# THE WORK OF WHO IN THE AFRICAN REGION 2010-2011

## Biennial Report of the Regional Director

World Health Organization

REGIONAL OFFICE FOR Africa

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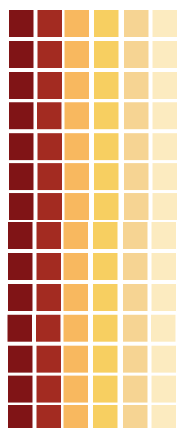

# THE WORK OF WHO IN THE AFRICAN REGION 2010-2011

## Biennial Report of the Regional Director

*To the Sixty-second session of the Regional Committee for Africa, Luanda, Republic of Angola, 19–23 November 2012*

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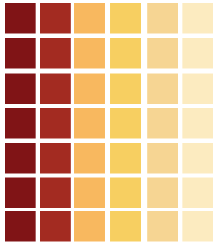
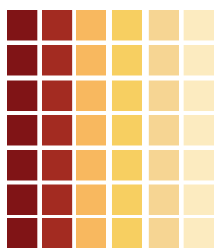


# FOREWORD

The Regional Director has the honour of presenting to the Regional Committee the report on the work of the World Health Organization in the African Region during the biennium 2010-2011.

Dr Luis Gomes Sambo
Regional Director



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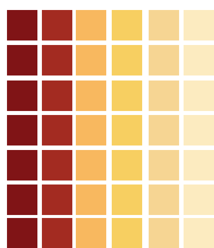
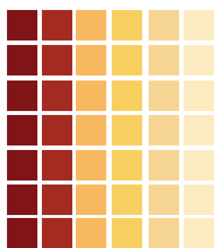


# ABBREVIATIONS

| | |
|---|---|
| AC | Assessed Contribution |
| ACT | Artemisinin-based Combination Therapy |
| AED | Academy for Educational Development |
| AHO | African Health Observatory |
| APOC | African Programme for Onchoceciasis Control |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral Drugs |
| ASSIST | Alcohol, Smoking and Substance Involvement Screening Test |
| CDTI | Community Directed Treatment with Ivermectin |
| COP | Conference of the Parties |
| CSIS | Centre for Strategic and International Studies |
| CARMMA | Campaign for Accelerated Reduction of Maternal Mortality in Africa |
| CILSS | Comité Inter-État de Lutte contre la Sécheresse au Sahel Permanent Inter-State Committee for Drought Control in the Sahel |
| CVD | Cardiovascular Disease |
| DPT3 | Diphtheria Pertussis Tetanus |
| DRR | Disaster Risk Reduction |
| ECSA-HC | The East, Central, and Southern African Health Community |
| ECOWAS | Economic Community of West African States |
| EmONC | Emergency Obstetric and Newborn Care |
| ENC | Essential Newborn Care |
| EVIPNet | Evidence Informed Policy Network |
| FCTC | Framework Convention on Tobacco Control |
| FGM | Female Genital Mutilation |
| GAVI | Global Alliance for Vaccines and Immunization |
| GFTAM | Global Fund to Fight Tuberculosis, AIDS and Malaria |
| GSM | Global Management System |
| GWH | Gender, Women and Health |
| HAT | Human African Trypanosomiasis |
| HELP | Health Emergencies in Large Populations |
| HiAP | The Adelaide Statement on integrating Health in all Policies |
| HPV | Human Papillomavirus |
| HHA | Harmonization for Health in Africa |
| H1N1 | Pandemic Influenza A |
| HRE | Human Rights and Ethics |

| | |
|---|---|
| IDSR | Integrated Disease Surveillance and Response |
| IHR | International Health Regulations (2005) |
| IGME | Interagency Group for Child Mortality Estimation |
| IMAAI | Integrated Management of Adult and Adolescent Illness |
| IMCI | Integrated Management of Childhood Illness |
| IMPACT | Integrated Management of Pregnancy and Childbirth |
| IRS | Indoor Residual Spraying |
| ISO | International Organization for Standardization |
| ITNs | Insecticide Treated Nets |
| IUHPE | International Union of Health Promotion and Education |
| IYCF | Infant and Young Child Feeding |
| LLINs | Long-Lasting Insecticidal Nets |
| MDR-TB | Multidrug-resistant TB |
| MMRs | Maternal Mortality Ratios |
| MNH | Maternal and Newborn Health |
| MNTE | Maternal and Neonatal Tetanus Elimination |
| NCDs | Noncommunicable Diseases |
| NECT | Nifurtimox-Eflornithine Combination Therapy |
| NEPAD | New Partnership for Africa's Development |
| NGS | New Growth Standards |
| NHA | National Health Accounts |
| NHIS | National Health Information Systems |
| NHSPs | National Health Strategic Plans |
| NTDs | Neglected Tropical Diseases |
| OCEAC | *Organisation de Coordination pour la Lutte contre les Endémies en Afrique Centrale* |
| OCR | Outbreak and Crisis Response |
| PCA | Partnerships and Collaborative Arrangements |
| PMTCT | Prevention of Mother-To-Child Transmission |
| REC | Regional Economic Communities |
| RED | Reaching Every District |
| RPC | The "*Recommandations pour la pratique clinique des soins obstétricaux néonataux d'urgence en Afrique - Guide du Prestataire*" |
| SCD | Sickle Cell Disease |
| STEPs | Stepwise approach for surveillance of risk factors |
| SHOC | Strategic Health Operations Centre |
| SIAs | Supplementary Immunization Activities |
| TM | Traditional Medicine |
| UA | Universal Access |
| UNDAF | United Nations Development Assistance Framework |
| UNDG | United Nations Regional Directors Group |
| VC | Voluntary Contribution |
| WAHO | West African Health Organization |
| WCO | WHO Country Office |
| WPV | Wild Poliovirus |
| XDR-TB | Extensively Drug-resistant TB |



# EXECUTIVE SUMMARY

1. The work of WHO in the African Region during the biennium was guided by the 11th General Programme of Work (GPW), the Medium-Term Strategic Plan (MTSP) 2008–2013, Country Cooperation Strategies (CCS) and the WHO African Region Strategic Directions 2010–2015, whose milestones define a set of deliverable results for the Region. Achievements under each of the 13 Strategic Objectives (SOs) are presented in the Executive Summary, under the six core functions of WHO, namely: (a) providing leadership on matters critical to health and engaging in partnerships where joint action is needed; (b) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; (c) setting norms and standards and promoting and monitoring their implementation; (d) articulating ethical and evidence-based policy options; (e) providing technical support, catalysing change and building sustainable institutional capacity; (f) monitoring the health situation and assessing health trends.

2. The Programme Budget 2010-2011 was implemented in a context of a heavy burden of communicable and noncommunicable diseases, with attendant high levels of maternal and infant mortality. In addition, the WHO Regional Office and Country Offices, many partners as well as Member States worked within the constraints of the current financial crisis. Notwithstanding this context, some significant progress was made across all SOs.

3. As at 31 December 2011, the total budget allocated for the African Region was US$ 1 593 411 000, though only US$ 1 163 824 000 was available by the end of the biennium. The funded amount was 92% of the initial allocation as approved by the World Health Assembly, but only 73% of the revised allocated budget. There was also an imbalance in funding among Strategic Objectives (SOs) due mainly to the earmarking of Voluntary Contributions. The Polio Eradication Programme under SO1 received 216% of its initial budget allocation, representing 51% of the regional Voluntary Contributions. Overall SO1 was funded at 156% of the initial budget allocation, while SOs 4, 9 and 10 received less than half of their allocated budget.

4. The role of WHO in providing leadership and engaging partners for joint action was demonstrated by intensive, high-level advocacy for increased investment in health, particularly in an era of severe financial constraints, through engagement

of national leaders, policy makers and international development partners. This has yielded positive results as evidenced by the increase in the contributions made by some Member States for immunization and other programmes. The Harmonization for Health in Africa initiative expanded its membership, synergized support to countries and further strengthened the alliance between the health sector and the financial sector, with the aim of improving health financing from national budgets in countries. Through the UNDAF the work of WHO has improved the harmonization of UN support for health thus reducing the transaction costs borne by governments.

5. WHO, as lead agency of the health cluster on humanitarian assistance, strengthened and improved resource mobilization, effectiveness, coordination of health response, and expansion and strengthening of partnerships. This has led to improved timeliness in the delivery of effective support in response to emergencies and disasters, while creating awareness and building capacity for disaster risk management. A total of 30 countries developed their health emergency contingency plans.

6. Furthermore, following advocacy and facilitation by WHO, Member States demonstrated ownership of the response to health emergencies by taking the decision to establish the African Public Health Emergency Fund (APHEF). This financial mechanism will mobilize and manage additional resources to support timely investigation and response to acute public health emergencies in the Region. The US$ 50 million total annual contribution by Member States to the Fund sets the stage for effectively addressing future public health emergencies in the Region. Heads of State and Government endorsed the APHEF at the African Union Summit in July 2012.

7. Thanks to intensified advocacy, more than 50% of countries included nutrition and food safety activities in their Poverty Reduction Strategies in 2010-2011. Through advocacy, 19 countries have removed user fees for child health services and 17 now provide life-saving treatments for integrated community case management of pneumonia, diarrhoea and malaria. This has increased the number of sick children correctly managed at community level, with one country achieving cure rates of over 90% for fever, diarrhoea and acute respiratory infections. The improved access to quality care has led to 3-5% increase in annual average rates of reduction in child deaths per year in 17 countries of the Region. Furthermore, the integrated approach at community level has attracted increased funding from partners for community-based interventions and will significantly improve child survival in Member States when it is fully implemented.

8. In exercising its convening and leadership role and helping to generate evidence-based policies, WHO supported Member States to commit to key strategic agreements and initiatives. In April 2011, the landmark Brazzaville Declaration on noncommunicable diseases (NCDs) prevention and control was adopted by

Member States. Three quarters of Member States have now developed and are implementing integrated NCD action plans. In response to the Fifty-eighth session of the Regional Committee Resolution AFR/RC58/R1 on Women's Health in the African Region, a Commission on Women's Health produced a report entitled, '*Addressing the Challenge of Women's Health in Africa*', that makes an indepth analysis of women's health issues and how women's potential can be unleashed to contribute significantly to the socioeconomic development of the Region.

9. The Sixtieth session of the Regional Committee adopted a Regional strategy that set the stage for addressing the determinants of health and reducing the harmful use of alcohol. On risk factors and key determinants of health, some countries have developed and enforced tobacco control legislation and action plans banning smoking in public places and workplaces, tobacco advertising, promotion, and sponsorship, and requiring health warnings on tobacco packaging.

10. The Second interministerial conference on health and environment in Africa was organized in Luanda in 2010, and a framework for public health adaptation to climate change was endorsed at the Sixtieth session of the Regional Committee through Resolution AFR/RC61/R2.

11. Through the Meningitis Vaccine Project, WHO supported the scientific research and regulatory oversight required by countries to successfully develop and license MenAfriVac, an effective vaccine against meningococcal A meningitis. Through this and other initiatives, the capacities of the national regulatory authorities and research ethics committees of several Member States were strengthened such that they now have the capacity to review clinical trial applications, approve clinical trials and conduct clinical trial site inspections based on Good Clinical Practice. With WHO's continued support, several countries issued marketing authorizations for vaccines and traditional medicines.

12. As a result of continued support provided for the development and adaptation of standards, guidelines and tools, countries have made significant strides in improving outcomes in health systems, maternal and child health, health promotion and many other areas of health in the Region. Normative and technical support provided to countries led to successful introduction of an unprecedented high number of new vaccines [pneumococcal conjugate vaccine (PCV), rotavirus, human papillomavirus (HPV), conjugate meningitis A (MenAfriVac)], improved access to essential drugs, medical products and technologies, better regulation of markets and a reduction in counterfeit medical products in the supply chain. Successful immunization of 54 million people living in the meningitis belt countries of Burkina Faso, Mali and Niger, using the newly introduced MenAfriVac, resulted in just four reported cases of meningococcal meningitis due to *Neisseria menigitidis Type A* in 2011, with none reported in the vaccinated population.

13. In addition to the provision of normative guidance, working with partners, WHO focused on capacity building and technical support towards attaining universal access to health interventions for Member States. One of the outcomes is an increase in the proportion of pregnant women living with HIV who received antiretroviral medicine for preventing mother-to-child-transmission from 54% in 2009 to 60% in 2010. Additionally, an estimated 5.1 million people with advanced HIV infection were receiving anti-retroviral therapy in 2010 as compared with 3.9 million in 2009. The burden of malaria in the Region fell in 2010, with 12 countries recording more than 50% reduction in either confirmed malaria cases or malaria admissions and deaths.

14. First-line and timely technical support was provided to countries by WHO Intercountry Support Teams (ISTs) through missions addressing all programme areas, in line with country needs. The technical support provided has facilitated the development and implementation of national policies, strategies and plans and yielded substantial achievements described in this report. For example, all the 12 countries, except one, that experienced importations or outbreaks of wild poliovirus (WPV) responded in a timely manner, interrupting polio transmission within the stipulated six months and meeting milestone 1 of the Global Polio Eradication Initiative (GPEI). Angola, which is one of the countries with re-established transmission, has remained polio-free since July 2011.

15. To enhance technical support to countries by improving coordination and timeliness of the responses to disease outbreaks and other public health emergencies in the Region, a Strategic Health Operations Centre (SHOC) has been established at the Regional Office in Brazzaville. The Centre for Tobacco Control in Africa was established in Uganda, serving as a resource centre for the Region. WHO facilitated and coordinated cross-border interministerial meetings in Abuja in October 2010 and in Lusaka in March 2011. This resulted in consistent, timely and coordinated responses to polio, other disease outbreaks, and public health emergencies. The health component of the humanitarian crisis in the Horn of Africa was addressed through the vaccination in Ethiopia and Kenya of 1.5 million children against polio and 7.2 million against measles. In addition, about 90 000 children were given Vitamin A and a de-wormer in Kenya, while health promotion in the two countries was intensified thereby helping to avert outbreak of diseases including cholera.

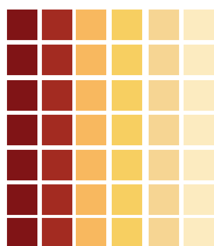
16. As part of support to countries to strengthen the capacity of their district and national health systems in the areas of policy, strategies, planning and evaluation, various tools and guidelines developed by WHO are being implemented based on the frameworks of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, and the Algiers Declaration on Research for Health. This has significantly helped countries to better coordinate and manage their health sectors including better utilization of national and external resources for achieving results. The African Health Observatory is now operational, facilitating the generation, sharing and use of information by countries for policy and decision making.

17. Systems for disease surveillance and trend monitoring have been strengthened. The International Health Regulation (2005), nutrition and noncommunicable diseases have been incorporated into Integrated Disease Surveillance and Response (IDSR), creating a single platform for vital monitoring of disease trends and impact of interventions, based on the routine data. The African Health Oberservatory has been launched and will support countries in information generation and sharing for policy and decision-making. The Atlas of Health Statistics for 2011, with detailed statistical profiles of all 46 countires, is a resource for understanding trends and making comparison between countries.

18. Through strengthened partnership with the African Union, technical support was provided for the organization of the Summit of Heads of State and Government on the theme '*Maternal, newborn and child health and development in Africa*', where significant decisions were taken on saving lives among women and children. WHO also supported countries in synergy with efforts of the Regional Economic Communities and the United Nations Regional Directors Teams (RDTs).

19. The enabling functions of WHO were further augmented by the successful installation in AFRO of the Global Management System (GSM) in 2011. This has ensured availability of more complete and timely financial and programmatic information to staff, management, Member States and donors for better performance monitoring. In addition it has allowed streamlining of the administrative functions of several units including finance, personnel, procurement and travel due to the automation. Certain functions were shifted to the WHO Global Service Centre in Kuala Lumpur, Malaysia, thus increasing administrative efficiency and lowering costs. However, the severe resource limitations necessitated the unfortunate separation from WHO of nearly 250 staff. Furthermore, a major tragedy occurred with the bombing of the United Nations compound in Abuja in August 2011, which claimed many lives including three WHO staff. However, WHO has been able to bear the loss and to reaffirm its commitment to continue and even strengthen operations in Nigeria.

20. The next biennium focuses on workplans with an adjusted number of priority activities in line with the core functions of WHO. These workplans also take into account the constraints of the persisting financial crisis as well as the on-going WHO reforms. In this perspective, WHO will aim at meeting the milestones defined for the period 2012-2013 within the WHO African Region Strategic Directions 2010–2015, while ensuring adequate and timely support to countries to attain their health objectives and global goals.



# 1. INTRODUCTION

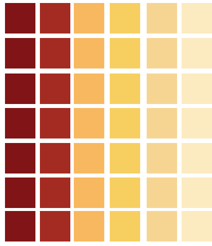
1. This biennial report of the Regional Director reflects the implementation of the Programme Budget 2010-2011 by country offices and the Regional Office in support to Member States towards improving the health of their people. The Region bears a high burden of communicable diseases and a rising burden of noncommunicable diseases with financial constraints affecting Member States, WHO and Partners. At the same time, Member States and Partners made every effort towards achieving the Millennium Development Goals (MDGs) and other regional and global goals.

2. The WHO Programme Budget 2010-2011 was adopted by the World Health Assembly in May 2009 with a regional budget of US$ 1 262 864 000. This budget covers the operational plans of Country Offices and the Regional Office, including Intercountry Support Teams (ISTs), developed in line with the 11th GPW, the MTSP, the WHO African Region Strategic Directions 2010–2015 as well as WHO Country Cooperation Strategies (CCS).

3. This report is organized into seven chapters, namely:

    1. Introduction.
    2. Context.
    3. Implementation of the Programme Budget 2010-2011.
    4. Significant achievements by Strategic Objective.
    5. Progress made in the implementation of Regional Committee resolutions.
    6. Challenges, constraints and lessons learnt.
    7. Conclusion.

4. There are two annexes to the report: Table 1, WHO Medium Term Strategic Plan 2008–2013: Statement of Strategic Objectives; and Table 2, Approved Programme Budget 2010-2011 allocation by strategic objective, source of financing and distribution between WHO Country Offices and the Regional Office (in US$ 000s).



# 2. CONTEXT

5. The current global financial crisis has had a significant adverse impact on the socioeconomic situation and health financing at country and international levels. It has also negatively affected funding to WHO. It is noteworthy that many donors and bilateral partners made efforts to keep their commitments to health funding mainly at country level, despite the financial constraints. In coping with the severe reduction in funding, and in the context of the on-going WHO reform process, the Regional Office for Africa has been restructured; this has particularly affected some priority programmes such as disease control as well as maternal and child health.

