

The Work of WHO in the African Region 2010

Annual Report of the Regional Director



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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 2010.



Dr Luis Gomes Sambo
Regional Director



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ABBREVIATIONS

AC	Assessed Contribution
ACT	Artemisinin-based Combination Therapy
AHO	The African Health Observatory
APOC	African Programme for Onchoceciasis Control
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AU	African Union
CDTI	Community Directed Treatment with Ivermectin
COP	Conference of the Parties
CSIS	Centre for Strategic and International Studies
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CILSS	<i>Comité Inter-État de Lutte contre la Sécheresse au Sahel</i> Permanent Inter-State Committee for Drought Control in the Sahel
CVD	Cardiovascular Disease
CPR	Contraceptive Prevalence Rate
DPT3	Diphtheria Pertussis Tetanus
DRR	Disaster Risk Reduction
DFID	Department for International Development
ECSA-HC	East, Central, and Southern African Health Community
ECOWAS	Economic Community of West African States
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
EVIPNet	Evidence Informed Policy Network
FCTC	Framework Convention on Tobacco Control
FGM	Female Genital Mutilation

GFN	Global Foodborne Infections Network
GFTAM	Global Fund to Fight Tuberculosis, AIDS and Malaria
GSM	Global Management System
HAT	Human African Trypanosomiasis
HELP	Health Emergencies in Large Populations
HHA	Harmonization for Health in Africa
H1N1	Pandemic Influenza A
IAEA	International Atomic Energy Agency
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations (2005)
IGME	Interagency Group for Child Mortality Estimation
IMAAI	Integrated Management of Adult and Adolescent Illness
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Agency
MDR-TB	Multidrug-resistant TB
MNH	Maternal and Newborn Health
MNTE	Maternal and Neonatal Tetanus Elimination
NCDs	Noncommunicable Diseases
NECT	Nifurtimox Eflornithine Combination Therapy
NEPAD	New Partnership for Africa's Development
NHA	National Health Accounts
NHIS	National Health Information Systems
NTDs	Neglected Tropical Diseases

OCEAC	<i>Organisation de Coordination pour la Lutte contre les Endémies en Afrique centrale</i>
OCR	Outbreak and Crisis Response
PAHO	Pan American Health Organization
PCA	Partnerships and Collaborative Arrangements
PEPFAR	President's Emergency Plan for Aids Relief
PMTCT	Prevention of Mother-To-Child Transmission
PMI	The President's Malaria Initiative
PLWHA	People Living with HIV/AIDS
RBM	Roll Back Malaria
RDTs	Rapid Diagnostic Tests
RED	Reaching Every District
RPC	<i>"Recommandations pour la Pratique Clinique des soins obstétricaux et Néonataux d'urgence en Afrique - Guide du Prestataire"</i>
SCD	Sickle-cell Disease
SHOC	Strategic Health Operations Centre
SIA	Supplementary Immunization Activities
TM	Traditional Medicine
UA	Universal Access
UNDAF	United Nations Development Assistance Framework
UNODC	United Nations Office on Drug and Crime
VC	Voluntary Contributions
WAHO	West African Health Organization
WCO	WHO Country Office
XDR-TB	Extensively Drug-resistant TB



EXECUTIVE SUMMARY

1. The WHO African Region Strategic Directions 2010–2015, defined in line with the Millennium Development Goals, the WHO 11th General Programme of Work 2006–2015, the WHO Medium Term Strategic Plan 2008–2013 and WHO's core functions, provide specific guidance for the work of the WHO Secretariat in the Region. The context within which WHO operated during the year under review was challenging while also providing opportunities for implementing the global health agenda in the African Region. Despite the current global financial crisis and its significant impact on the socioeconomic situation and health funding at country and international levels, many countries and international development partners made efforts to meet their commitments to health funding. The health systems in some countries showed significant improvement, although gaps in leadership and governance, insufficient financing and inadequate health workforce remain major bottlenecks.

2. The African Region was still characterized by high maternal and child mortality. The burden of communicable diseases remained high, despite the reduction of new cases of malaria and HIV in some countries. Millions of people were affected or threatened by epidemic-prone diseases, in addition to an increase in noncommunicable diseases and conditions (NCDs) including violence and injuries. The momentum in addressing the disproportionately high burden of neglected tropical diseases (NTDs) in the Region remained high in 2010.

3. The initial 2010-2011 approved budget allocation of US\$ 1 262 864 000 to the Region was increased to US\$ 1 467 221 000 during the first year, largely due to additional resources required for polio eradication activities. Overall implementation of the budget by the end of 2010 was US\$ 801 130 000, representing 63% of the initial approved budget. There was a significant income gap that was unevenly distributed among the 13 Strategic Objectives (SO).
4. The main achievements are presented below, by Strategic Objective.
5. **SO1: Communicable diseases:** Significant progress was made in polio eradication in West Africa, particularly in Nigeria that recorded a 95% reduction in the number of wild poliovirus cases in 2010 compared with 2009. The Regional Integrated Disease Surveillance and Response (IDSR) technical guideline was revised to incorporate the International Health Regulations (2005) and priority noncommunicable diseases. This has contributed to strengthening disease surveillance.
6. **SO2: HIV/AIDS, tuberculosis and malaria:** To address the HIV/AIDS, tuberculosis and malaria disease burden, the Regional Office continued to focus on the provision of normative guidance, capacity building and technical support for scaling up cost-effective interventions towards the attainment of Universal Access. Access to antiretroviral therapy (ART) improved a cumulative total of about 3.9 million People Living with HIV/AIDS (PLWHA) were receiving treatment in 2010. Success rates in TB treatment also improved, with 15 countries attaining treatment success rates of 85% or higher. Concerning malaria prevention, 23 countries have now adopted policies to provide Insecticide-treated Nets (ITNs) to all persons at risk, thus strengthening malaria control in the Region.
7. **SO3: Chronic noncommunicable conditions, mental disorders, violence and injuries:** The momentum towards controlling noncommunicable diseases (NCDs) is increasing in the Region. All countries have now conducted capacity assessment for prevention and control of NCDs. By incorporating NCD surveillance into the revised Regional Integrated Disease Surveillance and Response strategy, Member States have started to provide data regularly on common NCDs. The Regional Office continues to provide support to Member States through strengthening national NCD planning, advocacy, training and incountry support for the prevention of disease, disability and premature death from chronic noncommunicable conditions.
8. **SO4: Child, adolescent, maternal and reproductive health:** WHO supported countries to adopt and implement various technical guidelines and tools on maternal, newborn and child health including the “*Recommendations pour la Pratique Clinique des soins obstétricaux et néonataux d’urgence*”

en Afrique – Guide du Prestataire” (RPC). Countries adopted policies and developed strategic plans on maternal and child health. Training was expanded, with particular emphasis on community health workers. The Commission on Women's Health in the African Region, established in response to Resolution AFR/RC8/R1 of the Fifty-eighth session of the Regional Committee, made significant progress in its analysis of the status of women's health and its potential for advancing socioeconomic development.

9. **SO5: Emergencies, disasters, crises and conflicts:** The focus during 2010 was on strengthening capacity for disaster risk reduction and instituting a shift from crisis management to preparedness and risk assessment and management in line with World Health Assembly resolutions WHA58.1 and WHA59.22. Hazard maps were developed for all countries and 11 Member States drew up national emergency plans that cover multiple hazards. WHO coordinates the humanitarian health cluster in countries; this has improved the coordination and effectiveness of health response actions.

10. **SO6: Risk factors for health conditions:** National health promotion policies and action plans including those addressing alcohol use were developed in five countries, while understanding of health promotion approaches among government officials was improved through workshops. The Sixtieth session of the Regional Committee adopted the Regional Strategy to Reduce the Harmful Use of Alcohol, establishing the basis for policy development, resource allocation and action in countries. Surveillance of risk factors such as tobacco was expanded while seven countries enacted legislation to ban smoking in public and workplaces as well as tobacco advertising, promotion and sponsorship.

11. **SO7: Social and economic determinants of health:** With WHO technical and financial support, four countries undertook situation analyses of the social and economic determinants of health. The report on health aspects of urbanization in Africa, prepared in line with the theme of World Health Day 2010, demonstrates the widening gap in social equity within and between cities, including in access to health services. The Regional strategy for addressing the key determinants of health, adopted by the Regional Committee at its Sixtieth session, will guide policies and actions in countries.

12. **SO8: Healthier environment:** Needs assessments and situation analyses were conducted as the basis for the implementation of the Libreville Declaration on Health and Environment. WHO and UNEP jointly organized the Second Interministerial Conference on Health and Environment in Africa in Luanda, Angola, from 23 to 26 November 2010. The conference adopted the Luanda Commitment on the implementation of the Libreville Declaration, a Joint Statement of Ministers of Health and Ministers of Environment on climate change and health, and the arrangements for the Health and Environment Strategic Alliance.

13. **SO9: Nutrition, food safety and food security:** Advocacy for the inclusion of nutrition and food safety in national development plans and poverty reduction strategies continued during 2010, through the production of advocacy documents and the actions of the Regional Nutrition Champion. Institutional capacity to address nutrition and food safety issues was strengthened in countries; nine countries were supported to finalise strategies and action plans on the prevention and management of severe malnutrition. Surveillance of nutrition and foodborne diseases was strengthened through incorporation of indicators into the integrated disease surveillance tools, training activities and analysis of the readiness to scale up nutrition actions in countries.

14. **SO10: Health services:** A major focus in 2010 was on accelerating the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. Countries continued to strengthen the capacity of their national health systems in areas of policy, strategies, planning, and implementation using available tools.

15. **SO11: Medical products and technologies:** Evidence-based policy guidance was provided to promote scientifically-sound and cost-effective use of medical products and technologies by health workers and consumers. The end of a decade of promotion of the role of traditional medicine in health systems was marked by an assessment of achievements and the publication of a special issue of the African Health Monitor. The assessment and the publication showed the progress made by Member States in the area of traditional medicine. Several countries were supported to strengthen national laboratories and blood transfusion services. In order to improve biosafety and laboratory biosecurity, a training workshop was held for officials from six countries.

16. **SO 12: Leadership, governance and partnership:** The Regional Director advocated for increased investment in health through interactions with national leaders and development partners. The Regional Office adopted Strategic Directions to guide WHO action in the Region. Clusters and Programmes were restructured to align with the Strategic Directions and to optimise the use of limited financial resources. *The Harmonization for Health in Africa* partnership intensified joint advocacy and technical support to countries, focusing on national health strategic plan development and health financing. WHO country teams engaged actively in health partnerships at country level, leading the UN's work on health. Technical support was provided to the African Union for the preparation and follow up of the AU Heads of State and Government Summit on the theme 'Maternal, neonatal and infant health and development in Africa'. The WHO Intercountry Support Teams provided technical support and explored synergies with regional economic communities and the United Nations Regional Directors Teams (RDTs).

17. **SO13: Efficient and effective WHO:** Action in the year 2010 centred around three main areas – successful introduction of the Global Management System (GSM) in the Region; response to the financial crisis affecting the Organization; and support to the delivery of technical programmes. Senior Managers at country and regional levels were trained in GSM use and all workplans were converted to GSM by the end of 2010. A number of successful initiatives such as identification of vulnerable and at-risk areas and functions, reorganization of work and reassignment of staff among teams were undertaken to ensure effective functioning of the Regional Office. Various cost-saving measures in the areas of recruitment, communication and travel were instituted.

18. The lessons learnt during implementation of the Programme Budget in its first year will guide adaptation and action in 2012 and beyond. Member States' demand for WHO technical and policy support in priority areas continues to grow. The Organization will need to intensify and expand resource mobilization in order to sustain the capacity to provide adequate response. Collaboration with partners, including WHO collaborating centres, civil society organizations, the African Union and regional economic communities, provides an opportunity for further synergy. Cross-border collaboration among Member States, especially in addressing communicable diseases outbreaks and epidemics, enables timely response, thereby reducing the scale and duration of such occurrences.

19. Areas that will receive special emphasis in 2011 through the implementation of realistic workplans based on sound income projections include:

- (a) Continued focus on WHO's role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization;
- (b) Supporting the strengthening of health systems based on the primary health care approach;
- (c) Putting the health of mothers and children first;
- (d) Accelerated actions on HIV/AIDS, malaria and tuberculosis;
- (e) Intensifying the prevention and control of communicable and noncommunicable diseases; and
- (f) Accelerating response to the determinants of health.

20. These actions are currently being implemented against the backdrop of budget crisis and WHO reform.



INTRODUCTION



1. The WHO 11th General Programme of Work (GPW)¹ sets out a global health agenda for action to address gaps in social justice, accountability, implementation and knowledge. It acknowledges the unique opportunity to achieve the global goals set by an ever-increasing number of partners for health with WHO as the lead agency in international health.
2. WHO has defined its contribution to the global health agenda in its Medium Term Strategic Plan 2008-2013 (MTSP).² The MTSP articulates 13 Strategic Objectives (SO) and Organization-Wide Expected Results (OWERs) for each SO. The MTSP is being implemented through three biennial Programme Budgets and related operational plans formulated for the periods 2008-2009, 2010-2011, and 2012-2013 respectively.
3. In May 2009, the Sixty-second World Health Assembly adopted the WHO Programme Budget 2010-2011 as the basis for operational planning across the Organization. Workplans were developed based on the priorities defined in WHO Country Cooperation Strategies (CCS). These priorities reflected those identified by Member States in their national health development plans.
4. This report, *The Work of WHO in the African Region 2010*, presents the progress made in the first year of the biennium and has been prepared for submission to the Sixty-first session of the WHO Regional Committee for Africa.

5. The report has the following six chapters:

1. INTRODUCTION;
2. CONTEXT;
3. THE PROGRAMME BUDGET 2010-2011;
4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE;
5. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT; AND
6. WAY FORWARD.

