

AFR/RC57/2

The Work of WHO in the African Region

2006

Annual Report of the Regional Director



AFR/RC57/2
ORIGINAL: ENGLISH

The Work of WHO in the African Region

2006

Annual Report of the Regional Director

To the fifth-seventh session of the
Regional Committee for Africa
Brazzaville, Republic of Congo
27–31 August 2007

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville • 2007

AFRO Library Cataloguing-in-Publication Data

The Work of WHO in the African Region 2006:
Annual Report of the Regional Director

1. World Health Organization
2. Health priorities
3. Regional health planning
4. Africa

ISBN 92 9 023 115 7 (NLM Classification: WA 541)

© WHO Regional Office for Africa, 2007

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights reserved. Copies of this publication may be obtained from the Publication and Language Services Unit, WHO Regional Office for Africa, P.O. Box 6, Brazzaville, Republic of Congo (Tel: +47 241 39100; Fax: +47 241 39507; E-mail: afrobooks@afro.who.int). Requests for permission to reproduce or translate this publication – whether for sale or for non-commercial distribution – should be sent to the same address.

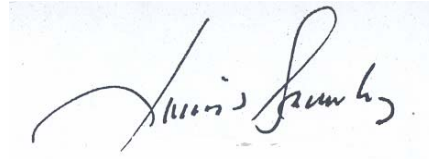
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization or its Regional Office for Africa be liable for damages arising from its use.

Printed in Mauritius

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 2006.

A handwritten signature in black ink, reading "Luis Gomes Sambo". The signature is written in a cursive style with a large initial 'L' and 'S'.

*Dr Luis Gomes Sambo
Regional Director*

CONTENTS

	Page
Abbreviations	vii
Executive summary	ix
	Paragraphs
1. INTRODUCTION.....	1–5
2. PROGRAMME BUDGET 2006-2007 IMPLEMENTATION	6–171
2.1 SIGNIFICANT ACHIEVEMENTS.....	6–160
OVERALL MANAGEMENT OF SECRETARIAT ACTIONS.....	6–39
Director-General, Regional Director and Independent Functions (DGO).....	8–12
WHO’s Core Presence in Countries (SCC)	13–17
External Relations (REC)	18–25
Governing Bodies (GBS).....	26–28
Planning, Resource Coordination and Oversight (BMR)	29–31
Health Information, Evidence and Research Policy (IER)	32–34
Knowledge Management and Information Technology (KMI).....	35–39
HEALTH SYSTEMS AND SERVICES DEVELOPMENT.....	40–54
Health System Policies and Service Delivery (HSP).....	41–43
Health Financing and Social Protection (HFS).....	44–45
Essential Medicines (EDM).....	46–48
Blood Safety and Clinical Technology (BCT)	49–51
Human Resources for Health (HRH).....	52–54
PREVENTION AND CONTROL OF COMMUNICABLE DISEASES	55–94
Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV)	56–63
Tuberculosis (TUB).....	64–66
Malaria (MAL)	67–69
Communicable Disease Prevention and Control (CPC).....	70–81
Communicable Disease Research (CRD).....	82–84
Epidemic Alert and Response (CSR)	85–89
Immunization and Vaccines Development (IVD)	90–94
PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES.....	95–114
Management and Surveillance of Noncommunicable Diseases (NCD)	96–100
Mental Health and Substance Abuse (MNH)	101–104
Tobacco (TOB).....	105–106

Health Promotion (HPR)	107–110
Violence, Injuries and Disabilities (INJ)	111–114
FAMILY AND REPRODUCTIVE HEALTH	115–135
Child and Adolescent Health (CAH)	116–121
Reproductive Health (RHR)	122–125
Making Pregnancy Safer (MPS)	126–128
Gender, Women and Health (WMH)	129–131
Nutrition (NUT)	132–135
HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT	136–151
Policy-making for Health in Development (HSD)	137–140
Health and Environment (PHE)	141–143
Emergency Preparedness and Response (EHA)	144–146
Food Safety (FOS)	147–151
ADMINISTRATION AND FINANCE	152–160
Infrastructure and Logistics (IIS)	153–155
Human Resources Management in WHO (HRS)	156
Budget and Financial Management (FNS)	157–160
2.2 FACTORS IN PROGRAMME BUDGET IMPLEMENTATION	161–171
Enabling Factors	161–168
Constraining Factors	169–171
3. PROGRESS TOWARDS IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS	172–200
Improving Access to Care and Treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and Beyond	172–178
Acceleration of HIV Prevention Efforts in the African Region	179–181
Control of Human African Trypanosomiasis: A Strategy for the African Region	182–186
Road Map for Accelerating the Attainment of the Millennium Development Goals Relating to Maternal and Newborn Health in Africa	187–191
Injury Prevention and Control in the African Region: Current Situation and Agenda for Action	192–195
Cardiovascular Diseases in the African Region: Current Situation and Perspectives	196–200
4. PERSPECTIVES FOR 2007	201–224
Overall Management of Secretariat Actions	201–204
Health Systems and Service Development	205–206
Prevention and Control of Communicable Diseases	207–212
Prevention and Control of Noncommunicable Diseases	213–215
Family and Reproductive Health	216
Healthy Environments and Sustainable Development	217–219
Administration and Finance	220–224

ANNEXES

	Pages
1. Budget Implementation, 2006, all sources and levels	47
2. Budget Implementation, 2006, by source of funds.....	48
3. Budget Implementation, 2006, by level	50

ABBREVIATIONS

ADB	African Development Bank
ACT	artemisinin-based combination therapy
ADB	African Development Bank
AFRO	Regional Office for Africa
AGFUND	Arab Gulf Programme for United Nations Development Organizations
AIDS	acquired immunodeficiency syndrome
APOC	African Programme for Onchocerciasis Control
ART	antiretroviral therapy
AU	African Union
CDC	Centers for Disease Control and Prevention (Atlanta, USA)
CDD	community-directed distributor
CDTI	community-directed treatment with ivermectin
CIDA	Canadian International Development Agency
CSDH	Commission on Social Determinants of Health
DALY	disability-adjusted life year
DFID	Department for International Development (UK)
DOTS	directly-observed treatment short-course
DPT	diphtheria, pertussis and tetanus
FAO	Food and Agriculture Organization
FGM	female genital mutilation
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSM	Global Management System
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i>
HIV	human immunodeficiency virus
HMN	Health Metrics Network
IBAR (AU)	International Bureau for Animal Resources
IDSR	Integrated Disease Surveillance and Response
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IPT	intermittent preventive treatment
IRS	indoor residual spraying
IST	Intercountry Support Team
ITN	insecticide-treated net
MDG	Millennium Development Goal
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization
NICD	National Institute for Communicable Diseases (South Africa)
OCHA	Office for the Coordination of Humanitarian Affairs (UN)
OFID	OPEC Fund for International Development
OPEC	Organization of the Petroleum Exporting Countries
PMTCT	Prevention of mother-to-child transmission (of HIV infection)
SADC	Southern African Development Community
TB	Tuberculosis
TDR	Special Programme for Research and Training in Tropical Diseases
UNDP	United Nations Development Programme

UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

1. *The work of WHO in the African Region 2006* is a progress report on the implementation of the Programme Budget 2006-2007 in the African Region for the first year of the biennium. As a general orientation for 2006-2007, the Director-General was committed to the decentralization policy in order to strengthen WHO's capacity in countries. This policy required delegation of authority and shifting appropriate human and financial resources to country level where they were most needed.
2. In line with this policy, the Regional Director, in a document entitled *Strategic orientations for WHO action in the African Region, 2005–2009*, defined five priorities for work. These included (i) strengthening the WHO country offices, (ii) improving and expanding partnerships for health, (iii) supporting the planning and management of district health systems, (iv) promoting the scaling up of essential health interventions related to priority health problems, and (v) enhancing awareness and response to the key determinants of health.
3. The areas of work constituted the essential organizational elements of the Programme Budget 2006-2007. This report thus presents the progress made during the year 2006 in the various areas of work. The report also highlights the main achievements with regard to the priorities of the Region.
4. The decentralization of WHO functions closer to countries and the establishment of the Inter-country Support Teams approached completion. There was increased technical support to all 46 countries based on the implementation of the *Strategic orientations for WHO action in the African Region*. This resulted in an increase of about 13% in technical support to countries over the previous year. The Regional Office was fully located in Brazzaville. Financial prudence was given considerable attention during the year.
5. In order to address the major health issues of the populations in the African Region, the main objective for 2006 was to scale up interventions and programmes towards achieving the Millennium Development Goals (MDGs). To achieve this, there was pursuit of greater partnerships and understanding of the critical factors affecting public health and the patterns of morbidity. A number of partnership meetings were held. One result was that various agencies, heads of state and stakeholders signed agreements to commit to specific health goals and intervention activities. In addition, the Partnership for Facilitating Health Development was created in collaboration with various development partners, the aim being to accelerate the achievement of the MDGs. Progress in reducing child and maternal mortality and morbidity remained slow, malnutrition was high, and there was increased stunting in several countries. Immunization services, however, made significant progress: DPT3 coverage was over 50% in 44 of the 46 countries of the Region.
6. HIV and AIDS remained major public health challenges in the African Region. An estimated 2.8 million adults and children were infected with HIV in 2006. This was more than all other regions of the world combined. HIV and AIDS remained the leading causes of mortality among adults aged 15–49. Provision of antiretroviral therapy (ART) expanded substantially. About 23% of the people in need of ART received the required drugs compared to 17% at the end of 2005.
7. The Africa Region continued to have the highest tuberculosis rates per capita. Defaulter and transfer out rates exceeded 15% in several countries. During the year, the existence of TB strains resistant to second-line anti-TB drugs was reported in the Region for the first time. Malaria still

negatively impacted on infant and maternal mortality. Despite the availability of cost-effective interventions and increased funding, coverage of at-risk populations remained unacceptably low. Avian flu received funding and technical support. Little progress was made in preventing and controlling the neglected tropical diseases.

8. Although access to prevention, treatment, care and support interventions for all conditions improved, it still fell short of demand. Inadequate human resources and weak health systems were some of the major contributing factors to limited access to health services. Gains were made in per capita expenditure on health, but macroeconomic policies did not fully impact on health service delivery. Improvements are still needed in a number of factors relating to public expenditure targets, inflation control, tobacco tax, and alternative health financing mechanisms.

9. In 2007, a concerted effort will be made to scale up activities using enabling factors such as synergistic interventions across the three levels of the Organization, as well as closer collaboration with the African Union, Economic Commission for Africa and regional economic communities. Working relationships with United Nations agencies, World Bank, International Monetary Fund, bilateral donors, and public and non-government sectors will be pursued.

1. INTRODUCTION

1. The WHO Programme Budget 2006-2007 is the first Programme Budget under the Eleventh General Programme of Work which covers the period 2006–2015. It is consistent with the Director-General's vision for improved results in countries and commitment to the decentralization policy in order to strengthen WHO's capacity in countries. This policy has been the basis of one of the main innovations of the biennium, the Intercountry Support Teams, which are bringing WHO support closer to beneficiary countries.

2. The implementation of Programme Budget 2006-2007 has offered an opportunity to develop operational workplans that are in line with the *Strategic orientations for WHO action in the African Region, 2005–2009*. The strategic orientations focus on five priorities: (i) strengthening the WHO country offices, (ii) improving and expanding partnerships for health, (iii) supporting the planning and management of district health systems, (iv) promoting the scaling up of essential health interventions related to priority health problems, and (v) enhancing awareness and response to the key determinants of health.

3. Despite the nominally increased Regular budget for 2006-2007 compared to the previous biennium, the approved funds were not sufficient to cover the health programme needs due to the high disease burden and weak health systems in the Region. However, with the allocated funds, the WHO Secretariat has effectively implemented planned activities and attempted to improve monitoring and accountability.

4. This report describes progress made on the implementation of the Programme Budget 2006-2007 for the first year of the biennium. It is based on findings for the Medium-Term Review exercise which is a mandatory Organization-wide requirement that aims to measure and assess achievements, promote a sense of performance orientation and accountability, and provide a basis for continuously improving the effectiveness and efficiency of the Organization. The report involved the compilation and consolidation of contributions from WHO country offices and Regional Office Divisions.

5. The report is organized according to 36 areas of work designated in the Programme Budget. The document comprises four parts and three annexes. The first part is the introduction. The second part presents main achievements of each area of work as well as implementation factors. The third part reports on the progress towards implementation of relevant Regional Committee resolutions. The fourth part is devoted to perspectives for the second year of the biennium. The annexes are tables showing budget implementation for the period covered by the report.

2. PROGRAMME BUDGET 2006-2007 IMPLEMENTATION

2.1 SIGNIFICANT ACHIEVEMENTS

OVERALL MANAGEMENT OF SECRETARIAT ACTIONS

6. The overall management of the WHO Secretariat in the African Region is conducted under the leadership of the Regional Director, while the Director, Programme Management coordinates the implementation of WHO programmes in the Region. All the strategic functions are implemented through the seven Divisions which aim at (i) leading the WHO Secretariat to assist Member States in

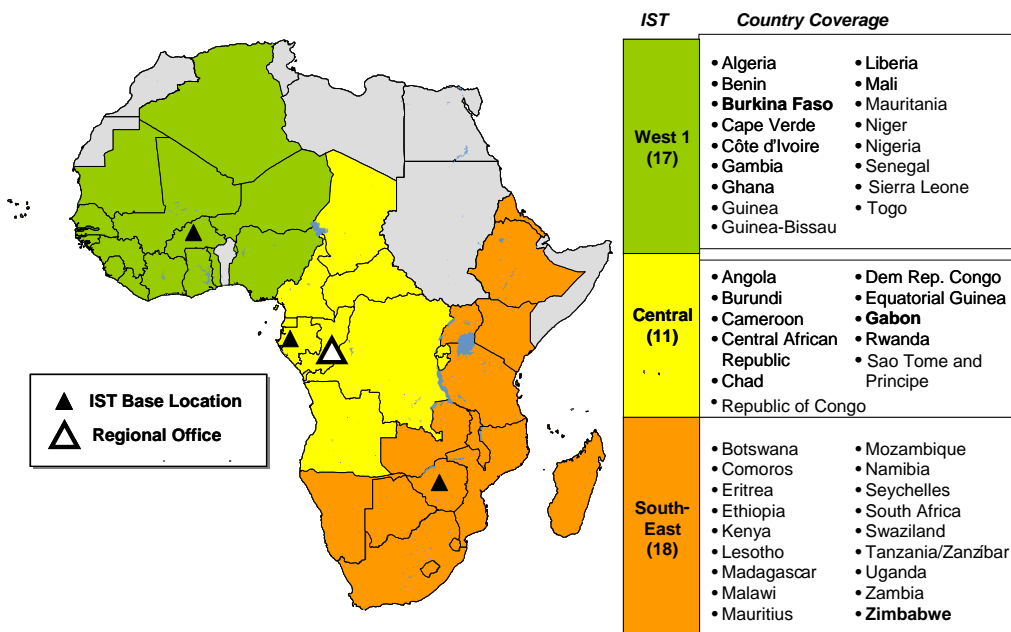
addressing health issues, (ii) applying the country focus policy, (iii) building partnerships and mobilizing additional financial resources, (iv) ensuring that countries implement the resolutions of WHO governing bodies, (v) improving the quality of planning and monitoring in the regional and country offices, (vi) promoting health research and ethics, and (vii) strengthening country capacity to generate and use quality health information.

7. For the first year of the biennium, efforts were made to implement the WHO decentralization policy and the Regional Office *Strategic orientations for WHO action in the African Region, 2005–2009*. The following sections describe the main achievements in the delivery of planned products and services by the various areas of work.

Director-General, Regional Director and Independent Functions (DGO)

8. In order to better support countries, the three Inter-country Support Team offices were established in Harare, Libreville and Ouagadougou. Each Inter-country Support Team (IST) covers a specific group of countries (Figure 1). This implementation was one of the most profound changes in the work of the Secretariat in the WHO African Region in recent years. In order to give proper orientations to the teams, guidelines were produced, and all teams were put in place.

Figure 1: Distribution of countries by Inter-country Support Team



9. High-level advocacy missions were undertaken and contributed to put priority health issues at the top of the action agendas of both heads of states and executive heads of major funding agencies such as the World Bank and African Development Bank. WHO and partners combined their efforts in the Abuja, Nigeria summit of June 2006. The result was the renewed commitment of heads of state to accelerate universal access to care, treatment and prevention of malaria, HIV/AIDS and TB. Additional support from the World Bank and African Development Bank was obtained to achieve the Millennium Development Goals.

10. Participation in high-level partnerships demonstrated the great interest and availability of WHO in partnerships to address major issues such as malaria as discussed at a meeting of the Presidential Malaria Initiative in Washington DC. The threat of an avian influenza pandemic triggered a permanent alert for the Region. The Regional Director called several meetings, and high-level commitments such as the Libreville Declaration on Avian Influenza were obtained. High-level authorities and national leaders urgently prioritized and addressed poliomyelitis eradication in Nigeria, which was also one of the countries in the Region experiencing avian influenza outbreaks.

11. The United Nations reforms were analysed according to feasibility and impact on WHO business in the African Region. Inputs were provided to the WHO perspectives for UN reforms coordinated by WHO headquarters.

12. The closure of the adjunct Regional Office in Harare and the subsequent transfer of staff and activities to Brazzaville was one of the important events of the year. On behalf of WHO, the Regional Director expressed his appreciation to the President, the government and people of Zimbabwe for the hospitality and support during the period of time the Regional Office was operating in that country. The transfer of the staff from Harare to Brazzaville was smoothly conducted though there remained very serious concern about logistics, office space and staff accommodation.

WHO's Core Presence in Countries (SCC)

13. The Regional Director gave orientation for the process of reprofiling WHO country offices to specifically support countries to achieve their challenges. All 46 country offices introduced the subject, and 33 countries submitted their final reports. Regional support for programme implementation will now come mainly from the subregional level, a shift from how business was previously conducted.

14. In order to ensure that the best candidates represent the Organization at the country level, posts of WHO representatives are widely advertised, and candidates go through a process of both written and oral interviews before appointments are made. Eight new WHO representatives were so interviewed in 2006. In addition, formal induction and capacity-building are now conducted for new representatives, and 16 representatives benefited from this innovation during the year.

15. Special attention was given to special health conditions and problems in some countries of the Region. In this regard, the Regional Office responded to the suggestion of the Minister of Health of Seychelles to hold a meeting addressing the peculiar health problems of small island developing states. The meeting was highly successful and the outcome was the Seychelles Declaration. Follow-up of the Seychelles Declaration started, and two of the island states began to accelerate surveillance and control of noncommunicable diseases.

16. The Regional Director visited 11 countries during the reporting period. These visits enabled the Regional Director to better appreciate the public health problems in the countries as well as understand the complex relationship between the level of general country development in comparison to the level of health development. The Regional Director appreciated how the key determinants of health varied from one country to another. On each occasion, the Regional Director used the country visit to advocate to the highest level of government and to partners for more investment in health.

