75 HEALTH FOR ALL

World Health Organization

African Region

ANNUAL REPORT

JULY 2022-JUNE 2023

OF THE REGIONAL DIRECTOR ON
THE WORK OF WHO IN THE AFRICAN REGION

Annual Report of the Regional Director on the work of WHO in the African Region, July 2022–June 2023

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REPORT

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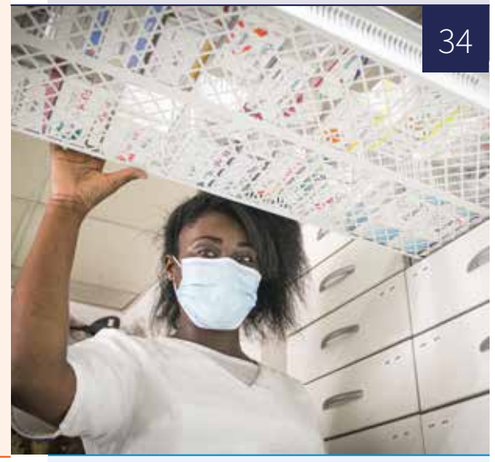
THE REGIONAL DIRECTOR ON THE WORK OF WHO IN THE AFRICAN REGION

CONTENTS



FOREWORD

In a year when our work focused on building responsive and inclusive health systems and saw an end to COVID-19 as a global health emergency, the Secretariat supported Member States in the African Region to transition to new working methods.

This report presents the results of the work of the WHO Secretariat in the African Region during the period 1 July 2022–30 June 2023. We supported countries in the Region to recover and address the losses engendered by the COVID-19 pandemic, respond to health emergencies resulting from infectious disease outbreaks and effects of climate change, and build strong primary health care foundations for national health systems. Multisectoral action to promote health and well-being was also supported.

As part of the Transformation Agenda, we continued to take action to ensure a fit-for-purpose organization that is responsive to the needs of its Member States.

I acknowledge with gratitude the immense efforts of governments, health care workers, partners, communities, and other stakeholders who, together with WHO, responded to the health needs of the people.

We cherish our partnerships with the African Union (AU), the Africa Centres for Disease Control and Prevention, bilateral and multilateral partners including UN entities, financial partners, civil society, academia, and the private sector.

Maintaining these hard-fought victories will require more sustainable investments, strong partnerships including with the private sector, effectively engaging communities and addressing social and economic determinants of health.

As WHO commemorates her 75th Anniversary this year, it is an important opportunity to reflect on the important lessons that we have learnt over the years and use them to adopt innovative strategies that will accelerate progress towards universal health coverage, health security and sustainable development.

Dr Matshidiso Moeti
World Health Organization
Regional Director for Africa

KEY RESULTS

JULY 2022-JULY 2023

THE DRC WAS CERTIFIED FREE OF
GUINEA-WORM DISEASE TRANSMISSION
in December 2022
bringing to **42 the total number of Member States** in the Region certified **guinea-worm-free.**

More than
4.5 MILLION CHILDREN
IN GHANA, KENYA, AND MALAWI
were vaccinated against malaria with the RTS,S/AS01 vaccine.

90% OF MEMBER STATES
in the WHO African Region
ACHIEVED THE CAPACITY
to genetically sequence confirmed SARS-CoV-2 isolates.

5 COUNTRIES
in the
WHO African Region
ACHIEVED THE
95-95-95 HIV/AIDS TARGETS
and an additional eight countries in the Region are very close to achieving them.

MORE THAN
209 MILLION DOSES
of COVID-19 vaccine
WERE ADMINISTERED IN THE WHO AFRICAN REGION
By June 2023, primary series COVID-19 vaccine coverage was 30%, an increase from 20% in June 2022.

TIMELY CONTAINMENT OF ACUTE OUTBREAKS:
- Ebola in DRC (within 3months) and Uganda (within 4 months);
- Marburg in Equatorial Guinea and Tanzania (within 3 months each).

122 MILLION CHILDREN
in 23 countries in the WHO African Region were vaccinated during
POLIO OUTBREAK RESPONSE IMMUNIZATION CAMPAIGNS.
The last confirmed wild poliovirus case in the Region was reported in August 2022.

