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TAKING STOCK OF WHO WORK IN EASTERN AND SOUTHERN AFRICA

2012 ANNUAL REPORT

INTERCOUNTRY SUPPORT TEAM FOR EASTERN AND SOUTHERN AFRICA
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA
Brazzaville • 2013

World Health Organization
REGIONAL OFFICE FOR Africa

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FOREWORD

The year 2012 was an eventful period for the Eastern and Southern African (ESA) Intercountry Support Team (IST). Many of the events, including natural disasters, emergencies and disease epidemics, the call for universal health coverage, the work of the UN General Secretary's Commission on Information and Accountability, the holding of the African Cup of Nations 2012 in South Africa and the operationalization of the new management support structures at intercountry team and in countries influenced the work of the WHO in the subregion during the year. Weak health systems, particularly inadequate health staffing in the ministries of health; weak disease surveillance, which makes real-time monitoring of the health situation in the subregion difficult; fragile management systems for supply chains for medicine and medical commodities; and low fund absorption capacity in the ministries of health continued to create a huge demand for technical and financial support during the year. This, coupled with reduction in available WHO resources, especially staffing and funding, meant that the IST had to depend on existing resources to meet the demands.

Despite these challenges, the IST was able to respond adequately to country demands and significantly contribute during the year to progress towards achievement of the health-related Millennium Development Goals in the subregion. Introduction of new management systems and technologies resulted in streamlined and improved operations and more efficient and cost-effective programme management. Creation of an enabling and conducive environment for the IST also facilitated strategic dialogue among both professional and administrative staff and programmes and further improved the way the IST does business.

For 2013 and beyond we plan to redouble our efforts to ensure that the achievements of 2012 are sustained and used as a springboard for our work. To improve our technical assistance to Member States and partners in 2013 and beyond we plan to introduce an integrated approach to provision of technical support, which will ensure joint, focused, timely and more effective technical support to countries and improve synergy among IST programmes. To ensure success we will initiate regular consultations with WHO country offices and through them with the countries and partners at the local level. We will tap effectively into mechanisms and groupings that bring together partners such as the United Nations Development Group, the Harmonization for Health in Africa initiative and subregional and national institutions.

I seize this opportunity to thank the Regional Director and all members of the senior management and technical programmes in the WHO African Region, the WHO Representatives (WRs) in the subregion and their teams, Member States and our partners within and outside the United Nations system without whose support we could not have come this far. We count on your usual support, collaboration and partnership as we take on the 2013 challenges.

I thank you very much.

Dr Chris Mwikisa
IST for ESA Coordinator

ACKNOWLEDGEMENTS

This report is produced by the Intercountry Support Team for the Eastern and Southern Africa subregion of the WHO African Region. It was compiled from reports written by IST programme and administrative staff with inputs from WHO country offices. We acknowledge the support and collaboration from the African Regional Office, the country offices in the subregion, donors and partners who contributed to our work in 2012. To everybody we say, thank you.

WHO Intercountry Support Team for Eastern and Southern Africa.

ABBREVIATIONS

AFP	acute flaccid paralysis
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CFR	case fatality rate
CoIA	Commission on Information and Accountability
CSU	country management support unit
DPT3	Third Dose of Diphtheria, Pertussis and Tetanus vaccine
DRM	disaster risk management
EAC	East African Community
ECSA-HC	East, Central and Southern Africa-Health Community
EMoNC	emergency obstetric and neonatal care
EPI	expanded programme on immunization
ePMDS	electronic performance management and development system
EQUINET	Regional Network on Equity in Health in Southern Africa
ERC	ethical review committee
ESA	Eastern and Southern Africa
FIFA	International Federation of Football Association
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global Drug Facility
GEF	Global Environmental Facility
GFTAM	Global Fund to Fight Tuberculosis, AIDS and Malaria
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* (German Agency for International Cooperation)
GLP	global learning programme
GSM	global management system
HHA	Harmonization for Health in Africa
HIV	Human Immuno-deficiency Virus
HTC	HIV testing and counselling
IATT	Interagency task team
ICATT	IMCI computerized adaptation and training tool

IGAD	Intergovernmental Authority on Development
IMCI	integrated management of childhood illnesses
INSPIRE	INtegrating and Scaling up PMTCT through Implementation REsearch
IRS	indoor residual spraying
IST	intercountry support team
ISU	intercountry management support unit
KNCV	*Koninklijke Nederlandse Chemische Vereniging* (Royal Dutch Chemical Association)
MDA	mass drug administration
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistant Tuberculosis
MIP	malaria in pregnancy
MNCH	maternal, newborn and child Health
MPS	making pregnancy safer
NGO	Non-governmental organization
NTD	neglected tropical diseases
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother to child transmission of HIV
RED	reaching every district
SADC	Southern Africa Development Community
SHA	system of health accounts
SIAs	supplementary immunization activities
SPR	short programme review
STH	soil transmitted helminthiasis
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNEP	United Nations environmental Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VHF	viral haemorrhagic fever

WHO	World Health Organization
WISN	workload indicators for staffing need
WR	WHO representative
XDR-TB	extensively drug-resistant tuberculosis

EXECUTIVE SUMMARY

The WHO Regional Office for Africa seeks to contribute towards strengthening of the capacity of its Member States to attain the health-related Millennium Development Goals (MDGs) and to address other regional public health priorities. Decentralized provision of technical support to countries is one of the strategies the Regional Office has adopted to ensure timely delivery and more sustainable long-term support. To this effect, three strategically located intercountry support teams (ISTs) were set up to work with groups of countries in West, Central and eastern and southern Africa. The IST for Eastern and Southern Africa (ESA) is based in Harare, Zimbabwe, and serves 19 countries in the subregion.

The key functions of the ISTs include providing technical and managerial support to countries for implementation of agreed plans of action, availing rapid response for disease outbreaks and other emergency situations, providing up-to-date information on strategic and technical policies to Member States, and executing and monitoring implementation of agreed programmes of work for the respective subregions.

The ESA subregion bears a disproportionate burden of the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis and extensively drug-resistant tuberculosis (XDR-TB). It remains the epicentre of the global HIV epidemic as it is where 45% of persons infected with HIV live and where almost half of all AIDS deaths occur. According to annual tuberculosis surveillance reports for the past five years, including the Global WHO tuberculosis report, 2012, the ESA subregion, which has less than half of the African Region's population, annually reports at least 60% of the Region's tuberculosis cases. Malaria also remains a major public health problem in the subregion with recent data showing high malaria parasite prevalence. Furthermore, an estimated one million children in ESA do not have access to childhood immunization services, increasing the risk of outbreaks of childhood illnesses, especially measles and polio. These challenges notwithstanding, there are renewed efforts by WHO and its partners to contribute to improvement of the health situation in the subregion.

In line with the IST's 2012–13 biennium plan, the key achievements during 2012 included:

- Support for expansion of HIV/AIDS services and adaptation of WHO guidelines and tools for HIV/AIDS by Member States.
- Tuberculosis prevalence surveys supported in 11 countries[1] and malaria therapeutic efficacy studies in 5 countries.[2]
- Technical support for successful response to three outbreaks of viral haemorrhagic fever (VHF) and polio and all the natural disasters that occurred in the subregion.
- Technical support to nine countries to introduce the pneumococcal vaccine and four countries to introduce the rotavirus vaccine.
- Support to assess the quality of paediatric referral care in order to improve paediatric quality of care in some hospitals.
- Technical support to complete needs assessments for emergency obstetric and neonatal care in some countries.

1. Gambia, Nigeria, Tanzania and Rwanda (conduct of national TB prevalence surveys). Ghana, Kenya, Malawi, South Africa, Uganda, Zambia and Zimbabwe (planning for national surveys). Ghana and Malawi (piloting prevalence surveys).
2. Eritrea, Malawi, Tanzania, Uganda and Zambia.

- Rapid assessment of paediatric HIV care in Swaziland, Tanzania, Uganda and Zimbabwe in collaboration with UNICEF.
- Publication of four articles on public health and the environment in peer-reviewed scientific journals.
- Support to a number of countries to develop national health sector strategic plans.
- Introduction of new and innovative information and communication technologies.