6. The burden of vaccine-preventable diseases generally remains high in the Region, due in part to the underlying low vaccine coverage. Despite an estimated 85% reduction in deaths attributable to measles in 2010 compared to the year 2000, several countries in Southern Africa experienced large outbreaks in 2010. This, coupled with the increase in wild poliovirus (WPV) transmission in Nigeria, the resurgence of WPV type 3 in West Africa, as well as the continued transmission of WPV1 in Angola, Chad and the Democratic Republic of the Congo, served to underscore the critical need to attain and maintain high vaccination coverage in all districts. The development and introduction of new vaccines in national immunization programmes has provided an opportunity to reduce the burden of some of the diseases.

7. The high burden of other communicable diseases is also reflected in the particularly elevated levels of morbidity and mortality associated with HIV/AIDS, tuberculosis and malaria. HIV prevention programmes have not yet adequately reached the most at-risk populations including the youth, sex workers, injecting drug users and prisoners, resulting in continuing high incidence of HIV infection. The TB epidemic is further complicated by a high prevalence of HIV co-infection. Approximately 51% of notified TB cases are co-infected with HIV while only 38% of these were accessing ART by the end of 2009.

8. There is a rising burden of noncommunicable diseases (NCDs), including mental health and injuries arising from violence, affecting the Region. The African Region is expected to have the highest increase (27%) in NCDs in the next two decades if urgent preventive measures are not taken. The common risk factors for these chronic NCDs are related to individual lifestyles and non-modifiable risk factors including

genetic and ethnic considerations, together with an increase in life expectancy, prenatal factors and gender. The situation is compounded by lack of comprehensive national health policies and strategic plans which incorporate NCDs as well as the inadequate coordination of efforts to improve the health situation of people. The lack of strong mechanisms to address the broad determinants of health e.g. food, education, shelter, housing, water, sanitation and climate change is also part of the context in which WHO is working in the African Region.

9. Sub-Saharan Africa suffers most from the risks of unsafe drinking water, inadequate sanitation and polluted indoor air. Approximately 677 000 child deaths are attributable to unsafe water, sanitation and hygiene while 500 000 child deaths are due to indoor smoke in the Region. In order to address the above issues, African countries under the leadership of WHO and UNEP adopted the Libreville Declaration on health and environment in Africa in 2010.

10. About 52% of global maternal deaths and 46% of global child deaths occur in the African Region, most being preventable. The estimates of trends in maternal mortality between 1990 and 2010 show that the WHO African Region still has the highest maternal mortality ratio (MMR) at 480 deaths per 100 000 live births.

11. Despite some modest improvements in the health systems of many countries, the weakness of the health systems in general contributes significantly towards the inadequate health outcomes in the Region. Among the areas needing strengthening are leadership and governance, community engagement, financing, the health workforce and access to essential medicines, new vaccines and health technologies. There is also fragmentation in partner support, culminating in unacceptably low levels of implementation of health policies and strategic plans, as well as delayed translation of evidence, new tools and innovations into services.

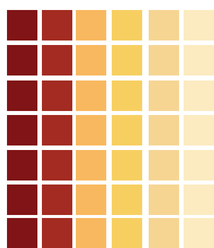
12. Countries in the African Region faced emergencies due to natural and man-made hazards and social unrest causing injury, death, and population displacement, as well as destruction of health facilities and disruption of services. In 2011, drought alone affected over 13 million people in the Horn of Africa, resulting in food insecurity and malnutrition. According to the UNHCR, countries in the Region hosted over 3 million Internally Displaced Persons (IDPs) and over 2 million refugees in 2010.[1] There is also the additional challenge of insecurity in parts of many countries, compounded by inadequate infrastructure and affecting the delivery of support at country level.

13. At the same time the period saw an increase in research and development of medicines, vaccines and other technologies. This has led to the availability to countries of new vaccines against pneumococcal pneumonia, cervical cancer and rotavirus diarrhoea.

14. Health is higher than ever before on the international political agenda, presenting opportunities for more commitment of resources and increased action by Member States and partners. The Region also saw an increase in health financing, particularly linked to the Global Health Initiatives, presenting WHO with the opportunity to provide normative and technical support for the most effective use of these resources. The expansion in health actors has presented an opportunity for increased allocation of human and other resources at country level, in support of health in general and health systems in particular.

15. In contributing towards accelerated efforts to achieve the Millennium Development Goals by 2015, mainly MDGs 4 and 5, the work of WHO during the biennium was guided by various initiatives and commitments by Member States and the Secretariat. These include: (i) Achieving Sustainable Health Development in the African Region: Strategic Directions for WHO 2010–2015; (ii) the Ouagadougou Declaration on Primary Health Care and Health Systems; (iii) the work of the Commission on Women's Health in the African Region; (iv) the Road Map for Accelerating the Attainment of the Millennium Development Goals related to Maternal and Newborn Health in Africa, and Repositioning Family Planning in the African Region; (v) Child Survival: A Strategy for the African Region; (vi) the UN Secretary-General's Global Strategy for Women and Children's Health; (vii) the Global Plan for Elimination of New Paediatric Infections and Keeping their Mother Alive by 2015; (viii) and the African Union's "Campaign for Accelerated Reduction of Maternal Mortality (CARMMA)".

16. Within this complex context, WHO has been engaged in reforms focusing on priority setting, governance and managerial matters, which aim to improve the Organization's effectiveness.



# 3. IMPLEMENTATION OF THE PROGRAMME BUDGET 2010-2011

17. The World Health Assembly, through its resolution WHA.62.9, approved the Programme Budget 2010-2011 with an allocation of US$ 1 262 864 000 for the African Region. Implementation of the Programme Budget was based on agreed health priorities of the Region and guidance given during the Fifty-ninth session of the Regional Committee held in Kigali, Rwanda.

18. The sources of financing for the programme budget were Assessed Contributions (AC) amounting to US$ 209 600 000 (17%) and Voluntary Contributions (VC) at an amount of US$ 1 053 264 000 (83%). Between 2008-2009 and 2010-2011, there was no increase in the Assessed Contributions share of the budget, while the proportion of the budget from Voluntary Contributions, which is characterized by a high degree of uncertainty and relies on resource mobilization efforts, continued to increase.

19. The Programme Budget has three segments: (i) WHO Base Programmes (BASE) covering activities for which WHO has the exclusive budgetary control; (ii) Special Programmes and Collaborative Arrangements (SPA), which WHO executes in collaboration with partners; and (iii) Outbreak and Crisis Response (OCR), covering WHO's response to unforeseen natural or man-made hazards and public health events. This budget segmentation aims to ensure greater transparency in the funding and implementation of the programme budget as well as to facilitate its management.

20. The share of the budget by Strategic Objective (SO) reflects the emphasis put on the prevention and control of communicable diseases (SO1) which accounted for 34% of the budget, in particular the global partnership and engagement towards poliomyelitis eradication. The rest was allocated to HIV/AIDS, malaria and tuberculosis (SO2) with 16%; WHO enabling functions including strengthened presence in Member States (SOs 12 and 13) which were together allocated 14%; Health systems strengthening (SOs 10 and 11) received a share of 12%; Child and maternal health, along with adolescent health, sexual and reproductive health and ageing (SO4) were allocated 9%; while 8% was devoted to emergency preparedness and response (SO5).

21. The Region's budget allocation was revised to US$ 1 593 456 000 during the course of the biennium, compared with the initial budget of US$ 1 262 864 000 approved by the Health Assembly. This 26% increase was mainly due to additional funding required for polio eradication.

22. The implementation of the Programme budget 2010-2011 showed significant differences across the 13 Strategic Objectives, in terms of funding gaps and budget implementation rates. Overall, 92% (US$ 1 162 601 000) of the total initial approved budget was funded, leaving a funding gap of US$ 100 263 000. This relatively high level of funding for the total budget approved by the Health Assembly however, hides substantial variation in funding gaps among the 13 Strategic Objectives. The largest funding gaps were in the Strategic Objectives related to food safety and nutrition – SO9 (70%); health systems – SO10 (60%); child and maternal health – SO4 (52%); AIDS, tuberculosis and malaria – SO2 (47%); health risk factors - SO6 (46%); and healthier environment - SO8 (42%). The Polio programme under SO1 received 216% of its approved budget.

23. Overall, 99% of the AC allocation was made available and 91% (US$ 954 000 205) of the VC allocation approved by the World Health Assembly had been funded by the end of the biennium. A total of US$ 1 059 656 575 (91%) of all funds made available was implemented, of which 76% was spent at country level. A summary of the 2010-2011 Programme Budget and corresponding implementation figures by Strategic Objective is provided in Table1.

24. The global financial crisis led to a significant funding gap in some programmes which did not allow the Region to meet all its funding requirements for planned activities. To accommodate the funding gap, most Budget Centres, at both the regional and country levels, revised and adjusted their workplans. This reprogramming exercise resulted in the cancellation of some activities and reduction of the number of expected results. By the end of the biennium, the attainment of some planned results had been jeopardized.

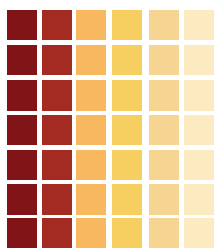
25. The performance assessment at the end of biennium shows that 54% of the 2554 Office Specific Expected Results (OSERs) were fully achieved. Nineteen per cent were partially achieved, while the remaining 27% were either reprogrammed or cancelled due to insufficient funding. Despite these constraints, significant achievements have been noted in all Strategic Objectives, and the effectiveness of technical cooperation with countries has been sustained, including through the direct support of the Intercountry Support Teams to countries.

26. In response to the budget shortfall, the Organization had to take cost-saving measures such as cancellation and reduction of the number of meetings and travels, as well as re-organizing the staffing structure in both country offices and the Regional Office, across all programmes. These measures implied significant reduction in the level of support to countries in such areas of work as HIV/AIDS, tuberculosis, and malaria; health systems; maternal, newborn and child health; health promotion and primary prevention including for noncommunicable diseases, most of which are MDG-related areas.

### Table 1: Programme Budget 2010-2011: Budget implementation by Strategic Objective as at 31 December 2011 (in US$ 000)

| SO* | Budget approved by Health Assembly (initial allocation) (1) | Allocated budget (2) | Total available funds (3) | % available funds against budget approved by Health Assembly (4)=(3/1) | Budget. implemen-tation (committed funds) (5) | % of budget implemen-tation against approved budget 6=(5/1) | % of budget implemen-tation against allocated budget 7= (5/2) | % of budget implemen-tation against available funds 8=(5/3) |
|---|---|---|---|---|---|---|---|---|
| SO 01 | 424 120 | 744 390 | 662 260 | 156% | 606 658 | 143% | 81% | 92% |
| SO 02 | 208 208 | 207 337 | 109 335 | 53% | 91 777 | 44% | 44% | 84% |
| SO 03 | 19 444 | 19 504 | 13 959 | 72% | 12 405 | 64% | 64% | 89% |
| SO 04 | 107 735 | 106 146 | 52 124 | 48% | 45 680 | 42% | 43% | 88% |
| SO 05 | 98 782 | 129 465 | 62 577 | 63% | 55 100 | 56% | 43% | 88% |
| SO 06 | 23 943 | 23 965 | 12 958 | 54% | 12 303 | 51% | 51% | 95% |
| SO 07 | 8495 | 8660 | 7579 | 89% | 6577 | 77% | 70% | 87% |
| SO 08 | 16 335 | 16 403 | 9518 | 58% | 8701 | 53% | 53% | 91% |
| SO 09 | 37 182 | 36 898 | 11 201 | 30% | 9832 | 26% | 27% | 88% |
| SO 10 | 124 035 | 122 645 | 50 132 | 40% | 44 792 | 36% | 37% | 89% |
| SO 11 | 19 663 | 20 300 | 16 528 | 84% | 13 199 | 67% | 65% | 80% |
| SO 12 | 49 735 | 51 140 | 49 701 | 100% | 49 455 | 99% | 97% | 100% |
| SO 13 | 125 187 | 106 603 | 104 729 | 84% | 103 181 | 82% | 97% | 99% |
| Grand Total | 1 262 864 | 1 593 456 | 1 162 601 | 92% | 1 059 657 | 84% | 67% | 91% |

* See Table 2 in Annex for the statements of all the 13 Strategic Objectives.



# 4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE

## 4.1 SO1: Communicable diseases

27. Routine immunization, polio eradication, neglected tropical diseases, integrated disease surveillance, research, international health regulations, and epidemic preparedness and response all contribute to strategic objective 1. This strategic objective aims to contribute to the reduction of the health, social and economic burden of communicable diseases.

28. At the end of December 2011, the reported administrative routine immunization coverage with three doses of Diphtheria–Pertussis–Tetanus–containing vaccine (DPT3) for the Region was sustained at 82%. To promote uptake of immunization services through advocacy and improved communication, the first African Vaccination Week (AVW) was commemorated in April/May 2011, with 36 out of 46 Member States participating in the initiative.[2] The AVW led to the vaccination of 75 million children and adults with oral polio vaccine by more than 325 000 health workers and volunteers within the week. The momentum generated by the AVW will result in improved access to vaccines especially in hard-to-reach communities.

29. Four new vaccines were introduced by countries of the Region. Pneumococcal conjugate vaccines were introduced in 13 Member States;[3] rotavirus vaccine was introduced in South Africa and Zambia while HPV vaccine was introduced in Lesotho and Rwanda. Nearly 54.6 million people in 6 countries[4] received the meningococcal meningitis A conjugate vaccine (MenAfriVac™) in 2010-2011. This resulted in a dramatic reduction in cases of type A meningococcal meningitis, with only four reported cases in Burkina Faso during the 2011 meningitis epidemic season, none of which were in vaccinated individuals.

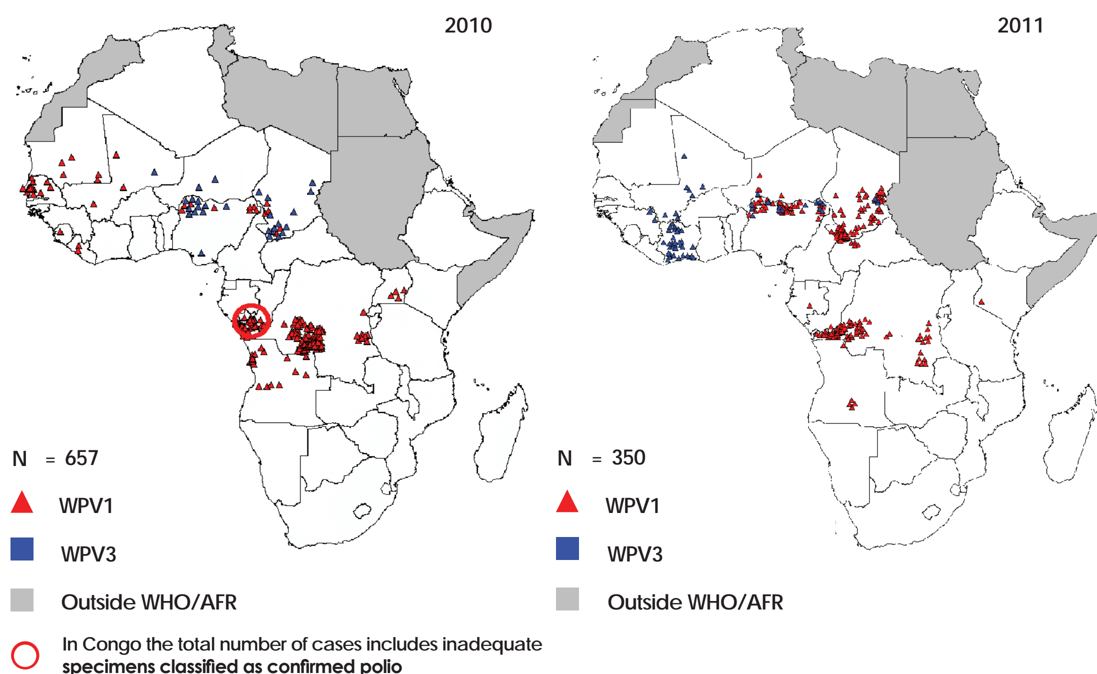
30. WHO continues to provide guidance and technical support and to compile and share best practices for the conduct of high quality integrated measles Supplementary Immunization Activities (SIAs) or campaigns. In 2010 and 2011, 31 countries[5] were supported to conduct measles follow-up and outbreak response SIAs reaching a total of 128 million children. In addition, six countries[6] were supported in 2011 to apply for GAVI support to introduce a second dose of measles vaccine in their routine

immunization schedules. In 2011, the regional incidence of measles dropped to 4.2 cases per 100 000 population, compared to 17.2 per 100 000 population in 2010. In September 2011, the Regional Committee adopted Resolution AFR/RC61/R1 aiming for regional measles elimination by 2020.

31. With regard to maternal and neonatal tetanus elimination, 13 countries conducted tetanus toxoid SIAs in 595 high-risk districts, targeting 37.1 million women of child bearing age. In addition, maternal and neonatal tetanus elimination was validated in a cumulative total of 24 countries[7] in the Region by the end of 2011, with the additional validation of five countries during the biennium.

32. Polio eradication remains one of the top priorities for WHO in the African Region. As a result of massive effort from governments, supported technically and financially by WHO and other international partners, the number of reported wild poliovirus cases in the African Region decreased from 657 to 350 between 2010 and 2011, representing a 47% reduction (Figure 1). Of the 657 cases reported in 2010, 64% were due to the outbreak in the adult population in the Republic of Congo and The Democratic Republic of the Congo. In 2011, some progress was made in stopping polio outbreaks in all countries, except one, within six months, thus attaining milestone 1 of the Global Polio Eradication Initiative (GPEI) strategy.

**Figure 1: Distribution of Wild Poliovirus cases, African Region, 2010 and 2011**




Source: WHO AFRO Polio Weekly Update, End 2011.

33. The Region is now in the "last lap" on the road to achieving guinea worm disease eradication. Chad, Ethiopia and Mali reported guinea worm disease cases in 2011, in spite of robust surveillance of the disease. The trends of guinea worm disease from 2009 to 2011 and the endemic countries as at the end of 2011 are shown in Figures 2a and 2b below. Ghana which interrupted guinea worm transmission in 2009 remained free of the disease throughout 2011. New cases of guinea worm disease decreased from 458 in 2009 to 100 in 2010 and 30 in 2011.

