

AFR/RC59/2

The Work of WHO in the African Region 2008

Annual Report of the Regional Director

AFR/RC59/2
Original: English

The Work of WHO in the African Region 2008

Annual Report of the Regional Director

To the fifty-ninth session of the
Regional Committee for Africa,
Kigali, Republic of Rwanda,
31 August–4 September 2009

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville • 2009

AFRO Library Cataloguing-in-Publication Data

The Work of WHO in the African Region 2008: Annual Report of the Regional Director

1. World Health Organization
2. Public Health Administration
3. Regional Health Planning
4. Health Priorities
5. Health Status
6. Africa

ISBN: 978 929 023 1332 (NLM Classification: WA 541 HA1 09 WH)

© WHO Regional Office for Africa, 2009

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

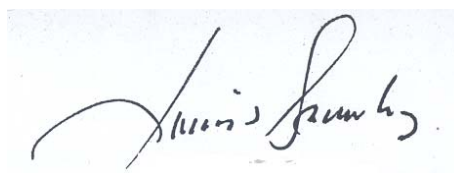
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation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

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

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

Printed in the Republic of Congo

The Regional Director has the honour of presenting to the Regional Committee the report on the work of the World Health Organization in the African Region during the year 2008.

A handwritten signature in black ink, reading "Luis Gomes Sambo". The signature is written in a cursive style with a large initial 'L' and a long horizontal stroke at the end.

Dr Luis Gomes Sambo
Regional Director

CONTENTS

	Page
ABBREVIATIONS	v
EXECUTIVE SUMMARY	ix
	Paragraphs
1. INTRODUCTION	1–3
2. CONTEXT	4–23
3. THE PROGRAMME BUDGET 2008–2009	24–39
4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE	40–73
4.1 SO1: Communicable diseases	40–58
4.2 SO2: HIV/AIDS, tuberculosis and malaria	59–73
4.3 SO3: Chronic noncommunicable conditions, mental disorders, violence and injuries.....	74–83
4.4 SO4: Child adolescent and maternal health, and ageing	84–99
4.5 SO5: Emergencies, disasters, crises and conflicts	100–106
4.6 SO6: Risk factors for health conditions	107–117
4.7 SO7: Social and economic determinants of health	118–120
4.8 SO8: Healthier environment	121–124
4.9 SO9: nutrition, food safety and food security	125–133
4.10 SO10: Health services	134–157
4.11 SO11: Medical products and technologies	158–170
4.12 SO12: Leadership, governance and partnership.....	171–181
4.13 SO13: Efficient and effective WHO	182–202
5. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT	203–221
5.1 Challenges and constraints	203–215
5.2 Lessons learnt.....	216–221
6. A WAY FORWARD	222–234

ANNEXES

1. WHO medium term strategic plan 2008–2013: statement of strategic objectives	43
2. Budget implementation status as of 31 December 2008 (amounts in US\$ thousands).....	44
3. List of regional committee resolutions reviewed	45

LIST OF FIGURES

1. Reported DPT coverage, 2007, WHO African Region	7
2. Wild poliovirus distribution, 2007-2008, WHO African Region	8
3. Countries reporting cholera in the WHO African Region, November 2008	10
4. DOTS case detection rates.....	11
5. Number of people on ART, 2004–2008, sub-Saharan Africa	12
6. Roadmap development and implementation status, December 2008	17
7. Policy and implementation, CCM for pneumonia, 2007, WHO African Region.....	18
8. Adoption of low osmolarity, ORS and zinc policy, WHO African Region	18
9. Emergency funds mobilized by country, 2008	20
10. STEPs surveys in the WHO African Region	21
11. Status of FCTC in the WHO African Region, December 2008	22

Abbreviations

AMSWEB	WHO Activity Management System WEB
APWs	Agreement Performance of Work
ART	Anti-Retroviral Treatment
ARVs	Anti-Retrovirals
CCSs	Country Cooperation Strategies
CD4	Cluster of differentiation antigen 4
CDC	Centers for Disease Control
CDS/ISIS	Computerized Documentation System/Integrated Set of Information Systems
CIDA-Canada	Canadian International Development Agency
COP3	3rd session of the Conference of Parties
CPT	Co-trimoxazole Preventative Therapy
DOTs	Directly Observed Treatment (short course)
DFID	Department For International Development
ECOWAS	Economic Community of West African States
ESA	Eastern and Southern Africa
FCTC	WHO Framework Convention on Tobacco Control
FGM	Female Genital Mutilation
GAVI	Global Alliance for Vaccines and Immunization
GFTAM	Global Fund for AIDs, Tuberculosis and Malaria
GDF	Global Drug Facility
GIP-ESTHER	Groupement d'Intérêt Public: Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau
GSC	Global Service Centre
GSS	Global Salm Surv
HACCP	Hazard Analysis critical Control Point
HELP	Health Emergencies in large Populations
ICT	Information Technology
IDSR	Integrated Disease Surveillance and Response
HHA	Harmonization Health in Africa
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illness
IOM	International Organization for Migration
ITIL	Information Technology Infrastructure Library
ITNs	Insecticide Preventative Therapy
ITOCA	Information Training and Outreach Centre for Africa
IPT	Isoniazid Preventative Therapy
IYCF	Infant and Young Child Feeding
MDR/XDR-TB	Management of Multi-drug Resistant TB
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding

NGOs	Non Governmental Organisations
NHA	National Health Accounts
NHIS	National Health Information Systems
OCEAC	Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale
OCHA	Office for the coordination of Humanitarian Affairs
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement & Supply Chain Management
RBM	Rollback Malaria
RC	Regional Committee
SADC	Southern African Development Countries
TA	Travel authorization
UEMOA	Union Economique et Monétaire Ouest Africaine
UN CERF	UN Central Emergency Response Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
W/A	West Africa
WB	World Bank
WCC(s)	WHO Collaborating Centre(s)
WHO/EC	WHO Economic Community
XDR-TB	Extensively Drug Resistant TB

EXECUTIVE SUMMARY

1. The year 2008 represents the first year of implementation of the Medium Term Strategic Plan (MTSP) of WHO. The MTSP defines the strategic direction of the Organization for the period 2008–2013. It aims at achieving 13 Strategic Objectives (SOs) for contributing to the improvement of global health.
2. During the year under review, HIV/AIDS, tuberculosis and malaria continued to be major public health problems with far-reaching consequences on development countries in the African Region. Other communicable diseases continued to be challenges, with Member States experiencing significant increases in outbreaks of Ebola and Marburg, and resurgence of old diseases such as cholera, meningococcal disease and yellow fever. Added to this was the growing burden of noncommunicable diseases with evidence of links to common lifestyle-related risk factors such as unhealthy diet, lack of physical activity, tobacco use and alcohol consumption.
3. The health situation of most African women and children remained critical. Prevailing trends in maternal mortality ratios and in under-five mortality rates in the African Region were such that targets related to Millennium Development Goals 4 and 5 are unlikely to be met. Emergencies and humanitarian crises continued to exert further strains on socioeconomic systems, with at least 40 of the 46 countries in the Region having experienced some form of emergency in 2008. These resulted in thousands of people being killed and millions displaced. Access to safe water and adequate sanitation, food security and safety, and under-nutrition remained unresolved in several countries in the Region.
4. Health systems in the African Region are generally weak, hampering the achievement of better health outcomes. Issues such as limited national capacities for governance and leadership, inadequate human resources, lack of comprehensive health financing policies, limited access to essential medicines, limited utilization of research-generated evidence and knowledge, poor information and surveillance systems, and inadequate community participation still need attention.
5. The work of WHO in the African Region was based on the Programme Budget (PB) 2008-2009. The approved budget for the African Region was US\$ 1 193 940 000, which represented 28.2% of the global approved WHO budget. The approved budget was distributed according to the 13 Strategic Objectives and related organization-wide expected results.
6. The conclusion of the Mid Term Review of the implementation of the Programme Budget 2008-2009 was that good progress was made in 2008 towards the achievement of planned results. Of the approved budget for the Region, US\$ 783 454 000 (66%) was allotted for activities. Of this allotted amount, US\$ 442 657 000 was obligated, representing an implementation rate of 57%.
7. The priorities defined in the Region are being addressed through the 13 Strategic Objectives (SOs). The salient activities of the SOs are described below.
8. ***SO1 Prevent and control communicable diseases:*** Significant progress was reported in routine immunization, measles control, maternal and neonatal tetanus elimination, neglected tropical diseases and yellow fever control. Leprosy was eliminated as a public health problem in the two remaining endemic countries, while guinea-worm disease was **eradicated** in three additional countries. In the campaign towards polio eradication, there was a resurgence of Wild polio virus type 1 transmission

in the northern states of Nigeria with subsequent spread to neighbouring countries. Surveillance was stepped up.

9. ***SO2 Combat HIV/AIDS, tuberculosis and malaria:*** Normative tools were developed to support countries in scaling up HIV/AIDS control and malaria control interventions, and in applying the **Stop TB strategy**. Access to HIV/AIDS treatment and care improved. Support was provided to countries to access TB medicines through the Global Drug Facility. The Global Fund to Fight AIDS, Tuberculosis and Malaria was the main mechanism to secure long-term predictable funds to countries. Collaboration was also undertaken with many other funding and implementation partners.

10. ***SO3 Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions:*** Focal points from ministries of health and WHO country offices were trained, and their capacity was strengthened in the prevention and control of NCDs, including oral-health conditions; sickle-cell-disease; violence, injury and disabilities; mental health and substance abuse problems. They also developed mental health policies and strategic plans. The first World No Noma Day was organized. Cancer prevention and control were strengthened. The publication *Violence and Health in the WHO African Region* was finalized, and a survey on the status of road safety in the Region was completed.

11. ***SO4 Reduce morbidity and mortality and improve health during key stages of life:*** WHO supported countries in developing, adopting and implementing various key interventions. Over 30 countries developed national strategies on Infant and Young Child Feeding with implementation plans. A total of 21 countries now have adolescent health strategic plans. During the fifty-eighth session of the WHO Regional Committee for Africa, the ministers of health adopted a resolution on women's health and declared 4 September as Women's Health Day.

12. ***SO5 Strengthen response to emergencies, disasters, crises and conflicts:*** WHO and national capacity for resource mobilization, project implementation and reporting was strengthened through training, delegation of authority to WHO Representatives, the adoption of standard operating procedures and the use of management and communication tools such as monthly bulletins and **e-work**. This produced tangible results in the increase in resources mobilized: US\$ 51 455 039 in 2008, representing a 35.7% increase over the US\$ 37.8 million raised in the 2006-2007 biennium. This enabled expanded and more timely action in support of response to emergencies such as floods, conflicts and disease outbreaks with WHO increasingly coordinating and leading health action.

13. ***SO6 Integrate comprehensive, multisectoral and multidisciplinary health promotion processes:*** Multisectoral teams in a number of countries were trained in the development of integrated health promotion interventions aimed at noncommunicable disease prevention. Most Member States conducted STEPS surveys, and most countries in the Region had ratified the Framework Convention on Tobacco Control by December 2008. Global surveys on alcohol and health, and resources for prevention and treatment of substance abuse disorders were conducted in all Member States and will constitute the basis for a regional information system.

14. ***SO7 Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches:*** Through the Ethics, Equity, Trade and Human Rights programme and the Gender and Women Health programme, the Regional Office supported countries participating in the WHO/EC MDGs Partnership and the WHO/Luxembourg project to finalize Phase I progress reports and prepare workplans for Phase II. Countries continued to be sensitized on the

need to address social determinants of health: the report of the WHO Commission on Social Determinants was widely disseminated and the Regional Office finalized a draft framework for advancing the work on social determinants of health in the Region.

15. ***SO8 Promote a healthier environment:*** WHO provided extensive support in the investigation and containment of a number of specific environmental health incidents. The first Inter-Ministerial Conference on Health and Environment in Africa was jointly organized by WHO and UNEP and hosted by the Government of Gabon. Participating countries adopted the Libreville Declaration on Health and Environment in Africa, mandating the establishment of a health and environment strategic alliance as the basis of joint action by both sectors.

16. ***SO9 Strengthen nutrition, food safety and food security:*** Intersectoral action and coordination in food safety was strengthened through the establishment of task forces and committees on food safety in several countries. Most countries joined the WHO Global Salmonella Surveillance. At its fifty-eighth session, the Regional Committee for Africa adopted the document on **“iodine deficiency disorders in the WHO African Region: situation analysis and way forward”**. A consultation on integration of nutrition in HIV/AIDS control programmes adopted a declaration. WHO organized seminars and workshops related to the Codex Alimentarius.

17. ***SO10 Improve health services through better governance, financing, staffing and management informed by reliable, accessible evidence and research:*** An international conference adopted the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium which was also endorsed at the fifty-eighth session of the Regional Committee. An implementation framework for this Declaration was developed. **The draft WHO Code of Practice for international recruitment of health personnel was finalized.** A ministerial conference on research for health in the African Region was held in Algiers, and the resulting Algiers Declaration was presented to the 2008 Bamako Global Ministerial Forum on Research for Health. **The African Regional Health Observatory** was established.

18. ***SO11 Ensure improved access, quality and use of medical products and technologies:*** At its fifty-eighth session, the Regional Committee adopted a resolution for strengthening public health laboratories in the WHO African Region. Most countries in the Region signed a pledge to tackle healthcare-associated infections. Workshops were held on injection safety, biosafety and laboratory biosecurity; evaluating quality management programmes in blood transfusion services; standardizing operational procedures and bench practices; and pharmaceutical policy analysis. Most countries in the Region now have national policies on traditional medicine.

19. ***SO12 and SO13 WHO Secretariat work, including strengthen WHO presence in Member States:*** WHO played its leadership role in health in the Region through continued advocacy at country and regional levels, strengthened the effectiveness of WHO country presence through development of Country Cooperation Strategies, improved guidance and delegation to WHO Representatives and decentralisation of technical cooperation functions from the Regional Office to Intercountry Support Teams. Other priority areas addressed include governance, partnership, resource mobilization and communication with Member States, partners and other stakeholders. The other main areas of focus were strategic and operational planning; performance monitoring; assessment; WHO resource management; **human** resource development and management; information technology and systems for WHO; managerial and administrative support services; and the working environment at WHO.

20. The challenges that persisted at the beginning of the reporting year still remain relevant. There is, therefore, the need to mobilize adequate resources for full implementation of planned activities both at regional and country levels. One key lesson learnt was the need for strong country leadership to facilitate rapid and sustainable scaling up of priority interventions, including coordination of partnerships; adoption of integrated approaches for the delivery of services; ensuring the availability of motivated human resources for health; availability and use of sustainable financial mechanisms to promote service utilization; and effective community participation.

21. Key lessons learnt included the need to adopt more effective communication and reporting strategies, closer coordination between technical programmes in planning and implementation, pursuing opportunities for long-term non-earmarked funding to ensure the presence of key technical staff in the Inter-country Support Teams and country offices, and putting in place effective mechanisms for close monitoring of income and budget implementation.

22. The Mid Term Review of the implementation of the Programme Budget 2008-2009 provided an opportunity for reprogramming of activities and resources, based on findings of the review and lessons learnt for the first year of the biennium. Several actions were identified as ways to improve implementation during the second year of the biennium. These include improvement of internal WHO capacity in advocacy, negotiation and resource mobilization; implementation of Country Cooperation Strategies, with emphasis on monitoring and engagement of stakeholders; implementation of the critical commitments made in various declarations in 2008 (Ouagadougou, Algiers and Libreville); consolidation of partnerships; intensified resource mobilization; and building capacities of WHO staff in country offices on programme planning, management, monitoring and evaluation as well as resource mobilization to improve support to ministries of health and partners.

23. The annexes provide the budget implementation status as of 31 December 2008 and list the Regional Committee resolutions reviewed.

1. INTRODUCTION

1. The year 2008 was the first year of implementation of the WHO Medium Term Strategic Plan (MTSP) for the period 2008–2013. The MTSP represents a new, result-based management framework with a new budget structure and new rules. During the year 2008, the Global Management System (GSM) was rolled out at headquarters and intensive preparations were undertaken for the same in the African Region, resulting in necessary adaptations to the organizational structure of the Regional Office, as well as clustering of programmes in WHO country offices.

2. The WHO Regional Office took advantage of Governing Bodies meetings to regularly inform Member States about new developments and orientations with regard to the WHO management framework and its implementation in the African Region. WHO Representatives, Divisional Directors and programme managers were delegated increased authority.

3. The purpose of this report is to present the work accomplished and progress made during the first year of the biennium 2008-2009. The report includes six main parts. After the Introduction, the second chapter describes the context of implementation of the Programme Budget 2008-2009 in the African Region. The third chapter, presents the priorities of the biennium and related planned resources. The fourth chapter reports on progress towards achievements of organization-wide expected results set for the biennium for each of the 13 Strategic Objectives, including the implementation of relevant resolutions of the WHO Regional Committee. The fifth chapter summarizes challenges, constraints and lessons learnt during the reported period. The sixth chapter proposes a way forward for the second year of the biennium. The report is supplemented by annexes on budget implementation level by Strategic Objective and source of funds, as well as the list of Regional Committee resolutions reviewed.

2. CONTEXT

4. The work of WHO in the African Region during the year under review was guided by the WHO Medium Term Strategic Plan (MTSP) 2008–2013 recently adopted by the WHO Governing Bodies.¹ The WHO Medium Term Strategic Plan defines the strategic direction of the Organization for the period 2008–2013. In the MTSP, a strategic shift has been made in the way the structure of the WHO Programme Budget is organized from areas of work to Strategic Objectives (SOs).

5. There are 13 SOs which seek to reduce the burden of communicable diseases; combat HIV/AIDS, tuberculosis and malaria; prevent and reduce disease, disability and premature death from chronic noncommunicable conditions; reduce morbidity and mortality and improve health during key stages of life and improve sexual and reproductive health; reduce the health consequences of emergencies and disasters; promote health and development; address the underlying social and economic determinants of health; promote a healthier environment; improve nutrition, food safety and food security; improve health services; ensure improved access, quality and use of medical products and technologies; provide leadership, strengthen governance and foster partnership and collaboration; and develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

6. The year under review saw the partial deployment of the Global Management System (GSM) in the Region. GSM is WHO's Enterprise Resource Planning System, an information technology system that enables data entry, collates and produces data in order to enhance efficiency in the

performance of the Organization. The Regional Office entered the transition period in July 2008. Initiation into access to GSM, improvement of the information technology (IT) infrastructure, and cleaning up and preparation of data for conversion into GSM progressed well.

