

THE WORK OF
WHO IN THE AFRICAN REGION
Biennial Report of the Regional Director



2016-2017



World Health
Organization

REGIONAL OFFICE FOR

Africa

THE WORK OF WHO IN THE AFRICAN REGION 2016–2017 BIENNIAL REPORT OF THE REGIONAL DIRECTOR

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Abbreviations

AICS	Accountability and Internal Control Strengthening	iCCM	Integrated Community Case Management
AMR	antimicrobial resistance	IDSR	Integrated Disease Surveillance and Response
ART	antiretroviral therapy	IGAD	Intergovernmental Authority on Development
AVW	African Vaccination Week	IHR	International Health Regulations
BMGF	Bill & Melinda Gates Foundation	IRIS	WHO's global Institutional Repository for Information Sharing
CRVS	Civil Registration and Vital Statistics	ITN	insecticide-treated net
DFC	Direct Financial Cooperation	ITU	International Telecommunication Union
DTP	diphtheria-tetanus-pertussis-containing vaccine	JEE	Joint External Evaluation
ECOWAS	Economic Commission of West African States	MIYCN	Maternal, infant and young child nutrition
eMTCT	elimination of mother-to-child transmission	MDGs	Millennium Development Goals
EPI	Expanded Programme on Immunization	MDR-TB	multidrug-resistant tuberculosis
EPI/IMCI	Expanded Programme on Immunization and Integrated Management of Childhood Illness	NCDs	noncommunicable diseases
EQA	External Quality Assessment	NTDs	neglected tropical diseases
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases	OAFLA	Organisation of African First Ladies against HIV/AIDS
EVD	Ebola virus disease	OIE	World Organisation for Animal Health
EVIPNet	Evidence-Informed Policy Network	PC-NTDs	NTDs amenable to preventive chemotherapy
FACE	Funding Authorization and Certification of Expenditure	RMNCAH	reproductive, maternal, newborn, child and adolescent health
FAO	Food and Agriculture Organization of the United Nations	RSPI	Regional Strategic Plan for Immunization
FIGO	Federation Internationale de Gyneco Obstetrique	SARA	Service Availability and Readiness Assessments
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	SDGs	Sustainable Development Goals
GOARN	Global Outbreak and Alert Response Network	TB	tuberculosis
GPW	General Programme of Work	UHC	universal health coverage
GVAP	Global Vaccine Action Plan	UNECA	United Nations Economic Commission for Africa
HHA	Harmonization for Health in Africa	USAID	United States Agency for International Development
HiAP	Health in All Policies	WAHO	West African Health Organisation
HPV	human papillomavirus	WHE	WHO Health Emergencies Programme
HRH	human resources for health	WHO FCTC	Framework Convention on Tobacco Control
IAG	Independent Advisory Group	WHO PEN	WHO Package of Essential Noncommunicable Disease Interventions
		WISN	Workload Indicators of Staffing Need

Dr Moeti in the SHOC Room of WHO DRC with WR and other experts in Kinshasa discussing issues towards a rapid, effective and coherent response to stop the recent Ebola virus disease outbreak in Likati health zone, Bas Uele Province.



Message from the Regional Director

This biennial report presents an overview of the contribution of WHO in the African Region to improving health in countries, through support to Member States in collaboration with health development partners. The work was carried out at a time of growing optimism, with stock-taking on the Millennium Development Goals having shown that African countries did make significant progress, including reductions in new HIV infections among young people and HIV-related and child deaths. The place of health on the global development agenda continues to improve; this was demonstrated by the G20 Heads of State at this year's G20 Summit in Germany, who committed to joint action to safeguard against health crises, strengthen health systems and combat antimicrobial resistance, while African Union Heads of State endorsed declarations on immunization and the International Health Regulations, in January and July 2017 respectively.

Member States in the African Region have seized the opportunities arising from global recognition of the urgency of improving countries' capacity and preparedness to address disease outbreaks and public health emergencies, highlighted by the tragic Ebola virus disease outbreak in West Africa. We have led independent evaluations of national capacities and are supporting the development of plans aimed at filling identified gaps; this will assist in mobilizing the required resources, moving countries closer to required IHR capacities, and ensuring that an epidemic of this magnitude does not recur. The reform of WHO's own Health Emergencies Programme is progressing apace and already demonstrating improved speed and effectiveness in supporting the control of outbreaks of meningitis, Lassa fever, Rift Valley fever, cholera and yellow fever in the Region.



A handwritten signature in black ink, appearing to read 'M. Moeti'.

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

Message from the Regional Director



The 2030 Agenda for Sustainable Development has ushered in new opportunities, with Sustainable Development Goal 3 - 'ensure healthy lives and promote well-being' - at the heart of all the others, promising synergies through multisectoral action. The work done during this biennium in supporting countries to strengthen the building blocks for a resilient health system – for example, on financing through National Health Accounts and the development of national health financing strategies; on national human resources for health observatories and accounts to inform policies and innovative strategies to appropriately distribute, retain and motivate health workers in countries – has laid the foundation for the use of the framework for universal health coverage (UHC) and the Sustainable Development Goals (SDGs) agreed with Member States, partners and experts, for making progress towards UHC. WHO has developed various tools for promoting action across different development sectors, to improve health outcomes. These will enable countries to address the socioeconomic determinants of health and improve health and well-being.

An exciting opportunity is presented by the exponential growth in the use of information technology in different spheres of development in the Region.

Message from the Regional Director

To benefit from digital technology and accelerate progress in diverse areas including disease surveillance, training and supervision of health workers, referral of patient dossiers to clinical specialists in far-away urban hospitals, support to patient treatment adherence, we have assisted countries in developing national eHealth strategies. Our newly-agreed partnership with the International Telecommunication Union will facilitate the mobilization of resources and capacities to expand the scope of this support.

Despite these opportunities, WHO in the African Region continues to work within a complex, multifaceted context. The Region is disproportionately prone to disease outbreaks and deals with over 100 public health events each year.

The burden of communicable diseases remains high, and the development and rapid spread of antimicrobial resistance is a fast-evolving threat to health security. Noncommunicable diseases (NCDs) and injuries are on the rise while policy and fiscal measures to prevent them are inadequately implemented and health systems are not adapted to chronic care. Climate change has a great impact on health in the Region, particularly for communities already vulnerable due to different social and economic factors.

We will remain focused on providing policy advice based on WHO norms, helping build capacities for leadership, management and service delivery in countries, generating data to inform action and promoting partnership. These actions will address the range of programmatic areas – to reduce illness and preventable deaths throughout the life-course; to control, eliminate and eradicate communicable diseases as appropriate; and to help establish resilient health systems with strong public health functions.

Our work will continue to be driven through the Transformation Agenda, as we make further progress to being the effective, responsive and accountable Organization that you, as Member States and stakeholders, want.

Finally, in presenting this report to the Sixty-seventh session of the Regional Committee, I would like to convey my sincere appreciation to Members States and partners, for the invaluable support and encouragement during this period. To my staff, their dedication, commitment and hard work is sincerely appreciated and I urge them to continue the good work, as we pursue the cause of improving the health and well-being of all people of the African Region.






Executive summary

The Regional Director is pleased to present this report on the work of WHO in the African Region for the period January 2016 to June 2017. The report outlines the significant achievements made under the six categories in the 12th General Programme of Work in supporting health development in Member States in the African Region. It reflects contributions from WHO country offices and the Regional Office, including the Inter-country Support Teams.

“ WHO in the African Region is committed to working with its Member States and partners to deliver results that transform the health of all Africa’s people through universal health coverage for achieving the Sustainable Development Goals (SDGs).

Dr Matshidiso Moeti
WHO Regional Director for Africa





WHO Emergency Response Team loading supplies into the United Nations Humanitarian Air Service flight, destined for Likati health zone, Bas Uele Province in northern DRC, to respond to the recent Ebola virus disease outbreak.

Executive summary

NEW WHO HEALTH EMERGENCIES PROGRAMME (WHE) HERALDS SIGNIFICANT IMPROVEMENTS IN HEALTH SECURITY

With over 150 public health events in 2016-2017, including outbreaks such as meningitis, Lassa fever and cholera, as well as the health effects of drought, floods and food insecurity, the African Region deals with more health events than any other region.

WHO's major reforms in health security to make the Organization fit for purpose for addressing global health threats have led to more effective support to countries' outbreak and emergency responses. The Regional Office coordinated the deployment of over 2500 experts in 2016, to respond to major public health events including Ebola, yellow fever, cholera, and Rift Valley fever outbreaks.

In several humanitarian crises, WHO supported the public health response, reaching over six million refugees and internally displaced people in the Region. In 2016, WHO together with Ministries of Health and partners in Angola and the Democratic Republic of the Congo (DRC), vaccinated over 30 million people in a matter of months, to end the largest ever yellow fever outbreak.

Furthermore, the exceptional use of emergency fractional dosing enabled the outbreak in Kinshasa, DRC to be controlled despite vaccine shortages. This innovative approach could potentially save lives in future outbreaks. Research is ongoing to determine the duration of immunity conferred by the fractional dose.

The Incident Management System used in the response to public health events is enabling better coordination and faster deployment of experts to support outbreaks and emergencies. In May 2017, the DRC confirmed a new Ebola outbreak. Within 48 hours of notification, the WHO Country Office and WHE Programme were working seamlessly with the Government and partners to set up a field and alert response system in the Likati health zone near the Central African Republic border. The outbreak was brought to an end within two months.

Using the new Joint External Evaluations (JEEs) tool, WHO with partners assessed and identified gaps in the core capacities of 18 countries to detect and respond to public health threats in line with the International Health Regulations (IHR, 2005).

The JEEs have informed the development of comprehensive, all-hazard country plans to address these gaps, and countries are now poised to mobilize resources for addressing them.

The Organization is mobilizing resources to recruit the staff required in the Member State-approved reformed, Health Emergencies Programme, and to consolidate this positive start.



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STRENGTHENING HEALTH SYSTEMS TOWARDS UNIVERSAL HEALTH COVERAGE (UHC)

Work on health system strengthening in the biennium has focused on supporting progress towards universal health coverage (UHC) for achieving the Sustainable Development Goals (SDGs). Several processes have enabled the development of a framework to guide country-led action with partners in building resilient health systems with improved financing, ensuring equitable access to good quality health services, and preparedness to contain outbreaks and respond to public health emergencies.

One significant step was the organization, by WHO AFRO, of the first ever Regional Forum on Health Systems Strengthening for the SDGs and UHC, in Windhoek, Namibia in December 2016, where the framework was agreed upon with senior Ministry of Health officials from all 47 Member States and partners. It will now guide action as countries address the SDGs. The framework was informed by an unprecedented baseline study which captured data from every Member State and will be used to develop a monitoring framework to inform on the progress made on UHC and SDG 3.

WHO supported countries to produce National Health Accounts which improve the availability of data for evidence-based decisions on fairer financing strategies for health, emphasizing increased domestic resources and financial protection for populations. The Regional Director, with the United Nations Economic Commission for Africa (UNECA), organized a high-level advocacy event on health financing in the Region. The aim was to understand the perspectives of Ministries of Finance and build consensus towards sustainable financing for health. Preliminary data from a WHO report showed that Africa lost up to US\$ 3 trillion due to ill-health in 2015. Achieving the SDG targets should reduce the loss in gross domestic product by at least 47%. Delegates identified joint action areas, and emphasized the importance of Ministries of Health and Finance working more closely together.

Other priority areas on which action was taken during the reporting period include conducting national health workforce accounts to generate data to guide the improvement of human resources for health policies, improving access to essential medicines, building regulatory capacity in countries and strengthening vital statistics and health information systems.

The Regional Director, with the United Nations Economic Commission for Africa, organized a high level advocacy event on health financing in the Region. The aim was to understand the perspectives of Ministries of Finance and build consensus towards sustainable financing for health. Evidence showed that Africa lost up to US\$ 3 trillion due to ill-health in 2015. Achieving the SDG targets should reduce the loss in gross domestic product by at least 47%.



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TACKLING ANTIMICROBIAL RESISTANCE (AMR) IN AFRICA

Antimicrobial resistance is an impending global problem which has serious implications for treatment failure, rising costs and increased disease burden, which needs to be better addressed in countries. In the African Region, AMR is related among other things to the irrational use of antimicrobials, poor infection prevention and control practices in hospitals and communities, and poor quality of antimicrobials. Recognizing this, WHO is supporting 44 countries to develop National Action Plans (NAPs) for antimicrobial resistance in line with the Global Action Plan, and mobilized catalytic funding to enable 25 countries to kick-start their NAP development process. As a result, NAPs have been approved or are pending approval by national authorities in 10 countries. WHO is working hard to have workplans in all 47 Member States by May 2018.

The threat of multidrug-resistant tuberculosis (MDR-TB) is very serious and will exacerbate the high incidence, prevalence and related-mortality per capita from tuberculosis in Africa. Drug-resistant TB is a growing problem and is very expensive to treat. Over the review period, WHO worked with countries to improve their capacity to detect MDR-TB and extensively drug-resistant TB (XDR-TB). In collaboration with Global Laboratory Initiative Africa partners, WHO published a Regional Framework for strengthening TB laboratory services (2016-2020) to improve diagnostic capacities in countries.

MDR-TB treatment programmes have been established in 40 of the 44 countries that have ever reported a case of MDR-TB.

To improve treatment outcomes, 11 countries from the Region worked with WHO and other partners to pilot short treatment regimens for MDR-TB.

WHO used the evidence to recommend shortening the duration of MDR-TB treatment from 24 to 9-12 months. At less than half the price of the longer course of treatment, the new regimen is expected to improve outcomes and decrease deaths due to better adherence to treatment and reduced loss to follow up.

Antimicrobial resistance (AMR) is a looming global problem which has serious implications for treatment failure, rising costs and increased disease burden, which needs to be better addressed in countries.





PROTECTING CHILDREN FROM ILLNESS AND MORTALITY

Immunization is a key public health intervention, saving millions of lives annually in the African Region. Seven countries have demonstrated substantial declines in illness, mainly diarrhoea, related to rotavirus infection and other causes, following vaccination of children against rotavirus and improved water quality, sanitation and hygiene practices. WHO and partners have supported the routine inclusion of pneumococcal conjugate and rotavirus vaccines in the national immunization schedules of 38 and 31 countries respectively. The RTS,S vaccine, which has demonstrated partial protection against the malaria parasite *plasmodium falciparum* in young children, will be piloted in Kenya, Malawi and Ghana in 2018 and is expected to contribute to reducing child deaths.

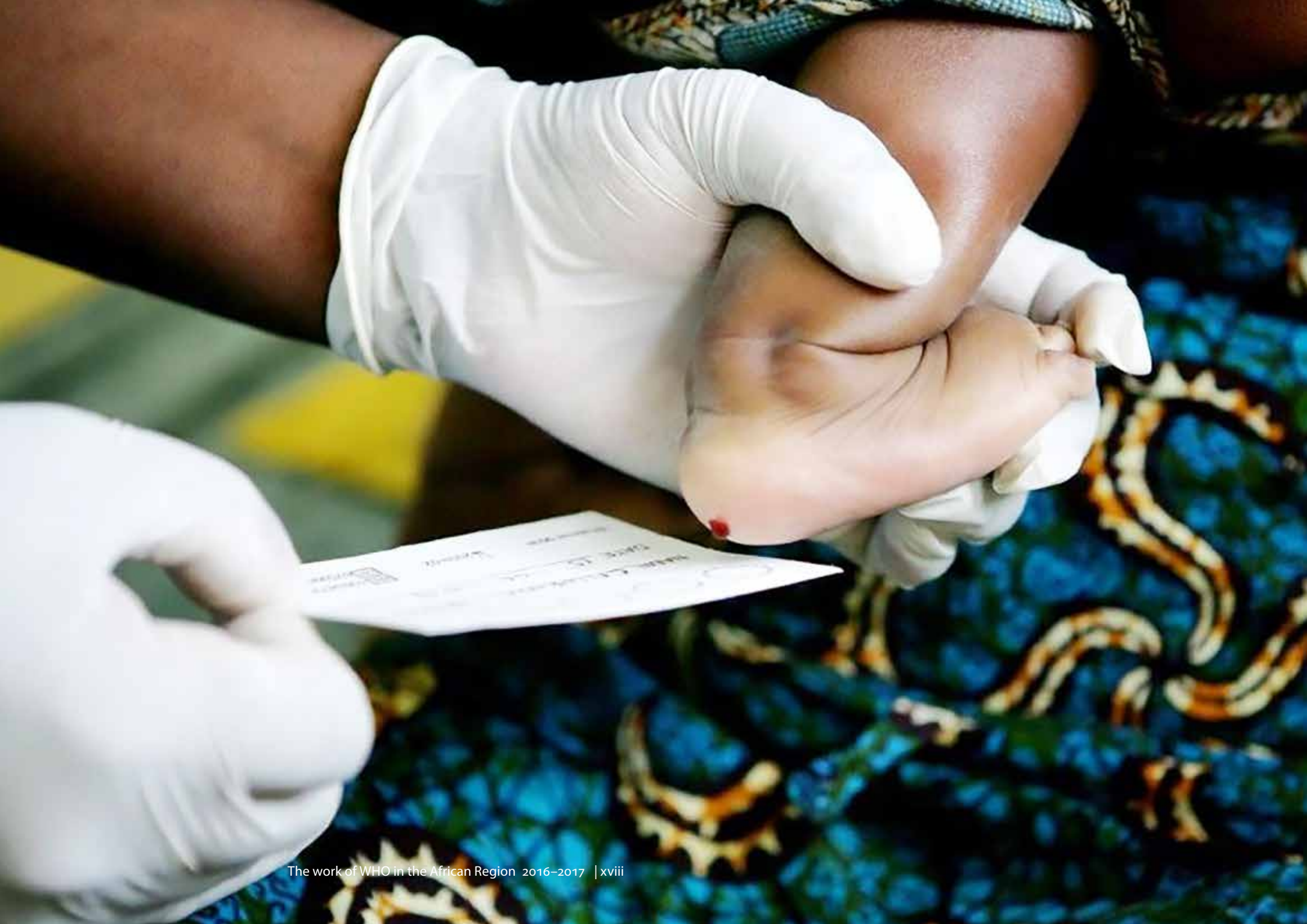
While national immunization coverage rates are high in many countries, one in five children still does not have access to all the vaccines they need. Inequities persist, with major coverage gaps associated with household income and mothers' education. Demonstrating strong political will, African Heads of State endorsed the Addis Declaration on Immunization (ADI) at the African Union Summit in January 2017.

