

AFR/RC58/2
Original: English

The Work of WHO in the African Region 2006-2007

Biennial Report of the Regional Director

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**To the fifty-eighth session of the
Regional Committee for Africa
Yaounde, Cameroon,
1-5 September 2008**

**WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville • 2008**

AFRO Library Cataloguing-in-Publication Data

The Work of WHO in the African Region 2006-2007: Biennial Report of the Regional Director

1. World Health Organization
2. Public Health Administration
3. Regional Health Planning
4. Health Priorities
5. Health Status
6. Africa

ISBN 92 9 023 131 9 (NLM Classification: WA 540 HA1)

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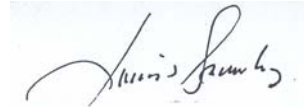
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The Regional Director has the honour of presenting to the Regional Committee the report on the activities of the World Health Organization in the African Region during the period 1 January 2006 to 31 December 2007.

A handwritten signature in black ink, appearing to read 'Luis Gomes Sambo', is centered on the page. The signature is fluid and cursive, with a large initial 'L'.

*Dr Luis Gomes Sambo
Regional Director*

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ABBREVIATIONS

ACT	artemisinin-based combination therapy
AFRO	World Health Organization Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
APOC	African Programme for Onchocerciasis Control
ART	antiretroviral therapy
AU	African Union
BFHI	Baby Friendly Hospital Initiative
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (USA)
CEMAC	Economic and Monetary Community of Central Africa
CFR	case fatality rate
CIDA	Canadian International Development Agency
CMH	Commission on Macroeconomics and Health
DALY	disability-adjusted life year
DANIDA	Danish International Development Agency
DFID	Department for International Development (UK)
DOTS	directly-observed treatment short-course
DPT3	diphtheria pertussis tetanus
ECOWAS	Economic Community of West African States
EPI	Expanded Programme on Immunization
EQA	external quality assessment
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSM	Global Management System
GSS	Global Salmonella Survey
GTZ	German Agency for Technical Cooperation
HHA	Harmonization for Health in Africa
HIS	Healthy Information System
HIV	human immunodeficiency virus
HMN	Health Metrics Network
HRH	human resources for health
HTC	HIV testing and counselling
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations 2005
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IPTp	intermittent preventive treatment in pregnancy
IST	Intercountry Support Team
ITN	insecticide-treated net
IYCF	Infant and Young Child Feeding
MDG	Millennium Development Goal
MDR	multidrug-resistant
MNCH	maternal, newborn and child health
MTEF	Medium-term Expenditure Framework
MTSP	Medium-Term Strategic Plan
NCD	noncommunicable disease
NEPAD	New Economic Partnership for Africa's Development

NHA	national health accounts
NHIS	National Health Information System
NORAD	Norwegian Agency for International Development
OFID	OPEC Fund for International Development
OPEC	Organization of Petroleum-exporting Countries
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
SADC	Southern African Development Community
SDH	social determinants of health
SIA	supplemental immunization activity
SWAp	sector-wide approach
TB	tuberculosis
TDR	WHO Special Programme for Research and Training in Tropical Diseases
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WPV	wild poliovirus
XDR	extensively drug-resistant

EXECUTIVE SUMMARY

1. During the 2006-2007 biennium, in line with WHO global agenda defined in the Eleventh General Programme of Work and *Strategic orientations for WHO action in the African Region 2005–2009*, the Secretariat provided support to Member States towards strengthening their health systems; addressing the burden of HIV/AIDS, tuberculosis and malaria; combating communicable and noncommunicable diseases; addressing child survival and maternal mortality; ensuring healthy environments; and responding to emergencies.
2. In order to bring WHO presence closer to countries, the Regional Office pursued decentralization of functions and resources, and the strengthening of WHO country offices. Three Inter-country Support Teams were established in Harare, covering Eastern and Southern Africa; Libreville, covering the countries of Central Africa; and Ouagadougou, covering West African countries.
3. The Regional Office further expanded and strengthened its partnerships for health. Thus, in collaboration with the African Development Bank, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, and the World Bank, WHO established the Harmonization for Health in Africa initiative aimed at assisting Member States of the African Region to efficiently mobilize and utilize investments in health. Harmonization for Health in Africa actions are fully in line with the Paris Declaration on Aid Effectiveness.
4. In June 2007, the Regional Office launched the first issue of *The African regional health report: the health of the people* highlighting the burden of preventable diseases, the solutions that are available by scaling up proven public health interventions, and the achievements made. The report received wide recognition as an unbiased and constructive reflection on the health situation in the Region.
5. The strengthening of health systems came into focus on the global health agenda during the biennium. WHO advocated for resource mobilization and provided technical support to countries resulting in substantive Global Alliance for Vaccines and Immunization grants to 15 countries for strengthening health systems; revision of national health policies; development of national health strategic plans; and assessment of district health systems. These efforts also resulted in the strengthening of medicines regulatory authorities in 12 countries as well as the creation of the Regional Human Resources for Health Observatory and the inception of national observatories in six countries.
6. In relation to the fight against HIV/AIDS, WHO supported 17 countries to update national guidelines on case management of sexually-transmitted infections. Support to the prevention of mother-to-child transmission (PMTCT) of HIV resulted in a rise in the number of women accessing PMTCT services from 190 000 in 2004-2005 to 300 000 in 2006-2007. Likewise, by the end of December 2007, 1.9 million persons living with HIV/AIDS had received antiretroviral therapy, representing 42% of those in need. Epidemiological estimates indicated an overall trend toward stabilization in the occurrence of new HIV infections in sub-Saharan Africa, and a decline in some countries. Member States strengthened implementation of collaborative HIV/tuberculosis activities. The average proportion of TB patients screened for HIV increased from 2% at the end of 2005 to 14% by the end of 2007. This proportion reached 75% in a few countries.
7. The Regional Office provided technical support for the preparation of the 2006 Abuja Summit on HIV/AIDS, Tuberculosis and Malaria. By the end of 2007, 41 countries had adopted artemisinin-based combination therapy for malaria. During 2006-2007 the Global Fund to Fight AIDS, Tuberculosis and Malaria approved 27 proposals with a malaria component. Over 33

million insecticide-treated nets were distributed, and the efforts deployed by Member States in the fight against malaria resulted in significant declines in malaria morbidity and mortality.

8. The prevention and control of other communicable diseases continued to be a priority for WHO actions in the African Region. The Regional Office reviewed implementation of interventions against dracunculiasis and certified ten countries as free of local transmission of the disease. Between 2005 and 2007, the annual incidence of the disease decreased by 28%. The efforts towards elimination of leprosy in remaining endemic countries resulted in a 30% reduction of leprosy prevalence. By the end of 2007, 44 countries in the Region had achieved the leprosy elimination goal.

9. The downward trend in the annual incidence of human African trypanosomiasis continued during the biennium 2006-2007. A 69% reduction was recorded for a group of 24 countries. Governments increased their contributions to the African Programme for Onchocerciasis Control by 38%; in 2007, the Programme operations averted an estimated 960 000 disability-adjusted life years.

10. Overall, the Expanded Programme on Immunization achieved significant results in the Region. DPT3 coverage reached levels of at least 90% in 15 countries. A total of 108 million children were immunized against measles in 2006-2007. With a 91% reduction in measles deaths, the African Region surpassed the measles elimination goal set for 2009. Following the introduction of yellow fever vaccine into routine immunization regimens, 22 countries achieved vaccination coverages equal to or above 80% for this antigen. Heightened efforts for poliomyelitis eradication resulted in a 70% decline in the number of reported polio cases in 2007 as compared to 2006. In 2007, 41 countries achieved certification-standard for acute flaccid paralysis surveillance.

11. Increased evidence for the heavy burden of noncommunicable diseases was gathered during 2006-2007 through STEP surveys. The findings indicated, inter alia, a high prevalence of hypertension and high blood sugar in some countries. This has resulted in the establishment of integrated noncommunicable disease control programmes in four countries. In 2007, WHO and UNECA sponsored the African Road Safety Conference in Accra. Participating countries adopted the Accra Recommendations and Declaration on Road Safety.

12. By December 2007, 35 countries had achieved ratification of the WHO Framework Convention on Tobacco Control. The Regional Office supported those countries to develop and implement legislation and national action plans for tobacco control. The Global Youth Tobacco Survey was completed in 31 countries. The findings showed that 30% to 80% of youth aged 13-15 years are exposed to second-hand smoke.

13. Participants at the fifty-sixth session of the Regional Committee for Africa adopted the child survival strategy jointly developed by UNICEF, the World Bank and WHO. Efforts to scale up the implementation of Integrated Management of Childhood Illness continued; as a result, 19 countries expanded coverage to more than half of their districts. By the end of the biennium, a cumulative total of 29 countries had developed national strategies on infant and young child feeding. The Regional Office trained 37 participants from 13 countries on utilization of the new WHO child growth standards.

14. By the end of 2007, an additional 21 countries had developed their national road maps for accelerating the attainment of the Millennium Development Goals related to maternal and newborn health, bringing the total to 37 countries. UNFPA, UNICEF and WHO combined their efforts to train country experts from eight countries on translating the Road Map into district operational plans. Prevention and control of cervical cancer received increased attention during

2006-2007. Regional training was provided in both visual inspection with acetic acid and cryotherapy treatment.

15. At its fifty-sixth session, the Regional Committee for Africa adopted Resolution AFR/RC56/R4 to address the health challenges of poverty. At its fifty-seventh session, the Committee endorsed the document entitled “Key social determinants of health: a call for intersectoral action to improve health status in the African Region”.

16. Half of the Member States in the African Region faced emergencies during the biennium. Therefore, the Regional Office strengthened country capacities for response and posted experienced international staff in the most affected countries and on the Intercountry Support Teams. Advocacy and support to countries in fund raising resulted in the mobilization of over US\$ 78 million for emergency relief activities during the biennium.

17. At its fifty-seventh session, the Regional Committee for Africa adopted Resolution AFR/RC57/R2 for implementation of the regional food safety strategy. Countries received Regional Office support for training in food safety. Outbreaks of foodborne diseases, such as acute aflatoxin poisoning in Kenya and bromide intoxication in Angola, were investigated with strong technical support, resulting in implementation of suitable control measures.

18. In administration and finance, the Regional Office implemented WHO contractual reform, resulting in the establishment of over 1200 fixed-term posts to replace previous temporary positions. For the 2006-2007 biennial period, WHO expenditures in the African Region amounted to US\$ 785.7 million, based on 31 December 2007 records, representing 82.8% of the approved budget.

19. The Regional Office monitored the implementation of 16 resolutions of the Regional Committee for Africa taken during the period 2003–2007. Part two of this report provides a detailed account of actions taken and significant achievements towards the realization of these resolutions.

INTRODUCTION

1. The years 2006-2007 constitute the first biennium under the WHO Eleventh General Programme of Work which sets the global health agenda for the period 2006 to 2015.¹ The Eleventh General Programme of Work describes six core functions based on the WHO mandate and comparative advantage, thus emphasizing the Organization's contributions towards closing the gaps in global health.

2. To better support Member States to attain country, regional and global health goals, the WHO Regional Office for Africa formulated five strategic orientations² at the beginning of the biennium. These are: (i) strengthening WHO country offices; (ii) improving and expanding partnerships for health; (iii) supporting the planning and management of district health systems; (iv) promoting the scaling up of essential health interventions related to priority health problems; and (v) enhancing awareness and response to the key determinants of health.

3. In order to implement the WHO 2006-2007 cooperation programme with the Member States of the African Region, the organizational structure included the Regional Office with seven divisions hosting regional technical programmes; three intercountry support teams serving countries in west, central, and southern and eastern Africa; and 46 country offices. The biennial Programme Budget 2006-2007 amounted to US\$ 945 million apportioned to 36 areas of work.

4. The progress achieved in the implementation of the Programme Budget was monitored every six months according to area of work. The Regional Director's report, *The work of WHO in the African Region 2006*, was presented during the fifty-seventh session of the WHO Regional Committee for Africa. That annual report summarized the mid-term assessment of work for the first year of the 2006-2007 biennium.

5. The purpose of the present document is to report on the implementation of the Programme Budget 2006-2007. The report includes two main parts: the first part, devoted to the implementation of the Programme Budget, presents the main achievements, enabling factors and constraints for the 36 areas of work; the second part reports on progress towards the implementation of relevant resolutions of the WHO Regional Committee for Africa. In addition, the report comprises a conclusion and way forward. The annex presents tables summarizing budget implementation at the end of the biennium.

PART 1: IMPLEMENTATION OF WHO PROGRAMME BUDGET 2006-2007

1.1. SIGNIFICANT ACHIEVEMENTS

OVERALL MANAGEMENT OF SECRETARIAT ACTIONS

6. The overall management of the WHO Secretariat in the African Region is conducted under the leadership of the Regional Director. The Director of Programme Management coordinates the implementation of WHO programmes in the Region. All the strategic functions are implemented through seven divisions: Division of Prevention and Control of HIV/AIDS, Tuberculosis and Malaria; Division of Administration and Finance; Division of Prevention and Control of Communicable Diseases; Division of Healthy Environments and Sustainable Development;

¹ WHO, *Engaging for health, Eleventh General Programme of Work, 2006–2015: A global health agenda*, Geneva, World Health Organization, 2006.

² WHO, *Strategic orientations for WHO action in the African Region 2005–2009*, Brazzaville, World Health Organization, Regional Office for Africa, 2005.

Division of Prevention and Control of Noncommunicable Diseases; Division of Family and Reproductive Health; and Division of Health Systems and Services Development. The Regional Director's Office comprises three areas of work, namely, Director-General, Regional Director and Independent Functions; WHO's Core Presence in Countries; and External Relations.

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

7. In the biennium 2006-2007, the WHO Regional Office for Africa was productive in pursuing the reforms aimed at enhancing the Region's capacity to implement its strategy for the period 2005-2009. Institutional reforms were undertaken; in particular, a new organizational chart was adapted to the priorities and challenges of the Region; country offices were re-profiled to reinforce WHO presence at country level; more effective human resource plans were developed for country offices and divisions; and the Intercountry Support Teams were established to decentralize the work and authority of the Regional Office. These processes were enthusiastically supported at all levels of the Organization.

8. Regular meetings of the Management Executive Committee, chaired by the Regional Director, served to strengthen the coordination and direction of the work of the Secretariat. Regional Programme Meetings provided regular discussion and recommendations to improve programme efficiency.

9. Under the principle of "One WHO", technical collaboration with WHO headquarters has been reinforced through regular interactions of the Strategy Committee. Collaboration with other regional offices was reinforced through exchange of high-level experts and cooperation to address major health priorities such as poliomyelitis eradication, avian influenza and knowledge management.

10. Systematic and structured briefings on technical issues and papers were conducted for Member countries representing the Region on the WHO Executive Board and at the World Health Assembly. Similarly, discussions of the Regional Committee provided the common position of Member States from the Region during meetings of these Governing Bodies.

11. High-level advocacy by the Regional Director with national authorities was instrumental in the success of these achievements. During the biennium, the Regional Director undertook advocacy visits to 12 countries in the Region, discussing national and regional priorities with Heads of state and government, and obtaining commitments for achieving the Millennium Development Goals and meeting other major health challenges. Furthermore, strong advocacy was deployed for the declaration of 2006 as the Year for Acceleration of HIV Prevention in the African Region.

12. Under the leadership of the Regional Director, successful policy dialogue was established with multilateral and bilateral organizations and agencies working in Africa. The excellent cooperation established and the high-level expertise provided by the Regional Office led to the recognition of WHO as the leader in health matters by the UN agencies operating in Africa. There was important collaboration with the African Union, and several WHO meetings were attended by the President of the African Union Commission; interaction with regional economic communities was optimized.

WHO's Core Presence in Countries (SCC)

13. Decentralization of the Regional Office to the three subregional Intercountry Support Teams (ISTs) was one of the main strategies for bringing technical support closer to countries. With material and logistical support from the host governments, the three ISTs became fully

functional in Harare, Libreville and Ouagadougou. Operational guidelines for the ISTs were developed to ensure coordination of activities between the Regional Office, the ISTs and the country offices. Thus, the Regional Office began to concentrate on normative work, standards, monitoring, evaluation and resource mobilization, while the ISTs began to provide more technical support to countries. Initial experiences were positive; for example, responses to epidemics and emergencies improved greatly.

14. Two capacity-building exercises were held to update WHO representatives with current public health and managerial processes. Due to the success of the exercise, which used a new in-house tool, more representatives would be involved in the future.

15. By the end of the 2004-2005 biennium, all the country offices of the WHO African Region had completed their Country Cooperation Strategy (CCS) documents. However, due to developments in aid procedures, the Eleventh General Programme of Work and the Medium-Term Strategic Plan, it became necessary to prepare second-generation CCS documents in the 2006-2007 biennium. The *Guidelines for updating CCS documents in the WHO African Region* were developed and published. By the end of 2007, six WHO country offices had completed the first draft of their second-generation Country Cooperation Strategy.

16. Resolution WHA58.25 mandated the Director-General to cooperate with the United Nations reform process and harmonize WHO work with that of other UN agencies. In compliance, the various WHO country offices collaborated with the United Nations Country Teams and were active in the development of new documents for the United Nations Development Assistance Framework. Furthermore, the Regional Office collaborated with headquarters to establish four "One UN" pilot countries under the Resident Coordination system. In conformity with the Paris Declaration, WHO headquarters and regional offices developed a harmonization and alignment training toolkit which was successfully tested in two country offices of the African Region.

17. For the majority of countries in the African Region, the attainment of the Millennium Development Goals requires much more investment. Thus, the Harmonizing for Health in Africa network was established in partnership with African Development Bank, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, the World Bank, and WHO headquarters. During the 2006-2007 biennium, the network supported 13 countries in strengthening health systems. A communication portal was established for exchange of information with other WHO regions.

External Relations (REC)

18. Building partnerships is a primary support function of WHO activities and is one of the core competencies required of WHO staff. In response to the increased relevance of partnerships and resource mobilization in the African Region, the WHO Regional Office for Africa restructured and re-profiled the unit in charge of external relations and resource mobilization and strengthened it with the recruitment of two new professional staff.

19. One emphasis was on partnerships at global level. A conference to examine and agree on new approaches for collaboration to improve the health situation in Africa was held in Nairobi in March 2007. The outcomes of the meeting were the preparation of clear interagency and intercountry communications on the roles and mandates of individual stakeholders, taking into account their competencies, capacities, capabilities and comparative advantages. Consensus was also reached on the development of mechanisms for pooling expertise; the establishment of mechanisms for collaboration and for peer review of performance and partnerships; partner focus

on efforts to strengthen country capacities to lead partnerships; and using the on-going reform in the United Nations system to support country and regional reform efforts.

20. Efforts were also made to strengthen partnerships with the African Union and the various regional economic communities. At a meeting in October 2006 these institutions agreed to revise the existing collaboration agreements, taking into account the changing international and regional health environment. Furthermore, a number of technical cooperation domains were discussed, and it was decided to take action on specific technical areas such as HIV/AIDS, vaccine regulation, counterfeit and substandard medicines, and gender-based violence. This was subject to a revised agreement to be signed in the new biennium.

21. Partnerships were also strengthened with UNAIDS, UNICEF, UNFPA, World Bank and the African Development Bank. Two high-level multi-partner meetings were held in February 2007 in Dakar and in November 2007 in Nairobi. The meetings recognized the leadership of WHO in health matters in the Region. The main outcomes of the Nairobi meeting were the endorsement of the concept paper on Harmonization for Health in Africa (HHA), the adoption of the HHA workplan 2008–2010 and a joint letter from the regional directors addressed to the country representatives and directors of the six agencies. The meeting restated that participation in this interagency collaboration was open and that new agencies were welcome to join and support HHA. The World Food Programme participated as an observer in the above-mentioned Nairobi meeting. The success of HHA will be enhanced by the commitment of development partners and of a strong “One UN” system.

22. During the biennium 2006-2007, the Regional Office signed a total of 62 bilateral and multilateral agreements with the following partners: the governments of Austria, Belgium, Canada, France, Germany, Ireland, Japan, Grand Duchy of Luxembourg, Portugal, South Korea, Sweden and Switzerland; Department for International Development (UK); United States Agency for International Development; Office for the Coordination of Humanitarian Affairs (UN); Central Emergency Response Fund; African Development Bank; the World Bank; European Commission; United Nations Development Programme; United Nations Population Fund; Arab Gulf Programme for United Nations Development Organizations; Global Fund to Fight AIDS, Tuberculosis and Malaria; Save the Children; and the Mectizan Donation Programme. In comparison with the previous biennium, this represented an increase of 72% in the number of signed partnership agreements.

23. Two workshops on resource mobilization and negotiation skills were held during the biennium. These workshops addressed the resource mobilization challenges facing WHO. They also aimed at developing effective partnership proposals as well as providing an exhaustive overview of WHO rules and procedures in partnership development and management.

24. The Regional Office produced more than a hundred press releases and 65 audiovisual programmes which were published and disseminated by the print and electronic media within and outside the Region. These materials, developed within the framework of the joint action for the achievement of the MDGs in the African Region, focused especially on advocacy and awareness raising in disease prevention and control in the Region.

25. Press conferences, media interviews and briefings as well as the distribution of information kits were organized at the occasion of major Regional Office meetings and events such as the fifty-sixth and fifty-seventh sessions of the Regional Committee, the launch of 2006 as the Year for Acceleration of HIV Prevention in the African Region, and the international conference on enhanced partnerships in March 2007, the first WHO partners forum in the Region. The Public Information and Communication Unit marshalled media support for these meetings.

PROGRAMME MANAGEMENT

26. The Director, Programme Management is responsible for the coordination of WHO technical programmes in the Region. The Division also has the responsibility of supervising the following areas of work: Governing Bodies; Planning, Resource Coordination and Oversight; Health Information, Evidence and Research Policy; and Knowledge Management and Information Technology.

Governing Bodies (GBS)

27. The delegates from Member States successfully participated in meetings of the WHO Executive Board and the World Health Assembly. During deliberations of the WHO Governing Bodies, the delegates from the African Region provided decisive policy orientations. Their valuable contributions to agendas and debates, supported by technical documentation, led to the adoption of important resolutions and decisions.

28. The fifty-sixth and fifty-seventh sessions of the WHO Regional Committee for Africa were successfully held in Addis Ababa and Brazzaville, respectively. A total of 13 resolutions of regional and global importance were adopted by the Regional Committee. These included resolutions on child survival; poverty, trade and health; health financing; avian influenza preparedness and response; knowledge management; food safety and health; and diabetes prevention and control.

29. In order to improve the effectiveness, efficiency and coordination of the African delegations during Governing Bodies meetings, important procedural changes were adopted. The membership of the Programme Subcommittee was increased from 12 to 16 members, and the terms of reference were reviewed to enhance Programme Subcommittee preparations for Regional Committee meetings.

30. The method of work of African Region delegates to the Executive Board and the World Health Assembly was revised and adopted at the fifty-seventh session of the Regional Committee. In liaison with Member State diplomatic missions in Geneva, the WHO Regional Committee for Africa granted the African Union Coordinator an important role in collating the statements of African Region delegations to the Executive Board and World Health Assembly.

Planning, Resource Coordination and Oversight (BMR)

31. Issues and challenges targeted by this area of work included improvement of the technical quality of operational plans, closer link between deliverables of technical programmes and budget consumption, and the development of capacity for planning, including joint planning processes.

32. With the elaboration of the Medium-Term Strategic Plan (MTSP) 2008–2013 and the Programme Budget 2008-2009 in the new environment of the Global Management System (GSM), the biennium 2006-2007 was a transition period for the introduction of the new WHO managerial framework.

33. Mandatory reporting was done in a timely manner. This included submissions for semi-annual monitoring reports, the mid-term report, Monitoring and Evaluation Committee Report, the Regional Director's reports and the end-of-biennium report, all accounting for the performance of the WHO African Region in the implementation of the Programme Budget.

34. Managerial capacities of programme managers at the Regional Office and national professional officers in charge of planning in country offices were strengthened in line with the

WHO results-based management approach. They developed skills in operational planning and self-performance assessment through regular briefings, peer review meetings and workshops. The introduction of peer review workshops in the process of the elaboration and production of plans and reports significantly improved planning and monitoring skills of staff members. Furthermore, the awareness of all professional staff members was raised with regards to the Global Management System (GSM) in the African Region.

35. There was considerable progress in the monitoring of budget consumption during the biennium despite difficulties in tracking Voluntary contributions that constitute the most important source of funding. Programme managers' awareness of responsibility for financial accountability and the collaboration between the Budget and Finance Unit and the various technical programmes were strengthened.

Health Information, Evidence and Research Policy (IER)

36. Health information and evidence play major roles in directing resource flows and health programmes. However, lack of basic health information and ignorance of best practices are critical causes of failure in health systems, including health research systems. Research is often poorly integrated into health information systems which in turn often fail to generate the kind of data that researchers and policy-makers need. The linkage between research, policy-making and decision-making is weak. Principles of ethics should also guide policy-making so as to ensure fairness, responsiveness, accountability and coherence of health-related policies and programmes.

37. WHO responded to these issues by promoting capabilities in (i) assessment of health situation and trends; (ii) evidence synthesis to improve practices, inform policies and decisions, and identify gaps in evidence; (iii) research to strengthen regional collaboration on specific priorities; (iv) enhancing the application of research to policy- and decision-making; and (v) ethics to ensure that research meets the highest standards of ethical conduct.

