

# The Work of **WHO** in the African Region

REPORT OF THE REGIONAL DIRECTOR



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# Abbreviations

AICS	Accountability and Internal Control Strengthening
AMA	African Medicines Agency
AMR	antimicrobial resistance
APHEF	African Public Health Emergency Fund
APOC	African Programme for Onchocerciasis Control
ART	antiretroviral therapy
AUC	African Union Commission
AVW	African Vaccination Week
BMGF	Bill & Melinda Gates Foundation
bOPV	bivalent oral poliovirus vaccine
CDC	Centers for Disease Control
CFR	case fatality rate
CLP	Country Learning Programme
COP21	Paris Climate Change Conference
DDT	dichlorodiphenyltrichloroethane
DOTS	directly observed treatment short-course
DST	drug susceptibility testing
DTP	diphtheria-tetanus-pertussis-containing vaccine
ECCAS	Economic Community of Central African States
EPI	Expanded Programme on Immunization
EPI/IMCI	Expanded Programme on Immunization and Integrated Management of Childhood Illness
EQA	external quality assessment
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases
EVD	Ebola virus disease
FCAC	Fonds communautaire de la Santé pour l'Afrique centrale
FIND	The Foundation for Innovative New Diagnostics
GFF	Global Fund Facility
GPEI	Global Polio Eradication Initiative
GPW	General Programme of Work
HiAP	health in all policies
HIS	health information systems
HPV	human papillomavirus
HRH	Human resources for health
HSS	health system strengthening
ICATT	Integrated Management of Childhood Illness Computerized Adaptation and Training Tool
iCCM	integrated community case management
IDSR	integrated disease surveillance and response
IHR	International Health Regulations

IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IPC	infection prevention and control
IPRs	Intellectual property rights
IPV	inactivated poliovirus vaccine
IRIS	WHO's global Institutional Repository for Information Sharing
ITN	insecticide-treated net
ITP	Implementation Through Partnership
M&E	monitoring and evaluation
MDA	mass drug administration
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
NCDs	noncommunicable diseases
NEPAD	New Partnership for Africa's Development
NHOs	National health observatories
NHPSPs	National health policies, strategies and plans
NHSP	National health sector plans
NTDs	neglected tropical diseases
NTD-RPRG	Neglected tropical diseases-Regional Programme Review Group
OAFLA	Organization of African First Ladies against HIV/AIDS
OPV	oral poliovirus vaccine
OSAC	Organisation de la Santé de l'Afrique centrale
PC-NTDs	NTDs amenable to preventative chemotherapy
PCV	pneumococcal conjugate vaccine
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHEIC	public health emergency of international concern
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
r-SIS	real-time Strategic Information System
SANA	situation analysis and need assessment
SDGs	Sustainable Development Goals
SHA	System of Health Accounts
SRH	Sexual and reproductive health
SRL	Supranational Reference Laboratory (SRL) Network
TB	tuberculosis
TMK	Traditional medical knowledge
tOPV	trivalent oral poliovirus vaccine
UHC	universal health coverage
USAID	US Agency for International Development
VPDs	vaccine-preventable diseases
WASH	water, sanitation and hygiene
WASHFIT	Water and Sanitation for Health Facilities Improvement Tool
WHO PEN	WHO Package of Essential Noncommunicable Diseases
WHO CFE	WHO Contingency Fund for Emergencies
WISN	Workload Indicators of Staffing Need

# Executive Summary

By the WHO Regional Director for Africa

The Regional Director is pleased to present this report on the work of WHO in the African Region for the period October 2015 to June 2016. The report outlines the significant achievements made under the six categories in the 12<sup>th</sup> General Programme of Work in supporting Member States in the African Region in health development. It reflects contributions from WHO country offices and the Regional Office, including the three Intercountry Support Teams.



“WHO in the African Region is committed to working with its Member States and partners to attain the highest possible level of health for Africa’s people by achieving the Sustainable Development Goals and universal health coverage.”

**Dr Matshidiso Moeti,**  
WHO Regional Director for Africa

## Successful interruption of Ebola Virus Disease (EVD) transmission and improvement of health security

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The longest and most severe EVD epidemic in known human history was stopped in West Africa in December 2015 after an intensive and sustained response by governments, civil society and development partners, including the UN system. At the height of the epidemic in August-September 2014, an average of 150-200 cases per week were being reported. By the end of 2015, only a few cases were being reported, with that plateau continuing into 2016. Based on the recommendations of the IHR Emergency Committee, the WHO Director-General lifted the declaration of the EVD epidemic as a Public Health Emergency of International Concern on 29 March 2016. By then, a total of 28 616 confirmed, probable and suspected cases had been reported in Guinea, Liberia and Sierra Leone, with 11 310 deaths.

Sierra Leone declared the end of Ebola human-to-human transmission on 17 March 2016 and Guinea on 1 June 2016, following the last flare-ups. Liberia first declared the end of Ebola human-to-human transmission on 9 May 2016, but thereafter new cases re-emerged three more times in the country.

The end of the last flare-up of EVD in Liberia was declared on 9 June 2016. No cases subsequently emerged over a 90-day period of heightened surveillance which ensured that any new cases would be identified quickly and contained before spreading.

The swift containment of the flare-ups indicates that capacity has been built in these countries. Vigilance continues to be maintained in all three countries to prevent, detect and respond to suspected cases, as the risk of additional flare-ups from exposure to infected body fluids of survivors remains.

WHO and partners continue to work with the Governments of Guinea, Liberia and Sierra Leone to help ensure that survivors have access to medical and psychosocial care and screening for persistence of the virus, as well as counselling and education to help them reintegrate into family and community life, reduce stigma and minimize the risk of Ebola virus transmission. WHO is also collaborating with partners to support the countries to restore and strengthen key public health programmes, especially maternal and child health.



WHO/S. Gborie



## Continued focus on preparedness and swift response to epidemics



WHO/P. Haughton

WHO continued to work with Member States and partners to improve national capacity for preparedness and response, notably by conducting a regional risk analysis and mapping exercise. The most vulnerable countries are receiving support to strengthen preparedness and to develop national plans and road maps towards achieving and sustaining the IHR core capacities. WHO is working with several global initiatives on health security, and there is ongoing advocacy for coordinated action among Member States and partners to improve preparedness, alert and response, and to strengthen cross-country and cross-institutional collaboration. Member States are expected to commit domestic resources to implement the priority interventions, since national health security is the primary responsibility of governments.

WHO has worked with the Governments of Angola, the Democratic Republic of the Congo (DRC) and Kenya to contain a yellow fever outbreak of unprecedented scale. The outbreak started in Angola in December 2015, and spread to the DRC and Kenya. As of 30 June 2016, 3552 cases including 355 deaths had been reported in Angola, and 1399 cases with 82 deaths in the DRC. Uganda had also reported 60 cases and 7 deaths in an outbreak not related to the one in Angola. WHO and partners quickly supported the affected countries to implement control measures.

By the end of June 2016, the Organization had deployed 126 international experts to support vaccination campaigns and strengthen surveillance, risk communication, community mobilization, case management and integrated vector control.

## Continued focus on preparedness and swift response to epidemics

Through the International Coordination Group mechanisms, WHO provided over 14 million doses of yellow fever vaccine to Angola, the DRC and Uganda. Funds amounting to approximately US\$ 1.6 million were disbursed from the WHO Contingency Fund for Emergencies (CFE) and the African Public Health Emergency Fund (APHEF) to support national response efforts. The risk of yellow fever in the Region has changed, and a new yellow fever strategy is being developed in the Region with emphasis on immunization and health security.



The Regional Office also supported Cabo Verde and Guinea-Bissau to respond to outbreaks of Zika virus which were reported in October 2015 and June 2016 respectively. These outbreaks are linked to the Zika outbreak in the Americas, which was declared a Public Health Emergency of International Concern by the WHO Director-General on 1 February 2016. By 30 June 2016, 7585 suspected cases of Zika including nine infants with microcephaly had been reported among newborn babies of Zika-infected mothers in the two countries, with 202 cases laboratory-confirmed. The number of reported cases in Cabo Verde has since declined with the last confirmed new cases reported in March 2016, while Guinea-Bissau had three confirmed cases by the end of June 2016.

WHO provided support for the initial investigation and confirmation of the diagnosis through the deployment of experts, while guidance and advice on Zika preparedness and response were provided to other Member States and partners.

### Reducing childhood illness and mortality

WHO continues to promote immunization as the most cost-effective life-saving intervention, especially for children. Coverage with the third dose of the diphtheria-pertussis-tetanus vaccine (DPT3) in the African Region has improved with 24 countries reaching coverage rates above 90% in 2015.

## Reducing childhood illness and mortality

Countries also made significant progress in introducing new vaccines such as pneumococcal conjugate vaccines (PCV) and rotavirus vaccines into their immunization programmes. Thirty-eight countries are using PCV, while 31 are using rotavirus vaccines. The increasing use of these vaccines is already having a positive impact on disease prevalence. For instance, Ghana, Rwanda and Togo have reported reductions of 45-65% of rotavirus hospitalizations in large referral hospitals for the period 2014-2015.

To further strengthen advocacy for immunization, ministers of health, parliamentarians and partners adopted a declaration on Universal Access to Immunization – “Universal Access to Immunization as a Cornerstone for Health and Development in Africa” – at the first ever Ministerial Conference on Immunization in Africa jointly organized with the African Union Commission and the Government of Ethiopia in February 2016. Implementation of the declaration will contribute to reducing child mortality within the context of the Sustainable Development Goals (SDGs).

### **Sustaining the momentum towards the eradication of polio in the Region**

The momentum towards polio eradication in the Region was sustained, with no confirmed wild poliovirus case in the Region since July 2014.



WHO/ Y. Selamawit

The African Region successfully completed phase 1 of polioviruses laboratory containment, with the destruction of polioviruses and potentially infectious materials by the first quarter of 2016.

In line with the Global Polio Eradication Global Action Plan requirements, the Region was among the first to successfully switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) in April-May 2016. Work to ensure the successful transition of polio staff and resources in the African Region is ongoing.

## Reducing the burden of **communicable diseases**

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As the world moves from the Millennium Development Goals (MDGs) and pursues the Sustainable Development Goals, WHO has made a significant contribution to Member States' progress in reducing the burden of communicable diseases including vaccine-preventable diseases, HIV/AIDS, tuberculosis, malaria and neglected tropical diseases. For example, the number of adults and children newly infected with HIV in the African Region has declined by 19% in the last 5 years, from 1.63 million to 1.37 million and treatment scale-up is continuing, with an estimated 12.1 million people (43% of those eligible) receiving antiretroviral therapy (ART) by the end of 2015. Annual HIV-related deaths in the African Region have dropped to 800 000 compared to the over 1.5 million deaths in 2004, the peak year of HIV deaths. Following the release of the new WHO "Treat All" guidelines on HIV prevention, treatment and care, 31 priority countries were supported to

develop plans for the new recommendations towards the "90-90-90" targets. Providing antiretroviral therapy for all persons who test HIV positive regardless of CD4 cell count will further reduce new HIV infections and HIV-related deaths in the Region.

While new TB cases and deaths continue to decline, multidrug-resistant TB (MDR-TB) is still a challenge in the Region. WHO has helped countries to scale up the management of drug-resistant TB through access to quality assured medicines. To address challenges in diagnosis, WHO together with partners developed and launched the Regional framework for strengthening the TB diagnostic network in Africa. As part of the process, WHO facilitated discussions with the Global Fund to procure prefabricated container laboratories with adequate biosafety for a few countries in the Region to perform TB cultures and drug susceptibility testing (DST). To accelerate the reduction of the TB burden, the Region has developed a framework to implement the post-2015 TB prevention, care and control "End TB" strategy, which was adopted by the Sixty-seventh World Health Assembly.

The African Region has made significant progress in malaria control. Malaria incidence and mortality rates declined by 42% and 66% respectively between 2000 and 2015, while the prevalence of infection in children aged 2–10 years has dropped by more than half. Six countries can potentially eliminate local transmission of malaria by 2020.

## Reducing the burden of **communicable diseases**



This progress is the outcome of the expanded implementation of cost-effective prevention and case management interventions, with about 67% of the general population in the Region having access to an insecticide-treated net (ITN) and 16% of children in need having access to artemisinin-based combination therapy (ACT) in 2014, up from less than 1% in 2005.

WHO's contribution to the progress made in addressing HIV, TB and malaria included technical assistance for various programmatic components as well as grant negotiations. The Regional Office responded to 62 requests for technical assistance from 15 countries between October 2015 and June 2016. Through the WHO/Global Fund (GF) cooperation agreement of May 2014, the Regional Office devoted US\$ 4 million to providing technical support to countries to write about 50 Concept Notes, of which over 85% had GF approval on first submission. More than US\$ 4 billion worth of grants has been raised since the inception of this agreement.

In November 2015, WHO entered into a GF-initiated partnership platform called "Implementation Through Partnership (ITP)". WHO is supporting 18 countries in the African Region with large GF portfolios and low utilization to accelerate implementation of their TB, HIV, malaria and health system programmes.

Neglected Tropical Diseases (NTDs) impact the poorest people and constitute a top priority for WHO in the Region. It is critical to have a strong thrust on targeted, cost-effective interventions to achieve ambitious targets such as the eradication of guinea-worm disease in the Region. To that end, after the planned closure of the African Programme for Onchocerciasis Control (APOC) in December 2015, WHO established the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) to support countries to tackle NTDs amenable to preventative chemotherapy (PC-NTDs). These are lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma. A total of 41 countries have partnered with WHO to map where these diseases occur and people are infected. This will allow countries to make evidence-based decisions on starting mass drug administration (MDA) for preventive chemotherapy.

Guinea-worm disease is on the verge of eradication. Reported cases of guinea-worm disease have dropped from 126 in 2014 to 22 in 2015 in the four remaining endemic countries (Chad, Ethiopia, Mali, and South Sudan) where WHO provides support for active community-based surveillance, daily reporting of rumours of suspected cases, and prompt containment of cases.

## Addressing the burden of **noncommunicable diseases**

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Noncommunicable diseases (NCDs) as well as disabilities, violence and injuries are a burgeoning problem in the African Region where it is projected that by 2025, 55% of all deaths will be attributable to NCDs and injuries. WHO conducted a country capacity survey which 35 countries have now completed, as the basis for action to strengthen capacity to respond to the growing burden in Member States. Eight more countries have developed national, multisectoral NCD plans, bringing to 23 the number of countries that are ready to accelerate action on these diseases, while seven countries have developed mental health policies and plans.

Cervical cancer is one of the most frequent cancers among all women in Africa. Most Member States lack facilities and trained staff for effective prevention, early detection or treatment. WHO contributed to enhancing cervical cancer services through

skills development in cancer registration in 21 countries, and trained trainers in Malawi, Zambia and Nigeria on cervical cancer prevention and control.

Efforts to address the major NCD risk factors – tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets – through prevention and control are being strengthened. In tobacco control, The Gambia became the first country to launch national clinical guidelines for tobacco cessation, while Botswana introduced an additional levy on all tobacco products, another first in the Region. In further initiatives to reduce tobacco use and exposure to tobacco smoke, five countries enacted legislation and regulations in line with the WHO Framework Convention on Tobacco Control. Burkina Faso, Côte d'Ivoire and Mali ratified the Protocol to Eliminate Illicit Trade in Tobacco Products in the reporting period, totalling five countries in the African Region out of 19 globally that are Parties to the protocol.

### **Promoting intersectoral action for health**

Addressing the social determinants of health is a major focus in the Region. Attention has been directed toward strengthening the capacity of countries to integrate “health in all policies” (HiAP) in other sectors as part of an intersectoral action plan. In November 2015, WHO organized a capacity strengthening workshop in Johannesburg, South Africa for policy-makers from sectors such as trade, social affairs and local government from 15 countries.

## Promoting **intersectoral action for health**

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Using various WHO tools, case studies and reports shared at the meeting including the Health in All Policies Training Manual, these countries have now developed implementation plans and policy briefs to address social determinants of health through intersectoral action. Cholera outbreaks are one example of such intersectoral action, where WHO has worked with countries and other UN agencies to support the water, sanitation and hygiene sectors.

The African Region is particularly vulnerable to environmental determinants of health, and is currently in the grip of an El Niño phenomenon which has led to extreme weather conditions and national drought disasters in several Member States.

This has affected millions of people in Eastern and Southern Africa. In line with the SDGs, the Regional Office has developed a Regional strategic agenda to stimulate investment and intersectoral action on priority health and environment programmes in Africa. Multidisciplinary teams of experts were deployed to give technical support to Eastern and Southern African countries experiencing the effects of El Niño, where they assisted in developing national health sector El Niño response plans, and providing financial resources for the cholera response. To broaden partnership and intersectoral collaboration on climate change, the Regional Office hosted an “Africa Pavilion Event” at the Climate Change Conference in Paris in December 2015.

## Promoting **intersectoral action for health**

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It showcased examples of cost-effective strategies to build community resilience and advocated for effective community participation to address the public health impact of climate change in Africa.

### Advancing **strategic partnerships for health**



The Regional Office is making strides in establishing and strengthening strategic partnerships. Working in close collaboration with the WHO Regional Office for the Eastern Mediterranean, the WHO Regional Office for Africa is supporting the African Union Commission (AUC) in its efforts to advance the health agenda on the continent.

WHO has supported the establishment of the Africa Centre for Disease Control and Prevention (Africa CDC) and will sign a collaboration framework with the AUC for synergy in addressing health security.

The Regional Director visited several major bilateral partners including a range of United States Government agencies and the United Kingdom Department for International Development (DFID) to reinforce existing partnerships.

As part of WHO's leadership role in health in the African Region, the Regional Director attended a ministerial meeting in the Republic of Gabon, where WHO provided technical support for the establishment of a Central African Health Organization and also the Central African Common Fund for Health. The Regional Director also paid a working visit to China in March 2016 during which she discussed China's potential role in promoting sustainable health development in Africa with senior government officials.

### Forging ahead **with the Transformation Agenda**

Implementation of the Transformation Agenda (TA) is proceeding apace, with a focus on strengthening WHO's human resources, delivering results, and improving accountability and transparency. The Regional Office has moved forward on realigning human resources with programmatic priorities.

Four of the five technical clusters in the Regional Office, including the Inter-country Support Teams (IST) have been realigned according to new organograms. A similar alignment is underway to ensure that staffing at country level takes into account the needs prioritized by Member States and WHO's competitive advantage.



## Forging ahead **with the Transformation Agenda**

Improved recruitment processes have been introduced using standardized assessment approaches, including selection panels; written tests, interviews, background checking and recourse to recruitment agencies when necessary. This is expected to ensure that the Secretariat recruits candidates of the highest quality. An induction programme for newly-recruited staff members has been developed.

The Regional Office has made progress in implementing the Accountability and Internal Control Strengthening (AICS) Project initiated early in 2015. Key Performance Indicators for management functions such as finance and accounts, procurement and human resources are monitored in all country offices and reviewed quarterly to show key trends. They indicate good performance in the areas of human resources management and security, and the need for significant improvement in procurement, travel, and the provision of information technology services.

To address the perceived culture of non-compliance, a Compliance and Risk Management Committee was formally established in the Regional Office to ensure a strategic, transparent and effective approach to risk and compliance management. The most critical risks identified include lack of sustainable funding, poor response to emergencies/outbreaks, inappropriate use of Direct Financial Cooperation, and inefficient procurement.

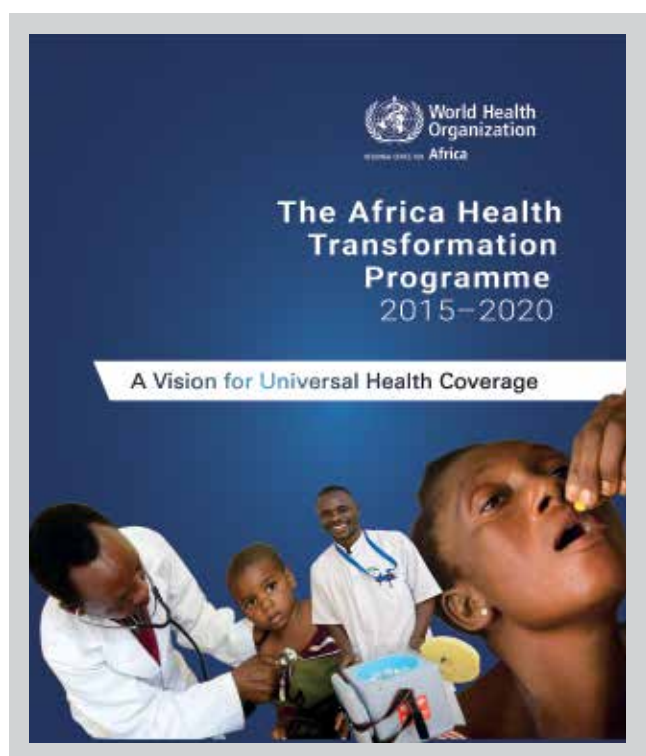
To assist newly appointed heads of country offices, joint administrative and programme reviews are conducted in countries within six months of their arrival, whenever feasible. These reviews highlight areas for improvement and document best practices to be shared with other country offices. In addition, given that many of the identified risks require action from Member States, WHO developed a handbook for ministries of health to inform their administrative and financial personnel on WHO rules and procedures.



