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THE WORK OF WHO
IN THE AFRICAN REGION
2008-2009

BIENNIAL REPORT OF
THE REGIONAL DIRECTOR

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA
BRAZZAVILLE 2010



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TO THE SIXTIETH SESSION
OF THE REGIONAL COMMITTEE FOR AFRICA,
MALABO, REPUBLIC OF EQUATORIAL GUINEA,
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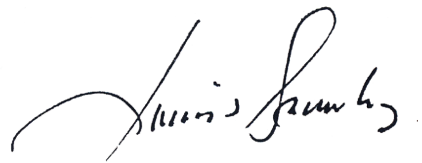
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Printed in Congo

The Regional Director has the honour of presenting to the Regional Committee the report on the work of the World Health Organization in the African Region during the period 1 January 2008 to 31 December 2009.

A handwritten signature in black ink, reading "Luis Gomes Sambo". The signature is fluid and cursive, with a large initial 'L' and 'S'.

*Dr Luis Gomes Sambo
Regional Director*

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ABBREVIATIONS

ACP	The African, Caribbean and Pacific Group of States
ACT	Artemisinin-based Combination Therapy
AFRO	WHO Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CILSS	<i>Comité Inter-État de Lutte contre la Sécheresse au Sahel</i> Permanent Inter-State Committee for Drought Control in the Sahel
CDV	Cardiovascular Disease
DALY	Disability-Adjusted Life Year
EC	European Commission
ECOWAS	Economic Community of West African States
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
GAVI	Global Alliance for Vaccines and Immunization
GSM	Global Management System
HELP	Health Emergencies in Large Populations
HHA	Harmonization for Health in Africa
HIV	Human Immunodeficiency Virus
IARC	International Agency for Research on Cancer
IHP+	International Health Partnership and related initiatives
IHR	International Health Regulations (2005)
ILO	International Labour Organization
IOM	International Organization for Migration
IRSP	<i>Institut Régional de Santé Publique</i> Regional Institute of Public Health
IST	Intercountry Support Team
ITOCA	Information Training and Outreach Centre for Africa
IYCF	Infant and Young Child Feeding
MDR-TB	Multidrug-resistant TB
MNCH	Maternal, Neonatal and Child Health
MNTE	Maternal and Neonatal Tetanus Elimination

MOSS	Minimum Operating Security Standards
MORSS	Minimum Operating Residential Security Standards
MTSP	Medium Term Strategic Plan
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHIS	National Health Information Systems
NHP	National Health Policy
NHSP	National Health Strategic Plan
NSA	National Strategic Applications
NTDs	Neglected Tropical Diseases
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PALOPs	<i>Países Africanos de Língua Oficial Portuguesa</i> African Countries using Portuguese as Official Language
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child Transmission
PRSP	Poverty Reduction Strategy Papers
RDT	UN Regional Directors Teams
REACH	Renewed Effort to End Child Hunger and Malnutrition
REC	Regional Economic Communities
RED	Reaching Every District
SADC	Southern African Development Community
SAICM	Strategic Approach to International Chemicals Management
SO	Strategic Objective
STEPS	Stepwise approach to surveillance of risk factors
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBCAP	TB Control Country Action Programme
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Teams
UNDAF	United Nations Development Assistance Framework
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
UNISDR	UN International Strategy for Disaster Risk Reduction
UNITAR	United Nations Institute For Training and Research
USAID	United States Agency for International Development
VIA	Visual Inspection Methods using Acetic Acid
VIL	Visual Inspection Methods using Lugol
WAHO	West African Health Organization
WCC	WHO Collaborating Centre
WCO	WHO Country Office
WHO	World Health Organization
XDR-TB	Extensively drug-resistant TB

EXECUTIVE SUMMARY

1. The 2008-2009 biennium was the second biennium in the implementation of the WHO global health agenda as defined in the 11th General Programme of Work 2006–2015. It was the first biennium of implementation of the WHO Medium Term Strategic Plan (MTSP) that sets out the WHO strategic directions for the period 2008–2013. The last year of the biennium marked the end of the first term of office of Dr Luis Gomes Sambo as WHO Regional Director for Africa and saw his re-election for a second term during the Fifty-ninth session of the Regional Committee, held in Kigali, Rwanda, from 31 August to 4 September 2009.
2. The biennium under review also saw the celebration of the 60th anniversary of the establishment of WHO and the 30th anniversary of the Alma Ata Declaration on Primary Health Care. The World Health Report 2008 and the World Health Assembly Resolution WHA62.12 on Primary Health Care, including Health System Strengthening reaffirmed the values and principles of the Alma Ata Declaration as central to health development. WHO global consultations, declarations and reports on major health issues such as social determinants of health; public health, innovation and intellectual property; research for health; and health promotion, have created opportunities to mobilize efforts and resources to address some of the main health challenges in the Region.
3. At the regional level, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, the Algiers Declaration on Research for Health in the African Region: Narrowing the knowledge gap to improve Africa's health and the Libreville Declaration on Health and Environment, all adopted in 2008, underscored the need to strengthen health systems and address environmental factors for better health outcomes.
4. WHO strenuously worked with governments of Member States of the African Region to strengthen their focus on health issues and their commitment to financing the health sector. WHO leadership in the health sector has been strengthened at country level, and its governance has been improved with the consolidation of its decentralization policy and the engagement and expansion of strategic partnerships for health in the light of the principles underpinning the Paris Declaration.
5. During the biennium the health status of people in the Region continued to be a matter of concern. Most of the countries in the African Region did not make sufficient progress towards achieving health MDG targets. The Region continued to

bear a high burden of communicable and noncommunicable diseases. Some Member States experienced outbreaks of diseases such as Ebola haemorrhagic fever and Rift Valley fever, and resurgence of cholera, meningococcal meningitis and yellow fever. Implementation of measles control strategies in the African Region led to 92% reduction of estimated measles deaths by the end of 2008. However, some countries faced constraints in sustaining the performance of immunization services.

6. The rapid human-to-human transmission of the Pandemic Influenza A (H1N1) Virus received all the attention it deserved. At both the fourth session of the Conference of African Ministers of Health of the African Union held in May 2009 and the Extraordinary Meeting of Ministers of Health of the Economic Community of Central African States in May 2009, Member States reaffirmed their commitment to mobilizing the resources needed to mitigate the potential impact of an influenza pandemic in Africa. The Regional Conference on Pandemic Influenza A (H1N1) 2009 held in Johannesburg in August 2009 contributed to assess the situation in the Region and provide technical guidance to strengthening the capacity of Member States to respond to the pandemic.

7. HIV/AIDS, tuberculosis and malaria remained major public health problems during the biennium. In line with the WHO Regional Committee Resolution AFR/RC55/R6 on Acceleration of HIV prevention efforts in the African Region, HIV prevention remained a major priority. Chronic noncommunicable diseases continued to be a growing public health problem. The 2009 Nairobi Call to Action for closing the implementation gap in health promotion and the 2009 Mauritius Call for Action for control of diabetes, cardiovascular diseases and other noncommunicable diseases provided opportunities to address the increasing burden of noncommunicable diseases in the Region.

8. The African Region still had the highest maternal, neonatal and under-five mortalities, estimated respectively at 900 deaths per 100 000 live births, 45 deaths per 1000 live births and 145 deaths per 1000 live births. The launch by the African Union Commission of the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA), the adoption by the Regional Committee of Resolution AFR/RC58/R1 on Women's health in the WHO African Region: A call for action, and the establishment of the Commission on Women's Health in the African Region by the Regional Director were some of the actions to address the worrying situation of maternal health.

9. The weakness of national health systems in the Region remained a matter of concern during the biennium. Member States continued to grapple with challenges related to inadequate financial and human resources and limited access to quality essential medical products and technologies including essential medicines, clinical laboratory services and diagnostic imaging services. The shortage of the health workforce continued to be most acute in the Region, with the majority of countries facing critical human resources for health (HRH) issues. In addition to the Ouagadougou Declaration, the Algiers Declaration and the Libreville Declaration, the 2008 Final Report of the WHO Commission on Social Determinants of Health has provided ideas to address some of the existing inequities in health.

10. In regard to regional priorities, the work of WHO was carried out within the framework of the 13 WHO Strategic Objectives. The main achievements are presented below by Strategic Objective.

11. SO1 Prevent and control communicable diseases: Several outbreaks were detected and effective response provided. The outbreaks included Pandemic Influenza A (H1N1) 2009, prompting significant improvements in the response capacity of the WHO Secretariat and Member States. Progress was made in routine immunization, measles control, maternal and newborn tetanus elimination, and neglected tropical diseases and yellow fever control. Measles mortality decreased by more than 90%. Leprosy was eliminated at the national level in all Member States.

12. SO2 Combat HIV/AIDS, tuberculosis and malaria: Normative tools were developed to support countries in scaling up HIV/AIDS and malaria control interventions and in applying the *Stop TB strategy*. Access to HIV/AIDS prevention, treatment and care improved and at least five countries reached the Universal Access target for prevention of mother-to-child transmission. Support was provided to countries to access TB medicines through the Global Drug Facility. The Global Fund to Fight AIDS, Tuberculosis and Malaria was the main external mechanism for securing funding for countries.

13. SO3 Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions: The Mauritius Call for Action for control of diabetes, cardiovascular diseases and other noncommunicable diseases increased the commitment of Member States to fight noncommunicable diseases including associated risk factors. The biennium saw the strengthening of the capacity of focal points from ministries of health and WHO country offices in the prevention and control of NCDs including oral-health conditions; sickle-cell-disease; violence, injury and disabilities; mental health and substance abuse problems. The first World No Noma Day was organized. By the end of

the biennium, noncommunicable diseases prevention and control had been introduced at primary care level and 35 Member States had signed the UN Convention on the Rights of Persons with Disabilities.

14. SO4 Reduce morbidity and mortality and improve health during key stages of life: WHO supported countries in adopting and implementing various key interventions for maternal and child health. Forty-three countries were implementing national Road Maps for maternal and newborn health. The African Union and WHO launched the Campaign for Accelerated Reduction of Maternal Mortality. The coverage of prevention of mother-to-child transmission (PMTCT) services increased to 45%. At the request of the Regional Committee, a Commission on Women's Health in the African Region was launched to generate evidence for improved advocacy and policy action. All countries were implementing reproductive health programmes based on the WHO reproductive health strategy.

15. SO5 Strengthen response to emergencies, disasters, crises and conflicts: The capacity of WHO to assist Member States to prepare for and respond to emergencies was strengthened, with significant improvements in the timeliness and quality of response. Adequate resources were mobilized timely for coordination of the health aspects of emergencies.

16. SO6 Promote health and development, and prevent or reduce risk factors for health: The Nairobi Call to Action for Closing the Implementation Gap in Health Promotion gave renewed impetus to disease prevention. Multisectoral teams in several countries were trained in the development of integrated health promotion interventions. Most Member States conducted surveys based on Stepwise Approach to Surveillance of Risk Factors (STEPS). A total of forty countries in the Region had ratified the Framework Convention on Tobacco Control by the end of the biennium. All Member States contributed to the preparation and completion of the second round of the Global Tobacco Control Report. Global surveys on alcohol and health were conducted in all Member States.

17. SO7 Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches: Member States were sensitized to the need for intersectoral actions for health through dissemination of relevant literature including the final Report of the Commission on Social Determinants of Health. Technical support was provided to at least 22 countries to initiate concrete action to address social

determinants of health including the development of national plans and frameworks, review of existing national policy guidelines, revision of poverty reduction plans, conduct of pilot studies on the social determinants, and training of personnel.

18. SO8 Promote a healthier environment: The First Interministerial Conference on Health and Environment was held. It adopted the Libreville Declaration on Health and Environment in Africa committing governments to implementing 11 priority actions including the establishment of a health and environment strategic alliance in order to address health and environment challenges in Africa. WHO supported at least 10 countries to conduct needs assessment reviews of national plans of joint action on health and the environment. In line with the 2008 World Health Assembly Resolution WHA61.19 on Climate Change and Health, the Regional Office prepared a framework for action to protect human health from climate variability and change within Africa.

19. SO9 Strengthen nutrition, food safety and food security: Countries were sensitized to the global food crisis. Actions for sustained salt iodization in order to address iodine deficiency were adopted by the Fifty-eighth session of the Regional Committee. Technical support was provided to 26 countries for the inclusion of nutrition, food safety and food security issues in national instruments for development; organization of national congresses on nutrition; capacity-building; development of national policies and strategies; adaptation of guidelines; development of strategic plans; implementation of activities; and evaluation of programmes. Support was also provided to countries to boost their participation in the work of Codex Alimentarius Commission.

20. SO10 Improve health services through better governance, financing, staffing and management informed by reliable, accessible evidence and research: Following the adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems and the Algiers Declaration on Research for Health in the African Region: Narrowing the knowledge gap to improve Africa's health, frameworks for their implementation were developed and disseminated to Member States. Support was provided to 27 countries for various aspects of health systems strengthening including the development of national policies and essential health packages, sustainable health financing, capacity-building and district and community-based services. Seven countries were supported to revise their national strategic plans. Thus, by the end of the biennium, 44 countries had developed or revised their national health strategic plans. The development of the African Health Observatory was initiated during the biennium. Nine countries were supported in enhancing their use of evidence for policy and decision by producing policy briefs based on a systematic review of the evidence on wider use of artemisinin-based combination

therapies. The Guide for Documenting and Sharing Best Practices in Health Programmes was published. The Regional Office continued to expand access to scientific and health literature through Access to Research Information initiative and the Blue Trunk Library.

21. SO11 Ensure improved access, quality and use of medical products and technologies:

Regional training courses were organized on the use of social health insurance schemes to expand the coverage of essential medicines, health technology management, biosafety and laboratory biosecurity, and screening of donated blood. Regional guidelines for the formulation, implementation, monitoring and evaluation of national medicine policies were revised. A report on the mid-term review of the decade of African Traditional Medicine (2001–2010) was issued. Support was provided to 15 countries for revision of essential medicines lists, capacity building, rational use of medicines, establishment of quality assurance systems, and assessments of programmes. In collaboration with the Centers for Disease Control and Prevention (CDC), a *"Guide for National Public Health Laboratory Network to Strengthen Integrated Disease Surveillance and Response"* was published.

22. SO12 Provide leadership, strengthen governance and foster partnership:

In accordance with the existing WHO policies and strategies, in particular the Strategic Orientations for WHO Action in the African Region, 2005–2009, partnerships were fostered with bilateral and multilateral bodies, with particular emphasis on UN Agencies through increased role of WHO in HHA and UNDG/Africa, the African Union, NEPAD, United Nations Economic Commission for Africa and Regional Economic Communities, NGOs, civil society and the private sector. This has resulted in ensuring WHO leadership in health matters with focus on country level, taking into account Aid Effectiveness in the context of the Paris Declaration. The Regional Office worked proactively towards advancing the agenda of UN Reform by hosting four out of the eight "Delivery as One" pilot countries, and a number of self starters. Focus is now placed on supporting the roll out and implementation of UNDAF.

23. SO13 Develop and sustain WHO as a flexible, learning organization:

To further improve the efficiency and effectiveness of the work of WHO in the African Region, and in line with the required change management for GSM, briefing sessions were organized for staff capacity building. Among others, these actions resulted in increased GSM awareness among staff in the Region; greater conformity with the planning, performance monitoring and reporting processes; marked improvement in the submission of financial reports by WHO country offices; consolidation of the regional in-service training learning network, and improved staff awareness of security matters on the field. In the area of

Information and Communication Technology (ICT), the entire Region was ready for GSM with the installation of a new computer and telephone network, standardized desktop personal computers, improved security of Information Technology (IT), and improved management of the Global Private Network (GPN) traffic. Effective administrative and logistic support as well as translation, interpretation, printing and language services were provided for more than 80 meetings including the Fifty-eighth and Fifty-ninth sessions of the Regional Committee.

24. The key lessons learnt during implementation of the Programme Budget 2008-2009 included the following: (i) making progress in delivering on global and regional commitments requires accelerated and scaled-up actions by Member States; (ii) country ownership, good governance and multisectoral collaboration are required for effective planning and delivery of interventions and services; (iii) financial resources, team work and well-trained and motivated health care workers facilitate implementation; (iv) the changing global landscape requires that WHO focus on its core functions and forge strategic partnerships; (v) WHO continuing dependence on voluntary contributions from donors needs to be addressed by identifying sustainable and predictable financial sources; and (vi) the presence of competent technical staff in WHO is critical for continuing WHO leadership.

25. Several priority areas that would require urgent action were identified. This underscored the need for WHO to position itself in the best way to perform its core functions in a more efficient and effective manner, focusing on the following strategic directions:

- (i) Continued focus on WHO's leadership role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization;
- (ii) Supporting the strengthening of health systems based on the primary health care approach;
- (iii) Putting the health of mothers and children first;
- (iv) Accelerated actions on HIV/AIDS, malaria and tuberculosis;
- (v) Intensifying the prevention and control of communicable and noncommunicable diseases;
- (vi) Accelerating response to the determinants of health.

26. The annexes provide information on the statement of Strategic Objectives and budget distribution by Strategic Objective and source of funds.

1. INTRODUCTION

1. The 2008-2009 biennium was the second biennium in the implementation of the WHO global health agenda as defined in the 11th General Programme of Work 2006–2015. It was the first biennium of implementation of the WHO Medium Term Strategic Plan (MTSP) that sets out the WHO strategic directions for the period 2008–2013. The MTSP is based on the WHO results-based management framework with a new budget structure.

2. The last year of the biennium marked the end of the first term of office of Dr Luis Gomes Sambo as WHO Regional Director and saw the publication of the *Strategic Orientations for WHO Action in the African Region (2005–2009): an Account of the Past five Years*. The same year also saw the re-election of the Regional Director for a second term during the Fifty-ninth session of the Regional Committee.

3. The Regional Director reports annually on the work of WHO in the African Region. This report, *The Work of WHO in the African Region 2008-2009: Biennial Report of the Regional Director*, has been prepared for submission to the Sixtieth session of the WHO Regional Committee for Africa.

4. In carrying out its core functions, the Secretariat, through its technical cooperation with Member States and partners, contributes to addressing priority health problems in the WHO African Region. This report provides a comprehensive update on the achievements and progress during the 2008-2009 biennium, assesses ongoing challenges and progress towards international health goals and presents priority actions for the future.

5. The report is structured as follows:

Chapter 1: provides a background to, and outlines the objectives of, the report.

Chapter 2: describes the context within which the Programme Budget 2008-2009 was implemented.

Chapter 3: presents the priorities of the biennium and the related planned resources.

Chapter 4: reports on achievements at both regional and country levels in addressing health priorities for each of the 13 Strategic Objectives including the implementation of relevant resolutions of the WHO Regional Committee.

Chapter 5: presents a summary of the challenges, constraints and lessons learnt during the reporting period.

Chapter 6: presents the conclusion of the report.

6. The annexes provide tables containing statement of the 13 Strategic Objectives and the approved Programme Budget allocation.

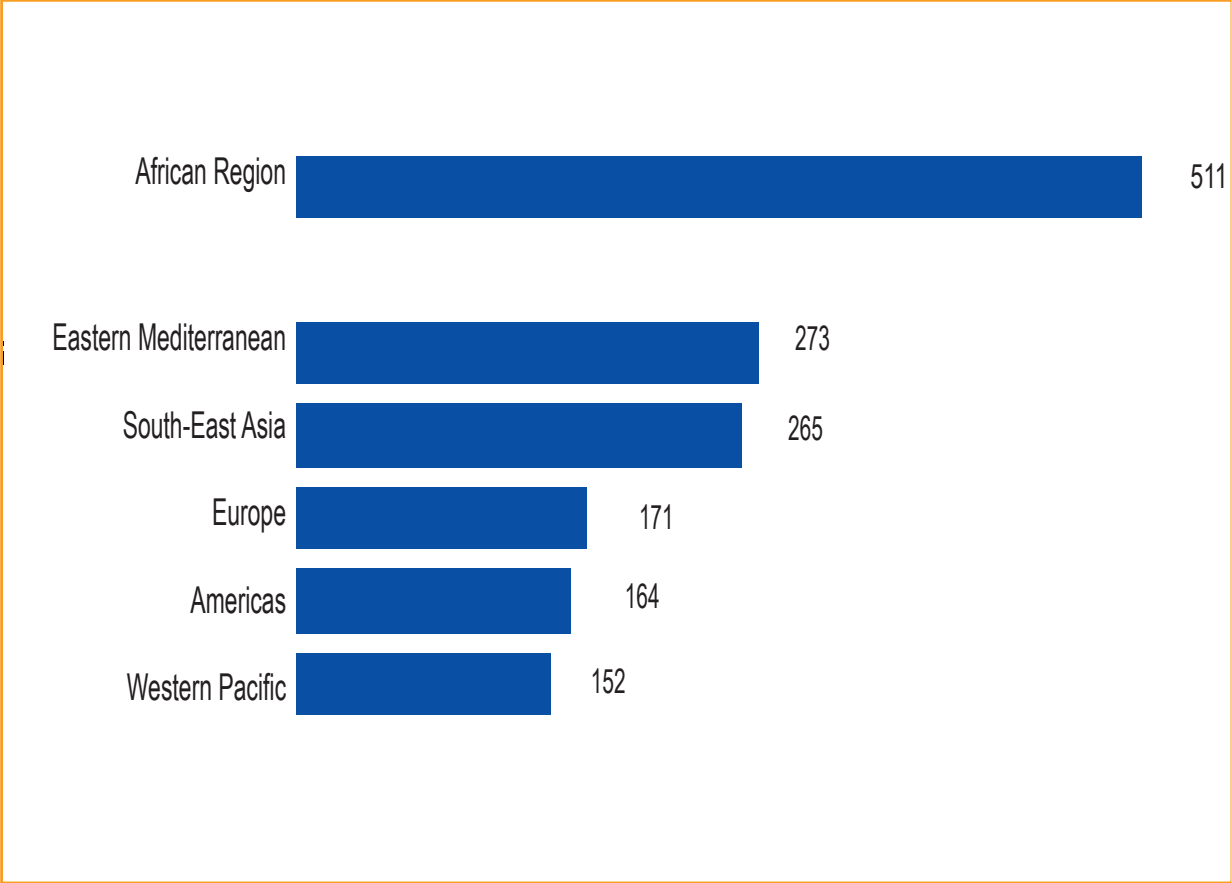
2. CONTEXT

7. The work of WHO in the African Region during the 2008-2009 biennium was carried out in the framework of the 11th General Programme of Work 2006–2015 and the Medium Term Strategic Plan 2008–2013. WHO’s work continued to be guided by global commitments such as the Millennium Declaration of 2000, the International Health Regulations (2005), and the 2006 commitment to ensuring universal access to HIV prevention, treatment, care and support services by 2010. Also considered were regional commitments to health development such as the 2001 Abuja Declaration calling for allocation of 15% of national budget to the health sector; the 2006 commitment to ensuring universal access to quality health care and a healthier future for the African people, made at the International Conference on Community Health; and the 2009 Nairobi Call to Action for closing the implementation gap in health promotion.

8. The 2008-2009 biennium witnessed the celebration the 60th anniversary of WHO and the 30th anniversary of the Alma-Ata Declaration on Primary Health Care. *The World Health Report 2008* and the World Health Assembly Resolution WHA 62.12 on Primary Health Care reaffirmed the values and principles of the Alma Ata Declaration as central to health development. At the regional level, the adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium and its endorsement by the Regional Committee for Africa in 2008 underscored the relevance of the declaration in addressing the health priorities of the Region. The Algiers Declaration on Research for Health in the African Region: *Narrowing the knowledge gap to improve Africa’s health* adopted in June 2008 and the Libreville Declaration on Health and Environment adopted in August 2008 also underscored the need to strengthen health systems for better health outcomes.

