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AFRICAN HEALTH VOLUNTEERS CORPS REPORT OF THE SECRETARIAT

BACKGROUND

1. The burden of disability and death from non-communicable diseases is growing at an alarming rate in Africa, with chronic diseases linked to demographic, behavioral and social changes, and urbanization becoming more prevalent. Hypertension, stroke, diabetes, chronic respiratory disease, the consequences of tobacco use, alcohol abuse and illicit drugs are becoming serious public health challenges. Injuries from violence, war, traffic accidents and other mostly preventable causes also result in widespread death and physical disability. It is also recognized that the impact of mental ill-health may have previously been underestimated yet it makes a significant contribution to the disease burden.
2. In Sub-Saharan Africa infectious diseases still cause the majority (69%) of deaths with chronic non-communicable diseases, such as cardiovascular disease, diabetes, chronic respiratory disease and cancers causing around 25% of deaths. However, this picture is changing as Sub-Saharan Africa undergoes an epidemiological transition, evidenced by a rapidly increasing chronic non-communicable disease burden.
3. The African region continues to be affected by recurring epidemics, natural disasters, conflicts, foodborne diseases and other public health emergencies. The region registers a significant number of events annually resulting in morbidity, mortality and disability. Although the majority of events are due to infectious diseases (80%) ongoing conflicts and natural disasters also play a role in humanitarian crises in the region. Africa also experiences various natural disasters, which affect health systems, causing disruption of health services delivery and subsequently impacting the individual health of those affected. According to the Centre for Research on the Epidemiology of Disasters (CRED), in 2014, the majority (61.5%) of the 39 natural disasters that occurred in Africa were hydrological, 15.4% were meteorological, 12.8% climatological and 10.3% geophysical.
4. On 21st March 2014, Ebola virus was confirmed to be the cause of an illness spreading through the forested areas of Guinea bordering Sierra Leone and Liberia. This outbreak spread quickly to Liberia initially, then to Sierra Leone, Nigeria, Mali and Senegal. At the same time, an unrelated Ebola Virus Disease (EVD) outbreak was confirmed in the Democratic Republic of Congo and Marburg in Uganda.
5. The EVD outbreak in West Africa, was by far the largest ever recorded. The outbreak shook the world and challenged the international community, leading to an outcry for the most powerful response possible. On 8th August 2014 with 1779 reported cases and 961 reported deaths affecting four countries; the World Health Organization (WHO) declared the EVD outbreak an international public health emergency and published a roadmap to guide and coordinate the international response to the outbreak, which aimed to stop ongoing Ebola transmission worldwide within 6–9 months. In this regard, WHO has progressively played a key leadership role in coordinating the epidemic response, mobilizing the international response and developing and supporting the implementation of the relevant health response strategies required to control the EVD epidemic. Subsequently,

multidisciplinary teams from the WHO African Region, other WHO regions, WHO headquarters, the US CDC, United Nations agencies, ECOWAS, the African Union, MSF and other NGOs were deployed to provide technical and humanitarian support to the epidemic response.

6. The African Union contributed significantly to continental efforts to respond to the epidemic. The African Union Peace and Security Council (PSC) in its 450th meeting of 19 August 2014 invoked Article 6 (f) of the Protocol Relating to the Establishment of the Peace and Security, and decided that given the emergency situation caused by the Ebola outbreak to authorize the “immediate deployment of an AU-led military and civilian humanitarian mission comprising medical doctors, nurses and other medical and paramedical personnel as well as military personnel as required for the effectiveness and protection of the mission”.
7. Subsequently, on 15 September 2014, the African union, to support the Ebola outbreak in West Africa (ASEOWA) deployed the first team of directly-recruited volunteers, comprising medical doctors, nurses and other medical and paramedical personnel, etc. to the West Africa Region, for the effective control of Ebola and the normalization of health services in the affected countries. This was followed by the deployment of Member State contingents from December 2014.
8. Considering the Ebola response by the international community, ASEOWA deployment had been among the largest with 855 personnel deployed, providing the much-needed human resources for health and deployed personnel were embedded with the national Ministries of Health.
9. The AU Assembly by its Decision No. Assembly/AU/Dec.570(XXV) of June 2015 requested the Commission, in collaboration with Member States and Development Partners, to establish an African Volunteer Health Corps. This Corps would be deployed during disease outbreaks and other health emergencies and report regularly to the Assembly on progress made. Subsequently, a draft proposal for the establishment of the Corps was developed by the Commission and during the review of the ASEOWA in October 2015; a Task Force was created which was composed of selected AU Member States and partners.

