THE WORK OF

WHO IN THE AFRICAN REGION

Report of the Regional Director

1 July 2018–30 June 2019

World Health Organization
REGIONAL OFFICE FOR Africa

The Work of the World Health Organization in the African Region
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Abbreviations

AA-HA!	Accelerated Action for the Health of Adolescents
AMR	antimicrobial resistance
ART	antiretroviral therapy
DFC	Direct Financial Cooperation
DFID	Department for International Development (United Kingdom)
DHIS2	District Health Information Software 2
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases
EVD	Ebola virus disease
Gavi	Gavi, The Vaccine Alliance
GIS	geographic information system
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
GSWCAH	Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)
GWD	guinea-worm disease
HHA	Harmonization for Health in Africa
HBV	hepatitis B virus
HAT	human African trypanosomiasis
IHR	International Health Regulations (2005)
IPC	infection prevention and control
IPV	inactivated polio vaccine
ISTs	intercountry support teams
IVM	integrated vector management
JEE	Joint External Evaluation
KPI	key performance indicator
M&E	monitoring and evaluation
NAP	national action plan
NCDs	noncommunicable diseases
NTDs	neglected tropical diseases
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PHC	primary health care
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Agency
SIDS	Small Island Developing States
SRHR	sexual and reproductive health and rights
STIs	sexually transmitted infections
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO FCTC	WHO Framework Convention on Tobacco Control
WHO PEN	WHO Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-Resource Settings
WPV	wild poliovirus

Foreword

by the Director-General of WHO

The African Region has many achievements to be proud of, and many causes for celebration. Between 2000 and 2015, life expectancy in Africa increased by 9.4 years, double the global average. Millions of cases and deaths from HIV, malaria and TB have been averted. The continent has not seen a case of wild poliovirus since August 2016. Millions of women are alive today who 20 years ago would not have survived childbirth, and millions more children have survived to celebrate their fifth birthdays.

Of course, many challenges remain. Life expectancy in Africa still lags 11 years behind the global average. Progress against malaria has stalled. Noncommunicable diseases have overtaken communicable diseases as the leading causes of premature mortality. And at the time of writing, we are fighting an Ebola outbreak in the Democratic Republic of the Congo that reminds us once again that a weak health system in one country can pose a regional and even a global threat.

Much work also remains to be done to realize the vision of universal health coverage across the Region. While there are many encouraging signs of progress, access to quality essential health services is lower in Africa than any other region, and 114 million people live in poverty because of health care costs. These gaps not only imperil the health of millions of people; they also endanger Africa's economic growth and prosperity.

Addressing each of these challenges requires a WHO that is effective, efficient, responsive and which works together seamlessly in pursuit of the "triple billion" targets outlined in the Thirteenth General Programme of Work. In particular, an increase in domestic public spending on primary health care, with an emphasis on promoting health and preventing disease, will be essential for building the healthier, safer, fairer Africa we all want.

That is the essence of Dr Moeti's Transformation Agenda in the African Region, which has paved the way for the transformation we are now embarking on across WHO globally.

I am pleased to jointly introduce this report of the work of WHO in the African Region, which highlights progress made in the past year. This progress has been achieved through the joint efforts of WHO staff working at country, regional and global levels, in collaboration with Member States and partners.

I look forward to continue working together for the people of the African Region and globally, to promote health, keep the world safe and serve the vulnerable.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization


WHO

Foreword

by the WHO Regional Director for Africa

This report presents the programmatic results that we have achieved through close cooperation with partners in support of countries. It has now been more than four years since the launch of the regional Transformation Agenda. The results of this reform strategy are encouraging, with clear progress in critical areas.

WHO staff are increasingly leading and institutionalizing change. We have rolled out leadership training and participating staff are enthusiastically articulating determination to lead and manage differently. Change agents across the Region are supporting their colleagues to scale initiatives to continuously improve how we work together.

Accountability and compliance with WHO rules have improved. The Secretariat is now more vigilant in preventing misuse of resources and ensuring value for money. The Region has received no unsatisfactory internal audit reports in the past four years. The Compliance and Risk Management Committee ensures our decisions are strategic, transparent and effective. Individual staff members understand the impact of their actions on the Organization and are working hard to achieve results according to agreed key performance indicators (KPIs) as part of their professional development.

Transparency and efficiency are being enhanced through online monitoring and reporting. The KPI dashboard generates information on the progress of every WHO team across the Region and facilitates timely intervention for better performance.

Our focus on achieving results is steadfast. Staffing is matched to priorities at the Regional Office and intercountry support teams (ISTs). Recently we have reinforced interaction between ISTs and directors in Brazzaville for improved oversight and stronger support to countries. We have streamlined recruitment procedures, introduced induction training for new staff, and are investing in staff development and learning.

Finally, we are reorganizing country offices to ensure they are fit for purpose to address the needs of Member States. Reviews of staff functions and profiles have been completed in 42 country offices, with 21 offices moving forward to implement approved plans. We will now work with staff to enhance skills in health systems strengthening, health security and promoting well-being, in line with the Thirteenth General Programme of Work.

The transformation of the Secretariat into a more responsive and accountable Organization is well underway. With the support of staff, Member States and partners, we will continue to work towards improving health outcomes for the one billion people of the African Region

Dr Matshidiso Moeti
Regional Director for Africa
World Health Organization

Executive Summary

This report outlines the significant results achieved by WHO in the African Region guided by the *Twelfth General Programme of Work* (2014–2019). These results reflect the contributions of WHO country offices, the Regional Office, including intercountry support teams, and WHO headquarters, in collaboration with Member States and partners, in supporting health development in the WHO African Region.

Transformation Agenda

The regional Transformation Agenda aims to ensure that WHO focuses on results to deliver concrete outcomes and impacts in countries. Shared values increasingly guide collective behaviour, to create an environment where all give their best in actions to address the highest priority health problems. These actions should be underpinned by efficiency and accountability in operations and interactions with partners. Through the Transformation Agenda, the Secretariat continually strives to ensure that WHO is the effective, accountable and transparent Organization that staff and stakeholders want.

Over the past four years, restructuring at the regional level and implementation of key performance indicators (KPIs) have contributed to better alignment of WHO resources with country priorities, along with stronger monitoring of progress in programmatic and managerial areas. Building on this, leadership training is enhancing the skills and competencies of 130 senior staff. This training is instilling in participants a collective determination to work differently. Across the Region, 150 volunteers are supporting change initiatives to improve how we work together. At the country level, reviews of staff profiles and functions are being used to ensure that country office teams are fit for purpose.

WHO aims to help countries prevent and ensure access to treatment for the most important causes of ill health and preventable death by prioritizing universal health coverage, addressing health emergencies and delivering high-impact health interventions. In furtherance of this goal, the Regional Director continues to advocate with Member States and partners, including for domestic financing, through official country visits, participation in high-level events, and constant interaction with partners. Results are being achieved in strengthening operations, sustaining compliance, promoting efficient resource use and ensuring an enabling environment for delivery of technical work. New partnerships are being established and existing ones expanded. Public health messages are reaching a wider audience and contributing to greater visibility of WHO's work in the Region, with almost one million new users to the WHO Regional Office website since the start of 2018 and increasing engagement via traditional and social media.

Enhanced regional health security and response to emergencies

Member States have made significant progress in strengthening and sustaining health emergency preparedness and response capacities in the Region. Thirty-three countries conducted risk profiling and mapping and 41 Member States completed joint external evaluations (JEEs) of their International Health Regulations (IHR) core capacities. All 47 Member States in the Region submitted the IHR State Party self-assessment annual report, from less than 50% that did so in 2015. In addition, 24 Member States developed all-hazards national action plans for health security incorporating the "One-Health" approach, which if funded and implemented will address the most important gaps.

To enhance monitoring of priority diseases and timely detection of epidemics, 19 Member States achieved Integrated Disease Surveillance and Response (IDSR) coverage of 90% at subnational level, including implementation of event-based surveillance. Capacities in conducting timely investigations and responding to outbreaks and other emergencies, have been strengthened through rapid response team training in 17 countries.

WHO continues to play a leading role as co-coordinator with governments in responding to outbreaks and public health emergencies. A recent example is seen in the Democratic Republic of the Congo, where WHO is coordinating the complex Ebola response with the Government and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Averting international spread and wider spread within the country remains a priority. The investigational Ebola candidate vaccine (rVSV-ZEBOV) has played a key role, with more than 147 000 people vaccinated.

Addressing the unfinished agenda of communicable diseases

Communicable diseases such as HIV, TB, malaria, viral hepatitis, sexually transmitted infections (STIs) and neglected tropical diseases (NTDs) continue to pose major public health challenges across the Region. In 2018, seventeen additional Member States adopted the "Treat All" policy for the 25.7 million people living with HIV in the African Region to be provided with antiretroviral therapy (ART), regardless of their immune status. An additional 1.3 million people living with HIV were newly started on ART in 2018, bringing the total number of people on ART to 16.3 million, representing a 64% coverage rate. Catch-up plans are being implemented in West and Central Africa to further expand coverage and significant progress has recently been reported.

The Region has continued to make progress in measuring the impact of TB, towards reaching the End TB Strategy and Sustainable Development Goal (SDG) targets. WHO, alongside other partners, supported Member States to accelerate progress towards ending TB and developed the African Continental End TB Accountability Framework for Action and an annual scorecard. A "high-burden to high-impact" country-led approach was launched in November 2018 to halt rising numbers of cases of malaria in high-burden countries. Member States developed and deployed strategies and tools for malaria prevention, control and elimination, and comprehensive malaria programme reviews were conducted in five countries.

The Expanded Special Project for Elimination of NTDs (ESPEN) helped 21 countries to reach more than 70 million people with preventive treatment through mass drug administration. In addition, ESPEN recovered more than 67 million medicines that had been lost or unaccounted for, resulting in savings of almost US$ 70 million in donated medicines. Eradication of guinea-worm disease is on track with endemicity remaining in four countries. Elimination of human African trypanosomiasis is projected to be achieved before the 2020 deadline.

By June 2019, no wild poliovirus (WPV) type 1 had been confirmed in the African Region for more than 34 months since the onset of the last case in Nigeria in August 2016. All Member States in the Region had introduced inactivated polio vaccine (IPV) as at March 2019, compared to only 36 Member States by early 2018. As of November 2018, forty Member States in the Region had their polio-free status documentation accepted by the African Regional Certification Commission for Polio Eradication. Hard work is ongoing, including campaigns, to end vaccine-derived poliovirus type 2 outbreaks, now in 10 countries.

Enhancing integrated and multisectoral approaches to prevent and control noncommunicable diseases

In collaboration with partners, WHO and Member States continued to respond to the noncommunicable disease (NCD) epidemic. Twelve countries are using the WHO Package of Essential NCD Interventions (WHO PEN) to integrate services for NCD prevention and management at the primary health care level in low-resource settings. Ethiopia and Nigeria are implementing the RESOLVE project to improve hypertension detection and control. To date, 35 Member States in the Region have NCD multisectoral action plans to ensure that efforts to prevent and control these diseases bring together the relevant stakeholders beyond the health sector.

In 2018–2019, ten Member States adopted laws and regulations on tobacco control. Five additional countries ratified the Protocol to Eliminate Illicit Trade in Tobacco Products in the Region, bringing the total number of Parties from the African Region to 17. In 2018, WHO began to implement a three-year project to strengthen national regulatory and fiscal environments to promote healthy diets and physical activity. WHO is working with 15 countries in the Region on cervical cancer prevention and control to save lives by integrating a "screen and treat approach" as part of primary health care.

Ongoing action to achieve universal health coverage

Work on universal health coverage has accelerated, with impetus from high-level political decisions in countries and at the Africa Union. Advocacy conducted with countries by the Regional Director has focused on investing in primary health care to achieve UHC, increasing domestic investments for health and reducing out-of-pocket payments. An Essential Health Services Package (EHSP) has been developed to guide Member States on primary health care and at least three countries are working to implement it.

In line with WHO's focus on improving financing and with a view to reducing costs and increasing efficiency, a side event on falsified and substandard

medicines was convened at the United Nations General Assembly. Subsequently, 15 Member States are now implementing surveillance mechanisms to reduce medicine costs in the context of the Medicines Availability and Price Platform hosted by the Regional Office.

To strengthen governance for antimicrobial resistance (AMR) and improve collaboration across the health, food and agriculture sectors, WHO supported the development of national action plans in 30 Member States.

Saving the lives of women, children and adolescents

Progress in expanding access to essential maternal, newborn and child health (MNCH) services continues to be made. The focus is on ensuring the provision of quality services in addition to scaling access to skilled birth attendants where needed. Nine countries are part of the Network for Improving Quality of Care for MNCH Services, and many more have expressed interest in joining. Fourteen countries reached the target of 90% antiretroviral (ARV) coverage for pregnant women and are working towards elimination of mother-to-child transmission of HIV and syphilis. To further improve the quality of available services in collaboration with partners and stakeholders, in 2018, seven Member States developed integrated plans on reproductive, maternal, newborn, child and adolescent health (RMNCAH) and nutrition.

Through the regional flagship programme on adolescent health, 36 countries are taking action to increase access to quality services for young people. Twenty-one countries are mainstreaming gender, equity and rights using WHO guidance and tools.

Following months of intensive preparation, the subnational pilot introduction of the first malaria vaccine to reach young children – RTS,S/AS01 – began in Ghana and Malawi. Rubella-containing vaccine has been introduced in 27 countries, and 26 countries now include a second dose of measles vaccine (MCV2) in routine immunization programmes. Twenty-four of the 31 targeted countries have introduced the yellow fever vaccine in their routine immunization programmes.

Strategic partnerships

Partnerships have been strengthened and resources mobilized for public health priorities. This has led to 142 cooperation agreements, including a partnership for the advancement of the health agenda on the continent with the Pan-African Parliament and a framework for Regional Collaboration with the Global Fund. WHO convened the second WHO Africa Health Forum (WAHF) in Praia, Cabo Verde in March 2019, providing a unique opportunity to consider pathways to achieving UHC and health security in the Region. The relaunched Harmonization for Health in Africa (HHA) platform is pursuing UHC as a collective priority. Within the platform, the provision of public financial management training in countries across the Region will improve the way domestic and international funds are used to improve health.

In relation to governing bodies, WHO in the African Region continued to streamline processes and strengthen support to delegates. The Sixty-eighth session of the Regional Committee adopted the first ever Code of Conduct for the Nomination of the Regional Director to promote a transparent, open and equitable process. The voice of African Member States at global governing bodies is stronger through intensified support from the Secretariat.

Communications have greatly improved in scope, quality and reach. Public information on outbreaks and on the activities of WHO and partners is shared in timely and relevant ways. Active advocacy for regional health priorities included around 100 media interactions and the training of more than 300 reporters from more than 10 countries on how to report on health emergencies, resulting in an initial 20 media products.

Consolidation and coordination of managerial initiatives

The Secretariat has continued to strengthen the strategic focus on results and has shifted energies towards the triple billion goal, as outlined in the *Thirteenth General Programme of Work 2019–2023* (GPW 13). Enhanced capacities in planning, budgeting, monitoring and evaluation have resulted in greater efficiency and effectiveness of WHO's work in the Region.

Structural and managerial reforms are being consolidated by strengthening internal control mechanisms; improving accountability, transparency and compliance; and enhancing the performance of individual staff and teams across the Region. As a result of these measures, audit report ratings in the Region have improved significantly in recent years.


World Health
Organization

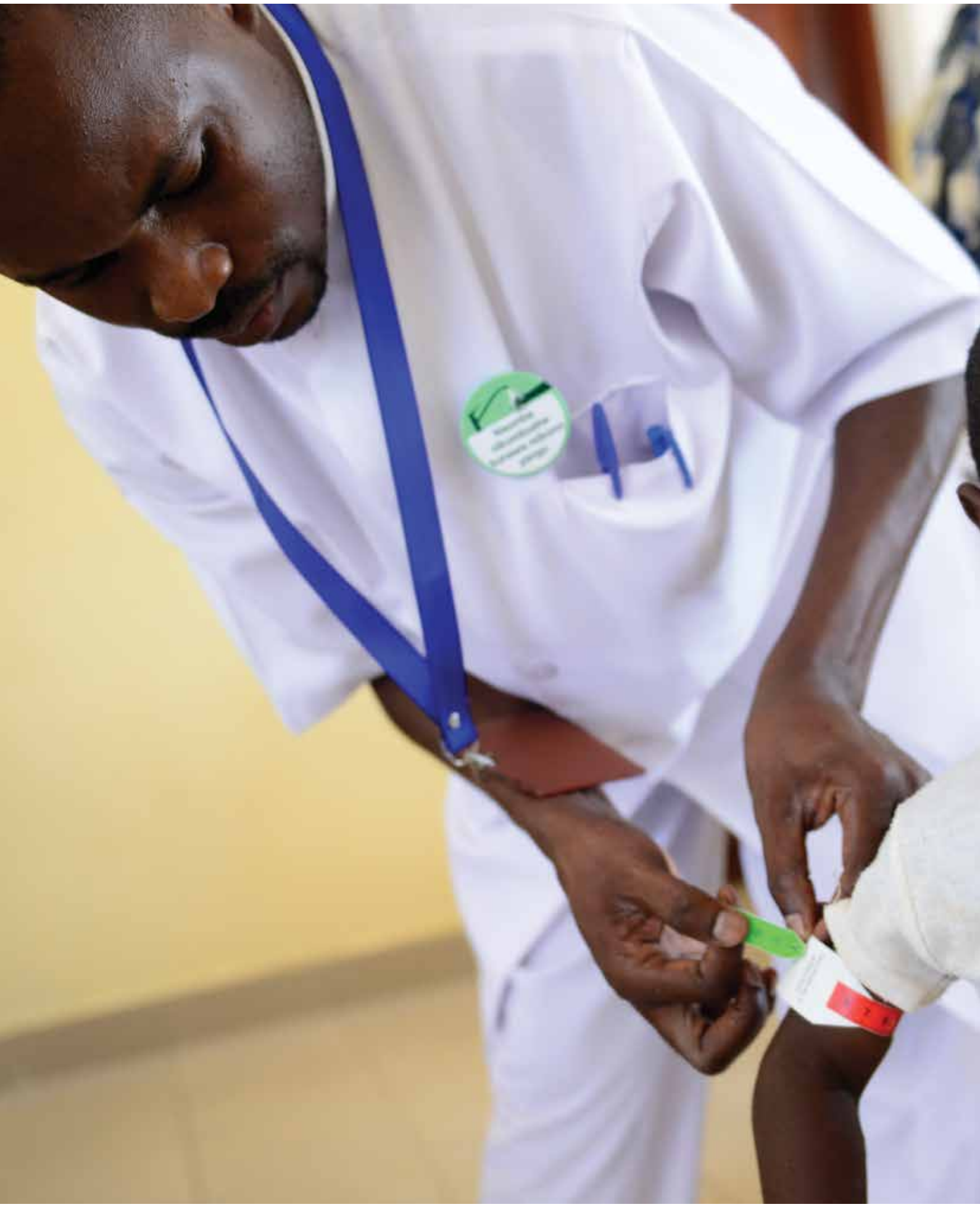
Programme delivery in line with key performance indicators (KPIs) continues to improve to enhance accountability, transparency and the focus on results. The KPIs measure WHO's contribution at the output level towards the achievement of national and Sustainable Development Goals (SDGs) in the African Region.

