

# **The work of WHO on Emergencies in the African Region**



**2010 Annual Report**



**World Health  
Organization**

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“In accordance with WHO’s mandate, vision and core functions, I have pledged to continue to focus on WHO’s leadership role in the provision of normative and policy guidance; strengthening of partnerships and harmonization of support to countries; supporting health systems strengthening based on the primary health care approach.....and accelerating response to the determinants of health”.

Dr. Luis G. Sambo

Regional Director

WHO Regional Office for Africa

Excerpted from “Achieving Sustainable Health Development in the African Region Strategic Directions for WHO 2010 - 2015”.

II II



## Acknowledgments

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Special thanks to Ms. Pauline Loyce Ajello for the editorial work, design and layout.

## List of Abbreviations

AFRO	African Regional Office
ADB	African Development Bank
APDA	Afar Pastoralist Development Association
AU	African Union
AWD	Acute Watery Diarrhoea
C4	Cholera Command and Control
CA	Central Africa
CAR	Central African Republic
CAP	Consolidated Appeal Process
CDC	Centre for Disease Control
CDS	Communicable Disease Surveillance
CERF	Central Emergency Response Fund
CFR	Case Fatality Rate
CHAP	Common Humanitarian Action Plan
CHDC	Community Health Development Committees
CMO	Chief Medical Officer
CRRTs	Country Rapid Response Teams
CVC	Core Voluntary Contribution
DHOs	District Health Officers
DHS	Demographic and Household Survey
DoH	Department of Health
DRC	Democratic Republic of Congo
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
ECHO	European Commission Humanitarian Aid
EHA	Emergency and Humanitarian Action
EHK	Emergency Health Kits
EHOs	Environmental Health Officers
EmONC	Emergency Obstetric and Newborn Care
EP	Emergency Preparedness
EPR	Emergency Preparedness and Response
ESA	Eastern and Southern Africa
GAM	Global Acute Malnutrition
GoU	Government of Uganda
HCCs	Health Cluster Coordinators
HELP	Health Emergency in Large Population
HERU	Health Emergency Response Unit
HCT	Humanitarian Country Team
HFA	Hyogo Framework for Action
HQ	WHO Headquarter
HMIS	Health Management Information System
IDPs	Internally Displaced Persons
IDSR	Integrated Disease Surveillance and Response
IFRC	International Federation of Red Cross and Red Crescent

abbreviations

## List of Abbreviations

IRC	International Rescue Committee
ISDR	International Strategy for Disaster Risk Reduction
ISTs	Inter Country Support Team
HCC	Health Cluster Coordinators
MAM	Moderate Acute Malnutrition
MoH	Ministry of Health
MoHCW	Ministry of Health and Child Welfare
MSF	Medicin Sans Fronteirs
ULO	Unliquidated Obligations
NDPMP	National Disaster Preparedness and Management Policy
NGO	Non-Governmental Organization
NIDs	National Immunization Days
NMRL	National Microbiology Reference Laboratory
OCR	Outbreak and Crisis Response
PHE	Protection of the Humanitarian Environment
PHCE	Public Health in Complex Emergency
PPE	Personal Protective Equipment
PRDP	Peace, Recovery and Development Plan
PRSP	Poverty Reduction Strategy Paper
RDTs	Regional Directors Teams
RRT	Rapid Response Teams
RIACSO	Regional Inter Agency Coordination Support Office
RHPT	Regional Humanitarian Partnership Team
SA	Southern Africa
SAM	Severe Acute Malnutrition
SEA	Southern and Eastern Africa
SHOC	Strategic Health Operations Centre
SIA	Supplementary Immunization Activities
SNNP	Southern Nations, Nationalities and People
TFU	Therapeutic Feeding Units
UN	United Nations
UNAIDS	United Nations Acquired Immune Deficiency Syndrome
UNDP	United Nations Development Program
UNICEF	United Nations International Children and Education Fund
UNISDR	United Nations International Strategy for Disaster Risk Reduction
UNOCHA	United Nations Office for Coordination of Humanitarian Affairs
VC	Voluntary Contributions
VHTs	Village Health Teams
VHWs	Village Health Workers
VRAM	Vulnerability and Risk Analysis and Mapping
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
WMC	WHO Mediterranean Centre

abbreviations

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# Executive Summary

Natural disasters and social unrests continue to cause displacements in many countries of the WHO African Region. In 2009 alone, over 6.9 million people were displaced among which were 4.9 million internally displaced persons and about 2 million refugees. Impact of climate change is leading to increasing droughts with its attendant food crises and malnutrition. Similarly, thousands of people are affected by floods and cyclones annually causing deaths and destruction of farmlands as well as housing and social infrastructure including health facilities. All these have direct and indirect impact on disease burden and health care delivery, thus negatively affecting the attainment of MDGs.

In support of the Member States, Guidelines for Disaster Risk Reduction and Emergency Preparedness have been drafted through global and regional consultations with partners. Hazards maps for all the countries in the region have been developed with the technical assistance of WHO Mediterranean Center on DRR. A task force has been commissioned to produce curricula and training modules for emergency preparedness and response in the Africa region.

Regional surge capacity is operational with a roster of trained emergency experts and rapid supply of logistics from sub-regional hubs. Almost all countries in the Region responded to emergencies in 2010 including floods, mud slides, food crisis, conflicts and disease outbreaks. The time used to deliver emergency health kits to countries affected by emergencies has greatly reduced from several months to just about one week showing overall increased efficiency in emergency operations. Coordinated technical support was provided to achieve communicable disease control including early warning and surveillance in 100% of conflicts and natural disasters.

The WHO is leading response and recovery activities in countries through health cluster/health sector coordination with strong inter-sectoral collaboration. Partnerships have been strengthened with various agencies at regional, sub-regional and country levels. The performance of the Region in the utilization of available emergency funds improved significantly in 2010.

summary



# 1. Emergency in the WHO African Region



*During times of disasters, women and children suffer the most: Women and children in Mozambique fleeing from their homes that were destroyed by floods. Mozambique is Susceptible to Annual flooding. Photo credit: WHO*

Natural disasters and social unrests continue to cause displacements in many countries of the WHO African Region. In 2009 alone, over 6.9 million people were displaced among which were 4.9 million IDPs and about 2 million refugees. In addition, countries of the African region of WHO were hosting over 2.15 million refugees, most of them from outside the region.

West Africa is witnessing an increase of natural disasters in addition to conflicts and communicable disease outbreaks. Over 10 million people were affected by drought due to poor 2009/2010 rainy season in the Sahel, causing food crises and malnutrition. At the same time, floods affected 1.45 million in the sub-region.

Floods and cyclones from the El-Nino phenomenon cause destruction in Southern Africa annually. By the end of the flooding season

in 2010, floods have affected over 368,000 people in southern African countries, displaced about 29,000 and destroyed 2 medical facilities in Angola, damaged 34 in Madagascar and made 4 inaccessible in Namibia.

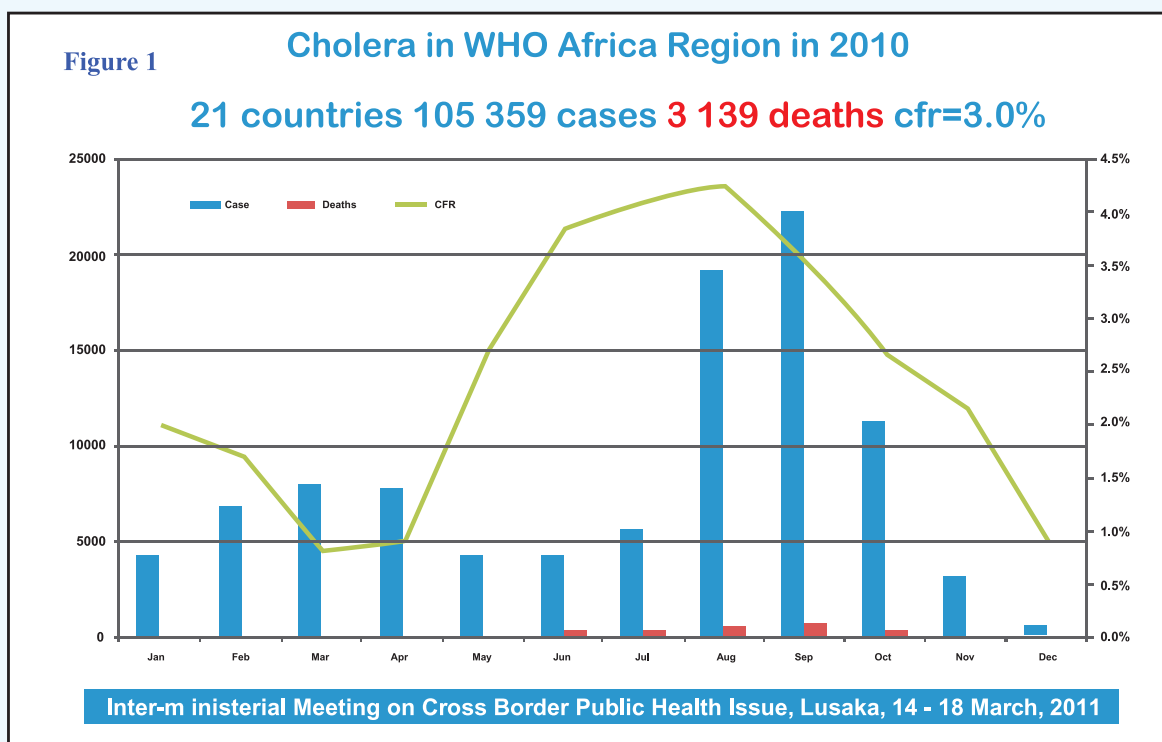
Some central African countries are still recovering from complex emergencies which caused internal and external displacements. Attacks by the armed groups caused new displacements often marked by Gender Based violence.



The EHA program supports the unit of Epidemic Alert and response (EPR) in coordination and resources mobilization for the control of disease outbreaks. In 2010, several countries reported outbreaks of cholera, meningitis, measles, yellow fever and viral hemorrhagic fevers. Meningitis was reported by 30 of the 46 countries in the region, reporting a cumulative of over 29,000 cases with more than 3,000 deaths. Similarly, in the same year over 100,000 cases of cholera with more than 3,000 deaths were reported from 21 countries. The graph below shows the number of cholera cases and death reported from countries in the African Region in 2010.