7. Proven health interventions are not implemented at full scale in several parts of the world, especially in Africa. While unprecedented scientific and technological advances have been achieved during the last decades, knowledge on effective ways to address some of the most important health challenges facing Africa and the rest of the developing world is still insufficient.

8. The health status of the people of the African Region is characterized by a high burden of communicable diseases. Member States are experiencing an increasing frequency of disease outbreaks, including Ebola, Marburg and Rift Valley fevers, and resurgence of cholera, meningococcal meningitis, yellow fever and shigellosis. As at the end of December 2008, a total of 920 wild poliovirus cases had been confirmed. Neglected diseases such as guinea-worm disease, leprosy, lymphatic filariasis, onchocerciasis, trypanosomiasis, Buruli ulcer, schistosomiasis, intestinal parasitosis, leishmaniasis, yaws and other treponematoses as well as zoonotic diseases still pose threats to the socioeconomic development of African countries.

9. HIV/AIDS, tuberculosis and malaria continue to be major public health problems with far reaching consequences. Sub-Saharan Africa carries the highest burden of HIV infections and HIV/AIDS-related mortality in the world. Within the Region, southern and eastern Africa bear the highest burden of the co-infection of HIV and tuberculosis. The situation is compounded by the emergence of multidrug-resistant (MDR) TB and extensively drug-resistant (XDR) TB. Scaling up effective malaria control interventions such as the use of insecticide-treated nets (ITNs), artemisinin-based combination therapies (ACTs) and intermittent preventive therapy (ITP) has not reached desired levels.

10. The burden of chronic noncommunicable diseases (NCDs) is growing in the Region while health systems are inadequately prepared to provide the services required for prevention disease management. There is growing evidence of the high prevalence of common risk factors which are lifestyle-related: unhealthy diet, lack of physical activity, hypertension, tobacco use and alcohol consumption.

11. The health situation of African women and children remains critical. The decline of maternal mortality ratios between 1990 and 2005 in sub-Saharan Africa was only 0.1% annually, while the annual reduction rate needed to achieve Millennium Development Goal 5 is at least 5.5% per year² mainly due to insufficient numbers of skilled birth attendants. Access to modern family planning is limited, with only 16% of women using modern methods.

12. Under-five mortality rates in the African Region dropped from 185 per 1000 live births in 1990 to 157 per 1000 in 2006,³ far from the MDG target of a two-thirds reduction by 2015. Available data indicate that only five countries in the African Region (Algeria, Cape Verde, Eritrea, Mauritius, Seychelles) are on track to achieve MDG 4.⁴ In countries where progress is lagging or where maternal, newborn and child mortality has increased, AIDS, malaria and conflict are likely to be major contributing factors.

13. At least 40 of the 46 countries in the Region experienced emergencies in 2008, further straining their socioeconomic situations. These included natural and man-made emergencies of various degrees: floods and subsequent cholera and other water-borne disease outbreaks; droughts

resulting in food crises and high malnutrition rates; conflicts resulting in mass population movement; earthquakes; mass casualties caused by road accidents, air crashes and capsizing of boats; chemical spills and the dumping of chemical waste; oil pipeline explosions and the collapse of buildings. As a result, thousands of people were killed and millions displaced.

14. There are unacceptable inequalities between and within countries in terms of health status, well-being and social practices linked to the social determinants of health prevailing in the African Region. These inequalities are impacting adversely on development of countries in the Region. Although nearly every country in the Region recognizes the existence of inequalities in health and access to health care, no adequate measures are taken, partly due to the complexity of the problem and the lack of data.

15. Around one quarter of the total burden of diseases in developing countries may be associated with environmental risk factors. In the African Region, traditional risk factors such as access to water and adequate sanitation have not been resolved while the Region also needs to cope with new and emerging risk factors. Over the past two decades, policy, legislation and regulatory frameworks that address environment-health linkages have been developed. However, the extent to which these instruments have been implemented and actually impacted on the reduction of the environmental burden of disease is uncertain.

16. Food insecurity in Africa threatens the lives of millions of vulnerable people, especially displaced persons and people living with HIV/AIDS. Food-borne and water-borne diseases remain major public health problems and important causes of malnutrition in children in the Region. In 2008, a high number of outbreaks of food-borne diseases were reported, including anthrax; typhoid fever; chemical poisoning from vegetables, mushrooms, seed beans and maize; cholera; botulism and Hepatitis A. The percentage of mothers exercising exclusive breastfeeding is low; complementary foods are inadequate, inappropriate and often contaminated resulting in up to five episodes of diarrhoea per child per year in the Region.

17. Health systems in the African Region are generally weak, hampering the achievement of better health outcomes. The way health systems are organized, managed and financed does not always contribute to increased access and utilization of health services. Gaps exist in national capacities for governance and leadership, leading to poor harmonization and coordination of partners as well as lack of accountability for results and ineffective community involvement.

18. Many countries lack the human resources required to deliver health care and services due to various reasons, including limited health workforce production and management capacity, inequitable and unbalanced geographical distribution, inadequate skills mix, substandard working conditions, migration and a weak knowledge base to inform health workforce policies and strategies to redress these challenges.

19. Countries of the Region also lack comprehensive health financing policies; many have not institutionalized the use of national health accounts to track expenditures, and there is widespread use of out-of-pocket payments which limit financial access to health services. There is limited coverage by prepaid health financing mechanisms; inefficient resource use; and weak mechanisms for coordinating partner support in the health sector.

20. Delivery of adequate health care depends on availability of medicines, vaccines and health technologies of assured quality as well as effective funding mechanisms. In the Region, about half of overall health expenditures are made on medical products, yet about 27 000 people die unnecessarily every day due to lack of access to basic and essential medicines. Paediatric formulations are still lacking. Furthermore, international market forces do not favour the development of new products for the diseases of poverty. Globalization is enhancing an unprecedented growth in counterfeit medical products. There are no adequate pharmacovigilance systems in place, creating concerns about monitoring the new medicines for HIV/AIDS, tuberculosis, malaria and other tropical diseases.

21. Information, evidence and research are required in countries for the development, monitoring and evaluation of national and regional policies and programmes. There is a wealth of knowledge on evidence-based and cost-effective interventions for improving health outcomes. However, countries in the Region continue to face challenges related to information access, quality, coverage and cost. Another challenge is the generation and consolidation of knowledge and evidence on public health issues, including publication of analytical and comparative reports, and promotion of research studies on key public health topics.

22. During the year under review, the Regional Office took decisive steps in reaffirming leadership in the health domain at country level, improving governance, consolidating the implementation of its decentralization policy, and establishing and reinforcing health partnerships. This resulted in strengthening the three Intercountry Support Teams and adoption of milestone Declarations, renewing the commitment of governments, WHO and partners to improve health outcomes in the Region.⁵

23. Overall, successful implementation of technical programmes in the Region depends in part on effective delivery of WHO support services. The creation of the ISTs was aimed at enhancing the capacity of WHO to provide technical support to countries. The Regional Office focuses on the development of essential policies and strategies, planning and budgeting, monitoring and evaluation, generating and sharing information and evidence, resource mobilization and management, and partnerships. The main role of WHO country offices is to influence implementation of health interventions at country level by moving WHO policies from the central level to local level while considering available resources and existing partnerships.

3. THE PROGRAMME BUDGET 2008-2009

24. The Programme Budget 2008-2009 is based on the principles of results-based management and integration. The approved budget for the African Region is US\$ 1 193 940 000 which represents 28.2% of the global approved WHO budget. The priorities defined in the Region are being addressed through the 13 Strategic Objectives of the MTSP (Annex 1).

25. The analyses of the WHO Country Cooperation Strategies (CCSs) as well as the document *Strategic orientations for WHO action in the African Region, 2005–2009* have shown that the main priorities are fighting against HIV/AIDS, tuberculosis and malaria; strengthening health policies and systems; enhancing effective rapid response to emergencies and disease outbreaks such as cholera; improving maternal and child health; combating neglected diseases; controlling the common risk factors of noncommunicable diseases; and scaling up proven cost-effective health interventions.

26. In the organizational structure of the Regional Office, the responsibility of tackling communicable diseases is under the leadership of the Division of Prevention and Control of Communicable Diseases. Unplanned activities to scale up poliomyelitis eradication efforts in response to the setbacks in Nigeria in 2008 led to an upward revision of the ceiling related to effective coordination and support to achieve certification of poliomyelitis eradication. Of the US\$ 345 157 000 allotted to Strategic Objective No. 1 (SO1) for 2008, 57% of the funding was implemented.

27. Strategic Objective No. 2 (SO2) is devoted to combating HIV/AIDS, tuberculosis and malaria. The three diseases claim millions of lives annually and contribute substantially to increasing poverty. In 2008, the focus was on accelerating the scaling up of cost-effective interventions. Thus, the Region was allotted US\$ 87 647 000 for SO2, and the consumption rate on the allotted amount was 58%.

28. Strategic Objective No. 3 (SO3) relates to prevention and reduction of disease, disability and premature death due to chronic noncommunicable conditions. For this SO, the allotted funds were US\$ 12 608 000, and the implementation rate was 41%.

29. Strategic Objective No. 4 (SO4) focuses on reduction of morbidity and mortality and improvement of health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals. For this SO, the Region was allotted US\$ 51 251 000, and the implementation rate was 44% in 2008.

30. Strategic Objective No. 5 (SO5) covers emergencies caused by natural and man-made disasters, including conflicts of various intensity. A sizable part of the Programme Budget was allocated to SO5 for the biennium, with US\$ 59 601 000 allotted for 2008; the consumption rate was 66%.

31. Strategic Objective No. 6 (SO6) concerns integrated, comprehensive, multisectoral and multidisciplinary health promotion processes and approaches across all relevant WHO programmes as well as the prevention and reduction of major disease risk factors such as tobacco use and consumption of alcohol, drugs and other psychoactive substances; unhealthy diet; physical inactivity; and unsafe sex. For this SO, US\$ 13 273 000 was allotted and the budget implementation rate was 53%.

32. Strategic Objective No. 7 (SO7) addresses the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches. For this SO, the allotted amount was US\$ 7 753 000 and the implementation rate was 35%.

33. Strategic Objective No. 8 (SO8) focuses on promotion of a healthier environment, intensifying primary prevention and influencing public policies in all sectors so as to address the root causes of environmental threats to health. Priorities for the biennium 2008-2009 have been to secure political commitment and catalyse the policy, institutional and investment changes that are needed to reduce environmental threats to health. With an allotted amount of US\$ 8 339 000, the implementation rate was 46% at the end of 2008.

34. Strategic Objective No. 9 (SO9) aims at improving nutrition, food safety and food security. Priority activities during the year concentrated on strengthening capacities; enhancing effective participation of countries in the Codex Alimentarius Commission; provision and development of food safety and nutrition legislation, norms, standards, policies, plans and strategies; strengthening information, education and communication; and managing the impact of food crises on health and nutritional status. The funds allotted were US\$ 6 756 000 and the implementation rate during 2008 was 37%.

35. Strategic Objective No. 10 (SO10) seeks the improvement of health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research. During the year under review, strengthening health systems was high on the agendas and priorities of Member States and the WHO Regional Office; there was additional focus on the district level using the Primary Health Care approach. Emphasis was on the revision and development of national health policies and plans that reflect PHC principles and values in order to increase the pace towards the attainment of the Millennium Development Goals (MDGs). Monitoring and evaluation of health sector reforms took advantage of opportunities from the global health initiatives to strengthen health systems. For SO10, the Region was allotted US\$ 42 913 000. The overall budget implementation rate of SO10 funds was approximately 49%.

36. Strategic Objective No. 11 (SO11) relates to improved access, quality and use of medical products and technologies. Medical products include chemical and biological medicines; vaccines; blood and blood products; cells and tissues mostly of human origin; biotechnology products; traditional medicines; and medical devices. Technologies include those for diagnostic testing, imaging and laboratory testing. In 2008, the focus was on making access to essential medical products and technologies more equitable as measured by availability, price and affordability; assuring the quality, safety, efficacy and cost-effectiveness of such products and technologies; and promoting correct and cost-effective use. SO11 was allotted US\$ 15 221 000; the budget implementation rate in 2008 was 57%.

37. WHO Secretariat work with regards to strengthened presence in Member States covered under Strategic Objective 12 (SO12) witnessed remarkable steps forward in terms of affirming WHO leadership in the health domain at country level; improving WHO governance; consolidating the implementation of the decentralization policy; and establishing and reinforcing health partnerships. In order to fulfil the mandate of WHO in advancing the global health agenda, SO12 was allotted US\$ 42 020 000. The implementation rate was 58% at the end of 2008.

38. Strategic Objective 13 (SO13) covers WHO Secretariat support functions which include providing WHO offices with core administrative and logistics resources to implement their programmes; developing and sustaining WHO as a flexible and learning organization, enabling it to carry out its mandate more efficiently and effectively; providing better quality strategic and operational plans; carrying out human resource transactions and responsibilities; providing financial management; updating standard operating procedures and logistics support. For SO13, an allotted amount of US\$ 90 915 000 was made available. The implementation rate in 2008 was 62%.

39. Overall, the Mid Term Review of the implementation of the Programme Budget 2008-2009 revealed good progress towards the achievement of planned results. Of the US\$ 1 193 940 000 allocated to the Region, US\$ 783 454 000 (66%) was made available for the first year. Of the allotted amount, US\$ 442 657 000 was obligated, representing an implementation rate of 57%.

4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE

4.1 SO1: Communicable diseases

40. Concerning routine immunization, by the end of 2007, 16 Member States⁶ reported 90% or higher DPT3 coverage and 15 countries⁷ had at least 80% of districts with 80% or more DPT3 coverage (Figure 1). Provisional data for January–November 2008 indicates that 11 countries attained DPT3 coverage of at least 90%, and 27 countries attained 80% or more.

Figure 1: Reported DPT3 coverage, 2007, WHO African Region

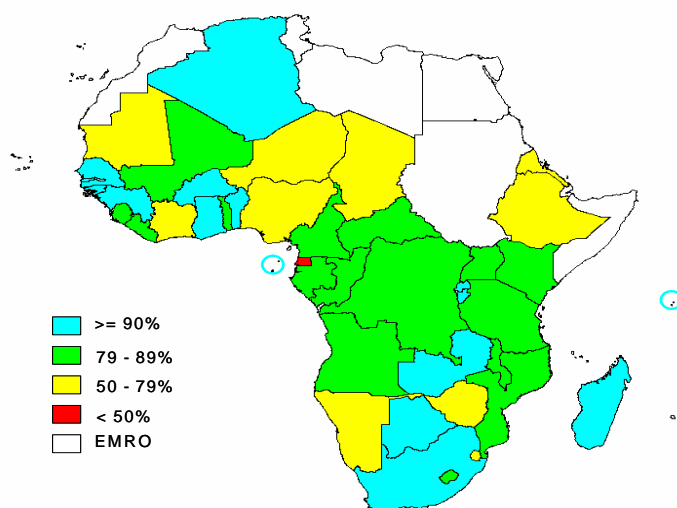


Figure SEQ Figure * ARABIC 1: Reported DPT3 coverage, 2007, WHO African Region

41. As of December 2008, 44 countries introduced Hepatitis B and 37 countries introduced Hib vaccine in their routine immunization schedules.

42. With regards to measles control in 2008, a total of 66.9 million children were reached in integrated measles supplemental immunization activities (SIAs) in 11 countries. At the end of 2007, the Region had attained 89% reduction in estimated measles deaths compared to the mortality estimates for 2000.

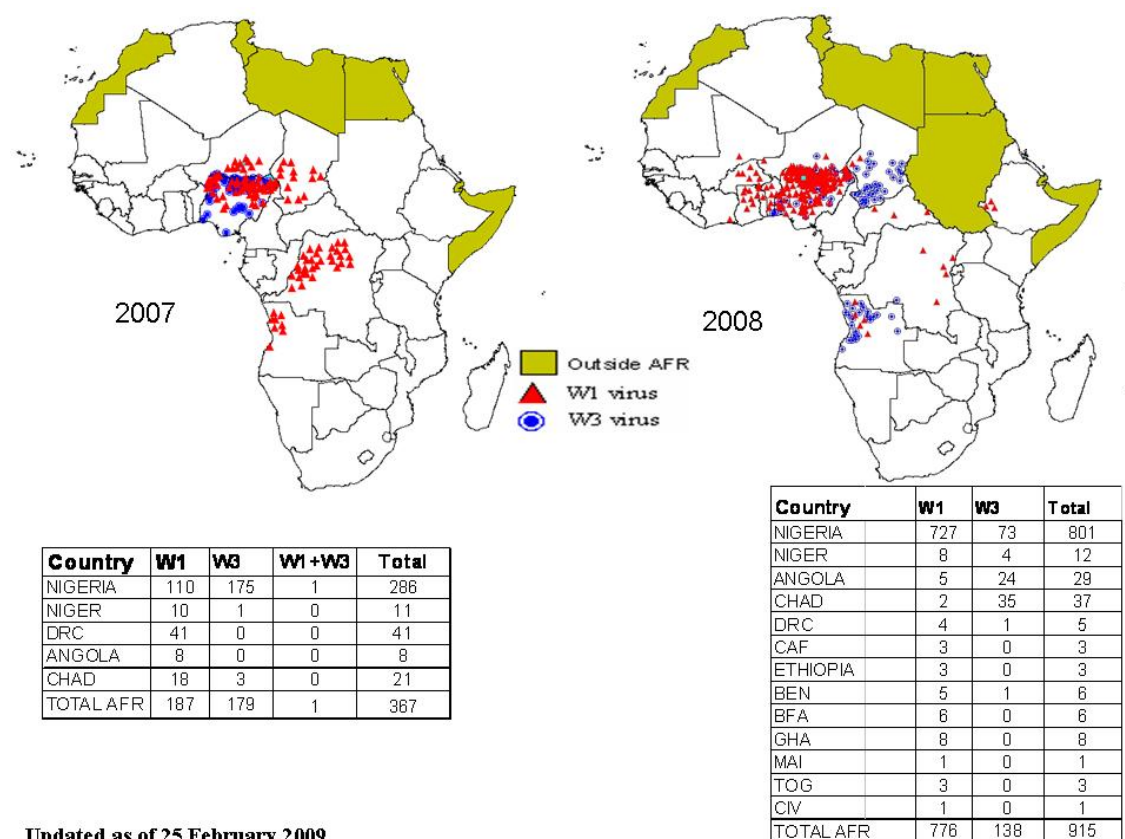
43. For maternal and neonatal tetanus elimination (MNTE), 21 countries implemented 59 rounds of tetanus toxoid SIAs in high-risk districts, targeting 60.1 million women of child-bearing age. So far, MNTE has been validated in 13 countries in the Region.