38. The major achievements include the publication of *The African regional health report 2006: The health of the people*. This document was awarded recognition by the British Medical Association for elucidating the regional health situation and the trend in Millennium Development Goal indicators. Improvement of the reporting on MDG indicators is ongoing in close collaboration with countries.

39. Sessions of the African Advisory Committee for Health Research and Development were held in 2006 and 2007. The Evidence-Informed Policy Network (EVIPNet-Africa) project involving seven countries was launched in March 2006; the main aim is to convert knowledge into action in order to improve health outcomes.

40. The Regional Office supported an eight-country steering committee to develop the draft objectives, programme and declaration in preparation for the Ministerial Conference on Research for Health planned for 2008 in Algiers, Algeria.

41. A total of 14 countries³ enhanced the production and use of health statistics. Reports of the World Health Survey conducted in 2003 in 18 countries were posted on the WHO web site, and fact sheets on MDG indicators were produced for all 46 Member countries. The booklet on core indicators, "Health situation analysis: basic indicators 2006", was published. It provided comprehensive summary statistics on the current status of public health and health systems at country level.

³ Algeria, Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Democratic Republic of Congo, Ghana, Guinea, Kenya, Mali, Mauritania and Senegal.

Knowledge Management and Information Technology (KMI)

42. The current progress made in knowledge management and advances in information and communication technology present both challenges and opportunities for addressing the immense burden of disease in the African Region. The challenges include limited access to health information and knowledge sources; weak culture of knowledge-sharing; low quality of the knowledge locally generated and published; limited infrastructure and services; computer illiteracy; and inadequate power supply, particularly in remote areas.

43. WHO responded by providing policy and technical guidance, and strengthening capacity for knowledge management in Member States. Efforts were made to improve access to health-related scientific knowledge using the Internet, library services and knowledge networks. Countries were also encouraged to adopt eHealth strategies to strengthen their health systems in order to improve performance and health outcomes.

44. At its fifty-sixth session, the Regional Committee for Africa reviewed the document entitled “Knowledge management in the WHO African Region: strategic directions” and adopted a resolution calling on Member States to prepare and implement national strategic directions for knowledge management, including eHealth.

45. New web sites were published for three WHO country offices (Cape Verde, Rwanda and Tanzania) and for the African Health Workforce Observatory. The SharePoint web site was established in the Regional Office to facilitate information-sharing and collaboration by divisions and technical units.

46. The African Index Medicus containing more than 8000 titles was published on the Internet as part of the Global Health Library. These titles were included in Google and Google Scholar.

47. Translation and interpretation services were provided in support of meetings of Governing Bodies and technical programmes. Corresponding reports and other related documentation were published in the three official languages.

48. The African Region Telemedicine Task Force, of which the Regional Office is the secretariat, published and submitted its reports, *Medical eContent via satellite for the African health work force* and *Satellite-based tele-consultation service for rural areas*, to the European Union Commission. The Commission subsequently decided to fund two pilot projects to guide a stepwise development of an eHealth network for sub-Saharan Africa.

49. The WHO global phone network connectivity infrastructure was standardized throughout the Region, and the bandwidth was upgraded to enhance connectivity. Preparations for the deployment of the WHO Identity Management System in the Regional Office and for a regional data hub for the Global Management System were completed.

HEALTH SYSTEMS AND SERVICES DEVELOPMENT

50. The strengthening of health systems continued to be a priority in WHO’s efforts to increase the chances of countries’ attaining the health-related Millennium Development Goals during the biennium. The prevailing poor health indicators remain a challenge aggravated by the inadequate financial and human resources and competing developmental priorities at national, regional and global levels.

51. The Division of Health Systems and Services Development addressed the above-mentioned challenges through five areas of work: Health System Policies and Service Delivery; Health

Financing and Social Protection; Essential Medicines; Blood Safety and Clinical Technology; and Human Resources for Health.

Health System Policies and Service Delivery (HSP)

52. The Regional Office continued to support countries in their efforts to develop national health policies and plans; diagnose and strengthen district health systems; enhance capacity building; support focused initiatives; and strengthen national health information systems.

53. Cape Verde developed a national health policy, 11 other countries⁴ revised their national health policies and 16 countries⁵ embarked on the development of national health strategic plans. This brings to 17 and 20, respectively, the number of countries that have developed and reviewed their policies and strategic plans during the last four years. Kenya, Malawi, Uganda and Zambia reviewed their health sector management structures. The Democratic Republic of Congo undertook health sector reform, focusing on the strengthening of district health systems.

54. A total of 11 countries⁶ reviewed the roles of hospitals in national health systems, shared good practices, identified hospital performance indicators and made recommendations for strengthening hospitals.

55. National health policies and plans from 37 countries were analysed to assess the extent to which priority programmes such as HIV/AIDS, tuberculosis, malaria, and child and maternal health were considered. A framework for policy analysis was developed and applied to analyse health policies and strategic plans.

56. A total of 24 countries undertook a rapid assessment of the operability of district health systems and assessed their capacity to scale up essential health interventions at district and subdistrict levels. Results from this assessment will be used for improving service delivery and informing the operational planning process. Another focus was on building capacity of key staff in countries and WHO offices in areas such as leadership and management (nine countries⁷) as well as the implementation of the third WHO strategic orientation on health policies and service delivery (14 countries⁸). Seven out of 14 countries⁹ completed the Health Service Availability Mapping exercise. The WHO-NORAD project was evaluated in seven countries, and results were documented and disseminated.

57. The Global Alliance for Vaccines and Immunization (GAVI) granted funds to 15 countries¹⁰ to strengthen their national health systems for a total amount of US\$ 282 112 000 covering the period 2007–2011. The Regional Office developed guidelines for monitoring and evaluation of health sector reforms and a framework for scaling up essential health interventions. At its fifty-sixth session, the Regional Committee for Africa endorsed the document entitled “Revitalizing health services using the Primary Health Care approach” and adopted the related Resolution AFR/RC56/R6.

⁴ Angola, Benin, Botswana, Burundi, Chad, Comoros, Eritrea, Gambia, Ghana, Liberia and Swaziland.

⁵ Algeria, Benin, Cape Verde, Republic of Congo, Côte d’Ivoire, Ethiopia, Gabon, Gambia, Guinea-Bissau, Liberia, Madagascar, Nigeria, Sierra Leone, Swaziland, Togo and Zambia.

⁶ Benin, Cameroon, Republic of Congo, Democratic Republic of Congo, Gabon, Guinea, Niger, Nigeria, Uganda, South Africa and Zambia.

⁷ Benin, Burkina Faso, Comoros, Cote d’Ivoire, Democratic Republic of Congo, Guinea, Madagascar, Niger, Senegal.

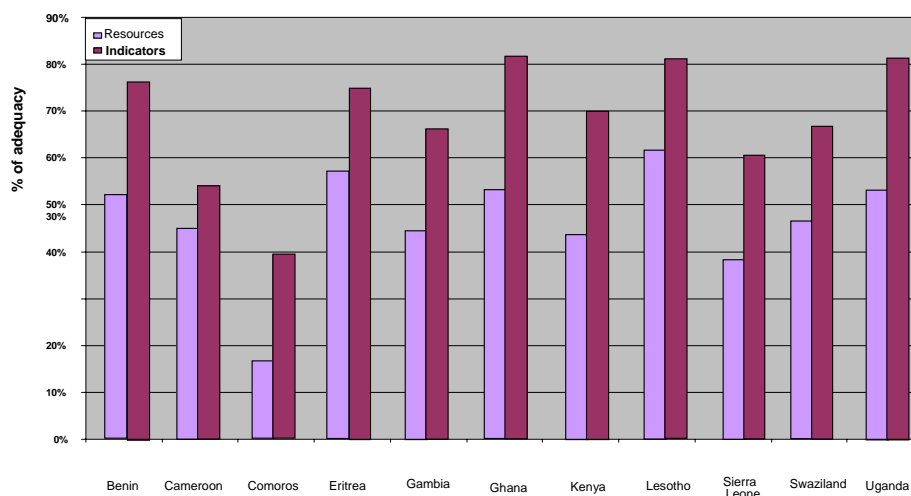
⁸ Cape Verde, Central African Republic, Republic of Congo, Democratic Republic of Congo, Ghana, Kenya, Madagascar, Malawi, Mali, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe.

⁹ Central Africa Republic, Republic of Congo, Democratic Republic of Congo, Ghana, Kenya, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Swaziland, Tanzania, Togo, Uganda and Zambia.

¹⁰ Burundi, Cameroon, Central African Republic, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Nigeria, Rwanda, Sierra Leone, Uganda and Zambia.

58. The Health Metrics Network (HMN) trained 77 participants from the 27 HMN-funded countries in using the HMN framework and Health Information System (HIS) assessment tool. The training aimed at developing capacity for the improvement of national health information systems. As a follow-up, 15 of the countries assessed their national health information systems. The findings of the assessment of resources and indicators in 11 countries show that 50% of the assessed countries need to strengthen their resources for HIS despite the adequacy in maintaining indicators (Figure 1). Based on these results, Sierra Leone developed a national HIS strategic plan and started its implementation with the support of DFID and the World Bank.

Figure 1: Adequacy of resources and indicators for national health information systems in countries supported by the Health Metrics Network, 2007



Health Financing and Social Protection (HFS)

59. The capacity of countries to ensure sustainable health financing continued to be strengthened during the biennium. Member States at the fifty-sixth session of the Regional Committee for Africa endorsed the document entitled “Health financing: A regional strategy for the African Region” aimed at providing guidance in the area of health financing; they adopted the related Resolution AFR/RC56/R5.

60. A total of 15 nationals from Burkina Faso, Ghana, Mozambique, Nigeria and Tanzania were trained in financial analysis of health financing mechanisms. Those participants started implementing research proposals on sustainable financing for HIV/AIDS. A total of 30 participants from 20 countries (i.e. out of 46 countries) were trained in undertaking and institutionalizing national health accounts (NHA) at workshops held in Bamako and Brazzaville.

61. Technical support was provided to 14 countries¹¹ for conducting assessments of national health accounts. However, only seven of them completed the NHA assessment and disseminated their findings.¹² This increased the number of countries that have undertaken at least one round of NHA assessment from 13 to 20. The studies are ongoing in the remaining countries. Eritrea and Nigeria developed comprehensive health financing policies.

¹¹ Botswana, Burkina Faso, Republic of Congo, Chad, Gambia, Guinea, Malawi, Niger, Rwanda, Sierra Leone, Sao Tome and Principe, Senegal, Tanzania and Zimbabwe.

¹² Botswana, Burkina Faso, Gambia, Malawi, Niger, Rwanda and Sierra Leone.

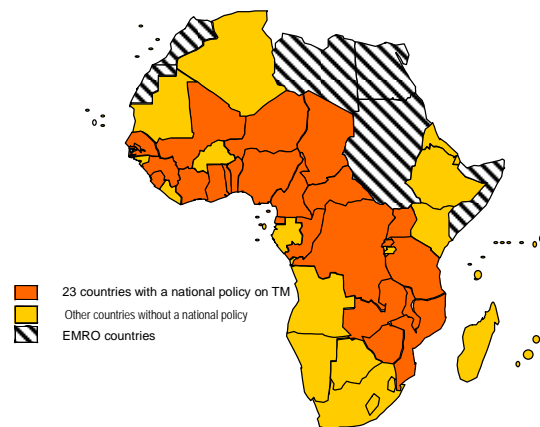
62. The following health economics technical documents were produced and disseminated through peer-reviewed journals: (i) an overview of health financing patterns and the way forward in the WHO African Region; (ii) the cost of the health professionals brain drain in Kenya; (iii) the cost of the health-related brain drain to the WHO Africa Region; (iv) equity in health and health care in Malawi; (v) efficient management of health centre human resources in Zambia; (vi) technical efficiency, efficiency change, technical progress and productivity growth in the national health systems of continental African countries; and (vii) health-related biotechnology transfer to Africa: principal-agency relationship issues.

63. Uganda developed a health financing database and produced a report on willingness to pay for social health insurance. The West African Health Economics Network was established, and its inaugural conference took place in August 2007, at the University of Nigeria.

Essential Medicines (EDM)

64. Economic and Monetary Community of Central Africa (CEMAC) Member States¹³ adopted a harmonized national medicines policy. Kenya, Gambia, Malawi and Swaziland reviewed and finalized their national medicines policies, making a total of 40 countries with such policies. Support was provided to 13 countries¹⁴ for national policies on traditional medicine, legal frameworks for the practice of traditional medicine, codes of ethics and strategic plans. This makes a total of 23 countries that have developed national policies (Figure 2) since the adoption of the regional strategy on promoting the role of traditional medicine in health systems in 2000. Participants at the fifty-seventh session of the WHO Regional Committee for Africa adopted the Brazzaville Declaration on Traditional Medicine.

Figure 2: Countries with national policies on traditional medicine, 2001–2007



65. The Regional Office training manual on drug management at the health centre level was revised to incorporate a chapter on the management of antiretroviral drugs and HIV/AIDS commodities. Software was developed to complement the training manual. The fourth edition of

¹³ Cameroon, Republic of Congo, Central African Republic, Chad, Equatorial Guinea and Gabon.

¹⁴ Cameroon, Central African Republic, Republic of Congo, Democratic Republic of Congo, Côte d'Ivoire, Ghana, Kenya, Nigeria, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe.

the *AFRO essential medicines price indicator* was published. In collaboration with headquarters, tools for mapping partners and financial flows to medicines and an in-depth assessment of the procurement and supply systems were developed and pre-tested in Ghana and Senegal; they were subsequently applied in six other countries.¹⁵ Guidelines for training health science students, for continuing education of conventional health practitioners in traditional medicine and for training traditional health practitioners in Primary Health Care were field-tested in nine countries.¹⁶

66. A regional consultation on public health, innovation and intellectual property was organized to enhance the work of the WHO Intergovernmental Working Group in finalizing the draft global strategy and plan of action.

67. Support was provided to Member States and the regional economic communities (East African Community, Economic and Monetary Community of Central Africa, Southern African Development Community and Economic Community of West African States) and to harmonize national medicine regulations and policies and for implementing their workplans. Participants at the fifty-sixth session of the Regional Committee for Africa endorsed document AFR/RC56/11 “Medicines regulatory authorities: current status and way forward” aimed at providing guidance for strengthening medicines regulatory authorities. Twelve countries¹⁷ assessed and strengthened their regulatory authorities. This brought to 24 the number of countries that are operating basic regulatory systems whereas 26 countries regulate herbal medicines.

68. The Regional Office produced guidelines on national policies for the protection of traditional medicine knowledge and access to biological resources and a draft WHO model law for the protection of traditional medical knowledge. A total of 40 (of the 46) countries developed national lists of essential medicines; 17 countries¹⁸ updated their lists of essential medicines during the biennium.

Blood Safety and Clinical Technology (BCT)

69. Efforts were made to strengthen clinical laboratory services, patient safety, health technology management, diagnostic imaging and blood safety. A regional external quality assessment (EQA) scheme in haematology and clinical chemistry involving 21 university teaching hospital laboratories was initiated (Figure 3). Twelve senior microbiologists from six countries¹⁹ were trained and financially supported to establish national schemes in peripheral laboratories. Furthermore, the integrated EQA programme in microbiology that started in 2002 was extended to malaria and TB laboratories in 44 countries. During the biennium, over 70 laboratories were involved in this integrated microbiology EQA scheme.

¹⁵ Burundi, Cameroon, Ethiopia, Nigeria, Rwanda and Zambia.

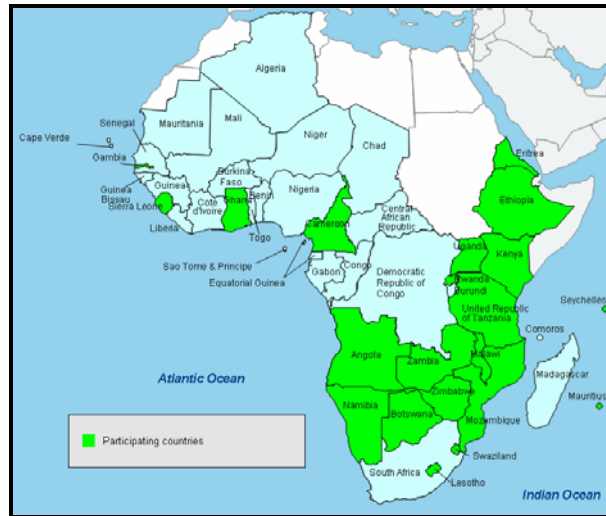
¹⁶ Cameroon, Republic of Congo, Democratic Republic of Congo, Ghana, Mali, Senegal, South Africa, Tanzania and Uganda.

¹⁷ Botswana, Burkina Faso, Cameroon, Chad, Cote d’Ivoire, Kenya, Malawi, Mali, Mozambique, Rwanda, Senegal and Zambia.

¹⁸ Burkina Faso, Cape Verde, Central African Republic, Chad, Comoros, Republic of Congo, Gambia, Liberia, Mali, Mauritania, Senegal, Seychelles, South Africa, Tanzania, Uganda, Zimbabwe and Zambia.

¹⁹ Mali, Niger, Rwanda, Senegal, Uganda and Zambia.

Figure 3: Countries participating in the WHO Regional Office external quality assessment scheme for haematology and clinical chemistry



70. Auditors for blood transfusion services were trained in Bamako, Mali. Central African Republic, Mali, Mauritius and Namibia successfully started the implementation of their quality management programmes. A total of 54 participants from both public health and national veterinarian reference laboratories were trained on biosafety and laboratory biosecurity.

71. Centres of excellence for continuing education in diagnostic imaging in Cameroon and Kenya were reactivated. A regional network for patient safety was initiated, and the first regional workshop on patient safety was organized. Study projects on adverse events occurring during clinical care in the public health and private sectors were finalized in Kenya and South Africa.

72. Eight countries²⁰ were supported to finalize their national blood policies. Angola, Gambia, Guinea-Bissau, Sao Tome and Principe, and Sierra Leone developed their strategic plans for strengthening blood safety programmes. Ghana was supported to formulate its national policy for health technology management. Mozambique, Lesotho and Liberia started developing national laboratory policies with Regional Office support.

73. Data on blood safety were collected in all the 46 Member States and the regional database was updated. Both the number of units of blood collected and the percentage of voluntary blood donors increased significantly. In addition, the report of the 2004 survey on blood safety in the WHO African Region was published. World Blood Donor Day was successfully celebrated in the Region. Sensitization materials, including videos, were produced and disseminated to Member States. A regional training workshop for donor recruiters was conducted and involved 50 participants.

Human Resources for Health (HRH)

74. The Regional Office continued to support countries in their efforts to formulate comprehensive human resource policies and plans; strengthen institutions to train appropriate

²⁰ Angola, Central African Republic, Eritrea, Gabon, Namibia, Nigeria, Sao Tome and Principe, and Senegal.

health workforces; develop regulatory frameworks; manage health workforces; generate evidence for planning and implementation; and advocate for enabling macroeconomic policies.

75. During the biennium 2006-2007 partnerships were strengthened with African Union; New Partnership for Africa's Development; European Commission; Germany Agency for Technical Cooperation; East, Central and Southern African Health Community; Southern African Development Community; Economic Community of West African States; and *Organisation de Coopération pour la lutte contre les Endémies en Afrique Centrale* to accelerate human resources for health (HRH) development in the Region. This led to increased support to countries, including support to the HRH component of priority programmes such as HIV/AIDS, Making Pregnancy Safer and immunization.

76. There was a significant increase in HRH information and evidence gathered through the establishment of the Regional Observatory, and national observatories were started in six countries.²¹ This evidence informed the development of various HRH guidelines, strategies and frameworks used by countries.

77. The national capacity for HRH policy, planning, production, management and implementation were strengthened at a number of meetings. A high-level inter-ministerial (health, finance, education, public service) meeting for policy-makers to strengthen national capacity for HRH development was attended by more than 100 participants from the continent. A regional meeting to strengthen nursing and midwifery was attended by 60 participants, and the meeting of deans of medical schools in the African Region was also attended by 60 participants.

HIV/AIDS, TUBERCULOSIS AND MALARIA

78. HIV/AIDS, tuberculosis and malaria remain major public health and developmental threats for the African Region. The direct and indirect morbidity, mortality and socioeconomic impacts of these communicable diseases continue to jeopardize progress towards the African Union's Abuja targets and the UN Millennium Development Goals.

79. In this context, the provision of timely and high quality support for accelerated programming and implementation of proven, cost-effective HIV/AIDS, tuberculosis and malaria interventions in Member States was a critical part of WHO's work in the African Region during the 2006-2007 biennium. This was achieved in collaboration with the many partners working in the Region.

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV)

80. HIV/AIDS continues to be an enormous barrier for economic and social development in sub-Saharan Africa which accounts for more than 68% of global HIV infections and more than 76% of AIDS-related deaths. In 2007 an estimated 1.7 million adults and children became infected with HIV.

81. To address this situation, WHO response consisted of normative guidance and technical support to countries. Member States adapted policies and tools, strengthened capacity for mobilizing technical and financial resources, focused on accelerating HIV prevention, and scaled up the delivery of comprehensive care for HIV/AIDS, including the provision of antiretrovirals, especially in emergency situations.

²¹ Benin, Burkina Faso, Cameroon, Ethiopia, Ghana and Uganda.

82. As a result of intensive advocacy campaigns and technical guidance, acceleration of HIV prevention was firmly on the agenda of countries and development partners, particularly partners in the UN system. The focus was on supporting countries to scale up cost-effective and evidence-based interventions and improving HIV/AIDS programming based on a good knowledge of the driving factors of the epidemic.

83. Through Regional Office support, 17 countries²² updated their national guidelines on comprehensive sexually-transmitted infection case management. Six countries²³ integrated case management into their reproductive health services. Updated guidelines on new approaches such as provider-initiated testing and counselling were made available to countries. Half of the countries in the Region (23) were supported to expand HIV testing and counselling (HTC) and prevention of mother-to-child transmission (PMTCT), resulting in an increase in the percentage of districts with at least one facility that provides HTC from 5% in 2004-2005 to 60% in 2006-2007. The total number of pregnant mothers accessing PMTCT services increased from 190 000 in 2004-2005 to over 300 000 in 2006-2007. Despite this significant progress, the coverage levels for HTC and PMTCT remained around 10%.

84. With the release of the WHO-UNAIDS recommendations on male circumcision and HIV prevention in March 2007, a UN joint plan was implemented under the leadership of the Regional Office. Particular focus was on countries of eastern and southern Africa which carry the heaviest HIV/AIDS burden and have very low male circumcision rates. As a follow-up to the recommendations at the fifty-seventh session of the Regional Committee, strategic orientations for scaling up male circumcision for HIV prevention were scheduled for discussion at an African experts meeting in March 2008.

85. Efforts were made for the expansion of antiretroviral therapy (ART) within the context of universal access. To date, 23 countries²⁴ are implementing the Integrated Management of Adult and Adolescent Illnesses approach to scale up ART. About 1.9 million people living with HIV/AIDS (PLWHA) were on ART at the end of December 2007—representing 42% of those in need, compared with 28% coverage at the end of 2006 and 17% at the end of 2005 (Figure 4). Seven countries²⁵ reached 50% or more coverage. Similar increase in coverage for care and treatment in children was documented, although the overall coverage is still very low at about 11%.

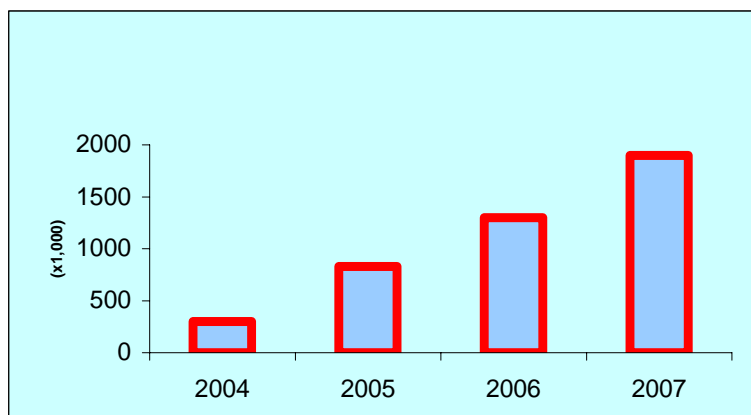
²² Cameroon, Central African Republic, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Lesotho, Liberia, Madagascar, Malawi, Mozambique, Rwanda, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe.

²³ Benin, Cameroon, Nigeria, Tanzania, Zambia and Zimbabwe.

²⁴ Benin, Botswana, Burkina Faso, Burundi, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

²⁵ Botswana, Kenya, Malawi, Namibia, Rwanda, Swaziland and Zambia.

