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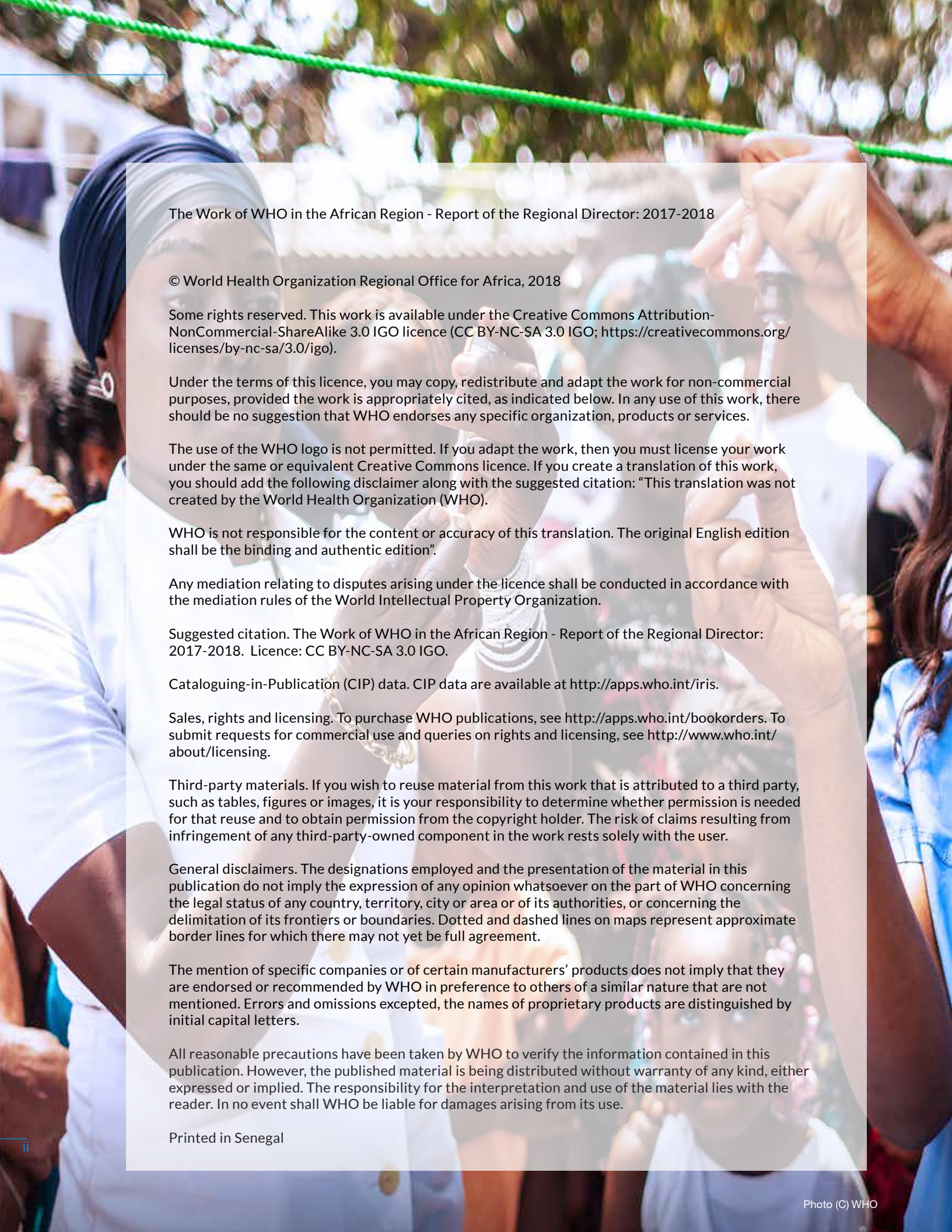
ANNUAL **REPORT**

# THE WORK OF WHO IN THE AFRICAN REGION

## REPORT OF THE REGIONAL DIRECTOR

World Health Organization
REGIONAL OFFICE FOR Africa



The Work of WHO in the African Region - Report of the Regional Director: 2017-2018



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# Abbreviations

| | |
|---|---|
| AA-HA! | Accelerated Action for the Health of Adolescents |
| APHEF | African Public Health Emergency Fund |
| ART | antiretroviral therapy |
| AUC | African Union Commission |
| BMGF | Bill & Melinda Gates Foundation |
| CAP-TB | Common African Position on ending TB |
| CCS | Country Cooperation Strategy |
| CFE | Contingency Fund for Emergencies |
| COPD | chronic obstructive pulmonary disease |
| CRMC | Compliance and Risk Management Committee |
| CVD | cardiovascular disease |
| DFC | Direct Financial Cooperation |
| DFID | Department for International Development (UK) |
| DTP | diphtheria-tetanus-pertussis-containing vaccine |
| EAC | East African Community |
| ECCAS | Economic Community of Central African States |
| ECOWAS | Economic Community of West African States |
| EDCTP | European and Developing Countries Clinical Trials Partnership |
| eMTCT | elimination of mother-to-child transmission |
| ERF | Emergency Response Framework |
| ESPEN | Expanded Special Project for Elimination of Neglected Tropical Diseases |
| EVD | Ebola virus disease |
| EYE | Eliminate Yellow Fever Epidemics strategy |
| Gavi | The Vaccine Alliance |
| GFF | Global Financing Facility |
| GIS | geographic information system |
| GOARN | Global Outbreak and Alert Response Network |
| GPW | General Programme of Work |
| GSWCAH | Global Strategy for Women's, Children's and Adolescents' Health |
| GVAP | Global Vaccine Action Plan |
| GWD | Guinea worm disease |
| HAT | Human African Trypanosomiasis |
| HDC | Health Data Collaborative |
| HiAP | Health in All Policies |
| HPV | human papillomavirus vaccine |
| HRH | human resources for health |
| IAG | Independent Advisory Group |
| IDSR | Integrated Disease Surveillance and Response |
| IEC | information, education and communication |
| IHR | International Health Regulations |
| ICASA | International Conference on AIDS and STIs in Africa |
| IMAI | Integrated Management of Adult and Adolescent Illness |
| IMS | incident management system |
| IRIS | WHO's global Institutional Repository for Information Sharing |
| ITU | International Telecommunication Union |
| IVDs | in vitro diagnostics |
| IVM | integrated vector management |
| JEE | Joint External Evaluation |
| KPI | key performance indicator |
| MIYCN | Maternal, infant and young child nutrition |
| MDR-TB | multidrug-resistant tuberculosis |
| NAP | national action plan |
| NCDs | noncommunicable diseases |
| NTDs | neglected tropical diseases |
| OAFLA | Organisation of African First Ladies against HIV/AIDS |
| OFID | OPEC Fund for International Development |
| PC-NTDs | NTDs amenable to preventive chemotherapy |
| PCV | pneumococcal conjugate vaccine |
| PMTCT | prevention of mother-to-child transmission |
| PSC | Programme Subcommittee |
| RAcE | Rapid Access Expansion project |
| RIASCO | Regional Inter-Agency Standing Committee |
| RMNCAH | reproductive, maternal, newborn, child and adolescent health |
| RSSH | resilient and sustainable systems for health |
| SADC | Southern African Development Community |
| SARA | Service Availability and Readiness Assessment |
| SCD | sickle cell disease |
| SDGs | Sustainable Development Goals |
| SIDA | Swedish International Development Agency |
| SIDS | Small Island Developing States |
| SMC | seasonal malaria chemoprevention |
| SMS | short message service |
| STIs | sexually transmitted infections |
| TB | tuberculosis |
| UHC | universal health coverage |
| UNICEF | United Nations Children's Fund |
| UNEP | United Nations Environment Programme (UN Environment) |
| WAHO | West African Health Organisation |
| WAEMU | West African Economic and Monetary Union (UEMOA) |
| WHE | WHO Health Emergencies Programme |
| WHO FCTC | WHO Framework Convention on Tobacco Control |
| WHO PEN | WHO Package of Essential Noncommunicable Disease Interventions |

# Executive Summary

**The Regional Director is pleased to present this report on the work of WHO in the African Region for the period July 2017 to June 2018.** The reporting period includes part of the last year of the WHO Programme Budget 2016-2017 and the first year of the WHO Programme Budget 2017-2018. The report outlines the significant results achieved under the six categories of work of the 12th General Programme of Work, which ends in December 2018. It reflects the contributions made by WHO country offices and the Regional Office, including the Intercountry Support Teams, in collaboration with partners, in supporting health development in Member States of the WHO African Region.

**The report also highlights some of the key achievements made in implementing "The Transformation Agenda of the World Health Organization Secretariat in the African Region; 2015-2020", launched by the Regional Director in February 2015 and endorsed by the WHO Regional Committee for Africa at its Sixty-fifth session in September 2015.** The Transformation Agenda seeks to make the WHO Secretariat in the African Region more responsive, effective, efficient and accountable in providing the best possible support to Member States, and has served as a programme for accelerating the implementation of WHO reform in the African Region. It is also informing the efforts by the new WHO Director-General to transform WHO, at the global level, into an organization that is better equipped to deliver improvements in health to the world's citizens.

**The report demonstrates how continued progress has been made in key areas of the Transformation Agenda, including improving the capacity of WHO and Member States to detect and rapidly respond to the multiple epidemics the Region experiences; the move towards universal health coverage (UHC) as part of efforts to achieve the Sustainable Development Goals (SDGs); and the push towards making the Secretariat of the WHO African Region more pro-active, results-driven and appropriately resourced to deliver on its mandate to serve Member States in attaining the highest possible level of health.**

**There is improved delivery and an emerging organizational culture change, including openly addressing harassment and creating a respectful work environment.** After three years, we are seeing fundamental shifts in our ways of working, thinking and engaging with others; there is increased accountability, effectiveness and transparency; and we are starting to show results in countries. A detailed report on the Transformation Agenda – *"The Transformation Agenda of the World Health Organization in the African Region: Delivering Results and Making an Impact"* – published and disseminated at the Seventy-first World Health Assembly in May 2018, is also being presented to the Regional Committee.

**In presenting this report to the Sixty-eighth Session of the Regional Committee, I extend my sincere thanks for the dedicated and collective efforts of Member States, partners and WHO staff across the Region** who have given unwavering support during this period of significant transformation.

**WHO in the African Region is committed to working with Member States and partners to make a measurable impact on the health of all people in Africa towards achieving UHC and the SDGs.** I am confident that together, we will achieve improved health and well-being and a better, more prosperous future for all people in the African Region.

Photo (C) WHO

## WHE Programme demonstrates gains in health security

**Investments made in WHO's Health Emergencies Programme (WHE) in the African Region are beginning to yield dividends, following the reform of WHO's work in emergencies.** The capacity of the WHO Secretariat to support Member States to detect and rapidly respond to epidemics and ensure health security in the Region is improving. During the reporting period, the Programme detected 331 signals of potential health threats in 29 countries. Following investigation, risk assessments were conducted and 110 were classified as public health emergencies consisting of outbreaks, natural disasters and ongoing humanitarian crises. An elevated response was required for 20 events in 13 countries, leading to activation of WHO's emergency procedures to provide increased support to Member States in line with the new WHO Emergency Response Framework. This showed a marked change from the Programme's past performance.

**WHO has established an Incident Management System (IMS) which is activated for all graded public health events (outbreaks, natural disasters and ongoing humanitarian crises) within 24-48 hours.** IMS support teams established at Regional Office and Headquarters ensure coordinated backup to country level operations. WHO deployed over 1100 experts to support response operations, and WHO country offices repurposed staff to accelerate response efforts. Contributing to this increased capacity to deploy was the establishment of two operational hubs in Dakar (for Central and West Africa) and Nairobi (for Eastern and Southern Africa), and one liaison office in Addis Ababa (for the Africa Centres for Disease Control and Prevention). The purpose of these hubs, established during the second half of 2017, is to build the capacity of Member States, leverage existing collaboration with regional and subregional partners, and strengthen communication and partnerships.

**The status of preparedness of Member States to detect and rapidly respond to epidemics is also improving.** Through the collaborative efforts of WHO and the African Union Commission, African Heads of State at their Summit in July 2017 adopted a declaration to accelerate implementation of the International Health Regulations (IHR 2005). In compliance with the IHR, Joint External Evaluations (JEEs) to assess the capacity of countries to detect and respond to public health threats were carried out in 18 Member States during the reporting period. In total, 36 countries have detailed information on their gaps, and WHO is supporting them to prepare plans and mobilize resources to address them. For the first time since the adoption of the IHR 2005, all 47 Member States submitted IHR annual reports in December 2017.

**WHO's Health Emergencies Programme was put to the test following a reported outbreak of Ebola virus disease (EVD) in the Democratic Republic of the Congo in May 2018.** The outbreak was reported in three health zones of Equateur Province, including Mbandaka town. The country's rapid, decisive declaration enabled WHO to coordinate an immediate response with Government, partners and donors. The initial focus was on enhanced capacity for case finding, contact tracing, and community engagement before moving to the strategy of breaking each chain of transmission. By the end of June 2018, the outbreak had been largely contained.

**For the first time, with the support of Gavi, health workers and people at risk in affected health zones were offered a safe, effective vaccine developed during the West African EVD epidemic in 2015.** WHO worked with at-risk neighbouring countries and multiple partners to improve surveillance, detection and case management, including advocating for resources for priority activities, community engagement and risk communication. The epidemic was declared over on 24 July 2018, and the Director-General and the Regional Director joined the Government in Kinshasa to celebrate the event. WHO is working with the country to intensify surveillance and strengthen capacity for early case-detection and response in the future.

**The yellow fever outbreak in Angola and the DRC highlighted the need for more focused attention to effective prevention in the Region.** In April 2018 in Nigeria, WHO launched the *"Regional Framework for implementing the Global Strategy to Eliminate Yellow Fever Epidemics"* adopted by the Sixty-seventh session of the Regional Committee. The Framework aims to increase the coverage of immunization through routine programmes and with catch-up campaigns. Since then, WHO and partners have supported the 11 highest-risk countries to develop three-year workplans for implementing the framework. Preventive campaigns have resulted in more than 3.2 million people in Angola and 8.8 million in Nigeria being vaccinated, representing 60% of the total population targeted for coverage in the Region by the end of 2018. The Region will have to address gaps in coverage and reduce inequities in order to maximize the required population levels of immunity to prevent large outbreaks.

## Advancing towards universal health coverage (UHC)

**WHO's work to support countries build responsive, resilient health systems is currently focusing on implementing the** *"Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals in the African Region"***,** adopted by Ministers of Health at the Sixty-seventh session of the Regional Committee in August 2017. The Framework guides Member States' efforts towards realigning their health systems to accelerate progress towards UHC and attainment of their sustainable development aspirations. It suggests actions to assist countries in determining and phasing priorities when planning, implementing and monitoring their national strategies towards UHC.

The AFRO **UHC Flagship Programme** will provide focused support to **selected countries, while guidelines and tools will enable all Member States to apply the strategies proposed in the Framework.** Scoping missions have been carried out in four countries - Nigeria, Eritrea, Kenya and Mozambique – to build consensus with governments and partners on the roadmaps and investments required for UHC.

**Underlying UHC is the need to ensure that all people and communities receive the quality health services they need without incurring financial hardship.** Institutionalizing National Health Accounts (NHAs) in countries is important for monitoring resources allocated for health, for making fairer financing decisions and monitoring progress on financial health protection. Towards this end, WHO supported 25 countries to produce NHAs. Countries are increasingly using the data to develop appropriate health financing strategies and mobilize additional domestic funding for the health sector.

**To improve the availability and equitable distribution of quality human resources for health for UHC, the Sixty-seventh session of the Regional Committee adopted the** *"African Regional Framework for the implementation of the Global Strategy on Human Resources for Health: Workforce 2030".* WHO worked with the West African Economic and Monetary Union (WAEMU) and the Southern African Development Community (SADC) countries to develop subregional five-year action plans and road maps for addressing the human resources for health crises most countries are facing. Namibia, Mozambique, Nigeria and Tanzania have moved ahead in establishing National Health Workforce Accounts which generate information for planning, implementing and monitoring workforce policies, while Algeria has established a National Health Workforce Observatory.

**Access to affordable and quality medicines is also essential for UHC.** WHO is providing technical support to SIDS countries in the Region – Cabo Verde, Comoros, Mauritius, Sao Tome and Principe, and Seychelles – to develop a pooled procurement strategy to achieve economies of scale and improve affordability and availability of medicines for noncommunicable diseases. Benin, Cabo Verde and South Sudan were also supported to develop national essential medicines lists to guide procurement and use. In addition, Cameroon, Central African Republic, Congo, Equatorial Guinea and Gabon were supported to implement their action plans on substandard and falsified medical products in line with the *"Regional Strategy on Regulation of Medical Products in the African Region, 2016-2025"* adopted by the Regional Committee during its Sixty-sixth session.

## Addressing the burden of Communicable Diseases

**The Region continued to make progress in addressing communicable diseases such as HIV/AIDS, viral hepatitis, tuberculosis and malaria.** Nearly two thirds of Member States have adopted and are implementing WHO's "Treat All" policy for people living with HIV to start antiretroviral therapy regardless of their CD4 count. Steady scale-up of HIV testing and antiretroviral therapy continues. Botswana, Eswatini and Namibia have nearly achieved "90-90-90" testing and treatment targets. Treatment coverage in West and Central Africa has improved significantly since WHO, UNAIDS and other partners developed catch-up plans in 2016 to accelerate the HIV response, with more than 40% coverage of HIV treatment compared to 28% in 2015. However, the latest global report indicates that if current trends continue, the HIV prevention target of a 75% reduction by 2020 (against a 2010 baseline) will not be reached.

**With the support of WHO and partners, the coverage of prevention of mother-to-child transmission (PMTCT) services in the African Region increased from 67% in 2015 to 79% by the end of 2017.** WHO and partners have developed a stepwise *"Path to Elimination"* approach to advance the elimination of mother-to-child transmission (eMTCT) of HIV and syphilis infections in infants by 2020. Countries will be supported to adopt this approach in order to meet the 2020 target.

**Momentum is building on action to address viral hepatitis, a long-neglected public health problem of global importance in the Region.** Following the adoption of the Regional Framework *"Prevention, Care and Treatment of Viral Hepatitis in the African Region: Framework for Action, 2016-2020"* by the Sixty-sixth session of the Regional Committee, Member States are taking concrete steps to address this disease. Nearly half have developed national action plans, and 16 countries now have national technical working groups and ministry of health focal points to oversee and coordinate the national response. Eleven countries have introduced the hepatitis B birth dose vaccine to reduce new cases of hepatitis B in children.

**While TB remains a major public health problem, the fight against the disease continues to make progress.** Countries were supported to implement strategic initiatives to find missing TB cases and adopt and scale up the more accurate molecular tests recommended by WHO as the first line of diagnosis to increase capacity to detect active TB cases. WHO supported five countries to initiate or prepare for national TB prevalence surveys to measure the true burden of disease, and a further five countries to determine the levels of resistance to anti-TB medicines. Twenty-one countries introduced the recommended shorter nine-month treatment regimens for multidrug-resistant TB as opposed to the 24-month long regimen. Laboratory capacity for detecting TB cases was strengthened in 21 countries, with the Benin National TB Reference Laboratory accredited as the fourth Supranational TB Reference Laboratory in the Region.

**The World Malaria Report 2017 shows that progress in the global response to malaria has stalled and many countries in the African Region are not on track to achieve the targets of the Global Technical Strategy for Malaria, 2016-2030.** About 70% of the estimated case burden and 71% of the estimated deaths occurred in 10 African countries. To reverse these trends, WHO and partners are spearheading a new "10+1" initiative to intensify support to these Member States and India to avert deaths from this preventable, curable disease.