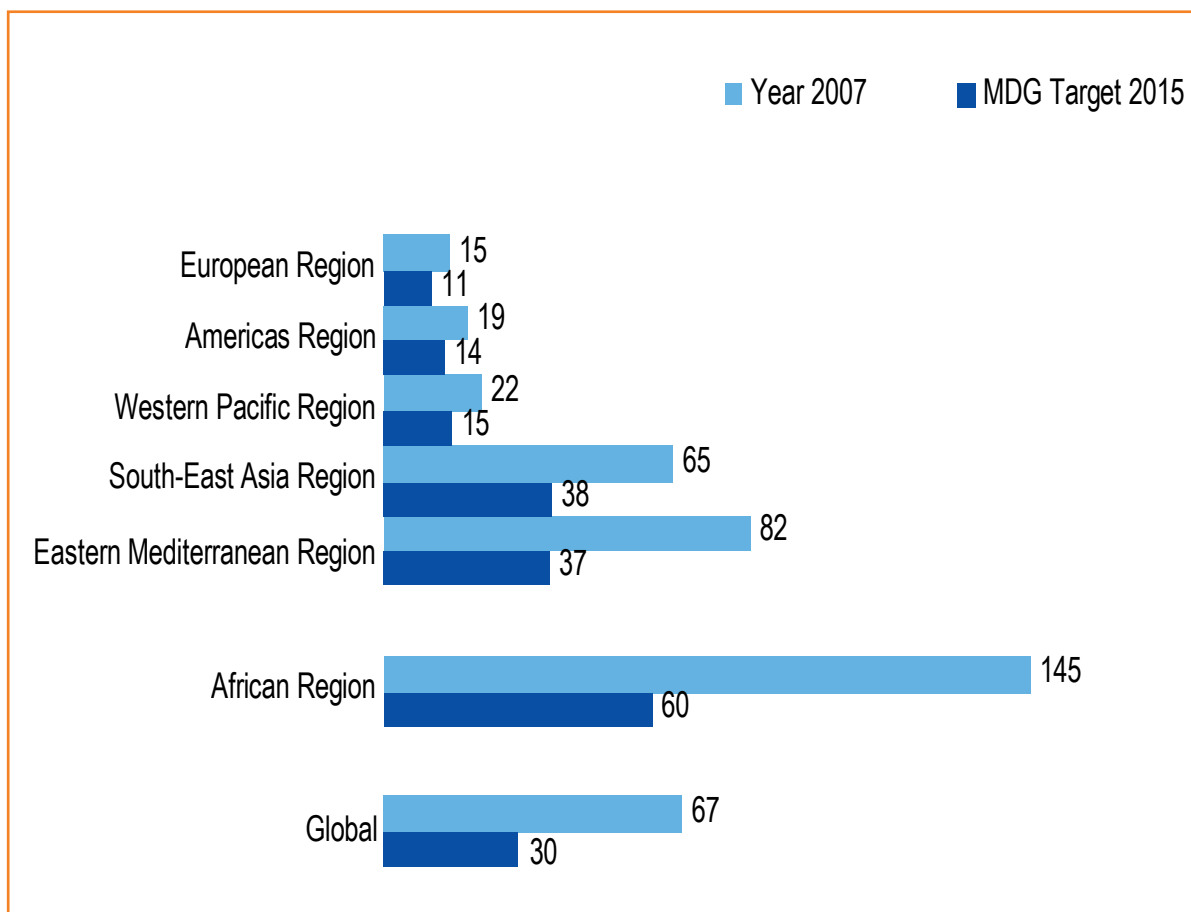
9. During the biennium the health situation continued to be a concern. WHO estimates that the global burden of disease, as measured by the loss of disability-adjusted life years (DALYs) per 1000 persons, was heaviest in sub-Saharan Africa, with 538 DALYs, compared with 190 DALYs in Latin America and the Caribbean, 387 DALYs in Asia, and 277 DALYs in the Eastern Mediterranean. Most countries in the African Region could not make sufficient progress towards achieving the targets of the Millennium Development Goals (see Figures 1 and 2).

FIGURE 1: TOTAL BURDEN OF DISEASE (DALYS PER 1000 POPULATION), 2004



Source: WHO, Burden of diseases Report 2008

FIGURE 2: UNDER-FIVE MORTALITY RATE (BOTH SEXES) PER 1000 LIVE BIRTHS



Source: WHO, Burden of diseases Report 2008

10. The Region continued to bear a high burden of communicable and noncommunicable diseases. Member States still experienced outbreaks of diseases such as Ebola haemorrhagic fever and Rift Valley fever and resurgence of cholera, meningococcal meningitis and yellow fever. By December 2009, the Region had reported 672 cases of wild poliovirus. Although this represented a decrease over the same period in 2008 due to over 90% reduction in wild poliovirus type 1 in Nigeria, there was nonetheless an increase in the number of countries reporting wild poliovirus cases mainly in West Africa. Implementation of measles control strategies in the African Region led to 92% reduction in estimated measles deaths between 2000 and 2008. However, some countries faced constraints in sustaining the performance of immunization services. The prevalence of lymphatic filariasis and guinea-worm disease decreased substantially and leprosy was eliminated at national level in all the 46 Member States. However, the Region still faced low coverage of interventions in rural areas and non-availability of appropriate medicines.

11. The rapid human-to-human transmission of Pandemic Influenza A (H1N1) Virus received the required attention. At both the fourth session of the Conference of African Ministers of Health of the African Union held in May 2009 and the Extraordinary Meeting of the Health Ministers of the Economic Community of Central African States in May 2009, Member States reaffirmed their commitment to mobilize the resources needed to mitigate the potential impact of an influenza pandemic in Africa. By the end of December 2009, 17 119 laboratory-confirmed cases had been reported from 33 of the 46 Member States with 166 deaths. The Regional Conference on Pandemic Influenza A (H1N1) 2009 held in Johannesburg in August 2009 contributed to strengthening the capacity of Member States to respond to Pandemic Influenza A (H1N1) 2009. The adoption by the Fifty-ninth session of the Regional Committee of a resolution on Strengthening outbreak preparedness and response in the African Region in the context of the current influenza pandemic and another resolution for the creation of an African Public Health Emergency Fund will contribute to strengthen epidemic preparedness and response.

12. HIV/AIDS, tuberculosis and malaria remained major public health problems during the biennium. Sub-Saharan Africa accounts for just 10% of the world population but has more than 60% of the global burden of HIV, TB and malaria. On average, 35% of tuberculosis cases in the Region are co-infected with HIV, and tuberculosis accounts for approximately 40% of deaths in people living with HIV/AIDS. In line with the Regional Committee Resolution AFR/RC55/R6 on Acceleration of HIV prevention efforts in the African Region, HIV prevention remained a major priority. During the biennium, scaling up male circumcision in combination with other HIV prevention interventions were given increased attention. Despite improvements in access to treatment, positive outcomes were hampered by the emergence of drug-resistance to HIV, TB and malaria.

13. By the end of the biennium, more than 25 countries had reported MDR-TB cases, and more than five countries had reported at least one case of XDR-TB. As countries scale up implementation of ACTs, resistance to ACT medicines has emerged in south-east Asia. This worrying situation prompted the Fifty-ninth session of the Regional Committee to adopt a resolution on Drug resistance related to AIDS, tuberculosis and malaria. The Regional Committee also observed that with high coverage of a comprehensive package of malaria prevention and control interventions, a rapid decline in malaria burden was possible and offered hope for malaria elimination. The Regional Committee passed a resolution to that end.

14. Chronic noncommunicable diseases continued to be a growing public health problem with Member States such as Algeria, Cape Verde, Mauritius and Seychelles already experiencing an epidemiological transition from communicable diseases to an increasing burden of noncommunicable diseases. The debilitating conditions and threatening complications associated with noncommunicable diseases such as blindness, renal failure, amputation of lower limb, hemiplegic conditions, myocardial infarction, violence and trauma, mental disorders and death are growing in the Region. There is growing evidence of the high prevalence of common risk factors such as unhealthy diet, lack of physical activity, hypertension, tobacco use and alcohol consumption. The 2009 Nairobi Call to Action for closing the implementation gap in health promotion and the 2009 Mauritius Call for Action for control of diabetes, cardiovascular diseases and other noncommunicable diseases provide frameworks for efforts to effectively reduce the burden of diabetes, cardiovascular diseases and other noncommunicable diseases in the Region.

15. The African Region has the highest maternal mortality in the world estimated at 900 deaths per 100 000 live births. It has also neonatal and under-five mortalities estimated at 45 deaths per 1000 live births and 145 deaths per 1000 live births, respectively. Infections, perinatal conditions, unsafe abortion, unwanted pregnancies, sexually transmitted infections including HIV/AIDS are among the most pressing sexual and reproductive health issues in Africa. Contraceptive prevalence among married women is very low (13%) while fertility rate is very high, estimated at 5.5 per woman. Cervical cancer accounts for 22% of cancer deaths. The launch of the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) by the African Union Commission and the adoption by the Fifty-eighth session of the Regional Committee of a resolution urging the establishment of the Commission on Women's Health in the African Region gave renewed impetus to efforts to address the worrying maternal and child health situation in the Region.

16. During the biennium, all countries of the Region reported at least one emergency. These included natural and man-made disasters such as floods, droughts, disease outbreaks and conflicts. There were 11.6 million Internally Displaced Persons (IDPs)¹ and 2.1 million refugees² in Africa in 2008³ as a result of conflicts and social unrest. In the Horn of Africa, 23 million people required humanitarian food assistance and more than 4.5 million children under five years were affected by acute malnutrition. In 2009 alone, floods occurred in 26 countries affecting over 1.5 million people.

17. The African Region is still exposed to health hazards resulting from known risk factors such as limited access to safe drinking water, inadequate sanitation, indoor and outdoor air pollution, lack of food hygiene, inadequate waste disposal, absent or unsafe disease vector control, exposure to chemicals, and injuries. In addition, the Region faces new and emerging environmental hazards to public health including climate change and persistent organic pollutants, electronic wastes, radiation and new occupational risks. During the First Interministerial Conference on Health and Environment in Africa in August 2008, Member States adopted the Libreville Declaration on Health and Environment in Africa, committing themselves to addressing health and environment challenges in their countries.

18. Globally, maternal and child undernutrition is the underlying cause of 3-5 million deaths and 35% of the disease burden in children younger than five years.⁴ Twenty-three of the 40 countries with child stunting prevalence of 40% or more are in Africa. This is due to low rate of exclusive breastfeeding and inadequate and inappropriate complementary foods. Contaminated complementary foods and water cause up to five episodes of diarrhoea per child per year. During the biennium, a high number of outbreaks of foodborne diseases were reported including cholera, anthrax, typhoid fever, chemical poisoning from vegetables, mushrooms, seed beans and maize, diarrhea, Botulism and Hepatitis A.

19. The weakness of national health systems in the Region remained a concern during the biennium. Member States continued to grapple with challenges related to inadequate financial and human resources and limited access to good quality essential medical products and technologies including essential medicines, traditional medicines, clinical laboratory services and diagnostic imaging services. The shortages of the health workforce continued to be most acute in the Region, with the majority of countries facing critical human resources for health (HRH) issues. The biennium saw renewed commitment to using Primary Health Care (PHC) as an approach to strengthening health systems in order to contribute to the attainment of health-related Millennium Development Goals (MDGs). The adoption of the Algiers Declaration also provided a framework for narrowing the knowledge gap in order to improve health in the Region. The 2008 Final Report of the WHO Commission on Social Determinants of Health has provided an opportunity to address some of the existing inequities in health.

20. During the biennium, the WHO Secretariat took decisive action to consolidate its leadership in health at international level, improving its governance, consolidating the implementation of its decentralization policy and reinforcing health partnerships. The

adoption of landmark declarations renewing the commitment of governments, WHO and partners to improving health outcomes in the Region was vital. The strengthening of the Inter-country Support Teams (IST) enhanced the capacity of WHO to provide technical support to countries. The Regional Office continued to focus its roles on policy and strategy development, planning and budgeting, monitoring and evaluation, generation and sharing of information and evidence. WHO country offices continued to influence the development of national health policies and strategic plans while advocating for the resources and interventions shifting the focus of ministries of health from the central level to the local level.

21. Efforts to develop and sustain WHO as a flexible and learning organization, enabling it to carry out its mandate more efficiently and effectively continued during the biennium. Partial deployment of the Global Management System (GSM) in the Region was initiated. The GSM, which is WHO's Enterprise Resource Planning (ERP) system, is based on information technology and enables data entry, collation and production in order to enhance management and efficiency in WHO. The Regional Office entered the transitional period in July 2008. Preparations for the full deployment of GSM continued with the installation and deployment of a new information technology (IT) infrastructure, the dissemination of revised and user-friendly tools and the organization of GSM briefing workshops.

22. In conclusion, the health status of people in the African Region continues to be unacceptable mostly due to low coverage of and limited access to health care, and adverse influence of broader determinants that are beyond the control of the health sector. There are cost-effective and proven interventions which, if fully implemented, would reverse the worrying trends in health status in the Region. It is the collective responsibility of all to ensure that the people of Africa have access to these essential interventions. Through implementing the Programme Budget 2008-2009, WHO in the African Region addressed country priorities by performing its core functions.

3. THE PROGRAMME BUDGET 2008-2009

23. The WHO Programme Budget 2008-2009 was adopted by Member States at the Sixtieth session of the World Health Assembly in May 2007. In the WHO African Region, specific orientations for the implementation of the Programme Budget (PB) in the Region were approved by Member States at the Fifty-seventh session of the Regional Committee in August 2007.

24. As defined in the WHO managerial framework, the principles of results-based management guided the development of the Programme-Budget 2008-2009. Its content was structured according to the 13 Strategic Objectives (Annex 1) of the WHO Medium Term Strategic Plan (2008–2013) to address global health challenges. The individual strategic objectives should not be viewed in isolation from one another as they reflect WHO's different but interdependent actions for realizing the "agenda for action".

25. Within the context of the WHO Organization-Wide Expected Results and the related targets for the biennium, the WHO Secretariat in the African Region defined its Regional Expected Results identifying the scope of activities and specifying achievements expected in the two-year period. WHO Divisions and Country Offices in the African Region defined Office-Specific Expected Results which provided clear, measurable and budgeted expected results, reflecting specific priorities and workplans to be implemented.

26. For the 13 Strategic Objectives, the approved WHO global budget was US\$ 4 227 480 000. The African Region received US\$ 1 193 940 000 representing a proportion of 28.2%, which was in line with the validation mechanism of the principles of strategic financial resource allocation.⁵ In terms of source of financing, US\$ 213 342 000 (18%) was planned to be provided by assessed contributions (AC) and US\$ 980 598 000 (82%) by voluntary contributions (VC).

27. The initial allocation of the regional budget to WHO Country Offices (WCOs) and the Regional Office, as approved by Member States, was 51% for WCOs and 49% for the Regional Office including the Inter-country Support Teams. Since the allocation to Inter-country Support Teams were earmarked to be spent in countries, the proportion of the total amount devoted to WCOs was actually 66%. The balance of 34% constituted the real portion that was planned to be spent at the Regional Office.

28. The level of implementation of the approved budget is presented by Strategic Objective (Figure 3), according to the structure of the WHO Medium Term Strategic Plan.

FIGURE 3: APPROVED BUDGET (IN US\$ 000S) AND IMPLEMENTATION RATES
BY STRATEGIC OBJECTIVE AS OF 31 DECEMBER 2009

Strategic Objective N° *	Total approved budget (1)	Total available Funds (2)	% of available Funds (2) / (1)	Total Obligations (3)	Budget Implementation Rate (3) / (2)
1	316 203	530 988	168	489 571	92
2	242 912	120 376	50	109 780	91
3	20 723	14 311	69	13 855	97
4	115 695	57 783	50	55 331	96
5	66 021	94 280	143	87 522	93
6	25 566	14 973	59	14 494	97
7	9 116	8 083	89	8 071	100
8	18 749	10 743	57	9 611	89
9	39 778	8 130	20	7 598	93
10	142 093	57 386	40	51 785	90
11	22 592	20 641	91	19 147	93
12	48 966	45 203	92	44 967	99
13	125 526	102 667	82	102 450	100
Total	1 193 940	1 085 564	91	1 014 182	93

*Annex 1

Source: WHO/AFRO, PB 2008 – 2009: End of Biennium Performance Assessment

29. Overall, in the African Region, the total approved budget for the biennium was US\$ 1.194 billion out of which US\$ 606.357 million (51%) was allocated for use in country offices while US\$ 587.583 million was allocated to the Regional Office including the three Intercountry Support Teams. The breakdown by Strategic Objective is presented in Annex 2.

30. Out of the total approved budget of US\$ 1.194 billion, US\$ 1.086 billion (91%) was made available for the implementation of the Programme Budget in the African Region (Figure 3). From this amount, US\$ 1.014 billion was spent during the biennium, corresponding to a budget implementation rate of 93% as compared to funds that were made available. It is important to note that expenditures related to administrative and support functions of the WHO Secretariat under Strategic Objectives 12 and 13 consumed only 14.5 % of total obligations.

31. With regard to the corporate commitment of the Organization to finance the Programme Budget 2008-2009 in the African Region, large variations across the 13 Strategic Objectives were observed. Funds mobilized and made available for Strategic Objectives 1 and 5 were beyond expectation due to the strong commitment of donors to polio eradication and the aggressive fund-raising mechanisms put in place to face up to emergencies and crises in the Region.

32. For nine other Strategic Objectives, the budget funding outcomes were satisfactory with at least 50% of the approved budget being funded. The remaining two Strategic Objectives (SOs 9 and 10) experienced difficulties in fund raising as funds available to finance the approved budget did not reach 50%. This unbalanced situation across SOs reflects the inconsistency between the regional priorities and WHO's corporate efforts in regard to resource mobilization.

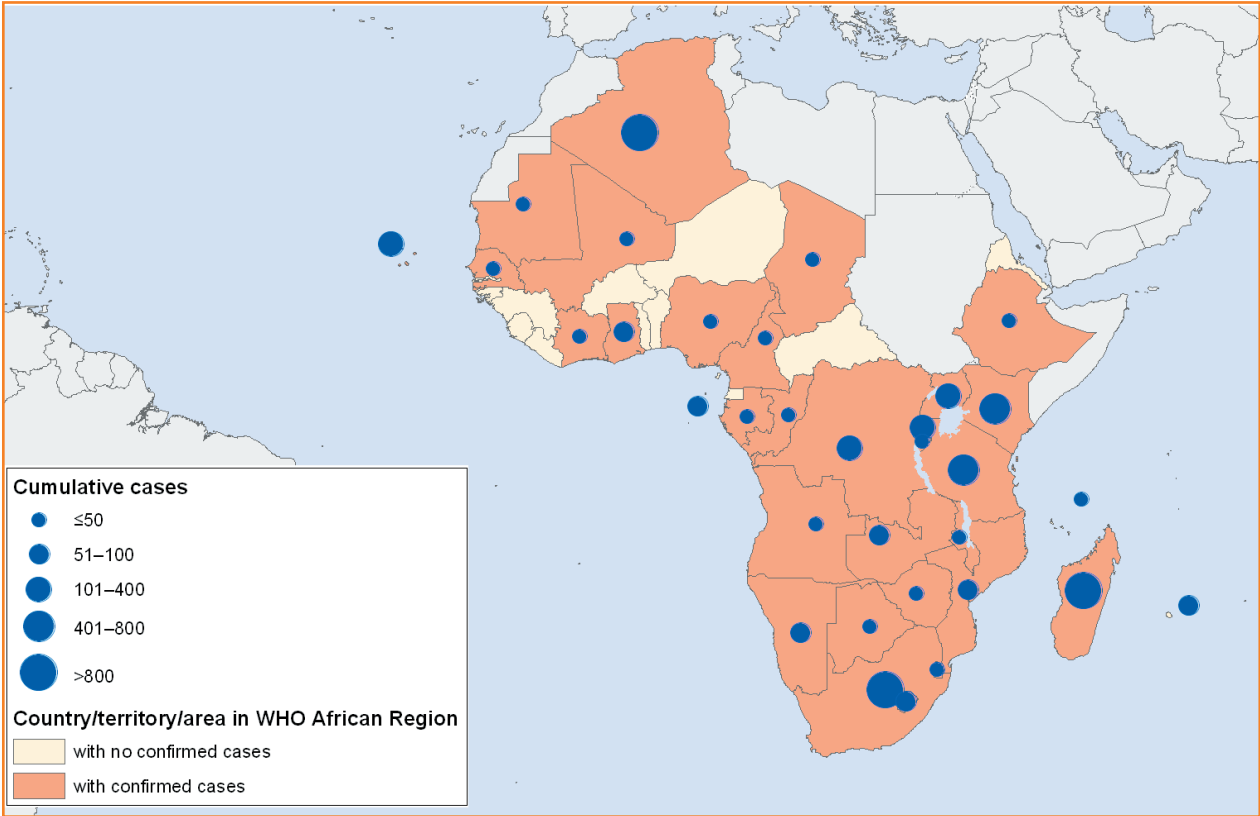
4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE

4.1 SO1: COMMUNICABLE DISEASES

33. One major focus in the prevention and control of communicable diseases during the biennium was early detection of outbreaks of infectious diseases through early warning and alert systems, enhanced public health function of laboratories, and integrated surveillance. Work was guided by related resolutions on global health security; epidemic alert and response; revision of the International Health Regulations; integrated disease surveillance and response; and strengthening outbreak preparedness and response in the context of the current pandemic influenza.

34. The biennium saw the emergence of Pandemic Influenza A (H1N1) 2009. The first laboratory-confirmed case of the pandemic influenza in the Region was reported by South Africa in June 2009. By the end of December 2009, 33 of the 46 countries in the Region had reported 17 119 laboratory-confirmed cases and ensuing 166 deaths (Figure 4). Laboratory confirmation is not recommended for all suspected cases of pandemic influenza A (H1N1). Thus the reported cases do not actually reflect the total number of cases.

FIGURE 4: DISTRIBUTION OF REPORTED LABORATORY-CONFIRMED CASES OF PANDEMIC INFLUENZA A (H1N1) 2009 IN THE WHO AFRICAN REGION, DECEMBER 2009



Source: Analysis of Pandemic Influenza A (H1N1) 2009 data submitted to the Regional Office by Member States; available on: <http://www.afro.who.int/en/pandemic-influenza-h1n1-2009/situation-updates.html>

35. In response to the pandemic, the WHO Secretariat created a multidisciplinary Crisis Management Team to coordinate response activities in the Region. Similar coordination structures were established at the Intercountry Support locations and in countries. Technical support was provided to Member States to update their national Influenza Preparedness and Response Plans in order to address the pandemic more effectively. Contingency funds totalling US\$ 2.3 million were disbursed, and health promotion materials, 300 sets of personal protective equipment, and more than 1 million treatment

courses of antiviral medicines (Tamiflu) were distributed to countries. In addition, 600 000 tablets of Tamiflu were prepositioned in Dubai for immediate dispatch to countries when required.

36. In order to improve the capacity of the Region to confirm cases of Influenza A (H1N1) 2009, 19 of the 22 influenza laboratories in the Region were equipped with Real-Time Polymerase Chain Reaction (PCR) materials and laboratory personnel trained in influenza specimen handling and diagnosis. All 46 Member States were provided with specimen collection and transport materials for use during the pandemic.

37. A Regional Conference on Pandemic Influenza A (H1N1) 2009 was convened in Johannesburg in August 2009. The Conference underscored the need for intensification of communication and social mobilization, improvement in case management, strengthening of surveillance, and improved availability of medicines and personal protective equipment. Furthermore, it contributed to the updating of Pandemic Influenza Preparedness and Response Plans by Member States.

38. In addressing other major epidemic-prone diseases during the biennium, 18 countries were supported to develop comprehensive epidemic preparedness and response plans while 21 countries were supported to update their meningitis plans. Support was provided to countries for the revision of standard operating procedures for meningitis, yellow fever, viral hemorrhagic fevers and plague. In response to cholera epidemics, technical guidelines, rapid diagnostic tests and cholera kits were provided to the affected countries.