Looking forward

Building on the significant progress achieved in the past year, the Secretariat is focused on working closely with Member States and partners to deliver on GPW 13. Improvements in organizational efficiency, accountability, quality and value for money will be further institutionalized, in line with the regional Transformation Agenda and the global WHO Transformation.

The UHC flagship programme will continue with a strong focus on primary health care and equity and the adolescent flagship programme will be used as a measure of progress towards UHC. These two areas will drive results towards health for all, at all ages. At the same time, the needs of older people will receive more attention. Using people-centred approaches, and with emphasis on integration of prevention and control services, the Secretariat will focus on strengthening health systems and in turn health security. WHO will continue to provide rapid and effective support to Member States to prevent and respond to acute events; this includes closing the Ebola outbreak in the Democratic Republic of the Congo.

The Secretariat will also expand partnerships, including with the private sector and advance digital health as a key tool to accelerate progress towards UHC. Through collective action with Member States and partners, WHO in the African Region will promote health, save lives and serve the vulnerable, in turn contributing to economic growth and national development across Africa.



Introduction

This report on the work of WHO in the African Region from 1 July 2018 to 30 June 2019 reflects the progress made since the Regional Director's last report to the Regional Committee in 2018. The report highlights the results achieved in supporting Member States and working with partners to improve health in the Region.

The WHO Secretariat in the African Region comprises 47 country offices and the Regional Office, as well as 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 investment in health, mobilizing resources and facilitating partner coordination.

This report comprises a section highlighting the achievements of the Transformation Agenda, followed by the presentation of results under the six categories of the *Twelfth General Programme of Work, 2014-2019* (GPW 12):

(1) Communicable diseases

(2) Noncommunicable diseases

(3) Promoting health through the life course

(4) Health systems

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

(6) Corporate services and enabling functions.

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 2018–2019.


Ouverture d'esprit
les collègues
Mon engagement
Sens de l'écoute
Critique Constructive

PROGRESS
OF THE TRANSFORMATION AGENDA

To improve WHO's performance, the regional Transformation Agenda aims to ensure that WHO is driven to deliver results in countries. Shared values and a focus on health priorities are the basis for determining ways of working across the Organization. These actions should be backed by operations that are efficient and accountable. The vital role of partners in supporting WHO's mandate should also be recognized. Building on gains in these areas to date, the Transformation Agenda is now focused on optimizing WHO's performance, improving quality, management and value for money, and ensuring effective partnerships.

The WHO Regional Office for Africa Pathway to Leadership Training Programme was launched in 2018 with the training of 130 staff including six from other WHO regions. The programme enhances the skills and knowledge of senior staff to understand the complex issues facing managers and leaders today and to anticipate those of the future. The programme has since been adopted Organization-wide.

The Agenda also recognizes that staff should be at the centre of change. In support of this view, 150 staff members volunteered as change agents in 2018. They have participated in training and embarked on projects to catalyse change, resulting in improved accountability and engagement among staff.

Functional reviews have now been completed in 42 country offices, 21 review reports have been approved and suggested changes are being implemented. At the programmatic level, key performance indicators (KPIs) are supporting results-based management and timely corrective actions. For example, the monitoring of KPIs demonstrated slow implementation of HIV programmes in West and Central Africa. In response to this, a catch-up plan was developed in collaboration with partners and is now being implemented.

The technical focus of WHO's work has been strengthened with comprehensive reviews in 12 Member States to identify priority interventions to accelerate the universal health coverage (UHC) agenda.[1] As part of improving the International Health Regulations (2005) core capacities, WHO has led independent joint external evaluations (JEE) in five additional Member States[2], bringing the regional total to 41. In 2018, the WHO Expanded Special Project for Elimination of NTDs (ESPEN) supported 23 Member States including two countries from the Eastern Mediterranean Region[3] in scaling up mass drug administration campaigns for more than 70 million people to address the five most prevalent NTDs amenable to preventive chemotherapy.

Compliance with WHO rules and regulations has improved, as has accountability. As a result, no unsatisfactory internal audit rating has been issued in the Region in the last four years. Efforts to improve processes related to procurement and supply of goods and services are contributing to more timely, better quality and more cost-effective transactions. As a result of these actions, significant cost savings of at least US$ 6 million have been made since January 2018.

To further enhance partnerships and communications, briefing sessions for newly appointed ministers of health and directors-general or permanent secretaries have been initiated. These briefings introduce the role of the WHO Secretariat, key issues in health governance and global health priorities. Collaboration with traditional partners continues to expand and new partners are being engaged. Based on the regional communications strategy, WHO has proactively engaged with strategic media, leading to more than 100 media interactions. In addition, through the active use of social media and innovative platforms, public health messaging has reached a wider audience and the visibility of the work of WHO and partners in the African Region has increased.

1 Benin, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Madagascar, Mozambique, Nigeria, Rwanda, Togo, Zambia and Zimbabwe.
2 Burundi, Central African Republic, Congo, Malawi, Sao Tome and Principe.
3 Burundi, Cameroon, Chad, Comoros, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Lesotho, Madagascar, Malawi, Namibia, Nigeria, Congo, Rwanda, Sierra Leone, South Sudan, Sao Tome and Principe, Sudan, Yemen.

CATEGORY 1:
COMMUNICABLE DISEASES

In 2018–2019, WHO in the African Region accelerated efforts to prevent, control and eliminate communicable diseases posing major public health challenges in most countries in the Region. These diseases include HIV, tuberculosis (TB), malaria, viral hepatitis, sexually transmitted infections (STIs) and neglected tropical diseases (NTDs).

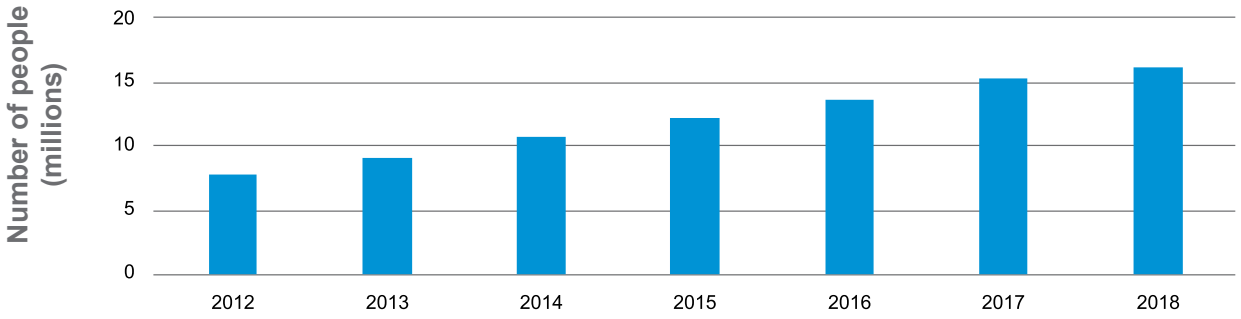
Expanding access to HIV treatment

In 2018, seventeen additional countries[4] adopted the "Treat All" policy to ensure the 25.7 million people living with HIV in the African Region are eligible for antiretroviral therapy (ART), regardless of their immune status. An additional 1.3 million people living with HIV were newly started on ART in 2018, bringing the total number of people on ART to 16.3 million, representing a coverage rate of 64%. In 2018, Eswatini and Namibia achieved the UNAIDS 90-90-90 targets.[5] Algeria, Botswana, Lesotho and Rwanda are on track to reach these targets. The West and Central Africa subregion is still lagging behind in the HIV response. However, the implementation of catch-up plans in the subregion has resulted in encouraging signs of expansion. Figure 1 shows how ART coverage in the African Region has more than doubled between 2012 and 2018.

With highly cost-effective and high-impact interventions, WHO is addressing communicable diseases and rolling out integrated disease-specific responses in people-centred health systems.

In January 2019, more than 200 participants gathered at a high-level meeting on elimination of mother-to-child transmission of HIV and universal coverage of paediatric HIV testing and treatment in West and Central Africa. High-level commitment was shown with the attendance of the First Lady of Senegal, Ministers of Health of Cabo Verde, The Gambia, the Executive Director of UNAIDS and the WHO Regional Director for Africa.

Figure 1: Number of people living with HIV receiving antiretroviral therapy in the African Region, 2012–2018



Source: UNAIDS Global Report 2019.

4 Burkina Faso, Cabo Verde, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, The Gambia, Guinea, Guinea-Bissau, Liberia, Mauritania, Mauritius, Sao Tome and Principe, Seychelles, Sierra Leone and Togo.

5 By 2020: 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained ART; and 90% of all people receiving ART will have viral suppression.

Following the emergence of evidence that the positive impact of the scale-up of ART was under threat from an increase in HIV drug resistance (HIV-DR), WHO developed *Preventing and Responding to HIV Drug Resistance in the African Region: Regional Action Plan 2019–2023*. The action plan calls on Member States to monitor, prevent and respond to HIV-DR. WHO has set up a web portal to serve as an early warning system and help in anticipating disruptions in the availability of medicines for patients, thus strengthening supply management systems to minimize drug stock-outs.

Working towards eliminating hepatitis as a public health threat by 2030

In June 2019, WHO launched the first African regional hepatitis scorecard showing the large burden of viral hepatitis B and C in the Region and the modest progress towards eliminating hepatitis as a public health threat by 2030, through implementation of *Prevention, care and treatment of viral hepatitis in the African Region: Framework for action, 2016–2020*. Only 11 countries in the Region[6] have implemented hepatitis B birth-dose vaccination. Hepatitis testing and treatment remains the biggest response gap, with only Rwanda and Uganda approaching the 2020 testing target of 20% of people with chronic hepatitis infections diagnosed.

Strong political commitment was shown at the first ever African Hepatitis Summit in June 2019. The Vice-President of Uganda, the Ministers of Health of Egypt and Uganda and the United States Ambassador to Uganda attended, along with more than 600 people from 32 countries. WHO promoted South-South cooperation and supported the participation of policy-makers from 10 countries.[7] The Minister of Health of Egypt announced the "Egypt Initiative" which involves partnering with 14 countries[8] to ensure that one million Africans receive free treatment for viral hepatitis, with the support of WHO.

High-level commitment to ending tuberculosis and fast declines in TB incidence

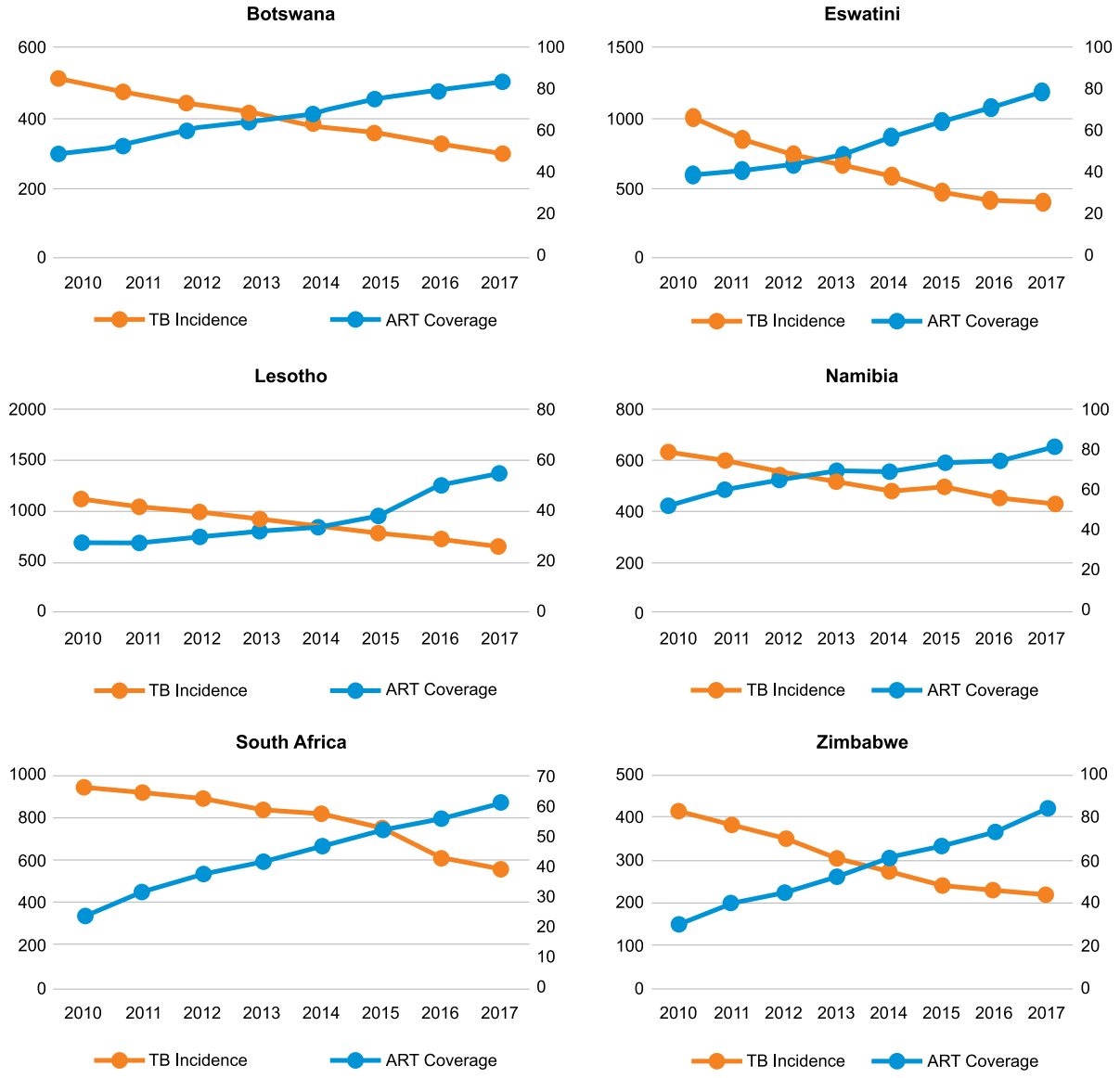
In 2018–2019, WHO and partners worked with Member States to accelerate progress towards ending TB. On behalf of the African Union Commission, WHO developed the African Continental End TB Accountability Framework for Action and an annual scorecard, which were endorsed by the African Union Assembly in 2018. Several African Heads of State and Government attended the inaugural United Nations General Assembly High-level Meeting on TB (HLM-TB) in 2018, where the African Union Commission, AUDA-NEPAD (the development agency of the African Union) and the WHO Regional Office for Africa jointly convened a special session.

The Region has made progress in measuring the impact of TB and in reaching the End TB Strategy and Sustainable Development Goal (SDG) targets. Eswatini, Lesotho, Mozambique and South Africa conducted TB prevalence surveys in 2018. So far 15 countries in the Region have conducted these surveys.[9] Among these, Ghana, Kenya, Nigeria and Uganda conducted TB patient cost surveys. The latest data show TB cases in the Region falling at an annual rate of 4% with some countries recording the fastest declines globally (4–8% annually) in TB incidence (Figure 2).

WHO continues to support the scaling up of programmatic management of drug-resistant TB (PMDT). Data published in 2018 show that all countries now have GeneXpert for TB diagnosis, while coverage of drug susceptibility testing to second-line TB drugs increased to 53% of multidrug- and rifampicin-resistant TB patients in 2017, up from less than 20% in 2010. The shorter treatment regimen and new multidrug-resistant TB drugs (Delamanid and Bedaquiline) are in use in 22 countries and 71.4% of detected cases were started on treatment in 2017, compared to 69% in 2016. However, only nine countries are using GeneXpert as the first-line test for TB diagnosis.

6 Algeria, Angola, Botswana, Cabo Verde, The Gambia, Mauritania, Mauritius, Namibia, Nigeria, Sao Tome and Principe and Senegal.
7 Algeria, Cameroon, Cabo Verde, Cote d'Ivoire, Ethiopia, The Gambia, Ghana, Nigeria, Sao Tome and Principe, and the United Republic of Tanzania.
8 Burundi, Chad, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Kenya, Mali, Somalia, South Sudan, Sudan, United Republic of Tanzania, and Uganda.
9 Eswatini, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

Figure 2: Trend of TB incidence (per 100 000 population) relative to ART coverage (%) in six southern African countries, 2010–2017[10]



A high-burden, high-impact approach to malaria prevention and control

A high-burden to high-impact country-led approach was launched in November 2018 to address the challenge of rising numbers of cases of malaria in high-burden African countries. The response seeks to galvanize political will nationally and globally to reduce malaria deaths; use strategic information to drive impact; implement the best global guidance, policies and strategies for malaria-endemic countries; and ensure coordinated responses by countries.