**Following extensive consultations with the national authorities, regulatory approval has been obtained to initiate pilot implementation programmes for the RTS,S malaria vaccine in Ghana, Kenya and Malawi during the second half of 2018.** The results of these pilots are expected to be a potential game-changer for malaria control in the Region.

## Continued progress towards the elimination and eradication of targeted diseases

**Work to eliminate and eradicate certain targeted diseases, such as poliomyelitis and neglected tropical diseases (NTDs) like onchocerciasis and Guinea-worm disease in the Region continued. The final push towards Polio eradication in the African Region continues to be a priority.** Tremendous progress has been made since the last wild poliovirus transmission in Nigeria in 2016. By 30 June 2018, it had been 22 months since the last case of wild poliovirus was reported in the African Region. The localized inaccessibility of children to be immunized due to insecurity as well as surveillance gaps remain the last "frontiers" for certification of polio eradication for the Region, and we are constantly working with Member States to surmount these challenges. Due to concerted efforts, 40 countries in the African Region have had their polio-free documentation accepted by the African Regional Certification Commission for Polio Eradication. If this progress is sustained, the African Region could be certified to have eradicated polio by the end of 2019.

**Outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2) were confirmed in the Democratic Republic of the Congo, Kenya and Nigeria.** To stop these outbreaks quickly, AFRO deployed 21 international WHO polio experts and 200 local public health personnel.

**During the Seventy-first session of the World Health Assembly in May 2018, the Regional Director convened with her counterpart, the WHO Regional Director for the Eastern Mediterranean, a polio side-meeting with Ministers of Health of Ethiopia, Kenya and Somalia to declare the cVDPV2 outbreak in Kenya and Somalia as a Horn of Africa subregional public health emergency.** Since then, WHO and partners have supported several synchronized cross-border vaccination campaigns.

**To ensure surveillance systems of adequate sensitivity for polio certification, Member States were urged during the Sixty-seventh session of the Regional Committee to adopt the AFRO Geographical Information Systems (GIS) tool for enhanced surveillance and to have "real-time" data for action.** By the end of the reporting period, 42 out of 47 Member States were using the system, resulting in improved performance of surveillance systems.

**With regard to the polio end-game, Member States have finalized the budgeted transition plans with support from WHO and partners,** and are encouraged to mobilize domestic resources and continue engagement with their international development partners to implement them.

Photo (C) WHO

**WHO and its partners, through the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), are working with Member States to mobilize political commitment and resources to control and eliminate the five most prevalent NTDs amenable to preventive chemotherapy (PC-NTDs) in Africa:** lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis and trachoma.

**ESPEN is proving to be an effective mechanism for combining the efforts of governments, partners, nongovernmental organizations and the private sector, particularly pharmaceutical companies in coordinating the supply and distribution of donated medicines.** With funding support from partners, at least 30 million people in 13 countries have benefitted from mass drug administration.

ESPEN has set up a fully-fledged laboratory in Ouagadougou, Burkina Faso to support regional efforts for scaling down treatment for onchocerciasis where appropriate impact has been achieved.

**Guinea-worm disease is on the verge of eradication, and Kenya became the 41st country to be certified free of local transmission.** Human African Trypanosomiasis, a disease prevalent only in the African Region, is moving towards elimination, while cases of Buruli ulcer halved between 2014 and 2017 through the use of WHO-recommended oral antibiotics and the integrated case management strategy for NTDs.

## Tackling Noncommunicable Diseases (NCDs)

**Deaths from NCDs in the Region are rising, along with the costs of treating these diseases and the related risk factors and ill health.** High-level advocacy urging Member States to adequately resource and prioritize NCDs in national health plans is beginning to bear fruit. WHO provided technical support to seven Member States to develop/finalize national multisectoral NCD Strategic/Action Plans in line with the UN Declaration on NCDs and the WHO Global NCD Action Plan 2013-2020. By 31 March 2018, thirty-one Member States had NCD Strategic/Action plans and in 17, significant action was ongoing.

**Following the adoption of the** *"Regional Framework for Integrating Essential NCD Services in Primary Health Care"* **at the Sixty-seventh session of the Regional Committee, WHO collaborated with the West African Health Organisation (WAHO) to train NCD programme managers on the WHO Package of Essential NCD Interventions (WHO PEN).** The package comprises cost-effective NCD actions which can be integrated into primary health care settings to assist countries scale up early detection and treatment of NCDs. By June 2018, ten countries were implementing the WHO PEN. Synergy between WHO PEN and the UHC Flagship Programme is expected to rapidly increase the coverage of an integrated package for the treatment and prevention of NCDs.

**WHO continued to support Member States to develop and enforce legislation and regulations on tobacco control.** Laws to address tobacco use in line with the WHO Framework Convention on Tobacco Control (WHO FCTC) were adopted in eight Member States. In addition, 17 Member States and three subregional blocs - the East African Community, the Economic Community of West African States and the West African Economic and Monetary Union - were supported to implement changes in their policies on tobacco taxation.


Photo (C) WHO/S.Gborie

## Saving the Lives of Mothers, Children and Adolescents

**The African Region has high maternal, newborn and child mortality as a result of low coverage of effective health interventions targeting reproductive, maternal, newborn, child and adolescent health (RMNCAH).** To help address the gaps, WHO is assisting Member States to operationalize the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (GSWCAH). So far, 24 countries have developed strategic plans that are aligned to the GSWCAH. Six countries were supported to mobilize resources through the Global Financing Facility (GFF) to implement the strategy, bringing to 13 the number of countries benefitting from the GFF.

**Immunization is one of the most effective public health interventions, saving lives and helping families and communities to thrive.** To break through the years-long stagnation of immunization coverage in the Region, estimated at 72% in 2017, new impetus is being generated through the *"Business Case for WHO Immunization Activities on the African Continent 2018–2030"*. It will build on the political commitment made by African Heads of State through the adoption of the Addis Ababa Declaration on Immunization. The aim is to support Member States achieve universal immunization coverage through a comprehensive, life-course approach that would save 1.9 million lives by 2030, and help countries transition smoothly from donor funding.

**A total of 41 countries were supported to introduce inactivated polio vaccine (IPV) into their routine immunization systems.** In addition, 38 and 33 countries are using pneumococcal conjugate vaccines (PCV) and rotavirus vaccines respectively. A WHO evaluation conducted in 2017 in 15 countries estimated that around 135 000 rotavirus hospitalizations and 21 000 rotavirus deaths in under-five children were prevented in 15 countries with the routine use of these vaccines.

**The Regional Office published the first Africa Nutrition Report in 2017,** *"Nutrition in the WHO African Region"* **to provide Member States and partners with an overview of the nutrition situation in relation to the global nutrition targets for 2025.** The report highlights the challenges in the nutritional status of populations in the African Region, including undernutrition, obesity and diet-related NCDs. The identified data gaps provide a strong rationale for advocacy and resource mobilization for quality improvement and use of the nutrition data collected as part of routine primary health services.

**Adolescent health remains a top priority in the Region and the Adolescent Health Flagship Programme launched in 2017 by the Regional Office presents a unique opportunity to lay the foundation for addressing the health problems of this group.**

For example, the Region has the highest HIV burden in adolescents aged 10–19 years, with over 70% of new infections affecting adolescent girls, and very high rates of early pregnancies and maternal mortality. The aim of the flagship programme is to guide and support countries and partners to implement evidence-based, effective interventions to improve the health and well-being of adolescents in the African Region. Thirteen countries were supported to leverage additional funding of US$ 50 million from the Global Fund for HIV interventions targeting adolescents and young women for the period 2017-2020. WHO is working with Member States to adopt effective strategies such as using social networks and peer support to create demand for adolescent-friendly services, care and treatment.

## Strengthening Strategic Partnerships

**WHO recognizes that healthy lives and well-being for all at all ages cannot be achieved by a single organization, and seeks to strengthen existing partnerships and engage new partners and donors to support Member States to address regional and global public health priorities.** A new Cooperation Agreement was signed with the International Telecommunication Union in October 2017 to leverage technological advancements and use of digital services to save lives and improve people's health.

**At the Second International Conference of Ministers of Health and Ministers for Digital Technical Technology on Health Security in Africa in Benin in June 2018, the Regional Director called on Member States to establish strong collaboration between the health, information and communication technology sectors to improve access to health care, patient safety and the achievement of universal health coverage**. WHO has supported 27 countries to develop eHealth strategies and 10 have successfully completed national eHealth inventories using WHO's digital health atlas to support coordination and scale-up.

**The International Federation of the Red Cross and Red Crescent Societies (IFRC) has been a key partner of the WHO Regional Office for Africa.** In May 2018, the two organizations agreed to broaden their collaboration to include promotion of high-level advocacy by identifying champions to work with the alliance of mayors on key health issues.

**WHO continued to expand its collaboration with key partners.** The Regional Director and the Executive Management Team embarked on extensive discussions and visits with partners such as the African Development Bank, the African Union Commission and the Africa CDC, China, the East African Community, the Economic Community of Central African States, Germany, South Korea, the Southern African Development Community, the United Kingdom and the United States, among others.

These dialogue efforts have resulted in the signing of a number of cooperation agreements and joint workplans.

**WHO in the African Region, within the framework of the global-level partnership, has consolidated its partnership with the UK by signing an Action Framework encompassing the Department of Health, Public Health England and the Department for International Development.** Funding agreements with donors to ESPEN, such as the Kuwait Fund and the OPEC Fund for International Development, are enabling WHO to accelerate work towards the elimination and eradication of NTDs.

**The donor report monitoring system implemented since 2016 to strengthen reporting and internal controls has improved the quality and timeliness of reporting, with the number of overdue documents reducing from 39% in July 2017 to 8% by June 2018.** WHO will continue to take advantage of resource mobilization opportunities at country level to ensure adequate resources to strengthen its work in countries in line with the WHO 13th General Programme of Work (GPW).

## Efficient and responsive operations enable delivery

**For a more efficient, results-focused and accountable WHO Secretariat in the African Region, and to help measure the Organization's contribution to health goals in the Region, a novel results framework with key performance indicators has been incorporated into daily management, programmes and activities.** Its purpose is to demonstrate clearly how WHO's work contributes towards its priorities, the health goals of Member States and the SDGs.

**Following the realignment of human resources with health priorities in the Regional Office and Intercountry Support Teams in 2016, work is progressing to ensure WHO country teams are fit for purpose to address country priorities.** By June 2018, functional reviews had been conducted in 25 country offices and implementation plans for 11 countries approved. Key shifts in staffing will enable WHO to better support Member States and health partners in health coordination, health security and health systems strengthening, among others.

**A mid-term evaluation conducted in January 2018 by the Evaluation Unit in WHO Headquarters concluded that the functional reviews are an important and timely exercise that will strengthen the capacity of country offices.**

Monitoring of the implementation of country office plans, following the functional reviews, is well underway. Already, five countries are implementing the recommendations and making progress towards achieving the desired human resource structures, resulting in an increase in and a better mix of staffing, an increase in international staff, and a decrease in administrative staff. The results of the functional reviews are aligned with the country operating models in the Director-General's Transformation Plan and Architecture.

**To ensure compliance with WHO's rules and efficient use of resources for the delivery of results, the Accountability and Internal Control Strengthening (AICS) initiative was launched in 2015.** The focus of this initiative has been to improve accountability, transparency and compliance; enhance performance of individual staff and teams; and establish mechanisms to measure, monitor and report on progress and trends. Positive strides have been made in this area. The Report of the Internal Auditor submitted to the World Health Assembly in May 2018 concluded that internal control effectiveness had significantly improved to 75% in 2018 from 50% in 2015. In addition, since 2016 no internal audits have been rated as unsatisfactory in the Region.

**The WHO African Region advances the greatest amounts of funding to governments to implement activities through a mechanism called Direct Financial Cooperation (DFC).** There have been improvements in DFC reports, with a reduction of 60% in overdue reports between February 2015 and April 2018. The DFC Accountability and Assurance Framework, developed during the previous reporting period, is being rolled out to ensure that DFC funds are used as intended and that recipients have the necessary controls to ensure compliance with the monitoring and reporting requirements. Member States are congratulated for the progress being made in this shared responsibility.

**To foster a more coordinated, cohesive approach to strengthen the control environment and to oversee issues related to accountability, risk management, audit and internal control in the African Region, the Compliance and Oversight Team in the Region was integrated into the General Management and Coordination Cluster.**

This is in accordance with the recommendation of the Independent Expert Oversight Advisory Committee in 2015, with the WHO Regional Office for Africa being the first to implement the recommendation. In September 2017, the establishment of local compliance and risk management committees to ensure adequate oversight in all WHO country offices and programmes at all levels in the Region was made mandatory.

## Looking forward

**The achievements highlighted in this report show that Member States in the African Region, with the support of WHO and partners, are making progress in their efforts to ensure healthy lives and promote well-being for all at all ages by achieving universal health coverage, addressing health emergencies, and promoting healthier populations.** The report also shows that more needs to be done if the targets set for achieving UHC and the SDGs are to be met.

**In April 2018, the Regional Director launched the second phase of the Transformation Agenda of the WHO Secretariat in the African Region, covering the period 2018-2020.** The agenda is aligned with WHO's Global Transformation Plan for improvements in global health through universal health coverage, health security and health through the life course, with greater focus at country level. The emphasis of this second phase will be ensuring that staff and workplans are aligned with the strategic priorities of the Organization, working through productive partnerships and stakeholders, and supporting Member States. A Change Agent Network of staff volunteers has been established to champion the principles of accountability, quality, value for money and promoting a healthy workplace.

**The launching of the second phase of the Transformation Agenda and the adoption of the WHO 13th GPW by the Seventy-first World Health Assembly in May 2018 are opportunities for building on the progress made and accelerating its pace.** The emphasis will be on effective delivery using the results framework and Key Performance Indicators, and better management of resources to generate value for money, while putting people at the centre of change.

**WHO staff members will be provided with the training required, including in leadership, management and diplomacy, and encouraged and supported to turn the pro-results values into behaviours and a culture that will ensure responsive and efficient delivery of results, in a just and respectful working environment.** The technical focus will be in line with the GPW and country priorities with strengthened WHO Country Office Teams in line with the functional reviews.

Photo (C) WHO/L. Mackenzie

**Implementation of the Framework for health systems development towards UHC, with emphasis on primary health care, will be accelerated to help countries improve access to quality health services that are centred on people's needs and circumstances, without the users enduring financial hardship.** Priority communicable diseases such as HIV, TB, malaria and NTDs, and noncommunicable diseases will be given due attention. The health of adolescents will be given the highest priority and a more multisectoral approach adopted in implementing the Adolescent Health Flagship Programme.

**The Secretariat will continue to build on the gains made in health security, and through the WHO Health Emergencies Programme and guided by its results framework**, will work with partners and Member States to maximize and sustain IHR capacity and health emergency preparedness of countries.

**Actions will be taken to consolidate and evaluate the achievements made in the Organization's strategic operations in order to strive towards more efficiency and better value for money.**

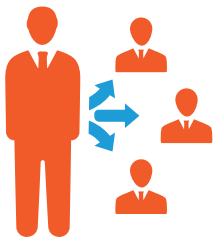
In addition, intensified efforts will be made to expand and diversify partnerships, and to more effectively communicate WHO's contributions to improving people's health.

**The Secretariat will work with Member States to make and effect policy and institutional arrangements that support and amplify the results of the change being seen.** Key areas that will be focused on include health governance, priority setting, coordination of partners and organizational efficiency.

**WHO reiterates its unwavering commitment to continue working with Member States and partners in implementing the new GPW in order to move towards UHC** and ensure that the people in the African Region attain the highest possible level of health and well-being.

# LOOKING FORWARD

## 1 The achievements highlighted in this report show that :



**Member States in the African Region, with the support of WHO and partners**

1. are making progress in their efforts to ensure healthy lives
2. promote well-being for all at all ages by achieving universal health coverage
3. addressing health emergencies
4. and promoting healthier populations

## 2 The launching of the second phase of the Transformation Agenda and the adoption of the WHO 13th GPW by the 71st WHA in May 2018 **are opportunities for building on the progress made and accelerating its pace.**

Emphasis will be on

1. Effective delivery for results using the results framework and Key Performance Indicators
2. Improving the quality of work and better management of resources to generate value for money
3. Putting people at the centre of change

## 3 The Secretariat will work with Member States to make and effect policy and institutional arrangements that support and amplify the results of the change being seen

**Key areas that will be focused on include**


- **health governance**
- **priority setting**
- **coordination of partners**
- **organizational efficiency**

## 4 WHO staff members will be provided with the training required,

- leadership
- management and
- diplomacy

and encouraged and supported to turn the pro-results values into behaviours and a culture that will ensure responsive and efficient delivery of results in a just and respectful working environment.

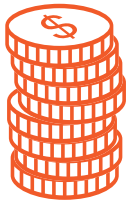
**Country priorities**

The **technical focus will be in line with the GPW** & with strengthened **WHO Country Office Teams** in line with the functional reviews

## 5 Implementation of the Framework for health systems development towards UHC

with **emphasis** on **primary health care**

will be **accelerated to help countries** improve access to quality health services **that are centred on people's needs** and **circumstances**



without the **users of the services** enduring **financial hardship.**

## 6 The Secretariat will continue to build on the gains made in health security, and through the WHO Health Emergencies Programme

and **guided by its results framework**, will work with **partners and Member States**

to maximize and sustain **IHR capacity** and **health emergency preparedness** of countries.

## 7 Striving towards more efficiency and better value for money

Actions will be taken to **consolidate** and **evaluate the achievements made** in the **Organization's strategic operations** in order to strive towards more efficiency and better value for money

more efficiency

&

better value for money

# 1. INTRODUCTION

# 1. Introduction

This report on the work of WHO in the African Region is for the period from July 2017 to June 2018 and reflects the work accomplished since the Regional Director's last report to the Regional Committee. The report highlights the results achieved in supporting Member States and collaborating with partners to improve health outcomes in the Region.

