AFR/RC53/2
ORIGINAL: ENGLISH

The Work of WHO in the African Region 2002

Annual Report of the Regional Director

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville

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To the fifty-third session of the Regional Committee for Africa, Johannesburg, South Africa, 1 to 5 September 2003

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Brazzaville • 2003

AFR/RC53/2

Printed in the Republic of South Africa

The Regional Director has the honour of presenting to the Regional Committee the report on the activities of the World Health Organization in the African Region during the year 2002.

Dr Ebrahim M. Samba
Regional Director

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ABBREVIATIONS

AACHRD	African Advisory Committee for Health Research and Development
ADB	African Development Bank
AFP	Acute Flaccid Paralysis
AMS	Activity Management System
AOW	Area of Work
ARCC	African Regional Certification Commission
ARICC	African Regional Interagency Coordination Committee
ARV	Antiretroviral
ATM	African Traditional Medicine
BE	Biennial Evaluation
BTS	Blood Transfusion Services
CCM	Country Coordinating Mechanism
CCS	Country Cooperation Strategy
CDP	Chronic Diseases Programme
DDP	Director-General's and Regional Director's Development Programme and Initiatives
DOTS	Directly-Observed Treatment, Short Course
EHA	Emergency and Humanitarian Action
EMRO	Regional Office for the Eastern Mediterranean
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunization
FGM	Female Genital Mutilation
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIS	Geographic Information System
HIV/AIDS	Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome
HQ	Headquarters
HRH	Human Resources for Health
HSR	Health Systems Research
IARC	International Agency for Research on Cancer
ICOH	Intercoutry Oral Health Centre
ICRC	International Committee of the Red Cross/Red Crescent
IDP	Internally Displaced Person
IDSR	Integrated Disease Surveillance and Response
IEC	Information-Education-Communication
ILO	International Labour Organization

IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IRM	Interagency Resource Management
IRSP	Regional Public Health Training Institute
IT	Information Technology
ITN	Insecticide-Treated Net
LHD	Long-term Health Development
MAP	Multicountry AIDS Programme
MCG	Multidisciplinary Collaborating Group
MDSC	Multi-Disease Surveillance Centre
MIM	Multilateral Initiative on Malaria in Africa
MLM	Mid-level Manager
MMR	Maternal Mortality Ratio
MTR	Mid-term Review
NEPAD	New Partnership for Africa's Development
NID	National Immunization Day
NORAD	Norwegian Agency for International Development
NPEC	National Polio Expert Committee
NPO	National Programme Officer
PHAST	Participatory Hygiene and Sanitation Transformation
PLWHA	Persons Living with HIV/AIDS
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother-to-Child Transmission
PPE	Planning, Monitoring and Evaluation
PRSP	Poverty Reduction Strategy Paper
PSC	Programme Subcommittee
RIACSO	Regional Interagency Coordination Support Office
RO/AFI	Regional Office Administration and Finance Information System
RPM	Regional Programme Meeting
SAM	Semi-annual Monitoring
SIA	Supplementary Immunization Activity
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UCI	Universal Child Immunization
UEMOA	Economic and Monetary Union of West Africa

VCT	Voluntary Counseling and Testing
WR	WHO Representative

INTRODUCTION

1. This regional report for the year 2002 reflects the work of WHO in the African Region as part of the implementation of the Programme Budget 2002–2003. As the first in the Tenth General Programme of Work (2002–2005), the Programme Budget 2002–2003 represents the WHO response to the challenges in the African Region.

2. The past few years show significant changes in international health as well as a better understanding of the causes and consequences of health problems. Considering the limited resources for health, the combined efforts of WHO, Member States and other partners concentrate on a limited number of clearly defined priorities which reflect country needs. These efforts are guided by the magnitude and persistence of health problems in the Region and by the Regional Health-for-All Policy for the 21st Century: Agenda 2020.

3. The WHO country focus initiative devised the Country Cooperation Strategy (CCS) as the key element to improve WHO contributions to people's health and development. The initiative aims at accelerating national health reforms to ensure better performance of health systems and make them more efficient and equitable. Health sector reforms depend on policies and programmes for promotion of good governance, reduction of poverty for sustainable development and cooperation at sub-regional and regional levels with organizations such as the Economic Community of West African States, Southern African Development Community, African Union and New Partnership for Africa's Development.

4. In addition, efforts have been complemented by several international initiatives such as the *Report on Macroeconomics and Health*, the World Summit on Sustainable Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Stop TB initiative, the Polio Eradication initiative and the Global Alliance for Vaccines and Immunization (GAVI). These initiatives give priority to the African Region and come with opportunities for increased partnerships and funding.

5. However, the African Region is still plagued by political instability and civil strife. This situation forces the majority of the population to endure devastating poverty which is one of the major constraints to health development. Efforts to address the inadequate health situation are constrained by weak national and district health systems, weak stewardship, brain drain, inadequate financing and limited cost-effective interventions. At the same time, investments in research into interventions for addressing priority diseases in the Region have been low. National health system performance is also worsened by insignificant national macroeconomic performance and by frequent natural and human-made emergencies.

6. Given that WHO has neither the resources nor the capacity to address the total health agenda of the African Region, the Programme Budget 2002–2003 seeks to:

(a) focus efforts and resources on a limited number of priorities consistent with the WHO mandate and comparative advantage;

(b) put in place mechanisms to mobilize additional resources to complement the limited Regular budget;
(c) promote effective partnerships with Member States and development partners so as to harness the existing opportunities for health and ensure synergy of efforts.

7. By extending the implementation of the results-based management approach, the 2002–2003 Programme Budget aims to improve the efficiency and effectiveness of WHO work in the African Region. The WHO Regional Office for Africa can be held accountable for the expected results defined in the Programme Budget, and these results define the framework for detailed operational planning, implementation, monitoring and reporting.

8. This report is a progress report of the implementation during the first year of the Programme Budget 2002–2003. It reflects the work achieved by WHO at the regional and country levels. It is written in two main parts. Part I of the report describes significant achievements in the various areas of work (AOW). It represents the key facilitating factors to be sustained as well as the constraining factors to be addressed for effective implementation of the Programme Budget. Part II presents the progress made in the implementation of resolutions adopted by the Regional Committee at its earlier sessions and for which reports are due at the fifty-third session. The conclusion summarizes the lessons emerging after the first year of implementation of the Programme Budget 2002–2003 as well as the progress of the implementation of Regional Committee resolutions. It also provides some perspectives for improving the work of WHO in the African Region. Tables on the implementation of the Regular Budget and funds from Other Sources are provided in the annex.

PART I: PROGRAMME BUDGET 2002–2003 IMPLEMENTATION FOR THE YEAR 2002

SIGNIFICANT ACHIEVEMENTS

General programme development and management

9. Under the guidance of the Regional Director, the management functions carried out through the managerial organs[1] of the Regional Office for Africa aim to ensure that programmes and technical cooperation with countries in the African Region are effective. Management thus efficiently applies the four World Health Organization corporate strategies of:

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

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

(c) developing health systems that improve health outcomes, respond to people's legitimate expectations and equitably finance care;

(d) framing an enabling policy and institutional environment for the health sector and promoting an effective health dimension to economic, social, environmental and developmental policy.

10. In addition to overall coordination of the work of WHO in the African Region, General Programme Development and Management covered specific areas of work (AOW), namely: Director-General's and Regional Director's Development Programme and Initiatives (DDP), Governing Bodies (GBS), Budget and Management Reforms (BMR), Resource Mobilization and External Cooperation and Partnerships (REC), Evidence for Health Policy (GPE), Health Information Management and Dissemination (IMD) and Research Policy and Promotion (RPC).

11. The priorities for these AOWs for the biennium 2002–2003 include:

(a) building on progress with results-based management through strengthening the systems for planning, monitoring and reporting;

(b) using evidence to ensure an appropriate balance between resources allocated for technical and administrative functions; normative work and support to countries; efforts to control diseases, promote reproductive health and address the broader determinants of health;

[1] The managerial organs of the Regional Office for Africa are: Regional Committee, Programme Subcommittee, Executive Management Committee, Regional Programme Meeting, Management Development Committee, Monitoring and Evaluation Committee, African Advisory Committee for Health Research and Development, Standing Committee on Emergency, Publications Committee and Research Development Committee.

(c) enhancing the relevance and responsiveness of WHO programmes to country needs through ensuring an appropriate country presence, further decentralization of responsibility to country offices within the context of the evidence emerging from the Country Cooperation Strategies (CCS) and reorienting the Regional Office to be more responsive to country needs and requests;

(d) coordinating the work of divisions and country offices in line with the Corporate Strategy and the Health-for-All Policy for the African Region: Agenda 2020 and facilitating the use of evidence for developing programmes;

(e) enhancing the performance of the managerial organs of the Regional Office in providing overall policy and strategic inputs to the work of WHO in the Africa Region;

(f) mobilizing resources from other sources to fill the resource gap identified in workplans and ensuring that resources are deployed and used in line with Regional Office priorities;

(g) strengthening partnerships within the United Nations family and with other agencies involved in health development in the African Region;

(h) making quality and relevant health information available and accessible to health policy planners, professionals and the general public.

12. A number of organizational changes were implemented to improve the functioning of the Regional Office. The Emergency and Humanitarian Action (EHA) AOW was transferred to the Division of Healthy Environments and Sustainable Development to provide an institutional anchor for the considerable work accomplished in environmental risk assessment and long-term health development. The Interagency Resource Management unit (IRM) and Governing Bodies (GBS) were merged to form External Relations and Governing Bodies under the supervision of the Director of Programme Management to promote collaboration with Member States, external partners and other international organizations and thus harmonize joint programming for health development, exchange information and mobilize resources to support country efforts. Health Information Management and Dissemination was transferred from the Division of Administration and Finance to the Division of Programme Management.

The Director-General's and Regional Director's development programme and initiatives (DDP)

13. The Regional Director's Development Fund is meant primarily for providing support to Member States to finance unforeseeable but urgent activities, promote good practices in the spirit of technical cooperation between developing countries and launch new initiatives likely to improve the health status of the populations, especially those in greatest need. In the year 2002, the fund was used for the following:

(a) Assistance was provided to some countries to cope with emergencies such as the arms explosion in an armoury in Nigeria; flooding and spells of cold weather in the Saint Louis and Louga regions of Senegal; yellow fever epidemic in Guinea and Senegal; sinking of the "Joola" ferry boat in Senegal; and the health impact of drought in Mozambique.

(b) Contributions were made to initiatives launched to benefit people in greatest need, specifically the establishment and extension of the Biofarm Project at Fistula village, Ethiopia; aid to the Women's Group in Semé-Podji, Benin; support to a very poor segment of the Cape Verde population, called Rabelados; assistance to the Bawjiase orphanage in Ghana; study visit to the AIDS orphanage, Mutoko, Zimbabwe; support to a poverty reduction project in Burkina Faso.

(c) Support was given for the implementation of priority programmes and activities, namely: control of tobacco use in Côte d'Ivoire; Dakar meeting on the Framework Convention on Tobacco Control; malaria control in the Republic of Congo; prevention, study and documentation of child sex abuse and violence in Togo; HIV/AIDS prevention and control in Niger.

(d) Assistance was provided for institutional capacity building in Member States: support to the organizing committee of the International Women's Day in Zimbabwe; connection of the WHO intranet in Senegal; donation of equipment to the Royal Victoria Hospital in the Gambia; support to the Ministry of Health and Environment of Uganda; provision of support to the Labour and Social Welfare Commission for celebrating the 25th anniversary of the OAU in Ethiopia; strengthening the institutional capacity of the Ministry of Health, Senegal; support for the organization of days of health study in Niger.

(e) Support was provided for initiatives to strengthen WHO country offices: rehabilitation of the WHO coordination offices in Goma, eastern Democratic Republic of Congo.

14. The foregoing actions, which are by no means exhaustive, give an overview of new concerns that Member States addressed and will deserve attention in the development of future programmes.

Resource mobilization and external cooperation and partnerships (REC)

15. The changing environment for health actions coupled with the fact that Member States expect WHO to contribute more effectively to address national health challenges has led to a reconsideration of WHO response to country needs and priorities. In the WHO African Region, the Country Cooperation Strategy (CCS) is considered to be the key instrument for articulating WHO response to country needs. It is expected to form the basis for developing country programme budgets and workplans and for coordinating support to countries from all three levels of the Organization. Hence, the CCS is the framework for strengthening technical cooperation with countries. Responding to national health challenges also requires improving partnerships with other development partners, mobilizing resources in support of country efforts and increasing access to information about WHO programmes in the African Region.

16. During the period under review, important collaborative efforts were made to strengthen the capacity of WHO country offices and better respond to country needs. Major achievements were made. Capacities were built in both the Regional Office and country offices for the formulation and implementation of CCSs. Support mechanisms and tools were developed, CCS

teams were established at regional and country levels and information on the CCS process was documented and shared. Support was given to countries for developing and implementing their CCS documents. As of December 2002, a total of 19 CCS documents[2] were approved by the Regional Director and submitted for the Director-General's approval; four CCS documents (from Cameroon, Namibia, Rwanda, Zimbabwe) were finalized and in the approval process; and several countries introduced CCS orientations in their workplans.

17. Another achievement was improving the leadership and managerial capacities of WHO representatives (WRs) and their staff. This was done by reviewing procedures for selection, rotation and briefing of WRs, Liasion Officers and other staff; recruiting essential staff; improving financial, logistic and communication support in country offices; and organizing regular retreats and intercountry meetings.

18. Collaboration and coordination were strengthened between the three levels of WHO. Overall programme management was enhanced with successful regional programme meetings which brought together all senior managers from the Regional Office, country offices and headquarters (HQ) to discuss key policy and strategic issues.

19. In order to mobilize resources from other sources to support programme implementation, 10 project agreements, valued at US$ 48 712 857, were finalized. Technical support was provided to divisions and country offices for preparation of project documents and to the WHO liaison offices in the European Union and African Development Bank (ADB). The capacity of the Interagency Resource Management unit was strengthened, and negotiation skills workshops were conducted in Togo and Kenya.

20. To make information about WHO more readily available in countries, the WHO country offices were supported to implement the information-education-communication (IEC) component of their workplans. Health reporting was improved in 14 countries[3] through technical support for workshops for media practitioners and with limited financial assistance to strengthen health desks in national media institutions. Rwanda was supported to develop a health IEC strategy. The Regional Office website has increased the flow of information to the media and the general public. This has helped to sustain a positive public image and professional credibility with media partners and other publishers in the Region.

[2]CCS documents were received from Algeria, Angola, Botswana, Burkina Faso, Cape Verde, Chad, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gambia, Ghana, Kenya, Mali, Mauritania, Nigeria, Senegal, Swaziland, Tanzania, Zambia.

[3]Benin, Botswana, Cape Verde, Democratic Republic of Congo, Eritrea, Gabon, Gambia, Ghana, Mali, Nigeria, Republic of Congo, Rwanda, Togo, Zambia.

Evidence for health policy (GPE)

21. In the area of Evidence for Health Policy, the Regional Office has been working with HQ and country offices to improve the generation and use of information for policy. During the biennium 2002–2003, one priority is to coordinate the generation and use of epidemiological and economic evidence for programme development. Another priority is to strengthen national health information systems as well as national analytical capacity in epidemiology and health economics.

22. During the period under review, the Regional Office organized the 2002 Health Economics Strengthening Workshop. Following the release of the report of the Commission on Macroeconomics and Health *(Macroeconomics and health: Investing in health for economic development),* Member States requested that the content of the workshop be expanded to include macroeconomics and health, national health accounts, health financing and Poverty Reduction Strategy Papers. Participants were increased from 20 health economists to 100, including public health physicians and health economists from 43 Member States.

23. In addition, other technical training was offered. Clinical coders in Mauritius were trained in ICD-10 classification, and workshops on data analysis and management were held in Guinea and Equatorial Guinea.

24. In order to reinforce the dissemination of evidence, the *African Journal of Public Health* was fully conceptualized, and the Editorial Team and Editorial Committee were constituted. The Regional Office brochure entitled "Health Situation in the WHO African Region: Basic Indicators" was finalized and disseminated. The production of weekly bulletins on epidemic-prone diseases continued throughout 2002. Two issues of "Communicable Diseases Epidemiological Report" (CDER AFRO Bulletin) were produced and disseminated; the subjects were HIV/AIDS and tuberculosis. In addition, the "Integrated Disease Surveillance Epidemiological Bulletin" was produced and disseminated to Member States and partners in both print and electronic forms.

25. Assistance was given to countries to generate evidence to support health policy and systems development. A capacity-building workshop was held to review the tools and methodologies for the world health survey; participants from 18 countries[4] learned how to use them. Six countries[5] strengthened their national health information systems. Orientation workshops in the use of the Geographic Information System (GIS) and EPI/INFO 2000 were conducted, and 12 countries[6] were able to upgrade their health infrastructure databases. Malawi and Senegal were assisted to develop tools for monitoring health services at district level.

[4]Burkina Faso, Chad, Comoros, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mali, Mauritania, Mauritius, Namibia, Republic of Congo, Senegal, South Africa, Swaziland, Zambia, Zimbabwe.
[5]Eritrea, Kenya, Mali, Mauritania, Swaziland, Togo.
[6]Angola, Comoros, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Zambia, Zimbabwe.

Governing bodies (GBS)

26. The focus of the Governing Bodies AOW is to enable the Regional Committee and the Programme Subcommittee (PSC) to contribute more effectively to the work of WHO in the African Region. For that purpose, the focus of the Regional Committee is on health priorities in the African Region and is synchronized with those of the World Health Assembly and Executive Board. Efforts were made to prepare delegates to effectively participate in the Regional Committee, Executive Board and World Health Assembly meetings.

27. Due to changes in the security situation in the Republic of Congo, the Programme Subcommittee meeting and the fifty-second session of the Regional Committee originally scheduled for Brazzaville were postponed and then held in Harare. Enormous efforts went into preparing the delegates and ensuring that they received technical and other background documents at least a month before the meetings. The results were critical analyses of the documents, valuable contributions and quality proposals from delegates.

28. The participation of the African delegates to the global governing bodies meetings was well coordinated with HQ and the country offices; delegates to the Executive Board and the Fifty-fifth World Health Assembly were adequately prepared to ensure effective participation.

Budget and management reform (BMR)

29. The Regional Office has been reforming its managerial process to ensure effective and efficient implementation of the Programme Budget and workplans in line with the Corporate Strategy. The priority reform during the biennium 2002–2003 is to put in place a fully integrated and results-based management system for planning, implementation, monitoring and reporting. Thus, the twenty-ninth Regional Programme Meeting (RPM) discussed the strategies for more integrated management of the Programme Budget. The aim was for country offices to adopt the global guidelines and instruments for planning, monitoring and reporting.

30. Furthermore, Regional Office guidelines for monitoring and reporting were adapted to the framework of results-based management to support the "One WHO" philosophy. Divisions and country offices used the guidelines to prepare the 2002 semi-annual monitoring (SAM) and mid-term review (MTR) reports. The regional orientations of the 2004–2005 Programme Budget and Regional Office contribution to the promotion and success of "One WHO" were prepared and adopted at the fifty-second session of the Regional Committee (RC52). The consolidated biennial evaluation (BE) report and the Regional Director's biennial report were also prepared after an evaluation of the 2000–2001 Programme Budget by divisions and country offices.

31. To further enhance capacity in programme management, the Activity Management System (AMS) was installed in 15 country offices.[7] All staff in the Regional Office and the managerial staff in 15 country offices were trained in monitoring and reporting in AMS. The Regional Director has requested that AMS be installed in all country offices by the end of 2003.

[7]The following have received AMS: Benin, Botswana, Cameroon, Chad, Comoros, Democratic Republic of Congo, Ghana, Mali, Mauritius, Nigeria, Republic of Congo, Senegal, Uganda, Zambia, Zimbabwe.

32. For AMS to succeed, it is important to improve the inadequate information technology (IT) environment in some country offices. This can be accomplished through upgrading the IT infrastructure and recruiting IT staff to support the country team. The AMS team in the Regional Office also needs to be strengthened to accelerate AMS implementation in countries, and also to cope with the increasing need for technical support to country offices and divisions. For these reasons, the Regional Director has instructed that the unit in charge of planning, monitoring and evaluation (PPE) in the Regional Office be strengthened.

Research policy and coordination (RPC)

33. The WHO Regional Office for Africa is promoting the role of research in programme development and decision-making through coordinating research activities, strengthening the institutional capacity in Member States to articulate national health research policies and priorities, and facilitating the use of research in policy and programme development.

34. During the period under review, research activities in the divisions were coordinated by linking the regional strategic health research plan to research in disease control, reproductive health and health systems. Meetings of divisional research focal persons and a meeting of the Research Development Committee were held to coordinate research work in the Region. The Regional Office continued to develop partnerships with nine WHO collaborating centres in Algeria, Burkina Faso, South Africa, Tanzania and Zimbabwe. A meeting of the African Advisory Committee for Health Research and Development (AACHRD) was held as part of the efforts to strengthen its guidance role in the African Region.