This encouraging commitment to greater domestic investment for achieving universal access to immunization in Africa will be followed up for translation into action in countries.

Capacity building for community interventions to improve child health, including Integrated Community Case Management (iCCM), has been expanded, resulting in increased identification of children exposed to TB and HIV in high burden countries. Managing sick infants in the community, when referral is not possible, has been another area of focus. Scaling up community-based management of malaria, diarrhoea and pneumonia in children has increased the number of children treated in a timely fashion.

Equitable access to care of good quality is fundamental for achieving UHC. WHO launched a Quality of Care Network in February 2017, initially involving nine countries worldwide of which seven are in the African Region, to improve services for mothers, newborns, children and adolescents. The network aims to halve maternal and newborn deaths in health facilities in five years.





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STRIVING TOWARDS ELIMINATION AND ERADICATION OF DISEASES

While bearing the heaviest burden of communicable diseases, Member States in the African Region have embraced ambitious targets on ending, eliminating and eradicating priority diseases. Following the dissemination of WHO's consolidated guidelines on HIV prevention and treatment in 2016, Member States are rapidly shifting their HIV policies to adopt "Treat All" recommendations for HIV-positive patients to start antiretroviral therapy (ART) without delay. This has resulted in the expansion of ART coverage, with 13.8 million individuals now receiving ART in the African Region, contributing to the reduction of HIV-related deaths to about 720 000 in 2016, compared to 800 000 in 2015.

WHO has prioritized neglected tropical diseases (NTDs) which impact the poorest people, and through unprecedented global support, some are very close to eradication. In July 2016, WHO celebrated success in controlling river blindness after more than 40 years of sustained effort, and is now working with countries and partners towards the goal of eliminating this disease. Togo is the first country in the African Region to achieve WHO's validation of elimination of lymphatic filariasis as a public health problem. For the first year ever, Mali, one of the four remaining endemic countries for guinea worm, reported no case.

The Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) works with partners to support the elimination of the five diseases amenable to preventive chemotherapy: onchocerciasis, lymphatic filariasis, schistosomiasis, soil-transmitted helminthiasis, and trachoma. ESPEN has leveraged medicines donations for mass drug administration (MDA), and reached 8.5 million people through direct support to MDA in 12 countries. Working with supply management systems, ESPEN recovered 132 million tablets previously unaccounted for, thus saving on programme costs. The first baseline endemicity atlas of the five PC-NTDs for the African Region has been produced and a portal is now available for all stakeholders working on NTDs.

Through the efforts of the priority programme housed in the office of the Regional Director, WHO works to support Africa to be polio-free by 2019. Following the detection of four cases of wild poliovirus in insecure areas of northern Nigeria in 2016, synchronized vaccination campaigns were conducted in Lake Chad Basin countries. The sub-regional response in the Lake Chad Basin was an example of best practice, as the full engagement of political and community leaders was critical to the success of campaigns. In addition, to avoid spread to other countries, the largest ever polio campaign

in Africa was conducted, with over 190 000 polio vaccinators immunizing more than 116 million under-five children in 13 countries in West and Central Africa. This has averted new cases of wild poliovirus. Surveillance is being strengthened in all countries as the world counts down to polio eradication, and polio resources are being transitioned to support other public health programmes.



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ADDRESSING ENVIRONMENTAL DETERMINANTS OF HEALTH



Africa is particularly vulnerable to climate change, and is currently facing disease outbreaks and malnutrition due to devastating levels of food insecurity through crop failures associated with drought and heavy flooding. Eleven countries have developed national health and climate country profiles, enabling them to be proactive in mitigating the health impacts of climate change. Capacity building on the health impacts of El Niño-induced extreme climate events has enabled 11 affected countries in Southern and Eastern Africa to plan and respond appropriately. A new regional strategy for managing environmental determinants of human health and ecosystem integrity in the African Region (2017 – 2021) will be submitted to the Sixty-seventh session of the Regional Committee.

WHO/AFRO coordinates the Clim-Health Africa Network, a virtual hub of international partners who share expertise and information. The network aims to strengthen resilience in African countries, to better manage the public health effects of climate change and plan resources for climate-sensitive health outcomes. Building on the momentum of the global Climate Change Conference in Paris in 2015, WHO and UN Environment (UNEP) are planning a high-level inter-ministerial conference on health and environment in October 2017.

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CONFRONTING THE THREAT OF NONCOMMUNICABLE DISEASES (NCDs)

The Region faces an impending threat of NCDs, with predictions that millions of people in Africa will die from NCDs by 2025. There is insufficient recognition of this in the allocation of resources to health in countries, and WHO supports advocacy to raise the profile of NCDs in the Region. WHO has supported countries to conduct STEPwise surveys to monitor trends in the main risk factors for NCDs, in order to guide action. The results from 33 countries show that most adults have at least one risk factor that increases their chances of developing a life-threatening NCD. These NCDs can be prevented through policy, fiscal and regulatory measures such as increasing excise taxes and food labelling, as well as through behaviour change programmes. The number of countries with operational multisectoral action plans on NCDs rose from 14 in 2013 to 22 in 2015, which is promising for increased action to address NCDs.

The African Region is leading in the adoption of the Protocol to Eliminate Illicit Trade in Tobacco Products, with 10 countries out of 27 in the world which have ratified the Protocol. In this reporting period, eight more countries ratified the Protocol following intense technical support and capacity building by WHO AFRO. WHO supported the Government of the Gambia to introduce a

tobacco taxation policy in 2013–2015 which helped to reduce tobacco importation and substantially increased government revenue. The Gambia has now extended the policy for a further three years. The WHO Director-General recognized these efforts in May 2017 by presenting the Ministry of Finance and Economic Affairs, and the National Assembly of the Gambia with two World No Tobacco Day Awards.

The African Region has a critical shortage of mental health workers, and access to treatment and care is severely limited. To address this, WHO has worked to integrate mental health in primary health care in several countries, in line with the Global Mental Health Action Plan (mhGAP). This will help cover the significant gaps and make progress towards equity and access to mental health services in the Region.

In relation to nutrition, the African continent is faced with a double burden of stunting and obesity. WHO supported 11 countries to implement a project on Accelerating Nutrition Improvements. These countries now have at least two of the Maternal, Infant and Young Child Nutrition indicators in their national information systems, and six include them in routine health reports. Over 2600 health managers and workers have been trained to collect and use surveillance data for action, laying a good foundation to support nutritional surveillance in countries.





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ENABLING THE WORK OF WHO THROUGH TRANSFORMATION

WHO in the African Region is undertaking major reforms aimed at transforming the Organization to become more responsive, results-oriented and efficient to better serve Member States. An independent evaluation of the first two years (2015-2016) of the WHO AFRO Transformation Agenda was undertaken in April 2017. The evaluation reaffirmed the significant progress made in the implementation of the Transformation Agenda in areas such as accountability, compliance and risk management, strategic partnerships, and improved donor grant management. A report on the progress of the Transformation Agenda will be presented to Member States and partners at the Sixty-seventh session of the Regional Committee.

Staff realignment has taken place at the Regional Office and in Inter-country Teams, to ensure that human resources match regional priority health needs. The process is now being rolled out in country offices through functional reviews that will objectively assess human resource needs while aligning them to country priorities. A dedicated team will drive the functional review process, starting with four pilot countries.

A number of changes have been instituted in AFRO's strategic operations to improve effectiveness, timeliness, efficiency and accountability of actions in support of Member States. In order to strengthen accountability for results, programmatic and managerial key performance indicators (KPIs) have been introduced to monitor performance in contributing efficiently to health development in the Region. The performance of all WHO country offices and Regional Office clusters (budget centres) is monitored on a monthly basis. In addition, a quarterly bulletin compares trends over time and performance between budget centres, to inform remedial action.

A new Direct Financial Cooperation (DFC) Accountability and Assurance Framework was developed to ensure that WHO funds advanced to implementers including governments (DFC funds) are used as intended and recipients have the necessary control functions to comply with monitoring and reporting requirements. The number of overdue DFC reports dropped by 60% between April 2016 and May 2017. Efforts to improve compliance with business rules are starting to show results - unsatisfactory audit reports were reduced to 0% in 2016, compared to 50-80% in previous years. All the new audits in 2016 were either fully or partially satisfactory.

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ADVANCING STRATEGIC PARTNERSHIPS FOR HEALTH

WHO recognizes that to achieve the health outcomes of the SDGs and promote the well-being of populations, collaboration between different actors and with other development sectors is essential. In June 2017, WHO held the first ever Africa Health Forum, themed “*Putting People First: The Road to Universal Health Coverage in Africa*” in Kigali, Rwanda. The Forum provided a platform for a unique mix of stakeholders – government ministers, international agencies, youth and the private sector – to discuss public health challenges and opportunities in the Region through the lens of universal health coverage. It explored innovative ways to advance the health agenda in Africa, including through a new partnership between WHO AFRO and the International Telecommunication Union to scale-up eHealth interventions in health systems delivery. The Forum adopted the *Kigali Call to Action* to promote working together for improved health in the Region.

The Regional Office is pursuing a deliberate strategy of engaging with partners to achieve better health outcomes in the Region. Partnership with the African Union Commission (AUC) has facilitated the adoption of important decisions on health by Heads of State and led to agreement on a framework for collaboration with the Africa CDC.

The Regional Director paid visits to, and welcomed several development partners to the Regional Office in Brazzaville, including the African Development Bank, the Bill and Melinda Gates Foundation, the UK Department for International Development, the UK Department of Health and Public Health England, USAID, and the US Department of Health and Human Security. Relations with governments and institutions in countries such as Germany, China and Japan are also strengthening.

The Harmonization for Health in Africa (HHA) regional mechanism to coordinate partners’ support to countries and enhance synergies in the health sector was re-launched after an independent review in 2016. WHO and partners reaffirmed their commitment to working together in priority areas, including advocacy for increased and sustainable domestic financing for health, and action towards UHC and the SDGs.

WHO in the African Region is transforming into an Organization driven to deliver results, and is committed to transparency, accountability and effectiveness to give the best support to countries, propelled by a desire for a healthier, more prosperous Africa.





1. Introduction

This report – The Work of WHO in the African Region, 2016-2017: Biennial Report of the Regional Director – covers the period from January 2016 to June 2017 and reflects the work accomplished over 18 months of the biennium. The report highlights the delivery of results achieved in supporting Member States and collaborating with partners to improve health outcomes in the Region.

The WHO Secretariat in the African Region comprises 47 country offices and the Regional Office, including Inter-country Support Teams. The Secretariat provides support by disseminating norms and standards, providing technical assistance to develop or update national policies, strategies and plans for cost-effective health interventions, strengthening national capacity to implement and monitor activities, advocating for investment in health, mobilizing resources and facilitating partner coordination.

WHO plans biennially and this is the last biennium in the 12th General Programme of Work (GPW), 2014 - 2019. The report is presented according to the six categories of the 12th GPW, namely:

- (i) Communicable diseases;
- (ii) Noncommunicable diseases;
- (iii) Promoting health through the life-course;
- (iv) Health systems;
- (v) WHO Health Emergencies Programme;
- (vi) Corporate services and enabling functions.





2. Implementation of the WHO Programme budget 2016-2017

The Programme budget for the African Region for 2016-17 as approved by the World Health Assembly (WHA) is US\$ 1 162 300 000, representing 27% of the global WHO budget. By 31 December 2016, which marked the mid-term, the funds available represented about 78% of the allocated budget.

By 30 June 2017, the total allocated budget for the Region had been revised upwards to US\$ 1 679 356 000, a net increase of US\$ 517 056 000 above the WHA-approved budget. The increase was mainly for health systems recovery and strengthening in the post-Ebola countries and the establishment of the WHO Health Emergencies Programme (WHE).

To date, 82% of the total allocated budget has been funded (Table 1), amounting to US\$ 1 376 975 000. Of this, 51% is for Emergencies Programmes, with the remaining balance (less than 50%) being distributed among all other programmes. The average implementation rate is 76% of funds available, varying across the technical categories of work from 69% to 80%. In comparison to other WHO regions and Headquarters, the African Region has the highest average number of outputs per budget centre, underscoring the need for better prioritization and selectivity in planning.

Based on lessons learned, a number of mechanisms were introduced to improve reporting on Programme-budget implementation.

These include the WHO Business Intelligence dashboards, the Mid-Term Reporting (MTR) Tool, and the designation of country MTR focal persons. A road map to enhance timely and effective implementation of the Programme Budget 2016-2017 has also been developed, to help budget centres keep on track.

With regard to sources of financing, the budget in the Region continues to be financed through a mix of flexible funds (18%) and specified voluntary contributions (82%). However, several health priorities such as noncommunicable diseases and health system strengthening remain underfunded.

WHO AFRO will continue to be engaged in the Financing Dialogue to advocate for more flexible funding. The Secretariat appreciated the approval by Member States of a 3% increase in assessed contributions at the World Health Assembly in May 2017, which demonstrates their support for more flexible, predictable funding.

In recognition of the need to broaden the resource base, WHO AFRO has developed a new resource mobilization strategy that seeks to intensify resource mobilization efforts by engaging with both traditional and new partners, especially the private sector and philanthropies.



2. Implementation of the WHO Programme Budget 2016-2017

Table 1: Budget implementation for PB 2016-2017 - As at 30 June 2017 (in US\$ 000)

Category	APPROVED BUDGET BY WHA ('000)	ALLOCATED PB ('000)	TOTAL AVAILABLE FUNDS ('000)	%FUNDING AGAINST APPROVED BUDGET ('000)	BUDGET UTILIZATION ('000)	% UTILIZATION AGAINST APPROVED BUDGET ('000)	% UTILIZATION AGAINST FUNDING ('000)
	[A]	[B]	[C]	[D = C/A]	[E]	[F = E/A]	[G = E/C]
Category 1: Communicable diseases	284 000	245 610	222 400	78%	149 340	53%	
Category 2: Noncommunicable diseases	61 800	56 240	32 607	53%	22 527	36%	69%
Category 3: Promoting health through the life-course	105 200	107 314	84 776	81%	67 995	65%	80%
Category 4: Health systems	89 000	106 890	92 572	104%	62 853	71%	68%
Category 5: Preparedness, surveillance and response	64 300	59 383	49 312	77%	46 700	73%	95%
Category 6: Corporate services and enabling functions	146 400	168 416	164 019	112%	113 789	78%	69%
Category 12: WHE programme		77 545	34 323		12 371		36%
Total Base Programmes	750 700	821 397	680 008	91%	475 575	63%	70%
Emergencies Programmes*							
05 - (Polio & OCR)	411 600	857 958	696 967	169%	573 204	139%	82%
Grand Total	1 162 300	1 679 356	1 376 975	118%	1 048 779	90%	76%

*The introduction of the new WHO Health Emergencies Programme (WHE) gave rise to category 12, which replaced category 5 for all the programmes falling under the WHE.

3. Significant achievements by category of work

3.1 CATEGORY 1: COMMUNICABLE DISEASES

Communicable diseases still remain a major challenge and contributor to the burden of disease in the Region. WHO plays a leading role in supporting countries to tackle diseases such as HIV, tuberculosis, malaria and neglected tropical diseases (NTDs), and to reduce vaccine-preventable diseases, including hepatitis. The focus of WHO's support is on scaling up coverage of effective interventions for prevention and treatment, including using new technologies for better impact.

WHO developed four regional frameworks to guide the implementation of global strategies, which were endorsed by the Sixty-sixth Regional Committee for Africa. These are Regional Frameworks for implementing the Global HIV¹, TB² and Hepatitis³ Strategies as well the Regional Framework for implementing the Global Malaria Strategy.⁴ Their implementation will help to reduce the burden of these diseases and accelerate progress towards the global targets.

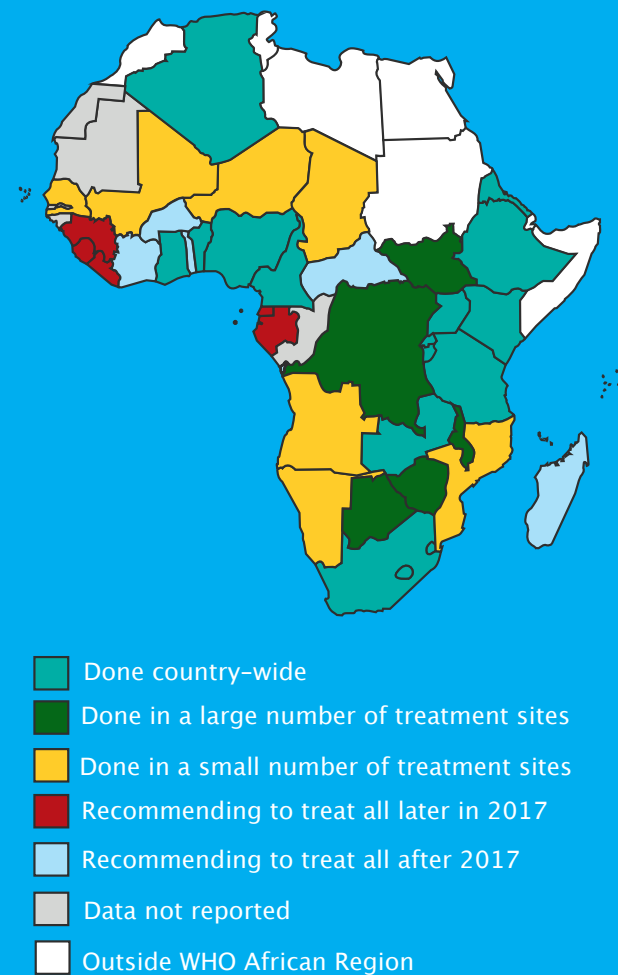
Following the dissemination of WHO's consolidated guidelines on HIV prevention and treatment in 2016, countries are rapidly shifting their HIV policies to adopt "Treat All" recommendations,⁵ to allow for prompt uptake of antiretroviral therapy (ART) among HIV-positive patients, regardless of their CD4 cell count.