6. Annexed to this report are two tables: Table 1 on WHO Medium Term Strategic Plan 2008–2013: Statement of Strategic Objectives; and Table 2 on Approved Programme Budget 2010-2011: Allocation by strategic objective, source of financing and distribution between WHO country offices and the Regional Office.

CONTEXT

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7. WHO contributes to progress in the implementation of the global health agenda as stated in the WHO 11th General Programme of Work 2006–2015. The work of WHO in the Region is guided by the Strategic Directions for the WHO African Region as set forth in the document entitled *Achieving Sustainable Health Development in the African Region: Strategic Directions for WHO 2010-2015*. These are linked to the WHO Medium Term Strategic Plan 2008–2013. The Strategic Directions focus specifically on the Region and are aligned with WHO's core functions. This section summarizes the financial, epidemiological and socioeconomic context within which WHO operated during the year under review.

8. The current global financial crisis has had a significant impact on the socioeconomic situation and health funding at country and international levels. It has also negatively affected funding for the work of WHO. However, it is noteworthy that many governments as well as international development partners have made efforts to meet their commitment to health funding especially at country level.

9. Although health systems in some countries have shown significant improvements, weakness of health systems continued to play a critical role in inadequate health outcomes in some countries. Major issues included weak leadership and governance, insufficient financing,

inadequate health workforce as well as limited access to medicines and health technologies. In some cases, these issues, coupled with fragmentation of partnerships, led to poor levels of implementation of national health policies and strategic plans.

10. The weakness of national health systems ultimately limits the capacity to ensure universal coverage of essential health interventions and services including the ability to effectively respond to disasters and disease outbreaks. Antimicrobial resistance to HIV, TB and malaria medicines and insecticide resistance threaten future progress and need to be urgently prevented and controlled. Evidence from research and information systems is not translated into policies and actions rapidly enough and adequately, contributing to delay of health development.

11. Despite these challenges, there has been progress reported in some programme areas such as HIV/AIDS, TB, malaria, immunization and child health mainly due to strong leadership and sound policies and plans in some countries. The Regional Office provided guidance and worked to maintain quality technical assistance to countries. It also contributed to strengthening and expanding partnerships for health; promoting the scaling up of essential health interventions; identifying and addressing gaps in national policies, strategies and regulatory frameworks; and strengthening surveillance, monitoring and evaluation. Multilateral and bilateral partners including GFATM, the President's Emergency Plan For AIDS Relief (PEPFAR), UNAIDS, STOP TB, RBM, US Presidential Malaria Initiative (PMI), World Bank, DFID and Foundations (Bill and Melinda Gates Foundation, etc.) and the private sector played a critical role as did the involvement of Civil Society Organizations and affected communities especially with regard to funding and developing large-scale campaigns and initiatives for accelerated impact.

12. Despite the reported improvement in recent years, the African Region is still characterized by high maternal and child mortality. Recent estimates indicate that most countries in the Region are not on track to achieve the Millennium Development Goal targets for maternal and child mortality. The average maternal mortality ratio in the African Region is 620 per 100 000 live births. WHO estimates that about 3.8 million children under the age of five years died of preventable and treatable conditions including pneumonia, diarrhoea and malaria in 2009.

13. The burden of communicable diseases remains high in the Region. The underlying factors include the resurgence and continued circulation of wild poliovirus which is associated with low population immunity as a result of failure to sustain high coverage of routine immunization. However, intense and high quality supplementary immunization campaigns and widespread implementation of the Reaching Every District (RED) approach are leading to significant reduction in the number of cases of poliomyelitis.

14. The high burden of communicable diseases also reflects the particularly high levels of morbidity and mortality associated with HIV/AIDS, tuberculosis and malaria. As at December 2009, the number of people living with HIV in sub-Saharan Africa was 22.5 million, representing two thirds of the global total of 33.3 million. The situation is equally serious for tuberculosis. Recent surveillance data shows that the Region accounts for 25% of TB cases notified globally. According to World Malaria Report 2010, malaria cases in the Region in 2010 was estimated at 212 million, representing 86% of the global total.

15. Progress has been made in regional response to HIV/AIDS, tuberculosis and malaria. Significant achievements have been seen in scaling up interventions related to HIV testing and counselling, PMTCT and the provision of ART. As of December 2009, Botswana and Rwanda had already achieved universal access to antiretroviral therapy. Scaled-up implementation of the Stop TB Strategy, especially the Directly Observed Treatment, Short course (DOTS) approach, has resulted in positive trends towards achieving the TB-related MDG targets in a few countries. The number of cases and deaths in health facilities has reduced dramatically in certain countries as a result of integrated malaria control interventions.

16. Neglected tropical diseases (NTDs) including Buruli ulcer, leprosy, human African trypanosomiasis, schistosomiasis, onchocerciasis, soil-transmitted helminthiasis, lymphatic filariasis and dracunculiasis affect an estimated one billion people worldwide with Africa bearing the highest burden. Various NTD control programmes have been implemented by some countries, with support from partners, resulting in a reduction in the burden of onchocerciasis, trypanosomiasis, dracunculiasis and leprosy.

17. Millions of people living in the African Region suffer from or are threatened by epidemic-prone diseases such as cholera, cerebrospinal meningitis, viral haemorrhagic fevers and, more recently, Pandemic Influenza A (H1N1) 2009. Cholera continues to be the most significant of the reported disease outbreaks in the Region. During 2010, a cumulative total of 105 369 cholera cases and 3139 deaths (CFR=3.0%) were reported from 21 Member States in the Region. Other outbreaks reported during the year included yellow fever, meningitis, measles, rift valley fever, typhoid, dengue, pandemic influenza A (H1N1) 2009, Lassa fever, plague and *chikungunya*.

18. The Region has been experiencing an increase in noncommunicable diseases (NCDs) such as cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases as well as mental disorders, violence and injuries, adding unto the already heavy burden of communicable diseases. According to the 2010 Global Status Report on NCDs, if nothing is done, this trend will worsen and the Region is expected to experience the highest

projected increase in NCDs (26%) by the year 2020. The major common risk factors for chronic NCDs are related to individual lifestyles such as tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets rich in fat, energy and salt and poor in fruits and vegetables.

19. In addition to the double burden of communicable and noncommunicable diseases, progress in health development is also hampered by gaps in leadership and poor governance in health. This is exemplified by lack of comprehensive national health policies and strategic plans and inadequate coordination of efforts to improve the health situation of people, mainly at national level. The lack of strong mechanisms for addressing the broad health determinants such as food, education, shelter, housing, water, sanitation and climate change is also part of the context in which WHO is working in the African Region.

20. The multiplicity of initiatives and players in health provides a great opportunity but poses a challenge to coordination and harmonization with national health systems. The Regional Office worked tirelessly to identify opportunities to strengthen collaboration among these stakeholders and, in line with the Paris Declaration on Aid Effectiveness, promote harmonization as well as alignment with the priorities of countries. The increasing trend of decentralization of decision making on funding to the country level, by major development partners, has demanded greater engagement in resource mobilization by WHO country offices.

THE PROGRAMME BUDGET 2010-2011

3

21. The WHO Programme Budget 2010-2011 was adopted by the World Health Assembly in its Resolution WHA.62.9. It is composed of three budget components: (i) The WHO Programmes, covering activities for which WHO has exclusive budget control; (ii) Partnerships and Collaborative Arrangements (PCA), which WHO is executing in collaboration with partners; and (iii) Outbreak and Crisis Response (OCR), covering WHO's response to unforeseen natural or man-made events, also executed in collaboration with partners.

22. The overall approved budget allocation for the African Region for the 2010-2011 biennium amounted to US\$1 262 864 000 with 17% as Assessed Contributions (AC) and 83% as Voluntary Contributions (VC).

23. The implementation of the Programme Budget 2010-2011 in the African Region was guided by principles such as results-based management, decentralization, accountability of both Member States and the WHO Secretariat vis-à-vis the governing bodies, and partnerships for health in the Region.

24. Within the WHO Secretariat in the African Region, the implementation of the Programme Budget 2010-2011 is overseen and guided by the Executive Management Committee, the Management Development Committee and the Regional Programme Meeting.

25. In order to ensure accountability in the use of WHO resources and achievement of planned results, compliance was strengthened through increasing oversight missions to budget centres and reporting to the Regional Director for appropriate action.

26. In December 2010, the Regional Office closed its financial accounts and consolidated it in the Global Management System (GSM), the new WHO management tool. Despite some shortcomings due to the transition from the legacy system, the status of implementation of the budget for this year was established using data from the GSM (see table below).

27. By the end of December 2010, the African Region had been allocated a total budget of US\$ 1 467 221 000 compared to the initial budget of US\$ 1 262 864 000 approved by the World Health Assembly. This increase was due to an increase in funding required for polio eradication activities. Out of the initial budget, US\$ 801 130 000 (63%) was available for implementation. Out of the available amount, US\$ 529 156 000 (66%) was implemented.

28. The overall funding gap amounted to US\$ 461 734 000 (37% of the initial approved budget). However, this percentage masks significant discrepancies between the 13 Strategic Objectives. The largest funding gap was observed in the Strategic Objectives related to Food safety and nutrition – SO9 (76%); Health systems – SO10 (65%); Child and maternal health – SO4 (60%); AIDS, Tuberculosis and Malaria – SO2 (60%); Emergencies and crises – SO5 (60%); and health risk factors – SO6 (52%).

29. Planning was based on high expectations of full budget funding. However, due to the global financial crisis it is to be expected that the ambitions could not be met, jeopardizing ability to attain planned results at the end of the biennium.

30. The assessment made in the Mid-term Review of progress towards the attainment of Office Specific Expected Results shows that out of a total of 2563 planned results, 1709 (67%) were assessed to be "on track", 523 (20%) were "at risk", 83 (3%) were "in trouble" and 248 (10%) could not be assessed due to insufficient information. The information would be available by the end of the biennium.

31. While ratings vary significantly across Strategic Objectives, the overall picture shows significant progress towards the achievement of results by the end of the biennium. Planned results that have "at risk" rating will require more attention and follow-up action in order to achieve them. "In trouble" rating implies that progress is seriously hampered. Results in this category may be cut back or reprogrammed for the next biennium. Notwithstanding some "at risk" and "in trouble" ratings, significant achievements have been noted across all Strategic Objectives.

Table: Programme Budget implementation rates by Strategic Objective as of 31 December 2010 (in US\$ 000)

SO	Budget approved by Health Assembly (1)	Allocated PB (2)	Total available funds (3)	% available funds against approved budget (4)=(3/1)	Budget implementation (5)	% of Budget implementation against approved PB 6=(5/1)	% of Budget implementation against allocated PB 7= (5/2)	% of Budget implementation against available funds 8=(5/3)
SO 01	424 120	605 635	393 419	93%	298 998	70%	49%	76%
SO 02	208 208	210 020	83 136	40%	51 544	25%	25%	62%
SO 03	19 444	19 675	12 452	64%	5603	29%	28%	45%
SO 04	107 735	108 308	42 623	40%	25 148	23%	23%	59%
SO 05	98 782	100 273	39 672	40%	27 374	28%	27%	69%
SO 06	23 943	24 807	11 421	48%	7081.02	30%	29%	62%
SO 07	8495	9201	6978	82%	3001	35%	33%	43%
SO 08	16 335	17 485	8413	52%	5131.93	31%	29%	61%
SO 09	37 182	37 790	8966	24%	4573	12%	12%	51%
SO 10	124 035	126 332	43 794	35%	24087	19%	19%	55%
SO 11	19 663	19 958	12 304	63%	7628	39%	38%	62%
SO 12	49 735	51 908	46 323	93%	24 088	48%	46%	52%
SO 13	125 187	135 821	91 630	73%	44 899	36%	33%	49%
Grand Total	1 262 864	1 467 211	801 130	63%	529 156	42%	36%	66%

32. The Mid-term Review of the implementation of the Programme Budget 2010-2011 provided an opportunity to reduce ambitions by reprogramming workplans and managing budgetary constraints in implementation of the Programme Budget in 2011. Thus, based on predictable financial resources available for 2011, recommendations were made for shifting of funds across planned results in order to implement activities of the highest priority. The process focused on WHO core functions and key priorities as stated in CCS documents for WHO country offices and on the milestones of the regional Strategic Directions as stated in the document “*Achieving Sustainable Health Development in the African Region: Strategic Directions for WHO 2010–2015*”.

SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE

4

4.1 SO1: Communicable diseases

33. Routine immunization, polio eradication, neglected tropical diseases, integrated disease surveillance, research, international health regulations, and epidemic preparedness and response all contribute to Strategic Objective 1. This strategic objective aims to contribute to the reduction of the burden of communicable diseases and towards global health security.

34. Routine immunization coverage has remained at around 80% over the past four years. At the end of 2010, the regional routine immunization coverage with three doses of DPT-containing vaccine (DPT3) was 82% compared to 81% in 2009. Approximately the same number of countries reported coverage of at least 90% DPT3 coverage at national level in 2009 and 2010.