The Task Force met twice from 30 November to 1 December 2015 and from 22 to 23 February 2016 to review the draft proposal before it was tabled to Ministers of Health for consideration.

JUSTIFICATION

10. The frequency and magnitude of public health emergencies in the African Region is increasing. An annual average of 80 to 100 public health events were reported in the WHO African Region between 2000 and 2012 (WHO, 2014). These events are caused by infectious disease outbreaks of known and unknown causes including zoonotic diseases, natural and manmade disasters or other humanitarian emergencies. Examples include the 2009 H1N1 influenza pandemic, the recent EVD outbreak in West Africa, health consequences of acts of terrorism and massive displacement of populations due to conflicts or insurgency.

11. The EVD epidemic was protracted and exacerbated by a backdrop of poor health infrastructure and performance. Major contributing factors were inadequate implementation of critical frameworks, mainly the international Health regulations (IHR 2005) as well as weaknesses of the health systems. Furthermore, other critical contributing elements to weak health systems in the region include insufficient funding, inefficient use of available resources, inadequate allocation of health resources to cost effective health services, lack of incentives for health workers to provide quality care, inadequate regulation, inadequate involvement of the private sector in supporting the provision of health care, inequitable distribution of resources between urban and rural areas and between poor and better-off populations, and high household health expenditures even in the midst of "free care" systems.
12. Public health events and emergencies affect vulnerable populations such as displaced persons, both refugees and internally displaced persons (IDPs), especially women and children.
13. However, the regional frequency of public health emergencies (PHEs) is not matched by the availability of solid technical guidelines and personnel for preparedness and response. Of note, gaps in the timely detection and notification of events and provision of appropriate emergency response such as infection prevention and control have been observed in some African countries, thus contributing to high morbidity and mortality as well as the spread of infectious diseases. Human resource capacity is also not available at all levels of the health system for mobilization in a timely manner, as was seen in the response to the EVD outbreak in West Africa.
14. A well-trained, multidisciplinary and stand-by response team should be available and able to respond in the shortest time possible. On 19th August 2014 the African Union PSC authorized the "immediate deployment of an AU-led military and civilian humanitarian mission", i.e the deployment of human resources. However, it was not until 15 September 2014 that the Commission could deploy the first set of volunteers to Liberia, and early December the first Member State teams arrived in the affected countries.
15. The main justification for the establishment of the African Volunteer Health Corps (AVoHC) is to contribute to filling this gap and to address the lack of a system to utilize the available capacity of human resources for health in the region to respond to the frequent regional epidemics, and other emergencies in a timely and effective manner in close collaboration with WHO and other relevant stakeholders.
16. AVoHC will not only be focused on emergencies, it will also help Member States in strengthening their human resources for health by providing specialized services.

MANDATE, MISSION, OBJECTIVES

Mandate

17. In their Decision No. Assembly/AU/Dec.570 (XXV) of June 2015, the African Union Heads of State and Government requested the Commission in collaboration with Member States, WHO and Development Partners to establish an African Volunteer Health Corps to be deployed during disease outbreaks and other health emergencies and to report regularly to the Assembly on progress made.