In 2010, many countries in the African Region faced epidemics like cholera. WHO supported countries to respond to these epidemics Above a patient receives treatment from CTC centre supported by WHO in Zambia. Photo credit: WHO



## Emergency Profile in the WHO African Region in 2010

**Table 1**

Countries affected	Natural disasters	Socio-political crisis	Outbreaks	Multiple Emergencies
1 Algeria	1 Benin	1 Algeria	1 Angola	1 Central African Republic
2 Angola	2 Angola	2 Central African Republic	2 Cameroun	2 Chad
3 Benin	3 Burkina Faso	3 Chad	3 Central African Republic	3 Lesotho
4 Burkina Faso	4 Burundi	4 Cote'Ivoire	4 Chad	4 Nigeria
5 Burundi	5 Burundi	5 DRC	5 Congo	5 Uganda
6 Cameroun	6 DRC		6 DRC	
7 Cape verde	7 Ethiopia		7 Ethiopia	
8 Central African Republic	8 Guinea		8 Guinea	
9 Chad	9 Madagascar		9 Kenya	
10 Comoros	10 Niger		10 Lesotho	
11 Congo	11 Togo		11 Liberia	
12 Coted'Ivoire	12 Uganda		12 Mauritania	
13 DRC	13 Zambia		13 Mozambique	
14 Eritrea			14 Niger	
15 Ethiopia			15 Nigeria	
16 Gambia			16 Senegal	
17 Guinea			17 Siera Leone	
18 Ghana			18 Zimbabwe	
19 Kenya				
20 Lesotho				
21 Liberia				
22 Madagascar				
23 Mauritania				
24 Mozambique				
25 Namibia				
26 Niger				
27 Nigeria				
28 Senegal				
29 Siera Leone				
30 Togo				
31 Uganda				
32 Zambia				
33 Zimbabwe				

# 1.0 Natural disaster by sub region

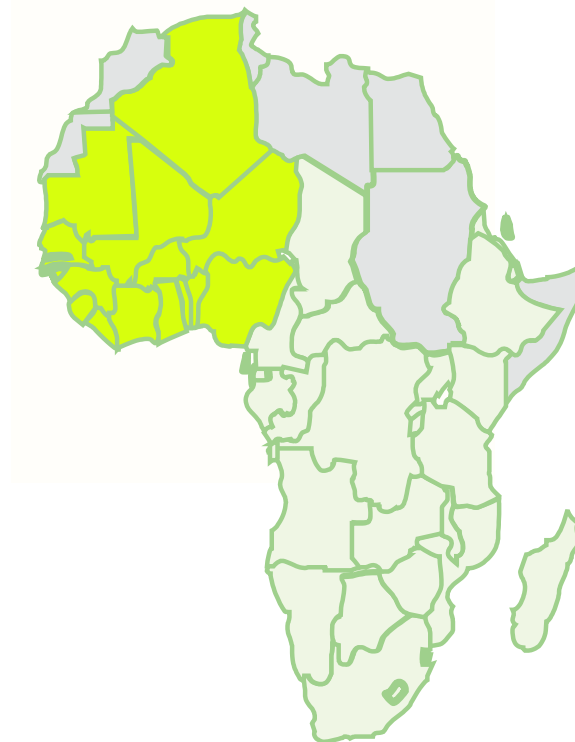
## 1.0.1 In West Africa

In West African sub-region, about 300 million people are subject to increasing and frequent emergency situations every year. In 2010, 9 countries reported natural disasters in West Africa mostly floods and drought. These emergencies disrupted the delivery of social and economic services like health, education, agricultures and trade. They also caused humanitarian crises to the communities.

During the year, the sub region faced a severe drought leading to high rates of malnutrition among the under five children, and affecting more than 10 million other people. More than one million people in the sub region were affected by floods with Niger being most hit with 252, 936 people from 465 communities and villages being affected. Other countries that were affected by the floods include: Benin (680,000 people affected, 8000 displaced and 46 deaths); Burkina Faso (105,000 people affected); Gambia (21,194 people affected) and Ghana that reported 52 deaths. Togo, Mauritania, Côte d'Ivoire and Senegal also reported floods.

During the year, the Zamfara state in Nigeria experienced an environmental disaster of chemical intoxication in which more than 2,000 children were poisoned by lead and 400 deaths recorded. In Niger, food and nutritional crisis arising from drop in crop production due to poor rainfall cycles led to a high rate of malnutrition among children.

The nutrition surveys conducted in 2010 revealed a global acute malnutrition (GAM) rate of 16.7 % in the country which is much higher than in 2009 (12.3%), and



a severe acute malnutrition (SAM) rate of 3.2%. In 2010, health facilities reported 533,811 cases of global acute malnutrition (GAM), 259,136 cases of moderate acute malnutrition (MAM) and 274,675 cases of severe acute malnutrition (SAM) in the country.

The EHA IST and WHO country teams supported countries and partners in the region with useful information on pre-existing risks and capacities to guide their interventions on natural disasters. In addition the EHA IST and country teams gave technical and financial support for the development of Country Emergency Preparedness and Response plans and the establishment of the Country Rapid Response Teams (CRRTs).



Participants in a meeting to develop flood action plans for the flood prone countries of Southern Africa. This meeting was held in Gaborone in Botswana. Photo credit: WHO 2010

## 1.0.2 Eastern and Southern Africa

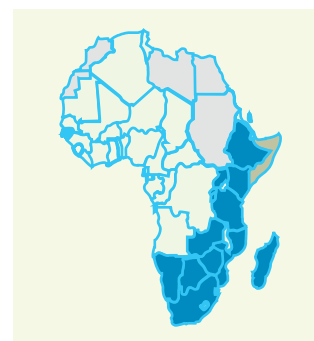
In 2010, the ESA sub-region witnessed a number of major emergencies, these negatively impacted on the health status of the people. In addition to the 5 countries that were affected by the natural disasters in 2009 were 3 new countries, making the total number of countries affected in 2010 in the Eastern and South African region 8. In northern Uganda, heavy rains resulted in floods, which destroyed several homes, roads, food crop and water sources. In Lira and Dokolo districts of Lango region, 546 households and 75,000 people were respectively affected.

In Mbire district of Zimbabwe, fresh floods, which resulted in loss of livelihoods, destruction of houses and property, affected an estimated 355 households (1,775 people) in March 2010. Incidences of flooding were also reported in northern Namibia, Mozambique and Central Zambia during the year although these were mild. Compared to the flooding of the previous years. In Ethiopia, flooding and landslides resulted in 37 deaths and displacement of 88,943 persons in 4 regions.

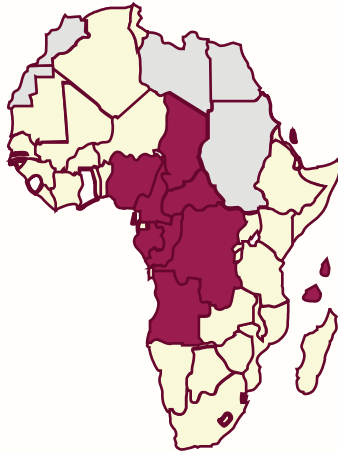
In order to better respond to the natural disasters, WHO/EHA technically and financially supported countries in the region with development of flood action plans for the flood prone countries and flood simulation exercises.



In 2010, Landslides hit Uganda, leaving over 300 persons dead and hundreds more homeless and sick. WHO stepped in to support the GoU and the districts to respond to the landslides and its affects including injuries, displacements and outbreaks of diseases due to poor sanitation



## 1.0.3 Central Africa



### Natural Disasters in Great Lakes Region (2005-2010)

Table 2

Country	Natural Disasters
Angola	Localized drought, floods, epidemics
Burundi	Drought, Floods, mudslides, epidemics
Cameroon	Localized drought, floods, mudslides, epidemics
DRC	Floods, mudslides, volcanic activity, earthquakes, epidemics
Republic of Congo	Floods, crop blight , epidemics
Gabon	Localized drought, floods, mudslides; epidemics
Chad	Drought, Floods, Mudslides, epidemics
Sao Tomé	Localized drought, floods, epidemics
Equatorial Guinea	Localized drought, floods, epidemics



A road in Central Africa is cut off as a result of floods. In 2010, ten countries reported cases of floods. This posed a huge public health problem as communities were unable to access health services. WHO supported countries in this sub region to respond to the most urgent health needs.”

In 2010, the humanitarian situation in Central Africa sub-region focused more on Angola, Burundi, Cameroon, Central African Republic and the Democratic Republic of Congo. The region witnessed different emergencies that greatly affected the livelihoods and health of the communities. Five countries in the region affected by the natural disasters during the year in review namely; Burundi, Chad, DRC, Central African Republic and Republic of Congo.

During the year, Burundi experienced: acute food crisis and acute malnutrition in Kirundo province in the north of Burundi affecting 38.100 households.

To support the countries in the region with timely response to disasters, WHO/EHA technically and logistically supported the Central African sub region with the creation of the National Councils for the preparation and response to disasters, elaboration of the national strategy for the preparation and response to disasters, preparation of the rainy season Contingency Plan and stimulation of a field visit to a disaster area.

### Trends of the Occurrence of disasters by type in the central Africa sub region: 2002 2010. Source:

*Computed from the CRED database*

Table 3

Type of disaster event	Share in total (%)	Frequency
Epidemics	46.5	+/-Annual basis
Flood	21.8	
Drought	16.1	
Windstorm	2.3	
Insect infestation	3.5	
Famine	2.9	
Earthquake	2.1	
Landslide	1.7	
Wildfire	1.2	
Volcano	3.5	
Extreme temperature	0.6	

## 1.1 Social political conflict by sub region



*As a result of the social political conflicts and pressure, many people will do anything to flee the country. A group of Ivoirians on transit to Liberia. Photo Credit: WHO*



*Partners in Côte d'Ivoire during one of the Cluster meeting to chart the way forward for the political Crisis in the region. WHO technically supported partners with coordination of all the health related efforts.*

### 1.1.1 West Africa

In 2010, West Africa experienced social economic and political crises in Nigeria, Mauritania, Togo, Côte d'Ivoire, Guinea and Niger. In Guinea where there was an ongoing social and political turmoil for the past three years, the country experienced a humanitarian crisis and reported 15 cases of sexual violence and over ,1000 injuries. In addition, the country also faced internal displacement of about 138.000 people during the year. Despite all the political turmoil that rocked the country during the year, a peaceful poll was held for new leadership. In Côte d'Ivoire where the post election dispute sparked off a cycle of violence, the country witnessed a surge of both external (refugees) and Internal (IDPs) displacement of people inducing a humanitarian crisis which spilled over to the neighbouring country of Liberia and other countries.

As of the end of 2010, an estimated 40,000 Ivoirians have found refuge in Liberia with about 30,000 IDPs living in camps and host families in the western parts of Côte d'Ivoire. This has led to poor access to health care, water and sanitation.

To support countries manage risks resulting from the political crises in the region, WHO supported countries in the region by providing technical support in the area of coordination, needs assessment, planning, resources mobilization, monitoring and evaluation



*A WHO staff donates some medical items to a refugee in the DRC during a humanitarian visit to one of the camps.*

## 1.1.2 Eastern and Southern Africa

In 2010, the Eastern and Southern Africa continued facing threats and emergencies resulting from imported political conflicts within the horn of Africa. During the year, the region recorded huge loss of lives and property in Uganda, Eritrea and Kenya. Though not part of imported conflict, Mozambique and Zimbabwe experienced internal political conflicts.

A twin bomb blasts rocked Kampala, the capital city of Uganda in July 2010 leaving at least 76 people dead and over 100 others injured while cattle rustling in northeastern parts of the country resulted in several deaths and internal displacements.