Health information management and dissemination (IMD)

35. Reliable health information is essential for raising awareness, formulating effective policies and strategies, and building the necessary expertise to address health issues. Consequently, the Regional Office pursues the important goal of making valuable and relevant health information available and accessible to health policy planners, professionals and the general public. In this effort, Health Information Management and Dissemination is responsible for editing, translating, printing, disseminating and conserving all documentation produced in the Regional Office.

36. During the period under review, all documents for the fifty-second session of the Regional Committee were edited, translated, produced and sent to the Member States in the three working languages of the Region. Simultaneous interpretation was provided when required during meetings organized in the Region.

37. To further enhance the quality of technical documents, guidelines for preparing and submitting technical reports were developed. A job tracking system is being developed in collaboration with the Information and Communication Technology unit to improve document production processes and the quality of service given to the technical divisions.

38. The Regional Office Library was reopened and renovated, and library services in the countries were strengthened. Blue Trunk Library managers in Rwanda and Comoros were trained and support visits were made to the Republic of Congo and Mauritius. Although hardly any countries chose IMD as an area of work, there was an average of 11 health information management and dissemination projects in each country; these were included in various technical programmes.

39. Training manuals, handbooks, guidelines and modules were planned, being developed or already published; they can assist in programme implementation. These tools can fill the gap in health and biomedical information currently hampering health development in the Region.

Health systems and services development

40. Strengthening health systems to deliver quality health services, especially to the poor and disadvantaged, is one of the priorities of WHO in the African Region. Support is currently being provided to countries to develop and update their health policies and strategies aimed at improving access to essential health services, including access to essential drugs for treating priority diseases such as malaria, HIV/AIDS, tuberculosis and childhood illnesses. In addition, efforts are being made to support research projects that foster collaboration between traditional medicine and conventional medicine practitioners. Methodologies for documenting the ethno-medical evidence of some traditional medicines have been developed and are in use.

41. Most countries have developed policies on blood safety and have trained their staff. These actions have contributed to the reduction in deaths and infections from transfusion with unsafe blood. Inadequate health financing and human resources for health, including continual "brain drain", are other challenges that are being tackled. Consequently, to respond to such challenges, support was provided to countries to reform and strengthen their health systems with particular attention to strengthening district or local health systems and with a view to improving performance of health systems within the context of health for all in the twenty-first century. This work was carried out by three AOWs: Organization of Health Services (OSD), Essential Drugs and Medicines Policy (EDM) and Blood Safety and Clinical Technology (BCT).

Organization of health services (OSD)

42. The key priority for Organization of Health Services is to support Member States in their health systems development efforts. This should enhance stewardship, service provision, fair financing and sustainable resource generation in ways that meet the needs of populations, particularly the poor and disadvantaged.

43. Various documents, tools and guidelines on health systems development, including human resource development, were developed, and appropriate support was given to countries. Documentation included a framework on enhancing the stewardship role of government, an update on health financing and another document on strengthening the role of hospitals in national health systems in the Region. To improve the performance of national health systems, Botswana, Comoros, Cape Verde and Ethiopia were supported to review their national health

policies and strategic plans. Health policy-makers in Côte d'Ivoire participated in a leadership and contracting workshop.

44. Support was provided to countries to strengthen district health systems within their national health sector reform programmes. A draft guide for the development of district minimum health care packages was finalized. Eleven countries[8] assessed operations in their district health systems; the information generated will be used to develop interventions to build district management capacity. A three-year project to strengthen district health systems partially supported by the Norwegian Agency for International Development (NORAD) was initiated and implementation is progressing.

45. A number of initiatives were undertaken to enable countries to address brain drain problem and weak motivation of health workers. Studies on the migration of skilled health personnel for the period 1990–2000 were conducted in Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe. The studies showed that migration mainly affected medical doctors and various cadres in nursing and pharmacy. The most common reasons for out-migration concerned salaries, living conditions, experience and economic decline of home country. Health workers intending to emigrate ranged from 26% in Uganda to 68% in Zimbabwe. This is a cause for concern, and policy-makers need to address the issues facing health professionals. Quality of health care decreased significantly in all the six study countries as a consequence of migration.

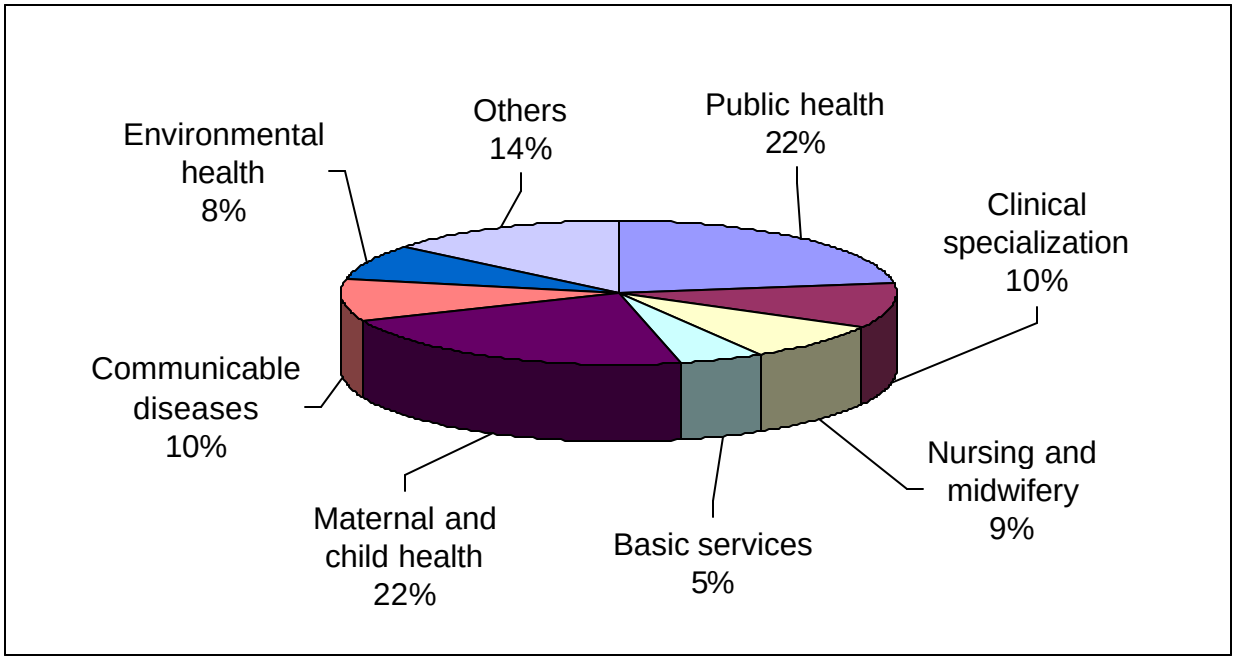
46. A brochure for advocacy on human resources for health (HRH) issues was developed. The Division of Health Systems and Services Development, in collaboration with the Regional Office for the Eastern Mediterranean (EMRO), produced a document for the African Union on the challenges and opportunities in the development of HRH in Africa. The capacity of the regional training institutions, such as Regional Public Health Training Institute (IRSP), Benin, and collaborating centres was strengthened as part of efforts to ensure availability of quality training in the African Region.

47. A review of the fellowships programme showed increased placement of fellows in African training institutions and that training is mainly in public health and related fields (see Figure 1) which is consistent with programme objectives. A total of 339 fellowships was awarded, and 33 HRH managers from 30 countries were trained in human resource management. Thirteen countries[9] were supported to develop and implement their HRH policies and plans. A new partnership with the International Organization for Migration deals with the brain drain of health workers from Africa, and a similar partnership with the African Union promises continuous advocacy on HRH issues.

[8] Benin, Botswana, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Republic of Congo, Sierra Leone, Swaziland, Tanzania, Zambia.

[9] Botswana, Cameroon, Chad, Côte d'Ivoire, Equatorial Guinea, Mali, Malawi, Mauritania, Namibia, Rwanda, Senegal, South Africa, Tanzania.

Figure 1: Fields of study for WHO fellows, 1990–2001 (n = 3,553)



Source: *Rapport d'évaluation du programme des bourses de l'OMS*, Brazzaville, November 2002

48. An evaluation of health systems research (HSR) was conducted to provide the basis for further support to countries. The results show that the major achievements were in development of training materials, capacity building and setting up focal points or units in countries. However, in many cases, research data have not been used, and countries in Central and West Africa still need support in capacity building. Eritrea has defined priorities for research; participants from five countries (Gambia, Eritrea, Guinea, Sao Tome and Principe, Zambia) were trained in proposal development, data analysis and report writing for HSR; support was provided for 12 research proposals from Gambia, Guinea, Sao Tome and Principe, and Zambia.

Essential drugs and medicines policy (EDM)

49. In Africa, 50% of the population, mostly the poor and disadvantaged, do not have access to existing essential medicines, and many more cannot access the new medicines for treating common diseases like malaria and HIV. Where essential medicines are available, their efficacy is doubtful due to poor quality, unethical promotion and irrational drug prescription and use. Recent global trade agreements also pose a threat to accessing essential medicines in the Region.

50. For effective support in implementation of national medicines policies, it was necessary to strengthen human resource capacity both at the Regional Office and in some countries. During the period under review, ten national programme officers were recruited to strengthen capacity in country offices; an EDM coordinator and two short-term professionals were recruited to strengthen capacity in the Regional Office. Guidelines for the formulation, implementation,

monitoring and evaluation of national medicines policies were published and disseminated to countries.

51. Support was provided to Botswana, Burkina Faso and Nigeria to review and update their national medicines policies and essential medicines lists. The state of pharmaceuticals was assessed in Chad, Ethiopia, Ghana, Nigeria, Tanzania and Uganda. A sensitization workshop on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was held for policy-makers from francophone countries to enable them to incorporate TRIPS safeguards in public health legislation on pharmaceuticals.

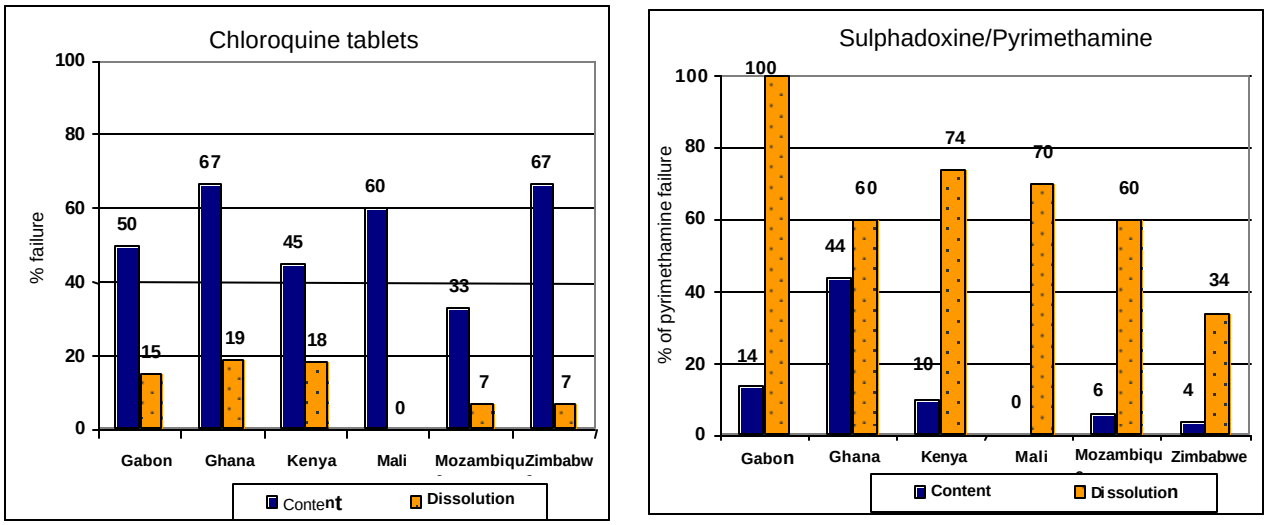
52. Equatorial Guinea and Mauritania were supported to establish central medical stores. A regional workshop on strengthening national medicines supply systems was organized and held for participants from anglophone countries.

53. To help countries improve quality of drugs, guidelines for the inspection of pharmaceutical products were field-tested, finalized and used in eight countries.[10] Pharmacy inspectors in Cameroon, Gambia, Lesotho and Nigeria were trained in inspection of pharmaceutical establishments such as pharmacies, factories and storage facilities. The WHO computer-assisted model for drug registration (SIAMED) was installed in Central African Republic.

54. A training manual on the management of drugs at health centre level was finalized and is now in use in countries. Participants from seven countries[11] were supported to attend a regional training course in rational medicines use. A pilot study on quality screening of chloroquine and sulphadoxine pyrimethamine was conducted in collaboration with Roll Back Malaria and HQ. Deficiencies in active ingredient and dissolution profiles of these medicines were revealed (see Figure 2). These deficiencies could explain the therapeutic failures of choroquine and sulphadoxine pyrimethamine which have been observed in most African countries. Samples were judged to have "failed" if content was <93% or >107%, and dissolution <80% in 45 minutes.

[10] Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Guinea, Mauritania, Togo.
[11] Algeria, Central African Republic, Chad, Guinea, Mali, Rwanda, Togo.

Figure 2: Quality of two antimalarials in six African countries



Source: Quality screening for antimalarial drugs in six African countries, Brazzaville, 2002. AFR/EDP/02.7

55. Similarly, to assure the quality, safety and efficacy of traditional medicines, generic protocols were developed and approved by the Regional Expert Committee on Quality screening for traditional antimalarial medicines. The protocols are necessary for documenting ethnomedical evidence and clinical evaluation of traditional medicines used for the management of HIV/AIDS, sickle-cell anaemia and diabetes.

56. General guidelines for documenting African traditional medicine were developed and made available to countries. Technical support was provided to 10 countries[12] for either evaluation of traditional medicines or development of their traditional medicine programmes. The inauguration of an African Traditional Medicine day for advocacy was approved; the first ATM day will be commemorated on 31 August 2003 with the theme "Traditional Medicine; Our Culture, Our Future".

Blood safety and clinical technology (BCT)

57. Working with countries to ensure access to and use of blood and blood products in a safe health care environment is one of the priorities of the WHO Regional Office for Africa. In 2002, the Regional Strategy for Blood Safety was disseminated to all Member States, and 12 countries[13] were supported to develop or implement national blood transfusion policies. The regional database for monitoring blood safety was updated for 35 countries.

[12]Burkina Faso, Ghana, Guinea, Kenya, Mali, Mauritania, Nigeria, Sao Tome and Principe, Tanzania, Uganda.
[13]Cameroon, Central African Republic, Comoros, Ethiopia, Gambia, Guinea-Bissau, Kenya, Mauritius, Niger, Seychelles, Swaziland, Zanzibar (Tanzania).

Screening for infections at National Blood Transfusion Centre, Abidjan, Côte d'Ivoire, 2002

Source: Blood Safety Unit, Division of Health Systems and Services Development, WHO/AFRO, Brazzaville, 2002

58. To improve the quality of blood transfusion services (BTS), nine countries[14] strengthened their blood donor recruitment programmes. Three quality management training courses were run at the national blood transfusion centres in Côte d'Ivoire and Zimbabwe, one of them a follow-up course for quality assurance managers trained in 2001. Ghana, Guinea and Mauritius formulated national guidelines on clinical use of blood. Eight countries[15] evaluated and strengthened their quality management programmes. Equipment and reagents for blood screening were procured to support BTS in 23 countries.

59. Support was provided to countries to set up quality assurance programmes in blood transfusion services as a follow-up to the training of 37 quality assurance managers. A workshop in quality management in clinical laboratories was held and resulted in the adoption of a minimum package of laboratory services. A health laboratory evaluation tool was developed and field-tested. Togo developed a national laboratory policy and a quality assurance programme for imaging services.

Prevention and control of communicable diseases

60. In the African Region, communicable diseases constitute the major burden of diseases and continue to impede social and economic development. Diseases such as malaria, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and tuberculosis (TB) disproportionately affect the poor and marginalized populations and have a devastating impact on human capital and the overburdened health systems.

[14]Benin, Burundi, Côte d'Ivoire, Ghana, Guinea, Mauritania, Mozambique, Niger, Rwanda.
[15]Algeria, Benin, Cameroon, Guinea, Kenya, Mauritania, Mozambique, Niger.

61. The Region is prone to epidemics from meningococcal meningitis, cholera, Ebola and yellow fever which disproportionately affect the poor and are associated with high morbidity and mortality rates. Similarly, vaccine-preventable diseases and other tropical diseases such as guinea worm, leprosy, onchocerciasis, lymphatic filariasis, schistosomiasis, trypanosomiasis, leishmaniasis, intestinal parasitosis and Buruli ulcer contribute to the high burden of diseases and poverty in Africa.

62. Even though Member States continue to respond to the challenge of communicable diseases, control efforts have been constrained by poor macroeconomic performance, widespread poverty, conflict, deteriorating infrastructure and migration of technical health staff. Despite advances in medical technology, adoption by national health systems has been slow. Meanwhile, tools, methods and strategies once considered sufficient for successful prevention and control of communicable diseases are failing because of drug resistance and implementation difficulties.

63. In support of country efforts, the Regional Office has developed several communicable disease control strategies. During the 2002–2003 biennium, the Regional Office maintained a focus on the poor while supporting countries to implement regional strategies. The priority objectives are to:

(a) scale up the integrated disease surveillance and response (IDSR) in Member countries and strengthen the Multi-Disease Surveillance Centre (MDSC) in Ouagadougou;

(b) scale up the HIV/AIDS health package within the framework of multi-agency interventions and increase TB case detection rates and number of successfully treated cases;

(c) increase technical interventions for malaria control;

(d) strengthen routine immunization and accelerate Polio Eradication Initiative;

(e) accelerate the eradication or elimination of targeted communicable diseases in the Region and scale up activities for the control of lymphatic filariasis.

64. The above agenda is to be implemented through the seven AOWs: Communicable Disease Surveillance (CSR), Communicable Disease Prevention, Eradication and Control (CPC); HIV/AIDS, Tuberculosis (TUB); Malaria (MAL); Immunization and Vaccine Development (IVD); and Research and Product Development for Communicable Diseases (CRD). Supervision is by the Director of Prevention and Control of Communicable Diseases (DDC). The objectives will be achieved through:

(a) developing new tools, guidelines and strategies to scale up implementation in countries;

(b) strengthening research and implementation capacities at regional, intercountry and country levels;

(c) sustaining existing strategic partnerships and building new ones;

(d) mobilizing technical and financial support to countries;

(e) surveillance, monitoring and evaluating of the implementation of communicable disease programmes.

Communicable diseases surveillance (CSR)

65. Within the framework of the "Regional Strategy for Integrated Disease Surveillance" (IDS), the Regional Office has been strengthening the capacities of countries to implement effective integrated disease surveillance systems. It has also supported national responses to epidemics, facilitating international assistance when needed. The Multi-Disease Surveillance Centre in Ouagadougou (MDSC) is being strengthened to monitor the antimicrobial susceptibility of the aetiological agents of priority communicable diseases, perform advance epidemiological analysis, including the testing of epidemic forecasting models, and support quality assurance programmes in national public health laboratories.

66. The Regional Office established a pool of anglophone and francophone consultants trained in IDSR to support country efforts. The third IDSR task force meeting was held to monitor implementation strategy, and documentation of implementation was carried out in four countries: Burkina Faso, Ethiopia, Mali and Uganda. The parasitology, bacteriology and molecular biology laboratories in the MDSC were assessed and improvement was started. The Regional Office has continued to support countries in implementing the "Regional Strategy for Integrated Disease Surveillance". Many countries adopted the technical guidelines and training material, and a number of them began training district health personnel (see Table 1).

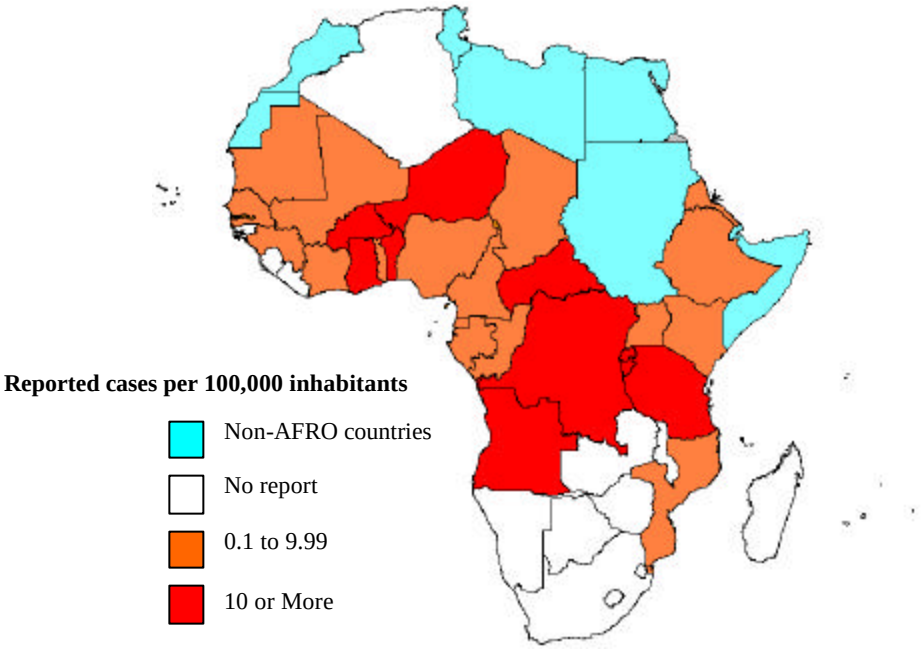
Table 1: Integrated Disease Surveillance and Response Implementation, 2002

Assessment	Benin, Burundi, Cape Verde, Central African Republic, Côte d'Ivoire, Niger, Sao Tome and Principe, Senegal.
Strategic plan prepared	Cameroon, Cape Verde, Central African Republic, Chad, Democratic Republic of Congo, Niger, Rwanda, Sao Tome and Principe.
Adopted technical guidelines	Burkina Faso, Cameroon, Chad, Democratic Republic of Congo, Equatorial Guinea, Gambia, Guinea, Kenya, Nigeria, Republic of Congo, Rwanda, Uganda.
Adopted training modules	Botswana, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Malawi, Mali, Namibia, Nigeria, Republic of Congo, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.
Launched training of district health personnel	Equatorial Guinea, Eritrea, Ethiopia, Kenya, Malawi, Mali, Zimbabwe.

