THE WORK OF WHO IN THE AFRICAN REGION 2000

ANNUAL REPORT OF THE REGIONAL DIRECTOR

To the fifty-first session of the
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INTRODUCTION

1. The Regional Director has the honour to present to the WHO Regional Committee for Africa this report for the year 2000. The report reflects the changes that are taking place in WHO in general and in the African Region in particular. A great deal has been accomplished despite the persisting socio-political, macroeconomic and public health problems. The Regional Office has been able to achieve significant results through effective partnerships and dedication of all WHO staff.

2. The African Region continues to face pressing health problems which must be addressed. The situation in regard to HIV/AIDS is alarming. The number of disadvantaged groups and the poor is ever on the increase. A number of the countries are afflicted by civil and political unrest, major economic problems and environmental disasters. WHO needs to mount a massive effort to assist Member countries to deal with the complexity of health problems and health systems.

3. During the year, the Regional Office focused on the following priority health areas as agreed by the 49th session of the Regional Committee for the current biennium: malaria; HIV/AIDS and tuberculosis prevention and control; child survival; safe motherhood; response to complex emergencies and epidemics; mental health; health sector reform; health promotion; and poverty reduction.

4. In order to contribute to the reduction of health and health-related problems in Africa, the Regional Office increased its resources and activities. Among the key achievements were the following: substantial progress toward polio case detection and eradication; improved control of tuberculosis, with 55% of the countries increasing the level of the direct observed therapy, short course (DOTS) by more than 50%; and the introduction of the Roll Back Malaria (RBM) programme at the district level in most countries. The Regular Budget and extrabudgetary resources have increased substantially, from US$176 000 000 in 1994-1995 to US$374 000 000 in 2000-2001. The rise in funding from other sources demonstrates a significant increase in donor confidence and response to regional health needs.

5. Through the Regional Director's Development Fund, and in addition to planned activities, the Regional Office supported directly several initiatives to improve the health conditions in the Region. In this respect, contributions were made to the following activities:

(a) Conduct of national workshops on health in Senegal which brought together national and international partners;

(b) Sponsoring of international participation in the Sixth Congress of the African Obstetric and Gynaecology Society;

(c) Support to St. Camille Medical Centre in Burkina Faso that treats AIDS patients with medicinal plants;

(d) Resettlement of displaced persons and refugees of Kisangani in the Democratic Republic of Congo;

(e) Organization of micro-credit in Harare, Zimbabwe, especially for the training of participants in an AIDS workshop;

(f) Training of trainers in reproductive health;

(g) Development of "Mother of Peace", an orphanage centre at Mutoko, Zimbabwe, in order to make the centre self-sufficient.

6. Capacity-building within the Regional Office as well as in the Member States is extremely important in order to improve performance to meet health and health-related needs. To assist WHO regional advisers and country representatives to better perform their tasks, a leadership and management training programme was conducted.

7. The ongoing restructuring process enunciated by the WHO Director-General, Dr Gro Harlem Brundtland, and guided by the WHO Corporate Strategy, also had an impact on the functioning of the Regional Office.

8. In line with the principles laid down under the WHO Corporate Strategy, the Regional Office, in collaboration with WHO headquarters, prepared the Programme Budget for the 2002-2003 biennium, with inputs from Member countries. These inputs were inspired by the four elements in the WHO Corporate Strategy, which are:

(a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;

(c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands and are financially fair; and

(d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.[1]

9. Efforts were made to improve mutual collaboration and cooperation in the field of development among various UN agencies at the Regional and country levels, WHO being the leader in the area of health. In several Member countries, WHO actively participated in the United Nations Development Assistance Framework (UNDAF), the Common Country Assessment (CCA), and the preparation of the Poverty Reduction Strategy Paper in order to strengthen the countries' institutional capacity.

[1]WHO, A Corporate Strategy for the WHO Secretariat, EB105/3, 10 December 1999.

10. WHO's Regional and country programmes were comprehensively reviewed in the 2000-2001 Mid-Term Review (MTR) at the end of 2000. This report is based on the findings of the MTR. It describes in detail the results achieved in the various areas of work as defined in the Programme Budget 2000-2001.

11. The report is divided into three parts. Part I describes the main achievements in the areas of work at regional and country levels, as well as the main enabling factors and constraints.

12. Part II describes the degree of implementation of some of the resolutions on specific programmes adopted by the Regional Committee at its various sessions. These resolutions concern: the regional strategy on mental health; integrated disease surveillance; poliomyelitis eradication; leprosy elimination in the African Region; the regional strategy on emergency and humanitarian action; Integrated Management of Childhood Illness; and essential drugs in the African Region.

13. Part III relates to the progress made in regard to the situation of the WHO Regional Office for Africa in Brazzaville.

PART I: THE IMPLEMENTATION OF ACTIVITIES IN THE AFRICAN REGION

SIGNIFICANT ACHIEVEMENTS

General programme development and management

14. The Regional Office embarked upon the implementation of the budget and management reforms of WHO in the African Region. The preparation of the 2000-2001 Programme Budget marked a significant departure from the past. It reflects the first attempt to incorporate the principles of the WHO Corporate Strategy. In the spirit of "One WHO", it was the first time that Clusters at WHO headquarters and the Regional Office undertook the process of joint planning. The 24th Regional Programme Meeting provided an opportunity for discussion and coordination between the WHO country representatives and Regional Office staff. The exchange of views during these interactions helped to improve the content and format of the plans of action.

15. The ***Budget and management reform (BMR)*** area of work was marked by an improvement in the process of monitoring and evaluation in a critical and systematic way. A biennial evaluation of the implementation of the Programme Budget 1998-1999 and a semi-annual monitoring and mid-term review of the Programme Budget 2000-2001 were conducted. The Activity Management System (AMS) was introduced in the Regional Office in order to facilitate the monitoring and evaluation of the Programme Budget.

16. The preparation of the Programme Budget 2002-2003 prompted an unprecedented level of coordinated interaction between headquarters and the Regional Office. The preparation of the guidelines for the planning, monitoring and evaluation of the Programme Budget 2002-2003 at the country level was preceded by two global consultations between BMR/HQ and regional advisers in charge of planning, programming and evaluation in the WHO regions. The African Regional Office hosted the second consultation.

17. In the area of ***Technical cooperation with countries (TCC),*** special emphasis was placed on building WHO's capacity at the country level through leadership and management programmes for WHO representatives (WRs) and WHO liaison officers (WLOs); supporting WHO country office workshops and retreats for performance improvement; collection and exchange of best practices among country offices; and increased delegation of authority to WRs and WLOs. Two regional programme meetings, which brought together WRs, WLOs and senior staff of the Regional Office, took place to examine the implementation of the current Programme Budget, the preparation of the 2002-2003 Programme Budget and to explore ways and means to improve WHO's work in and with countries, based on country cooperation strategies.

18. The preparation of country cooperation strategies will offer a fresh approach to country work that will enhance the corporate culture of being "One WHO", while fostering strategic thinking, with a switch to fewer priorities and addressing gaps in WHO's response mechanism. This will help adapt the programme of cooperation to country-specific needs, harmonize support from all levels of WHO, and strengthen partnership for health development.

19. In the area of ***Research policy and coordination (RPC)***, the Regional Office stressed the pivotal role of health research in the production of reliable information that would influence the decision-making process with a view to enhancing the effectiveness of health delivery and financing in Member States. In view of its importance, all regional programmes were encouraged to include a research component in their plans of action (POAs) and programme activities.

20. Research coordination was strengthened, and the role of the African advisory committee for health research and development (AACHRD) was revived to provide strategic advice to the Regional Director, based on informed opinion about critical research issues of relevance to the Region. The Regional Office embarked on a vigorous effort to enhance the relevance of WHO collaborating centres and centres of excellence and to encourage the utilitization of expert advisory panels in the work of WHO in the Region. The Regional Office also encouraged the development of vital research capacity in Member States, including making available catalytic seed funds to support research work in priority health areas.

21. In the area of ***Evidence for health policy (GPE)***, efforts were made to strengthen capacities in the generation and use of evidence in decision-making at regional and country levels. The main achievements during the reporting period included: establishment of a regional database on health and health-related information; training of 21 WHO country office resource persons in economic evaluation, economic impact analysis of health problems, health measurement, economic viability analysis, national health accounts, and health facility efficiency analysis. The health facility efficiency analysis studies were completed in two countries, while draft data collection tools for economic evaluation of health interventions, national health accounts and health facility efficiency analysis were developed.

22. In the areas of ***Resource mobilization (RMB)*** and ***External cooperation and partnership (ECP)***, the ***Interagency resource mobilization*** unit ***(IRM)*** contributed to the preparation and implementation of legally-binding documents concerning extra-budgetary funding and partnerships at country and regional levels. It also produced a standard format for the preparation of project documents by the Regional Office.

23. In addition, efforts were made to improve the capacity of Member countries and Regional Office staff to negotiate. National negotiation workshops were held in Togo, Seychelles and the Democratic Republic of Congo.

24. An analysis of nongovernmental organizations working in health and health-related areas in the Region was undertaken and the results published. The inventory of the recommendations contained in this publication forms a useful set of guidelines that Member countries can adapt to suit their respective needs or use to develop their plans of action.

25. Significant achievements were made in the area of ***Public information.*** The Information unit increased considerably the production and dissemination of press releases and health-related audiovisual materials for use by the print and electronic media in the Region. A new initiative introduced during the year was a regional health magazine, the *African health monitor*, to enhance the dissemination of health information and increase the visibility of the work of WHO in the Region.

26. In regard to the WHO ***Governing Bodies,*** the Regional Office supported the participation of the Member States in the meetings of the WHO Executive Board and the World Health Assembly. Briefing sessions were organized for delegates attending the Executive Board. Working documents and resolutions relating to various Governing Bodies were distributed to Member countries. The 50th session of the Regional Committee for Africa was held in Ouagadougou, Burkina Faso, in September 2000.

Source: RC50 Ouagadougou, 2000

Country delegates at the fiftieth session of the WHO Regional Committee for Africa, held in Ouagadougou, Burkina Faso, 28 August to 2 September 2000, with His Excellency Mr Blaise Compaore, President of Burkina Faso, and Dr Gro Harlem Brundtland, WHO Director-General, after the opening of the meeting.

27. The ***Emergency and humanitarian action (EHA)*** unit focused on developing preparedness programmes, strengthening emergency response capacity and improving WHO's role in the overall context of the United Nations system's common action in emergencies.

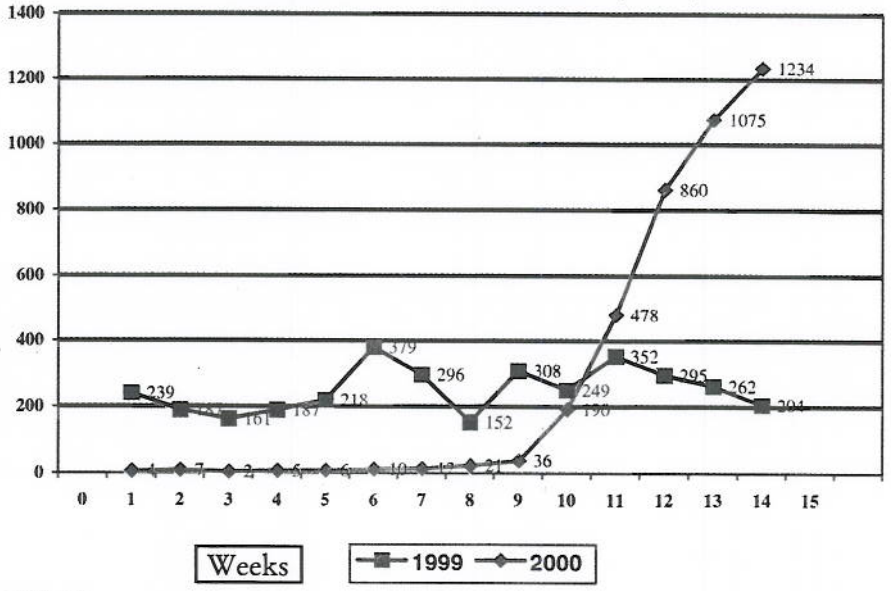
28. The ***Emergency preparedness and response (EPR)*** focal points assigned to the ministry of health and WHO country office in 45 Member countries were trained in the development and implementation of emergency preparedness and response programmes at country level. Draft guidelines on the assessment of the vulnerability of countries to emergencies were prepared, and a comprehensive policy framework for the implementation of the programme at country level was drawn up. Twenty health officials drawn from districts in ten English-speaking countries were trained in the management of the complex process of assessing community vulnerability to emergency situations. Countries in the Southern Africa Development Community (SADC) grouping attended a WHO workshop on hospital preparedness in emergencies. Under this activity, which continued in the countries, 30 participants from six provincial hospitals in Swaziland were trained, while Tanzania received support specifically for enhancing the health sector's emergency preparedness and response capacity.

29. The EHA programme took several actions to ensure a quick, adequately-funded and technically-correct response to emergencies in the Region. Assistance was provided to SADC's initiative to set up intercountry structures to support national emergency preparedness and response programmes. Emergency kits were provided to some countries to improve on their intervention time. To ensure inter-agency coordination, a workshop was held in collaboration with headquarters on the preparation of the interagency consolidated appeal, which is a tool of the United Nations system for planning, resource mobilization and evaluation in countries in emergencies. Support was provided to Uganda during the outbreak of viral haemorrhagic fever, to the Democratic Republic of Congo during the organization of national immunization days (NIDs) for poliomyelitis, to Liberia to contain the yellow fever epidemic, and to Mozambique for adequate response to floods.

COLD, WET, HUNGRY AND SICK. THAT IS THE PLIGHT OF ABOUT SEVEN MILLION DISPLACED PERSONS IN AFRICA

Source: WHO/AFRO, 2000

Figure 1: WEEKLY ACUTE DIARRHOEA INCIDENCE IN MAPUTO CITY, MOZAMBIQUE: 1999 (NO FLOODS) AND 2000 (FLOODS)



Source: WHO/AFRO, 2000

30. The graph above demonstrates the dramatic epidemiological effect of a natural disaster on a single disease - diarrhoea - in an urban setting.

The Emergency and Humanitarian Action (EHA) unit in the Regional Office estimates that Africa had an estimated 7 million people displaced from their homes at the end of December 2000. Driven from their homes by war, floods, drought, famine or epidemic diseases, almost 7 million people in at least 44 countries in the Region are exposed to harsh environmental conditions, hunger, physical and sexual violence and communicable diseases. Children and women, often travelling alone, are in particular danger. To assist in a timely and efficient manner, host countries and their assistance partners must operate in a coordinated manner, providing minimum essential health services, shelter, food and clothing. WHO supports the United Nations Consolidated Appeal process in emergency situations in order to ensure a coordinated and efficient response.

PEOPLE DISPLACED BY FLOODS: MOZAMBIQUE

Source: WHO/AFRO; 2000

31. In the African Region, emergencies are now being addressed in a systematic way. Many countries are now well on their way to creating coherent, decentralized emergency response capacities, with components for prevention, mitigation, preparedness, rapid response, reconstruction and rehabilitation. A phased programme sequence has been agreed upon and most countries in the Region are developing their emergency preparedness and response programmes in an orderly fashion, with technical back-up from the Regional Office, through the following stages:

(a) legal framework;

(b) vulnerability assessments;

(c) planning for emergencies;

(d) creating management structures; and

(e) training for emergency preparedness and response, leading to the creation of a "critical mass" of trained personnel in countries.

EMERGENCIES: THE BIG PICTURE

There is a growing awareness of the importance of emergencies, and, with this, an increasing demand for international agencies and governments to take steps to minimize their effects on populations:

- *While WHO projects that global mortality due to maternal, prenatal and nutritional disorders will decrease by 40% from 1990 to 2020, deaths from injuries are expected to increase by 65% during the same period.*
- *The magnitude of social and economic losses from natural disasters and epidemics are huge. Approximately 20 million people were displaced by floods in Bangladesh in 1998. Two million people were affected by flooding in Mozambique in 2000. An estimated US$770 million of economic loss was caused by the 1992 cholera epidemic in Peru, and US$1.7 billion by the plague epidemic in India in 1994.*
- *Complex emergencies (civil war, breakdown of state authority) cause damage far beyond the immediate effects of war injuries and damaged buildings. Of the 1.7 million excess deaths during the civil conflict in the Democratic Republic of Congo, a majority were due to common childhood illnesses. During the nine-year complex emergency in Sierra Leone, even some districts not affected by the fighting lost over 50% of their functioning peripheral health units because of the indirect economic and logistic effects of the war. These systemwide effects must be appreciated in preparing for and responding to emergencies.*

The global community has responded by increasing humanitarian assistance for emergencies from US$3 million in 1969 to US$4 000 million in 1995 (a greater than thousand-fold increase). However:

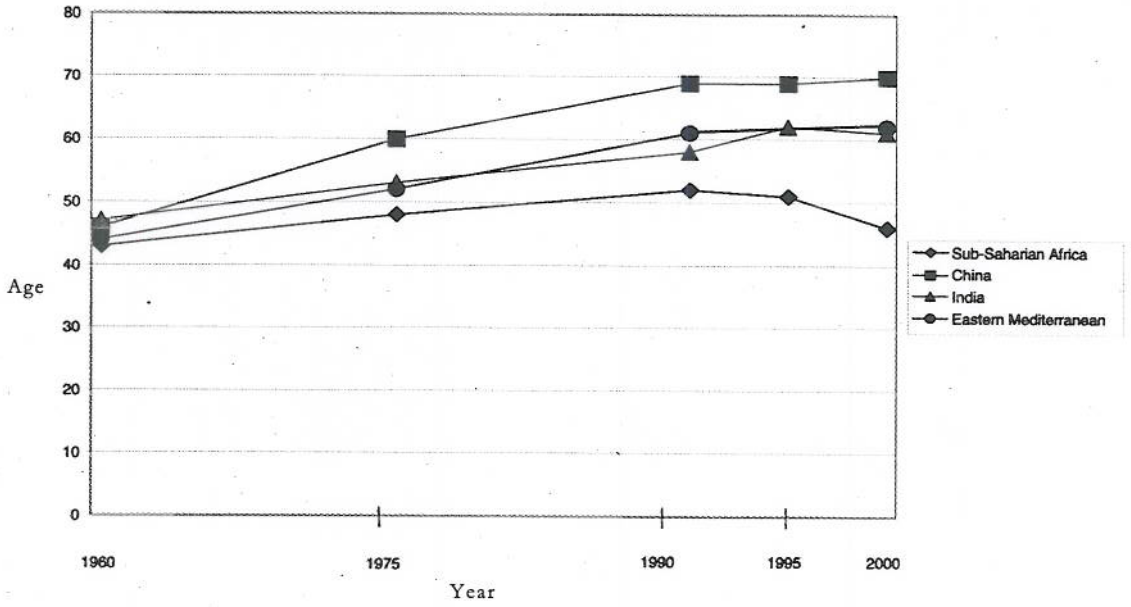
- *This massive investment is often made in a poorly coordinated fashion, with assistance mobilized only after a disaster has occurred.*
- *WHO estimates that for every $100 spent on humanitarian assistance, only $4 is spent to prepare for emergencies, to prevent them where possible, or to mitigate their impact.*

Every year there are earthquakes, floods or epidemics somewhere in the world. The time has come to ensure that every country has capacity for emergency prevention, reparedness and response.

Health systems and services development

32. The ultimate goal of any health system is the improvement of the health status of the people. In the African Region, life expectancy, as a measure of the achievement of this goal, shows that the health status of the region lags far behind that of other WHO regions. For example, according to the World Health Report 2000, the average life expectancy in the American Region as also in the European Region is 76 years whereas it is 46 years in the African Region. Even when life expectancy in sub-Saharan Africa is compared with that in the Eastern Mediterranean Region and in China and India, where, in 1960, it was almost at the same levels as in Africa, these regions now fare far better. As the HIV/AIDS epidemic takes its toll, and if the current trends continue without improvement, life expectancy is set to decrease further in the African Region. Widespread civil strife, political instability and poverty are other factors which are responsible for the poor performance of national health systems. The effects of globalization also need to be considered while forecasting the future development of health systems in the Region.

Figure 2: LIFE EXPECTANCY AT BIRTH IN THE AFRICAN REGION AS COMPARED TO OTHER REGIONS AND COUNTRIES



Source: WHO/AFRO-Adapted from the World Bank Report 1993, World Health Report 1998 and World Health Report 2000

33. Less than 50% of the population in sub-Saharan Africa has regular access to life-saving drugs. The situation is worse in the case of drugs for relatively new diseases such as HIV/AIDS. Poor drug quality, irrational drug use, negative impact of global trade agreements on access to drugs and insufficient resources are challenges faced by most national health systems.

34. The mission of the Division of health systems and services development in the Regional Office is to contribute to the attainment of the goal of Health for All by supporting Member countries in the strengthening of their health systems.

35. The division is responsible for three areas of work: Organization of service delivery (OSD); Essential drugs and medicines policy (EDM); and Blood safety and clinical technology (BCT).

36. The Organization of service delivery covers the following programmes: National health systems, District health systems, Health information systems, Health systems research, and Human resources development.