## Moving forward

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The Regional Office has developed “*The Africa Health Transformation Programme, 2015-2020: A Vision for Universal Health Coverage*” to provide a framework for the future work of WHO in the Region. The goal is to support all Member States to ensure universal access to a basic package of essential health services, with minimal financial, geographic and social obstacles to users. The adoption of the SDGs provides an opportunity to push forward on this goal as it places a premium on inclusive engagement across development sectors and levels of society, expanding intersectoral collaboration and focuses strongly on equity and reaching the hardest to reach populations, so that no person is “left behind”.



Implementation of the SDGs will require key strategic actions from Member States, including political commitment shown through investment of domestic resources and a focus on results; incorporation into national health and development plans; stronger partnerships and involvement across sectors and society; strengthened national and subnational systems for monitoring; and effective accountability mechanisms.

The WHO Secretariat in the African Region will advance implementation of the SDGs by intensifying its advocacy efforts with governments. It will support health planning, including translating health-related SDGs into relevant national goals through the revision of national health policies and strategic and investment plans. It will drive implementation through universal health coverage (UHC), including improving service delivery by strengthening the health workforce and adopting an integrated, people-centred health services approach which emphasizes functional health districts and enhanced community engagement; working with governments to maximize the use of resources; promoting partnerships; and strengthening the management of information for action and accountability.

WHO in the African Region is committed to working with its Member States and partners to achieve universal health coverage and the Sustainable Development Goals.

## Moving forward

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In the area of health security, WHO is undertaking major reforms to make it fit for purpose to address global public health threats. A new WHO Health Emergencies Programme has been established and will offer a single platform across all the three levels of the Organization to address disease outbreaks and other health emergencies. The WHO Secretariat in the African Region will have capacity to better support Member States to prevent, detect and respond to health emergencies using the “all-hazards approach”.

To help improve national capacity for preparedness and response, a Regional strategy for health security and emergencies will be presented for adoption by the Sixty-sixth session of the Regional Committee. The strategy emphasizes the “all hazards approach” which incorporates planning for all potential natural and technological hazards. WHO will support Member States

to implement the strategy which specifies priority interventions to strengthen and sustain their capacity to prepare for, prevent, promptly detect and confirm outbreaks, and respond to and recover from outbreaks and emergencies. Member States are expected to commit domestic resources to implement the priority interventions.

It is expected that the fundamental shifts in organizational culture and systems being promoted through the Transformation Agenda will fortify WHO in the African Region and endow it with the leadership, efficiency, transparency and responsiveness it requires to drive a new health agenda for universal health coverage in Africa.

**Dr Matshidiso Moeti**  
*WHO Regional Director for Africa*



# 1. Introduction



WHO/M. Winkler

This report – *The Work of WHO in the African Region, 2016: Annual Report of the Regional Director* – covers the period from October 2015 to June 2016 and reflects the work accomplished since the last Regional Director’s report to the Regional Committee.

The report highlights progress made by Member States to improve health outcomes with the support of the WHO Secretariat in the African Region, which comprises the country offices and the Regional Office, including Intercountry Support Teams. The support was provided through the dissemination of norms and standards, provision of technical assistance for the development/updating of national policies, strategies and plans for scaling up cost-effective health interventions, strengthening national capacity for implementation and monitoring, and support for resource mobilization and partner coordination.

The report is presented according to the six categories of the 12<sup>th</sup> GPW. These categories are: (i) communicable diseases; (ii) noncommunicable diseases; (iii) promoting health through the life course; (iv) health systems; (v) preparedness, surveillance and response; and (vi) corporate services and enabling functions.

It is organized into seven chapters as follows:

- (i) Introduction
- (ii) Context
- (iii) Implementation of the WHO Programme budget 2014-2015 and 2016–2017
- (iv) Significant achievements by category of work
- (v) Progress made in the implementation of Regional Committee resolutions
- (vi) Challenges and constraints
- (vii) Conclusion.



## 2. Context



WHO/C. Black

During the period under review, WHO performed its work within a complex, multifaceted context. This included moving from outbreak response to building resilient health systems in the countries most affected by the Ebola virus disease (EVD) epidemic; new health security and emergency challenges including re-emerging communicable diseases and the El Niño phenomenon in Southern and Eastern Africa; transitioning from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs); the increasing burden of noncommunicable diseases; the global fall in commodity prices that has affected government funding for health; and the ongoing implementation of the Transformation Agenda in the African Region.

The successful interruption of EVD transmission in Guinea, Liberia, and Sierra Leone and WHO's declaration that the outbreak no longer constituted a public health emergency of international concern, led to heightened efforts to rebuild the health systems in these three most affected countries.

WHO and partners invested significant resources to help these countries revise their National Health Strategic Plans, build health workforce capacity in the area of epidemic preparedness and response, re-establish critical health services such as maternal and child health services, and strengthen infection prevention and control in health facilities.



The successful containment of the sporadic cases of EVD that occurred in these countries after the outbreak reflects the tremendous investments made by these governments and partners towards building resilient health systems.

Unfortunately, further outbreaks and emergencies occurred which demanded prompt action and resources. The Region is experiencing an unprecedented yellow fever outbreak in large urban areas with low vaccination coverage. The disease spread rapidly from Angola to the Democratic Republic of the Congo (DRC), while Kenya and China also reported imported cases. The outbreak in these large urban areas required urgent action by the affected countries and by WHO and other partners.

These included deployment of technical experts, resource mobilization and mass vaccination campaigns, including the vaccination of nearly six million people. The nature of the outbreak has highlighted the need for a new strategy on yellow fever in the Region.

In October 2015, the Zika virus disease linked to the outbreak in Latin America surfaced in the Region, notably in Cabo Verde and Guinea-Bissau. WHO worked hard to engage governments and partners around preparedness and response, including mobilizing financial resources, and developing a risk assessment framework.



Cholera was another outbreak which affected thousands of people in Tanzania, Kenya and Ethiopia. WHO and the relevant health ministries deployed rapid response multidisciplinary teams to work with regional and district officials to strengthen the cholera outbreak management. A very strong El Niño episode causing intense drought is being experienced in Southern and Eastern Africa. This has resulted in severe malnutrition, especially among children and displaced populations, and impacted on delivery of health services. WHO provided financial support from the African Public Health Emergency Fund (APHEF) to establish emergency treatment centres and provide health products to manage cholera.

The scale and effort required to contain these emergencies has galvanized WHO into overhauling its response to health emergencies. This reform culminated in the establishment of WHO's Health Emergencies Programme in January 2016 as a single programme with one workforce, one budget, one set of rules and processes and one clear line of authority.<sup>1</sup> The new Programme is designed to address all hazards flexibly, rapidly and with a principle of 'no regrets'. In the WHO Regional Office for Africa, the Health Security and Emergencies Cluster is leading efforts to tackle the urgent need for greater, more integrated efforts on health security and emergencies in the Region. It will work with a network of partners, experts and institutions to stimulate better integration and effectiveness of disease surveillance, epidemic and pandemic alert and response, and emergency risk and crisis management.

This period marked the transition from the MDG agenda to the initiation of work on the SDGs. Member States of the African Region made significant investments and



progress towards achieving the MDGs, specifically in meeting the child health, malaria and HIV targets. However, by the end of 2015, due to a number of challenges, no country had fully achieved all the health-related targets of the MDGs.

In September 2015, Heads of State and Government, meeting at the United Nations Headquarters in New York, adopted 17 SDGs and 169 targets to guide global development over the 15 years to 2030.<sup>2</sup> Goal 3 of the SDGs is on health and aims to "ensure healthy lives and promote well-being for all at all ages". This goal has an ambitious agenda, while the cross-cutting nature of health ensures that other goals also involve elements of health. The Region is engaging Member States through various partnerships on how to better monitor the implementation of the SDGs which require society-wide actions to address the social and economic determinants of health.



The burden of communicable diseases such as malaria, neglected tropical diseases (NTDs), HIV and TB continues to impact on the delivery of health services at country level as well as WHO's support to countries. WHO anticipates, for example, that it will require greater resources to support countries to implement the recommended "treat all" policy of the revised HIV treatment guidelines.

Meanwhile, the burden of noncommunicable diseases (NCDs) has continued to increase, linked partly to rapid urbanization and lifestyle changes. WHO estimates that the increase of NCDs in the African Region in the next ten years will be almost double that of developed countries,<sup>3</sup> and may constitute the leading cause of disability and premature deaths.

It is critical that countries integrate the prevention and control of NCDs into relevant policies of non-health government departments and promote interventions to reduce their main risk factors.

The period under review also witnessed a significant global fall in the prices of oil, metals and other commodities, which has affected the capacity of many Member States to use their own resources to implement some priority health programmes. In some cases, governments have cut budget allocations to the social sectors, including health. Member States need to devote more efforts to mobilizing additional domestic resources to address health priorities and improve progress towards attaining regional and global targets.

The programmatic and managerial reforms implemented during the development of the 2014-2015 Programme Budget are the building blocks of this biennium's Programme Budget. Overall, the global WHO programme budget for 2016-2017 increased by US\$ 236.6 million, representing an 8% increase over the previous biennium for Base Programmes. The approved budget for the African Region for 2016-2017 increased by US\$ 42.3 million (4%). The allocation to countries increased to 80% in 2016-2017, with 20% allocated to the Regional Office, compared to 75% and 25% in 2014-2015.

WHO continues to forge ahead with its reform agenda to transform health in Africa, with universal health coverage as its overarching goal. Work on the Secretariat's Transformation Agenda has concentrated on strengthening accountability and compliance, realigning staff needs with regional priorities and improving partnership with health stakeholders. WHO has invested time in this necessary change which has required staff adjustment at all levels. The Transformation Agenda has so far contributed to more focused support for WHO's work in Member States and is instituting a culture of transparency and accountability as WHO strives to deliver on its commitments.



### 3. Implementation of the WHO Programme Budget 2014-2015 and 2016-2017



The reporting period October 2015 to June 2016 saw the closure of Programme Budget (PB) 2014-2015 and the opening of PB 2016-2017. The WHO Programme Budget 2014-2015 for the African Region initially approved by the Sixty-sixth World Health Assembly was US\$ 1 120 000 000. By the end of 2015, this had been increased to US\$ 1 804 428 000. However, the funds available for the biennium in the Region was US\$ 1 602 862 000.

The increased funding was entirely due to the two emergency segments of the WHO budget: the Global Polio Eradication Initiative (GPEI) and the outbreak and crisis response (OCR) segment, which together had a total budget allocation of US\$ 1 087 246 000, but available funds were US\$ 932 579 000.

The base segment of the budget, excluding polio eradication and outbreak and crisis response, was allocated US\$ 717 182 000 and was funded up to US\$ 670 283 000.

The programme budget performance assessment for 2014-2015 showed an overall implementation rate of 91% (Table 1). This was the first end-of-biennium exercise to be undertaken under the Twelfth General Programme of Work (2014-2019). It was also the first assessment of the implementation of the programme budget based on the new results chain, one of the major products of the WHO programmatic reform, combining both the WHO financial report and assessment of organizational performance during the biennium.

**Table 1: Budget implementation for PB 2014-2015 – As at 31 December 2015 (in US\$ 000)**

Category	Approved Budget by WHA	Allocated PB	Total Available Funds	% Funding against Approved Budget	Budget Utilization	% Utilization against Approved Budget	% Utilization against Funding
	(A)	(B)	(C)	(D=C/A)	(E)	(F=E/A)	(G=E/C)
<b>Category One</b> Communicable diseases	266 700	279 779	260 649	98%	233 344	87%	90%
<b>Category Two</b> Noncommunicable diseases	56 500	57 587	50 043	89%	47 035	83%	94%
<b>Category Three</b> Promoting health through the life course	92 000	105 673	92 266	100%	84 003	91%	91%
<b>Category Four</b> Health systems	71 300	84 170	79 686	112%	72 607	102%	91%
<b>Category Five</b> Preparedness, surveillance & response	55 500	57 792	51 699	93%	49 702	90%	96%
<b>Category Six</b> Corporate services & enabling functions	130 500	132 181	135 946	104%	129 553	99%	95%
<b>Total Base Programmes</b>	<b>672 500</b>	<b>717 182</b>	<b>670 283</b>	<b>100%</b>	<b>616 244</b>	<b>92%</b>	<b>92%</b>
<b>Emergency Programmes</b>							
05 - (Polio & OCR)	447 500	1 087 246	932 579	208%	847 660	189%	91%
<b>Grand Total</b>	<b>1 120 000</b>	<b>1 804 428</b>	<b>1 602 862</b>	<b>143%</b>	<b>1 463 904</b>	<b>131%</b>	<b>91%</b>



The WHO Programme Budget for 2016-2017 was adopted by the Sixty-seventh World Health Assembly with a total of US\$ 1 162 300 000, representing 27% of the global approved budget of US\$ 4 384 900 000, allocated to the African Region. As a result of the ongoing emergencies within the Region, the total allocated budget for the Region was increased by 17%, bringing the total allocated budget for the Region to US\$ 1 355 325 525 (Table 2).

The distribution of the budget to various categories of work is still uneven, with the greatest share dedicated to emergency programmes (polio eradication and OCR), which were allocated 45% (US\$ 604 600 000) of the Regional budget. The remaining 55% (US\$ 750 725 525) is distributed among the other programme areas, with some priority programmes receiving a limited budget.

Against the total budget of US\$ 1 355 325 525 allocated to the Region, funds actually available as at the end of June 2016 amounted to US\$ 908 582 830, representing 67% of the budget allocation.

Of the available resources, the emergency programmes have US\$ 434 944 777 available so far, which is about 48% and highly specified, while the balance is distributed among other programmes. As at 30 June 2016, US\$ 383 309 014 had been utilized, representing an implementation rate of 42% (Table 2). Across the technical categories of work, implementation ranges from 31% for Category Two (noncommunicable diseases) to 52% for emergency programmes. On the whole, implementation is on target.

The budget for the entire Region will continue to be financed through a mix of assessed contributions from Member States and voluntary contributions from State and non-State actors. The Secretariat will continue its engagement in the financing dialogue as this is critical in coordinating the mobilization of resources towards better alignment of financing, transparency and a clear understanding of WHO's long-term financing needs for effective implementation of its strategies.

**Table 2: Budget implementation for PB 2016-2017 - As at 30 June 2016 (in US\$ 000)**

Category	Approved Budget by WHA	Allocated PB	Total Available Fund	% Funding against Approved Budget	Budget Utilization	% Utilization against approved Budget	% Utilization against Funding
	(A)	(B)	(C)	(D=C/A)	(E)	(F=E/A)	(G=E/C)
<b>Category One</b> Communicable diseases	284 000	245 610	130 866	46%	45 061	16%	34%
<b>Category Two</b> Noncommunicable diseases	61 800	56 240	19 413	31%	6032	10%	31%
<b>Category Three</b> Promoting health through the life course	105 200	97 310	61 672	59%	28 646	27%	46%
<b>Category Four</b> Health systems	89 000	96 890	61 144	69%	19 440	22%	32%
<b>Category Five</b> Preparedness, surveillance & response	64 300	94 260	51 086	79%	25 050	39%	49%
<b>Category Six</b> Corporate services & enabling functions	146 400	160 416	149 458	102%	35 072	24%	23%
<b>Total Base Programmes</b>	<b>750 700</b>	<b>750 726</b>	<b>473 638</b>	<b>63%</b>	<b>159 301</b>	<b>21%</b>	<b>34%</b>
<b>Emergency Programmes</b>							
05 - (Polio & OCR)	411 600	604 600	434 945	106%	224 008	54%	52%
<b>Grand Total</b>	<b>1 162 300</b>	<b>1 355 326</b>	<b>908 583</b>	<b>78%</b>	<b>383 309</b>	<b>33%</b>	<b>42%</b>



## 4. Significant achievements by category of work



WHO/E. Kabambi Kabangu

### 4.1 Category 1: Communicable Diseases

WHO supported Member States to reduce the burden of communicable diseases including vaccine-preventable diseases, HIV/AIDS, tuberculosis, malaria and neglected tropical diseases. The support of WHO and its partners enabled Member States to implement activities which raised and sustained coverage of proven interventions, resulting in the reduction of the burden of communicable diseases.

To promote immunization as a life-saving intervention, WHO together with the African Union and the Government of Ethiopia organized the first ministerial conference on immunization in the Region. Forty-six countries endorsed a declaration

on “Universal Access to Immunization as a Cornerstone for Health and Development in Africa”, thereby affirming immunization’s place at the top of the health development agenda. Forty-four Member States used the 5th African Vaccination Week (AVW) in April 2016 to advocate for increased demand for immunization and intensify campaigns.

All 47 countries of the African Region successfully switched from using trivalent oral poliovirus vaccine (tOPV) (against poliovirus types 1, 2 and 3) to bivalent OPV (against poliovirus types 1 and 3) in their routine immunization schedules, eliminating the risk of paralysis due to vaccine-derived poliovirus type 2.

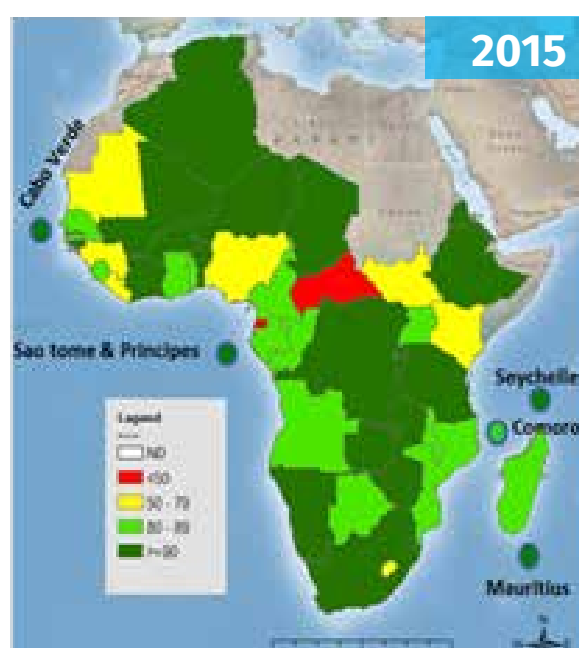
Prior to the switch, the inactivated polio vaccine (IPV) was introduced by 21 countries<sup>4</sup> to further boost population immunity against the three types of poliovirus.



WHO/J. Pudlowski

With support from WHO and its partners, six countries<sup>5</sup> were able to increase their diphtheria-tetanus-pertussis-containing vaccine (DTP3) coverage between 2014 and 2015 by at least seven percentage points, including two of the priority countries which developed improvement plans, namely Ethiopia and Chad. Ethiopia's coverage increased from 87% to 96%, while Chad's improved from 83% to 92%. Two others with improvement plans (Nigeria and DRC) reported smaller increases in coverage. South Sudan recorded decreased coverage, from 58% to 50% over the same period due to the multiple challenges the country is facing. Figure 4.1.1 shows DTP3 coverage in 2014 and 2015, where 22 countries in 2014 and 24 in 2015 had coverage above 90%. In the meantime, by June 2016, the second dose of the measles vaccine, and the rubella vaccine had been introduced in routine immunization programmes in 24<sup>6</sup> and 10 countries<sup>7</sup>, respectively.

