
SUMMARY

Reinforcing institutional capacity for disaster preparedness and response (DPR) is of the utmost importance in the African Region — a region suffering from frequent conflicts and natural emergencies. A five-year strategy to improve emergency preparedness and response was initiated in 1997 and bolstered in 2005 by the Hyogo Framework for Action 2005–2015. Particular emphasis was given to building health systems and increasing community resilience. To this end the African Public Health Emergency Fund was established in 2009. In 2010, a survey of 46 countries in the African Region was undertaken to review the five-year strategy across health systems — 43 countries responded. Some modest improvements were noted; however, many challenges remain. This paper describes the new 10-year disaster risk management (DRM) strategy.
on Disaster Reduction in Hyogo, Japan, in 2005, adopted the Hyogo Framework for Action 2005–2015. It calls on all nations to support the creation and strengthening of multisectoral national platforms for coordinated action on disaster risk reduction. In addition, the International Health Regulations (2005) provide a framework for implementing alert and response activities to control international outbreaks and other public health risks and emergencies.

In 2005 a United Nations independent commission proposed reforms in the management of humanitarian response. These reforms were subsequently adopted in 2006 by the United Nations General Assembly. The reforms focus on three areas namely:

- building strong UN leadership at the field level;
- improving efficiency, accountability and coordination of interventions through sectoral working groups (humanitarian clusters) and;
- creating predictable sources of funding to facilitate effectiveness of humanitarian response.

In line with the Hyogo Framework for Action and the principles underpinning humanitarian reform, Member States adopted World Health Assembly Resolution WHA59.22 in 2006. The resolution requests Member States to further strengthen their national programmes with a special focus on building health systems and increasing community resilience. The establishment of the African Public Health Emergency Fund, as requested in Resolution AFR/RC59/R5 adopted in 2009 by the 59th session of the WHO Regional Committee for Africa, will further improve the funding of disaster preparedness and response.

In the past 13 years, Member States have made efforts to strengthen their institutional capacities for emergency preparedness and response with the support of partners. The level of implementation of the resolution, as reflected in the outcome of a survey conducted among the 46 countries in the Region in February 2010, is presented in Table 1. National emergency funds were available in 19 countries (41%). Twenty countries have conducted vulnerability assessments and risk mapping, the health component of which was adequately reflected in 12 of the countries. Only 11 countries have national emergency preparedness plans that cover multiple hazards. Simulation tests, required in order to update plans, are conducted in only 19 countries.

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

**ISSUES AND CHALLENGES**

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

Although modest achievements in disaster preparedness have been recorded by Member States, several challenges remain. This report highlights key issues and challenges and proposes a way forward.
Countries lack comprehensive disaster risk reduction and preparedness programmes containing the minimum WHO recommended elements regarding policy and legislation, capacity building, disaster risk analysis and mapping, and planning. Implementation of the Hyogo Framework calling on countries to assess the status and build the resilience and risk management capability of hospitals and other key health infrastructures has yet to commence.

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

Coordination is still a major challenge as national multisectoral committees lack the capacity and resources to coordinate the multiple components of DPR. Only 21 of the 46 Member States have established national platforms for disaster risk reduction. Observations made during monitoring visits showed that the participation of the health sector needs to be improved in most of the countries.

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

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

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

**Reserve allocation for emergencies by Member States remains inadequate.** Only 19 countries in the Region have established a national emergency fund 12 years after the adoption of Regional Committee Resolution AFR/RC47/R1 calling for its establishment.\textsuperscript{13} Most countries depend mainly on donor funding usually earmarked for acute response. Disaster prevention and preparedness and post-disaster health system recovery remain

### Table 1. Level of implementation of Regional Committee Resolution AFR/RC47/R1 by country, February 2010

<table>
<thead>
<tr>
<th>Action</th>
<th>Number of countries</th>
<th>Percentage of countries in the Region</th>
</tr>
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<tbody>
<tr>
<td>Have persons trained in public health pre-deployment (PHPD) or in health emergencies in large populations (HELP)</td>
<td>28</td>
<td>60.8</td>
</tr>
<tr>
<td>Established Early Warning System</td>
<td></td>
<td></td>
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<tr>
<td>Communicable diseases</td>
<td>40</td>
<td>86.9</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>25</td>
<td>54.3</td>
</tr>
<tr>
<td>Natural disasters</td>
<td>23</td>
<td>50.0</td>
</tr>
<tr>
<td>Established national emergency funds</td>
<td>19</td>
<td>41.3</td>
</tr>
<tr>
<td>Integrated DPR into national health plans</td>
<td>31</td>
<td>67.4</td>
</tr>
<tr>
<td>Involve communities in DPR</td>
<td>28</td>
<td>60.9</td>
</tr>
<tr>
<td>Promptly declare</td>
<td>35</td>
<td>76.1</td>
</tr>
<tr>
<td>Conducted vulnerability assessment and mapping</td>
<td>20</td>
<td>43.5</td>
</tr>
<tr>
<td>Vulnerability assessment covers health component</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>Set up multisector emergency committees</td>
<td>39</td>
<td>84.6</td>
</tr>
<tr>
<td>Cooperate with and support neighbouring countries in emergency issues</td>
<td>31</td>
<td>67.4</td>
</tr>
</tbody>
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Survey sample: 46 African countries; response: 43 countries.
under-funded; these components are weak in several countries.