67. To improve communication systems for timely and effective reporting at country level, 33 national public health reference laboratories were provided with laptop computers and e-mail facilities. Burkina Faso, Ghana, Guinea and Mali assessed and developed plans for strengthening national communication systems. With regard to epidemic control, *Neisseria meningitidis* W135 was identified as an emerging aetiological agent for meningococcal

meningitis epidemics in the African meningitis belt (Figure 3) through longitudinal surveillance put in place in Burkina Faso, Niger and Mali. The Regional Office played a key role in the timely detection and response to various epidemic-prone diseases such as: *N. meningitidis* W135, Ebola, yellow fever: Guinea (20 cases and 17 deaths), Central African Republic (one case), Côte d'Ivoire (156 cases and 23 deaths), Nigeria (20 cases and 11 deaths), Senegal (68 cases and 14 deaths).

Figure 3: Magnitude of meningitis in the African Region by country, 2002



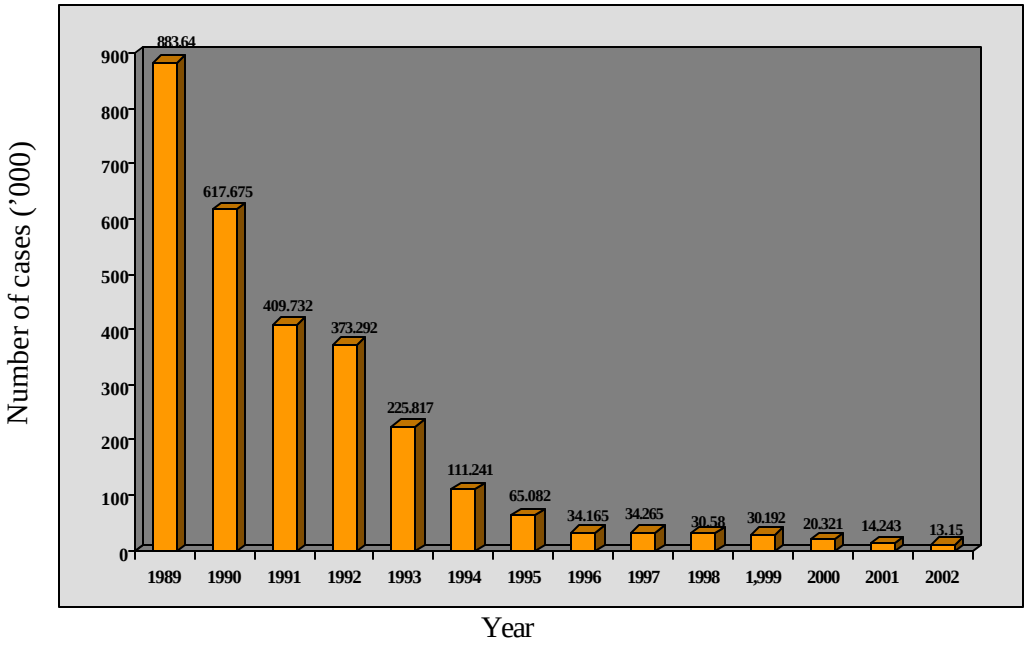
Source: Country reports, ministries of health

Communicable disease prevention, eradication and control (CPC)

68. The Regional Office has defined several targets for the prevention and control of communicable diseases. Guinea worm is to be eradicated; leprosy, onchocerciasis and lymphatic filariasis are to be eliminated; and schistosomiasis, trypanosomiasis, leishmaniasis, intestinal parasitosis and Buruli ulcer are to be controlled. Vector control, which is a crosscutting issue, will be emphasized in disease control programmes.

69. The programme to eradicate guinea worm from the African Region has reached a critical stage following the 98% reduction in incidence. The Regional Office supported eight endemic countries to intensify their guinea worm eradication activities and nine non-endemic countries to initiate the process for certification of guinea worm eradication. Wars in some of the affected communities and laxity in surveillance are constraining further reduction in the number of cases (see Figure 4).

Figure 4: Number of guinea worm cases notified by year in the African Region, 1989 to 2002



70. Leprosy control efforts progressed in 2002. Angola, Madagascar and Mozambique, with prevalence rates higher than two cases per 10 000, have developed strategic plans for intensifying leprosy elimination activities. All national programmes were restocked with a year's supply of drugs for multi-drug therapy. Guidelines for integrating leprosy control into general health services were developed and distributed to Member States.

71. With respect to other tropical diseases, 18 African experts were trained to serve as consultants to support national efforts to control schistosomiasis and soil-transmitted helminthiasis. Databases for lymphatic filariasis, schistosomiasis and trypanosomiasis were finalized and used to train national managers in programme management and monitoring. A regional database on malaria vector resistance to insecticides was created. Based on this, a regional map on resistance distribution was produced.

72. Some countries have scaled up programmes on the elimination of lymphatic filariasis[16] (about nine million people received mass treatment in nine countries in 2002). The Regional Office supported the control of trypanosomiasis in Guinea and control of schistosomiasis in Cameroon and Uganda. Seventeen experts were trained to support Member States in the development and implementation of integrated vector management. Countries were supported to increase the use of insecticide-treated materials, particularly insecticide-treated nets (ITNs), to contribute towards the control of malaria, lymphatic filariasis, leishmaniasis and

[16] Benin, Burkina Faso, Comoros, Ghana, Kenya, Tanzania, Togo, Zanzibar.

trypanosomiasis. As part of the process, 325 health staff and community health workers in six countries were trained in net treatment techniques. In selected districts of five countries, more than 500 000 nets were treated, and net treatment coverage was increased from 10% to 50%.

73. Continuous advocacy for the control of tropical diseases is required to sustain the commitment of Member States and build partnerships with development agencies. Field workers, including volunteers, need to be motivated and provided with technical and logistic support.

Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV)

74. The HIV/AIDS epidemic continues to spread relentlessly in the African Region. Currently, about 29 million (70%) of the global total of 42 million people infected with human immunodeficiency virus (HIV) are in the WHO African Region, and an estimated 3 million adults and children died of acquired immunodeficiency syndrome (AIDS) in 2002. While the overall adult HIV prevalence in the Region is about 9%, the epidemic has been characterized by marked sub-regional variations, with adult HIV prevalence less than 1% in some countries and over 30% in others. Southern Africa has the highest adult prevalence rates, over 20% in seven countries and more than 30% in Botswana, Lesotho, Swaziland and Zimbabwe. The interaction between poverty, malnutrition and HIV/AIDS was starkly illustrated in Southern Africa where 13 million people faced famine because HIV/AIDS undermined the capacity of households and communities to withstand drought.

75. HIV/AIDS interventions for prevention, life-saving treatment and support among Africans is still low. Only 50 000 of the 4.5 million people who need antiretroviral therapy have access to treatment despite significant reductions in cost. Access to voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services are only 6% and 1%, respectively.

76. The priority of the WHO Regional Office for Africa is to support Member States to scale up the implementation of health sector programmes that deliver effective public health interventions. For this purpose, agreements on actions to implement health sector plans were obtained after the "Regional Strategy on HIV/AIDS" was disseminated to eastern, southern, western and central African countries.

77. Building on the regional strategy and the need to clarify health sector response to HIV/AIDS, an essential package for health interventions against HIV/AIDS was proposed. Guidelines for developing various health system interventions against HIV/AIDS and sexually-transmitted infections (STIs) were developed. These included planning, care, provision of ARVs, nutritional care and support, voluntary counselling and testing (VCT), STI prevention and treatment in the context of commercial sex. Ten countries[17] involved in the WHO Italian initiative prepared a health sector package for district level. This has increased access to services for care, PMTCT, VCT and management of STIs. There is further potential to use larger resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank Multi-country AIDS Programme (MAP).

[17] Angola, Burkina Faso, Burundi, Cote d'Ivoire, Mozambique, Rwanda, Swaziland, Tanzania, Uganda, Zimbabwe.

78. Botswana, Cameroon, Mauritania, Swaziland and Tanzania have developed health sector plans. HIV/AIDS interventions were enhanced through establishing a functional network of laboratories for monitoring HIV resistance to ARVs; establishing an external quality assurance programme for HIV testing; expanding the pool of technical experts well oriented in WHO guidelines for HIV/AIDS surveillance, STI management and care of persons living with HIV/AIDS (PLWHA); and recruiting national programme officers (NPOs) in six country offices. Secretariat staff and consultants provided support to Member States through 55 technical missions to 18 countries.

79. The Regional Office and country offices supported Member States in their mobilization of financial resources through GFATM. The Regional Office participated actively in the Country Coordinating Mechanisms (CCMs) and provided technical support for the development of proposals and negotiation of funding agreements. As a result, 18 countries will have greatly increased funding for their programmes.

Tuberculosis (TUB)

80. Because of the HIV/AIDS epidemic, the tuberculosis situation in the African Region continues to grow, despite the efforts by WHO and partners to control the disease. In the year 2000, 40 (85%) of the 46 Member States were implementing the directly-observed treatment, short course (DOTS) strategy; 19 countries had nation-wide coverage of DOTS services, mainly in public health institutions. In spite of progressive increases in the Region, the average case detection rate is still very low at 44% compared to the target of 70%. Similarly, the average treatment success rate of 68% is far below the target of 85%. Frequent shortages of anti-TB drugs, inadequate human resource capacity and insufficient diagnostic and treatment facilities are some of the challenges which are frustrating control efforts.

81. The priority of the Regional Office is to assist Member States to accelerate the coverage of DOTS strategy in the population by taking advantage of the opportunities arising from the Stop TB partnership initiative, Global TB Drug Facility and Global Fund to Fight AIDS, Tuberculosis and Malaria. Specifically, the Regional Office is supporting Member States to build capacity in laboratory and treatment services, and in advocacy. These efforts should facilitate the effective implementation of innovative approaches involving communities and the private sector in DOTS expansion and in TB/HIV collaborative activities.

82. In the year under review, 18 countries[18] initiated and developed implementation of multi-year strategic plans for DOTS expansion. For TB/HIV collaborative activities, the Regional Office supported eight countries[19] with high TB/HIV burdens to develop operational plans for the phased implementation of collaborative activities; 10 countries[20] developed community TB care activities. To facilitate implementation, 13 countries[21] were supported to obtain drug grants

[18] Angola, Botswana, Burkina Faso, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Liberia, Mali, Mauritania, Nigeria, Republic of Congo, Senegal, Sierra Leone, South Africa, Togo, Uganda, Zambia.
[19] Ethiopia, Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia.
[20] Botswana, Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Senegal, Tanzania, Togo, Uganda, Zambia.
[21] Angola, Central African Republic, Democratic Republic of Congo, Gambia, Kenya, Liberia, Mauritania, Nigeria, Republic of Congo, Sierra Leone, Togo, Uganda, Zambia.

from the Global TB Drug Facility (GDF). A comprehensive report on TB surveillance in the region was prepared.

Immunization and vaccine development (IVD)

83. In spite of the availability of vaccines with proven efficacy, vaccine-preventable diseases still constitute major public health problems in the African Region. For example, measles-related deaths are still extremely high at 445 000 annually; pertussis causes 106 000 to 190 000 deaths annually; yellow fever is still endemic in 34 countries, causing about 30 000 deaths annually; and mortality from neonatal tetanus is about 5–10 per 1 000 live births. New vaccines such as Hep B and Hib have been included in only a few national programmes.

84. Despite these shortcomings, countries have made progress towards polio eradication and have reversed the declining trend in immunization coverage experienced after the Universal Child Immunization (UCI) initiative. Building on this positive trend, the Regional Office supports Member States to accelerate polio eradication, maternal and neonatal tetanus and measles elimination, and yellow fever control; implement quality and sustainable strategies for routine immunization; and introduce new vaccines and technologies in a sustainable manner.

85. The fifty-second session of the Regional Committee endorsed the "Regional Strategy for Immunization 2003–2005" as the framework for strengthening immunization support systems in Member countries. Several capacity-building initiatives were undertaken to strengthen immunization systems in countries. For example, 12 modules for training mid-level managers (MLMs) were finalized and used at three intercountry training sessions for participants from anglophone, francophone and lusophone countries. A total of 47 WHO/UNICEF focal points and 97 national focal persons, including EPI managers, were trained to form a pool of trainers of trainers for MLMs. Subsequently, Burundi, Chad, Côte d'Ivoire, Ethiopia, Ghana and Mauritania were supported to carry out national MLM courses. The Regional Office also supported countries to develop proposals for funding from the Global Alliance for Vaccines and Immunization (GAVI). Hence, 21 countries were awarded funds for new or underused vaccines, 21 countries were awarded funds for immunization system support, and 10 countries were awarded funds for injection safety. Monitoring of immunization was effectively implemented in West African Member States and introduced in others.

86. In 2002, polio eradication efforts progressed and the Region attained certification level surveillance for the first time. For the third consecutive year, 16 West African countries synchronized their national immunization days (NIDs). In central Africa, seven countries[22] held two or three synchronized NIDs. The repeated synchronization of NIDs accounts for the 50% reduction in the number of polio-endemic countries from six in 2001 to three in 2002.

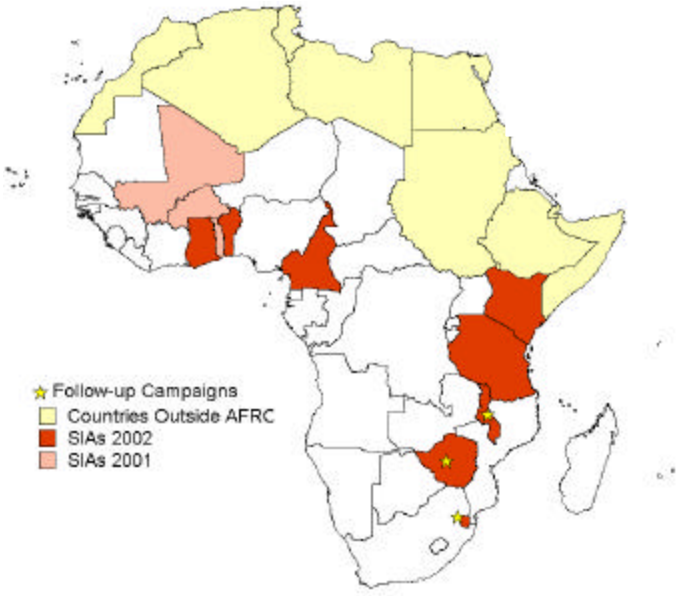
87. Participants from 42 of the 46 countries were trained and supported to establish national polio expert committees (NPECs) and national certification committees. The African Regional Certification Commission (ARCC) requested eight countries to prepare and submit interim or

[22] Chad, Cameroon, Central African Republic, Equatorial Guinea, Gabon, Republic of Congo, Sao Tome and Principe.

final reports by August 2003. Of the 16 polio network laboratories in the Region, 15 were fully accredited; one was partially accredited. Sequencing of wild poliovirus improved after including 90% (134) of all the 2002 viruses in the dendogram.

88. The WHO Regional Office for Africa also supported countries to implement strategies for the control of other vaccine-preventable diseases. Support was provided to nine countries (Figure 5) to implement supplementary immunization activities (SIA) for measles. Seven countries, 30% of the Region's population, established case-based measles surveillance systems. Laboratories in southern African countries were supported in measles surveillance, and laboratories in west Africa supported the surveillance of both measles and yellow fever.

Figure 5: Supplementary immunization activities for measles, 2001–2002



89. Neonatal tetanus surveillance was integrated into acute flaccid paralysis (AFP) surveillance so that 60% of Member countries are using the AFP system for surveillance of other diseases of public health importance. Nine countries[23] conducted SIAs for tetanus toxoid, targeting 6.5 million women of reproductive age. Maternal and neonatal tetanus activities were validated in Malawi and South Africa, and revalidated in Gambia.

Malaria (MAL)

90. In the African Region, malaria annually causes more than 270 million episodes of acute illness, over 900 000 deaths and significant loss in household earnings. The annual economic loss from malaria is estimated at US$ 12 billion. Malaria parasite resistance to commonly used antimalarials, such as chloroquine, and the low coverage of insecticide-treated nets (ITNs)

[23] Burkina Faso, Chad, Cameroon, Ethiopia, Ghana, Kenya, Niger, Uganda, Zambia.

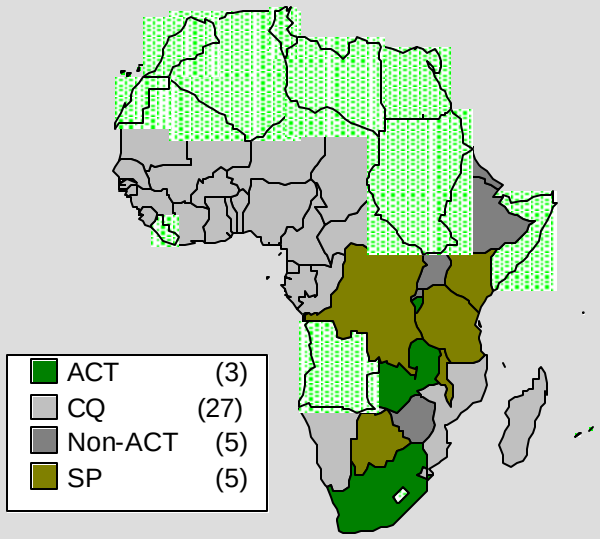
among the populations at risk present major challenges to malaria control in national health systems.

91. In the last two years, there has been increased commitment to the Roll Back Malaria initiative by heads of state and government as well as development partners. The priority of the Regional Office is to support countries to work in partnerships to improve coverage of RBM interventions. The capacity of Member States was strengthened for improved case management (some countries updated their treatment policy due to drug resistance) and increased use of ITNs for vulnerable groups. Member States were supported to adopt effective strategies for prevention and control of malaria in pregnancy; reduce mortality due to malaria among children under five years; conduct epidemic forecasting, early detection and early response; and initiate operations research and overall programme management, including building partnerships.

92. Antimalarial drug resistance has become a major threat to effective treatment of malaria cases. The Regional Office has been supporting countries to collect information on drug resistance to inform drug policy change; hence, 13 countries[24] have updated their antimalarial drug policies, and several others are in the process of collecting data (see Figure 6).

[24]Burundi, Botswana, Eritrea, Ethiopia, Democratic Republic of Congo, Kenya, Malawi, Rwanda, South Africa, Tanzania (Zanzibar), Uganda, Zambia, Zimbabwe.

Figure 6: National first-line treatment policies for uncomplicated malaria, December 2002



Non-ACT: CQ+SP or AQ+SP combination.
CQ: Chloroqine
SP: Sulphadoxine-pyrimethamine
ACT: Artemisinin (AS)+AQ, AS+SP, or coartem.
In Cameroon, recommendation is amodiaquine

Countries that changed recommendation from CQ to SP:

Malawi (1993)

Kenya (1998)

Botswana (1997)

Tanzania (2001)

Countries where change to ACT has been fully implemented:

Selected provinces in South Africa: Coartem in KwaZulu-Natal and artesunate + SP in Mpumalanga (2001)

Countries which adopted ACT but are yet to implement the policy fully:

Tanzania (Zanzibar) 2001

Zambia (2001)

Burundi (2002)

(Numbers in brackets indicate the year of policy adoption)

93. During 2002, key performance indicators for malaria control improved as a result of Regional Office support to countries. The training in case management, which occurred at district level in nine countries,[25] improved the proportion of properly managed children from 30% to 35%. The proportion of children under 5 years and pregnant women sleeping under ITNs improved from 5% to 10% in selected districts of some countries. The rate of re-treatment of

[25] Burkina Faso, Comoros, Ghana, Liberia, Mali, Senegal, Sierra Leone, Republic of Congo, Rwanda.

mosquito nets increased from 5% to 80% in the districts of the five countries where mass mosquito net treatment campaigns were organized.

