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Biennial Report of the Regional Director

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Regional Committee for Africa,
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the work of WHO in the African Region 2000-2001

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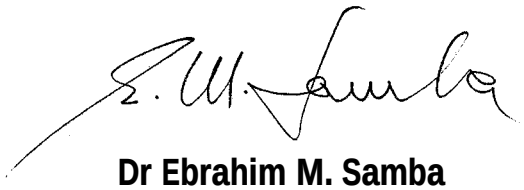
The Regional Director has the honour to present to the Regional Committee the report on the activities of the WORLD HEALTH ORGANIZATION in the African Region during the period 1 January 2000 to 31 December 2001.



Dr Ebrahim M. Samba
Regional Director

WORLD HEALTH ORGANISATION

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INTRODUCTION

1 The 2000-2001 Programme Budget was the last to be implemented under the Ninth General Programme of Work (1996-2001) and the first in the new millennium. It was developed at a time when the Director-General, Dr Gro Harlem Brundtland, had initiated Organization-wide reforms, including changes in the budget structure. The Regional Office for Africa was also operating from a temporary location in Harare. At the same time, Member States in the Region were plagued by the HIV/AIDS pandemic, widespread poverty, economic decline, political instability and frequent natural and man-made disasters.

2 The 2000-2001 Programme Budget sought to improve the effectiveness of WHO in the entire Region, but with a special focus on countries in ways that help them cope with key health and development challenges. The priorities identified in the Programme Budget are shown in the box.

PRIORITIES FOR 2000-2001

1. PREVENTION AND CONTROL OF MALARIA
2. HIV/AIDS AND TUBERCULOSIS
3. MATERNAL HEALTH AND CHILD SURVIVAL
4. RESPONSE TO COMPLEX EMERGENCIES AND EPIDEMICS
5. MENTAL HEALTH
6. HEALTH SECTOR REFORMS
7. HEALTH PROMOTION
8. POVERTY REDUCTION
9. PROMOTION OF HEALTHY ENVIRONMENTS

3 This report outlines the main achievements during the past biennium, as well as the most significant facilitating and constraining factors associated with those achievements. Specifically, the attention of the Regional Committee is drawn to some general trends in our work. They are as follows:

a The WHO African Region maintained a balanced focus on the broader determinants of health and diseases (environment, nutrition, poverty, risks related to lifestyles, health risks facing women, other socioeconomic factors) and on the control of specific health problems. It is increasingly clear that there will be no sustainable progress in improving the health status of our people unless we direct our efforts to the root causes of ill-health in Africa.

b Results-based Management (RBM) was introduced in which work plans were developed and implemented for each area of work (AOW) and regularly monitored at the Regional Office and country levels. As a result activities are now linked to financial data, using the Activity Management System (AMS), which allows WHO to analyse the degree of achievement of expected results and the cost-effectiveness of technical cooperation with Member States.

c The work of WHO country offices was enhanced through greater flexibility in programme management, increased decentralization of financial management and greater attention to capacity-building. Country offices have therefore become more responsive to country needs. What we are seeing today is the result of the collective efforts of the country teams and regional advisers.

d As a result of improved performance in the field, combined with rigorous and transparent performance-reporting standards, donor confidence in WHO reached a new high in 2000-2001 when there was a ten-fold increase (to more than US$ 317 000 000) in Other Sources funding as compared to 1996-1997.

e Stronger functional linkages have been forged between WHO programmes at global, regional and country levels, with corporate goals, objectives and expected results in all areas of work. WHO Programme Budgets are now strategically oriented. For each global expected result, the specific contributions of headquarters, the Regional Office and country offices are defined. In this way, the concept of "One WHO" has been translated into action.

f In pursuance of the Regional Committee recommendations, full renovation of the office and residential complexes of the Regional Office at Djoue was completed. In view of the improved security situation, I am pleased to note that the Regional Office has formally returned to Brazzaville.

g Through the Regional Director's Development Fund, it was possible to meet urgent needs beyond those anticipated and planned for in the biennial plans of work. This Fund supported the following:

(i) Special initiatives for community development, HIV/AIDS control and poverty alleviation in the Democratic Republic of the Congo, Ethiopia, Mali, Rwanda and Zimbabwe. Of these, WHO's support to the Mother of Peace Orphanage in Mutoko, Zimbabwe, stands out. The orphanage is now virtually self-supporting as a result of successful agricultural and livestock projects. Child mortality has dropped among the orphans, and the income-generating initiatives have spread to the surrounding villages. Similar programmes are now being undertaken at other sites in Zimbabwe and in other countries, for example, at the Orphelinat Ruyigi in Rwanda.

(ii) Resolution of priority problems of HIV/AIDS, tuberculosis and malaria: responding urgently to unmet needs in AIDS education for students (Liceu Nacional in Sao Tomé and Principe), the prevention of infant infection (African First Ladies' Summit in Rwanda on child protection from HIV/AIDS), strengthening of tuberculosis laboratory services (national TB laboratory in Gambia), and community-based malaria control (the Kanyemba project in Zimbabwe with Rotary International).

(iii) Response to floods (Ghana), support to eye camps for blindness prevention and treatment (Zimbabwe), recruitment of a health economist (Niger), and support to *Institut Islamique africain-américain de Kaolack* (Senegal).

These examples show how the Development Fund gives the Regional Director the flexibility to respond to special needs in the course of the biennium beyond what is provided for in the Regular budgets of the Regional Office and Member countries. 4

Many other achievements, as well as constraints, are documented in Part I. Part II reports on the progress made in the implementation of Regional Committee resolutions. 5

PART I:
IMPLEMENTATION OF THE 2000-2001 PROGRAMME BUDGET

SIGNIFICANT ACHIEVEMENTS

General programme development and management

Governing Bodies (GBS)

6 The key issues during the 2000-2001 biennium were how to further enhance the relevance of the work of the Regional Committee and Programme Subcommittee, and improve the preparedness of African delegations for more active and effective participation in the meetings of the World Health Assembly and the WHO Executive Board.

7 To this end, the Regional Office successfully organized the 50th and the 51st sessions of the Regional Committee and the related meetings of the Programme Subcommittee and ensured that their agendas were more focused on the key health priorities in the African Region. The quality of the technical documents prepared for these meetings was also improved through vigorous in-house peer reviews. Special efforts were made to ensure that all technical documents were sent to country delegates well in advance of the meetings.

8 African delegates to the World Health Assembly and Executive Board meetings were also adequately briefed on the agendas and procedures for the meetings. This ensured more effective participation of Member States in the debates on policies and strategies relevant to the African Region.

9 During the 2002-2003 biennium, efforts will be made to ensure greater synchronization of the agendas of the World Health Assembly, the Executive Board and the Regional Committee meetings.

Budget and management reforms (BMR)

10 During the 2000-2001 biennium, the WHO corporate strategy set out the ways in which the Organization intended to address health challenges in the rapidly evolving international context. The key issue was how the Regional Office could implement the Organization-wide reforms without compromising its ongoing support to countries.

11 Building on the corporate strategy orientations, the Regional Office implemented a fully integrated and results-based management system throughout the Region. This was achieved by establishing a participatory managerial process oriented to country needs, strengthening the Regional Office and country offices' capacity in programme management and adopting the Activity Management System (AMS).

A strategic framework to guide the work of WHO in the African Region during 2002-2005 was developed and disseminated. The Programme Budget for 2002-2003 and related workplans for the Regional Office and country offices were formulated in consultation with headquarters and national counterparts in ministries of health. 12

GUIDING PRINCIPLES OF RESULTS-BASED MANAGEMENT

1 ONE WHO

2 CLEARER FOCUS ON RESULTS

3 GREATER ACCOUNTABILITY

4 OWNERSHIP OF WORKPLANS

5 USE OF BUDGET FOR AGREED PRIORITIES AND EXPECTED RESULTS

6 CONSULTATIVE AND COLLABORATIVE APPROACH TO PLANNING AND MANAGEMENT

7 INCORPORATION IN WORKPLANS OF FUNDS BOTH FROM THE REGULAR BUDGET AND OTHER SOURCES

8 GREATER USE OF MANAGEMENT INFORMATION SYSTEM

The regional capacity for planning, programming and evaluation was strengthened through the recruitment of technical staff, and training of regional AOW focal points and seven WHO country teams. 13

In the next biennium, the WHO African Region will continue to consolidate the gains of results-based management while dealing with other emerging challenges. The areas of focus will include: 14

a further enhancement of the Regional Office and country office capacities in programme management;

b scaling up the implementation of the AMS;

c improvement in the linkage between programme implementation and budget implementation;

d support for the integration of the corporate strategy, the strategic framework for the African Region and the ongoing country cooperation strategy (CCS) exercise into the managerial process of the Regional Office.

External cooperation and partnerships (ECP)

15 The key issues under *External cooperation and partnerships* were to enhance external support and partnerships for health, to ensure more effective and efficient health programmes, and to improve technical cooperation with countries.

16 In order to address these issues, WHO promoted and reinforced coordination with partners in health development in Africa, provided guidance, technical assistance and support for programme development and management, and supported WHO country offices to build capacity.

17 With regard to external support and partnerships for health development, the flow of funds from Other Sources increased and partnerships were strengthened. To facilitate the mobilization and management of these resources, the Regional Office developed tools, provided continuous technical support and followed up on the preparation of legally-binding documents, donor round table conferences and other partner meetings. Partnerships between nongovernmental organizations (NGOs) and the Regional Office were improved through advocacy efforts, the organization of national NGO forums and through the initiation and support of NGO activities in the African Region.

18 Technical cooperation with countries has been improved through: implementing the newly-adopted WHO Country Cooperation Strategy (CCS) and its subsequent formulation in seven countries; improving the operations of country offices using staff briefing and training; rotation of WHO Representatives and Liaison Officers (WRs/WLOs); greater delegation of authority to WRs/WLOs; and improved office management. Furthermore, the Regional Programme Meetings (RPMs), held twice a year, provided all WRs/WLOs the opportunity to examine with the Regional Director ways and means of improving technical cooperation with countries in terms of effectiveness and efficiency.

19 Improved access to health information in the Region has been achieved through increased production of radio and television programmes and the issuing of periodicals such as *AFRO News* and the *African Health Monitor.* Guidelines were also produced to facilitate effective collaboration between the media and the health sector. The Regional Office also worked with countries to improve the coverage of priority health issues through support to national media seminars and workshops.

The main priorities for the next biennium will be: 20

a strengthening and monitoring of partnerships;

b continued technical assistance in the mobilization and management of resources;

c adaptation of WHO presence to country needs;

d management of WHO staff and improved leadership;

e improved coordination among the three levels of the Organization;

f improved production of health information materials;

g improvement in the capacity of the media and information networks to produce and disseminate relevant health information.

Resource mobilization (RMB)

The main issues tackled during the biennium were: improving the negotiation skills of Member States in their interactions with donors; and improving the capacity of the Regional Office in the standardization of legal instruments for support to Member States. 21

In order to develop and improve the negotiation skills of Member States, the Regional Office provided training to high-ranking officials of ministries of health, finance and external cooperation of the Republic of the Congo, the Democratic Republic of the Congo, Chad, Seychelles and Togo. Other participants in the training workshops included representatives of other UN agencies, donors and accredited missions at country level. 22

Since legal instruments are required for establishing formal working relations with donors and other partners, and since WHO has its own standard sets of rules, procedures and practices in the area of administration, budget and finance, a Regional Office standard format for fund-raising purposes was developed. This has been extremely useful judging from its wide use by all WHO country offices. 23

Given the continued growth in funds from Other Sources, and the need to account for these resources and report on their use, the Regional Office has also developed a system for monitoring funds from Other Sources. 24

25 The focus for the coming biennium will be on continued technical assistance for resource mobilization through (a) provision and review of instruments and tools for this purpose; and (b) capacity-building.

Research policy and cooperation (RPC)

26 In 2000-2001, the *Research policy and cooperation* AOW focused on the implementation of the regional strategic health research plan whose main thrust is the promotion of the role of research as a tool for rational decision-making. The PoA addressed specific issues related to the strengthening of research coordination at the Regional Office, promotion of research in Member States, development of research capacity, and enhancement of the effectiveness of the African Advisory Committee for Health Research and Development (AACHRD).

27 Major efforts were directed towards reviving and strengthening the role of the AACHRD, promoting priority research in Member States and streamlining the procedures for the selection of WHO collaborating centres as a means of enhancing effective research in the Region.

28 Regarding the main achievements under this area of work, the AACHRD provided major inputs for addressing the challenges facing health research in the Region. A number of countries received support for the development of their national research policies and priorities. Collaboration with centres of excellence and WHO collaborating centres was improved and coordination of research efforts in the Region enhanced. The development of vital research capacity in Member States was pursued through the encouragement of the development of research coordination and management organs in Member States and the provision of catalytic seed funds to support research on priority health problems. Furthermore, the Regional Office intensified efforts to increase research in traditional medicine.

29 Steps undertaken to strengthen national health research capacities will be continued in the next biennium. Special efforts will be made to provide support to and advice on national research policy and the translation of research results into effective policy decision-making.

Evidence for health policy (EHP)

30 In the area of *Evidence for health policy,* the Regional Office focused on strengthening capacity for generating evidence for decision-making at the regional and country levels.

A conceptual framework on the "Development of a management information system in the WHO African Region" was finalized and a regional database on health and health-related information was established within the context of the WHO global information system. Seventeen resource persons were trained in the burden-of-diseases measurement techniques. Seychelles was supported to implement ICD-10 and a national burden-of-diseases study. Mauritius was supported to implement ICD-10. 31

Concerning *Health economics,* resource persons from 18 WHO country offices were trained in economic evaluation, study of national health accounts and total cost of illness, economic viability analysis and health facility efficiency analysis. Health facility efficiency data collection instruments were developed and support provided to Chad, Ghana and Mozambique to pilot-test them. Health facility efficiency analyses of public hospitals and health centres in Kenya, South Africa and Zambia were also completed. 32

The Regional Office also organized an intercountry workshop on the development of tuberculosis and Integrated Management of Childhood Illness (IMCI) cost-effectiveness analysis and provided technical support to Swaziland to undertake a cost-effectiveness analysis of establishing a distance and continuing education programme for its health personnel. The economic burden of HIV/AIDS, maternal mortality and natural disasters in the African Region was also estimated and documented. 33

Over the next biennium, this area of work will continue to strengthen national capacity for generating and using epidemiological and economic evidence in decision-making. 34

Emergency and humanitarian action (EMH/EHA)

Under *Emergency and humanitarian action* the key issue was how to deal with the frequent emergencies occurring in the African Region. 35

The Regional Office responded with a dual approach: develop an institutional base for emergency preparedness and response in every country in the Region, and support urgent interventions in crisis situations. 36

During the biennium, the Regional Office undertook the following activities: 37

a deployed and trained emergency and humanitarian action focal points of WHO and ministries of health in 43 countries. Through these focal points, several countries have established EHA units, and the rest of the countries are committed to establishing these units (Pretoria, October 2001);

b created, for intercountry technical support, a decentralized pool of country-based experts trained in various aspects of emergency preparedness and response. The first group of 12 consultants from WHO country offices and ministries of health was trained in vulnerability assessment. Southern African Development Community (SADC) countries were also provided technical support to undertake hospital emergency planning and to develop a SADC disaster management structure;

c assisted Swaziland to conduct a vulnerability assessment for communities at risk of drought;

d assisted the Health Disaster Management Committee in Niger to develop a national emergency preparedness and response plan;

e recruited regional experts in emergency management to support response to acute emergencies in countries such as the Democratic Republic of the Congo, Guinea, Mozambique and Uganda. In cases where regional expertise was not available, suitable experts from elsewhere were recruited. For example, international consultants were sent on short- or intermediate-term basis to Mozambique, Nigeria, the Great Lakes subregion and Guinea (where a WHO sub-office has been established in Kissidougou to support the multi-agency response to the refugee crisis). In critical situations, WHO also provided emergency health kits containing essential drugs and supplies. For better resource mobilization and coordination of emergency interventions, the Horn of Africa Initiative and the WHO Coordination Office for the Great Lakes subregion, based in Nairobi, were reactivated;

f strengthened collaboration between the various technical units (e.g. nutrition and malaria) to ensure that their respective programmes were prepared to meet emergencies;

g worked with UNICEF to organize consultations, bringing together participants from all regions of the Democratic Republic of the Congo and representatives from 17 partner NGOs and donors in Nairobi, to develop a "minimum package" of public health interventions for emergency situations.

38

During the next biennium, the focus will be to:

a support ministries of health to create EHA units (and not just designated focal points);

b continue to train staff, improve the technical tools for planning and assessment and further develop the regional network of consultants to improve information exchange between countries;

c improve coordination with headquarters, particularly in the management of the Consolidated Appeal Process;

d improve the performance of WHO country offices in emergencies, particularly in their leadership role in health interventions of UN agencies and partners;

e intensify cooperation with subregional groupings and organizations, including SADC, the Mano River Union and the Intergovernmental Authority on Development (IGAD), for improved cross-border operations and management of population displacement.