37. Major activities during the reporting period included the finalization of the regional health-for-all policy for the 21st century, which was adopted by the Regional Committee in September 2000. Support was provided to nine countries (Botswana, Burkina Faso, Gabon, Guinea, Mozambique, Niger, Rwanda, Seychelles, Swaziland) for the development of their national health policies within the context of health sector reform. Further support was provided to Central African Republic, Uganda and Zambia for sensitization on sector-wide approaches (SWAps) and intercountry study visits on health sector reform. In recognition of the need to systematically monitor and evaluate health sector reform in Member countries, a tool was developed through a joint effort with the World Bank.

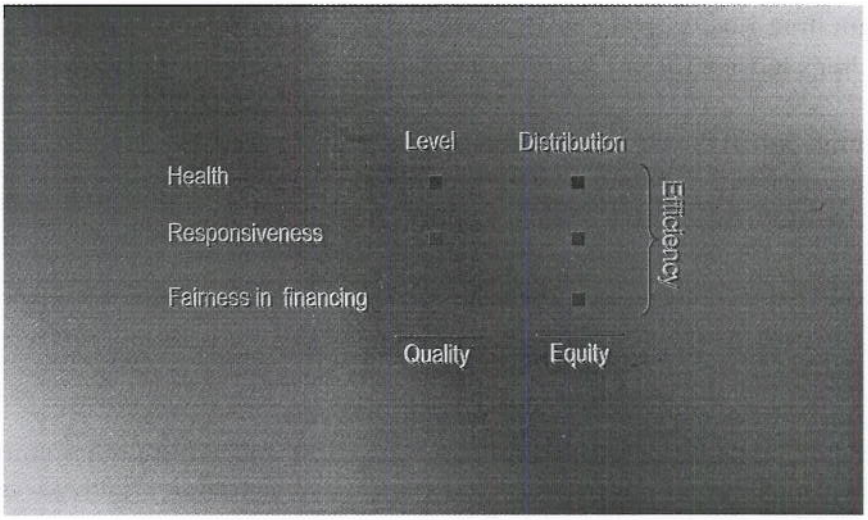
REGIONAL HEALTH-FOR-ALL POLICY FOR THE 21st CENTURY IN THE AFRICAN REGION: AGENDA 2020

As a framework for national health policy formulation, the document addresses the strategic directions that are expected to help achieve health for all in the 21st century. These strategic directions are:

(a) Creation and management of enabling environments for health
(b) Undertaking health system reform by drawing upon primary health care principles
(c) Empowerment and support at individual, family and community levels
(d) Creation of the conditions that will enable women to participate in, benefit from and play a leadership role in health development.

38. The World Health Report 2000 was released by headquarters during the year. The report presents a new framework for measuring the performance of national health systems, taking into account achievements with respect to both the levels and distribution of each of the three goals of the health system, which are: health, responsiveness and fairness in financing. Discussions were held with eight Member countries (Chad, Côte d'Ivoire, Kenya, Malawi, Mozambique, Senegal, South Africa, Zimbabwe) on applying the new framework in generating evidence for use in policy dialogues and while choosing interventions. In the years to come, this process will be expanded to more and more countries in the Region.

Figure 3: HEALTH SYSTEM GOALS



Source: World Health Report 2000

39. The tool for assessing the operationality of district health systems was published. Support was provided to Equatorial Guinea, Togo and Uganda in the selection of essential health indicators. The Republic of Congo, Gabon and Gambia received support for the development of their health information systems. In addition, two important guidelines were developed: one, on the evaluation of the global performance of health information systems, and two, on the utilization of essential health indicators in monitoring progress at country level within the Region. The district, as an administrative unit, remains the main focus of health sector reforms in the Region.

40. A tool for developing national health research profiles was developed and transmitted to all Member countries. Gaps and areas for research development and support were identified. In addition, two key meetings on Health systems research (HSR) were convened. The first intercountry meeting was held in Harare, Zimbabwe, for HSR focal points and policy analysts. It identified areas of collaboration between HSR and policy development and analysis and the revised roles and functions of HSR focal points and units. The second meeting was held in Pretoria, South Africa, on priority HIV/AIDS issues for health systems research. Five frameworks to support the development of research were developed by 11 countries most affected by HIV/AIDS.

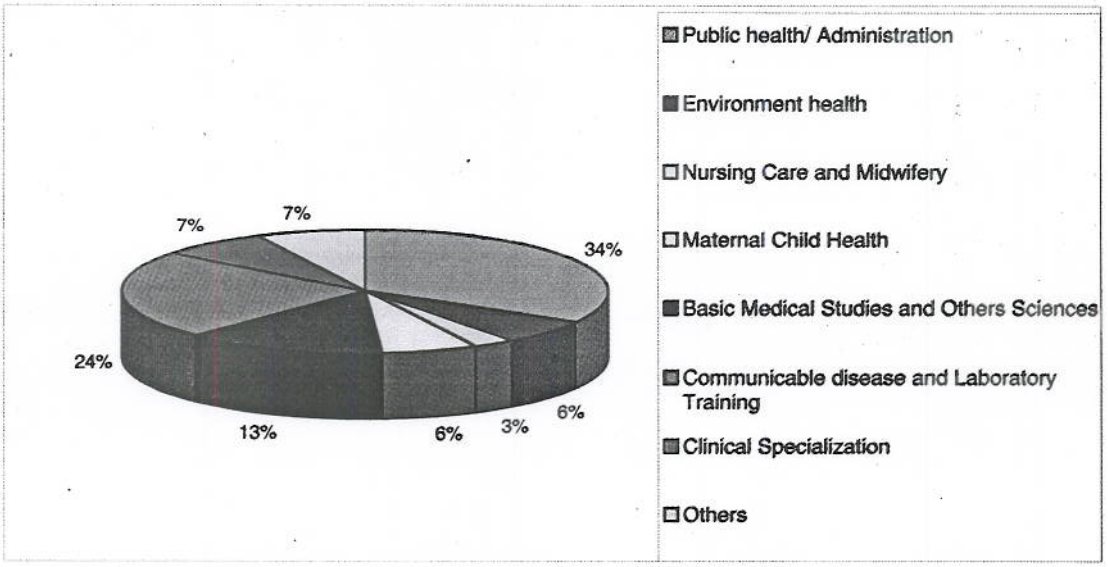
41. Work undertaken in the area of Human resources for health (HRH) was guided by the Regional Strategy for the Development of Human Resources for Health, adopted by the Regional Committee in 1998. The level of implementation of this strategy in the Region has been slow, as evidenced by the HRH issues most countries still face.

42. Capacity-building for human resources managers from 24 French-speaking countries was undertaken through a training programme organized in Algeria. A similar programme has been arranged for English-speaking countries and will be held in early 2001. The Multidisciplinary Advisory Group (MAG) on human resources for health was set up and it held its first meeting. One of the recommendations of the MAG was to develop an advocacy package on HRH. This has since been done in collaboration with the University of Western Cape, South Africa, and the package has been shared with Member countries. A situation analysis on human resources for health in the Portuguese-speaking countries was undertaken; it confirmed an acute shortage of skilled health personnel in all the five countries.

43. In the area of nursing and midwifery, there were four main achievements: (i) case studies on strengthening nursing and midwifery services were finalized and areas for nursing and midwifery development identified; (ii) guidelines for the evaluation of training programmes in health sciences were developed; (iii) an HIV/AIDS fact sheet for nurses and midwives was developed and launched; and (iv) the African Journal for Nursing and Midwifery was produced and distributed to all countries.

44. A total of 351 fellowships were awarded in the year 2000; 133 other applications were under consideration.

Figure 4: WHO/AFRO: FELLOWSHIPS BY FIELD OF STUDY, 2000 (TOTAL = 351)



Source: HRD/DSD, WHO/AFRO, 2000

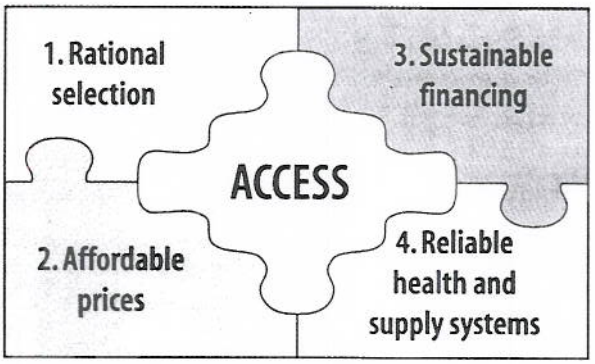
Objective 1. Policy

The national drug policy process brings all interested parties together to focus political commitment, financing and human resources on pharmaceutical sector improvements. A national drug policy therefore provides a framework for action relating to pharmaceuticals within an overall national health policy. Its goals should be consistent with broader health system objectives, and its implementation should support those objectives. WHO will help countries to actively implement national drug policies and monitor their impact. The policy objective has two main components: implementation and monitoring of national drug policies, and integration of essential drugs policies and programmes with health systems development.

Objective 2. Access

Access to essential drugs is a key priority for WHO. Four enabling factors need to be firmly in place to increase and ensure sustainable access:

- *rational selection based on a national essential drugs list and treatment guidelines*
- *affordable prices for governments, health care providers and consumers*
- *sustainable financing through equitable funding mechanisms such as government revenues or social health insurance*
- *reliable supply systems incorporating a mix of public and private supply services.*



From the patient's or consumer's point of view, access to essential drugs means that such drugs can be obtained within reasonable travelling distance (i.e. geographically accessible), they are readily available in health facilities (i.e. physically available), and affordable (i.e. financially available).

Objective 3. Quality and safety

Global standards for drug quality are becoming increasingly rigorous. Yet the quality of drugs on the market in many countries remains a major public health concern. Similarly, major efforts to improve drug regulation at national and international levels have been instigated, but enforcement of regulatory standards remains a challenge for every country. WHO's work under the quality and safety objective has four components: norms, standards and guidance for pharmaceuticals; drug regulation and quality assurance systems; information support for pharmaceutical regulation; and guidance for control and use of psychotropics and narcotics.

Objective 4. Rational Use

The essential drugs concept is now applied worldwide. A growing number of countries, both developed and developing, have used it to help them improve drug use by prescribers, dispensers and the general public, and to contain drug expenditure.

The challenge now is how best to ensure therapeutically sound and cost-effective use of drugs, at all levels of the health system, in both the public and private sectors, by both health professionals and consumers. WHO is working to support three components: rational drug use strategy and monitoring; rational drug use by health professionals; and rational drug use by consumers.

Source: WHO/AFRO- Division of health system development (Traditional Medicine)

45. The *Essential drugs and medicines policy* programme covers two areas of work: *Essential drugs,* and *Traditional medicine.*

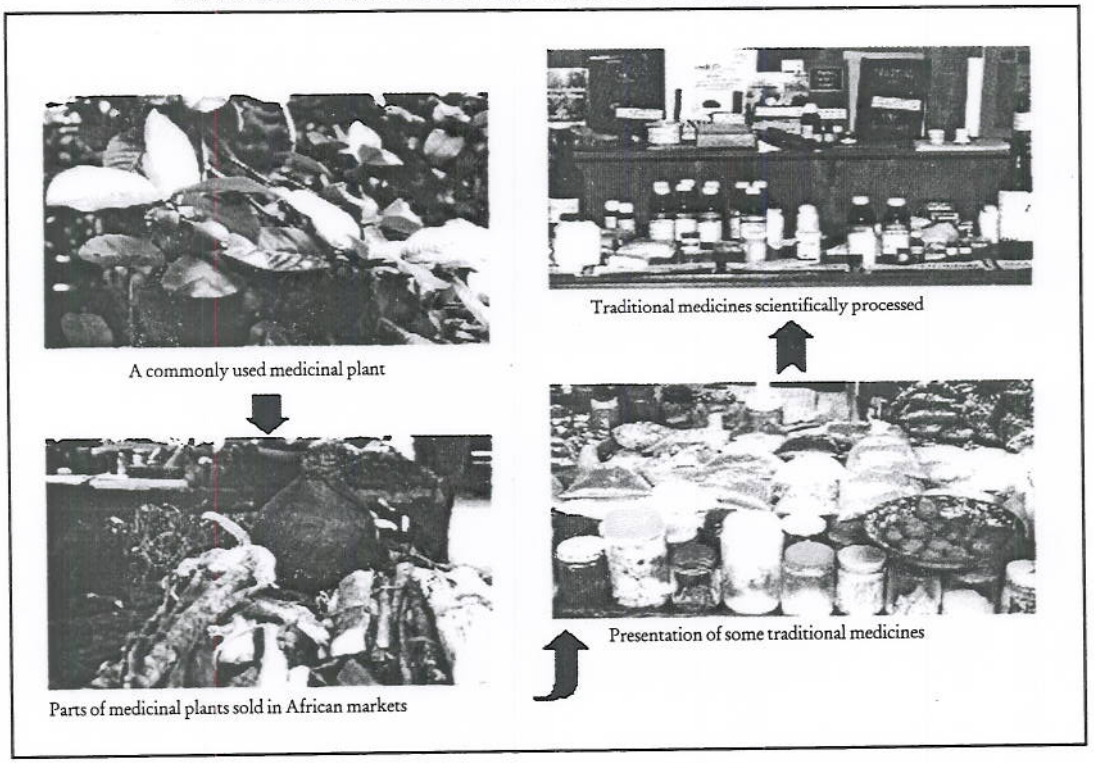
46. In the domain of Essential Drugs, there are four main areas of activity. These are: policy, access, quality and safety, and rational use. Activities carried out included the finalization of the training manual on the management of drugs at the health-centre level.

The second edition of the AFRO Essential Drugs Price Indicator was produced and published jointly with the WHO Collaborating Centre on Quality of Medicines at the University of Potchefstroom in South Africa. The third edition of the brochure on Quality Control Laboratories in the African Region was developed. Training of drug inspectors and laboratory personnel in laboratory management and thin-layer chromatography techniques for screening anti-TB drugs was held in South Africa.

47. Support was given to Guinea-Bissau, Sao Tome and Principe and Seychelles in carrying out situation analyses, leading to the formulation of national drug policies. Botswana, Cameroon, Lesotho, Liberia, Mauritania and Swaziland were also assisted in the process of adopting their national drug policies. Namibia was supported in the selection of national drug policy monitoring indicators. A joint mission with UNAIDS was undertaken to Swaziland to examine the country's access to drugs for HIV/AIDS.

48. Thirty-six participants attended a course on the rational use of drugs organized in Nigeria. Two more courses were conducted, one on rational prescribing, in Algeria, and the other on pharmacotherapy, in South Africa.

FROM MEDICINAL PLANTS TO SCIENTIFICALLY PROCESSED TRADITIONAL MEDICINES

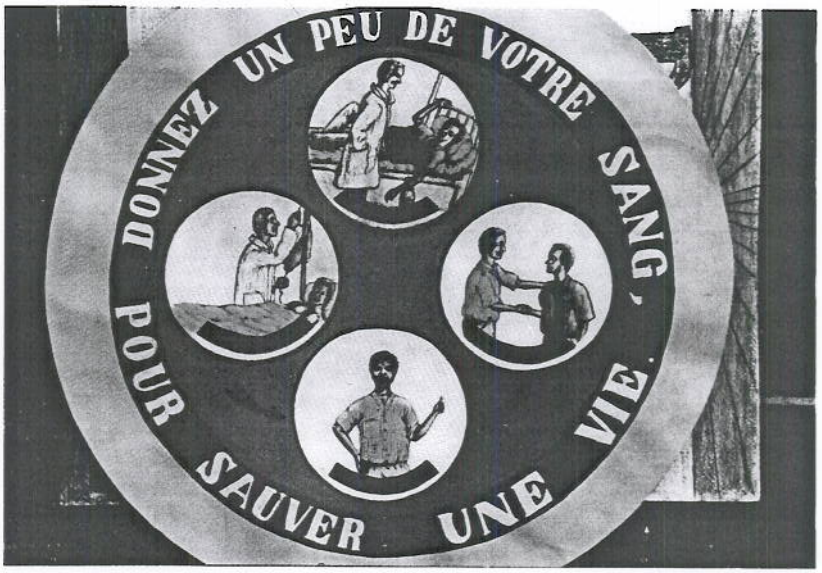


Source: WHO/AFRO- Division of health systems development (Traditional Medicine) 2000

49. The Regional Committee, at its 50th session in 2000, adopted the Regional Strategy on the Role of Traditional Medicines in Health Systems. The strategy was developed after wide consultations with Member countries and an African Forum on traditional medicine. Generic protocols for the evaluation of traditional medicines as well as specific protocols for ethno-medical studies and clinical trials for HIV/AIDS and malaria drugs were finalized and adopted at a workshop held in Antananarivo, Madagascar. Technical support was provided to Namibia and Zambia for the development of legislation on traditional medicines. Support was also provided to Burkina Faso and Zimbabwe for undertaking ethno-medical evidence studies on herbal preparations used for the treatment of HIV/AIDS.

50. The area of Blood safety and clinical technology covers two programmes. These are: Blood safety, and Clinical technology and quality of care. Three workshops were organized in these areas of work: one, on blood safety for directors of national blood transfusion services, in Harare, Zimbabwe; two, on quality assurance in clinical laboratories in Dakar, Senegal; and three, on quality assurance of care, in Kampala, Uganda. Member countries agreed to prepare plans of action for implementing quality assurance programmes.

BLOOD SAFETY: WORLD HEALTH DAY, 7 APRIL 2000 SCHOOLS POSTER COMPETITION WINNER



Source: Kokou Fétiba, a student of Collège Privé "Espoir" in Kara, Togo, was the winner for this poster he designed for a competition held for schools on the occasion of World Health Day, 7 April 2000, which had "Safe Blood Starts with Me" as its theme.

51. Blood safety is an area grossly neglected as shown by the fact that only 16 out of the 46 Member countries have a national blood transfusion policy. Unfortunately, even in those countries where such a policy exists, it is not being fully implemented. In many countries, individual hospitals have set up their own blood banks, and, sometimes, due to lack of a clear policy, patients end up receiving unscreened blood.

52. The regional Strategy on Blood Safety was prepared, and the evaluation tools for the situation analysis of blood safety in Member States were developed. The technical capacity of the National Blood Transfusion Service (NBTS), Harare, was strengthened. This centre hosted the first course on Quality Management for Blood Safety. Algeria and Côte d'Ivoire were provided support to implement distance-learning programmes on blood safety. Angola, Democratic Republic of Congo and Ghana received support to carry out situation analysis and prepare plans of action. Gambia and Swaziland finalized their national policy for blood safety, and Mali and Central African Republic developed and implemented quality assurance programmes with support from the Regional Office. As part of the activities organized to commemorate World Health Day in April 2000, which had as its theme "Safe Blood Starts with Me", the Regional Office organized a poster competition for primary and secondary school children, and produced a video film on safe blood.

53. The Regional Office provided support for the strengthening of laboratory services in Niger and Togo. In response to the need for a tool to guide Member countries in formulating national health care equipment policies, guidelines were finalized which would be ready for distribution during 2001. After a series of intercountry workshops on the subject, guidelines for implementing quality of care programmes in Member countries and evaluation tools for laboratories were developed.

Prevention and control of communicable diseases

54. For the biennial period 2000-2001, and in line with the regional priorities, the programme of the Prevention and control of communicable diseases comprises five areas of work:

(a) Communicable diseases prevention and control (CPC)

(b) Communicable diseases surveillance and response (CSR)

(c) Communicable diseases eradication and elimination (ERD)

(d) Communicable diseases research and development (CDR)

(e) Vaccines and other biologicals (VOB)

55. There are six main disease control programmes under the area of work (AOW) of ***Communicable diseases prevention and control***: HIV/AIDS (RPA); Tuberculosis (TUB); Malaria (MAL); Integrated management of childhood illness (IMCI); Other Tropical diseases (OTD); and Trypanosomiasis (TRY). The AOW of ***Communicable diseases surveillance and response*** includes two programmes: Integrated disease surveillance (IDS) and Emerging and other communicable diseases (EMC). The AOW of ***Communicable diseases eradication and elimination*** comprises: Leprosy elimination programme (LEP); Poliomyelitis eradication (POLIO); Guinea worm eradication (GWE); Onchocerciasis elimination (ONCHO); Neonatal tetanus elimination (NNT), and Lymphatic filariasis (LF).

56. A strategic plan for accelerating support to countries in the context of the International Partnership Against AIDS in Africa (IPAA) was developed, taking due cognizance of the Regional HIV/AIDS and STI programme. Support was provided to the meeting of the OAU ministers of health on HIV/AIDS in Ouagadougou in May 2000. The summit of the OAU heads of state and government in Lomé, Togo, in July 2000, adopted a declaration that provides policy guidance for the acceleration of the response to the HIV/AIDS epidemic in the African Region. A framework for the implementation of the regional HIV/AIDS strategy was developed. It was adopted by the 50th session of the Regional Committee in 2000. Intercountry meetings were held on HIV/AIDS/STI surveillance, STI syndromic case management and laboratory requirements for providing safe antiretroviral therapy and integrated care of HIV and TB. Technical support was provided to Member countries through visits of Regional Office staff and consultants. In Ghana, the WHO Country Office played a catalytic role in the formation of the Ghana AIDS Commission under the chairmanship of the Head of State.

