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THE WORK OF WHO IN THE AFRICAN REGION 1998-1999

BIENNIAL REPORT OF THE REGIONAL DIRECTOR TO THE REGIONAL COMMITTEE FOR AFRICA

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Harare, Zimbabwe

The Regional Director has the honour to present to the Regional Committee the report on the activities of the World Health Organization in the African Region during the period 1 January 1998 to 31 December 1999

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PREAMBLE

The Regional Director's Annual Report on the Work of WHO in the African Region, which was presented to the forty-ninth session of the Regional Committee, followed the new format that the Committee endorsed at its forty-seventh session for presenting annual reports *in a non-budget year*. In view of the Regional Committee's warm appreciation of the clarity and reader-friendliness of the Annual Report in its new format, the Secretariat decided to adopt the same format for this biennial report, although this is *a budget year*. The new presentation is expected to facilitate consideration of the report and the deliberations of the Regional Committee .

This report is presented in three parts. Part I contains the 1998-1999 biennial report of the Regional Director. It addresses important aspects of the results of the biennial evaluation which should be brought to the attention of the Regional Committee. It is important to add that Part I has three sub-parts. The first reports on the evaluation of the work of WHO at country level; the second evaluates the work of WHO at regional and inter-country levels; the third is the overall conclusion of the evaluation report.

Part II sets forth the progress made in the implementation of programme-specific resolutions adopted by the Regional Committee at its earlier sessions and for which reports are due at the fiftieth session. These programmes are emergency and humanitarian action (resolution AFR/RC47/R1); human resources for health (resolution AFR/RC48/R3); research policy and coordination (resolution AFR/RC48/R4); and oral health (resolution AFR/RC48/R5).

Finally, Part III reports on the situation of the WHO Regional Office in Brazzaville, Congo.

PART I

THE WORK OF WHO
IN THE AFRICAN REGION

INTRODUCTION

1. It should be noted that 1998-1999 covers the second biennial period of the Ninth General Programme of Work (1996 - 2001)

2. It should also be recalled that when the 1998-1999 Programme Budget and the corresponding plans of action were being developed, the main thrusts foreseen for WHO's collaboration with Member States were namely, health sector reforms to improve the functioning of health systems and the health status of the populations; development of human resources for health; prevention and control of communicable diseases; response to emergencies and epidemics; reproductive health; acceleration of child survival strategies and initiatives; health promotion and advocacy; and fostering greater coordination among health development partners at country and regional levels.

3. On assumption of duty, the new Director-General of the World Health Organization, Dr. Gro Harlem Brundtland, re-defined the priorities of WHO at the global level and reorganized the structure at headquarters accordingly. The reorganization led to the creation of nine clusters in addition to the Director-General's office. The Regional Office then made changes in its structure and functions in order to align itself with the reforms introduced at headquarters, and also to respond to the pressing problems encountered in health development in the African Region.

4. The new Regional Office structure lead to new thrusts being added to those defined during the preparation of the 1998-1999 Biennial Programme Budget and the corresponding plans of action. These thrusts were prevention and control of noncommunicable diseases; malaria; HIV/AIDS and tuberculosis; and poverty reduction and sustainable development.

5. Lessons learnt in the course of evaluating the implementation of the 1996-1997 Programme Budget and its corresponding plans of action guided the implementation of the 1998-1999 Programme Budget and the corresponding plans of action for regional, intercountry and country level activities. In other words, efforts were made to build on the factors that facilitated implementation and to overcome constraints. The efforts did yield dividends because about 80% of the overall expected results, including those at both country and Regional Office levels, were fully or partially achieved. Also, the budget implementation rate at both country and Regional Office levels was 100% (see Annex 1). These achievement levels in relation to expected results and the budget implementation rate were much higher than the levels attained during the preceding biennium.

6. At the country level, the factors that facilitated implementation (as contained in Annex 2) included decentralization and delegation of authority; good technical support by the Regional Office; stronger country support teams (in terms of their dedication, commitment, team spirit, good follow-up of programmes, pivotal role of WHO country representatives); high quality planning; effective partnerships; effective collaboration and communication between WHO country offices and national authorities; favourable political and development agenda including availability of national policies, plans and legal frameworks; and strengthened capacity in ministries of health, including training of national programme managers. Factors that impeded implementation at country level included the limited capacity in WHO country offices; planning that included too many priority programmes; additional activities and apportionment of funds between activities; limited financial resources; overlap with other national activities; limited knowledge of the WHO managerial process and procedures; weak communication and collaboration with national authorities; political instability; changes in government priorities, policies or leadership in the ministry of health; and weaknesses in the ministry of health.

7. At the Regional level, the factors that facilitated implementation (as contained in Annex 2) included

availability of relevant frameworks and technical tools; increase in human resources for some programmes; successful mobilization of financial resources; restructuring of WHO; team spirit; better collaboration between units and divisions; delegation and decentralization; improved partnerships; existence of inter-country teams; better communication and collaboration with countries; and greater commitment and increasing requests on the part of Member States to implement some activities and initiatives. The factors that constrained implementation, on the other hand, included the temporary relocation of the Regional Office; frequent mobility of WHO staff; limited human and financial resources for some programmes; weak planning process including joint planning with countries; weak coordination within the three levels of the Organization; absence of or delays in responses from countries; and political instability in some countries.

8. It is important to add that the evaluations of WHO country programmes were conducted in close collaboration with national authorities. Relevant detailed reports were submitted by each country and each division at the Regional Office.

THE WORK OF WHO AT COUNTRY LEVEL

ALGERIA

Introduction

1. The 1998-1999 biennium coincided with the end of the political crisis in the country. Institutional stability resulted in an improvement in the health situation of the country and the revival of its health system. The Committee for the selection, follow-up and evaluation of cooperation projects with WHO was chaired by the Secretary General of the Ministry of Health and Population and comprised members from all the central departments of the Ministry of Health and institutions under its supervision. The Committee conducted, with the participation of WHO Liaison Office, a quarterly evaluation of the projects using the monitoring and evaluation indicators jointly adopted with the institutions responsible for WHO projects.

Achievements

2. During the biennium, the reform activities launched during the previous biennium were pursued with the support of WHO. They included the reform of the National Health Information System; decentralization and regionalization of health activities; continuous training in public health; support to surveys; assistance to ensure safe blood transfusion; school health and the strengthening of information and communication. New avenues that were in line with the objectives and targets pursued by WHO during the biennium were explored. They mainly concerned contracting services, provision of supplies and support for activities to monitor the side effects of drugs, development of initiatives to monitor chemical hazards and strengthening of the integrated management of noncommunicable diseases.

Analysis

3. Factors that facilitated achievements included the setting up of a committee for the monitoring and evaluation of progress in the implementation of WHO/Algeria technical cooperation programme; regular meetings of the Committee; direct contact between WHO and the project managers; and training of the WHO Liaison Officer and the Administrative Officer. Constraining factors included delays by the project managers in providing relevant documents for processing requests; insufficient human resources in the Liaison Office; and delays in the delivery of orders coupled with incomplete deliveries.

Conclusion

4. In order to further facilitate and enhance the implementation of the technical cooperation programme in the next biennium, it is important to improve the monitoring system, the WHO supply system and coordination and complementarity among partners in order to avoid duplication and inefficient use of resources. It will also be necessary to ensure that activities included in the technical cooperation programme are consistent with national priorities.

ANGOLA

Introduction

5. The implementation of transition and rehabilitation programmes, which followed the restoration of the peace process, stalled. Security became a major obstacle to the accessibility of some segments of the population to basic health services, particularly in the rural areas. This situation drastically reduced health care coverage throughout the country, resulting in outbreaks of epidemics, an increase in incidence of endemic diseases and malnutrition, especially among displaced persons and other vulnerable groups.

Achievements

6. WHO increased its involvement in health policy formulation and review and focused attention on health sector reform. Municipal health management capacity was strengthened, a national policy human resources for health was formulated, a nursing training programme was reformulated while national capacity was strengthened through the award of fellowships for training within and outside the country.

7. The goals of attaining 80% in correct management of acute and complicated cases of malaria in all referral units and reducing mortality by 30% were nearly achieved. Reproductive, family and community health received attention by way of training nurses, midwives and supervisors, particularly in safe motherhood techniques. WHO assisted the national Tuberculosis programme in coordinating control activities. Ministry of Health capacity was strengthened to facilitate the implementation of water supply and sanitation projects and the surveillance of water quality. The 2000-2002 National Strategic Plan, formulated through wide stakeholder participation, was approved by the National Assembly.

8. The national policy on blood transfusion was approved; laboratory technicians were trained in blood screening; HIV screening was established in seven provincial hospitals; better diagnosis and management of sexually transmitted diseases (STDs) using the syndromic approach was achieved; care management and counselling of people living with AIDS was improved. WHO supplied blood bank equipment, including HIV test kits, to the worst affected provinces .

9. Guidelines for the management of malnutrition during emergencies were prepared. The health and nutritional situation of displaced persons was a major focus of attention. The emergency response programme was decentralized and extended to all provinces to ensure rapid intervention during emergencies.

10. Epidemiological surveillance was strengthened throughout the country. As a result of the meningitis epidemic outbreak which occurred in the provinces of Bie, Huambo and Malanje and also the poliomyelitis epidemic outbreak in the provinces of Luanda, Bengo and Benguela, the Regional Office sent three consultants to strengthen the national expanded programme on immunization. The national immunization days (NIDs) achieved great success in spite of the unfavaourable environmental condition in the country. The investigation of cases of suspected acute flaccid paralysis (AFP) was conducted.

Analysis

11. Factors that facilitated achievements included close collaboration between WHO and Ministry of Health; frequent meetings with the Minister and programme directors to ensure timely implementation and follow-up of activities; delegation of authority to the WHO representatives to issue stickers; improved communication with all levels of WHO; prompt response to requests by the Regional Office; and transparency in the implementation of the Plan of Action. Factors that constrained achievements were: reversal of the peace process; frequent changes in Ministry of Health top management; low staff morale due to low salaries and late payment; low absorptive and response capacity of some programmes; poor communication between central, provincial, and municipal levels in the country.

Conclusion

12. The future of the WHO/Angola technical cooperation programme will depend on the evolution of the peace process and the consolidation of recent gains. WHO will have to continue providing leadership to support the Ministry of Health to clearly define priorities, draw appropriate strategic intervention plans and mobilize necessary resources to deal with priority health problems. There is also need to ensure that

health is placed at the centre of all reconstruction and development initiatives, including poverty eradication.

BENIN

Introduction

13. Sources of information for this evaluation included the activity reports of the Ministry of Health, biennial and mid-term reports on the implementation of the Plan of Action, reports on activities carried out as well as various surveys undertaken, reports of meetings of the WHO country team and direct observations.

Achievements

14. The achievements during the biennium included the effective consultation with NGOs operating in the area of health; training of women's groups to enable them to take care of their own health; drawing up and providing epidemiological profiles and scientific information to zonal hospitals; provision of direct support for the management of two districts and for the process of establishing health zones; participation in the conduct of health sector analysis to produce a health sector development plan; continuation of the training of medical and paramedical staff; development of a national blood transfusion policy; compilation of the directory of medicinal plants and traditional healers; provision of support to the reproductive health research centre and conduct of female genital mutilation (FGM) awareness campaigns in two of the most affected districts; updating of school health policy; and revitalization of community-based rehabilitation programmes.

15. There was remarkable improvement in the management of epidemic diseases through an effective alert system and the development of a national plan. Surveillance activities were carried out at the country's borders with Niger and Burkina Faso. The AIDS prevention and control programme was better structured and HIV case management was introduced with the involvement of the civil society. The integrated management of childhood illness (IMCI) strategy was adopted. Progress was made in the effort to eradicate guinea worm disease. Existence of the wild poliovirus was discovered, leading to the conduct of a large-scale mopping up campaign and the decision to carry out four rounds of NIDs in the year 2000. The Roll Back Malaria (RBM) Initiative is being introduced while activities of the accelerated malaria control programme were pursued.

Analysis

16. Factors that facilitated implementation were the effective collaboration between Government and health development partners; appointment of a Permanent Secretary in the Ministry of Health, which helped to improve coordination of activities; creation of a new ministry in charge of planning and coordination of government action, which broadened inter-sectoral consultation on health issues; improved team spirit at the WHO country office; regular meetings for work planning and review; organization of an annual retreat; and delegation of authority to issue stickers at the country level. The personal involvement of the Head of State in health actions helped to raise the visibility and importance of the health sector.

17. However, the lack of a comprehensive framework for overall planning of health activities was a major drawback. Also worth noting is the difficulty in determining the real impact of cooperation activities on health indicators. This sometimes raised the question of whether the planned activities reflected the country's actual needs. The tendency to request disbursement of country budget funds for other activities initiated by the Regional Office often posed constraints. Fellowships management

by both WHO and the Government did not really improve.

Conclusion

18. Compared to the previous biennium, and notwithstanding the foregoing, there was significant improvement in the management of the cooperation programme by both the Government and the WHO country team. What still needs to be improved is the identification of cooperation priorities. The formulation of a health sector development plan, clearly defining the priorities for the next five to ten years and the indicators to be specifically monitored, would enable WHO cooperation activities to address more clearly the health concerns of the people.

BOTSWANA

Introduction

19. The 1998-1999 biennium was a transition period in WHO's technical cooperation with Botswana because of the new approach which involves greater participation of nationals in the planning, monitoring and evaluation of the Plan of Action. During the biennium the need was recognized to better focus WHO's technical cooperation on limited programme areas in order to achieve greater impact. The present evaluation was based on the following documents: the 1998-1999 Plan of Action; semi-annual monitoring reports; quarterly financial monitoring reports; and programme reviews such as those of the tuberculosis and malaria programmes.

Achievements

20. The major achievements included the revision of the health manpower plan; conduct of a national workshop in emergency preparedness for district health teams; successful organization of school health competition in four districts; awareness training of twenty-five executives in occupational health hazards; organization of consultative and planning meetings for environmental health officers; provision of health education materials; introduction of IMCI; achievement of immunization coverage of above 90% for all antigens; review of the Tuberculosis programme and implementation of its recommendations; production and dissemination of the sixth edition of the national Tuberculosis control manual; and revision and printing of guidelines on the management of HIV/AIDS.

Analysis

21. There was continuous reprogramming of activities throughout the 1998-1999 biennium. The WHO Country Office allowed some degree of flexibility which made it possible to divert funds allocated to some planned activities to unplanned but important requirements in order to meet evolving national needs. Lack of regular financial monitoring of the implementation of activities largely contributed to discrepancies between projected and actual expenditures. Budget estimates during the planning process were consequently not always accurate, resulting in many cases, in some substantial cost variations in the implementation process.

Conclusion

22. A number of lessons were learnt in the implementation and evaluation of the biennial plan of action. There is a need to involve nationals in the planning process from the early stage, as was the case for the 2000-2001 programme budget. Budget allocation for the various activities should be as accurate as

possible during the development of the Plan of Action. Reprogramming of activities, allowed by the WHO Country Office during the biennium, may be unnecessary in the future because of greater involvement of programme managers in the planning process. Unplanned or additional activities should exceptionally be allowed only when justified. Implementation of activities should be closely and regularly monitored during the entire biennium in accordance with expected results and budget estimates.

BURKINA FASO

Introduction

23. The 1998-1999 technical cooperation programme was developed in line with the priorities selected by the Ministry of Health, following Government's orientations and the relevant resolutions of the Regional Committee. The programme thus focused on the health policies and strategies, promotion of safe motherhood, health education and communication, healthy environment and control of major local epidemics and endemic diseases.

24. The biennial evaluation sought to assess the level of success achieved in the implementation of the Plan of Action in order to improve subsequent planning. The evaluation was based on activity reports of both national coordinators and WHO programme officers whose work plans were drawn up within the context of the WHO cooperation programme, the Plan of Action of the Ministry as well as quarterly and annual reviews.

Achievements

25. The major achievements recorded during the biennium were as follows: a great boost to health research activities due largely to the technical and financial support provided by the Ministry of Higher Education and Scientific Research as well as partners including WHO; operationalization of health districts; strengthening of the hygiene training programme in the girls' training centres based in Niassan and Debe; public awareness of problems of mental ill-health, diabetes and tobacco use; development of community-based malnutrition monitoring mechanisms and tools; full application of directly observed treatment short course (DOTS) in the management of identified tuberculosis cases; more comprehensive presentation of epidemic case notification reports; prompt and effective response to all epidemics; substantial mobilization of financial resources for AIDS/STD control; acceleration of malaria control activities at the field level and the launching of the Roll Back Malaria (RBM) Initiative.

Analysis

26. The 1998-1999 WHO/Burkina Faso programme of cooperation was satisfactorily implemented as a result of greater delegation of authority to country representatives; better administrative support; greater involvement of national officials in programme formulation, implementation, monitoring and evaluation; and strengthening of local partnerships through the organization of the annual conference of health partners held under the auspices of the Ministry of Health, quarterly meetings of partners held under WHO auspices, and meetings of theme groups.

27. Constraints included the frequent changes of national officials, inadequate grasp of the managerial process, and inadequate involvement in planning at the intermediate and peripheral levels as well as limited participation of some stakeholders such as the Ministry for the Economy and Finance, NGOs and civil society. Meetings between WHO and programme managers were rarely held during the year 1999. This hampered the proper monitoring of biennial activities by the Ministry of Health. Lessons from these inadequacies led to the expansion of participation in the 2000-2001 Plan of Action formulation process

to include key socioeconomic development actors, namely the Ministry for Economic Development, Planning and Finance, United Nations agencies, the media as well as provincial and national officials of the Ministry of Health.

Conclusion

28. Strengthened leadership role of the Ministry of Health supported by WHO in health matters and in coordination of the actions of partners should enhance the performance of the health system. Improved programme implementation and general coordination of overall planning within the Ministry of Health are therefore a *sine qua non* for successful management of the cooperation programme.

BURUNDI

Introduction

29. This contribution was based on information from the following documents: *the Work of WHO in the African Region*, 1996-1997; the 1998-1999 Programme Budget; the 2000-2001 Programme Budget; status reports of the country office for 1998 and 1999; and the country profile and health map of Burundi.

Achievements

30. The major achievements were the development of the biennial plan for granting fellowships and the award of new fellowships based on the plan; development of a national plan on safe motherhood; completion of a survey on adolescent health; formulation of a 5-year strategic plan on adolescent health; development of a plan of action for mental health; organization of study tours on IMCI; training of trainers in mental health; training of laboratory staff and supplies of reagents in both the national and regional blood transfusion centres; training of 120 health workers in the diagnosis of sexually transmitted diseases; and successful organization of national immunization days (NIDs).

Analysis

31. The main constraint was and still remains insecurity and the socio-political crisis which hampered the effective and full implementation of the national health system reform adopted in 1995. This situation affected food security and caused the general malnutrition observed. The progressive impoverishment of communities also hampered the autonomy of health facilities management, cost recovery and the improvement of access to quality health care. The importance of WHO technical expertise was not always understood by the country which tended to request funds for direct financing of activities. Inadequate knowledge of the managerial process by the country team persisted throughout the period under review and this was compounded by the sharp reduction in team membership, particularly with the death of two members in the same year.

Conclusion

32. The amounts estimated per programme at the time of the preparation of the Programme Budget were generally quite different from those finally adopted during detailed planning. This was because proposals were submitted two years before the beginning of the biennium and, at the time of planning, the situation had changed. There is, therefore, a need to review the programme budget preparation cycle

of the Organization to ensure that information contained in the Programme Budget would remain relevant for operational planning.

CAMEROON

Introduction

33. Priority areas for the biennium were the eradication of poliomyelitis; elimination of neonatal tetanus and leprosy; promotion of primary health care; promotion of a healthy environment in rural and suburban communities; promotion of healthy behaviour with emphasis on information and education; control of prevalent diseases (tuberculosis, malaria, trypanosomiasis, diarrhoea and acute respiratory infections); and health systems development and management. This evaluation is based on the mid-term review of the implementation of cooperation activities and related activity reports.

Achievements

34. WHO supported the development of priority health programmes. It also provided technical support for the preparation of a national health development plan and for strengthening the technical and managerial capacities of national staff. The support helped in the preparation of various policy documents; establishment of a national centre for essential drug and pharmaceutical supplies; initiation of staff audit in the Ministry of Health; functioning of the National Laboratory for Quality Control; and provision of quality water supply in areas of the country with a high incidence of diarrhoeal diseases. Sustained advocacy was undertaken among the health development actors, leading often to greater visibility and mobilization of resources for health.

35. The actions of WHO and other health partners led to remarkable progress towards the elimination and eradication of certain diseases. The prevalence of leprosy declined from 3.5 cases per 10,000 inhabitants to 1.5 cases per 10,000 inhabitants in 1998-1999. Similarly, no indigenous case of dracunculiasis was observed in the foci under surveillance. National Immunization Days (NIDs) for polio and measles control were successfully implemented and coverage was over 80%. Epidemiological surveillance of cases of acute flaccid paralysis (AFP) was also generally satisfactory. Efforts were made to take advantage of the NIDs to re-launch routine expanded programme on immunization (EPI) activities.