Health systems and services development

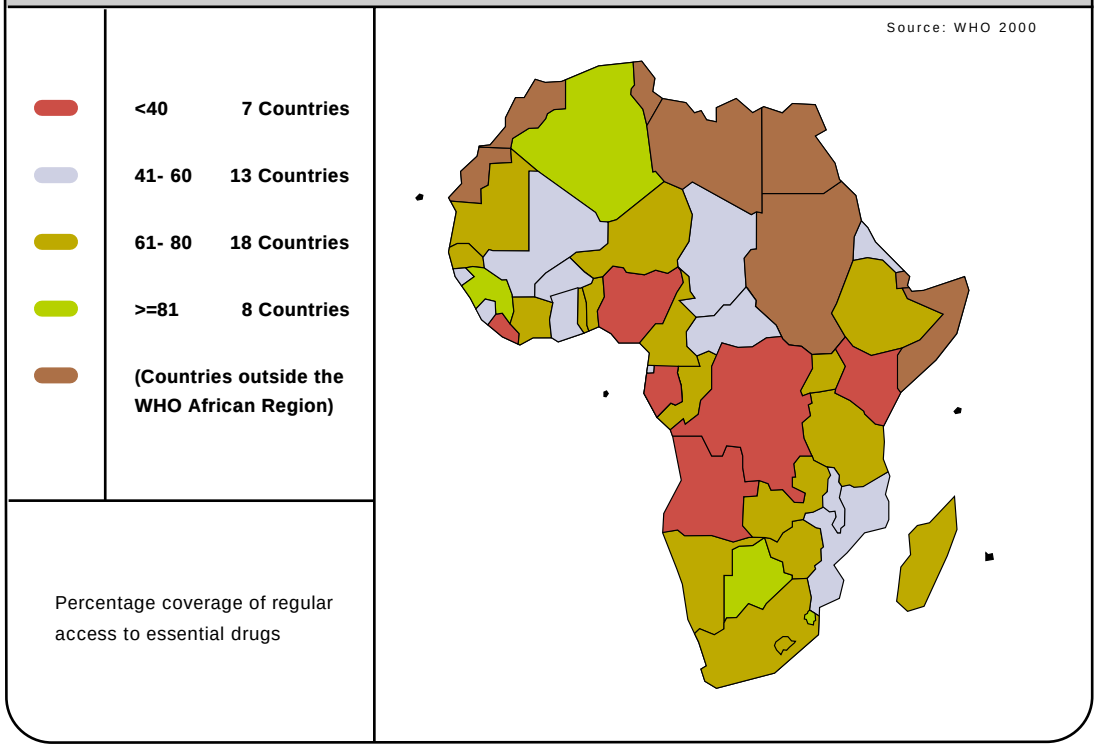
39

In the area of *Health systems and services development,* the Regional Office supported countries to develop their health systems based on primary health care, with a special focus on local or district level. The strategic priorities were: health policy analysis, restructuring of national health systems, development of sustainable health financing mechanisms and organization of district health systems; human resources policy development including strengthening of nursing and midwifery personnel; and provision of quality care based on appropriate use of health technologies.

40

The biennial evaluation of the Programme Budget shows that 98% of the planned expected results were fully or partially realized. However, health systems in the Region remain weak as shown by the fact that life expectancy in the Region is the lowest when compared to other regions. The situation with regard to human resources for health continued to worsen, with large numbers of health workers migrating to developed countries. Member States are concerned about this situation which is threatening health development in the Region and are engaging the international community to address it. The availability of drugs and medicines remains critical. In seven countries, some of them highly populated, the coverage in essential drugs is estimated to be less than 40%. In general, it is estimated that 50% of the population in the Region do not have regular access to essential drugs (Figure 1). Growing poverty at both national and individual levels and very low expenditure on health are the main reasons for poor health outcomes.

FIGURE 1: Status of access to essential drugs in the African Region



Organization of health service delivery (OSD)

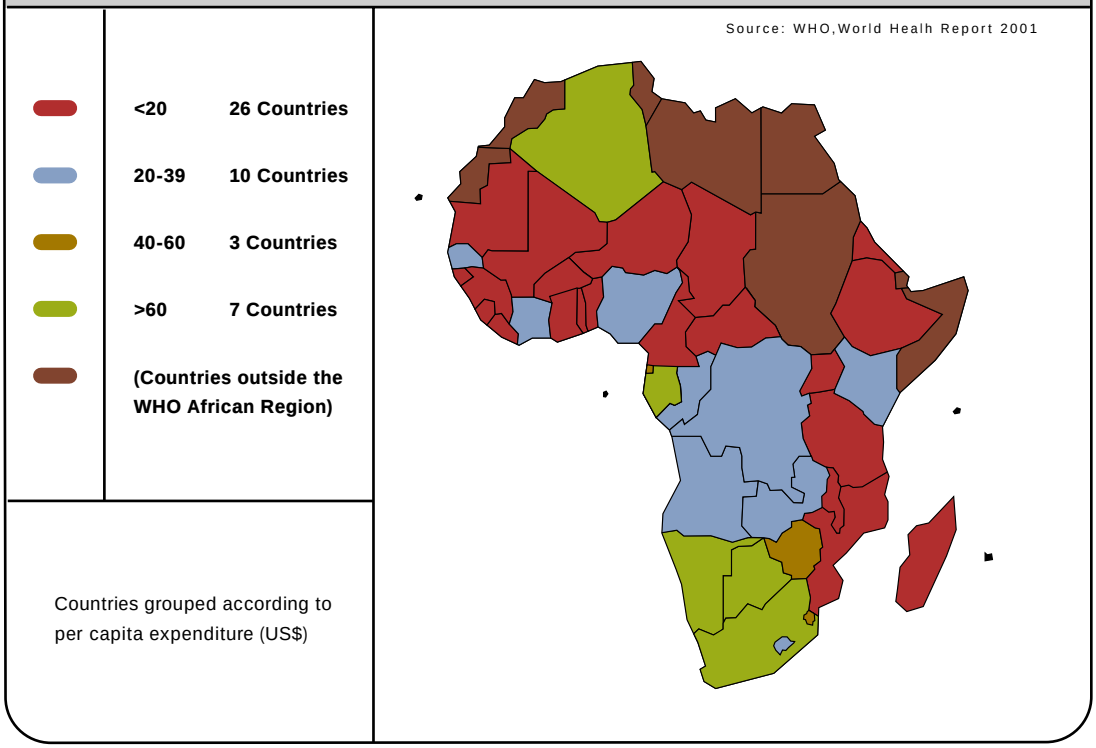
41 A critical landmark during the biennium was the adoption of *Health-for-All Policy for the 21st Century in the African Region: Agenda 2020* during the 50th session of the Regional Committee in Ouagadougou in 2000.

42 Thirty-four countries were supported in their health sector reform processes, mainly to review their national health policies and plans and/or to reorganize their national health systems. This was done in collaboration with partners such as the African Development Bank, the World Bank and bilateral and multilateral agencies. Two consultations were held, one on the implementation of Sector-Wide Approaches (SWAps) in the context of health sector reforms, and the other on the health systems performance assessment framework first published in the World Health Report 2000. Six countries (Gambia, Ghana, Mozambique, Seychelles, Uganda and Zambia) undertook study tours to exchange experiences in health sector reforms. Guidelines and tools for the monitoring and evaluation of health sector reforms were finalized.

43

In collaboration with other partners, support was provided to 10 countries to undertake national health accounts studies. Capacity-building for the studies was carried out through a training course in Lusaka (Zambia). An analysis of the per capita health expenditure shows that amounts spent on health in the African Region remain very low (Figure 2).

FIGURE 2: Total per capita health expenditure (US$) in the African Region



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Training modules for district health management and tools for the assessment of district operationality were finalized and are now available for use. Twelve countries were supported to assess the operationality of their district health systems. The new operational framework of the Bamako Initiative (BI) was developed and finalized in collaboration with UNICEF and other health development partners.

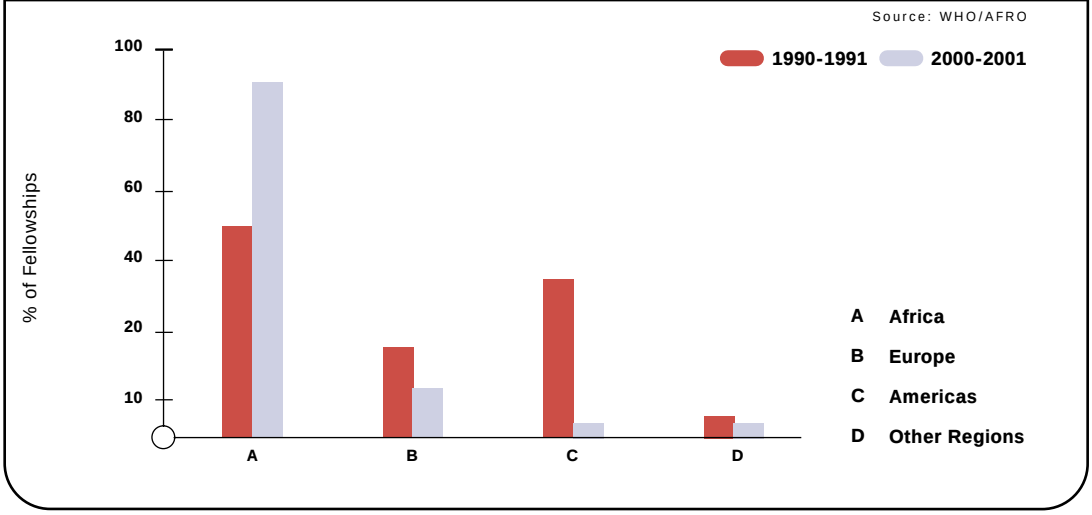
45

Ten countries (Burkina Faso, Congo, Equatorial Guinea, Gabon, Gambia, Mauritania, Mozambique, Sao Tomé and Principe, Togo and Uganda) received support to strengthen their health information systems. Four of the countries developed essential health indicators.

46 A regional meeting of health systems research (HSR) focal points and policy analysts was held in Harare to share experiences on HSR development. Tools for defining health research country profiles were developed and used in 21 countries. Burundi, Eritrea, Ethiopia, Gambia, Madagascar, Malawi, Mali, Nigeria, Sao Tomé and Principe, Senegal, Zambia and Zimbabwe were supported in HSR skills development. Fifteen HSR proposals on priority health problems were supported.

47 Two courses on human resources management were organized and 41 human resources managers from 34 countries were trained. Guidelines for evaluating health sciences training programmes were developed and used in Gabon, Tanzania and Zimbabwe. Support was given to the five Portuguese-speaking countries for the preparation of the medium-term (2002-2006) plan for the development of human resources for health. A study on the migration of skilled health personnel was started in six countries (Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe). Five hundred and fifty-six fellowships were awarded and 90 per cent of the fellows were placed in training institutions within the African Region, in conformity with resolution AFR/RC39/R5 (Figure 3).

FIGURE 3: Number of fellowships awarded and WHO regions of placement of fellows



48 Future prospects include the need to consolidate the gains achieved so far and to extend efforts to other countries; strengthen the stewardship role of governments; develop appropriate tools in health financing including national health accounts; and develop human resources and the organization and management of health systems, especially with regard to the provision of services in the context of health sector reforms.

Essential drugs and medicines policy (EDM)

49 The key issues in the area of *Essential drugs and medicines policy* were securing universal access to good quality drugs at affordable costs, and ensuring their rational use. WHO's strategy in addressing these issues was to work in the following main areas, namely: policy development and implementation; strengthening drug supply systems and drug regulatory authorities; rational use of drugs; and development and implementation of traditional medicines policies.

50 Some gains were made at the regional and country levels, but they need to be further consolidated. National essential drugs and medicines advisers were recruited in 10 countries to provide technical support required by them. A training manual on the management of drugs at the health-centre level was produced and 40 nurses were trained in Gambia, Lesotho and Malawi using this tool. The second edition of the *AFRO Essential Drugs Price Indicator* was published and many countries and partners are now using it.

51 Other tools which were produced are: the third edition of the brochure on quality control laboratories; the second edition of the chart on the status of drug regulatory and quality assurance elements in the African Region; the second edition of the guidelines for the formulation, implementation, monitoring and evaluation of national drug policies; *AFRO Pharmaceutical Newsletter;* guidelines for the inspection of pharmaceutical establishments; and, at the request of Nigeria, guidelines on the management of snakebite.

52 Several training courses and workshops on capacity building were organized. These included: a course on good manufacturing practices (GMP); training in quality screening of TB drugs using thin-layer chromatography techniques; training of quality control laboratory managers and technicians; workshops for drug inspectors and other drug regulatory staff in Ghana, Kenya and Uganda; a rational drug-use course in Nigeria; and two courses on rational prescribing in Algeria and on pharmacotherapy teaching in South Africa. In response to an urgent request from countries, a sensitization meeting on the implementation of safeguards of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement was held for English-speaking countries.

53 A pilot study on the quality of drugs commonly used to treat malaria was undertaken in six countries. The results of the study showed that in many cases these drugs were of poor quality. Appropriate action was taken, in collaboration with countries, to address this issue.

54 Support was provided to Botswana, Cameroon, Cape Verde, Equatorial Guinea, Ghana, Lesotho, Liberia, Mauritania, Namibia, Sao Tomé and Principe, Seychelles and Swaziland to develop and adopt national drug policies or to select national drug policy indicators. Joint needs-assessment missions were undertaken with UNAIDS to Lesotho and Swaziland.

55 A regional strategy on promoting the role of traditional medicine in health systems was adopted in September 2000. A regional expert committee on traditional medicine was established which provided valuable support to the programme. Other activities undertaken during the biennium included collaboration with research institutions to evaluate herbal preparations used for treating priority health conditions. Mechanisms for developing capacities for large-scale local production of safe, efficacious and good quality medicines are being put in place.

56 Protocols for the evaluation of traditional medicines and ethnomedical studies on HIV/AIDS, malaria, hypertension, diabetes and sickle cell anaemia drugs were prepared and adopted at the Regional meeting on the institutionalization of traditional medicine in health systems, held in Harare in November 2001. Results of these studies showed that traditional medicines contained pharmacologically-active ingredients. Further research on this aspect is being undertaken.

57 During the next biennium, the key areas of focus will be the provision of further support to countries in securing durable and affordable access to essential drugs for priority diseases such as malaria and HIV/AIDS, and the implementation of the traditional medicine strategy. Support to countries in understanding the implications of the TRIPS agreement and the implementation of its safeguards will receive particular attention.

Blood safety and clinical technology (BCT)

58 The key issues addressed by the *Blood safety and clinical technology* area of work were: the provision of support to countries to improve the quality of care through appropriate and affordable technologies, and to set up mechanisms to enable them to provide adequate and safe blood to patients.

59 Considerable efforts went into the preparation of a regional strategy for blood safety, which was adopted at the 51st session of the Regional Committee in Brazzaville in August 2001. The first draft of the guidelines for blood transfusion policy formulation in Member countries was produced. Support was provided to Cameroon, Central African Republic, Democratic Republic of the Congo, Gambia, Ghana, Guinea-Bissau, Mali, Mauritania, Swaziland and Seychelles to finalize their national blood transfusion policies. Seventeen countries in the Region now have a blood transfusion policy.

60 The capacities of national blood transfusion services in Harare (Zimbabwe) and Abidjan (Côte d'Ivoire) were strengthened in order to enable them to provide technical services to Member countries, including training programmes for blood transfusion personnel. Courses were organized for 64 quality assurance managers in the two countries. Two workshops for the directors of national blood transfusion services were held during which the situation of blood safety in the

Region was reviewed, constraints identified and solutions proposed for service improvement. Tools for the evaluation of blood transfusion services in Member States were developed and have been used to collect information on the status of blood transfusion safety in all countries.

61 The main achievements in the area of *Quality of care and clinical technologies* were the organization of two workshops, one on quality assurance of care and the other on quality assurance in clinical laboratories. Guidelines for the formulation of a national health care equipment policy were finalized. Support was provided to Burundi, Chad, Congo, Eritrea, Malawi and Niger to implement quality-of-care programmes in district hospitals and quality assurance programmes in clinical laboratories.

62 The focus of the blood safety programme in the next biennium will be to consolidate the implementation of the regional strategy for blood safety, with special emphasis on policy development, blood-donor recruitment, training in quality and implementation of quality assurance programmes.

63 The Regional Office will endeavour to develop norms and standards for the management of hospital equipment and to strengthen quality of care through the promotion and implementation of quality assurance programmes, with special focus at the district level.

Prevention and control of communicable diseases

64 Communicable diseases are still among the major killers in the African Region. They are the causes and the consequences of poverty. During 2000 – 2001, strategies and frameworks for the prevention and control of major communicable diseases which were formulated and adopted by the Regional Committee were implemented. Member countries were supported to implement proven interventions and improvements were observed in many areas of work.

Communicable disease surveillance (SUR)

65 A number of communicable diseases such as meningococcal meningitis, cholera, yellow fever and viral haemorrhagic fevers are prone to severe and deadly epidemics, causing significant disruption in social and health services. Disease-specific control programmes need updated and reliable information on morbidity, mortality and trends in order to guide public health interventions. Unfortunately, the surveillance of communicable diseases is still weak in most Member States. Furthermore, the level of preparedness and the capacity of countries to respond to the likely epidemics were often less than optimal.

66 Since 1996, the Regional Office has supported countries in signing protocols of cooperation in epidemic prevention and control. Through these protocols, countries with common epidemiological and geographical characteristics committed themselves to sharing information and resources for epidemic prevention and response, with support from WHO. The Member States adopted, in 1998, the regional strategy on integrated disease surveillance. The strategy promotes integration and coordination of disease surveillance activities. It focuses on the linkage of surveillance data to public health action, stressing national ownership, decentralized decision-making and action at all levels of the health system.

67 In terms of key achievements, the *Technical guidelines for integrated disease surveillance and response* and assorted training materials were provided to all Member States. The assessment of existing communicable disease surveillance and epidemic preparedness and response systems was conducted in 27 countries. Twenty of these countries have formulated plans for integrated disease surveillance and response, while 12 initiated implementation.