To respond to the Twin bomb blasts in Uganda, WHO supported the Government of Uganda with assorted items used for hospital management of bomb blast victims. In addition body bags were also provided to the MoH for the burial of the those who died as result of the bomb blasts.

## 1.1.3 Central Africa

Central Africa continued facing humanitarian crises resulting from political conflicts in the African re-

gion. Since 2003 Chad has hosted over 250,000 refugees from Sudan. This has led to an acute humanitarian situation in the country.

In 2010, the situation was made worse with the inflow of 60,000 refugees from the CAR. As a result of the internal conflict within the country in 2010, Chad experienced a displacement of an estimated 170,000 people. To date a total of 700,000 people leave in the IDP camps in Chad.

During the year, CAR had an estimated population of 70,000 refugees from Chad and Sudan as well as 150,000 IDPs. The country also had an estimated one million people in the crisis-ridden north who were in need of humanitarian assistance.

In 2010, the DRC continued to face the most deadly conflicts in the world, with over 3 million IDPs in the eastern part of the country and sexual and gender-based violence in the north east and eastern provinces. As a result of the conflicts in the neighbouring countries of Sudan, Rwanda, Republic of Congo, Burundi and Angola, the DRC experienced an influx of refugees numbering about 330,000. WHO through the IST and the country teams supported countries in the region to review joint health assessments and epidemiological surveillance including IDPs and IDP camps.



## 1.2 Epidemics by sub region

### 1.2.1 West Africa

Epidemics represent the most common and lethal threats to West African countries while floods, drought and locust represent the major natural hazards in the region.

In 2010, eight countries in the sub-region reported a total of 17,559 cases of meningitis and 1,897 deaths (CRF 10.8%). Yellow Fever outbreak was reported in Cote d'Ivoire with 120 cases and 42 deaths (CFR 35%) and Mali with 3 cases and 2 deaths (CFR 67%). In Cape Verde, Benin, Cote d'Ivoire and Nigeria 276 cases and 0 deaths, 2 cases and 0 deaths, 12 cases and 1 death and 9 cases and 2 deaths of Dengue were reported respectively during the year).

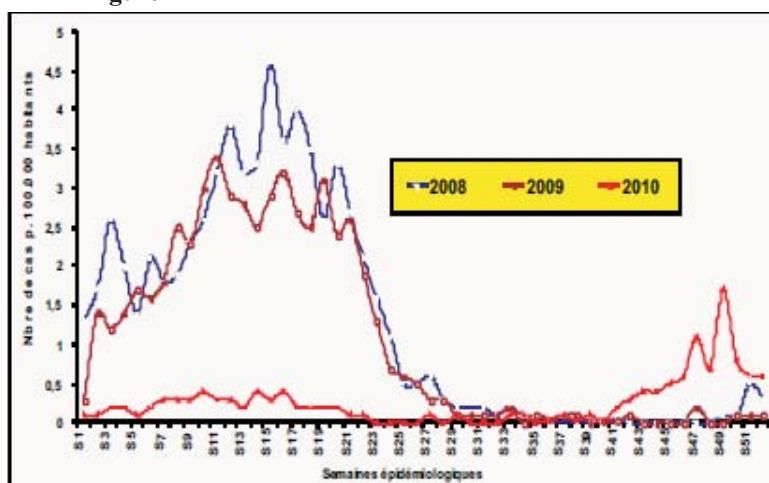
During the year under review, Cholera, was reported in eight countries namely: Benin 969 cases and 7 deaths, (CFR 0.7%) ; Côte d'Ivoire 32 cases and 0 deaths, Liberia ,1546 cases and 0 deaths and Ghana 456 cases and 15 deaths (CFR 3.3%). Niger reported 1,193 cases and 70 deaths (CFR 5.9%), Nigeria 41,866 cases and 1,719 deaths (CFR 4.1%), Senegal 3 cases and 0 deaths and Togo 75 cases and 3 deaths (CFR 4%). Cholera outbreaks were also reported in other countries surrounding Lake Tchad (Cameroun and Tchad). In 2010, Rift Valley fever was reported in Mauritania while Niger reported cases of meningitis with 3025 cases and 265 deaths (CFR 8.8%) .

In Grand Bassa and Nimba counties in Liberia, 53 suspected cases of Lassa fever were reported. 17 of them confirmed and 7 deaths registered with (CFR= 13.2%). Still in Liberia, over 1500 cases of measles with 25 deaths were registered in Grand Bassa, Grand Gedeh, Margibi, Montserrado and Lofa Counties.

In 2010, Measles case load steadily dropped in Niger down from 9,976 cases and 43 deaths in 2008; 7,429 cases and 49 deaths in 2009 to 2,213 cases and 12 deaths in 2010. This drop was attributed to vaccination campaigns carried out in the 42 health districts in the country. Vaccination coverage was reported at above 90%.

**The graph below shows measles trends in Niger over a three years period.**

**Figure 2**



*Three Years reported Trend of measles cases in Niger*

“

To respond to the epidemics in West Africa, WHO/EHAIST and country teams provided joint technical and logistical support to the Emergency Health Action & Epidemic Preparedness and Response /CDS to a number of disease outbreaks that were reported in the sub region.”

2010

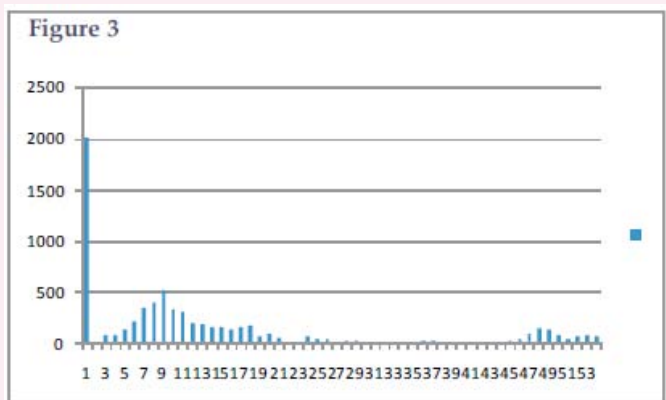


Partners in Ivory Coast participating in a disaster preparedness and response training. Photo Credit: WHO

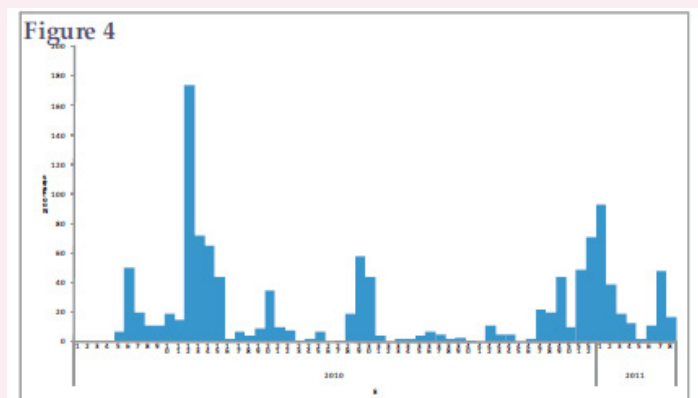


A WHO staff examines a malnourished child in Ivory Coast.

### Cholera cases in Mozambique: January to December 2010



### Cholera Cases in Zimbabwe: January to December 2010





A WHO staff participates in a polio immunization exercise in Nakapiripirit district in Karamoja region of Uganda

## 1.2.2 Eastern and Southern Africa

Disease outbreaks remained a major problem in the sub-region in 2010. In Uganda, outbreaks of cholera, dysentery, hepatitis E and polio were reported. In Ethiopia, 3,120 cases and 36 deaths (CFR1.1%) of AWD/ cholera were reported from 56 districts of the country while in Zimbabwe, 1,172 cases and 25 deaths (CFR of 2.1%) due to cholera were reported during the year. In Zambia and Mozambique, 6,794 and 5,097 cases of cholera were reported respectively during the year. Almost all countries of the sub-region were affected by measles outbreaks in 2010. In Ethiopia, 37,307 cases and 60 deaths of the disease were reported while in Zimbabwe, 13,783 cases and 631 deaths of measles were recorded.

Other countries which reported measles outbreaks during the year include South Africa, Swaziland, Malawi, Zambia and Lesotho.

Other important outbreaks in the sub-region during the year include H1N1 in Zimbabwe and Namibia, typhoid in Zimbabwe and Meningitis in Namibia. To strengthen responses at the country levels, WHO/EHA supported countries in the region with response and investigation activities.



WHO supported the district with transport to over see the burial of a cholera patient as a risk reduction to the spread of cholera

## 1.2.3 Central Africa

In 2010, the Central African Republic experienced several disease outbreaks. Among them; Malaria, acute respiratory infections and diarrheal diseases including cholera. In Chad, 5,606 cases of cholera and 161 deaths (CFR 2.9%) were registered during the year. In three provinces of Katanga, Kivu North and South Kivu in the DRC, a total of 12,261 cases of cholera were registered and 178 death (CFR of 1.5%).

In addition, the DRC also experienced an outbreak of the acute paralytic polio, registering 397 cases and 165 death (CFR41.6%) Cholera outbreak affected Cameroon from 6 May 2010. It started in the Far North Region, and later spread to the whole of the Northern Region. Before the end of the year 2010, 7 of the 10 regions in the country were reporting cholera cases. By end of December 2010, the country reported a total of 10,728 cases and 652 deaths (CFR6.07%).

In Bubanza, Cibitoke and Bujumbura Mairie provinces of Burundi, 308 cases of cholera epidemic were reported and 2 deaths (CFR 0.6%). Still in Bubanza, Cibitoke and Kirundo provinces, 8 cases and one death (CFR 12.5%) of measles epidemics were reported. In addition, a polio epidemic was reported in Rugombo and an outbreak of malaria in the northern provinces with increased mortality in the province of Ngozi. A total of 3.650.108 Malaria and 1893 deaths (CFR0.1 %) were reported.

WHO/EHA supported countries in the Central African sub region with Contingency Planning to support basic health care and communicable disease detection and response in emergencies.



Partners in the DRC hold a contingency planning meeting for a planned mass polio vaccination exercise. Photo credit: WHO



WHO staff in company of other partners in DRC visit a CTC centre for an assessment. Photo Credit: WHO

## 2. Key Achievements

### 2.0 Emergency preparedness, Early warning and Response by sub region

In line with the WHO's commitment to the key principles of the Hyogo Framework for Action (HFA), which is, manifested through World Health Assembly (WHA) resolutions WHA 59.22 and 58.1, the organization scaled up its support to Member States in the African region in the areas of DRR and EPR during the year.

### 2.1 Regional Consultation on DRR

In June 2010, the EHA/AFRO organized a consultative meeting on DRR for the African region. Participants were drawn from HAC/HQ, PHE/HQ, UNDP/SA, WMC, GRIP, ISDR, CDC/Nairobi, IFRC, Merlin, UNAIDS/SA, ISTs CA and SEA, and HCCs from Chad, DRC and Zimbabwe.

