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**REGIONAL STRATEGY FOR HEALTH SECURITY AND EMERGENCIES 2022–2030**

**Report of the Secretariat**

**EXECUTIVE SUMMARY**

1. Health emergencies exact a heavy toll on African health systems and economies, threatening to erase decades of hard-earned gains. Each year, the African Region contends with over 100 health emergencies. Climate-related events, including prolonged droughts, destructive floods, and cyclones are increasing in number and severity.
2. In 2016, health ministers endorsed the “Regional strategy for health security and emergencies 2016–2020”, which supported Member States to prepare for, rapidly detect, and promptly respond to health emergencies. Subsequently, the median time used to contain outbreaks has shortened. However, the devastating effects of COVID-19 require building resilient health systems capable of providing quality health care while coping with health emergencies.
3. This strategy, that incorporates lessons learnt from COVID-19, aims to reduce the health and socioeconomic impacts of health emergencies. The strategy emphasizes building responsive health systems to effectively manage health emergencies while ensuring continuity of essential services. Aligned with strategies for achieving the health-related Sustainable Development Goals (SDGs) and WHO’s General Programme of Work (GPW 13), it underscores the implementation of recommendations of recent global reviews.
4. As part of this strategy, WHO proposes three targeted efforts led by Member States with coordination and support from WHO. They focus on preparedness (Promoting resilience of systems for emergencies, “PROSE”), detection (Transforming African surveillance systems, “TASS”) and response (Strengthening and utilizing response groups for emergencies, “SURGE”).
5. The Regional Committee is invited to review and adopt this strategy.

## CONTENTS

	<b>Paragraphs</b>
INTRODUCTION .....	1–7
SITUATION ANALYSIS AND JUSTIFICATION .....	8–15
THE REGIONAL STRATEGY .....	16–41
RESOURCE IMPLICATIONS .....	44–45
MONITORING AND EVALUATION .....	46
CONCLUSION .....	47–50

## ANNEX

	<b>Page</b>
Detailed milestones and targets .....	11

## INTRODUCTION

1. The WHO African Region is prone to health and humanitarian emergencies because of its biogeographical location. Annually, the Region reports over 100 health emergencies.<sup>1</sup> Public health events originating from the human-animal-environmental interface occur frequently.<sup>2</sup> Concomitantly, the occurrence of climate-related events, including prolonged droughts, destructive floods and cyclones is increasing.<sup>3</sup>
2. The Region is also affected by many protracted humanitarian crises. Mass refugee migration, internal population displacements and cross-border movements provide opportunities for spreading infectious diseases.<sup>1</sup>
3. Health emergencies have a dual impact on human health, livelihoods, national economies and development. The West African Ebola epidemic (2013–2016) and the 2018 Ebola outbreak in the Democratic Republic of the Congo negatively impacted on the health of communities and caused major socioeconomic losses. The economic loss from the West African outbreak in the most affected Member States was approximately US\$ 2.2 billion – about 16% of their collective gross domestic product.<sup>4,5</sup>
4. COVID-19 has revealed significant gaps in emergency preparedness and health system resilience worldwide. In Africa, over 11 million people have been infected, including over 245 000 deaths.<sup>6</sup> Additionally, public health and social measures (PHSMs) implemented to contain the pandemic have significantly interrupted trade, travel and supply chains. Consequently, stock markets have plunged, unemployment rates have risen and economic gains have been reversed.<sup>7</sup>
5. In 2016, the Region endorsed the “Regional strategy for health security and emergencies 2016–2020”, which supported Member States to better prepare for and manage all public health emergencies.<sup>8</sup> The strategy embraced the “One Health” approach defined as a collaborative, multisectoral, and transdisciplinary approach – working at the local, regional, national, and global levels – with the goal of achieving optimal health outcomes, recognizing the interconnection between people, animals, plants, and their shared environment.

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<sup>1</sup> Mboussou F, Ndumbi P, Ngom R, Kamassali Z, Ogundiran O, Van Beek J, et al: Infectious disease outbreaks in the African region: overview of events reported to the World Health Organization in 2018. *Epidemiol Infect.* 2019; 147: e299.

<sup>2</sup> Nyakarahuka L, Ayebare S, Mosomtai G, Kankya C, Lutwama J, Mwiine FN, et al (2017). "Ecological niche modeling for filoviruses: a risk map for Ebola and Marburg virus disease outbreaks in Uganda." *PLoS currents*.