QUOTATIONS ON HIV/AIDS

"Our continent did not have to be devastated by HIV/AIDS like this. We should not have allowed it to get to this stage and we therefore have the responsibility to reverse the situation. I made a conscious effort to be a leader in showing that an HIV diagnosis is not the end of one's life."

Charlotte Mjele, a 22-year-old South African living with HIV/AIDS, at the African Development Forum 2000

"Let us be united and demand comprehensive care packages as antiretrovirals alone are not a magic bullet. Let us be united in negotiating affordable prices for all drugs required in the treatment and care of our people."

His Excellency President Festus Mogae of Botswana at the African Development Forum 2000

"This is a battle for the continent's survival. This is not a policy issue: this is ourselves, our families, our communities, our hopes. And this is our decisive moment."

Mr K.L. Amaoko, Executive Secretary, Economic Commission for Africa, at the African Development Forum 2000

Figure 5: TRENDS IN HIV PREVALENCE IN SUB-SAHARAN AFRICA, 1984 TO 1999

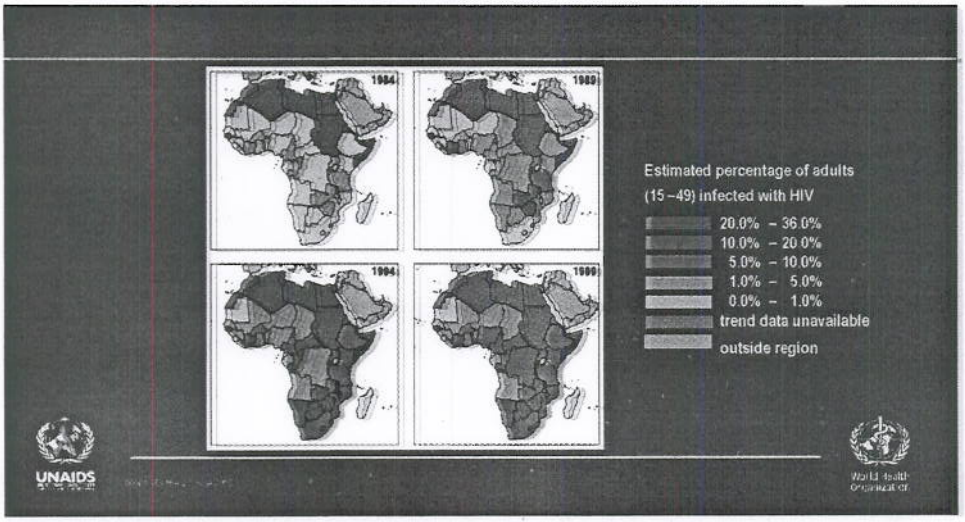
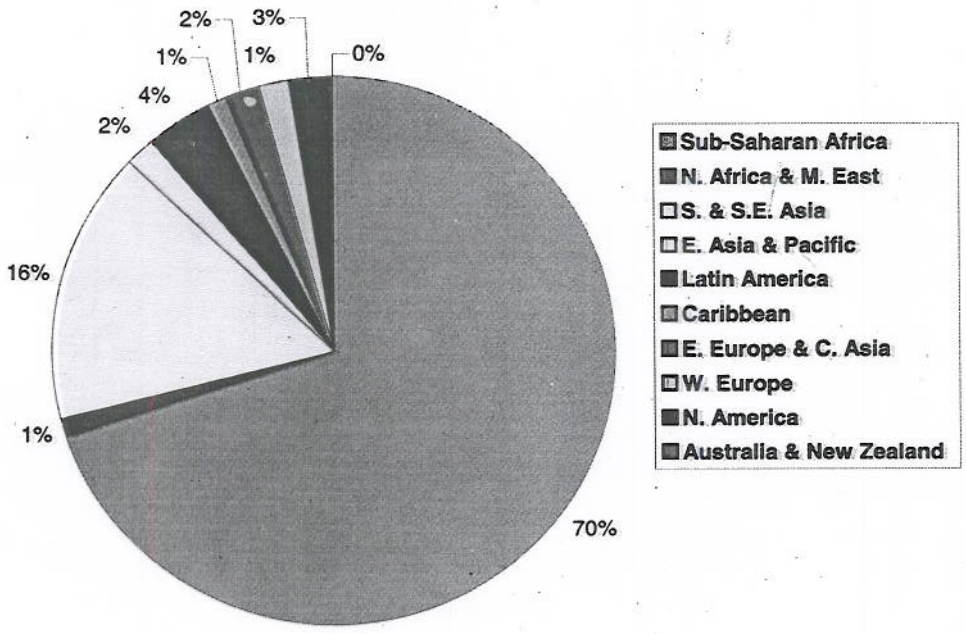


Figure 6: GLOBAL DISTRIBUTION OF PEOPLE LIVING WITH HIV/AIDS, AS AT END 2000 - (TOTAL = 36.1 MILLION)



Source: AIDS Epidemic Update; Dec. 2000, UNAIDS/WHO

57. During 2000, the ***Tuberculosis and buruli ulcer control programme*** achieved the following results:

(a) 55% of the Member countries increased their current directly observed treatment, short course (DOTS) coverage by 50%.

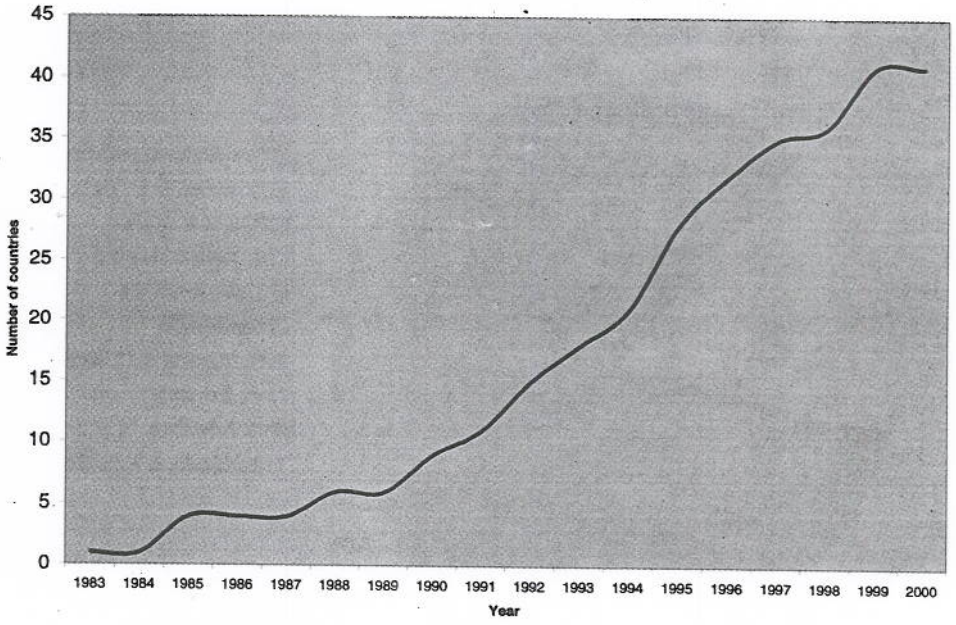
(b) 20% of the Member countries developed plans of action to control the dual epidemics of tuberculosis and HIV/AIDS.

(c) A regional tuberculosis database was created.

(d) The lessons learnt from community tuberculosis care projects directed by the programme are being translated into policy guidelines to incorporate community tuberculosis care into the overall national tuberculosis control programme strategy.

(e) Three-fifths of the affected countries in West Africa developed five-year plans of action for buruli ulcer control.

Figure 7: TREND IN THE NUMBER OF COUNTRIES ADOPTING THE DOTS STRATEGY IN THE WHO AFRICAN REGION (N = 46)

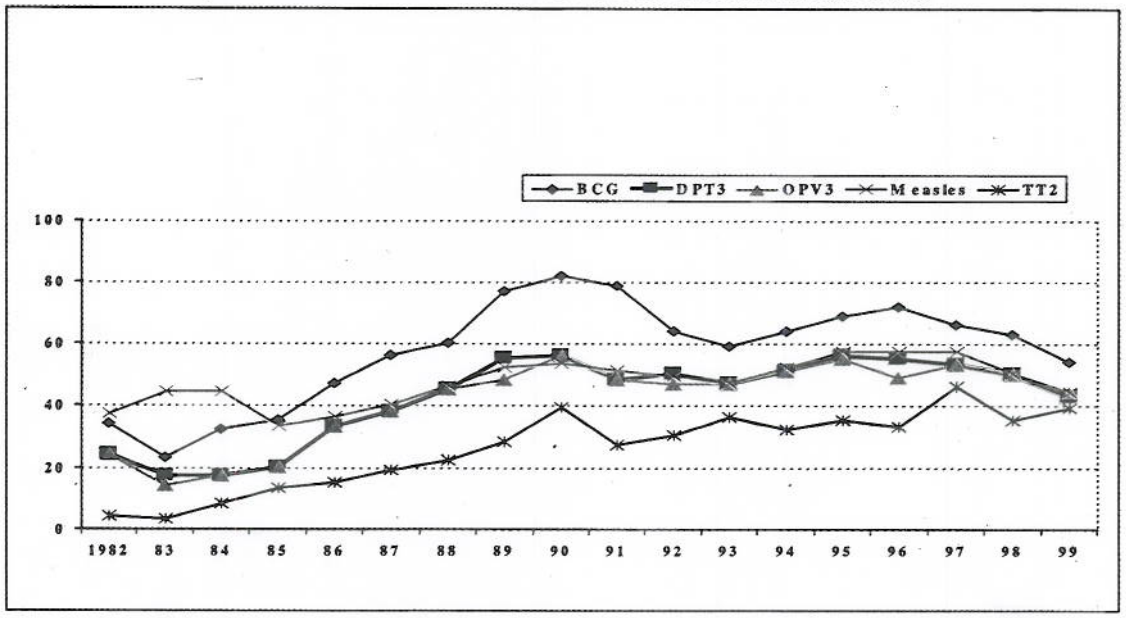


Source: WHO, Global tuberculosis report, 1999

58. The ***Vaccines preventable diseases*** programme ***(VPD)*** finalized the regional five-year strategic plan of action for strengthening routine immunization services in the Region. It developed the five-year regional plan of action for maternal and neonatal tetanus elimination,

and produced a document on the accelerated control and elimination of measles which was discussed with partners at the 8th meeting of the Task Force on Immunization. Transport management support was provided to five Member countries. Injection safety exercises were carried out in nine countries, and training in vaccine management was conducted in countries in the West and Central Africa. Technical support was provided to seven countries to assess their immunization systems. As part of programme support, 13 countries in the Region qualified for the grant of GAVI/Global Fund for Children's Vaccines, with the introduction of new vaccines in nine of those countries.

Figure 8: IMMUNIZATION COVERAGE WITH EPI VACCINES AFRICAN REGION, 1982-1999

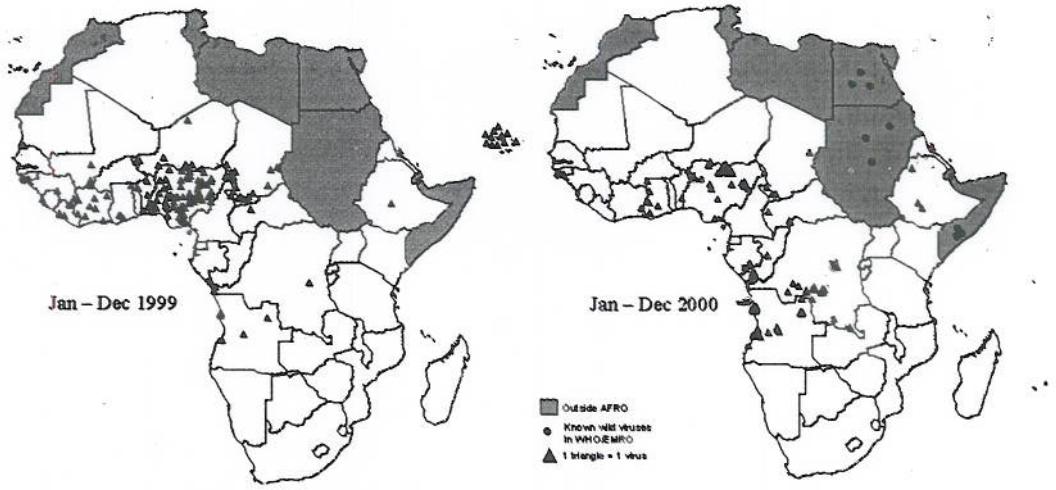


Source: WHO/AFRO, 2000

59. A breakdown of the immunization coverage by epidemiological bloc shows that some countries, especially Nigeria and those considered to be facing difficult circumstances, are pulling down the Regional level of the coverage. A part of the global effort towards polio eradication was the strategy of national immunization days which is contributing significantly to increase the vaccination coverage in the Region.

60. Surveillance of acute flaccid paralysis (AFP) and poliomyelitis has improved, leading to an increased detection of cases (Ghana, Ethiopia, DRC, Angola, Cape Verde). Polio control has also improved (Chad, Côte d'Ivoire) and support should be maintained to sustain these results.

Figure 9: WILD POLIOVIRUS IN AFRICA, 1999-2000



Source: WHO/AFRO, 2000

61. During 2000, the programme of Integrated management of childhood illness (IMCI) supported 10 Member countries in the initiation of IMCI implementation, bringing the number of countries that have adopted the strategy to 37. Implementation was accelerated in eight countries, with innovative approaches towards capacity-building, including 'contracting out' of training and using NGOs/PVOs. In order to establish sustainability, IMCI was introduced into pre-service training in five more countries and studies were completed on referral and caretaker compliance. The results of these studies are being used to develop strategies to improve the health systems. An intercountry orientation meeting for lusophone countries was held, which was followed by the training of lusophone consultants on IMCI. These add to the pool of Regional consultants who would be able to assist countries in the Region.

62. In view of the increasing incidence of HIV/AIDS in young children resulting from mother-to-child transmission, promotion of breast-feeding and HIV/infant feeding counselling have been included in the IMCI programme. Collaboration with partners was enhanced, particularly in regard to the implementation of the community component, which has been introduced in 23 Member countries. Close collaboration with the Roll Back Malaria (RBM) programme was continued with the adoption of a framework for collaboration, scaling-up of implementation and holding of a Joint Task Force meeting.

"Even though exclusive breast-feeding remains the best feeding option for most infants irrespective of the mother's HIV status, women infected with HIV need sufficient information to make informed choices on how to feed their infants."

Regional Consultation on HIV/AIDS, Durban, August 2000

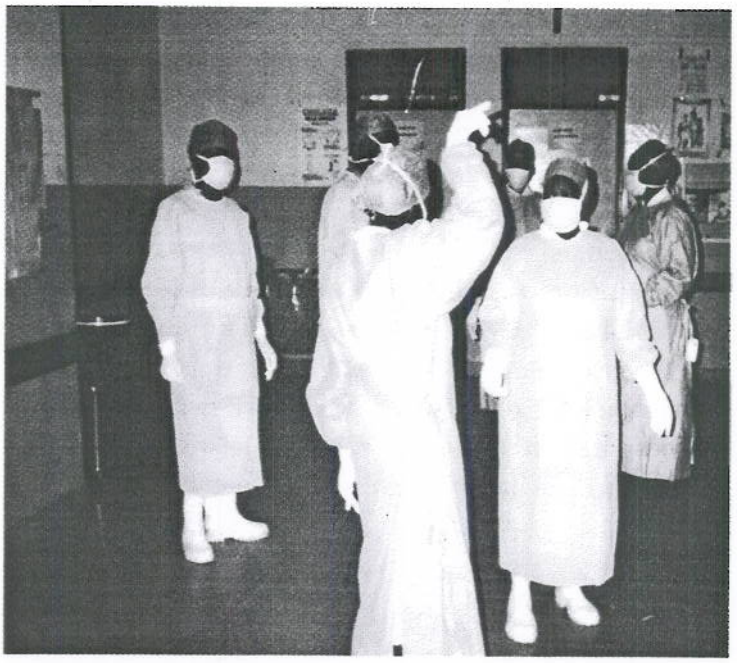
63. The control of malaria is a top priority in the African Region. During the year, the Malaria Control Programme developed a Framework for the Implementation of Roll Back Malaria in the African Region, which was adopted by the Regional Committee at its 50th session. Thirty countries were supported in the implementation of the RBM activities. Guidelines and data collection tools for the monitoring and evaluation of RBM in the Region were finalized for use at country level. The promotion and use of insecticide-treated materials was supported in 11 countries. Nineteen participants were trained in the monitoring and management of vector resistance. A guide to accelerate the implementation of RBM at the district level and a framework for the promotion and implementation of community-based interventions for malaria control were developed. Frameworks for collaboration between IMCI and RBM at country level and for scaling-up the implementation of the two programmes were developed. One hundred and eight sentinel sites for monitoring the efficacy of first-line antimalarial drugs were established in 37 Member countries. Three intercountry courses to strengthen national capacity on malariology and planning of malaria control were organized where 74 participants from 26 countries were trained.

ABUJA SUMMIT ON ROLL BACK MALARIA, APRIL 2000
THE COMMITMENT OF AFRICAN HEADS OF STATE/GOVERNMENT

The Heads of State and Government of African countries, meeting in Abuja, Nigeria, on 25 April 2000 have resolved to initiate appropriate and sustainable action to strengthen the health systems to ensure that, by the year 2005, at least 60% of those suffering from malaria have prompt access to and are able to use correct, affordable and appropriate treatment within 24 hours of the onset of symptoms; at least 60% of those at risk of malaria, particularly pregnant women and children under five years of age, benefit from the most suitable combination of personal and community protective measures such as insecticide-treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering; and at least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment.

64. Under the ***Other tropical diseases programme***, a draft regional strategy for the control of schistosomiasis in the African Region was developed. The process of the development of the regional strategy for the elimination of lymphatic filariasis was started. A workshop on lymphatic filariasis mapping method was conducted in collaboration with headquarters and 27 officials from seven Member countries were trained.

65. An assessment of national epidemic preparedness and response systems was initiated in 21 countries with support from the programme on Emerging and other communicable diseases. Of these countries, 11 have formulated national plans of action. In order to help countries implement their national plans, generic guidelines were prepared.



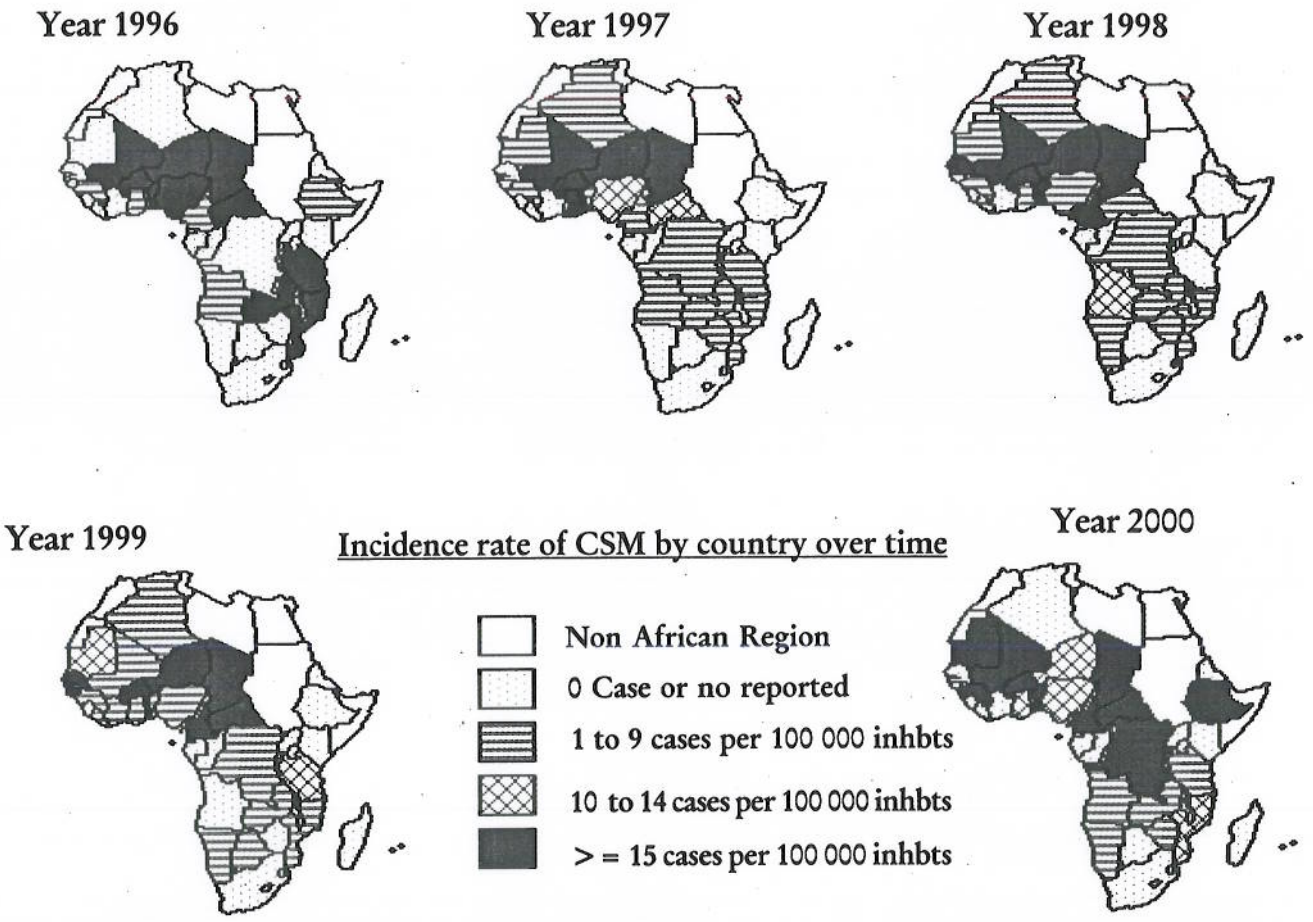
Source: WHO Annual Report 2000 (Uganda)

66. The presence of the intercountry technical support teams was sustained in the five epidemiological blocs in the Region. These teams, as well as staff from the Regional Office, provided timely technical support to the countries which faced major outbreaks or epidemics, such as cholera and *Ebola* haemorrhagic fever.