17. During visits to the country offices, the Regional Director emphasized the complex issues surrounding country office capacities, especially in relation to the strategic directions of the health sectors in countries. The Regional Director also used the country visits to consolidate the good relationship between WHO and the other UN Country Team members while underscoring the comparative advantage of WHO in the field of public health. With respect to bilateral partners, the visits were used to advocate for harmonization, alignment and cooperation in line with country priorities. Partners were urged to invest more in health which is the foundation for development.

External Relations (REC)

18. The dwindling Regular budget made it necessary to seek new partnerships and sources of funding. Both country offices and Regional Office Divisions enhanced their resource mobilization activities, and various Regional Office technical areas trained 30 staff members in resource mobilization and negotiation skills. The Regional Office signed 27 funding agreements with the following partners: African Development Bank (ADB); Department for International Development–UK (DFID); World Bank; Office for the Coordination of Humanitarian Affairs (OCHA); United Nations Development Programme (UNDP); United States Agency for International Development (USAID); Arab Gulf Programme for United Nations Development Organizations; and the governments of Belgium, France, Grand Duchy of Luxembourg and Portugal. Additional resources were mobilized for some avian influenza projects in high-risk countries from sources such as the Centers for Disease Control and Prevention, USAID, ADB, and the Global Alliance for Vaccines and Immunization yellow fever project.

19. The Regional Office strengthened child and adolescent health through partnerships with the African Union, United Nations Children’s Fund, World Bank, DFID, USAID, the Bill and Melinda Gates Foundation and Ford Foundation. The Office also established or reinforced partnerships with the Centers for Disease Control and Prevention (project in Kenya) and the following collaborating centres: National Institute for Communicable Diseases (NICD) (South Africa), *Institut Pasteur de Dakar* (Senegal), *Institut de Pasteur Madagascar*, *Centre International de Recherche Médical de Franceville* (Gabon), International Bureau for Animal Resources, *Commission de l’Océan Indien* (Mauritius) and *Coopération Française*.

20. Technical areas provided support to the East, Central and Southern Africa Health Community to develop a strategic plan and policy briefs on malaria in pregnancy. The global review of the joint WHO/UNICEF/UNFPA statement on female genital mutilation (FGM) provided the opportunity for WHO to reiterate its commitment to FGM elimination. The Regional Office assisted the *Gesellschaft für Technische Zusammenarbeit* (GTZ) to develop their action plan to address FGM among migrant and refugee women. The Gender Analysis Matrix provided six regional economic communities with better planning, programming, advocacy and capacity-building skills. In collaboration with the African Union, countries and partners harmonized the African regional nutrition strategy with the nutrition concept note of the New Partnership for Africa’s Development (NEPAD).

21. Regional Office staff also organized or attended a number of partnership meetings. These included the regional meeting on pandemic influenza; the regional workshop on strengthening local production capacity for essential medicines, including antiretrovirals; the continental consultative meeting on scaling up towards universal access to HIV/AIDS prevention, treatment and care in Africa; United Nations meeting on the avian influenza situation in Africa; the WHO-ADB

consultative meeting; the regional economic communities workshop on health financing; and the regional conference on health in the countries of the Horn of Africa.

22. Five agencies (WHO, UNICEF, UNFPA, World Bank, ADB) initiated steps to establish a partnership and jointly provide technical support to countries in the Region. This was a follow-up to the High-level Forum discussions to advocate and provide more technical support for harmonization and alignment as proposed in the Paris Declaration.

23. The Regional Office strengthened relations with the regional and international media in 2006, ensuring visibility and publicity for activities, meetings, conferences, workshops and events organized by WHO. The Information Unit ensured continued public access to information through the dissemination of information kits and press materials, including 58 press releases, 30 radio programmes, 18 videos, and the journal, *The African Health Monitor*.

24. The theme of World Health Day 2006 was “Working together for health”. Member States celebrated it successfully with the main launch of *The world health report 2006* which took place in Lusaka, Zambia.

25. The development and consolidation of new links on the AFRO web site strengthened electronic publishing. These links provided public access to major activities, meetings, events, Regional Director messages and full texts of publications such as *The work of WHO in the African Region 2004-2005* and *The African regional health report 2006*.

Governing Bodies (GBS)

26. The relation with governing bodies was profoundly enhanced. In particular, regular interaction with the Regional Office facilitated and reinforced the contributions of African Region Member States to the Executive Board.

27. In 2006, Member States attending governing bodies meetings encountered a new challenge. For the first time, they had to deal with the death of a serving Director-General, Dr Jong-Wook Lee, and determine the process for succession. The World Health Assembly eventually elected Dr Margaret Chan as the Director-General at a special session held in November 2006. A delegate from the African Region chaired the World Health Assembly during these successful deliberations.

28. The implementation framework for strengthening pandemic influenza preparedness and response, including application of the International Health Regulations (2005), and a global strategy and plan of action to promote innovation in public health were issues that received significant attention during the year. The Regional Committee raised concerns about poverty and health, child survival, the Primary Health Care approach, the continuing retention of variola virus stocks and health research. The discussion of these items, among others, showed the increasing correlation between the work of the different governing bodies. Both the agenda and the programme of the work showed significant improvement in management of time.

Planning, Resource Coordination and Oversight (BMR)

29. The Programme Budget 2006-2007 put greater emphasis on planning, coordination and oversight so as to improve the achievement of expected results. However, a number of challenges

needed to be addressed in order to achieve the expected results. These included, among others, improving the technical quality of operational plans, creating a closer link between the achievements and budget consumption of technical programmes, and developing capacity for joint planning and budgeting.

30. The Region actively participated in all the steps towards the preparation of the Eleventh General Programme of Work 2006–2015, the Medium-Term Strategic Plan 2008–2013 and the refinement of the WHO results-based management framework. The Regional Office was involved in the refinement of the Global Management System, particularly the requirements, definition, preliminary analysis and testing of target applications, and design of a future process model. The African Region was selected alongside headquarters to implement the first phase of the system, which aims at improving management oversight and responsibility in monitoring technical programmes. Successful implementation will improve administrative efficiency, consolidate the implementation of results-based management, support ongoing decentralization and delegation of authority, and break geographical boundaries.

31. Based on key elements of the results-based management framework, two meetings of country office planning coordinators strengthened their capacities in operational planning, performance monitoring and assessment. This activity benefited all 46 countries of the African Region.

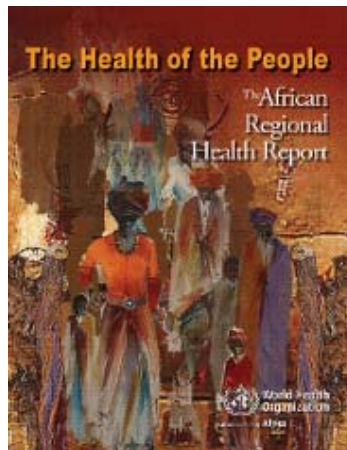
Health Information, Evidence and Research Policy (IER)

32. The link between research, policy-making and decision-making continued to be weak in 2006. Significant attention was needed to accelerate the implementation of health information management systems in order to promote the generation and utilization of evidence in decision-making. WHO responded by providing strategic direction and appropriate support to countries for improving the knowledge and evidence basis for health decision-making by synthesis and publication of existing information; facilitation of knowledge generation in areas that needed special attention; and establishing country mechanisms to translate research into policy and action. The Regional Office also sought the active participation of WHO collaborating centres to strengthen national health research systems.

33. With assistance from HQ, the Regional Office produced and disseminated *The African regional health report: The health of the people* (Figure 2) to Member States and partners. The report provided an overview of the public health situation across the 46 Member States. The area of work also produced a booklet on core indicators, “Health situation analysis: Basic indicators 2006”. It provided comprehensive statistics on the current status of public health and health systems at country level. Preparatory work for a regional survey on health research and knowledge enterprises was initiated.

34. The African Advisory Committee for Health Research and Development met in September for its twenty-third session. Eight countries established the Evidence-Informed Policy Network at a workshop for senior health policy-makers and researchers in March. As part of the preparation for the 2008 Global Conference on Research for Health, the area of work produced a document describing the health research agenda for the African Region and subsequently presented it for adoption during the fifty-sixth session of the WHO Regional Committee for Africa in August.

Figure 2: *The African Regional Health Report* was launched globally in November 2006



Knowledge Management and Information Technology (KMI)

35. To mobilize support for knowledge management in Member States, the area of work presented a regional strategy document, “Knowledge management in the WHO African Region: Strategic directions”, and its resolution at the fifty-sixth session of the Regional Committee. The Regional Office also established partnerships with the African Union, New Partnership for Africa’s Development, European Union, African Development Bank and Department for International Development (UK) to develop projects to facilitate the use of e-Health for strengthening health systems.

36. By the end of the year, the Regional Office Library contained 2200 records in its database (<http://afrolib.afro.who.int>). The multimedia centre, which has 19 workstations, provided important access to the Internet, especially for external users. The African Index Medicus was active with materials on African health and biomedical information, including those published by African medical researchers. It was accessible on the Internet through the web site <http://indexmedicus.afro.who.int>. The library made available online about 85 African medical periodicals and medical theses.

37. The library published a monthly awareness bulletin called *Infodigest*. The Blue Trunk Libraries and the AIDS Library in support of health districts in the African Region remained in circulation. The library contributed to the implementation of the Global Health Library by supporting countries to develop their own health information portals.

38. The library continued its cooperation with the Association for Health Information and Libraries in Africa and contributed US\$ 35 000 towards its last congress. The library also supported training programmes in Member States, including outreach training in the use of the Health InterNetwork Access to Research Initiative. Librarians from the Regional Office facilitated training sessions in Senegal for users from Côte d’Ivoire, Gambia, and Senegal, and in Mali for users from Burkina Faso, Guinea and Mali. The Regional Office implemented this activity in collaboration with the e-Health unit in headquarters and the Information Training and Outreach Centre for Africa (South Africa).

39. To promote multilingualism in the work of the Organization, the publishing unit provided language interpretation for meetings, as well as editing, translation and printing of documents for the

various technical units. The unit also printed and distributed documents for meetings of governing bodies in the three official languages of the Region.

HEALTH SYSTEMS AND SERVICES DEVELOPMENT

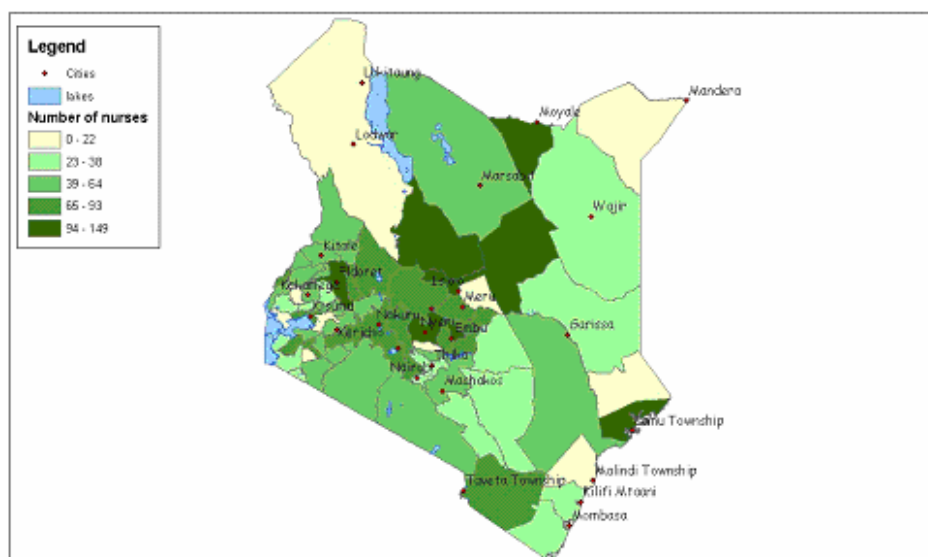
40. The Division of Health Systems and Services Development addressed issues relating to health systems development. Five areas of work provided support to Member States for developing policies and strategic plans; strengthening human resources for health; collecting and analysing data for evidence-based decision-making; and promoting quality of care through development of norms, standards and guidelines.

Health System Policies and Service Delivery (HSP)

41. Nine countries developed or reviewed their national health policies and strategic plans with WHO support. Kenya, Malawi, Uganda and Zambia reviewed their health sector management structure. The Democratic Republic of Congo undertook health sector reform to strengthen district health systems. At a meeting organized by WHO, ten countries reviewed the roles of hospitals in national health systems, shared good practices and made recommendations for strengthening hospitals. The ten countries joined a network to continue sharing their experiences.

42. The area of work improved capacity-building for the generation and use of relevant health information. The Health Metrics Network partnership implemented activities in 20 countries to strengthen their national health information systems. The Regional Office trained more than 60 persons in using the Health Metrics Network and health information assessment tool. Kenya (see Figure 3), Rwanda, Tanzania, Uganda and Zambia completed health service availability mapping, and nine other countries initiated the process.

Figure 3: Number of nurses per 100 000 population in health districts in Kenya, 2004



43. The area of work presented a document entitled “Revitalizing health services using the Primary Health Care approach in the African Region” at the fifty-sixth session of the Regional Committee; it was adopted along with a resolution. The evaluation of the Norway-funded project for strengthening district health systems in eight countries¹ resulted in the production of various reports. Participants from the countries held an intercountry meeting to share experiences involving countries within and outside the project.

Health Financing and Social Protection (HFS)

44. The capacity of countries to ensure sustainable health financing continued to be strengthened during 2006. Nigeria drafted a comprehensive health financing policy. Also, six countries² performed activities related to national health accounts. Maputo hosted an intercountry workshop to train 15 nationals from five countries³ in costing and feasibility analysis of health financing mechanisms. Workshops held in Bamako and Brazzaville trained 30 nationals to undertake and institutionalize national health accounts.

45. The area of work produced four technical documents: “Health financing: A regional strategy for the African Region” adopted at the fifty-sixth session of the WHO Regional Committee for Africa; “An overview of health financing patterns and the way forward in the WHO African Region”; “Technical efficiency of health clinics in Seychelles”; and “The cost of health professionals brain drain in Kenya”. The Regional Office, in close collaboration with partners from the World Bank, regional economic communities, African Health Economics Advisory Committee, ILO and UNICEF, developed the health financing strategy.

Essential Medicines (EDM)

46. The implementation of regional strategic plans on the availability of affordable essential medicines, their quality, safety and appropriate use continued in 2006. Eleven countries⁴ developed national policies on traditional medicine, legal frameworks for the practice of traditional medicine, codes of ethics and strategic plans. Five other countries (Central African Republic, Republic of Congo, Eritrea, Kenya and Rwanda) revised their national essential medicines lists and standard treatment guidelines to promote the rational use of medicines.

47. The area of work revised the training manual on drug management at the health centre level to incorporate a chapter on management of antiretrovirals and HIV/AIDS, and developed a software program (Manadrugs) to complement the manual. Staff prepared the document, “Medicines regulatory authorities: Current situation and way forward,” for the fifty-sixth session of the Regional Committee.

48. For the harmonization of national medicine regulations, policies and implementation of workplans, the area of work provided technical and financial support to the regional economic communities: East African Community; Economic and Monetary Community of Central Africa; Southern African Development Community; and Economic and Monetary Union of West Africa.

¹ Eritrea, Ethiopia, Tanzania, Malawi, Mozambique, Uganda, Zambia and Zimbabwe.

² Botswana, Malawi, Sao Tome and Principe, Sierra Leone, Tanzania and Zimbabwe.

³ Burkina Faso, Ghana, Mozambique, Nigeria and Tanzania.

⁴ Cameroon, Republic of Congo, Democratic Republic of Congo, The Gambia, Ghana, Kenya, Malawi, Rwanda, Tanzania, Zambia and Zimbabwe.

Blood Safety and Clinical Technology (BCT)

49. The Regional Office made efforts in the development of clinical laboratory services, diagnostic imaging and patient safety. The technical unit initiated a regional external quality assurance programme for clinical laboratories (haematology and chemical pathology). The Regional Office reactivated the Centres of Excellence for Continuing Education in Diagnostic Imaging in Cameroon and Kenya in an effort to improve the quality of radiological diagnostic services and initiated a regional network for patient safety support. Kenya and South Africa conducted studies on adverse events occurring during clinical health care in the public and private sectors.

50. The appropriate clinical use of blood is essential to protect the limited stocks available and ensure quality of services and safety of patients. Angola, Democratic Republic of Congo, Ethiopia, Liberia and Sierra Leone conducted situation analyses on blood safety to generate information for evaluation and planning. Seven countries formulated or reviewed their national blood policies. The Gambia, Guinea-Bissau, and Sao Tome and Principe developed strategic plans for implementation. Ethiopia and Namibia developed national guidelines on the appropriate clinical use of blood, and they trained 227 clinicians, nurses and laboratory staff.

51. The Regional Office organized two regional training workshops for national blood donor recruiters in Ghana and Mozambique in collaboration with Safe Blood for Africa. Eleven countries trained quality officers in quality management. Nine countries trained laboratory staff in the blood cold chain. The Regional Office provided support for the development of technical materials, standards, guidelines on the minimum requirements for national transfusion services, and indicators for monitoring national blood transfusion services.

Human Resources for Health (HRH)

52. Appreciation of the role of functional human resources in health development and the visibility of the human resource crisis in the African Region increased in 2006 as more objective evidence was made available. *The world health report 2006: Working together for health* devoted its contents to human resources for health; it contributed greatly to sensitizing stakeholders and partners. Zambia launched World Health Day 2006 on 7 April with various policy briefs, and the Democratic Republic of Congo celebrated the day with a photo shoot and stories of unsung heroes for health.

53. Addressing the human resources for health crisis, the Regional Office provided 158 fellowships for 22 countries in 2006 and finalized the Human Resource for Health status report. The area of work designated the African Health Workforce Observatory web site and held a regional consultative meeting to develop a regional strategy for strengthening nursing and midwifery services. The Regional Office established the African Health Workforce Platform, including various regional stakeholders and civil society organizations, and supported the Steering Committee meetings, administration, resource mobilization and dissemination of documents and reports.

54. The Global Health Workforce Alliance provided US\$ 300 000 to each of five countries (Angola, Benin, Cameroon, Uganda and Zambia) to accelerate actions in human resources for health and produce examples of country-led approaches that could be emulated by others. Twelve countries conducted in-depth situational analyses and reviewed, developed and implemented their policies and plans. The technical unit assisted Nigeria and Uganda in policy document reviews. The Regional

Office supported medical and nursing/midwifery schools in nine countries to evaluate and develop training programmes. The area of work developed core competencies for skilled birth attendants to improve safe motherhood and newborn and child care.

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

55. The African Region today lacks the capacity for effective diagnostic, preventive or treatment options for the control of many of the infectious diseases it faces. Despite the continued resources and efforts put into prevention, infectious diseases—mainly HIV/AIDS, malaria and tuberculosis—persist and constitute a major part of the disease burden in the Region. In 2006, communicable diseases continued to impede social and economic development, disproportionately affect poor and marginalized populations, and remain a major hindrance to achieving the Millennium Development Goals. The Regional Office strengthened partnerships for accelerating the control of the control of HIV/AIDS, tuberculosis and malaria control with the African Union, UNAIDS, UNICEF, UNFPA and the World Bank, among others.