7 COUNTRIES
ELIMINATED AT LEAST ONE NEGLECTED TROPICAL DISEASES (NTDS)
as a public health problem.

THE REGIONAL eHEALTH STRATEGY
jointly developed by **WHO and the International Telecommunication Union (ITU) guided the**
DEVELOPMENT OF NATIONAL DIGITAL HEALTH STRATEGIES IN 4 COUNTRIES AND TELEMEDICINE ROAD MAPS IN 17 COUNTIRES

4 AUG

HEALTHY LIFE EXPECTANCY INCREASED BY ALMOST 10 YEARS IN AFRICA

WHO ANNOUNCES THAT HEALTHY LIFE EXPECTANCY IN AFRICA INCREASED BY ALMOST 10 YEARS BETWEEN 2000 AND 2019

(Tracking Universal Health Coverage in the WHO African Region, 2022 report)

22 AUG

WHO CERTIFIES TOGO

as having eliminated lymphatic filariasis human African trypanosomiasis and guinea-worm disease.

25 AUG

The Regional strategy for health security and emergencies **2022–2030**

was endorsed by African Health Ministers during the **Seventy-second session of the WHO Regional Committee for Africa.**

21 SEP

WHO validates Malawi for eliminating trachoma as a public health problem. It is the fourth country in the African Region to achieve this significant milestone.

16 SEP

END OF Marburg outbreak 2 PEOPLE DIED

Ghana announces the end of its **first-ever Marburg outbreak, after nearly two months.** Three cases were confirmed, with two deaths.

27 SEP

Vaccinantion of + 500 PEOPLE

The DRC declares its 15th Ebola outbreak over after six weeks, with only one confirmed case. Over 500 people were vaccinated against Ebola soon after the declaration of the outbreak.

17 NOV

WHO convenes a high-level human resources for health (HRH) policy dialogue, attended by ministries of health and finance from 26 countries together with key development, bilateral, multilateral and international financing partners, and commits to the development of an African health workforce investment charter.

1 DEC

Official launch of the Atlas of African Health Statistics 2022, a comprehensive tool for monitoring the health situation in the WHO African Region.

8 DEC

The first doses of **one of three candidate vaccines against Sudan ebolavirus arrive in Uganda** for evaluation in a clinical trial.

11 JAN

END OF Ebola outbreak 4 MONTHS LATE

Uganda declares the end of the Ebola disease outbreak caused by Sudan ebolavirus, less than four months after the first case was confirmed.

23 JAN

WHO certifies Ghana for **eliminating human African trypanosomiasis.**

4 JUL

The Democratic Republic of the Congo declares the end of its Ebola outbreak after three months. Five people died, compared to 55 in the previous outbreak in 2020.

2 JUN

The United Republic of Tanzania declares the end of its first-ever Marburg virus disease outbreak after slightly over two months.

8 JUN

END OF MARBURG OUTBREAK

Equatorial Guinea's first-ever outbreak of Marburg virus disease ends after less than four months.

25 MAY

WHO and the Africa Centres for Disease Control and Prevention (Africa CDC) launch a five-year Joint Emergency Preparedness and Response Action Plan (JEAP) **to strengthen continental emergency preparedness and response systems.**

24 MAY

At the Seventy-sixth World Health Assembly, the WHO Regional Office for Africa, together with African governments and Amref Health Africa, launched a **regional initiative to tackle the health impacts of climate change in Africa.**

5 MAY

WHO declares that COVID-19 **no longer constitutes a public health emergency of international concern (PHEIC).**

16 MAY

6 COUNTRIES ELIMINATED TRACHOMA

Benin and Mali are validated by WHO as the fifth and sixth **countries in the African Region to eliminate trachoma as a public health problem.**

3 MAY

UNIVERSAL HEALTH PREPAREDNESS REVIEW

Sierra Leone becomes the second African country to undertake a **national Universal Health Preparedness Review to bolster health preparedness and response capacity.**

"THE BIG CATCH UP" 33 MILLION CHILDREN in Africa

20 APR

WHO, UNICEF, Gavi, the Vaccine Alliance and IA2030 launch "The Big Catch-Up" campaign to address an estimated backlog of **33 million children in Africa who need to be vaccinated before 2025 to put the continent back on track to achieve the 2030 global immunization goals.**

8 MAR

WHO in the African Region and the United Nations Volunteers (UNV) Programme launch the second phase of the Africa Women Health Champions (AWHC) initiative, **to recruit young African women professionals to continue driving the Region's health agenda.**

17 MAR

POLIO VACCINATION

WHO supports Burundi to ramp up polio vaccination, after the **country declares an outbreak of circulating vaccine-derived poliovirus type 2 (cVDPV 2),** the first such outbreak in more than three decades.

9 FEB

EXPONENTIAL RISE IN CHOLERA CASES

WHO warns of an exponential rise in cholera cases, with **the number of cases recorded in the first month of 2023 already totalling more than 30% of the total caseload for 2022.** Between 1 and 29 January, nearly 80 000 cases and 1863 deaths were recorded in 15 countries.

