AFR/RC55/2

The Work of WHO in the African Region

2004

Annual Report of the Regional Director

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville

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To the fifty-fifth session of the
Regional Committee for Africa,
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WORLD HEALTH ORGANIZATION
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The Regional Director has the honour of presenting to the Regional Committee the report on the activities of the World Health Organization in the African Region during the year 2004.

Dr Luis Gomes Sambo
Regional Director

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ABBREVIATIONS

AACHRD	African Advisory Committee for Health Research and Development
ACT	artemisinin-based combination therapy
AED	Academy for Educational Development
AFRO	Regional Office for Africa
AGFUND	Arab Gulf Program for United Nations Development Organizations
AIDS	acquired immunodeficiency syndrome
AM	artemether
APADOC	Alliance of Parents, Adolescents and Communities
AQ	amodiaquine
ARCC	African Regional Certification Commission
ART	antiretroviral therapy
AS	artemisinin
AU	African Union
AWARE-RH	Action for West Africa Region Reproductive Health and Child Survival Project
BASIC	British Association for Immediate Care
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CMH	Commission on Macroeconomics and Health
CREPA	*Centre Régional pour l'Eau Potable et l'Assainissement*
DFID	Department for International Development (UK)
DOTS	directly-observed treatment short-course
DPT	diphtheria pertussis tetanus
EC	European Commission
EDCTP	European and Developing Countries Clinical Trials Partnership
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
FGM	female genital mutilation
FP	family planning
FTCT	Framework Convention on Tobacco Control
GAEL	Global Alliance for the Elimination of Leprosy
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPN	global private network
GTZ	*Gesellschaft für Technische Zusammenarbeit*
HIV	human immunodeficiency virus
HQ	headquarters
HRH	human resources for health
ICT	intercountry team
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IOM	International Organization for Migration
IPT	intermittent preventive treatment
IPTp	intermittent preventive treatment for pregnant women
ITN	insecticide-treated net
LF	lymphatic filariasis
LLIN	long-lasting insecticidal net
LM	lumefantrine
MAP	Multisectoral AIDS Programme
MDG	millennium development goal
MIP	malaria in pregnancy
MOSS	minimum operating security standards

NCD	noncommunicable disease
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization
NID	national immunization day
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission (of HIV)
RH	reproductive health
RHL	reproductive health library
RIACSO	Regional Interagency Coordination Support Office
RMB	Roll Back Malaria Initiative
SADC	Southern African Development Community
SIA	supplemental immunization activity
SP	sulfadoxine-pyrimethamine
SPP	Strategic Partnership Programme
STI	sexually-transmitted infection
SWAp	sector-wide approach
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

INTRODUCTION

1. This annual report of the Regional Director is a progress report on the work of the WHO in the African Region during the first year of the 2004–2005 biennium Programme Budget, which is part of the Tenth General Programme of Work (2002–2005).

2. The period covered by the report marks a transition in the management of the Regional Office. This period ends the mandate of Dr Ebrahim Malick Samba as Regional Director and opens a new chapter in the work of WHO in the African Region with the election of Dr Luis Gomes Sambo as the new Regional Director.

3. As indicated by WHO representatives, several successes have been noted. These include improved performance, improved staff strength, better quality staff, improved quality of technical support to countries, interventions of better quality, as well as rapidly increasing funding from Other sources.

4. However, there are still many important challenges. These include weak and fragmented health systems; inadequate resources for scaling-up proven cost-effective interventions; limited access by the poor to available health technology and services; inadequate management of human resources for health which worsens the brain drain; weak application of policy to address health determinants; limited information for decision-making; recurrent natural and human-made disasters and emergencies; and extreme poverty.

5. To face these challenges, the Programme Budget 2004–2005 has identified certain areas of work as priorities; some of these are new priorities and others were previously stated in the Programme Budget 2002–2003. Protection of Human Environment is a new priority, whereas Making Pregnancy Safer, children's health, health systems and essential medicines continue as priorities from the previous budget.

6. This report presents a review of the progress made in responding to regional and country priorities through all areas of work that have been grouped under the relevant divisions. It reflects the achievements made by the Regional Office as well as the 46 WHO country offices in support of health development in the African Region.

7. The content of the report is organized in two main parts. Part I describes the significant achievements as well as the main enabling and constraining factors. Part II describes the progress made in the implementation of resolutions adopted at various sessions of the Regional Committee. The implementation rates of Regular budget and Other sources funds are summarized in the three annexes.

PART I: PROGRAMME BUDGET 2004–2005 IMPLEMENTATION FOR THE YEAR 2004

SIGNIFICANT ACHIEVEMENTS

GENERAL PROGRAMME DEVELOPMENT AND MANAGEMENT

8. Under General Programme Development and Management, interventions in the eight areas of work focus on enhancing capabilities for transparency and accountability, supporting country teams, mobilizing extrabudgetary resources, generating evidence-based information, participating in institutional decision-making, applying results-based management, strengthening knowledge, and disseminating reliable and timely information.

Director-General, Regional Directors and Independent Functions (DGO)

9. In spite of some progress in health, the health status of the population in the world and especially in Africa requires increased coordinated efforts involving all levels of the World Health Organization. Countries have been at the centre of WHO policy and intervention, especially countries in difficult situations. Being a technical agency, WHO has essential functions as an advocate among partners for increased and sustainable investments in health and as the high-level policy and technical adviser to Member States.

10. WHO has been involved in many high-level advocacy activities. It has also embarked on initiatives to sustain and expand health partnerships globally and regionally. As a result, health and other human development issues have been on the agendas of various international forums. WHO has provided policies, resolutions and guidance to countries with a view to improving WHO capacity in responding to country needs. In addition, the Organization provided technical and financial support to all Member States, with special attention given to countries in difficult situations.

11. Some of the major achievements include:

(a) improved collaboration between WHO and various health development partners through high-level advocacy and participation in several international and regional forums on health-related issues;

(b) closer contact with countries through advocacy visits to Heads of State and Government and policy-makers in the African Region;

(c) improved working relationship with headquarters through intensified consultation and coordinated efforts, focusing on countries, as well as increased HQ participation in Regional Committee meetings and Regional Programme meetings;

(d) improved country capacity to cope with special situations such as earthquakes, arms explosions, floods, epidemics, drought and displacement;

(e) disbursement of seed monies from the Regional Director's Development Fund to vulnerable groups in greatest need, including AIDS orphans, street children, women in particularly difficult circumstances[1] amounting to a total of US$ 206 600;

(f) contribution to the implementation of key priority programmes such as prevention and management of HIV/AIDS, malaria, tuberculosis, childhood illnesses and maternal complications in several countries.

[1] In the following countries: Angola, Cameroon, Republic of Congo, Gambia, Kenya, Liberia, Madagascar, Senegal.

WHO's Presence in Countries (SCC)

12. Mainstreaming the Country Focus Policy across the Organization has brought the health needs of countries onto centre stage. However, in their Country Cooperation Strategies, Member States requested WHO to take a more technical leadership role in facilitating partnerships at country level and to support countries to strengthen their health systems.

13. The WHO response is based on the needs articulated in the Country Cooperation Strategies. These emphasize promotion of programme and technical support as well as enhancement of country team competencies for effectively responding to national demands.

14. Major achievements of this area of work include:

(a) completing CCS articulation in six additional countries, bringing the total to 45 strategy documents;

(b) undertaking an in-depth analysis of the country cooperation strategy documents and presentation to the Regional Programme Meeting (RPM 33) to give programme direction and focus to the regional and country offices;

(c) convening a workshop in Nairobi of 45 senior management staff from country, regional and headquarters offices to put in place a new way of working across levels and programmes in WHO as well as propose a five-component framework for undertaking result-oriented strengthening of WHO support for more effective response at country level;

(d) embarking on region-wide systematic strengthening of WHO support to countries for better health outcomes, starting with Kenya, Malawi and Tanzania, using the five-component framework that takes cognizance of the Country Cooperation Strategy; integrating health systems development; re-profiling country teams; strengthening administrative, financial and knowledge management capacities; and developing a "One-country" plan and budget;

(e) convening two Regional Programme Meetings for WHO representatives, technical advisers of the African Region and participants from headquarters;

(f) participating in two inter-regional Country Support Unit Network meetings in Copenhagen and Cairo and one inter-regional planning officers meeting in Washington DC, with outcomes leading to development of a global CCS template; strengthened articulation between the CCS, planning process and allocation of resources; strengthened WHO support to national health systems; and refined results-based management framework and the Eleventh General Programme of Work.

Resource Mobilization and External Cooperation and Partnerships (REC)

15. Considering the dwindling resources in most countries of the Region and the rapidly-deteriorating health of the populations, special emphasis was put on extrabudgetary resource mobilization. Intensive information and communication activities were supported to increase awareness of health issues and to promote both the work and visibility of the Organization in the Region.

16. Improved project management capacities at regional and country levels have increased partner confidence in WHO. As a result, more and more funding institutions are choosing WHO as the implementing agency for their health projects in countries.

17. In the year 2004, a total of 19 cooperation agreements were signed with various funding institutions and partners for the implementation of projects in Member States.[2] Agreements with the World Bank, African Development Bank, United States Agency for International Development, Ford Foundation, International Atomic Energy Agency, African Intellectual Property Organization and various nongovernmental organizations totalled over US$ 15 000 000. These results have been facilitated by better mutual understanding of funding and implementation procedures with partners as well as improved collaboration and exchange of information between Regional Office divisions, headquarters and countries.

18. Efforts are still being made to refine project implementation and monitoring capacities as well as resource mobilization capacities through training workshops on negotiation skills for all staff.

19. Activities undertaken in the area of public information and communication include the production and dissemination of audiovisual material for broadcast by the electronic media nationally and regionally; the preparation of press releases and feature articles; the organization of press briefings and conferences; and the publication of periodicals such as the *African Health Monitor*.

Evidence for Health Policy (GPE)

20. The main issues in Evidence for Health Policy are the weak culture for generating and utilizing evidence in decision-making; low investment in generation and dissemination of evidence for health at both regional and country levels; limited capacities in ministries of health for generating evidence; dearth of reliable, timely and usable information on vital registration systems; cost, effectiveness and efficiency of interventions (and health facilities) for the poor.

21. The WHO response comprised provision of strategic direction and appropriate support to countries for the growth of evidence generation capacities in the African Region. The African Health Economics Advisory Committee was established and convened its first meeting in November. A plan of action for strengthening health information systems at regional and country levels was prepared, including the establishment of a regional integrated database. A new version of the health indicators database was designed and tested, and is in the process of implementation. In close collaboration with the Information and Communication Technology Unit and the AFRO Website Committee, web site publishing was initiated, including hosting of country web sites at headquarters.

22. The Strategic Health Economics Plan for the WHO African Region: 2006–2015 was drafted, and a revised edition of the draft pamphlet on basic indicators was prepared. Technical documents were produced on the status of national research bioethics committees in the WHO African Region; productivity growth, technical progress and efficiency change among public hospitals in Angola; documentation of best practices in health; and determinants of health insurance ownership among South African women.

Governing Bodies (GBS)

23. The WHO Governing Bodies are administrative and policy structures in charge of drawing up health policies and ensuring their implementation. In Africa, in particular, health policies aim to ensure sustainable development of Member States. The Governing Bodies have the responsibility to ensure that WHO delivers on its commitment to advise countries and provide them with technical support to enable them to implement their health policies. Attaining these objectives is still a challenge which WHO must meet.

24. In 2004, special emphasis was placed on information dissemination between countries, country offices, the Regional Office and headquarters. This new drive enabled Member States to participate effectively in the various meetings of the WHO Governing Bodies. The fifty-fourth session of the

[2] Botswana, Chad, Gambia, Kenya, Liberia, Madagascar, Mauritania, Tanzania, Togo, Swaziland.

Regional Committee was held in Brazzaville which saw the election of Dr Luis Gomes Sambo, former Director of Programme Management, to the post of Regional Director.

25. African delegations participated in, and contributed significantly to, the one-hundred-and-thirteenth Executive Board and the Fifty-seventh World Health Assembly. The commitment of the African delegations helped decisively to ensure that health realities in the African Region were taken into account in the Governing Bodies' directives and recommendations.

Programme Planning, Monitoring and Evaluation (BMR)

26. The Regional Office, in line with the implementation of managerial reform in WHO, focused on the introduction of results-based management supported by consistent and uniform processes for planning, budgeting, implementing, monitoring and reporting. These remain continuous programme management issues in the Region. A new and difficult task is integrating the Country Cooperation Strategies into the WHO managerial processes at country level.

27. Approaches to programme planning, monitoring and evaluation are constantly changing in response to emerging health challenges, the scarcity of resources and the quest to improve service delivery to Member States. Progress has been made in the past two biennia in terms of consistency and uniformity of planning and monitoring processes, but more work needs to be done with quality control, performance measurements and monitoring tools. A further challenge is to condition WHO staff to utilize programme management processes and associated tools and technology.

28. Interaction at planning stage involves headquarters, regional and country levels; this process has been institutionalized in the African Region to streamline WHO support to country offices. Performance measurements such as deliverable products or services and performance indicators as well as traditional financial measurements have been introduced and are widely used in the Region. With the deployment of the Activity Management System, the Regional Office and 11 country offices[3] have a programme planning and performance monitoring information system. WHO staff and their counterparts in the ministries of health were briefed in results-based planning and performance monitoring.

Research Policy and Promotion (RPC)

29. The main focus of research in 2004 was to assist countries to identify and conduct research and come up with interventions for the achievement of the health and health-related Millennium Development Goals (MDGs). A regional consultation meeting of researchers and policy-makers was held in Brazzaville, Congo, from 14 to 16 April to finalize the draft of the World Report on Knowledge for Better Health. Participants recommended that governments take ownership, provide leadership and develop national health sector policies and strategies that create an enabling environment to support research relating to the MDGs. In addition, governments should demonstrate active commitment to transforming research findings into policies and strategies for delivery of the MDGs.

30. The Regional Office provided financial and technical support to Algeria and Cape Verde for developing health research policies. Five countries[4] participated in a health research systems analysis using tools developed by WHO with the aim of ultimately strengthening their systems.

31. The African Advisory Committee for Health Research and Development met 27–29 October and developed an African voice document for presentation at the Ministerial Summit on health research in Mexico City, 16–20 November. The Summit was meant to encourage the international community to invest more resources in health research. The AACHRD further assisted in developing

[3] Burundi, Cote d'Ivoire, Eritrea, Guinea, Kenya, Madagascar, Mauritania, Mozambique, Namibia, Niger, Rwanda.
[4] Cameroon, Ghana, Kenya, Senegal, Tanzania.

an African position on the International Convention Against the Reproductive Cloning of Human Beings.

32. The European and Developing Countries Clinical Trials Partnership held its first forum in September to review the initial phases of projects, some of which include capacity building for African researchers. The target diseases are HIV/AIDS, malaria and tuberculosis; many projects concern using new medicines and vaccines for these killer diseases, a response to the Abuja Summit of 2000.

Health Information Management and Dissemination (IMD)

33. Reliable and timely information is vital in the development, production and distribution of all goods and services. In the health sector, information enriches and guides health workers, policy-makers, researchers and the general public. It is a major tool in health promotion, and in disease prevention and control. Unfortunately, good, reliable and up-to-date information is not easily accessible, even when it exists. Obstacles to accessibility include poor communication, cost and the nature of the information to be conveyed. The Health Information Management and Dissemination area of work is responsible for editing, translating, printing, disseminating and conserving all documentation produced in the Regional Office. The WHO responsibility remains the provision of timely evidence-based health and biomedical information for use by Member States, partners, staff and the general public.

34. During the period under review, all documents for the fifty-fourth session of the Regional Committee were edited, translated, published and sent to Members States in the three working languages of the Region.

35. The Health Information Management and Dissemination Unit was equipped to upgrade information production in the Regional Office. At the same time, more training manuals, handbooks, guidelines and modules were published or are in the process of being published in order to assist programme implementation. The Regional Office continued to work with the Forum for African Medical Editors to stimulate research, improve the quality of health journals in Africa and increase the visibility of health informaion.

36. The Regional Office Library was reopened and renovated. The library database now contains over 1200 bibliographic entries (some of them in full text) and continues to publish the bulletin *Info Digest*. To promote the Blue Trunk Libraries, staff trained 60 more managers from four countries.

37. A multi-media centre for training staff and other researchers on the use of the Internet is now operational. The Regional Office took part in the Ninth Congress of the Association of the Health Information Libraries in Africa held in Malawi, 24 to 29 October.

HEALTH SYSTEMS AND SERVICES DEVELOPMENT

38. The health systems in the countries of the African Region have continued to worsen in the face of inadequate financing, human resource crises and inadequate access to essential medicines and health technology, including access to safe blood. This situation has contributed greatly to the poor prevailing health indicators, a challenge to the achievement of the Millennium Development Goals.

39. The Division of Health Systems and Services Development, poised to address the current situation, is responsible for three areas of work, namely Organization of Health Services; Essential Medicines: Access, Quality and Use; and Blood Safety and Clinical Technology.

Organization of Health Services (OSD)

40. In response to insufficient human, financial and material resources, countries are undertaking health reforms to reduce inequity, promote universal coverage and improve efficiency in order to make progress towards meeting the MDGs. Countries are consequently asking for policy guidance for implementation of their reforms. The WHO response has been to develop knowledge databases on health systems, enhance capacity building, and establish and support focused initiatives.

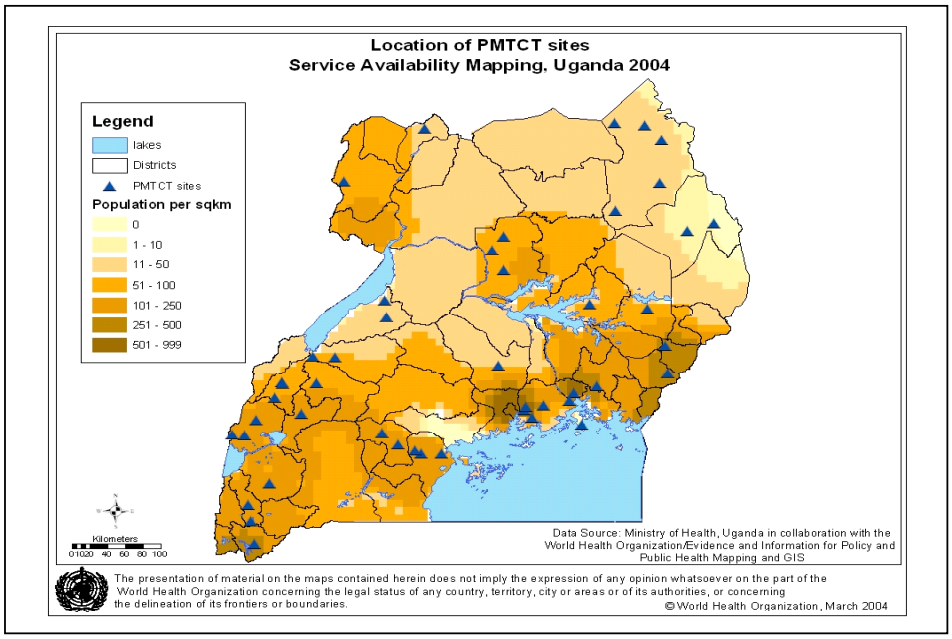
41. A major effort during the period under review has been towards building capacity among WHO staff and key personnel in countries to enable them to effectively carry out their work in health systems development. In this regard, a meeting of directors of medical services and other high-level officials was held to review the operationalization of health systems at local level. The meeting participants reconfirmed the district health systems approach approved by the Regional Committee in 1987 and encouraged all countries to operationalize their health systems based on this concept. To support this, the Regional Office developed and provided guidelines to countries for use in formulating their national health policies and plans, as well as in operationalizing district health systems. Five countries[5] developed or reviewed their national health policies or strategic plans.

42. Countries are showing a keen interest in developing alternative financing mechanisms such as health insurance. Work on national social health insurance development is on-going in Ghana, Kenya and Zambia. In Kenya, a national health insurance scheme was approved by parliament and implementation continues. Five countries[6] undertook national health account activities: a situation analysis in Botswana and Seychelles, an orientation workshop for government officials in Chad, a training workshop for technical officials from the Economics Department of the University of Zambia, and a training course in Ghana (with participants from Gambia, Ghana, Nigeria and Sierra Leone).