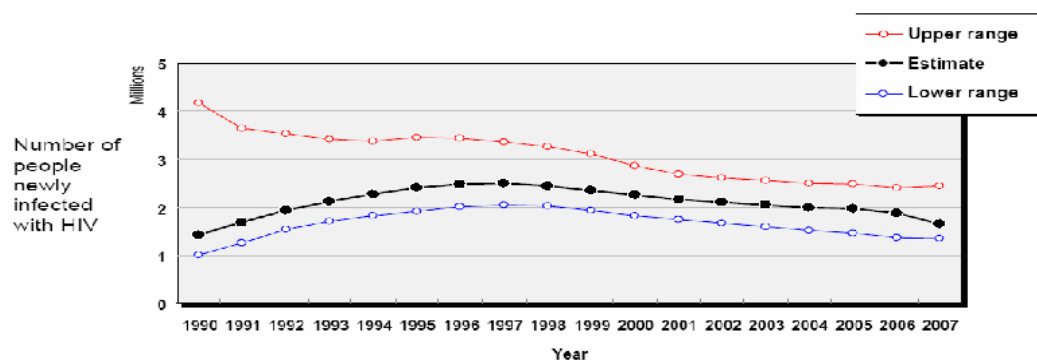
Figure 4: Number of people living with HIV/AIDS on antiretroviral therapy, WHO African Region, 2004–2007



Source: Regional database, WHO Regional Office for Africa, 2007.

86. A regional strategy for the control of the dual TB/HIV epidemic was adopted by Member States at the fifty-seventh session of the Regional Committee. The AIDS epidemic update of December 2007 by UNAIDS and WHO indicated that in most sub-Saharan countries, national HIV prevalence either stabilized or showed signs of a decline (Figure 5). However, AIDS remained the leading cause of mortality in sub-Saharan Africa, illustrating the long-term challenges that lie ahead for provision of care, treatment and support, particularly at the primary care level.

Figure 5: Estimated number of people newly infected with HIV in sub-Saharan Africa, 1990–2007



Source: WHO/UNAIDS Report on HIV Epidemic, November 2007.

87. To ensure progress towards universal access, it is important to continue advocacy for acceleration of HIV prevention, full integration of comprehensive PMTCT in maternal and child health services and scaling up of antiretroviral therapy. Monthly monitoring and evaluation of implementation of activities and budget utilization is necessary, and partnerships will continue to be promoted at all levels.

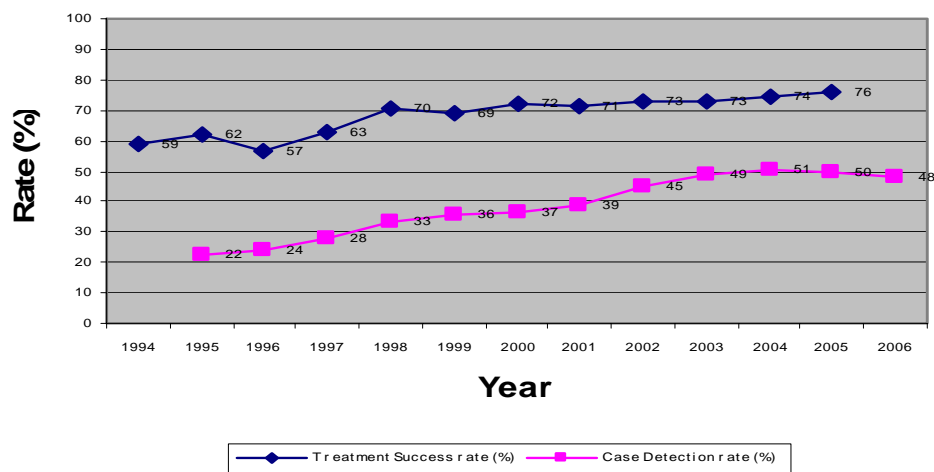
Tuberculosis (TUB)

88. Improvement in the directly-observed treatment short-course (DOTS) quality and coverage is the focus for tuberculosis control in the Region. However, the negative impact of HIV/AIDS on TB incidence has reversed gains made in the recent past. In addition, the reported existence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB cases has compounded the problem. Inadequate laboratory services limit the capacity to routinely test for drug-resistant TB in 12 countries.

89. During the 2006-2007 biennium, WHO response focused on: (i) support for development and implementation of emergency plans of action for DOTS expansion; (ii) technical support to increase and improve TB diagnostic services; (iii) promotion of collaborative TB/HIV interventions; (iv) public-private partnerships and community TB care initiatives; (v) enhanced access to high-quality anti-TB medicines; and (vi) enhanced surveillance and monitoring, including that for drug resistance.

90. All countries were supported to develop and implement plans and strategies towards reaching the World Health Assembly and Millennium Development Goal TB control targets. The proportion of 34 regional high-burden countries attaining a case detection rate of 70% increased from 12% (4/34) in 2005 to 29% (10/34) in 2007. Similarly, the proportion of countries attaining a treatment success rate of 85% marginally increased from 20% (7/34) in 2005 to 23% (8/34) in 2007. However, the proportion of high-burden countries implementing community DOTS in at least 50% of the districts increased from 6% (2/34) in 2005 to 44% (15/34) in 2007. As a result, the proportion of countries with cumulative default and transfer-out rates equal to or less than 10% increased from 35% in 2005 (12/34) to 73% (25/34) in 2007. Figure 6 shows regional trends in case detection and treatment success rates.

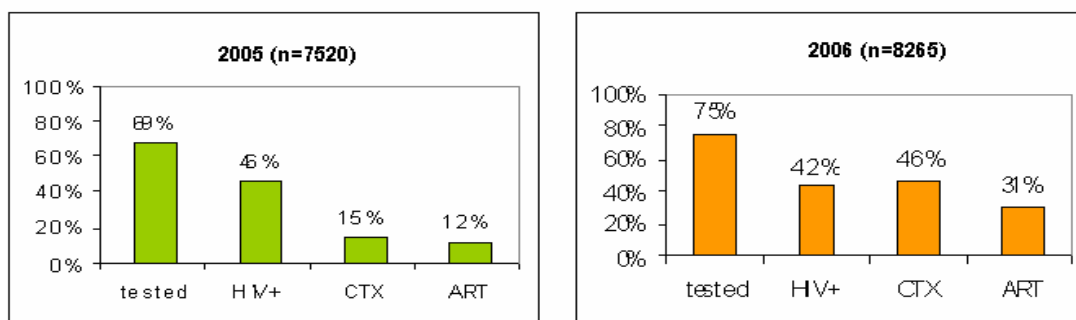
Figure 6: Regional trends in global TB control targets, 1994–2006



Source: Compiled from annual TB control programmes surveillance data, 1994–2006.

91. The number of countries implementing TB/HIV collaborative activities increased from 15 in 2005 to 34 in 2007 as a result of the technical support provided. This resulted in an increased proportion of TB patients being screened for HIV from an average of 2% to 14%. This proportion increased to 75% in some countries like Rwanda (Figure 7). In order to provide guidance on how to enhance TB/HIV collaboration, a regional strategy was developed by the Regional Office and adopted by Member countries at the fifty-seventh session of the WHO Regional Committee for Africa.

Figure 7: HIV testing and treatment among TB patients in Rwanda



Source: Compiled from annual TB control programmes surveillance data, 2005-2006

92. Support provided to countries for strengthening systems for TB surveillance resulted in 45 countries providing regular, accurate and timely TB reports to WHO for the compilation of Global Tuberculosis Control Reports. In addition, a total of 7023 MDR-TB cases were reported from 19 of 22 countries where active surveillance for drug-resistant TB was undertaken. The majority of countries were able to access second-line anti-TB drugs from either the Global Drug Facility or from own sources. For the first time in the Region, 393 XDR-TB cases were reported, from Mozambique and South Africa. In response to this threat to TB control, the Regional Office developed a framework for the management of drug-resistant TB; support continues to be provided to countries to develop action plans for TB control.

Malaria (MAL)

93. Malaria impacts heavily on Africa's development by causing intolerable morbidity and mortality rates and impairing economic growth. In spite of the various strategies for malaria control, the availability of cost-effective interventions and increased funding for at-risk populations remains unacceptably low.

94. During the 2006-2007 biennium, focus was on (i) promoting the scaling up of comprehensive malaria control packages which include effective case management; prevention with intermittent preventive treatment in pregnancy, insecticide-treated nets (ITNs) and indoor residual spraying; and epidemic preparedness and response; (ii) enhancing integrated service delivery by maximizing opportunities offered by strategies and programmes such as Integrated Management of Childhood Illness (IMCI), the Expanded Programme on Immunization (EPI) and antenatal clinics; (iii) strengthening partnerships to harness additional resources and improve partner coordination and harmonization around country priorities, plans and monitoring and evaluation frameworks; (iv) reinforcing monitoring, evaluation and evidence-based planning.

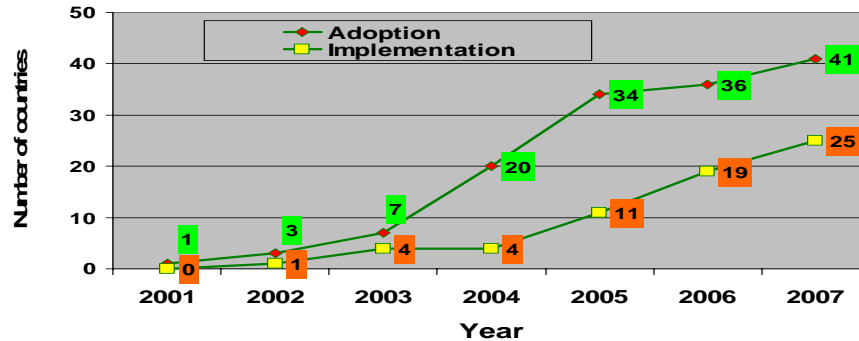
95. Technical support was provided to the African Union to prepare and organize the Special Heads of State summit on HIV/AIDS, TB and malaria in May 2006 in Abuja. In 2006 and 2007, technical support was provided to 16 countries²⁶ to develop second-generation malaria strategic plans, taking into account the need for universal access to malaria prevention and control services.

96. Regarding the scaling up of malaria control interventions, by the end of December 2007, 41 countries had adopted the artemisinin-based combination therapy (ACT) policy (Figure 8) compared to 34 at the beginning of 2005. Of these, 25 implemented the malaria treatment with

²⁶ Botswana, Burundi, Burkina Faso, Comoros, Republic of Congo, Ethiopia, Guinea-Bissau, Madagascar, Mali, Mozambique, Niger, Nigeria, Senegal, Tanzania (Zanzibar), Uganda and Zambia.

WHO-recommended ACT and 20 reported countrywide implementation compared to seven at the beginning of the biennium.

Figure 8: Artemisinin-based combination therapy policy adoption and implementation trends

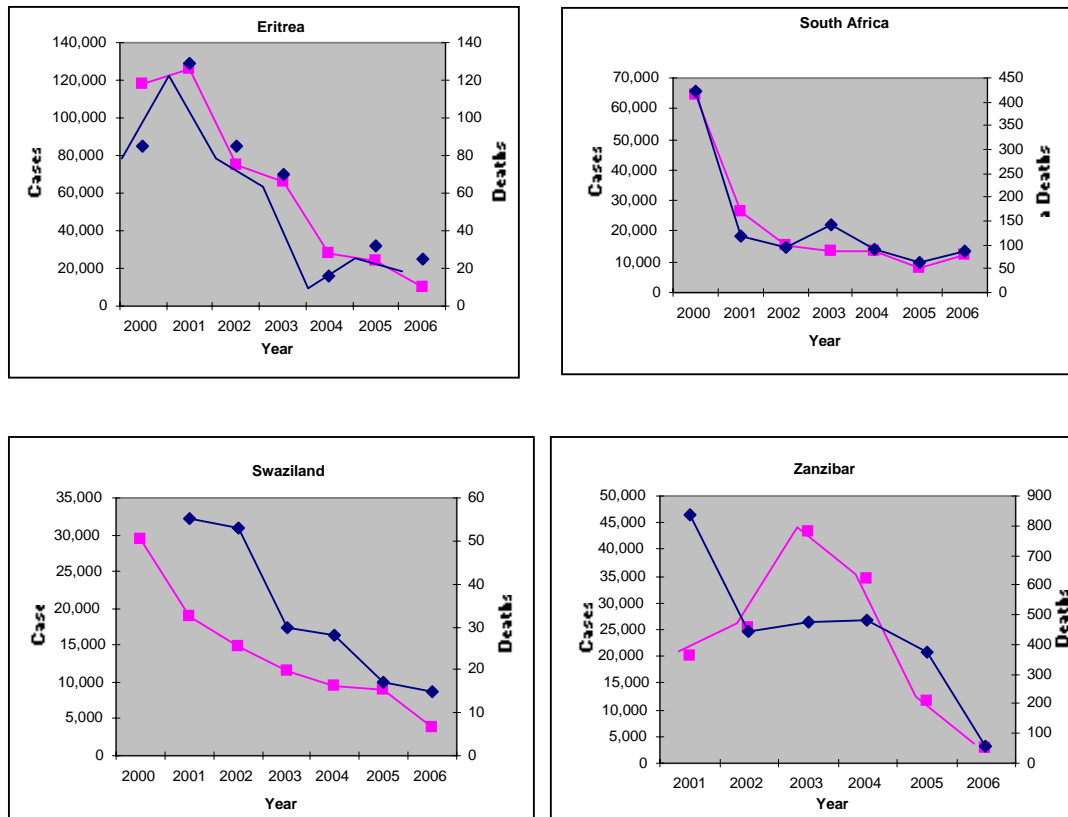


97. The intermittent preventive treatment in pregnancy (IPTp) strategy was adopted in all the 35 endemic countries where it was recommended while 20 implemented IPTp countrywide. Over 33 million insecticide-treated nets were distributed through various mechanisms, including integration with other child survival interventions.

98. As a result of large-scale implementation of proven cost-effective interventions, reduction of the malaria burden was recorded in some countries such as Eritrea, Kenya, South Africa, Swaziland and Tanzania (Zanzibar) (Figure 9).

99. Sustained large-scale integrated long-lasting insecticidal nets and ACT policy implementation markedly reduced the burden of malaria in Gambia, Rwanda, Sao Tome and Principe, Togo, and other central and west African countries. Moreover, the reported success of cross-border initiatives such as the Lubombo Spatial Development Initiative between the governments of Mozambique, South Africa and Swaziland reduced malaria transmission throughout the target area, providing a strong argument for investment in regional malaria control. In Kenya, free mass distribution of ITNs had positive effects on child survival, confirming results from previous randomized controlled trials.

Figure 9: Examples of countries with declining malaria cases at health facility level, 2000–2006



Key: Blue: deaths; Pink: cases

100. Significant progress was made in strengthening partnerships to fight malaria. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) approved 27 proposals with malaria components. With improved support for proposal development, 13 out of 19 proposals for Round 7 were approved, resulting in WHO and the Roll Back Malaria partnership receiving public commendation of this effort from the Global Fund. In addition, strengthened collaboration with partners such as the U.S. President’s Malaria Initiative and the World Bank Booster Program for Malaria has resulted in increased availability and utilization of resources at country level.

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

101. The Division of Prevention and Control of Communicable Diseases of the WHO Regional Office for Africa provides technical orientation and support to countries of the Region based on the resolutions and recommendations of the Governing Bodies regarding the prevention and control of communicable diseases. During the 2006-2007 period, the Division was responsible for four areas of work, namely: Communicable Disease Prevention and Control; Epidemic Alert and Response; Immunization and Vaccines Development; Communicable Disease Research.

Communicable Disease Prevention and Control (CPC)

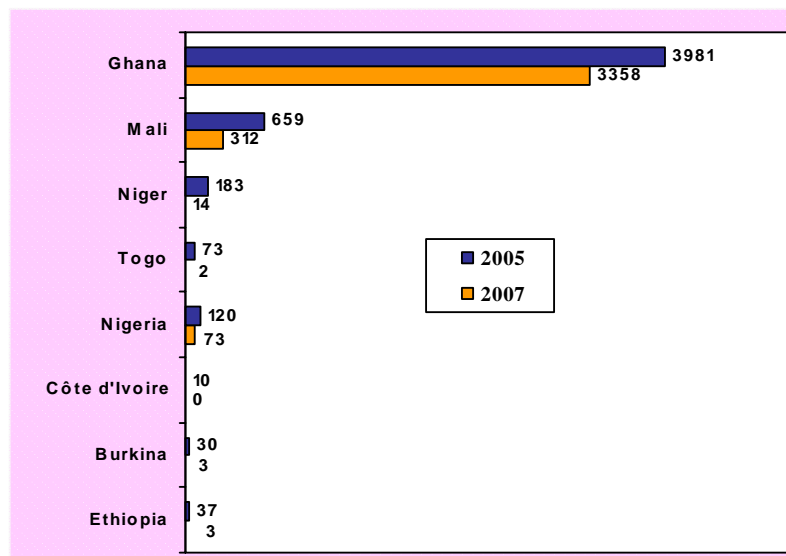
102. In the 2006-2007 biennium, the Regional Office focused on support to countries for implementation of programmes for eradication of dracunculiasis; elimination of leprosy, lymphatic filariasis and trypanosomiasis; and control of onchocerciasis, Buruli ulcer,

schistosomiasis, intestinal parasites, leishmaniasis and rabies. These diseases affect one billion people, 90% of whom are in Africa. The control of these diseases is grossly under-funded; hence the term *neglected tropical diseases*.

103. WHO, in collaboration with partners, provided technical and financial support to affected countries to develop appropriate advocacy and disease control strategies and plans of action. Specific activities supported supply of medicines as well as monitoring and evaluation.

104. **Dracunculiasis:** The Regional Office divisional staff carried out 17 missions and held eight intercountry review meetings. As a result, ten countries were certified free of local transmission of dracunculiasis. The annual incidence was reduced by 28% during the biennium. Burkina Faso, Côte d'Ivoire, Ethiopia and Togo reported zero indigenous cases in 2007 (Figure 10).

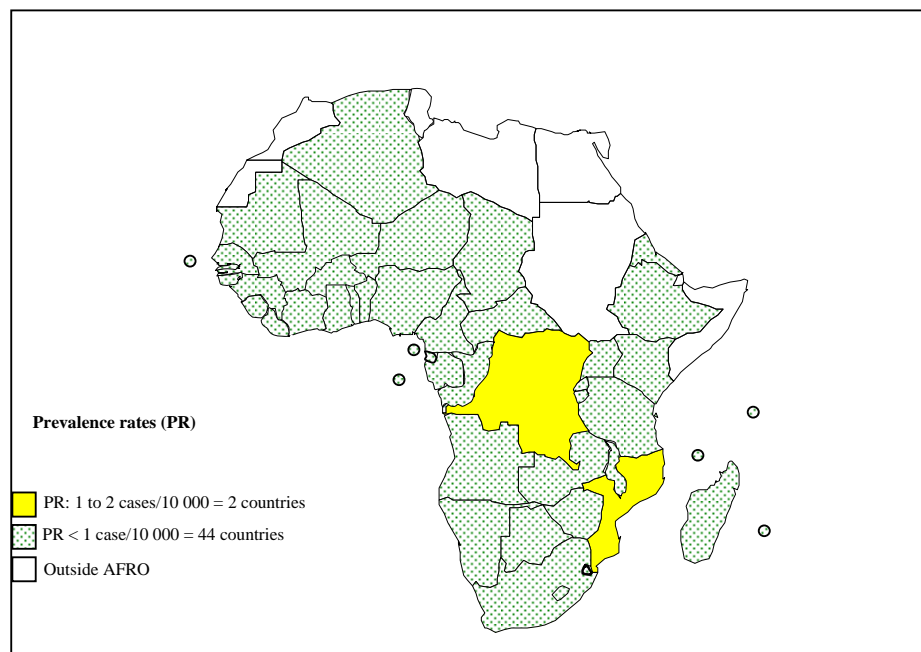
Figure 10: Number of dracunculiasis cases in the WHO African Region, 2005–2007



Note: Cases from Burkina Faso, Ethiopia and Togo are imported cases.

105. **Leprosy:** All seven remaining countries where the leprosy elimination goal was not achieved were supported to develop, implement and evaluate intensified leprosy plans. As a result, the prevalence decreased from 53 952 to 37 663 registered cases. This represents 30% reduction in prevalence. The average leprosy prevalence rate of the Region is 0.51 cases per 10 000 inhabitants. By the end of 2007, 44 out of 46 countries had achieved the elimination goal (Figure 11).

Figure 11: Leprosy situation in the African Region, end of 2007



106. **Integrated preventive chemotherapy:** Burkina Faso, Ghana, Mali, Niger and Uganda pioneered integrated mass drug administration in the Region using a set of low-cost or free drugs to treat four of the highest-burden neglected tropical diseases: lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminths.

107. **Lymphatic filariasis:** Mass drug administration programmes covered 33 million people in 12 out of the 39 endemic countries of the Region. Zanzibar, Tanzania, had the second most successful programme after Togo to interrupt lymphatic filariasis transmission. Integrated delivery of treatment for lymphatic filariasis, schistosomiasis, soil-transmitted helminths and onchocerciasis was achieved in five countries. School-based deworming for soil-transmitted helminthiasis was implemented in 16 endemic countries. Some of these countries integrated deworming with vitamin A supplementation, vaccination campaigns and other child health interventions.

108. **Onchocerciasis:** As of December 2006, in partnership with staff from the health systems, community-directed distributors treated over 48.6 million persons in 111 210 communities in 15 countries endemic for onchocerciasis. The African Programme for Onchocerciasis Control (APOC) averted an estimated 960 000 disability-adjusted life years (DALYs) in 2007. The community-directed treatment with ivermectin strategy was also used to deliver multiple health interventions, including vitamin A supplementation, distribution of insecticide-treated nets, and home management of malaria. Government financial contributions to onchocerciasis control activities for 13 APOC countries increased by 38% by the end of the 2006-2007 biennium.

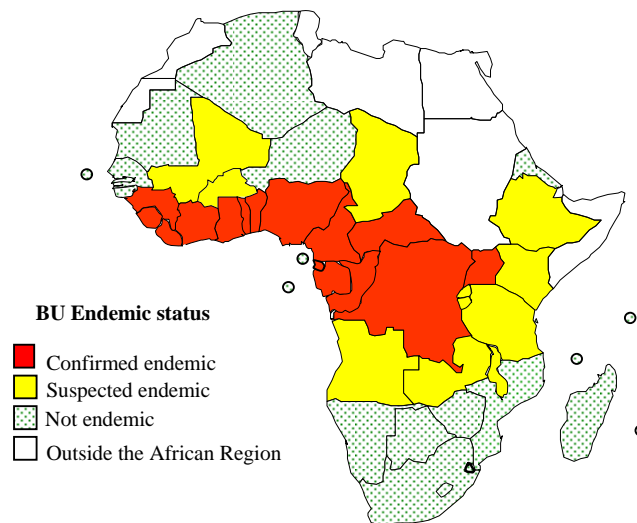
109. **Human African trypanosomiasis:** Active surveillance was reinforced, resulting in a downward trend in the annual incidence of the disease over the past five years. In 15 countries²⁷ transmission seems to have stopped as no new case has been reported in many years. A 69% reduction in new reported cases was observed in 24 countries endemic for *Trypanosoma*

²⁷ Benin, Botswana, Burundi, Ethiopia, Gambia, Ghana, Guinea-Bissau, Liberia, Mali, Namibia, Niger, Senegal, Sierra Leone, Swaziland and Togo.

gambiense. Ten countries²⁸ reported less than 50 new cases per year; eight countries²⁹ reported 50 to 1000 cases; and two countries (Angola and Democratic Republic of Congo) reported more than 1000 cases. All sleeping sickness patients were treated free-of-charge.

110. **Buruli ulcer:** The Regional Office supported three countries to assess the Buruli ulcer situation and establish surveillance activities. In the African Region, 15 countries were confirmed endemic and implemented control activities (Figure 12).

Figure 12: Buruli ulcer in the African Region, 2007



Epidemic Alert and Response (CSR)

111. The challenges in epidemic alert and response included strengthening and sustaining disease surveillance systems for timely epidemiological information; setting up response systems for rapid containment of public health emergencies of national and international concern; and strengthening laboratory capacity to confirm causative agents of disease outbreaks.

112. The successful implementation of Integrated Disease Surveillance and Response (IDSR) in countries greatly contributed to the early detection and rapid control of epidemics. Training in IDSR was conducted in 33 out of 46 Member States for at least 60% of their districts. Furthermore, IDSR training was introduced at the *Institut Regional de Sante Publique* in Ouida, Benin and in mid-level health training institutions in six countries.³⁰ WHO also provided technical and financial support to countries for organizing training sessions on avian influenza caused by H5N1.

113. Timely technical support was provided by the Regional Office and the Inter-country Support Teams to countries experiencing major epidemics such as cholera, meningitis, Ebola and Marburg viral haemorrhagic fevers, and avian influenza. These countries were supported to develop and implement their national epidemic preparedness and response plans. The Regional Epidemic Rapid Response Network members received a refresher orientation to update them on new developments, including human infection by A/H5N1 and the *International Health Regulations 2005*. National rapid response teams on pandemic influenza containment from 28 countries were trained. Technical and financial support was provided to countries to set up and

²⁸ Burkina Faso, Cameroon, Equatorial Guinea, Gabon, Kenya, Mozambique, Nigeria, Rwanda, Zambia and Zimbabwe.

²⁹ Central African Republic, Chad, Republic of Congo, Côte d'Ivoire, Guinea, Malawi, Tanzania and Uganda.

³⁰ Benin, Eritrea, Gambia, Ghana, Guinea and Malawi.

orient national epidemic rapid response teams. Emergency stocks of personal protective equipment were provided to all three Intercountry Support Teams.