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

The report includes a section highlighting the achievements of the Transformation Agenda (TA) and then presents information under the six categories of the 12th General Programme of Work (GPW) 2014 – 2019, namely:

(i) Communicable diseases

(ii) Noncommunicable diseases

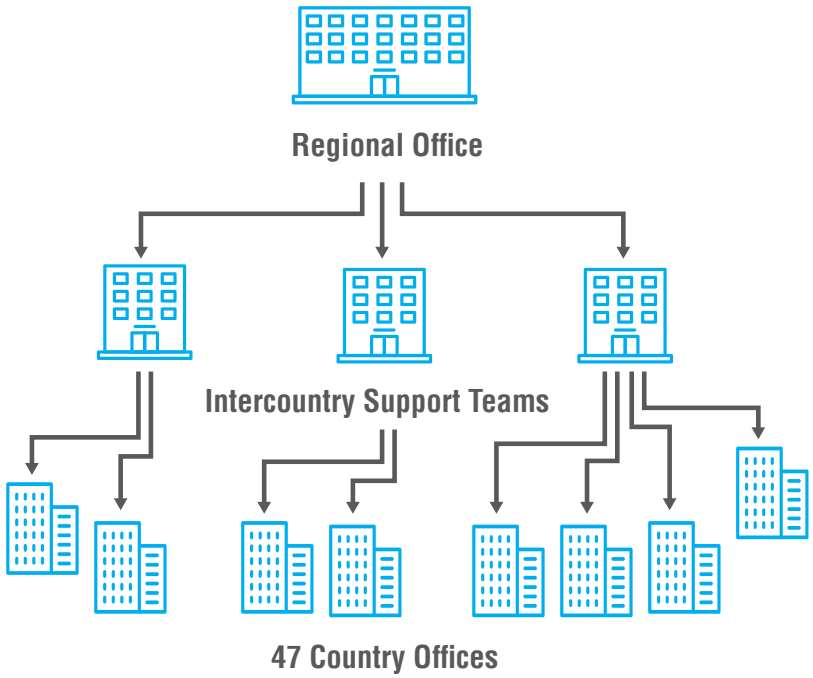
(iii) Promoting health through the life-course

(iv) Health systems

(v) Polio Eradication Programme (category 5) and the WHO Health Emergencies Programme (category 12)

(vi) Corporate services and enabling functions

**The WHO Secretariat in the African Region comprises 47 country offices and the Regional Office, including Intercountry Support Teams**




**Providing support by disseminating norms and standards, providing technical assistance to develop or update national policies, strategies and plans for cost-effective health interventions, strengthening national capacity to implement and monitor activities, advocating for investment in health, mobilizing resources and facilitating partner coordination**

## 2.1 Pro-results values

**Objectives:**
An organizational culture that is defined by the values of excellence, teamwork, accountability, integrity, equity, innovation and openness

**Some achievements are:**

1. Collective support of senior leadership
2. Improved staff awareness
3. Better staff engagement and ownership
4. Improved partner recognition

## 2.2 Smart technical focus

**Objectives:**
An organization providing effective technical and policy support for all Member States, and WHO's priorities defined, addressed and financed in alignment with agreed priorities

**Some achievements are:**

1. Strengthened health security with improved prevention, detection, and response
2. Progress towards polio-free certification and good polio transition planning
3. Strengthening of health systems and the UHC/SDGs Framework of Actions
4. Creation of the Adolescent Flagship Programme and Expanded Special Project for Elimination of Neglected Tropical Diseases
5. Progress in communicable and noncommunicable disease, and health through the life course

## 2.3 Responsive strategic operations

**Objectives:**
An organization with enabling functions that efficiently support the delivery of programmes

**Some achievements are:**

1. Improved internal controls, performance of individual staff and budget centres, and mechanisms to measure, monitor and report on progress and trends (for example through Key Performance Indicators)
2. Realignment of human resources at Regional, Intercountry Support Team, and Country Office level
3. Setting up of emergency hubs in Dakar and Nairobi
4. Better value for money in the procurement of goods and services

## 2.4 Effective communications and partnerships

**Objectives:**
A more responsive and interactive organization, internally among staff members and externally with stakeholders

**Some achievements are:**

1. Enhanced internal communications through a regional communications strategy
2. Reinforced external communications through engagement of strategic regional and global media and stakeholders
3. Strengthened strategic partnerships for example through the Harmonization for Health in Africa platform and the Africa Health Forum

# 2. Progress of the WHO AFRO Transformation Agenda

The Transformation Agenda of the WHO Secretariat in the African Region 2015–2020, endorsed by the Sixty-fifth session of the Regional Committee, is the Regional Director's vision to accelerate WHO reform in the African Region to transform the Organization into the "WHO that staff and stakeholders want." The Transformation Agenda is the force that is driving the change in WHO/AFRO to ensure that every dollar spent produces results that contribute to improved health outcomes in the Region.

The Transformation Agenda focuses on four areas, namely: pro-results values, smart technical focus, responsive strategic operations and effective communication and partnerships. Details beyond this summary are found in later sections.

A global WHO organizational culture survey conducted in November 2017 reflects the contribution of the Transformation Agenda towards pro-results values through AFRO's perceived stronger culture of accountability compared to other Regions. WHO/AFRO staff have more positive perceptions of the Organization's culture than WHO staff overall, and they believe that the Organization has a clear direction and strategy. A culture of transparency and openness to feedback is emerging, strengthened by the establishment of the position of a full-time ombudsman.

The Regional Office developed a results framework using 44 prioritized key performance indicators (KPIs) to measure its contribution to achieving WHO priorities, the health goals of Member States and the SDGs. This has been instrumental in demonstrating results, particularly in operations and administrative functions, reinforcing accountability and improving transparency. It also enables closer alignment with priorities of Member States, highlights neglected areas and enables WHO to prioritize allocation of funds.

Regarding smart technical focus, the Region has made significant progress in responding to public health events and building a culture of preparedness in Member States. The restructuring of WHO's Health Emergencies Programme led to the creation of hubs in Dakar and Nairobi, and increased staffing in all programme areas.[1] This is contributing to a culture of preparedness in Member States, enabling WHO to respond swiftly to public health events.

Similarly, the restructuring of polio teams and the use of dashboards and Geographic Information Systems for monitoring is ensuring that the Region is making steady progress towards achieving polio-free status by the end of 2019. Two flagship programmes on UHC and adolescent health are fostering increased alignment of health system strengthening efforts across AFRO and within countries. The Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) is making steady progress towards the goal of eliminating PC-NTDs in the African Region.

The Transformation Agenda is the force that is driving the change in WHO/AFRO to ensure that every dollar spent produces results that contribute to improved health outcomes in the Region.

Ensuring that every dollar spent

produces results that contribute to improved health outcomes

1 Infectious Hazards Management (IHM); Country Health Emergency Preparedness & International Health Regulations (CPI); Health Emergency Information & Risk Assessment (HIM); Emergency Operations (EMO); and Management and Administration (MGA)

Strategic operations in the Secretariat continued to improve. Four internal and nine external audit reports (February 2015–April 2018) were fully closed to the satisfaction of the auditors, and there were no audit reports issued since 2016 with an unsatisfactory rating, a considerable improvement from previous years. Internal controls have improved significantly, with overall control effectiveness increasing from 50% in 2015 to 75% in 2018. AFRO has installed software for electronic document management and sharing, which will increase efficiency across the Regional Office. The human resources realignment process has been completed for all staff in the Regional Office and Intercountry Support Teams.

Tremendous progress has been made in the functional reviews of country offices. Governments and partners have highlighted key functions they expect WHO to perform, including supporting health coordination, generating and disseminating health information, and reinforcing health systems strengthening and outbreak and emergency preparedness. The functional reviews incorporate the WHO Health Emergency business model, polio transition and the investment case for strengthening routine immunization in Africa, to ensure that all country offices have the required capacity to deliver results.

Strategic partnerships and stakeholder engagement for collaboration and resource mobilization are expanding, and WHO/AFRO established relationships with a number of new partners over the period. A regional partnership strategy is being developed to expand partnerships to include academics, regional philanthropists and civil society organizations.

Over the period, AFRO hosted visits by the Regional Director and senior management of the Western Pacific Region, and a Global Transformation Team from Headquarters to share experiences and best practices of the Transformation Agenda, such as the UHC Framework, the Results Framework and the functional reviews. A side event at the Seventy-first World Health Assembly highlighted achievements of the Transformation Agenda and engaged Member States on reforms required at country level.

Online platforms have been created to improve communication with internal and external stakeholders and monitor activities of the Transformation Agenda. Internal communication is being enhanced through regular e-alerts and bimonthly staff meetings with the Regional Director, where staff interaction has increased markedly. External communication is being reinforced through proactive media engagement to showcase WHO's work. Stakeholders are responding very positively to the weekly online bulletin issued by the Health Emergencies Programme. AFRO's social media presence achieved over 14 million tweet views and nearly 835 000 reaches on Facebook by June 2018. AFRO's Facebook page allows for live question and answer sessions with senior staff members, while events such as the Sixty-seventh Regional Committee (RC) were live-streamed on YouTube.

In an effort to save money and the environment while optimizing technology, AFRO is moving towards paperless meetings. For the first time, an application was launched at the Sixty-seventh Regional Committee allowing for digital access to documents and the RC Journal. The "app" reduced the need to print the RC report, thereby cutting printing and shipping costs.

## A global WHO organizational culture survey conducted in November 2017

reflects the contribution of the TA towards pro-results values through AFRO's perceived stronger culture of accountability compared to other Regions

WHO/AFRO staff have more positive perceptions of the organization's culture than WHO overall, and they believe that the Organization has a clear direction and strategy

A culture of transparency and openness to feedback is emerging, strengthened by the establishment of the position of a full-time ombudsman

# 3. Implementation of the WHO Programme Budget 2016-2017 and 2018-2019

The July 2017-June 2018 reporting period covers the closure of the Programme budget (PB) 2016-2017 and the opening of the PB 2018-2019. For the 2016-2017 biennium, the World Health Assembly approved a total PB of US$ 1 162 300 000 for the African Region, representing 27% of the global WHO budget. By 31 December 2017, the total budget allocated to the African Region was US$ 1 748 428 000 and the total funds available represented about 82% of the allocated budget.

The approved PB 2018-2019 for the African Region is US$ 1 161 600 000, which is 26% of the global PB of US$ 4 421 500 000. The approved budget does not include the Outbreaks and Crisis Response segment, in recognition of the event-driven nature of this portion of the budget which will be determined by needs during emergencies. Except for the Polio component of the budget, 5% of the approved budget is still withheld at the global level to support programmatic alignments between the 12th General Programme of Work and the 13th General Programme of Work, which will come into force from 2019 (overlapping with the former). As such, by 30 June 2018, the total allocated budget for the Region was US$ 1 119 895 000, which is US$ 41 705 000 less than the WHA-approved budget.

By the end of June 2018, fifty-two per cent of the total allocated budget was funded (Table 1). Of the available funds of US$ 599 428 990, thirty-three per cent is earmarked for the Polio Programme. The average utilization rate of available funds is 45%, with the Polio Programme having the highest rate (51%) and the noncommunicable diseases programme the lowest (29%).

The budget in the Region continues to be financed through a mix of flexible funds and specified voluntary contributions. Of the funding so far available, over 70% is highly earmarked. This situation further compounds the already limited support for noncommunicable diseases and other chronically underfunded programmes, as flexible funds are the primary source of support for priorities that fail to attract specified voluntary contributions. WHO/AFRO will continue to use its new resource mobilization strategy to expand its outreach to both traditional and new partners, especially the private sector and philanthropies to further broaden its financial resource base.

Planning and reporting have improved following the introduction of initiatives and mechanisms. Overall, the Region has improved in the timeliness and quality of statutory and donor reporting. Budget centres (WHO country offices and Regional Office clusters) have also demonstrated greater focus during operational planning by selecting a more strategic number of outputs.

There are plans to further enhance the quality of programme management by ensuring that implementation and monitoring are driven by results, and information is utilized for decision-making. These improvements are expected to showcase our programmatic results effectively, accurately and timeously, and support evaluation for organizational learning.

**The approved Programme Budget 2018-2019 for the African Region is**

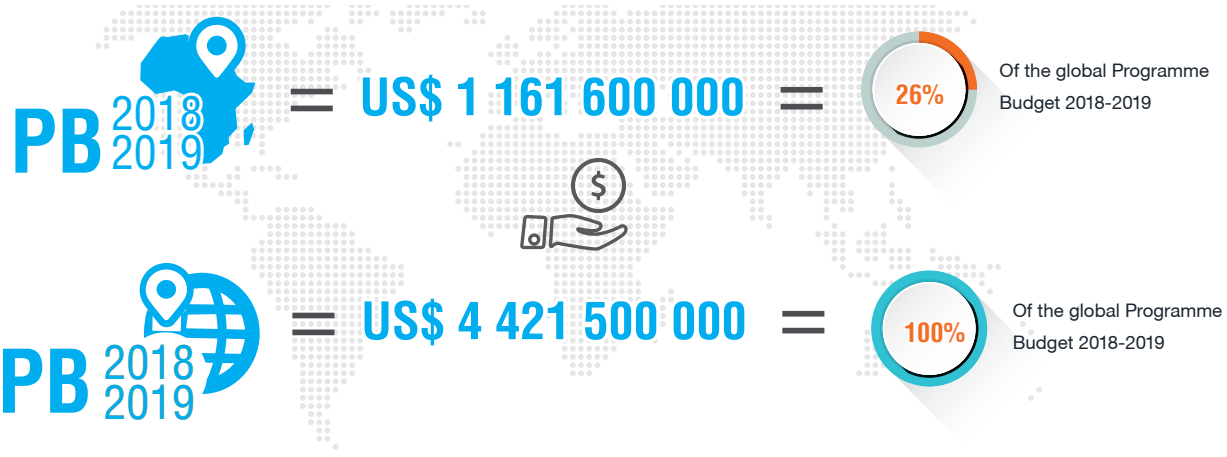


Photo (C) WHO/Lushumo

# TABLE 1: BUDGET IMPLEMENTATION FOR PB 2018-2019 AS AT 30 JUNE 2018 (IN US$ 000)

**APPROVED PB 2018-2019 FOR THE WHO AFRICAN REGION**

| | Category of work | Approved Budget by WHA ('000) | Allocated PB ('000) | Total Available Funds ('000) | %Funding against Approved Budget ('000) | Budget Utilization ('000) | % Utilization against Approved Budget ('000) | % Utilization against Funding ('000) |
|---|---|---|---|---|---|---|---|---|
| | | *[A]* | *[B]* | *[C]* | *[D = C/A]* | *[E]* | *[F = E/A]* | *[G = E/C]* |
| *Category 1* | Communicable diseases | 291 100 | 276 545 | 125 528 | 43% | 57 065 | 20% | 45% |
| *Category 2* | Noncommunicable diseases | 61 0000 | 57 950 | 20 569 | 34% | 6 016 | 10% | 29% |
| *Category 3* | Promoting health through the life-course | 105 300 | 100 035 | 42 178 | 40% | 14 299 | 14% | 34% |
| *Category 4* | Health systems | 88 500 | 84 075 | 58 355 | 66% | 20 185 | 23% | 35% |
| *Category 5* | WHE Programme | 141 200 | 134 140 | 65 749 | 47% | 32 462 | 23% | 49% |
| *Category 6* | Corporate services & enabling functions | 147 000 | 139 650 | 88 725 | 60% | 35 838 | 24% | 40% |
| | Total Base Programmes | 834 100 | 792 395 | 401 107 | 48% | 165 868 | 20% | 41% |
| Polio & Special Programmes | | | | | | | | |
| | 10 - (Polio) | 327 500 | 327 500 | 198 321 | 61% | 100 922 | 31% | 51% |
| | Grand Total | 1 161 600 | 1 119 895 | 599 428 | 52% | 266 790 | 23% | 45% |

# 4.1

# COMMUNICABLE DISEASES

The burden of communicable diseases and outbreaks in the African Region remains high and most severely affects the most vulnerable, the poorest and disadvantaged communities. WHO worked with Member States and partners to scale up proven interventions for prevention and treatment of diseases such as HIV/AIDS, hepatitis, tuberculosis, malaria, vaccine-preventable diseases and neglected tropical diseases.

# 4. Significant achievements by category of work

## 4.1 Category 1: Communicable Diseases

The burden of communicable diseases and outbreaks in the African Region remains high and most severely affects the most vulnerable, the poorest and disadvantaged communities. WHO worked with Member States and partners to scale up proven interventions for prevention and treatment of diseases such as HIV/AIDS, hepatitis, tuberculosis, malaria, vaccine-preventable diseases and neglected tropical diseases.

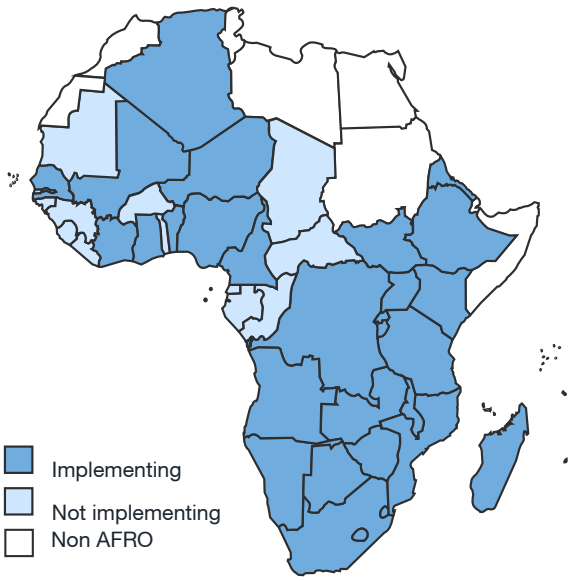
Since WHO's consolidated guidelines on HIV prevention and treatment were disseminated in 2016, thirty countries[2] have adopted and are implementing the "Treat All" policy that allows for HIV positive patients to start antiretroviral therapy (ART), regardless of their CD4 cell count (Fig 4.1.1). Nearly 70% of people living with HIV knew their status in 2016, almost 13.8 million people living with HIV were receiving antiretroviral treatment (53%), and viral suppression rates were at 44%. Scale-up of HIV testing and antiretroviral therapy is continuing steadily. Botswana, Eswatini and Namibia have nearly achieved the 90-90-90 testing and treatment targets.

Treatment coverage in West and Central Africa remains a challenge, although there has been some progress with the HIV response exceeding 40% treatment coverage compared to 28% in 2015. This was due to high-level advocacy, mobilization of resources and partners, political mobilization through the African Union, and the 19th International Conference on AIDS and STIs in Africa (ICASA) in 2017.

Following the adoption of the Regional Framework on Hepatitis 2016-2020, WHO supported 20 countries[3] to develop national action plans in line with the global strategy, and 16 countries[4] now have national technical working groups and health ministry focal points to oversee the national hepatitis response. Eleven countries[5] have introduced the hepatitis B vaccine birth dose to reduce new cases of hepatitis B in children.

The African Region has one of the highest TB incidence rates in the world, second only to South East Asia, and a rising incidence of drug-resistant TB. With WHO support, virtually all Member States in the Region have adopted the targets of the Sustainable Development Goals (SDGs) and the End TB strategy. Out of the 1 200 078 new cases started on treatment in 2015, eighty-three per cent were successfully cured, preventing millions of new infections[6].

**Figure 4.1.1: Number of countries implementing WHO's consolidated guidelines for HIV/AIDS treatment by the end of 2017**




2. Algeria, Angola, Benin, Botswana, Burundi, Cameroon, Comoros, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
3. Benin, Botswana, Burkina Faso, Cameroon, Cote d'Ivoire, DRC, Ethiopia, The Gambia, Ghana, Liberia, Mauritania, Niger, Nigeria, Rwanda, Senegal, South Africa, Togo, Uganda, Tanzania, Zimbabwe
4. Benin, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, The Gambia, Ghana, Mauritania, Niger, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Togo, Uganda
5. Algeria, Angola, Botswana, Cabo Verde, The Gambia, Mauritania, Mauritius, Namibia, Nigeria, São Tome and Principe, Senegal
6. Based on accepted theory that left untreated, each person with active TB will infect on average between 10 and 15 people every year https://en.wikipedia.org/wiki/World_Health_Organization : "Tuberculosis Fact sheet N°104". November 2010

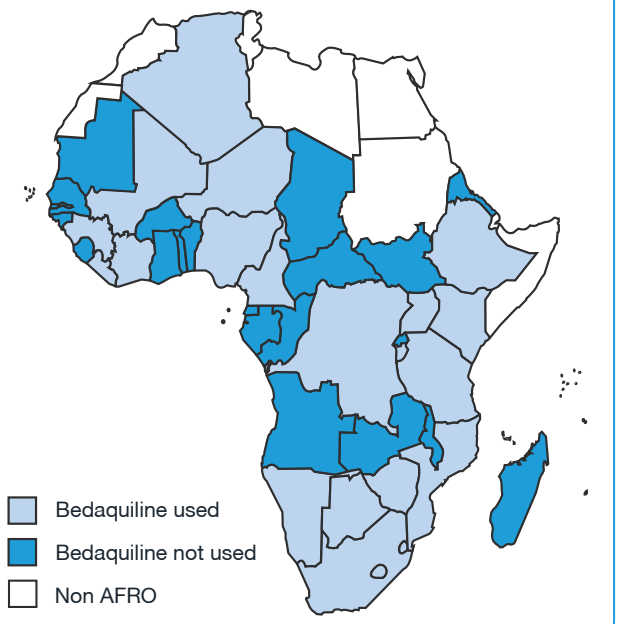
Photo (C) Maggie Hallahan

New anti-TB medicines and shorter, nine-month treatment for multidrug-resistant TB (MDR-TB) have been rolled out in 21 countries[7], with 11 more[8] geared to begin the new regimen in 2018 (Fig 4.1.2). WHO supported 43 Member States to scale up services for drug-resistant TB, and assisted Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana and Eswatini to conduct national surveys to establish the profile of resistance to anti-TB drugs. The results will inform the updating of national TB treatment guidelines, including for drug-resistant TB.