**Figure 4.1.1. Immunization coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine (DTP3) for countries of the WHO African Region, 2014-2015**

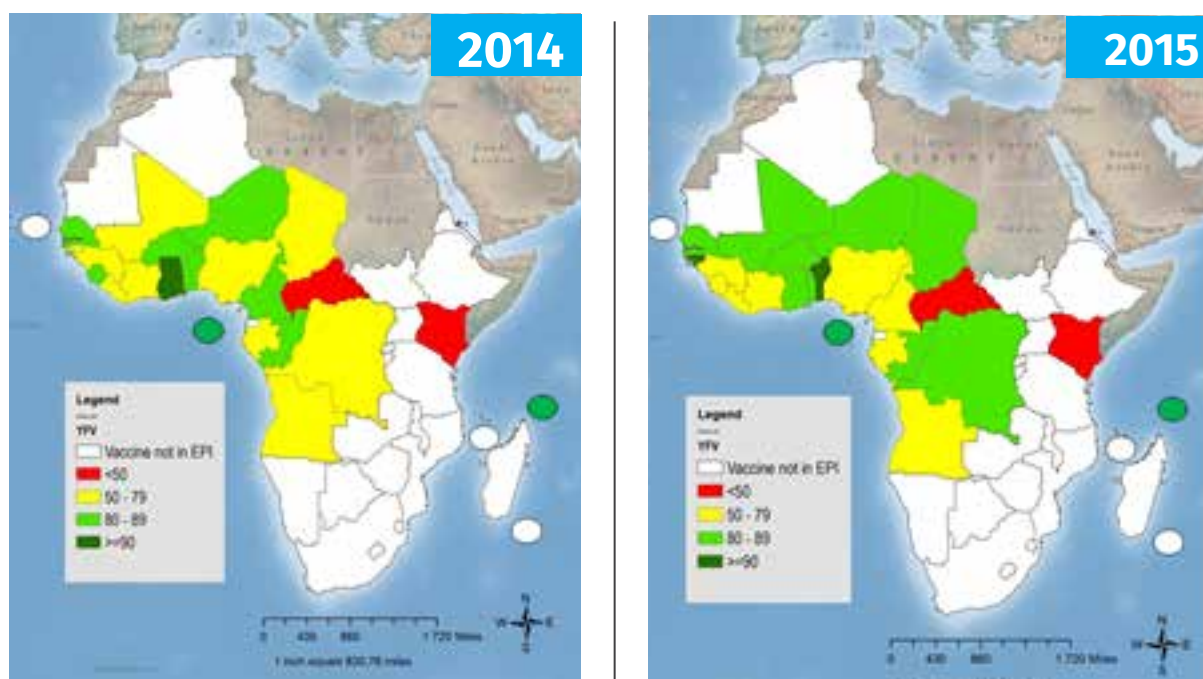


Source: National official reported coverage by member states in the joint reporting form 2015 (JRF)

Member States are increasingly introducing new vaccines into their immunization programmes. By the end of June 2016, Eritrea, Lesotho and Mauritius had introduced the pneumococcal conjugate vaccine (PCV), totalling to 38 countries<sup>8</sup> now using this vaccine in their routine EPI programmes. Seven additional countries<sup>9</sup> introduced rotavirus vaccines, bringing to 31 the number of countries<sup>10</sup> using these vaccines in routine childhood immunization, a development that will further reduce the burden of vaccine-preventable diseases. Fourteen countries<sup>11</sup> are currently using the WHO sentinel surveillance system to monitor the impact and effectiveness of rotavirus vaccines. The results show a reduction of 45-65% in rotavirus hospitalizations in large referral hospitals in Ghana, Rwanda and Togo.<sup>12</sup>

Yellow fever vaccination was first introduced into the routine EPI schedule in the African Region in 1979 in Burkina Faso and The Gambia. Since then, 22 additional high risk Member States<sup>13</sup> have introduced yellow fever vaccination in their EPI programmes with the latest being Guinea-Bissau in 2008. Of these, Benin, The Gambia, Guinea-Bissau, Sao Tome and Principe and Seychelles have reached the recommended coverage of 90% at national level. The Gambia, Sao Tome and Principe and Seychelles have been able to maintain a national coverage of at least 90% for two consecutive years (2014 and 2015), while Benin, Chad, the Democratic Republic of the Congo, Gabon, Guinea-Bissau and Mali increased their coverage by at least 7 points between 2014 and 2015 (Figure 4.1.2).

**Figure 4.1.2: National administrative coverage with Yellow Fever vaccine in the AFR, 2014-2015**



Source: Official coverage JRF 2015, [http://www.who.int/immunization/monitoring\\_surveillance/routine/reporting/en/](http://www.who.int/immunization/monitoring_surveillance/routine/reporting/en/)

The current yellow fever outbreak is unprecedented and poses a different risk to health security in the Region. It highlights the need for high risk countries to attain and maintain yellow fever vaccine coverage of 90% to minimize outbreaks of the disease. This will require ensuring the availability of vaccines at health facility level and sustainable financing for immunization.



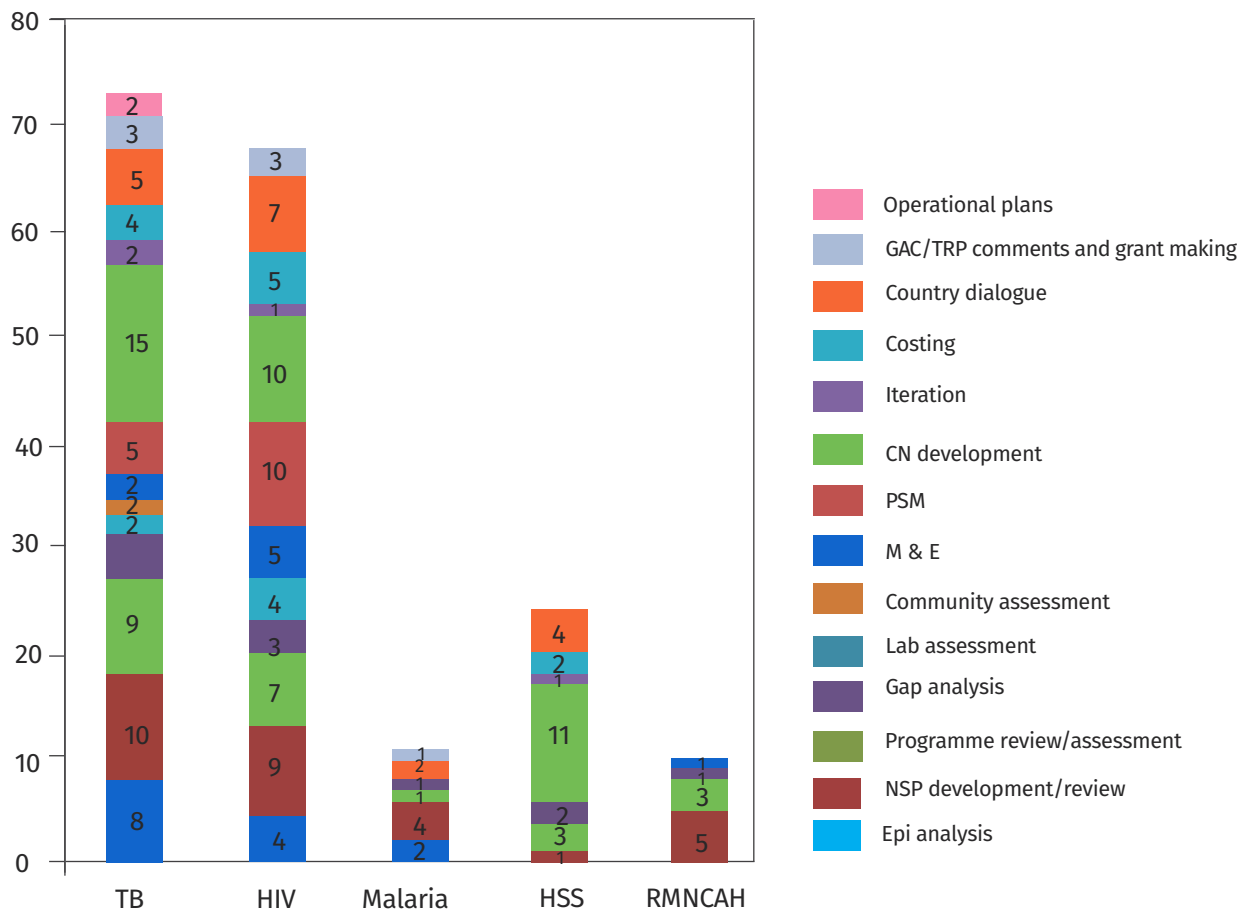
The Region still has a high burden of communicable diseases, despite progress made in reducing incidence and mortality. There were 25.6 million people living with HIV at the end of 2015. Of these, 2.3 million are children aged below 15 years who represent almost 90% of the global burden of HIV/AIDS among children.<sup>14</sup> HIV/AIDS and TB are very closely linked. The Region has the highest incidence, prevalence and mortality per capita from TB and accounts for 28% of the estimated 9.6 million tuberculosis cases that occurred worldwide in 2014.<sup>15</sup> It also had 74% of the estimated 1.2 million HIV-infected TB patients notified globally in 2014.

Malaria remains a major health and development problem in Africa. Over 800 million people in the Region are at risk of malaria, with 82% at high risk of the disease.<sup>16</sup> An estimated 190 million cases (89% of the global total) and 400 000 deaths (91% of the global total) occurred in the Region in 2015, with the Democratic Republic of the Congo and Nigeria alone accounting for over 35% of global estimated malaria deaths.<sup>17</sup> The vast majority of these deaths are among children under the age of 5 years.

WHO did extensive work to address these communicable diseases. Through the WHO/Global Fund (GF) cooperation agreement of May 2014, the Regional Office responded to 62 requests for technical assistance from 15 countries<sup>18</sup> between October 2015 and June 2016. Over US\$ 4 billion worth of grants has been raised since the inception of the agreement with a cumulative response to over 180 requests from 39 countries (Figure 4.1.3).

The Organization provided technical assistance for various programmatic components (epidemiological analysis, programme reviews, strategy development, gap analysis and concept note development, procurement and supply management, monitoring and evaluation, grant negotiations) for TB, HIV, malaria, health system strengthening (HSS) and reproductive, maternal, newborn, child and adolescent health (RMNCAH). Through the agreement, the Regional Office used over US\$ 4 million to provide support to countries, which resulted in the submission of about 50 concept notes (out of a total 97 concept notes submitted in the Region) since the beginning, with over 85% GF approval on their first submission.

Figure 4.1.3: Technical support provided within WHO/GF partnership: Jan 2014-Jun 2016

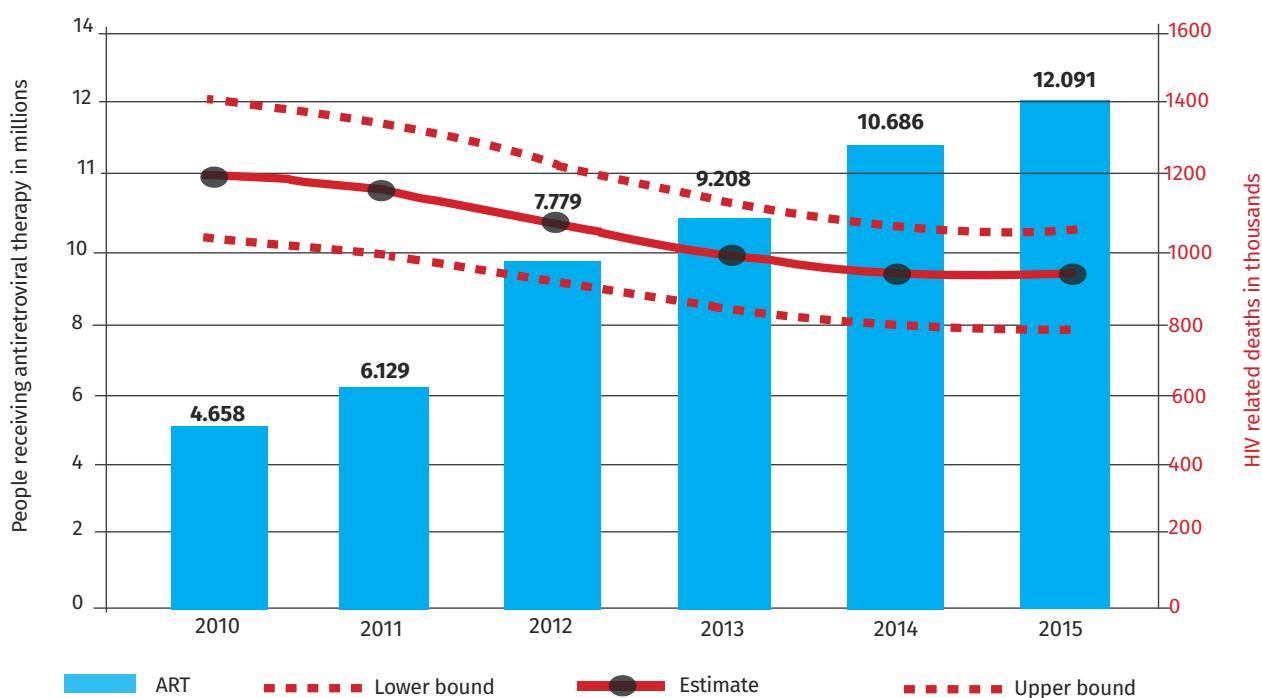


Source: Report on WHO/GF Agreement, December 2015 - June 2016

To support priority countries to implement their TB, HIV, malaria and health system programmes, in November 2015 WHO entered into a GF-initiated partnership platform called Implementation Through Partnership (ITP). This is a time-bound partnership framework to support 20 priority countries (18 in the African Region)<sup>19</sup> in improving implementation of their TB, HIV, malaria and HSS programmes through partner coordination. The countries were identified on the basis of having large GF portfolios but with historically low fund absorption rate. The priority actions were identified through partner consultations and agreement for high impact support. WHO has mobilized US\$ 6.7 million from PEPFAR to support countries in the implementation of agreed ITP actions.

In response to the HIV/AIDS pandemic, all countries within their multisectoral response scaled up the implementation of health interventions to fight the epidemic with the support of WHO and its partners. As a result, the number of adults and children newly infected with HIV in the African Region has been reduced by 19% in the last 5 years, from 1.63 million to 1.37 million.<sup>20</sup> The treatment scale-up is continuing, with an estimated 12.1 million people (43% of those eligible) receiving antiretroviral therapy (ART) by the end of 2015 (Figure 4.1.4). HIV-related deaths in the African Region have dropped to 800 000 compared to the over 1.5 million people who lost their lives to HIV in 2004 when HIV deaths peaked.<sup>21</sup>

**Figure 4.1.4: Antiretroviral therapy coverage and number of AIDS-related deaths, African Region, 2010-2015**



Source: GARPR 2016. UNAIDS

In December 2015, WHO released the revised consolidated guidelines for the prevention, treatment and care of HIV,<sup>22</sup> removing all limitations on eligibility for antiretroviral therapy (ART) among people living with HIV. These new “Treat All” guidelines are a game-changer: all persons living with HIV/AIDS are now eligible for treatment, regardless of CD4 cell count, age or gender. The Regional Office organized three dissemination workshops to give countries clear guidance on these, and 31 priority countries were supported to develop plans for sequencing the uptake and implementation of the new recommendations to achieve the 90-90-90 targets. In addition, the national HIV/AIDS strategic information systems in 15 selected fast track countries have been strengthened to provide quality and timely data to assess performance along the continuum of services provided.<sup>23</sup>

While TB incidence and mortality continue to decline, overall prevalence for the Region in the latest year of reporting has been revised upwards due to findings from the prevalence survey in Nigeria (Figure 4.1.5). WHO supported the development of the TB prevalence survey protocol in South Africa, Mozambique and Swaziland, and the ongoing prevalence survey implementation in Kenya.

Multi-drug resistant tuberculosis (MDR-TB) continues to be a major challenge, with WHO estimates of between 32 000 to 49 000 multidrug-resistant tuberculosis cases occurring in the Region in 2014.<sup>24</sup> Countries have scaled up programmatic management of drug-resistant TB (PMDT), resulting in the detection of 26 531 (83%) of the 32 000 estimated MDR-TB cases among notified TB patients in 2014.<sup>24</sup>

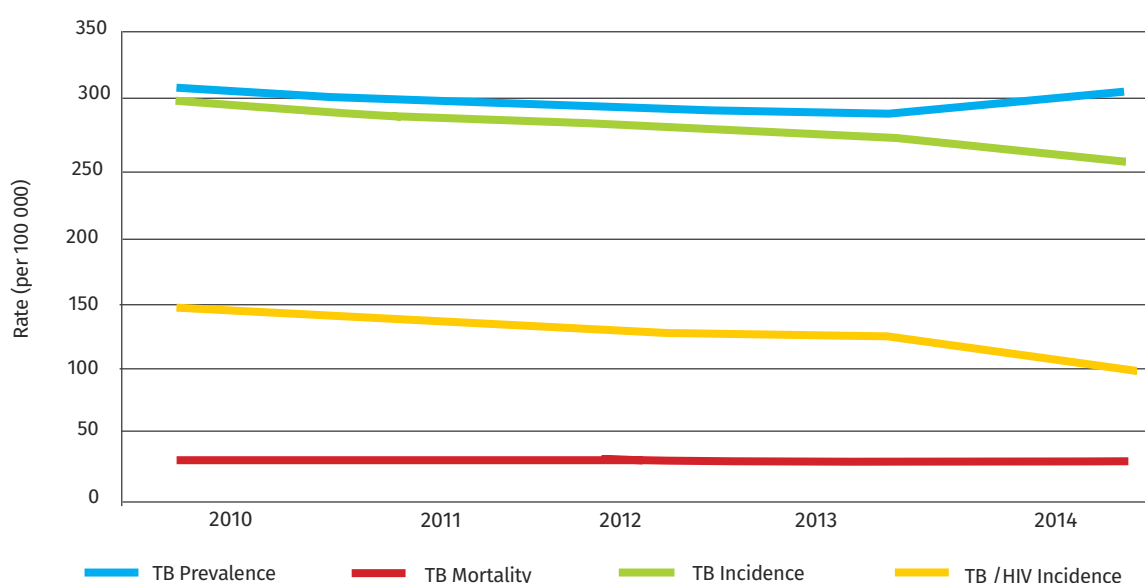
The Regional Office supported PMDT by ensuring access to quality assured medicines through the Regional Green Light Committee, a technical committee appointed by the Regional Director to provide technical support for the management of drug-resistant TB. The Regional Office hosts the secretariat of this committee. WHO assisted 10 countries<sup>25</sup> to implement the short MDR-TB regimen, supported South Africa to revise its guidelines to adopt the new short-course MDR-TB regimen, and conducted PMDT technical support missions in Malawi, Lesotho, Swaziland, Kenya, Rwanda, and South Sudan.

To address challenges in diagnosis, the Regional framework for strengthening the TB diagnostic network in Africa<sup>26</sup> was developed and launched. Together with partners (USAID, CDC, FIND and SRL), WHO undertook a joint assessment of the TB laboratory network in Nigeria, which has now adopted the rapid diagnostics test as the first line TB test for the whole country. WHO is also facilitating discussions with

the Global Fund to procure prefabricated container laboratories with adequate biosafety for the Congo, Chad and Gabon to perform TB cultures and drug susceptibility testing (DST) and thereby improve their TB diagnostics. Overall, the capacity for DST is steadily increasing (Figure 4.1.6). Kenya, Namibia, South Africa and Uganda conducted Drug-resistant TB Surveillance (DRS), and WHO is supporting the development of the DRS protocol in Côte d'Ivoire, Tanzania, Burkina Faso and Ghana. The surveys will start in the latter half of 2016.

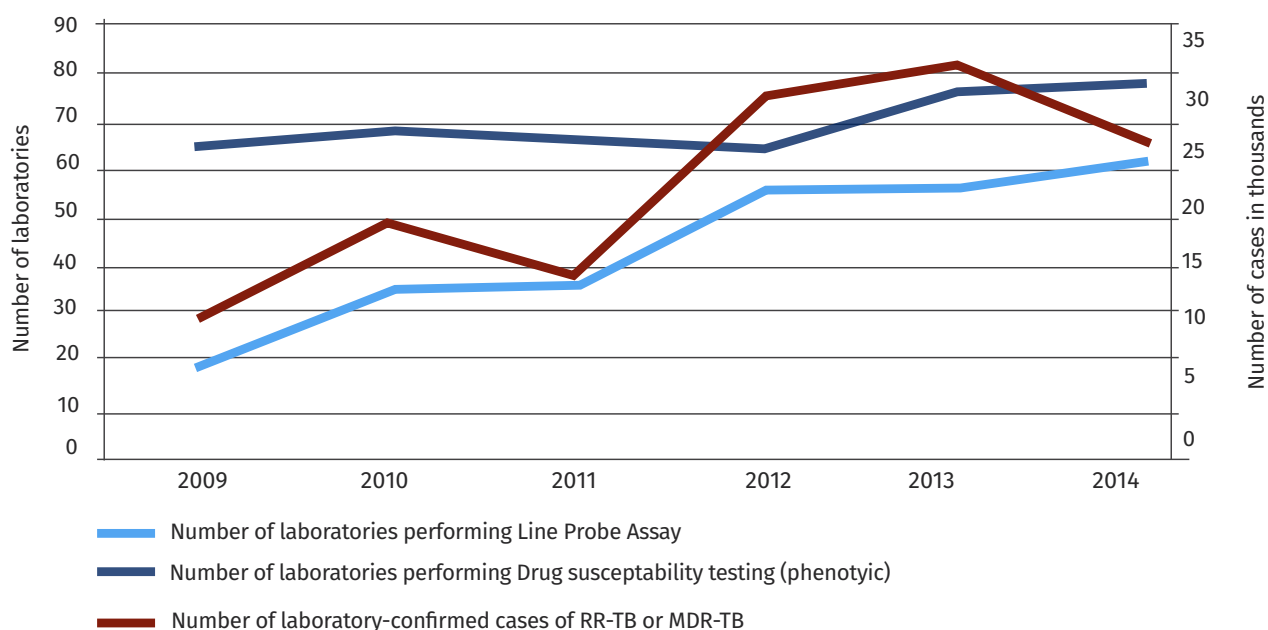
In May 2014, the Sixty-seventh World Health Assembly adopted a post-2015 TB prevention, care and control strategy known as the End TB Strategy, with the aim of ending the global TB epidemic. The Region has developed a framework for implementing the End TB Strategy to accelerate the reduction of the TB burden. The strategy will be presented for adoption by the ministers of health at the Sixty-sixth session of the Regional Committee.

