The Work of the World Health Organization in the African Region

Report of the Regional Director, 1 July 2019 – 30 June 2020

World Health Organization
REGIONAL OFFICE FOR Africa

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Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
ANC	antenatal care
AMR	antimicrobial resistance
ART	antiretroviral therapy
DFID	Department for International Development (United Kingdom)
DHIS2	District Health Information Software 2
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases
Gavi	Gavi, the Vaccine Alliance
GIS	geographic information system
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPEI	Global Polio Eradication Initiative
GPW 13	Thirteenth General Programme of Work, 2019–2023
HHA	Harmonization for Health in Africa
IHR	International Health Regulations (2005)
IPC	infection prevention and control
ISTs	intercountry support teams
KPIs	key performance indicators
NCDs	noncommunicable diseases
NTDs	neglected tropical diseases
PHC	primary health care
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SDGs	Sustainable Development Goals
SRHR	sexual and reproductive health and rights
STIs	sexually transmitted infections
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO FCTC	WHO Framework Convention on Tobacco Control

Foreword

This annual report of WHO's work between July 2019 and June 2020, was finalized four months after the COVID-19 pandemic first arrived in the WHO African Region. As we publish this report on 10 August 2020, there are more than 892 000 reported cases in the Region and 16 600 people have sadly lost their lives. This pandemic is taking a tremendous toll on individuals, societies and economies in the Region and globally, and we must be prepared for the long battle ahead.

In every phase of the response, and in every community, it is imperative that public health measures are in place to find, test, isolate and care for people with COVID-19, and to trace and quarantine their contacts. As we have seen in the response to HIV/AIDS, Ebola, polio and other health issues, empowered and enabled communities are central to preventing the spread of infectious diseases.

This pandemic confirms once again, that preparedness is a sound investment in saving lives and mitigating the socioeconomic impacts of external shocks and threats. Resilient health systems are the foundations for better health: even as we fight COVID-19, access to essential services, such as immunization, safe deliveries and care for acute and long-term illness must be assured.

As we find safer ways of working, we have had to adjust activities, reprogramme and reprioritize our work. In doing so, we are guided by value-for-money principles and actions that will make a lasting difference.

As we have seen in the response to HIV/AIDS, Ebola, polio and other health issues, empowered and enabled communities are central in preventing the spread of infectious diseases.

Our celebration of the certification of regional eradication of wild poliovirus has been postponed to 25 August 2020, and we have included a special section in this report, highlighting our collective work in this important area.

Finally, this is the first report in my second term as WHO Regional Director for Africa. I would like to sincerely thank our Member States for the trust placed in me, to lead the Organization's work in the Region for a further five years.

Making good health a reality for all people in Africa is a collective effort of Member States, partners, communities, and colleagues. Now more than ever, I would like to thank everyone for their support, in working day and night to save lives, promote health and serve the vulnerable.

Dr Matshidiso Moeti
Regional Director for Africa
World Health Organization

Executive Summary

Over the past year, WHO country offices, emergency hubs, intercountry support teams and the Regional Office for Africa, with the support of WHO headquarters, have worked together in implementing the *WHO Thirteenth General Programme of Work, 2019–2023* (GPW 13), which focuses on the global triple billion goal: one billion more people benefitting from universal health coverage; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being.

Embedding the Transformation Agenda

To deliver on the triple billion goal, globally WHO is undergoing a transformation, building on and influenced by the regional Transformation Agenda, which is now in its sixth year. The focus in the Region is on putting people at the centre of change through five key initiatives: leadership training of more than 180 mid-level and senior staff; engaging 237 staff as change agents to implement organizational change activities; introducing new mentoring and team performance programmes; and striving for gender parity through a dedicated programme, including the launch of the Africa Young Women Volunteers Initiative, with work underway to recruit 100 UN volunteers. The recommendations from reviews of staff profiles and structures of our country offices are being implemented with the support of partners, and the WHO Regional Office for Africa has also been restructured towards better delivery of GPW 13.

Towards a polio-free Africa

The year 2020 constitutes a milestone, with certification of eradication in the WHO African Region, of wild poliovirus (WPV). August 2020 marks four years since the last WPV case was reported in the African Region. This is the most significant public health achievement in Africa since the eradication of smallpox 40 years ago.

Regional eradication of wild poliovirus represents the culmination of efforts by thousands of front-line health workers, governments and partners and will leave a legacy of millions of lives saved in years to come. To finish polio once and for all, outbreak response to circulating vaccine-derived poliovirus type 2 is underway, supported by the anticipated roll-out of the novel oral polio vaccine type 2 and action to transition the polio infrastructure to be integrated within routine immunization and health systems and advance other priorities.

Accelerating progress to attain universal health coverage

WHO's top priority is to support countries in ensuring every person has access to health care without suffering financial hardship. The political declaration on universal health coverage (UHC) adopted by the United Nations General Assembly in September 2019 provides a strong foundation, and builds on the commitment of African leaders in February 2019 at the African Union, as well as the work of WHO's regional UHC flagship programme. The *Global Action Plan on Healthy Lives and Well-being for All* further provides a framework for multisectoral action, partnerships and tracking progress towards UHC and the Sustainable Development Goals.

Countries have developed strategies to achieve UHC with a strong focus on primary health care and accompanying the implementation of national policies at the district level. Action is also underway to strengthen public-private partnerships, and a side event convened by the WHO Regional Office for Africa at the UN General Assembly in 2019 ignited interest in the dividends of jointly investing in health security and health systems.

Over the reporting period, South Africa and Zambia introduced national health insurance legislation as part of efforts to attain UHC. Eswatini and South Sudan produced their first ever national health accounts reports to guide financing decisions.

30 June 2020, sixteen countries have signed the treaty to establish the African Medicines Agency and two have ratified it. Ministers of Health of Small Island Developing States in the African Region agreed on a pooled procurement strategy to make NCD medications more affordable.

A master protocol for clinical trials of traditional medicines for COVID-19 was developed jointly with Africa CDC, with oversight by a newly established Expert Advisory Committee.

In 2020, WHO is celebrating the International Year of the Nurse and Midwife. Work is ongoing to support countries in developing national health workforce accounts and other analyses to inform decision-making towards optimizing health workforce retention and distribution in each context.

Action on gender, equity and rights is advancing, including advocacy and analytical work on gender-based violence, which has been brought into relief by social distancing measures and stay-at-home rules.

Better health outcomes for women, adolescents, children and older people

The quality of reproductive, maternal, newborn, child and adolescent health (RMNCAH) care has been further improved including through the establishment of an RMNCAH Technical Advisory Group to guide action in countries. Almost all countries are implementing maternal death surveillance and response, and capacity-building in early essential newborn care is ongoing. Between 2017 and 2019, four countries reported increases in contraceptive prevalence, including an increase from 25% to 31% among women aged 15 to 49 years in Burkina Faso.

The adolescent health flagship programme catalysed the removal of barriers in accessing care and increased support to district health management teams to strengthen services for young people.

Countries are also increasing the focus on the health and well-being of older people with support from WHO. This included training of health and social care provider teams to deliver integrated care to older people in health facilities.

Eradicating, eliminating, preventing and controlling diseases

Integrated and cross-cutting approaches are increasingly being pursued in the Region to reduce the disease burden in countries. More people are getting tested for HIV, two out of three people in need are getting treatment, and half are achieving viral suppression with no risk of infecting other people. Thirty-two countries are recording fast declines of at least 4% in new TB cases each year. Through the Cairo Declaration on Viral Hepatitis in Africa in 2020, more than 30 632 people were screened for hepatitis C.

The African Region accounts for 93% of global malaria cases and WHO is supporting countries to implement a “high-burden to high-impact” approach and the Eliminate Malaria by 2020 (E–2020) Initiative. In the first year of the malaria vaccine pilot programme, 300 000 children were reached in Ghana, Kenya and Malawi. Endemic countries are making progress towards guinea-worm eradication and in 2019, Togo submitted a request for validation of human African trypanosomiasis elimination. The Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN) scaled up mass drug administration campaigns, targeting over 53 million people in 21 Member States. In 2019, the Sixty-ninth WHO Regional Committee for Africa endorsed the *Framework for implementation of the Global Vector Control Response in the WHO African Region*.

To improve prevention and management of noncommunicable diseases, an increasing number of countries are implementing an integrated NCD service package at the primary health care level.

High-level commitment to strengthen immunization was reinforced, through the Kinshasa Declaration on Immunization and Polio Eradication. Despite progress in countries, the regional average immunization rate is 76% for DTP3, far short of the 90% target. In line with the Addis Declaration on Immunization of 2017, and with the strong support of African Heads of State, increased action is urgently needed.

Six countries reported major measles outbreaks. The most severe one, in the Democratic Republic of the Congo, resulted in 372 615 cases and 6800 deaths as of May 2020. More than 6.8 million people received yellow fever vaccination. Côte d'Ivoire and Equatorial Guinea introduced hepatitis B birth-dose vaccination, bringing the total to 13 countries in the Region. This is short of the target of 25 countries by 2020, indicating that greater investment is needed to protect communities with lifesaving vaccines.

Protecting people from health emergencies

With the COVID-19 pandemic, outbreaks of Ebola, cholera, measles and other diseases, and a total of some 100 acute health events occurring in the Region each year, WHO's work in emergency preparedness and response continues to be a key area of focus.

Ongoing improvements in this area resulted in quicker detection of outbreaks, from a regional median of 17 days in 2016 to four days in 2019, and quicker containment from 418 days in 2016 to 40 days in 2019.

Work with countries to build capacities in line with the International Health Regulations (2005) resulted in 46 countries completing joint external evaluations and 30 developing national action plans for health security to address the identified gaps. Funding of these plans remains a challenge, and the COVID-19 pandemic has drawn renewed attention to the importance of investing in preparedness.

After almost two years, the 10th Ebola outbreak in the Democratic Republic of the Congo was declared over in June 2020. This outbreak occurred in an active conflict zone, with a protracted humanitarian crisis, and intense population movement. The lessons learned and the capacities built for preparedness and response to Ebola and other epidemics, have been quickly activated in response to COVID-19.

All countries in the Region have reported cases of COVID-19 and as of 30 June 2020, thirty were experiencing community transmission. WHO country teams are on the front lines of the response as the principal advisor and source of technical support for countries and have helped to establish incident management systems in countries. Laboratory capacity has been strengthened in all countries, in close collaboration with the Africa Centres for Disease Control and Prevention (Africa CDC).

Strong action by countries, with the support of partners, has helped to avert the large numbers of cases and deaths initially projected. Supplies of laboratory test kits and personal protective equipment continue to be a key challenge and WHO is working with other UN agencies and the African Union in supporting replenishments. More than 900 WHO staff have been repurposed across the Region to respond to the pandemic, and over 200 international experts have been deployed. Over 10 000 health workers have been trained in case management and infection prevention and control. Action to reverse the disruption of essential health services, such as routine immunization, is being accelerated and should be prioritized, with precautions in place for health workers and communities.

Promoting health and well-being

To ensure that people live healthier, longer lives, WHO supported countries in addressing social and economic determinants of health, including through a health-in-all-policies approach. Cabo Verde's action in this area was recognized with an award from the UN Interagency Task Force on NCDs in 2019.

For the first time in the Region, baseline information is available on water, sanitation and hygiene in schools and health facilities, through a joint report by UNICEF and WHO, to which all countries contributed.

To address the double burden of malnutrition in the Region, the WHO Regional Committee for Africa adopted a strategic plan in 2019. Subsequently and in full alignment with the strategic plan, the Southern African Development Community

adopted a nutrition strategy. Burkina Faso, Ghana and Senegal established national rapid alert networks for food safety, thereby increasing their participation in the International Food Safety Authorities Network (INFOSAN).

Using legislation for health, six countries adopted tobacco control laws and six increased tobacco taxes to reduce demand for tobacco products. Eight countries strengthened their policies on harmful alcohol use and three countries are implementing fiscal and regulatory measures for diet and physical activity. Regional capacity-building was conducted on road safety data systems.

Cross-cutting integrated action for better health

Five key cross-cutting areas have been identified in WHO's work in the Region: primary health care; antimicrobial resistance; laboratory services; data and health information; and innovation, digital health and research.

Primary health care remains a key approach towards achieving UHC and tools have been developed and contextualized to the Region, to assess the district health system and health facility functionality towards identifying and taking action on gaps and areas for improvement.

To combat antimicrobial resistance (AMR), Algeria and Burundi enrolled in the WHO Global AMR Surveillance System (GLASS) in the reporting period; so far, 21 countries in the Region are participating in this system. Action is also ongoing to strengthen laboratory quality assurance and optimize antibiotic use to safeguard these essential medicines.

Laboratory capacity has been strengthened, particularly as part of the COVID-19 response; from Senegal and South Africa at the start of the pandemic, all countries now have the capacity and equipment to diagnose COVID-19. The strengthened capacity will be used to improve diagnosis of other diseases.

Through the African Health Observatory, analytical information on health systems and sector performance are being developed, and tools for modelling COVID-19 case projections have been used to guide decision-making in countries. The availability and use of real-time data from health information systems continued to be strengthened, including through the use of DHIS2 and geographic information system technologies.

In March 2020, the inaugural virtual WHO COVID-19 Hackathon was convened, with seed funding provided to the most promising emerging innovations. One of these, a health information management platform called NextGeniCoviAI is now being used at the Mbarara Regional Referral Hospital in Uganda with plans to roll out to other regions in Uganda.

The reconstituted African Advisory Committee for Health Research and Development (AACHRD) met in October 2019. Through a small grant competition launched by WHO and the European & Developing Countries Clinical Trials Partnership (EDCTP), 30 young researchers in several areas received awards, including studies in the Democratic Republic of the Congo and Ethiopia. With the United States National Institutes of Health and the Bill & Melinda Gates Foundation, a new long-term partnership was launched to develop gene-based cures for HIV and sickle cell disease.

Providing better support to countries

To make WHO more effective, results-driven and accountable, action is ongoing to strengthen WHO support to countries by moving ahead with implementation of the functional review outcomes.

Coordination with sister UN agencies, the African Union, regional economic communities and other partners continues to be enhanced, particularly in the context of the COVID-19 pandemic, with the convening of weekly and monthly virtual monitoring meetings. In 2019, WHO and the African Union signed a memorandum of understanding on key joint priorities, and at the regional level, WHO and the Africa CDC agreed to a joint workplan to ensure complementary actions on health security.

The first virtual World Health Assembly was convened in 2020, and the first virtual WHO Regional Committee for Africa is scheduled for 25 August 2020. Both events focus primarily on the COVID-19 pandemic.

Using proactive communications, WHO is sharing information with the general public, regional leaders and opinion makers for behaviour change through weekly regional virtual press conferences on COVID-19, the regional website is growing in terms of users, with increased reach on Twitter and Facebook and around 500 media engagements in the past year, almost a five-fold increase on the previous year.

As the COVID-19 pandemic evolved in the Region, hundreds of WHO staff transitioned to teleworking with strong operational support, including expansion of the use of information technology platforms and translation and interpretation services for virtual meetings.

The COVID-19 pandemic prompted the reprogramming of activities in some areas and efforts are underway to ensure that gains made in previous years are sustained and advanced. Key performance indicators continue to be used to strengthen staff accountability for results, guided by the value-for-money framework and integration of risk management in programme planning and implementation.

Looking forward

The COVID-19 pandemic is affording opportunities to strengthen capacities, leverage good practices and advance health and development in the Region. In the coming year, we will continue working with Member States and partners towards attaining universal health coverage by expanding service coverage and access, protecting people from emergencies, and promoting and enabling well-being.

The deadline for achieving the Sustainable Development Goals is now 10 years away, and with the global pandemic, some targets are at risk of falling further off track. New ways of working and stronger integration will be taken on board to accelerate progress. Fixing this situation requires solidarity across countries, supported by the same all-of-government and all-of-society approaches that have been used to slow the spread of COVID-19. With strong commitment and action at all levels, we can achieve our shared goals and make health a reality for all people in the African Region.

Timeline of key events

2019

17 JULY

WHO declares the **Ebola outbreak** in the Democratic Republic of the Congo a public health emergency of international concern.

AUGUST

WHO Regional Committee for Africa endorses strategies on integrated disease surveillance and response, and the double burden of malnutrition, and frameworks on strengthening district/local health systems, and vector control,[1] and nominates Dr Matshidiso Moeti to serve as WHO Regional Director for Africa for a second five-year term.

After a two-year process, **reviews of staff profiles and structures of all 47 WHO country offices in the African Region are completed**, to ensure alignment with host Government priorities, to accompany countries towards attaining universal health coverage and the Sustainable Development Goals.

23 SEPTEMBER

United Nations General Assembly:

- Heads of State adopt the political declaration on universal health coverage
- WHO AFRO presents the dividends of joint investment in health systems and health security in a side event with Member States and partners

12 NOVEMBER

WHO prequalifies an Ebola vaccine for the first time, a critical step to speeding up licensing, access and roll-out in countries most at risk of Ebola outbreaks. This marks the fastest vaccine prequalification process by WHO.

2020

30 JANUARY

Coronavirus declared a public health emergency of international concern.

25 FEBRUARY

First confirmed case of COVID-19 in the WHO African Region.

8 MARCH

WHO Regional Director for Africa launches the **Africa Young Women Champions Initiative** in collaboration with the UN Volunteers programme to boost equity and empowerment by recruiting 100 UN volunteers from the Global South to work with WHO in the African Region.

18–19 MAY

First ever virtual **World Health Assembly** convened, endorsing a resolution on the COVID-19 response, with consideration of other items suspended until later in the year.

1 JUNE

More than 100 000 COVID-19 cases and 2600 deaths in the WHO African Region.

25 JUNE

The Government of the Democratic Republic of the Congo declares the **end of the Ebola outbreak** in North Kivu and Ituri Provinces, after almost two years of sustained emergency response.

30 JUNE

More than 300 000 COVID-19 cases and 6000 deaths in the WHO African Region.

25 AUGUST

WHO African Region certified free of wild poliovirus.