114. In 2007, 30 of the 46 countries reported cholera epidemics to the Regional Office (Figure 13). The cumulative number of cases was 106 141, and there were 2172 deaths. The overall case fatality rate was 2.05%, ranging from less than 1% to 12.5%. Angola, Democratic Republic of Congo and Ethiopia reported 68 401 (64.4%) cases and 1364 (12.8%) deaths. The main risk factors were lack of potable water, poor sanitation, social and political unrest, and internal conflict leading to massive population displacement and disrupted social services. The incidence of cholera has increased since the 1990s. The case fatality rates are decreasing but are still unacceptably high (2.05%) (Figure 14).

Figure 13: Countries affected by cholera in the African Region, 2007

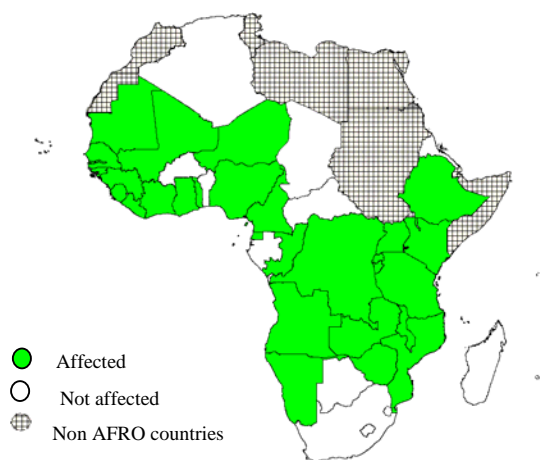
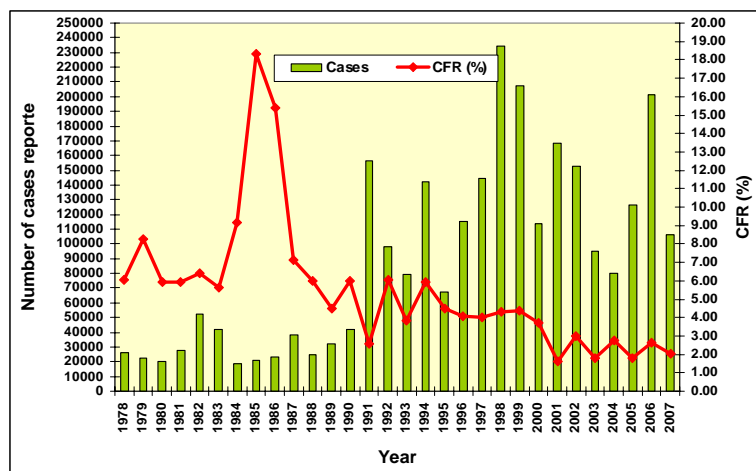


Figure 14: Cholera trends in the African Region, 1978–2007



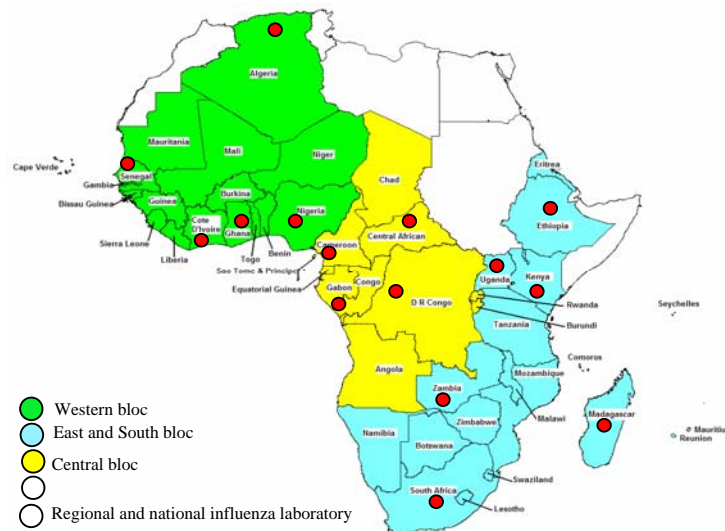
115. A total of 15 laboratories were identified as national and regional influenza reference laboratories for the Region (Figure 15). Heads of laboratories and senior technicians were trained on surveillance and diagnosis of influenza virus, including the highly pathogenic avian influenza. In 2007, over 70 laboratories from 44 African countries participated in the Regional External

Quality Assessment Programme in bacteriology, and six national influenza laboratories participated in the WHO External Quality Assessment Programme for the detection of influenza virus type A by polymerase chain reaction.

116. The Regional Office continued to provide evidence-based information for monitoring disease trends and evaluating public health interventions. In addition, the Regional Office developed, adapted and disseminated data management tools, including Epi-info applications and user manuals.

117. A partnership to implement the *International Health Regulations 2005* (IHRs) was developed. The partnership prepared a regional framework, briefed national IHRs focal points and divisional staff, and developed a regional communication plan to advocate and sensitize stakeholders. In addition, all 46 Member States designated national IHRs focal points. A pool of experts was created and information, education and communication materials were developed.

Figure 15: Regional and national influenza laboratory network, WHO African Region



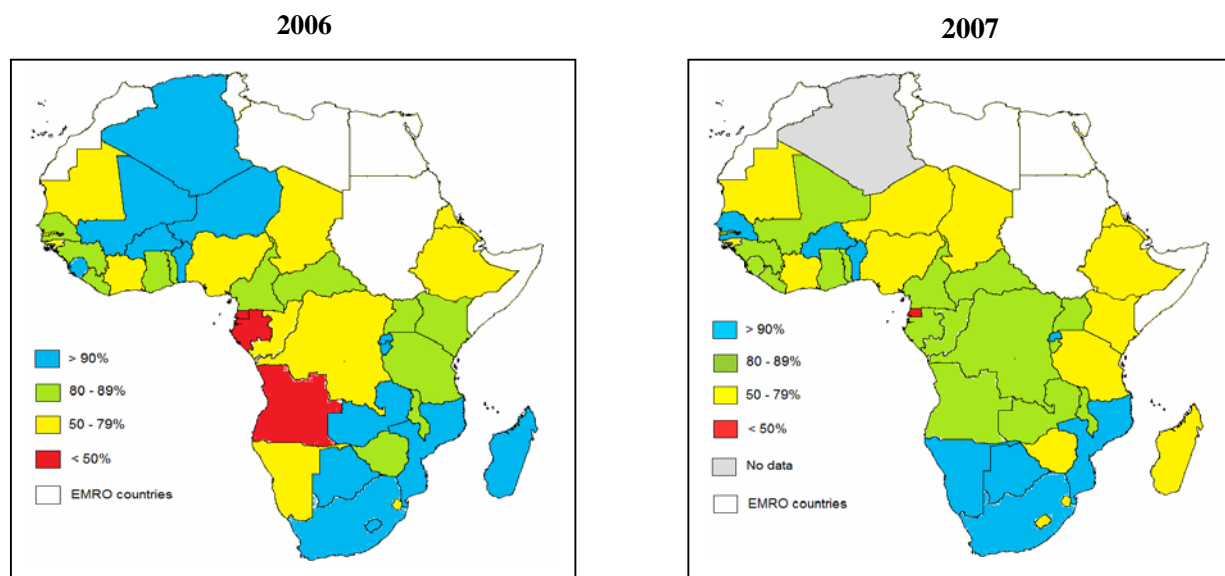
118. In 2007, the Multi-Disease Surveillance Centre in Ouagadougou continued to focus on surveillance of meningitis and onchocerciasis, providing technical support for meningitis surveillance and response in affected countries, including production and provision of trans-isolate media. Enhanced surveillance of meningitis in 13 countries allowed early detection and timely response to meningococcal meningitis epidemics. Meningococcal meningitides were subtyped to guide vaccination campaigns. Antimicrobial resistance of meningitis pathogens was monitored to guide case management.

119. Pool screening of vectors using polymerase chain reaction allowed the identification of prevalence rates in vectors which were proxy for monitoring any recrudescence or re-emergence of the disease in human populations. Lack of funds was the major constraint deterring the Multi-Disease Surveillance Centre from achieving the proposed targets.

Immunization and Vaccines Development (IVD)

120. By the end of 2006, 15 Member States³¹ reported at least 90% coverage of the third dose of diphtheria, pertussis and tetanus (DPT3), and 14 countries³² had at least 80% of districts with 80% or more DPT3 coverage (Figure 16). Provisional data for 2007 indicated that ten countries attained DPT3 coverage of at least 90%, and 28 countries attained 80% or more.

Figure 16: Reported DPT3 coverage for the WHO African Region, 2006 and 2007



121. As of December 2007, 38 countries had introduced hepatitis B vaccine, and 30 countries had introduced Hib vaccine in their routine immunization schedules. A total of 38 countries (83%) completed their comprehensive multiyear plans and received support to make use of debt relief initiatives to strengthen health systems, including immunization programmes.

122. **Polio**: In 2007, 367 wild poliovirus cases were reported from five countries compared to 1192 from nine countries over the same period in 2006, representing a 70% decline. In addition, the number of wild poliovirus type 1 cases over the same period declined by 80% from 911 to 188 (Figure 17). The response to wild poliovirus importations in Angola, Democratic Republic of Congo and Niger were encouraging, whereas challenges remained in Chad.

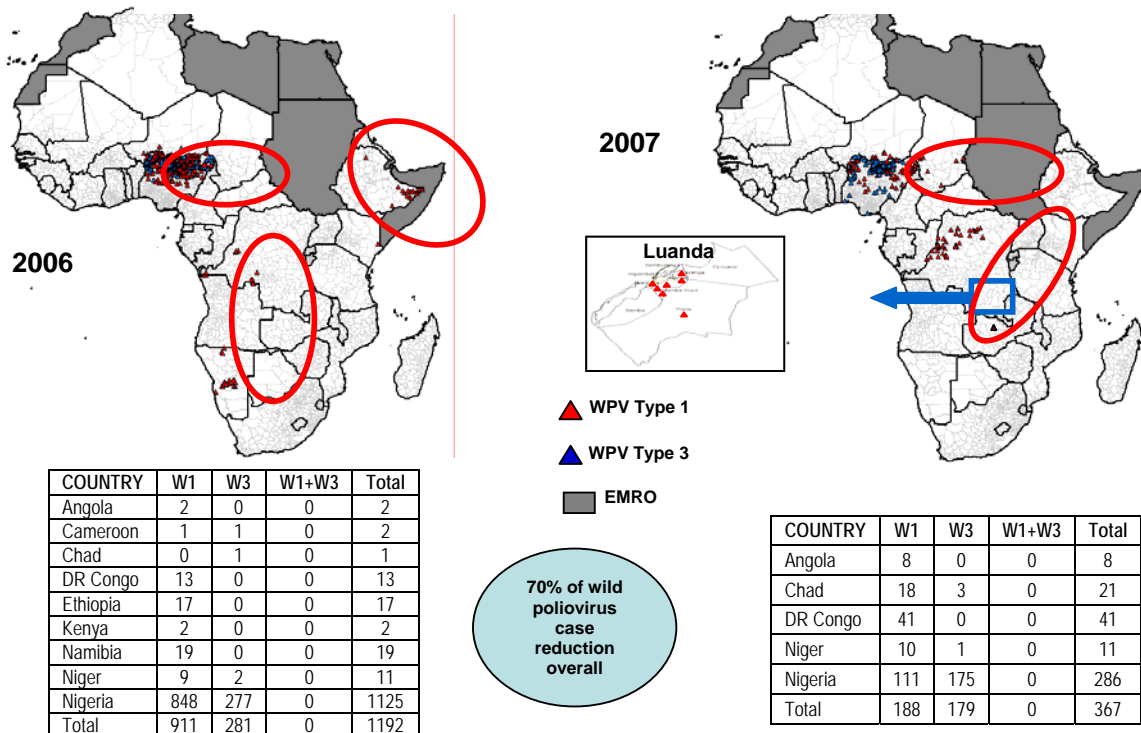
123. In 2007, 41 countries attained certification standard for acute flaccid paralysis surveillance. Polio-free documentation was accepted by the African Regional Certification Commission from six additional countries³³ in 2007, bringing the total number of countries with complete documentation to 21.

³¹ Algeria, Benin, Botswana, Burkina Faso, Burundi, Lesotho, Madagascar, Mali, Niger, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa and Zambia.

³² Botswana, Burkina Faso, Cape Verde, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Niger, Rwanda, Sao Tome and Principe, Seychelles, Togo and Zambia.

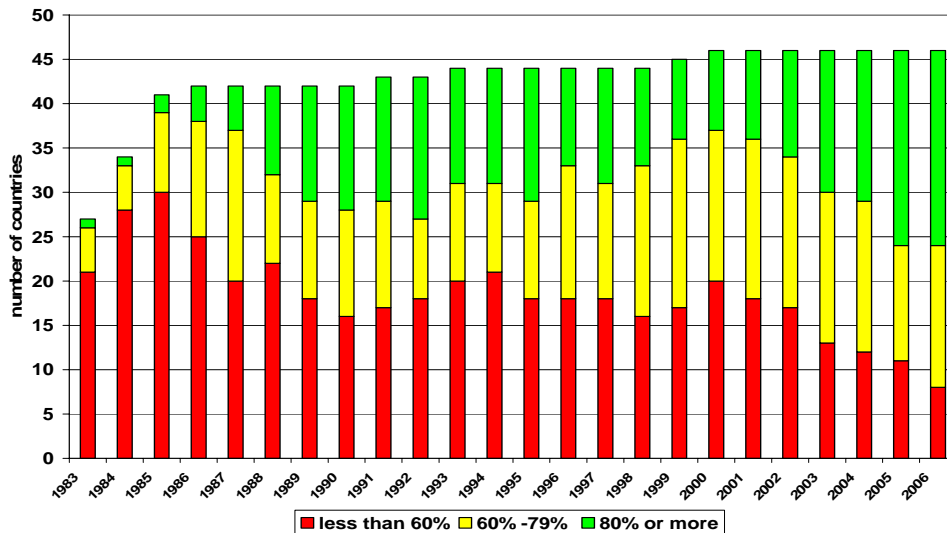
³³ Republic of Congo, Ghana, Guinea, Mauritania, Sierra Leone and Togo.

Figure 17: Wild poliovirus distribution, WHO African Region, 2006-2007



124. **Measles:** In the 2006-2007 biennium, 108 million children were reached in measles supplemental immunization activities (SIAs) in 35 countries. During these measles SIAs, 34 of the 35 countries integrated at least one additional child survival intervention, including distribution of insecticide-treated nets, vitamin A supplementation and deworming. In 2006, 22 countries attained 80% or more routine measles immunization coverage (Figure 18). At the end of 2006, the Region had attained a 91% reduction in estimated measles deaths compared to the estimates for 2000, thus surpassing the goals set for 2009.

Figure 18: Reported measles vaccination coverage in the WHO African Region, 1983–2006



125. **Maternal and neonatal tetanus:** All countries in the Region except Equatorial Guinea and Gabon have updated their maternal and neonatal tetanus elimination plans. In 2007, 16 countries implemented tetanus toxoid SIAs in high-risk districts. In the African Region, 13 countries were validated as having eliminated maternal and neonatal tetanus.

126. **Yellow fever:** Of the 31 countries at risk of yellow fever in the African Region, 22 introduced the yellow fever vaccine in their routine Expanded Programme on Immunization. Nine countries attained coverage of 80% or more in 2006. All 12 countries selected for support from the Global Alliance for Vaccines and Immunization for yellow fever control activities had their country teams briefed; the countries developed tentative plans for the conduct of preventive campaigns, risk assessments and strengthening surveillance. By the end of 2007, five countries completed risk assessments. Togo vaccinated the populations in the listed high-risk districts, attaining a mean coverage of 96%.

127. **Immunization systems support:** Assessments of vaccine management and procurement systems were conducted in at least ten countries, and 18 countries developed health-care waste management plans. Efforts are underway to explore possibilities of using debt relief funds to finance immunization and setting up a revolving fund for vaccine procurement. Human resource capacity strengthening has continued with the development of integrated training packages on child health.

Communicable Disease Research (CRD)

128. During the 2006-2007 biennium, the Regional Office focused on activities to sustain and increase national capacity for research through training and implementation of research projects to develop and implement new and improved communicable disease control approaches. New ways of collaborating and working with the WHO Special Programme for Research and Training in Tropical Diseases (TDR) were also explored.

129. The Regional Office finalized a strategy on communicable disease research. This strategy contributed to the document, "Health research: agenda for action in the WHO African Region", which was adopted at the fifty-sixth session of the WHO Regional Committee for Africa. The Division updated databases on research institutions and researchers in the Region and shared them with interested parties. Six countries³⁴ developed databases on research and development activities.

130. The area of work convened two high-level meetings on health research to identify key issues and an African perspective on health research. The outcomes led to the new 10-year vision and strategy for TDR. The strategy will form the basis for an African agenda at the Global Conference on Research for Health to be held in Bamako, Mali in 2008.

131. Contributions were given to the twenty-fourth session of the African Advisory Committee for Health Research and Development. Due to the active engagement and participation of the Regional Office in TDR working groups and meetings, institutions and individuals in 18 countries received 33 research and training grants. In February 2007, a meeting was co-organized with partners (African Programme for Onchocerciasis Control and the Special Programme for Research and Training in Tropical Diseases) to identify onchocerciasis control as a research priority.

132. A total of 23 countries implemented new or improved approaches for preventing, diagnosing, treating and controlling communicable diseases. Clinical trials and capacity building

³⁴ Ghana, Kenya, Mali, South Africa, Tanzania and Zambia.

in malaria and tuberculosis were organized with support from the European and Developing Countries Clinical Trials Partnership. Active discussions continued for establishing the Regional Office TDR small grants scheme targeted at countries receiving funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

133. The Regional Office initiated efforts to increase human resources in research in order to better support countries to strengthen research capacity and capabilities. Therefore, financial support was provided to participants from countries to attend the TDR Joint Coordinating Board meeting.

PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

134. The burden of noncommunicable diseases (NCDs), injuries, mental health problems and substance abuse, including tobacco and excessive alcohol consumption, is increasing in the Region; these are now a major public health concern. The epidemiological situation in the African Region is the double burden of communicable diseases and the growing problem of noncommunicable diseases.

135. Malnutrition is still one of the most important risk factors for disease in the Region. However, obesity is growing and is already a major cause of chronic diseases, especially in urban areas. Violence and injuries are among the ten main causes of death and disability in Africa. Mental disorders and substance abuse are major concerns throughout the Region. This situation places a huge demand on over-stretched health services. The significance of chronic diseases in the Region is still inadequately recognized.

136. The Division of Prevention and Control of Noncommunicable Diseases supports Member States to collect data on chronic and noncommunicable disease risk factors, morbidity and mortality and to implement evidence-based interventions for disease prevention, management and control. During the 2006-2007 biennium, the Division was responsible for five areas of work: Management and Surveillance of Noncommunicable Diseases; Violence, Injuries and Disabilities; Health Promotion; Mental Health; and Tobacco.

Management and Surveillance of Noncommunicable Diseases (NCD)

137. Noncommunicable diseases such as heart diseases, stroke, cancer, diabetes, chronic respiratory diseases, oral health conditions and sensory disorders have only recently been recognized as having an extremely high toll in both morbidity and mortality in the developing world, including the African Region. Already faced with a high burden of communicable diseases, Member States in the Region must deal simultaneously with the growing burden of NCDs.

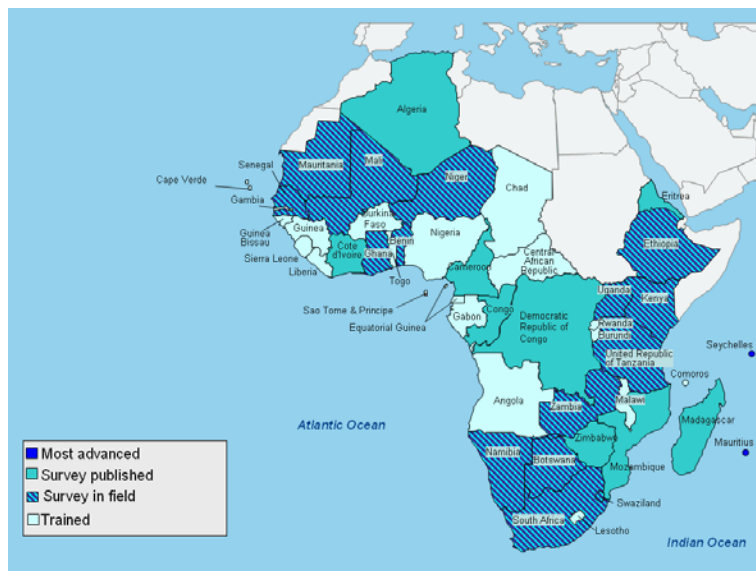
138. During the biennium, 16 Member States were trained in STEPS methodology for NCD surveillance (Figure 19). By the end of 2006, all Member States in the Region had benefited from this training, and technical or financial support had been provided for countries to undertake surveys. A total of 15 countries³⁵ completed and published their survey results on NCD risk factors. Additionally, seven³⁶ countries conducted the survey and are about to publish their results; in eight others, the survey is ongoing. STEPS data for the adult population from some countries indicate that around 30% have high blood pressure. In some other countries, such as Zimbabwe, 10% of those surveyed have high blood sugar. The prevalence of preventable

³⁵ Algeria, Benin, Botswana, Cameroon, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Madagascar, Mauritania, Mauritius, Mozambique, Seychelles and Zimbabwe.

³⁶ Cape Verde, Ghana, Niger, Sao Tome and Principe, Swaziland, Tanzania and Zambia.

blindness is currently 1% in the Region (blindness is preventable in 80% of cases). Without action, the consequence of these levels of prevalence will be, in the future, a high rate of diabetes, strokes, cancers and deaths related to cardiovascular disease.

Figure 19: STEPS surveys in the African Region, September 2007



139. During the biennium, progress was made in NCD programme development. By the end of 2007, Cote d'Ivoire, Eritrea, Madagascar and Mozambique had developed integrated NCD control programmes. The small island states initiated an exchange of their NCD experiences in the field and issued the Seychelles Declaration, a commitment by ministers of health to prevent and control NCDs with the support of the WHO Regional Office for Africa. Member States such as Cape Verde used this framework to develop multisectoral and multidisciplinary NCD prevention and control interventions. Primary prevention of NCDs based on diet and physical activity, using health promotion approaches, was initiated in eight countries,³⁷ and three countries started implementation. Interventions aimed at increasing fruit and vegetable consumption were reported in Benin, Cameroon, Madagascar, Mauritius and Seychelles.

140. Cervical cancer prevention efforts were expanded. Participants from 15 countries³⁸ were trained in visual inspection of the cervix after acetic acid/lugol application and cryotherapy for treatment of low-grade dysplasia lesions; some countries were provided with screening material. Support training was provided to 12 countries for setting up cancer registries. With support from the Regional Office, Guinea established a training centre for cervical cancer prevention. Three Member States used the WHO regional framework document on development of national programmes for management of sickle-cell disease.

141. Eight Member States³⁹ agreed to implement the WHO strategy for controlling avoidable blindness by developing their national plans and signing the Global Declaration of Support: Vision 2020: The Right to Sight. Deafness and hearing impairment surveys were undertaken in

³⁷ Algeria, Cameroon, Eritrea, Ghana, Mauritius, Senegal, Seychelles and South Africa.

³⁸ Benin, Cape Verde, Cote d'Ivoire, Guinea, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Nigeria, Togo, Senegal, South Africa, Zambia and Zimbabwe.

³⁹ Angola, Comoros, Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Mauritania, Sao Tome and Principe, and Seychelles.

one country. Training capacities for prevention of avoidable blindness were strengthened through the provision of equipment to the WHO collaborating centre in Nigeria.

142. A catalogue of essential oral health indicators was developed and made available to countries for surveillance and monitoring. Eight countries⁴⁰ implemented national noma programmes.

143. The Regional Office initiated collaboration with the following partners: World Diabetes Foundation, International Diabetes Federation, Programme of Action for Cancer Therapy, International Agency for Research on Cancer, *Union Internationale Contre le Cancer*, World Heart Federation, International Agency for the Prevention of Blindness, Food and Agriculture Organization of the United Nations and others. These partnerships fostered development of country programmes for integrated secondary prevention and management of the main noncommunicable diseases.

Violence, Injuries and Disabilities (INJ)

144. Intentional injuries (violence) from armed conflict, interpersonal violence (including gender-based violence and violence against children) and suicide are serious public health problems in most countries of the Region. Where data are available, such as in Tanzania, homicide has been shown to be an important cause of non-natural deaths. Injuries from land mines and firearms are major causes of disabilities. In most countries, unintentional injuries, particularly from road traffic crashes, cause most non-natural deaths. Data from Ghana, Kenya, Mauritius, South Africa and Uganda, among others, place road traffic crashes among the five leading causes of hospitalization and non-natural deaths. Other injuries include drowning, falls and burns.

145. In September 2006, the Regional Office started the development of the Report on Violence and Health in Africa. The report will provide the latest data on violence and will be launched in 2008.

146. In February 2007, the WHO Regional Office in conjunction with the United Nations Economic Commission for Africa convened 34 African countries for the African Road Safety Conference, during which the countries adopted the Accra Recommendations and Declaration on Road Safety. The Regional Office supported countries to develop strategies for improving road safety, ranging from improvement of traffic data systems (in Ethiopia, Mozambique and Uganda) to instituting a multisectoral approach and formulation of road safety strategic plans (in Ethiopia, Kenya and Mozambique). With Regional Office advocacy, some countries adopted new traffic safety legislation (e.g. Kenya, Niger, Rwanda and Uganda), and others⁴¹ increased traffic law enforcement. Some countries (e.g. Kenya and South Africa) registered reduced traffic crash rates. In April 2007, WHO and other UN agencies commemorated the Global Road Safety Week. WHO coordinated the World Youth Assembly on Road Safety. These were highly visible and successful advocacy events that increased Member States' commitment to road safety.