<sup>3</sup> Labbé J, Ford JD, Berrang-Ford L, Donnelly B, Lwasa S, Namanya DB, et al (2016). "Vulnerability to the health effects of climate variability in rural southwestern Uganda." *Mitigation and adaptation strategies for global change* 21(6): 931-953.

<sup>4</sup> UNDP. Socio-economic Impact of Ebola virus disease in West African countries: a call for national and regional containment recovery and prevention. United Nations Development Group – Western and Central Africa. Nairobi, 2015;. ([www.africa.undp.org/content/dam/rba/docs/Reports/ebola-west-africa.pdf](http://www.africa.undp.org/content/dam/rba/docs/Reports/ebola-west-africa.pdf), accessed 15 February 2022).

<sup>5</sup> World Bank. The Economic Impact of the 2014 Ebola Epidemic: short and medium-term estimates for West Africa. Washington DC, 2015. (<http://www.worldbank.org/en/region/afr/publication/the-economic-impact-of-the-2014-ebola-epidemic-short-and-medium-term-estimates-for-west-africa>, accessed 15 February, 2022).

<sup>6</sup> World Health Organization (WHO), Coronavirus disease (COVID-19) Weekly Epidemiological Update and Weekly Operational Update, (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>, accessed 14 February 2022)

<sup>7</sup> Resolve to Save lives. Responding to COVID-19 in Africa: Using data to find a balance. (<https://reliefweb.int/report/world/responding-covid-19-africa-using-data-find-balance>, accessed 14 February 2022)

<sup>8</sup> World Health Organization (WHO). Regional strategy for health security and emergencies 2016–2020 (Document AFR/RC66/6), (<https://apps.who.int/iris/handle/10665/252834>, accessed 16 February 2022)

6. Some of the components of the new strategy will include strengthening mechanisms for partnerships and multisectoral collaborations; increasing advocacy to invest in health systems for health security; and exploring ways of making better use of innovative approaches and new technologies for data collection, analysis and timely information sharing. Importantly, it is aligned with strategies for achieving the health-related SDGs and WHO's GPW 13.

7. The strategy will ensure sustained and predictable investments, leverage the current favourable political will, and enable the repurposing of resources from polio eradication and COVID-19 to support strategic investments in systems and tools for health emergencies. Aligned with efforts for achieving universal health coverage, the health-related SDGs and building resilient health systems, the new strategy will accelerate the use of contemporary evidence and innovations.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situational analysis

8. The WHO African Region experiences more epidemics than any other part of the world. Before the emergence of COVID-19, the top five causes of epidemics were cholera, measles, yellow fever, meningococcal meningitis, and influenza, most of which are preventable by strengthening routine immunization.<sup>9</sup>

9. Presently, all Member States of the Region are implementing the International Health Regulations (IHR, (2005)) to strengthen national capacities, and have submitted annual self-assessment IHR reports for 2017–2021 with a regional average score of 49. Only 13 countries<sup>10</sup> had at least eight core capacities at developed level or more in 2021. In addition, all Member States have completed joint external evaluations (JEEs) of their IHR capacities. The mapping of the 19 JEE technical areas to the health systems building blocks reveals significant gaps in leadership and governance, medicines, and technologies, and multisectoral collaboration.

10. To address the gaps identified, 39 Member States<sup>11</sup> have developed a National Action Plan for Health Security (NAPHS), which, if funded and implemented, can significantly improve health security, while the remaining Member States are in the process of developing their plans. The resources needed to fill these gaps have been costed in the national action plans for health security (NAPHS), demonstrating that an average annual cost of US\$ 150 million per Member State is required.<sup>12</sup>

11. A review of four key health system attributes, namely access, quality, demand, and resilience has shown that across the Region, health systems are functioning at around 51% of their potential.<sup>13</sup> Major gaps have been identified in the areas of access to services and resilience, which are the two attributes with the biggest impact on health security. As COVID-19 has shown, if people cannot access

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<sup>9</sup> Talisuna AO, Okiro EA, Yahaya AA, Stephen M, Bonkougou B, et al. Spatial and temporal distribution of infectious disease epidemics, disasters and other potential public health emergencies in the World Health Organization African region, 2016–2018, *Global Health*. 2020; 16: 9. Published online 2020 Jan 15. doi: 10.1186/s12992-019-0540-4.