Inadequate staffing and funding remained the most critical challenges to the scaling up of IST programmes during the year. Despite the limited human and financial resources, requests for technical support by Member States continued to increase, given their weak health systems and enhanced collaboration with other partners, overstretching the limited resources. Frequent changes in country priorities and postponement of activities and last minute requests for technical support also were major factors that hampered the work of the IST during the year.

A number of lessons were learnt during 2012. We realized that strong partnerships, joint planning and coordinated and integrated technical support were critical in improving the effectiveness and efficiency of the support provided to the countries. Networking with other partners and agencies is an important factor in terms of complementarity in an environment of the limited human and other resources in the IST. Good communication on the work of the organization and sharing of knowledge and information improve the visibility and image of the organization. Acquisition of real-time data on health situations in the subregion empowers WHO to play its lead role of guiding other partners in health and improves its ability for timeous response to emergencies and outbreaks.

Drawing from the lessons and key challenges of 2012, the strategic vision of IST for ESA in 2013 and the coming years is to ensure an integrated approach is adopted for technical support to Member States so that their demands are addressed in a holistic and harmonized manner. To this end, approaches for strengthening health systems will be mainstreamed into all programmes and joint technical support missions involving various WHO programmes and relevant partners will be encouraged. The lessons and key achievements made so far will be consolidated and used to further strengthen IST capacity to offer technical support to Member States.

1. INTRODUCTION

1.1 Background

The WHO Regional Office for Africa seeks to contribute to the strengthening of the capacity of its Member States to attain the health-related Millennium Development Goals (MDGs) and to address other regional public health priorities. Decentralized provision of technical support to the countries is one of the strategies the Regional Office has adopted to ensure timely and more sustainable long-term support. To this effect, three strategically located intercountry support teams (ISTs) were set up to work with groups of countries in West, Central and eastern and southern Africa. The IST for Eastern and Southern Africa (ESA) is located in Harare, Zimbabwe, and serves 19 countries.[3] The key functions of the ISTs include providing technical and managerial support to countries for the implementation of agreed plans of action; availing rapid response for disease outbreaks and other emergency situations; providing up-to-date information to Member States on strategic and technical policies; and executing and monitoring the implementation of agreed programmes of work for the respective subregions. In the execution of its functions of providing technical support to countries, the IST for ESA recognizes the crucial role of partnerships and consequently is fully involved with the United Nations Development Group (UNDG) for ESA as chair of the Health Working Group, and with Harmonization for Health in Africa (HHA) initiative.

During 2012, IST work was guided by the *WHO general programme of work 2006–2016*, the *WHO medium-term strategic plan 2008–2013*, and *Achieving sustainable health development in the African Region, strategic orientations for 2010–2015*. All these documents target the achievement of the MDGs.

This annual report provides an overview of the collective work of the IST as well as contributions by specific units and technical programmes. It summarizes the major achievements, challenges and lessons and provides perspectives for 2013, reflecting the strategic priorities for 2013 that align with global, regional and national commitments and orientations.

1.2 Key health issues and challenges in eastern and southern Africa in 2012

The disease burden in the ESA subregion is characterized by high crude and under-five mortality rates. The subregion bears a disproportionate burden of the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB), and extensively drug-resistant TB (XDR-TB) has been reported over the past four

3. Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

years. The subregion remains the epicentre of the global HIV epidemic, being home to 45% of persons infected with HIV and accounting for almost half of all AIDS deaths. At more than 10%, HIV prevalence among pregnant women remains high in the southern African countries but is relatively lower in eastern Africa, ranging from 1.8% in Eritrea to 6.8% in Tanzania. However, table 1 shows a notable decline in the HIV incidence in 11 countries in the sub-region, for the period of 2010-2011. According to the annual TB surveillance reports from the past five years including the Global WHO tuberculosis report, 2012, the ESA subregion, which has less than half of the Africa's population, annually accounts for at least 60% of the TB cases reported in the African Region. At the same time, ESA accounts for over 84% of reported multidrug-resistant TB (MDR-TB) cases and over 90% of all extensively drug-resistant TB (XDR-TB) cases.

Table 1: Changes in the incidence of HIV infection among adults 15–49 years old, 2001–2011 in selected ESA countries

Trend	Increasing (>25%)	Stable (change less than 25% up or down)	Decreasing (26–49%)	Decreasing (>50%)
ESA countries	None	Lesotho, Uganda, United Republic of Tanzania	Kenya, Mozambique, South Africa, Swaziland	Botswana, Ethiopia, Malawi, Namibia, Rwanda, Zambia, Zimbabwe
ESA countries/ total countries	0/9	3/12	4/14	7/25

Source: UNAIDS Global AIDS Report 2012.

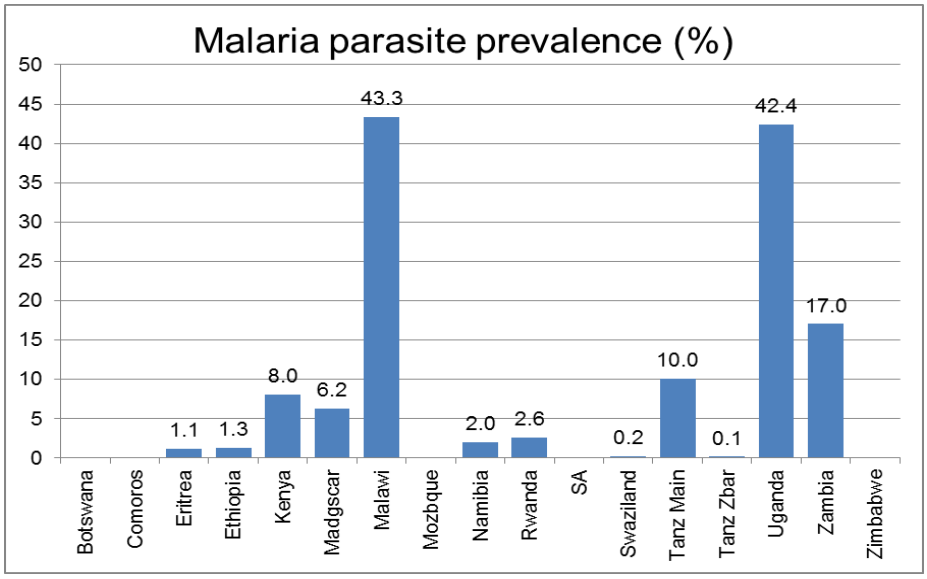
Note: Countries not included in this table have insufficient data and/or analyses to estimate recent trends in incidence among adults and to assess the impact of HIV prevention programmes for adults.

Malaria remains a major public health problem despite important political commitments such as the Abuja Declaration, the African Union malaria elimination campaign, the Southern Africa Development Community (SADC) Malaria Elimination Framework and the WHO African Office Regional Committee on Accelerated Malaria Control. Recent data on malaria parasite prevalence from surveys in countries where this was assessed in 2009–12 indicate levels were lowest in Zanzibar and highest in Malawi and Uganda as indicated in Figure 1.

Using the criteria for classifying countries on the continuum of malaria control to elimination, the Eastern and Southern Africa subregion has 11 countries[4] classified as having high transmission and are thus in the control phase, 6 countries[5] moving towards the pre-elimination phase and three countries[6] in the prevention of re-introduction phase. The majority of people in the high transmission countries face a high malaria risk. In a few exceptions, more than 20% of the population live in malaria-free areas, for example in Ethiopia (33%) and Kenya (26%).

4. Comoros, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Uganda, United Republic of Tanzania mainland, Zambia and Zimbabwe.
5. Botswana, Eritrea, Namibia, South Africa, Swaziland and Zanzibar.
6. Lesotho, Mauritius and Seychelles.