44. For yellow fever control, 23 of the 31 countries at risk for yellow fever in the Region introduced yellow fever vaccine in their Expanded Programme on Immunization routines, with a coverage of 73% in 2008. During the same year, Burkina Faso, Mali, Senegal and Togo completed preventive yellow fever SIAs in 114 high-risk districts.

45. With regards to polio eradication, the northern states of Nigeria experienced a resurgence of Wild polio virus type 1 transmission with subsequent spread to neighbouring countries (Figure 2). At the end of 2008, a total of 915 cases of wild poliovirus were reported from 13 countries.⁸ In response to this resurgence, high-quality SIAs were implemented and supported with intensive monitoring in order to better guide efforts in places that were performing sub-optimally.

46. In 2008, 44 countries achieved certification level for acute flaccid paralysis surveillance. Four more countries successfully submitted their complete documentation to the Africa Regional Certification Commission as evidence of their polio-free status, bringing the total number to 25 countries as of 31 December 2008.

Figure 2: Wild poliovirus distribution, 2007 and 2008, WHO African Region



Updated as of 25 February 2009

47. For neglected tropical diseases (NTDs), mapping was conducted in four countries (Ethiopia, Rwanda, Sao and Principe, Swaziland); plans to accelerate or scale-up NTD interventions were adopted in seven countries;⁹ mass drug administration was organized in 12 countries;¹⁰ early diagnosis and recommended treatment of Buruli ulcer increased in 12 countries; and monitoring and evaluation of NTD programmes were organized in nine countries.¹¹

48. Elimination of leprosy was achieved in the two remaining countries, Democratic Republic of Congo and Mozambique. All countries developed new strategic plans to target the elimination of leprosy at the district level. Eradication of guinea-worm disease was achieved in three additional countries, and certification was concluded in Cote d'Ivoire, Ethiopia and Mauritania.

49. In relation to communicable disease surveillance, the Integrated Disease Surveillance and Response (IDSR) technical guidelines were revised taking into account the International Health Regulations 2005 (IHR-2005) and other priority diseases. Subsequently, 16 countries updated their national IDSR guidelines and seven countries evaluated their IDSR and revised their action plans.¹² Four countries (Cape Verde, Kenya, Sao Tome and Principe, Seychelles) scaled up IDSR implementation in districts.

50. The WHO Regional Office for Africa finalized and disseminated a guide for national public health laboratory networking to strengthen IDSR. Six countries¹³ were supported to implement national external quality assurance programmes on microbiology for intermediate and peripheral laboratories. In 2008, 72 laboratories from 45 African countries participated in the Regional External Quality Assessment Programme in bacteriology, and 13 influenza laboratories participated in the WHO External Quality Assessment Programme for the detection of Influenza virus type A by polymerase chain reaction.

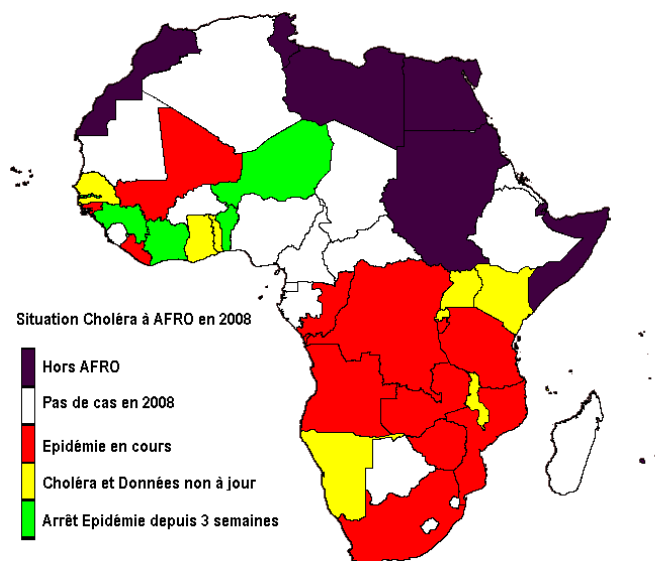
51. Sentinel surveillance was introduced in the African Region to document the burden of rotaviral diarrhoeal disease, with 10 countries reporting as of December 2008. A total of 19 countries regularly reported paediatric bacterial meningitis sentinel surveillance data.

52. With regards to vaccine research and development, capacity-building was conducted targeting the national regulatory authorities in 19 countries. A malaria candidate vaccine research protocol was jointly reviewed by the seven countries targeted for clinical trials.

53. In order to meet the requirements of International Health Regulations–2005, tools for assessing core capacity were developed and disseminated to selected countries.¹⁴ The Regional Office contributed to the finalization of a checklist for monitoring core capacities for surveillance and response.

54. Timely and effective technical and logistics support was provided by WHO to Member States with suspected cases and outbreaks of epidemic-prone disease and to those experiencing major epidemics of cholera (Figure 3), meningitis, plague and viral haemorrhagic fevers, including a new arenavirus. As of 28 November 2008, 26 countries reported 84 074 cholera cases and 1989 deaths, with an overall case fatality rate of 2.4%. In 2008, yellow fever outbreaks were confirmed in six countries,¹⁵ and mass reactive vaccination campaigns were conducted in the affected areas.

Figure 3: Countries reporting cholera in the WHO African Region, November 2008



55. Other epidemic-prone diseases reported in the Region included dengue fever (in Cote d'Ivoire and Mali), Crimea-Congo haemorrhagic fever (Mauritania), Lassa fever (Liberia, Nigeria, Sierra Leone), a new strain of arenavirus, plague (Democratic Republic of Congo, Madagascar, Uganda), Hepatitis E (Chad and Uganda) and meningococcal meningitis.

56. For the implementation of Resolution AFR/RC56/R7 on avian influenza: preparedness and response to the threat of a pandemic, as of December 2008, eight countries in the WHO African Region reported avian outbreaks of H5N1 infection. The only human H5N1 infection case was reported from Nigeria. The Regional Office began formation of the Regional Influenza Virus Surveillance Network composed of national influenza surveillance systems.

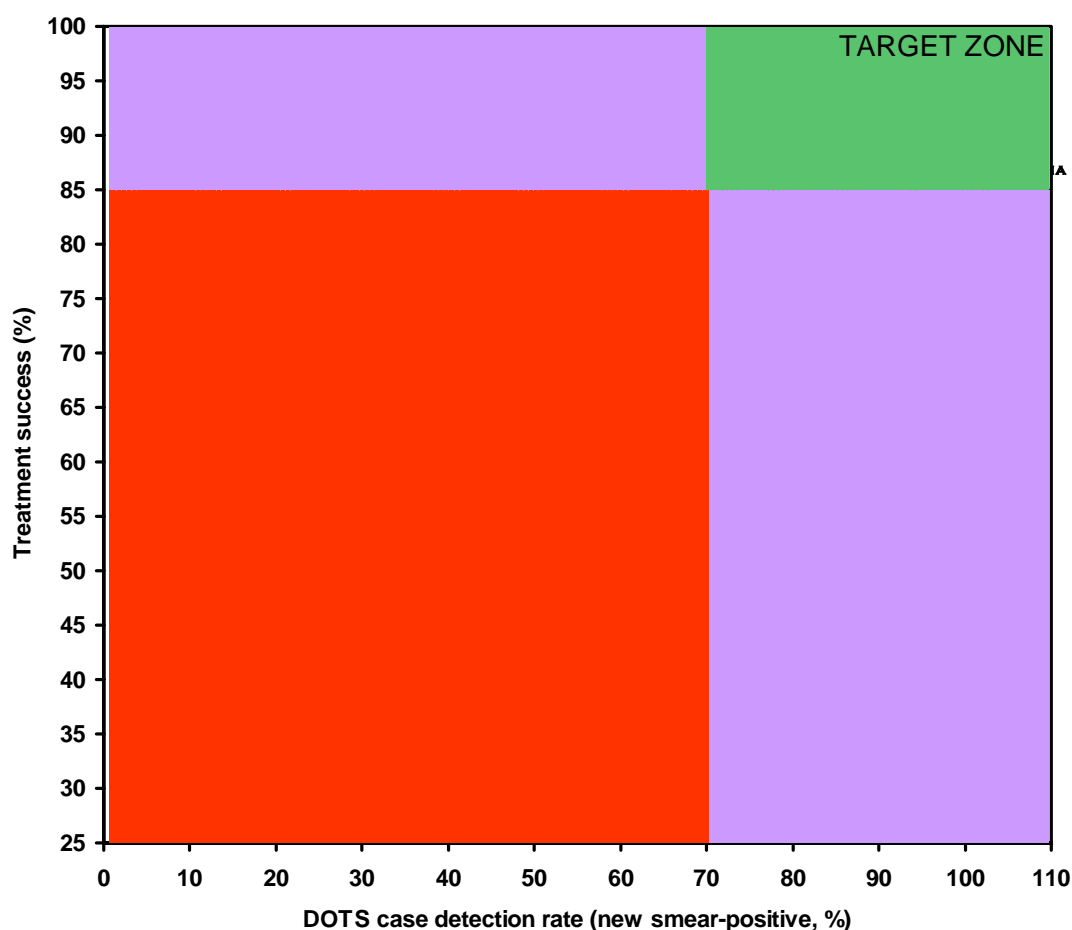
57. At least 14 countries¹⁶ in the Region implemented virological surveillance for influenza and submitted **representative** isolates from patients with influenza-like illness to WHO collaborating centres for antigenic and genetic analyses. At least 30 laboratories in the Region received support or are designated to receive support to implement influenza testing.

58. For implementation of Resolution AFR/RC57/R1 on resurgence of cholera in the WHO African Region: current situation and way forward, WHO continued to provide technical assistance, equipment and supplies, and health-care worker incentives to affected countries, notably Guinea-Bissau, South Africa and Zimbabwe. In May 2008, WHO, UNICEF and the UN Office for the Coordination of Humanitarian Affairs (OCHA) agreed to collaborate and to work jointly to support countries to prevent and control cholera in the Region. Large outbreaks continued to prevail in two countries in complex emergencies, Democratic Republic of Congo and Zimbabwe. In some countries, 10% or more of the reported cases died, indicating problems with the provision of timely and appropriate case management.

4.2 SO2: HIV/AIDS, tuberculosis and malaria

59. Normative tools were developed to support countries in scaling up HIV/AIDS cost-effective interventions, namely regional guidelines on HIV testing and counseling (HTC); harmonized and standardized technical and operational recommendations for HIV laboratory testing; and strategic orientations for scaling up male circumcision. The availability of these normative tools facilitated 25 countries¹⁷ to update their guidelines and other tools for scaling up HTC, prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART).

Figure 4: DOTS case detection rate (new smear-positive, %)



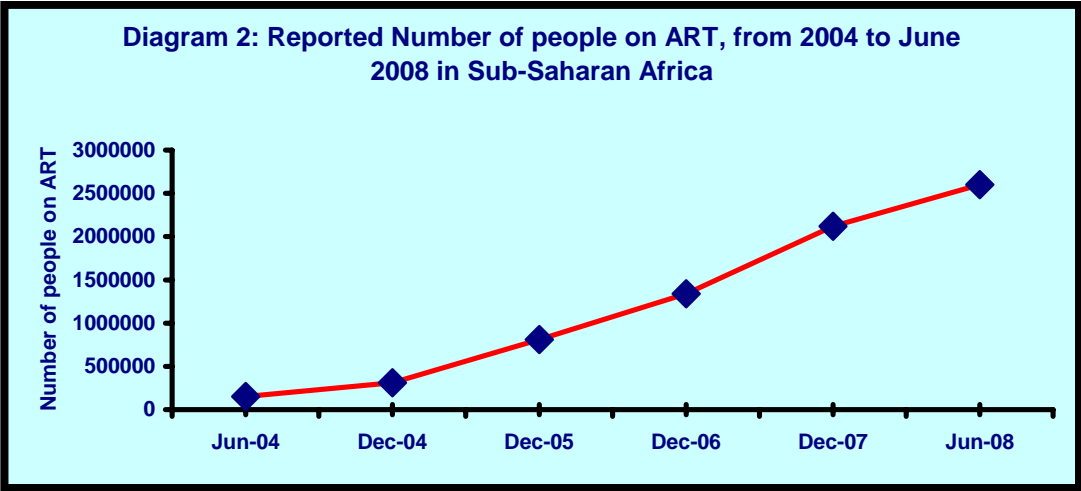
60. The support provided to 34 countries enabled them to adapt tools and policies to implement and expand the new Stop TB strategy which now includes TB/HIV collaborative activities and MDR/XDR-TB. According to the 2008 WHO Global TB Control Report (Figure 4), 10 countries¹⁸ met the 70% case detection rate, compared to nine countries the previous year. Eight countries¹⁹ achieved the 85% treatment-success rate, the same as the previous year's cohort. However, four more countries (Kenya, Rwanda, Tanzania, Zambia) made good progress and attained treatment success rates of 80%.

61. Strategic, normative and technical documents were developed to support the scaling up of malaria control interventions at country level. These include a framework for accelerated malaria control and elimination, malaria treatment algorithms and a malaria case management operational manual.

62. In relation with Regional Committee resolutions AFR/RC55/R6 and AFR/RC56/R3, by June 2008, the median percentage of health facilities providing HIV testing and counselling rose to 32%, based on updates received from 23 countries,²⁰ compared to 23% in 2007 among 31 countries.²¹ By the end of 2007, over 470 000 HIV-positive pregnant women reportedly received ARVs for PMTCT purposes, representing an increase of over 50% from 2006. The number of antenatal clinics that provide PMTCT services increased from 10 600 in 2007 to over 13 000 by mid 2008. By early 2008, out of 46 countries, 40 reported that 100% of blood was screened for HIV before transfusion.

63. Access to HIV/AIDS treatment and care improved. At the end of 2007, over 2.1 million people received ART in the Region (Figure 5). By end of June 2008, an additional half million were administered ART, representing a 24% increase in just six months. Reports from 24 countries²² in the Region indicate that the percentage of health facilities that provide ART services increased by at least 7% from 3400 in 2007 to 3680 by the end of June 2008.

Figure 5: Number of people on ART, 2004–2008, sub-Saharan Africa



64. Scaling up collaborative TB/HIV activities continued in most TB/HIV high prevalence countries. To further accelerate the scaling up process, WHO supported 13 countries to develop roadmaps to scale up TB/HIV collaborative activities with a focus on intensified TB case finding, isoniazid preventive therapy (IPT) among people living with HIV and TB infection control—"the 3 Is strategy". According to the 2008 WHO Global Tuberculosis Control Report, the proportion of TB patients screened for HIV rose from 22% in 2006 to 38% by the end of 2007. Of those who tested positive, 37.1% were started on ART, increasing from 27.3% in the previous year. Furthermore,

89.1% of HIV-positive TB patients were started on co-trimoxazole preventive therapy (CPT) compared to 72.2% in the previous year's cohort. Of the 46 countries in the Region, 41% have adopted the policy on isoniazid prophylaxis, but only 6% of the 250 546 TB/HIV co-infected and eligible patients are receiving isoniazid therapy.

65. Management of multidrug-resistant TB (MDR-TB) is a new challenge in the Region. By December 2008, 36 countries had local laboratory capacity to identify MDR-TB, and 18 countries were supported to develop treatment programmes for MDR-TB. Following an outbreak of extensively drug-resistant TB (XDR-TB) in the Region in January 2006, eight high-risk countries²³ were supported in undertaking rapid XDR-TB surveys.

66. In order to better determine the burden of TB in countries, 12 countries were supported to develop protocols for TB disease prevalence surveys, while 10 countries carried out countrywide anti-TB drug resistance surveys to determine the profile of anti-TB drug resistance.

67. A total of 23 countries were supported to update their malaria strategic plans, and 12 countries conducted comprehensive needs assessments that contributed to identifying gaps in scaling up malaria control interventions towards achieving the 2010 Roll Back Malaria (RBM) targets. The "Tools for Malaria Programme Reviews" were revised in collaboration with the WHO Global Malaria Programme and the subregional networks and are in use in comprehensive programme reviews.

68. Between 2000 and 2008, the number of insecticide-treated bednets (ITNs) distributed increased between 3- and 10-fold in most malaria-endemic countries. On average, 34% of households owned at least one ITN, while 23% of children under-five and 19% of pregnant women slept under an ITN. In case management, all but two of the malaria-endemic countries adopted the artemisinin-based combination therapy (ACT) policy. However, based on data from 14 countries, on average, 3% of children under-five with a history of fever received ACT. Technical support was provided to Ghana, Senegal and Togo for establishing pharmacovigilance systems for malaria treatment. Benin, Ghana, Senegal, Togo and Uganda were supported to expand the deployment of ACTs at community level.

69. Assessment of procurement and supply chain management (PSM) was conducted in collaboration with WHO headquarters, UNICEF and GIP-ESTHER (*Groupement d'Intérêt Public: Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau*) in 24 countries out of which 11 were supported to undertake mapping of their PSM systems. Eight of these countries²⁴ from Central and West Africa received support for mapping their PSM systems for ARVs. The main findings revealed that the poor performance of the PSM system was the consequence of a combination of factors, among which poor quantification capacity, human resource constraints and inadequate coordination among various stakeholders rated the highest. The Regional Office, UNICEF and GIP-ESTHER organized a meeting to present the report of this assessment to countries, inform and advocate on availability of technical support, and launch a platform for coordination of partners at country level. Based on recommendations from this meeting, three countries (Benin, Central African Republic and Republic of Congo) were supported to address their PSM gaps.

70. Support was provided to countries to access TB medicines through the Global Drug Facility (GDF). By December 2008, 36 countries had ongoing GDF grants for first-line anti-TB medicines. By June 2008, eight countries²⁵ had secured approval for quality-assured and concessionary-priced second-line anti-TB medicines through the WHO Green Light Committee mechanism. Consequently, available information indicates that 93% of countries had uninterrupted supply of anti-TB medicines

at peripheral level. Of the 27 countries reporting any MDR-TB cases during 2007, only 17 were known to have an MDR-TB treatment programme. Even where treatment programmes exist, not all confirmed cases are accessing treatment.

71. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been the main mechanism to secure long-term predictable funds to countries. WHO in collaboration with other partners supported 35 countries to put in place functional country coordination mechanisms for HIV/AIDS, TB and malaria control that included civil society participation and development of Round 8 disease-specific as well as health system strengthening GFATM proposals.

72. In Round 8, WHO in collaboration with UNAIDS supported 30 countries²⁶ for development of HIV/AIDS proposals with a success rate of 70% (21/30). In malaria, WHO and the RBM partnership supported 16 countries²⁷ with a success rate of 82% (14/17). Finally, for tuberculosis, WHO and the Stop TB partnership supported 15 countries²⁸ with a success rate of 60% (9/15).

