) in Somalia and over 28,000 more admissions (50% increase) in Kenya compared to the same time in 2022. WHO AFRO continues to provide the necessary support on leadership and coordination, surveillance and health information, outbreak prevention and control, essential nutrition actions, and health services to all seven countries in the greater horn of Africa.

61 million people were acutely food insecure in the quarter of which an estimated **11.5 million developed acute malnutrition**

WHO continued supporting countries affected through strengthening coordination and outbreak response. In addition, in South Sudan and Somalia, WHO continues to provide essential life-saving emergency time ensuring the provision of life-saving healthcare accessibility and availability to the affected population, including IDPs, as well as the hosting communities. WHO also supported MOH to strengthen surveillance and early warning system. WHO also continue supporting nutrition treatment and stabilization centres.

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

4 Humanitarian crisis – Sudan, South Sudan, Central African Republic, Chad, and Ethiopia

WHO African Region assisted 04 FCV countries in providing a package of essential health services to the victims of the Sudan crisis

Ethiopia has received 78,171 refugees from Sudan, and the Central African Republic (CAR) has received 18,001 refugees

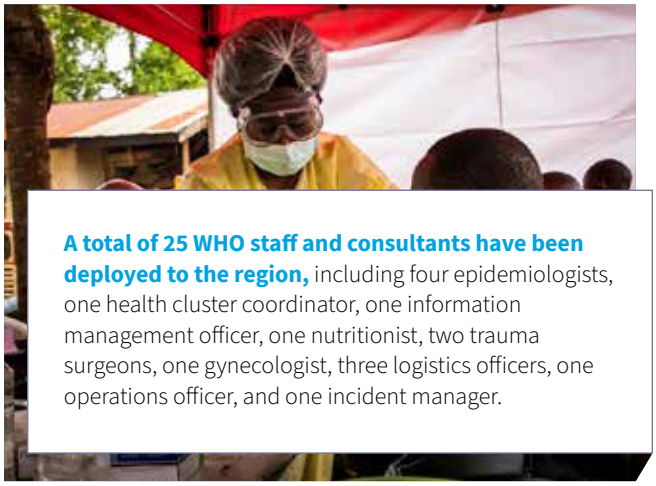
In Sudan, a civil conflict that began in April 2023 has since displaced over 9 million people. The humanitarian situation was classified as a grade 2 event on 20 April 2023, then reclassified as grade 3 on 5 June 2023.

An estimated 8 million people are internally displaced within Sudan, while 1,073,246 have fled to neighboring countries. WHO African Region Member States are currently hosting 784,238 Sudanese refugees, representing 73.1% of the total refugee population created by the crisis. Of these, 444,086 have sought refuge in Chad, where the local health system is receiving trauma cases. Meanwhile, 243,980 displaced people have entered South Sudan, 91.3% of whom are South Sudanese returnees. Ethiopia has received 78,171 refugees from Sudan, and the Central African Republic (CAR) has received 18,001.

In addition to coordinating the cross-border response effort, the WHO African Region continues to provide in-country support to the areas most affected by displacement.

In collaboration with health-cluster partners, the WHO African Region assisted four FCV countries in providing a package of essential health services to the victims of the Sudan crisis. This effort included scaling up surveillance activities, managing non-communicable and vaccine-preventable disease cases, severe acute malnutrition (SAM) management, trauma-case management, support for survivors of SGBV, reproductive health services, routine and reactive mass vaccination campaigns, mental health and psychosocial support, laboratory testing services, and WASH/IPC activities.

WHO African Region donated 150 medical beds with mattresses to facilities in the Adre health district and is currently renovating guest houses in the Abéché, Fachana, and Adre offices.



A total of 25 WHO staff and consultants have been deployed to the region, including four epidemiologists, one health cluster coordinator, one information management officer, one nutritionist, two trauma surgeons, one gynecologist, three logistics officers, one operations officer, and one incident manager.

The WHO African Region mobilized two EMTs to support the response in Ethiopia and Chad, and over 30 WHO staff and consultants were deployed in Eastern Chad. Training and capacity-building activities focusing on surveillance, cholera, nutrition screening, WASH/IPC, SGBV, and MHPSS were conducted for health professionals and community health workers in the four neighboring FCV countries. Nevertheless, the available funding and material resources remain insufficient to meet the needs of such a vast displaced population.

WHO African Region helped mobilize US$ 5,619,181 to finance the implementation of the response plans in the four countries

An additional US$ 500,000 has been pledged

A total of US$ 496,000 has been disbursed from the CFE to support the response effort

WHO African Region has donated 28 tonnes of essential medicines and medical equipment to the Chadian Ministry of Health

In continuation of the support that the WHO African Region is providing towards the humanitarian response in South Sudan, 686 Interagency Emergency Health Kits (IEHK) worth US$ 409,492 were delivered to six strategic locations. These provisions are anticipated to benefit a total of 227,950 individuals. WHO African Region staff also assisted countries in strengthening their capacity to implement peace-building activities and supported the development of the Global Health for Peace Initiative Roadmap.

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WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

5 Sahel region humanitarian crisis – multiple countries

Across the Sahel region, a combination of violent conflicts, population displacement, and food insecurity has created a complex and widespread humanitarian crisis. The Sahel crisis was deemed a grade 2 event on 10 February 2022, with Burkina Faso, Cameroon, Chad, Mali, Niger, and Nigeria being the most-affected countries.

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

6 Multidimensional humanitarian crisis – Democratic Republic of the Congo

Since June 2023, violence and natural disasters have affected millions of people in the Democratic Republic of the Congo (DRC), contributing to an ongoing grade 3 emergency. In the eastern part of the country, a marked increase in violence between December 2022 and March 2023 resulted in at least 530 casualties, with an additional 150 civilian deaths reported in Ituri during the first half of April. Surging violence has led to the internal displacement of an estimated 6.6 million people in Ituri, Mai-Ndombe, Tshopo, North Kivu, and South Kivu, with about 2.3 million people displaced in North Kivu alone.

Natural disasters and population displacement have compounded these challenges. Floods and landslides have affected 230,000 people in South Kivu, Kasaï, and Tshopo. South Kivu hosts about 40,000 displaced people from Burundi, and Ituri hosts another 10,000 from South Sudan, while an estimated 21,000 returnees from Angola have entered Kasai, and another 33,000 have entered Tshopo. As the humanitarian situation has deteriorated, the affected areas have faced outbreaks of infectious diseases such as cholera, mpox, plague, measles, and meningitis.