The meeting had four main objectives namely; (a) To reach a consensus on concepts and terminology on Health Disaster Risk Reduction and Emergency Preparedness including component and key steps for its implementation, b) to agree on common tools for vulnerability and risk assessment, mapping and preparedness planning and (c) to strengthen Regional partnership for training and community support programme, and (d) to explore funding opportunities for Health Disaster Risk Reduction and Emergency Preparedness.



*WHO regional Consultation meeting with Public Health teaching Institutions, NGOs and Donors from the African region. The meeting was held at the Regional Office in Brazzaville, Congo on the development of Emergency Training curriculum. Photo Credit: WHO*



*A regional consultation on the development of Emergency Training curriculum. Photo credit: WHO*

The definitions provided by ISDR on disasters and emergencies including concepts were discussed and their applications and operational definitions within the health sector agreed upon. A health system based approach for the implementation of health DRR was adopted and will mainly focus on strengthening all the six building blocks of the health system through 9 functional components to ensure that the system is adequately prepared for disasters and the reduction of its impact .

It was agreed that all existing vulnerability and risk assessment and mapping tools are to be considered in detail and relevant tools harmonized and adapted for use in the health sector. The group also agreed that a Health DRR training package, including community support program will be developed in collaboration with the task force on the development of training curriculum on Emergency. Several possible funding mechanisms for DRR were identified and a resource mobilization strategy will be developed and incorporated into the regional resource mobilization strategy for the African region.

### **Six Health System building**

**Table 5**

- 1. Stewardship and Governance**
- 2. Health Workforce**
- 3. Medical product & Technology**
- 4. Health Information**
- 5. Health Financing**
- 6. Service Delivery**

### **Nine functional components of health DRM**

**Table 6**

- 1. Institutional Framework**
- 2. Health sector coordination mechanisms**
- 3. Health Emergency Risk Assessment and Information Management**
- 4. Response and Recovery Planning**
- 5. Response and Recovery Operations**
- 6. Community Support Programmes**
- 7. Safer and Prepared Hospitals and Health Facilities**
- 8. Information, Education and Community**
- 9. Knowledge Management and Capacity Development**



## 2.1.1 West Africa

In 2010, in collaboration with other IST units/programmes, technical support on emergency preparedness for H1N1 influenza pandemic was provided to sixteen countries out of seventeen in the sub-region.

Technical and financial support was also provided for the development of Country Emergency Response plans and the establishment of the Country Rapid Response Teams (CRRTs) in 15 Counties of Liberia. Still in Liberia, a draft of Emergency Preparedness and Response Standard Operating Procedures were developed to facilitate the work of Country Rapid Response Teams.

During the year, four countries namely; Benin, Togo, Mali and Niger were supported to revise their National Contingency Plans. In Côte d'Ivoire, the vulnerability analysis of health districts provided health partners with useful information on pre-existing risks and capacities to guide their interventions. A guide on food safety in humanitarian context was also developed in collaboration with food safety unit. Together with other partners, a DRR sub-regional common conceptual framework was developed during the year in collaboration with UNISDR, UNDP, Red Cross Federation and Oxfam.

## 2.1.2 Eastern and Southern Africa

In Zimbabwe, WHO supported the MOH to update District and National Emergency Preparedness/Contingency Plans; revise the Integrated Disease Surveillance and Response guidelines; and to develop national guidelines on Typhoid management, which improved the country's emergency preparedness level. In addition, WHO supported the procurement and pre-positioning of cholera buffer stocks at provincial and district levels and also provided motorbikes for environmental health officers, bicycles and kit for Village Health Workers (VHWs) to enhance surveillance both at the health facility and community levels.

In Ethiopia, the national MOH was supported to develop a National Policy and Strategy on Disaster Risk Management in addition to provision of technical support to all 9 regions of the country to develop emergency contingency plans including flood contingency plans in Afar, Amhara, Oromia and SNNP regions. Furthermore, 30 emergency health kits and other medical supplies were procured and prepositioned in all 9 regions.

In Uganda, the organization continued to support the Office of the Prime Minister to finalize the National Disaster Preparedness and Management Policy (NDPMP), which is currently in form of a bill before parliament. In Namibia, the development of the 2010/11 flood action plan for the flood prone areas of the country and simulation exercise for floods were supported by WHO.

In addition, WHO supported Rwanda MOH to develop an all-hazard health emergency contingency plan and the Department of Health (DOH) of South Africa to develop a health disaster risk reduction strategy.

Furthermore, the IST/ESA team contributed to the development of a concept note on DRR strategy for the health sector of Africa.

“WHO supported Rwanda MOH to develop an all-hazard health emergency”







WHO team members delivering assorted medical supplies to the health team in DRC to support a response to a cholera outbreak. Photo credit: WHO

## 2.1.3 Central Africa

During 2010, in the Central African region; WHO supported CAR, Cameroon, Chad, Congo, DRC, Burundi to improve emergency preparedness and risk reduction. In Sao Tome and Principe, WHO supported the creation of the National Council of preparation and response to disasters; elaboration of the national strategy for the preparation and response to disasters and preparation of the rainy season Contingency Plan including stimulation exercise to reinforce preparedness in the region, WHO pre-positioned supplies. These include: 1 trauma kit A & B, 6 IEHK basic for 1000, 1 IEHK for 10,000 and 23 High Frequency radio sets.

In Burundi, the organization supported the department for Public Health and AIDs with 30 cholera Kits, drugs and medical equipment. WHO supported the DRC with the development and evaluation of contingency plans; the volcanic risk plans and plans to respond to armed conflicts.

## 2.2 Surge Capacity and Technical Support

### WHO headquarters

In 2010, WHO's Health Action in Crises (HAC) cluster in Geneva worked with the WHO Regional Office for Africa (AFRO) on the response to large scale crises that required a concerted international response and major resource mobilization efforts. HAC provided technical assistance and quality assurance for needs assessments in more than 20 crisis countries in the region. The results of these assessments provided the background for the appeals which provided the financial support for the health sector response in these countries.

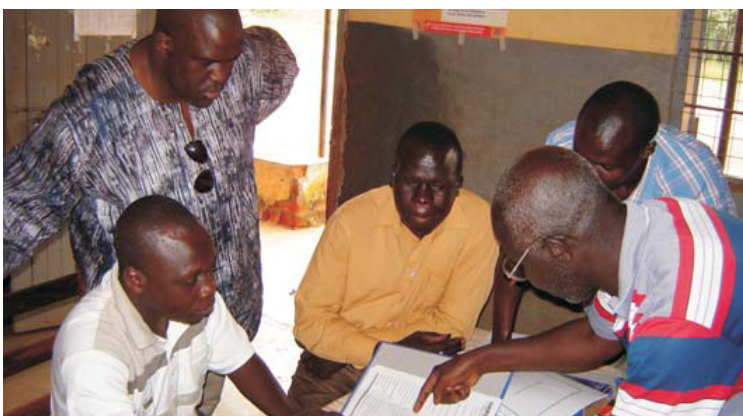
In addition, HAC promoted the use and supported the implementation of the Health Resources and Services Availability Mapping System (HeRAMS), a Health Cluster tool designed to provide information deemed essential to decision-makers involved in the health sector response.

HAC provides oversight of the CERF process which includes supporting the drafting of proposals, writing reports and contract amendment. Based on discussions

with the Regional Office, HAC negotiated at the inter-agency level for the inclusion of AFRO emergency priority countries in the CERF. In 2010, a total of 28 country proposals were prepared and approved to receive CERF funding.

Resource mobilization and advocacy efforts require needs assessments, technical updates and monitoring and reporting on project outcomes. Based on assessments carried out in countries affected by crises, the actors develop common strategies and plans that form the basis for CAPs, Flash Appeals, work plans or other similar documents. HAC liaises with the country offices to prepare these documents and then disseminates them among donors. The projects are also posted on the HAC web site with the aim of facilitating partners and donor's understanding of WHO's operations and financial needs.

The HAC African Region desk facilitated and contributed to the production of reports on contributions received from the CERF, the CAP and for flash and other types of appeals for 62 projects in 25 countries. HAC works to strengthen partnerships by presenting advocacy papers to donors to raise awareness on the needs of the countries in the African region.



## Regional office

Inadequate numbers of well trained and skilled emergency public health experts remains one of the

critical challenges for effective preparedness and response to the natural and man-made disasters in the African Region. Furthermore, suitably trained and experienced candidates who understand WHO emergency procedures and can rapidly be deployed (as consultants or staff members) to countries facing disasters are scarce.

To address this constraint, the Emergency and Humanitarian Action Program of WHO African Regional Office (EHA/AFRO), established a roster of experts for rapid deployment to countries in emergencies. During the year experts were carefully selected, screened and trained. Using the roster, trained public health experts were deployed to support operations when the need arose. Currently, the roster has 49 deployable experts in public health comprising 20 staff and 29 consultants. Two experts from the roster are currently deployed to Cote d'Ivoire.

The regional office also established SHOC room which was used during the year for coordination at various levels and departments/programmes within the organization. This was meant to provide efficient response to outbreaks, natural disasters and socio-political crises.

Currently, WHO has EHA focal points in nine countries (CAR, Chad, DRC, Ethiopia, Guinea, Kenya, Liberia, Niger and Uganda) out of the 13 with ongoing emergencies and a humanitarian coordinator. Health Cluster Coordinators were specifically recruited for DRC, Chad and Zimbabwe. In 2011, the contracts of the focal points in Burundi, Cote d'Ivoire and Eritrea as well as that of the Health Cluster Coordinator in Zimbabwe had to be discontinued due to lack of funding. Continuation of the maintenance of focal points in other countries is also threatened by lack of funding.

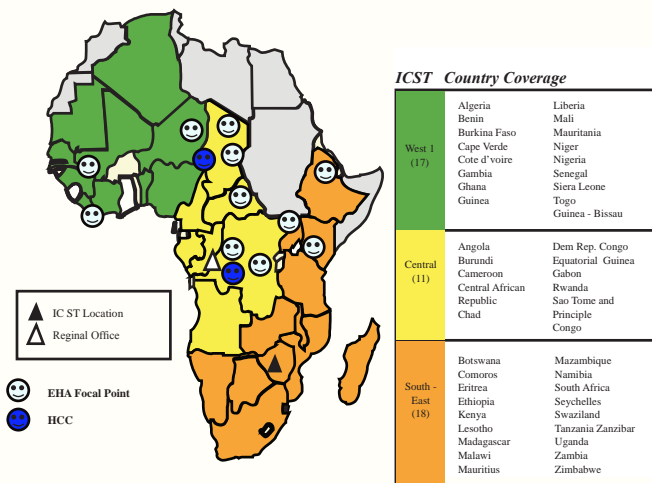
During the year, IST EHA Focal point's actively participated in the RDT meetings and supported countries with coordinating technical support. Their participation in the sub regional meetings strengthened partnership and collaboration.



