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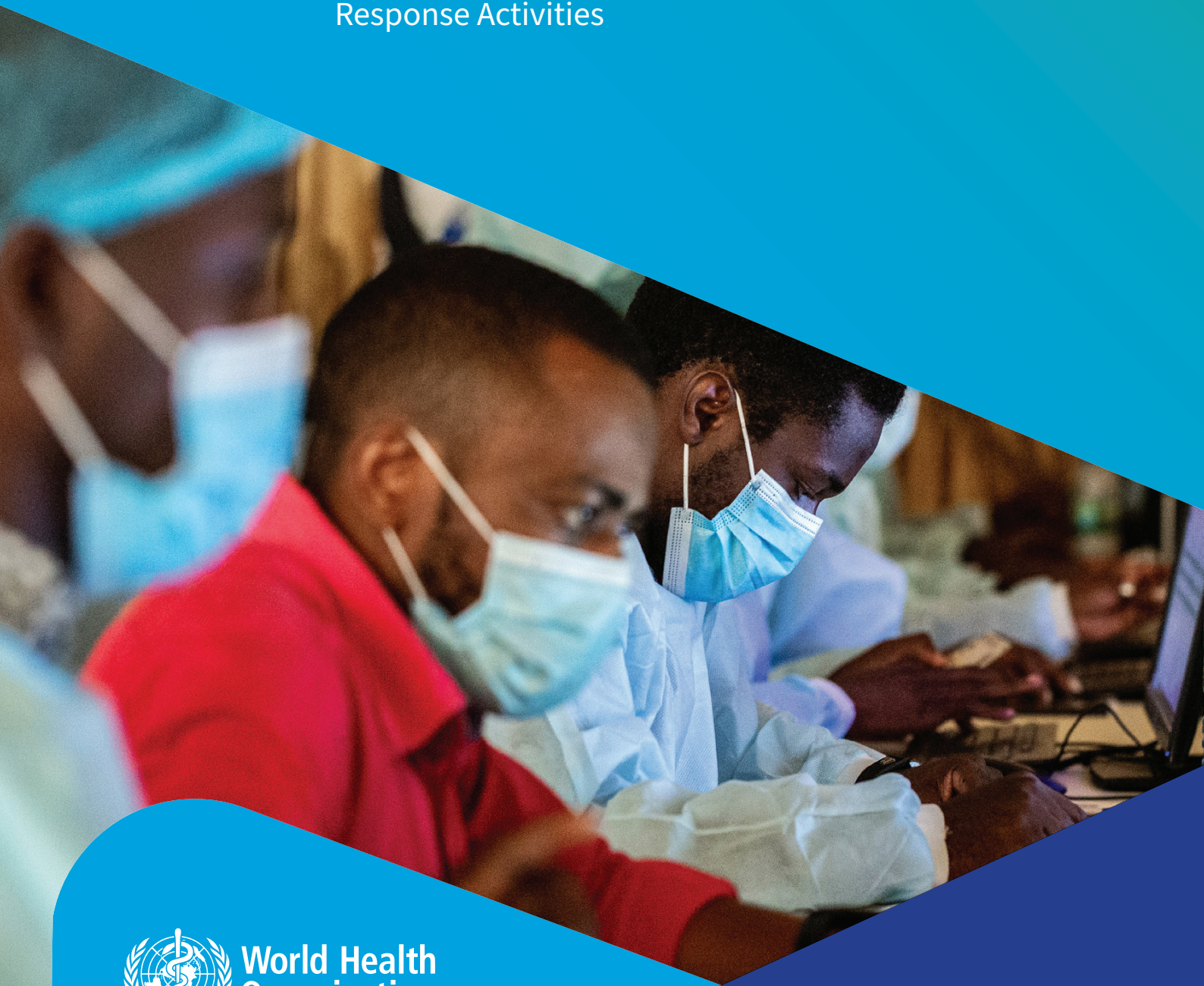
QUARTERLY REPORT

JULY 2023

ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency Preparedness and Response Activities



World Health Organization

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Acronyms

AKI	Acute Kidney Injury
BCP	Business Continuity Plan
CCC	Command Center Coordination
CDC	Centers for Disease Control and Prevention
CFE	Contingency Fund for Emergencies
CFR	Case Fatality Rate
CHWs	Community Health Workers
DRC	Democratic Republic of the Congo
ECCAS	Economic Community of Central African States
EMT	Emergency Medical Team
EPR	Emergency Preparedness and Response
ERF	Emergency Response Framework
FCV	Fragility, Conflict and Violence
FENSA	Framework of Engagement with Non-State Actors
GAM	Global Acute Malnutrition
GOARN	Global Outbreak Alert and Response Network
GPHI	Global Peace and Health Initiate
GPW-13	WHO's Thirteenth General Programme of Work
HeRAMS	Health Resources Availability Mapping System
HRPs	Humanitarian Response Plans
IASC	UN's Interagency Standing Committee
ICG	International Coordinating Group
ICT	Information and Communication Technology
IEHKs	Interagency Emergency Health Kits
IHR	International Health Regulations
IMS	Incident Management System

IPC	Infection Prevention and Control
IDSR	Integrated Disease Surveillance and Response
JOR	Joint Operational Review
MHPS	Mental Health and Psychosocial Support
MS	Member States
MVD	Marburg Virus Disease
NBW	National Bridging Workshop
NCPs	National Cholera Plans
NDoH	South African National Department of Health
NTF	National Task Force
OCHA	UN Office for the Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
OH-JPA	One Health Joint Plan of Action
OSL	Operational Support and Logistics
PAMI	Priority Areas for Multisectoral Interventions
PHEIC	Public Health Event of International Concern
PHEOC	Public Health Emergency Operations Center
PPE	Personal Protective Equipment
PRSEAH	Prevention and Response to Sexual Abuse and Harassment
PROSE	Promoting Resilience of Systems for Emergencies
PSA	Pressure Swing Adsorption
RCCE	Risk Communication and Community Engagement
RDTs	Rapid Diagnostic Tests
RED	Regional Emergency Director
REPREP	Response Preparedness
RRAs	Rapid Risk Assessments
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAM	Severe Acute Malnutrition

SGBV	Sexual and Gender-Based Violence
SimEx	Simulation Exercise
SOPs	Standard Operating Procedures
SPRP	Strategic Preparedness and Response Plan
STAR	Strategic Tool for Assessing Risks
SURGE	Strengthening and Utilizing Response Groups for Emergencies
TASS	Transforming African Surveillance Systems
TESK	Trauma Emergency Test Kits
TOT	Training-of-Trainers
UNICEF	United Nations Children's Fund
UNISS	The United Nations Integrated Strategy for the Sahel
WASH	Water, Sanitation, and Hygiene
WFD	Workforce Development
WFP	World Food Programme
WHO	World Health Organization
WHO AFRO	World Health Organization’s Regional Office for Africa

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

Dr Abdou Salam Gueye
Regional Emergency Director, WHO AFRO

> The second quarter of 2023 was marked by new disease outbreaks and complex humanitarian crises, as violence and food insecurity compounded health risks across multiple countries in Sub-Saharan Africa.

In this challenging context, the World Health Organization's Regional Office for Africa (WHO AFRO) focused on strengthening Emergency Preparedness and Response (EPR) capabilities across the continent.

Over the past three months, WHO Africa region staff worked closely with Member States and international partners to develop the human resources and logistical capabilities necessary to rapidly identify and effectively respond to disease risks, especially those arising amid fragile and conflict-affected situations.

This report describes the outputs and outcomes of the combined efforts of WHO AFRO, Member States, and other partners to prepare and respond to health emergencies in the region. While the previous quarterly reports highlighted the accomplishments of the EPR cluster based on the three flagship initiatives (PROSE, TASS, and SURGE), this report adopts a results-based reporting approach consistent with the WHO's Thirteenth General Programme of Work (GPW13). Future reports will be aligned with the GPW-14 once it comes into effect. The report includes sections on preparedness, detection, and response, followed by two sections that highlight the emergency health events responded to during the quarter and the logistical support provided to the Member States.

During the second quarter, 21 public health emergency events were responded to including two new major humanitarian events due to the conflicts in DRC and the Sudan(with impact on four neighboring countries). More than US$ 2.1 million was spent to provide logistical support to Member States and expand the regional stockpile of emergency supplies. Forty-two shipments were deployed to 18 countries as part of response efforts to Marburg, cholera, mpox, and meningitis outbreaks, as well as cyclones, and worsening humanitarian crises. WHO AFRO supported the efforts of the six countries most affected by the Sahel crisis to strengthen data collection, track key indicators, and develop humanitarian response plans. In addition, they were supported to rollout the Health Resources and Services Availability Monitoring System (HeRAMS) to inform planning and resource mobilization to address gaps in quality and coverage of health services.

WHO AFRO also continued to support Member States in implementing the three flagship initiatives as means to advance health security in the region. Countries were supported in adopting the third edition of the Integrated Disease Surveillance and Response (IDSR) Guidelines, and training-of-trainers sessions were conducted on IDSR, risk communication and community engagement, and the One Health approach. WHO AFRO also supported Member States in operationalizing their Public Health Emergency Operations Centers and building capacity of emergency workforce. WHO AFRO remains grateful to the Member States and partners, whose collaborative efforts remain the cornerstone of EPR activities across the AFRO region.

Introduction

Across Sub-Saharan Africa, escalating threats from natural disasters, political instability, and the ramifications of climate change have further increased the importance of regional crisis preparedness and response efforts. Close collaboration with national governments and international partners is vital to address the compounding risks posed by insecurity and violence, population displacement, environmental degradation, and infectious disease. Underdeveloped infrastructure and limited public services continue to complicate emergency response efforts, especially in remote areas, underscoring the importance of building local capacity while establishing innovative, flexible, and responsive operational and logistics systems. As it operates in fragile situations and among highly vulnerable communities, WHO AFRO continues to mainstream cross-cutting interventions around prevention and response to sexual abuse and harassment (PRSEAH) and sexual and gender-based violence (SGBV). During the second quarter of 2023, WHO AFRO focused on providing technical support to strengthen the prevention, detection, and response capabilities of Member States while building its internal capacity to operate effectively in underserved areas and address multidimensional crises.

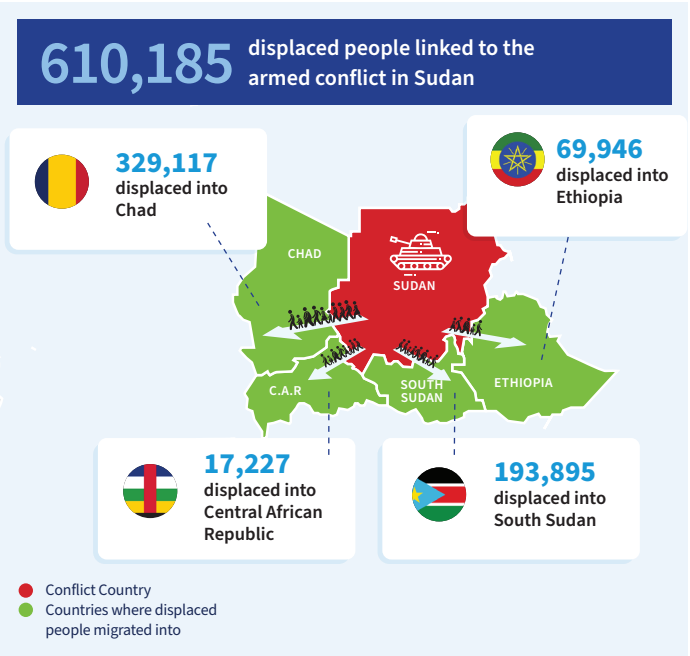
Emergency Response

During Q2, WHO AFRO continued supporting the efforts of Member States to develop their capacities and respond to public health emergencies in line with the ERF and IHR. More countries are implementing the SURGE flagship, and trained AVoHC-SURGE and Triple-E[1] members have been deployed in response to health emergencies.

