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EMERGENCY PREPAREDNESS AND RESPONSE IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD

Report of the Regional Director

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BACKGROUND

1. The WHO African Region continues to be challenged by frequent conflicts and natural emergency events causing injury, death, population displacement, destruction of health facilities and disruption of services, often leading to disasters. The total economic loss resulting from disaster-related deaths in the Region in 2007 is estimated at US$ 117.2 million.[1] During 2008 over 12 million refugees and Internally Displaced Persons were registered[2] compared with about 6 million in 1997.[3] In 2009 in the Horn of Africa, about 23 million people required humanitarian food aid,[4] and more than 1.5 million people in 26 countries were affected by floods.[5]

2. In 1997, the Forty-seventh session of the Regional Committee adopted Resolution AFR/RC47/R1 on the Regional Strategy for Emergency and Humanitarian Action. The five-year strategy called on all Member States to strengthen their institutional capacity for Emergency Preparedness and Response (EPR) through self-reliance.

3. Recent major disasters including tsunami in the Indian Ocean in 2004 have prompted the emergence of new global initiatives aimed at further strengthening of EPR. The World Conference on disaster reduction in Hyogo, Japan, in 2005, adopted the Hyogo Framework for Action 2005–2015.[6] It calls on all nations to support the creation and strengthening of multisectoral national platforms for EPR to ensure coordinated action on disaster risk reduction. In addition, the International Health Regulations (2005) provide a framework for implementing alert and response activities to control international outbreaks and other public health risks and emergencies.

4. In 2005 a United Nations independent commission proposed reforms in the management of humanitarian response.[7] These reforms were subsequently adopted in 2006 by the United Nations General Assembly.[8] The reforms focus on three areas namely: (a) building strong UN leadership at the field level; (b) improving efficiency, accountability and coordination of interventions through sectoral working groups (Humanitarian Clusters) and; (c) creating predictable sources of funding to facilitate effectiveness of humanitarian response.

5. In line with the Hyogo Framework for Action and the principles underpinning humanitarian reform, Member States adopted World Health Assembly Resolution WHA59.22 on EPR in 2006. The resolution requests Member States to further strengthen their national EPR programmes with a special focus on building health systems and increasing community resilience. The establishment of the African Public Health Emergency Fund, as requested in Resolution AFR/RC59/R5 adopted in 2009 by the Fifty-ninth session of the WHO Regional Committee for Africa, will further improve the funding of EPR.

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1 Kirigia JM. The Economic Burden of Health Emergencies in the African Region. African Health Monitor, Volume 8, Number 2, June – December, 2008.
2 UNHCR, 2008 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons, June 2009.
3 UNHCR, Refugees and Others of Concern to UNHCR 1997 Statistical Overview, Geneva, July 1998.
4 OCHA, Humanitarian Snapshot October, 2009.
5 OCHA, West Africa Humanitarian Profile, October, 2009 and Southern Africa Floods and Cyclones Situation Report No. 1, March 2009.
6 Hyogo Framework for Action 2005–2015: Building the resilience of nations and communities to disasters (HFA) www.unisdr.org/eng/hfa.
7 Humanitarian Response Review; An Independent report commissioned by the United Nations Relief Coordinator and Under-secretary General for Humanitarian Affairs, Office for the Coordination of Humanitarian Affairs (OCHA); United Nations, New York and Geneva, 2005.
8 UN General Assembly A/RES/60/124; on "Strengthening of the Coordination of Emergency Humanitarian Assistance of the United Nations", New York, March 2006.

6. In the past 13 years, Member States have made efforts to strengthen their institutional capacities for emergency preparedness and response with the support of partners. The level of implementation of the resolution, as reflected in the outcome of a survey conducted among the 46 countries in the Region in February 2010, is presented in the Annex. National Emergency Funds were available in 15 countries (38%). Nineteen countries have conducted vulnerability assessments and risk mapping, the health component of which was adequately reflected in nine of the countries.[9] Early warning systems have been developed in countries for natural disasters (51%), communicable diseases (92%) and malnutrition (59%). Communities are involved in EPR in 67% of countries.

7. Although modest achievements in EPR have been recorded by Member States, several challenges remain. This report highlights key issues and challenges and proposes a way forward.