**Figure 2a: Trends of Guinea Worm Disease 2009, 2010 and 2011**

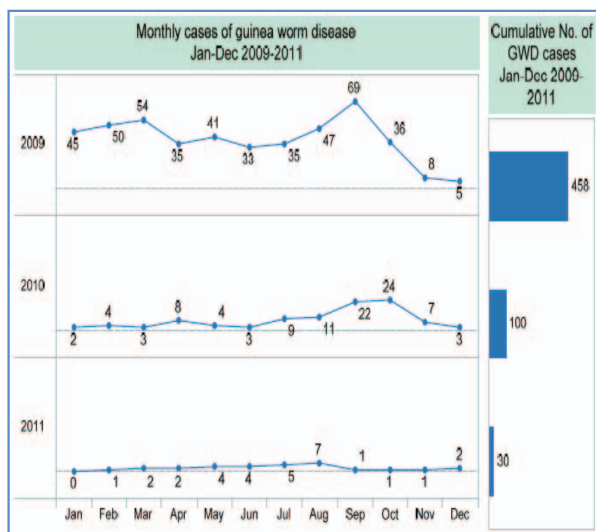
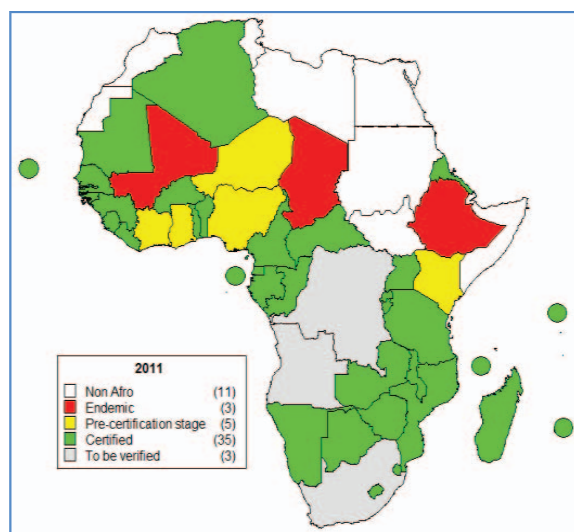



**Figure 2b: Distribution of Guinea Worm Eradication disease endemicity, 2011**



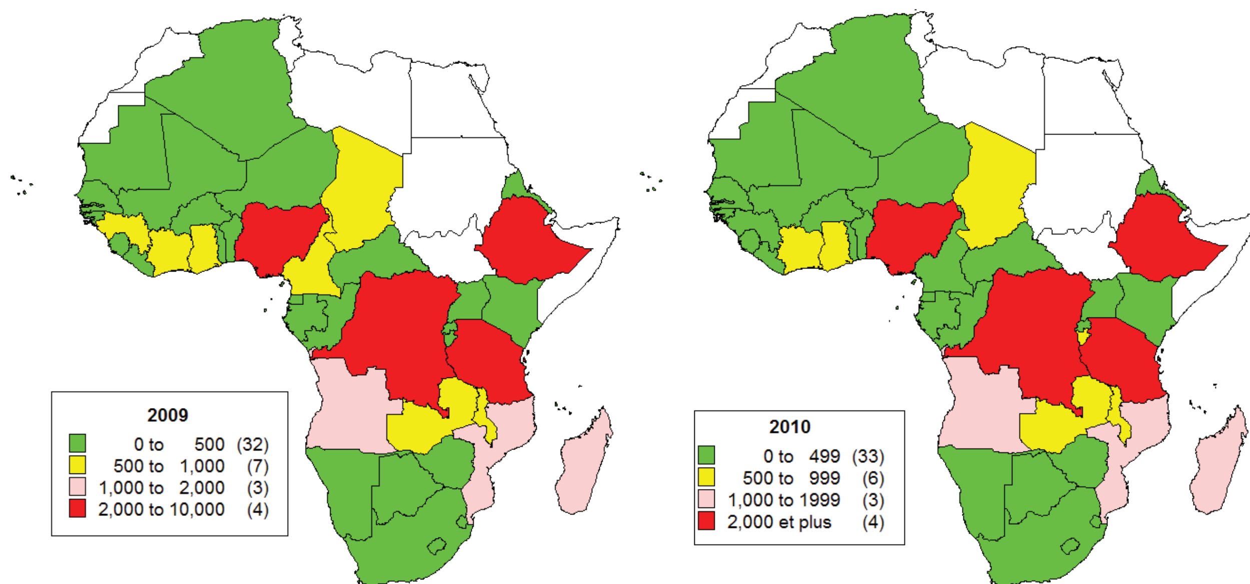

Source: WHO Regional Office for Africa Database

34. The goal of elimination of leprosy at national level was sustained in countries during 2010/2011 (Figure 3). Leprosy prevalence dropped further from 31 996 cases in 2010 to 30 405, representing a reduction of 5% in the burden of the disease. However, hotspots for leprosy remain in the Comoros and Liberia and at district level in some countries. The UN General Assembly adopted a resolution in December 2010 urging countries to take appropriate action with the focus shifting toward district level elimination, prevention of new cases and assuring human rights for persons affected.

35. With regard to the elimination of Human African Trypanosomiasis (HAT), which is targeted for 2015, the HAT prevalence dropped from 9878 cases in 2010 to 7141 in 2011, representing a reduction of 28% in the burden of the disease. In order to sustain progress, the new Nifurtimox-Eflornithine Combination Therapy (NECT) was introduced in the treatment of the Gambiense form, which is the most severe form of sleeping sickness.

36. Strong and new momentum - at the global, regional and country levels - currently exists towards the control of NTDs. The scale-up of simple, safe and cost-effective preventive chemotherapy for NTDs is also increasing rapidly. New drugs donated from the pharmaceutical industry are now available. Toward the elimination of lymphatic filariasis, 84 million people were treated in the latest round of mass drug administration in 2010, which represents a 30% increase when compared with 65 million in 2009.

**Figure 3: Trend of Leprosy Elimination, 2009 and 2010**




Source: WHO Regional Office for Africa, NTD Database

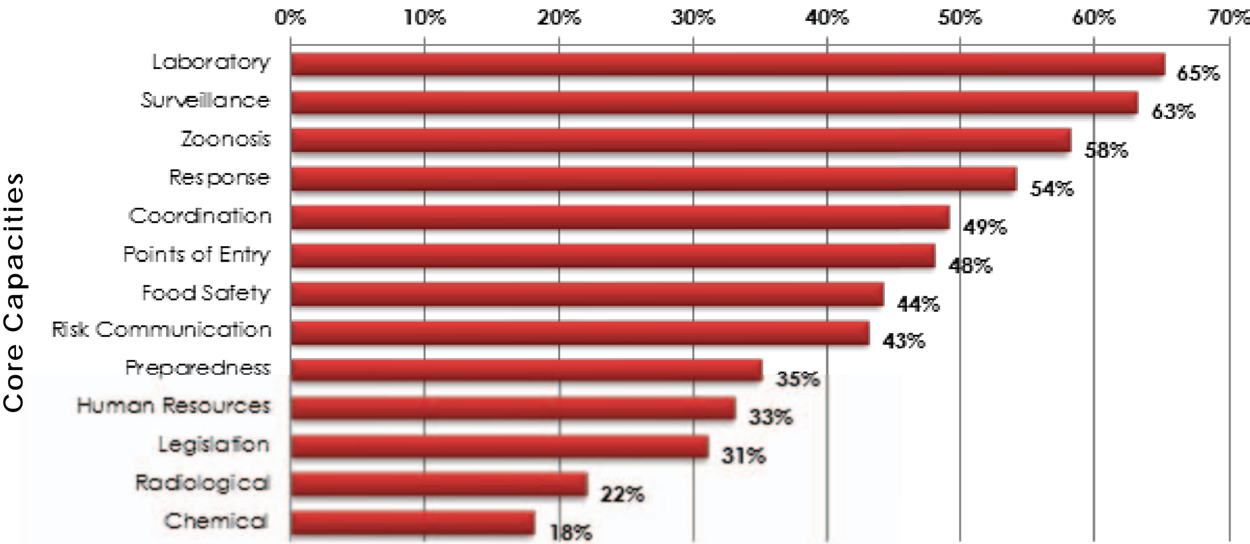
37. A regional NTD strategic plan for 2011–2015 was finalized based on WHO guidelines. All targeted countries have developed their national multi-year NTD Master Plans, which was essential for enhancing their capacity to mobilize the required resources and improve the integration of interventions to control neglected tropical diseases. That will ultimately contribute to further reduction in the NTD disease burden.

38. WHO continued to provide guidance on epidemic and pandemic disease surveillance and response. The focus was on enhancing disease surveillance and response systems; implementing the International Health Regulations within the context of Integrated Disease Surveillance and Response (IDSR); strengthening cross-border collaboration in outbreaks; improving coordination of response to outbreaks and other public health emergencies through the Strategic Health Operation Centre (SHOC) and; establishing the African Public Health Emergency Fund.

39. The Regional IDSR Technical Guidelines and related training materials were revised to incorporate the International Health Regulations (2005) and priority noncommunicable diseases. By the end of the biennium, 10 countries[8] had completed adaptation of their national IDSR technical guidelines. The use of the guidelines by Member States will contribute to the improvement of health information systems for better decision making, monitoring of disease trends, planning and evaluation of public health policies and interventions.

40. For IHR implementation, though most of the countries have not achieved the global targets for developing the required capacities, 40 countries[9] conducted assessment of the national core capacities. Following core capacity assessment, 37 countries[10] have developed IHR national implementation plans. In line with the requirement of annual reporting to the World Health Assembly, 23 countries[11] and 37 countries[12] respectively completed the annual IHR monitoring questionnaires in 2010 and 2011. The major achievements and gaps in national core capacities for surveillance and response to public health events as defined by the IHR (2005) are illustrated in Figure 4.

**Figure 4: Status of IHR core capacities in the African Region based on States Parties Report, December 2011**




Source: States Parties IHR monitoring reports, 2011

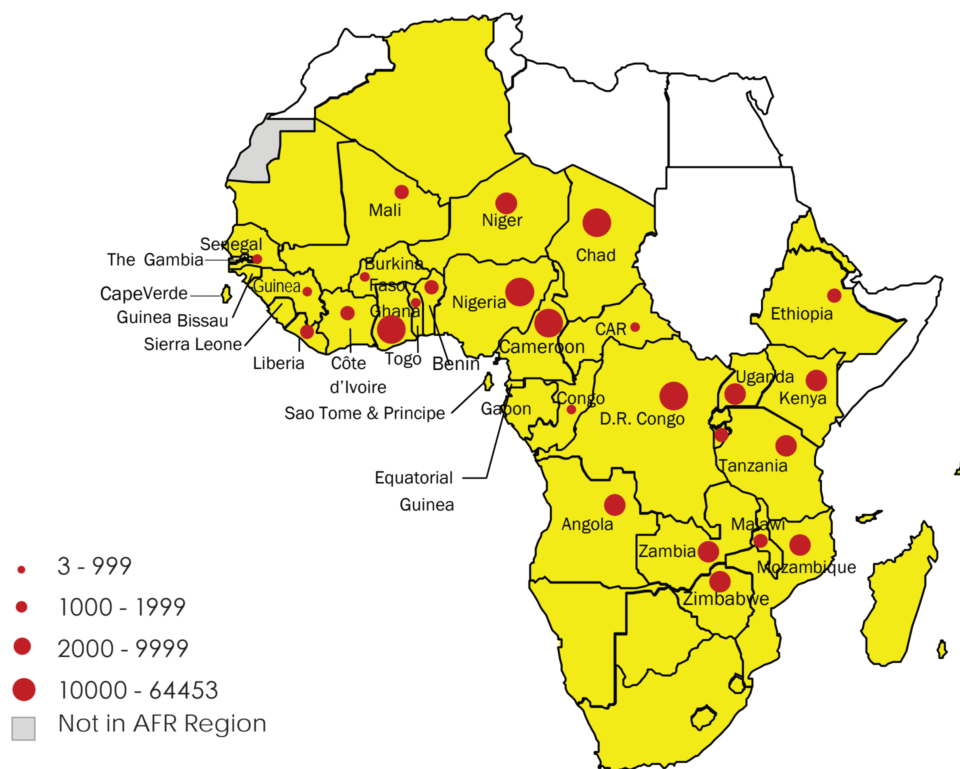
41. Laboratory capacity to improve confirmation of suspected outbreaks continued to be strengthened in the Region. Guidelines for establishing Centres of Excellence (CoE) were finalized and subsequently Angola, Kenya and Uganda developed

national plans for establishing Centres of Excellence. The protocol for national influenza sentinel surveillance was finalized and subsequently adapted by eight countries.[13] Data from the national influenza laboratories is being analysed and shared with Member States and partners on a weekly basis to enhance seasonal and pandemic influenza preparedness and response.

42. Epidemiological monitoring of priority disease trends resulted in better understanding of the regional profile of major epidemic and pandemic threats. During the biennium, 38 Member States[14] reported 201 acute public health events to WHO. Although the vast majority of these events were of infectious origin, 12% were due to other causes such as natural and man-made disasters as well as chemical and food poisoning.

43. To curb the spread of cholera in the Region, WHO provided support to countries in the areas of surveillance, case management including provision of cholera kits, public health awareness, coordination and intersectoral collaboration. During the biennium, a total of 207 996 cholera cases and 6070 deaths were reported from 26 countries[15] (Figure 5), giving a case fatality rate of 2.9%. Cameroon, Chad, the Democratic Republic of the Congo, Ghana and Nigeria together accounted for 79% of cholera cases and 88% of cholera deaths in the Region.

**Figure 5: Geographical distribution of cholera cases in WHO African Region, 2010-2011**




Source: IDSR weekly reports from Member States

## 4.2 SO2: HIV/AIDS, Tuberculosis and Malaria

44. In its technical cooperation with Member States to address the burden of HIV/AIDS, tuberculosis and malaria in the Region, WHO, in collaboration with partners, focused on the provision of normative guidance, capacity building and technical support for scaling up cost-effective interventions towards attaining Universal Access (UA), defined as coverage of at least 80% of the target population.

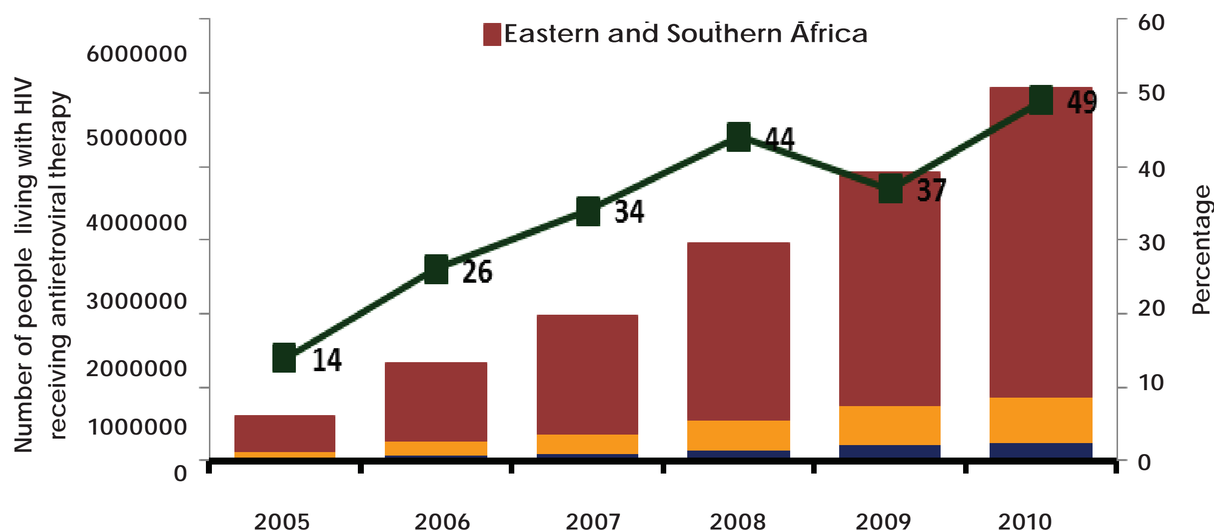
45. HIV remained a priority in the Region. The number of people who were newly infected with the virus continued to decline in 2010, dropping to 1.9 million compared with 2 million new infections in 2009. The most significant declines were in 22 countries[16] in the Region including some of the countries with the largest epidemics such as Ethiopia, Nigeria, Zambia and Zimbabwe.[17]

46. Progress towards achieving universal access to key HIV interventions continued during the biennium. In 2010, 42% of pregnant women received an HIV test compared with 35% in 2009. The proportion of pregnant women living with HIV who received antiretroviral medicine for preventing mother-to-child-transmission increased from 49% in 2009 to 60% in 2010. Among the 21 priority countries[18] for elimination of mother-to-child transmission of HIV in the Region, seven[19] exceeded 80% coverage, achieving the universal access target of effective regimens of antiretroviral medicine. However, the coverage of antiretroviral therapy for children was still low at 21% in 2010, ranging from 9% in western and central Africa to 26% in eastern and southern Africa.

47. By the end of 2010, 14 priority countries[20] in Eastern and Southern Africa with high HIV prevalence and low rates of male circumcision (MC) had put in place key programmatic elements to support the roll-out of male circumcision programmes. More than 400 000 males in these countries were reported to have been circumcised for HIV prevention in 2010 compared with 122 988 in 2009. This is expected to contribute to a reduction in HIV incidence in the countries.

48. WHO continued to provide technical support to countries to expand antiretroviral therapy (ART) in line with the 2010 WHO guidelines. An estimated 5.1 million people with HIV infection in sub-Saharan Africa were receiving antiretroviral therapy in 2010 (Figure 6), compared with 3.9 million in 2009. This represents a regional increase of 30% in one year and a coverage of 49% in 2010 compared with 37% at the end of 2009. The rapid scale up of ART programmes has resulted in a steady reduction of the number of people dying from AIDS-related causes with an estimated 1.2 million deaths in 2010 compared with 1.3 million in 2009.

**Figure 6: Number of people with HIV infection receiving antiretroviral therapy in the WHO African Region, 2005-2010**




Source: Global HIV/AIDS Response: Progress Report, 2011

49. With regard to tuberculosis control, the regional targets for DOTS expansion are to detect at least 70% of estimated TB cases and to cure at least 85% of cases on treatment. In 2010, 15 countries (33%)[21] in the Region reached the target of 70% case detection rate and 20 countries (43%)[22] achieved the treatment success rate target of 85%. These compare with the 15 countries (28%)[23] that achieved the 70% case detection rate and 13 countries (28%) that attained the 85% cure rate in 2009. In 2010, eight countries[24] achieved both targets compared with five countries[25] in 2009. This improvement in the attainment of indicators is a result of sustained efforts in rolling out DOTS expansion and implementing all the components of the WHO STOP TB Strategy in 37 countries[26] during the biennium. TB prevalence surveys are at different stages of preparation/implementation in eight countries[27] to confirm the real TB burden in these countries.