The capacity to coordinate the response to public health emergencies is being reinforced through the operationalization of Public Health Emergency Operation Centres (PHEOCs) in 25 countries. The timely grading of events, adherence to ERF performance standards, and the prompt release of catalytic funding from the CFE enabled a rapid and comprehensive response to cholera, MVD, and natural disasters, protecting thousands from the harmful effects of health emergencies. The two MVD outbreaks were successfully contained without any cross-border spread—a major achievement.

In Q2, WHO AFRO supported four of the 13 countries affected by fragility, conflict, and violence (FCV) in responding to an influx of refugees and returnees linked to the armed conflict in Sudan, a WHO EMRO Member State. The conflict has displaced 329,177 people into Chad, 193,895 into South Sudan, 69,946 into Ethiopia and 17,227 into Central African Republic.

Together, these four countries received over 70% of the refugees that fled Sudan, and the support provided to them enabled essential health services to be delivered to highly vulnerable populations.



1 Botswana, Central African Republic, Chad, Republic of Congo, Kenya, Mauritania, Niger, Togo, Madagascar, Uganda, Nigeria, DRC, Senegal, Côte d'Ivoire, Tanzania, Mozambique, Ghana, Malawi, Cameroon, The Gambia, Namibia, Mali, South Africa, Angola, Ethiopia, Guinea, Rwanda, and Lesotho

Response to Acute Health Emergencies Leveraging Relevant National and International Capacities

The grade-3 events responded to in Q2 included two major new events: (i) the humanitarian crisis in Sudan, along with its impact on neighboring Chad, South Sudan, Ethiopia, and Central African Republic, and (ii) the intensification of the humanitarian crisis in the six provinces of DRC. WHO AFRO set up an incident management support team at the regional office to support the response to both humanitarian events, and incident managers were deployed to DRC and Chad. Life-saving interventions were underpinned by US$2.5 million in emergency funding from the CFE.

WHO AFRO responded effectively to several outbreaks during Q2. The MVD outbreaks in Equatorial Guinea and Tanzania were contained without cross-border spread. WHO AFRO technical and operational support enabled the rapid containment of the outbreaks in Equatorial Guinea and Tanzania within 107 days and 83 days, respectively. Political challenges were experienced that hindered deployment of resources for the Marburg response and compromised the timeous attainment of ERF performance standards. To mitigate this, high-level advocacy led by the Regional Emergency Director, the Regional Director and the Director General was conducted which facilitated deployment of critical staff. This highlighted the need for a rolling high-level engagement strategy for countries experiencing outbreaks for the first time.

WHO AFRO also ramped up support for cholera response to reverse the upward trend of cases and deaths that was being experienced in the 14 affected countries in the first quarter. Support provided to Member States in the form of human resources, cholera control supplies, and funding resulted in a reduction of cases by 14% and reduction in deaths from 1,033 to 365 within the quarter. In four countries[2] a consecutive decline of cases was reported for over four weeks including significant decline in the major drivers of cases, Malawi, Kenya, and Mozambique with Malawi and Mozambique recording this decline despite the devastating effects of Cyclone Freddy. By the end of the quarter, cholera transmission was active in only nine out of the 14 countries.

The cholera responses in Malawi and Mozambique were integrated with the cyclone response, and the same incident management teams led the response effort. This approach was designed to mitigate the challenge posed by multiple health emergencies increasing demand for financial and human resources by eliminating the need to set up another incident management team to lead the cyclone response. To address the issue of inadequate resources, there is a need to go beyond traditional resource mobilization approaches and engage with the private sector and philanthropists in line with the Framework of Engagement with Non-State Actors (FENSA) during emergencies.

In the quarter, WHO AFRO continued to support emergency response activities through the SURGE flagship. A scoping mission was successfully completed in Malawi with participation of about 12 government ministers and other stakeholders. The scoping mission culminated in drafting of a two-year costed roadmap and sensitization of emergency stakeholders on the roadmap.

A total of 813 AVoHC-SURGE members were trained as core responders in nine countries[3] and the trained AVoHC-SURGE members participated in the response to Marburg outbreaks and flooding in Tanzania and Rwanda, respectively. Seven WHO AFRO Triple-E members were deployed to support cholera, MVD, and acute kidney injury (AKI) outbreaks, as well as the response to Cyclone Freddy. As of Q2, about 1,218 AVoHC-SURGE members had uploaded their credentials on the emergency responders' database, along with an additional 250 Triple-E members.

Highlights

Support provided to Member States in the form of human resources, cholera control supplies, and funding resulted in **a reduction of cholera cases by 14% and reduction in deaths from 1,033 to 365 within the quarter**

WHO AFRO technical and operational support enabled the outbreaks in **Equatorial Guinea and Tanzania to be contained within 107 days and 83 days**, respectively

2 Malawi, Kenya, Cameroon, and Mozambique

3 Central African Republic, Chad, Democratic Republic of Congo, Kenya, Ethiopia, Republic of Congo, Rwanda, Senegal, and Zanzibar-United Republic of Tanzania

A cyclone command centre was activated in Nairobi, where four experts were deployed to provide technical support in the response to cyclones in southern Africa. The experts provided technical guidance for the response to Cyclone Cheneso and Cyclone Freddy and coordinated risk analysis and the timely provision of operational and logistic support in Madagascar, Malawi, and Mozambique in addition to the development of response strategies and plans.

In Cameroon, four surge personnel were deployed to support the investigation and response to acute kidney injury that was caused by falsified medicine. The investigation identified the falsified medicine, 'naturacold,' and a chemical analysis confirmed that the medicine contained very high levels of diethylene glycol, which had caused the deaths of 11 children. Due to the prompt response to the emergency, the medicine was recalled, preventing further deaths, and a global alert against falsified 'naturacold' syrup has been issued. Another two SURGE personnel were deployed to Kenya to respond to acute gastroenteritis among school children.

Out-of-country deployment of AVoHC-SURGE core responders, however, proved challenging due to the WHO HR process. To enable the cost-effective international deployment of the trained and equipped workforce in the region, the WHO AFRO EPR team engaged the Global Outbreak Alert and Response Network (GOARN) to explore the possibility of integrating health ministries and NPHI/PHEOCs into GOARN. The Member States were sensitized on the application process, and GOARN has started receiving applications from countries.

WHO extended the IMS supporting response to severe drought in the greater Horn of Africa. More than 10 experts were deployed in Q2 to support response coordination, resource mobilization, information management, and logistics. Key achievements include the incorporation of nutrition indicators in weekly surveillance, which enabled the monitoring of trends in severe acute malnutrition (SAM) and global acute malnutrition (GAM). The experts also supported advocacy for the allocation of more resources to combat malnutrition, the provision of training on the management of children with SAM and medical complications, and the provision of essential supplies to health facilities.

WHO AFRO handed over eight vehicles each to the government authorities in Namibia, Kenya, and Ethiopia to support the AVoHC-SURGE core responders' emergency management roles. To date, as part of the SURGE flagship initiative, vehicles have been handed over to national authorities in 12 countries[4]. WHO AFRO also supported operationalization and strengthening of PHEOCs across the Member States, which included organizing the 3rd Regional ToT, developing physical infrastructure and deploying ICT equipment, conducting assessment missions to evaluate implementation progress, and creating key PHEOC documents. These efforts are detailed in the Operations Support and Logistics (OSL) section.

In Q2, joint operations reviews (JORs) were conducted for the humanitarian response efforts in Mali, Nigeria, Cameroon, Burkina Faso, Niger, and Ethiopia. The assessments highlighted the key challenges, and achievements and identified key recommendations. The countries' response plans for these humanitarian events were revised based on the findings of the reviews.

4 Botswana, Niger, Togo, Mauritania, Central African Republic, DRC, Rwanda, Senegal, Tanzania, Namibia, Kenya, and Ethiopia

During the quarter, funding constraints limited WHO AFRO's capacity to support the implementation of the country-level SURGE roadmaps and to respond to the multicountry outbreaks and humanitarian crises. For example, only 24% of the HRPs for the four FCV countries in the AFRO region impacted by the Sudan crisis had been established prior to the onset of the crisis, and just 56.7% had been established prior to the crisis in DRC. Ongoing resource mobilization, both from the regional office and at the country level, is supporting the implementation of the SURGE roadmap. The World Bank is currently supporting four Economic Community of Central African States (ECCAS) countries (Chad, CAR, Republic of the Congo, and DRC) in implementing the SURGE flagship. Discussions are ongoing with the East African Community to support the East African countries.

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

During the quarter, WHO AFRO supported the scaling up of humanitarian response interventions in DRC, Chad, South Sudan and Northern Ethiopia. In DRC, support was provided to the country for the provision of essential emergency health services, which included surveillance, sexual and gender-based violence (SGBV) prevention and response, mental health and psychosocial support services (MHPSS), vaccination (routine immunization and reactive vaccination campaigns), management of SAM, improvements in water, and sanitation hygiene (WASH), infection prevention and control (IPC), and case management during disease outbreaks. WHO AFRO also supported the mobilization of US$2.5 million in domestic funding to support the response. WHO AFRO supported the training of health workers and deployed more than 40 staff and consultants to support in the response to the crisis. More than seven tonnes of essential medicines and medical equipment, including Interagency Emergency Health Kits, as well as cholera and pneumonia kits, were supplied to DRC during the quarter.

In addition, WHO AFRO supported the efforts of the four FCV countries neighboring Sudan to provide essential health services to victims of the crisis. The support provided by WHO AFRO encompassed expanded surveillance activities, treatment of non-communicable diseases, management of vaccine-preventable diseases, SAM management, trauma case management, clinical and psychosocial support for SGBV victims, reproductive health services, routine vaccination and reactive mass vaccination campaigns, MHPSS, laboratory testing services, and WASH/IPC activities.

WHO AFRO also provided human resources, including two emergency management teams in Ethiopia and Chad and more than 30 WHO AFRO staff in the four countries.

The staff deployed included epidemiologists, surgeons, public health officers, nutritionists, health cluster coordinators, communication officers, nurses, midwives, medical doctors, and OSL specialists, among others. Support was also provided to train local health workers and community health workers in the four FCV countries on surveillance, including community-based surveillance by community health workers and community leaders, as well as cholera management, nutritional screening, WASH, IPC, SGBV, and MHPSS. This training helped address some of the epidemiological challenges arising from gaps in the surveillance system, a lack of sample collection from suspected cases, inadequate investigation of suspected cases, and delays in getting laboratory results.