Figure 1: Malaria parasite prevalence rate in ESA

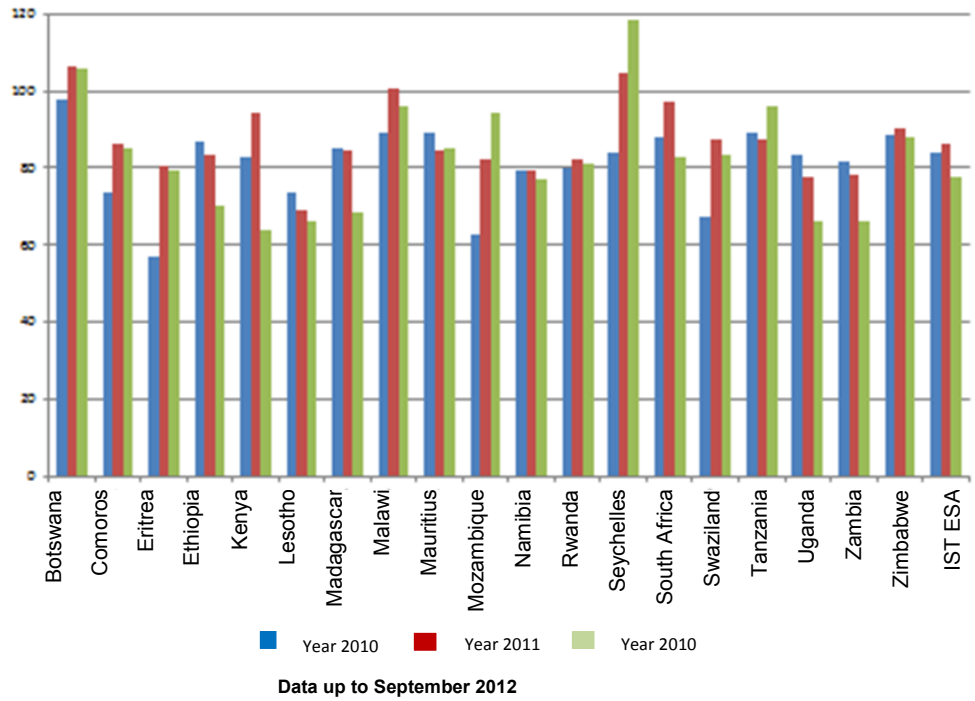


Neglected tropical diseases (NTDs), about 17 in all, are a group characterized by their association with poverty and their proliferation in tropical environments where multiple infections in a single individual are common. More than 1 billion people worldwide suffer from one or more NTDs, with Africa bearing a disproportionately high burden of 50% of the cases. These tropical diseases have been neglected for a long time. A workshop was organized in Harare, Zimbabwe, where Anglophone countries finalized their NTD master plans. Kenya launched its master plan within the year. Although significant progress has been made over the past years in the control of the different NTDs and to regularly implement mass drug administration (MDA) in several countries, regional achievements are still very far from the disease control targets. By 2011, only 19%, 13% and 30% of people requiring treatment for lymphatic filariasis, schistosomiasis and soil transmitted helminthiasis (STH), respectively, were treated. There was an increase in the number of countries and people treated in 2012 using the MDA approach. Among the new countries that started MDA in 2012 were Zimbabwe, which launched its first MDA for schistosomiasis; Kenya, which resumed the school-based deworming campaign for STH; and Zambia, which conducted MDA for schistosomiasis, STH and trachoma in some districts.

Many countries in the subregion experienced a form of a natural disaster or complex emergencies involving population displacement. Emergencies and disease outbreaks occurred as they do annually in the subregion. During 2012 three outbreaks of the viral haemorrhagic fever (VHF) were reported in Uganda, two of which were of Ebola haemorrhagic fever and one of Marburg disease. Outbreaks of vaccine derived polio were recorded in Uganda and Kenya. Only 33% of ESA countries had reached a vaccination coverage of 90% for diphtheria pertussis and tetanus 3 (DPT3), polio 3 and measles by the end September 2012 (Figure 2). An estimated one million children in the subregion were not reached with immunization services, 80% of them in Ethiopia, Kenya, Madagascar, Tanzania and Uganda. With fairly good Acute Flaccid Paralysis (AFP) surveillance performance in 17 of the 19 countries, the subregion has not had any confirmed

incident of wild polio virus circulation since July 2011. Furthermore, all the countries in the subregion continued to have unlimited and real-time access to and support of accredited laboratories during the year. Severe flooding affecting more than 80 000 people was reported in three of the Comoros islands and a ferry accident in Zanzibar killed over 100 people. These incidents epitomize the vulnerability of the subregion to public health emergencies of international concern.

Figure 2: Pentavalent and measles vaccine coverage in ESA, 2010–12



While diseases such as HIV/AIDS have been given high political profiles, high maternal mortality has persisted in the last decade with minimal financial or political attention. In countries such as Botswana significant gains have been realized in reducing mother-to-child HIV transmission but high infant and under-five mortality rates still prevail. Progress in the reduction of child mortality in the subregion remains slow and inadequate to achieve MDG 4 targets in many of the countries. Of the 19 countries in the subregion, only nine[7] (47%) are currently on track to achieve those targets, seven[8]

7. Botswana, Ethiopia, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Tanzania and Zambia.
8. Comoros, Eritrea, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Tanzania and Zambia.
9. Lesotho, Swaziland and Zimbabwe.

(37%) progress, made no

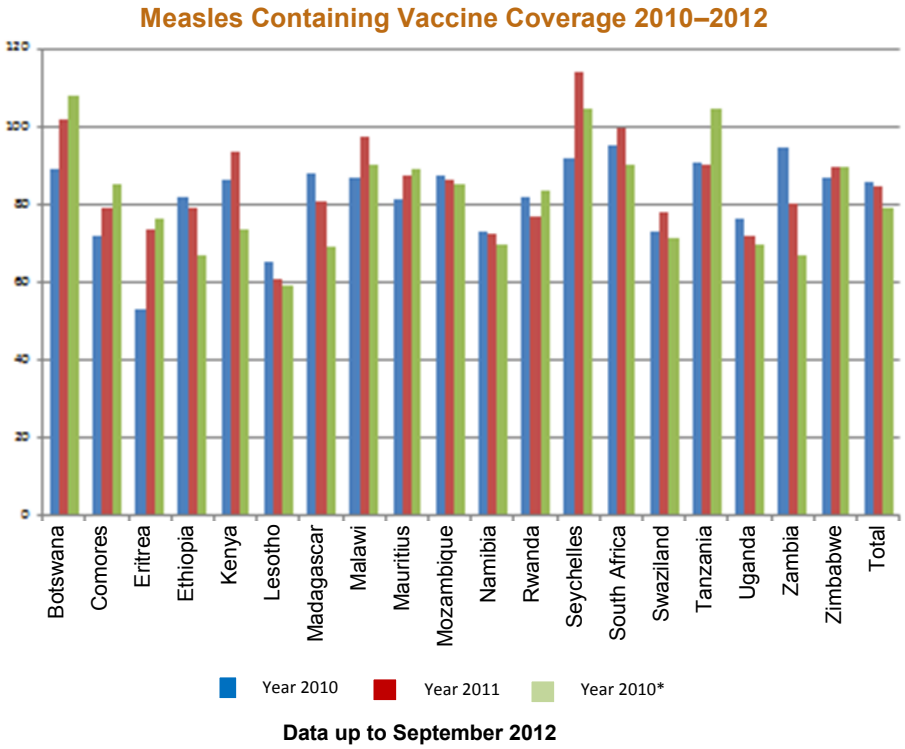
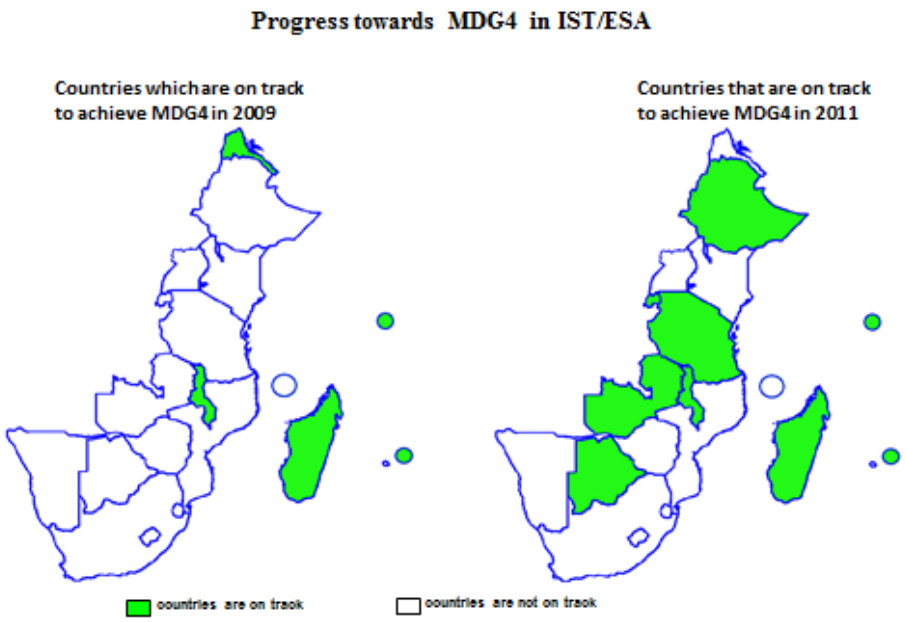


Figure 3: Progress toward achievement of MDG 4 in ESA

have made insufficient and three[9](16%) have progress at all (Figure



With increasing u surfaced in many countries in ESA. ght about a "dual epidemic" in the s ajority of countries in the subregion progress towards achieving the heal

These challenges in the subregion. Initiatives such as mergency Plan for AIDS Relief (PEPF countries. Regional partners such as East, Central and Southern Africa-H and commitments. The humanitariar olled out in most countries and pr nd responding to emergencies.