39. In addition, 200 000 sets of personal protective equipment, 32 field dispensary tents and six sets of radio communication equipment were prepositioned in the ISTs as part of logistical support. Technical and financial support was provided for investigation, management and control of typhoid fever in Malawi and Mozambique, Ebola virus disease in the Democratic Republic of Congo, Arena virus in South Africa and Zambia, and Dengue fever in Cape Verde, Mauritius and Senegal.

40. Considering the occurrence and continuing threat of disease outbreaks in the Region and the need to make resources readily available for emergency response, the Fifty-ninth session of WHO Regional Committee for Africa adopted a resolution for establishing the African Public Health Emergency Fund. The Fund is expected to help address the huge funding gap in the WHO Programme Budget.

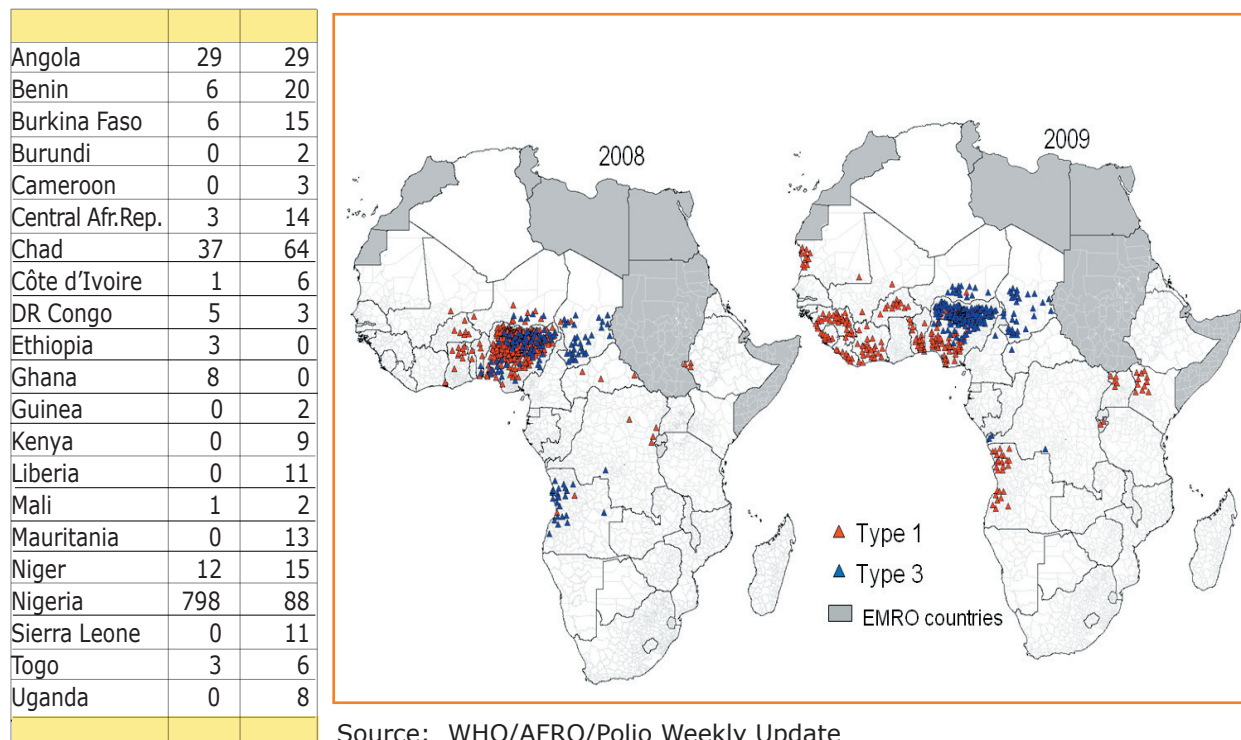
41. With regard to routine immunization, by December 2009, 15 Member States⁶ had reported at least 90% coverage of Diphtheria-Pertussis-Tetanus vaccine (DPT3) at national level. As of December 2009, 45 and 43 Member States had introduced Hepatitis B vaccine and *Haemophilus Influenza* type B (Hib) vaccine respectively in their routine immunization schedules. Gambia, Rwanda and South Africa introduced Pneumococcal conjugate vaccine.

42. Twenty-six Member States⁷ attained more than 80% coverage with measles vaccination and the African Region attained 92% reduction in measles mortality in the year 2008. In addition, all countries in the African Region updated their maternal and neonatal tetanus elimination (MNTE) plans and 21 countries implemented 59 rounds of Tetanus Toxoid supplementary immunization (SIAs) in high-risk districts targeting 60.1 million women of childbearing age. Maternal and neonatal tetanus elimination was validated in 14 countries.⁸

43. Twenty-three of the 31 countries at risk of yellow fever introduced yellow fever vaccine in their routine Expanded Programmes on Immunization (EPI), achieving a mean coverage of 73%. Preventive vaccination campaigns were conducted in 282 high-risk districts in nine countries.⁹

44. Concerning polio eradication, by the end of 2009, the Region had experienced a decrease in the total number of cases of wild poliovirus (WPV) reported with 691 cases in 2009 compared to 912 in 2008 (Figure 5). However, the number of countries reporting wild poliovirus cases increased from 13¹⁰ to 19. Eleven out of the 19 countries are in West Africa.¹¹ The decrease in the total number of reported cases of wild poliovirus was due to the over 90% reduction in wild poliovirus type 1 cases in Nigeria.

FIGURE 5: WILD POLIOVIRUS CASE DISTRIBUTION IN THE WHO AFRICAN REGION, 2008 AND 2009



45. In response to the polio outbreaks, multiple synchronized Supplementary Immunization Activities were implemented in 2009 in 24 countries,¹² administering oral polio vaccine to over 138 million children in the Region. High quality acute flaccid paralysis (AFP) surveillance was maintained in the Region with 38¹³ out of 46 countries achieving polio eradication certification standard in 2009. However, significant subnational surveillance gaps persist in some countries.

46. During the biennium, the Africa Regional Certification Commission, a body set up primarily to certify polio-free status of countries in the Region, had reviewed and accepted 25¹⁴ complete country documentations. However, by the end of the biennium, ten¹⁵ of the countries had been re-infected by the recent spread of wild polioviruses.

47. Neglected tropical diseases (NTDs) were a major cause of ill health in the African Region during the biennium. By the end of 2009, 16 countries¹⁶ were implementing an integrated neglected tropical disease control programme targeting leprosy, guinea-worm disease (dracunculiasis), and Human African Trypanosomiasis. Mapping of NTDs was done in 26 countries¹⁷ and partially implemented in 11 countries.¹⁸ Integrated mass drug administration for the treatment of lymphatic filariasis, schistosomiasis and soil-

transmitted helminthiasis was conducted in endemic areas of 17 countries,¹⁹ benefiting 56 million people. Progress was made in the guinea-worm disease eradication programme and the Region is on track to eradicate the disease by 2015.

48. By the end of the biennium, leprosy had been eliminated at the national level by all Member States. The elimination of leprosy at the subnational level was achieved in four countries.²⁰ A 10% reduction of reported cases of Human African Trypanosomiasis was recorded during the biennium. More than 2.5 million people were actively surveyed in the 35 endemic countries with 10 215 cases of *T. b. gambiense* being confirmed. Efforts were made to improve access to treatment with the adoption of Nifurtimox and Eflornithine combination therapy (NECT) to treat second stage of *T. b. gambiense* sleeping sickness.

49. Forty-four Member States were implementing the Integrated Disease Surveillance (IDS) strategy in the African Region during the biennium. The Integrated Disease Surveillance and Response (IDSR) technical guidelines were revised taking into account the International Health Regulations 2005 and other priority diseases. Subsequently, support was provided to 23 Member States²¹ to adapt their core IDSR tools. A guideline for strengthening National Public Health Laboratory Networks was developed and disseminated to all Member States. By the end of 2009, 77 laboratories from 46 countries were participating in the microbiology external quality assurance programme.

50. Tools for assessing core capacities to implement the International Health Regulations 2005 were developed, field-tested and disseminated to all countries. Fourteen countries assessed one or more of the national core capacities in surveillance and developed implementation plans. Eight countries²² conducted an in-depth assessment using the International Health Regulations tools. Training in IHR assessment was held for 26 potential consultants who could be mobilized to support countries in IHR implementation. Twenty-five communication experts were trained and made available for risk communication support in countries. An IHR communication plan was developed and disseminated for use in countries.

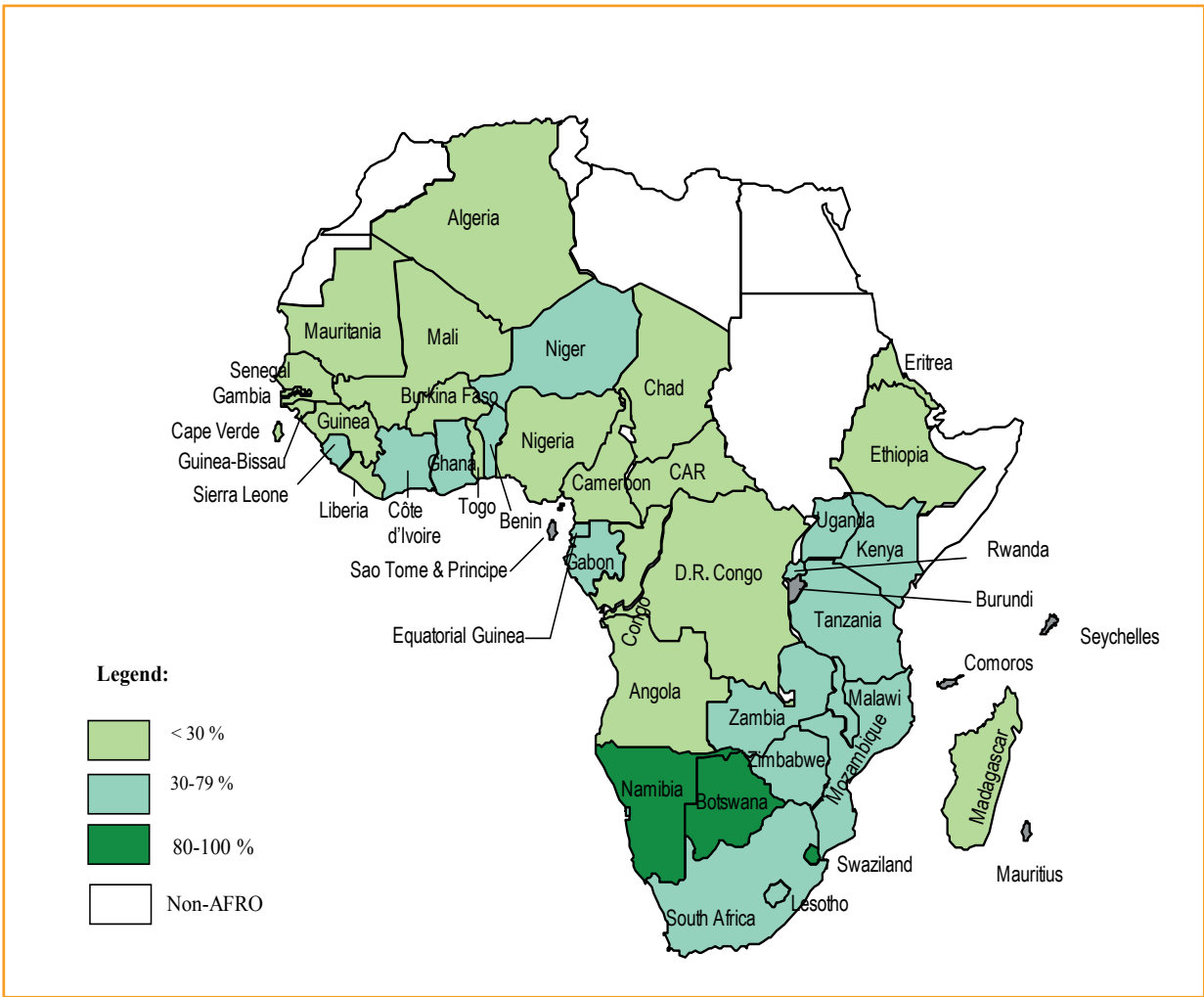
4.2 SO2: HIV/AIDS, TUBERCULOSIS AND MALARIA

51. The strategy adopted during the biennium was to contribute to a reduction of the disease burden due to HIV/AIDS, tuberculosis and malaria in countries of the WHO African Region through the provision of normative guidance and technical support for scaling up

the implementation of cost-effective interventions within the context of primary health care in order to ensure Universal Access (UA).

52. There was an improvement in the HIV/AIDS monitoring mechanism in all countries during the biennium. Data were gathered from 44 out of the 46 countries in the Region on progress in HIV prevention, treatment and care and were published by WHO, UNAIDS and UNICEF in the Universal Access report.²³ By the end of the biennium, there was a 15% reduction in the number of new HIV infections in the Region as compared to the situation in 2001.²⁴ At the end of 2008, there were more than 16 000 health facilities providing HIV testing and counselling in the Region, representing an increase of about 10% in one year which in turn improved access to HIV Testing and Counselling (HTC) services in the Region. The proportion of HIV-infected pregnant women accessing antiretroviral drugs to prevent mother-to-child transmission (PMTCT) increased from 35% in 2007 to 45% by the end of 2008. Four countries²⁶ reached the UA target for PMTCT (Figure 6).

FIGURE 6: PROPORTION OF HIV-INFECTED PREGNANT WOMEN ACCESSING ARVs FOR PMTCT PURPOSES IN THE AFRICAN REGION, DECEMBER 2008

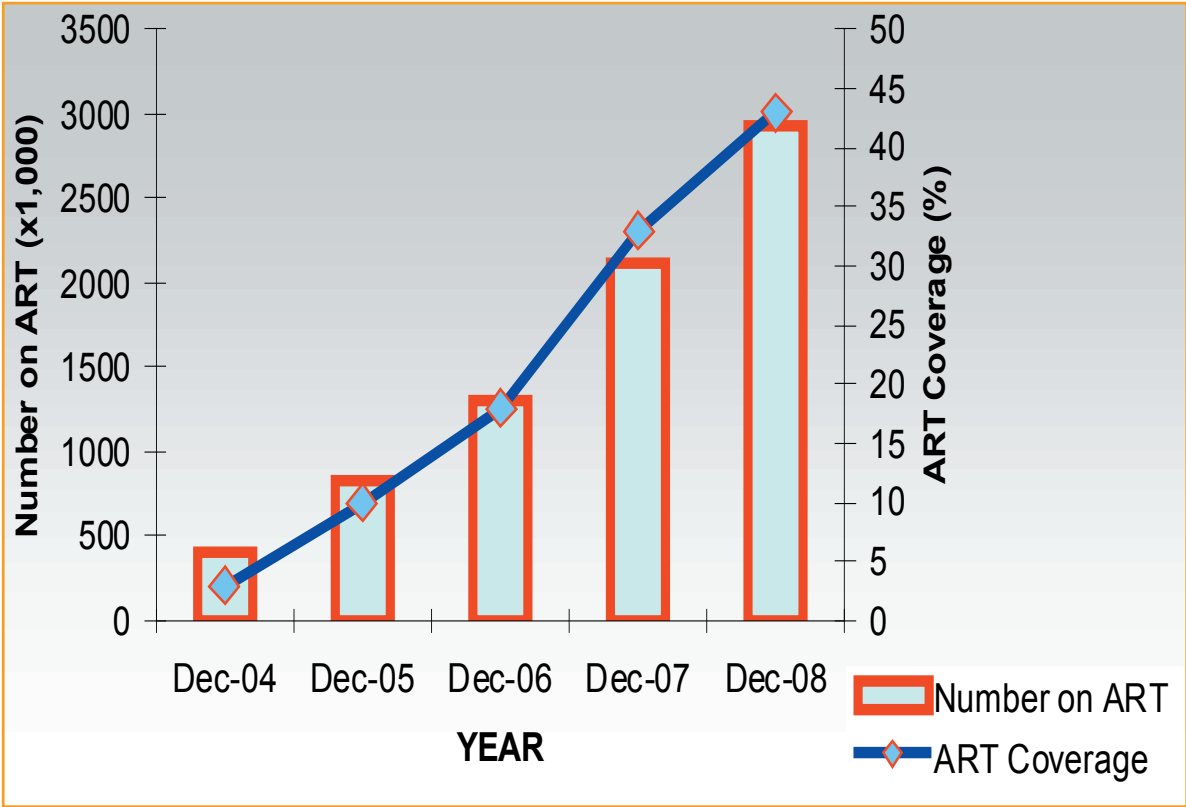


Source: AFRO database, Universal Access

53. To support the scaling up of HIV prevention, strategic partnerships were forged with other UN agencies and organizations such as the Champions for an HIV-free generation, an initiative led by former heads of state and prominent persons in the Region, and the African Broadcast Media Partnership against HIV/AIDS. Policies and scale-up plans for male circumcision were developed in 14 high-burden countries²⁶ with WHO support.

54. With regard to HIV treatment and care, an estimated 2.9 million people with advanced HIV infection were put on antiretroviral therapy by the end of 2008²⁷ in sub-Saharan Africa. This represented a regional increase of 39% in one year and a 30-fold increase since the end of 2003 when the initiative to provide antiretroviral therapy to three million HIV positive eligible individuals by the end of 2005 (3 by 5 Initiative) was launched (Figure 7).

FIGURE 7: NUMBER OF HIV PATIENTS ON ANTIRETROVIRAL TREATMENT (ART) AND ART COVERAGE IN SUB-SAHARAN AFRICA, 2004–2008



Source: WHO/AFRO database: Universal Access

55. Through the IST’s and the Knowledge Hubs, support was provided for the training of clinical teams in Integrated Management of Adult and Adolescent Illnesses to improve the quality of care and treatment in countries. More than 600 health workers from 20

countries²⁸ were trained during the biennium. Thirty countries²⁹ were supported to strengthen their Procurement and Supply Chain Management (PSM) systems through training in quantification, forecasting, warehousing and distribution of medicines. This contributed to increased access to affordable HIV/AIDS medicines and commodities as well as reduction of stock outs.

56. Fifteen countries³⁰ in the Region implemented one or more WHO strategies such as compiling data on Early Warning Indicators and conducting threshold surveys to monitor the emergence of HIV drug resistance (HIVDR). National HIVDR threshold surveys conducted during the biennium in 20 countries showed that HIVDR was less than 5%.

57. During the reporting period, 38 countries³¹ were supported to update their HIV/AIDS strategic plans including the National Strategic Applications (NSAs) submitted to the Global Fund by Kenya, Malawi and Rwanda. In addition, the HIV/AIDS programme developed technical guidelines and training materials to guide countries in scaling up priority interventions for health sector response to HIV/AIDS within the context of Universal Access.

58. With regard to TB, nine Member States³² achieved the global target of 70% case detection rate, while 10 Member States reached the 85% treatment success rate by the end of the biennium.³³ Four countries³⁴ achieved both targets in 2008. Regarding achievement of the targets of Millennium Development Goals, estimated TB incidence remained static at 363 per 100 000 population between 2006 and 2007 while estimated prevalence declined from 547 to 475 per 100 000 and mortality rose from 83 to 93 per 100 000 population between 2006 and 2007.

59. The monitoring, recording and reporting of TB cases improved in all countries during the biennium. WHO supported all countries to adapt the electronic TB monitoring and reporting system. Six countries³⁵ were supported to finalize TB prevalence survey protocols and to mobilize resources for the surveys.

60. The global targets for DOTS expansion are: (i) at least 70% case detection rate; and (ii) at least 85% treatment success rate. As shown in Figure 8, nine countries in our region reached the global target of 70% case detection rate in 2008. This represents an improvement from the situation in 2007 when only seven countries³⁶ were able to achieve the target. Furthermore, fifteen countries³⁷ attained the treatment success rate target in 2008. This was also an improvement compared to the situation in 2007, when only nine countries³⁸ attained this target. Four countries³⁹ achieved both targets in 2008, compared to three countries (Algeria, Kenya, and Tanzania) in 2007.

FIGURE 8: DOTS STATUS IN THE WHO AFRICAN REGION IN 2008*



Source: WHO Global TB report, 2009

* Cohort which completed treatment in 2008 and patients detected in 2008, and data compiled in 2009

- Countries attaining both targets
- Countries attaining 85% treatment success only
- Countries attaining 70% case detection only
- Countries below targets

61. Thirty-six countries⁴⁰ received Global Drug Facility (GDF) grants for first-line anti-TB drugs, while 16 countries⁴¹ secured approval for quality-assured concessionarily-priced second-line anti-TB drugs through the WHO Green Light Committee (GLC) mechanism. Five countries⁴² were supported to mobilize funding from USAID while Nigeria was supported to access funding from the TB Capacity-building project (TBCAP).

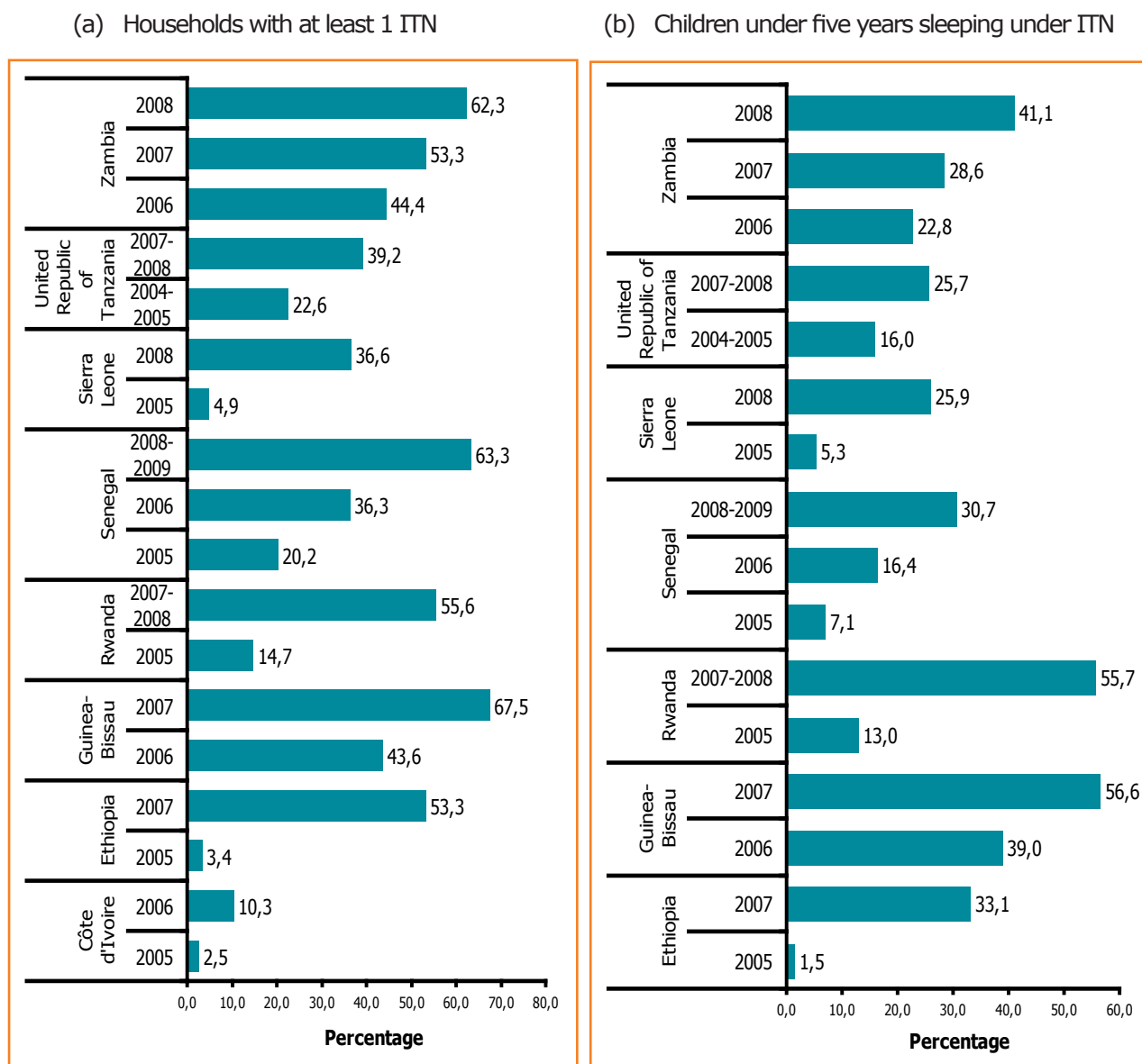
62. Support was provided to 37 countries⁴³ to adapt global and regional policies and tools for implementation of the Stop TB strategy that includes TB/HIV and MDR-TB/XDR-TB activities. The proportion of TB patients screened for HIV rose from 37% in 2007 to 45% in 2008. Of those co-infected, 72% were able to access co-trimoxazole preventive treatment and 41.5% were on antiretroviral treatment. In collaboration with partners, support was provided to 30 countries⁴⁴ to scale up collaborative TB/HIV activities through training, planning support and sharing information through the Stop TB partnership.