1 Access the documentation of the Sixty-ninth session of the WHO Regional Committee for Africa: https://www.afro.who.int/about-us/governance/sessions/sixty-ninth-session-who-regional-committee-africa

Introduction

This report on the work of WHO in the African Region from 1 July 2019 to 30 June 2020 highlights the results achieved in the past year in accompanying Member States towards universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

Almost 2500 staff are working for WHO in the African Region, across 47 country offices, two emergency hubs, three intercountry support teams and the Regional Office in Brazzaville, Republic of the Congo. Our work is guided by the Transformation Agenda and the organization-wide strategy, the *Thirteenth General Programme of Work, 2019–2023* (GPW 13). This strategy sets the triple billion targets of ensuring that one billion more people benefit from UHC, one billion more are protected from health emergencies, and one billion more enjoy greater well-being.

This report starts by looking at how the Transformation Agenda is being embedded in the DNA of WHO in the African Region. Results are then considered in line with the triple billion target areas: UHC, health emergencies, and improving population well-being. A further chapter is dedicated to cross-cutting and integrated approaches in the Region and another to how WHO is providing better support through leadership, governance, and effective management of resources.

Embedding the Transformation Agenda

The regional Transformation Agenda provides the guiding framework for all programmatic and managerial activities. By placing people at the centre of change, the Transformation Agenda strives to make WHO more effective, results-driven, and accountable.

People at the centre of change

Five initiatives are ongoing to build staff capacities and create an enabling environment for change:

1. Leadership training: over 180 mid-level and senior managers have participated in training and follow-up coaching sessions to build skills and competencies in appreciative leadership, emotional intelligence, performance management and coaching. Eight cohorts have gone through the programme, which has been run in English, French and Portuguese. Gender balance is a priority with women making up 50% of participants. From 2020 onwards, the programme will be extended to Member States and a training needs analysis has been conducted for permanent secretaries of health.

2. Mentoring programme: this six-month programme launched in 2020, matches mentors and mentees based on shared values. In the first cohort, 21 mentors and mentees have been paired, with funding for a second cohort in September 2020. All participants in the leadership programme are encouraged to participate as mentors in this programme.

3. Change network: 237 staff have volunteered and been trained to initiate and implement organizational change activities. Change agents have been instrumental in launching initiatives to improve the working environment in country offices and the well-being of staff.

4. The Team performance programme was launched in March 2020 in recognition that we cannot only train some team members or team leaders to improve performance. All team members contribute and should be empowered with the skills to enhance their performance.

5. Gender programme: achieving gender parity among WHO staff in the Region is a priority, and to do so several initiatives have been implemented. An all-female target cohort of the leadership programme was delivered, and guidelines were developed for supporting women on travel and meetings. A taskforce was also established to advise on and monitor initiatives to make the working environment in the Region more conducive to female staff.

Aligning for better health outcomes

Functional reviews of all 47 WHO country offices were completed between 2017 and August 2019. Offices are now moving forward to implement the outcomes of the reviews, including mobilizing resources for needed positions at country level.

The WHO Regional Office for Africa was also restructured to achieve three objectives. **First**, the new structure aligns with WHO's headquarter structure, to facilitate better delivery of the *Thirteenth General Programme of Work, 2019–2023*.

Second, teams have been organized to enhance collaboration, cross-cutting approaches and integration. **Third**, the new structure promotes the strengthening of health systems to meet people's needs throughout their lives.

Best practices in the regional Transformation Agenda were appreciated in discussions of the WHO Executive Board in February 2020, and in the United Nations Joint Inspection Unit (JIU) report on change management submitted to the United Nations General Assembly in 2019.[2]

2 Prom-Jackson, S. Cronin, E. A. Review of change management in United Nations system organizations: Report of the Joint Inspection Unit JIU/REP/2019/4, United Nations, Geneva, 2019 https://www.unjiu.org/sites/www.unjiu.org/files/jiu_rep_2019_4_english.pdf

Eradication of wild poliovirus in the WHO African Region

In June 2020, the independent African Regional Certification Commission accepted the complete documentation of the remaining countries in the Region claiming wild poliovirus-free status: Cameroon, Central African Republic, Nigeria, and South Sudan.

Polio outbreak response

Finishing polio once and for all requires sustained commitment. Between July 2019 and June 2020, three hundred and ninety confirmed cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) were reported across 15 African countries.

In September 2019, WHO led the creation of an interagency rapid response team to coordinate outbreak responses to circulating vaccine-derived poliovirus. The team of 20 experts in operations and vaccination management, epidemiology, logistics, and communications is based at the Regional Office in Brazzaville, bringing together staff from the core partners of the Global Polio Eradication Initiative (GPEI): WHO, the United Nations Children's Fund (UNICEF), Rotary International, the US Centers for Disease Control and Prevention, and the Bill & Melinda Gates Foundation.

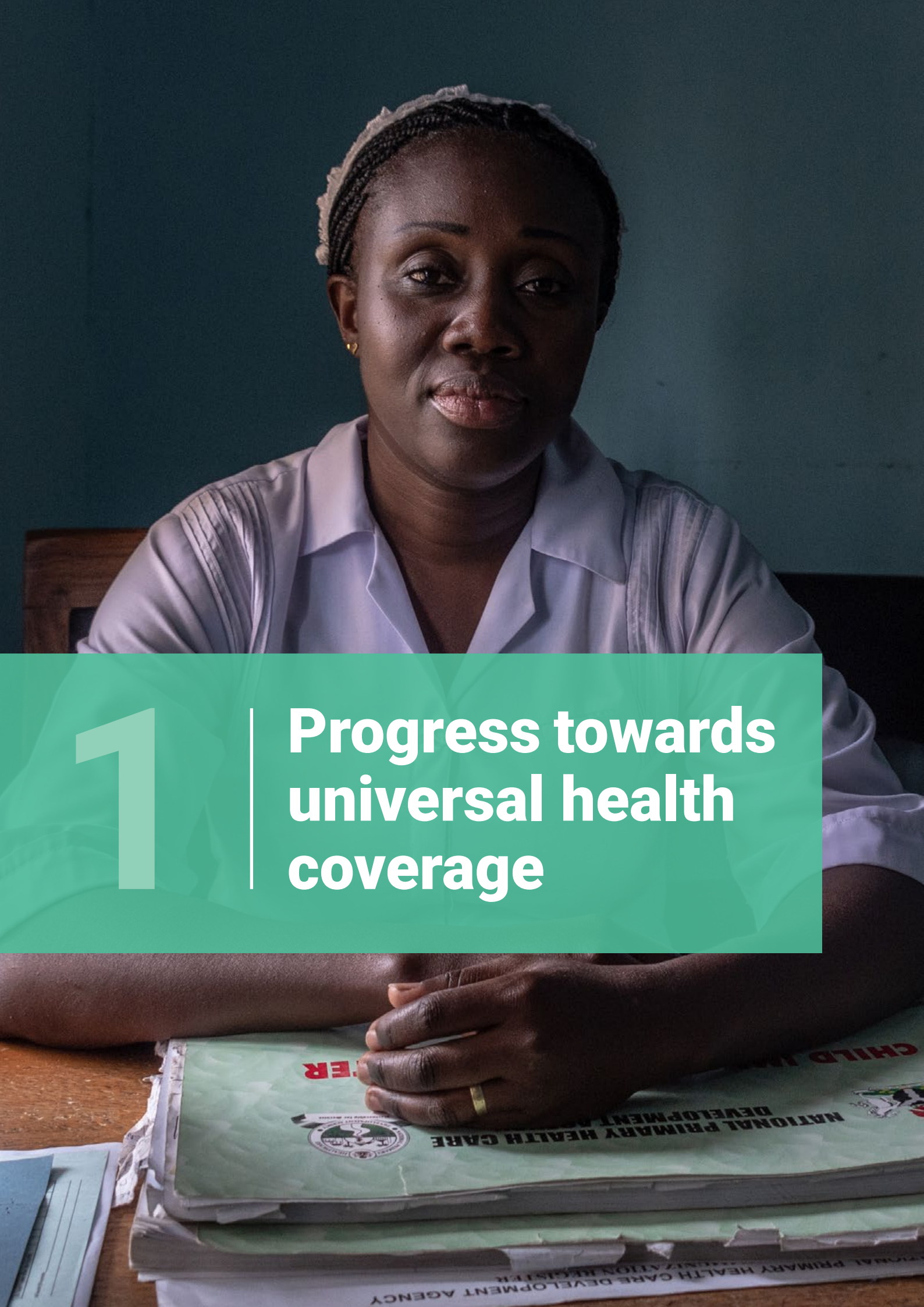
Eradication of wild poliovirus in the WHO African Region

When a new polio outbreak is suspected in the Region, a team of six experts is dispatched within 72 hours and stays in the country for 6–8 weeks, working under the leadership of a nominated GPEI coordinator, to put in place risk assessment, coordination, budget and campaign mechanisms for the response. A surge support team then takes over, for longer-term deployment with a one-week complete and detailed handover, to continue the response operations until the end of the outbreak.

The strategy of WHO and the GPEI partners from January 2020 to June 2021 comprises a series of risk mitigation measures to stop the spread of cVDPV2. These measures include utilization of the novel oral polio vaccine type 2 (nOPV2), which is anticipated to provide comparable protection to the current vaccine countries are using, while being more genetically stable and therefore reducing the risk of cVDPV2 outbreaks in communities with low immunization coverage. Novel OPV2 is expected to be available by the last quarter of 2020 via the WHO Emergency Use Listing procedure.

GIS for polio eradication: Through the Regional Geographic Information System (GIS) Centre, 43 countries have real-time surveillance and reporting of polio immunization activities. In 2020, Chad, Togo and Zambia piloted the use of business intelligence tools to strengthen campaigns and outbreak response. These innovative technologies are expected to cover all priority countries by the end of 2020. The GIS Centre has started using advanced artificial intelligence and machine learning tools to identify previously unreached communities and ensure they too have access to immunization against polio.

Continuity of polio services: Acute flaccid paralysis surveillance and environmental surveillance, vaccine supply and management, and planning for the roll-out of the novel oral polio vaccine are continuing uninterrupted. As we learn to live with COVID-19, rapid action is needed to catch up on postponed immunization campaigns.

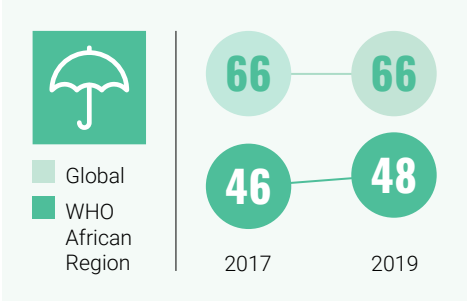


1 Progress towards universal health coverage

Achieving universal health coverage (UHC) is a top priority in the global health community, and the COVID-19 pandemic has once again highlighted the importance of affordable access to quality health care for everyone, everywhere.

Momentum towards UHC is accelerating in the African Region. In September 2019, the United Nations General Assembly adopted the first global high-level political declaration on UHC. This declaration builds on commitments at the African Union in February 2019 and on the work of WHO's regional UHC flagship programme over the past four years.

Fig. 1
UHC index



The UHC index measures country progress towards this shared goal. The African Region average was 48 in 2019, a modest improvement from 46 in 2017, compared to a global average of 66 in 2017 and 2019. Accelerated action is still needed to ensure more people in Africa can access quality, essential health services without facing financial hardship.

1.1 Strategic action to improve access to quality essential health services

Countries have developed roadmaps,[3] costed strategies,[4] and evidence-based strategic plans[5] to achieve UHC, with high-level political commitment. In the Democratic Republic of the Congo, for example, under the President's leadership, WHO supported the development of a national UHC plan, incorporating action plans for every district. This work is strongly linked to post-Ebola transition and recovery. In September 2018, Burundi also organized a national health conference under the leadership of the late President Pierre Nkurunziza, with the objective of revitalizing primary health care towards achieving UHC.

Progress towards UHC advanced in protracted emergency settings. In South Sudan a stabilization and recovery plan was developed to support the recovery of the health system, in line with the national health sector strategic plan 2017–2022. In Nigeria, three-year recovery plans and annual operational plans were developed in Adamawa, Bornu and Yobe States.

Gabon, Nigeria, Senegal and Uganda reviewed private sector engagement in health and health security. The findings of these reviews will inform the development of a regional guide on private sector engagement in health for UHC.

Opportunities for intercountry learning were strengthened, including through a planning and policy meeting for ministry of health directors in November 2019. Collaborative action is also underway to develop an evidence base on the political, social, economic and public health benefits of integrating health security and health system strengthening. This includes a side event convened during the UN General Assembly on the dividends of investing in health security and health systems.

3 Cameroon, Democratic Republic of the Congo, Eswatini, Madagascar, Niger, Sierra Leone, South Sudan, Uganda, United Republic of Tanzania, Zambia.
4 Benin, Burundi, Cabo Verde, Congo, Democratic Republic of the Congo, Eswatini, Equatorial Guinea, Eritrea, Ghana, Guinea-Bissau, Kenya, Malawi, Mauritius, Nigeria, Senegal.
5 Liberia, Mozambique, Zambia and Zimbabwe.

1.2 Expanding protection against financial hardship

In 2019, South Africa and Zambia introduced national health insurance legislation. WHO supported South Africa through expenditure tracking, fiscal space analysis, financial risk protection and cross-programmatic efficiency analyses. In Zambia detailed analyses using the financing progress matrix informed the development of the health financing strategy. Ghana, Kenya and the United Republic of Tanzania are reforming their health insurance schemes to increase coverage and sustainability.

WHO supported capacity-building, including training on health financing for UHC for 34 countries.[6] Following the training, Member States have developed evidence-based strategies and have been able to design health financing reforms that are UHC-focused, reducing the risks of financial hardship and impoverishment caused by health care in the Region. This effort will improve strategic planning and utilization of the limited financing available for health, while also supporting advocacy for resource mobilization.

Country teams comprising WHO, ministries of health and finance from 27 countries[7] were trained on the generation of national health accounts (NHA) and Eswatini and South Sudan subsequently produced their first ever draft NHA reports.

1.3 Strengthening supply management, infrastructure and access to quality-assured medical products

As of June 2020, sixteen African Union Member States had signed the treaty for the establishment of the African Medicines Agency (AMA) and two had ratified it.[8]

In December 2019, Ministers of Health of Small Island Developing States in the Region agreed on a joint strategy to make NCD medicines more affordable through pooled procurement.[9] This mechanism is expected to result in a 40% reduction in the price of medicines for the participating countries, and will facilitate a continuous supply of quality medicines, with procurement streamlined through a single tender. Strategic procurement and price negotiation were also established in the Southern African Development Community.

6 Botswana, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Namibia, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Uganda, Zambia, Zimbabwe, Angola, Cabo Verde, Guinea-Bissau, Mozambique, Sao Tome & Principe, Benin, Burkina Faso, Côte d'Ivoire, Mali, Mauritania, Senegal, Togo.

7 Benin, Botswana, Burkina Faso, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Malawi, Mali, Mauritania, Niger, Sao Tomé and Principe, Senegal, Seychelles, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania (and separately for Zanzibar) and Zimbabwe.

8 Algeria, Benin, Chad, Gabon, Ghana, Guinea, Madagascar, Mali, Morocco, Niger, Rwanda, Sahrawi Arab Democratic Republic, Senegal, Seychelles, Sierra Leone and Tunisia; ratification: Rwanda, Mali.

9 Cabo Verde, Comoros, Guinea-Bissau, Madagascar, Mauritius, Sao Tome and Principe, and Seychelles.

In Ethiopia and Sierra Leone medicines policies and strategies have been developed, as well as guidelines to strengthen the pharmacovigilance system and market authorization. Both countries also launched a mobile application to monitor adverse drug events.

Alerts on substandard and falsified medical products in the Region

Alerts issued in the reporting period demonstrate the use of sensitive surveillance systems in the reporting countries and help to raise awareness and trigger action on products of unacceptable quality in the Region. The alerts were for:

- falsified Augmentin in Uganda and Kenya in August 2019,
- falsified Quinine Bisulphate in Uganda and Quinine Sulphate in Central African Republic and Chad in October 2019,
- falsified antimalarials in West and Central Africa displaying an outdated WHO Essential Drugs Programme logo in March 2020,
- falsified HIV rapid diagnostic tests in the WHO Regions of the Americas and Africa in March and April 2020, and
- falsified chloroquine products in the African Region between April and June 2020.

Botswana launched its national regulatory authority in July 2019. An institutional development plan (IDP), which provides a roadmap for strengthening regulatory systems was developed in Nigeria and Ghana, and the progress of IDP implementation was assessed. In May 2020, the Ghana Food and Drug Authority was confirmed to have attained maturity level 3, the second authority in the Region to attain this level after the United Republic of Tanzania.

Rwanda established a partner coordination platform to operationalize the regulatory authority created in 2018. Inspection capacity for distribution chains was strengthened in Ghana and Senegal. Regulatory systems in nine countries[10] were benchmarked to evaluate performance.

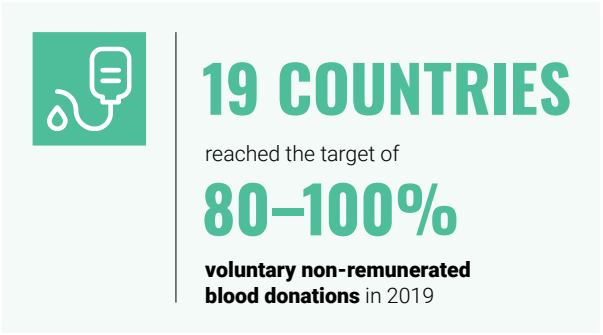


Fig. 2 Voluntary non-remunerated blood donations

Safe blood saves lives

Thirty countries[11] have national guidelines on the appropriate clinical use of blood and blood products, 16 countries[12] have established a national haemovigilance system, and five countries[13] have accredited blood transfusion services. The regional average blood donation rate is 4.9 units (blood bags) per 1000 population, ranging from 0.5 in South Sudan to 36.6 in Mauritius. Eight countries are collecting 10 units or more as recommended by WHO. Nineteen countries reached the target of 80–100% voluntary non-remunerated blood donations in 2019.[14]

10 Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Guinea, Nigeria, Senegal.
11 Angola, Benin, Botswana, Burkina Faso, Burundi, Chad, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, South Sudan, United Republic of Tanzania, Uganda, Zimbabwe.
12 Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Eswatini, Gabon, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, Uganda.
13 Mauritius, Namibia, Rwanda, South Africa, Uganda.
14 Benin, Botswana, Burkina Faso, Burundi, Central African Republic, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Kenya, Malawi, Mauritius, Namibia, Rwanda, Senegal, South Africa, Togo, Uganda, Zimbabwe.