50. All the countries have adapted the web-based electronic data notification system resulting in 100% reporting during the biennium. In addition to case notification and treatment outcomes, more reliable data are being captured in areas such as TB/HIV and MDR/XDR-TB activities. The implementation of the Stop TB strategy resulted in increasing uptake of such strategies as the Community TB care, public private partnerships and greater impact of collaborative TB/HIV activities. Collaborative TB/HIV activities continued to be strengthened in 30 countries.[28] This resulted in 59% HIV screening of TB patients in 2010 compared with 56% in 2009. With the support of WHO and partners TB/HIV interventions resulted in 255 000 HIV-infected TB patients being put on ARVs in 2011, compared with about 80 000 in 2010.

51. In 2010 alone, over 9750 new MDR-TB and 536 XDR-TB cases were reported. By mid-2011 forty-two countries[29] had notified at least one case of MDR-TB while nine countries[30] had reported at least one case of XDR-TB. The true magnitude of MDR-TB is not yet known due to the low capacity for diagnosis in many countries. By the end of the biennium, WHO and partners had supported 18 countries[31] to build national capacity to detect MDR-TB. By May 2011, twenty-eight countries in the African Region had introduced drug-resistant TB treatment Programmes.[32] While the regional treatment success rate with first-line smear-positive TB is 80%, MDR-TB treatment success rate is 50% with 19% death rate while XDR-TB treatment success is 27% with 43% death rate.[33]

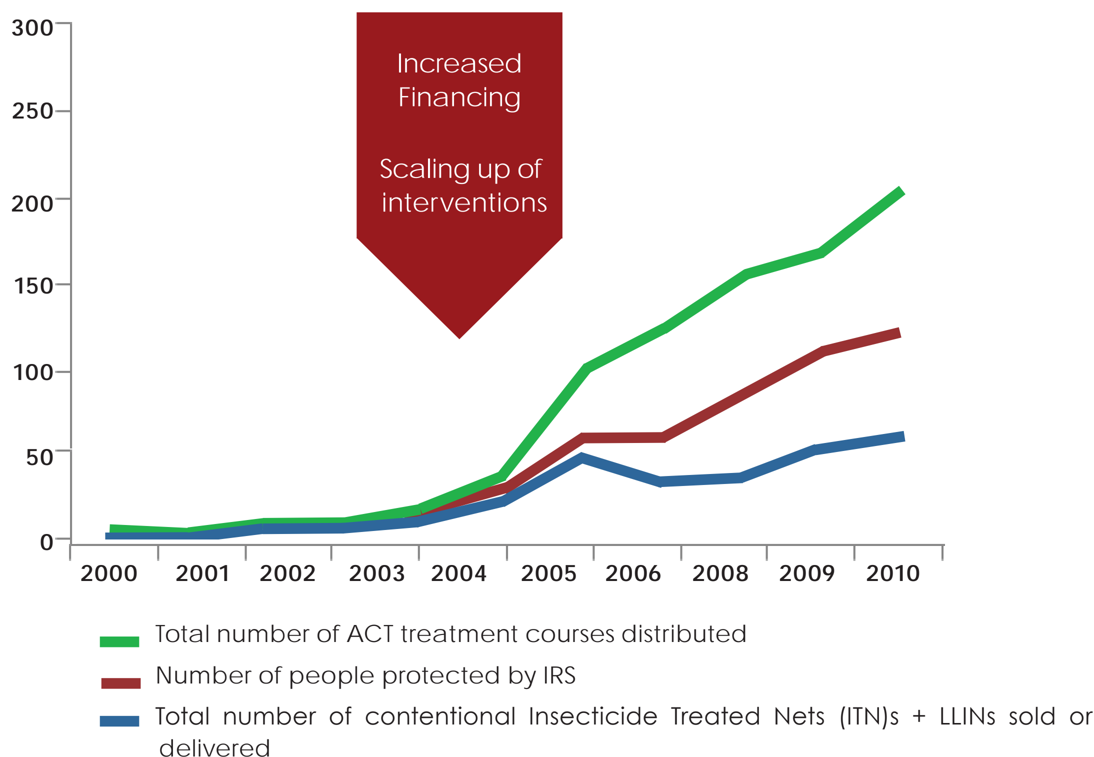
52. By the end of 2010, 12 countries in the Region[34] had recorded over 50% reduction in the malaria burden. This success is mainly attributed to national leadership, evidence-based strategic planning and implementation, partner's harmonization and alignment and the availability of resources to scale up the main interventions.

53. Progress was made in scaling up the different malaria interventions during the UN decade to roll back malaria in Africa (2000–2010) as shown in Figure 7. Long-Lasting Insecticidal Nets (LLINs) used by children under five years exceeded 40% in 10 countries,[35] reaching 70% in Mali and 75% in Madagascar. The proportion of pregnant women sleeping under a LLIN exceeded 40% in 14 countries, reaching 60% in Rwanda and 71% in Niger and Madagascar.[36] The number of countries applying indoor residual spraying (IRS) for malaria control increased from 24 in 2009 to 29 in 2011. Subsequently, population coverage of IRS increased from about 50 million in 2009 to about 75 million people during 2011.

54. Thirty-three countries[37] have adopted a policy of parasitological testing of all malaria cases and all endemic countries are implementing artemisinin-based combination therapy as the first-line treatment for malaria. Community-based approaches have contributed to scaling up malaria diagnosis with rapid tests. In 2011, it was estimated that all endemic countries in the Region, except four, had sufficient funding for ACT treatment courses to cover all the reported cases of malaria.[38]

55. Following the Regional Committee's call in 2009 for "accelerating malaria control towards elimination", a SADC malaria initiative which involves four "frontline" countries[39] and four low-transmission countries[40] was established to promote sustained control and capacity strengthening for transition to pre-elimination. During the biennium, support was provided to the four low transmission countries to develop and implement malaria elimination strategies, including Cross-border activities.

## Figure 7: Trends of the number of nets distributed/sold and people protected by IRS and ACT, 2000-2010




Source: WHO Regional Office for Africa Database, 2011

56. WHO provided support to the African Union Commission, regional economic communities and other partnership mechanisms in the area of HIV/AIDS, tuberculosis and malaria control. This included the organization of the fifth Conference of African Ministers of Health held in 2011 and the work of the African Leaders Malaria Alliance and the Champions for an HIV-free Generation. With regard to funding for HIV/AIDS, tuberculosis and malaria, the Global Fund remained the main source for the three diseases. WHO played a unique role in providing technical guidance and support for proposal development and programme monitoring and evaluation. The Region has secured more than US$ 12 billion[41] in funding since the launch of the GFATM. A ministerial session on the GFATM was organized during the Sixty-first session of the Regional Committee in order to maximize access to and utilization of GFATM resources.

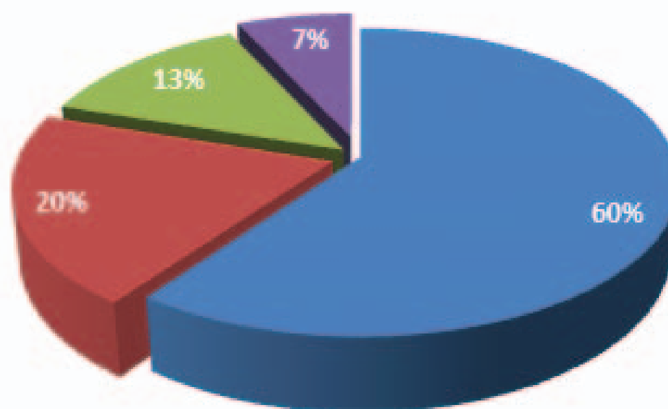
## 4.3 SO3: Chronic noncommunicable conditions, mental disorders, violence and injuries

57. Noncommunicable diseases (NCDs) such as cardiovascular diseases (CVD), cancers, diabetes, chronic respiratory diseases, sickle-cell disease (SCD) and conditions like mental disorders, violence and injuries, oral diseases, and eye and ear disorders, have increasingly become significant causes of ill health in the Region. In 2010, NCDs were responsible for more than 3 million deaths, representing 40% of all deaths in the WHO African Region (Figure 8). The Region has the highest age-standardized NCDs mortality rates for all ages – 844 per 100 000 for males and 724 per 100 000 for females. About half of all deaths due to NCDs occur in persons aged less than 70 years, making NCDs a significant contributor to premature death and disability in Africa. Globally, deaths from NCDs are projected to increase by 17% over the next 10 years, and the greatest increase (27%) is expected to be in the African Region. If current trends continue, NCDs are projected to exceed communicable, maternal, perinatal, and nutritional diseases as the most common cause of death in Africa by 2025.

**Figure 8: Deaths from NCDs in the African Region in 2010**

**40%**

of deaths in Africa are from NCDs and injuries




- Group 1 - Communicable diseases, maternal, perinatal and nutritional conditions
- Group II - Premature deaths from NCDs ( below the age of 70), which are preventable
- Group III - Other deaths from NCDs
- Group IV - Injuries

Source: Global Status Report on Noncommunicable Diseases, 2010

58. During the biennium, the main achievements were related to high level advocacy for increased prioritization of NCDs; development of policies, strategies and plans; establishment of collaboration, partnerships and networking; implementation of integrated national NCDs action plans; surveillance; national capacity building; and improvement of care and services including at primary care levels.

59. Member States' political commitment to the prevention and control of NCDs increased with high level advocacy conducted by WHO in the Region. The landmark Brazzaville Declaration on NCDs was adopted in April 2011 at a Regional ministerial consultation organized by the Regional Office and attended by more than 30 ministers of health, as well as some 150 experts from the Region, partners and civil society organizations. The Brazzaville Declaration, which recognizes NCDs as a global development issue, increased awareness and outlined the actions required for NCDs prevention and control. The Declaration was used worldwide and served as the Region's position at the first Global Ministerial Conference on NCDs and Healthy Lifestyles in Moscow in April 2011. It is now being implemented in Member States with WHO technical support.

60. Furthermore, intensified advocacy by WHO resulted in a high level of attendance by Heads of State and Government from the Region and significant contribution to the UN Political Declaration on NCDs, adopted in September 2011 during the UN High-level Meeting on NCDs Prevention and Control. WHO forged partnerships with subregional economic communities,[42] other UN agencies[43] and international NGOs.[44] These resulted in the adoption by subregional economic communities of two resolutions on NCDs, calling upon Member States to implement WHO's strategies for NCDs prevention and control. In addition, there is an increased donor base with the signing of four new memoranda of understanding providing additional resources for NCD prevention and control in the Region.

61. With the support of WHO, Member States developed national policies, strategies and integrated action plans for the prevention and management of NCDs including mental health,[45] violence, injuries, disability and rehabilitation. Twenty-seven[46] countries were supported during the biennium, bringing to 32 the number of countries in the African Region that have now developed and are implementing integrated NCD action plans (see Figure 9). A regional strategy for sickle-cell disease prevention and control was adopted in 2010 providing countries with a clear Road Map to implementing priority interventions aimed at reducing the burden of this disease.

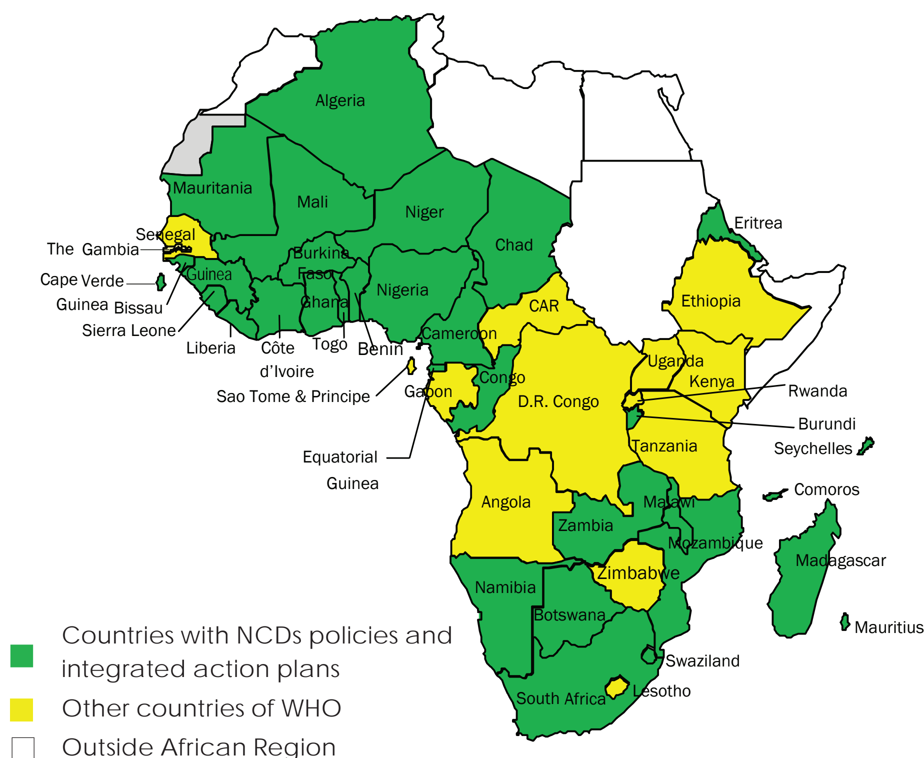
62. Furthermore, eight countries[47] developed and finalized national cancer control plans and have been supported in their implementation. With WHO support, 11 countries[48] have developed and are implementing national oral health and noma strategies/action plans while in 19 countries[49] oral health strategies have been integrated into NCD programmes. Congo, Madagascar and Seychelles developed policies and plans for eye health and for the prevention of hearing impairment. The decade of action for road safety which is a commitment by Member States to reduce traffic injury and fatalities was launched in 20 countries. Implementation of these policies, strategies and action plans is contributing to reducing NCDs morbidity and mortality and the related suffering of populations.

63. Mozambique, Kenya and Seychelles conducted assessments of their mental health services using WHO-AIMS and seven countries conducted situation analyses of hearing impairment. Furthermore, 41 countries carried out situation analyses of oral health. These assessments served as the basis for policy development and planning.

64. NCDs management capacities were strengthened in five countries including the use of the WHO package of essential NCD interventions at primary care level (WHO-PEN) and the use of the mental health Global Action Plan (mh-GAP) aiming at identifying and treating common mental disorders, in Nigeria and Ethiopia. WHO supported the integration of Primary Eye Care into Primary Health Care services in 12 countries. Management of NCDs at primary care level contributed to the increase of access to services and equity.

65. The next phase in NCDs prevention and control in the African Region will build on the achievements of this biennium to better integrate prevention and control approaches and increase access to services.

**Figure 9: Countries with NCDs policies and integrated action plans in the WHO African Region**




Source: NPC Programme WHO Regional Office for Africa

## 4.4 SO4: Child, adolescent and maternal health, and ageing

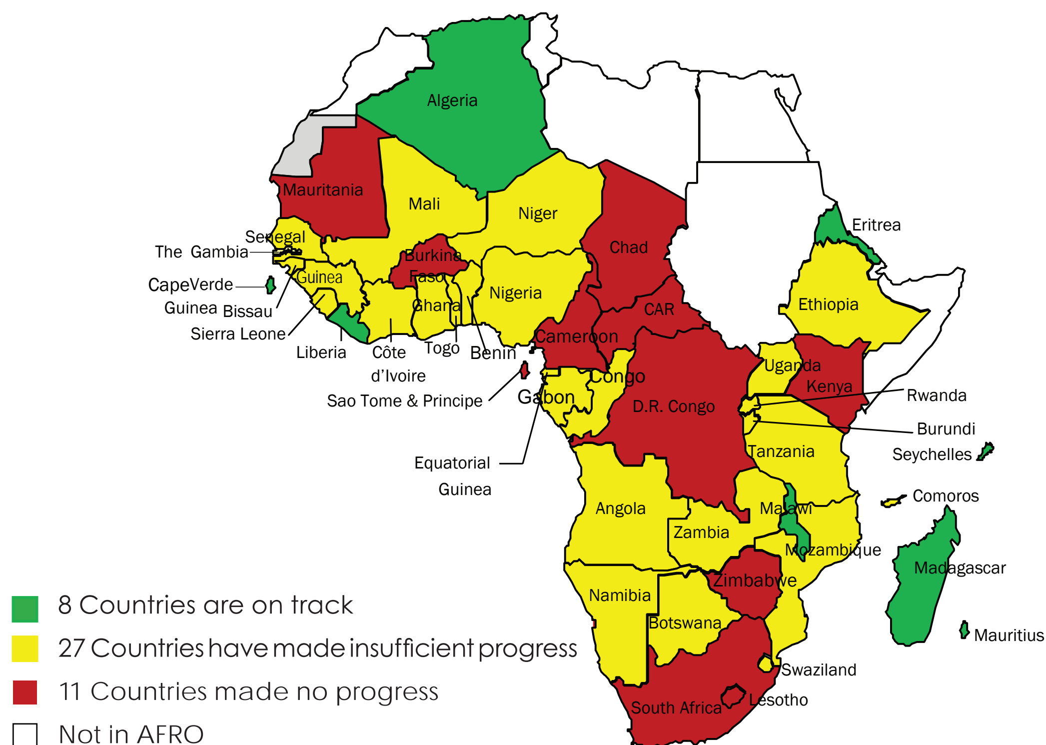
66. Strategic objective 4 aims at reducing morbidity and mortality and improving health during the key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing for all individuals.

67. Sub-Saharan Africa has doubled[50] its average annual rate of reduction in under-five mortality from 1.2 per cent per year over 1990–2000 to 2.4 per cent per year over 2000–2010. In 2010, eight countries[51] in the Region were on track to reduce child deaths by two-thirds between 1990 and 2015, compared with five in 2008 (Figure 10). Though only two countries, Equatorial Guinea and Eritrea, are on track to achieve MDG5, some progress has been observed as there are now 26 African countries with 40% or more decrease in maternal mortality ratio from 1990 to 2010, compared to only 15 in 2008.[52] In addition, some East and Southern African (ESA) countries such as Botswana, Lesotho, Namibia, South Africa and Swaziland, where the MMR had increased partly due to the severe HIV epidemic from 1990 to 2000, are now demonstrating declines due to the availability of antiretroviral therapy.

68. With the support of WHO and partners, 27 African countries[53] renewed their commitment to improving access to family planning, antenatal care and skilled birth attendance in order to reduce maternal, newborn and child mortality. This was in response to the UN Secretary-General's Global Strategy for Women and Children's Health, aimed at saving the lives of 16 million women and children over the next five years.

69. Significant progress has been made in countries in adopting policies and strategies conducive to maternal, newborn, child, adolescent and reproductive health. Currently, 38 of the 46 countries in the Region have comprehensive national maternal and child health policies, strategies and plans. Twenty-three countries[54] adopted policies for community case management of pneumonia[55] compared to 10 countries in 2008. Consequently 17 countries[56] are implementing integrated community case management of pneumonia, diarrhoea and malaria.[57] Twelve countries[58] developed or adapted their national reproductive health/family planning policies, norms and guidelines while 19 countries[59] removed user fees for maternal and child health services, in order to improve access to effective MNCH interventions. Eleven countries[60] finalized their adolescent health strategic plans, bringing the total number of countries with such plans to twenty-nine.[61] Six countries[62] revised their adolescent health strategies or plans in the context of HIV.