68 Comprehensive regional and subregional databases were also established for priority communicable diseases. Key staff of national public health laboratories were trained in diagnostic methods for bacterial diseases and provided with communication equipment and diagnostic kits to facilitate the starting of national, subregional and regional public health laboratory networks. Surveillance of acute flaccid paralysis in all countries reached the standards set by WHO.

69 Nine countries trained their health personnel in epidemic preparedness and response where, as a result, outbreak detection and reporting have significantly improved. Well-coordinated efforts by national health authorities, WHO and other partners resulted in rapid and effective control of epidemics of Marburg haemorrhagic fever in the Democratic Republic of Congo, Ebola haemorrhagic fever in Uganda, yellow fever in Côte d'Ivoire and Guinea, and meningitis and cholera in several other countries.

70 During the next biennium, the implementation of strategies for integrated disease surveillance and epidemic preparedness and response will be scaled up. National ownership and strong partnership will be of paramount importance in this process. The Regional Office will also establish and support the Multidisease Surveillance Centre in Ouagadougou (Burkina Faso) as a centre of excellence for integrated disease surveillance.

Prevention and control of communicable diseases (PCC)

71 The *Prevention and control of communicable diseases* area of work comprised the following disease control programmes: malaria, tuberculosis (including Buruli ulcer), trypanosomiasis, HIV/AIDS/STI, and Other Tropical Diseases (OTD) which focused on the following diseases: onchocerciasis, schistosomiasis, lymphatic filariasis, etc. The key issues that were addressed during the biennium were:

a strengthening of national capacities in the planning, implementation, monitoring and evaluation of the recommended control strategies (e.g. DOTS for tuberculosis, Expanded Programme on Immunization, Roll Back Malaria, etc.);

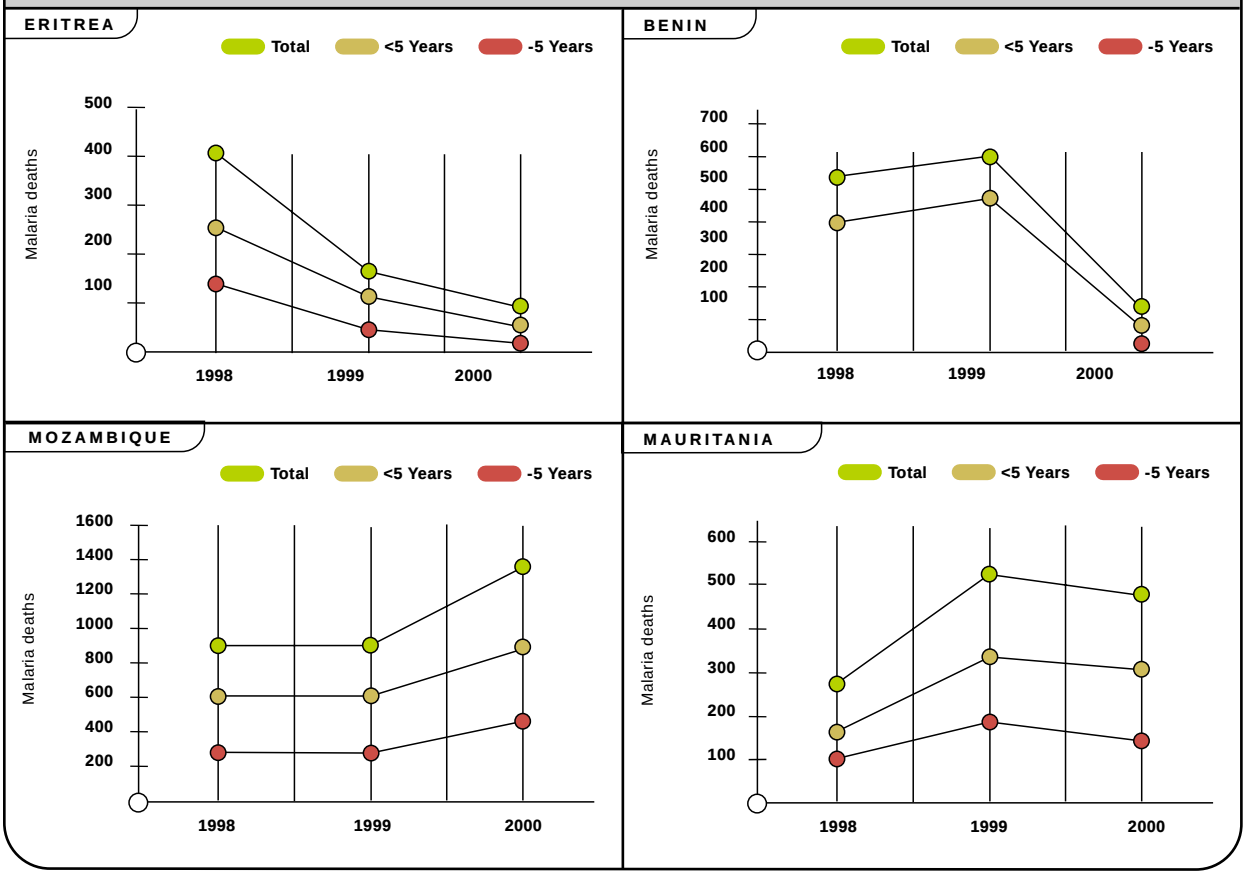
b strengthening of the capacity of WHO intercountry and country teams to provide, upon request, rapid and effective technical support to countries.

72 To address these issues and challenges, WHO developed new tools and strengthened Member States' capacity to scale up the implementation of prevention and control strategies in order to ensure an effective health system response to the targeted diseases. Furthermore, partnerships with key stakeholders were developed to mobilize the needed resources. Monitoring and evaluation of the implemented activities was also conducted. In addition, policy and structural reorganization was undertaken, including the creation of a Vector Biology and Control (VBC) unit, to effectively integrate all vector control activities across programmes and thereby improve efficiency.

73 The following were achieved in terms of the expected results, products and services that were set for the biennium: capacity was developed in 36 (86%) of the 42 endemic countries to plan, implement, monitor and evaluate malaria control activities; correct management of malaria cases was ensured in 27 (64%) of these countries; capacity was built in all 18 epidemic-prone countries to forecast, detect early and respond adequately to malaria epidemics. Furthermore, active promotion of innovative ways for malaria control through community-based interventions, including home treatment of malaria episodes and distribution of insecticide-treated bednets, was encouraged in 26 countries; baseline data for the monitoring and evaluation of the results and impact of Roll Back Malaria were collected in 13 of the 42 endemic countries; and lastly, 11 (26%) of these countries, with support from the Regional Office, completed their strategic plans to roll back malaria.

74 Figure 4 shows the trends in malaria mortality in selected countries in 1998-2000. While net decreases in mortality were observed in Benin, Eritrea and Mauritania, increases were recorded in Mozambique, probably due to the effects of floods during 2000.

FIGURE 4: Core impact indicator 2B: trends in Malaria mortality from selected health facilities in selected countries (1998-2000)



75 In line with the creation of a regional programme for vector biology and control, a framework for the development and implementation of vector control interventions was developed and its dissemination to Member States for adaptation is under way. A training course on vector control, focusing on insecticide-resistance testing, monitoring and management, was developed and implemented in collaboration with three research institutions (the South African Institute for Medical Research, Centre Muraz in Burkina Faso, and the OCEAC in Cameroon). Forty participants from 25 countries were trained in this course and provided with equipment and seed funds to initiate insecticide-resistance testing activities in their respective countries. Lastly, the Regional Office actively contributed to the negotiations on international action against persistent organic pollutants (POPs), including DDT, leading to an international consensus on the continual use of DDT for disease control purposes in the Region.

76 The regional strategy for the control of tuberculosis was revised and implemented to effectively address the growing need to rapidly expand the implementation of the directly-observed treatment, short-course (DOTS) strategy, using innovative approaches such as community involvement, and to meet the new challenges

posed by the dual TB/HIV epidemic. In the 30 countries targeted, population access to DOTS services increased from 70% in 2000 to 86% in 2001. Nineteen (63%) of these countries increased their DOTS coverage to 90% or more, while the treatment success rate for new cases increased from 62% in 1999 to 67.4% in 2000 (though it still fell short of the regional target of 85%). Seven of the 16 countries that applied to the global tuberculosis drug facility for support were approved and drug shipment to those countries was ongoing.

77 During the biennium, the results of the operational research project on community TB care were translated into policy guidelines, the implementation of which is being expanded in at least four countries. A new initiative to strengthen the collaborative implementation of joint TB/HIV control activities was successfully introduced in at least six highly affected countries. Technical support to nine countries with a high TB burden was strengthened through the recruitment of national professional officers.

78 New regional technical guidelines for the control of Buruli ulcer were developed and shared with affected Member States. At least three (60%) of the five countries targeted developed and implemented national control programmes based on these guidelines. Furthermore, development of draft training modules for use by Member States to strengthen the knowledge and skills of health workers in the control of Buruli ulcer was successfully completed.

79 Resource mobilization and strengthening of partnerships, notably the Italian Initiative on HIV/AIDS in Africa, provided US$ 8 million to support 10 countries. Fifty technical support missions to 32 countries were carried out, which contributed to improved surveillance activities, treatment of sexually transmitted infections, laboratory services and treatment and care of AIDS patients including the use of antiretrovirals. Twenty intercountry meetings and expert consultations were conducted, which resulted in technical policy updates, intercountry exchange of best practices and experience and expanded networks of consultants. National programme officers were recruited, which resulted in strengthened capacity for direct and continuous support in 15 countries. Support was given to international advocacy and mobilization, notably the OAU Heads of State and Government Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases, whose declaration is a key policy directive at the highest level.

80 Regional strategies for the control of four diseases (schistosomiasis, lymphatic filariasis, soil-transmitted helminthes and trypanosomiasis) were developed and shared with countries. Using these strategies, seven countries prepared national plans for the control of schistosomiasis, and three countries are already implementing their plans for the control of trypanosomiasis. Lymphatic filariasis mapping was either completed or is ongoing in nine countries, five of which implemented mass drug administration, with 92% coverage in at least one coun-

try. Furthermore, a regional database for lymphatic filariasis was created as was the regional lymphatic filariasis elimination programme review group. Onchocerciasis devolution projects were successfully reinforced in six countries through the provision of technical support in collaboration with the African Programme for Onchocerciasis Control.

81 For the 2002-2003 biennium, the *Communicable diseases prevention and control* area of work has been reorganized, promoting some programmes such as malaria, tuberculosis and HIV/AIDS as areas of work. However, the key orientations given below for the next biennium are the same as for the original programmes that constituted the Prevention and control of communicable diseases area of work.

82 Key priorities for *Malaria control* will be to reinforce country capacity to scale up the implementation, supervision, monitoring and evaluation of Roll Back Malaria interventions based on the national strategic plans developed during the biennium under review.

83 In the area of *Vector biology and control,* the focus will be on three major areas, namely:

a supporting countries in the preparation and adaptation of national frameworks and guidelines for vector control;

b building capacity, including appropriate staffing at all three levels, for vector control;

c supporting countries to establish vector control demonstration projects in selected districts, using the integrated vector management approach.

84 For *Tuberculosis control,* priority will be given to the reinforcement of capacity-building at all levels in order to:

a accelerate DOTS coverage in all countries, using innovative approaches such as community involvement, public-private partnership development, etc.;

b develop, implement and expand appropriate interventions to contain the dual TB/HIV epidemic;

c improve monitoring and surveillance.

Buruli ulcer control will aim at: 85

a supporting countries to develop, implement, monitor and evaluate national programmes, using the technical guidelines and training modules developed by the Regional Office;

b promoting and supporting relevant operational research to improve the existing tools for prevention and control in collaboration with relevant key stakeholders.

HIV/AIDS/STI will focus attention on supporting health systems delivery of a package of care as well as prevention interventions at district and community levels, expanding networks of technical experts at country and subregional levels, and supporting Member States in the application of technical tools for programme planning and assessment. 86

Finally, priorities for *Other tropical diseases* will include: 87

a scaling up the lymphatic filariasis elimination programme in affected countries;

b supporting countries to develop and implement control programmes for schistosomiasis, soil-transmitted helminthes and trypanosomiasis.

Communicable disease eradication and elimination (ERD)

Member States continued to move towards achieving communicable disease eradication and elimination goals, particularly the eradication of poliomyelitis and elimination of neonatal tetanus and leprosy. Nonetheless, neonatal tetanus still accounted for 110,000 infant deaths yearly in the Region. The interruption of the circulation of dracunculiasis has yet to be realized in 13 countries. 88

The objectives of the *Communicable disease eradication and elimination* area of work during the 2000-2001 biennium were to support Member States to: 89

a achieve and maintain the interruption of the transmission of wild poliovirus and dracunculiasis;

b accelerate and/or maintain the elimination of neonatal tetanus and leprosy.

90 Tremendous progress was made in the Region with regard to the eradication and elimination initiatives. Although initiated late (in 1995), all 32 "polio endemic" countries in the Region successfully implemented national immunization days and established surveillance of acute flaccid paralysis (AFP) by the beginning of the biennium. AFP surveillance dramatically improved in 2001 to reach non-polio AFP rate of 2.7 cases per 100,000 children aged 15 years and above. Also in 2001, wild polio was detected in seven countries in the African Region – down from 12 in 1996. The successful synchronization of national immunization days in West and Central Africa during the biennium contributed to these achievements. Maternal and neonatal tetanus has been virtually eliminated in 12 countries. Leprosy elimination was validated in nine countries, while the regional prevalence rate dropped to 0.98 cases per 10,000 inhabitants in July 2001 – down from 1.29 in December 1999. A global 55% reduction of dracunculiasis incidence was achieved during the biennium. Four countries in the Region were declared "free of circulation of dracunculiasis", and requests for certification were submitted for yet another four countries.

91 In the next biennium efforts will be made to interrupt the transmission of wild poliovirus in the remaining endemic countries and to achieve and maintain the certification level of AFP surveillance in all countries in the African Region. Indeed, there is a need for further government and donor commitment in order to secure timely financial support for polio eradication, elimination of neonatal tetanus and leprosy, and eradication of dracunculiasis in the remaining endemic countries. Integrated disease surveillance at all levels, including at community level, will be key to monitoring the progress made.

Communicable disease research and development (CDR)

92 The focus of *Communicable disease research and development* area of work was to build the capacities of countries in planning, implementing, evaluating and disseminating research for the purpose of influencing strategies and policies for the control of communicable diseases, lymphatic filariasis and Buruli ulcer.

93 The WHO strategy was to provide support to countries in order to strengthen their capacity for operational research in communicable diseases and to use results obtained to influence policy and practice for their prevention and control.

94 Capacity was built through workshops and country technical support missions, leading to the design and conduct of operational research studies in 32 countries as against the 21 malaria-endemic countries in the Region that were targeted. Seventeen countries received financial support to undertake research studies that were developed at these workshops. Technical and financial support was provided to 15 countries for ongoing studies on the therapeutic efficacy of antimalarial drugs as well as for the establishment of 10 new sentinel sites. During the period under review, six countries reviewed their antimalarial treatment policy and four initiated the process of change. Capacity was built in 14 countries in the economic analysis of malaria.

95 Under *Integrated Management of Childhood Illness (IMCI),* the major achievement was the dissemination of research results to countries in the implementation phase of IMCI and the translation of these results into policy and practice in some countries. Four countries conducted studies on the operational effectiveness of DOTS and results are being translated into policy guidelines for managing tuberculosis in the community. In HIV/AIDS, support was provided to ten countries through the interagency working group on the prevention of mother-to-child transmission of HIV/AIDS in order to pilot intervention studies in this area. Concerning the control of schistosomiasis and lymphatic filariasis, data was generated that will be used for resource mobilization among partners.

96 During the next biennium, emphasis will be on using new and proven technologies and approaches for the control of communicable diseases and on the identification of areas where traditional remedies could be adapted for use within current health structures.

Prevention and control of noncommunicable diseases

97 The prevention and control of noncommunicable diseases and health promotion are gradually gaining importance in WHO cooperation programmes. This is a fortunate development, for global projections[1] and specific studies backed by actual controlled data[2] show that noncommunicable diseases are a major public health concern.

Surveillance, prevention and management of noncommunicable diseases (NCD)

98 This area of work comprises the programmes on chronic diseases, oral health as well as ageing and health.

Chronic diseases

99 A regional strategy for the prevention and control of noncommunicable diseases was adopted by the 50th session of the Regional Committee, which was a milestone in the control of noncommunicable diseases. Following this, a consultation of experts prepared a framework for the implementation of that strategy.

[1]Based, though, on estimates and extrapolations – given the lack of reliable mortality and morbidity data – studies on the overall disease burden conclude that the probability of death from noncommunicable diseases is, in absolute terms, higher in sub-Saharan Africa than in developed countries that have established market economies.

[2]Some countries have been able to gather data either through a systematic noncommunicable disease data collection system (e.g. Mauritius, Seychelles) or through pilot studies in some geographical areas (Tanzania). In the latter case, the conclusion drawn from the study on the overall disease burden is confirmed by field data from both rural and urban areas: See Unwin N.& Col. "Noncommunicable diseases in subSaharan Africa: where do they feature in the health research agenda? WHO bulletin, 2001; 79 (10): 947-953.

100 An analysis of national capacities to prevent and control noncommunicable diseases was conducted, and the results were disseminated in countries. The Regional Office provided support for analysing the situation of noncommunicable diseases in six countries (Botswana, Burkina Faso, Cameroon, Democratic Republic of the Congo, Gambia and Zimbabwe).