63. Multidrug resistant TB (MDR-TB) assumed increasing importance during the reporting period as a result of increasing awareness following reports of the emergence of XDR-TB in some countries since 2006. In 2008 alone, over 6588 new MDR-TB and 536 XDR-TB cases were reported. By the end of 2009, 31 countries⁴⁵ had notified at least one case of MDR-TB while eight⁴⁶ had reported at least one case of XDR-TB. By the end of the biennium, WHO and partners had supported 9 countries⁴⁷ to build national capacity to detect MDR-TB.

64. All malaria-endemic countries provided data that were published in the World Malaria Reports 2008 and 2009 with 15 countries⁴⁸ having installed the malaria database. Comprehensive Monitoring and Evaluation plans were developed in 30 countries while 11 countries⁴⁹ conducted the Malaria Indicator Survey. Malaria impact assessments were conducted in health facilities in 11 countries.⁵⁰

65. The median household possession of insecticide-treated nets (ITNs) in the Region increased from 31% in 2006 to 56% in 2008. For the period 2006–2008, the median ITN use was 21% among children under five years and 24% among pregnant women. However, ITN use among children under five years exceeded 40% in 12 countries that have recent data⁵¹ (Figure 9).

FIGURE 9: TRENDS OF HOUSEHOLD POSSESSION OF ITNS AND THE USE OF ITNS AMONG CHILDREN UNDER FIVE YEARS IN SELECTED COUNTRIES DURING THE PERIOD 2005–2008



Source: WHO/AFRO malaria database.

66. In 2008, 13 countries⁵² reported that Indoor Residual Spraying (IRS) was their main vector control method while several countries piloted the feasibility of deploying IRS. Between 2006 and 2008, the number of persons protected by IRS increased from 15 to 59 million. Ten per cent of the population at risk of malaria had protection in seven countries as of the end of 2008.⁵³

67. All but one of the malaria-endemic countries in the Region implemented the Artemisinin-based Combination Therapy (ACTs) as first-line treatment for malaria. The median proportion of children with fever who received ACT within 24 hours in selected countries⁵⁴ increased from 2% in 2006 to 6% in 2007 and to 12% in 2008.

68. Resource materials that were developed included “Malaria case management operations manual”; “Malaria Programme Reviews; a manual for reviewing the performance of malaria control and elimination programmes”; “Training modules for the international malaria courses”; and “Checklist for developing a monitoring and evaluation plan for malaria control”. Experts from 28 countries⁵⁵ were trained in case management, therapeutic efficacy testing and parasite-based diagnosis. Thirty-five countries have updated malaria strategic plans. Malaria programme reviews were undertaken in Botswana, Kenya and South Africa.

69. Eight countries⁵⁶ simultaneously implemented a comprehensive package of malaria prevention and control interventions in the same geographical area. As a result, these countries experienced a rapid decline in malaria burden during the biennium. In addition, intensified malaria control led to a reduction in malaria mortality in 14 countries.⁵⁷ Surveillance data from nine countries⁵⁸ demonstrated reductions in malaria-related mortality between 2002 and 2008, exceeding the 2010 target of 50% reduction. These achievements prompted the Fifty-ninth session of the Regional Committee to adopt a resolution on acceleration of malaria control in the Region.

70. Annual malaria review and planning meetings organized with partners resulted in the development of costed country road maps towards the achievement of the 2010 targets. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was the main external source of funding to countries. WHO in collaboration with UNAIDS supported these countries to develop funding proposals submitted to GFATM for both rounds eight and nine with success rates of up to 74% for malaria proposals, 55% for TB proposals and 48% for HIV/AIDS proposals. In addition, 10 countries⁵⁹ were supported to access funding from the Affordable Medicines Facility-malaria (AMFm).

4.3 SO3: CHRONIC NONCOMMUNICABLE CONDITIONS, MENTAL DISORDERS, VIOLENCE AND INJURIES

71. Activities in the biennium focused on providing support to Member States to reduce the disease burden due to chronic and noncommunicable diseases through technical guidance and support; health promotion; and advocacy for action at national and regional levels. This included the establishment of national policies and plans for the prevention and control of noncommunicable diseases in line with the Primary Health Care (PHC) approach and provision of support to reduce the level of exposure of individuals and populations to the main common modifiable risk factors for noncommunicable diseases namely tobacco use, unhealthy dietary habits, physical inactivity and harmful use of alcohol.

72. A landmark regional conference on diabetes and associated diseases organized by the WHO Regional Office, in collaboration with the Government of Mauritius and the International Diabetes Federation, in Port Louis, Mauritius, from 12–14 November 2009, came out with the *Mauritius Call for Action* for control of diabetes, cardiovascular diseases and other noncommunicable diseases. Member States committed themselves to implementing the diabetes prevention and control strategy of the WHO African Region to effectively reduce the burden of diabetes, cardiovascular diseases and other noncommunicable diseases and to scale up the implementation of essential interventions in line with the Primary Health Care approach.

73. Noncommunicable diseases (NCDs) prevention and control was promoted through the celebration of various world days specifically for mental health, cancer, diabetes, sickle-cell disease, cardiovascular diseases and sight. The first-ever world “No Noma Day” was organized in May 2008 to increase noma awareness.

74. During the biennium, more than 60 focal points from ministries of health and WHO country offices of 17 countries⁶⁰ participated in capacity-building programmes on the development and implementation of comprehensive, integrated health promotion approaches and health promotion-based interventions. The focus was on the prevention and control of oral health problems, sickle-cell disease, violence, injury and disabilities, mental health problems and substance abuse. Health personnel from three Member States were trained and supported in noncommunicable diseases management at primary care level. WHO partnered with the West African Health Organization (WAHO) to organize training in the development of integrated action plans for all 15 WAHO countries and ten Member States developed integrated noncommunicable diseases action plans.

75. In addition, participants from 18 countries were trained in the promotion of physical activity and consumption of fruits and vegetables by the population. Locally-adapted algorithms for cardiovascular diseases (CVD) management at primary care level and CVD risk factors including general awareness campaign to reduce salt consumption, were introduced.

76. Surveillance of noncommunicable diseases was integrated into the revised Integrated Disease Surveillance and Response guidelines. Cancer registries were established in five countries.⁶¹ A package of essential noncommunicable diseases at primary care level was developed. Benin, Eritrea and Mozambique received training in regard to the package and started its implementation. A manual guiding oral health programme managers on how best to formulate oral health policies was developed and

published. Subsequently, a catalogue of essential oral health indicators was developed and a progress report on the implementation of the Oral Health Strategy was presented during the Fifty-eighth session of the Regional Committee. In the same period, new WHO guidelines on wheelchairs provision services were promoted in four countries.⁶²

77. Eleven focal persons from ministries of health and WHO country offices⁶³ were trained to develop policy and strategic mental health planning documents. Seven countries⁶⁴ reviewed and analyzed their mental health situation. Benin, Burundi and Ethiopia assessed their services and resources and initiated measures to improve the management of mental health problems at district and community level. Mental Health (MNH) policy documents were developed in Liberia and Sierra Leone while Lesotho, Mauritania and Namibia started the first steps to develop their mental health legislation. The WHO *mental health Gap Action Programme* (mhGAP) was launched in Abuja in October 2009 to scale up care for MNH disorders in seven countries.⁶⁵

78. Cancer prevention and control was strengthened through training in diagnostic methods of visual inspection using acetic acid or lugol VIA/VIL and cryotherapy for cervical cancer prevention and control. A regional consultation was held on cervical cancer prevention to explore the possibilities of introducing Human Papilloma Virus (HPV) vaccine in the Region. Partnership and collaboration with UN agencies such as the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA) and with NGOs such as the American Cancer Society were strengthened by conducting joint and collaborative activities in countries and establishing mutual agreements and memoranda of understanding.

79. National policy documents on blindness control and plan of action were developed in Gabon and Madagascar, while national Vision 2020 plans were developed in Algeria, Gabon and Mauritius. Training in the Blindness Control Programme was conducted in nine countries.⁶⁶ Ethiopia was supported to train 10 ophthalmic nurse trainers in trachomatous trichiasis surgery while Madagascar received support for the training of primary health care workers in primary ear and hearing care.

80. By the end of the biennium, 35 African countries had signed the UN Convention on the Rights of Persons with Disabilities while the World Health Assembly Resolution on "Disability, including Prevention, Management and Rehabilitation" was being implemented with the support and collaboration of the Pan-African disabled people organizations.

81. Training of health rehabilitation professionals in prosthetics and orthotics was conducted in Tanzania and Togo. A survey on the status of road safety in 41 countries was completed. The survey showed that the Region has the highest per capita rate of road traffic deaths with 32.2 per 100 000 population and recommended the development of policies and strategic plans. A national policy on disability was developed in Sierra Leone and the medical rehabilitation sector was strengthened in Ghana by training four orthopaedic technologists in the design and production of prosthetics and orthotics devices.

82. A subregional Conference on Sickle-Cell Disease was organized in Madagascar from 27 to 29 November 2008 in collaboration with the Ministry of Health and the *Association Drepanocytose et vie* (DEPRAVIE) on the state-of-the-art and information gaps, and to strengthen south-south and north-south collaboration in harmonizing sickle-cell disease management.

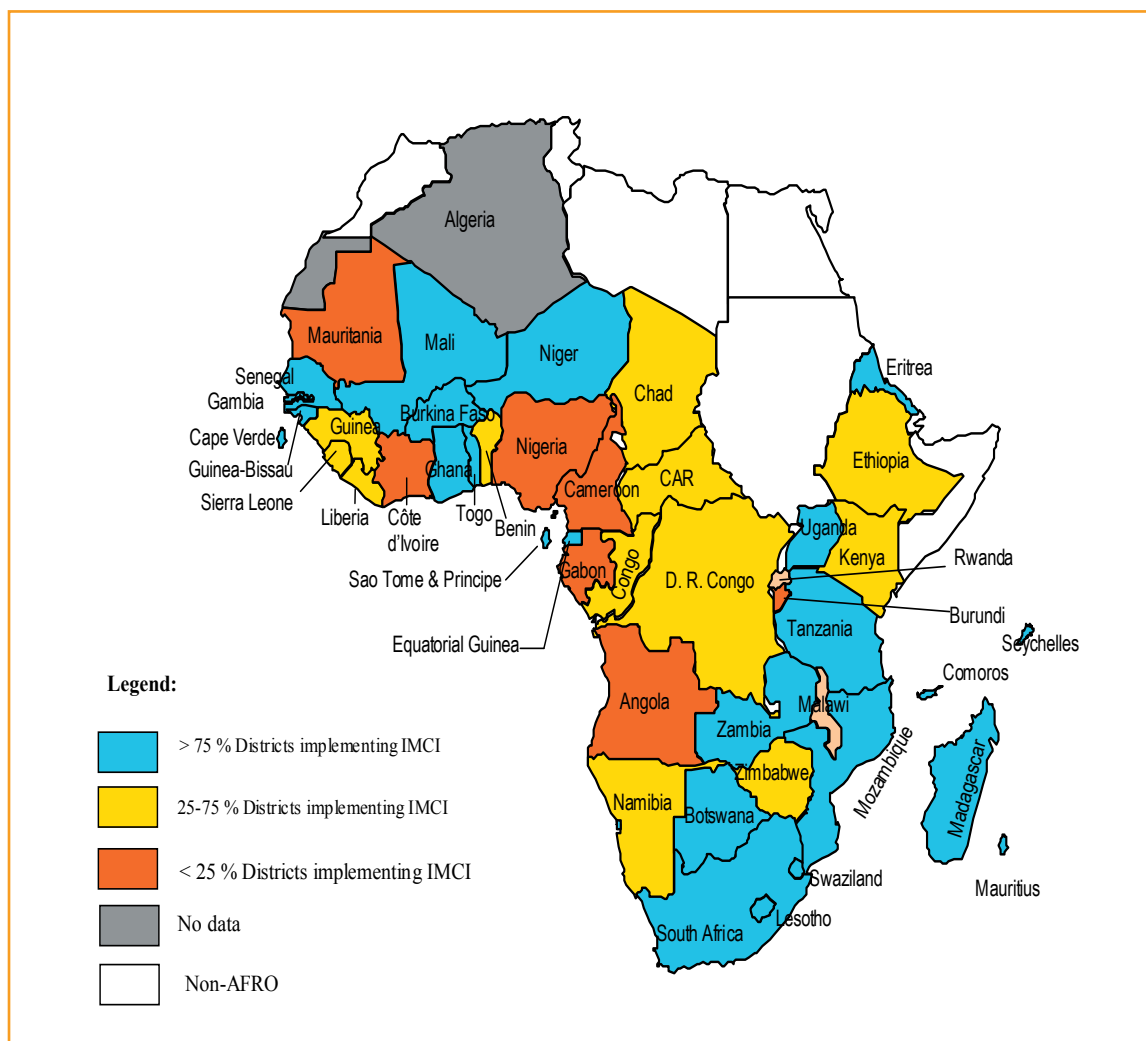
4.4 SO4: CHILD, ADOLESCENT AND MATERNAL HEALTH, AND AGEING

83. The focus of activities during the biennium was on supporting Member States to attain universal coverage of, and access to, cost-effective interventions to reduce morbidity and mortality and promote Family and Reproductive Health outcomes during the key stages of life including pregnancy, child birth, neonatal period, childhood, adolescence and ageing. Actions were implemented within the framework of the Making Pregnancy Safer initiative, the Integrated Management of Childhood Illnesses (IMCI) approach, and the Road Map for accelerating the attainment of the Millennium Development Goals related to maternal and newborn health in the African Region.

84. Following the adoption by the Fifty-sixth session of the Regional Committee of the Child Survival Strategy for the African Region, support was provided to 22 countries to develop or update comprehensive child health policies, strategies and plans, bringing to 27 the number of countries in the Region with national child survival policies, strategies and plans.⁶⁷ The capacity of 185 child health managers from 19 countries⁶⁸ was developed to improve their skills in the management of child health programmes.

85. During the biennium twenty-two countries were implementing the Integrated Management of Childhood Illness (IMCI) strategy in over 75% of their districts⁶⁹ (Figure 10). Thirty-two countries⁷⁰ and 36 countries⁷¹ adapted their IMCI guidelines to include HIV and the first week of life respectively.

FIGURE 10: COUNTRIES IMPLEMENTING THE INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS STRATEGY IN THE WHO AFRICAN REGION, JUNE 2009



Source: WHO/AFRO CAH database 2009.

86. Seven countries⁷² built the capacity of over 150 trainers including tutors from pre-service health institutions to scale up Infant and Young Child Feeding (IYCF) counselling and support, bringing to over 32 the total number of countries⁷³ with more than 7500 health workers trained. Five countries⁷⁴ reviewed their IYCF policies and strategies. Kenya, Nigeria and Zambia documented best practices in IYCF and demonstrated progress in their key indicators. Fourteen countries⁷⁵ adapted the new WHO child growth standards bringing to 20 the total number of countries to have done so.

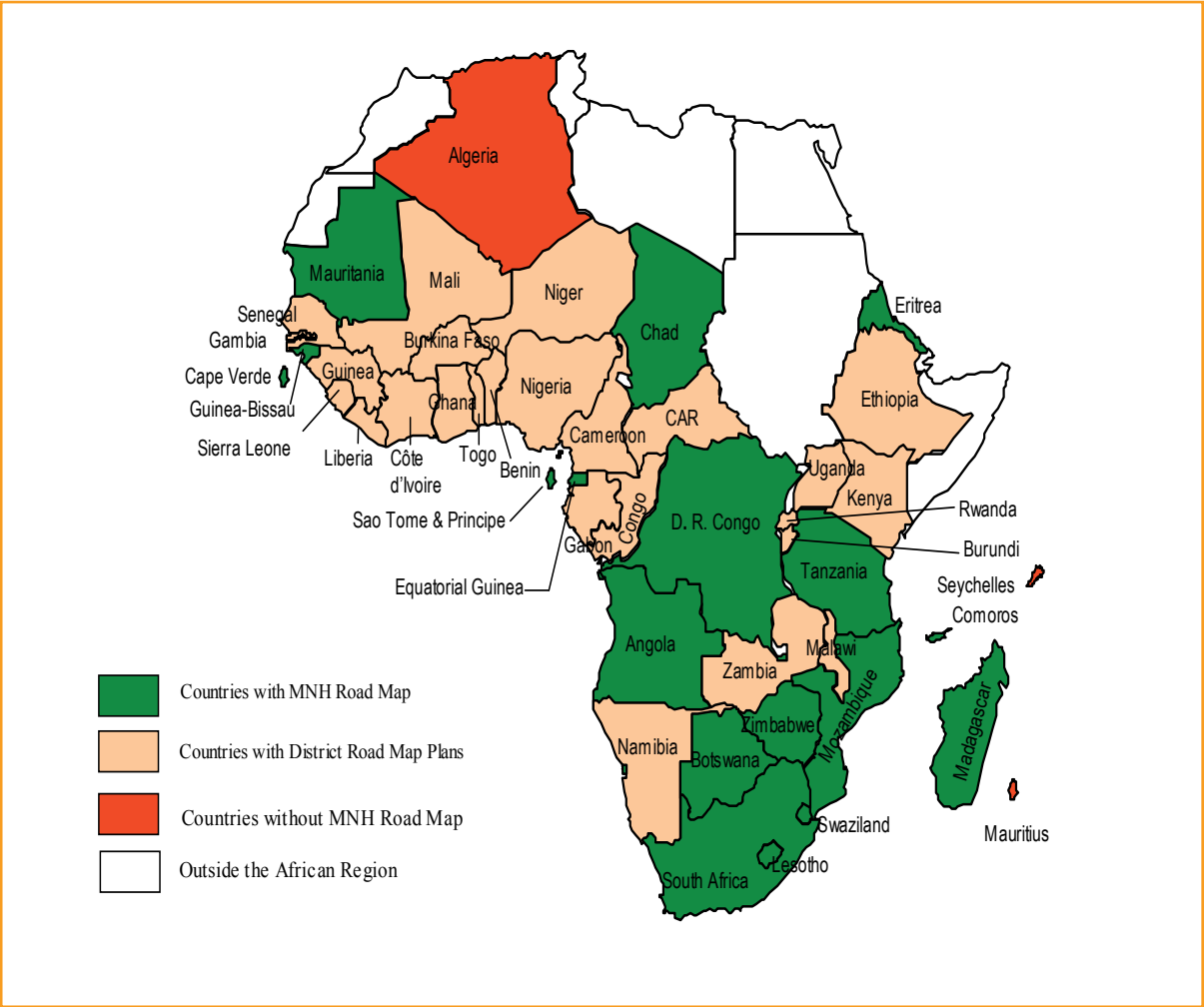
87. Child Health Facility Surveys were conducted in five countries,⁷⁶ bringing to 14 the total number of countries⁷⁷ that have conducted such surveys. Key findings from the surveys were that with training, adequate medicines, referral and supervision, and within the context of affordable health services, integrated management of childhood

illnesses was feasible in countries and could lead to improved quality of care in health facilities. In Tanzania, the survey showed that IMCI had contributed to 13% mortality reduction in children under five years over a two-year period.

88. Ten countries⁷⁸ developed adolescent health strategic plans, bringing to 28⁷⁹ the total number of countries with Adolescent Health strategic plans. Thirteen countries developed standards for adolescent and youth-friendly health services.⁸⁰

89. Among the 43 countries implementing national Road Maps including the newborn component (Figure 11), 17 integrated the maternal and newborn health component in their district operational plans, bringing to 25 the total number of countries with district maternal and newborn health plans.⁸¹

FIGURE 11: STATUS OF ROAD MAP DEVELOPMENT IN THE AFRICAN REGION, DECEMBER 2009



Source: WHO/AFRO DRH database 2009

90. Factors that contributed to the availability of and access to qualified skilled health workers for maternal and newborn care were the implementation of the Road Map, partnership building, advocacy, development of guidelines and training in Emergency Obstetric and Newborn Care (EmONC). By the end of the biennium, with the support of WHO and other partners, 28 (61%)⁸² of the 46 Member States had at least 50% of births attended by skilled attendants compared to 21 (46%) countries at the beginning of the biennium.

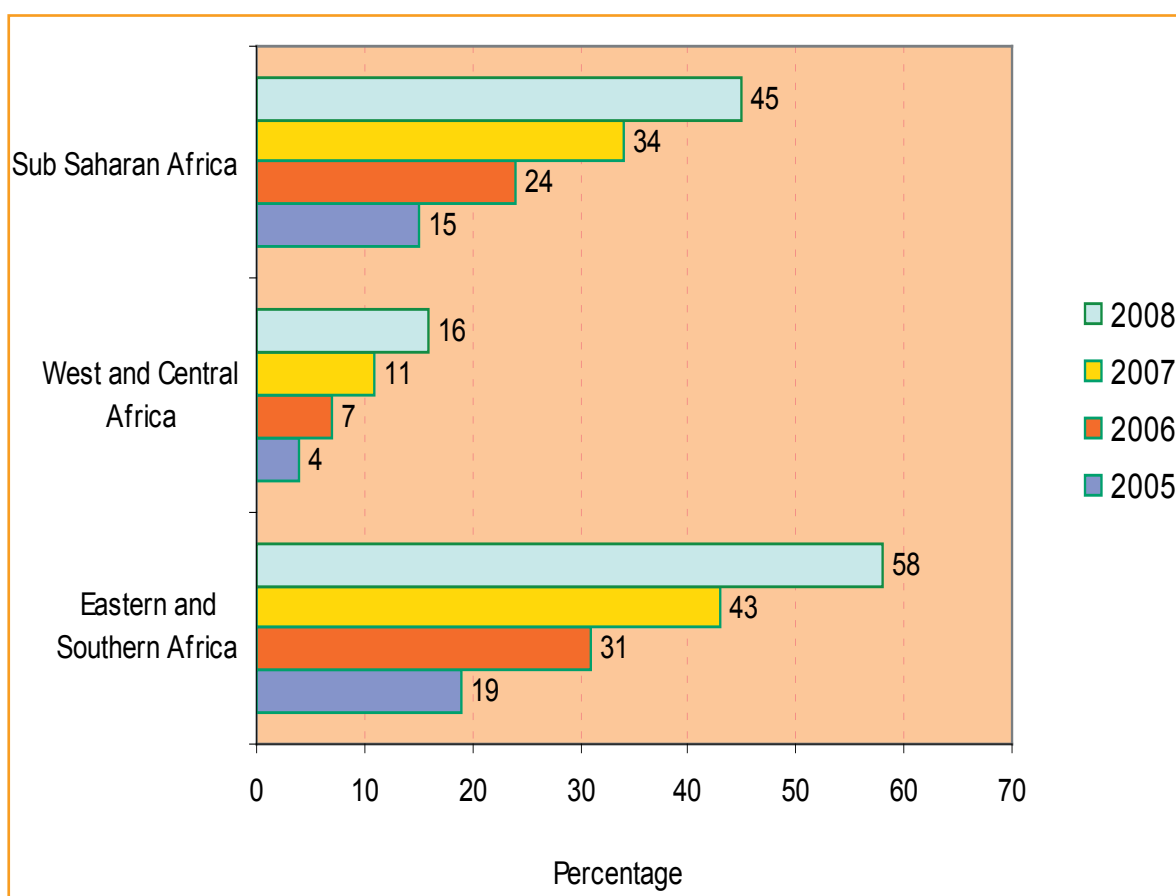
91. Emergency Obstetric and Newborn care (EmONC) needs assessment and maternal and newborn health Service Availability Mapping were conducted in six countries⁸³ and introduced in 15 others.⁸⁴ The findings were used to advocate for increased resources and to develop strategies to address existing gaps. Pre-service and in-service training in EmONC was conducted in 24 countries.⁸⁵

92. Maternal and Perinatal Deaths Reviews were institutionalized in 27 countries.⁸⁶ Seventeen countries⁸⁷ improved the skills of health workers in essential newborn care using WHO course materials. Thanks to advocacy, thirteen countries⁸⁸ have removed financial barriers to EmONC. In collaboration with partners, maternal and newborn health tools and guidelines⁸⁹ were developed and published. They include the Framework for integrated community level health promotion interventions in support of priority WHO programmes and a guide for recommendations for clinical practice for emergency obstetric and neonatal care (RPC) and the Home-based newborn care training materials for community health workers.