On 16 June 2023, the WHO African Region scaled up its response effort, targeting the provinces of Tshopo, Kasaï, South Kivu, North Kivu, and Mai-Ndombe. Altogether, 170 WHO staff and consultants have been deployed in the affected provinces, including 135 national staff, 17 international experts, and 18 visitors. The deployed experts supported the health authorities in DRC in providing essential emergency health services, including surveillance, care for sexual and gender-based violence (SGBV), mental health and psychosocial support (MHPSS), vaccination, treatment for severe acute malnutrition, WASH, IPC, as well as case management during disease outbreaks.

WHO African Region deployed **115 tonnes of materials and supplies across six provinces and mobilized US$ 2.9 million** with an additional **US$ 2.5 million from the Central Emergency Response Fund (CERF) currently in the pipeline**

The Ministry of Health is leading the response effort with support from the WHO African Region and other partners. The National Public Health Institute activated an Incident Management Support Team at the Ministry of Health, and coordination meetings were held weekly at the national level and in each province, sometimes led by the provincial governors. The governors also led efforts to launch vaccination campaigns and distribute materials donated by WHO or other partners. Staff from the Ministry of Health were deployed for one month in each province to coordinate the response at the provincial level. Operational plans aligned with the WHO response plan were prepared at the national and provincial levels. Ten staff were recruited for the response effort, and 15 staff were deployed from Kinshasa to the provinces. In total, 45 staff are supporting the response in six provinces, and another 111 In Vitro Diagnostics staff and consultants were deployed to assist with system scale-up activities.

WHO AFRO'S RESPONSE TO GRADED HEALTH EVENTS

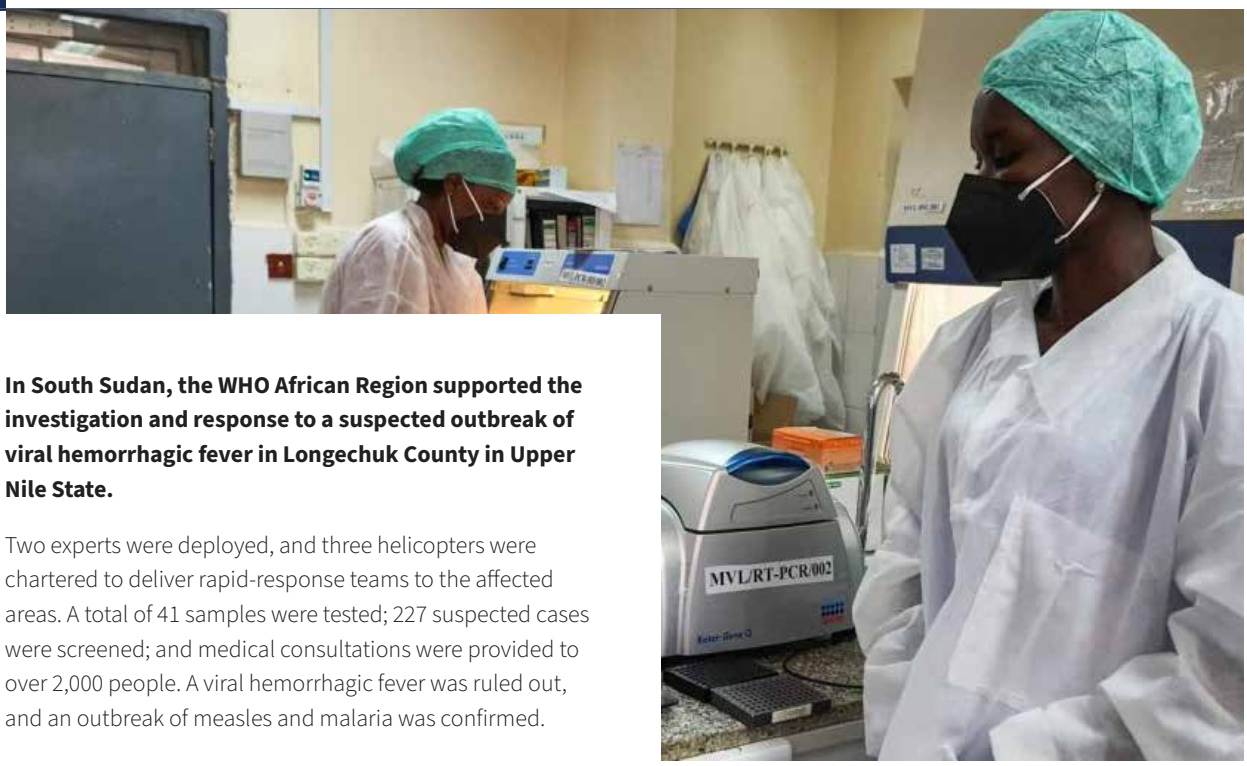
7 Northern Ethiopia Humanitarian Response

WHO African Region supported the response to the protracted humanitarian crisis in Northern Ethiopia, expediting the shipment of six metric tonnes of cholera supplies to four health facilities in the Afar region. In collaboration with Tigray Regional Health Bureau (RHB), the WHO African Region provided rapid response team (RRT) training to 220 participants from 37 districts of the central and northwest zones of Tigray. Prevention and response to sexual abuse and harassment (PRSEAH) orientation was provided to 202 health workers and Tigray Bureau of Industry staff during the RRT training and a mental health and psychosocial support (MHPSS) training in Adigrat, Tigray. The WHO African Region support enabled Emergency Medical Team (EMTs) and Mobile Health and Nutrition Teams (MHNTs) to provide basic health services to 1,089 people at Metema and Kurmuk. Treatment was provided for upper respiratory tract infections and acute gastroenteritis.

8 Bacterial intestinal infections – The Republic of Congo

In the Republic of Congo, a grade 1 outbreak of bacterial intestinal infections was reported on 5 September 2023. A total of 2,389 suspected cases of intestinal infections were reported—including 1,200 cases of typhoid fever, 1,120 cases of shigellosis, and 69 cases of cholera—resulting in 52 deaths. During the quarter, the case fatality rate was 2.2%. Of the suspected cases, 88 have undergone emergency surgery due to intestinal perforation. A total of US$ 250,000 in funding enabled the expansion of isolation and treatment facilities in the epicenter, Dolisie, as the local facilities in the affected area were overwhelmed. Additional surgeons were deployed to operate on patients with perforation, and care plans were developed based on antibiotic sensitivity patterns. The WHO African Region support also included the deployment of one international epidemiologist and 15 national epidemiologists along with five staff from the WHO Country Office and nine surge experts as well as a provision of US$ 300,000. As a result of the support, by the end of Q3, the response had been closed.