<sup>10</sup> Algeria, Angola, Eritrea, Ethiopia, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda and Zambia

<sup>11</sup> All except Algeria, Cabo Verde, Equatorial Guinea, Madagascar, Mauritius, Sao Tome and Principe, Seychelles and Togo.

<sup>12</sup> World Health Organization (WHO). The investment case for public health emergency preparedness and response (Unpublished). World Health Organization. 2019

<sup>13</sup> Humphrey Cyprian Karamagi, Prosper Tumusiime, Regina Titi-Ofei, Benson Droti, Hillary Kipruto, et al., Towards universal health coverage in the WHO African Region: assessing health system functionality, incorporating lessons from COVID-19. *BMJ Glob Health*. 2021; 6(3): e004618.

services and systems are not resilient, Member States will continue to face challenges in safeguarding health.<sup>14</sup> One clear way of sustainably improving preparedness and response is to invest in national health system strengthening.

12. Despite all the gaps highlighted in the required capacities for health security, reforms in the health emergency programme are beginning to produce results. Responses to health emergencies are now faster, better coordinated and more effective. The median time from detection to containment reduced from 418 days in 2016 to 51 days in 2018.<sup>15</sup> Nevertheless, health emergencies continue to exact a heavy toll on health systems and economies, threatening to erase decades of hard-earned gains.

13. Opportunities do exist for enhancing national capacities to manage health and humanitarian emergencies. Among these are the lessons learnt from the COVID-19 pandemic response, which were clearly articulated in resolution WHA73.1 (2020) on the COVID-19 response and the recommendations of three major reviews: those of the Independent Panel for Pandemic Preparedness and Response (IPPPR); the Independent Oversight and Advisory Committee (IOAC); and the IHR Review Committee. Finally, all Member States need to commit to implementing the African Union summit declarations on increasing domestic health financing.<sup>16</sup>

14. Despite the progress made, the Region still lags behind in IHR (2005) capacities. The need for predictable and sustainable financing, stronger national planning and multisectoral action were emphasized by the Seventy-fourth World Health Assembly and the G20 High-level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response.<sup>17</sup> These developments call for a new strategy to support Member States.

15. After five years of implementing the Regional strategy for health security and emergencies 2016–2020, no Member State has achieved all the required IHR (2005) capacities.<sup>18</sup> The COVID-19 pandemic and the resultant socioeconomic impact negatively affected the achievement of the set targets as available resources had to be reprioritized for the response. While the median time required to contain outbreaks has improved,<sup>15</sup> health emergencies continue to exact a heavy toll on African health systems and economies alike. This calls for a new strategy to build on the previous one, drawing lessons from the COVID-19 response and considering recent recommendations from global reviews.

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<sup>14</sup> Health systems resilience during COVID-19: Lessons for building back better: (<https://apps.who.int/iris/rest/bitstreams/1390564/retrieve> accessed 1 April 2022)

<sup>15</sup> Benido Impouma, Maoussia Roelens, George Sie Williams, Antoine Flahault, et al., Measuring Timeliness of Outbreak Response in the World Health Organization African Region, 2017–2019. *Emerg Infect Dis.* 2020 Nov; 26(11): 2555–2564.

<sup>16</sup> African Union Commission (AUC). Africa's leaders gather to launch new health financing initiative aimed at closing funding gap and achieving universal health coverage, accessed 16 Feb 2022 at : <https://au.int/en/pressreleases/20190209/african-leaders-gather-launch-new-health-financing-initiative-aimed-closing>.

<sup>17</sup> National Academy of Medicine. G20 High Level Independent Panel Releases Report on Financing the Global Commons for Pandemic Preparedness and Response. (<https://nam.edu/g20-high-level-independent-panel-releases-report-on-financing-the-global-commons-for-pandemic-preparedness-and-response>, accessed 16 February 2022)

<sup>18</sup> World Health Organization (WHO). Progress report on the implementation of the regional strategy for health security and emergencies 2016–2020: information document. (<https://apps.who.int/iris/handle/10665/331442>, accessed 16 February 2022)

## **THE REGIONAL STRATEGY**

### **Aim, Objectives, Targets and Milestones**

#### **16. Aim**

To contribute to the reduction of morbidity, mortality, disability and socioeconomic disruptions due to disease outbreaks and other health emergencies in the WHO African Region.