147. Disabilities remain neglected, partly because of scarce data. Based on the UN Disability Statistics Database, WHO estimates that over 81 million people in Africa have disabilities. More precise figures for the WHO African Region are not available but are thought to be even higher. Disability is often related to poverty and represents a serious social and economic burden. The

⁴⁰ Angola, Comoros, Republic of Congo, Cote d'Ivoire, Equatorial Guinea, Mauritania, Sao Tome and Principe, and Seychelles.

⁴¹ Benin, Burkina Faso, Central African Republic, Democratic Republic of Congo, Mali, Niger, Senegal, Togo and Uganda.

grossly inadequate response to these challenges is linked to poorly defined or absent policies and strategies.

148. WHO's strategic approach regarding disabilities is based on the 2006 UN Convention on the Rights of Persons with Disabilities; the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities; and World Health Assembly Resolution WHA58.23 on disability. The Regional Office provided technical and financial support to Eritrea, Ethiopia, Ghana and Mozambique to fulfil these obligations. The Regional Office worked with the following partners for strategic planning, capacity development and the improvement of services for persons with disabilities: African Rehabilitation Institute, Pan Africa Wheelchair Builders Association, Community-Based Rehabilitation Africa Network and the *Fédération Africaine des Techniciens Orthoprothésistes*. More countries implemented community-based rehabilitation.

Health Promotion (HPR)

149. Countries of the African Region are experiencing rapid societal transformation brought about by increased population, greater urbanization, environmental and other changes, globalization of markets and communication, and emergencies. These changes are affecting the underlying determinants of health according to various specific country circumstances.

150. During the 2006-2007 biennium, eight countries⁴² expanded health promotion capacity to initiate development of national health promotion policies and strategic plans with Regional Office support in the form of direct technical oversight and seed funding. Seven other countries⁴³ continued developing policy documents while Ghana and Nigeria finalized the process.

151. Multisectoral teams from Comoros, Madagascar, Mauritius and Seychelles were trained in development and implementation of comprehensive health promotion. Orientation courses were offered at *Institut Régional de Santé Publique* (Benin), Iringa Primary Health Care Institute (Tanzania) and University of Ibadan (Nigeria) with Regional Office technical oversight and funding. Development of generic health promotion courses by universities in Kenya, Mozambique, Tanzania, Uganda and Zimbabwe was supported through training and training materials.

152. A framework for integrated community-level health promotion was compiled with an element of noncommunicable disease prevention; the framework interventions supported the WHO priority programmes of Child and Adolescent Health, Disease Surveillance and Response, HIV/AIDS, Malaria, Tuberculosis, Immunization, Making Pregnancy Safer, and Sexual and Reproductive Health. A health promotion module was developed for reorienting trainers of trainers in the Regional Avian Flu Preparedness and Response Plan. Health promotion focal persons were trained in the use of health promotion approaches and methods for acceleration of HIV prevention, treatment and care. With Education International, Inc., the Regional Office supported implementation of school-based HIV/AIDS prevention and mitigation activities in 23 countries;⁴⁴ interventions included major risk factors for noncommunicable diseases such as tobacco, poor diet and physical inactivity in Benin, Burundi and Ghana. Comprehensive school health activities were implemented in 12 other countries.⁴⁵

⁴² Guinea-Bissau, Madagascar, Malawi, Namibia, Senegal, Swaziland, Zambia and Zimbabwe.

⁴³ Algeria, Cameroon, Cape Verde, Cote d'Ivoire, Eritrea, Ethiopia and Zambia.

⁴⁴ Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Cote d'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Lesotho, Malawi, Mali, Mauritania, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

⁴⁵ Algeria, Benin, Madagascar, Malawi, Mauritius, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Uganda and Zambia.

153. Health promotion youth health projects were implemented in Mozambique, Namibia and Zimbabwe. Documentation of best practices in health promotion was supported in South Africa and Uganda. The International Union for Health Promotion and Education was assisted to compile a regional report on the effectiveness of health promotion. General increase in health promotion was reported in 13 countries.⁴⁶ Ten countries⁴⁷ reported strengthened implementation of community-level health promotion activities.

Mental Health (MNH)

154. According to data published in *The African regional health report 2006*, in 2002 mental disorders accounted for 5% of the total burden of disease in the Region and 19% of all disability in Africa. Despite this challenging situation, slow progress has been made, especially in the development of national legislation and health plans. Significant progress on policy development has been made by countries.

155. During the 2006-2007 biennium, Burundi, Gambia, Lesotho, Mali and Namibia finalized their national mental health policies or plans, bringing the number of countries with policies to 30; the process is ongoing in seven other countries.⁴⁸ Ghana and Mauritius finalized their mental health legislation. A total of 15 countries⁴⁹ reported the commemoration of World Mental Health Day to raise awareness on stigma and discrimination related to mental health problems.

156. Seven countries undertook an assessment based on the *World Health Organization assessment instrument for mental health systems*, and Republic of Congo, Eritrea, Ethiopia and Nigeria published their results. The main findings were: lack of accurate information on mental diseases; insufficient financial and human resources; lack of psychotropic medicines; need for training of health workers, with less than 1% of total training hours dedicated to mental health. Some countries took action accordingly by making psychotropic medicines available in primary care settings and strengthening health workers' capacity to use them.

157. Acknowledging the role of nurses and midwives in improving the care of persons with mental health disorders, all 46 countries in the Region participated in the Atlas: Nurses in Mental Health survey (Figure 20). The survey revealed that the number of nurses trained in mental health care was too small compared to the needs. These findings reflect the low priority accorded to mental health care and highlight the need for more investment and attention.

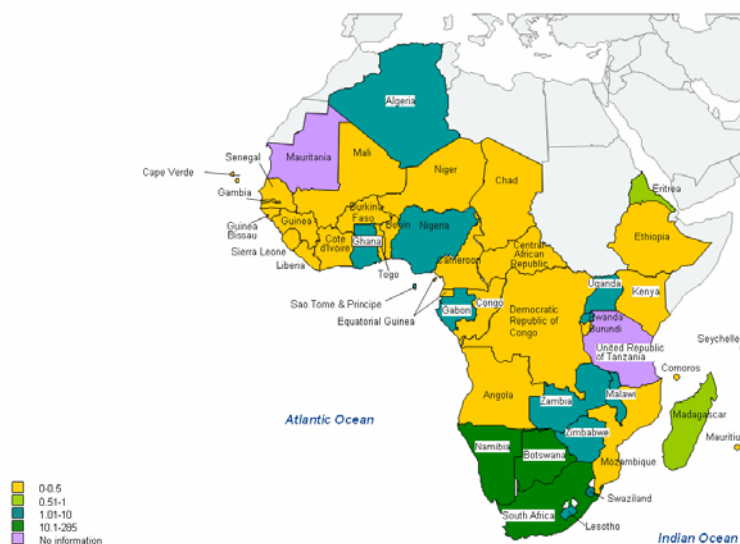
⁴⁶ Algeria, Angola, Cameroon, Eritrea, Gambia, Ghana, Lesotho, Madagascar, Mozambique, Rwanda, Senegal, South Africa and Zambia.

⁴⁷ Algeria, Angola, Cameroon, Eritrea, Gambia, Ghana, Mozambique, Rwanda, Senegal and Uganda.

⁴⁸ Benin, Central African Republic, Eritrea, Ethiopia, South Africa, Uganda and Zambia.

⁴⁹ Benin, Burundi, Cape Verde, Republic of Congo, Democratic Republic of Congo, Gabon, Guinea, Mali, Mauritania, Niger, Rwanda, Senegal, Togo, Zambia and Zimbabwe.

Figure 20: Nurses with formal training in mental health per 100 000 population, 2007



Source: Atlas: Nurses in Mental Health, 2007

158. A total of 35 countries participated in the global survey Atlas: Global Resources for Persons with Intellectual Disabilities. The survey revealed a lack of adequate policy and legislative response and a serious deficiency of services and resources allocated to the care of persons with intellectual disabilities in the Region. These weaknesses contribute to increased exposure to human rights violations and lack of access to basic health and educational services for this population.

159. Integration of mental health into the general health-care system is one of the major strategies recommended for mental health work in the Region. Following a consultation with experts, the Regional Office began the development of teaching modules and guidelines.

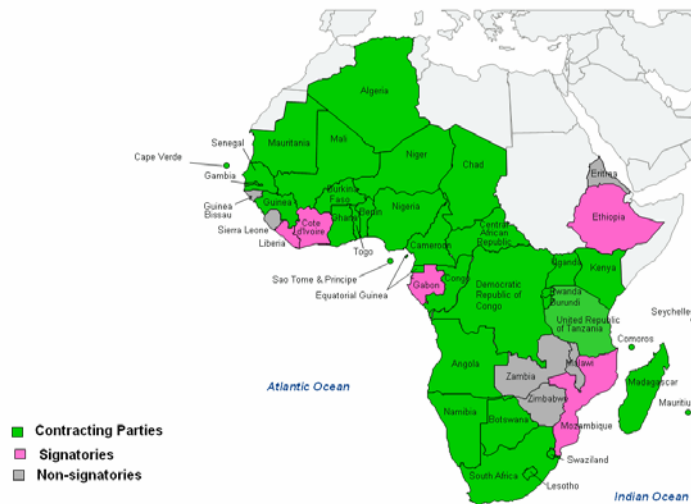
160. Health professionals from seven countries were trained to use the Alcohol, Smoking, and Substance Involvement Screening Test and Brief Intervention tools and strategies for the management of substance use. These professionals will be training others at primary and community care levels during the next biennium as a way of strengthening capacity to screen for and prevent problems caused by substance use.

Tobacco (TOB)

161. Currently, over a billion people worldwide use tobacco, which is the second major cause of death in the world, responsible for about 5 million deaths each year, most of which occur in developing countries. WHO projections indicate that the number of smokers in the Region will increase from 84 million in 2000 to 208 million in 2030. Transnational tobacco companies are exploring every part of the Region for market expansion. Dependence on revenue from tobacco export is a problem for some countries in the Region.

162. WHO has assisted countries to become Parties to the Framework Convention on Tobacco Control (FCTC), with capacity building as well as preparation of guidelines and materials for surveillance, research, legislation, economics, health promotion and smoking cessation. By December 2007, 35 countries had ratified the FCTC (Figure 21).

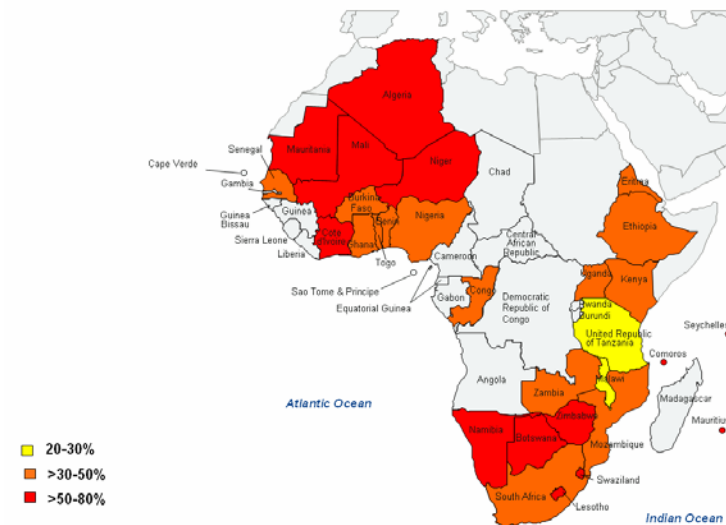
Figure 21: Ratification of the FCTC in the African Region, December 2007



163. During the 2006-2007 biennium, the Regional Office accelerated efforts for implementation of the FCTC. The basis for implementation is now firmly in place in the Region. With support, 30 Parties to the FCTC developed and implemented legislation and national plans of action on tobacco control, bringing to 44 the number of countries having tobacco legislation or regulations. Among these, four have developed and are implementing comprehensive legislation and 16 have adopted more limited legislation; 20 countries have drafted national plans of action. Most countries have a focal person and a multisectoral committee for tobacco control.

164. The collection of data was strengthened during the biennium. A total of 26 countries were trained to prepare and conduct surveys for the Global Youth Tobacco Survey and Global School Personnel Survey. In the African Region, 31 countries completed the tobacco survey. Results confirm high rates (30%–80%) of exposure to second-hand smoke in public places among youth aged 13 to 15 years (Figure 22). Countries have used the survey results in planning, developing, implementing and evaluating their comprehensive tobacco control programmes.

Figure 22: Youth aged 13–15 years exposed to second-hand tobacco smoke in public places



Sources: Global Youth Tobacco Survey, 2007

165. Member States participated actively in the first two Conferences of Parties with WHO financial support. The Region will host the third such conference in South Africa in the last quarter of 2008. With Regional Office financial support, World No Tobacco Day was successfully commemorated throughout the Region, and 30 countries submitted evidence-based reports.

166. Continued advocacy and awareness raising are the keys to increasing the number of Member States which ratify or accede to the WHO Framework Convention on Tobacco Control. Capacity building on tobacco control in Member States is crucial to the implementation of the FCTC in the Region. The involvement of policy-makers and relevant stakeholders in tobacco control is essential for community mobilization and implementation of the Convention.

FAMILY AND REPRODUCTIVE HEALTH

167. Maternal, newborn and child morbidity and mortality constitute major public health challenges in all African countries. Through the Division of Family and Reproductive Health, the WHO Regional Office for Africa supports countries to attain universal coverage and access to cost-effective interventions to reduce morbidity and mortality and improve health outcomes during the key stages of life: pregnancy, childbirth, neonatal period, childhood, adolescence, reproductive age and ageing.

168. During the 2006-2007 biennium, the Division of Family and Reproductive Health was responsible for five areas of work, namely: Child and Adolescent Health; Reproductive Health; Making Pregnancy Safer; Gender, Women and Health; and Nutrition.

Child and Adolescent Health (CAH)

169. In Africa, each year, about 4.6 million children under five die of preventable and treatable conditions such as pneumonia, malaria, diarrhoea, measles, malnutrition, HIV/AIDS and neonatal conditions. About 27% of all under-five deaths are among newborns. Adolescents continue to be victims of sexually-transmitted infections, HIV/AIDS, unwanted pregnancy and abortions. In the African Region, adolescents and young people (15–19 years old) account for 50% of new HIV infections and 30% of maternal mortality.

170. WHO's response includes supporting countries to improve child survival through scaling up newborn health interventions, Integrated Management of Childhood Illness (IMCI), promoting adolescent health and strengthening partnerships for maternal, child and adolescent health and development.

171. Participants at the fifty-sixth session of the Regional Committee for Africa adopted the jointly-developed UNICEF, World Bank and WHO Regional Office "Child survival: a strategy for the African Region". As a follow-up, the Regional Office supported 17 countries⁵⁰ to develop national child survival strategies and strategic plans. Furthermore, training of trainer courses on essential newborn care were conducted for 12 countries⁵¹ and national training courses were conducted in six countries.⁵²

172. IMCI training materials were adapted in 24 countries to include evidence-based updates on new formulations for oral rehydration solutions; zinc supplementation; paediatric HIV/AIDS

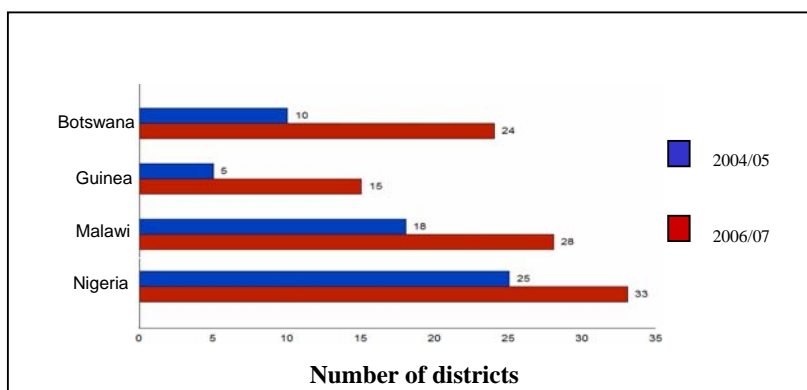
⁵⁰ Angola, Benin, Burkina Faso, Eritrea, Ghana, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.

⁵¹ Angola, Cape Verde, Kenya, Malawi, Mozambique, Nigeria, Sao Tome and Principe, Swaziland, Tanzania (Zanzibar), Uganda, Zambia and Zimbabwe.

⁵² Kenya, Malawi, Nigeria, Tanzania, Uganda and Zambia.

and newborn health, and capacity building in knowledge management. Democratic Republic of Congo, Madagascar, Namibia, Niger and South Africa conducted evaluation of IMCI preservice. Efforts to scale up IMCI continued in various countries (Figure 23). Currently, 19 countries⁵³ have expanded geographical coverage of IMCI to more than 50% of their districts.

Figure 23: District expansion of IMCI in selected countries, 2004–2007



173. With Regional Office support, seven countries⁵⁴ developed national community-IMCI plans. Madagascar and Niger also developed their training materials on community case management of childhood illnesses. In their efforts to provide an integrated package of child health and nutrition interventions, nine countries⁵⁵ organized Child Health Weeks. Kenya, Niger, Senegal and Zimbabwe conducted health facility surveys.

174. Programme managers in adolescent health from 38 countries were oriented on systematic implementation of adolescent health and development, facilitating the development of strategic plans in Democratic Republic of Congo, Eritrea, Mali, and Sao Tome and Principe. Six countries⁵⁶ initiated or expanded their Adolescent Friendly Health Services. Mozambique, Namibia and Zimbabwe strengthened their Alliance of Parents, Adolescents and Community approaches, documenting and sharing the lessons learnt.

175. Efforts were invested in the development of guidelines and tools, in particular: *Programme management guidelines; IMCI computerized adaptation and training tool; Skills mix matrix for implementing maternal, child and adolescent health interventions; Management guideline for child sexual abuse; and Joint Child and Adolescent Health and Making Pregnancy Safer monitoring and supervision tools.*

176. Seven countries⁵⁷ strengthened partnerships for maternal, newborn and child health. Various countries achieved successful resource mobilization. For example, Democratic Republic of Congo and Ethiopia mobilized funds from GAVI and GlaxoSmithKline; Kenya mobilized funds from DANIDA; Burkina Faso, Malawi and Mozambique began implementing programmes with funding from the Bill and Melinda Gates Foundation.

⁵³ Benin, Botswana, Burkina Faso, Eritrea, Gambia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.

⁵⁴ Burkina Faso, Republic of Congo, Gabon, Guinea-Bissau, Madagascar, Mauritania, and Sao Tome and Principe.

⁵⁵ Botswana, Kenya, Ghana, Malawi, Madagascar, Tanzania, Uganda, Zambia and Zimbabwe

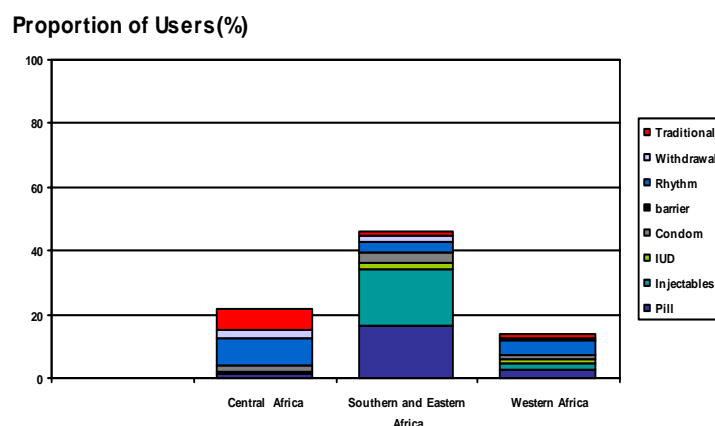
⁵⁶ Burkina Faso, Malawi and Swaziland initiated; Lesotho, Senegal and Tanzania expanded.

⁵⁷ Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Tanzania and Zambia.

Reproductive Health (RHR)

177. Poor reproductive health accounts for up to 18% of the global burden of disease and 32% of the total burden of disease for women of reproductive age. The indicators include high maternal mortality; high unmet family planning needs; unsafe abortions; and lack of access to key reproductive health services such as cervical cancer screening. In the African Region, low contraceptive prevalence among married women is estimated at 13% (Figure 24), and 80% of cervical cancer cases are diagnosed late. In this context the UN General Assembly has adopted the target of achieving universal access to reproductive health by the year 2015 as an additional target for Millennium Development Goal number 5.

Figure 24: Utilization of contraceptive methods by subregion, 2006



178. Regional Office actions to address access, poor quality and low utilization of reproductive health services were inspired by the “Reproductive health strategy for the African Region 1998–2007” adopted at the forty-seventh session of the Regional Committee for Africa and “Repositioning family planning in reproductive health: framework for accelerated action 2005–2014” adopted at the fifty-fourth session of the Regional Committee for Africa.

179. In 2006-2007, demonstration projects on cervical cancer prevention and control at primary health care services using visual inspection with acetic acid and cryotherapy were carried out in six countries.⁵⁸ Following positive review of the projects, the countries developed scaling up plans; Nigeria developed subsequent training and Madagascar extended inspection services to a second district. Similar regional training was conducted in eight additional countries.⁵⁹

180. Other achievements included the finalization and dissemination of guidelines and training materials on sexual and reproductive health, including the “Medical eligibility criteria for contraceptive use” in 15 countries,⁶⁰ the “Regional framework for integrated sexual and reproductive health services” and a family planning advocacy tool. For improved collaboration between WHO and research centres, the Regional Office assessed reproductive health research centres in Burkina Faso, Ghana, Malawi, Nigeria and Senegal.

181. Capacity building sessions were conducted on (i) maternal and newborn health programme development for reproductive health programme managers from Angola, Cape Verde, Guinea-Bissau, Mozambique, and Sao Tome and Principe in the context of the “Road

⁵⁸ Madagascar, Malawi, Nigeria, Tanzania, Uganda and Zambia.

⁵⁹ Benin, Cape Verde, Cote d’Ivoire, Guinea, Mali, Mauritania, Senegal and Togo.

⁶⁰ Benin, Botswana, Cameroon, Guinea, Kenya, Lesotho, Madagascar, Namibia, Nigeria, Rwanda, Swaziland, South Africa, Tanzania, Zambia and Zimbabwe.

Map”; (ii) use of maternal, newborn and child health integrated monitoring and supervision tools for programme and data managers from 12 countries;⁶¹ (iii) turning research into practice for researchers and professionals from nine countries;⁶² (iv) integration of sexual and reproductive health essential medicines into national essential medicines lists for programme managers from Ethiopia, Kenya, Ghana, Nigeria and Zambia; (v) methodologies for measuring maternal mortality ratios and action plans for strengthening the health information systems for monitoring and evaluation of sexual and reproductive health indicators for experts from 20 countries.⁶³

Making Pregnancy Safer (MPS)

182. The levels of maternal and newborn mortality are still unacceptably high in the African Region. The decline of maternal mortality between 1990 and 2005 in sub-Saharan Africa was only 0.1% per year while the Millennium Development Goals target is to decline at least 5.5% per year. This calls for intensified efforts for scaling up priority interventions to improve access to and availability of skilled attendance. Additional issues include weak health systems, lack of funds, poor community participation in maternal and newborn health interventions, and increased malaria and HIV.

183. During the 2006-2007 biennium, the WHO Regional Office response was guided by the “Road Map for accelerating the attainment of Millennium Development Goals related to maternal and newborn health”. The emphasis was on supporting countries to increase availability of skilled attendants; improve community participation; strengthen capacity in planning, management, monitoring and evaluating programmes; and scaling up prevention of mother-to-child transmission (PMTCT) of HIV.

184. Among the main achievements, 21 countries⁶⁴ developed national Road Maps, bringing the total number to 37 countries. Of these, 25 countries received support to implement their Road Maps, mainly through development of operational plans, building capacity of health professionals in emergency obstetric care, strengthening newborn care, and institutionalizing maternal death reviews. In collaboration with UNFPA and UNICEF, 54 national experts from eight countries⁶⁵ were trained in converting national Road Maps into district operational plans.

185. Ethiopia, Ghana, Malawi and Tanzania strengthened their preservice midwifery education. Ten new countries⁶⁶ were involved in two intercountry training sessions on multidrug-resistant TB, bringing the total number of countries with trained experts to 25. The Regional Office oriented 58 participants from eight countries⁶⁷ on delivering quality integrated maternal, newborn and child health (MNCH) services through focused antenatal care. WHO country office programme managers from ten countries were introduced to tools and guidelines on Integrated Management of Pregnancy and Childbirth. Integrated MNCH tools for monitoring and supervision were introduced in 12 countries.⁶⁸ In collaboration with *Société Africaine de*

⁶¹ Benin, Burkina Faso, Republic of Congo, Eritrea, Kenya, Mali, Mozambique, Niger, Tanzania, Togo, Uganda and Zimbabwe.

⁶² Ethiopia, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

⁶³ Angola, Benin, Burundi, Cameroon, Central African Republic, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Kenya, Liberia, Madagascar, Mali, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Togo and Uganda.