9 Suspected viral hemorrhagic fever – South Sudan



In South Sudan, the WHO African Region supported the investigation and response to a suspected outbreak of viral hemorrhagic fever in Longechuk County in Upper Nile State.

Two experts were deployed, and three helicopters were chartered to deliver rapid-response teams to the affected areas. A total of 41 samples were tested; 227 suspected cases were screened; and medical consultations were provided to over 2,000 people. A viral hemorrhagic fever was ruled out, and an outbreak of measles and malaria was confirmed.

Overall, WHO African Region provided support for various emergency response efforts, both at the national and international levels. The WHO African Region facilitated the deployment of Ethiopia's national EMT to the Sudanese border to offer healthcare services to returnees and refugees and Türkiye in response to the devastating February earthquake.

The Uganda EMT received WHO backing for its cholera response, as did the Malawi EMT. The regional EMT was dispatched to Chad to address the Sudan crisis. The Togo EMT, specializing in surgery, was deployed early in the response, and additional teams from DRC, Burkina Faso, and Togo were subsequently sent to address the ongoing crisis in Chad. EMT capacity-building efforts in Uganda and Botswana focused on induction for cholera response and general EMT induction, respectively.

Significant progress in responding to acute health emergencies was achieved during Q3. Two new cholera outbreaks were contained, and a comprehensive and aggressive response from the national health ministries, with support from the WHO African Region and other partners, saved thousands of lives. The public health emergencies caused by Cyclones Cheneso and Freddy were closed as the acute phase had passed, but the WHO African Region supported the provision of healthcare to over 730,000 displaced persons, including 660,000 in Malawi and 70,000 in Mozambique. The two Cyclones struck when both countries were at the peak of their cholera outbreaks, and the readiness actions implemented before and the response interventions immediately after the Cyclones prevented a catastrophic escalation of cholera transmission.

Operations Support and Logistics

Operationalization of Hubs and Partner Engagement

Building EPR capacity at the national level requires strengthening the Regional Emergency Hubs, which is critical to shorten WHO African Region's response time. During Q3, WHO African Region continued to operationalize the Senegal Hub and advocate for greater resource mobilization among Member States and partners.

As part of the Invest in Senegal forum held in Dakar from 6-8 July, the government of Senegal and the WHO African Region hosted a high-level panel titled "Emergency Hub in Senegal: An unprecedented partnership to strengthen emergency preparedness, response, and resilience." The panel emphasized the urgent need to raise the necessary funds to construct and operationalize the Senegal Hub, which will play a vital role in strengthening the resilience of regional health systems and enhancing global health security.

Several donors attended the panel, including the African Development Bank (AfDB), the European Investment Bank (EIB), and other local and international partners. AfDB expressed its interest in supporting health projects in Africa, including crisis response, with an envelope of three billion US Dollars between now and 2030 to support health infrastructure in the region. In addition, a meeting with diplomatic officials from the United Arab Emirates (UAE) was organized to deliberate on fundraising strategies, and a meeting was requested between representatives of the Senegalese government, the UAE government, and WHO to mobilize resources for the construction of the Senegal Hub.

The departure of the UN Multidimensional Integrated Stabilization Mission (MINUSMA) from Mali has coincided with the establishment of the Senegal Hub. During Q3, WHO African Region staff conducted a mission to Bamako to visit several MINUSMA camps and explore the possibility of acquiring materials and equipment that could be repurposed for use at the Senegal Hub. Several meetings were held with the head of the Mission Support Center and other relevant officials to negotiate prices and discuss shipping logistics. A delegation from the UN Department of Operational Support (UNDOS) visited the temporary WHO Regional Emergency Hub site in Diamniadio as well as the 5000 m2 container yard that the WHO African Region secured to store supplies and equipment procured from MINUSMA. This visit offered an opportunity to discuss further collaboration with UNDOS on a cost-recovery basis, which will contribute to the hub's sustainability plan, and

a technical agreement is being finalized to provide a legal framework for this collaboration.

On 28 September, a joint meeting was held in Oslo, Norway, between Kenya's Principal Secretary for Public Health and Professional Standards, Senegal's Deputy Director General of the Agency for the Promotion of Investments and Major Works (APIX-SA), WHO staff, and officials from the Norwegian Ministry of Foreign Affairs. Norway's Ambassador for Global Health, John-Arne Røttingen, chaired the meeting, at which WHO African Region staff presented the WHO Regional Emergency Hubs projects in Kenya, Senegal, and South Africa. A joint proposal for financing the Kenya Hub is being prepared by the WHO African Region and the Kenyan government which will be submitted to the Norwegian government through its embassy in Nairobi. A joint technical working group consisting of representatives of the host governments and WHO African Region staff is being formed to further support the development of the regional hubs.

A high-level meeting was held with Kenya's Head of Public Service during Q3. The meeting focused on the status of the Kenya Hub, the implementation of the Blanket Customs Clearance granted by the Kenyan government, the need to designate a government institution as an implementing entity for the project, and the disbursement of the US$ 5 million committed to support the project. The Head of Public Service took immediate action to address all matters raised by WHO, and H.E. President William Ruto subsequently endorsed the allocation of the land for the hub and affirmed the commitment of US$ 5million in funding.

Support for Emergency Response Efforts

During Q3, WHO African Region delivered 42 outbound supply shipments to 20 countries, including Chad, Tanzania, South Sudan, Botswana, Malawi, Kenya, Rwanda, DRC, Uganda, Niger, the Republic of Congo, Ethiopia, Burundi, Mozambique, Benin, Liberia, Namibia, Mauritius, Eswatini, and Cameroon. The total value of the outbound supplies was $1,273,747, and the shipments weighed a combined 121 tonnes.