In collaboration with WHO EMRO, WHO AFRO launched an appeal that helped mobilize about US$4.4 million to support humanitarian response plans (HRPs) in the four FCV countries. WHO AFRO held press briefings and advocacy sessions and entered several bilateral collaborations with donors to support the resource mobilization efforts for the four countries. Moreover, WHO AFRO donated more than 40 tonnes of essential medicines, medical equipment, and emergency surgical kits to Chad in support of the country's response efforts. Three fully kitted ambulances were also supplied to support patient referrals and transport cold-chain equipment.

As insecurity and inaccessibility of several intervention areas threatened response activities, WHO AFRO supported 13 FCV countries in developing their capacity to implement peacebuilding activities in line with the Global Peace and Health Initiate (GPHI) Roadmap. WHO AFRO continued advocacy for peace and humanitarian access, and ongoing assessment of the possibility of cross borders operations to circumvent insecurity areas to access populations in need. Several mitigation plans were put in place to overcome the inaccessibility challenges such as the use of plane to supply commodities and equipment to inaccessible areas.

WHO AFRO also continued to support the implementation of the Health Resources and Services Availability Monitoring System (HeRAMS) in the six most-affected Sahel countries. HeRAMS was implemented in Niger and is currently being rolled out in Cameroon. The monitoring system enables the continuous collection, analysis, and dissemination of information on the availability of essential health services and resources to the point of service delivery, which will inform efforts to restore services impacted by the Sahel crisis. Niger is developing a recovery plan based on the findings of the HeRAMS. WHO AFRO also supported the establishment of an online platform for monthly reporting of health-service delivery indicators for all six countries. The platform has information on the supply and availability of services in the areas of immunization (Penta-3 vaccine coverage), nutrition, SGBV, mental health, and reproductive health.

Emergency Response Achievements

ONLINE DATA-COLLECTION
systems were launched in six priority Sahel countries to provide monthly reports on **indicators of Penta-3 vaccine coverage, nutrition, food security, GBV, mental health, and reproductive health**

THE CHOLERA RESPONSE RESULTED IN
14% **REDUCTION IN CASES AND A DECLINE IN THE NUMBER OF DEATHS**
FROM **1033** TO **365**
DURING THE QUARTER

Marburg virus outbreaks
WERE RESPONDED TO EFFECTIVELY
and contained without cross-boarder spread

WHO AFRO supported
13 FCV COUNTRIES
IN DEVELOPING THEIR CAPACITY
to implement peacebuilding activities in line with the **GPHI Roadmap**

JORS WERE CONDUCTED FOR THE HUMANITARIAN RESPONSES IN
MALI, NIGERIA, CAMEROON, BURKINA FASO, NIGER, AND ETHIOPIA.
A TOTAL OF **813 AVOHC-SURGE MEMBERS WERE TRAINED**
as core responders in nine countries[5], and they participated in the responses to the Marburg outbreak in Tanzania and flooding in Rwanda

5 Central African Republic, Chad, Democratic Republic of Congo, Kenya, Ethiopia, Republic of Congo, Rwanda, Senegal, and Zanzibar-United Republic of Tanzania

WHO RESPONSE TO GRADED HEALTH EVENTS

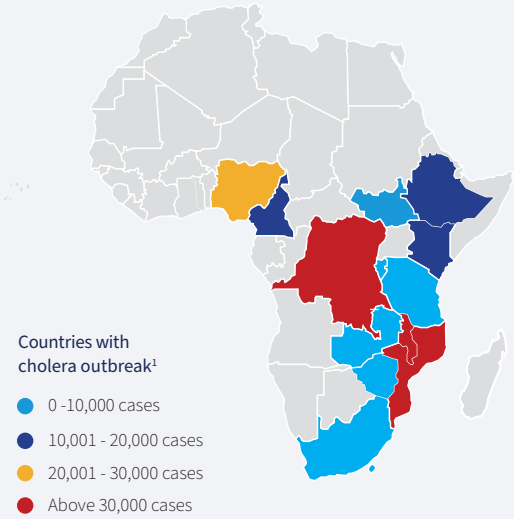
1 Cholera outbreak - multiple countries

Between 1 January 2022 and 25 June 2023, WHO AFRO recorded a total of 209,047 cholera cases and 3,922 deaths across 14 countries, indicating a case-fatality ratio (CFR) of 1.9%[6]. The multicountry cholera outbreak was deemed a grade-3 event on 30 January 2023, and a subsequent review on 18 May 2023 reaffirmed that status. This event remains active, though the number of reported cases and deaths both declined in the second quarter (Q2) of 2023.

WHO AFRO increased its support to the 14 affected countries during Q2. In South Africa, 183 health workers received training on infection prevention and control (IPC) techniques, while another 16 were trained in case management, and 73 clinical staff were instructed on proper procedures for donning and doffing personal protective equipment (PPE). In addition, health screening procedures were administered to 78,887 travelers at all seven formal entry points into the country. In Malawi, cross-border surveillance and management intervention was undertaken along the border with Mozambique, and a risk communication and community engagement (RCCE) campaign raised awareness by showing films to 23,899 students, staff, and other community members in 14 primary schools in Blantyre.

78 887 travelers were screened at all the seven formal entry points in South Africa

23 899 students, staff, and community members were part of the film screening in Malawi



6 Malawi:58 986 cases, 1 765 deaths, CFR=3.0%, Democratic Republic of Congo: 42 958 cases, 441 deaths, CFR=1.0%, Mozambique: 32 972 cases, 141 deaths, CFR=0.4%, Nigeria: 25 678 cases, 662 deaths, CFR=2.6%, Cameroon: 18 784 cases, 439 deaths, CFR=2.3%, Kenya: 11 631 cases, 190 deaths, CFR=1.6%, Ethiopia:11 960 cases, 165 deaths, CFR=1.4%, Zimbabwe: 3 027 cases, 71 deaths, 2.3%, South Sudan: 1 471 cases, 2 deaths, CFR=0.1%, Zambia: 757 cases, 14 deaths, CFR=1.8%, Burundi:542 cases, 9 deaths, CFR=1.7%, South Africa:197 cases, 20 deaths, CFR=10.2%, United Republic of Tanzania: 82 cases, 3 deaths, 3.7%, The Kingdom of Eswatini: 2 cases, zero death, CFR=0%

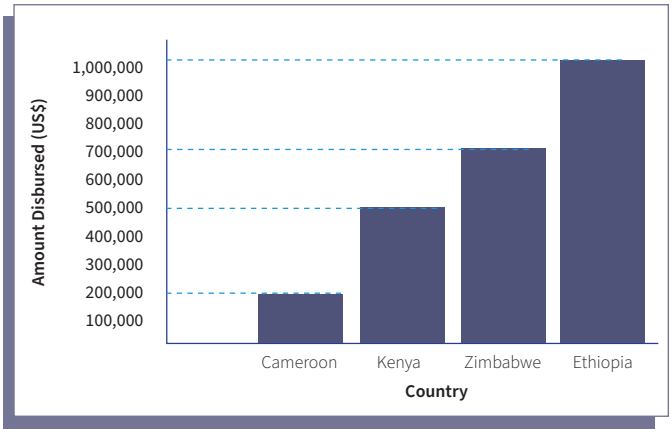
Water quality was tested at 693 water points in 17 districts in Malawi. In Mozambique, WHO AFRO treated the water in six reservoirs and disinfected 110 houses in Cabo Delgado. Reactive vaccination campaigns administered 1,910,416 doses of Oral Cholera Vaccine (OCV) in 17 wards in Ethiopia, 1,947,695 doses in five districts in Malawi, and 491,771 doses in Mozambique's Tete Province.

WHO AFRO deployed a total of 33 human resources to Malawi (17), Mozambique (3), Eswatini (5), and South Africa (8) and provided supplies to support the response effort (Table 1). In addition, a total of US$2.4 million was provided to Cameroon, Kenya, Ethiopia and Zimbabwe from the WHO Contingency Fund for Emergencies (CFE) (Figure 1) to respond to the cholera outbreak.

Table 1: Supplies Provided in Response to the Multicountry Cholera Outbreak

Country	Supplies Provided
Cameroon	50 cholera beds
Kingdom of Eswatini	32 000 liters of ringers' lactate
Malawi	500 gum boots, 10 beds and mattresses, 110 Interagency Emergency Health Kits (IEHKs), 50 pneumonia kits, 12 600 liters of ringers' lactate
Mozambique	15 cholera beds, 90 kg of chlorine, installed a cholera treatment unit (CTU) in Cabo Delgado, established 6 oral rehydration points (ORP) in Sofala, 10 000 cholera community kits

Figure1: Financial Support Disbursed in Response to the Multicountry Cholera Outbreak



1,910,416 doses of OCV were administered in Ethiopia

1,947,695 doses of OCV in Malawi,

491,771 OCV doses in Mozambique through reactive vaccination campaigns.

Cyclone Freddy complicated the cholera response by damaging and flooding health facilities and water, sanitation, and hygiene (WASH) infrastructure in Malawi and Mozambique. Inadequate WASH services hindered efforts to swiftly and sustainably resolve the outbreak. In addition, cross-border coordination was suboptimal, and insufficient resource mobilization at the country level prevented the timely replenishment of funds disbursed from the CFE, which limited the scope of the response efforts. However, despite the inadequate WASH services intensified response actions in Malawi and Mozambique mitigated the impact of the cyclone on cholera transmission and by 30 June the cases and deaths were on decline in the affected districts in both countries.

WHO RESPONSE TO GRADED HEALTH EVENTS

2 Humanitarian crisis - Democratic Republic of the Congo

Humanitarian conditions in Democratic Republic of the Congo (DRC) deteriorated in Q2 2023, and the crises spread to additional provinces. In Eastern DRC, where armed intercommunity conflicts have persisted for nearly three decades, the humanitarian situation was classified as a grade-3 event on 21 June 2023, after 150 civilians were killed in the first two weeks of April in Ituri in addition to deaths being experienced since December 2022.

Over the past 12 months, rising violence has internally displaced 6.3 million people in Ituri, North Kivu, and South Kivu, with clashes between government forces and the M23 movement displacing an estimated 2.3 million people in North Kivu alone. The UN's Interagency Standing Committee activated a system-wide scale-up for the North Kivu, South Kivu, Ituri, Tshopo, Kasaï and Maindombe Provinces, which have also experienced outbreaks of cholera, mpox, plague, measles, and meningitis. In tandem, WHO AFRO operations were escalated to the level of a grade 3 public health emergency, incident management system with 42 national and international experts were deployed to strengthen different domains of health service delivery including prevention and response to SGBV.

With WHO AFRO support, 356,370 people were vaccinated against cholera in three health zones in North Kivu, and 1,816,869 children were vaccinated against measles. A total of 910 health workers were trained in community-based surveillance in North and South Kivu. In North Kivu, the redeployment of 39 national staff and three international SURGE responders, combined with the disbursement of US$2.5 million in CFE funds. This enabled WHO AFRO to supported field operations, provide emergency essential health services, provide essential medicines in the form of the IEHKs, and to sensitize 222,000 people on cholera, COVID-19, and PRSEAH. A total of 43 community cholera kits and 17 Interagency Emergency Health Kits (IEHKs) were distributed in North Kivu, South Kivu, and Kasai, which enabled the treatment of 170,000 people for three months.