73. Collaboration was also undertaken with many other partners such as USAID, CDC, DFID, Spanish Government, CIDA and Sida who provided funding for country activities to support the scaling up of agreed cost-effective interventions. Non-funding partners such as Family Health International, African Broadcasting Media Partnership and Alliance for Malaria Prevention, civil society groups and the International Committee of the Red Cross collaborated in advocacy and support to implementation of country activities.

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

74. During 2008, 51 focal points from ministries of health and WHO country offices from 17 countries²⁹ were trained and their capacity strengthened to develop and implement comprehensive, integrated health promotion approaches and health promotion-based interventions in the prevention and control of NCDs, including oral-health and sickle-cell disease, violence, injury and disabilities, mental health and substance abuse problems.

75. In addition, 11 focal persons from ministries of health and WHO country offices³⁰ were trained to develop mental health policies and strategic plans. Five countries (Gabon, Ghana, South Africa, Uganda, Zambia) reviewed and analysed their mental health situation, and three countries (Benin, Burundi, Ethiopia) assessed their services and resources and are now undertaking measures to improve the management of mental health problems at district and community levels. Lesotho took the first steps to develop mental health legislation. A list of some essential health indicators was adopted, and assessment tools were developed.

76. Training workshops on policy development for prevention and management of NCDs were conducted. NCDs prevention and control were strengthened through celebration of World Health Days specifically designated for mental health, cancer, diabetes, sickle-cell disease, cardiovascular diseases and sight. The first World No Noma Day was organized with partners to increase noma awareness. Technical documents on updated information were developed and disseminated to increase knowledge and good practices, especially at community level. Regional conferences on sickle-cell disease and diabetes were organized to increase political and financial commitment, public awareness, and NGO and civil society involvement. Capacity-building for tobacco cessation activities and advocacy contributed to the scaling up of essential health interventions in countries.

77. Six Member States developed integrated NCD action plans. A study protocol on cost-effectiveness of essential drugs was drafted for use in selected countries of the Region. NCD surveillance was integrated into the revised IDSR guidelines, and cancer registries were established in selected countries. A package of essential NCD interventions at Primary Health Care level was developed. Technical support was provided to Member States to increase the number of NCD units with focal points in ministries of health.

78. Cancer prevention and control were strengthened with training in visual inspection with acetic acid (VIA), visual inspection with Lugol's iodine and cryotherapy for the prevention and control of cervical cancer. A regional consultation was conducted on cervical cancer prevention and the possibility of introducing human papilloma virus vaccine in the Region. Partnership and collaboration with other UN agencies (International Agency for Research on Cancer and the International Atomic Energy Agency) and NGOs (American Cancer Society) were strengthened.

79. A catalogue of essential oral health indicators was developed. A progress report on the implementation of the Oral Health Strategy was presented during the fifty-eighth session of the Regional Committee, showing significant progress in oral health in most Member States.

80. Implementation of Resolution AFR/RC55/R4 on cardiovascular diseases in the African Region: current situation and perspectives continued during the year under review. A total of 18 countries organized training activities to increase physical activity and to promote population consumption of fruits and vegetables. Locally-adapted algorithms for cardiovascular disease management at PHC level were introduced with efforts to reduce risk factors, including a general awareness campaign to reduce salt consumption.

81. The document on violence and health in the WHO African Region were undertaken, and a survey on the status of road safety in 40 countries was completed. Implementation of interventions was started simultaneously with the situation analysis on child maltreatment. A national policy on disability was developed in Sierra Leone and the medical rehabilitation sector was strengthened in Ghana. Training of health rehabilitation professionals in prosthetics and orthotics was conducted in Tanzania and Togo.

82. A total of 34 African countries signed the UN Convention on the Rights of Persons with Disabilities. World Health Assembly Resolution WHA58.23, "Disability, including prevention, management and rehabilitation," was implemented with the support and collaboration of the Pan African Federation of Disabled People. The new WHO guidelines on wheelchair provision services were promoted in Kenya, Malawi, Namibia and Tanzania.

83. Guidelines for management of refractive errors were drafted. National policy documents and plans of action on blindness control were developed in Gabon and Madagascar, whereas national Vision 2020 plans were developed in Gabon and Mauritius. Training for blindness control programmes was conducted in nine countries,³¹ and 10 ophthalmic nurse trainers received training in trachoma surgery in Ethiopia.

4.4 SO4: Child adolescent and maternal health, and ageing

84. In 2008, WHO supported Member States to develop, adopt and implement “The Road Map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa”³² as well as various strategies on child survival, women's health and family planning.

85. Support was provided for 12 countries³³ to develop policies, strategies and plans for child survival, bringing the total number of countries with comprehensive strategies for scaling up child survival to 21. Six additional countries³⁴ developed national roadmaps, bringing the total number of countries with roadmaps to 42 (Figure 6). In addition, six countries³⁵ developed integrated maternal, newborn and child health strategies to address MDGs 4 and 5. Liberia, Senegal, Sierra Leone and Zambia updated their existing sexual and reproductive health policies and strategies.

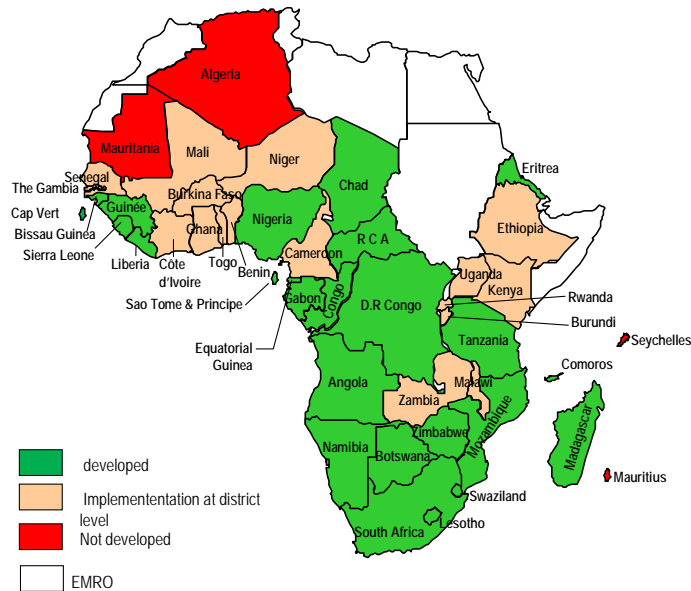
86. WHO provided support for newborn research and Integrated Management of Childhood Illness (IMCI) in Ghana and Uganda, respectively. Kenya piloted on-the-job IMCI training in three districts. In collaboration with AFRICA 2010, activities commenced to assess the availability and use of oral rehydration salt in six countries.³⁶ A facility-based maternal, neonatal and child health (MNCH) survey and a household survey on MNCH continuum of care at community level were conducted in Gambia and Tanzania, respectively. Tanzania and Uganda conducted situation analyses on newborn health and developed a newborn component for the MNCH strategies.

87. Capacity-building of 110 health personnel from 17 countries was conducted for the implementation of maternal and newborn health operational plans at district level. Guidelines were developed for the operationalization of roadmaps at district level and for integrated MNCH services delivery. Maternal deaths review methodology was introduced in four additional countries, bringing to 27 the number of countries that have institutionalized such reviews in order to provide quality care. Both pre-service training and in-service training on emergency obstetric care were strengthened in 12 countries.³⁷

88. Plans for scaling up PMTCT interventions were developed in nine countries.³⁸ A guide with recommendations on clinical practices for improved maternal and newborn health (MNH) care was developed in collaboration with SAGO and UNFPA.

89. Three best practices on MNH interventions were documented: Delegation of competence in major obstetric surgery—experiences of mid-level providers in Mozambique; Rwanda experience in scaling up MNH interventions; and Building zero tolerance for maternal and infant death in Kogi State, Nigeria. Two of the documents were shared during the fifty-eighth session of the Regional Committee held in Yaounde, Cameroon. Twelve countries³⁹ were supported to institutionalize MNH days and weeks for increased public awareness and political commitment. Four additional countries were supported to develop an advocacy tool and plan, bringing the total number to 12 countries.⁴⁰ Support was provided to six countries for proposal development for the Global Fund; two were approved (Burundi and Côte d’Ivoire).

Figure 6: Roadmap development and implementation status, December 2008



90. Health worker capacity for implementation of neonatal survival activities was strengthened in 11 countries,⁴¹ bringing the total to 31 countries supported to build capacity for neonatal survival activities. Six countries⁴² improved care of newborns by including the first week of life in IMCI guidelines; there are now 21 countries with care of newborns in their IMCI algorithm.

91. The Regional Office conducted capacity-building in newborn care for 25 consultants from over one third of the countries in the Region. These consultants supported training of trainers in home-based newborn care in eastern, southern and west African countries and training of community health workers in six countries⁴³ as well as expanding essential newborn care training in three more countries (Angola, Ghana and Nigeria).

92. Child health programme management skills of 27 managers from 12 countries⁴⁴ were strengthened. Integrated Child Health Days were conducted in 12 countries.⁴⁵ These mini-campaigns contributed to increased coverage of key child survival interventions. For example, in Togo in December 2008, 99% of children aged 6 to 59 months received a dose of vitamin A, 98% of children 12 to 59 months received albendazole for de-worming and 98% of children under-five received ITNs. Ghana, Nigeria, Tanzania and Zambia strengthened breastfeeding and infant feeding practices in relation to HIV following the review of their national Infant and Young Child Feeding (IYCF) policies and strategies. Over 30 countries developed national strategies on IYCF with implementation plans. Support was provided to 24 countries for adoption of policies on the use of low osmolarity, oral rehydration salts and zinc in the management of childhood diarrhoea (Figure 7); and 17 countries adopted policies of community case management for pneumonia by community health workers (Figure 8).

Figure 7: Policy and implementation status of CCM for pneumonia, 2007 WHO African Region

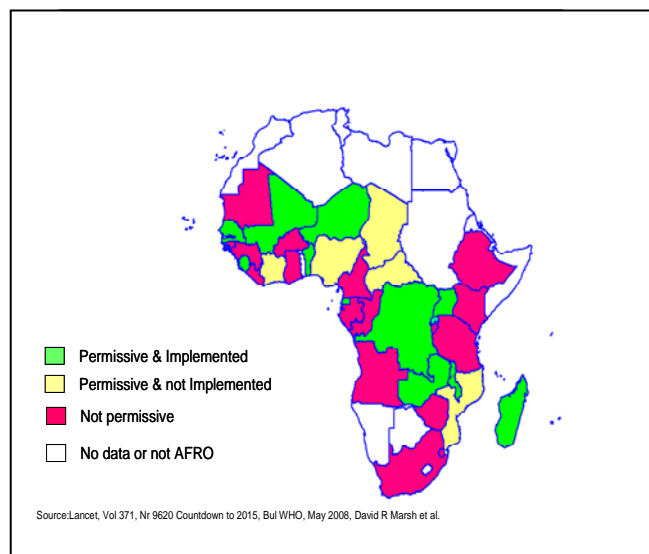
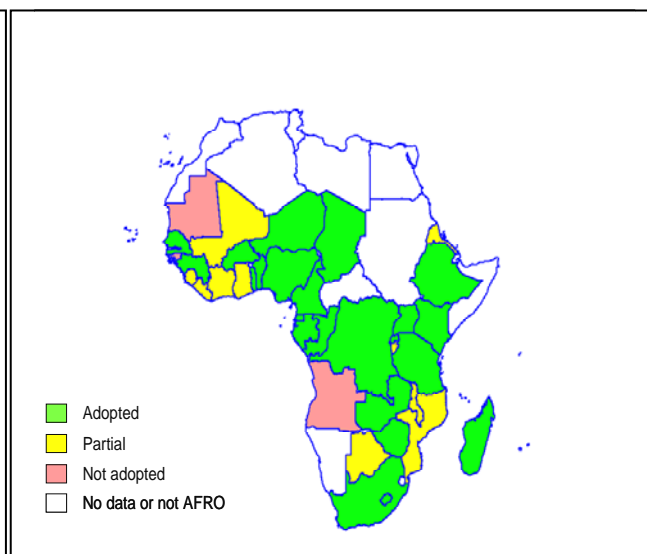


Figure 8: Status of adoption of low osmolarity ORS and zinc policy, 2007 WHO African Region



93. Partnerships for MNCH were enhanced through joint tracking of country progress in child survival. Joint regional child survival capacity-building activities and experience-sharing enhanced collaboration between WHO and its partners.

94. Seven countries⁴⁶ were supported to develop adolescent health strategic plans, bringing the total number of countries with such plans to 21. Democratic Republic of Congo and Togo developed standards for Adolescent and Youth Friendly Health Services, bringing the total number of countries with such standards to seven. Ethiopia received technical assistance to launch the implementation of the national adolescent health standards.

95. Through the WHO/UNFPA Strategic Partnership Programme, 12 countries⁴⁷ updated their existing tools, guides, policies and strategies for performance, monitoring and evaluation of reproductive health programmes, including family planning. WHO in collaboration with partners developed an advocacy toolkit for repositioning family planning, and 14 countries⁴⁸ were supported in the use of the toolkit. WHO assisted four countries (Botswana, Senegal, South Africa, Zambia) to upgrade their family planning guidelines and manuals. Based on the experience and lessons learnt from the pilot project on early detection of cervical cancer, a regional consultation was conducted for participants from 23 countries. The consultation recommended that countries should introduce VIA into their health systems.

96. A total of 16 countries were supported to develop women's health profiles. Most profiles highlighted the main ideas that women's health is not approached in a holistic fashion in health and development programmes; the role played by women in national socioeconomic development is not well appreciated; and women are agents of social change.

97. The WHO Regional Office for Africa participated in a global survey to assess mainstreaming of gender into the work of the Organization. The findings are being compiled.

98. An evaluation of 10 years of implementation of accelerated action for the elimination of female genital mutilation (FGM) was conducted in 12 countries.⁴⁹ According to the results, all 12 countries have established national laws against FGM. In addition, national institutions have been established to fight FGM in 10 of the 12 countries that participated in the evaluation.

99. During the fifty-eighth session of the WHO Regional Committee for Africa, ministers of health declared 4 September as Women's Health Day. The establishment of a Women's Health Commission was also proposed.

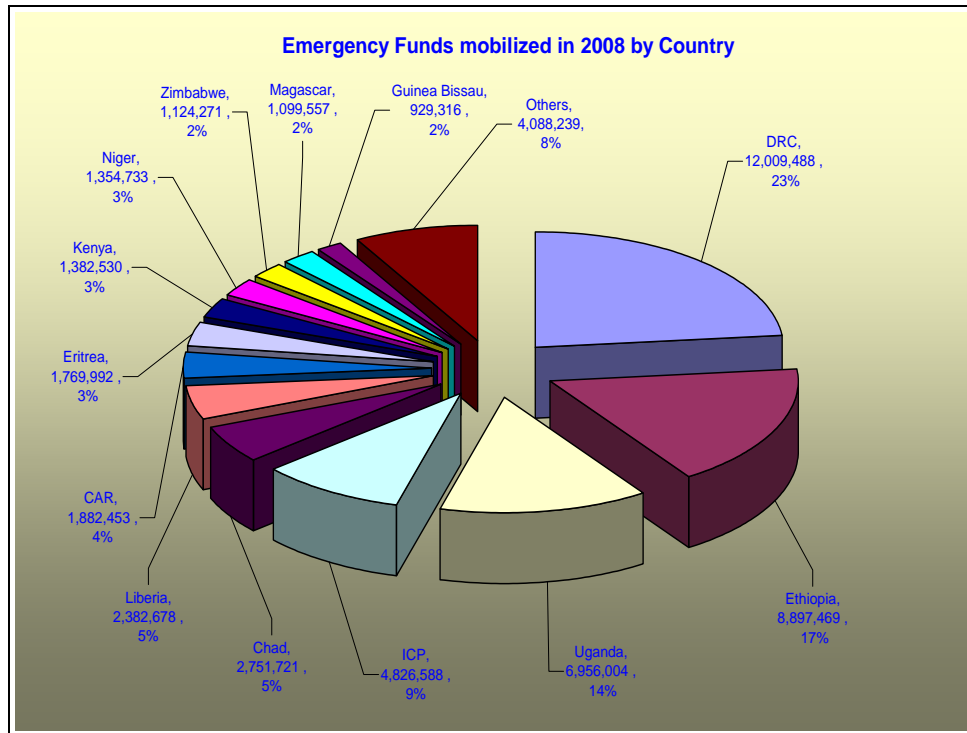
4.5 SO5: Emergencies, disasters, crises and conflicts

100. The WHO capacity to assist Member States to prepare for and respond to emergencies within the context of humanitarian reform was strengthened through field presence in 20 countries⁵⁰ and at subnational locations in Central African Republic, Chad, Democratic Republic of Congo and Uganda. Back-up technical and operational support was further consolidated in the three Inter-country Support Teams and in the Regional Office with an increase of four international experts in Ethiopia, Zimbabwe and the Regional Office as well as 10 national experts in Central African Republic, Eritrea, Ethiopia and Liberia. This resulted in faster and more efficient response.

101. National capacity for response to emergencies was further strengthened in 16 countries⁵¹ with vulnerability assessments conducted; contingency plans and guidelines developed; emergency stocks pre-positioned; emergency task forces and committees formed; and Epidemic Preparedness and Response training conducted. Cote d'Ivoire and Guinea finalized disaster policies. In addition, national officials from seven countries⁵² were sent on short courses (Health Emergencies in Large Populations—HELP) at the Regional Institute of Public Health in Ouidah, Benin and at the University of Pretoria in South Africa.

102. National and WHO capacity for resource mobilization, project implementation and reporting was further strengthened through training, delegation of authority to WHO Representatives, adoption of standard operating procedures and use of management and communication tools such as monthly bulletins and e-work. This resulted in increased mobilization of resources: US\$ 51 455 039 in 2008, representing a 35.7% increase over the US\$ 37.8 million raised in the 2006-2007 biennium. These funds were mainly mobilized through the UN Central Emergency Response Fund (UN CERF) Rapid Response window for response to acute emergencies, while the Consolidated Appeal Process and UN CERF Under Funded window contributed to address health needs for countries in transition and recovery. The funds supported 210 projects in 28 countries (Figure 9).

Figure 9: Emergency funds mobilized by country, 2008



103. Almost all countries responded to emergencies which included floods, food crises, conflicts and disease outbreaks during the year in review. Major response operations provided support for health action coordination, information management, identifying and filling gaps in training and supplies, and local capacity-building. Partnerships with national disaster management agencies were strengthened.