Capacity-building interventions, such as external competency assessments for malaria microscopists, were conducted for 166 participants from 24 countries[11]. Fifty participants from 23 countries[12] benefited from trainings on malaria surveillance and data management. Support was provided to five countries[13] to train key laboratory personnel on WHO-recommended malaria diagnosis quality assurance/quality control systems and to develop malaria diagnosis quality assurance/quality control guidelines. Key laboratory personnel from 12 countries[14] developed and strengthened national and regional malaria slide banks.

10 https://www.who.int/tb/country/data/download/en/ for TB data and http://aidsinfo.unaids.org/ for ART coverage data.
11 Angola, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Congo, Democratic Republic of Congo, Eritrea, Eswatini, Gabon, Kenya, Madagascar, Morocco, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Uganda, Zambia and Zimbabwe.
12 Algeria, Angola, Burundi, Cameroon, Congo, Comoros, Benin, Burkina Faso, Cabo Verde, Chad, Côte d'Ivoire, Gabon, Guinea, Guinea-Bissau, Equatorial Guinea, Madagascar, Mali, Mauritania, Niger, Central African Republic, Democratic Republic of the Congo, Senegal and Togo.
13 Cameroon, Kenya, Eritrea, Eswatini and Sao Tome and Principe.
14 Botswana, Burkina Faso, Burundi, Democratic Republic of the Congo, Eritrea, Eswatini, Ghana, Kenya, Nigeria, Senegal, South Africa and Zambia.

Algeria became the second country in the Region to be certified malaria-free (following Mauritius in 1973). Five other countries in the Region[15] have the potential to eliminate the local transmission of malaria by 2020. Member States developed and deployed strategies and tools for malaria prevention, control and elimination. Comprehensive malaria programme reviews in five countries[16] informed the updating or development of new malaria strategic plans and policies in line with the *Global Technical Strategy for Malaria 2016–2030*. Six countries[17] successfully developed or updated their strategic plans. These plans are also used to mobilize funds from partners, such as the Global Fund.

In February 2019, the Global Fund and WHO in the African Region signed a strategic framework for collaboration to support countries to scale HIV, TB and malaria interventions, strengthen health systems, enhance collaboration to accelerate UHC, and support regional attainment of the SDGs.

Striving to achieve an Africa free of neglected tropical diseases

National NTD master plans 2016–2020 continued to be implemented in line with the *Regional Strategic Plan for Neglected Tropical Diseases in the African Region 2014–2020*. The Regional strategic plan seeks to eradicate two diseases (guinea-worm disease and yaws), to eliminate or sustain elimination of human African trypanosomiasis (HAT) and leprosy as public health problems, and to advance control of other NTDs, mainly Buruli ulcer and leishmaniasis.

The eradication of guinea-worm disease is on track with endemicity remaining in Chad, Ethiopia, Mali and South Sudan. This progress was achieved with support from WHO and the Carter Centre, in collaboration with UNICEF for the provision of safe drinking-water. A Brazilian Company (EMS) is supplying Azithromycin for mass treatment of yaws, and resource mobilization for implementation has started for the yaws eradication strategy.

The elimination of HAT is achievable before the deadline of 2020. In 2018, there were less than 1000 cases, which is below the threshold of 2000 cases by 2020. This success is due to the substantial support provided by Sanofi, Gilead, Bayer, the Drugs for Neglected Diseases Initiative and HAT collaborating centres. With the support of the Nippon Foundation and a donation of medicines by the Novartis Foundation, leprosy elimination as a public health issue defined as prevalence of less than one case per 10 000 population, has been sustained in all countries, except Comoros. At the end of 2018, the regional leprosy prevalence rate was 0.22 cases per 10 000 people.

Progress in controlling Buruli ulcer in endemic countries continues and requires efforts to be maintained, with 2335 reported cases in 2018, up from 1832 cases in 2017. This is still significantly less than the 4850 cases in 2010. The use of Ambisome – a safer and potent medicine donated by Gilead – and combination regimens supported by the Department of International Development of the United Kingdom has contributed to falling case fatality rates of leishmaniasis from 1.7% in 2017 to 1.3% in 2018.

Established in 2016 as a public-private partnership between the WHO Regional Office for Africa, Member States and NTD partners, the Expanded Special Project for Elimination of NTDs (ESPEN) strives to achieve an Africa free of NTDs with the mission of accelerating the elimination of the five NTDs amenable to preventive chemotherapy (PC-NTDs) to protect 600 million people in Africa. In 2018, ESPEN helped 21 countries to scale up mass drug distribution targeting more than 70 million people, and also supported three Member States[18] to complete mapping for schistosomiasis, soil-transmitted helminths and lymphatic filariasis.

The ESPEN portal was launched in 2017 and enhanced in 2018. In 2018–2019, ESPEN worked with countries and partners to compile over 4000 maps and include trachoma on the portal. ESPEN was recognized as a ground-breaking public-private partnership at the 2018 UHC conference organized during the United Nations General Assembly, with WHO Director-General, Dr Tedros Adhanom Ghebreyesus, presenting the UHC Innovative Partnership Award to ESPEN.

ESPEN's work made it possible to save 285 280 139 medicine tablets, which had been previously lost or unaccounted for, resulting in savings of US$ 69 740 537 in donated medicines. This result was obtained through the provision of in-country technical support and critically reviewing applications for donated medicines. As of December 2018, forty-four endemic Member States had developed second-generation NTD master plans

15 Botswana, Cabo Verde, Comoros, Eswatini and South Africa.
16 Cabo Verde, Kenya, Liberia, Senegal and South Africa.
17 The Gambia, Kenya, Liberia, Senegal, South Africa and United Republic of Tanzania.
18 Angola, Central African Republic and South Sudan.

for 2016–2020, which were subsequently made available through the ESPEN portal.

Multisectoral action for environmental health

Environmental risks account for 23% of the burden of disease and have a substantial socioeconomic impact in the African Region, including vector-borne diseases, cancers, lower respiratory tract infections, diarrhoeal and cardiovascular diseases. Air pollution, poor water, sanitation and hygiene conditions and unsound management of chemicals and hazardous wastes are the main drivers of these diseases. WHO partnered with the United Nations Environment Programme to support health and environment ministers from 46 countries[19] attend the Inter-ministerial Conference on Health and Environment in Africa (IMCHE3) and adopt a strategic action plan 2019–2029 to scale up health and environment interventions in Africa. *The Regional Plan of Action for SIDS in the African and South East Asian Regions* was developed to address high vulnerability of the health sector to climate change.[20] Climate change interventions, including climate-resilient water and sanitation planning were conducted in Ethiopia, Malawi, Mozambique and the United Republic of Tanzania through the contribution of key donors.[21]

Fifteen Member States[22] were supported to develop policies and implement the concept of climate-resilient water safety planning which is widely considered the most reliable and effective way to manage drinking-water supplies to safeguard public health. This comprehensive risk assessment and risk management approach covers the drinking-water supply chain from the catchment to the point of use. In 2018, ten countries[23] established the African Network of Poison Control Centres (ANPCC) to strengthen their systems of toxicovigilance and share experiences. Actions facilitating evidence-based environmental health risk prevention and mitigation policies/strategies were also conducted in several Member States. Seven Member States[24] initiated development of their health national adaptation plan (H-NAP), and nine others[25] revised and finalized their H-NAP. The Global Environment Fund (GEF) funded a project entitled "Demonstration of effectiveness of innovative implementation of integrated vector management (IVM) for disease prevention and control", and Botswana and Uganda developed their IVM strategic plan in line with the Global Vector Control Response (GVCR).

Viral hepatitis in focus in Uganda

Although viral hepatitis affects more than 350 million people worldwide, the disease has been largely ignored and never received the same level of political advocacy, funding or education that drove the HIV response. Recently, global recognition and acknowledgment of the rising number of deaths from viral hepatitis is increasing. Uganda has high prevalence of viral hepatitis B (HBV) and its associated sequelae of advanced chronic liver disease and cancer. Following the adoption of the WHO *Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection* in 2015, the Government of Uganda embarked on a massive hepatitis B screening programme. By June 2019, some 3.7 million adolescents and adults (15–65 years) had been screened in 71 districts with the highest burden of chronic HBV infection.

Uganda is thus the first country in the African Region to achieve a coverage rate of over 30% of the HBV-infected population knowing their status, therefore exceeding the global target and the 2020 timeline in the 36 regions where testing was conducted. The project has led to significant community awareness and strengthening of laboratory and diagnostic capacity for hepatitis serological and viral load testing. The key success factors were: strong political and parliamentary commitment; mobilization of domestic funding; and extensive health promotion, awareness and social mobilization. There is an increasing need to expand access to care for infected people and optimize capacity-building, and service decentralization in addition to taking advantage of the availability of locally manufactured Tenofovir for the treatment of hepatitis B.

19 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Morocco, Mozambique, Namibia, Niger, Nigeria, Congo, Rwanda, Sao Tome and Principe, Sierra Leone, Senegal, Seychelles, Somalia, South Africa, Togo, Tunisia, Uganda, Zambia and Zimbabwe.

20 Cabo Verde, Comoros, Mauritius, Sao Tome and Principe, and Seychelles.

21 DFID, the Flanders local government and Global Framework for Climate Services Adaptation Programme in Africa (GFCS APA).

22 Botswana, Eritrea, The Gambia, Ghana, Kenya, Liberia, Malawi, Mauritius, Mozambique, Rwanda, Seychelles, Sierra Leone, South Sudan, Uganda and Zambia.

23 Algeria, Ethiopia, Ghana, Kenya, Madagascar, Nigeria, Senegal, South Africa, United Republic of Tanzania and Zimbabwe.

24 Benin, The Gambia, Malawi, Sierra Leone, South Africa, Zambia, Zimbabwe.

25 Ethiopia, Ghana, Lesotho, Liberia, Madagascar, Seychelles, Togo, United Republic of Tanzania, and Uganda.

CATEGORY 2:
NONCOMMUNICABLE DISEASES

In the African Region, while deaths from communicable diseases are declining due to effective public health measures, deaths from NCDs are increasing rapidly.[26] NCDs constitute a health and development issue and should be tackled through an integrated and multisectoral approach. WHO in the African Region, in collaboration with partners, is supporting Member States to respond to the NCD epidemic by developing and implementing multisectoral policies and strategies, strengthening health systems, reducing exposure to risk factors, tracking trends and monitoring progress towards the nine voluntary global NCD targets in the *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.*[27]

Multisectoral action plans and preventing NCD risk factors

To ensure a coherent response to NCD prevention and control, WHO supported four Member States[28] in the Region to develop, review or update their plans in line with the Global action plan, bringing the regional total to 35 Member States having NCD action plans. Botswana and Uganda conducted costings of their plans to support implementation. In Togo, a multisectoral coordination mechanism has been established to strengthen involvement of non-health sectors in the implementation of the plan and to support the prioritization of NCDs in national development plans. WHO has supported the implementation of STEPwise approach to surveillance (STEPS) surveys in six Member States,[29] which has improved the availability and quality of data on NCD risk factors at the national and regional levels.

The WHO PEN approach integrates prevention and management of NCDs, to make them available as part of primary health care services in communities.

The WHO Package of Essential NCD Interventions in Low-Resource Settings (WHO PEN) has been introduced in 12 countries.[30] The WHO PEN approach integrates prevention and management of NCDs, to make them available as part of primary health care services in communities. In the past year, Benin, Lesotho and Togo have developed PEN guidelines and conducted training of health-care workers. WHO has supported Ethiopia and Nigeria to implement the RESOLVE project, which aims to improve hypertension detection and control. This could be a model in settings with limited resources for replication in other countries. In Ethiopia, the project is targeting 50 primary health care facilities serving 10 million people. In 2018 with WHO support, Seychelles reviewed and updated management guidelines for diabetes as part of the diabetes passport project, which aims to improve the treatment of diabetic patients.

Strengthening tobacco control legislation and policies

In 2018–2019, ten Member States[31] adopted laws and regulations on tobacco control that are compliant with the requirements of the WHO Framework Convention on Tobacco Control (WHO FCTC). The Parliaments of the Democratic Republic of the Congo, Ethiopia and Mauritania passed laws on tobacco control. In addition, laws and regulations were endorsed by the Heads of State of Burundi, Cabo Verde, Congo and Côte d'Ivoire, and tobacco control regulations

26 WHO, Global Health Estimates (2015): Geneva, World Health Organization. http://www.who.int/healthinfo/global_burden_disease/estimates/en/index.html
27 WHO (2013). Global Action Plan for the prevention and control of NCDs 2013-2020. Geneva: World Health Organization.
28 Burundi, Niger, Togo and Zambia.
29 Cabo Verde, Ghana, Mauritania, Nigeria, Sao Tome and Principe and Zimbabwe.
30 Benin, Botswana, Burkina Faso, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Guinea, Lesotho, Malawi, Sierra Leone and Togo.
31 Burundi, Cameroon, Cabo Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, The Gambia and Mauritania.

were endorsed by the ministers of health and other ministers in three further countries.[32]

A regional training manual was developed on enforcement and compliance-related issues to accelerate implementation of the WHO FCTC. WHO also built the capacity of countries in the Region for tobacco tax analysis and modelling. This resulted in changes of tobacco taxation policies in five countries.[33] Following WHO interventions to increase the number of Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products in the Region, five additional countries[34] ratified the Protocol, bringing the total number of Parties from the African Region to 17.[35] This facilitated the entry into force of the Protocol and subsequent efforts to tackle the growing illicit trade in tobacco products in the Region.

Four countries[36] completed tobacco surveys and used the data to inform and improve tobacco control policies and enhance programme capacity. Ten countries[37] used tobacco-related data to develop policy briefs to support advocacy and decision-making. Work is currently ongoing on the seventh round of the regional Report on the Tobacco Epidemic, which involves collecting data on the tobacco burden and tobacco control policies from all 47 countries in the Region. The report will help to monitor the implementation of the WHO FCTC and trends in the tobacco burden.

Promoting healthy diets and physical activity

In September 2018, WHO in the African Region began to implement a three-year project to strengthen national regulatory and fiscal environments to promote healthy diets and physical activity. The project aims to strengthen the capacity of government officials responsible for formulating policies and regulations on diets and physical activity.[38] A needs assessment was conducted in three countries[39] to map regulatory and fiscal capacity and identify country needs and priorities to inform the development and implementation of appropriate regulatory and fiscal measures to address unhealthy diets and physical inactivity in these countries. This will be followed by in-country training and technical assistance to increase and strengthen the regulatory and fiscal capacity of the countries, as well as promote healthy diets and physical activity for the prevention and control of NCDs.

As part of efforts to reduce salt consumption among populations in the Region, 16 NCD programme managers from various ministries of health[40] participated in a training workshop and gained knowledge and tools to implement salt reduction strategies and contribute to the achievement of the global targets of a 30% relative reduction of salt intake and a 25% reduction in raised blood pressure in these countries.

Preventing injuries and violence and making roads safer

In 2018–2019, thirty-six Member States developed and/or updated road safety policies and strategies to strengthen collaboration for collective action by ministries of health, transport, public works, interior and justice, among others. Six additional countries[41] implemented provisions under the Decade of Action for Road Safety. WHO is also continuing to collect data to develop reports on road safety and violence against children.

WHO in the African Region supported the Government of Uganda to strengthen school-based violence prevention by convening a national policy dialogue. The dialogue was instrumental in ensuring that Uganda's work on school-based violence prevention is informed by evidence and makes the best possible use of home-grown programmes, such as the "Good School Toolkit." With WHO's technical assistance, Namibia and South Africa strengthened child injury prevention. A pilot implementation of four WHO basic emergency care tools in two district hospitals in Uganda contributed to a 50% reduction in deaths due to injuries and acute conditions.

32 Cameroon, Chad and The Gambia.
33 Côte d'Ivoire, Gabon, Mozambique, Rwanda and Togo.
34 Benin, Chad, Mauritius, Nigeria and Togo.
35 Benin, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, The Gambia, Guinea, Madagascar, Mali, Mauritius, Niger, Nigeria, Senegal, Eswatini and Togo.
36 Madagascar, Mauritania, Uganda and United Republic of Tanzania.
37 Botswana, Ethiopia, The Gambia, Ghana, Mauritania, Mauritius, Senegal, South Africa, Sierra Leone and United Republic of Tanzania.
38 This project is a collaborative programme (Global Regulatory and Fiscal Capacity Building Programme: Global RECAP) between WHO in the African Region, the International Development Law Organization (IDLO), the Swiss Agency for Development and Cooperation (SDC), the OPEC Fund for International Development, and the 'Think NCDs Initiative' of the International Development Research Centre (the Democratic Republic of the Congo).
39 Kenya, Uganda and the United Republic of Tanzania.
40 Botswana, Eswatini, Lesotho, Malawi, Namibia, Seychelles, South Africa and Zimbabwe.
41 Cameroon, Ethiopia, Ghana, Kenya, Namibia and the United Republic of Tanzania.

Better cancer surveillance, prevention and control

In 2018–2019, WHO in the African Region assisted Nigeria, the United Republic of Tanzania and Zambia to finalize, cost and ensure the smooth implementation of their respective national cervical cancer strategies. This technical support included adapting WHO recommendations on screening and treatment protocols for cervical cancer – also known as the screen and treat approach – to national contexts, thus ensuring a more coherent and coordinated approach to the prevention and control of cervical cancer. Seychelles and Liberia both developed national cancer control plans with WHO's support. WHO is also supporting the functioning of cancer registries in Botswana.