**Figure 4.1.5: Trends of TB Prevalence, Mortality and Incidence in the African Region: 2010-2014**



Source: Global Tuberculosis Report 2015

**Figure 4.1.6: Drug-resistant TB Laboratory Services in Africa, 2009-2014**



Source: WHO, Global Tuberculosis Report 2015: Geneva, World Health Organization, 2015

The African Region has made significant progress in malaria control. Malaria incidence and mortality rates declined by 42% and 66% respectively between 2000 and 2015<sup>27</sup> (Figure 4.1.7), while the infection prevalence in children aged 2–10 years has dropped by more than half. Six countries<sup>28</sup> can potentially eliminate local transmission of malaria by 2020.<sup>29</sup>

This progress is a result of the expanded use of cost-effective prevention and case management services. In 2015, about 67% of the general population in the Region had access to an insecticide-treated net (ITN). The proportion of children under the age of 5 years sleeping under an ITN increased from 2% in 2000 to 68% in 2015 (Figure 4.1.8), and the proportion of those who were treated with artemisinin-based combination therapy (ACT) is estimated to have increased from less than 1% of children in need in 2005 to 16% in 2014.<sup>30</sup> However, access to treatment remains poor.



WHO/Maggie Hallaha



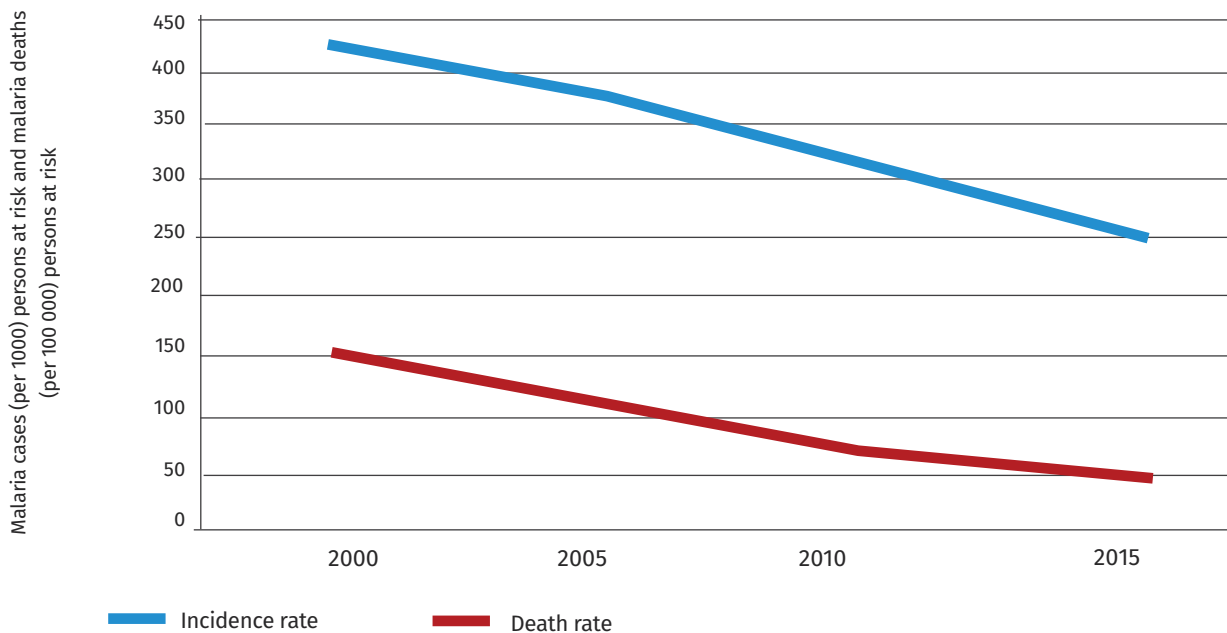


WHO/Maggie Hallaha

Populations remain vulnerable to resurgent malaria (for example, in Angola, Burundi, Democratic Republic of the Congo, Namibia and Uganda), and insecticide resistance is a major threat to malaria elimination in the Region. There is widespread resistance of the major malaria vector, *Anopheles*

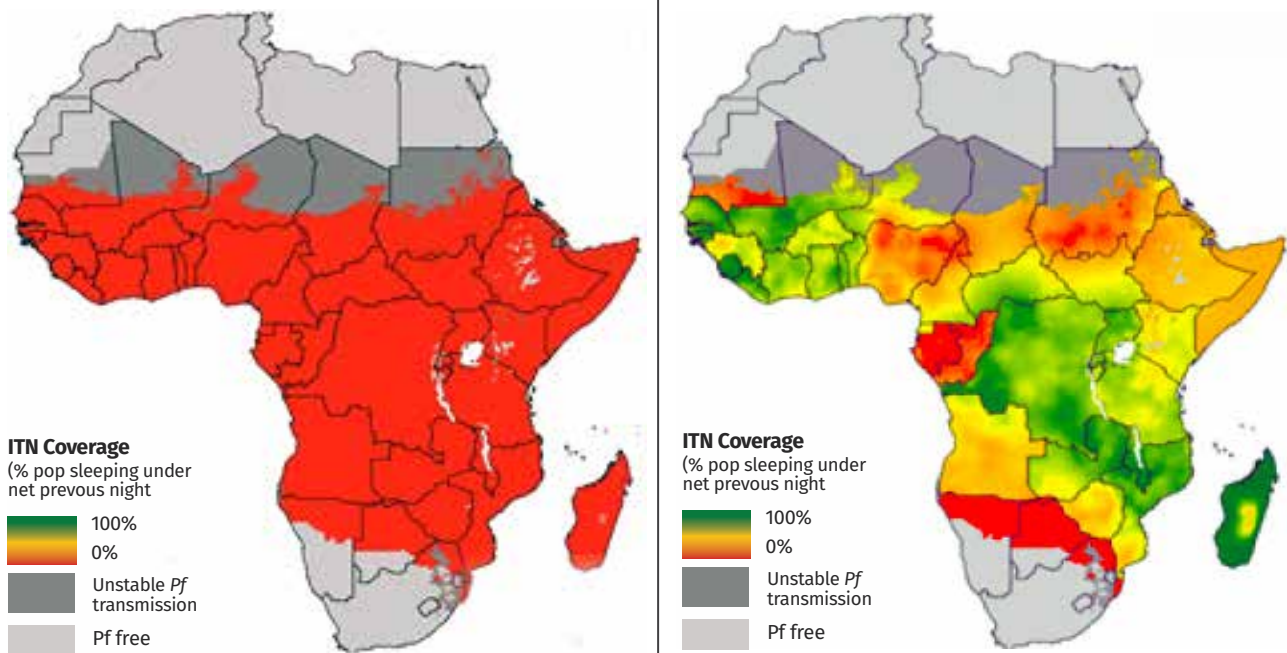
*gambiae* s.l., to DDT and pyrethroids. Based on data from 37 of the 43 endemic countries, 12 countries<sup>31</sup> have developed insecticide resistance management plans to mitigate the problem and sustain vector control effectiveness for malaria control and elimination.

**Figure 4.1.7: Estimated malaria incidence and death rate in the African Region (2000-2015)**



Source: World Malaria Report 2015

**Figure 4.1.8: Proportion of population sleeping under an ITN, sub-Saharan Africa, 2000-2015,**



Source: Malaria Atlas Project 2015

The Global Technical Strategy (GTS) for Malaria (2016 – 2030)<sup>32</sup> will guide countries towards a world free of malaria. To prepare for this, 42 countries in the Region benefited from capacity building activities to generate, manage and use evidence-based data for decision-making using the regional real-time Strategic Information System (r-SIS) platform. Countries and institutions received training on conducting entomological studies, therapeutic efficacy testing and knowledge generation on malaria transmission patterns. WHO guided 11 countries<sup>33</sup> to re-orientate their malaria control programmes based on evidence gathered through Malaria Programme Review (MPR) and Mid-Term Review (MTR).

Neglected tropical diseases (NTDs) constitute another important area in this category of work, and the scaling up of major interventions towards reducing the burden of NTDs in the Region continues to be a priority.

To enable the start of mass drug administration (MDA) for preventive chemotherapy in 2016, ten additional countries were fully mapped between October 2015 and June 2016. In total, 41 countries now have maps where these diseases occur, with only six countries left where mapping is ongoing.<sup>35</sup> WHO also supported newly mapped countries to start or scale up MDA for NTDs in confirmed endemic districts, bringing the total number of countries that are implementing MDA to 36. Following successful transmission assessment surveys, Togo and Malawi have stopped MDA for lymphatic filariasis, while ten other countries<sup>36</sup> have stopped MDA in some districts. Lymphatic filariasis elimination is being verified in Togo.

The Region is progressing towards guinea-worm disease eradication. Reported cases of guinea-worm disease have dropped from 126 in 2014 to 22 in 2015 in the remaining four endemic countries – Chad (9 cases), Ethiopia (3 cases), Mali (5 cases) and South Sudan (5 cases) – where WHO is providing support

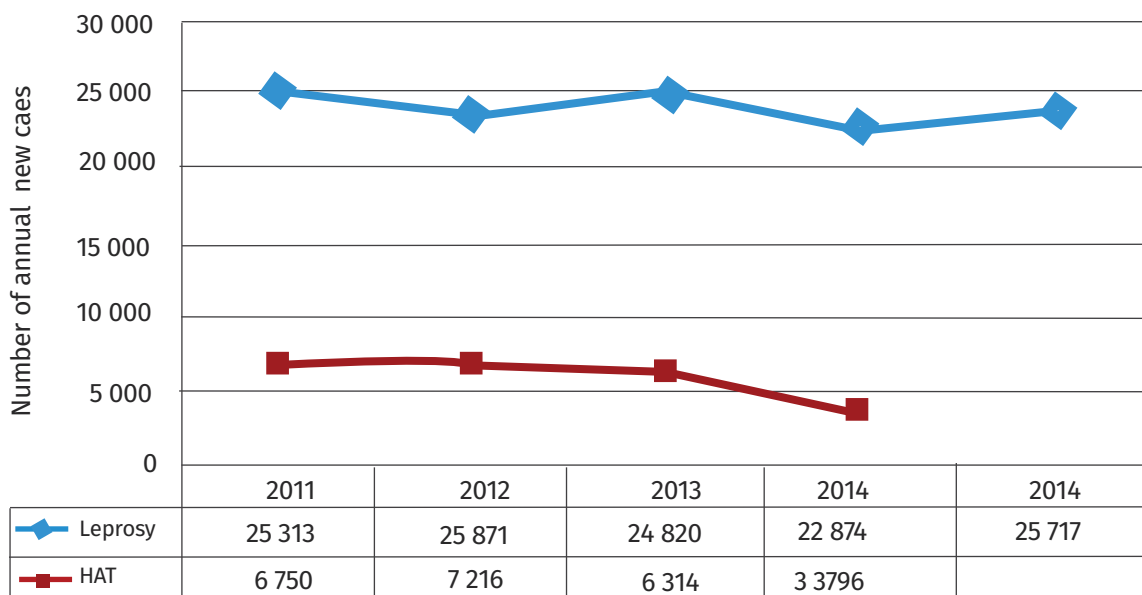
for active community-based surveillance, daily reporting of rumours of suspected cases and prompt containment of cases. Efforts to verify the absence of the disease in Angola and DRC are ongoing, while Kenya is at the pre-certification stage for eradication.

Leprosy and human African trypanosomiasis elimination were sustained with less than 24 000 and 4000 cases reported respectively in 2015 (Figure 4.1.9). WHO prepared and disseminated the Regional Strategy on Integrated Case Management of NTDs and three integrated guidance documents on these diseases at the first joint meeting of case management NTD National Programme Managers and the Regional Programme Review Group (RPRG) held in June 2016 in Cotonou, Benin. Forty-five countries are developing or have completed their NTD master plans for 2016-2020. Mauritius and Seychelles have low

endemicity for leprosy and do not need to develop an NTD master plan. Following four meetings of the NTD-RPRG on preventive chemotherapy and case management, mapping results of PC-NTDs were validated, and joint application packages for medicines were approved, along with reports and eligibility requests for lymphatic filariasis transmission assessment surveys (TAS).

WHO has established the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), following the planned closure of the African Programme for Onchocerciasis Control (APOC) in December 2015. ESPEN will support countries as they map the burden of PC-NTDs,<sup>37</sup> deliver treatment accurately and efficiently, monitor progress and secure certification when they successfully eliminate diseases from within their borders.

**Figure 4.1.9. Trends in the detection of leprosy and human African trypanosomiasis over the last 5 years (2011-2015) based on reports received from endemic countries**



Source: Country annual reports on Leprosy and HAT

Since it started in January 2016, the Project has ensured continued technical support to countries through coordination and review of medicines applications in preparation for MDA<sup>38</sup> and impact surveys including TAS which enable decisions on when to stop MDA for lymphatic filariasis.<sup>39</sup> Activities have included a gap analysis of the situation

of NTDs in countries, development of technical support plans, an NTD database and portal, and mobilization of resources. The first meeting of its steering committee was held from 18 to 22 April 2016 in Accra, Ghana. ESPEN was officially launched during the Sixty-ninth session of the World Health Assembly in Geneva.



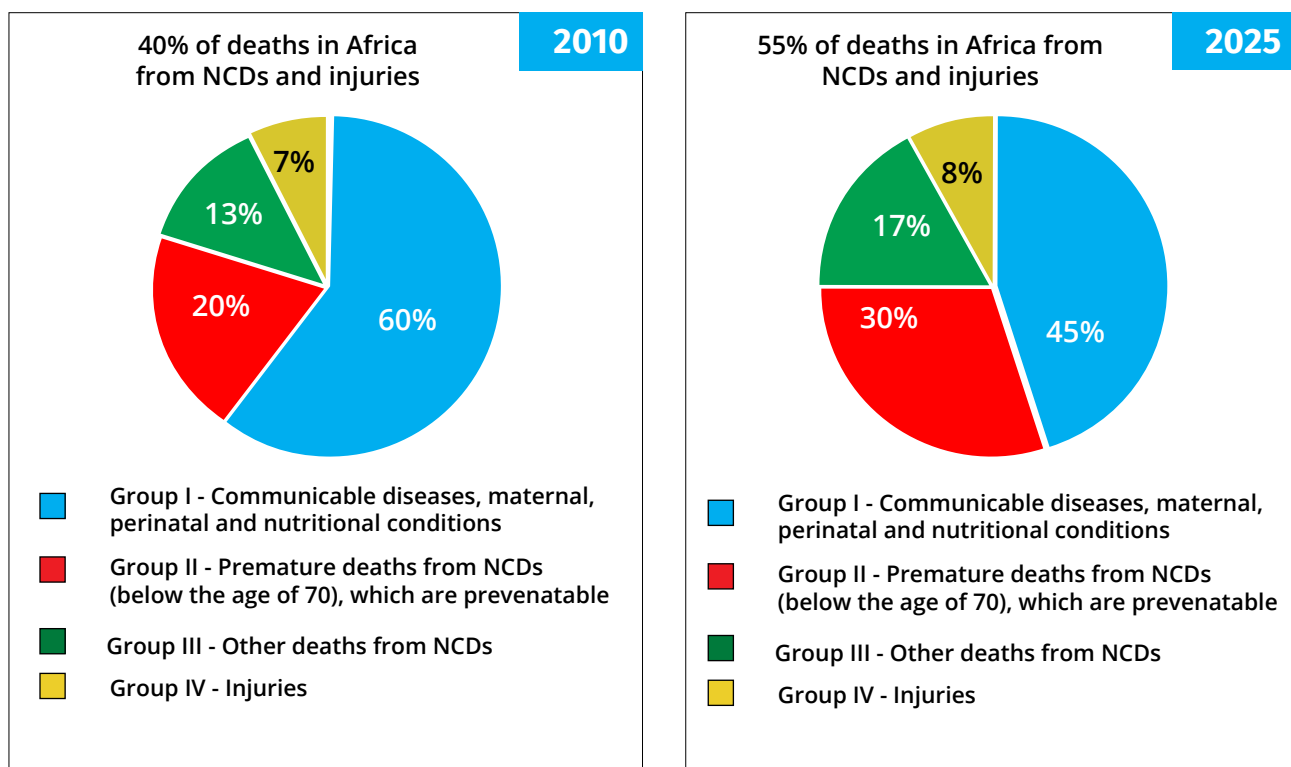
(R-L) Dr Matshidiso Moeti, WHO Regional Director for Africa, Prof Isaac Adewole, the Minister of Health of Nigeria, and Dr Margaret Chan, WHO Director-General at the launch of ESPEN in Geneva.

## 4.2 Category 2: Noncommunicable Diseases

The work of WHO under this category aims to reduce the burden of noncommunicable diseases (NCDs) and their risk factors. These diseases include heart diseases, cancers, lung diseases, diabetes, mental disorders and oral diseases, as well as disability, violence and injuries. To do this, WHO focuses on health promotion and risk reduction, prevention, treatment and monitoring of NCDs and their risk factors such as tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity.

In many developing countries, NCDs such as cardiovascular diseases, diabetes, cancer and chronic respiratory diseases are leading causes of death. In 2010, 40% of deaths in the African Region were from NCDs and injuries. Projections are that by 2025, over half of all deaths (55%) in the Region will be attributable to NCDs and injuries (Figure 4.2.1).<sup>40</sup> In addition to the major NCDs, the African Region faces a high burden of sickle cell disease as well as oral, eye and ear diseases.

**Figure 4.2.1: Projected NCD Deaths in the African Region by 2025**



Source: WHO Global status report on NCDs 2010

WHO conducted the 2015 NCD country capacity survey (NCD CCS) between August and October 2015 to measure Member States' capacity to respond to the burden of NCDs. In total, 35 countries<sup>41</sup> completed and submitted the questionnaire. Preliminary results show that only 17% of countries have structures to oversee national NCD policies, strategies or actions across all government and non-government sectors. One third of countries have an integrated, multisectoral NCD plan that covers the four main risk factors and four main diseases, while half of the countries reported having a population-based cancer registry. The results will guide Member States and WHO on future actions and technical support needed to prevent and control NCDs across the Region. The global CCS report will be released in September 2016.

To assist countries to realize the global NCD targets as set out in the WHO Global NCD Action Plan 2013-2020,<sup>42</sup> WHO provided technical support to eight Member States<sup>43</sup> to develop national multisectoral NCD strategic plans. In addition, the Organization supported the West African Health Organization (WAHO) to develop a subregional NCD Strategic Plan for Member States in that subregion to implement the Global Action Plan.

In line with the UN Political Declaration on NCDs, 23 of the 47 Member States<sup>44</sup> of the African Region currently have multisectoral NCD action plans. WHO led the UN Inter-Agency Task Force (UNIATF) on NCDs to assess the capacity of the Democratic Republic of the Congo to respond to the NCD epidemic and to support the development of the national multisectoral action plan on NCDs.

WHO strengthened the capacity of Member States to develop and implement policies and strategies on prevention and control of NCDs by organizing a Regional workshop in October 2015 in Togo for National Programme Managers and NCD focal points from WHO country offices in French-speaking countries. This followed a similar workshop for English-speaking countries held in July 2015 in Ethiopia. Programme managers reviewed the progress of their national multisectoral NCD action plans and agreed to accelerate their implementation to realize the global and regional commitments on NCDs.



Over 60% of new cancer cases worldwide occur in Africa, Asia, and Central and South America, and these regions account for 70% of the world's cancer deaths.<sup>46</sup> Cervical cancer is the leading cause of cancer-related deaths among women aged 30 years and older, and is one of the most frequent cancers among all women in Africa.<sup>47</sup> Around one third of cancer deaths are due to the five leading behavioural and dietary risks: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use and alcohol consumption. In Africa, cancer-causing viral infections such as the hepatitis B and C viruses (HBV/HCV) and the human papillomavirus (HPV) cause up to 30% of cancer deaths. Most sub-Saharan countries lack the facilities and trained personnel necessary to provide effective prevention, early detection or adequate treatment of cancer.

To improve the prevention and control of cancer, WHO supported Chad, Malawi, Mauritania and Zambia to develop cancer prevention action plans, and assisted Nigeria and Zambia to develop comprehensive cervical cancer plans. With the support of the Centers for Disease Control and Prevention (CDC) and the Bill & Melinda Gates Foundation, WHO developed training toolkits for strategic planning, advocacy, information, education and communication (IEC), screening using visual inspection and treatment of precancerous lesions for cervical cancer prevention and control. The toolkits were used to train trainers in Malawi, Zambia and Nigeria. A national training manual on cervical cancer screening using visual inspection with acetic acid (VIA) and treatment of pre-cancer with cryotherapy was developed in Malawi, while 21 countries<sup>48</sup> were trained in cancer registration.