43. In an effort to strengthen national health information systems in the African Region, the fifty-fourth session of the Regional Committee adopted the document, "Priority interventions to strengthen national health information systems" (AFR/RC54/12 Rev 1). Using this guidance, the Regional Office supported ten countries[7] in strengthening information by assessing their systems, developing policy and plan documents or reviewing their health information collecting tools. The health service availability mapping tool was introduced in Kenya, Rwanda, Tanzania and Uganda to monitor implementation and scaling up of health programmes. Such mapping focuses on the availability of key health personnel, equipment and infrastructure. In Uganda, mapping was used to show the location of prevention of mother-to-child transmission (of HIV) sites (Figure 1), and the exercise was found to be very useful for national authorities. Activities are underway to use such mapping in five other countries.[8]

[5] Burundi, Central African Republic, Gabon, Mauritania, Tanzania.
[6] Botswana, Chad, Seychelles, Swaziland, Zambia.
[7] Burkina Faso, Cape Verde, Chad, Comoros, Republic of Congo, Namibia, Nigeria, Seychelles, South Africa, Tanzania (Zanzibar).
[8] Botswana, Burkina Faso, Mozambique, Nigeria, Tanzania.

Figure 1: Service availability mapping, Uganda, 2004



Source: World Health Organization, March 2004

44. A recent survey[9] revealed that 42% of the 31 countries which responded had development plans for human resources for health, while 55% did not; 45% indicated having a policy and strategy document. In response, the Regional Office provided support to 19 countries[10] to conduct an in-depth situation analysis and review to develop and implement their policies and plans.

45. In order to ensure that competent practitioners with appropriate skills are available, the Division evaluated pre-service nursing and midwifery training programmes in four countries: Ethiopia, Ghana, Rwanda and Tanzania. Results showed that educational curricula were relevant to individual country needs. Three-month training programmes held from 1998 to 2001 for various health cadres in four selected countries (Cameroon, Mali, Namibia, Uganda) and in the Regional Office were also evaluated. The results showed a high involvement of health professionals (6574 participants), relevant training programmes, good quality materials but poor coordination of training activities. It was also observed that such activities are very costly, and there is insufficient follow-up of trainees at country level. Improved coordination of all such training programmes is necessary in future.

46. Burkina Faso completed a study on the impact of HIV/AIDS on human resources for health which focused on individual perceptions of vulnerability to contracting the infection in their workplace. The results revealed that health workers are aware of their risks due to insufficient protection measures within health facilities and limited managerial support.

47. Through active collaboration with other partners, the Regional Office prepared a strategy paper on the health human resources crisis in Africa for the second high-level forum meeting on health MDGs. The forum was a breakthrough for human resources for health development. Forum decisions were to develop a plan to review fiscal constraints to personnel supply at country level, develop mechanisms to accelerate country level response and harmonize agenda, and continue collaborations with countries and all partners for implementation.

[9] WHO, *Report on human resources for health status in the WHO African Region,* Brazzaville, World Health Organization, Regional Office for Africa, 2004.

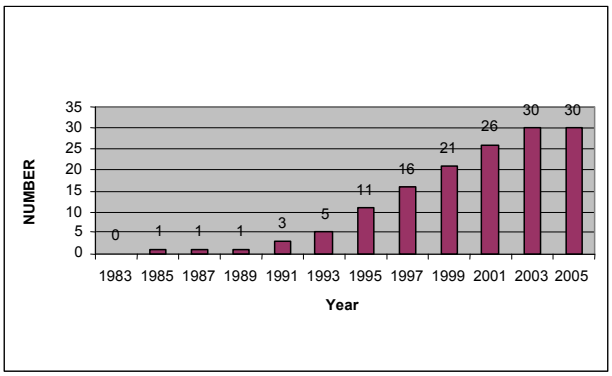
[10] Algeria, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, Comoros, Ethiopia, Guinea, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Rwanda, Swaziland, Tanzania, Uganda.

Essential Medicines: Access, Quality and Use (EDM)

48. In the African Region, there is widespread inequity in medicine supply, there is inadequate financing for medicines and about half of the people lack access to essential medicines. The main focus in this area of work was to support countries to develop, implement and monitor national medicine policies; increase access to medicines, particularly for priority health programmes; ensure safety, quality and efficacy of medicines; and improve rational use.

49. To improve access to medicines, the Regional Office supported countries in developing and implementing national medicine policies. Comoros and the Republic of Congo finalized their national medicine policies, and Senegal, Sierra Leone and Tanzania drafted or reviewed their policies within the year. Since 1983, a considerable number of countries have developed national medicine policies (Figure 2).

Figure 2: Member States with official national medicine policies, WHO African Region

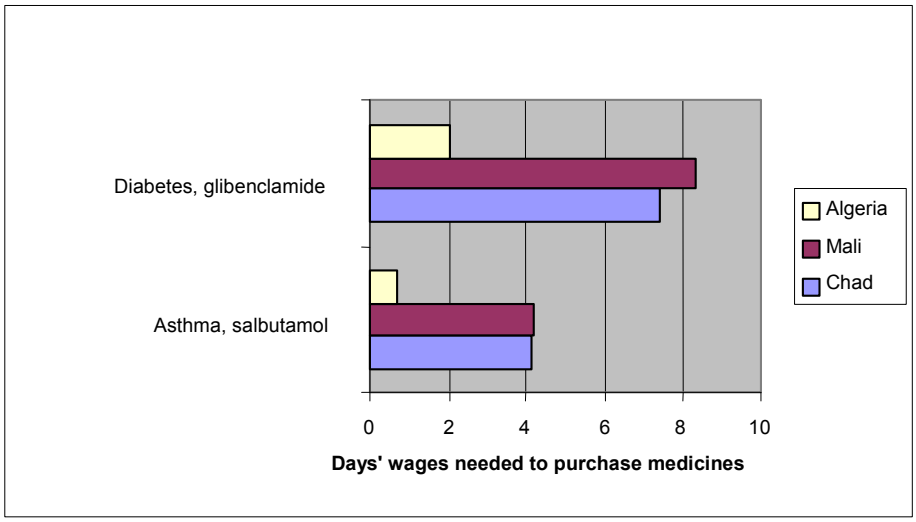


Source: WHO/AFRO/EDM

50. The Division held training workshops on medicine price surveys and trained national authorities from 11 countries[11] to carry out such surveys. Findings from the surveys indicated that the lowest-paid government workers would have to work for 4.2 days in Mali, 4.1 days in Chad and 0.7 days in Algeria in order to pay for a standard course of asthma treatment; similarly, the same workers would work 8.3 days in Mali, 7.4 days in Chad and 2 days in Algeria to pay for a one-month standard course of diabetes treatment in the private sector. Surveys on medicine prices revealed useful information that will help countries to identify possible policy actions to improve affordability of essential medicines (Figure 3).

[11] Algeria, Chad, Ethiopia, Ghana, Kenya, Mali, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe.

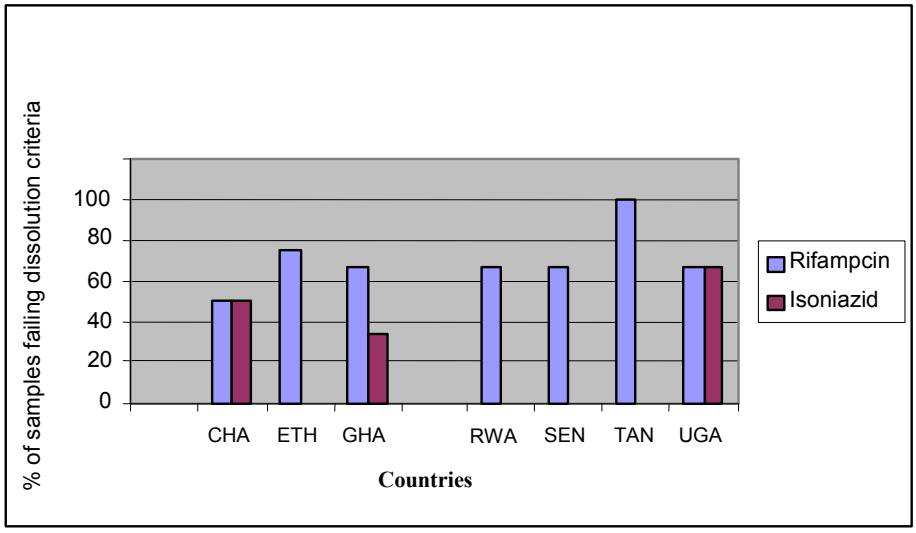
Figure 3: Affordability of standard treatments for asthma and diabetes in selected countries, 2004



Source: WHO/AFRO/EDM

51. With support, five countries[12] strengthened their medicine registration systems. WHO experts evaluated and re-designated collaborating centres for quality assurance of medicines in Potchefstroom, South Africa and Algiers, Algeria. Eritrea established an adverse drug reaction monitoring centre; advisers evaluated and supported national drug regulatory authorities in Ghana, Nigeria and Tanzania. Ten nationals from five countries[13] were trained in medicine quality control and managing analytical laboratories. Officials in nine countries[14] collected and analysed samples for quality control of anti-tuberculosis medicines, including rifampicin, isoniazid and their combinations. Results revealed some deficiencies in active ingredients and dissolution profiles (Figure 4).

Figure 4: Quality control of anti-tuberculosis drugs, selected countries, 2004



Source: WHO/AFRO/EDM

52. Regional experts finalized the book, *African traditional medicine: The journey so far*. The second African Traditional Medicine Day was commemorated on 31 August with the theme, "Moving

[12] Cape Verde, Guinea, Mali, Niger, Senegal.
[13] Cameroon, Mali, Niger, Nigeria, Uganda.
[14] Cameroon, Chad, Ethiopia, Ghana, Nigeria, Rwanda, Senegal, Tanzania, Uganda.

the African health agenda forward with traditional medicine". The Regional Office supported the Republic of Congo, the Democratic Republic of Congo, Malawi and Nigeria to develop national policies; Malawi and Nigeria to develop legal frameworks for the practice of traditional medicine; and Malawi to create codes of ethics and practice.

53. In collaboration with the African Union Scientific and Technical Research Commission, the Division assessed the situation of local production of traditional medicines to identify areas for support in Burkina Faso, Democratic Republic of Congo, Ghana, Madagascar and Nigeria. The WHO Regional Expert Committee on traditional medicine met in Brazzaville, 16 to 19 November, and it included an exhibition of samples of traditional medicines. The national drug regulatory authorities in Madagascar and Nigeria provided marketing authorization for traditional medicine products for diabetes and sickle-cell anaemia.

Traditional medicines available in new packaging

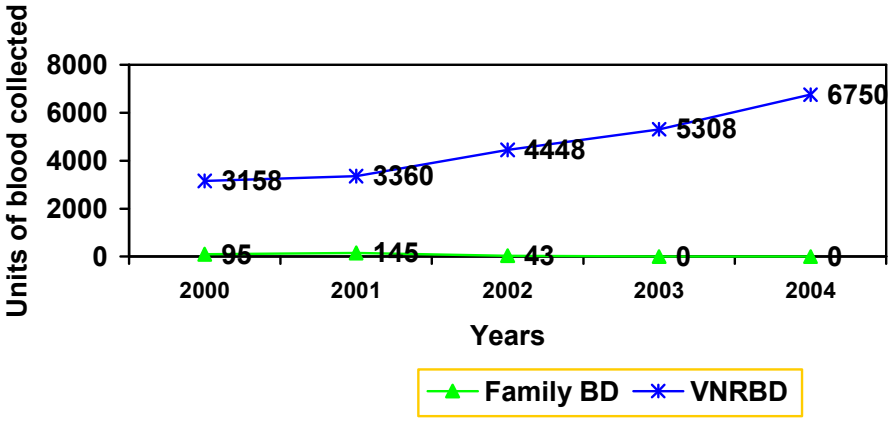
Blood Safety and Clinical Technology (BCT)

54. As countries scale up interventions to tackle major diseases, the need for essential technology increases. Thus, there is need for development and implementation of technology and blood safety policies, improvement of capacity building for quality care in health services, development and dissemination of guidelines, and development and implementation of national standard operating procedures and corrective measures.

55. The Blood Safety and Clinical Technology area of work supported Lesotho, Madagascar, Rwanda and Tanzania (Zanzibar) to finalize their national blood policies. The unit also conducted a detailed situation analysis of blood transfusion services in Ethiopia and Namibia, and assisted the Democratic Republic of Congo to devise a strategic plan for development of blood transfusion services.

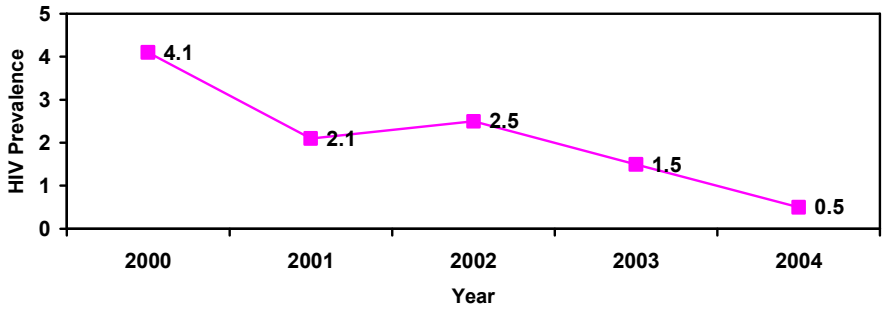
56. The unit held two national training workshops for donor recruiters in Burkina Faso. As a result of that training, the blood donor recruitment system has improved and all blood donors recruited in Bobo Dioulasso are now voluntary (Figure 5). This improvement has also led to the decrease of HIV prevalence among blood donors (Figure 6).

Figure 5: Blood donations in Bobo Dioulasso, Burkina Faso



Source: Blood Transfusion Centre, Bobo Dioulasso, Burkina Faso, 2004

Figure 6: HIV prevalence among blood donors in Bobo Dioulasso, 2000–2004



Source: Blood Transfusion Centre, Bobo Dioulasso, Burkina Faso, 2004

57. In Bobo Dioulasso, Burkina Faso, 50 medical practitioners attended a national workshop on clinical use of blood. During the workshop, the national guidelines on clinical use of blood were finalized and the decision was made to transfuse only the needed component to individual patients. Since then, blood transfusion services in Bobo Dioulasso are preparing blood components.

58. The National Centre for Tranfusion Services in Abidjan started the regional external quality assessment scheme for blood group serology; 15 countries are involved in the process, and 90% of the results received were satisfactory. Corrective measures are being taken to improve quality in blood transfusion services with poor performance.

59. In Ethiopia and Namibia, a total of US$ 416 939 was raised to support national blood programmes. After the situation analysis and needs assessment, priority was given to capacity building, organization and management, data collection and information management, voluntary blood donation, and a study on funding and sustainability of blood transfusion services.

60. To improve performance of laboratory services, the Regional Office supported the design and implementation of the Essential Laboratory Technology Package in two district hospitals in the Republic of Congo. Guinea, Mali and Niger conducted rapid assessments of national quality

assurance programmes and drafted action plans to implement corrective measures. In Cameroon, the radiology centre for continuing education of radiographers and radiologists from west and central Africa trained a core group of 16 national trainers in radiology.

61. Surveys conducted in Kinshasa and some provinces of Democratic Republic of Congo raised great concern about the high risk of irradiation in and around diagnostic imaging services. The Regional Office provided support to train radiographers, supervise and check up or maintain X-ray devices in use, and supply personal dosimeters.

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

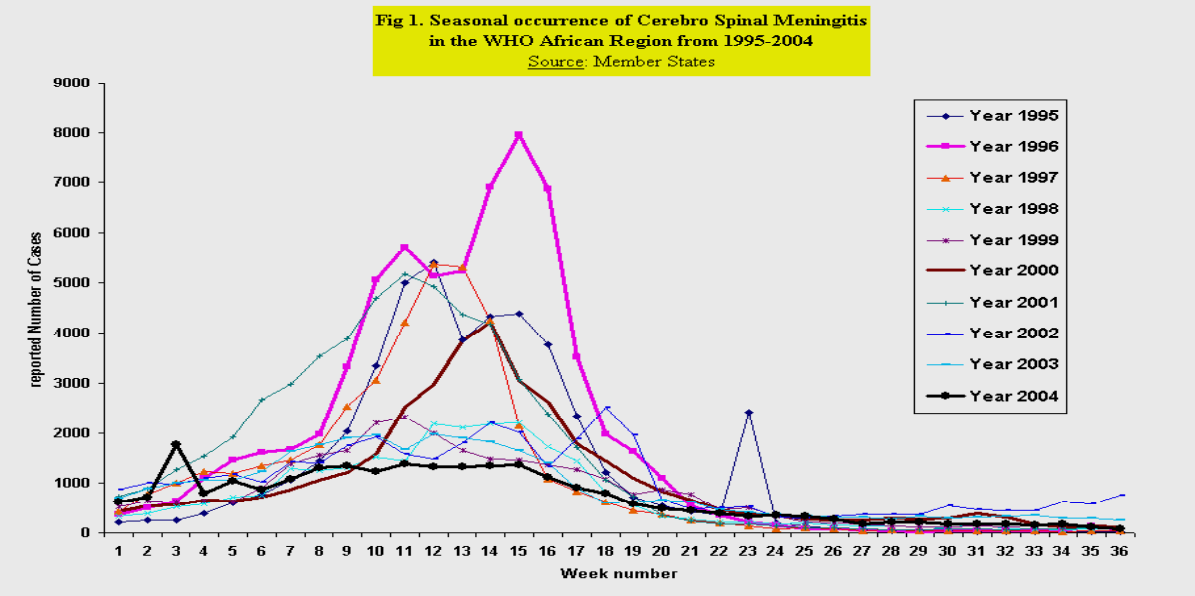
Communicable Disease Surveillance (CSR)

62. National disease surveillance systems are still weak, and various factors contribute to the re-emergence of previously controlled epidemic-prone diseases. Trained staff, critical supplies and logistics are often insufficient. As a consequence, existing control measures have limited effect on the course of epidemics. Globally, threats to international health security necessitated the revision of the International Health Regulations with the participation of Member States.

63. The Integrated Disease Surveillance Strategy approved by the Regional Committee for Africa provides a policy basis for strengthening national disease surveillance and response systems. The support provided to Member States aims at strengthening health staff, laboratory and data management capacities as well as disease reporting, epidemic response, and monitoring Integrated Disease Surveillance and Response (IDSR) implementation.

64. By the end of the year, 26 countries were submitting monthly disease surveillance reports, and regular feedback information was provided to Member States (see Figure 7 for meningitis surveillance data).

Figure 7: Seasonal occurrence of cerebrospinal meningitis, WHO African Region, 1995–2004



Source: Data from Member States

65. Ten additional countries developed training material in IDSR for district health personnel; 12 countries trained health workers in charge of IDSR in at least 60% of the districts. IDSR was introduced in two regional courses in applied epidemiology for senior health personnel in Kenya and Mali. The Regional Office strengthened regional capacity for epidemic response by orientating 56 experts in epidemic rapid response. In addition, it trained laboratory experts from 10 plague-endemic countries in diagnosis of this disease and 12 senior microbiologists from six countries in laboratory management. More than 80% of reported outbreaks were confirmed by laboratory tests.

66. The Division provided timely technical support to countries confronted with epidemics of cholera, meningitis, yellow fever, hepatitis E and aflatoxin poisoning. The Regional Office provided support to accredit eight subregional and two regional public health bacteriology reference laboratories, to extend the regional laboratory external quality assurance programme to all national bacteriology reference laboratories, and to install a bacteriology laboratory in the Multidisease Surveillance Centre of Ouagadougou. As part of a global effort, delegates from 32 Member States participated in the revision of the International Health Regulations.

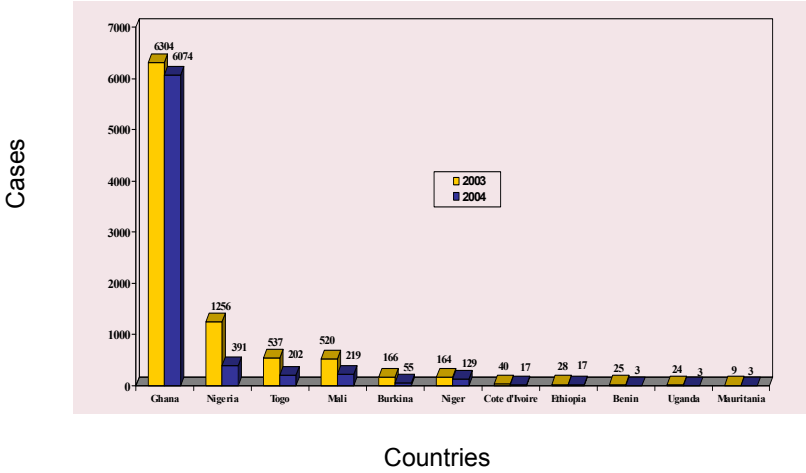
Communicable Disease Prevention, Eradication and Control (CPC)

67. The diseases under consideration in the Communicable Disease Prevention, Eradication and Control area of work are known to affect mostly poor and neglected segments of the populations. These diseases have low profiles in most affected Member countries.

68. The final phase of eradication of guinea worm faces donor fatigue. Moreover, the dramatic decrease of the incidence of the disease has a negative impact on government financial commitment and community participation in endemic countries. Over the years, achieving and sustaining mass treatment coverage rates compatible with elimination goals has proved to be difficult. Revival of vector control is hindered by limited capacity at country level. The main WHO response has been to provide technical support to affected countries to (i) build national capacity, (ii) develop appropriate strategies and plans of action to fight disease, (iii) monitor and evaluate control interventions and (iv) conduct advocacy activities.