Thirty Member States⁶ (Figure 3.1.1) have adopted the policy and are implementing the "Treat All" recommendations. As a result, ART expanded to reach over 13.8 million people in the Region by the end of 2016, representing a coverage rate of 54%.

The number of people dying in the Region from HIV-related causes declined to about 720 000 in 2016 from 800 000 in 2015, and over 1.2 million people in 2010. However, major differences in ART coverage exist, with West and Central Africa having much lower rates. Men and key populations, in particular, are not being reached sufficiently with HIV testing and treatment services.

In 2016, WHO, UNAIDS and other partners in the Region developed a "catch-up" plan to accelerate the HIV response in West and Central Africa, and triple the HIV treatment coverage by 2019. At a high-level event co-organized by WHO and UNAIDS on the margins of the Seventieth World Health Assembly, Ministers of Health from 11 countries in West and Central Africa⁷ and partners agreed to adjust policies and strategies and accelerate action for the scale-up of HIV treatment in the West and Central African sub-region.

Figure 3.1.1: Countries implementing the WHO "Treat All" policies; 30 June 2017





3. Significant achievements by category of work

3.1 CATEGORY 1: COMMUNICABLE DISEASES

The catch-up plan was also endorsed by African Heads of State during the 29th African Union Summit in July 2017. At least 10 Member States⁸ have already developed their national acceleration plans. WHO, working with partners, is committed to supporting the implementation of the national catch-up plans.

Viral hepatitis is a major, under-recognized problem in the Region. Eleven Member States⁹ had introduced the Hepatitis B birth dose vaccine by the end of 2016, and coverage in the African Region currently stands at 77%. Eleven countries¹⁰ have developed national action plans, while five Member States¹¹ established national treatment programmes for viral hepatitis.

Africa has the highest incidence, prevalence and mortality per capita from tuberculosis (TB), and a growing problem of drug-resistant TB (DR-TB), which is very expensive to treat. Nearly 27 000 DR-TB cases were reported in 2015 alone, and only 70% of them accessed treatment. This is a serious challenge, partly because of lack of adequate laboratory capacity to detect it. In 2014, WHO/AFRO and partners established the Global Laboratory Initiative (GLI) Africa to support countries to achieve quality-assured, accessible and sustainable TB laboratory services in the Region.

Working with the Africa Society for Laboratory Medicine (ASLM) and GLI Africa, WHO launched a regional framework to strengthen TB laboratory services and diagnostics, including drug susceptibility testing and quality assurance. Countries are now being supported to adapt the framework to their local contexts.

Capacity to detect MDR-TB and XDR-TB has been established in 32¹² and 22¹³ Member States respectively. Furthermore, MDR-TB treatment programmes have been established in 40/44 of the 44 countries that have ever reported a case of MDR-TB.

WHO worked with 11 countries in the African Region to generate evidence on the effectiveness of a short treatment regimen for multidrug-resistant TB (MDR-TB) between 2014 and 2016. Based on the results from this pilot work, WHO recommended shortening the duration of treatment for uncomplicated MDR-TB from 24 to 9-12 months. At less than half the price of the longer course of treatment, the new regimen is expected to improve outcomes and decrease deaths due to better adherence to treatment and reduced loss to follow up.



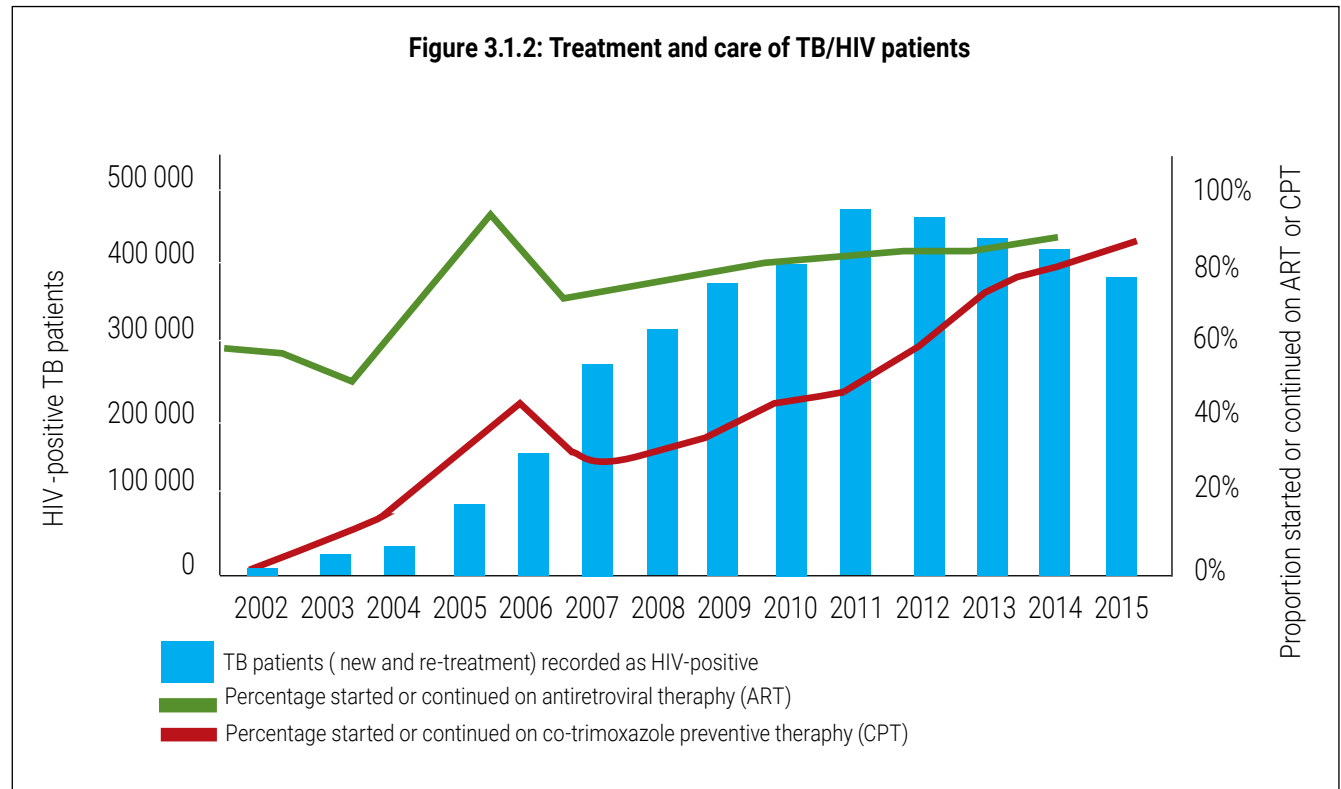
3. Significant achievements by category of work

3.1 CATEGORY 1: COMMUNICABLE DISEASES

Programmatic management of drug-resistant TB was assessed in 11 countries,¹⁵ and the reports are helping countries to apply for continued funding for drug resistant TB control from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donors. South Africa's decentralized management of drug-resistant TB was evaluated and the Regional Office assisted the country to develop a road map for introducing new anti-TB medicines. These efforts will improve case detection and management, ensuring that the threat of multidrug-resistant tuberculosis is more effectively addressed.

The Transformation Agenda emphasizes smart technical focus throughout WHO's programmatic work. As part of this, mid-term and end-term reviews help to inform the development or adjustment of country strategic plans. WHO conducted end-term reviews of the TB and leprosy strategic plans for Namibia, Zambia and Zimbabwe, and the mid-term review of TB control strategic plans of Rwanda and Mozambique. The reports from these reviews are guiding new strategic plans aligned to the SDGs and the End TB Strategy, and applications for funding to the GFATM.

Independent evaluations of WHO's direct support to countries to develop concept notes for GFATM funding in 2014-2016 highlighted the quality of support and emphasized the need for continued collaboration.



Over US\$ 4 billion worth of grants was raised during this period with WHO contributing technical support, for over 180 requests for technical assistance from 40 countries. In addition, WHO supported 18 priority countries¹⁶ to accelerate the utilization of GFATM grants for TB and HIV through the Implementation Through Partnership (ITP) project.

HIV is an important driver of TB, and implementation of TB/HIV collaborative activities continues to be a priority in countries. HIV screening and uptake of ART is increasing. This has resulted in a recent decline in HIV co-infected TB patients (Figure 3.1.2).

3. Significant achievements by category of work

3.1 CATEGORY 1: COMMUNICABLE DISEASES

In September 2016, WHO's TB and HIV programmes organized the first joint national TB and HIV programme managers' meeting in Addis Ababa for 21 countries. Participants agreed that GeneXpert technology was an opportunity for both programmes to diagnose TB, MDR-TB, and HIV in infants and hepatitis, as well as test HIV viral loads, in the same setting. All 21 countries are working to integrate the tests using this technology, and WHO Country Representatives are facilitating and monitoring the optimal use of this approach.

Twenty-two countries¹⁷ have developed plans on childhood TB after WHO and the Child TB taskforce conducted a needs assessment.

In the area of malaria control, one of the key activities for building capacity for countries to implement the Global Technical Strategy for Malaria 2016–2030 is training laboratory personnel on malaria microscopy. WHO supported 104 microscopists from 24 countries¹⁸ to undertake refresher training and complete external competency assessments.

Of these, 35 now have expertise in malaria parasite species and quantification. These master trainers will train other laboratory personnel on malaria microscopy.

One of the major achievements in malaria control was the announcement in November 2016 of the world's first malaria vaccine pilot project in

sub-Saharan Africa, with funding from the GFATM, UNITAID, and Gavi, the Vaccine Alliance. The RTS,S vaccine, which has been shown to provide partial protection against the malaria parasite *Plasmodium falciparum* in young children, will be piloted in Kenya, Malawi and Ghana.

To strengthen the use of data for malaria programme decision-making and action in the Region, WHO is improving data availability through a project funded by DFID. In addition, a regional atlas of insecticide resistance in malaria vectors was produced to guide targeted interventions in Member States, in keeping with integrated vector control.

Eighty government officials in Burkina Faso, Kenya, Uganda and Zimbabwe were trained in integrated vector management, to boost human resources capacity in control programmes. Post epidemic vector surveys were conducted in Angola (yellow fever), Cabo Verde, and Guinea (Zika). Important information was gathered on the vector density and species distribution for better preparedness and response for future epidemics.

In addressing NTDs, the Preventive Chemotherapy Neglected Tropical Diseases (PC-NTD) mapping project, supported by the Bill and Melinda Gates Foundation (BMGF), was successfully concluded in December 2016 with surveys conducted in 28 countries.¹⁹



3. Significant achievements by category of work

3.1 CATEGORY 1: COMMUNICABLE DISEASES

The surveys filled in mapping gaps identified from data collected by all historical and recent mapping efforts of PC-NTDs in 47 Member States. This resulted in the first baseline endemicity atlas of the five PC-NTDs for the African Region and marked the completion of mapping of three PC-NTDs (lymphatic filariasis, schistosomiasis and soil transmitted helminths) in all Member States except the Central African Republic and South Sudan, for security reasons. Maps and data are now available for countries and partners, to guide their decision-making and actions, including on discontinuation of mass drug administration (MDA).

Forty-one out of the 44 Member States²⁰ requiring PC-NTDs carried out at least one round of MDA for at least one disease by the end of 2016. In July 2016, WHO celebrated success in the control of onchocerciasis (river blindness) in the Region, after more than 40 years of work by the Onchocerciasis Control Programme (OCP) followed by the African Programme for Onchocerciasis Control (APOC). With a new goal of elimination, onchocerciasis is now addressed within the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN).

ESPEN was established in 2016 as a special project between endemic countries in the African Region, PC-NTD partners and WHO, to provide technical guidance, coordination and operational support for the elimination of the PC-NTDs.

With start-up funds of US\$ 12 million, the project has already recorded encouraging outcomes: 8.5 million people were reached through MDA conducted in 12 countries²¹ to fill MDA gaps in districts not covered by other partners; 132 million tablets that were previously unaccounted for were recovered through supply chain analysis in seven countries;²² 14 countries²³ submitted their annual action plans and requests to ESPEN; and 40 countries are now sharing their subnational data and maps through the NTD portal.

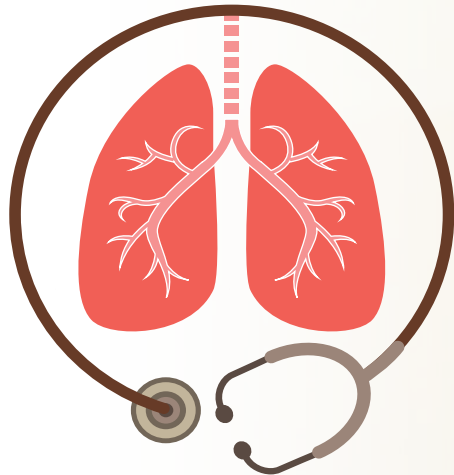
In the context of elimination and eradication, Togo is the first country in the Region to achieve WHO's validation of elimination of lymphatic filariasis as a public health problem, highlighting what can be accomplished in the Region for PC-NTDs. Guinea worm disease (GWD) surveillance was sustained. In 2016, for the first year ever, Mali, one of the four endemic countries, reported no case of GWD.

Africa is particularly vulnerable to climate change which has direct and indirect impacts on health. In 2016, WHO built capacity to plan and respond to the health impacts of El Niño-induced extreme climate events (drought, heavy rains and flooding) in 11 affected countries²⁴ in Southern and Eastern Africa. By February 2017, ten Member States²⁵ had completed comprehensive risk assessments to identify and plan for the health impacts of climate

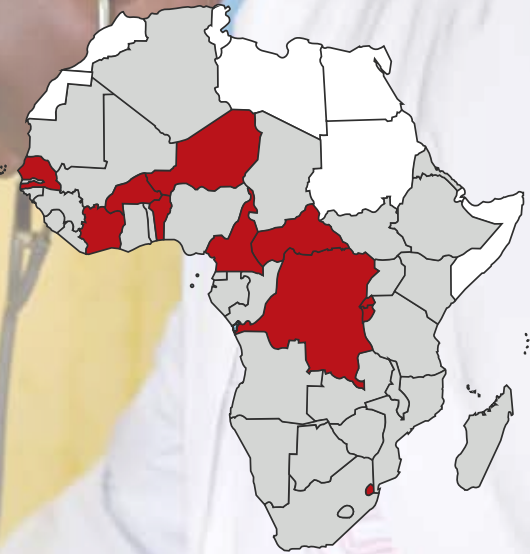
change, while 11 Member States²⁶ developed national health and climate country profiles²⁷ as a proactive measure to mitigate these impacts. A new regional strategy for managing the environmental determinants of human health and ecosystem integrity in the African Region (2017–2021) will be submitted for adoption by the Sixty-seventh session of the Regional Committee.

WHO/AFRO coordinates the Clim-Health Africa Network, a group of African and international institutions which collaborate to strengthen the resilience of African countries to manage the public health effects of climate variability and plan resources for climate-sensitive health outcomes. The Network serves as a virtual hub for sharing of expertise and information. Building on the momentum of the global Climate Change Conference in Paris in 2016, WHO and UN Environment (UNEP) are planning a high-level inter-ministerial conference on health and environment in October 2017.

SUCCESS STORY EVIDENCE FROM AFRICA LEADS TO SHORTER, CHEAPER TB TREATMENT REGIMEN



The bacteria that cause tuberculosis (TB) can develop resistance to the antimicrobial drugs used to cure the disease. Multidrug-resistant tuberculosis (MDR-TB) is TB that does not respond to at least the two most powerful anti-TB drugs (isoniazid and rifampicin), mainly due to inappropriate use of antimicrobial drugs or premature treatment interruption.



The African Region is facing a growing problem of drug-resistant TB which is very expensive to treat. Nearly 27 000 drug resistant TB cases were reported in 2015 alone, and only 70% of them accessed treatment. Only about half the people with drug-resistant TB started on treatment are cured.

WHO worked with 11 countries in the African Region²⁸ between 2014 to 2016 to generate evidence on the effectiveness of a short treatment regimen for MDR-TB.

Based on results from this pilot, WHO made a global recommendation in May 2016, shortening the duration of treatment of uncomplicated MDR-TB from 24 months to 9-12 months.

At less than half the price of the longer course of treatment, the new regimen is expected to improve outcomes and potentially decrease deaths due to better adherence to treatment and reduced loss to follow up.

Anticipated cost savings from rolling out this regimen could be reinvested in MDR-TB services to enable more patients to be tested and kept on treatment.

The new recommendations offer hope to thousands of MDR-TB patients who can complete the treatment in half the time and at nearly half the cost.