In Ethiopia, the blood quality management system is certified as Step 2, out of three steps, based on the African Society for Blood Transfusion stepwise accreditation programme.

Scaling up the use of effective traditional medicine in national health systems

To maximize African traditional medicine and the continent's rich diversity of medicinal and aromatic plants, and to fast-track and scale up the use of effective traditional medicines and remedies for COVID-19, a master protocol for clinical trials was developed. In collaboration with Africa CDC and AUDA-NEPAD, an Executive Advisory Committee has been set up to oversee multicentre studies in line with the protocol and provide guidance on research and development of traditional medicine-based therapies for COVID-19. A Data and Safety Monitoring Board has also been established. This independent Committee will assess the ongoing scientific and ethical integrity of clinical trials in Member States by reviewing and evaluating data on clinical efficacy and safety collected during the studies.

1.4 Towards more health workers, in the right places, with the right skills

In 2020, WHO is celebrating the International Year of the Nurse and Midwife, including the launch of a global report on the State of Nursing,[15] to which almost all African countries contributed. A regional report is also being developed.

Through the development or review of national human resources for health strategies,[16] subregional strategic plans,[17] investment plans,[18] and rapid assessment of health professions education,[19] countries identified priorities and adopted policies to address workforce shortages. In addition, countries are using national health workforce accounts[20] and labour market analyses[21] to strengthen evidence-informed decision-making.

Kenya developed a framework to link health workforce productivity with wages for better efficiency. Following discussions at a national conference, a productivity index is being developed to implement the framework. In Namibia, the Health Labour Market Analysis (HLMA) was used to gain approval for a new structure/establishment for the Ministry of Health.

WHO's Workload Indicators of Staffing Need (WISN) methodology was used in Algeria to introduce and revise staffing standards by facility. Burkina Faso used the tool to inform the development of staffing norms and standards and in Ghana it was used in a health workforce gap analysis leading to evidence-informed mass recruitment.

15 https://www.who.int/publications/i/item/9789240003279
16 Eswatini, Kenya, Mauritania, Namibia, Nigeria, South Africa, and Uganda.
17 Southern African Development Community.
18 Development in Rwanda and South Africa, review in Benin, Burkina Faso, Burundi, Côte d'Ivoire, Eswatini, Gambia, Mauritania, Niger, Nigeria, South Africa, Zambia.
19 Congo and Togo.
20 Algeria, Botswana, Burkina Faso, Burundi, Eswatini, Ethiopia, Gambia, Kenya, Malawi, Mauritania, Namibia, Seychelles, Uganda, Zambia and Zimbabwe.
21 Ethiopia, Kenya, Lesotho, Mauritania, Namibia, Niger, Rwanda, Seychelles, Sierra Leone, South Africa and Zimbabwe.

1.5 Better health for women, children, adolescents and older people

Enhancing the quality of reproductive, maternal and newborn health

In 2020, WHO established a Reproductive, Maternal, Newborn, Child and Adolescent Health Technical Advisory Group (RMNCAH-TAG). To improve quality of care for women and children, WHO has supported countries in assessing health services,[22] developing national strategies,[23] conducting integrated programme reviews,[24] including relevant indicators in the DHIS2 platform,[25] and developing profiles in all countries to facilitate evidence-informed action and strengthen quality systems. These efforts informed policy dialogue, including with the Pan African Parliamentary Committee on Health, Labour, and Social Affairs.

Forty-six countries are implementing maternal death surveillance and response (MDSR). Capacity-building and strengthening of data analysis and reporting are ongoing to address challenges in identification, notification and response.

Competency-based training of trainers in early essential newborn care was conducted in six countries[26] while health-care providers and managers in 10 countries were trained in the management of neonatal sepsis when referral is impracticable.

In 24 countries,[27] prevention of mother-to-child transmission of HIV was advocated through the Free to Shine campaign and key interventions were integrated into antenatal and postnatal care in 16 countries.[28] Antiretroviral coverage among pregnant women in the African Region increased from 79% in 2018 to 83% in 2019.

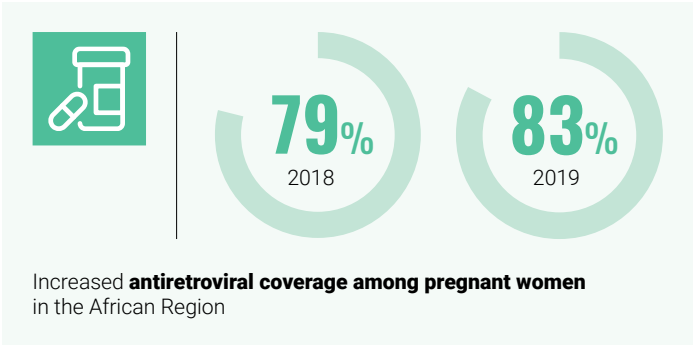


Fig. 3 Antiretroviral coverage among pregnant women

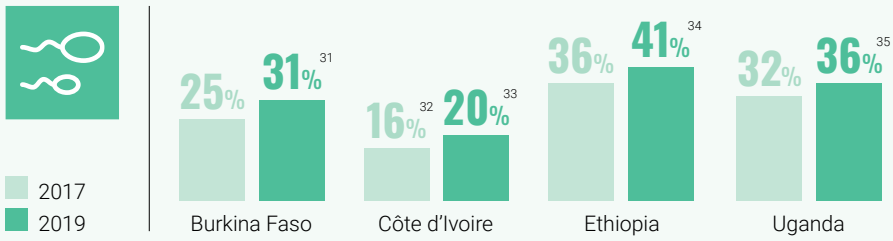
To implement the standards and recommendations of the Network for improving the quality of care for maternal, newborn and child health, the nine Network countries in the Region continue to systematically identify the needed actions and processes. These efforts have led to better understanding of what needs to be done and also the challenges facing health systems. For example, results from four of the 14 learning districts in Ethiopia, showed better assignment of causes of maternal and neonatal deaths as well as the facilities contributing to most of the deaths, thereby providing a good opportunity for targeting the response. Some facilities in these districts reported a decline of 5% in the median neonatal mortality rate between 2017 and 2019.

22 Burundi, Cabo Verde, Congo, Gabon, Lesotho, Mali, Uganda.
23 Ghana, Malawi, Nigeria and Sierra Leone.
24 Burundi, Chad, Democratic Republic of the Congo, Eswatini, Gabon, Ghana, Mali, Niger, Sao Tome et Principe and Seychelles.
25 Ghana, Malawi, Nigeria, and Uganda.
26 Eritrea, Eswatini, Ethiopia, Kenya, Malawi, Namibia.
27 Angola, Benin, Botswana, Burundi, Cabo Verde, Central Africa Republic, Eswatini, Ghana, Gambia, Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Liberia, Rwanda, Sierra Leone, Uganda, Zambia, Zimbabwe.
28 Burundi, Chad, Congo, Democratic Republic of the Congo, Ethiopia, Eritrea, Eswatini, Gabon, Ghana, Niger, Malawi, Mali, Mozambique, Seychelles, South Africa, Zimbabwe.

Development of national integrated RMNCAH and nutrition strategic plans continued in line with the *Global Strategy for Women's, Children's and Adolescents' Health*.[29] As an example of how these national plans are implemented, Gabon used its plan to revise the essential medicines list to include lifesaving medicines for mothers and children. The country developed a supply plan, and mobilized resources from Japan to build capacity for supply chain management in districts and provinces.

The French Muskoka Initiative is supporting RMNCAH and nutrition activities in eight countries in West and Central Africa,[30] including implementation of comprehensive sexuality education in Benin, Côte d'Ivoire, Niger and Togo.

Fig. 4 Contraceptive prevalence with modern methods



Increased contraceptive prevalence with modern methods among women aged 15-49 years with the support of the Africa Strategic Technical Engagement with Evidence for Results (Af-STEER) grant and the Sexual and Reproductive Health and Rights (SRHR) Initiative

WHO supported the development of national strategies and guidelines on sexual and reproductive health and rights, including on: STIs;[36] cervical cancer;[37] family planning;[38] policies, norms and protocols;[39] and preventing unsafe abortion.[40] In seven countries,[41] a core team of champions was trained to disseminate WHO guidelines and cascade trainings. A regional SRHR scorecard was also developed.[42]

To reduce reporting burdens and harmonize data collection processes and investments, a review of population-based survey tools and processes is underway. Additionally, in collaboration with UNAIDS, UNICEF and UNFPA through the 2gether4SRHR (sexual and reproductive health and rights) initiative, a review of sexual and reproductive health tools is being undertaken in 10 countries[43] in East and Southern Africa.

Improving the quality of care for children and adolescents

Capacities were strengthened in 16 countries[44] in programming for early childhood development. Multisectoral and/or multidisciplinary coordination mechanisms were strengthened in five countries.[45]

29 Burundi, Democratic Republic of the Congo, Eswatini, Gabon, Ghana, Mali, Niger, United Republic of Tanzania and Zambia developed these plans in the reporting period; so far 37 countries in the African Region have RMNCAH plans.
30 Benin, Chad, Côte d'Ivoire, Guinea, Mali, Niger, Senegal and Togo.
31 Burkina Faso PMA 2020 round 3, Burkina Faso PMA 2020 round 5.
32 Côte d'Ivoire, Cinquième Enquête par grappe à indicateurs multiples 2016.
33 Côte d'Ivoire PMA2020 round 2.
34 Ethiopia DHS 2016, Ethiopia mini DHS 2019.
35 PMA2020 round 4 and PMA 2020 round 6 Uganda.
36 Angola, Congo, Eswatini, Gabon, and Kenya.
37 Burkina Faso, Eritrea, Kenya, Liberia, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania.
38 Namibia and Madagascar.
39 Benin, Burkina Faso, Congo, Gabon, Mauritania, Niger.
40 Benin, Botswana, Burkina Faso, Eswatini, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Sierra Leone, Zambia, Zimbabwe.
41 Benin, Burkina Faso, Democratic Republic of the Congo, Mali, Nigeria, Rwanda and South Africa.
42 https://www.afro.who.int/publications/score-card-sexual-and-reproductive-health-and-rights-who-african-region
43 Botswana, Eswatini, Kenya, Lesotho, Malawi, Namibia, South Africa, Uganda, Zambia, Zimbabwe.
44 Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Ethiopia, Gabon, Kenya, Malawi, Mali, Mozambique, Niger, São Tomé and Principe, Senegal, United Republic of Tanzania, Zambia, Zimbabwe.
45 Ethiopia, Kenya, Malawi, Mozambique and Zambia.

Ethiopia, Kenya, Mozambique and Zambia are implementing nurturing care for early childhood development in demonstration areas. Liberia convened a high-level meeting to adopt and plan for all components of early childhood development with members of senate and parliament, deputy ministers, technical officers of the ministry of health, civil society and development partners including USAID, the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JPIEGO) and UN agencies.

In 12 countries, 100 health workers were oriented on *Standards for improving the quality of care for children and adolescents in health facilities* (WHO, 2018).[46] Sierra Leone established a dedicated Quality Management Unit, and early results from 13 high-burden hospitals in the country indicate that deaths among children reduced by 39%, from 15.6% in 2017 to 9.6% in 2019. Cabo Verde, Lesotho and Zambia have assessed the quality of care for child health services and the results are being used to improve quality of care.

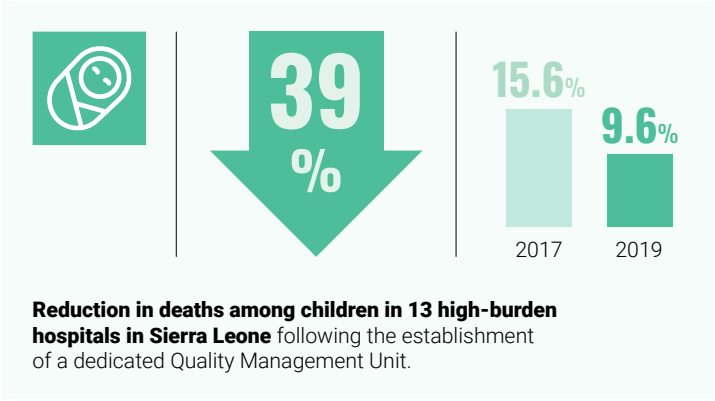


Fig. 5 Reduction in deaths among children in Sierra Leone

Reduction in deaths among children in 13 high-burden hospitals in Sierra Leone following the establishment of a dedicated Quality Management Unit.

Through the regional adolescent health flagship programme, capacities were built in 16 countries[47] to identify and address access-to-care barriers among adolescents, and in eight countries[48] to strengthen use of routine data for adolescent health.

The Third Global Action for Measurement of Adolescent Health (GAMA) meeting in Cape Town, South Africa in February 2020, led to the development of technical guidance for measurement of priority indicators. WHO launched a web platform to monitor implementation of the Global Standards for Quality health Care services for adolescents, which Ghana has introduced. An atlas on adolescent health with disaggregated data by age and sex was developed.

District health management teams strengthening adolescent health services

In the Democratic Republic of the Congo and Ethiopia, district health management teams improved planning, monitoring and review of adolescent health activities with WHO support. This resulted in 62 348 young people using health services in Burie Town, Godar Town and Sululat health district in Ethiopia and Kalamo, Kitambo and Makala health zones in DRC. This result was achieved over an implementation period of 11 months (July 2019 to May 2020). During the implementation period, the target was to reach at least 10% of young people out of 500 324 living in the supported districts.

46 https://www.who.int/maternal_child_adolescent/documents/quality-standards-child-adolescent/en/
47 Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Mali, Mozambique, Namibia, Nigeria, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
48 Burkina Faso, Cabo Verde, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea-Bissau, Niger and Mauritania.

Integrated care for older people

More countries are now implementing healthy ageing policies, strategic plans and integrated care for older people (ICOPE) in line with the priorities of the proposed *Decade of Healthy Ageing 2020–2030*. Cameroon, Botswana, Burundi and Niger assessed the health status and well-being of older persons to inform their healthy ageing strategic plans. So far, 23 Member States[49] have developed these plans. Thirty-eight country teams[50] made up of health and social care providers are now able to implement the WHO ICOPE toolkit to deliver integrated care for older people at front-line health-care facilities in the context of UHC. This represents an increase from 19 countries in 2019.

1.6 Mainstreaming and integrating gender, equity and human rights

In line with WHO's mission to serve the vulnerable, more countries are now identifying and addressing underlying gender-based issues and barriers to effective health services coverage using the WHO country support package for gender, equity and rights mainstreaming. An additional nine countries[51] are now using these tools in 2020, bringing the total to 29 Member States.[52] Twenty Member States[53] including those with humanitarian situations in West and Central Africa are now using WHO tools to strengthen their health systems response to gender-based violence and child sexual violence.

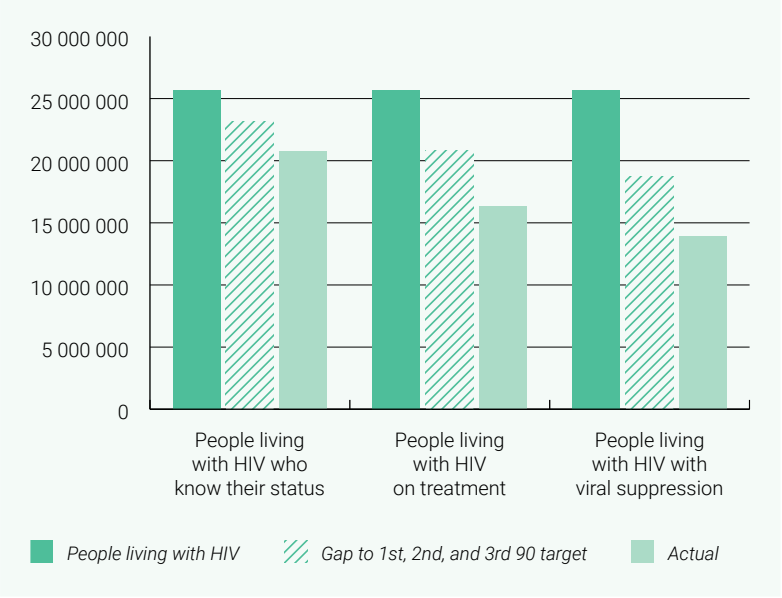
1.7 Eradicating, eliminating, preventing and controlling diseases

Scaling up antiretroviral therapy for HIV

More people are getting tested for HIV, two out of three people living with HIV are getting treatment (64% or 16.3 million) and half of them are achieving viral suppression with no risk of infecting other people.

49 Algeria, Benin, Burkina Faso, Botswana, Cabo Verde, Cameroon, Côte d'Ivoire , Ethiopia, Eritrea, Gabon, Gambia, Ghana, Madagascar, Mauritius, Niger, Nigeria, Mozambique, Rwanda, Congo, Senegal, United Republic of Tanzania, Zambia, Zimbabwe.
50 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Comoros, Côte d'Ivoire, Ethiopia, Eritrea, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mauritius, Namibia, Niger, Nigeria, Rwanda, Mozambique, Congo, Senegal, Seychelles, Sierra Leone, South Africa, Eswatini, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.
51 Ethiopia, Lesotho, Madagascar, Namibia, Liberia, South Africa, Togo, Uganda and Zambia.
52 Benin, Burkina Faso, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Mali, Madagascar, Mauritania, Namibia, Liberia, Nigeria, Niger, Congo, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, Uganda and Zambia.
53 Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Lesotho, Kenya, Mali, Malawi, Mozambique, Namibia, Niger, Nigeria, Eswatini, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Fig. 6
Progress of HIV testing and treatment in the African Region



The Region has made substantial progress towards the UNAIDS 90-90-90 targets[54] and is currently at 81-79-86 (Figure 6). Botswana, Eswatini and Namibia have achieved all three 90 targets. All Member States are implementing the "Treat All" policy and 44[55] have also adopted the new WHO HIV treatment guidelines and introduced Dolutegravir as a first-line regimen for HIV treatment. In December, WHO and partners unveiled a five-year plan to monitor, prevent and respond to growing HIV drug resistance in Africa.[56]

Key regional challenges include low coverage of early infant diagnosis and paediatric treatment; high rate of infection among young women aged 15–24 years, who account for 37% of all infections; and the persistence of stigma and discrimination among key populations, including young women and girls.