69. During the year, 7113 cases of guinea worm were reported compared to 9179 cases in 2003 (see Figure 8); this represents a 22.5% reduction. A total of 11 countries was certified free of guinea worm transmission. The prevalence rate of leprosy decreased to 0.8 cases per 10 000 inhabitants and three countries reached the elimination goal, bringing the total to 39 out of 46 Member countries.

Figure 8: Guinea worm cases notified by country 2003–2004



70. Countries carried out assessment of lymphatic filariasis disease burden. Malawi completed mapping, and Cape Verde and Guinea-Bissau started the exercise. All nine countries[15] that started LF mass drug administration successfully conducted their annual treatment. Mali is preparing for the first round of mass drug administration.

71. Burkina Faso, Cameroon, Mali and Mozambique launched national deworming programmes while Lesotho, Niger and Zambia collected baseline data as part of the preparations for treatment. While scaling up its schistosomiasis and soil-transmitted helminths control programme, Uganda also repeated the linking of deworming with measles vaccination campaigns.

72. The Division provided support to 20 countries[16] to conduct situation analyses or scale up case detection and treatment for human African trypanosomiasis in priority areas. As of October, those countries reported 13 000 new cases in the 1.5 million persons examined.

73. WHO supported distribution of free insecticide-treated nets (ITNs) to vulnerable groups, mass re-treatment of nets and linking ITN delivery programmes with immunization activities. Ghana distributed ITNs during national immunization days (NIDs) in 10 districts, and Togo distributed about 750 000 nets countrywide during a measles campaign in December.

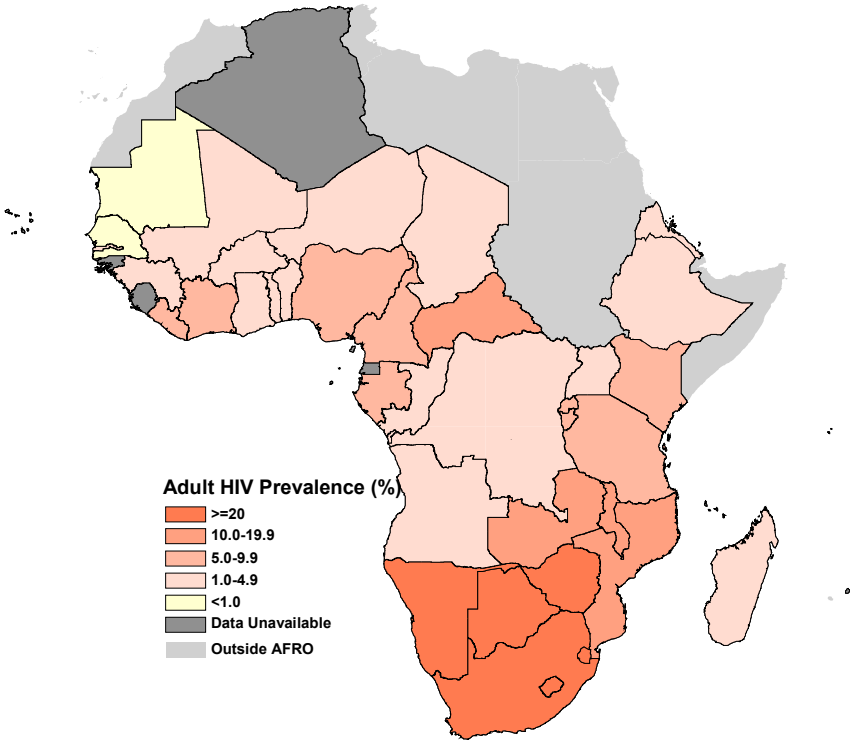
Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV)

74. The HIV/AIDS burden is still high in the African Region despite early indications of HIV prevalence stabilizing in central and west Africa and declining in some east African countries. Southern Africa remains worst-affected (Figure 9). Expanding access to antiretroviral therapy was a priority in the past year, in line with The 3 by 5 Initiative of placing 3 million people in developing countries on treatment by the end of 2005 and in order to contribute to the achievement of the Millennium Development Goals. Coverage of HIV/AIDS interventions continues to be too low.

[15] Benin, Burkina Faso, Comoros, Ghana, Kenya, Nigeria, Tanzania, Togo, Uganda.

[16] Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Gabon, Guinea, Kenya, Malawi, Mozambique, Tanzania, Togo, Uganda, Zambia, Zimbabwe.

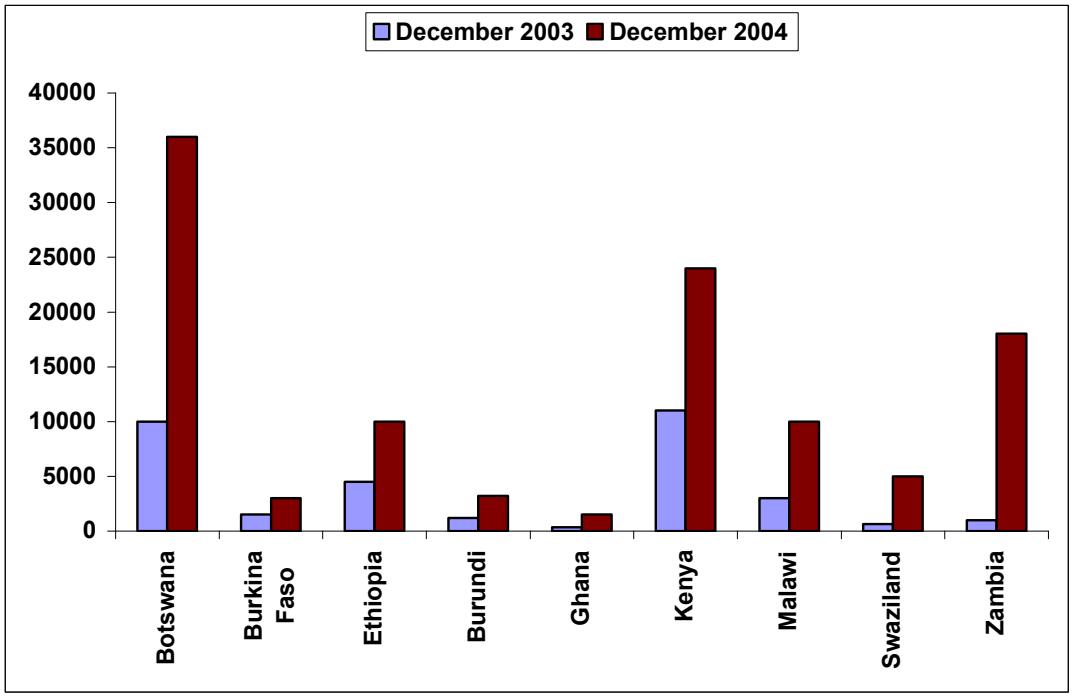
Figure 9: Adult HIV prevalence, WHO African Region, end of 2003



Source: UNAIDS/WHO, Report on the global AIDS epidemic, 2004

75. Normative guidance and technical support to countries were provided in the delivery of health sector interventions for HIV/AIDS prevention, treatment and care, mobilizing technical expertise and strengthening national capacity in partnership with other key stakeholders. Advocacy on The 3 by 5 Initiative resulted in 30 countries scaling up antiretroviral therapy (ART) and adopting the public health approach to service delivery; 22 have since developed and started or accelerated the implementation of national treatment plans. WHO supported 14 countries to submit proposals incorporating treatment for funding by the Global Fund to Fight AIDs, Tuberculosis and Malaria (GFATM), and others to improve their implementation of previously-approved grants. The Regional Office assisted 23 countries in adaptation and training for Integrated Management of Adolescent and Adult Illness, the simplified and decentralized approach to ART delivery. Subregional knowledge hubs for ART expansion in east and west Africa conducted training, provided technical support to countries, and improved regional technical capacity for HIV/AIDS treatment and care. More than 30 of the 46 Member States carried out training in ART, resulting in increased ART coverage (Figure 10). About 325 000 PLWHA in the African Region accessed treatment by the end of 2004 compared to 100 000 at the end of 2003.

Figure 10: Number of persons receiving antiretroviral therapy, WHO African Region, selected countries, 2003–2004



Source: WHO/AFRO

76. With WHO support, 26 countries developed HIV laboratory plans, now funded through the GFATM and Multisectoral AIDS Programme (of the World Bank), and eight countries carried out antiretroviral drug resistance monitoring surveys. The Regional Quality Assurance Programme supported 42 countries to maintain the quality of HIV testing. A total of 16 countries now deliver the essential package of HIV/AIDS health system interventions at district level, especially voluntary counselling and testing, and prevention of mother-to-child transmission (of HIV) services; 20 countries are adopting the new WHO/UNAIDS policy on HIV testing and counselling and will expand provider-initiated testing to support treatment access.

77. The Regional Office strengthened national HIV/AIDS surveillance systems in 10 countries through training of trainers and national-level training. WHO, the World Bank and GFATM held training workshops in 36 countries to improve capacity to develop procurement and supply management plans. As a result, 13 countries developed plans for HIV/AIDS medicines and diagnostics.

Tuberculosis (TUB)

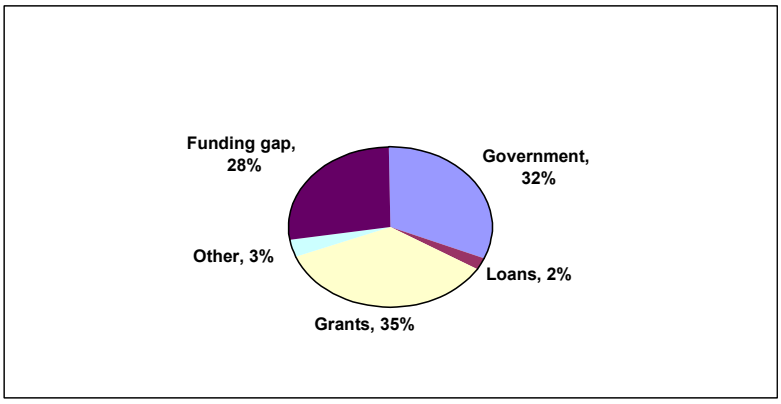
78. Critical issues in the year directly related to the achievement of World Health Assembly (WHA) and Millennium Development Goal (MDG) targets for tuberculosis control as well as Regional Committee Resolution AFR/RC44/R6 on tuberculosis control. Major concerns are the low geographical access to directly-observed treatment short-course services (DOTS); low case detection and treatment success rates; the dual epidemic of TB and HIV; and limited human and financial resources.

79. Technical and financial support for programme development and expansion dominated the WHO response. Specific interventions included technical support to countries to accelerate DOTS

expansion initiatives, access Global TB Drug Facility drugs, apply for Global Fund resources, develop human resources and monitor programme performance. Others included advocacy for sustained political commitment and resources, and partnership building, including collaboration with regional bodies such as the New Partnership for Africa's Development. The Regional Office provided technical support to six countries to develop GFATM proposals and worked with four countries to accelerate implementation of activities.

80. An accumulative total of 42 (91.3%) of the 46 Member States currently implements the DOTS strategy. This has been static for the past two years. However, all the accessible countries are now expanding the implementation of the strategy, and 29 countries have reached a population coverage of more than 90%. Several countries implemented DOTS expansion initiatives: 22 for community TB care, 15 for collaborative TB and HIV activities, and eight for public-private partnerships. To enhance country-level capacity, 17 national TB professional officers are in place in 13 countries. Based on assessments done in 32 countries, 32% of the national TB control programme budgets for 2003 were government-funded (Figure 11).

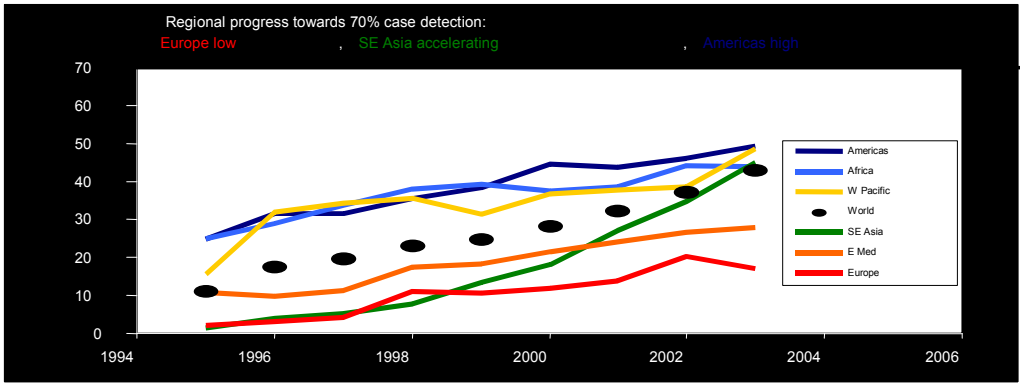
Figure 11: National tuberculosis control programmes: Budget funding sources



Source: Country TB data, 2003

81. Case detection of infectious TB cases rose from 44% in 2002 to 50% in 2003 (2004 case detection reports were completed by countries after December 2004). Although this is still lower than the 70% WHA target, it compares favourably with other WHO regions (Figure 12) and the average global rate of around 47%.

Figure 12: Tuberculosis case detection rates by WHO region, 1994–2003

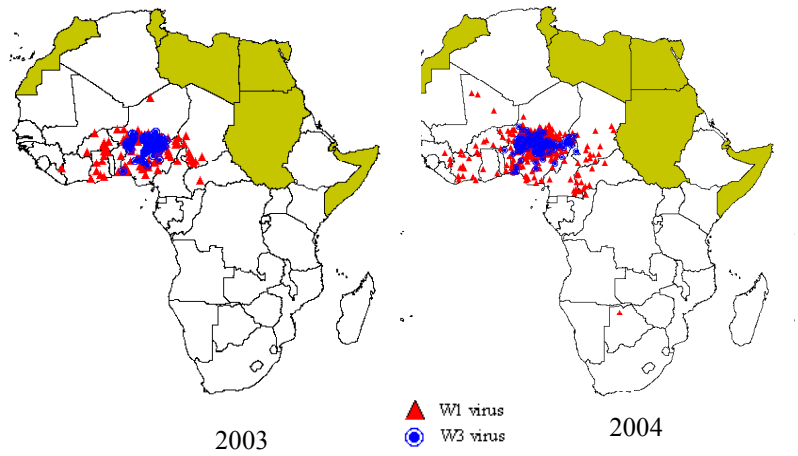


Source: WHO/HQ/TME

Immunization and Vaccines Development (IVD)

82. Vaccine preventable diseases remain major causes of morbidity and mortality in the African Region, despite a 50% reduction of measles mortality between 1999 and 2003. The Region accounted for approximately 36% of neonatal tetanus and 60% of measles cases reported globally. Niger and Nigeria continued to be the only polio-endemic foci in the Region. During the year, the intense wild poliovirus transmission in these foci spread to 13 previously polio-free countries[17] (Figure 13). Despite DPT3 vaccination coverage reaching 63%, approximately 10 million infants were not immunized, 70% of which were from Angola, Democratic Republic of Congo, Ethiopia and Nigeria (Figure 14). High costs and lack of disease burden data continued to limit the up-take of new vaccines.

Figure 13: Distribution of wild poliovirus cases, WHO African Region, 2003–2004



Updated as of 21 November 2004

Source: WHO/AFRO

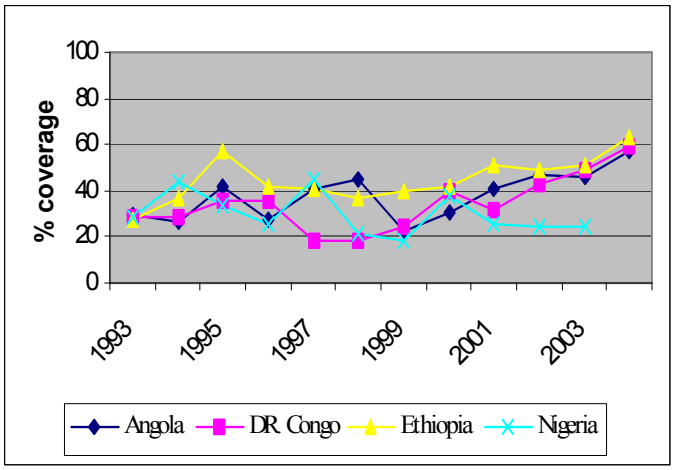
83. To address the critical issues of polio endemicity, poor access to routine immunization and high mortality due to measles and neonatal tetanus, WHO strengthened national, regional and global partnerships and mobilized resources to support interventions outlined in Resolution AFR/RC54/R8. These efforts contributed to Goal 4 of the Millennium Development Goals, that is, to reduce child mortality, the target of which is to reduce by two thirds between 1990 and 2015, the under-five mortality rate. In addition, WHO supported countries to optimally utilize available resources and the polio eradication infrastructure to accelerate routine immunization.

84. There were major achievements during the year. Five polio-free countries and 11 countries with importations of polio cases conducted nationwide polio supplemental immunization activities (SIAs). In central and western Africa, 24 countries conducted synchronized SIAs, vaccinating over 80 million children. Nigeria resolved the oral polio vaccine safety controversy, and by August all Nigerian states participated in SIAs. By September, 35 countries had achieved certification standard for acute flaccid paralysis surveillance. At least 20 countries implemented the Reach Every District strategy to improve access to quality immunization services. Angola, Democratic Republic of Congo and Ethiopia increased DPT3 coverage to 12% from the 2003 coverage of 10%.

[17] Benin, Botswana, Burkina Faso, Cameroon, Central Africa Republic, Chad, Cote d'Ivoire, Ethiopia, Ghana, Guinea, Mali, Sudan, Togo.

85. To address the high turnover of trained personnel in countries, WHO trained 87 tutors from health training institutions. The Organization supported countries to implement various control strategies: 11 countries conducted measles supplemental immunization activities, and seven countries conducted tetanus toxoid SIAs using the high-risk approach. One more country was validated to have eliminated neonatal tetanus (that is, having less than one case per district), bringing the total number of validated countries to 15 in the African Region.

Figure 14: Reported DPT3 vaccination coverage, selected countries



Source: WHO/AFRO

Malaria (MAL)

86. The availability of cost-effective interventions for malaria prevention and control creates the challenge of scaling-up to increase coverage in all at-risk and disadvantaged populations in endemic countries. Increasing and widespread resistance to antimalarials; high cost of new antimalarial drugs; unaffordable insecticide-treated bednets and long-lasting insecticidal nets (ITNs/LLINs); and poor policies to improve access by vulnerable and disadvantaged populations interferred with major interventions.

87. To face these challenges, WHO is promoting cost-effective strategies. These include improving case management using artemisinin-based combination therapy (ACT); use of ITNs or LLINs; increasing coverage with intermittent preventive treatment in pregnancy (IPTp); focused community-based activities; and operational research. Mechanisms have been developed and implemented for countries to improve health systems to take interventions close to the home. A combination of prevention, access to treatment, IPTp, and detection and response to epidemics has been promoted. In addition, global advocacy and national mobilization campaigns have been undertaken to sustain commitment for malaria control.

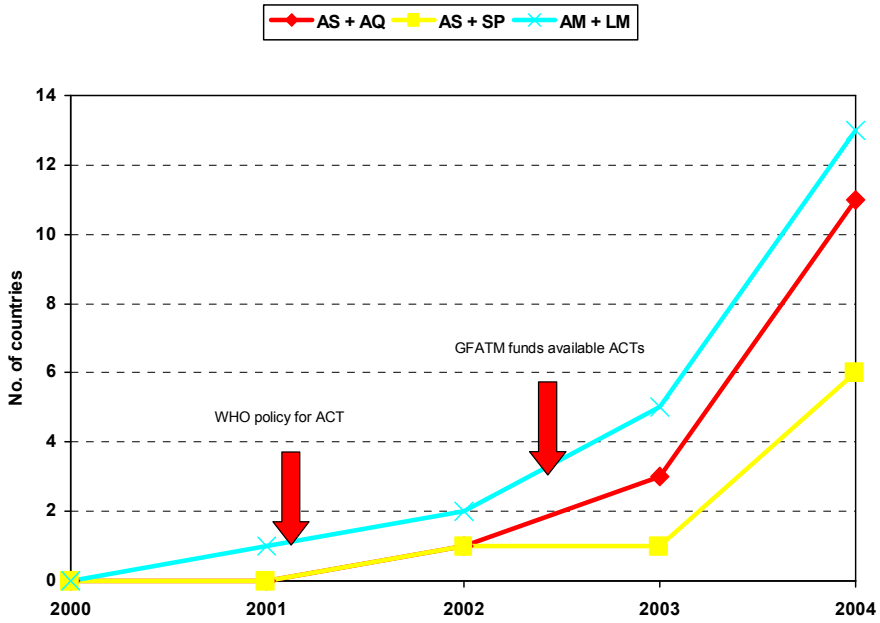
88. The Regional Office provided strategies, guidelines and country support[18] in home management of malaria and community-based interventions. To move malaria control closer to the home, the Division prepared a position paper on home management of malaria and artemisinin-based combination therapy.