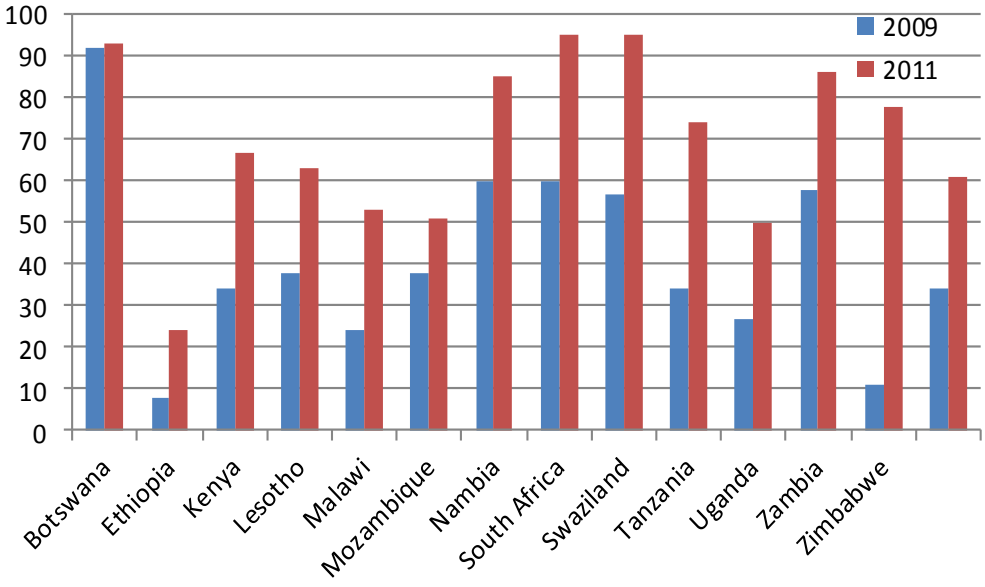


Figure 4: Percentage of HIV positive pregnant women is ESA countries receiving ARVs for PMTCT, 2011 compared with 2009

2. TAKING STOCK: KEY ACHIEVEMENTS IN 2012

2.1 Disease prevention and control cluster

HIV/AIDS

During the year, technical support was provided for expansion of HIV/AIDS services and adaptation by Member States of WHO guidelines and tools on HIV/AIDS. In all, eight guidelines were developed specifically on antiretroviral therapy (ART), pre-exposure prophylaxis, male circumcision devices, HIV testing and counselling (HTC), care and treatment decentralization, adolescents, and hormonal contraception and HIV. Various guidelines, including those on ART, PMTCT, HTC, most-at-risk populations, TB and HIV, integrated management of adolescent and adult illness, integrated management of childhood illness, and integrated management of AIDS in pregnancy and childbirth were adapted and revised in five countries. Programme reviews were conducted in five countries for seven programme areas and feedback was provided to the countries. Furthermore, 14 countries were assisted to build capacity for implementation of WHO guidelines and tools. Eritrea, Lesotho, Mauritius, South Africa and Zanzibar received support to develop policies, strategies and national health sector strategic plans for HIV/AIDS.

In the areas of HIV/AIDS, TB and malaria surveillance systems, monitoring and evaluation, Kenya, Mozambique, Swaziland, Tanzania and Zimbabwe received support to build capacity for disease and drug resistance surveillance, population-based surveys and special studies. In addition, the programme contributed to the development of the 2012 WHO Global HIV drug resistance and global AIDS reports. Monitoring and support missions for voluntary medical male circumcision were also undertaken in Lesotho and Zimbabwe in collaboration with the Gates Foundation.

Regional economic communities such as SADC and the East African Community (EAC) received support to build regional

partnerships. SADC and ECSA-HC received help to develop regional HIV/AIDS guidelines. Resource mobilization efforts of the programme resulted in mobilization of US$ 100 000 from the German Agency for International Cooperation (GIZ) for strategic use of antiretrovirals in 2013 and US$ 310 000 from the Global Fund to conduct a HIV serobehavioural survey. Namibia and SADC received support to develop phase 2 proposals for funding by the Global Fund.

Tuberculosis

All countries in the subregion were successfully supported to implement and sustain their medium-term development plans for TB control, which are consistent with the global Stop TB strategy. The majority of the countries successfully used the medium-term plans to secure TB control funding from the Global Fund. End-term TB programme reviews were conducted in Angola and Sao Tome and Principe. The TB unit for the ESA IST led the comprehensive review of the Malawi TB and HIV operational plan as a precursor to the development of a successor operation plan.

Jointly with the Dutch KNCV Tuberculosis Foundation, the ECSA-HC secretariat and the Centre of Excellence for Multidrug-resistant TB in Rwanda, best practices in TB and HIV were shared, new WHO guidelines for TB and TB and HIV control were disseminated, and capacity was strengthened in programmatic management of drug-resistant TB.

In collaboration with the Global Drug Facility (GDF), the IST (i) provided support to all eligible countries to apply for and access free quality-assured, first-line anti-TB medicines, (ii) conducted annual monitoring missions to GDF-supported programmes to ensure renewal of GDF grants for the full three-year course, and (iii) successfully brokered agreements for cross-country donations or lending to cover shortfalls in the countries. Furthermore, partnering with the African Pharmaceutical Society, the IST helped built capacity in supply chain management in 15 countries. Practically all the countries in the subregion now have capacity for or access to early diagnosis of TB and drug-resistant TB for all suspects. Uganda qualified as a candidate for a TB supranational laboratory and is currently providing that service on a probation basis.

In the area of partnerships and mobilization of resources, support was provided to the regional economic communities, especially ECSA-HC and SADC; international NGOs such as the International Union Against Tuberculosis and Lung Disease (or The Union); KNCV Tuberculosis Foundation; the Regional Centre for Quality of Health Care; the Centre of Excellence for Multidrug-Resistant Tuberculosis for East Africa; and the Global Fund in the area of TB control and prevention. With this support, the SADC Secretariat drafted a Heads of State Declaration on Tuberculosis Control in the Mines and the code of practice to implement the declaration. All countries supported through two special joint initiatives to apply to the GF Transitional Funding Mechanism were successful in mobilizing financial resources for maintaining essential services or scaling up established TB control programme activities.

In the areas of TB surveillance and operational research, the IST provided support to conduct national TB prevalence surveys in the Gambia, Nigeria, Tanzania and Rwanda during the year and to plan for similar surveys in Ghana, Kenya, Malawi, South Africa, Uganda, Zambia and Zimbabwe. Field operations were piloted in Ghana and Malawi, and Kenya, Zambia and Zimbabwe finalized their survey protocols.

Malaria

The malaria programme review guidelines were appraised and project proposals developed for mobilizing resources from partners such as the Office of International Cooperation — Principality of Monaco/French Cooperation and the Global Fund. Partnerships were established with SADC, the Southern African Regional Network for Roll Back Malaria, the East African Roll Back Malaria Network, the African Leaders' Malaria Alliance and the French Cooperation. Eight countries received support to develop strategic plans for malaria elimination.

A joint IST/ESA and WCO team assessing a refugee camp in Rwanda

Eritrea, Malawi, Tanzania, Uganda and Zambia received support to conduct therapeutic efficacy studies on malaria case management and diagnosis. Assessments were undertaken on malaria in pregnancy (MIP) in Malawi, Uganda and Zambia, best practices were documented and solutions were provided to the challenges identified for improved MIP outcomes.