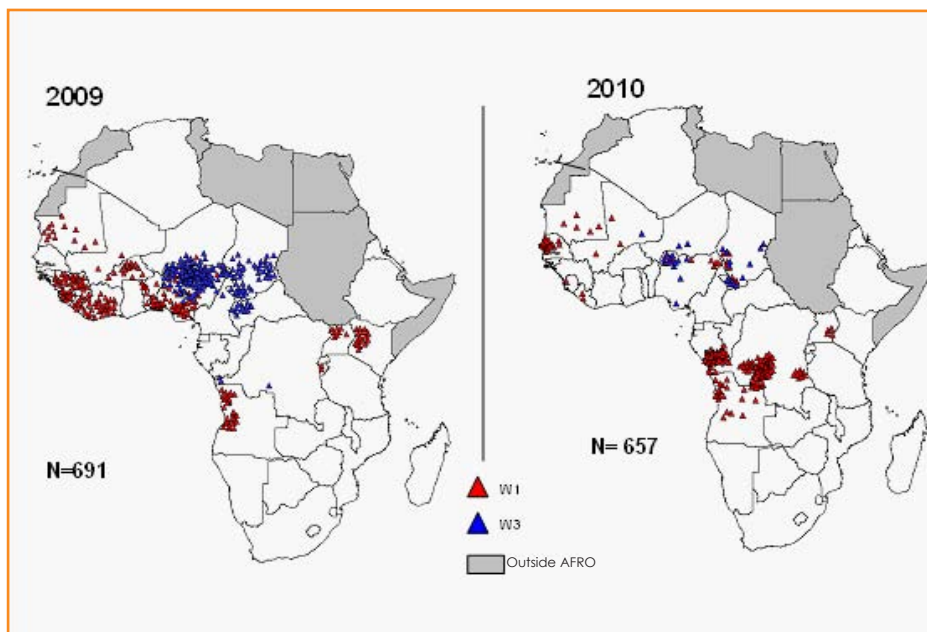
35. Progress was made in the introduction of new vaccines in the Region. By end of 2010 a cumulative total of 45 and 44 countries had introduced hepatitis B and *haemophilus influenzae* type b vaccines respectively. In addition pneumococcal conjugate vaccine was introduced in five countries³ while rotavirus vaccine was introduced in all districts of South Africa. The new conjugate meningococcal A vaccine was successfully introduced in three hyperendemic countries in West Africa, namely Burkina Faso, Mali and Niger.

36. During the year under review, a total of 45.2 million children were reached with measles supplementary immunization activities (SIAs) in 14 countries. Seven of these countries attained coverage of more than 95% at national level. Thirteen countries conducted tetanus toxoid SIAs in 595 high-risk districts, targeting 37.1 million women of childbearing age. In addition, maternal and neonatal tetanus elimination (MNTE) was validated in a cumulative total of 19 countries in the Region by the end of 2010.

37. Polio eradication continues to be a regional priority. In 2010, significant progress was made in West Africa, particularly in Nigeria which achieved a 95% reduction in the number of wild poliovirus cases compared to 2009. Despite this progress and due largely to the outbreak in Congo with 441 confirmed cases, involving mostly adults, the total number of cases reported in the Region in 2010 was 657, compared with 691 cases in 2009 (Figure 1). The reduction in the total reported cases in West Africa was a result of the implementation of high-quality supplementary immunization activities that reached over 114 million children under five years.

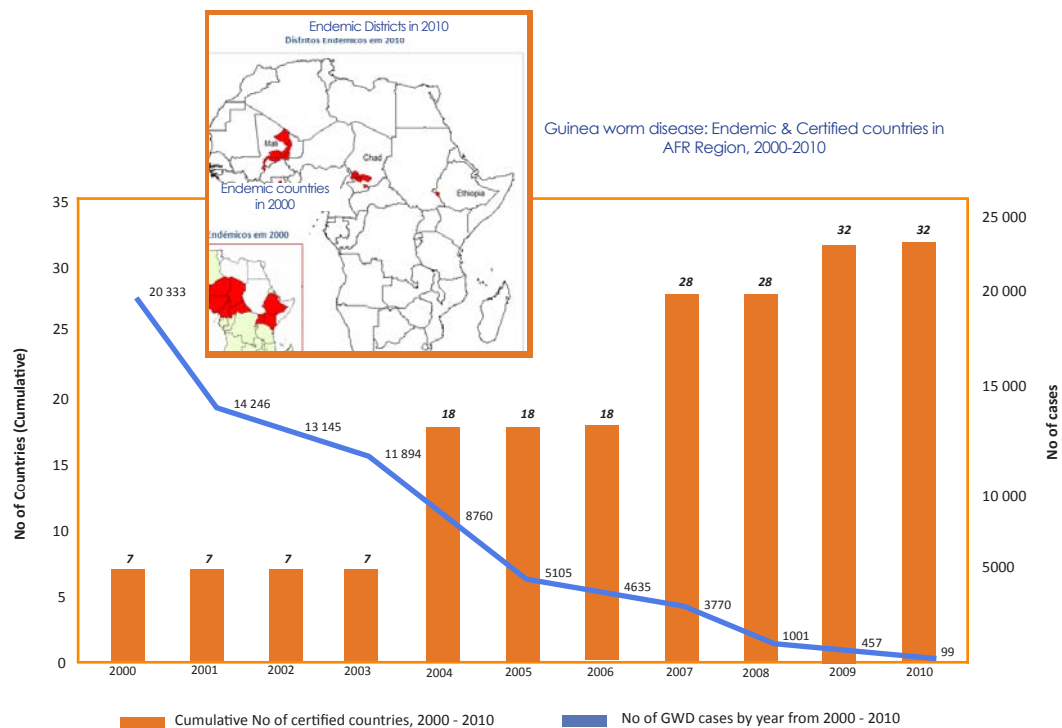
38. The progress made in immunization is contributing to the reduction of child mortality. However, more effort is required not only to sustain the results obtained thus far but also to improve the progress towards the achievement of MDG 4.

Figure 1: Distribution of wild poliovirus cases in the African Region, 2009 and 2010



39. Significant progress has been made in the area of Guinea worm disease eradication. The annual incidence of the disease decreased by 99% over the period from 2003 to 2010. Ghana, Ethiopia and Mali remain endemic. In 2010, an outbreak of Guinea worm disease was reported in Chad (Figure 2). Nigeria which interrupted Guinea worm transmission in 2008 remained free of the disease throughout 2010.

Figure 2: Trends of Guinea Worm Disease Eradication, 2000 –2010



40. Leprosy cases dropped from 43 381 in 2005 to 32 382 in 2010, representing a reduction of more than 25%. By implication, leprosy prevalence decreased from 0.63 to 0.43 case per 10 000 inhabitants in that period, confirming the elimination of leprosy as a public health problem in the Region.

41. However, a few leprosy hot spots remain and the persons affected continue to suffer from stigmatisation, discrimination, inadequate access to public services and violation of their human rights. To address these challenges, the UN General Assembly adopted a resolution in December 2010 urging countries to take appropriate action.

42. The regional NTD multi-year strategic plan for 2011–2015 was finalized. Furthermore, guidelines were developed for supporting countries to develop national multi-year comprehensive NTD strategic plans (NTD Master Plans). All targeted countries have developed NTD Master Plans, which will enhance their capacity to mobilize the required resources and improve the integration and performance of interventions to control neglected tropical diseases.

43. Toward the elimination of lymphatic filariasis, 64.9 million people were treated in the latest round of mass drug administration in 2009, which is an increase from 56.3 million in 2008. Regarding the control of Human African Trypanosomiasis (HAT), Nifurtimox-Eflornithine Combination Therapy (NECT) was introduced in the treatment of Phase II *Gambiense* form of sleeping sickness. The number of new HAT cases reported in 2009 dropped below the symbolic threshold of 10 000 for the first time in 50 years and remained under this threshold during 2010.

44. The second edition of the Integrated Disease Surveillance and Response (IDSR) technical guidelines incorporating International Health Regulations (2005) and priority noncommunicable diseases was produced in English language, with contribution from partners. That edition has been translated into French and Portuguese and disseminated to all Member States in the African Region.

45. A survey was conducted on the status of implementation of the IDSR strategy in the African Region. Findings from this survey indicate that 43 of the 46 countries in the Region were implementing the strategy and regularly reporting on national priority diseases. In recognition of the importance and critical role that community-based approaches play in early detection of public health events, community surveillance systems were established in 23 countries.

46. Regarding International Health Regulations (IHR), 12 countries⁴ were supported to conduct IHR core capacity assessments and development of implementation plans in 2010, bringing to 20 the total of countries that have done so. Regional IHR and country profiles were also developed and disseminated to the Member States during the period.

47. Systematic collection of information on epidemic-prone diseases and other public health emergencies of international concern is critical in ensuring that outbreaks are detected early and trigger adequate response by Member States. By the end of December 2010, a total of 99 public health events had been reported by Member States to the Regional Office. The main events included outbreaks of cholera, meningitis, yellow fever and lead poisoning.

48. Recognizing the need to strengthen outbreak preparedness and response in the Region, particularly cross-border transmission of infectious diseases, WHO supported the hosting of a high-level interministerial meeting bringing together seven countries⁵ in Abuja, Nigeria. The ministers from the participating countries established a joint initiative that permits multisectoral involvement in the prevention and control of common cross-border public health events.

49. In order to support coordination and improve on communication in response to public health emergencies, a Strategic Health Operations Centre (SHOC) was established at the WHO Regional Office for Africa in Brazzaville. During the year, the SHOC played a critical role in coordinating response to major outbreaks such as cholera in Cameroon, Chad and Nigeria; yellow fever in Côte d'Ivoire and Uganda; lead poisoning in Nigeria; and investigation of a suspected Ebola outbreak in Congo.

4.2 SO2: HIV/AIDS, Tuberculosis and Malaria

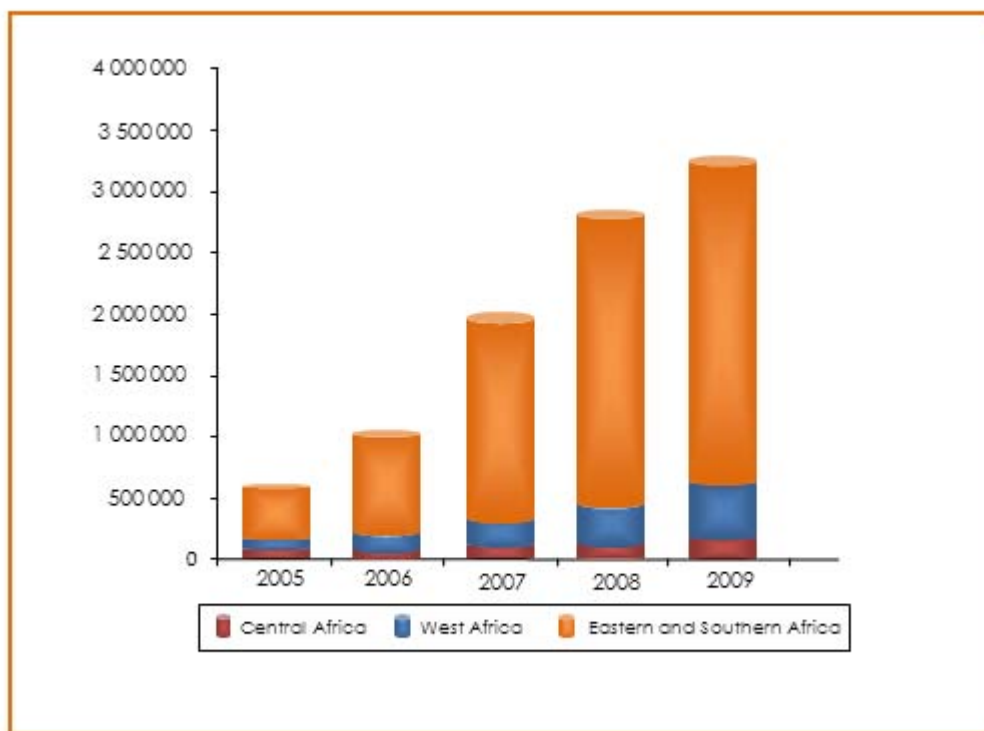
50. Guidance and technical assistance related to SO2 focused on strengthening the capacity of Member States in the areas of programme reviews and planning; resource mobilization; implementation of proven interventions using WHO guidelines and tools; and improving data collection, analysis and reporting to monitor progress towards achieving universal access and MDG targets.

51. In order to address the burden of HIV/AIDS, tuberculosis and malaria, WHO focused on normative guidance, capacity building and technical support for scaling up cost-effective interventions towards attaining Universal Access (UA) defined as coverage of at least 80% of the target population. The use of research results and technologies (male circumcision, Short-Message-Service [SMS] for life, etc.) for programme implementation has fostered progress in the Region in HIV/AIDS control.

52. Based on the most recent UNAIDS/WHO estimates, as at December 2009, the number of people living with HIV in sub-Saharan Africa was 22.5 million. The prevalence of HIV in adults aged 15–49 years decreased from 5.9% in 2001 to 5.0% in 2009. In 2009, AIDS-related mortality decreased in 16 countries, the decrease ranging from 11% in Congo to 72% in Rwanda, thanks to improved availability of antiretroviral therapy, care and support to Persons Living with HIV.

53. The proportion of HIV-infected pregnant women accessing antiretroviral medicines to prevent mother-to-child transmission (PMTCT) increased from 45% in 2008 to 54% by the end of 2009. Four countries⁶ achieved the UA target of at least 80% for PMTCT. Based on the new WHO guidelines for initiation of ART, by the end of 2009, an estimated 3.9 million PLWHA had been put on ART (Figure 3), translating into ART coverage of approximately 37%, compared with 8% in 2005.