104. The cluster approach, one of the three main pillars of humanitarian reform, was implemented in 13 countries⁵³ with WHO as cluster lead, compared to nine countries in 2007. In addition, in all countries with emergencies in the Region, WHO was the lead agency in the health response, with or without formal declaration of the cluster approach.

105. Support was strengthened for countries in health transition and recovery with the development of health recovery strategies, including district-specific health recovery plans in Liberia and Uganda. Special emphasis was placed on supporting health information and surveillance systems in countries. Health facilities were rehabilitated and provided with essential medicines in various countries. Ongoing support was provided to implement essential life-saving interventions.

106. Within the Regional Office and Intercountry Support Teams, cross-departmental collaboration was strengthened for improved response to cross-cutting emergencies, including control of outbreaks of communicable diseases in eight countries,⁵⁴ and in addressing the food crises in the Horn of Africa and in eastern and southern Africa.

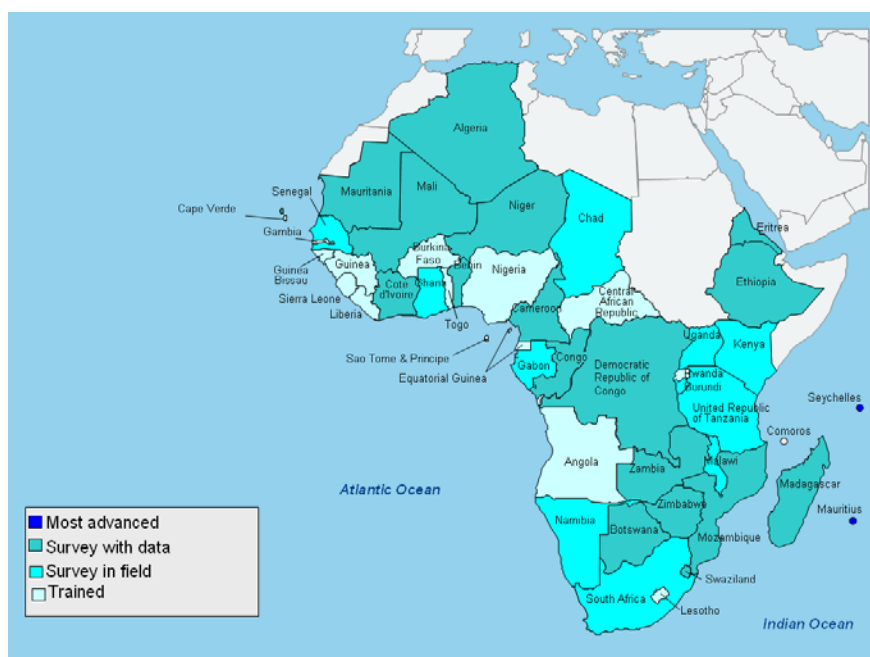
4.6 SO6: Risk factors for health conditions

107. Multisectoral teams from 16 countries⁵⁵ were equipped with skills for the development of integrated health promotion-based interventions aimed at noncommunicable disease prevention. This was done through participatory training at the Regional Institute of Public Health (Ouidah, Benin) and in Entebbe, Uganda. Training was accompanied by provision of technical oversight, guidelines and seed funds to 19 countries⁵⁶ to support implementation of integrated NCD prevention using health promotion approaches and methods. During the report period, eight countries⁵⁷ initiated NCD prevention activities with significant community participation.

108. Based on Regional Office guidelines and technical oversight, seven countries⁵⁸ developed national health promotion policy documents. The documents emphasize multisectoral, integrated health interventions and programmes.

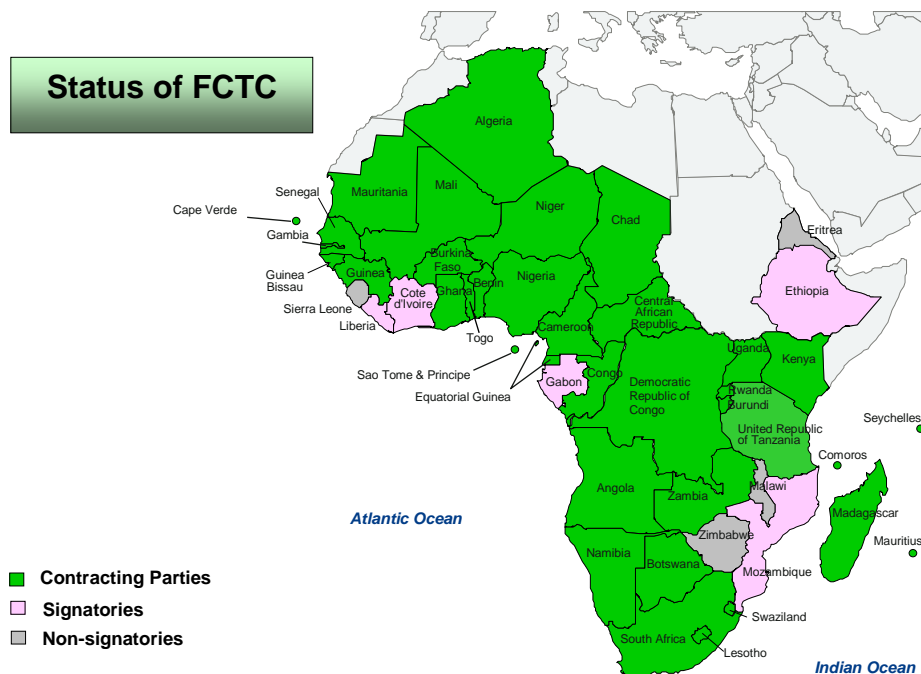
109. Fifteen additional countries initiated STEPS surveys, bringing the total to 21 Member States which have conducted STEPS surveys (Figure 10). A regional database on the first 18 countries that have completed and published their survey results was developed. The African Region is the first WHO region to develop this type of database. The Regional Office continues to support countries to conduct surveys and analyse data; NCDs were included in the revised draft Integrated Disease Surveillance and Response guidelines.

Figure 10: STEPs surveys in the WHO African Region



110. During the year in review, Member States raised awareness on the implementation of the Framework Convention on Tobacco Control (FCTC) and on the process for becoming Parties to the FCTC. Three countries ratified or acceded to the FCTC and two others undertook steps to be part of the process. By the end of December 2008, 37 countries had ratified the FCTC (Figure 11).

Figure 11: Status of FCTC in the WHO African Region, December 2008



111. Technical and financial support was provided to 10 countries for the development and implementation of legislation and national plans of action on tobacco control. All 46 Member States now have a tobacco control focal person, and eight additional countries established multisectoral committees.

112. Member States in the Region participated actively at the Third Session of the Conference of the Parties (COP3) to the FCTC, held in Durban, South Africa in November 2008. South Africa was elected as one of the members of the new Bureau of the Conference of the Parties, with the Director-General of the South African Health Department elected as the President of COP4.

113. Capacity of Member States in surveillance and research was strengthened in 2008; 15 countries were supported to undertake the Global Youth Tobacco Survey and 30 countries were assisted in data analysis. In addition, 42 countries now have data on tobacco prevalence among youth. The findings from the survey were used to plan and develop comprehensive tobacco control programmes, particularly addressing the needs of youth. World No Tobacco Day was successfully commemorated in the Region with a television production to raise awareness on tobacco use that was shared with countries.

114. In 2008 efforts were made to improve **data collection** on substance abuse in the Region. Two global surveys⁵⁹ that will constitute the basis for a regional information system were conducted in all 46 countries. Eight countries⁶⁰ were supported to implement plans to introduce evidence-based interventions addressing substance abuse in Primary Health Care. The Regional Office began supporting four countries (Botswana, Liberia, Namibia, Zambia) in the development of evidence-based national policies and plans. The fifty-eighth session of the Regional Committee adopted the document entitled “Actions to reduce harmful use of alcohol”.

115. Support was provided to Mauritania and Mozambique to elaborate their NCD action plans based on the results of STEPs. The workshop conducted in Mauritania was a prototype meeting that links the findings of STEPs surveys with the development of a comprehensive NCD action plan with the participation of various stakeholders. Some Member States began implementing diet and physical activities. Participants from 20 countries were trained to use health promotion in primary prevention of NCDs.

116. An NCD component was added to a health promotion-based framework for integrated community level health interventions which were developed in support of WHO priority programmes (Child and Adolescent Health, Epidemic and Pandemic Alert and Response, HIV/AIDS, Malaria, Tuberculosis, Immunization and Vaccine Development, Making Pregnancy Safer, Sexual and Reproductive Health). The framework is aimed at enabling programme managers to work effectively with communities and with other programmes.

117. Among young people in the Region, risk factors for HIV, such as unsafe sex, usually cluster with poor diet, physical inactivity, tobacco use, and alcohol and other substance abuse. These are risk factors for common NCDs such as diabetes, cardiovascular disease, some cancers and stroke. The Regional Office in collaboration with Education International supported testing the incorporation of an NCD risk factor component in school-based HIV/AIDS prevention projects in Benin, Burundi and Ghana. By the end of the report period, the project proved highly successful and will be expanded to 25 countries starting in 2009.

4.7 SO7: Social and economic determinants of health

118. Through the Ethics, Equity, Trade and Human Rights Programme and the Gender and Women’s Health programmes, the Regional Office in 2008 supported the countries participating in the WHO/EC MDGs Partnership and the WHO/Luxembourg project to finalize Phase I, work and submit progress reports and prepare workplans for Phase II. The report of the WHO Commission on Social Determinants was disseminated to all Member States. Countries continued to be sensitized on the need to address social determinants of health. The Regional Office finalized a draft framework for advancing the work on social determinants of health in the Region. A draft report on the situation of the social and economic determinants of health in 31 countries in the Region was prepared, using district health systems data. Malawi was supported to build Ministry of Health capacity for the analysis of equity in health and health care. Literature on human rights was disseminated to countries. A proposal on establishing a Regional Office research ethics review committee was prepared as well as a draft of its rules of procedure.

119. Some countries (Algeria, Burkina Faso, Gambia, Kenya) designed plans to enhance the significance of the social determinants of health, including efforts to make the determinants a priority for the Ministry of Health and central government and emphasizing a whole-government approach or intersectoral collaboration. Seven countries⁶¹ planned pilot studies on the situation of social

determinants of health (including needs assessments) to inform the design of strategies or to guide planning and resource allocation (Lesotho). Mozambique began the process of setting up a national commission on social determinants of health.

120. A related activity undertaken in a number of countries was the strengthening of capacities of ministries of health to address the social determinants of health (Angola and Chad); collect data (Guinea); and perform monitoring and evaluation (Equatorial Guinea, Gambia and Malawi). Health days were organized to combine information dissemination and advocacy for health promotion with the role of the social determinants of health (Comoros). Advocacy for the review of the national health development plan to address the social determinants of health was carried out in Equatorial Guinea. The mainstreaming of gender and human rights into the operational approaches in the health sector was strengthened in a number of countries (Algeria, Burkina Faso and Kenya). The strengthening of country capacities to address ethical issues was undertaken in Algeria and Burkina Faso.

4.8 SO8: Healthier environment

121. The Regional Office contributed to the work of the WHO-UNICEF Joint Monitoring Programme on access to safe drinking water and safe sanitation. Data collated from various countries show that in 2006, only 58% of the total population in sub-Saharan Africa had access to an improved drinking water source with a major discrepancy between urban (81%) and rural areas (46%). Barely 31% of the population in sub-Saharan Africa used improved sanitation, again with a significant difference between urban areas (42%) and rural areas (24%).

122. During the year in review, WHO provided extensive support in the investigation and containment of various environmental incidents. In Senegal, an outbreak of lead intoxication in Thiaroye-sur-Mer resulted in more than 200 cases and 18 deaths. In Nigeria, there was an outbreak of acute renal failure in children due to the presence of diethylene glycol in a locally-made paracetamol syrup. By 2 December 2008, there were 56 reported cases and a total of 40 deaths. Six countries benefited from technical and financial support from the Bill and Melinda Gates Foundation to WHO; funds were used to reduce the health risks posed by pesticides by strengthening national capacities for adequate pesticide management. The GAVI Alliance project for strengthening health-care management in Africa continued in 18 countries; a proposal was made to extend this project to nine additional countries. A workshop was held to build specific capacities of municipalities for the implementation of healthy cities projects.

123. In line with the 2008 World Health Assembly resolution on climate change and health, the Regional Office supported the development of a framework for action to protect human health from climate variability and change within Africa. This framework focused on four main focal areas: (i) awareness-raising to place health concerns at the centre of national, regional and international action on climate variability and change; (ii) implementation of adaptive strategies to minimize impacts of climate variability and change on population health, and integrate them into national climate change adaptation plans and programmes; (iii) engagement of the health sector in development strategies in order to protect and promote health through actions taken by other sectors; (iv) strengthening the institutional capacity of public health systems for providing guidance and leadership on health protection from climate change.

124. The first Inter-ministerial Conference on Health and Environment in Africa was jointly organized by WHO and UNEP and hosted by the Government of Gabon, 28-29 August 2008. Participating countries adopted the Libreville Declaration on Health and Environment in Africa, in which they decided to establish a health and environment strategic alliance as the basis of joint action by both sectors. A WHO-UNEP joint task team was established to support the implementation of the Libreville process; a roadmap and action plan were prepared.

4.9 SO9: Nutrition, food safety and food security

125. Intersectoral action and coordination in food safety were strengthened through the establishment of task forces and committees on food safety in Gabon, Ghana and Kenya. The membership in the WHO Global Salm surv increased to 84 members from 30 countries,⁶² but only six countries⁶³ participated in the Quality Assurance System. Ethiopia was supported to conduct research on *Salmonella concord*. The Cysticercosis Working Group for East and Southern Africa was supported to develop an action plan for intervention research on *Taenia solium*. A tool for the evaluation of national food control systems was developed and field-tested in Ghana.

126. In nutrition, a landscape analysis on readiness to react was conducted in Burkina Faso, Ghana and Madagascar. The current global food crisis was addressed by developing an information note for stakeholders, including ministers of health. The Unit participated in a number of high-level meetings and together with SO5 implementers, supported seven countries to raise a total of US\$ 2 370 450 from OCHA and CERF.

127. A number of guidelines and manuals were developed, adapted and implemented, including a training manual on food safety risk analysis. A regional training workshop on risk analysis was organized in collaboration with the University of Mauritius for 27 participants from Mauritius and seven focal points from other countries.⁶⁴ Seven countries⁶⁵ conducted food safety workshops using the WHO manual on hazard analysis critical control points (HACCPs) and food inspection. In Gambia, public health officers were trained in HACCP while Lesotho and Mozambique adapted HACCP training manuals. Inspection agents were trained in Guinea and Madagascar, and inspection guidelines were adapted in Kenya. In Seychelles, the government evaluated an abattoir for HACCP readiness and trained stakeholders in an HACCP-compliant meat inspection system.

128. Burkina Faso, Chad, Ghana and Madagascar conducted nutrition surveillance activities. The Regional Office supported a regional workshop on an integrated approach to the management of severe acute malnutrition for South Africa, Swaziland, Zambia and Zimbabwe; the Office further contributed to capacity-building for integrated management of severe acute malnutrition in emergency and development contexts. Gambia, Malawi, Namibia, Niger and Nigeria were supported to organize national training of trainers to address malnutrition. Seven regional facilitators and 27 national facilitators from nine countries⁶⁶ were trained in child growth assessment, including the use of the height-length board, weighing scale, plotting of measurements, interpretation and counseling. Seven countries⁶⁷ organized national orientations on the new growth standards.

129. Participants at the fifty-eighth session of the Regional Committee for Africa adopted document AFR/RC58/7 on iodine deficiency disorders in the WHO African Region: situation analysis and way forward which proposed actions towards sustained salt iodization to tackle iodine deficiency. Kenya field-tested the draft manual on implementing community activities on Infant and Young Child Feeding (IYCF) within the constraints of existing health systems. The Regional Office supported the

International Atomic Energy Agency to formulate a new five-year project on assessing regional nutrition programmes using isotope techniques.

130. A consultation on integrating nutrition in HIV/AIDS control programmes was attended by participants from 20 countries during which a declaration was adopted. Gambia, Nigeria, Seychelles, Uganda and Zambia conducted national training of trainers in the integrated Infant and IYCF counseling course. More than 150 trainers, including tutors from pre-service health institutions, were trained to support the scaling up of IYCF counseling and support. Over 32 countries conducted training for 6500 health workers. Ghana, Nigeria, Tanzania and Zambia conducted national assessments of implementation of the Global Strategy on Infant and Young Child Feeding.

131. Concerning integrated food-borne disease surveillance, the Regional Office provided support to Ethiopia for investigation of the outbreak of an unknown liver disease in Tigray. National authorities were informed on melamine contamination of milk and methods for detection using the International Food Safety Authorities Network. Tanzania developed guidelines for surveillance and prevention of new public health and food safety problems. GSS Level I training was organized in Kenya and Madagascar for 40 microbiologists from 14 countries,⁶⁸ and Algeria organized training on microbiological analysis of food.

132. In collaboration with FAO and other partners, WHO held a regional Codex seminar in Cameroon to strengthen national activities and enhance participation in the standard setting work of the Codex Alimentarius Commission; 40 participants from seven countries⁶⁹ attended. A similar workshop was organized for 50 regulators from 35 countries⁷⁰ who attended the 17th session of the Codex Coordinating Committee for Africa. National Codex committees were strengthened in Botswana, Guinea, Kenya, Sierra Leone and Uganda.

133. Within the Region, 17 countries⁷¹ evaluated national food safety programmes and developed food safety policies, legislation, strategies and plans of action. In addition, 18 countries⁷² expanded information, education and communication activities using the WHO Five Keys to safer food. Ghana and Sierra Leone promoted hand-washing among children, parents and teachers as part of the Global School Health Programme.

4.10 SO10: Health services

134. Work was done through the programmes of Health Systems Policies and Services Delivery; Information, Evidence and Research; Human Resources for Health; and Health Financing and Social Protection.

135. In 2008, the International Conference on Primary Health Care and Health Systems was successfully sponsored by WHO, UNICEF, UNFPA, UNAIDS, AfDB and World Bank and hosted by the Government of Burkina Faso. The Conference adopted the “Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium”. This Declaration was endorsed at the fifty-eighth session of the WHO Regional Committee for Africa which also adopted the related Resolution AFR/RC58/R3. A generic framework for the implementation of the Declaration was subsequently prepared.