67. Data collected during 1996-2000 indicated a southward decline of the meningitis belt. However, evidence gathered in some countries indicated a reduction in the magnitude of the cerebrospinal meningitis (CSM) epidemics in the African Region as a whole and in one country (Burkina Faso) which is given as an example (*Figures 10 and 11*).

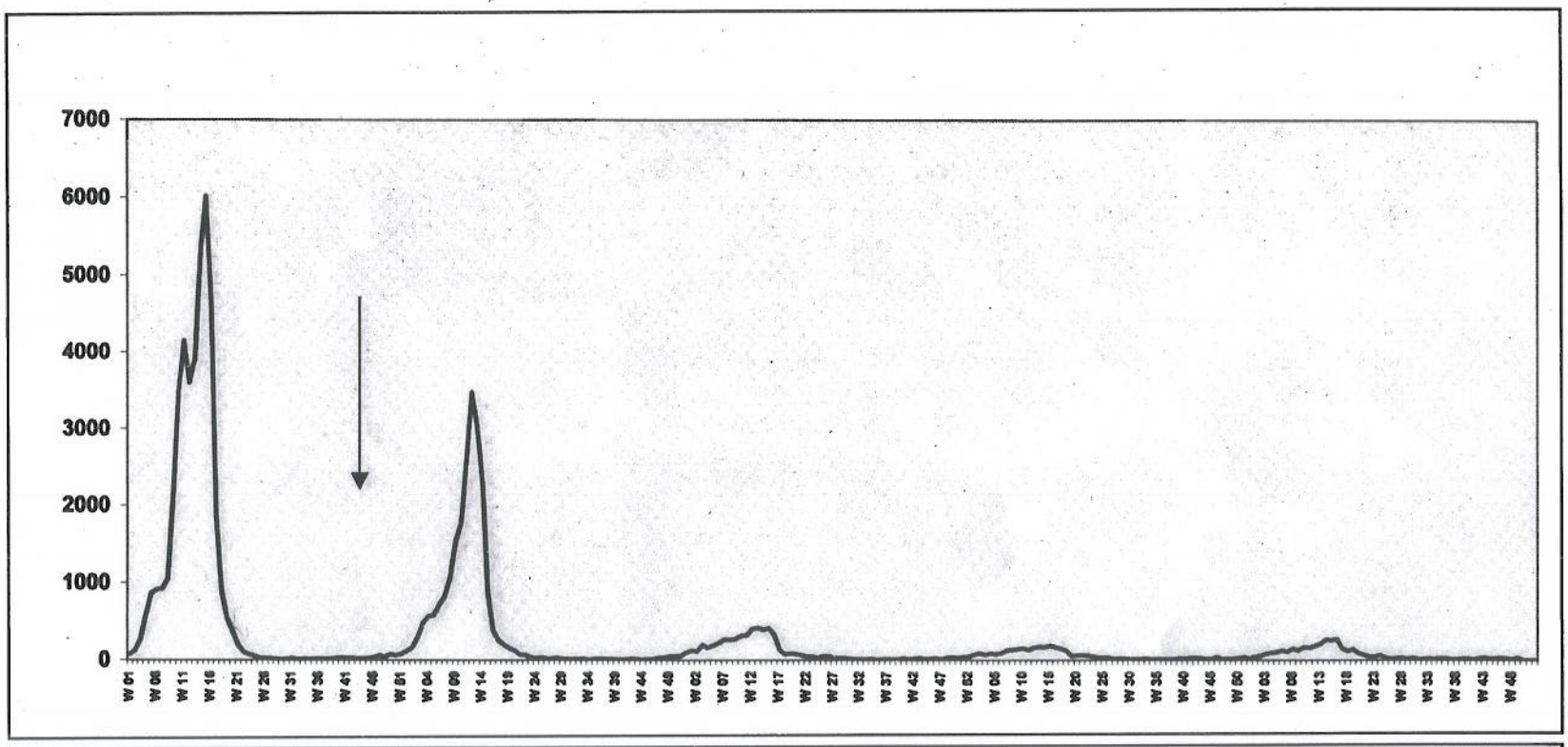
68. During the same period, cholera appeared to be taking on endemic features in areas with equatorial climate and in southern Africa and the Great Lakes countries, as well as Madagascar and Comoros (*Figure 12*). Efforts are being made to reverse this situation.

Figure 10: INCIDENCE OF MENINGITIS IN THE AFRICAN REGION AS REPORTED TO WHO, 1996-2000



Source: Ministries of health

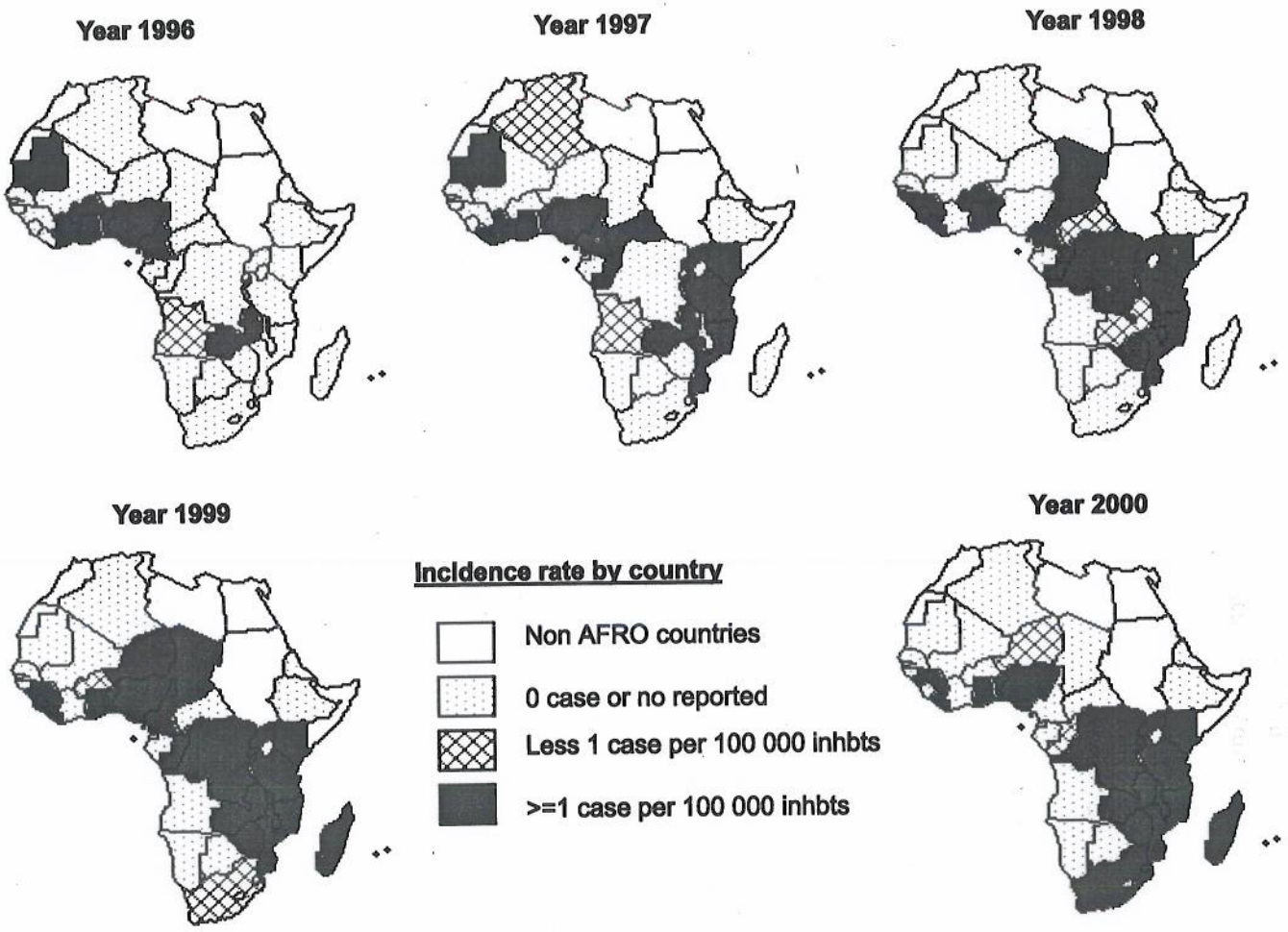
Figure 11: CSM TRENDS IN BURKINA FASO AS REPORTED TO WHO FROM 1996 TO 2000



Cerebrospinal meningitis peaks around the 14th week every year. Notice the dramatic decline of the magnitude of these seasonnal epidemics: among other causes such as the herd immunity that followed the epidemic years (1996-1997) and the mass vaccination campaigns, the WHO backed August 1996 protocol of health cooperation may have contributed to this decline. Efforts should be made to sustain this decline.

Source: Ministries of health

Figure 12: INCIDENCE OF CHOLERA IN THE AFRICAN REGION AS REPORTED TO WHO, 1996-2000

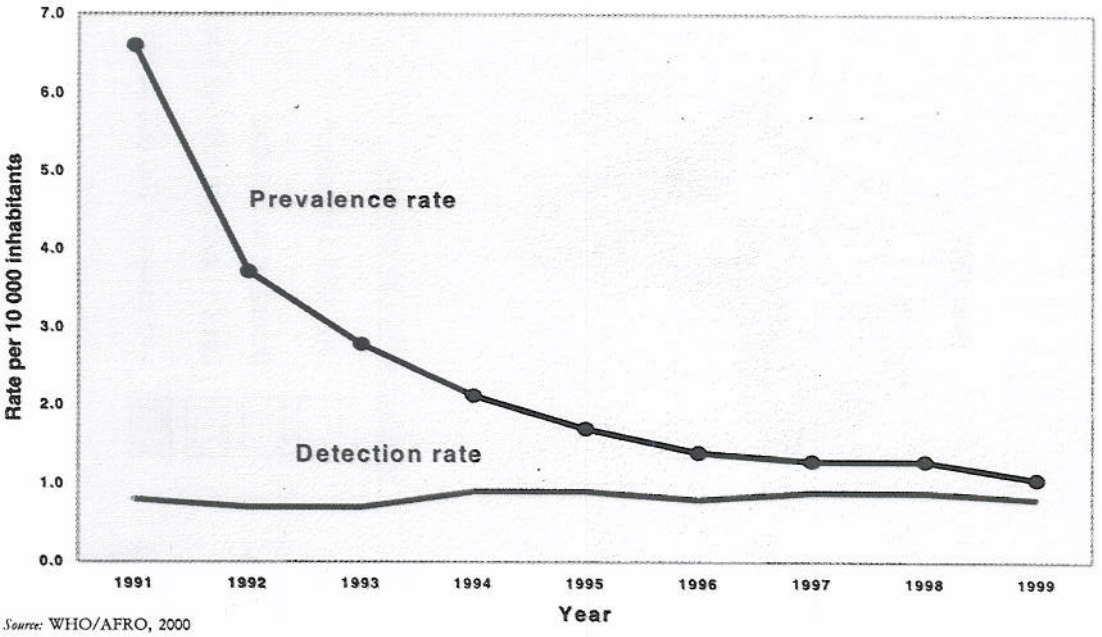


Source: Mini

69. Major achievements were made by the programme on Integrated disease surveillance (IDS) which will result in effective implementation of the IDS strategy at country level. Seventeen countries were supported in carrying out an assessment of their surveillance systems, and technical guidelines were developed for use in Member countries. Training material and adaptation guidelines are now being developed. At the regional level, a database on priority communicable diseases has been set up and an epidemiological bulletin is regularly being produced. The IDS team at the Regional Office was strengthened during the year. Technical support to countries was provided through WHO staff and consultant missions.

70. The ***Leprosy elimination programme (LEP)*** supported effective interventions to eliminate leprosy in the African Region. Hence, the prevalence and incidence of the disease was sharply on the decline.

Figure 13: LEPROSY PREVALENCE AND DETECTION RATES AS REPORTED TO WHO IN THE AFRICAN REGION, 1991-1999



Source: WHO/AFRO, 2000

71. The leprosy programme at the Regional Office carried out 14 evaluation, monitoring or assessment missions in Member countries during the year. Six national programme meetings, five follow-up meetings, five national programme reviews, four planning programmes and one training programme were conducted to support national teams. Seven leprosy elimination campaigns, three treatment trial projects and one national training course were financially supported. Seven national programme officers also received financial support for undertaking managerial activities. Twenty Member countries requested multidrug therapy (MDT) medicines from WHO which were supplied. At the end of 1999:

(a) the prevalence of leprosy had been reduced from 82 022 cases (1.2/10 000 pop.) to 67 526 cases (1.06/10 000 pop.);

(b) annual case detection had decreased from 56 521 new cases to 51 963 new cases; this reduction was not significant, but considering the case-finding activities implemented through SAPEL projects and leprosy campaigns, this decrease revealed a progressive control of the disease in communities; and

(c) the number of countries where the elimination goal had been achieved increased from 26 to 31.

72. The ***Guinea worm eradication*** programme ***(GWE)*** supported 12 countries during the year. From January to September, the overall disease incidence in the Region was reduced by 24%: 17 290 cases reported in 2000 as compared to 22 852 cases during 1999. Countries which interrupted the transmission of the disease (Cameroon, Chad, Kenya, Senegal) - as evidenced by their maintaining the "zero indigenous case" level - were provided WHO technical assistance to initiate or pursue eradication certification activities. Out of the nine countries in the Region that applied for guinea worm eradication certification to the International Certification Commission, four have been certified. Thus, efforts towards the eradication of this disease should be maintained. The WHO country office in Ghana facilitated the formation of an interagency committee on guinea worm to revamp the guinea worm eradication efforts in the country.

Prevention and control of noncommunicable diseases

73. Advocacy for the ***Surveillance of noncommunicable diseases (NCDs)*** was initiated through the organization of two intensive intercountry courses on the epidemiology and surveillance of diabetes to serve as an example of the public health concern for a noncommunicable disease. The two courses were organized in Uganda (for English-speaking countries) and in Benin (for French-speaking countries).

NONCOMMUNICABLE DISEASES IN THE AFRICAN REGION

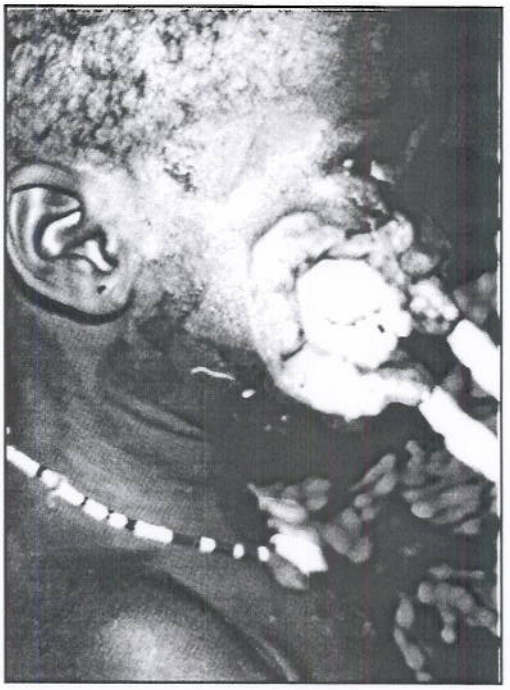
Cardiovascular diseases and diabetes, together with cancer, constitute the most prevalent noncommunicable diseases. Therefore they pose an increasingly serious threat to public health. High blood pressure is the most important and frequent risk factor for heart disease, accounting for more than 20 million patients in the Region. With adequate case management, at least 250 000 deaths could be prevented. Hypertension is also a major cause of cerebrovascular injuries that are among the principal causes of disability. Rheumatic heart disease remains prevalent (up to 15 per 100 000 among children) despite the availability of efficacious and inexpensive preventive measures. Cancer of the cervix in women and of the liver in men (and Kaposi sarcoma in areas of high prevalence of HIV/AIDS) are the most important cancers in the Region and are, at least, in part, avoidable through prevention.

74. In addition, the Regional Office contributed to the process of development of a methodology for the preparation of a global report on the risk factors of NCDs, which would be finalized in 2002.

75. In the coming years, special attention will be accorded to the implementation of simplified surveillance systems for the most common NCDs (cardiovascular diseases, diabetes and cancer) and their risk factors in order to measure their effectiveness in terms of prevention and management. In real terms, it will entail supporting countries to establish programmes for the early screening and treatment of hypertension and cervical cancer and strengthening of the WHO programme on the control of rheumatic fever/rheumatic heart disease.

76. As part of the activities for the preparation of a community-based integrated approach to the prevention of NCDs in the Region, a systematic approach to collect the existing data in the countries was started in the 2000 and is continuing.

77. Some countries such as Ghana, Nigeria and Zimbabwe were supported in the organization of activities for the prevention of noncommunicable diseases. Partnership with other WHO regions and stakeholders, including the European Union, was increased in the area of NCDs and should be producing results in terms of strengthened capacities to support the countries. Increased collaboration with the International Agency for Research on Cancer (IARC) enabled the organization of a training workshop on the prevention and screening of cervical cancer and the sponsoring of experts from Burkina Faso, Congo, Guinea and Niger for training in cancer registration methods.



Source: Noma Children Hospital, Sokoto, Nigeria

Noma (Cancrum oris) is a severe gangrene that eats away both soft and hard tissues of the mouth and face of mainly children aged 2-16 in sub-Saharan Africa. In January 2001, management and implementation of Noma activities were transferred from HQ to AFRO.

78. Concerning the ***management of NCDs***, important recommendations were made by the Regional Committee through the adoption, in 2000, of the Regional Strategy for the Control of Noncommunicable Diseases. Some countries have already requested from the Regional Office support for the actual implementation of these recommendations. The development of oral health policies and programmes was continued through technical and financial support that was provided to some Member countries (Burundi, Cote d'Ivoire, Guinea-Bissau, Rwanda, Seychelles, Swaziland).

79. The WHO collaborating centres for ***oral health*** in the Region were more involved than ever before. Their contribution in terms of research skills, especially in traditional practices in oral hygiene and in the development of guides and other documents, added to the strengthened capacities to support all Member countries. Special emphasis was placed on noma, the activities for which have been fully managed by the Regional Office since the end of 2000.

80. Collaboration was initiated with HelpAge International, an NGO, and the Organization of African Unity (OAU) in order to establish a structure for the development of national policies on aging in Africa. Increased collaboration with headquarters led to the implementation of a research protocol on the development of a set of minimum data that would provide information on aging and the situation of the elderly in a given country. This research is being continued in four Member countries, namely, Ghana, South Africa, Tanzania and Zimbabwe.

81. The ***Nutrition for health and development (NHD)*** programme supported four countries (Benin, Burkina Faso, Mali, Togo) in the conduct of studies on iodine deficiency. The African Task Force on Micronutrient Deficiency that had met at the end of 1999 had examined the progress made in this area. Many surveys have shown a reduction in iodine deficiency and increased availability of iodized salt. In all Member countries, vitamin A coverage among the under-fives is assured through national immunization days into which the distribution of vitamin A capsules has been integrated. Concerning baby-and-young-child feeding, training of trainers for the implementation of national breast-feeding policies was organized for the five Portuguese-speaking countries (Angola, Cape Verde, Guinea-Bissau, Mozambique and Sao Tome and Principe) and Equatorial Guinea.

82. The follow-up of the International Conference on Nutrition (ICN) was continued through the organization of an intercountry workshop that brought together French-speaking countries; an identical workshop has been planned for 2001 for English-speaking countries. A progress report on the implementation of national plans of action will be prepared following this meeting. Finally, the Regional Office provided technical and financial support to Mozambique for tackling the consequences on nutrition of the February 2000 floods.

83. The activities relating to ***Health promotion (HPR)*** were undertaken in a spirit of inter-divisional and inter-programme collaboration. The programme is designed as a tool to support the priority areas of work of the Regional Office. A regional strategy has been prepared for submission to the current (51st) session of the Regional Committee. The capacity of the national focal points for health promotion programmes in 17 countries (Algeria, Angola, Benin, Burundi, Gabon, Ghana, Guinea, Kenya, Mauritius, Mozambique, Namibia, Uganda, Senegal, South Africa, Swaziland, Togo and Zambia) was strengthened through an intercountry workshop.