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV)

56. HIV and AIDS continued to be major public health challenges in the African Region. An estimated 2.8 million adults and children became infected with HIV in 2006, more than in all other regions of the world combined. Access to prevention, treatment, care and support interventions improved but still fell short of demand. Inadequate human resources and weak health systems were the major contributing factors to the limited access. The Regional Office provided normative guidance and technical support to countries for developing and adapting policies and tools; strengthening capacity; mobilizing technical and financial resources for accelerating HIV prevention; scaling up the delivery of comprehensive care; and providing antiretrovirals.

57. At its fifty-sixth session, the Regional Committee adopted the document, “HIV prevention in the African Region: A strategy for renewal and acceleration” and its resolution. The area of work carried out an intensive regional advocacy campaign for acceleration of HIV prevention throughout the year, and the campaign was officially launched by the African Union in Addis Ababa on 11 April 2006 with simultaneous launches in Johannesburg, Khartoum and Ouagadougou. Between April and December, 45 countries officially launched the campaign and started developing plans for acceleration and mobilizing the necessary resources for implementation. Further advocacy took place at the Brazzaville continental consultation on universal access to HIV/AIDS prevention, treatment and care and the Abuja special summit on AIDS, tuberculosis and malaria. WHO, UNAIDS and other partners held joint meetings on HIV prevention and universal access. All these activities were part of the Year for Acceleration of HIV Prevention in the African Region and to promote multi-agency implementation of the strategy.

58. With support from WHO, 43 countries developed plans of actions for strengthening national quality laboratory services, and five countries developed national quality assurance protocols for HIV/AIDS testing services. Emphasis was also placed on monitoring HIV drug resistance, and three countries developed protocols for undertaking HIV drug resistance surveillance.

59. The area of work developed regional HIV testing and counselling guidelines and training manuals. With Regional Office support, 14 countries developed national guidelines on HIV testing

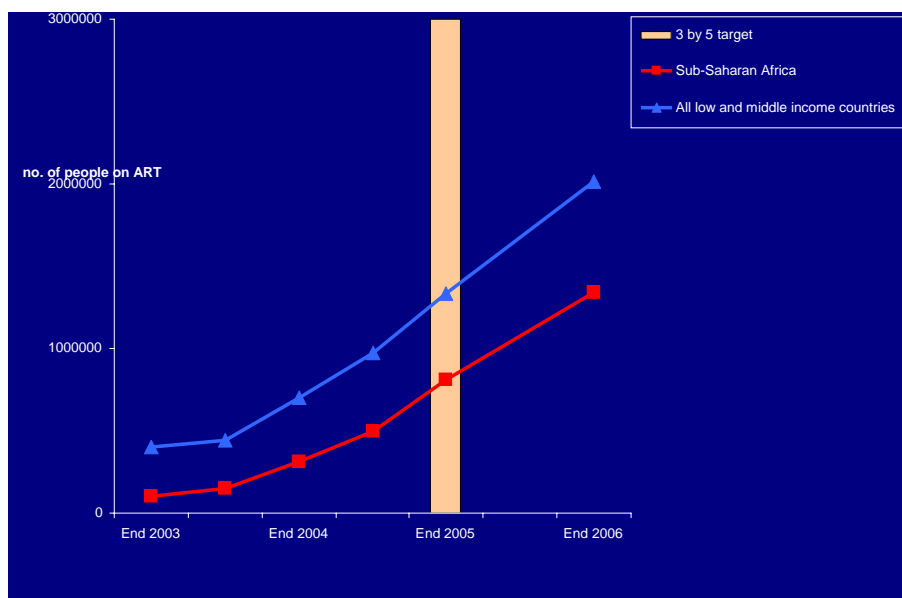
and counselling; 16 countries trained counsellors; and five countries scaled up plans for prevention of mother-to-child transmission (PMTCT), including increased access to antiretroviral therapy for pregnant women with HIV. Thirteen countries trained 34 health workers in the integration of PMTCT in maternal, newborn and child health services.

60. WHO also supported countries to develop policies and tools, strengthen capacity, and mobilize technical and financial resources. The Regional Office provided guidelines to 23 countries for developing integrated and comprehensive services aimed at scaling up interventions, including the provision of antiretrovirals. Eleven Member States developed specific plans to promote universal access to prevention, treatment and care. The Integrated Management of Adolescent and Adult Illness (IMAI) adaptation process and training continued in 23 countries.

61. The Regional Office supported 12 countries to implement second-generation surveillance and to strengthen their monitoring and evaluation systems for health sector response to HIV/AIDS. Participants from countries attended a training workshop on monitoring antiretroviral therapy (ART), and 13 countries developed proposals to mobilize more financial resources during round six of the Global Fund to Fight Aids, Tuberculosis and Malaria. Subregional and national laboratories performed quality control of antiretrovirals and condoms.

62. All these efforts yielded positive results. For instance, in December, about 28% (24%–33%) of people in need (more than 1 300 000 patients) received ART compared to 17% at the end of 2005 (see Figure 4). Eight countries⁵ experienced significant gains in scaling up. Demand in the entire Region, however, was still not met due to inadequate human resources and weak health systems which resulted in limited access to ART and supply of necessary commodities.

Figure 4: Antiretroviral therapy coverage in sub-Saharan Africa



Source: WHO, UNAIDS and UNICEF, Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report, Geneva, April, 2007

⁵ Botswana, Kenya, Malawi, Namibia, Rwanda, South Africa, Uganda and Zambia.

63. Even though the African Region has the highest HIV burden worldwide, in 2006, the epidemic showed evidence of diminishing or stabilizing in many eastern and western African countries, while in southern Africa, Zimbabwe was showing decline in its national HIV prevalence rates. This is a clear indication that the current tools to combat the pandemic are working, and the universal access initiative represents a new momentum and a window of hope to consolidate and reverse the trends.

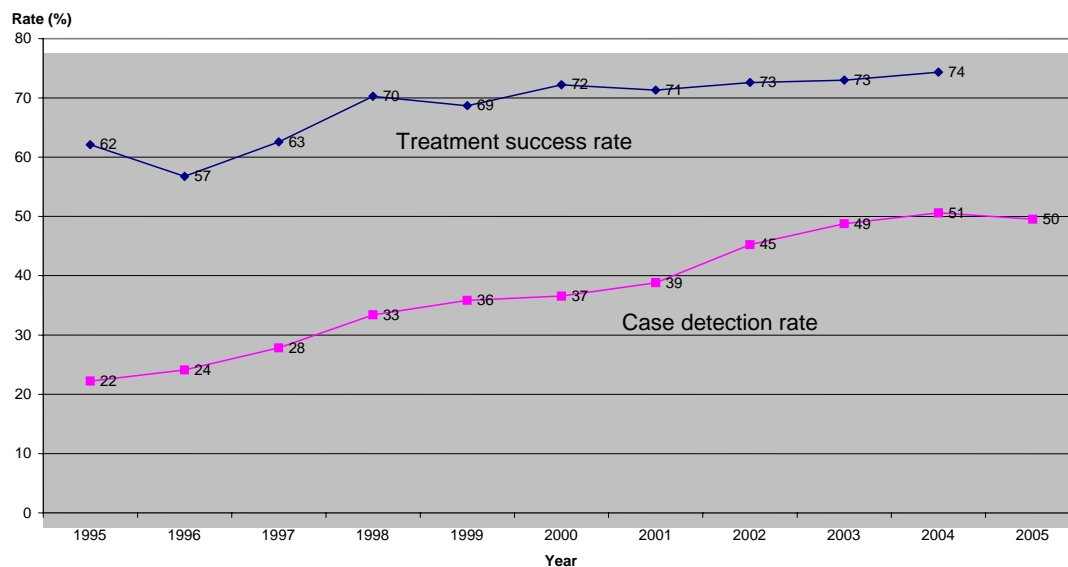
Tuberculosis (TUB)

64. The African Region continued to have the highest tuberculosis rates per capita in 2006. This situation worsened due to poor programme management, low access to control services, and limited human and financial resources for accelerating control interventions. Treatment success rates increased marginally, rising from 72% in 2000 to 74% in 2004, and case detection rates stayed at 50% between 2003 and 2005 (Figure 5). Preventable adverse treatment outcomes, especially defaulter and transfer out rates, exceeded 15% in several countries in 2006. Death from TB/HIV co-infection was high. The technical unit reported the existence of TB strains resistant to second-line anti-TB drugs in the Region for the first time in 2006.

65. The area of work developed two new regional strategies for TB control and advocacy, communication and social mobilization. With Regional Office support, 21 countries, including the 13 which declared TB a national emergency, developed plans to scale up TB control interventions. The two countries previously not implementing DOTS adopted and implemented the strategy. The technical unit provided support to a new set of 12 countries to implement combined TB/HIV interventions, starting with voluntary counselling and testing. Once a diagnosis of TB is confirmed, collaboration with HIV interventions will begin; 33 countries have implemented this combined intervention. The Southern African Development Community Health Desk developed a Community-wide plan for management of drug-resistant TB.

66. With support, 16 countries developed proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and 34 countries prepared proposals to access anti-TB drug grants from the Global Drug Facility. It should be noted that these applications have not always achieved the desired results. While many countries accessed significant amounts of additional funding for TB control from GFATM and other donor initiatives, funding for TB control in particular continued to remain insufficient relative to the magnitude of the problem. Although WHO expected Member States to tackle the disease with enthusiasm, less than half responded to the call to declare TB an emergency as agreed during the fifty-fifth session of the Regional Committee in 2005. This lack of country commitment dampened efforts for external support.

Figure 5: Trend of TB case detection and treatment success rates, African Region, 1995–2005



Source: Compiled from annual national TB control programmes surveillance data, 1995–2005

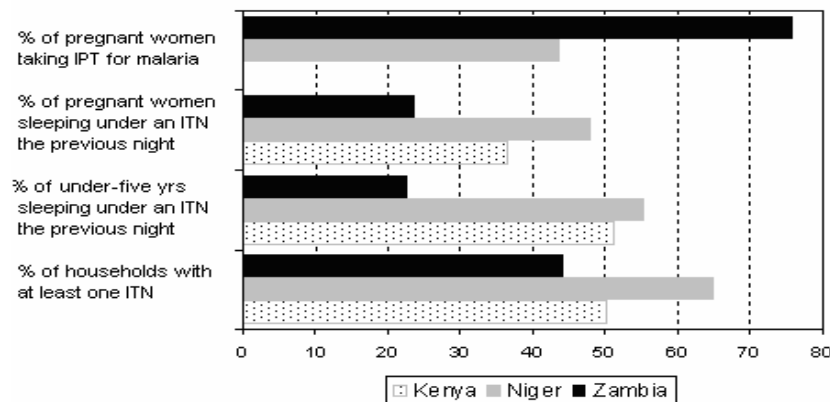
Malaria (MAL)

67. During 2006, WHO provided technical support for scaling up comprehensive malaria control packages; enhancing integrated service delivery through integrated management of childhood illness antenatal care expanded programme on immunization; strengthening disease surveillance, drug efficacy and insecticide resistance monitoring; and reinforcing monitoring, evaluation and evidence-based planning.

68. The distribution of insecticide-treated nets expanded significantly (Figure 6). Eleven countries, including Cameroon, Equatorial Guinea, Gabon and Sierra Leone, distributed over nine million insecticide-treated nets. Antenatal clinics and integration with immunization campaigns were popular channels for distribution. In response to demand from Member States, WHO developed a statement on the use of DDT for indoor residual spraying which was adopted by Member States; Angola, Burundi, Ghana, Tanzania and Uganda initiated spraying operations. During 2005 and 2006, 20 countries sprayed over five million physical structures, leading to protection for more than twenty million people. The average operational coverage was 84%, ranging from 65% in Botswana to 98% in Madagascar.

69. In terms of policy and strategy development, the Region established the AFRO Advisory Committee of Experts on Malaria as a platform for dialogue, scientific advice and guidance on implementation of recommendations. Mali, Niger and Senegal initiated collaboration for epidemic forecasting between national malaria control programmes and meteorological agencies. The Republic of Congo, Equatorial Guinea, Mauritania and Zimbabwe adopted policies for artemisinin-based combination therapy (ACT); 38 countries adopted ACT; and 22 countries began implementing such policies. Benin, Kenya, Senegal and Uganda set up drug quality assurance and pharmacovigilance systems for ACTs.

Figure 6: Household ITN possession, ITN coverage and use of IPT for malaria, selected countries, 2006



Sources: Kenya 2006 ITN Distribution Post-Campaign Survey; Niger 2006 ITN Distribution Post-Campaign Survey; Zambia 2006 Malaria Indicator Survey

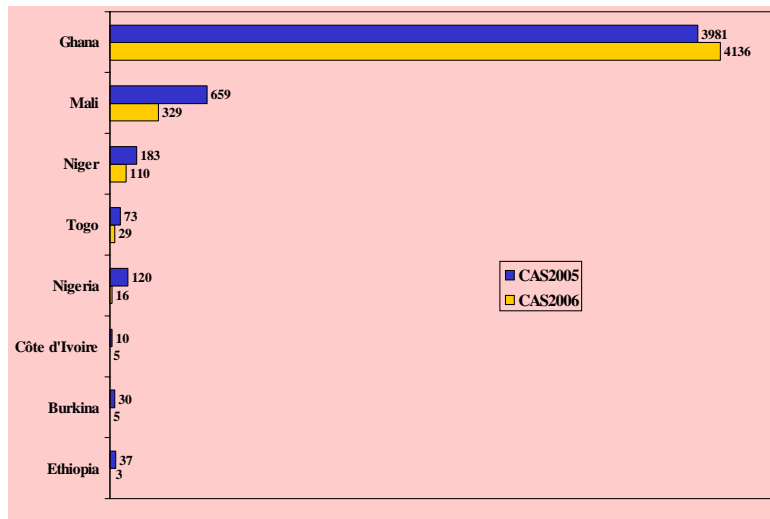
Communicable Disease Prevention and Control (CPC)

70. In 2006, leprosy, dracunculiasis, lymphatic filariasis, onchocerciasis, trypanosomiasis, Buruli ulcer, schistosomiasis, intestinal helminthiasis and leishmaniasis continued to affect the poorest populations among the poor. Most of these diseases lead to negative social stigma and are rarely allocated resources for control. These diseases, therefore, are termed *neglected tropical diseases*.

71. In 2006, WHO sought to help countries address these issues through technical support and financial contribution to affected countries to develop appropriate strategies and plans of action for control; monitoring and evaluation of programmes; and advocacy at national, regional and global levels.

72. Specifically, the Regional Office supported four more countries to organize Buruli ulcer control programmes; 14 countries are currently implementing control activities. The annual incidence of dracunculiasis in the Region decreased from 5105 reported cases in 2005 to 4635 reported cases in 2006. Ghana had the largest number of cases, 4136, cases in 2006 (Figure 7). An external evaluation team confirmed the interruption of local transmission of dracunculiasis in Benin and Mauritania. Cameroon, Central African Republic, Chad, Guinea, Liberia and Sierra Leone presented national reports for certification of dracunculiasis eradication.

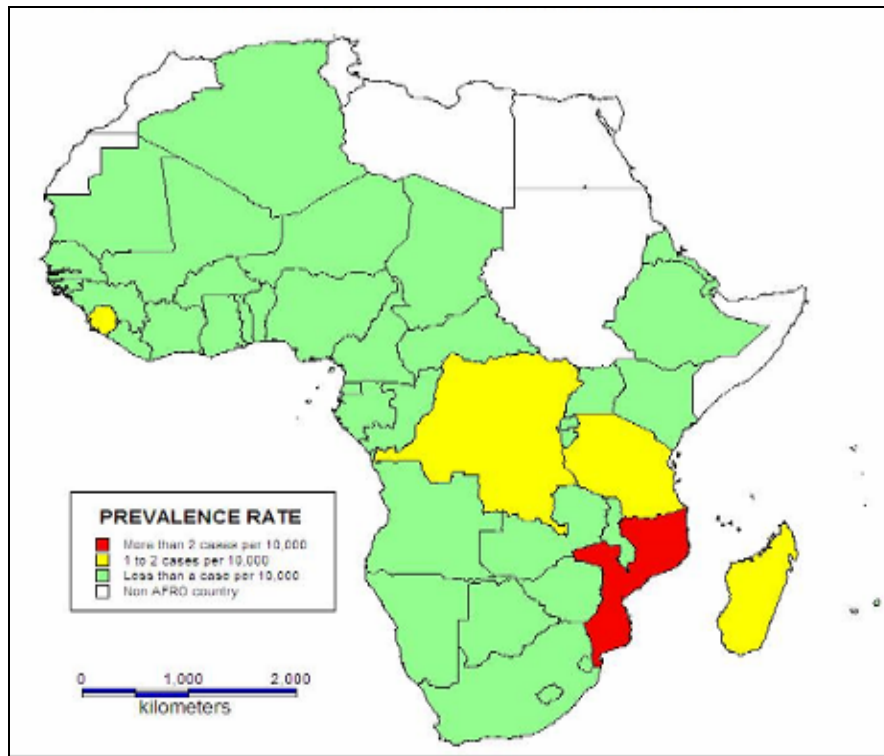
Figure 7: Notified dracunculiasis cases, selected countries 2005 and 2006



Source: L'Ouganda a notifié 9 cas en 2005 et 2 cas en 2006 tous importés du Soudan en 2005

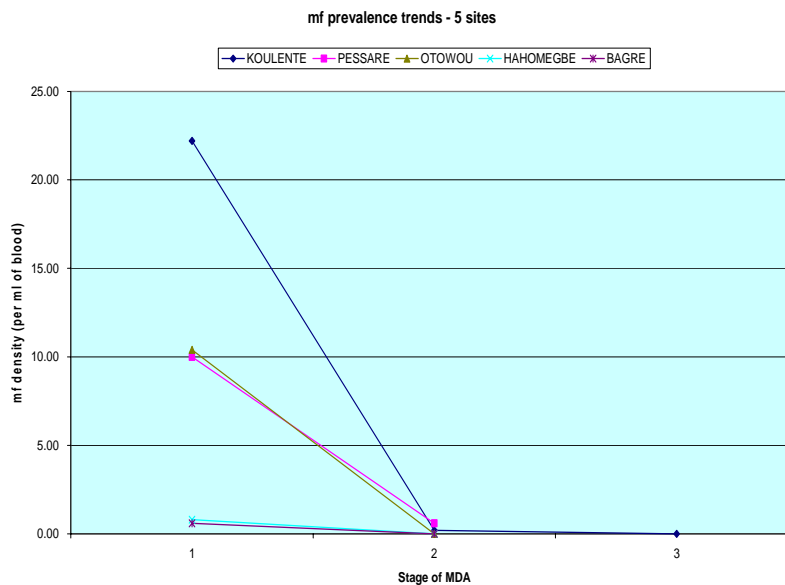
73. More than one million leprosy cases were detected and cured in the Region during the past 10 years. With assistance from the Novartis Foundation for Sustainable Development, WHO supplied countries with leprosy medicines. With additional support from the Sasakawa Foundation, 42 countries reached the leprosy elimination goal. The regional leprosy prevalence reached 43 382 cases, and the rate was 0.63 cases per 10 000 (Figure 8).