Support was provided to all the countries to submit data for the World malaria report, 2012 and to Rwanda, South Africa, Uganda and Zimbabwe to monitor and evaluate development of their plans. In addition, Botswana, Comoros, Eritrea and Zimbabwe received support for community-based surveys. In collaboration with WHO country offices, malaria bulletins were started in Malawi and Uganda and the IST/ESA malaria surveillance bulletin was produced for the first time (Malaria Surveillance Bulletin Number 1, December 2012).

Disaster preparedness and response and disease surveillance and response

Technical support was provided to respond to Ebola and Marburg VHFs in Uganda, resulting in timely control of the outbreaks and reasonable case fatality rate (CFR), which was 67% for Ebola and 47% for Marburg. Although these levels are high, they could easily have been 100% given the extremely virulent nature of the viruses. Timely and successful public health responses were mounted for flooding in the Comoros and the refugee crises in Rwanda. In both situations, there was no disease outbreak and the health situation of the affected populations remained stable throughout. The lessons learnt from the emergency health response to the 2011/2012 Horn of Africa drought crisis were documented and are being used to guide ongoing response by partners to the crisis.

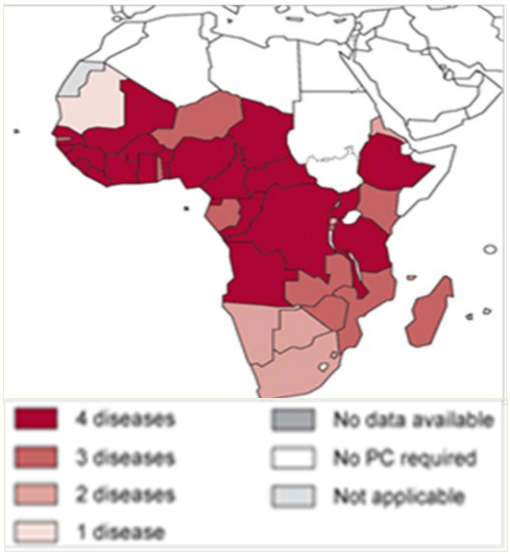
Technical support was provided to develop three key guidance documents required to implement the regional disaster risk management (DRM) strategy, namely, the framework for post-conflict or disaster health system recovery, assessment guidelines and tools for country capacity for DRM, and guidelines for developing standard operating procedures for health response to emergencies and disasters.

Neglected tropical diseases

As effective and sustainable NTD programmes require integrated and multiyear country plans, the NTD programme, in collaboration with the Regional Office for Africa, organized three workshops in 2012 to accelerate the finalization of country master plans. Each master plan was summarized into four pages and all briefs of master plans were

consolidated into a single document, which will facilitate overall understanding of NTD goals, priorities and milestones in the African Region. The master plan document provides an overview of the strategic approach for the control and elimination of NTDs in the African Region. Information on the financial resource requirements for the control or elimination of NTDs in the African Region was put together and shared with partners.

Figure 5: Countries requiring preventive chemotherapy by number of diseases in the African Region (lymphatic filariasis, soil transmitted helminthiasis, onchocerciasis and schistosomiasis)



Source: NTD/WHO, Geneva 2010

Guidelines for the coordinated mapping of NTDs in the African Region were reviewed and finalized. In addition, tools and mechanisms for coordinating support for NTD mapping were agreed upon, the mapping status and needs of prophylactic or preventive chemotherapy were updated and a schedule for NTD mapping in the countries in the WHO African Region was developed. As shown in Figure 5, more than half of the countries in the subregion are affected by three or more NTDs.

Technical assistance and guidance were provided to the countries on different aspects of their NTD control and elimination programmes, including programme review, management of drug donations, and capacity building in monitoring and evaluation. The first of the series of training workshops on monitoring and evaluation of integrated national NTD programmes for more efficient and effective measurement of progress towards control, elimination and eradication of targeted NTDs trained 27 participants from nine countries.

There is an increase in the number of countries and people within the countries that are covered by MDA activities in all NTD programmes. Some new countries started the MDA approach in 2012, such as Zimbabwe, which launched its

first MDA for schistosomiasis; Kenya, which resumed the school-based deworming campaign for STH; and Zambia, which implemented schistosomiasis, STH and trachoma MDA in some districts.

2.2 Immunization and vaccine development cluster

To sustain the interruption of transmission of the wild polio virus in the subregion, preventive polio supplementary immunization activities (SIAs) were conducted with support from the IST to boost immunity against polio in high risk districts in Eritrea, Ethiopia, Kenya and Uganda. Support was provided to Kenya to contain an outbreak of confirmed circulating vaccine-derived poliovirus related to a Somalia outbreak that occurred in the Dadaab refugee camp in the Garisa district of Kenya.

In the areas of routine immunization and new vaccines, accelerated efforts to immunize unimmunized children using the reaching every district (RED) strategy, including the use of the African vaccination week in 14 countries, resulted in about 60% of the countries in the subregion achieving DPT3 coverage greater than 80% (Figure 2). Nine countries[10] were supported to introduce the pneumococcal vaccine, and Botswana, Malawi, Rwanda and South Africa introduced the rotavirus vaccine during the year. Essential vaccine management assessments were conducted in Malawi,

Country	Target age	Target population	Vaccinated	Adm coverage	Post SIAs coverage survey	Admi cov % districts >95%	Other interventions
Eritrea	9–47 months	371 000	277 928	75%	95.7%	16%	OPV, Vitamin A, deworming
Uganda	6–59 months	6 314 309	6 283 441	100%	95%	73%	OPV, Vitamin A, deworming
Namibia	9 months–14 years	1 235 850	1 166 796	94%	89%	84%	Vitamin A, OPV
Zambia	9 months–14 years	6 458 977	7 503 515	116%	96%	93%	OPV, Vitamin A, deworming
Zimbabwe	9–59 months	1 566 444	1 613 437	103%	92%	92%	OPV, Vitamin A
Kenya	6–59 months	6 022 264	6 022 264	101%	90%	66%	OPV, Vitamin A
Total		21 968 844	22 867 381	104%			

Mozambique, Swaziland and Tanzania, countries that also received technical support to assess the adequacy and functionality of their cold chains for routine and new vaccines. In addition, all countries in the subregion received support to update their multiyear plans.

With support from the IST, a total of 22 867 381 children in Eritrea, Kenya, Namibia, Uganda, Zambia and Zimbabwe received measles and oral polio vaccination and vitamin A supplements (Table 2). Deworming exercises were conducted in Eritrea, Uganda and Zambia. Twelve[11] of the nineteen countries in the subregion received support to develop strategic plans for measles elimination for the period 2012–20. Tanzania was validated as having achieved elimination of maternal neonatal tetanus, leaving only three countries (Somali region of Ethiopia, Kenya and

10. Botswana, Kenya, Malawi, Madagascar, Rwanda, South Africa, Tanzania, Uganda and Zimbabwe.
11. Botswana, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Mauritius, Rwanda, Swaziland, Uganda, Zambia and Zimbabwe.

Madagascar) out of 19 as yet to achieve that status.

Table 2: Countries that implemented integrated measles SIAs in 2012 in ESA

2.3 Health promotion cluster

Child and adolescent health

An intercountry course on essential newborn care was conducted for 21 resource people from six countries. Kenya, Mozambique, Rwanda and Zanzibar received support to adapt their facility-level, essential newborn care training materials to incorporate into the resuscitation component content on helping babies breath in their first golden minute.

In the area of integrated management of childhood illnesses (IMCI), a multicountry orientation and capacity building workshop was conducted in Uganda for 38 participants drawn from eight countries[12] to fast-track implementation of the IMCI computerized adaptation and training tool (ICATT) as a training approach to scale up IMCI implementation. The cumulative total number of health workers trained in ICATT now stands at 115 from 15 countries. The next step for implementation of ICATT will see the development of the tool in the respective countries. Support was provided to Eritrea, Kenya, South Africa and Zambia for national level orientation and training of trainers and to finalize them with ICATT adaptation.

With technical support from IST and using a grant from the Russian Federation, Ethiopia conducted countrywide orientation and adaptation of the WHO generic hospital assessment tool to evaluate the quality of paediatric referral care and hospital performance to improve paediatric care in 10 hospitals. The results from this assessment were disseminated and support was provided to implement the plans to address the gaps identified.