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

**ACTIONS PROPOSED**

In view of the continuing threat posed by emergencies to socioeconomic development, there is a need to strengthen emergency preparedness and response. The new disaster risk management strategy developed by WHO comprises a minimum set of required priority interventions for each country which will assist in establishing the necessary enabling environment and capacities to manage disaster risks.

These priority interventions are guided by the following principles:

a) Gender and human rights principles that ensure incorporation of gender equity and human rights perspectives into policies and programmes as well as neutrality and impartiality in humanitarian response;

b) Equity in access to services, with special focus on highly vulnerable population groups including migrant populations and people living in Small Island Developing States;

c) Country ownership, with governments coordinating and ensuring that all interventions by partners are in line with relevant national guidelines;

d) Participation, with the involvement of communities and civil society;

e) Strengthening partnerships within the health sector, using the humanitarian reform principles; and

f) Fostering sustainable intersectoral collaboration at local and regional levels.

The strategic approach is to consider all potential hazards and all potential contributing factors that may affect health, including health determinants; climate change adaptation interventions; and action involving all ministry of health departments. The strategy may not require the development of new documents and structures, but an updating and strengthening of what exists. The following are the proposed interventions, the prioritization of which would depend on country context and specificities.

**Update national health policies, strategies and regulations** in order to incorporate provisions on prevention, preparedness and readiness, as well as response to the health impact of all potential hazards. The revisions should be congruent with national multisectoral legislation, policies and plans on DRM. The policy should cover all hazards and be based on all likely health risks (whole-health approach); this implies that all actors “manage the risks, not the crisis”. This approach was reinforced in 2011 by the 64th World Health Assembly in its Resolution WHA64.10.

**Build the capacities of existing units in the ministries of health** for risk management in order to coordinate multidisciplinary health action and facilitate the integration of health with multisectoral actors; including the national platform on disaster risk reduction and the development of networks and communities of practice on DRM.

**Develop education and training programmes in line with DRM.** This is important at undergraduate and graduate levels as well as continuing professional education to develop and maintain the knowledge, skills and performance of the health emergency management community. The training should be aligned with the regional standard package on emergency training and appropriate financial resources should be made available.
Assess hazards, vulnerabilities, risks and capacities from a health sector perspective. This should include assessment of the safety of health facilities and related infrastructure. The results of the assessment should be mapped to serve as the basis for programme development and health contingency, response and recovery planning that follows a process of engagement with stakeholders. The plans need to be updated regularly following simulation exercises and post operation evaluations.

Build health facilities and community resilience interventions. This involves designing the structural, non-structural and functional requirements of new health facilities to enable them to withstand the impact of hazards, and be functional in emergencies. Existing health facilities should be retro-fitted. Health facility disaster plans should be developed and tested. Community leaders and health workers should be engaged in risk assessment, planning and preparedness to build on local knowledge, experience and capacity. Community members should also play decisive roles in the execution, monitoring and evaluation of DRM intervention at community level.

Prepare and provide timely and adequate response to emergencies. Preparedness should be strengthened by developing, evaluating and revising response plans based on comprehensive risk analysis, taking into account all prevalent hazards. The plans should involve identifying rapid response teams at local and national levels including sources of surge support; pre-positioning medical supplies and other logistics; designating isolation units and safe areas; and organizing mass casualty management services. Procedures should be regularly tested. Standard operating procedures (SOPs) for health response and recovery operations should be developed to determine what needs to be done, by whom and how, before, during and after emergencies and disasters. Post-disaster needs assessment should be conducted to foster continuity of service, and rebuild public health services.

Improve funding for disaster prevention, emergency preparedness and post-emergency health system recovery. Existing resource mobilization mechanisms should be explored. The creation of a national emergency fund in line with Resolution AFR/RC47/R1 constitutes an additional funding opportunity.

Strengthen early warning for the health components of natural disasters and food crises. Information on the projected and actual health consequences of disasters including event-based surveillance should be generated and monitored, using appropriate indicators, through the national surveillance system. This will provide early warning and guide preparedness and health response. At the community level, actions should be taken to help the community identify risks and develop the predictive capacity towards the consequences of the disaster.

REFERENCES
9. Algeria, Benin, Burundi, Chad, Democratic Republic of the Congo, Guinea, São Tomé and Príncipe, Togo and Zimbabwe.
12. In addition to WHO guidelines, there are several others developed or in process of development by the Inter-Agency Standing Committee (IASC), International Committee of the Red Cross and Red Crescent (ICRC), Médecins Sans Frontières (MSF) among others.