101 The strengthening of national capacities was undertaken through sustained training effort. Many training sessions were organized for health professionals of the Region in areas such as early detection and treatment of cervical cancer, and epidemiology and management of diabetes. Support was given to several national and subregional workshops. A project aimed at improving long-term care for cancer and HIV/AIDS patients started in six countries of the Region, namely, Botswana, Ethiopia, South Africa, Tanzania, Uganda and Zimbabwe.

102 The first stages of the establishment of an African network of initiatives in the prevention and control of noncommunicable diseases were started. Collaboration was established between the Regional Office and the European Union in the surveillance and community management of hypertension in some countries.

Oral health

103 Activities emanated from the 1998 regional strategy on oral health. The Regional Office continued advocacy and support to countries.

104 Four more countries, namely Burkina Faso, Guinea, Mauritius and Seychelles, formulated national oral health plans and/or policies.

105 The provision of preventive oral health care in districts was supported in five countries, namely Benin, Côte d'Ivoire, Democratic Republic of the Congo, Guinea and Rwanda.

106 A workshop on atraumatic restorative treatment (ART) techniques helped provide training for 34 participants from 16 countries (Botswana, Burkina Faso, Cameroon, Eritrea, Ethiopia, Gambia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, Sierra Leone and Swaziland).

107 WHO collaborating centres in the Region developed teaching documents on oral health, in general, and HIV/AIDS-related aspects of oral health, in particular, for use by health professionals and the general public.

108 Research started on the efficacy and safety of the use of traditional methods of oral hygiene.

Concerning noma, the Regional Office, in addition to providing direct support to affected countries, proposed the integration of the methods of prevention, early detection and treatment into the routine activities of integrated management of childhood illness. 109

Aging and health (AHE)

The project for developing a minimum evidence-based policy support for the elderly continued in four countries (Ghana, South Africa, Tanzania and Zimbabwe) with the collaboration of the WHO Headquarters. Five countries (Gambia, Ghana, Nigeria, Senegal and Togo) were assisted to develop a national policy for the elderly. Furthermore, 18 health teams in Senegal were trained in care of the elderly. 110

Orientations for 2002-2003

Normative work in noncommunicable diseases will continue; in fact a methodology for setting up a noncommunicable diseases surveillance system is now available. Training of national focal points and some experts in this methodology has been planned to enable 24 participants from seven countries (Algeria, Cameroon, Côte d'Ivoire, Ghana, Mozambique, Senegal and Zimbabwe) to be initiated to the methodology in order to start its gradual implementation in their respective countries, with WHO's support. 111

In the next biennium, activities will focus on the following areas: development of guidelines for the prevention and monitoring of the main noncommunicable diseases; and support to operational research on noncommunicable diseases and noma. 112

Nutrition (NHD)

During the biennium under review, activities focused on four priority areas: adoption and implementation of national plans of action on nutrition (NPAN); control of nutritional deficiencies; infant and young child feeding; and nutrition in emergency situations. 113

Two intercountry meetings (involving 46 countries), organized with FAO, analysed the follow-up to the International Conference on Nutrition and the implementation of national plans of action on nutrition (NPAN). The Regional Office supported four countries (Burkina Faso, Comoros, Seychelles and Togo) to adopt their NPAN. 114

115 The Regional Office supported six countries (Benin, Burkina Faso, Gabon, Mali, Sao Tomé and Principe and Togo) to conduct surveys on iodine deficiency. Two feasibility studies on food fortification were supported in Guinea and Mauritania.

116 A regional consultative meeting, organized with UNICEF, analysed the draft global strategy on infant and young child feeding and made relevant proposals, taking account of the African context. The fifty-first session of the Regional Committee endorsed those proposals.

117 Support for training in breast-feeding continued in six countries (specifically the five Portuguese-speaking countries and Equatorial Guinea). Furthermore, over 80% of the countries undertook sensitization activities focused on the risks of mother-to-child transmission of HIV and about ten countries developed a comprehensive programme on the prevention of mother-to-child transmission of HIV.

118 An intercountry workshop on nutritional emergencies was organized in October 2001 for the French-speaking countries.

119 During the 2002-2003 biennium, the same thrusts of work will be maintained but efforts will be made to integrate related activities and programmes and to pursue active partnerships with sister agencies and NGOs like the International Baby Food Action Network (IBFAN) and Helen Keller International (HKI).

Health promotion (HPR)

120 The *Health promotion* programme sought to assist countries to consider the global health determinants underpinning the heavy disease burden in the Region.

121 The implementation of the programme focused on: (i) strengthening national and regional capacities to develop health-promoting curriculums; (ii) supporting countries to establish comprehensive school health education programmes; and (iii) encouraging health-promoting schools networking.

122 In September 2001, the Regional Committee adopted a regional strategy on health promotion. A group of African experts produced two guides, one on the formulation of health promotion policies and the other on the creation of health-promoting schools.

123 The Regional Office supported and coordinated Africa's participation in the World Conference on Health Promotion that took place in Mexico in June 2000.

The missions and functions of officers responsible for health information and health promotion in country offices were reviewed in the light of the orientations contained in the new regional strategy. 124

An active partnership was also built with regional and international institutions: University of Moi, Kenya; University of Zimbabwe; African Medical Research Foundation (AMREF); International Union for Health Promotion; Education International and CDC, Atlanta. 125

National focal points from Algeria, Angola, Benin, Burundi, Gabon, Ghana, Guinea, Kenya, Mauritius, Mozambique, Namibia, Senegal, South Africa, Swaziland, Togo, Uganda and Zambia were trained in health promotion programme development methods. 126

Guinea and Zimbabwe received support to initiate health promotion activities. 127

Fifteen countries were supported to implement the health-promoting schools initiative by training thirty national focal points and disseminating a number of documents. The countries are: Benin, Burundi, Chad, Gambia, Ghana, Kenya, Madagascar, Malawi, Mauritania, Mauritius, Namibia, South Africa, Swaziland, Seychelles and Togo. Nine countries were supported, financially, to implement school health promotion activities that are not part of the health-promoting schools initiative. 128

The main orientations for 2002-2003 will remain unchanged. In this regard, emphasis will be put on the interactive and participatory health promotion approaches, especially through health education, social policies and actions to promote a healthy environment. 129

Disability and injury prevention and rehabilitation (DPR)

In spite of the limited human and financial resources, the programme was able to make some achievements. 130

In that respect, the Regional Office supported two subregional meetings to launch the "Vision 2020" Initiative for the prevention of blindness. Four countries (Burkina Faso, Chad, Ghana and Zimbabwe) received support to develop programmes on the prevention of avoidable blindness. 131

In the area of community-based rehabilitation, twenty-two participants from six countries were trained in the management of community-based rehabilitation programmes (CBR). Six countries (Cape Verde, Democratic Republic of the Congo, Equatorial Guinea, Kenya, Madagascar and Mali) were supported to develop and implement CBR programmes. In addition, four countries (Angola, Democratic Republic of the Congo, Ethiopia and Mozambique) were assisted to integrate the victims of antipersonnel mines into community-based rehabilitation programmes. 132

133 A situation analysis of physical and/or sensorial disabilities was conducted in eight countries, namely, Algeria, Congo, Democratic Republic of the Congo, Gambia, Liberia, Mozambique, Seychelles and Sierra Leone.

134 Two countries received support to establish a system of surveillance of intentional and accidental injuries.

135 In the next biennium, the programme will be revitalized and will focus its intervention on community-based rehabilitation and the prevention of violence and injury as well as blindness.

Mental health (MEH)

136 The needs of countries were addressed in accordance with the regional strategy on mental health which emphasizes the integration of mental health and the prevention and control of the use of drugs in the general health system, in terms of the organization of care, on the one hand, and its funding and legislations, on the other.

137 The entire Region undertook a colourful commemoration of the World Health Day 2001 whose theme was "Stop exclusion, dare to care." The commemoration was graced with the presence, in Kenya, of the WHO Director-General who was accompanied by the WHO Regional Director for Africa.

138 The World Health Report 2001 was entitled *Mental Health: New Understanding, New Hope.* The report was prepared in close collaboration with all the countries, which made it possible to gather a wealth of information subsequently published in the first edition of a publication titled *Atlas: Mental Health Resources in the World.*

MINIMUM MEASURES FOR MENTAL HEALTH

Source: World Heath Report, 2001

1 MANAGING DISORDERS AT PRIMARY HEATH CARE LEVEL
2 ENSURING THE AVAILIBILITY OF PSYCHOACTIVE SUBSTANCES
3 GIVING CARE IN THE COMMUNITY
4 EDUCATING THE GENERAL PUBLIC
5 INVOLVING COMMUNITIES, FAMILIES AND CONSUMERS
6 ADOPTING POLICIES, PROGRAMMES AND LEGISLATION AT NATIONAL LEVEL
7 DEVELOPING HUMAN RESOURCES
8 ESTABLISHING LINKAGES WITH OTHER SECTORS
9 UNDERTAKING SURVEILLANCE OF THE MENTAL HEALTH OF COMMUNITIES
10 SUPPORTING RESEARCH

Those two events (World Health Day and the launch of the World Health Report) provided a platform for creating awareness of problems related to mental health and for combating the related stigmatization. 139

A group of mental health experts was set up to support countries in the implementation of the regional strategy. 140

Many intercountry meetings were devoted to strengthening the capacities of mental health programme coordinators in the ministries of health, NGOs and partners involved in mental health promotion activities. 141

Direct technical support was provided to five countries (Angola, Chad, Equatorial Guinea, Mozambique and Sao Tomé and Principe) for the development of policies, strategic plans and health personnel training materials. 142

Activities relating to the global campaign against epilepsy were supported in 12 countries namely, Cameroon, Ethiopia, Kenya, Lesotho, Mozambique, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda and Zimbabwe. In addition, some Member States (Benin, Ethiopia, Ghana, Madagascar, Mauritania and Nigeria) involved in the Nations for Mental Health project received support from the Regional Office. 143

Two intercountry workshops were held on community-based psychosocial rehabilitation and five countries (Angola, Burundi, Democratic Republic of the Congo, Sierra Leone and Uganda) received financial support for the implementation of specific projects. 144

The department of psychiatry of the University of Zimbabwe received assistance for its suicide prevention activities. 145

The 2000-2001 biennium helped put mental health on the agenda of health programmes of the majority of countries of the Region. It is important to keep up this momentum in order to pursue the fight against the exclusion and stigmatization attached to mental disorders. 146

Substance abuse (SAB)

The efforts of the Regional Office were directed at two areas: strengthening of the tobacco control programme and prevention and control of psychoactive substance abuse. 147

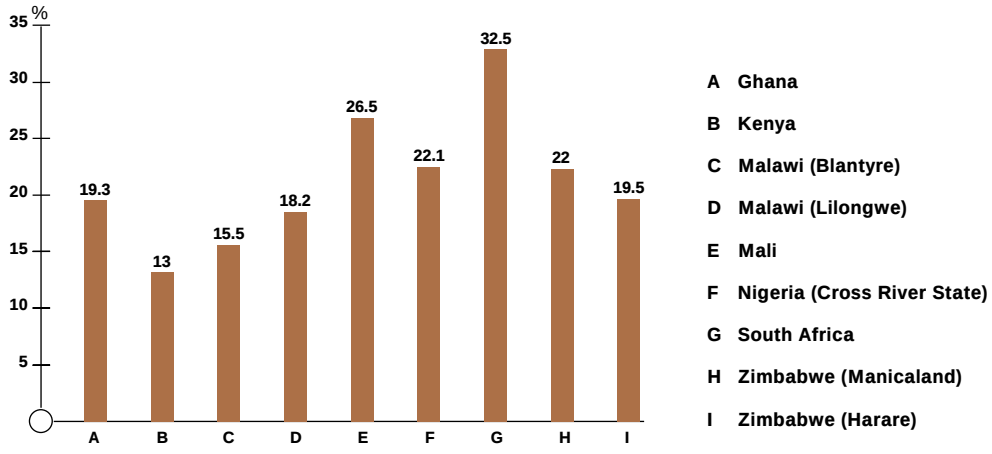
Tobacco control programme

148 In the area of *Tobacco control,* several intercountry meetings addressed the problems of legislation, policy and programme formulation, data collection and research.

149 In Nairobi, in October 2000, parliamentarians from the English-speaking countries, like their French-speaking counterparts, advocated for the formulation of strong legislations in their respective countries and for networking between themselves and NGOs in support of the process of development of the Framework Convention on Tobacco Control.

FIGURE 5: Current use of any tobacco product among school youth (ages 12-17 years)

Source: Global Youth Tobacco Survey



150 Concerning this framework convention, the African group developed a consensual approach through regional consultations preceding intergovernmental negotiations. Two meetings were thus organized by Algeria and South Africa respectively. The meetings reviewed the draft documents that were to be discussed by "the Intergovernmental Negotiation Body" and reached a consensus that greatly facilitated the adoption of a common African position during the negotiations.

151 The Regional Office created a Website on the regional tobacco control programme and developed a database for accessing the profile of each country in regard to production, consumption, legislation and tobacco-related health problems.

Twenty-two countries were supported to organize a survey on tobacco use among youths in schools, using a standardized methodology that countries apply to either a national sample of schools or a regional sample. Initial results that give cause for concern are already available. The survey showed, for example, that 13% to 32% of youths aged from 12 to17 years commonly use tobacco products (Figure 5). It also showed that, on average, 16% of these youths were offered free cigarettes by representatives of tobacco companies. 152

Several countries such as Botswana, Kenya, Lesotho, Namibia, Rwanda, Togo and Uganda have either passed anti-tobacco bills in parliament or are in the process of preparing such bills. Three African cities in Botswana, Gambia and Seychelles received a WHO prize for their role in ensuring that public places are tobacco free. 153

The Regional Office strengthened its collaboration with the CDC, Atlanta, the World Bank, the International Labour Office and the OAU. 154

In the present biennium, efforts will remain focused on the same priority areas, particularly on support to the development of a strong framework convention that protects the health of individuals while taking into account the attendant economic problems facing some major tobacco-producing countries. 155

Prevention and control of substance abuse

Support was provided to South Africa, Tanzania and Zambia as part of the global initiative on primary prevention of substance abuse among youths. Community workers from 75 NGOs and governmental departments were trained in the development, management and evaluation of cost-effective prevention interventions. Twenty-one NGOs received assistance for the development of pilot projects on the prevention of substance abuse. 156

Two countries in post-conflict situation, namely Liberia and Sierra Leone, received support for the organization of substance abuse prevention activities. Four other countries received technical support to develop sensitization campaigns in the area of substance abuse prevention. 157

The prospects for 2002-2003 are that ongoing activities will be continued, situation analyses will be conducted while activities will be implemented in psychoactive substance abuse prevention. 158

Family and reproductive health

159 The promotion of the reproductive health of families and individual women, men, adolescents and children was the focus of support to Member States during the biennium. Special emphasis was placed on capacity-building, research, programme development and improvement of service delivery. This was accomplished through four areas of work, namely: Research and programme development in reproductive health (including Training in reproductive health and prevention of mother-to-child transmission of HIV); Making pregnancy safer; Child and adolescent health; and Women's health and development (including social aspects of family and reproductive health).

Research and programme development in reproductive health (RHR)

160 Access to quality reproductive health care remains elusive for many people in the Region. Despite many studies conducted by institutions and individuals, the research findings are not utilized for policy and programme development. This situation is aggravated by the HIV/AIDS epidemic, with increasing incidence of mother-to-child transmission. Consequently, maternal and neonatal morbidity and mortality are unacceptably high.

161 In this context, the Research and programme development in reproductive health area of work provided support to 22 Member States[3] to undertake research and utilize their findings. Member States were oriented on the collection, review, analysis and utilization of existing data, which led to the compilation of baseline data for regional mapping of maternal mortality.

162 Epidemiological and operational research as a strategic tool in problem-solving was reinforced in cooperation with training institutions, research networks and WHO collaborating centres. The Reproductive Health Unit, University of Witswatersrand, Johannesburg, South Africa, was recommended to the Global Screening Committee for consideration as a collaborating centre for research in human reproduction.

163 Research institutions in 12 countries[4] were briefed on priority setting in reproductive health research, dissemination of results and their utilization for policy and programme development. Technical discussions with researchers from seven countries[5] stimulated community-based operations research aimed at reducing maternal and neonatal deaths. Twenty experts from ten countries[6] met in Ghana to examine and harmonize reproductive health indicators for the Region. The global indicators were retained while 13 process indicators were recommended.

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[3]Benin, Cameroon, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mauritania, Mozambique, Nigeria, Sao Tomé and Principe, Senegal, South Africa, Swaziland, Uganda, Zambia and Zimbabwe.

[4]Ethiopia, Cameroon, Guinea, Gabon, Kenya, Nigeria, Benin, Senegal, Uganda, Zambia, South Africa and Zimbabwe.

[5]Kenya, Malawi, Nigeria, South Africa, Uganda, Zambia and Zimbabwe.