136. Within the context of implementing the Ouagadougou Declaration, four countries (Angola, Equatorial Guinea, Mozambique, Nigeria) started the process of revitalization of PHC, including community-based health services. Ten countries⁷³ strengthened capacities of their district health systems in areas such as planning, management, integration of activities, supervision, monitoring and evaluation. Republic of Congo, Ethiopia and Mauritania developed tools and reviewed their essential health packages to concentrate scarce resources on high-impact interventions. Madagascar undertook a district health system rapid assessment while Niger developed a strategy on quality assurance.

137. The Regional Office continued to provide support to Member States to revise or develop their national health policies and strategic plans. Eritrea and Malawi developed their national health policies. Benin and Swaziland developed their health strategic plans while Comoros, Eritrea, Namibia and Senegal began the process of revising their plans.

138. Ghana, Madagascar, Uganda and Zambia organized their annual joint health sector reviews. Comoros developed the Public Health Code. Benin and Democratic Republic of Congo undertook an organizational audit of their health ministries. Uganda finalized its stakeholder mapping and developed and costed a plan for scaling up. Ghana strengthened partner coordination.

139. Significant efforts were made to build capacity among both WHO staff and key staff in countries to enable them to effectively contribute in health systems development, including the preparation of proposals for health systems strengthening in the context of GAVI Alliance and Global Fund assistance. To date, out of 36 eligible countries in the African Region, 22 countries⁷⁴ have had their proposals approved to the amount of US\$ 309 824 995. The Global Fund granted funds amounting to US\$ 230 857 867 for the first two years to 12 countries⁷⁵ to strengthen their national health systems.

140. In line with the implementation of Resolution AFR/RC56/R6 on revitalizing health services using the Primary Health Care approach in the African Region, technical support was provided to countries for implementation of priority interventions, namely establishment of community committees with clear terms of reference (Eritrea), review of district partnership structures (Kenya), review of national partnership and coordination mechanisms (Ghana, Kenya and Zambia), and decentralization of health services (in six countries⁷⁶).

141. A regular forum bringing together the Regional Directors of six agencies (namely WHO, UNAIDS, UNICEF, UNFPA, WB and AfDB) was held in the year under the aegis of Harmonization for Health in Africa. One of the outcomes was agreement to jointly support countries to implement the Ouagadougou Declaration on PHC.

142. Five countries (Angola, Eritrea, Kenya, Madagascar, Swaziland) were supported to develop their Human Resources for Health strategic plans while four countries (Benin, Botswana, Mauritania, Mozambique) launched their plans. Situation analyses concerning nursing and midwifery were conducted in Guinea, Sierra Leone and Zimbabwe. The Regional HRH observatory was established. Ghana launched a national HRH observatory, while four countries (Angola, Chad, Republic of Congo, Madagascar) began the process. Updating the Human Resources Information Systems database continued in five countries (Benin, Burkina Faso, Cape Verde, Mali, Niger).

143. The education capacity project commenced in two pilot countries (Republic of Congo and Guinea-Bissau), which were assessed for training infrastructure and capacity to scale up training. The Regional Office evaluated the 15 nursing and midwifery programmes of private and public training

institutions in five countries (Angola, Cape Verde, Guinea-Bissau, Mozambique, Sao Tome and Principe) and health sciences training institutions in Benin and Burkina Faso. Support was provided to the organization of CAMES in the Republic of Congo and Mali, and to medical schools in Eritrea and Niger.

144. Deans of health institutions and human resource directors from 25 West and Central African countries were oriented on the Human Resource for Health Observatory, human resources information systems, leadership and management. A pool of 20 HRH experts was formed to support HRH development in countries according to the global recommendations and guidelines on task-shifting introduced at a consultative meeting in November 2004.

145. A grant from the Bill and Melinda Gates Foundation was awarded for a Master of Public Health course to be offered by a consortium of universities in the Region; the University of Western Cape, South Africa, a WHO collaborative centre, will be the lead institution, and the focus will be on health workforce development. The African Leadership and Management Network was established at a meeting in Nairobi, Kenya, December 2008, where 22 institutions and 10 partners were represented. Case studies on aid effectiveness for HRH were conducted in Ethiopia, Liberia and Sierra Leone, and existing information was compiled in Mozambique.

146. Mobilizing additional funding was a priority for the HRH programme in 2008. Two proposals to the European Commission were approved for three-year projects, one for strengthening HRH information systems and development in PALOPs, which commenced in November 2008, and the other for HRH development, to commence in January 2009. The amount approved was euros 4 397 252. The Global Health Workforce Alliance contributed US\$ 250 000 for dissemination of HRH tools and guidelines. Partnerships on the HRH Agenda were strengthened with regional economic communities (ECSA, SADC, OCEAC), WAHO, Global Health Workforce Alliance, ILO, IOM, APhRH, Capacity Project of USAID and WHO collaborative centres in a number of joint activities.

147. A total of 45 participants from 16 West African countries⁷⁷ were trained in national health accounts (NHA) and their institutionalization. Technical support was provided to 10 countries⁷⁸ for conducting NHA studies. Gambia, Kenya, Malawi and Rwanda disseminated their NHA reports. Uganda trained 30 subdistrict managers using the newly-developed modules on the basics of health economics, costing and efficiency analysis.

148. Regional guidelines for developing health financing policy were drafted. Gambia developed a comprehensive national health financing policy. Cape Verde and Kenya drafted health financing strategies. Uganda developed a roadmap for formulating a health financing strategy. Niger developed a strategy for developing health mutual funds. Social health insurance capacities were strengthened in Ethiopia and Uganda.

149. Support was provided for undertaking the following studies: feasibility analyses of social health insurance in Swaziland and Uganda; an institutional and organizational situation analysis of health system financing in Rwanda; willingness-to-pay for community health insurance in Nigeria; situation analysis of community financing in Liberia; situation analysis of health mutual funds in Madagascar; and efficiency analysis of health facilities in Ghana and Malawi.

150. The following five technical documents on health economics were produced and disseminated through peer-reviewed journals: “Can countries of the WHO African Region wean themselves off the donor funding for health?”; “A comparative assessment of performance and productivity of health

centres in Seychelles”; “A performance assessment method for hospitals: the case of municipal hospitals in Angola”; “The economic burden of diabetes mellitus in the WHO African Region”; and “The essence of leadership in health development”.

151. WHO supported Member States in capacity-building to generate and use relevant information, evidence and research; strengthen the evidence base at regional and country levels to inform policies and strategies; and monitor health, including progress towards the MDGs. The Regional Office continued to address challenges by supporting Member States to strengthen their national health research systems as well as adopt and implement policies and strategies for knowledge management and sharing, including eHealth.

152. With WHO support, seven countries⁷⁹ assessed their national health information systems (NHISs) and seven others began developing their NHIS strategic plans. A pamphlet on core health indicators related to national health systems was published and disseminated. Technical support was provided to Democratic Republic of Congo for the training of representatives of national stakeholders in the use of the NHIS framework and assessment tool; to Cape Verde and Mozambique for training in ICD-10; and to Gambia and Mauritania for data management training. Four countries (Burkina Faso, Ghana, Kenya, Tanzania) were supported to analyse data on the measurement of national health systems performance as well as share their findings during an international meeting in Tanzania.

153. The African Regional Health Observatory was initiated with basic stock-taking of several databases and benchmarking exercises that were conducted with various partners. *The African regional health report 2008: narrowing the knowledge gap to improve Africa's health* was finalized and made ready for printing. A technical report on options for improving the monitoring of the health-related MDGs was produced and submitted to the Harmonization for Health in Africa (HHA) Regional Directors meeting in Nairobi in November.

154. The national health research systems of 44 countries of the Region were surveyed using standardized tools, and seven technical reports were produced and disseminated. The Algiers Ministerial Conference on Research for Health in the African Region adopted the Algiers Declaration which was later presented at the 2008 Bamako Global Ministerial Forum on Research for Health. National capacities for using evidence for policy were strengthened by training teams from seven countries⁸⁰ on the development of policy briefs. Support was also given to Lesotho and Swaziland to train members of ethics review committees.

155. A technical report on knowledge for health in the African Region was produced and disseminated. This was based on the assessment of national systems of knowledge for health of 44 countries. Country profiles were also prepared for all countries. A guide for documenting and sharing best practices in health programmes was prepared and disseminated. Another guide for the preparation of national knowledge management strategic plans was prepared and shared with WHO country offices to guide their implementation work in countries. eHealth was promoted through presentations of technical papers at two conferences in Ghana and Seychelles and at a round-table in South Africa. The new WHO Collaborating Centre for Research Synthesis on Reproductive Health was designated, and an electronic system for managing collaborating centres was introduced. A new platform for the web site for the WHO African Region was also developed.

156. In 2008, the Regional Office Library renewed its print and electronic collections and disseminated information to internal and external users. The AFROLIB database was updated. In collaboration with the WHO headquarters library and the Information Training and Outreach Centre for Africa (ITOCA), training workshops for the use of HINARI were held in Burkina Faso, Burundi and Cameroon.

157. In collaboration with ITOCA, the West African Regional Programme for Health and the West African Health Organisation, 35 medical health librarians were trained in Lome, Togo. The first meeting of WHO librarians and documentalists in the African Region was organized and held in Brazzaville. With support from the Mozambique country office, Regional Office librarians attended the congress of the Association for Health Information and Libraries in Africa held in Maputo. During the congress, Regional Office library staff offered training to medical librarians in the use of CDS/ISIS software.

4.11 SO11: Medical products and technologies

158. The work of WHO in the African Region under this SO was carried out by two interrelated programmes: Health Technologies and Laboratories, and Essential Medicines.

159. In health technologies, blood safety and laboratories, the document “Strengthening public health laboratories in the WHO African Region: a critical need for disease control” (AFR/RC58/6) and its resolution, AFR/RC58/R2, were adopted during the fifty-eighth session of the Regional Committee. A document entitled “Patient safety in African health services: issues and solutions” was also adopted during the same session. During the year in review, 29 countries signed a pledge articulating commitment to tackle healthcare-associated infections. Technical support was provided to Gambia, Lesotho and Mozambique to finalize their national laboratory policies. Benin, Cameroon and Democratic Republic of Congo reviewed or finalized their national blood policies and strategic plans.

160. A document entitled “Guide for national public health laboratory network to strengthen Integrated Disease Surveillance and Response” was finalized and published in close collaboration with the Centers for Disease Control and Prevention (USA) and other partners. A regional workshop on injection safety involving 38 participants from 16 countries and partner organizations was held with the general objective of equipping Member States with knowledge and skills that will enable them to ensure safe injection practices. A similar workshop involved 75 participants from 23 countries who were trained in biosafety and laboratory biosecurity in order to strengthen and build capacity to improve diagnosis of dangerous pathogens; a special session was held on the transportation of infectious substances.

161. The regional proficiency testing in haematology and clinical chemistry involving 21 countries and the external quality assessment scheme for enteric and meningitis pathogens, plague, tuberculosis and malaria involving 45 countries were evaluated; corrective actions were conducted in countries with poor performance. A workshop for evaluating quality management programmes in blood transfusion services and reviewing standard operating procedures and bench practices was held in Burkina Faso.

162. The Blood Donor Day was successfully commemorated at the Regional Office and in countries. Materials to sensitize people about voluntary blood donation were produced and disseminated. A total of 20 participants from 12 countries were trained in blood donor recruitment

and counseling. Tools for collecting data on blood safety were finalized in collaboration with WHO headquarters, and data collection was started in countries. The report of the 2006 survey on blood transfusion in the Africa Region was finalized for publication. Evaluation of the cold chain in blood transfusion services was conducted in Burkina Faso and preparations for similar exercises were started for Mali and Senegal.

163. Benin, Malawi and Swaziland were supported to adopt updated national medicine policies. The Regional Office provided technical and financial support to regional economic communities (CEMAC, EAC, SADC, UEMOA) for initiatives to harmonize medicine policies and regulations. The regional guidelines for development of national medicine policies were revised and translated into French.

164. The WHO Good Governance for Medicines programme was introduced in Benin and Zambia, and technical support was provided to seven countries.⁸¹ Collaborative efforts began to coordinate programme activities at country level with DFID's Medicines Transparency Alliance pilot projects in Ghana, Uganda and Zambia.

165. During the year in review, 27 countries developed national policies on traditional medicine, making a total of 39 countries with such policies since the adoption of the Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems at the fifty-fifth session of the Regional Committee. In collaboration with the African Union, a panel discussion on best practices of traditional medicine using the PHC approach was conducted during the fifty-eighth session of the Regional Committee in Yaounde.

166. A report was prepared as the mid term review of the Decade of African Traditional Medicine (2001–2010). The training manual on the management of medicines at health centre level was revised and the regional guidelines for prevention and clinical management of snakebite were finalized.

167. Procurement and supply management systems were reviewed and strengthened in Swaziland and Uganda. The national central medical stores in Uganda reviewed the entire business process and evaluated the management information system to improve efficiency. With WHO support, Mauritius and Zambia carried out surveys on availability and affordability of essential medicines; the results will inform national policy, regulatory measures and decisions. Ghana, Kenya and Uganda undertook household surveys to measure access to and appropriate use of medicines. The Regional Office in collaboration with the WHO Collaborating Centre for Pharmaceutical Policy at Harvard Medical School, the Noguchi Memorial Institute for Medical Research and the Ministry of Health of Ghana organized the first regional training course on pharmaceutical policy analysis which emphasized the need for strengthening public sector health insurance schemes to improve coverage and access to essential medicines.

168. National medicines regulatory authorities were strengthened in five countries. In collaboration with the French Cooperation, the Quality Control Laboratory Network including ten countries⁸² was created and supported. The Centre for Scientific Research into Plant Medicine in Ghana and the WHO Collaborating Centre for Quality Assurance in Algiers were evaluated for designation and re-designation, respectively. The Centre for Quality Assurance of Medicines in Potchefstroom, South Africa was re-designated as a collaborating centre for four additional years.

169. With WHO support, the first edition of the *Nigerian herbal pharmacopoeia* was published; Chad and Nigeria documented traditional recipes used for the management of malaria and other priority diseases. A regional strategic framework to strengthen local production capacities for traditional medicine was developed. In collaboration with WAHO, the Regional Office supported the forum to review research data on West African medicinal plants for the development of the ECOWAS herbal pharmacopoeia and to develop a tool for identification and registration of traditional health practitioners in the subregion.

170. In collaboration with headquarters, the Regional Office provided support to a SADC ministerial subcommittee on traditional medicine to undertake a study tour to China and supported ten countries to participate in the WHO Congress on Traditional Medicine. Support was provided to Democratic Republic of Congo, Ghana, Nigeria, Tanzania and Zambia to field-test two draft regional guidelines, one for training traditional health practitioners in PHC, and another for training health science students in traditional medicine.

4.12 SO12: Leadership, governance and partnership

171. Several high-level advocacy visits were undertaken to countries in order to strengthen their focus on health issues and improve the prioritization of health in national development agendas. Official visits to 17 countries⁸³ sensitized policy-makers, strengthened relationships with WHO and provided relevant technical inputs. Three major inter-ministerial conferences were organized: the Conference on Primary Health Care in Ouagadougou; the Conference on Research for Health in Algiers, and the Conference on Health and Environment in Libreville. These conferences grouped the ministries of health, research and environment with relevant health partners. The conferences produced milestone declarations which will have significant impacts on Primary Health Care; health research; and the interrelationship between health issues and the environment. The Algiers Conference was the key in gathering African Region consensus in preparation for the Global Conference on Research for Health held in Bamako.

172. WHO country offices were strengthened and supported through information and guidance that stimulate improved leadership in relation to WHO's work and presence in the health field; the UN reform process; harmonization and alignment principles that improve aid effectiveness; oversight of health indicators; and better synergy between WHO country and intercountry actions. Two regional programme meetings were held for all WHO Representatives and Regional Office senior management to reach common understanding of important issues. Decisions on follow-up action were taken. Induction orientation was provided for new senior staff and potential WHO Representatives as part of the agenda for enhancing the quality of WHO leadership and support at country level.

173. With regards to Country Cooperation Strategies (CCSs), the second generation CCSs built on the experience and lessons learnt from the implementation of the first, with a sharp focus on analysis of challenges and opportunities at country level. The aim was to be more responsive to country needs, more selective and oriented to national health priorities within the framework of WHO regional and global priorities. Through the CCS, WHO's strategic agenda in countries was aligned with national and international priorities, including the MDGs; WHO engagement in the UNDAF process was also improved. The preparation of CCS documents reached the final stages in most countries in 2008 and will be completed by June 2009. The CCSs will also serve as reference documents for the preparation of biennial workplans, 2010-2011.

174. The decentralization of the technical cooperation functions of the Regional Office to the Inter-country Support Teams (ISTs) was rapidly consolidated. The ISTs provided timely and relevant technical support through missions and the selective organization of meetings on priority MDG-related programmes, including HIV/AIDS, TB and malaria; child health and immunization; management of epidemics and outbreaks of cholera, Ebola and meningitis; response to emergencies; and health systems strengthening. IST capacity to place this support within the context of improved aid effectiveness was reinforced through training workshops on alignment, harmonization and resource mobilization. They will continue to play an important role in strengthening partnerships at subregional level, given their proximity to and close links with subregional entities such as the UN Regional Directors' Teams and the secretariats of Regional Economic Communities.

175. The effectiveness of the ISTs and their ability to carry out rapid response and support was enhanced by considerable delegation of authority from the Regional Office and the production of operational guidelines. The latter clarify roles and responsibilities of the various WHO levels in supporting countries.

176. With regard to governance, the preparation and participation of Member State delegations to WHO Governing Bodies improved with support and facilitation from the Regional Office and country offices. Regular briefings with ministers of health were organized before and during Governing Bodies meetings. Common selected agenda item statements of African Region delegations were successfully prepared, and Member States were able to provide policy orientations that reflected positions relevant for the Region and that contributed to the adoption of important resolutions and decisions.

177. The fifty-eighth session of the Regional Committee was successfully held in Yaounde, Cameroon. Three resolutions of regional and global importance were adopted. These dealt with women's health; public health laboratories; and the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.

178. WHO consolidated its leadership role in strengthening commitment among UN agencies and development partners to improve collaboration and better support to Member States, to scale up essential health interventions for the attainment of the MDGs. There were a number of major achievements. Health Clusters were established within the Regional Directors' Teams, led by WHO, and there was better coordinated support through UN Country Teams. In addition, there was improved UN health action coordination within Harmonization for Health in Africa (HHA) which contributed to the formulation and signature of two country compacts in Ethiopia and Mozambique; HHA also conducted joint support missions to various countries, including Ghana and Zambia. Technical guidance and inputs were given to the "Delivery as One" pilots, as well as to several reform self-starter countries. South-south collaboration was initiated as part of the UN Reform agenda with Brazil and with the Community of Portuguese-Speaking Countries.