93. The African Union (AU), in collaboration with WHO, launched the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) at the Fifty-ninth session of the Regional Committee. The Campaign was subsequently launched in seven countries.⁹⁰

94. Plans for comprehensive and accelerated prevention of mother-to-child transmission (PMTCT) of HIV were implemented in 34 countries⁹¹ of the Region, contributing to improved uptake of services. The coverage of PMTCT services continued to increase during the biennium with 45% of pregnant women living with HIV in the Region receiving antiretroviral regimens to prevent HIV transmission to their fetus or infants. This contrasts with only 15% in 2005 as shown in Figure 12. The progress was made mostly in East and Southern Africa where HIV prevalence is highest in the Region.

FIGURE 12: TRENDS OF THE PERCENTAGE OF HIV-INFECTED WOMEN RECEIVING ARV FOR PMTCT FROM 2005 TO 2008



Source: WHO, UNAIDS and UNICEF. Towards Universal Access — Scaling up priority HIV/AIDS interventions in the health sector, Progress Report 2009.

95. WHO supported 11 countries⁹² to implement community initiatives for increasing participation in maternal, neonatal and child health (MNCH). One third of the countries in the Region have policies and/or plans to improve community participation.

96. In response to Regional Committee Resolution AFR/RC58/R1 on Women's health in the WHO African Region: a call for action, the Commission on Women's Health in the African Region was established to generate evidence on the key factors influencing the current state of women's health in WHO African Region and to recommend actions from the political, socioeconomic, cultural and health systems perspectives in order to improve women's health and particularly to reduce the unacceptably high levels of maternal deaths in the Region. The Commission is a multidisciplinary body composed of high level political personalities including parliamentarians, a representative of the African Union and a group of experts in various disciplines.

97. Programme Managers at the Regional Office and Maternal and Child Health focal persons from 44 countries were given orientation on gender issues and gender mainstreaming into health programmes. Ghana and Kenya were supported to build national capacity in gender mainstreaming.

98. A mid-term evaluation of the implementation of the action plan for accelerated elimination of female genital mutilation (FGM) by 2015 was conducted in 12 countries⁹³ out of 27 countries where FGM is practised. The report indicated that 11 countries have enacted laws against the practice of FGM. In addition, the report shows a downward trend in the practice of FGM in nine countries.

99. By the end of the biennium, all countries in the Region were implementing their Reproductive Health (RH) programmes based on the principles and recommendations contained in the WHO Reproductive Health Strategy. Eight countries⁹⁴ revised their Reproductive Health policies and strategic plans, aligning them to the new MDG5b target on universal access to Reproductive Health, and to the principles derived from the global reproductive health strategy adopted by WHO Member States.

100. A briefing session on the use of the Family Planning (FP) Advocacy tool kit was conducted for experts from 17 countries,⁹⁵ and financial support was provided to nine countries⁹⁶ to implement advocacy activities to reposition family planning in accordance with the Regional Committee resolution on Repositioning family planning in reproductive health services.⁹⁷

101. Experts from 26 countries⁹⁸ received orientation on the implementation framework of the global Sexual and Reproductive Health strategy; national-level monitoring of the achievement of universal access to Reproductive Health including conceptual and practical considerations and related indicators; revision and adaptation of Reproductive Health and Family Planning norms and technical guidelines. Twelve countries⁹⁹ were supported to revise their guidelines and eight countries¹⁰⁰ updated their guidelines. Experts from 10 countries¹⁰¹ participated in a Training of Trainers workshop on early detection and treatment of precancerous conditions and cervical cancer. The workshop took place in Libreville in 2009.

102. Despite the above efforts by Member States to improve maternal and child survival in the Region, only six countries¹⁰² are on track to achieve MDG4 and no country is on track to achieve MDG5 by the year 2015. With less than 5 years to the MDG target

year, what is needed now is not necessarily a new science, but a new commitment to prioritize, allocate resources to, and accelerate maternal and child mortality reduction efforts in countries of the African Region.

4.5 SO5: EMERGENCIES, DISASTERS, CRISIS AND CONFLICTS

103. As part of the implementation of World Health Assembly Resolution WHA59.22, the focus of activities was on strengthening the capacities of Member States to prepare and respond adequately to emergencies and public health events in order to mitigate the health-related consequences and impact. This included the development of contingency plans, the establishment of emergency units, emergency stockpiling, and capacity building at district and community levels through training.

104. During the biennium, 11 countries¹⁰³ were supported to develop national emergency preparedness plans that covered multiple hazards. Health recovery strategies were developed by five countries.¹⁰⁴ By the end of the biennium, the cluster approach, one of the three main pillars of humanitarian reform, was being implemented in 13 countries¹⁰⁵ with WHO as Health Cluster lead and with full-time cluster coordinators assigned to Chad, Democratic Republic of Congo and Zimbabwe. In addition, in countries in emergencies, WHO was the lead agency in health response.

105. The time frame for delivery of emergency kits was reduced by using a humanitarian depot in Accra, Ghana, and a procurement mechanism in the Department of Health Action in Crisis (HAC), WHO headquarters, Geneva. Two regional HELP courses, held in English and French, were supported and used to increase national surge capacity to provide rapid response.

106. WHO capacity to assist Member States to prepare for, and respond to, emergencies within the context of humanitarian reform was strengthened through field presence in 20 countries, and at subnational locations in four countries.¹⁰⁶ Back-up technical and operational support was further consolidated in the three Inter-country Support Teams and in the Regional Office.

107. Almost all countries responded to emergencies including floods, food crises, conflicts, and disease outbreaks during the biennium. Member States were able to provide initial response to various emergencies within 48 hours. The progress made in countries was achieved with the support of the regional platform established for surge

capacity to provide rapid response during emergencies. Through this, technical support was provided to Member States in addition to capacity building in needs assessment, planning and implementation of transitional and recovery actions in post-conflict and post-disaster situations.

108. Partnerships were initiated with the UN International Strategy for Disaster Risk Reduction (UNISDR), regional humanitarian groups such as OCHA in Dakar, Johannesburg and Nairobi, and NGOs (Merlin, Save the Children Fund). The strategic presence and participation of WHO in the monthly and ad hoc meetings of Regional Directors Teams (RDTs) in Dakar, Johannesburg and Nairobi, greatly improved joint support to countries in emergencies. The performance of the Region in the utilization of available funds improved significantly, reducing the proportion of expired project funds from 40% in 2006-2007 to 2% in the biennium under consideration.

4.6 SO6: RISK FACTORS FOR HEALTH CONDITIONS

109. During the biennium, emphasis was put on supporting countries to implement health promotion strategies to address risk factors such as unsafe sex, physical inactivity, unhealthy diet, tobacco use, alcohol and other substance abuse through comprehensive interventions. Activities included advocacy for the use of health promotion to improve health and prevent disease, capacity building for the strengthening of health promotion policies, mechanisms and interventions, and incorporation of health promotion components into non-health sector interventions and programmes.

110. The Seventh Global Conference on Health Promotion was held in Nairobi, Kenya from 26 to 30 October 2009. This was the first global conference on health promotion ever held in the African Region. The theme of the conference was "Promoting health and development: Closing the implementation gap." The main outcome of the Conference was the Nairobi Call to Action for Closing the Implementation Gap through Health Promotion. The Nairobi Call to Action urges Member States, WHO and partners to mainstream health promotion across sectors, population groups and disease-specific issues using the primary health care (PHC) approach to collectively address the social determinants of health.

111. Multisectoral teams from 16 countries were provided skills for development of integrated health promotion-based interventions aimed at noncommunicable diseases prevention. This was done through participatory training sessions held in Benin and

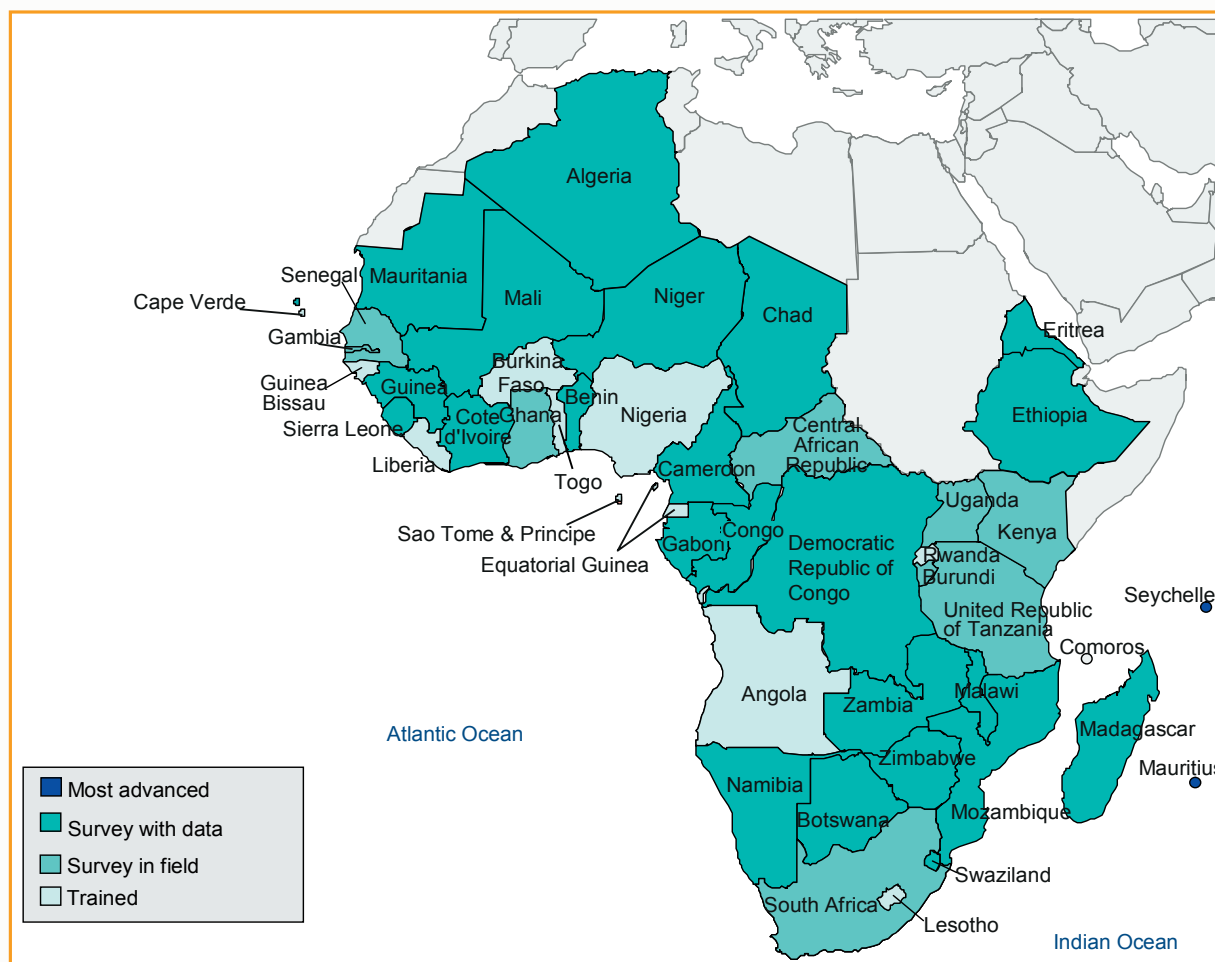
Uganda. Nineteen countries were supported to implement integrated noncommunicable diseases prevention using health promotion approaches and methods. Eight countries¹⁰⁷ initiated noncommunicable diseases prevention activities with significant community participation.

112. By the end of the biennium, 21 countries in the Region had approved or drafted health promotion policies and/or strategies. These countries set up multisectoral teams for health promotion. Participants from twenty-nine countries were trained in effective use of health promotion methodology. Eleven countries developed school health strategies and adapted the WHO regional guidelines on health-promoting schools and initiated health promotion activities in schools.

113. Partnership with Education International (EI) and Education Development Center (EDC) to address HIV/AIDS in schools was strengthened through implementation of the Education-for-All and HIV/AIDS prevention (EFAIDS) programme. A consortium for noncommunicable diseases prevention and control in sub-Saharan Africa was formed with membership from various organizations. The consortium seeks to address both programme and policy issues related to the prevention and control of noncommunicable diseases in order to reduce ill-health and premature deaths as well as improve the health and quality of life of the people of sub-Saharan Africa.

114. Twenty-six Member States were supported to conduct surveys on the Stepwise Approach to Surveillance of Risk Factors (STEPS). The results, available from 18 countries (Figure 13), showed that the level of risk factors is high in most of these countries. Following the surveys, countries such as Benin, Botswana, Cape Verde and Mauritania organized national workshops to develop or update their noncommunicable diseases action plans, focusing particularly on primary prevention. Support was provided to Mauritania and Mozambique to develop their noncommunicable diseases action plans.

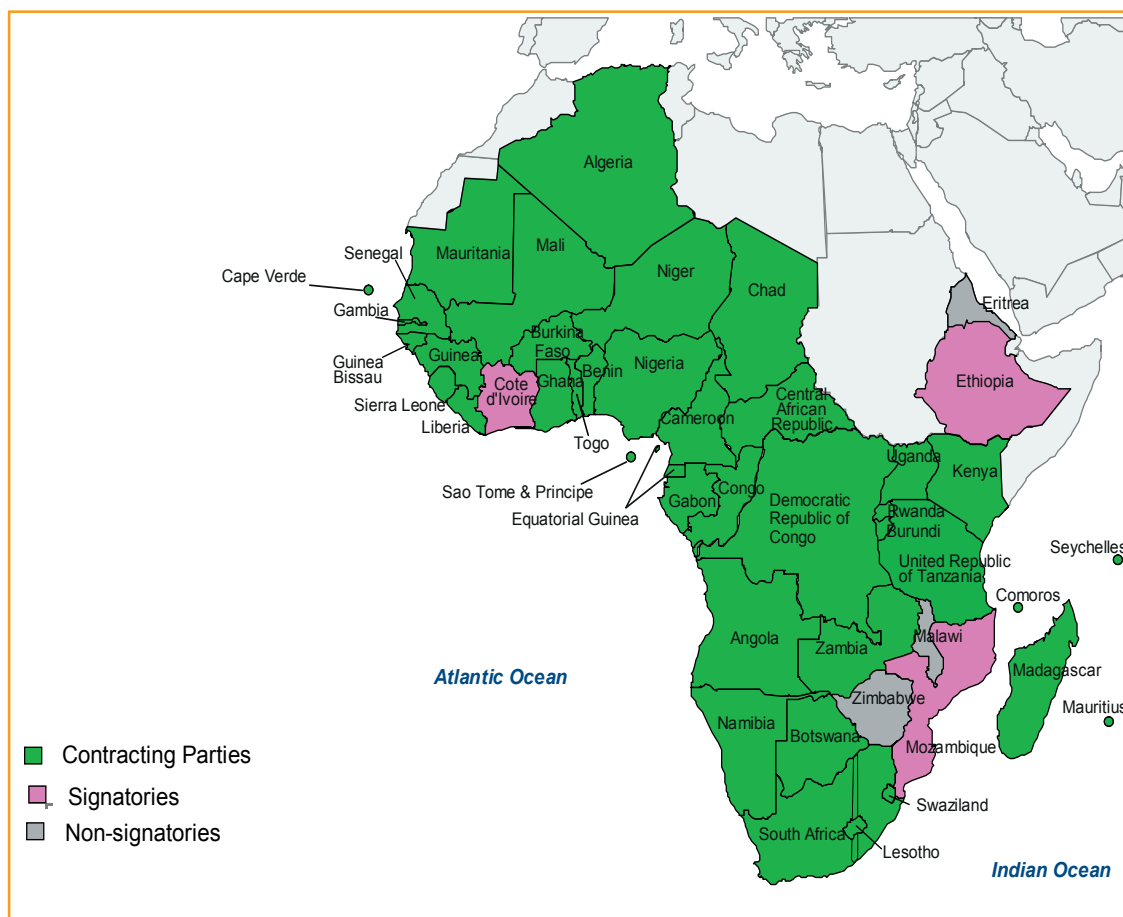
FIGURE 13: STATUS OF IMPLEMENTATION OF STEPS SURVEYS, NOVEMBER 2009



Source: AFRO STEPS Database.

115. During the biennium, Member States' awareness of the implementation of the WHO Framework Convention on Tobacco Control (FCTC) and the process of becoming a Party to the FCTC increased. The 'World No Tobacco Day' was used to increase tobacco awareness by sharing information materials to countries for dissemination through the media. The third Session of the Conference of Parties to the FCTC was held in Durban, South Africa, in November 2008 and adopted comprehensive guidelines on public health policies, packaging and labelling of tobacco, and prohibition of its advertising. Economically sustainable alternatives to tobacco growing and the issues of tobacco dependence and cessation were addressed. Five countries ratified or acceded to the FCTC and two others initiated steps to become part of the process. Forty countries had ratified the FCTC by December 2009 (Figure 14).

FIGURE 14: STATUS OF FCTC RATIFICATION IN THE AFRICAN REGION



Source: WHO Report on the global tobacco epidemic, 2009

116. By the end of the biennium, all 46 Member States had tobacco control focal persons. Technical and financial support was provided to 22 countries for the development of tobacco control legislation and national plans of action for tobacco control.

117. The capacity of Member States in surveillance and research was strengthened during the biennium. Twenty-five countries were supported to undertake the Global Youth Tobacco Survey and 38 countries were assisted in data analysis. By the end of the biennium, forty-three countries had data on tobacco use among the youth.

118. All Member States contributed to the preparation and completion of the second round of the Global Tobacco Control Report. Forty-two countries were trained in the use of the data to assess and revise their tobacco control policies and strategies in order to improve implementation of their programmes.

119. During the biennium, data on alcohol policy and legislation, supply and consumption and information on health indicators (mortality and morbidity, social consequences and treatment) in the Region were collected. Forty-six countries from the African Region participated in the survey and validated the data which was later used to prepare country profiles on alcohol consumption and related harm in the Region. The two main characteristics that describe alcohol consumption patterns in the Region are the high level of abstention and the high volume of consumption by drinkers. Furthermore, the process showed that although surveillance data from Member States provides some insight into the impact of harmful use of alcohol in the Region, regular systematic surveillance and recording systems of alcohol production, consumption and harm are not in place in many countries.

120. Technical support was provided for the development of evidence-based alcohol policies in Botswana, Ghana and Namibia. Cape Verde and Ghana developed their country plans for integrating early detection of people at risk of harmful use of alcohol and other drugs in primary health care. Focal points from WHO country offices and ministries of health units from nine countries¹⁰⁸ attended a briefing session on the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) instrument at a training course on noncommunicable diseases, held at the IRSP, Ouidah, Benin. A regional consultation on the global strategy to reduce harmful use of alcohol, bringing together participants from 43 countries, was held in Brazzaville in March 2009 and helped gather inputs from Member States for the draft Regional strategy on harmful use of alcohol to be submitted to the Sixtieth session of the Regional Committee for consideration and adoption.

121. WHO in collaboration with Education International (EI), an international union of teachers, supported the development and implementation of school-based health promotion activities toward prevention and control of HIV/AIDS. The school-based activities were later expanded to address also the prevention of substance use (alcohol and tobacco) and promotion of physical activity among school pupils. Training of school teachers in instructional methods to deliver content and skills on prevention and control of HIV/AIDS, tobacco, alcohol and other substance abuse was conducted in Liberia and Sierra Leone. Joint monitoring missions by WHO and IE to Botswana and Zimbabwe were undertaken to assess progress and efficacy in the implementation of the agreed activities.

4.7 SO7: SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

122. The focus during the biennium was to provide support to Member States to implement World Health Assembly Resolution WHA62.14 on Reducing health inequalities through action on the social determinants of health, within the framework of the Final Report of the Commission on Social Determinants of Health. This included efforts to ensure that the policies and work plans of the health sector and priority non-health sectors such as agriculture, energy, education, finance and transport address gender equality, human rights and equity in their design and implementation.

123. Member States were sensitized to the need for intersectoral actions for health through dissemination of literature and posters on human rights and intersectoral actions for health. The Final Report of the Commission on Social Determinants of Health, which was released during the biennium, was disseminated to Member States. The report outlines actions needed and provides examples of actions of proven effectiveness in improving health and health equity in countries at all levels of socioeconomic development.

124. A regional workshop was organized in Dar es Salaam, Tanzania, from 22 to 23 April 2009, bringing together participants from diverse fields and selected from eight countries in the Region¹⁰⁹ and beyond. The aim of the workshop was to consolidate experiences gained so far in operationalising human rights principles in health practice, consider available tools and methodologies being used, and future challenges. The workshop, whose outcomes included Alumni of the health and human rights online course offered by WHO in collaboration with InWent, Germany, shared experiences and provided suggestions on how the course can be improved and made available to others.

125. WHO organized a capacity-building workshop in the area of analysis of equity in health and health care in Johannesburg, South Africa, from 28 September to 2 October 2009. Seven countries¹¹⁰ participated in the workshop. Support was provided to Angola and Chad to build capacity to address the social determinants of health; to Guinea to improve data collection; to Equatorial Guinea, Gambia and Malawi in monitoring and evaluation; and to Algeria and Burkina Faso to address ethical issues. In addition, Malawi was supported to train 18 participants from the Ministry of Health in the analysis of equity in health and health care. Seychelles was supported to draft a legislation governing stem cell research and to build capacity to address the ethical issues involved.

126. With the support of WHO, four countries¹¹¹ developed plans to make social determinants of health a priority for the ministry of health and the government as a whole, emphasizing a whole-government approach to intersectoral collaboration. Mozambique started the process of setting up a National Commission on the Social Determinants of Health. Algeria, Burkina Faso and Kenya strengthened the mainstreaming of gender and human rights in the operational health sector's approaches while, in Uganda, a health and human rights study was carried out as part of the mid-term review of the health sector strategic plan.

127. Eight countries¹¹² prepared plans to conduct pilot studies on their situation regarding the social determinants of health including needs assessments in order to inform the design of strategies to address social determinants of health and guide planning and resource allocation.

128. WHO supported countries participating in the WHO/EC MDGs Partnership and the WHO/Luxembourg project to finalize Phase I, work and submit progress reports and prepare work plans for Phase II. The projects addressed various aspects of health system strengthening in order to achieve the Millennium Development Goals.

4.8 SO8: HEALTHIER ENVIRONMENT

129. The focus of WHO action was to support countries to develop policies and strategies on environmental health, establish or strengthen appropriate structures for environmental health services, improve human resource capacities in environmental health in ministries of health and foster health sector collaboration and partnership.