[18] Cameroon, Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea, Niger, Nigeria, Togo, Zambia.

89. With WHO support, six countries[19] strengthened their traditional medicine health systems for malaria control and trained 500 traditional health practitioners in treatment and prevention of malaria utilizing sulfadoxine-pyrimethamine and ITNs. WHO and the Canadian International Development Agency supported countries to evaluate antimalarial herbal medicines. Preliminary results with *Artemisia annua* "herbal tea" indicate cure rates over 80%. The Regional Office collaborated with various countries in *Artemisia annua* cultivation projects.

90. The Regional Office developed algorithms on case management and supported five countries[20] to update treatment guidelines and training manuals following drug policy change. Thirteen countries[21] adopted ACTs for treatment of non-severe malaria, and four countries (Burundi, South Africa, Tanzania [Zanzibar], Zambia) implemented the change (Figure 15).

Figure 15: Country adoption of specific ACT



AM = artemether AQ = amodiaquine SP = sulfadoxine-pyrimethamine
AS = artemisinin LM = lumefantrine

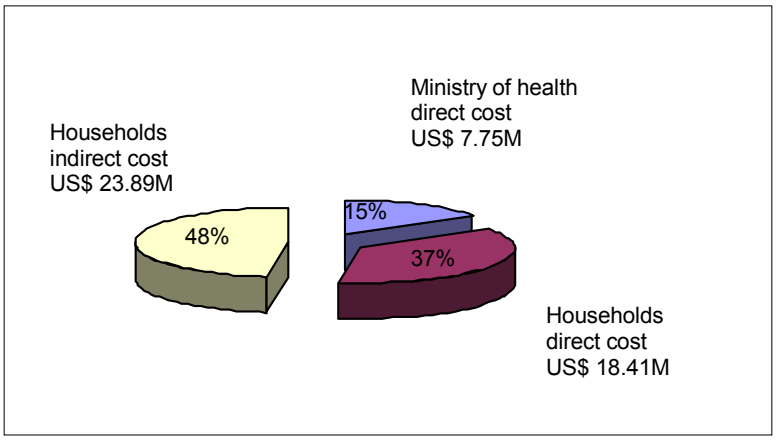
Source: WHO/AFRO

91. In collaboration with the Regional Office for the Eastern Mediterranean, the Regional Office for Africa established the Horn of Africa Network for Monitoring Antimalarial Treatment. The unit published *A strategic framework for malaria prevention and control during pregnancy in the African* Region, supported 12 countries[22] to adopt IPTp, reviewed international and national malaria course curricula against emerging needs, observed Africa Malaria Day with a regional event in Senegal, and produced the first progress report on the implementation of the Abuja Declaration plan of action.

[19] Benin, Ghana, Kenya, Mozambique, Uganda, Zambia.
[20] Benin, Burundi, Ethiopia, Ghana, Sao Tome and Principe.
[21] Benin, Cameroon, Comoros, Eritrea, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Namibia, Sierra Leone, Tanzania, Uganda.
[22] Cameroon, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Madagascar, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Togo.

92. Regarding finances, 14 countries[23] developed proposals for submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). To date, the Fund has committed US$ 327 850 815 to 35 proposals. In partnership with Roll Back Malaria, the unit developed a tool for costing malaria interventions and briefed target personnel from countries on how to use it. The Regional Office completed a study on the economic consequences of malaria (Figure 16), and the findings provide impetus for advocacy.

Figure 16: Total cost of malaria illness, Ghana, 2002



Source: WHO/AFRO

Research and Product Development for Communicable Diseases (CRD)

93. The Research and Product Development for Communicable Diseases area of work focused on building country capacities for planning, implementing and evaluating operational research projects so that data generated can be used to inform policy and practice. In addition, developing and validating new and existing tools, technologies and strategies for communicable disease prevention and control remained priorities.

94. In collaboration with the Special Programme for Research and Training in Tropical Diseases, 18 operational research projects were funded in nine countries. Four countries developed study protocols on malaria in pregnancy in areas of low transmission and are currently being supported in implementation. A priority operational research agenda in Integrated Disease Surveillance and Response (IDSR) implementation has been developed that includes cost and cost-effectiveness of IDSR and risk factors for high mortality in meningococcal meningitis in the Sahel.

95. Two new partners are actively engaged in supporting research and research capacity strengthening in the countries of the Region. The new partners are the European and Developing Countries Clinical Trials Partnership (EDCTP) and the Arab Gulf Program for United Nations Development Organizations (AGFUND). Through a coordinating centre established in Cape Town, South Africa, EDCTP is supporting clinical trials in malaria, tuberculosis and HIV in countries. AGFUND will support monitoring of antimalarial drug resistance in Mauritania.

96. The in vivo monitoring of therapeutic efficacy of antimalarial drugs has continued and now covers 41 of the 42 malaria-endemic countries of the Region with a total of 188 sentinel sites. The data formed the basis for malaria treatment policy change in 13 countries. The regional database on

[23] Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Sao Tome and Principe, Sierra Leone, Zambia.

therapeutic efficacy of antimalarial drugs has been updated and has provided a basis for the global drug resistance report being compiled for publication by headquarters.

97. The operational plan for integration of communicable disease interventions at national and district levels elaborated in 2003 is now being piloted in four countries. Integration may be a valuable tool for scaling-up coverage of cost-effective interventions.

PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

98. Noncommunicable diseases (NCDs) are increasing in the Region and are now a major public health concern. NCD prevention and control also incorporate injuries, mental disorders and substance abuse, including tobacco and excessive alcohol consumption.

99. The epidemiological peculiarity of the African Region is the double burden of disease: A heavy burden of infectious diseases coupled with a growing problem of chronic noncommunicable diseases. Malnutrition is still the most important risk factor for diseases. However, obesity is growing and is already a major cause of chronic diseases, especially in urban areas. Violence and injuries are among the top ten causes of death and disability in Africa. Mental disorders and substance abuse are major concerns throughout the Region.

100. This situation places a huge demand on over-stretched health services. NCDs are not given the priority they deserve, and scarce funds are used for treatment rather than prevention of established diseases.

101. During the year 2004, some milestone events took place in the NCD approach. Further to the adoption of the Framework Convention on Tobacco Control in 2003, the Global Strategy on Diet, Physical Activity and Health was unanimously adopted by the WHA. A declaration on oral health in Africa was adopted by 38 countries.

Surveillance, Prevention and Management of Noncommunicable Diseases (NCD)

102. The Surveillance, Prevention and Management of Noncummunicable Diseases area of work comprises the two programmes on chronic diseases (CDP) and oral health (ORH).

103. Regarding the Chronic Diseases Programme, the most important NCDs in the African Region are cardiovascular diseases, diabetes, cancer, chronic obstructive pulmonary disease and sickle-cell disease. Whereas sickle-cell disease is genetic, the other NCDs share common risk factors related to unhealthy lifestyles based on poor diet, tobacco use, physical inactivity and excessive alcohol consumption. Control of these risk factors will reduce the burden of NCDs. Unfortunately, cost-effective medications which could prevent complications are usually not available in most health-care services of the Region.

104. WHO provided technical assistance to countries for building capacity in the STEPwise approach to surveillance of risk factors for NCD; cancer registries; early detection and management of cervical cancer; setting up national NCD programmes; diabetes control; prevention and management of sickle-cell disease. A total of 50 participants from 19 countries were trained in the WHO STEPS approach. Six countries[24] were assisted to conduct the survey of risk factors. The first experience of integrating communicable disease and noncommunicable disease surveillance systems was initiated in Mozambique. A workshop in Dakar trained 32 participants from 13 countries[25] in setting up diabetes control programmes. Strong advocacy was done in Ghana and Zimbabwe on the occasion of World Heart Day and World Diabetes Day. Screening for early detection and treatment of cervical cancer

[24] Botswana, Republic of Congo, Democratic Republic of Congo, Eritrea, Mauritius, Namibia.
[25] Algeria, Benin, Burkina Faso, Cameroon, Republic of Congo, Democratic Republic of Congo, Cote d'Ivoire, Gabon, Guinea, Mali, Mauritania, Senegal, Togo.

was undertaken in eight countries.[26] Extranet (e-community) facilities for the Network of African NCD Activities were created in the three official languages.

105. In the Oral Health Programme, the key issues addressed were the epidemiological analysis of oral diseases and the development of national oral health plans. Special emphasis was given to noma. WHO assisted countries to prepare or strengthen their national oral health programmes. The Regional Office assisted affected countries to implement noma control programmes.

106. Five additional countries[27] were supported. The African Declaration on Oral Health was adopted by 38 countries attending a regional conference in Nairobi jointly organized with the World Dental Federation. Steps were taken to establish a network of oral health training and care institutions in west African countries. Tools were developed for country needs assessments. The Regional Centre for Oral Health Research and Training Initiatives, a WHO collaborating centre in Nigeria, was strengthened and some relevant research projects were supported. Benin, Burkina Faso, Mali and Niger started implementing noma programmes; five countries received support to continue programmes.[28]

Mental Health and Substance Abuse (MNH)

107. Mental and neurological disorders and substance abuse have negative implications on the health of individuals, families and communities. Good mental health is a positive resource that allows individuals to work productively, cope with the stresses of life without using alcohol or psychoactive substances and make a contribution to the community.

108. The portion of the global burden of disease attributable to mental, neurological and substance use disorders is expected to rise from 12.3% in 2000 to 15% by 2020. This does not include the significant 1.3% of the burden due to both attempted and completed suicide. Alcohol consumption alone contributes to the global burden of disease with 3% to 4%. The rise in the burden of mental, neurological and substance use disorders will be particularly sharp in developing countries, primarily because of the projected increase in the number of individuals entering the age of risk for the onset of these disorders.

109. A WHO survey, Project Atlas of Mental Health Resources, showed that only half of the 46 countries of the Region have mental health and substance abuse policies. Mental health data collection is present in 40% of the countries. The finances available for mental health care are very limited: 84% of the countries are spending less then 1% of their total health budget on mental health.

110. The *Regional strategy for mental health 2000–2010* was adopted at the forty-ninth session of the Regional Committee. It has contributed to the development of national programmes in Member States and has encouraged the involvement of partners and stakeholders.

111. In 2004, the Regional Office provided technical and financial support to six countries[29] to develop appropriate strategies to protect human rights in the context of mental health and substance abuse. Ghana and Malawi used WHO tools to review their mental health legislation. A report, entitled *Epilepsy in the WHO African Region: Bridging the gap,* was published. Senegal and Zambia received financial support to launch and consolidate epilepsy projects at district level.

[26] Angola, Cape Verde, Republic of Congo, Democratic Republic of Congo, Guinea, Mali, Mauritania, Tanzania.
[27] Benin, Burkina Faso, Mozambique, Rwanda, Uganda.
[28] Democratic Republic of Congo, Lesotho, Mozambique, Uganda, Zambia.
[29] Algeria, Benin, Cape Verde, Namibia, Nigeria, Zimbabwe.

112. During the second phase of Project Atlas, 16 countries[30] of the Region provided data on country resources for neurological disorders, and 13 countries[31] provided data on child and adolescent mental health resources. All 46 countries provided data on country resources for mental health.

Tobacco (TOB)

113. The first WHO global treaty, the Framework Convention on Tobacco Control (FCTC), was adopted in May 2003. The adoption of the Convention marks the beginning of a new phase in building an effective international legal system to counter the increasing use of tobacco globally. In the WHO African Region, 39 out of 46 Member States have signed the treaty; five countries[32] ratified and are Parties to the Convention as of 30 November 2004. The Treaty shall become binding international law for the first 40 parties, on 27 February 2005. A major challenge is to build awareness and political support for ratification by Member States that are not Parties. This phase will require close collaboration with Member States to build national capacity.

114. WHO assisted countries in strengthening national capacities for advocacy to support ratification and implementation of the FCTC. Technical support was also provided to strengthen capacity of research coordinators in tobacco survey methods. In east and west Africa, 25 countries[33] participated in FCTC subregional workshops in awareness raising and capacity building. NGOs from eight countries participated in an advocacy training workshop.[34] Support was also provided to NGOs to initiate advocacy activities for support of FCTC at country level. Ten countries[35] participated in the data management workshop for the Global Youth Tobacco Survey.

Health Promotion (HPR)

115. Urbanization as well as demographic, environmental and other changes stimulated by globalization and emergencies in countries require innovative approaches for addressing the broad determinants of health. Health promotion is a cost-effective means for supporting health and improving quality of life. Key health promotion strategies include use of integrated approaches, focus on poor and marginalized groups, and advocacy among decision-makers to ensure political support and resources for health.

116. *The world health report 2002* documented the health impact of several major risks reducible through health promotion: poor diet and nutrition, tobacco use, alcohol consumption, physical inactivity, poor hygiene, lack of safety and unsafe sex. These risks are influenced by gender, culture, education and income. Health promotion therefore calls for multisectoral collaboration with WHO playing a stewardship role; it facilitates recognition of health as an investment in development.

117. In most Member States, health promotion currently receives inadequate financial and political support compared to the support given to curative health services. Sustainable resources for funding are needed.

118. In 2004, the Regional Office provided support to countries for strengthening national capacity, policies and evidence of health promotion; promoting intersectoral action and awareness

[30] Algeria, Benin, Burkina Faso, Central African Republic, Gambia, Ghana, Kenya, Madagascar, Malawi, Mali, Niger, Nigeria, Senegal, South Africa, Togo, Zambia.
[31] Benin, Burkina Faso, Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea, Kenya, Madagascar, Niger, Senegal, Zambia, Zimbabwe.
[32] Ghana, Kenya, Madagascar, Mauritius, Seychelles.
[33] Benin, Burkina Faso, Burundi, Cape Verde, Comoros, Cote d'Iviore, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Nigeria, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, Tanzania, Togo, Uganda.
[34] Ghana, Kenya, Malawi, Mauritius, South Africa, Tanzania, Uganda, Zambia.
[35] Benin, Cote d'Ivoire, Ethiopia, Mauritius, Mozambique, Namibia, Seychelles, Tanzania, Togo, Zimbabwe.

about the determinants of health; encouraging community participation and development of partnerships to create environments supportive of health.

119. Two training workshops on implementation of health promotion were conducted in Ouagadougou and Kampala; the first trained teams from six countries[36] and the second trained teams from eight countries.[37] Participants were from health and education ministries, WHO country offices and civil society. Nigeria developed a curriculum for inducting health educators into health promotion. South Africa implemented health promotion interventions for noncommunicable disease prevention in two provinces. Collaboration with the Reproductive Health Division resulted in integrated adolescent reproductive health projects in Mozambique, Namibia and Zimbabwe, and development of a promotional package for repositioning family planning. A health promotion component was included in the long-term programme for cholera prevention and control in Mozambique. In Benin, a school-based project used an integrated health promotion model to address various health problems.

120. The Regional Office participated in implementation of school health projects executed by Education International in 15 countries[38] with funding from WHO and the Centers for Disease Control and Prevention. African delegates participated in the 17th Global Conference on Health Promotion in Melbourne, Australia, and health promotion officials developed a multidisciplinary course for prevention of chronic diseases in Ghana. Both activities were supported by the International Union for Health Promotion and Education.

Nutrition (NUT)

121. Hunger and malnutrition are among the most devastating problems faced by developing countries, mainly in Africa. In sub-Saharan Africa, about 200 million people are undernourished. Food insecurity threatens about 800 million individuals, 25% of whom live in Africa. These people are exposed to the grave consequences of protein energy malnutrition and micronutrient deficiencies of iron, vitamin A, iodine and zinc.

122. The Regional Office provided technical support to countries based on the recommendations of the International Conference on Nutrition (1992), the Global Strategy on Infant and Young Child Feeding, *WHO guidelines on infant and young child feeding* and *WHO guidelines on micronutrient deficiency control*. The Regional Office also supplied training materials and tools as well as financial support at regional and country level for the training of personnel and implementation of activities and priority interventions.

123. An intercountry workshop was organized on implementation of the Global Strategy on Infant and Young Child Feeding; it was attended by 20 participants from four west African countries who began development of a national strategy on infant and young child feeding. A round table on the nutritional situation in the African Region was organized for the fifty-fourth session of the Regional Committee.

124. Two regional training workshops were held on development and implementation of national food and nutrition policies and plans of action; participants were 39 decision-makers from 13 countries. Two countries tested integrated modules on training health workers in breastfeeding counselling, complementary feeding counselling, infant and young child feeding and HIV/AIDS counselling. Modules on training of health workers on management of severe malnutrition were translated into French with collaboration from headquarters.

[36] Burkina Faso, Cameroon, Gabon, Guinea-Bissau, Mauritania, Togo.
[37] Ethiopia, Liberia, Malawi, Namibia, Seychelles, Swaziland, Tanzania, Uganda.
[38] Botswana, Burkina Faso, Cote d'Ivoire, Guinea, Lesotho, Malawi, Mali, Namibia, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe.

125. With support, seven countries implemented various activities. One country improved population feeding according to its plan of action. Three countries developed and implemented programmes in prevention of mother-to-child transmission (of HIV). Three countries trained health workers in the implementation of integrated micronutrient deficiency programmes.

Injuries and Disabilities (INJ)

126. Violence, injuries and disabilities remain major challenges to public health in the African Region. In addition to numerous armed conflicts, there is also a high burden from interpersonal violence, especially among young men. Gender-based violence and child abuse remain serious challenges. Unintentional injuries, in particular, road traffic injuries, drowning and burning, remained leading causes of injuries.

127. Physical, mental and sensory disabilities continue to be major problems in the Region. There are an estimated 9 million blind people in sub-Saharan Africa, and 27 million people are visually impaired. This represents the highest regional burden of blindness ratio in the world.

128. In April, the WHO and the World Bank launched the *World report on road traffic injury prevention* which was formally launched by five countries[39] within the African Region. In some countries, some of the recommendations of the report are already being taken up at policy level and in programmes. Support continues to country policies and programmes consistent with the recommendations of the report.

129. WHO support on injury and violence surveillance continues in Ethiopia and Mozambique. In Ethiopia, there is innovative collaboration with the Traffic Police Department on traffic injuries. Rehabilitation projects were supported in Liberia and Togo. An intercountry workshop on the Standard Rules on the Equalization of Opportunities for Persons with Disabilities was held in Brazzaville. In June, an expert on community eye care articulated a proposal for scaling up Vision 2020 to assist the Region to meet the proposed targets. An action plan was developed, and country level activities will follow as resources become available.

FAMIILY AND REPRODUCTIVE HEALTH

130. The Division of Family and Reproductive Health contains four critical areas of work: Child and Adolescent Health, Research and Programme Development in Reproductive Health, Making Pregnancy Safer, and Women's Health and Development; each implementing specific programmes. The Division is on the road towards attainment of the Millennium Development Goals relating to maternal, newborn and child health. Emphasis is on addressing the deadly triad of HIV/AIDS, tuberculosis and malaria; managing common causes of child mortality; eliminating gender-based violence and harmful traditional practices; and improving access to quality health services by women and men of all ages.

Child and Adolescent Health (CAH)

131. The Child and Adolescent Health area of work includes the Newborn and Child Health Programme and the Adolescent Health and Development Programme. Throughout 2004, the Division used evidence-based strategies to reduce health risks as well as the morbidity and mortality affecting newborns, children and adolescents. Despite the lack of funds for newborn and adolescent health activities, important results were achieved.

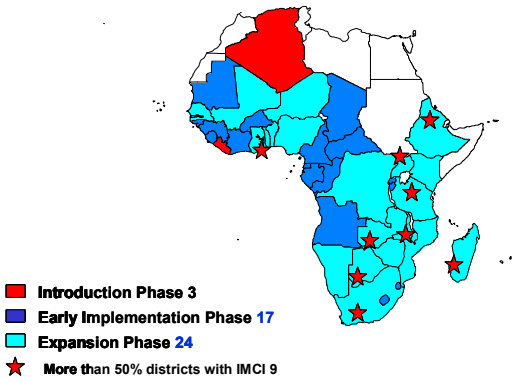
132. Effective interventions for Integrated Management of Childhood Illness (IMCI) delivered at a high level of population coverage can reduce by two-thirds the 12 000 under-five deaths occurring daily in the African Region. Accordingly, by end of the year, 44 of the 46 countries in the WHO

[39] Kenya, Nigeria, Namibia, South Africa, Tanzania.

African Region were implementing IMCI (Figure 17). This was achieved through increased health service delivery, enhanced health worker skills, and improved family and community practices.