Figure 8: Achievement of leprosy elimination in the African Region, 2006



74. Suitable documentation on the human African trypanosomiasis situation exists in the African Region. Data show a downward trend in the annual incidence of the disease over the past years. With Regional Office support, 16 out of 21 endemic countries implemented control activities in priority areas. These countries attained 100% performance in treatment of cases detected. Similarly, 11 of the 39 endemic countries conducted annual mass drug administration for lymphatic filariasis elimination. Four countries reached total coverage of the population at risk, and 30 million people received treatment in the year under review. Togo interrupted lymphatic filariasis transmission (that is, reduced microfilaremia to 0%) (Figure 9).

Figure 9: Interruption of lymphatic filariasis in Togo, 2006



75. Six of the 40 schistosomiasis-endemic countries sustained national treatment programmes for schistosomiasis and soil-transmitted helminths; four of these programmes reached national scale. Four countries developed integrated plans of action for control of neglected tropical diseases; 16 countries with endemic soil-transmitted helminths implemented school-based deworming programmes. Some of these countries integrated deworming with vitamin A supplementation, vaccination campaigns and other child health interventions.

76. Onchocerciasis or river blindness is a disease of poverty, affecting vulnerable communities in remote areas. River blindness has a negative impact on agricultural production and economic growth in sub-Saharan Africa.

77. In 2006, the African Programme for Onchocerciasis Control (APOC) trained 31 000 health workers and 350 000 community-directed distributors (CDDs) to implement the community-directed treatment with ivermectin strategy (CDTI) (see Figure 10). In partnership with country health system staff, CDDs treated over 45 million persons in 15 countries.

78. In the same year, APOC operations averted 850 000 DALYs. For all 97 projects distributing ivermectin, mean geographic and therapeutic coverage rates of 90% and 69%, respectively, were recorded. Projects in countries with stable social conditions maintained high therapeutic coverage

between 78% and 85%. The vector elimination achieved in two foci in Itwara, Uganda and Bioko, Equatorial Guinea was maintained. Partners in Guinea, Liberia and Sierra Leone held cross-border meetings to review treatment activities in border areas.

79. The CDTI strategy was also used to deliver multiple health interventions, alongside ivermectin treatment, to communities living in remote areas. A total of 16 million people in 61 CDTI projects operating in five countries received additional interventions, including drugs for malaria, lymphatic filariasis and schistosomiasis; vitamin A supplementation; and ITNs.

80. At a partners' meeting held in Yaounde, Cameroon, in September, African ministers of health reaffirmed their commitment to accelerate the elimination of river blindness as a public health and socioeconomic problem in all countries; they urged endemic countries to make annual budgetary commitments for onchocerciasis control activities. The Yaounde Declaration bolstered APOC efforts to transfer the responsibility for onchocerciasis control to the concerned countries.

81. In December 2006, countries and development partners agreed to extend the operations of APOC from 2010 to 2015. APOC was mandated to assume a wider role in the fight against neglected tropical diseases, expand its strategy to include the control of malaria and help countries to achieve the MDGs. A more complete account of APOC activities will be provided in 2007, at the end of the biennium.

Figure 10: A community distributor of ivermectin measures a child with the dose-pole to determine correct dosage



Communicable Disease Research (CRD)

82. Activities in research aimed to sustain and increase national capacity for research through training and implementation of research projects. The Regional Office also explored new ways of collaborating and working with the WHO Special Programme for Research and Training in Tropical Diseases (TDR).

83. The Regional Office finalized a strategy on communicable disease research; this strategy contributed to the paper, "Health research: Agenda for action in the WHO African Region" which was adopted at the fifty-sixth session of the WHO Regional Committee for Africa. The office updated databases on research institutions and researchers in the Region and shared them with interested parties.

84. The area of work convened two high-level meetings on health research to identify key issues and an African perspective on health research; the outcomes led to the new 10-year vision and strategy for TDR. The strategy will form the basis for an African agenda at the Global Conference on Research for Health to be held in Bamako, Mali in 2008. Due to the active engagement and participation of the Regional Office in TDR working groups and meetings, institutions and individuals in 18 countries received 33 research and training grants. Active discussions continued for establishing the AFRO-TDR small grants scheme targeted at countries receiving funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Regional Office initiated efforts to increase human resources in research in order to better support countries to strengthen research capacity and capabilities.

Epidemic Alert and Response (CSR)

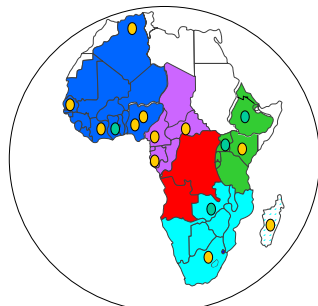
85. The Regional Office continued to address the epidemic alert and response challenges designated in the biennial workplan. These included strengthening and sustaining disease surveillance systems for timely epidemiological information; setting up response systems for rapid containment of public health emergencies of national and international concern; and strengthening laboratory capacity to confirm causative agents of disease outbreaks, including monitoring resistance to antimicrobial agents.

86. The occurrence of avian influenza in poultry in Burkina Faso, Cameroon, Côte d'Ivoire, Niger and Nigeria posed a major challenge for the Region in 2006. The Regional Office area of work was intensely involved in providing technical support for risk assessment; development of national preparedness and response plans; and training of health personnel to update skills. In addition, technical staff wrote and disseminated the Regional Pandemic Preparedness and Response Plan. The unit held regional and subregional meetings; conducted workshops for training of trainers from 42 countries; and undertook joint missions with other UN agencies.

87. The successful implementation of Integrated Disease Surveillance and Response in countries greatly contributed to the early detection and rapid control of epidemics; generation of evidence-based information for monitoring disease trends; and evaluation of interventions. The Public Health Reference Laboratories actively supported the confirmation of causative agents of all major outbreaks in 2006. External quality assurance of national reference laboratories (Figure 11) continued in collaboration with the National Institute for Communicable Disease of South Africa; 72 laboratories

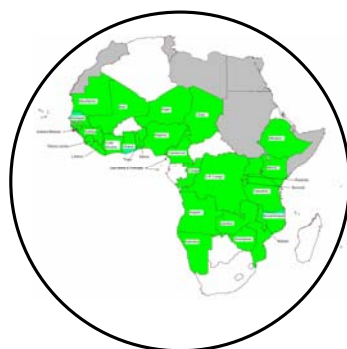
from 46 countries participated in this scheme. Implementation of the *International Health Regulations* (2005) was a priority.

Figure 11: African Region influenza laboratory network



88. The Regional Office continued to provide timely technical support to countries experiencing major cholera outbreaks. In 2006, 31 countries⁶ reported a cumulative number of 172 813 cases and 4680 deaths, with an overall case fatality rate of 2.7% (Figure 12). Angola reported the highest numbers of cases and deaths (67 257 cases and 2722 deaths), followed by Democratic Republic of Congo (12 049 cases and 269 deaths) and Ethiopia (42 953 cases and 455 deaths), accounting for a significant proportion (71%) of the burden of cholera. Four countries (Burkina Faso, Kenya, Niger and Uganda) reported meningococcal meningitis, whereas five countries (Burkina Faso, Côte d'Ivoire, Guinea, Mali and Togo) reported yellow fever. Other outbreaks reported were plague from Democratic Republic of Congo; Rift Valley fever from Kenya; and *chikungunya* (one of many viral fevers) from Comoros, Madagascar, Mauritius and Seychelles. The Epidemic Alert and Response (CSR) area of work collaborated with Emergency Preparedness and Response (EHA) and Health and Environment (PHE) to provide coordinated support to affected countries.

Figure 12: Incidence of cholera, WHO African Region, 2006



89. The Multi-Disease Surveillance Centre in Ouagadougou focused on surveillance of meningitis and onchocerciasis in 2006, providing technical support for meningitis surveillance and response in six countries.⁷ The Centre trained health personnel; conducted 20-year retrospective analyses of meningitis data from Burkina Faso, Mali and Niger; and developed a 10-year strategic plan (2008–

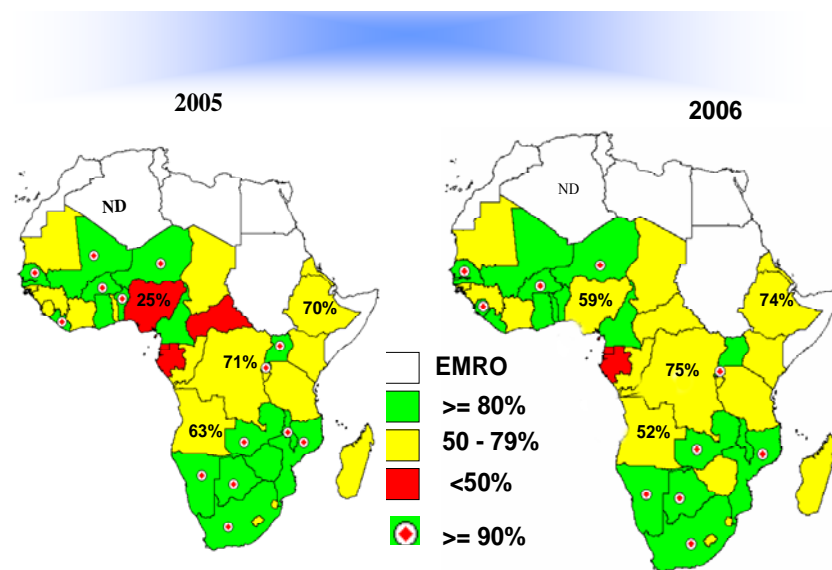
⁶ Angola, Benin, Burundi, Cameroon, Chad, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
⁷ Burkina Faso, Central African Republic, Chad, Niger, Nigeria and Togo.

2016). The molecular biology laboratory analysed more than 400 000 blackfly samples from many countries in the Region in order to determine the infectiousness of onchocerciasis parasites in the flies. The infectivity rates formed the basis for epidemiological investigation.

Immunization and Vaccines Development (IVD)

90. Routine immunization coverage for DPT3 improved significantly from 73% in 2005 to 82% in 2006 (Figure 13). All countries except Angola, Equatorial Guinea and Gabon achieved DPT3 coverage greater than 50% at national level, compared to 2005, where four countries were below this mark. Nigeria made the most gains, rising from 25% in 2005 to 77% in 2006. These achievements can be attributed to the success of the introduction and scaling up of the Reach Every District Initiative.

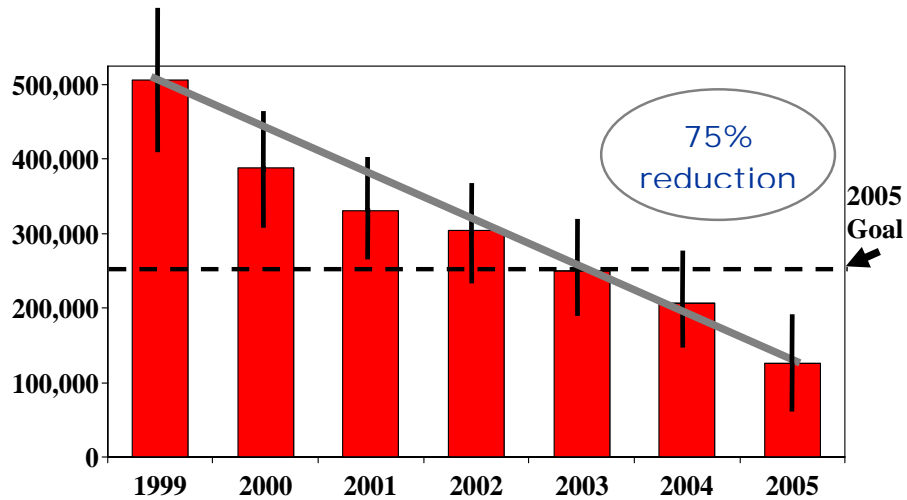
Figure 13: Reported DPT3 coverage in the WHO African Region, 2005 and 2006



Source: WHO, Expanded programme on immunization, monthly report, Brazzaville, Regional Office for Africa, 2006

91. Small measles outbreaks were reported in 11 countries, mostly due to suboptimal routine immunization coverage. Otherwise, measles immunization outcomes were very positive. A total of 35 countries established case-based measles surveillance, and 54% of the districts investigated at least one suspected case of measles. A second opportunity measles vaccination with supplemental immunization activities benefited more than 75.7 million children in 20 countries. This resulted in a 75% reduction in estimated measles deaths in the Region, surpassing the 2005 target (Figure 14). Supplemental immunization activities complemented other child survival interventions.

Figure 14: Estimated reduction in measles mortality in the African Region, all ages, 1999–2005

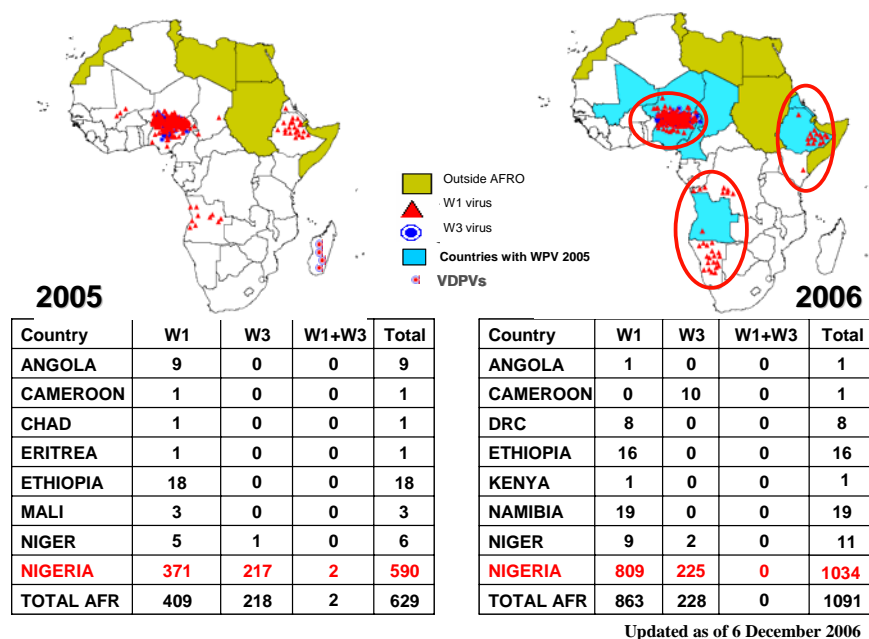


92. With support, 26 countries drew up institutional development plans for national regulatory authorities. The area of work developed two Expanded on Programme Immunization curriculum prototypes for medical and nursing schools; adopted a regional plan of action for preservice training; held two intercountry mid-level manager courses; and conducted ten in-country mid-level manager courses.

93. A total of 1091 polio cases were reported in 2006 compared to 629 in 2005. The majority of the cases were geographically confined to northern Nigeria, with Nigeria remaining the only polio-endemic country. However, the previously polio-free countries of Angola, Cameroon, the Democratic Republic of Congo, Ethiopia, Kenya, Namibia and Niger experienced wild poliovirus importations (Figure 15).

94. Supplemental immunization activities for polio were conducted in 15 countries and targeted more than 73 million children. Nigeria implemented Immunization Plus Days, with up to 25% more children being immunized in the high-risk states of Kaduna, Kano, Katsina and Zamfara. Throughout the Region, 41 countries attained certification standard acute flaccid paralysis surveillance indicators. The African Regional Certification Commission accepted polio-free documentation from Burundi, Mauritius, Seychelles, South Africa and Uganda.

Figure 15: Comparison of wild poliovirus cases, African Region, 2005 and 2006



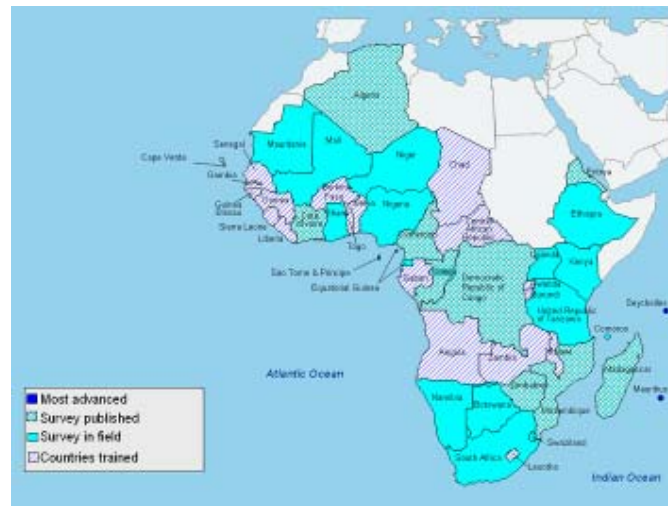
PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

95. Noncommunicable diseases and injuries represent a growing public health problem in the African Region, placing large social and economic burdens on countries. Noncommunicable diseases such as stroke, cardiovascular disease, diabetes and cancer are becoming increasingly common in the Region. Mental health problems have also been increasing, partially as a result of conflict and post-conflict situations. Tobacco is responsible for the death of one in ten adults worldwide, most of whom live in poorer developing countries where increasing tobacco use is largely due to aggressive marketing by the industry.

Management and Surveillance of Noncommunicable Diseases (NCD)

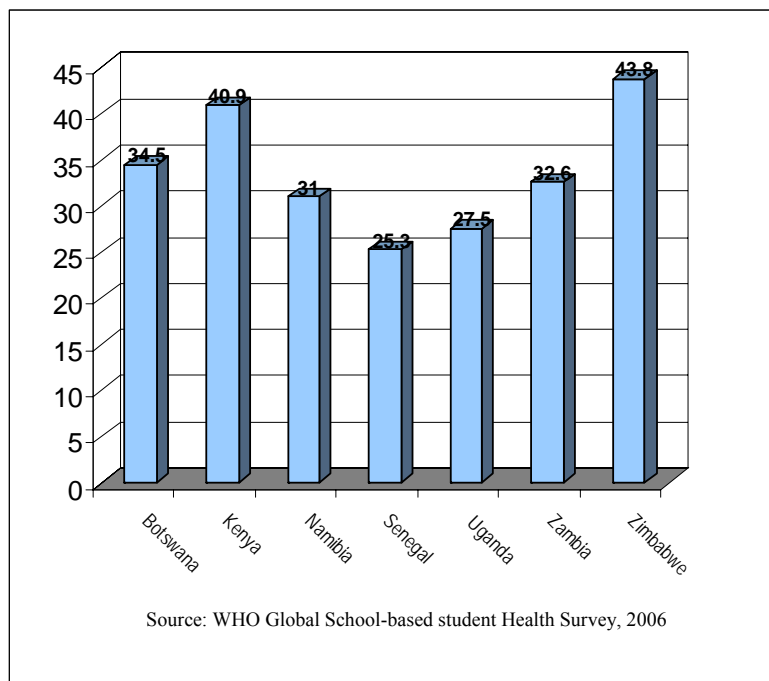
96. The WHO African Region was the first to complete STEPS (STEPwise approach to Surveillance) training methodology introduced by WHO for the surveillance of noncommunicable diseases. In 2006, 11 countries completed their STEPS surveys; 15 undertook the survey; and the remaining 20 countries received training in how to conduct the survey (Figure 16). The data from the 11 countries indicate a high prevalence of risk factors for noncommunicable diseases in the Region. Elevated blood pressure rates were 33.1% in Mozambique, 32.5% in the Republic of Congo, 29.1% in Algeria and 27.6% in Zimbabwe. Zimbabwe also reported 10% elevated blood sugar prevalence. The prevalence of preventable blindness is currently between 0.4% and 4%.