84. The "Healthy Schools" initiative was strengthened at the national level and subregional networking of its components was encouraged through two subregional consultations that brought together 15 countries (Benin, Burundi, Gambia, Ghana, Kenya, Madagascar, Malawi, Mauritius, Mauritania, Namibia, Seychelles, South Africa, Swaziland, Chad and Togo). The Regional Office is contributing actively to the conceptualization and development of health promotion at different international forums.

85. Despite insufficient financial and human resources, the programme on ***Disability prevention and rehabilitation (DPR)*** supported the launch, in the Region, of the Global Vision 2020 Initiative on Prevention of Avoidable Blindness. Mauritania was supported for the development of a programme on the prevention of avoidable blindness, and Angola was supported for the implementation of a trauma prevention and control programme.

86. ***Mental health (MEH)*** is one of the global priorities and constitutes a priority area of work in the 2000-2001 Programme Budget and the WHO Corporate Strategy. The recommendations of the Regional Strategy on Mental Health were widely disseminated through various activities, including some intercountry workshops of coordinators of national mental health programmes and focal points of WHO country offices, NGOs, WHO collaborating centres and other partners. Direct technical and financial support was provided to some countries (Benin, Burundi, Equatorial Guinea, Ghana, Liberia, Madagascar, Mauritania, Mozambique, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Zimbabwe) for the development of mental health policies and programmes.

AFR/RC49/R3: REGIONAL STRATEGY FOR MENTAL HEALTH (EXTRACT)

The Regional Committee,
Aware of the magnitude and the public health importance of mental, neurological and psychosocial problems which have been aggravated by the stigma attached to them; (...)

Recognizing the need to review existing approaches in this area and develop a comprehensive strategic framework for mental health and the prevention and control of substance abuse in the countries of the African Region; (...)

REQUESTS the Regional Director:

(i) to provide technical support to Member States for the development of national policies and programmes on mental health and the prevention and control of substance abuse as well as elaboration or revision of mental health legislation;
(ii) to take appropriate measures to enhance WHO's capacity to provide timely and effective technical support, at regional and country levels, to national programmes on mental health and the prevention and control of substance abuse;
(iii) to increase support for the training of health professionals in mental health at different levels of the health system and promote the use of traditional medicine within the context of African realities; ...

87. Under the auspices of the Global Campaign against Epilepsy, representatives from the health and social sciences sectors of the countries of the Region adopted the African Declaration on Epilepsy in Dakar, Senegal, in May 2000.

88. An expert group was set up to assist Member countries in the implementation of the Regional Strategy on Mental Health. An inter-divisional working group was put in place for the preparation of World Health Day 2001, devoted to mental health. Technical and financial support was given to all Member States to prepare and commemorate the Day, the theme of which was "Stop Exclusion - Dare to Care". Systematic interaction with the countries enabled the collection of relevant data that would contribute to the preparation of the World Health Report 2001.

89. The ***Substance abuse (SAB)*** programme includes the Tobacco-Free Initiative (TFI). Advocacy and information activities of the Regional Office targeted national as well as WHO country office focal points responsible for tobacco control programmes and the programmes for the prevention and control of substance abuse.

90. Financial and technical support was given to Member countries for the commemoration of international days (World No-Tobacco Day on 31 May and International Day Against Illicit Trafficking and Drug Abuse on 26 June). Collaboration with parliaments and NGOs has been established to strengthen the development of tobacco control policies and to assist countries to contribute to the preparatory work on the Framework Convention for Tobacco Control.

AFRICAN DECLARATION ON EPILEPSY
DAKAR, 6 MAY 2000

Professionals from health and social sciences sectors and representatives from the universities of the countries of the African Region unanimously agree to the following declaration:

Considering that:

- *Epilepsy is the most common and serious chronic brain disorder, estimated to affect at least 50 million people in the world, 10 million of them in Africa...*
- *All people with epilepsy can be effectively and inexpensively treated,...*
- *Epilepsy has serious physical, psychological and social consequences for the afflicted and their families,...*
- *In Africa, preventable causes of epilepsy are more frequent than elsewhere, including infectious diseases, head trauma, insufficient perinatal care and consanguinity...*

We proclaim the following:

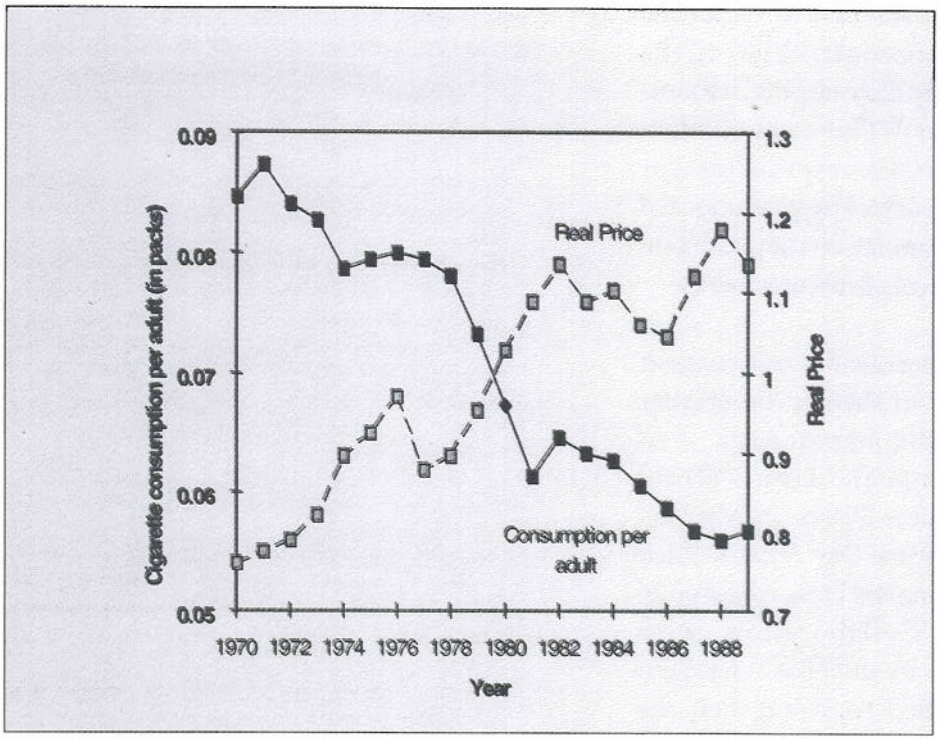
Epilepsy is a health care priority in Africa, requiring every government to develop a national plan to:

- *Address the needs with respect to epilepsy in terms of access to trained personnel, modern diagnostic equipment, anti-epileptic medication...information, prevention and social integration;*
- *Educate and train health care and other relevant professionals about epilepsy;*
- *Encourage incorporation of prevention and treatment of epilepsy in national plans for other health care issues such as maternal and child care, mental health,... community-based rehabilitation programmes;*
- *Promote interaction with traditional health systems;*
- *Proclaim a national Epilepsy Day.*

The Global Campaign Against Epilepsy is under the aegis of the World Health Organization (WHO), the International League Against Epilepsy (ILAE), and the International Bureau for Epilepsy (IBE).

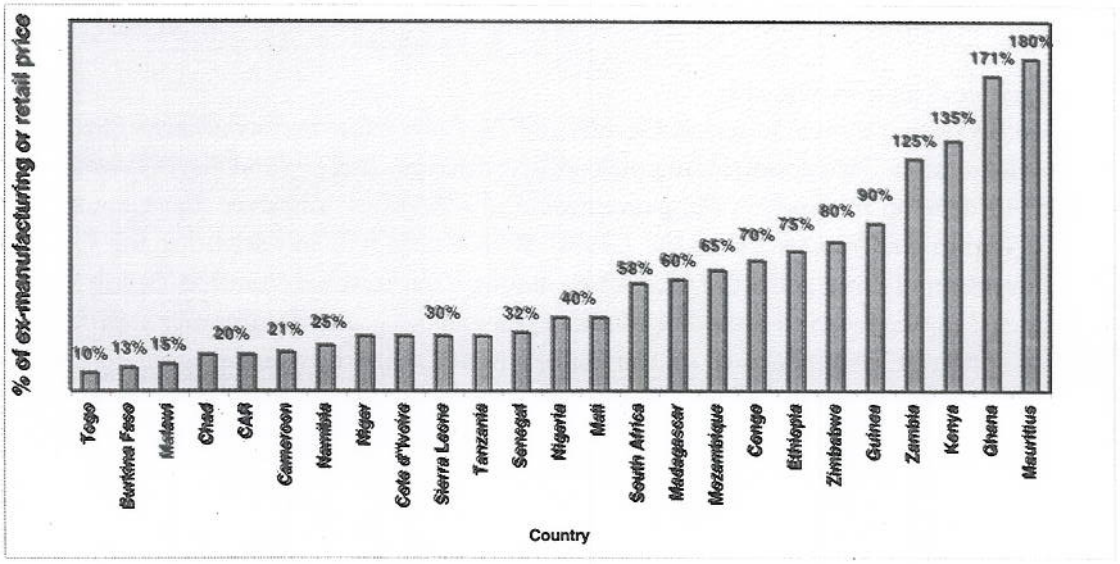
91. Technical support was also given to Botswana, Kenya, Lesotho, Uganda and Zimbabwe for the formulation of tobacco control legislation. Two countries in post-conflict situations (Liberia and Sierra Leone) were assisted to develop projects on the prevention and control of substance abuse among the youth. Within the framework of the Global WHO/UNDCP Initiative for the Control and Prevention of Drug and Substance Abuse among Youths, three countries (South Africa, Tanzania, Zambia) received assistance to put in place an integrated community approach for the prevention of, and reduction in, the use of narcotic drugs by youths.

Figure 14: REAL PRICE OF CIGARETTES AND THE ANNUAL CIGARETTE CONSUMPTION PER ADULT IN SOUTH AFRICA, 1970-1989



Source: The World Bank, Curbing the Epidemic, Governments and Economics of Tobacco Control, 1999

Figure 15: RATES OF EXCISE TAX ON CIGARETTES IN SELECTED COUNTRIES IN AFRICA



Source: The World Bank, Curbing the Epidemic, Governments and Economics of Tobacco Control, 1999

Family and reproductive health

92. Almost all Member States in the African Region have embarked on the path of improving the reproductive health of their populations. The Regional Office, therefore, identified the needs to be addressed in the development of regional and national reproductive health programmes. These are listed in the box below.

93. One of the major achievements of the ***Reproductive health and research (RHR)*** area of work consisted of adding 14 African experts to the existing panel of 12 for the rapid implementation of the reproductive health strategy for the African Region. As a multidisciplinary professional group, their services will be utilized as consultants for facilitating the process of developing reproductive health activities in their own countries and elsewhere.

REPRODUCTIVE HEALTH DEVELOPMENT NEEDS

- *Introduction of the reproductive health concept in all countries through a multisectoral approach;*
- *Provision of comprehensive services that are of good quality, equitably accessible, affordable and appropriate to the needs of individuals, families, and communities, especially under-served groups;*
- *Reorientation of planning processes for a more pragmatic and participatory approach to the identification of problems, needs and interventions;*
- *Removal of all forms of barrier to reproductive health, such as political, legal, socio-economic, cultural, behavioural or gender-based barriers;*
- *Improving the knowledge and skills of all people for the purpose of establishing responsible relationships and parenthood so as to enhance their ability to promote their own health;*
- *Establishing an enabling environment for service providers;*
- *Recognizing and supporting the roles of professional bodies;*
- *Enhancing the institutional capacity of the national health system to adequately address reproductive health needs.*

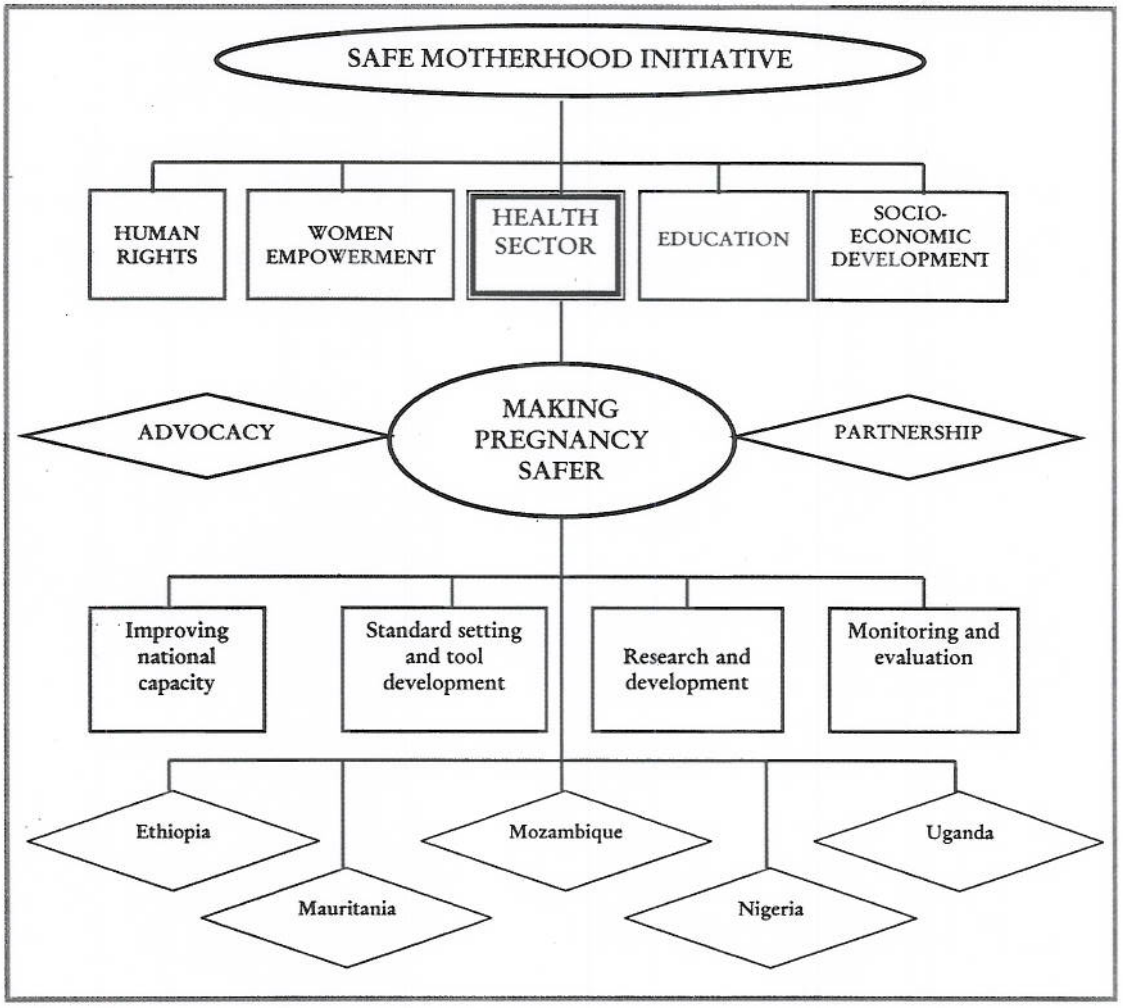
AFR/RC47/8

94. Technical and financial support was provided to Burundi, Central African Republic, Liberia and Sao Tome and Principe to initiate their safe motherhood needs assessment exercise. Support was also given to other countries to complete such exercise. Burkina Faso, Gabon, Gambia and Senegal were supported in the introduction of the Mother-Baby Package at the district level and in the development of a national reproductive health programme.

95. A feasibility study of the Regional Centre for Training and Research in Family and Reproductive Health in Kigali, Rwanda, was undertaken by a consultant team from the John Hopkins Programme on International Education in Gynaecology and Obstetrics (JHPIEGO) to study a proposal for establishing a high-profile reference centre for reproductive health, which will have the following components: (i) training; (ii) research and development; (iii) quality reproductive health services; and (iv) consultation services. This would include development of a framework for strategic planning detailing the conditions and resources required for the Kigali centre to become functional in terms of training, research capabilities as well as fund-raising for self-sufficiency. A draft report by the consultant team has suggested a phased approach, starting on a small scale, for meeting local needs for a transitional period of two to three years, and then expanding the centre gradually.

96. In its initial phase (2000-2001), the ***Making pregnancy safer (MPS)*** initiative had targeted five Member countries: Ethiopia, Mauritania, Mozambique, Nigeria and Uganda. A joint meeting took place in November 2000 between the Regional Office and headquarters staff and representatives from selected MPS countries. This led to the development of a plan of action for each country. In the context of the MPS initiative, a joint WHO Regional Office and headquarters preparatory mission was undertaken in Mauritania to coincide with the ongoing work on health sector reform, in order to develop a national strategy for reducing maternal morbidity and mortality.

Figure 16: MAKING PREGNANCY SAFER



Source: WHO/AFRO, 2000

97. Technical Discussions at the 50th session of the Regional Committee identified a wide range of factors that contribute to the increase or reduction in maternal mortality. The following six major regional priority interventions were proposed:

(a) Emergency obstetric care, training, retraining and quality of care;

(b) Community involvement from the beginning to ensure ownership, sustainability and effectiveness;

(c) Information gathering to ensure evidence-based interventions;

(d) Maternal death audit at community level and at different levels of health care and research to improve performance;

(e) Male involvement in all activities; and

(f) Elimination of the "three delays" (listed below) implying functional referral systems, backed by radio communication:

ELIMINATION OF THE "THREE DELAYS"	
The three delays	**Strategies**
1. Delay in perception of the maternal problem	• Creating or reinforcing community awareness and participation on the need for emergency care
2. Delay in referral of maternity cases	• Improving referral facilities
3. Delay in instituting effective and efficient emergency obstetric care	• Providing quality emergency care

98. With regard to prevention and care in HIV/AIDS, the following activities were undertaken:

(a) clinical guides on HIV management in maternity settings were reviewed and plans developed for field-testing and capacity-building at country level;

(b) the strategic framework for the implementation of projects on the prevention of mother-to-child transmission of HIV was revised to include the latest scientific and programmatic evidence;

(c) models for psychosocial support to HIV-infected pregnant women and their families were developed, and the first demonstration project was implemented in Zimbabwe; and

(d) participants from five Member countries were trained in the use of mass media for the education and promotion of family and reproductive health and prevention of HIV/AIDS.

99. The progress made in the area of ***Child and adolescent health (CAH)*** was very rewarding. The main achievements were in the field of reduction and prevention of newborn mortality. Tools were developed and adapted for use in the assessment of the capacity of health facilities to manage and care for the newborn. A schedule was drawn up for field visits to conduct the assessments in Burundi, Ethiopia, Mauritania, Mozambique, Namibia, Nigeria, Swaziland and Uganda. This activity was undertaken in collaboration with the MPS programme.

100. With regard to newborn care and management, Burundi and Swaziland requested an assessment of the quality of care and management of the newborn in their plans of action. Angola developed a national children's health programme and trained 25 personnel in child health.

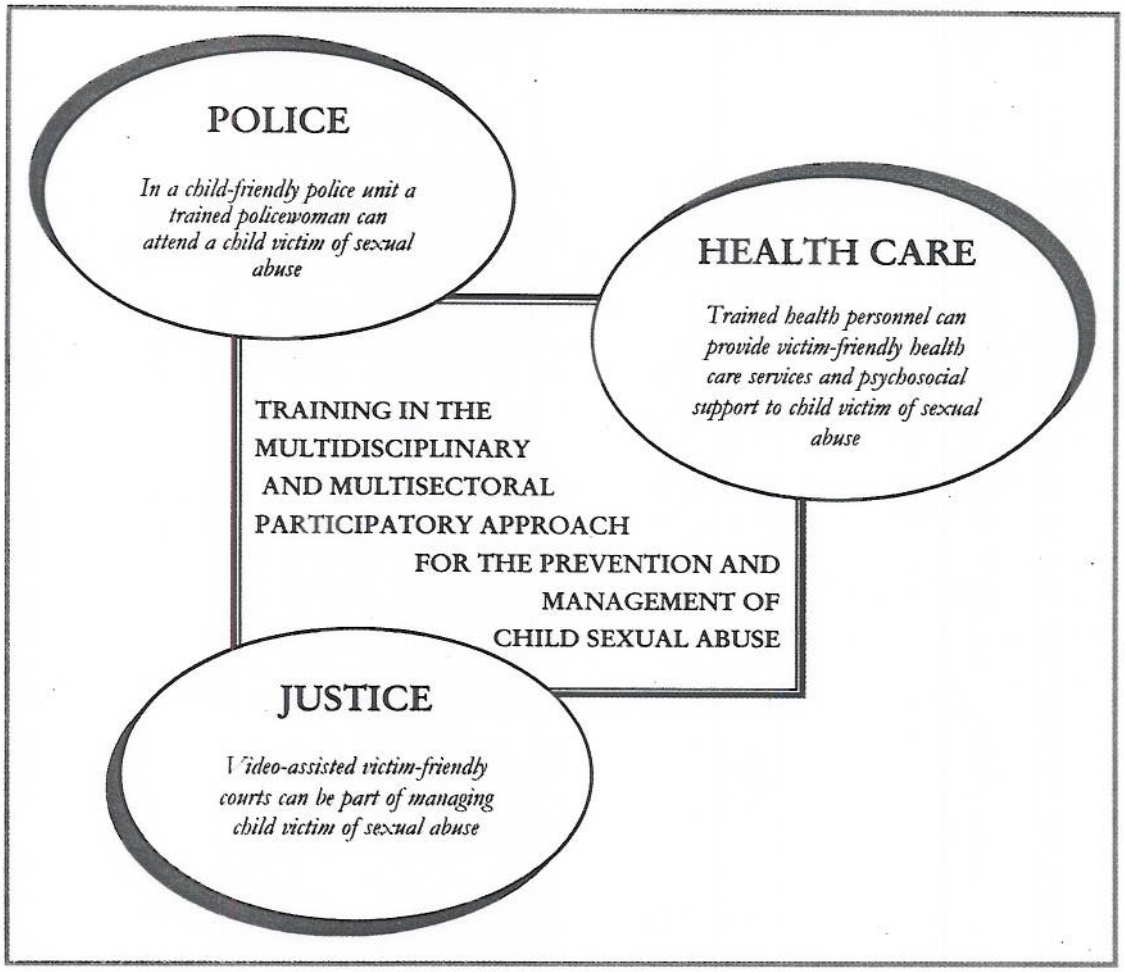
101. However, ***Child sexual abuse*** (CSA) and neglect have become a major public health threat to the well-being of children, particularly the girl-child. As part of the promotion of psychosocial development of the child and the prevention of child abuse and neglect, participants from 15 countries were trained in the prevention and management of child sexual abuse (PMCSA). To date, participants from 28 Member countries Angola, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of Congo, Guinea, Kenya, Liberia, Mali, Mauritania, Mauritius, Mozambique, Niger, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Rwanda, Tanzania, Chad, Togo, Uganda, Zambia, Zimbabwe have been trained in this area. As part of the training, participants identified the various types of CSA occurring in their respective countries; those occurrences are listed in the *box*.