#### **17. Objectives**

- (a) To strengthen and sustain national capacity to prepare for public health emergencies – including anticipating risks, planning for contingencies, and preparing to mobilize financial, human and material resources.
- (b) To strengthen public health surveillance and response systems at the national, subnational, district, health facility and community levels to enable quicker detection of high-threat pathogens.
- (c) To ensure effective responses to health emergencies and humanitarian crises within the first 24 hours of confirmation.
- (d) To ensure the provision of quality essential health services during health and humanitarian emergencies using a multisectoral approach.
- (e) To strengthen systems for accountability, monitoring, evaluation, and peer review.
- (f) To promote strategic, synergistic and mutually trusting partnerships.

#### **18. Targets and Milestones**

The major targets by 2030 are stipulated hereunder while the baseline and milestones are detailed in the Annex.

##### **To strengthen and sustain national capacity to prepare for public health emergencies.**

- (a) 80% of Member States have multihazard preparedness and response plans.
- (b) 80% of “districts” in each Member State have capacities for rapid response to high-threat pathogens.
- (c) 80% of Member States will have predictable and sustainable health security financing.

##### **To strengthen public health surveillance and response systems at the national, subnational, district, community, and health facility levels to enable quicker detection of high-threat pathogens.**

- (a) At least five subregional epidemic and pandemic intelligence hubs will be functional.

##### **To ensure effective responses to health emergencies and humanitarian crises within the first 24 hours.**

- (a) At least 90% of Member States mobilize an effective response to graded emergencies within 24 hours of detection.

**To ensure provision of quality essential health services during health and humanitarian emergencies using a multisectoral approach.**

- (a) All Member States have 80% of “districts” with functional service delivery and quality improvement programmes.
- (b) 80% of Member States have at least 80% vaccination coverage for vaccine-preventable health hazards.
- (c) 80% of Member States in fragile and conflict settings have at least 80% of health facilities providing a comprehensive essential service package.

**To strengthen systems for accountability, monitoring, evaluation, and peer review.**

- (a) 80% of Member States will have conducted at least two universal health and preparedness reviews (UHPRs).
- (b) At least 80% of Member States will have conducted at least two nationwide simulation exercises to test health systems resilience.
- (c) 50% of Member States will have all IHR capacities that meet the requirements of at least Level 3 (developed capacity) based on the IHR State Party Annual Self-Assessment Report (IHR-SPAR).

**To promote strategic, synergistic, and mutually trusting partnerships**

- (a) 80% of Member States will have at least two annual partnership and multisectoral forums to review the performance of their annual health security plans.

**Guiding principles and values**

19. **Member State ownership and leadership:** Enhancing health security is the primary responsibility of national governments. Consequently, this strategy urges all Member States to demonstrate political commitment and technical leadership at all levels.

20. **WHO leadership and strategic partnerships:** The success of this strategy is contingent on a well-funded WHO Secretariat and partner technical support. At all times, such support shall be complementary and synergistic.

21. **Multisectoral collaboration:** Enhancing and optimizing health security requires multisectoral coordination underpinned by the One Health approach. This strategy urges planning across multiple sectors with strong emphasis on all-hazards preparedness and readiness.

22. **Gender, equity and human rights:** Effective implementation of this strategy requires the active participation of the entire community. Due consideration will be given to equity, which is a goal and principle, and gender mainstreaming. Emphasis will be on ensuring the safety and security of affected populations, with particular attention to safeguarding the welfare of affected and most vulnerable populations especially women, girls, children and persons with disabilities.

23. **Monitoring results:** This strategy stipulates the required monitoring, evaluation, and peer review mechanisms at all levels. Its implementation will be evidence-led and forward-looking to take into account emerging trends, risks and health innovations.

24. **Accountability:** As a principle, accountability needs to be institutionalized at all levels. Accountability should be based on a people-centred and rights-oriented framework that is concerned with respecting the rights, dignity and safety of people affected by health emergencies.

25. **The humanitarian-development-peace nexus:** As the number of health emergencies occurring in complex humanitarian crises grows, it is important to integrate health emergencies in the humanitarian-development-peace nexus. This will reduce duplication and improve efficiency in the use of scarce resources.