In addition, WHO worked with NCD focal points in 15 countries[42] to intensify efforts to reduce the burden of cervical cancer in the Region. This support is expected to result in the elaboration and implementation of coherent and comprehensive cervical cancer plans. WHO in the African Region developed policy briefing notes for cancer in general, as well as for cervical, breast and prostate cancers. The policy briefs were designed to target high-level policy-makers to gain political commitment to, and investments in, national cancer control interventions.

Enhancing eye and oral health care

In 2018, WHO in the African Region, with the support of Sightsavers, developed and launched the Primary Eye Care (PEC) training manual.[43] The manual serves to strengthen eye care services by integrating eye health in primary health care settings and is contributing to higher quality eye care delivered in a harmonized manner across the Region. To promote the use of the manual, WHO trained a pool of expert trainers from six Member States[44] and held an orientation meeting with key partners in eye health (the International Agency for the Prevention of Blindness (IAPB) Africa and its member agencies), ministries of health and eye health experts from 15 Member States.[45] Rwanda trained 7900 nurses on primary eye care using the manual.

For the first time, on the basis of information collected in 2015, data on the status of eye health in the Region have been published on the African Health Observatory. Eighteen Member States[46] shared data and information on eye health, helping partners and stakeholders evaluate current needs and gaps. A new round of data collection is underway to complement existing datasets.

Following the adoption of the regional oral health-care strategy at the Sixty-seventh session of the Regional Committee in 2017, WHO has supported Member States to develop and implement cost-effective oral health interventions within the framework of the NCD multisectoral strategy and UHC. Support was also provided to 10 Member States[47] to develop and implement their noma triennial plans.

Increasing tobacco taxation in Gabon

In 2018, Gabon adopted a new tax system for cigarettes with a cigarettes and at the same time the Ministry of Finance allocated US$ 140 000 for the activities of the National Tobacco Control Programme. This is an example of a best practice where revenues accrued from tobacco taxation are channeled towards sustainable domestic funding for public health interventions.

For many years, Gabon was administering an ad valorem tax of 32% on cost insurance freight (CIF) plus customs duties for all cigarettes. This approach is known to have no impact on tobacco pricing, nor on tax revenue, and is open to tobacco industry manipulation. In 2017, WHO supported Gabon to conduct tax analysis and modeling using the WHO Tax Simulation model (WHO TaxSim). A proposal was then elaborated in line with the recommendations of WHO FCTC Article 6 Guidelines on tobacco taxation. The Government accepted the proposal, and in 2018 adopted a mixed tax system for cigarettes of 25% ad valorem on CIF plus custom duties and a specific tax of 300 FCFA per pack. This new approach aligns with the Economic and Monetary Community of Central Africa (CEMAC) recommendation of a maximum 25% ad valorem for imposing a specific tax. The new system will lead to an increase in tobacco tax revenue and a reduction in tobacco consumption

42 Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
43 Available at: https://www.afro.who.int/publications/primary-eye-care-training-manual
44 Cameroon, Ghana, Kenya, Malawi, Rwanda and Sierra Leone.
45 Botswana, Eswatini, The Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Rwanda, Seychelles, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
46 Algeria, Benin, Burkina Faso, Cabo Verde, Cameroon, Congo, Eswatini, Gabon, Ghana, Kenya, Lesotho, Mauritania, Mozambique, Nigeria, Senegal, South Africa, Zambia, Zimbabwe.
47 Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Guinea-Bissau, Niger, Nigeria, Mali, Senegal and Togo.

CATEGORY 3:
PROMOTING HEALTH THROUGH THE LIFE COURSE

High levels of maternal, newborn, child and adolescent mortality persist in the African Region, and there are insufficient effective health interventions targeting reproductive, maternal, newborn, child and adolescent health (RMNCAH). Faced with these challenges, WHO in the African Region supports Member States to operationalize a range of global instruments, such as the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* (GSWCAH); the *Global health sector strategy on Sexually Transmitted Infections, 2016–2021* and the *Regional Strategic Plan for Immunization 2014–2020.*

Saving the lives of children, women and adolescents

Fourteen countries[48] have reached the target of 90% antiretroviral (ARV) coverage in pregnant women and are currently proceeding on the path to elimination of mother-to-child transmission of HIV and syphilis. WHO has provided tools and trained national validation committees established in six of these 14 Member States.[49]

Following the World Health Assembly resolution on the GSWCAH in 2016, Member States have formulated integrated national strategic plans on RMNCAH and nutrition. In 2018, six Member States[50] finalized plans in line with the Global strategy. The most recent WHO guidelines on antenatal and intrapartum care, sexually transmitted infections (STIs), family planning and early childhood development (ECD) were disseminated to all countries.[51] Member States were supported in adapting, adopting and implementing these guidelines to improve quality of care and ensure standardization of services. Eight Member States[52] are currently implementing quality-of-care improvement approaches for the health of women, children and adolescents.

Many countries in the Region have seen remarkable progress in expanding access to essential maternal, newborn and child health (MNCH) services. However, this has not necessarily resulted in accelerating the reduction of deaths among mothers and newborns because of the lack of quality services.

Capacity-building is ongoing for all 47 Member States in the Region to improve maternal and newborn care practices in line with WHO recommendations.

WHO in the African Region is supporting countries to strategize on redesigning their health services to improve care. Through the Network for Improving Quality of Care for MNCH services, WHO is supporting eight countries in the Region[53] to implement system redesign and interventions. Among implementing health facilities, the aim is to halve maternal and newborn mortality by 2022 and improve women's perception of health-care services. Progress has been made in helping countries to design and implement national quality strategies, mobilize substantial financial and technical resources, and create a movement for improved quality of care for MNCH services across the Region. Kenya has recently formally joined the Network as the ninth country and many more countries have expressed interest to be part of the Network.

Efforts are ongoing to strengthen family planning and sexual and reproductive health and rights (SRHR) services for young people in focus countries[54] through the implementation of two

48 Botswana, Burkina Faso, Cabo Verde, Eswatini, Lesotho, Malawi, Mauritius, Namibia, Rwanda, Seychelles, South Africa, Uganda, Zambia and Zimbabwe.
49 Botswana, Cabo Verde, Eswatini, Seychelles, Uganda and Zimbabwe.
50 Botswana, Congo, Lesotho, Niger, United Republic of Tanzania (Zanzibar) and Zimbabwe.
51 These resources or guidelines include: Global Health Sector Strategy on Sexually Transmitted Infections 2016–2021; 2016 STIs Treatment guidelines; 2016 antenatal care recommendations; 2018 intrapartum care; and WHO Quality of Care Vision and MNH standards.
52 Côte d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania and Uganda.
53 Cote d'Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania and Uganda.
54 Burkina Faso, Côte d'Ivoire, Ethiopia and Uganda for the Af-STEER grant, and Lesotho, Malawi, Uganda, Zambia and Zimbabwe for the joint United Nations SRH Regional Project for East and Southern Africa.

grants, namely Africa: Strategic Technical Engagement with Evidence for Results (Af-STEER) (2017–2019) and Strengthening integrated sexual and reproductive health and rights and sexual and gender-based violence services in East and Southern Africa. WHO in the African Region also supported the development of the Southern African Development Community (SADC) 2019–2030 SRHR strategy and corresponding scorecard.

WHO facilitated the development and implementation of a new grant proposal for reduction of maternal mortality through comprehensive SRHR services. This four-year grant will initially focus on Benin, Burkina Faso, Rwanda and South Africa, with the intention of progressively extending it to more countries in the Region. The grant is contributing to strengthening the institutional capacity of countries with the recruitment of nine international staff.

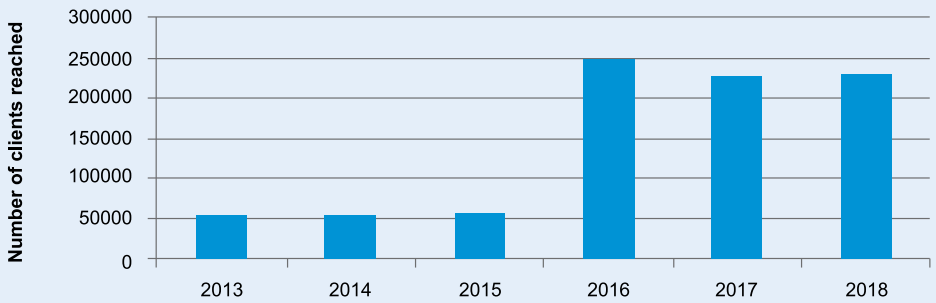
Maternal death surveillance and response (MDSR) is a continuous cycle of notification, review, analysis and response. MDSR aims to prevent maternal mortality by involving all stakeholders in identifying maternal deaths, understanding why these deaths occurred and taking action to prevent similar deaths occurring in the future. All countries in the Region, except South Sudan, are implementing MDSR with WHO support. Only two Member States – Equatorial Guinea and South Sudan – do not currently have a national policy for mandatory maternal death review.

Family planning campaign weeks accelerate contraceptive uptake in Burkina Faso

The demand for family planning involving the use of modern contraceptive methods in the African Region is low. From 2011 to 2015, the family planning needs of women in Burkina Faso were met at the rate of 37.1%, while unmet family planning needs stood at 26.3%. To address these needs, since 2013, the Ministry of Health has organized annual national family planning weeks to accelerate access to and uptake of family planning services. The event is usually launched by a high-level political figure and comprises social mobilization activities, including on radio, television, social media and at sporting events, as well as through outreach activities, such as community theatre, debates, films, home visits and animation stalls. At the same time, family planning services are provided free of charge in public health facilities, clinics and outreach sites.

The success of these events is largely due to Ministry of Health leadership, multisectoral involvement, availability and commitment of health workers, availability of adequate stocks of contraceptives and consumables at points of care, provision of free family planning services, involvement of community members, and commitment of religious, customary and administrative authorities. The observance of the national family planning weeks has proved to be an excellent way of promoting family planning through enhanced advocacy with political and administrative authorities, as well as customary and religious leaders. In addition, it has enabled increased social mobilization, access and provision of family planning services to the population, especially those in rural areas. From 2016, the national family planning weeks were organized on a biannual basis in May and November. Figure 3 shows the number of clients reached each year. In the last three years, the number of clients has quadrupled since the inaugural event in 2013.

Figure 3: Number of women and girls reached by family planning campaigns, 2013–2018



Implementation of the flagship programme for adolescent health

Two years after the launch of the Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance, 36 of the 47 Member States in the African Region (76%)[55] are using it to plan, implement and increase access to quality services for adolescents. WHO in the African Region, in collaboration with the Global Fund, UNFPA, UNICEF, Catholic Organization for Relief and Development Aid (CORDAID), the National Network of NGOs for the Development of Women (RENADEF) and the Packard Foundation, is supporting an innovative approach to strengthen district health systems, improve the performance of providers and ensure better access of adolescents to health services in the Democratic Republic of the Congo and Ethiopia. In Zimbabwe, assessment of health facilities using WHO standards resulted in the accreditation of 309 adolescent-friendly health facilities out of 356 (87%) supported facilities to improve the quality of care for adolescents.

In 2018, in collaboration with UNFPA, WHO facilitated access to contraception for 185 389 adolescents and young girls in Côte d'Ivoire. WHO also supported Côte d'Ivoire, the Democratic Republic of the Congo, Nigeria and Zimbabwe to incorporate adolescent health indicators into their respective national health management information system (NHMIS) tools and district health information systems (DHIS). Finally, WHO completed the development of country factsheets on adolescent health which contained disaggregated data for all Member States.

Healthy ageing and integrated care for older people

An additional nine countries[56] in the Region are now implementing national healthy ageing policies and strategic plans and using the WHO toolkit to deliver integrated care for older people in the context of UHC, bringing the total of countries implementing these plans and toolkit to 19 Member States[57] (40%) in 2019. More countries now have capacity for implementing healthy ageing policies, strategic plans and integrated care for older people (ICOPE) by frontline health-care providers.

Mainstreaming gender, equity and human rights

WHO guidance and tools on gender, equity and rights mainstreaming, including gender analysis and assessment instruments, barrier assessment guidance and other tools[58] (Innov8, HEAT and HEAT plus etc.) have been introduced in 21 countries.[59] This has helped to strengthen country capacity to identify and address underlying gender-based issues and barriers to effective health services coverage. Nigeria and Sierra Leone were supported to mainstream gender, equity and rights (GER) and social determinants in their respective policies, plans and programmes. Thirteen Member States[60] are using WHO tools to strengthen their health systems response to gender-based violence (GBV) and child sexual assault.

Immunization and vaccine development

In 2018–2019, WHO in the African Region supported the introduction of several new vaccines in countries, including for typhoid, meningitis and Ebola outbreak response. Zimbabwe became the first country on the continent and the second country in the world to introduce the typhoid conjugate vaccine in response to the typhoid outbreak that started in October 2017. The country also became the last country in the Region to introduce the inactivated polio vaccine (IPV).

In response to the Ebola virus disease outbreak which started in August 2018 in the Democratic Republic of the Congo, WHO and partners

55 Algeria, Benin, Burkina Faso, Burundi, Cameroon, Chad, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Niger, Central African Republic, Senegal, Togo, Botswana, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Eswatini, United Republic of Tanzania , Uganda and Zimbabwe.

56 Benin, Cabo Verde, Cameroon, Côte d'Ivoire, Eritrea, Gabon, The Gambia, Madagascar and Nigeria.

57 Algeria, Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Eritrea, Gabon, The Gambia, Ghana, Madagascar, Mauritius, Niger, Nigeria, Mozambique, Congo , Senegal, United Republic of Tanzania and Zimbabwe.

58 Innov8 - approach for reviewing national health programmes to leave no one behind that brings together equity, gender, human rights and social determinants of health in an integrated approach. The software application HEAT (the Health Equity Assessment Toolkit) facilitates the assessment of in-country health inequalities using an in-built database. HEAT Plus, an enhanced version of the software, allows users to upload and work with their own database.

59 Benin, Burkina Faso, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Nigeria, Niger, Congo, Sao Tome and Principe, Senegal, Sierra Leone and Togo.

60 Botswana, Eswatini, Lesotho, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

supported the country to vaccinate 147 120 people using the investigational Ebola candidate vaccine (rVSV-ZEBOV).[61] Those vaccinated were primary and secondary contacts of Ebola cases in the Democratic Republic of the Congo and frontline health workers in unaffected neighbouring countries.[62] The latter countries were also supported for Ebola preparedness. Meanwhile, WHO in the African Region is supporting countries using the African Vaccine Regulatory Forum (AVAREF) platform to jointly undertake regulatory review and licensure of the vaccine for easier implementation and use in outbreaks.

Vaccination campaigns to control yellow fever were conducted in Congo, Ethiopia, Nigeria, Sierra Leone and South Sudan. Approximately, 85 million people were reached during these campaigns. In Cameroon, the Democratic Republic of the Congo, Mozambique, Niger, Nigeria, South Sudan, Zambia and Zimbabwe vaccination campaigns against cholera were conducted. During the reporting period almost nine million people across the Region received oral cholera vaccine.

Following months of intensive preparation, the subnational pilot introduction of the RTS,S/AS01 vaccine began in Ghana and Malawi. This is the first malaria vaccine to show protection among young children and will target more than 1.1 million children in the next three years. Twenty-seven countries[63] have introduced rubella-containing vaccine. Namibia has introduced a second dose of measles-containing vaccine (MCV2), bringing the total number of Member States providing the vaccine to 26.[64] Twenty-four[65] of the 31 targeted countries have introduced the yellow fever vaccine in routine immunization programmes. Three of the remaining countries (Kenya, South Sudan and Uganda) have partially introduced the vaccine, while Ethiopia has developed and adopted a national introduction plan.

Several factors have hampered the introduction of the human papillomavirus vaccine; these include barriers in accessing eligible out-of-school adolescent girls, high vaccine prices for non-Gavi-eligible countries and global supply constraints. However, despite these challenges, five additional countries[66] introduced the human papillomavirus vaccine nationally. Introduction increased from two Member States in 2013 to 10 Member States by December 2018.[67]

Thirty-five out of 47 countries have introduced rotavirus vaccine as part of routine immunization. An analysis in 2018 showed declines of 30–39% in the proportion of total hospitalizations among children under five years due to diarrhoea in many countries, with larger declines of 36–54% observed among children under one year following rotavirus introduction.[68]

By December 2018, forty Member States[69] had achieved maternal and neonatal tetanus (MNT) elimination, and 21 Member States[70] in the meningitis belt have also introduced MenAfriVac through vaccination campaigns. Seven Member States[71] have introduced the vaccine in their routine immunization schedules. WHO in the African Region, in collaboration with Gavi and Oslo University, developed immunization data management modules within the District Health Information Software (DHIS2) platform to promote information systems integration, as well as data analysis and use at all levels with special focus on the district and health facility levels.

With WHO support, in May 2019, the Pan-African Parliament adopted a resolution on the establishment of an African Parliamentarian Caucus on Immunization, towards ensuring that all children across the Continent have access to the vaccines they need. Parliamentarians also expressed their commitment to achieving universal health coverage by 2030 and contributed their perspectives on each country's unique pathway to attaining health for all.