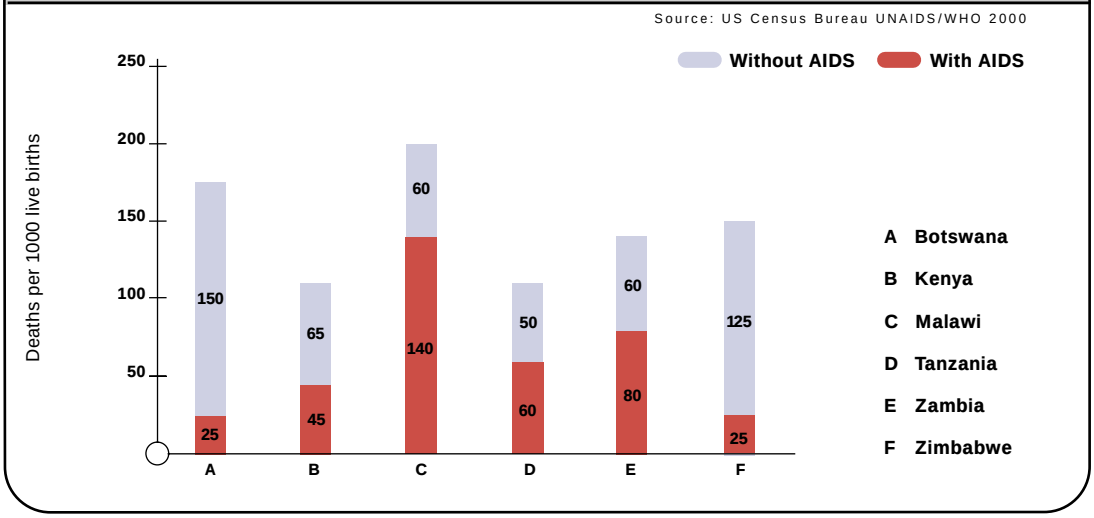
[6]Guinea, Ghana, Côte d'Ivoire, Cameroon, Mauritania, Nigeria, Senegal, Uganda, Mozambique and Zimbabwe.

Reproductive health needs assessment was supported in Lesotho and Liberia, and national reproductive health plans were developed in Malawi and Kenya. 164

Zimbabwe was supported to develop a tool for perinatal survey. Maternal, perinatal and neonatal surveys were conducted in Gambia and Swaziland and the results were used for developing national strategic plans. Assessment of male involvement in reproductive health in the Region was conducted in 12 countries and the results were presented at the global meeting of regional advisers for reproductive health. 165

HIV among children is a growing problem in sub-Saharan Africa where nearly 80% of all infected children live. Projections by UNAIDS indicate that under-five mortality will increase if no action is taken (Figure 6). Because most HIV infections in children are acquired from their mothers, prevention of mother-to-child transmission was given high priority. 166

FIGURE 6: Estimated impact of AIDS on under-five mortality in selected African countries by 2010



Achievements in the prevention of mother-to-child transmission of HIV included: 167

a Training of nationals from 11 countries[7] in the integration of reproductive health and HIV/STI, including training in dual protection.

b Strengthening of laboratory diagnosis capacity in 20 countries.

[7]Burkina Faso, Central African Republic, Ethiopia, Ghana, Kenya, Mali, South Africa, Togo, Uganda, Zambia and Zimbabwe.

c Development and field-testing of a training package on value for health and social workers.

d Development and field-testing in Zimbabwe of a needs assessment protocol and tools for psychosocial support to HIV-infected pregnant women and their families.

e Production of a set of four clinical guides for providing care for HIV-positive pregnant women; the guide covers antenatal care, labour and delivery care, voluntary counselling and testing, and postpartum care for mother and infant.

f Support to nine countries[8] to implement pilot projects in the prevention of mother-to-child transmission of HIV; development or review of proposals in five countries[9] for interventions or the integration of mother-to-child transmission activities into reproductive health services.

g Development of indicators for monitoring and evaluating the prevention of mother-to-child transmission as part of the national health information system.

h Ongoing development of a strategic paper for policy-makers and programme managers for the design of national programmes for the prevention of mother-to-child transmission of HIV.

Making pregnancy safer (MPS)

168

The Making pregnancy safer initiative focuses on five countries in the Region: Ethiopia, Mauritania, Mozambique, Nigeria and Uganda. In November 2000, the intercountry orientation meeting on making pregnancy safer reviewed the maternal mortality situation in the different MPS-focused countries, identified the major causes of and constraints to the reduction of maternal mortality; in May 2001, at an intercountry meeting, the meeting finalized the first drafts of their plans of action. Subsequently, the following activities were supported:

a Assessment of needs for emergency obstetric care in Ethiopia, Mauritania, Nigeria and Uganda.

b Training of health care providers in life-saving skills in Mauritania, Nigeria and Uganda.

[8] Botswana, Burkina Faso, Côte d'Ivoire, Kenya, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe.

[9] Ethiopia, Lesotho, Malawi, Nigeria and South Africa.

c Procurement of equipment and supplies for emergency obstetric care (including equipment and supplies for blood banks) in Mauritania, Mozambique and Nigeria.

d Strengthening of the referral system through the installation of two-way radio communication in the districts of Uganda involved in Making pregnancy safer activities; and procurement of ambulances for Ethiopia, Mauritania, Nigeria and Uganda.

e Publication of "The Road to Safe Motherhood" which addresses the Three Delays to the reduction of maternal mortality.

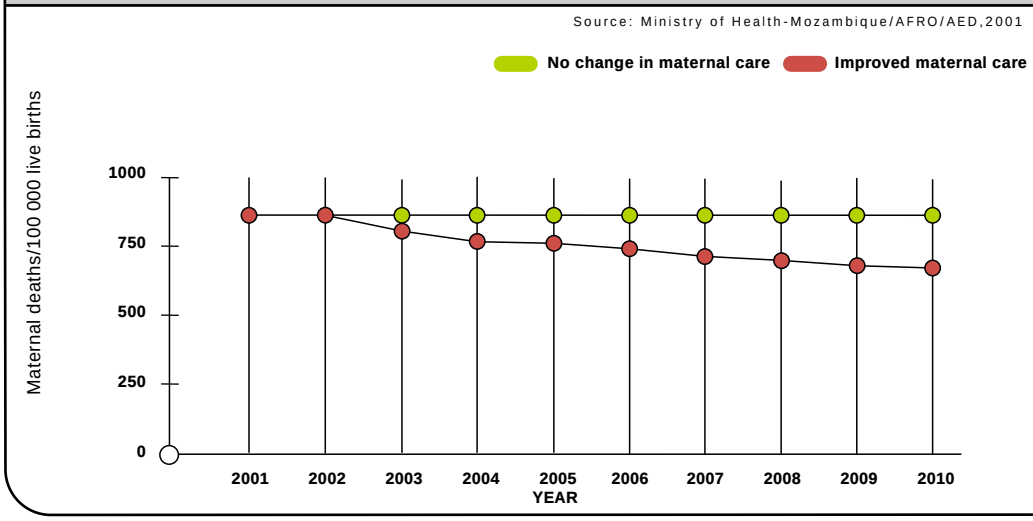
169 To strengthen partnerships for the accelerated reduction of maternal mortality at country level, the Regional Office convened a regional consultation in Kampala (Uganda) in October 2001, which was attended by seventy partners from multilateral and bilateral development agencies, government institutions and NGOs in nine African countries[10]. Country teams developed and committed themselves to national frameworks of action focusing on priority areas for the next biennium. These included malaria control in pregnancy. A major step was thus accomplished in partnership programming

170 Advocacy is one of the major pillars for making pregnancy safer. The "REDUCE" advocacy tool uses the best available country-specific data on maternal and neonatal health to project the survival, health and economic impact of maternal morbidity and mortality. It also predicts possible economic gains to the country if effective evidence-based interventions promoted through making pregnancy safer are implemented.

171 From an analysis of the burden of disease due to poor maternal health in Mozambique, two scenarios are illustrated in Figure 7 below. The green line shows the trends in maternal mortality when no interventions are implemented. The red line shows the projected decrease if effective evidence-based interventions are implemented.

[10]Ethiopia, Ghana, Kenya, Malawi, Mauritania, Nigeria, Senegal, Tanzania and Uganda.

FIGURE 7: Trends in the reduction of maternal mortality



172 In Nigeria, the "REDUCE" advocacy tool demonstrated that, without further efforts to improve maternal health, the country will suffer economic losses estimated at US$ 341 million over a ten-year period due to loss of productivity related to maternal morbidity and mortality. With effective implementation of evidence-based interventions, however, Nigeria will gain US$ 536 million over the same period.

173 In response to the need to provide countries with appropriate tools and standards in maternal and newborn care, a regional consultation was organized in Harare to review the Integrated management of pregnancy and childbirth tools for content and applicability in Africa. An addendum, which takes into consideration specific epidemiological and working conditions in the Region, was developed to accompany the *Management of complications of pregnancy and childbirth* manual.

Child and adolescent health (CAH)

174 During the biennium, the *Child and adolescent health and development* area of work made significant progress in newborn care and in child and adolescent health and development.

175 A facility-based assessment of care and management of the newborn was conducted in 18 health facilities in seven countries[11] using a tool developed by African experts (see box). Subsequently, these countries received training and funds for basic but essential equipment and supplies.

[11] Burundi, Ethiopia, Mauritania, Namibia, Nigeria, Swaziland and Uganda.

FACILITY-BASED ASSESSMENT OF NEWBORN CARE: KEY FINDINGS

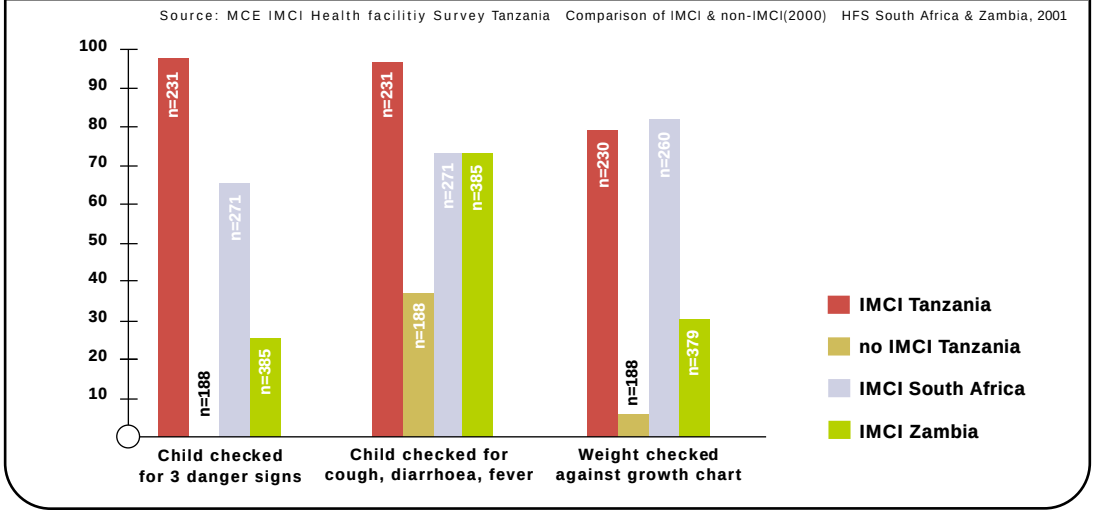
Source: WHO/AFRO

1. ALL THE 18 FACILITIES ASSESSED LACKED LIFE-SAVING RESUSCITATIVE MEASURES SUCH AS BLOOD TRANSFUSION SERVICES, BAGS AND MASK KITS
2. ERRATIC SUPPLY OF ESSENTIAL AND EMERGENCY DRUGS FOR MOTHERS AND NEWBORNS
3. INADEQUATE LABORATORY SERVICES IN 88% OF FACILITIES
4. POOR COMMUNICATION AND TRANSPORT SYSTEMS BETWEEN DIFFERENT LEVELS OF CARE
5. INADEQUATE PREVENTION AND CONTROL MEASURES; INADEQUATE INFECTION SURVEILLANCE
6. LOW STAFF MORALE

Participants from 28 African countries were trained in the prevention of child sexual abuse. The importance of close collaboration between health, the judiciary, the police and social welfare as a strategic approach was emphasized, and so was community participation. 176

With respect to *Integrated Management of Childhood Illness* (IMCI), following the adoption of resolution AFR/RC49/R4 urging all Member States to accelerate the implementation of IMCI, 40 out of the 46 countries have now adopted it. In fact, they have started integrating the IMCI strategy into their national health systems. Currently, six countries are in the introduction phase, 22 are in the early implementation phase, and 12 are in the expansion phase. IMCI was also implemented in all districts in the 11 countries that alone account for 80% of child mortality in the Region. Health facility surveys conducted in South Africa, Tanzania and Zambia show how the care of children under five years improved with the implementation of IMCI (Figure 8). 177

FIGURE 8: Improved health worker skills: quality of care on assessment of severity of illnesses



178 With the increasing prevalence of HIV among children, a study aimed at validating the inclusion of HIV/AIDS in IMCI materials was conducted. The results were disseminated and 10 countries have already integrated HIV/AIDS into IMCI. The Regional Office also provided orientation to 25 countries on infant-feeding policies related to HIV and organized courses in both planned breast-feeding and HIV/infant-feeding counselling. The sustainability of the implementation of IMCI was also enhanced through the introduction of the IMCI strategy in pre-service training.

179 Participants from 17 countries contributed to the development of the *Regional strategy on adolescent health and development.*

180 A regional consultation on adolescent-friendly health services organized in Harare to enhance the quality of health services for adolescents culminated in a regional consensus statement on adolescent-friendly health services. The consultation involved researchers and managers from 14 countries.[12] Botswana and Lesotho received technical support to develop their adolescent-friendly health services. This included a review of the pilot centres and clinics, the training of health workers and the conduct of research. Training guidelines are being developed for the training of health workers in Lesotho.

181 The following were achieved in collaboration with headquarters:

a recruitment of a consultant for the adolescent health programme to facilitate the implementation of the regional strategy;

[12]Botswana, Cameroon, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

b development and use of training modules for the training of trainers in adolescent-friendly health services in Guinea, Mali and Senegal, and for training health workers in Botswana; and

c organization, in the context of the World AIDS Campaign 2000-2001 and in collaboration with UNAIDS, of a regional consultation to identify current research and programming approaches to the promotion of the health and development of male adolescents and young men. A technical document in this area was produced to guide Member States.

182 For capacity-building, and to ensure the full involvement of the youth in the planning, implementation, monitoring and evaluation of adolescent health programmes, 30 youths from Cameroon, Lesotho, Kenya, Malawi, Mozambique and Zambia were trained in operations research methodology and in project proposal writing skills. As a result, six proposals were developed. They covered HIV/AIDS among the youth in rural Cameroon; teenage pregnancy (Lesotho); factors affecting health-seeking behaviour among the youth (Kenya); unsafe abortions among youth (Malawi); sexual exploitation among the youth (Mozambique); and drug and substance abuse among the youth (Zambia). The Regional Office provided support for data collection and analysis.

183 Seven countries[13] reviewed health promotion approaches and life-skills development in adolescent health programmes. Subsequently, a regional mapping of life-skills programmes was developed. An adolescent health curriculum for nursing and midwifery training is currently being developed.

184 In order to help Member States to implement the health component of the Convention on the Rights of the Child and the African *Charter on the Rights and Welfare of the Child,* an orientation programme on the rights-based approach to child health programmes was conducted for Regional Office staff. A similar programme was conducted for country-level staff in Gambia using the IMCI strategy as a basis for the analysis of the approach.

Women's health and development (WMH)

185 During the biennium, the *Women's health and development* area of work started the process of collecting data on women's health and social status. A tool for assessing and planning women's health and development (APT/WMH) was developed using key indicators to establish the women's health and development profile. APT/WMH was tested and reviewed in 15 countries.[14] In December 2001, an intercountry consultation gathered country reports to be consolidated into a regional WMH profile. Ghana was supported to develop and implement its national women's health policy.

[13]Kenya, Lesotho, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe.

[14]Botswana, Cape Verde, Ethiopia, Ghana, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Democratic Republic of the Congo, Seychelles, South Africa, Tanzania and Zimbabwe.

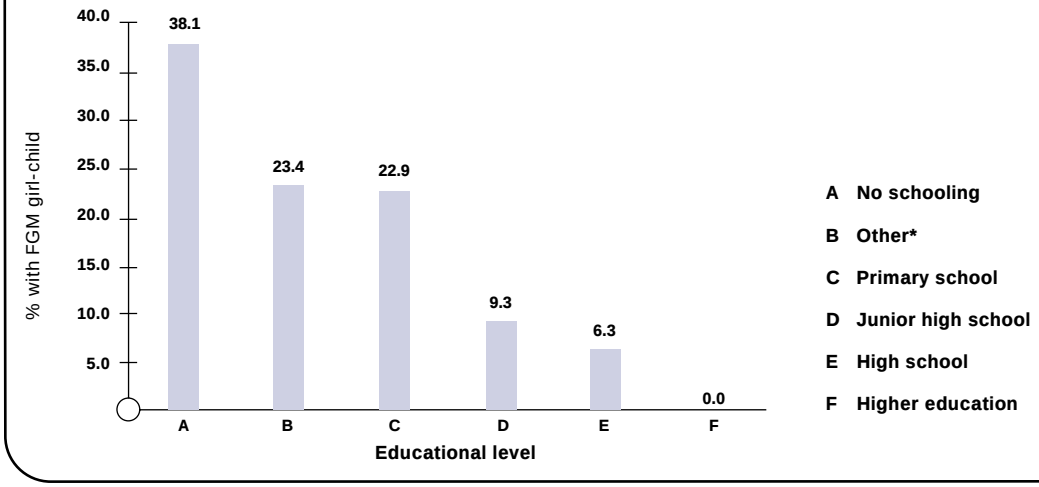
186 In order to commence the process of creating a pool of regional experts on gender and health, two nationals from Mali and Zimbabwe were sponsored for the leadership course on gender and reproductive health. Networking with four national and international NGOs has been established: Women's Health Project of South Africa, Masses Project of Zimbabwe, Mali Association for the Prevention of Harmful Traditional Practices, and International Medical Women Association for Africa. Gender mainstreaming was put on the global and regional agendas during the biennium.