26. **Whole-of-society approach:** This strategy supports the engagement of all sectors of society in emergency preparedness with particular emphasis on safeguarding the welfare of affected and vulnerable populations. This may necessitate forging inclusive alliances with community leaders, academia, and the private sector. Communities must take ownership of their preparedness and response capacity building.

### **Priority interventions**

#### **Prevention and Preparedness/PROSE**

27. **Identify gaps for evidence-led planning:** Gap identification will be conducted using the IHR monitoring and evaluation framework (IHR-MEF), universal health and preparedness reviews, risk profiling and mapping, scoping missions and other relevant assessments, including health system resilience assessments. Member States and partners should continue to jointly conduct these assessments which will form the basis for planning.

28. **Develop One Health, all-hazards preparedness and response plans:** Member States should develop comprehensive multihazard preparedness and response plans. Plans should be formulated by multidisciplinary and cross-sectoral teams including civil society and the private sector, with roles and responsibilities clearly stipulated.

29. **Commit to predictable and sustainable financing:** Member States should develop a financing strategy or investment case and plan to mobilize the required resources. This necessitates mapping of existing and potential funding sources and engagement of legislators and local governments to advocate for increased domestic funding aligned with national budget and planning cycles.

30. **Assess and strengthen health system resilience:** This strategy urges Member States to incorporate health system resilience into routine national health security assessments. Member States should track continuity of essential health services including mental health services in response and non-response times and plan for alterations and additional investments to enhance health service provision. They should strengthen the humanitarian-development-peace nexus and leverage the resources from humanitarian responses to enhance the resilience of their systems.

#### **Detection/TASS**

31. **Implement the IDSR and strengthen information management:** Member States are urged to fully implement the Integrated Disease Surveillance and Response strategy with up-to-date country-level surveillance plans in line with the evolving landscape. Member States should establish innovative



e-surveillance systems and data-sharing arrangements, which are critical for analysis of patient-level data across laboratory, clinical and functional multisectoral coordination mechanisms.

32. **Strengthen the surveillance workforce:** Member States are encouraged to ensure surveillance systems have sufficient well-trained and equipped staff at all levels, including by building on the Global Polio Eradication Initiative infrastructure. This should be sustained through institutionalization of IDSR training and pandemic preparedness in the pre-service curricular of training institutions.

### **Response/SURGE**

33. **Train and equip the health emergency workforce:** Member States should conduct training needs assessments. Subsequently, they should train cross-sector, multidisciplinary teams at the national and subnational levels. In addition, they should conduct periodic team-based drills and simulations to test health workforce capacity to collaborate effectively during health emergencies. Importantly, there is need to establish geospatial databases containing inventories of trained personnel in each health district to facilitate timely and efficient deployment.

34. **Scale up technology-based capacity building programmes:** Member States should be supported to establish sustainable capacity for training, using a pool of regional trainers and mentors, who will be coordinated through the WHO hubs to cascade trainings. All trained staff records shall be entered into a regional, national, and subnational human resource information system (HRIS) and mapped for deployment when needed.

35. **Improve readiness and response coordination:** Member States will be supported to establish, operationalize and maintain fully functional public health emergency operations centres (PHEOCs) to improve readiness and response coordination. This capacity will be tested regularly to ensure its functionality.

36. **Strengthen risk communication and community engagement (RCCE):** Member States should be supported to develop RCCE strategies/plans and to establish multisectoral RCCE coordination mechanisms at national and subnational levels. Such coordination mechanisms need to be linked to expert training and scientific resources on RCCE science. Finally, there is a need to develop frameworks and tools to engage communities as partners in emergency preparedness and response.

37. **Strengthen capacity to assure timely and equitable distribution of essential supplies:** Member States are urged to collaborate and invest in actions to prevent a repeat of the supply challenges encountered during the COVID-19 response. This may necessitate legislation to facilitate pooled procurement and purchasing; expedited supply chain procedures during emergencies; mainstreaming supply chain and logistics training into training institutions; and recruiting qualified logisticians and supply chain specialists into the health sector. The Region should establish and operate a regional logistics information system to manage timely distribution of essential supplies from regional depots and timely redistribution from Member States with surpluses.