**Figure 10: Progress towards achieving the 4th Millennium Development Goal: reduce under-five mortality rates by two thirds between 1990 and 2015**




Source: UNICEF, WHO, World Bank, UNDESA, Levels and Trends in Child Mortality: Report 2011 – Estimates Developed by the United Nations Interagency Group for Child Mortality Estimation, New York, UNICEF 2011.

70. WHO developed a regional strategic framework in response to the 'Global Commitment to the Elimination of New Paediatric HIV infections Among Children and Keeping Their Mothers Alive'. Ten countries[63] developed their national plan towards the elimination of paediatric HIV infections in line with the regional strategic framework.

71. The capacity to implement child survival interventions was strengthened. The number of countries implementing the Integrated Management of Childhood Illness strategy (IMCI) in more than 75% of their districts increased from 22 in 2009 to 26 countries[64] by the end of 2011. In collaboration with health ministries, UNICEF and other partners, WHO conducted three regional workshops to facilitate the implementation of coordinated and expanded interventions for the control of pneumonia and diarrhoea among children under five years. The workshops which covered 23 countries reinforced the importance of a focused and coordinated approach to pneumonia and diarrhoea control as part of the integrated approach to child survival and health. In addition to making a key contribution to

the achievement of Millennium Development Goal 4 on reducing child mortality, reducing the burden of these diseases will also contribute to achieving Millennium Development Goal 1 on eradication of extreme poverty and hunger.

72. The scaling up of various health interventions to community level has resulted in encouraging outputs and outcomes. Evidence from the African Region has shown that trained community health workers can correctly assess sick children, dispense antibiotics, oral rehydration salts and antimalarial medicines (e.g. in the Democratic Republic of the Congo, Malawi, Rwanda and Senegal). This has increased the number of sick children being correctly managed at community level, with one country showing cure rates of more than 90% for fever, diarrhoea and acute respiratory infections. Government leadership in the integration of community case management of childhood illnesses, using standardized guidelines, has resulted in strengthened partnerships between ministries of health and implementing partners e.g. nongovernmental organizations. The integrated approach at community level has also attracted increased funding from partners for community-based interventions e.g. the child health grant from the Government of France, focusing on integrated community case management for seven countries in the Region, and the Canadian International Development Agency grant for the Global Programme on Malaria for five countries.

73. Monitoring of maternal and newborn health strategies was strengthened during the biennium. Ten countries[65] conducted mid-term reviews of their national road maps for accelerating maternal and newborn mortality reduction and appropriate remedial measures were taken to address the gaps and bottlenecks identified. An additional 13 countries[66] conducted Emergency Obstetric and Newborn Care – (EmONC) Needs Assessment and developed plans to address the identified gaps. As a measure of the improvement in the quality of care, four countries[67] have made maternal death a notifiable event within 48 hours.

74. Several guidelines and tools were developed and disseminated and are now being used to improve the quality of Maternal and Newborn Health services. These include: (i) *"Les Recommendations pour la pratique clinique des soins obstétricaux et néonataux d'urgence en Afrique - Guide du Prestataire"* (RPC); (ii) Framework for Integrated community-level health promotion Interventions and (iii) Short Programme Review Tool for the Road Map Review.

75. WHO developed and introduced two training packages for newborn health: (1) the Essential Newborn Care Course (in 26 countries[68]) and (2) Caring for the Newborn at Home, A Training Course for Community Health Workers (in 22 countries.[69]) In addition, a strategic document on *Cancer of the cervix in the African Region: current situation and way forward* was adopted by the Sixtieth session of the Regional Committee. Seven countries[70] developed strategies for cervical cancer prevention and control.

76. During the biennium, partnership for maternal, newborn and child health improved. In response to the emphasis on the MDGs at the 2010 meeting of G8 countries in Muskoka, a number of countries including Canada and France committed substantial amounts of financial support, complemented by WHO's invaluable technical input. This support requires and encourages partnerships such as the H4+ (WHO, UNICEF, UNFPA, World Bank, UNAIDS) and beyond (e.g. HHA and bilateral partners).

77. Advocacy for removal of all barriers to maternal, newborn and child health care services increased substantially. Eleven countries[71] launched "The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)" under the slogan "Africa cares: No Woman Should Die While Giving Life". Thirty-five countries[72] have now launched their national CARMMA.

78. In response to the Fifty-eighth session of the Regional Committee Resolution AFR/RC58/R1 on Women's Health in the African Region, the Regional Director established a Commission on Women's Health in the African Region. The Commission generated evidence on the role of improved women's health in socioeconomic development in the Region and produced a report entitled *Addressing the Challenge of Women's health in Africa*. The report highlights the often complex relationships between women's health and socioeconomic development in the African Region and calls for multisectoral approaches, among others, to deal with the issue.

## 4.5 SO5: Emergencies, disasters, crises and conflicts

79. Work on Strategic Objective 5 during the biennium placed emphasis on disaster risk management, preparedness and readiness to provide timely and effective response. Countries in the African Region continue to be affected by emergencies resulting in disasters with loss of lives and huge socioeconomic costs. As many as 35 countries[73] reported emergencies in 2011. There was a strong emphasis on delivering coordinated support from all the levels of WHO and across programmatic areas, notably with the Epidemic and Pandemic Alert and Response and Nutrition programmes.

80. The Region made a significant contribution towards the process leading to the adoption of resolution WHA64.10 urging Member States to strengthen health emergency and disaster risk management programmes. A tool to assess existing capacities and develop a road map for the implementation of comprehensive disaster risk management (DRM) was adopted and field-tested. This was used in Sierra Leone to identify gaps and develop a road map for DRM for that country. Hazards maps (e-atlas) have been developed for all the countries in the Region with the technical assistance of the WHO Mediterranean Centre on DRR as a first step to conducting risk analysis and mapping. Technical support was provided to 30 countries[74] to develop all-hazard health emergency contingency plans.

81. The Region participated in the development and adoption of the WHO Emergency Response Framework. Regional surge capacity for emergency response was consolidated during the biennium using the regional roster of emergency experts and the humanitarian depot in Accra, Ghana. This has resulted in continued improvement in the timeliness of response to emergencies, facilitated by rapid deployment of experts and reduction in delivery time of emergency kits to countries. Countries were supported to provide health response during emergencies and disasters, including the Côte d'Ivoire crisis, the Horn of Africa drought, the floods in southern and western Africa and the complex emergencies in Chad, Central African Republic and the Democratic Republic of the Congo, resulting in lives being saved. WHO support focused on health response coordination and identification and filling of gaps. Frequently identified gaps were in areas including training, response strategy development, surveillance and resource mobilization. WHO support enabled the vaccination of hundreds of thousands of children against polio, measles and other vaccine-preventable diseases, and the enhancement of health promotion towards the prevention of disease outbreaks during emergencies.

82. Improved performance during emergency response as well as increasing recognition of the risk management approach were observed following the training of WHO staff, partners including NGOs and ministry of health personnel. The programme supported training institutions by facilitating two courses on Health Emergency in Large Populations (HELP) at the University of Pretoria, South Africa, and the Regional Public Health Training Institute, Ouidah, Benin. The Public Health in Complex Emergencies course at the University of Makerere in Uganda was also facilitated. A total of 88 participants were trained in those courses during the biennium. In order to harmonize the content of emergency training courses and activities in the Region, a task force has been commissioned to produce curricula and modules for pre-service, in-service and post-service training in the next biennium.

83. Leadership was provided for the activated humanitarian health clusters in countries, resulting in improved resource mobilization and better coordination of health response actions. Regional health partners were constantly updated on health situations through monthly bulletins as well as monthly meetings chaired by the WHO, facilitating informed decision-making for the health emergency response. Partnerships were strengthened and expanded during the biennium to include collaboration with ECOWAS, SADC and the United Nations International Strategy for Disaster Reduction (UN ISDR) resulting in the health component's inclusion in the African Strategy and Programme of Action on Disaster Risk Reduction 2010–2015.

84. Countries were supported to mobilize resources during both acute and protracted emergencies through advocacy and inputs to improve the quality of proposals. As at the end of the biennium, over US$ 77 million had been mobilized. Support was provided to countries for the utilization of resources, through the use of an

on-line tracking system and continuous follow-up, to ensure compliance with donor requirements. The completeness and timeliness of reporting to donors was significantly improved.

## 4.6 SO6: Risk factors for health conditions

85. Strategic objective 6 seeks to promote health and development and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

86. The Regional Office made significant efforts to strengthen the capacity of Member States to implement the multisectoral approach to health promotion and prevention of health risk factors. During the biennium, tangible results were achieved in developing national health promotion-related policies and legislations. Five countries developed national health promotion policies.[75]

87. The WHO Regional Office increased its support to Member States to strengthen capacity to develop evidence-based national plans to promote healthy lifestyles and prevent and control key health risk factors. Consequently, four countries[76] were each supported to develop national strategic Plans of Action to implement the health promotion policies. Furthermore, four countries[77] adopted national strategic plans for tobacco control. Health Promotion and Global Alert and Response teams from WHO organized training on application of health promotion strategies during disease outbreaks. As a result, consensus was reached on the key elements to be included in communications during disease outbreaks.

88. Seven countries[78] have enacted legislation to ban smoking in public places and workplaces, tobacco advertising, promotion and sponsorship, and to require pictorial health warnings on tobacco packaging. Kenya, Mauritius and Uganda held national workshops to develop and strengthen national tobacco control policies, regulations and workplans.

89. Member States were supported to implement the WHO Framework Convention on Tobacco Control (FCTC). Côte d'Ivoire became the 41st country in the Region to ratify the FCTC. Participants from 16 countries[79] representing ministries of health and ministers of finance attended a workshop on instituting higher tobacco taxation. The meeting participants agreed to revise tax regimes in order to contribute to the public health objective of tobacco control. Consequently, four countries have initiated the process of revising their tax regimes.[80]

90. With support from WHO in collaboration with the United States Centers for Disease Control and Prevention (CDC), the availability of data on tobacco has improved in countries. Forty-five countries now have data on tobacco use and exposure among youth, of which 24 have trend data. The Global Youth Tobacco Survey (GYTS) data shows that the prevalence of tobacco use among youths in the Region ranges from 6.6% to 36.1% with a median of 17.5%. Trends show an increase of the prevalence of tobacco use among girls which becomes as high as for boys. All countries in the Region participated in the third round of the WHO report on the global tobacco epidemic and their policy and legislation data is available on the WHO Regional Office web site.

91. The Centre for Tobacco Control in Africa was established by WHO with financial support from the Bill and Melinda Gates Foundation. The Centre is hosted by the *Makerere* School of Public Health in Uganda and will act as the resource centre for tobacco control in the Region. The Centre is building capacity for tobacco control in five target countries[81] to effect policy change.

92. In order to facilitate the implementation of the Regional strategy to reduce harmful use of alcohol in the Region, the Regional Network of WHO National Counterparts has been established. This network, with focal points from all the 46 countries in the Region, met in 2011 to revise the draft Alcohol Action Plan for the period 2012–2020 for the WHO African Region. Through the Regional Office's support, five countries[82] have developed national alcohol policy documents, while several NGO leaders, politicians, government staff and members of the media from Lesotho and Madagascar were trained to develop evidence-based alcohol policy based on their countries' specific socioeconomic situations. A guide to support Member States in implementing each of the policy areas identified in the regional strategy is being developed.

93. To address the absence of data regarding alcohol marketing practices in countries, WHO conducted a pilot study to monitor industry action in alcohol marketing in four countries.[83] Results of the study, published in 2011, show that in the absence of regulatory and legislative mechanisms that address this policy area, populations are exposed to very high levels of alcohol marketing that could lead to increased harmful use.

94. The use of available data for programme planning, monitoring and evaluation is imperative in public health response to the burden of noncommunicable diseases. In this regard, the Regional Office supported five countries[84] to apply available health risk factors data from the STEPwise approach for surveillance of health risk factors (STEPS) or global school-based health survey (GSHS), to develop or update national NCD action plans, with particular focus on primary prevention for reducing the identified key health risk factors.

95. WHO supported the strengthening of national systems for surveillance of key health risk factors through existing tools such as STEPS and GSHS. During the 2010-2011 biennium, seven countries[85] conducted STEPS surveys, bringing to 37 the total number of countries with baseline population data on major health risks. STEPS data in the Region shows that the prevalence of tobacco use among adults aged 25 to 64 years ranges from 2.4% in Ethiopia to 23% in Sierra Leone, with a regional median of 9.3%. For obesity in the same age group, the range is from 1% in Ethiopia to 31% in South Africa, with a median of 5% across the Region.

## 4.7 SO7: Social and economic determinants of health

96. Strategic Objective 7 addresses the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

97. The Sixtieth session of the Regional Committee held in Malabo, Equatorial Guinea, approved a strategy and adopted a resolution for addressing the key determinants of health in the African Region. Subsequently, five countries[86] were supported to conduct national workshops to strengthen leadership and stewardship roles of the Ministry of Health in addressing key social determinants in priority public health conditions. Health equity trends were monitored in four countries.[87] Levels of poverty, education, political stability and access to health services were identified as key drivers of the health equity gap within countries.

98. Eight countries[88] have been supported to document experiences in implementing multisectoral actions in addressing communicable disease outbreaks, NCD risk factors, HIV/AIDS prevention, nutrition and promotion of adolescent health. The case studies which were presented as background documents at the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil, in October 2011, highlighted the importance of multisectoral actions such as health in all policies, good governance for health, partnership and community participation in addressing social determinants of health.

99. Continued advocacy has led to an increasing level of engagement and commitment among countries of the African Region to address health inequities and social determinants of health. A review of second generation Country Cooperation Strategies (CCS) shows that 40 countries identify social and economic determinants as a priority area of work in their CCS. Furthermore, 38 out of the 46 countries of the African Region were represented at the World Conference on Social Determinants of Health held in Rio de Janeiro. Fourteen ministers of health from the African Region made statements on Social Determinants of Health.[89]

100. In order to support countries to translate international agreements into clear action at the national level, three training workshops on "Mainstreaming gender equity, human rights and family planning into health programmes" were organized and attended by participants from 18 countries.[90] These training workshops contributed to the development of policy documents, guidelines and laws on gender and gender-based violence in countries. In four countries,[91] WHO supported orientation meetings on gender-sensitive analysis and planning, and sensitization seminars for addressing gender disparities and promoting gender considerations in health. Studies on gender-based violence against women and children, and the elimination of female genital mutilation (FGM) were undertaken in five countries.[92]

101. A survey was undertaken to generate information on the existence and capacities of National Ethics Review Committees. Preliminary findings from 29 countries indicate that, while some countries have national ethics review committees with an overarching policy and/or law regulating research involving human subjects, a good number do not. Since 2006 the national ethics committees of 19 African countries[93] have been supported within a network, "the African Vaccine Regulatory Forum (AVAREF)". This has resulted in joint reviews by ethics committees and national regulatory authorities of different countries. The joint reviews have considered clinical trial applications for approval and have provided regulatory and ethical oversight for major vaccine clinical trials in the Region, including the conjugate meningitis A vaccine and the RTS,S/AS01 malaria vaccine. A course on legislation for regulation of clinical trials is being implemented. This, together with additional capacity building, will further strengthen existing national ethics committees and support the establishment of others. That will ensure the safety and protection of the rights of participants in research as well as the generation of reliable data from research to inform policy decisions in the Region.

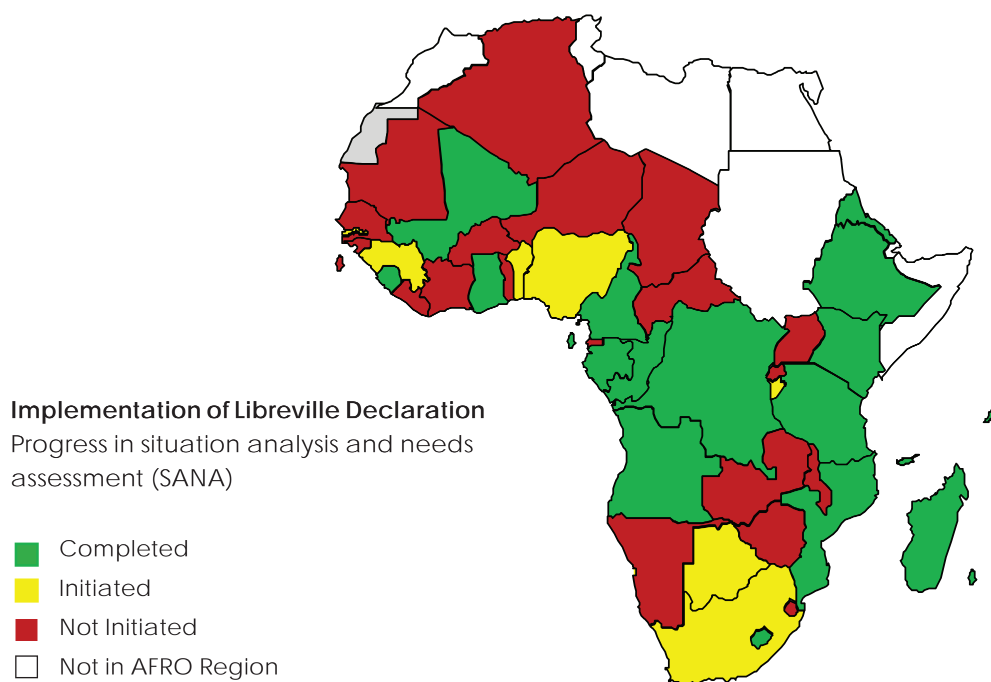
## 4.8 SO8: Healthier environment

102. Strategic objective 8 aims to promote a healthier environment, intensify primary prevention, and influence public policies in all sectors so as to address the root causes of environmental threats to health.

103. WHO continued to lead and coordinate the activities of the Health and Environment Strategic Alliance and organized the second interministerial Conference on Health and Environment in Africa, in Luanda in 2010, jointly with UNEP and the Government of Angola. The conference adopted three major documents of high political significance. They are the "Luanda Commitment", "Arrangements for the Health and Environment Strategic Alliance", and the "African Ministers of Health and Environment Joint Statement on Climate Change and Health".

104. WHO strengthened its partnership with UNEP to continue their support for the implementation of the Libreville Declaration on health and environment in Africa, especially by assisting more countries technically and financially to undertake their situation analyses and needs assessments (SANAs). By the end of 2009, only Gabon and Kenya had completed their SANAs. By the end of 2011, 13 additional countries[94] had finalized their SANAs by endorsing their national reports. Nine more countries[95] have initiated the process (Figure 11).