94. Capacity was developed for monitoring the implementation of activities and evaluating RBM interventions. Baseline surveys were conducted in five more countries, bringing the total to 21. A composite database on RBM regional core indicators was established at regional level, and support was provided to countries to create their own databases. Compilation of malaria morbidity and mortality data among target groups from 25 countries for the period 1998 to 2001 was completed. National capacity in programme management was strengthened through two international courses organized for 32 participants from anglophone countries and 30 participants from francophone countries. The proportion of countries able to mobilize resources towards agreed RBM budgets increased from 0% to 16%.

Research and product development for communicable diseases (CRD)

95. Due to drug resistance and difficulties with implementation in the African Region, tools, methods and technologies once considered effective for the management of communicable diseases are failing rapidly. At the same time, the acceptance of new and effective drugs and vaccines by national health systems has been slow due to inadequate investments. To help address this situation, the Regional Office aims to work in partnership with organizations such as the Multilateral Initiative on Malaria in Africa (MIM) to strengthen national research and programme development capacity. Such partnerships will generate new knowledge for better use of existing tools and strategies for the prevention and control of communicable diseases; at the same time, they will facilitate the development and integration of new tools into national health systems.

96. The Regional Office RBM/TDR/MIM initiative on operations research in Africa was established and provided with an initial capital of US$ 700 000. An IMCI/MAL research group was also constituted to advise on a priority research agenda and review research proposals. A research institution was identified for collaboration in malaria research, and the designation process as WHO collaborating centre was initiated.

97. The Regional Office also supported a number of operations research activities. For example, 46 research projects were developed in 18 malaria-endemic countries; 21 of these projects are currently being implemented with funding from the Regional Office. A database was established for monitoring operations research in Africa. A generic plan for integrating communicable diseases at district level was developed and piloted in Benin, Ghana, Togo, Uganda and Zambia.

Prevention and control of noncommunicable diseases

98. Noncommunicable diseases (NCDs), mental disorders and substance abuse, including tobacco consumption, are becoming major public health challenges in the African Region. NCD surveillance and primary prevention are insufficiently emphasized in Member States, and treatment is not universally available or affordable. The lack of long-term commitment to NCD control in countries coupled with the progressive increase of NCDs, especially among poor and disadvantaged populations, is contributing to widening health gaps between and within countries. All of this is threatening development in the African Region.

99. The threat of noncommunicable diseases and the need to provide urgent and effective public health responses led to the formulation of global and regional strategies endorsed by the World Health Assembly and the Regional Committee. During the 2002–2003 biennium, the Regional Office is working with Member States and development partners to:

(a) map the emerging epidemics of NCDs, mental disorders and substance abuse and analyse their determinants;

(b) devise tools for improving intersectoral collaboration, community participation, policy formulation, disease management, and prevention and management of disabilities;

(c) promote good practices and evidence-based methods and strategies for promoting health and preventing and controlling noncommunicable diseases;

(d) develop or update national policies and plans of action;

(e) establish systems for the surveillance of noncommunicable diseases;

(f) build national capacities in programme development and implementation.

100. The above agenda is implemented through six areas of work: Integrated Approach to Surveillance, Prevention and Management of Noncommunicable Diseases (NCD), Mental Health (MNH), Tobacco (TOB), Health Promotion (HPR), Nutrition (NUT) and Disability and Injury Prevention and Rehabilitation (DPR). Supervision is by the Director, Prevention and Control of Noncommunicable Diseases (DNC) and the country offices.

Integrated approach to surveillance, prevention and management of noncommunicable diseases (NCD)

101. This area of work comprises three programmes: chronic diseases, oral health, ageing and health.

Chronic diseases

102. In line with the Regional Strategy for noncommunicable diseases adopted in 2000 and its implementation plan developed in 2001, priority was given to prevention and surveillance. In noncommunicable disease surveillance, the STEPwise approach, a tool developed by WHO, has

been adopted as the framework for NCD risk factor surveillance. The STEPwise approach to surveillance (STEPS) is characterized by:

(a) the establishment of standardized tools for achieving data comparability between periods and between countries;

(b) the use of STEPwise surveillance depending on available resources;

(c) preferential surveillance of main risk factors common to many NCDs.

103. The surveillance is modular and in three steps:

Step 1: Questionnaire-based measurements;

Step 2: Questionnaire-based and physical measurements;

Step 3: Questionnaire-based and physical measurements, and biochemical assessment.

104. Movement from one step to another or the decision to start at one level instead of another depends on the technical and human resources available to the country. For each step, there are three optional modules, depending on the available resources and the information required for each risk factor: core module, expanded core module, optional module. The basic standardized tools for the first two modules are available.

105. In March 2002, 21 participants from seven countries[26] were trained in the STEPS methodology and in other aspects of NCD surveillance. Situation analyses using different methodologies were carried out in Burkina Faso, Chad, Mauritania and Niger.

106. Two centres for screening, treatment and follow-up of cervical cancer were established in Luanda for lusophone countries and in Dar es Salaam for anglophone countries;[27] 33 professionals from seven countries[28] were trained at two workshops in Luanda and Dar es Salaam for early detection and management of cervical cancer. As part of Regional Office support for the development of cancer registers, financial assistance was provided to enable 17 experts[29] to attend a cancer register training course organized by the International Agency for Research on Cancer (IARC), Lyon, France.

107. Phase I of the project on palliative care for HIV/AIDS and cancer patients was implemented and involved a situation analysis and needs assessment in the following countries: Botswana, Ethiopia, South Africa, Tanzania, Uganda and Zimbabwe. Work began on the development of a database on noncommunicable diseases.

[26] Algeria, Côte d'Ivoire, Ghana, Mozambique, Nigeria, Senegal, Zimbabwe.
[27] A similar centre was established in Guinea in 2000 for francophone countries.
[28] Angola, Cape Verde, Guinea-Bissau, Mozambique, Sao Tome and Principe, Tanzania, Uganda.
[29] From Burkina Faso, Côte d'Ivoire, Gabon, Gambia, Guinea, Kenya, Malawi, Mali, Mauritius, Niger, Nigeria, Republic of Congo, South Africa, Swaziland, Tanzania, Uganda, Zimbabwe.

108. The African Region made a substantial contribution to the preparation of the Global Strategy on Diet, Physical Activity and Health as a major step towards the adoption of comprehensive, cohesive, affordable and effective measures to reduce the rising incidence of noncommunicable diseases, using interventions aimed at reducing known risk factors.

Oral health

109. The adoption in 1998 of a regional strategy for oral health for the next ten years was a milestone in implementing the new policy approach to oral health. The Regional Office continued to support countries to implement the strategy. Two more countries, Lesotho and Kenya, received support for epidemiological analysis of oral diseases and for the formulation and development of national oral health plans.

110. As part of regional capacity building in oral health, the Regional Office provided sustained technical support to strengthen the Intercountry Oral Health Centre (ICOH) in Jos, Nigeria. A regional consultation was held on the appropriateness of oral health training and research to the specific needs of the African Region. The meeting which brought together 22 deans of dental faculties and six directors of auxiliary dental schools described the new approach to oral health.

111. Democratic Republic of Congo, Niger, Nigeria and Uganda received support for strengthening their national noma control programmes. The development of teaching materials for noma prevention, screening and treatment methods continued in 2002.

Ageing and health

112. Ethiopia, Tanzania and Zambia received technical and financial assistance to start interventions targeting elderly persons affected by or infected with HIV/AIDS and to produce training materials.

Nutrition (NUT)

113. The numerous activities were carried out under the nutrition programme in coordination with HQ and related regional programmes such as Integrated Management of Childhood Illness and HIV/AIDS.

114. Countries continued to receive support for the adoption of national food and nutrition policies and for the implementation of national plans of action. In 2002, support included an intercountry workshop which brought together seven Member States;[30] technical assistance to Togo for the adoption of its national plan; and financial assistance to Chad, Democratic Republic of Congo and Lesotho for the control of protein-energy malnutrition. The Profiles[31] methodology was used in Cameroon and Zimbabwe as an advocacy tool for acquiring funds for nutrition programmes.

[30] Eritrea, Ethiopia, Kenya, Liberia, Seychelles, Sierra Leone, Zimbabwe.

[31] Profiles (or country nutrition profiles) is a description of nutrition problems followed by a vivid account of the benefits that countries derive from implementing appropriate interventions.

115. Two intercountry workshops were held. One on micronutrient deficiencies, brought together participants from 20 countries[32] and was organized in collaboration with partners of nutrition programmes. The other, on infant and young child feeding, was held for 11 countries[33] to train evaluators of the Baby-Friendly Hospitals Initiative.

116. Specific support was given for the collection of baseline nutrition data on micronutrient deficiencies (Eritrea and Guinea-Bissau) and knowledge, attitudes and practices concerning breastfeeding (Burkina Faso). Besides, numerous nutrition-related training activities were supported at national level. Nutrition was also a component of WHO support to countries in southern Africa which are facing food crises.

Health promotion (HPR)

117. The main activities carried out in the period under review concerned the training of national focal points in the planning and implementation of health promotion activities. Training documents were thus prepared and used at two workshops, one in Cotonou for eight francophone countries[34] and the other in Harare for 11 anglophone countries.[35] The training provided participants with the knowledge and skills needed for the formulation of health promotion policies and programmes.

118. The "Regional Strategy for Health Promotion" and various related guides were disseminated to countries. Technical and financial support was given to Botswana, Mozambique, Nigeria, South Africa and Tanzania to review their health promotion policies and programmes. The duties assigned to health information and promotion officers in country offices were revised to increase their involvement in health promotion activities.

119. A meeting on the role of partnerships in health promotion development was organized jointly with the International Union for Health Promotion and Education. In addition, the Regional Office coordinated the celebration of World Health Day in countries. Technical and promotional documents were disseminated in print form and posted on the internet. In school health, technical and financial support was provided for starting activities under the LIFE project in six countries (Côte d'Ivoire, Ghana, Guinea, Senegal, Rwanda and Swaziland). Nine countries[36] were given support to evaluate the Healthy Schools project.

[32] Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Guinea, Mali, Mauritania, Niger, Rwanda, Sao Tome and Principe, Senegal, Togo.

[33] Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Gabon, Guinea, Mali, Niger, Senegal, Togo.

[34] Algeria, Benin, Cape Verde, Central African Republic, Democratic Republic of Congo, Côte d'Ivoire, Rwanda, Senegal.

[35] Botswana, Eritrea, Gambia, Ghana, Kenya, Lesotho, Mozambique, Nigeria, South Africa, Zambia, Zimbabwe.

[36] Burkina Faso, Côte d'Ivoire, Guinea, Malawi, Mali, Rwanda, Senegal, Zambia, Zimbabwe.

Disability and injury prevention and rehabilitation (DPR)

120. Following the international launch of the *World Report on Violence and Health* in Brussels, Belgium on 3 October 2002, several Member States in the African Region requested similar national launchs of the report in 2003. The report was widely disseminated.

121. Ethiopia and Mozambique were identified for support in the establishment of violence and injury surveillance systems. Ethiopia successfully implemented the project; Mozambique submitted a proposal, and funds are being released.

122. A workshop on improving rehabilitation services was conducted for eight francophone countries.[37] Kenya submitted a proposal and funds have been released. Financial support was provided to Angola, Comoros, Democratic Republic of Congo, Ghana, Gambia and Tanzania to undertake deafness and blindness situation analyses. Three institutions dealing with injury prevention and rehabilitation were assessed in 2002, and their applications for status of WHO collaborating centre were considered.

Mental health and substance abuse (MNH)

123. Good mental health is a positive resource that allows individuals to realize their abilities to work productively, cope with the stresses of daily life and make a valuable contribution to the community. The portion of the global burden of diseases attributable to mental and neurological disorders and substance abuse is expected to rise from 11.5% in 1998 to 15% in 2020.

124. Regional Office responses to country needs were guided by the integration of mental health and prevention and control of substance abuse issues in national health sector reforms, particularly with regard to policy development, organization of services, financing and human rights legislation. These principles are stated in the "Regional Strategy for Mental Health 2000–2010" (resolution AFR/RC49/R3) adopted by ministers of health in 1999.

Mental Health Policy Questions

1. **Does the policy promote the development of** *community-based* **care?**
2. **Are services comprehensive and integrated into** *primary health* **care?**
3. **Does the policy encourage** *partnerships* **between individuals, families and health professionals?**
4. **Does the policy promote the** *empowerment* **of individuals, families and communities?**
5. **Does the policy create a system that respects, protects and fulfils the** *human rights* **of people with mental disorders?**
6. **Is there an adequate supply of** *appropriately trained* **service providers to ensure that the policy can be implemented?**
7. **Is adequate attention paid to strategies for** *prevention* **and** *promotion***?**
8. **Does the policy foster** *intersectoral* **links between mental health and other sectors?**

Source: WHO World Health Report 2001—Mental Health: New Understanding, New Hope. World Health Organization, Geneva, 2002, p.80.

125. The theme for World Health Day 2001 was "Mental Health: Stop Exclusion, Dare to Care". Similarly, the *World Health Report 2001* was entitled *Mental Health: New Understanding, New Hope*.

[37] Benin, Burkina Faso, Burundi, Gabon, Republic of Congo, Rwanda, Senegal, Togo.

These emphases along with World Health Assembly ministerial round tables have influenced most countries of the Region to choose mental health and substance abuse as priority domains for technical cooperation with WHO.

126. The implementation of the Global Campaign Against Epilepsy was extended to 17 francophone countries which participated in an intercountry meeting in Lomé in March 2002.[38] Technical support was provided to selected countries (Botswana, Central African Republic, Lesotho, Mauritius, Rwanda) for revision of their mental health and substance abuse policies and plans. Participants from twelve countries attended a training workshop on drug use epidemiology, and participants from 15 countries in the Region[39] attended the first training forum on policy-making and service development held in Tunis, 27–29 November 2002. The Department of Psychiatry of the University of Zimbabwe was supported in suicide prevention activities.

127. The availability of resources facilitated the success of the implementation of the activities planned for this period. Better interaction with HQ and the country offices as well as improved collaboration with various partners such as the WHO collaborating centre on research and training, International League Against Epilepsy and International Bureau for Epilepsy contributed greatly to the successful implementation of activities. Delays in submission of quality project proposals from the targeted countries remain a major constraining factor.

Tobacco (TOB)

128. Globally, tobacco use causes 4.9 million deaths, with 70% of these deaths occurring in developing countries. In most Member States, there is limited awareness of the extent, depth and severity of the problem in their countries, and many countries are under intense pressure to increase tobacco production and consumption due to globalization and economic issues. A major goal of tobacco control is to improve the health of all by eliminating or reducing tobacco use and exposure.

129. Key strategies in the tobacco AOW are strengthening community action for tobacco control, reducing availability and supply, reducing tobacco promotion, enacting legislation and issuing regulations, reducing exposure to environmental tobacco smoke and promoting cessation of tobacco use.

130. With the increased awareness of mortality due to tobacco use and exposure, Member States have responded with growing concern. Almost all of the countries in the African Region participated in the intergovernmental negotiation sessions for the Framework Convention for Tobacco Control. The Region has been a strong leader in the development of a realistic and relevant document. African regional consensus meetings were held in Côte d'Ivoire and Malawi. Community participation was enhanced in the Channelling the Outrage project in which NGOs in Malawi, Mauritania, Mozambique, Nigeria, Togo and Zambia were funded to conduct programmes at country level.

[38] Algeria, Benin, Burundi, Burkina Faso, Cape Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Guinea, Mali, Mauritania, Niger, Rwanda, Senegal, Togo.

[39] Angola, Botswana, Cape Verde, Ghana, Ethiopia, Lesotho, Malawi, Mauritania, Mozambique, Rwanda, South Africa, Tanzania, Togo, Uganda, Zambia.

131. The increase in demand by countries for technical assistance for the development of comprehensive tobacco control policies and legislation also indicates that Member States want tobacco control. Requests were received from Benin, Botswana, Lesotho, Swaziland and Uganda.

132. Twelve countries[40] were trained in the conduct of the Global Youth Tobacco Survey, and 16 countries[41] received training in analysis and report writing for the survey. The pilot project of the United Nations fund for Protecting Youth Against Tobacco is making progress in Kenya and Senegal. Most countries continue to participate in World No Tobacco Day, with Malawi participating for the first time through a major activity. A successful workshop for major media practitioners and health promoters was held in Benin. The objective was to address tobacco control issues in francophone Africa by sensitizing the media, health promoters and the general public.

133. The First Ministerial Conference on Drug Control in Africa was held in Yamoussoukro, Côte d'Ivoire. It was a significant meeting in which members of the African Union developed and endorsed a plan of action which included alcohol control.

134. In recognition of the negative effects of psychoactive substances on the population, Botswana requested and obtained support to develop a substance abuse strategy. To build technical capacity on substance abuse epidemiology, 13 countries[42] sent participants to a training of trainers workshop on the epidemiology of drug use in Zimbabwe.

Family and reproductive health

135. Family and reproductive health (RH) problems in the African Region are of public health concern in spite of the availability of cost-effective interventions and several global and regional resolutions and strategies aimed at supporting actions in Member States. A meeting of programme managers and the establishment of a regional RH task force during 2002 enhanced the promotion of RH for families, individual adults, adolescents and children. They have also helped to further integrate the activities of the four areas of work (AOW): Child and Adolescent Health (CAH); Research and Programme Development in Reproductive Health (RHR, including training and Prevention of Mother-to-Child Transmission [PMTC] of HIV), Making Pregnancy Safer (MPS) and Women's Health and Development (WMH, including Social Aspects of Family and Reproductive Health).

136. In the period under review, all of the AOWs received very low budgetary allocations. This constituted a severe constraint to the implementation of planned activities. However, the Division was able to fulfil its mission despite limited human resources, moving offices from Harare to Brazzaville and a difficult security situation at the duty station.

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[40] Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea, Mauritius, Rwanda, Seychelles, Tanzania, Togo, Zimbabwe.

[41] Botswana, Burkina Faso, Chad, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritania, Nigeria, Niger, Senegal, South Africa, Swaziland, Uganda, Zambia.

[42] Botswana, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Liberia, Namibia, Seychelles, Sierra Leone, Uganda, Zimbabwe, Zambia.

Child and adolescent health (CAH)

137. The Child and Adolescent Health area of work addressed high perinatal and newborn mortality and morbidity, the negative consequences of child abuse and neglect, and reducing the vulnerability of adolescents to morbidity associated with early sexual activity and other risky behaviour. Intensive technical and financial support focused on the countries that experience 80% of the childhood mortality in the Region. Support included regional, national and district level capacity-building and pre-service training.

138. Based on the results of the assessment of care and management of newborns conducted in seven countries in 2001,[43] interventions were developed to reduce perinatal and newborn mortality and morbidity. Burundi, Namibia, Nigeria and Swaziland implemented activities to improve newborn health through needs assessment, training, and procuring equipment and supplies. Advocacy for newborn health and its integration into maternal and child health programmes was strengthened.

139. A brochure, "Africa's newborns: The forgotten children," was developed in collaboration with the Academy of Education and Development and produced in three languages. It focuses on common causes of newborn deaths and the capacity of health facilities to provide quality care for mothers and their newborns.

Are Africa's newborns forgotten?

Source: WHO/AFRO

140. The Integrated Management of Childhood Illness (IMCI) component of CAH aims at reducing under-5 morbidity and mortality through improving health systems, health worker skills and key family practices. Analyses in 12 countries[44] revealed that 60% of IMCI-trained health workers were correctly treating pneumonia, diarrhoea and fever. Furthermore, health facility survey results in Tanzania showed that following counselling by IMCI-trained health workers, care takers had improved their knowledge of care for children during illness. Fifteen IMCI national programme officers were recruited to strengthen country offices, and 48 senior health workers were trained in IMCI case management using the newly developed 6-day course.

[43] Burundi, Ethiopia, Mauritania, Namibia, Nigeria, Swaziland, Uganda.
[44] Botswana, Ethiopia, Ghana, Kenya, Malawi, Mali, Niger, Nigeria, South Africa, Tanzania, Uganda, Zambia.

141. In order to promote optimal infant feeding practices, four countries (Botswana, Ethiopia, Ghana and Zimbabwe) developed plans for implementation of the Global Strategy for Infant and Young Child Feeding. Seven countries were assisted to review policy and legislation on infant feeding in the context of HIV/AIDS. Seventeen consultants were trained in HIV counselling for breastfeeding and infant feeding; 44 consultants were trained in planning the family and community components of IMCI. A study was conducted in 24 health schools on pre-service IMCI, and the results were used for planning in 10 countries.[45] Eight countries[46] started planning for IMCI pre-service training. One intercountry pre-service orientation meeting was conducted for francophone countries. Quality of care at the referral level was addressed in 11 countries[47] through introduction of an assessment tool and manual.

142. In adolescent health policy, programme development and research, 21 countries[48] were assisted. Botswana, Cameroon, Lesotho, Madagascar and Namibia were supported to provide adolescent-friendly health services, including the creation of a supportive environment within the family, school and community. Situation analyses on adolescent health policies and programmes were conducted in nine countries[49] jointly with the Commonwealth Regional Health Community Secretariat.