36. Management of tuberculosis improved in the country as a result of an awareness drive on the DOTS strategy which was directed at the public and government and the introduction, with WHO support, of the strategy in one of the provinces of the country. Interventions were initiated in the area of emerging and re-emerging diseases. A plan for epidemics control was prepared and an emergency stock of essential drugs and supplies was constituted at the central level. Within the UNAIDS framework, WHO focused special attention on efforts to control the HIV/AIDS epidemic. This resulted in strengthening awareness among the different target groups concerning the dangers of the pandemic and in a re-organization of control efforts at all levels of the health system. In the control of endemic diseases, management of severe malaria improved while bednet insecticide treatment techniques expanded with the creation of three centres in three provinces of the country and the training of their personnel.

Analysis

37. The implementation of the WHO technical cooperation programme with Cameroon benefited immensely from the close involvement of the authorities and the full participation of beneficiary populations. Better collaboration among partners, increased external funding for the implementation of

health programmes, better resource mobilization response in the wake of emergencies and disasters as well as political will and general stability of the country were other factors that facilitated implementation. Major constraints were the slow release of funds for implementation of regular budget activities during the first year of the biennium and frequent implementation delays by the Government.

Conclusion

38. WHO's action in the future will aim at mobilizing additional resources for better organization of the national health system and improvement of the health of the populations.

CAPE VERDE

Introduction

39. WHO technical cooperation aimed to promote primary health care, environmental health among the communities, emergency and epidemic preparedness and response, development of human resources for health, control of latent malnutrition and development of healthy lifestyles. The evaluation of the cooperation programme was based on the following sources of information: periodic progress reports prepared jointly by WHO and the Ministry of Health; financial reports on activities carried out; reports on programme activities; and biennial and mid-term evaluation reports for 1998.

Achievements

40. The major achievements during the biennium were the increased number of specialized staff, especially in the area of sanitary engineering; upgrading of health personnel; expeditious delivery of vaccines and other supplies needed for emergency situations and provision of essential drugs for the districts; capacity building for management and intervention at the district level; control of epidemics; operationalization of the library of the Ministry of Health; commemoration of world days that are of greatest importance to health; and the production and distribution of the brochure on the mother-baby package.

Analysis

41. Implementation of some planned activities took more time and funds than expected while funds were frequently requested for the implementation of unplanned activities. These problems resulted from managerial constraints and the heavy workload in the Ministry of Health. However, the holding of periodic joint reviews by the WHO country team and Ministry of Health officials as well as the improvement noted in communication helped to minimize the adverse impact and to redirect funds to activities which better addressed national needs.

Conclusion

42. In spite of the constraints noted above, the 1998-1999 cooperation programme was successfully implemented judging from the results achieved and WHO's enhanced visibility. Worthy of note in this regard is the timely response to country requests by the Regional Office. This contributed decisively to the successful implementation of the planned activities of the biennial programme.

CENTRAL AFRICAN REPUBLIC

Introduction

43. The health situation of the country is marked by high infant (97 per 1 000 livebirths) and maternal (948 per 100 000 livebirths) mortality rates. Life expectancy at birth is 49 years. The epidemiological profile is dominated by infectious and parasitic diseases, including STDs/AIDS, and a recrudescence of endemic diseases like tuberculosis and trypanosomiasis. The main objectives of WHO's technical cooperation with the country were to strengthen health development policies and strategies, promote reform, support control of communicable diseases (including HIV/AIDS) and noncommunicable diseases, and develop human resources for health.

Achievements

44. The most significant achievements were as follows: evaluation of the National Health Development Plan for 1994-1998; ongoing formulation of the health policy and the interim health development plan; training of medical and paramedical specialists; successful organization of the 1998-1999 NIDS; establishment of an efficient mechanism for the integrated epidemiological surveillance of diseases, particularly acute flaccid paralysis (AFP) and the control of epidemics; improvement of the quality of services in 74 peripheral health facilities following staff training and retraining; and monitoring and supervision.

45. Other achievements were the establishment of an information database in primary health centres and community health posts; consensus building on the minimum package of health services; development and dissemination of a national adolescent health policy and programme; training of 200 village heads, 20 health workers and 30 food sellers in environmental health; and determination of the chloroquine resistance level in three regions.

Analysis

46. The main difficulties encountered in the attainment of set objectives related essentially to the non-payment of workers' salaries and the insecurity in the remote areas of the country which restricted travel for field activities.

Conclusion

47. On the whole, the implementation of the programme of cooperation for the 1998-1999 biennium was satisfactory. Seventy-three per cent of the expected results were completely achieved and 27% partially achieved. It is hoped that a stable political and economic environment will facilitate implementation of the programme of cooperation for the next biennium.

CHAD

Introduction

48. This contribution was based on the results of epidemiological records, mission reports, financial reports and survey findings.

Achievements

49. The integrated epidemiological surveillance system established in 1997, mainly for acute flaccid paralysis (AFP) cases, became fully operational in 1999 with four regional branches. Three rounds of NIDs were organized, two in 1998 and one in 1999. The 1998 immunization coverages were 93% during the first round and 91% during the second round; and in 1999, tentative results for the first round, with the door to door strategy, was 108.5%. Vitamin A supplementation was administered during these NIDs. Immunization coverage in 1999 for measles in 44 urban areas of at least 5000 inhabitants was 81%.

50. The number of malaria cases recorded annually rose steadily due in part to the increase in the number of health units that became operational. However, there was a marked decline in hospital deaths thanks to a significant improvement in the management of malaria cases. The number of bednet treatment centres rose from 54 in 1998 to 85 in 1999.

51. In 1997, 25 new cases of guinea worm were reported, with 22 cases isolated, whereas in 1998 only three cases were recorded and isolated. In 1999, no active case was reported in the country, except for a case imported from Nigeria. Five prefectures benefited from community-directed ivermectin treatment, with a coverage rate of about 82%. Multi-drug therapy coverage for leprosy was 100%. The prevalence rate fell from 2.21 per 10,000 in 1997 and 1.38 per 10,000 in 1998 to 0.87 per 10,000 in 1999.

52. The Psycho-medical and Social Support Centre which started functioning with assistance from NGOs, and United Nations agencies helped in the management of patients and persons affected by HIV/AIDS. Since its development in 1998, the national mental health programme has became better understood by the public. This is as a result of social mobilization activities carried out by interest groups for the support, rehabilitation and management of mental patients as well as the effectiveness of radio programmes, lectures and discussions. Fifteen health units were supplied with essential drugs as part of the implementation of the Bamako Initiative.

53. Training programmes for social workers were improved and implemented; four regional training centres for health technicians became functional; the first batch of thirty medical students graduated from the School of Medicine in 1999; the scholarship programme was strengthened; fellowships were provided by WHO for training within and outside the country.

54. A national workshop was organized for consensus building with a view to preparing a Plan of Action on reproductive health while an advocacy workshop was organized for the fight against female genital mutilation. Commemoration of world and national days for health promotion provided opportunities for the production and dissemination of health messages. Four issues of the WHO news bulletin and a leaflet were published and distributed.

Analysis

55. Despite constraints imposed by scarce material and financial resources and the lack of qualified personnel and the outbreaks of cholera and meningitis, among other factors, the biennial Pland of Action

was satisfactorily implemented.

Conclusion

56. The preparation of the 2000-2001 Plan of Action took account of the constraints encountered in the implementation of the 1998-1999 Plan of Action.

COMOROS

Introduction

57. During the 1998-1999 biennium, the WHO technical cooperation programme with Comoros led to the attainment of priority national health development objectives by focusing on the following areas: health sector reform and management of facilities; support to community-based initiatives and human resources development; health promotion; environmental hygiene; disease prevention and control (promotion and use of insecticide-treated bednets); and epidemiological surveillance.

Achievements

58. The major achievements were the operationalization of the national health development plan; formulation of a plan for the development of human resources for health; development of training programmes for 1998-1999 and 2000-2001; completion of the legal framework governing the entire pharmaceutical sector; completion of the national drug policy for adoption by Cabinet; mobilization and distribution of funds for managing district health pharmacies; strengthening of the public health information system; sensitization of the population to major health problems; training of 30 journalists in health-related issues; training of 38 insecticide treatment workers and supply of kits to 17 insecticide treatment centres; training and retraining of laboratory technicians; purchase and distribution of anti-malarial drugs; provision of laboratory equipment; development and dissemination of information on the national STD/AIDS programme; conduct of monthly active surveillance; adoption and dissemination of national policy document on tuberculosis and on leprosy; training and retraining of 40 medical officers and 19 laboratory technicians in tuberculosis and leprosy control; 80% immunization coverage of under-one children; and conduct of a national survey on mental health.

Analysis

59. The objective of technical cooperation between the Islamic Federal Republic of Comoros and WHO was to provide support for the attainment of the country's priority objectives and for strengthening the health system in the following areas : management, decentralization and integration of programmes and community-based initiatives within the framework of primary health care, operationalization of health districts, training of personnel and disease control. The programmes were adequate and resources sufficient. However, preparation of the implementation plans by the relevant departments of the Ministry of Health was slow. The limited capacity in the Ministry of Public Health, coupled with lack of material and financial resources of its own, hindered the effectiveness of the technical cooperation. Frequent changes of health ministers as well as socioeconomic and political crises that the country experienced during the biennium were other factors that hindered implementation.

Conclusion

60. In order to ensure the effective implementation of programmes in the future, it will be necessary to strengthen the managerial capacity of the Ministry of Public Health; ensure effective decentralization of resources and the empowerment of the intermediate level; provide technical and material support to

health districts; pursue the implementation of the national health development plan; provide support to health sector reform, especially through management support for reactivating the Bamako Initiative; and strengthen the technical capacities of the WHO Country Office to better provide support to programme implementation.

CONGO (REPUBLIC OF)

Introduction

61. The 1998-1999 biennial technical cooperation programme was conceived and developed taking into account the need to support the humanitarian action put in place after the civil war that broke out in Brazzaville between June and October 1997. Implementation of activities under this programme was interrupted following the crisis that erupted in December 1998. Humanitarian needs resulting from the crisis prompted two successive programme reviews in January and August 1999. Following these reviews, the majority of ongoing activities were strengthened; activities planned for the second year were simply abandoned and new objectives established.

Achievements

62. The major achievements were limited to the following: training of health care staff in epidemiological surveillance at local level; dispensing of essential drugs by health workers at the peripheral facilities in conformity with guidelines; disinfection of public and private establishments by the Hygiene Centre; proper management of acute respiratory infections (ARI) by health workers at peripheral units; and correct application of protocols for treating mild and severe malaria by health workers.

Analysis

63. The crisis in the Congo and its multiple consequences constituted a major obstacle to the implementation of the activities planned for the 1998-1999 biennium. The most significant effects were the loss of office equipment; political instability resulting in the slackening of cooperation; and limited movement of teams, even within Brazzaville; major disruptions in the banking system limiting access to funds that had been transferred for the implementation of activities; low response capacity of the Ministry of Health due essentially to the instability of officials of central management structures and technical services; transfer to the Country Office of responsibility for administrative management of Regional Office staff left in Brazzaville without adequate provisions; and delays by or lack of response from the Regional Office to requests for various local purchases to help recreate the basic conditions for the functioning of the office.

Conclusion

64. Despite the stated constraints, emergency and humanitarian aid activities were carried out and significant results achieved.

COTE D'IVOIRE

Introduction

65. Under its technical cooperation programme with Côte d'Ivoire, WHO contributed to the strengthening

of the health system in line with the 1996-2005 Health Development Plan. The ongoing operationalization of district health systems and improvement of staff skills at the district level were supported through several workshops and seminars. This evaluation was based on the analysis of activity reports and reviews.

Achievements

66. As part of measures to improve the skills of health personnel, several training workshops and refresher courses were organized. A large number of staff were trained both within and outside Côte d'Ivoire, in line with the priority health programmes. Traditional healers from three regions were trained with a view to integrating traditional medicine into primary health care. In collaboration with UNFPA and UNICEF, WHO contributed to the development of the skills of personnel in charge of EPI, IMCI, and AIDS control. The Organization encouraged sensitization and advocacy in favour of the tuberculosis and Buruli ulcer control programmes.

67. Epidemiological surveillance was intensified and management of severe cases of malaria improved while devolution of the Onchocerciasis Control Programme was under way. The quality of the activities carried out was such that the biennial targets were fully achieved. The communities and health personnel were sensitized on the Africa 2000 Initiative and on the advantages of healthy lifestyles as well as the risks associated with major endemic diseases and noncommunicable diseases. WHO contributed to the implementation of the Plans of Action on nutrition, reproductive health and school health.

Analysis

68. WHO technical cooperation with the country benefited from the commitment of the national authorities. It encouraged development partners to give priority to district-oriented interventions and to take advantage of the positive experiences to promote technical cooperation among developing countries. Programming of activities on the basis of expected results made it possible to carry out a more rigorous follow-up and evaluation. The delegation of authority to the Country Representative facilitated decision-making. Despite the results achieved, the cooperation between WHO and Côte d'Ivoire was somewhat hampered by inadequate country team staff and overlapping of planned activities with other national activities.

Conclusion

69. Eliminating the shortcomings observed will ensure the success of WHO's technical cooperation programme with Côte d'Ivoire in the next biennium.

DEMOCRATIC REPUBLIC OF CONGO

Introduction

70. The 1998-1999 biennial evaluation was based largely on various field activity reports and implementation plans formulated by the Ministry of Health, the 1998-1999 Programme Budget, half-yearly reports, the 1998 mid-term review report, and budget revisions during the period.

Achievements

71. The major achievements during the biennium included the development and dissemination of guidelines for mass immunization against meningitis, measles and yellow fever; development of two provincial plans of action in order to integrate the interventions of all health development partners;

development of human resources through fellowships for training locally and abroad; sensitization of relevant people and groups on reproductive and family health; formulation of a national plan on the elimination of female genital mutilation (FGM) and other harmful traditional practices; preparation and implementation of safe motherhood activities; commemoration of world health days; training of 40 health journalists in health information; and successful implementation of two national immunization days (NIDs).

72. Other achievements were as follows: evaluation of the IMCI initiative; establishment of a special surveillance unit for emerging and reemerging diseases (e.g. Ebola, monkeypox and kinzo); availability of up-to-date data on trends in HIV/AIDS and STDs from the sentinel sites; updating of the national policy, strategies and PoA on malaria control; development and dissemination of the national policy and corresponding PoA on the control of onchocerciasis.

Analysis

73. Despite the war and the emergencies and disasters, a determinant of the success in the implementation of the WHO cooperation programme was the complementarity between the planned activities of the regular programme and those implemented under projects financed with extra-budgetary funds. The supervision of activities undertaken by a united and dynamic team was a major asset in ensuring the visibility of WHO's work in the Democratic Republic of Congo. Also beneficial was close collaboration with the Ministry of Health, whose officials were associated with the entire process, from the planning and field monitoring up to the evaluation stage.

74. The execution of the 1998-1999 Programme Budget was marked by numerous difficulties relating to the civil war. It also resulted in the inaccessibility of occupied zones, except for humanitarian missions and specific activities like NIDs. The peculiar situation which prevailed throughout the biennium led the Government to take special measures, which also had negative consequences on the implementation of activities. In the course of the implementation, the budget was revised twice in order to adapt the planned activities to the situations created by the war. Those revisions hindered the attainment of some expected results.

Conclusion

75. Despite the peculiar circumstances prevailing in the country, the implementation of the technical cooperation programme was considered successful in the case of both the regular programmes and the project financed with extra-budgetary resources. The remarkable dedication of all the actors who contributed to the implementation of the field activities should be noted, as should the personal involvement of the Minister of Health and his office. However, it would be necessary to adequately brief participants in the programme on the use of the new tools proposed by the Regional Office. The WHO Country Office will have to use these tools to exercise greater control over actual expenditures in order to comply with the proposed guidelines.

EQUATORIAL GUINEA

Introduction

76. The health situation in Equatorial Guinea during the 1998-1999 biennium remained a cause for concern. The country recorded high infant (over 110 per 1000 livebirths) and maternal (over 350 per 100 000 live births) mortality rates. The epidemiological profile was dominated by the high incidence of communicable diseases, particularly malaria, chronic respiratory infections, diarrhoeal diseases and malnutrition. The main priorities of the technical cooperation programme were to enhance control of specific communicable diseases, including AIDS and epidemics; promote health sector reform and

primary health care; integrate health services; promote healthy environment within communities; and improve essential drugs availability.

Achievements

77. The most significant achievements were technical support for the review of the national health development plan; annual update and dissemination of the health profile; studies for the establishment of a health insurance scheme; strengthening of national capacities in the districts and training of staff outside the country; intensification of malaria control activities; and training of public and private communicators in the health sector.

Analysis

78. The main difficulty that hampered the optimal achievement of objectives was limited human resources. In addition, the biennium was marked by periods of social unrest, especially during the first quarter of 1998 and the legislative elections in February-March 1999, which slowed down the implementation of activities.

Conclusion

79. Despite some socio-economic difficulties, the 1998-1999 WHO technical cooperation programme with Equatorial Guinea was implemented in accordance with the set objectives. With about 90% overall rate of utilization of financial resources, all expected results were achieved particularly in health sector reform.

ERITREA

Introduction

80. In order to evaluate the implementation of the 1998-1999 biennial plan of action, multiple and regular review meetings were held, semi-annual monitoring reports prepared and mid-term reviews conducted jointly by WHO and the Ministry of Health. Preparatory meetings chaired by the WHO Representative were held prior to the evaluation which was undertaken in collaboration with Ministry of Health officials, the PHARPE project manager and the WHO Country Office.

Achievements

81. In the area of human resources for health, fellowships were provided and a short training course for 18 programme managers and health workers organized by WHO. Seventy-one nationals were supported to attend meetings and training workshops in their respective fields. With WHO funds and technical expertise, several preventive measures against malaria (i.e. chemoprophylaxis, construction of fish ponds for biological control and integrated vector control) were implemented. Health personnel of various categories were trained to undertake the Chloroquine Therapeutic Efficacy study. A national Roll Back Malaria conference was held with the help of WHO and other UN agencies.

82. Over 58% of children under one year of age were fully immunized, DPT3 being used as an indicator of full immunization. National immunization days (NIDs) were conducted and more than 90% of eligible children were vaccinated. Acute flaccid paralysis surveillance was strengthened and it is hoped that polio could be eradicated by the end of year 2000. The national HIV/AIDS policy was developed and a national AIDS committee formed. A manual on HIV/AIDS care and counselling at facility level and home-based care was developed. WHO's support to the national AIDS prevention and control

programme through the UNAIDS Theme Group helped to strengthen advocacy. The first sentinel surveillance report was compiled. WHO provided office equipment and other supplies to various Ministry of Health programmes. The capacity of Ministry of Health staff at the central and regional offices was also strengthened.

83. The WHO Country Office received and distributed a number of press releases, newsletters and other WHO publications to the Ministry of Health, the College of Health Sciences, other health personnel training institutions, medical and paramedical professional associations, the mass media and other related institutions. The World Health Day, World AIDS Day, World No Tobacco Day and NIDs marked nationwide in 1998-1999 were all supported by WHO.

Analysis

84. The major constraints on the implementation of planned activities were the inadequate logistics, lack of demographic and health information and inadequate human resources for health. These constraints were further aggravated by the border conflict. Nonetheless, most of the activities in the Plan of Action were carried out.

Conclusion

85. The evaluation helped in the assessment of the level of success achieved in the implementation of the biennial plans of action. Lessons learnt will contribute to the improvement of planning and implementation in the next biennium.

ETHIOPIA

Introduction

86. The main areas of WHO co-operation with Ethiopia were the development of managerial capability, disease prevention and control and health promotion. Twelve WHO-Ethiopia collaborative programmes were formulated in line with the health sector development programme (HSDP), which emphasized a decentralized approach to meeting the needs of the regions requiring special assistance.

Achievements

87. Ethiopia restructured its health service delivery system and adjusted the health training programmes to fit the new development. WHO strengthened regional and district health management in support of the decentralization process. Twelve regional training centres were given technical and material support. Postbasic training programmes on health management were organized for over 300 health workers.

88. Several in-country meetings were organized to promote the exchange of experiences. Three regions were given support to produce health education materials locally, in three major local languages. WHO provided technical and financial support for the implementation of the Africa 2000 Initiative while twenty health units were supplied with adequate water supply and waste disposal facilities. The healthy cities project was initiated in five towns.

89. WHO supported the integrated management information system as one of the components of the HSDP. The national drug policy was developed, printed, distributed and popularized through drug information bulletins and posters.

90. Ten medicinal herbal species were collected and extracts prepared from seven of them. The biological preparations are currently being tested for their effectiveness. Equipment for extraction, standardization, and dosage formulation was procured, installed and made fully functional. WHO

supported the training of 22 nurses in the provision of care for mental disorders. Six course coordinators attended a short course in Zimbabwe while refresher courses were organized for twenty-three previously trained psychiatric nurses. WHO assisted in the strengthening of surveillance activities and the control of major epidemic diseases.