Table 1: TYPES OF CSA, REPORTED BY 28 PARTICIPATING AFRICAN COUNTRIES

Types	No. of Countries	%
- Rape, sodomy, defilement	22	79
- Sexual harassment and coercion	13	46
- Early/forced marriage	11	39
- FGM, genitalia interference	11	39
- Child prostitution	10	38
- Commercial sexual exploitation	10	36
- Incest	9	32
- Paedophilia	7	25
- Trafficking, cross-border sale	4	14
- Forced/early pregnancy	2	7
- Sexual abduction and kidnapping	2	7

102. The intercountry training used a multidisciplinary and multisectoral approach to PMCSA. Experience from Zimbabwe in developing victim-friendly services was used to demonstrate the importance of collaboration between key institutions such as the police and the departments of justice and health *(Figure 17)*. Guidelines for initiating a systematic intervention for PMCSA were developed in English and French for use in Member countries.

Figure 17: A MULTIDISCIPLINARY AND MULTISECTORAL PARTICIPATORY APPROACH TO THE PREVENTION AND MANAGEMENT OF CHILD SEXUAL ABUSE



Source: WHO/AFRO, 2001

103. Achievements in the area of promotion of healthy development and reduction of mortality and morbidity among adolescents have been through consultations and contributions of participants from 17 Member countries (Angola, Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Mali, Nigeria, Rwanda, Senegal, Sierra Leone) in two expert meetings which contributed to the development of a regional strategy on adolescent health.

104. Seven countries - Kenya, Lesotho, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe - participated in a meeting to review the health promotion approaches and life-skills development in the ***Adolescent health (ADH)*** programme. The need for developing a strategic approach to strengthen interventions for promoting healthy behaviours, reducing risk-taking behaviours and developing healthy lifestyles during adolescence was underscored.

ESSENTIAL ELEMENTS IN CHILD AND ADOLESCENT HEALTH

- *There are 1.7 billion young people in the world. Young people (10-24 years) constitute 33% of the total population in the Region.*
- *Recreation, adequate nutrition and social skills are part of health development of young people.*
- *Youth involvement in income generation and poverty alleviation is important.*
- *The support and participation of community members for young people's health and development are essential.*

105. Within the context of the World AIDS Campaign 2000-2001, eleven countries (Botswana, Ghana, Kenya, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Zambia, Zimbabwe) participated in a review of the health of male adolescents and youth and their role in reproductive health. This activity was conducted in collaboration with headquarters, UNAIDS, UNICEF, the Population Council and Pathfinder, an NGO. It was felt that the influence of young males over the sexual and reproductive health decision-making processes needed to be recognized and addressed while developing adolescent health programmes.

106. In addition, there is need to develop programmes which address a wider range of risk behaviours and problems such as alcohol, tobacco and substance use and abuse. Researchers and ADH field programme managers from 14 Member countries (Botswana, Cameroon, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Uganda, Zambia, Zimbabwe) participated in a meeting to exchange their experiences and research in adolescent-friendly health services (AFHS), in collaboration with UNICEF, the German technical aid agency GTZ, the African Medical Research Foundation (AMREF), Pathfinder and the Population Council. The meeting issued a statement on the critical and key issues and made recommendations for establishing, expanding and sustaining AFHS in the Region. These will form a part of the Regional Office's contribution to the global consultation on adolescent-friendly health services to be held in March 2001.

107. Technical support was provided to Guinea, Mali and Senegal for the training of trainers of health workers in the use of training modules for adolescent health services. In Botswana, health workers were trained on how to make health services adolescent-friendly.

108. The training of school teachers in the provision of school health services in Ghana was in the process of implementation, while coordination between the ministries of health and education had been established. Swaziland trained 340 teachers in the psychosocial development of the child. Côte d'Ivoire has integrated ADH into its existing health programmes.

QUOTATIONS FROM STATEMENTS MADE BY ADOLESCENTS AT ADH MEETINGS

- *"Advocate for the youth of Africa to have basic education." - A Zimbabwe participant*
- *"There is a need to teach abstinence which has been ignored as people concentrate on promoting condoms." - A young person*
- *"It is important to note that behaviour takes time to change and that focus demands sacrifice." - A Zambian participant*
- *"Fathers should be taught to be youth-friendly. When dad comes home the children sit quietly in their rooms while when they were with mum, they were chatting and laughing." - A youth panellist*
- *"When young people are abused as children they tend to become abusers. Traumatised young people tend to behave like their parents." - A youth panellist*
- *"Youth with disabilities are often ignored in adolescent health programmes and yet they suffer more due to their unfortunate circumstances." - A Kenyan participant*
- *"Change is made by a few individuals and the people here should be able to make a difference." - A WHO resource person*
- *"When schools are closed youth can be reached through work camps." - A WHO resource person*
- *"Youth are not just a bunch of problems. If well guided, youth solve their problems best." - A Zambian participant*
- *"I like to be around people older than me who respect my views."- A youth participant*

109. Some countries have developed reproductive health policies that include a component on adolescents and youth (Burundi, Ghana, Zambia). Others have adopted a broad-based youth policy that has a component on health (Seychelles, Zimbabwe). Still others have a youth reproductive health policy (Algeria, Botswana, Gambia). A few countries have a comprehensive adolescent and youth health policy. In many countries, these policies have been evolved through consultative and participatory processes which involved key partners and stakeholders. Many such policies are still in a draft form, awaiting adoption by national governments.

110. Nearly all Member countries have a focal point in the ministry of health who is responsible for ADH. This is a positive development, considering that young people aged 10 to 24 years constitute about 33% of the total population in most countries in the Region. Most of the activities and interventions targeting ADH are spearheaded by NGOs in collaboration with government. Some of these activities are:

(a) prevention of HIV/AIDS/STI among young people (Gambia);
(b) training of youth in life-skills and peer education (Swaziland);
(c) development of adolescent-friendly services (Botswana, Republic of Congo, Namibia, Nigeria);

(d) situation analysis of the health and health-related issues of adolescents and youth, and community sensitization about the health of adolescents (Cameroon, Liberia, Kenya, Uganda); and

(e) study of the health-seeking behaviour of adolescents (Mauritius, Seychelles).

111. The approaches used in the development of AFHS are in an experimental phase, with different models of service provision, with a view to selecting the best model. However, some constraints are being experienced which are related to the long process of consultations with key stakeholders before starting the pilot projects. Moreover, the cost of sustaining these "model" services is high in some situations and the non-availability of extrabudgetary funds for the completion of this process may hinder progress.

112. Future cooperation in CAH between WHO and Member countries will be facilitated by the existence of national focal points and the goodwill prevailing among collaborating partners and government institutions. As the late South African leader, Oliver Tambo, pointed out, "Any nation, any people, any community that does not take care of its children does not have a future."

113. During the reporting period, the ***Women's health and development (WHD)*** programme focused mainly on developing its content and activities. A consultation meeting with WHO regional and national focal points for women's health, held in Geneva in October 2000, emphasized the need for advocacy, information-sharing and collaboration. The meeting also stressed the importance of cataloguing key regional and international NGOs working in the fields of women's health and gender issues. Activities in this regard were undertaken and WHO country offices were requested to identify potential NGOs for listing.

114. The process of developing a regional strategy for women's health is under way. A needs-assessment study is being designed and conducted by a highly-specialized NGO from South Africa. The objective is to identify key elements which should form part of the strategy document. Regional and national consultations will be organized late in 2001 to seek additional information and to build a consensus on the development and implementation of the regional strategy.

115. In relation to ***gender issues***, three workshops have been planned to be organized during 2001 to sensitize WHO staff and national focal points on the importance of gender analysis and monitoring in health-related issues. For this purpose, a questionnaire was sent to all Member countries. Meanwhile, training modules are being revised to reflect WHO's priority programmes that have a strong bearing on gender-based issues (STI/HIV/AIDS, blood safety, malaria, poverty alleviation). WHD activities related to cervical cancer and gender-based violence will also be incorporated into the training modules. As several Member countries

have expressed the need to study infertility, cervical cancer and gender violence, WHD has initiated participatory action-research and will collaborate with the Division of Noncommunicable Diseases on these issues.

116. The ***Social aspects in family and reproductive health*** programme was able to map out and document patterns of and causal factors for gender-based violence in the African Region, with practical recommendations for national and regional actions.

117. In the area of ***Prevention and management of harmful traditional practices (HTP)***, several countries have formulated policies and passed legislation on the prevention of female genital mutilation (FGM), with a corresponding increase in the number of countries that have implemented intervention programmes for FGM/HTP prevention.

118. In Nigeria, for example, five states have legislated against FGM. Guinea has recently passed a law on reproductive health, with focus on FGM prevention. Kenya, Mali, Tanzania and Togo have developed national and regional plans of action to accelerate the elimination of FGM and other cultural practices that affect the health of women and children, and have embarked on the implementation of the activities contained in the plans.

BRAVO AFRICA!

Moving towards legislation against FGM

- *Prohibiting all forms of FGM: Burkina Faso, Cote d'Ivoire, Senegal, Central African Republic*
- *Prescribing imprisonment and/or fines for both those who perform the procedure on a woman or girl, and those who request, incite or promote excision by means of bribe, money, goods and/or support: Burkina Faso, Cote d'Ivoire, Ghana*
- *Other laws prohibiting injury that impact the function of the body, such as cruel and inhuman treatment (penal code in Guinea) and outlawing assault and grievous bodily harm (penal code in Mali)*

WHAT MAKES INTERVENTION IN FGM PREVENTION WORK

- *Respecting and tolerating people's cultures and traditions*
- *Understanding the origins of FGM*
- *Working within the system and among the people*
- *Identifying the positive mores and building upon them*
- *Creating awareness and educating people*
- *Seeking acceptable alternatives*
- *Developing appropriate marketing strategies*
- *Ensuring that no one becomes a loser in the process*

Source: DRH/WHO/AFRO

119. Based on the lessons learned from the Nigerian experience, it was found that functional literacy and income-generating activities are factors that contribute to the enhancement of women's health. In collaboration with headquarters, financial support was given to Bubi District, Matabeleland North province in Zimbabwe to replicate the lessons learned from the Chivi Women's Health project of Masvingo Province on promoting health through women's functional literacy and intersectoral action.

Healthy environments and sustainable development

120. This division covers three areas of work: Protection of the human environment; Food safety; and Health in sustainable development. The implementation of regional and country plans of action under these areas of work was actively pursued.

121. The ***Protection of the human environment (PHE)*** area of work covers: water, sanitation and health; environmental risk assessment and management; rural and urban environmental health; and occupational health.

122. The water and sanitation sector assessment report of the WHO African Region for the year 2000 was published.

Table 2: SUMMARY OF GLOBAL AND REGIONAL WATER AND SANITATION COVERAGE TRENDS, 1970-1999

Service Area	Population served (%)								
	1970	1975	1980	1983	1985	1988	1990	1994	1999
Global									
Urban water	65	74	73	74	75	83	95	82	94
Rural water	13	20	32	39	42	57	66	70	71
Total	-	-	46	-	54	6.	79	75	82
Urban sanitation	54	50	49	52	59	67	81	63	86
Rural sanitation	9	11	13	14	16	19	35	18	38
Total	-	-	39	-	31	37	55	34	60
Africa									
Urban water	66	68	66	61	78	83	81	-	83
Rural water	13	21	22	26	25	31	36	-	42
Total	-	-	32	-	40	46	49	-	56
Urban sanitation	47	75	54	68	73	54	79	-	81
Rural sanitation	23	28	20	25	25	21	47	-	41
Total	-	-	28	-	38	30	56	-	55

Notes:

(1) Global coverage: data for 1970-1988 taken from WHO assessments; data for 1990-1999 taken from WHO/UNICEF JMP assessments.

(2) Regional coverage: Refers to the African Region of WHO. All data for 1970-1999 were obtained from WHO assessments.

(3) (-) = no calculation made

Source: Water supply and sanitation sector assessment 2000, African Region, Part 1

123. Technical and financial support was provided to 20 countries (Benin, Botswana, Burkina Faso, Chad, Eritrea, Ghana, Guinea, Lesotho, Madagascar, Mauritania, Mozambique, Niger, Namibia, Sao Tome and Principe, South Africa, Swaziland, Tanzania, Togo, Zambia, Zimbabwe) to implement community-based water supply and sanitation microprojects in cholera-affected districts using the Participatory Hygiene and Sanitation Transformation (PHAST) approach.

124. Guidelines for the coordination and networking of the water supply and sanitation sector were developed and distributed to Member countries. Six countries (Eritrea, Malawi, Togo, Swaziland, Zambia, Zimbabwe) were supported to formulate environmental health policies.

125. Ghana and Uganda were supported to execute pilot projects on drinking water quality surveillance, while Eritrea, Kenya, Namibia, South Africa, Tanzania and Zimbabwe received assistance to implement hospital waste management pilot projects. Mali and Tanzania were supported to implement activities related to chemical safety.

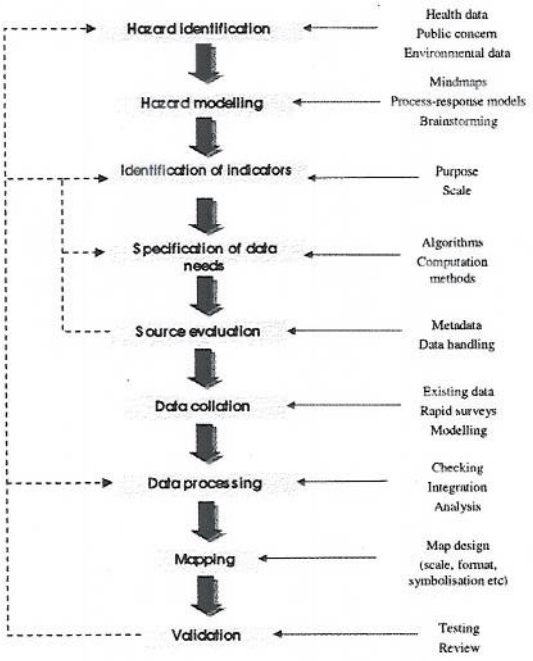
126. There is a need for environmental health hazard mapping in Africa at the regional, national and local levels. That will contribute immensely towards adopting a more preventive approach to environmental health problems, for example, in the areas of:

(a) emergency preparedness and early warning of environmental hazards;
(b) strategic environmental health assessment of policies, programmes and plans;
(c) long-term planning for hazard prevention, mitigation and control; and
(d) awareness - raising and commnity empowerement.

PROMOTION OF HYGIENE AND SANITATION EDUCATION IN SCHOOLS

Source: WHO/AFRO, 2000

Figure 18: STEPS IN ENVIRONMENTAL HEALTH HAZARD MAPPING



Source: Environmental Health Hazard Mapping WHO/AFRO, 2000

127. Guidelines on health hazard mapping and environmental health impact assessment were disseminated to the countries.

128. Twenty French-speaking countries were supported to draw up their ***Rural and urban environmental health (RUE)*** plans of action during the period under review, and six countries (Cameroon, Congo, Ghana, Guinea-Bissau, Tanzania, Uganda) were assisted in the implementation of healthy cities projects. A meeting of mayors from French-speaking countries and donor agencies was organized to help cities mobilize resources for their healthy cities programmes.

129. The ***Occupational health*** programme is currently supporting pilot projects in five cities (Yaoundé, Cape Town, Johannesburg, Dar-es-Salaam and Harare). The African Initiative on Occupational Health was launched jointly with headquarters, the International Labour Organisation (ILO) and WHO collaborating centres.

130. In the area of ***Food safety***, activities focused on identifying priority technical support functions and collaborative partners. The Regional Office participated in several intercountry meetings and international conferences on food vulnerability, food risk assessment and food labelling, and standards of Codex Alimentarius Commission.

131. The ***Health in sustainable development (HSD)*** area of work covers: long-term health development; poverty and ill-health; and environmental health and sustainable development information management. Awareness of sustainable development issues has considerably increased throughout the WHO African Region, following the development of a number of tools and the organization of workshops and meetings.

132. The guidelines for long-term health development were reviewed by an expert panel, which were later published and disseminated to Member countries.

133. The ***Poverty and ill-health*** programme organized the Regional Consultation on Poverty and Health in Harare, Zimbabwe, in July 2000. The meeting was attended by participants drawn from all walks of life. The consultation made a number of important recommendations to governments, WHO and development partners. The governments were encouraged to adopt an epidemiological approach to poverty alleviation. Given the bi-directional relationship between poverty and health, ministries of health were requested to play a key role in national poverty reduction efforts. WHO and other partners were urged to advocate for total debt cancellation, document and disseminate best practices, and assist ministries of health to strengthen their advocacy capacity vis-á-vis other sectors with respect to poverty issues.




Source: WHO/AFRO, 2000

An orphanage centre located in Mutoko district of Zimbabwe is home to some 124 AIDS-affected and destitute children. They are being looked after by the "Mother of Peace Community", which is a nongovernmental organization. This community-based centre aims at setting a strong and visionary foundation for the future life of AIDS-affected children. WHO Regional Office staff and friends are supporting the process of poverty reduction and sustainable development by contributing generously to the centre to make it self-sufficient in all respects.

134. A strategic framework on poverty and health has been prepared. A Regional task force on poverty and health, as well as a committee comprising poverty and health focal points in all the technical divisions at the Regional Office, have been established. The Regional Programme meetings provided a platform for briefing WHO representatives in the Region on the poverty programme.

Table 3: SOME KEY STATISTICS ON POVERTY IN AFRICA

Population	778.4 million **(1999)**
Number of absolute poor	240 million (31%), i.e. living on less than US$1 per day
Number of poor:	387 million (49%), i.e. living on less than US$2 per day
Percentage of African poor	16% in 1985; 29% in 2000 in the total world poor population
Population growth (%):	**1999:** 2.4
GDP growth (%):	**1999:** 2.3
Infant mortality rate:	**1998:** 91.8 per 1 000
Life expectancy at birth	**1998:** 50.4 yrs
Mortality rate (under 5)	**1998:** 151 per 1 000
Total net overseas development assistance per capita (in US$):	**1996:** 30.7 1998: 20.6
Total debt service:	**1998:** US $14.1 billion (50% of exports)
Short-term outstanding debt:	**1996:** US$40.8 billion (140% of exports) **1998:** US$42.5 billion (150% of exports) *(i.e. eroding the capacity of governments to commit new resources for investment and human development due to increasing burden of short-term debt).*

Sources: UNDP, World Bank, DFID

Administration and finance

135. The ***Administration and finance*** division covers four broad areas of work: Health Information Management and Dissemination; Human Resources; Financial Management; and Informatics and Infrastructure Services. Administrative, management and financial work demands considerable attention and ingenuity, particularly in the face of budgetary constraints. Work is on track and the division has been able to substantially implement most of its activities as planned.

Health information management and dissemination

136. The Library at the Regional Office has continued to expand its functions, particularly in the area of providing information through electronic channels. With its larger office space, visitors will now have easier access to its resources. The Publications section continues to increase its capacity to translate and print WHO publications and provide interpretation and translation services at WHO meetings.

Human resources

137. The filling of key senior positions has enabled the division to respond more expeditiously to the needs of some 1 300 staff members employed under a variety of contractual arrangements. Medical clearance, which sometimes delays recruitment, will soon be taken over by the regional medical services with the appointment of a medical referee and the

establishment of proper facilities. With regard to training, about 100 administrative staff from WHO country offices completed an intensive two-week course. About 30 other staff members were trained at the WHO country office in the Democratic Republic of Congo.