Between 2013 and 2018, regional immunization coverage levels increased from 70% to 76% for

61 More information is available at: https://www.who.int/csr/don/17-august-2018-ebola-drc/en/
62 Burundi, Rwanda, South Sudan and Uganda.
63 Algeria, Angola, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Côte d'Ivoire, Eritrea, Eswatini, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Rwanda, Sao tome and Principe, Senegal, Seychelles, United Republic of Tanzania, Zambia, Zimbabwe, and Togo.
64 Algeria, Angola, Botswana, Burkina Faso, Burundi, Cabo Verde, Eritrea, Eswatini, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Zambia and Zimbabwe.
65 Angola, Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Cameroon, Democratic Republic of the Congo, Congo, Equatorial Guinea, Gabon, Ghana, Guinea, The Gambia, Guinea-Bissau, Kenya, Liberia, Mali, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone and Togo.
66 Ethiopia, Kenya, Malawi, Senegal and Zambia.
67 Botswana, Ethiopia, Mauritius, Sao Tome and Principe, Senegal, Seychelles, South Africa, Uganda, Rwanda, and United Republic of Tanzania.
68 Mwenda JM, Parashar UD, Cohen AL, Tate JE. Impact of rotavirus vaccines in Sub-Saharan African countries. Vaccine. 2018 Nov 12; 36(47):7119-7123.
69 All Member States, with the exception of Angola, Central Africa Republic, Democratic Republic of the Congo, Guinea, Mali, Nigeria and South Sudan.
70 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Mali, Niger, Nigeria, The Gambia, Guinea, Guinea-Bissau, Ghana, Mauritania, Uganda, Senegal, South Sudan, and Togo.
71 Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Ghana, Mali, and Niger.

the third dose of the diphtheria-tetanus-pertussis containing-vaccine (DTP3); from 71% to 74% for the third dose of oral polio vaccine (OPV3); and from 70% to 74% for the first dose of measles-containing vaccine (MCV1). Yellow fever vaccination coverage in the Region increased from 39% to 51% in the same period (WHO/UNICEF coverage estimates). Twenty-one countries[72] reached the target of at least 90% coverage for DTP3 and 14 countries[73] reached the target of at least 90% coverage for MCV1.

Nutrition and food safety

Malnutrition, which includes undernutrition, overweight/obesity and diet-related noncommunicable diseases (NCDs), is among the major health threats in the African Region. Whereas programmes to address undernutrition are now well established, actions to prevent obesity and diet-related noncommunicable diseases are lagging behind. Nine Member States[74] undertook situational analyses of food marketing practices that target children in the Region. Analysis of data collected found that sugar-sweetened drinks, fine bakery goods and confectionery (candy) were among the most advertised products. Over 90% of these products contain excessive amounts of sugar and total calories.

WHO in the African Region developed a nutrient profile model, a tool to assist Member States[75] in defining standards to control the marketing of foods and non-alcoholic beverages to children. This tool is available in French and English and four Member States will begin using it in 2019 to inform obesity-prevention policies.

To address the high burden of foodborne diseases, WHO supported Member States to implement the "One Health" approach to food safety. The analytical capacities of national reference laboratories in 11 Member States[76] were strengthened for integrated surveillance of antimicrobial resistance (AMR) in foodborne pathogens and outbreak detection. In addition, WHO supported the generation of baseline information on AMR in foodborne pathogens in five Member States.[77] In collaboration with FAO, WHO is supporting the improvement of national codex structures in four Member States.[78] This has resulted in the creation of a national Codex Task Force for AMR in Ghana and standards for the fisheries and the groundnut sector in Senegal.

72 Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Comoros, Eritrea, Eswatini, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Uganda, United Republic of Tanzania and Zambia.

73 Botswana, Cabo Verde, Comoros (the), Eritrea, Gambia, Ghana, Lesotho, Liberia, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, United Republic of Tanzania and Zambia.70 Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Ghana,Mali, and Niger.

74 Algeria, Cabo Verde, Cameroon, Kenya, Mauritius, Senegal, Seychelles, Uganda and Zimbabwe.

75 Cabo Verde, Cameroon, Seychelles, Zimbabwe.

76 Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Mauritius, Mozambique, Namibia, United Republic of Tanzania, Zambia and Zimbabwe.

77 Chad, Ethiopia, United Republic of Tanzania, Zambia and Zimbabwe.

78 Burkina Faso, Ghana, Madagascar and Senegal.

CATEGORY 4:
HEALTH SYSTEMS

In 2018–2019, the Health Systems and Services (HSS) cluster has focused on high-level advocacy for universal health coverage, including increasing domestic financing coupled with better efficiency in the delivery of health services. The Cluster has supported strengthening of the health-care workforce, boosting the performance of health systems, and improving the quality, safety and efficacy of products and services through the generation of evidence, the delivery of public goods, forging partnerships, and providing technical support and training to health-care leaders, managers and professionals.

Universal health coverage: a top priority

As part of the implementation of the UHC flagship programme, scoping missions were conducted in 11 Member States.[79] These missions sought to identify bottlenecks, strengths and opportunities. Working with governments and partners, roadmaps were developed to accelerate the implementation of UHC. Forty-five Member States participated in the 3rd annual Directors of Planning meeting and shared their experiences on UHC; they also received guidance on new tools for supporting health systems strengthening and identified their technical support needs.

In 2018–2019, scoping missions were undertaken under the WHO regional UHC flagship programme to identify bottlenecks, strengths and opportunities and develop roadmaps to accelerate the implementation of UHC.

Collaboration on an integrated approach for health financing between officials from ministries of health and finance from 46 countries was strengthened through a workshop on public finance management. The workshop considered options for health budget formulation, execution and accountability. In 2018, a side event on public health finance management was organized during the Regional Committee to raise awareness among ministers of health. WHO contributed to the development of technical content to promote domestic resource mobilization, which was presented to and adopted by the African Union Heads of State summit in 2019. WHO also supported the design and implementation of health financing reforms in five Member States.[80]

Four further Member States[81] were supported to review the progress and performance of their national health strategies and plans, and eight Member States were supported to develop their respective national health strategies and plans.

Actions to strengthen primary health care

A working technical paper on establishing an Essential Health Services Package (EHSP) was developed to guide Member States on primary health care (PHC); EHSPs are now in development development in Eritrea, Kenya and Mozambique. Four Member States[82] have used a WHO regional tool for assessing district health system functionality to identify and bridge gaps in emergency preparedness frameworks, in compliance with the requirements of the International Health Regulations (IHR, 2005). Eleven Member States[83] conducted the service availability and readiness assessment (SARA) in health facilities and used the results to improve their health plans. Some key findings from these assessments include the need to improve infection, prevention and control practices and to improve availability of essential medicines and diagnostics. Côte d'Ivoire, Eritrea and Mozambique identified

79 Benin, Burkina Faso, Cameroon, Ethiopia, Ghana, Madagascar, Mozambique, South Sudan, United Republic of Tanzania, Togo, and Zambia.
80 Comoros, Kenya, Mauritania, Rwanda and Zimbabwe.
81 Burkina Faso, Cabo Verde, Ghana and Liberia.
82 Cabo Verde, Central African Republic, Cameroon and Uganda.
83 Burkina Faso, Central African Republic, Kenya, Malawi, Mauritania, Mozambique, Niger, Congo, Seychelles, South Sudan and Uganda.

the training needs of district health management teams. A regional report was developed highlighting achievements in primary health care (PHC) strengthening in the 40 years since the adoption of the Declaration of Alma Ata in 1978.[84]

Enhancing health workforce capacities and improving infection prevention and control

Côte d'Ivoire, Liberia and Sierra Leone reviewed the implementation of national infection prevention and control (IPC) guidelines. An assessment of the status of IPC programmes was undertaken in four[85] of the 20 Member States that are signatories to the WHO "Clean Care is Safer Care" challenge. Refresher training on Ebola virus disease IPC preparedness was conducted in Burundi, Central African Republic and Congo. The WHO Handbook on National Quality Policy and Strategy[86] was developed and made available online for countries; Ethiopia, Ghana and South Africa have already begun to apply this guidance.

Member States strengthened health workforce capacities through the training of a pool of 50 experts on National Health Workforce Accounts (NHWA). At least five[87] countries conducted NHWA; 10 Member States[88] developed or updated human resources for health strategies and investment plans; and six countries[89] conducted health labour market analyses.

Reducing medicine costs and strengthening regulatory systems

Fifteen Member States[90] are now implementing surveillance mechanisms to reduce medicine costs in the context of the Medicines Availability and Price Platform hosted by the Regional Office. WHO trained and supported officials from 14 Member States[10] to update their national essential medicines lists. Training was provided for officials from 21 Member States[92] to monitor antimicrobial consumption. This spurred countries in the Region to provide information on this issue. A framework for the pooled procurement of medical products was developed and will be used by Small Island Developing States. The Regional Office hosts the pooled procurement secretariat and shares data on medicine prices to enable procurement efficiency for medical products. For the first time in Africa, Rwanda hosted the global World Blood Donor Day on 14 June 2019 to promote voluntary donations.

Botswana, Eritrea and Nigeria developed road-maps to establish national regulatory systems for medical products. In 2018, the United Republic of Tanzania achieved a well-functioning regulatory system for medical products – the first country to do so in the African Region. WHO worked with the African Union to develop a treaty to establish the African Medicines Agency, which was approved by the African Union Heads of State and Government in February 2019. WHO in the African Region, in collaboration with the African Union, organized a high-level side event during the United Nations General Assembly in 2018 to raise awareness on the quality of medical products.

Training on the prevention, detection and response to substandard and falsified medical products was provided for 38 countries.[93] Twenty countries[94] benefited from training on blood regulation and nine[95] on plague diagnosis. Four Member States[96] developed national policies and strategic plans to improve access to quality-assured medical products. Benin, Côte d'Ivoire and Madagascar established regulatory professional bodies for traditional medicine following encouragement from WHO, and Eritrea developed a legal framework for traditional medicine.

84 WHO (2018) Primary Health Care Programme in the WHO African Region from Alma-Ata to Ouagadougou and beyond. https://www.who.int/docs/default-source/primary-health-care-conference/phc-regional-report-africa.pdf?sfvrsn=73f1301f_2
85 Burundi, Chad, Democratic Republic of the Congo and Equatorial Guinea.
86 WHO Handbook on National Quality Policy and Strategy: https://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/
87 Algeria, Burkina Faso, Côte d'Ivoire, Mozambique and Namibia
88 Benin, Burundi, Chad, Comoros, Côte d'Ivoire, Eswatini, Guinea, Mali, Mauritania, and Niger.
89 Benin, Chad, Côte d'Ivoire, Namibia, Niger, and Rwanda
90 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Madagascar, Mali, Niger, Senegal, and Togo.
91 Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Madagascar, Mali, Niger, Senegal, and Togo.
92 Algeria, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mali, Mauritius, Niger, Rwanda, Senegal, South Africa, United Republic of Tanzania, Togo, Zambia and Zimbabwe.
93 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Ghana , Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.
94 Algeria, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mali, Mauritius, Niger, Rwanda, Senegal, South Africa, United Republic Tanzania, Togo and Zimbabwe
95 United Republic of Tanzania. Indonesia and La Reunion (France) were invited in agreement with their respective regional offices.
96 Chad, Guinea, Mauritania and Sierra Leone.

Addressing antimicrobial resistance

WHO supported the development of national action plans for antimicrobial resistance (AMR) in 33 Member States; sixteen[97] of these countries subsequently officially approved the plans. Examples of implementation of these plans include setting up a national AMR surveillance system in Ethiopia with the Ethiopian Public Health Institute (EPHI) as a referral laboratory along with five sentinel sites. Plans are underway to further increase subnational sentinel surveillance. In Nigeria, advocacy activities have included working with the DRASA (Dr Ameyo Stella Adadevoh) Health Trust to train more than 300 secondary-school students in Lagos as AMR ambassadors. To date, 19 Member States[98] in the Region have enrolled in the WHO Global AMR Surveillance System to enhance the evidence base for decision-making to contain AMR.

19 Member States in the Region have enrolled in the WHO Global AMR Surveillance System to enhance the evidence base for decision-making to contain AMR.

Redesign of the African Health Observatory

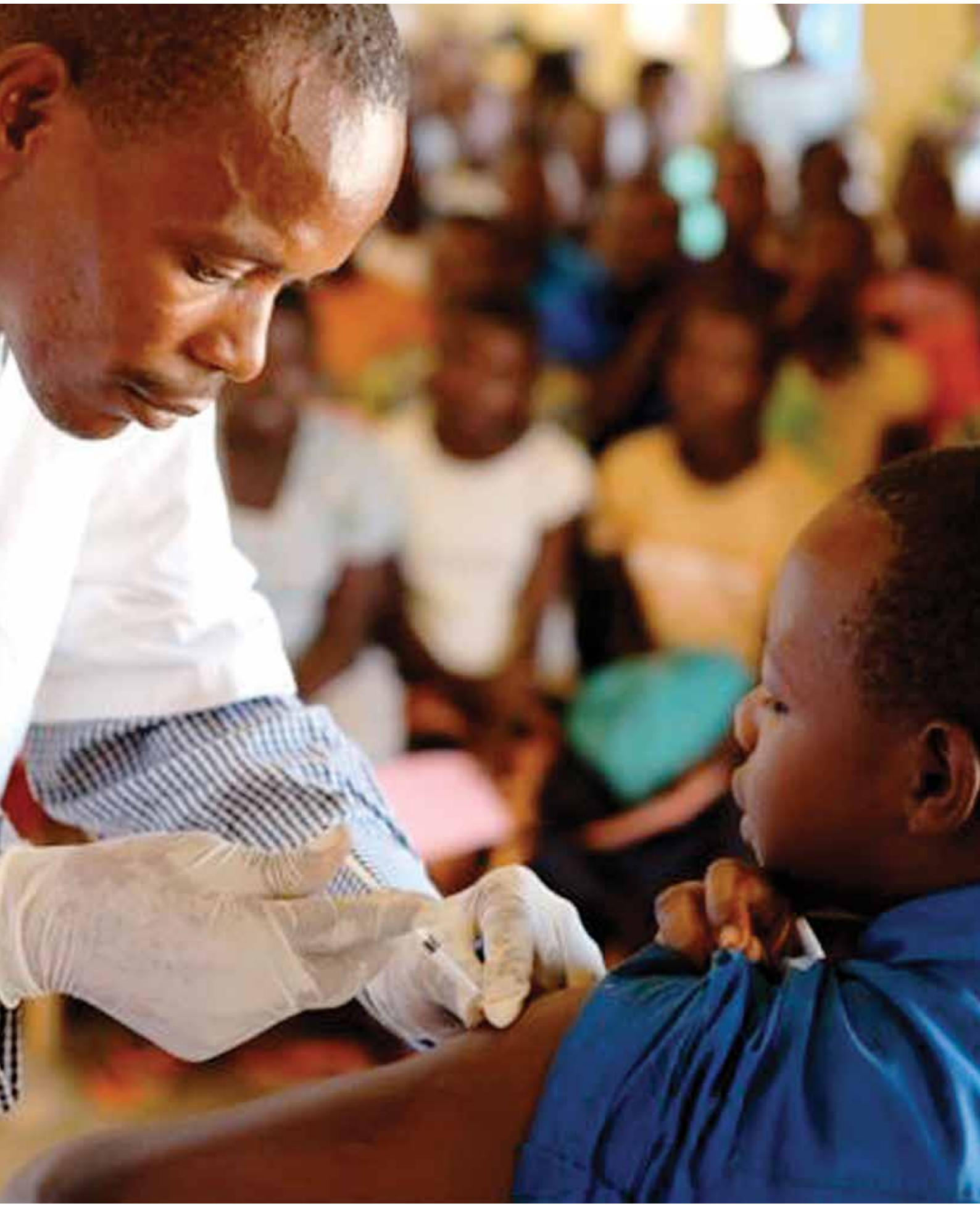
The African Health Observatory (AHO) was redesigned as an integrated platform for the regional and national health observatories (NHOs). Burundi and Eritrea were supported to establish NHOs. The annual Atlas of African Health Statistics[99] was produced. A scorecard was developed for Eritrea to monitor its health sector strategic plan. Using the adapted guide to establish DHIS2, Comoros and Mauritius mapped data sources, engaged partners and mobilized funds in preparation for DHIS2 implementation. Technical content was provided to Rwanda's eLearning platform for health data analysis. Botswana and Congo reviewed their health information systems (HIS). SCORE *(Survey, Count, Optimize, Review, Enable)* assessments were completed in all 47 Member States in the Region to assist them in strengthening their HIS. Officials from nine Member States[100] were trained on health data analysis to improve the accuracy and reliability of their analysis of UHC indicators. This resulted in improved country-level use of data and provision of guidance to decision-makers on the paths to take to UHC. Officials in Liberia received training on the eleventh revision of the International Classification of Diseases (ICD-11) and cause of death certification.

Facilitating access to health information

The WHO Regional Office for Africa Library continues to manage and disseminate health information across the Region. Technical documents from the now terminated African Programme for Onchocerciasis Control (APOC) were digitized to facilitate further usage. Training on Hinari and Digital Access to Research in Health was conducted in 12 Member States.[101] Officials from nine[102] Member States were trained on using WHO's Digital Health Atlas,[103] while five[104] have begun to use the Atlas. Five Member States[105] developed eHealth strategies to advance their digital health agendas. A digital health curriculum was developed and has been used to train 12 officials from Member States[106] to implement their eHealth strategies.

An assessment of national health research systems (NHRS) was conducted for all Member States and results were presented at a side event at the Sixty-eighth Regional Committee. The objective of the side event was to stimulate discussion and increase the commitment of Member States to strengthen NHRSs.

97 Cameroon, DRC, Ethiopia, Gabon, Ghana, Kenya, Liberia, Malawi, Mauritius, Mozambique, Nigeria, South Africa, Sierra Leone, United Republic of Tanzania, Zambia and, Zimbabwe.
98 Cote d'Ivoire, Ethiopia, Gabon, The Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Nigeria, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
99 Atlas of African Health Statistics 2018: http://www.aho.afro.who.int/en/atlas/atlas-african-health-statistics-2018
100 Burkina Faso, Burundi, Cameroon, Eritrea, Ghana, Kenya, Rwanda, United Republic of Tanzania and Uganda.
101 Burkina Faso, Congo, Côte d'Ivoire, Ghana, Liberia, Madagascar, Malawi, Mozambique, Rwanda, Senegal, United Republic of Tanzania and Uganda.
102 Ghana, Kenya, Malawi, Namibia, Nigeria, Rwanda, Seychelles, South Africa and Lesotho.
103 https://digitalhealthatlas.org/en/-/
104 Kenya, Lesotho, Nigeria, Malawi, and Uganda.
105 Benin, Lesotho, Mauritania, Niger, and Sierra Leone,
106 Sierra Leone, Ghana, Nigeria, United Republic of Tanzania, Rwanda, Niger, Mozambique, South Africa, Zimbabwe, Zambia, Lesotho and Eritrea



Collaboration for universal health coverage

WHO in the African Region is conducting UHC scoping missions as a collaborative effort between clusters, external partners and experts in the Region. This holistic approach to supporting Member States helps foster integration and improves WHO's efficiency.