EXECUTIVE SUMMARY

During the period covered by this report, the WHO Secretariat in the African Region continued to support Member States in their efforts to effectively respond to the COVID-19 pandemic, reinforce the delivery of essential health services and respond to other public health emergencies. WHO also supported actions by Member States to accelerate progress towards universal health coverage (UHC) and health security by strengthening national health systems that are anchored to a strong primary health care (PHC) foundation.

Leading up to the COVID-19 pandemic, the WHO African Region had experienced a steady improvement in health and well-being. A person born in 2021 had an additional 10 years of healthy life expectancy compared to one born in 2000.[1]

Effective implementation of whole-of-government, whole-of-society COVID-19 national response strategies and plans resulted in decreasing numbers of COVID-19 deaths, COVID-19-related hospitalizations and increasing population immunity to SARS-CoV-2 in the African Region and globally. On 5 May 2023, the WHO Director-General determined that COVID-19 no longer constituted a public health emergency of international concern (PHEIC). By the end of June 2023, the WHO African Region had registered over 9.5 million cases of COVID-19 and 175 000 COVID-19 deaths. Surveillance has been strengthened in all countries in the Region, with up to 90% of the countries in the Region now having the capacity for genetic sequencing of confirmed SARS-CoV-2 specimens. By June 2023, primary series COVID-19 coverage in the WHO African Region stood at 30%, an increase from the 20% COVID-19 vaccination coverage rate in 2022.

Disruptions in the delivery of essential health services due to the COVID-19 pandemic negatively impacted utilization of these services. The overall utilization of essential services (measured by the UHC service coverage index) in the WHO African Region declined in 2021, constituting the first decline observed since 2000.[2]

DURING THE REVIEW PERIOD,
the Regional Office mobilized and utilized

US$ 1.219 BILLION

- strengthen health systems, as well as;
- promote, provide and protect health.

The Regional Office mobilized and utilized US$ 1.219 billion over the review period, to support implementation of health programmes across its 47 Member States.

Despite the challenges, the success stories in this report demonstrate how WHO in the African Region, working closely with partners, is supporting Member States to strengthen health systems, as well as promote, provide and protect health.

IMPACT OF THE TRANSFORMATION AGENDA

The Secretariat's Transformation Agenda continued to produce results towards strengthening the health leadership role of WHO and ensuring a fit-for-purpose organization that responds optimally to the needs of its Member States. The focus over the review period was on strengthening WHO's engagement at country level; strengthening partnerships; harnessing young talent; and fostering a productive work environment through improved team performance. Prevention of sexual exploitation, abuse and harassment (PRSEAH) remained high on WHO's agenda. This was enhanced through training and awareness-building among staff, community members and implementing partners.

To continue building diversity, equity and inclusivity, a women's speaker series honed the leadership skills of women within the Organization, while the Africa Women Health Champions initiative proved highly successful in attracting more young professionals. This contributed to ongoing improvements in the ratio of women within overall staffing structures. The focus on youth also gained notable momentum, with 428 young interpreters from 19 Member States participating in the AFRO online conference interpretation internship programme. WHO and the United Nations Volunteers programme successfully deployed 120 Health Champions representing 36 nationalities and covering over 25 professional areas, to 34 countries.

WHO & THE UN VOLUNTEERS PROGRAMME

428 YOUNG INTERPRETERS from **19 MEMBER STATES** receiving training

- **120 HEALTH CHAMPIONS** representing 36 nationalities
- **34 NATIONALITIES** over 25 professional areas

ERADICATION OF WILD POLIOVIRUS IN THE WHO AFRICAN REGION

In its commitment to quell the polio resurgence and stamp out the disease, the Secretariat strengthened human and institutional capacity and provided funding to support both routine and supplementary immunization activities (SIA). As a result, more than 122 million children in 23 countries were vaccinated during coordinated outbreak response campaigns. All 47 Member States sustained functional polio surveillance systems. Genetic sequencing capacity was stepped up through training and testing technologies, and eight laboratories in the Region now have sequencing capacity. Countries are successfully leveraging existing polio structures and assets to support other crucial public health priorities.

PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

Prior to the pandemic, the WHO African Region was making notable progress towards UHC. Over the review period, progress was made in strengthening the health systems of Member States. This was especially important to recover the pandemic-related losses. Health sector governance at country level was supported through the development of sector strategies that incorporated lessons learnt from the COVID-19 pandemic to build the resilience of systems and communities. Development of legal frameworks for UHC is ongoing, in partnership with the Inter-Parliamentary Union and the International Labour Organization. Private sector resources and expertise, which proved crucial during the pandemic response, were also harnessed to support UHC, through strengthened public-private sector engagements in seven countries.