During 2017, Namibia and South Africa commenced national TB disease prevalence surveys to measure the TB burden, and similar surveys are planned in 2018 for Botswana, Lesotho, Mozambique and Eswatini, bringing to 17 the number of countries that have undertaken such surveys in the past five years.

Laboratory services are critical for detecting TB cases. Laboratory capacity for detecting TB cases was strengthened in 21 countries[9] and WHO provided technical assistance to support the assessment of laboratory networks in six countries[10]. By the end of 2017, twenty-two countries[11] had acquired Line Probe Assay technology for detecting resistance to first and/or second line anti-TB medicines. The National TB Reference Laboratory of Benin became the fourth Supranational TB Reference Laboratory in the Region, one of 32 such laboratories globally.

**Figure 4.1.2: Countries that introduced shorter MDR-TB treatment regimens by the end of 2016**




**WHO SUPPORTED 43 MEMBER STATES TO SCALE UP SERVICES FOR DRUG RESISTANT TB AND ASSISTED:**

- *Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana and Eswatini conducted national surveys to establish the profile of resistance to anti-TB drugs.*
- *The results will inform the updating of national TB treatment guidelines, including for drug-resistant TB.*
- *During 2017, Namibia and South Africa commenced national TB disease prevalence surveys to measure the burden of TB, and similar surveys are planned in 2018 for Botswana, Lesotho, Mozambique and Eswatini, bringing to 17 the number of countries to have undertaken such surveys in the past five years.*

In sub-Saharan Africa, 14 countries[12] accounted for 80% of the global malaria burden[13], and the pace of progress in many countries has stalled, with significant gaps in implementation of measures to prevent malaria. Through WHO support to review malaria strategic plans, 24 countries[14] have updated their national policies and guidelines, and are implementing evidence-based interventions in line with the Global Technical Strategy for Malaria 2016-2030.

WHO/AFRO partnered with the Global Malaria Programme, the Université Cheick Anta DIOP in Senegal and the African Medical and Research Foundation in Kenya to assess the competency of 137 malaria microscopists, thereby helping to strengthen the capacity of core National Malaria Programme teams in 23 countries.[15] Capacity was built in 12 francophone countries[16] to improve the quality of therapeutic efficacy studies, while national malaria staff in 43 countries[17] were trained on malaria surveillance to improve quality and use of malaria data for decision-making.

7. Benin, Burkina Faso, Burundi, Cameroon, CAR, Capo Verde, Chad, DRC, Ethiopia, Gabon, Ghana, Guinea, Kenya, Mali, Mauritania, Namibia, Rwanda, Eswatini, Tanzania, Uganda, Zimbabwe
8. Algeria, Botswana, Congo, Gabon, The Gambia, Liberia, Madagascar, Malawi, Mozambique, Sierra Leone, Togo
9. Angola, Botswana, Burkina Faso, Cabo Verde, Cameroon, DRC, Eritrea, Eswatini, Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Nigeria, Rwanda, Senegal,Tanzania
10. Angola, Burkina Faso, Cameroon, DRC, Madagascar and Rwanda
11. Algeria, Angola, Benin, Botswana, Burundi, Cameroon, Cote d'Ivoire, DRC, Ethiopia, The Gambia, Guinea-Bissau, Madagascar, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania; Zambia, Zimbabwe
12. Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Uganda, United Republic of Tanzania
13. World Malaria Report, 2017
14. Benin, Botswana, Central African Republic, Comoros, Congo, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea Bissau, Madagascar, Mali, Mauritania, Mozambique, Namibia, Nigeria, Senegal, South Sudan, Togo, Uganda and the United Republic of Tanzania (Mainland and Zanzibar).
15. Algeria, Angola, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Democratic Republic of Congo, Eritrea, Eswatini, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
16. Angola, Burundi, Cameroon , Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea , Gabon, Madagascar, Sao Tome and Principe
17. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinee Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania (Mainland and Zanzibar), Zambia, Zimbabwe

To facilitate monitoring of incidence and prevalence rates, a malaria online database[18] for the Eastern African Region was launched in the first quarter of 2018. In addition to providing information on malaria burden reduction, elimination, quality control and surveillance, the platform also allows for cross-border data sharing for subregional collaboration. This data platform will shortly be expanded to cover the entire African Region.

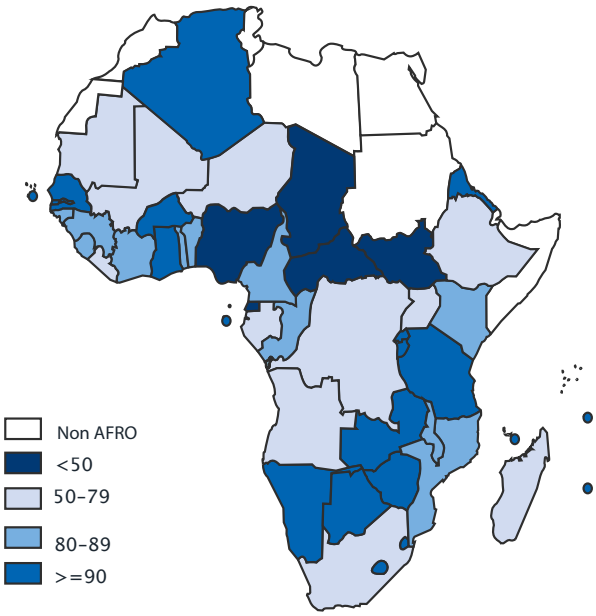
The malaria vaccine, RTS,S was given special regulatory approval by Ghana, Kenya and Malawi for use in the pilot implementation programme, expected to begin in September 2018. It will generate information on how best to deliver this vaccine through routine health systems, consolidate its safety profile and evaluate impact on child survival. As a new tool, the vaccine will complement existing malaria interventions which have proven very effective in controlling malaria, with the potential to change the malaria landscape in Africa.

Photo (C) WHO

The Regional Director visited Nigeria in October 2017 to strengthen collaboration between WHO and the Government of Nigeria. A highlight of the visit was the launch of the Integrated Polio/ Seasonal Malaria Chemoprevention (SMC) campaign where existing polio infrastructure was used to conduct house-to-house malaria chemoprevention and polio vaccination.

WHO has renewed its partnership with the Global Fund to support countries to mobilize resources for the 2017-2019 cycle. Under an agreement signed in December 2017, thirty-six countries[19] received grants following WHO's support to develop funding applications through strategic initiatives on HIV/AIDS, TB, malaria, resilient and sustainable systems for health (RSSH), and reproductive, maternal, newborn, child and adolescent health (RMNCAH).

**Figure 4.1.3: DTP3 coverage in the African Region in 2017**




Immunization protects children from vaccine-preventable diseases that cause high morbidity and mortality in the Region. Regional immunization coverage estimates indicate that coverage of Diphtheria-Tetanus-Pertussis-containing vaccine (DTP3) stagnated at 72% in 2017[20] (Figure 4.1.3).

A total of 25.3 million children were vaccinated with DTP3, while 125.5 million children received measles or measles-rubella supplemental vaccine doses in mass vaccination campaigns in 14 countries.



18. https://who-dev.baosystems.com/dhis-web-dashboard-integration/index.html
19. Angola, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Madagascar, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Sudan, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
20. WHO/UNICEF estimates of National Immunization Coverage, July 2018

Photo (C) WHO

A total of 25.3 million children were vaccinated with DTP3, while 125.5 million children received measles or measles-rubella supplemental vaccine doses in mass vaccination campaigns in 14 countries. Capacity building and technical assistance to strengthen routine immunization resulted in 20 countries reaching ≥90% DTP3 coverage. In total, 38 countries in the African Region have attained the status for validation of elimination of maternal and neonatal tetanus.

Despite the global shortage of inactivated polio vaccine (IPV) and human papillomavirus vaccine (HPV), WHO continued to support countries to ensure readiness for introduction once vaccines became available. An additional 11[21] countries have introduced IPV into their routine immunization systems, bringing the total to 41. Tanzania and Zimbabwe will introduce HPV in 2018.

Through sustained support and advocacy from WHO and its partners, countries have continued to use pneumococcal conjugate vaccines (PCV) and rotavirus vaccines that have been introduced in 38 and 33 countries respectively, although coverage remains low at 65% and 43% respectively.

WHO has evaluated the impact and effectiveness of these vaccines on the disease burden in 15 countries, and found a substantial reduction in rotavirus diarrhoea hospitalization, paediatric bacterial meningitis, invasive pneumococcal diseases and pneumonia in countries using these vaccines routinely. Estimates show that 135 000 rotavirus hospitalizations and 21 000 rotavirus deaths in under-five children were prevented by the end of 2017.[22]

In May 2018, at the World Health Assembly, the *Business Case for WHO Immunization Activities on the African Continent 2018-2030* was launched. It aims to save 1.9 million lives and avert 167 million vaccine-preventable cases by 2030, potentially generating US$ 58 billion in economic benefits.

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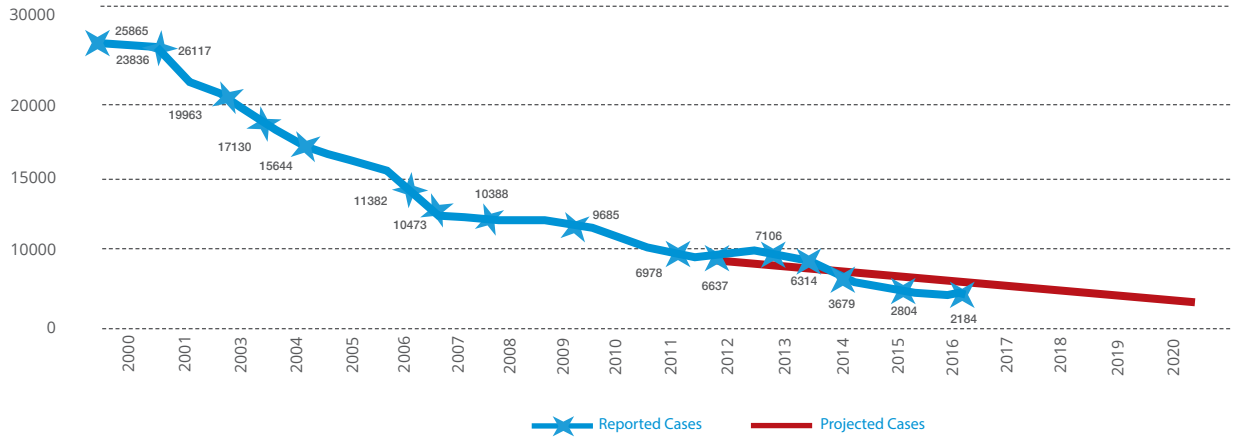
Photo (C) WHO/J. Pudlowski

**Figure 4.1.4: Trends and prospects for HAT elimination by 2020**




The business case outlines the resources required to help Member States strengthen national immunization programmes through an integrated, life-course approach and mitigate the transition from donor to domestic funding.

Addressing environmental determinants of health such as safe drinking water, sanitation and hygiene, management of water, soil and air pollution, vector control and climate change is a key priority in the Region. An estimated 28% of premature deaths are attributable to unhealthy environments.[23]

Following the adoption of the new Regional Strategy for the management of environmental determinants of human health in the African Region 2017-2021, WHO has produced the first regional report on arboviral vectors including country profiles in collaboration with the Pasteur Institute of Dakar, Senegal. The report focuses on integrated vector surveillance and control to strengthen evidence-based implementation of integrated vector management (IVM), particularly in emergency situations and epidemics. In addition, five countries[24] have developed insecticide resistance management plans. The report will guide action by countries in preventing outbreaks.

WHO and UNICEF produced a Joint Monitoring Update[25] on access to water and sanitation in 2017 with data from all 47 countries. It shows that only 59% of the population had access to safe drinking water, 31% had access to basic sanitation, and 18% had access to basic handwashing facilities. This underscores the gaps in resources to achieve the SDGs.

WHO mobilized US$ 15 million to implement priority intersectoral programmes on health and environment and multilateral environmental agreements (MEA) in 12 countries.[26] WHO/AFRO will implement operational research and country capacity building on integrated vector control in 14 countries[27] over the next five years through a grant of US$ 9.5 million from the United Nations Environment Programme (UNEP). Under another project worth US$ 10 million, prepared and approved by the Global Environment Facility through UNEP, WHO will build capacity in chemical surveillance in nine countries[28] to ensure the sound management of chemicals and to mitigate their health impact.

The African Region bears around 40% of the global burden of neglected tropical diseases (NTDs).[29] As a result of efforts deployed by WHO and its partners, Guinea worm disease (GWD) is on the verge of eradication. Kenya was certified free of local transmission of Guinea worm in February 2018, bringing the total number of certified countries to 41. Only Angola and the DRC need to be certified, while South Sudan is in the pre-certification stage. While Chad, Ethiopia and Mali remain endemic for GWD, Chad and Ethiopia reported 15 cases each in 2017. Yaws, which is endemic in at least 10 countries,[28] is now targeted for eradication through mass Azithromycin administration. Mapping is underway to identify all at-risk communities for this large-scale, rapid impact intervention to eradicate yaws.

Through sustained surveillance and control, human African trypanosomiasis, a disease prevalent only in the African Region, is moving towards elimination (Fig 4.1.4), while for leprosy, only Comoros has a prevalence rate that exceeds the threshold of one case per 10 000 population.

With support from DFID and the Gilead Foundation, WHO helped to save the lives of around 6700 people in three countries[30] by providing medicines and diagnostic kits for the treatment and control of visceral leishmaniasis. The number of Buruli ulcer cases dropped from 2933 in 2014 to 1914 in 2017 with the use of WHO-recommended oral antibiotics and implementation of the integrated case management strategy for NTDs.

23. WHO 2016. Preventing diseases through Health Environment: A global estimate of the burden of disease from environment risks. World Health Organization, Geneva.
24. Benin, Burkina Faso, Niger, Nigeria, Zimbabwe
25. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene "A snapshot of Drinking Water, Sanitation and Hygiene in the WHO African Region" September 2017
26. Benin, Burkina Faso, Ghana, Guinea, Mali, Mozambique, Niger, Nigeria, Senegal, South Africa, Togo, Zambia.
27. Botswana, Eswatini, The Gambia, Kenya, Liberia, Madagascar, Mozambique, Namibia, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
28. Ethiopia, Gabon, Kenya, Mali, Madagascar, Senegal, South Africa, Zambia, Zimbabwe
29. Information document AFR/RC67/INF.DOC/3
30. Ethiopia, Kenya, South Sudan

Photo (C) WHO

WHO, through the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), is working with partners and Member States to mobilize political commitment and resources to reduce and eliminate the five most prevalent NTDs amenable to preventive chemotherapy (PC-NTDs) in Africa: lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis and trachoma.

WHO succeeded in mobilizing US$ 16 million by the end of 2017 to scale up geographic coverage of the five PC-NTDs to 100%, strengthen information sharing, and improve utilization of donated medicines, among others.

Following a gap analysis and funding from partners, ESPEN supported 13 countries[31] to scale up mass drug administration, targeting at least 30 million people. An additional 14 countries[32] received support for programmatic activities including impact assessments, planning and budgeting.

ESPEN has set up a fully-fledged laboratory in Ouagadougou, Burkina Faso to support regional efforts to scale down treatment of onchocerciasis where appropriate impact has been achieved.

To facilitate access to current data, ESPEN worked with Member States to set up a mobile data system for collection and transmission of data from remote locations to a centralized database at the Regional Office.



31. Burundi, Cabo Verde, Chad, Comoros, Congo, Democratic Republic of the Congo, Ethiopia, Lesotho, Nigeria, Sao Tome and Principe, South Sudan, Sudan, Zambia
32. Benin, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Ethiopia, Guinea, Guinea-Bissau, Nigeria, Sao Tome & Principe, South Sudan, Togo, United Republic of Tanzania

SUCCESS STORY

# PROGRESS TOWARDS ERADICATING GUINEA-WORM DISEASE

In February 2018, Kenya became the 41st country in the WHO African Region to be certified free of Guinea-worm disease (GWD), following a strategic, three-pronged approach of monitoring and reporting, research and education that began in 2012.

GWD (also known as Dracunculiasis) is a crippling parasitic disease caused by Dracunculus medinensis, a long, thread-like worm. It is transmitted when a person drinks unsafe water contaminated with parasite-infected water fleas. It affects people who have no access to safe drinking-water, and who have to drink from stagnant, open and unprotected drinking-water sources. It is an indicator of poverty and underdevelopment.

Surveillance hotlines for reporting GWD were set up and strengthened, and cash rewards to incentivize reporting of the disease were offered nationally. Research was conducted through case studies, documentation and investigation of rumours within 24 hours of reporting, and health staff were sensitized on GWD to further strengthen surveillance.

WHO/AFRO supported the Kenya Guinea Worm Eradication Programme through the National Certification Committee, established in November 2014, to lead these activities which were conducted through the Ministry of Health with the aim of preparing the country for certification.

Photo (C) WHO

WHO/AFRO supported the Kenya Guinea Worm Eradication Programme through the National Certification Committee, established in November 2014, to lead these activities which were conducted through the Ministry of Health with the aim of preparing the country for certification.

# 4.2

# NONCOMMUNICABLE DISEASES

Noncommunicable diseases (NCDs) are a major contributor to the burden of disease in the Region, and deaths from NCDs in the African Region are on the increase. NCDs include cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases, which are largely preventable by addressing their major risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

# 4. Significant achievements by category of work

## 4.2 Category 2: Noncommunicable Diseases

Noncommunicable diseases (NCDs) are a major contributor to the burden of disease in the Region, and deaths from NCDs in the African Region are on the increase.[33] NCDs include cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases, which are largely preventable by addressing their major risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. WHO supports countries to reduce the impact of NCDs through health promotion and risk reduction, as well as prevention, treatment and monitoring of these diseases and their risk factors.

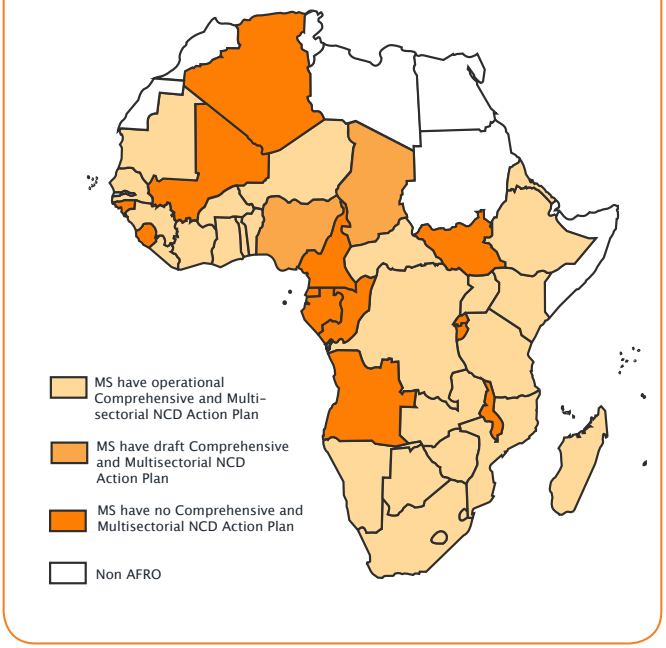
High-level advocacy urging Member States to adequately resource and prioritize NCDs in national health plans is beginning to bear fruit. WHO provided technical support to seven Member States[34] to develop/finalize national multisectoral NCD Strategic/Action Plans in line with the UN Declaration on NCDs and the WHO Global NCD Action Plan 2013-2020.