143. Together with relevant technical units from the Regional Office and HQ, 20 participants from nine countries[50] were trained using the WHO kit, *Working with Street Children: A training package on substance use, sexual and reproductive health, including HIV/AIDS and STDs.* Capacity building on the application of the Convention on the Rights of the Child in CAH programmes was achieved in Cameroon involving 28 participants from NGOs and the public sector. In addition, technical units in the Division of Family and Reproductive Health, Division of Prevention and Control of Communicable Diseases and the Division of Prevention and Control of Noncommunicable Diseases provided support to nine countries[51] to develop and implement integrated project proposals on sexual and reproductive health, HIV/AIDS/STIs and substance abuse.

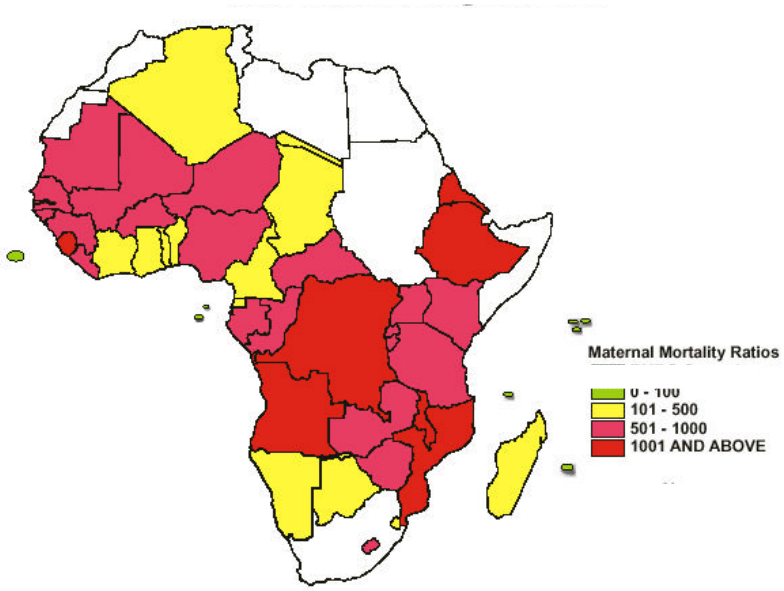
144. Tools developed for advocacy and strengthening adolescent health in countries include the "Framework for Implementation of the Regional Adolescent Health Strategy" and the *Adolescent Health and Development Briefing Kit*. The framework was meant to accelerate the transition of strategy into interventions at national and sub-national levels.

[45] Ethiopia, Ghana, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.
[46] Kenya, Ghana, Mozambique, Malawi, Niger, Madagascar, Zambia, Zimbabwe.
[47] Botswana, Eritrea, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe.
[48] Angola, Benin, Botswana, Burkina Faso, Cameroon, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Senegal, Sierra Leone, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe.
[49] Benin, Burkina Faso, Eritrea, Lesotho, Malawi, Senegal, Uganda, Zambia, Zimbabwe.
[50] Angola, Ethiopia, Ghana, Kenya, Lesotho, Sierra Leone, Uganda, Zambia, Zimbabwe.
[51] Botswana, Ethiopia, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia, Zimbabwe.

Research and programme development in reproductive health (RHR)

145. As part of efforts to accelerate the implementation of the regional reproductive health strategy, a framework was developed to guide countries to determine priorities, define effective and affordable interventions, and implement appropriate programmes. A joint plan of action (POA) 2002–2003 with HQ facilitated missions, funding and implementation. Reproductive health programme managers in government institutions and focal points in country offices from 44 Member States met in Johannesburg in June 2002, to review, update and harmonize programme activities at both regional and national levels. In addition, they shared best practices and experiences in reproductive health.

Figure 7: Maternal mortality ratios in Africa, 2001



Source: Country ministries of health

146. In 2002, the Regional Reproductive Health Task Force of experts and partners was established. At its first meeting in October, thematic and programmatic areas were discussed as the basis for improving reproductive health services in the Region.

147. At 940 per 100 000 live births,[52] the maternal mortality ratio (MMR) in Africa is the highest in the world. Based on data received from countries, MMR mapping was carried out (Figure 7), and posters were created in the three working languages for distribution to policy-makers, managers, researchers, partners and country offices for sensitization, advocacy and monitoring of trends. A regional reproductive health database was developed for monitoring trends in reproductive health indicators.

[52] WHO/UNICEF/UNFPA. Maternal mortality in 1995. WHO/RHR/01.9. Geneva, World Health Organization, 2001.

148. In spite of high single antenatal clinic attendance (more than 80% in the Region), delivery with skilled attendants stands at 42%. Researchers from Cameroon, Ghana, Kenya, Mozambique, Nigeria and Senegal are receiving technical and financial support for operations research aimed at increasing the percentage of women delivering with skilled attendants in health facilities. Angola, Ethiopia, Nigeria and Senegal were supported to document the pattern and outcome of home deliveries and how they link with the health system. The study results will assist the Regional Office to make recommendations regarding home deliveries in the Region.

149. Technical and financial support was provided to institutions and national and sub-regional medical associations for promoting reproductive health research and interventions. Three research institutions — Institute of Primate Research in Kenya; Korle-bu Teaching Hospital, Medical School in Ghana and *Centre de Recherche pour la Population et le Développement* (Centre for Population and Development Research) in Mali — were assessed for re-designation or pre-designation as WHO collaborating centres.

150. Networks of institutions involved in RH research were established in Cameroon and Nigeria. Technical and financial support was provided to Sao Tome and Principe, South Africa, Swaziland and Togo to conduct RH needs assessments. A training package, *Evidence-Based Decision-Making in Reproductive Health Care*, was developed and used to train 11 regional trainers. In Benin, doctors were trained in operations research.

151. Kenya, Malawi, Tanzania, Uganda and Zambia were supported to integrate activities for the prevention and control of malaria in pregnancy into RH programmes. Botswana, Uganda and Zambia were supported for similar integration of STI services into RH services, including the development of training guidelines on syndromic management. Seven countries[53] were supported to implement screening programmes for cervical cancer by visual inspection using acetic acid.

152. After 18 months of implementation, the Psychosocial Support Project for women and families living with HIV/AIDS in Zimbabwe was evaluated. The evaluation results confirmed the usefulness of the project. One recommendation was to extend the project for another year; a second recommendation was to incorporate a research component for the development of a model. Four clinical guides for the management of pregnant women with HIV infection were produced. They covered voluntary counselling and testing, antenatal care, labour and delivery care, and post-pregnancy care. In order to expand the activities in Prevention of Mother-to-Child Transmission, an expert was recruited at regional level.

Making pregnancy safer (MPS)

153. In the African Region, the average lifetime risk of maternal death is estimated at 1 in 14. Making Pregnancy Safer (MPS) is the WHO initiative for reducing maternal mortality through strengthening health sector capacities to implement cost-effective interventions and control the risk associated with pregnancy. More than 75% of the 600 000 annual deaths from pregnancy and childbirth-related causes can be prevented through timely access to essential obstetric care (EOC).

[53] Ethiopia, Lesotho, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe.

154. So far, in the biennium 2002–2003, 34 of the 46 Member States have implemented Making Pregnancy Safer. These countries received continued support to strengthen their health systems with equipment, including blood banks and blood supplies, training of health personnel in Life Saving Skills, and development of tools and protocols. Uganda was supported to upgrade a national pharmaceutical plant for the production of intravenous fluids.

155. Malaria accounts for 15% of the cases of severe anaemia in pregnant women. Ten countries[54] were supported to establish anglophone and francophone networks for the Integration of Prevention and Control of Malaria in Pregnancy. The antenatal services were strengthened and health personnel trained in the administration of intermittent preventive treatment (IPT) for pregnant women.

156. In Uganda, the Making Pregnancy Safer mid-term review in Soroti District revealed a decline in case fatality rate from 16% to 8%. There was increased community awareness, utilization of antenatal clinic facilities for care and delivery, contraceptive prevalence rates and intermittent preventive treatment of malaria.

157. The MPS area of work encouraged the use of appropriate technology in providing transportation for an effective referral system. Ghana and Malawi were supported to develop community ambulance systems for transporting pregnant women to health facilities during emergencies. The role of the community in an effective referral system to ensure continuous care was recognized. In Uganda, a community committee was created to manage and ensure proper use of the ambulance.

Appropriate technology ambulance

Source: WHO/Ghana

158. In Nigeria, Making Pregnancy Safer worked with the community to define the minimum package of care at each level; this resulted in the mapping of essential obstetric care services in the Yagba West Local Government Area. To improve financial access to maternal health care, Mauritania put in place an insurance scheme based on cost sharing. Following the consolidation of MPS in Nouakchott Region, it was extended to Gorgol Region.

159. Technical and financial assistance was provided to Uganda, Swaziland and South Africa for maternal death audits. To institutionalize maternal death audits and strengthen national capacity, the WHO generic guidelines for investigating maternal mortality, *Beyond the numbers*, were presented at the Regional Reproductive Health Task Force meeting and to various professional associations.[55]

[54] Benin, Burkina Faso, Cote d'Ivoire, Malawi, Mali, Senegal, Tanzania, Uganda, Zambia, Zimbabwe.

[55] Ethiopian Association of Surgeons; Association of Obstetricians and Gynaecologists from the East, Central and Southern African sub-Regions; Société Africaine des Gynécologues et Obstétriciens; Society of Obstetricians.

160. Professional associations were also supported to introduce the Integrated Management of Pregnancy and Childbirth (IMPAC) tools into pre-service institutions. The African Addendum to the *Management of Pregnancy and Childbirth* manual was finalized and printed. Guidelines for the promotion and implementation of community-based interventions were finalized and submitted for printing. Health workers and community members in 10 countries[56] were trained in Life Saving Skills for improved essential obstetric care. The revision of protocols, partogrammes and training modules and dissemination of reference documents and tools were undertaken in Guinea, Nigeria, Sierra Leone and Uganda. A national campaign for skilled attendants at childbirth was carried out in Côte d'Ivoire.

161. In collaboration with the USAID/SARA Project, advocacy tools based on the REDUCE model, including national advocacy plans for reducing maternal mortality, were developed for Mauritania and the African Region. The REDUCE model was presented at the first reproductive health task force and donors' meeting in Nairobi and at the First Ladies' meeting in Cameroon; it has since been distributed to all country offices for advocating for maternal health.

Women's health and development (WMH)

162. Countries were supported to incorporate Women's Health and Development (WMH) perspectives into national policies and programmes, and adopt a multisectoral and multidisciplinary approach to the promotion and protection of women's health. Emphasis was also given to programmes that address the needs of the most vulnerable, marginalized and disadvantaged women, and to the reduction of all forms of violence against women.

163. National Women's Health and Development profiles were compiled in 18 countries.[57] These highlighted differences between women and men in terms of seeking health care, accessing quality health services and purchasing health services. Kenya and Nigeria developed national policies and guidelines on WMH. Lesotho and Namibia developed programmes for mainstreaming gender issues into health. Preparation of the national WMH profile for Sao Tome and Principe began. Ethiopia assessed the reproductive rights of women and men and collected data on common illnesses affecting poor women.

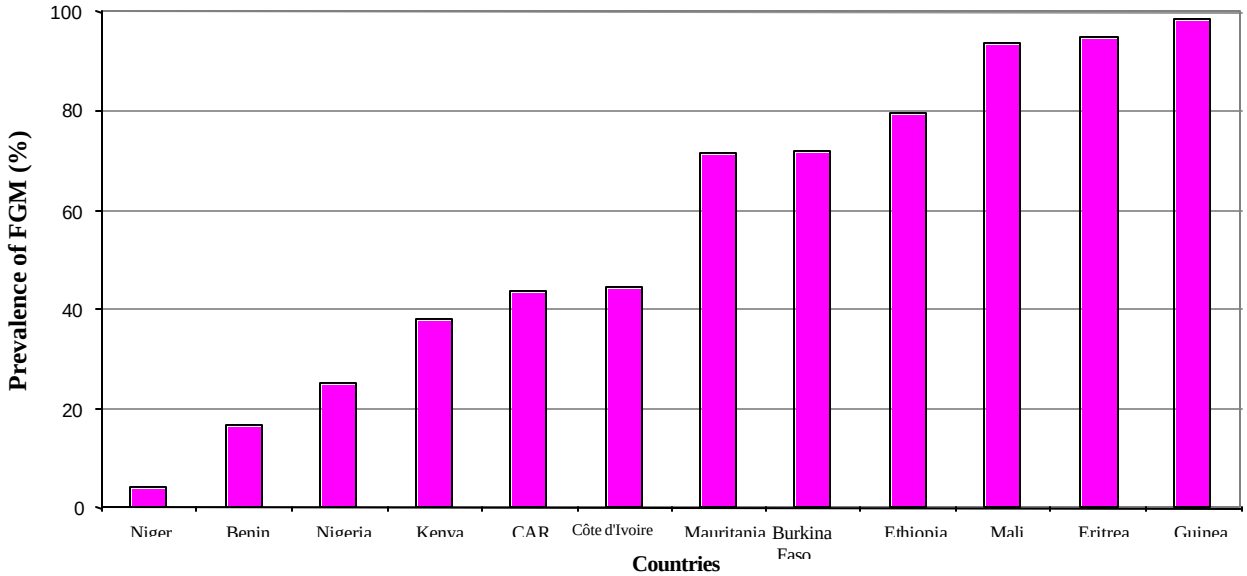
164. The "Regional Strategy for Women's Health and Development" was written and peer reviewed at the national and regional levels. A conceptual framework on gender, health and development was presented at the twenty-ninth Regional Programme Meeting; it emphasized the need for integrating gender analysis and results into WHO programmes. The WHO gender policy was disseminated to countries following which the regional focal persons in gender and WMH met with personnel at HQ to discuss goals, objectives and communication strategies for gender mainstreaming. In Nigeria, key stakeholders and policy-makers were sensitized on WMH issues; International Women's Day was observed in Guinea.

[56] Comoros, Ethiopia, Ghana, Guinea, Liberia, Malawi, Mauritania, Nigeria, Sierra Leone, Uganda.
[57] Algeria, Burkina Faso, Cape Verde, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Lesotho, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Seychelles, South Africa, Tanzania, Zimbabwe.

165. To establish evidence on gender-based violence, Algeria and Guinea carried out surveys on violence against women; Benin conducted a survey on the status of young domestic female employees; and Mozambique implemented activities for the prevention of violence against women. In collaboration with the Emergency and Humanitarian Action Unit in the Division of Healthy Environments and Sustainable Development (EHA/DES), Guinea was supported for the prevention and management of sexual and gender-based violence in camps for refugees and internally displaced persons in Kissidougou sub-region. Technical assistance was provided to the Republic of Congo and Zambia for reporting on the WMH component of the Committee on the Elimination of Discrimination Against Women. South Africa implemented programmes for counselling and caring for abused women and improving men's participation in reproductive health issues.

166. Prevalence of female genital mutilation (FGM) varies from country to country, ranging from less than 10% in Niger to more than 98% in Guinea (Figure 8). The Regional Office continued to provide technical assistance to seven countries[58] which are conducting research on FGM and other forms of harmful traditional practices. Alternative rites of passage without female excision were promoted in Kenya and Guinea-Bissau. Advocacy, social mobilization and involvement of community leaders, policy-makers and parliamentarians were used as critical strategies for FGM elimination in Burkina Faso, Chad and Senegal.

Figure 8: Prevalence of female genital mutilation in selected African countries



Source: Compiled from country demographic health surveys

[58] Burkina Faso, Chad, Ghana, Kenya, Mali, Nigeria, Tanzania.

167. The WHO female genital mutilation training materials for nursing and midwifery curricula were translated into French for distribution in 2003. Nigeria developed an action plan for the dissemination and use of the training manual. Burkina Faso, Ghana, Kenya and Tanzania reviewed existing curricula at nursing, midwifery and medical schools with the aim of integrating FGM prevention and care into pre-service institutions. Information-education-communication (IEC) materials on female genital mutilation were distributed to countries.

168. Ten countries[59] were supported to establish a multidisciplinary collaborating group (MCG) on female genital mutilation to collect data, document findings and promote best practices for FGM elimination. A regional database on FGM for the collection, collation and analysis of country data was established, and data from the MCGs will be analysed periodically.

169. In June 2002, 30 members of multidisciplinary collaborating groups on female genital mutilation together with representatives from the World Bank, USAID, Population Council and HQ met in Mali to conduct a nine-month review of activities in countries; they also proposed effective interventions for FGM elimination in the African Region. Progress was assessed in terms of policy development, interventions and community involvement. Various effective interventions were identified: village empowerment, alternative rites of passage and government commitment to promote legislation and policies that protect the rights of women and children.

Healthy environments and sustainable development

170. The extent and depth of poverty as well as threatening environmental conditions represent major threats to health development in the African Region. Over 450 million poor Africans lack access to safe water, 490 million are without adequate sanitation and one out of every five children dies from a communicable disease linked to environmental conditions. Poverty is also the main cause of food insecurity and consumption of unsafe food. Together, these factors contribute to the complex natural and human-made emergencies occurring on a large scale in the Region.

171. The links between poverty, environment, food and health, on the one hand, and between health and human development, on the other hand, require that Member States, international organizations and development agencies broaden the prevailing medical paradigm in health systems development to one that addresses the determinants of health. The WHO Regional Office for Africa is responding to this challenge by expanding its work in health and sustainable development. The aim is to provide Member States with high level policy and technical support for promoting a health dimension to social, economic, environment and development policies and actions. The key areas of emphasis are:

(a) strengthening the analysis and linkages between poverty and ill-health so as to ensure that the poverty issues are addressed in national and regional health development efforts;

[59] Burkina Faso, Cameroon, Chad, Democratic Republic of Congo, Ghana, Kenya, Mali, Niger, Nigeria, Tanzania.

(b) promoting a long-term strategic and sustainable approach to health development;

(c) incorporating effective environmental health dimensions in the management of the human environment and in the development of other national policies and actions;

(d) addressing the high morbidity and mortality attributed to inadequate food safety and food hygiene;

(e) strengthening national capacity for emergency preparedness and response, and providing technical and financial support in crisis situations.

172. The above agenda is being implemented through four AOWs: Sustainable Development (HSD), Health and Environment (PHE), Food Safety (FOS) and Emergency Preparedness and Response (EHA). These are under the supervision of the Director, Healthy Environments and Sustainable Development (DES).

Sustainable development (HSD)

173. Good health, especially for the poor, is a precious asset that contributes to poverty reduction in a sustainable way. Poverty is a determinant and a consequence of ill-health in the African Region. Tackling poverty through health is therefore necessary for achieving sustainable development. For these reasons, the Regional Office aims to support Member States to make health central to sustainable development through promoting a strategic, systematic and integrated approach to tackling poverty and other determinants of health. Specifically, the Regional Office aims at strengthening capacity in countries to confront the long-term challenges facing the health sector, incorporating a poverty dimension in health policy and programmes, and relating health dimensions to overall national and regional development strategies.

174. During the fifty-second session of the Regional Committee, the poverty reduction and health strategy was endorsed. The annual meeting of the African Advisory Committee on Poverty and Health was also held. The Regional Office contributed to the module for training in poverty and health at the workshop on evidence and information for policy held in Greece. Support was also given to countries to implement community-based poverty and health programmes. The Republic of Congo was supported to start a project on community development.

175. A meeting was held with the Economic and Monetary Union of West Africa to review the scope, terms of reference and modalities for financing a long-term health planning study for member countries. To build capacity in the Region, a training module in long-term health development (LHD) was created, and participants from francophone countries were trained. Four national workshops were held to raise awareness on the LHD approach. LHD technical support was provided to various countries.

Health and environment (PHE)

176. The African Region faces several environmental threats: climate changes, rapid demographic growth, urbanization, large and sudden population movements. In addition, toxic and hazardous chemicals from outdated industrial processes and municipal and agricultural wastes pollute the scarce water resources. As a result, natural disasters, vector-borne diseases and communicable diseases such as cholera, diarrhoea and respiratory infections, which are linked to poor environmental conditions, are very prevalent in the Region.

177. To improve these conditions, the WHO Regional Office for Africa aims to work with development partners and Member States to reduce the adverse effects of the environment on health by promoting sustainable management of the environment. The priority areas include generating information through environmental risk assessment and hazard mapping, improving water and sanitation, emphasizing occupational health and promoting a healthy "setting" approach as a tool for intersectoral action.

178. The fifty-second session of the Regional Committee adopted the Regional Strategy on Health and Environment; hence, guidelines for environmental risk assessment and guidelines for formulating policies on health and environment were developed. A meeting was held for health and environment focal points in country offices and ministries of health, and a training module on environmental risk assessment was started. Consequently, Swaziland developed an environmental health policy, Tanzania developed guidelines for environment and health, Equatorial Guinea developed public health norms and Mauritania passed legislation on clean water.

179. The capacity of countries to implement environmental health programmes was strengthened through raising awareness and training workshops. Key personnel involved in environmental health activities were trained in Burundi, Côte d'Ivoire, Gambia, Kenya, Republic of Congo, South Africa and Uganda. An orientation workshop on Participatory Hygiene and Sanitation Transformation (PHAST) was organized for public health personnel in the Republic of Congo and Malawi. A workshop on healthy prisons was organized in Ethiopia.