Figure 3: Number of people with advanced HIV infection receiving antiretroviral therapy in the WHO African Region, 2005–2009



Source: WHO, UNAIDS, UNICEF; Towards universal access; scaling up priority HIV/AIDS interventions in the health sector: Progress Report 2010 (<http://www.who.int/hiv/pub/2010progressreport/en/>, at last accessed on 25 February 2011)

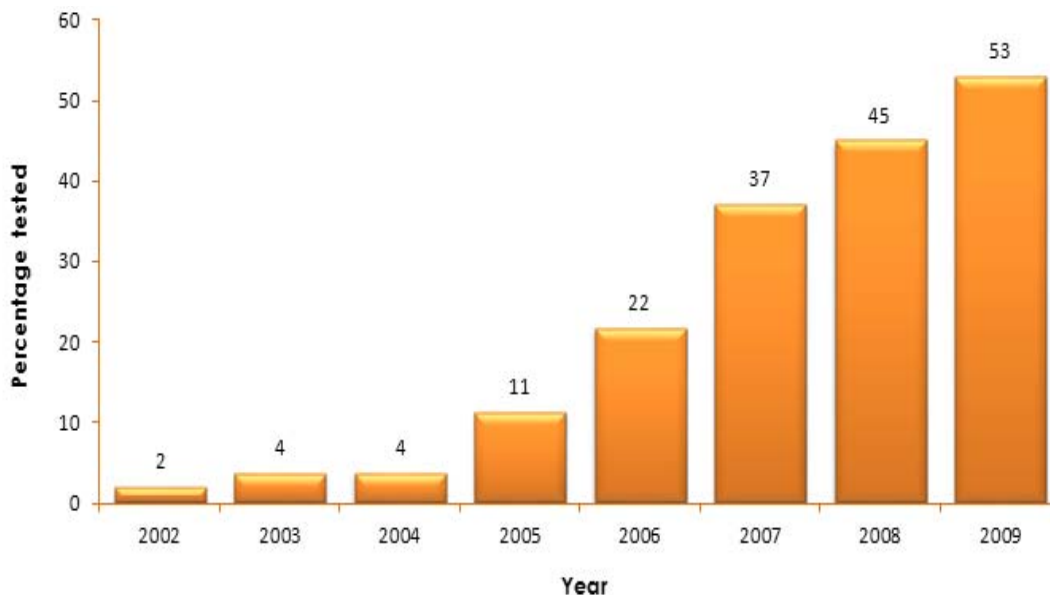
54. WHO supported Member States to adopt the 2010 guidelines on the treatment of HIV-infected children, adults and adolescents; prevention of mother-to-child transmission of HIV; and infant feeding in the context of HIV. The guidelines were introduced to 27 countries at four WHO workshops.

55. Sixteen countries⁷ were supported to develop or update their HIV/AIDS strategic plans. These plans form the basis for preparing grant proposals for submission to Global Fund to fight AIDS, Tuberculosis and Malaria. In addition, they facilitate coordination of the numerous actors. Twelve countries⁸ had their health sector HIV/AIDS programmes reviewed and eight countries⁹ were supported to develop plans of action for strengthening national laboratory services. Forty-eight laboratory technicians from 18 countries¹⁰ were trained in HIV infection diagnosis and monitoring. Seven countries¹¹ participated in the WHO Regional Office accreditation process.

56. Seventeen countries¹² were supported to strengthen their HIV drug resistance (HIVDR) systems and four national laboratories¹³ were accredited for HIVDR monitoring. Seven countries¹⁴ were trained in conducting HIV surveillance in most-at-risk populations and eight countries¹⁵ were supported to implement their HIV surveillance systems.

57. With regard to tuberculosis control, the Regional Office developed a set of training modules for national tuberculosis control programme managers and launched the first institutional training course on management of TB/HIV and MDR-TB.

Figure 4: HIV testing for TB patients in the African Region, 2002–2009



Source: Global Tuberculosis Control, WHO Report 2010

58. Fifteen countries¹⁶ attained treatment success rates of 85% or higher and seven countries¹⁷ attained 70% case detection rate. The proportion of TB patients screened for HIV rose from 45% in 2008 to 53% in 2009 (Figure 4).¹⁸ However, only 36% were accessing antiretroviral treatment.

59. WHO has been supporting countries to determine the level of resistance and establish treatment programmes for confirmed cases. By the end of the year, MDR-TB cases had been notified from a cumulative 39 countries.¹⁹ Eight²⁰ of these countries had also notified extensively drug-resistant TB (XDR-TB) cases. With advocacy and support from WHO and partners, a total of 28 countries²¹ established MDR-TB treatment programmes compared with 16 countries in 2009. Between 2009 and 2010 nine countries²² were supported to conduct country-wide drug resistance surveys and five more countries²³ were supported to finalize survey protocols.

60. Between 2009 and 2010, 12 countries were supported to develop protocols and conduct countrywide TB disease prevalence surveys to improve estimation of TB burden as a baseline for assessing progress towards achieving MDG targets.

61. Malaria continues to be a significant contributor to morbidity and mortality in the Region. By the end of 2010, 23 countries²⁴ had adopted policies to provide insecticide-treated nets (ITNs) to all persons at risk. During the same period 289 million ITNs were distributed. The estimated proportion of households owning at least one ITN increased from 27% in 2007 to 42% in 2010 while the proportion of children under five years sleeping under an ITN increased from 17% in 2007 to 35% in 2010.²⁵ Figure 5 illustrates the trends in probable and confirmed malaria cases reported in Botswana, Eritrea, Madagascar and South Africa.

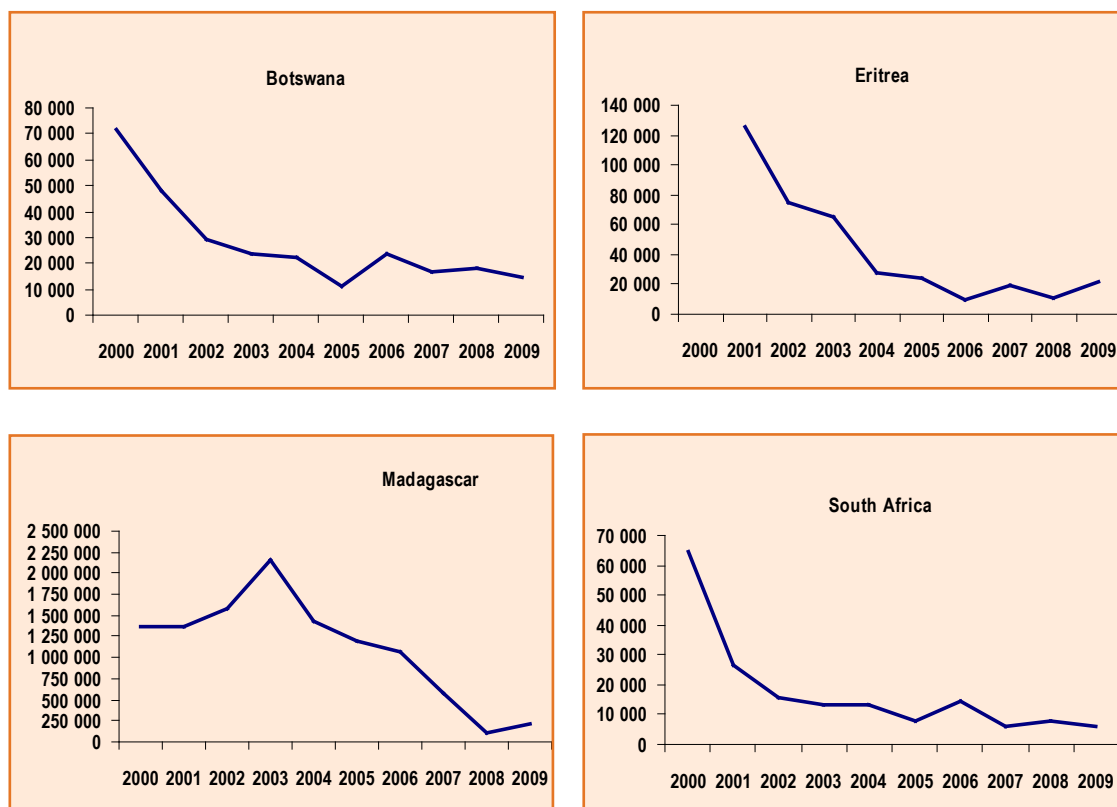
62. Twenty-seven countries²⁶ reported implementing indoor residual spraying (IRS). It is estimated that in 2009, 73 million people, i.e. about 10% of the population at risk of malaria, were protected by IRS. Thirty-three countries²⁷ have adopted a policy of parasitological confirmation of all malaria cases. The proportion of malaria cases undergoing parasitological testing increased from 26% in 2005 to 35% in 2009. All but one of the endemic countries in the Region now use Artemisinin-based combination therapy (ACTs) as first-line treatment for malaria following WHO advocacy and support for policy change and ACT implementation.

63. To enhance malaria control programming in the Region, WHO developed and disseminated Malaria Strategic Planning Guidelines and trained experts from all the endemic countries in the Region. Subsequently, 12 countries²⁸ conducted malaria programme reviews and updated their malaria strategic plans. Experts from 17 countries²⁹ were trained in malaria surveillance.

Experts from seven countries³⁰ were trained in therapeutic efficacy testing of antimalarial medicines, and twelve countries³¹ were supported to improve malaria diagnosis and treatment using ACTs and Rapid Diagnostic Tests (RDTs). Between 2000 and 2010, 12 countries recorded over 50% reduction of malaria burden.

64. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) remained a significant source of funding for the three diseases in countries in the year under review. During Round 10, WHO supported 29 countries to develop funding proposals and continued to provide technical assistance for the implementation of previous successful grants. The contributions from other partners such as PEPFAR, the US Presidential Malaria Initiative, UNAIDS, Stop-TB and Roll Back Malaria partnerships, and Bill and Melinda Gates Foundation contributed to the progress made in providing response to the three diseases during the year. However, the global financial crisis that has impacted negatively on resources for addressing the three diseases is eroding the gains made by countries and the capacity of WHO to provide the required policy advice and technical support.

Figure 5: Decreasing trends in malaria cases (probable and confirmed) reported in selected countries of the African Region, 2000–2009



Source: WHO/AFRO Database

65. In summary, the fight against HIV/AIDS, TB and malaria remains a core area of focus of the work of WHO in the African Region. Challenges and bottlenecks related to weak health systems and inadequate access to health services at subnational level continue to hinder the scale up of proven interventions. There is urgent need to continue advocacy for financial and human resources and to improve the performance of programmes at district and community levels with the involvement of all stakeholders.

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

66. Noncommunicable diseases (NCDs) such as cardiovascular diseases (CVD), cancers, diabetes, chronic respiratory diseases, sickle-cell disease (SCD) and mental disorders, violence and injuries, oral health conditions, and eye and ear conditions, have become increasingly significant causes of ill health in the Region. In order to reduce the burden of disease due to these conditions, the Regional Office has been promoting the implementation of NCD prevention and control activities based on global and regional strategies.

67. At the beginning of the year under review, most countries lacked policies and plans for NCD prevention and control. The main achievements in 2010 are in the areas of advocacy, policy development, implementation of integrated national NCDs action plans, NCDs surveillance and health promotion interventions.

68. In this regard, WHO organized two regional conferences on SCDs in Benin and Madagascar with a view to increasing the political and financial commitment of Member States. In addition, an Asia-Africa chronic diseases summit aimed at accelerating the implementation of the WHO Action Plan for the global strategy on NCDs was organized in Kenya. Subsequently, an international conference on diabetes and associated diseases was organized in Mauritius, leading to the adoption of the landmark Mauritius Call for Action on Diabetes, CVDs and NCDs.

69. In partnership with WAHO and ECSA, WHO organized two ministerial conferences that adopted two resolutions on NCDs, calling upon Member States to implement the strategies for NCD prevention and control in the African Region and to report on progress to subsequent meetings of ministers of health.

70. Baseline country capacity assessments on the prevention and control of NCDs were conducted in all 46 Member States. In addition, field missions were conducted jointly with the International Atomic Energy Agency (IAEA) in

ten Member States³² to assess the capacity of countries in cancer prevention and control. At the same time, seven countries³³ were supported to conduct situation analyses on deafness and causes of hearing impairment.

71. As a result, Member States were supported to develop policies and integrated action plans for the prevention and management of NCDs including mental health, violence and injuries. Twenty-two countries developed and are implementing integrated NCD action plans (Figure 6). Furthermore, the Regional Office supported the development and finalization of specific action plans, namely: national cancer control plans in 10 countries³⁴; national noma programmes in highly-endemic countries;³⁵ and policies and plans for eye health and for the prevention of hearing impairment in Congo, Madagascar and Seychelles.

72. To improve the availability of NCD data, surveillance of NCDs including road traffic injuries and epilepsy has been integrated into the revised IDSR guidelines to enable Member States to enter their data directly into the database and generate outputs. They will also be able to compare their performance in surveillance with other Member States in real time. The Status Report on road safety and the Report on Violence and Health in the African Region have been published.

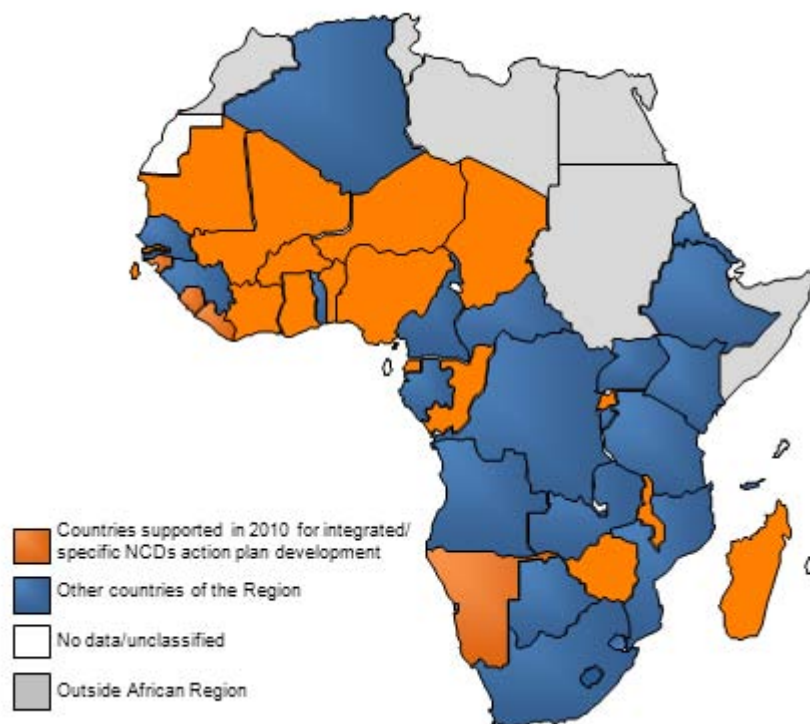
73. Three workshops on health promotion approaches in NCD prevention and control were conducted for national health promotion coordinators in ministries of health and NCDs programme managers in WHO country offices. Training and support in the use of the WHO Package of Essential NCD (WHO-PEN) interventions at primary care level were provided in four countries.³⁶ Furthermore, the Regional Office supported the training of national coordinators of eye health from 12 countries³⁷ on the integration of Primary Eye Care into Primary Health Care services.