Figure 16: Progress in the use of STEPS surveys in the African Region, December 2006



97. Other STEPS methods such as the Global School-based student Health Survey revealed that these risk factors occur at early ages because students spend three or more hours per day in sedentary activities such as watching television, playing computer games or talking with friends (Figure 17). The consequence of these levels of prevalence is a high rate of mortality due to cardiovascular disease, diabetes, stroke and cancer.

Figure 17: Percentage of students 13–15 years spending three or more hours per day in sedentary activities, selected countries, WHO African Region, 2006



98. The Regional Office facilitated a framework for developing national programmes for management of sickle-cell disease. The framework, which had been requested by Member States at the fifty-sixth session of the Regional Committee, was reviewed at the third scientific congress on

sickle-cell disease in Dakar, Senegal. WHO organized a special meeting for five small island states (Cape Verde, Comoros, Mauritius, Sao Tome and Principe, and Seychelles) who reviewed the noncommunicable disease situation in their countries. With support, countries such as Cote d'Ivoire, Eritrea, Madagascar and Mozambique developed integrated control programmes.

99. Cameroon and the Democratic Republic of Congo started updating their diabetes control programmes. Angola, Cape Verde, Republic of Congo, Guinea-Bissau and Mauritania developed national preventable blindness programmes, and 39 countries developed national blindness prevention plans and participated in Vision 2020 workshops. Some countries, such as Ethiopia, Kenya, Rwanda, Tanzania and Uganda, developed district planning capacity for Vision 2020.

100. A manual entitled *Writing oral health policy* was published and disseminated in the African Region. Lesotho, Rwanda and Uganda finalized their national oral health policies. With support, 33 countries created national focal points for oral health at Ministry of Health level. As a result of integrating oral health into noncommunicable disease surveillance, the area of work developed a list of essential oral health indicators. A total of 23 countries⁸ reported cases of noma. The Regional Office reinforced the noma partnership with Winds of Hope which supported six countries to implement their national noma programmes.

Mental Health and Substance Abuse (MNH)

101. Progress made in the prevention and treatment of communicable and noncommunicable diseases was compromised by the consequences of civil and political conflicts, wars and disasters, all leading to displacement of populations. In this context, the burden attributable to mental and neurological disorders as well as psychosocial problems associated with harmful use of alcohol and illicit drugs, especially among the young people that represent about 45% of Africa's population, increased in the year under review.

102. Following World Health Assembly Resolution WHA58.26, Public health problems caused by harmful use of alcohol, the Regional Office trained 28 professionals from 16 countries in how to identify and implement appropriate strategies. The training focused on detection, management, treatment and prevention of the social and health consequences associated with alcohol and other psychoactive substances.

103. In 2006, the area of work conducted a skills mapping exercise in the African Region. All 46 countries gathered information regarding nursing resources for mental health. The survey pointed out needs in training, capacity building, environment and conditions of work. There were also issues related to carrying out appropriate mental health interventions at different levels of the health care systems in countries, especially primary care level.

104. Twelve experts from 10 countries in the Region reviewed and selected priority areas and levels of intervention for integrating mental health into primary health care services. They gave priority to conditions associated with epilepsy, psychosis, depression and substance abuse. With assistance from the Regional Office, Ghana and Mauritius trained experts in developing and reviewing national

⁸ Angola, Benin, Botswana, Burkina Faso, Central African Republic, Chad, Comoros, Republic of Congo, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

mental health legislation. The Gambia developed a mental health policy and a five-year plan of action. Benin, Central African Republic and Republic of Congo engaged in similar participative processes to develop mental health policies. The focus was on ensuring the protection of basic rights of individuals, particularly those living in difficult conditions. Cape Verde, Gabon and Namibia produced audio-visual materials to promote awareness.

Tobacco (TOB)

105. The Regional Office created a database containing the prevalence rates for tobacco use for 90% of the countries in the African Region. Tobacco use was still relatively high in Algeria (12.8%), Republic of Congo (14.4%), Madagascar (20%), Mozambique (18.7%), and Zimbabwe (12.1%) in the year under review. Global Youth Tobacco Surveys undertaken in countries indicated that regular smoking starts earlier in male adolescents with attention deficit disorder. The reasons for high rates of smoking among persons with mental and behavioural disorders were not clear. The exposure to second-hand tobacco smoke remained a problem in African countries where measures banning smoking in public places were weak. Children represented a large percentage of the population suffering from passive smoking.

106. The WHO Framework Convention on Tobacco Control was ratified by 30 countries. The first Conference of the Parties was successfully held in February 2006 in Geneva, with 16 low-income countries from the African Region attending. The Regional Office developed guidelines on implementation for the contracting Parties. Some countries developed and began enforcing tobacco control legislation. With support, ten new countries trained health staff to prepare and conduct Global Youth Tobacco Surveys; workshops trained participants from 18 countries in conducting data analysis.

Health Promotion (HPR)

107. In 2006, the Regional Office undertook capacity-building as a response to the emphasis on the various underlying determinants of health. This capacity-building enabled the national teams to implement comprehensive health promotion policies, actions, innovative interventions, and the collection and dissemination of information. With support from the Regional Office, countries trained experts to review national health promotion policies, and Eritrea, Guinea-Bissau, Malawi, Mozambique, Senegal and Swaziland embarked on broadening their policies. Other countries developed new policies to facilitate intensification and expansion of intersectoral collaboration for promoting health and preventing disease. The *Institut Régional de Santé Publique* in Benin and the Iringa Primary Health Care Institute in Tanzania initiated the development of new health promotion courses. The courses are competency-based; those who complete the courses will be able to facilitate implementation of integrated actions in response to prevalent and emerging diseases.

108. After an intercountry seminar organized by the Regional Office, 14 countries of the Southern African Development Community embarked on a long-term process of strengthening their health promotion infrastructure, policies and funding. South Africa implemented interactive community-based noncommunicable disease prevention projects in two provinces. The projects used both local and national resources.

109. With support, Mozambique, Namibia and Zimbabwe implemented comprehensive interventions aimed at enabling youth to respond to HIV, AIDS, substance abuse, physical inactivity, poor diet and other health problems. WHO worked with Education International to enable 14 countries⁹ to mobilize teachers to take action to prevent HIV infection and also support those among them infected with HIV and AIDS. Implementation of model school health interventions continued in Benin and Zambia; Algeria, Mauritius, Namibia, Seychelles and South Africa, continued implementing the health promoting school initiative.

110. Cameroon, Ghana, Mauritius, Seychelles and South Africa introduced or continued lifestyle-related activities as a way of addressing noncommunicable diseases. Physical activity and proper diet were the main areas of focus. A keen interest in health promotion by national focal persons, regional experts and WHO programme managers facilitated development and use of health promotion in the Region, while lack of high-level personnel and weak national infrastructure were major constraints.

Violence, Injuries and Disabilities (INJ)

111. In many countries, drowning was a common cause of death, but this was seldom recognized as most victims died before reaching hospital. Other important causes of injuries in 2006 were falls and burns. Disabilities, including blindness, were serious problems. Road traffic accidents caused the highest number of non-natural deaths and remained among the top five causes of death and disability in persons aged 5–44 years.

112. In October 2005, the United Nations General Assembly adopted a road safety resolution (A/60/5) which recognized the need for creating continuous awareness. It invited the UN regional economic commissions and WHO to jointly organize the first United Nations Global Road Safety Week. In 2006, the WHO Regional Office for Africa forged partnerships with the Economic Commission for Africa and other international NGOs to plan the high-level African Road Safety Conference for 2007.

113. Injuries from armed conflict, interpersonal violence, suicide and violence against children remained significant. Sustained advocacy from the Regional Office caused a number of countries in the Region to place injuries and violence high on their agendas. In April, South Africa hosted the Eighth World Conference on Violence and Injury Prevention which was attended by participants from 11 countries.

114. Work began on *The African report on violence and health* to be launched in 2007. The report will chart the way for countries, communities and civil society to advocate for and implement interventions to prevent violence. Ethiopia developed an injury and violence prevention policy using a comprehensive multisectoral consultative process. Ghana developed and launched a policy on disability and rehabilitation.

FAMILY AND REPRODUCTIVE HEALTH

115. Within its five areas of work, the Division of Family and Reproductive Health in 2006 provided support to Member States towards the achievement of Millennium Development Goals 3, 4, 5 and 6.

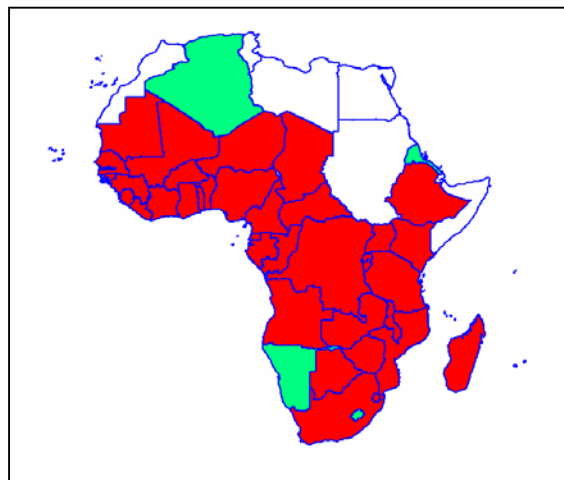
⁹ Botswana, Burkina Faso, Cote d'Ivoire, Guinea, Lesotho, Mali, Mauritania, Namibia, Niger, South Africa, Swaziland, Togo, Zambia and Zimbabwe.

Support provided continuous improvement of maternal, newborn, child and adolescent health; prevention and management of sexual and gender-based violence; and prevention of mother-to-child transmission of HIV infection. Moreover, nutrition and women’s health programmes enabled countries to control malnutrition and the devastating emerging diseases among vulnerable groups.

Child and Adolescent Health (CAH)

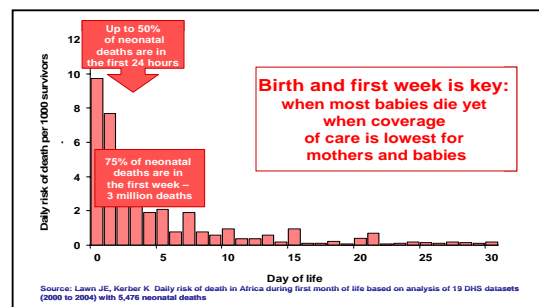
116. It is estimated that 4.6 million children under five years die yearly from preventable and treatable conditions in the African Region. Most countries have under-five mortality rates higher than 90 per 1000 live births (see Figure 18). Ministers of health concerned with this situation adopted the Child Survival Strategy and its resolution jointly developed by WHO, UNICEF and the World Bank at the fifty-sixth session of the Regional Committee in 2006. Subsequently, the Regional Office supported some countries to develop national child survival strategies and others to promote newborn health.

Figure 18: The 37 African countries (37) with the highest child mortality,



117. Given that neonatal mortality is highest during the first 24 hours of life (Figure 19), countries such as Eritrea, The Gambia, Malawi and Mozambique adapted Integrated Management of Childhood Illness (IMCI) guidelines for appropriate and timely newborn care. Cape Verde and Cote d’Ivoire conducted their first national IMCI training courses. Liberia, Rwanda and Sierra Leone reviewed and adapted IMCI guidelines. Central African Republic, Gabon and Guinea introduced IMCI pre-service training. Democratic Republic of Congo and South Africa conducted IMCI evaluations.

Figure 19: Newborn deaths in Africa



118. Tanzania and Zambia conducted assessments of newborn care, and operational research in Zambia compared the skills of primary health workers in managing sick children. The Zambian research analysed the effectiveness of training in the 11-day and 6-day IMCI courses. As a result, a policy decision was made to use the 6-day IMCI course to train primary health care workers.

119. Ghana, Mali and Senegal conducted assessments of the quality of care at referral health facilities. Nigeria provided training in emergency triage, assessment and treatment, and disseminated standards of care for sick children in referral facilities.

120. With Regional Office support, Ethiopia, Nigeria, Uganda and Zambia trained workshop participants to manage paediatric HIV/AIDS using the IMCI approach; 16 other countries received updates on diarrhoea management as well as prevention, treatment and care for paediatric HIV/AIDS. Gabon, Guinea-Bissau and Mauritania developed national Community-IMCI plans. Madagascar and Niger developed training materials for community case management of childhood illnesses. Ghana, Madagascar, Uganda and Zambia held Child Health Weeks which provided integrated packages of health and nutrition interventions.

121. During the year, 38 countries systematically implemented adolescent health and development programmes. Burkina Faso, Malawi and Swaziland initiated adolescent-friendly health services, and Lesotho, Senegal and Tanzania expanded their services. Mozambique, Namibia and Zimbabwe strengthened the Alliance of Parents, Adolescents and Community approach. The area of work documented and disseminated lessons learnt.

Reproductive Health (RHR)

122. To respond to the issues and challenges, the Reproductive Health area of work provided technical support to countries to strengthen capacities for planning, implementing and evaluating reproductive health services; promoted utilization of evidence-based practices for the implementation of services; promoted research and research-generated information for the improvement of sexual and reproductive health programmes and service delivery.

123. Burkina Faso, Ghana and Senegal, with Regional Office support, assessed reproductive health research centres to improve research and training capacities and to develop collaboration plans. Angola, Cape Verde, Guinea-Bissau, Mozambique, and Sao Tome and Principe trained 25 WHO and Ministry of Health programme managers in maternal, newborn and child health. Eritrea, Kenya, Mozambique, Tanzania and Zimbabwe trained 16 programme and data managers in the use of integrated monitoring and supervision tools. In the context of monitoring the Vision 2010 Initiative of West African First Ladies, the first maternal, newborn and child health taskforce meeting in October reached a consensus on the regional list of maternal and newborn health indicators.

124. Six countries¹⁰ implemented demonstration projects on the feasibility and acceptability of integrating cervical cancer screening into reproductive health services. Eleven countries¹¹ disseminated guidelines and training materials on maternal health, family planning and sexually-transmitted infection. Eleven countries promoted the use of operational research results to improve quality of care; one example was a study on the use of the partogramme in Guinea.

¹⁰ Madagascar, Malawi, Nigeria, Tanzania, Uganda and Zambia.

¹¹ Benin, Cameroon, Guinea, Kenya, Madagascar, Nigeria, Tanzania, Rwanda, South Africa, Zambia and Zimbabwe.

125. The technical unit developed a regional framework for integrating family planning, prevention of mother-to-child transmission (of HIV), malaria in pregnancy and nutrition into maternal and child health services. The Regional Office provided support for the formulation of the reproductive health strategy of the Southern African Development Community. The review of family planning advocacy tool started during 2006 and will be finalized in 2007.

Making Pregnancy Safer (MPS)

126. Maternal mortality in the African Region remained high in 2006. In addition to the absence of skilled birth attendants, HIV infection and malaria in pregnant women contributed significantly to maternal mortality and poor newborn health outcomes. Making Pregnancy Safer collaborated with other areas of work to develop a draft framework for integrating maternal, newborn and child health services.

127. The Regional Office assisted 25% of the countries in the African Region to develop national Road Maps for accelerating the reduction of maternal and newborn mortality. Burkina Faso, Mali, Mauritania, Senegal and Togo trained 16 facilitators to use the REDUCE/ALIVE tool, resulting in the adoption of national policies for the provision of free services for pregnant women. Nine countries in west Africa strengthened the capacities of 30 journalists to report on maternal and newborn health. Eritrea, Kenya, Mozambique, Tanzania and Zimbabwe trained 14 programme managers to use the WHO computer tools for monitoring and supervising maternal, newborn and child health activities.

128. Several countries provided training in HIV interventions for prevention of mother-to-child transmission (of HIV) as well as paediatric HIV care, treatment and support. Cameroon, Central African Republic, Equatorial Guinea, Eritrea and The Gambia reviewed their Malaria in Pregnancy policies and programmes. The Regional Office provided technical support to the East, Central and Southern Africa Health Community to develop policy briefs and a strategic plan on Malaria in Pregnancy.

Gender, Women and Health (WMH)

129. In 2006, many African women still lacked universal coverage and access to quality comprehensive sexual and reproductive health care. A WHO study on women's health and violence reported high prevalence of sexual and gender-based violence. Over three million girls in Africa undergo female genital mutilation (FGM) each year. The Regional Office continued implementation of the Women's Health Strategy developed in 2003. The emphasis during the year was to respond to three main issues: raising awareness on the health needs of women, sexual and gender-based violence, and female genital mutilation.

130. With Regional Office support, Kenya, Nigeria, Tanzania and Uganda shared experiences and trained health professionals in gender analysis and mainstreaming. The same countries used the gender and health kit, the gender mainstreaming guidelines and the gender analysis matrix to review their workplans on HIV and AIDS, malaria, and maternal morbidity and mortality. WHO advocated using the gender analysis matrix for obtaining sex-disaggregated data; as a result, the regional economic communities used gender analysis for better planning and programming.

131. The African Union, African Parliamentary Union and International Medical Women Association used WHO expertise to review and establish their programmes on FGM and sexual and

gender-based violence. In collaboration with the WHO Regional Office and FORWARD, Kenya hosted Burkina Faso, Mauritania, Nigeria and South Africa to look at the legal dimensions and the child abuse and protection issues of FGM; 25 countries participated in a telemedicine session on FGM. National medical journeys in Mali and Senegal reinforced the commitment to eradicate FGM. The Regional Office assisted GTZ to develop their action plan regarding FGM among migrant and refugee women.

Nutrition (NUT)

132. In the African Region, inappropriate infant and young child feeding as well as nutritional deficiencies remained major underlying factors of mortality and morbidity. More than 50% of mortality and morbidity in pregnant women and children under five was a result of malnutrition. In addition, obesity, diabetes, certain diet-related cancers and cardiovascular diseases accounted for 28% of morbidity and 35% of mortality.