Emergency supplies have been provided to Sudan's four neighboring countries in the AFRO region—CAR, Chad, Ethiopia, and South Sudan—since the beginning of the Sudan crisis. WHO African Region actively coordinates with the major humanitarian agencies in the region, including MSF, the ICRC, the IRC, Premier Urgence – Aide Medicale Internationale, and various UN agencies (IOM, UNHCR, WFP, UNHAS, and UNDSS). WHO African Region also provides ongoing operational support for the WHO Eastern Mediterranean Regional Office (EMRO) team's cross-border activities. WHO African Region manages the delivery of emergency health kits and other supplies to N'Djamena and the distribution of emergency kits to national and international partners. WHO African Region staff have negotiated with the Ministry of Defense to secure the air transport of supplies between the Regional Emergency Hub in Kenya and Abéché, and four shipments have been successfully delivered. WHO African Region offices and two guest houses have been established in Abéché, along with offices in Farchana and Adre.

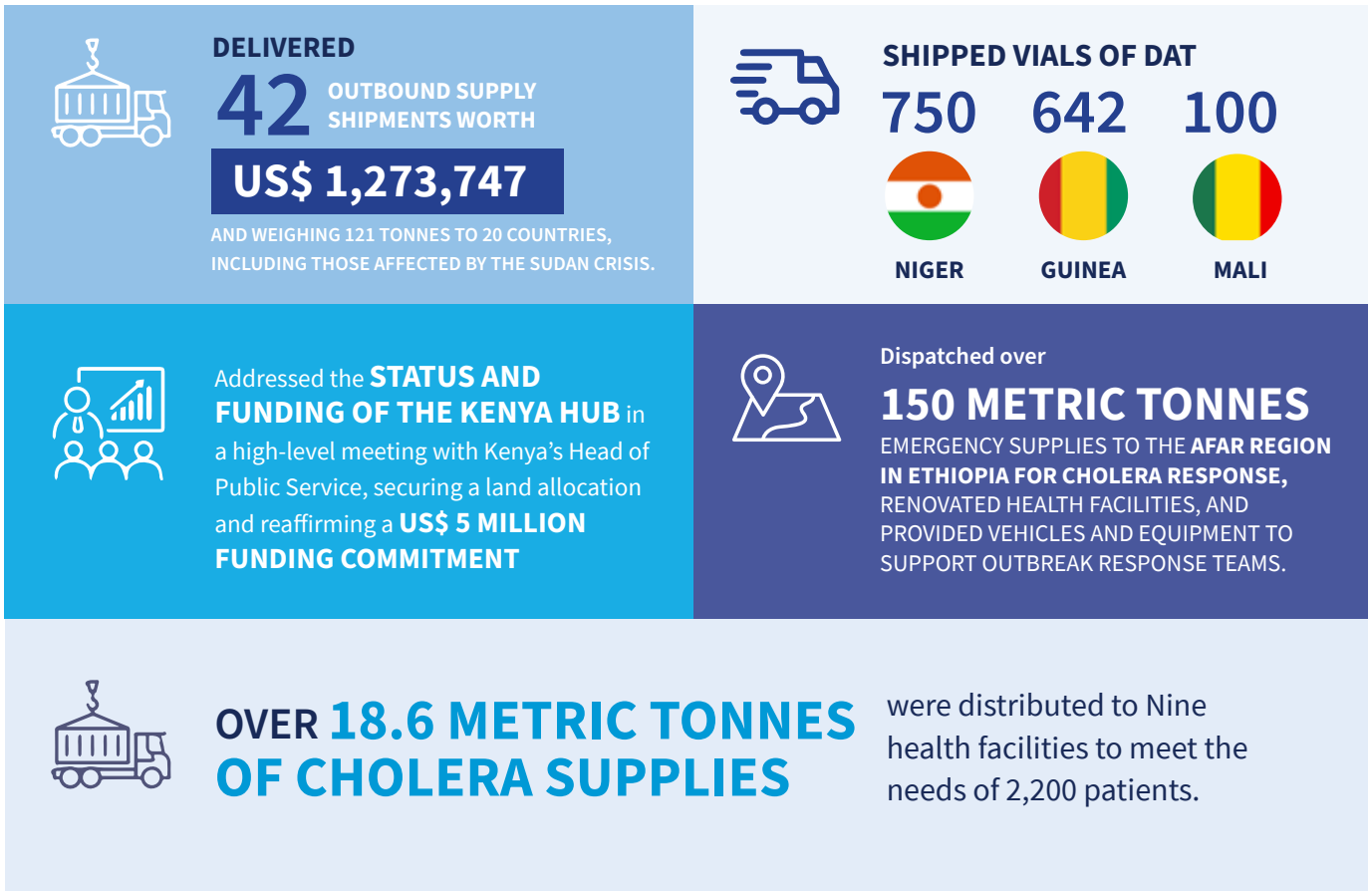
While Chad hosts the largest share of refugees from the Sudan crisis, the WHO African Region is also active in CAR, Ethiopia, and

South Sudan. In CAR, 27 health emergency kits and modules have been delivered in Vakaga Province. In Ethiopia, supplies have been dispatched to areas hosting Sudanese refugees and returnees. In South Sudan, supplies have been dispatched to Malakal, Wau/Raja, Aweil, Renk/Palouch, and Bentiu.

During the multi-diphtheria outbreak, establishing an adequate supply of DAT was a key challenge. Responding to the diphtheria outbreak required the large-scale deployment of supplies and equipment across multiple countries. With the support of the diphtheria focal point in the Senegal Hub, the WHO African Region procured a standard list of emergency medicines and EPR supplies to address the outbreak—including DAT, antibiotics, and personal protective equipment—necessary to treat 250 patients. DAT was procured with the support of WHO HQ in collaboration with MSF and the allocation committee. The WHO African Region distributed the procured supplies and equipment to health centers in Nigeria, Niger, Mali, and Guinea. To date, 750 vials of DAT have been shipped to Niger, 642 to Guinea, and 100 to Mali. The team is currently forecasting DAT needs in Chad and projecting DAT needs for Q4 2023 and Q1 2024, as well as arranging to secure an adequate supply despite the global shortage. The procurement of additional medical supplies, especially antibiotics, is ongoing. In Nigeria's Borno State, the WHO African Region is supporting the state government and the governments of neighboring states to repurpose their former COVID-19 treatment centers into diphtheria treatment facilities, which requires implementing additional biosecurity measures. WHO African Region is supporting the conversion of the treatment centers by providing beds, IPC kits, and other materials. WHO African Region is also reviewing the layout of diphtheria treatment centers and isolation units to identify opportunities to improve efficiency.