74. Partnerships were forged with Winds of Hope; International Agency for the Prevention of Blindness; Sight Savers International; Right to Sight; World Heart Federation; World Diabetes Foundation; UNFPA; and with regional economic communities such as WAHO and ECSA. In addition, interregional collaboration was forged between the Regional Office and Pan American Health Organization in the area of NCDs.

75. Overall, the work WHO has increased NCD prevention and control awareness in the Region. Significant progress has been made, with many countries developing and implementing integrated action plans for the reduction of NCD risk factors and management including at PHC level. However, major challenges remain and there is an urgent need for countries and partners to allocate adequate resources for combating NCDs. The

momentum towards the prevention and control of NCDs is increasing and WHO is supporting countries to prepare for the UN Heads of State and Government High Level Summit on NCDs which will lead to an action-oriented document committing countries and all stakeholders to NCD control.

Figure 6: Countries with NCDs policies and intergrated action plans in the African Region



4.4 SO4: Child, adolescent, maternal and reproductive health

76. Strategic objective 4 aims to reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth, the neonatal period, childhood and adolescence; improve sexual and reproductive health; and promote active and healthy ageing for all individuals.

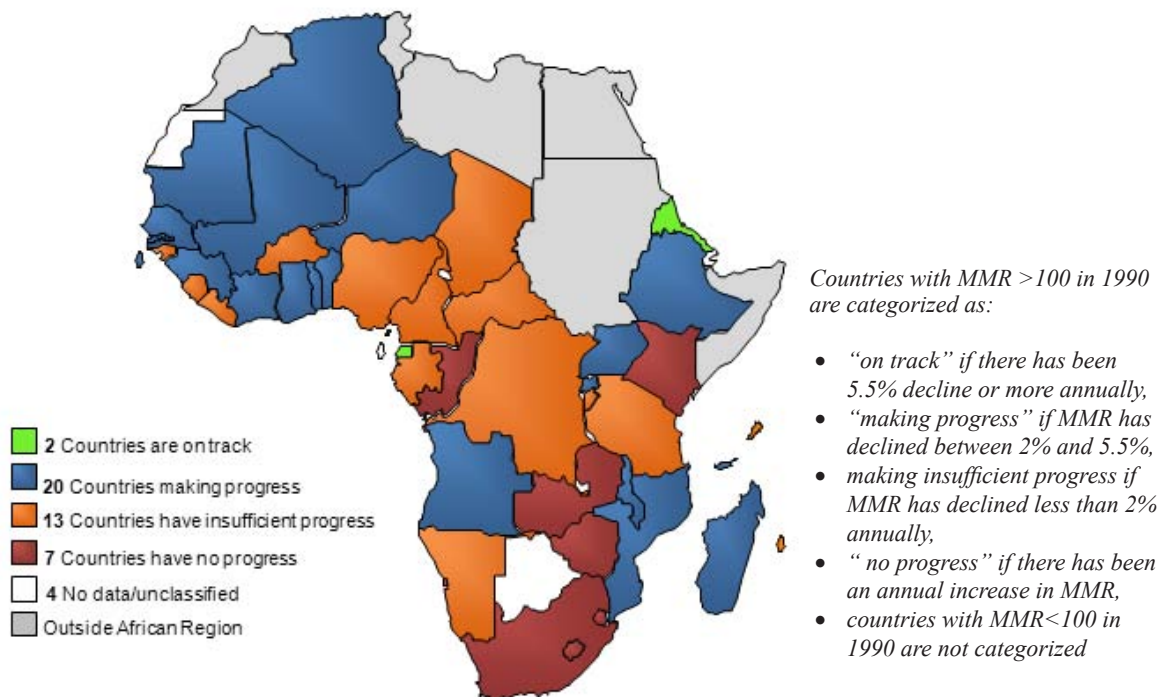
77. In line with the Strategic Directions 2010–2015 of the WHO African Region, specifically on “Putting the health of mothers and children first”, the main achievements during 2010 were related to development of policies, strategies, norms and guidelines; capacity building in the areas of maternal, newborn and child health; and monitoring of the implementation of strategies and planned activities.

78. Improving maternal and newborn health remains a significant challenge in the African Region. In order to address this issue, WHO and partners developed the regional Road map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health (MNH) in Africa, that was adopted by Member States in 2004. In 2010, WHO developed a Programme Review Tool for national roadmaps, and subsequently four countries³⁸ conducted reviews of their MNH Road maps.

79. Progress in maternal mortality reduction has been unsatisfactory. Only Eritrea and Equatorial Guinea are on track towards achieving MDG 5 on improving maternal health while 20 countries are making progress. The remaining 20 countries have made either insufficient progress or no progress at all (Figure 7).

80. To address the issue of availability and quality of MNH services, 10 countries³⁹ conducted Emergency Obstetric and Newborn Care (EmONC) needs assessment and service availability mapping. This exercise was followed by the development of strategies and plans to address the identified gaps. In addition, seven countries⁴⁰ conducted maternal death reviews to identify areas requiring quality improvement measures.

Figure 7: Progress in MDG5 on Maternal Mortality in the African Region



Sources: Trends in Maternal Mortality 1990 to 2008- Estimates developed by WHO, UNICEF, UNFPA and The World Bank and World Health Organization 2010. WHO web accessed on September 2010; Family and Reproductive Health/WHO-AFRO Database 2010

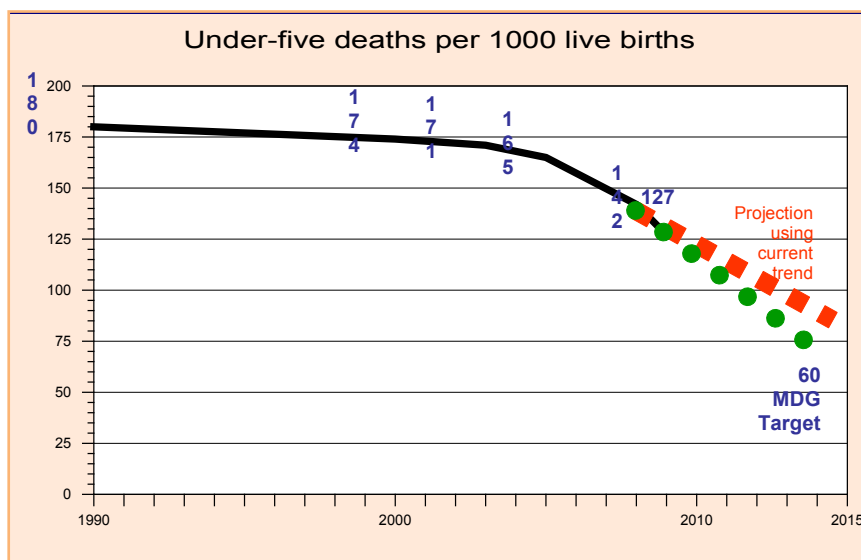
81. In collaboration with other partners, WHO developed and disseminated guidelines and tools to assist countries in improving maternal and newborn health. These included: (i) “*Recommandations pour la Pratique Clinique des soins obstétricaux et néonataux d’urgence en Afrique-Guide du Prestataire*” (RPC); (ii) Framework for Integrated Community-level Health Promotion Interventions; (iii) WHO Training Manual on Essential Newborn Care (ENC) and (iv) WHO/UNICEF Training Guidelines on Caring for the Newborn at Home Using Community Health Workers.



82. In collaboration with the African Union, nine countries⁴¹ launched “The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)” under the slogan “Africa cares: No Woman Should Die While Giving Life”, bringing the number of countries with national CARMMA to twenty-four.⁴² Five countries⁴³ conducted Maternal Health Day/Weeks. These campaigns have heightened advocacy for free maternity care. To date, 15 countries⁴⁴ have institutionalized policies reducing financial barriers to EmONC.

83. The Region has made insufficient progress towards the achievement of the fourth Millennium Development Goal (MDG 4) on child mortality (Figure 8). Currently only seven countries⁴⁵ are on track to achieve MDG 4.

Figure 8: Trend in under-five mortality in the African Region, 1990 –2009, with projection to 2015



Source: WHO World Health Statistics 2011, Interagency Group for Child Mortality Estimation (IGME) report, 2010

84. WHO supported Eritrea, Swaziland and Zimbabwe to develop national child health strategies. To date, 38 of the 46 countries in the Region have comprehensive national child health policies, strategies and plans.⁴⁶

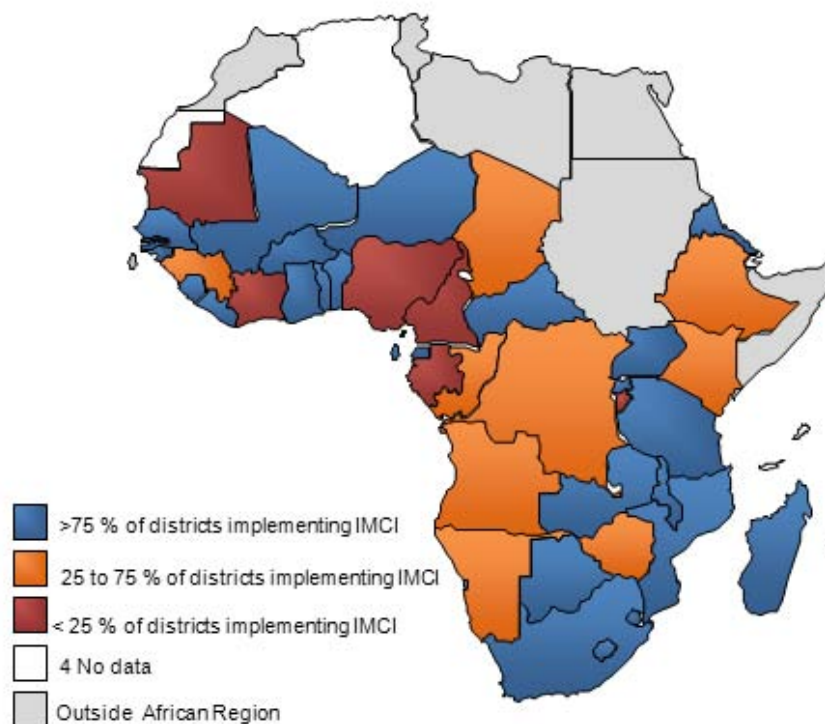
85. To continue building regional capacity in neonatal survival strategies, WHO conducted a regional training on the WHO/UNICEF package on home-based newborn care for six countries,⁴⁷ bringing to 13 the number of countries⁴⁸ with a core group of trainers of community health workers. Subsequently training of community health workers has started in eight countries.

86. During the year, WHO accelerated its support to build the capacity of over 220 national and district child health programme managers from 18 countries⁴⁹ in planning and management of child health programmes including resource mobilization, communication and interpersonal skills. This brings to over 400 the total number of trained child health programme managers in 27 countries⁵⁰ since 2008.

87. WHO and partners continue to support the expansion of Integrated Management of Childhood Illness Strategy (IMCI) in the Region. The number of countries implementing IMCI in more than 75% of their districts increased from 22 in 2009 to 26 countries⁵¹ by the end of 2010 (Figure 9). Furthermore, a WHO/UNICEF generic training manual for care for the sick child aged from two months up to five years at community level was developed. It was subsequently used to train community health workers in Malawi, Uganda and Zambia.

88. Child health programme reviews were conducted in Benin and Malawi. In addition, Kenya and Mali conducted health facility surveys to assess the quality of care provided to sick children.

Figure 9: Map of status of implementation of the Integrated Management of Childhood Illness Strategy in the African Region, December 2010



89. WHO worked with AFRICA 2010 Project; West African Health Organisation (WAHO); and East, Central and Southern Africa Health Community (ECSA-HC) to develop two documents: (i) "Child Sexual Abuse in sub-Saharan Africa: A Review of the Literature" and (ii) "Clinical Management of Child Sexual Abuse in Africa". These two documents would help Member States to recognize the magnitude of child sexual abuse in the Region, take action to prevent it and improve its clinical management.

90. To enable countries to improve adolescent health, WHO supported six countries⁵² to finalize their adolescent health strategic plans, bringing the total number of countries with adolescent health strategic plans to twenty-six.⁵³ WHO also supported four countries⁵⁴ to develop Youth-Friendly Health Services Standards. Mali and Gabon were supported to develop training tools for implementation of adolescent health standards.

91. Noting the key role that family planning plays in reducing maternal mortality and in an effort to address the low contraceptive prevalence rate (CPR) in the Region, WHO supported 12 countries⁵⁵ to develop/adapt their national Reproductive Health/Family Planning policies, norms and guidelines. A capacity building workshop on advocacy for repositioning family planning was also organized for 11 countries.⁵⁶

92. In response to the Fifty-eighth Regional Committee Resolution AFR/RC58/R1 on Women's Health in the African Region, the Regional Director established the Commission on Women's Health in the African Region to generate evidence on the key factors underlying the current status of women's health. The Commission is expected to report by the end of 2011, paving the way for advocacy and policy action.