By 31 March 2018, thirty-one[35] Member States had developed NCD Strategic/Action plans and seventeen[36] of these were operational, having been endorsed by their respective governments (Fig 4.2.1). Such multisectoral plans will ensure a coherent response through NCD prevention and control, and mobilize stakeholders towards achieving set national targets. Furthermore, WHO provided support to Seychelles and Namibia to develop and implement their National Cancer Control Plans, while the National Cervical Cancer Strategic Plan for Zimbabwe was finalized and endorsed.

Global and regional leaders have committed to addressing the high burden of NCDs. In August 2017, Member States adopted the Regional Framework for integrating essential NCD services in primary health care. The framework guides Member States to strengthen prevention, early detection and treatment of NCDs at peripheral levels.

The WHO Package of Essential NCD Interventions (WHO PEN) comprises priority, cost-effective NCD actions which can be integrated into primary health care settings to assist countries implement these commitments. To expand capacity and health coverage of NCD interventions using the WHO PEN, WHO collaborated with the West African Health Organisation (WAHO) to train NCD programme managers from 14[37] West African Ministries of Health on the WHO PEN.

**Figure 4.2.1: Status of NCD multisectoral plans in the Region**




33. WHO, Global Health Estimates 2015, Geneva, World Health Organization, 2015 http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html, accessed 21 March 2018.
34. Botswana, Mauritania, Namibia, Niger, Togo, Uganda, United Republic of Tanzania
35. Benin, Botswana, Burkina Faso, Cabo Verde, Chad, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Seychelles, South Africa, Togo, Uganda, United republic of Tanzania, Zambia, Zimbabwe
36. Benin, Bostwana, Burkina Faso, Cabo Verde, Central African Republic, Côte d'Ivoire, Eswatini, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Lesotho, Niger, Seychelles, Togo, United Republic of Tanzania
37. Benin, Burkina Faso, Côte d'Ivoire, Ghana, The Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo

In Lesotho, the pilot phase of the tool started in December 2017 following WHO support to develop national NCD guidelines and train health care workers. Technical support was also provided to Nigeria to develop the WHO PEN guideline and protocol. With 10 countries[38] in the Region implementing the WHO PEN, efforts need to be escalated to reach the target of 24 countries by 2020.

To prevent heart attacks and strokes, WHO supported Ethiopia and Uganda to develop and implement the Global HEARTS technical package in selected districts. In addition, the HEARTS module was combined with the NCD training module on the Integrated Management of Adult and Adolescent Illness (IMAI) and the WHO PEN to further improve integration of NCD programmes and offer clinical decision support to health workers. The NCD module comprises three patient monitoring tools for cardiovascular disease (CVD)/diabetes, asthma/chronic obstructive pulmonary disease (COPD), and rheumatic heart disease and a patient longitudinal register. These integrated tools will contribute to early detection, diagnosis and better treatment of NCDs in primary health care facilities. WHO trained 41 health workers at Masaka Regional Hospital in Uganda on the NCD module which can now be rolled out to other districts.


Photo (C) WHO

Sickle cell disease (SCD) is the most prevalent genetic disease in the African Region and is a major cause of morbidity and mortality in high-burden countries. WHO provided technical support to the Republic of Congo to strengthen the National Reference Centre for SCD[39] in Brazzaville which will guide and support the management of SCD in the country, and also prevent, treat and provide care for patients with the disease in the city.

WHO and the National Sickle Cell Centre in Lagos, Nigeria developed a handbook on the management of sickle cell disorders for doctors and nurses. In Western Kenya, WHO supported a consultative workshop on SCD aimed at improving the quality of life of individuals affected by the disease. Recommendations included the urgent need to improve screening, diagnostics and treatment of patients with SCD, integration of SCD management into other programmes especially in health care settings and schools, and highlighted the need for resource mobilization to tackle SCD.

WHO and its partners[40] continue to support the *"Be He@lthy-Be Mobile"* programme that uses mobile technology to improve the prevention and control of NCDs. In Zambia and Burkina Faso, the emphasis is on cervical cancer, while an mDiabetes programme in Senegal reaches populations directly with key SMS messages via mobile phones. The programme in Senegal has recorded a steady increase in subscribers since its launch in 2014. By 2017, approximately 117 800 diabetic patients and 5000 health care providers were participating in the programme. An assessment to evaluate the programme's capacity to improve diabetes management and document the improvement in glycaemic control among participants was conducted in 2017. The evaluation found that sending diabetes education messages via SMS was associated with improved glycaemic control in people with type 2 diabetes and concluded that mHealth is both a cheap and effective tool for the therapeutic education of people with diabetes in Senegal.[41]

WHO provided technical support to the Republic of Congo to strengthen the National Reference Centre for SCD in Brazzaville which will guide and support the management of SCD in the country, and also prevent, treat and provide care for patients with this disease.

38. Benin, Botswana, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Malawi, Nigeria, Sierra Leone, Togo
39. Centre National de reference de la Drepanocytose, CNRD, "Maman Antoinette Sassou-N'Guesso"
40. ITU and Bloomberg Philanthropies
41. Wargny M, Kleinebreil L, Diop S, Ndour-Mbaye M, Ba M, Balkau B, Simon D. SMS-based intervention in type 2 diabetes: clinical trial in Senegal, BMJ Innovations 2018, Vol 4:142-146.

In line with the goal of eliminating noma[42] as a public health problem in the Region, WHO supported the development and implementation of noma triennial plans in 10 Member States,[43] and supported the development and dissemination of noma information, education and communication (IEC) materials. In addition, the oral health manual developed in 2016 has now been translated into Arabic for wider dissemination.

Mental, neurological and substance use disorders place a heavy burden on the affected persons, their families and the community. These disorders affect all social groups and ages, and more than 75% of people suffering from mental disorders in low- and middle-income countries receive no treatment or care.

Photo (C) WHO/J. Pudlowski

WHO supported six countries[44] to revise or develop national mental health policies which aim to improve access to mental health services in Member States. More than 300 primary health care workers were trained to respond to mental health challenges in normal and post emergency circumstances using WHO tools. As a follow up to the Sixth Meeting of African Ministers of Health of Small Island Developing States (SIDS) in September 2017, WHO supported Cabo Verde to develop a plan on harmful use of alcohol, and Mauritius and Seychelles to develop action plans to respond to alcohol and other drugs.

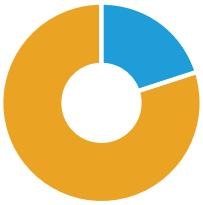
WHO continues to support Member States to develop and enforce legislation and regulations on tobacco control. Laws to address tobacco use in line with the WHO Framework Convention on Tobacco Control (WHO FCTC) were adopted in eight Member States.[45]

In addition, 17 Member States[46] and three subregional blocs – the East African Community (EAC), the Economic Community of West African States (ECOWAS) and the West African Economic and Monetary Union (WAEMU) - were supported to undertake tobacco tax policy changes and tax simulation. ECOWAS and WAEMU adopted reformed tobacco excise tax directives. WHO also provided technical support for ratification of the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products. As a result, Mozambique ratified the WHO FCTC and three additional Member States[47] ratified the Protocol.

WHO supported 12 countries[48] that have completed the Global Adult Tobacco Survey and/or additional rounds of the Global Youth Tobacco Survey to use the evidence to inform and improve tobacco control policies and enhance programme capacity. Tobacco control country profiles[49] featuring data on the tobacco burden and information on its control were produced and published for all 47 countries in the Region. These country profiles provide information about tobacco prevalence, preventive measures, cessation and tobacco economics in Member States.

WHO provided technical support and equipment to Malawi and Zambia to conduct STEPwise[50] surveys on NCDs and their risk factors. These surveys will shed light on the burden of NCDs and their risk factors in the two countries and inform interventions to prevent escalation of these diseases.

Mental, neurological and substance use disorders place a heavy burden on the affected persons, their families and the community. These disorders affect all social groups and ages, and more than



**75/100**

**of people suffering from mental disorders in low- and middle-income countries receive no treatment or care**

42. Noma, a necrotizing and destructive disease affecting the mouth and face of children aged 2 to 6 who are malnourished and living in extreme poverty.
43. Benin, Burkina Faso, Côte d'Ivoire, DRC, Guinea-Bissau, Mali, Niger, Nigeria, Senegal, Togo
44. Central African Republic, Eritrea, Ethiopia, Ghana, Namibia, Sierra Leone
45. The Gambia, Gabon, Ghana, Nigeria, Senegal, United Republic of Tanzania, Togo, Uganda
46. Benin, Burkina Faso, Côte d'Ivoire, Ethiopia, Gabon, The Gambia, Guinea, Guinea-Bissau, Kenya, Madagascar, Mauritania, Niger, Rwanda, Senegal, Togo, Uganda, United Republic of Tanzania
47. Madagascar, Niger, Togo
48. Cameroon, Kenya, Mauritania, Mozambique, Nigeria, Senegal, Seychelles, South Africa, Tanzania, Uganda, Zambia, Zimbabwe
49. http://www.who.int/tobacco/surveillance/policy/country_profile/en/
50. STEPwise surveys are a WHO tool to assess the magnitude of NCD risk factors and are conducted every 3-5 years in countries.

Photo (C) WHO/Lushumo

SUCCESS STORY

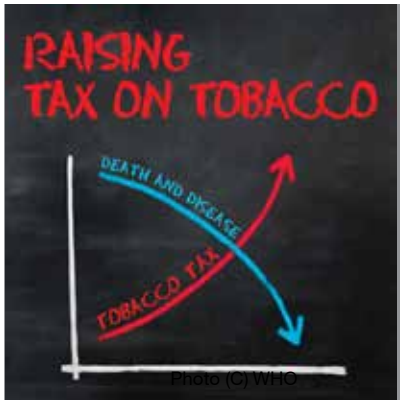
## TAXING TOBACCO: THE GAMBIA SHOWS THE WAY

Increasing the price of tobacco through higher taxes is the single most effective way to decrease consumption and encourage tobacco users to quit. In 2012, The Gambia was among countries with the lowest prices for cigarettes globally, with tax comprising 40% of the retail price, down from 50% in 2008.

With technical support from WHO, the country changed its cigarette tax structure in 2013, moving from overall weight to number of sticks as the base for the tax. The Gambia adopted a three-year plan for annual tax increases to raise the average price of cigarettes to be close to the regional average for Africa (US$ 1.24/pack) by 2016.

The actual increase in prices and revenues exceeded forecasts every year after the plan was implemented. Cigarette imports declined immediately after the 2014 tax increase, reflecting reduced consumption. The share of excise tax also climbed in successive years, reaching 54% of the retail price in 2016, while an environmental tax on cigarettes and tobacco products resulted in a 15-fold increase in environmental tax revenues.

The Gambia implemented a new and more ambitious taxation plan in 2016, which will raise the tax per pack by US$ 0.10 each year until it reaches US$ 0.63 per pack in 2019. The tax share is estimated to reach 63% of the average retail price by 2019.




Increasing the price of tobacco through higher taxes is the single most effective way to decrease consumption and encourage tobacco users to quit.

The country's commitment to using tobacco taxation to its full potential is expected to lead to further reductions in consumption and a decline in the tobacco-related burden of disease and death.

# 4.3

## PROMOTING HEALTH THROUGH THE LIFE-COURSE

WHO supports countries to promote health along the life cycle from conception to old age, with a specific focus on improving the health of children, adolescents and women through interventions such as immunization, prevention of mother-to-child transmission of HIV and syphilis, and nutrition, among others.

# 4. Significant achievements by category of work

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

WHO supports countries to promote health along the life cycle from conception to old age, with a specific focus on improving the health of children, adolescents and women through interventions such as immunization, prevention of mother-to-child transmission of HIV and syphilis, and nutrition, among others.

The African Region has high maternal, newborn and child mortality and low coverage of effective health interventions targeting reproductive, maternal, newborn, child and adolescent health (RMNCAH). Maternal mortality in the African Region (546 deaths/100 000 live births[51]) is unacceptably high and far from the 2030 target (less than 70 deaths/100 000 live births[52]). Likewise, newborn mortality (27/1000 livebirths[53]) falls significantly short of the interim targets for 2020 (less than 15 deaths per 1000 live births[54]).

To address this situation, WHO is assisting Member States to operationalize the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (GSWCAH). So far, 24 countries[55] have developed strategic plans with priority interventions aligned to the GSWCAH to guide the collective action of government, partners and stakeholders. A further six countries[56] have mobilized resources through the Global Financing Facility (GFF) to implement the strategy, bringing to 13 the number of countries[57] benefitting from the GFF.

WHO and partners[58] disseminated the new WHO guidelines on antenatal and intrapartum care to 38[59] and 17 countries[60] respectively, as well as on newborn health to 37 countries,[61] including for perinatal death surveillance and response, and guidelines on the management of possible serious bacterial infections in newborns and young infants. These countries are expected to use the guidelines to adapt their national policies to accelerate implementation of in-country actions.

In addition, countries were supported to track maternal and neonatal health standards, and maternal deaths surveillance and response which are systems for identifying gaps in care and taking remedial actions. WHO/AFRO has assessed maternal mortality trends and the impact of these interventions and is developing factsheets for the 47 Member States. This information will be used to advocate for greater engagement of countries and partners towards reducing maternal and newborn mortality.

Quality of care is critical to achieving GSWCAH targets. Countries are prioritizing the quality of care that mothers and newborns receive in health facilities, and 17 countries[62] have assessed their service quality using the WHO tools. Eight countries[63] in the African Region have joined the Quality of Care Network, committing to reduce maternal and newborn mortality by 50% in participating facilities within five years. WHO has supported these countries to mobilize funding for catalytic activities such as developing national road maps, operational plans and quality of care packages, and setting up learning systems for sharing best practices between facilities and districts.

Working towards the target of zero new HIV and syphilis infections in infants by 2020 and elimination of congenital syphilis as a public health threat by 2030, WHO/AFRO established a Regional Validation Team with key partners,[64] which developed a stepwise approach to advance elimination of mother-to-child transmission (eMTCT). The *"Path to Elimination"* recognizes the remarkable progress of high-burden countries striving for eMTCT of HIV and syphilis. It was endorsed by the Global Validation Advisory Committee and launched at the International Conference on AIDS and STIs in Africa (ICASA) in December 2017.

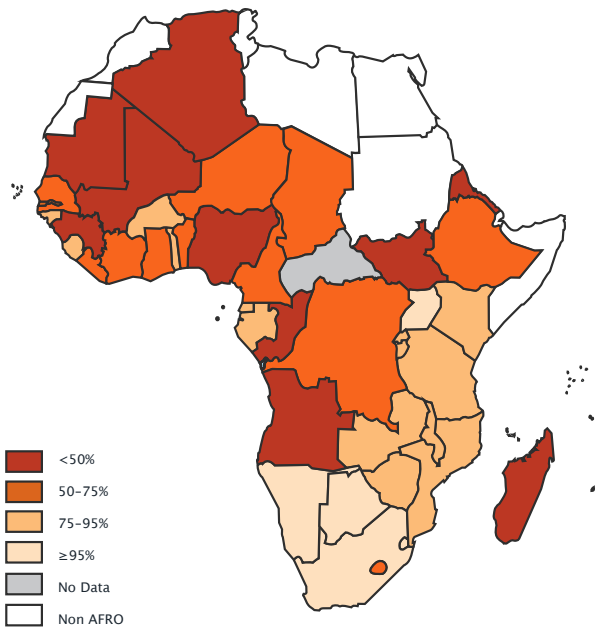
51. WHO et al: Trends in Maternal Mortality: 1990 to 2015 WHO Geneva, 2015
52. Every Woman Every Child: The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), 2015
53. UN Inter-agency Group for Child Mortality Estimates: Levels & Trends in Child Mortality, 2017
54. WHO and UNICEF: Every Newborn: An Action Plan to End Preventable Deaths June 2014.
55. Benin, Botswana, Burkina Faso, Burundi, Central Africa Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, The Gambia, Ghana, Guinea, Lesotho, Liberia, Malawi, Mauritania, Namibia, Niger, Togo, Sierra Leone, South Sudan, United Republic of Tanzania, Zimbabwe
56. Burkina Faso, CAR, Côte d'Ivoire, Madagascar, Malawi, Rwanda
57. Burkina Faso, Cameroon, CAR, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Rwanda, Uganda, United Republic of Tanzania
58. UNICEF, UNFPA, BMGF, USAID, JHPIEGO and UNWOMEN
59. Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
60. Benin, Burkina Faso, Burundi, Cameroon, CAR, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Niger, Senegal, Togo
61. Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, , Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
62. Congo, Cote d'Ivoire, Ethiopia, Eswatini, Ghana, Guinea, Lesotho, Malawi, Niger, Nigeria, Rwanda, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
63. Côte d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, Uganda, United Republic of Tanzania
64. UNAIDS, UNICEF, UNFPA, AU, CDC, EGPAF and Women living with HIV network (ICW)


WHO supported priority countries to revise national eMTCT plans, implement WHO guidelines and accelerate prevention of mother-to-child transmission (PMTCT) services, including community peer support. As a result, by the end of 2017, the Region achieved PMTCT coverage of 79%, up from 67% in 2015, thus showing good progress towards the elimination target of 95% (Fig 4.3.1). Eight countries[65] are now qualified to undertake the validation process.

In addition, WHO engaged its 47 country offices in the *"Free to Shine"* campaign launched in January 2018 by the Organisation of African First Ladies against HIV/AIDS (OAFLA), the African Union and the WHO Regional Director for Africa. The campaign aims to accelerate actions to end childhood AIDS in the African Region by 2030.

Pneumonia, malaria and diarrhoea are the leading causes of death among under-five children after the first 60 days of life. To increase access to simple and affordable treatment of these conditions, WHO implemented the Rapid Access Expansion (RAcE) project in five African countries[66] from 2013 to 2017. Following a positive independent evaluation of the project, the countries have developed sustainability road maps to institutionalize integrated community case management of malaria, pneumonia and diarrhoea as part of government health services.