Other challenges include: suboptimal linkage between HIV testing, treatment and care; persistent absence of data on key populations; low retention in treatment and care, particularly among high-burden groups; and the continued dependence of HIV programmes on external funding. Member States need to enhance domestic financing; Integrate sexually transmitted infection (STI) services into other programmes including antenatal care, adolescent health and family planning services; strengthen STI surveillance and ensure regular reporting into Global AIDS Monitoring. HIV drug resistance is also threatening the significant progress made in the global fight against the virus.

Enabling communities leads to better HIV prevention and care

Communities continue to play a central role in the African Region by ensuring that the HIV/AIDS response is grounded and centred on people. For example, trained peers or community health workers can deliver rapid diagnostic tests with same-day results in Rwanda and South Africa. Community members in Benin, mentor mothers in Lesotho, adherence groups in Mozambique, community pharmacists in Nigeria, and adolescent treatment supporters in Zimbabwe continue to improve linkages to care, adherence to treatment and the overall well-being of people living with HIV. In Zambia, an intensive door-to-door effort in selected periurban communities by community health workers to promote and provide a range of HIV and health services has achieved the 90-90-90 testing and treatment targets and dramatically reduced new HIV infections by 30% in the target communities.

54 By 2020: 90% of all people living with HIV know their HIV status; 90% of all people with diagnosed HIV infection receive sustained ART; and 90% of all people receiving ART have viral suppression.
55 Except for Comoros, Madagascar, Mauritania.
56 https://www.afro.who.int/publications/preventing-and-responding-hiv-drug-resistance-african-region-regional-action-plan-2019

Towards ending the TB epidemic in the African Region

African countries are recording some of the fastest declines globally in TB incidence. Thirty-two Member States recorded declines of at least 4% in the number of new TB cases per year. Between 2015 and 2018, there was a 33% decline in HIV-related TB deaths. Increased coverage of treatment services saved the lives of 1 066 382 TB patients (82% of those started on treatment) and prevented over 10 million new infections.

At the same time, Africa has the highest TB rates with low coverage of bacteriological confirmation of notified new cases (65%) and treatment (56%). Few people living with HIV (60%) and child household contacts of confirmed active TB cases (29%) receive TB preventive therapy.

The Global Tuberculosis Report 2019[57] indicates that 2.5% and 12% of new and previously treated TB cases notified in the Region respectively have rifampicin- or multidrug-resistant TB (MDR-TB). All 47 Member States use rapid molecular diagnostics, especially GeneXpert, for testing TB and rifampicin resistance. Twenty-four countries[58] have also acquired line probe assays for testing resistance to TB medicines (thus facilitating more specific diagnosis and timely treatment combinations) and improved treatment for MDR-TB.[59]

Patient cost survey data from eight Member States[60] indicated out-of-pocket expenditures consistent with catastrophic costs. Insecurity and minimum intersectoral engagement have adversely affected TB control and domestic financing. To end the TB epidemic, Member States need: quality diagnostics, treatment and community follow-up; integrated people-centred care; increased domestic financing; strengthened policy and regulations for introducing effective diagnostics and treatments; and to implement minimum standards of care and multisectoral collaboration on TB control.

Eliminating hepatitis as a public health threat by 2030

With increasing regional awareness, the viral hepatitis response is gaining momentum. Five priority Member States[61] – accounting for 25% (or over 18 million people infected) of the hepatitis B and C burden in the Region – have piloted integrated hepatitis surveillance reporting on the online Global hepatitis platform.

The Cairo Declaration on Viral Hepatitis in Africa, endorsed in February 2020 by the Heads of State of the African Union, provides a unique opportunity for political advocacy and commitment to action. As part of the Egyptian Presidential Initiative for the treatment of hepatitis C in one million Africans, the Government of Egypt has strengthened laboratory capacity, including point-of-care and molecular testing of hepatitis C infection and provided clinical support in Chad, Eritrea and South Sudan. So far, 30 632 people have been tested and 376 people provided free treatment of direct-acting antiviral drugs.

57 Global Tuberculosis Report 2019 (WHO/CDS/TB/2019.15) https://www.who.int/tb/publications/global_report/en/
58 Algeria, Benin, Botswana, Cameroon, Democratic Republic of the Congo, Ethiopia, Gabon, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Ghana, Guinea-Bissau, Kenya, Lesotho, Madagascar, Eswatini, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
59 Benin, Botswana, Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Guinea, Kenya, Lesotho, Liberia, Mali, Malawi, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Eswatini, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
60 Burkina Faso, the Democratic Republic of the Congo, Kenya, Ethiopia, Uganda, Zimbabwe, South Africa and the United Republic of Tanzania.
61 Uganda, United Republic of Tanzania, Cameroon, Nigeria and South Africa.

With 93% of global malaria cases, accelerated action is urgently needed

In the African Region 213 million malaria cases and 380 000 deaths were reported in 2018.[62] Member States are implementing the "high burden to high impact" approach[63] and the E–2020 malaria elimination initiative.[64] Algeria developed a post-malaria-free certification plan to prevent re-establishment of indigenous malaria transmission.

Malaria programme or mid-term reviews in 28 Member States[65] led to the alignment of national policies with the Global Technical Strategy for Malaria in 24 Member States.[66] Global Fund concept notes were developed by 24 Member States.[67] Malaria epidemic response was conducted in Burundi and other countries. Capacities were also strengthened for malaria surveillance, diagnosis and data management, including external competency assessment of 12 malaria microscopists from Ghana and Kenya.

In 2019, implementation of the WHO malaria vaccine pilot programme was launched in Ghana, Malawi and Kenya. As of April 2020, more than 300 000 children had received their first dose of the RTS,S/AS01 malaria vaccine. The pilot programme aims to reach approximately 360 000 children per year across the three pilot countries.

Fig. 7
WHO malaria vaccine pilot programme

300 000 CHILDREN

received their first dose of the RTS,S/AS01 malaria vaccine as part of the pilot programme launched in Ghana, Malawi and Kenya in 2019.

The Sixty-ninth WHO Regional Committee for Africa endorsed the *Framework for implementation of the Global Vector Control Response in the WHO African Region*. By June 2020, seven Member States[68] had aligned their integrated vector management strategies with the framework and incorporated insecticide resistance management plans. Four Member States[69] integrated entomological surveillance into routine health information systems. Establishment of the harmonized entomological surveillance programme for arboviruses was validated for 13 Member States.[70]

The AFRO II Project[71] on integrated vector management entered the second phase of data collection in six Member States.[72] To improve the quality and effectiveness of vector control, a harmonized training manual for indoor residual spraying was developed for the Southern African Development Community's eight Member States

62 World Malaria Report, 2019 https://www.who.int/publications/i/item/world-malaria-report-2019
63 Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, Mali, Mozambique, Niger, Nigeria, Uganda, United Republic of Tanzania.
64 Botswana, Cabo Verde, Comoros, Eswatini, and South Africa.
65 Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Somalia (supported with EMRO), Sao Tome and Principe, South Sudan, Uganda, United Republic of Tanzania, Zimbabwe, Zambia.
66 Burkina Faso, Cabo Verde, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Gambia, Ghana, Liberia, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.
67 Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Guinea-Bissau, Malawi, Mozambique, Namibia, Nigeria, Niger, Sao Tome and Principe, Senegal, Togo, Rwanda, Uganda, United Republic of Tanzania, Zimbabwe.
68 Angola, Cameroon, Eswatini, Liberia, Namibia, Niger and South Africa.
69 Ghana, Mozambique, Gambia and Madagascar.
70 Benin, Burkina Faso, Cabo Verde, Gambia, Ghana, Guinea, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
71 Project on "demonstration of effectiveness of innovative alternative interventions for Integrated Vector Management".
72 Botswana, Eswatini, Mozambique, Namibia, Zambia and Zimbabwe.

targeting malaria elimination.[73] Master trainers from Member States were oriented and are using the curricula. A regional programme on control of vector-borne diseases is being developed.

To sustain vigilance on the emergence of resistance to antimalarial medicines, nine countries[74] were supported in the preparation and conduct of therapeutic efficacy studies.

In July 2019, health ministers of Sahelian countries agreed to work more closely to end malaria by 2030 and proposed the creation of a fund to bridge critical gaps in essential medicines and supplies for malaria response. By June 2020, nine countries had started the process of creating the fund.[75]

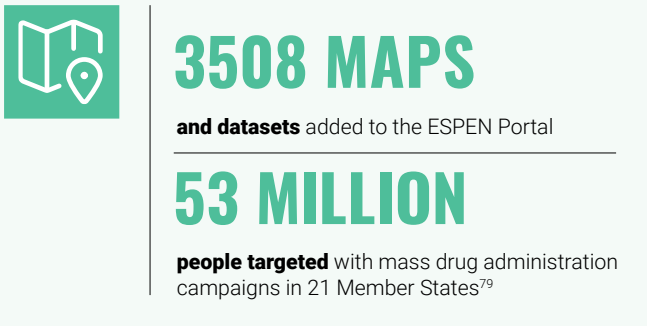
Eradicating, eliminating and controlling neglected tropical diseases

With WHO support, countries are working towards eradication of guinea-worm disease and yaws; elimination of several other neglected tropical diseases (NTDs) as public health problems;[76] and control of others.[77] These efforts are in line with the *Regional Strategic Plan for NTDs in the African Region, 2014–2020*.

Angola and the Democratic Republic of the Congo are at the pre-certification phase for guinea-worm disease, while four Member States remain endemic.[78] Mass treatment of yaws with azithromycin is being scaled up with a donation by a Brazilian company.

In 2019, Togo submitted a request for validation of human African trypanosomiasis elimination. Comoros organized a leprosy elimination campaign in 2019 to achieve leprosy elimination by 2020. Kenya diagnosed and treated 1463 cases of visceral leishmaniasis in 2019, in addition to 18 273 cases that were treated in nine countries in 2018.

Fig. 8
ESPEN Portal revamp and mass drug administration campaigns



The Expanded Special Project for Elimination of NTDs (ESPEN) revamped the ESPEN Portal to include 3508 maps and datasets for all preventive chemotherapy (PC) NTDs, and scaled up mass drug administration campaigns, including a triple-drug combination (ivermectin, DEC and albendazole) targeting over 53 million people in 21 Member States.[79] Three Member States submitted elimination dossiers for lymphatic filariasis (Malawi) and trachoma (Mauritania and Togo). Ghana, Malawi and Togo have now eliminated at least one PC-NTD.

73 Angola, Botswana, Eswatini, Mozambique, Namibia, South Africa, Zambia, Zimbabwe.
74 Benin, Burundi, Chad, Kenya, Niger, Nigeria; Rwanda, South Sudan and Zimbabwe.
75 Eswatini and Zambia have set up national councils and created a national fund for malaria elimination. Burkina Faso, the Democratic Republic of the Congo, Ghana, Kenya, Mozambique, Rwanda and Uganda have started the process of dialogue to establish national councils and create national funds for malaria elimination.
76 Human African trypanosomiasis (HAT), leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis and trachoma.
77 Buruli ulcer, dengue, chikungunya, echinococcosis, foodborne trematodiases, leishmaniasis, rabies, soil-transmitted helminthiases and taeniasis/cysticercosis and mycetoma, chromoblastomycosis and other deep mycoses, scabies and other ectoparasites and snakebite envenoming (newly added NTDs).
78 Chad, Ethiopia, Mali, South Sudan.
79 Burundi, Cameroon, Cabo Verde, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Equatorial Guinea, Eswatini, Gabon, Gambia, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Nigeria, Sao Tome and Principe, Senegal, South Sudan, Zambia.

Curbing the rise of noncommunicable diseases

To ensure communities can access services to prevent and control chronic diseases in primary health care settings, 23 Member States[80] are implementing an integrated approach to the management of noncommunicable diseases at the primary health care level, based on the WHO Package of Essential NCD Interventions (WHO PEN) and HEARTS technical package.[81] This is part of efforts by the 31 African countries that have developed national NCD multisectoral plans.[82]

Six Member States[83] have scaled up cervical cancer screening and treatment. Ghana, Senegal and Zambia have improved outcomes for children with cancer through increased access and coverage of services. Health-care workers in Ghana, Kenya and Rwanda are using the primary eye care manual to improve access to eye care services.

Oral health action plans focusing on noma are being implemented in nine high-burden countries[84] to ensure early detection and prompt management.

Kenya and Ghana are implementing mental health quality rights. Nigeria, Sierra Leone and South Sudan have developed and strengthened legislation and strategic plans to improve service delivery for mental health.

Prioritizing vaccine-preventable diseases

In the Addis Declaration on Immunization of 2017, Member States committed to increasing government funding for immunization, but more action is needed to implement this Declaration. The changing funding landscape for immunization – including the imminent decrease in resources from the Global Polio Eradication Initiative (GPEI) and Gavi – puts progress at risk, unless domestic resources are increased.

The Kinshasa Declaration on Immunization and Polio Eradication, signed on behalf of the President of the Democratic Republic of the Congo in July 2019, includes commitments to fully immunize at least 80% of infants before their first birthday by 2024, to increase the domestic budget for traditional vaccines, to meet the requirements for co-financing new vaccines, and to scale up free access to immunization for all citizens.

The Presidents of Burkina Faso and Niger have been honoured as “Vaccine Champions” by Gavi. As of June 2020, thirty-two African countries[85] had established national immunization technical advisory groups, of which 21 are fully functional.[86]

Despite this progress, every year, more than 30 million children under the age of five years in Africa fall ill and half a million die from vaccine-preventable diseases: 58% of global deaths from vaccine-preventable diseases occur in Africa. The current regional

80 Benin, Botswana, Burkina Faso, Cabo Verde, Côte d’Ivoire, Eritrea, Eswatini, Ethiopia, Guinea, Lesotho, Malawi, Mali, Niger, Nigeria, Senegal, Togo, Senegal, Seychelles, Sierra Leone, South Sudan, Uganda, Zambia, Zimbabwe.
81 Learn more about the HEARTS package at: https://www.who.int/cardiovascular_diseases/hearts/en/
82 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Madagascar, Mauritania, Namibia, Niger, Nigeria, Senegal, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia.
83 Eswatini, Guinea, Malawi, Rwanda, Uganda and Zambia.
84 Benin, Burkina Faso, Côte d’Ivoire, Democratic Republic of the Congo, Mali, Niger, Nigeria, Togo, Senegal.
85 Algeria, Angola, Benin, Burkina Faso, Cameroon, Côte d’Ivoire, Comoros, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Senegal, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.
86 Algeria, Benin, Côte d’Ivoire, Ghana, Guinea, Mali, Niger, Nigeria, Senegal, Togo, Democratic Republic of the Congo, Ethiopia, Kenya, Mauritius, Mozambique, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe, South Sudan.

average immunization rate, measured as the percentage of children who have received the third dose of the diphtheria-tetanus-pertussis-containing vaccine (DTP3) is 76%, far short of the 90% target.

A plea for accelerated action on measles and rubella elimination

Recent measles outbreaks underscore the significant risks of under-immunization. Between June 2019 and June 2020, six Member States reported major outbreaks, due to low routine coverage and/or delayed supplementary immunization activities. The most severe epidemic occurred in the Democratic Republic of the Congo with over 372 615 people affected and more than 6800 deaths as of the end of May 2020. Targeted outbreak response activities were done in mid–2019, alongside nationwide preventive supplementary immunization which were completed by December 2019, resulting in a significant reduction in the disease incidence. Further mop-up vaccination was done in March and April 2020.

To achieve the measles elimination target, coverage of over 95% with the first dose of measles-containing vaccine (MCV1) must be attained in all districts, but regional progress has stagnated between 70% and 75% over the past 10 years. Thirty-two Member States have introduced MCV2 into their routine immunization programmes, and at least four more will introduce MCV2 by December 2020.[87]

Although 27 Member States have introduced rubella-containing vaccine in routine immunization, overall coverage in the Region remains low at 32%. The disease is not well recognized and is often misdiagnosed as a fever and rash. As a result, it has been a challenge to sensitize national programmes to collect the data necessary to document the burden of rubella disease.

Progress towards eliminating maternal and neonatal tetanus

Forty-two Member States have validated elimination of maternal and neonatal tetanus,[88] including the Democratic Republic of the Congo, which was validated in July 2019. Although tetanus cannot be eradicated (tetanus spores exist in the environment), highly effective interventions and strategies, including maternal immunization, clean delivery practices, and post-elimination surveillance are essential to controlling and ultimately eliminating the disease.

Fig. 9
Elimination of maternal and neonatal tetanus

42 COUNTRIES

validated elimination of maternal and neonatal tetanus,[88] including the Democratic Republic of the Congo, which was validated in July 2019.

Need to protect gains against meningitis

Over 315 million people aged 9 months to 29 years were vaccinated against meningitis A with MenAfriVac© between 2010 and 2019. This represents significant progress towards achieving the target of vaccination campaigns in 26 Member States; so far the target has been achieved in 25 countries.[89] While studies have documented a substantial decrease in the burden of meningitis due to group A

87 Cameroon, Chad, Madagascar, Nigeria.
88 Defined as less than one case per 1000 live births in every district.
89 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Mali, Niger, Nigeria, Gambia, Guinea, Guinea-Bissau, Ghana, Mauritania, Uganda, Senegal, South Sudan, and Togo, Eritrea, Kenya, Rwanda, and United Republic of Tanzania.

meningococcal meningitis, outbreaks caused by other types of bacterial meningitis[90] are increasing. Appropriate control measures which include early outbreak detection, reporting, outbreak investigation, case management and reactive immunization, are being implemented by Member States facing epidemics.