138. Although the ***Personnel*** services have now been sufficiently strengthened to better attend to the needs of the staff in the Region, modern personnel systems and practices still need to be developed as part of the ongoing improvement process.

Financial management

139. The financial services at the Regional Office have been considerably strengthened and are functioning quite effectively in support of technical programmes. As part of the ongoing devolution of administrative and financial services to the technical divisions, a support unit has been created in the Poliomyelitis programme and posts of administrative officer established in each of the divisions. This should help provide stronger and more expeditious support to the programmes. In addition, plans are under way to introduce more automation in the financial functions.

Informatics and infrastructure services

140. In the area of informatics, all WHO country offices are linked by e-mail, fax and telephone, contributing considerably to speedier programme implementation in the Region. The greatest challenge is now to strengthen communication with Member countries, which is an ongoing exercise. The Global Programme Network (GPN) linking headquarters and the WHO regional offices is now functioning. Linking the country offices to the GPN is the next challenge which seems to be quite formidable. Another challenge is to make the regional Activity Management System (AMS) more user-friendly and more responsive to the needs of technical staff.

141. The ***General administrative services*** unit pursued its effort to alleviate the problems of office space for the Regional Office staff. In this respect, a part of the office was moved to the Highlands premises which the Government of Zimbabwe gave free of charge to WHO. At the same time, close contact has been maintained with the Congolese authorities in charge of the ongoing renovations at the Regional Office premises in Brazzaville, Congo.

142. As before, the ***Supply services*** continued to provide and deliver supplies and equipment for projects most expeditiously and at the best possible prices.

FACILITATING FACTORS AND CONSTRAINTS IN THE IMPLEMENTATION OF THE PROGRAMME BUDGET

143. A mid-term review of implementation in the first year of the 2000-2001 Programme Budget was conducted. This review highlighted the major facilitating factors and constraints at the regional and country levels. These are summarized below.

At regional level

Facilitating factors

144. The joint planning process employed for the preparation of the Programme Budget was a learning experience for WHO as a whole. The content of the 2000-2001 plans of action for the African Region improved considerably. The joint planning exercise contributed to enhanced inter-divisional collaboration at the Regional Office and greater interaction between headquarters and the Regional Office. Mainly as a result of the time constraint, the involvement of WHO country offices in the planning process was limited, which will be improved in the next biennium. As stated in the mid-term review report, better team spirit prevailed within the divisions and between divisions and country offices. That made the implementation of activities easier. The role of experts in various areas of work and their willingness to support the implementation of programmes at country level also contributed immensely to the high rate of success. Greater use of electronic and telecommunications facilities enhanced interaction among different levels of WHO, and among WHO, Member countries and partners.

Constraints

145. Despite the fact that the planning of the Programme Budget improved collaboration between different levels of WHO, it also highlighted the need to improve coordination mechanisms. In addition, many areas of work still lacked adequate human and financial resources and these constraints hampered the implementation of activities. There was a heavy dependence on non-Regular Budget resources and the skills and time needed to mobilize adequate funds was a major constraint.

146. Other constraints that were identified in the mid-term review were lack of data, shortage of new and innovative initiatives, and delays in the submission of country project proposals for funding. Monitoring of programmes should be improved through the use of the Activity Management System (AMS) and establishment of linkage with the Accounting and Finance Information (AFI) system. There is a need for an appropriate mechanism to reschedule activities that are not implemented due to budgetary or other constraints. Also needed is an improved system of allocating or mobilizing adequate resources. With appropriate monitoring, activities can be reprogrammed well in time. It is important to note that during the year security issues in the African Region delayed, or necessitated changes in the process of, implementation of activities. Numerous complex emergencies and natural disasters affected the African continent; this also prompted rescheduling of activities.

At country level

Facilitating factors

147. Close collaboration among various stakeholders and WHO at national level was a major factor that facilitated programme implementation. In addition, the commitment and enthusiasm shown by national health staff responsible for different areas of work contributed a great deal. Frank and sincere consultations and negotiations held regularly between governments and partners on the implementation of activities boosted their commitment. Collaboration and networking among all stakeholders, including national authorities, nongovernmental organizations, the private sector and UN agencies, contributed to the success of programmes. Coordination of activities such as national immunization days and the existence of programme advisory bodies or programme steering committees also facilitated implementation.

148. The inter-organizational facilitating factors identified by WHO country offices were many, and included: good programme support and management; good leadership by WHO representatives; decentralization of administrative functions (e.g. issuance of sticker numbers); financial support from the Regional Office and timely release of funds; the quality of technical support given by the Regional Office and headquarters; decentralization of authority by the Regional Director to WHO representatives; the Regional Director's willingness to support country requests; timely preparation and dissemination of background documents; appropriate guidance to WHO programme officers and administrative staff; and the availability of focal persons in the country offices.

Constraints

149. At country level, general problems such as political unrest, natural disasters, economic decline, absence of sectoral reforms and lack of efficient road and communication infrastructures were serious constraints in the overall implementation of programmes. At ministry of health, the shortage of qualified staff and the high turn over of management staff, lack of ownership and funding, and inadequate communication on sensitive health topics were also contributory factors. Besides, lack of policy guidelines on effective implementation also adversely affected programme delivery.

150. Duplication of activities at national level and the multiplicity of additional activities called for much greater coordination among partners and more responsiveness to country needs. Inadequate national capacity to monitor and absorb financial resources is an area that needs to be addressed.

151. The shortage of human resources or funding also affected the work of WHO country offices. Changes of WHO representatives, bureaucracy, delays in recruiting consultants or in receiving technical and financial information, the short deadlines set for the budgeting process and the lack of links with the financial system of the Regional Office were noted as constraints. Sometimes, WHO's programmatic approach interfered with the integrated or more holistic approach at country level.

PART II: PROGRESS REPORT ON THE IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

Regional strategy for mental health

152. The *Regional Strategy for Mental Health 2000-2010* (document AFR/RC49/9), adopted by the Regional Committee at its 49th session, aims to strengthen the capacity of Member States to improve the quality of life of people by promoting healthy lifestyles and preventing and controlling mental, neurological and psychosocial disorders.

153. By its resolution AFR/RC49/R3, the Regional Committee requested the Regional Director to report to the 51st session on the progress made in implementing the regional strategy for mental health.

154. The dissemination of the Strategy and the drawing up of operational plans for its implementation were effected through intercountry meetings involving most of the Member States (September 1999, Praia, for Portuguese-speaking countries; November 1999, Nouakchott, for a group of French-speaking countries; February 2000, Harare, for a group of countries in conflict or post-conflict situations, and again in Harare in May 2000 for the Southern African countries and Indian ocean islands). National mental health coordinators and focal persons for the programme in WHO country offices attended these meetings.

155. In collaboration with the Department of Mental Health and Substance Dependence at headquarters, 18 African mental health experts were given orientation on needs assessment, programme development and management. This group will support Member countries in the implementation of the Regional Strategy.

156. In consultation with WHO country offices and national authorities, support was provided to some countries to draw up or revise their mental health policies and programmes. Encouragement was given to the integration of mental health and the prevention and control of substance abuse into the ongoing health sector reforms. Actions for the strengthening of inter-divisional collaboration at the Regional Office were initiated. Working groups were set up on: Violence Against Women and Children; Victims of Landmines; Preparation for World Health Day 2001 and other activities (Implementation of the Renewed Bamako Initiative; preparation of the Adolescent Health Strategy; implementation of the HIV/AIDS Strategy. The Director-General has decided to devote the World Health Day and World Health Report 2001 to mental health).

157. The training of staff to deal with mental health and the prevention and control of substance abuse received priority. Using WHO fellowship facilities, some countries sponsored candidates for training in mental health disciplines. The use of training institutions in the African Region for this purpose was encouraged. Reports from countries indicated that

there are mental health modules in the training courses of general health workers. In some countries, this training is not regularly organized but is accomplished through on-the-job training.

158. In collaboration with different partners, and in consultation with national authorities, some countries received technical and financial support for the implementation of specific projects such as the Global Initiative on the Prevention of Substance Abuse in Young People; Nations for Mental Health; the Initiative on Epilepsy "Out of the Shadow", and Community-Based Psychosocial Rehabilitation in Conflict and Post-Conflict Situations.

159. In collaboration with headquarters and other regions, a global project on the Electronic Atlas for Mental Health was started. The questionnaire (Phase I) was sent to Member States in order to gather information on country resources for mental health. At the time of compiling this report, 42 countries (97%) had responded. Out of these, 57% indicated that they had a mental health policy in place. Seventy-six per cent indicated that they had mental health programmes, most of which were established in the last five years. Although training of primary health workers in mental health is not done regularly in some countries of the Region, 76% of the countries stressed the importance of integrating mental health into primary health care.

160. The main constraints or weaknesses identified in the development of mental health and the prevention of substance abuse programmes include: lack of awareness about the importance of mental health as an integral part of health; insufficient qualified personnel in this area; inadequate financial resources (in most of the countries it is difficult to specify the percentage of funds allocated to the programme, while in others the amount allocated is less than 1%); and lack of access to psychotropic drugs which contribute to an increased gap in the treatment of common mental and neurological diseases in the Region.

161. To ensure steady monitoring, it is recommended that a progress report on the implementation of the *Regional Strategy for Mental Health, 2000-2010*, be included in the agenda of the 53rd session of the Regional Committee.

Regional strategy on integrated disease surveillance

162. The 48th session of the Regional Committee, by its resolution AFR/RC48/R2, adopted the Regional Strategy on integrated disease surveillance (IDS). The resolution also requested the Regional Director to report to the Regional Committee every two years on the implementation of the strategy.

163. The IDS unit was therefore established at the Regional Office to coordinate the implementation of the strategy and is being strengthened to support countries in its implementation. Meetings to sensitize Member States and partners have been held at regional and intercountry levels. The IDS strategy documents were disseminated to Member States.

164. The Regional Office, in collaboration with headquarters and partners such as the Centers for Disease Control and Prevention, Atlanta, USA, has developed generic tools and guidelines for integrated disease surveillance to support the implementation of the strategy at country level. Training materials are being developed. The steps to be followed in the implementation of the IDS strategy were delineated.

165. A task force has been set up to advise the Regional Office on the implementation of the IDS strategy in the African Region. Twenty of the 46 Member countries have completed the assessment of their national surveillance and epidemic preparedness and response (EPR) systems, including the laboratory component, in order to document the existing situation and identify areas that need to be strengthened. Thirteen countries have already developed a five-year plan of action on IDS, EPR and strengthening of laboratories, based on the findings and recommendations of the assessment.

166. Major challenges faced in the effective implementation of IDS include ensuring effective and reliable laboratory support and building partnerships at all levels. The number of committed partners in this programme area is increasing and there is potential for further growth as IDS matures and starts to show results.

Poliomyelitis eradication initiative

167. In 1995, the Regional Committee adopted resolution AFR/RC45/R5 on poliomyelitis eradication. It also requested the Regional Director to report annually on the progress made towards the achievement of the poliomyelitis eradication goal. Initially set for the year 2000, the target year for achieving poliomyelitis eradication was shifted to 2005 due to the delay in the interruption of transmission in some countries of South-East Asia, the Horn of Africa, and West and Central Africa.

168. Since the launch of national immunization days (NIDs) in 1996, substantial progress has been made towards achieving the goal of poliomyelitis eradication in the African Region. NIDs have been organized in all the 32 endemic countries in the African Region. The number of countries reporting endemic circulation of wild polioviruses were reduced from 32 in 1995 to 17 in 1999 and then to 11 in 2000.

169. During the year, the Regional Office coordinated the implementation of the first-ever synchronized NIDs which involved 17 countries in West and Central Africa, using mainly door-to-door strategies to deliver poliomyelitis vaccines (as well as vitamin A in some countries). The Regional Office has ensured the deployment of over 150 international staff and 320 national consultants (including epidemiologists, logisticians, social mobilization

experts and administrative staff) to work with government employees at central and operational levels. The recruitment of these staff was facilitated by the creation of a special Administrative Support Unit at the Regional Office. On the other hand, some 160 additional vehicles, 200 motorcycles and over 100 motor boats were purchased and delivered for use in the countries.

170. In the area of poliomyelitis surveillance, the Regional Office supported countries to expand their activities by means of staff postings, funding of operations and data management. The detection rates of acute flaccid paralysis (AFP) increased to 1.3 per 100 000 children aged below 15 years, which is above the global target of 1 per 100 000. The percentage of AFP cases with two stool specimens collected within 14 days is now close to 60%. All countries have access to a polio-accredited laboratory.

Elimination of leprosy in the African Region

171. In the reservoir countries, accelerated efforts for improved NIDs will continue. Surveillance will be expanded so that surveillance indicators could be monitored at provincial or district level. The poliomyelitis laboratory network will be further strengthened in response to the increased workload and staff retention efforts will be pursued.

172. The Regional Committee, by its resolution AFR/RC44/R5, requested Member States to eliminate leprosy in the Region by the year 2000. Leprosy elimination is defined as the reduction of the prevalence rate to less than one case per 10 000 population.

173. In 1994 when the resolution was adopted, 113 650 cases of leprosy were recorded in the African Region. The prevalence rate was 2.1 per 10 000 population and more than half of the countries were still endemic. By the end of 2000, the prevalence had dropped to 64 381 cases (1.0 per 10 000 pop.). This means that the elimination goal has been achieved in the African Region.

Table 4: TRENDS IN LEPROSY PREVALENCE IN NEW CASES RECORDED IN THE AFRICAN REGION (1994-2000)

	1994	1995	1996	1997	1998	1999	2000
Registered cases	113 650	95 901	82 758	81 920	82 022	67 526	64 381
New cases	47 900	46 516	46 489	56 515	56 521	51 963	55 628

174. The achievement of the goal of elimination was made possible by the implementation of national leprosy control programmes in all endemic countries, applying the WHO-recommended multidrug therapy (MDT) to treat patients. With strong political commitment of countries and sustained support of partners, WHO supplied sufficient blister packs of MDT to all requesting countries and gave technical support to national programmes for planning, organizing and evaluating elimination activities. The MDT coverage increased by

up to 100 per cent of registered patients. Since 1991, about 645 000 cases of leprosy have been cured by means of MDT, with a relapse rate of less than one per cent. Staff capacity-building at different levels of the health system in countries through training and supervision activities, and community awareness activities have helped maintain an appreciable level of case-finding. Leprosy elimination campaigns and the Special Action Project for the Elimination of Leprosy (SAPEL), launched in 1997, made it possible to diagnose hidden cases of leprosy. Annual detection thus increased from 49 700 cases in 1994 to 56 515 cases in 1997 and remained above 50 000 in the years that followed.

175. However, those encouraging results at the Regional level mask disparities between countries. Although 31 countries of the Region reached the elimination threshold, the 15 remaining countries still have to intensify activities in order to achieve the leprosy elimination goal. Seven African countries, with a prevalence rate of more than two cases per 10 000 population, are among the 12 most endemic countries in the world.

176. Difficulties in implementing leprosy elimination activities in the African Region, especially in the remaining 15 endemic countries, stemmed from:

(a) persistent armed conflict in some countries, which hampered the expansion of health activities and MDT coverage nationwide;

(b) poor health coverage and insufficient integration of leprosy elimination activities into general health services, which made MDT non-accessible to some communities;

(c) insufficient involvement of communities due to the limited awareness of leprosy and MDT availability and the persistent stigmatization of leprosy; and

(d) decreasing involvement of countries in leprosy control due to the numerous health problems in the Region, most of which are caused by poverty.

177. A strategy to accelerate and intensify leprosy elimination in the 15 remaining endemic countries in the Region was defined and adopted at the Third International Conference on Leprosy Elimination, held in Abidjan, in November 1999. At that conference, a Global Alliance for the Elimination of Leprosy was formed. It brought together the 12 most endemic countries, partners and WHO to work towards the elimination of leprosy by 2005.

178. At a meeting organized by WHO in Maputo, Mozambique, in September 2000, the seven most endemic counties in the African Region proposed intensified plans of action for leprosy elimination. Participating in the meeting, the partners and WHO agreed upon these plans and pledged their support to the countries in carrying out these intensified actions.

Integrated management of childhood illness

179. The 49th session of the Regional Committee adopted resolution AFR/RC49/R4 by which it approved the Regional Strategic Plan for the Integrated Management of Childhood Illness (IMCI) as set forth in document AFR/RC49/10. The plan aims to help reduce morbidity and mortality and promote growth and development among children under five years of age.

180. As of December 2000, 37 countries had adopted the IMCI strategy and were at various stages of implementation. The progress made was as follows:

(a) Capacity-building: National professional officers (NPOs) were recruited in 10 countries (Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Mali, Malawi, Mozambique, Tanzania, Uganda, Zambia) to help accelerate IMCI implementation. Furthermore, over 100 regional consultants were trained and assigned to assist countries in the implementation of the IMCI strategic management. The Regional Office and intercountry teams were strengthened and an intercountry medical officer was recruited for countries in Central Africa and the Great Lakes. At national level, over 6 500 first-level health workers were trained and are practising IMCI case management. More than 70% of these health workers were paid follow-up visits in their health facilities to consolidate their skills and help solve implementation issues related to the health system. Breast-feeding counselling and promotion activities were undertaken and training in HIV/Infant feeding counselling was held in five countries. The community component was introduced in 23 countries and is already being implemented in nine countries. Guidelines for the introduction of the community component at country level were developed in addition to a briefing package for consultants.

(b) Promotion of sustainable IMCI implementation: To foster sustainability, IMCI is now being included in pre-service training (medical, paramedical and nursing) in eight countries. In that regard, over 600 students were trained and assessed in IMCI. Drug availability was assessed in Uganda and Zambia and the results are being used to prepare regional strategies for improving drug availability at first-level health facilities.

(c) Building partnerships: Partnerships for resource mobilization were strengthened at both regional and country levels. Grants to strengthen regional support to countries were received from the Department for International Development (DFID) (U.K.), the United States Agency for International Development (USAID) and the United Nations Foundation UNF). At country level, UNICEF, USAID, UNF and the World Bank were among the key partners.

(d) Promotion of operational research: Operations research was conducted to seek solutions to implementation problems such as referral and caretaker compliance. Results are being used to improve referral care and systems in Niger, Tanzania and Uganda. Other research areas included improving the quality of care of children at the referral level and validation of HIV/AIDS adaptation.

Regional strategy for emergency and humanitarian action

181. Since the adoption of the strategy, WHO's cooperation with Member countries in the area of emergency operations and humanitarian action has been considerably strengthened.

182. The year under review enabled the creation of a network of focal points in 44 countries in the Region. The programmes for the prevention of, preparation for and response to, emergencies in the countries will be firmly based on that network. Support was given to a number of countries in the initial phase of the development of this programme, known as the vulnerability analysis phase.

183. The heightened awareness of national authorities, both central and provincial, in regard to the human consequences of the disasters experienced by some countries, considerably facilitated the realization of the common objectives.

184. The Regional Office supported the countries that were experiencing emergency situations. Financial resources as well as regional and international expertise were mobilized to rehabilitate the health facilities and to reduce human suffering.

185. The Regional Office also organized and coordinated a solidarity fund through which health personnel of Portuguese-speaking countries contributed in order to support their colleagues in Mozambique during the floods.

Essential drugs in the African Region

186. WHO's mission in the area of essential drugs is to help save lives and improve health by bridging the gap between the potential that medicines offer and the reality that, for millions of people, medicines are unavailable and unaffordable. The WHO Medicines Strategy pursues four objectives: policy, access, quality and safety, and rational use. These objectives are spelled out in the Intensified Essential Drugs Programme (IEDP) adopted by the 49th session of the Regional Committee, which invited the WHO Regional Office to develop a comprehensive strategy on traditional medicines. Resolution AFR/RC49/R5 requested the Regional Director, inter alia, to support Member States in carrying out research on medicinal plants and promoting their use in health care delivery systems and to report to the Regional Committee's 51st session on the progress made and problems encountered in the implementation of IEDP.

187. *Policy and programme development, implementation and monitoring:* Support in carrying out situation analysis leading to the formulation of national drug policies (NDPs) was provided to Seychelles, Guinea-Bissau and Sao Tome and Principe. Thirty-seven countries now have NDPs, up from 33 in 1988. Botswana, Lesotho, Swaziland, Mauritania, Liberia and Cameroon are in the process of adopting NDPs and Namibia has received assistance for the indicator selection process. WHO will support the implementation of the pharmaceutical component of the Sierra Leone Health Services Rehabilitation Project with funds from the African Development Bank (ADB). The document, *Guidelines for the formulation, implementation, monitoring and evaluation of national drug policies* (2000) has been finalized.

188. Legislation, quality and safety: A preliminary review of pharmaceutical legislation revealed that, as a requirement, in some countries medicines must be registered and handled by registered personnel. Seventy-eight personnel of the drug regulatory authorities (DRA) in 21 countries have been trained in collaboration with the African DRA Network (AFDRAN); funding for the training was provided by the Irish government. Support was provided for the harmonization of drug regulations in the SADC region. Drug quality assurance staff from 16 Member countries (including Yemen in the WHO Eastern Mediterranean Region) have been trained in laboratory management and laboratory technicians from eight countries have also been trained in the screening of tuberculosis drugs.