187 Violence against women and children has become a major public health problem. To understand issues related to violence against women and children, support was given to Lesotho, Mozambique and Tanzania. Human trafficking, especially targeting women and children, is on the increase globally and particularly in the Region. Discussions are ongoing on the role of WHO in this area.

188 Female genital mutilation (FGM) remains one of the most harmful traditional practices (HTP) still widely carried out in 27 countries in the Region. However, many countries have taken concrete steps toward the elimination of FGM. In Mali and Burkina Faso, studies on the social determinants of FGM were funded. Preliminary results from a study in Burkina Faso involving 1 861 women of reproductive age showed that the incidence of FGM decreases in the girl-child as the level of maternal education increases (Figure 9).

FIGURE 9: Effect of formal education of mothers on the girl-child in regard to FGM in Burkina Faso[15]

Source: MASSN/CNLPE/WHO,2001



(*)Koranic education and functional literacy

[15]Etude sur la prevalence de l'excision au Burkina Faso: Provisional report. Ministry of Social Welfare and National Solidarity; national FGM control committee and World Health Organization, Burkina Faso,

189 In collaboration with headquarters, Burkina Faso, Cameroon, Kenya, Ghana and Nigeria were supported to establish a national multidisciplinary collaborative group on FGM prevention and care. The work has been extended to five additional countries: Chad, Democratic Republic of Congo, Mali, Niger and Tanzania. A regional database on HTP/FGM has been initiated and will cover 15 countries.[16]

190 The Regional Office hosted the Global Dissemination Workshop on FGM training materials for nurses and midwives. Sixty-five participants from 15 African countries and two Eastern Mediterranean countries shared experiences with experts from the WHO European and Eastern Mediterranean regions. Individual country teams developed plans of action for integrating FGM training materials into nursing and midwifery curricula and for monitoring and evaluation.

191 The Regional Office also participated in Forum Vision 2010 in Mali. Eight First Ladies of African countries endorsed the "2001 Bamako declaration on advocacy for maternal and neonatal mortality and morbidity reduction in Central and Western Africa". Support was provided to Zimbabwe for expanding the Chivi district poverty alleviation experience to Bubi, and for documenting experience in female functional literacy and viable economy as an entry point for health development.

Healthy environments and sustainable development

192 Three areas of work are covered under Healthy environments and sustainable development: food safety; protection of the human environment; and health in sustainable development. The focus is on the management of the interface between food, environment, development and health. The goals are twofold: to reduce risks for health and to promote healthy environments in a sustainable development context. In that perspective, poverty reduction is considered as a cross-cutting value that influences all activities implemented by the three areas of work.

Food safety (FOS)

193 Poverty is the principal cause of consumption of unsafe food. Other factors such as weak institutional structures, demographic pressures, trade liberalization and poor environmental conditions merely exacerbate this situation. Food safety is a public health issue in the African Region. Despite the lack of accurate scientific data on food-borne diseases, it can be safely asserted that if current trends continue, the situation will only become worse.

[16]Burkina Faso, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, Eritrea, Ghana, Guinea-Bissau, Kenya, Mali, Niger, Nigeria, Tanzania, Senegal and Uganda.

194 In response to the increasing morbidity and mortality attributable to poor food safety and hygiene, and in order to better support Member States to address food safety and hygiene issues, the Regional Office recently strengthened its food safety programme by increasing its expertise in the area (recruitment of technical staff) and by creating two sub-programmes, which are food safety and hygiene, and food, health and development.

195 During the biennium, only a few activities were supported, due, largely, to the fact that the food safety area of work only became operational in July 2001. Severe resource constraints also limited the scope of financial and technical support that could be provided to countries. In spite of the above, the Regional Office provided expertise to assess the impact of beverage additives[17], and supported the training of street vendors in safe food handling practices[18]. Furthermore, the Regional Office actively participated in African regional meetings of the CODEX Alimentarius.

196 In the near future, more will be done to capitalize on the increasing public awareness of food safety and hygiene concerns. Furthermore, because food safety and hygiene is a global priority for WHO, additional resources and the necessary expertise will be mobilized. However, sensitization efforts will have to be strengthened so as to ensure that decision-makers and populations are fully informed of food-related health risks. Countries will have to considerably strengthen their institutions and capacities to address this issue, and in-house technical capacity will also have to be reinforced if the Regional Office intends to mount an effective response to this public health problem.

197 To obtain more evidence for decision-making on the sources and magnitude of food-borne illness in the African Region, a regional situation analysis of food safety and hygiene will be carried out during the next biennium. The Regional Office will also aim to develop an approach for food-borne disease surveillance systems as an integral part of national epidemiological surveillance systems. Since street vending of foodstuffs is very widespread in the Region and such food is consumed by millions of people in cities, training materials for safe food handling by street vendors will be developed. Finally, advocacy for food safety and hygiene will be constantly carried out.

[17]Mali received technical assistance to assess the health impacts of beverage additives.

[18]Street vendors of food were trained in safe food handling practices in Ghana.

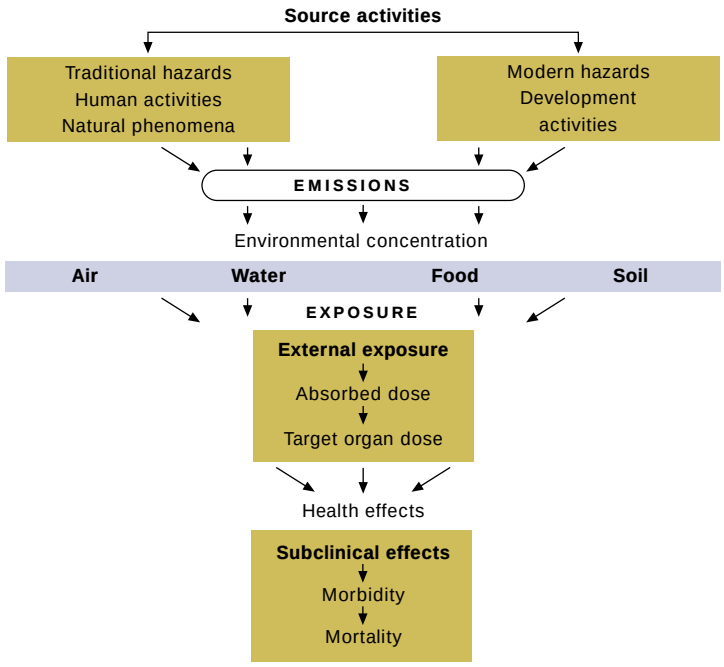
Protection of the human environment (PHE)

198

In the African Region, poor environmental conditions continue to have severe adverse effects on health. At the start of the new millennium, the bleak reality is that 450 million Africans lack access to safe water, 490 million are without adequate sanitation, and infectious diseases linked to poor environmental conditions kill one out of every five children in the Region. The dominant medical paradigm, which focuses extensively on curative services and tertiary care at the expense of preventive and promotive activities at the primary health care level, has proved to be expensive, ineffective and unsustainable, especially for poor countries.

FIGURE 10: Environmental health hazards pathways: conceptual framework at the individual level

Source: WHO/EHG/95.26,page 8



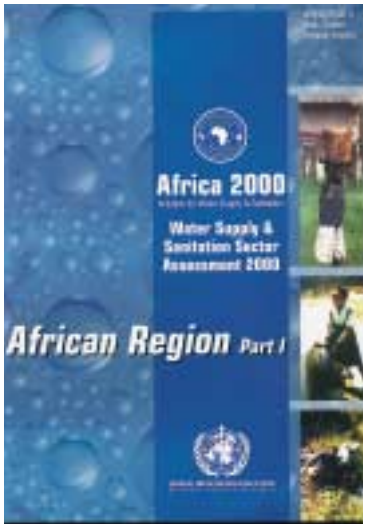
199

Prevention, though long-term in nature, has proved to be less costly and more effective than curative care. In the light of the pervasive poverty that is affecting African countries, and the unabated devastation being caused by preventable diseases, a paradigm shift will, sooner than later, become necessary.

200

At the beginning of the biennium, the Protection of the human environment programme was restructured with a view to focusing WHO support on the provision of high-level expertise to influence policy. In this respect, technical assistance (for water and sanitation, policy formulation, risk assessment, etc.) was provided to all countries in the Region.

201



Within the framework of the Africa 2000 Initiative, a comprehensive assessment report on the water and sanitation sector in the African Region, containing information on water and sanitation coverages, trends, emerging issues and national profiles, was published.

202

Member States were provided with technical and financial assistance to implement the Healthy Settings approach (cities, villages, schools, etc.) which encapsulates the philosophy of prevention. More specifically, countries were assisted to prepare project documents, and dialogue was facilitated between countries and their development partners for the mobilization of resources to implement the Healthy Settings approach[19]. The Regional Office also co-sponsored, along with headquarters, the International Programme on Chemical Safety (IPCS) and other partners, an international conference on chemical safety in Africa, the objective of which was to prepare the health sector for the challenges of the 21st century. Considerable resources were also dedicated to advocacy and capacity-building. Environment and health micro-projects were supported[20].

203

With regard to policy guidance, the Regional Office published a landmark document on Environmental Health Hazard Mapping, which will assist countries to develop their anticipatory capacities and better manage health risks caused by the environment. Guidelines on environmental health impact assessment were also prepared and will be published in 2002. In the area of occupational health, the WHO-ILO joint effort was formalized and pilot projects for the promotion of occupational health in the informal sector were supported[21].

204

During the next biennium, the Regional Office will aim to facilitate the incorporation of effective environment and health dimensions into regional policies affecting health and the environment and into national development policies and action plans for environment and health, including legal and regulatory frameworks governing the management of the human environment. In order to do so, the Organization will continue to play an active role in the preparation of the upcoming World Summit on Sustainable Development, as well as develop and

[19]A resource mobilization workshop for Healthy Cities projects in French-speaking countries was organized in November 2000 in Lome, Togo. This was a follow-up to the francophone workshops organized in 1999 in Libreville and Conakry.

[20]This refers mainly to interventions in water and sanitation and to the PHAST (Participatory Hygiene and Sanitation Transformation) approach that were supported in over 20 countries of the Region.

[21]The cities supported were: Cape Town, Dar es Salaam, Harare, Johannesburg and Yaoundé.

submit a regional strategy on environmental health to the 52nd session of the Regional Committee for Africa. WHO's partnership with other development partners, especially UNEP, ILO, IPCS, UNICEF and the World Bank, will be strengthened. Countries will be supported to develop and revise national environment and health policies and plans, national capacities will be reinforced, best practices will be documented and disseminated and a regional information system for decision-making in environment and health will be established.

Health in sustainable development (HSD)

205

The increasing awareness of the role of health in development led the Regional Office to pay considerable attention to issues relating to health and sustainable development. The extent, depth and unabated growth of poverty in the African Region presents the greatest obstacle to health development in the Member States. That is why the Health in sustainable development area of work consists of two programmes, Poverty and ill-health and Long-term health development. The Poverty and ill-health programme aims to analyse the linkages between poverty and ill-health and to ensure that health considerations, when addressed in the context of national and regional development, do not bypass the concerns of the poor. The Long-term health development programme is concerned with the promotion of a long-term strategic approach to health development.

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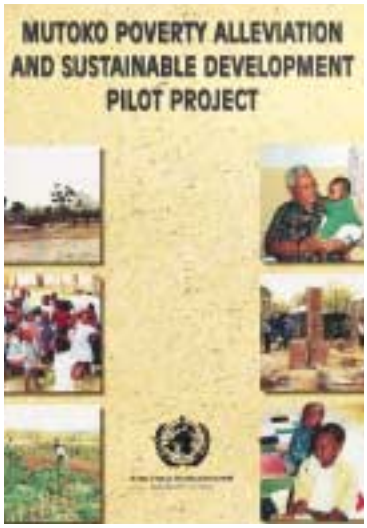

In 2000-2001, the Regional Office published a position paper on poverty and health, successfully organized a regional consultation on poverty and health, supported poverty alleviation through implementing poverty and health projects in eight countries[22], and raised awareness of poverty and health issues among decision-makers by organizing a round table on this theme during the 51st session of the Regional Committee. Furthermore, guidelines for scenarios-based health development were published and an awareness-raising and training workshop on long-term planning was held for five English-speaking countries (Eritrea, Liberia, Malawi, Uganda and Zimbabwe). In partnership with the World Bank and UNICEF, the Regional Office co-sponsored two workshops (for both English-speaking and French-speaking countries) on the role of health, nutrition and population in the context of poverty reduction strategy papers.

[22]Cameroon, Cape Verde, Ghana, Mali, Mauritania, Nigeria, Sao Tomé and Principe and Zimbabwe.

207 During the next biennium, efforts will be directed at developing and submitting a regional strategy on poverty and health to the 52nd session of the Regional Committee. Community-based health improvement through poverty alleviation activities will also be supported, and indicators for monitoring the contribution of health activities to poverty alleviation will be developed. Research will also be conducted on the health of indigenous and marginalized groups in Africa with the aim of identifying appropriate health interventions. With regard to capacity-building, training workshops on the role of health in poverty reduction, within and beyond the PRSP/HIPC context, as well as on long-term health planning will be organized. Countries will also be provided with technical assistance to incorporate a long-term approach in their national health development plans. Lastly, the Regional Office will aim to strengthen its partnership with other development agencies, particularly the World Bank, UNICEF and UNDP, and with nongovernmental organizations.

Administration and finance

Health information management and dissemination (IMD)

208 The main objective of this area of work was to improve the quality and presentation of valid statutory, technical and scientific information products and to make them available to the Member States, the Regional Office staff, health workers, researchers and development partners. Activities in this regard included increasing the staff strength in the Publications, Distribution and Sales (PDS) unit; publishing technical and scientific information products for the Regional Office; providing language services to statutory and other meetings in order to facilitate communication; responding to requests from Member States for health literature centres; and broadening the implementation of the Blue Trunk Library concept.

209 In terms of achievements at the Regional Office level, support was provided for language and publication work, which included the publication of volume IV of the *Handbook of Resolutions of the Regional Committee,* the Regional Director's reports and some 60 technical documents and publications.

210 The Regional Office continued to conduct bibliographic searches for countries, organize and set up health literature centres in the Region, publish the *Index Medicus,* and help countries order more Blue Trunk Libraries and train staff who head them. Eighteen additional titles were printed and added to the Library in the Portuguese-speaking countries.

211 During the next biennium, the focus will be to provide access to reliable, valid and up-to-date health and biomedical information for policy-making and practice by Member States as well as development partners. More specifically:

a there will be an increased emphasis on improved management and dissemination mechanisms;

b priority statutory documents will continue to be produced and made available to Member States;

c the needs of target audiences will continue to be identified and addressed;

d greater use will be made of electronic media, particularly the Internet and the Intranet, in order to improve access to health literature;

e work will continue on the *Index Medicus* and on the expansion of the Blue Trunk Library concept in Member States.

Human resources development (HRS)

212 During the biennium, the key issues for the Human resources development services were: improving the timeliness of response to requests for human resources; implementing efficient, effective and proactive human resources management practices and procedures; improving staff productivity; and establishing effective communication channels with the staff in the Region, headquarters and other WHO regions.

213 Within the framework of the regional HR management policy, the Regional Office focused its efforts on the following areas: full computerization and automation of the activities of the HR services; streamlining of personnel practices and procedures; implementation of a programme of support visits to country offices; recruitment of additional staff to cope with the increasing workload and to provide better support for existing demands for personnel services; redefinition of tasks and responsibilities, with increased specialization and improved coordination of activities; and greater interaction with technical divisions and WHO country offices.

214 Special attention was paid to staff development and training. A Staff Development and Training Officer was recruited and several workshops, including the ones on the new performance management and development system, were organized.

215 A number of activities aimed at improving the HR services provided to staff throughout the African Region were also implemented. A retreat of all HR services staff was organized to review the organizational structure of the HR services unit, identify bottlenecks, and make recommendations to overcome them. During this retreat, a new organizational chart was adopted, following which the HR services unit was reorganized into the following six specialized sub-units:

a Contract Administration and Legal Matters (CAS/LEG)

b Short-Term Staff (STS)

c Recruitment (REC)

d Classification (CLA)

e Staff Development and Training

f Medical Services (AON)

216 An HR sub-unit was also established in Brazzaville in October 2001 to provide services to the staff working there until the return of the main unit in March 2002.

217 During the next biennium, efforts will continue to be focused on the above-mentioned issues. Particular emphasis will be placed on the development of a briefing package for new staff and the formulation of guidelines on the establishment of posts and recruitment of fixed-term and short-term staff to assist the technical divisions and units and WHO country offices. It is anticipated that these functions will be fully computerized and automated. A regional rotation policy will also be developed, and workshops on negotiating skills as well as briefing workshops for administrative officers and administrative assistants from country offices will be organized. A needs assessment in the area of staff development and training will be conducted and a staff development and training strategy for the whole Region will be developed. An HR services sub-unit will be established in Harare to service those staff who would remain in Zimbabwe after March 2002.