**Figure 11: Status of situation analysis and needs assessment (SANA) for the implementation of the Libreville Declaration in the African Region from 2009 to 2011**




Source: PHE Programme, WHO Regional Office for Africa

105. In 2010, The WHO-led UN-Water Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) published its first global report, featuring a detailed review in 26 African countries[96] of the key determinants influencing progress on water, sanitation, hygiene and health (WASH). In 2012, WHO in collaboration with UNICEF published the report on their Joint Monitoring Programme on access to safe drinking water and safe sanitation using 2010 data. The report showed that the use of improved sanitation facilities in the Region significantly increased from 31% to 49% between 2008 and 2010, while access to safe drinking water stayed the same (61% in 2010 compared to 60% in 2008). According to the report's findings, only five countries[97] are on track to achieve MDG 7c by 2015.

106. WHO supported countries to implement health care waste management and occupational health interventions. The regional framework for health care waste management was developed, which facilitated the implementation of the GAVI-supported health care waste management activities in 27 countries.[98]

107. About 100 cities and towns in the African Region joined the campaign associated with the 2010 World Health Day theme "1000 CITIES 1000 lives" to highlight the health risks in urban settings as well as the opportunities and policies to improve health in urban areas. The Urban Health Equity Assessment and Response Tool (Urban HEART) was developed by WHO to assist policy-makers and programmers to assess and respond to health inequities in cities. This tool was introduced in seven more countries in 2010-2011, bringing the total number using the tool to 10 countries.[99]

108. The work on health adaptation to climate change gained momentum during the biennium. In 2010, WHO undertook a review of health considerations in national adaptation programmes of action (NAPA) prepared by 41 least developed countries (including 29 from Africa). The assessment concluded that 39 out of the 41 NAPA reviewed considered health as being one of the sectors in which climate change has an impact. However, only nine of these plans were found to be comprehensive in their health-vulnerability assessment. In total, 30 of the NAPA included health interventions within adaptation needs and proposed actions, but only eight of these interventions were found to be adequate. As a follow up to the above, in September 2011, ministers of health at the Sixtieth session of the WHO Regional Committee for Africa by Resolution AFR/RC61/R2 endorsed a framework for public health adaptation to climate change. Guidelines for the development of country adaptation plans were prepared and five countries[100] have developed action plans for climate change and health.

## 4.9 SO9: Nutrition, food safety and food security

109. Between 2010 and 2011, the Horn of Africa faced one of the biggest food insecurity crises affecting the Region in 60 years, with 10 million people being food-insecure and needing urgent humanitarian assistance in Ethiopia, Kenya and Uganda. This resulted in high levels of malnutrition with child malnutrition ranging from 15%–45% across the affected countries. WHO responded by supporting countries through capacity building to improve skills for the management of severe acute malnutrition as well as supporting vaccination campaigns against measles and cholera prevention interventions in these particularly vulnerable populations.

110. WHO worked in partnership with the West African Health Organization (WAHO), *Comité Inter-Etats de Lutte contre la Sécheresse au Sahel (CILSS)*, UNICEF, World Food Programme (WFP), The East, Central, and Southern African Health Community (ECSA-HC), *Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale (OCEAC)*, other UN agencies and the African Union/New Partnership for Africa's Development (NEPAD) to strengthen capacities and harmonize indicators for nutrition surveillance. A workshop on nutritional surveillance was organized in Grand Bassam, Côte d'Ivoire, for nine countries,[101] to revitalize the existing nutrition surveillance systems to follow trends for timely action.

111. To improve prevention, early detection, timely intervention, and management of cases, nutrition and food safety indicators were integrated into the IDSR. As a result, foodborne diseases and nutrition conditions are routinely reported through the IDSR and 22 countries[102] currently have national surveillance data on malnutrition. To strengthen countries' capacities in foodborne diseases surveillance, 50 epidemiologists and microbiologists from public health, veterinary and food sectors in 10 countries[103] were trained in Kenya on laboratory-based foodborne disease surveillance. The Global Food Infections Network (GFN) level IV workshop was held in Cameroon for 14 Francophone countries[104] and in Southern Africa for nine countries.[105] So far 33 countries[106] have plans for reducing the incidences of at least one major foodborne disease.

112. Thanks to intensified advocacy for food safety and nutrition, the number of countries that have included nutrition and food safety activities in their Poverty Reduction Strategies rose from six in 2008-2009 to 23 countries[107] in 2010-2011. Oversight and awareness of food safety and nutrition thus improved, resulting in the reinforcement of multisectoral Food Safety and Nutrition Coordination Teams in 32 countries.[108]

113. WHO supported countries in the implementation of norms, standards, guidelines and strategies to improve infant feeding, especially in children with mothers living with HIV/AIDS. Three subregional workshops were held for 26 countries[109] on the new WHO recommendations on infant feeding in the context of HIV, PMTCT and ART. Twenty countries[110] adapted the new recommendations into national guidelines. Nine countries[111] finalized their strategies and action plans for prevention and management of severe malnutrition. Six countries[112] conducted Infant and Young Child Feeding assessment and used the findings to revise their national strategies.

114. The legal and policy basis for food safety regulations was strengthened through assessment of the food control systems for development of food safety policies, national action plans and bills in 13 countries,[113] bringing the total number to 28 countries.[114] Eight countries[115] conducted landscape analysis on readiness to scale up nutrition and are revising their nutrition policies based on the findings. "Healthy

Food Market" pilot programmes were established in five countries,[116] to improve environmental hygiene, food safety and nutrition. Action plans for National Codex *Alimentarius* Committee were developed in Gabon, Eritrea and the Democratic Republic of the Congo, with joint WHO and FAO support, to strengthen the operations of their National Codex Committees.

## 4.10 SO10: Health services

115. This Strategic Objective aims to improve the accessibility, quality and safety of health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research. Weak health systems impact negatively on progress towards achieving the MDGs, on the control and prevention of communicable and noncommunicable diseases and on maternal, child and women's health.

116. As part of support to strengthening the capacity of district and national health systems in the areas of policy, strategies, planning and implementation, various tools and guidelines developed by WHO are being implemented, based on the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, and the Algiers Declaration on Research for Health. Thus, 21 countries[117] strengthened the capacity of their district health systems to plan, manage, supervise, monitor and evaluate their work. With the use of the WHO guidelines on National Health Strategic Plans (NHSPs), 15 countries[118] revised their national health policies and another 18 countries[119] revised their national health strategic plans.

117. Twenty-two countries[120] developed and revised GAVI and GFATM proposals on health systems strengthening. This resource mobilization effort has helped improve health systems financing in these countries. Thirteen countries[121] held their joint annual health sector reviews during which they assessed the level of partners' alignment to national policies and strategic plans. Comoros and the Democratic Republic of the Congo developed a public health code in 2010. Mechanisms for strengthening the coordination of partners were established in Burundi, Cameroon and Ghana. Nineteen countries[122] adopted the International Health Partnership (IHP+) Compact arrangement and signed the global IHP+ Compact[123] for harmonized and efficient technical support.

118. In response to the health workforce crisis in the Region, a roadmap for scaling up the health workforce for improved health service delivery in the African Region was developed at a regional consultation. Thirteen countries[124] were supported in various aspects of the development of national Human Resources for Health (HRH) policies and plans, to allow them to perform their governance function in a transparent and accountable manner. Namibia

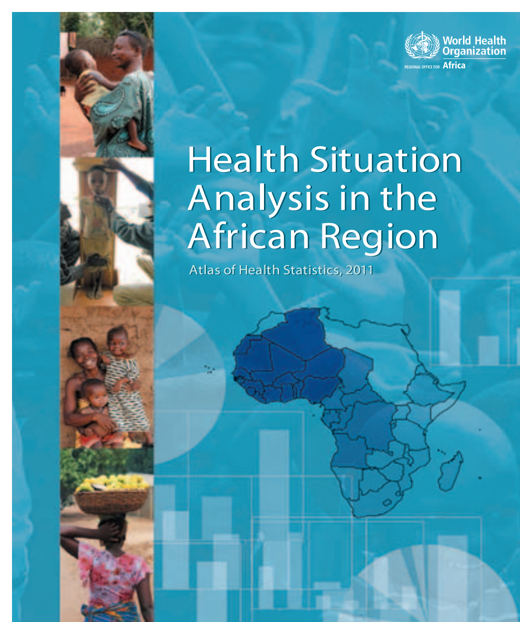
and Zimbabwe developed HRH retention strategies. The implementation of the African Initiative for Learning and Teaching Resources for Health Worker Education model was initiated in the Region to boost the education and production of human resources for health.

119. Eritrea and Sierra Leone evaluated their training programmes and curricula while Lesotho and Swaziland conducted feasibility studies for the establishment of medical schools. Comprehensive HRH country profiles were developed in 15 countries[125] while nine countries[126] established national health workforce observatories needed for evidence-based decision-making and progress monitoring. Sierra Leone and the Gambia established new databases for HRH. Fifty-four policy-makers and managers from 21 countries[127] were trained with a view to strengthening HRH policy, leadership and governance. The aim of this is to enable countries to exercise their oversight role, define clear visions of HRH development and plan strategically, using evidence. It will also enable them to establish and use effective mechanisms for dialogue and consensus-building among key stakeholders, for priority setting and long-term planning and investment in HRH.

120. In the area of health information systems (HIS), Mozambique, Sierra Leone and Uganda organized country workshops to strengthen their capacity while four countries[128] finalized strategic plans for strengthening their health information systems.

121. There was significant progress in making health information and data more readily available to Member States and stakeholders. As mandated by both the Ouagadougou Declaration and the Algiers Declaration, an African Health Observatory is now operational to support countries to generate, share and apply information for policy- and decision-making. Detailed analytical profiles were produced for the African Region as well as for Cape Verde, Congo and Zambia. A new HRH Regional Observatory portal was developed and launched in the three official languages. Regional progress on the health and health-related MDGs was assessed. An Atlas of Health Statistics for 2011 was produced for the Region as were detailed statistical profiles of the 46 countries (Figure 12).

**Figure 12: Atlas of health statistics, 2011**



122. Four issues of the African Health Monitor were produced in 2010-2011, covering the MDGs, health system strengthening, African traditional medicine, and reproductive health. The African Index Medicus posted 22 new African medical journals and added 12 519 new records. Member States[129] were trained in information retrieval and in the use of the Blue Trunk Libraries. The Library scanned and recorded 700 documents of the Regional Committee (dating from 1997 to 2010) and 522 documents of the World Health Assembly and the Executive Board (dating from 2009 to 2011) for inclusion in IRIS which is the WHO online institutional repository.

123. Evidence-Informed Policy Network (EVIPNet) country teams were assisted to develop policy briefs for better decision-making.[130] In collaboration with TDR, the Regional Office participated in the establishment and operationalization of the African Network for Drugs and Diagnostic Innovation, (ANDI). Thirty-two Centres of Excellence in health innovation in Africa have now been created and 29 of them are in the Region.[131] The 25th meeting of the African Advisory Committee for Health Research and Development (AACHRD) recommended the drawing up of a plan of action for the development of research in the Region. The WHO Regional Office and the African Programme for Onchocerciasis Control sponsored a multi-country operational research study entitled "The delivery of essential health services in Africa: realities and people's perceptions and perspectives". Two new WHO collaborating centres were designated in Benin and South Africa in 2011, bringing to 27 the total number of WHO collaborating centres in the African Region, located in 12 countries.[132]

124. Progress was made in supporting countries' efforts to improve health systems financing in terms of the availability and efficient use of resources. In the context of the institutionalization of the national health accounts (NHA), 13 countries[133] undertook NHA and disseminated the findings. An Atlas was developed on *The Health Financing Situation in Africa*, for the 46 countries of the Region.[134] The status of implementation of the Abuja Declaration on health financing was evaluated in all countries, 10 years after its adoption. The evaluation showed that only five countries had achieved the 15% budget allocation to health as at 2010.[135]

125. Five countries[136] evaluated different practices in health financing and social protection mechanisms needed for the development of comprehensive health financing policy. Three success stories on health financing were documented as technical briefs for policy makers. The success stories were: "Building from the bottom, steering and planning from the top in Rwanda"; "Coverage expansion through political commitment and innovative policy choices in Ghana" and "Adoption of performance-based finance to fund fee-exempt health services in Burundi". Two papers on health insurance;[137, 138] two papers on best practices[139] and studies[140] on hospital efficiency in Benin and Botswana were published.

126. Staff from 27 countries[141] were trained in tracking total health spending on Maternal, Newborn and Child Health by financing source, to enable them to improve equity in resource use. Nine countries[142] were trained in "How to move forward to universal coverage" and another nine[143] were supported to analyse their health financing situations to enable them to implement Universal Health Coverage with evidence-based policy.

127. Awareness of the importance of patient safety at national and institutional levels has improved in the Region. Six countries[144] established partnerships with hospitals in England and Switzerland for mutual learning and exchange as part of capacity building, while the African Partnership for Patient Safety was expanded to eight new countries.[145] Forty-two senior surgeons and anesthesiologists from 20 countries[146] were trained in the use of the WHO Safe Surgery Checklist in order to increase adherence to safety standards in surgical care, improve the safety of surgical operations and reduce unnecessary surgical deaths and complications.

## SO11: Medical products and technologies

128. This Strategic Objective focuses on the provision of evidence-based policy guidance for the development, implementation and monitoring of comprehensive national policies and strategies in order to improve access to and the quality and rational use of medical products and technologies.

129. Using a WHO tool, 37 countries[147] collected comprehensive data and developed their pharmaceutical sector profiles, which are useful for tracking progress, identifying gaps and informing the development and updating of national medicines policies. A regional synthesis report on the pharmaceutical sector profiles was prepared and will be used to assess countries' pharmaceutical sector capacity in the GFATM grant approval process, for the procurement of essential medical products for priority diseases.

130. South Africa developed its national blood policy while five countries[148] revised their national strategic plans for blood safety. These documents have contributed to standardizing and improving blood transfusion practices. In an effort to improve coordination and management of related services, Sierra Leone and the Democratic Republic of the Congo developed national laboratory policies and plans; Kenya developed its health technology management policy; Gabon, Guinea-Bissau and Togo developed national traditional medicine policies.

131. The year 2010 marked 10 years since the adoption of the regional strategy on promoting the role of traditional medicine in health systems and the end of the African Traditional Medicine Decade (2001–2010). A progress report on the implementation of the Strategy and Plan of Action for the next Decade were endorsed by the Sixty-first session of the Regional Committee. The report highlighted the progress made by countries, particularly in the area of traditional medicine awareness and popularization. Using WHO guidelines, 22 countries[149] conducted research and some produced traditional medicines for malaria, HIV/AIDS, sickle-cell anaemia, diabetes and hypertension. As a result of WHO's continued support, 12 countries[150] issued marketing authorizations for traditional medicines. Some of the medicines have been included in national essential medicines lists.

132. Ensuring the quality, efficacy and safety of medical products remains a priority area for Member States and WHO. In October 2010 in Abuja, Nigeria, the Ministers of Health of seven countries[151] agreed to establish a national agency in each country for medicines control as well as intercountry and intracountry multidisciplinary and multisectoral committees, to monitor the circulation of counterfeit medicines as well as enforce regulations, including quality control. In March 2011, in Lusaka, Zambia, the Ministers of Health of five countries,[152] concerned about the increasing circulation of counterfeit medicines within and between their borders, agreed to strengthen national medicines regulatory authorities and to share laboratory capacities to test medicines' quality in their respective countries. Furthermore, the ministers agreed to establish national multisectoral teams including customs and police to monitor illicit importation of poor quality medicines across borders.

133. The WAHO Five-year Strategic Plan (2011–2016) on Anti-Counterfeit Medicines was reviewed and a platform for technical and financial partners was set up to enhance advocacy and resource mobilization to fight the production, sale and circulation of counterfeit medicines in ECOWAS Member States. The Strategic Plan was developed with the involvement of WHO, the Economic Community of West African States, the Economic and Monetary Union of West Africa, the French Ministry of Foreign and European Affairs, and the Chirac Foundation. The strategic plan represents a framework for mobilization of funding by countries in order to fight counterfeit medicines.

134. Thirty-nine Member States[153] in the Region completed the global survey on medical devices. The survey revealed that 32% of countries had a health technology policy while 51% had units with a regulatory mandate for medical devices. In addition, 38% of countries had approved the list of medical devices for procurement purposes. Based on information provided by this survey, the capacity of staff in eight countries[154] was built in the use of tools and guidelines to optimize the acquisition, management and appropriate use of medical devices.

135. In order to improve quality in blood transfusion services and ensure appropriate clinical use of blood, national capacity in management and maintenance of the cold chain was built in four countries.[155] Support was provided to Mauritius to finalize its legislation on the removal, preservation and transportation of human tissue and organs under optimum medical conditions and to establish a national haemovigilance system.

136. The regional proficiency testing in haematology and clinical chemistry involving 17 countries[156] and the External Quality Assessment scheme for enteric and meningitis pathogens, plague, tuberculosis and malaria involving 45 countries were evaluated. To build laboratory capacity for antimicrobial resistance surveillance, nationals from 22 countries[157] were given laboratory bench training in antimicrobial susceptibility testing. Corrective actions were implemented in countries that had poor performance.

137. Strengthening biosafety and laboratory biosecurity is another crucial priority area, as the Region is regularly affected by epidemics due to dangerous pathogens such as Ebola, Marburg and Lassa fever viruses among others. In addressing this issue, 55 biosafety and quality management officers, and mid- to senior-level laboratory staff with safety responsibilities from all countries were trained and certified compliant with the shipping regulations of the International Airlines Transport Association.

138. To improve injection safety in countries, simplified tools for collecting data on injection practices were developed, pre-tested in Ethiopia, Mozambique and Uganda, and validated for use by countries.

139. The capacities of national technical advisory committees for medicines were strengthened in seven countries[158] under the WHO project on "Better Medicines for Children". Ten countries[159] revised their National Essential Medicines Lists and Standard Treatment Guidelines. Training was provided for 205 medical doctors, nurses and midwives from six countries[160] on good prescribing practices and rational use of medicines.

140. The capacities of the national regulatory authorities (NRAs) of 19 Member States[161] were strengthened within the framework of the network of regulators, the African Vaccine Regulatory Forum (AVAREF) and by supporting countries to develop and periodically update their institutional development plans based on country visits and assessments, using local expertise. These countries now have the capacity to review clinical trial applications, approve clinical trials and conduct clinical trial site inspections based on good clinical practice.