91. HIV diagnostic kits and laboratory equipment were provided to major facilities countrywide. To respond to malaria epidemic outbreaks, a great proportion of WHO's regular budget went into malaria control activities while an additional amount of 100,000 US dollars was reprogrammed from other projects. In-service training in integrated management of childhood illness (IMCI) was organized for 155 health professionals. In addition, two Ethiopian medical schools trained 225 academic and support staff in IMCI.

92. In 1998 and 1999, DPT3 coverage was 57% and 66%, measles coverage 45% and 56% and oral polio vaccine coverage 107% and 100.9% respectively. For the same periods, the coverage of children under 5 years for poliomyelitis eradication was 9.1 million and 10.7 million. The targeted detection rate for acute flaccid paralysis was 1/100,000 but the achievements for 1998 and 1999 were 0.3 per 100,000 and 0.63 per 100,000 respectively.

Analysis

93. The factors that facilitated achievements were the adoption of the HSDP; the federal structure of the country with its decentralized system whereby regions are responsible for actual implementation of programmes; and delegation of certain powers by the Regional Director to the country representatives. The main constraints were the failure of the government to submit financial and technical reports on time; delays in the submission of quarterly plans by the implementing departments; non-adherence to the WHO fellowships policy; problems of securing placement for short- and long-term training; low morale of Ministry of Health staff; and drought.

Conclusion

94. The level of implementation of the 1998-1999 Plan of Action was over 90%. Successful implementation of the 2000-2001 Pland of Action will be ensured by WHO through regular meetings with the technical counterparts of the Ministry of Health to monitor progress; field trips to supervise WHO staff seconded to health offices of the emerging regions and to monitor plans of work with the regions; an increased Country Office budget to strengthen WHO technical advisory capacity and a greater technical leadership role in the inter-agency group.

GABON

Introduction

95. The main objective of the 1998-1999 technical cooperation programme between Gabon and WHO was to provide quality health care to the entire population of the country. The programme priorities focused on health systems development and management; promotion of primary health care, reproductive health and nutrition; control of communicable diseases; availability of essential drugs; development of human resources for health; control of mental disorders; and promotion of environmental health and safe water supply under the Africa 2000 Initiative. Evaluation of the cooperation programme focused on the implementation of priority programmes in the Plan of Action. The sources of information were progress reports of national programme managers; financial reports; reports of the WHO country team, and the mid-term evaluation conducted in 1998.

Achievements

96. The NGO forum was organized. Support was provided for the management of Congolese refugees. A short-term training plan was prepared by the Ministry of Health and fellowships were granted for training in different disciplines. The national essential drug policy was adopted and its implementation will help launch the Bamako Initiative. The essential drug list was revised. A workshop for consultation with traditional healers was organized. Midwives were trained and a workshop organized on the quality of care provided to patients.

97. In the area of healthy behaviour and mental health, a plan was prepared for the reorganization of the psychiatric hospital; a training course was organized for some staff of the hospital while a mental patients' management system was established. The 1998 National Immunization Days were successfully organized. Ivermectin was distributed, the impact of onchocerciasis in Gabon evaluated and the mapping of the disease completed.

Analysis

98. Factors that hindered implementation of the programmes included insufficient human resources; inadequate motivation of personnel; implementation of unplanned activities in response to requests from the Ministry of Health; poor distribution of financial resources; imprecise formulation of expected results; and the fact that some national programmes were not operational.

Conclusion

99. For the next biennium, it will be necessary to set realistic objectives, taking due account of the overall human and financial resources of the nation, in order to attain the expected results.

GAMBIA

Introduction

100. The 1998-1999 Technical Co-operation Agreement between the Government of The Gambia and WHO served as the framework within which the 1998-1999 technical co-operation programme was implemented.

Achievements

101. The finalization of the health component of the Social Sector Document with support from WHO was a major achievement. It was part of the efforts to assist the Government to move closer to addressing health priorities through proper planning and co-ordinated donor support. A number of nationals completed long-term training while others were still on training in various health disciplines. Nationals participated in short courses and workshops to keep them abreast of developments and trends in global health issues. As part of the regional information and education strategy, WHO sponsored the participation of journalists in a media workshop held in Nairobi.

102. Relevant world health days were commemorated. National AIDS Control Programme activities, focusing on commercial sex workers, were supported while due attention was given to the Africa 2000 Initiative. Refurbishment and training activities were carried out, with WHO support, in the area of sanitary waste disposal in one of the district health headquarters (Mansakonko).

103. The plan of action for the implementation of the accelerated malaria control programme was fully implemented, although with slight adjustments to suit changing needs. Serious gaps were identified in the transportation fleet of the Department of State for Health which made it necessary to reprogramme some of the activities to accommodate the changes made. Seven vehicles were therefore ordered, one for each of the six district health teams and the seventh for the central level.

104. Apart from playing a key role in the operations and surveillance of national immunization days for the control of poliomyelitis, EPI/AFRO procured a surveillance vehicle to strengthen control activities on polio AFP at the country level. Following the declaration of a state of natural disaster in August 1999 by the Vice President and Secretary of State for Health, WHO provided support to flood victims in the provinces. In addition, WHO provided emergency health kits and participated in joint United Nations activities to assess the level of damage.

105. Notable achievements, through WHO support, in the areas of family and reproductive health and integrated management of childhood illness (IMCI) were the finalization of the safe motherhood needs assessment exercise; dissemination of findings of mother-to-child transmission of HIV/AIDS/STIs; the organization of orientation meetings on IMCI for policy-makers and technical experts; the conduct of a baseline survey on female genital mutilation within the context of reproductive health and of a national survey on iodine deficiency disorders.

Analysis

106. Frequent changes occurred in the leadership of the Department of State for Health, thus making it difficult to achieve a systematic and logical implementation of planned activities as contained in the Plan of Action. Health care delivery needs were also changing constantly. The WHO Country Office therefore had no option but to adjust to the needs of the constantly changing situation and implement activities accordingly.

Conclusion

107. Even though a smooth implementation of the Plan of Action for the period under review was not possible, remarkable achievements were made and more unplanned activities were successfully implemented. More consultation and dialogue with national counterparts at the planning stage will ensure greater national ownership of technical co-operation programmes and facilitate timely implementation. To this end, relevant mechanisms are already in place for the next biennium.

GHANA

Introduction

108. The period under review saw the consolidation of the implementation of the Ministry of Health's Five-year Plan of Work, which captures the implementation framework of the health sector reform process in Ghana. A number of changes were made at the ministerial and top technical levels within the Ministry of Health. Major sources of information for the evaluation exercise included programme, technical and financial reports from the Ministry of Health.

Achievements

109. The main achievements during the biennium included training of district health team members in essential health information and health programme management; successful contribution to the commemoration of the World Health Day; implementation of health insurance schemes in five districts; improved supervisory skills in the management of priority programmes for regional and central administration staff; upgrading of health workers' skills in early detection and management of epidemics; development of human resources for health through award of fellowships for local and external training in relevant fields; increase in basic psychiatric coverage at district level; establishment of the integrated management of childhood illness programme; institutional strengthening to facilitate confirmation of outbreaks of epidemics; review and dissemination of epidemics management tools; development of a yaws control programme document and of protocols for the management of yaws cases; production and

dissemination of the guidelines on the management of Buruli ulcer; updating of drug sensitivity maps for anti-malarials; and increase in the use of insecticide treated materials for malaria prevention.

Analysis

110. Factors that facilitated achievement of results included decentralization of the issuance of stickers which resulted in the timely execution of planned activities. In addition, the cordial relationship between the Ministry of Health, WHO Country Office and other partners in health facilitated the successful implementation of the Plan of Action.

111. Factors that constrained achievement of results were the unforeseen demands during the implementation of health sector reform which led to the revision of certain products and reprogramming of some activities under many programmes; slow rate of implementation of activities in the first year of the biennium, necessitating accelerated implementation in the second year; delays in transmission of financial and technical reports on implemented activities; changes of key officials in the Ministry of Health during the period under review; and difficulties in getting funds to reach the operational levels for disease eradication programme activities within the framework of the health sector reform process.

Conclusion

112. 1998-1999 represented the mid-period in the five-year plan of work of the Ministry of Health. In line with the health sector reform, there have been institutional changes in the way the Ministry is supported to provide a package of health care services at the district level, and cutting across programmes. Joint planning, funding and monitoring and evaluation arrangements are the hallmarks of the common basket approach for support to the health sector. Some partners and donors who opted to stay out of the arrangement still provided earmarked funding to specific programme areas of interest.

113. In the case of WHO, arrangements for providing support for the implementation of activities have largely remained unchanged. Though WHO is not participating in the common funding, it is involved in the joint monitoring and evaluation activities. The frequent meetings between programme staff and WHO Country Team will further enhance the monitoring and evaluation of the implementation of the Plan of Action. The WHO Country Office is eagerly awaiting the results of the assessment of the funding support provided to the districts for time-targeted priority programmes, specifically activities under the poliomyelitis and guinea worm eradication programmes.

GUINEA

Introduction

114. Despite the efforts made and the encouraging results obtained in recent years by Guinea in the health sector, major problems persist. Infectious, parasitic and nutritional diseases dominate the epidemiological scene while diseases and problems like hypertension, diabetes, substance abuse and road accidents are on the increase. Thus, infant mortality (136 per 1000 livebirths), child mortality (229 per 1000 livebirths) and maternal mortality (666 per 100,000 livebirths) rates remain high.

Achievements

115. Major achievements included the supply of emergency kits to four districts; formulation of a national health development plan; definition of a health financing policy; construction of a health library in each district and supply of required documentation to 10 districts; development of a programme on urban health; initiation of two community health programmes with NGOs; strengthening of the management system for 38 health districts; human resources development through the maintenance of

existing fellowships and the award of new ones; training of central and district level staff in the rational use of drugs; training of 50 traditional practitioners in the judicious use of traditional medicine; strengthening of two structures in charge of promotion of reproductive health; sensitization of five women associations on the prevention of neonatal tetanus and female genital mutilation; social mobilization for health through the observance of world health days; and formulation of the Plan of Action for the Africa 2000 Initiative.

116. Other achievements were the training of 25 health workers in disease surveillance; organization of two national immunization days; conduct of a vaccination campaign on neonatal tetanus in 50% of the districts; training of 20 health workers in charge of acute respiratory infections and supervision of the control of diarrhoeal diseases in 25% of the districts; training of health staff in epidemiology, prevention of HIV/AIDS, treatment of severe malaria cases; devolution of the onchocerciasis programme; supply of equipment to five district laboratories to enhance their capacity to control communicable diseases; evaluation of the national health information system; supply of equipment to six hospitals for diagnostic testing for HIV/AIDS; evaluation of the national programme for the control of onchocerciasis; and initiation of a project for the promotion of oral health.

Analysis

117. Factors that facilitated the reported achievements included the involvement of national officials in the entire implementation process; close monitoring of the implementation of activities by the country team; the commendable work done by the WHO Country Team; and effective partnerships with other stakeholders in the sector. The main constraints observed were the overlap of planned activities with other national activities; inadequate coordination among the various partners in the sector; delays in the implementation of planned activities; and the burden of unplanned activities.

Conclusion

118. Aware of the health problems facing the communities, the Guinean Government made considerable effort to strengthen and expand its health system. This made it possible to achieve 70% of the expected results under the 1998-1999 Cooperation Programme, in line with WHO guidelines, and with the full participation of the actors in the country. Future WHO cooperation with Guinea should enable the latter to pursue the necessary reforms in order to revitalize the health system, prevent and control diseases, promote and protect health, and provide adequate and sustainable financing for health services. WHO should continue to provide support for the attainment of the health objectives defined by the Government.

GUINEA-BISSAU

Introduction

119. The cooperation programme between Guinea-Bissau and WHO for the 1998-1999 biennium was in line with the strategies proposed by the Ministry of Health and Social Welfare, namely: institutional support, implementation of the minimum package of activities, human resources development, implementation of a national water and sanitation policy, control of communicable diseases, and promotion of family health and essential drugs policy.

Achievements

120. The management committee for the implementation of the national health development plan was established, the accounting information system was defined and the administrative and financial procedures manual drafted. WHO's support during the conflict of 7 June 1998 was in line with the United Nations plan for supporting emergency and humanitarian aid activities.

121. WHO financed several missions abroad and provided technical assistance in various areas, including: training of senior staff; finalization of the national human resources plan; computerization and maintenance of databases; and drafting of the administrative procedures manual.

122. WHO contributed to the organization of national immunization days; preparation of the Roll Back Malaria plan; training in the management of severe cases of malaria; insecticide-treatment of bednets; launching of national social mobilization activities and malaria control days; supervision and training of laboratory technicians in the diagnosis of tuberculosis and control of the quality of bacilloscopy; training of technicians in STD/AIDS diagnosis; sensitization on AIDS; training of health technicians and volunteers in community treatment of onchocerciasis; and implementation of community-based micro-projects.

123. Achievements in epidemics control included the preparation of the cholera prevention and control plan; supply of drugs and reagents for the blood bank and vaccines against measles, meningitis and yellow fever; successful management of meningitis and measles epidemics; and preparation of the inter-country cooperation plan dubbed the "Health for Peace Initiative".

124. The national health development plan management committee resumed its activities aimed at assisting the health regions in the planning and analysis of protocol agreements. New drug lists were introduced and staff were trained in the use of the administrative and management procedures manual.

125. High risk pregnancies were detected and managed, staff were trained and mother-care structures were put in place in hospitals. Staff were also trained in various areas and the integrated management of childhood illness manual was translated. The Africa 2000 Initiative was launched at the national level through the implementation of community-based micro-projects such as the construction of latrines and the improvement of water points. A study on HIV prevalence in pregnant women is under- way. Some information and education activities related to HIV/AIDS/STDs were implemented.

Analysis

126. Excellent working relations with the Ministry of Health and Social Welfare contributed to efficient implementation of activities. Operating as a focal point for all health actions, the WHO Country Office served to link the Ministry with other cooperation agencies and played a catalytic role in implementation processes. The results of the implementation of the biennial programme were not fully satisfactory due to the political and military crisis of 7 June 1998. That situation had very serious consequences for the entire health system: flight of personnel, lack of motivation of personnel due to very low salaries, and destruction of the health system, including infrastructure and logistical equipment.

Conclusion

127. On the whole, WHO's contribution was quite positive, in spite of the armed conflict which made implementation of programmed activities difficult. Although the national health development plan was not implemented from the first year of its launch, major actions aimed at repositioning the health system were carried out as part of the emergency plans.

KENYA

Introduction

128. The evaluation was based on various Ministry of Health programme reports, notably post-activity reports, annual reports, programme review reports and specific Ministry of Health strategic documents and plans of action. In addition, discussions and consultations were held with different programme managers.

Achievements

129. Health advocacy was successfully carried out countrywide particularly during the commemoration of internationally recognized health days. Emergency supplies were made available within 72 hours after the Nairobi bomb blast in 1998. Support was provided for the development of the 1999-2004 National Health Sector Strategic Plan. The results of the decentralization study, supported by WHO and other partners, were used to fine-tune the approaches to decentralization. Pretesting of the Regional Office instrument for assessing the operationality of district health systems was undertaken in three districts.

130. The Kenya National Drug Policy Implementation Programme, which was implemented with technical support from WHO, the executing agency, achieved the following results: operationalization of a national pharmacy and therapeutic committee; development of guidelines on Kenya Drug Donations and on the safe disposal of pharmaceutical waste; development of teaching materials on effective drug management and rational use of drugs; review and updating of pharmaceutical legislation. Technical and financial support was also provided to the Kenya Medical Supplies Coordinating Unit to turn it into a semi-autonomous drug supply agency.

131. Support was provided for three students to undertake postgraduate training in public health in Kenyan universities; for four students to study applied epidemiology; and for attachment courses for six postgraduate radiology students at the rural training site. Support was also provided for the review of the district health management information system and the tools used at that level. Capacity-building activities were undertaken in 10 districts for midwives, members of district health teams and traditional birth attendants. Sensitization of policy-level health personnel to the integrated management of childhood illness (IMCI) led to its systematic introduction in the country.

132. Support was provided for assessment of water and sanitation in Thika District and of water quality in three municipalities; for the strengthening of the Department of Environmental Health at Moi University; and for the development of a sanitation policy. Based on data generated through the HIV sero-prevalence assessment undertaken in 23 sentinel sites, the Government declared in December 1999 that AIDS is a national disaster. To ultimately strengthen district disease surveillance, support was provided for the development of a strategic national framework for use at all levels.

133. Support was provided for the development and nationwide distribution of guidelines for malaria treatment. Training activities were undertaken in epidemic-prone districts in three provinces. Guidelines for epidemic preparedness and control were developed, published and distributed to 13 epidemic-prone districts. Training of the respective provincial health teams was undertaken. The expanded programme on immunization was strengthened while the poliomyelitis eradication programme was sustained. Through concerted advocacy, Government budget contribution to the programme rose from a negligible level to almost 33% between 1997 and 1999. Two rounds of National Imunization Days were undertaken in 1998 and in 1999, with a coverage level of 82%. The acute flaccid paralysis detection rate rose from 0.07 per 100,000 to 1.64 per 100,000.

Analysis

134. The achievements made were largely due to the dynamic commitment of the Interagency Coordination Committee inaugurated during the period. Greater achievements were hindered by deteriorating district level infrastructures and transport logistics, low staff motivation and the withdrawal of support by some key partners. Lack of information, education and communication strategies also hampered programme implementation. Other constraints were the nurses' strike during the period November 1998 to February 1999; scheduling of newly prioritized activities; and outbreaks of epidemics.

Conclusion

135. In spite of the constraining factors, achievements during the biennium were generally remarkable. Especially significant was the adoption of the National Health Sector Strategic Plan as well as the IMCI and safe motherhood strategies. WHO is now regarded as the leading partner in health development.

LESOTHO

Introduction

136. The major sources of information for the biennial evaluation were programme managers' reports, WHO country team quarterly reports, workshop reports, monitoring visit reports, interviews and meetings with officials from the Ministry of Health and Social Welfare. A three-day retreat was held in July 1999 to review the implementation of the 1998-1999 Plan of Action. At the retreat, the Ministry was represented by the Hon. Minister of Health, the Principal Secretary, senior officials from headquarters, the districts and health zones while WHO was represented by its Country Representative and members of the Country Team.

Achievements

137. Major achievements during the biennium included the review of the implementation of the Bamako Initiative; partial formulation of the national drug policy; training in food safety policy; development of an adolescent health baseline study and an adolescent health training manual; training in the national safe motherhood initiative and sensitization of districts to the initiative; partial introduction of the integrated management of childhood illness (IMCI); successful commemoration of international health days; purchase of instructional dental models; capacity building and networking among health facilities in emergency preparedness and response as well as formulation of hospital emergency plans; and development of an HIV/AIDS control policy and strategic plan and production of the 1996-1997 HIVsentinel surveillance report.

Analysis

138. Lesotho achieved considerable success during the 1998-1999 biennium. Improved cooperation between the Country Office and counterparts in the Ministry and joint site visits with counterparts and *ad hoc* meetings held with programme staff in the Ministry largely contributed to the achievement of the majority of the expected results. Multisectoral planning, particularly for campaigns such as those for poliomyelitis, tuberculosis and measles, and commemoration of international health days and the Tobacco-Free Initiative were other contributing factors. Timely response by the Regional Office to requests for technical assistance greatly facilitated work at the country level.

139. Lesotho experienced severe drought during the biennium. The situation was aggravated by the large number of the male labour force laid off by the South African mining industry. Increasing levels of unemployment, estimated at 54% in rural areas and 27% in the urban areas, exacerbated the prevalence of abject poverty. Since the first year of the biennium was an election year in Lesotho, the first half of 1998 was characterized by political campaigns and unrest. Consequently, most programmes started implementing activities in 1999. The late start in implementation, the decision to suspend most activities

in favour of poliomyelitis and measles national immunization days and the limited institutional capacity in the Ministry resulted in the reprogramming of some funds, postponement of activities to the next biennium and implementation of unplanned activities. Frequent changes of programme managers and the high turnover of senior staff in the Ministry further constrained programme implementation.

Conclusion

140. Good planning, a conducive political atmosphere and close collaboration with appropriate counterparts in the Ministry of Health and Social Welfare were critical to the implementation of WHO biennial activities. In the next biennium, the Country Office will ensure that partners fully understand WHO procedures for accessing assistance. Regular review meetings to report on the plan of action implementation and attend to problems, if any, will be formalized.

LIBERIA

Introduction

141. Liberia continued to face numerous complex problems of transition from war to peace. A joint UNDP/WHO-sponsored national health planning conference in 1997 defined the framework for health care delivery in 1998-1999. This period witnessed the decentralization of the health system with the re-establishment and strengthening of country health offices in all 13 counties. Health developments, which began to gradually take root, were interrupted in April and more severely in August 1999 by the crisis situation in the country.

Achievements

142. The development of a national health policy in support of health sector reform was initiated along with the completion of policy guidelines in nursing, nutrition, primary health care, women in health and environmental health. Medical education continued to be supported by providing salary subsidies to 32 professors and staff of the Medical College; instructional materials, laboratory equipment and teaching aids for training institutions; and electricity supply and vehicles for the rotation of students. Six nationals benefited from fellowships for graduate studies overseas.