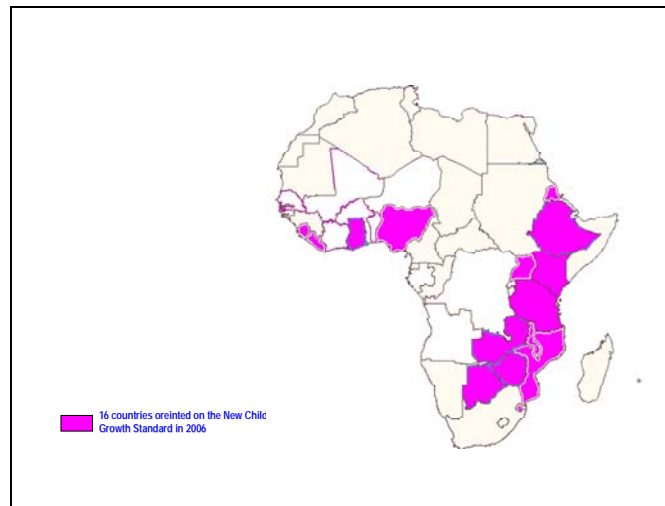
133. The Regional Office developed the plan of action for implementing the nutrition strategy, and 23 countries made commitments to control malnutrition in Africa using a multisectoral approach. Benin, Mali, Niger Togo and Zambia developed national infant and young child feeding strategies. The Regional Office also developed frameworks to integrate nutrition in maternal, newborn and child health services and to include people living with HIV/AIDS in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO strengthened organizational partnerships and those with key stakeholders to mainstream nutrition and mobilize resources for actions at regional and country levels.

134. With support, eight countries reviewed maternal and child under-nutrition policies. Botswana, Eritrea, Guinea, Kenya and Malawi finalized food and nutrition policies and plans; 11 countries developed implementation plans for the Baby-Friendly Hospital Initiative in the context of HIV/AIDS. In order to integrate nutrition into their national Road Maps for reducing maternal and newborn mortality, 22 countries developed action plans for promoting optimal fetal growth and development. Nigeria finalized a training manual on the International Code of Marketing of Breast-milk Substitutes; Gambia and Zambia enacted the code into national laws.

135. Botswana, Madagascar, Niger and Tanzania conducted training for the development of national guidelines on facility-based management of severe malnutrition. Eight countries¹² used the Integrated Infant and Young Child Feeding Counselling Course for training of trainers. The area of work orientated 16 countries on the new WHO child growth standards (Figure 20) and the revitalization of the nutritional surveillance system to monitor nutritional status in the Region.

¹² Cameroon, Cote d'Ivoire, Ghana, Nigeria, Sierra Leone, Tanzania, Zambia and Zimbabwe.

Figure 20: Countries orientated on the new WHO child growth standards, Africa Region, 2006



HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT

136. In 2006, the Regional Office addressed some of the healthy environments and sustainable development challenges through contributions from the four areas of work within the Division of Healthy Environments and Sustainable Development: Policy-making for Health in Development; Health and Environment; Emergency Preparedness and Response; and Food Safety.

Policy-making for Health in Development (HSD)

137. Poverty, conflicts and risks associated with contaminated water and food, poor sanitation and unsuitable environmental conditions remained the key determinants of health in Africa in 2006. The target date for the Millennium Development Goals was less than eight years away. Interest in the progress towards the MDGs acted as a push factor for achievement in many countries. The *Strategic orientations for WHO action in the African Region, 2005–2009* refined the Region’s priorities for responding to the key determinants of health.

138. Financial support through the EU-WHO partnership programme assisted six countries in the Region to address the MDGs. The Regional Office commissioned a report to review countries’ achievements in meeting the MDGs, and the initial data suggested that few countries in the African Region were tracking the MDGs. The paucity of information available required that a more detailed review be carried out. The challenge for WHO was to help countries monitor and evaluate progress. WHO continued to develop frameworks and guidelines for helping countries develop and implement policies and strategies to reduce inequalities and increase health investments for the poor.

139. The Regional Office prepared a draft framework on the social determinants of health. The Office held a meeting of African civil society facilitators to produce a workplan for civil society involvement in the WHO Commission on Social Determinants of Health (CSDH). The CSDH secretariat supported studies on equitable access to health care services in several countries.

140. Kenya hosted the fifth meeting of the WHO Commission on Social Determinants of Health in Nairobi and agreed to establish a national commission on social determinants of health. To promote

issues on trade, poverty and health in sustainable development, technical staff prepared a paper for the consideration of Member States during the fifty-sixth session of the Regional Committee. Member States subsequently passed a resolution to commit countries to promote equity in issues of health development.

Health and Environment (PHE)

141. In 2006, between 60% and 70% of infectious and parasitic diseases within the African Region were attributed to environmental factors. These factors were associated mainly with the spread of unplanned poorly-constructed urban settlements. Within households and communities, inadequate supply of safe drinking water and poor sanitation and hygiene behaviours contributed significantly to ill-health. Many of these diseases could be prevented if adequate resources and political will for change were made available. There was also growing evidence that climate change contributed significantly to increases in disease transmission rates.

142. During the year, Comoros, Gabon, Guinea, Kenya and Rwanda initiated preparations to develop national policies on environmental health; The Gambia and Swaziland focused on occupational health development. A total of 18 countries developed specific action plans for waste management. Five countries strengthened activities for the monitoring quality of drinking water. Guinea-Bissau, Sao Tome and Principe, and Zimbabwe improved sanitation through the construction of wells and latrines. Cameroon, Kenya, Mali and Mozambique documented school grounds, food safety and hygiene conditions. With Regional Office technical support, Côte d'Ivoire managed a hazardous waste dumping crisis.

143. Kenya initiated a project to decrease health vulnerability due to climate variability and climate change. Cameroon and Republic of Congo prepared malaria entomological profiles, while Democratic Republic of Congo, Ethiopia and Nigeria initiated such profiles. With Regional Office support, Angola, Cameroon, Kenya, Mali and Mozambique assessed the food safety and environmental health needs of schools.

Emergency Preparedness and Response (EHA)

144. In 2006, health-related emergencies due to civil conflict, crop failure, drought and floods continued to challenge the African Region. Governance affected agricultural activities and food insecurity in some southern African countries, and drought and floods continued their co-existence in the Horn of Africa. The Regional Office initiated a Global Health Action in Crises Survey which will serve as the basis for preparedness and response support to countries. However, existing capacity to address these issues remained remarkably low.

145. The Region engaged three additional nutritionists as part of the three Inter-country Support Teams and recruited six other focal persons, increasing the area of work staff to 21 in 2006. To further develop and implement plans of action, the Region also recruited national personnel. The Regional Office provided technical, material and financial support to 23 countries for their emergency preparedness and response activities. With support, Mozambique and Sao Tome and Principe participated in senior management emergency preparedness and response training in Brazil. Nationals from Benin, Cote d'Ivoire, Democratic Republic of Congo, Senegal and Togo participated in a similar course provided by the *Institut de Santé Publique* (Benin).

146. Both the African Regional Office and the Eastern Mediterranean Regional Office of WHO opened a Horn of Africa collaboration centre in Nairobi, Kenya to address the chronic natural disasters and crisis situation in that part of the continent. The efforts of Emergency Preparedness and Response (Regional Office) and Health Action in Crises (headquarters) in this Region and the successful implementation of OCHA-funded projects in the Horn helped secure grants from the Central Revolving Emergency Fund for 11 countries in Africa, with many already receiving more than two grants.

Food Safety (FOS)

147. In 2006, contaminated food and water continued to cause up to five episodes of diarrhoea per child per year, resulting in a total mortality of around 700 000 for all age groups in Africa. Several food-related outbreaks occurred in the Region, and the fatality rates for acute aflatoxicosis increased to 40%. Other food safety concerns were associated with the new and emerging threats of chemical contaminants such as pesticides, nuclear contamination and microbial toxins. Funding for food safety assurance remained inadequate. Most national food control systems remained fragmented in several sector agencies with insufficiently-defined mandates, inadequate food laws, poor laboratory infrastructure and weak surveillance activities.

148. Taking guidance from Resolution AFR/RC53/R5 on food safety, Regional Office activities for the year focused on strengthening capacities for food-borne disease surveillance; enhancing participation of countries in the Codex Alimentarius Commission; developing food safety policies and strategies; training staff on implications of the unsafe mycotoxins in food; and food safety education.

149. The Regional Office finalized guidelines for food-borne disease surveillance and food monitoring and the guidelines on food safety policy and legislation. Kenya reviewed its food safety policy, and Algeria launched a national food safety action plan. The Regional Office provided support during outbreaks of aflatoxicosis in Kenya, infantile diarrhoea in Botswana and acute watery diarrhoea in Ethiopia. Senegal established a food-borne disease surveillance system.

150. Participants from Cameroon and Ghana attended the Total Diet Training Workshop in October, acquiring skills for monitoring of chemicals in foods. Participants from Botswana, Lesotho, Namibia, South Africa, Zambia, and Zimbabwe attended a joint WHO/FAO workshop on strengthening food safety in small and less-developed food businesses. The Regional Office pilot-tested the document, FAO/WHO guidance on the application of hazard analysis and critical control points in small and less-developed food businesses, and prepared proposals requesting World Trade Organization funds for projects in Benin and Tanzania.

Figure 21: Expired products seized during a food safety campaign in Lesotho



151. The Regional Office reported on capacity-building activities at the twenty-ninth session of the Codex Alimentarius Commission and at the Codex Coordinating Committee for Africa. The Codex Trust Fund supported 22 African countries to attend various Codex meetings. The Republic of Congo and Lesotho re-inaugurated their national codex committees. The Republic of Congo and Democratic Republic of Congo attended a WHO/FAO course on the Codex. Participants from Cameroon, Chad, Republic of Congo, Guinea, Lesotho and Mali initiated food safety educational projects using the WHO Five Keys to Safer Foods.

ADMINISTRATION AND FINANCE

152. The successful implementation of WHO's technical programmes with countries partly depends on the effective delivery of support services by the Division of Administration and Finance. In 2006, the Division's focus in service delivery was dominated by the establishment of the Intercountry Support Teams (ISTs) in three countries (Burkina Faso, Gabon and Zimbabwe); reassignment and appointment of staff to the Regional Office in Brazzaville; and the closure of the adjunct regional office in Harare. To support and sustain the implementation of the restructuring process, the Division placed more emphasis on services from the following areas of work: Infrastructure and Logistics; Human Resources Management in WHO; and Budget and Financial Management.

Infrastructure and Logistics (IIS)

153. In 2006, the Regional Office implemented the decision by Member States to return all functions and staff to the original location in Brazzaville. However, office space within the Regional Office complex was still very limited compared to needs. Provision of accommodation for all international staff within the environs of the offices was no longer feasible. As a consequence, staff reassigned to Brazzaville were encouraged to lease private accommodation outside the WHO compound. In Gabon, the government donated a building for the Intercountry Support Team, and extensive refurbishment began to bring it to the required standards.

154. Tender for supplies and services using approved tendering procedures significantly improved at both regional and country levels. This was partially due to the installation of an updated database of suppliers and a statistical data recording system.

155. For field security, the area of work installed the Integrated Services System database to streamline operations. The system was available on the AFRO Intranet and was accessed by staff members through the self-service function. It was extended to cover all 46 country offices in the African Region. The purchase of photo equipment enabled ease of staff identification by relevant security agencies.

Human Resources Management in WHO (HRS)

156. At the end of 2006, staff strength of WHO in the African Region was 2547, those at the Regional Office numbering 436. The Regional Office recruited eight new WHO country representatives based on examinations and interviews. The Regional Office worked in close collaboration with technical divisions, country offices and headquarters to finalize the regional staff development and learning strategy. It also developed a plan to decentralize some human resource functions to the Intercountry Support Teams. In the context of contract reform, the area of work established more than 500 posts to convert temporary positions to fixed-term positions. Eleven first-

time WHO country representatives trained in capacity-building. The Global Management and Leadership Programme held regional workshops for senior managers. The area of work supported the reprofiling exercise in both the Regional Office and the country offices, and assisted with the closure of the adjunct office in Harare. A major constraint remained the limited number of professional staff to handle the heavy workload and increasing demand for human resource services.

Budget and Financial Management (FNS)

157. For the 2006-2007 biennium, a total of US\$ 203.6 million was approved from the Regular budget. This constituted 21.4% of the actual budget needed. It is anticipated that an amount of US\$ 746.8 million will be received from sources other than the Regular budget. As of December 2006, the total expenditure of the approved budget was US\$ 360.4 million which represented 37.9% of the projected total for the biennium. In more recent meetings, the budget implementation status was exhaustively discussed and funds were re-allocated according to needs.

158. During the year, budget and finance functions were consolidated in Brazzaville. The Regional Office also changed from an electronic banking system to a web banking system for international transfers to replenish country office imprest accounts. This significantly reduced the time lag for transfers to country offices and thus expedited the implementation of operations and activities.

159. Some financial management was decentralized when some finance officers were deployed to the Inter-country Support Teams. Additional functions were considered for decentralization when the global management system is implemented in the Region.

160. The move towards delegation of authority to country offices and ISTs will place more emphasis on Regional Office oversight and increase the number of budget monitoring reports produced. This will also require more activities related to staff reviews and training at the country office level. However, the limited number of staff at middle management level significantly limit direct supervision of activities and hinder efforts to improve internal control, compliance and monitoring. This needs to improve significantly before effective monitoring and more prudent financial management can be established.

FACTORS IN PROGRAMME BUDGET IMPLEMENTATION

Enabling Factors

161. Several factors contributed to achievements in 2006. There has been a high level of cooperation from the countries as well as a high level of professionalism by country office staff. For many programmes, the presence of counterparts (national professional officers) in some country offices improved implementation and follow-up on activities.

162. Establishment of the Inter-country Support Teams very early on demonstrated the effectiveness of bringing support closer to countries. Among others, the availability of Epidemic Alert and Response teams at inter-country level and the use of Regional Rapid Response Network members constituted excellent examples of timely provision of technical support. The Network facilitated the implementation of activities related to the improved detection of disease outbreaks and rapid notification to WHO.

163. Close collaboration of some areas of work across Divisions produced positive results. Inter-programme collaboration was critical for effective health promotion actions. Collaboration with colleagues at HQ and in country offices, ministries of health, and other key national and international stakeholders also facilitated progress. Regional staff were very proactive and cooperative. The climate of excellent interaction between HQ and the Director-General, Regional Director and Independent Functions area of work (DGO) was helpful. Possibly the most important lesson learnt in the past year was that personal visits of the Regional Director to country level are irreplaceable.

164. Internally at the Regional Office, regular meetings of the Executive Management Committee and the Management Development Committee provided opportunities to share strategic information and harmonize views on the strategic orientations. The positive communication between the two committees was very instrumental in reaching the expected results and delivering most of the desired products.

165. Increasing country ownership and leadership as well as the collaboration and joint planning with other United Nations agencies facilitated many achievements. The Regional Office practised closer collaboration with the African Union, the Economic Commission for Africa and the regional economic communities; and reinforced positive working relationships with various United Nations agencies, World Bank, International Monetary Fund, bilateral donors, and public and non-government sectors.

166. Some areas of work benefited from the availability of voluntary funds to scale up interventions. Assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria benefited several national tuberculosis programmes, and availability of free quality anti-TB drugs from the Global TB Drug Facility significantly facilitated TB control interventions. In polio, donor funding for the interruption of wild poliovirus transmission, GAVI support for routine immunization and measles partnership support mobilized resources to implement vaccination activities and the integration of child survival interventions in supplemental immunization activities.

167. To reinforce collaboration with key stakeholders as well as support countries in the mobilization of funds, Regional Office staff participated in various meetings. These included attending the meeting of the European Commission Humanitarian Aid Department (ECHO) in Brussels as the HQ Human Action in Crises member of delegation; two Global Scenario Group meetings in Bogota and Geneva; meetings in Cairo and Nairobi for the Horn of Africa countries; and Health Cluster Coordination meeting in west Africa, the Great Lakes and the Horn of Africa.

168. Based on the success of managing the replenishment of imprest accounts on the web bank, the Budget and Financial Management area of work will actively explore the possibility of extending the application to include the banking needs for payroll and payment of vendor claims. The challenge will be to ensure that web banking is compatible with the payment platform of the WHO Global Management System.

Constraining Factors

169. Delays in disbursement of funds and late requests for technical support from countries were some of the major constraints to the implementation of activities. Furthermore, in some areas of work

planned voluntary contributions were not received and thus compromised the implementation of the Programme Budget.

170. The low human resource capacities in some areas of work, some country offices and most ministries of health remain major constraints. Areas of work have pivotal roles during this transition period; therefore, issues related to limited budget and capital resources have been brought to the forefront of constraints that need to be addressed in order to sustain the current service delivery momentum. Insufficient national stewardship and coordination were reported as obstacles to scaling up key maternal and newborn interventions at regional, intercountry and country levels.

171. In some specific programmes dealing with noncommunicable diseases, major constraints such as scarcity of resources, inadequate awareness by people and policy-makers, and limited data compounded the situation and call for intensified action. The low priority given to noncommunicable diseases at country level exists because the increasing negative effects of these diseases on public health are not recognized. Another continuing constraint is that conflicting priorities, such as major outbreaks, often divert staff from implementing planned activities. In communicable diseases, constraining factors were the suboptimal routine immunization coverage leading to wild poliovirus importations and measles outbreaks, and the weakness of health systems to deliver high-quality immunization services.

3. PROGRESS TOWARDS IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

Improving Access to Care and Treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and Beyond

172. The WHO Regional Committee for Africa, at its fifty-fourth session, adopted a resolution (AFR/RC54/R5) welcoming the WHO/UNAIDS strategy to mobilize resources globally and support developing countries to place 3 million people on antiretroviral therapy by the end of December 2005.

173. Since the launch of The 3 by 5 Initiative, coverage of antiretroviral therapy (ART) has increased tremendously—from less than 1% in December 2003 to 17% in December 2005, then to 28% in December 2006. By the end of 2005, Botswana, Namibia and Uganda had reached the target coverage of 50%. At the end of 2006, Botswana, Namibia and Rwanda had coverages above 50% and 11 other countries had coverages between 30% and 49%. By the end of December 2006, ART coverage in children was 13%, coverage of PMTCT services was 11% and HIV testing and counselling coverage was 12% and 10% for men and women, respectively.

174. The Regional Director convened a meeting of regional heads of United Nations agencies to develop a joint plan for HIV prevention and universal access to treatment. WHO jointly organized with UNAIDS three subregional meetings on universal access to undertake advocacy for accelerating universal access to HIV prevention, care, treatment and support.

175. The Regional Office developed HIV testing and counselling guidelines and training manuals, and later updated the guidelines to include the new provider-initiated testing and counselling approach. With support, all the countries developed plans for scaling up ART. The Regional Office established two subregional knowledge hubs to provide technical support for training health workers

in HIV care and treatment using the Integrated Management of Adolescent and Adult Illness approach.

176. The Secretariat organized two training workshops on the development of proposals for GFATM Round 7; 25 countries that had earlier developed proposals for GFATM Rounds 5 and 6 received support to develop proposals for Round 7. The WHO Director-General and Regional Director helped mobilize resources from CDC, CIDA, DFID, the government of Angola, GTZ, Italian Initiative and OFID for improving access to antiretroviral therapy.