In times of epidemics and disasters, WHO responds by supporting members states with supplies. WHO staff delivering assorted drugs and supplies to support an outbreak on Hepatitis E: Photo Credit: WHO

## 2.3 Emergency Response by Sub region

### WHO AFRO ISTs coverage and Location of EHA Focal Points



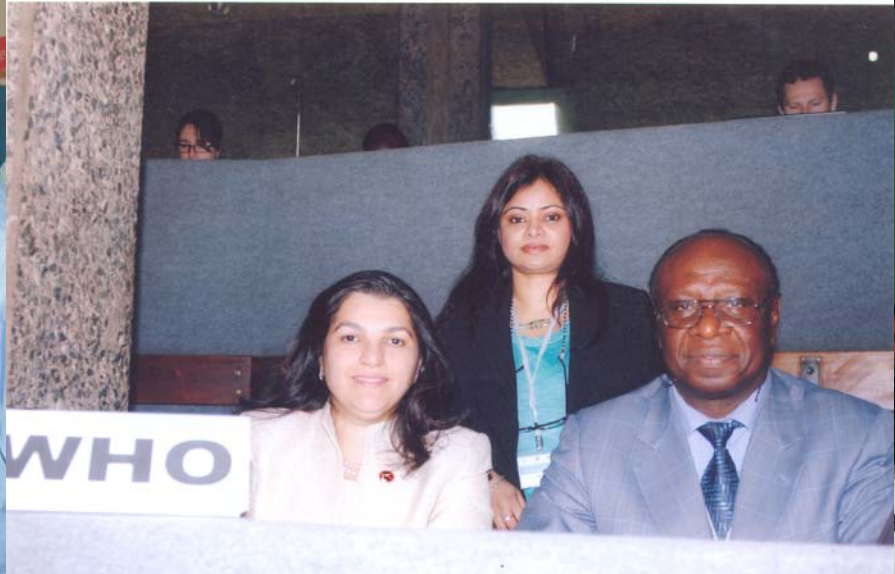
WHO focus in response is based on its core functions in emergency namely; Assessment and information management, coordination, gap identification and filling and capacity building.

During the year, the delivery time of emergency kits greatly reduced from average of 2 months to average of 1 week using the humanitarian sub-regional depots, improving the overall efficiency in emergency operations.

Through 2010, the WHO coordinated and mobilized health responses in all reported emergencies in the region through inter-agency humanitarian health cluster or country team health sector. This was made possible by the availability of a regional rapid response platform that provides support operations during times of need through the regional roster and SHOC room.



WHO staff together with MoH official in Uganda conduct a support supervision of Dokolo HC III



WHO delegation; from L to R Dr. Qudsia, EHA/EMRO, Dr. Naeema, ARD/EMRO and Dr. Kalambay, ECB/EHA/AFRO at the second Ministerial conference on Disaster Risk Reduction in Nairobi, April 2010. Photo credit: WHO EMRO

## 2.3.1 West Africa

In 2010, WHO supported flood response activities in Burkina Faso, Senegal, Mali, Niger and Togo by providing technical support in the area of coordination, needs assessment, planning, resources mobilization, monitoring and evaluation. In addition, WHO supported the evaluation of EPR in Niger, Liberia and Benin.

To ensure effective coordination of inter-country health interventions, the organization supported sub-regional health cluster meetings during which 8 monthly coordination meetings were held across the 3 countries in the region. WHO further supported Niger, Liberia and Benin with the development of Consolidated Appeal Process (CAP) documents or EHAP and submitted to donors.

During the year, WHO provided joint technical support to the Emergency Health Action & Epidemic Preparedness and Response /CDS to, Burkina Faso in response to meningitis and measles; Cap Verde in response to Dengue and H1N1; Côte d'Ivoire in response to H1N1, Niger in response to meningitis and Nigeria in response to meningitis and lead intoxication.

In response to the wild polio virus and measles campaigns in 2010, WHO supported Liberia, with

the implementation of seven rounds of Supplementary Immunization Activities (SIAs) that reached 750,000 under five children.

Financial and technical support were provided for vaccination campaigns. In addition, WHO supported H1N1 vaccination campaigns and simulation exercises involving 75,623 health staff and other vulnerable groups in Liberia.

WHO also supported Burkina Faso, Benin, Liberia, Mali, Guinea, Niger, Senegal and Togo, with emergency kits and other medical supplies to respond to different emergencies. In addition, the organization supported Niger with a yellow fever vaccination exercise covering 276,918 people. Similarly a case management monitoring and provision of drugs to five Therapeutic Feeding Units (TFU) was conducted. Drugs and supplies in response to a flood emergency were provided.



*Donors Consultative meeting in the Saraoui refugee camp (Tindouf/Algeria 2010) . Photo credit: WHO*



*A WHO staff participating in the 2010 Rapid Multi Sectoral Floods Assessment in Schumansburg, Caprivi Region, Namibia*

## 2.3.2 Eastern and Southern Africa

During the year, WHO continued to support the MOHs in all countries of ESA to timely and effectively respond to emergencies. The support provided includes support to measles and cholera outbreak response in Zimbabwe, Zambia, South Africa, Ethiopia, Kenya and Uganda and support to investigate and respond to outbreaks of measles, H1N1 and meningitis in Namibia. In addition support was provided to Uganda MOH to investigate and respond to outbreaks of yellow fever and hepatitis E.

Furthermore, WHO provided technical, logistic and financial support to natural disaster response efforts in Namibia (floods), Uganda (landslide and floods), Kenya (drought) and Ethiopia (floods).

## 2.3.3 Central Africa

In the Central African region, WHO supported the countries in developing proposals for the use of CERF to support basic health care and communicable

disease detection and response in emergencies. The organization also supported Focal points of countries in the region to review joint health assessments. Other areas that WHO supported include: countries with epidemiological surveillance in terms of data collection and data analysis, preparation and dissemination of situation reports on crises, interagency and cluster coordination meetings.

In the DRC and Chad, WHO facilitated joint responses to emergencies include; Avian Flu , cholera and measles. A cholera command and control center C4 established in Cameroon to increase the management capacity. In addition, Chad was supported with the revision and implementation of the national protocol on the management of malnutrition.

Preventive and control measures on cholera in the central Africa region are being implemented by national authorities with support from several partners (IRC, CICR, Oxfam, AMI, MSF, UNICEF etc). Coordination, reactivation of epidemic preparedness and response plans are the main challenges highlighted in the most recent MoH report on cholera in DRC.

## 2.4 Capacity building by sub region

In 2010, the regional office supported four regional training programs on public health emergency operations namely: two HELP courses in English and French at University of Pretoria South Africa and PRSP Ouidah, Benin respectively; the public health in complex emergencies course at University of Makerere; and the AFRO Public Health Predeployment Course. The Organization continued providing its

technical support to the 3 training programs outside of the WHO.

During the year, a Task force was set up to develop and update training modules for disaster risk reduction, emergency preparedness and response for different cadres at pre-service, in-service and specialized levels. The table below summarizes the 12 core modules whose development is in process.

**Figure 4: This table shows EHA AFRO proposed Modules.  
Module 0: Introduction to Health and Disasters**

S/N	Category	Module	Existing Module	Reference	Writer	Co -Writer	Pre - Validators	Deadline
1	Pre-disaster	IHL and Geneva Conventions			Michel	John		Draft 0
2		Disaster Risk Assessment	ISDR/Ans/WB/ Universities /WHO-WMC		WMC/ WHO	Mapatano	Cape town ISDR - Dominic	May 2011
3		Risk Reduction & Mitigation	ISDR/Ans/ Universities /WHO-WMC		WMC/ HO	Mapatano	Cape town ISDR	May 2011
4		Health systems in emergencies	WHO/RC movement /Sphere		Kuku	Micheal, Nable Angela	WHO/AFRO	May 2011
5		Emergency Preparedness and readiness	UNDP/WHO/USG/ Aus/ UK/EU/Bangladesh/ India		Micheal	Kuku Kalambay	WHO /EPC	May 2011
6	Disaster	Incident Command Systems	UNDP/WHO/Aus/UK/ NATO		WMC/ WHO	Nable	OCHA	May 2011
7		Needs Assessment and Information Management	OCHA/UNDP/WHO/ IASC/WB		Chris	Usman	AFRO	May 2011
8		Logistics in Emergency			Michel	John		May 2011
9		Search and Rescue	OCHA/RC movement /Aus/other GOVT		Micheal	?????	OCHA	May 2011
10		Public health Programs in emergencies	WHO/CDC/IASC/ RC movement		Chris	Michel, Kuku & Isseu	AFRO	May 2011
11		Health care and services delivery in emergencies	WHO/MSF/CDC/ UNICEF/UNFPA/ IMC/IRC		Nable	Micheal Sebastiana Sookram Isseu	WHO	May 2011
12	Post disaster	Rehabilitation/ Reconstruction for health sector: Build Back Better	WH/regional banks/ UNDP		WMC	?????	WB	May 2011

Facilitators Guide



*Training of selected candidates for the regional emergency response roster in Harare - Zimbabwe. Photo credit: WHO*

## 2.4.1 West Africa

In 2010, WHO supported the briefing of 1 EHA focal point and 10 health cluster members in Benin on key cluster approach components and deliverables.

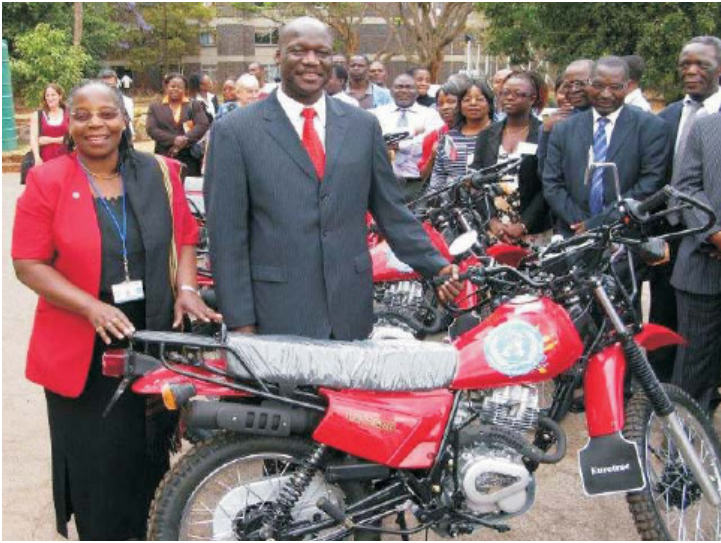
The Organization also supported the Ministry of Health and Social Welfare and the Medical College, University of Liberia to develop a proposal to the African Development Bank (ADB) so as to support the increase of its human resource development capacity. In addition, WHO supported the training of 1,158 community volunteers in community based surveillance of priority diseases.

The organization further supported the training of 17 data managers in surveillance data/information collation, analysis, utilization and dissemination. Finally in the West Africa, WHO supported 18 Community Health Development Committees

(CHDC) to implement and manage community initiative project(s) meant to sustain the motorcycle ambulance services following the phase out of WHO assistance at the end of 2010.