Mission

18. The African Volunteer Health Corps is established under the framework of the Africa Centers for Disease Control and Prevention which will assemble and equip a roster of volunteer medical and public health professionals which will constitute AVoHC. The mission of the AVoHC is to support Member States with surge capacity during public health events or other situations with public health consequences.

Objective

19. The objective of the establishment of the AVoHC is to provide Member States with a rapid and effective means to respond to public health emergencies and matters of global concern, including health impacts of natural disasters and humanitarian crises. The AVoHC will enhance Africa's emergency response capacity.

COORDINATION AND COLLABORATION MECHANISMS

20. Disaster mitigation, preparedness, response and recovery are the end products of complex political and administrative interactions and the results cannot be easily controlled or anticipated. Analyzing the best way to approach these tasks is valuable, since improved performance in emergency management depends, to a great extent, on the ability of public officials to fully comprehend the complexities of the policy networks operating in the areas in which they work, and to think strategically about how to use or alter them.
21. AVoHC tasks will be accomplished through joint and collaborative operations with WHO, assigned relevant government institutions, other International Organizations and NGOs throughout the duration of its operations. The nature of these joint operations shall be informed by the nature and duration of the public health threat, and the type and duration of assistance that is to be provided. The execution of the assistance will vary by location and period depending on the nature of the public health threat. The key to the operational success of AVoHC will be in ensuring coordination with other actors, in particular the national authorities considering the existing comparative advantages of different stakeholders for coordination and operation during public health events. This approach will ensure harmonization of planning processes and field interventions and avoid duplication of technical assistance.

ACTIONS PROPOSED

Member States

22. To support the implementation of the AVoHC, a position already adopted by the AU Assembly, by making available their workforce to be part of the volunteers' roster.

African Union Commission

23. To develop a legal/operational framework for AVoHC;
24. To provide the leadership and oversight for the implementation of AVoHC.

WHO

25. To provide technical support and engage other relevant international organizations, institutions and stakeholders to ensure their support toward effective implementation and sustainability of AVoHC.

ANNEX: DECISION ON THE ESTABLISHMENT OF THE AFRICA HEALTH VOLUNTEERS CORPS

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**DECISION ON EBOLA VIRUS DISEASE (EVD) OUTBREAK
Doc. Assembly/AU/6(XXV)**

The Assembly,

1. TAKES NOTE of the Commission Progress Report on the Ebola Virus Disease (EVD) outbreak and **NOTES** that the EVD outbreak emergency is over and ASEOWA is preparing for the final exit by the end of its current mandate on **18 August 2015**;

2. CONGRATULATES the People and Government of Liberia on being declared Ebola free by the WHO on 9 May 2015;

3. EXPRESSES APPRECIATION:

i) to all Member States that contributed volunteer health workers to ASEOWA and **COMMENDS** the Commission for putting in place adequate safety measures that ensured the safe return of all the volunteer health workers;

ii) To Member States and Partners that supported ASEOWA and the affected countries with financial and material resources.

4. INVITES all Member States to participate at the highest level, in the International Conference on Africa's Fight against Ebola being organized under the theme: "***Africa Helping Africa in the Ebola Recovery and Reconstruction***", that will take place in Malabo, Equatorial Guinea from 20 to 21 July 2015;

5. COMMENDS the African Private Sector for their financial and material support and **REQUESTS** Member States to facilitate the continuation of the SMS initiative by granting required approval through their national regulatory authorities to the Mobile Network Operators;

6. REQUESTS the Commission:

i) to undertake a comprehensive review of the Humanitarian Policy Framework in order to capture an expanded disaster management protocol that addresses the current gaps in the coordination of response to disasters and emergencies by the Commission and to submit to the January 2016 Summit;

ii) In collaboration with Member States and Development Partners to establish an African Volunteer Health Corps to be deployed during disease outbreaks and other health emergencies and to report regularly to the Assembly on progress made.

7. DECIDES to remain seized of the matter and **REQUESTS** the Commission to report on progress and the implementation of this decision to the Executive Council in January 2016.