The support provided will contribute to strengthen cervical cancer services and cancer registries, improve national surveillance and generate evidence on cancer prevalence and incidence in countries. The evidence will also inform cancer prevention and control programming.

WHO has developed a Package of Essential Noncommunicable Diseases (WHO PEN)<sup>49</sup> interventions for primary health care in low-resource settings. Together with the Integrated Management of Adolescent and Adult Illness Alliance (IMAI Alliance), WHO adapted and incorporated the WHO PEN tools into the IMAI acute and chronic care guideline module which was subsequently field-tested in Masaka, Uganda in December 2015, and further testing is planned in Ethiopia before the end of 2016. The adapted IMAI-WHO PEN module will enable Member States to increase the use of the WHO PEN tools.

WHO continues to strengthen the capacity of Member States to implement mental health action plans. The Organization supported Kenya to develop and launch its Mental Health Policy 2015-2030 and assisted Rwanda to develop a mental health policy and a strategic plan 2016-2023. While Botswana, Lesotho, Namibia, Swaziland and Tanzania were supported to integrate mental health into their NCD plans.

WHO has developed and disseminated a manual entitled *"Promoting oral health in Africa - Prevention and management of oral diseases and noma as essential interventions against noncommunicable diseases"*.<sup>50</sup> The manual guides Member States on how to improve oral health, especially in primary health care centres, schools and communities.



The Minister of Public Health of Niger, Mr Kalla Moutari, at the launch of the Oral Health Manual in Niamey, May 2016

It describes cost-effective and sustainable ways to reduce the burden of oral diseases and other NCDs and proposes a basic Package of Oral Care. The Minister of Public Health of Niger, Mr Kalla Moutari, launched the manual in May 2016 at a ceremony attended by ambassadors, heads of United Nations agencies, directors from the Ministry of Health, NGO representatives, members of the National Order of Dental Surgeons in Niger, and national oral health coordinators from 11 countries of the West and Central African subregions.

Noma is a destructive disease of the mouth and the face which mostly affects malnourished children below the age of six years living in extreme poverty. and is a disease of public health importance in several Member States. Within the

framework of the regional noma control programme, WHO continues to support national efforts on advocacy, social mobilization, production of IEC literature and training manuals, training of trainers and health workers, and management of the disease. Over the reporting period, WHO supported eight countries<sup>51</sup> to implement their three-year national action plans on the prevention, early diagnosis and treatment of noma.

Every day 650 people are killed on Africa's roads.<sup>52</sup> At 26.6 per 100 000 population, the African Region has the highest road traffic fatality rate compared to the global rate of 17.4 per 100 000 population, despite being the least motorized Region. Half of all deaths in the Region are among people with the least protection – motorcyclists,



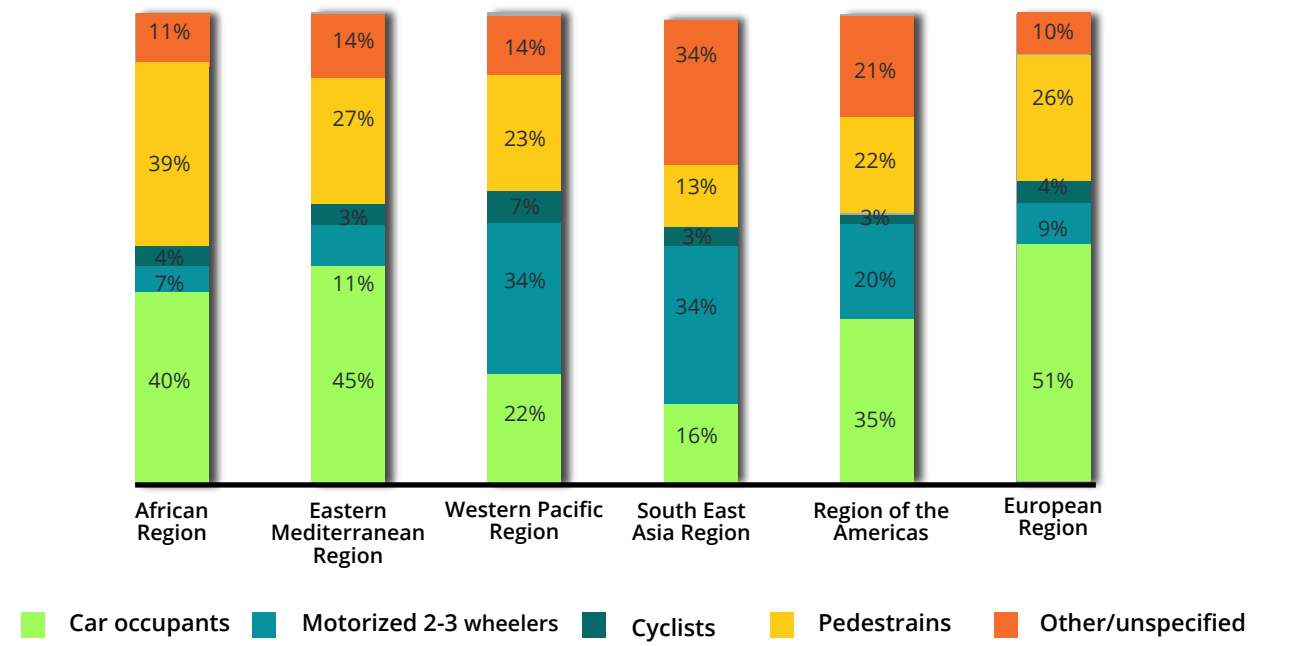
pedestrians and cyclists – while it has the highest proportion of pedestrian-related deaths at 39% (Figure 4.2.2). WHO supported the collection of data on road safety in 43 Member States to identify gaps, stimulate road safety action and monitor progress in implementing measures identified in the Global Plan of Action.<sup>53</sup> The data contributed to the Global Status Report on Road Safety 2015,<sup>54</sup> which was published in 2016. The report highlights the need for multisectoral action to make roads safe, including enforcement of legislation on seat belts, speed limits, prevention of drink-driving, wearing of motorcycle helmets and child restraints.

The African Region has a high burden of malnutrition, yet nutrition interventions are fragmented and surveillance systems for monitoring countries' efforts to meet global nutrition targets are lacking. Through a Canada-funded project involving 11 countries,<sup>55</sup> the Regional Office is providing

technical support and capacity building for nutrition surveillance and scaling-up of nutrition interventions targeting adolescents, mothers, infants and young children. Overall, 3646 government officials and health workers were trained in delivering nutrition interventions in Ethiopia, Tanzania and Uganda and 2774 were trained on surveillance methods and tools. Côte d'Ivoire, Sierra Leone and Tanzania initiated pilot processes for community engagement in stunting prevention.

Tobacco use and exposure to tobacco smoke is one of the leading risk factors for NCDs. The Regional Office has intensified its support to countries and the African Region has made significant strides in tobacco control. The Gambia became the first country to launch national clinical guidelines for tobacco cessation, while Botswana introduced an additional levy on all tobacco products, another first in the Region.

**Figure 4.2.2: Proportion of road traffic deaths by type of road users and region, 2015**



Source: Road Safety in the African Region, 2015

Burkina Faso, Chad, Gabon, Kenya and Uganda enacted legislation and regulations which are in line with the WHO Framework Convention on Tobacco Control (WHO FCTC).<sup>56</sup> Burkina Faso, Côte d'Ivoire and Mali ratified the Protocol to Eliminate Illicit Trade in Tobacco Products in the reporting

period, bringing to five the number of countries in the African Region out of 19 globally that are Parties to the protocol. These initiatives will support further reduction of tobacco use and exposure to tobacco smoke in the Region.

## 4.3 Category 3: Promoting health through the life course



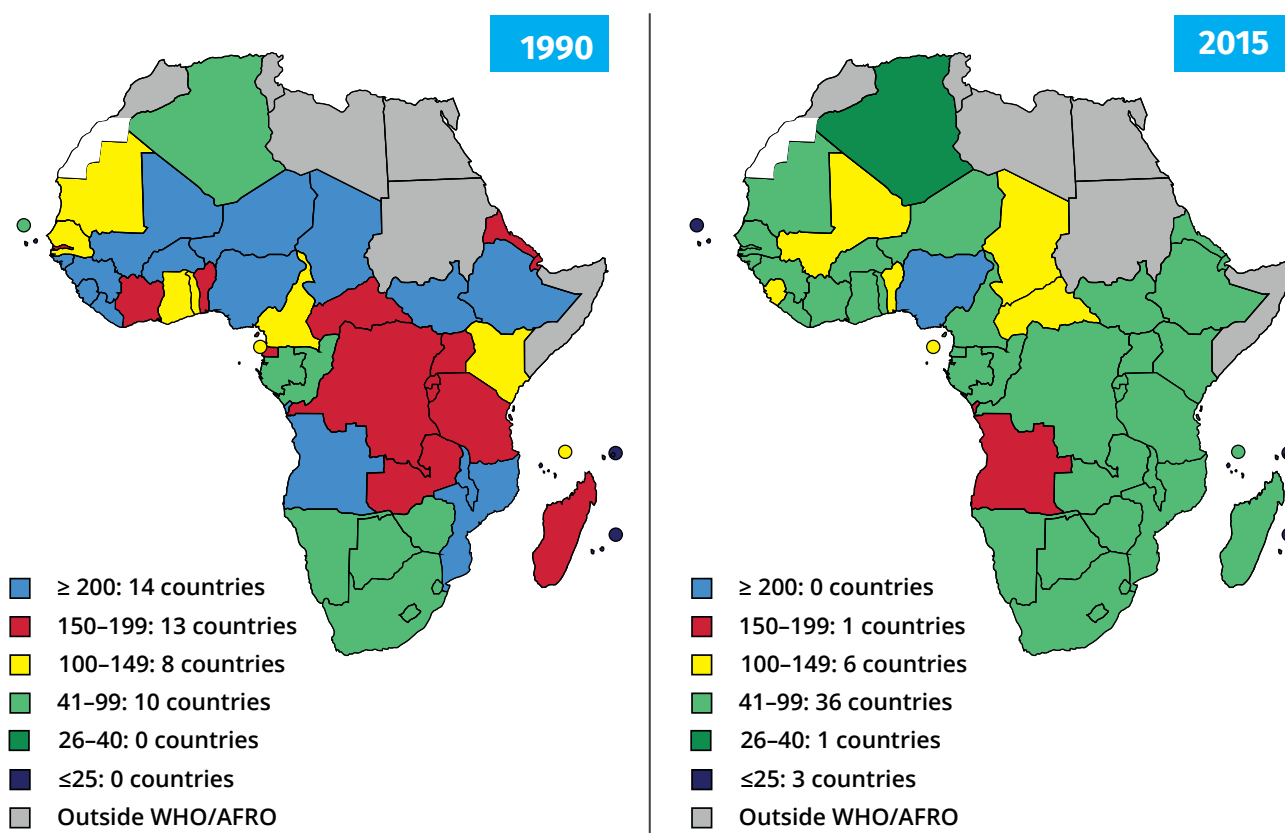
WHO provides guidance and support to Member States to promote good health at key stages of life from conception to old age. This considers the need to address health equity and the social and environmental determinants of health and human rights, with a focus on gender equality. The category includes a specific focus on improving women's, children's and adolescents' health.

The period under review saw the end of the MDG era (2000 – 2015) and the start of the SDGs (2016 – 2030). Although many countries fell short of their MDG targets,

the Region nevertheless saw a 45% reduction in maternal mortality, a 38% drop in neonatal mortality and a 54% decline in under-five mortality.<sup>57</sup>

Despite these advances, by the end of 2015 only twelve countries<sup>58</sup> had achieved the MDG target on child mortality reduction (Figure 4.3.1). Only Cabo Verde and Rwanda achieved the target on maternal mortality reduction, while no country achieved the targets on reproductive health.

Figure 4.3.1: Under-five mortality in the WHO African Region, 1990-2015



Source: UN Inter-agency Group for child Mortality (IGME), 2015 Report

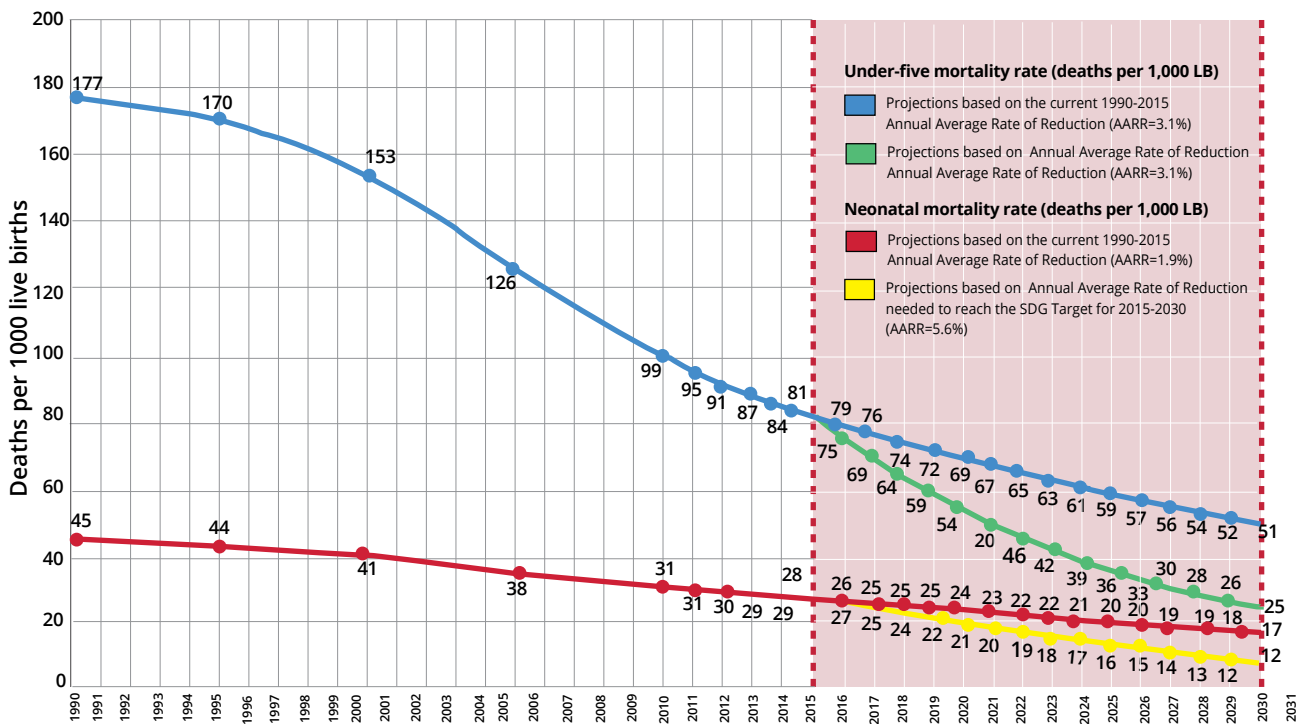
The Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030 launched in September 2015 will address the SDG 3 targets in these populations. It proposes that in the next 15 years, countries should reduce the global maternal mortality ratio to less than 70 deaths per 100 000 live births. Every country is expected to reduce the newborn and under-five mortality rates to less than 12 and 25 per 1000 live births respectively.<sup>59</sup>

The Region will need as much as a seven-fold reduction of the current rates to achieve these targets (Figure 4.3.2). Consequently, WHO is supporting countries to develop and implement national strategies to contribute to the survival, development and transformation of the lives of women,

children and adolescents in the African Region. WHO is supporting countries to improve the survival of newborns in the Region by implementing its guidelines on the management of sick infants when referral is not possible.<sup>60</sup>

In November 2015, WHO built the capacity of 21 master trainers to facilitate the implementation of the guidelines in countries. These master trainers are already assisting to implement the guidelines in Ethiopia, the Democratic Republic of the Congo and Nigeria. To further circulate the guidelines, WHO organized a dissemination and policy dialogue meeting for 10 Member States<sup>61</sup> in Addis Ababa, Ethiopia in June 2016.

**Figure 4.3.2: Under-five mortality rate (deaths per 1000 live births) vs Neonatal mortality rate (deaths per 1000 live births), African Region, 1990-2015 with projections to 2030**



Source: Data for 1990-2015 from UN Inter-agency Group for Child Mortality (IGME), 2015. Data for 2016-2030 from WHO/AFRO Estimates based on AARR

Partners who attended (Bill & Melinda Gates Foundation, UNICEF, Save the Children, USAID and the USAID-funded Maternal, Child Survival Program) pledged to support countries in the implementation of the guidelines.

In child health, WHO supported Senegal and Togo to adapt the Integrated Management of Childhood Illness Computerized Adaptation and Training Tool (ICATT). This innovative capacity-building option for rapid scale up of IMCI is now being used in eight countries.<sup>62</sup> In addition, Swaziland, Zambia and Zimbabwe were supported to build national capacity for on-the-job distance learning for IMCI, another route for rapid scale up of IMCI. This approach will increase the coverage of IMCI and contribute to improving child survival in the Region.

Efforts to scale up integrated community case management of childhood illness (iCCM) are increasing. WHO and UNICEF held a workshop in Nairobi, Kenya in February 2016 to brief 19 countries on the iCCM implementation plan which they are expected to use to accelerate implementation of community-based interventions. The countries peer-reviewed and updated their plans, including mechanisms for accelerating the use of available grants. Furthermore, to improve the identification of childhood tuberculosis in the community, capacity was built for Ethiopia, Malawi, Uganda and Zambia on a new iCCM guideline that includes TB and HIV. Implementation of this guideline will increase the referral of children exposed to TB and HIV in high-burden countries.



Adolescent health has been a neglected area in the Region. WHO supported five countries<sup>63</sup> to develop or review their national adolescent strategic plans. Benin, Burkina Faso, Democratic Republic of the Congo and Niger developed national standards for adolescent-friendly health services using the recommended global standards. Once implemented, these guidelines and standards will contribute to improving adolescent health programmes in these countries.

To improve maternal health, WHO and UNFPA held two subregional capacity building meetings for 22 countries<sup>64</sup> in May 2016 on improving maternal death surveillance and response (MDSR). MDSR aims to identify, notify, review and respond to every maternal death. The meetings were conducted in Yamoussoukro, Côte d'Ivoire, for 13 Francophone countries<sup>65</sup> and in Johannesburg, South Africa, for nine Anglophone countries.<sup>66</sup> The participants recommended that MDSR be integrated into the curriculum of doctors and midwives.

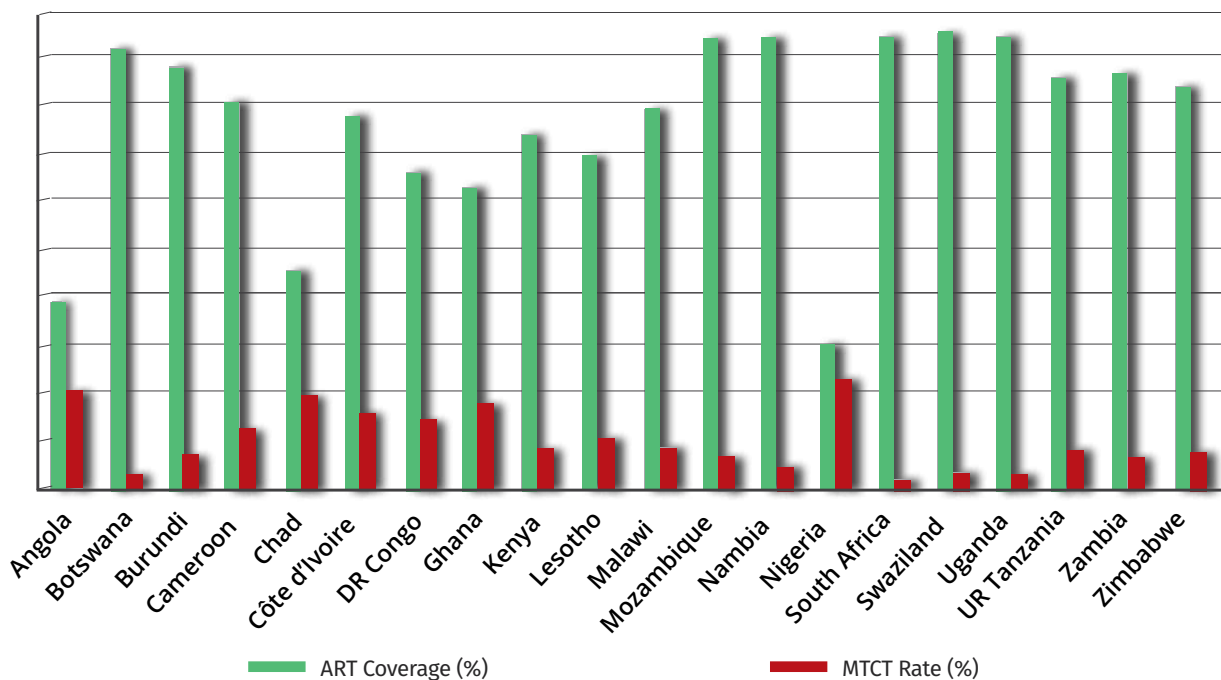
They also discussed and agreed on strengthening links with civil registration and vital statistics. To date, 33 countries are reporting maternal deaths through the IDSR weekly bulletin.