ISSUES AND CHALLENGES

8. Less than half of Member States in the Region have conducted vulnerability assessments and risk mapping. In this group, the health component was adequately reflected in only 12 countries.[10] The EPR plans developed by most countries are therefore not based on assessment of vulnerabilities and capacities, and mapping of risks, but usually target single hazards, mostly epidemic and pandemic diseases. Only 11 countries have national emergency preparedness plans that cover multiple hazards.[11] Simulation tests, required in order to update plans, are conducted in 19 countries as shown by the survey in Member States.

9. In 15 countries, national health development plans do not incorporate emergency and humanitarian activities. Consequently many countries affected by emergencies have not developed a transitional strategy to boost health system recovery and ultimately link it to national health sector development. Where such health system recovery transitional strategies exist, implementation has been difficult because of shortage of funding as several priority programmes compete for the limited funds available.

10. Countries lack comprehensive disaster risk reduction and preparedness programmes containing the minimum WHO-recommended elements regarding policy and legislation, capacity building, disaster risk analysis and mapping, and planning. Implementation of the Hyogo Framework calling on countries to assess the status and build the resilience and risk management capability of hospitals and other key health infrastructures has yet to commence.

11. The capacity to enforce national standards remains inadequate due to the absence of policies, procedures and coordination units. Fifteen countries do not have functional emergency units and, where these exist, they are under-staffed and under-resourced. Yet these units are essential, given that several humanitarian actors have emerged in the field and follow different strategies and technical guidelines that, in many instances, are not in line with national standards.[12]

12. Coordination is still a major challenge as national multisectoral committees lack the capacity and resources to coordinate the multiple components of EPR. Only 21 of the 46 Member

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[9] Algeria, Benin, Burundi, Chad, Democratic Republic of the Congo, Guinea, Sao Tome and Principe, Togo and Zimbabwe.

[10] Algeria, Benin, Burundi, Chad, Democratic Republic of the Congo, Ghana, Guinea, Lesotho, Sao Tome and Principe, Senegal, Togo and Zimbabwe.

[11] Burkina Faso, Gambia, Ghana, Kenya, Lesotho, Liberia, Mozambique, Rwanda, South Africa, Swaziland and Tanzania.

[12] In addition to WHO guidelines, there are several others developed or in process of development by Humanitarian Inter-Agency Standing Committee (IASC), International Committee of the Red Cross and Red Crescent (ICRC), *Médecins Sans Frontières (MSF)*, etc.

States have established national platforms for disaster risk reduction. Observations made during monitoring visits showed that the participation of the health sector needs to be improved in most of the countries.

13. The health component of the early warning systems for natural disasters usually overseen by the multisectoral national platforms is weak. Half of the countries do not have health early warning systems for natural disasters, while 25 countries have reported that they have nutrition early warning systems (Table 1).

14. The critical mass of trained persons needed to support countries in EPR is not yet in place. Eighteen countries lack human resources with even the basic training to manage emergency responses. In countries where trained persons exist, they are limited in number ranging between 1 and 5. Exceptions can be made in only three countries where the Red Cross has conducted training in Health Emergencies in Large Populations (HELP) for significant numbers of its volunteers. This shortage of trained persons is due to the limited access to training courses most of which are run in institutions located outside the Region.

15. Member States action to empower communities in disaster risk reduction is mostly limited to sensitization activities and disease surveillance. Consequently, during most emergencies communities are inadequately equipped to cope with the effects, resulting in disasters.

16. Resource allocation for emergencies by Member States remains inadequate. Only 19 countries in the Region have established a national emergency fund 12 years after the adoption of Regional Committee Resolution AFR/RC47/R1 calling for its establishment.[13] Most countries depend mainly on donor funding usually earmarked for acute response. Disaster prevention and preparedness and post-disaster health system recovery remain under-funded; these components are weak in several countries.

17. The existing regional strategy needs to be updated to incorporate new global approaches and resolutions. The non-updating of the strategy limits the efforts of Member States to consolidate the gains made in EPR and poses a challenge to aligning the various regional initiatives and declarations that have an impact on readiness and response.[14]

ACTIONS PROPOSED

18. In view of the continuing threat posed by emergencies to the socioeconomic development of countries in the African Region, there is a need to strengthen emergency preparedness and response. In this regard, the actions described below need to be undertaken.