The first intercountry advocacy and capacity building workshop was conducted in Botswana for 21 trainers from Botswana, Eritrea, Ethiopia, Malawi and Zambia on caring for the child's healthy growth and development in the community. The trained facilitators further trained 30 community health workers, all from Botswana, in early child development.

Making pregnancy safer

Ethiopia, Kenya, Zambia and Zanzibar received support to revise their maternal and newborn health road map for accelerating the reduction of maternal and newborn mortality. This was done using the short programme review (SPR) tool. Technical support was provided also to Swaziland to review and finalize its midwifery curriculum, protocols and

12. Eritrea, Ethiopia, Kenya, Lesotho, Malawi, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
13. Botswana, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Liberia, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

standards and the sexual and reproductive health strategy.

Lesotho and Zanzibar were supported to complete their emergency obstetric and neonatal care (EMoNC) needs assessments to inform policies on the gaps and remedial actions needed in the countries. In the context of the UN Secretary General's global plan for women's and children's health and the recommendations of the Commission on Information and Accountability (CoIA) for women's and children's health, eighteen[13] CoIA Anglophone countries were supported to strengthen maternal death surveillance and response as a way of improving the quality of care for mothers and newborns and to address the barriers to quality emergency obstetric and neonatal care.

In some of these activities the IST partnered with relevant WHO partners, the African Union, USAID, the ECSA-HC, and United Nations agencies such as UNFPA and UNICEF at both the headquarters and in the subregion.

Prevention of mother-to-child transmission

Technical support was provided for planning, including developing costed plans, and reviewing progress towards elimination of mother-to-child transmission of HIV and syphilis in the countries. Ethiopia received support to plan and coordinate the interagency task team (IATT) and to draft a plan for elimination of mother-to-child transmission of HIV and syphilis, a major step in their acceleration plan launched in December 2011.

In collaboration with UNICEF, UNFPA and UNAIDS, the IST finalized the Africa Region's strategic framework document for the elimination of mother-to-child transmission of HIV. The document was used together with information from the unit on HIV in planning activities for the 2012–13 biennium. WHO, in collaboration with UNICEF and UNAIDS, will publish and print the document for dissemination. The programme also collaborated with UNICEF to undertake a rapid assessment of paediatric HIV care in Swaziland, Tanzania, Uganda and Zimbabwe as well as orient staff on tools to facilitate integration and scaling up of prevention of mother-to-child transmission interventions under the maternal, newborn and child health (MNCH) platform.

Madagascar, Mozambique, Tanzania and Zambia were supported to scale up interventions for elimination of congenital syphilis after a workshop using seed funding for these activities. The INtegrating and Scaling up PMTCT through Implementation REsearch (INSPIRE) project was developed to support the countries to conduct research and document best practices in maternal, newborn and PMTCT, working in collaboration with research institutions and partners. Activities included provision of technical assistance for the preparation of documentation for submission of research protocols to local ethics review boards and WHO Expert Review Committee (ERC). The INSPIRE investigator project, which is a partnership of WHO, the PMTCT Programme and the Canadian International Development Agency, was coordinated by regular conference calls involving all levels of WHO and with the implementing partners, ministries of health in Malawi and Zimbabwe and meetings with grantees in Zimbabwe.

Protection of human environment

The protection of human environment programme contributed to the development of the global plan on insecticide resistance management, which was created by the Global Malaria Programme, worked with the Regional Office for

Africa to develop a standardized protocol for testing malaria vector susceptibility to insecticides in the African Region and contributed to the development of a protocol for yellow fever vector surveillance.

To date the vector control strategy heavily relies on two major insecticide-based interventions, indoor residual spraying (IRS) and use of long-lasting, insecticide-treated nets. These interventions use a limited group of insecticides. Efforts to produce and document the scientific evidence on the potential role of other interventions such as larval control methods and anti-adult interventions are underway through pilot projects. Implementation of pilot projects looking at these particular issues continued in five countries with financial support from the Global Environmental Facility (GEF) and in collaboration with the United Nations Environment Programme (UNEP). Evidence-based policy development is one of the challenges for malaria-endemic countries in controlling the disease due to the lack of a well-established mechanism of trade-off analysis.

As part of the project on reduction of health risks through the management of public health pesticides, a number of studies were conducted globally on related issues, resulting in the publication of four articles in peer-reviewed scientific journals during the year.

An IST/ESA HPR team provide technical support for Ebola outbreak response in Uganda

Support was provided to Ethiopia to develop a national strategy for insecticide resistance monitoring and management, to Rwanda to develop a comprehensive five-year strategic plan for environmental health management and to Botswana for guidance on how to target and intensify IRS, based on malaria case distribution and the use of larviciding in malaria elimination.

Social determinants of health

Support was provided to Namibia, South Africa and Zimbabwe to review and revitalize school health approaches. A major outcome of IST's technical support to South Africa was the official launching by the South African president of the integrated school health programme. Mozambique and Zimbabwe received support to undertake a global school-based student health survey, and Uganda was provided with support to respond to Marburg and Ebola outbreaks. At the regional level, the unit provided technical support for the global school-based health policy study.

South Africa was helped to document public health lessons learnt from the 2010 FIFA World Cup, in preparation for the 2013 African Cup of Nations.

Collaboration with the malaria programme helped create the 2012 malaria slogan for the World Malaria Day. Botswana received support to develop health-promotion messages for malaria elimination, and Mozambique to finalize the national malaria advocacy and communication strategy. In collaboration with the Making Pregnancy Safer (MPS) programme capacity in advocacy skills was built among SRH programme managers, health communicators and

promoters and community actors. This strengthened national capacity for effective advocacy for renewed emphasis on family planning and for increased visibility, availability, utilization and quality of family planning services.

2.4 Health systems strengthening cluster

Health policies and service delivery

Lesotho and Rwanda received help to develop new national health sector strategic plans, Kenya was provided support for a joint review of the national health sector plan, and Comoros, Rwanda and Zimbabwe were assisted to develop proposals for GAVI Alliance. Kenya, Lesotho, Malawi, Mozambique and Rwanda were helped to develop proposals for health systems strengthening, and proposals from Eritrea and Zambia for reprogramming were peer reviewed. Zimbabwe and Comoros were supported to respond to comments from the independent review committee on the GAVI Alliance health strengthening proposals. The programme participated in the regional human resources for health expert working group in Addis Ababa, Ethiopia, to initiate work on regional health workers' norms and standards, training of WHO staff[14] in the Global Learning Programme (GLP) on national health policies and strategic plans, and updating of the GLP training materials for the Regional Office.

Other important collaborative activities included (i) participation in the Regional Coordinating Mechanism for Africa, the UNDG-ESA health working group, the HHA initiative steering committee meeting, the two GAVI Alliance subregional working group meetings, and the EPI managers' meeting; (iii) collaboration with other programmes to develop a framework for post-disaster health recovery with the disease prevention and control cluster; (iv) joint development and updating of comprehensive multiyear plans for five countries,[15] (v) and development of the concept note for integrated technical support by the IST to countries.

Human resources for health

Capacity was built for a total of 180 participants in the use of workload indicators for staffing need (WISN) tool in South Africa, Swaziland and Zambia. In addition, Namibia was helped to finalize its human resources for health strategic plan and policy, and guidance was provided to Malawi and Swaziland to draft health workforce strategic plans. Support was provided to Swaziland to develop a competency-based midwifery curriculum and standards and to train 22 staff in curriculum review and development. Strategic discussions were held with partners, namely with ECSA on strengthening

14. WHO country offices of Botswana, Eritrea, Gambia, Ghana, Lesotho, Liberia, Namibia, South Africa and Swaziland, and IST/ESA.
15. Ethiopia, Lesotho, Mozambique, Tanzania and Uganda.

national human resource units, with the Regional Network on Equity in Health in Southern Africa (EQUINET) on research work on the engagement and implementation of the WHO Code of Practice on International Recruitment of Health Personnel in ESA countries, and with the African Medical School Association on the progress made and strategies for marketing as part of its revitalization.

Health financing and social protection

Support was provided for costing of a hospital strategic plan in Seychelles, and Botswana received support for a situation analysis on health financing. The countries in the subregion were supported to prepare for the July 2012 Conference of Ministers of Finance and Health in Tunis, Tunisia, and 17 CoIA countries[16] in the African Region were helped to develop road maps for tracking resources. Over 40 national health accounts experts were trained on the newly revised system of health accounts (SHA 2011), and Comoros was supported to initiate a new national health accounts study.