177. With support, 23 countries developed draft institutional development plans for vaccine regulatory systems in order to promote HIV vaccine development research. The Regional Office established the Regional Regulatory Advisory Panel to support countries to develop and strengthen their regulatory capacity to approve and monitor clinical trials and evaluate clinical data for HIV vaccines.

178. Although access to HIV prevention, care and treatment in the African Region increased, it was not yet universal. There is need to continue to accelerate the scale-up efforts. There is need also to scale up paediatric HIV care and treatment. Despite the reduction of the prices of medicines, advocacy for further price reductions is needed, especially for second-line treatment regimens. Health systems need to be strengthened further.

Acceleration of HIV Prevention Efforts in the African Region

179. In August 2005, the Regional Committee adopted Resolution AFR/RC55/R6 in Maputo. The resolution declared 2006 the Year for Acceleration of HIV Prevention in the African Region and urged Member States to intensify HIV prevention efforts. In addition, it requested the Regional Director to develop a strategy for accelerated HIV prevention; provide technical support to Member States in the development and implementation of action plans for acceleration of HIV prevention; mobilize long-term international support; ensure effective leadership and coordination of HIV prevention efforts in collaboration with UNAIDS; monitor progress in scaling up HIV prevention efforts in the Region; and report to the Regional Committee every two years.

180. In August 2006, the Regional Committee at its fifty-sixth session in Addis Ababa adopted the strategy for HIV prevention in the African Region together with Resolution AFR/RC56/R3. This strategy aimed to scale up health sector HIV prevention interventions and integrate HIV prevention with treatment, care and support in order to make a meaningful impact.

181. The Regional Office officially launched the campaign for accelerating HIV prevention in the African Region in Addis Ababa in April 2006 under the auspices of the African Union along with satellite subregional launches in Johannesburg, Khartoum and Ouagadougou. By December 2006, with WHO technical and financial support and inputs from other United Nations agencies, all countries but one had officially launched national campaigns to accelerate HIV prevention under the leadership of the highest national authorities, including heads of state and government and first ladies, and with the involvement of all key stakeholders at country level.

Control of Human African Trypanosomiasis: A Strategy for the African Region

182. Regional Committee Resolution AF/RC55/R3 urged Member States of affected countries to develop national policies, strategies and plans to implement human African trypanosomiasis (HAT) control programmes and to control tsetse. It requested the Regional Director to provide technical support to countries and report on progress at the fifty-seventh session of the Regional Committee, and every three years thereafter.

183. As part of the implementation of the resolution, 16 endemic countries carried out HAT control activities in priority areas with the result that all the countries achieved 100% treatment of all detected cases. Angola and Kenya developed project proposals for fundraising and strategic plans for HAT elimination, and the Regional Office developed draft guidelines for *T.b. rhodesiense* HAT control. Angola, Benin, Democratic Republic of Congo, Gabon, Malawi, Nigeria, Tanzania and Uganda strengthened their national capacities by training 80 staff members in diagnosis and treatment and to conduct situation analyses and develop action plans for scaling up control activities.

184. The Regional Office collaborated with TDR, the Drugs for Neglected Diseases Initiative and national research institutions to promote clinical trials of combination therapy in Angola, Republic of Congo, Democratic Republic of Congo and Uganda where HAT was refractory to the trypanocides being used. The Regional Office developed partnerships for resource mobilization with the Japanese International Cooperation Agency in Guinea; with the French Research Institute for Development in Burkina Faso, Côte d'Ivoire and Guinea; and with the ADB-sponsored Pan-African Tsetse and Trypanosomiasis Eradication Campaign projects in Burkina Faso, Ghana, Kenya, Mali and Uganda.

185. Major constraints to the implementation of HAT activities included inadequate funding of programmes; slow implementation of activities by countries; and difficult access to areas affected by insecurity and sociopolitical upheaval. Support from private partners and bilateral cooperation agencies as well as joint planning with countries have been major enabling factors that need to be sustained.

186. Future prospects include intensified yearly case detection in all active foci and advocacy for resource mobilization in order to significantly increase the coverage of the populations at risk.

Road Map Accelerating for the Attainment of the Millennium Development Goals Relating to Maternal and Newborn Health in the Africa

187. The Regional Committee by Resolution AFR/RC54/R9 requested the Regional Director to provide technical support to Member States for the development, implementation, monitoring and evaluation of the national Road Maps; to develop relevant tools and guidelines; and to support countries to embark on aggressive campaigns for the training of middle-level health workers in obstetric care.

188. In this context, WHO and other relevant partners provided financial and technical support to 31 countries to develop their national Road Maps. In addition, WHO trained a core group of 40 consultants in order to increase the availability of technical assistance at country level for the development and implementation of national Road Maps.

189. To strengthen maternal and newborn health service delivery, the Regional Office developed a framework for integrated maternal and newborn health services; and provided countries with guidance for the integration of different key interventions to improve the quality of services; and disseminated Tools for Integrated Management of Pregnancy and Childbirth. Furthermore, ten countries received guidance for integrated supervision and monitoring of maternal, newborn and child health services.

190. Participants at a regional consultation reached a consensus on what should constitute the minimum essential competencies of a skilled attendant. These competencies formed the basis for the development of an adequate curriculum for training in emergency obstetric care for middle-level personnel.

191. Strong political commitment, increased volume of resources and greater interest of partners in joint action at country level facilitated the development and implementation of the Road Map. Understaffing of the Making Pregnancy Safer area of work was a major constraint. Inadequate technical resources and poor infrastructure hampered efforts to increase access to skilled attendance and scale up key maternal and newborn mortality and morbidity reduction interventions.

Injury Prevention and Control in the African Region: Current Situation and Agenda for Action

192. At its fifty-third session, the Regional Committee requested (AFR/RC53/R3) the Regional Director to provide countries with guidelines and other tools for advocacy and action; support Member States to mobilize the resources needed for injury and violence prevention as well as build networks and partnerships; support national and regional research on the causes, risk factors and consequences of injury and violence; document and disseminate examples of best practices in injury and violence prevention; and assist Member States to acquire adequate information systems and monitor their operation.

193. The Regional Office provided the following tools to Member States: Guidelines for conducting community surveys on injuries and violence (2004); Guidelines for Essential Trauma Care (2004); Prehospital trauma care systems (2005); and Guidelines for the medico-legal care of victims of sexual violence (2004). Preparation of the report on violence and health in Africa began, and it is expected to be launched in late 2007. The report identifies the main causes and risk factors, proposes preventive measures and showcases best practices. The Regional Office worked jointly with partners to organize high-level advocacy events or at least provided technical support to Member States to organize such events which included a ministerial consultation on violence and injuries held in Durban, South Africa, in April 2004 and a ministerial round table on road safety, held in Accra, Ghana in February 2007.

194. The Regional Office gave technical and financial support to Cameroon, Ethiopia, Kenya, Mozambique, Nigeria and Uganda to conduct road safety research; and to Cameroon, Eritrea, Ethiopia, Mozambique and Uganda to develop or improve data systems for injuries and violence. In addition, the Regional Office conducted a capacity building workshop for Benin, Burundi, Cameroon, Democratic Republic of Congo and Rwanda to strengthen the integration of injuries and violence in disease prevention and control efforts in countries through a special curriculum. Similar workshops are planned to cover all countries eventually.

195. The Regional Office took the initiative for establishing a network of Ministry of Health focal persons responsible for violence and injury prevention, and linked this network with international networks in an effort to strengthen capacity at country level. In partnership with the United Nations Economic Commission for Africa, African Union and World Bank, the Regional Office initiated and strengthened multisectoral linkages within countries to deal with road safety issues.

Cardiovascular Diseases in the African Region: Current Situation and Perspectives

196. At its fifty-fifth session, the Regional Committee by Resolution AFR/RC55/R4 requested the Regional Director to provide technical support for the development of national policies and programmes; to increase support for training of health professionals in Member States; to prevent and control cardiovascular diseases, including monitoring and evaluation; and to mobilize additional resources for the implementation of national cardiovascular disease control programmes.

197. In order to build an evidence base for informed decision-making, the Regional Office trained all Member States in the STEPS methodology by the end of June 2006, making the African Region the first to complete training in the conduct of the STEP surveys. With support, 15 countries¹³ implemented the STEPwise approach.

198. Comoros, Sao Tome and Principe, and Tanzania organized national workshops on noncommunicable diseases. Eritrea used available information to prepare a noncommunicable disease policy. Cote d'Ivoire, Eritrea and Madagascar, undertook health promotion activities which emphasized control of noncommunicable disease risk factors.

199. The Regional Office implemented priority interventions to reduce the burden of cardiovascular diseases. An intercountry workshop on the use of physical activity and diet as entry point for the prevention of noncommunicable diseases in Kampala brought together 27 participants from Botswana, Eritrea, Ghana, Kenya, Mauritius, Seychelles, Uganda, and Zimbabwe. WHO staff from headquarters, the Regional Office and Uganda and representatives of partners such as Right to Play and UNICEF also attended that workshop. The overall objective was to contribute to the prevention of noncommunicable diseases through the promotion of physical activity and other appropriate interventions, especially diet. The specific objectives were to discuss the justification for investing resources in physical activity and diet programmes at national and local levels; identify key settings, populations and stakeholders, including stakeholders, in physical activity and other relevant interventions; examine key approaches to addressing issues related to physical activity; and agree on mechanisms for networking among stakeholders.

200. In order to reduce cardiovascular disease co-morbidities, the Regional Office developed a framework national action plan on sickle-cell disease prevention and control for Member States, thus providing a guide and basis for establishing national programmes and plans for the prevention and control of sickle-cell disease. A workshop in Bamako on systems for diabetes management in the African Region brought together participants from eight countries.¹⁴

¹³ Botswana, Comoros, Cote d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ghana, Mali, Mauritania, Mozambique, Sao Tome and Principe, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe.

¹⁴ Benin, Burkina Faso, Central African Republic, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Mali and Senegal.

4. PERSPECTIVES FOR 2007

Overall Management of Secretariat Actions

201. In 2007, one of the most important tasks of the WHO African Region will be the firm establishment of the Intercountry Support Teams. The guidelines for the operations of the Intercountry Support Teams will be further strengthened to enable the Regional Office to build a stronger workforce at the intercountry level and thereby allow the Regional Office to devote more time to normative work, planning, monitoring and evaluation.

202. WHO country offices will be further strengthened to align with the strategic orientations and directions. With the Intercountry Support Teams in place, follow-up and monitoring of national and international health milestones and goals such as the MDGs will be intensified. The Regional Office will facilitate the sharing of best practices among countries. It will continue its effort to provide countries with the best technical staff while building on the existing human resources base, strengthening their capacities through the electronic media and other means.

203. With regard to knowledge and evidence bases for health decision-making, the key orientation for 2007 will be to forge greater linkages in health information, research and knowledge management. Preparations for the Global Conference on Research for Health scheduled for Bamako in 2008, strengthening of EVIPNet and expansion of the impact of WHO collaborating centres will continue.

204. One of the key activities in 2007 will be the preparation of 2008-2009 workplans. Ongoing efforts at rolling out the Global Management System will focus on functional and technical design, customization, preparation for conversion and system testing, among other things.

Health Systems and Service Development

205. Joint planning between WHO headquarters, Regional Office and country offices, and collaboration with key stakeholders will be enhanced. Integrated technical support to countries is expected to improve efficiency.

206. WHO will continue to support countries to formulate or revise policies and strategic implementation plans that address prevailing local situations. This will require in-depth situation analyses as well as identification and sharing of documented best practices. Resource mobilization will be strengthened and efforts will be made to increase collaboration among headquarters, Divisions of the Regional Office, and key partners.

Prevention and Control of Communicable Diseases

207. Scaling up HIV prevention will be accelerated, building on the gains made in increasing access to HIV/AIDS prevention, treatment, care and support services in the pursuit of universal access. Greater emphasis will be put on supporting the expansion of a core group of health sector HIV prevention interventions comprising testing and counselling, with focus on the provider-initiated testing and counselling approach. Prevention of mother-to-child transmission, prevention and control of sexually-transmitted infections and male circumcision will be given emphasis; partnerships for more effective multisectoral involvement will be strengthened in addition to scaling up antiretroviral therapy to ensure maximum impact. Effective monitoring and evaluation systems will be strengthened and partnerships promoted at all levels.

208. As regards malaria, the Regional Office will provide appropriate support to countries for strategic planning and programme development; full and correct implementation of the artemisinin-based combination therapy policy; scaling-up community-based management and key malaria prevention interventions such as ITN, IRS, IPT in pregnancy; strengthening epidemic preparedness, surveillance, monitoring and evaluation.

209. Under tuberculosis control, the Regional Office will provide appropriate support to countries to increase the case detection rates; ensure full implementation of quality DOTS services; develop and implement the policy for controlling the TB-HIV dual epidemic; and prevent and manage drug resistance.

210. Concerning neglected tropical diseases, an integrated approach to the implementation of activities, advocacy for commitment of all partners and development of the resource mobilization plan will be the key orientations for 2007. The focus will be on advocacy and integration of control interventions. In research, emphasis will be on ensuring that available drugs, technologies and interventions remain viable and that new ones are developed to replace those that are inadequate. Priority will be given to strengthening national capacity to document research and disseminate results in order to enhance their use in both policy and practice.

211. Expanding partnerships and scaling up the implementation of Integrated Disease Surveillance and Response to reach all districts in all countries will be pursued and consolidated to ensure the sustainability of epidemic alert activities. Preparedness for implementation of the *International Health Regulations* (2005), including assessment of capacities, will be enhanced to support Member States. Furthermore, Member States will be supported to build minimum emergency stocks for prompt response to any disease outbreak. Support for implementation of the national pandemic influenza preparedness and response plan will be further intensified and streamlined in collaboration with other UN agencies and partners.

212. Immunization and vaccine priority areas will include implementing measures to limit wild poliovirus transmission in the remaining endemic country; stopping the spread of wild poliovirus in importation countries; sustaining certification level surveillance in all Member States; accelerating the achievement of measles control goals; and strengthening immunization systems.

Prevention and Control of Noncommunicable Diseases

213. In 2007, the Regional Office will work with Member States to develop national plans of action, legislation and policies covering all major noncommunicable disease control programmes such as tobacco, mental health, health promotion, noma, injury prevention and oral health. The focus will be on capacity-building for selected countries, including working with leading training institutions in the Region to initiate a consolidated health promotion training that builds on existing information, education and communication as well as health education courses, starting with the *Institut Régional de Santé Publique* in Benin. The Regional Office will develop frameworks for increasing community participation in WHO priority programmes and in epidemic preparedness and response, based on health promotion approaches.

214. Concerning surveillance, some countries will be assisted to undertake surveys in STEPS, tobacco and school student health as appropriate, and others will be supported to integrate oral health and noma into noncommunicable disease control surveillance. The Mental Health area of work will

coordinate the collection of data, at national and regional levels, on mental health and substance abuse.

215. Countries will be supported to document community-based rehabilitation activities. Programmes and advocacy to increase political support for noncommunicable disease prevention and control and, in particular, to sustain the momentum gained in tobacco control and mental health will be sustained. Some countries will be supported to improve data on blindness and strengthen capacity for blindness prevention and care.

Family and Reproductive Health

216. In 2007, the Regional Office will intensify its efforts to accelerate the attainment of MDGs related to maternal, newborn, child, reproductive, gender and women's health in countries of the African Region. To this end, it will provide support to countries to accelerate the implementation of integrated maternal, newborn and child health interventions using the Child Survival Strategy adopted at the fifty-sixth session of the Regional Committee and the Road Map for accelerating the reduction maternal and newborn mortality; contribute towards the strengthening of health systems and community structures for improved accessibility and quality of maternal, newborn, child and adolescent health services; and strengthen partnerships and advocacy for increased resources to attain universal coverage of and access to quality maternal, newborn, child and adolescent health services.

Healthy Environments and Sustainable Development

217. The Regional Office will continue to provide technical support to Member States to enhance their capacity to address the social determinants of health, including advocacy for increased emphasis on health development in the context of poverty reduction strategies that are sensitive to human rights and attainment of the MDGs. Appropriate policy analysis and action on health equity depend on the availability of information that is disaggregated into relevant indicators of social exclusion. The Regional Office will support and strengthen national capacities in this area.

218. Furthermore, given that 24% of the global disease burden and 23% of all deaths are attributable to environmental factors, malaria, diarrhoea and lower respiratory tract infections being the main contributors, the Regional Office will continue to work with Member States to raise policy-makers' awareness of the linkages between environment and health in order to influence national policies in health and other sectors; facilitate capacity building for health and environment services; and support local initiatives for healthier environments.

219. The Regional Office will also support and work with Member States to enhance adoption of risk-based approach to food safety and nutrition; development of policies, norms and standards for food safety and nutrition; strengthening of the surveillance of nutrition, food-borne and zoonotic diseases; health promotion; and promotion of partnerships and collaboration among stakeholders. The Regional Office will continue to support countries faced with emergencies with a view to mitigating the health impact of emergencies and other crises common in the Region.

Administration and Finance

220. In 2007, human resources development efforts will focus on supporting and streamlining human resource functions, decentralizing them to the Intercountry Support Teams and the country offices,

and implementing the staff development and learning plan and strategy. In addition, the Division of Administration and Finance will continue to provide support to the reprofiling exercise, the roll-out of the Global Management System (GSM) and the implementation of contractual reforms. There will also be more emphasis on human resource planning.

221. Priority will be given to setting up the final infrastructural arrangements for the Inter-country Support Teams in the three locations. Timely completion of the building project in Ouagadougou to ensure smooth settlement of the Inter-country Support Team for West Africa and provision of additional support to the Harare and Libreville locations will be pursued to create conducive working conditions for team operations. The Regional Office conference facilities will be reinforced in order to meet requirements for holding a larger number of meetings in Brazzaville. Greater attention will be given to the implementation of the Real Estate Fund projects approved to reinforce Regional Office infrastructure and equipment.

222. Oversight will be enhanced, given the increased delegation of authority to country offices and Regional Office Divisions. In this regard, monitoring of budget implementation will be enhanced, and there will be more country visits aimed at reviewing and training staff.

223. In preparation for the Global Management System, more resources will be allocated to data cleansing to facilitate the migration of data in a more accurate manner. Active attention will be given to training exercises and to the running of conference room pilots before rolling out the new system.

224. Based on the success of managing the replenishment of imprest accounts in the web banking system, the Regional Office will actively explore the possibility of extending the application to manage the banking needs for payroll and payment of vendor claims in a way that will be compatible with the GSM platform. Upon receiving the final GSM service delivery model and the overall delegation of authority framework, several units in the Division of Administration and Finance will undergo further reprofiling for adaptation to the new business model.