In Ethiopia, over 150 metric tonnes of emergency supplies have been dispatched to the Afar region since the beginning of 2022. Of the total, 14.6 metric tonnes were WASH/IPC supplies distributed to hospitals and health centers, while over 18.6 metric tonnes were cholera supplies distributed to nine health facilities to meet the needs of 2,200 patients. WHO African Region renovated and handed over three incinerators and ashpits in Aysaita Hospital and health centers in Semera and Dupti in 2023. Since the beginning of the cholera outbreak in the Afar region, WHO has constructed and upgraded contact tracing centers in health facilities in Semera, Sabure, Worer, and Aysaita, as well as Mohammed Akile Hospital. WHO African Region also renovated and furnished the maternity ward of Logia health center; established two ORPs in Dupti and Gelaelo; and handed over one ambulance to Dupti General Hospital, one vehicle to the Afar Regional Health Bureau, and one container to the Afar Regional Health Bureau. Vehicles were deployed to support cholera outbreak response teams in Aysaita, Afambo, Amibara, and Gewane.

Figure 2: Operations Support and Logistics Highlights

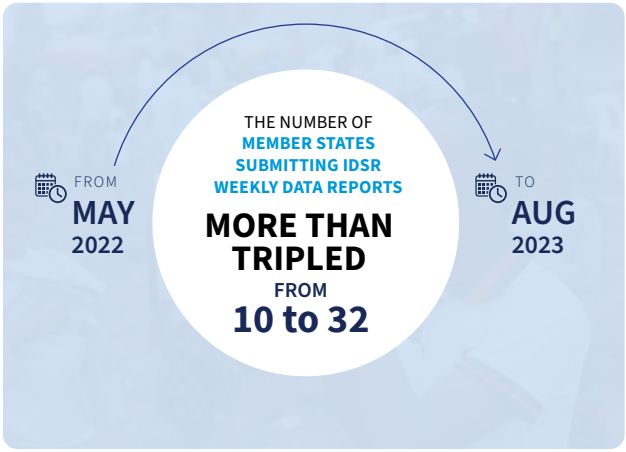


Emergency Detection

Potential health emergencies rapidly detected, and risks assessed and communicated

Across the AFRO region, a total of 24 new public health events were detected and reported to WHO between 1 July and 30 September 2023. Since January, a total of 71 events have been reported. Of all events reported since the beginning of the year, 54% were detected within seven days of onset.

Weekly reporting of Integrated Disease Surveillance and Response (IDSR) data to WHO African Region by the Member States improved significantly during Q3.



The completeness rate of these reports significantly increased from 21% to 68%, and the timeliness rate rose from 11% to 51%. However, a modest decline in all three indicators was observed in August 2023, which may reflect the transition to online submission.

During Q3, a total of six Rapid Risk Assessments (RRAs) and two Long-term Risk Assessments (LTRA) were undertaken for selected disease outbreaks that require a WHO response as per the Emergency Response Framework (ERF). In total, 23 RRAs and two LTRAs have been carried out since the start of the year. Of the 15 RRAs assessed at the national level, four were classified as “very high risk”—the Marburg virus disease outbreaks in Equatorial Guinea and Tanzania and the cholera outbreaks in Kenya and Mozambique—while the other 11 were assigned as “high risk.” In addition, three Public Health Situation Analyses (PHSAs) were conducted during Q3, and a total of 15 PHSAs have been conducted since 1 January.

Member States continued to scale up IDSR implementation during the reporting period. The Gambia and Mauritius each conducted a national IDSR training of trainers (ToT). The Gambia’s ToT had 50 participants, while Mauritius’s had 36. Mauritius also conducted a regional IDSR ToT with 151 participants. The ToTs set the stage for cascading IDSR training to the subnational levels. Ghana and Namibia conducted IDSR cascade trainings for 750 and 46 health workers, respectively.

Mauritius, South Africa, and Tanzania developed national IDSR strategic plans to guide implementation. Tanzania reproduced 10,000 copies of health-facility registers to improve data capture and reporting.

Between May 2022 and August 2023, a total of 1,010 trainers were successfully trained across 10 countries, representing 97% of the ToT target. These countries include CAR (175), the Republic of Congo (22), Côte d'Ivoire (210), The Gambia (50), Kenya (47), Madagascar (249), Mali (28), Niger (20), South Africa (150), and Togo (59). The high training rate underscores the commitment of these countries to build a skilled cadre of trainers to effectively implement the IDSR TGs and TMs across their health systems.

WHO African Region conducted training workshops on the use of the genomic surveillance costing tool in Ghana and Namibia. Ten experts were trained in Ghana, and another 15 were trained in Namibia. WHO African Region commissioned a genomic surveillance evaluation survey of all 47 Member States to gather information on the current capacity and prevailing challenges in each country. The survey findings will inform WHO African Region technical support to strengthen genomic surveillance. The Republic of Congo and Mauritania provided laboratory reagents and supplies, including PCR kits and virus-transport medium, to the national authorities to improve diagnostics. Ghana developed a national strategy for genomic surveillance and supported the integration of the Lassa fever virus into its viral hemorrhagic fever surveillance system. The WHO African Region onboarded eight Member States to the centralized IDSR data platform and IDSR Panorama, a tool developed by the WHO African Region to promote the seamless sharing of weekly IDSR reports. Meanwhile, Ghana rolled out the Surveillance Outbreak Response and Analysis System (SOMARS) surveillance tool in five regions.

An adaptation workshop to support the adoption of the 3rd edition of the IDSR Technical Guidelines and Training Manuals took place from 3-7 July in Durban, South Africa. The workshop was attended by 133 participants from various departments of the Ministry of Health. A second adaptation workshop with 45 participants was held in Port Louis, Mauritius between 28 August and 1 September. WHO African Region provided technical experts and financial support to both countries to facilitate the workshops.

Figure 3: Emergency Detection Highlights

OF 71 PUBLIC HEALTH EVENTS REPORTED IN THE AFRO REGION DURING 2023, 54% WERE DETECTED WITHIN SEVEN DAYS OF ONSET.