In 2018, following a WHO scoping mission, Eritrea developed a roadmap to accelerate progress towards UHC. This mission enhanced opportunities for making direct contact with policy-makers and service users, allowing WHO to clearly identify what is working and what is not working well in the country. Combined with the strong leadership and engagement from the Government of Eritrea, WHO in the African Region has been able to provide technical support towards the implementation of the roadmap in health policy and strategy development; a public health act; an essential health package; AMR; and regulation of medical devices.

In response to the President of Kenya's "big four agenda" WHO provided support to the Government of Kenya to develop a roadmap on UHC, a health financing strategy and a benefits package.

Support from WHO and partners has resulted in most countries of the Region now implementing reforms towards achieving UHC. Of specific note are reforms in Kenya and South Africa (financing reforms); Eritrea, Ethiopia and Mozambique (service package design reforms); and Mauritania, Comoros, Namibia and Botswana (information system reforms). Support to ensure sustainable financing has been provided in Côte d'Ivoire, Zambia (a new national health insurance law has been adopted) and Zimbabwe (user fees have been abolished).

A guide has been developed to identify best practices and share cross-regional experiences on specific UHC programmes and interventions. Best practices were documented in Algeria (regulation of medical products), Cabo Verde (people-centred care), Ghana (AMR, domestic resource mobilization, and staffing norms), Mauritius (cancer registration and virtual health library) and Seychelles (NCD control).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CATEGORY 5 and 12:
POLIO ERADICATION PROGRAMME AND THE WHO HEALTH EMERGENCIES PROGRAMME

Outbreaks and other public health emergencies in the African Region threaten the safety and well-being of communities. Each year, the Region experiences more than 160 acute health emergencies, 82% of which are due to preventable infectious disease outbreaks. The Health Emergencies Programme works with Member States and partners to strengthen core capacities to implement the International Health Regulations (IHR) and build resilient communities and health systems.

Stronger compliance with the International Health Regulations (2005)

In 2018–2019, Member States made significant progress in strengthening and sustaining their capacities for prevention, preparedness, detection and response to health emergencies, in line with the International Health Regulations (2005). To guide evidence-based planning, risk profiling and mapping[107] was conducted in 33 of the 47 Member States in the Region and 41 Member States completed joint external evaluations (JEEs).[108] After-action reviews to learn from experiences and improve future responses were carried out in 18 Member States[109] following acute public health events. Twenty-Two Member States[110] conducted at least one simulation exercise to test the functional capacity of their preparedness and response systems. All Member States in the Region submitted IHR State Party self-assessment annual reports for the second consecutive year, up from a baseline of less than 50% in 2015. In addition, 24 Member States[111] developed an all-hazards national action plan for health security incorporating the "One-Health" approach.

Improved surveillance and response capacities

To enhance monitoring of priority diseases and timely detection of epidemics, 19 Member States[112] achieved an Integrated Disease Surveillance and Response (IDSR) coverage rate of 90% at the subnational level, including implementation of event-based surveillance. In addition, rapid response team (RRT) trainings were conducted in 17 Member States[113] to establish a functional, multidisciplinary national health workforce which can promptly investigate and respond to health emergencies. Emergency medical supplies were strategically pre-positioned and maintained in the United Nations warehouse in Accra, Ghana. To complement national capacities, a mapping of the capacities of 170 partners and a roster of both internal WHO and external experts continued to be developed and utilized. A total of 1480 multidisciplinary global and regional experts were deployed to support 43 emergency responses in 24 Member States[114] from July 2018 to June 2019.

In 2018–2019, Member States made significant progress in strengthening and sustaining their capacities for prevention, preparedness, detection and response to health emergencies.

107 Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania and Zambia.

108 All Member States with the exception of: Algeria, Angola, Cabo Verde, Equatorial Guinea, Gabon, and Guinea-Bissau.

109 Angola, Benin, Burkina Faso, Burundi, Central African Republic, Cabo Verde, Chad, Madagascar, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Togo and Uganda.

110 Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda and Zimbabwe.

111 Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Eritrea, Ghana, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Namibia, Nigeria, Senegal, Sierra Leone, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

112 Angola, Burundi, Chad, Comoros, Côte d'Ivoire, Guinea, Liberia, Namibia, Nigeria, Mali, Senegal, Sierra Leone, Togo, Gabon, Lesotho, Rwanda, Uganda, Seychelles and South Africa.

113 Angola, Benin, Burundi, Cabo Verde, Central African Republic, Chad, Guinea-Bissau, Mozambique, Niger, Nigeria, Congo, Rwanda, South Sudan, Sao Tome and Principe, United Republic of Tanzania, Uganda and Zambia.

114 Angola, Benin, Botswana, Cameroon, Central Africa Republic, Congo, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Madagascar, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, South Africa, South Sudan, United Republic of Tanzania, Uganda and Zimbabwe.

To further enhance early detection and rapid response to public health threats, more than 2000 media reports were screened. This led to early detection of 103 events, 36 risk assessments and grading of 29 events in line with the WHO Emergency Response Framework. Subsequently, appropriate lifesaving and emergency control and mitigation measures were instituted including the activation of an incident management system (IMS) within 24 hours for all graded events.

Reducing risks for epidemic-prone vaccine-preventable diseases

To reduce the risk of common preventable epidemic-prone diseases, strategies for the elimination of cholera and yellow fever were developed and are being implemented in the Region. Measures are now being enhanced to prevent, detect and promptly respond to these targeted diseases. The regional capacity to confirm yellow fever clinical specimens has doubled with the designation of the Uganda Virus Research Institute (UVRI) as a second regional reference laboratory. Subsequently, a suspected yellow fever case in South Sudan was rapidly confirmed by UVRI in December 2018. This led to a reactive vaccination campaign to halt the further spread of yellow fever. Significant improvements have also been made in diagnostic capacities using GeneXpert and other rapid diagnostic tests, as well as the use of Ebola vaccines and experimental therapeutic drugs.

Sharing timely and relevant information on health emergencies

The programme continues to have a wide reach with information products such as the Weekly Bulletin on Outbreaks and Other Emergencies (http://newsletters.afro.who.int/outbreaks-weekly-bulletin) which has a global audience of more than 1500 readers. The Bulletin continues to be a key regional publication providing countries with information for action to mitigate potential outbreaks and informing partners of significant events impacting the Region.

The Ebola virus disease outbreak in the Democratic Republic of the Congo continues to dominate the outbreak landscape in the Region. Due to its adverse health impacts, publications in journals detailed preparedness actions in neighbouring countries and lessons learned from previous outbreaks. This provided key knowledge to prevent potential outbreaks and to improve future outbreak response.

Rapid containment of Ebola in Equateur Province of the Democratic Republic of the Congo

The Ministry of Public Health of the Democratic Republic of the Congo declared its ninth outbreak of Ebola in Equateur Province in May 2018 following reports of 54 cases and 33 deaths. The risk of the disease spreading to the nine neighbouring countries was rated “high” due to the cross-border movement and flow of people including refugees, goods and services. A readiness assessment conducted in June 2018 in these countries showed limited capacities in emergency preparedness and response.

The Ministry of Public Health, with the support of WHO and partners, led the outbreak response. WHO graded the outbreak as an Internal Grade 3 Emergency, activated an Incident Management System at the national, regional and global level and deployed an Incident Manager within 24 hours of grading. More than 560 experts were mobilized and deployed to support the Government in controlling the outbreak.

All nine neighbouring countries were supported to build their preparedness capacities to promptly detect, investigate and report potential Ebola cases, and to mount an effective response. A total of 220 multidisciplinary experts were deployed for capacity-building. Country progress was monitored using key performance indicators (KPIs) with regular feedback.

The Ebola outbreak in Equateur Province was swiftly contained in 77 days by an aggressive and efficient response, serving as a model for containing Ebola in urban settings and remote locations. In terms of preparedness capacities in the neighbouring countries, eight of the nine countries achieved a score of at least 50% based on the KPIs. More than 400 alerts were detected and investigated within 24–48 hours by trained multidisciplinary rapid response teams. In South Sudan, yellow fever was detected from one of the alerts reported and effectively responded to, including vaccination of 1.2 million people.

All the nine countries now have laboratory capacity for Ebola testing using GeneXpert and/or polymerase chain reaction, thereby facilitating early confirmation of suspected cases. Six of the nine countries have established a fully functional public health emergency operations centre (PHEOC) and 12 Ebola treatment centres.

Although there has been significant progress in developing capacities for emergency preparedness and response in the Democratic Republic of the Congo and the nine high-risk countries, gaps still exist, particularly at the subnational level.

Update on Ebola outbreaks in the Democratic Republic of the Congo and Uganda (as at 30 June 2019)

The Ebola outbreak in North Kivu and Ituri provinces in the Democratic Republic of the Congo, which started in August 2018, is of great concern especially with the deterioration of the security situation, which has hampered access to communities and resulted in increasing cases. The risk of spread to other provinces and neighbouring countries remains very high. As of 30 June 2019, there were 2338 cases (2244 confirmed and 94 probable) including 1571 deaths and 653 survivors. Since August 2018, a total of 147 120 people have been vaccinated and 70 622 506 travellers have been screened at points of entry.

On 11 June 2019, the Ministry of Health of Uganda declared the sixth outbreak of Ebola in the country affecting Kasese District. All three confirmed cases belonged to one family with a previous history of travel to the Democratic Republic of the Congo. The three people were under monitoring as high-risk contacts following the burial of a household member who had succumbed to Ebola. All the three patients died. To date, no new confirmed case of Ebola has been reported in Uganda.

WHO will continue working with the Government and other UN agencies and partners to strengthen political engagement, negotiate access to communities, support humanitarian coordination and improve preparedness and readiness in Goma and other surrounding provinces and neighbouring countries. For the first time, the UN has activated the humanitarian system-wide scale-up protocol for the control of infectious disease events.

This internal mechanism is used to collectively step-up assistance by all relevant UN agencies. The protocol is effective for three months initially and will be reviewed regularly.

The response continues to be strengthened across five pillars:

(1) **political engagement, security and operations support** led by the Special Representative of the United Nations (UN) Secretary General to provide: (a) negotiated access to communities, (b) wider-area security without securitization of response and (c) a safe working environment for all response operations, including increased logistics and MOP capacity;

(2) **multisectoral humanitarian coordination** led by the UN Office for the Coordination of Humanitarian Affairs (OCHA) with representation expanded to international nongovernmental organizations to: (a) improve community engagement and social cohesion, (b) increase the role of civil society and promote local public and private sector ownership and (c) provide greater direct support to communities outside the public health response;

(3) **financial planning, monitoring and reporting** led by the World Bank and OCHA working with key donors;

(4) **public health response** led by the WHO Assistant Director-General for Emergency Response in support of the Ministry of Health to adapt strategies to enable: (a) early detection, isolation and treatment of Ebola cases, (b) expanded and streamlined vaccination (both ring and targeted geographically) and (c) decrease of nosocomial transmission in public and private health centres; and

(5) **Establishment of a leadership and coordination cell for contingency, preparedness and readiness planning** for Goma and surrounding countries, led by OCHA with WHO leading on public health readiness.

The contributions of partners have been vital in supporting the Government on the emergency response. Continued investment and attention will be required for a collective effort to close the outbreak.

WHO Health Emergencies Programme achievements in advancing the Transformation Agenda

Since the launch of the Transformation Agenda in 2015, Member States have made significant progress in strengthening preparedness and response capacities. WHO in the African Region has ensured the implementation of the full emergency management cycle, with health security as a critical component of health system strengthening and economic development.

High-level advocacy and dialogue for building partnerships at various forums have enhanced ownership and leadership of Member States in the implementation of resolution AFR/RC66/R3 on the *Regional Strategy for Health Security and Emergencies 2016–2020*. Forty-five Member States have nominated IHR state experts in various disciplines from the relevant sectors to strengthen IHR implementation. These experts are part of IHR global committees. More than 200 regional experts from Member States, WHO and partners were trained and deployed to conduct JEEs. Some of the key partners supporting the implementation of IHR include DFID, Public Health England, the US CDC, USAID, RESOLVE, Africa CDC, Médecins Sans Frontières, International Federation of Red Cross and Red Crescent Societies, Korea International Cooperation Agency (KOICA) and other global health security partners.

The creation of a unified WHO Health Emergencies Programme contributed to enhancing the regional capacity to respond to health emergencies

Within the framework of IHR (2005), WHO supported Member States to enhance their capacities to prepare for and respond to emergencies. Comprehensive national action plans for health security were developed based on the findings of the independent joint assessment of IHR core capacities. To date, no Member State in the Region has met all the required IHR core capacities. However, 20–40% of Member States have demonstrated capacities in technical areas such as immunization, surveillance and laboratory systems. Fourteen countries have established functional public health emergency operations centres for effective coordination and improved control of outbreaks. The 24 completed national action plans for health security have an estimated budget of about US$ 3 billion for IHR implementation.

The number of staff working on health security at the Regional Office, ISTs and Hubs rose to 79 as of 30 June 2019, up from 16 in 2015. The WHO transformation is further strengthening this capacity by equipping country offices with one to 18 health security staff depending on their vulnerability. To establish a regional workforce on emergency management, WHO in partnership with the Africa CDC, the West African Health Organisation (WAHO), the Global Outbreak and Alert Response Network (GOARN) and others, identified 844 multidisciplinary regional experts and trained them to be readily deployable for emergency response.

The biennial funding of the work of the WHO Health Emergencies programme in the Region progressively increased from US$ 37 million in 2014–2015 to US$ 45 million in 2016–2017. For the 2018–2019 biennium, more than US$ 55 million had been disbursed as of 30 June 2019. A dedicated global Contingency Fund for Emergencies was launched in 2015 to ensure timely response to health emergencies. As of March 2019, over US$ 81.8 million had been disbursed for emergencies in the Region, constituting 79% of the global allocation (US$ 104 165 395).

Polio eradication in the African Region

By June 2019, no wild poliovirus (WPV) type 1 case had been confirmed in the African Region for more than 34 months. The onset of the last case occurred in Nigeria in August 2016. In September 2015, the Global Certification Commission (GCC) for Polio Eradication declared that WPV type 2 had been eradicated globally, and that the last case of WPV type 3 was reported in November 2012, more than six years ago. As WPV2 was certified to have been eradicated globally, the type 2 component of the oral polio vaccine (OPV) was successfully withdrawn in all Member States with the intention of introducing inactivated polio vaccine (IPV) in routine immunization services. With the recent increase in global availability of IPV, all 47 Member States had introduced IPV by March 2019, as compared to only 36 Member States in early 2018. In 2018, the Global Polio Eradication Initiative (GPEI) introduced guidelines for the containment

of poliovirus potentially infectious materials to avoid leakage of polioviruses into the community and populations. By April 2019, potentially infectious materials containment had been conducted in 40 Member States in the Region with a technical support plan in place to finalize containment of potentially infectious materials in all Member States by May 2019. By April 2019, the African Regional Commission for Certification of Polio Eradication had accepted the polio-free status documentation of 41 out of 47 Member States.[115]

GIS technological innovations for real-time reporting of polio surveillance, immunization activities, integrated field supervision and benefiting other health interventions, such as outbreaks and control activities have been established in 42 Member States.

A plan was finalized for the African Regional Commission for Certification of Polio Eradication to accept the documentation of the remaining six countries. With the current momentum and progress, the African Region is on course for certification of polio eradication by the end of 2019 or in early 2020. The Framework for Certification of Polio Eradication in the African Region was endorsed by the Sixty-eighth session of the WHO Regional Committee for Africa in 2018. In April 2019, the first scorecard report on the performance of Member States based on the agreed milestones in the Framework, as requested by ministers of health, was finalized. Pursuant to the WHO Executive Board decision,[116] since 2017, the African Region has systematically implemented the ramp-down of polio-funded staff in Member States based on projected country human resource budget ceilings, except for the Lake Chad Basin countries that were affected by a WPV type 1 outbreak. The ramp-down had been implemented in all Member States, except Nigeria, which is still polio endemic.

On polio transition planning, by June 2019, six of the seven priority Member States in the Region had costed and endorsed polio transition plans, up from four Member States in June 2018.[117] Of the 17 priority Member States globally, only seven have a national costed and endorsed transition plan and six of these Member States are from the African Region.

Using geographic information system technologies for real-time reporting

Geographic information system (GIS) technological innovations for real-time reporting of polio surveillance, immunization activities, integrated field supervision and benefiting other health interventions, such as outbreaks and control activities had been established in 42 Member States,[118] up from 36 Member States in 2018. The main objective of introducing this innovative technology is to empower senior management by providing real-time data for performance monitoring and to ensure ownership of the generated data for action. Trained staff and availability of GIS technology in ministries of health, is quickly being adapted for control of other outbreaks and public health interventions.

115 The six remaining Member States are: Cameroon, Central African Republic, Equatorial Guinea, Guinea Bissau, Nigeria and South Sudan.
116 Executive Board decision 140(4) on poliomyelitis.
117 Angola, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia and South Sudan had plans in place. Nigeria is also a priority country.
118 The five remaining Member States are: Algeria, Burundi, Comoros, Lesotho, and Sao Tome and Principe.


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Flooding, Cyclone Idai and Cyclone Kenneth in Mozambique

In March and April 2019, flooding, Cyclone Idai and Cyclone Kenneth caused significant devastation in Mozambique. Flooding and Cyclone Idai also affected Malawi and Zimbabwe and Cyclone Kenneth affected Comoros.