*Demonstration of Use of PPE*



WHO exhibition during the second ministerial conference on Disaster Risk reduction in Nairobi. Photo Credit: WHO stand



Strengthening surveillance system for early warning. The WR Zimbabwe presents motorbikes for surveillance to the PS, MOH to strengthen the surveillance system in the districts in Zimbabwe.

## 2.4.2 Eastern and Southern Africa

During the year 2010, the World Health Organization supported several capacity building activities in the ESA sub-region. In Zimbabwe, 36 laboratory scientists were trained in the isolation and identification of *V. cholera* and other organisms in order to ensure early detection and confirmation of epidemics. Selected health workers from all 10 provinces of the country were trained on IDSR, EPR and case management of epidemic-prone diseases. In addition, several EHOs were trained on water quality monitoring.

In Ethiopia, over 300 health workers from 5 regions were trained on EPR and surveillance of the major epidemic-prone diseases in the country while regional health supervisors were trained on data management to enhance capacity for planning and decision making.

At the sub-regional level, the organization continued with its collaboration with academic and public health institutions to train emergency public health practitioners for the African region during the year. Furthermore, IST/ESA/EHA collaborated with the relevant units in the IST to plan and implement a cholera cross-border meeting between Kenya and Uganda.



A participant reviews a training material during a Cholera Management Training in Ethiopia organised by WHO; Photo credit: WHO



## 2.4.3 Central Africa

In 2010, WHO supported the Central African region with a considerable number of capacity building activities. In the DRC, the organization supported strengthening of the capacities of the management team of the DPS for the emergency management through monitoring of proximity. In addition, WHO supported strengthening the capacity of health stakeholders (NGOs) in imple-

mentation of their activities in the field. To strengthen institutional capacities of emergency and humanitarian programmes, WHO further supported the Central African region Ministries of health to establish provisional teams that handle interventions and management of crises and disasters.

The Table below shows number of personnel trained on emergency by type of training

S/N	Type of Training	West Africa	East and Southern Africa	Central Africa	Total
1	Help	16	0	10	26
2	Public Health Pre-deployment	3	10	1	14
3	ECHO Financing Procedures	10	12	18	40
4	Health Cluster Coordinator training	7	14	6	27
5	Humanitarian health projects designing and implementation	14	4	8	26
6	Standard Operating Procedure (SOPs)	9	6	13	28
7	Transforming Health Priorities into Projects	9	25	15	49
8	Renforcement des capacites de gestion de urgences sous l'approche integree	3	0	4	7
9	Analysing Disrupted Health Systems in Countries in Crisis	7	5	1	13
10	WHO course on communicable diseases in emergencies *		2		2
11	Emergency preparedness and disaster management *		1		1
12	Health cluster capacity building workshop**		23		23
		78	102	76	256

## 2.5 Transition, Recovery, Post Disaster and Post Conflict

During the post disaster and protracted conflicts, the major concerns for health recovery are; reconstruction of health infrastructure, provision of supplies and restoring of public health functions. In 2010, WHO led response and recovery activities in the region through the health cluster/sector coordination with strong intersectoral collaboration. WHO/AFRO used the Post Disaster and Post Conflict Needs Assessments guidelines for recovery planning. The regional office will continue participating in the ongoing processes to harmonize the two guideline to include the support of health system through the CHAPs/CAPs and pooled funds

### 2.5.1 West Africa

In view of strengthening the recovering health system in Liberia in 2010, WHO provided drugs and medical supplies to Curran, Kolahun and Foya hospitals in Lofa County to enhance and support Emergency Obstetric and Newborn Care (EmONC) services. The Organisation also introduced 19 community motorcycle ambulances to three districts in Liberia to improve community emergency referral services and supported the installation of 10 codan radios, to link the motorcycles ambulances and vehicle ambulances to the health facilities.

Still in Liberia, WHO, supported the review of the national health policy and plan, provided technical and logistical support to enable supervision of health services, validation of HMIS data and the analysis of maternal and newborn data. Further support was provided by WHO to Agadez in Niger during the development of the health sector recovery plan.

### 2.5.2 Eastern and Southern Africa

In line with its core functions in emergencies, WHO continued to support the strengthening of the health system of disaster-affected countries in the ESA sub-region during the year.

In Ethiopia, WHO provided financial support to train community health extension workers in Gambella and Benzangul Gumuz, which are among the least developed regions in the country.

In Uganda, the organization continued to support the government to implement its Peace, Recovery and Development Plan (PRDP) in the northern parts of the country. As part of this support, the organization technically and financially supported the conduction of a mini Demographic and Household Survey (DHS) in Karamoja and Acholi regions of the country. The results of the survey, which was released in August 2010, are being used by government and partners to monitor gaps in the implementation of the PRDP and other development plans; prioritize interventions and to guide health planning at both national and district levels.

In addition, the organization supported the construction and equipping of a maternity unit at Pabwo HC III in Gulu district; renovation of Alenga HC III maternity unit in Apac district; and training of health workers on cancer screening and provision of a cancer screening machine to Gulu District Hospital, all in Northern Uganda

In Zimbabwe, a country recovering from a chronic humanitarian crisis, funds were mobilized from the

Government of Finland, African Development Bank (ADB), CERF and ECHO to compliment efforts of other health development partners to strengthen the health system of the country. In addition, the organization procured a real-time PCR machine and necessary supplies for the National Virology Laboratory to support confirmatory testing of Pandemic Influenza viruses and supported the revitalization of the Village Health Worker (VHW) programme with the aim to train a minimum of 10,000 in the next two years.

Other health system strengthening support to the country include establishment of a water quality monitoring system and strengthening of the surveillance system through installation/repair of radio communication systems and provision of equipment, supplies and reagents to the National Microbiology Reference Laboratory (NMRL) for microbiology testing and confirmation of disease outbreaks.

### 2.5.3 Central Africa

WHO has also contributed to the rehabilitation and provision of emergency health kits to Bunyakiri BCZS to enable provision of free care to the displaced and host families. The Organization further contributed to the updating of the criteria and standards used for the exit implementation of projects of emergency in North Kivu province. In addition, WHO contributed to the consolidation of the provincial health sector 2011, humanitarian action plan and the mid-term evaluation of North Kivu health sector Humanitarian Action Plan 2010.



*A WHO Afro staff verifying data during a training of partners on Transition, Recovery, Post disaster and Post conflict management in the DRC. Photo credit: WHO*

### 3. Resource Mobilization and Project Management

As of 30 December, 2010, the total voluntary contribution for strategic objective 5, (Emergency and Humanitarian Action) for the WHO African Region was USD 43,674,956. These funds were mobilized in 127 approved projects initiated from January to December, 2010 and are being managed in both AFRO and HQ.

Figure 5 shows the funds mobilized compared to the biennium for 2010/2011 budget allocation for the regional office, inter country support team and countries. The sum of USD 33,998,910 (35.6%) of the total biennial VC allocation of USD 95,342,000 has been funded to the various work plans in the Region.

The funds mobilized are mainly used for Outbreak and Crisis Response (OCR) at country level, Thus OCR component is better funded (43.8%) compared to flexible Core Voluntary Contribution (CVC) at 16.1% required for improving WHO core capacity and use in under funded areas.

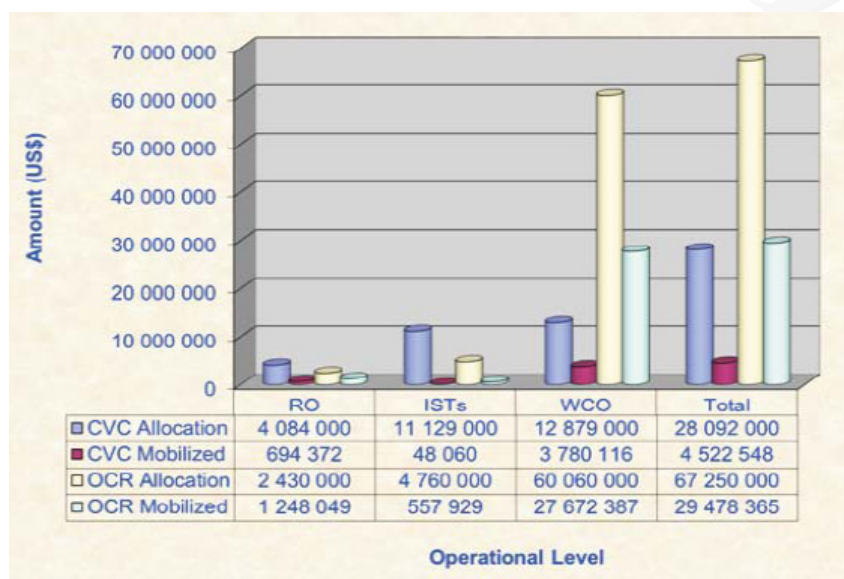
In 2010, the major source of funding was the pooled funds including Central Emergency Response Fund (CERF) contributing about 53% of the funds (Figure 6). This was followed by ECHO and Finland together contributing a quarter of the mobilized funds with 14 and 11% respectively. The bulk of mobilized funds were used for response operations constituting 81% of all funds.

The major response operations were control of outbreaks (55%) and provision of basic services in conflict affected areas (37%). Nutritional crisis and flood response constituted 12 and 4% respectively. Institutional strengthening, preparedness and recovery operations were poorly funded in 2010.

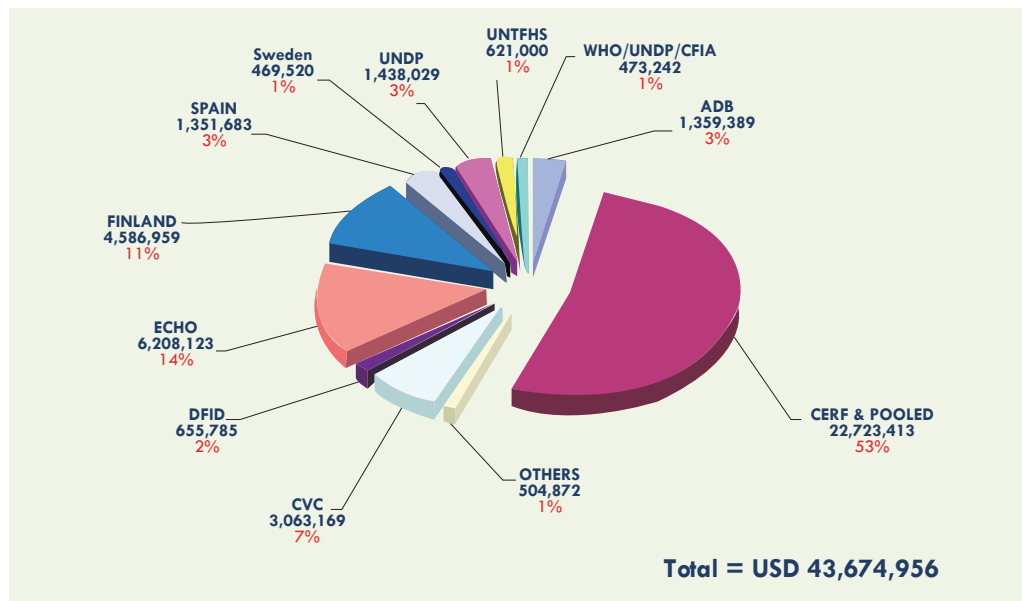
The implementation rate of the projects greatly improved in 2010. The 34 country offices, ISTs and Regional office expended 85% of all mobilized funds as of 30 December 2010.