133. With WHO support, seven countries[40] developed IMCI national strategic plans, three countries (Cameroon, Republic of Congo and Rwanda) adapted and completed IMCI training guidelines, and five countries[41] reviewed their infant feeding policies in relation to HIV. Eight countries[42] conducted training-f-trainers on infant feeding counselling and HIV counselling.

Figure 17: IMCI in the African Region, status of implementation, December 2004



Source: IMCI/AFRO

134. Seven countries[43] implemented activities to improve quality of care at referral level, and four countries (Kenya, Nigeria, Tanzania and Zimbabwe) developed integrated supervision tools. A briefing package for the community component of IMCI planning was finalized and 48 consultants were trained. They provided support to ten countries[44] to develop national and district plans.

Figure 18: Impact of IMCI on mortality reduction, Tanzania, 2003

District	Under-five mortality rate (per 1000 births)	
	BEFORE	AFTER
IMCI districts	128	115
Comparison districts	127	133

Source: MCE, Tanzania Site

135. One of the facilitating factors in reducing child mortality was the commitment of Member States to accelerate IMCI implementation. For example, an IMCI evaluation study in Tanzania showed a 13% reduction in child mortality in IMCI implementation districts as compared to non-IMCI districts (Figure 18). Shared vision of governments and partners expressed by implementation of a common child survival strategy, such as IMCI, is a key in reducing child mortality. However, insufficient resources at all levels and weak health systems have been impediments to scaling-up IMCI implementation.

[40] Botswana, Burkina Faso, Ethiopia, Gambia, Lesotho, Swaziland, Zambia.
[41] Eritrea, Kenya, Mozambique, Namibia, Nigeria.
[42] Burkina Faso, Burundi, Cote d'Ivoire, Guinea, Malawi, Mali, Mozambique, Níger.
[43] Benin, Eritrea, Guinea, Kenya, Malawi, Niger, Tanzania.
[44] Botswana, Burkina Faso, Burundi, Ghana, Guinea, Kenya, Lesotho, Madagascar, Nigeria, Rwanda.

136. The Healthy Newborn Partnership successfully organized a meeting in Ethiopia which resulted in increasing the focus on the improvement of maternal and newborn health in the Region. Further support came from the Safe Motherhood and Child Survival Partnership.

137. The culture of silence and the stigma surrounding the epidemic of child sexual abuse have made it a silent health emergency of grave public health concern. At the fifty-fourth session of the Regional Committee, ministers of health adopted the Agenda for Action and its resolution AFR/RC54/R6 to break the silence, create awareness and urge governments to take concrete actions to fight child sexual abuse in line with the Convention on the Rights of the Child.

Children are not a cure for HIV/AIDS

Source: WHO/AFRO

138. Throughout the year, the Regional Office continued to extend adolescent-friendly health services. Activities on young people and HIV/AIDS, sexual and reproductive health, fight against substance abuse and mental health were carried out through the broad integrated strategic approach of the Alliance of Parents, Adolescents and Communities (APADOC) in about 19 countries.[45] The Ford Foundation funded APADOC activities in Mozambique, Namibia and Zimbabwe. Eritrea received technical support from the Regional Office and United Nations Population Fund through a joint mission to assist the government in developing a national adolescent health policy.

139. The Interagency Working Group on HIV and Young People (including United Nations Population Fund, United Nations Children's Fund, the World Bank, and other bilateral agencies) launched the Civil Society Coalition for Youth Health and Development. Funds from Netherlands were provided to support activities for HIV and young people in four priority countries (Cameroon, Malawi, Nigeria and Tanzania). In an effort to contribute to the attainment of the MDGs, the Adolescent Reproductive Health Programme strengthened HIV/AIDS and young people partnerships with other UN agencies, bilateral agencies (such as USAID-funded projects) and other relevant Regional Office programmes.

Research and Programme Development in Reproductive Health (RHR)

140. The Research and Programme Development in Reproductive Health area of work includes Reproductive Health Research (RHR), Reproductive Health Training (RHT) and Prevention of Mother-to-Child Transmission of HIV (PMTCT). There was significant progress during the period in review.

141. Two WHO collaborating centres were contracted at the Department of Obstetrics and Gynaecology, Korlebu Teaching Hospital in Ghana and the *Centre d'Etude et de Recherche en matière de Population et Developpement,* in Mali. Institutional profiles and four-year workplans are under development. Nationals from seven countries,[46] including the WHO representatives and reproductive health focal persons, were trained in conducting operational research. The output was the development of a research protocol on the reduction of maternal mortality or improving family planning services. WHO is assisting these countries to source funds for implementation.

[45] Botswana, Cameroon, Chad, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Lesotho, Malawi, Mozambique, Namibia, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.

[46] Benin, Burkina Faso, Chad, Mali, Mauritania, Niger, Senegal.

142. The second regional meeting of reproductive health programme managers was held in July. National managers and advisers from 20 anglophone countries[47] and 24 francophone countries,[48] six partners[49] and WHO staff reviewed the activities conducted during the biennium 2002-2003. Best practices in reproductive health programmes were shared, and recommendations for increased commitment at all levels were stressed. Participants from all four areas of work of the Division and partners contributed to the success of the meeting.

143. The third Regional Reproductive Health Task Force Meeting was held in Harare in October. It was devoted to the effective implementation of the Road Map for accelerating the attainment of the millennium development goal related to maternal and newborn health in Africa. Critical reproductive health issues were analysed and concrete documents were developed to guide programmes in the Region. The documents included a guide for the implementation of the Road Map at country level; a consensus statement on the role of traditional birth attendants; a paper stating the African position on the International Convention Against Reproductive Cloning of Human Beings; and a proposal for the establishment of a special fund for maternal and newborn health.

144. In collaboration with the Division of Health Systems and Services Development, eight countries[50] were supported in the development of a project proposal for strengthening health systems to better deliver priority programmes. These projects are to be funded by the Norwegian Agency for International Development. Participation in the Working Group for the establishment of the Regional Health Information System resulted in indicators for the regional database.

145. At Regional Programme Meeting 32, all WHO representatives were sensitized in the evidence-based reproductive health care approach and how to use the WHO Reproductive Health Library (RHL). National programme managers and advisors from 44 countries were also sensitized on the evidenced-based training kit and trained in the use of RHL. More specific training workshops were carried out in Kenya, Nigeria and Zambia which now have a critical mass of core trainers in the use of the two approaches. With over 2000 RHL subscribers, it is hoped that the evidenced-based approach will lead to policy change where applicable so as to improve the quality of service provision.

146. Concerns about the low contraceptive prevalence rates led to the development of a 10-year framework for repositioning family planning in the African Region which was adopted by Regional Committee Resolution AFR/RC54/R2. The aim is to provide guidance on how to revitalize the family planning component of reproductive health programmes in order to improve maternal and newborn health. The following tools were developed to assist countries in strengthening their family planning (FP) programmes: advocacy tool for repositioning family planning; guidelines on contraceptive logistics management; evidence-based guidelines for family planning and sexually-transmitted infections (STIs).

147. The Implementing Best Practices Initiative was launched in the African Region in June, with 12 countries[51] participating. The main focus was on sharing experiences, mapping out the way forward and implementation based on scientific evidence, specifically in family planning. To improve quality of FP and STI services, the WHO/UNFPA Strategic Partnership Programme for Africa[52] was

[47] Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Seychelles, Sierra Leone, South Africa, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe.

[48] Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Niger, Rwanda, Sao Tome and Principe, Senegal, Togo.

[49] Advance Africa, AWARE-RH, BASIC, USAID, AED/SARA, UNFPA.

[50] Algeria, Angola, Democratic Republic of Congo, Ethiopia, Kenya, Niger, Nigeria, Uganda.

[51] Benin, Cameroon, Ethiopia, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.

[52] The SPP countries are Benin, Cameroon, Mozambique, Nigeria, Rwanda, South Africa, Tanzania (including Zanzibar), Zambia, Zimbabwe.

launched in Tanzania in September. At the launching, evidence-based guidelines were disseminated for country adaptation.

148. In the context of The 3 by 5 Initiative, prevention of mother-to-child transmission (PMTCT) intervention is the entry point for pregnant women who are HIV-positive and their families to access care, antiretroviral therapy and psychosocial support services. Eleven countries[53] benefited from PMTCT activities, including access to antiretroviral therapy. Tools to guide the provision of psychosocial support services for pregnant women and families were disseminated in 19 countries[54] with high HIV burden. A skills-building workshop on psychosocial support was held for health professionals and community workers from 13 countries.[55] Ethiopia integrated PMTCT in reproductive health services and Zambia finalized its strategic framework to include PMTCT in maternal, newborn and child health.

149. Partnerships were strengthened. With the contribution from the Division, the World Bank Treatment Accelerated Programme Funds to scale up PMTCT increased access to antiretroviral therapy in Burkina Faso, Ghana and Mozambique. The Netherlands Innovative Fund helped the development of a framework on integration of PMTCT in maternal and newborn services using districts in Mozambique and Uganda as demonstration sites. *Gesellschaft für Technische Zusammenarbeit* (GTZ) Backup Initiative provided institutional support for the establishment of a post in the Regional Office for a medical officer to manage PMTCT. For maximum impact, PMTCT must be integrated into maternal and newborn health-care services at primary health care level.

Making Pregnancy Safer (MPS)

150. In February, the Road Map for accelerating the attainment of the MDGs related to maternal and newborn health was developed in Harare by the Regional RH Task Force members, partners and representatives of Member States. One of the specific objectives of the Road Map is to increase skilled attendance during pregnancy, childbirth and postpartum at all levels. The Road Map was presented to the African Union (AU) and subsequently formed the basis for the development of the AU Road Map for maternal and newborn morbidity and mortality reduction in Africa. The Road Map was discussed at the fifty-fourth session of the Regional Committee which adopted Resolution AFR/RC54/R9 on accelerated reduction of maternal and newborn morbidity and mortality. To assist countries in implementing the Road Map at country level, a Framework for the implementation of the Road Map was developed, and 16 countries[56] have started implementation.

151. To promote integrated maternal and newborn health service delivery, the Integrated Management of Pregnancy and Childbirth manual series on the Management of Complications in Pregnancy and Childbirth were sent to all the countries for distribution to medical, midwifery and nursing training institutions as practice and reference documents. These manuals are used at country level for in-service continuing training in maternal and newborn health. In February, a workshop on emergency obstetric care was held during the annual conference of the West African College of Surgeons in Banjul, Gambia.

152. Community involvement and participation is critical in maternal and newborn health. During the second regional programme managers meeting in July, national managers from 44 countries and their partners were introduced to the Regional Office document, *Maternal and newborn health: Framework for the promotion and implementation of community-based interventions*. It included a comprehensive approach to birth and emergency preparedness and ways of working with individuals,

[53] Angola, Cameroon, Kenya, Lesotho, Mali, Mozambique, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.
[54] Angola, Botswana, Cameroon, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Rwanda, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe.
[55] Burkina Faso, Ethiopia, Kenya, Malawi, Mali, Namibia, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia.
[56] Angola, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Liberia, Madagascar, Senegal, Seychelles, Zambia.

families and communities. National plans of action for increased community involvement and participation were developed.

153. To increase awareness, Ethiopia, Ghana, Mali and Uganda worked in partnership with AED, USAID and the World Bank to develop the REDUCE/ALIVE advocacy tool. The first issue of the *African Health Monitor* for the year was dedicated to the theme, "Reducing maternal and newborn mortality in Africa". The main articles and four country reports (from Burundi, Ghana, Mauritania and Sierra Leone) were about maternal and newborn health.

154. A meeting to review midwifery care competences and standards was held in September, bringing together health professionals involved in the education and training of midwives and midwifery practices from 12 countries.[57] The main outcomes were a consensus on the minimum competences for midwifery care in the Region, a framework for the development of midwifery care standards and development of national plans of action for strengthening midwifery care.

155. The Regional Office supported the Republic of Congo to organize a national consensus meeting for collaboration between the National Reproductive Health Programme and the National Malaria Control Programme on the prevention and treatment of malaria in pregnancy (MIP). The workshop officially launched the new malaria policy on intermittent preventive treatment (IPT) and insecticide-treated nets (ITNs). Mozambique adapted its national reproductive health policy to include MIP and developed protocols and guidelines on maternal and newborn health which include IPTs and ITNs. The Central African Republic and Mali integrated MIP into their reproductive programme services.

Women's Health and Development (WMH)

156. During 2004, the Women's Health and Development area of work undertook several activities to promote gender perspectives in the work of WHO. Advocacy continued for the prevention and management of all forms of sexual and gender-based violence, including female genital mutilation and other harmful traditional practices.

157. The Regional Office, in collaboration with the Department of Gender, Women and Health within the Family and Community Health Cluster at headquarters disseminated tools to countries to accelerate capacity building, advocacy and implementation of gender mainstreaming in health. A

[57] Ethiopia, Eritrea, Ghana, Gambia, Lesotho, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe.

reader-friendly kit on gender and health is being developed. The Road Map on maternal and newborn health is being reviewed to incorporate gender perspectives.

158. The Regional Office also developed a new tool, *Using human rights for maternal and newborn health: A tool for strengthening laws, policies and standards of care.* The tool is to assist countries in reviewing their legal, policy and regulatory environment around maternal and newborn health using a human rights framework. Mozambique is currently field-testing the tool; the national team conducted a systematic review of the application of human rights to policies and programming in relation to maternal and newborn health and in line with government obligations.

159. Using Finnish Funds, WHO implemented a project on non-violence in Democratic Republic of Congo and Liberia. The project assists victims of sexual and gender-based violence in war-affected African countries facing humanitarian crises. The objective was to improve the availability of quality health services for women and children victims of violence. The Division of Family and Reproductive Health, Division of Healthy Environments and Sustainable Development, and the WHO representatives in Liberia and the Democratic Republic of Congo conducted fact-finding missions in the two countries from March to May. The objective was to support national authorities to review existing information and develop national plans of action for prevention and management.

160. In Liberia, the mapping of ongoing activities and organizations identified approximately 66 national and international institutions, mostly faith-based, involved with sexual and gender-based violence and operating across the country. In Democratic Republic of Congo, the Regional Office fact-finding mission revealed a high degree of awareness and concern about such violence and the victims of it. The institutions provide prevention, care and psychosocial services with various degrees of commitment, resources and capacity for quality response. In both countries, WHO acted as the normative technical agency for prevention and management.

Sign-board in internally displaced persons camp

Source: WHO/AFRO

161. The Regional Office and the WHO Representative to the African Union participated at the second ordinary session of the Labour and Social Affairs Commission of the African Union held in Cotonou, Benin. Technical advice was given for three documents stressing the importance of the health of women and children: the plan of action on trafficking of human beings, especially women and children; a strategic framework for a policy on migration in Africa; and a plan of action on the family in Africa as a contribution to the tenth anniversary of the International Year of the Family.

162. In Ethiopia, Guinea, Niger and Nigeria, and at the Regional Office, February 6 was celebrated as International Day of Zero Tolerance for Female Genital Mutilation. Results of the five-year implementation of the Regional Plan of Action to Accelerate the Elimination of FGM in 15 countries[58] revealed that all the surveyed countries had increased their political and legislative policies regarding FGM elimination. Civil society and development partners have been actively involved in advocacy and legal reform.

163. Partnerships in Guinea established a national multidisciplinary collaborative group on FGM, developed a plan of action for the elimination of FGM practices by health professionals and conducted an awareness workshop for decision-makers and programme managers. Research on FGM obstetric sequelae was conducted in six countries[59] covering 28 393 women, 74% of which had had FGM. The study underlined the adverse obstetric and perinatal outcomes that can be added to the known harmful immediate and long-terms effects of FGM. Best practice initiatives in FGM abandonment were undertaken in seven countries[60] in the Region. It was found that because FGM is a sociocultural practice, its abandonment must address community rather than individual needs for effective and sustainable results.

HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT

164. Poverty and poor environmental conditions are major threats to health development in the African Region. People lack access to safe water and adequate sanitation. Communicable diseases

[58] Burkina Faso, Cameroon, Chad, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Mali, Niger, Nigeria, Senegal, Tanzania.
[59] Burkina Faso, Ghana, Kenya, Nigeria, Senegal, Sudan.
[60] Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Senegal, Uganda.

linked to poor environmental conditions kill one out of every five children before they reach their fifth birthday.[61] Poverty is also the principal cause of food insecurity and consumption of unsafe food. Acting singularly or together, and in conjunction with natural and human-made emergencies, these factors pose the greatest challenge to the achievement of the Millennium Development Goals in the African Region. In 2004, the WHO Regional Office for Africa responded to these challenges through the work carried out in the Division of Healthy Environments and Sustainable Development.

165. The Division consists of four areas of work: Sustainable Development, Protection of Human Environment, Emergency and Humanitarian Action, and Food Safety. The Division continues to strengthen the analysis and linkages between poverty and ill-health so as to ensure that poverty issues are addressed in national and regional health development agenda, including promoting a long-term strategic and sustainable approach to health development; incorporate effective environmental health dimensions in the management of the human environment and in the development of other national policies and actions; address the high morbidity and mortality attributable to poor food safety and food hygiene; strengthen national capacity for emergency preparedness and response, including providing technical and financial support in crisis situations.

Sustainable Development (HSD)

166. Poverty continues to affect the health status of people in the African Region by creating socioeconomic conditions that make people prone to sickness and disease and limit their access to health services. The Sustainable Development (HSD) area of work includes three programmes—Poverty and Ill-Health, Long-term Health Development, and Macroeconomics and Health—which support countries to deal with this situation mainly through capacity building, specialized technical assistance and advocacy.

167. Capacity building and specialized technical assistance were given to countries to conceptualize the linkage between poverty and ill-health, and to propose and support relevant priority interventions for the promotion of health in development. These were accomplished through various documentation. *Poverty and health: A strategy for the African Region* and *Health futures: Scenarios based health development guidelines* were distributed to Member countries and other development partners. A position paper on the health Millennium Development Goals was prepared for discussion by health ministers at the fifty-fifth session of the Regional Committee. A guide for the development of national health policies and plans was prepared and distributed jointly with other Regional Office divisions.

168. Technical assistance was provided to prepare a funding application to the Global Fund to Fight AIDS, Tuberculosis and Malaria and for the proposed national social health insurance scheme in Kenya. There was preliminary preparation on the work of the Commission on Social Determinants of Health.

169. Various promotion and support efforts were provided to countries based on the macroeconomics and health (CMH) initiative. The CMH report was distributed, and a web page was opened on the AFRO Intranet. Specific technical assistance was provided to nine countries.[62] This included setting up CMH task forces; supporting long-term health investment plans and strategies needed to scale up cost-effective interventions; and engaging stakeholders for pro-poor health development through the poverty reduction strategy papers, health ministry plans and national efforts to achieve the MDGs, including contribution to studies on accelerated expansion of primary health care and the minimum essential health-care package.

[61] WHO, *Water and sanitation sector assessment 2000,* Brazzaville, World Health Organization, Regional Office for Africa 2000 (AFR/WSH/00.3).

[62] Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Senegal, Swaziland, Uganda.

170. As part of the country focus strategy of WHO, the Regional Office strengthened WHO country offices in Kenya, Malawi and Tanzania in matters regarding health in sustainable development. WHO national programme officers dealing with health systems received orientation with regard to millennium development goals, poverty reduction strategy papers, medium-term expenditure frameworks, sector-wide approaches and macroeconomic aspects of health and development. The African Advisory Committee for Poverty and Health was revitalized. The Regional Office further enhanced the capacity of country offices to support priority programmes in HIV/AIDS, health systems development, health economics, and poverty and ill-health.

171. The Sustainable Development area of work promoted working relationships with collaborating institutions dealing with capacity building for health and development in Africa. This included evaluation of training and research programmes.

Protection of Human Environment (PHE)

172. The Protection of Human Environment area of work includes four programmes: Promotion of Health and Environment, Environmental Risk Assessment, Occupational Health, Environmental Health Policy, and Environment Information and Management. Since 35%–40% of the total burden of diseases is attributable to unhealthy environmental conditions, various activities were undertaken by the programmes.

173. The Promotion of Health and Environment Programme advised on the creation of supportive environments such as healthy cities, villages, schools, markets and workplaces. Activities focusing on children's environmental health were promoted in the Republic of Congo and Namibia. The Programme also assisted countries to prepare and submit proposals to headquarters to access seed funds.

174. The Environmental Risk Assessment Programme reviewed and finalized the environmental health impact assessment guidelines in preparation for publishing. The programme collaborated with the Environment Information and Management Programme to finalize a brochure on environmental health hazards mapping. A workshop with 30 participants from African countries promoted the establishment of new poisons centres for the management of chemical safety in the Region. Another workshop and a consultative meeting promoted awareness about air pollution in African cities.

175. The Regional Office evaluated the following new WHO collaborating centres: National Institute for Occupational Health, Johannesburg, South Africa; Centre for Environmental Health Risk and Economics, University of Pretoria, South Africa; Atmospheric Research and Information Analysis Laboratory, Ife University, Nigeria; Centre for Occupational and Environmental Health, University of Natal, Durban, South Africa. The Regional Office and collaborating centres conducted a one-week environmental health course for health professionals held at the Medical Research Council, South Africa.