3. Significant achievements by category of work

3.2 CATEGORY 2: NONCOMMUNICABLE DISEASES

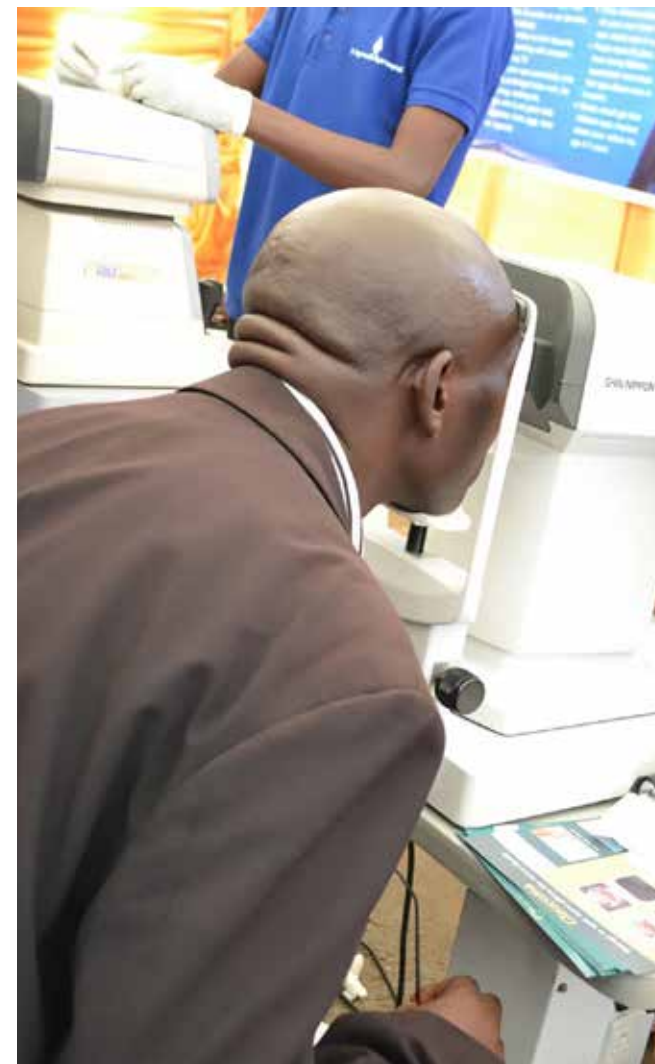
The work of WHO under this category aims to reduce the burden of NCDs such as cardiovascular diseases (CVD), cancers, chronic respiratory diseases, diabetes, eye and oral diseases, as well as violence, injuries, disability and mental health problems. The four major NCDs (CVD, cancer, respiratory diseases and diabetes) share four common risk factors: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. WHO focuses on advocacy, health promotion and risk reduction as well as the prevention, treatment and monitoring of these diseases and their risk factors. NCDs are not sufficiently prioritized and resourced in national health agendas; advocacy and making the investment case are critical, while prevention, early detection and treatment are pursued.

With predictions that millions of people in Africa will die from NCDs by 2025, WHO supported countries to conduct STEPwise surveys²⁹ to assess prevalence and trends in related risk factors. The results from 33 countries show that most adults have at least one risk factor that increases their chances of developing a life-threatening NCD.

The prevalence of hypertension in the African Region is the highest worldwide, affecting an estimated 31% of adults compared to the global average of 22%.³⁰ NCDs can be prevented through policy and fiscal measures such as increasing excise taxes, limiting hours of sale and food labelling, as well as lifestyle and behavioural changes.

WHO engaged in high-level advocacy with Member States, to stress the importance of addressing NCDs in national health plans. WHO organized two meetings in Mauritius in 2016, aimed at strengthening networking, advocacy, partnership and action for the prevention and control of NCDs. The first, organized in partnership with the NCD Alliance, was a regional consultation for civil society organizations (CSOs) involved in NCD prevention and control in the African Region. The main outcome of the meeting was the formation of an AFRO Regional NCD CSO Network which will focus on information sharing and capacity building, and strengthen advocacy for prioritizing NCDs in national development agendas.

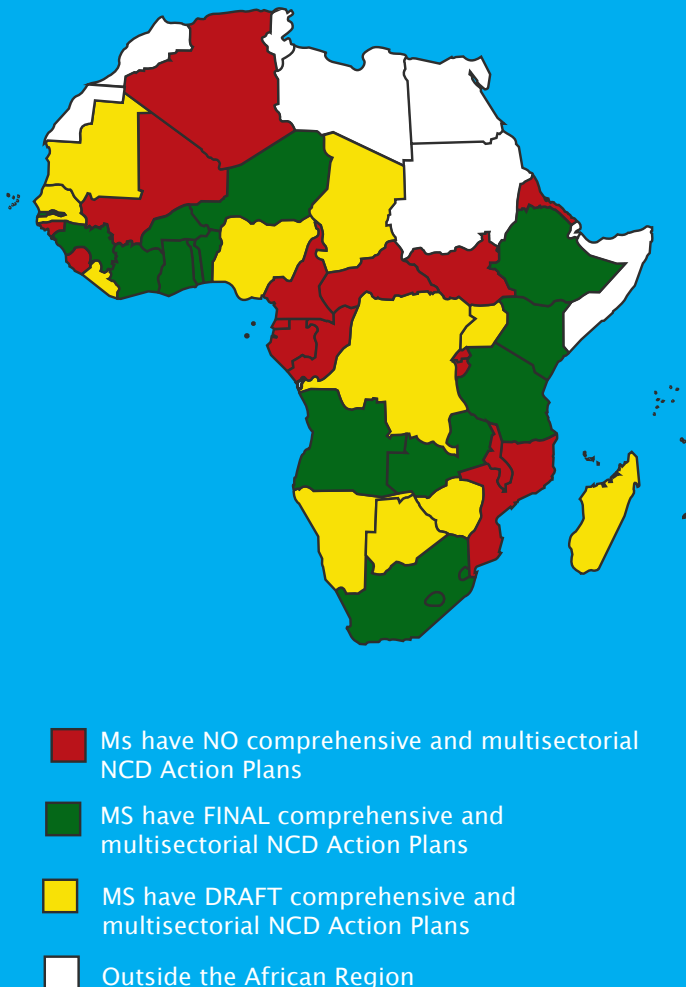
The second was a Global Dialogue Meeting for representatives of Member States, UN agencies, other intergovernmental organizations and non-State actors (nongovernmental organizations, philanthropic foundations, business associations, and academic institutions). They agreed on how non-State actors can support governments to meet their commitments to implement the NCD Global Action Plan, and the NCD targets in the 2030 Agenda for Sustainable Development. At the end of the Dialogue, the Governments of France and Mauritius jointly issued a co-chairs' statement which includes specific recommendations for each group of actors, in support of governments.



3. Significant achievements by category of work

3.2 CATEGORY 2: NONCOMMUNICABLE DISEASES

Figure 3.2.1: The status of Comprehensive and Multisectoral NCD Action Plans in the African Region



In other advocacy efforts to promote awareness of NCDs, the Prime Minister of the Republic of Guinea hosted a high-level meeting where State and non-State actors agreed on roles and responsibilities for preventing and controlling NCDs. WHO provided technical support for the meeting which drew together ministers from the departments of health, justice, environment, and higher education, UN agencies, representatives of civil society and national and international NGOs. They agreed on a road map to develop and implement comprehensive, integrated and multisectoral NCD action plans with appropriate coordination mechanisms in place.

WHO provided technical support to eight Member States³¹ to develop national integrated and multisectoral NCD policies, strategies or action plans aligned with the WHO Global NCD Action Plan 2013-2020.³² By March 2017, 28 of the 47 Member States³³ had integrated NCD strategy/action plans at various stages of development, and 14³⁴ had finalized their integrated NCD Action Plans covering the four main risk factors and four main conditions (see Figure 3.2.1). These plans will enable resource mobilization and monitoring of progress and outcomes as countries address this growing problem.

Significant progress has been made in the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in the African Region. During the biennium, WHO updated the database on the existence and implementation of national policies on tobacco control, as well as on the legal and regulatory measures put in place. The information showed that more countries have adopted laws and regulations, established multisectoral coordination mechanisms, and updated information on prevalence and trends, which will help to strengthen WHO FCTC compliance. The Regional Office developed five practical guidelines³⁵ on core articles of the WHO FCTC which countries are using to support the implementation of WHO FCTC measures.

Member States met in Algiers in October 2016 for the 2nd high-level meeting on the implementation of the WHO FCTC. In the Algiers Declaration, they committed to accelerating action on tobacco control, including the implementation of tobacco taxation and pricing policies and accession to or ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products.

3. Significant achievements by category of work

3.2 CATEGORY 2: NONCOMMUNICABLE DISEASES

The African Region³⁶ is leading in the adoption of this Protocol. The Regional Office has provided technical support to Member States and convened multicountry and national capacity building workshops, to accelerate ratification and accession. In the reporting period, eight more countries have ratified the Protocol, bringing the number of African countries³⁷ to 10 out of 27 countries that have done so worldwide.

With WHO support, the Gambia introduced a three-year tobacco taxation policy in 2013-2015, which helped to reduce tobacco importation and substantially increased revenue for the Government and as a result of this success, the country's Ministry of Finance and Economic Affairs has enacted a new three-year tobacco taxation policy for 2017 – 2019. In recognition of these efforts, the WHO Director-General presented the Ministry of Finance and Economic Affairs, and the National Assembly of the Gambia with World No Tobacco Day awards. Eleven countries³⁸ adopted legislation and regulations in line with the WHO FCTC. Action is being taken in more countries to ban smoking in public places and tobacco advertising, and to feature health warnings on tobacco packages.

In order to support case management for NCDs, WHO has developed a Package of Essential Noncommunicable (WHO PEN) disease interventions for primary health care.

To support the implementation of WHO PEN, WHO provided medical equipment and supplies to 13 Member States³⁹ to improve early detection, diagnosis and treatment of NCDs at primary care level.

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.⁴⁰ Up to 30% of the deaths are due to cancers induced by viral infections such as hepatitis B and C (HBV/HCV) and the human papillomavirus (HPV). In sub-Saharan Africa 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.

The Regional Office organized a number of meetings to support countries carry out holistic planning and advocacy, and strengthen cancer prevention and control, including early detection. Thirty-one experts from 10 Member States⁴¹ were trained on WHO's approach to cervical cancer prevention and control including Visual Inspection using Acetic Acid (VIA) and cryotherapy. This will contribute to scaling up VIA screen-and-treat services in countries, improving screening coverage and strengthening efforts to reduce the burden of cervical cancer in the Region.



3. Significant achievements by category of work

3.2 CATEGORY 2: NONCOMMUNICABLE DISEASES

While there are continuous efforts to focus on cancer prevention and control, there is a serious paucity of cancer data in the Region. To address this, WHO conducted two training workshops on cancer registration and the integration of cancer registries into NCD surveillance and national information systems. Participants from French-⁴² and English-speaking⁴³ countries have now learnt how to establish and operate population-based cancer registries to strengthen cancer surveillance in their countries.

Mental disorders, which include neurological abnormalities and substance abuse, affect all social groups and ages and place a heavy burden on individual sufferers, their families and communities. People with mental illness are among the most vulnerable, impoverished and neglected populations. For example, in the African Region, nine out of ten people suffering from epilepsy receive no medical treatment.

The workforce for mental health care is woefully inadequate in the African Region, as are appropriate health facilities and therefore access to treatment. Work has been done to integrate mental health in primary health care services in several countries, in line with the Global Mental Health Action Plan (mhGAP).

WHO assisted Ghana, Mozambique and Uganda to strengthen their community mental health services, focusing on epilepsy treatment, attitudes and knowledge, while over 150 non-specialist care providers in Guinea, Liberia, Sierra Leone and Zimbabwe were trained to identify and treat common mental health problems in primary care settings. WHO provided training in seven Member States⁴⁴ on how to develop and implement suicide prevention strategies, based on WHO's guidelines. These efforts will help cover the significant gaps and make progress towards equity and access to mental health services in the Region.

To improve surveillance in eye health, AFRO published a *Catalogue of Key Eye Health Indicators in the African Region* in April 2017.⁴⁵ The catalogue will be used to monitor trends in the prevalence and causes of visual impairment, including blindness, to support annual data collection and the monitoring of the implementation of the WHO (NCD) Global Action Plan 2014-2019.

In August 2016, the Regional Committee endorsed the *Regional Oral Health Strategy 2016-2025: addressing oral health as part of NCDs*.⁴⁶

To complement this key policy milestone, AFRO published a manual on preventing and managing oral diseases and Noma,⁴⁷ which demonstrates cost-effective and sustainable ways to reduce the burden of oral diseases and other NCDs in health facilities, schools and community settings. A WHO guide containing new classification and management of Noma has been published and disseminated.

The African Region has the highest road traffic fatality rate globally at 26.6 per 100 000 population, and 39% of all road traffic deaths in Africa are among pedestrians, the highest proportion in the world. Half of the road traffic deaths are among those with the least protection (motorcyclists, pedestrians and cyclists).^{49,50} Thirty-six Member States now have a dedicated, intersectoral national strategy for road traffic safety, compared with 11 in 2011. Officials in all countries have been trained and are collecting data for selected road safety indicators for the Global Status Report on Road Safety, to monitor the implementation of the Decade of Action for Road Safety, 2011-2020. However, there is still low recognition of road traffic injuries as a public health problem, and this will be discussed at the Sixty-seventh session of the Regional Committee.

SUCCESS STORY

eHEALTH SOLUTION: mDIABETES PROMOTES MORE EQUITABLE ACCESS TO CARE⁵¹



Khady received SMS messages on his mobile phone before, during and after the 2016 Ramadan. Before the Ramadan, the message said: “You have diabetes; Ramadan is soon! See a doctor now. If your blood sugar is between 0.90g/l and 1.20g/l, then you surely could fast”. During Ramadan, every time he received the message “Get used to checking your blood sugar everyday, at least in the morning and in the evening; objective: blood sugar before meal between 0.90g/l and 1.20 g/l”, he was reminded and checked his blood sugar before meals.



The mDiabetes programme is part of the WHO “Be He@lthy, Be Mobile” initiative using mobile technology to improve prevention and control of NCDs and their risk factors. Senegal, one of the pilot countries, chose to use mobile telephony to prevent diabetes and its complications by reminding patients to check their blood sugar regularly. Launched by WHO, the Ministry of Health and Social Action and the International Telecommunication Union (ITU), the programme also aimed to help over 12 000 people to prepare for the month of Ramadan.

The mDiabetes programme is an efficient tool for reducing unequal access to care due to financial, geographic or social reasons. It is planned to deliver voice messages or SMS in national languages. Khady thinks it would be really good to send to the general population and patients, not only text but also voice messages, in particular for illiterate people who cannot read or write.

SDG 3 seeks to ensure healthy lives and promote well-being for all at all ages. Through mobile telephony that reaches populations directly, the mDiabetes programme is making strides towards achieving this Goal. The pilot phase of the mDiabetes was assessed in January 2017 and the results will be available soon.



3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

Health needs to be promoted at every stage of life, within the context of the societal conditions in which people are born, grow up, live, work and age, together with equity and human rights. WHO promotes the continuum of health care spanning the pre-pregnancy, pregnancy and childbirth to childhood, adolescence stages and beyond, bringing care closer to the home by empowering families and communities and by improving primary care facilities and providing referral health services.

In the reporting period, the Regional Office disseminated new guidelines and tools to support Member States, established and strengthened strategic partnerships, and advocated for and mobilized resources. Technical support was provided to countries to improve the quality of care and expand health services through community involvement, for women, newborns, children and adolescents. WHO facilitated consensus on global and national priorities for better planning, and assisted with monitoring and evaluation of programmes. Key areas of work included interventions for newborns, elimination of mother-to-child transmission, maternal death surveillance and review, management of childhood illness, family planning, nutrition and immunization.

The Sixty-sixth WHO Regional Committee for Africa adopted the implementation framework of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) in August 2016. In collaboration with H6 partners, WHO organized workshops to orientate Ministry of Health officials of 41 countries, WHO country offices and UN sister agencies on the objectives and priority actions of the Global Strategy, including tools and guidelines for use by countries in developing integrated, costed strategies and plans for reproductive, maternal, newborn, child and adolescent health (RMNCAH). Thirteen Member States reviewed their RMNCAH programmes in order to develop integrated strategic plans, and the process is still underway in seven more countries. This will help to inform investments, coordinate partners' actions and accelerate progress.

Improving quality of care is critical to achieving the objectives of the Global Strategy and needs greater focus in many countries. WHO supported 14 Member States to assess the quality of RMNCAH services in hospitals and action will be taken by the countries to address the identified gaps. The Quality of Care Network, targeting services for mothers, neonates, children and adolescents, was launched in February 2017, initially involving nine countries, including seven in the African Region.

The network aims to halve maternal and newborn deaths and stillbirths in health facilities within five years.

WHO/AFRO and partners held a Regional Inter-Agency Forum on Neonatal Health in Senegal in October 2016 to develop a road map for moving forward the agenda of neonatal health (NNH) in 16 West and Central African countries. A major outcome of the meeting was the launch of the regional task force on NNH for more effective coordination and accountability mechanisms, including sharing of tools for tracking progress on key indicators.



3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

To accelerate progress in the elimination of mother-to-child transmission (eMTCT), nine countries⁶⁰ were supported to develop or update their eMTCT plans. Given that the focus is now on dual elimination, WHO established a multi-agency regional mechanism to support countries to undergo validation for eMTCT of HIV and syphilis, and developed and disseminated tools for assessing country readiness for elimination.