93. WHO collaborated with other partners to advocate for the elimination of Female Genital Mutilation (FGM). A report of the mid-term evaluation of the "Regional FGM Action Plan" was produced and disseminated. One of its key findings was that there was increased commitment of Heads of State and First Ladies, especially of Burkina Faso, Eritrea, Ghana, Mali and Nigeria, to lead national efforts to eliminate FGM in their countries.

94. Despite various institutional and national challenges in the African Region, joint efforts to improve the health of women and children resulted in significant progress in 2010. With continued synergistic action of national governments and partners, acceleration of progress towards achieving MDGs 4 and 5 can be realized.

4.5 SO5: Emergencies, Disasters, Crises and Conflicts

95. The aim of Strategic Objective 5 is to prevent or limit morbidity and mortality related to natural and man-made disasters and emergencies including ensuring the safety of health facilities. Work in this area during the year focused on strengthening the capacity of Member States in disaster risk reduction (DRR) and instituting a shift from crisis management to risk management in line with the World Health Assembly resolutions WHA 58.1 and WHA 59.22. The ability to prepare for, respond to and recover from emergencies and public health events is generally improving in the Region and has resulted in mitigation of health consequences and socioeconomic impact.

96. The Region played a leading role in the development of global guidelines for Disaster Risk Management and Emergency Preparedness through advocacy with the Headquarters department and the organization of regional consultations with partners. Hazard maps (e-atlas) have been

developed for all countries in the Region with the technical assistance of the WHO Mediterranean Center on Disaster Risk Reduction as a first step to conducting risk analysis and mapping. During 2010, the cumulative number of countries that have developed and finalized their National Emergency Preparedness Plans covering multiple hazards increased from 13 to 24.

97. Timeliness in responding to emergencies continued to improve as a result of effective technical and logistic support. This was made possible through the functional regional roster of 21 trained emergency experts for rapid deployment and back-up support from Inter-country Support Teams. Delivery time of emergency kits to countries within a week was maintained in 2010 using the United Nations humanitarian depot in Accra.

98. With regard to capacity building WHO facilitated two courses on Health Emergency in Large Populations (HELP) at University of Pretoria, South Africa and at the Regional Public Health Training Institute, Ouidah, Benin. Another course on Public Health in Complex Emergencies was undertaken at the University of Makerere in Uganda. A total of 75 participants were trained in those three courses in 2010. In order to harmonize the content of emergency training courses, a Task Force has been commissioned to revisit curricula and modules for pre-service, in-service and post-service training.

99. The capacity to mobilize resources for emergencies has been improved. Efficient management of funds for SO5 is crucial due to the extremely short duration and high turnover of emergency grants (over 100 projects per year lasting on average 3–6 months). The proportion of expired project funds in the Region was reduced from 25% at the end of 2008 to 3% at the end of 2010 through the use of an on-line tracking system and continuous follow-up between the Regional Office and country offices.

100. Concerted efforts to improve the timeliness and effectiveness of response to emergencies in countries including better coordination of health clusters are yielding positive results. The shift to disaster risk reduction will guide updating of the Regional Strategy for Disaster Preparedness and Response that will be presented to the Sixty-second session of the Regional Committee.

4.6 SO6: Risk factors for health conditions

101. Strategic objective 6 seeks to promote health and development and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and psychoactive substances, unhealthy diets, physical inactivity and unsafe sex. Although health promotion is not a new concept, its appropriate application has required renewed emphasis to ensure comprehensive and multisectoral approaches that achieve results.

102. Mauritania, Namibia, Sierra Leone and Zimbabwe were supported in developing national health promotion policies. Mauritania, Namibia and Sierra Leone were each assisted in developing a Strategic Plan of Action to implement the health promotion policy. Furthermore, Côte d'Ivoire became the 41st Member State in the Region to ratify the WHO Framework Convention on Tobacco Control (WHO FCTC).

103. An intercountry workshop on health promotion and prevention of noncommunicable diseases (NCDs) was held in Harare, Zimbabwe. The workshop brought together 32 health and non-health professionals from 12 Anglophone countries.⁵⁷ The participants were trained in health promotion methods.

104. WHO organized training in the applications of health promotion strategies during disease outbreaks. Twenty-four participants from ministries of health and WHO offices attended the training. The workshop highlighted the important role of social mobilization and the need to conduct research to understand behavioural and cultural factors related to health.

105. Four countries⁵⁸ organized national workshops to develop or update their NCD action plans, focusing on primary prevention for reducing identified risk factors. Currently, 34 Member States have regulations and provisions for tobacco control and seven of these⁵⁹ enacted legislation in 2010. Congo has adopted a national strategic plan for tobacco control.

106. Thirty-one countries of the Region participated in the 4th session of the Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control, held in Uruguay from 15 to 20 November 2010, and 14 countries are members of various working groups established by the COP.

107. Surveillance has strengthened data availability and increased awareness of NCD risk factors in the Region. Angola and Sao Tome and Principe have completed the Global Youth Tobacco Survey and five countries⁶⁰ are planning to repeat the surveys. Six countries⁶¹ completed the STEPS survey and identified risk factors for NCDs. The first set of data has been uploaded into the AFRO database and is accessible to the public. Health risk factors surveillance has been incorporated into Integrated Disease Surveillance and Response (IDSR) to monitor trends.

108. The Sixtieth session of the Regional Committee adopted the Regional Strategy to Reduce Harmful Use of Alcohol in the African Region. Four countries⁶² received technical support to develop evidence-based national alcohol policies. Botswana finalized its policy and the first draft of its national alcohol action plan.

109. A pilot study on alcohol marketing practices in the Region was conducted in Ghana, Nigeria and Uganda. The findings show that policies and legislation are required in order to restrict alcohol marketing and advertising to young people.⁶³ Several NGO leaders, politicians, government officials and members of the media from Botswana, Chad and Namibia were trained to develop evidence-based alcohol policy.

110. The joint United Nations Office on Drugs and Crime (UNODC)/WHO Programme on Drug Dependence, Treatment and Care,⁶⁴ supported Cape Verde to develop a national plan to improve the coverage and quality of services provided to people with drug dependence-related diseases.

111. Cape Verde and Ghana developed country plans for integrating early detection of people at risk of harmful use of alcohol and other drugs using the "Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)."

4.7 SO7: Social and economic determinants of health

112. A regional strategy for addressing the key determinants of health and a related resolution were adopted by the Sixtieth session of the Regional Committee in Malabo, Equatorial Guinea. A review of country cooperation strategies (CCS) showed that 43 countries had included actions on social and economic determinants of health in their CCSs.

113. Four countries⁶⁵ received technical and financial support to undertake a situation analysis of the social and economic determinants of health. Furthermore, Mali and Mozambique each held a workshop to disseminate the key recommendations of the WHO Commission on Social Determinants of Health.

114. The report on *Health aspects of urbanization in Africa* was prepared as part of the 2010 World Health Day commemoration under the theme: Urbanization and Health. The report features the urban health profiles of 10 cities from the African Region showing widening gaps in social disparities within and between cities, particularly in housing, water and sanitation, transportation and access to health services. These inequities and inequalities are partly due to changes in population demography, with rapid growth in urban areas, resulting in unplanned infrastructures.

115. Two workshops were organized on "Mainstreaming gender, equity, human rights and family planning into health programmes". They were attended by participants from 12 West African countries. The workshop outlined the key steps for integrating human rights, equity and gender aspects in health policies and programmes.

4.8 SO8: Healthier environment

116. With the financial support of WHO-Gates Foundation Project on Vector Biology and Control, national capacities for surveillance of insecticide resistance in malaria vectors were strengthened. In addition, an assessment of pesticide management capacities was completed in five countries.⁶⁶

117. Implementation of integrated vector management has been initiated in Ethiopia and Madagascar with financial support from the Global Environment Facility. The Global Plan of Action for Occupational Health has been monitored through a survey in 26 countries.⁶⁷ The survey showed that only half of these countries had developed national policies on occupational health.

118. An analysis of national adaptation programmes of action for climate change has been undertaken to assess the extent to which health has been reflected in the programmes. The assessment concluded that African countries were ill-prepared to cope with the negative impacts of climate change on health. After the assessment, the development of a framework to enhance health resilience to climate change in developing countries was initiated.

119. Twelve countries⁶⁸ conducted needs assessments and situation analyses in order to implement the Libreville Declaration on Health and Environment. Five of them⁶⁹ prepared national plans of joint action. WHO and UNEP jointly coordinate the activities of the Health and Environment Strategic Alliance.

120. The Second Interministerial Conference on Health and Environment in Africa was held in Luanda, Angola, in November 2010. The conference adopted the Luanda Commitment on the implementation of the Libreville Declaration, a Joint Statement of Ministers of Health and Ministers of Environment on climate change and health, and the arrangements for the Health and Environment Strategic Alliance. The programme will continue to implement the Libreville Declaration and strengthen programmes on climate change in the Region.

4.9 SO9: Nutrition, food safety and food security

121. The Strategic Objective seeks to improve nutrition, food safety and food security. To this end, the Sixth-third session of the World Health Assembly adopted resolution WHA63.3 on *Advancing food safety initiatives* and WHA63.23 on *Infant and young child nutrition*. This together with various regional frameworks including Document AFR/RC57/4, *Food Safety and Health: a Strategy for the WHO African Region* adopted in 2007 and the *Africa Regional Nutrition Strategy (2005 to 2015)* formed the basis for nutrition and food safety work in the Region.

122. Working together with partners, including West African Health Organisation (WAHO), *Comité Inter-Etats de Lutte contre la Sécheresse au Sahel* (CILSS), UNICEF, WFP, ECSA, OCEAC, other UN Agencies and African Union/NEPAD, WHO supported countries to strengthen capacities for surveillance; enhance participation in Codex; develop food safety and nutrition legislation, norms, standards, policies, plans and strategies; and strengthen information, education and communication (IEC). WHO continued to participate in the activities of the Food Security cluster and Nutrition Sub-Working Group of the Regional Directors Team (RDT) that developed joint projects.

123. The Regional Nutrition Champion continued advocacy for incorporation of nutrition and food hygiene into the Poverty Reduction Strategies of countries. A framework for strengthening nutrition actions in countries was prepared.

124. Nine countries⁷⁰ were supported to finalize strategies and action plans on the prevention and management of severe malnutrition. Three subregional workshops were held for 26 countries⁷¹ on the new WHO recommendations on infant feeding in the context of HIV, PMTCT and ART. Eight countries⁷² were supported to adapt the new recommendations to their national guidelines.

125. Nutrition indicators were integrated into the IDSR guidelines, for routine monitoring of the nutrition situation in countries. Nutrition surveillance was strengthened in five countries.⁷³

126. WHO jointly with FAO supported African countries in activities of the Codex Alimentarius Commission including revitalization of the National Codex Committee in Gabon and Eritrea to enhance the participation of countries in international standard-setting.

127. Four countries⁷⁴ conducted national training-of-trainers' workshops for over 100 medical and nursing tutors in Infant and Young Child Feeding (IYCF) counselling. Six countries⁷⁵ mobilized funds for training in IYCF counselling. Four countries⁷⁶ conducted IYCF assessment and revised their national strategies based on findings published in a scientific journal.

128. Foodborne disease surveillance was strengthened in the Region by working together with the Global Foodborne Infections Network (GFN) to prevent the spread of outbreaks due to food contamination. GFN level III training in laboratory-based foodborne disease surveillance was organized for 50 epidemiologists and microbiologists from public health, veterinary and food sectors from 10 countries.⁷⁷ The participating countries received laboratory supplies through a donation from CDC, Atlanta to strengthen research and routine data collection.

4.10 SO10: Health services

129. This Strategic Objective aims to improve health services through better governance, financing, staffing and management, taking into account patient safety informed by reliable and accessible evidence and research. The improvement of health services will contribute to the attainment of health Millennium Development Goals.

130. The focus of activities in 2010 was to accelerate the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa and the Algiers Declaration on Research for Health in the African Region. Eighteen countries⁷⁸ continued to strengthen the capacity of their district health systems in the areas of management and integrated delivery of health care.

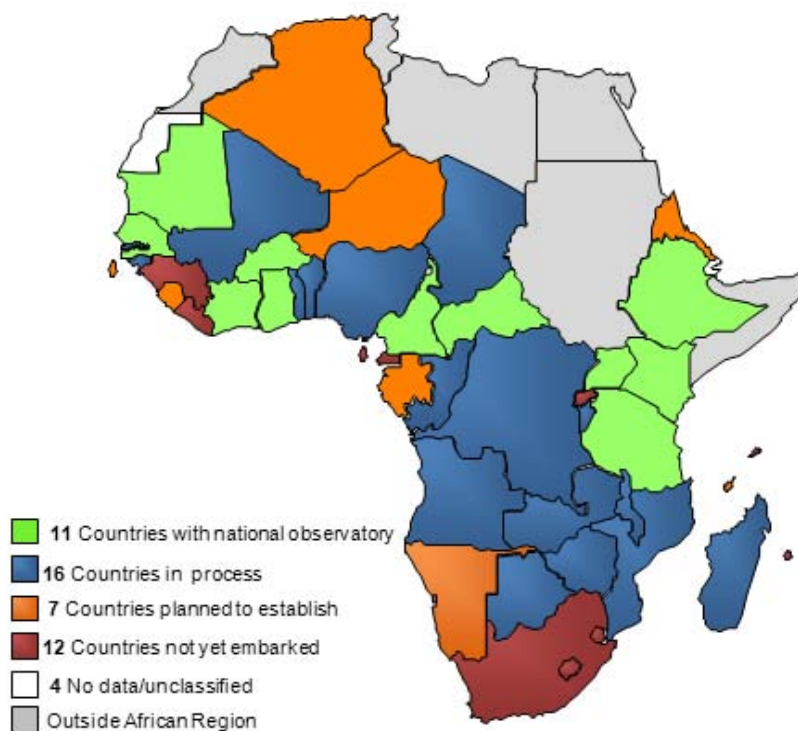
131. The guide to the development of national health policies and strategic plans was revised and is available on the WHO African Region web site. Thirteen countries⁷⁹ revised their national health policies and 14 others⁸⁰ updated their national health strategic plans.