143. Through WHO support, 11 doctors, 2 pharmacists and 196 mid-level health workers completed their basic studies while 66 completed basic training in primary health care. Continuing education programmes for national capacity building were implemented in the rational use of drugs; malaria control; disease surveillance; health promotion; and health and sanitation for scores of community members throughout the country. Traditional birth attendants were identified and trained to provide reproductive health care to internally displaced persons in camps in 2 counties; 20 midwives were trained in the use of the partograph while 2 senior national staff benefited from reproductive health training in Mauritius.

144. The Ministry of Health and peripheral health facilities were provided with essential drugs and medical supplies, including tuberculosis and anti malaria drugs, TBA kits, and sanitation tools. The Government was provided with eight vehicles to strengthen central coordination and supervision. Epidemic investigations were conducted for yellow fever in Nimba and Lofa counties and the subsequent campaigns achieved immunization coverages of 89.5% and 50% respectively. Outbreaks of dysenteric diarrhoea due to resistant shigellosis were investigated and nalidixic acid provided. In addition, cholera outbreaks were investigated and contained in 4 out of the 13 counties in the country.

145. In fostering regional cooperation, WHO re-introduced Liberia into the regional and sub-regional health communities. Collaboration was strengthened between the WHO Country Office in Liberia and other WHO country offices in the African Region for disease control, particularly of acute flaccid paralysis surveillance, yellow fever and diarrhoeal diseases. Partnership with NGOs was strengthened

with the establishment of a WHO/NGO desk at the Country Office and a consensus workshop was conducted. Projects funded by other UN agencies in reproductive health, HIV/AIDS, primary health care and disease surveillance were executed under the WHO/Liberia technical cooperation programme. Drug efficacy studies were undertaken for chloroquine in Bong and Maryland. HIV/AIDS situation analysis was conducted for Liberia and the strategic plan received funding from UNAIDS. A safe motherhood needs assessment was initiated.

Analysis

146. Major factors that contributed to the non-implementation of some planned activities were the limited capacity at the Ministry of Health for programme implementation; WHO's efforts to respond to emergency situations; delayed response from the Regional Office regarding technical assistance availability for the micro-nutrient survey; and the rapid turnover of Ministry of Health senior staff; for example, the Minister of Health, the Chief Medical Officer and the Comptroller were replaced during the biennium.

Conclusion

147. The prospects for the implementation of WHO technical cooperation activities for the next biennium are bright thanks to the favourable conditions for peace as well as economic and political stability. Many professional health workers have returned home and more are expected to do so if conditions remain stable.

MADAGASCAR

Introduction

148. During the biennium, cooperation between Madagascar and WHO contributed to the implementation of the national policy and master plan drawn up by the Ministry of Health. A number of results in health system development and disease control were achieved under the technical cooperation programme which contributed to poverty alleviation in Madagascar.

Achievements

149. The health information system reform facilitated the collection of reliable data used in preparing the statistical directory and for the development and management of the national health system. Analysis of the funding of essential social services under the 20%-20% initiative was carried out in collaboration with the United Nations system. To facilitate the development of the national health system, the following were prepared: a guide for drawing up district development plans; a document on minimum package of activities in basic health centres; a guide on operationalization of the financial participation of users containing guidelines on tariffs and payment principles and modalities; a document on the financial autonomy of district hospitals; and training modules in the management of the family planning units in collaboration with the European Union.

150. The Ministry of Health, WHO and UNICEF formulated and developed the joint action plan of the Fahasalamana Iraisam-Bahoaka/BI programme and reviewed the relevant management tools. Policy documents on oral health and school health were prepared. The national health policy was revised to take into account prevention of blindness, quality of care, reproductive health.

151. WHO contributed to human resources development through training of 15 national officials in health systems research methodology; 36 members of 12 health teams in health planning, management, monitoring and evaluation; and about 40 managers of pharmaceutical products at referral hospitals. Five medical inspectors were awarded WHO fellowships to pursue public and community health courses

locally at the Befelatanana Training Centre and 16 postgraduate students were offered short-term internships in Senegal and Côte d'Ivoire.

152. Achievements in the area of disease control included the commencement of training for a core of trainers in each province in the implementation of integrated management of childhood illness; implementation of DOTS; support to the leprosy elimination campaign which was intensified in 20 health districts; implementation of the malaria control programme involving two cycles of DDT spraying in the highlands, case management and the use of more than 20,000 insecticide-treated bednets; organization of National Immunization Days with coverage rates of between 112% and 119%; and provision of advisory support, drugs and hygiene materials during the cholera epidemic that occurred in March-April 1999.

Analysis

153. Delegation of sticker issuance to the Country Office resulted in the elimination of delays in the release of funds in response to requests from the Ministry of Health; better monitoring of fund disbursements; and effective monitoring of activities for which funds had been disbursed. The most important constraint related to the restriction of programme implementation to departments already overburdened by other activities planned by the Ministry of Health.

Conclusion

154. Cooperation between Madagascar and WHO contributed to the development of the national health system; development of human resources; formulation of oral and school health policies; and intensification of communicable disease control programmes and epidemiological surveillance. During the next biennium, however, emphasis will be placed on poverty reduction through the promotion of access to quality health care for the majority of the population, using a comprehensive health care approach.

MALAWI

Introduction

155. The WHO Country Office continues to play its important role of coordinating health actions with other UN agencies and bilateral and multilateral organizations. WHO is intensifying its advocacy activities on behalf of the Ministry of Public Health.

Achievements

156. The major achievements during the biennium included the capacity building through the training of various categories of health staff; implementation of the integrated management of childhood illness (IMCI) in six districts; strengthening of district and national health systems and policy development; development of human resources for health through the award of WHO fellowships; production and dissemination of health information messages and IMCI training materials; successful commemoration of the World AIDS Day; protection of 60 water sources and construction of 60 improved pit latrines; reduction of child malnutrition; improvement in the quality of reproductive health services; and the purchase and distribution of drugs.

Analysis

157. The cordial relationship and cooperation between the WHO Country Office and the Ministry of Health and Population facilitated the implementation of the biennial plan of action. Under-staffing of the

WHO Country Office and the Ministry of Health and Population negatively affected programme implementation. Government's delay in submitting activity and financial reports to facilitate the payment of committed expenditures resulted in some programmes being unable to complete their planned activities at the end of the biennium. Most programmes did not receive adequate budget allocations at the beginning of the biennium. Requests from government programme managers for more money could not be met due to limited funding under the regular budget.

Conclusion

158. Increased transparency and frequent exchanges of information through various fora, workshops, seminars, and regular formal meetings with the Ministry staff considerably raised the degree of Government's trust in WHO. Shortage of material resources should be addressed through an aggressive resource mobilization drive. Shortage of human resources will remain a problem in the foreseeable future but WHO will continue to do its best to support the Medical College by increasing the number of fellowships awarded with a view to strengthening national capacity.

MALI

Introduction

159. Information for the present evaluation was drawn from the half-yearly reports for 1998 and 1999, the 1998 Annual Report, the monthly or quarterly reports of the country team and the technical reports of the Ministry of Health.

Achievements

160. The Ten-Year Health and Social Development Plan and the Five-Year Health and Social Development Programme as well as the tools for their implementation were prepared. Collaboration between the Ministry of Health and NGOs in the health sector improved and operational research was initiated. The hospital information system improved in line with the new priorities adopted in the Five-Year Health and Social Development Programme. The review of the Bamako Initiative took place. Seven community health centres became operational.

161. Drug prescribers in the three regions of the North were trained; a study was conducted on the determinants of illicit marketing of drugs; and drug quality control was ensured. The Scholarship Board was revived. Eighteen new fellowships were granted and former fellows were evaluated. The political and social mobilization programme was strengthened through the organization of various days to commemorate and publicize events.

162. Standards and procedures in the area of reproductive health and family planning were prepared. A study was conducted to prepare the health profile of elderly persons. Seventy social and health workers were trained in the management of elderly persons at home and in hospitals. The national mental health programme is being revised. Ten city health plans were prepared. Mechanisms for community participation, inter-sectoral cooperation, cost-sharing and private sector involvement were strengthened. The quality control of potable water was ensured regularly in the urban centres.

163. Generic modules for the integrated management of childhood illness (IMCI) were adopted. Fourteen social and health workers were trained in case management and ten workers were trained as facilitators. Mali's capacity to control meningitis, cholera and measles epidemics was enhanced mainly

as a result of the establishment of a rapid intervention team, the improvement of the national reference laboratory, the revision of the national plan for the prevention of and response to epidemics and the training of 40 doctors to manage epidemics in districts.

164. The second Mid-Term Programme for STD/AIDS Control was evaluated. Blood transfusion centres were reinforced in two regions and ten technicians now master blood transfusion techniques. Tuberculosis and malaria control activities were decentralized through the implementation of the DOTS strategy in 30 districts and the training of 45 doctors in the management of acute malaria. EPI evaluation revealed that immunization coverage was below set targets and that the dropout rates for DPTP1/DPTP3 were high. The second and third rounds of National Immunization Days (NIDs) for poliomyelitis involved the administration of vitamin A and immunization against measles. The coverage rates achieved exceeded 100%. The epidemiological surveillance of dracunculiasis was pursued in the endemic areas and the reduction rate was 98%.

Analysis

165. The Five-Year Health and Social Development Programme served as a reference for all activities and enhanced cooperation with the Ministry in the planning of activities. Furthermore, it increased political commitment to the organization of poliomyelitis NIDs, assured the timely availability of financial resources and the maintenance of permanent dialogue between all the partners in development. Inadequacy of technical services, weaknesses in the coordination of activities, administrative delays, and staff instability were some of the factors that impeded programme implementation.

Conclusion

166. The implementation of the 1998-1999 cooperation programme revealed that permanent dialogue between the various partners on the one hand, and between these partners and the Ministry of Health, on the other, is a major determinant of the effectiveness and efficiency of actions undertaken.

MAURITANIA

Introduction

167. The biennium saw the adoption of the sectoral approach to national health development. The new national health development plan for 1998-2002 aimed to provide the population by the year 2002 with the best health possible and to establish the basis for sustained health development through six major priorities. In October 1999, the third annual review of the project for support to the health sector was held. Results demonstrated that although some progress had been made, health indicators were still below expectation.

Achievements

168. Achievements recorded during the biennium included the preparation and implementation of an integrated social and health development plan; provision of support to many community-based initiatives; organization of a consensus workshop on the results of the evaluation of the National Health Information System and its future prospects; organization of a workshop to select monitoring and evaluation indicators; dissemination of essential biomedical and health information and distribution of the WHO Blue Trunk Libraries to 8 of the 13 regions of the country; situation analysis of the

pharmaceutical sector and preparation of the draft national drug policy; analysis of the situation of cost recovery in hospitals; provision of financial support for the training of 6 specialist and 4 generalist doctors; strengthening of 2 medical and paramedical institutions; creation of a new branch of training

in the National Public Health School aimed at involving future doctors in the implementation of the Safe Motherhood Initiative; development of a detailed plan of action for the implementation of a quality assurance system; establishment of a safe motherhood project in the Nouakchott region; successful commemoration of world health days; and completion of a plan of action on nutrition.

169. Other achievements were the involvement of the President of the Republic in National Immuniazation Days (NIDs) which integrated the administration of measles vaccines and vitamin A; strengthening of EPI routine activities; introduction of IMCI; expansion of the multidrug therapy to three regions; preparation of a three-year plan of action for tuberculosis control; setting up of an integrated epidemiological surveillance system; institutionalization of a multi-sectoral epidemiological surveillance commission; nationwide training of staff in epidemiological surveillance; improved national capacity for malaria control; readily available stock of anti-malarial drugs and intravenous glucose solution for response to epidemics; creation of 140 bednet treatment centres; organization, under the auspices of the Prime Minister, of the fourth and fifth national social mobilization days for malaria control; completion of a three-year plan of action for the implementation of Roll Back Malaria ; systematic screening of blood for transfusion; and training of health staff in 6 of the 13 regions of the country in the management of sexually transmitted disease syndromes.

Analysis

170. In spite of the achievements recorded, inadequate coordination of development partners resulted in difficulties in the implementation of certain programmes. Other problems encountered related to the weak capacity of hospitals in the regions, inadequate decentralization of activities and absence of a drug policy.

Conclusion

171. Implementation of priority activities and consolidation of achievements will be pursued through the 17 programmes retained under the 2000-2001 technical cooperation programme. In this connection, decentralization will be supported in order to ensure integrated regional development, formulate a drug policy, to ensure the surveillance of communicable diseases and strengthen the control of common diseases. More efforts will be made to improve the monitoring and evaluation system, including national capacity building.

MAURITIUS

Introduction

172. The technical cooperation programme between WHO and the Government of Mauritius was implemented through the 1998-1999 biennial plan of action. The amount of US$1,221,600 was allocated for implementation of the technical cooperation programme during the 1998-1999 biennium.

Achievements

173. WHO assisted in the formulation and development of a new integrated approach to health care delivery. A pilot project was initiated in a relatively under-served region with a view to upgrading two existing health care centres to Medi-Clinics which would function as community day care hospitals. WHO also trained the medical and paramedical staff of the Medi-Clinics in district health management and the information-based health management system. WHO provided support for improvement of the functioning of health care infrastructure at both the hospital and peripheral levels. A national baseline and prevalence study on noncommunicable diseases was successfully carried out with the technical support of the WHO collaborating centres. However, funds allocated under the regular country budget, as under

other sources of funding, were channelled to other priority areas, in particular the National Cancer Screening Programme.

174. WHO support to the ongoing information and education campaigns against HIV/AIDS and also the training of health personnel in universal precautions contributed to increased general awareness. The Regional Office, with the support of UNAIDS, fielded a mission to undertake an assessment of the impact of HIV/AIDS and tuberculosis on health care and on access to drugs.

175. Fellowships were awarded for further training in cardiology and drug quality control which are specialities with scarce human resources. A short-term training course was also successfully organized for the nursing staff of maternal and child health units to remedy the lack of this category of staff who are conversant with ultrasound imaging techniques.

176. WHO support in the area of health education and promotion of healthy behaviour focused on the empowerment of communities and high-risk groups and on the promotion of healthy lifestyles. Support was provided, more specifically, for matters pertaining to food safety and eating habits, healthy ageing, mental health and diabetes. Social mobilization and visibility were ensured through the observance of world health days in collaboration with national authorities.

177. The Division of Essential Drugs at headquarters and the Regional Office, in close collaboration with the University of Montpellier I, organized a three-month specialized training course in drug management for the public sector. The last of a series of three training courses for the public sector was successfully conducted in late 1999. It brought together 22 participants, including 5 local pharmacists employed in the public sector.

Analysis

178. Delegation of authority for the issuance of stickers at the Country Office level facilitated the implementation of activities approved in the Plan of Action. There were however delays in the implementation of additional but unplanned activities.

Conclusion

179. The current evaluation has shown the need for WHO to further focus resources on national priorities in areas where it has a distinct comparative advantage. This will entail the redirection of WHO resources to areas where results are more easily observable and measurable. To avoid the problems associated with delays in implementation, regular consultative meetings between the WHO Country Team and the programme manager and coordinators will be organized to ensure that all partners are abreast of WHO procedures.

MOZAMBIQUE

Introduction

180. The main sources of information for the preparation of this biennial evaluation included the following: annual plans of action; programme reports; semi-annual monitoring reports; allotment status from the Regional Office and reports on retreats organized for the WHO Country Team, and for the Ministry of Health and the WHO Country Office.

Achievements

181. Major achievements during the biennium included the organization of a national health research conference and the training of national health researchers; evaluation of operational research and health systems research in the country; provision of support for the development of a health care financing strategy as well as a national health policy; development of human resources for health through fellowships for study within and outside the country; completion of safe motherhood needs assessment with community involvement; implementation of a minimum package of mental health activities; evaluation of micro-nutrient deficiencies; situation assessment as a basis for environmental health policy formulation; conduct of two rounds of NIDs with a coverage rate of 90% and establishment of an acute flaccid paralysis surveillance system; reduction of leprosy prevalence from 6/10,000 to 3/10,000 inhabitants; development of an action plan for the implementation of IMCI; development of a training package in basic epidemiology at district level as well as a plan of action for the phased training of batches of trainees in basic epidemiology at district level; implementation of the national policy and mid-term plan of action on malaria control.

Analysis

182. The factors that facilitated achievements included the delegation of authority to the Country Representatives to issue stickers, which led to timely responses to country needs; increased collaboration and dialogue with the programme officers in the Ministry of Health; a stronger WHO advocacy role in a number of areas including reproductive health; strong support from the Regional Director through his two visits and the visit of the Director-General, which helped to place health high on the political agenda; increased collaboration with bilateral and multilateral partners; good working relations with the media which contributed to a new dynamism of WHO; increased response capacity of the Country Office as its staff strength more than doubled and working conditions improved considerably.

183. The major constraints encountered were the shortage of human resources and weak technical and managerial capacity in a number of units and programmes in the Ministry of Health which sometimes resulted in inadequate, poor and delayed response; national import regulations which caused serious delays in the implementation of some programmes; and lack of precise information on disbursement of funds for each expected result.

Conclusion

184. There is a need for greater articulation of support from the different levels of WHO. This would result in more effective, efficient and relevant interventions from WHO and would also help reach a consensus on the areas in which WHO's interventions could make a difference.

NAMIBIA

Introduction

185. The 1998-1999 biennial evaluation was based on programme reports, annual reports of the Ministry

of Health and Social Services and the WHO Country Office as well as on activity reports of professionals within the Ministry.

Achievements

186. Achievements during the biennium included the provision of support to central-level units of the Ministry and to priority health programmes in order to facilitate the restructuring and decentralization of the health system; identification of priority tasks to be implemented at district level; partial formulation of the national human resources development plan; strengthening of capacities at central and district levels through training in relevant areas; partial formulation of the reproductive health policy and strategy; development of health profiles of selected groups of youth; integration of youth groups into the national campaign for STD/AIDS control; development of the EPI policy document; establishment of the EPI surveillance system and its integration into actual epidemiological surveillance; formulation and implementation of regional and district plans for disease prevention and control; formulation of district plans for malaria prevention and control; and completion of drug resistance studies.

Analysis

187. The expected results were achieved where provision of technical or financial support coincided with relevant changes in the political agenda and developments in the national health policy. Additional determinants of the achievements were the increasing recognition by the Ministry of Health and Social Services of the burden of disease on the health care system and the collaborative approach of development partners, including the UN agencies, in addressing health problems and in creating an enabling environment for pooling resources. The availability of an experienced WHO technical adviser to follow up on planned activities facilitated the achievements. Clarification of the roles and functions of counterparts ensured their optimal utilization by the Ministry of Health and Social Services.

188. One of the factors that constrained the implementation of interventions was inadequate human resources. For example, shortage of senior level professionals and lack of expertise delayed the formulation and implementation of the emergency preparedness and response plan. Various additional activities and changing priorities prevented the achievement of some results. Although the adopted participatory development process promoted national ownership and capacity building, it hindered the achievement of some of the results, notably the development of the reproductive health policy and the national and regional health profiles. Lastly, the limited support of the central level of the Ministry of Health and Social Services hampered the implementation of district and community activities such as the formulation of district plans for community water supply in selected districts.

Conclusion

189. WHO will, through regular discussions and meetings with the Ministry and the National Planning Commission, anticipate health policy developments in order to provide more effective and efficient support. The Country Office needs to play a more prominent role among the multi-sectoral partners providing technical support to health sector reform.

190. WHO will continue to provide support for the monitoring of the national epidemiological profile, particularly of communicable diseases. Whenever an epidemic or priority health problem is not acknowledged at the outset or receives limited response, WHO will continue to provide technically sound support, including the identification of priority interventions. WHO will strengthen support to the districts in identifying priorities and improving planning and management capacity, and encourage the piloting of innovative approaches to health problems and alternative implementation mechanisms.

NIGER

Introduction

191. WHO technical cooperation with Niger during the second half of 1999 was carried out in a socio-political context characterized principally by the implementation of the transition led by the National Reconciliation Council, following the *coup d'état* of April 1999.

Achievements

192. Major achievements during the biennium included completion of the review of the curriculum of the Faculty of Health Sciences of the University of Niger; preparation of a national health policy document; human resources development through continued financial support to former recipients of fellowships and the award of new fellowships; provision of an adequate stock of essential drugs for the control of epidemics and response to emergencies at the district level; training of various categories of staff at district level in rational use of drugs; evaluation of the national drug policy; sensitization of communities to reproductive health, including family planning; formation of 42 district committees to regularly monitor the implementation of the Africa 2000 Initiative.

193. Other achievements were the training of community representatives in social mobilization and of health workers in the control of diarrhoea and acute respiratory infections; establishment of a national team responsible for other communicable diseases and provision of adequate support to the team; training of village health workers in onchocerciasis control; training at district level in insecticide treatment of bednets; and sensitization of populations in urban and rural districts to the control of tropical diseases.

Analysis

194. Delegation of authority to the WHO representatives by the Regional Director is a good management decision. Difficulties were however faced in putting together supporting documents for committed expenditures, which led to delays, for precautionary reasons, in the disbursement of funds for subsequent activities. Emergency situations necessitated budget reprogramming.