Implementation research was conducted in three high-burden countries (Malawi, Nigeria and Zimbabwe) to improve the access, quality and uptake of prevention of mother-to-child transmission (PMTCT) services. Results of the five-year project to enhance service delivery in health facilities and strengthen national programmes were published in a supplement of the *Journal of Acquired Immune Deficiency Syndromes (JAIDS)* in June 2017.⁶¹

WHO staff at country, regional and headquarters level provided substantial support to the research teams composed of national scientists based at local institutions. A key finding of this research was that there were improved rates of adherence to treatment, because of support from other HIV-positive mothers. WHO is disseminating these findings to Member States and will organize regional workshops for Ministry of Health officials and community networks to agree on joint actions to improve retention on ART for women living with HIV.



Capacity building to strengthen community-based interventions for child survival has expanded. In addition to training 21 master trainers in Burundi, Cameroon, Congo and DRC on how to manage sick young infants in the community when referral is not possible, Burundi has already cascaded this training to community health workers.

Training on Integrated Community Case Management (iCCM), adapted to include TB and HIV, was conducted. Following the training, Ethiopia, Malawi, Uganda and Zambia have built national capacity to ensure early implementation.

3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

This is a collaborative innovation involving child health, HIV and TB programmes and supported by WHO and UNICEF to increase the identification of children exposed to HIV and TB in high-burden countries.

WHO continued to provide support to the Rapid Access Expansion (RACe) project for scaling up community-based management of malaria, diarrhoea and pneumonia in children in five countries.⁶² Since the start of the project in 2013, over six million cases of malaria, pneumonia and diarrhoea have been treated at community level in project sites in these countries. The RACe project demonstrated that when community health workers are trained and supported, they can provide adequate treatment for malaria, diarrhoea and pneumonia. It brought policy change in countries, such as the introduction of rapid diagnostic tests for malaria at community level, the use of amoxicillin dispersible tablets for pneumonia and the use of zinc for the treatment of diarrhoea. The project results are being used in countries to scale-up integrated case management for diarrhoea, malaria and pneumonia.

Vertical programming in service delivery for immunization and child health results in missed opportunities for children and mothers to receive integrated services.





3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

To strengthen integrated service delivery, WHO shared revised Reaching Every District (RED) guidelines that include best practices on EPI and Child Health integration with countries. Furthermore, WHO developed and disseminated an EPI/IMCI computer programme to build the capacity of frontline health workers to improve the quality of service delivery.

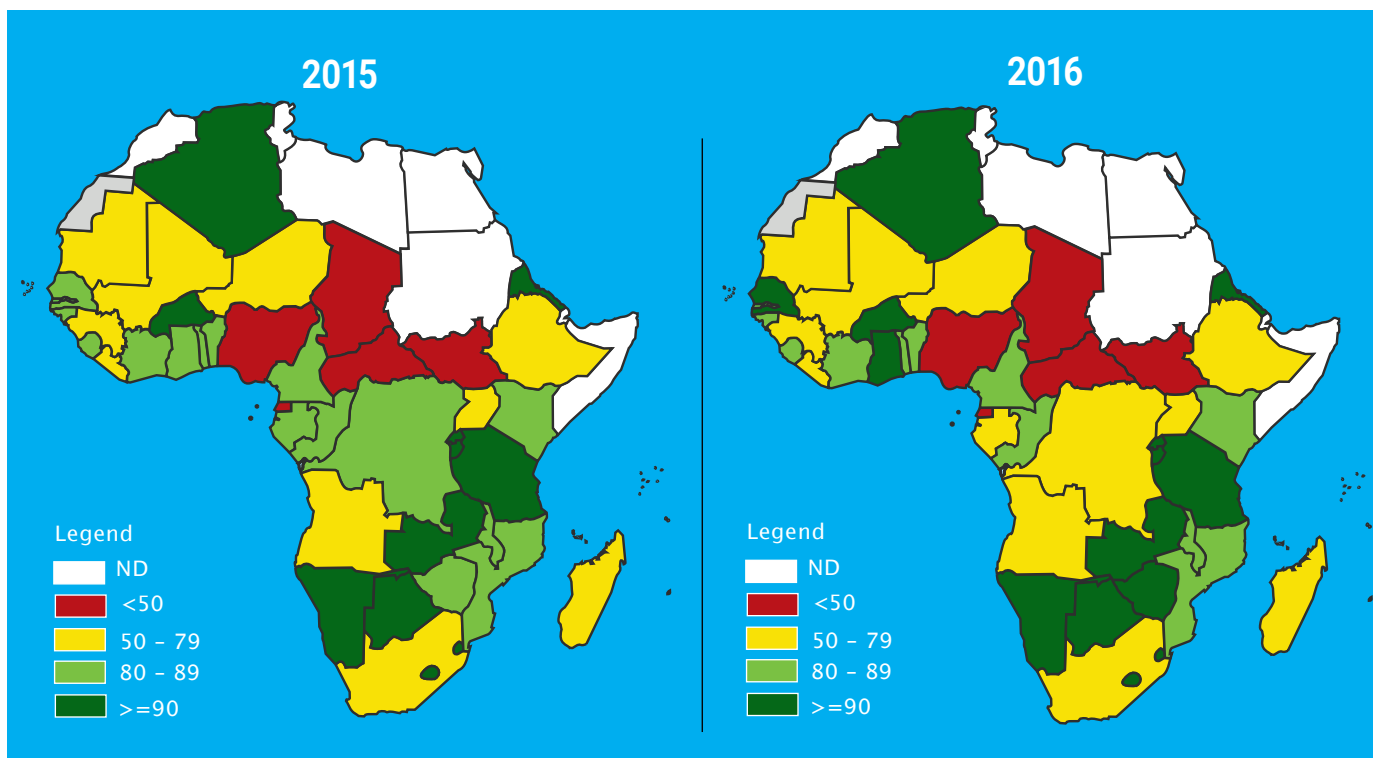
Immunization is an important, cost-effective public health intervention, saving millions of lives annually in the countries of the African Region. The regional immunization coverage with three doses of DTP3 stagnated at 74% in 2016, and similarly for coverage with measles-containing vaccine dose 1 (MCV1) at 72%.⁶³ These remain below the expected coverage target of at least 90%, in line with the Global Vaccine Action Plan (GVAP).

However, 20 countries⁶⁴ in 2016 attained the target of >90% for DTP3 vaccine, compared to 17 countries⁶⁵ in 2015, and 17 countries⁶⁶ achieved an MCV1 coverage of at least 90% in 2016, compared to 13 countries⁶⁷ in 2015 (Figure 3.3.1). The Regional coverage with the third dose of pneumococcal conjugate vaccine (PCV3) also increased from 59% in 2015 to 65% in 2016.

Vaccine coverage in countries facing humanitarian crises remains persistently low (below 50%)

(Figure 3.3.1); intensified support will be provided to these as well as countries with weak immunization systems or large numbers of unimmunized children, in order to get the greatest impact.

Figure 3.3.1: DTP3 coverage in the African Region, 2016 vs 2015



Source: WHO/UNICEF estimates of National Immunization Coverage (WUENIC) 2016, released in July 2017

3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

To further improve the immunization coverage, WHO supported advocacy and community mobilization to drive demand for immunization services. In 2016, countries took advantage of the African Vaccination Week (24–30 April) to implement the largest ever synchronized switch from trivalent oral polio vaccine to bivalent oral polio vaccine in routine immunization services. The Region was among the first to successfully switch.

To generate more reliable data from periodic surveys to supplement performance monitoring and action, WHO trained officials from 16 priority countries⁶⁸ to use the revised survey methodology for the Expanded Programme on Immunization (EPI) and Health Information System. In addition, WHO and partners developed a process for integrating immunization data systems into the overall health information system.

WHO and partners helped countries to accelerate the introduction of additional new vaccines in their routine immunization schedules. Human papillomavirus vaccine has been introduced nationwide in six countries,⁶⁹ and yellow fever vaccine in 24 Member States,⁷⁰ respectively. Yellow fever coverage has stagnated at 45%. The yellow fever long-term strategy recently developed by WHO and partners, following a large outbreak in Angola and the DRC, supports stockpiling of yellow fever vaccine, risk assessment to support introduction of the vaccine in routine EPI and reactive campaigns.

Evaluation of the duration of immunity following vaccination with a fractional dose of yellow fever vaccine is underway in the Democratic Republic of the Congo, and through a clinical trial at the Kenya Medical Research Institute.

Pneumococcal conjugate vaccines and rotavirus vaccines have been introduced by 38⁷¹ and 31 countries⁷² respectively. Seven countries⁷³ have demonstrated substantial declines in diarrhoea-related child morbidity and mortality following rotavirus vaccination provided as part of integrated interventions since 2014, including improvements in water quality, sanitation and hygiene practices.

To tackle epidemic meningitis A outbreaks, intermittent mass immunization campaigns have been conducted, and from 2016, over 48 million people were vaccinated. Only one case of meningitis due to *N meningitidis* type A was reported in 2016–2017. Despite the progress, outbreaks of meningitis due to meningococcal C have occurred. To address epidemics due to other serogroups of *Neisseria meningitidis*, a new polyvalent (ACYWX) meningococcal conjugate vaccine is under development for the Region. Once licensed and used, this vaccine has the potential to end epidemics of meningitis within the Region.

In February 2016, WHO's Regional Offices for Africa and the Eastern Mediterranean, together with the African Union and the Government of Ethiopia, organized the first ever Ministerial Conference on Immunization in Africa in Addis Ababa, Ethiopia. This conference of African political leaders and immunization stakeholders adopted the Addis Declaration on Immunization (ADI),⁷⁴ committing African ministers to 10 objectives to achieve universal access to immunization in Africa. The ADI was subsequently endorsed by the Heads of State during the AU Summit in January 2017. Eleven countries⁷⁵ currently fund more than 50% of their national immunization programmes and many more are expected to follow.

At 28%, the African Region has the lowest family planning coverage compared to other regions.⁷⁶ The SDG target for maternal mortality is 70 deaths per 100 000 live births; countries in the African Region need to make significant efforts to achieve this target, from the 2015 average of 542/100 000. Increasing uptake of family planning, and providing better quality emergency obstetric care, will be crucial to reducing mortality. The Regional Office disseminated new family planning guidelines in 16 countries⁷⁷ in 2016, and provided technical and financial support to seven countries⁷⁸ to adapt their national guidelines.

3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

In addition, through the 2016-2018 umbrella project “Strengthening Family Planning and Contraceptive Services using WHO guidelines”, WHO mobilized resources to support the implementation of family planning programmes in 10 countries.⁷⁹ Funding was also mobilized for four countries (Burkina Faso, Côte d’Ivoire, Ethiopia and Uganda) to improve availability of and access to contraceptive information and services, with a focus on adolescent girls and women after delivery or abortion, working in close collaboration with partners.

At an average of 116 per 1000 girls aged 15-19 years,⁸⁰ the birth rate among adolescent girls in the African Region is the highest in the world. The same age group has a contraceptive prevalence rate ranging from 2% to 43%, and an unmet need for family planning of 6% to 62% across countries. WHO has decided to pursue a Flagship Programme on Adolescent Health, to help countries bridge such gaps and provide access to services that address their priority health needs.

Together with other partners, WHO/AFRO convened a regional consultation to strengthen school health programmes in the Region. Twenty-nine countries⁸¹ formulated road maps to improve the health of adolescents, using the school health setting as a vehicle to reach more adolescents with interventions.



3. Significant achievements by category of work

3.3 CATEGORY 3: PROMOTING HEALTH THROUGH THE LIFE COURSE

The Organization provided technical support to eight countries⁸² to develop HIV proposals for interventions targeting adolescent girls and young women, and US\$ 35 million was mobilized from the Global Fund. An atlas on adolescent health was developed to provide countries with data, and the Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance document, launched during the Seventieth World Health Assembly, which requires a “whole of government” approach, will be disseminated to Member States.

In the area of nutrition, WHO assisted 11 countries⁸³ to implement a project on Accelerating Nutrition Improvements (ANI, 2013-2016), supported by a grant from the Canadian Government. All 11 countries now have at least two of the Maternal, Infant and Young Child Nutrition (MIYCN) indicators in their national health information systems, and six⁸⁴ include them in routine health reports. A good foundation has been laid to support nutrition surveillance through these systems. As a result of the project, 2689 health managers and workers were trained to collect and use surveillance data for action, and 4115 health workers to deliver nutrition interventions.

In addition, best practice briefs have been developed to scale-up nutrition interventions based on experiences in Ethiopia, Uganda and the United Republic of Tanzania.⁸⁵

Findings from the Sierra Leone national survey on micronutrient nutrition⁸⁶ have been used to inform a national strategy to address anaemia in women of reproductive age. The country is using innovative

nutritional assessment tools to enable mother-to-mother support groups to screen for stunting and counsel caregivers on prevention of malnutrition.



SUCCESS STORY NOTIFY, REVIEW, ACT: THE ROLE OF MATERNAL DEATH SURVEILLANCE AND RESPONSE



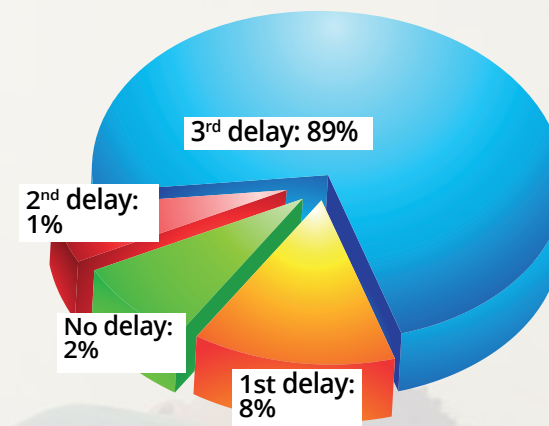
Maternal deaths are a real public health problem and a major cause of death among women in the African Region. A maternal death is one of the priority public health events to be notified weekly as recommended in the Integrated Disease Surveillance and Response (IDSR) technical guidelines. Despite this, there is severe underreporting and notification of maternal deaths due to lack of prioritization and inability to correctly classify a maternal death.

In response, WHO has built the capacity of country teams to correctly identify and notify maternal deaths in health facilities using the International Classification of Diseases-Maternal Mortality (ICD MM). In addition, links with Civil Registration and Vital Statistics (CRVS) and IDSR were created through joint sessions to facilitate weekly reporting of maternal deaths through the IDSR system and correct certification of maternal deaths.

WHO tracks maternal death notifications in countries. In 2015, seventeen countries reported 1045 maternal deaths. By the end of 2016, thirty-eight countries had reported 16 760 maternal deaths. Despite this encouraging increase in the number of reporting countries, underreporting is still occurring.

WHO is working with countries to improve reporting by incorporating maternal death reviews at facility and community levels, and initiating confidential enquiries into maternal deaths, including annual reporting. Maternal death audits show that most of these deaths could have been prevented with good quality care. For example, of the 205 maternal deaths reviewed in 2016 in Congo, delay of action in the health facility (the third delay) contributed to 89% of deaths; only 8% of the deaths were due to delay in seeking care (the first delay) and 1% to delay in getting to a facility (the second delay) (Figure 3.3.2).⁸⁷

Figure 3.3.2: Delays that contributed to maternal death in the Congo, 2016.



Report of the National Observatory of Maternal, Neonatal and Child Deaths in the Congo, 2016

WHO is helping countries to strengthen the teaching of Maternal Death Surveillance and Response in pre-service education by building the capacity of national training institutions in Maternal and Perinatal Deaths Surveillance and Response (MPDSR). Consequently, several countries have expanded their pre-service curricula for comprehensive inclusion of MPDSR.



3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

WHO contributes to the attainment of health for all by helping countries to develop responsive, resilient health systems that are centred on people's needs and circumstances, giving them access to quality health services without enduring financial hardship. This includes strengthening leadership and governance, improving health financing, strengthening human resources for health, promoting access to affordable, safe and effective health technologies, ensuring integrated service delivery, and generating and using health information and health research.

For the first time, the Regional Office convened a regional forum on health systems strengthening for UHC and the SDGs for senior Ministry of Health officials from all 47 Member States and other technical experts, partners and academics in Windhoek, Namibia in December 2016. The meeting focused on the challenges and requirements for building resilient and responsive health systems, within the context of health systems strengthening for progress towards UHC and the achievement of SDG 3. The key output was an action framework on health system strengthening to guide countries in strategic planning, setting investment priorities with the greatest impact, and monitoring progress. Four Communities of Practice were also established, allowing participants and others to continue sharing experiences and solving problems jointly on country challenges on governance, human resources for health, district health systems and health financing.

In unprecedented action to capture data on UHC, a baseline study was conducted in all 47 countries as the basis for developing a regional UHC monitoring framework.

Data were collected from publicly available sources and included 51 indicators, 17 of which were used for the proposed monitoring framework. The resultant framework will be adapted by countries to gauge their progress in achieving UHC and the SDGs.

Progress on UHC and the SDGs will require multisectoral action to address the socioeconomic determinants of health. WHO has developed tools for integrating health impacts in the policies of other development sectors. The Health in All Policies Training Manual⁸⁸ has been used to build capacity in some countries, while the Action Toolkit for Social Determinants in the African Region,⁸⁹ a learning and problem-solving resource for health and non-health professionals, is available online. WHO supported Rwanda to undertake an analysis of its performance in intersectoral action for equity and health outcomes. Key achievements observed were decentralization of authority and finances, the development of pro-poor programmes supporting poverty reduction, and the creation of policy, institutional and legal frameworks to protect vulnerable populations.

The Regional Office improved capacity for monitoring financial risk protection within the overall framework of monitoring UHC. In 2016 and 2017, officials in 11 Member States⁹⁰ were trained on methods of estimating financial risk protection. These countries are now able to produce estimates of catastrophic health expenditure and monitor their progress in reducing financial barriers to access to health services.