365 370 people were vaccinated against cholera in North Kivu and over 1 million children were vaccinated against measles.

Limited logistical capacity to meet the population's needs for medicine and medical supplies posed challenges during the response effort in DRC. In addition, too few healthcare providers were trained in complete management of abortion and post-abortion care, safe-delivery procedures, and emergency obstetric and neonatal care. These challenges were compounded by the insecurity of the situation in DRC, which hindered response activities.

WHO RESPONSE TO GRADED HEALTH EVENTS

3 COVID-19 in all countries in the region

The COVID-19 pandemic, which started on 26 December 2019 and was declared a public health event of international concern (PHEIC) on 30 January 2020. Then, on 5 May 2023, WHO Director-General Dr. Tedros Ghebreyesus announced that COVID-19 was no longer a PHEIC, but an ongoing health issue. On 30 May 2023, it was reclassified as a protracted grade-3 event. As of 28 June 2023, over 12.8 million cases of laboratory-confirmed COVID-19 and 257,872 deaths had been registered in Africa.

In Q2, WHO AFRO continued to support the COVID-19 response efforts of all regional Member States. Case-management refresher trainings were conducted for 95 health workers in Lesotho, Botswana, and Eswatini. In Ghana, a five-day hands-on training was delivered to 89 clinical engineers on Pressure Swing Adsorption (PSA) oxygen equipment. In Zambia, Malawi, and Cameroon the WHO AFRO SURGE teams and other partners supported the successful implementation of mass-vaccination campaigns.

As a result, Zambia's coverage rate for the complete primary series increased from 31% to 43%, Malawi's rate improved from 13% to 17%, and Cameroon's rate increased from 4.6% to 10% following a 10-day mass vaccination campaign. WHO AFRO also developed a Regional COVID-19 Strategic Preparedness and Response Plan (SPRP) for 2023-2025.

COVID-19 Vaccine coverage rate

Zambia's **rate for the complete primary series increased from 31% to 43%**, Malawi's rate improved from **13% to 17%**, Cameroon's rate increased from **4.6% to 10%** following a **10-day mass-vaccination** campaign supported by WHO AFRO

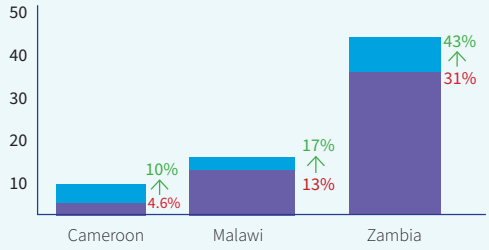


Table 2: Countries where experts were deployed

Country	Experts Deployed
São Tomé and Príncipe	2
Republic of the Congo	2
Tanzania	1

Inadequate surveillance and low vaccination coverage in several countries posed key challenges to the COVID-19 response, but WHO AFRO continued to support Member States' efforts to control the pandemic.

WHO RESPONSE TO GRADED HEALTH EVENTS

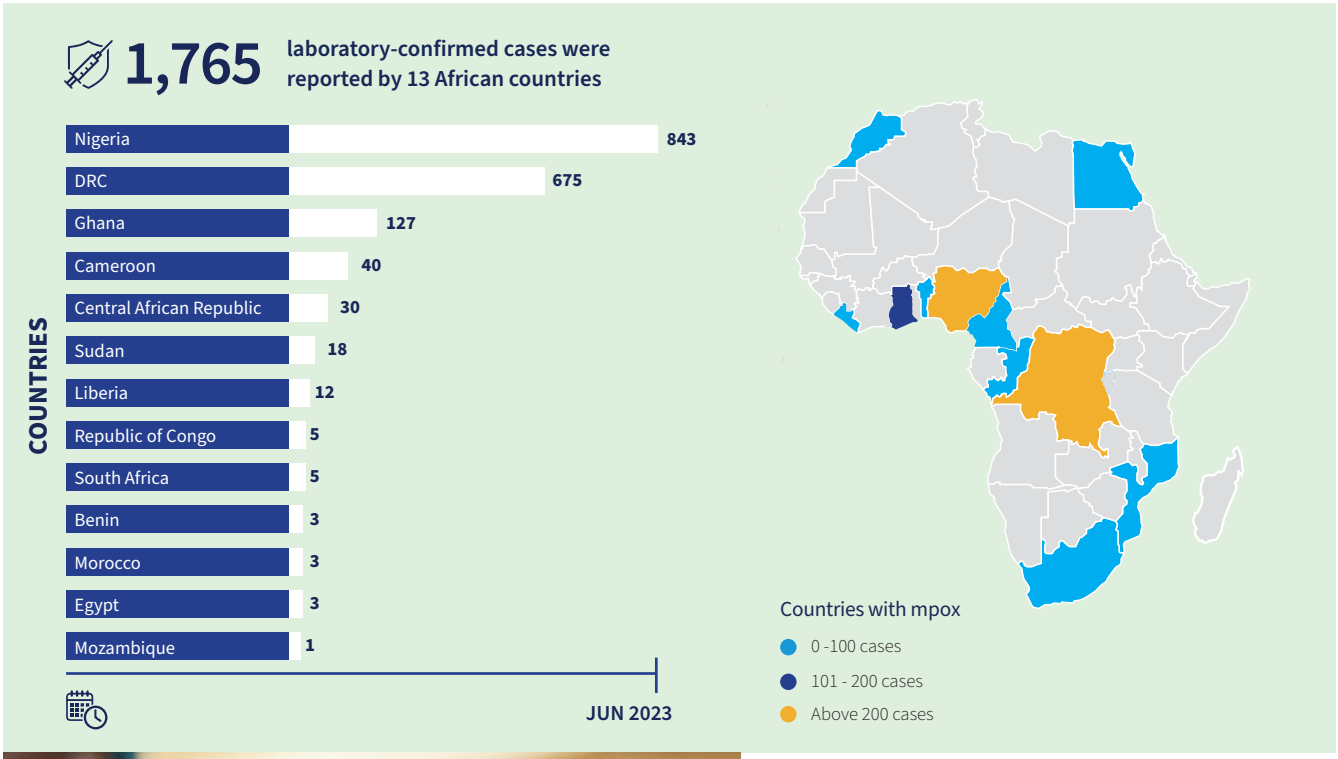
4 Mpox - multiple countries

On 30 May 2023, the multicountry mpox outbreak was reclassified from a grade-3 event to a protracted grade-2 event. The outbreak had previously been declared a PHEIC on 23 July 2022, but PHEIC status was lifted on 11 May 2023. As of 30 May 2023, a total of 87,858 laboratory-confirmed cases and 1,098 probable cases, including 143 deaths, had been reported to WHO by 111 Member States across all six WHO regions.

WHO AFRO is supporting Member States in researching the potential impact of mpox on animal populations and wastewater systems

WHO AFRO continues to support measures to strengthen laboratory capacity, information management, and genomic sequencing

Figure 2: Confirmed Laboratory mpox cases



WHO African region is supporting country-level efforts to strengthen mpox-related RCCE and surveillance and response. In line with the One Health Approach, Member States are being supported to research the potential impact of mpox on animal populations and wastewater systems, and to strengthen laboratory capacity, information management, and genomic sequencing.

Extended epidemiological investigations are planned in Nigeria and DRC to better understand mpox transmission dynamics and enhance response efforts. During Q2, key challenges faced in the mpox response included insufficient surveillance due to stigma and discrimination, issues involving isolation and quarantine, and an inadequate vaccine supply.

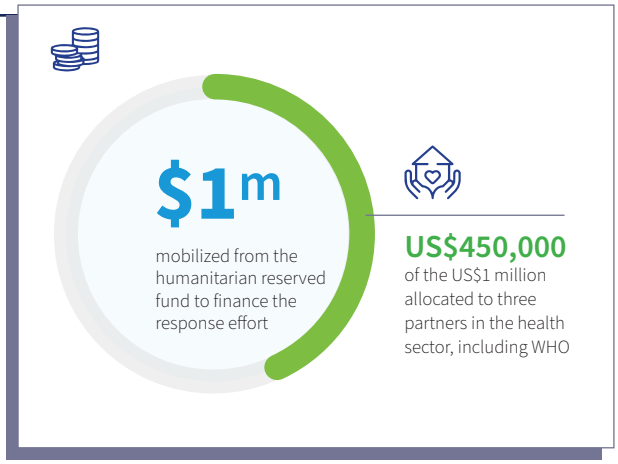
WHO RESPONSE TO GRADED HEALTH EVENTS

5 Humanitarian crisis - Sudan and impact on neighboring countries

On 15 April 2023, intense fighting in the streets of Khartoum erupted between the Sudanese Armed Forces and the Rapid Support Forces. By 5 June 2023, over 1.2 million people had been internally displaced, and another 400,000 had become refugees in neighboring countries.

The humanitarian situation was initially deemed a grade-2 event on 20 April 2023, then reclassified as grade-3 on 5 June 2023. Official figures report at least 800 deaths and nearly 6,000 injuries. Sudan shares borders with five WHO AFRO Member States: Chad, South Sudan, Central Africa Republic, Ethiopia, and Eritrea. As of 30 June, four of these five countries had reported an influx of displaced people from Sudan. Outbreaks of measles and other communicable diseases have been reported, and the continued movement of refugees raises the risk of a cholera outbreak.

WHO AFRO is providing ongoing support in the form of case management, mental health and psychosocial support (MHPS), vaccination campaigns against measles, and surveillance activities. Seven experts have been deployed to Chad to strengthen response coordination, and enhance delivery of essential health services. The UN Office for the Coordination of Humanitarian Affairs (OCHA) has mobilized US$1 million from the humanitarian reserved fund to finance the response effort, of which US$450,000 will go to three partners in the health sector, including WHO.



WHO RESPONSE TO GRADED HEALTH EVENTS

6 Cyclone Freddy

Cyclone Freddy began to form on 4 February 2023 in the Indian Ocean. It travelled westward, making landfall on the African continent multiple times before dissipating on 14 March near the border between Mozambique and Malawi. The storm, which affected Madagascar, Malawi, and Mozambique, was classified as a grade-2 event on 6 February 2023.

MADAGASCAR

Affected nearly 299,000 people, **displacing 72,700, and causing at least 17 deaths**

WHO AFRO dispatched emergency kits and supplies to the affected areas, and **both medical care and psychological support have been reinforced and optimized**

WHO AFRO supported the provision of mobile health services through deployment of 19 mobile clinics. **A total of 4,190 patients were treated and 2,180 people** were vaccinated for routine immunizations and COVID-19 at the mobile clinics. Thirty-seven emergency health kits including malaria and PED SAM were provided

After Cyclone Cheneso hit Madagascar from 19-23 January 2023, Cyclone Freddy made landfall twice, first on 21 February and again on 5 March. The storm affected nearly 299,000 people, displacing 72,700, and causing at least 17 deaths. In total, 391,000 people have been affected by cyclones since the beginning of 2023, causing at least 53 deaths and displacing 124,975 people.