Twenty one priority countries<sup>67</sup> made progress in preventing mother-to-child transmission of HIV. In these countries, the proportion of pregnant women living with HIV who received antiretroviral treatment has more than doubled from a baseline of 36% in 2009 to 80% in 2015. Seven countries<sup>69</sup> in Eastern and Southern Africa achieved more than 90% coverage of maternal ART. This has resulted in the reduction of mother-to-child transmission of HIV to less than 5% of the breastfeeding population (Figure 4.3.3). These countries can now start being assessed and certified for pre-elimination status. WHO will support this through a regional multi-agency secretariat established in April 2016. WHO supported five Member States<sup>70</sup> to develop and validate strategies and plans for sexual and reproductive health (SRH) including family planning.

These strategies will guide SRH service delivery at all levels of care and will serve as policy documents for achieving universal access to sexual and reproductive health and rights. Through a grant from the

Bill & Melinda Gates Foundation, WHO assisted 10 countries<sup>71</sup> to build capacity for improving the availability and quality of family planning services.

**Figure 4.3.3: Antiretroviral coverage and mother-to-child transmission rate of HIV in 21 priority countries, 2015**



Source: Global AIDS update, UNAIDS, May 2016

In terms of quality of care, WHO supported 10 Member States<sup>72</sup> to undertake an assessment of reproductive, maternal, newborn, child and adolescent health (RMNCAH) services in hospitals, and five countries<sup>73</sup> to undertake short programme reviews for RMNCAH. The results identified gaps which informed the development of national health sector plans (NHSP) or validation of the revised post-2015 strategic plans, and necessary resource mobilization. To harmonize programme reviews in countries, the Regional Office developed a programme review guide for integrated RMNCAH and nutrition programmes. The draft guide is being field-tested in two countries, Eritrea and South Sudan, currently undertaking national RMNCAH programme reviews.

As a follow up action of the 2013 resolution on Healthy Ageing in the African Region,<sup>74</sup> the Regional Office organized a regional consultation on "Health and Ageing" in September 2015 in Brazzaville, Congo. This informed the development of the Global Strategy and Action Plan, adopted in May 2016 by the Sixty-ninth session of the World Health Assembly, and a technical document of the Sixty-sixth session of the Regional Committee entitled "Multisectoral action for a life course approach to healthy ageing: Global Strategy and Plan of Action on ageing and health: Implementation Framework for the African Region". The proposed Regional implementation framework aims to provide programmatic and policy orientations to Member States for the period 2016-2020.



WHO supported five countries to leverage resources for scaling up RMNCAH interventions in adolescent health through an investment case for the Global Fund Facility (GFF).<sup>75</sup> The GFF aims to increase external and domestic resources for implementing the Global Strategy for Women's, Children's and Adolescents' Health. As it expects countries to increase their requests for assistance in this area, WHO has built the capacity of 30 consultants and 11 WHO staff to support countries as needed.

To further the important work of strengthening country capacity in gender, equity and human rights (GER), WHO adapted and disseminated a software application, the Health Equity Assessment Toolkit (HEAT),<sup>76</sup> to assist countries to analyse inequalities. Participants from Mozambique and the United Republic of Tanzania were trained to use the toolkit and have since implemented it. Eight countries<sup>77</sup> received support to integrate GER into health policies and programmes.

WHO assisted The Gambia, Mauritania, Rwanda and South Africa to conduct the health-related aspects of their universal periodic review, a Member States-driven process under the auspices of the UN Human Rights Council. Health-related human rights recommendations were made on health security, emergencies and disaster relief, mental health, and sexual and reproductive health among others.

The area of social determinants of health (SDH) ensures that programmes address the causes of disease, disabilities and premature deaths that exist outside the health sector. To strengthen country capacity for integrating Health in All Policies (HiAP), WHO organized a multisectoral workshop for 50 policy-makers from 15 countries<sup>78</sup> representing ministries of trade, social affairs, local government and academic institutions. Using various WHO tools, case studies and reports including the *Health in All Policies Training Manual*,<sup>79</sup> each country has now developed a policy brief and an implementation plan to address the social determinants of health through intersectoral action. In addition, Malawi, South Africa and Zimbabwe have reviewed the policies of selected government ministries and have documented the status of HiAP integration.

Environmental health is a key determinant of health. About 28% of the total burden of disease and 25% of deaths are attributable to avoidable environmental risk factors. Up to 70% of the population in the African Region do not have access to improved sanitation, 40% use unimproved drinking water sources, and there is widespread human exposure to toxic materials and environmental contamination of hazardous chemicals.



The African Region has made significant progress in environmental health in the areas of policy and strategy development, capacity strengthening, and global and regional partnerships. In 2015, for the first time, WHO and UNICEF assessed the status of water, sanitation and hygiene (WASH) in health-care facilities in low- and middle-income countries.<sup>80</sup> The findings show that in the African Region, nearly 42% of facilities lack improved water, and nearly 20% are without sanitation.<sup>81</sup> The recent WASHFIT (Water and Sanitation for Health Facilities Improvement Tool) initiative of WHO and UNICEF has helped to mainstream WASH in infection prevention and control. To date, the approach has been used in Mali, in cholera hotspots in Chad, and in Liberia to help in the post-Ebola recovery and health systems strengthening efforts.



TrackFin is a further tool which helps countries to track financing flows in the WASH sector. In December 2015, national experts in 11 countries<sup>82</sup> were trained to use the tool and to utilize the information to address challenges.

Furthermore, in line with the Libreville Declaration,<sup>83</sup> three more countries<sup>84</sup> have developed national plans for joint action, bringing the total to 23.

The Region is particularly vulnerable to climate change which affects the environmental determinants of health and exacerbates risks. WHO held two capacity-building workshops on vulnerability and adaptation assessment to help 10 countries<sup>85</sup> implement the health component of national adaptation plans to climate change. In line with the Sustainable Development Goals, the Regional Office has developed a Regional strategic agenda (2016-2020) to stimulate investment in priority health and environment programmes in Africa.

Ahead of the global Climate Change Conference in Paris (COP21), the Regional Office convened the third meeting of the Clim-Health Africa Initiative in South Africa. This multisectoral meeting set benchmarks for joint projects, stimulated dialogue between partners, and explored advocacy opportunities for COP21 in December 2015. At the Paris conference, the Regional Office organized an “Africa Pavilion Event” showcasing examples of cost-effective and proven strategies of building community resilience to climate change. These included Del’Agua Health’s Rwanda programme, the biggest integrated community action of an improved cooking stove project in the Region; the Afrique verte Association which profiled auto-generated and self-managed cereal banks by rural communities in west Africa (Niger, Mali and Burkina Faso); and Ethiopia’s combined delivery of primary prevention intervention as an essential package. The event strengthened intersectoral collaboration and increased advocacy for effective community participation to address the public health impact of climate change in Africa.

## 4.4 Category 4: Health Systems



WHO supports countries to develop resilient health systems with the main goal of achieving universal health coverage. This entails strengthening leadership and governance; health financing, human resources for health (HRH); promoting access to affordable, safe and effective health technologies; integrated service delivery; health information systems (HIS); and health research.

Comprehensive and evidence-based national health policies, strategies and plans (NHPSPs) provide the platform for government leadership and partner coordination. Most countries in the Region have not adopted a multisectoral approach to developing NHPSPs. This has undermined their ability to leverage other stakeholders and sectors such as finance, education, and public works as

well as NGOs and CSOs whose activities also impact on health. To address this gap, WHO is developing training modules of the Country Learning Programme (CLP) to strengthen the capacity of national stakeholders and development partners to collaborate on developing sound NHPSPs.

In 2010, the WHO Regional Committee for Africa (Resolution AFR/RC60/WP/3) encouraged Member States to promote the development and implementation of eHealth policies and strategies. By the end of 2015, only 20 countries<sup>86</sup> had developed their eHealth strategy. To accelerate implementation, WHO trained an additional 17 countries<sup>87</sup> on the use of the *National eHealth Strategy Toolkit*<sup>88</sup> to develop an eHealth strategy and subsequently supported five countries<sup>89</sup> to develop their eHealth strategy.

To facilitate health sector reviews, WHO is developing a *“Guide to harmonize and standardize health sector reviews and evaluations in the WHO African Region.”* The guide will provide standardized indicators that allow comparisons between countries in monitoring and evaluating progress made in priority health areas. The results of these health sector reviews will inform the necessary strategic and operational adjustments to improve the performance of the health sector.

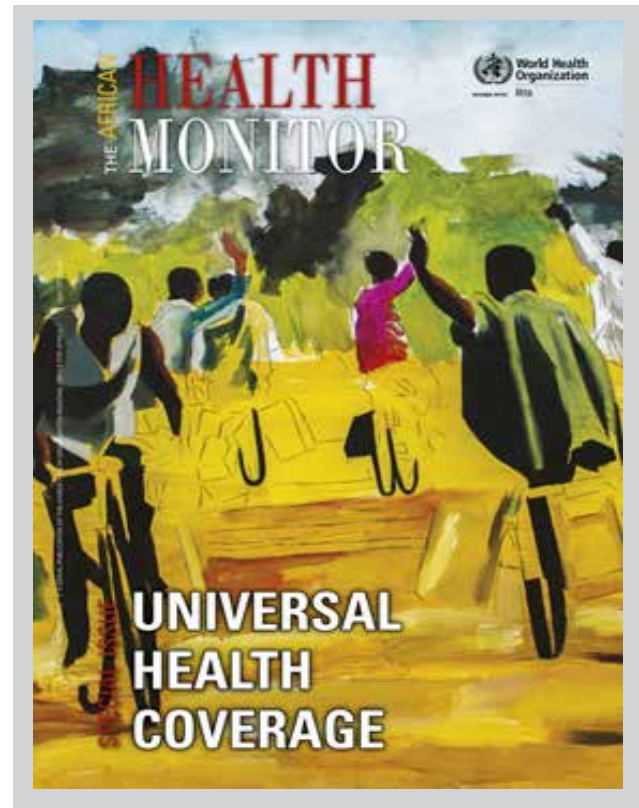
WHO trained staff in 39 countries<sup>90</sup> on the System of Health Accounts (SHA) framework to assist Member States to align their expenditure on health priorities with per capita income. The training will contribute to improved planning and allocation of resources according to health priorities and increase systems accountability in health. Nineteen countries<sup>91</sup> are using the SHA framework to review of their national health accounts (NHA).

Health financing is crucial for providing the essential components of health systems for implementing UHC. WHO, in collaboration with the African Health Economics and Policy Association (AfHEA), conducted several studies to understand the challenges and constraints faced by Member States, and to identify capacity building needs.

Selected results on the situation of health financing in the Region are now available in a special issue of the *African Health Monitor* (Figure 4.4.1).<sup>92</sup> Constraints included insufficient financial resources, heavy reliance on out-of-pocket health expenditure, inefficiency in the management of health systems, weak research, and poor monitoring and evaluation.

These results indicate that robust health financing policies, strategies and sustainable financing mechanisms are important for implementing the key components of UHC.

**Figure 4.4.1: African Health Monitor- Special issue on UHC**



Thirty-seven out of the 47 countries of the Region continue to face critical shortages of health workers, while the rest face relative shortages in terms of geographical distribution and skills mix.<sup>93</sup> WHO supported five countries<sup>94</sup> to develop investment plans and training for scaling up their health workforce consistent with the Regional road map.<sup>95</sup> Eritrea and Swaziland received support to conduct a midterm review of their HRH plans in 2015 which led to re-prioritization of interventions.

The Secretariat built capacity in eight countries<sup>96</sup> to use the WHO Workload Indicators of Staffing Need (WISN) planning tool<sup>97</sup> to determine staffing norms and standards for health facilities. Teams of between 35 and 60 participants per country were trained to apply the tool in assessing the workload of health facilities to identify the health workforce requirements in their countries. In addition, a ‘train the trainer’ workshop was organized with 26<sup>98</sup> participants from six countries to build a pool of experts which WHO can use to support WISN implementation in countries on their own.

Access to quality assured essential medicines is critical for UHC. WHO supported 15 countries<sup>99</sup> to strengthen their pharmaceutical systems, including the selection of essential medicines. Ghana developed a strategic plan to improve good governance in the pharmaceutical sector and a risk management policy to address the vulnerabilities of its Central Medical Stores. Pricing and availability surveys on medicines were carried out in Ethiopia, Mali, Togo and Zimbabwe, while assessments of medicine pricing and reimbursement systems in health insurance schemes were done in Ethiopia, Gabon, Ghana, Rwanda, Senegal and South Africa.

Antimicrobial resistance (AMR) poses an unprecedented threat to public health in the Region, where public awareness remains weak. To build capacity to implement the AMR Global Action Plan in Member States, in March 2016 WHO trained 45 focal points from 12 countries<sup>100</sup> in Harare, Zimbabwe to develop national action plans on AMR using the One Health approach. This recognizes the connection between human health and the health of animals and the environment. In addition, WHO developed a package for surveillance of antimicrobial use,<sup>101</sup> and trained participants from 12 countries<sup>102</sup> on

its use in Ouagadougou in May 2016. The current coverage of functional laboratories is inadequate to contribute to resilient health systems in the Region. WHO supported an External Quality Assessment (EQA) of 90 laboratories in 46 Member States to validate laboratory competency to identify enteric and meningitis pathogens, plague, tuberculosis and malaria, and provided corrective actions and support for poorly performing laboratories. WHO assisted three EVD-affected countries to develop national plans for strengthening national blood transfusion systems. In addition, with WHO support, Liberia developed a national laboratory strategic plan to set up a national public health institute, a priority component for the country’s recovery from the EVD outbreak and rebuilding its health system.

WHO developed a Regional framework for the regulation of traditional medicine practitioners, practices and products,<sup>103</sup> which complements the tools for institutionalizing traditional medicine in health systems and the guidelines on the registration of traditional medicines in the African Region. Four countries have adopted the framework.<sup>104</sup> The protection of intellectual property rights (IPRs) and traditional medical knowledge (TMK) in the Region has been challenging.

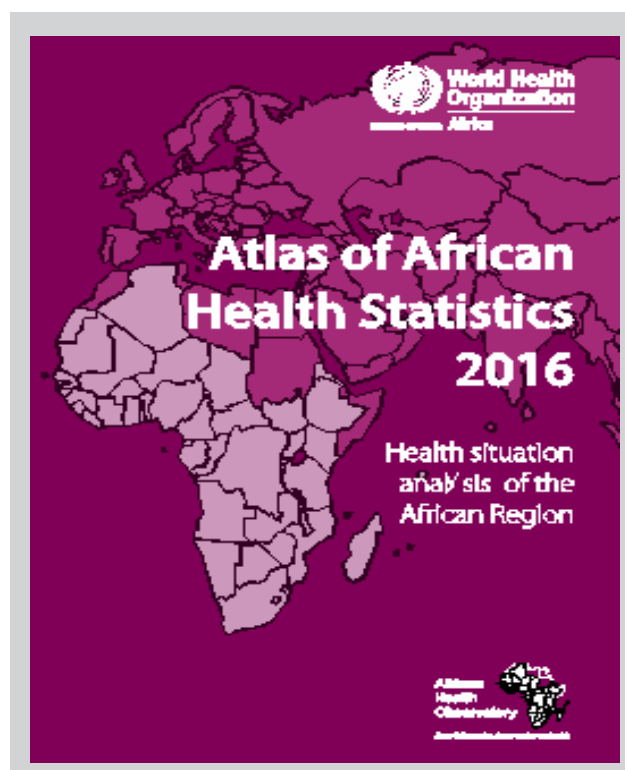
The Regional Office has led the way in protecting indigenous knowledge, being the first of the WHO regions to develop policy guidance<sup>105</sup> and a legislative framework<sup>106</sup> on IPRs, TMK and access to biological resources. Twelve countries<sup>107</sup> have now formulated their national legislation. Madagascar developed a national traditional medicine policy in November 2015, while Côte d’Ivoire developed a code of ethics and practice for traditional health practitioners in 2016.

As recommended by African ministers of health during the first meeting jointly organized by the African Union Commission (AUC) and WHO in Luanda in 2014, WHO, the AUC and the New Partnership for Africa's Development (NEPAD) Planning and Coordinating Agency continue to collaborate on the establishment of the African Medicines Agency (AMA). For this purpose, WHO supported the AUC to develop a legal and institutional framework and a business plan for the AMA to ensure that it is anchored on strong institutional capacity, an effective legislative framework and a clear accountability structure.

To disseminate available health evidence and best practices, WHO maintains the African Health Observatory (AHO)<sup>108</sup> to provide comprehensive analytical health profiles of national health systems. AHO data are collected at country level in each of the 47 Member States, then analyzed in collaboration with UNICEF and the World Bank for the annual publication of the Atlas of African Health Statistics (Fig 4.4.2). The 2015 edition of the Atlas<sup>109</sup> provides a basis for monitoring the health-related SDGs. The quality, quantity, and timeliness of data from Member States have been suboptimal in most cases. Therefore, WHO developed a guide in April 2016 on establishing national health observatories<sup>110</sup> which is already assisting 10 countries<sup>111</sup> to develop health observatories.

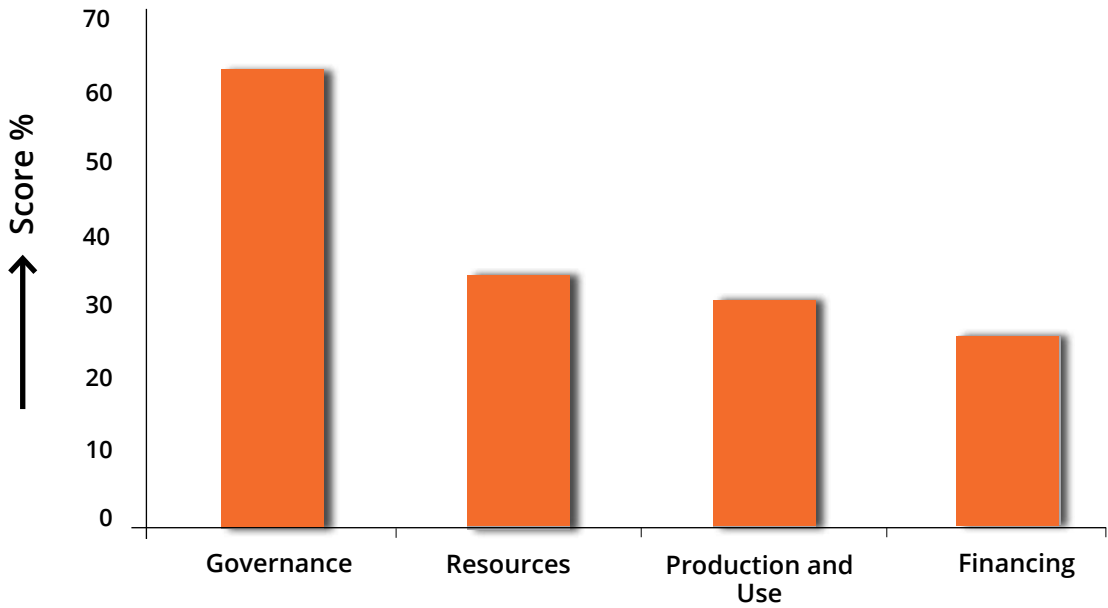
Regarding National Health Research Systems (NHRS), in December 2015 WHO developed the first African NHRS Barometer,<sup>112</sup> in line with the framework of the regional strategy for research adopted in 2015. This tool measures the performance of 17 parameters of governance, finance, human and infrastructural resources, as well as the production and utilization of health research.

**Figure 4.4.2: Atlas of African Health Statistics 2016**



The Barometer has been shared with all Member States to monitor the performance of their NHRS. In February 2016, WHO used the NHRS Barometer to determine the Regional score from data collected on NHRS from all Member States.<sup>112</sup> The overall score for the four NHRS functions was 42% for the African Region, which is below average. The score for the governance function was relatively higher than those for financing, human and infrastructural resources, and production and utilization of research, which were far below average (Figure 4.4.3). Countries need to invest more in strengthening their NHRS, and these scores should guide policy-makers and partners to identify sources of poor performance for designing interventions for improvement.