The level of regional performance in terms of the utilization of funds was mostly affected by the cumulative performance of the 8 countries implementing projects costing more than USD 1 million. As of the end of December 2010; three of these countries namely Zimbabwe, Uganda and Ethiopia had performed extremely well with utilization of more than 80% of the mobilized funds each. The balance of 15% unutilised funds are for projects that commenced in the 3rd quarter of the year for which implementation continues in 2011.

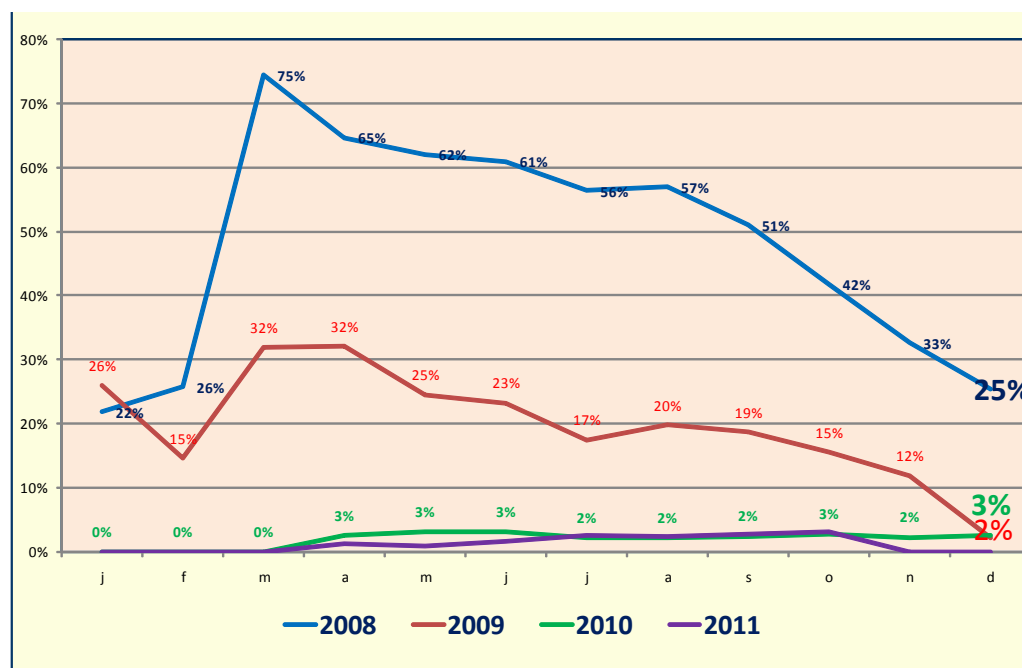
**Figure 5: Level of voluntary funds mobilization as of December**



**Figure 6: Distribution of AFRO EHA 2010/2011 Funds by Donor as of December 2010**



**Performance of funds utilized: Monthly trends of expired funds: 2008 - 2011**



## 4. Building effective partnerships

In order to improve the WHO's capacity at the regional, sub regional and country levels, the organisation partnered with several organisations to produce positive results during 2010. During the year in review, partnerships were also established with UN International Strategy for Disaster Risk Reduction (UNISDR) and NGOs like Merlin and Save the Children.

Through her lead role in the cluster approach, WHO continued supporting 13 countries in the region. In addition, the organization assigned clusters coordinators to provide support to Chad, DRC and Zimbabwe.

During the year, WHO continued providing technical advice and guidance on health issues to the Regional Humanitarian Partnership Team (RHPT) in Central and East Africa and Regional Inter Agency Coordination Support Office (RIACSO) in Southern Africa.

Support provided to these regional humanitarian groups included; technical presentations on topical health issues such as cholera and H1N1 to members, review of health components of CERF and FLASH

appeals from countries, technical advice on the public health aspects of emergencies, elaboration of the health component of regional strategies and facilitation of health aspects of regional humanitarian work shops among other supports. The organization provided leadership and technical guidance to the regional cholera task force and project, which is being jointly planned and implemented by WHO, UNICEF, UNOCHA and OXFAM at the sub-regional level.

In addition, the organization continued to provide monthly updates on the health situation in the sub-region to all partners in the sub-region during the year. Furthermore, effective partnerships were established with regional economic bodies such as SADC in the areas of health emergency preparedness, response and disaster risk reduction.

WHO supported SADC to facilitate its 2010 pre-season Emergency Preparedness and Response (EPR)workshop.



*EHA focal points attending the fifth Emergency and Humanitarian Action Annual Review Meeting. Photo credit: WHO*

In West Africa, WHO initiated partnership with an international educational institution based in Ouagadougou (2iE) for a joint capacity building program in Epidemic Preparedness and Response and Disaster Risk Reduction that targeted field officers from government as well as other non-governmental organizations. In Liberia, the organization participated in the Health Sector Coordination Committee and Pool Fund Steering Committee meetings.

In collaboration with other UN and NGO agencies in Liberia, WHO supported implementation of seven rounds of the Supplemental Immunization Days (SIAs) and in the measles campaigns. In collaboration with, WHO provided technical and financial support towards immunization campaigns in Liberia.

In Zimbabwe, WHO continued to lead the Health Cluster and provide technical guidance to the

MOH and other health partners in the country throughout the year. In addition, the organization continued to participate in all Inter-Cluster Forums such as the Humanitarian Country Team (HCT) and the Cluster Coordinators' Meeting.

In Uganda, WHO provided technical support to the MoH to develop a concept note on effective coordination of emergency health responses at the national and district levels as part of the health cluster phase-out activities. While at the district level the organization continued to provide technical support to the offices of the District Health Officers (DHOs) to coordinate emergency health responses. In Ethiopia, the organization proactively engaged and collaborated with partners such as MSF, GOAL, MERLIN and Afar Pastoralist Development Association (APDA) in the areas of nutrition response, cholera prevention, control and capacity building.

### **WHO strongly recommends partnership and coordination for an effective response.**



*Left: A WHO staff in company of other partners in DRC visit a CTC centre. Photo credit: WHO*



*Right: WHO staff attending a coordination meeting on Cholera in the DRC. Photo credit: WHO*

## 5. Best practice from selected countries

### 5.0 Polio Immunization Campaign in Liberia

One of the best practices during the past seven rounds of the SIAs in Liberia was the ownership of the immunization campaign by the local authorities, traditional leaders, Commissioners and Chiefs to ensure that eligible children in their areas or communities are vaccinated.

This was due the high level field supervision by the central Ministry of Health and Social Welfare. As stressed by Liberia's Chief Medical Officer (CMO), "there will be no Christmas this year because we shall all get to the field and vaccinate all eligible children". One of the major emergencies managed by Liberia in 2010 was the nationwide response to interrupt transmission of wild polio virus. In 2010 seven rounds of SIAs were conducted within an interval of 12 months. Two out of the seven NIDs rounds were integrated with Vitamin A supplementation and de-worming with Mebendazole.

The polio immunization campaigns that benefited approximately 750,000 under five children were conducted with technical and financial support from WHO and UNICEF. Based on the lessons learned from the previous polio campaigns, new strategies were employed to improve the quality and coverage of the immunization campaigns. These included: Review of the County preparation and implementation plans with focus on the hard to-reach areas. Mobilization of political leaders at the highest level with in the county and One of the best practices during the past seven rounds of the SIAs in Liberia was the ownership of the immunization campaign by the local authorities, traditional leaders, Commissioners and Chiefs to ensure that eligible

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*Vaccination of a baby by one of the community members in Grand Bassa county in Liberia. Photo credit: WHO*



## 5.1 Response to Nutrition Crisis in Niger

The best practice in the response to the nutrition crisis in Niger is addressing the direct and underlying causes of malnutrition through partnership and collaboration. Severe Acute Malnutrition (SAM) increases the incidence, duration and severity of infectious diseases such as measles, malaria, diarrhoeal and acute respiratory infections among children.

These four childhood killers may in turn contribute to malnutrition through loss of appetite, mal absorption of nutrients, and loss of nutrients through diarrhoea or vomiting, or through altered metabolism. Improved access to health care services is one of the key interventions in malnutrition emergencies because treating individually malnourished children has only a direct life saving impact, and its gain may be limited to the duration of the intervention. A joint project on the nutrition crisis in Niger was implemented by UNICEF, WFP and WHO alongside other activities to address the direct causes of malnutrition and its underlying causes. During the implementation of the project, WHO supported Case management of severe acute malnutrition (SAM).



*Supportive supervision in TFU in Maradi, Niger. Photo credit MS/Niger*

## 5.2 Flood Response in Mount Elgon Region of Uganda

In Uganda, the best practice highlighted WHO's comprehensive support to the flood and landslide districts using the DRR principles from immediate response to recovery, mitigation and preparedness phases. Between February and March 2010, the Mount Elgon Region of Uganda experienced heavy rains, which resulted in flooding and landslides in two districts of the area. In Bududa district, a massive landslide resulted in complete destruction of 3 villages and health facilities with 96 persons killed and 3,746 individuals (932 households) displaced into camps. In Butaleja district, flooding severely affected 3 sub-counties with over 10,000 persons temporarily displaced to neighbouring communities. The floods also resulted in destruction of property and crops worth millions of dollars.

These events resulted in a humanitarian crisis, which was devastating to the local population. The living conditions in the displacement camps were very poor, characterized by poor access to safe water and sanitation, overcrowding, poor access to health services and inadequate shelter. Furthermore, the sudden loss of close family members, disruption of sources of livelihood and population displacement resulted in mental stress and psychosocial trauma among the affected population.



*Training of health workers in SAM case management. Photo credit: WHO*

To support the response to this humanitarian crisis, WHO deployed a full-time epidemiologist whose terms of reference was to support the affected districts to conduct rapid health assessments, strengthen the disease surveillance system and identify and fill the critical gaps in the emergency health response. One of the most critical gaps in the response effort was lack of access to basic health services as the health facilities serving the affected areas had been destroyed killing some of the health staff. To fill this gap, WHO supported the district to establish 2 health centres within the displacement camp in Bududa district, provided emergency kits, drugs and other medical supplies and recruited health workers to manage the health units.

To further improve access to health care, WHO supported the training of 380 Village Health Teams (VHTs) from Bududa and Butaleja in community mobilization and sensitization, hygiene education and community-based disease surveillance. In addition 128 health workers from the districts of Bududa, Butaleja and Manafa were trained in epidemic preparedness and response.