⁶⁴ Angola, Botswana, Burkina Faso, Republic of Congo, Cote d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Swaziland, Togo and Zimbabwe.

⁶⁵ Benin, Burkina Faso, Cote d'Ivoire, Guinea, Mali, Mauritania, Senegal and Togo.

⁶⁶ Burundi, Cameroon, Cape Verde, Republic of Congo, Democratic Republic of Congo, Gabon, Guinea-Bissau, Madagascar, Mauritania and Mauritius.

⁶⁷ Gabon, Ghana, Kenya, Mali, Niger, Rwanda, Tanzania and Zambia.

⁶⁸ Benin, Burkina Faso, Republic of Congo, Eritrea, Kenya, Mali, Mozambique, Niger, Tanzania, Togo, Uganda and Zimbabwe.

Gynécologie et d'Obstétrique and UNFPA, 20 experts from 11 countries reviewed and adapted the *WHO guidelines on pregnancy, childbirth, postpartum and newborn care*.

186. Eleven countries⁶⁹ strengthened experts' capacity to accelerate the scaling up of programmes for PMTCT and paediatric HIV care, support and treatment. In collaboration with partners, 14 countries⁷⁰ adapted their national curricula and developed plans to commence training. Joint technical missions with partners were conducted in seven countries⁷¹ to assess the status of implementation of PMTCT and make recommendations; the result was the UNITAID initiative which will provide US\$ 20 million to accelerate PMTCT and paediatric AIDS interventions in seven countries.⁷² Capacity-building workshops were conducted in institutionalizing HIV testing and counselling in PMTCT; using more efficacious antiretroviral regimens; and integration and linkages in maternal and child health programmes.

Gender, Women and Health (WMH)

187. Biological vulnerability, low social status, limited access to health services, low level of literacy, lack of economic autonomy and few decision-making powers are among the major determinants of women's ill-health. Gender-based inequalities and violence expose women to HIV/AIDS and other diseases. Harmful traditional practices such as female genital mutilation and early marriages of girls increase the risk of maternal morbidity and mortality. In Africa, one woman in 26 dies due to complications related to pregnancy, childbirth or the postpartum period.

188. Implementation of the regional strategy for women's health was facilitated through technical support to countries. A regional survey based on the women's health framework was conducted in 16 countries.⁷³ The results were discussed during a regional consultation held in Brazzaville in May 2007. Social and health professionals from the selected countries also defined the critical steps towards the effective integration of gender equality and women's empowerment in each of the eight Millennium Development Goals.

189. Throughout 2006, the six WHO regions worked together to develop the strategy on integrating gender analysis and actions into the work of WHO; this strategy was adopted by a resolution of the World Health Assembly in May 2007. The implementation plan includes raising awareness on gender, women and health at global, regional and national levels as well as mainstreaming gender into public health programmes. The WHO gender policy analysis tools were disseminated to Ethiopia, Rwanda, Tanzania, Uganda and Zimbabwe, including focal points in the regional economic communities.⁷⁴

190. Technical support was provided to Democratic Republic of Congo, Liberia and Uganda to train health workers in the prevention and management of sexual and gender-based violence. Workshops were conducted in Burkina Faso, Kenya and Tanzania on legal dimensions and child protection issues in the context of female genital mutilation. Guinea developed a protocol for integrated prevention and care of victims of rape and sexual violence.

⁶⁹ Burkina Faso, Cameroon, Central African Republic, Cote d'Ivoire, Democratic Republic of Congo, Kenya, Malawi, Nigeria, Senegal, Zambia and Zimbabwe.

⁷⁰ Burkina Faso, Republic of Congo, Cote d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Swaziland, Tanzania (Zanzibar), Uganda and Zambia.

⁷¹ Burkina Faso, Botswana, Cameroon, Lesotho, Nigeria, Swaziland and Zambia.

⁷² Burkina Faso, Cameroon, Cote d'Ivoire, Malawi, Rwanda, Tanzania and Zambia.

⁷³ Burkina Faso, Cape Verde, Democratic Republic of Congo, Ethiopia, Ghana, Lesotho, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Seychelles, South Africa, Tanzania and Zimbabwe.

⁷⁴ West African Health Organisation, Common Market for Eastern and Southern Africa, Economic Community for West African States, New Partnership for Africa's Development, United Nations Economic Commission for Africa, and United Nations Development Fund for Women.

191. Advocacy on women's health was one of the areas of focus during the reporting period. Democratic Republic of Congo produced a documentary on WHO and the prevention of sexual and gender-based violence, including income-generating activities. In collaboration with People's TV, the Regional Office created a documentary on women's health and sexual and gender-based violence in Democratic Republic of Congo, Liberia and Mauritania; the film was transmitted on more than 50 TV channels worldwide. Moreover, the result of a study on the obstetrical outcomes of female genital mutilation was published in *The Lancet* and launched in Burkina Faso, Ghana, Kenya, Tanzania and Uganda.

Nutrition (NUT)

192. In Africa, over 50% of deaths of children under five are directly or indirectly related to malnutrition, and under-nutrition among pregnant women remains a concern. Under-nutrition is also a great concern among displaced persons, including refugees, and people living with HIV/AIDS. Diet-related diseases are increasing. One of the greatest challenges is the investment in effective nutrition interventions which are still grossly inadequate.

193. To respond to these challenges during the 2006-2007 biennium, the WHO Regional Office action included development of strategies, norms, standards and technical guidance on infant and young child feeding, nutrition and HIV, and severe malnutrition. These efforts supported country implementation of national nutrition policies and plans to promote adequate nutrition.

194. Key achievements in the biennium included finalization of food and nutrition policies and plans in Botswana, Eritrea, Guinea, Kenya and Malawi. Maternal and child nutrition policies were updated in eight countries.⁷⁵ The regional plan of action for implementing the African regional nutrition strategy was developed in collaboration with the African Union. A total of 18 countries developed national implementation plans on the Global Strategy on Diet, Physical Activity and Health.

195. Seven countries⁷⁶ developed national strategies on infant and young child feeding (IYCF), bringing the total to 29 countries. Eleven countries developed action plans for the Baby Friendly Hospital Initiative (BFHI) in the context of HIV/AIDS; Botswana, Malawi, Niger, Uganda and Zambia conducted BFHI assessments and designation of baby-friendly facilities. Fourteen countries⁷⁷ conducted national training of trainers, and 22 regional consultants were trained in an integrated IYCF counselling course. Gambia and Zambia enacted the International Code of Marketing of Breast-milk Substitutes into national laws and Nigeria revised their law. Twelve countries trained staff on implementation and monitoring of the Code.

196. Sixteen countries received technical orientation, and 37 participants from 13 countries were trained on the new WHO child growth standards (Figures 25 and 26). Draft guidelines on integration of nutrition into Integrated Disease Surveillance and Response (IDSR) were developed to strengthen nutrition surveillance. Training on management of severe malnutrition was conducted for 30 regional consultants from eight countries.

⁷⁵ Democratic Republic of Congo, Ethiopia, Kenya, Madagascar, Nigeria, South Africa, Tanzania and Uganda.

⁷⁶ Benin, Burundi, Mali, Niger, Rwanda, Togo and Zambia.

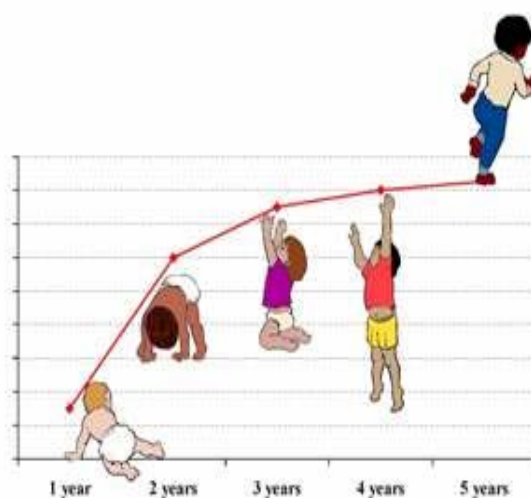
⁷⁷ Benin, Cameroon, Cote d'Ivoire, Ghana, Mali, Niger, Nigeria, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Figure 25: Countries oriented on new WHO child growth standards



197. A total of 58 experts from nine countries were updated on the current WHO recommendations on HIV and infant feeding. In addition, 94 participants from 13 countries reviewed progress on the Durban consultation on nutrition and HIV/AIDS recommendations at a regional meeting on HIV and nutrition. Frameworks were developed to integrate nutrition into maternal, newborn and child health services and Global Fund proposals for PLWHA; the frameworks were also used for joint Regional Office divisional workshops on Global Fund proposal development. Partnerships within WHO and with other key stakeholders⁷⁸ were strengthened for resource mobilization. Three nutritionists were recruited to join the Intercountry Support Teams.

Figure 26: New WHO child growth standards



198. It is vital that WHO support countries to implement policies, plans and strategies; build capacities to tackle malnutrition; raise the profile of nutrition; and strengthen strategic partnerships for resource mobilization.

⁷⁸ AU; UNICEF; FAO; East, Central and Southern African Health Community; West African Health Organisation; Helen Keller International; International Baby-Food Action Network; USAID; WFP.

HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT

199. Poverty, conflicts and risks associated with poor environmental conditions and contaminated food are major threats to health and development in the African Region. More than 45% of the population in the Region are poor, living on less than US\$ 1 a day. The challenge for WHO is to help countries in the Region to develop and implement policies and strategies that will increase health investment, focus on the poor, reduce inequalities and build institutional capacities.

200. In the 2006-2007 biennium, the Regional Office strengthened the inclusion of poverty-related issues and long-term strategic thinking with national and regional health development efforts; facilitated programmes for the achievement of the health-related Millennium Development Goals (MDGs); strengthened the incorporation of environmental health in the development of national policies and actions; addressed the high morbidity and mortality associated with microbial and chemical contaminants in foods; and strengthened preparedness and response to crises. The different activities were organized under the following four areas of work: Policy-making for Health in Development; Health and Environment; Emergency Preparedness and Response; and Food Safety.

Policy-making for Health in Development (HSD)

201. Health is central to the achievement of the MDGs. Yet health development and health status in the African Region continue to be less favourable compared to other parts of the world. The MDGs provide an important opportunity to promote the incorporation of health priorities in national, regional and international development processes. Keeping in focus WHO's contribution and leadership in the achievement of the health-related MDGs and other internationally agreed goals, the Regional Office converted this opportunity into policies and strategies through the provision of guidance, advocacy and technical support to countries on issues relating to health and human rights, poverty, aid effectiveness, macroeconomics, equity, ethics and globalization, among others.

202. The Regional Office provided technical support in collaboration with partners to several countries⁷⁹ to develop strategies for strengthening health systems towards the achievement of the health MDGs. The area of work assessed countries' progress towards the health MDG targets and prepared a draft report. Through the EU-WHO partnership programme, six countries⁸⁰ received financial support to address the MDGs. Nationals from Cameroon, Kenya, Mozambique, Rwanda and Uganda participated in a capacity-building workshop on health, human rights and poverty reduction strategies. Most countries in the Region participated in at least one of the three capacity-building workshops on health, poverty reduction and economic development. The Regional Office provided technical support to countries⁸¹ in relation to health sector-wide approaches (SWAs) and the Medium-Term Expenditure Framework (MTEF) and the costing of health components in Poverty Reduction Strategy Papers.

203. With support, Burkina Faso, Ghana, Mali and Mozambique documented best practices in health sector SWAs, budget support and MTEFs. Countries were sensitized on the need to address the social determinants of health. The area of work prepared a draft framework outlining the work of the Regional Office on social determinants of health (SDH) in the Region. Two meetings of African civil society facilitators for the WHO Commission on Social Determinants of

⁷⁹ Benin, Burkina Faso, Burundi, Chad, Ethiopia, Madagascar, Mali, Mozambique, Nigeria, Sao Tome and Principe, and Zambia.

⁸⁰ Angola, Burkina Faso, Kenya, Malawi, Niger and Tanzania.

⁸¹ Cameroon, Chad, Ethiopia, Kenya, Madagascar and Mozambique.

Health were held in January and December 2006 to produce a workplan for civil society involvement in addressing SDH in the Region. The Regional Office prepared a regional report on health inequalities in the African Region, using data from 30 countries.

204. Participants at the fifty-sixth session of the Regional Committee for Africa endorsed the document entitled “Poverty, trade and health: an emerging health development issue” and adopted Resolution AFR/RC56/R4 to address the health challenges of poverty and international trade. The Regional Office supported 20 Member States⁸² to undertake preliminary studies on trade in health services and prepared terms of reference to guide in-depth country studies on trade in health services. Participants at the fifty-seventh session of the Regional Committee for Africa adopted the document entitled “Key social determinants of health: a call for intersectoral action to improve health status in the WHO African Region”.

Health and Environment (PHE)

205. Infectious and vector-borne parasitic diseases are determined by environmental factors that can be controlled. The burden of disease from traditional health risks is aggravated by the spread of unplanned, poorly-constructed urban settlements and also by climate change. An estimated 288 million people in sub-Saharan Africa still lack access to improved drinking water, and 437 million people lack access to basic sanitation. Chemical substances are used with little or no understanding of their immediate and long-term effects. Every year, mismanagement of chemicals leads to a significant burden of injury, ill-health and mortality. This happens in a context of poor waste management, particularly health-care waste, in addition to occupational diseases and injuries.

206. During the 2006-2007 biennium, the WHO contribution to improving the environmental health situation in the African Region was achieved through enhancing awareness and response to key determinants and by promoting interventions for primary prevention. As a result, ten additional countries finalized their national policies for health and environment based on guidelines prepared by the Regional Office. The area of work provided technical support to more than two thirds of the countries in the Region to implement their environmental health programmes. Eleven municipalities in five countries developed plans for Healthy Cities Projects. A total of 18 countries strengthened capacity to develop national action plans for the management of health-care waste.

207. The Region contributed to the production of the “African Newsletter on Occupational Health and Safety,” and various occupational health and safety documents were sent to countries to raise awareness and improve knowledge. Participants from eight countries⁸³ attended a workshop on workers’ health in Africa jointly organized by WHO and collaborating centres in Finland and the United Kingdom. Gambia and Swaziland developed policies and implementation strategies. Other collaborating centres worked on identified priority areas such as the basic occupational health and safety package. In Tanzania (Zanzibar) the area of work collaborated with the HIV/AIDS Division to develop a post-exposure strategy paper. The area of work also contributed to two International Labour Organization meetings on occupational safety and health. There was improved collaboration with ILO on occupational health and safety matters.

208. A children’s environmental educational toolkit was developed. Pilot projects to address children’s health in various settings were implemented in four countries; experiences and lessons

⁸² Burundi, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.

⁸³ Benin, Botswana, Gambia, Kenya, Namibia, South Africa, Swaziland and Tanzania.

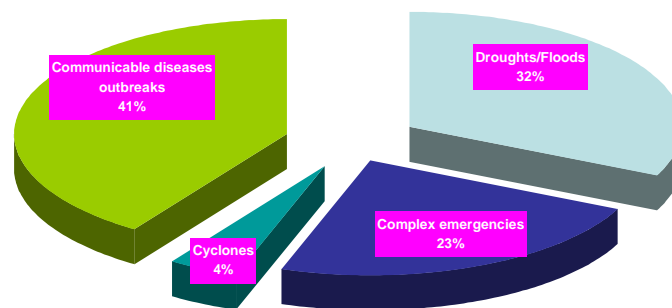
learnt were documented. A core set of Children Environmental Health Indicators was developed; the status of these indicators was documented in Cameroon, Kenya and Zimbabwe.

209. In the area of vector control, the Regional Office, in collaboration with WHO headquarters and partners, prepared a set of guidelines and toolkits to improve the implementation of vector control activities. With support, Comoros, Gabon, Madagascar, Reunion and Seychelles successfully controlled vectors of Chikungunya during outbreaks. Cameroon, Republic of Congo, Democratic Republic of Congo, Ethiopia and Nigeria developed entomological profiles. The Regional Office provided technical support to 26 countries for delivery of vector control services with a specific emphasis on indoor residual spraying of insecticides and mass distribution of insecticide-treated nets integrated with immunization campaigns. The area of work produced regional progress reports on the implementation and coverage of the two major interventions, indoor residual spraying and insecticide-treated nets. Vector resistance to insecticide continued to be monitored by the WHO African Network on Vector Resistance to Insecticides. The area of work developed a draft framework towards accelerated malaria control and elimination.

Emergency Preparedness and Response (EHA)

210. During the biennium, half of the Member countries⁸⁴ in the WHO African Region reported one emergency. Several countries⁸⁵ reported more than one emergency. Outbreaks of communicable diseases, droughts and floods constituted the commonest emergencies reported (Figure 27). Malnutrition remained an issue in crisis- and drought-affected countries. The impact of sexual violence was a serious issue in some countries.⁸⁶

Figure 27: Types of emergencies reported by countries in the African Region, 2006-2007



211. The Emergency Preparedness and Response units in ten WHO country offices⁸⁷ strengthened their capacity to respond to emergencies, including the addition of internationally-recruited focal persons. In addition, six country offices⁸⁸ opened suboffices for Emergency Preparedness and Response. The country teams were supported by focal persons in the Inter-country Support Teams. Seven focal persons participated in pre-deployment training, thus qualifying them to be on the international emergency roster.

⁸⁴ Angola, Burundi, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mauritania, Mozambique, Niger, Senegal, Sierra Leone, Tanzania, Uganda and Zimbabwe.

⁸⁵ Angola, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Kenya, Mozambique and Uganda.

⁸⁶ Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Guinea and Uganda.

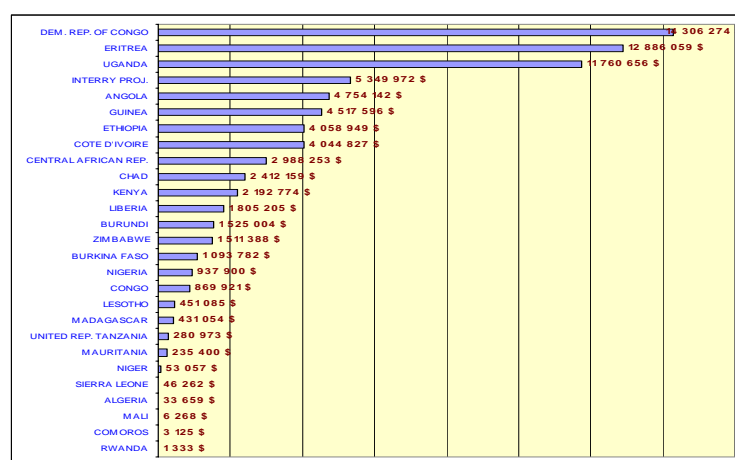
⁸⁷ Burundi, Chad, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Liberia, Niger and Uganda.

⁸⁸ Central African Republic, Chad, Democratic Republic of Congo, Guinea, Liberia and Uganda.

212. During the 2006-2007 biennium, over US\$ 78 million was raised from various donors to address emergencies in countries (Figure 28). The increased field presence and resource mobilization led to improved response capacity. The Health Action in Crisis component provided support to all the countries affected by crises; this support included needs assessments with health situation monitoring, coordination of health responses, filling critical life-saving gaps, and capacity-building for effective preparedness and response.

213. The Regional Office supported countries affected by crises with vulnerability assessments, rapid assessments, food security assessments, nutrition and mortality surveys, and strengthening Integrated Disease Surveillance and Response. The area of work produced regular health information bulletins and shared them with all partners. Vital health services for populations affected by crises included the distribution of medical supplies, deployment of health workers, dissemination of guidelines, training of health workers, revitalization of primary health care activities, outreach immunizations and community-based therapeutic feeding.

Figure 28: Resources mobilized for Emergency Preparedness and Response, 2006-2007



214. The United Nations humanitarian reform has three main elements: humanitarian coordination, the cluster system and the Central Emergency Response Fund. Clusters are humanitarian groups created to improve efficiency, accountability and coordination of interventions. Among the nine global clusters, the health cluster is under the leadership of WHO. During the biennium, the Regional Office piloted health clusters in nine countries,⁸⁹ and clusters continue to be rolled out in more crisis-affected countries.

215. The Emergency Preparedness and Response unit supported the Epidemic Alert and Response unit (Division, Prevention and Control of Communicable Diseases) to respond to Marburg haemorrhagic fever in Uganda, Ebola in Democratic Republic of Congo and other outbreaks in other subregions. The Ebola outbreak in Democratic Republic of Congo occurred in the districts of Mweka, Luebo and Bulape from April to mid-October, 2007, resulting in 264 cases and 187 deaths. The epidemic curve (Figure 29) shows that the outbreak continued for over 20 weeks, with multiple peaks and high case fatality rates. The same districts experienced outbreaks of typhoid fever and shigellosis during the same period.

⁸⁹ Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Kenya, Liberia, Madagascar, Mozambique, Uganda and Zimbabwe.

216. As in all other outbreaks of communicable diseases, the Emergency Preparedness and Response unit provided support by developing project proposals to mobilize resources through the Central Emergency Response Fund and flash appeals. The resources mobilized prior to the Ebola outbreak were used to support outbreak investigations; logistics costs, including transport of personnel and equipment; social mobilization; procurement and transport of drugs; and training and deployment of health workers (Figure 30).

Figure 29: Weekly cases and case fatality rates for Ebola in Democratic Republic of Congo, 2007

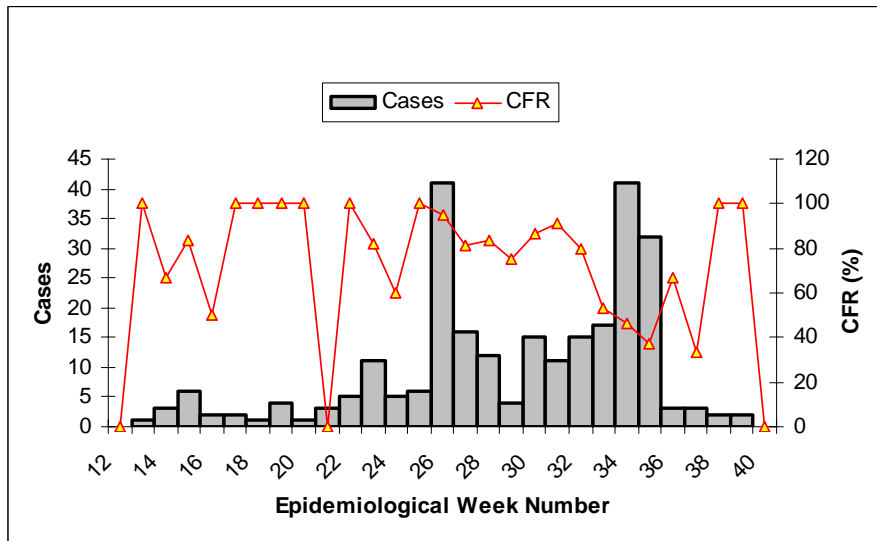


Figure 30: Staff in action during Ebola outbreak in the Democratic Republic of Congo

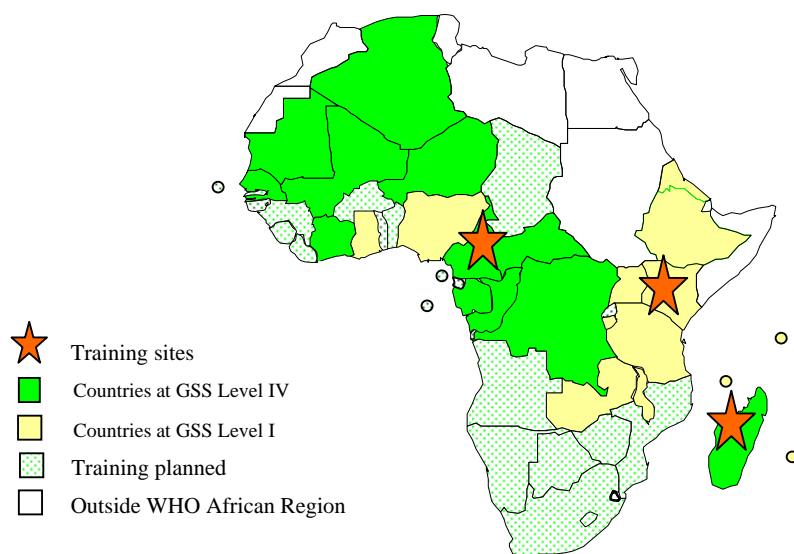


Food Safety (FOS)

217. During the 2006-2007 biennium, the Food Safety area of work addressed weaknesses in food control systems and the recurrence of outbreaks due to consumption of microbial and chemical contaminants in food. Emphasis was on strengthening capacity for foodborne disease surveillance; effective participation of countries in the Codex Alimentarius Commission; food legislation and food law enforcement; information, education and communication.

218. Participants at the fifty-seventh session of the WHO Regional Committee for Africa adopted the document entitled “Food safety and health: a strategy for the WHO African Region” and the related Resolution AFR/RC57/R2. With support, participants from Cameroon, Ghana, Nigeria and Uganda attended the International Total Diet Study training courses for the detection of chemicals in food. Participants from Comoros, Mauritius and Seychelles attended the Global Salmonella Survey (GSS) Level I training course in Madagascar, and 30 microbiologists from ten countries⁹⁰ attended the Level I training in Kenya. Training at Level IV continued for 25 participants from 12 countries.⁹¹ This brings the number of training sites in the Region to three (Figure 31). Cameroon and Cote d’Ivoire received training in the production of antisera for salmonella poisoning.