ENABLED A SIGNIFICANT INCREASE IN THE NUMBER OF MEMBER STATES SUBMITTING **IDSR DATA WEEKLY AND SUBSTANTIAL IMPROVEMENTS IN THE COMPLETENESS AND TIMELINESS OF THESE REPORTS.**

08 Member States onboarded to the centralized IDSR data platform

Enhanced weekly IDSR reporting from Member States: the number of reporting countries rose from 10 to 32; the report completeness rate significantly increased from **21% to 68%; and the timeliness rate increased from 11% to 51%.**

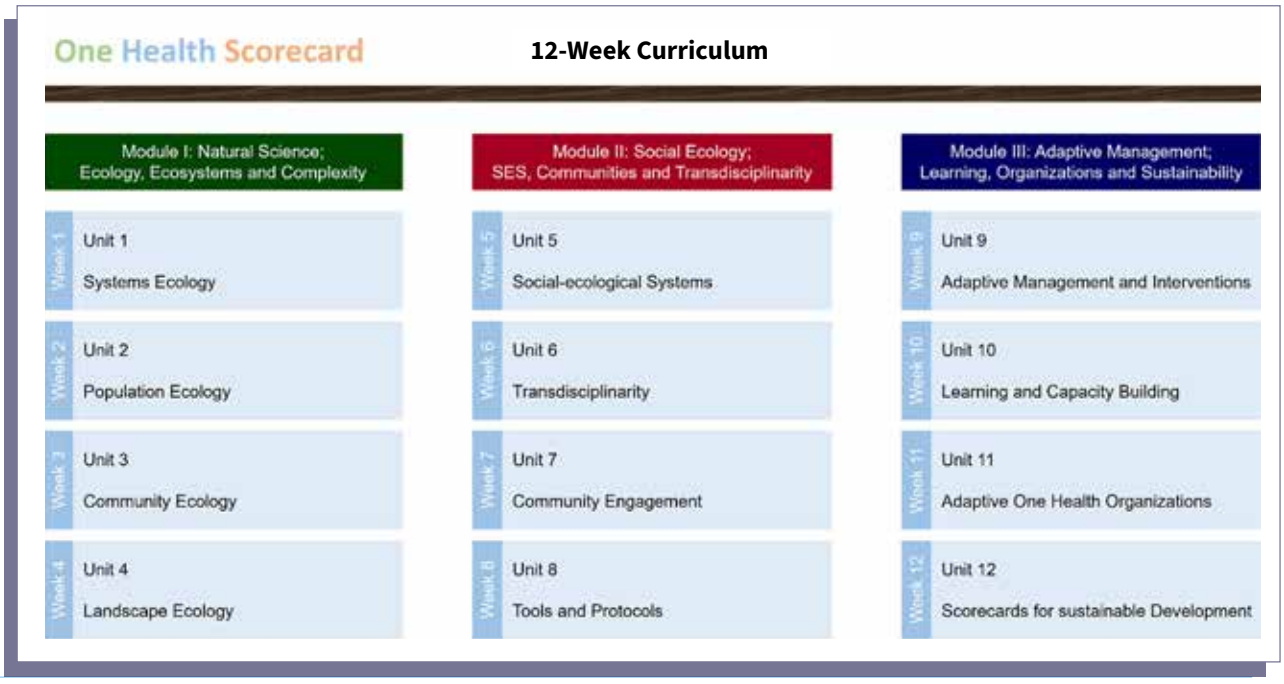
Trained **IN TEN COUNTRIES ON DISEASE SURVEILLANCE**, 86 participants in two countries on IDSR, 25 experts in two countries on genomic surveillance, and 178 participants in two countries on the 3rd edition of the IDSR Technical Guidelines.

Emergency Preparedness

Assessment and Reporting on All-Hazards Emergency Preparedness Capabilities

During Q3, the WHO African Region continued to strengthen the emergency preparedness capacity of the Member States. As part of efforts to bolster planning, implementation, facilitation, and evaluation capabilities, the WHO African Region launched trainings on intra-action review (IAR) and after-action review (AAR) procedures in Cape Verde, Liberia, Mali, and Equatorial Guinea. The training provided in Cape Verde, Liberia, and Mali focused on COVID-19, while the training in Equatorial Guinea focused on Marburg virus disease. The WHO African Region supported five countries in strengthening their capacity to use simulation exercises for emergency response planning, implementation, and evaluation. Tabletop exercises were conducted with counterparts in Cameroon and Nigeria; functional exercises were conducted in Mali; and a mix of tabletop and functional exercises were conducted in Ethiopia and Kenya.

The adoption of regulatory standards and reporting practices was also a key area of focus during Q3. WHO African Region assisted eight countries[5] in performing comprehensive assessments of their capacity to implement International Health Regulations (IHR) by conducting Joint External Evaluations (JEE) and other preparedness assessments.



5 Senegal, Benin, Chad, Nigeria, Liberia, CAR, Angola, Ethiopia, and Tanzania (with separate assessments for mainland Tanzania and Zanzibar)

With support from the WHO African Region, 27 countries in West and Central Africa submitted a State Party Annual Report (SPAR). WHO African Region supported Cameroon and the Republic of Congo in conducting a Universal Health and Preparedness Review (UHPR) designed to strengthen their capacity to perform mid-term reviews of emergency response efforts and map resources. WHO African Region is also supporting Tanzania to complete the UHPR, which is now in its advanced stages. Malawi also received support for the development of its National Action Plan for Health Security (NAPHS).

By the end of Q3, WHO African Region had supported all West and Central African Member States in implementing AARs, conducting simulation exercises, and performing risk assessments using the Strategic Tool for Assessing Risks (STAR). Technical reports and timetables for all activities are now available. Several Member States are finalizing their JEE reports, which will be published on the WHO website, and additional JEEs are planned.

Building capacity for emergency preparedness

During Q3, WHO African Region provided technical support to the Member States for establishing and strengthening infection prevention and control (IPC) programs at the national and facility levels. With assistance from WHO African Region, Uganda, Comoros, Cameroon, and Niger developed and implemented national strategic plans for IPC. In addition, Namibia, Uganda, and South Sudan developed national IPC guidelines that are evidence-based, tailored to the country context, and aligned with international standards. WHO African Region worked with health authorities in South Sudan to conduct facility assessments using the IPC assessment framework (IPCAF-MR) in 18 primary, secondary, and tertiary healthcare facilities.

To promote the development and dissemination of evidence-based approaches to IPC, WHO African Region staff facilitated the exchange of knowledge and experiences between health authorities in the Member States. Representatives of 19 countries in Eastern and Southern Africa attended five virtual experience-sharing webinars. Focusing on IPC best practices and lessons learned during the COVID-19 pandemic, these discussions aimed to accelerate the process of aligning national health systems with WHO recommendations and the global strategy for IPC.