Conclusion

195. The improvement of means of communication between the WHO Country Office and the Regional Office contributed to the high level of performance attained. This and other factors are expected to positively influence the implementation of the 2000-2001 Plan of Action.

NIGERIA

Introduction

196. The Technical Cooperation Programme between WHO and the Federal Government of Nigeria for the 1998-1999 Biennial Plan of Action focused on four major priority programmes. These were integrated disease prevention and control; strengthening of district health systems; improved planning, financing and monitoring of health care services; and health promotion and protection. In line with the guidelines provided by the Regional Office, the WHO Country Team based its evaluation on programme

implementation reports, monthly technical reports, half-yearly reports as well as surveys and studies carried out during the biennium.

Achievements

197. Achievements recorded included advocacy and consensus building on the adoption of the Roll Back Malaria Initiative in the country and promotion of the use of insecticide-treated bednets and materials. The country also attained the WHO-indicated national level leprosy elimination target, with a prevalence rate of 0.8 per 10 000 during the first quarter of 1998. A national HIV/AIDS sero-prevalence survey was conducted in 1999. The emergency preparedness and response plans put in place were used to contain and manage outbreaks of cholera, cerebro-spinal meningitis and measles in various parts of the country.

198. Two rounds of National Immuniazation Days (NIDs) were conducted in 1998 and in 1999 and two rounds of supplemental National Immuniazation Days conducted in 15 states in 1999. The house-to-house strategy was adopted for the 1999 rounds. During the first round of the 1999 NIDs, a total of 34 196 224 children under the age of five years were immunized. An integrated surveillance system was also put in place throughout the country, with emphasis on detection of acute flaccid paralysis cases.

199. The country also intensified efforts aimed at implementing the IMCI strategy, through various training workshops and adaptation of the WHO/UNICEF training materials. The National Policy on the Elimination of Female Genital Mutilation and the National Policy on Health Education and Promotion were developed. The Female Functional Literacy for Health Promotion project, which started in two states, was extended to 10 states, 13 local government authorities and 33 communities. A national conference on adolescent reproductive health was held and Government declared 2 April as national safe motherhood day in support of the implementation of the WHO *Reproductive Health Strategy for the African Region.*

Analysis

200. Some factors either facilitated or constrained the achievement of the expected results. For instance, activities under the plan of action were not implemented in good time in 1998 because of a backlog of unimplemented activities dating back to 1997. This situation however improved in 1999 following the delegation of authority to WHO Country Offices to issue stickers. Planning and coordination of activities were slightly hampered by the movement of top officials of the Federal Ministry of Health from Lagos to Abuja, the federal capital. However, the dedication and commitment of staff as well as adequate guidance from management contributed to the achievements outlined above.

Conclusion

201. The evaluation of the cooperation programme during the biennium was very useful as it once again underscored the need for team work. It also helped the Country Office to identify areas of strength and weakness in the implementation of activities on which greater emphasis should be placed in the coming biennium.

RWANDA

Introduction

202. The programme of cooperation between WHO and Rwanda for the period covered by this evaluation comprised the following priority programmes: emergency and humanitarian action; national health policy; human resources for health; programme of action for essential drugs; reproductive health; mental health; health promotion; nutrition; water supply and sanitation; vaccine-preventable diseases; control of diarrhoeal and acute respiratory infections; and emerging diseases, including cholera and other epidemics, zoonoses and antimicrobial resistance. The major sources of information used for the evaluation were the 1998-1999 Plan of Action; 1998 and 1999 implementation plans; half-yearly reports; reports on specific programmes; and monthly financial statements of programmes provided by the Regional Office.

Achievements

203. Major achievements during the biennium included the preparation of district health plans; strengthening of the capacity of the division responsible for quality of care in the Ministry of Health; development of guidelines on management procedures and of training modules for financial management; development of human resources for health through fellowships; implementation of the mechanism for the supervision and monitoring of private pharmacies; organization of training in management for chiefs of hospital-based pharmacies; integration of mental health into the activities of all district hospitals; successful observance of all world health days; implementation of National Immuniazation Days; incorporation of the control of diarrhoea and acute respiratory infections into the curriculum of nursing schools; training of various categories of health staff in the control of communicable diseases and epidemics; and development of a guide on epidemiological surveillance and the management of epidemics.

Analysis

204. The major factors that facilitated achievements were the issuance of stickers by the WHO representative; presence of an international administrator and an administrative assistant unlike in the previous biennium; presence of a stable and experienced WHO Country Team; a climate of confidence and mutual understanding between WHO and the Ministry of Health; close collaboration with other partners; close collaboration between the officials of the Ministry of Health and members of the WHO Country Team and compliance with the timetable for implementation of activities.

205. In contrast, the factors that hindered the implementation of the cooperation programme were the low rate of absorption of WHO funds because many other partners whose procedures are less stringent often contributed to the same activities; a government reshuffle which led to the simultaneous replacement of the Minister of Health and the Secretary-General of the Ministry in January 1999; allocation of funds by WHO for the financing of unplanned activities at the expense of regular programme activities; absence of or late requests for financing from the Ministry of Health; difficulty

faced by Ministry staff in obtaining official travel authorizations for missions and seminars abroad; inadequate budgetary allocations for some programmes in relation to expressed needs; delays by the Regional Office in placing fellowship applicants for the 1998-1999 biennium; and delay in replacing one of the WHO Country Office staff who left in April 1999.

Conclusion

206. To enhance the implementation of WHO's cooperation programme in future, it will be important to hold at least one meeting each quarter with officials of the Ministry of Health in order to monitor programme implementation; simplify WHO procedures further; ensure more equitable distribution of financial resources between programmes; ensure greater flexibility, at national level, in the distribution of budgetary allocations between the various programmes under the Plan of Action. Also, the Human

Resources for Health Unit in the Regional Office will make greater effort to place fellowship applicants in order to help resolve the problem of human resources at country level.

SAO TOME & PRINCIPE

Introduction

207. The health situation remained precarious as the major health problems were not adequately addressed. The environment continued to deteriorate and health system management and organization capacity remained weak. The main sources of information for evaluation of the cooperation programme were bi-annual progress reports on WHO/country cooperation activities for 1998-1999; the annual report of WHO/country cooperation activities for 1998; the report of the retreat on health in Sao Tome & Principe (March 1998); and the National Health Policy document.

Achievements

208 The health sector reform process initiated in March 1999 through the holding of retreats resulted in the drafting of a national health policy document. The process involved all societal strata. In order to pursue the process, a schedule of activities for the year 2000 was prepared including the production of a health map, a human resources development plan, and a health information system with a view to formulating a national health development plan and organizing a sectoral roundtable.

209. Traditional birth attendants were trained in home-based child delivery, counselling on reproductive health and referral for complications of pregnancy and childbirth. The training was aimed at reversing the trend of declining trained health worker-assisted deliveries. All the district teams were trained in epidemic, emergency and disaster preparedness and response. A measles control campaign was conducted over a nine-month period, leading to an average coverage rate of 93% among the 15 years age group. The national laboratory system was evaluated in terms of rapid confirmation of epidemics. The plan of action for malaria control was prepared and the process for launching the Roll Back Malaria Initiative was initiated. The epidemiological profile of the country was finalized.

Analysis

210. The factors that contributed to achievements included proper coordination at the level of the WHO Country Office; effective strengthening of the Country Office through the recruitment of members of the WHO Country Team; improved intervention capacity of WHO Country Office, now assisted by consultants and regional and sub-regional advisers; closer collaboration between the Ministry of Health and the Country Office; better collaboration and coordination among all the agencies of the United Nations system; delegation of issuance of stickers to WHO representatives, thus reducing the time of response to requests from the Ministry of Health and improving the performance of the WHO Country Office.

211. The factors that constrained implementation were lack of systematic quarterly programming of the implementation of cooperation activities by the Ministry as well as excessive requests for reprogramming; scarce technical and managerial resources; high staff turnover due basically to poor conditions of work and poor salaries; and frequent delays in exchanges of information between the Regional Office and the Country Office, particularly concerning administrative and financial matters and specifically for the payment of WHO Country Office staff salaries.

Conclusion

212. Budget targets were met, in spite of excessive reprogramming requests. WHO will support the strengthening of the capacity of the Ministry of Health in the coming biennium. Some of the lessons

learnt include the need to increasingly involve national counterparts in preparations for the evaluation and to train the staff of the Ministry of Health in the WHO managerial process.

SENEGAL

Introduction

213. The aim of the Cooperation Programme between WHO and Senegal for the period under review was to strengthen, through priority programmes, the functioning of health districts by implementing the national priorities defined in the Integrated Health Sector Development Plan (1997-2002). This evaluation was based on the November 1998 mid-term review of the Plan of Action, progress reports on programmes, Regional Office financial reports, and Ministry of Health review and evaluation reports.

Achievements

214. WHO contributed to the strengthening of health services management through coordination and supervision meetings and to the improvement of the operational capacity of staff by providing equipment and materials for the regions and districts. WHO also helped to build the capacity of health teams by organizing regional exchange and reflection workshops on the Integrated Health Sector Development Plan, by supporting decentralization and contract awards and the conduct of a survey on the operational capacity of districts.

215. Eight fellowships were granted or consolidated especially for the training of public health doctors and health economists. WHO also contributed to the organization of two overseas training schemes for four staff of the Ministry of Health and one seminar on health insurance funding. The HIV prevalence rate was maintained at below 2% as a result of defined and implemented strategies. Consequently, UNAIDS cited Senegal's STD/AIDS Control Programme as one of the best in Africa, which earned the Head of State an award.

216. Other achievements were the construction of sanitation facilities in six cholera-prone health districts; effective supervision and training of staff and facilitation of exchange of visits between countries on guinea worm eradication; completion of two studies with a view to formulating the national health research plan; organization of a training seminar on research methodology for 30 health staff; completion of two studies on the health needs of the elderly and health-related micro-enterprises; increased awareness of health staff in 8 of the 10 regions of the country in respect to IMCI and commencement of its implementation in three districts: drawing up of the National Plan of Action for combating female genital mutilation; finalization of the national reproductive health programme; improvement of the quality of safe motherhood services in the Vélingara District through the training of health staff and the construction of 4 health posts; strengthening of the epidemic management system by organizing short training courses for health staff in 3 regions and for 50 guides in all the 50 districts of the country; strengthening of inter-country cooperation in the control of communicable diseases by formulating the action plan entitled 'Health for Peace Initiative'; evaluation of the implementation of the Plan of Action for accelerated malaria control; extension of malaria control activities to all the health districts and commencement of the implementation of Roll Back Malaria; provision of a consignment of drugs and support for disease control following the floods as well as provision of vaccines to help control the meningitis epidemic; and successful NIDS with a coverage rate of over 90%.

Analysis

217. The achievements were facilitated by the effective empowerment of the Ministry of Health. Efforts to improve the management process will focus on the following major inadequacies: inaccurate planning of activities; late submission of requests for funds; and poor quality of technical reports.

Conclusion

218. The implementation of the WHO/Senegal Cooperation Programme significantly improved collaboration with the Ministry of Health as illustrated by greater consultation between the country team and the programme managers.

SEYCHELLES

Introduction

219. The major sources of information for this contribution were minutes of the regular meetings on technical cooperation between the Ministry of Health and WHO; mid-term review reports; and some end-of-activity reports. Since Seychelles is a small country with only a few programme areas for cooperation, it was relatively easy to monitor and evaluate their implementation. During the 1998-1999 biennium, cooperation focused mainly on technical cooperation with countries, human resources for health; primary health care; mental health; health promotion; assessment of environmental hazards; and other communicable diseases.

Achievements

220. The major achievements during the biennium were improvement of the documentation centre; sensitization of youth from the outer islands to the problem of substance abuse; promotion of better record keeping for the preparation of reports for police and court cases; development of an emergency preparedness plan to cope with various emergencies; provision of laboratory support for rapid diagnosis of endemic diseases and the identification of foci of epidemic risk; provision of guidelines on the use of laboratory equipment and interregional networking; updating of the latest advances in the diagnosis, treatment and prevention of AIDS; successful commemoration of World AIDS and World No Tobacco Days; training of record clerks and medical consultants; and development of human resources for health by continuing to award fellowships.

Analysis

221. The achievements of the major programmes of cooperation between WHO and the Government of Seychelles were generally very positive. The low population and the small surface area of Seychelles are a major facilitating factor in programme implementation. However, the main constraint on optimal achievement of expected results was the haphazard and rather frequent apportionment of funds allocated for planned activities to some other unplanned, though necessary, activities. This is an indication that adequate planning and prioritization of proposed activities should have preceded the finalization and implementation of the 1998-1999 Plan of Action.

Conclusion

222. The biennial evaluation was an excellent method for both WHO and the Ministry of Health to review objectively the activities of the past biennium, with a view to improving the visibility of WHO's technical co-operation in the country. The evaluation definitely helped to improve the planning and quality of the 2000-2001 Plan of Action.

SIERRA LEONE

Introduction

223. For the greater part of the biennium, Sierra Leone faced problems of continuing civil war, deteriorating health conditions, massive destruction of health facilities and political instability. Despite these constraints, most planned activities were completed on time and within budget. A planning process was undertaken from mid-1999, first as an in-house activity and then in consultation with the Ministry of Health and Social Welfare.

Achievements

224. Some of the major achievements during the biennium included capacity building for the implementation of various programmes through the organization of training workshops for senior health staff in case management of severe and complicated malaria; and for community health workers in 6 districts in the prevention and control of malaria; 12 laboratory technicians in surveillance of epidemic-prone diseases; 120 district health management team members in data processing and analysis; primary health unit staff at the district level in emergency preparedness; health staff at district level in tuberculosis case management; 240 community health workers in the prevention of tuberculosis in 4 districts; midwives, community health officers and MCH aides in emergency obstetrics care and maternal and new born care as well as in information and education for health. Other achievements were training of EPI vaccinators in 6 districts in maternal and new born care; health staff in micro-nutrient deficiencies; and district health team staff in case detection and reporting of acute flaccid paralysis (AFP). World health days were successfully observed; human resources for health developed through WHO fellowships and salaries paid to 3 teaching staff of the College of Medicine and Allied Health Sciences. The achievements also included the production of training guidelines for reproductive health and family planning; the production of nutrition guidelines; the development of the Plan of Action for poliomyelitis eradication; and sensitization of local and international partners to poliomyelitis eradication strategies.

225. Substantial progress was made in poliomyelitis eradication. Seventy-six percent, 85% and 84% respectively of all target children under five years of age were covered in the three rounds of National Immuniazation Days (NIDs). Provision of oral polio vaccine and vitamin A to the nation's children during these NIDs was the first and only government service to reach the entire country in the past nine years of civil war, thus opening up an opportunity to deliver other essential child survival services and serving as a bridge to peace in Sierra Leone.

226. Another achievement concerned the national staff of the WHO Country Office. They remained at post during the period of military rule when all expatriate UN staff, including the Country Representative, were evacuated out of the country, and also during the January 1999 invasion of Freetown. As a result, WHO, unlike some other UN agencies, lost very few vehicles.

Analysis

227. Collaboration with the Ministry of Health, UN agencies and NGOs was productive and cordial. However, constraints which affected performance included continued insecurity in the country; a non-existent Government funding base, due to the stalled disarmament, demobilization, and integration process; massive population displacements and the resulting overcrowding, poverty and cultural dislocation posed serious disease transmission risks, including the risk of HIV; looted or destroyed health facilities in most rural areas; unpaid and demoralized district health management teams and the non-functioning disease surveillance system. One other major constraint was that WHO programmes seemed unclear to other health partners.

Conclusion

228. Considering the prevailing conditions, performance was quite good. With a more strategically focused approach, increased mobilization of extrabudgetary resources and careful attention to technical

content, performance will be improved in the coming biennium.

SOUTH AFRICA

Introduction

229. Data for the evaluation of WHO's 1998-1999 programme of technical cooperation with the Republic of South Africa were obtained from semi-annual monitoring reports; programme reports from the National Department of Health; and interviews with programme managers.

Achievements

230. Several pieces of legislation concerning national health development were prepared and endorsed by the provinces. The activities under the 1998-1999 technical cooperation programme were regularly monitored. All WHO sponsored programmes of the Department of Health are now using WHO's managerial and financial tools routinely. WHO's support to national health development was evaluated. Seventeen new WHO fellowships were awarded in line with the national human resources development policy.

231. Midwives, doctors, and policy-makers were briefed on modern midwifery problems and solutions and provincial health workers were trained in advanced midwifery. Health care workers acquired skills to better care for the mental health needs of children. Reports on occupational respiratory diseases were produced and distributed. Occupational health service programmes were developed at the district and provincial levels and the expertise of national and provincial health and safety staff was improved.

232. A draft proposal was developed for the establishment of pilot school-based prevention programmes. Special campaigns were conducted during the World Environment Day to raise the awareness of school children nationwide on the need for a safe and healthy environment. Pipe-borne water and toilets were provided to 63 rural clinics and schools and 215 environmental health officers acquired skills in environmental impact assessment and participatory methodology. A blueprint for IMCI was developed and 350 health workers, 50 facilitators, and 21 supervisors in 8 provinces acquired skills in IMCI implementation.

Analysis

233. Programme performance was facilitated by improved communication between the WHO Liasion Office and the National Department of Health, and by the development of a critical mass of knowledge over the past several years of WHO's managerial process and procedures.

234. Performance was, however, constrained by the continued absence of a country team, which limited both the quality and efficiency of technical support from the WHO Liaison Office; lack of knowledge of WHO's managerial process and procedures, mainly at the provincial and district levels; consultants' fees which are considered low by national standards; staff shortage in the National Department of Health, resulting in last-minute efforts to utilize available resources from WHO; failure to finalize the National Health Act, which delayed the development of provincial health legislation; resignation of the health information and promotion officer, which prevented effective promotion of WHO's policies for health development; and implementation of a large number of priority programmes, which blurred the significance of WHO's contribution to health development in the areas concerned and adversely affected the seriousness with which programme activities were undertaken.

Conclusion

235. Notwithstanding the relative success achieved in the Plan of Action implementation, the following lessons should further improve quality and efficiency in future biennia: limiting the number of activities under the technical cooperation programme in the future to about four should increase the impact of these activities on national health development; mobilization of a WHO Country Team consisting of four or five national professional officers should improve both the quality and efficiency of WHO's technical support to the National Department of Health; health authorities at the provincial and district levels need to be trained in WHO's managerial process and procedures. This will impact positively on the management of resources at the provincial and district levels, enhance the participation of health authorities in the determination of technical cooperation priorities and accelerate the implementation of cooperation activities.

SWAZILAND

Introduction

236. Working arrangements between the Regional Office and the WHO Country Office were improved significantly, particularly concerning the coordination of technical support to the country and the provision of technical materials and publications. The national authorities placed greater confidence and trust in the Regional Office's ability to select, recruit and support technical experts.

Achievements

237. The national health policy was reviewed. Successful training sessions on health management skills were conducted for senior health staff. Advocacy and briefing meetings were held with the mass media, especially on major health issues. The number of WHO-supported fellows increased significantly as a result of the introduction of the distance education project. The pharmacy bill, drug legislation, and the medicine and related substances bill were finalized. The implementation of the Bamako Initiative was strengthened.

238. The launching of the Safe Motherhood Initiative increased general public awareness of the problem. Many traditional birth attendants and rural health motivators were trained in safe deliveries and midwives were successfully trained in life-saving skills. The proposal on elimination of congenital syphilis was implemented. Two national meetings were held to train nurses and laboratory technicians. A project was initiated on the psycho-social development of the newborn and rehabilitation of teenage mothers. Promotion of healthy behaviour and mental health was strengthened. Awareness campaigns on tobacco, drugs and substance abuse were expanded through Anti-Drug Clubs with the assistance of young people in schools. Health promotion and education coverage was greatly increased with successful training of media staff in positive reporting on health issues.

239. The national food and nutrition policy was reviewed and Phase 2 of the curriculum for nutrition was completed. Research on indigenous foods that impact on the prevention of diet-related diseases was conducted. Key target groups were successfully trained in safe food handling. The construction of sanitation facilities and the upgrading of water systems in underserved communities were expanded and communities were successfully trained in the maintenance of these facilities. Occupational health became more visible through the completion of the baseline information on chemical risk assessment for the country. Awareness training sessions on chemical risks were conducted.

240. National Immuniazation Days (NIDs) for measles were successfully conducted in 1998, in association with poliomyelitis mopping up activities and vitamin A supplementation. The second phase

of the NIDs was conducted in 1999 with a high coverage rate. Epidemiological surveillance of non-flaccid paralysis was strengthened. The IMCI strategy was introduced and promoted through the training of nationals in its implementation. The implementation of the DOTS strategy was initiated in 2 regions. The sixth HIV/AIDS sentinel surveillance survey was conducted successfully. The medium-term plan was developed and the community-based care project was successfully launched. Many health professionals were trained in the management of severe and complicated malaria. A cancer registry was established and the awareness drive continued to focus on the control of noncommunicable diseases.