132. Ten countries⁸¹ conducted joint annual health sector reviews on the work and contribution of all stakeholders and partners and assessed the level of alignment to national policies and strategic plans. Comoros and Democratic Republic of the Congo developed a Public Health Code. Burundi, Cameroon and Ghana established mechanisms to strengthen the coordination of partners.

133. In the area of Human Resource for Health (HRH), global guidelines for the retention of health workers in rural areas were launched in South Africa in September 2010. Six countries⁸² developed their national HRH policies or plans.

134. A new HRH regional Observatory web page (www.hrh-observatory.afro.who.int) was developed and launched in English, French and Portuguese. Fifteen countries⁸³ developed their comprehensive HRH country profiles in 2010. In order to improve the generation and use of HRH evidence, five countries⁸⁴ established their national HRH observatories in 2010 (Figure 10) The Sixtieth session of the Regional Committee for Africa adopted the document "eHealth solutions in the African Region: Current context and perspectives", laying the basis for intensified action to leverage information and communication technology in health services.

**Figure 10: Status of establishment of national HRH observatories
in the African Region as of 2010**



135. A network of nursing educators and regulators was formed in West Africa and a joint plan developed with West African Health Organisation to review existing school curricula. By the end of 2010, 20% of the countries had a functional network of researchers and policy/decision makers through the EVIPNet.⁸⁵ Two new WHO collaborating centres in Burkina Faso and Kenya were designated in 2010, bringing to 27 the total number of collaborating centres in the African Region, located in 11 countries.⁸⁶

136. The African Health Observatory (AHO) web portal was completed and populated and further work was undertaken to test the portal and fill the Observatory with content. The Observatory is a collaborative platform that supports and facilitates multi-stakeholder partnership, harmonization and synergy to improve national capacity in the acquisition, generation, dissemination, translation and use of information to improve national health systems. Analytical country profiles were developed for Cape Verde, Congo and Zambia and statistical profiles were produced for all the 46 countries and posted in the web portal.

137. The new AFRO web site (www.afro.who.int) was launched. The African Index Medicus (AIM) continued to record an increasing number of African health and medical publications. For example, new African medical journals were posted in AIM and 11 438 records were added.

138. In the area of health information, evidence and research, WHO continued to strengthen the evidence base for health policy and action at regional and country levels. Angola, Benin and Burkina Faso finalized their health information systems (HIS) strategic plans. Three issues of the African Health Monitor (Figure 11) were produced in 2010.

Figure 11: Cover pages of selected issues of the African Health Monitor



139. The WHO Regional Office for Africa and the African Programme for Onchocerciasis Control (APOC) initiated a multicountry operational research entitled “The delivery of essential health services in Africa: realities and people’s perceptions and perspectives”. Its results will be analyzed in 2011.

140. Sierra Leone and Botswana developed comprehensive health financing policies. Gabon completed an analysis of its health financing system. Benin and Botswana undertook health facility efficiency analyses to improve the use of scarce health sector resources. Eight countries⁸⁷ prepared their national health accounts (NHAs) and disseminated the findings.

141. There was increased awareness and improvements in patient safety at national and institutional levels across the African Region. With WHO support six countries⁸⁸ established partnerships with hospitals in England and Switzerland. National patient safety advocacy days were observed in each of the six countries.

142. Despite various challenges in the Region, strengthening health systems is very high in the agenda and priorities of Member States and WHO, with a focus on the Primary Health Care approach. There is emphasis on the revision/development of national health policies and plans that reflect the Primary Health Care principles and values in order to increase the pace towards the attainment of MDGs.

4.11 SO11: Medical products and technologies

143. The work of WHO in this Strategic Objective supports the development and monitoring of comprehensive national policies to improve the accessibility, quality and use of essential medical products and technologies. WHO develops and promotes evidence-based policy guidance on rational use of medical products and technologies by health workers and consumers.

144. South Africa developed its National Blood Policy while Central African Republic, Malawi, Sierra Leone and Senegal revised and/or finalized their national strategic plans for blood safety.

145. As part of the implementation of Resolution AFR/RC58/R2 on Strengthening Public Health Laboratories, a document entitled "AFRO guidance for establishing a National Laboratory System" was developed and tested. Support was provided to Sierra Leone to develop its national laboratory policy and to Kenya to develop its health technology management policy.

146. With WHO support, regional proficiency testing in haematology and clinical chemistry involving 17 countries, and the External Quality Assessment scheme for enteric and meningitis pathogens, plague, tuberculosis and malaria involving 45 countries, were evaluated and appropriate measures were taken in countries that had poor performance.

147. Strengthening biosafety and laboratory biosecurity is another crucial priority area as the Region is regularly affected by epidemics due to dangerous pathogens such as Ebola, Marburg, and Lassa fever viruses. To help address this issue, 18 Biosafety Officers, Quality Management Officers, and mid-to-senior level laboratory staff with safety responsibilities from six countries⁸⁹ were trained.

148. Thirty-nine Member States⁹⁰ in the Region completed the global survey on medical devices. Currently, 34 Member States⁹¹ have regulations and provisions for tobacco control and seven of these⁹² enacted legislation in 2010.

149. Based on assessments of 26 National Medicines Regulatory Authorities in the African Region a synthesis report⁹³ providing an overview of the regulatory situation in the African Region was published.

150. Strengthening Member States' capacity to ensure the quality, efficacy and safety of medicines is one of the priorities of the Regional Office. In this context, following a decision of the Sixty-third session of the World Health Assembly, the Regional Office organized a task force consultative meeting on prevention and control of substandard/spurious/falsely labelled, falsified/counterfeit medical products. The meeting brought together medicine regulatory experts from Member States. The Sixtieth Session of the Regional Committee endorsed the actions proposed by the task force.

151. A high level interministerial meeting on cross-border public health issues involving seven countries⁹⁴ was held in Abuja, Nigeria, in October 2010. It addressed weak regulatory structures and inadequate intra-country mechanisms to control the circulation of fake and counterfeit medicines in the subregion. The countries agreed to strengthen medicines control using intercountry and intra-country mechanisms to monitor the circulation of counterfeit medicines as well as enforce regulations, including quality control.

152. To mark the end of decade of promotion of the role of traditional medicine in health systems, a special issue⁹⁵ of the African Health Monitor dedicated to traditional medicine was published.

153. During the period under review, WHO supported Benin, Cameroon, Equatorial Guinea, Ethiopia, Madagascar, Malawi, Tanzania, Uganda, the African Union and the African Organization for Intellectual Property to develop advocacy materials to mark the end of a decade of promotion of the role of African traditional medicine in health.

154. In order to provide health care providers and the general public with practical information for dealing with snakes and snakebites within and outside health care facilities, comprehensive guidelines⁹⁶ for the Prevention and Clinical Management of snakebites in Africa were developed and published.

4.12 SO12: Leadership, governance and partnership

155. The focus of the Strategic Objective in 2010 was on provision of leadership, strengthening of governance, and fostering of partnerships and collaboration with countries, and other health and development stakeholders, including within the UN system.

156. During his visits to 12 countries,⁹⁷ the Regional Director advocated for increased investment in the health sector and accelerated effort towards national and international health development goals. He also undertook high-level advocacy visits to Germany, Portugal, the United States of America, the United Kingdom, The World Bank, the Sabin Vaccine Institute, the Centre for Strategic and International Studies (CSIS) and the Vatican to raise international awareness of the health needs of Africa and garner support to effectively address them.

157. The production and dissemination of communication and advocacy materials in the three working languages of the African Region promoted increased public understanding and awareness of WHO's leadership role in health. The work of the Region was further highlighted in 56 media releases and feature articles, 42 Radio and TV programmes, three issues of AFRO News, two issues of *La Toile*, a Malaria newsletter. Most of these materials are available on the AFRO web site, which has experienced a significant increase in the number of viewers.

158. The Sixtieth session of the WHO Regional Committee for Africa in Malabo, Equatorial Guinea, adopted five public health resolutions on (i) the key determinants of health; (ii) reduction of the harmful use of alcohol; (iii) e-Health solutions; (iv) the status of routine immunization and polio eradication; and (v) establishment of the African Public Health Emergency Fund.

159. The Harmonization for Health in Africa (HHA) partnership was recently expanded with new members (USAID, JICA and GFATM). The partnership, led by WHO Regional Office for Africa, has further improved joint advocacy and technical support to countries. Its emphasis continued to be on providing coordinated support to strengthen national health strategic plans (including national compacts), and improving health financing. The latter is addressed in a report on 'The Investment Case for Health in Africa' produced by the HHA partnership. Furthermore, HHA is working to build an alliance between the health sector and the financial sector through joint ministerial meetings.

160. WHO country representatives, with support from the Regional Office and ISTs, actively engaged in the development of United Nations Development Assistance Frameworks (UNDAF) in 17 'roll-out' countries. WHO is the health lead agency within UN country teams in providing support to national development plans.

161. The Regional Office provided technical support to the African Union (AU) Heads of State and Government Summit on the theme "Maternal, neonatal and child health and development in Africa", and assisted in the

preparations for the AU Conference of Health Ministers. Technical support was provided to WAHO/ECOWAS and SADC in the prevention and control of HIV/AIDS and communicable diseases and in capacity building for resource mobilization.

162. Mapping of Country Cooperation Strategies against MTSP Strategic Objectives, carried out for 45 countries, led to the identification of common regional priorities; this will guide planning and resource allocation in the preparation of the next biennial Programme Budget.

4.13 SO13: Efficient and effective WHO

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

164. For the year 2010, the main focus of SO13 activities concerned: (i) successful implementation of the Global Management System (GSM); (ii) responding to the financial crisis affecting the whole Organization in general and the African Region in particular; (iii) continuous improvement of the support provided to technical programmes in countries.

165. The Global Management System (GSM) aims to streamline administrative processes, enhance financial and programmatic transparency, and improve timeliness and effectiveness in the delivery of health activities. In anticipation of GSM implementation in January 2011, significant effort and attention was directed at validating data prior to conversion, upgrading IT infrastructure and network security, and establishing system and user support structures such as the Help desk.

166. By 31 December 2010, 287 workplans from all AFRO offices, comprising 2540 office-specific expected results, 7000 products and services, and 21 400 activities were converted to the GSM.

167. Over 3000 positions in the Region were established in GSM, and 2600 active staff were pay-rolled in the global system. In addition, more than 5000 suppliers of goods and services – WHO contractors in the Africa Region - were recorded and available in GSM for placing orders.

168. All regional staff — Executive Management, WHO Representatives, IST Coordinators, Programme Managers and administrative support personnel — were trained in GSM roles, responsibilities and operations before the system became operational.

169. On 4 January 2011, all offices and staff in the Region were able to connect to and access GSM despite concerns previously expressed about inadequate IT infrastructure. The Executive Board of WHO recognized the successful rollout of GSM in the African Region, thereby completing global implementation of the new system as a major achievement for the entire Organization.

170. The successful roll out was achieved despite unprecedented financial pressure on the Region at the time. A number of initiatives and austerity measures were put in place to mitigate risks to the delivery of major health technical programmes. These included reorganizing operations and reallocating staff to priority areas, freezing recruitment, using video conferencing in lieu of travel, reducing mailing of diplomatic pouches (resulting in lowering costs by 37% since 2009), and making increased use of internal printing capacity rather than external contractors.

171. Moreover, a number of projects aimed at improving facilities and staff working conditions were undertaken to improve programme delivery. These included refurbishing meeting rooms, offices and equipment; building and outfitting a secure SHOC Room for use in emergencies; and establishing Cold Rooms for vaccine storage.

172. Notwithstanding the above-mentioned achievements, many challenges remain in order to adapt operations to a new management system (GSM) and to the reality of fiscal constraints. Nevertheless, the administrative units that contribute to Strategic Objective 13 continue to strive to improve the delivery of timely, high quality support to enable efficient implementation of health programmes in countries and across the Region.

CHALLENGES, CONSTRAINTS and LESSONS LEARNT

5

5.1 Challenges and constraints

173. Across all the Strategic Objectives, one of the main challenges is to ensure adequate coverage of essential interventions and services in order to make the required progress towards achieving regional and global health goals. In immunization, for example, the challenges resulted in inadequate immunization coverage, with approximately 6.8 million eligible children not receiving DPT3 vaccination in 2010 and 28 countries experiencing measles outbreaks with a cumulative total of 223 016 cases and 1193 related deaths. Service coverage has been inadequate in other areas, including in the prevention of HIV/AIDS, TB and malaria; the provision of maternal and child health services; the control of NTDs; and the prevention and control of epidemics of communicable diseases.

174. The key factors associated with this are related to the persistent weakness of health systems, related to all the components. Countries are still facing challenges related to availability of costed national health strategic plans; adequate human resources with the required range of competencies; procurement and supply management systems that ensure the availability of medicines, vaccines and diagnostic technologies; data and information systems that allow the monitoring and projection of disease trends and evaluation of interventions and programmes; and effective accountability mechanisms that involve civil society.

175. The number and range of actors engaged in health has continued to increase, presenting challenges in aligning contributions to national priorities and in coordinating actions. In the control of NTDs, for example, the global momentum has led to an increase in partners which, due to weak coordination, has compromised the capacity for implementation and monitoring of schistosomiasis and soil-helminths control programmes in countries. The multiplicity of health initiatives and health actors in the regional health development arena calls for a stronger brokerage role by WHO.