## Cross-cutting

38. **Institutionalize accountability, monitoring and evaluation:** Member States should be supported to monitor the implementation of plans across the human, animal and environmental health sectors. Member States should conduct periodic multisectoral reviews to assess multihazard preparedness capacities, conduct after-action reviews (AARs) to learn lessons for improvement, and conduct simulation exercises (SimEx) to test the functionality of preparedness and response capabilities for different hazards.

39. **Strengthen community systems:** This regional strategy calls upon Member States to strengthen community systems to prevent, detect and respond to outbreaks, ensuring full compliance with mechanisms for preventing and responding to sexual exploitation, abuse and harassment. This could be achieved through strengthening community-based IDSR, conducting routine community dialogue, and working with trusted community actors and local leaders to educate communities.

40. **Invest in innovation, research and development (R&D):** Member States should invest in building national capacity for innovation and R&D for life-saving countermeasures such as vaccines, diagnostics and therapeutics. This requires working in synergy and close collaboration with national as well as regional academic and research institutions.

41. **Adopt and use the novel global 7-1-7 target:** Identify the outbreak within seven days of emergence, report to public health officials within one day, and effectively respond within seven days.<sup>19</sup>

42. **Harmonization, synergies and alignment:** Harmonization and synergies between the WHO Secretariat and regional institutions such as Africa Centres for Disease Control and Prevention (Africa CDC) to reduce fragmentation, improve alignment and impact of the proposed interventions. This should be supported at country level by strong intra-country and cross-border collaborations.

43. **Roles and responsibilities**

### Member States should:

- (a) commit political will and provide technical leadership;
- (b) mobilize domestic and external resources and ensure sustainable financing to support the implementation of the strategy;
- (c) provide adequate human and logistic resources;
- (d) review the structures, systems, and tools at national and subnational levels;
- (e) raise the profile of the One health approach and strengthen the coordination mechanism to oversee its implementation;
- (f) conduct needs assessments and build capacity at national and decentralized levels;
- (g) monitor, evaluate and periodically review progress.

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<sup>19</sup> 7-1-7: an organising principle, target, and accountability metric to make the world safer from pandemics ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01250-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01250-2/fulltext), accessed 1 April 2022)

**The WHO Secretariat and partners should:**

- (a) disseminate technical guidelines, guidance, and review recommendations to support strategy implementation;
- (b) provide technical and financial support to Member States to develop evidence-led plans that are regularly monitored and evaluated;
- (c) ensure that the regional pool of trainers is operational and serves as a platform for coordinated action to cascade country-level training;
- (d) facilitate synergy and complementarity in the partnerships for IHR implementation;
- (e) establish a regional team of experts to build country capacity;
- (f) implement the supranational actions stipulated in this strategy;
- (g) mobilize partners and all actors to support the implementation of the strategy;
- (h) support increased Member State capacity through coordinating the implementation of PROSE, TASS and SURGE.

**Resource implications**

44. In the WHO African Region, multiyear national action plans for health security (NAPHS) are being used by Member States to accelerate the implementation of the IHR core capacities. The NAPHS capture national priorities for health security. With WHO assistance, 39 Member States have developed and costed their NAPHS.

45. The annual investment needed for the Region from external and domestic sources to fully fund the NAPHS is costed at US\$ 3-4 billion. This translates into US\$ 2.5–3.5 per person per year.<sup>20</sup> Additional financing will be required for WHO Secretariat and partner support activities.

**Monitoring and evaluation**

46. Progress in implementing this strategy by Member States will be tracked annually using the milestones and targets stipulated in the Annex, annual IHR reports, as well as GPW 13 key performance indicators (KPIs). Monitoring and evaluation will be conducted routinely and adjusted based on the prevailing context. Every two years, the Regional Director will report on progress in implementing this strategy to the Regional Committee.

**CONCLUSION**

47. COVID-19 has shown the need for preparedness to mitigate the effects of health emergencies. Building resilient health systems integrated with public health emergency preparedness and response – including through PROSE, TASS and SURGE – is the avenue to achieve this goal.

48. All Member States are urged to implement this strategy to contribute to building resilient health systems able to mitigate the effects of health and humanitarian emergencies from all hazards. Robust

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<sup>20</sup> Financing for Global Health Security and Pandemic Preparedness - Taking Stock and What's Next: (<https://www.cgdev.org/blog/financing-global-health-security-and-pandemic-preparedness-taking-stock-whats-next>, accessed 1 April 2022)

country capacity – to prepare for, detect and respond to health emergencies – is vital to ensure that future disease outbreaks can be effectively addressed and controlled to limit their spread and impact.