19. **Assess hazards, vulnerabilities, risks and capacities** from a health sector perspective including assessment of the safety of health facilities and related infrastructure. The results of the assessment should be mapped to serve as the basis for programme development and health contingency, response and recovery planning that follows a process of engagement with stakeholders. The plans need to be updated following simulation exercises and post operation evaluations.

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[13] Algeria, Benin, Botswana, Burkina Faso, Congo, Côte d'Ivoire, Ethiopia, Gambia, Guinea, Kenya, Lesotho, Mali, Mauritania, Namibia, Senegal, South Africa, Swaziland, Tanzania, and Zambia.

[14] Algiers Declaration on Research for Health in the African Region, Algiers, June, 2008; Cape Verde Declaration by Ministers of Health of Small Island Developing States of the African Region, Praia, 19 March 2009; Libreville Declaration on Health and Environment in Africa, Libreville, 29 August 2008; and Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, Ouagadougou, 30 April 2008.

20. **Update national health development plans to incorporate post-disaster health system recovery.** Recovery strategies aimed at strengthening the health system to make it more resilient should be implemented after major emergencies and be interfaced with the national health development plan. Advocacy should be intensified at the highest levels of government and among partners for funding of the recovery strategy.

21. **Reduce disaster risks** by implementing disaster risk reduction and preparedness programmes based on health emergency management policy, strategies and specific legislation linked to national intersectoral policy on emergency management. The policy should cover the full range of hazards and emergencies (All-Hazards) and be based on all likely health risks (Whole-Health approach), including resilience and risk management capability of hospitals and other key health infrastructures.

22. **Build the capacities of existing units** in the ministries of health to coordinate multidisciplinary health action and the integration of health with multisectoral actors; including the national platform on disaster risk reduction. The staff of the unit should receive the necessary technical training and the required resources.

23. **Create or strengthen a multisectoral emergency committee** and provide it with the necessary technical capacity and resources. The committee should also be given the necessary legal backing to ensure that the development and implementation of all aspects of the health emergency management cycle (policy development, risk assessment, risk reduction, preparedness, response and recovery) are coordinated and involve all stakeholders from the health sector and other sectors.

24. **Strengthen early warning for the health components of natural disasters and food crises** through the identification and monitoring of appropriate indicators and incorporate them into the early warning systems established by the national platforms. The data generated should be analyzed and disseminated through the surveillance information sharing mechanisms.

25. **Develop and fund education and training programmes** at undergraduate and graduate levels as well as continuing professional education to develop and maintain the knowledge, skills and performance of the health emergency management community. The training should be aligned with the regional standard package on emergency training.

26. **Develop awareness, risk communication, training and other programmes that ensure a "prepared community"** involving community leaders and health workers at the community level. This should be based on the principles of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.[15]

27. **Improve funding for disaster prevention, emergency preparedness and post-emergency health system recovery** through the creation of a national emergency fund in line with Resolution AFR/RC47/R1.

28. **Develop a new regional strategy for EPR and a framework to guide Member States** in the light of the several actions to be undertaken. The new strategy should be in keeping with the Algiers Declaration on Research for Health; Cape Verde Declaration on Small Islands Developing States; Libreville Declaration on Health and Environment; and Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.[16] It should incorporate

[15] http://intranet.afro.who.int/declarations.
[16] Ibid.

components of new global initiatives on disaster risk reduction, humanitarian reform and the International Health Regulation (2005).

29. The Regional Committee is invited to examine the document and endorse the proposed actions.

ANNEX

Table 1: Level of implementation of Regional Committee Resolution AFR/RC47/R1 by countries, February 2010.*

Action		Number of countries	Percentage of countries in the Region[17]
Have persons been trained in Public Health Pre-deployment (PHPD) or in Health Emergencies in Large Populations (HELP).		28	60.8
Established Early Warning System	Communicable diseases	40	86.9
	Nutrition	25	54.3
	Natural disasters	23	50.0
Established national emergency funds		19	41.3
Integrated EPR into national health plans		31	67.4
Involve communities in EPR		28	60.9
Promptly declare		35	76.1
Conducted vulnerability assessment and mapping		20	43.5
Vulnerability assessment covers health component		12	26.1
Set up multisectoral emergency committees		39	84.8
Cooperate with and support neighbouring countries in emergency issues		31	67.4

** Survey Sample: 46 African Region countries, Response: 43 Countries*

[17] Denominator includes the three countries that did not respond to the survey namely Angola, Comoros and Seychelles.