3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

The Region has made progress towards institutionalizing National Health Accounts in countries, to monitor resources allocated for universal health coverage. By the end of 2016, sixteen countries⁹¹ had produced health expenditure data for two consecutive years while four countries (Burkina Faso, the DRC, Niger and Uganda) had produced annual reports of the National Health Accounts since 2012.

The biannual Health Expenditure Atlas for the Region, launched in 2016, summarizes the current health financing situation in countries and provides policy guidance for attaining UHC based on better implementation of health budgets to maximize outcomes. The report notes that public spending on health in the Region has grown from US\$ 70 purchasing power parity (PPP) in the early 2000s to US\$ 160 PPP in 2014, while external financing for health grew from 13% to 24% of total health expenditure. It nevertheless highlights that, given the broader scope of the SDGs and new health challenges, further efforts are needed to mobilize domestic resources in a predictable manner, while ensuring greater efficiency to maximize health gains with available resources.

In March 2017, the Regional Director hosted a high-level advocacy event on health financing in collaboration with the United Nations Economic Commission for Africa (UNECA).

The meeting brought together a wide range of stakeholders to understand the perspectives of Ministries of Finance in the Region and achieve consensus on joint action for sustainable financing for health. Preliminary data from a WHO report⁹² indicate that in 2015, the African continent lost up to US\$ 3 trillion due to ill-health, and achieving the SDGs target should reduce the loss in GDP by at least 47%.

Key areas for action include greater domestic resource mobilization for health such as mandatory health insurance; setting up management systems which increase the efficiency of health resources; increasing absorptive capacity in Ministries of Health; and generating evidence linking the economy and human development, such as through food security and the social determinants of health. Together with UNECA, WHO will assist in developing a platform for Ministries of Health and Finance to share relevant information to generate evidence-based policies.

Based on the lessons learnt from the EVD outbreak, WHO assisted the strengthening of district health systems in Guinea, Liberia and Sierra Leone. One of the key lessons learnt was the importance of involving communities as well as linking them to the health service delivery systems. The Organization helped the countries to improve service delivery by strengthening leadership and management of the district health teams.

Over the reporting period, WHO supported four countries (Benin, Burundi, Seychelles and Sierra Leone) to organize and conduct service availability and readiness assessments (SARA) and utilize the results to further improve access to services. By June 2017, seventeen countries⁹³ had organized at least one SARA survey since 2011. Efforts are being made to synchronize the SARAs with national health planning cycles in order to make the results more useful for evidence-based decision-making.

Work to support countries to improve the available data on their health workforce continued, with support for the establishment of national health workforce observatories in Algeria, Cameroon, Comoros and Côte d'Ivoire. To date, 17 countries⁹⁴ have set up national health workforce observatories which are used for Human Resources for Health (HRH) information analysis and policy dialogue with the relevant stakeholders, to guide their collective action towards having the necessary human resource capacity.

Seventeen countries⁹⁵ were oriented to develop national health workforce accounts, which help to generate reliable HRH information and evidence for planning, implementation and monitoring of workforce policies towards UHC.

3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

WHO's Workload Indicators of Staffing Need (WISN) is an HRH management tool that assesses the actual workload of staff in health facilities to help countries determine staffing requirements and develop staffing norms. Capacity development for using the tool was done in Côte d'Ivoire and Guinea, leading to a pool of 35 francophone WISN experts for expanded country support. Mali was supported to develop an investment case in HRH, while Algeria and Comoros were supported for HRH planning.

Four Regional competency-based curricula and a regulatory framework on nursing and midwifery were published in English and French and disseminated to all countries for use by regulatory bodies and training institutions. WHO recognizes the importance of a strong health workforce in moving toward UHC, and has developed an implementation framework for the Global Strategy on HRH that will be presented to the Sixty-seventh Regional Committee for Africa in 2017.

The Regional Office supported the Ministry of Health of Togo in conducting Good Manufacturing Practice (GMP) inspections to assess compliance with WHO GMP guidelines. This was part of WHO action to foster local production of quality-assured medicines. WHO used this opportunity to conduct unique, hands-on training for the junior GMP inspectors from Burkina Faso, the DRC and Togo.



3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

Under the leadership of WHO experts, the trainees mastered inspection techniques and practical approaches for manufacturing quality systems and product quality assurance.

WHO is supporting countries to enhance the capacity of national regulatory authorities, striving for effective quality assurance of medical products, cross-country harmonization of medicines registration requirements and improved clinical trial oversight. It will also enable regulatory governance, streamlined licensing and inspection functions, laboratory control, pharmacovigilance and post-marketing surveillance. In February and March 2017, eight core medicine regulation functions were assessed in Eritrea, Ethiopia, Kenya, South Sudan and Uganda as well as Intergovernmental Authority on Development (IGAD) member states in the neighbouring Eastern Mediterranean Region. Among other things, the benchmarking exercise found regulatory checks and controls missing in the legislative framework, and identified measures to bridge the gaps.

Antimicrobial resistance (AMR) is a growing problem with serious implications for treatment failure, rising costs and increased disease burden. In the African Region, AMR is associated with the irrational use of antimicrobials, poor infection prevention and control practices in hospitals and communities, inadequate diagnostic capacity, as well as poor hygiene and environmental conditions.



3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

There is also little information sharing between the human, animal and food sectors to track and contain the emergence of resistant organisms.

To support countries in the Region to implement the Global Action Plan on Antimicrobial Resistance, WHO trained nearly 300 officials from 44 countries⁹⁶ in 2016-2017 to develop national action plans (NAPs) for antimicrobial resistance using a 'One Health approach' encompassing human, animal and environmental health. Catalytic funding from the UK Fleming Fund is supporting efforts in 25 countries⁹⁷ to develop NAPs, and 30 master trainers are ready to assist these efforts. As a result, national authorities have approved the NAPS in four countries, while six⁹⁹ are pending approval. Thirteen countries¹⁰⁰ received training to monitor the rational use of antimicrobials. A solid foundation is now in place in the Region for better monitoring of antimicrobial consumption, price and availability, and stronger national regulatory systems to curtail substandard and falsified antimicrobial products. WHO is working strenuously to have NAPs in all 47 Member States by May 2018.

WHO worked with regional partners to facilitate the implementation of *Improving Mortality Statistics in Africa – Technical Strategy 2015–2020* at country level. Software tools¹⁰¹ and training were provided at three regional workshops to integrate cause-of-death vital statistics data collection in health facilities and strengthen the links to civil registration and country statistics systems.

Follow-up technical support and tracking were provided to 15 countries¹⁰² to improve their vital registration and routine health facility data collection, and a regional network was initiated to facilitate intercountry collaboration and harmonize technical approaches among regional partners.

Eight countries¹⁰³ were supported to develop their national health observatories (NHO). Country health profiles including UHC indicators are now available for Burkina Faso, Cameroon, Ghana and Rwanda and will be updated with more analytical work and data from routine health information systems. This will help in tracking progress on UHC and the SDGs.

WHO assisted six countries¹⁰⁴ to develop or review their national eHealth strategies during the period, and is partnering with the International Telecommunication Union (ITU) and others to strengthen eHealth support.

The Organization is also supporting the scale-up of information and communication technology in health, as is the case in Sierra Leone and Lesotho, with a partial roll-out of the District Health Information System.

WHO's HINARI Programme enables low- and middle-income countries to access one of the world's largest collections of biomedical and health literature.



3. Significant achievements by category of work

3.4 CATEGORY 4: HEALTH SYSTEMS

The Regional Office organized HINARI training sessions in eight Member States¹⁰⁵ to build capacity to effectively use HINARI resources. Participants were medical practitioners, medical students, researchers, representatives of NGOs and librarians. Through this training, participants can retrieve information and use evidence for decision-making.

WHO's EVIPNet platform was established in the African Region in 2006 to promote the systematic and transparent use of health research evidence in policy-making. Ten years later, a review shows that the vision is becoming a reality. EVIPNet in Malawi has established "science cafés" where national health statistics and policy briefs on important public health issues are displayed. Staff of "science cafés" also assist clients to search and analyse health information using the database and software. Ministry of Health staff and policy-makers can now access, appraise, synthesize and apply evidence, eventually enabling them to do this on their own.

Through evidence-based policy briefs and dialogue that demonstrated the cost-benefit analysis, EVIPNet in Nigeria influenced the Government's Free Maternal and Child Health-Care Programme. By encouraging community involvement, there was an increased demand leading to the scale-up of malaria control interventions such as insecticide-treated nets (ITN) in Cameroon, and mandatory food fortification policy in Uganda.

As a knowledge-based Organization, WHO increasingly emphasizes evidence-based programming and support to health care delivery in Member States. This is demonstrated by the promotion of the conduct, publication and utilization of research by both the Member States and WHO, to inform practice in the Region. The number of manuscripts that Regional Office staff submitted for uploading to the website tripled between 2015 and 2016, from 27 to 79.

This has stimulated interest in publishing scientific papers and journal supplements in high impact factor, peer-reviewed journals. In addition to a regional health research strategy and a health research systems barometer which guide Member States on functional health research systems, a page on AFRO's website¹⁰⁶ has been established for WHO staff publications.



SUCCESS STORY CIVIL REGISTRATION AND VITAL STATISTICS SYSTEMS STRENGTHENING IN KENYA



Although the coverage of death registration is still below 60%, the country is working to improve registers and re-engineer mobile-based applications, for better tracking and cause-of-death data quality verification, as well as real-time death notification.



In Kenya, WHO has worked closely with partners and other sectors, through the Ministry of Health, to support the improvement of civil registration and vital statistics systems. Kenya for the first time produced its national civil registration reports in 2016. The country has built its mortality and cause-of-death data using ICD10 standards available to WHO for international use.

Although the coverage of death registration is still below 60%, the country is working to improve registers and re-engineer mobile-based applications, for better tracking and cause-of-death data quality verification, as well as real-time death notification. Under the Health Data Collaborative initiative in Kenya, development partners have worked together to synergize efforts on investing in the national health information system.

The recent analysis of results indicates a remarkable improvement of the routine health facility data through HMIS, and consistency with data generated through surveys.



3. Significant achievements by category of work

3.5 CATEGORY 5: WHO HEALTH EMERGENCIES PROGRAMME

The WHO Health Emergencies Programme (WHE) in the African Region was established in 2016 as part of the reform of WHO's work on outbreaks and emergencies. The comprehensive global programme is designed to accelerate preparedness and response, promoting collective action across the three levels of the Organization. It functions with one clear line of authority, one workforce, one budget, one set of rules and processes and one set of standard performance metrics.

The WHE structure reflects WHO's major functions in health emergencies: infectious hazards management; country health emergency preparedness and the International Health Regulations (IHR, 2005); health emergency information and risk assessment; and emergency operations. The WHE Programme in the African Region is already improving the Region's work on public health events.

The three countries affected by the 2014-2016 Ebola virus disease outbreak (Liberia, Sierra Leone and Guinea) with support from a wide range of partners including WHO, controlled and officially declared the end of the EVD epidemic in West Africa. Due to the capacity built and maintained in these countries, national teams were able to rapidly detect and control subsequent EVD flare-ups early in 2016, with minimal external support.

In May 2017, the DRC confirmed a new Ebola outbreak in a very remote area near the border with the Central African Republic. The quick response of the Government in declaring the outbreak in line with the IHR and the regional strategy adopted by the Sixty-sixth Regional Committee was good practice and enabled WHO to share information and coordinate closely with partners to support the response.

The Government, WHO and partners moved swiftly to set up an intensified field and alert response system in the affected area. WHO deployed experts to provide the leadership and technical expertise for a coordinated and effective response, which included adapting existing technology to rapidly diagnose EVD. The outbreak was declared over after two months, with eight cases (five confirmed and three probable) officially reported. The need to utilize the candidate Ebola vaccine tested in Guinea in 2015 was considered; however, given the rapid control of the outbreak, it was not regarded as appropriate.

In 2016-2017, WHO in its leadership role in responding to outbreaks and public health emergencies, deployed over 2500 experts including members of the Global Outbreak Alert and Response Network.

In the largest and most challenging urban outbreak of yellow fever on record, 25 million people in Angola and 14 million in the DRC were vaccinated, and 755 experts were deployed, to strengthen the response capacity in the two countries.

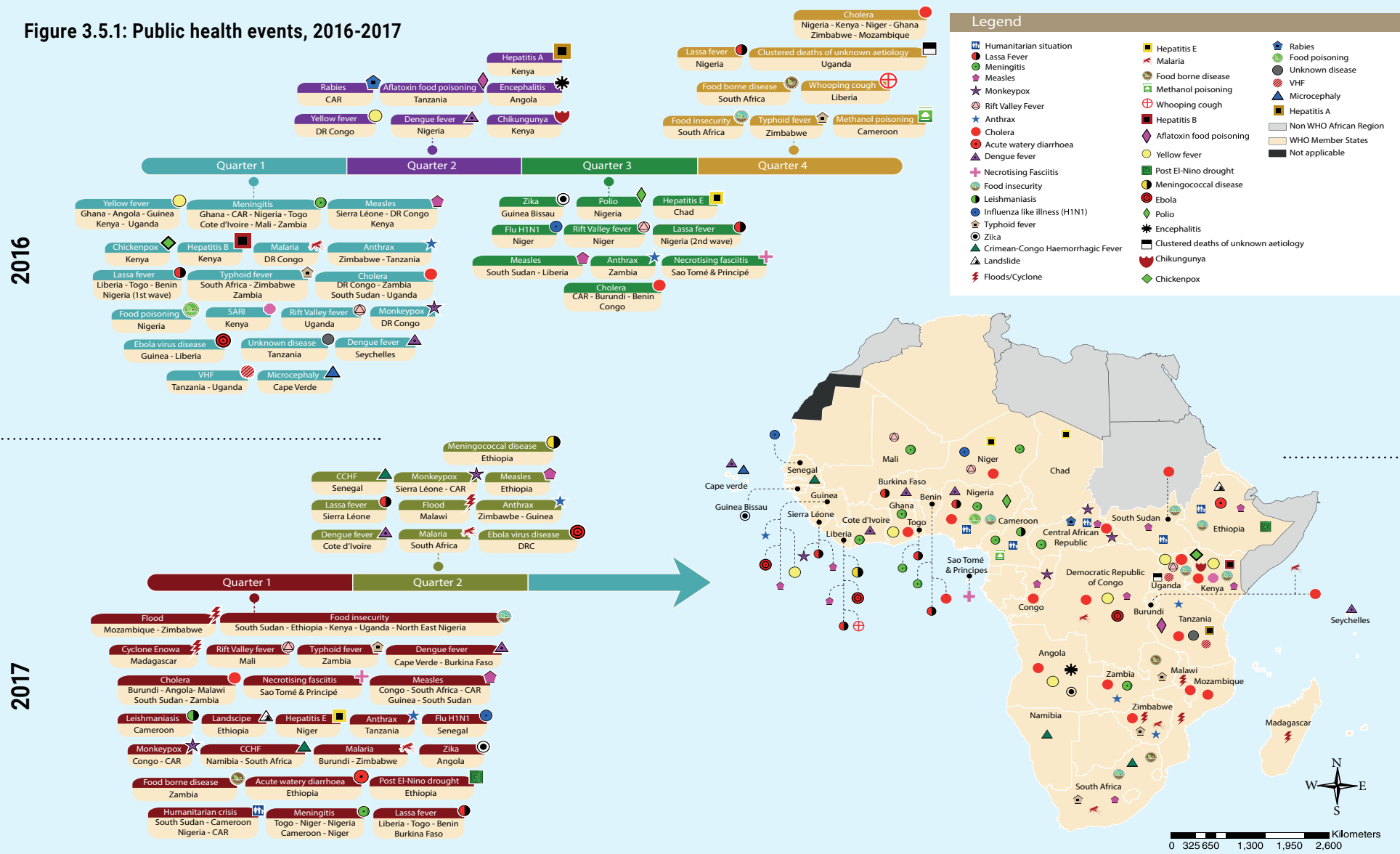
WHO is working closely with Member States to strengthen their ability to detect and control outbreaks. The Organization has led the response to public health events including outbreaks of Rift Valley fever, cholera, Monkey Pox, Lassa fever, meningitis and Hepatitis E in countries across the Region.



3. Significant achievements by category of work

3.5 CATEGORY 5: HEALTH EMERGENCIES PROGRAMME

Figure 3.5.1: Public health events, 2016-2017



3. Significant achievements by category of work

3.5 CATEGORY 5: HEALTH EMERGENCIES PROGRAMME

Support has also been provided to the response to public health emergencies linked to extreme weather events – drought and floods – in several countries. The Incidence Management System adopted as part of WHO's Emergency Response Framework, has enabled better coordination in health emergencies and faster deployment of WHO and partner experts to support outbreak responses (Figure 3.3.2).

In humanitarian crises, WHO supported the public health response, reaching over six million internally displaced persons (IDP) and refugees in South Sudan, Nigeria, Burundi, the DRC and the Central African Republic. WHO's rapid response was supported through the new Contingency Fund for Emergencies (CFE) which allocated US\$ 14 million to the Region over the reporting period.

In addition to the response to public health events, countries were supported to improve their preparedness. WHO has led Joint External Evaluations (JEEs) of the IHR core capacities (to detect and respond to public health events) in 18 countries¹⁰⁷ in the Region since February 2016, a third of JEEs conducted globally. Countries are now being supported to develop national plans to address gaps and mobilize financing for their implementation through domestic and international funding, including global health initiatives and development banks.