Annex 1

Table 1: Budget implementation, 2006, all sources and levels (US\$)

Serial no.	Area of work	Approved budget as per WHA and EB	Adjustments / Reprogramming	Workplan amounts (3 - 4)	Funds available as at 31.12.06	Expenditure	Implementation rate	
							Approved budget (7/3)	Available funds (7/6)
1	2	3	4	5	6	7	8	9
01.1.01	CAH	27,500,000	490,000	27,010,000	15,791,651	6,459,701.32	23%	41%
01.1.02	CPC	59,179,000	187,000	58,992,000	8,729,356	5,305,141.12	9%	61%
01.1.03	EHA	34,988,000	341,000	34,647,000	38,578,207	26,606,247.04	76%	69%
01.1.04	CSR	45,000,000	877,000	44,123,000	28,236,989	10,643,749.54	24%	38%
01.1.05	HIV	135,597,000	-283,000	135,880,000	53,566,422	32,351,805.03	24%	60%
01.1.06	IVD	234,680,000	54,000	234,626,000	221,289,860	143,885,539.00	61%	65%
01.1.07	MPS	14,816,000	588,000	14,228,000	18,460,489	4,607,341.33	31%	25%
01.1.08	MAL	59,000,000	471,000	58,529,000	29,405,630	19,174,675.94	32%	65%
01.1.09	MNH	4,680,000	152,000	4,528,000	2,911,185	754,931.97	16%	26%
01.1.10	RHR	8,193,000	176,000	8,017,000	5,308,217	2,270,594.28	28%	43%
01.1.12	NCD	8,500,000	459,000	8,041,000	8,295,205	2,757,393.79	32%	33%
01.1.12	TUB	30,000,000	143,000	29,857,000	14,716,474	8,253,356.77	28%	56%
02.1.01	BCT	4,118,000	158,000	3,960,000	4,176,643	1,677,257.78	41%	40%
02.1.02	EDM	11,500,000	213,000	11,287,000	11,282,126	3,692,800.09	32%	33%
02.1.03	HFS	5,174,000	46,000	5,128,000	1,676,577	1,043,803.90	20%	62%
02.1.04	IER	13,904,000	52,000	13,852,000	3,189,103	1,345,689.03	10%	42%
02.1.05	HSP	30,826,000	442,000	30,384,000	14,232,820	7,644,375.18	25%	54%
02.1.06	HRH	28,233,000	651,000	27,582,000	13,873,840	6,659,427.75	24%	48%
02.1.07	HSD	6,549,000	303,000	6,246,000	4,865,944	1,515,674.40	23%	31%
03.1.01	CRD	2,585,000	34,000	2,551,000	1,129,769	596,490.44	23%	53%
03.1.02	FOS	4,000,000	-331,000	4,331,000	2,007,079	446,357.77	11%	22%
03.1.03	WMH	3,000,000	78,000	2,922,000	1,746,334	342,996.33	11%	20%
03.1.04	PHE	9,000,000	145,000	8,855,000	6,328,386	2,240,257.81	25%	35%
03.1.05	HPR	6,598,000	309,000	6,289,000	5,646,466	3,096,173.54	47%	55%
03.1.06	NUT	4,500,000	155,000	4,345,000	2,926,837	631,744.78	14%	22%
03.1.07	TOB	5,000,000	187,000	4,813,000	3,939,002	735,103.82	15%	19%
03.1.08	INJ	1,997,000	46,000	1,951,000	1,592,368	785,736.45	39%	49%
04.1.01	FNS	10,058,000	202,000	9,856,000	8,976,000	7,689,241.75	76%	86%
04.1.02	DGO	2,128,000	-145,000	2,273,000	2,672,996	1,627,289.29	76%	61%
04.1.04	GBS	3,142,000	78,000	3,064,000	2,364,000	1,053,693.81	34%	45%
04.1.05	HRS	6,400,000	138,000	6,262,000	7,587,377	5,297,341.72	83%	70%
04.1.06	IIS	24,000,000	604,000	23,396,000	20,453,000	14,833,836.45	62%	73%
04.1.07	KMI	15,000,000	345,000	14,655,000	8,181,266	6,686,516.70	45%	82%
04.1.08	BMR	2,768,000	88,000	2,680,000	2,217,000	1,130,042.69	41%	51%
05.1.01	SCC	76,580,000	3,837,000	72,743,000	66,180,510	34,393,062.35	45%	52%
06.1.01	ERH	-	0	0				
06.1.02	ITF	-	0	0				
06.1.03	REF	4,770,000	0	4,770,000	452,648	40,983.11	1%	9%
06.1.04	SEF		0					
	Total	949,453,000	12,224,000	937,229,000	646,839,331	370,923,266.28	39%	57%

Table 1 continued....

Annex 2

Table 2: Budget implementation, 2006, by sources of funds (US\$)

Regular budget							Funds from other sources				
Serial no.	Area of work	Approved budget as per WHA and EB add.1	Available funds	Expenditure	Implementation rate		Approved budget as per WHA and EB add.1	Available funds	Expenditure	Implementation rate	
					Approved budget	Available funds				Approved budget	Available funds
1	2	3	4	5	6	7	8	9	10	11	12
01.1.01	CAH	8,168,000	7,678,000.00	2,109,896.83	26%	27%	19,332,000.00	8,113,651.00	4,349,804.49	23%	54%
01.1.02	CPC	3,130,000	2,943,000.00	1,718,946.24	55%	58%	56,049,000.00	5,786,356.00	3,586,194.88	6%	62%
01.1.03	EHA	2,236,000	1,895,000.00	739,289.41	33%	39%	32,752,000.00	36,683,207.00	25,866,957.63	79%	71%
01.1.04	CSR	14,617,000	13,740,000.00	3,624,908.70	25%	26%	30,383,000.00	14,496,989.00	7,018,840.84	23%	48%
01.1.05	HIV	4,662,000	4,811,000.00	2,109,163.00	45%	44%	131,069,000.00	48,755,422.00	30,242,642.03	23%	62%
01.1.06	IVD	902,000	848,000.00	363,091.88	40%	43%	233,778,000.00	220,441,860.00	143,522,447.12	61%	65%
01.1.07	MPS	9,778,000	9,190,000.00	2,243,253.91	23%	24%	5,038,000.00	9,270,489.00	2,364,087.42	47%	26%
01.1.08	MAL	2,020,000	1,549,000.00	1,140,566.70	56%	74%	56,980,000.00	27,856,630.00	18,034,109.24	32%	65%
01.1.09	MNH	2,530,000	2,378,000.00	618,617.51	24%	26%	2,150,000.00	533,185.00	136,314.46	6%	26%
01.1.10	RHR	2,925,000	2,749,000.00	1,168,259.17	40%	42%	5,268,000.00	2,559,217.00	1,102,335.11	21%	43%
01.1.12	NCD	7,641,000	7,182,000.00	2,090,608.86	27%	29%	859,000.00	1,113,205.00	666,784.93	78%	60%
01.1.12	TUB	2,371,000	2,228,000.00	603,322.50	25%	27%	27,629,000.00	12,488,474.00	7,650,034.27	28%	61%
02.1.01	BCT	2,647,000	2,489,000.00	851,695.66	32%	34%	1,471,000.00	1,687,643.00	825,562.12	56%	49%
02.1.02	EDM	3,556,000	3,343,000.00	1,060,275.69	30%	32%	7,944,000.00	7,939,126.00	2,632,524.40	33%	33%
02.1.03	HFS	755,000	709,000.00	601,914.62	80%	85%	4,419,000.00	967,577.00	441,889.28	10%	46%
02.1.04	IER	864,000	812,000.00	328,518.70	38%	40%	13,040,000.00	2,377,103.00	1,017,170.33	8%	43%
02.1.05	HSP	7,358,000	6,916,000.00	4,288,070.63	58%	62%	23,468,000.00	7,316,820.00	3,356,304.55	14%	46%
02.1.06	HRH	11,258,000	10,607,000.00	5,476,373.60	49%	52%	16,975,000.00	3,266,840.00	1,183,054.15	7%	36%
02.1.07	HSD	3,414,000	3,111,000.00	760,592.69	22%	24%	3,135,000.00	1,754,944.00	755,081.71	24%	43%
03.1.01	CRD	553,000	519,000.00	210,295.30	38%	41%	2,032,000.00	610,769.00	386,195.14	19%	63%
03.1.02	FOS	1,595,000	1,926,000.00	415,216.34	26%	22%	2,405,000.00	81,079.00	31,141.43	1%	38%
03.1.03	WMH	1,320,000	1,242,000.00	323,354.46	24%	26%	1,680,000.00	504,334.00	19,641.87	1%	4%
03.1.04	PHE	6,210,000	6,065,000.00	2,046,443.99	33%	34%	2,790,000.00	263,386.00	193,813.82	7%	74%
03.1.05	HPR	5,169,000	4,860,000.00	2,721,197.91	53%	56%	1,429,000.00	786,466.00	374,975.63	26%	48%

TABLE 2 continued...

Regular budget							Funds from other sources				
Serial no.	Area of work	Approved budget as per WHA and EN add.1	Available funds	Expenditure	Implementation rate		Approved budget as per WHA and EB add.1	Available funds	Expenditure	Implementation rate	
					Approved budget	Available funds				Approved budget	Available funds
1	2	3	4	5	6	7	8	9	10	11	12
03.1.06	NUT	2,589,000	2,434,000.00	329,422.39	13%	14%	1,911,000.00	492,837.00	302,322.39	16%	61%
03.1.07	TOB	3,113,000	2,926,000.00	440,420.07	14%	15%	1,887,000.00	1,013,002.00	294,683.75	16%	29%
03.1.08	INJ	751,000	705,000.00	279,542.63	37%	40%	1,246,000.00	887,368.00	506,193.82	41%	57%
04.1.01	FNS	3,372,000	3,170,000.00	1,555,057.75	46%	49%	6,686,000.00	5,806,000.00	6,134,184.00	92%	106%
04.1.02	DGO	1,536,000	1,444,000.00	734,105.12	48%	51%	829,000.00	1,228,996.00	893,184.17	108%	73%
04.1.03	REC	2,257,000	1,694,000.00	653,103.56	29%	39%	2,862,000.00	2,157,555.00	1,993,788.65	70%	92%
04.1.04	GBS	1,287,000	1,209,000.00	421,344.81	33%	35%	1,855,000.00	1,155,000.00	632,349.00	34%	55%
04.1.05	HRS	2,287,000	2,149,000.00	1,107,473.13	48%	52%	4,113,000.00	5,438,377.00	4,189,868.59	102%	77%
04.1.06	IIS	10,029,000	9,425,000.00	4,389,044.45	44%	47%	13,971,000.00	11,028,000.00	10,444,792.00	75%	95%
04.1.07	KMI	5,753,000	5,408,000.00	2,555,413.34	44%	47%	9,247,000.00	2,773,266.00	4,131,103.36	45%	149%
04.1.08	BMR	1,459,000	1,371,000.00	612,783.69	42%	45%	1,309,000.00	846,000.00	517,259.00	40%	61%
05.1.01	SCC	63,515,000	59,678,000.00	32,050,270.00	50%	54%	13,065,000.00	6,502,510.00	2,342,791.57	18%	36%
06.1.01	ERH		0.00				0.00				
06.1.02	ITF		0.00				0.00				
06.1.03	REF		0.00				4,770,000.00	452,648.00	40,983.08	1%	9%
06.1.04	SEF										
	Total	203,627,000	191,403,000.00	82,741,855.24	41%	43%	745,826,000.00	455,436,331.00	288,181,410.23	39%	63%

Annex 3

Table 3: Budget implementation, 2006, by level (US\$)

Countries							Regional Office				
Serial no.	Area of work	Approved budget as per WHA and EB	Available funds	Expenditure	Implementation rate		Approved budget as per WHA and EB	Available funds	Expenditure	Implementation rate	
					Approved budget (5/3)	Available funds (5/4)				Approved budget (10/8)	Available funds (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
01.1.01	CAH	8,388,000	6,881,330.00	1,201,833.92	14%	17%	19,112,000	8,910,321.00	5,257,867.40	28%	59%
01.1.02	CPC	25,646,000	4,233,317.00	2,214,203.32	9%	52%	33,533,000	4,496,039.00	3,090,937.80	9%	69%
01.1.03	EHA	30,132,000	32,863,590.00	23,438,512.03	78%	71%	4,856,000	5,714,617.00	3,167,735.01	65%	55%
01.1.04	CSR	17,881,000	16,663,358.00	4,575,591.58	26%	27%	27,119,000	11,573,631.00	6,068,157.96	22%	52%
01.1.05	HIV	97,325,000	25,577,170.00	18,267,309.08	19%	71%	38,272,000	27,989,252.00	14,084,495.95	37%	50%
01.1.06	IVD	108,104,000	98,906,084.00	62,064,025.54	57%	63%	126,576,000	122,383,776.00	81,821,513.46	65%	67%
01.1.07	MPS	6,476,000	11,274,324.00	2,626,270.95	41%	23%	8,340,000	7,186,165.00	1,981,070.38	24%	28%
01.1.08	MAL	25,468,000	12,678,553.00	8,283,111.58	33%	65%	33,532,000	16,727,077.00	10,891,564.36	32%	65%
01.1.09	MNH	3,050,000	1,299,894.00	233,826.84	8%	18%	1,630,000	1,611,291.00	521,105.13	32%	32%
01.1.10	RHR	4,502,000	2,436,159.00	1,180,883.47	26%	48%	3,691,000	2,872,058.00	1,089,710.81	30%	38%
01.1.12	NCD	4,140,000	3,908,538.00	357,628.08	9%	9%	4,360,000	4,386,667.00	2,399,765.71	55%	55%
01.1.12	TUB	11,984,000	8,783,916.00	5,504,008.61	46%	63%	18,016,000	5,932,558.00	2,749,348.16	15%	46%
02.1.01	BCT	1,661,000	1,334,000.00	283,169.67	17%	21%	2,457,000	2,842,643.00	1,394,088.11	57%	49%
02.1.02	EDM	8,124,000	2,469,339.00	608,800.01	7%	25%	3,376,000	8,812,787.00	3,084,000.08	91%	35%
02.1.03	HFS	2,668,000	342,247.00	554,828.04	21%	162%	2,506,000	1,334,330.00	488,975.86	20%	37%
02.1.04	IER	12,893,000	677,025.00	335,968.02	3%	50%	1,011,000	2,512,078.00	1,009,721.01	100%	40%
02.1.05	HSP	17,164,000	8,891,093.00	5,427,175.51	32%	61%	13,662,000	5,341,727.00	2,217,199.67	16%	42%
02.1.06	HRH	18,110,000	8,751,280.00	4,427,289.82	24%	51%	10,123,000	5,122,560.00	2,232,137.93	22%	44%
02.1.07	HSD	4,138,000	2,871,804.00	709,401.81	17%	25%	2,411,000	1,994,140.00	806,272.59	33%	40%
03.1.01	CRD	208,000	215,000.00	20,141.00	10%	9%	2,377,000	914,769.00	576,349.44	24%	63%
03.1.02	FOS	1,292,000	1,147,000.00	53,943.97	4%	5%	2,708,000	860,079.00	392,413.80	14%	46%
03.1.03	WMH	1,199,000	609,059.00	77,788.65	6%	13%	1,801,000	1,137,275.00	265,207.68	15%	23%
03.1.04	PHE	4,632,000	3,908,437.00	1,031,257.42	22%	26%	4,368,000	2,419,949.00	1,209,000.39	28%	50%
03.1.05	HPR	4,825,000	4,531,001.00	2,583,953.97	54%	57%	1,773,000	1,115,465.00	512,219.57	29%	46%

Table 3 continued....

Countries							Regional Office				
Serial no.	Area of work	Approved budget as per WHA and EB	Available funds	Expenditure	Implementation rate		Approved budget as per WHA and EB	Available Funds	Expenditure	Implementation Rate	
					Approved budget (5/3)	Available funds (5/4)				Approved budget (10/8)	Available funds (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
03.1.06	NUT	1,866,000	1,665,474.00	54,137.44	3%	3%	2,634,000	1,261,363.00	577,607.34	22%	46%
03.1.07	TOB	1,867,000	1,427,787.00	56,150.30	3%	4%	3,133,000	2,511,215.00	678,953.52	22%	27%
03.1.08	INJ	1,331,000	482,811.00	269,379.48	20%	56%	666,000	1,109,557.00	516,356.97	78%	47%
04.1.01	FNS		0.00				10,058,000	8,976,000.00	7,689,241.75	76%	86%
04.1.02	DGO		0.00				2,128,000	2,672,996.00	1,627,289.29	76%	61%
04.1.03	REC	395,000	351,000.00	20,896.57	5%	6%	5,095,000	3,500,555.00	2,625,995.64	52%	75%
04.1.04	GBS		0.00				3,142,000	2,364,000.00	1,053,692.81	34%	45%
04.1.05	HRS		0.00				6,400,000	7,587,377.00	5,297,341.72	83%	70%
04.1.06	IIS		0.00				24,000,000	20,453,000.00	14,833,836.45	62%	73%
04.1.07	KMI	1,007,000	261,000.00	553.36	0%	0%	13,993,000	7,920,266.00	6,685,963.34	48%	84%
04.1.08	BMR	493,000	0.00		0%		2,275,000	2,217,000.00	1,130,042.69	50%	51%
05.1.01	SCC	74,583,000	63,276,890.00	33,405,161.38	45%	53%	1,997,000	2,903,620.00	987,900.97	49%	34%
06.1.01	ERH		0.00					0.00			
06.1.02	ITF		0.00					0.00			
06.1.03	REF		0.00				4,770,000	452,648.00	40,983.08	1%	9%
06.1.04	SEF		0.00					0.00			
	Total	501,552,000	328,718,480.00	179,867,201.42	36%	55%	447,901,000	318,120,851.00	191,056,063.83	43%	60%

Areas of Work

BCT	Blood Safety and Clinical Technology
BMR	Planning, Resource Coordination and Oversight
CAH	Child and Adolescent Health
CPC	Communicable Disease Prevention and Control
CRD	Communicable Disease Research
CSR	Epidemic Alert and Response
DGO	Director-General, Regional Director and Independent Functions
EDM	Essential Medicines
EHA	Emergency Preparedness and Response
FNS	Budget and Financial Management
FOS	Food Safety
GBS	Governing Bodies
HFS	Health Financing and Social Protection
HIV	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
HPR	Health Promotion
HRH	Human Resources for Health
HRS	Human Resources Management in WHO
HSD	Policy-making for Health in Development
HSP	Health System Policies and Service Delivery
IER	Health Information, Evidence and Research
IIS	Infrastructure and Logistics
INJ	Violence, Injuries and Disabilities
IVD	Immunization and Vaccines Development
KMI	Knowledge Management and Information Technology
MAL	Malaria
MNH	Mental Health and Substance Abuse
MPS	Making Pregnancy Safer
NCD	Management and Surveillance of Noncommunicable Diseases
NUT	Nutrition
PHE	Health and Environment
REC	External Relations
REF	Real Estate Fund
RHR	Reproductive Health
SCC	WHO's Core Presence in Countries
TOB	Tobacco
TUB	Tuberculosis
WMH	Gender, Women and Health