**Figure 4.4.3: Performance Scores of the four major functions of national health research systems in the African Region <sup>112</sup>**



Source: African National Health Research Systems Barometer

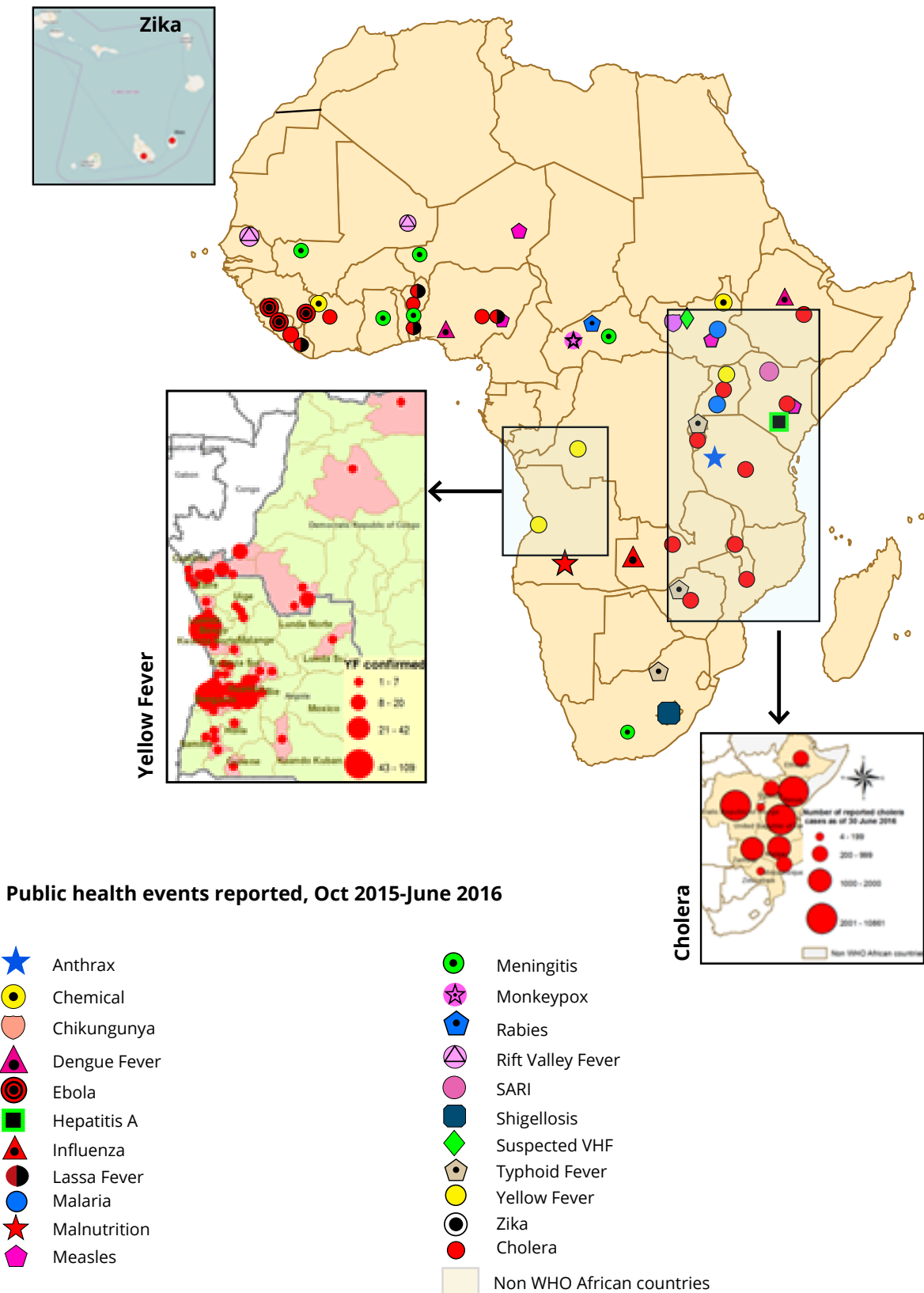
## 4.5 Category 5: Preparedness, Disease Surveillance and Response



WHO's work in this category supports preparedness, surveillance and response to epidemics, natural disasters, conflicts and environmental, chemical, radio-nuclear and food-related emergencies, as well as antimicrobial resistance. Currently the African Region continues to experience recurring major public health events such as the yellow fever, cholera and Zika outbreaks, the effects of El Niño, and humanitarian conflicts, which engender high morbidity and mortality (Figure 4.5.1).

The EVD epidemic was successfully controlled in December 2015 and the WHO Director-General lifted its declaration as a Public Health Emergency of International Concern (PHEIC) following the recommendations of the IHR Emergency Committee, on 29 March 2016. A total of 28 616 confirmed, probable and suspected cases had been reported in Guinea, Liberia and Sierra Leone, with 11 310 deaths.

Figure 4.5.1: Public health events in the African Region, October 2015–May 2016



Source: WHO Afro Outbreaks and Emergencies Bulletin, Issue 3, 30 May 2016





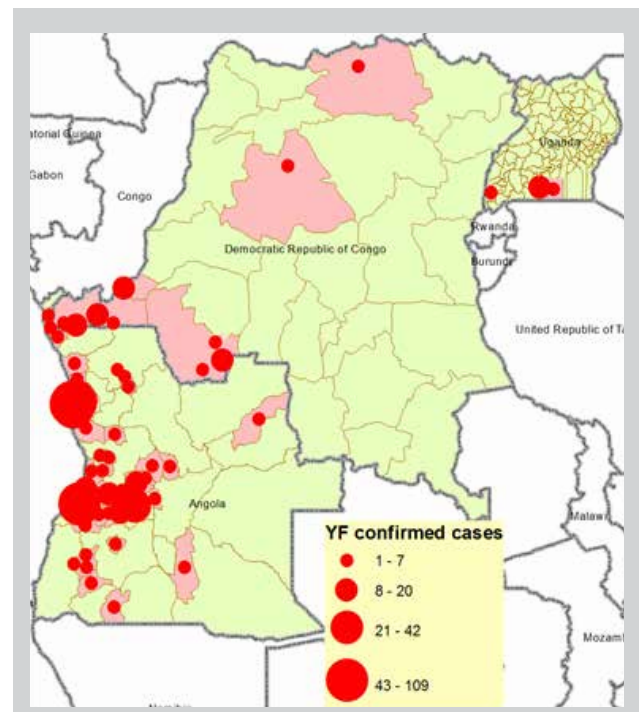
There were subsequent sporadic cases by the end of the reporting period in June 2016. In south-eastern Guinea, seven confirmed and three probable EVD cases were reported between 17 March and 6 April, while three confirmed cases were reported between 1 and 5 April from Monrovia in Liberia. In Guinea, the last case tested negative for Ebola virus for the second time on 19 April, and Guinea declared an end to Ebola virus transmission on 1 June 2016. On 9 June 2016, WHO declared the end of the most recent EVD outbreak in Liberia.

The swift containment of the flare-ups indicates that response capacity has been built in these countries, which WHO supported through regular coordination meetings of all three levels of WHO, and deploying experts. All three countries remain vigilant as the risk of flare-ups remains. WHO continues to work with its partners and the Governments of Guinea, Liberia and Sierra Leone to counsel survivors to help them reintegrate into communities, and to screen for persistence of the virus. Lessons learned from the EVD outbreak have contributed to improving the response to public health emergencies in the Region, such as the establishment of an incident management system for all major outbreaks and humanitarian crises.

The Region is currently experiencing the largest ever yellow fever outbreak, which started in Angola in December 2015, and spread to the Democratic Republic of the Congo (DRC) and Kenya. As of 30 June 2016, 3552 cases including 355 deaths had been reported in Angola, and 1399 cases with 82 deaths in the DRC. Uganda had also reported 60 cases and 7 deaths in an outbreak unrelated to the one in Angola (Figure 4.5.2).

To assess efforts to prevent and control the yellow fever epidemic, the Director-General and the Regional Director visited the Republic of Angola in April 2016 where they met President José Eduardo dos Santos and other senior government officials to discuss how WHO could better support the country.

**Figure 4.5.2: Geographic distribution of yellow fever cases as of June 2016**



Source: WHO Afro Outbreaks and Emergencies Bulletin, Issue 3, 30 May 2016



Dr Matshidiso Moeti, WHO Regional Director for Africa and Dr Margaret Chan, WHO Director-General meet Angolan President, His Excellency Jose Eduardo dos Santos in Luanda, Angola, April 2016.

The Director-General and the Regional Director also visited a yellow fever vaccination post in Luanda and the Luanda General Hospital treatment centre that handles the most severe yellow fever cases.

In response to the outbreak, WHO and partners supported the affected countries to implement control measures. By the end of June 2016, 126 international experts had been deployed to strengthen efforts towards surveillance, vaccination, risk communication, community mobilization, case management and integrated vector control.

In line with the IHR recommendations, WHO advised yellow fever screening and vaccination of travellers at the major points of entry. In addition, through the International Coordination Group (ICG)

mechanisms, WHO provided over 14 million doses of yellow fever vaccine to Angola, the DRC and Uganda. Funds amounting to approximately US\$ 1.6 million were disbursed from the WHO Contingency Fund for Emergencies (CFE) and the African Public Health Emergency Fund (APHEF) to support national response efforts. WHO is developing a new yellow fever strategy to address the different risk now facing the Region, which will emphasize immunization and health security.

In the African Region, Zika virus was confirmed in Cabo Verde and Guinea-Bissau in October 2015 and June 2016 respectively. This is linked to the outbreak in the Americas and a PHEIC was declared on 1 February 2016. By 30 June 2016, 7585 suspected cases of Zika including nine microcephaly cases were reported among newborn babies of Zika-infected

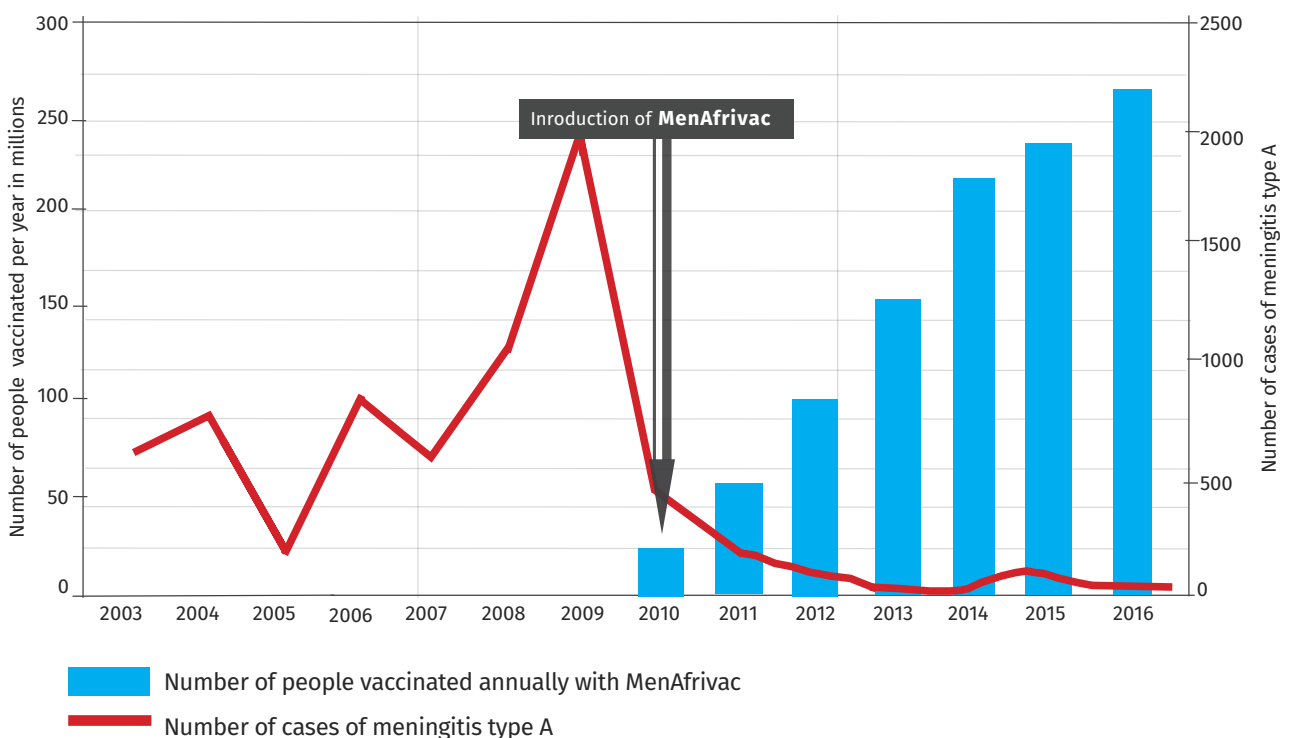
mothers in these two countries, with 202 cases laboratory-confirmed. The number of reported cases in Cabo Verde has since declined with the last confirmed new cases reported in March 2016, while Guinea-Bissau had three confirmed cases by the end of June 2016. WHO provided support for the initial investigation and confirmation of the diagnosis through the deployment of experts and guidance documents to Member States and partners for preparedness and response to Zika virus disease.

Another significant public health event was an outbreak of Lassa fever in Nigeria, Benin and Togo. By 30 June 2016, Nigeria had reported 272 cases and 149 deaths (CFR: 55%), with 165 cases laboratory-confirmed, including 89 deaths.

Although Lassa fever had been previously reported in Nigeria and Benin, Togo experienced it for the first time this year. In response, WHO deployed epidemiologists, laboratory and logistics experts and social mobilizers to provide technical support, while also providing financial support to procure laboratory reagents and supplies and donating Ribavirin to Nigeria for case management.

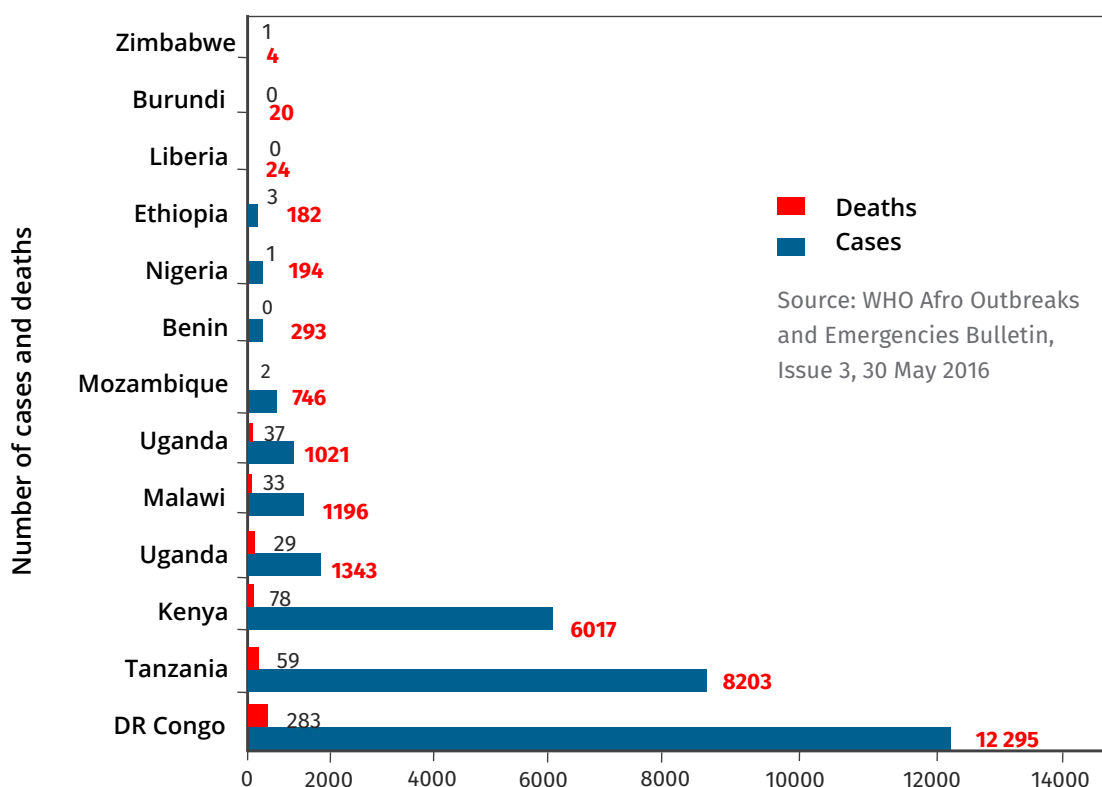
There is persistent seasonal occurrence of meningococcal meningitis in the Region, particularly with *Meningococcus meningitidis* A strain. To reduce this, WHO and its partners introduced MenAfriVac (meningitis A vaccine). Over 255 million people in 18 countries have now been vaccinated since 2010.

**Figure 4.5.3. Cumulative number of people vaccinated through campaigns and cases of meningococcal meningitis type A in 18 countries of the meningitis belt**



Source: Campaign Data compiled by IST West Africa

**Figure 4.5.4: Distribution of cholera cases and deaths by country, January-May 2016**



Source: WHO Afro Outbreaks and Emergencies Bulletin, Issue 3, 30 May 2016

The vaccine's effectiveness has led to a reduction of the meningitis A strain from 90% in 2007 to 35% in 2010, and to less than 5% in 2016 (Figure 4.5.3). Despite these efforts, an outbreak of meningitis occurred in Ghana, Benin, Togo, Niger and Burkina Faso between January and May 2016, with type W135 strain, not contained in the MenAfriVac vaccine, causing an increasing proportion of the disease. The number of cases reported in the five countries was 7559 including 642 deaths (CFR 8.5%). WHO and its partners supported the Ministries of Health of Ghana, Benin and Togo to enhance surveillance and planning, conduct reactive vaccination campaigns and disseminate appropriate messages targeting the affected populations. WHO also deployed two international laboratory experts to support laboratory quality assurance.

As a result of global climate change, the Region has experienced El Niño-related<sup>113</sup> extreme weather conditions over the past two years which have significant public health consequences. About 52 million people in Eastern and Southern Africa countries are affected by the El Niño phenomenon, which has severely impacted their health and livelihoods. For example, Ethiopia is currently facing its worst drought in 30 years and 10.2 million people require emergency food assistance. Over one million children under five years of age are malnourished, while over two million people have no access to safe water. In Zimbabwe, about 1.49 million people are food insecure. Furthermore, the DRC, Ethiopia, Malawi, Mozambique, Kenya, Tanzania and Zambia are currently experiencing cholera outbreaks due to the effects of El Niño (Figure 4.5.4).



Five Member States - Ethiopia, Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe - have declared national drought disasters and appealed for urgent international assistance. In response, WHO deployed multidisciplinary teams of experts to give technical support to develop El Niño regional preparedness and response plans to guide the health sector in affected countries on key health interventions. The Organization deployed multidisciplinary experts on cholera to give technical support to the United Republic of Tanzania, Democratic Republic of the Congo, Mozambique, Malawi and recently to Ethiopia, and provided financial resources for the cholera response.

The Regional Office has developed a Regional strategic agenda to stimulate investment and intersectoral action on priority health and environment programmes in Africa. Although the Region is facing major outbreaks, the Organization continuously strives to

strengthen preparedness, particularly by drawing on the lessons learned from the recent EVD epidemic in the Region. Efforts included finalizing comprehensive public health emergency risk profiling and mapping which was published on the WHO AFRO website<sup>114</sup> and supporting 19 priority high risk countries<sup>115</sup> to establish national Emergency Operating Centres (EOCs). The Secretariat has provided technical support in risk and emergency communications through its Emergency Communications Network and continues to use eSurveillance to do real-time surveillance for alerts and early detection.

Given the increasing global health threat posed by infectious diseases, health partners have developed a Global Health Security Agenda in line with the IHR (2005) core capacities to prevent avoidable epidemics, detect threats early, and respond rapidly and effectively to biological threats of international concern.

In its key coordinating and monitoring role, WHO found that Member States were not sufficiently objective when completing their annual self-assessments on IHR, as seen by the countries most affected by EVD which reported satisfactory surveillance systems. The World Health Assembly (WHA 68/22 Add.1) subsequently recommended a move from exclusive self-evaluation to a combined evaluation process. WHO has developed a joint external evaluation tool, conducted evaluations in Tanzania, Ethiopia and Mozambique and identified priority actions. A similar process is planned for other countries in the Region.

Following WHO's contribution to the establishment of the Africa Centre for Disease Control and Prevention (CDC), a framework for collaboration between the African Union Commission and WHO was developed. This framework considers the comparative advantages and synergy between the two organizations and ensures that WHO continues to provide technical support to Member States, as seen in the joint missions to assess potential Africa CDC subregional hubs in Zambia, Nigeria, Gabon and Ethiopia.

The African Region has made tremendous progress towards polio eradication, with no confirmed case of wild poliovirus since the last case was reported in Nigeria on 24 July 2014. The African Region successfully completed phase 1 polioviruses laboratory containment with the destruction of polioviruses and potentially infectious materials by the first quarter of 2016.