3. Significant achievements by category of work

3.5 CATEGORY 5: WHO HEALTH EMERGENCIES PROGRAMME

Recognizing that many outbreaks and emerging infectious diseases are linked to the human, animal and environmental interface, WHO and partners - FAO, the World Organisation for Animal Health (OIE), West African Health Organisation (WAHO) and USAID - organized a 'One Health' meeting in November 2016 in Dakar, Senegal, with ministers responsible for human and animal health, agriculture, wildlife and the environment in West African countries.¹⁰⁸ They signed a communique renewing their commitment to prevent and control outbreaks of zoonotic diseases by implementing existing frameworks including the IHR 2005, the IDSR and the Performance of Veterinary Services (PVS).

Over 80% of the more than 100 major public health events notified to the Regional Office in 2016 required laboratory confirmation for identification, leading to appropriate case management and control. This was achieved through regional and national laboratory networks. The Regional Office is currently implementing a comprehensive strategy on laboratory strengthening across the Region, providing guidance, training laboratory staff, procuring supplies and reagents and enrolling laboratories in an external quality assurance programme, as well as monitoring antimicrobial resistance.

In 2016, WHO compiled an inventory of all epidemics reported in Africa from 1970 to 2016.

This was used to develop a comprehensive, spatially defined database of outbreaks and epidemics to set the ecological zones of diseases classified as 'Public Health Emergencies of International Concern' (PHEIC) according to the IHR 2005. A technical report entitled "*Mapping the risk and distribution of epidemics in the WHO African Region*" has led to a greater understanding of the disease-specific risks and subnational distribution of outbreaks. This in turn supports the epidemic risk vulnerability analysis necessary for prioritizing country support. The databases and maps produced in the report are the foundation for tracking epidemics subnationally within the Region.

Following the confirmation of Zika virus transmission in Cabo Verde, WHO assessed the risk of a Zika outbreak by country in the WHO African Region, as well as capacity to contain and prevent it from becoming an epidemic. Countries were classified as being at high, medium or low risk with recommended preparedness activities in line with the classification. As part of this evidence-based preparedness, WHO supported 21 Member States¹⁰⁹ to perform outbreak risk profiling to strengthen their responses in emergencies.

After almost two years without any reported case of wild poliovirus (WPV), four new cases were reported in security-compromised areas in northern Nigeria.



3. Significant achievements by category of work

3.5 CATEGORY 5: HEALTH EMERGENCIES PROGRAMME

The country was placed back on the list of endemic countries in September 2016. A subregional response in the countries of the Lake Chad Basin and vaccination campaigns in other countries were implemented. No further wild poliovirus cases have been reported, and the date of onset of the last case was 21 August 2016.

Best practices of the polio eradication initiative were systematically documented and shared widely through the publication of a special edition of the journal *Vaccine* in October 2016.¹¹⁰ Countries are already using these to improve on key areas such as micro planning for routine immunization service delivery, new vaccine introduction, disease surveillance and impact assessment of vaccines.

Communicating information on public health events has been significantly improved through health information management and risk assessment. An example is the weekly *AFRO Bulletin on Outbreaks and Other Emergencies* launched in March 2017 which provides real-time updates on the current status of outbreaks and emergencies in the Region. It highlights both the public health actions and gaps that need addressing, and is a platform for sharing information and approaches used by countries in responding to public health events. Countries and partners have welcomed the Bulletin as an invaluable resource for the international public health community, citing its timeliness and usefulness in keeping track of disease outbreaks and other emergencies on the continent.

The Regional Office is broadening partnership for strengthening emergency responses. Key partners include the UK Government through the 'Tackling

Deadly Diseases in Africa' project, the US CDC and the Africa Centre for Disease Control and Prevention (Africa CDC).



SUCCESS STORY **LARGEST YELLOW FEVER OUTBREAK CONTAINED**



WHO facilitated the procurement and delivery of 30 million doses to the countries (more than four times the annual volume normally planned for outbreak use) for mass vaccination campaigns.



In 2016, WHO, the Ministries of Health of Angola and the DRC and partners responded to the largest urban outbreak of yellow fever to date by conducting one of the biggest ever emergency vaccination campaigns. Within two weeks of Angola notifying WHO of the outbreak, 1.8 million vaccines were shipped to the country from the emergency stockpiles managed by the International Coordination Group (ICG) for Vaccine Provision - a partnership including Médecins Sans Frontières (MSF), International Federation of the Red Cross and Red Crescent Societies (IFRC), UNICEF and WHO, with Gavi the Vaccine Alliance financing a significant proportion of these vaccines.

WHO facilitated the procurement and delivery of 30 million doses to the countries (more than four times the annual volume normally planned for outbreak use) for mass vaccination campaigns. These vaccines were obtained from the global stockpile co-managed by the ICG.

By 10 June 2016, over 10.6 million people had been vaccinated using the 11 635 800 vaccines received by the country. In Kinshasa, DRC where 10 million people were at risk ahead of the rainy season, the exceptional use of emergency fractional dosing was implemented. This successfully ended the outbreak. Angola declared its outbreak officially over on 23 December 2016, while that of the DRC ended on 14 February 2017.

The outcome in the DRC has confirmed that the innovative approach in using a fractional dose of the vaccine could potentially save lives in any future outbreaks. Ongoing data collection from a subset of vaccinated people will establish the duration of immunity conferred by the fractional dose.



3. Significant achievements by category of work

3.6 CATEGORY 6: CORPORATE SERVICES AND ENABLING FUNCTIONS

This category focuses on organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO. It covers the following programme areas: leadership and governance; transparency, accountability and risk management; strategic planning, resource coordination and reporting; management and administration; and strategic communications.

The Regional Director continued to promote WHO's leadership and governance through missions to Member States, engagement with strategic partners and reform of the work of the Secretariat in the African Region.

She engaged national leaders, including Heads of State, advocating for prioritization, improved financing, intensified action and partnership on health, including the reforms needed to ensure better preparedness for and response to outbreaks, and accelerated progress towards universal health coverage. Visits were undertaken to Côte d'Ivoire, Angola, Niger, Nigeria, Guinea, the Central African Republic and Rwanda.

Collaboration with the African Union Commission facilitated joint action including in advocacy with national leaders for priority areas that require particular attention.

The Addis Declaration on Immunization (adopted by governments, parliamentarians, civil society and partners in February 2016) and the Declaration on Accelerating Implementation of the International Health Regulations in Africa were endorsed by Heads of State at the AU Summits of January and July 2017 respectively. This reflects commitment which will facilitate investment and intensified action on child survival and health security on the continent.

A framework for collaboration with the Africa CDC will ensure synergistic action on outbreak preparedness and response and enable regular reporting on progress to Heads of State.

A Cooperation Agreement was signed between the Regional Office and the West African Health Organisation (WAHO), a specialized institution of the Economic Commission of West African States (ECOWAS) during a visit to AFRO in December 2016. Joint action to improve the health of the people of the ECOWAS region will be undertaken on a range of priority areas, particularly on health security, including with the ECOWAS Regional Centre for Disease Surveillance and Control.

The Organisation of African First Ladies Against HIV/AIDS (OAFLA) is a unique advocacy alliance that is determined to work towards the improvement of the health of women, adolescents and children, including eliminating HIV.

A plan of action on joint advocacy has been agreed upon, and the Regional Director has consolidated the partnership by attending the OAFLA General Assemblies at the January and July 2017 AU Summits.

WHO has continued to seek out strategic partners to help mobilize resources and improve health outcomes in the Region. The Regional Director participated in key global and regional meetings such as the UN General Assembly, the World Health Summit in Berlin, the 2nd Global Partners Meeting on Neglected Tropical Diseases in Geneva and TICAD-VI.¹¹¹



3. Significant achievements by category of work

3.6 CATEGORY 6: CORPORATE SERVICES AND ENABLING FUNCTIONS

In the period under review, the Regional Office hosted a number of visits from senior officials of key partners.

The Harmonization for Health in Africa (HHA) mechanism, established by WHO and regional health partners 10 years ago, was re-launched in March 2017. Following an independent review in 2016, WHO AFRO and UN and bilateral partners reaffirmed their commitment to supporting countries' progress towards UHC and the Sustainable Development Goals, emphasizing equity, better investment in health with greater value for money, improving the health of women and children, and guiding countries on the potential of greater private sector involvement in health.

WHO's Framework of Engagement with Non-State Actors (FENSA) has opened the way for engagement with new health players. In June 2017, WHO held the first ever Africa Health Forum, themed "*Putting People First: The Road to Universal Health Coverage in Africa*" in Kigali, Rwanda. The Forum provided a platform for a unique mix of stakeholders, including government ministers, young professionals and health activists, the private sector, UN and bilateral partners, to discuss public health challenges and opportunities in the Region, and explore ways of contributing to WHO's reform agenda. *The Kigali Call to Action*¹² provides a framework for acting together to improve health in the Region.

The Regional Director continues to benefit from the recommendations of the Independent Advisory Group (IAG), which comprises experienced health experts who provide strategic policy advice on the work of WHO in the African Region. At its second meeting in October 2016, the IAG reiterated the importance of the Transformation Agenda and provided advice on improving capacity and strengthening WHO's work in the Region. It encouraged the Regional Director to work with Heads of State, political, academic and civil leaders, to reinforce advocacy and the provision of evidence to support policies that improve health.

An independent evaluation of the Transformation Agenda, AFRO's implementation of WHO's global reform, was completed in April 2017 by the WHO Evaluation Office in Geneva, at the request of the Regional Director. This evaluation aimed to review progress, document achievements and best practices, identify challenges and areas for improvement and provide recommendations on the way forward.

The evaluation noted significant progress towards achieving objectives as set out in the Transformation Agenda to render WHO in the African Region more effective, responsive and efficient in providing the best possible support to Member States. This was mainly in the introduction and implementation of initiatives to promote accountability and improve risk management.

In the area of strategic partnership, engagement with traditional and new donors had increased collaboration and expanded the financial resource base. It was also noted that AFRO's capacity to contribute to health security through improving countries' preparedness and timely response to disease outbreaks and emergencies had been strengthened.

However, any reform requires not only a change in processes but also of behaviours, and requires a dedicated change management team. The evaluation noted completion of, and progress in, many activities that were planned and also an emerging change in behaviours and mindset. More effort was recommended to bolster internal communication and institute a change management support system.

Staff realignment has taken place at the Regional Office and Intercountry Support teams to match staffing with national and regional priorities. The General Management and Coordination Cluster has been reorganized with the introduction of a new service delivery model to enhance efficiency and ensure that the highest quality support is provided to countries and technical programmes.

The focus of reform is now moving to country offices, the most important interface of the Organization with Member States.



The First WHO Africa Health Forum

PUTTING PEOPLE FIRST

The Road to Universal Health Coverage in Africa

africahealthforum.afro.who.int Kigali, Rwanda, 27 - 28 June 2017 www.africahealthforum.afro.who.int



3. Significant achievements by category of work

3.6 CATEGORY 6: CORPORATE SERVICES AND ENABLING FUNCTIONS

A tool for informing the realignment of country office staff with country needs and priorities, based on evidence, will be applied, starting with Senegal, Sierra Leone, South Africa and Togo. Country Cooperation Strategies articulate the priorities agreed between WHO and Member States, and are a key instrument for guiding the Organization's support. To date, 26 country offices have reviewed their CCS' in line with new guidelines emphasizing integrating the SDGs into WHO's work.

WHO's managerial reforms continue to be implemented to enhance the responsiveness of strategic operations. Several initiatives aimed at transforming WHO AFRO into a more responsive, results-oriented Organization were implemented. The Accountability and Internal Control Strengthening (AICS) website¹¹³ has been launched with all relevant policies, standard operating procedures and guidelines in the languages of the Region. The website also hosts the Key Performance Indicator (KPI) dashboard and includes information on audits, best practices and generic control weaknesses.

WHO continues to strengthen controls and improve compliance around the use of the Direct Financial Cooperation (DFC) mechanism, a payment advance approach to financing activities implemented by governments.

This included the development and use of a DFC Accountability and Assurance Framework to ensure that DFC funds are used for intended purposes, and that recipients have the necessary control functions to comply with monitoring and reporting requirements. Self-assessments and internal control checklists have been rolled out to all Ministries of Health, and training sessions on working with WHO are underway. Controls on DFC reporting have been strengthened to include mandatory technical reports to accompany the financial reports.

In December 2016, countries with the highest financial risk, which were often those most vulnerable to emergencies, were selected for post facto checks on Funding Authorization and Certificate of Expenditure (FACE). Additional funding for human resources was secured to expand these activities in 2017. Reviews of IT infrastructure were conducted in 30 country offices to ensure robust IT platforms to support preparedness and response activities. A road map is being finalized which, once implemented, will bring country offices up to the corporate standard.

The number of audit reports issued in 2016 with an unsatisfactory rating has been reduced to 0%, compared to 50-80% in previous years. Of the new audits, 100% were fully or partially satisfactory. The number of overdue DFC reports decreased from 1907 on 1 April 2016 to 764 on 24 May 2017, a drop of 60%.

WHO in the African Region is determined to manage for results through rigorous planning and clear performance indicators to demonstrate value for money. Managerial and programmatic KPIs have been introduced and expanded to include all programme support functions. Monitoring of the performance of individual WHO country offices and Regional Office clusters (budget centres) using managerial KPIs is carried out monthly and reported quarterly to the Compliance and Risk Management Committee. Those which are underperforming receive support to address the causes of suboptimal performance, which includes targeted training.

To improve procurement activities in the Region, an official account has been created in the US Government's comprehensive and competitive catalogue of goods and services, to overcome the risk of weak procurement processes. This significantly adds to the procurement options available in the Region and piggy-backing on this comprehensive catalogue will reduce risks and accelerate programme implementation.

To improve value-for-money, the globally used, web-based e-Tender system was launched and implemented for procuring goods in the Regional Office. This will ensure full transparency, adequate internal controls in bidding processes, and effective competition by using the system's database of global suppliers.

3. Significant achievements by category of work

3.6 CATEGORY 6: CORPORATE SERVICES AND ENABLING FUNCTIONS

The UN Global Marketplace tool was introduced to publish Request for Proposals for procuring services. This has led to reputable global consulting firms being engaged, which has contributed to high-quality outputs and supported the implementation of the Transformation Agenda.

In developing workplans, defining resource requirements and clear formulation of results are vital to effectively assessing delivery. The Regional Office successfully formulated a results framework to enhance transparency and accountability for results of individuals and teams.

Capacity building for programme managers in the Regional Office and country offices was undertaken to reinforce the principles of the logical approach to results-based programme management and ensure quality workplans for the Programme budget 2018-2019.

To ensure effective management and administration, six programme and administrative reviews were carried out in country offices,¹¹⁴ while compliance reviews took place in Togo and Sierra Leone. These reviews identified best practices and areas for improvement which were shared with other country offices.

Regarding human resources, greater efforts to improve staff well-being at the Regional Office in Brazzaville are ongoing through a comprehensive induction programme, an intranet welfare site and a monthly newsletter identifying social and sporting events.

As a learning Organization, WHO has launched the global *i*learn portal with a wide range of opportunities which have enhanced staff knowledge at Regional, IST and Country Office levels.

In relation to strategic communications, improved media outreach resulted in increased awareness of health issues in Member States and WHO's leadership role in health. Some significant WHO activities which attracted global media coverage included the release of research on NCD risk factors in the African Region in December 2016, the endorsement of the ADI by Heads of State at the African Union Summit in 2017, the roll-out of the world's first malaria vaccine pilot project in April 2017 and the First Africa Health Forum.

In a new collaborative effort, WHO sponsored the 2016 CNN Multichoice African Health and Medical Journalism award, to encourage in-depth reporting

of public health issues on the continent, and raise the profile of the Organization among media stakeholders.

Social media activity has also improved significantly, and by June 2017, WHO in the African Region had received over 5.7 million tweets, up from 3.3 million in 2015.

The Organization launched a new, visually appealing website which provides easier access to information and improved security. Staff capacity in communication was improved through training courses. Furthermore, the roll-out of key performance outputs in communications for each country office, and the dissemination of essential health information and other communication products, are contributing to improving stakeholders' understanding of the Organization's work.



SUCCESS STORY MEASURING WHO'S CONTRIBUTION IN THE AFRICAN REGION – THE BURUNDI ACCOUNT

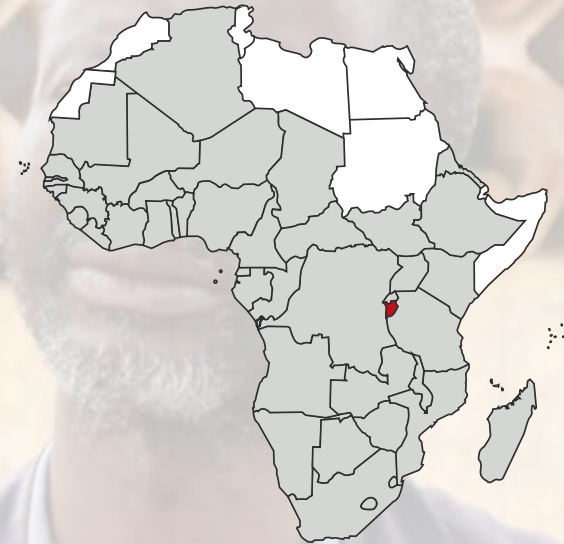


As part of the Transformation Agenda, WHO in the African Region developed a results framework with indicators linked to performance management – a first for the Organization globally - to better serve Member States while improving transparency, reinforcing accountability and demonstrating results. Managerial and programmatic key performance indicators (KPIs) were developed to measure WHO's contribution to Africa's health. They are aligned with the SDGs and the Programme budget, staff performance appraisals, and at country level with Country Cooperation Strategies. The WHO Country Office (WCO) experience in Burundi is a tangible account of how the KPIs have helped to improve performance at country level.