180. Healthy cities projects were initiated or continued in many countries. The healthy market-places initiative, which is a key component of the healthy city project in Dar es Salaam, Tanzania, was evaluated. Cape Verde and Cameroon developed plans of action on healthy cities. Kenya received support to address solid waste management in urban areas within the context of the healthy settings approach. Côte d'Ivoire implemented two community-based initiatives, and Benin received support to build incinerators and treat well water. In collaboration with the WHO Collaborating Centre for Urban Health, a short course on urbanization and health in developing countries was held in Cape Town, South Africa.

181. To promote occupational health, the Regional Office initiated discussions with the International Labour Organization (ILO) on the possibility of establishing a WHO/ILO Joint Effort in Occupational Health. The Regional Office also initiated a process that will enable the universities of Cape Town and Benin to serve as WHO collaborating centres for occupational health. A survey of occupational health in the region was conducted. Botswana developed a

strategic plan in occupational health, and environmental health officers in Nigeria received training in occupational health.

Emergency preparedness and response (EHA)

182. Resolutions AFR/RC47/R1 and WHA48.2 requested WHO to intensify cooperation with countries on emergency and humanitarian action. Within this framework, the Regional Office is currently playing the leadership role in coordinating health sector preparedness for and response to emergencies. Specifically, the Regional Office supports Member States to prepare for emergencies and, where necessary, reduce the health effects of disasters.

183. Due to the increasing number of catastrophes in the Region, activities during 2002 focused on supporting national responses to emergencies. The Regional Office coordinated the humanitarian response to emergencies in the Democratic Republic of Congo and also provided drugs and vaccines. Support was provided to Guinea for the prevention and management of sexual abuse and violence in Kissidougou. A total of 136 emergency kits costing US$ 811 652 were sent to countries. Vaccines, drugs and medical supplies were provided to Eritrea, Madagascar, Togo and Uganda. The Republic of Congo was supported to conduct a rapid health assessment; the country was also supplied with essential vaccines and materials for the control of meningitis.

184. To address the humanitarian crisis in West Africa, technical support in rapid assessment and contingency planning was provided to Burkina Faso and Mali. Guinea was supported to manage internally displaced persons (IDPs) and other vulnerable groups. Key personnel were recruited to strengthen the Regional Interagency Coordination Support Office (RIACSO) dealing with the humanitarian crisis in southern African countries.

185. Some countries were supported to improve their emergency preparedness. Cameroon, Guinea, Malawi and Swaziland developed national emergency response plans. Mozambique, Nigeria and Zimbabwe developed guidelines for management of emergencies. Key stakeholders in Cape Verde, Mozambique and Zimbabwe were sensitized on emergency response, and district level staff in Mozambique were trained in emergency preparedness and response. The EHA intranet page was revised to make relevant information on emergencies available to other programmes.

Food hygiene is important in market-places

Source: WHO/AFRO

Food safety (FOS)

186. Though data on food safety is lacking in countries in the African Region and surveillance systems are weak, the frequent outbreaks of acute food poisoning and the high incidence and prevalence of diarrhoeal diseases among newborns and young children give indications of poor food hygiene in Member States. The WHO Regional Office for Africa, therefore, aims to assist countries to incorporate food safety in health programmes through strengthening capacity in food surveillance and supporting the development of relevant legislation, standards and projects for promoting food hygiene and safety.

Safe food handling is critical for reducing food-borne illness

Source: WHO/AFRO

187. During the period under review, the Regional Office conducted a survey on food safety which analysed the health risks associated with food handling. To raise awareness about food safety, a workshop was held in Bamako, and the Regional Office website was revised to include information on food safety.

188. As a result of these efforts, Member States have started responding positively to the need to improve food safety. Botswana conducted workshops in six communities to raise awareness on food safety; Kenya was supported to develop tools for food surveillance; and food inspectors and other relevant officers were trained in Algeria, Botswana and Kenya in order to build national capacity for improving food safety. Chad and Nigeria conducted situation analyses in order to develop national programmes on food safety.

Administration and finance

189. The successful implementation of the WHO Corporate Strategy through programmes and technical cooperation with Member countries requires improving, and in some cases, re-organizing business processes and systems to make them more supportive of the expected results defined in the Programme Budget and workplans. To that end, the Regional Office has been steadily:

(a) streamlining and improving the processes for managing financial, human and other resources in the Region;

(b) implementing a programme to devolve certain administrative and financial functions to country offices and divisions;

(c) strengthening administrative capacity through recruiting or training administrative officers and other critical support staff to enable the divisions and country offices to perform their duties;

(d) providing guidance and relevant support to divisions and country offices as they realize their functions.

190. The return to Brazzaville of all divisions except one (Division of Communicable Diseases) resulted in the need to establish and strengthen administrative support services in both Brazzaville and Harare. This support includes financial and human resources services, logistics management, and information and communications infrastructure, all of which are critical for successful implementation of the Programme Budget.

191. The above agenda is being implemented through the three AOWs, Human Resources (HRS), Financial Management (FNS) and Informatics and Infrastructure Services (IIS), supervised by the Director of Administration and Finance (DAF).

Human resources (HRS)

192. Promoting the well-being of staff and ensuring adequate quantities and optimum mix of qualified, motivated and committed fixed- and short-term staff as well as technical and administrative staff are essential for effective implementation of the Programme Budget and workplans. In this regard, the policies and procedures for establishing posts, recruiting staff, issuing contracts, appraising performance, and administering benefits and entitlements need to be fair and equitable. The implementation of policies should address geographic and gender imbalances among staff without compromising the quality of human resources.

193. With the increased staff necessary to implement the Programme Budget and the increased devolution of human resource management functions from headquarters to the Regional Office, the volume of work in HRS has escalated. For these reasons, the Personnel Unit in the Regional Office was strengthened to perform management services more efficiently. The unit was also equipped with a new filing sub-unit and counterpart in Harare to provide personnel management services in the subregional office.

194. To improve general personnel management, a new procedure was instituted for testing temporary general service staff, collaboration with technical divisions was strengthened, and administrative officers and administrative assistants were trained in personnel management at a workshop held in November. In addition, briefings on the new performance appraisal system (Performance Management and Development System, PMDS) were conducted at the Regional Office and in some country offices. A strategy on staff development and training for the whole Region was initiated.

Financial management (FNS)

195. The WHO Regional Office for Africa aims to promote efficient and transparent financial management services which support programme management, promote accountability and ensure dispersal of funds in accordance with corporate procedures and regulations. To that end, the capacity of the Financial Management Services area of work, which is responsible for implementation, is being strengthened, and systems in the Region are being enhanced.

196. Concurrently, the process of decentralization of financial management functions to divisions and country offices, which started in the 1998–1999 biennium when country offices were authorized to issue obligations, was extended. In 2002, divisions were authorized to prepare obligation documents and issue stickers. To sustain the quality of decentralized financial management services, AOs in divisions and country offices were trained in financial management.

197. For successful implementation of workplans, allotments were issued at the beginning of the biennium and when the Regional Office mobilized extra resources during the year. Financial management services, including processing of obligations, claims and benefits, were provided to divisions and country offices; also, financial reports on budget implementation were prepared and shared with divisions and country offices. The budget tables were prepared for the 2004–2005 Programme Budget in agreement with the Regional Office priorities and the orientations from the Director-General and the Regional Director.

Informatics and infrastructure services (IIS)

198. The Regional Office and country offices require adequate office accommodation, procurement services, travel arrangements, logistics and communications technology to implement the Programme Budget and workplans. During the period under review, one of the major priorities was to make both the Harare and Brazzaville offices functional.

199. Beginning late 2001, over two hundred personnel and 300 tonnes of office equipment and personal effects were successfully transferred from Harare to Brazzaville. At the same time, major steps were made towards improving the Regional Office premises in Brazzaville (Djoue). In 2002, residential accommodation was provided in Djoue for international staff; security and cleaning companies were contracted to maintain the premises; feasibility studies into improving electricity and water supply were conducted after which two boreholes were sunk to minimize the frequent water shortages; and electricity generators were procured and installed to minimize power cuts. To improve security, work began on the construction of a peripheral fence for the Djoue compound. Fire detectors and an alarm system were installed in Djoue. The offices at the Highlands location in Harare were also expanded.

200. Information and communication infrastructure in both Harare and Brazzaville was improved. The computer and communication network was enhanced and made secure in both Harare and Brazzaville; the Regional Office intranet was completed; and an accounting software package for managing imprests was developed and made available to country offices. The

Activity Management System (AMS) and Regional Office Administration and Finance Information System (RO/AFI) were made fully functional, and the country office connectivity project was begun.

201. In addition to meeting the requirements resulting from the return of the Regional Office to Brazzaville, efforts continued towards providing timely and relevant logistical support. These included the procurement of goods and services at the best possible prices, the maximization of cost-effective travel, and the organization of the fifty-second session of the Regional Committee in Harare.

FACTORS IN PROGRAMME BUDGET IMPLEMENTATION FOR 2002

202. The mid-term review of the Programme Budget 2002–2003 was conducted. This review highlighted the major facilitating and constraining factors at the regional and country levels.

Enabling factors

203. The first year of Programme Budget implementation was facilitated by global political will and government commitment to health problems. Several international initiatives provided opportunity for funding the main priorities in the Region through fruitful cooperation with external partners. Increased global commitment to health sector reforms and human resource development issues and strengthened partnerships with other agencies were instrumental in the progress made.

204. Close collaboration among various stakeholders and WHO at national and global levels was a major factor that facilitated programme implementation. In addition, the commitment and enthusiasm of national health staff contributed a great deal. Consultations and negotiation between the Regional Office, governments and partners was well-integrated in the process of implementation of the Programme Budget in the Region. This boosted the commitment of all partners.

205. The inter-organizational facilitating factors included excellent collaboration between HQ, the Regional Office and country offices; commitment from staff; positive stewardship from Regional Office management; strong team spirit and networking among WHO staff. Also, improvement of human resources and changes in the Regional Office organizational structure contributed to achievements in the first year. Empowerment of staff at all levels facilitated the implementation of activities.

Constraining factors

206. Security problems, complex emergencies and natural disasters in the African Region contributed to increase the number of unimplemented activities. The move of the Regional Office from Harare to Brazzaville also disrupted implementation of programmes. The mid-term review identified the operation of the Regional Office from two different locations (Brazzaville and Harare) as a major challenge.

207. Despite the close collaboration with Member States, their frequent delayed responses were identified as constraining factors in the implementation of activities.

208. In the Regional Office, major constraints were limitations in human and financial resources. Many AOWs still lacked adequate human and financial resources. There was a heavy dependence on other sources of funds and skills, and time needed to mobilize funds was a major constraint. In the ministries of health, the shortage of qualified staff and the brain drain of professionals were constraining factors.

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

Regional programme for tuberculosis

209. Regional Committee resolution AFR/RC44/R6 on the Regional Programme for Tuberculosis adopted in September 1994 calls upon Member States to show maximum political commitment by setting up national control programmes with central units and providing budgetary allocations to implement the WHO control strategy. Member States should also strengthen management capacity and capability within national programmes, particularly at district level, using the training modules and strengthen health education activities through various approaches, including community participation, particularly in respect of the social stigma attached to tuberculosis. The resolution also calls upon international, governmental, nongovernmental and private voluntary organizations to further provide financial and technical support for tuberculosis control activities in the African Region.

210. By the end of December 2000, 40 of the 46 Member States had established national tuberculosis (TB) control programmes with central units. Thirty-five of these countries had updated their medium-term strategic plans based on the directly-observed treatment, short-course (DOTS) strategy. Twenty of the countries had attained nationwide coverage with DOTS services (mainly in the public health system). Budgetary allocations for TB from the national health budget had been made available in all the countries for staff, maintenance of infrastructure and purchase of anti-tuberculosis drugs and consumables. More than 50% of the countries still rely heavily on external funding to support some tuberculosis control activities such as training.

211. By the end of 2000, management capacity and capability within national TB control programmes had been built both at national and district levels through training workshops at intercountry and country levels. National TB programme managers from 46 countries had been trained in programme development, implementation, monitoring and evaluation. At least two health staff at district level in all 46 countries had been trained in the principles of organizing and managing TB control services at district level. Several country training workshops for district health staff had also been held in at least 35 countries.

212. Various health education and social mobilization activities have been undertaken over the years. Since 1995, the annual commemoration of the World Tuberculosis Day on 24 March has been carried out by all countries, as well as at the Regional Office. This has contributed significantly to raising awareness about TB and the DOTS strategy among communities at country and regional levels and in the international community. The Regional Office also developed some health education materials on tuberculosis and the DOTS strategy in the form of posters and brochures that were widely distributed in all countries. Four years ago, a specific initiative to mobilize communities to participate in the delivery of DOTS services was initiated by the Regional Office in collaboration with partners. This initiative, known as Community TB Care, has already been successfully implemented in four countries and, by the end of 2002, 10 countries had started implementing their plans for expansion of the approach.

213. With the intensification of advocacy at international, regional and country levels, which began in mid-1997 and culminated in the launch of the Stop TB Partnership Initiative by the Director-General in November 1998, the partnership base for support to tuberculosis control activities in the Region broadened significantly. By the end of 2002, at least 24 of the 34 high burden tuberculosis countries in the Region had at least one financial partner supporting governments in tuberculosis control activities. Sixteen of these countries have established a Stop TB Partnership coordinating body at country level made up of financial and technical partners to provide support to DOTS expansion. This trend is expected to grow in the coming years.

214. In 2000, the Global TB Drug Facility (GDF) was created by the Global Stop TB Partnership to address the problem of frequent anti-tuberculosis drug shortages and facilitate the rapid expansion of DOTS. The GDF aims at attainment of the tuberculosis control targets adopted by the World Health Assembly in 1993. Since its launch, 18 countries in the African Region have been awarded anti-tuberculosis drug grants to facilitate the expansion of DOTS.

215. The recently launched Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has also added more financial resources for DOTS expansion to countries in the Region. During the first two rounds of applications to the Fund, 13 countries in the Region were awarded funds for tuberculosis; this was accomplished with technical support from the Regional Office. Four countries with joint TB/HIV proposals were also awarded funds. Thus, a total of over US$ 65 million was granted to countries in the Region for tuberculosis control activities.

Regional strategy for emergency and humanitarian action

216. The implementation of the regional strategy for emergency and humanitarian action, adopted in 1997, continued during the 2002–2003 biennial period through strengthening the capacity of the countries in emergency preparedness, response and resource mobilization. Resolution AFR/RC47/R1, which adopted the strategy, requests the Regional Director to provide necessary support to Member States in their efforts to develop capacity to manage emergencies and to cooperate with Member countries on issues related to emergency and humanitarian action.

217. In emergency preparedness, efforts were focused on providing training in vulnerability assessment by setting up a group of consultants to give technical support to countries of the Region. Vulnerability assessment is the first step in the development of programmes on emergency preparedness and response, and humanitarian action at country level.

218. To strengthen capacity in planning, a technical guide was prepared and discussed with EHA focal points of all countries of the Region with a view to enriching it and adopting its methodological principles.

219. Mastering the processes of vulnerability assessment and planning for the management of emergencies has provided Member States with two essential tools. These activities require multisectoral and multidisciplinary approaches at country level and partnership among agencies of the United Nations and other institutions operating in this area of emergency and humanitarian action.

220. Through collaboration between WHO and the International Committee of the Red Cross/Red Crescent (ICRC), a workshop on emergency response (HELP) was organized at the Regional Public Health Training Institute (IRSP) in Ouidah, Benin. This effort is continuing and being diversified in order that the African Region will have a critical mass of human resources well trained in emergency preparedness and response.

221. Towards improving technical support and ensuring close collaboration between Member States in emergency situations, EHA coordinators have been assigned to Harare for southern Africa, Abidjan for west Africa, Nairobi and Brazzaville for central Africa and the Great Lakes region, and Addis Ababa for the Horn of Africa. This decentralization should foster close-to-client actions, reduce delays in interventions and enhance quality. In addition, stocks of emergency kits have been kept in readiness in Brazzaville, Dakar and Harare.

222. The Regional Office organized intercountry meetings to prepare strategies and responses for the humanitarian crises afflicting parts of southern Africa and west Africa. Concrete plans of action were drawn up and served as a basis for implementing resource mobilization strategies as part of the Consolidated Appeal process. Increased involvement of countries in the management of Consolidated Appeals made it possible to mobilize substantial resources, especially for southern Africa. The Regional Office supported a meeting of countries of the Manu River Union, bringing together Sierra Leone, Guinea and Liberia, in order to develop joint transborder interventions.

223. All countries facing emergencies received technical and financial support. This effort should continue through adequate financial resource allocation to ensure that if disaster strikes the Regional Office will be immediately present, providing prompt response until such time that interventions are organized jointly with international partners and appeals for funds are launched.

224. Emergency preparedness and response units are being established on a wide scale within the ministries of health in all countries of the Region.

Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases

225. The regional strategy for integrated epidemiological surveillance of diseases was adopted in September 1998 through resolution AFR/RC48/R2. The resolution requests the Regional Director to provide technical support to Member States to enable them to implement the present strategy and put in place technical epidemiological teams to provide countries with the support they need to implement epidemic preparedness and rapid response within the framework of subregional cooperation protocols and corresponding plans of action. The resolution also requests Member States to mobilize resources from the regular budget and other sources to support the implementation of the strategy at country, epidemiological bloc and regional levels.

226. Financial and technical support was provided to 36 Member States to assess their surveillance systems. Of these, 32 prepared their national strategic plans, and 35 developed national technical guidelines for integrated disease surveillance and response (IDSR). To ensure better coordination of IDSR implementation in countries, multidisciplinary IDSR coordination committees were established in the 36 countries; 20 of these committees are fully functional.

227. Financial and technical support was also provided to all Member States for strengthening their communicable disease surveillance systems. Resources from different WHO supported programmes were pooled to provide the epidemiological surveillance units of Member States with data processing equipment (computers) and communication facilities (fax and e-mail). To enhance the analysis and use of surveillance data, data managers from all Member States were trained in data management software and mapping.

228. Support was provided to 20 Member States to develop national training modules for district health personnel; 11 countries initiated the training of district health personnel in integrated disease surveillance.

229. All Member States were supported in strengthening the diagnosis of priority diseases by building the capacity of laboratory personnel through training in standard operating procedures (SOP), and provision of critical reagents and supplies. To enhance regional and subregional laboratory networking, laptop computers with e-mail connections were provided to the national public health laboratories. A network of reference laboratories has been put in place for the diagnosis of haemorrhagic fevers.

230. Member States were also given financial and technical support to prepare for detection and response to all priority diseases, particularly epidemic-prone diseases. Countries now have access to critical stocks of drugs and supplies at regional and subregional levels. As a result, there has been a significant improvement in the surveillance system of priority diseases in some countries. For example, there was timely detection, confirmation of and response to meningitis epidemics in the meningitis belt; yellow fever in Côte d'Ivoire, Guinea, Liberia and Senegal; and Ebola in Gabon and Uganda. There is weekly reporting of epidemic-prone diseases to track down epidemics.

231. Intercountry teams are in place in all the five epidemiological blocs (West Africa, Central Africa, Great Lakes, Southern Africa and Horn of Africa). These teams consist of epidemiologists, laboratory experts and data managers and are fully functional in supporting the implementation of IDSR within the framework of the subregional cooperation protocol. In addition, networks of consultants have been put in place to provide technical support when needed.

232. A Multi-Disease Surveillance Centre was established in Ouagadougou, Burkina Faso. The centre was strengthened to monitor antimicrobial susceptibility of aetiological agents of priority communicable diseases, perform advance epidemiological analysis, including the testing of epidemic forecasting models, and support quality assurance in national public health laboratories.

233. Resources from other sources were raised through sustained advocacy to support regional, intercountry and national implementation of IDSR. Key partners, such as the United States Agency for International Development (USAID), the Rockefeller Foundation and the Bill and Melinda Gates Foundation, provided financial support for IDSR implementation. Member States were requested to mobilize existing surveillance resources for IDSR implementation.

234. At the regional level, the surveillance of communicable diseases was reorganized to streamline surveillance resources from different units of the Division of Prevention and Control of Communicable Diseases. The IDSR task force put in place by the Regional Director meets annually to review the implementation of IDSR activities and make recommendations for improvement. Representatives of Member States, technical partners and donors form this task force.

Regional strategy for mental health

235. The "Regional Strategy for Mental Health 2000–2010" (resolution AFR/RC49/R3) was adopted in 1999. In this resolution, the Regional Committee requests the Regional Director to provide technical support to Member States for the development of national policies and programmes on mental health and the prevention and control of substance abuse. Specifically, the resolution requests the development or revision of mental health legislation; appropriate measures to enhance WHO capacity to provide timely and effective technical support, at regional and country levels, to national programmes on mental health and substance abuse; increased support for the training of health professionals in mental health; and the promotion of traditional medicine within the context of African realities. The resolution further requests the Regional Director to facilitate mobilization of additional resources for the implementation of the mental health strategy in Member States and to report on the implementation of the regional strategy should be made to the fifty-first session of the Regional Committee.