EQUINET received support to provide training on health financing and health equity. The draft dashboard for prioritization of country needs based on GAVI Alliance cofinancing requirements was reviewed and, in collaboration with the Immunization and Vaccine Development Unit, the comprehensive multiyear plans were reviewed and data on vaccine prices from countries in eastern and southern Africa were collected for a database of vaccine prices and procurement systems.

Patient safety programme

Patient safety situation analyses were completed in 14 countries[17] in the African Region as well as in nonprogramme hospitals in countries such as the Democratic Republic of Congo, Nigeria and Zimbabwe and a first-of-its-kind report on the situation of patient safety in the African Region was produced. Furthermore, support was provided for a survey to capture the response of the ministries of health to the programme in eight countries,[18] patient safety sensitization visits were made to 10 countries[19] for hand hygiene and the safe surgical checklist initiatives, and a survey to assess the implementation of the WHO surgical safety checklist was completed in 15 African countries[20] and the report shared with the implementers.

Training workshops and national patient safety implementation workshops engaged representatives from 18 countries; all three IST sites were briefed about the tools, resources and goals of patient safety practices; and following a

16. Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Zambia, Rwanda and Zimbabwe.
17. Burundi, Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Mali, Malawi, Mozambique, Niger, Rwanda, Senegal, Tanzania, Uganda and Zambia.
18. Benin, Burkina Faso, Cape Verde, Guinea, Liberia, Mauritania, Sierra Leone and Togo.
19. Benin, Burkina Faso, Burundi, Côte d'Ivoire, Gabon, Ghana, Lesotho, Nigeria, Rwanda and Swaziland.
20. Botswana, Burundi, Comoros, Kenya, Madagascar, Mali, Namibia, Niger, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
21. Cameroon, Ethiopia, Ghana, Kenya, Mozambique, Nigeria, South Africa, Tanzania and Zimbabwe.
22. Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

successful pilot testing conducted in Ethiopia and Zimbabwe, the WHO patient safety multiprofessional curriculum guide was disseminated to ESA countries. A guidance document on the development of national patient safety policy and strategic plans was created and refined by an expert committee for the use of all Member States' policy-makers.

Essential medicines

Support was provided for the finalization of the Region's health systems strengthening master draft proposal, "Strengthening health systems to accelerate the achievement of health Millennium Development Goals in the African Region". In collaboration with the HIV/AIDS programme, a module on procurement and supply management of HIV/AIDS medicines was reviewed and finalized and pilot training on HIV/AIDS was provided to national programme managers from nine countries.[21] Working with the TB programme, the IST facilitated the second Africa Regional Conference on Management of TB Medicines with the participation of 13 countries.[22]

Technical support was provided to the SADC secretariat to review and finalize a strategy for pooled procurement of essential medicines. This document was adopted by SADC Member States. The Democratic Republic of Congo received support for a rapid assessment of the current procurement and supply management situation and for building a consensus on a national procurement and supply management system with the support of various stakeholders operating in the country.

2.5 General management cluster

Finance and budget management

Timely and appropriate budget and finance support was provided throughout the year to both the technical units in ESA and the country offices for implementation of programmes. Nine country offices[23] were given such support, which led to significant improvements in their financial and budgetary management and resulted in higher quality of work. Guidance was provided to ensure compliance with WHO rules and regulations and, as planned and agreed on with donors, there was continual review of work plans and related awards for all country offices and IST technical units. At the IST, several cost-recovery and cost-cutting measures were implemented during the year to ensure that office running costs were kept at practical low levels, given the budgetary constraints in the organization, but without compromising quality, efficiency or effectiveness. Air ticket costs were reduced from US$ 967 000 in 2011 to US$ 846 000 in 2012.

Human resources management

Six country offices[24]received support to implement Country Management Support Units (CSUs), bringing the coverage to 88%. Furthermore, support was provided to organize 41 regional meetings that were held in Harare, Zimbabwe,

23. Botswana, Kenya, Lesotho, Mozambique, Namibia, Rwanda, Swaziland, Tanzania and Uganda.
24. Eritrea, Lesotho, Namibia, Rwanda, Zambia and Zimbabwe.

during the year, and to recruit 35 international interpreters to service 13 subregional meetings that required interpretation. In addition, technical support missions to country offices were undertaken in Lesotho, Namibia, Rwanda, South Africa and Tanzania to strengthen human resources management.

In collaboration with the Regional Office's staff development and learning unit, several capacity building workshops were supported during the year. These included training on the new Inter-country Management Support Unit (ISU) and Central Support Unit structures, end-to-end processes in the global management system (GSM), operations and administrative officers' roles and responsibilities under the Central Support Unit structure, and human resources, e-Imprest and programme management modules in GSM.

The staff clinic provided 505 consultations, treated 244 patients, conducted 59 periodic medical examinations and facilitated 18 referrals, six hospital admissions and five medical evacuations during the year.

Information and technology management

Back-up support was provided to the IST and all country offices in the subregion and a number of new systems were introduced to improve and streamline IT management. An electronic document approval routing system (Docushare) that reduced printing of documents for approval in addition to facilitating speedy approval of memos was introduced in the IST. A shared and centrally managed printing service was introduced, leading to consolidation of printers and reducing their number from 105 to 40. This reduced printing volumes from 88 000 sheets in October 2012 to 11 000 sheets by December 2012. Printing cost information is accessible through software monitoring of printing volume per staff or unit.

Installation of closed-circuit television in the office led to a decrease in security costs as a result of the reduction in number of guards required. The installation of a wireless system enables staff to connect to the Internet from anywhere in the office premises. Staff capacity in MS Office and general IT was improved through training, and online training was provided for 50 staff members to acquire the International Computer Driving License.

On-site support was provided to seven countries,[25] which has improved information technology management, quality of service and maintenance of IT infrastructure. Implementation of technology management projects has been completed in 15 out of the 19 country offices and financial support was provided to five country offices. Online training and testing were undertaken for 23 information technology management focal points in ESA in information technology infrastructure library, leading to certification of all the focal points.

3. LOOKING BACK: KEY LESSONS FROM 2012

3.1 Important enabling factors

[25] Botswana, Ethiopia, Mauritius, Mozambique, Namibia, Swaziland and Tanzania.

A number of enabling factors contributed to the success of IST work during the year. Chief among these were:

- Delegation of authority: Decentralization and delegation of authority by the Regional Director has resulted in semi-autonomy and created an enabling environment in the ISTs, leading to quick decision-making, speedy turnaround of requests and fast administrative support. This contributed greatly to timely country support. Decentralization of funding for some of the programmes supported by the IST also facilitated decision-making and country support.
- Partnerships: Strong collaboration and partnerships within WHO (with the Regional Office and headquarters and across the IST programmes) and outside WHO with other UN partners in the context of the UNDG, donors and regional economic communities such as SADC, EAC and Intergovernmental Authority on Development (IGAD) facilitated country support and resource mobilization.
- Networking: Use of country-level national professional officers and staff of the Regional Office and headquarters to complement the technical capacity of the IST and undertake critical missions ensured that most requests for technical assistance were met. In addition, deployment of the national professional officers for subregional and regional missions helped to strengthen these staff's technical capacity and improve their confidence and field experience. This practice should be encouraged through regular dialogue with WHO regions to facilitate timely release of their staff for subregional duties. However, caution is needed to ensure implementation of country offices' plans is not disrupted.
- Advocacy and resource mobilization: High-level advocacy by the IST resulted in increased funding, especially to the neglected tropical diseases, immunization and vaccine development, malaria, and disaster preparedness and response programmes, ensuring their timely implementation.
- Improved capacity: Recruitment of two additional staff boosted administration and financial and human resources management in the IST. Furthermore, introduction of new information technologies such as GSM, Docushare and ePMDS, and printer rationalization contributed to making IST operations faster and more cost-effective.
- Commitment and leadership: The dedication, commitment and hard work of the IST technical and administrative staff contributed immensely to the success achieved during the year. Committed and cooperative leadership in some of the ministries of health was a significant factor in reaching IST targets and generating deliverables during the year.