176. The Occupational Health Programme developed and presented a paper, "Occupational health and safety: Situation analysis and perspectives in the African Region," at the fifty-fourth session of the Regional Committee. The document was meant to assist the health sector to engage other social sectors and their partners in developing health-promoting policies and action plans. In partnership with the International Labour Organization, a consolidated country profile was developed to assist countries to collect data for the formulation of occupational health policies and implementation plans. Kenya, Tanzania and Uganda piloted their country profiles. A toolkit on best practices in the prevention of needle-stick injuries is being piloted in South Africa and Tanzania. The lessons learnt will inform a roll out programme throughout the Region. As a follow-up of the information strategy workshop held at the end of 2003, there was improved distribution of information materials to countries to enable them to take informed decisions based on current information and technologies. The University of Cape Town and National Institute of Occupational Health were accepted as collaborating centres for occupational health in the Region.

177. In 2004, the Environmental Health Policy Programme assisted countries in the formulation of environmental health policies to realize the implementation of the Regional Strategy on Health and Environment adopted during the fifty-second session of the Regional Committee. The programme provided technical development support and reviewed national environmental health policies of seven countries.[63]

178. The Environment Information and Management Programme continued working on the Division database to provide suitable and updated information and maintained the Division web site by posting technical publications and informative documents. The programme worked with the Environmental Risk Assessment Programme to develop a brochure and other materials.

Emergency Preparedness and Response (EHA)

179. Many severe human-made crises and natural disasters affected the African Region causing serious socioeconomic and health problems, population movements, increased burden of diseases, deaths of thousands of people, and huge national losses. During 2004, a total of 59 countries worldwide were affected by crises; 25 were African countries. In the African Region, 512 million persons were exposed to various risks, HIV/AIDS, malaria and other communicable diseases as well as numerous and severe health problems, including diarrhoeal diseases.

180. During 2004, the Regional Office supported countries in need and worked for national capacity development for emergency preparedness, response, mitigation and rehabilitation. Health workers in Namibia and six other southern African countries affected by food and HIV/AIDS crises were trained in vulnerability assessment. Health impact assessments were undertaken in Lesotho, Swaziland, Zambia and Zimbabwe. Technical or financial assistance was provided to six west African countries[64] affected by crises of war and civil strife. The Programme supported six countries in conflict[65] and three countries facing natural disasters and disease outbreaks, including Madagascar for cyclones, and Liberia and Sierra Leone for Lassa fever and yellow fever. Five countries[66] received assistance to deal with the menace of locust invasion.

181. Member States were given capacity-building support to be self-reliant in emergency and humanitarian-related situations. For quick and appropriate interventions, the Regional Office decentralized the Programme, creating intercountry teams for west, southern and central Africa; the Great Lakes; and the Regional Interagency Coordination Support Office for the southern African crisis (RIACSO). Cross-border emergency activities in some subregions and countries were initiated in the Horn of Africa and west Africa, with offices created in Chad and Guinea for the management of the consequences of crises in neighbouring countries. Thirteen new staff members were recruited to strengthen the Regional Office and the intercountry teams. The recruitment and activities during the next three years will be funded by a three-year programme of the European Commission Humanitarian Office and other donors. Funds are mobilized directly for some countries through different appeal and advocacy processes.

182. The commitment and collaboration of governments, WHO country offices and headquarters, and partners as well as the coordinated funds mobilization enabled the Region Office to realize the foregoing achievements. The country offices and their partners played a major role in managing crises, and emergency activities remained a priority in their programmes. Many of the countries used a consolidated appeal process for funds mobilization. The Regional Office provided financial or technical support. However, the insufficiency of the Regular budget and the lack of human resources at regional and country levels delayed some activities or timely support to countries.

[63] Central African Republic, Republic of Congo, Mali, Mozambique, Namibia, Rwanda, Sao Tome and Principe.
[64] Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Nigeria, Sierra Leone.
[65] Angola, Burundi, Central African Republic, Chad, Democratic Republic of Congo, Uganda.
[66] Burkina Faso, Mali, Mauritania, Niger, Senegal.

Food Safety (FOS)

183. In 2004, there were a number of outbreaks of foodborne diseases, among them acute aflatoxicosis due to consumption of contaminated maize. This affected more than 317 people and had an estimated case fatality rate of around 39%. Consumption of contaminated food is also associated with at least 70% of the estimated 3.3 to 4.1 episodes of diarrhoea per child per year. About 30 660 African children die every year from consumption of contaminated food. These data make foodborne illness a major public health and economic problem in a region where the scarcity of food precludes any attention to the assurance of food safety. Despite limited resources, the Regional Office continued to assist Member States to improve food safety by strengthening local capacity for foodborne disease surveillance, food law and legislation, implementation of Codex standards, participation in international standard-setting processes and activities to promote food safety and hygiene.

184. WHO and the Food and Agriculture Organization of the United Nations jointly prepared a training guide on the procedures and work of the Codex Alimentarius Commission. The guide was field-tested at a workshop attended by 24 members of the National Codex Committees of Kenya, Tanzania and Uganda; it is being finalized for use in further capacity building. The Codex Trust supported 23 nationals from 19 countries to attend several meetings. In order to strengthen food law enforcement, 26 Kenyan nationals attended a course on prosecution. Seychelles organized training courses in food inspection and handling through collaboration with FAO and the United Nations Industrial Development Organization. Niger organized two seminars on food safety and meat safety.

185. A third training course on foodborne disease surveillance was held in Yaounde, Cameroon. Kenya received technical support during an aflatoxicosis outbreak and to draft national tools for foodborne disease surveillance. Seychelles drafted a proposal for equipping national laboratories to detect foodborne pathogens, toxins and antibiotic residues in imported meat products. Benin and the Republic of Congo conducted activities to strengthen surveillance and microbiological monitoring of foods.

Surveillance and monitoring of foodborne illness provides information for decision-making and epidemic prevention

Source: WHO/Global Salm-Surv

186. The Food Safety area of work drafted a regional guide for microbiological monitoring of food. Gabon, Mali and Rwanda prepared national strategies and action plans. Benin implemented school food safety programmes, and the Department for International Development (DFID, UK) provided modest resources for pilot programmes using the WHO Five Keys for Safer Food. Gabon conducted a national food safety survey and sensitized street food vendors and handlers on safe food handling.

187. A regional newsletter and documentation of national food safety activities promoted exchange of information and best practices. The Programme also created a database on food safety and disseminated information on important decisions by Codex Committees.

188. Outbreaks of foodborne diseases in Kenya and elsewhere emphasized the importance of food as a vehicle for transmission of disease and showed gaps in surveillance and laboratory systems.

Collaboration with FAO, UNIDO and other partners facilitated the implementation of programmes aimed at improving food safety in the African Region.

ADMINISTRATION AND FINANCE

Human Resources Development (HRS)

189. The main challenges in the Human Resources Development area of work in 2004 were related to the timely provision of services to the 2800 staff members working in the 46 countries of the WHO African Region. Activities included establishment of posts, selection and recruitment of staff, issuance of contracts, administration of benefits and entitlements, performance management, staff development and training, and provision of medical services for medical evacuations.

190. The Regional Office aims to implement modern human resource systems and practices in order to meet current and future needs of the WHO in the African Region. This is done in a proactive and responsive manner, including promotion of the well-being of the staff and the continuous improvement of their capabilities and effectiveness.

191. In 2004, the Human Resources Development area of work automated and computerized its main activities, including the development of templates for issuance of temporary contracts. Particular emphasis was put on the training of staff, including the development of a draft regional staff development and training strategy. Key performance indicators were established and increased delegation was given within the area of work.

192. Among the major achievements in 2004 were increased responsiveness and reduced delays in response to requests, as well as the organization of a number of training activities on administration, security, contractual arrangements and compensation issues. Other important achievements included the implementation of a computerized personnel management system, the streamlining of selection procedures for temporary staff, the use of the e-recruitment system, finalizing and dissemination of the Regional Office Handbook, and the strengthening of links with technical divisions and country offices. Visits were made to country offices for purposes of participating in retreats, reviewing administrative procedures and structures, briefing staff, and training staff. To strengthen WHO capacity at country level, three country offices conducted re-profiling exercises. Regional Office discussions aimed at implementing a global management system in WHO in 2006.

Budget and Financial Management (FNS)

193. The Budget and Financial Management area of work is responsible for financial management in the Region, including timely implementation of the Progamme Budget and provision of services to staff and suppliers. A key challenge is the installation of an on-line interactive integrated financial system throughout the Region. Another is continual improvement in the provision of financial services. In 2004, another challenge was the provision of timely accounting and financial services in the two locations of Harare and Brazzaville.

194. Budget and Financial Management was also responsible for ensuring accountability of funds given for programme implementation. Recent audits especially at country level continue to show that improvements are needed in the area of accountability and adherence to procedures. The goal continues to be to provide appropriate and timely financial support to the programme managers.

195. Major achievements included support to countries in the areas of budget management and oversight functions; revision of delegation of authority procedures; active participation in the global management system project; preparation of the budget tables for inclusion in the 2006–2007 Programme Budget document; opening of allotments to enable implementation; continual

improvement of services; increased monitoring of Programme Budget implementation; upgrading the Accounting and Information Management System to include expenditure control; providing staff members with intranet personal account access; supporting other regions and headquarters by training their staff in the use of the Regional Office imprest system; and loaning two staff to clear backlogs in headquarters.

Infrastructure and Informatics Services (IIS)

196. The Infrastructure and Informatics Services area of work is responsible for delivery of efficient, cost-effective procurement services, provision of appropriate information technology infrastructure and systems, and administrative and logistical services. This area of work includes the office and secretariat of the Director, Administration and Finance. The main challenges in 2004 were to improve the procurement process through investments in technology, thereby lowering costs and reducing lead times; to consolidate and strengthen the existing Regional Office data and communication infrastructure; to provide a regional management and health data warehouse system; to efficiently run the Regional Office by creating favourable working and living conditions as well as maximizing cost-efficiencies in all administrative and logistic services.

197. In supply services, the aim is to introduce a new global procurement system that would allow access to more competitive prices. With regard to information technology, the Regional Office continued to develop appropriate software and maintain existing systems while collaborating with headquarters and other regional offices in developing global programmes. Administrative Services focused on improving the working conditions in the Regional Office, both in Brazzaville and Harare, as well as on containing the operating costs within reasonable limits. For printing services, it is planned to strengthen the unit in terms of staffing and equipment, which would reduce dependence on outsourcing, hasten the production process, and reduce costs.

198. A total of 1721 supply requests, 380 purchase authorizations and 1341 local purchase orders were processed, amounting to a total of US$ 21 615 764. A staff retreat helped identify areas and recommendations for improvement. Several major achievements were recorded. Deployment of an e-procurement system has simplified and accelerated the procurement process as it allows access to lower prices through electronic catalogues. There has been significant reduction in the number of complaints from country offices and projects due to follow-up by the new tracking section. Ten countries tested new local purchase management software, and new inventory management software was acquired for country offices and projects.

199. In information and communications, 15 country offices have now been connected to the WHO global private network (GPN), providing reliable and cost-effective communication, and enabling smooth exchange of data and information within the Region. Similar efforts are currently underway in the 31 remaining countries. An integrated information system was also implemented in the Regional Office, allowing staff to update their personal profiles, a mechanism critically important for security purposes. E-billing was introduced to enable Regional Office staff to view their utility bills online. In addition, online access was provided to staff to view the status of financial transactions affecting their accounts. The deployment of fibre optics between the Brazzaville and Harare offices significantly improved the quality of voice communication between the Divisions. The e-mail domain names for the Regional Office locations were merged, giving a single cyber identity and improved e-mail service.

200. In administrative and logistical services, good working and living conditions continued to be maintained in Brazzaville and cost savings of approximately US$ 250 000 were made in 2004 through favourable re-negotiated rates for outsourced services. In Brazzaville, 20% of the 2004/2005 real estate projects were achieved. The Harare office was provided with a new back-up generator, new water reticulation system, borehole and a new potable water reservoir in order to overcome the frequent electricity and water outages. In security preparedness and as required by UN standards, the

Regional Office achieved an average of 80% of the minimum operating security standards (MOSS) compliance in Brazzaville and Harare. This is evidenced by completed security plans; a fully-equipped and operational radio room in Brazzaville; efficient security services and twice-weekly radio call checks in both Brazzaville and Harare; and improved access control to offices in Harare. The Unit held staff retreats which are expected to greatly improve services.

201. Substantive participation was given to a number of global initiatives, including a pilot programme on strengthening WHO presence in countries, the Global Staff Development and Learning Programme, and meetings of the Audit Committee and Executive Board. The fifth in a series of meetings for senior administrative staff of the Region was successfully held in March. The Regional Office Handbook was updated and made available to all staff of the Region via the intranet in November.

FACTORS IN PROGRAMME BUDGET IMPLEMENTATION FOR 2004

Enabling factors

202. The mid-term review of the Programme Budget 2004-2005 was conducted as planned. It highlighted the major factors that enable or constrain the implementation of activities at regional and country levels.

203. Global political will and government commitment to health problems facilitated the implementation of the Programme Budget during the first year. A strong desire to achieve the millennium development goals provided opportunity for funding the main priorities in the Region through several international initiatives and fruitful cooperation with partners.

204. The collaboration of various stakeholders and WHO at national and global level enabled the implementation of programmes. Consultations and negotiations between the Regional Office, government and partners were well-integrated in the process of implementation of the Programme Budget in the Region.

205. WHO internal facilitating factors included excellent collaboration between headquarters, the Regional Office and country offices; commitment from staff; positive stewardship from Regional Office management; strong team spirit and networking among WHO staff. Smooth transition at the regional management level permitted implementation of the Programme Budget.

Constraining factors

206. Complex emergencies and natural disasters in the African Region hampered the implementation of a number of activities. Although operating from two different geographical locations has become routine, it still represents a major challenge for the implementation of the Programme Budget.

207. Collaboration with Member States has improved. However, their delays in response to requests from regional and country offices have been identified as important constraints for adequate implementation of activities.

208. In the Regional Office, the limitation of financial resources remains a major constraint at all levels. Many areas of work lack adequate and skilled human resources. Donors still represent the main sources of funds for the implementation of activities.

PART II: PROGRESS REPORT ON IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

Elimination of leprosy in the African Region

209. Regional Committee Resolution AFR/RC44/R5 Rev.1 calls upon Member States in the African Region to eliminate leprosy by 2000. Elimination is defined as a prevalence rate of 1 case per 10 000 inhabitants.

210. In 1994, when the resolution was passed, 113 650 cases of leprosy (prevalence rate of 2.1 per 10 000 inhabitants) were recorded in the African Region. By the end of 2000, the total of recorded cases was 64 381, representing a prevalence rate of 1.02 cases per 10 000 inhabitants. The elimination goal had thus been achieved at regional level. However, 10 countries remained endemic. From 2000, a "Final push" strategy was introduced especially to intensify activities in countries where the disease was still endemic. By 2004, 39 countries had eliminated leprosy (Figure 19), three were at the elimination threshold and four were still endemic (prevalence rate above 2 cases per 10 000 inhabitants). Table 1 below illustrates the trend of prevalence and detected cases between 1994 and 2003.

Table 1: Leprosy prevalence and detected cases in the African Region, 1994-2003

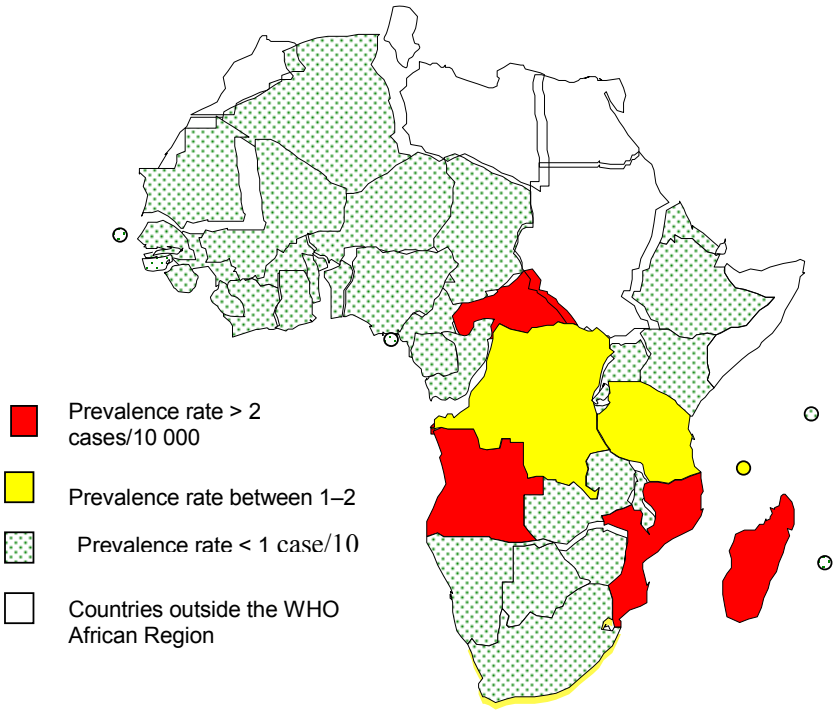
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Prevalence	113 650	95 901	82 758	81 920	82 022	67 526	64 381	58 063	55 558	51 233
Detected cases	47 900	46 516	46 489	56 515	56 521	51 963	55 628	51 357	51 976	47 006

211. The constraints included insecurity and wars in some of the affected countries; poor health services coverage; and reluctance on the part of some NGOs to implement the "Final push" strategy.

212. The opportunities included the existence of strong partnership for elimination through the Global Alliance for the Elimination of Leprosy (GAEL); and the commitment of countries to the elimination goal.

213. Leprosy elimination was achieved at regional level in 2000 as projected. It can also be achieved at national level by 2005, subject to sustained commitment of countries and availability of financial support especially through GAEL. Increased involvement of communities in control activities is needed to achieve the goal in countries where leprosy is still endemic.

Figure 19: Leprosy situation in the African Region, beginning of 2004



Regional programme for tuberculosis

214. Regional Committee Resolution AFR/RC44/R6, calls upon international organizations, among others, to provide financial and technical support for tuberculosis control in the Region. As part of DOTS implementation, the Regional Office and other partners supported 42 of the 46 member countries to adopt the DOTS strategy (Figure 20). Almost all countries planned activities up to 2005 and 22 countries made efforts to scale up DOTS expansion initiatives.

215. A total of 24 countries received technical and financial support through Stop TB Partnership, specifically from international or local partners for TB control. In addition, 25 of 33 applicant countries were awarded GDF grants; 33 countries successfully applied to the GFATM for support in TB and TB/HIV activities during the first four rounds; the Regional Office supported 21 countries to develop TB training plans and assisted 21 TB and AIDS country staff to attend international TB and TB/HIV courses; TB programme managers and training focal points from 13 countries were trained as trainers; regional DOTS frameworks and guidelines were developed and circulated.

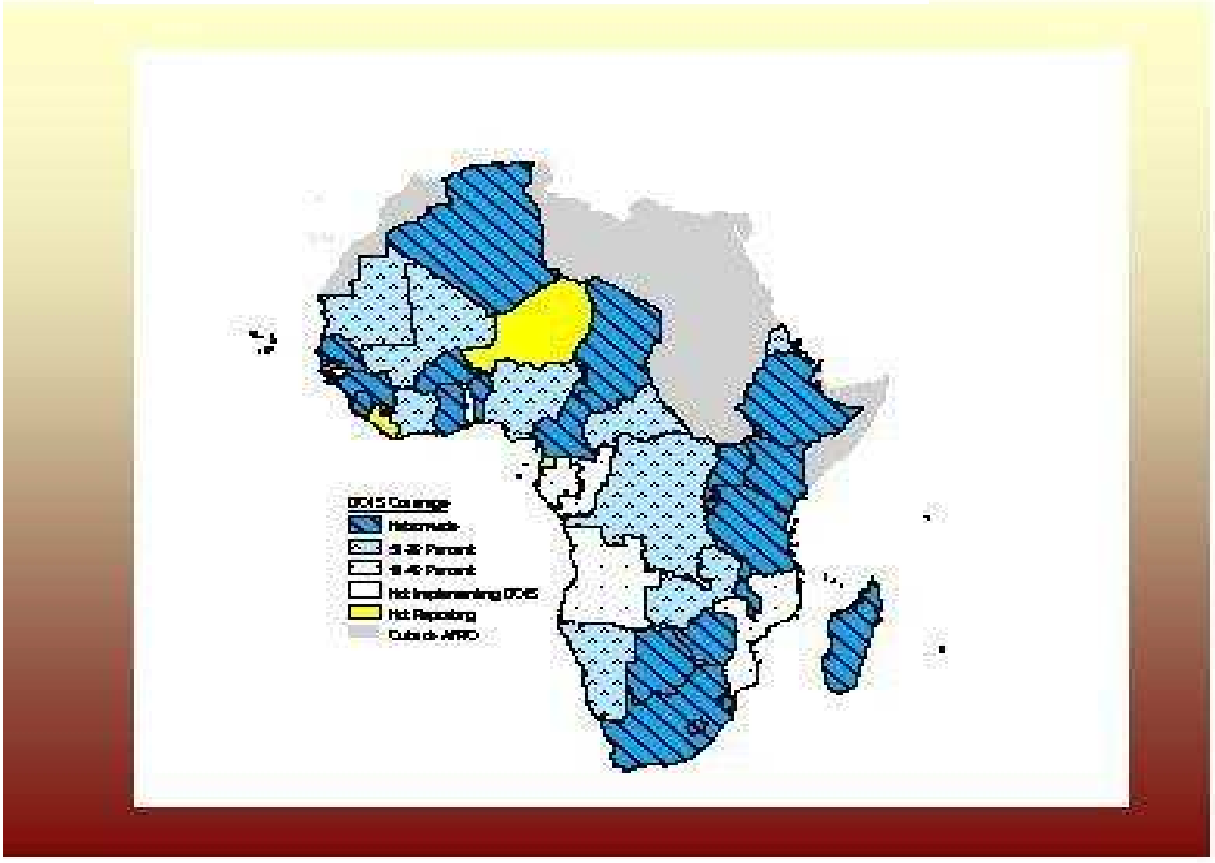
216. Constraints included the negative impact of HIV/AIDS on TB incidence; inadequate human resources; low coverage of health services and TB laboratory services; and poverty which continues to undermine TB control efforts.