Regional coordination under the One Health approach remains a cornerstone of WHO African Region's activities. As part of a broader effort to adapt and operationalize One Health tools and training materials across the region, IHR-PVS Bridging Workshops on zoonotic disease risks were conducted to strengthen coordination and collaboration between professionals working in healthcare, veterinary medicine, environmental quality, and other sectors. These workshops were held in Togo (6-8 June), CAR (21-23 June), and South Africa (4-6 September), while Joint risk assessments (JRAs) were conducted in Kanilai, The Gambia from 25-28 September and in 10 prefectures in Guinea[6] from 8-30 September. WHO African Region also supported the operationalization of the One Health approach in Nigeria, Cameroon, Kenya, Ethiopia, Guinea, Sierra Leone, and Liberia. In South Africa, the WHO African Region helped the health authorities establish a coordination mechanism using the One Health Multisectoral Tool (MCOH).

6 Faranah, Kissidougou, Guéckédou, Macenta, N'Zérékoré, Beyla, Lola, Yomou, Forécariah, and Coyah

WHO African Region supported the development of the 2022-2026 One Health Joint Plan of Action (OH-JPA) during Q3. A Workforce Development Operational Tool (WFD OT) was created from 25-27 September to strengthen One Health's capacity at the national level. The rabies-elimination program and efforts to combat antimicrobial resistance (AMR) remain key priorities for collaboration among the Member States. To promote the adoption of IHR, an onboarding workshop was held in Mauritius from 4-8 September. WHO African Region staff also participated in the global consultation process for updating the STAR and National Health Emergency Response Operations Plan (NHEROP) methodologies. In Zambia, the WHO African Region provided technical support for the Capacity for Disaster Reduction Initiative (CADRI) to assess country-level capacity for hospital disaster risk management (HDRM). Throughout Q3, the WHO African Region supported countries in identifying priority zoonotic diseases and developing emergency response plans.

Improving Operational Readiness to Assess and Manage Identified Risks and Vulnerabilities

During Q3, the WHO African Region continued to work with the Member States to assess and strengthen their operational readiness to address priority health risks. A Readiness Intelligence Tool (RIT) developed at WHO Headquarters was piloted in Nigeria. The RIT links STAR to readiness actions for identified high-risk hazards. A version of the RIT tool designed for humanitarian settings was piloted in South Sudan, and the pilot's findings were incorporated into the existing operational readiness tools. WHO African Region provided technical support to staff at the South African Department of Health on operational readiness planning and training to prepare for cholera outbreaks. Three trainings were conducted, and 1,580 health workers were trained on the holistic management of cholera.

WHO African Region's STAR Dashboard displays country risk profiles and readiness capacities to clarify the relationship between the risk calendar and readiness actions for high-priority diseases. During Q3, WHO African Region supported the Member States as they created or updated their risk profiles and mapping using STAR. In Lesotho, the WHO African Region collaborated with the national health authorities to complete a risk assessment and a capacity assessment at national points of entry using the STAR methodology.

During Q3, Benin completed its NHEROP with support from the WHO African Region. The Republic of Congo and CAR are formulating similar plans. The health authorities in Kenya developed an NHEROP informed by a country risk assessment, and a structured plan of action was agreed upon. Technical support was provided to Eswatini as it finalized an NHEROP developed in consultation with relevant stakeholders.

WHO African Region is supporting the efforts of the Member States to strengthen risk communication and community engagement (RCCE) by establishing multisectoral national networks. Côte d'Ivoire, Togo, Burkina Faso, Liberia, and Guinea have set up RCCE networks at the subnational level, and WHO African Region is providing support to strengthen the management of their national networks by adapting standard operating procedures, terms of reference, work plans, training modules, and other materials developed at the subnational level. WHO African Region conducted a global review of operational readiness, and Operations Support and Logistics (OSL) staff participated in a scoping mission in Uganda from 4-8 September. A follow-up business seminar is currently being planned for Uganda, which will target suppliers of key materials and equipment.

Substantial progress was made toward ensuring that the Member States are operationally ready to assess and manage identified risks and vulnerabilities. Health authorities in multiple countries updated their risk profiles, and the data they provided will be analysed to develop a regional risk profile. The RIT is being rolled out across the region, and a protocol for national emergency response operations in the health sector is being developed.

Nevertheless, the WHO African Region encountered several important challenges in this area during the quarter. The uptake of standardized tools such as STAR, JRA, AAR, and NHEROP remains limited among the Member States. Assessment results are not effectively utilized to inform multi-hazard preparedness plans, and insufficient documentation and reporting at the country level compounds this problem. The existing NAPHS are not reliably funded and consistently implemented, resulting in uneven levels of emergency preparedness and response capacity across the Member States. To address these challenges, the WHO African Region is organizing a review meeting on the status of emergency preparedness and operational readiness in West and Central Africa. Technical support is provided to the Member States, with monthly meetings to follow up on activities and document progress. The WHO African Region is also working with health authorities to develop and implement resource-mobilization plans.

Research agendas, predictive models, and innovative tools, products, and interventions made available for high-threat health hazards

WHO African Region conducted operational research and developed innovative approaches to RCCE in collaboration with Member States and other partners. In Côte d'Ivoire, the WHO African Region assisted the health authorities in carrying out in-depth anthropological investigations to understand community perceptions related to the outbreak of botulism and the unexplained deaths of children in the district of Bouaké. WHO African Region is also working to enhance the emergency preparedness and response (EPR) capabilities of the Member States by training social scientists on emergency management and health threats.

WHO African Region coordinated the provision of support to the Member States as they implemented the Regional Framework for Cholera Prevention and Control, which is part of the 2018 – 2030 Global Strategy for Cholera Prevention and Control. WHO African Region assisted South Sudan and Tanzania health authorities in finalizing their National Cholera Plans (NCPs). Tanzania launched its plan at the country level, while South Sudan is finalizing its plan. In Malawi, the WHO African Region helped define Priority Areas for Multisectoral Interventions (PAMIs), formerly known as "hotspots." As a first step toward developing an NCP, the PAMI process identified 121 traditional authorities across 20 districts of Malawi.

In Q3, the WHO African Region assessed progress achieved during the first five years of implementing the Regional Framework for Cholera Prevention and Control. The assessment's findings revealed that 53% of the framework has been implemented at the regional level. At the national level, however, only three Member States are proceeding on schedule, 14 have made fair progress, and 10 are progressing slowly or have made very little progress. Six countries have full-fledged NCPs, and three more are ready to launch NCPs. In addition, the WHO African Region conducted two webinars at the regional level. The first, focusing on PAMI methodology, had 564 participants from across the WHO African Region. Another 485 participants attended the second webinar centered on NCP development and Oral Cholera Vaccine (OCV) strategies. In South Africa, the WHO African Region supported training initiatives focused on cholera preparedness and response. A total of 531 healthcare workers from the country's nine provinces received training.