179. The implementation of Phase I of the EC/ACP/WHO Partnership on Health MDGs was successfully reviewed and the European Commission validated WHO's workplan for Phase II. Partnerships with the African Union and the regional economic communities were strengthened, with all parties participating in joint meetings and exchanging information and experiences. WHO provided relevant technical inputs to the newly-adopted AU Africa Health Strategy. Partnership with health actors was expanded: 19 memoranda of understanding were signed, strengthening partnerships with key health partners, such as USAID, DFID, Government of France and AfDB. A comprehensive Partnership Strategy was finalized and will be the basis for improved WHO action in this domain.

180. Given the increased need and demand for technical support from Member States and recognizing the limited resources in all WHO programmes in the Region, a new focus was put on resource mobilization. A five-year resource mobilization strategy was developed to guide Regional Office work in mobilizing and utilizing resources and forging strategic partnerships. It identified a series of strategic approaches and activities to further advance the work of the Regional Office in supporting country capacity to raise adequate resources for the implementation of agreed workplans. It led to the establishment of a cross-cutting inter-divisional team to engage proactively in partnership and resource mobilization across the Organization. Furthermore, awareness was raised at all levels with regard to resource mobilization roles and responsibilities through enhancement of skills and capacities of IST and country office staff. A web-based database was developed that will help capture data for programmatic review and donor reporting, and enhance monitoring of the utilization of funds in the Organization throughout the Region.

181. Communication with Member States, partners and other stakeholders was improved through dissemination of essential health information, resolutions and decisions of Governing Bodies and the sharing of information on the implementation of the Strategic Objectives. This was achieved through press releases, publications, multimedia products, Internet and the facilitation of media coverage for major international events and meetings involving the Organization. A communications and advocacy strategy was developed to further support strategic programme objectives through strengthened advocacy and communications to ensure stakeholders' understanding of the Organization's roles, priorities, key messages, strengths and achievements.

4.13 SO13: Efficient and effective WHO

182. In line with strategic and operational planning, performance monitoring and assessment activities, new developments in the Medium Term Strategic Plan and WHO managerial framework rules and procedures were widely explained during institutional meetings such as the Monitoring and Evaluation Committee meeting, Regional Programme Meeting, Global Management System (GSM) awareness workshops, Management Development Committee meetings and briefing sessions for programme managers. Regional senior staff capacities were built for workplan management, mainly in the context of the transition into GSM. In addition, relevant staff members received briefings and training on the use of new tools such as AMSWEB for the preparation of workplans in compliance with the GSM.

183. With regard to the monitoring and assessment processes of the Programme Budget, guidelines were developed and disseminated, and briefing sessions and individual assistance were provided for country office, Regional Office and IST staff. Mandatory reports such as the Semi Annual Monitoring reports and the Mid Term Review were issued as per standard organizational procedure.

184. For WHO resource management, the Budget and Finance Unit conducted over ten country visits to offer budget and financial management support. As a result of these visits, there was marked improvement in the financial management reports received from eight of the countries.⁸⁴ In addition, a training course on imprest processing was conducted for the finance staff in the Nigeria country office which then began directly processing all the imprest returns from the various states in that country. As a result, the monthly backlog for Nigeria at the Regional Office was reduced from three months to only one month by the end of 2008.

185. With assistance from the South-east Asia Regional Office Personnel and Information Technology units, the Budget and Finance Unit was able to finalize the compilation of payroll data on all Regional Office short-term staff. This data will become essential when GSM is fully implemented in 2010.

186. In order to meet the requirements of newly-introduced changes in financial regulations, all efforts are being made to develop and disseminate revised and user-friendly tools to concerned stakeholders and staff in a timely manner. Data cleansing and conversion testing for GSM will be a major challenge in this context in 2009.

187. In 2008, the Human Resources Management Unit provided continuous support to all technical divisions, country offices and staff on all human resource transactions and responsibilities. This included selection and recruitment; contract administration; performance assessment; classification and reclassification; staff learning, training and development; administration of justice; and medical services. The human resource officers who left the Regional Office in 2007 were replaced. Approximately 700 personnel actions were processed into GSM as a result of new appointments made in 2007 and early 2008. There were interactions with the newly-established Global Service Centre in Kuala Lumpur to effect other Regional Office human resource transactions into GSM. The human resource teams in the ISTs were consolidated. Further support was provided to re-profiling exercises at both Regional Office and country levels.

188. Main achievements were the timely provision of human resource services to all technical programmes and staff; the implementation of contractual reform within the Region with the conversion of most temporary appointments to fixed-term appointments by the end of 2008; the first formal staff awards ceremony during the fifth-eighth session of the WHO Regional Committee for Africa in Yaounde, Cameroon, in September, during which six awards were presented by the WHO Director-General to nominated staff members and teams; the consolidation of the Regional Learning Network, including the establishment of the Regional Learning Board at the Regional Office, the designation of learning focal points in each Division and the creation of local learning committees in all country offices.

189. Additional achievements included the successful re-profiling exercises in technical divisions and in some country offices, taking into account GSM preparedness requirements. Training courses were conducted in a variety of areas, including language courses in the three official languages of the WHO African Region (English, French and Portuguese); HIV/AIDS prevention for staff and dependants; and GSM awareness for programme managers, WHO Representatives and administrative officers. Financial support was provided to country offices for the implementation of staff training and learning activities and the development of a mandatory induction programme for staff. Regional Office staff participated in important global meetings, namely those of the Global Staff Management Committee, Global Learning Committee and Global Human Resource Officers.

190. The Information Technology and Systems Unit improved the governance of activities by setting up and conducting weekly ICT regional review meetings to monitor activities throughout the Region. The Unit also reviewed and updated standard operating procedures.

191. In order to comply with corporate GSM ICT requirements, a new local area network and cabling infrastructure were implemented at the Regional Office; it will be completed in 2009 by a disaster recovery system and storage area network to secure data and provide a wide storage capacity for users. An assessment of the ICT infrastructure was conducted in all country offices. In addition,

ICT support operations were strengthened with the implementation of the GPN backup solution, new and more reliable email systems, and storage pools, among others.

192. The WHO Identity Management Service was deployed in the Region to allow all staff to access GSM. ICT provided technical support to the Knowledge and Management Information Unit to design and implement a new web site for the Regional Office, including a web content management system which allows decentralized procedures and processes for updating web content.

193. Several GSM roadmaps for legacy systems were completed in 2008, and support was provided for data cleansing and the preparation for the legacy cutover period. An integrated health database was finalized and will be released in January 2009 for both the Division of Prevention and Control of AIDS, Tuberculosis and Malaria and the Division of Prevention and Control of Communicable Diseases. A Regional Office global atlas system was made accessible online for annual health statistics updates.

194. User support and ICT staff skills were strengthened with several training exercises in various programs: ITIL, CISCO, SIEBEL, SQL2005 and ORACLE. Helpdesk procedures were reviewed to match ITIL compliance. Personal computer data collection was done to assess individuals' readiness for GSM at the Regional Office and in country offices. Desktop standardization began in order to harmonize ICT resource usage and discipline.

195. In the area of managerial, administrative and logistics support services, one of the major achievements in 2008 was the quality of support provided to more than 100 meetings held at the Regional Office and elsewhere. The Administration Services and Operations Unit also implemented a number of real estate projects aimed at improving staff working and living conditions. These included the construction and opening of a second cafeteria for general service and support staff; the renovation and expansion of existing sport facilities; and the construction and renovation of security gates and fences. The Regional Office official and staff transportation fleet was partly renewed, and a new office occupancy master plan was developed and implemented to rationalize and streamline fairer and more effective office space distribution to all Divisions.

196. The Procurement and Supply Unit continued to play an important role in procuring essential goods and services for the Regional Office, country offices, programmes and projects. Global procurement was handled through GSM as of July 2008, which opened more opportunities for obtaining cost-effective services. The Regional Catalogue was updated and expanded which led to enhanced and more frequent competitive bidding processes by the end of the year. In line with the GSM-related delegation of authority, new procurement guidelines were developed and distributed to Regional Office technical units, ISTs and country offices.

197. Various compliance and oversight achievements were experienced in 2008. Assistance was provided to the country offices in Cameroon, Malawi, Nigeria and South Africa, as well as to those Regional Office technical units involved in internal and external audits, in order to better prepare them for auditor visits and, thereafter, to adequately address findings and observations made. There was closure of two internal audit reports dating back to 2006 and 2007 for CSR and administrative support at the Regional Office. Random monitoring and verification of various contractual service commitments and purchase orders issued by country offices, ISTs and Regional Office technical

units were conducted to verify (and correct as necessary) compliance with regulations and rules. A user-friendly Regional Office-specific accountability framework was developed in conjunction with implementation of the new delegation of authority introduced in July (to be finalized in 2009). A number of checklists were updated with respect to administrative and financial audit preparedness for country offices.

198. The Translation, Interpretation, Printing and Library Services Unit assisted the publication of 67 statutory and technical volumes in three official languages in order to improve access by Member States to health and biomedical information. This was a significant increase in the number of publications as compared to previous years. In addition, almost 8 million words were edited, translated or revised in the three languages of the Region and made available to technical programmes and Member States.

199. Language services were also provided to support the fifty-eighth session of the Regional Committee, the one-hundred-and-twenty-fourth session of the Executive Board, the Ninety-fourth World Health Assembly, and other major meetings such as the Ouagadougou Conference on Primary Health Care, the Algiers Conference on Research for Health, and the Libreville Conference on Health and Environment.

200. A questionnaire was developed for the collection of data on schools and training institutions for translation and interpretation in the African Region. The aim of this activity was to promote collaboration in the future provision of language services in the Region.

201. The *African Index Medicus* managed by the Regional Office's Library remained active and provided health and biomedical information, including materials published by African medical researchers. It continued to be accessible on the Internet through the web site <http://indexmedicus.afro.who.int>.

202. The Field Security Operations Unit continued to provide necessary technical assistance to country offices in addition to its direct support functions at the Regional Office. Several assistance and support missions were conducted in 2008 to countries where security was challenged (Algeria, Chad, Democratic Republic of Congo, Kenya). At the Regional Office, the physical security infrastructure continued to be upgraded. Staff awareness on security matters was raised with the dissemination of security advisory notes. Briefings, workshops and training sessions were conducted, and UN Minimum Operating Security Standards and Minimum Operating Residential Security Standards were implemented in the Regional Office and in countries.

5. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT

5.1 Challenges and constraints

203. Given the high burden of disease in the African Region, the main challenge is to mobilize adequate resources for full implementation of planned activities both at regional and country levels. Persistent gaps in immunization and quality of surveillance data remain among the major challenges. There is continued circulation of wild poliovirus in Nigeria and in countries that had importations, and there are large numbers of non-immunized children in populous countries with sub-optimal immunization coverage. Capacity-building for the regulation and ethical review of clinical trials remains a critical need.

204. Concerning HIV/AIDS, tuberculosis and malaria, challenges to be addressed for scaling up key interventions include the following: (i) sustaining political commitment for the expansion of services across all population groups, particularly the most-at-risk populations; (ii) human resource management, particularly task-shifting, in order to allow a lower level cadre to take up higher level tasks and responsibilities; (iii) laboratory capacity to perform basic tests as well as to undertake more demanding procedures, such as acid-fast bacillus cultures, CD4 counts and drug resistance monitoring; (iv) procurement and supply systems which avoid frequent stock-outs of life-saving medicines, especially second-line drugs; and (v) funding that enhances Regional Office capacity to support countries in the implementation of their workplans.

205. For noncommunicable diseases, implementation is constrained by prevailing insufficiencies in the availability of relevant documents, guidelines and tools in the working languages of some countries and in planning.

206. Despite the achievements made on issues related to reproductive health, WHO faced constraints in the provision of support to Member States for the improvement of women and children's health in the Region. These include inadequate funding at country level for the implementation of priority interventions. Weak health systems in countries, including human resource constraints, hinder progress at all levels. In addition, weaknesses in systems for tracking progress towards meeting Millennium Development Goals hamper advocacy and resource mobilization efforts.

207. In the area of emergencies, disasters, crises and conflicts, challenges include the following: (i) mobilizing resources for emergency preparedness; (ii) supporting Member States in strengthening and sustaining the health components of national disaster management bodies; (iii) providing effective response within the context of insecurity during crisis, especially for local staff; and (iv) training adequate numbers of nationals in emergency preparedness and response, given the lack of relevant training courses within the Region and the high costs of training abroad.

208. There are various challenges related to the promotion of health and development and preventing or reducing risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances; unhealthy diets; physical inactivity; and unsafe sex. They include lack of capacity, and inadequate financial and human resources.

209. One of the main challenges in addressing the social determinants of health in the Region is the absence of reliable data; this is compounded by the limited capacity of staff and inadequate funding. The poor performance of many economies in the Region adds to the complexity of addressing the social determinants of health. This is further complicated by pervasive and growing inequalities. In the Regional Office, there was only one person in charge of the programme.

210. Environmental risk factors to human health are diverse in nature and have specific determinants. An important challenge being faced by countries and partners relates to mainstreaming risk-factor responses into health programmes and sectors. Interventions are often risk-specific and do not favour an integrated approach. Another challenge is establishing an adequate balance in prioritization of interventions. In most countries primary prevention is at the bottom of priorities. The most important constraint is the shortage of resources, both human and financial.

211. The global food crisis remains a challenge to reducing the growing nutrition and food safety emergencies in the Region. In addition, inadequate human resources for nutrition and food safety at regional and national levels affect the implementation of activities in nutrition.

212. The following constitute important challenges to strengthening health systems in Member States: improving the capacity of countries in policy analysis; ensuring access to high impact health interventions; establishing a network of a full range of health providers, both public and private; reducing duplication and fragmentation of health services; putting in place effective accountability mechanisms that involve civil society; ensuring capacity to take advantage of opportunities offered by global health initiatives; ensuring that health systems are organized, managed and financed as efficiently as possible; ensuring quality of services; and designing prepaid health financing mechanisms that protect populations from catastrophic out-of-pocket expenditures.

213. Health services at local level are usually inaccessible, inconvenient, inadequate or unaffordable. The number and quality of human resources for health are insufficient at all levels. With regard to medical products and technologies, major challenges include how to ensure access to populations in dire need, and safety monitoring of new medicines for HIV/AIDS, tuberculosis, and tropical diseases, especially malaria. An additional challenge is how to secure adequate resources for ensuring scientifically-sound and cost-effective use of traditional medicines, other medical products and technologies, and protection of African traditional medical knowledge. Constraining factors include inadequate human and financial resources in the ministries of health; limited capacity and slow progress in implementation of policies in some countries; delayed implementation of planned activities and reporting from some countries.

214. The challenges related to WHO leadership, governance and partnerships include: (i) intensifying and sustaining advocacy, at all WHO levels, for increased prioritization and action on health; (ii) managing and meeting divergent expectations from Member States and development partners, ranging from policy setting to technical support for programme implementation; (iii) addressing resource gaps in order to meet health-related requests by Member States; (iv) ensuring that decisions taken by the Governing Bodies are implemented, monitored, evaluated and reported; (v) improving the existing mechanisms of coordinated support to countries; (vi) adopting policies and strategies to better define and guide partnerships with civil society and the private sector; and (vii) increased demand for communications support by technical divisions, WHO country offices and ministries of health. Among major constraints, the insufficient financial resources impact on the implementation of planned activities and limit the recruitment of competent staff. These constraints have also impacted on the capacity for in-house production of public information and advocacy materials.

215. WHO support functions also experience a number of challenges. There is the need to reinforce the overall results-based management framework, including joint planning, quality assurance, and peer review processes. Another challenge is the need to operate two parallel systems after the launching of the GSM in headquarters and the related establishment of the Global Service Centre in Kuala Lumpur. Additional important challenges relate to ICT infrastructure and equipment readiness in preparation for GSM initiation in the African Region.

5.2 Lessons learnt

216. Several key lessons were learnt during the year under review. Good governance and strong country leadership are required for health systems to be efficient and effective, and to facilitate rapid and sustainable scaling-up of priority interventions.

217. Multisectoral collaboration is required for effective planning and delivery of interventions and services. The health sector is able to influence policies in other sectors when evidence is generated and shared with policy-makers in such sectors. Coordination and collaboration between all stakeholders and partners are crucial for advocacy, resource mobilization and implementation of activities in order to promote health and development, and prevent or reduce risk factors for health conditions. In addition, strong partnerships and collaboration with regional political groupings and relevant technical institutions are required to enhance WHO action in support of Member States.

218. Team work, integrated approaches, and well-trained and motivated health-care workers facilitate implementation of activities in countries.

219. The inclusion of high-impact interventions in country proposals for GFATM and other global health initiatives can improve resources available for health programmes.

220. The presence of technical staff at IST and country levels is the key to providing timely and efficient technical assistance to countries. Strengthening WHO country capacity with adequately skilled and experienced staff is the key for delivering quality support in response to country requests.

221. There is a need for establishing more effective communication and reporting mechanisms to better involve technical divisions in coordination and close monitoring of income as well as monitoring of budget implementation under the responsibility of all programme managers.

6. A WAY FORWARD

222. The Mid Term Review of implementation of the Programme Budget 2008-2009 provided information needed for reprogramming activities and resources. This section provides orientations towards enhancing Programme Budget implementation in order to maximize the achievement of planned results at the end of 2009.

223. For programmes in communicable diseases, efforts to further improve programme performance will aim at: (i) decentralizing measures to improve data quality; (ii) conducting operational research to determine reasons for failure to reach large numbers of non-immunized children; (iii) intensifying resource mobilization efforts; (iv) adopting and disseminating reviewed IDSR guidelines and tools and conducting related training; (v) finalizing IHR assessment tools, establishing a consultant roster, **conducting orientation** workshops and supporting selected countries to assess core capacities; (vi) improving coordination mechanisms for surveillance within and across divisions; (vii) establishing virtual teams for epidemic investigation and response; and (viii) increasing staff for epidemic preparedness and response as well as for preventive chemotherapy at the country level.

224. Within the fast-changing landscape of HIV/AIDS, tuberculosis and malaria prevention and control, WHO and Member States will define priority interventions and advocate for suitable implementation. Programme reviews will be supported to ensure more effective strategic

programming and implementation, informed by a strong monitoring and evaluation system. In addition, a concerted effort is needed to mobilize resources. Strengthening of health systems remains a key requirement for scaling up cost-effective interventions.