176. The global financial crisis has adversely affected the magnitude of voluntary contributions to WHO in the African Region. This has exacerbated the existing earmarking of income and inability to protect priority programmes in WHO, such as control of HIV/AIDS, TB and malaria, and maternal and child health.

177. In the area of human resources management, the financial crisis is negatively affecting the funding of activities and staff positions at the Regional Office and country offices.

5.2 Lessons learnt

178. There is an increased demand for WHO technical support to Member States in the African Region. Resource mobilization will be critical to meet this increasing demand.

179. Collaboration with partners including regional economic communities facilitated implementation of planned activities.

180. In order to achieve planned results within the prevailing tight global financial situation, it is vital to work effectively with other UN agencies and optimize the capacity to support countries within UNDAFs at country level, leveraging the resources allocated for joint UN work. Country Cooperation Strategies are instrumental to harmonize and align WHO and other development partners' contribution to national health policies and plans. Focusing the limited available resources on activities that have the greatest impact towards planned expected results will also be an important adjustment to the situation.

WAY FORWARD 6

181. Priority will be given to providing support to countries to accelerate progress towards the Millennium Development Goals.

182. The Regional Office will focus on the implementation of World Health Assembly and Regional Committee resolutions as well as the Strategic Directions for WHO 2010–2015 as set forth below:

- (a) Continued focus on WHO's role in the provision of normative and policy guidance as well as strengthening partnerships and harmonization;
- (b) Supporting the strengthening of health systems based on the primary healthcare approach;
- (c) Putting the health of mothers and children first;
- (d) Accelerated actions on HIV/AIDS, malaria and tuberculosis;
- (e) Intensifying the prevention and control of communicable and noncommunicable diseases; and
- (f) Accelerating response to the determinants of health.



**Table 1: WHO Medium Term Strategic Plan 2008–2013:
Statement of Strategic Objectives**

01	To reduce the health, social and economic burden of communicable diseases.
02	To combat HIV/AIDS, malaria and tuberculosis.
03	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
04	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
05	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
06	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
07	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and 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.

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

SOs	Regional Office / ISTs			Country Offices			Total African Region		
	AC	VC	Total	AC	VC	Total	AC	VC	Grand Total
SO 1	4875	109 782	114 657	11 780	297 683	309 463	16 655	407 465	424 120
SO 2	4686	79 952	84 638	4662	118 908	123 570	9348	198 860	208 208
SO 3	3226	4446	7672	4934	6838	11 772	8160	11 284	19 444
SO 4	5443	36 244	41 687	10 086	55 962	66 048	15 529	92 206	107 735
SO 5	1563	22 403	23 966	1877	72 939	74 816	3440	95 342	98 782
SO 6	3218	6884	10 102	5151	8690	13 841	8369	15 574	23 943
SO 7	2102	1490	3592	2961	1942	4903	5063	3432	8495
SO 8	1595	5405	7000	3263	6072	9335	4858	11 477	16 335
SO 9	1729	17 372	19 101	2538	15 543	18 081	4267	32 915	37 182
SO 10	8100	32 407	40 507	10 933	72 595	83 528	19 033	105 002	124 035
SO 11	2457	3796	6253	2826	10 584	13 410	5283	14 380	19 663
SO 12	8847	6526	15 373	34 362	0	34 362	43 209	6526	49 735
SO 13	28 831	53 965	82 796	37 555	4836	42 391	66 386	58 801	125 187
TOTAL	76 672	380 672	457 344	132 928	672 592	805 520	209 600	1 053 264	1 262 864

END NOTES

1. World Health Organization (2006): Engaging for Health, Eleventh General Programme of Work 2006–2015, A Global Health Agenda for Action.
2. World Health Organization (2008): Amended Medium-term Strategic Plan 2008–2013 and Programme-Budget 2010–2011.
3. Gambia, Kenya, Rwanda, Sierra Leone and South Africa.
4. Comoros, Ethiopia, Gambia, Madagascar, Mauritius, Mozambique, Nigeria, Seychelles, South Africa, Swaziland, Tanzania and Zambia.
5. Benin, Cameroon, Central African Republic, Chad, Equatorial Guinea, Niger and Nigeria.
6. Botswana, Namibia, Swaziland and Tanzania.
7. Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Congo, Côte d'Ivoire, Gabon, Ghana, Guinea-Bissau, Lesotho, Sierra Leone, South Africa, Swaziland and Tanzania.
8. Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Congo, Ghana, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa and Swaziland.
9. Burkina Faso, Central African Republic, Côte d'Ivoire, Equatorial Guinea, Guinea, Liberia, Sao Tome and Principe, and Sierra Leone.
10. Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Gabon, Guinea, Kenya, Lesotho, Mali, Nigeria, Rwanda, Senegal, South Africa and Zimbabwe.

11. Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Senegal and Togo.
12. Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Guinea, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, Swaziland, Togo, Uganda and Zimbabwe.
13. Kenya, Senegal, South Africa and Uganda.
14. Angola, Burundi, Côte d'Ivoire, Democratic Republic of Congo, Madagascar, Sao Tome and Principe, and Senegal.
15. Botswana, Cameroon, Chad, Namibia, Rwanda, Swaziland, Tanzania and Zimbabwe.
16. Algeria, Benin, Burundi, Comoros, Democratic Republic of Congo, Ghana, Kenya, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Tanzania and Zambia.
17. Algeria, Angola, Kenya, Lesotho, Namibia, Tanzania and Zambia.
18. Global Tuberculosis Control 2010.
19. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
20. Botswana, Burkina Faso, Kenya, Lesotho, Mozambique, Namibia, South Africa and Swaziland.
21. Algeria, Benin, Botswana, Burundi, Burkina Faso, Cameroon, Democratic Republic of Congo, Eritrea, Ethiopia, Guinea-Bissau, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, Senegal, South Africa, Swaziland, Zambia and Zimbabwe.
22. Botswana, Malawi, Mozambique, Namibia, Senegal, South Africa, Swaziland, Tanzania and Zambia.
23. Angola, Gambia, Kenya, Liberia and Zimbabwe.
24. Angola, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mozambique, Nigeria, Senegal, Sierra Leone, Swaziland, Tanzania, Zambia and Zimbabwe.
25. WHO, World Malaria Report 2010, Geneva, World Health Organization 2010.
26. Algeria, Angola, Benin, Botswana, Burundi, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mozambique, Namibia, Rwanda, Sao Tome and Principe, Senegal, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.

27. Algeria, Angola, Botswana, Burkina Faso, Burundi, Cape Verde, Central African Republic, Comoros, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, Tanzania and Zambia.
28. Benin, Botswana, Kenya, Malawi, Mozambique, Namibia, Niger, Rwanda, Senegal, South Africa, Togo and Zambia.
29. Angola, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
30. Burundi, Eritrea, Ethiopia, Kenya, Rwanda, Tanzania and Uganda.
31. Benin, Botswana, Burkina Faso, Eritrea, Kenya, Malawi, Namibia, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
32. Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana, Mauritania, Namibia, Niger, Senegal, Tanzania and Zimbabwe.
33. Burkina Faso, Central African Republic, Gabon, Guinea, Madagascar, Niger, and Sao Tome and Principe.
34. Madagascar, Mali, Mauritania, Namibia, Niger, Rwanda, Sierra Leone, Tanzania, Zambia and Zimbabwe.
35. Benin, Burkina Faso, Mali, Niger, Senegal and Togo.
36. Benin, Botswana, Eritrea and Mozambique.
37. Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Mozambique and Rwanda.
38. Guinea-Bissau, Lesotho, Liberia and Malawi.
39. Angola, Benin, Burkina Faso, Burundi, Chad, Congo, Côte d'Ivoire, Malawi, Madagascar and Niger.
40. Angola, Central African Republic, Equatorial Guinea, Liberia, Mauritania, Sierra Leone and Tanzania.
41. Angola, Cameroon, Eritrea, Guinea-Bissau, Kenya, Senegal, Togo, Zambia and Zimbabwe.
42. Angola, Burkina Faso, Cameroon, Central African Republic, Chad, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

43. Burkina Faso, Cameroon, Democratic Republic of Congo, Togo and Uganda.
 44. Angola, Benin, Burkina Faso, Burundi, Congo, Ghana, Kenya, Liberia, Malawi, Mali, Niger, Senegal, Sierra Leone, South Africa and Tanzania.
 45. Algeria, Cape Verde, Eritrea, Liberia, Madagascar, Mauritius and Seychelles.
 46. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
 47. Democratic Republic of Congo, Ethiopia, Kenya, Nigeria, Rwanda and Tanzania.
 48. Botswana, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.
 49. Benin, Burkina Faso, Burundi, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Togo, Uganda and Zambia.
 50. Benin, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Congo, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
 51. Benin, Botswana, Burkina Faso, Central African Republic, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
 52. Cape Verde, Central African Republic, Côte d'Ivoire, Liberia, Niger and Sierra Leone.
 53. Botswana, Cameroon, Cape Verde, Central African Republic, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Tanzania, Togo and Zambia.
 54. Central African Republic, Guinea, Liberia, and Sao Tome and Principe
 55. Cape Verde, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Senegal and Togo.
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56. Angola, Burundi, Central African Republic, Cameroon, Chad, Comoros, Congo, Equatorial Guinea, Gabon, Madagascar, and Sao Tome and Principe.
57. Ethiopia, Eritrea, Lesotho, Gambia, Kenya, Malawi, Namibia, Nigeria, Rwanda, Swaziland, Zambia and Zimbabwe.
58. Benin, Botswana, Cape Verde and Mauritania.
59. Burkina Faso, Chad, Comoros, Ethiopia Mali, Namibia and Togo.
60. Eritrea, Ethiopia, Seychelles, Uganda and Zambia.
61. Central African Republic, Eritrea, Gambia, Guinea, Mauritania and Togo.
62. Botswana, Ghana, Malawi and Namibia.
63. World Health Organization, Monitoring alcohol marketing in Africa. Brazzaville: WHO Regional Office for Africa, 2011.
64. UNODC-WHO Joint Programme on Drug dependence and care. Austria: UNODC, WHO, May 2009.
65. Guinea-Bissau, Mali, Sierra Leone and Uganda.
66. Cameroon, Kenya, Madagascar, Senegal and Tanzania.
67. Algeria, Botswana, Central African Republic, Comoros, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Mauritania, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Togo, Uganda, Zambia and Zimbabwe.
68. Angola, Cameroon, Congo, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Madagascar, Mali and Tanzania.
69. Cameroon, Gabon, Kenya, Madagascar and Mali.
70. Malawi, Mozambique, Namibia, Lesotho, Niger, Rwanda, Swaziland, Tanzania and Zimbabwe.
71. Angola, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d' Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
72. Botswana, Cameroon, Ethiopia, Kenya, Namibia, Nigeria, Tanzania and Zimbabwe.
73. Angola, Central African Republic, Chad, Equatorial Guinea and Lesotho.
74. Côte d'Ivoire, Mauritania, Rwanda and Togo.
75. Ghana, Guinea, Kenya, Malawi, Nigeria and Zambia.

76. Ghana, Côte d'Ivoire, Tanzania and Togo.
77. Eritrea, Ethiopia, Kenya, Ghana, Malawi, Nigeria, Rwanda, Tanzania, Uganda and Zambia.
78. Botswana, Burkina Faso, Burundi, Cape Verde, Eritrea, Ethiopia, Guinea, Guinea-Bissau, Lesotho, Malawi, Mauritania, Namibia, Niger, South Africa, Swaziland, Tanzania, Uganda and Zambia.
79. Benin, Botswana, Burkina Faso, Burundi, Eritrea, Gabon, Malawi, Namibia, Nigeria, Sierra Leone, Togo, Uganda and Zambia.
80. Benin, Burkina Faso, Burundi, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Guinea-Bissau, Niger, Sierra Leone, Togo, Uganda and Zambia.
81. Burkina Faso, Ghana, Kenya, Lesotho, Madagascar, Mauritania, Niger, Togo, Uganda and Zambia.
82. Central African Republic, Comoros, Eritrea, Kenya, Liberia and Zimbabwe.
83. Benin, Botswana, Burkina Faso, Burundi, Central African Republic, Ghana, Lesotho, Malawi, Mali, Namibia, Rwanda, Senegal, Swaziland, Togo and Zambia.
84. Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire and Kenya.
85. List of EVIPNet countries: Algeria, Benin, Botswana, Burkina Faso, Central African Republic, Ghana, Madagascar, Nigeria, Senegal, South Africa, Uganda and Tanzania.
86. Algeria, Benin, Botswana, Burkina Faso, Ghana, Madagascar, Nigeria, Senegal, South Africa, Uganda and Tanzania.
87. Angola, Burkina Faso, Cape Verde, Democratic Republic of Congo, Guinea-Bissau, Mauritania, Nigeria and Togo.
88. Cameroon, Ethiopia, Malawi, Mali, Senegal and Uganda.
89. Botswana, Kenya, Nigeria, South Africa, Uganda and Zambia.
90. AFRO Member States except Algeria, Congo, Equatorial Guinea, Lesotho, Malawi, Nigeria and Rwanda.
91. Algeria, Benin, Botswana, Burkina Faso, Cameroon, Cape Verde, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Equatorial Guinea, Gabon, Gambia, Guinea, Kenya, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

92. Burkina Faso, Chad, Comoros, Ethiopia, Mali, Namibia and Togo.
93. Assessment of medicines systems in sub-Saharan African countries, WHO/EMP/QSM/2010.4.
94. Benin, Cameroon, Central African Republic, Chad, Equatorial Guinea, Niger and Nigeria.
95. The African Health Monitor, Special Issue 31 August, WHO/AFRO 2010.
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97. Angola, Burkina Faso, Congo, Equatorial Guinea, Gabon, Liberia, Mali, Nigeria, Senegal, South Africa, Uganda and Zambia.