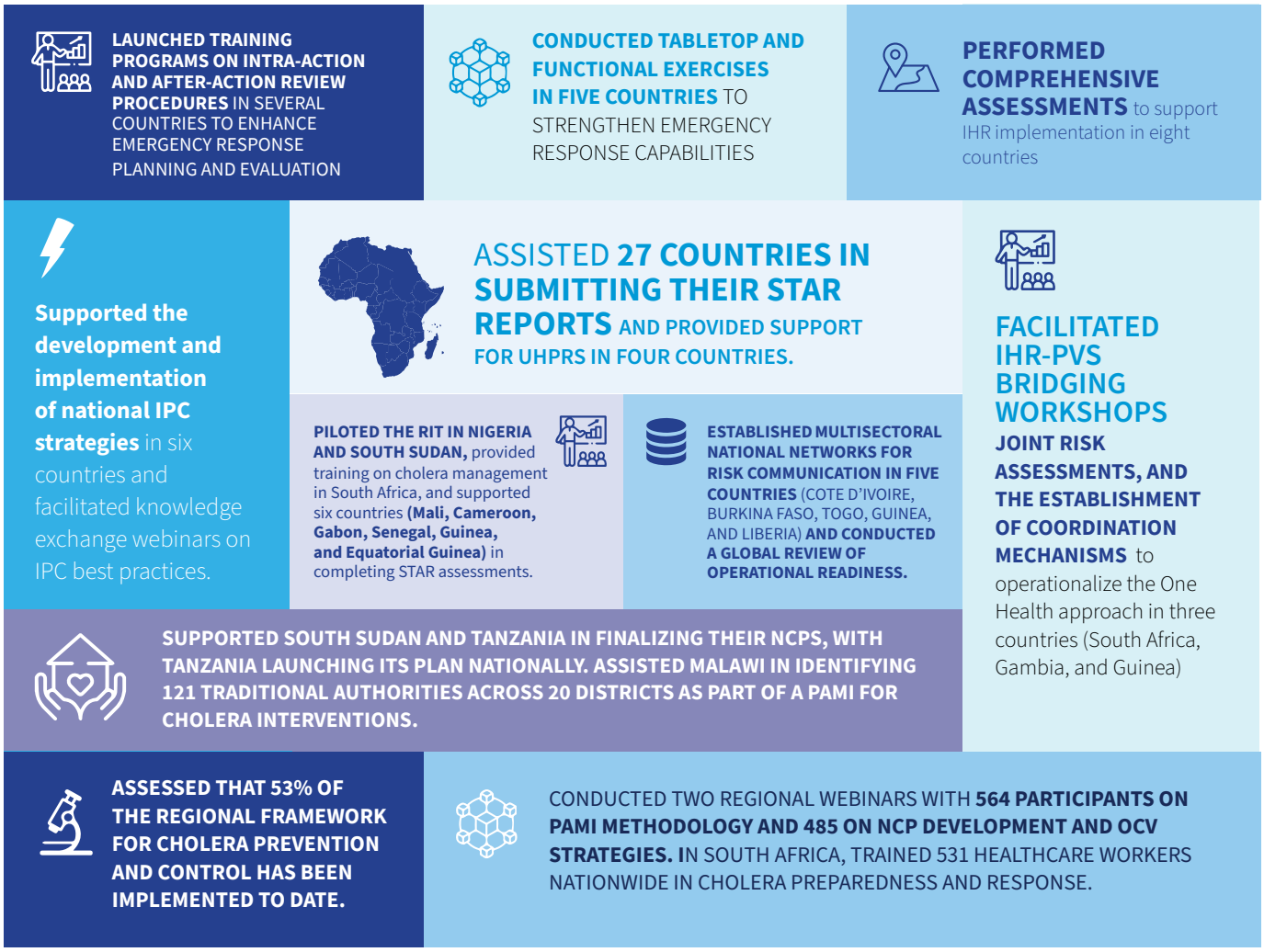
Proven prevention strategies for addressing priority pandemic- and epidemic-prone diseases implemented at scale

WHO African Region worked closely with health authorities in Benin, Guinea, Mali, and Kenya to develop their national plans to defeat meningitis by 2030. This effort is part of a broader initiative under which 12 countries have developed similar plans thus far. In response to meningitis outbreaks in Niger, Nigeria, and Togo, WHO African Region organized bi-weekly response coordination meetings, conducted needs assessments, mobilized resources, and convened partners. WHO African Region also contributed to the development of a regional bulletin on cerebrospinal meningitis surveillance and conducted a region-wide survey on lumbar-puncture practices, laying the groundwork for a more detailed analysis of shared challenges.

WHO African Region supported Benin, Togo, Mali, Burkina Faso, and Niger in updating their cholera PAMI maps using recent epidemiological data and identifying key activities for an effective emergency response. Training workshops for frontline water, sanitation, and hygiene (WASH) staff were facilitated in Ghana, Togo, Benin, and Niger. In Cameroon, the WHO African Region continues to support the development and implementation of a plan to eliminate cholera by 2030, which includes an ongoing WASH project.

From 4-8 September, the WHO African Region held IHR-PVS Bridging Workshops to strengthen cross-sectoral coordination in addressing zoonotic diseases in South Africa and supported a review of the country's One Health Strategic plan using the OH-JPA Implementation Guide. JRAs were conducted in The Gambia from 25-28 September and in Guinea from 8-30 September. From 24-27 October, cross-border One Health simulation exercises were facilitated in Ethiopia, Kenya, and Somalia. WHO African Region also contributed to the development of the Workforce Development Operational Tool (WFD OT) to strengthen One Health's capacity from 25-27 September. In Ghana, the WHO African Region conducted leadership training for AMR coordination using the One Health approach. Overall, the WHO African Region has made considerable progress in supporting Member States to manage and mitigate the risks associated with high-threat pathogens.

Figure 4: Emergency Preparedness Highlights



Partner Acknowledgment

United Nations Agencies

IOM UN MIGRATION

WFP Programme Alimentaire Mondial PAM

UNHCR The UN Refugee Agency

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