Furthermore, the global switch from the trivalent oral polio vaccine (tOPV) to the bivalent OPV was completed on time with validation reports from all 47 countries. The next milestones include implementing the phase 2 biocontainment of oral polio vaccine virus type 2 from July 2016, and ensuring proper documentation of polio-free status of the remaining 11 countries<sup>116</sup> to the African Regional Certification Commission (ARCC), according to planned country schedules until September 2017. With the continued momentum, the African Region could be certified to have eradicated polio by the end of 2017. This means that the support of the Global Polio Eradication Initiative (GPEI) to the Region would start to reduce as the regional and global polio eradication certification draws to a close. Work is ongoing to ensure the successful transition of polio staff and resources in the Region.

In addressing the challenges related to the recurrent outbreaks and other health emergencies, a regional strategy for health security and emergencies has been developed. The strategy is based on the "all-hazards" principle with emphasis on the One Health approach. This draft strategy will be presented to the Sixty-sixth session of the Regional Committee.

## 4.6 Category 6: Corporate services and enabling functions

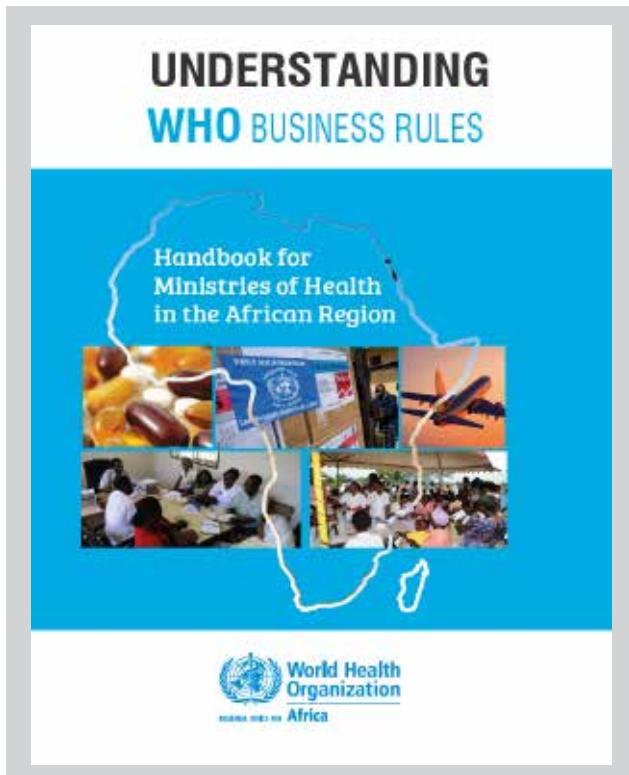


This category focuses on WHO leadership and the corporate services required to maintain the integrity as well as the effective and efficient functioning of the Organization. Corporate services enable the other categories of work and cover procurement, administration, finance, audit and compliance, human resources, information technology, security, communications, partnership and resource mobilization and country support. Between October 2015 and June 2016, work in this category was carried out in line with the principles and priorities of the Transformation Agenda of the WHO Secretariat in the African Region.

One key area of work has been improving accountability and internal controls in the African Region through an Accountability and Internal Control Strengthening (AICS) project.

Its objectives include improving internal controls and accountability, and enhancing the performance of individual staff and budget centres at Regional and country level. The Regional Office has tailored some Organization-wide initiatives in this area, such as the use of Key Performance Indicators (KPIs), to respond to its own specific needs.

An important output of the AICS project was a dedicated website to provide staff with information and guidance documents on the accountability and internal control frameworks in both English and French. To improve understanding of WHO's rules and procedures, the Regional Office developed a handbook for administrative and technical staff of Member States' ministries of health.



Available in English, French and Portuguese, the handbook will be distributed to all countries in the African Region. In addition, WHO continues to strengthen accountability with recipients of Direct Financial Cooperation (DFC) by assessing their capacity and ensuring that WHO funds advanced to governments are properly accounted for and used for intended activities.

To further enhance accountability, the Regional Office has established a Compliance and Risk Management Committee (CRMC) to address non-compliance holistically. The Committee ensures a strategic, transparent and effective approach to risk and compliance management, in line with WHO's accountability and internal control frameworks. Chaired by the Regional Director, the Committee comprises the executive management team and regularly considers reports on achievement of risk-related objectives, decides on risk mitigation and gives feedback on compliance reviews.

The Region has developed key performance indicators (KPIs) for many aspects of management and administration, which are being used at the Regional and country offices. The results from these KPIs are reviewed regularly and reported to the Compliance and Risk Management Committee at the Regional Office as well as to WHO Country Representatives (WRs). A recent report on KPI implementation shows that all Country Office Administrators or Operations Officers are now keenly aware of the importance of showing progress in achieving these indicators. While there has been progress in the fields of human resources management and security operations, areas most in need of improvement are procurement, travel and the provision of information technology services.

A related initiative is underway with independent consultants to develop KPIs that measure the programmatic performance and the delivery of results by technical clusters and country offices. The aim is to demonstrate how WHO's work contributes to results that lead to improved health outcomes in countries and ultimately lead to progress towards the health-related SDGs. These KPIs will be used to assess individual staff as well as team/programme contributions and the corporate performance of WHO in the African Region, including tracking the quality and efficiency of the delivery of the Organization's core areas of responsibility.

Work is well underway in realigning WHO's human resources with the programmatic priorities identified in the Transformation Agenda. By the end of June 2016, the alignment exercise had been concluded for four of the five technical clusters in the Regional Office and related functions at Intercountry Support Team (IST) level. The structures of Clusters and Programmes have been defined, new post descriptions



matching functions to regional priorities prepared, with a measure of staff turnover. A similar review at country office level is progressing.

To assist newly appointed heads of country offices, joint administrative and programme reviews are conducted in countries within six months of their arrival whenever feasible. These reviews highlight areas for improvement as well as document best practices to be shared with other country offices. Induction sessions were organized for 10 newly appointed WRs, while nine WRs attended UN Country Team Leadership Skills Courses organized by the United Nations System Staff College in Thailand and Kenya. To increase the success rate of regional candidates, two regional orientation workshops were organized in December 2015 to prepare 50 potential candidates for the placement test for the roster of WHO Representatives.

Country cooperation strategies (CCS) provide the strategic vision for WHO's cooperation with Member States, ensuring that national health priorities, including readiness for emergency response, inform WHO workplans at country level. A total of 23 countries<sup>117</sup> have updated their CCS, while 24 countries<sup>118</sup> are renewing their CCS using a new guidance tool for mainstreaming the 2030 agenda for sustainable development. All countries need to assess the quality and relevance of the CCS focus areas within the context of the SDGs and the Transformation Agenda.

WRs continued to play an important role in providing leadership for WHO's contributions to health development within the UN Development Assistance Framework (UNDAF) at country level.

WHO is the lead agency for health in the health development partners' group, including the health component of UNDAF. Standard operating procedures have been developed for countries wishing to adopt "Delivering as One", and WHO is actively involved in policy and strategic discussions in this process in 33 countries in the Region.

WHO actively sought to strengthen partnerships during the period under review. For example, the Regional Office worked closely with the WHO Regional Office for the Eastern Mediterranean to support the African Union Commission to advance the health agenda on the continent. Outputs included finalization of a framework for collaboration with the Africa Centre for Disease Control (Africa CDC) to work in a complementary way in promoting health security, including improving IHR capacity in countries.

Other notable activities included partnership agreements signed by the Regional Director with the UN Economic Commission for Africa to strengthen the capacity of countries in data and knowledge management, and with the Organization of African First Ladies Against HIV/AIDS (OAFILA) to advocate for effective policies and strategies towards the elimination of HIV, reduction of maternal and child mortality and the empowerment of women and children.

WHO is undertaking a review of the Harmonization for Health in Africa (HHA) initiative, a regional mechanism for providing support to countries in the African Region, to identify progress made by HHA partners and identify a way forward to improve health systems in the African Region.

The Regional Office launched a donor report monitoring report system on 10 March 2016 to improve the timelines and quality of technical and financial reports to development partners supporting WHO in the African Region. Within three months of its implementation, it has helped to reduce the number of overdue reports by almost half, from 242 to 126 (48%). The Regional Office will strive for zero reporting delays and high quality reports.

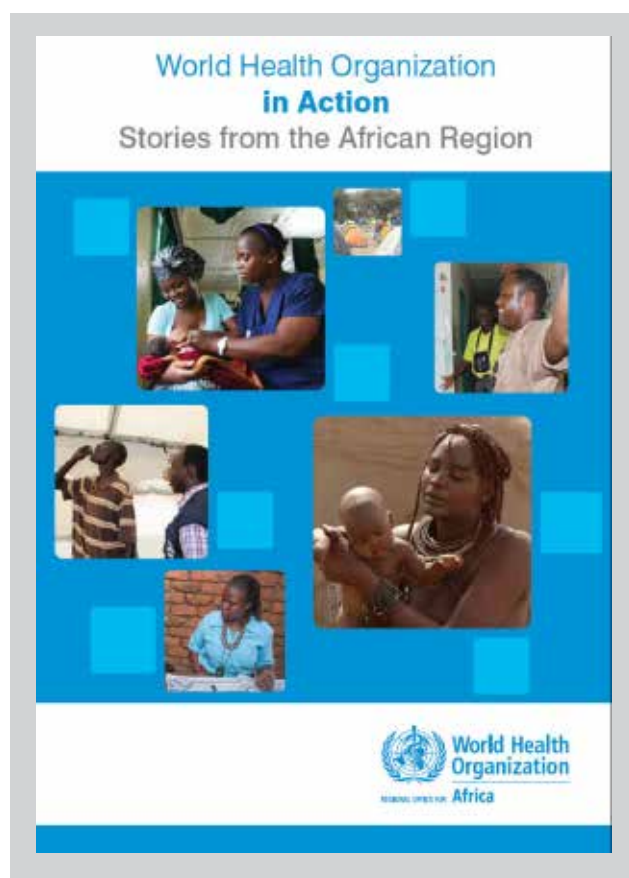
To enhance the contributions of delegations of the African Region to the work of WHO Governing Bodies, the Regional Office and the African Group Coordinator organized preparatory workshops and daily coordination meetings ahead of the Sixty-ninth World Health Assembly sessions in Geneva in May 2016. These forums enabled Member States to have equitable and effective participation, a common understanding and also assisted them in formulating shared positions on key issues discussed by the WHA.

The Regional Director promoted WHO's leadership and governance in health through a number of missions to Member States and partners. In particular, the Regional Director visited the Republic of Gabon in February 2016, where WHO provided technical support for the establishment of a Central African Health Organization, "L'Organisation de la Santé de l'Afrique centrale (OSAC)", and also the "Central African Common Fund for Health", "Fonds communautaire de la Santé pour l'Afrique centrale (FCAC)".

This is the first intergovernmental health organization involving the Economic Community of Central African States (ECCAS) located in this sub-region,

and it is hoped that by working together, WHO will be able to scale up support to the relevant Member States. The Regional Director also paid a working visit to China in March 2016 during which she discussed with senior government officials the role that China could play in promoting sustainable health development in Africa.

The Regional Office continued to raise public awareness on health issues and its work through advocacy, media relations, online communications and public health information products, using traditional and new media channels in the three official languages. This has led to an increase in the number of visits to its website during the reporting period.



## 5. Progress made in the implementation of Regional Committee resolutions



WHO/E. Kambambi Kabangu

The Secretariat is responsible for monitoring the implementation of resolutions passed by Member States in past sessions of the Regional Committee. The progress reports of some of the resolutions are presented in this chapter. Each report summarizes the resolution, the activities implemented and the results or impact achieved.

### **AFR/RC65/R1–The African Public Health Emergency Fund (APHEF): Stocktaking**

This resolution requested the Regional Director to establish a multidisciplinary expert group to review the current APHEF mechanism and to propose alternatives that will improve Member States' contribution and intensify high-level advocacy with relevant ministries.

WHO convened an experts' consultative meeting in Brazzaville in June 2016 which brought together ministries of health and finance to reflect on the challenge of the low level of contributions received from Member States.

The experts proposed potential solutions to enhance contributions which include increased advocacy, developing a coordinated resource-mobilization strategy, and convening resource-mobilization forums such as round table discussions with donors and pre-identified African leaders as champions for APHEF. The report of the experts' meeting will be presented to the Regional Committee.



## **AFR/RC61/R4 Poliomyelitis eradication in the African Region**

Pursuant to the Regional Committee resolution on poliomyelitis eradication (AFR/RC61/R4), the Regional Office through the country offices provided technical and financial support to Member States for the implementation of identified poliomyelitis eradication priorities which successfully led to the interruption of poliovirus transmission in 2015, bio-containment of the polioviruses and the global switch from tOPV to bOPV in 2016.

## 6. Challenges and Constraints



WHO/E. Kabambi Kabangu

The WHO Secretariat in the African Region faced several challenges and constraints during the reporting period, several of which were not new. The Region faces the triple disease burden of emergencies and outbreaks, communicable and noncommunicable diseases, which occur in the context of underfunded and weak health systems in many countries of the African Region. WHO has had to be flexible in adapting its operations to the diversity of countries and contexts while supporting governments in their coordination and stewardship functions.

The African Region continues to have a high burden of disease compared to other regions. While much progress was made, fragmented action and investment by countries meant that by the end of 2015, most countries had not fully achieved the health-related MDGs.

Populations were left behind and failed to benefit sufficiently from the cost-effective public health interventions that were implemented. To achieve Universal Health Coverage (UHC), resilient and responsive health systems are required.

These need to overcome deficiencies in access, gaps in using information and communication technologies for health, and facilitate translation of new evidence from research into public health policies and programmes.

Inadequate health financing has contributed to these challenges. This includes the over-dependence of national governments on external funding from donors and development partners and a lack of political awareness within countries of their international obligations to commit funding for health.

Countries need to increase their domestic contributions from both government and the private sector, and make better use of available resources to ensure value for money. Health development needs to be a high priority in national investment and development plans. At the same time, countries are not investing sufficiently in health research and development, and health information systems to deliver quality, timely health data for decision-making. This hinders the ability to make priority, cost-effective decisions to improve health outcomes.

The African Region is facing a burgeoning epidemic of noncommunicable diseases. The four main risk factors for the major NCDs in the region - tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets – are becoming increasingly common. Unless urgent action is taken to prevent and control NCDs, they will become the leading cause of ill health, disability and premature death in the Region. The challenge is to address the low priority given to NCDs, invest more resources in addressing their risk factors and reconfigure health services to integrate chronic care and rehabilitation into primary health care systems, including reducing the high costs of treating NCDs, especially cancer.

Poverty, food insecurity, environmental degradation and unemployment are enormously challenging. These social and economic determinants of health, coupled with gender inequity and harmful cultural practices have aggravated the high double burden of communicable and noncommunicable disease in the Region. This calls for a multisectoral approach with deliberate action to ensure that all policies consider effects on health. The challenge is to convince non-health actors and society at large of the importance of committed collaboration to address social, economic and health inequities.

There is an urgent need for a greater focus on health security and emergencies in the Region. Countries have made progress in responding more effectively to emergencies, but to date, no country in the Region has put in place all the core capacity requirements for the legally-binding International Health Regulations (IHR, 2005). Many ministries of health struggle to manage intersectoral coordination which is key to responding to emergencies and disasters adequately. The challenge is how to work with Member States to ensure that high level political commitment is available, including the allocation of adequate domestic resources, and that national plans and road maps with clear milestones are developed and implemented in collaboration with other sectors to achieve and sustain the IHR core capacities.

The WHO Secretariat has faced its own challenges in its efforts to accelerate its reforms in the African Region. The human resources realignment became protracted with high levels of anxiety and uncertainty among staff members, in some instances reducing the Secretariat's capacity to respond to requests and to complete some tasks in the workplan on time. While the level and availability of funding has improved, the budget is still dominated by inflexible voluntary contributions for some areas of work, while others remain underfunded. The ultimate challenge is to ensure that the human, financial and material resources available to the Secretariat are aligned with agreed Regional and country priorities, and are effectively and efficiently used to support Member States in moving towards universal health coverage to achieve the highest possible level of health for their people.

## 7. Conclusion



WHO/G Rohrig

The period of this report coincides with the transition from the MDGs to the SDGs, the commencement of the second biennium of the 12<sup>th</sup> General Programme of Work, and the accelerated implementation of the WHO's reform through the Transformation Agenda of the WHO Secretariat in the African Region.

The report highlights key achievements and progress made, including stopping the EVD outbreak in West Africa, reductions in the burden of communicable diseases such as HIV/AIDS, TB and malaria, the further progress towards elimination/eradication of some NTDs, reductions in child and maternal mortality, and the steady progress towards eradicating polio from the Region by 2017.

However, the quest to improve the health status of the people in the African Region is far from over and the Secretariat will need to intensify its efforts in support of Member States as articulated in the "*The Africa Health Transformation Programme, 2015-20: A Vision for Universal Health Coverage*".<sup>119</sup> The goal is to ensure universal access to essential health services in all Member States of the Region and thus achieve UHC with minimal financial, geographic and social obstacles.

The adoption of the SDGs provides an opportunity to push forward on this goal. It places a premium on inclusive engagement across all sectors, expanding intersectoral collaboration and focusing strongly on equity and reaching the hardest to reach populations, so that no person is "left behind".

SDG 3, the most visible expression of health in the SDGs, not only addresses the unfinished agenda of the MDGs in areas such as HIV, TB, malaria, and maternal and child health, but also expands the agenda to include NCDs, mental health and substance abuse, and universal health coverage and access to quality health care.

Implementation of the SDG agenda will require key strategic actions from Member States as discussed, including political commitment; incorporation into national health and development plans and budgets; societal partnerships; strengthened systems for monitoring at national and subnational levels; and effective accountability mechanisms.

The WHO Secretariat in the African Region will advance implementation of the SDGs by intensifying its advocacy efforts with governments; supporting health planning, including translating health-related SDGs into relevant national goals through the revision of national health policies and strategic and investment plans; driving implementation through UHC, including the improvement of service delivery by the strengthening of the health workforce and adoption of an integrated, people-centred health services approach with emphasis on district health development and enhanced community engagement; working with governments to improve cost-efficiency of their programmes; promoting partnerships; and strengthening the management of information for action and accountability.

Achieving the SDG 3 targets will require well-functioning health systems that can serve as the vehicles for implementing programmes on all diseases and health through the life course.

The targets can be achieved by applying the lessons learnt from the challenges that hindered the attainment of the MDGs, and by using research to guide health systems in the design and implementation of health programmes. National Health Observatories or similar platforms will be promoted to strengthen the capacity to collect, analyse and interpret real-time health data to inform decisions and actions.

Learning from the recent EVD epidemic and response, WHO is undertaking major reforms to make it fit for purpose to address global health security. A new WHO Health Emergencies Programme, which is a single platform across all the three levels of the Organization, has been created to address disease outbreaks and other health emergencies. The WHO Secretariat will have greatly increased capacity to support Member States to prevent, detect and respond to health emergencies in the African Region.

To help improve national capacity for preparedness and response, a regional strategy for health security and emergencies will be presented to the Sixty-sixth session of the Regional Committee. WHO will support Member States to implement the strategy and will work with other health security initiatives to achieve and sustain the IHR core capacities. Member States are expected to commit domestic resources to implement the priority interventions. WHO will continue to work hard with partners to establish a regional partnership forum which can respond promptly to outbreaks and health emergencies.



The report highlights the progress made in controlling polio. With the current progress and momentum, the African Region is on track to being certified to have eradicated polio by the end of 2017.

As we approach this, the amount of polio resources allocated to the African Region will start to dwindle. It is therefore important that the transitioning of the existing polio infrastructure, such as staff and equipment required to sustain eradication efforts and benefit other public health interventions, be closely managed with government ownership and leadership. WHO will provide technical support and advocate with partners, donor governments and development agencies to ensure that this is done successfully.

The report has also highlighted key achievements and progress made in the implementation of the Transformation Agenda, including efforts to improve efficiency, compliance and accountability in operations, and to enhance human resource capacity in the Regional Office and Inter-country Support Teams. The process to realign human resources to regional priorities has led to a better definition of staff functions and the matching of staff positions with the required profile. The realignment process will now move to WHO Country Offices.

In order to ensure more structured and successful implementation, the Transformation Agenda will be costed and fully integrated into the Programme Budget. A Project Management Team and an Oversight Committee will be established to oversee effective implementation, monitoring and reporting. An online platform to collate, monitor, assess and report on the TA activities will be created. The platform will be made accessible to all Member States and partners as part of the efforts to enhance accountability and transparency.

The ongoing and future changes being effected within the framework of the Transformation Agenda seek to strengthen the capacity of the WHO Secretariat in the African Region to meet the expectations of Member States and partners. It will continue to advocate for Member States to increase allocations to their health budgets and to mobilize external funding to accelerate scaling up and implementation of proven health interventions for the improvement of the health of the population.

The Secretariat is fully committed to working with Member States and partners to ensure universal access to a basic package of essential health services in all Member States of the Region to achieve the best possible health outcomes for Africa's people.



# Endnotes

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