236. Although mental health programmes exist in 74% of the countries of the Region, only half of the countries have mental health and substance abuse policies.[60] The theme for World Health Day 2001 was "Mental Health: Stop Exclusion, Dare to Care". The World Health Report 2001 was entitled "Mental Health: New Understanding, New Hope". These emphases together with World Health Assembly ministerial round tables influenced about 80% of the countries in the African Region to choose mental health and substance abuse as priority domains for technical cooperation with WHO. These countries are developing or updating their mental health policies and programmes and at the same time improving the accessibility to mental health services.

237. Some countries[61] were supported in the formulation or revision of their mental health policies and programmes. Integration of mental health and prevention and control of substance abuse into the ongoing health sector reforms was encouraged. A pool of African experts on mental health was constituted and familiarized with WHO tools on needs assessment, programme preparation and

[60] Global questionnaire on mental health resources undertaken during the biennium 2000–2001 and now available as a publication and on the Internet.

[61] Angola, Botswana, Central African Republic, Chad, Gabon, Gambia, Lesotho, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Sierra Leone.

management. This group will be used to support countries in the implementation of the mental health strategy.

238. WHO prepared and provided modules on the development of mental health policies and services. Several countries of the Region[62] took part in two global meetings held to familiarize mental health planners and managers with the documents.[63] Reports from the countries indicate the integration of modules on mental health into the training courses of general health workers and the holding of on-the-job training workshops. Some countries selected candidates to be trained in mental health disciplines (neuropsychiatry, psychology, psychiatry, psychiatric nursing) in regional training institutions[64] through WHO fellowships.

239. In collaboration with various partners, some countries were supported in the implementation of specific projects such as: Global initiative on prevention of substance abuse in young people; Training in drug use epidemiology; Integration of mental health into primary health care; Child and adolescent mental health; Suicide prevention and community-based psychosocial rehabilitation in conflict and post-conflict situations. World Mental Health Day (10 October) is now observed by all Member States as an opportunity for advocacy and mental health promotion.

240. The implementation of the Global Campaign Against Epilepsy was extended to several countries through two intercountry meetings[65] involving national focal points and NGOs[66] dealing with the management of epilepsy. The campaign was launched in at least 10 selected countries with WHO support. Further interaction with HQ and country offices and improved collaboration with different partners[67] contributed significantly to the implementation of activities.

241. This is the second progress report on the implementation of the regional strategy for mental health following the recommendation of the fifty-first session of the Regional Committee. In spite of the progress made, awareness of the mental health component of public health programmes remains a major challenge. Other constraints are inadequate human and financial resources; lack of accessible essential psychotropic drugs for common mental and neurological disorders; and insufficient research culture. In order to maintain the monitoring process, it will be necessary to include the next progress report (the mid-term evaluation) in the agenda of the fifty-sixth session of the Regional Committee in 2006.

[62] Angola, Botswana, Cape Verde, Gambia, Ghana, Ethiopia, Lesotho, Malawi, Mauritania, Mauritius, Mozambique, Rwanda, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia.
[63] Miami meeting, July 2002 and Tunis meeting in November 2002.
[64] Universities of Cape Town, Dakar and Abidjan.
[65] Harare, June 2001 and Lomé, March 2002.
[66] Chapters of the International League Against Epilepsy (ILAE) or International Bureau for Epilepsy (IBE).
[67] WHO collaborating centres on research and training in Zimbabwe and Cape Town, ILAE, IBE, World Federation for Mental Health, etc.

Health-for-all policy for the 21st century in the African Region: Agenda 2020

242. By resolution AFR/RC50/R1 the Regional Committee adopted the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020. The resolution requests the Regional Director to mobilize Member States and the international community to update national health policies by drawing upon global and regional policies and thus contribute to the mobilization and rational use of resources for implementing these policies. The resolution also requests technical support to Member States for the continuous review of national health policies and strategies whenever necessary, a mechanism to monitor and evaluate progress in the implementation of the health-for-all policy, and continued strong advocacy for debt cancellation and use of the savings for health development. The resolution asked that a progress report be made to the fifty-third session of the Regional Committee, and then triennially, on the implementation of the health-for-all policy.

243. The Millennium Declaration adopted by heads of state at the United Nations led to the development of millennium development goals (MDGs), some of which relate to health: reducing child mortality; improving maternal health; combating HIV/AIDS, tuberculosis, malaria and other infectious diseases; reducing poverty. The MDGs and targets are being incorporated in national health policies and strategic plans.

244. African heads of state adopted the New Partnership for Africa's Development (NEPAD) which has since received support from many quarters, including the G8.[68] The Regional Office has contributed to the development of the health component of NEPAD which focuses on strengthening health systems and reducing the disease burden. The Commission on Macroeconomics and Health published its report which clearly shows the linkage between health and development. Discussions on this issue were held with HQ and implementation of the recommendations has already started in the Region.

245. Support was provided to countries to develop proposals for obtaining funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and some countries of the Region have already received funding.

246. An analysis of case studies was undertaken to provide experiences in health sector reform and implementation of the sector-wide approaches (SWAps). A meeting to share these experiences and propose future action was held.

247. At the local level, efforts to operationalize district health systems are ongoing and have received support from partners such as the Norwegian Agency for International Development (NORAD). In order to enhance, revive and refocus reform efforts, a framework for enhancing the stewardship role of government was developed.

248. An African strategy on poverty and health was developed. It advocates for consolidation of global partnerships for health, including those with bilateral and multilateral agencies involved in the preparation of Poverty Reduction Strategy Papers.

[68] Canada, Italy, France, Germany, Japan, Russia, United Kingdom, United States of America.

249. A WHO/World Bank joint meeting was held to determine the framework for contributions of health professions to health sector reform. Technical support is being provided, and 34 countries have received support to review their national health policies and plans or reorganize their national health systems in collaboration with other partners such as the African Development Bank and the World Bank.

250. Monitoring and evaluation tools for health sector reform were developed and are being used. The Regional Framework for the Management Information System was developed, and it provided data on health indicators in the Region during the fifty-second session of the Regional Committee in Harare. Through integrated disease surveillance, reporting on disease conditions, especially communicable diseases, greatly improved. Eighteen countries in the Region undertook world health surveys to provide information for assessing the performance of health systems and for monitoring and evaluating the millennium development goals.

251. National Health Accounts (NHA), which are used to monitor the adequacy of financial resources to meet MDGs and allocation of resources to priority interventions as stipulated in the report of the Commission on Macroeconomics and Health, were implemented in 10 countries; implementation continues in six other countries of the Region.

252. Support was provided to countries to update their national health policies and strategic plans in order to take into account country Poverty Reduction Strategy Papers (PRSPs). Support was also given to countries to develop their PRSPs.

253. Implementation of the resolution needs to be continued and improved. To this effect, there is a need for increased global and high-level political commitment, provision of funding to the health sector and strengthening of partnerships between countries, WHO and other agencies in health system development. More resources need to be mobilized to support health development in the Region. Particular attention has to be paid to addressing the problem of inadequacy and poor motivation of human resources. There is a need to incorporate international health initiatives into country strategies and programmes and adopt appropriate policies in line with global policies and the MDGs in order to optimize and guarantee resources for health. While NEPAD provides a good political framework for implementation of the Health-for-All Policy for the 21st Century consistent with the African Union development programme, there is also a need to strengthen internal mobilization of resources.

Noncommunicable diseases: A strategy for the African Region

254. Resolution AFR/RC50/R4 on noncommunicable diseases was adopted by the fiftieth session of the Regional Committee held in September 2000 in Ouagadougou, Burkina Faso. In this resolution, the Regional Committee urges the Regional Director to provide technical support to Member States for the development of national policies and programmes to prevent and control NCDs. It also requests the Regional Director to increase support to countries for the training of health professionals in NCD prevention and control, including monitoring and evaluation of programmes at different levels and promoting the use of regional training institutions; to facilitate the mobilization of additional resources for the implementation of the

regional strategy; to draw up operational plans for the decade 2001–2010; and to report implementation progress to the fifty-third session of the Regional Committee in the year 2003.

255. A situation analysis of NCDs was conducted in four countries, namely Botswana, Burkina Faso, Democratic Republic of Congo and Zimbabwe. A regional consultation was held to review the hypertension guidelines developed by WHO and the International Society of Hypertension and the WHO global package for cardiovascular disease control. The objective was to study their applicability to the African Region. Training was provided to 26 participants from 12 countries in methods of setting up national diabetes control programmes in the framework of NCD prevention and control programmes. A workshop on health care coverage for diabetes in Africa was organized in Zanzibar, Tanzania, for 22 participants from 12 anglophone and lusophone countries[69] who were updated with skills and knowledge in assessing the coverage and quality of care for diabetes at country level. A second workshop was held for francophone countries.

256. In the prevention and control of NCDs, three training centres for cervical cancer control were established: one in Conakry (Guinea) for francophone countries, one in Luanda (Angola) for lusophone countries and the third in Dar es Salaam (Tanzania) for anglophone countries. So far, participants from 24 countries have been trained in these centres. A cervical cancer control programme was established in 12 countries. These activities were jointly organized with the International Agency for Research on Cancer (IARC).

257. In the area of research, priority was given to the conduct of surveys on risk factors considering the scarcity of data on NCDs and the non-existence of NCD surveillance systems. Nine countries were technically and financially supported in this area.

258. In the surveillance of NCDs and their risk factors, 23 participants from nine countries were trained in the WHO STEPwise approach to surveillance (STEPS) of NCDs. STEPS was used as a tool for data collection in surveys in nine countries,[70] with support from HQ and the Regional Office for Africa. The Chronic Disease Programme (CDP) was reinforced by the recruitment of a professional to deal mainly with surveillance and the creation of a database on NCDs. Thanks to strong advocacy, about two-thirds of Member States now have NCD units within ministries of health.

259. The strategy is a response to the growing threat posed by noncommunicable diseases (NCDs) in the Region. It is aimed at strengthening the capacity of Member States to improve quality of life by alleviating the burden of NCDs and promoting healthy lifestyles among the populations of the African Region.

260. Following the wide distribution of the strategy and resolution to Member States and relevant institutions, the Regional Office, in collaboration with WHO headquarters, held a consultative meeting on the implementation of the strategy in Harare, Zimbabwe, in April 2001.

[69] Angola, Botswana, Gambia, Ghana, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.

[70] Algeria, Cape Verde, Côte d'Ivoire, Eritrea, Ghana, Mozambique, Nigeria, South Africa, Zimbabwe.

The outcome of the consultation was a framework to address priority areas of surveillance, prevention and management of the main NCDs and their risk factors; an outline of key elements to be included in a regional plan of action for the period 2002–2003 and a network of partnerships. The final report of the meeting was widely disseminated to Member States and NCD-related institutions, including WHO collaborating centres.

Adolescent health: A strategy for the African Region

261. By resolution AFR/RC51/R3 the Regional Committee approved the regional strategy on adolescent health. The resolution requests the Regional Director to continue to advocate for adolescent health programmes and to mobilize adequate resources for their implementation; to provide technical support to Member States for the development and implementation of national policies and programmes; to mobilize governments, agencies of the United Nations, NGOs and other stakeholders to organize youth seminars and conferences to discuss the problems and challenges to improving the health and development of adolescents. The resolution also requests support to institutions and national experts to carry out research on the problems and needs in adolescent health. The resolution requested that a progress report be given to the fifty-third session of the Regional Committee regarding implementation of adolescent health programmes at national and regional levels.

262. The regional strategy on adolescent health is now available in the three working languages of the Region and has been distributed to Member States and partners. Because of its relevance and usefulness to adolescent health, several countries have requested and received additional copies for distribution to their collaborating partners. Adolescent health is now included in the biennial plan of action (2002–2003) of 29 Member States.

263. Posters for the promotion of adolescent-friendly health services and life skills education (development of social competency skills) were developed in all the three working languages and distributed to Member States and partners.

264. A framework for the implementation of the adolescent health strategy and a "briefing kit" on adolescent health and development were produced to facilitate the implementation of the strategy and its translation into relevant policies and programmes in Member States. These documents will be translated and distributed shortly.

265. Advocacy was undertaken with national programme implementers and experts. The adolescent health strategy and its implementation framework were presented to reproductive health programme managers from all Member States during a meeting in Johannesburg in June 2002. Subsequently, 34 of the 46 countries requested technical and financial support from the Regional Office to translate the regional strategy into programmes at country level. Many are now implementing programmes for adolescents.

266. As a result of sensitization on adolescent health within the Regional Office, there is close collaboration among the technical divisions and units, namely Division of Family and Reproductive Health (DRH), Division of Communicable Disease Prevention and Control (DDC) (Regional Programme of AIDS), Division of Noncommunicable Diseases (DNC) (Health Promotion, Substance Abuse) and Division of Health Systems and Services Development (DSD) (Health Sector Reforms, Human Resources for Nursing) in the implementation of interventions. In addition, collaboration with partners such as the Commonwealth Regional Health Community Secretariat for Eastern, Central and Southern Africa has enhanced the visibility of adolescent health.

267. Technical support was provided to Member States to develop skills in working with street children by mobilizing and training NGO managers from nine countries.[71] Some of the NGOs are now implementing specific interventions based on such training in Uganda and Zambia. Gambia and Cameroon were supported to integrate child rights perspectives into their sexual and reproductive health programmes. Nine countries[72] were supported to develop integrated adolescent health projects.

268. In collaboration with the Commonwealth Regional Health Community Secretariat, adolescent health policies and programmes were reviewed, developed or strengthened in 15 countries.[73] The findings of the reviews will form the basis for the development of adolescent health policy guidelines for the Region and for the strengthening of adolescent health interventions in countries.

269. Technical support was provided for regional and national meetings, workshops and seminars on adolescent health. A presentation on the regional adolescent health strategy and Regional Office cooperation with countries was made during the WHO intercountry technical cooperation meeting held in Swaziland for eight southern African countries.[74] Technical and financial support was provided to the Seventh Congress of the African Society of Gynaecology and Obstetrics planned for Mali in 2003. One day was devoted to adolescent health issues. The Regional Office presented a paper on strategic orientations and perspectives on adolescent health.

270. Young people were trained in research and project proposal writing. Six projects on factors contributing to priority health problems among youth were developed: STIs/HIV/AIDS (Cameroon), teenage pregnancy (Lesotho), unsafe abortion (Malawi), sexual exploitation (Mozambique), substance use and abuse (Zambia), health-seeking behaviour among young people (Kenya). Countries received funds for the implementation of their projects. The results are being compiled for dissemination to countries.

[71] Angola, Ethiopia, Ghana, Kenya, Lesotho, Sierra Leone, Uganda, Zambia, Zimbabwe.
[72] Botswana, Ethiopia, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia, Zimbabwe.
[73] Benin, Botswana, Burkina Faso, Cameroon, Eritrea, Guinea, Lesotho, Mauritania, Mozambique, Namibia, Senegal, Tanzania, Uganda, Zambia, Zimbabwe.
[74] Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, South Africa, Zambia.

Regional strategy for immunization during the period 2003–2005

271. By its resolution AFR/RC52/R2 the WHO Regional Committee for Africa adopted the regional strategy for immunization for 2003–2005. The resolution requests the Regional Director to monitor the implementation of accelerated disease control strategies with particular emphasis on achieving polio eradication, eliminating neonatal tetanus, controlling measles and yellow fever and strengthening routine immunization systems. The resolution seeks to strengthen further collaboration with all international agencies, donor organizations and Expanded Programme on Immunization partners so as to better coordinate policies and resource utilization in an efficient and sustainable manner. A yearly progress report should be made to the Regional Committee.

272. The Regional Office provided further support to Member States in strengthening their national immunization programmes and in implementing the "Reaching Every District" strategy, including district level microplanning and programme monitoring in 17 countries. Support was provided to conduct reviews and implement recommendations to reverse the downward trend in immunization coverage in Botswana, Namibia and Swaziland. Eleven countries were supported in the planning or assessment of vaccines, cold chains, transport and injection safety (including waste management).

273. Technical assistance was given to 18 countries to process proposals and applications for review by the Global Alliance for Vaccines and Immunization (GAVI) Independent Review Committee. The proposals concerned immunization systems support, injection safety and new vaccines. The Regional Office supported post-introduction evaluation of new vaccines in five countries. The recommendations from some of these reviews are already being implemented. In collaboration with the GAVI secretariat, the Regional Office assisted seven countries to develop and submit financial sustainability plans for their EPI programmes.

274. Support was provided to Member States for polio eradication. By December 2002, there were only three polio-endemic countries in the African Region; this included Nigeria which accounted for over 97% of the wild polioviruses identified. AFP surveillance certification standards were attained for the first time at the regional level and in almost 70% of countries at the national level. Almost 60% of countries in the Region used the resources and experience of AFP surveillance to support the surveillance of other priority communicable diseases.

275. The lessons learned from external AFP surveillance reviews conducted in eight priority countries in 2002 were used to guide the preparation of 2003 surveillance workplans to improve the quality of surveillance in all countries that still have sub-optimal performance at national or sub-national levels.

276. The African Regional Certification Commission (ARCC) reviewed reports submitted by five national certification committees and provided guidance for preparation for polio-free certification status. The Regional Office trained members of national certification committees (NCCs) and national polio expert committees (NPECs) in 13 countries. Polio containment plans were completed in two countries.

277. With regard to the accelerated reduction of measles mortality, WHO provided technical support to eight countries for supplemental immunization and surveillance. Together with UNICEF, WHO supported four countries to provide a second opportunity for measles vaccination. An additional US$ 20 million was secured for activities in 2003 targeting 37 million children in nine countries to prevent an estimated 161 023 measles cases annually. Five more countries established intensified measles surveillance, bringing the total number of countries involved in this activity to 18.

278. Regarding maternal and neonatal tetanus elimination, 14 more countries were assisted to develop multi-year plans for maternal and neonatal tetanus elimination. Ten countries conducted tetanus toxoid supplemental immunization, and neonatal tetanus elimination was validated in three countries.

279. To improve access to the yellow fever vaccine, the joint WHO/UNICEF proposal to the GAVI Board to increase the global stockpile of the vaccine for emergency response from two to six million doses was approved at the Board's meeting in November 2002.

280. The 2002 annual meetings of the Task Force on Immunization (TFI) and the African Regional Interagency Coordination Committee (ARICC) were held in Abuja, Nigeria. Eighteen partners attended the meetings and deliberated on the way forward in strengthening immunization activities in the African Region, including issues relating to efficient utilization of resources and sustainability.

281. WHO country representatives continued to support national interagency coordination committees (ICCs) to enhance coordination, resource mobilization and monitoring. GAVI has been a catalyst in this area. WHO has continued to spearhead the activities of the GAVI subregional working groups. In this regard, all the major partners concerned hold regular meetings to discuss progress and plan for technical support.

CONCLUSION

282. The contributions and progress made by the Regional Office for Africa reflect the work of WHO in the Region as noted in 2002 during the mid-term review of the 2002–2003 Programme Budget. Over that period emphasis was placed on product and service delivery, on the one hand, and the level of implementation of Regional Committee resolutions, on the other.

283. Overall, remarkable progress was noted throughout the Region. From the financial standpoint, an average rate of budget implementation of about 67% was attained, which was well beyond the set target of 55%.

284. Notable among the achievements was the strengthening of programme management capacity. That involved both the development of new Country Cooperation Strategies (for 23 countries) and the implementation of the results-based management approach with the establishment of the computerized Activity Management System (AMS).

285. Concerning the management of priority health problems, mention should be made of the increased support given to the countries for the development or renewal of care provision strategies, guidelines and protocols; the allocation of additional resources and the provision of experts for the control of communicable diseases; the reduction of known noncommunicable disease risk factors; and the promotion of reproductive health, especially through maternal mortality reduction.

286. Also notable are the adoption of the regional strategies for poverty reduction, health and environment, and immunization (2002–2005); accelerated implementation of the regional strategy for the development of human resources for health; and adoption of the Programme Budget for 2004–2005.

287. Other remarkable achievements include the continuing support for the development of human resources in the Region, the improvement of information and communication technology at the Regional Office and in the countries, and the successful relocation of staff and shipment of their personal effects from Harare to Brazzaville.

288. Regarding Regional Committee resolutions, substantial efforts were made in their implementation in which varying degrees of progress were made. Activities recommended in some of the resolutions are currently in the expansion phase of implementation. An example is the resolution on the DOTS strategy which is now applied on a wide scale in countries and the increased access of the population to health services. Similarly, the implementation of the regional strategy for mental health is in the expansion phase in 74% of the countries in the Region.

289. The implementation of some resolutions started successfully. An example is the resolution on integrated epidemiological surveillance which started in 35 of the 46 countries of the Region. Concerning noncommunicable diseases, efforts are currently geared at setting up specific structures within ministries of health in about two-thirds of the countries and at analysing the

epidemiological situation and risk factors. Technical support was provided to 15 countries to develop or update specific adolescent health policies and to some nongovernmental organizations working on street children projects in nine countries. The regional strategy for emergency and humanitarian action has helped strengthen the capacity of countries in preparedness, response and resource mobilization, especially through Consolidated Appeals.

290. As regards the implementation of Agenda 2020, the Millenium Development Goals are being increasingly reflected in national health policies (in 34 of the 46 countries), and various initiatives such as the New Partnership for Africa's Development (NEPAD) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria are contributing to its implementation.