## 4.12 SO12: Leadership, governance and partnership

141. The focus of WHO activities was on providing leadership, strengthening governance and fostering partnership in health development. The Regional Director undertook high-level missions to 19 countries in the Region and abroad, advocating for increased investment in strengthening of national health systems in order to accelerate the achievement of national and international health development goals. His visits to, among others, Germany, Portugal, United States of America, the United Kingdom of Great Britain and Northern Ireland, the World Bank, the European Union, the Bill and Melinda Gates Foundation and the Vatican, focused primarily on raising international awareness of regional health needs and garnering support to effectively address them.

142. Restructuring of the Regional Office in 2010 enabled increased emphasis on delivery on the new Strategic Directions guiding the work of WHO in the Region for the period 2010 to 2015. This included greater focus on health promotion and disease prevention as well as more efficient use of available resources. Three Clusters, namely: (i) HIV/AIDS, Malaria and TB; (ii) Disease Prevention and Control and; (iii) Noncommunicable Diseases, were merged into the Disease Prevention and Control Cluster in order to provide more integrated and coherent support to countries. The Health Promotion Cluster and the Family and Reproductive Health Cluster were also merged.

143. The Sixtieth and Sixty-first sessions of the WHO Regional Committee for Africa, held respectively in Malabo, Equatorial Guinea and Yamoussoukro, Côte d'Ivoire, adopted public health resolutions which addressed (i) the key determinants of health; (ii) reduction of the harmful use of alcohol; (iii) e-Health solutions; (iv) the status of routine immunization and polio eradication; and (v) the establishment and framework document of the African Public Health Emergency Fund; (vi) measles elimination by 2020; (vii) the framework for public health adaptation to climate change; and (viii) poliomyelitis eradication. A Panel Discussion entitled "Health Financing: Sharing experiences in securing funding to achieve national health development goals", was held during the Sixty-first session of the Regional Committee. Its recommendations have been published.

144. During the period under review, membership of the Harmonization for Health in Africa (HHA) partnership, a WHO-led initiative, expanded. Joint advocacy, interagency collaboration as well as technical support to countries were further strengthened. The primary areas of focus continued to be on development and costing of national health policies and strategic plans along with improving financing for the health sector. The HHA further strengthened dialogue between the health sector and the finance sector, through organizing joint ministerial meetings on Health Financing in Kampala, Addis Ababa and Yamoussoukro. A report on 'The Investment Case for Health in Africa' was produced by the HHA partnership. WHO collaboration with civil society and academia was intensified across the Region.

145. WHO's continued effort in providing support to national development plans and reinforcing partnerships has consolidated its leadership in health within UN Country Teams. WHO country offices and country teams are actively engaged in United Nations Development Assistance Framework (UNDAF) processes in 40 countries in the Region, helping to harmonize UN support. WHO proactively supported UN 'Delivering as One' in four pilot African countries[162] as well as in the ten self-starter countries.[163]

146. The Regional Office provided technical support to the African Union (AU) Heads of State and Government Summit on the theme "Maternal, neonatal and child health and development in Africa", as well as in the preparation of the AU Conference of Health Ministers. Regional Economic Communities were supported in the development of several policies, strategies and reports as well as in capacity building in different areas including medicines, nutrition and resource mobilization.

147. Advocacy and communication with all health development stakeholders were strengthened through the production and dissemination of user-friendly communication and advocacy materials (in the three official languages) on the implementation of resolutions and decisions of WHO Governing Bodies, the Strategic Directions 2010–2015 for the African Region as well as other activities organized by WHO. Most of these materials including over 100 media releases and feature articles; 64 radio and TV programmes; five issues of 'AFRO News', four issues of 'La Toile', a Malaria newsletter and over 30 bulletins from country offices are available on the WHO Regional Office web site. Staff capacity in communication was enhanced through a range of training courses.

148. Mapping of Country Cooperation Strategies against Strategic Objectives of the Medium-term Strategic Plan was carried out for 45 countries, resulting in the identification of common regional priorities that contributed to the operational planning process for the 2012-2013 biennium. Three regional programme meetings (RPMs 44, 45 and 46) were held for all WHO representatives and Regional Office senior management. Decisions were taken and recommendations made on critical issues including health systems strengthening, WHO reforms, the WHO African Region Strategic Directions 2010–2015, supporting achievement of the MDGs as well as budgetary matters.

149. The African Region Compendium of National Public Health experts (institutions and individuals) was launched as part of the WHO Global Compendium, to identify and facilitate the use of regional expertise in health. In 2010, 27 institutions and 97 experts from 12 countries were included in this Compendium. The WHO Regional Office roster of experts was developed, with 1216 WHO experts registered.

## 4.13 SO13: Efficient and effective WHO

150. The main objective of SO13 is to efficiently support the technical clusters, ISTs and WCOs in programme management; financial management; administrative services, human resources management; information technology management; procurement and supply services and translation, interpretation, and printing. The successful implementation of technical programmes, in countries in particular, depends in part upon the delivery of effective and timely support services.

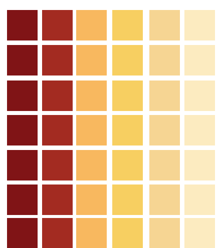
151. Among the main activities for 2011 was the full implementation of the Global Management System (GSM). Among the system's benefits in the Region was greater visibility of programme and financial information within the Region and throughout WHO, which facilitates programme planning and management. Data from country offices in particular is much more up to date now than it was pre-GSM. The system also presented challenges to users, such as time lags due to limited connectivity, and imperfectly understood roles and responsibilities that could result in control weaknesses. The challenges were addressed through further investments in infrastructure and training, which continue to date.

152. The Regional Office made diligent effort and analysis over several months to clean and reconcile salary advances in its accounts at the time of the conversion to the GSM. This matter was extensively discussed at the Executive Board and the World Health Assembly, and Member States requested a status report on the resolution of this matter by year-end. In response, the Regional Director has taken a personal interest in the exercise to clean AFRO's accounts and ensure strict control over any further advances. As a consequence, more than 95% of the advances had been cleared — from a starting point of US$ 2.4 million, only a small balance of US$ 128 000 remained outstanding by the end of 2011. With additional scrutiny and enhanced controls in place, an accumulation of unaccounted advances is not likely to recur.

153. The effects of the shocking bombing of the UN Compound in Abuja in August 2011 continue to be felt. Three WHO staff members lost their lives and many were injured, some seriously enough to be evacuated to South Africa for treatment. All evacuees and other staff survived their injuries due to courageous acts by staff and others at the scene and the effective response by WHO and UN emergency and medical staff in the immediate aftermath. Ongoing counseling was provided to affected staff. Since the bombing the WHO Country Office in Nigeria has been operating from temporary offices at dispersed locations, adding to the challenge of programme delivery. Additional resources were provided to enhance security in Abuja and the numerous satellite offices throughout Nigeria. Security reviews were also undertaken elsewhere in the Region to identify and mitigate risks and make all offices compliant with the UN Minimum Operational Security Standards (MOSS).

154. The ongoing financial crisis prompted the Region to cut costs during the year, in the areas of contracting, communication and travel, and ultimately, reductions in staff became unavoidable. Nearly 250 staff were separated during the year, about half in the General Services category, and the remainder divided equally between International Professionals and National Professional Officers. The reductions affected nearly all locations - 38 countries and all of the regional office clusters. The process of separating staff highlighted the misalignment of WHO's staffing and funding. While most funding is earmarked for specific purposes and projects of limited duration, staff contracts are often long-term and de-linked from their funding sources. This mismatch is a topic in the WHO reforms.

155. Many challenges remain in order to continue to adapt operations to GSM and to the reality of fiscal constraints. Nevertheless, the administrative units that contribute to Strategic Objective 13 continue to deliver timely, high quality support to enable effective delivery of health programmes in countries and across the Region.



# 5. PROGRESS MADE IN THE IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

## 5.1 Poliomyelitis eradication in the African Region: progress report

156. In 2011, high level advocacy visits undertaken to priority countries[164] by the WHO Director-General, Regional Director and other partners, namely UNICEF, Rotary International, and the Bill and Melinda Gates Foundation, created renewed momentum for polio eradication. Supplementary immunization was provided to over 140 million children below five years of age. The number of wild poliovirus (WPV) cases decreased from 657 in 2010 to 350 in 2011, despite persistent transmission in Chad, the Democratic Republic of the Congo and Nigeria. Angola remained polio-free for eight months, while the outbreaks of WPV type 3 transmission in West Africa were successfully interrupted.

157. The Regional Director convened consultations with WHO teams from priority countries which agreed on key actions and additional resources required to achieve the eradication milestones while monitoring progress through monthly reporting. It is proposed to Member States to strengthen national oversight and accountability while treating WPV outbreaks as a public health emergency and to mobilize and allocate more resources to fully implement activities towards interruption of WPV transmission.

## 5.2 A strategy for addressing the key determinants of health in the African Region: progress report

158. Five countries[165] conducted national workshops to strengthen multisectoral actions in addressing key determinants of health by identifying main challenges and actions. In addition, eight countries[166] have been supported to document experiences in implementing multisectoral actions in addressing communicable disease outbreaks, NCD risk factors, HIV/AIDS prevention, nutrition and promotion of adolescent health.

159. Health equity trends were monitored in four countries[167] through health equity analysis and four Island States[168] are finalizing their health equity reports. Plans are underway to disseminate the findings during national meetings, and to apply them to national policies and programmes aimed at reducing the health equity gap across population groups.

## 5.3 Implementation of the WHO Framework Convention on Tobacco Control in the African Region: progress report

160. In 2005, the Fifty-fifth session of the Regional Committee for Africa reviewed the first report[169] on the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in the Region, and endorsed the proposed actions. The Regional Committee also recommended that Member States ratify the WHO FCTC and further develop and implement comprehensive legislation and national plans of action in accordance with the Convention.

161. Of the 41 Member States[170] in the Region who have so far ratified or acceded to the WHO FCTC, 37 have submitted their first report on implementation of the Convention as required by the WHO FCTC. Support continues to be given to Member States to meet their obligations to the WHO FCTC.

## 5.4 Implementation of the regional child survival strategy: progress report

162. The adoption of the child survival strategy for the African Region by the Fifty-sixth session of the Regional Committee has boosted progress made by countries in improving child survival in the Region. These improvements include 13 countries[171] having introduced the pneumococcal conjugate vaccine compared to none at the end of 2009. Coverage of antiretroviral medicines for the prevention of mother-to-child transmission of HIV has increased from 35% in 2007 to 60% in 2010 in the Region.[172] The use of ITNs and effective treatment for malaria has resulted in a reduction in morbidity and mortality by more than 50% in 12 countries.[173] In 2010, 81% of children under-five years of age received vitamin A supplementation.[174]

163. To accelerate progress in reducing child deaths, Member States and partners should: address health system bottlenecks that hamper child survival; increase resources allocated for child health; invest in improving quality health care during childbirth and the immediate post-natal period; mobilize families and communities to scale up integrated interventions; and advocate for improved sanitation, clean water supply and good nutrition.

## 5.5 Measles elimination in the African Region: progress report

164. In 2011, 14 countries conducted follow-up Supplementary Immunization Activities (SIAs) as planned and, together with outbreak response vaccination against measles, a total of 81.8 million children were reached. The 43 countries in the Region with established case-based surveillance reported 32 323 confirmed cases

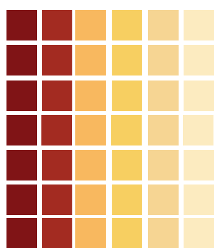
of measles in 2011. Seventeen of these 43 countries attained the targets for the two main surveillance performance indicators in 2011. Measles outbreaks continue to pose challenges related to lack of adequate financing for the implementation of strategies, delays in conducting measles follow up SIAs and gaps in routine immunization and SIAs coverage. In 2011, the Democratic Republic of the Congo experienced a large outbreak with more than 134 000 cases reported through the aggregate reporting system.

165. WHO is supporting countries to develop their multi-year strategic plans for measles elimination. WHO and its partners are advocating for more resources to enable the full implementation of strategies to attain the pre-elimination goals and eventually, the elimination of measles as endorsed by Member States. In addition to the ongoing mobilization of resources from the traditional donors to the measles programme, the Measles Initiative has mobilized US$ 55 million from GAVI to address measles outbreaks and emergencies requiring rapid responses, and additional funding to support four priority countries[175] considered to be at risk of recurring outbreaks to conduct measles SIAs in the years up to 2017.

## 5.6 Implementation of the Regional Strategy to reduce harmful use of alcohol in the Region : progress report

166. Based on the direction provided by the "Regional Strategy to reduce harmful use of alcohol in the Region" (Document AFR/RC60/4) adopted at the Sixtieth session of the Regional Committee in 2010, nine countries[176] have revised, or are in the process of revising, their policy documents in order to ensure that they are guided by public health principles and present evidence-based approaches and interventions for national action. At the same time, as requested in Resolution AFR/RC60/R2 endorsed by Member States at the same session, the Regional network of national counterparts for the implementation of the strategy has been established and a draft action plan was discussed with representatives of 43 countries at a regional consultation in February 2011.

167. In order to strengthen countries' capacity to implement identified actions to reduce harmful use of alcohol at national level, the Regional Office developed a guidance document for implementing the 10 priority areas set out in the regional strategy; this will be disseminated to all countries. Also, as a result of ongoing collaboration with countries in collecting data to set up a surveillance system on alcohol for the Region, the AFRISAH (African Information System on Alcohol and Health), a regional interface of the Global Information System on Alcohol and Health, is now available.



# 6. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT

## 6.1 Challenges and constraints

168. Overall, a key challenge for the African Region has been how to mitigate the impact of a severe financial crisis that affects priority programmes such as health systems; HIV/AIDS, tuberculosis and malaria; maternal, newborn and child health; health promotion and primary prevention including for noncommunicable diseases. This meant adjusting the Organization's plans to resource constraints and preparing for the possibility of further reductions. Given that the most affected programmes are areas in which countries need increased technical cooperation, a major challenge was to maintain an effective and optimal level of response to country requests for technical support.

169. Despite their own efforts coupled with support provided by WHO and other partners, the coverage of essential interventions and services required to make progress towards achieving regional health goals remains a challenge. Countries still experience inadequate immunization coverage, measles outbreaks, inadequate service coverage in other areas such as the prevention of HIV/AIDS, TB and malaria; maternal and child health; the control of NTDs; and the prevention and control of epidemics of communicable diseases.

170. Where progress has been made in scaling up interventions and services such as in the 12 countries that have significantly reduced their malaria burden, maintaining the focus including resource allocation and actions, and sustaining the achievement in the context of multiple competing public health priorities, has been noted to be a challenge in some cases.

171. The persistent weakness of health systems manifests itself in many ways, including lack of sufficient human resources that have the required range of competencies; procurement and supply management systems that fail to ensure the availability of medicines, vaccines and diagnostic technologies; inadequate data collection and information systems that do not allow effective monitoring and projection of

disease trends and evaluation of interventions and programmes; and ineffective accountability mechanisms. The effective engagement of communities in promoting their own health and influencing the quality of services delivered is also a challenge.

172. An additional constraint is the insecurity that prevails in parts of some countries. This has affected the optimal delivery of technical support.

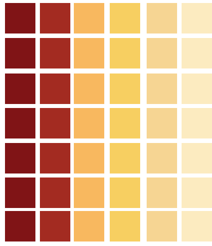
## 6.2 Lessons Learnt

173. The burden of priority health problems can be reduced by scaling-up proven high impact interventions such as ART, DOTs LLINs and ACTs. Furthermore, the scaling up of IDSR and IHR to the community level contributed to timely detection and effective response to outbreaks.

174. Cross-border collaboration between Member States in the area of epidemic preparedness and response, collaboration with partners, the pre-positioning of emergency kits and the establishment of rapid response teams in the field contributed to rapid containment and effective control of outbreaks and other disasters. The capacities of WHO country office teams, based on existing staff, need to be optimized in addition to national expertise for involvement in emergency preparedness, response and recovery.

175. Continuous collaboration with UN agencies and other partners through existing mechanisms such as UNDAFs at country level facilitated support to Member States. The Harmonization for Health in Africa partnership which serves as a useful platform for synergizing support to countries has been a worthwhile investment. In addition, WHO should continue fostering alliances including public/private partnerships and mobilization of civil society leaders and organisations for action on health.

176. Working with Member States and partners including those in private organizations, where each brings to the table their capacities and resources, coupled with the expertise and convening role of WHO, has been very productive. This is exemplified by the Meningitis Vaccine Project (MVP), with joint effort in the development and widespread implementation of the conjugate meningitis A vaccine (MenAfriVac). This has dramatically reduced the number of cases of meningococcal meningitis A in some of the countries of the meningitis belt.

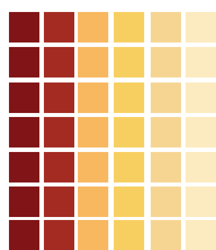


# 7. CONCLUSION

177. The African Region is still characterized by a severe burden of communicable diseases and increasing burden of noncommunicable diseases, as well as a high level of maternal and child mortality. The Region continues to be challenged by frequent emergencies and disasters. In addition, the global financial crisis has significantly reduced WHO's funding and capacity to respond to the needs of Member States. Despite these challenges, progress was made in the implementation of the WHO Programme Budget, and WHO has been engaged in reforms focusing on priority setting, governance and managerial matters.

178. The significant achievements made during the biennium include the consolidation of the HHA partnership and facilitation of dialogue between ministries of finance and ministries of health for improved health sector funding; strengthening of Integrated Disease Surveillance systems in countries; adoption of the Brazzaville Declaration on NCDs prevention and control; increase in access to HIV/AIDs treatment, HIV testing and ARV prophylaxis for PMTCT; effective coordination of health response actions during emergencies; enforced tobacco control legislation and action plan in an increasing number of countries; endorsement of the Regional strategy for key determinants of health; the Luanda commitment for health and environment Strategic Alliance; increased awareness of food safety and nutrition; and acceleration of the implementation of the Ouagadougou Declaration on Primary Health care and Health Systems in Africa.

179. In the context of limited financial resources, the work of WHO in the African Region for the next biennium focuses on the highest priority activities aimed at meeting the milestones defined for the period 2012-2013 within the WHO African Region Strategic Directions 2010–2015, in line with the WHO core functions.