The Burundi WCO had been facing difficulties in meeting its managerial KPIs in 2016. When the new WHO Representative (WR) assumed office in February 2016, he soon mobilized his staff around the Transformation Agenda, with a strong focus on WHO's accountability and internal control frameworks. Under his leadership, the WCO developed its road map for implementation of the reform agenda. Change agents appointed by their peers were regularly involved in management committee meetings chaired by the WR, to report progress on key transformation milestones, including the KPIs.

To further support the WR, experts from AFRO, the Inter-country Support Team and Headquarters undertook a programme monitoring and administrative assessment mission. The review was instrumental in helping to build on previous efforts to improve risk and compliance management, as well as accountability in administration and programme delivery. Recommendations from the review led to a management response action plan. Workflows and internal controls were strengthened in all enabling functions, and the WCO's responsiveness to emergencies and cooperation with key stakeholders was reinforced.

Managerial KPIs improved significantly over time, translating into results in the country. A cholera outbreak was quickly brought under control after the WCO effectively coordinated and implemented the WHO Emergency Response Framework and related standard operating procedures.



As a result, the Ministry of Public Health and HIV/AIDS, donors and other stakeholders are now relying on WHO leadership to further guide their actions during emergencies. A malaria outbreak response plan, developed under the aegis of the WCO, has received strong support and is being used to guide a multipronged response to a protracted malaria outbreak. The Burundi Country Office has now selected 20 KPIs and is strengthening its operations and implementation of the managerial KPIs, thus maintaining a strategic focus on effective transformation.



4. Conclusion and looking ahead

During this biennium, Member States of the WHO African Region made progress towards ensuring longer, healthier lives and well-being for their populations, with support from WHO and other health development partners. WHO in Africa will build on this, and on identified home-grown solutions and lessons learned, in defining priority actions to be incorporated into the WHO Programme budget for the 2018-2019 biennium.

In pursuit of UHC and the SDGs, the framework adopted by the Region and partners will be used to guide country-led action. Emphasis will be placed on monitoring to ensure equity in health financing, actions and outcomes, with evidence-based targeting, so that the poor and marginalized are not disadvantaged. Promoting and supporting integrated, people-centred services delivered through a primary health care approach, with anticipated efficiencies and synergies, will be prioritized. This will start with a strong drive for greater integration across programmes in WHO's own work.

The renewed Harmonization for Health in Africa partnership agreed to pursue analysis and greater understanding of the potential contribution of the private sector to UHC; the outputs of this work will be incorporated into advice and support to Member States.

With these partners, WHO will also redouble efforts to advocate for increased and sustained domestic financing for health, accompanied by efforts to ensure value for the money invested, based on efficiency of financial management, allocation and utilization.

The opportunities offered by the 2030 Agenda for Sustainable Development for multisectoral collaboration in addressing the socioeconomic determinants of health will be exploited, and approaches to working across the different Goals, and their related sectors, for mutual benefit with health, will be developed and promoted for adoption in countries. WHO in the African Region will reinforce collaboration with relevant partners within the United Nations and beyond, to this end. At country and regional levels, our contribution to joint UN action through UN Development Group mechanisms will be further strengthened.

Member States of the African Region have demonstrated their commitment to building their IHR-related capacities and preventing and controlling epidemics; they are making the fastest progress in assessing their gaps and developing plans to cover them. The WHO Secretariat will strongly advocate for financing of these plans – from international and domestic resources.

The adoption of the Declaration on Accelerating Implementation of International Health Regulations in Africa by African Union Heads of State and Government is an unprecedented opportunity to advance health security in the Region. WHO will coordinate regional and multisectoral collaboration, build capacity and consolidate the reform of our Health Emergencies Programme.





4. Conclusion and looking ahead

We will strive to enhance synergies between Member States and partners, working together to investigate alerts early, deploy experts faster, declare disease outbreaks immediately and bring them under control quickly.

The use of information technology is expanding rapidly in the African Region – in different spheres and sectors of development. Its potential will be strongly leveraged to advance public health in the Region – from disease surveillance to ensuring that patients are reminded about adherence to treatment. WHO will work with the International Telecommunication Union (ITU) and other partners to advance eHealth in countries.

Africa is the only continent in the world where the number of adolescents is predicted to increase over the next fifty years. Twenty-eight per cent of the world's adolescents and youth will be living in Africa in 2040, a projected increase from 18% in 2012. This presents unique opportunities for an adolescent-centred approach in addressing health development in the Region. WHO AFRO, through our Adolescent Health Flagship Programme, will promote prioritization and adaption of strategies to meet the needs of adolescents across all relevant programmes, including those addressing HIV/AIDS, sexual and reproductive health, violence and injuries, and mental health.

4. Conclusion and looking ahead

WHO projections indicate that by 2025, fifty-five per cent of all deaths in the African Region will be from NCDs and injuries. The Region has a rapidly-closing window of opportunity to avert this, if relevant preventive action is taken, primarily through legislation, regulation, taxation and other public policy measures, to moderate the risk factors that are driving the rise in NCDs. Such action, decisively taken now, will save countries spending large sums of money in future treatment costs and lost contribution to economic development due to illness and premature deaths. The next biennium will see additional focus on evidence-based advocacy for attention and financing for NCDs, both for programmes and action in countries, and for WHO's supportive work.

While the 3% increase in assessed contributions approved by the World Health Assembly in May 2017 is most welcome and will reduce the financing deficit experienced by WHO in the current biennium, added focus will be placed on prioritizing areas for action in the next biennium.

Greater efforts will be made on cost saving, especially on travel related to meetings and staff missions and on procurement, and using the KPIs as a key tool. Action to mobilize resources, including through broadening the range of donors, will be intensified.

This biennial report highlights a number of significant achievements in the 2016-2017 biennium. The independent evaluation of the Transformation Agenda has shown that the reform is changing WHO in the African Region towards the effective, results-driven and transparent Organization that Member States and stakeholders would like to see. This positive start will be consolidated in the next biennium, with strong focus on improvements at country level. WHO in the African Region is determined to play a transformational role, working with countries and partners to help to achieve the health goals in the new era of sustainable development.







Annex 1 : Selected WHO/AFRO publications by cluster

COMMUNICABLE DISEASES

1. Boeras DI, Peeling RW, Onyebujoh P, Yahaya AA, Gumede-Moeletsi HN, Ndiokubwayo JB. The WHO AFRO external quality assessment programme (EQAP): Linking laboratory networks through EQA programmes. *Afr J Lab Med.* 2016; 5(2), a560. [http://dx. doi.org/10.4102/ajlm. v5i2.560](http://dx.doi.org/10.4102/ajlm.v5i2.560)¹¹⁵
2. Oriol Mitja, Michael Marks, Sally-Ann Ohene, Daniel Argaw, Ahmed H. Fahal, Claire L. Fuller et al. "Integrated Control and Management of Neglected Tropical Diseases" *PLOS Neglected Tropical Diseases.* DOI:10.1371/journal.pntd.0005136 January 19, 2017¹¹⁶

NONCOMMUNICABLE DISEASES

1. Report on the status of major health risk factors for noncommunicable diseases: WHO African Region, 2015¹¹⁷
2. Catalogue of Key Eye Health Indicators in the African Region¹¹⁸
3. Promoting oral health in Africa - Prevention and management of oral diseases and Noma as essential interventions against noncommunicable diseases¹¹⁹

PROMOTING HEALTH THROUGH THE LIFE-COURSE

1. Nineteen papers in *The Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, June 1, 2017 – Volume 75, Supplement 2¹²⁰
2. Several papers on a child survival study using data from 46 countries assessing factors associated with declining under-five mortality rates in the Region were published in the *British Medical Journal* and *Health Policy and Planning*^{122, 123}

Annex 1 : Selected WHO/AFRO publications by cluster

HEALTH SYSTEMS

1. Public financing for health in Africa: from Abuja to the SDGs¹²⁴
2. Assessment of Medicine Pricing and Reimbursement Systems in Health Insurance Schemes in Selected African Countries¹²⁵
3. Health Policy Dialogue: Lessons from Africa¹²⁶
4. Policy Brief: Community health workers in the African Region¹²⁷
5. Blood safety and availability in the African Region¹²⁸
6. The Implementation of the WHO Regional Office for Africa Stepwise Laboratory Quality Improvement Process Towards Accreditation¹²⁹

WHO EMERGENCIES PROGRAMME

1. Polio Eradication Initiative (PEI) contribution in strengthening public health laboratory systems in the African Region¹³⁰
2. An interim guidance document on yellow fever laboratory diagnostic testing in Africa¹³¹
3. Assessment Tool for Key Processes associated with the Design, Construction, Operation, Maintenance and Regulation of BSL-3 Laboratories in the WHO African Region¹³²

CORPORATE SERVICES AND ENABLING FUNCTIONS

1. Understanding WHO Rules: Handbook for Ministries of Health in the African Region¹³³









Endnotes

1. WHO, HIV/AIDS: Framework for Action in the WHO African Region 2016 – 2020, Brazzaville, World Health Organization, Regional Office for Africa, 2016 (AFR/RC66/10).
2. WHO, Framework for the Implementation of the “End TB Strategy” in the African Region (2016-2020), Brazzaville, World Health Organization, Regional Office for Africa, 2016 (AFR/RC66/10).
3. WHO, Prevention, Care and Treatment of Viral Hepatitis in the African Region, Framework for Action, 2016-2020, Brazzaville, World Health Organization, Regional Office for Africa, 2016 (AFR/RC66/12).
4. WHO, Framework for Implementing the Global Technical Strategy for Malaria 2016-2030 in the African Region, Brazzaville, World Health Organization, Regional Office for Africa, 2016 (AFR/RC66/14).
5. <http://www.who.int/hiv/pub/arv/arv-2016/en/>.
6. Algeria, Angola, Benin, Botswana, Burundi, Cameroon, Chad, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
7. Benin, Burkina Faso, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of Congo, Gabon, Guinea, Liberia, Nigeria and Sierra Leone.
8. Benin, Cameroon, Central African Republic, Côte d’Ivoire, Democratic Republic of Congo, Guinea, Liberia, Nigeria, Senegal and Sierra Leone.
9. Algeria, Angola, Botswana, Cabo Verde, Gambia, Mauritania, Mauritius, Namibia, Nigeria, Sao Tome Principe and Senegal.
10. Algeria, Benin, Burkina Faso, Eritrea, Ethiopia, Ghana, Guinea, Mauritania, Nigeria, Rwanda and Uganda.
11. Cameroon, Nigeria, Rwanda, South Africa and Uganda.
12. Algeria, Angola, Benin, Botswana, Burundi, Cameroon, Central African Republic, Côte d’Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
13. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Côte d’Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Madagascar, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. <https://extranet.who.int/tme/generateCSV.asp?ds=labs>
14. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Côte d’Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
15. Botswana, Ethiopia, Kenya, Lesotho, Malawi, Nigeria, Rwanda, Senegal, Swaziland, United Republic of Tanzania and Zimbabwe.

Endnotes

16. Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, South Africa, South Sudan, United Republic of Tanzania and Uganda.
17. Angola, Botswana, Burkina Faso, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Guinea, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, United Republic of Tanzania, Uganda and Zimbabwe.
18. Angola, Benin, Botswana, Cabo Verde, Central African Republic, Chad, Democratic Republic of Congo, Equatorial Guinea, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Namibia, Nigeria, Sao Tome and Principe, Senegal, Somalia, Swaziland, Togo, Zambia and Zimbabwe.
19. Angola, Benin, Botswana, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Mauritius, Namibia, Niger, Nigeria, Sao Tome and Principe, Seychelles, South Africa, South Sudan, Swaziland, Uganda and Zimbabwe.
20. Countries not requiring PC are Algeria, Mauritius and Seychelles. Countries that did not carry out MDA in 2016 are Cabo Verde, Central African Republic and South Sudan, the last two because of security issues.
21. Cabo Verde, Chad, Democratic Republic of Congo, Eritrea, Gambia, Kenya, Malawi, Nigeria, Sao Tome and Principe, South Sudan, Swaziland and Zambia.
22. Angola, Democratic Republic of Congo, Ethiopia, Kenya, Nigeria, Uganda and Zambia.
23. Benin, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Guinea, Guinea-Bissau, Nigeria, South Sudan, Sao Tome and Principe, United Republic of Tanzania and Togo.
24. Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, South Sudan, Swaziland, United Republic of Tanzania, Uganda and Zimbabwe.
25. Benin, Burkina Faso, Ethiopia, Ghana, Guinea, Madagascar, Malawi, Mali, United Republic of Tanzania and Zambia.
26. Algeria, Botswana, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Nigeria, South Africa, United Republic of Tanzania and Uganda.
27. Health and Climate country profiles, Geneva, World Health Organization, 2015 <http://www.who.int/globalchange/resources/country-profiles/en/>; accessed on 5 February 2017.
28. Benin, Burundi, Burkina Faso, Central African Republic, Cameroon, Democratic Republic of Congo, Côte d'Ivoire, Niger, Rwanda, Senegal and Swaziland.
29. STEPwise surveys are a WHO tool to assess the magnitude of NCD risk factors and are conducted every 3-5 years in countries.
30. WHO Global Status Report on NCDs, 2014.
31. Botswana, Chad, Côte d'Ivoire, Liberia, Gambia, Guinea, Namibia and Uganda.
32. WHO, WHO Global Action plan for the Prevention and control of NCDs 2013-2020, Geneva, World Health Organization, 2013.
33. Benin, Botswana, Burkina Faso, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Namibia, Niger, Nigeria, Senegal, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.
34. Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Niger, Swaziland, United Republic of Tanzania and Togo.
35. (i) National coordination mechanism; (ii) Becoming a Party to the Protocol to eliminate illicit trade in tobacco products; (iii) Model strategic plan for tobacco control; (iv) Model tobacco control policy; (v) Guide on compliance and enforcement of tobacco control laws.
36. https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4-a&chapter=9&clang=_en
37. Burkina Faso, Comoros, Côte d'Ivoire, Gambia, Guinea, Mali, Senegal and Swaziland.
38. Burkina Faso, Chad, Ethiopia, Gabon, Gambia, Ghana, Nigeria, Rwanda, Senegal, Seychelles and Uganda.
39. Benin, Botswana, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Lesotho, Nigeria, Sierra Leone, Swaziland, Togo and Uganda.
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43. Angola, Ethiopia, Gambia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, Seychelles, Sierra Leone, South Africa, Swaziland, Uganda and Zimbabwe.
44. Ghana, Kenya, Namibia, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

Endnotes

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55. Burkina Faso, Burundi, Congo, Côte d'Ivoire, Chad, Gabon, Guinea Bissau, Lesotho, Mali, Malawi, Niger, Rwanda, Swaziland and Togo.
56. www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/
57. Côte d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, United Republic of Tanzania and Uganda.
58. UNICEF, UNFPA, BMGF, USAID, JHPIEGO and UNWomen.
59. Benin, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
60. Eritrea, Mali, Niger, Côte d'Ivoire, Burundi, Sao Tome and Principe, Cameroon, Chad and Democratic Republic of Congo.
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65. Algeria, Burundi, Burkina Faso, Botswana, Comoros, Cabo Verde, Eritrea, Gambia, Lesotho, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Swaziland, Seychelles, United Republic of Tanzania and Zambia.
66. Algeria, Burundi, Botswana, Comoros, Cabo Verde, Eritrea, Gambia, Lesotho, Mozambique, Mauritius, Rwanda, Senegal, Sao Tome and Principe, Seychelles, United Republic of Tanzania, Zambia and Zimbabwe.
67. Algeria, Burundi, Botswana, Comoros, Cabo Verde, Gambia, Lesotho, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, United Republic of Tanzania and Zambia.
68. Benin, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Liberia, Mali, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Uganda and Zimbabwe.
69. Botswana, Lesotho, Rwanda, Seychelles, South Africa and Uganda.
70. Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone and Togo.
71. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Central African Republic, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, South Africa, Swaziland, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.
72. Angola, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Sierra Leone, Sao Tome & Principe, South Africa, Swaziland, United Republic of Tanzania, Togo, Zambia and Zimbabwe.
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78. Botswana, Kenya, Nigeria, Rwanda, United Republic of Tanzania, Uganda and Zambia.
79. Burkina Faso, Democratic Republic of Congo, Ethiopia, Kenya, Madagascar, Nigeria, Rwanda, United Republic of Tanzania, Uganda and Zambia.
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82. Lesotho, Malawi, Namibia, United Republic of Tanzania, South Africa, Uganda, Zambia and Zimbabwe.
83. Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
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91. Benin, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Ghana, Liberia, Malawi, Mauritania, Niger, Sierra Leone, South Africa, United Republic of Tanzania and Uganda.
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94. Angola, Benin, Burundi, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Ghana, Madagascar, Mauritania, Malawi, Mozambique, Niger, Nigeria and Togo.
95. Benin, Burkina Faso, Côte d'Ivoire, Gabon, Guinea, Ghana, Kenya, Liberia, Mali, Malawi, Mozambique, Niger, Nigeria, Senegal, Togo, Zambia and Zimbabwe.
96. All except Gambia, Guinea-Bissau and Uganda.
97. Botswana, Burkina Faso, Burundi, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.
98. Ethiopia, Kenya, South Africa and United Republic of Tanzania.
99. Burkina Faso, Ghana, Mauritius, Nigeria, Uganda and Zimbabwe.
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103. Burkina Faso, Cameroon, Democratic Republic of Congo, Ghana, Kenya, Rwanda, Uganda and United Republic of Tanzania.
104. Benin, Burkina Faso, Swaziland, Comoros, Lesotho and Mauritania.
105. Angola, Algeria, Congo, Côte d'Ivoire, Ghana, Mauritania, Mozambique and the United Republic of Tanzania.
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108. Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.

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