217. On the other hand, international commitment to TB control and to achieving the Millennium Development Goals (MDGs) represent real opportunities to improve TB control. The Stop TB Partnership, GFATM and NEPAD are specific opportunities for enhanced action.

218. Significant progress is being made in TB control in the region. Case detection and treatment success rates have been increasing. Global and regional commitment is also increasing. However, programmatic and geographical access to services as well as the epidemiological impact on the

disease burden are still low. Universal application of available interventions and enhanced research on more effective tools and strategies are needed in order to reduce TB disease burden.

Figure 20: DOTS coverage in the African Region, 2003



Regional strategy for emergency and humanitarian action

219. Resolution AFR/RC47/R1 stresses the need for countries to include emergencies in their priorities, reinforce their response and prevention capacity, allocate sufficient financial resources to emergencies, create national funds and take such other actions as are needed for appropriate management of emergencies. The resolution also requests the Regional Director to provide the necessary support to Member States for their preparedness and response to crises. It underlines the need for technical guidance and intercountry cooperation, reinforcement of coordination and strengthening of partnership. Information dissemination is mentioned as important for better outcomes.

220. The Regional Office provided support to countries in need and helped build preparedness and response capacity. Heath impact assessment and training in vulnerability assessment were undertaken for national staff in Namibia and other countries in southern Africa mostly affected by the food and HIV/AIDS crises (Lesotho, Malawi, Mozambique, Swaziland, Zambia, Zimbabwe). Technical or financial assistance was provided to west African countries affected by wars and civil strife (Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Nigeria, Sierra Leone). The Regional Office also supported other countries facing consequences of conflicts (Angola, Burundi, Central African Republic, Chad, Democratic Republic of Congo, Uganda, among others). Assistance was provided to countries affected by natural disasters (cyclones, Lassa fever, yellow fever, locust invasion, etc) in collaboration with headquarters and partners.

221. The region decentralized the Emergency and Humanitarian Action Unit and is creating intercountry teams (ICT) for West Africa, Southern Africa, Eastern and Central Africa. The African Region and headquarters prepared a three-year EHA Programme funded by the European Commission's Humanitarian Office and other donors. Other funds were mobilized for some countries through the appeals processes. The Regional Office started crossborder emergency activities: Horn of Africa Initiative as well as EHA offices created to manage crises in neighbouring countries (Guinea for the conflicts in Côte d'Ivoire, Liberia and Sierra Leone; Chad for refugees from Darfur).

222. The enabling factors were the increasing interest and commitment of Member States in emergencies in the Region; the involvement and effective support of partners; and the decentralization of the emergency unit.

223. The constraints included understaffing of the EHA Unit, particularly at the regional level; insufficiency of financial resources; limited expertise in emergency and humanitarian interventions in the Region; lack of emergency preparedness and response units in most of the countries; and weakness of existing ones.

224. The strengthening of emergency management capacity in the Region will continue, focusing on: reinforcing and decentralizing the EHA Unit; strengthening advocacy and technical support to countries for emergency preparedness and response; reinforcing EHA teams at all levels; improving the logistic system and increasing the subregional stocks of material for providing timely support to countries; reinforcing the fund mobilization mechanism at all levels.

Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases

225. Regional Committee Resolution AFR/RC48/R2 requests that surveillance of priority communicable diseases be done in an integrated manner. Furthermore, the resolution gives each country a ten-year time frame, with support from WHO, to assess its surveillance systems, put in place at all levels of the health system a surveillance coordination body, and strengthen laboratory and communication networks so that epidemics could be detected early and responded to effectively, building on the experience of proven systems and integrating core surveillance tools, functions and activities. Finally the countries should become well prepared to prevent, detect promptly and respond adequately to epidemics, and be able to generate evidence-based surveillance information for public health interventions, programme design, monitoring, evaluation, and advocacy.

226. By 31 August 2004, 43 Member States had assessed their diseases surveillance and epidemic preparedness and response systems; 39 countries had formulated strategic plans for implementing integrated disease surveillance and response; 34 countries had developed technical guidelines and 23 countries had launched training at district level. Laboratory strengthening continued. As a result, the analysis of the core indicators of integrated disease surveillance and response showed improvements in the detection of outbreaks, reporting of priority diseases and data analysis. All major outbreaks are now confirmed by laboratory.

227. Technical support teams were posted to the five epidemiological blocs. These teams are composed of epidemiologists and laboratory experts in two of the blocs, and epidemiologists only in the remaining three blocs. The protocol of cooperation in epidemic prevention and control, signed in 1996 in West Africa, was reviewed in 1998 and the protocol signed among the countries of the Great Lakes was reviewed in 2003.

228. Member States demonstrated consistency in adhering to the regional integrated disease surveillance strategy. Some donors provided substantial support for the implementation of the strategy. The Regional Office strongly supported the integration of the surveillance functions existing in most communicable disease control programmes. Insufficiency of financial resources still hampers full establishment of intercountry technical support teams and poses a major constraint. Countries

made significant progress in the implementation of the regional strategy for integrated disease surveillance. Findings from the evaluation conducted in selected countries showed improvement in disease notification, outbreak detection and laboratory confirmation.

229. Countries should make integrated surveillance activities a key component of all disease prevention and control activities.

Regional strategy for immunization during the period 2003-2005

230. Regional Committee Resolution AFR/RC52/R2 urges Member States to strengthen the delivery of quality immunization services; accelerate efforts to achieve polio eradication, measles control, neonatal tetanus elimination and yellow fever control; and introduce new vaccines into national immunization programmes.

231. As part of the implementation of the resolution, an operational manual on the reaching every district strategy aimed at improving access to quality immunization services in all districts was developed; 34 countries were assisted to achieve national DPT3 coverage of at least 60% by the end of 2003; over 80 million children were vaccinated during the NIDs conducted in two endemic countries and 21 other high-risk countries in 2004; over 105 million children in 23 countries in the WHO African Region were vaccinated during measles supplemental immunization activities (SIAs); an estimated 125 000 childhood deaths were averted, thanks to these SIAs; case-based measles surveillance was implemented in 26 countries; 15 countries in the Region achieved neonatal tetanus elimination; 23 countries introduced hepatitis B vaccine into their national EPI programmes; 17 countries introduced yellow fever vaccine while nine countries introduced *Haemophilus influenzae* type B vaccine; 23 countries carried out sentinel surveillance of pediatric bacterial meningitis.

232. Major opportunities include the high commitment of governments and the support received through existing partnerships such as GAVI, Polio Eradication Initiative and Measles Partnership. Among others, the main constraints were high staff turnover, insufficient financial resources and competing health priorities.

233. Considerable progress was made in improving the performance of national immunization programmes in the Region. To build on the gains, there is need to continue advocacy to governments to fund immunization services, mobilize additional resources through existing and new partnerships and strengthen links between the delivery of immunization and integrated child health interventions.

Health and environment: A strategy for the African Region

234. The Regional Committee, by its Resolution AFR/RC52/R3, requests the Regional Director to improve the capacity of WHO to effectively provide technical support to Member States for the development and implementation of policies on health and environment; to support the improvement of the capacity of countries to implement and monitor programmes and action plans; and to update the Regional Committee in 2005 on the progress made in the implementation of the strategy.

235. As part of efforts to improve the capacity of WHO to effectively provide technical support to Member States, technical staff were recruited and collaborating centres in health and environment were more actively engaged. Technical and financial support was thus given to more than eleven countries in developing and finalizing national policies. Secondly, guidelines and a checklist were developed to further assist countries to accelerate the formulation and review of national policies and legislation.

236. National environmental health policy profiles were updated and environmental health concerns identified, thereby enabling countries to rapidly develop action plans. Eleven countries were supported to develop and finalize their national policies. As a result, 19 countries are now at different stages of developing their national policies and reviewing their health and environment legislations.

237. To support countries to improve their capacity to implement and monitor programmes and action plans, the Regional Office, in collaboration with collaborating centres, organized short courses meant to improve the skills and expertise of nationals and equip them to engage other social sectors in health and environment. The two collaborating centres—*Centre Regional pour l'Eau Potable et l'Assainissement* (CREPA) in Burkina Faso and Medical Research Council in South Africa—were also supported to work together in developing and presenting health and environment modules in the biennium 2006–2007. This cooperation and development of skills and expertise are continuing.

238. The skills of nationals were further improved through consultancies and visits from the region, with nationals participating in the visits and consultancies. In particular, this led to the intensification of the healthy settings approach to addressing environmental concerns in pursuit of the Johannesburg Platform for implementation of the decisions of the World Summit on Sustainable Development. A number of countries embraced the healthy settings approach to addressing environmental concerns in schools, workplaces and markets. These efforts will continue into the 2006–2007 biennium.

Poverty and health: A strategy for the African Region

239. By resolution AFR/RC52/R4, the Regional Committee urged the Regional Director: to provide technical support to Member States for the development of national health policies and programmes for poverty reduction; to increase support, through training institutions, to national professionals in the field of health and development in order to strengthen their capacities for policy analysis, monitoring and evaluation; to assist in mobilising additional resources for the implementation of this strategy; and to report to the fifty-fifth session of the Regional Committee in 2005 on the progress made in the implementation of this Strategy.

240. Efforts were made to provide technical support to Member States for the development of national health policies and programmes for poverty reduction. Several countries received technical support to develop and/or improve the health component of their respective national poverty reduction strategy papers. Some others were given financial support to implement community-based poverty and health programmes. Some countries were assisted to carry out studies or reviews in the following areas: access to health services by the poor; community-based health initiatives; public health financing and expenditure directed at the poor, including sector-wide approaches (SWAps); equity issues and out-of-pocket health expenditures by the poor.

241. The African Advisory Committee on Health and Poverty, a body of experts in health and poverty set up to advise the Regional Director, met in Brazzaville in December 2004 to review and finalise two key documents: (i) guidelines for incorporating poverty and health issues in national health sector strategic plans and poverty reduction strategies; and (ii) guidelines for designing poverty monitoring and evaluation systems.

242. As part of the effort to increase support, through training institutions, to national professionals in the field of health and development in order to strengthen their capacities for policy analysis, monitoring and evaluation, the Tropical Institute for Community Health and Development, based in Kisumu, Kenya was identified as a working partner in the area of poverty and ill health and was given a seed grant. The institute trains middle-level community health and development practitioners in matters of health and development. Its curriculum has been evaluated. In addition, a training module on poverty and health was developed and used at a workshop on evidence and information for policy making.

243. The Regional Office divisions and programmes made continuous efforts to mobilise additional resources needed for implementing the Strategy. This effort has been accelerated, focusing now on joint programming to achieve the MDGs as evidenced, for example, by the recently-initiated EC-WHO collaboration.

Human resources development for health: Accelerating implementation of the regional strategy

244. In October 2002, the Regional Committee adopted Resolution AFR/RC52/R5 on human resources development for health: accelerating implementation of the regional strategy. The resolution requests the Regional Director to accelerate the implementation of the regional strategy for the development of human resources for health; to support the forging and coordination of partnerships; and to strengthen collaboration with partners including continuing advocacy for the development of human resources for health.

245. The Regional Office undertook advocacy for human resources for health (HRH) development. This has increased awareness of, and created demand for, human resources for health (HRH) policy and plan development and review. Technical advice and support were provided to 17 countries[67] in this respect. Comprehensive HRH planning was advocated including HRH management aspects especially motivation and retention.

246. Preparatory works for the commemoration of the African year of HRH including the production of a plan of action and a media campaign document to mark the African year of HRH (2005) were carried out jointly with the Regional Office for the Eastern Mediterranean to support the African Union (AU).

247. Debate at international level on HRH in general and migration in particular led to the passing of a resolution at the World Health Assembly (WHA 54.19). The second high-level forum on MDGs in Abuja, Nigeria held in December 2004 had a session on HRH with special focus on Africa and a follow-up meeting in Oslo, Norway in February 2005 called for country action on HRH agenda with regional and global support. There is ongoing lobby with the World Bank and IMF to remove the ceiling on health budgets and the recruitment cap for some countries to facilitate recruitment of the available health workers in order to deal with the shortages.

248. Activities jointly carried out with IOM on migration of health workers and interactions with the diaspora are ongoing including joint planning of specific issues of common interest such as contribution to the content of the African Union's Migration Policy framework document.

249. The WHO Director-General has advised that the 2006 World Health Report should be on human resources for health and the theme of World Health Day 2006 will also be on human resources for health.

250. The commitment of Member States as well as increased collaboration and support from headquarters facilitated implementation while insufficient resources and capacity posed obstacles to implementation.

251. For the future, the HRH development agenda will be implemented capitalizing on the momentum gained during the last biennium at regional and international levels and especially the increased attention of partners to issues regarding motivation and retention. Themes on scaling up production, motivation and retention, management of migration, HRH information and evidence, among others, will be used as a means of advocacy for HRH at country and regional levels, especially for mobilisation of sufficient resources for HRH development.

[67] Algeria, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, Comoros, Ethiopia, Guinea, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Tanzania, Uganda.

Macroeconomics and health: The way forward in the African Region

252. Regional Committee Resolution AFR/RC53/R1 requests the Regional Director: to continue advocating for increased investments in health as an effective way of reducing poverty and accelerating economic development; to support countries to strengthen their existing institutional arrangements for planning, implementing and monitoring the CMH recommendations; to monitor and document lessons emerging from the implementation of the CMH recommendations in different countries and facilitate sharing of lessons learned; to provide support to regional institutions that train health economists and conduct health economics research; to report annually to the Regional Committee on the progress made in the implementation of the Commission's recommendations. Copies of the report of the Commission on Macroeconomics and Health (CMH) was distributed to countries for sensitization and advocacy purposes. A web page has been opened on the AFRO Intranet, focusing on the need for more investments in health and other health-related sectors. CMH, in collaboration with other programmes, is developing proposals for resource mobilization.

253. Technical support was provided on macroeconomics and health to Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Senegal, Swaziland and Uganda.

254. The Ghana Macroeconomics and Health Initiative mobilized and engaged different stakeholders in the macroeconomics and health process and a strategy paper outlining the investments needed to scale up cost-effective interventions was developed. A draft investment plan is being produced and, when finalized, would provide input in the poverty reduction strategy paper and the plan of work for the Ministry of Health.

255. In Ethiopia, a contribution was made to studies on accelerated expansion of primary health care and minimum health services package. This will influence the health sector plans of action. Some work was done on poverty and health in Ethiopia; unit-cost analysis methodologies for primary health care services; and terms of reference for conducting a unit cost analysis in Ethiopia.

256. In Rwanda, the Macroeconomics and Health Task Force is to establish a linkage between the sector-wide approaches on the one hand, and the task force's work on various issues such as financing strategies for health mutuals; cost of financing robust package of essential health services; future needs for developing a higher-capacity health workforce in Rwanda, and macroeconomic impact of health spending in Rwanda, on the other.

257. Discussions will be held with stakeholders in Malawi, Senegal, Swaziland, and Uganda to sensitise them and build consensus on the importance of macroeconomics and health. All stakeholders agreed with the key recommendations of CMH to provide country evidence, strengthen health systems and scale up cost-effective interventions to improve the health status of the poor. Plans of action were drawn up in Kenya, Mozambique, Senegal and Uganda.

Food safety and health: A situation analysis and perspectives

258. The fifty-third Regional Committee, held in Johannesburg, South Africa in September 2003, adopted Resolution AFR/RC53/R5 on food safety: The resolution assigns and roles to Member States and the Regional Director. WHO is working collaboratively with countries and partners on the implementation of the resolution.

259. Food safety education was strengthened in Benin through a programme on school food safety. Modest resources were obtained from DFID for pilot training in food hygiene in schools using the WHO Five Keys for Safer Food.

260. In order to ensure the harmonization of food safety regulations with international food standards and norms, the health sector increased its participation in the international standards-setting activities of the Codex Alimentarius Commission. The Codex Trust Fund supported about 23

nationals from 19 countries[68] to attend Codex meetings. The Regional Office participated in the Joint FAO/WHO workshop on Food Control Systems—Practical Approaches by SADC. Twenty-four members of the National Codex Committees of Kenya, Tanzania and Uganda attended an FAO/WHO workshop that field-tested a training guide on the procedures and work of the Codex Alimentarius Commission. WHO also participated in the Second Global Forum for Food Safety Regulators which was held in Bangkok, Thailand from 12 to 14 October 2004 at which 32 countries were represented. The African Group met to discuss issues concerning the Codex Coordinating Committee for Africa and the FAO/WHO Regional Conference for Food Safety planned for 2005.

261. Kenya received support to conduct a prosecution course for 26 public health officers to strengthen law enforcement in food safety. Seychelles organized training courses on food inspection and handling and Niger organized two seminars on the safety of meat in collaboration with FAO and UNIDO.

262. Benin and the Gambia were supported to develop tools for foodborne disease surveillance. Support was provided to Kenya during the outbreak of aflatoxicosis attributed to consumption of contaminated maize. WHO collaborated with *Institut Pasteur* and organised courses on foodborne disease surveillance and microbiological monitoring of foods for senior epidemiologists and microbiologists of French-speaking countries. Similar training courses are planned for English-speaking and Portuguese-speaking countries.

263. In order to promote the exchange of information and best practices, a regional newsletter was developed and information was collected from countries to document national food safety activities. A database on food safety issues and summaries of important decisions by Codex Committees were started.

264. Collaboration with headquarters, FAO and other partners and establishment of the Codex Trust Fund facilitated the implementation of the resolution. The main constraint was inadequate funding for the food security area of work. Over the next years, emphasis will be put on foodborne disease surveillance, food law and legislation, education of consumers and food handlers and development of a regional strategy for food safety.

Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region

265. Resolution AFR/RC53/R6 requests the Regional Director to technically support countries to develop and implement strategic plans for scaling-up interventions against AIDS, tuberculosis and malaria; support operational research on approaches for scaling-up; advocate for more resources and infrastructure building; collaborate with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM*)* to set up mechanisms to facilitate rapid fund disbursement in countries, monitor scaling up and report on progress every two years.

266. Community-based interventions for malaria have now been documented in 20 countries. Seven countries were supported to implement scaling-up plans. A total of 42 countries have DOTS plans for TB control up to 2005. Countries are at various stages of implementing community-based DOTS, public-private mix in tuberculosis control and collaborative TB/HIV activities.

267. Most countries established multisectoral national AIDS councils and developed HIV/AIDS health sector plans. Jointly with partners, the Regional Office supported Member States to scale up HIV interventions for prevention, control and surveillance. Twenty-two countries developed and are

[68] Benin, Botswana, Burkina Faso, Burundi, Cameroon, Republic of Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Lesotho, Mali, Mauritania, Niger, Rwanda, Tanzania, Togo, Uganda, Zambia, Zimbabwe.

implementing plans to scale up access to antiretroviral treatment. Partnerships for HIV/AIDS policy development and service delivery were expanded and strengthened at regional and country levels.

268. GFATM grants were obtained for 18 countries on the three diseases, 34 countries on malaria and 33 countries on tuberculosis and TB/HIV. The Regional Office organized an intercountry meeting to identify challenges and solutions to accessing GFATM funding.

269. Progress was made in scaling up interventions against the three diseases. Despite funding opportunities for scaling up interventions, programmatic and geographical coverage is still low. Inadequate resources, weak infrastructure and insufficient geographical access to health services still hamper the scaling up of interventions. Logistical challenges in accessing GFATM grants still exist. However, the GFATM, Stop TB Partnership, The 3 by 5 Initiative, the United States President's Emergency Plan for AIDS Relief, NEPAD and the Abuja Declarations are opportunities for scaling up interventions.