Progress towards eliminating yellow fever

By June 2020, twenty-four of the targeted 27 Member States had introduced the yellow fever vaccine in routine immunization. No country introduced the vaccine during the reporting period, but Uganda submitted an application to Gavi for upcoming introduction. Annual meetings of Eliminating Yellow Fever Epidemics (EYE) strategy partners including vaccine manufacturers have improved the global supply of vaccines for routine immunization, preventive campaigns and outbreak response. Five Member States achieved coverage rates of 90% or more.

36 MILLION+

people protected against yellow fever in Nigeria and Ghana in 2019 following preventive mass vaccination campaigns

Fig. 10 Yellow fever vaccination campaign

To control yellow fever epidemics, reactive mass vaccination campaigns were conducted in Mali, Nigeria and South Sudan in 2019, and in Ethiopia, Nigeria and Uganda in 2020. From 2017 to June 2020, more than 50 million people had been vaccinated, including 6 832 126 people vaccinated during the reporting period. Preventive mass vaccination campaigns against yellow fever in Nigeria and Ghana in 2019 protected more than 36 million people.

Introducing new vaccines for better protection from disease

By June 2020, thirty-seven Member States had introduced the rotavirus vaccine, and 40 had introduced the pneumococcal conjugate vaccine. The use of the typhoid conjugate vaccine and oral cholera vaccine led to the effective containment of simultaneous disease outbreaks in Zimbabwe in 2019. Oral cholera vaccine was used to manage outbreaks in six additional Member States,[91] alongside water, sanitation and hygiene interventions.

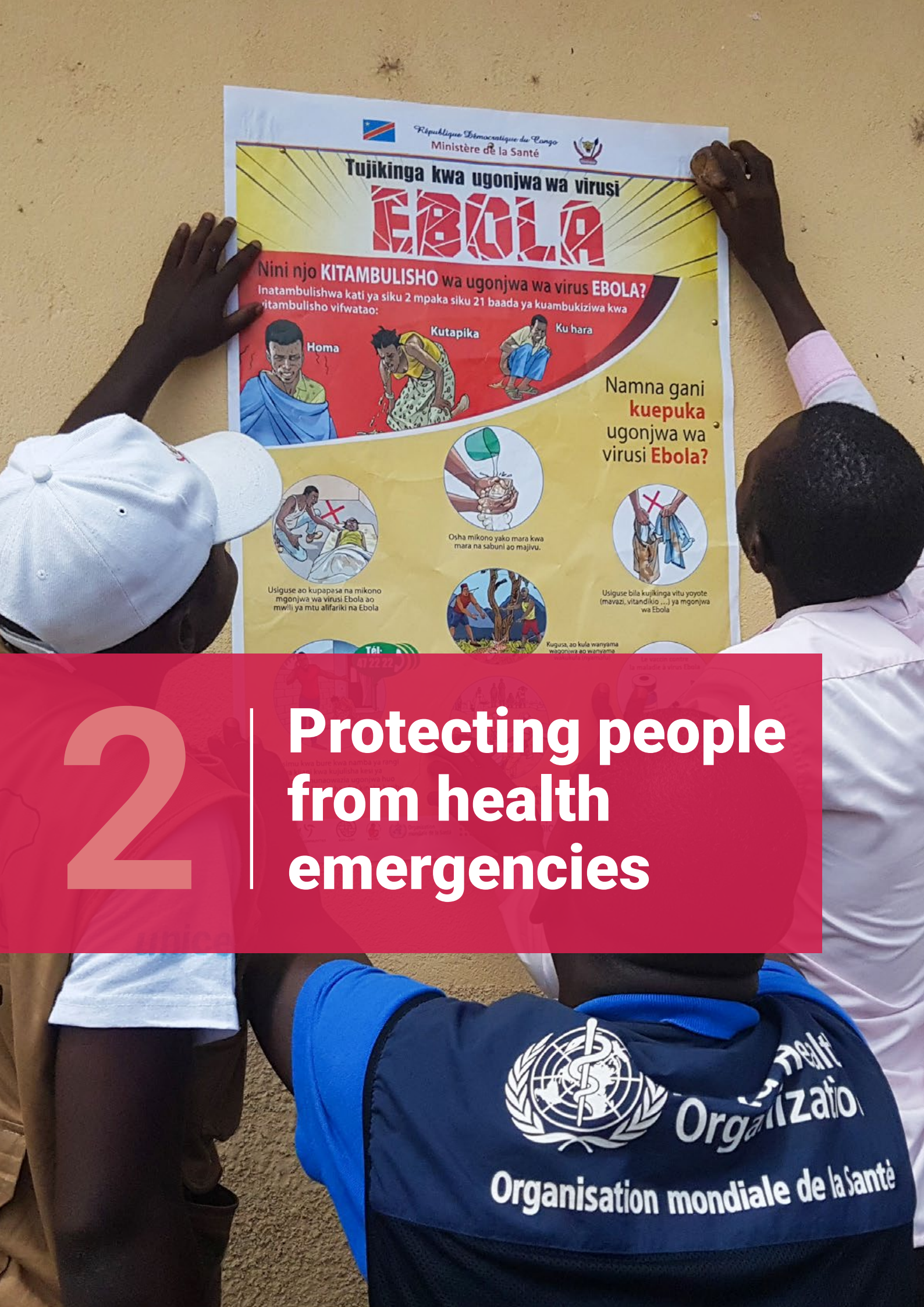
Despite the global shortage of human papillomavirus (HPV) vaccines, 15 of the targeted 35 Member States introduced the HPV vaccine by June 2020. Factors contributing to low HPV vaccine introduction rates in the African Region include low demand, barriers in accessing eligible girls, high vaccine prices for countries that do not receive Gavi funding, and global supply constraints.

Côte d'Ivoire and Equatorial Guinea introduced hepatitis B birth dose in 2019, bringing the number of countries now providing this vaccine to newborns to 13.[92] This falls 12 countries short of the regional target of at least 25 Member States introducing the vaccine by 2020.

90 Trotter CL, Lingani C, Fernandez K, Cooper LV, Bita A, Tevi-Benissan C, Stuart JM. The impact of MenAfriVac in nine countries of the African meningitis belt, 2010–2015: an analysis of surveillance data. Lancet Infectious disease, volume 17, issue 8, p867-872, August 01, 2017 DOI: https://doi.org/10.1016/S1473-3099(17)30301-8. Lingani et al. Meningococcal Meningitis Surveillance in the African Meningitis Belt, 2004–2013.Clin Infect Dis 2015;61(Suppl 5): S410-15. AA Bita. Impact of the meningococcal A conjugate vaccine introduction in the African meningitis belt, 2010–2017". American Journal of Biomedical and Life Sciences. 2019: 7(4): 84-92, doi: 10.11648/j.ajbls.20190704.13

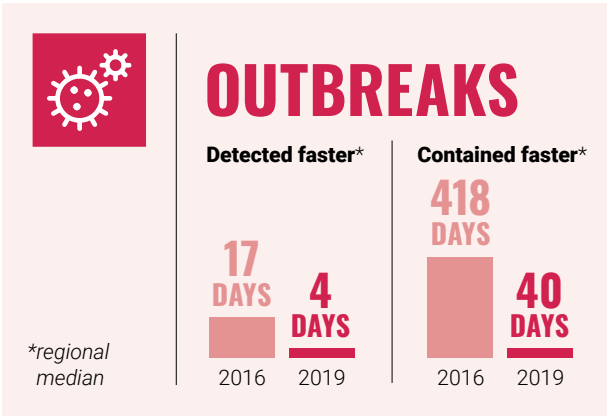
91 Democratic Republic of the Congo, Mozambique, Nigeria, Uganda, United Republic of Tanzania, and Zambia.

92 Algeria, Angola, Botswana, Cabo Verde, Côte d'Ivoire, Equatorial Guinea, Gambia, Mauritania, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal.



2 Protecting people from health emergencies

Fig. 11
Outbreak control



WHO continues to provide support for countries in the Region to develop capacities to prevent, detect and rapidly respond to public health threats, including infectious diseases, in line with the International Health Regulations (IHR, 2005).

2.1 Preparing for all hazards

In recent years, joint external evaluations of IHR capacities have been completed in 46 countries[93] and 30 national action plans for health security[94] have been developed to address the identified gaps. Funding for these preparedness plans remains an ongoing challenge. Six after-action reviews of emergency response operations were carried out and 25 simulation exercises were conducted. The results from these activities triggered corrective actions to improve IHR capacities, inform the development of preparedness plans and mobilize resources. For the third year in a row, all 47 countries submitted IHR State Party annual reports in 2019. The capacities of IHR national focal points were strengthened through training and a functional knowledge network.

Countries were also supported to use the Strategic Tool for Assessing Risks (STAR)[95] and the Vulnerability Risk Assessment and Mapping (VRAM) platform.[96] Rapid response capacities were enhanced through the training of more than 1500 members of national rapid response teams and of a pool of more than 300 facilitators able to provide training in English, French and Portuguese across the Region.

The revised regional strategy for integrated disease surveillance and response 2020–2030, endorsed by the Regional Committee in 2019, is accompanied by a training package and innovative approaches such as the use of key performance indicators, eLearning and partnering with training institutions. This has resulted in increased capacities to detect, notify and respond to acute events with 90% integrated disease surveillance and response (IDSR) coverage at the subnational level in 23 countries.[97]

Operational readiness interventions have contributed to early detection of outbreaks, such as yellow fever in South Sudan and Ebola in Uganda.

2.2 Assessing risks and sharing information

Each year, around 100 outbreaks and other public health emergencies in the African Region are reported to WHO. Using innovative digital tools such as the Epidemic Intelligence from Open Sources (EIOS) platform to conduct event-based surveillance through daily media monitoring, over 14 000 media reports were screened, leading to early detection of 84 events reported across 44 Member States. Outbreaks account

93 All except Algeria.
94 Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Uganda, Zambia, Zimbabwe.
95 Algeria, Burundi, Comoros, Côte d'Ivoire, Guinea, Eswatini, Eritrea, Lesotho, Liberia, Madagascar, Namibia, Nigeria, Sierra Leone, South Sudan, United Republic of Tanzania, Zambia, Zanzibar, Zimbabwe.
96 Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Eritrea, Eswatini, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania (and Zanzibar), Togo, Uganda, Zimbabwe.
97 Botswana, Burundi, Chad, Comoros, Côte d'Ivoire, Eritrea, Gabon, Gambia, Guinea, Lesotho, Liberia, Mali, Mozambique, Namibia, Niger, Rwanda, Senegal, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda and Zambia.

for over 85% of reported events in the Region, and among them in the past year nearly half (44%) related to the COVID-19 pandemic. Forty-six events were graded in line with the WHO Emergency Response Framework; this triggered lifesaving and emergency control and mitigation measures, including the activation of an incident management system within 24 hours for all graded events.

To ensure timely public information is made available, WHO has continued to publish weekly bulletins on outbreaks and other emergencies in the Region. Regular external situation reports on the Ebola outbreak in the Democratic Republic of the Congo and the COVID-19 pandemic in the WHO African Region have also been published and widely disseminated.

In collaboration with the International Organisation for Animal Health (OIE), 13 countries[98] improved intersectoral collaboration for zoonotic disease outbreaks at the human-animal-environmental interface and developed roadmaps to strengthen multisectoral coordination. Nine countries[99] piloted the WHO-FAO-OIE Tripartite Joint Risk Assessment tool for evaluating the risk of zoonotic diseases and antimicrobial resistance at the human-animal-ecosystem interface.

2.3 Timely and effective response to health emergencies

WHO's support to countries in responding to emergencies is progressively faster, more coordinated and more effective in a context of continued severe and widespread epidemics. In the past 12 months, support has been provided in the response to a number of threats, including COVID-19, Ebola, cholera, yellow fever, monkeypox and plague.

On 1 June 2020, the Government of the Democratic Republic of the Congo declared the country's eleventh outbreak of Ebola in Equateur province. As of 30 June 2020, there were 34 cases and 14 deaths. WHO has deployed more than 50 people to the field to support the response and more than 7000 people have been vaccinated. During the last Ebola outbreak in Equateur Province in May 2018, it took two weeks to start vaccination; this time it took four days.

COVID-19 readiness and response in the WHO African Region

The COVID-19 pandemic has affected all countries in the Region and is evolving in different ways in different countries. As of June 2020, South Africa was the most affected country and was one of 30 countries with community transmission. Some countries are reporting fewer new cases, and as measures are eased in an effort to save lives and livelihoods, continued vigilance remains important to suppress transmission.

Even before the first case was confirmed in the Region, in Algeria on 25 February 2020, WHO, with partners, including UN agencies and Africa CDC, were working with countries to strengthen readiness to respond to COVID-19. African Heads of State have led the way with all-of-government, all-of-society approaches implemented early to contain the pandemic. Many countries implemented social distancing measures like lockdowns and curfews, and used the window of opportunity they created to

98 Benin, Chad, Ethiopia, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania and Uganda.
99 Cameroon; Côte d'Ivoire; Ethiopia; Ghana; Kenya; Rwanda; Senegal; United Republic of Tanzania; Uganda.

strengthen public health capacities to find, test, isolate and care for cases, and to trace and quarantine contacts. WHO is on the front lines of the response, through country teams in all Member States. These teams play critical roles in advising and providing technical support to ministries of health and coordinating health partners in the response. WHO has repurposed more than 900 staff across the Region, and deployed over 200 international experts to support the COVID-19 response.

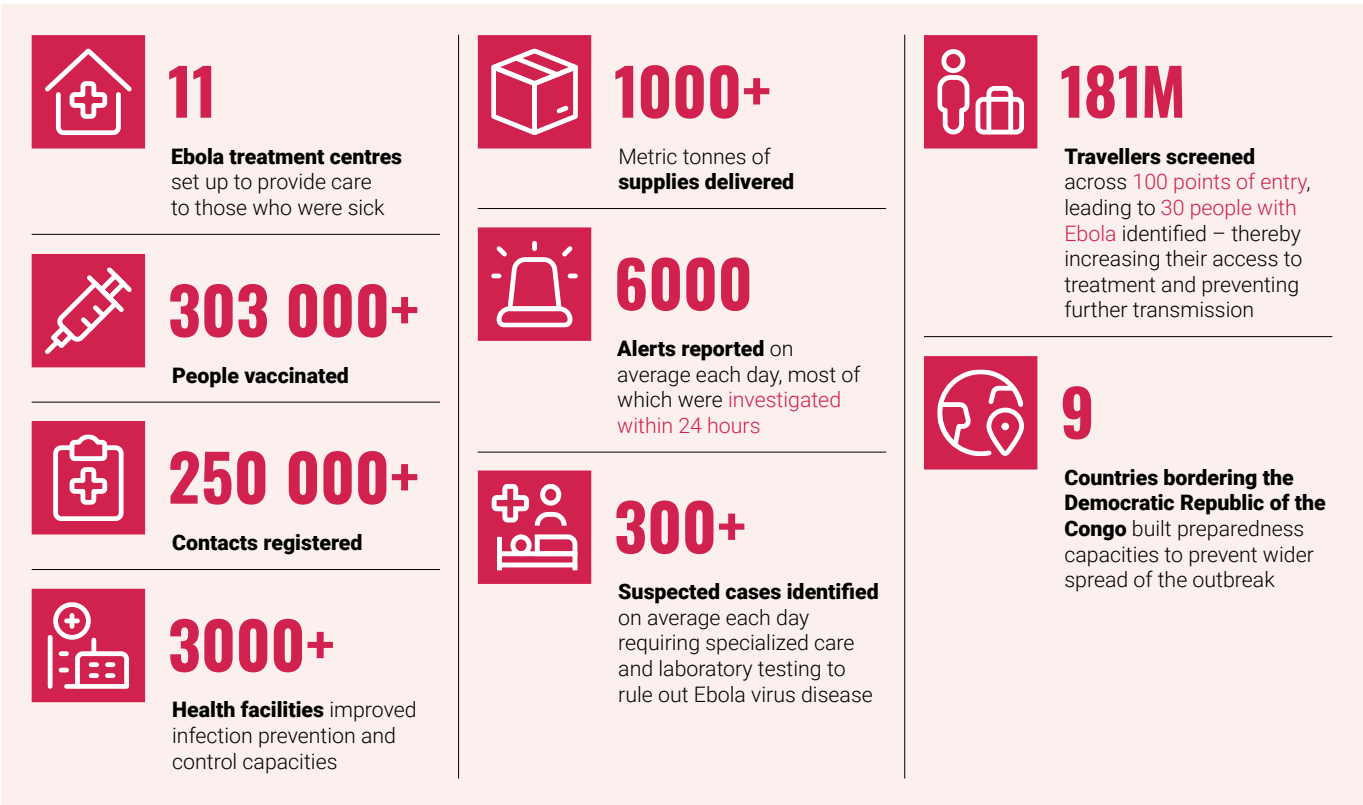
Initially only Senegal and South Africa had diagnostic capacity for COVID-19; now all countries do. With border closures and flight cancellations, WHO has scaled up innovative ways of working, including virtual learning to build the capacities of more than 10 000 health workers in infection prevention and control and case management. Countries have cascaded training in these areas. For instance, in Côte d'Ivoire, almost 10 000 health workers have been trained locally using online platforms. Since the onset of the pandemic, experience-sharing sessions have also been organized to guide adjustments to response measures in line with lessons learned and best practices.

Enabled and empowered communities are central to preventing the spread of COVID-19. For example, in Chad more than 100 000 people were reached through a door-to-door campaign to share information on the virus and to combat the spread of misinformation.

Ebola in the Democratic Republic of the Congo

After almost two years of responding to a complex outbreak in North Kivu and Ituri Provinces, the Government of the Democratic Republic of the Congo declared the end of the 10th outbreak of Ebola in the country on 25 June 2020. This was the second largest Ebola outbreak in the world and occurred in an active conflict zone, with a protracted humanitarian crisis and intense population movement.