Figure 31: Participating countries and training sites for laboratory-based foodborne disease surveillance, 2007



219. The Regional Office provided Kenya with technical support for investigation, management and control of an aflatoxicosis outbreak. In particular, resources were provided for strengthening the capacity of the National Public Health Reference Laboratory to monitor food, serum and other biological specimens for aflatoxins. The Regional Office also supported Angola and Ethiopia during outbreaks of cholera. In Ethiopia, technicians evaluated the hygiene of food enterprises and trained food vendors in safe food handling; in Angola, they evaluated the food control system and training of trainers in food hygiene. Similarly, the area of work provided

⁹⁰ Eritrea, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda and Zambia.

⁹¹ Algeria, Cameroon, Central African Republic, Republic of Congo, Cote d’Ivoire, Democratic Republic of Congo, Gabon, Madagascar, Mali, Mauritania, Niger and Senegal.

technical support to Cote d'Ivoire for a chemical incident that occurred in August 2006. The Regional Office supported Angola during an outbreak of bromide poisoning which was attributed to the use of sodium bromide instead of sodium chloride as table salt.

220. Several countries conducted food safety capacity-building workshops on foodborne disease surveillance, Hazard Analysis and Critical Control Points, food inspection and Codex Alimentarius. Six countries⁹² participated in a joint WHO/FAO workshop which piloted the *Guide on strengthening of Hazard Analysis and Critical Control Points in small and less developed food businesses*.

221. A workshop on the work of Codex was organized for 50 participants from 35 countries. The Codex Coordinating Committee for Africa was attended by 79 nationals from 36 countries, and Ghana was elected as the new coordinating country. A total of 38 nationals from 35 countries attended 17 Codex meetings with support from the Codex Trust Fund. Republic of Congo and Lesotho re-launched their National Codex Committees; participants from Chad, Republic of Congo and Democratic Republic of Congo attended a workshop on Codex information. Sierra Leone created food safety task forces and provided training on norms and standards. Twelve countries⁹³ established or amended policies, plans of action, legislation or enforcement strategies for food safety. With support, Angola, Botswana, Ethiopia and Kenya investigated and controlled food-related outbreaks, including acute aflatoxicosis and cholera.

222. A total of 13 countries⁹⁴ implemented the WHO Five Keys to Safer Foods tool; and they translated the tool poster into the local languages. Malawi and Nigeria established healthy food market programmes. Mali and Senegal organized celebrations for "Food Safety Week" and national "Hand-washing with Soap Day".

223. The area of work prepared two regional guides on the development and implementation of food law and the detection and control of food-related emergencies. Other tools include an adaptation of the WHO Five Keys Manual, information and advocacy materials, a regional newsletter, documentation of national food safety activities, and a database on food safety located at <http://www.afro.who.int/des/fos/index.html>.

ADMINISTRATION AND FINANCE

224. The Division of Administration and Finance is responsible for ensuring the optimal use and rational management of the Organization's financial, technical and human resources. It provides efficient, effective and flexible administrative services to all regional programmes and activities, and exercises oversight to ensure that the financial regulations and ethical principles of the Organization are observed. During the biennium 2006-2007, the Division fulfilled the above responsibilities through three areas of work, namely, Infrastructure and Logistics; Human Resources Management in WHO; and Budget and Financial Management. The Division was organized in six functional units: Infrastructure and Logistics Services; Budget and Finance; Human Resource Services; Information and Communications Technology; Publication and Language Services; and Procurement Services.

⁹² Botswana, Lesotho, Namibia, South Africa, Zambia and Zimbabwe.

⁹³ Algeria, Burundi, Equatorial Guinea, Ethiopia, Guinea Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zambia.

⁹⁴ Angola, Cameroon, Republic of Congo, Democratic Republic of Congo, Ghana, Guinea, Kenya, Lesotho, Mali, Mauritania, Mozambique, Rwanda and South Africa.

Infrastructure and Logistics (IIS)

225. The Infrastructure and Logistics area of work is responsible for provision of administrative and logistical services. During the 2006-2007 biennium, the main challenge was providing acceptable working and living conditions in Brazzaville for relocating staff from Harare. Although new offices were made available in the Regional Office annex buildings (Estate) to accommodate staff members from Harare, shortage of housing remained a major issue. Limited hotel facilities coupled with the limited capacity of Regional Office meeting rooms hampered efforts to adequately support meetings and conferences.

226. However, one of the major achievements during the biennium was the support provided to more than 90 meetings held at the Regional Office, including the fifty-seventh session of the Regional Committee. The area of work supplied additional office space by rehabilitating and extending the Estate building to accommodate re-assigned staff members. The area of work also created suitable working space for the newly established Intercountry Support Teams in Libreville and Ouagadougou.

227. Procurement Services are closely related to logistical services, the objective being to deliver efficient and cost-effective services and supplies. The main challenge during the biennium was the implementation of the new WHO streamlined global procurement service for cost-effective supplies and equipment. The tendering process for local purchases for both the Regional Office and country offices was greatly improved. Furthermore, an updated database of suppliers was put in place along with a statistical data recording system.

228. During the biennium, Publications and Language Services included editing, translation, printing and dissemination of statutory documents for the fifty-sixth and fifty-seventh sessions of the Programme Subcommittee and Regional Committee in Addis Ababa and Brazzaville. The unit worked closely with all the Divisions in their production of guidelines, strategies, policies, newsletters and other technical documents.

229. In the area of security, the Integrated Services System database was successfully installed to streamline the management of security for the 436 staff members at the Regional Office. The system is available on the AFRO Intranet and can be accessed by all staff members.

Human Resources Management in WHO (HRS)

230. The Human Resources Management area of work deals with all human resource issues in the WHO African Region, both at the Regional Office and in the 46 country offices. The key challenges addressed during the biennium were related to the re-profiling exercises conducted at the Regional Office and the country offices, the closure of the Regional Office component in Harare, the decentralization process and creation of three Intercountry Support Teams, the implementation of the regional staff development and learning plan, preparations for the Global Management System (GSM) and the implementation of contract reform.

231. To address the above challenges, human resource procedures, processes and activities were streamlined to include the implementation of contract reform; decentralization of a number of activities to the Intercountry Support Teams; implementation of the regional staff development and learning plan; GSM representation at global level; and launching of the regional learning network.

232. The main achievements during the biennium included: timely and effective human resource services provided for technical programmes and individual staff members; support and advice provided for the re-profiling exercises conducted in technical divisions and country

offices; effective contribution to the smooth closure of the Regional Office in Harare; timely and effective support provided to the establishment of the three Intercountry Support Teams, including three human resource subunits at that level; implementation of various learning and training activities at the Regional Office and in the country offices; involvement in and effective support provided to the implementation of GSM, including the participation of a human resource officer at global level; implementation of contract reform, including the issuance of new contractual arrangements and the establishment of over 1200 fixed-term posts.

Budget and Financial Management (FNS)

233. During the 2006-2007 biennium, the Budget and Financial Management area of work focused on managing budget implementation; ensuring accountability of all sources of funds; overseeing the decentralization of budgetary and financial management functions to 46 country offices, technical divisions and Intercountry Support Teams; implementing audit recommendations; and ensuring timely payment of staff entitlements and vendor invoices.

234. The key issues during the biennium included monitoring scarce budgetary resources, especially at country level; strengthening budgetary and financial controls to minimize adverse audit reports and mitigate risk; and providing administrative and financial support in a decentralized manner, especially to the three Intercountry Support Teams.

235. The area of work developed budget reports which became accessible on the AFRO Intranet for use by focal persons in the Regional Office and by WHO representatives in country offices to monitor budgetary resources. Monthly budget monitoring reports were also prepared and shared widely.

236. With support from headquarters, the area of work conducted training on budget and financial management for all administrative officers in the various offices and technical units in order to strengthen financial and management controls. Each Intercountry Support Team was staffed with one professional finance officer to offer finance management support to the countries in their respective subregions.

237. There was marked improvement in budget and financial management support as a result of consolidating of the Budget and Finance unit in Brazzaville and recruitment of staff to fill vacant positions. There was timely replenishment of country imprest accounts as a result of the implementation of web banking. With the support of a short-term auditor consultant and the newly-recruited compliance officer, the Regional Office was able to close over 80% of all outstanding internal audit recommendations.

238. For the 2006-2007 biennium, a total of US\$ 203.6 million was approved from the Regular budget. This constituted 21.4% of the actual budget needed. It was anticipated that an amount of US\$ 745.9 million would be received from Other sources. As of December 2007, the total expenditures for the approved budget totalled US\$ 785.7 million, representing 82.8% of the projected total for the biennium.

1.2 FACTORS IN PROGRAMME BUDGET IMPLEMENTATION

Enabling Factors

239. Increased dialogue through visits and direct support from the Regional Director facilitated effective collaboration and partnerships with the African Union Commission, regional and subregional institutions, the European Union Commission and WHO headquarters. Staff were also motivated through such contacts and the favourable environment provided by governments.

The active involvement of ministries of health in programme implementation contributed immensely to the achievements of the biennium. Specifically, increased partnership at global, regional and country levels facilitated the achievements in reproductive health programmes.⁹⁵

240. Good collaboration between different Regional Office programmes and headquarters facilitated joint planning and implementation of activities, maximization of resource utilization, and harmonization of support to countries. Responses to crises in countries were facilitated by increased commitment from relevant national authorities and governments.

241. The current interest in monitoring progress towards the Millennium Development Goals motivated countries to scale up relevant interventions. The *Strategic orientations for WHO action in the African Region 2005–2009* provided further direction on regional priorities, including enhancing responses to the key determinants of health.

242. At country office level, specific networks of designated focal persons for specific technical programmes and programme coordination were revealed to be very effective. One network set up during the biennium included focal persons for health information, research and knowledge management. A second network was established for the 46 national professional officers in charge of planning in all the WHO country offices.

243. For programme implementation, strong advocacy, country ownership, leadership, coordination, harmonization and alignment of partnerships contributed to ensure acceleration towards universal access. In addition, the timely response by national professional officers to country requests for technical support enabled successful programme implementation.

Constraining Factors

244. Delays in disbursement of funds and late or unplanned requests for technical support from countries forced several Regional Office programmes to work continuously in emergency mode. Furthermore, for the majority of areas of work, unavailability of funds budgeted under Voluntary contributions remained a concern throughout the biennium, especially for WHO country offices. At the same time, some areas of work experienced weak absorption capacity for available funds, limiting the expansion of interventions.

245. In reference to countries, gaps in human resource numbers and quality to support the scaling up of priority interventions at peripheral country level constituted the most important constraints. These gaps resulted from migration, inadequate production and losses caused by the negative impact of the HIV/AIDS pandemic, particularly in southern Africa.

246. Capacity for surveillance, monitoring and evaluation remained weak at country level. As a result, countries experienced difficulties in obtaining timely information, as well as regular quarterly and annual progress and performance reports on service utilization and coverage. This situation was caused by weak and inefficient health information management systems. For disease surveillance, specifically, the weakness of laboratory capacities, procurement and supply systems as well as obsolete information and communications technology infrastructure constituted the main issues and constraining factors.

247. Other obstacles to scaling up key interventions in some countries included inadequate country stewardship and coordination for cross-cutting interventions of priority programmes, especially those related to the health Millennium Development Goals.

⁹⁵ The WHO, UNFPA, UNICEF, female genital mutilation joint statement of 1997 was enlarged to include UNAIDS, UNDP, UNECA, UNESCO, UNHCR and UNIFEM in 2007.

PART 2: PROGRESS TOWARDS IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

Resolution AFR/RC53/R1: Macroeconomics and health: the way forward in the African Region

248. The resolution requested 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 recommendations of the Commission on Macroeconomics and Health (CMH); to monitor and document lessons emerging from the implementation of the CMH recommendations in different countries and facilitate sharing of lessons learnt; to provide support to regional institutions that train health economists and conduct health economics research; and to report annually to the Regional Committee on the progress made in the implementation of the Commission's recommendations.

249. Dissemination of the CMH recommendations and related documents continued. The AFRO Intranet web page was maintained and improved. The Regional Office linked the CMH agenda directly with work on the social determinants of health as both have some overlapping areas and some common objectives, as well as with work on the MDGs. Technical support was provided to Mozambique, Nigeria and Uganda.

250. The need for increased financial resources to help build human resources and strengthen health systems is now acknowledged by key development partners, especially the World Bank. Furthermore, countries are increasingly aware of the need to link sectoral policies with their macroeconomic policies. Financial resources to support seed funding for countries willing to implement the CMH recommendations are inadequate. In some countries, there is insufficient technical capacity, low level of advocacy and sensitization, a multiplicity of processes and lack of clarity about the linkages between them.

251. Plans are underway to engage international partners and advocate for more resources for the health sector. Ministries of health are to be supported to strengthen the health component of poverty reduction strategies; to effectively advocate and participate in intersectoral actions and macroeconomic policy discussions; to advocate for the inclusion of social dimensions in macroeconomic policy discussions; and to reallocate resources in favour of priority areas.

Resolution AFR/RC53/R6: Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region

252. The resolution requested the Regional Director to provide technical support to Member States in the development and implementation of strategic plans; to support operational research and documentation and disseminate information on effective approaches to scaling up interventions; to advocate for more resources and long-term international support; to collaborate with the GFATM, advocating for mechanisms which facilitate rapid disbursement of funds to countries; and to monitor the scaling up of interventions and report on progress to the Regional Committee every year.

253. In the area of HIV/AIDS, updated guidelines on new approaches such as provider-initiated testing and counselling, male circumcision, and paediatric HIV treatment and care were provided to all countries. Fourteen countries⁹⁶ were supported to review and update their national

⁹⁶ Burkina Faso, Burundi, Cameroon, Cape Verde, Republic of Congo, Gabon, Gambia, Guinea-Bissau, Liberia, Mauritius, Sao Tome and Principe, Tanzania, Togo and Uganda.

HIV/AIDS health sector plans. Twenty-one countries⁹⁷ were also supported to develop their Road Map for acceleration of HIV prevention while more than half (24) of the Member countries updated their strategic plans to strengthen the HIV/AIDS prevention component. Strong advocacy and partnerships for resource mobilization were undertaken at all levels for scaling up HIV/AIDS interventions. That has resulted in additional funding through various donors such as PEPFAR, CIDA, DFID, OFID, Italian government, Spanish government and French Cooperation, among others.

254. The proportion of countries submitting Global Fund proposals with fairly good success is on the increase—from 40% in Round 6 to 62% in Round 7. Collaboration with GFATM has been strengthened through several meetings organized to identify and provide solutions to the bottlenecks hampering adequate implementation of the grants. Several reports were produced, including the report on the acceleration of HIV prevention in the African Region.

255. Regarding tuberculosis, all 34 TB high-burden countries in the Region were supported to develop or update strategic plans using the new WHO planning and budgeting tool. In collaboration with TDR, a multicountry study on drug interactions in TB/HIV co-infected patients was launched in 2007 and the results are expected to provide the evidence-base for treatment of such patients. All key partners in TB control are fully engaged in supporting countries to implement quality DOTS expansion programmes, including surveillance and management of drug-resistant TB.

256. A further 19 countries were successful in their applications to the Global Fund, thus increasing to 26 the total number of countries with approved Global Fund proposals for TB control. The scaling up of interventions has resulted in an average regional DOTS coverage of 89% and an improvement in treatment success rates from 72% in 2000 to 76% in 2006. Most Member States (40/46) provided timely and accurate reports to WHO for the compilation of TB global surveillance reports.

257. Concerning malaria, 16 countries⁹⁸ were supported to review and update malaria strategic plans for scaling up universal access. In the area of operational research, community-based interventions were documented in 20 countries as was the innovative approach to scaling up ITN distribution through immunization campaigns or other child survival interventions. Financial resources for malaria control at country level significantly increased with support from partners such as GFATM, World Bank, U.S. President's Malaria Initiative, Bill and Melinda Gates Foundation.

258. WHO and Roll Back Malaria partners supported countries to develop technically sound proposals accessing the listed sources of funding. Collaboration with GFATM to improve the disbursement rate was very active. Joint meetings were organized with the different GFATM geographic clusters and countries to identify the bottlenecks undermining the appropriate implementation of grants and to implement corrective actions. In the area of monitoring and evaluation, regular reports were prepared.

⁹⁷ Angola, Botswana, Burundi, Cameroon, Cape Verde, Comoros, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Guinea, Kenya, Niger, Nigeria, Rwanda, Sao Tome and Principe, Swaziland, Tanzania, Uganda and Zambia.

⁹⁸ Botswana, Burkina Faso, Burundi, Comoros, Republic of Congo, Ethiopia, Guinea-Bissau, Madagascar, Mali, Mozambique, Niger, Nigeria, Senegal, Tanzania, Uganda and Zambia.

Resolution AFR/RC54/R2: Repositioning family planning in reproductive health services: framework for accelerated action, 2005–2014

259. Regional Committee Resolution AFR/RC54/R2 requested the Regional Director to continue to advocate for a strategic approach to the reduction of maternal morbidity and mortality and the pivotal role of family planning; to provide technical support to Member States for the planning, implementation, monitoring and evaluation of the framework for repositioning family planning in reproductive health services; and to develop relevant guidelines for use by Member States to advocate for and accelerate the implementation of the framework. In order to intensify advocacy, WHO, in collaboration with partners, developed the family planning advocacy toolkit targeting the different stakeholders, including policy-makers and community leaders. The toolkit has been disseminated to all the countries, and some countries, like Nigeria, have used it for initiating the consumer and provider dialogue for improved family planning services.

260. WHO, in collaboration with UNFPA, provided support to countries to build national capacity in family planning service provision, including for pre-service and in-service training through orientation workshops on updating family planning tools and guidelines. So far, 18 countries⁹⁹ have benefited from this support. Following the orientation, countries were given financial support for the adaptation and adoption of family planning guidelines and protocols to improve the quality of family planning services.

261. Furthermore, to address unmet needs in family planning, national reproductive health and essential medicines programme managers from six countries¹⁰⁰ were given guidance both on the methodologies for integration of reproductive health essential medicines into the national essential medicines list and on assessing the availability of sexual and reproductive health medicines to improve the procurement of family planning medicines and devices.

262. In order to provide guidance in the planning, implementation, monitoring and evaluation of the framework for repositioning family planning, WHO, in collaboration with UNFPA, started developing a set of tools for integration of family planning into sexual and reproductive health services, namely: the framework for the integration of family planning into maternal, newborn and child health services, and a tool for the assessment of linkages between sexual and reproductive health and sexually-transmitted infections, HIV and AIDS.

Resolution AFR/RC54/R3: Priority interventions for strengthening national health information systems

263. The Regional Committee by its Resolution AFR/RC54/R3 requested the Regional Director to provide support to Member States to enable them to implement priority interventions for strengthening national health information systems; to promote technological options that facilitate networking, communication, access, use and feedback of health information; and to provide support to countries for resource mobilization and capacity building in national health information systems.

264. Six countries¹⁰¹ conducted comprehensive evaluation of their national health information systems (NHIS) to identify their weaknesses and needs in terms of human, financial and material resources. All 46 Member States were sensitized to the use of the Health Metrics Network (HMN) framework in order to align their NHIS to the international norms and standards adopted

⁹⁹ Benin, Botswana, Cameroon, Central African Republic, Cote d'Ivoire, Guinea, Kenya, Lesotho, Madagascar, Namibia, Niger, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

¹⁰⁰ Ethiopia, Ghana, Kenya, Nigeria, South Africa and Zambia.

¹⁰¹ Botswana, Chad, Republic of Congo, Liberia, Rwanda and Senegal.

during the World Health Assembly in May 2006. Service Availability Mapping and other geographic information systems were implemented in 13 countries¹⁰² to facilitate communication, access, use and feedback in regard to health information.

265. The Regional Office has been working closely with the HMN and WHO headquarters and in collaboration with multilateral and bilateral agencies, foundations, other global health partnerships, and technical experts to support countries to strengthen their national health information systems. Five workshops were organized for 41 countries using the harmonized HMN framework for country health information systems development which describes standards for NHIS and the NHIS assessment and monitoring tool. Consequently, more than 170 participants from 26 countries were trained using these standards. An additional 15 HMN-funded countries evaluated their NHIS. Sierra Leone developed its NHIS strategic plan and started implementing it with the support of DFID and the World Bank. The financial support provided to countries since 2006 amounted to US\$ 2 million in the first year and about US\$ 500 000 during the second year.

Resolution AFR/RC54/R4: Occupational health and safety in the African Region: situation analysis and perspectives

266. Regional Committee Resolution AFR/RC54/R4 requested the Regional Director to provide technical support for the development and strengthening of occupational health and safety policies, legislation and programmes; to sustain dialogue with ILO; to promote and support research and surveillance; and to support resource mobilization.

267. WHO and ILO issued a joint letter of intent by which the two organizations committed themselves to uniting their efforts and working together in selected areas of occupational health and safety for the benefit of Member States.

268. In addition, WHO provided financial and technical support to Botswana, Comoros, Gambia, Namibia and Swaziland to collect baseline data and information on occupational health and safety in order to start the process of policy formulation and implementation of plans. As a result, Botswana and Namibia developed their policy documents. Gambia and Swaziland started the process, while Comoros undertook to analyse and interpret the data collected. Nigeria is in the process of developing its policy. In all these countries, the Ministry of Health in collaboration with the Ministry of Labour involved all other sectors—nongovernmental organizations, employers, workers and other institutions such as universities and researchers—in this activity.

269. The process included mobilizing resources within and outside the health sector and working with other stakeholders to sustain the programmes. It is therefore inclusive of small-, medium- and large-scale enterprises and the formal and informal sectors. In addition, it addresses the management of illnesses such as tuberculosis, malaria and HIV/AIDS.

Resolution AFR/RC54/R5: Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond

270. The resolution requested the Regional Director to strengthen the role of WHO in providing technical leadership and direction to health system response to HIV/AIDS; to provide technical support and guidance for the development, monitoring and evaluation of treatment and care programmes; to advocate for more resources to increase access to care and treatment, including through the Global Fund to Fight AIDS, Tuberculosis and Malaria; to facilitate

¹⁰² Central African Republic, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Swaziland, Tanzania, Togo, Uganda and Zambia.

partnerships at regional level; and to advocate continuously for research and development of new drugs and vaccines.

271. The Regional Director convened a meeting of regional heads of United Nations agencies to develop a joint plan on HIV prevention and universal access. WHO and UNAIDS co-organized three subregional meetings on universal access. All the 46 countries of the Region were supported to develop their plans for scaling up antiretroviral therapy mainly with CIDA funding. The WHO Director-General and Regional Director mobilized resources from DFID, CIDA, CDC, Angola, GTZ, Italian Initiative and the OPEC Fund for International Development (OFID). Most of the countries increased their funding for HIV/AIDS care and treatment through GFATM grants.

272. Since the launch of The 3 by 5 Initiative, antiretroviral therapy coverage has increased from less than 1% in December 2003 to 17% in December 2005 and to 35% as at the end of September 2007. At least 14 countries reached 50% coverage; however, coverage in children is still low, estimated at 11%.

Resolution AFR/RC54/R6: Child sexual abuse: a silent health emergency

273. The resolution requested the Regional Director to continue to play a leadership and advocacy role for integrated prevention, care and management of child sexual abuse; to provide technical support to Member States; to mobilize resources; and to encourage partnerships.

274. A review of existing national and international guidelines on child sexual abuse was conducted. Based on the review, generic regional guidelines for clinical management of child sexual abuse were developed.

275. A capacity building workshop on the Convention on the Rights of the Child was held for 20 WHO regional, subregional and national staff working in the Child and Adolescent Health programme. The workshop put emphasis on the mechanisms available for monitoring and protecting children generally and against sex abuse in particular. Cameroon, Gambia and Lesotho participated in training and incorporated the rights-based approach into the planning and implementation of their national child and adolescent health programmes, with Cameroon and Gambia focusing particularly on IMCI while Lesotho focused on adolescent sexual and reproductive health policy.

276. In November 2007, the Office of the High Commissioner for Human Rights, UNICEF, Plan International, WHO and the Ministry of Promotion of Human Rights, Burkina Faso, convened a meeting in Ouagadougou to assess the implementation of the final Convention observations from eight countries.¹⁰³ One of the key recommendations that the meeting made to Member States was to implement the child survival strategy which includes interventions to address child sexual abuse.

277. A partnership was established with AFRICA 2010 and the Academy for Educational Development to work together and co-finance key activities related to child sexual abuse, including literature reviews, consultative meetings and developing clinical guidelines and advocacy materials.

¹⁰³ Benin, Burkina Faso, Cote d'Ivoire, Guinea, Mali, Niger, Senegal and Togo.

Resolution AFR/RC55/R2: Achieving the health Millennium Development Goals: situation analysis and perspectives in the African Region

278. The resolution, among other things, requested the Regional Director to provide technical support to countries in the scaling up of interventions to reduce child mortality (Goal 4), maternal mortality (Goal 5), and morbidity and mortality due to HIV/AIDS, tuberculosis, malaria, and other priority diseases (Goal 6); and to support countries in the use of appropriate monitoring and evaluation frameworks in order to track progress in achieving the health MDGs.

279. The Harmonization for Health in Africa (HHA) initiative supported 11 countries.¹⁰⁴ In collaboration with partners, technical support was provided to several countries in various aspects of developing strategies for strengthening health systems in order to achieve the health MDGs.