130. A landmark conference, the First Interministerial Conference on Health and Environment, was jointly organized by WHO and UNEP and hosted by the Government of Gabon in August 2008. The Conference adopted the Libreville Declaration on Health and Environment in Africa, committing governments of Member States to implementing 11 priority actions¹¹³ including the establishment of health and environment strategic alliance in order to address health and environment challenges in Africa.

131. As a follow up to the Interministerial Conference on Health and Environment, WHO and UNEP jointly convened the First Meeting of Partners for the Health and Environment Strategic Alliance, in Windhoek, Namibia, in February 2009. The partners issued the "Windhoek Statement of Partners on the implementation of the Libreville Declaration on Health and Environment in Africa". By that statement, the partners committed themselves

to providing support for the creation of the Health and Environment Strategic Alliance and to promoting the initiation of rapid country Situation Analysis and Need Assessments (SANAs) for the preparation of national plans for joint action. A road map describing the process and the key milestones for implementing the Libreville Declaration at national and international levels was adopted.

132. A Joint Task Team to coordinate the implementation of the Libreville Declaration at the country and international levels was established. The Task Team developed guidelines for conducting a situation analysis and needs assessment (SANA). The guidelines were tested in Gabon and Kenya, and finalized and disseminated to countries for use. The Joint Task Team also prepared guidelines for the development of national plans for joint action as well as a computer-based programme for the management of information on linkages between health and the environment. By the end of 2009, with technical and financial support from WHO, 10 countries had initiated the process for developing national plans for joint action on health and environment.

133. WHO and UNICEF continued their collaboration on the Joint Monitoring Programme on access to safe drinking water and sanitation. A joint report, issued during the biennium, showed that in 2006 only 58% of the total population of sub-Saharan Africa had access to improved drinking water source, with a major disparity between urban areas (81%) and rural areas (46%). The report also showed that only 31% of the population had access to improved sanitation and that a significant difference exists between urban areas (42%) and rural areas (24%).¹¹⁴

134. In line with World Health Assembly Resolution WHA61.19 on Climate change and health, the Regional Office organized a regional consultation to develop a framework for action to protect human health from climate variability and change within Africa. The framework focused on four main areas: (i) awareness-raising to place health concerns at the centre of national, regional and international action on climate variability and change; (ii) implementation of adaptive strategies to minimize the impact of climate variability and change on the health of the population; (iii) engagement of the health sector in development strategies in order to protect and promote health through actions by other sectors; (iv) strengthening of the institutional capacity of public health systems to provide guidance and leadership in health protection from climate change.

135. In collaboration with the World Meteorological Organization, WHO organized a regional consultation to develop an agenda on climate change and health in Africa. The report of this consultation served as the contribution of the Region to the preparation of the Global Action Plan on Climate Change.

136. WHO strengthened its cooperation with countries in key technical areas. Health care waste management received special attention through a GAVI-funded project which was implemented in 36 countries. Technical support was provided to all malaria-endemic countries for effective vector control in the context of integrated vector management in order to scale up vector control interventions for the control of malaria and other neglected tropical diseases. WHO partnered with UNEP, UNITAR, the SAICM Secretariat and the Stockholm Convention Secretariat in joint implementation of initiatives and programmes for strengthening chemicals management in the Region. WHO also partnered with ILO to implement the Global Action Plan on Occupational Health and Safety.

4.9 SO9: NUTRITION, FOOD SAFETY AND FOOD SECURITY

137. The approaches adopted in this area included supporting Member States to strengthen food safety and nutrition surveillance, develop or update nutrition plans and policies as well as food safety legislation, policies and plans that are based on scientific risk assessment along the entire food chain, integrate food safety matters into education programmes for consumers and participate actively in the work of the Codex Alimentarius Commission.

138. During the biennium, five countries¹¹⁵ included nutrition, food safety and food security in new sector-wide approaches and in Poverty Reduction Strategy Papers. Guidelines for inclusion of food safety, nutrition and food security in Poverty Reduction Strategy Papers were developed. The Regional Office contributed to the work of the Food Security and Nutrition Working Group (FSNWG). Ministers and key stakeholders were sensitized to the global food crisis through an information note.

139. The Regional Office participated in high-level meetings with AU/NEPAD, FAO, UNICEF, WHO headquarters, OCHA, CILSS and WAHO and strengthened partnerships by articulating WHO position on management of nutritional problems and by clearly defining collaboration with different partners. The Regional Office contributed to the West African Health Organization mid-term review of Nutrition; and the West Africa Regional Alliance REACH/Infant and Young Child Nutrition. Rwanda organized a national congress on nutrition jointly with UNICEF.

140. Actions towards sustained salt iodization to tackle iodine deficiency were adopted by the Fifty-eighth session of the Regional Committee. Five countries¹¹⁶ prepared strategic plans and held national dialogue to address Iodine Deficiency Disorders. Ghana, Kenya and Tanzania carried out activities for prevention and control of iron deficiency anaemia and vitamin A deficiency.

141. Training materials on nutrition care and support for People Living with HIV were finalized jointly with FAO. The Regional Office worked together with UNICEF, Food and Nutrition Technical Agency (FANTA/USAID) and Valid International to develop training materials on management of acute malnutrition in outpatient facilities. Contributions were made towards the organization of nutrition in emergency training courses and the revision of the global emergency toolkit. Guidelines on integrated nutritional care of HIV-infected children were developed and field-tested in Malawi and South Africa and a communication strategy on appropriate feeding of HIV-infected infants was developed in Kenya. Ghana adapted the Diet and Physical Activity Strategy (DPAS) and Benin and Eritrea incorporated DPAS into School Health Education Programmes.

142. A regional workshop on Integrated Management of Acute Malnutrition (IMAM) was organized for South Africa, Swaziland, Zambia and Zimbabwe in addition to national training of trainers in seven countries.¹¹⁷ Furthermore, WHO collaborated with UNICEF to provide support for Namibia in organizing a training course in IMAM for 20 health workers and for Zimbabwe to improve training in IMAM, use the WHO New Child Growth Standards and develop a flow chart for management of acute malnourished cholera cases. Botswana was supported to train 30 participants in malnutrition management during diarrhoea outbreak.

143. Seven countries¹¹⁸ strengthened their response to nutritional problems and six countries¹¹⁹ strengthened their surveillance systems by using landscape analysis and review. Mapping of the nutrition surveillance profile was conducted in 12 countries.¹²⁰ Côte d'Ivoire prepared a plan of action for malnutrition management.

144. The WHO New Child Growth Standards were used in two regional training sessions, one in Benin for West African countries and the other in Cameroon for Central African countries. Fifteen countries¹²¹ adapted the new child growth standards, bringing to 20 the total number of countries that have adapted the growth standards. Child growth standards capacity building was organized for 13 regional facilitators, 64 national facilitators from 20 countries¹²² and 21 national facilitators from seven countries.¹²³

145. Five countries¹²⁴ developed national nutrition policies and strategies on HIV in Infant and Young Child Feeding (IYCF). Eight countries conducted landscape analysis and revised nutrition strategies and action plans.¹²⁵ Six countries¹²⁶ conducted national training of trainers in integrated IYCF counselling and Kenya, Nigeria and Zambia documented best practices and experiences. Seven countries¹²⁷ trained 150 trainers in scaling up IYCF counselling and support. Ghana, Nigeria and Zambia reviewed the implementation of their national IYCF strategy. Fourteen countries¹²⁸ developed plans to accelerate implementation and monitoring of the International Code for Marketing of Breast-milk Substitutes. Health facilities were assessed and designated as Baby Friendly Hospitals in Malawi and Rwanda and Nutrition Baby Friendly Schools Initiative was implemented in Benin. Ghana, Côte d'Ivoire and Malawi celebrated the World Breastfeeding Week.

146. Food safety was included in guidelines for nutrition in HIV/AIDS programmes. Guidelines for strengthening national food control were prepared and field-tested in six countries.¹²⁹ A training manual on food safety risk analysis was developed and field-tested by involving 34 participants from eight countries.¹³⁰ Regional guidelines on food-borne disease surveillance were developed.

147. WHO worked with the African Union and the European Union on food inspection and animal health. National authorities were informed of food-related incidences including Melamine contamination of milk and support was provided for laboratory testing of milk. Ten countries¹³¹ conducted workshops on Hazard Analysis Critical Control Point (HACCP) and food inspection activities including capacity building, sensitization, adaptation of guidelines, decentralization of services, and evaluation of a slaughterhouse.

148. In collaboration with partners, a regional seminar on the work of Codex was organized in Cameroon for 40 delegates from seven countries. Six countries¹³² were supported to strengthen their National Codex Committees. Jointly with FAO and the Codex Coordinating Committee for Africa (CCAFRICA) a training course on Codex requirements concerning mycotoxins in foods was organized. The CCAFRICA was supported to organize its biennial meeting and provided with resources to maintain its web site. Countries received technical support during the 32nd session of the Codex Alimentarius Commission.

149. Courses in laboratory-based food-borne diseases surveillance were organized for eleven countries¹³³ and respective laboratories were provided with laboratory supplies. The capacity of food control laboratories was strengthened in Botswana and Rwanda. Support was provided for the investigation of food-related disease outbreaks in many countries including an unknown liver disease in Ethiopia, typhoid fever in Malawi, aflatoxicosis in

Kenya, and Salmonellosis in Mauritius. Research was conducted on *Salmonella concord* in Ethiopia and *Salmonella* Hiduddify in Nigeria. The Cysticercosis Working Group for East and Southern Africa was supported to develop intervention research on *Taenia solium* and South Africa was supported to conduct studies on the microbiological safety of infant foods.

150. Sixteen countries¹³⁴ evaluated their national food safety programmes and five countries¹³⁵ developed national food safety plans. Kenya, Rwanda and Uganda drafted national food safety policies and bills. Gambia and Kenya trained food control officers in prosecution and food regulators in the Food Act respectively. Sensitization to food safety norms and standards was undertaken in Sierra Leone while the food safety legal framework was reviewed in Malawi. Twenty countries¹³⁶ expanded food safety education using the WHO Five Keys to Safer Food. The Five Keys messages were adapted and translated into local languages. Four countries¹³⁷ organized food safety competitions for school children. In addition, healthy foods markets were established in six countries.¹³⁸

4.10 SO10: HEALTH SERVICES

151. The focus of activities during the biennium was to support countries to implement the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa and the Algiers Declaration on Research for Health in the African Region in order to improve the performance of health services in terms of quality, effectiveness, efficiency, coverage and equitable access.

152. Interest in the use of Primary Health Care (PHC) as an approach to strengthening health systems in order to contribute to the attainment of health-related Millennium Development Goals was renewed during the biennium. An International Conference on Primary Health Care and Health Systems was successfully co-organized by WHO, UNICEF, UNFPA, UNAIDS, AfDB and World Bank and hosted by the Government of Burkina Faso in April 2008. The Conference adopted the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. The Declaration was subsequently endorsed by the Fifty-eighth session of the Regional Committee which also adopted a related resolution.¹³⁹ A generic Framework for the Implementation of the Ouagadougou Declaration was adopted by the Fifty-ninth session of the Regional Committee in 2009.

153. As part of the implementation of the Ouagadougou Declaration, four countries¹⁴⁰ initiated the process of strengthening community-based health services. Thirteen countries¹⁴¹ strengthened the capacity of their district health systems in areas such as planning, management, integration of activities, supervision, and monitoring and evaluation. Four countries¹⁴² developed tools and reviewed their essential health packages to concentrate scarce resources on high-impact interventions while Niger developed a strategy for quality assurance.

154. Support was provided to Member States to revise or develop their national health policies and national health strategic plans. Botswana, Eritrea and Malawi developed their National Health Policy (NHP), bringing to 45 the number of countries that developed or reviewed their NHPs over the past five years. Seven countries¹⁴³ were supported to develop or review their national health strategic plans (NHSPs), bringing to a total of 44 the number of countries that developed or reviewed their NHSPs in the past five years.

155. Six countries¹⁴⁴ organized their joint annual health sector reviews. Comoros developed a Public Health Code. Benin and the Democratic Republic of Congo undertook an organizational audit of their ministries of health. Uganda finalized its stakeholder mapping and developed a costed scale-up plan. Burundi and Ghana strengthened the coordination of partners. Eight countries¹⁴⁵ adopted the Compact arrangement with the support of the IHP+.

156. Significant efforts were made to build capacity among both WHO staff and key staff in countries to enable them to effectively contribute to health systems development. Health professionals from nine countries¹⁴⁶ were trained in health systems diagnostics and health performance monitoring. In the same context, 135 national health professionals in all the 17 countries covered by the Inter-country Support Team of West Africa were trained in monitoring and evaluation of health systems strengthening at three workshops in Abuja, Dakar and Niamey.

157. At a workshop held in Lilongwe, Malawi, six countries¹⁴⁷ shared their experiences in health services decentralization. Two annual planning and review meetings were organized for the 18 countries of East and Southern Africa to review implementation and facilitate integrated planning. At the Fifty-ninth session of the Regional Committee, four countries¹⁴⁸ shared best practices in the strengthening of district or local health systems.

158. Nineteen countries¹⁴⁹ were supported in the preparation of their funding proposals for Rounds 8 and 9 of Global Fund applications. Out of the 19 countries, 14 received a total of US\$ 256 938 066 and US\$ 391 937 979 for health systems strengthening in round 8 and round 9 respectively.¹⁵⁰ In Round 8 successful countries were Burkina Faso-US\$ 4 085 815; Cote d'Ivoire-US\$ 607 145; Eritrea-US\$ 14 939 526; Lesotho-US\$ 39 684 361; Mauritania-US\$ 3 942 505; Swaziland-US\$ 15 136 443; Tanzania-US\$ 96 794 017; Zimbabwe-US\$ 81 748 254. In Round 9 successful countries were Benin-US\$ 43 711 267; Cote d'Ivoire-US\$ 97 590 298; Eritrea- US\$ 17 928 527; Guinea-US\$ 34 553 455; Senegal-US\$ 22 064 454; Tanzania-US\$ 176 089 979.

159. In the area of human resources for health (HRH), policy and planning guidelines were printed and disseminated to Member States. Eight countries¹⁵¹ developed their human resources for health strategic plans. Support was provided for the development of the nursing and midwifery strategies and action plans of four countries,¹⁵² and for reviewing the human resources for health component of Ethiopia's health sector mid-term review.

160. Regarding work on the Africa Health Workforce Observatory, communication materials such as briefing notes, booklets, posters, flyers and newsletters were produced and disseminated to provide information for human resources for health policy-making and planning. Ten countries¹⁵³ were supported to establish national health workforce observatories. A Steering Group of the Africa Health Workforce Observatory was established to strengthen partnership in the development of human resources for health.

161. In order to strengthen the management of human resources for health in countries, tools for assessing the capacity of national human resources for health units were developed. In addition, guidelines for evaluation of basic nursing and midwifery programmes were developed and disseminated to countries. Using these tools, evaluation of nursing and midwifery programmes were undertaken in eight countries.¹⁵⁴ Three countries Congo, Guinea-Bissau and Liberia were supported during the biennium to assess the capacity of their health sciences training institutions including medical schools. Furthermore, the Regional Office contributed to the preparation of the Code of Practice for International Recruitment.

162. Partnerships in the human resources for health agenda were strengthened with Regional Economic Communities (RECs), the Global Health Workforce Alliance (GHWA), ILO, IOM, and WHO Collaborating Centres. In collaboration with WHO headquarters, two project proposals were prepared and submitted to the EU for funding. These two projects were for the development of human resources for health information systems

in PALOP¹⁵⁵ countries and for human resources for health development in general. Both projects were funded and their implementation commenced during the biennium.

163. The capacity of countries to ensure sustainable health financing continued to be strengthened during the biennium. Regional guidelines for developing health financing policies were developed. Gambia developed a comprehensive national health financing policy. Cape Verde and Kenya developed health financing strategies. Uganda developed a Road map for formulating a health financing strategy. Niger developed a strategy for developing health mutual funds. Social health insurance capacities were strengthened in Ethiopia and Uganda.

164. A total of 159 persons from 26 countries¹⁵⁶ were trained at various workshops¹⁵⁷ on National Health Accounts (NHA) methodology, data collection tools, data collection, data analysis and report writing. Technical support was provided to 14 countries¹⁵⁸ for conducting NHA studies and eight of those countries¹⁵⁹ produced their NHA reports during the biennium 2008-2009. Seventy-three persons from 15 countries¹⁶⁰ were trained in NHA institutionalization and fourteen of those countries¹⁶¹ developed a plan of action (2010-2013) for institutionalization and harmonization of NHAs within countries of the Economic Community of West African States (ECOWAS). All the countries that undertook NHA studies usually used the results for various purposes such as development of policy, plan and PRSP, and guidance of health sector reforms.

165. In order to build sufficient evidence and information on health financing in the Region, WHO provided support for undertaking the following studies: feasibility studies of social health insurance in Swaziland and Uganda; institutional and organizational situation analysis of health system financing in Rwanda; willingness to pay for community health insurance in Nigeria; situation analysis of community health financing in Liberia; situation analysis of mutual health funds in Madagascar; documentation of health contracting practices in Burundi, Niger and Rwanda; and efficiency analysis of health facilities in four countries.¹⁶²

166. Relevant health information, evidence and research are crucial to informing national policies and strategies. WHO continued to strengthen evidence base at regional and national levels of Member States. Twenty-four countries¹⁶³ assessed their national health information systems (NHIS), seven¹⁶⁴ finalized their strategic plans for strengthening their NHIS and seven others¹⁶⁵ began developing their strategic plans. These assessment reports, combined with the implementation of population-based census and surveys in

countries, were used to map and produce NHIS profiles. WHO, in collaboration with the Health Metrics Network, strengthened the NHIS in Ethiopia, Sierra Leone and Zambia.

167. An assessment of national health systems performance was carried out in five countries.¹⁶⁶ A workshop was held to strengthen the capacity of 30 participants from 20 countries in mortality data analysis and planning for capturing data relating to maternal deaths during national censuses.

168. The development of the African Health Observatory was initiated during the biennium. The Observatory includes an integrated database, integrated Country Health Profiles and a range of information products. Six thematic working groups to promote networking and collaboration and to guide and produce the technical content of the Observatory were established. The working groups cover health systems; HIV/AIDS, TB, and malaria; communicable diseases; family and reproductive health; chronic diseases; risk factors, nutrition and food safety; and the broader determinants of health. The *African Health Monitor* was reconstituted into a quarterly publication and a new management and editorial structure comprising an Editorial Board, a Core Editorial Group and Associate Editors was established.

169. A mapping of Health Research systems and Knowledge Management systems was conducted in 44 countries. This informed discussions during the Algiers Ministerial Conference on Research for Health in the African that was held in June 2008. The Conference adopted the Algiers Declaration that aims to narrow the knowledge gap to improve Africa's health.

170. A Framework for the Implementation of the Algiers Declaration was discussed in a Regional consultation and was later adopted by the Fifty-ninth session of the Regional Committee. Nine countries¹⁶⁷ were supported in enhancing their use of evidence for policy and decision by producing policy briefs on wider use of artemisinin-based combination therapies in the treatment of uncomplicated malaria and prevention of malaria.

171. To facilitate documentation and sharing of knowledge on effective health interventions, a guidance document - "Guide for Documenting and Sharing Best Practices in Health Programmes" was published. The document was used during the Fifty-eighth session of the Regional Committee to share best practices in scaling up interventions for reducing maternal and newborn mortality, prevention and control of malaria, HIV/AIDS prevention, treatment and care, and routine immunization. During the Fifty-ninth

session of the Regional Committee, best practices from Burkina Faso, Ghana, Rwanda and Uganda on “Strengthening District/Local Health Systems” were shared.

172. In collaboration with the WHO headquarters Library and the Information Training and Outreach Centre of South Africa (ITOCA), training sessions in the use of Access to Research Information (HINARI) were organized in four countries.¹⁶⁸ In collaboration with ITOCA, the West African Regional Programme for Health and the West African Health Organization, a training session was organized to build the capacity of 35 West African medical librarians. New Blue Trunk libraries were acquired and distributed to all Member States.

173. An electronic system for managing WHO Collaborating Centres (eCC System) was introduced during the biennium. Four new WHO Collaborating Centres were designated during the biennium. These were the WHO Collaborating Centre for Advocacy and Training in Pharmacovigilance, University of Ghana Medical School, Ghana; the WHO Collaborating Centre for Research Synthesis on Reproductive Health, Effective Care Research Unit, University of Fort Hare, South Africa; the WHO Collaborating Centre for Training in Access and Use of Electronic Scientific technological and Medical Information, Information Training Outreach Centre for Africa, South Africa; and the WHO Collaborating Centre for Training, Education and Emergency and Surgical Care, St. Francis Hospital, Ifakara, Tanzania. As at the end of the biennium, there was a total number of 27 WHO Collaborating Centres located in 12 countries¹⁶⁹ in the WHO African Region.

4.11 SO11: MEDICAL PRODUCTS AND TECHNOLOGIES

174. The focus during the biennium was to support Member States in ensuring access to essential medicines and safe and appropriate health technologies within health systems. Efforts included supporting the work of medicines regulatory systems; ensuring efficiency in medicine procurement, supply and distribution systems; promoting rational prescription and use of medicines by prescribers and consumers respectively; improving access to safe blood and blood products, diagnostic imaging services, diagnostic technologies and laboratory services; and promoting patient safety.

175. The capacities of national medicine technical advisory committees in seven countries¹⁷⁰ were strengthened under the new project on Better Medicines for Children. Seven countries¹⁷¹ revised their national Essential Medicines Lists and Standard Treatment Guidelines. During the biennium, with WHO support, 6 countries organized training

sessions on good prescribing practices and rational use of medicines and the capacity of a total of 205 medical doctors, nurses and midwives was strengthened. Tanzania developed a communication strategy to improve rational use of medicines by communities.

176. Regional guidelines for the formulation, implementation, monitoring and evaluation of national medicine policies were revised. The revision covered additional components such as good governance, effective medicine regulation, monitoring the impact of trade agreements on access to essential medicines, institutionalization of traditional medicine in health systems, clinical trials and technical cooperation and harmonization.

177. A document entitled "*Regional perspective to implement the Global Strategy and Plan of Action for Public Health, Innovation and Intellectual Property in the African Region*" was prepared. The document was endorsed by the Fifty-ninth session of the WHO Regional Committee. National capacities to identify and implement priority activities consistent with public health needs were strengthened. A total of 26 senior officials from the ministry of health, ministry of trade and patent offices in 18 countries were trained in Public Health, Innovation and Intellectual Property Rights. The training courses aimed at increasing awareness and building national capacity to develop and implement policies and strategies consistent with public health needs. The training courses were organized in collaboration with the United Nations Development Programme, the University of Cape Town, Intellectual Property Law and Policy Research Unit, and Al Akhawayn University, Ifran, Morocco in June 2009 and December 2009 respectively.

178. A progress report and mid-term review report on the implementation of the plan of action on the Decade of African Traditional Medicine (2001-2010) were prepared for discussion by the African Ministers of Health in Geneva and Yaoundé in May and August 2008 respectively and by the meeting of experts and the Fourth Session of the Conference of African Ministers of Health (CAMH) in Addis Ababa in May 2009. The CAMH conference recommended that a final report on the review of the implementation of the plan of action on the Decade of African Traditional Medicine be submitted to the ministers for consideration in regard to the way forward.

179. With WHO support, the first edition of the *Nigerian herbal pharmacopoeia* was published in 2008. Chad carried out an inventory of traditional medicine recipes used for the management of malaria and diabetes. Nigeria also carried out an inventory of traditional medicine recipes for hypertension, sickle-cell anaemia and opportunistic infections of PLWHA. A regional strategic framework to strengthen local capacities in

traditional medicine production was developed. In collaboration with WAHO, the Regional Office supported a forum to review research data on West African medicinal plants for the development of the ECOWAS herbal pharmacopoeia.