**Figure 4.3.1: Coverage of antiretrovirals for pregnant women, 2017**

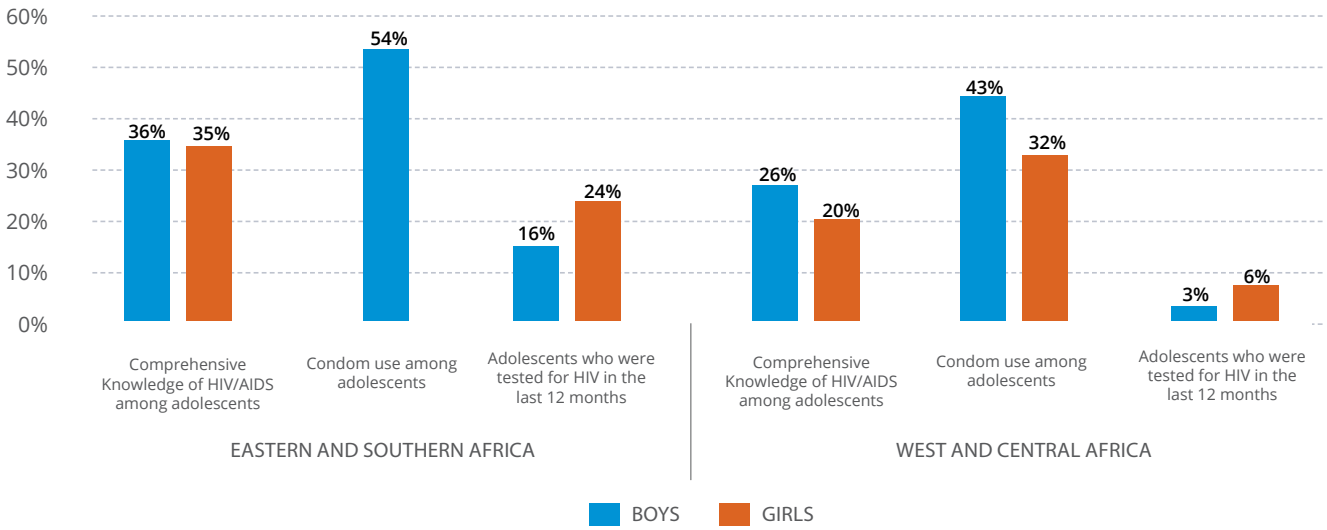



Source: WHO Global Health Observatory 2017, UNAIDS



65. Botswana, Cabo Verde, Eswatini, Mauritius, Namibia, Seychelles, South Africa, Uganda
66. Democratic Republic of the Congo, Malawi, Mozambique, Niger, Nigeria

## Figure 4.3.2: Coverage of selected HIV indicators among adolescent girls and boys by subregion, December 2016[68]




In the African Region, as many as 1500 adolescents die every day from treatable or preventable health issues and challenges in accessing services. The Region accounts for 80% of the global HIV burden in adolescents aged 10–19 years, and over 70% of new HIV infections are among adolescent girls. To address this, WHO/AFRO is spearheading a flagship programme on adolescent health.

Thirteen countries[67] were supported to leverage additional funding of US$ 50 million from the Global Fund for HIV interventions targeting adolescents and young women over a period of four years (2017-2020). WHO is working with Member States to adopt effective strategies such as using social networks and peer support to create demand for adolescent-friendly services, care and treatment.

Road maps of adolescent health interventions have been developed for eight priority countries.[69] Country factsheets for monitoring trends were developed to show the status, gaps and availability of age-related data, as well as legal or regulatory mechanisms. These are helping to identify opportunities for interventions in these countries.

Officials from 33 countries[70] were trained using the global Accelerated Action for the Health of Adolescents (AA-HA!) guidance document for developing country adolescent health implementation plans. In the Democratic Republic of the Congo, a guide for collaborative learning was developed and implemented in 30 health facilities, resulting in improved performance of health providers and better access of adolescents to quality health services.

WHO/AFRO also equipped 26 adolescent and youth organizations with health promotion skills to identify various determinants of adolescent health. This led to the development of road maps to be implemented in 2018.

Access to sexual and reproductive health services is important for preventing sexually transmitted infections (STIs). Member States adopted the Regional Implementation Framework for the Global Health Sector Strategy on Sexually Transmitted Infections (STIs) 2016-2021 in August 2017 which aims to eliminate STIs by 2030.

To obtain a holistic picture of STI management and control in the Region, WHO/AFRO supported a survey which found gaps in data reporting within and among countries, low coverage of syphilis screening among antenatal care clients, and shortages of recommended antibiotics, which compromises the treatment of adult syphilis and the prevention of congenital syphilis. WHO will work with countries to improve tracking and the use of dual rapid tests for HIV/syphilis to strengthen diagnosis, and increase the availability of medicines for timely treatment. This will contribute to the dual elimination of mother-to-child transmission of HIV and syphilis.

Globally, the African Region has the lowest coverage of family planning at 28%. Following the dissemination of new family planning guidelines in 2016, WHO trained 252 trainers and more than 300 service providers on family planning. The trainers are expected to cascade the training to boost the numbers of skilled family planning providers in countries for improved quality of care and contraceptive uptake.

67. Botswana, Cameroon, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
68. Data source: UNAIDS/UNICEF/WHO 2016 Global AIDS Response Progress Reporting; UNAIDS 2017 estimates.
69. Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Mozambique, Namibia, Nigeria, Rwanda, Zimbabwe
70. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe


Photo (C) WHO/J. Pudlowski

Furthermore, a three-year WHO project funded by the Bill and Melinda Gates Foundation (BMGF) targeting postpartum family planning and post-abortion contraception for youth and adolescents has resulted in a greater number of new contraceptive users reached, new guidelines disseminated in four countries,[71] and pilot projects on task sharing to address the shortage of human resources for health. WHO contributed to a joint United Nations proposal to the Swedish International Development Agency (SIDA) to mobilize about US$ 47-million for a project on sexual and reproductive health in five Southern African countries.[72]

While tools for equity-oriented, rights-based and gender-responsive systems strengthening are available, awareness and capacity to use them are limited in the African Region, whereas they constitute the main enablers for achieving the SDG targets and UHC. WHO collaborated with partners[73] to build capacity in 12 countries[74] to utilize WHO tools for strengthening the health systems response to gender-based violence and child sexual assault. Gender, equity and rights have also been integrated into the certification process for eMTCT of HIV and syphilis in 11 countries.[75]

Capacity was strengthened in seven countries[76] to integrate and implement equity, rights and gender responsive approaches within their RMNCAH programmes.

WHO/AFRO has launched the first Africa Nutrition Report[77] to provide Member States and partners with an overview of the nutrition situation in relation to the global nutrition targets for 2025. It highlights challenges in the nutritional status of populations in the African Region, including undernutrition, obesity and diet-related NCDs. The lack of reliable data to support programmatic action and monitor progress remains a major challenge. The identified data gaps provide a strong rationale for advocacy and resource mobilization for quality improvement and use of the nutrition data collected as part of routine primary health services.

Africa's population in the 60 years and above age bracket will increase from 46 million in 2015 to 147 million by 2050. To support countries to prioritize healthy ageing, WHO developed a regional framework to implement the comprehensive Global Strategy and plan of action on ageing and health, and supported 20 Member States[78] to develop policies and strategic plans on ageing towards the Decade of Healthy Ageing 2020-2030.

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71. Burkina Faso, Côte d'Ivoire, Ethiopia and Uganda
72. Lesotho, Malawi, Uganda, Zambia, Zimbabwe. The three-year project (2018–2020) includes family planning, STIs, prevention and control of unsafe abortion and addressing gender-based violence.
73. USAID, JHPIEGO and CDC
74. Botswana, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
75. Botswana, Cabo Verde, Eritrea, Eswatini, Mauritius, Namibia, Rwanda, Seychelles, South Africa, Uganda, Zimbabwe,
76. Eswatini, Ghana, Liberia, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania
77. http://www.afro.who.int/publications/nutrition-who-african-region
78. Benin, Burkina Faso, Cabo Verde, Congo, Côte d'Ivoire, Eswatini, Gabon, The Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Mauritius, Mozambique, Senegal, Seychelles, South Africa, , United Republic of Tanzania, Zimbabwe

SUCCESS STORY

# RAcE AND iCCM IMPLEMENTATION DRIES TEARS IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

In the DRC province of Tanganyika, malaria, pneumonia and diarrhoea cause 42% of deaths in under-five children. The people live in remote areas with poor access to health care due to lack of transport and poverty.

To address this situation, in 2012 Global Affairs Canada provided a grant of US$ 75 million over six years to WHO to fund the Rapid Access Expansion programme (RAcE) to reduce child mortality in the DRC, Malawi, Mozambique, Niger and Nigeria. The programme complemented efforts of the DRC Ministry of Public Health to achieve universal health coverage by reaching a large number of children in remote villages with no access to health facilities through integrated community case management (iCCM).

Volunteer community health workers (CHW) underwent training to correctly diagnose and treat children, referring the gravely ill to health centres. They used a checklist and simple equipment such as rapid diagnostic tests for malaria and tape measures for malnutrition. CHWs administered the first dose of oral treatments, counselled patients on treatments and preventive measures such as using mosquito nets, and arranged follow-up visits. To improve reporting, data collection tools, indicators and a data module for the online District Health Information Management System Tool (DHIS2) were developed.

The RAcE end-of-programme evaluation report published in May 2018 found that ICCM can advance universal health coverage by creating access to services for children who need treatment for malaria, pneumonia and diarrhoea, thereby contributing to child survival.

The RAcE community health workers managed 1.4 million new cases between January 2014 and September 2017. Quality of care improved, and care-givers were very satisfied with the services provided by CHWs. The flow of data from the community to the district health level was enhanced, although stock outs remain a concern.


Photo (C) WHO/J. Pudlowski

The RAcE end-of-programme evaluation report published in May 2018 found that ICCM can advance universal health coverage by creating access to services for children who need treatment for malaria, pneumonia and diarrhoea, thereby contributing to child survival.

The DRC Ministry of Public Health, with technical support and guidance from WHO, is using lessons learnt to scale up iCCM nationwide in collaboration with other partners.

# 4.4

# HEALTH SYSTEMS

WHO supports countries to attain health for all through actions which strengthen health leadership and governance, financing, service delivery and health information systems. Efforts to build responsive, resilient health systems have focused on implementing the Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals (SDGs) in the African Region.

# 4. Significant achievements by category of work

## 4.4 Category 4: Health systems

WHO supports countries to attain health for all through actions which strengthen health leadership and governance, financing, service delivery and health information systems. Efforts to build responsive, resilient health systems have focused on implementing the Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals (SDGs) in the African Region, adopted by Member States at the Sixty-seventh Regional Committee (RC67) in 2017. The Framework offers options for countries to determine and phase priorities when realigning their national strategies to accelerate progress towards UHC. Scoping missions have been carried out in Nigeria, Eritrea, Kenya and Mozambique to build consensus with governments and partners on the roadmaps and investments required for UHC.

Addressing the determinants of health - the underlying causes of ill health, health inequality and inequity - is one of the strategic priorities for achieving universal health coverage (UHC) and the health targets across the SDGs. Following agreement by Member States at RC67 to reduce health inequities through intersectoral actions on the social determinants of health, WHO supported Guinea, Lesotho and Zambia to conduct health inequities assessments. The findings are being used for policy- and decision-making to ensure that 'no one is left behind' and also in developing the implementation framework for Health in All Policies (HiAP) with a view to advancing the 2030 Agenda for Sustainable Development.

Several Small Island Developing States (SIDS) in the Region have integrated HiAP to address illicit drug use and substance abuse through mechanisms, policies, legislation and regulations, as well as treatment in health care facilities. Botswana is using HiAP to address road traffic accidents and prevention of injuries. WHO played a lead role in supporting the Ministry of Health to establish the Intersectoral Road Safety Task Force. This has resulted in a mobile alcohol testing lab ("buzz bus") to strengthen compliance of the management of the Motor Vehicle Accident Fund in reducing health care costs and saving the lives of citizens. In Namibia, following WHO training of policy-makers to ensure that all public policies systematically take health into account, the National Strategy for HiAP was developed under the coordination of the Prime Minister's Office to ensure policy coherence. Moving from policy to practice, the strong intersectoral coordination within the City of Windhoek is yielding effective responses to public health emergencies such as the Hepatitis E outbreak. Zambia's multisectoral response following WHO support in developing the HiAP Implementation Framework contributed to halting the cholera epidemic and commencing cholera vaccination in Lusaka.[79]

To strengthen health system governance, WHO convened the first advisory group on health system governance to build consensus on a model for generating evidence and technical support required for health governance in the African Region. The multidisciplinary group consisted of senior experts drawn from academia, government, the legal fraternity, public health practitioners and regional economic communities. In addition, the curriculum for the Country Learning Programme for developing national health policies, strategies and plans was finalized and piloted in Guinea. This led to the development of a road map for implementing activities that strengthen health system governance in Guinea.

Institutionalizing National Health Accounts (NHAs) in countries is important for monitoring resources allocated for UHC. The Regional Office provided technical and financial support to 25 countries[80] to produce National Health Accounts, which entails collecting, analysing and reporting health expenditure data needed to make fairer financing decisions and monitoring progress on financial health protection. Seven of these countries[81] have produced final reports. To date, 36 Member States have used the data from NHAs to develop health financing strategies and design reforms. In Gabon, this has led to evidence-based advocacy for improved financing, including involvement of the Prime Minister and the Minister of State for the Budget. To this end, at the Seventieth World Health Assembly, the Minister of Health of Gabon advocated the use of National Health Accounts as a powerful tool for supporting decision-making.[82]

WHO supported 11 countries[83] to plan and organize service availability and readiness assessments (SARA). Of these, four[84] are already analyzing, interpreting and using the results to improve

79. http://www.afro.who.int/news/ministry-health-reiterates-its-commitment-ending-cholera-epidemic-through-multi-sectoral
80. Angola, Burkina Faso, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Ghana, Guinea, Malawi, Mali, Mauritania, Mauritius, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania
81. Côte d'Ivoire, Democratic Republic of Congo, Gabon, Malawi, Mauritius, Senegal, Uganda
82. Seventieth World Health Assembly; Address in plenary session by the Minister of Public Health and Population of Gabon, Professor. Léon N'ZOUBA : Theme «Mettre en place de meilleurs systèmes pour la santé à l'ère du développement durable» («Establishing better health systems in the sustainable development era»)
83. Burundi, Congo, Democratic Republic of the Congo, Eswatini, Mauritania, Mozambique, Namibia, Lesotho, Sierra Leone, Seychelles, South Sudan
84. Burundi, Eswatini, Seychelles, Sierra Leone.

service delivery. WHO enhanced its support to the SARA by assisting countries to advocate and develop road maps focusing on key actions to improve service delivery.

A survey on the status of hospital services in the African Region has informed the development of a draft strategy for strengthening hospital and clinical services. Capacity for hospital management has been improved in Eritrea through hospital managers' training, in Kenya through electronic medical records, and in Liberia through support to update referral hospital strategies.

The Regional Office has developed an implementation manual for the District Health System model to support three countries[85] to serve as sites for generating district level evidence on developing resilient health systems. WHO/AFRO reinforced ongoing reform efforts in Côte d'Ivoire to revitalize district health systems, and supported the West African Health Organisation (WAHO) to develop and validate a guide for the formulation of national policy documents for community-based interventions.

While the development of human resources for health (HRH) is critical to achieving the health targets across the SDGs, coverage and inequity in access to health workers remain a challenge in the Region. In 2017, the Regional Committee adopted the *"African Regional Framework for the implementation of the Global Strategy on Human Resources for Health: Workforce 2030"*, which aims to ensure equitable access to qualified health workers.

To advance health employment and economic growth, subregional five-year action plans and road maps of countries of the West African Economic and Monetary Union (WAEMU) and the Southern African Development Community (SADC) were developed and endorsed by Ministries of Health. Namibia, Mozambique, Nigeria and United Republic of Tanzania have moved ahead in establishing National Health Workforce Accounts which generate information for planning, implementing and monitoring workforce policies, while Algeria has established a National Health Workforce Observatory. WHO assisted eight countries[86] to develop and revise policies and strategies on quality health service delivery, specifically for maternal, newborn and child health.

In the area of access to medicines, WHO is supporting SIDS countries[87] in the African Region to achieve economies of scale by developing a pooled procurement strategy to improve affordability and availability of medicines for noncommunicable diseases. Benin, Cabo Verde and South Sudan were supported to develop national essential medicines lists to guide country medicines procurements and use.

Cameroon, Central African Republic, Congo, Equatorial Guinea and Gabon are implementing an action plan on substandard and falsified medical products in line with the Regional Strategy on regulation of medical products in the African Region, 2016-2025. Furthermore, Burkina Faso, Benin, Côte d'Ivoire and Mauritania have strengthened market surveillance of medical products through measures that ensure the enforcement of national legislation and regulations to preserve the integrity of the supply chain, leading to the seizure and destruction of substandard and falsified medical products. Burundi, Côte d'Ivoire, Eritrea and Gabon have developed ethical codes and legal frameworks for the practice of traditional medicine to ensure the observance of high standards of service delivery and the regulation of traditional health practitioners. Over the period, the Regional Office contributed to the sharing of knowledge through the publication of two papers on the traditional medicine situation in Africa[88] and traditional medicinal and aromatic plants of Africa.[89]

To further strengthen the capacity of national regulatory authorities, WHO trained end-users and regulators from 18 countries[90] to bridge the gap in post-marketing surveillance of in-vitro-diagnostics (IVDs) in the Region.

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Benin, Cabo Verde and South Sudan were supported to develop national essential medicines lists to guide country medicines procurements and use

85. Burkina Faso, Libreville, Zimbabwe
86. Côte d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, Uganda, United Republic of Tanzania
87. Cabo Verde, Comoros, Mauritius, Sao Tome and Principe, Seychelles
88. Traditional Medicine Situation in Africa: Where Are We? In: Charles Wambebe (Eds.), African Indigenous Medical Knowledge and Human Health. London: CRC Press, Taylor & Francis, pp 1-50, 2018
89. Kasilo OMJ, Tsekpo KM and Gathai F (2017). Traditional Medicinal and Aromatic Plants of the World–Africa. In: Medicinal and Aromatic Plants of the World - Africa Volume 3. Editors: Neffati Mohamed, Najjaa Hanen and Máthé, Ákos (Eds.) 2017. Available at: http://www.springer.com/it/book/9789402411195
90. Benin, Burkina Faso, Burundi, Cameroon, Chad, Eswatini, Ethiopia, Gabon, Guinea, Kenya, Mali, Nigeria, Rwanda, Senegal, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

The WHO/AFRO external quality assessment programme continues to contribute to the sustainability and improvement of the quality and capacity of laboratories in 45 countries to diagnose infectious and outbreak-prone diseases. To strengthen laboratory capacity in the Region, WHO supported the health, agricultural, and veterinary sectors of seven countries[91] to build capacity in laboratory surveillance and control of major foodborne diseases.

Access to quality-assured blood and blood products is important for health safety in the Region. Institutionalization of blood regulation was facilitated by training national regulatory authorities and heads of national blood transfusion services from 19 countries,[92] thus paving the way for the establishment of the African Blood Regulators Forum.

Additionally, WHO trained officials of national blood transfusion services from 11 countries[93] on blood infection risks and safety. A survey on : Organ and tissue donation and transplantation in the WHO African Region involving 30 countries has provided the baseline for WHO support to countries to strengthen legal and regulatory frameworks.

Fighting antibiotic resistance is a top priority for WHO, given the important and critical role of antibiotics in combatting infectious diseases in both humans and animals. To implement the Global Action Plan on Antimicrobial Resistance in the African Region, a pool of established experts has supported a further 19 Member States[94] to develop and implement national action plans (NAPs).

In the area of data and knowledge management, WHO updated the health observatory approach to focus more on targeted health intelligence generation for UHC. Comprehensive national health profiles that provide a detailed description of the health situation, national trends and their determinants, were produced for four countries,[95] and national health observatories were operationalized in eight others.[96] Launched in March 2016, the Health Data Collaborative (HDC) is a coalition of over 40 partners committed to aligning resources and investments to support country priorities for strengthening health information systems and building country capacities to monitor and track progress towards UHC and health targets across the SDGs. The HDC was rolled out in three countries.[97]

Digital health is a key way to accelerate attainment of the SDGs in Africa by improving access to services and efficiencies in health service delivery. WHO/AFRO and the International Telecommunication Union (ITU) signed a Cooperation Agreement to expand digital health in the African Region by optimizing WHO's strength in designing and ITU's capacity to roll out digitization for health. WHO supported eight countries[98] to develop national eHealth strategies, and 10 countries[99] successfully undertook national eHealth inventory management using the WHO digital health atlas to support digital health scale-up and coordination.