BRIEFING PACKAGE

ABOUT WHO
- Mission
- Vision
- Global structure
- UN common system

WHO IN THE AFRICAN REGION
- Regional structure

CONTRACTUAL ARRANGEMENTS
- Fixed-term appointments
- Time limited appointments
- Short-term appointments
- Other contractual arrangements

STAFF ENTITLEMENTS
- Compensation (Grade & Remuneration)
- Allowances (Education grant, Rental subsidy,...)
- Travel entitlements
- Social security
- Staff Pension Fund
- Accident and illness insurance

ADMINISTRATIVE PROCEDURES
- Recruitment separation & retirement
- Other administrative procedures
- Other contractual arrangements

DUTIES, OBLIGATIONS AND PRIVILEGES

STAFF DEVELOPMENT

Financial services (FNS)

The main objectives in the area of Budget and finance were: provision of efficient and timely support in the implementation of programme activities; provision of support to technical divisions at the Regional Office and WHO country offices in the area of finance, budget and accounts; and collaboration with technical divisions in the preparation of the Programme Budget for the 2002-2003 biennium. 218

The following were some of the achievements during the biennium: installation of an automated payment system and use of electronic banking to speed up financial remittances to Member countries and WHO staff; efficient management of Imprest accounts of countries; lodging and follow-up of financial claims with concerned authorities and financial and insurance companies for the losses incurred due to the 1997 civil war in the Republic of Congo; strengthening of internal controls to safeguard the assets of the Organization; timely preparation of the Programme Budget 2002-2003; monitoring and assisting the implementation of programme activities to ensure 100% implementation; maintenance of accounts and financial reporting to donors under the Trust Fund with the Regional Office; and provision of financial and budgetary services to technical divisions and country offices, especially in the area of poliomyelitis and malaria, and to other major programmes receiving funds from Other Sources. 219

During the 2002-2003 biennium, financial and budgetary support to the technical divisions and country offices in the implementation and evaluation of the activities contained in their plans of action, including the monitoring and accounting of local costs, will be further strengthened. 220

The Regional Office will continue to provide full financial support through the timely replenishment of Imprest accounts, payment of claims and obligation of funds by delegation of authority to country offices and technical units. The Regional Office also plans to participate actively in the integration of the AMS with the AFI system in country offices in order to improve their information systems. 221

Lastly, the new organizational structure of the Budget and Finance unit, discussed during a staff retreat in November 2001, will be implemented in early 2002 with a view to providing the best possible financial services. 222

Informatics and infrastructure services (IIS)

The area of work of *Informatics and infrastructure services* comprises the following five units: 223

a Administrative services (ASU)

b The Printing Press (DUP)

c Informatics (PHI)

d Supply services (SSU)

e Division of Administration and Finance (DAF)

224 During the biennium, the challenge was to further improve the efficiency and effectiveness of the Regional Office and country offices, and to reinforce communication facilities for the implementation of regional programmes. The key priorities were: strengthening the informatics services; resolving the problem of office space at the temporary location of the Regional Office in Harare; following up on renovations at the Regional Office in Brazzaville; and improving the delivery of normative support services.

225 Attention was focused on alleviating the problem of space in Harare and ensuring that the Regional Office in Brazzaville was rehabilitated according to WHO standards. Negotiations with airlines in Harare resulted in several contracts which brought considerable savings for WHO.

226 Information technology (IT) support was provided to country offices and the Regional Office, which included support to and maintenance of the Local Area Network (LAN) infrastructure and the Administration and Financial Information (AFI) system.

227 The following activities were also undertaken: design and maintenance of the AFRO website; distribution of Imprest software to country offices; and commencement of work, in collaboration with headquarters, on the implementation of the Global Voice IP and Internet facilities in country offices. Furthermore, in anticipation of the return of the Regional Office, communications network and facilities were set up in Brazzaville.

228 About 98% of the supplies and equipment ordered for countries and programmes were delivered. The management of inventories, both at the Regional Office and in country offices, was improved and the development of a computerized procurement system started. These achievements were facilitated by an in-built monitoring system and by the recent acquisition of asset-tracking software for inventory management.

229 The WHO corporate goal during the 2002-2003 biennium will be to apply the best practices in all aspects of general management at all organizational levels. The challenge would be to provide timely logistical, relevant and cost-effective technological support to the Regional Office. In Informatics, such support will

include: ensuring full functionality of the network and telecommunication facilities at the Regional Office in Brazzaville; pursuing the implementation of databases in different divisions; securing the AFRO network; installing an AFRO Intranet; and finalizing the migration to a standard PABX at the Regional Office as well as in Harare.

230 For Supply services, the overall aim will be to obtain and deliver supplies and equipment at the best possible prices. For Administrative services, continued efforts will be made to maximize cost-efficiencies in travel costs as well as in maintenance and operating expenses. The phased return to Brazzaville of the Regional Office, which commenced in October 2001, will be continued.

CONSTRAINTS AND FACILITATING FACTORS IN PROGRAMME BUDGET IMPLEMENTATION

Facilitating factors

231 Government commitment to health, particularly in areas of confluence between global and national priorities, facilitated the implementation of country programmes. Global initiatives such as Roll Back Malaria, national immunization days (NIDs), directly-observed treatment, short-course (DOTS) and Global Alliance for Vaccines Initiative (GAVI) were particularly instrumental in this regard. They helped to strengthen partnerships between WHO and development partners, facilitated resource mobilization and contributed substantially to the visibility of WHO. The political will of governments to implement regional strategies, arising in part from the increasing level of awareness of ministers of health and national leaders about regional challenges and priorities, also contributed to the achievements of the Regional Office.

232 Technical cooperation with countries was further enhanced by the adoption of a Health-for-all policy in the 21st Century in the African Region, the development of a strategic framework to guide the work of WHO in the African Region, and the implementation of a programme to develop the country cooperation strategy. The work of WHO was also enhanced in situations where Member States had a clear policy framework to guide the work of key players in the health sector, and where there were functional interagency coordination mechanisms and well-trained and highly motivated teams at both national and district levels of the health system.

233 Programme implementation in the Region was also facilitated by the implementation of a participatory managerial process involving closer interaction between the divisions at the WHO Regional Office, WHO country offices and Member States. The decentralization of financial management to country offices created flexibility in programme management and improved the responsiveness of country teams to country needs. With the adoption of results-based management, senior management has increased its emphasis on the need for both divisions and country offices to demonstrate results while ensuring accountability for resources.

234 Complementing the above were the significant increases in the financial and human resources for the implementation of the Programme Budget at both the Regional Office and country offices. The increase in financial resources despite the zero growth of the Regular budget can be attributed to increased funds from Other Sources arising, among other things, from the sustained interest of partners in the work of the Regional Office, the increased focus on accountability for resources within the Region, greater emphasis on establishing strategic partnerships with key donors, and good collaboration with development partners.

235 The capacity of technical and administrative staff in the Regional Office improved. Pools of consultants were also established to provide technical support in various programmes. All this tended to improve the quality and relevance of technical support to countries. The impact of the Regional Office in countries was also better where the country teams were stronger and well motivated.

Constraining factors

236 The pace of implementation of some of the planned activities such as integrated disease surveillance, Roll Back Malaria, making pregnancy safer and results-based management was, however, slower than expected. This was due mainly to the underestimated complexity of implementation processes, the need for wider stakeholder consultations and limited human and financial resources for such new initiatives within both WHO and Member States.

237 The implementation of the Programme Budget was also constrained by the exodus of highly qualified staff from the ministries of health, resulting in overloading of existing staff and low productivity of the health sector in general.

238 The working environment in some Member States was also challenging. The challenges arising in countries experiencing complex emergencies due to both natural and man-made disasters meant that the Regional Office had to reprogramme several planned activities and resources in order to provide relevant support to such countries. Political instability and insecurity in some countries also limited access within such countries, and hence, the scope of activities of the Regional Office. The weak macro-economic environment in some countries resulted in inadequate resources for the health sector, as well as lack of foreign exchange for international procurement of drugs, essential logistics and fuel. In others, the absence of a clear policy framework to guide donor support and programme implementation usually resulted in the implementation of unplanned activities (most of them donor-driven), lack of ownership of programmes, poor coordination of efforts and fragmentation of support.

PART II:
PROGRESS REPORT ON IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

Regional strategy for promoting the role of traditional medicine in health systems

239 Resolution AFR/RC50/R3 calls upon Member States to develop mechanisms for enhancing collaboration between traditional health practitioners and conventional health practitioners, to protect intellectual property rights, and to produce evidence on the safety, efficacy and quality of traditional medicines.

240 Support from stakeholders for the creation of an enabling environment for traditional medicine practice received a big boost through the declaration by the Organization of African Unity (OAU) Summit of Heads of State and Government that research on traditional medicine should be a priority, and that the period 2001-2010 be the decade for African traditional medicine. Additional resources, both human and financial, were mobilized to support the implementation, monitoring and evaluation of the strategy.

241 The regional workshop for the evaluation of traditional medicines, held in Antananarivo (Madagascar) in November 2000, agreed on a generic methodology for the preliminary evaluation (ethnomedical studies) of the safety, efficacy and quality of traditional medicines and on specific protocols on herbal preparations used for the treatment of malaria and HIV/AIDS. Support was provided to institutions in Burkina Faso, Côte d'Ivoire, Kenya, Nigeria and Zimbabwe to evaluate medicines used for the treatment of these diseases and develop pharmacopoeia and monographs of African medicinal plants.

242 Guidelines were developed on the formulation, implementation and evaluation of national policy on traditional medicine, a model traditional medicine bill, a model code of ethics, a plan of action for large-scale production of traditional medicines, a marketing authorization for drugs derived from traditional medicine and the conduct of ethnomedical studies for evaluating herbal preparations for the treatment of diabetes, sickle cell anaemia and hypertension.

243 Equatorial Guinea, Namibia, Swaziland, Uganda and Zambia received support for policy development, enactment of legislation and establishment of traditional medicine associations and councils. Ethiopia, Gabon, Ghana, Madagascar, Mali and Sao Tomé and Principe were given support for documenting traditional medicine. Furthermore, situation analyses and feasibility studies were undertaken for local production of traditional medicines.

244 A Regional Expert Committee on Traditional Medicine was established to support countries to effectively monitor and evaluate the progress made in the implementation of the regional strategy.

HIV/AIDS strategy in the African Region

245 The key issues facing Member States in the African Region are the continuing rise in HIV prevalence, coupled with the millions of people living with HIV/AIDS for whom care and treatment are inaccessible and unaffordable; deepening poverty among individuals, communities and countries which has created conditions for vulnerability to the infection while limiting possibilities for the provision of prevention and care services; and the high cost of essential drugs and technologies, particularly antiretroviral drugs, which has impeded countries' response to HIV/AIDS.

246 The Regional Office, within the context of the UN systemwide action on HIV/AIDS, supported countries to intensify and decentralize their health system response to the epidemic. The following activities were undertaken which aimed at strengthening Member States' capacity to expand programmes for HIV/AIDS surveillance, prevention and care:

a Resource mobilization and strengthening of partnerships, notably the Italian Initiative on HIV/AIDS in Africa, which has provided US$ 8 million to 10 countries;

b Fielding of 50 technical support missions to 32 countries which contributed to the improvement of surveillance, treatment facilities for sexually transmitted infections (STIs), laboratory services and treatment and care of AIDS patients including the use of antiretroviral drugs;

c Holding of 20 intercountry meetings and expert consultations which resulted in technical policy updates, intercountry exchange of best practices and experiences and expanded consultant networks;

d Recruitment of national professional officers which resulted in strengthened capacity for direct and continuous support in 15 countries;

e Provision of support for international advocacy and mobilization, notably to the OAU Heads of State and Government Summit on HIV/AIDS, TB and Other Infectious Diseases, whose declaration is a key policy directive at the highest level.

Several facilitating factors strengthened international advocacy and increased resource allocation to HIV/AIDS, including activities within WHO. Constraints at country level included lack of clarity in roles and weakening of programmes of ministries of health in the transitional period during which multisectoral national HIV/AIDS commissions were being set up in some Member States. 247

The Regional Office's emphasis in the next biennium will be on supporting health systems' delivery of a package of care and prevention interventions at district and community levels. Networks of technical experts at country and subregional levels will be expanded and Member States supported in the application of technical tools for programme planning and assessment. Response to the HIV/AIDS epidemic in countries affected by complex emergencies will be expanded, building on actions initiated in the 2000-2001 biennium. 248

Roll Back Malaria in the African Region

In line with the spirit of the biennial plan of action 2000-2001, attention was focused on the implementation of Roll Back Malaria (RBM) at country level. It was time for the programme to slowly scale up interventions of tested efficacy, though at a small scale. Capacity has been developed in 36 Member countries to plan, implement, monitor and evaluate malaria control activities and correct management of malaria cases has been ensured in 27 countries. Capacity has also been developed in all epidemic-prone countries to forecast, detect early and respond adequately to epidemics. 249

Furthermore, innovative ways of controlling malaria through community-based interventions, including home treatment of malaria episodes and distribution of insecticide-treated bednets, were actively promoted in 26 countries. Baseline data for the monitoring and evaluation of the results and impact of RBM have been collected in 42 endemic countries. Twenty-six operational research studies have been developed in 21 countries with technical and financial support of the Regional Office in order to find practical solutions to the problems malaria control programmes often experienced in the implementation of new strategies. 250

In the latter part of the biennium, 11 countries were supported to complete their strategic plans to roll back malaria, based on the situation analysis and partnership-building process they had implemented earlier in the biennium. 251

252 Some of the major enabling factors in the implementation of Roll Back Malaria were the political will of governments to implement planned activities, the sustained interest of partners, the development of partnerships, and the availability of financial resources. However, the scarcity of human resources at all levels and the difficulty in simultaneously conducting partnership-building and implementation of activities at country level were some of the constraints. The process of introducing RBM at country level has been long, involving many intercountry meetings, which diverted key programme officers from implementing technical interventions.

Regional strategy for emergency and humanitarian action

253 After the adoption of the Regional Strategy for Emergency and Humanitarian Action at the 47th session of the Regional Committee for Africa in September 1997, emergency preparedness and response programmes at regional and national levels were reoriented towards a more systematic approach, with an increased emphasis on the development of national systems and capacity, advanced planning, interdisciplinary approaches, and capacity-building through the creation of a roster of country-based experts in disaster preparedness and response.

254 The implementation of the strategy requires a technically-correct intersectoral approach to emergencies, executed by trained staff and operating through defined institutional structures at all levels. Progress toward this goal has been substantial within Member States and at the regional level, primarily because of the successful development of a system of trained "focal points" in ministries of health and in WHO country offices in almost all countries and the creation of emergency units and divisions in many countries.

255 There has also been satisfactory progress in the development and implementation of intercountry emergency operations, for example, in IGAD (a Horn of Africa Initiative) and the Southern African Development Community (SADC) countries.

256 Additional actions to be carried out will be to:

a encourage and support those Member States which have not yet done so to establish functional emergency preparedness and response offices or units and to develop clear emergency policies and plans;

b expand training of experts in ministries of health and WHO country offices in vulnerability assessment, planning and logistics, early warning and geographic information systems (GIS), etc.;

c develop additional guidelines and assessment tools, e.g. the minimum package for public health interventions in complex emergencies;

d improve communications between neighbouring countries facing cross-border emergencies, using high-frequency (HF) radios, satellite telephones, etc.;

e strengthen the Emergency and Humanitarian Action unit at the Regional Office to facilitate the provision of better technical support to Member States and WHO country offices;

f complete vulnerability assessments for major hazards in all countries.

Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases

257 By resolution AFR/RC48/R2 the Regional Committee approved the regional strategy for integrated disease surveillance (document: AFR/RC48/8). The resolution calls for an evaluation of disease surveillance systems and public health laboratories in Member States. It also urges Member States to rapidly notify WHO and neighbouring countries in the event of epidemics as agreed in the subregional cooperation protocols. The resolution requests the Regional Director to support the implementation of the strategy in Member States, provide technical support for epidemic preparedness and response, and mobilize funds from Other Sources to support the implementation of integrated disease surveillance at all levels.

258 Disease surveillance systems and public health laboratories have been assessed in 27 countries. Epidemic notification to WHO and neighbouring countries has significantly improved. The Regional Office has provided all Member States with generic guidelines on integrated disease surveillance and response and has already helped with the adaptation of these guidelines in six countries. Eight countries have received support for the implementation of surveillance activities at district level. Key laboratory personnel of 38 countries have received training and diagnostic kits for the confirmation of aetiological agents of epidemic-prone diseases. Additional funds have been mobilized for the implementation of the strategy in four countries.

259 Political commitment from Member States and donor support have provided good opportunities for the implementation of the strategy. Existing disease control programmes such as the poliomyelitis eradication initiative constitute a model and a basis for integrated disease surveillance and public health laboratory networking. The main limiting factor was the inadequacy of financial support to Member States.

260 The momentum created by the political commitment and the initiation of integrated disease surveillance implementation need to be sustained. The biennial period 2002-2003 should be one of scaling up surveillance activities. This will require sustained technical support and monitoring. Advantage should be taken of the numerous opportunities existing at subregional level and within Member States.

Regional strategy for the development of human resources for health

261 The Member States adopted the regional strategy for the development of human resources for health (resolution AFR/RC48/R3) during the 48th session of the Regional Committee in 1998. This is the second progress report following the adoption of the strategy.

262 Support was provided to 12 countries to develop and update their policies for the development of human resources for health. Five regional training centres and five WHO collaborating centres provided support to countries for the implementation of the strategy. Guidelines for the evaluation of health sciences training programmes were developed and pilot-tested. Curriculum guidelines for reviewing pre-service nursing and midwifery were developed and applied in several countries. A training course in the management of human resources for health has been developed and 41 managers were trained. The Multidisciplinary Advisory Group of Experts in Human Resources for Health held its first meeting in March 2000. WHO allocated 556 fellowships for training in 2000-2001. At the Regional Office level, the Human Resources for Health unit was strengthened. It now has experts for each of the major areas of policy and planning, education and training, management, and nursing and midwifery.