180. A regional training course on Pharmaceutical Policy Analysis for Health Insurance Systems was organized in November 2008 in Ghana. The course was conducted in collaboration with the Ministry of Health, Noguchi Memorial Institute for Medical Research in Ghana and the WHO Collaborating Centre for Pharmaceutical Policy at Harvard Medical School. A total of 25 participants including Ministry of Health representatives and managers of national health insurance organizations drawn from 6 countries¹⁷³ attended the training course. Five countries¹⁷⁴ carried out assessment of medicines benefits and available data for decision making in health insurance organizations.

181. Forty-six medical engineering experts from the ministries of health of Kenya, Tanzania and Uganda participated in the advanced maintenance training for priority ministry of health clinical laboratory, medical imaging and intensive care and surgery equipment. Thirty-two engineering managers and senior ministry of health decision-makers received training in advanced health technology management and policy implementation.

182. Seventy-five nationals from 23 French-speaking and Portuguese-speaking countries¹⁷⁵ were trained in biosafety and laboratory biosecurity. The aim of the workshop was to build capacity to improve Africa's response in diagnosis of dangerous pathogens. Thirty nationals from 12 countries¹⁷⁶ were trained in the development of national systems for 100% quality-assured screening of donated blood for Transfusion-transmissible Infections (TTIs). During the workshop, strategies and plans for a Stepwise development of these systems were developed by the participants.

183. With WHO support, Medicine Regulatory Authorities were assessed in nine countries¹⁷⁷ and the development of plans of action to strengthen their capacity and implementation started. The quality control laboratory of the Democratic Republic of Congo was audited and quality control laboratories of six countries¹⁷⁸ participated in the WHO external quality assessment scheme for essential medicines. In general, the assessment indicated that 93% (40 out of 43) of all laboratories that participated in the assessment reported satisfactory results. A meeting of African medicines regulators was held in Maputo in November 2009 on how best to intensify approaches to improving the availability of essential medicines that meet safety, efficacy and quality standards and to operationalize the ongoing medicines regulation harmonization initiative in the Region.

That meeting, organized by the Regional Office in collaboration with the Ministry of Health of Mozambique, brought together 56 participants including the heads and officials of national medicines regulatory authorities from 40 countries and an expert invited from Brazil.

184. The regional haematology and clinical chemistry proficiency testing involving 16 countries¹⁷⁹ was conducted. Sixty-five per cent of the participating countries had generally good performance while the haematology and clinical chemistry proficiency testing schemes in the remaining countries need to be strengthened. Feedback and technical guidance were provided to countries that had inadequate performance. The external quality assessment schemes for enteric and meningitis pathogens, plague, tuberculosis and malaria involving 81 laboratories in all countries of the Region, except South Africa, were evaluated. The assessment of the EQA results showed that laboratories vary in performance. Antimicrobial susceptibility testing remains to be one of the major challenges. Feedback and technical guidance including standard operating procedures and selection of antibiotics were provided to those laboratories that were performing inadequately. In close collaboration with WHO headquarters, nine countries¹⁸⁰ were supported to establish their national external quality assessment schemes. An evaluation of quality management programmes in blood transfusion services and standardization of standard operating procedures and bench practices were carried out in Burkina Faso.

185. In close collaboration with Centers for Disease Prevention and Control (CDC/Atlanta) and other partners, a document entitled *Guide for National Public Health Laboratory Network to Strengthen Integrated Disease Surveillance and Response* was published. The document provides guidance on the establishment of national laboratory networks. A report on the *Status of blood safety in the WHO African Region* was published. The report provides information for evidence-based planning and implementation to achieve universal access to safe blood supply in the African Region.

186. The Fifty-eighth session of the WHO Regional Committee for Africa adopted a document on *"Patient safety in the African health services: issues and solutions"* and passed Resolution AFR/RC58/R2 on *Strengthening public health laboratories in the WHO African Region: a critical need for disease control*. Recommendations and strategic decisions were made to implement measures to promote and protect patient safety and strengthen public health laboratories. Nine countries¹⁸¹ were thus supported to set up a regional network for patient safety. The network was used to mobilize health policy-makers in the Region to address patient safety issues in their health care settings.

187. The African Partnerships for Patient Safety was launched to support six countries.¹⁸² This project aims to establish sustainable partnerships focusing on patient safety and will be aligned with each country's individual health policy framework.

188. A regional consultation on cells, tissue, and organ donation and transplantation: legal and organizational aspects, was held in Abuja, Nigeria, from 29 to 31 July 2009. Eighteen specialists and policy-makers from 11 countries¹⁸³ participated in the consultation. The participants were given guidance on the development of legal framework and regulatory oversight for organ transplantation to avoid unethical practices such as commercialism, organ trafficking and transplant tourism.

189. Technical support was provided to Swaziland in setting standards, rules and regulations for use of ionizing radiation and for setting up a radiation board at the Raleigh Fitkin Memorial Hospital in Manzini. Furthermore, recommendations were provided to the Ministry of Health for overall improvement of the quality of diagnostic imaging services across the country.

4.12 SO12: LEADERSHIP, GOVERNANCE AND PARTNERSHIP

190. The focus of action during the biennium was on supporting leadership, partnership and resource mobilization for health in countries and at the regional level. This was done through strengthening WHO's leadership and governance and providing strong assistance to countries and partners. Emphasis was put on coherent support to national health policies and strategic plans for example through strengthened engagement in the UN Reform and implementation of the Country Cooperation Strategies.

191. Several high-level advocacy visits were undertaken to countries with a view to improving the prioritization of health in national development agendas. The Regional Director paid official visits to Member States during which policy-makers were sensitized and relationships with WHO were strengthened. Major conferences leading to the adoption of landmark declarations were organized.

192. Decentralization efforts continued during the biennium. The capacity of Intercountry Support Teams (ISTs) to provide rapid response by way of technical support was consolidated and strengthened. The ISTs provided to countries normative and technical support in MDG-related programmes and in other public health domains.

193. An induction course was conducted for newly-appointed and potential WHO country representatives in order to improve their performance in leadership, negotiation, management and technical support to countries. Furthermore, the policy of rotation and mobility of WHO country representatives and senior staff was implemented in line with the WHO country focus policy and reforms. The knowledge and understanding of WHO country representatives in key policy and strategic matters were improved through the organization of four Regional Programme Meetings and provision of regular updates by the Regional Office.

194. Forty-five country offices completed their second-generation Country Cooperation Strategy (CCS) documents which were widely disseminated among health development actors in countries. Efforts were undertaken to align the CCSs, the health dimension of the UNDAF and the other partnership platforms with national health strategies and plans in accordance with the principles of Aid harmonization, alignment and effectiveness.

195. In regard to the governing bodies' activities, the Fifty-eighth and Fifty-ninth sessions of the WHO Regional Committee for Africa were successfully held in Yaounde, Cameroon and Kigali, Rwanda, respectively. Nine resolutions related, *inter alia*, to women's health; strengthening public health laboratories; Ouagadougou Declaration on Primary Health Care and Health Systems in Africa; drug resistance related to AIDS, tuberculosis and malaria; strengthening outbreak preparedness in the African Region including the establishment of an 'African Public Health Emergency Fund to support investigation of, and response to, epidemics and other public health emergencies; and migration of health personnel, were adopted.

196. The participation of the delegates of Member States of the African Region in four sessions of the Executive Board and two World Health Assemblies was strongly facilitated by the Secretariat. Technical briefings notes were shared with all delegations. The preparation and participation of Member State delegations improved as a result of the revised procedures adopted during the biennium, with closer collaboration between the Regional Office, the African Union and the African Group Coordinator in Geneva.¹⁸⁴

197. Partnership for health in Africa was strengthened through participation in key events organized by partners such as the African Union (AU), regional economic communities and EC/ACP/WHO. These events included the 14th Ordinary Session of the Executive Council of the AU and 12th Ordinary Session of the AU Assembly, the 12th World Congress on Public Health, the meetings of the UNDG Regional Groups in East and Southern Africa and in West and Central Africa as well as the AU Conference of African Ministers of Health.

198. The Regional Office developed and published strategy documents on Partnerships and Resource Mobilization, covering the period 2009–2013. These publications will guide actions with partners at country and regional levels. The capacity of the WHO Regional Office, ISTs and country offices in Partnership and Resource Mobilization was strengthened through a series of workshops including training sessions held in four countries.¹⁸⁵

199. During the reporting period, WHO was more actively engaged in health partnership processes and mechanisms. This includes chairing or co-chairing health partners' groups, being increasingly in the front line in health in many countries and leading the work of UNDAF health thematic group and UN Country Teams in health. Concrete outcomes included improved coordination of the activities of the Health Cluster within the UNDG Regional Groups.

200. There was improved collaboration with several partners including the GAVI Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Health Workforce Alliance. Work on the International Health Partnership+ and Harmonization for Health in Africa (HHA) became more visible by providing coordinated support to countries. The number of partners (development partners, civil society, partner countries and related initiatives such as GAVI Alliance, Global Fund, Bill and Melinda Gate Foundation) having signed IHP+ at global level has increased since 2007 from 27 to 46, of which 17 are partner countries from the African Region.¹⁸⁶ Four countries¹⁸⁷ signed local compacts with their partners. In terms of HHA activities, Joint technical support was provided to 18 countries¹⁸⁸ to develop or review Medium-Term Expenditure Frameworks (MTEF), donor mapping, costing and budget reviews, health strategic plans, sector-wide approaches, poverty reduction strategy papers, joint results frameworks and human resources development plans.

201. A total of 38 agreements were signed in the Region between Member States and donors including Department for International Development (DFID), USAID, African Development Bank, African Broadcast Media Partnership, Winds of Hope Foundation and the Governments of Congo, France and Gabon. The implementation of donor agreements improved with more timely reporting and a higher rate of budget utilization.

202. The Regional Directors involved in HHA institutionalized their annual review meetings and the fourth session of their meetings was organized in 2009. In the last annual meeting held in Tunis in 2009, the ministries of health and finance met and initiated a dialogue expected to improve mutual understanding and collaboration between the two ministries and increase budget allocations to health in countries.

203. Information and communication activities undertaken at the Regional Office resulted in increased awareness of health issues in Member States and the profile of the WHO Regional Office remained high on the agenda of policy-makers, partners, the media and the general public. A communications strategy was developed. With the growing interest in Pandemic Influenza A (H1N1) 2009, the communications team focused on the development of pandemic advocacy materials and intensified interaction with the media. The Regional Office established a new form of collaboration and partnership by working with two major regional broadcasters that have outlets in all 46 Member States. Press conferences greatly increased the outreach of the materials produced.

4.13 SO13: EFFICIENT AND EFFECTIVE WHO

204. In order to foster successful implementation of WHO technical cooperation with countries, emphasis was placed on compliance with operational planning guidelines; timely provision of services for financial and human resource management; improvement in the performance of the Information and Communication Technology infrastructure; and proper management of administrative, logistic and security support services in the working environment.

205. Following the amendment of the MTSP 2008–2013, the introduction of new rules and procedures of the WHO managerial framework and preparations for deployment of GSM in the Region, systematic briefing sessions were organized for staff members. This resulted in increased conformity with the planning processes and the use of clear evidence for performance monitoring and reporting functions.

206. Concerning Programme Budget monitoring and assessment processes, the quality of contributions and the timeliness of reporting improved significantly especially as regards WHO country offices, Inter-country Support Teams and the Regional Office programmes' mandatory reporting such as the Mid-term Review and End-of-Biennium Assessment.

207. With the assistance of a professional accounting firm, a reconciliation of staff personal accounts was conducted, leading to a reduction of staff personal account balances. The work of data cleansing continued in preparation for the introduction of GSM in the Region. In order to meet the requirements of the newly-introduced changes in financial regulations, revised and user-friendly tools were developed and disseminated.

208. In the area of Human Resources Management (HRM), the main activities during the biennium included: (i) provision of continuous support to Technical Divisions, WHO country offices and staff in general; (ii) establishment of a regional learning network and the development and implementation of learning and training plans; (iii) processing of approximately 1100 Personnel Actions into GSM as a result of new appointments made in 2007 and early 2008; (iv) interactions with the newly established Global Service Centre, Kuala Lumpur, to carry out further Human Resources transactions in GSM; (v) consolidation of the Human Resources Teams in the ISTs and; (vi) support to re-profiling exercises.

209. Achievements included the conversion of the majority of temporary appointments into fixed-term appointments; organization of formal staff award ceremonies during the Fifty-eighth and Fifty-ninth sessions of the WHO Regional Committee for Africa; consolidation of the regional learning network; organization of training courses in a variety of areas including language courses in English, French and Portuguese, the three official languages of the WHO African Region; training in HIV/AIDS prevention measures for staff and their dependants; management courses for mid-level managers and senior General Services staff; and organization of GSM awareness workshops.

210. Financial support was provided to WHO country offices for the implementation of staff training and learning activities; the development of a mandatory induction programme for staff; further decentralization of human resources transactions to the Inter-country Support Teams.

211. In the area of Information and Communication Technology (ICT), efforts to prepare the WHO African Region in readiness for GSM continued. This involved the collaboration of ICT staff in the Region and WHO headquarters as well as private companies and the support of global IT companies such as CISCO, Microsoft and Hewlett-Packard. By the end of the biennium, the entire Region was ready for GSM in the area of ICT. In this regard, a new computer and telephone network became operational; desktop personal computers in the Regional Office were standardized; management of the Global Private Network (GPN) traffic was improved; the Regional Office Integrated Health Database systems were extended to all technical divisions and its web interface improved; a regional ICT profile database was prepared; and WCOs were connected to GSM.

212. In the area of Administrative and Logistic Support services, key achievements during the biennium included the provision of support to more than 80 meetings including the Fifty-eighth and Fifty-ninth sessions of the Regional Committee. At the Regional

Office, a new cafeteria and new sporting facilities were built and equipped including a children's playground at the Apartment Complex. In addition, meeting rooms were refurbished and equipment upgraded in order to improve staff working conditions. The software "Inventif" was installed in WHO country offices in order to improve tracking and control of the assets of the Organization.

213. In the area of Procurement and Supply, essential goods and services were procured for the Regional Office, country offices, programmes and projects. Global procurement was done through GSM as from July 2008, opening more opportunities for obtaining cost-effective services. The Regional Catalogue for procurement was updated and expanded in 2008, leading to more competitive bidding processes.

214. In the area of Compliance and Oversight, assistance was provided to WHO country offices and technical units in the Regional Office. This involved internal and external audits to better prepare them for external auditors' visits and to comply adequately with audit findings and observations. Two internal audit reports dating back to 2003 for Nigeria and 2008 for Cameroon and Malawi were finally brought to closure during the biennium.

215. As a result of random monitoring and verification of commitments made under Agreements for Performance of Work, Technical Services Agreements, and purchase orders issued by WCOs, ISTs and Technical Units at the Regional Office, the Region was better prepared for compliance with regulations and rules.

216. With regards to the Translation, Interpretation, Printing and Library Services, 247 statutory and technical information products were issued in the three official languages. Support was provided to meetings of WHO Governing Bodies and major international conferences. Word processing equipment and language reference sources were upgraded. In order to further improve management of publications, a work flow tracking system based on the PAHO model was developed.

217. Concerning Field Security operations, in addition to the Regional Office, technical assistance was provided to country offices, including support missions to four countries.¹⁸⁹ At the Regional Office, the physical security infrastructure continued to be upgraded. Staff awareness of security matters increased with the dissemination of security advisories and the organization of briefing and training sessions and workshops. Implementation of MOSS and MORSS standards and requirements in the Regional Office and WHO country offices continued during the biennium. Five WHO country offices¹⁹⁰ received funding to strengthen their security measures as required under the MOSS policy.

5. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT

5.1. CHALLENGES AND CONSTRAINTS

218. The work of WHO in the African Region has been largely influenced by the high burden of diseases and the weakness of health systems in countries. In this context, Member States continue to face many challenges in improving the health of their population. These challenges include ensuring good governance, country ownership and accountability; improving the availability and efficient use of internal and external resources allocated to health and adequately addressing the broader determinants of health.

219. Some of the constraints in countries include the global economic downturn; poor economic performance leading to inadequate resource allocation to health; political instability; natural disasters; household poverty; unpredictability of external resources and their lack of harmony and alignment to country priorities; and limited capacity to translate health policies into action in some countries.

220. Addressing the shortage of the health workforce remains a key challenge for Member States. The low budgetary allocation to the health sector is one of the constraints to production, deployment, retention and motivation of health workers. The limited capacity of health training institutions does not allow sufficient and consistent replenishment of the dwindling human resources for health due mainly to attrition and the growing needs of the populations. Difficult working conditions characterized by heavy workloads, lack of equipment, low salaries and diminishing opportunities for advancement are other key challenges contributing to demotivation and poor performance of health workers in countries. The situation is worse in rural areas as compared to urban areas.

221. In order to improve access to and use of existing health services and to protect the population from catastrophic health expenditures, one of the challenges for Member States is to institute financial protection schemes through mechanisms that pool risks such as health insurance. In the absence of such schemes health services especially at local level remain financially inaccessible to large proportions of the population.

222. Improving the availability of inexpensive and safe medicines to reduce dependency on counterfeit and/or overpriced medicines, and unregulated outlets poses another challenge. Access to quality medicines and other technologies needs to be improved to address inappropriate use of low-quality medicines and to prevent the emergence of drug-resistance.

223. Reaching the MDGs remains a challenge as most countries in the African Region have not made sufficient progress. Only six countries are on track to achieve Goal 4 (Reduce child mortality). Estimates of maternal mortality ratio for 2005 indicate that the Region has made no progress towards achieving Goal 5 (Reduce maternal mortality). Although there has been an improvement in access to treatment, only 40% of the population with advanced HIV infection in the Region had access to antiretrovirals (Goal 6). While there has been an increase in the proportion of under-five children sleeping under insecticide-treated nets, coverage rates were lower than 50% (Goal 6). Only two countries were on track to achieve the target for tuberculosis.

224. In the area of vaccine-preventable diseases, the persistent gaps in immunization and the quality of surveillance data continue to be among the major challenges in many countries. Several countries still face the challenge of sustaining high levels of immunization coverage through routine and outreach services and supplemental immunization campaigns.

225. With regard to HIV/AIDS, tuberculosis and malaria, the key challenges are (i) sustaining political commitment to scaling up and expanding services across all population groups, particularly the most-at-risk populations in order to move towards universal access; (ii) adequately addressing the human resource crisis in countries in the short, medium and long term; (iii) strengthening laboratory capacity to perform basic tests and undertake drug resistance monitoring; (iv) improving procurement and supply systems to avoid frequent stock-outs of life-saving medicines; and (v) preventing the development of drug resistance.

226. In the area of maternal health, one of the key challenges is to increase the proportion of deliveries assisted by skilled attendants and improve access to emergency obstetric care. An outstanding challenge in child health is to scale up and sustain the implementation of all components of integrated child survival interventions and adopt the Reaching-Every-District approach while ensuring adequate monitoring in all countries.

227. Concerning the promotion and sustenance of a healthy environment, one key constraint has been insufficient expertise particularly at country level. The challenge is for the health sector to assume leadership in coordinating the efforts of all stakeholders and partners in such a cross-cutting area that requires an effective inter-sectoral and participatory approach.

228. Difficulties in changing the behaviours and lifestyles of individuals presented the most daunting challenge to the promotion of health and development and the prevention or reduction of risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances; unhealthy diets; physical inactivity; unsafe sex; and violence and injury. Ageing of the population in most countries in the Region is expected to pose a challenge in the near future with regard to the prevention and management of noncommunicable diseases.

229. The global food crisis continues to pose a challenge to efforts to reduce the problems associated with appropriate nutrition and food safety in the Region. With regards to addressing other social and health determinants, the absence of reliable data on the current situation, the lack and/or limited capacity of staff working in this area, the complexity of the issue and limited awareness are some of the challenges. In addition, the health sector faces problems in collaborating adequately with other relevant sectors such as education, environment, agriculture, animal health, trade and finance, etc. to ensure that their policies and actions contribute to health development and their strategies address cross cutting areas such as poverty and gender inequality.

230. While supporting Member States to address their key challenges, the WHO Secretariat faces its own specific and key challenges which include:

- (a) mobilizing adequate financial resources to enable it to carry out its core functions effectively and efficiently;
- (b) meeting the increasing demands of Member States and development partners, which go beyond the WHO core functions, in a context of limited resources;
- (c) responding to the competing demands of Member States for unplanned but important activities.

231. In working with partners, key constraints the WHO Secretariat faces include late disbursements of funds; limited duration and lack of flexibility in the use of donor funding; lack of donor interest in critical areas such as research, surveillance and information systems; and short lead-times for co-organizing technical support missions to countries.

5.2 LESSONS LEARNT

232. Strengthening multisectoral collaboration is required to effectively support Member States to implement priority programmes. The health sector can influence other sectors through generating and sharing evidence to inform their policies and actions.

233. The inclusion of high-impact interventions in country proposals for GFATM and other global health initiatives has the potential to expand and strengthen the resource base available for implementing a wide range of health programmes including health systems.

234. The changing global health landscape and architecture requires that WHO adapts to new realities, focuses on its core functions and expands strategic partnerships and alliances, as needed, in order to effectively carry out its mandate.

235. Given the global economic crisis, the availability of voluntary funds will continue to be unpredictable and much below the budget ceilings adopted by the World Health Assembly even in priority areas. WHO's continued dependence on voluntary contributions from donors for the implementation of the Programme Budget calls for the identification of sustainable and predictable funding sources.

236. The presence of competent technical staff in the WHO country offices, Inter-country Support Teams and the Regional Office, the delegation of authority and the availability of appropriate guidelines and tools were critical for assuring WHO's continued leadership role and visibility in health and for delivering quality support in response to countries' requests.

6. CONCLUSION

237. Despite the global economic recession and the food crisis, major achievements were made in the implementation of the WHO Programme Budget 2008–2009. At the political and policy levels, landmark declarations on strengthening health systems and scaling up high-impact interventions were adopted by Member States in order to improve the health status of the African people.

238. WHO played its leadership role in health in the Region through continued advocacy at all levels, decentralization of some technical cooperation functions from the Regional Office to the Intercountry Support Teams and strengthening its presence in countries. Other areas that saw improvements include governance; partnerships; resource mobilization; accountability; and timely communication with Member States, partners and other stakeholders in areas of common interest.

239. WHO will continue advocacy among national authorities and partners for governments to take up strong country ownership and leadership for accelerated, evidence-based and comprehensive scaling up of proven cost-effective interventions for primary prevention and control of AIDS, malaria and tuberculosis, the reduction of maternal and child mortality and the prevention and control of other communicable diseases and noncommunicable diseases. WHO will also advocate for increased domestic resources and the engagement of international partners in mobilizing resources for health systems strengthening in line with the Primary Health Care approach and to deliver primary health programmes that promote universal coverage towards achieving the MDGs.

240. WHO will continue strengthening and focusing on its core functions. An African Health Observatory aimed at improving the monitoring of health status and trends and the generation, sharing and use of information, evidence and knowledge to inform policy and decision-making will be established at the Regional Office.

241. For even greater effectiveness in the work of WHO in the African Region, increased priority will be given to the identification and mobilization of more sustainable funding to meet the increasing demands of Member States. One such effort by the Regional Office will be to facilitate the establishment of the proposed African Public Health Emergency Fund. In addition to other measures, coordination and collaboration within the WHO Secretariat for joint missions to countries will be reinforced to ensure efficient use of available resources.

242. Opportunities have clearly emerged on the horizon as we enter the new biennium. Health is now recognized as central to development. This is evident in the several global and regional commitments to health such as the Millennium Development Goals (MDGs) and the drive towards Universal Access to high impact health interventions. At country level, health now features in national instruments for economic and social development such as the Poverty Reduction Strategies. Making good use of all these opportunities will augur well for health development in the WHO African Region.