Access to scientific data was enhanced during this period through various platforms including the Global Information Full Text (GIFT) access for WHO staff, WHO's Health InterNetwork Access to Research Initiative (Hinari) that gives low- and middle-income countries access to approximately 14 000 biomedical journals in 45 different languages and 56 000 e-books, and the WHO Institutional Repository for Information Sharing (IRIS) to which WHO/AFRO uploaded 212 publications. In addition, 128 articles have been published in external journals by staff in the African Region.

The Region has a functional health research barometer which maps the status and key issues for strengthening across health research information systems for Member States. Collaboration has been strengthened with the European and Developing Countries Clinical Trials Partnership (EDCTP) and WHO's global special programme for research and training in tropical diseases (TDR) to mobilize resources to fund the Small Grants Scheme for young African scientists to conduct implementation research.

Digital health is a key way to accelerate attainment of the SDGs in Africa by improving access to services and efficiencies in health service delivery. WHO/AFRO and the International Telecommunication Union (ITU) signed a Cooperation Agreement to expand digital health in the African Region by optimizing WHO's strength in designing and ITU's capacity to roll out digitization for health.

91. Ethiopia, Kenya, Mauritius, , United Republic of Tanzania, Zambia, Zimbabwe
92. Algeria, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Côte d'Ivoire, Ghana, Kenya, Mali, Mauritius, Niger, Nigeria, Rwanda, Senegal, South Africa, Togo, United Republic of Tanzania, Zimbabwe
93. Algeria, Burkina Faso, Burundi, Chad, Cameroon, Côte d'Ivoire, Guinea, Mali, Rwanda, Senegal, Togo
94. Botswana, Burkina Faso, Congo, Chad, Ethiopia, Gabon, Ghana, Kenya, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Senegal, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
95. Burkina Faso, Cameroon, Ghana, Rwanda
96. Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, Kenya, Rwanda, Uganda, United Republic of Tanzania
97. Cameroon, Kenya, United Republic of Tanzania
98. Benin, Burkina Faso, Comoros, Gabon, Lesotho, Mauritania, Sierra Leone, Senegal
99. Cabo Verde, Kenya, Lesotho, Liberia, Malawi, Nigeria, Sierra Leone, South Africa, Uganda, United Republic of Tanzania



Photo (C) WHO

SUCCESS STORY

# BALANCING PRIMARY AND TERTIARY CARE: COTE D'IVOIRE STRENGTHENS DISTRICT HEALTH SYSTEMS

WHO's Framework for action to strengthen health systems for universal health coverage (UHC) emphasizes district and community health systems for improving the health and well-being of all people. Since 2017, and in line with its primary health care policy, the WHO Country Office in Côte d'Ivoire has engaged in policy dialogue with national health authorities and partners to strengthen district health systems.

In March 2017, an investment case on primary health care demonstrated that 70% of financial resources for health in the country were allocated to referral hospitals in Abidjan and 17 health regions. Furthermore, to provide evidence for decision-making, the WHO Country Office commissioned a study in September 2017 on efficiencies in health financing of services between 1993 and 2015.

The study found that the same health outcomes could have been attained if half the financial resources had been used efficiently. Other weaknesses included staff shortages and ineffective referral systems which resulted in poor health outcomes such as the maternal mortality ratio, estimated at 614 per 100 000 livebirths. These findings were confirmed in the results of the District Health Systems functionality survey (2015-2017).

Following a workshop in November 2017 to reflect on the country's health systems performance, the Ministry of Health and WHO concluded that district, peripheral and community health systems needed strengthening. As a first step, the Minister of Health appointed a designated official within his office to support capacity strengthening at district and peripheral levels. Management of district health services is already improving: new district health officers (DHOs) have been appointed, existing DHOs reassigned, and non-performing DHOs removed. Now, with WHO's support, the Ministry of Health has adopted programmatic key performance indicators, such as DTP3 coverage, the proportion of births attended by skilled health personnel, and the number of maternal deaths for each health district. A monthly coordination and monitoring system ensures that reports are shared regularly with the Minister.


Photo (C) WHO/J. Pudlowski

With WHO's support, the Ministry of Health has adopted programmatic key performance indicators, such as DTP3 coverage, the proportion of births attended by skilled health personnel, and the number of maternal deaths for each health district.

In December 2017, Côte d'Ivoire also adopted a strategic plan to strengthen community health services. This is expected to improve community participation in health, and improve links between community members and peripheral or district health facilities. In addition, President Alassane Ouattara has approved a three-year plan to construct 200 health centres and deploy appropriate health workers to increase the coverage of health services towards UHC.

# 4.5

## 5 AND 12: POLIO ERADICATION PROGRAMME AND THE WHO HEALTH EMERGENCIES PROGRAMME

The polio eradication programme in the African Region has made tremendous progress. By 30 June 2018, twenty-two months had elapsed since the last case of wild-type polio was reported in the African Region.

The WHO Health Emergencies Programme (WHE) in the African Region enhances preparedness, surveillance and response to public health outbreaks and emergencies.

# 4. Significant achievements by category of work

## 4.5 Categories 5 and 12: Polio Eradication Programme and the WHO Health Emergencies Programme

The polio eradication programme in the African Region has made tremendous progress. By 30 June 2018, twenty-two months had elapsed since the last case of wild-type polio was reported in the African Region. Forty countries in the African Region have had their polio-free status documentation accepted by the African Regional Certification Commission for Polio eradication. If this progress is sustained, the African Region could be certified to have eradicated polio by the end of 2019.

Outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2) were confirmed in the Democratic Republic of Congo, Kenya and Nigeria. To stop the outbreak quickly, AFRO deployed additional surge capacity of 21 international WHO polio experts and 200 local public health personnel. At a side event during the Seventy-first Session of the World Health Assembly in May 2018, Ministers of Health of Ethiopia, Kenya and Somalia declared the cVDPV2 outbreak in Kenya and Somalia as a Horn of Africa subregional public health emergency. WHO and partners have supported several synchronized cross-border vaccination campaigns.

WHO is leading an initiative in the Lake Chad Basin, regarded as the 'last frontier' for polio eradication on the continent, which has combined the efforts of partners and countries to reach every child. Strategies have included close collaboration with national security authorities, the use of geographic information systems for surveillance, and integration with humanitarian nongovernmental delivery systems to reduce the number of unreached children.

For polio eradication status, surveillance performance of sufficient quality needs to be maintained. WHO has established a state-of-the-art geographic information system (GIS) centre to strengthen surveillance for the polio programme and serve other programmes. The GIS real-time surveillance and reporting of immunization activities in the field has expanded to 42 out of 47 countries since WHO offered the technology to Ministers of Health in August 2017. Since then, the GIS centre has recorded over 108 790 geo-coded integrated supportive supervision visits for surveillance of vaccine-preventable diseases and routine immunization activities. Of these, 76 764 visits (70%) were conducted jointly by WHO staff and 3338 government health workers, demonstrating governments' rapid uptake of this technology.

As part of the polio legacy, the polio-GIS system has been used to improve real-time reporting of integrated disease surveillance (IDSR) in Liberia; reporting and investigation of non-vaccine-preventable disease outbreaks such as the cholera epidemic in Zambia; and the Ebola virus disease outbreak in the Democratic Republic of the Congo. In 2018, it was used to implement immunization coverage surveys in South Africa, Ethiopia and Sierra Leone with real-time availability of improved data quality and reliability. In addition to evaluating the quality of polio campaigns in countries, the GIS system was used for real-time monitoring and for evaluating the quality of the mass meningitis vaccination campaign in South Sudan.

The African Region is being cited as a good example for polio transition planning by WHO's Policy Group. A detailed strategic plan on polio transition, aligned with the strategic approaches of the draft 13th General Programme of Work 2019 - 2023 was discussed at the Seventy-first World Health Assembly. As the polio programme ramps down in line with the end-game strategy, Member States are finalizing their polio transition plans to facilitate domestic resource mobilization for sustaining a polio-free Region after certification of polio eradication.

The WHO Health Emergencies Programme (WHE) in the African Region enhances preparedness, surveillance and response to public health outbreaks and emergencies. This work across the three levels of the Organization focuses on country health emergency preparedness and the International Health Regulations (IHR 2005); infectious hazard management; health emergency information and risk assessment; and emergency operations.

On 8 May 2018, the Democratic Republic of the Congo declared an outbreak of Ebola virus disease (EVD) in three health zones of Equateur Province which borders the Central Africa Republic and the Republic of Congo. The Government's prompt declaration enabled WHO to deploy experts immediately and conduct a rapid risk assessment which found the national risk to be very high, with high risk of regional spread to neighboring countries. To avert this, WHO and partners provided technical support to at-risk Member States to enhance preparedness for EVD outbreaks, including strengthening surveillance at major points of entry and raising awareness.

For the first time, the vaccine that proved to be safe and effective against the Zaire ebolavirus during a trial in Guinea and Sierra Leone in 2015, was deployed as an additional intervention to ring-vaccinate people at high risk of infection. WHO worked closely with the Ministry of Health, Gavi, the Vaccine Alliance, Médecins Sans Frontières, UNICEF and other partners to offer vaccination to health workers and people at risk (contacts of Ebola patients) in affected health zones.

By the end of June 2018, the outbreak had largely been contained. WHO will continue to train multidisciplinary teams in all priority countries, and advocate for resource mobilization to implement priority activities.

A key priority in the Region is the elimination of yellow fever epidemics. The Regional Framework for implementing the Global Strategy to Eliminate Yellow Fever Epidemics (EYE), adopted by Member States during the Sixty-seventh session of the Regional Committee, aims to protect nearly one billion people at risk of yellow fever and eliminate yellow fever epidemics in Africa by 2026. It was launched in Nigeria in April 2018. WHO and partners assisted the 11 highest risk countries for yellow fever epidemics to develop three-year workplans for rolling out the Regional Framework. In addition, through preventive campaigns in Angola and Nigeria, more than 3.2 million people in Angola and 8.8 million in Nigeria were vaccinated. This represents 60% of the total population targeted for coverage in the Region by the end of 2018.

Joint External Evaluations (JEEs) assess country capacities to detect and respond to public health threats in compliance with the International Health Regulations.

During the period, over 150 regional experts from Member States, WHO and partners were trained to conduct JEEs, and their capacities were further strengthened during JEE missions to countries. Between July 2017 and May 2018, eighteen Member States undertook JEEs, bringing the regional total to 36, and nine completed national action plans for health security. Following WHO's advocacy at various forums, and for the first time since the adoption of the IHR, all 47 Member States submitted IHR annual reports in December 2017.

WHO provided support to the African Union Commission (AUC) to develop a resolution on the International Health Regulations (IHR 2005) to advocate for health security at the highest level in the Region. In July 2017, African Heads of State endorsed a declaration to accelerate the implementation of the IHR (2005). It calls on WHO and the AUC to work together to support and monitor its implementation. In February 2018, WHO and the AUC held discussions with a delegation of UK partners, the Africa CDC and UN agencies in Addis Ababa, Ethiopia on uniting efforts to promote health security in Africa.

Six Member States[103] completed epidemic risk profiling to assess their vulnerability and ensure evidence-based preparedness and prioritized support, bringing the total to 24 countries.[104] After-action reviews were undertaken on 17 public health events in 16 Member States to document lessons learned and improve future responses.[105]

Between July 2017 and May 2018, eighteen Member States undertook JEEs, bringing the regional total to 36, and nine completed national action plans for health security and for the first time since the adoption of the IHR, all 47 Member States submitted IHR annual reports in December 2017

100. Angola, Congo, Democratic Republic of the Congo, Ethiopia, Gabon, Guinea, Guinea-Bissau, Niger, Nigeria, South Sudan, Uganda
101. Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Democratic Republic of the Congo, Eswatini, The Gambia, Lesotho, Niger, Rwanda, Seychelles, South Africa, South Sudan, Togo, Zambia, Zimbabwe
102. Chad, Côte d'Ivoire, Liberia, Mauritania, Mozambique, Namibia, Senegal, Sierra Leone, Uganda
103. Benin, Comoros, Guinea, Mozambique, Nigeria, South Sudan
104. Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cabo Verde, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Malawi, Mauritania, Niger, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania
105. Angola (Yellow Fever), Benin (Lassa), Burkina Faso (Dengue), Burundi (Malaria), Central African Republic (Cholera), Madagascar (plague), Mauritania (CCHF), Mozambique (Cholera), Namibia (CCHF), Niger (RV Fever), Nigeria (Lassa fever), Senegal (Dengue), Sierra Leone (Mudslides and floods), Togo (Meningitis and Lassa), Uganda (Marburg), United Republic of Tanzania (Cholera)

WHO continued to conduct simulation exercises to test emergency response capabilities and identify areas for improvement. Simulations were organized in Cameroon, Mauritania and Nigeria, and also during the SADC Ministers of Health meeting, the Fourth Annual Global Health Security Agenda Ministerial Meeting in Uganda, and the Regional Programme Meeting of WHO heads of country offices in Ghana. These contributed to a better understanding of emergency response mechanisms in the Region, and will ultimately lead to improved and timely decision-making by Member States.

Since July 2017, over 2500 unverified media reports on health threats in the African Region have been screened using the Hazard Detection and Risk Assessment System. An internal verification process detected 331 signals of potential health threats in 29 countries. Of these, 110 were substantiated as outbreaks and humanitarian crises and recorded in the WHO Event Management System (EMS) to initiate a response. Twenty-four (22%) of the outbreaks were due to cholera, followed by viral haemorrhagic fevers (15%).

Over the period, rapid risk assessments led to the grading of 20 events in 13 countries and a timely, effective emergency response to all these public health events in line with the new Emergency Response Framework (ERF). WHO worked closely with Member States and partners across the Region to rapidly control major outbreaks including viral haemorrhagic fevers, Rift Valley fever, Lassa fever, plague, malaria and meningitis. Nearly four million meningitis vaccines were administered, leading to a break in transmission in Niger and Nigeria.

WHO supported Ministries of Health in five Member States[106] to launch the largest cholera vaccination drive in history, targeting over two million people, with vaccines funded by Gavi, the Vaccine Alliance. This followed cholera outbreaks in 16 Member States,[107] highlighting the need for a multisectoral approach to ensure clean water and sanitation for all. In addition, WHO worked with Zambia and Haiti to sponsor a resolution on cholera at the Seventy-first World Health Assembly calling for more investment and multisectoral actions on cholera prevention and control. All 47 Member States provided inputs for the draft resolution.

In response to these emergencies, WHO activated its incident management system (IMS) for all graded emergencies within 24-48 hours. To ensure effective coordination, incident management support teams were established at global and regional levels to support the IMS at country level for all graded emergencies. WHO deployed over 1100 experts to support response operations, and WHO country offices repurposed staff to accelerate response efforts.

The IMS is ensuring better coordination and deployment for responses to public health emergencies resulting from extreme weather events, such as drought and floods, and humanitarian crises across the Region. WHO worked with partners and the Regional Inter-Agency Standing Committee (RIASCO) to implement Joint Action Plans to reduce the consequences of these natural disasters and to better prepare Member States to cope with natural emergencies.

Humanitarian crises in several Member States[108] caused deaths, displacement, disease outbreaks and food insecurity, which affected millions of people. In most of these Member States, WHO established response teams at subnational level to work closely with humanitarian partners to manage severely malnourished patients in nutrition centres.

South Africa experienced the world's worst outbreak of listeriosis, a serious foodborne disease, beginning in early 2017. The food source was identified in early March 2018. WHO organized a Listeriosis Regional Technical Meeting in Johannesburg in April 2018 for 16 Member States[109] to learn about managing a listeriosis outbreak and increase awareness in the Region. Countries developed contingency plans which will enable them to respond and control any potential listeriosis outbreak and strengthen their food safety systems. WHO continues to monitor the situation to ensure compliance with IHR (2005).

In terms of resource mobilization to respond to emergencies, US$ 9 217 243 was made available for the response to graded emergencies through the Contingency Fund for Emergencies (CFE), a fast, flexible financing instrument that enables WHO to respond rapidly. An additional US$ 23 364 252 was mobilized through other mechanisms to support the response to emergencies in the Region during the period. Annual contributions to the African Public Health Emergency Fund (APHEF) remain low, and WHO/AFRO has developed a resource mobilization strategy and plan focusing on non-State actors to replenish the Fund.


106. Malawi, Nigeria, South Sudan, Uganda, Zambia
107. Angola, Benin, Burundi, Chad, Congo, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Malawi, Mozambique, Namibia, Nigeria, South Sudan, Uganda, United Republic of Tanzania
108. Burundi, Cameroon, Central African Republic, Congo, Democratic Republic of the Congo, Ethiopia, Kenya, Mali, Niger, Nigeria, Uganda, United Republic of Tanzania, South Sudan
109. Angola, Botswana, Democratic Republic of the Congo, Eswatini, Ghana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, South Africa, Uganda, Zambia, Zimbabwe

Photo (C) WHO

In-house capacity to respond to outbreaks was strengthened by training 165 WHO staff from all WHO country offices and the Regional Office on the new ERF,[110] IMS and on managing 21st century epidemics. WHO country representatives were also trained in Emergency Response Management. There is a better understanding now of the IMS across all levels of the Organization, resulting in the more rapid release and deployment of staff for emergency response.

Additionally, over 150 staff from country offices in 12 WHO emergency priority countries[111] were trained on the emergency management portal (vSHOC).The Regional Office supported the development of national implementation plans for public health emergency operations centres, and trained officials in eight countries[112] to operate and manage these centres for improved responses to outbreaks.

WHO/AFRO and the Global Outbreak Alert and Response Network (GOARN) organized the first Regional Partnership Meeting on Emergencies. As a result, 50 operational partners are now actively engaged in joint planning, information sharing and health emergency response. Together with GOARN, WHO also organized scenario-based training for 30 WHO and health cluster coordinators on their respective leadership roles in responding to emergencies.

In addition, based on capacities and experience in responding to emergencies, 10 Member States[113] are being supported to set up national and/or international Emergency Medical Teams to strengthen the quality of the response to health emergencies.

To build capacity in IDSR, WHO and US CDC finalized the IDSR eLearning courses, and so far, 180 people have registered and 95 have completed the course and received certificates. Approximately 5000 people from the African Region have registered for the OpenWHO online training on health emergency management and outbreaks.

AFRO's WHE information products are reliable sources of up-to-date health emergency information, which are distributed regularly to national authorities, partners and the media, among others. During the reporting period, WHO/AFRO disseminated 52 editions of the *Weekly Bulletin on Outbreaks and Other Emergencies*, 312 articles and over 40 external situation reports on the Ebola virus disease outbreak and plague. With more than 1500 readers, the *Bulletin* is widely acclaimed, frequently reposted on social media and is cited by public health information websites such as ProMED and Outbreak News Today. The first edition of a *Compendium of Short Reports on Selected Outbreaks in the WHO African Region* was published in October 2017.