3.2 Major constraints

The IST for ESA faced a number of constraints during the year that affected its work, including the following:

- Staffing: Inadequate staffing was one of the critical challenges to the operations of the team during the year. Following staff rationalization and reduction by 30% in 2011, many programmes supported by the IST now have only

one or two programme officers to cover all the countries in the subregion, which rose from 18 to 19, and will increase 20 when South Sudan joins the African Region.

- Funding: Some of the IST programmes were not fully funded. For instance, there was a significant reduction in the funding level for IST administration and operations, going from US$ 3 million in the 2010–11 biennium to US$ 1 million in the 2012–13 biennium. This is a major obstacle to scaling up some IST programmes. Despite the limited human and financial resources, requests for technical support from Member States continued to increase during the year, overstretching available resources.
- Multiplicity of partners: The increased global momentum in the control of important diseases such as AIDS, TB, malaria and neglected tropical diseases has resulted in many partners offering parallel support to Member States, hampering effective coordination.
- Poor coordination: Frequently changing country priorities, last minute requests for technical support by Member States and frequent postponement of activities were major constraints to the work of the IST.

3.3 Key lessons

Many lessons were learnt in 2012 that will help to shape the strategic focus and operations of the IST. These include:

- Integrated approach to provision of technical support: Provision of technical support to countries in an integrated manner reduces costs associated with financial, human and time resources. Joint planning and identification of country priorities with WHO country offices—and by extension the ministries of health—is key to effective, long-term and sustainable technical support.
- Programme coordination and partnerships: Effective coordination and strong partnerships within and outside the organization are critical for resource mobilization and effective, long-term and sustainable technical support.
- Whereas real-time monitoring of the health situation in the subregion is desirable, it requires substantial support from the IST to enhance the countries' capacity for disease surveillance.
- Communication: Good communication and knowledge and information sharing across and outside the organization are very important factors for promoting WHO core principles and strategies and have the potential to improve the visibility of the organization.
- Networking: Innovative ways such as accessing expertize from other partners through sharing of their staff rosters and using experienced ministry of health staff to support other countries will add value to the work and ensure increase in the technical capacity base of the IST.

4. LOOKING FORWARD: STRATEGIC VISION FOR 2013 AND BEYOND

Drawing from lessons learnt and key challenges of 2012, the strategic vision of IST in 2013 and the coming years is to ensure an integrated approach to providing technical support to Member States to meet their requirements in a holistic and harmonized manner. To this end, approaches for health systems strengthening will be mainstreamed into all programmes and joint technical support missions involving different programmes of the WHO and relevant partners

will be encouraged. The lessons learnt and key achievements made so far will be consolidated and used to further strengthen IST capacity for providing technical support to Member States.

IST strategies and deliverables will be realigned to ensure that they contribute not only to the overall strategic vision of WHO but also ultimately to achieving key global and regional targets such as those of the Millennium Development Goals, International Health Partnerships, the Ouagadougou Declaration on Primary Health Care, and the Abuja and Tunis declarations on health financing. In this regard, partnerships and the advocacy role of the organization will be enhanced to ensure mobilization of the required resources to support Member States and also for the organization's activities. The countries will be required to prioritize their interventions.

To achieve its strategic goals, the IST will specifically support the implementation of the following key interventions:

- Development and review of relevant national health sector policies and strategic plans and strengthening of country capacity for their implementation.
- Provision of technical support to the countries to adapt the disease treatment and management guidelines to their local context.
- Review of disease prevention and control programmes, programme development, development of strategic and operational plans in collaboration with the regional economic communities, and strengthening of supply chain management to ensure uninterrupted availability of medicines and other essential commodities.
- Acceleration towards achievement of universal health coverage.
- Implementation of the adopted African Region's strategies.
- Strengthening of the capacity for disease outbreak and disaster preparedness and response.
- Conducting of operational research and documentation of experiences and best practices.
- Strengthening of team building and staff motivation through staff retreats. Furthermore, teleconferences will be held regularly with country offices to improve communication and information sharing between the two arms of the organization and to ensure more purposeful and effective collaboration and technical support.
- Strengthening of the support unit of the IST to improve human resources management and understanding of WHO financial rules and regulations and GSM's end-to-end processes at both IST and country levels and to establish a strategic health operation centre.

5. CONCLUSION

The IST for ESA has had a significant number of achievements in the course of responding to the technical support needs of the countries. IST support has provided the countries with guidelines, tools and frameworks to facilitate improvement of their health outcomes. Furthermore, the IST has contributed to capacity building in various areas through training and on-site support. Health systems in the countries have been reviewed and policies and plans reviewed or developed. The outcomes, as seen from the country reports, indicate improvements in service coverage, reduction in morbidity and mortality and progress towards the achievement of the targets of the health MDGs.

Despite the achievements and improvements in health outcomes at the country level, a lot of work remains to be done for the countries to achieve universal health coverage and adequate progress towards the targets of the health MDGs, given the little time left before 2015. This will require more functional health systems, better coordination, improved partnerships and full commitment by the national authorities and their development partners. Indeed, universal health coverage provides the theme for IST technical support to countries for the period to and beyond 2015, a development agenda that is already being discussed globally.

To effectively provide the necessary technical support in the subsequent period, the IST will build on the lessons learnt and adopt an integrated approach for providing the support. This will help the IST to tap the synergies across the

ANNEXES

Annex 1: Table 1: ESA IST programmes by cluster

Cluster	Programmes represented	Programmes not represented
Disease prevention and control	Neglected tropical diseases	Mental health
	Acquired immunodeficiency syndrome (AIDS)	Violence and injuries
	Malaria	Noncommunicable disease prevention and control
	Tuberculosis	Integrated disease surveillance
	Disaster preparedness and response	Epidemic and pandemic alert and response
Immunization and vaccine development	Routine immunization and new vaccines	
	Polio eradication	
	Accelerated immunization initiatives	
Health promotion	Child and adolescent health	Gender, women's health and ageing
	Making pregnancy safer	Food safety
	Prevention of mother-to-child transmission of HIV	Nutrition
	Protection of the human environment	Health risk factors
	Social and economic determinants of health	
Health systems strengthening	Human resources for health	Health information system
	Health policies and services delivery	Knowledge management and sharing
	Health financing and social protection	Research policy and coordination
	Patient safety programme	Blood safety and laboratory technology
	Essential medicines	
General management	Accounts and finance management	
	Human resources management	
	Information and communications technology management	

Annex 2: Table 2: Reported MDR Cases in the ESA Subregion, by year for period 2004–2011

Country	2004	2005	2006	2007	2008	2009	2010	2011	Total to date	% of Regional notifications	Rank among notifiers
Botswana	0	12	0	139	126	101	106	46	530	0.8	7
Comoros	0	0	0	0	2	0	0	0	2	0.0	
Eritrea	0	0	0	0	0	0	0	11	11	0.0	
Ethiopia	0	0	0	145	130	233	140	212	860	1.4	4
Kenya	36	44	89	82	102	150	112	166	781	1.2	5
Lesotho	4	0	0	46	0	0	527	64	641	1.0	6
Madagascar	10	0	2	5	6	3	3	9	38	0.1	14
Malawi	0	9	0	12	25	6	40	26	118	0.2	13
Mauritius	0	0	2	0	1	1	2	1	7	0.0	
Mozambique	75	115	129	163	181	140	165	283	1251	2.0	2
Namibia	0	0	0	291	221	301	214	192	1219	1.9	2
Rwanda	0	35	0	105	79	78	90	76	463	0.7	8
Seychelles	0	0	0	0	0	0	0	0	0	0.0	
South Africa	3219	4120	5774	7429	8198	9070	7386	10085	55281	87.4	1
Swaziland	3	0	0	110	170	0	326	332	941	1.5	3
Uganda	17	46	0	67	26	57	93	71	377	0.6	9
United Republic of Tanzania	4	10	13	169	24	24	34	68	346	0.5	10
Zambia	37	0	50	27	56	29	0	nr	199	0.3	12
Zimbabwe	0	0	0	1	1	29	28	118	177	0.3	12
Total	3405	4391	6059	8791	9348	10222	9266	11760	63242		
Regional totals	3501	4577	6120	9031	9751	12563	11771	14395	65679	100	
ESA totals as % of regional totals	97.3	95.9	99.0	97.3	95.9	81.4	78.7	81.7	96.3		