225. In addressing noncommunicable diseases, emphasis will be placed on implementing integrated approaches for the prevention and control of chronic noncommunicable conditions with community involvement, especially at peripheral, district and other local levels. Strengthening of country capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions will be accelerated to provide evidence for advocacy. Maximum effort will be devoted to supporting Member States to build capacities in health promotion and to develop partnerships, strengthen international collaboration, and consolidate resource mobilization for NCD programmes.

226. In 2009, WHO will heighten advocacy, resource mobilization and partnerships to accelerate progress in maternal, newborn and child survival at country level. WHO will also focus the limited available resources on countries with the highest burden of morbidity and mortality but which are making the least progress in improving survival of women and children. Country capacity will be built for inclusion of MNCH interventions in available funding opportunities such as those from GFATM and the GAVI Alliance. Countries will be supported in planning, implementation and evaluation of MNCH and reproductive health services, including family planning. In addition, research and use of information generated through research for the improvement of service delivery will be supported.

227. Regarding emergencies, disasters, crises and conflicts in the Region, interventions will focus on (i) assuring adequate institutional capacity to maintain minimal presence at field level through sustaining emergency staff positions in key countries; (ii) continuing to vigorously pursue fund-raising through existing mechanisms and exploring new channels; (iii) enhancing national capacities to prepare and respond to emergencies through advocacy on the need to establish and strengthen emergency units in ministries of health; (iv) organizing courses in Africa in collaboration with African institutions; and (v) further strengthening inter-programme and intersectoral collaboration.

228. The final report of the Commission on Social Determinants of Health describes key living conditions and the underlying factors that influence them. It suggests actions and gives examples that have proven effective in improving health and health equity in countries at all levels of socioeconomic development. Countries in the African Region will require support in their endeavours to implement the report's recommendations. The Ethics, Equity, Trade and Human Rights Programme will identify existing capacity as well as develop the required capacity for addressing social determinants of health in the Region in readiness to support country requests.

229. The Libreville Declaration on Health and Environment in Africa provides a new momentum to develop integrated health and environment policies and programmes as a cohesive response to both health and environmental challenges. Transforming the Declaration commitments into concrete actions will be the focus in 2009.

230. For food safety and nutrition, emphasis will be placed on provision of support to countries to develop and implement national policies and action plans; intensify resource mobilization; and strengthen or build partnerships and collaboration.

231. Efforts will be pursued in supporting Member States to strengthen their national health systems and services, in particular at district health system level, using the PHC approach. To that end, WHO will promote universal coverage and contribute to improving the efficiency of health systems in line with the MDGs. Coordination and collaboration efforts within WHO for joint missions and coordinated support that are beneficial to countries will be reinforced. More attention will be given to enhancing inter-programme dialogue and collaboration aiming at optimizing the synergy between programmes and systems in order to improve health outcomes. Quality of technical support to countries will be improved through productive interaction with country offices and better preparation of missions at all levels.

232. Collaboration with governments and national stakeholders in pharmaceuticals and traditional medicine as well as suitable institutions and consultants in various disciplines will ensure coordinated implementation of health technologies and medicine programmes and meet their increasing needs. Another priority is the mobilization of additional partners to support countries in their efforts to develop and implement suitable, comprehensive national policies on health technology management and health laboratory services.

233. Internal WHO capacity in advocacy, negotiation and resource mobilization will be improved through relevant training. The implementation of Country Cooperation Strategies, with emphasis on monitoring and engagement of stakeholders, will be pursued. The implementation of the critical commitments made in various declarations in 2008 will be harmonized at country level. It is envisaged that the HHA Secretariat will be strengthened in Brazzaville in 2009. The finalization of the General Agreement between the African Union and WHO and of the draft comprehensive umbrella memorandum of understanding with the regional economic communities will be accelerated. Consolidation of all partnership and resource mobilization activities will be in line with the recently-developed strategies. Collaboration with non-traditional partners will be further explored, particularly with the nongovernmental and private sectors.

234. For efficient and effective WHO work in the Region, it is crucial to build capacities of country office staff in programme planning, management, monitoring and evaluation as well as resource mobilization to provide more coherent and continued support to ministries of health. Some units will work with the Global Management System and the Global Services Centre (GSC) in order to ensure that related GSM activities are concluded in a timely manner. Units also intend to spend a substantial amount of time in 2009 on data cleansing, data conversion testing, and budget and finance readiness for GSM initiation in the Region in 2010. Communication and interaction with the GSC will be strengthened, and support from the Region to the GSC will continue to be provided during the transition period. The implementation of the GSM in the African Region will require human resource management to change from paper management to talent management. Some programmes will need to be re-profiled in order to adjust to the new working conditions created by GSM. The identification and mobilization of more sustainable funding in order to ensure the successful provision of logistics and support services at the Regional Office are definitely priorities for the years ahead.

ANNEX 1

WHO Medium Term Strategic Plan 2008–2013 statement of strategic objectives

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

ANNEX 2

Budget implementation status as of 31 December 2008(Amounts in US\$ thousands)

1. Assessed Contributions			
SO	Allotted Amounts	Obligations	Implementation Rate (%)
1	19,114	8,130	43
2	12,986	6,208	48
3	9,319	3,082	33
4	18,114	9,009	50
5	3,767	1,596	42
6	9,837	4,622	47
7	5,781	2,167	37
8	5,532	2,326	42
9	4,724	1,578	33
10	22,176	11,880	54
11	6,072	2,493	41
12	34,895	20,845	60
13	54,422	33,176	61
Total	206,739	107,112	52

2. Voluntary Contributions			
SO	Allotted Amounts	Obligations	Implementation Rate (%)
1	326,043	189,713	58
2	74,661	44,970	60
3	3,289	2,063	63
4	33,137	13,619	41
5	55,834	37,540	67
6	3,436	2,456	71
7	1,972	514	26
8	2,807	1,535	55
9	2,032	920	45
10	20,737	9,075	44
11	9,149	6,223	68
12	7,125	3,617	51
13	36,493	23,300	64
Total	576,715	335,545	58

3. Consolidated (AC +VC)			
SO	Allotted Amounts	Obligations	Implementation Rate (%)
1	345,157	197,843	57
2	87,647	51,178	58
3	12,608	5,145	41
4	51,251	22,628	44
5	59,601	39,136	66
6	13,273	7,078	53
7	7,753	2,681	35
8	8,339	3,861	46
9	6,756	2,498	37
10	42,913	20,955	49
11	15,221	8,716	57
12	42,020	24,462	58
13	90,915	56,476	62
Total	783,454	442,657	57

ANNEX 3

List of Regional Committee resolutions reviewed

- AFR/RC53/R1:** Macroeconomics and health: the way forward in the African Region
- AFR/RC53/R4:** Women's health: a strategy for the African Region
- AFR/RC53/R6:** Scaling up the interventions against HIV/AIDS, tuberculosis and malaria
- AFR/RC54/R5:** Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond
- AFR/RC54/R9:** Road Map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa
- AFR/RC55/R2:** Achieving the health Millennium Development Goals: situation analysis and perspectives in the African Region
- AFR/RC55/R4:** Cardiovascular diseases in the African Region: current situation and perspectives
- AFR/RC55/R5:** Tuberculosis control: the situation in the African Region
- AFR/RC55/R6:** Acceleration of HIV prevention efforts in the African Region
- AFR/RC56/R1:** The Regional Strategic Plan for the Expanded Programme on Immunization 2006–2009
- AFR/RC56/R6:** Revitalizing health services using the Primary Health Care approach in the African Region
- AFR/RC56/R7:** Avian influenza: preparedness and response to the threat of a pandemic
- AFR/RC57/R2:** Food safety and health: a strategy for the WHO African Region

ENDNOTES

1. WHO, Medium Term Strategic Plan 2008-2013; Programme Budget 2008–2009, Geneva, World Health Organization, 2007.
2. WHO, Maternal mortality in 2005, estimates developed by WHO, UNICEF, UNFPA and the World Bank, Geneva, World Health Organization, 2007.
3. WHO, World health statistics, Geneva, World Health Organization, 2008.
4. UNICEF, Countdown to 2015: Tracking progress in maternal, newborn and child survival, New York, UNICEF, 2008.
5. International Conference on Primary Health Care and Health Systems, Ouagadougou, Burkina Faso, 28–30 April 2008; Ministerial Conference on Research for Health in the African Region, Algiers, Algeria, 23–26 June 2008; and Libreville Declaration on Health and Environment in Africa, Libreville, Gabon, 28–29 August 2008.
6. Algeria, Benin, Botswana, Burkina Faso, Burundi, Gambia, Ghana, Guinea, Guinea-Bissau, Madagascar, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Zambia.
7. Algeria, Benin, Botswana, Burkina Faso, Burundi, Gambia, Ghana, Guinea, Malawi, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Togo.
8. Angola, Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Mali, Niger, Nigeria, Togo.
9. Angola, Benin, Burundi, Chad, Republic of Congo, Senegal, Uganda.
10. Benin, Burundi, Equatorial Guinea, Guinea-Bissau, Ghana, Guinea, Kenya, Madagascar, Malawi, Rwanda, Sao Tome and Principe, Swaziland.
11. Benin, Cape Verde, Comoros, Republic of Congo, Democratic Republic of Congo, Ethiopia, Eritrea, Gabon, Zimbabwe.
12. Angola, Benin, Cape Verde, Equatorial Guinea, Eritrea, Gambia, Kenya.
13. Mali, Mauritania, Niger, Rwanda, Uganda, Zambia.
14. Angola, Cameroon, Republic of Congo, Eritrea, Ghana, Kenya, Sierra Leone, Zambia.
15. Burkina Faso, Central African Republic, Cote d'Ivoire, Guinea, Liberia, Sierra Leone.
16. Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Kenya (KEMRI), Madagascar, Mauritius, Nigeria (Abuja), Rwanda, Senegal, South Africa (NICD), Uganda, Zambia.
17. Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Comoros, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe.
18. Algeria, Angola, Benin, Botswana, Cameroon, Kenya, Lesotho, Madagascar, Namibia, South Africa.
19. Algeria, Benin, Comoros, Democratic Republic of Congo, Eritrea, Gambia, Mauritius, Sierra Leone.
20. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Republic of Congo, Ethiopia, Gambia, Guinea-Bissau, Madagascar, Malawi, Mali, Namibia, Nigeria, Rwanda, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zimbabwe.
21. Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Republic of Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Guinea-Bissau, Lesotho, Madagascar, Malawi, Mali, Mauritania, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zimbabwe.
22. Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Republic of Congo, Ethiopia, Gambia, Guinea-Bissau, Madagascar, Malawi, Mali, Namibia, Nigeria, Rwanda, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zimbabwe.

23. Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia.
24. Benin, Burkina Faso, Cameroon, Central African Republic, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Ghana.
25. Burkina Faso, Democratic Republic of Congo, Guinea, Kenya, Lesotho, Rwanda, Tanzania, Uganda.
26. Burundi, Cameroon, Cape Verde, Chad, Comoros, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Gabon, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania (and Zanzibar), Togo, Zambia, Zimbabwe.
27. Burkina Faso, Central African Republic, Comoros, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Kenya, Nigeria, Rwanda, Swaziland, Tanzania (and Zanzibar), Zimbabwe.
28. Angola, Burkina Faso, Central African Republic, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Guinea-Bissau, Kenya, Lesotho, Madagascar, Nigeria, Sao Tome and Principe, Swaziland, Zimbabwe.
29. Angola, Benin, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, Ghana, Guinea-Bissau, Liberia, Mali, Mozambique, Sierra Leone, South Africa, Tanzania, Togo, Uganda.
30. Angola, Cameroon, Chad, Republic of Congo, Democratic Republic of Congo, Gabon, Guinea-Bissau, Mauritania, Niger, Sao Tome and Principe, Togo.
31. Cameroon, Democratic Republic of Congo, Ethiopia, Kenya, Mali, Nigeria, Senegal, Uganda, Zambia.
32. Developed by 16 partners in the Region and adopted in 2004 by the ministries of health of the Region, AFR/RC54/R9.
33. Burkina Faso, Eritrea, Ethiopia, Gabon, Ghana, Kenya, Malawi, Mozambique, Rwanda, Senegal, Tanzania, Zimbabwe.
34. Cameroon, Cape Verde, Equatorial Guinea, Guinea, Mali, Sao Tome and Principe.
35. Ethiopia, Malawi, Mozambique, Nigeria, South Africa, Tanzania.
36. Ethiopia, Malawi, Mozambique, Nigeria, South Africa, Tanzania.
37. Ethiopia, Gabon, Gambia, Guinea-Bissau, Malawi, Mozambique, Niger, Senegal, Tanzania, Uganda, Zambia, Zimbabwe.
38. Central African Republic, Democratic Republic of Congo, Ethiopia, Lesotho, Mozambique, Nigeria, Swaziland, Zambia, Zimbabwe.
39. Burkina Faso, Burundi, Republic of Congo, Eritrea, Ethiopia, Kenya, Madagascar, Mauritania, Niger, Nigeria, Tanzania, Uganda.
40. Burkina Faso, Cameroon, Ethiopia, Ghana, Mali, Mauritania, Niger, Nigeria, Senegal, Togo, Uganda, Zambia.
41. Botswana, Eritrea, Gambia, Kenya, Lesotho, Liberia, Malawi, Namibia, Sierra Leone, South Africa, Swaziland.
42. Botswana, Lesotho, Namibia, Rwanda, Senegal, South Africa.
43. Ghana, Kenya, Malawi, Senegal, Uganda, Zambia.
44. Burkina Faso, Ghana, Ethiopia, Kenya, Liberia, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda, Zambia, Zimbabwe.
45. Burkina Faso, Cote d'Ivoire, Ghana, Kenya, Madagascar, Mali, Mozambique, Senegal, Sierra Leone, Togo, Zambia, Zimbabwe.
46. Cameroon, Gabon, Ghana, Guinea, Madagascar, Mali, Togo.
47. Angola, Botswana, Ethiopia, Gambia, Ghana, Lesotho, Liberia, Nigeria, Sierra Leone, Swaziland, Tanzania, Zambia.

48. Benin, Botswana, Burkina Faso, Cote d'Ivoire, Guinea-Bissau, Lesotho, Liberia, Mozambique, Namibia, Niger, Nigeria, Sierra Leone, Swaziland, Zimbabwe.
49. Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Eritrea, Ethiopia, Guinea, Liberia, Mali, Mauritania, Nigeria, Senegal.
50. Algeria, Angola, Burundi, Central African Republic, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mozambique, Niger, Sierra Leone, Uganda, Zimbabwe.
51. Angola, Botswana, Burundi, Chad, Eritrea, Ethiopia, Gambia, Kenya, Lesotho, Liberia, Madagascar, Niger, Nigeria, Rwanda, Swaziland, Uganda.
52. Benin, Burkina Faso, Central African Republic, Republic of Congo, Sierra Leone, Swaziland, Tanzania (and Zanzibar).
53. Burundi, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Niger, Uganda, Zimbabwe.
54. Angola, Burkina Faso, Democratic Republic of Congo, Ethiopia, Guinea-Bissau, Madagascar, Niger, Zimbabwe.
55. Angola, Benin, Botswana, Cape Verde, Central African Republic, Chad, Ghana, Guinea-Bissau, Liberia, Madagascar, Mali, Mozambique, Sierra Leone, Tanzania, Togo, Uganda.
56. Algeria, Angola, Benin, Botswana, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Gabon, Ghana, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Sao Tome and Principe, Senegal, Sierra Leone, Tanzania, Togo.
57. Angola, Benin, Botswana, Eritrea, Ghana, Madagascar, Mozambique, Senegal.
58. Benin, Gabon, Guinea, Liberia, Madagascar, Malawi, Namibia.
59. "Alcohol and health" and "Resources available for treatment and prevention of substance abuse disorders".
60. Burundi, Cape Verde, Central African Republic, Ghana, Senegal, Tanzania, Uganda, Zimbabwe.
61. Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Mozambique.
62. Algeria, Cameroon, Central African Republic, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Tanzania (and Zanzibar), Uganda, Zambia, Zimbabwe.
63. Cameroon, Central African Republic, Ethiopia, Nigeria, Senegal, South Africa.
64. Ethiopia, Gambia, Guinea, Malawi, Rwanda, South Africa, Uganda.
65. Gambia, Guinea, Kenya, Lesotho, Madagascar, Mozambique, Seychelles.
66. Benin, Burkina Faso, Republic of Congo, Democratic Republic of Congo, Gabon, Mali, Niger, Senegal, Togo.
67. Benin, Democratic Republic of Congo, Kenya, Malawi, Nigeria, Senegal, Uganda.
68. Comoros, Eritrea, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mauritius, Nigeria, Rwanda, Seychelles, Tanzania, Uganda, Zambia.
69. Cameroon, Ghana, Liberia, Malawi, Nigeria, Sierra Leone, Zambia.
70. Angola, Benin, Botswana, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe.
71. Algeria, Benin, Burundi, Equatorial Guinea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Malawi, Mauritania, Mozambique, Rwanda, Tanzania, Togo, Uganda, Zambia.

72. Angola, Cameroon, Comoros, Republic of Congo, Democratic Republic of Congo, Gambia, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Mauritania, Mozambique, Rwanda, South Africa, Togo, Uganda.
73. Burkina Faso, Burundi, Cape Verde, Eritrea, Guinea, Guinea-Bissau, Lesotho, Mauritania, Swaziland, Tanzania.
74. Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, Zambia.
75. Burkina Faso, Ethiopia, Gambia, Guinea-Bissau, Lesotho, Liberia, Mauritania, Mozambique, Nigeria, Swaziland, Zambia, Zimbabwe.
76. Republic of Congo, Democratic Republic of Congo, Ethiopia, Lesotho, Madagascar, Mauritania.
77. Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo.
78. Burundi, Cape Verde, Cote d'Ivoire, Ghana, Liberia, Madagascar, Mauritania, Mozambique, Niger, Uganda.
79. Burkina Faso, Burundi, Guinea, Liberia, Mali, Mozambique, Rwanda.
80. Burkina Faso, Cameroon, Ethiopia, Mozambique, Tanzania, Uganda, Zambia.
81. Benin, Cameroon, Ethiopia, Kenya, Malawi, Mozambique, Zambia.
82. Algeria, Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Guinea, Madagascar, Mali, Niger, Senegal.
83. Algeria, Angola, Botswana, Burkina Faso, Cameroon, Republic of Congo, Gabon, Kenya, Lesotho, Mali, Mauritius, Nigeria, Senegal, Seychelles, South Africa, Uganda, Zimbabwe.
84. Angola, Burkina Faso, Central African Republic, Democratic Republic of Congo, Ethiopia, Nigeria, Seychelles, Tanzania.