Implementation of The 3 by 5 Initiative in the African Region

270. The Regional Committee, by Resolution AFR/RC54/R5, requests the Regional Director to provide support to countries to improve access to care and treatment for HIV/AIDS: The 3 by 5 Initiative.

271. As a result of intensive advocacy, 30 countries decided to scale up HIV/AIDS treatment services and appealed for support under The 3 by 5 initiative; 24 countries were supported to define the key steps for scaling up antiretroviral therapy (ART) in line with 3 by 5 targets. Technical support was provided to 19 countries to develop ART implementation plans, five countries to strengthen human resources planning and capacity building for training, three countries to strengthen medicines procurement and supply management and eight countries to strengthen capacity for laboratory services.

272. Tools, training materials and guidelines for clinical management, PMTCT, testing and counselling were all disseminated and countries were supported in their adaptation and use. More than 12 000 health workers were trained in ART out of the expected 70 000. Regional technical capacity for HIV/AIDS treatment was strengthened. Subregional ART Knowledge Hubs were established and given orientation in the use of WHO tools, one for east and southern Africa and the other for west and central Africa in Uganda and Burkina Faso, respectively. The entry points for antiretroviral therapy (TB/HIV, testing and counselling, PMTCT) were strengthened and formed the basis for scaling up ART.

273. Catalytic funds were provided to support the implementation of strategic activities in the national plans and strengthen the technical capacity of WHO country offices. Partnership forums, one for east and southern Africa and the other for west and central Africa with mechanisms of operation were established with the partners involved in scaling up ART.

274. The commitment of countries, the increased financial resources and the increasing interest of partners are all opportunities to scale up 3 by 5 interventions. Inadequate technical resources, weak infrastructure and insufficient access to health services still hamper the scaling up of interventions.

275. Considerable progress was made in scaling up ART. However, coverage is still low. Strengthening health systems in the context of 3 by 5 and improving the human resources situation will be important not only for the achievement of 3 by 5 but also for the sustainability of services established.

Implementation of the regional strategy against malaria in the African Region

276. The Regional Committee at its fiftieth session adopted Resolution AFR/RC50/R6 which calls upon the Regional Director to support countries to develop and implement action plans on the Roll Back Malaria Initiative (RBM); advocate for human resources development and mobilize regular and extrabudgetary resources; facilitate crossborder collaboration; and support countries in monitoring and evaluating RBM.

277. All 42 malaria-endemic countries have now been supported to develop and implement RBM action plans. International courses on malaria were held annually and over 200 health workers have since been trained. There was a net increase in regular and extrabudgetary resources. A number of subregional networks are now functional, enabling countries to share experiences in malaria control. Fifteen countries adopted ACTs and 23 countries adopted or are implementing IPT for prevention of malaria in pregnancy.

278. Ten countries were supported to establish monitoring and evaluation systems. A "Malaria Country Profiles" and a "Progress Report on the Implementation of the Plan of Action of the Abuja Declaration" were published. Crossborder activities are being promoted between Angola and Namibia, South Africa and Zimbabwe, among others. The Lebombo and Health for Peace Initiatives were established in southern Africa and west Africa, respectively.

279. Additional resources for increasing coverage with cost-effective malaria interventions are now available through the GFATM. However, the high cost of ACTs and LLINS, and their limited production capacity constitute significant constraints. Inadequate human resources for health also emerged as one of the major constraints.

280. With the availability of cost-effective interventions and additional resources, a real opportunity exists to roll back malaria. Countries are urged to adopt a comprehensive package of interventions and address the human resource challenge, in order to achieve maximum impact.

Poliomyelitis eradication

281. Given the resurgence of wild poliovirus transmission in the African Region in 2003/2004, the fifty-fourth Regional Committee passed Resolution AFR/RC54/R8 urging Member States to sustain the existing political commitment to facilitate quality implementation of polio eradication strategies; support polio eradication activities in remaining polio-endemic countries; develop polio importation preparedness plans; strengthen routine immunization and polio surveillance; and mobilize resources for polio eradication activities.

282. Three rounds of supplemental immunization activities (SIAs) were conducted in endemic states in Niger and Nigeria in the last quarter of 2004. A total of 23 countries in west and central Africa conducted SIAs in the last quarter of 2004 and over 80 million children were thus vaccinated. These activities were conducted synchronously with SIAs in polio-endemic countries. Eight countries finalized wild poliovirus importation preparedness plans, and 35 countries now have sustained certification standard polio surveillance indicators. Over US$ 35 million was mobilized from both domestic and partner agency resources to support SIAs conducted in the last quarter of 2004. Under the guidance of the Africa Regional Certification Commission (ARCC), eight countries submitted polio-free documentation while 26 other countries submitted annual polio eradication progress reports.

283. High political commitment, financial and technical support from the Global Polio Eradication Initiative and additional interventions e.g. delivery of vitamin A during NIDs are all opportunities for polio eradication. The main constraints are the spread of wild poliovirus transmission facilitated by population immunity gaps and rumours about the non-safety of oral polio vaccine.

284. The progress in late 2004, that is, resumption of immunization in all endemic areas in Nigeria and the synchronized NIDs conducted in 23 priority countries in the Region, should be sustained by conducting repeat synchronized NIDs in 2005.

CONCLUSION

285. The main achievements of the year 2004 presented in this progress report were reviewed during the Monitoring and Evaluation Committee meeting at the Regional Office.

286. In line with the Country Focus Policy, interventions stressed systematic strengthening of WHO support to countries for better health outcomes. Many achievements were realized. In General Programme Development and Management, 45 out of the 46 countries now have a Country Corporation Strategy document and, in most of them, programme management capacity was improved, partly through partnership agreements.

287. In Health Systems and Services Development, national capacities in developing national health policies were strengthened and the implementation of action plans for health information systems, human resources development, traditional medicine and blood safety was supported.

288. In Prevention and Control of Communicable Diseases, increased support to countries led to a number of significant achievements such as sustained polio-free status in 35 countries; timely technical support to countries to control yellow fever, meningitis, cholera and hepatitis E epidemics; setting up of a comprehensive database for communicable diseases; implementation of The 3 by 5 Initiative in 21 countries; production of the first report on implementation of the plan of action of the Abuja Declaration; increased monitoring of the therapeutic efficacy of antimalarial drugs, which now covers 41 of the 42 endemic countries with a total of 188 sentinel sites; and screening of 1.5 million persons in 20 countries for human African trypanosomiasis.

289. Regarding Prevention and Control of Noncommunicable Diseases, teams from several countries received training in prevention of noncommunicable disease risk factors and implementation of comprehensive health promotion components. A total of 39 Member States were mobilized to sign the Framework Convention on Tobacco Control. In addition, a regional survey on violence and injury prevention was completed.

290. In Family and Reproductive Health, with the support of 14 partners and the African Union, 19 countries started implementation of the Road Map for achieving the Millennium Development Goals related to maternal and newborn health; 44 countries implemented IMCI and received training for the development of skills in the application of tools and guidelines for prevention of mother-to-child transmission of HIV.

291. In Healthy Environments and Sustainable Development, a regional strategy for occupational health, which provides guidance to countries on the formulation of policies and implementation plans, was developed; humanitarian assistance was provided to countries in need and support was provided to countries to strengthen national capacity for emergency preparedness, response, mitigation and rehabilitation. In addition, a few countries were assisted in addressing outbreaks of foodborne diseases.

292. In Administration and Finance, there was enhanced budget monitoring and implementation through staff training, development of new tools, and improvement of systems of communication between the Regional Office and countries.

293. The major constraints encountered during 2004 were inadequacy of funds to implement some activities and the unpredictability of funds from Other Sources in terms of amount and timing.

294. The key lessons learnt for this first year of the biennium are that realistic budget estimates, especially regarding funds from Other Sources, makes for better planning and implementation of plans of action; regular dialogue between WHO country offices and the focal persons of ministries of health can facilitate implementation of planned activities; much is gained when WHO representatives coordinate integrated support in response to the needs of the countries; communication within WHO and with countries must be further improved; staff determination and innovativeness sustains their motivation and productivity; proactive follow-up of planned activities is essential for timely provision of support to countries.

295. The achievements reported in this document were made possible by the commendable collaboration across the areas of work, divisions, and various levels of WHO (country offices, Regional Office, headquarters). In addition, the work of the Regional Office was greatly enhanced by the excellent collaboration with national authorities and other health development partners. In 2005, concerted efforts will be made to implement, monitor and evaluate the remaining aspects of the 2004-2005 plan of action. In addition, the plan of action for 2006-2007 will be finalized and approved by the end of 2005.

ANNEX 1

Implementation of the WHO 2004-2005 Programme Budget, Regional Office, Regular Budget

Area of work *		Initial allocation	Adjustments/ reprogramming	Funds available	Implementation	% implementation based on initial allocation	% implementation based on final allocation
		1	2	3	4	5	6
01.1.01	CSR	2 277 000	232 000	2 509 000	1 336 000	59	53
01.2.01	CPC	1 132 000	(34 000)	1 098 000	708 000	63	64
01.3.01	CRD	377 000	(11 000)	366 000	157 000	42	43
01.4.01	MAL	1 122 000	(34 000)	1 088 000	516 000	46	47
01.5.01	TUB	973 000	(29 000)	944 000	316 000	32	33
02.1.01	NCD	2 438 000	(202 000)	2 236 000	1 251 000	51	56
02.2.01	TOB	696 000	(58 000)	638 000	369 000	53	58
02.3.01	HPR	687 000	(51 000)	636 000	340 000	49	53
02.4.01	INJ	273 000	361 000	634 000	376 000	138	59
02.5.01	MNH	1 341 000	(164 000)	1 177 000	238 000	18	20
03.1.01	CAH	1 212 000	(37 000)	1 175 000	539 000	44	46
03.2.01	RHR	1 653 000	284 000	1 937 000	1 064 000	64	55
03.3.01	MPS	2 082 000	(394 000)	1 688 000	866 000	42	51
03.4.01	WMH	855 000	(26 000)	829 000	344 000	40	41
03.5.01	HIV	2 994 000	49 000	3 043 000	1 476 000	49	49
04.1.01	HSD	1 619 000	(164 000)	1 455 000	697 000	43	48
04.2.01	NUT	925 000	(77 000)	848 000	416 000	45	49
04.3.01	PHE	2 237 000	(108 000)	2 129 000	950 000	42	45
04.4.01	FOS	397 000	63 000	460 000	180 000	45	39
04.5.01	EHA	1 216 000	45 000	1 261 000	799 000	66	63
05.1.01	EDM	1 597 000	(48 000)	1 549 000	722 000	45	47
05.2.01	IVD	412 000	(12 000)	400 000	218 000	53	55
05.3.01	BCT	1 860 000	(356 000)	1 504 000	810 000	44	54
06.1.01	GPE	1 493 000	(45 000)	1 448 000	661 000	44	46
06.2.01	IMD	3 649 000	(111 000)	3 538 000	2 244 000	61	63
06.3.01	RPC	711 000	(21 000)	690 000	431 000	61	62
06.4.01	OSD	7 454 000	78 000	7 532 000	3 912 000	52	52
07.1.01	GBS	1 363 000	(66 000)	1 297 000	1 073 000	79	83
07.2.01	REC	1 996 000	270 000	2 266 000	1 178 000	59	52
08.1.01	BMR	801 000	(24 000)	777 000	452 000	56	58
08.2.01	HRS	2 423 000	(73 000)	2 350 000	1 250 000	52	53
08.3.01	FNS	3 572 000	(108 000)	3 464 000	1 646 000	46	48
08.4.01	IIS	12 778 000	(382 000)	12 396 000	8 003 000	63	65
09.1.01	DGO	1 701 000	(51 000)	1 650 000	802 000	47	49
10.1.01	SCC	1 086 000	(338 000)	748 000	400 000	37	53
11.1.01	ERH	0	0	0	0	0	0
12.1.01	ITF	0	0	0	0	0	0
13.1.01	REF	0	0	0	0	0	0
14.1.01	SEF	0	0	0	0	0	0
Totals		**69 402 000**	**(1 642 000)**	**67 760 000**	**36 740 000**	**53**	**54**

* See page 58 for abbreviations.

ANNEX 2

Implementation of the 2004-2005 Programme Budget, Countries, Regular Budget

Area of work *		Initial allocation	Adjustments/ reprogramming	Funds available	Implementation	% implementation based on initial allocation	% implementation based on final allocation
		1	2	3	4	5	6
01.1.01	CSR	5 324 000	567 000	5 891 000	3 313 000	62	56
01.2.01	CPC	3 184 000	(402 000)	2 782 000	1 501 000	47	54
01.3.01	CRD	208 000	(168 000)	40 000	21 000	10	53
01.4.01	MAL	2 018 000	(371 000)	1 647 000	841 000	42	51
01.5.01	TUB	1 538 000	(353 000)	1 185 000	575 000	37	49
02.1.01	NCD	2 467 000	(1,040 000)	1 427 000	739 000	30	52
02.2.01	TOB	253 000	(129 000)	124 000	42 000	17	34
02.3.01	HPR	4 825 000	(201 000)	4 624 000	2 542 000	53	55
02.4.01	INJ	201 000	(27 000)	174 000	77 000	38	44
02.5.01	MNH	1 410 000	(681 000)	729 000	385 000	27	53
03.1.01	CAH	3 028 000	(1 455 000)	1 573 000	877 000	29	56
03.2.01	RHR	1 446 000	(150 000)	1 296 000	686 000	47	53
03.3.01	MPS	3 044 000	(482 000)	2 562 000	1 472 000	48	57
03.4.01	WMH	542 000	(95 000)	447 000	260 000	48	58
03.5.01	HIV	2 945 000	(662 000)	2 283 000	1 153 000	39	51
04.1.01	HSD	1 997 000	(507 000)	1 490 000	727 000	36	49
04.2.01	NUT	1 866 000	(1 349 000)	517 000	238 000	13	46
04.3.01	PHE	4 341 000	(1 405 000)	2 936 000	1 726 000	40	59
04.4.01	FOS	1 292 000	(931 000)	361 000	205 000	16	57
04.5.01	EHA	2 080 000	(558 000)	1 522 000	980 000	47	64
05.1.01	EDM	2 170 000	(941 000)	1 229 000	612 000	28	50
05.2.01	IVD	1 544 000	(824 000)	720 000	400 000	26	56
05.3.01	BCT	1 243 000	(475 000)	768 000	430 000	35	56
06.1.01	GPE	694 000	(376 000)	318 000	129 000	19	41
06.2.01	IMD	295 000	102 000	397 000	229 000	78	58
06.3.01	RPC	204 000	(99 000)	105 000	32 000	16	30
06.4.01	OSD	20 581 000	(2 145 000)	18 436 000	11 070 000	54	60
07.1.01	GBS	0	0	0	0	0	0
07.2.01	REC	395 000	(290 000)	105 000	0	0	0
08.1.01	BMR	0	0	0	0	0	0
08.2.01	HRS	0	0	0	0	0	0
08.3.01	FNS	0	0	0	0	0	0
08.4.01	IIS	0	0	0	0	0	0
09.1.01	DGO	0	0	0	0	0	0
10.1.01	SCC	51 198 000	8 578 000	59 776 000	35 595 000	70	60
11.1.01	ERH	0	0	0	0	0	0
12.1.01	ITF	0	0	0	0	0	0
13.1.01	REF	0	0	0	0	0	0
14.1.01	SEF	0	0	0	0	0	0
Totals		**122 333 000**	**(6 869 000)**	**115 464 000**	**66 857 000**	**55**	**58**

*See page 58 for abbreviations.

ANNEX 3

Implementation of the 2004-2005 Programme Budget, Other sources

Area of work *		Initial allocation	Adjustments/ reprogramming	Funds available	Implementation	% Implementation based on initial allocation	% Implementation based on final allocation
		1	2	3	4	5	6
01.1.01	CSR	18 000 000	(7 866 000)	10 134 000	6 342 000	35	63
01.2.01	CPC	42 000 000	(34 977 000)	7 023 000	4 168 000	10	59
01.3.01	CRD	6 000 000	(5 930 000)	70 000	21 000	0	30
01.4.01	MAL	40 000 000	(14 799 000)	25 201 000	17 331 000	43	69
01.5.01	TUB	19 000 000	(10 746 000)	8 254 000	4 622 000	24	56
02.1.01	NCD	1 000 000	385 000	1 385 000	649 000	65	47
02.2.01	TOB	1 500 000	(891 000)	609 000	337 000	22	55
02.3.01	HPR	1 000 000	(754 000)	246 000	106 000	11	43
02.4.01	INJ	500 000	431 000	931 000	450 000	90	48
02.5.01	MNH	1 500 000	(1 382 000)	118 000	20 000	1	17
03.1.01	CAH	12 000 000	(2 910 000)	9 090 000	6 639 000	55	73
03.2.01	RHR	2 000 000	856 000	2 856 000	1 312 000	66	46
03.3.01	MPS	7 500 000	(6 981 000)	519 000	386 000	5	74
03.4.01	WMH	1 000 000	(844 000)	156 000	90 000	9	58
03.5.01	HIV	115 000 000	(92 183 000)	22 817 000	11 352 000	10	50
04.1.01	HSD	2 500 000	(807 000)	1 693 000	617 000	25	36
04.2.01	NUT	0	92 000	92 000	11 000	0	12
04.3.01	PHE	1 000 000	(151 000)	849 000	325 000	33	38
04.4.01	FOS	1,500,000	(1 480 000)	20 000	2 000	0	10
04.5.01	EHA	37 000 000	(22 498 000)	14 502 000	8 610 000	23	59
05.1.01	EDM	8 000 000	(3 021 000)	4 979 000	3 172 000	40	64
05.2.01	IVD	181 000 000	(7 935 000)	173 065 000	141 423 000	78	82
05.3.01	BCT	1 000 000	(557 000)	443 000	84 000	8	19
06.1.01	GPE	10 000 000	(9 128 000)	872 000	396 000	4	45
06.2.01	IMD	0	643 000	643 000	50 000	0	8
06.3.01	RPC	3 500 000	(3 348 000)	152 000	95 000	3	63
06.4.01	OSD	11 000 000	(3 341 000)	7 659 000	4 372 000	40	57
07.1.01	GBS	0	0	0	0	0	0
07.2.01	REC	0	2 590 000	2 590 000	1 017 000	0	39
08.1.01	BMR	500 000	718 000	1 218 000	780 000	156	64
08.2.01	HRS	3 000 000	1 693 000	4 693 000	2 177 000	73	46
08.3.01	FNS	5 000 000	248 000	5 248 000	3 194 000	64	61
08.4.01	IIS	5 000 000	7 953 000	12 953 000	6 965 000	139	54
09.1.01	DGO	0	0	0	0	0	0
10.1.01	SCC	15 000 000	(8 366 000)	6 634 000	3 030 000	20	46
11.1.01	ERH	0	0	0	0	0	0
12.1.01	ITF	0	0	0	0	0	0
13.1.01	REF	0	2 225 000	2 225 000	226 000	0	10
14.1.01	SEF	0	0	0	0	0	0
Totals		**553 000 000**	**(223 061 000)**	**329 939 000**	**230 371 000**	**42**	**70**

* See page 58 for abbreviations.

BCT	Blood Safety and Clinical Technology
BMR	Programme Planning, Monitoring and Evaluation
CAH	Child and Adolescent Health
CPC	Communicable Disease Prevention, Eradication and Control
CRD	Research and Product Development for Communicable Diseases
CSR	Communicable Disease Surveillance
DGO	Director-General, Regional Director and Independent Functions
EDM	Essential Medicines: Access, Quality and Rational Use
EHA	Emergency Preparedness and Response
ERH	Exchange Rates Hedging
FNS	Budget and Financial Management
FOS	Food Safety
GBS	Governing Bodies
GPE	Evidence for Health Policy
HIV	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
HPR	Health Promotion
HRS	Human Resources Development
HSD	Sustainable Development
IIS	Infrastructure and Informatics Services
IMD	Health Information Management and Dissemination
INJ	Injuries and Disabilities
ITF	Information Technology Fund
IVD	Immunization and Vaccines Development
MAL	Malaria
MNH	Mental Health and Substance Abuse
MPS	Making Pregnancy Safer
NCD	Surveillance, Prevention and Management of Noncommunicable Diseases
NUT	Nutrition
OSD	Organization of Health Services
PHE	Protection of Human Environment
REC	Resource Mobilization and External Cooperation and Partnerships
REF	Real Estate Fund
RHR	Research and Programme Development in Reproductive Health
RPC	Research Policy and Promotion
SCC	WHO's Presence in Countries
SEF	Security Fund
TOB	Tobacco
TUB	Tuberculosis
WMH	Women's Health and Development