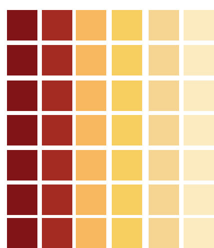


# ANNEXES

| Table 1: WHO Medium-Term Strategic Plan 2008–2013: Statement of Strategic Objectives | |
|---|---|
| 01 | To reduce the health, social and economic burden of communicable diseases. |
| 02 | To combat HIV/AIDS, malaria and tuberculosis. |
| 03 | To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment. |
| 04 | To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals. |
| 05 | To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact. |
| 06 | To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex. |
| 07 | To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrates pro-poor, gender-responsive, and human rights-based approaches. |
| 08 | To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health. |
| 09 | To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development. |
| 10 | To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research. |
| 11 | To ensure improved access, quality and use of medical products and technologies. |
| 12 | To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work. |
| 13 | To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively. |

## Table 2: Approved Programme Budget 2010-2011: allocation by strategic objective, source of financing and distribution between WHO country offices and the Regional Office (in US$ 000s)

| SOs | Regional Office / ISTs | | | Country Offices | | | Total African Region | | |
|---|---|---|---|---|---|---|---|---|---|
| | AC | VC | Total | AC | VC | Total | AC | VC | Grand Total |
| SO 1 | 4875 | 109 782 | 114 657 | 11 780 | 297 683 | 309 463 | 16 655 | 407 465 | 424 120 |
| SO 2 | 4686 | 79 952 | 84 638 | 4662 | 118 908 | 123 570 | 9348 | 198 860 | 208 208 |
| SO 3 | 3226 | 4446 | 7 672 | 4934 | 6838 | 11 772 | 8160 | 11 284 | 19 444 |
| SO 4 | 5443 | 36 244 | 41 687 | 10 086 | 55 962 | 66 048 | 15 529 | 92 206 | 107 735 |
| SO 5 | 1 563 | 22 403 | 23 966 | 1877 | 72 939 | 74 816 | 3440 | 95 342 | 98 782 |
| SO 6 | 3218 | 6884 | 10 102 | 5151 | 8690 | 13 841 | 8369 | 15 574 | 23 943 |
| SO 7 | 2102 | 1490 | 3 592 | 2961 | 1942 | 4903 | 5063 | 3432 | 8495 |
| SO 8 | 1595 | 5405 | 7 000 | 3263 | 6072 | 9335 | 4858 | 11 477 | 16 335 |
| SO 9 | 1729 | 17 372 | 19 101 | 2538 | 15 543 | 18 081 | 4267 | 32 915 | 37 182 |
| SO 10 | 8100 | 32 407 | 40 507 | 10 933 | 72 595 | 83 528 | 19 033 | 105 002 | 124 035 |
| SO 11 | 2457 | 3796 | 6253 | 2826 | 10 584 | 13 410 | 5283 | 14 380 | 19 663 |
| SO 12 | 8847 | 6526 | 15 373 | 34 362 | 0 | 34 362 | 43 209 | 6526 | 49 735 |
| SO 13 | 28 831 | 53 965 | 82 796 | 37 555 | 4836 | 42 391 | 66 386 | 58 801 | 125 187 |
| **TOTAL** | **76 672** | **380 672** | **457 344** | **132 928** | **672 592** | **805 520** | **209 600** | **1 053 264** | **1 262 864** |



# END NOTES

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3. Benin, Burundi, Cameroon, Central Africa Republic, The Democratic Republic of the Congo, Ethiopia, Gambia, Kenya, Malawi, Mali, Rwanda, Sierra Leone and South Africa.
4. Burkina Faso, Cameroon, Chad, Mali, Niger and Nigeria.
5. Angola, Benin, Burkina Faso, Burundi, Central African Republic, Comoros, Congo, Democratic Republic of Congo, Côte 'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Swaziland, Tanzania, Togo, Zambia and Zimbabwe.
6. Burundi, Gambia, Ghana, Eritrea, Malawi and Zambia.
7. Algeria, Benin, Botswana, Burundi, Cape Verde, Comoros, Congo, Eritrea, Ethiopia, Gambia, Ghana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Swaziland, Togo, Uganda, Zambia and Zimbabwe.
8. Burkina Faso, Cameroon, Central African Republic, Chad, The Democratic Republic of the Congo, Guinea, Kenya, Uganda, Tanzania and Zimbabwe.
9. Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
10. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
11. Algeria, Benin, Botswana, Cameroon, Cape Verde, Congo, The Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Swaziland, Togo and Uganda.
12. Algeria, Angola, Benin, Burundi, Cameroon, Chad, Central African Republic, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
13. Angola, Cameroon, Ghana, Nigeria, Rwanda, Senegal, Sierra Leone and Zambia.
14. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Central African Republic, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
15. Angola, Benin, Burkina Faso, Burundi, Cameroon, Chad, Central African Republic, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
16. Botswana, Burkina Faso, Central African Republic, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Guinea, Guinea-Bissau, Malawi, Mali, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Swaziland, Togo, Tanzania, Zambia and Zimbabwe.
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19. Botswana, Lesotho, Namibia, South Africa, Swaziland, Tanzania and Zimbabwe.

20. Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
21. Algeria, Angola, Botswana, Burundi, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Ghana, Kenya, Lesotho, Namibia, Sao Tome and Principe, South Africa, Tanzania and Zambia.
22. Algeria, Benin, Burundi, The Democratic Republic of the Congo, Eritrea, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Tanzania and Zambia.
23. Algeria, Benin, Burundi, Comoros, The Democratic Republic of the Congo, Eritrea, Kenya, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Tanzania and Zambia.
24. Algeria, Burundi, Ghana, Namibia, Kenya, Sao Tome and Principe, Tanzania and Zambia.
25. Algeria, Benin, Kenya, Seychelles and Tanzania.
26. Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central Africa Republic, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
27. Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania and Uganda.
28. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Gabon, Guinea, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
29. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.
30. Botswana, Burkina Faso, Ethiopia, Kenya, Lesotho, Mozambique, Namibia, Swaziland, and South Africa.
31. Botswana, Burkina Faso, Cameroon, The Democratic Republic of the Congo, Kenya, Ethiopia, Guinea, Lesotho, Liberia, Mali, Mozambique, Nigeria, Rwanda, Senegal, Swaziland, Tanzania, Uganda and Zambia.
32. Benin, Botswana, Burkina Faso, Burundi, Cameroon, The Democratic Republic of the Congo, Ethiopia, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Tanzania, Uganda, Senegal, South Africa, Swaziland, Zambia and Zimbabwe.
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34. Algeria, Botswana, Cape Verde, Madagascar, Namibia, Sao Tome and Principe, South Africa, Swaziland, Eritrea, Rwanda, Zambia and Tanzania (specifically Zanzibar).
35. Burkina Faso, The Democratic Republic of the Congo, Kenya, Madagascar, Malawi, Niger, Rwanda, Tanzania, Uganda and Zambia.
36. Burkina Faso, Burundi, Eritrea, Gambia, Kenya, Liberia, Madagascar, Malawi, Mali, Niger, Rwanda, Sao Tome and Principe, Tanzania and Zambia.
37. Algeria, Angola, Botswana, Burkina Faso, Burundi, Cape Verde, Central African Republic, Comoros, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
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46. Benin, Botswana, Burkina Faso, Burundi, Cape Verde, Chad, Congo, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Equatorial Guinea, Liberia, Madagascar, Malawi, Mali, Mauritania, Namibia, Niger, Nigeria, Togo, Sierra Leone, South Africa, Swaziland, Zambia and Zimbabwe.
47. Eritrea, Madagascar, Mali, Namibia, Niger, Rwanda, Tanzania and Zimbabwe.
48. Benin, Burkina Faso, Central African Republic, Gabon, Madagascar, Mali, Niger, Nigeria, Senegal, Togo and Uganda.
49. Algeria, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, The Democratic Republic of the Congo, Gabon, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Niger, Rwanda, Senegal and Togo.

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54. Benin, Burkina Faso, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo and Uganda.
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59. Angola, Benin, Burkina Faso, Burundi, Congo, Côte d'Ivoire, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Niger, Rwanda, Senegal, Sierra Leone, South africa, Togo and Tanzania.
60. Botswana, Cape Verde, Côte d'Ivoire, Ethiopia, Eritea, Ghana, Guinea, Madagascar, Namibia, Zambia and Zimbabwe.
61. Botswana, Cameroon, Cape Verde, Central African Republic, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Eritrea, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Zambia and Zimbabwe.
62. Botswana, Eritrea, Namibia, Swaziland, Zambia and Zimbabwe.
63. Botswana, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Swaziland and Uganda.
64. Benin, Botswana, Burkina Faso, Central African Republic, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
65. Benin, Ethiopia, Gabon, Guinea-Bissau, Lesotho, Liberia, Malawi, Namibia, Senegal and Zimbabwe.
66. Angola, Benin, Burkina Faso, Burundi, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Gabon, Malawi, Madagascar, Niger and Tanzania.
67. Liberia, Malawi, Namibia and South Africa.
68. Angola, Botswana, Burkina Faso, Burundi, Cape Verde, Central Africa Republic, Chad, Congo, The Democratic Republic of the Congo, Gabon, Ghana, Lesotho, Liberia, Kenya, Malawi, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Sierra Leone, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
69. Angola, Botswana, Burkina Faso, The Democratic Republic of the Congo, Ethiopia, Ghana, Liberia, Kenya, Malawi, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Gambia, Togo, Uganda, Zambia and Zimbabwe.
70. Madagascar, Mali, Mauritania, Rwanda, Tanzania, Uganda and Zimbabwe.
71. Botswana, Burkina Faso, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Kenya, Lesotho, Liberia, Mauritanie, Niger and Tanzania.
72. Angola, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, The Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Eritrea, Kenya, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Mauritius, Malawi, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, Swaziland, Rwanda, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
73. Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Togo, Uganda, Zambia and Zimbabwe.
74. Algeria, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Namibia, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
75. Congo, Mauritania, Namibia, Sierra Leone and Zimbabwe.
76. Namibia, Sierra Leone, Mauritania and Eritrea.
77. Burkina Faso, Congo, Kenya, and Tanzania.
78. Burkina Faso, Chad, Comoros, Ethiopia, Madagascar, Namibia and Togo.

79. Angola, Burkina Faso, Cameroon, Congo, Ghana, Guinea, Kenya, Madagascar, Mali, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda and Zambia.
80. Ghana, Kenya, Senegal and Zambia.
81. Angola, Kenya, Mauritania, South Africa and Uganda.
82. Botswana, Ghana, Lesotho, Malawi and Namibia.
83. Ghana, Uganda, Gambia and Nigeria.
84. Benin, Botswana, Cape Verde, Mauritania and Sao Tome and Principe.
85. Central African Republic, Comoros, Eritrea, Gambia, Liberia, Tanzania (specifically Zanzibar) and Togo.
86. Equatorial Guinea, Namibia, Senegal, Swaziland and Zimbabwe.
87. Guinea-Bissau, Mali, Mozambique and Sierra Leone.
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91. Ethiopia, Ghana, Lesotho and Tanzania.
92. Comoros, Senegal, Niger, Gabon and, Sao Tome and Principe.
93. Botswana, Burkina Faso, Cameroon, Ethiopia, Gabon, Ghana, Gambia, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.
94. Angola, Cameroon, Congo, The Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Lesotho, Madagascar, Mali, Mozambique, Sierra Leone and Tanzania.
95. Benin, Botswana, Burundi, Comoros, Gambia, Guinea, Nigeria, Seychelles and South Africa.
96. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda and Zimbabwe.
97. Algeria, Angola, Botswana, Rwanda and South Africa.
98. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Congo, The Democratic Republic the Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Rwanda, Senegal, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
99. Cameroon, Congo, The Democratic Republic of the Congo, Ethiopia, Kenya, Mali, Mozambique, Tanzania, Uganda and Zambia.
100. Benin, Ethiopia, Kenya, Mali and South Africa.
101. Benin, Côte d'Ivoire, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Senegal and Togo.
102. Angola, Benin, Botswana, Burundi, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Guinea-Bissau, Malawi, Mali, Mauritania, Mauritius, Namibia, Rwanda, Senegal, Swaziland, Togo, Uganda, Zambia and Zimbabwe.
103. Eritrea, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda and Zambia.
104. Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Gabon, Madagascar, Mali, Mauritania, Niger and Senegal.
105. Angola, Botswana, Lesotho, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Zimbabwe.
106. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Ghana, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, Senegal, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
107. Angola, Benin, Burkina Faso, Chad, Congo, Ethiopia, Guinea-Bissau, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
108. Algeria, Angola, Botswana, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
109. Angola, Burundi, Burkina Faso, Botswana, Central African Republic, Cameroon, Chad, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
110. Botswana, Burundi, Cameroon, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
111. Lesotho, Malawi, Mozambique, Namibia, Niger, Rwanda, Swaziland, Tanzania and Zimbabwe.
112. Côte d'Ivoire, Ghana, Rwanda, Senegal, Tanzania and Togo.

113. Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Chad, Gabon, Gambia, Ghana, Guinea, Kenya, Mali, Namibia and Seychelles.
114. Algeria, Benin, Burkina Faso, Burundi, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Gambia, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo and Uganda.
115. Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana,Madagascar, Mali, Mozambique and Zambia.
116. Congo, Chad, The Democratic Republic of the Congo, Gabon, and Togo.
117. Botswana, Burkina Faso, Burundi, Cape Verde, Eritrea, Ethiopia, Guinea, Guinea-Bissau, Kenya, Lesotho, Malawi, Mauritania, Namibia, Niger, Rwanda, South Africa, Swaziland Tanzania, Togo, Uganda and Zambia.
118. Benin, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Eritrea, Gabon, Malawi, Mauritania, Namibia, Nigeria, Sierra Leone, Togo, Uganda and Zambia.
119. Benin, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Niger, Sierra Leone, Togo, Uganda, Zambia and Zimbabwe.
120. Burundi, Burkina Faso, Central African Republic, Chad, Comoros, Côte d'Ivoire, Ethiopia, Ghana, Guinea-Bissau, Lesotho, Liberia, Malawi, Mauritania, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Togo, Zambia and Zimbabwe.
121. Burkina Faso, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Mauritania, Niger, Rwanda, Tanzania, Togo, Uganda and Zambia.
122. Benin, Burkina Faso, Burundi, Cameroon, The Democratic Republic of the Congo, Ethiopia, Kenya, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Uganda and Zambia.
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124. Chad, Congo, Eritrea, Ghana, Liberia, Namibia, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, Zambia and Zimbabwe.
125. Benin, Burkina Faso, Burundi, Botswana, Central African Republic, Ghana, Lesotho, Malawi, Mali, Namibia, Rwanda, Senegal, Swaziland, Togo and Zambia.
126. Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Kenya, Mozambique, Nigeria and Zambia.
127. Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Gambia, Ghana, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Namibia, Niger, Senegal, Togo, Sierra Leone, Zambia and Zimbabwe.
128. Angola, Benin, Burkina Faso and Senegal.
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132. Algeria, Benin, Botswana, Burkina Faso, Central African Republic, Ghana, Madagascar, Nigeria, Senegal, South Africa, Uganda and Tanzania.
133. Botswana, Burkina Faso, Cape Verde, Central African Republic, The Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Niger, Nigeria, Rwanda, Tanzania and Togo.
134. See http://apps.who.int/nha/database/StandardReportList.aspx.
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141. Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Gabon, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
142. Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo.
143. Chad, Kenya, Madagascar, Mali, Rwanda, Senegal, Tanzania, Togo and Uganda.
144. Cameroon, Ethiopia, Malawi, Mali, Senegal and Uganda.
145. Burundi, Côte d'Ivoire, Ghana, Mozambique, Niger, Rwanda, Tanzania and Zambia.

146. Botswana, Burkina Faso, Burundi, Cameroon, Comoros, Côte d'Ivoire, The Democratic Republic of the Congo, Kenya, Madagascar, Malawi, Mali, Namibia, Niger, Rwanda, Senegal, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
147. Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Senegal, Seychelles, Sierra Leone, Tanzania, Togo, Zambia and Zimbabwe.
148. Central African Republic, Ethiopia, Malawi, Sierra Leone and Senegal.
149. Benin, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, The Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Madagascar, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
150. Burkina Faso, Cameroon, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Ghana, Madagascar, Mozambique, Niger, Nigeria, Tanzania and Zambia.
151. Ethiopia, Ghana, Kenya, Nigeria, Tanzania, Uganda and Zambia.
152. Angola, Congo, The Democratic Republic of the Congo, Namibia and Zambia.
153. Angola, Benin, Botswana, Burkina Faso, Burundi, Chad, Côte d'Ivoire, Cameroon, Comoros, Cape Verde, Central Africa Republic, The Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Sao Tome and Principe, Senegal,Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
154. Botswana, Ethiopia, Gambia, Ghana, Namibia, South Africa, Tanzania and Zimbabwe.
155. Burkina Faso, Mali, Niger and Senegal.
156. Botswana, Cameroon, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
157. Angola, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Lesotho, Madagascar, Mauritania, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, Tanzania, Togo and Uganda.
158. Ethiopia, Ghana, Kenya, Nigeria, Tanzania, Uganda and Zambia.
159. Benin, Comoros, Côte d'Ivoire, The Democratic Republic of the Congo, Eritrea, Mali, Mauritius, Mozambique, Sao Tome and Principe, and Zimbabwe.
160. Burkina Faso, Chad, The Democratic Republic of the Congo, Ethiopia, Mali and Senegal.
161. Botswana, Burkina Faso, Cameroon, Ethiopia, Gabon, Ghana, Gambia, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.
162. Cape Verde, Mozambique, Rwanda and Tanzania.
163. Benin, Botswana, Burkina Faso, Comoros, Lesotho, Liberia, Malawi, Namibia, Sierra Leone and Zambia.
164. Angola, Chad, The Democratic Republic of the Congo and Nigeria.
165. Equatorial Guinea, Namibia, Senegal, Swaziland and Zimbabwe.
166. Botswana, Kenya, Mozambique, Namibia, Rwanda, Swaziland, Uganda and Zimbabwe.
167. Guinea-Bissau, Mali, Mozambique and Sierra Leone.
168. Madagascar, Mauritius, Sao Tome and Principe, and Seychelles.
169. Implementation of the Framework Convention on Tobacco Control in the African Region: Current Status and the Way Forward; (AFR/RC55/13); 17 June 2005.
170. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, The Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
171. Benin, Burundi, Cameroon, Central African Republic, The Democratic Republic of the Congo, Ethiopia, Gambia, Kenya, Malawi, Mali, Rwanda, Sierra Leone and South Africa.
172. WHO, UNICEF and UNAIDS. Towards universal access: scaling up priority interventions in the health sector: progress report 2010. Geneva, World Health Organization, 2010. p.88.
173. Algeria, Botswana, Cape Verde, Eritrea, Madagascar, Namibia, Rwanda, Sao Tome and Principe, South Africa, Swaziland, Tanzania (specifically Zanzibar) and Zambia.
174. United Nations Children's Fund, The State of the World's Children: Adolescence an Age of Opportunity, UNICEF, New York, 2011.
175. Chad, The Democratic Republic of the Congo, Ethiopia and Nigeria.
176. Botswana, Ghana, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa and Zimbabwe.

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