Fig. 12
Key achievements in the Ebola response



There were more than 3400 cases, 2200 deaths and 1100 survivors. For the first time, an effective vaccine and therapies were available to support the response.

This massive response was a triumph of solidarity, science, courage and commitment, achieved by 16 000 front-line responders, supported by partners, including more than 1500 staff deployed by WHO.

A significant proportion of the capacities strengthened in relation to Ebola has been quickly activated in response to COVID-19, including coordination mechanisms, surveillance platforms, points-of-entry screening, contact tracing strategies, isolation facilities, and health education.

Support to the Democratic Republic of the Congo on Ebola has also contributed to work on universal health coverage, with the President spearheading a conference on UHC and the launch of the national UHC plan in 2020, recognizing that strengthening health systems is the most sustainable way to prevent and quickly contain epidemics.

In transitioning out of North Kivu and Ituri Provinces, a small WHO programme presence remains to support a survivors' programme and to further strengthen the capacities of the local and national authorities.

In line with the International Health Regulations, WHO will support the national health authorities to perform an after-action review with all stakeholders to learn from the response and strengthen the core functions to detect and control any public health event. Internally, in line with standard practice, WHO will also review our operations and set up a plan to address gaps based on lessons learned to improve future operations.

3 Promoting health and well-being

To ensure that people live healthier, longer lives, it is imperative that we reduce inequities, preventable diseases and injuries caused by environmental, social, economic, commercial, political and cultural determinants of health. This requires leadership, partnership and collaborative action across sectors to make a positive impact on the physical, social and mental health of people in Africa.

3.1 Promoting health and addressing social determinants

In 2019, WHO supported countries in adopting and adapting tools for strengthening intersectoral collaboration through health-in-all-policies (HiAP) in Small Island Developing States. As a result, the Healthy Cities Initiative was introduced in Cabo Verde to promote physical activity, healthy markets, address inequities, and advocate for environmental measures to control vector-borne diseases. The UN Interagency Task Force on NCDs recognized the efforts of the National Association of Cabo Verdean Municipalities to drive intersectoral action, and presented an award to the Prime Minister of Cabo Verde, Dr Ulisses Correia e Silva during the Seventy-fourth UN General Assembly.

Burundi and the United Republic of Tanzania both launched reports on the assessment of intersectoral action to address determinants of health towards achieving the SDGs. In Tanzania, capacity was built on HiAP orientation for 16 policy-makers from Government and nongovernmental agencies and civil society organizations. A sector-wide approach is being implemented under the leadership of the Prime Minister.

The Ministry of Health of Zambia and WHO jointly published a report on health equity and social determinants of health in November 2019. A plan of action was developed to ensure key findings are used to influence policy decisions related to early childhood, nutrition, water and sanitation, including at provincial level.

A health literacy approach was introduced to 23 African youth organizations and networks for promoting adolescent health in four countries.[100] The approach helped the organizations to build skills in working with policy-makers and in representing their peers in local and international forums to ensure that they are coopted in planning, coordination and implementation of programmes related to their health and developmental needs.

In collaboration with WHO headquarters and with support from Resolve to Save Lives, risk communication and community engagement training modules were adapted to the African Region and piloted in six countries.[101] Participants used the skills and knowledge gained in these trainings for COVID-19 readiness and response.

3.2 Environmental health and proactively adapting to climate change

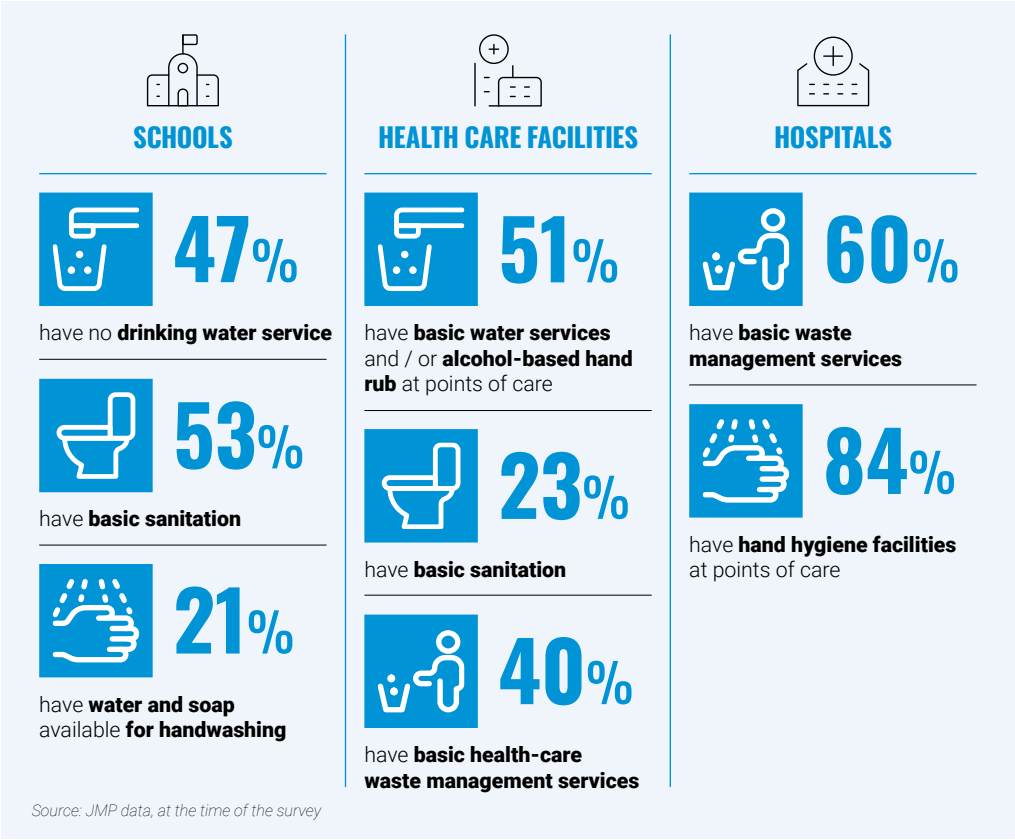
WHO continued to support community-based adaptation measures, focusing on climate-resilient water safety plans implemented in Ghana, Ethiopia, Mozambique and the United Republic of Tanzania. In November 2019, Mali launched an urban climate-resilient water safety planning initiative with advocacy briefings, staff training and initiation of a water safety planning pilot project in Bougouni commune.

100 Democratic Republic of the Congo, Niger, Rwanda and Uganda.
101 Burundi, Côte d'Ivoire, Nigeria, Rwanda, Senegal and South Sudan.

At the African ChemObs Project regional steering committee meeting in December 2019 in Addis Ababa, 20 health and environment project coordinators from nine countries were trained in the use of decision-making tools.[102]

Forty-one countries[103] contributed data to the UN-Water Global Assessment and Analysis of Sanitation and Drinking-Water (GLAAS) and all countries contributed to the UNICEF-WHO Joint Monitoring Programme (JMP) in relation to water, sanitation and hygiene (WASH) in schools and health facilities. This is the first time this baseline information is available in the Region.

Fig. 13
Sanitation in sub-Saharan Africa



According to the JMP data, 47% of schools in sub-Saharan Africa have no drinking water service and only 53% have basic sanitation. Only 21% of schools had water and soap available for handwashing at the time of the survey. Fifty-one per cent of health care facilities in sub-Saharan Africa had basic water services and/or alcohol-based hand rub at points of care. Only 23% had basic sanitation services and 40% had basic health-care waste management services. Sixty per cent of hospitals had basic waste management services and 84% had hand hygiene facilities at points of care.

A global event in Zambia in October 2019 kick-started implementation of the World Health Assembly resolution on improving access to water, sanitation and hygiene services in health-care facilities including waste management.[104] The Regional Office supported delegations from 11 countries to attend this event.[105]

3.3 Addressing the double burden of malnutrition and ensuring food safety

The Sixty-ninth WHO Regional Committee for Africa endorsed the *Strategic plan to reduce the double burden of malnutrition in the African Region (2019–2025)*. The technical discussion of the strategic plan was complemented by a low-salt, low-sugar

102 Ethiopia, Gabon, Kenya, Madagascar, Mali, Senegal, United Republic of Tanzania, Zambia and Zimbabwe.
103 All countries except Algeria, Cabo Verde, Equatorial Guinea and Guinea-Bissau participated in the exercise; Cameroon and Rwanda have not yet submitted their survey outcomes.
104 WHA72/A72-R7
105 Democratic Republic of the Congo, Ethiopia, Ghana, Guinea-Bissau, Malawi, Mali, Mozambique, Rwanda, United Republic of Tanzania, Zambia and Zimbabwe.

lunch of minimally processed indigenous foods and conversation notes placed on tables to encourage healthy food marketing in the African Region.

In November 2019, ministers of health of the Southern African Development Community (SADC) adopted a nutrition strategy that fully aligns with WHO's regional strategic plan, to be monitored using the Global Nutrition Monitoring Framework for the World Health Assembly 2025 nutrition targets. WHO and UNICEF in collaboration with other regional partners have developed plans for joint support to Member States to implement country priorities for infant and young child feeding. In ongoing collaboration with the FAO, Burkina Faso, Ghana and Senegal established national rapid alert networks for managing food safety events, thereby enhancing their participation in the International Food Safety Authorities Network (INFOSAN). Additionally, Senegal developed a national food safety emergency response plan and protocol for information sharing in the event of foodborne disease outbreaks. Botswana, Rwanda and Zambia received support to update food safety regulatory frameworks.

3.4 Tackling tobacco use and other risk factors for noncommunicable diseases

To accelerate implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC),[106] six countries adopted new tobacco control laws and regulations,[107] and six increased tobacco taxes.[108]

Countries have also established or revitalized tobacco control committees,[109] and developed multisectoral strategic plans.[110] Cabo Verde, Kenya and Seychelles ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, bringing the regional total to 20 countries.[111]

Ethiopia, Gambia, Togo and Uganda used the WHO TaxSim model analysis to inform their tobacco tax policy change. Through a study tour to the Kenya Revenue Authority, officials from Ethiopia, Nigeria and Uganda learned about track and trace systems and tax administration policy.

To raise awareness and better publicize decisions in countries, tobacco surveys were conducted in Chad, Congo, Senegal and Togo. The African Region Atlas on Tobacco Surveillance, the WHO report on the global tobacco epidemic,[112] and the WHO report on trends of tobacco use[113] were widely disseminated as well as a summary report on the status of MPOWER measures in the Region.[114]

In the African Region there is a high rate of heavy episodic drinking, especially among young people.[115] Sixteen countries[116] reviewed the implementation of the *Global strategy to reduce the harmful use of alcohol* and a regional report was submitted

106 All countries except Eritrea, Malawi and South Sudan are parties to the WHO FCTC.
107 Côte d'Ivoire, Ethiopia, Gambia, Nigeria, Senegal and Uganda.
108 Ethiopia, Gambia, Kenya, Rwanda, Togo and Uganda.
109 Cabo Verde, Gambia, Kenya Madagascar, Mauritania, Nigeria, Niger and Uganda.
110 Botswana, Burkina Faso, Cabo Verde, Kenya, Madagascar, Nigeria, Rwanda and Uganda.
111 https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4-a&chapter=9&lang=en
112 https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf?ua=1
113 https://www.who.int/publications/i/item/who-global-report-on-trends-in-prevalence-of-tobacco-use-2000-2025-third-edition
114 https://www.afro.who.int/sites/default/files/pdf/AFR_MPOWER_Summary_2019.pdf
115 https://www.who.int/publications/i/item/global-status-report-on-alcohol-and-health-2018
116 Botswana, Burkina Faso, Cameroon, Cabo Verde, Congo, Côte d'Ivoire, Eswatini, Kenya, Lesotho, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Uganda and Zambia.

to the 146th Session of the WHO Executive Board. Eight countries strengthened implementation of policies and legislation to reduce the harmful alcohol use.

In collaboration with the West African Health Organisation, 15 countries[117] were supported to strengthen regulation of food, alcoholic, non-alcoholic beverages and tobacco. In seven countries[118] communication and mobilization plans on salt reduction strategies were developed to combat the increasing trend of hypertension in the Region.

Through the Regulatory and Fiscal Capacity Building Programme (RECAP), Kenya, Uganda and the United Republic of Tanzania implemented measures to encourage healthy diets and physical activity. Seventeen countries[119] were supported to advance national implementation of the *Global Action Plan on Physical Activity 2018–2030*.

In the context of COVID-19, WHO is providing guidance and support to countries to reduce tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity. Emerging evidence indicates that current smokers and people living with noncommunicable diseases are at higher risk of contracting COVID-19 and progressing to severe disease.

3.5 Enhancing road safety

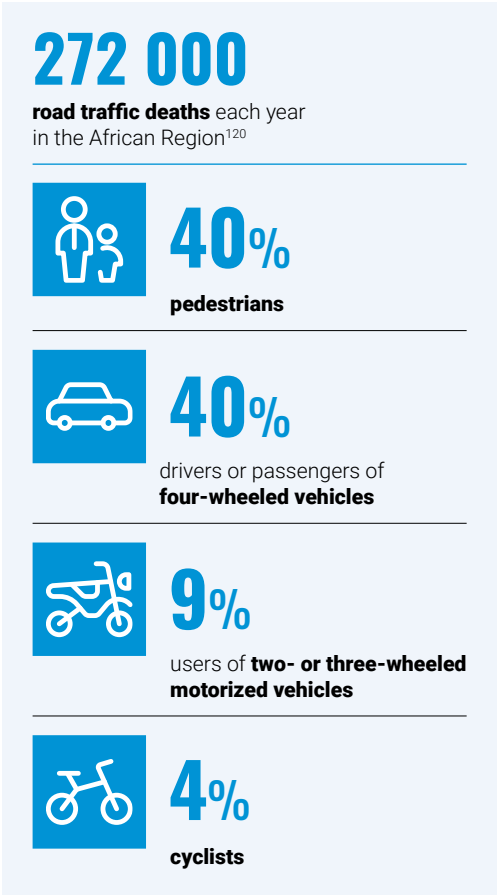


Fig. 14 Road traffic deaths in the African Region

A set of regional road safety fact sheets were published by WHO in 2019. The fact sheets highlight weaknesses in enacting laws to address key risk factors such as speeding, drinking alcohol and driving, and failure to use seat belts, helmets and child restraints.

In December 2019, WHO and the World Bank organized a regional training in Ethiopia to strengthen road safety data systems in countries. Côte d'Ivoire and Senegal improved the management of data on traffic fatalities by setting up multisectoral steering committees. WHO also supported Cameroon, Ethiopia, Ghana, Kenya, Namibia, and the United Republic of Tanzania to implement and monitor policies and strategies to reduce road traffic injuries and deaths in line with the UN Decade of Action for Road Safety 2011–2020.

117 Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
118 Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Senegal and Togo.
119 Botswana, Cameroon, Cabo Verde, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Madagascar, Mali, Nigeria, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
120 Road-user category for the remaining 7% of victims is unspecified.

4 Cross-cutting integrated action for better health

4.1 Increasing access to quality primary health care

Primary health care is the key approach to achieving universal health coverage. To support countries in achieving this goal, the WHO Regional Committee for Africa in 2019 endorsed the *Framework for provision of essential health services through strengthened district/local health systems to support UHC in the context of the SDGs*. Eritrea, Mozambique and Zanzibar are using the framework to strengthen primary health care. Planning, management and monitoring capacities have been strengthened at subnational levels in Mozambique, Sierra Leone and Zimbabwe, leading to the development of comprehensive district plans for 2020.

A range of tools and guidance documents have been developed including materials for "model" PHC districts, training modules for district health management teams (DHMTs) and a tool to rapidly assess district health service functionality for the International Health Regulations and service delivery. The latter was piloted in Cameroon and the Central African Republic. Countries used the service availability and readiness assessment (SARA) tool in health facilities and the results informed updates of health plans. Côte d'Ivoire, Eritrea and Mozambique identified the training needs of their district health management teams. In Côte d'Ivoire, the district management teams training will be organized by the end of 2020.

Integrated people-centred health services have been mainstreamed in the national health strategic plans and UHC roadmaps of the Democratic Republic of the Congo, Guinea-Bissau and Congo. Burkina Faso developed a national strategy on integrated people-centred health services, quality of care, and patient safety. Through the Global Emergency and Trauma Care Initiative (GETI),[121] Cameroon and Ethiopia developed roadmaps.

Eswatini, Seychelles and South Africa reviewed the implementation of national infection prevention and control (IPC) guidelines. Burundi, Cameroon and Chad assessed IPC capacities nationally and in selected health facilities. Zimbabwe conducted IPC assessments in 34 health facilities. Capacity-building was conducted in line with the WHO national quality policy and strategy (NQPS) process. Several Member States are now developing their NQPS. Burundi was supported to develop health-care quality norms and standards, with implementation starting in five pilot districts.

The WHO Global Patient Safety Collaborative was launched in Kenya in 2019.[122] The first World Patient Safety Day was observed on 17 September 2019 with the holding of seminars or workshops in most Member States. In October 2019 a high-level meeting was held to plan and implement an African Patient Safety Initiative with partners.[123]

121 https://www.who.int/emergencycare/global-initiative/en/
122 https://www.who.int/patientsafety/partnerships/GPS-collaborative/en/
123 Institute for Health Improvement (IHI), International Society for Quality in Health Care (ISQua), and Patient Safety Movement Foundation (PSMF).

Accelerating primary health care in Sierra Leone

To operationalize the Declaration of Astana on primary health care in Sierra Leone, the President engaged multilateral and bilateral partners, nongovernmental and civil society organizations to explore ways of harnessing the role of community health workers to strengthen primary health care (PHC). A national PHC handbook has also been developed to facilitate a standardized approach to service provision and monitoring, and to guide system changes. The country also developed an infection prevention and control reference manual, established a patient safety technical working group and celebrated the inaugural World Patient Safety Day in 2019.