Madagascar's National Office for the Management of Risks and Disasters coordinated the response effort. A multisectoral rapid assessment was conducted on the effects of the cyclone, and financial support was mobilized from various donors to address the most pressing humanitarian needs. Surveillance activities were strengthened in affected areas, focusing on malaria and plague. WHO AFRO continues to dispatch emergency kits and supplies to the affected areas, and both medical care and psychological support have been reinforced and optimized. Mobile clinics were assembled to facilitate vaccination campaigns and among affected communities. Ongoing RCCE activities have engaged community leaders and various media platforms.

MOZAMBIQUE

Since the beginning of the rainy season, natural disasters have affected **1.4 million people, causing 314 deaths, destroying 1,043 schools and disrupting the education of about 1.2 million students, and devastating 133,979** hectares of land

Medical care, food, and non-food items were provided to affected populations

WHO AFRO disbursed USD 742,275 from the CFE to support the response in Mozambique. **Emergency health kits: 72,400 litres of ringers' lactate, 13 tents, 55 beds, 10 boxes of cholera kit investigations, and 30 boxes of rapid diagnostic test kits** for cholera were deployed to support the response in Mozambique

Cyclone Freddy first made landfall in Vilankulo district of Inhambane province on 24 February 2023 as a moderate tropical storm with winds of 95 km/h. However, by the time it made its second landfall on 11 March 2023 in Quelimane district of Zambézia province it had become a tropical cyclone with maximum windspeeds of 148 km/h and gusts up to 213 km/h. The storm contributed to heavy rains between 31 January and 12 March 2023, which affected over one million people, causing flooding and accelerating the spread of cholera. Since the beginning of the rainy season, natural disasters have affected 1.4 million people, causing 314 deaths, destroying 1,043 schools and disrupting the education of about 1.2 million students, and devastating 133,979 hectares of land.

The National Institute for Disaster Management and Risk Reduction has coordinated the response. A rapid evaluation of damages was conducted in areas affected by Cyclone Freddy's second landfall. Accommodation centres were established to host displaced people across the districts and provinces of Zambezia, Sofala, Tete, Manica, and Niassa. Medical care, food, and non-food items were provided to affected populations. RCCE interventions are ongoing, including community engagement and awareness-raising on cyclones and related health threats.

MALAWI

Cyclone Freddy affected **2,267,458 people in Malawi and caused at least 679** deaths

WHO AFRO deployed international experts over a period of three months to support coordination, provision of essential services and case management, surveillance, IPC/WASH, RCCE, operations and logistics Support (OSL), EMT coordination, health cluster coordination, and partner coordination in Malawi

A total of 45 national surge staff were deployed in Nsanje district to support service provision and mobile clinics while 37 health workers were trained on basic emergency care to support Phalombe, Blantyre, and Mulanje districts

A static clinic was established at Bangula camp, which hosts an estimated population of 20,000 IDPs and is expected to be operational in the medium term. Three Emergency medical teams (UK-EMT, Team Rubicon and IFRC) were also deployed to provide emergency medical services, together, they provided 127 daily reports, which includes data of 14,692 consultations

Cyclone Freddy affected 2,267,458 people in Malawi and caused at least 679 deaths. As of 25 May, 86 camps hosted a total of 120,124 internally displaced persons. On average, over five of these camps were decommissioned each day between 4-30 May 2023. While the completeness rate of daily reporting from the camps is low, acute respiratory infections and malaria cases were reported. Further actions are being planned as part of the cholera response. An After-Action Review must be completed to prepare for the next cyclone season.

The Department of Disaster Management Affairs coordinated the response. A national Emergency Operations Centre was established, and local authorities conducted rapid assessments in accessible parts of affected districts, including Blantyre City, with support from humanitarian partners. Search-and-rescue teams were deployed, and over 200 people were rescued between 13-15 March 2023. Medical care and assistance were provided to affected communities. With support from WHO AFRO and other partners, Emergency medical supplies, including for cholera response, as well as food and non-food items were dispatched to affected areas, including dignity kits, hygiene kits, kitchen sets, mobile latrines, tarpaulins, and blankets.

Warning and awareness-raising messages were disseminated to the population through mobile vans, national and community radio stations, and door-to-door services. Actions were taken to prevent and respond to SGBV, strengthen child protection, and provide MHPS.

WHO AFRO established a cyclone command centre in Nairobi to coordinate response in the three countries. A total of 10 experts were deployed to support the response to Cyclone Freddy, including eight to Malawi and two to Mozambique. Lack of Portuguese-speaking experts was a challenge that limited the deployment of human resources to Mozambique. The cyclone exacerbated the cholera outbreaks in Malawi and Mozambique.

WHO RESPONSE TO GRADED HEALTH EVENTS

7 Marburg Virus Disease - Tanzania and Equatorial Guinea

TANZANIA

Six deaths were reported, indicating a **case fatality rate of 67%**

The outbreak was classified as a grade-2 event, but by 12 June 2023 it was no longer considered a graded emergency

On 21 March 2023, Tanzania's Ministry of Health declared an outbreak of Marburg virus disease (MVD) after investigating reports of five deaths in the Bukoba Rural District of Kagera Region. On 22 March 2023, the outbreak was classified as a grade-2 event, but by 12 June 2023 the outbreak was contained, and the event closed. A total of nine cases, including eight laboratory-confirmed cases and one probable case (the index case), and six deaths were reported, indicating a case fatality rate of 67%. On 2 June 2023, the Ministry of Health declared the end of the MVD outbreak. Only two districts in one region were affected. Response efforts were led and coordinated at the national and provincial levels. Active case search, contact tracing, and case investigation were conducted, along with RCCE. WHO AFRO provided viral haemorrhagic fever kits and IPC supplies, deployed one coordination expert, and disbursed US$750,000 from the CFE. Readiness activities were scaled up in neighbouring Uganda, Rwanda, Burundi, DRC, and Kenya. However, challenges involving the laboratory testing of samples and delayed genomic sequencing hindered the investigations into the source of the outbreak.

EQUATORIAL GUINEA

17 confirmed and **23 probable cases** were reported in continental Equatorial Guinea. Of the confirmed cases, 12 patients died, four recovered, and the outcome of one case is unknown

Readiness activities were scaled up in neighbouring Cameroon and Gabon, supported by **US$2.7 million in USAID funding**

An MVD outbreak was officially declared on 13 February 2023 after suspected viral haemorrhagic fever deaths were reported between 7 January and 7 February, with the initial case testing positive on 12 February. The outbreak was presumed to have started in Nsok-Nsomo and Ebibeyin Districts of Kié-Ntem Province, and transmission was later identified in Evinayong and Bata Districts. On 25 February, the outbreak was categorized as a grade-2 event, and it was raised to grade-3 on 4 April 2023. Graded status was lifted on 12 June, and the Ministry of Health declared the end of the MVD outbreak on 8 June. As of 7 June, a total of 17 confirmed and 23 probable cases were reported in continental Equatorial Guinea. Of the confirmed cases, 12 patients died, four recovered, and the outcome of one case is unknown. The case fatality rate among confirmed cases was 75%.

The response was coordinated at the national and provincial levels. Active case search, contact tracing, RCCE, and case-investigation activities were conducted, and three isolation and treatment centres were set up. WHO AFRO deployed 15 experts to support various Incident Management System (IMS) functions and disbursed US$1.2 million from the CFE. Readiness activities were scaled up in neighbouring Cameroon and Gabon, supported by US$2.7 million in USAID funding. This was the first ever Marburg outbreak in the country, thus there was limited institutional capacity. However, with strong technical and operational support from WHO, US CDC and other partners the outbreak was contained within three months with cross border spread.

Challenges included a delay in processing approvals for the deployment of experts to the country and limited laboratory capacity at the country level. Two laboratory experts from Institute Pasteur Dakar were deployed to build capacity to conduct molecular tests in the country. Equatorial Guinea has developed a one-year transition and recovery plan.

WHO RESPONSE TO GRADED HEALTH EVENTS

8 Meningitis in Togo

On 15 February 2023, Togo's Ministry of Health declared an outbreak of meningitis (Streptococcus pneumoniae) in Oti South, a district of the Savana region in the northern part of the country.

On 27 March 2023, the outbreak was categorized as a grade-2 event. However, following successful response efforts, the grading was removed on 9 May 2023. The country deployed the in-country SURGE team trained by WHO AFRO as part of its Emergency Preparedness and Response flagship initiative.

WHO AFRO conducted case-management activities, including the provision of antibiotics and surveillance (active case search).

The total number of cases at the end of the outbreak was **141, including 12 deaths, indicating a case fatality rate of 8.5%.**

SPOTLIGHT

MARBURG VIRUS DISEASE OUTBREAK INVESTIGATION AND RESPONSE IN **TANZANIA**

BACKGROUND

An unknown disease was first reported in Tanzania on 16 March 2023, and WHO was notified on 17 March 2023. On 21 March, the disease was confirmed and declared by the Ministry of Health to be Marburg Virus Disease (MVD). This was the first MVD outbreak in the country. It occurred in Maruku Ward, Bukoba District Council in the Kagera region of northern Tanzania. The outbreak was classified as a grade-2 event on 22 March 2023. By the end of the outbreak on 31 May, nine cases had been reported (eight confirmed, one probable) along with six deaths, indicating a case fatality rate of 67%.

ACTIVITIES

An investigation team comprising trained AVoHC-SURGE members was sent to the Kagera region and supported the Bukoba District Council with case investigations, risk assessments, and other aspects of outbreak response. Specimens from deceased and living patients were collected and tested at the pre-deployed mobile laboratory in Kagera region. The specimens were then confirmed to be MVD by RT-PCR tests at the National Public Health Laboratory. Both laboratories tested samples within six hours of receiving them. The risk assessment identified gaps, including insufficient capacity in the affected region and district across most response pillars, especially in coordination, surveillance and early detection, case management, IPC practices, risk communication and community engagement and supplies.

The national and regional PHEOCs were activated and remained operational throughout the response period. The IMS was also activated, with about 30 AVoHC-SURGE team members deployed to respond under all the pillars. A response plan was developed, and daily IMS meetings were conducted at the regional PHEOC. Twice-weekly national IMS coordination and weekly National Task Force (NTF) meetings were also held. Surveillance, contact tracing, and monitoring were conducted in affected communities and in health facilities. A total of 212 people who had been in contact with MVD cases were monitored for 21 days. Marburg Treatment Units were set up in the areas where cases were managed, while PPE was procured and prepositioned both in the affected areas and in neighboring regions and districts. After the Minister of Health declared the outbreak over on 2 June 2023, a three-month national post-MVD recovery plan was developed and implemented.

Results

Early detection and response limited the **MVD outbreak to nine cases and six deaths**.

The effectiveness of the response effort was reflected in the **containment of the outbreak within 90 days**, including the WHO-recommended 42 days (two incubation periods) without a confirmed case.

In addition, Intensive case investigation, contact tracing, infection prevention and control measures along with community engagement halted further spread and community transmission of the MVD was limited to the family members of the index case and two healthcare workers who were infected while providing initial care.

The national capacities developed during **preparedness and readiness against the recent Ebola Virus Disease outbreak in the neighboring Uganda in 2022** was instrumental in enabling the early detection and control of the MVD outbreak.

The **strong commitment and political leadership** provided by the Minister of Health and government officials ensured effective coordination and the timely availability of resources.