49. All Member States are urged to raise the profiles of the units responsible for IHR implementation. Importantly, there is need to use innovations in technology and to allocate adequate domestic funding.

50. The Regional Committee is invited to review and adopt this strategy.

**Annex: Detailed milestones and targets**

Objective	Indicator	Baseline	Milestones			Target
		2022	2024	2026	2028	2030
		(%)	(%)	(%)	(%)	(%)
<b>Objective 1: To strengthen and sustain national capacity to prepare for public health emergencies</b>	Percentage of Member States with a multihazard preparedness and response (MHPRP) plan	19	30	50	60	80
	Percentage of Member States with predictable sustainable health security financing	30	40	60	70	80
	Percentage of Member States with 80% of “districts” with multidisciplinary rapid response teams (RRTs)	20	30	50	60	80
	Percentage of Member States with an active national infection prevention and control programme	2	30	50	60	80
	Percentage of Member States with adequate logistics management systems for response to health emergencies	TBD	30	50	60	80
	Percentage of targeted Member States with 80% of “districts” with capacities for rapid response to cholera	0	30	60	80	100
	Percentage of Member States with 80% of “districts” with capacities for rapid response to yellow fever	20	50	80	100	100
<b>Objective 2: To strengthen public health surveillance and response systems at the national, district, community, and health facility levels to enable quicker detection of high-threat pathogens</b>	Number of functional subregional epidemic and pandemic intelligence hubs	0	3	4	5	6
	Percentage of Member States with a functional border health (BH) security strategy and programme	TBD	30	50	60	80
	Percentage of Member States with updated risk communication and community engagement strategies	11	30	50	60	80
	Percentage of Member States with 80% of “districts” implementing e-IDSRS with over 90% nationwide coverage	70	80	90	95	100
	Percentage of Member States with adequate national laboratory system and network	30	50	70	80	100
	Percentage of Member States with 80% of districts with capabilities for epidemiologic and laboratory data analysis and programme evaluation	13	30	50	60	80
	Number of countries that have identified the outbreak within 7 days of emergence, report to public health officials within 1 day of detection, and effectively respond within 7 days	0	47	47	47	47
<b>Objective 3: To ensure effective</b>	Percentage of Member States with at least 80% of acute health events responded to in accordance with global and national performance standards	80	90	95	100	100

Objective	Indicator	Baseline	Milestones			Target
		2022	2024	2026	2028	2030
		(%)	(%)	(%)	(%)	(%)
<b>responses to health emergencies and humanitarian crises within the first 24 hours</b>	Percentage of Member States with fully functional public health emergency operations centres (PHEOCs) according to minimum standards	60	75	90	95	100
	Percentage of Member States with 80% of “districts” with functional service delivery and quality improvement programmes	TBD	40	60	80	100
<b>Objective 4: To ensure provision of quality essential health services during health and humanitarian emergencies</b>	Percentage of Member States with 80% of districts implementing non-outbreak related public health activities that are impacted by outbreaks	TBD	30	50	60	80
	Percentage of Member States at risk with 80% vaccination coverage of targeted population for vaccine-preventable health hazards (yellow fever, meningitis)	12*	30	50	60	80
	Percentage of Member States in fragile and conflict settings with at least 80% of target health facilities providing a comprehensive essential service package	TBD	30	50	60	80
	Percentage of Member States implementing all the components of the IHR-MEF	32	50	70	80	100
<b>Objective 5: To strengthen systems for accountability, monitoring, evaluation and peer review</b>	Percentage of Member States that have conducted the UHPR	2	30	50	60	80
	Percentage of Member States that have conducted a SIMEX to test health systems resilience	47	60	70	80	90
	Percentage of Member States that have institutionalized SPAR in sector reviews	TBD	30	50	60	80
	Percentage of Member States with all IHR capacities at the developed level based on SPAR reporting	0	10	30	40	50
	Percentage of Member States that have at least two annual partnership and multisectoral forums to review the performance of their annual health security plans	TBD	30	50	60	80
<b>Objective 6: To promote strategic, synergistic, and mutually trusting partnerships</b>	Percentage of Member States with an operational One Health roadmap for improved IHR capacities and health security	36	60	80	90	100

\*Yellow fever only; TBD: To be determined