280. Recent assessments show that even though some countries are on track to achieve at least some of the Millennium Development Goals, most countries are not on track to meet the MDGs. None of the countries have been able to make significant progress in reducing extreme poverty; maternal, infant and child mortality rates are still very high and progress remains insufficient.

281. HIV prevalence has either stabilized or is showing signs of decline in most countries of sub-Saharan Africa. Some countries have tremendously reduced the malaria and tuberculosis burden, but the large majority of them are unlikely to achieve that target. Only one country is on track to meet the sanitation goal. Lack of adequate funding, potential instability in some areas, weak health systems and brain drain of the health workforce are the most important health threats to achievement of the health MDGs.

282. Through the EU-WHO partnership programme, six countries¹⁰⁵ received financial support in the area of MDGs. The Regional Office organized workshops on health, poverty reduction, human rights and economic development. Through the HHA network, technical support was provided to countries in regard to SWAps, MTEF and the health component of PRSPs. The countries were also supported to incorporate the MDG targets and indicators into their development policies and plans, including the PRSPs, MTEFs and SWAps.

Resolution AFR/RC56/R1: The regional strategic plan for the Expanded Programme on Immunization 2006–2009

283. The fifty-sixth session of the Regional Committee for Africa, by its Resolution AFR/RC56/R1, approved the Regional Strategic Plan for the Expanded Programme on Immunization 2006–2009. The resolution urged Member States to increase budgetary allocations for immunization activities; ensure that immunization remains a priority; and accelerate and sustain the achievement of certification-standard poliomyelitis surveillance. It requested the Regional Director to continue advocating for the polio eradication goals; to monitor the accelerated disease control activities; and to work closely with partners in line with the Global Immunization Vision and Strategy.

284. As of 11 November 2007, 11 countries had concluded one or more rounds of poliomyelitis supplemental immunization activities. Nigeria remained the only country with continued transmission of wild poliovirus. There were importations of wild poliovirus into Angola, Chad, Democratic Republic of Congo and Niger. A total of 289 confirmed cases of wild poliovirus infection had been reported by the end of October 2007, compared to 994 during the

¹⁰⁴ Benin, Burkina Faso, Burundi, Chad, Ethiopia, Madagascar, Mali, Mozambique, Nigeria, Sao Tome and Principe, and Zambia.

¹⁰⁵ Angola, Burkina Faso, Kenya, Malawi, Niger and Tanzania.

same period in 2006. Moreover, 43 countries achieved and sustained certification-standard surveillance.

285. In 2006, measles supplemental immunization activities reached out to 81.4 million children in 20 countries, and 31.6 million more children were reached in 16 countries by the end of 2007. All countries integrated other child survival interventions with the measles supplemental immunization activities.

286. In 2006, 15 countries¹⁰⁶ reported at least 90% DPT3 coverage and 14 countries¹⁰⁷ reported that at least 80% of districts had achieved 80% or more DPT3 coverage. As of July 2007, 38 countries had introduced hepatitis B vaccine and 20 countries had introduced *Haemophilus influenzae* type b vaccine in their routine immunization schedule. Only three countries increased their budget line for immunization.

287. A total of 38 countries (83%) completed their comprehensive multiyear planning. Countries were supported to make use of debt relief initiatives to strengthen immunization programmes. The debt relief funds therefore served as excellent means to improve and maintain high immunization within countries.

288. Progress towards achieving the goals set in the EPI strategic plan was satisfactory. However, efforts to maintain the gains should continue through adequate funding and programme support for routine immunization services.

Resolution AFR/RC56/R2: Child survival: a strategy for the African Region

289. Resolution AFR/RC56/R2 urged Member States to put in place policies needed for effective implementation of the child survival strategy. Furthermore, it requested the Regional Director to, among other things, stimulate partnerships; advocate for the scaling up of priority interventions; and provide technical support to countries to scale up child survival interventions.

290. A framework for achieving the MDGs concerning child survival in Africa was developed in collaboration with the African Union and was officially endorsed by the AU ministers responsible for child affairs during the Second Pan-African Forum on Children held in Cairo, Egypt, 29 October–2 November 2007.

291. WHO, in close collaboration with UNICEF, continued to support Member States to improve child survival. Seventeen countries¹⁰⁸ received support to develop national child survival strategies and strategic plans using the regional strategy as a framework. Training-of-trainers courses on essential newborn care were conducted for 12 countries,¹⁰⁹ and national training courses were conducted in six countries.¹¹⁰

292. IMCI training materials were adapted to include evidence-based updates on concentrations of oral rehydration solutions, zinc supplementation, paediatric HIV/AIDS and newborn health. Capacity-building workshops for introduction of the updated material were

¹⁰⁶ Algeria, Benin, Botswana, Burkina Faso, Burundi, Lesotho, Madagascar, Mali, Niger, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa and Zambia.

¹⁰⁷ Botswana, Burkina Faso, Cape Verde, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Niger, Rwanda, Sao Tome and Principe, Seychelles, Togo and Zambia.

¹⁰⁸ Angola, Benin, Burkina Faso, Eritrea, Ghana, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.

¹⁰⁹ Angola, Cape Verde, Kenya, Malawi, Mozambique, Nigeria, Sao Tome and Principe, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

¹¹⁰ Kenya, Malawi, Nigeria, Tanzania, Uganda and Zambia.

organized for programme managers from 24 countries. As a result, 19 countries have expanded geographical coverage of IMCI to more than 50% of their districts.

293. Madagascar and Niger were supported to develop training materials for community-based case management of childhood illnesses. “Child Health Weeks” helped provide an integrated package of child health and nutrition interventions in nine countries.¹¹¹ Effective partnerships for maternal, newborn and child health were strengthened in seven countries,¹¹² and resources were successfully mobilized in six countries.¹¹³

Resolution AFR/RC56/R3: HIV prevention in the African Region: a strategy for renewal and acceleration

294. The resolution requested the Regional Director to provide technical support to Member States in the development and implementation of health sector-based HIV prevention strategies; to advocate for more resources and help mobilize long-term international support for scaling up HIV prevention efforts; to monitor progress in the implementation of the strategy; and to report to the Regional Committee every other year.

295. Updated guidelines on new approaches such as provider-initiated testing and counselling and male circumcision were produced and disseminated to all countries. HIV prevention committees were established in nine countries to spearhead acceleration of HIV prevention. Seventeen countries were supported to update their sexually-transmitted infections guidelines on comprehensive case management. Fourteen countries received support to develop and implement national guidelines on HIV testing and counselling. Seven countries were supported to develop and implement plans to accelerate the scaling up of prevention of mother-to-child transmission (PMTCT) interventions and paediatric HIV care. The Regional Office jointly organized several meetings with the AU; regional and subregional bodies such as SADC, ECOWAS, CEMAC; as well as other UN agencies like UNAIDS, UNFPA, UNICEF and ILO. A progress report was made available during the fifty-seventh session of the Regional Committee for Africa.

Resolution AFR/RC56/R4: Poverty, trade and health: an emerging health development issue

296. The resolution requested the Regional Director to provide support to Member States to frame coherent policies to address the relationship between trade and health; to support Member States’ efforts to build capacity to understand the implications of international trade and trade agreements for health; to address relevant issues through policies and legislation that take advantage of the potential opportunities; to address the potential challenges that trade and trade agreements may have for health; to continue collaborating with international organizations in order to support policy coherence between trade and health sectors at national and regional levels, including generating and sharing evidence on the relationship between trade and health; and to continue implementing Resolution AFR/RC52/R2, in particular, paragraphs 3(a) and 3(c).

297. Twenty-one Member States¹¹⁴ received support to undertake preliminary studies on trade in health services. The Regional Office prepared terms of reference for a guide to conducting in-depth country studies on trade in health services in the Region.

¹¹¹ Botswana, Kenya, Ghana, Madagascar, Malawi, Tanzania, Uganda, Zambia and Zimbabwe.

¹¹² Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Tanzania and Zambia.

¹¹³ Burkina Faso, Democratic Republic of Congo, Ethiopia, Malawi, Mozambique and Kenya.

¹¹⁴ Angola, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.

298. Activities relating to poverty and poverty reduction strategies continued to be a key aspect of country approaches to development. Technical support was provided to countries to develop or improve the health component of their Poverty Reduction Strategy Papers. Participants from Cameroon, Kenya, Mozambique, Rwanda and Uganda attended a capacity-building workshop on health, human rights and poverty reduction strategies. Most of the countries in the Region participated in at least one of three capacity-building workshops on health, poverty reduction and economic development organized by the Regional Office. Technical support was also provided to six countries¹¹⁵ as regards health SWApS, MTEF and the costing of the health component of PRSPs.

Resolution AFR/RC56/R5: Health financing: a strategy for the African Region

299. The resolution urged Member States to strengthen or develop comprehensive health financing policies and strategic plans. It requested the Regional Director to provide technical support for health financing to countries and report on progress every two years.

300. As part of the implementation of the resolution, Eritrea and Nigeria were supported to draft comprehensive health financing policies. Lesotho and Zambia were supported to undertake feasibility analyses of social health insurance.

301. In collaboration with headquarters and USAID, the Regional Office trained 36 nationals from 25 countries in undertaking and institutionalizing national health accounts (NHA) at workshops held in Bamako and Brazzaville in June 2006 and November 2006, respectively. After the training, some of the countries¹¹⁶ started the NHA process; Burkina Faso, Niger and Rwanda completed their NHA studies. In addition, technical support in NHA was provided to 13 countries;¹¹⁷ six of those countries¹¹⁸ completed and disseminated the NHA studies. Studies were started in seven other countries.

302. In Maputo, in May 2006, 15 participants from Burkina Faso, Ghana, Mozambique, Nigeria and Tanzania were trained in costing and feasibility analysis of prepaid health financing mechanisms. Those participants started country studies on sustainable financing for HIV/AIDS. At another workshop held in May 2007, health economists and consultants of WHO country offices were trained in costing, cost-effectiveness analysis, health financing and PRSPs.

303. In order to facilitate sharing of health financing research findings, support was provided for the establishment of the West African Health Economics Network and for organizing its inaugural meeting at the University of Nigeria in August 2007. A series of seven articles on health economics was published for wide dissemination.

Resolution AFR/RC56/R7: Avian influenza: preparedness and response to the threat of a pandemic

304. The Regional Committee Resolution AFR/RC56/R7 requested the Regional Director to strengthen the capacity of the Regional Office for provision of timely and effective technical support to Member States; to strengthen partnerships for technical and financial support to countries; and to support capacity building of subregional and regional reference laboratories.

¹¹⁵ Cameroon, Chad, Ethiopia, Kenya, Madagascar and Mozambique.

¹¹⁶ Burkina Faso, Chad, Republic of Congo, Guinea, Niger, Rwanda, Sao Tome and Principe, and Senegal.

¹¹⁷ Angola, Botswana, Burkina Faso, Chad, Republic of Congo, Gambia, Guinea, Malawi, Namibia, Niger, Sao Tome and Principe, Sierra Leone and Zimbabwe.

¹¹⁸ Botswana, Burkina Faso, Gambia, Malawi, Niger and Sierra Leone.

305. By the end of 2007, eight countries of the WHO African Region had reported avian influenza outbreaks.¹¹⁹ Nigeria reported the first confirmed human case of avian influenza (H5N1) in the Region in January 2007. Almost all countries developed national influenza preparedness and response plans and established national multisectoral task forces.

306. Training-of-trainers workshops on rapid containment were organized for West Africa and Central Africa in November and December 2007, respectively. Technical and financial support was provided to countries to expand training on avian influenza. Efforts to strengthen the laboratory network for confirmation of avian influenza were pursued, and Member States were provided with avian influenza investigation kits and Tamiflu®.

Resolution AFR/RC56/R8: Knowledge management in the WHO African Region: strategic directions

307. The resolution recognized the importance of knowledge management for improving national health systems performance and the opportunities provided by the efficient use of information and communication technology in all health development areas. It urged Member States to develop and implement national knowledge management strategies. It requested the Regional Director to continue advocacy for knowledge management as a key approach to strengthening health systems; to provide technical support to Member States for the development and implementation of national policies and plans; and to build regional partnerships, in particular with the African Union, NEPAD and regional economic communities.

308. To enhance understanding of the knowledge management situation in the Region, two surveys were conducted: the Global Survey on eHealth (in 2006) and the Knowledge Systems for Health Survey (in 2007). The results of these surveys are being used to prepare guidelines to strengthen knowledge management in Member States. In collaboration with the East African Community, Burundi, Kenya, Rwanda, Tanzania and Uganda were supported to develop national eHealth strategies. Gambia and Ghana were selected to pilot the WHO Health Academy Project with support from OFID. The project uses information technology for health promotion and is part of the AU Commission-NEPAD eSchools project.

309. Improvement of access to current health-related scientific knowledge continued with the promotion of Health Inter-Network Access to Research Information. By the end of 2007, the number of institutions with access to the network had increased to 867 in 41 Member States. To improve the sharing of knowledge generated in the African Region, the African Medicus Index, containing more than 8000 titles, was published on the web site as part of the Global Health Library.

310. Regional partnerships for knowledge management were strengthened through the work of the African Region Telemedicine Task Force which comprises representatives of WHO, African Union Commission, regional economic communities and other partners. The task force published and submitted its report to the European Union Commission in July 2007; subsequently, the Commission decided to fund two pilot projects to guide step-wise development of an eHealth network in the Region.

311. The strong collaboration and partnership established with the African Union Commission and the regional economic communities offer a good opportunity for improving knowledge management in the Region.

¹¹⁹ Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Ghana, Niger, Nigeria and Togo.

AFR/RC57/R3: Onchocerciasis control in the WHO African Region: current situation and way forward

312. Resolution AFR/RC57/R3 reinforced the September 2006 Yaounde Declaration by ministers of health of onchocerciasis-endemic countries in Africa. It urged the affected Member States to include onchocerciasis control activities in their national development agenda, ensure sustainable financing, and intensify cross-border collaboration to sustain the gains already made. It also urged the countries to submit annual comprehensive progress reports to the WHO Regional Office. The resolution requested the Regional Director to report on progress in onchocerciasis control to the Regional Committee in 2008 and every two years thereafter.

313. The African Programme on Onchocerciasis Control (APOC) and partners used the resolution as a tool to obtain more commitment from decision-makers at country level. The financial contribution of governments to onchocerciasis control activities in 13 APOC countries increased by 38%. More than US\$ 1 million had been disbursed by countries by the end of 2007 for key activities in onchocerciasis control, including distribution of ivermectin. This does not include payment of salaries to health workers. However, in countries in post-conflict situations, government contributions were unsatisfactory.

314. The African Development Bank was asked to increase its support to APOC. Furthermore, the Joint Action Forum met in Brussels in December 2007 and recognized WHO's strong commitment to onchocerciasis control. This resulted in the extension of APOC to 2015 and acceptance of the APOC Plan of Action and Budget for 2008–2015.

CONCLUSION AND WAY FORWARD

Conclusion

315. The 2006-2007 biennium was the first under the WHO Eleventh General Programme of Work. In line with global health priorities and taking into account regional specificities, the WHO African Region provided support to Member States in the areas of work that had been clearly identified in respective WHO Country Cooperation Strategy documents. This support covered a fairly wide scope, including communicable diseases, with particular emphasis on HIV/AIDS, tuberculosis, malaria, poliomyelitis and vaccine-preventable diseases; maternal and child health; health systems strengthening; emergency preparedness and response; and noncommunicable diseases.

316. The overall level of achievement of the expected results under the different areas of work was satisfactory. Of the expected results, 91% were either totally achieved or partially achieved. Significant progress was made compared to the results of the previous biennium, when 67% of the expected results were achieved.

317. Of the approved Regular budget of US\$ 203.6 million, a total of US\$ 193.8 million was recorded as expenditures as of December 2007, representing a budget implementation rate of 95.2%. The implementation rate for Voluntary contributions during the same period was 78.6%. A total of US\$ 59.2 million was carried over to the 2008-2009 biennium.

318. Key factors that facilitated the achievement of the expected results were related to prevailing country environments and factors internal to the Organization. Most importantly, the political commitment of governments of Member States facilitated dialogue and partnerships, and motivated health workers and development partners, thus boosting programme implementation. Several Member States also undertook strong advocacy and exercised ownership and adequate leadership and coordination over their interventions. Thanks to increased collaboration between

the three levels of WHO, i.e. headquarters, Regional Office and country offices, strategic direction was adequately provided, and joint planning and networking enhanced programme implementation.

319. However, in some instances, the implementation of the Programme Budget was hampered by unforeseen circumstances. The late disbursement and, sometimes, unavailability of Voluntary contribution funds was a major concern. This situation very often compelled the Regional Office to function in emergency fashion, which hampered the achievement of the desired results. Some countries experienced difficulties in absorbing the available funds often due to major human resource gaps, thereby limiting the scaling up of interventions.

Way Forward

320. In May 2007, the World Health Assembly adopted the Programme Budget for the 2008-2009 biennium which is the first under the WHO Medium-Term Strategic Plan 2008-2013. The new structure of the Programme Budget is characterized by a shift from areas of work to strategic objectives. The shift is expected to provide a longer time span for the realization of objectives and results. It also emphasizes synergy among the different programmes and departments of the WHO Secretariat in efforts to support Member States to address health gaps and scale up their efforts towards the attainment of the health Millennium Development Goals.

321. During 2008-2009, WHO will roll out its Global Management System in the African Region. This system will significantly change the way the Organization operates. It will streamline and automate most standard management procedures; enhance decentralization and delegation of authority and responsibility; facilitate joint programme planning and implementation; and increase transparency and accountability in actions at all levels.

322. In the African Region, WHO will continue to mobilize the necessary resources to support Member States to address priority health issues, including poliomyelitis eradication; HIV/AIDS, tuberculosis and malaria prevention and control; maternal morbidity and mortality; child survival; gender mainstreaming; and the increasing burden of noncommunicable diseases. Particular emphasis will be placed on support to countries for strengthening their health systems which constitute the pillar for sustaining and scaling up key health interventions. Attention will also be placed on strengthening disease surveillance and health information systems in countries. Where possible, the establishment of centres of excellence in disease control will be supported.

323. To that end, WHO will pursue its efforts to strengthen country offices by strengthening their staff profile. Furthermore, the Regional Office will continue the decentralization of programme implementation functions to the already-established Inter-country Support Teams, thus bringing technical support closer to countries. This will allow the Regional Office to concentrate on normative and strategic functions.

324. In the framework of United Nations reforms, the African Region will draw upon lessons from the experience of the eight UN pilot country teams, four of which are in the African Region. This experience is expected to help improve harmonization among UN agencies and alignment of their activities with country priorities. The advances already made in establishing the Harmonization for Health in Africa initiative among the WHO Regional Office, UNICEF, African Development Bank and World Bank, as well as the International Health Partnership will be consolidated for improved coordination of financial and technical support to countries in formulation of their strategic plans, negotiations with donors and implementation of funded interventions.

325. The WHO Regional Office will expand its collaboration with the African Union Commission, regional economic communities, nongovernmental organizations and civil society by providing the usual technical expertise and comparative advantage in health while benefiting from their political support, financial resource mobilization capabilities and comparative advantage in community-based interventions.

ANNEX: Budget implementation, WHO African Region, 2006-2007

Table 1: Regular budget implementation by area of work, December 2007

Areas of work*	Approved budget 000s US\$	Obligations 000s US\$	% implemented
BCT	2,647	1,958	74.0
BMR	1,459	1,338	91.7
CAH	8,168	5,407	66.2
CPC	3,130	3,863	123.4
CRD	553	71	12.8
CSR	14,617	10,966	75.0
DGO	1,536	1,387	90.3
EDM	3,556	3,961	111.4
EHA	2,236	2,996	134.0
FNS	3,372	3,740	110.9
FOS	1,595	839	52.6
GBS	1,287	1,184	92.0
HFS	755	1,786	236.6
HIV	4,662	4,784	102.6
HPR	5,169	6,455	124.9
HRH	11,258	9,905	88.0
HRS	2,287	2,103	92.0
HSD	3,414	1,931	56.6
HSP	7,358	10,176	138.3
IER	864	1,213	140.4
IIS	10,029	9,548	95.2
INJ	751	604	80.4
IVD	902	2,509	278.2
KMI	5,753	5,318	92.4
MAL	2,020	3,179	157.4
MNH	2,530	1,390	54.9
MPS	9,778	6,151	62.9
NCD	7,641	4,763	62.3
NUT	2,589	797	30.8
PHE	6,210	4,429	71.3
REC	2,257	1,549	68.6
REF	-	-	0.0
RHR	2,925	3,040	103.9
SCC	63,515	70,730	111.4
TOB	3,113	1,494	48.0
TUB	2,371	1,610	67.9
WMH	1,320	652	49.4
TOTAL	203,627	193,826	95.2

* For areas of work, see p. 68.

Table 2: Voluntary contributions budget implementation by area of work, December 2007

Areas of work*	Approved budget 000s US\$	Obligations 000s US\$	% implemented
BCT	1,471	1,812	123.2
BMR	493	9	1.8
CAH	19,332	8,408	43.5
CPC	56,049	10,340	18.4
CRD	2,032	612	30.1
CSR	30,115	15,429	51.2
DGO	-	199	0.0
EDM	7,944	6,964	87.7
EHA	32,752	58,903	179.8
FNS	-	52	0.0
FOS	2,405	204	8.5
GBS	-	-	0.0
HFS	4,419	990	22.4
HIV	130,935	52,633	40.2
HPR	1,429	944	66.1
HRH	16,975	2,811	16.6
HRS	-	1,536	0.0
HSD	2,817	2,125	75.4
HSP	23,150	9,170	39.6
IER	13,040	1,902	14.6
IIS	-	264	0.0
INJ	1,246	1,100	88.3
IVD	233,510	308,645	132.2
KMI	6,542	159	2.4
MAL	56,712	38,594	68.1
MNH	2,150	429	20.0
MPS	5,038	6,567	130.3
NCD	591	918	155.3
NUT	1,911	572	29.9
PHE	2,790	429	15.4
REC	22	189	859.1
REF	4,770	598	12.5
RHR	4,950	2,235	45.2
SCC	12,093	5,369	44.4
TOB	1,887	1,066	56.5
TUB	27,629	14,923	54.0
WMH	1,680	298	17.7
TOTAL	708,879	557,398	78.6

* For areas of work, see p. 68.

Table 3: Consolidated budget implementation by area of work, December 2007

Areas of work*	Approved budget 000s US\$	Obligations 000s US\$	% implemented
BCT	4,118	3,771	91.6
BMR	2,768	2,050	74.1
CAH	27,500	13,815	50.2
CPC	59,179	14,203	24.0
CRD	2,585	683	26.4
CSR	45,000	26,395	58.7
DGO	2,128	2,505	117.7
EDM	11,500	10,925	95.0
EHA	34,988	61,899	176.9
FNS	10,058	11,581	115.1
FOS	4,000	1,043	26.1
GBS	3,142	2,049	65.2
HFS	5,174	2,776	53.7
HIV	135,597	57,417	42.3
HPR	6,598	7,399	112.1
HRH	28,233	12,716	45.0
HRS	6,400	7,544	117.9
HSD	6,549	4,056	61.9
HSP	30,826	19,346	62.8
IER	13,904	3,115	22.4
IIS	24,000	22,456	93.6
INJ	1,997	1,704	85.3
IVD	234,680	311,266	132.6
KMI	15,000	10,518	70.1
MAL	59,000	41,773	70.8
MNH	4,680	1,818	38.8
MPS	14,816	12,717	85.8
NCD	8,500	5,681	66.8
NUT	4,500	1,370	30.4
PHE	9,000	4,858	54.0
REC	5,490	3,540	64.5
REF	4,770	598	12.5
RHR	8,193	5,589	68.2
SCC	76,580	76,503	99.9
TOB	5,000	2,560	51.2
TUB	30,000	16,533	55.1
WMH	3,000	950	31.7
TOTAL	949,453	785,722	82.8

* For areas of work, see p. 68.

Areas of Work

BCT	Blood Safety and Clinical Technology
BMR	Planning, Resource Coordination and Oversight
CAH	Child and Adolescent Health
CPC	Communicable Disease Prevention and Control
CRD	Communicable Disease Research
CSR	Epidemic Alert and Response
DGO	Director-General, Regional Director and Independent Functions
EDM	Essential Medicines
EHA	Emergency Preparedness and Response
FNS	Budget and Financial Management
FOS	Food Safety
GBS	Governing Bodies
HFS	Health Financing and Social Protection
HIV	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
HPR	Health Promotion
HRH	Human Resources for Health
HRS	Human Resources Management in WHO
HSD	Policy-making for Health in Development
HSP	Health System Policies and Service Delivery
IER	Health Information, Evidence and Research
IIS	Infrastructure and Logistics
INJ	Violence, Injuries and Disabilities
IVD	Immunization and Vaccines Development
KMI	Knowledge Management and Information Technology
MAL	Malaria
MNH	Mental Health and Substance Abuse
MPS	Making Pregnancy Safer
NCD	Management and Surveillance of Noncommunicable Diseases
NUT	Nutrition
PHE	Health and Environment
REC	External Relations
REF	Real Estate Fund
RHR	Reproductive Health
SCC	WHO's Core Presence in Countries
TOB	Tobacco
TUB	Tuberculosis
WMH	Gender, Women and Health