263 Not much progress was made in the area of establishment of new models of care. This activity was deferred and planned under the 2002-2003 plan of action when a strategy will be developed to assist countries to shift the paradigm of care from a medical to a health-focused model.

264 Despite efforts by countries to optimize the utilization of human resources for health, the implementation of the strategies was slow. The main constraints were:

a demotivated health workers due to poor remuneration and working conditions, resulting in migration and serious shortage of workers, particularly in rural areas;

b poorly-structured and equipped national departments of human resources for health lacking the clout and skills to influence policy to ensure a sustained impact on the development of human resources for health;

c lack of comprehensive policies and plans.

Member States will be requested to provide the necessary leadership in addressing this issue at the highest level in order to find sustained solutions. 265

Strategic health research plan for the WHO African Region

While adopting the strategic health research plan for the WHO African Region (document AFR/RC48/11) at its forty-eighth session, the Regional Committee also adopted resolution AFR/RC48/R4 which, among other things, requested the Regional Director to report every two years on the implementation of the strategic plan. This brief account is intended to serve that purpose. 266

Resolution AFR/RC48/R4 requested Member States to determine priority research areas, draw up their research policies and build the necessary national research capacities. At the Regional Office level, the resolution laid emphasis on enhancing the effectiveness of the African Advisory Committee for Health Research and Development (AACHRD), strengthening the research aspect of regional programmes, optimizing the role of WHO collaborating centres and promoting research. 267

In response to the resolution, a major effort was directed towards the revival and strengthening of the role of the AACHRD to provide strategic advice to the Regional Director. Through its annual meetings and regular contact with the Regional Office, the AACHRD provided useful inputs for addressing challenges facing health research in the Region, especially those related to emerging bioethical concerns and coordination of research activities. 268

Regarding WHO collaborating centres, the Regional Office embarked on efforts to enhance the relevance of these centres and that of other institutions of excellence. There was an extensive Organization-wide review of the status of existing centres during 1998 and 1999. The review led to the adoption, at the beginning of the year 2000, of standard guidelines and procedures for the designation and redesignation of these centres. More efforts were made to recruit new centres and to strengthen the capacity of the existing ones. 269

On research promotion, the Regional Office actively encouraged investments in research. At present all technical programmes at the Regional Office have a budgetary provision for research, and there has been a significant increase in research activities in Member States. Several countries have defined their health research priorities, while others have put in place research coordination mechanisms. But the rise in research activities has come along with other challenges, especially those related to bioethics. This is an area that calls for the attention and response of all countries. 270

Health sector reform in the WHO African Region: Status of implementation and perspectives

271 The Regional Committee in 1999 adopted resolution AFR/RC49/R2, which calls upon Member States to intensify their efforts to undertake appropriate health sector reforms, and asks WHO to provide the necessary support.

272 The Health-for-all policy for the 21st Century in the African Region: Agenda 2020 was adopted by the 50th session of the Regional Committee as a framework for enhancing health sector reform at the dawn of the new millennium.

273 A synthesis of the status of the health sector reform in the African Region was prepared and made available to Member countries after three sensitization meetings on the United Nations Special Initiative for Africa held in Cotonou (Benin), Addis Ababa (Ethiopia) and Maputo (Mozambique). A meeting on the implementation of sector-wide approaches in the context of health sector reform for Eastern and Southern Africa gave an opportunity, to among other things, review countries' experiences. Study tours, as mechanisms for sharing experiences between countries, were supported in Zambia, Mozambique, Ghana and Gambia. Guidelines and tools for the monitoring and evaluation of health sector reforms were developed. Most of the achievements were made by working in close collaboration with the African Development Bank, the World Bank, other agencies and health development partners.

274 The WHO framework for health system performance assessment provided further orientation to review health systems and identify areas that needed strengthening. Tools are being developed for the assessment of the functioning of health systems and sustainable health financing approaches in the Region.

275 Major constraints included: the high turnover of decision-makers, the loss of skilled and experienced health workers, the burden of HIV/AIDS, and the diminishing amount of resources allocated to the health sector. However, the commitment of African leaders expressed in the Abuja Declaration, the New Partnership for African Development (NEPAD) Initiative and the Global Fund for Health provide a conducive environment for health development in the Region.

Review of the implementation of the Bamako Initiative

276 The Regional Committee adopted resolution AFR/RC49/R6 in 1999, which calls upon Member States to include the Bamako Initiative in their health development agenda and implement the Initiative as the community dimension of health sector reform. It also calls upon WHO to develop a new implementation framework for the Bamako Initiative.

277 The regional directors of the WHO African Region, UNICEF Eastern and Southern African Region and UNICEF Western and Central African Region met in Windhoek (Namibia) in August 1999 and agreed to set up a technical working group to develop a new operational framework for the implementation of the Initiative.

278 The technical working group met twice, in Harare (Zimbabwe) in October 1999, and in Abidjan (Côte d'Ivoire) in March 2000, and defined the essential health package, identified the key elements to support the implementation of the package, and drafted a new operational framework for the implementation of the Initiative.

279 An interagency meeting for the implementation of the Bamako Initiative, held in Nairobi (Kenya) in November 2001, reached a consensus on a new operational framework. The vital role of community participation and empowerment was taken into account while formulating the new framework. Mechanisms identified for strengthening coordination and support to countries for the implementation of the new operational framework include support for the development of comprehensive national development policies and implementation plans, harmonization of agency activities and procedures and buying into national priorities and programmes. A framework for monitoring and evaluating the implementation of the new framework was prepared.

280 Developing the new operational framework for the implementation of the Bamako Initiative took longer than anticipated because of the need for extensive consultations with UNICEF, other agencies and Member countries.

281 The opportunities for the implementation of the new operational framework for the Bamako Initiative include: ongoing health sector reforms in health-care financing; political and health services decentralization in most of the Member States; and the existence of community components of ongoing programmes like IMCI, TB (DOTS) and HIV/AIDS, and poverty alleviation efforts through the development of Poverty Reduction Strategy Papers (PRSP) in countries.

CONCLUSION

282 WHO's work in the African Region was very productive during the 2000-2001 biennium.

283 By focusing on the *determinants of health and disease,* WHO and its Member States were in a better position to bring about long-term and sustainable improvements in the health status of all African people.

284 By applying new management standards at all levels of the Organization following the adoption of results-based management, increased accountability for both the results and resources was achieved.

285 There was *increased donor confidence* which resulted in a ten-fold increase in donor support, making it possible to broaden and intensify country-level work in areas such as prevention, surveillance and control of diseases especially malaria, TB and HIV/AIDS; improve health systems particularly at the district level; and improve capacity in countries to deal with emergencies, both natural and man-made. Almost every country in the African Region benefited from this improved flow of resources.

286 There is, however, no room for complacency. A realistic look at the health conditions in Africa today shows that in some key areas, we are losing ground and in others success is far from certain. For example:

a Macro-economic conditions, which directly or indirectly influence health outcomes, have deteriorated in many African countries. Crushing debt burdens, unfavourable terms of trade for African commodities and raw materials on the world market, and insufficient investment in infrastructure and human capital are undermining Africa's development.

b Although a few Member States have stabilized or even reversed the upward trend in HIV seropositivity, progress against the HIV/AIDS pandemic is unsatisfactory in most countries of the Region. And even in those few countries which are seeing a levelling off of the epidemic curve, the social and economic burden of caring for patients already affected and the social catastrophe of over 11 million AIDS orphans left in the wake of the pandemic seem to be beyond the capacity of national authorities and communities to cope.

c Poverty and the diseases of poverty (HIV/AIDS, TB, malaria) are receiving increased attention. However, more work is needed to better understand the two-way linkage between poverty and ill-health and to develop cost-effective remedies. While intensifying our efforts to control the diseases of poverty, we must also mount an attack on poverty itself, beginning at the community level with income-generating projects. All efforts of this kind must address the special needs of women and children, who are poverty's chief victims.

d Social and political instability, including war and mass population displacement in several countries, have disrupted health services, exposed people to new disease risks (cholera, malnutrition, HIV/AIDS), compromised disease control and eradication programmes including poliomyelitis eradication, and weakened the capacity of Member States to respond. Countries need more assistance to prepare and respond to disasters, both natural and man-made.

e Poliomyelitis eradication has reached a point which many experts thought impossible only a few years ago. With support from the Member States and its partners, WHO has done the near impossible in the African Region. By 2001, wild poliovirus was detected in only seven countries in the Region. Well-designed surveillance systems are in place in every one of the 46 countries; and residual cases, as well as any cases re-introduced into polio-free areas, will be detected. However, eradication of poliomyelitis from the few remaining difficult-to-reach areas in the Region will not be easy, and success is by no means guaranteed. At this juncture, we must intensify, not relax, our joint effort to eradicate poliomyelitis.

f Cancer, hypertension, cardiovascular diseases, stroke, metabolic diseases including diabetes, tobacco-related illnesses, drug abuse and neuro-psychiatric illnesses were earlier thought to be problems of industrialized societies only. But the importance of these and other noncommunicable diseases in Africa is increasingly being recognized and documented. In the African Region, WHO is now addressing these problems at the divisional level. Well-designed strategies and technical protocols exist or are under development, but funding, and, in some cases, national commitment is not proportional to the disease burden represented by noncommunicable diseases.

This list of the challenges still to be met is incomplete. While there is no doubt that WHO has done well in the African Region, we must now do even better. We must work faster. We must do more with less. With the continuing support and cooperation of our Member States and development partners, we are ready.

ANNEX – 1

TABLE I: IMPLEMENTATION OF THE WHO REGULAR BUDGET IN THE AFRICAN REGION (REGIONAL OFFICE)

Area of work Number	Code	Initial allocation	Adjustments/ reprogramming	Final allocation and implementation	Implementation rate based on initial allocation	Implementation rate based on final allocation
		1	2	3	4	5
01.1.01	CSR	496,000	298,000	794,000	160%	100%
01.2.01	CPC	4,170,000	200,000	4,370,000	105%	100%
01.3.01	CEE	0	233,000	233,000		100%
01.4.01	CRD	511,000	-159,000	352,000	69%	100%
02.1.01	NCS	1,729,000	-655,000	1,074,000	62%	100%
02.2.01	NCP	0	319,000	319,000		100%
02.3.01	NCM	0	286,000	286,000		100%
03.2.01	CAH	974,000	226,000	1,200,000	123%	100%
03.3.01	RHR	2,267,000	3,290,000	5,557,000	245%	100%
03.4.01	WMH	566,000	246,000	812,000	143%	100%
04.1.01	HSD	1,922,000	-372,000	1,550,000	81%	100%
04.2.01	NHD	780,000	-100,000	680,000	87%	100%
04.3.01	PHE	2,865,000	291,000	3,156,000	110%	100%
04.4.01	EHA	806,000	830,000	1,636,000	203%	100%
05.1.01	HPR	532,000	480,000	1,012,000	190%	100%
05.2.01	DPR	306,000	-141,000	165,000	54%	100%
05.3.01	MNH	711,000	270,000	981,000	138%	100%
05.4.01	SAB	378,000	70,000	448,000	119%	100%
06.1.01	EDM	1,170,000	596,000	1,766,000	151%	100%
06.2.01	VAB	461,000	118,000	579,000	126%	100%
06.3.01	BCT	900,000	659,000	1,559,000	173%	100%
07.1.01	GPE	445,000	-67,000	378,000	85%	100%
07.2.01	IMD	4,661,000	-313,000	4,348,000	93%	100%
07.3.01	RPC	351,000	422,000	773,000	220%	100%
07.4.01	OSD	9,351,000	-2,883,000	6,468,000	69%	100%
08.1.01	GBS	1,467,000	230,000	1,697,000	116%	100%
08.2.01	RMB	350,000	-130,000	220,000	63%	100%
08.3.01	ECP	2,347,000	581,000	2,928,000	125%	100%
09.1.01	BMR	0	353,000	353,000		100%
09.2.01	HRS	2,713,000	-852,000	1,861,000	69%	100%
09.3.01	FNS	3,714,000	50,000	3,764,000	101%	100%
09.4.01	IIS	14,480,000	159,000	14,639,000	101%	100%
10.1.01	DGO	2,405,000	-1,457,000	948,000	39%	100%
10.3.01	DDP	698,000	57,000	755,000	108%	100%
Totals		64,526,000	3,135,000	67,661,000	105%	100%

ANNEX – 2

TABLE 2: IMPLEMENTATION OF THE WHO REGULAR BUDGET IN THE AFRICAN REGION (COUNTRIES)

Area of work Number	Code	Initial allocation	Adjustments/ reprogramming	Final allocation and imple-mentation	Implementation rate based on initial allocation	Implementation rate based on final allocation
		1	2	3	4	5
01.1.01	CSR	8,911,000	-3,937,000	4,974,000	56%	100%
01.2.01	CPC	5,073,000	1,343,000	6,416,000	126%	100%
01.3.01	CEE	0	833,000	833,000		100%
01.4.01	CRD	25,000	103,000	128,000	512%	100%
02.1.01	NCS	685,000	-398,000	287,000	42%	100%
02.2.01	NCP	0	232,000	232,000		100%
02.3.01	NCM	0	690,000	690,000		100%
03.2.01	CAH	2,055,000	-1,052,000	1,003,000	49%	100%
03.3.01	RHR	9,441,000	-5,949,000	3,492,000	37%	100%
03.4.01	WMH	225,000	391,000	616,000	274%	100%
04.1.01	HSD	606,000	-311,000	295,000	49%	100%
04.2.01	NHD	896,000	-358,000	538,000	60%	100%
04.3.01	PHE	5,060,000	-1,735,000	3,325,000	66%	100%
04.4.01	EHA	870,000	1,546,000	2,416,000	278%	100%
05.1.01	HPR	1,474,000	1,422,000	2,896,000	196%	100%
05.2.01	DPR	124,000	67,000	191,000	154%	100%
05.3.01	MNH	801,000	-264,000	537,000	67%	100%
05.4.01	SAB	132,000	15,000	147,000	111%	100%
06.1.01	EDM	1,915,000	-107,000	1,808,000	94%	100%
06.2.01	VAB	1,406,000	-831,000	575,000	41%	100%
06.3.01	BCT	441,000	142,000	583,000	132%	100%
07.1.01	GPE	2,214,000	-1,298,000	916,000	41%	100%
07.2.01	lMD	132,000	671,000	803,000	608%	100%
07.3.01	RPC	82,000	71,000	153,000	187%	100%
07.4.01	OSD	26,056,000	-5,413,000	20,643,000	79%	100%
08.2.01	RMB	0	38,000	38,000		100%
08.3.01	ECP	1,966,000	-1,549,000	417,000	21%	100%
09.1.01	BMR	0	1,000	1,000		100%
09.4.01	lIS	55,000	-55,000	0	0%	
10.1.01	DGO	620,000	-620,000	0	0%	
11.1.01	COO	41,031,000	12,713,000	53,744,000	131%	100%
Totals		112,296,001	-3,598,998	108,697,003	97%	100%

ANNEX – 3

TABLE 3: IMPLEMENTATION OF THE WHO BUDGET IN THE AFRICAN REGION (OTHER SOURCES)

Area of work Number	Code	Approved budget	Available funds	Implemented funds	Implementation rate based on initial allocation
		1	2	3	4
01.1.01	CSR	3,700,000.00	13,353,000.00	7,765,000.00	58%
01.2.01	CPC	127,294,000.00	42,316,000.00	20,253,000.00	48%
01.3.01	CEE		2,230,000.00	1,508,000.00	68%
02.1.01	NCS	-	358,000.00	245,000.00	68%
02.2.01	NCP		512,000.00	382,000.00	75%
02.3.01	NCM		5,000.00	5,000.00	100%
03.2.01	CAH	2,467,000.00	10,871,000.00	7,633,000.00	70%
03.3.01	RHR	2,247,000.00	11,747,000.00	5,601,000.00	48%
03.4.01	WMH	32,000.00	397,000.00	263,000.00	66%
04.1.01	HSD		149,000.00	104,000.00	70%
04.2.01	NHD	245,000.00	148,000.00	31,000.00	21%
04.3.01	PHE		257,000.00	135,000.00	53%
04.4.01	EHA		10,337,000.00	6,280,000.00	61%
05.1.01	HPR		125,000.00	45,000.00	36%
05.2.01	DPR		688,000.00	150,000.00	22%
05.3.01	MNH		110,000.00	75,000.00	68%
05.4.01	SAB		294,000.00	56,000.00	19%
06.1.01	EDM		2,249,000.00	734,000.00	33%
06.2.01	VAB	245,000.00	201,492,000.00	186,766,000.00	93%
07.1.01	GPE		52,000.00	25,000.00	48%
07.2.01	IMD		12,000.00	12,000.00	100%
07.3.01	RPC		5,000.00	-	0%
07.4.01	OSD	526,000.00	6,839,000.00	2,997,000.00	44%
08.1.01	GBS		35,000.00	31,000.00	89%
08.2.01	RMB	1,019,000.00			
08.3.01	ECP	245,000.00	1,456,000.00	1,229,000.00	84%
09.2.01	HRS	463,000.00	1,547,000.00	1,365,000.00	88%
09.3.01	FNS	1,149,000.00	1,993,000.00	1,948,000.00	98%
09.4.01	IIS	3,932,000.00	7,690,000.00	7,322,000.00	95%
Totals		143,564,000.00	317,267,000.00	252,960,000.00	80%