4.2 Combating antimicrobial resistance

In the past year, Chad and Madagascar officially approved their multisectoral national AMR plans. Algeria and Burundi enrolled in the WHO Global AMR Surveillance System (GLASS), which so far includes 24 African countries.[124] Fifteen countries[125] reported information on the implementation of national surveillance systems in the second data call contributing to the 2020 GLASS report.[126] The data are used to monitor emerging resistant pathogens and their potential international spread, and also to inform implementation of targeted prevention and control programmes.

Forty-nine laboratories from 28 countries[127] are participating in the WHO External Quality Assurance for Antimicrobial Susceptibility Testing. Analytical skills were enhanced for a pool of 24 national trainers from 14 laboratories in Zimbabwe and 20 laboratory scientists in Zambia for the implementation of the Global protocol for extended spectrum beta-lactamase surveillance concurrently in the food chain, humans and the environment.

In line with strategies to optimize the use of antibiotics, in 2019, Congo, Gabon and Namibia updated their essential medicines lists to include the AWaRe categorization of antibiotics which enhances stewardship interventions to curb the misuse and abuse of antibiotics. National antibiotic consumption data from Burkina Faso, Burundi and Côte d'Ivoire showed that 75%, 90% and 82% respectively of antibiotic consumption in these countries was from the "Access group"[128] in line with WHO recommendations that at least 60% of antibiotic consumption be from the Access group of antibiotics as part of efforts to optimize their use.

Ten countries have established national antimicrobial consumption surveillance systems,[129] four of which contributed to the first WHO global report on surveillance of antimicrobial consumption,[130] and 15 countries carried out point prevalence surveys on antimicrobial use in hospitals, which will inform policy and stewardship interventions.[131]

124 Algeria, Benin, Burundi, Chad, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Nigeria, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
125 Ethiopia, Côte d'Ivoire, Gambia, Kenya, Liberia, Madagascar, Mali, Mauritius, Mozambique, Nigeria, South Africa, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
126 https://www.who.int/glass/reports/en/
127 Algeria, Angola, Burkina Faso, Cameroon, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Rwanda, Senegal, Seychelles, United Republic of Tanzania, Togo, Uganda and Zimbabwe.
128 The Access group refers to a collection of antibiotics that have activity against a wide range of common pathogens, and they are recommended for first or second choice empiric use because they also show lower resistance potential than antibiotics in the Watch and Reserve groups.
129 Burkina Faso, Burundi, Côte d'Ivoire, United Republic of Tanzania, Mali, Niger, Benin, Senegal, Ethiopia, Congo.
130 Burkina Faso, Burundi, Côte d'Ivoire, United Republic of Tanzania.
131 Botswana, Burkina, Burundi, Cameroon, Congo, Côte d' Ivoire, Kenya, Mozambique, Nigeria, United Republic of Tanzania, Zimbabwe, Madagascar, Mauritius, Mali, Ethiopia.

In 19 countries, first-line antibiotics now account for more than 80% of available antibiotics thanks to concerted efforts to improve selection processes and revise pharmaceutical policies.[132]

Research into, and development of alternatives to antibiotics has resulted in the development of monographs on medicinal plants with antimicrobial properties in collaboration with experts of the Economic Community of West African States (ECOWAS). These are part of the 30 monographs of the Second Volume of the West African Herbal Pharmacopoeia which will be published by the West African Health Organisation in 2020.

In November 2019, the Government of Kenya hosted a regional World Antibiotic Awareness Week (WAAW) event co-organized by FAO, OIE, WHO and the African Union Commission. The event brought together over 200 journalists to learn about the regional and national vision for AMR mitigation. It also included a high-level advocacy meeting to strengthen commitment on the implementation of national action plans and scale up coordination among partners.

4.3 Strengthening laboratory services

As part of COVID-19 readiness, the Laboratory Strategic Advisory Group (SAG-Lab) organized the supply of detection kits, sample transport media and other supplies to national reference laboratories. In early February 2020, only Institut Pasteur in Dakar and the National Institute for Communicable Diseases in South Africa had COVID-19 diagnostic capacity; now all countries have the capacity to diagnose the disease. Laboratory technicians were trained in the use of virus detection methods and laboratory data management. Through partnership with Africa CDC and other entities, there is regular monitoring of progress, sustained technical support, and a quality control system to monitor laboratory performance.

The second edition of the Guide for the Stepwise Laboratory Quality Improvement Process towards Accreditation (SLIPTA) in the WHO African Region was published in 2019.[133] The guide is the fundamental document of the SLIPTA programme, for which a memorandum of understanding with the main implementer (African Society for Laboratory Medicine, ASLM) has been developed. Guidance on harnessing the support of district and peripheral laboratories for universal health coverage was developed in 2019. Cameroon and Ghana are among the countries using the guide to improve decentralized diagnostic and laboratory services.

4.4 Improving the availability and quality of information for action

In the past year, activities focused on strengthening the African Health Observatory, the development of analytical products on health systems and sector performance, and the operationalization of the *Global Action Plan for Healthy Lives and Well-being for All*, providing countries with a data tracker on progress towards the health-related SDG targets. A report on health system performance in the Region was published in 2020 as part of progress monitoring towards UHC and the SDGs. The 2019 Atlas of African Health Statistics was also published as part of progress monitoring on SDG 3.

132 Benin; Burkina, Burundi, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Mali, Mauritius, Rwanda, Sao Tome and Principe, Senegal, Seychelles, United Republic of Tanzania, Zambia and Zimbabwe.

133 https://www.afro.who.int/publications/guide-stepwise-laboratory-quality-improvement-process-towards-accreditation-slipta-who

Through the integrated African Health Observatory (iAHO), WHO, the Bill & Melinda Gates Foundation, the European Health Observatory for Health Systems and Policies and the London School of Economics launched the development of country health system profiles, aimed at providing a detailed snapshot of health systems investments and performance areas in five countries.[134] These profiles will be published on the iAHO along with additional resources to improve primary health care system design and performance.

To strengthen evidence-informed decision-making, countries have produced comprehensive health situation and trends assessments.[135] More than 190 focal points from 15 countries[136] were trained on WHO standard packages[137] for analysis and use of health facility data.

With the increasing demand for real-time, accurate statistics on mortality and cause of death to inform policy-making, Namibia reviewed its civil registration and vital statistics system, and Liberia and Uganda were oriented on the Eleventh Revision of the International Classification of Diseases 11 (ICD-11). Six additional Member States integrated immunization data in their national health information systems and are now reporting data using DHIS2, bringing the regional total to 24 countries.[138] A COVID-19 predictive model was also developed for the Region, which details the implications of widespread community transmission of SARS-CoV–2 infection in the WHO African Region. This tool provided Member States with information needed for resource planning and implementation of non-pharmaceutical interventions aimed at flattening the curve of the epidemic.

4.5 Promoting innovation, including digital health

Scaling innovation

Building on the success of the inaugural Innovation Challenge that was launched in 2018, Member States are increasingly calling on WHO to play a coordinating role in harnessing and scaling up health innovations in the Region. This has led to the development of a regional strategy on scaling up innovations in the WHO African Region to guide the collective action of WHO, Member States and partners. In addition, to ensure a focused approach, the WHO Secretariat has since institutionalized its work on innovations and strengthened partnerships with key innovation ecosystem players in the Region and globally. In 2019, a memorandum of understanding was signed between the WHO Regional Office for Africa and the Africa Academy of Sciences (AAS) on collaboration in supporting countries to adopt and scale up locally generated innovations.

134 Kenya, Ethiopia, Nigeria, Rwanda, Senegal.
135 Angola, Cabo Verde, Chad, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, Sierra Leone, South Africa, South Sudan, Uganda, Zambia and Zimbabwe.
136 Botswana, Burkina Faso, Cabo Verde, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ghana, Guinea-Bissau, Mauritania, Namibia, Niger, Nigeria and Uganda.
137 WHO standard packages for analysis and use of health facility data https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/
138 Angola, Benin, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nigeria, Sao Tome and Principe, South Sudan, Togo, Uganda, and Zimbabwe.

Fig. 15
COVID-19 hackathon

A major outcome of the partnership with the AAS has been the award of a scaling grant made available through an AAS funding mechanism to the innovators selected from the Innovation Challenge, to support them in scaling up their innovations. WHO has further engaged with innovators on the continent to develop innovations that could be deployed for the COVID-19 response.

Advancing digital health

Consultation on the Global Strategy on Digital Health took place during the Sixty-ninth Regional Committee for Africa in 2019. A high-level training on digital health was organized for 14 Member States in Cotonou, Benin in 2019. Six countries developed and started implementing national digital health strategies.[139]

The development of an integrated digital health platform that automates all the functions of health facilities is being implemented in Kenya and Seychelles. The platform will be monitored as a pilot in these countries during the second half of 2020. The mobile health noncommunicable disease platform (BeHeathy BeMobile) will be expanded to an additional four countries in 2020, with a special focus on diabetes, cervical cancer, harmful consumption of alcohol and tobacco cessation.

Promoting research

Engagement with the African Advisory Committee for Health Research and Development (AACHRD) was strengthened in the past year, including through the first meeting of the reconstituted group in October 2019. Performance monitoring of national health research systems (NHRS) continued.

With the United States National Institutes of Health and the Bill & Melinda Gates Foundation, we were excited to announce a new partnership to develop gene-based cures for sickle cell disease and HIV. The partnership was established two months after our Regional Committee side event on sickle cell disease, attended by a global advocate for the disease, the First Lady of the Republic of Congo, Antoinette Sassou Nguesso.

Thirty proposals were funded in a small grant competition from WHO/TDR and the European and Developing Countries Clinical Trial Partnership (EDCTP) in 2019/2020. The young researchers made significant findings that will support public health interventions in the Region. For instance, there was a study on virtual community health-care facility optimization of malaria treatment in the Democratic Republic of the Congo. Another study in Ethiopia examined contact investigation as a strategy to improve tuberculosis case detection among university students. These, and other studies have relevance for programming of public health interventions in this era of epidemics and pandemics.

139 Benin, Botswana, Congo, Lesotho, Namibia and Niger.

5 Providing better support to countries

5.1 Leadership, governance and advocacy for health

Delivering at country level and intercountry support

To enhance the diplomatic, political and managerial skills of WHO heads of country offices, regional and global induction programmes were carried out, along with preparatory workshops with roster applicants to increase the success rate of regional candidates.

The availability of a WHO country cooperation strategy (CCS) is now a key indicator expected by the International Aid Transparency Initiative (IATI). In the past year, 14 countries were supported to develop a new CCS,[140] bringing the total to 26 countries with a CCS in the Region. In Benin, South Sudan and Uganda, CCSs were evaluated to assess WHO's contribution to, and influence on the national health development agenda. These evaluations led to greater use of the CCS to inform the implementation of the United Nations Sustainable Development Cooperation Framework in each country.

Reviews of the staff profiles and structures of all WHO country offices in the Region were completed in August 2019, and implementation of the recommendations is underway with the support of partners. The reviews included more than 800 responses to anonymous stakeholder surveys and 300 face-to-face consultations, including with ministers of health and senior officials of ministries of finance, planning and agriculture, UN agencies, bilateral partners, and civil society organizations.

A case for the delivery of results at country level was developed, identifying 10 critical thematic functions for WHO's country-level work in the African Region:

1. Building partnerships for UHC, leveraging United Nations reform to achieve SDG 3 targets;
2. Strengthening the functionality of district health systems to achieve UHC;
3. Building capacities for health governance at the national level;
4. Ensuring the availability of health data, information and evidence to inform decision-making;
5. Building International Health Regulations (2005) capacities, including surveillance and laboratory;
6. Strengthening health systems focusing on the health workforce, medicines and supplies regulation, and supply chain management;
7. Addressing health financing including sustainable strategies and efficient use of resources;
8. Engaging key sectors to address noncommunicable diseases and their risk factors, preventing deaths among mothers and improving adolescent health;
9. Ensuring effective operational support; and
10. Sustaining Regional Office support to implement the critical thematic functions.

140 Burkina Faso, Burundi, Cabo Verde, Congo, Eritrea, Ethiopia, Ghana, Mali, Namibia, Liberia, Mali, Mozambique, Senegal, Togo.

Efforts are underway to accelerate implementation of the review recommendations, including a prioritization exercise for human resource implementation support, rosters for key functions, and development and implementation of an integrated strategy to foster delivery at country level.

Enhancing external relations and partnerships

Action continued on building and maintaining effective and impactful collaboration geared towards common goals. Bilateral meetings were held with the Governments of Denmark, France, Japan, Morocco, the Netherlands, Norway, Qatar, Sweden, the United Kingdom, and the United States of America, and with the African Union Commission and the Bill & Melinda Gates Foundation. Outcomes of these meetings included setting an agenda for enhanced collaboration between France and WHO, and a memorandum of understanding (MOU) between the African Union Commission and WHO.

In August 2019, a two-year WHO–Africa CDC joint workplan was agreed, to streamline and coordinate actions to improve health security in Africa in line with the MOU between WHO and the African Union Commission. Joint technical working groups were also established to facilitate information exchange and development of joint products. As part of the implementation, a framework for cross-border collaboration on Ebola control was agreed by the Democratic Republic of the Congo and its nine neighbours.

To enhance engagement with regional economic communities, the Regional Director has nominated WHO representatives as liaisons based on proximity to their headquarters: that is, for SADC headquartered in Botswana, ECOWAS in Burkina Faso, and the Intergovernmental Authority on Development (IGAD) and the East African Community (EAC) in Kenya. The WHO Representative in South Africa continued to represent the Region in discussions with the BRICS countries.

An MOU was signed between the East African Community Secretariat and the Regional Director, and a strategy for cross-border collaboration in the subregion in the context of COVID-19 was developed. WHO engaged with members of the Pan-African Parliament on UHC, including maternal mortality, health security (Ebola and coronavirus) and noncommunicable diseases. WHO also provided technical guidance to the UN Economic Commission for Africa on the pharmaceutical initiative and collaborated on civil registration and vital statistics to jointly increase the capacity of Member States to generate mortality statistics.

WHO's active collaboration with partners of the Harmonization for Health in Africa (HHA) initiative led to important achievements in governance and health financing that will help countries in their march towards UHC. Practical guides on value for money in health and public-private collaboration were developed for decision-makers and managers.

The first official visit of a WHO Regional Director for Africa to Japan, took place in August 2019 for the Tokyo International Conference on African Development (TICAD7). During this event, HHA partners held a side event with ministers of health and the African Union Commission on the urgent need for better coordination of action to achieve UHC and efforts to strengthen health security.

Implementation of the WHO Framework of Engagement with Non-State Actors (FENSA) continued, including the development of a "one-stop shop" document for WHO staff to facilitate easy access to tools, guidelines, and standard formats for each type of collaboration. These efforts contributed to an increase of 73% (from 49 approved engagements with non-State actors in July 2019 to 85 in June 2020) in engagement with non-State actors.

Innovative approaches for WHO governing bodies

The WHO Secretariat continues to strive to improve the methods of work of the governing bodies and to support Member States in their oversight role. In March 2020, the Secretariat published the first edition of the WHO Regional Committee for Africa: Guide for Member States and other participants. The document provides guidance to Member States and other participants on preparing for and effectively participating in sessions of the WHO Regional Committee for Africa.

The Sixty-ninth session of the Regional Committee for Africa nominated Dr Matshidiso Moeti for a second term as the Regional Director for Africa. The nomination was endorsed by the 146th session of the Executive Board in February 2020. The election was held following the adoption of the Code of Conduct for the nomination of the Regional Director, which has been instrumental in continuing to promote a transparent, equitable and open nomination process.

The scheduling of the governing body sessions was severely disrupted by the COVID-19 pandemic. Informal consultations and meetings were cancelled at global and regional level and a major effort was made to replace some with virtual meetings.

Proactive WHO communications

Significant progress continues to be made in enhancing external communication towards achieving the GPW 13 triple billion targets. A new strategy that is oriented more towards proactive rather than reactive communication is expanding audience reach and lifting product quality, leading to higher visibility for WHO and strengthened advocacy on key health issues.

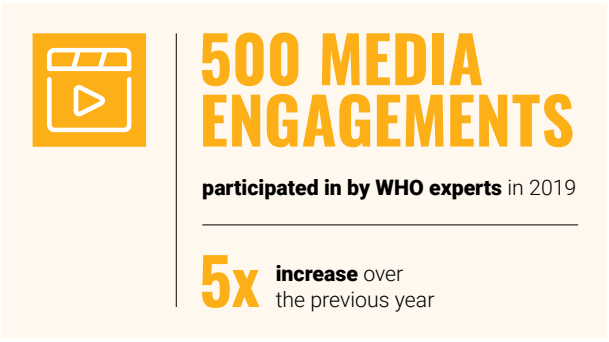
To step up coverage of WHO's work at country level,18 country communication focal points were trained in November 2019 in feature writing, photography and social media. Collaboration is ongoing to increase multimedia production from the field.

A studio which had fallen into disuse in recent years underwent technical improvements in August 2019, enabling the space to once again be used to record and edit multimedia products. The communications team was able to conduct its first Facebook live sessions in the Regional Office as well as produce dozens of social videos, video messages and media interviews.

Between June 2019 and June 2020, followers on Twitter @WHOAFRO grew by 500% (160 000 new followers) and those on @MoetiTshidi more than quadrupled to 25 000. On Facebook (WHOAFRO), engagement has largely been driven by increases in followers, clearer messaging, use of quality images as well as the use of a wider variety of multimedia visual content such as infographics, GIFs and animations. The account now boasts 250 000 followers, up from 20 000 in June 2019.

In 2019, the social media-driven advocacy campaign for young people known as #TheTeaOnHIV was used to educate adolescents and young people about HIV and to fight stigma. The campaign reached 1.7 million young Africans.

Fig. 16
WHO media engagements



WHO experts participated in around 500 media engagements, a five-fold increase over the previous year. WHO spokespeople featured on SABC, AllAfrica.com, Jeune Afrique, BBC Afrique, BBC Focus on Africa, New York Times, BBC World Service, Radio France Internationale, France 24, Der Spiegel, Le Figaro, Voice of America, CNN, Le Monde, Associated Press, NBC, Bloomberg, CGTN and Deutsche Welle, among others. Media relations have also deepened, with WHO, for instance, featuring in various programmes within a single media house – global and regional.