Furthermore, the district surveillance teams in the 3 districts were provided with technical, logistical and financial support to strengthen reporting and conduct active case searches. The district health offices were also provided with technical and financial support to conduct support supervision to the peripheral health facilities offering services to the floods affected population. Environmental health staffs in Manafa district were supported to intensify public health information and hygiene promotion activities. Radio programmes to enhance public health information and community mobilization activities were also supported in Manafa district.

During the recovery phase of the disaster, WHO supported MoH and the districts to conduct joint post-conflict needs assessments. The findings of these assessments were used to guide the relocation of over 2000 landslide survivors away from the steep

mountainous slope to safer areas where basic health services could easily be provided. During the relocation operation, WHO assisted the Government of Uganda (GoU) to strengthen health service delivery in the resettlement site through donation of assorted drugs and medical supplies to the existing health units in the areas.

This operation provided a real-time opportunity for WHO to support the affected districts from the response to the recovery, mitigation and preparedness phases using the principles of health DRR. The training and use of VHTs for community based disease surveillance and training of health workers on EPR facilitated timely identification and response to occurrences of epidemic diseases thereby reducing morbidity and mortality due to epidemic diseases to a minimum. The use of VHTs to deliver basic health services and education at the community greatly increased access to basic health care services, which also contributed to reduction in morbidity and mortality.



*A WHO staff delivering drugs and medical supplies to a health centre in a resettlement area of Mt. Elgon, Uganda*

## 5.3 Using RRT for timely and effective Response to health Emergencies in Zimbabwe

Zimbabwe showed marked improvement in the investigation, management and reporting of outbreaks using the RRTs and HERU. Currently Zimbabwe is undergoing a fragile transition from chronic humanitarian crises to recovery and development. Although some progress has been made in the recovery efforts, humanitarian threats such as epidemics of cholera, measles and other diseases outbreaks persists.

Given the country's weak health systems, it is important to put in place mechanisms aimed at boosting the rapid response capacity of the Ministry of Health and Child Welfare (MoH CW) at provincial and district level, while also providing support to the Emergency Primary Health Care Components of the District Health System.

To this effect, a Health Emergency Response Unit (HERU) comprising of six international agencies (Goal, International Medical Corps, International Rescue Committee, Medecins du Monde and Save the Children UK as well as the World Health Organization) and funded by European Commission Humanitarian Aid (ECHO) was established in 2009.

The goals of HERU are to strengthen (i) epidemic diseases surveillance, early warning and response system; (ii) strengthen drugs management including the supply chain/mechanism; and (iii) reinforce the capacities of clinics and the district hospitals to increase access to basic emergency maternal and child health care and services in HERU supported districts. To effectively implement the HERU strategy, the country was divided into groups of provinces and districts and assigned

to participating organization based on capacity and comparative advantage as in the map below. MdM and SCUUK were assigned to only one district each and reported to the partner covering the province in which these districts were located.

WHO, in its capacity as the health cluster lead and co-chair of the Cholera Command and Control Centre (C4) was assigned the responsibility of coordinating HERU at the national level.

Implementation of the HERU strategy resulted in significant improvements in the management of outbreaks in the country. Almost all outbreaks are now investigated and responded to within 24 hours, which is well within the 72 hours benchmark set by the cluster.

In addition, improved reporting of epidemic prone diseases has been observed in HERU supported districts, contributing to the overall improvement in national timeliness and completeness of weekly surveillance reports. This together with capacity building of provincial and district health staff in epidemic preparedness and response and prepositioning of emergency stocks by HERU partners have improved epidemic response and reduced morbidity and mortality due to epidemics in the country.

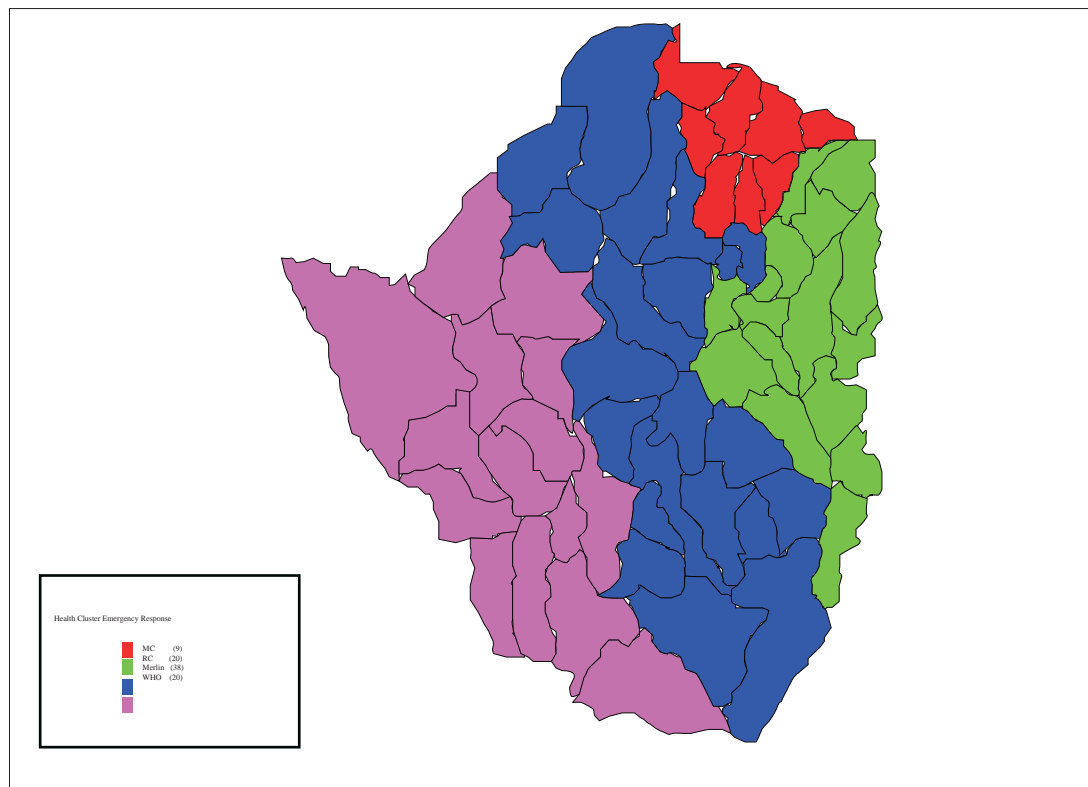
As an exit strategy for HERU, new health staff have been recruited, trained on EPR and constituted into district level RRTs as an exit strategy for HERU.

## 5.4 Joint Response to Meningitis Outbreak Response in CHAD

Joint monitoring of meningitis outbreak in Chad led to high coverage of 97% and a reduced CFR 2010, Chad experienced a major meningitis outbreak. During the epidemic 9 districts crossed epidemic threshold with the first one crossing epidemic threshold at the 4 epidemiological week. A cumulative number of 2, 729 cases and 240 deaths (CFR: 8.8%) of meningitis were notified for the year 2010. Laboratory tests revealed that the epidemic was due to both *Neisseria meningitidis* A and W135.

WHO, UNICEF and MSF-France jointly supported the MOH to respond to the outbreak in a

coordinated manner meant to support resource mobilization and field interventions. WHO and UNICEF submitted a joint proposal to CERF where as MSF-France was subcontracted by WHO to implement part of activities in the proposal. The project that was jointly implemented strengthened the ongoing emergency response and extended case management and immunization activities to all affected regions while focusing on underserved health districts. This resulted in high immunization coverage that reached 1,057,368 people against the targeted 1,096,926 (coverage of 97%). Making it possible for a timely outbreak control and a reduced CFR.



## 5.5 Joint Response to Emergencies in DRC

WHO provides technical support to MoH as the country moves from emergency to transition and recovery. The synergy created by the partnership between WHO, the Ministry of health and NGOs, was very instrumental in the implementation of activities in an emergency situation and provision of basic health care in an environment of insecurity. The fact that the MSP has health personnel in all health facilities has been a major asset for the sick, especially in places where one cannot access services due to insecurity.

Despite this strong humanitarian mobilization, in 2010, health needs remained huge. It is therefore essential to continue mobilizing resources for health services to people living in areas with poor health indicators, and conduct activities aimed at transitioning from emergency to recovery. In 2010, WHO contributed to: Improve prepositioning of strategic definition stock and selection of pre-positioning sites in the country, taking into

account existing major hazards mapping, enhanced partnership with all actors in health particularly with the NGO sector and refreshed mapping of donors while expanding the list of new donors to the WHO.

WHO also supported the strengthening of planning and implementation of interventions meant to assist facilitation of transition from Emergency to development through encouraging the development of rehabilitation plans, early post disaster or post conflict and consolidating the contribution of the WHO in response to the problems of Nutrition, water, sanitation and hygiene. In addition, WHO supported the, Initiation of research and implementation of activities that meet the environmental health field, trained teams in the areas of health emergencies and consolidated the assessments of the health status of vulnerable communities through mortality surveys.



*Plane crash in the city of Goma (DRC).  
Photo credit: WHO*

## 6. Issues and challenges in 2010 and a look in to 2011

### Year in Review

In 2010, the African region faced immense challenges that negatively impacted on the timely response to disasters and emergencies. During the year, WHO faced inadequate funding which was also one of the most important challenges to implementation of DRR and EP activities in the African region. This challenge prevented the implementation of key activities, which were planned for the 2010/11 biennium.

At the Regional Office, due to inadequate numbers of staff, implementation of response and emergency activities were delayed implementation of activities at the country level. Secondly due to insufficient numbers of experts in emergency in the region support to countries was delayed. Finally inadequate reference guidelines at on DRR and preparedness made the implementation challenging. Inadequate staffing, high turnover rate of the few available health staff and lack of required skills and knowledge is another key challenge, which constrained effective implementation of DRR and EP activities. Other challenges include lack of reliable data for evidence-based planning, poor access to health services, difficulty in integration of DRR actions into sectoral development plans, weak intersectoral collaboration for DRR and EP and weak community participation and involvement in DRR and EP activities.

Furthermore, Disaster Risk Reduction (DRR) is a new concept which many partners (both in government and humanitarian agencies) are yet to understand. Weak surveillance system as a result of poor communication between central and peripheral health facilities is still a key problem in some of the countries of the sub-region.

### Looking a head

EHA/AFRO and IST will continue to support countries Emergency risk management approach to help to integrate aspects of the emergency management cycle (namely risk assessment, risk reduction, emergency preparedness, response and recovery measures) Strengthen partnership and build new alliances for effective outbreak and disaster response. Support the cluster approach in countries where the approach is existent.

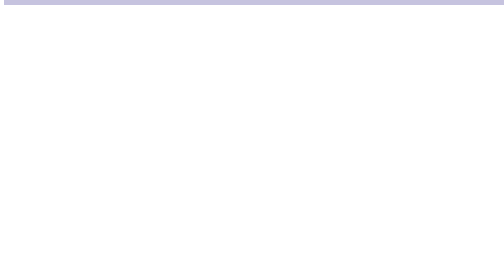
Support National governments and partners in understanding the DRR and EP concepts. Continue advocacy and technical support for resource mobilization for all phases of Disaster Risk Management.











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