In Mozambique, the cyclones and flooding affected more than 1.85 million people, including 400 000 displaced and 648 deaths. The flooding resulted in loss of livelihoods and crops, while more than 100 health facilities were partially or totally destroyed. The disaster led to a United Nations humanitarian system-wide scale-up and corresponding classification as a Grade 3 emergency according to WHO's Emergency Response Framework.

The Government, WHO and partners worked together in responding to the disaster with efforts focused on deploying rapid response teams, restoring primary and secondary health services, preventing and responding to outbreaks and providing nutritional support to children and pregnant women.

Key actions included establishing national and provincial emergency operations centres and health cluster coordination mechanisms, and rolling out the WHO early warning, alert and response system for priority infectious diseases in 68 health facilities, with daily reporting achieved in 66 facilities.

Twelve international emergency medical teams were deployed to support the provision of clinical care. Cholera outbreaks were quickly contained through the rapid conduct of oral cholera vaccination campaigns that reached more than 800 000 people. Monitoring of water, sanitation and hygiene conditions was conducted in accommodation centres and affected communities. To protect communities from marketing, partners issued a Joint Statement on Infant and Young Child Feeding urging stakeholders not to accept or distribute donations of breastmilk substitutes to affected populations.

Priorities going forward include: formalizing the national Emergency Operations Centre; developing a national manual for emergencies; strengthening support for health workers affected by emergencies; continuous training for rapid response teams; strengthening emergency teams at national and provincial levels; and community education on what to do in different types of disaster.

CATEGORY 6:
CORPORATE SERVICES AND ENABLING FUNCTIONS

To maintain the integrity and efficient functioning of the WHO Regional Office, ISTs, hubs and country offices, the General Management Cluster provides and seeks to continuously improve corporate services. These services include compliance and quality assurance; transparency, accountability and risk management; procurement of goods and services; financial and human resources management; and management and administration of services.

Consolidation and coordination of managerial initiatives

In 2018–2019, the Cluster focused on consolidation of structural and managerial transformation initiatives. These initiatives involved strengthening internal control mechanisms; improving account-ability, transparency and compliance; and enhancing performance of individual staff and budget centres.

The Regional Office launched a robust platform in January 2018 to record, monitor, measure and report on performance and progress across all areas of work. The platform hosts the managerial key performance indicators (KPIs) dashboard. This dashboard generates real-time information on the situation, performance and progress of each WHO country office, making it possible to provide timely support.

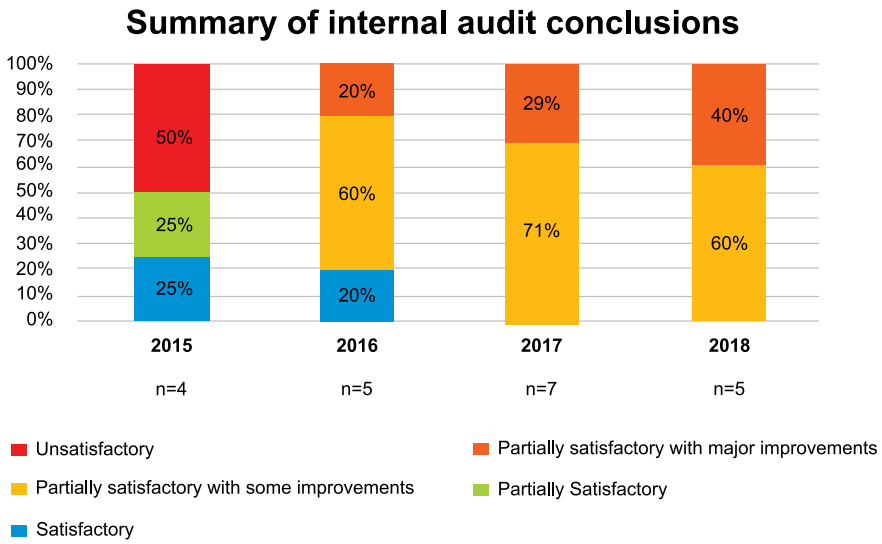
Key performance indicators (KPIs) generate information on the performance and progress of each WHO country office, facilitating benchmarking and priority-setting.

Figure 4 provides information on the performance trend of country offices from 2017 to 2018 for the award management KPI. The top section displays the number of compliant (green) and non-compliant (red) country offices for this particular KPI. The bottom section shows the trend of the average level of compliance, which improved from 60% in 2017 to around 75% by the end of 2018.

Audit report ratings of WHO in the African Region over the past four years have improved significantly as a result of efforts to reinforce internal control and compliance mechanisms through the monitoring and measuring of KPIs and service level agreements (SLAs), as well as timely interventions to support budget centres. Figure 5 illustrates the positive progress made in audit reports between 2015 and 2018 due to efficient support to countries.

Figure 4: Managerial KPIs dashboard

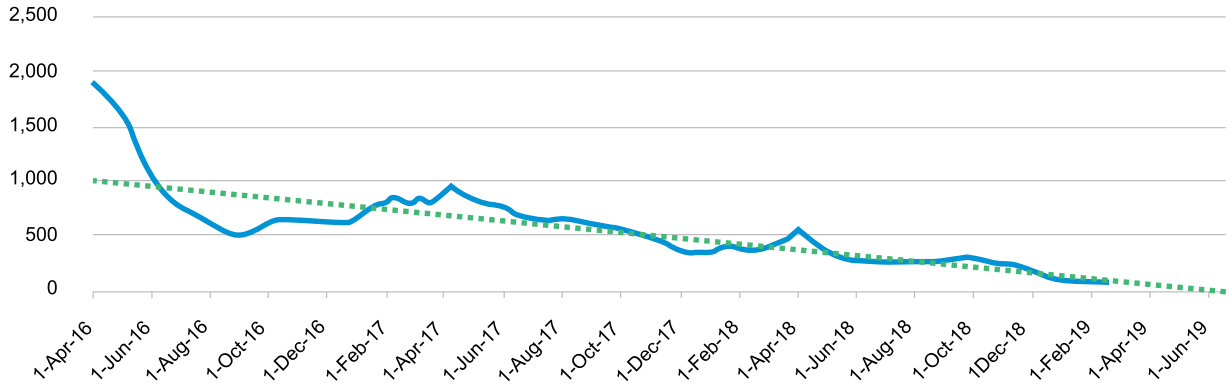
Figure 5: Progress achieved in audit reports, 2015–2019



A new approach to reinforcing accountability and compliance consisted of accompanying managers at regional and country office levels through briefings and sharing of basic information on existing policies and procedures. Managers have been trained on risk measurement, management and mitigation, the impact of their actions and decisions on the Organization, while they have also been guided and supported to ensure that their offices meet the required standards of compliance as provided in the rules and regulations of the Organization. Pre-audit support missions were conducted in eight country offices[119] and a donor verification mission was conducted in Namibia to assist in the preparation of audit reviews. Programme Management and Administrative (PM&A) reviews were conducted in seven country offices,[120] and a compliance review was carried out in the Central African Republic to familiarize newly appointed WHO representatives on their roles and responsibilities; the challenges existing in their respective offices; the level of compliance in their country offices and the possible solutions and measures to be implemented to reinforce compliance and risk mitigation.

Country support missions were also organized to selected countries to brief the staff of ministries of health on WHO procedures and to guide them on how to manage funds provided through Direct Financial Cooperation (DFC) to improve compliance, monitoring and reporting on funds received. Country support missions were undertaken in 12 Member States,[121] resulting in strengthened Member State engagement and improvements in the DFC reporting process. The impact of country support missions is reflected in the fact that no unsatisfactory internal audit has been issued for any budget centre in the Region for the past four consecutive years; and that the number of overdue DFC reports declined by 80% in 2018 (Figure 6).

Figure 6: Decline of overdue DFC reports, 2016–2019



119 Angola, Chad, Ethiopia, Kenya, Liberia, Madagascar, Nigeria and United Republic of Tanzania.

120 Central African Republic, The Gambia, Mauritania, Senegal, Uganda, Zambia and Zimbabwe.

121 Benin, Chad, Democratic Republic of the Congo, The Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Sierra Leone and Uganda.

Value for money

Positive results were achieved in managing and monitoring financial transactions to ensure value for money and the cost-effectiveness of managerial transactions. A cost-recovery scheme was introduced for medical services provided by the Regional Office Clinic and for internet services provided to staff for personal use in their residence in the WHO compound.

Transparent and efficient bidding processes for the procurement and supply of goods and services were carried out through the UN Global Marketplace, E-TEND and the establishment of long-term agreements (LTAs). This approach has significantly improved the timeliness, quality of goods and services and cost-effectiveness of procurement and supply services. Independent assessments of bids, after-market research and large competitions resulted in a significant cost saving of US$ 6 million, representing 46% of all selected goods and services transactions (US$ 13 million) since January 2018. These gains from value-for-money practices contributed in providing additional support to ministries of health in terms of medical materials, commodities and services in a timely and efficient manner.

Moreover, new measures to improve value for money were introduced in translation, interpretation and printing services. A roster of professional interpreters based in all 47 countries of the Region is being developed. The recruitment of more local interpreters resulted in cost savings of US$ 204 320 between October 2018 and June 2019. Remuneration for translation services was also reviewed and a new scale established in October 2018, resulting in additional savings of US$ 64 000 as of June 2019. New methods of selecting interpreters by pairing one senior interpreter with junior interpreters, resulted in savings of around US$ 1000 per five-day meeting per junior interpreter. This initiative also ensures capacity-building of the next generation of interpreters in the Region. These measures have resulted in substantial savings. From October 2018, when these measures were launched, to 30 June 2019, WHO in the African Region made savings of US$ 296 248 on interpretation and translation services.

Finally, to improve efficiency, cost effectiveness and value for money, a paperless office environment was introduced through an automated approval workflow process currently in use in the General Management and Health Systems and Services Clusters. Online workflows were created through various new eForms and a workflow platform to initiate and circulate memoranda and adjudication reports for approval. In total 1086 memos and adjudication reports were approved through this system between June and December 2018. As a result, a 12.8% reduction in printing cost was recorded from US$ 192 201 in 2017 to US$ 170 388 in 2018.

Staff integration, support and development

Initiatives have been introduced, and concrete actions taken to ensure that staff are well received, briefed and guided in their functions, roles and responsibilities.

Induction sessions are programmed three times a year for all newly recruited staff across the Region. Human Resources Management (HRM) works closely with all clusters and units to coordinate the content of each induction session and to ensure that the information provided is comprehensive and relevant to new staff.

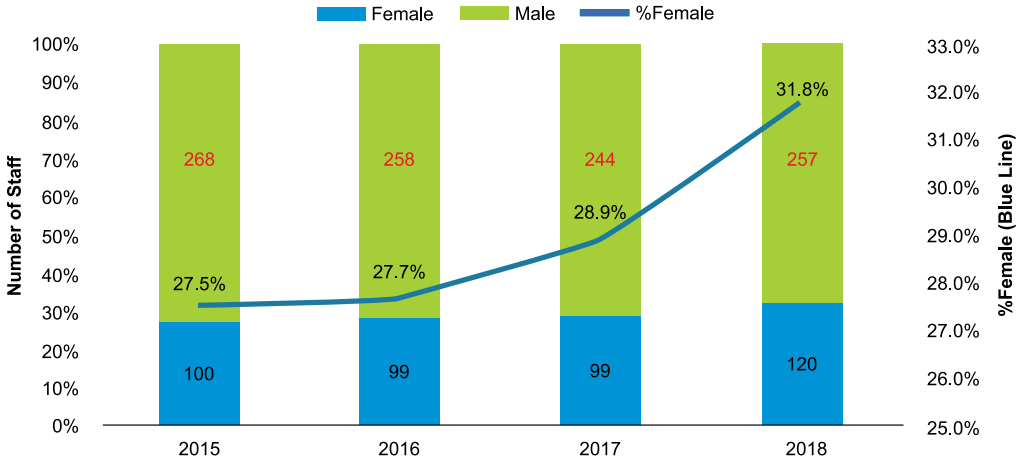
The Regional Office launched the Staff Welfare Committee and the Nutrition Committee in 2018. The Staff Welfare Committee's mandate is to encourage, advise on and promote activities that ensure the physical, mental and social well-being of staff so that work remains a vehicle for self-fulfilment and self-realization for all. The Nutrition Committee's mandate is to promote nutrition and healthy food services at the Regional Office. The Committee has made several recommendations towards improving the quality and options of food and beverages made available at the Regional Office.

Information sessions and trainings have been offered to staff on a variety of topics, including on topics such as competency-based assessments and staff relations. An open-door day was introduced to offer staff an opportunity to discuss their individual needs and concerns while visiting various HRM services. Briefing sessions are also offered on various information technology (IT) subjects every Thursday and an open clinic for IT support once a month.

In response to the ongoing restructuring of country offices, career counselling services are provided by staff of the functional review team to accompany staff through the functional review exercise.

A new regional rewards system for the recognition of outstanding performance has been introduced to increase staff motivation, job satisfaction and ensure staff retention. The number of women in the professional or higher categories rose to 31.8% in 2018, up from 28.9% in 2017 (Figure 7).

Figure 7: Progression of gender representation, 2015–2018



Asset management and infrastructure improvement

Information technology infrastructure continues to be maintained and improved across the Region; a case in point is the review of equipment and installations in 30 country offices to ensure that adequate IT platforms are in place to support preparedness and response activities. An IT roadmap is being finalized which, once implemented, will see the upgrading of country office infrastructure to corporate standards. Internet performance has been significantly improved at the Regional Office following the adoption of a Congo Telecom fibre optic link (last mile) of 100 MB.

Intensified training and technical support were provided to country offices to build their capacity for efficient asset management. All country offices now systematically record and monitor all WHO physical assets in compliance with International Public Sector Accounting Standards Board (IPSASB) requirements. Disposal of obsolete assets at the Regional Office generated a total of US$ 100 000, which was used to purchase new and better performing equipment. All WHO country offices in the Region were also supported to go through a similar exercise. In 2018, the Country Offices in Burkina Faso, Comoros, Niger and South Sudan implemented infrastructure assessment and rehabilitation projects.

The renovation of the main conference room in the Regional Office was completed in 2018. The conference room was upgraded to international standards, with a 400-seat capacity and equipped with modern conferencing technology. In addition, 10 offices for 25 staff members were created in newly installed prefabricated containers.

Strategic partnerships

In fulfilment of the pledge of the Regional Director to build strategic partnerships, 142 cooperation agreements were concluded in the reporting period. WHO convened the second WHO Africa Health Forum (WAHF) in Praia, Cabo Verde in March 2019. With the theme of "Achieving universal health coverage and health security in Africa: the Africa we want to see", the WAHF provided a platform to discuss innovative strategies to address persistent public health challenges in the African Region. The Forum also promoted reinforced country ownership and governance for health and explored concrete ways in which partners can contribute to the work of WHO and fulfil the aims of *The Africa Health Transformation Programme 2015–2020.*

The Forum provided a unique opportunity for participants to explore avenues for achieving universal health coverage and health security in Africa, including deliberating on ways of improving health security, accelerating progress towards equity and universal health coverage (UHC) and the unfinished agenda of communicable diseases, and tackling the social and economic determinants of health on the Continent. Participants at the Forum included leaders and policy-makers, advocates,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implementers and partners from various countries and affiliations – ministers, donor partners, United Nations agencies, nongovernmental organizations, the private sector, academia, youth activists and the media.

Partners and resources were mobilized for public health priorities in 2018–2019. Discussions have been held with the Bill & Melinda Gates Foundation, the African Development Bank, the Saudi Fund for Development, the Arab Gulf Program for Development, the Qatar Fund for Development, the Global Fund, the Pan-African Parliament, France, Saudi Arabia, the United Kingdom and the United States of America. These discussions led to a partnership to advance the health agenda on the continent with the Pan-African Parliament and a framework for regional collaboration with the Global Fund.

To enhance donor relations and maintain trust, the donor report monitoring system rolled out in March 2016 to strengthen reporting and internal controls has improved the quality and timeliness of reporting, with the number of overdue reports continuing to reduce from 39% in July 2017 to 3% in June 2019.

WHO's commitment to the Harmonization for Health in Africa (HHA) platform has been strengthened. The HHA platform was relaunched in March 2017 and partners – WHO, other UN agencies and bilateral and multilateral health development partners – reaffirmed their commitment to working together to enhance impact in key thematic areas, including public-private partnerships in health, public financial management in the health sector and the broader area of value for money to achieve tangible results for women, adolescents and children in Africa. In 2018, the HHA regional directors issued a joint Call-To-Action inviting country representatives of HHA agencies to collectively bolster the implementation of UHC, and improve collaboration in health systems strengthening towards PHC and UHC.

In October 2018, the HHA regional directors concluded that good progress had been made in implementing the action plan. Progress included synergies created by partners in strengthening policy dialogue between ministries of health and finance, particularly in public financial management, and the development of national health policies and strategies, including in RMNCAH. Partners jointly disseminated several new RMNCAH guidelines, while the alignment of public financial management approaches of different organizations is under way in 44 Member States. The HHA regional directors agreed on a joint action plan for 2019–2021 that includes strengthening public-private collaboration to foster progress towards health security and UHC.

Governing bodies

The Secretariat continues to improve preparations related to WHO governing bodies. These improvements include online registration for the Regional Committee and use of the Regional Committee application for online access to documents. To ensure the smooth functioning of Regional Committee meetings and to assist delegates in preparing for these meetings, a Regional Committee guide is being developed for Member States and other participants.

The inaugural "Walk the Talk" event was held in Senegal at the Sixty-eighth Regional Committee to promote physical activity and celebrate the 70th anniversary of WHO. This event will continue to be a key feature of future regional committees. The Sixty-eighth session also adopted the first ever Code of Conduct for the Nomination of the Regional Director to promote a transparent, open and equitable nomination process.