Analysis

241. Increased planning and collaboration with the Ministry of Health and Social Welfare resulted in successful implementation of the programmes. The level of commitment of, and desire by, all NGOs and other partners active in the health sector to collaborate was a facilitating factor.

Conclusion

242. The Ministry of Health and Social Welfare continued to pull together all relevant partners to participate in joint planning and evaluation meetings, with WHO acting as facilitator, in order to ensure the smooth delivery of services and avoid duplication of efforts and resources. The finalization of the country's national health policy would have a more positive outcome for all the parties concerned and would enhance the delivery of services to the grass-roots level.

TOGO

Introduction

243. Togo's health situation is characterized by the predominance of infectious and parasitic diseases, the most important of which is malaria. Maternal and infant mortality rates are high, standing at 478 per 100 000 live births and 80 per 1000 livebirths respectively. Shortage of staff is persisting in spite of the recruitment of 1 088 workers in 1998. Health facilities are not maintained. Primary health care coverage is steady at 60%. This evaluation was based on the 1998-1999 programme budget, the biennial plans of action (1998-1999), the 1998 and 1999 plans of implementation, biennial and annual reports and progress reports on programmes, studies and surveys.

Achievements

244. The national health policy and the national strategy note were finalized and adopted by the Government. Emergency situations in the health districts were efficiently managed. Generic essential drug coverage in health districts reached 100% and district health staff were trained in the use of these drugs as well as in the detection and proper management of neuropsychiatric diseases. Twenty traditional birth attendants in villages with difficult access to health services were trained. Thirty delivery kits and thirty weighing scales were supplied to maternities. The implementation of the national nutrition plan was initiated. Reliable data on water and sanitation coverage are available. Thirty unskilled builders were trained and 90 demonstration sanitation facilities were constructed.

245. Promotion of condom use was strengthened. EPI was supported and all children aged 0 to 59 months were immunized against poliomyelitis during the first and second rounds of National Immunization Days. Five thousand mosquito nets were distributed; 200 litres of K. Othrine (insecticides) were supplied; and 659 health workers trained to reinforce malaria control. One hundred thousand doses of meningococcus vaccine A+C and 60 000 ampoules of chloramphenicol were purchased and 289 workers trained in ARI case management techniques. One hundred and six schools were provided with first-aid boxes. Seven trainers and 12 workers were trained in community-based rehabilitation and 50% of health care providers were trained in IMCI.

246. The national health care quality assurance team was trained while 120 fellowships and study grants were awarded or consolidated. The No Tobacco Day, the Diabetes Day, the Tuberculosis Day, the AIDS Day and the Nurses Day were commemorated. Ten studies, surveys and research projects were conducted. The research findings and statistical data were used in the preparation of national reference documents in the areas of health policy and management, health services development, health promotion and protection and integrated disease control. Fifty-five supervision, monitoring, evaluation and investigation tours, 107 field trips and technical support missions were undertaken. The use of computers in the regions and in some health districts facilitated the production of reliable data for decision making at those levels.

Analysis

247. Decentralization of sticker issuance to WHO Country Offices was a valuable asset which helped to improve the plan implementation. The performance of programme managers was improved through various training workshops. Factors that hindered implementation included disruptions from presidential and parliamentary election campaigns; lack of mastery of or compliance with WHO management procedures by some programme managers; underestimation of the cost of some activities; and the large number of programmes supported by WHO.

Conclusion

248 The health districts are being made operational through health data computerization, staff training, capacity building for planning and resource management, and implementation of health promotion and integrated disease control activities. As the National Health Development Plan is being finalized, WHO priorities and areas of intervention will be redefined.

UGANDA

Introduction

249. The biennium witnessed intensive work on the major elements of Uganda's National Health Sector Reform Programme in which WHO played a central role as both technical adviser for the Government and its health development partner. The WHO Country Office acted as secretariat for the finalization of most of the health sector reform process documents. The Joint Consultative Group, chaired by the WHO Representative, paved the way for wide consensus on the adoption of a sector-wide approach to health in Uganda.

Achievements

250. WHO actively participated in the development of the new National Health Policy and of the Health Sector Strategic Plan for 2000-2001 and 2004-2005 by facilitating the acceptance of the sector-wide approach to health by all stakeholders, co-ordinating the donors, and providing technical input to the costing and financing of the Strategic Plan. The Bamako Initiative, successfully piloted in one district, is being extended to three other districts.

251. Ten districts were assisted in district-level reproductive health planning. Thirty percent of the

reproductive health staff from health centres and referral facilities in 7 of the 10 districts were trained in emergency obstetric care. Social marketing of the Clean Delivery Kit is ongoing, with start-up kit production. WHO supported the Ministry of Health in formulating a draft adolescent health programme. A health worker training manual on communication and counselling skills is being finalized. Capacity building was undertaken and support provided for the promotion of sanitation, specifically, with respect to water quality.

252. Marked reductions in reported cases of guinea worm and improvements in case containment were observed. The third and fourth rounds of National Immunization Days (NIDs) achieved coverage levels of 98% and 107% respectively in 1998 and 107% and 113% in 1999. Measles control campaigns had been integrated in the NIDs in 7 districts for the purpose of drawing lessons for replication. Forty-five district health teams and operational-level health workers from 25 districts were trained in epidemiological surveillance. Ivermectin was distributed to all the 17 onchocerciasis-endemic districts and marked progress noted in the control of the disease. Vector eradication activity is virtually completed in one of the two implementation areas.

253. Major achievements in the implementation of the malaria control programme included the development of essential guidelines and training modules, training of core facilitator teams in severe malaria management, vector control and drug efficacy follow up. Authorities agreed to waive taxes on insecticide- treated materials. The collaboration between the malaria control and IMCI programmes enhanced co-ordination of the implementation of the two programmes. Six trial courses on IMCI for nursing aides were successfully conducted. At least 40% of professional health workers in 20 districts were trained in IMCI. The addition of other IMCI components further consolidated the capacity of those districts. Referral care guidelines and a pre-service training course were also being developed. Eight districts implemented DOTS. The work of WHO was promoted through the celebration of WHO commemorative days, production and distribution of health promotion materials, and the training of journalists.

Analysis

254. The biennial Plan of Action implementation was facilitated by, among other things, decentralization policy of the Regional Office; the co-operative attitude of stakeholders and dynamic donor co-ordination; the active involvement of relevant ministries, especially the Ministries of Local Government and of Finance; greater inter-departmental collaboration within the Ministry of Health; and existing grass-roots structures. Major factors that delayed programme implementation included the restructuring of the Ministry of Health; the Local Council elections in early 1998; low public service staff morale; vertical approaches in programmes; weak data management; insecurity in some districts; and delays in compliance with accounting procedures which led to the late release of funds.

Conclusion

255. The evaluation of WHO/Uganda technical cooperation showed that co-ordination of stakeholders enhances smooth programme implementation and that sustained service quality requires regular provision of essential materials and supervision of trained personnel. There is a need for the use of facilitation techniques and social mobilization in introducing community- health approaches into health facilities and systems; and that “cascade” training is inexpensive but poor in technical content.

UNITED REPUBLIC OF TANZANIA

Introduction

256. This evaluation is based on national plans and strategies, bi-annual and annual reports, and work

plans and technical reports of the Ministry of Health and WHO regarding the implementation of specific programmes.

Achievements

257. The major achievements during the biennium included participation in the preparation and establishment of joint plans of action between WHO and the Essential Health Intervention Programme (TEHIP) for the provision of technical support to districts; participation in national planning of interventions for implementation at district level; review of one year's implementation of IMCI and printing of IMCI training materials. Other achievements were the establishment of formal collaboration with WHO in the essential health intervention programme aimed at conducting IMCI effectiveness studies for the global evaluation of IMCI; the attainment of 97% and 100% NID coverage during 1998 and 1999 respectively and the attainment of 92% coverage in 31 selected districts during the 1999 measles campaign; improvement in timeliness and completeness of AFP surveillance which resulted in an AFP detection rate of 1.13 per 100 000 children under 15 years of age; and production of a report on an analytical study on food safety. Human resources for health were developed through WHO fellowships and recipients successfully placed; research proposals were developed for later implementation; a training of trainers workshop was conducted in management for district health management teams as part of health reform; and active support to, and participation in, the ongoing health sector reform process was assured.

Analysis

258 Determinants of the positive results achieved included a clearly defined joint plan of action in terms of objectives and expected outcomes, agreed by the Ministry of Health and WHO; adherence to national priorities and use of existing mechanisms for plan implementation; concurrent monitoring and evaluation as well as requests for additional support from health partners; coordination of and close collaboration with key partners, namely the Government, NGOs, UN agencies, donors and the private sector. Constraints on implementation and achievements included the discrepancy between budgetary allocations and actual funds made available; heavy workload and the need for additional technical support; limited capacity of districts to implement their own plans; delays in districts awaiting implementation of health sector reforms; delays in the release of funds from the Regional Office and lack of oral polio vaccine for use within the expanded programme on immunization.

Conclusion

259. Overall, the outcomes for the 1998-1999 biennium were positive. Budgetary discrepancies between allocated and available funds need to be further addressed. To avoid spreading resources too thinly over many programmes, it is recommended to have fewer comprehensive programmes with more tangible goals. Due to the broad nature of the national health system and managerial processes as well as heavy reliance on extrabudgetary funds to accomplish targeted goals, the WHO/Tanzania cooperation programme will require more support in the future.

ZAMBIA

Introduction

260. WHO provided technical and financial support to the Ministry of Health and to the Central Board of Health. Early in 1998, these two bodies and WHO held a tripartite meeting to align WHO's targets with the country's strategic objectives. These meetings formed the basis for monitoring the implementation of the programme throughout the biennium.

Achievements

261. The key achievements involving close collaboration among WHO, the Ministry, the Board and other partners included strengthening of the health reform in Zambia; development of a reproductive health policy and strategy; successful implementation of the National Immunization Days and the supplemental national immuniazation days in 1998 and 1999 respectively with average coverage of over 90%; completion of the Vaccine Independence Initiative in collaboration with EPI partners; development of the national health financing policy; successful implementation of IMCI with the training of 208 and 157 health workers and community health workers; and development of an HIV/AIDS training manual for counselling and care as well as initiation of the process for developing the policy relating to voluntary HIV testing and counselling.

262. Other achievements were the development of an RBM inception plan and the implementation of key activities for an evidence-based malaria control programme; expansion of the use of insecticide treated nets; successful implementation of the Africa 2000 Initiative, especially in rural areas; the completion of the global water supply and sanitation assessment and finalization of the national health communication strategy; support to training programmes on communication planning and implementation in the districts; support to specific themes of world health days; launching of the national environmental sanitation strategy in rural and peri-urban areas; and the production of trainers' modules on toxic chemicals, environment and health.

Analysis

263. Achievements were facilitated by, among other things, regular consultative meetings of WHO, the Ministry and the Board in order to assess the implementation level of the Plan of Action as well as the appointment of focal points and programme managers to implement the different programmes; strengthening of the Country Office by recruiting national professional officers to work with the programme managers; the excellent and reliable communication facilities in the WHO Country Office; and the successful training by WHO of Ministry and Board staff to carry out activities in line with its objectives and guidelines.

264. Constraints on implementation included non-disbursement of extra-budgetary funds for regular budget programmes with limited funding; Government's ban on the organization of workshops; inadequate human resources in the Country Office; reallocation of funds from the regular budget for shipment of medical supplies, purchase of drugs or supplies for emergencies such as cholera outbreaks and the influxes of refugees; lack of support for early response to natural and man-made disasters; and the fact that proposals submitted by the Ministry and the Board were either late or not in line with priorities and targets.

Conclusion

265. Major lessons learnt were as follows: the use using extrabudgetary funds for regular budget programmes is an indication that those programmes need an increase in budget allocations; mid-term reviews and regular meetings serve to accelerate implementation and improve the degree of achievement of objectives; extrabudgetary funds, in particular, can improve the efficiency and degree of achievement during emergencies or for other priorities; the level of efficiency is directly linked to the allocation of adequate funds and the availability of manpower for programme implementation; and consultative meetings bringing together WHO, the Ministry and the Board are a mechanism for ensuring that set targets are in line with objectives.

ZIMBABWE

Introduction

266. Sources of information for the preparation of this report included the annual reports of various programmes, survey reports, reports on workshops and training courses.

Achievements

267. Major achievements during the biennium included capacity building for emergency preparedness by the multi-sectoral civil protection committees at provincial and district levels; comprehensive review of the health information system; development of the 1997-2007 National Health Strategy through consultation with and the participation of stakeholders; translation of the strategy into action through the development of a three-year rolling plan and a programme implementation plan; adoption of the Health Review Commission report and the subsequent restructuring of the Ministry of Health and Child Welfare based on the recommendations of the Commission; development of human resources for health through WHO fellowships in various fields as well as strategies for human resources for health, reproductive health and adolescent reproductive health.

268. Other achievements included the establishment of the school health programme; organization of a national workshop on HIV/AIDS reporting for journalists and the designation of some of them to report on HIV/AIDS; successful commemoration of six health days; provision of water supplies and sanitary facilities to some cholera-prone areas of 24 villages; launching by the President of the National AIDS Policy; formation of the National AIDS Council and gazetting of the AIDS levy; successful EPI campaigns with a 93% coverage rate and an AFP detection rate of 1/100 000 of children under 15 years of age; the reintroduction of the Hepatitis B vaccine into the EPI schedule and Government's commitment to purchase its own vaccines to enhance EPI sustainability; availability of standard guidelines on the diagnosis and treatment of complicated and uncomplicated malaria cases in 70% of the districts; proper case management in 93% of the facilities; consensus building around the RBM Initiative; a successful pilot study on the implementation of DOTS at community level in 7 districts; and quick response to cholera and malaria epidemics.

Analysis

269. Political will and support was important in epidemic control, RBM and poliomyelitis eradication. Due to staff turnover, the capacity to implement planned activities in reproductive health was low. Lack of behavioural change in spite of high awareness was a major constraint on the implementation of the HIV/AIDS programme. A disturbing trend was that EPI coverage was decreasing due to lack of transport and other logistics which made outreach efforts impossible.

Conclusion

270. Lessons learnt from the evaluation were that priorities set with the Ministry of Health need to be reviewed twice a year to take account of unforeseeable developments; officers in the Ministry of Health and the WHO Country Office should constantly keep track of their spending patterns, given the complex nature of the WHO accounting system; budgetary support to HIV/AIDS will be increased to reflect the magnitude of the HIV/AIDS pandemic; and half-yearly meetings with the Country Office are needed to facilitate monitoring and evaluation of the Plan of Action.

THE WORK OF WHO AT THE REGIONAL AND INTERCOUNTRY LEVELS

GENERAL PROGRAMME DEVELOPMENT AND MANAGEMENT

Introduction

271. General Programme Development and Management, which encompasses all the technical divisions, comprised three major programmes, namely, Health, Science and Public Policy (HSP), Inter-Agency Resource Mobilization (IRM) and Emergency and Humanitarian Action (EHA). HSP consisted of the specific programmes: Health in Sustainable Development (HSD), Technical Cooperation with Countries (TCC) and Research Policy and Strategy Coordination (RPS). The main sources of information for this evaluation were the 1998-1999 plans of action, mid-term reviews of the programmes, reports on important activities such as Regional Programme Meetings (RPMs), the 1998-1999 programme-budget, and financial statements provided by the Budget and Finance Unit (BFO).

Achievements

272. The major achievements over the biennium were the increase in the capacities of the Regional Office and WHO country offices to mobilize extrabudgetary resources for the implementation of WHO programmes in the countries; the organization of three inter-country meetings for sharing experiences in the design, implementation and monitoring of health sector reforms; better organized and focused Regional Programme Meetings; greater coordination of support to country offices in the management of WHO programmes, especially in preparing plans of actions; development of clearer guidelines for planning, monitoring and evaluation; development of a plan of action for implementing the regional strategy for research; and increased capacity in the countries for emergency preparedness and response.

Analysis

273. The IRM unit played a key facilitating role in the mobilization of extrabudgetary funds, particularly after the secondment of one of the technical officers to the WHO Office in the European Union.

274. Some of the activities under the HSD programme were transferred to other divisions (DSD and DES, notably) as a result of the current restructuring. Compilation of inventories of micro-financing enterprises and health legislation was not undertaken. However, three inter-country meetings on health sector reform were organized.

275. Regarding the intercountry programme (ICP) and RPS, staff mobility and work overload affected the effectiveness of planned activities. Besides, there was need to improve the quality of project proposals submitted for funding. Nonetheless, some achievements were recorded as a result of the recruitment of a regional adviser for TCC, and a short-term professional for planning, programming and evaluation and for research policy and coordination.

276. The EHA programme, despite staff turnover, recorded valuable results in planned as well as unplanned but relevant activities. Major determinants of achievements were the full commitment of Member States to embark on emergency preparedness and improved coordination between EHA and other Regional Office technical divisions (DDC, DSD, DRH and DNC) in addressing country-specific needs.

Conclusion

277. The biennium, particularly the second year, was a transition period for the conversion of the TCC,

PDC and EHA programmes into full fledged units. Given the strengthening of these units through the revision of job descriptions and the recruitment of regional advisers for the various areas of work, the effectiveness and efficiency of future action will significantly improve in the areas of technical support to countries, research policy and coordination, evidence and information for health policy, planning, monitoring and evaluation, and emergency preparedness and response.

DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT

Introduction

278. The implementation of the 1998-1999 Plan of Action of Health Systems and Services Development (DSD) was influenced by factors and events related, in particular, to the re-organization and re-structuring of the Regional Office during the biennium. In addition, new priorities and financial constraints led, among other things, to the revision of the plans of action of several programmes.

Achievements

279. A major achievement of the National Health Systems programme (NHS) was the development of the Regional Health-For-All Policy for the 21st century which provides a long-term vision for health development in the African Region. Guidelines were produced for health policy development and countries received support to update their policies and strategies. Fourteen countries received sustained technical support in health sector reform. The programme contributed to the introduction of health systems development issues within the context of special initiatives such as Roll Back Malaria and the health component of the United Nations system-wide Initiative for Africa.

280. For the District Health Systems (DHS) programme, the main achievements were the development of training materials for strengthening district health management teams and tools for assessing the operationality of district health system. These tools were field-tested in four countries. A second regional meeting, organized jointly with UNICEF and the Government of Mali to review the implementation of the Bamako Initiative, led to the development of the community dimension of health sector reform which was initiated in collaboration with various partners in the Region. The DHS programme contributed in strengthening the links between district health systems and specific initiatives such as RBM and Safe Motherhood. The contributions also included support for the local and district response initiative for HIV/AIDS prevention and control and community home-based care.

281. Countries were supported in the evaluation and reform of their health information system, preparation of a plan of action for the development of their HIS and selection of essential health indicators. An expert meeting was organized to evaluate the approaches and tools developed as well as to design a framework for evaluating the regional initiative for strengthening health information system.

282. Major changes took place in the area of health systems research. The original joint subregional project was changed into a programme and expanded to cover the whole African Region. More than 80 health workers were trained in health systems research methodology and some of them were trained as trainers. A directory of persons trained in health systems research was developed. Technical and financial support was given to ministries of health.

283. The *Regional Strategy for the Development of Human Resources for Health* was adopted by the Regional Committee. Three inter-country meetings were held during which the Strategy was presented to countries; human resources for health country profiles were also prepared. A regional framework for the implementation of the regional strategy was produced on the basis of the information received

during the meetings. Guidelines were developed for human resources for health policy and planning and for the design of the curriculum for nurses and midwives. The HRH programme contributed to the publication of the first issue of the African Nursing and Midwifery Journal.

284. The Essential Drugs Programme provided support to countries for drug policy and programme development. The promotion of bulk purchasing mechanisms and the creation of subregional capacities for quality control were the other major achievements. A regional meeting on local production of essential drugs was held. The forty-ninth session of the Regional Committee adopted the Intensified Essential Drugs Programme. A technical briefing session on the anti-malaria drug quality study and the review of the HIV/AIDS/Pharmacist project were examples of the collaboration with and contributions to priority regional programmes.

285. Actual development of the Traditional Medicine Programme (TRM) started and its relationship with the four WHO collaborating centres was revitalized. The database on the situation of traditional medicine in the Region was set up. A draft *Regional Strategy for Traditional Medicine* was formulated and subsequently reviewed during an expert consultative meeting. A report on the Strategy will be presented to this fiftieth session of the Regional Committee.

286. The forty-ninth session of the Regional Committee adopted the *Regional Health Technology Policy*. Support was given to countries for the implementation of quality control systems for laboratories and for the development and strengthening of national programmes for quality assurance in health care. Guidelines for developing national policies on health care technology were developed. Blood Safety activities were intensified and a successful subregional workshop for directors of national blood transfusion services was organized for French-speaking countries.

Analysis

287. The work of the Division was facilitated by the development of operational tools for planning, monitoring and evaluating the Plan of Action. Various programmes benefited from professional staff strengthening and the development of a strong team spirit.

288. The major constraints were staff turnover and the large number of additional activities in response to requests from countries which compromised the performance of some specific programmes.

Conclusion

289. Despite the various constraints, 75% of the expected results for the Division for the 1998-1999 biennium were partially or fully achieved. The restructuring and strengthening of the various programmes resulted in increased output and is expected to improve the performance of the Division in the 2000-2001 biennium.