The WHO Regional Office for Africa website saw impressive growth in the number of visits. Website users between June 2019 and May 2020 rose by 200% to three million and page views increased by 114%. Audience reach through Poppulo, the newsletter distribution platform, has also improved. Around 1.2 million messages were sent through the Poppulo Stakeholder Engagement platform between June 2019 and May 2020, with subscribers doubling to almost 28 000. Health and foreign ministers, donors, embassies and media houses are among the main audience.

The communications unit has since February 2020 produced a weekly COVID-19 newsletter featuring top-line press releases and feature stories, infographics and videos highlighting the efforts countries in the Region are making and challenges in curbing the spread of the virus. The COVID-19 newsletter has recorded an average open rate of 60%, including forwarded messages.

Additionally, since March 2020, with the support of the World Economic Forum, the Regional Office has held weekly virtual press briefings on the COVID-19 pandemic led by the Regional Director and a panel of experts. The briefings have drawn hundreds of reporters from across the world, tens of thousands of live viewers, and addressed key questions about the response in the Region.

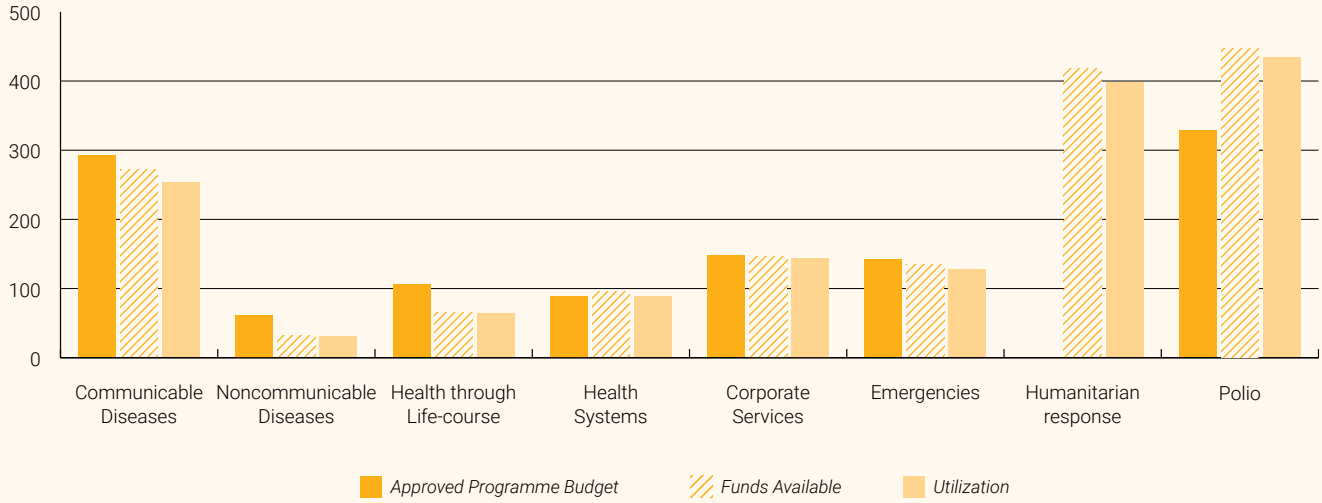
5.2 Financial, human and administrative resources managed effectively

In the context of the COVID-19 pandemic, business continuity planning was scaled up in all offices across the WHO African Region. These plans have been activated and implemented in line with the severity of the risk posed by COVID-19 in each country context. With restricted movement and travel, the General Management Cluster has supported staff to transition to teleworking arrangements. Support provided included increased use of cloud-based technologies and seamless remote simultaneous interpretation for virtual trainings and meetings.

Implementing the WHO Programme Budget 2018–2019 and 2020–2021

The reporting period includes part of the last year of the *WHO Programme Budget 2018–2019* and the first half of the first year of the *WHO Programme Budget 2020–2021*.

Fig. 17
Approved Programme Budget for the African Region, 2018–2019 (US$ Millions)
(as of 31 December 2019)



By the end of the 2018–2019 biennium, 89% (US$ 741.9 million) of the WHA-approved base budget (US$ 834.1 million) was funded and 85% (US$ 707.1 million) had been implemented. Compared to 2016–2017, the base budget increased by 11%.

WHO's work on health system strengthening and communicable diseases was well-funded through specified contributions. Work on noncommunicable diseases remains chronically underfunded, despite being a high priority for Member States. Shortfalls restrained the Organization's capacity to support countries in this critical area. Flexible funds account for 34% (US$ 281.6 million) of the US$ 834.1 million base segment and their utilization for underfunded areas was prioritized.

Humanitarian response plans and other appeals, being event-driven in nature, did not have a predetermined budget. Over the biennium, US$ 500.4 million was allocated, of which 83.4% (US$ 417.5 million) was financed by December 2019.

Fig. 18
Approved Programme Budget for the African Region, 2020–2021 (US$ Millions)
(as of 30 June 2020)

Segment	Category	Approved Programme Budget	Funds Available	Utilization	Funding available as % of Approved PB	Utilization as % of Approved PB
Base budget	Universal Health Coverage	358.4	185.4	64.2	52%	18%
	Emergencies	282.5	118.3	62.2	42%	22%
	Health and well-being	111.5	17.8	6.5	16%	6%
	Effective WHO	240.0	102.0	46.4	43%	19%
Outbreak and crisis response	Humanitarian response	274.0	249.6	152.7	91%	56%
Polio		252.8	141.5	71.5	56%	28%
Base total		**992.4**	**423.5**	**179.3**	**43%**	**18%**

The base segment of the approved Programme Budget 2020–2021 increased by 19% (US$ 158.3 million), compared to 2018–2019. The increase will support regional priorities, which are: to strengthen WHO's capacity to deliver impact in countries; to transition polio assets and mainstream essential public health functions such as polio surveillance, immunization, containment and preparedness and response into the base budget; to expand WHO's work in data and innovation; and to ensure financing for the UN reform levy to support the strengthening of the Resident Coordinator system.

The COVID-19 pandemic has resulted in imbalanced financing and implementation of Programme Budget 2020–2021. As of 30 June 2020, forty-three per cent of the base segment was funded in comparison to 91% for the humanitarian response segment. Implementation is being closely monitored and workplans are being reviewed in the context of COVID-19 to ensure optimal implementation of the Programme Budget.

To contribute to enhanced delivery of GPW 13, strategic approaches have been adopted, including the reprioritization and reprogramming of targets, budgets and resources by all budget centres as part of semi-annual reporting, alignment of programmatic KPIs to GPW 13 and harmonization with COVID-19 indicators, institutionalization of joint programme management, establishment of output delivery teams, recruitment of country-level programme management officers and fostering of a region-wide culture of value for money.

Improving compliance and accountability

Progress was achieved in strengthening risk management across the Region, and this was supported by an external audit evaluation of the improving quality of risk registers and the more inclusive approach to risk management processes conducted in budget centres. The most significant risks include: lack of sustainable funding for programmes; political instability and/or limited capacity or commitment of Member States; security of staff and premises; misalignment of resources with strategic priorities. The effectiveness and timeliness of mitigation plans have been enhanced through periodic assessments. Further attention will be given to capacity building of technical staff and to more fully integrating risk management with planning and monitoring.

Managerial key performance indicators (KPIs) continued to be used to monitor, measure and reinforce internal control and compliance mechanisms, individual and team performance as well as efficiency and timely delivery of services. In relation to Programme budget implementation, use of KPIs led to closer monitoring of awards, faster and more effective implementation of available resources with reduced risks, reductions in overspending, and better relations with donors.

With the COVID-19 pandemic, fast-tracking and recording of income enabled prompt allocation of resources to countries. This made it possible to take swift action for preparedness and response at country level.

In May 2020, there were 38 outstanding reports for direct financial cooperation (DFC), representing 4% of the total DFCs issued in 2018–2019, and 1% of the value of all DFCs. This is a reduction from 6% in 2019.

In ensuring sound cash management at country level, support from the Regional Office improved compliance with imprest account reconciliation requirements. The

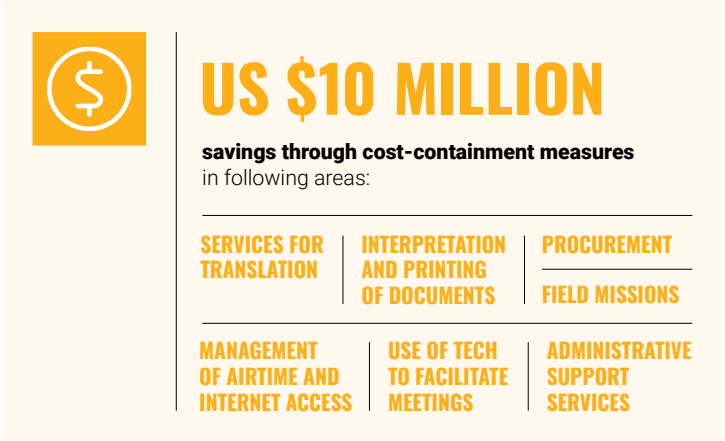
compliance rate increased from 96% in 2018 to 99% in 2019, slightly below the target value of 100% reconciliations with no outstanding item over 90 days.

Audits by the Office of Internal Oversight Services (IOS) were conducted in the Central African Republic, the Democratic Republic of the Congo (including the Ebola response) and Kenya. There were no unsatisfactory audit results, for the fourth year in a row. In 2019, external audits of financial statements were conducted in WHO country offices in Nigeria, Uganda and the WHO Regional Office for Africa with no major issues identified.

In 2019–2020, due diligence assessments of WHO were conducted by DFID in the Regional office, Democratic Republic of the Congo, Ghana, Liberia, South Sudan and Uganda as a prerequisite for continued support for regional and country operations. The assessments confirmed the robustness of WHO systems, with sound management policies and effective internal controls and accountability mechanisms. DFID noted improvements in safeguarding measures in operations and further integration of risk management in the planning and implementation of programmes.

To ensure every single dollar spent by WHO translates into advancing outputs and outcomes, WHO has been implementing the value-for-money principle since 2018. In the African Region, WHO has developed a value-for-money policy framework, designated champions to support staff in implementing this approach, and conducted training-of-trainers workshops.

Fig. 19
Cost-saving and cost-containment measures



Cost-saving and cost-containment measures have led to savings of at least US$ 10 million in the past year, in services for translation, interpretation and printing of documents; procurement; management of airtime and internet access; use of technology to facilitate meetings (Zoom, MS Teams, WebEx and Skype for business); administrative support services (travel, asset management, utilities); and field missions.

Ensuring staff safety, security and well-being

Rapidly changing security environments and fluctuating threat levels in many African countries require significant support, investment and constant and detailed monitoring.

Investments have been made from the global security fund, increasing the level of operational security in 18 high-security-risk countries in the Region. Investments have focused primarily on strengthening the security infrastructure and communications to improve compliance with United Nations Department of Safety and Security (UNDSS) operating security standards.

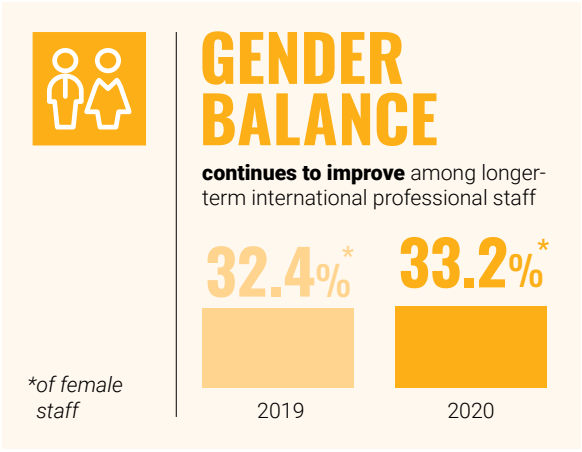
The Ebola outbreak in the Democratic Republic of the Congo required extensive security support as the Organization was operating in a conflict-affected area, in collaboration with the UNDSS, the United Nations Organization Stabilization Mission

in the Democratic Republic of the Congo (MOUNSCO) and other UN system partners. As in any conflict area when providing humanitarian support, there is a very fine balance between ensuring the safety of humanitarian personnel and getting the support of the people who need it. The deployment of a team of international and local security officers helped WHO to find that balance and facilitate contract tracing and immunization in remote and hard-to-reach locations.

Empowering staff and striving for gender parity

In the African Region, WHO continues to invest in recruiting, retaining and developing our staff as part of the regional Transformation Agenda. Gender balance continues to improve among longer-term international professional staff, increasing from 32.4% in 2019 to 33.2% in 2020.

Fig. 20
Gender balance



The *Africa Young Women Health Champions* Initiative was jointly launched by WHO and the United Nations Volunteers in March 2020 to identify and develop early to mid-career African professionals to build global health skills and competencies. The target is to recruit 100 UNVs and so far, 12 have been recruited (83% female).

In line with the ongoing functional review and restructuring across the Organization in the Region, the Human Resources team guided managers in implementing recommendations and supported staff through a series of career counselling sessions.

More connected, through information and communication technology management

Continuous improvements are being made to the IT services and tools used by WHO in the African Region. These include electronic workflows for document clearance, resulting in better tracking, secure archiving, and reduced use of paper.

Use of cloud-based technologies for internal and external meetings has scaled up significantly in the first half of 2020, in the context of the COVID-19 pandemic.

Enhancing multilingualism

In the past year, the drive to improve value for money in translation, interpretation and printing services was sustained. Measures introduced in 2018 to recruit more local interpreters, pair senior interpreters with junior interpreters, and review the remuneration scale for translation services continued to yield significant cost savings of more than US$ 460 000.

The introduction of computer-assisted translation and terminology (CATT) tools (Memsource, and the imminent roll-out of the eLUNa system designed specifically for UN agencies) will enhance the quality and consistency of translations, while opening up prospects for additional cost and time savings by making all previous translations immediately available and accessible.

Strong operational support

Support for the organization of intercountry meetings, conferences and trainings resulted in 682 events being convened in the past year. These events brought together more than 12 500 participants to advance strategic and technical priorities to improve public health in Africa.

The H-CORPO project launched in pilot cities in the African Region resulted in cost containment in excess of US$ 1.43 million.

At the WHO Regional Office for Africa, the compound is made up of the main office building and 124 villas and apartments for staff. Several renovation projects are ongoing, including installation of a new chilled-water air-conditioning system, upgrading of sanitary facilities and water systems, and replacement of broken elevators in the main building. Three high-capacity inverters have been purchased and installed to improve the autonomy of the internet connection.

A study to determine the presence or absence of asbestos found traces of asbestos, which do not present a danger. A mapping of their location is underway, and precautions will be taken in removing them. Greening of the campus is also ongoing, through planting of more than 200 trees in the past year, and an annual target to plant 100 trees up to 2025. The Regional Office's fleet renewal plan continues and has improved the comfort and visibility of the Organization.

With the launch of the fleet management project in a few pilot countries in the Region, trackers have been installed in vehicles, providing reliable statistics and improving the operational safety and efficiency of WHO ground transportation. WHO country offices in collaboration with UNICEF are now disposing of obsolete assets, through public auction in many countries. This has resulted in a return of over US$ 500 000.

Conclusion and looking ahead

The COVID-19 pandemic continues to take a heavy toll on individuals, societies and economies in Africa and globally. Suppression of the virus is the goal, but we need to acknowledge the challenges of balancing this goal against the economic impacts it entails. As we adjust to the new normal, countries, with the support of WHO and other partners, should continue scaling up effective public health capacities and very critically ensuring knowledgeable and enabled individuals adopt the behaviours that minimize the spread of the virus.

Action on preparing for a rapid roll-out of any vaccine that becomes available is going to start now on the regulatory aspects and delivery planning, in addition to continuing advocacy for equity in access, and working with Member States for their engagement in all mechanisms aimed at achieving equitable access.

This crisis is also an opportunity to build health system resilience and enhance access to health care for vulnerable groups. The year 2020 holds the potential to constitute a turning point towards greater solidarity, science and equity.

In the coming year, WHO will continue to work with Member States and partners towards ensuring that everyone, everywhere has access to health care without incurring financial hardship. This will include responding to the needs of different population subgroups, continuing efforts to eradicate, eliminate, control and prevent diseases, and promoting population well-being by addressing the determinants of health.

With 10 years to go until the deadline for achieving the Sustainable Development Goals, progress towards some health-related targets is off-track and threatens to be further derailed by ongoing disruptions. The same urgency, all-of-government and all-of-society approaches used for COVID-19, should be used to accelerate action on global goals, thereby saving lives and advancing national development and economic growth. WHO in the African Region is committed to continue working with Member States and partners towards achieving these goals.

Annex. Recent publications by WHO in the African Region

Caboré, Joseph et al. The potential effects of widespread community transmission of SARS-CoV–2 infection in the World Health Organization African Region: a predictive model, BMJ Global Health, Vol. 5, Issue 5, 2020
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Loua, André et al. A review of policies and programmes for human organ and tissue donations and transplantations, WHO African Region (28 April 2020), Bull World Health Organ 2020;98:420–42
https://www.who.int/bulletin/volumes/98/6/19–236992.pdf

Mwenda, Jason et al. Pediatric Bacterial Meningitis Surveillance in the World Health Organization African Region Using the Invasive Bacterial Vaccine-Preventable Disease Surveillance Network, 2011–2016, Clinical Infectious Diseases® 2019;69(S2):S49–57 DOI: 10.1093/cid/ciz472

Ousman K et al., The impact of Infection Prevention and control (IPC) bundle implementation on IPC compliance during the Ebola virus outbreak in Mbandaka/ Democratic Republic of the Congo: a before and after design. BMJ Open. 2019; 9(9): e029717. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6731777/

Talisuna A et al., Joint external evaluation of the International Health Regulation (2005) capacities: current status and lessons learnt in the WHO African region, BMJ Glob Health. 2019; 4(6): e001312. Published online 2019 Nov 1.
doi: 10.1136/bmjgh–2018-001312

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