SPOTLIGHT

RESPONSE TO THE INFLUX OF INJURED PERSONS INTO CHAD BY EMERGENCY **MEDICAL TEAMS**

BACKGROUND

On 15 April 2023, armed violence broke out in the West Darfur region of Sudan, along with intercommunity clashes. Hundreds of thousands of refugees leaving Sudan continued to arrive in eastern Chad, mostly in Ouadda Province. An estimated 40% of persons displaced from Sudan entered Chad, and by 18 May the total number of recorded arrivals was estimated to be 61,120. The inflow included individuals who had been injured in combat, most of whom were treated in Adré District Hospital, with serious cases being sent to Abeché University Teaching Hospital in the provincial capital.

The number of injured continued to rise until it exceeded the capacity of the available teams, with a peak of 437 patients on 16 June. WHO AFRO received an official request for surgeons from the Ministry of Health.

By 21 July, a total of 2,357 people had been wounded in the conflict. Of these, 0.4% received triage classifications as black (injury resulting in death), 5% red (life-threatening injury), 70% yellow (moderate injury), and 24.6% green (able to walk).Out of the total wounded, 78% were injured by bullets or shells, and 41% had open wounds. 32% of the injured were women, and 11.5% were children under five years.

ACTIVITIES

One week after receiving the Ministry of Health's request for surgeons, an emergency medical team from Togo consisting of one general and vascular surgeon, one plastic surgeon, and one surgical nurse arrived at Abaché University Teaching Hospital and began performing all major surgeries on patients referred from Adré District Hospital.

Results

Following triage at the entry point, wounded patients were referred to Adré District Hospital, with severe cases referred to Abaché University Teaching Hospital, where the emergency medical team performed **a total of 65 life-saving emergency surgeries** between 6 June to 23 July.

These surgeries were performed on patients with injuries that included **abdominal wounds with evisceration, cranioencephalic trauma, post-traumatic dermabrasion, post-traumatic hemothorax, and splenic pedicle resection**. The number of casualties admitted to Abaché University Teaching Hospital began to decline on 16 June.

The rapid deployment of the emergency medical team was critical to the success of the response efforts. The team arrived one week after the request from the Ministry of Health. **Holistic care for catastrophic injuries, which included plastic surgery and physical rehabilitation**, was also a key component of the response.

Operations Support and Logistics

Procurement and Distribution of Supplies and Equipment

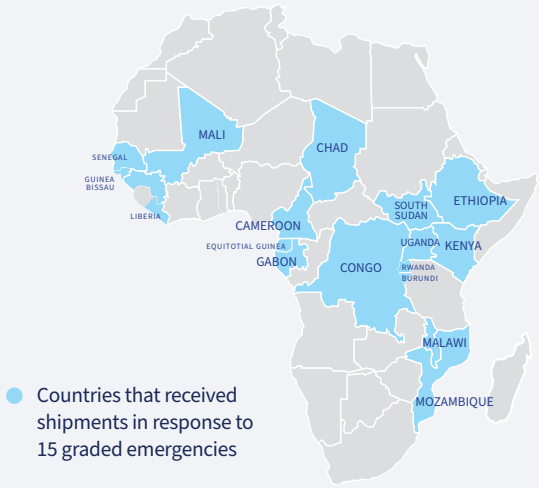
In line with the ERF, WHO AFRO has continued to track and monitor all acute public health events and provide technical and operational oversight to support an effective emergency response at the country level. During the reporting period, **42 shipments were sent to 18 countries in response to 15 graded emergencies. These shipments weighed a combined 120 tonnes and had a total value of just under US$1.19 million.** The largest response operations during the period were mobilized to address outbreaks of cholera, Marburg virus, and COVID-19, as well as the impact of a drought in Kenya, a cyclone in Malawi, the humanitarian crisis in DRC, and the Sudan crisis.

During the second quarter, the Operations Support and Logistics (OSL) team procured and distributed PPE, ringers, trauma kits, and other essential supplies to support WHO AFRO response activities. The team strengthened the capacity of 18 Member States to respond to emergencies by fulfilling stock requirements and expanded the regional stockpile of emergency supplies by procuring over US$1.87 million worth of ringer lactate, oral rehydration salts, multipurpose tents, and other critical items. WHO AFRO continued to identify local and regional sources of supply during the period.

Support for Emergency-Response Efforts

In Equatorial Guinea, WHO AFRO played a key role in addressing the outbreak of Marburg virus. WHO AFRO facilitated 16 cargo shipments (87 cubic meters weighing 13 tonnes) to combat the Marburg outbreak. The team established a Marburg Treatment Center in Mondong Hospital, distributed Marburg-related supplies to the Ministry of Health and created a new system to manage internal requests for local procurement. A national consultant was trained to act as a storekeeper and logistics focal point, and this consultant continues to work with WHO in Guinea.

To ensure accountability, OSL conducted a complete inventory of all Marburg-related supplies procured during the reporting period.



WHO AFRO continued to support efforts to combat the ongoing COVID-19 pandemic in multiple countries. During the second quarter, a total of 5,615 kg of rapid diagnostic tests (RDTs), oxygen cylinders, biomedical equipment, and other COVID-related supplies were shipped to The Gambia, Libera, Republic of the Congo, and Guinea-Bissau.

Responding to the multicountry cholera outbreak continues to require extensive logistical support. Operational readiness activities were undertaken in 15 countries at risk of cholera outbreaks in line with an updated list of activities provided by Concept of Operations. In Cameroon, WHO AFRO completed a quantitative analysis of cholera-related needs and prepared a new request for supplies following a renewed surge in reported cases.

WHO AFRO shipped **13 tonnes of cholera kits and ringers** to Ethiopia

500 cholera RDTs and **three cholera investigation kits** shipped to Burundi

WHO AFRO also distributed **6,400 cholera RDTs in Kenya and 10 metric tonnes (Tm) of cholera kits**, visibility materials, and WASH supplies

WHO AFRO shipped **cholera kits and 32,000 liters of ringers** to Eswatini

The team improved water-quality testing and Cholera Treatment Center infrastructure in cholera hotspots, established a water-quality database both at the WHO country office and at the Ministry of Water and Sanitation

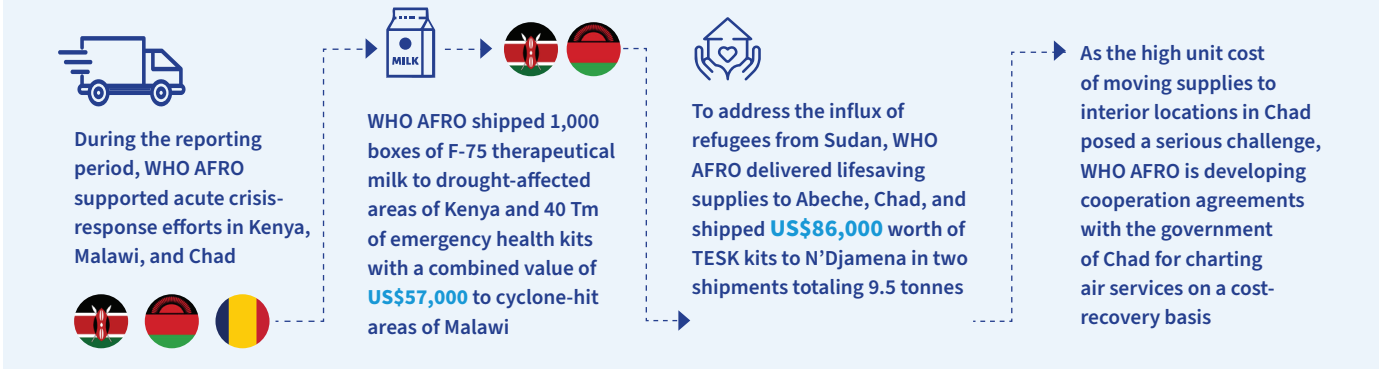
During the period, WHO AFRO shipped 13 tons of cholera kits and ringers to Ethiopia, 500 cholera RDTs and three cholera investigation kits to Burundi, and nine cholera kits and 32,000 liters of ringers to Eswatini. WHO AFRO also distributed 6,400 cholera RDTs in Kenya and 10 metric tonnes (Tm) of cholera kits, visibility materials, and WASH supplies.

The cholera response in Malawi required especially intense support, due in part to the concurrent impact of the cyclone and associated flooding. To reduce morbidity and mortality, WHO AFRO provided technical guidance and support to scale up WASH and health-logistics activities, conducted WASH assessments in cholera-treatment centers, supported the Infection Prevention and Control (IPC) team's efforts to build the capacity of health-surveillance officers to treat household water and conduct basic water-quality tests. WHO AFRO provided technical support for the establishment of the Lumbazi Cholera treatment center, improved the management of healthcare waste in cholera treatment centers, and oversaw the decommissioning of obsolete cholera treatment centers and the redistribution of usable assets.

WHO AFRO also worked to strengthen collaboration on WASH activities between WHO, UNICEF, the CDC, and Malawi's Ministry of Water and Sanitation. The team improved water-quality testing and Cholera Treatment Center infrastructure in cholera hotspots, established a water-quality database both at the WHO country office and at the Ministry of Water and Sanitation, and performed WASH assessments at camps around Blantyre hosting persons displaced by the cyclone. During the second quarter, over 100 healthcare workers were trained in WASH and IPC techniques, and WHO AFRO facilitated training sessions on the World Food Programme's Health Supply Chain Simulation Exercise (SimEx).

WHO AFRO continues to support efforts to strengthen health-system resilience in fragile and conflict-affected settings. Between May 27 and June 10, OSL deployed a civil engineer to assist the WHO Country Office in DRC to prepare technical specifications and bidding documents for the construction of five three-bed triage units in the provinces of North Kivu, South Kivu, Kinshasa, Kongo Central, and Lualaba, as well as 16 one-bed triage units in the provinces of Mai-Ndombe, Tshuapa, Mongala, and Sud-Ubangi. The engineer supported the procurement team in evaluating bids and the WHO AFRO in supervising the construction of the three-bed triage units. Successful bidders have been identified for the one-bed triage units, and construction is expected to begin.

Figure 3: Support for Acute Crisis-Response to Kenya, Malawi, and Chad



Support for PHEOC operationalization and capacity strengthening

WHO AFRO remains instrumental to the operationalization of the PHEOCs. During Q2, WHO AFRO ensured that there was availability of the tools and equipment necessary to conduct a simulation exercise under the SURGE flagship, and it procured and delivered eight vehicles for EPR activities. In collaboration with key partners, WHO AFRO developed standard operating procedures (SOPs) for managing surge staff.

On May 2-14 2023, WHO AFRO and its partners successfully organized a third regional TOT in Seychelles, which included in-person and online course components focused on PHEOCs and incident management systems. WHO AFRO provided support to South Africa, Madagascar, Republic of the Congo, DRC, Equatorial Guinea, and Niger in operationalizing and strengthening their PHEOCs. This support included guidance provided through briefing calls with the WHO Country Office, investments in physical and digital infrastructure, missions conducted to evaluate implementation progress, the development of PHEOC documents, and the provision of basic and advanced training on PHEOCs and the IMS.