DIVISION OF FAMILY AND REPRODUCTIVE HEALTH

Introduction

290. The mission of the new Family and Reproductive Health Division (DRH) is to promote, through a life cycle approach, the health of families and individuals. Its major thrusts include the implementation of interventions to prevent maternal and neonatal mortality; creation of awareness on emerging problems in child and adolescent health; support to country and inter-country planning for the elimination of female genital mutilation (FGM); and improvement of access by women to health care.

Achievements

291. New developments in the area of Family and Reproductive Health included initiation of the implementation of the *Regional Strategy on Reproductive Health for the period 1998-2007* adopted by the Regional Committee in 1997 and the selection of the Safe Motherhood programme as one of the regional priorities.

292. In the area of safe motherhood and newborn care**,** the Mother-Baby Package was disseminated at the district-level in five out of the ten selected countries, with support from the country offices or the Regional Office. District plans were prepared for adapting relevant priority interventions. Guidelines and protocols were updated while refresher courses were organized for health care providers involved in midwifery practice. The six countries targeted for the implementation of the Initiative started or completed a needs assessment on maternal health services for the purpose of conducting an evidence-based review of safe motherhood country plans. Resource mobilization and joint programming with inter-agency theme groups and other mechanisms for improving access to quality reproductive health services, particularly safe motherhood, were successfully carried out in three out of nine countries of the Region.

293. Regarding neonatal health**,** stronger inter-agency partnership was forged in the prevention of mother-to-child transmission of HIV/AIDS infection. A comprehensive approach to the formulation and management of pilot projects was developed in nine countries with very high HIV prevalence in pregnant women. Broad consensus was developed in addressing HIV-related issues through maternity settings and within national reproductive health programmes.

294. The *Regional Reproductive Health Strategy* adopted at the forty-seventh session of the Regional Committee was launched and disseminated. An orientation meeting was organized for national programme managers and WHO representatives. Three out of fifteen target countries (20%) subsequently used the strategic framework to reorganize the reproductive health programme, review and adopt national reproductive health priority components and conduct an in-depth analysis on relevant policies and on gaps in the availability, accessibility and quality of services.

295. In the absence of a formal plan of action on child health, *ad hoc* activities were undertaken to strengthen country-level capacity to address public health issues concerning the *well child*. These activities included the organization of a training workshop for thirteen countries on the prevention and management of child sexual abuse; provision of support to infant and child feeding in emergency situations, through an inter-country network; and initiation, in three countries, of demonstration projects on the psycho-social development of the child.

296. A regional strategy on adolescent health was initiated in the light of new developments and knowledge on adolescent health. Support was given to three countries to enhance response to the specific needs of adolescents in conflict situations and to four countries to develop culture-sensitive programmes for effective control of HIV/AIDS transmission.

297. In the area of women's health**,** achievements were made in the areas of female genital mutilation, gender violence and functional literacy. Seven out of the ten countries targeted for FGM elimination (70%) developed national plans, with technical and financial support from the Regional Office, and four of them (40%) actually started the implementation phase. Other countries concerned by the problem benefited from inter-country activities on advocacy.

298. Two subregional consultations were convened to review country experiences in developing multisectoral strategies for the prevention of violence against women and girls, and in providing physical and psychosocial support and care to victims of violence. The meetings mapped out strategies for strengthening the role of the health sector in the prevention of violence. The four countries implementing the functional literacy strategy were provided with technical and financial support to expand their activities. Strategies were developed for incorporating into this initiative the needs of HIV-

affected women and their families.

Analysis

299. The low rate of achievement of most of the targets is probably due to inadequate planning, monitoring and implementation. In addition, the relocation of the Regional Office which led to increased mobility of the few available staff, seriously constrained the implementation of programmes.

Conclusion

300. Since the adoption of the ten-year strategic framework on reproductive health, Safe Motherhood has yet to receive adequate focus at both the regional and country levels. It is important to build linkages among the existing programmes within and outside the Division since enhanced synergy is necessary for the reduction of maternal and neonatal mortality and for dealing with other issues of concern in the health of women, children, and young people in the Region.

DIVISION OF COMMUNICABLE DISEASES PREVENTION AND CONTROL

Introduction

301. With increased collaboration from Member States, the Division was able to implement its plan of action. New strides and approaches to disease prevention and control emerged. These achievements were due largely to increased collaboration and continued support from partners.

Achievements

302. Eleven Member States conducted a preliminary assessment of the feasibility of IMCI implementation. Seven countries pursued IMCI implementation by holding orientation meetings to reach a common understanding of the programme. Eleven countries adapted the generic IMCI training materials and 7 countries reached the stage of conducting a planning meeting for the first year of implementation. Thirty-two countries started IMCI implementation. Operational research on IMCI was also started. A strategic plan for the period 2000-2005 was adopted by the forty-ninth session of the Regional Committee.

303. Schistosomiasis control activities were revived and 5 countries developed or revised their national plan for schistosomiasis control. In collaboration with the African Programme on Onchocerciasis Control (APOC), the following activities were undertaken during the biennium: rapid epidemiological mapping in 15 countries; 57 projects on ivermectin treatment, 48 of them community-directed; 4 projects on vector elimination; and 5 headquarters projects to support national task forces.

304. The African Region accounted for nearly 20% of all cases of tuberculosis notified worldwide in 1998. Five new countries were supported to implement the DOTS strategy for tuberculosis control, which raised to 37 the total number of countries that are implementing the DOTS strategy. This means that 61% of the target population now have access to DOTS-based services in the Region. Treatment results for new smear-positive patients improved by 50% in 12 countries. The overall success rate of treatment in the Region was 62% in 1998 as against the set target of 85%. Major programme reviews carried out in three countries resulted in re-planning of interventions to help address new challenges like the HIV/AIDS epidemic. Orientation workshops were held in 16 countries on the introduction of the DOTS strategy into the teaching curriculum of medical schools, with curriculum revisions starting in six countries. Eighteen countries in the Region were supported to establish a tuberculosis laboratory quality control system to improve case detection and management.

305. The capacity of four countries to manage HIV/AIDS programmes was strengthened by providing

them with national programme officers. Technical support was provided to eight countries, which led to improvements in HIV/AIDS and STI surveillance systems. A technical network and guidelines on HIV/AIDS/STI surveillance were produced in the biennium and have helped to strengthen country programmes. Five countries were supported to develop national blood safety policies and plans, thus increasing to 15 the number of countries in the Region which have blood safety policies. A regional task force for STI control was established. It made recommendations which accelerated the implementation of the regional STI strategy in the countries.

306. A generic system of Buruli ulcer surveillance was developed, introduced and implemented by four out of five endemic countries. Furthermore, a generic strategy for Buruli ulcer control was developed. The incidence of dracunculiasis was reduced from 34 261 to 18 500 cases and the number of endemic countries decreased from 16 to 13. The Integrated Disease Surveillance Unit (IDS) is developing the IDS surveillance tool and is putting in place a computerised regional communicable diseases surveillance database. The unit also conducted training courses and workshops in data management.

307. The Regional Programme on AIDS recruited national project officers in 4 countries to strengthen the capacity of the countries in programme management. The inter-country technical network on HIV/AIDS/STI surveillance was established at the Regional Office. Consensus was reached on basic HIV/AIDS and STI surveillance systems for the Region and guidelines developed. Generic guidelines on equitable, safe and effective ways of providing ARV therapy were prepared and field-tested in 4 countries. A regional task force for STI control was established. Technical support was provided to 5 countries in the development of national policies and plans for blood safety.

308. The African Region, with 67,526 registered cases of leprosy at the end of 1998, accounted for less than 10% of leprosy prevalence worldwide. However, of the 12 most endemic countries in the world, seven are in the African Region. At the end of the biennium, as a result of the implementation of core activities, leprosy was eliminated in five countries. This increased to 26 out of 40 the number of countries in the Region that have already reached the elimination target.

309. In 1998, the accelerated malaria control programme was extended to cover 27 countries as compared to 21 in 1997. Four countries in emergency situations were given special technical support. Forty-five health staff from 25 countries attended a three-month international training course on the planning, implementation, monitoring and evaluation of malaria control activities. Thirty-four out of the forty-two endemic countries created 97 sentinel sites in order to monitor antimalarial drug efficacy. Thirty countries in the Region instituted a systematic process of promoting the large-scale use of insecticide-treated materials. In 1999, after a process of consultation with the senior officials of 43 countries, the Roll Back Malaria initiative was introduced in 30 countries.

310. Six countries undertook an evaluation of epidemic preparedness and response and consequently developed their national plans of action. Thirty-nine countries established district teams. A subregional network of laboratories in 17 countries was progressively established, thus strengthening the capacity of their laboratories to rapidly confirm epidemics. Five inter-country teams were strengthened with epidemiologists in order to support the countries.

311. In the area of vaccine preventable diseases**,** logistical support was strengthened. Cold chain rehabilitation plans, including plans for training in maintenance and repair, were prepared in 13 countries. Of the 38 countries that produced national EPI plans, 7 developed comprehensive plans into which injection safety plans were incorporated. Forty-one national logistics managers from 21 countries were trained in logistics and cold chain management.

312. NIDs were successfully conducted in 33 countries, 94% of which attained at least 80% coverage. Supplemental national immunization days (SNIDs) were conducted mainly in countries of the southern and eastern epidemiologic blocs, producing at least 80% coverage on average.

313. AFP surveillance in the Region increased dramatically in 1999 with 3134 cases reported from

January to September 1999 as against 1699 in 1998. The non-polio AFP detection rate doubled from 0.3 in 1998 to 0.6 in 1999. A regional poliomyelitis laboratory network, consisting of 3 regional reference laboratories and 12 national or intercountry laboratories, was created. In 1999, four poliomyelitis network laboratories were accredited.

314. East African countries adopted a strategy to improve routine coverage, implement case-based surveillance, and conduct supplemental vaccination strategies. Many countries in southern Africa embarked on a measles elimination programme.

Analysis

315. Achievements were facilitated by improved communication with countries and stronger collaboration between the Regional Office regional advisers and national programme managers; the new facility to issue travel authorizations at country and Regional Office levels; the involvement of intercountry teams in the implementation of country programmes; technical guidelines and various framework documents provided to countries; involvement of partners in the implementation, monitoring and evaluation of activities; and availability of extrabudgetary funds for additional activities.

316. The main constraints on implementation were the large number of additional unplanned activities; limited staff in some programmes; political instability and social unrest in many countries; problems of coordination and of interaction with other programmes and divisions due to the geographic dispersion of divisional staff and teams.

Conclusion

317. Implementation of the 1998-1999 Plan of Action demonstrated the necessity to plan rationally, formulate clearly and appropriately the expected results, monitor budget implementation, continue to improve communication with country offices, and move key programmes back to the Regional Office.

DIVISION OF HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT

Introduction

318. The new division of Healthy Environments and Sustainable Development (DES) is responsible for supporting countries to identify, control and prevent the adverse effects of environmental and economic conditions on health. It is also for assuring that health is integrated into sustainable development policies of countries.

Achievements

319. In the area of community water supply and sanitation, almost all the countries of the Region launched the AFRICA 2000 Initiative and prepared plans of action. The Second Regional Consultation on AFRICA 2000 was successfully organized. Sixteen countries, most of which were affected by the cholera epidemic, were able to implement community-based rural water supply and sanitation projects. Operation and maintenance workshops were planned for ten countries, five of which successfully carried out the activity while the remaining five countries could not as a result of the prevailing political situation. A consolidated report on operation and maintenance activities in Africa was prepared.

320. The evaluation of the participatory hygiene and sanitation transformation (PHAST) project was carried out in eight pilot countries and the expansion of the PHAST approach was endorsed by 10 countries at the regional workshop held in Harare in September 1999. The global assessment of the

water supply and sanitation sector required all the countries of the Region to conduct an assessment of their water supply and sanitation sector.

321. In the area of promotion of chemical safety, more than 4 countries prepared their chemical safety profile. The Radiation Safety Programme was supported in two countries. Campaigns for public awareness and prevention of chemical and radiation dangers took place in two countries while national workshops were organized in five countries.

322. Although status reports on the implementation of World Health Assembly resolution WHA 50.13 in 8 countries were not received, the Regional Office contributed to the WHO plans of action for phasing out DDT. One country received technical support to map out its chemical management system. Five countries prepared country reports on the management of dangerous chemicals.

323. In respect of environmental health hazards (EHH), status reports on the implementation of resolution WHA 50.14 were not received from six countries. Nonetheless, the Regional Office contributed to and participated in the international meeting on water supply and sanitation in island countries. Only three out of six status reports on the Global Environmental Monitoring Systems (GEMS) were received. Courses on water quality control were supported in three countries and the necessary equipment bought for one country.

324. An information network of EHH focal points in ten countries was established. Questionnaires on national environmental health action plans and on institutional development were collated and analysed. Four countries were supported in the development of environmental health policy. Technical discussions on the role of the ministry of health in environmental health were held during the forty-eighth session of the Regional Committee. Activities on environmental health impact assessment and hazards mapping were initiated. A discussion paper was prepared on the effects of desertification and drought on human health in Africa.

325. In the area of rural and urban development, four healthy-city planning workshops were organized, bringing together 172 delegates from 45 countries. Congo, Gabon, Equatorial Guinea, Mali and Togo received specific support for drawing up healthy cities plans of action and four countries were supported to implement the healthy schools project.

326. The Long-Term Health Planning and the Poverty and Ill Health programmes were created within the Division during the biennium.

327. A draft position paper on poverty and ill health proposing a conceptual framework for the linkages between poverty and health as well as new strategies and approaches to deal with the health aspects of poverty reduction in Africa was developed. The WHO regional offices and Headquarters undertook joint consultation and planning exercises on poverty reduction.

328. The draft methodological guidelines for long-term health studies were made available to countries. The briefing of WHO representatives during the 24th session of the Regional Programme Meeting raised awareness about the Long-Term Health Planning and the Poverty and Ill Health programmes in all countries. The responses received indicated that the programmes addressed the felt needs of the countries and could contribute effectively to the Regional Office's efforts to make a difference.

Analysis

329. The creation of the Division to replace the former unit in charge of environmental health was a major event during the biennium. This resulted in new and innovative orientations within both the Division and the Regional Office. One major constraint was the shortage of human resources.

Conclusion

330. The biennium under review, particularly the second year, was devoted to the production of background documents on the new areas of work and also to the strengthening of former programmes. The visibility of the Division increased accordingly and it is expected that greater strides will be made in the next biennium.

DIVISION OF NONCOMMUNICABLE DISEASES

Introduction

331. The 1998-1999 biennium was a period of major reorganization and restructuring of the Regional Office. This gave rise to the new structure of the division in charge of disease control and the creation of the Division of Noncommunicable Diseases in September 1998. The Chronic Diseases Programme as part of the Division of Noncommunicable Diseases was established. Its mandate included supporting the countries to prevent and control such diseases as cancer, cardiovascular diseases and diabetes.

Achievements

332. The Division supported one country to organize the first congress on hypertension in Africa; one country to conduct research on hypertension in infants; one country to organize a training workshop on sickle cell disease in addition to supporting the country's national programme; one country to develop its national capacity to control diabetes by funding the participation of its nationals in a course on the epidemiology of diabetes; four countries to develop their capacity in cancer registry techniques by funding their participation in a course organized by the International Agency on Research against Cancer (IARC) in Lyon; and one country to equip its cancer registry centre.

333. In addition, the Division prepared a draft strategy document on noncommunicable diseases in Africa. It also organized a WHO consultative meeting to adapt the WHO-ISH International Guidelines for Hypertension to the African situation and compiled both published and unpublished research data on noncommunicable diseases in Africa through a consultant recruited to undertake the task.

Analysis

334. Factors that facilitated achievements included the recruitment of a short-term consultant. This enhanced the work of the Programme and led to increased requests from the countries as national authorities became more aware of the noncommunicable disease burden in their countries.

335. Factors that hindered achievements included an inadequate budgetary allocation to support the implementation of planned intercountry programmes; lack of evidence, which hampered Members States' efforts to embark on noncommunicable diseases programmes; and shortage of skilled manpower for programme design and implementation at country level.

Conclusion

336. Once a regional strategy is adopted and more evidence provided on the burden of noncommunicable diseases, WHO and Member States should more adequately address this programme area. Hopefully, the above-mentioned constraints would be overcome and the Regional Office would be in a better position to effectively deal with the prevention and control of the emerging epidemic of noncommunicable diseases in the Region.

DIVISION OF ADMINISTRATION AND FINANCE

Introduction

337. As in the past, immense challenges were faced during the period under review in providing effective and timely support to technical units and country offices to enable them to implement their programmes. The Division of Administration and Finance (DAF) successfully continued to provide routine services.

Achievements

338. In the area of Budget and Finance, the major achievements included close collaboration with the technical divisions in preparing the programme budget for the 2000-2001 biennium; creation of allotments for implementing the various activities planned for the 1998-1999 biennium in accordance with approved plans of action; decentralization of sticker issuance to the country offices, thereby facilitating timely implementation of activities; timely preparation of the financial reports for 1998 and 1999; continuous monitoring of implementation rates, which enabled the Region to fully utilize the funds allocated for the 1998-1999 biennium; and installation of a new administrative and finance information system at the Regional Office as part of a global programme to facilitate the processing of accounts at the Regional Office.

339. In the area of Personnel Services, the Personnel Unit was reorganized. The Unit now comprises four separate services dealing with Classification and Recruitment, Contract Administration, Short-term Staff and Medical Services. The reorganization fostered specialization and standardization and led to overall improvement in the functioning of the Unit. New personnel policies on the length of assignment at different duty stations, overtime payments for drivers and briefing or debriefing of professional staff were developed. Authority for the issuance of short-term general service staff contracts was delegated to country offices.

340. In order to address the increasing needs of Member States and changing priorities, the recruitment of staff continued to be an important part of the Unit's activities. Twenty new or vacant posts were filled through international recruitment and a total of 92 new national professional officer (NPO) posts were established in various countries. With these and other recruitments, the total number of fixed-term staff in the Region has almost reached 700. Many more staff were employed on short-term contracts or through other types of contractual arrangements.

341. Accomplishments in the area of Management and Information support were the establishment of the basic technological environment for the Regional Office and country offices; improved access to informatics and telecommunication facilities; operationalization of the new administrative and finance information system at the Regional Office; establishment of the WHO/Regional Office Website; dissemination of informatics tools and assurance of compatibility of the tools at the WHO Regional Office, country offices and headquarters; the introduction of a number of new projects to help improve communication between countries, regional offices and headquarters; ensuring that the Regional Office's Computerized Imprest Account System and its informatics and telecommunication central systems were Y2K compliant; and provision of guidance to country offices to ensure their preparedness for the Y2K challenge.

342. In the area of publication and documentation services, the major achievements included the continued provision in the three official languages of the Region of valid and up-to-date statutory, technical and scientific documentation to Member States; the provision of language services in support of meetings held in the Region as part of the implementation of the regional programme; marked improvements in the quality and presentation of regional publications; translation into Portuguese of Blue Trunk Library titles for Member States of the Region; translation of the Regional Office Health Information Package into vernacular languages in the countries; continued promotion of WHO publications in collaboration with headquarters; and provision of assistance to Member States for

purchasing documents published by WHO and other agencies.

343. The unit responsible for supplies was able to fully carry out its activities despite the disruption caused by the relocation of the Regional Office. Computerization of the unit, which started in Brazzaville but was interrupted during the whole of 1998, resumed and is ongoing. In addition, the unit carried out its routine functions such as maintaining inventory records at the Regional Office and in country offices as well as analysing contract proposals for submission to the Contracts Review Committee.

344. The unit responsible for administrative services continued to provide the Harare Temporary Regional Office with sufficient office accommodation and adequate equipment as the number of staff members increased from 120 at the end of 1997 to over 310 at the end of 1999. At the same time, considerable preparatory work was done to identify alternative solutions to the shortage of office space.

345. Three evaluation missions were undertaken to Brazzaville with a view to assessing not only the possibility of returning Regional Office staff to the permanent headquarters in Brazzaville but also the damage caused to the Regional Office facilities as a result of the 1997 war in Congo.

Analysis

346. The period covered by this report spanned the relocation of the Regional Office from Brazzaville to its temporary location in Harare. The Administration was therefore faced with the challenge of trying to relocate, under difficult circumstances, while still maintaining normal services. Major constraints included shortage of staff, the need to recruit and train new staff in Harare, difficult working conditions and budgetary constraints. Despite these constraints, the Division was able to meet its objectives. The period also witnessed a consolidation of the Division, including the reorganization of the Budget and Finance Unit and the Personnel Unit to better respond to demands. Intensified training of administrative staff in the country offices resulted in improved output from the country offices as evidenced by the gratifying findings of the Internal Auditor's report to the World Health Assembly in May 1999 which stated that "the audit of the Regional Office had revealed continuous and satisfactory improvement in its affairs as compared to the previous reporting period".

Conclusion

347. Despite a number of serious constraints, the Division was able to meet its objectives in providing the necessary support to technical programmes and to country offices.