110. http://apps.who.int/iris/handle/10665/258604, accessed 26 April 2018
111. Burkina Faso, Democratic Republic of the Congo, Ethiopia, Kenya, Madagascar, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, South Sudan
112. Angola, Benin, Burundi, Central African Republic, Comoros, Ghana, Mali, Zambia
113. Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Kenya, Madagascar, Nigeria, Rwanda, Senegal, South Africa

SUCCESS STORY

# WHO'S INCIDENT MANAGEMENT SYSTEM (IMS) HELPS TO END UNPRECEDENTED PLAGUE OUTBREAK IN MADAGASCAR

On 13 September 2017, the Ministry of Public Health in Madagascar notified WHO of an outbreak of pneumonic plague detected in different parts of the country, including non-endemic areas and major cities. From August to mid-December 2017, a total of 2601 confirmed, probable and suspected cases of plague, including 225 deaths (a case fatality rate of 8.7%), were reported from over half the districts in 17 out of 22 regions in Madagascar.


Photo (C) WHO

The timely activation of the IMS, as the outbreak was graded at level 2, resulted in the deployment of an Incident Manager and health experts within 48 hours. Country office staff were repurposed to support activities in order to interrupt ongoing transmission, provide care for the affected, prevent further spread, and implement effective coordination.

The IMS helped WHO and the Global Outbreak Alert and Response Network (GOARN) staff to deploy over 140 experts from all three levels of the Organization as well as partners, and US$ 1.5 million was released through the Contingency Fund for Emergencies, enabling WHO/AFRO to initiate response activities. Further financial support from the Governments of Italy, Norway and the Republic of Korea facilitated the donation of medicines and other medical supplies to treat nearly all identified plague patients and more than 7300 contacts free of charge.

WHO and partners shared guidelines on case management and safe burials, supported surveillance and laboratory testing, and strengthened public health measures at ports and airports. More than 4400 people were trained to identify, refer and care for close contacts of plague patients to prevent the disease from spreading. WHO supported nine countries (South Africa, Mozambique, United Republic of Tanzania, Mauritius, Comoros, Seychelles, Ethiopia, Kenya and Reunion) to prepare for plague. The outbreak was brought under control in less than four months thanks to the tireless efforts of Malagasy health workers, WHO and partners.

Although the acute phase of the epidemic was declared over by health authorities in late November 2017, WHO sustained response operations until April 2018, as plague usually occurs between September and April each year in Madagascar.

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# 4.6

# CORPORATE SERVICES AND ENABLING FUNCTIONS

This category covers organizational leadership and corporate services that enable the Organization to function effectively and efficiently. Such services include strategic planning; partnerships, resource coordination and reporting; country support; human resources; effective communications; risk management and internal controls; and management and administration.

# 4. Significant achievements by category of work

## 4.6 Category 6: Corporate Services and Enabling Functions

This category covers organizational leadership and corporate services that enable the Organization to function effectively and efficiently. Such services include strategic planning; partnerships, resource coordination and reporting; country support; human resources; effective communications; risk management and internal controls; and management and administration.

In the area of health leadership and governance, the Regional Director embarked on a number of missions and official visits to Member States[114] during the reporting period to advocate at the highest level for integrating global health priorities such as health security and universal health coverage (UHC) into national development agendas, as well as for improved domestic resources for health. All the countries visited are prioritizing the attainment of UHC and taking steps to improve the performance of their health service delivery systems, increase access for disadvantaged groups, and strengthen resilience to outbreaks and other shocks.

In its leadership role in health, WHO convened a biennial meeting for the five Ministers of Health of the Small Island Developing States (SIDS)[115] in the WHO African Region in Seychelles to discuss social determinants of health, universal health coverage and innovative health financing, and the emergence of NCDs in these countries. As an outcome of this meeting, WHO is working with these countries to develop a strategy for pooled procurement of medicines and medical products to achieve economies of scale.

Advocacy at global health forums such as the UN General Assembly and the World Health Summit in Berlin is contributing to high-level commitments to improve health outcomes in the African Region. For instance, following advocacy and technical support from WHO and the AUC, African Union Ministers of Health agreed on a Common Africa Position on ending the TB epidemic (CAP-TB) at the First Global Ministerial Conference on Ending TB held in Moscow in November 2017, to be presented at the high-level meeting of the UN General Assembly in September 2018.

In addition, 24 ministers from the African Region committed to the Moscow Declaration which calls for decisive actions to end the epidemic by 2030.

Extensive discussions by the Regional Director and her management team with partners and donors have strengthened multiple partnerships and mobilized resources for public health priorities. These include partners such as the African Development Bank, the African Union Commission, China, the East African Community, the Economic Community of Central African States, Germany, South Korea, the Southern African Development Community, the United Kingdom and the United States, among others. The discussions have led to a number of cooperation agreements and joint workplans, including an Action Framework with the UK Department of Health, Public Health England and Department for International Development.

A new cooperation agreement with the International Telecommunication Union in October 2017 will leverage advances in technology and digital health to save lives and improve people's health. At the Second International Conference of Ministers of Health and Ministers for Digital Technical Technology on Health Security in Africa held in Benin in June 2018, the Regional Director called on Member States to establish strong collaboration between the health, information and communication technology and other sectors to improve access to health care, patient safety and the achievement of universal health coverage.

The WHO Regional Office for Africa has strengthened ties with one of its key partners, the International Federation of the Red Cross and Red Crescent Societies (IFRC). The two organizations agreed in May 2018 to expand their collaboration to include promotion of high-level advocacy by identifying champions to work with the alliance of mayors on key health issues.

In April 2018, the Regional Director explored innovative resource mobilization strategies for the African Public Health Emergency Fund with young philanthropic entrepreneurs in Nigeria.

114. Botswana, Cabo Verde, Congo, Ghana, Madagascar, Mauritania, Nigeria, Senegal, Seychelles
115 SIDS countries in the African Region: Cabo Verde, Comoros, Mauritius, Sao Tome and Principe, Seychelles


Photo (C) WHO

Agreements with donors such as the Kuwait Fund and the OPEC Fund for International Development (OFID) are enabling WHO to accelerate efforts to end neglected tropical diseases.

Furthermore, new managerial key performance indicators (KPIs) for strengthening partnerships are improving the tracking, timeliness and quality of donor technical and financial reporting. The number of overdue reports dropped from 39% in July 2017, to 8% by the end of June 2018.

The Independent Advisory Group (IAG) continues to provide strategic and policy advice to the Regional Director. At its meeting in March 2018, the IAG welcomed the progress of the Transformation Agenda over the past 18 months. Recommendations included strengthening the capacity of WHO country representatives to communicate the impact of work at country level, and advancing UHC through strategic dialogue with ministries of finance and sectors beyond health.

Country Cooperation Strategies (CCS) guide the strategic vision and agreed priorities of WHO's support to countries. Technical support was provided to 39 country offices to review, extend or renew their CCS through joint planning and country partner dialogues for more responsive, effective medium-term strategic plans. WHO/AFRO set up a steering committee to support the development of CCS and undertook a desk review for quality assurance of the final documents.

Human resource capacity is critical to the success of WHO in the African Region. In consultation with key stakeholders, the Regional Office is systematically reviewing the structure of WHO country offices to ensure that they are correctly staffed and fit for purpose to address country priorities.

By June 2018, functional reviews had been conducted in 25 country offices[116] and implementation plans drawn up at country level for WHO to better support Member States and health partners in health coordination, health security and health systems strengthening, among others.

The Regional Office is also succeeding in attracting and retaining highly qualified and motivated candidates through outreach initiatives that target diversity, gender balance and geographical representation. Between December 2015 and December 2017, longer term female staff representation increased from 24.3% to 30.7% while temporary female staff representation rose from 17.5 % to 20.5%. To enhance staff capacity and performance, a Regional Learning Focal Point Network was established to identify training needs and in addition, a range of mandatory training initiatives are being implemented. New staff routinely complete induction programmes to facilitate their settling in.

Improved communication is one of the pillars of the Transformation Agenda of WHO in the African Region. WHO strengthened its internal communication through regular e-alerts, newsletters and Town Hall (staff) meetings.



116. Angola, Benin, Botswana, Burundi, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, The Gambia, Kenya, Lesotho, Liberia, Mauritania, Mauritius, Mozambique, Namibia, Rwanda, Senegal, South Africa, South Sudan, Togo

External visibility through social media platforms continues to grow. For instance, Twitter views soared from 5.7 million in June 2017 to 14.1 million views by June 2018, while over 834 000 reaches were recorded on Facebook during the same period.

The revamped WHO website was visited 2.7 million times since its launch in June 2017, compared to 0.9 million visits throughout 2015. The Regional Office has introduced a new electronic platform called Poppulo to strengthen outreach and stakeholder engagement. WHO continues to attract the attention of global media in promoting its work in the African Region.

In line with new terms of reference to strengthen oversight functions, the Programme Subcommittee (PSC) for the first time reviewed the report on regional managerial compliance activities and matters arising out of internal and external audits. WHO's close liaison with the African Group in Geneva in preparing for the Executive Board and World Health Assembly led to Member States adopting common positions on key agenda items such as the 13th Global Programme of Work and WHO reform.

The Regional Office undertook several activities to strengthen internal controls and managerial oversight for improved accountability, transparency and compliance of staff and teams. These included establishing an office for country support based in Pretoria, South Africa which has substantially reduced staff and operational costs while providing rapid support to country offices.

A Regional Compliance and Risk Management Committee (CRMC) and local committees at country office level are providing oversight and direction to all compliance and risk management activities in the Region. Risk registers with response plans and internal control self-assessments have been completed for all WHO country offices and Regional Office clusters (budget centres). Programme management, administrative and compliance reviews in 16 countries[117] have helped to identify control weaknesses and target actions for improvement.

A dedicated team was established to conduct compliance reviews of the Direct Financial Cooperation (DFC) mechanism, a payment advance approach to financing activities implemented by governments, to ensure that funds are spent as intended. Over the period, missions were carried out in eight countries[118] and random checks of the accounts allowed for irregularities to be identified and addressed. Burkina Faso, Democratic Republic of the Congo, Mali and Niger received compliance ratings above 80%.

To further increase country office capacity and managerial efficiency, a five day workshop was organized for senior administrative staff from 47 countries to discuss progress, challenges and ways of enhancing accountability and internal controls in the areas of finance, human resources management, audit and compliance, fraud and investigation, among others.

The workshop generated a renewed commitment from senior administrative staff to improve managerial performance and efficiency at country level.

All 47 country offices were supported to develop IT business continuity plans and infrastructure reviews, and three[119] conducted simulation exercises to enhance their ability to continue operations during major disruptions.

Several infrastructure projects were carried out to improve WHO working and living environments, such as the renovation of the main conference room and the building of two water reservoirs at the Regional Office, and new accommodation for international staff in South Sudan.

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117. Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Ethiopia, Equatorial Guinea, The Gambia, Liberia, Madagascar, Mali, Nigeria, Senegal, Sierra Leone, South Sudan, Togo
118. Burkina Faso, Chad, Democratic Republic of the Congo, Ethiopia, Kenya, Mali, Niger, Uganda
119. Ghana, Lesotho and Sao Tome and Principe

## SUCCESS STORY
## KPI INNOVATION STRENGTHENS ACCOUNTABILITY AND PERFORMANCE IN AFRO

AFRO's unique managerial Key Performance Indicators (KPIs) introduced in 2015 have been refined and implemented by all country offices and clusters.

They are used to monitor, manage and evaluate the performance of all WHO country offices and Regional Office clusters (budget centres), and have strengthened accountability and discipline across AFRO. A "traffic light" dashboard provides real-time information on progress and allows for prompt and targeted interventions to address weaknesses in budget centres whose performance is declining.

A review of compliance and quality assurance functions using internal and external audits by the Office of Internal Oversight Services (IOS) found that this innovation has significantly improved controls within AFRO. Between August 2015 and March 2018, overall control effectiveness improved from 50% in 2015 to 75% in 2018, thus putting AFRO ahead of some other major WHO Offices.

The KPIs are promoting a culture of excellence and provide evidence for recognizing performance. At a five-day workshop for all senior administrative staff from 47 countries, performance improvement trends across budget centres were highlighted and awards were presented to the best performing country offices.

A review of compliance and quality assurance functions using internal and external audits by the Office of Internal Oversight Services (IOS) found that this innovation has significantly improved controls within AFRO.

Between August 2015 and March 2018, overall control effectiveness improved from 50% in 2015 to 75% in 2018, thus putting AFRO ahead of some other major WHO Offices.

Furthermore, the managerial KPIs are taking on global importance: the UK Government's Department for International Development (DFID) has included three AFRO-specific indicators in it's results framework for WHO which links 50% of it's core voluntary contributions to WHO's performance. As such, AFRO's performance can influence DFID's global funding to the Organization, providing an incentive for all levels of WHO to demonstrate improved performance.

SUCCESS STORY

## "PEOPLE ARE AT THE CENTRE OF EVERYTHING WE DO" – DR MATSHIDISO MOETI

WHO international staff in Juba, South Sudan live in one of the most stressful, crisis-afflicted areas in the Region. The Regional Office had genuine concerns about their well-being, moved staff into more secure and comfortable accommodation in the city. Staff wrote to thank the Regional Director:

"The improvement in well-being has motivated the staff and will surely improve workplace performance. We are sure that we will be better versions of ourselves both at work and at home and help the Organization stand out.

There is no way to fully express our gratitude for your supportive leadership and level of engagement. We at WHO South Sudan are continually inspired by the dedication and commitment of the senior management to supporting employee well-being as one of the pillars underpinning shared value creation for the country office, employees and the people of South Sudan.

"People are at the centre of everything we do" – Dr Matshidiso Moeti

WHO international staff in Juba, South Sudan live in one of the most stressful, crisis-afflicted areas in the Region. The Regional Office had genuine concerns about their well-being, and moved staff into more secure and comfortable accommodation in the city.

Our very big thanks for building a tailored well-being solution for us to live healthier lives in all three key pillars of well-being: Physical, Mental and Financial."


# 5.0
# CONCLUSION AND LOOKING AHEAD

# 5. Conclusion and Looking Ahead

The reporting period coincides with the end of the 2016-2017 biennium and the finalization of the 12th General Programme of Work (GPW). Member States in the African Region are making good progress in advancing towards universal health coverage, complying with the requirements of the IHR (2005) for global and continental health security, and implementing legislation, regulations and programmes to promote the health of their populations. WHO and its partners are working steadfastly to maintain and accelerate this momentum towards a healthier, more equitable and prosperous Africa. However, more needs to be done to achieve UHC and the SDG targets.

In April 2018, the Regional Director launched the second phase of the Transformation Agenda (2018-2020) which puts people at the centre of change, and is aligned with WHO's Global Transformation Plan launched in the second half of 2017. In May 2018, Member States approved WHO's ambitious five-year plan of the 13th GPW (2019 – 2023) for one billion more people to benefit from UHC, one billion more better protected from health emergencies, and one billion more enjoying better health and well-being.

To achieve the triple billion target, WHO in the African Region will focus on making a real impact at country level. We will affirm our position as the leading and coordinating authority on international health work across the SDGs, and drive policy dialogue with all stakeholders, including governments, donors, the UN system, civil society and academia.

Within WHO/AFRO, work will continue to complete the functional reviews of country offices and engage staff in activities which promote transformation.

WHO staff members will be provided with the training required, including in leadership, management and diplomacy, and encouraged and supported to turn the pro-results values into behaviours and a culture that will ensure responsive and efficient delivery of results, in a just and respectful working environment. Actions will be taken to consolidate and evaluate the achievements made in the Organization's strategic operations in order to strive towards more efficiency and better value for money.

In addition, intensified efforts will be made to expand and diversify partnerships to support countries to deliver better health through more equitable, accessible health care for all people everywhere. High-level meetings on TB and NCDs at the UN General Assembly in September 2018 will help to accelerate multisectoral action in these priority areas.

Investing in stronger health systems and committing to UHC afford an opportunity to improve people's lives in the African Region. We will continue to encourage greater domestic investment in health to improve health systems as well as public health preparedness and response in order to strengthen global health security. We are greatly encouraged by the uptake of our Framework on UHC and the growing political commitment towards achieving UHC, and will continue to work with countries to advance towards more equitable access to health in the Region. . The Secretariat will work with Member States to make and effect policy and institutional arrangements that support and amplify the results of the change being seen. Key areas that will be focused on include health governance, priority setting, coordination of partners and organizational efficiency.

WHO reiterates its unwavering commitment to continue working with Member States and partners in implementing the new GPW in order to move towards UHC and ensure that the people in the African Region attain the highest possible level of health and well-being.

# 6.0
# ANNEXES

Selected WHO/AFRO publications by cluster and endnotes

# Annex 1: Selected WHO/ AFRO publications by cluster

## Communicable Diseases

1. Case management of malaria in Swaziland, 2011-2015: on track for elimination? Dlamini, S. V.; Kosgei, R. J.; Mkhonta, N.; Zulu, Z.; Makadzange, K.; Zhou, S, et al. *Public Health Action,* Vol 8 (Supp 1), S3-S7, 25 April 2018
2. Advances in malaria elimination in Botswana: a dramatic shift to parasitological diagnosis, 2008-2014. Moakofhi, K.; Edwards, J. K.; Motlaleng, M.; Namboze, J.; Butt, W.; Obopile, M. et al. *Public Health Action*, Vol 8 (Supp 1), S34-S38, 25 April 2018
3. Changing distribution and abundance of the malaria vector Anopheles merus in Mpumalanga Province, South Africa. Mbokazi, F.; Coetzee, M.; Brooke, B.; Govere, J.; Reid, A.; Owiti, P. et al. *Public Health Action*, Vol 8 (Supp 1), S39-S43, 25 April 2018
4. Did microbial larvaciding contribute to a reduction in malaria cases in eastern Botswana in 2012-2013? Obopile, M.; Segoea, G.; Waniwa, K.; Ntebela, D. S.; Moakofhi, K.; Motlaleng, M. et al. *Public Health Action*, Vol 8 (Supp 1), S50-S54, 25 April 2018
5. Elimination roadmap for lymphatic filariasis http://www.afro.who.int/publications/elimination-roadmap-lymphatic-filariasis
6. Guidelines for treatment of drug-susceptible tuberculosis and patient care (2017 update) http://www.afro.who.int/publications/guidelines-treatment-drug-susceptible-tuberculosis-and-patient-care-2017-update

## Noncommunicable Diseases

1. WHO, Strategic planning for cervical cancer prevention and control in Africa: facilitator manual, Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/strategic-planning-cervical-cancer-prevention-and-control-africa-facilitator-manual
2. WHO, Information, Education and Communication for cervical cancer prevention and control in African countries: Training guide, Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/information-education-and-communication-cervical-cancer-prevention-and-control-african
3. WHO, Strategic Planning for Cervical Cancer Prevention and Control in Africa: Training Manual, Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/strategic-planning-cervical-cancer-prevention-and-control-africa-training-manual
4. WHO, Assessing Country Capacity and Preparedness for Introducing or Scaling up a Comprehensive Cervical Cancer Prevention and Control Programme: Baseline Report, Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/assessing-country-capacity-and-preparedness-introducing-or-scaling-comprehensive
5. WHO, Information, Education and Communication for cervical cancer prevention and control in African countries: Training guide, Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/information-education-and-communication-cervical-cancer-prevention-and-control-african
6. WHO, Advocacy for cervical cancer prevention and control in Africa, , Brazzaville, WHO/AFRO, 2017; http://www.afro.who.int/publications/advocacy-cervical-cancer-prevention-and-control-africa

## Promoting Health through the Life-Course

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## Corporate Services and Enabling Functions

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**WORLD HEALTH ORGANIZATION**
**REGIONAL OFFICE FOR AFRICA**
Cité du Djoué, P.O. Box 06, Brazzaville, Republic of Congo
Telephone: + (47 241) 39100 / + (242) 770 02 02 |
Fax: + (47 241) 39503 | E-mail: afrorgocommunications@who.int |
Website: http://www.afro.who.int | Twitter: @WHOAFRO |
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