As a component of WHO AFRO's EOC-Net initiative, an online platform has been developed to foster collaboration, communication, and information exchange among public health professionals in the Africa region. The software is currently undergoing testing by other partners. A collection of guides and SOPs for Member States has also been prepared, which includes:

1. a handbook for PHEOC watch teams,
2. a PHEOC BCP Handbook for Member States,
3. SOPs for logistics and finance management,
4. coordination and communication SOPs for incident management, and
5. SOPs for PHEOC activation and deactivation. With multiple health emergencies increasing demand for supplies, OSL is leveraging trend analysis to predict and proactively stock the type of supplies that are most likely to be needed.

Operations Support and Logistics Achievements

THIRTEEN TONNES OF CHOLERA KITS AND RINGERS WERE SHIPPED TO ETHIOPIA, 500 CHOLERA RDTS AND THREE CHOLERA INVESTIGATION KITS TO BURUNDI, AND CHOLERA KITS AND 32,000 LITERS OF RINGERS TO ESWATINI. 6,400 CHOLERA RDTS WERE DISTRIBUTED IN KENYA ALONG WITH 10 TM OF CHOLERA KITS, VISIBILITY MATERIALS, AND WASH SUPPLIES

WHO AFRO expanded the regional stockpile of emergency supplies by procuring over **US$1.87 million** worth of ringer lactate, oral rehydration salts, multipurpose tents, and other critical items

Forty-two shipments were sent to 18 countries in response to 15 graded emergencies. These shipments weighed a combined 120 tonnes and had a total value of just under US$1.19 million

To address the influx of refugees from Sudan, lifesaving supplies were delivered to Abeche, Chad, and US$86,000 worth of TESK kits shipped to N'Djamena in two shipments totaling 9.5 tonnes

WHO AFRO shipped 1,000 boxes of F-75 therapeutical milk to drought-affected areas of Kenya and 40 Tm of emergency health kits with a combined value of US$57,000 to cyclone-hit areas of Malawi

Altogether 5,615 Kg of COVID supplies (RDT, oxygen cylinders, biomed supplies) to Gambia, Libera, Congo Brazza and Guinea Bissau

Emergency Detection

During Q2, WHO AFRO detected 21 new public health events and reported them to WHO. Of the 49 health events reported in the region during the first half of the year, 58% were detected within seven days of onset.

Between 1 April and 30 June, the EPR team conducted six Rapid Risk Assessments (RRAs) for disease outbreaks that require a WHO response under the Emergency Response Framework (ERF). A total of 19 RRAs were conducted during the first half of the year, including 13 national-level assessments. Of the 13 RRAs at the national level, four outbreaks were rated "very high risk": MVD in Equatorial Guinea and Tanzania and cholera in Kenya and Mozambique. The other nine outbreaks were rated "high risk."

To strengthen emergency-detection capacity, WHO AFRO continues to support the implementation of the Integrated Disease Surveillance and Response (IDSR) technical guidelines by Member States. During the second quarter, South Africa and Mauritius adopted the 3rd edition of the IDSR technical guidelines. In addition, 10 Member States[7] held national-level training-of-trainers (TOT) workshops on the IDSR , while six Member States[8] cascaded IDSR training at the subnational level.

In Q2, WHO AFRO conducted the third webinar in the TASS-IDSR webinar series, which was designed to inform and engage with key stakeholders on issues around IDSR implementation. The third webinar, conducted on 10 May 2023, focused on introducing the WHO AFRO centralized IDSR regional data platform to Member States and stakeholders. The IDSR data platform was developed at the request of Member States expressed during the first webinar and at the regional consultative meetings. During the webinar, participants were familiarized with the new tool, gained hands-on experience, and provided feedback and input on the platform. By June 2023, WHO AFRO had onboarded 28 countries and supported the development of TASS-IDSR Acceleration workplans based on key priorities identified by the national authorities to address major gaps in country-level surveillance systems. A total of US$14,783,860 was disbursed to the targeted countries as a first tranche of financial assistance.

WHO AFRO supported the South African National Department of Health (NDoH) to conduct a country-wide baseline assessment of the surveillance system in May-June 2023. The baseline assessment aimed to ascertain the structure, capacity, resources, and performance of the existing IDSR system and make recommendations for improving it in line with the IDSR strategy. An assessment protocol was developed, and desk reviews of related policy documents, reports, guidelines, and other relevant materials were undertaken. Structured data-collection tools were developed, pretested, updated, and uploaded onto a cloud database; data was collected and analysed; and findings were summarized in a report.

7 Central African Republic, Republic of the Congo, Côte d'Ivoire, The Gambia, Kenya, Madagascar, Mali, Niger, South Africa, and Togo

8 Botswana, Republic of the Congo, Kenya, Madagascar, Niger, and Togo

A total of 658 respondents (27 national and provincial officials, 41 district officials, 142 health facility staff, and 448 community health workers) participated in the baseline assessment. As a follow-up action, the NDoH, with technical and financial support from WHO, conducted an IDSR Action Planning workshop during 8-12 May 2023 in Johannesburg. The workshop's main goal was to develop a strategic framework for strengthening the national IDSR system based on the findings of the baselines assessment. The workshop was attended by 88 participants from the NDoH Departments of Epidemiology and Surveillance; Communicable Diseases Control; Health Information and M&E; and Malaria, Tuberculosis, HIV/AIDS, and Sexually Transmitted Infections; as well as the Expanded Program on Immunization. In addition, representatives from the National Institute for Communicable Diseases, South Africa Medical Research Council, the South Africa Health Products Regulatory Authority, and Statistics South Africa also attended the workshop.

To achieve the objectives of the TASS initiative, WHO AFRO extended financial support to 28 Member States[9]. By the end of Q2, 16 of the participating countries (61.5% of the total) had submitted their financial reports. These reports indicated expenditures totaling US$4,715,743, which corresponds to approximately 32% of the funds allocated to these countries.

Emergency Detection Achievements

DIAGNOSTIC AND GENOMIC-SEQUENCING capacities were strengthened in seven countries

SIX RAPID RISK ASSESSMENTS (RRAS) were conducted for disease outbreaks that require a WHO response under the ERF

SOUTH AFRICA AND MAURITIUS adopted the **3rd edition of the IDSR**

58% of the **49 health events reported in the region during the first half of the year were detected within seven days of onset**

A TOTAL OF 40,537 assorted IDSR materials and primary tools were reproduced in seven countries

Key advocacy activities were undertaken by five countries

A centralized IDSR data management platform (DHIS2) was developed

TEN MEMBER STATES HELD NATIONAL-LEVEL TOT WORKSHOPS ON THE IDSR, WITH **1,010 TRAINERS TRAINED**

MEMBER STATES cascaded IDSR training at the subnational level, with **3,717 HEALTH WORKERS TRAINED**

9 Botswana, Central African Republic, Chad, Republic of Congo, Kenya, Mauritania, Niger, Togo, Madagascar, Uganda, Nigeria, DRC, Senegal, Côte d'Ivoire, Tanzania, Mozambique, Ghana, Malawi, Cameroon, The Gambia, Namibia, Mali, South Africa, Angola, Ethiopia, Guinea, Rwanda, and Lesotho

Emergency Preparedness

Risk Communication and Community Engagement (RCCE)

During Q2, WHO AFRO continued to strengthen emergency preparedness among Member States by working with selected countries to build their RCCE capacity. In Benin, Côte d'Ivoire, and Mauritania, 237 trainers were provided training on RCCE and its role in EPR, these included central government officials, district leaders, mayors, prefects, and other political and administrative authorities. RCCE training was also provided to participants in national and regional One Health platforms. In Benin, an advocacy campaign aimed at strengthening RCCE in EPR systems reached 29 high-level political authorities, and local WHO Country Office capabilities have been reinforced to allow for effective follow-up and to support similar advocacy efforts in the future. To ensure that Member States effectively consolidate the knowledge and recommendations imparted through RCCE training, the EPR team will hold monthly meetings with national health officials to review key messages and assess progress.

Epidemic and Pandemic Prevention

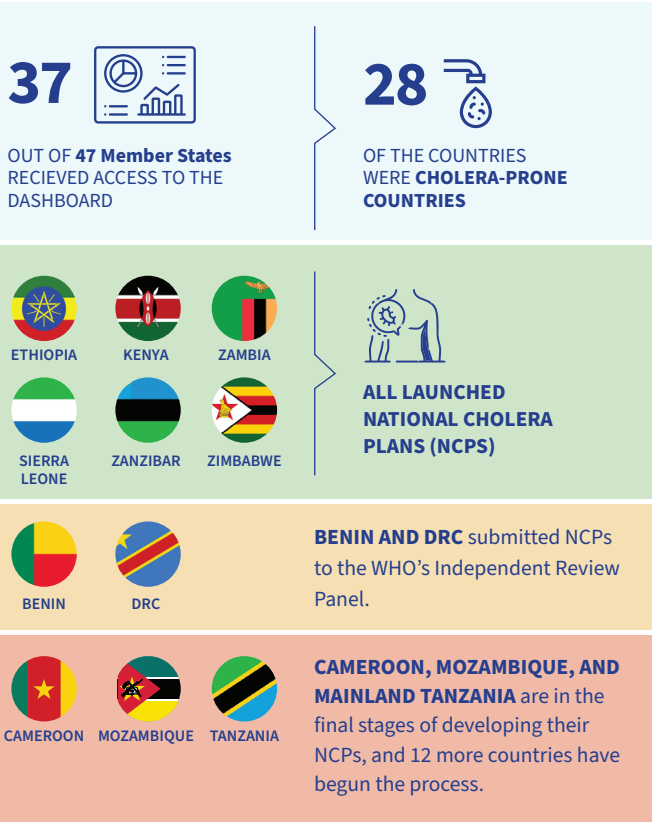
WHO AFRO continues to use research, predictive modelling, and innovative intervention strategies to address priority health hazards.

To help formulate its research objectives for health emergencies, WHO AFRO held a webinar at which over 200 participants reviewed and validated the outcome of the consultation meeting held in October 2022. Cholera has been identified as an especially high-risk pathogen, particularly in the context of the multiple humanitarian crises now unfolding in Sub-Saharan Africa, and during the second quarter the EPR team developed a new protocol for estimating the cost of cholera control. WHO AFRO also supported an in-depth epidemiological and anthropological investigation into an outbreak of botulism in Kpo-Kahankro in Côte d'Ivoire's Bouake District. Given the sensitive context in which WHO AFRO operates, the EPR team developed a methodology for assessing gaps in ethical capacity in the region and worked closely with partners to deploy a new qualitative research protocol for identifying ethical issues in Equatorial Guinea during the recent Marburg virus outbreak response. WHO AFRO also developed a methodology for administering Knowledge, Attitude and Practice surveys to healthcare workers during a preventative vaccination campaign for Ebola virus and developed a research protocol for assessing the effectiveness of Ebola vaccines in DRC.