189. *Access to essential drugs:* A training manual on the management of drugs at the health-centre level and the second edition of the AFRO Essential Drugs Price Indicator have been finalized. A review of the situation of local drug production in some countries revealed that only about 50% of the industries used more than 50% of the installed capacity. Fifteen countries have benefited from training in good manufacturing practices (GMP). The Lesotho Pharmaceutical Corporation was audited with respect to GMP as part of the preparations to register its products outside the country.

190. The Association of Central Medical Stores is pursuing bulk purchasing initiatives and the SADC bulk purchasing initiative for TB drugs is on track. A study on the integration of drugs required for vertical programmes into the medical supply system was carried out in Tanzania. The situation in other countries is being monitored in order to ascertain how the integration process was proceeding.

191. *Rational drug use (RDU)*: A course on rational drug use was organized in Nigeria which brought together 36 participants from different countries of the Region. Two countries published their national essential drug lists and five published their standard treatment guidelines, bringing the total number of countries in the former category to 43 and in the latter to 33. Courses on rational prescribing and pharmacotherapy were organized in Algeria and South Africa respectively. Mauritania and Seychelles received support to consolidate their national drug information centres.

192. *Traditional medicine:* An African Forum on the Role of Traditional Medicine in Health Systems was held in Zimbabwe. Furthermore, a consultative meeting was organized in Zimbabwe to review the draft of the regional strategy on the role of traditional medicine in health systems. The strategy was subsequently adopted by the 50th session of the Regional Committee. An implementation plan for the strategy is in place. Generic protocols for the evaluation of traditional medicines and specific protocols for ethnomedical studies and clinical trials on HIV/AIDS and malaria drugs were agreed on at a regional workshop held in Madagascar. A database on traditional medicines has been updated.

193. Furthermore, documents were developed on the following: guidelines for the formulation and implementation of a national policy on traditional medicines; a legal framework for the practice of traditional medicines; and situation analysis on local production of traditional medicines. National institutions in Ghana, Kenya, Madagascar, Nigeria and South Africa were assessed with a view to designating them as WHO collaborating centres. Support was given to Equatorial Guinea, Namibia and Zambia to develop their national policies on traditional medicine and the legal framework for its practice. Support was provided to Burkina Faso and Zimbabwe to carry out research on herbal preparations used for the treatment of malaria and HIV/AIDS. Ethiopia and Swaziland were supported to hold workshops on traditional medicine. In addition, Swaziland received support to establish a research centre on medicinal plants.

PART III: SITUATION OF THE WHO REGIONAL OFFICE IN BRAZZAVILLE, CONGO

194. Following the outbreak of hostilities in the Republic of Congo, the WHO Regional Office closed its offices on 7 June 1997, and the last group of staff members left Brazzaville on 17 June 1997. The WHO Representative in the Republic of Congo, who had moved to Kinshasa after the outbreak of hostilities, returned to Brazzaville in October 1997.

Developments up to the fiftieth session of the Regional Committee

195. Between November 1997 and September 1998, the major developments that took place, and which the Regional Director reported to the forty-ninth session of the Regional Committee in 1999, included the following:

(a) The first joint mission (for fact-finding), undertaken by headquarters and the Regional Office to Brazzaville in November 1997, prepared a report that prompted the Executive Board to decide on 13 January 1998 to temporarily transfer the Regional Office from Brazzaville to Harare.

(b) The second joint mission (for assessment) undertaken to Brazzaville in June 1998 recommended to the Regional Director that the Regional Office could begin a phased return to Brazzaville soon after the Regional Committee in September 1998.

(c) After the third mission in July 1998 to clarify a few issues with the Government of the Republic of Congo and in preparation for the gradual return of the Regional Office to Brazzaville, the Regional Director instructed that all locally-recruited Regional Office staff still in Brazzaville should resume their work as from 1 August 1998.

(d) In line with Regional Committee resolution AFR/RC48/R6, arrangements were made for the return to Brazzaville, before December 1998, of the staff of the Library and the Duplication and Printing unit whose facilities, left behind in Brazzaville, could not be fully reconstituted in Harare.

(e) The renewed hostilities from December 1998 to January 1999 not only shelved the arrangements but also prevented the conduct of a second assessment mission that was to help draw up a plan for the gradual return of the Regional Office to Brazzaville.

(f) The report of the second assessment mission, which was finally undertaken in July 1999, was used to update the information WHO had provided to its insurance company and to provide a better basis to the Congolese Government for carrying out its work of rehabilitating the Regional Office's infrastructure, installations and equipment.

196. Pursuant to Regional Committee resolution AFR/RC48/R6, and at the invitation of the Government of the Republic of Congo, the Regional Director headed a mission to Brazzaville in October 1999 during which the President of the Republic of Congo reaffirmed his commitment to make reparation for the damage caused to the facilities of the WHO Regional Office.

197. It was noted during the mission that the extent of damage to the Regional Office was far greater than what had been reported previously.

198. Given that the Congolese Government had made substantial progress in the rehabilitation of the Regional Office in December 1999, a third assessment mission to Brazzaville was undertaken in March 2000. According to projections, the rehabilitation would be far advanced by July 2000 and the premises made ready for occupancy by the end of December 2000. From then on, planning for the progressive return of staff could be envisaged in accordance with the security norms of the United Nations.

199. In order to further assess the situation, a ministerial mission visited Brazzaville from 31 July to 2 August 2000. The mission was led by Dr Libertina Amathila, Chairman of the 49th session of the Regional Committee and Minister of Health and Social Services of Namibia, and included Professor Marina d'Almeida Massougbodji, Minister of Health of Benin and senior officials of the Regional Office. The mission reported to the 50th session of the Regional Committee that the overall situation in the country appeared to be normalizing, and noted the political commitment of the Government to provide the necessary funds and efforts for the rehabilitation of the Regional Office. Work on the Regional Office building was progressing steadily; the 46 residential villas were 90% refurbished but much work was needed on the 78 apartments. Renovations at the Regional Office building were continuing, with much work completed on the third floor, including the Regional Director's office and the Library and the restaurant. The mission noted the Government's deadline to complete the work by December 2000.

200. The Regional Committee took note of the mission's report, including the options of the staff returning to Brazzaville progressively as the Regional Committee had originally envisaged or en masse when the time was right to do so. In the meantime, the work of the WHO Regional Office to serve its 46 Member States had to continue and, for this reason, the generous offer by the Government of Zimbabwe to make available, free of charge, a third location to accommodate about 50% of the staff, was accepted with gratitude.

Developments after the fiftieth session of the Regional Committee

201. On 9 February 2001, the Regional Director paid an official visit to His Excellency the President of the Republic of Congo to assure him that Brazzaville remained the official location of the Regional Office and that the staff would return once the Regional Office building and staff residences had been totally rehabilitated and the security phase had dropped

to at least Phase II, according to the UN security norms. The Regional Director expressed concern, however, that the rehabilitation work had not progressed as expected and that the deadline of December 2000 set by the Government had not been met. The Regional Director accepted another invitation from the Government of Congo to visit Brazzaville again in April 2001 to assess the progress of work on the Djoué Estate, the location of the Regional Office.

202. From 10 to 12 February 2001, a ministerial evaluation team visited Brazzaville in accordance with Decision 10 of the 50th session of the Regional Committee. The team was composed of Dr Libertina Amathila, Minister of Health and Social Services of Namibia (Head of Evaluation Team), Mr Pierre J. E. Tapsoba, Minister of Health of Burkina Faso, Dr Pascal Dossou-Togbé, Permanent Secretary of Health, representing the Minister of Health of Benin, and senior officials of the Regional Office. In Part I of its report, the team recommended, based on the situation as at the time of its visit, that the 51st session of the Regional Committee could be held in Brazzaville, Congo. In Part II, the team briefly reported on the situation of the Regional Office and noted that progress continued to be made in the rehabilitation work on the office building. However, work on the 78 apartments had not commenced. The team noted the Government's new deadline of April 2001 for total rehabilitation of the Regional Office and staff accommodation.

CONCLUSION

203. The year 2000 was a very dynamic and productive year for the WHO Regional Office. Activities and staff strength were doubled. The performance of the Regional Office improved through able leadership, sound management practices, quality of work and dedication of staff.

204. In the spirit of the WHO Corporate Strategy, interactions were improved between different levels of the Organization. The joint learning process contributed to increased dedication of staff to programme implementation. There was a significant increase in interactions and exchanges among staff at headquarters, the Regional Office and the country offices. Guidelines issued by the Regional Office for planning, monitoring and evaluation were invaluable tools for reviewing the implementation of the 2000-2001 Programme Budget.

205. Improved partnerships, bringing together various UN agencies, the private sector and NGOs, led to a substantial increase in the availability of extrabudgetary funds, which boosted the volume and quality of activities undertaken.

206. Within the policy framework, the Regional Office played an important role in advocacy and capacity-building at the Regional and country levels, providing direct technical assistance as and when needed. This was made possible because of the hand of partnership that WHO extended to African experts and researchers in their countries and institutions. The Regional Office will continue to pursue this policy in the future as well.

207. The main results of all these actions were:

(a) Greater awareness of the importance of good leadership at the Regional Office and country offices, and of the need for the Regional Office to improve its administrative and management skills. The ongoing staff development programme should ultimately result in a significant improvement in WHO's work in the Region as a whole.

(b) Greater consistency in the choice of priorities at the three levels of WHO and in the consequent budgetary reallocations that have benefited the African Region.

(c) More active participation of the African members of the Executive Board in its work.

208. African technical expertise is Africa's strength, and it shall continue to excel, year after year. Without the immense contribution from its Member States, WHO cannot achieve its mission in the African Region. WHO needs support from all.

IMPLEMENTATION OF PROGRAMME BUDGET 2000-2001
(REGIONAL OFFICE) AS OF DECEMBER 31, 2000

	Area of work		Regular Budget				Other Funds Budget			
Division/Unit	Number	Code	Available	Implemented	Rate	Balance	Available	Implemented	Rate	Balance
DAF	07.2.01	IMD	4,161,000	3,970,000	95%	191,000	-	-		-
DAF	09.2.01	HRS	2,186,000	1,806,000	83%	380,000	1,453,000	708,000	49%	745,000
DAF	09.3.01	FNS	3,460,000	2,932,000	85%	528,000	2,205,000	1,475,000	67%	730,000
DAF	09.4.01	IIS	11,993,000	11,792,000	98%	201,000	5,380,000	2,895,000	54%	2,485,000
DAF Total			**21,800,000**	**20,500,000**	**94%**	**1,300,000**	**9,038,000**	**5,078,000**	**56%**	**3,960,000**
DDC	01.1.01	CSR	771,000	712,000	92%	59,000	5,212,000	2,271,000	44%	2,941,000
DDC	01.2.01	CPC	3,895,000	3,736,000	96%	159,000	10,763,000	6,495,000	60%	4,268,000
DDC	01.3.01	CEE	252,000	94,000	37%	158,000	674,000	497,000	74%	177,000
DDC	01.4.01	CRD	511,000	124,000	24%	387,000	-	-		-
DDC	03.2.01	CAH	595,000	400,000	67%	195,000	3,275,000	3,324,000	101%	(49,000)
DDC	06.2.01	VAB	461,000	541,000	117%	(80,000)	51,612,000	41,160,000	80%	10,452,000
DDC Total			**6,485,000**	**5,607,000**	**86%**	**878,000**	**71,536,000**	**53,747,000**	**75%**	**17,789,000**
DES	04.1.01	HSD	1,596,000	1,084,000	68%	512,000	271,000	13,000	5%	258,000
DES	04.3.01	PHE	2,865,000	2,272,000	79%	593,000	109,000	1,000	1%	108,000
DES Total			**4,461,000**	**3,356,000**	**75%**	**1,105,000**	**380,000**	**14,000**	**4%**	**366,000**
DNC	02.1.01	NCS	1,268,000	881,000	69%	387,000	495,000	29,000	6%	466,000
DNC	02.2.01	NCP	236,000	191,000	81%	45,000	378,000	128,000	34%	250,000
DNC	02.3.01	NCM	230,000	172,000	75%	58,000	-	-		-
DNC	04.2.01	NHD	794,000	442,000	56%	352,000	264,000	2,000	1%	262,000
DNC	05.1.01	HPR	532,000	1,000,000	188%	(468,000)	5,000	(2,000)	-40%	7,000
DNC	05.2.01	DPR	306,000	31,000	10%	275,000	-	-		-
DNC	05.3.01	MNH	1,061,000	530,000	50%	531,000	89,000	85,000	96%	4,000
DNC	05.4.01	SAB	373,000	271,000	73%	102,000	23,000	3,000	13%	20,000
DNC Total			**4,800,000**	**3,518,000**	**73%**	**1,282,000**	**1,254,000**	**245,000**	**20%**	**1,009,000**

IMPLEMENTATION OF PROGRAMME BUDGET 2000-2001

(REGIONAL OFFICE) AS OF DECEMBER 31, 2000

	Area of work		Regular Budget				Other Funds Budget			
Division/Unit	**Number**	**Code**	**Available**	**Implemented**	**Rate**	**Balance**	**Available**	**Implemented**	**Rate**	**Balance**
DPM	04.4.01	EHA	1,106,000	1,232,000	111%	(126,000)	165,000	6,000	4%	159,000
DPM	07.1.01	GPE	445,000	163,000	37%	282,000	-	-		-
DPM	07.3.01	RPC	796,000	718,000	90%	78,000	5,000	1,000	20%	4,000
DPM	08.1.01	GBS	1,467,000	993,000	68%	474,000	39,000	21,000	54%	18,000
DPM	08.2.01	RMB	350,000	182,000	52%	168,000	-	-		-
DPM	08.3.01	ECP	3,402,000	1,666,000	49%	1,736,000	1,423,000	861,000	61%	562,000
DPM	09.1.01	BMR	526,000	236,000	45%	290,000	-	-		-
DPM Total			**8,092,000**	**5,190,000**	**64%**	**2,902,000**	**1,632,000**	**889,000**	**54%**	**743,000**
DRH	03.2.01	CAH	379,000	382,000	101%	(3,000)	-	-		-
DRH	03.3.01	RHR	5,494,000	3,380,000	62%	2,114,000	3,414,000	848,000	25%	2,566,000
DRH	03.4.01	WMH	566,000	642,000	113%	(76,000)	48,000	37,000	77%	11,000
DRH Total			**6,439,000**	**4,404,000**	**68%**	**2,035,000**	**3,462,000**	**885,000**	**26%**	**2,577,000**
DSD	06.1.01	EDM	1,170,000	1,183,000	101%	(13,000)	28,000	15,000	54%	13,000
DSD	06.3.01	BCT	1,700,000	847,000	50%	853,000	-	-		-
DSD	07.4.01	OSD	6,578,000	4,421,000	67%	2,157,000	1,437,000	559,000	39%	878,000
DSD Total			**9,448,000**	**6,451,000**	**68%**	**2,997,000**	**1,465,000**	**574,000**	**39%**	**891,000**
RD	10.1.01	DGO	1,005,000	826,000	82%	179,000	-	-		-
RD	10.3.01	DDP	698,000	462,000	66%	236,000	-	-		-
RD Total			**1,703,000**	**1,288,000**	**76%**	**415,000**	**-**	**-**		**-**
Grand Total			**63,228,000**	**50,314,000**	**80%**	**12,914,000**	**88,767,000**	**61,432,000**	**69%**	**27,335,000**

IMPLEMENTATION OF 2000-2001 PROGRAMME BUDGET
(COUNTRIES) AS OF DECEMBER 31, 2000

	Regular Budget				Other Budget			
Country	**Available**	**Implemented**	**Rate**	**Balance**	**Available**	**Implemented**	**Rate**	**Balance**
Madagascar	2,232,000	1,428,000	64%	804,000	1,960,000	659,000	34%	1,301,000
Malawi	2,385,000	1,590,000	67%	795,000	607,000	264,000	43%	343,000
Mali	3,032,000	1,986,000	66%	1,046,000	853,000	505,000	59%	348,000
Mauritania	2,453,000	1,609,000	66%	844,000	1,334,000	436,000	33%	898,000
Mauritius	1,559,000	677,000	43%	882,000	180,000	79,000	44%	101,000
Mozambique	2,749,000	1,752,000	64%	997,000	1,948,000	1,155,000	59%	793,000
Namibia	2,003,000	1,333,000	67%	670,000	320,000	143,000	45%	177,000
Niger	3,078,000	1,979,000	64%	1,099,000	3,197,000	2,601,000	81%	596,000
Nigeria	3,855,000	2,268,000	59%	1,587,000	12,968,000	10,762,000	83%	2,206,000
Reunion	196,000	35,000	18%	161,000	-	-	-	-
Rwanda	2,985,000	2,200,000	74%	785,000	1,386,000	632,000	46%	754,000
Saint Helena	144,000	-	0%	144,000	-	-	-	-
Sao Tome & Principe	1,762,000	1,531,000	87%	231,000	118,000	81,000	69%	37,000
Senegal	2,350,000	1,388,000	59%	962,000	353,000	240,000	68%	113,000
Seychelles	1,422,000	664,000	47%	758,000	26,000	(2,000)	-8%	28,000
Sierra Leone	2,192,000	1,500,000	68%	692,000	3,359,000	1,813,000	54%	1,546,000
South Africa	3,683,000	1,838,000	50%	1,845,000	498,000	184,000	37%	314,000
Swaziland	1,977,000	1,189,000	60%	788,000	104,000	64,000	62%	40,000
Togo	2,206,000	1,305,000	59%	901,000	675,000	387,000	57%	288,000
Uganda	2,594,000	1,867,000	72%	727,000	4,043,000	2,221,000	55%	1,822,000
United Republic of Tanzania	2,494,000	2,016,000	81%	478,000	4,820,000	2,575,000	53%	2,245,000
Zambia	2,947,000	2,128,000	72%	819,000	683,000	217,000	32%	466,000
Zimbabwe	2,916,000	1,910,000	66%	1,006,000	3,625,000	2,065,000	57%	1,560,000
Totals	**112,296,000**	**74,442,000**	**66%**	**37,854,000**	**86,494,000**	**54,756,000**	**63%**	**31,738,000**

IMPLEMENTATION OF 2000-2001 PROGRAMME BUDGET

(COUNTRIES) AS OF DECEMBER 31, 2000

		Regular Budget			Other Budget			
Country	Available	Implemented	Rate	Balance	Available	Implemented	Rate	Balance
Algeria	1,820,000	1,232,000	68%	588,000	90,000	42,000	47%	48,000
Angola	2,752,000	1,554,000	56%	1,198,000	6,327,000	4,346,000	69%	1,981,000
Benin	2,347,000	1,419,000	60%	928,000	648,000	215,000	33%	433,000
Botswana	1,951,000	1,605,000	82%	346,000	178,000	81,000	46%	97,000
Burkina Faso	2,627,000	1,641,000	62%	986,000	1,630,000	1,083,000	66%	547,000
Burundi	2,794,000	2,064,000	74%	730,000	490,000	239,000	49%	251,000
Cameroon	2,189,000	1,292,000	59%	897,000	2,892,000	583,000	20%	2,309,000
Cape Verde	2,034,000	1,328,000	65%	706,000	43,000	6,000	14%	37,000
Central African Republic	2,649,000	1,675,000	63%	974,000	273,000	104,000	38%	169,000
Chad	2,789,000	1,960,000	70%	829,000	1,035,000	626,000	60%	409,000
Comoros	2,370,000	1,314,000	55%	1,056,000	273,000	42,000	15%	231,000
Congo	2,147,000	1,821,000	85%	326,000	1,010,000	545,000	54%	465,000
Cote D'Ivoire	1,856,000	1,153,000	62%	703,000	1,797,000	956,000	53%	841,000
Democratic Republic of Congo	2,906,000	2,305,000	79%	601,000	8,977,000	6,719,000	75%	2,258,000
Equatorial Guinea	1,511,000	1,143,000	76%	368,000	80,000	9,000	11%	71,000
Eritrea	2,045,000	1,963,000	96%	82,000	307,000	163,000	53%	144,000
Ethiopia	4,126,000	2,473,000	60%	1,653,000	9,498,000	7,126,000	75%	2,372,000
Gabon	1,688,000	1,246,000	74%	442,000	165,000	125,000	76%	40,000
Gambia	1,979,000	1,637,000	83%	342,000	599,000	290,000	48%	309,000
Ghana	2,143,000	1,413,000	66%	730,000	2,220,000	1,266,000	57%	954,000
Guinea	2,700,000	1,740,000	64%	960,000	561,000	173,000	31%	388,000
Guinea-Bissau	2,251,000	1,410,000	63%	841,000	343,000	168,000	49%	175,000
Kenya	2,386,000	1,788,000	75%	598,000	3,181,000	2,211,000	70%	970,000
Lesotho	2,398,000	1,067,000	44%	1,331,000	125,000	108,000	86%	17,000
Liberia	2,624,000	2,006,000	76%	618,000	695,000	449,000	65%	246,000

Regular Budget Implementation
Amount in US $
200,000,000
180,000,000
160,000,000
140,000,000
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
63,228,000
50,314,000
112,296,000
74,442,000
175,524,000
124,756,000
Regional Office
Countries
Total

Other Sources Budget Implementation
Budget
Implemented
175,261,000
116,188,000
86,494,000
54,756,000
88,767,000
61,432,000
Total
Countries
Regional Office
Amount in US $