ANNEX 1: WHO MEDIUM TERM STRATEGIC PLAN 2008–2013: STATEMENT OF STRATEGIC OBJECTIVES

1.	To reduce the health, social and economic burden of communicable diseases.
2.	To combat HIV/AIDS, malaria and tuberculosis.
3.	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
4.	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
5.	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
6.	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
7.	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.
8.	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.
9.	To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.
10.	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.

11.	To ensure improved access, quality and use of medical products and technologies.
12.	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work. combat HIV/AIDS, malaria and tuberculosis.
13.	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

ANNEX 2: APPROVED PROGRAMME BUDGET ALLOCATION BY STRATEGIC OBJECTIVE, SOURCE OF FINANCING AND DISTRIBUTION BETWEEN WHO COUNTRY OFFICES AND THE REGIONAL OFFICE (IN US\$ 000s):

Strategic Objective N°	Assessed Contribution	Voluntary contribution	Total approved budget	Total country approved budget	Total regional approved budget
1	20 049	296 154	316 203	130 422	185 781
2	11 364	231 548	242 912	144 179	98 733
3	9869	10 854	20 723	11 958	8765
4	18 748	96 947	115 695	49 461	66 234
5	4172	61 849	66 021	47 502	18 519
6	10 118	15 448	25 566	12 926	12 640
7	6128	2988	9116	4995	4121
8	5857	12 892	18 749	9324	9425
9	5162	34 616	39 778	17 994	21 784
10	23 059	119 034	142 093	84 072	58 021
11	6411	16 181	22 592	13 217	9375
12	35 704	13 262	48 966	37 372	11 594
13	56 701	68 825	125 526	42 935	82 591
Total	213 342	980 598	1 193 940	606 357	587 583

ENDNOTES

1. Internal Displacement: Global Overview of Trends and Developments in 2009. Internal Displacement Monitoring Center, Norwegian Refugee Council; May 2010.
2. 2008 Global Trends: Refugees, Asylum Seekers, Returnees, Internally Displaced and Stateless Persons; June 2010.
3. Figures includes Sudan and Somalia.
4. Black RE, Allen LH, Bhutta ZA, et al. Maternal and child undernutrition: global and regional exposures and health consequences: The Lancet, Volume 371, Issue 9608, Pages 243–260.
5. World Health Organization: Document EB118/7/2006, Strategic resource allocation.
6. Algeria, Benin, Botswana, Burkina Faso, Burundi, Gambia, Ghana, Liberia, Malawi, Mauritius, Mozambique, Rwanda, Sao Tome and Principe, Seychelles and South Africa.
7. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Eritrea, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Rwanda, Sao Tome and Principe, Seychelles, South Africa, Tanzania, Zambia and Sierra Leone.
8. Algeria, Botswana, Comoros, Eritrea, Gambia, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Togo, Zambia and Zimbabwe.
9. Benin, Burkina Faso, Cameroon, Central African Republic, Liberia, Mali, Senegal, Sierra Leone, and Togo.
10. Angola, Benin, Burkina Faso, Côte d'Ivoire, Central African Republic, Chad, Democratic Republic of Congo, Ethiopia, Ghana, Mali, Niger, Nigeria and Togo.
11. Benin, Burkina Faso, Côte d'Ivoire, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Sierra Leone and Togo.
12. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Togo, Uganda and Zambia.
13. Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Eritrea, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Seychelles, Swaziland, Tanzania, Togo, Uganda and Zambia.

14. Botswana, Burundi, Congo, Eritrea, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Mauritania, Namibia, Rwanda, Senegal, Sierra Leone, Seychelles, South Africa, Swaziland, Togo, Uganda, Zambia and Zimbabwe.
15. Burundi, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Sierra Leone, Togo and Uganda.
16. Benin, Burkina Faso, Comoros, Gambia, Ghana, Guinea-Bissau, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Sierra Leone, Tanzania, Togo and Uganda.
17. Angola, Benin, Burkina Faso, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Sao Tome and Principe, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
18. Botswana, Cameroon, Central African Republic, Chad, Democratic Republic of Congo, Eritrea, Mauritania, Namibia, Nigeria, Senegal and Swaziland.
19. Benin, Cameroon, Chad, Comoros, Equatorial Guinea, Eritrea, Guinea, Guinea-Bissau, Kenya, Madagascar, Mozambique, Nigeria, Sao Tome and Principe, Senegal, Tanzania, Togo and Zambia.
20. Algeria, Mauritius, Seychelles and Sierra Leone.
21. Benin, Botswana, Burkina Faso, Cape Verde, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Malawi, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Seychelles and Zimbabwe.
22. Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Eritrea, Kenya, Sierra Leone and Uganda.
23. Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, WHO/UNAIDS/UNICEF, 2009.
24. UNAIDS/WHO 2009 AIDS epidemic update, November 2009.
25. Botswana, Namibia, Swaziland and Tanzania.
26. Botswana, Burundi, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
27. WHO/UNAIDS/UNICEF: Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. September 2009.
28. Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Ethiopia, Gabon, Guinea, Kenya, Mali, Mozambique, Namibia, Tanzania, Chad, Togo, Uganda, Zambia and Zimbabwe.

29. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sao Tome and Principe, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
30. Botswana, Ethiopia, Lesotho, Kenya, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
31. Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
32. Algeria, Angola, Benin, Cameroon, Kenya, Namibia, Sao Tome and Principe, South Africa and Tanzania.
33. Algeria, Benin, Democratic Republic of Congo, Eritrea, Kenya, Mauritius, Rwanda, Sierra Leone, Tanzania and Zambia.
34. Algeria, Benin, Kenya and Tanzania.
35. Ethiopia, Kenya, Nigeria, Rwanda, South Africa and Zambia.
36. Algeria, Angola, Cameroon, Kenya, Namibia, Sao Tome and Principe, and South Africa.
37. Algeria, Benin, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Kenya, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Sierra Leone, Sychelles, Tanzania and Zambia.
38. Algeria, Democratic Republic of Congo, Eritrea, Kenya, Mauritius, Rwanda, Sierra Leone, Tanzania, and Zambia.
39. Algeria, Kenya, Tanzania, and Zambia
40. Benin, Burkina Faso, Burundi, Cameroon, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Swaziland, Tanzania, Togo, Uganda and Zambia.
41. Burkina Faso, Cameroon, Democratic Republic of Congo, Ethiopia, Guinea, Kenya, Lesotho, Liberia, Mozambique, Nigeria, Rwanda, Senegal, Swaziland, Tanzania, Uganda and Zambia.
42. Democratic Republic of Congo, Kenya, Malawi, Tanzania and Zambia.

43. Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central Africa Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
44. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
45. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Congo, Cote d Ivoire, DR Congo, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritanie, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, Seychelles, Sierra Leone, Swaziland, Tanzania, Togo, Uganda and Zambia.
46. Botswana, Burkina Faso, Kenya, Mozambique, Lesotho, Namibia, South Africa and Swaziland.
47. Botswana, Burkina Faso, Kenya, Lesotho, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe.
48. Angola, Botswana, Burkina Faso, Burundi, Chad, Gabon, Kenya, Namibia, Democratic Republic of Congo, Rwanda, Sao Tome and Principe, Senegal, South Africa, Zambia and Zimbabwe.
49. Angola, Eritrea, Ethiopia, Kenya, Mozambique, Namibia, Rwanda, Senegal, Tanzania, Zambia and Zimbabwe.
50. Burundi, Ethiopia, Ghana, Mali, Rwanda, Senegal, Sierra Leone, Tanzania, Togo, Uganda and Zambia.
51. Ethiopia, Equatorial Guinea, Gabon, Guinea-Bissau, Kenya, Madagascar, Rwanda, Sao Tome and Principe, Sierra Leone, Tanzania Mainland, Zanzibar (Tanzania) and Zambia.
52. Algeria, Angola, Botswana, Equatorial Guinea, Ethiopia, Madagascar, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zanzibar (Tanzania) and Zimbabwe.
53. Botswana (38%), Equatorial Guinea (56%), Ethiopia (51%), Madagascar (32%), Mozambique (30%), Namibia (16%) and Zambia (47%).
54. 2006: Benin, Cameroon, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Malawi, Mauritania, Senegal, Togo, Uganda, Zambia. 2007: Angola, Democratic Republic of Congo, Kenya, Liberia, Zambia. 2008. Equatorial Guinea, Gabon, Ghana, Rwanda, Tanzania, Togo, Zambia and Zanzibar (Tanzania).

55. Angola, Benin, Botswana, Cameroon, Chad, Congo, Democratic Republic of Congo, Eritrea, Gabon, Gambia, Equatorial Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
56. Botswana, Eritrea, Ethiopia, Kenya, Rwanda, Sao Tome and Principe, South Africa and Swaziland.
57. Botswana, Burundi, Bioko Island (Equatorial Guinea), Eritrea, Ethiopia, Gambia, Kenya, Madagascar, Rwanda, Sao Tome and Principe, South Africa, Swaziland, Zambia and Zanzibar (Tanzania).
58. Botswana, Côte d'Ivoire, Eritrea, Namibia, Rwanda, Sao Tome and Principe, Swaziland, Zambia and Zanzibar (Tanzania).
59. Benin, Ghana, Kenya, Madagascar, Niger, Nigeria, Rwanda, Tanzania, Uganda and Zanzibar (Tanzania).
60. Angola, Benin, Botswana, Burkina Faso, Cape Verde, Central Africa Republic, Chad, Guinea-Bissau, Ghana, Liberia, Mali, Mozambique, Sierra Leone, South Africa, Tanzania, Togo and Uganda.
61. Cape Verde, Mauritania, Senegal, Seychelles and Zambia.
62. Kenya, Malawi, Namibia and Tanzania.
63. Angola, Cameroon, Congo, Chad, Democratic Republic of Congo, Gabon, Guinea-Bissau, Mauritania, Niger, Sao Tome and Principe, and Togo.
64. Botswana, Eritrea, Gabon, Ghana, South Africa, Uganda and Zambia.
65. Burundi, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Liberia and Nigeria.
66. Cameroon, Democratic Republic of Congo, Ethiopia, Kenya, Mali, Nigeria, Senegal, Uganda and Zambia.
67. Angola, Benin, Botswana, Burkina Faso, Cameroon, Central Africa Republic, Chad, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Togo, Uganda and Zambia.
68. Botswana, Burkina Faso, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Sierra Leone, Tanzania, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania Uganda and Zambia.
69. Botswana, Burkina Faso, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Lesotho, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.

70. Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
71. Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central Africa Republic, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
72. Ethiopia, Gabon, Ghana, Kenya, Malawi, Nigeria and Zambia.
73. Benin, Botswana, Burundi, Burkina Faso, Cameroon, Cote d' Ivoire, Democratic Republic of Congo, Ethiopia, Eritrea, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Seychelles, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
74. Ghana, Lesotho, Nigeria, Sierra Leone and Zambia.
75. Benin, Botswana, Cameroon, Democratic Republic of Congo, Guinea-Bissau, Guinea, Central African Republic, Kenya, Malawi, Namibia, Nigeria, Senegal, South Africa and Uganda.
76. Ethiopia, Ghana, Kenya, Malawi and Zambia.
77. Botswana, Eritrea, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.
78. Cameroon, Côte d'Ivoire, Gabon, Ghana, Guinea, Liberia, Madagascar, Sierra Leone, Tanzania and Zambia.
79. Botswana, Burkina Faso, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, Tanzania, Togo and Uganda.
80. Burkina Faso, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Malawi, Mali, Senegal, South Africa, Tanzania and Togo.
81. Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Malawi, Mali, Mauritania, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, Togo and Zambia.
82. Algeria, Benin, Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Togo and Zimbabwe.

83. Angola, Ethiopia, Malawi, Mozambique, Sierra Leone and Rwanda.
84. Benin, Botswana, Burkina Faso, Burundi, Chad, Congo, Côte d'Ivoire, Ghana, Kenya, Liberia, Madagascar, Niger, Nigeria, Sierra Leone and Zambia.
85. Angola, Botswana, Burundi, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.
86. Benin, Botswana, Burkina Faso, Burundi, Congo, Cameroon, Côte d'Ivoire, Ghana, Equatorial Guinea, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Mali, Mauritania, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda and Zambia.
87. Botswana, Eritrea, Gabon, Ghana, Kenya, Lesotho, Madagascar, Malawi, Namibia, Nigeria, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
88. Angola, Benin, Burkina Faso, Burundi, Ghana, Kenya, Liberia, Malawi, Mali, Niger, Senegal, South Africa and Tanzania.
89. Framework for Integrated Community-level Health promotion Interventions in support of priority WHO programs; guide for Recommendations for clinical practice for emergency obstetric and neonatal care (RPC), Home based New born Care training materials for CHW.
90. Angola, Burkina Faso, Ethiopia, Ghana, Malawi, Nigeria and Tanzania.
91. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
92. Angola, Benin, Burkina Faso, Ethiopia, Gambia, Kenya, Madagascar, Malawi, Niger, Rwanda and Uganda.
93. Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Liberia, Mali, Mauritania, Nigeria and Senegal.
94. Côte d'Ivoire, Kenya, Liberia, Malawi, Mauritania, Senegal, Sierra Leone and Zambia.
95. Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.
96. Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Niger, Nigeria, Liberia, Sierra Leone and Zambia.

97. AFR/RC54/R2: Repositioning family planning in reproductive health services: Framework for accelerated action, 2005–2014. In: Fifty-fourth Session of the WHO Regional Committee for Africa, Brazzaville, Republic of Congo, 30 August–3 September 2004, Final Report, Brazzaville, World Health Organization, Regional Office for Africa, 2004 (AFR/RC54/19), pp. 9–11.
98. Angola, Botswana, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Mauritania, Mozambique, Nigeria, Senegal, Sierra Leone, Togo, Zambia and Zimbabwe.
99. Angola, Botswana, Lesotho, Liberia, Mozambique, Nigeria, Gambia, Ghana, Guinea, Senegal, Sierra Leone and Zambia.
100. Benin, Cameroon, Côte d'Ivoire, Gabon, Guinea, Mauritania, Senegal, and Tanzania.
101. Angola, Central African Republic, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon, Guinea-Bissau, Mozambique and, Sao Tome and Principe.
102. Botswana, Cape Verde, Eritrea, Malawi, Mauritius and Seychelles.
103. Burkina Faso, Gambia, Ghana, Kenya, Lesotho, Liberia, Mozambique, Rwanda, South Africa, Swaziland and Tanzania.
104. Burundi, Côte d'Ivoire, Liberia, Uganda and Zimbabwe.
105. Burundi, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Niger, Uganda and Zimbabwe.
106. Central African Republic, Chad, Democratic Republic of Congo and Uganda.
107. Angola, Benin, Botswana, Eritrea, Ghana, Madagascar, Mozambique and Senegal.
108. Angola, Benin, Burkina Faso, Cape Verde, Central African Republic, Chad, Guinea-Bissau, Mali and Togo.
109. Cameroon, Ethiopia, Kenya, Malawi, Nigeria, Rwanda, Tanzania and Uganda.
110. Malawi, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Zimbabwe.
111. Algeria, Burkina Faso, Gambia and Kenya.
112. Eritrea, Ethiopia, Gambia, Guinea, Kenya, Lesotho, Liberia and Mozambique.
113. Libreville Declaration on Health and Environment in Africa, Libreville, 29 August 2008.

114. UNICEF and WHO – A snapshot of drinking water and sanitation in Africa. Prepared for AMCOW as a contribution to the African Union Summit on Water Supply and Sanitation, 30 June–2 July 2008.
115. Benin, Burkina Faso, Côte d'Ivoire, Liberia and Togo.
116. Burundi, Comoros, Côte d'Ivoire, Guinea and Kenya.
117. Burundi, Gambia, Ghana, Malawi, Namibia, Niger and Nigeria.
118. Benin, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.
119. Burundi, Côte d'Ivoire, Madagascar, Malawi, Uganda and Zimbabwe.
120. Botswana, Burkina Faso, Comoros, Equatorial Guinea, Chad, Ghana, Madagascar, Sao Tome and Principe, Sierra Leone, South Africa, Zimbabwe and Zambia.
121. Benin, Botswana, Cameroon, Central African Republic, Democratic Republic of Congo, Ghana, Guinea, Guinea-Bissau, Kenya, Malawi, Namibia, Nigeria, Senegal, South Africa and Uganda.
122. Benin; Botswana, Burkina Faso, Congo, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Kenya, Malawi, Mali, Niger, Nigeria, Senegal, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
123. Benin, Congo, Côte d'Ivoire, Gabon, Mali, Niger and Togo.
124. Ethiopia, Lesotho, Mozambique, Guinea-Bissau and Swaziland.
125. Burkina Faso, Comoros, Ghana, Madagascar, Mauritania, Niger, Sao Tome and Principe, and South Africa.
126. Gambia, Mauritania, Nigeria, Seychelles, Uganda and Zambia.
127. Ethiopia, Gabon, Ghana, Kenya, Malawi, Nigeria and Zambia.
128. Angola, Benin, Botswana, Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mauritania, Rwanda, Uganda and Zimbabwe.
129. Benin, Côte d'Ivoire, Gambia, Ghana, Seychelles and Uganda.
130. Ethiopia, Gambia, Guinea, Malawi, Mauritius, Rwanda, South Africa and Uganda.
131. Gambia, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mauritius Mozambique, Rwanda, and Seychelles.
132. Botswana, Eritrea, Guinea, Kenya, Sierra Leone and Uganda.
133. Comoros, Eritrea, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mauritius, Nigeria, Rwanda and Uganda.

134. Benin, Burkina Faso, Burundi, Côte d'Ivoire, Gambia, Ghana, Guinea, Liberia, Mauritania, Mauritius, Niger, Rwanda, Senegal, Seychelles, Togo and Uganda.
135. Algeria, Benin, Côte d'Ivoire, Niger and Togo.
136. Angola, Cameroon, Comoros, Congo, Chad, Democratic Republic of Congo, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Mauritania, Mozambique, Rwanda, South Africa, Togo and Uganda.
137. Angola, Gambia, Lesotho and Mali.
138. Comoros, Democratic Republic of Congo, Guinea, Malawi, Mali and Togo.
139. Resolution AFR/RC58/R3, The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. In: Fifty-eighth Session of the WHO Regional Committee for Africa, Yaounde, Republic of Cameroon, 1–5 September 2008, Final Report. Brazzaville, World Health Organization, Regional Office for Africa, 2008 (AFR/RC58/20) pp. 13–15.
140. Angola, Guinea, Mozambique and Nigeria.
141. Burkina Faso, Burundi, Cape Verde, Eritrea, Guinea, Guinea-Bissau, Lesotho, Malawi, Mauritania, Niger, South Africa, Swaziland and Tanzania.
142. Congo, Ethiopia, Mauritania and Swaziland.
143. Benin, Côte d'Ivoire, Eritrea, Guinea-Bissau, Sierra Leone, Swaziland and Togo.
144. Ghana, Kenya, Lesotho, Madagascar, Uganda and Zambia.
145. Benin, Burkina Faso, Burundi, Ethiopia, Mali, Niger, Nigeria and Senegal.
146. Botswana, Comoros, Eritrea, Lesotho, Madagascar, Mozambique, Namibia, Swaziland and Zimbabwe.
147. Ethiopia, Malawi, South Africa, Tanzania, Uganda and Zambia.
148. Burkina Faso, Ghana, Rwanda and Uganda.
149. Angola, Benin, Burkina Faso, Burundi, Congo, Côte d'Ivoire, Eritrea, Gabon, Guinea, Lesotho, Mauritania, Mauritius, Namibia, Niger, Sao Tome and Principe, Senegal, Swaziland, Tanzania and Zimbabwe.
150. Accessed from <http://portfolio.theglobalfund.org/?lang=en>.
151. Botswana, Cameroon, Eritrea, Kenya, Seychelles, Sierra Leone, Rwanda and Zimbabwe.
152. Kenya, South Africa, Swaziland and Zambia.
153. Benin, Cameroon, Central African Republic, Chad, Congo, Gambia, Madagascar, Mali, Mauritania and Zimbabwe.

154. Benin, Burkina Faso, Cape Verde, Gambia, Mali, Niger, Sierra Leone and Zambia.
155. PALOP: Países Africanos de Língua Oficial Portuguesa. The group of five African countries where Portuguese language is the official language: Angola, Cape Verde, Guinea-Bissau, Mozambique and, Sao Tome and Príncipe.
156. Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritius, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
157. Workshops held in Burkina Faso, Burundi, Cameroon, Kenya and Senegal.
158. Burkina Faso, Burundi, Cameroon, Congo, Cape Verde, Gambia, Guinea, Guinea-Bissau, Mali, Mauritania, Mozambique, Niger, Senegal and Togo.
159. Burkina Faso, Burundi, Liberia, Malawi, Mozambique, Niger, Nigeria, and Senegal.
160. Benin, Burkina Faso, Burundi, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
161. Benin, Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
162. Benin, Ghana, Malawi and Sierra Leone.
163. Benin, Burkina Faso, Burundi, Cameroon, Comoros, Congo, Côte d'Ivoire, Gambia, Ghana, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mali, Mauritius, Mozambique, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda and Zambia.
164. Cameroon, Eritrea, Gambia, Ghana, Kenya, Sierra Leone and Zambia.
165. Burkina Faso, Ethiopia, Lesotho, Malawi, Mauritius, Swaziland and Uganda.
166. Burkina Faso, Ethiopia, Kenya, Tanzania and Zambia.
167. Burkina Faso, Cameroon, Central African Republic, Ethiopia, Mali, Mozambique, Tanzania, Uganda and Zambia.
168. Burkina Faso, Burundi, Cameroon and Madagascar.
169. Algeria, Benin, Botswana, Burkina Faso, Central African Republic, Ghana, Madagascar, Nigeria, Senegal, South Africa, Tanzania and Uganda.
170. Ethiopia, Ghana, Kenya, Nigeria, Tanzania, Uganda and Zambia.
171. Burundi, Central African Republic, Ethiopia, Kenya, Nigeria, Tanzania and Zambia.
172. Central African Republic, Chad, Ethiopia, Mali, Senegal and Zambia.
173. Ghana, Kenya, Nigeria, South Africa, Tanzania and Uganda.
174. Ghana, Kenya, Nigeria, Tanzania and Uganda.

175. Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Mozambique, Niger, Sao Tome and Principe, Senegal and Togo.
176. Cameroon, Eritrea, Ethiopia, Gambia, Ghana, Lesotho, Liberia, Malawi, Nigeria, Sierra Leone, Swaziland and Tanzania.
177. Benin, Burundi, Central African Republic, Congo, Democratic Republic of Congo, Gabon, Namibia, Niger and Uganda.
178. Algeria, Benin, Cameroon, Cote d'Ivoire, Ethiopia and Guinea.
179. Botswana, Cameroon, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe.
180. Burkina Faso, Mali, Niger, Rwanda, Senegal, Togo, Uganda, Zambia and Zimbabwe.
181. Benin, Burkina Faso, Côte d'Ivoire, Guinea, Guinea-Bissau, Mali, Mauritania, Senegal and Togo.
182. Cameroon, Ethiopia, Malawi, Mali, Senegal and Uganda.
183. Algeria, Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Mali, Nigeria, Senegal, South Africa and Tanzania.
184. See document AFR/RC59/13: Terms of reference of the meeting of African Region delegations to the World Health Assembly and the Executive Board. In: Fifty-ninth Session of the WHO Regional Committee for Africa, Kigali, Republic of Rwanda, 31 August–4 September 2009, Final Report. Brazzaville, World Health Organization, Regional Office for Africa, 2009.
185. Eritrea, Mozambique, Nigeria and Zimbabwe.
186. Benin, Burkina Faso, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Uganda and Zambia.
187. Ethiopia, Mali, Mozambique and Niger.
188. Angola, Benin, Burkina Faso, Burundi, Cameroon, Chad, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Sao Tome and Principe, Tanzania and Zambia.
189. Burundi, Kenya, Mauritania and Uganda.
190. Côte d'Ivoire, Mauritania, Niger, Swaziland and Uganda.