Implementing proven prevention strategies for the pandemic- and epidemic-prone diseases remains a key priority and in the second quarter WHO AFRO helped Member States develop implementation plans for the regional frameworks to defeat meningitis in Africa by 2030. To assist 15 priority countries[10] in developing their national plans to defeat meningitis by 2030, the EPR team held an in-person workshop in Brazzaville, Republic of the Congo, during June 12-15. WHO AFRO also directly supported meningitis response efforts in Niger, Nigeria, and Togo and helped introduce the meningitis A conjugate vaccine (MenAfriVac) into the national routine immunization schedule in Guinea-Bissau, bringing to 15 the number of countries that include MenAfriVac in their routine immunization schedules. To guard against future outbreaks, WHO AFRO strengthened laboratory capacity for meningitis testing through the procurement and distribution of sample-collection and transportation materials, reagents, and other supplies in four high-risk countries: Chad, DRC, Nigeria, and Togo. Lack of funding is the most critical obstacle to the finalization of country-level plans to defeat meningitis by 2030, and the EPR cluster leadership and international partners are mobilizing additional funding.

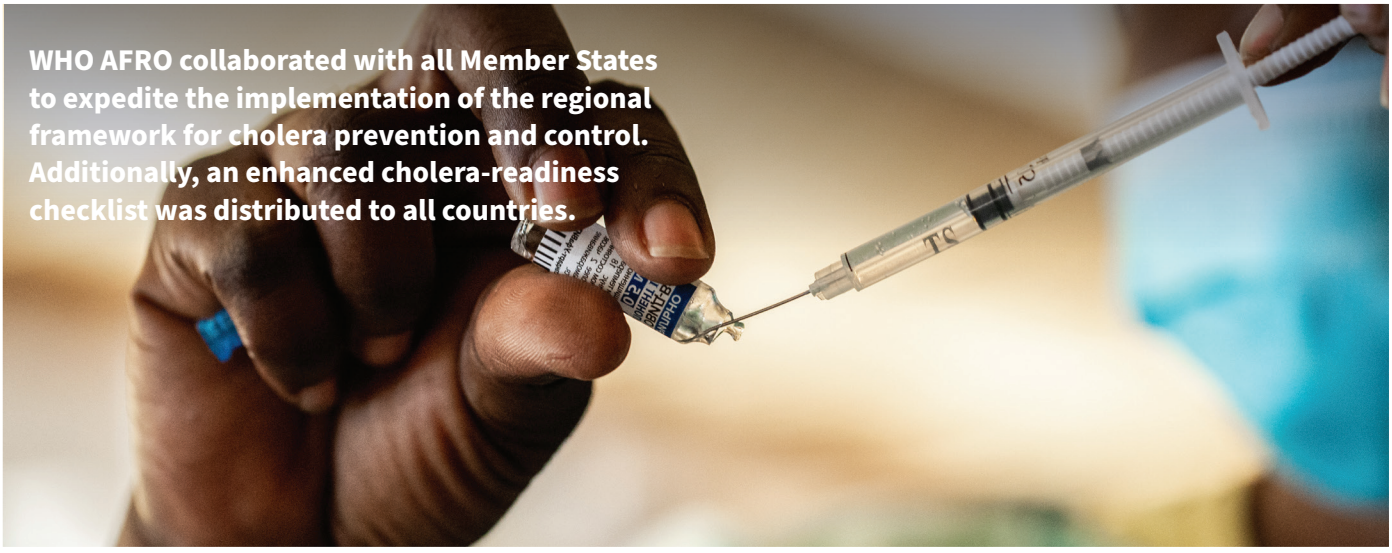
Mitigating the risks posed by high-threat diseases requires building national capacity to generate real-time information and communicate targeted messages. In Equatorial Guinea WHO AFRO supported the creation of an RCCE management system during the Marburg outbreak while working closely with partners to enhance planning, leverage technical expertise, develop guidelines and messages, coordinate interventions, compile, and disseminate knowledge, and manage human resources. These efforts enabled the EPR team to produce a set of key messages and RCCE materials to inform and engage communities in Equatorial Guinea during the Marburg outbreak response. Based on this experience, WHO AFRO supported health authorities in Cameroon and Gabon in producing key information and messages designed to prevent the spread of Murine Hepatitis Virus.

Cholera prevention and control remains a key priority in Sub-Saharan Africa. WHO AFRO developed a dashboard to track progress on the implementation of the regional framework for cholera prevention and control.



WHO AFRO continued to work with all Member States to accelerate the implementation of the framework, and an updated cholera-readiness checklist was shared with all countries.

Coordinated cholera risk assessments were completed in Togo, Benin, Burkina Faso, Mali, Niger, and Chad. These assessments included reviews of hotspots and the Strategic Tool for Assessing Risks (STAR) results. The EPR team provided technical support and supervision for the assessment process, and guidance to inform the development of NCPs.



10 Burundi, Republic of the Congo, Côte d'Ivoire, The Gambia, Guinea, Guinea-Bissau, Liberia, Madagascar, Malawi, Mali, Namibia, Senegal, Sierra Leone, Tanzania, and Uganda

Health authorities in Malawi and South Africa received assistance in hotspot mapping using the Priority Areas for Multisectoral Interventions (PAMI) methodology. Both countries have demonstrated a commitment to developing effective long-term NCPs and are in the process of engaging the Global Task Force on Cholera Control. WHO AFRO supported South Africa in developing plan, budget, and agenda for strengthening cholera preparedness, and capacity-building activities are planned for all nine provinces during July and August 2023.

Mitigating the Risk of the Emergence and Reemergence of High-Threat Pathogens

Community engagement is vital to effective disease surveillance and response efforts. During Q2, WHO AFRO developed a regional strategy for empowering communities to recognize risks to public health and wellbeing, participate in development initiatives, strengthen primary healthcare, and help mitigate the risks and consequences of public health events. A complete draft of the Community Engagement Regional Strategy was finalized and submitted to the AFRO Peer Review Group along with a resolution for its adoption.

WHO AFRO continues to support the efforts of Member States to strengthen their capacity to mitigate the risk of emerging and re-emerging high-threat pathogens. Because over 70% of high-threat pathogens are known to be zoonotic, WHO AFRO works with regional and global technical and financial partners to improve joint preparedness and response to health threats at the human-animal-environment interface. In collaboration with the Human-Animal Interface Unit of the Health Security Preparedness Department at WHO HQ and regional partners, WHO AFRO continues to support national catalysts recruited to facilitate the implementation of National Bridging Workshops (NBWs) and promote the use of operational tools and approaches to strengthen One Health systems at the country level.

Under a US-funded project, Cameroon, Guinea, Kenya, Liberia, Nigeria, Sierra Leone, and Tanzania have received support to strengthen the implementation of the 2005 International Health Regulations (IHR). WHO AFRO is working to improve coordination and collaboration to operationalize the multisectoral One Health approach for complex health threats. Ethiopia, Uganda, and Senegal are currently benefiting the technical and financial support under the NBW program.

WHO AFRO and its partners continue to operationalize the One Health approach in evaluating country-level capacity to implement the 2005 IHR. The results of the Joint External Evaluation and other assessment tools are used during the NBWs to improve the effectiveness of interventions at the human-animal interface. NBWs coordinated by WHO, the World Organization for Animal Health, and the UN Food and Agriculture Organization have been conducted in Togo, Central African Republic, and South Africa. The NBWs allow national experts from human, animal and environmental health sectors and relevant disciplines to jointly review synergies and gaps in the coordination and collaboration mechanism to swiftly detect, prevent, and control zoonotic diseases and other threats to health security occurring at the human-animal-environment interface.

In addition, other One Health operational tools have been used to support joint preparedness and response to zoonotic disease threats in Guinea, Sierra Leone, Liberia, Ethiopia, Nigeria, and The Gambia. A ToT workshop on joint risk assessments was conducted in The Gambia to evaluate capacity gaps in the management of highly pathogenic avian influenza (H5N1) and other zoonoses. The health authorities in Guinea were supported to decentralize and operationalize the One Health platforms, and national experts were trained to conduct joint risk assessments at the subnational level.

Like other WHO Regional Offices, WHO AFRO has been contributing to the development and implementation of the One Health Joint Plan of Action (OH JPA), which was launched globally in October 2022. WHO and its partners have developed the OH JPA implementation guide, which will be released by the end of the year. In Q2, representatives from 25 countries were briefed on how to use the existing One Health operational framework and tools to counter antimicrobial resistance at all levels of the health system.

During Q2 WHO AFRO supported health officials in Togo and Central African Republic as they conducted NBWs to identify strengths and weaknesses in multisectoral collaboration around the management and control of zoonotic disease outbreaks. At each workshop, an average of 80 national human, animal, and environmental health experts from the central, regional, and district levels were trained to develop a joint roadmap of activities to improve collaboration. In addition, a workshop was organized in Ethiopia to pilot the Response Preparedness and Workforce Development operational tools, which are designed to help manage health risks by building capacity for collaboration, coordination, and communication.

WHO AFRO continues to support targeted efforts to address priority infectious diseases. Given the especially severe threat posed by cholera, WHO AFRO is working with Member States to develop multiyear action plans for administering oral cholera vaccines. Two such plans were developed during the period and reviewed for Gavi Independent Review Committee submission. In addition, the EPR team and national health authorities in DRC conducted a joint mpox risk assessment and formulated a set of strategic risk-mitigation and risk-management measures.

The One Health Implementation Roadmap

During Q2, WHO AFRO supported the development of the One Health Implementation Roadmap for capacity building for complex problem-solving including zoonotic disease risk and impact management. Training on the One Health Scorecard Curriculum (Figure 4) is slated to start in early December 2023.

Figure 4: One Health Scorecard Curriculum

One Health Scorecard **12 Week Curriculum**

Module I: Natural Science; Ecology, Ecosystems and Complexity	Module II: Social Ecology; SES, Communities and Transdisciplinarity	Module III: Adaptive Management; Learning, Organizations and Sustainability
Week 1 — Unit 1 Systems Ecology	Week 5 — Unit 5 Social-ecological Systems	Week 9 — Unit 9 Adaptive Management and Interventions
Week 2 — Unit 2 Population Ecology	Week 6 — Unit 6 Transdisciplinarity	Week 10 — Unit 10 Learning and Capacity Building
Week 3 — Unit 3 Community Ecology	Week 7 — Unit 7 Community Engagement	Week 11 — Unit 11 Adaptive One Health Organizations
Week 4 — Unit 4 Landscape Ecology	Week 8 — Unit 8 Tools and Protocols	Week 12 — Unit 12 Scorecards for sustainable Development

The full One Health Scorecard Curriculum can be accessed at:
https://onehealthscorecard.org/one-health-scorecard-curriculum/

Emergency Preparedness Achievements

237 TRAINERS

including central government officials, district leaders, mayors, prefects, and other political and administrative authorities **were trained on** RCCE and its role in EPR

A Dashboard to track progress on the implementation of the regional framework for cholera prevention and control was developed and shared with **37 Member States, of which 28 are cholera-prone countries**

RCCE for EPR advocacy efforts reached

29

political authorities

IN BENIN

15 PRIORITY COUNTRIES

were **supported to develop their national plans to defeat meningitis by 2030**

25 COUNTRY REPRESENTATIVES

were briefed on how to use the **One Health operational framework and tools to counter antimicrobial resistance** (AMR) at all levels of the health system

10

COUNTRIES

were supported in implementing the One Health strategy through the **National Bridging Workshop (NBW) programme**

World Health Organization