291. Other initiatives like the Global Alliance for Vaccines and Immunization (GAVI) are contributing to accelerated implementation of the Expanded Programme on Immunization (EPI) (for 2003–2005), especially routine EPI. There are now only three countries where wild polioviruses are known to circulate, evidence that progress is being made towards poliomyelitis eradication. Efforts were also made in immunization against measles, neonatal tetanus and yellow fever.

292. Notwithstanding the constraints encountered in the first year of implementation of the Programme Budget 2002–2003, a number of favourable factors contributed to achievements recounted in this report, and indeed to many others. The year 2002 was marked by unprecedented commitment to health-related issues on the part of Member States and international cooperation agencies. In addition, there was greater understanding of the managerial process of the WHO programme in the African Region. The concept of "One WHO" found expression both in harnessed efforts at all levels of WHO and in staff devotion.

293. Faced with the numerous challenges, our orientation has been to focus our efforts and resources on areas where WHO intervention can make a difference. For this reason, an appeal is being made to Member States to show greater understanding of this option and to lend support to our efforts in that direction.

294. In conclusion, and as is evident in this report, the staff of WHO to whom I dedicate this report, made remarkable progress, with all hands being on deck, under difficult conditions. That is why I wish to use this opportunity to express to them my gratitude for their devotion.

ANNEX 1

IMPLEMENTATION OF THE 2002–2003 PROGRAMME BUDGET—APPROPRIATION SECTIONS

As of 31 December 2002

	Appropriation Section	Regular Budget					Funds from Other Sources				Total			
#	Description	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate
01	Communicable diseases	5,428,000	575,000	6,003,000	4,281,000	71%	104,500,000	30,854,000	16,728,000	54%	109,928,000	36,857,000	21,009,000	57%
02	Noncommunicable diseases and mental health	5,226,000	473,000	5,699,000	3,060,000	54%	2,500,000	1,668,000	1,129,000	68%	7,726,000	7,367,000	4,189,000	57%
03	Family and community health	8,864,000	46,000	8,910,000	6,257,000	70%	38,684,000	12,717,000	7,622,000	60%	47,548,000	21,627,000	13,879,000	64%
04	Sustainable development and healthy environments	5,443,000	300,000	5,743,000	4,122,000	72%	268,000	1,467,000	685,000	47%	5,711,000	7,210,000	4,807,000	67%
05	Health technology and pharmaceuticals	3,898,000	-140,000	3,758,000	2,504,000	67%	91,832,000	63,406,000	47,602,000	75%	95,730,000	67,164,000	50,106,000	75%
06	Evidence and information for policy	13,410,000	92,000	13,502,000	7,887,000	58%	268,000	2,858,000	871,000	30%	13,678,000	16,360,000	8,758,000	54%
07	External relations and governing bodies	3,979,000	408,000	4,387,000	3,143,000	72%	1,462,000	3,427,000	2,077,000	61%	5,441,000	7,814,000	5,220,000	67%
08	General management	18,977,000	6,063,000	25,040,000	17,102,000	68%	12,168,000	16,430,000	10,093,000	61%	31,145,000	41,470,000	27,195,000	66%
09	Director-General, Regional Directors and Independent Functions	1,714,000	-15,000	1,699,000	1,196,000	70%	0	0	0		1,714,000	1,699,000	1,196,000	70%
10	Countries	119,533,000	-11,645,000	107,888,000	72,678,000	67%	1,458,000	123,533,000	81,038,000	66%	120,991,000	231,421,000	153,716,000	66%
Total		186,472,000	-3,843,000	182,629,000	122,230,000	67%	253,140,000	256,360,000	167,845,000	65%	439,612,000	438,989,000	290,075,000	66%

ANNEX 2

IMPLEMENTATION OF THE 2002–2003 PROGRAMME BUDGET—AREAS OF WORK

As of 31 December 2002

Area of Work			Regular Budget					Funds from Other Sources				Total			
		Description	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemente d	Rate
01.1.01	CSR	Communicable disease surveillance	1,795,000	195,000	1,990,000	1,573,000	79%	3,000,000	8,354,000	3,598,000	43%	4,795,000	10,344,000	5,171,000	50%
01.2.01	CPC	Communicable disease prevention, eradication and control	1,141,000	675,000	1,816,000	1,425,000	78%	65,000,000	1,855,000	1,611,000	87%	66,141,000	3,671,000	3,036,000	83%
01.3.01	CRD	Research and product development for communicable diseases	380,000	-9,000	371,000	158,000	43%		-	-		380,000	371,000	158,000	43%
01.4.01	MAL	Malaria	1,131,000	-301,000	830,000	398,000	48%	34,500,000	17,470,000	10,463,000	60%	35,631,000	18,300,000	10,861,000	59%
01.5.01	TUB	Tuberculosis	981,000	16,000	997,000	727,000	73%	2,000,000	3,175,000	1,056,000	33%	2,981,000	4,172,000	1,783,000	43%
02.1.01	NCD	Integrated approach to surveillance, prevention and management of noncommunicable diseases	2,457,000	-87,000	2,370,000	1,119,000	47%	1,000,000	511,000	214,000	42%	3,457,000	2,881,000	1,333,000	46%
02.2.01	TOB	Tobacco	701,000	308,000	1,009,000	509,000	50%	1,000,000	819,000	749,000	91%	1,701,000	1,828,000	1,258,000	69%
02.3.01	HPR	Health promotion	442,000	124,000	566,000	566,000	100%		279,000	140,000	50%	442,000	845,000	706,000	84%
02.4.01	DPR	Disability/injury prevention and rehabilitation	275,000	295,000	570,000	301,000	53%		26,000	3,000	12%	275,000	596,000	304,000	51%
02.5.01	MNH	Mental health and substance abuse	1,351,000	-167,000	1,184,000	565,000	48%	500,000	33,000	23,000	70%	1,851,000	1,217,000	588,000	48%
03.1.01	CAH	Child and adolescent health	1,221,000	255,000	1,476,000	559,000	38%	7,000,000	7,612,000	4,871,000	64%	117,654,000	44,225,000	25,198,000	57%
03.2.01	RHR	Research and programme development in reproductive health	1,666,000	198,000	1,864,000	1,625,000	87%	1,684,000	1,577,000	839,000	53%	3,350,000	3,441,000	2,464,000	72%
03.3.01	MPS	Making pregnancy safer	2,098,000	-429,000	1,669,000	1,292,000	77%		-	-		2,098,000	1,669,000	1,292,000	77%
03.4.01	WMH	Women's health and development	862,000	92,000	954,000	535,000	56%		225,000	61,000	27%	862,000	1,179,000	596,000	51%

IMPLEMENTATION OF THE 2002–2003 PROGRAMME BUDGET—AREAS OF WORK

As of 31 December 2002

Area of Work			Regular Budget					Funds from Other Sources				Total			
		Description	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate
03.5.01	HIV	HIV/AIDS	3,017,000	-69,000	2,948,000	2,247,000	76%	30,000,000	3,303,000	1,851,000	56%	33,017,000	6,251,000	4,098,000	66%
04.1.01	HSD	Sustainable development	1,132,000	200,000	1,332,000	935,000	70%	268,000	280,000	189,000	68%	1,400,000	1,612,000	1,124,000	70%
04.2.01	NUT	Nutrition	682,000	152,000	834,000	659,000	79%	0	117,000	96,000	82%	682,000	951,000	755,000	79%
04.3.01	PHE	Health and environment	2,254,000	-374,000	1,880,000	1,375,000	73%		110,000	12,000	11%	2,254,000	1,990,000	1,387,000	70%
04.4.01	FOS	Food safety	150,000	150,000	300,000	123,000	41%		-	-		150,000	300,000	123,000	41%
04.5.01	EHA	Emergency preparedness and response	1,225,000	172,000	1,397,000	1,031,000	74%		960,000	389,000	41%	1,225,000	2,357,000	1,420,000	60%
05.1.01	EDM	Essential drugs and medicines policy	1,609,000	-37,000	1,572,000	1,133,000	72%		469,000	446,000	95%	1,609,000	2,041,000	1,579,000	77%
05.2.01	IVD	Immunization and vaccine development	415,000	240,000	655,000	397,000	61%	91,832,000	62,937,000	47,156,000	75%	92,247,000	63,592,000	47,553,000	75%
05.3.01	BCT	Blood safety and clinical technology	1,874,000	-343,000	1,531,000	974,000	64%		-	-		1,874,000	1,531,000	974,000	64%
06.1.01	GPE	Evidence for health policy	1,505,000	25,000	1,530,000	604,000	39%	0	27,000	25,000	93%	1,505,000	1,557,000	629,000	40%
06.2.01	IMD	Health information management and dissemination	3,677,000	85,000	3,762,000	2,620,000	70%		25,000	21,000	84%	3,677,000	3,787,000	2,641,000	70%
06.3.01	RPC	Research policy and promotion	716,000	-16,000	700,000	332,000	47%		5,000	1,000	20%	716,000	705,000	333,000	47%
06.4.01	OSD	Organization of health services	7,512,000	-4,000	7,508,000	4,330,000	58%	268,000	2,801,000	824,000	29%	7,780,000	10,309,000	5,154,000	50%
07.1.01	GBS	Governing bodies	1,374,000	318,000	1,692,000	1,570,000	93%		-	-		1,374,000	1,692,000	1,570,000	93%
07.2.01	REC	Resource mobilization and external cooperation and partnerships	2,605,000	90,000	2,695,000	1,573,000	58%	1,462,000	3,427,000	2,077,000	61%	4,067,000	6,122,000	3,650,000	60%
08.1.01	BMR	Budget and management reform	557,000	118,000	675,000	489,000	72%	0	229,000	98,000	43%	557,000	904,000	587,000	65%
08.2.01	HRS	Human resources	2,442,000	0	2,442,000	988,000	40%	1,691,000	2,601,000	1,011,000	39%	4,133,000	5,043,000	1,999,000	40%
08.3.01	FNS	Financial management	3,600,000	0	3,600,000	1,847,000	51%	3,141,000	3,241,000	2,553,000	79%	6,741,000	6,841,000	4,400,000	64%

IMPLEMENTATION OF THE 2002–2003 PROGRAMME BUDGET—AREAS OF WORK

As of 31 December 2002

Area of Work			Regular Budget					Funds from Other Sources				Total			
		Description	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemented	Rate	Approved	Effective Budget	Implemente d	Rate
08.4.01	IIS	Informatics and infrastructure services	12,378,000	5,945,000	18,323,000	13,777,000	75%	7,336,000	10,359,000	6,430,000	62%	19,714,000	28,682,000	20,207,000	70%
09.1.01	DGO	Director-General's and Regional Directors' Offices (including audit, oversight and legal)	1,084,000	-25,000	1,059,000	675,000	64%	0		0		1,084,000	1,059,000	675,000	64%
09.2.01	DDP	Director-General's and Regional Directors' development programme and initiatives	630,000	10,000	640,000	521,000	81%	0		0		630,000	640,000	521,000	81%
Countries			119,533,000	-11,645,000	107,888,000	72,678,000	67%	1,458,000	123,533,000	81,038,000	66%	120,991,000	231,421,000	153,716,000	66%
Total			186,472,000	-3,843,000	182,629,000	122,230,000	67%	253,140,000	256,360,000	167,845,000	65%	439,612,000	438,989,000	290,075,000	66%

ANNEX 3

IMPLEMENTATION OF THE 2002-2003 PROGRAMME BUDGET—COUNTRIES

As of 31 December 2002

Country	Regular Budget					Funds from Other Sources					Total				
	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate
Algeria	1,870,000	(94,000)	1,776,000	950,000	53%		48,000	48,000	29,000	60%	1,870,000	(46,000)	1,824,000	979,000	54%
Angola	3,135,000	(172,000)	2,963,000	2,207,000	74%		10,021,000	10,021,000	7,249,000	72%	3,135,000	9,849,000	12,984,000	9,456,000	73%
Benin	2,447,000	(156,000)	2,291,000	1,819,000	79%		1,011,000	1,011,000	190,000	19%	2,447,000	855,000	3,302,000	2,009,000	61%
Botswana	2,001,000	(46,000)	1,955,000	1,110,000	57%		160,000	160,000	61,000	38%	2,001,000	114,000	2,115,000	1,171,000	55%
Burkina Faso	2,927,000	(287,000)	2,640,000	1,780,000	67%		3,138,000	3,138,000	1,732,000	55%	2,927,000	2,851,000	5,778,000	3,512,000	61%
Burundi	2,894,000	(431,000)	2,463,000	1,647,000	67%		1,320,000	1,320,000	555,000	42%	2,894,000	889,000	3,783,000	2,202,000	58%
Cameroon	2,239,000	(237,000)	2,002,000	1,460,000	73%	400,000	153,000	553,000	407,000	74%	2,639,000	(84,000)	2,555,000	1,867,000	73%
Cape Verde	2,084,000	(273,000)	1,811,000	1,245,000	69%		63,000	63,000	12,000	19%	2,084,000	(210,000)	1,874,000	1,257,000	67%
Central African Republic	2,699,000	(162,000)	2,537,000	1,763,000	69%		133,000	133,000	38,000	29%	2,699,000	(29,000)	2,670,000	1,801,000	67%
Chad	2,989,000	(219,000)	2,770,000	2,365,000	85%		1,040,000	1,040,000	794,000	76%	2,989,000	821,000	3,810,000	3,159,000	83%
Comoros	2,420,000	(286,000)	2,134,000	1,593,000	75%		155,000	155,000	41,000	26%	2,420,000	(131,000)	2,289,000	1,634,000	71%
Congo	2,247,000	(272,000)	1,975,000	1,224,000	62%		770,000	770,000	513,000	67%	2,247,000	498,000	2,745,000	1,737,000	63%
Côte d'Ivoire	2,256,000	(252,000)	2,004,000	1,336,000	67%		1,228,000	1,228,000	771,000	63%	2,256,000	976,000	3,232,000	2,107,000	65%
Democratic Republic of Congo	3,206,000	(293,000)	2,913,000	2,489,000	85%	500,000	15,029,000	15,529,000	12,977,000	84%	3,706,000	14,736,000	18,442,000	15,466,000	84%
Equatorial Guinea	1,561,000	(136,000)	1,425,000	1,104,000	77%		201,000	201,000	166,000	83%	1,561,000	65,000	1,626,000	1,270,000	78%
Eritrea	2,245,000	(142,000)	2,103,000	1,419,000	67%		1,244,000	1,244,000	371,000	30%	2,245,000	1,102,000	3,347,000	1,790,000	53%
Ethiopia	4,526,000	(540,000)	3,986,000	2,466,000	62%		15,219,000	15,219,000	10,390,000	68%	4,526,000	14,679,000	19,205,000	12,856,000	67%
Gabon	1,738,000	(246,000)	1,492,000	986,000	66%	326,000	58,000	384,000	219,000	57%	2,064,000	(188,000)	1,876,000	1,205,000	64%

IMPLEMENTATION OF THE 2002-2003 PROGRAMME BUDGET—COUNTRIES

As of 31 December 2002

Country	Regular Budget					Funds from Other Sources					Total				
	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate
Gambia	2,029,000	(197,000)	1,832,000	1,495,000	82%		762,000	762,000	434,000	57%	2,029,000	565,000	2,594,000	1,929,000	74%
Ghana	2,245,000	(326,000)	1,919,000	1,175,000	61%		2,106,000	2,106,000	1,010,000	48%	2,245,000	1,780,000	4,025,000	2,185,000	54%
Guinea	2,900,000	(254,000)	2,646,000	1,750,000	66%		1,110,000	1,110,000	715,000	64%	2,900,000	856,000	3,756,000	2,465,000	66%
Guinea-Bissau	2,308,000	(109,000)	2,199,000	1,533,000	70%		56,000	56,000	31,000	55%	2,308,000	(53,000)	2,255,000	1,564,000	69%
Kenya	2,586,000	(209,000)	2,377,000	1,641,000	69%		4,429,000	4,429,000	2,432,000	55%	2,586,000	4,220,000	6,806,000	4,073,000	60%
Lesotho	2,454,000	(564,000)	1,890,000	729,000	39%		384,000	384,000	116,000	30%	2,454,000	(180,000)	2,274,000	845,000	37%
Liberia	2,724,000	(166,000)	2,558,000	2,127,000	83%		899,000	899,000	701,000	78%	2,724,000	733,000	3,457,000	2,828,000	82%
Madagascar	2,532,000	(318,000)	2,214,000	1,175,000	53%		3,767,000	3,767,000	3,105,000	82%	2,532,000	3,449,000	5,981,000	4,280,000	72%
Malawi	2,685,000	(303,000)	2,382,000	1,426,000	60%		2,913,000	2,913,000	673,000	23%	2,685,000	2,610,000	5,295,000	2,099,000	40%
Mali	3,153,000	(372,000)	2,781,000	1,769,000	64%		913,000	913,000	707,000	77%	3,153,000	541,000	3,694,000	2,476,000	67%
Mauritania	2,553,000	(255,000)	2,298,000	1,376,000	60%		807,000	807,000	457,000	57%	2,553,000	552,000	3,105,000	1,833,000	59%
Mauritius	1,609,000	(111,000)	1,498,000	627,000	42%		13,000	13,000	2,000	15%	1,609,000	(98,000)	1,511,000	629,000	42%
Mozambique	3,149,000	(172,000)	2,977,000	1,916,000	64%		2,529,000	2,529,000	1,118,000	44%	3,149,000	2,357,000	5,506,000	3,034,000	55%
Namibia	2,103,000	(478,000)	1,625,000	1,331,000	82%		380,000	380,000	251,000	66%	2,103,000	(98,000)	2,005,000	1,582,000	79%
Niger	3,178,000	(123,000)	3,055,000	2,335,000	76%		1,408,000	1,408,000	1,118,000	79%	3,178,000	1,285,000	4,463,000	3,453,000	77%
Nigeria	4,255,000	(268,000)	3,987,000	2,789,000	70%		21,112,000	21,112,000	16,725,000	79%	4,255,000	20,844,000	25,099,000	19,514,000	78%
Reunion	196,000	(4,000)	192,000	37,000	19%		-	-	-		196,000	(4,000)	192,000	37,000	19%
Rwanda	3,085,000	(435,000)	2,650,000	1,395,000	53%		1,510,000	1,510,000	1,137,000	75%	3,085,000	1,075,000	4,160,000	2,532,000	61%
Saint Helena	144,000	(3,000)	141,000	15,000	11%		-	-	-		144,000	(3,000)	141,000	15,000	11%

IMPLEMENTATION OF THE 2002-2003 PROGRAMME BUDGET—COUNTRIES

As of 31 December 2002

Country	Regular Budget					Funds from Other Sources					Total				
	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate	Approved	Transfers	Effective Budget	Implemented	Rate
Sao Tome & Principe	1,812,000	(327,000)	1,485,000	995,000	67%		36,000	36,000	27,000	75%	1,812,000	(291,000)	1,521,000	1,022,000	67%
Senegal	2,450,000	(156,000)	2,294,000	1,370,000	60%		1,038,000	1,038,000	463,000	45%	2,450,000	882,000	3,332,000	1,833,000	55%
Seychelles	1,522,000	(135,000)	1,387,000	702,000	51%		6,000	6,000	(2,000)	-33%	1,522,000	(129,000)	1,393,000	700,000	50%
Sierra Leone	2,492,000	(130,000)	2,362,000	1,533,000	65%		3,101,000	3,101,000	1,105,000	36%	2,492,000	2,971,000	5,463,000	2,638,000	48%
South Africa	3,733,000	(430,000)	3,303,000	2,185,000	66%		2,033,000	2,033,000	1,063,000	52%	3,733,000	1,603,000	5,336,000	3,248,000	61%
Swaziland	2,077,000	(148,000)	1,929,000	1,278,000	66%		759,000	759,000	385,000	51%	2,077,000	611,000	2,688,000	1,663,000	62%
Togo	2,324,000	(140,000)	2,184,000	1,504,000	69%		640,000	640,000	127,000	20%	2,324,000	500,000	2,824,000	1,631,000	58%
Uganda	2,894,000	(356,000)	2,538,000	2,560,000	101%	200,000	2,887,000	3,087,000	2,140,000	69%	3,094,000	2,531,000	5,625,000	4,700,000	84%
United Republic of Tanzania	2,894,000	(354,000)	2,540,000	1,700,000	67%		7,119,000	7,119,000	3,637,000	51%	2,894,000	6,765,000	9,659,000	5,337,000	55%
Zambia	2,997,000	(439,000)	2,558,000	1,653,000	65%		2,168,000	2,168,000	1,404,000	65%	2,997,000	1,729,000	4,726,000	3,057,000	65%
Zimbabwe	2,966,000	(119,000)	2,847,000	1,594,000	56%	32,000	6,199,000	6,231,000	3,442,000	55%	2,998,000	6,080,000	9,078,000	5,036,000	55%
Total	119,533,000	(11,645,000)	107,888,000	72,678,000	67%	1,458,000	122,075,000	123,533,000	81,038,000	66%	120,991,000	110,430,000	231,421,000	153,716,000	66%