Participation of non-State actors in the Regional Committee has continued to increase – including through hosting side events and making interventions – with 70 observers in 2018, up from 21 observers in 2015. The Secretariat continues to support the participation of African Member States in the World Health Assembly, Executive Board and Programme Budget and Administration Committee through providing briefings, preparatory workshops, daily coordination meetings and in formulating group positions on key issues.

In November 2018 and March 2019, ten newly appointed ministers of health[122] participated in workshops to develop a better understanding of the global and regional context, the work of WHO governing bodies in the African Region, and managerial procedures. The workshops provided an opportunity to enhance the commitment of national leaders to priority health problems in the Region, including increasing domestic resources allocated to health. The sessions also enable the executive management of WHO in the Region to hold round-table discussions; encourage increased ownership and implementation of regional and global strategies and frameworks on health; and advocate for improved capacity of countries

122 Benin, Burkina Faso, Cameroon, Côte d'Ivoire, The Gambia, Guinea, Liberia, Lesotho, Sierra Leone, and Congo.

to respond to public health events, including mobilization of additional domestic resources.

Improved scope, quality and reach of WHO communications

To support effective communications at the country level, the Regional Office conducted a survey of communication needs with WHO country offices, and based on the findings and communications trends adopted by a three-level communications working group, a regional communications strategy was finalized and endorsed by WHO Executive Management in the Region. Proactive engagement with strategic media led to about 100 media interactions, including with global media outlets such as the New York Times, British Broadcasting Corporation (BBC), Radio France Internationale (RFI), Cable News Network (CNN), Le Monde, Associated Press and the Economist, as well as many important regional and national media organizations. High interest in the Ebola response drove a large share of the coverage, but WHO experts were also interviewed on other important issues, such as the impact of climate change on health, air pollution and noncommunicable diseases.

Recognizing the growing importance of multimedia products, the regional Health Emergencies Communications Unit acquired a video camera and produced more than 20 video products, some of which were picked up by broadcasters in the Region and beyond, while others were used on social media. To support communications during health emergencies, trainings were conducted for close to 300 reporters from more than 10 countries on how to report on health emergencies. Following these trainings, participants developed an initial series of 20 media products, including feature stories on yellow fever and cholera outbreaks. Standard operating procedures for communicating during health emergencies were developed for emergency operations centres in countries of the Region.

Stakeholder engagement has been enhanced through active use of social media and innovative platforms, thereby greatly increasing the Secretariat's capacity to provide key public health information. The web site of the WHO Regional Office for Africa – www.afro.who.int – has grown in terms of users, with more than 988 731 new users since the start of 2018. During the same period, the Twitter account @WHOAFRO doubled its followers to 39 000 with over 16 million Twitter impressions. The Facebook account has also grown from 4500 likes at the beginning of 2018 to more than 14 840 as of June 2019. Over 12 000 stakeholders were engaged using the Popullo Electronic newsletter application which also facilitates a common brand across the Region.

There has been regular reporting on the Transformation Agenda and ongoing media training of senior Regional Office staff. A range of publications on the progress of the Transformation Agenda were produced in three languages and disseminated to key stakeholders across the Region. Internal communications have also improved through regular staff briefings by the Regional Director, online platforms and strengthened communications between countries, the Region and headquarters.


WHO values
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Implementation of the PROGRAMME BUDGET 2018–2019

The Planning, Budgeting, Monitoring and Evaluation (PBM) Unit ensures that the WHO General Programme of Work (GPW), Programme Budget and operational plans in the Region are developed, implemented, monitored and evaluated in line with organizational guidance and standards, to deliver results and effectively address priority health needs in countries. In 2018–2019, PBM supported strengthening of the strategic focus on results and the shifting of organizational energies towards the triple billion goal of the Thirteenth General Programme of Work (GPW 13).

Improved planning for results

In 2018–2019, WHO implemented a theory-of-change approach across all budget centres in preparation for the GPW 13 strategic planning process and to further mainstream the application of results-based management. As an integral part of the global transformation process currently underway, the implementation of theory-of-change principles and tools provides the basis for analysis and effective articulation of country health priorities in Strategic Results Notes (SRNs), which set the strategic direction of country offices and defines their contribution to the GPW 13 outcomes over the next five years. Strategic Results Notes have helped to shape country support plans (CSPs) which measure each country's contribution to GPW 13 and how the WHO country office, regional office, and headquarters will work more effectively together to deliver impact at the country level.

Implementation of the new strategic planning process under GPW 13 has enabled a clear delineation of results for which WHO in the African Region will be accountable for delivering (outputs) and those to which it will be accountable for contributing (outcomes) on the basis of national health priorities and strategies. By aligning the strategic planning process with GPW 13, WHO in the African Region has an opportunity to cumulatively contribute to the achievement of SDG 3 in the Region.

Optimized resource utilization

The approved Programme Budget 2018–2019 for the African Region is US$ 1 161 600 000, which represents 26% of the global Programme Budget of US$ 4 421 500 000. As of 30 June 2019, the total allocated budget for the Region was US$ 1 717 435 890 – US$ 555 835 890 more than the World Health Assembly-approved budget. Of the additional portion, 85% (US$ 471 429 356) is allocated to humanitarian response plans and other appeals. Recognizing the event-driven nature of this portion of the budget (primarily determined by needs during emergencies), humanitarian response plans and other appeals are not included in the approved Programme Budget.

By 30 June 2019, ninety per cent of the allocated budget for the base segment (US$ 745 839 176) was funded (Table). The polio and humanitarian appeals segments have a total funding of US$ 723 966 832, representing 42% of the allocated Programme Budget. The average utilization rate of available funds is 73%, with the polio programme segment accounting for the highest rate (80%) and communicable diseases for the lowest (60%).

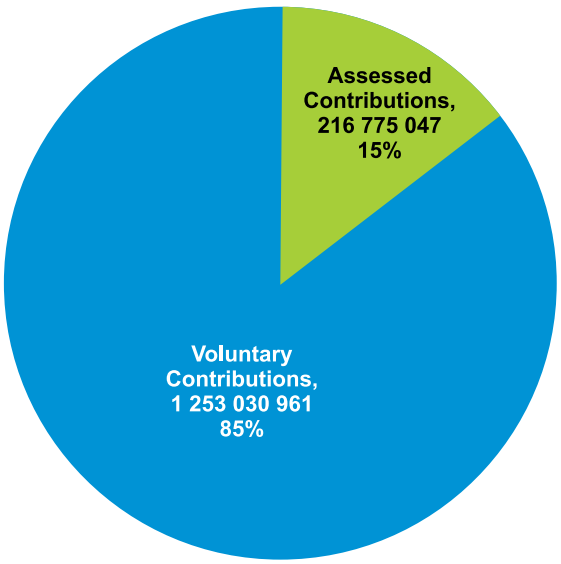
Table: Financial utilization of the approved Programme Budget 2018–2019 (as of 30 June 2019)

Category of work		Approved Programme Budget by the World Health Assembly	Allocated Programme Budget	Total Available Funds	% Funding against Approved Budget	Budget Utilization	% Utilization against Approved Budget	% Utilization against Funding
01	Communicable diseases	291 100 000	290 545 090	283 135 663	97%	170 173 478	58%	60%
02	Noncommunicable diseases	61 000 000	55 043 000	32 724 109	54%	20 488 718	34%	63%
03	Promoting health through life-course	105 300 000	103 190 000	66 770 499	63%	45 591 547	43%	68%
04	Health systems	88 500 000	92 925 000	90 740 117	103%	64 908 481	73%	72%
06	Corporate services and enabling functions	147 000 000	151001300	144 359 786	98%	105 037 935	71%	73%
12	WHO Health Emergencies Programme	141 200 000	133 625 000	128 109 002	91%	95 025 282	67%	74%
Total Base Programmes		**834 100 000**	**826 329 390**	**745 839 176**	**89%**	**501 225 441**	**60%**	**67%**
10	Polio	327 500 000	419 677 144	397 336 903	121%	316 911 324	97%	80%
13	Humanitarian response plans & other appeals	0	471 429 356	326 629 929		259 589 915		79%
Grand Total		**1 161 600 000**	**1 717 435 890**	**1 469 806 008**		**1 077 726 680**		**73%**

The earmarking of voluntary contributions contributes to the uneven distribution of funding and limits flexibility in the implementation of the Programme Budget. Although assessed contributions from Member States increased by 3% this biennium, voluntary contributions continue to account for the bulk of other budget segments (i.e. polio, special programmes and humanitarian response plans and appeals). Although the reprogramming process could help rectify some distortions in the funding of programmes, the portion of flexible funds in the funding pattern needs to increase (Figure 8).

The Regional Office and country offices have been proactive in advocating for flexible and predictable funding; strengthening partnerships with traditional donors; and fostering relationships with potential partners to further support countries in health development. WHO in the African Region has continued to strengthen its resource mobilization capacities and enhance accountability to donors. It is promoting the leveraging of business intelligence technology and processes and piloted the Programme Management Officers mechanism in six countries to further strengthen the planning, monitoring and utilization of resources and their redistribution, as well as compliance with statutory reporting of workplan implementation. WHO continues to focus on increased domestic accountability, strong national ownership and domestic investments in health.

Figure 8: Proportion of assessed contributions and voluntary contributions (as of 30 June 2019)



Enhanced monitoring and evaluation for impact

The African Region Results Framework was established in 2017 with the support of the Bill & Melinda Gates Foundation to achieve the results contained in the Transformation Agenda. As part of the process, programmatic key performance

indicators (KPIs) were defined to enhance accountability, transparency and the focus on results. They measure WHO's contribution at the output level towards the achievement of national and Sustainable Development Goals in the African Region. Currently, there are 43 prioritized programmatic KPIs spanning clusters and enabling functions, which are being measured and reported on by each of the 47 country offices in the Region.

The availability of timely KPI performance data and the analytical capacity to assess health development linkages are critical for effective, evidence-based decision-making. To this end, the Organization developed the online Tool for African Region Results (TAR). The TAR was conceived to enhance efficiency, automate the process of KPI reporting, ensure data accuracy, standardize the data validation process and create a central repository for KPI data for dissemination. By improving the capacities of WHO country offices in KPI data collection and in communicating results, WHO has been able to generate usable intelligence for health programme planning and to position itself as a vocal and visible health development partner within the Region.

Fostering a culture of evaluation within WHO

To reaffirm the vital role played by monitoring and evaluation (M&E) in the work of WHO in the African Region, the Monitoring and Evaluation Committee continues to meet annually to assess and continuously improve results-focused implementation of health programmes.

In 2018, WHO issued the draft African Region Guidelines on Evaluation (AGE) to foster learning, promote a culture of evaluation and identify, harness and disseminate best practices, as well as to facilitate assessment of what has been working and what has not been working within the health sector in the Region. Linked to the new WHO Evaluation Policy (2018) and the Transformation Agenda, the AGE provides practical guidance on how to prepare for and conduct evaluations in the Region, and how best to utilize evaluative evidence to improve programme design and implementation for results. The AGE has been applied in two regional evaluations, namely the Noma Control project, supported by Hilfsaktion Noma e.V. Regensburg and implemented in 10 countries,[123] and the evaluation of the Programme Management Officer mechanism[124] supported by the Bill and Melinda Gates Foundation. The results of these two evaluations are being disseminated to stakeholders for validation and subsequent implementation of recommended actions. WHO will continue to promote evidence-based learning and programme development and conduct high-quality evaluations to inform management actions.

Looking forward: an enhanced focus on managing for GPW 13 results

"For a long time, WHO in the African Region has faced challenges in measuring the outputs and outcomes of our support to Member States. The KPIs offer all of us an opportunity not only to measure results but also to focus our work on what will make a difference in our Region"
– Dr Matshidiso Moeti, WHO Regional Director for Africa

Greater efficiencies and effectiveness of WHO activities to promote health in the African Region have been achieved through enhanced capacities in planning, budgeting and monitoring and evaluation (M&E). In addition, WHO is ensuring that the efficient utilization of resources, timely achievement of results and alignment of resources to country priorities will drive impact at the country level. Efforts will also be pursued to enhance the Region's commitment to being more accountable, transparent and responsive, and to ensure that the work of the Secretariat at the country, subregional and regional levels is planned on the basis of country priorities.

123 Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Guinea-Bissau, Mali, Niger, Nigeria, Senegal and Togo.
124 Democratic Republic of the Congo, Eswatini, Ethiopia, Lesotho and South Africa.


WHO
OMS

Conclusion
AND LOOKING AHEAD

With the collective efforts of Member States and partners, significant progress has been made in the past year. Guided by the *Twelfth General Programme of Work 2014–2019*, priorities have been advanced in combatting communicable and noncommunicable diseases, promoting health through the life course, strengthening health systems towards universal health coverage, protecting populations from health emergencies and eradicating polio.

As of January 2019, work under the *Thirteenth General Programme of Work 2019–2023* (GPW 13) has been initiated, focusing on the triple billion targets: one billion more people benefiting from universal health coverage, one billion more people protected from health emergencies, and one billion more people enjoying better health and well-being.

To advance universal health coverage, WHO in the African Region will continue implementation of the UHC flagship programme, including supporting development of national roadmaps towards UHC. Primary health care remains central in achieving UHC and initiatives such as the Essential Health Services Package (EHSP) and support at the district health systems level will continue to be priority areas of work. Attention will also focus on health financing, equity, digital health, and ensuring access to medicines and vaccines, as well as their rational use, to ensure protection against antimicrobial resistance.

The Region will continue to face infectious disease outbreaks and other health emergencies in the coming 12 months, highlighting the importance of health security. The Ebola virus disease outbreak in the Democratic Republic of the Congo calls for regional and global investment. Investment is also needed to prevent and respond to outbreaks of cholera, measles, meningitis and other vaccine-preventable diseases. WHO will continue working with countries to strengthen emergency preparedness through the all-hazards and "One Health" approaches, focusing on strengthening surveillance and rapid response. The Secretariat will also continue supporting countries towards achieving global eradication of polio.

To ensure that more people across the Region enjoy better health and well-being, WHO will continue to support countries in preventing, controlling and treating communicable diseases such as HIV, TB, malaria, viral hepatitis, sexually transmitted infections, and neglected tropical diseases. Key interventions include ensuring access to ART for people living with HIV, the world's first malaria vaccine (RTS,S/AS01) pilot, and the Expanded Special Project for Elimination of Neglected Tropical Diseases. To prevent and manage noncommunicable diseases, WHO will continue to support countries to reach the nine voluntary global NCD targets and to integrate NCD services as part of primary health care. Expanding access to skilled birth attendants and improving the quality of reproductive, maternal, newborn, child and adolescent health (RMNCAH) care and integrating nutrition programmes will also continue to be priorities. Key activities will include advancing the Network for Improving Quality of Care for MNCH Services and the regional flagship programme on adolescent health. Healthy ageing will also be a priority.

In the coming year, the Secretariat will continue to implement the Transformation Agenda with a focus on building the managerial and leadership capacity of all senior staff, finalizing the functional reviews and developing a new regional performance framework to monitor the Transformation Agenda in line with the GPW 13 triple billion targets. The Secretariat will continue to promote efficiency, accountability, quality and value for money, as well as more effectively communicating WHO's work in the Region and scaling up implementation of UHC in countries in the context of primary health care in alignment with GPW 13 targets.

In transitioning to GPW 13, WHO in the African Region will step up efforts to improve and mainstream results-based management and value for money. A more effective and efficient WHO in the African Region is not only poised to better promote health, save lives and serve the vulnerable, but also to play a pivotal role in boosting economic growth and national development across the Region.

Annex 1:
SELECTED WHO PUBLICATIONS IN THE AFRICAN REGION, 2018–2019

WHO Health Emergencies Programme

Yahaya A.A., Talisuna A.O., Conteh I., Oke A., *et.al* (2019). Operational readiness and preparedness for Ebola virus disease outbreak in countries neighbouring the Democratic Republic of the Congo: progress, challenges and the way forward. *Weekly epidemiological record*, 94, 39-43.

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WHO (2018). Primary Eye Care Training Manual - A course to strengthen the capacity of health personnel to manage eye patients at primary-level health facilities in the African Region. Available at: https://www.afro.who.int/sites/default/files/2018-06/WEB–2835-OMS-Afro-PrimaryEyeCaretrainingmanual–20180406.pdf

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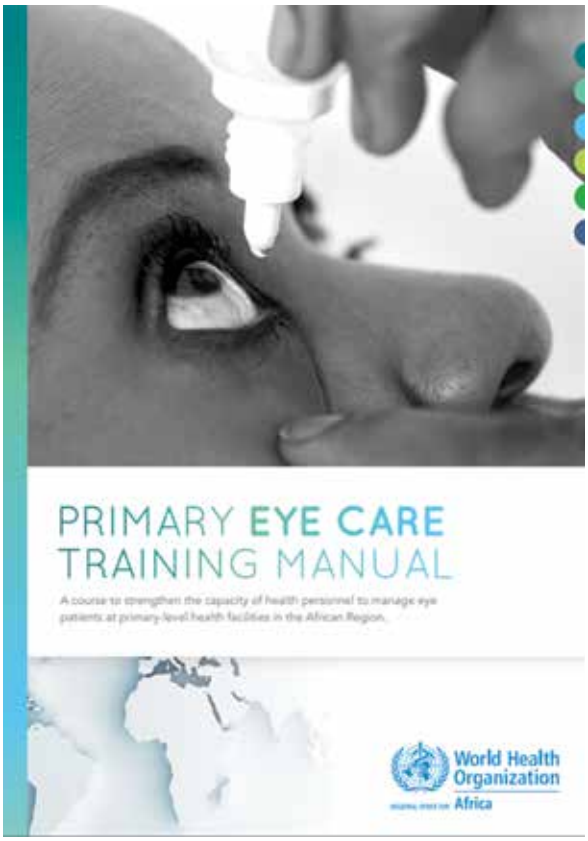

Notes

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