OVERALL CONCLUSION OF THE REPORT

LESSONS LEARNED

348. Compared to the 1996-1997 biennium, the provision of clearer and more user-friendly guidelines in 1998-1999 contributed to greater success in developing, implementing, monitoring and evaluating regional and intercountry activities as well as activities under the WHO programmes of technical cooperation with the countries. However, there is still room for improvement. An examination of the development, implementation and evaluation of the 1998-1999 plans of action shows that:

(1) Focusing on country-defined health priorities, close collaboration between the WHO country teams and officials of the ministry of health and placing emphasis on areas where WHO has a comparative advantage are very important measures for ensuring the relevance, effectiveness and efficiency of the choice and implementation of activities under the technical cooperation programme.

(2) Focusing WHO interventions on priority areas avoids spreading WHO's limited resources too thinly.

(3) Flexibility should continue to guide the implementation of the WHO programme of technical cooperation with the countries in order to respond to changing needs, arising particularly from unforeseeable occurrences such as epidemics and disasters in the countries.

(4) Given the increasing recognition of WHO as the lead agency in health matters at the international level, the need to strengthen the capacity of WHO country offices to enable them to effectively play their role cannot be overemphasized;

(5) The consolidation of the mechanism involving ministry of health officials and the WHO country team in the planning, monitoring and evaluation of WHO technical cooperation with countries will facilitate achievement of the objectives and expected results.

(6) Peace as well as economic and political stability in each country are important prerequisites for the successful implementation of the WHO technical cooperation programme.

(7) There is also a need to further enlighten national authorities on WHO managerial processes and procedures and WHO's Corporate Strategy. Such enlightenment will facilitate the work of WHO in and with the countries.

(8) greater and closer WHO collaboration with health development partners at both regional and country levels has become more and more compelling if limited health resources are to be optimally used to achieve specific health outcomes in countries.

(9) In view of the importance of managing resources more efficiently, WHO and ministries of health should intensify their efforts to enhance management capacities.

OUTLOOK FOR THE 2000-2001 BIENNIUM

349. The evaluation of the implementation of 1998-1999 biennial plans of action and a close study of the orientations provided by the Regional Committee show that the effectiveness of WHO's health interventions in the Region can be ensured in the following priority areas:

(1) Malaria

(2) HIV/AIDS and tuberculosis

(3) Safe motherhood

(4) Child survival (including the integrated management of childhood illness and the eradication of poliomyelitis)

(5) Mental health

(6) Preparedness and response to emergencies, including epidemics and disasters

(7) Health sector reform (and the development of sustainable health systems), focusing particularly on management, capacity building, research and resource mobilization

(8) Health promotion

(9) Poverty reduction through better health.

350. The aforementioned regional priority areas will be used as the basis for discussing the Regional Office's technical cooperation with Member States. These priorities would be used to redirect resources and provide support to country and intercountry activities. Norms and standards will be developed where none exist and adapted where they already do.

351. WHO health interventions in the 2000-2001 biennium will be designed, existing evidence and information for policy development gathered from both epidemiological and economic evaluation, and primary research initiated by all technical divisions and units to support the indicated priority areas.

PART II

PROGRESS REPORT
ON SPECIFIC PROGRAMMES

EMERGENCY AND HUMANITARIAN ACTION

352. In adopting the regional strategy for emergency and humanitarian action at its forty-seventh session, the Regional Committee also adopted resolution AFR/RC47/R1 which, among other things, requested the Regional Director to report annually to the Committee on the implementation of the said strategy. This brief account is intended to serve that purpose.

353. WHO continued to provide support to Member States affected by natural or man-made disasters. WHO also provided long-term expertise in public health to Angola, Rwanda and Sierra Leone and in epidemiology to Burundi as well as short-term consultancies upon request. The technical support focused on rapid assessment of the health situation, development of the health component of national emergency programmes and support to the national coordination mechanisms of health partners.

354. In close collaboration with nongovernmental organizations, WHO investigated cases of epidemics in order to help control outbreaks of poliomyelitis in Angola, measles in eastern part of Democratic Republic of Congo, and meningitis in Angola, Burundi and Sierra Leone. WHO coordinated international response to the lassa fever outbreak in the eastern region of the Democratic Republic of Congo.

355. WHO promoted joint cross-border public health activities. Initiatives such as epidemic control and mass campaign for poliomyelitis eradication in the Democratic Republic of Congo brought together health professionals from the different parties in conflict to discuss public health measures needed to protect the civilian population. In the same context, WHO also supported initiatives in Gambia, Guinea-Bissau and Senegal to address the health needs of the population as a contribution to peace in the subregion.

356. Essential drugs and other medical supplies were provided to countries affected by emergencies in order to enhance their access to quality care. This support, provided within the basket of coordinated support of the United Nations agencies, nongovernmental organizations and other bilateral cooperation bodies, included the supply of medicine and chlorine tablets to improve water safety and of HIV test kits (Congo Brazzaville); the provision of medical supplies to meet the needs of people affected by the conflict in Eritrea and Ethiopia; the provision, in collaboration with NGOs, of support for immunization against yellow fever for populations that did not benefit from the previous campaign; vaccination of 163 000 people in three counties (Liberia); the provision of medical supplies, including vaccines against meningitis and yellow fever, and specific drugs for tuberculosis and leprosy patients abandoned during the civil unrest (Guinea-Bissau); and assistance to mitigate the health impact of flooding and restore access to health care for 20 000 people living in affected areas (Gambia).

357. In line with the recommendations of the forty-seventh session of the Regional Committee, WHO continued to advocate for the promotion and strengthening of emergency preparedness. Concrete achievements in the areas of emergency preparedness and response included the designation by 30 countries of focal points within the ministry of health to be directly supported by the WHO country offices whose capacities will be strengthened; discussion and endorsement of a framework for emergency preparedness and response at country level by 30 countries; capacity building in the area of hospital emergency planning by training three national health staff from Angola, Lesotho, Mozambique, Namibia and Zimbabwe.

358. Due to the magnitude of the social consequences of land mines in the African Region, WHO set up a regional working group to address the impact of land mines on public health. Cooperation with Burundi, Mozambique and Uganda in the area of injury prevention was intensified and focused on surveillance, pre-hospital and hospital care as well as psychosocial and physical rehabilitation.

HUMAN RESOURCES FOR HEALTH

359. In adopting the *Regional Strategy for the Development of Human Resources for Health* (document AFR/RC48/10) at its forty-eighth session, the Regional Committee also adopted resolution AFR/RC48/R3 which, among other things, requested the Regional Director to report every two years on the implementation of the strategy. This brief account is intended to serve that purpose.

360. The regional human resources programme has now been restructured into three subprogrammes: Human Resources for Health (HRH) responsible for the strengthening of institutional capacities, the promotion of research on the development of human resources for health and the provision of direct support to training institutions, professional associations and councils; Human Resources Management (HRM) responsible for the formulation and implementation of policy and plans for the development of human resources for health and the national health development plan; and Human Resources for Education (HRE) responsible for promoting reforms in education and practice in health care and the health sciences.

361. Three intercountry meetings to promote advocacy for the strategy were organized respectively in Maputo for the Portuguese speaking countries, in Abidjan for the French-speaking countries, and in Pretoria for the English-speaking countries. The main outcomes of the meetings were better knowledge of country situations as well as identification of key actors and priority interventions for the development of human resources for health.

362. A training programme on human resources management was established in collaboration with the National Public Health School (Algiers) and the Centre for Human Resources for Health at the University of the Western Cape. The programme aims to strengthen the capacity of health workers and officials of health services and ministries of health in the administration and management of human resources. Twenty-five participants met during the first session in April 2000. The second session will be held in October 2000.

363. A human resources development project was drawn up for the Portuguese-speaking countries of the Region. The project, based on projections for the next twenty years, aims to put in place, in each country and within the framework of WHO country operations, the mechanisms for addressing needs for human resources for health and undertaking common actions or actions specific to each country.

364. The conference on nursing and midwifery practice took place from 3 to 7 April 2000 in Durban, Republic of South Africa. It was organized by the Regional Office and the collaborating centre for basic training and research in nursing, Department of Nursing, University of Natal. The conference produced a plan of action for the harmonization of training programmes in nursing as well as guidelines for the accreditation of that category of professionals in five countries.

365. Every country in the Region is undertaking some form of health sector reform, with a view to guaranteeing equity in, and universal access to, health care and services; improving the quality and efficiency of health care and services; controlling health expenditure increases; assuring the efficient management of available resources; and increasing the level of satisfaction of users and health staff. To attain these goals, it was deemed necessary to resolve the urgent problems of scarce and poorly distributed staff, lack of mechanisms for continuing training and quality maintenance, poor performance and lack of motivation among health personnel.

366. The activities implemented consisted mainly of the formulation of policies and plans for the development of human resources for health; the evaluation of training programmes and the revision of curricula; the establishment of management information systems for human resources; the strengthening of the capacities of the personnel departments of ministries of health and development of the skills of serving staff within the framework of specific programmes and initiatives such as essential drugs, integrated management of childhood illness, Roll Back Malaria, distance learning.

367. The Regional Office provided technical and financial support to the following countries to undertake the aforementioned activities: Angola, Benin, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, Eritrea, Guinea, Guinea Bissau, Lesotho, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Swaziland, Seychelles, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

RESEARCH POLICY AND COORDINATION

368. In line with the orientations given by the Technical Discussions, especially during the forty-second session (AFR/RC42/TD/1) and the forty-seventh session (AFR/RC47/TD/1) of the Regional Committee, the *Strategic Health Research Plan for the WHO African Region* was prepared and subsequently adopted by the forty-eighth session of the Regional Committee in its resolution AFR/RC48/R4.

369. As a first step towards the implementation of the regional research strategy, the Regional Office appointed and assigned a full-time staff member to the Programme Development and Coordination unit to run the Research, Policy and Coordination programme. The role of the programme is to coordinate and support health research at the regional level, set up mechanisms for monitoring and evaluating the progress made in the Region and provide technical support to Member States in research matters. The strategic research plan has been published and is currently being disseminated to guide research work in the Region.

370. A notable aspect of research coordination is the monthly evaluation of research proposals submitted to the various programmes and divisions of the Regional Office for possible funding. The Research Development Committee which meets regularly to assess research proposals for funding by the Regional Office has been strengthened. The Committee has, in the past one year, received and reviewed over 20 research proposals. Unfortunately, many of these proposals failed to meet the required quality standard. Consequently, a standard format for submission of research protocols has been developed to help improve the quality of proposals submitted. This format can be obtained from the WHO country offices.

371. A computer database for compiling an inventory of health research and research institutions in the Region has been developed. Gathering the necessary information to be fed into the database is a major component of the Research Policy and Coordination plan of action for the 2000–2001 biennium. As part of a collaborative effort and in an attempt to involve other partners, the Regional Office has held discussions with and requested the African Essential National Health Research Network to take part in compiling this information.

372. The recommendations of the regional consultation on WHO collaborating centres are being followed up. These recommendations formed part of the Regional Office's input into the recent global review on WHO collaborating centres. The WHO Executive Board has since approved several changes in the designation and redesignation of collaborating centres. A major procedural innovation is that the Regional Office will now play an important role in the process. Accordingly, the Regional Office has set up a special committee to handle matters concerning WHO collaborating centres.

373. Health research covers a vast area and involves many interested parties. It is acknowledged that WHO on its own does not have enough resources to meet the demand for health research. Therefore, collaboration with other partners who have shown interest in promoting research in the Region was encouraged during the biennium. In particular, the Regional Office now works closely with the Council on Health Research for Development to mobilize financial and technical resources to support Member States.

374. A major component of the Research, Policy and Coordination Plan of Action for the 2000-2001 biennium is the provision of support to countries to develop research capacity. Provision has been made in the Plan of Action to create or strengthen research coordination mechanisms in the countries and

provide some direct support to country research activities. Countries will be assisted to identify their research priorities and provided with the necessary support for research work in those priority areas.

ORAL HEALTH

375. In adopting the *Regional Strategy on Oral Health* (document AFR/RC48/9) at its forty-eighth session, the Regional Committee also adopted resolution AFR/RC48/R5 which, among other things, requested the Regional Director to report every two years on the implementation of the Strategy. This brief account is intended to serve that purpose.

376. After distribution of both the Strategy and resolution to Member States, the Regional Office, in collaboration with Headquarters, organized a consultative meeting on the implementation of the Strategy. The purpose of the meeting which was held in Harare, Zimbabwe, in March 1999, was to identify concrete actions to assist countries in implementing the strategy and the resolution. The meeting brought together chief dental officers from 17 African countries, experts in oral health in the African Region, some oral health partners and heads of some WHO oral health collaborating centres. The outcomes of the meeting included a framework to address priority areas of prevention and other interventions at country level; an outline of key elements to be included in a regional plan of action for the period 2000-2001; and the creation of a network of partners. The final report of the meeting was also disseminated to Member States, oral health partners and WHO collaborating centres for oral health. The Regional Office has already received pledges of support from some partners.

377. The *Regional Strategy* has no doubt inspired countries in the Region to pay more attention to oral health, focusing on local priorities. In this connection, a number of countries have embarked on various activities which are largely guided by the principles of the Strategy. Reports received from the countries indicate tha,t since the adoption of the Strategy and the resolution, eleven more countries have either developed or are developing national oral health strategies and implementation plans with emphasis on prevention, early detection and management of oral diseases; seven more countries have developed appropriate programmes on the oral health needs of their communities; ten more countries are placing particular emphasis on severe oral health problems like noma, oral cancer and oral manifestations of HIV/AIDS; six more countries are integrating oral health activities into all primary health care programmes; and three more countries are integrating oral health into national health management information systems.

378. The Regional Office continued to promote advocacy for this new paradigm of oral health in the African Region and to intensify efforts to mobilize resources for its implementation in countries. Major activities for the implementation of the strategy during the 2000-2001 biennium will include the preparation of guidelines for the development of country oral health plans, the establishment of a database with indications on the efficacy and cost-effectiveness of existing traditional oral health practices and the organization of an intercountry workshop on training in atraumatic restorative treatment techniques. In collaboration with Headquarters, activities in connection with the noma action plan for Africa will be intensified. These activities will include the raising of public awareness, the production of health education materials, training, noma screening campaigns and epidemiological and etiological research. In addition, support will be provided to more countries to initiate and evaluate district-focused preventive oral health care programmes.

PART III

REPORT ON THE SITUATION OF THE WHO REGIONAL OFFICE IN BRAZZAVILLE, CONGO

INTRODUCTION

379. Following the outbreak of hostilities in the Republic of the Congo, the WHO Regional Office closed its offices on 7 June 1997 and the last group of staff members left Brazzaville on 17 June 1997. The WHO Representative in the Republic of Congo, who had also moved to Kinshasa upon the outbreak of hostilities, returned to Brazzaville in October 1997.

DEVELOPMENTS UP TO THE FORTY-NINTH SESSION OF THE REGIONAL COMMITTEE

380. Between November 1997 and September 1998, the major developments that took place and which had already been reported to the forty-ninth session of the Regional Committee by the Regional Director, included the following:

(1) The first joint mission (for fact-finding) undertaken by Headquarters and the Regional Office to Brazzaville in November 1997 prepared a report that prompted the Executive Board to decide on 13 January 1998 to temporarily transfer the Regional Office from Brazzaville to Harare.

(2) The second joint mission (for assessment) undertaken to Brazzaville in June 1998 recommended to the Regional Director that the Regional Office could begin a phased return to Brazzaville soon after the Regional Committee in September 1998.

(3) After the third mission in July 1998 to clarify a few issues with the Government of the Republic of Congo and in preparation for the gradual return of the Regional Office to Brazzaville, the Regional Director instructed that all locally recruited Regional office staff still in Brazzaville should resume work in Brazzaville as from 1 August 1998.

(4) As part of the implementation of Regional Committee resolution AFR/RC48/R6, arrangements were made for the return to Brazzaville, before December 1998, of the staff of the Library unit and the Duplication and Printing unit whose facilities, left behind in Brazzaville, could not be reconstituted in Harare.

(5) The renewed hostilities from December 1998 to January 1999 not only shelved the arrangements but also prevented the undertaking of a second assessment mission that was to help draw up a plan for the gradual return of the Regional Office to Brazzaville.

(6) The report of the second assessment mission which was finally undertaken in July 1999 was used to update the information WHO had provided to its insurance company and to provide a better basis to the Congolese Government for carrying out its work of rehabilitating the Regional Office's infrastructure, installations and equipment.

DEVELOPMENTS AFTER THE FORTY-NINTH SESSION OF THE REGIONAL COMMITTEE

381. Pursuant to Regional Committee resolution AFR/RC48/R6 and at the invitation of the Government of the Republic of Congo, the Regional Director headed a mission to Brazzaville in October 1999, during which the President of the Republic of Congo reaffirmed his commitment to make reparation for the damage caused to the facilities of the WHO Regional Office for Africa. He also enquired about how the UN Security Phase is assessed and about rumours that some countries had proposed a permanent relocation of the Regional Office. The Regional Director explained that the United Nations Security Phase is determined by the United Nations Security Coordinator (UNSECOORD) in accordance with well-defined criteria and also reassured the President that no Head of State had ever contacted WHO about a permanent relocation of the Regional Office from Brazzaville.

382. It was noted during the mission that the extent of damage to the Regional Office was far greater than had been reported by the second assessment mission in July 1999 or even by the Congolese Minister of Health and Humanitarian Action at the forty-ninth session of the Regional Committee in Windhoek in September 1999.

383. Given that the Congolese Government had made substantial progress in the rehabilitation of the Regional Office in December 1999, a third assessment mission to Brazzaville was undertaken in March 2000. According to projections, the rehabilitation will be far advanced by July 2000. It is expected that the rehabilitation will be completed and the premises ready for occupancy by the end of December 2000. From then on, planning for the progressive return of staff could be envisaged in accordance with the security norms of the United Nations. The Regional Director will further update the Regional Committee on this issue.

ANNEXES

ANNEX 1

IMPLEMENTATION OF THE 1998-1999 REGULAR BUDGET IN THE AFRICAN REGION

Implementation of the Region's regular budget for the 1998-1999 biennium has been one of the best ever. Funds were fully obligated by the end of October 1999 and fully utilized by the end of the biennium. This was due partly to greater decentralization at the WHO country offices which allowed faster implementation of programmes in the countries and partly to stringent measures that enabled the countries and divisions to implement their programmes in a timely manner.

The following two tables show implementation rates by programme: one table showing the Regional Office implementation rate and the other the country level rate. In addition, each table contains two implementation rates: one based on the original allocation as approved by the World Health Assembly, and the other based on the final allocation which takes into account adjustments, reprogrammings and transfers that were made between programmes during the biennium. These include currency adjustments at the Regional Office, a 3% withholding by the Director General, reprogramming due to shifts in priorities, and transfers from a few programmes which, for one reason or another, did not fully utilize the amounts originally allocated to them.

The overall implementation rate for the Region was 100% of the funds allocated i.e. US$ 154 million.

Annex 1

Annex 1

ANNEX 2

ABBREVIATIONS

ADH	Adolescent health
ADT	Substance abuse, including alcohol and tobacco
AHE	Ageing and health
BFI	Budget and finance
CDR	Diarrhoeal and acute respiratory disease control
CHD	Child health
COR	Coordination with other organizations. Mobilization of external health resources
CTD	Control of tropical diseases
CWS	Water supply and sanitation in human settlements
DAF	Administration and finance
DAP	Action programme on essential drugs
DCP	External coordination and programme promotion
DDC	Prevention and control of communicable diseases
DES	Healthy environments and sustainable development
DGP	Director General's and Regional Director's development programmes
DHS	District health systems
DNC	Prevention and control of noncommunicable diseases
DPM	Programme management
DRH	Family and reproductive health
DSD	Health systems and services development
EHA	Emergency and humanitarian action
EHH	Assessment of environmental health hazards
EMC	Emerging diseases
EUD	Environmental health in urban development
EXM	Executive management
FOS	Food safety
GAD	Administrative support to technical programmes
GEE	Global eradication or elimination of specific communicable diseases
GPD	General programme development and management
HEP	Health promotion
HRH	Human resources for health
HSD	Health in socioeconomic development
HSR	Health systems research and development
HST	Epidemiology, statistics, trend assessment and country health information
ICO	Collaboration with countries and peoples in greatest need
INF	Communications and public relations
ISM	Management and support to information systems
MFP	Fellowships
MNH	Mental health
NCD	Noncommunicable diseases
NHP	National health systems and policies
NUT	Nutrition, food security and safety
OCD	Other communicable diseases
OCH	Occupational health
PBD	Prevention of blindness and deafness
PCS	Promotion of chemical safety

ABBREVIATIONS

PER	Personnel services and administration
PLL	Publishing, language and library services
RCO	Regional committees
RD	Regional Director
RHB	Rehabilitation
RPH	Reproductive health
RPS	Research policy and strategy coordination
SUP	Procurement services
TCC	Technical cooperation with countries
TDR	Special programme for research and training in tropical diseases
THC	Technology for health care
TRM	Traditional medicine
TUB	Tuberculosis
VID	Vaccinepreventable diseases
WHD	Women's health