To improve access to quality essential health services, the Secretariat supported evidence-based planning and implementation approaches in countries and quality improvement initiatives, while embracing innovation and technologies to enhance service delivery and ensure no one is left behind. The provision of tools, funding and technical support enabled several countries to conduct programme reviews for HIV, tuberculosis and malaria. The evidence generated informed the development of subsequent programme strategies to guide implementation, resource mobilization and allocation, and to align partners with common objectives. Improved surveillance boosted malaria control in seven countries that developed and implemented evidence-based vector control strategies.

Quality of care improvements were pursued by updating health service policies, guidelines and testing algorithms. Six countries were provided with tools and expertise to review HIV pre-exposure prophylaxis (PrEP) and testing algorithms, while 30 countries updated their multidrug resistance TB treatment policies. Sector-wide approaches to quality improvement were implemented in 17 countries that developed and are

implementing national quality strategies and plans. This number more than doubled, from only eight in 2021.

The Secretariat supported Member States to increase coverage of essential interventions, through the provision of tools and technical assistance to develop essential health service packages that respond to the health needs of the population. Guidance provided on the operationalization of PHC in the African Region will inform the design of responsive service delivery models. Equity is a core component of the UHC agenda, and the Secretariat supported 43 Member States to mainstream gender, equity and human rights in health planning and implementation. Strong partnerships availed resources to support gender programme implementation and recruitment of staff at the regional level.

Payments at the point of seeking health services are still a barrier to access in Africa, which is home to two in every three of the world's poorest people who make out-of-pocket payments for health. Commitment to tackling financial barriers to access was galvanized through the endorsement of the report on "Financial risk protection towards universal health coverage in the WHO African Region" by the Seventy-second Regional Committee, while emphasis on prioritizing funding for PHC was endorsed by the 20 countries of the East and Southern African subregion following a dialogue that resulted in an outcome statement and the development of country road maps.

FINANCIAL RISK PROTECTION & UNIVERSAL HEALTH COVERAGE
IN THE WHO AFRICAN REGION

endorsed by the

20 countries
of East & Southern Africa

To counter significant health worker shortages in the Region, WHO AFRO focused on generating evidence to guide regional- and country-level dialogue to renew the commitment to address the crisis. The development of an Africa Health Workforce Investment Charter served to guide collective action at regional level, with three countries developing human resource investment plans.

Efforts to ensure sustainable access to quality essential medicines centred on building regulatory capacity through national regulatory agencies. WHO AFRO supported both formal and self-assessments, with identified weaknesses informing the development of institutional development plans which are currently being implemented. Strengthened regulatory capacity will also support local manufacturing and promote research, especially clinical trials. WHO continued to provide strategic support for the African Medicines Agency (AMA).

To address the consistently low coverage of noncommunicable disease interventions despite the rising burden of disease in the Region, countries were supported to integrate the WHO Package of Essential Noncommunicable (WHO PEN) disease interventions into primary health services.

In Ghana, Zimbabwe, and Ethiopia, among other countries, mental health is being rolled out through WHO's mhGAP training for primary health care workers. In Zimbabwe, the training increased availability of mental health and psychosocial support services to 131 000 people, achieved through the training of close to 3000 health care workers or persons working in community mental health organizations as part of the COVID-19 response.

Significant progress was registered in the control and elimination of neglected tropical diseases (NTDs), with seven countries eliminating at least one NTD as a public health problem. The Democratic Republic of the Congo was certified free of the local transmission of guinea-worm disease, while Benin, Malawi and Togo eliminated trachoma, and Ghana, human African trypanosomiasis. Burkina Faso, Mali, Niger and Senegal reduced the prevalence of soil-transmitted helminthiases (STH) to less than 2%.

Efforts to reverse the huge increase in unvaccinated and undervaccinated children in the Region are underway through the implementation of the multipartner-supported 'Big Catch-up" campaign. Measles mass vaccination campaigns in 17 countries reached 87 million children aged six months to 15 years with supplementary doses of measles-containing vaccine. Forty-six of the 47 Member States in the Region increased coverage of the COVID-19 vaccine primary series. The regional COVID-19 vaccination coverage increased from 20% in June 2022 to 30% in June 2023.

1.5 MILLION CHILDREN
WERE VACCINATED
with the first malaria vaccine through a WHO-coordinated pilot programme

Several countries were supported to add new vaccines to their routine immunization schedules. The human papillomavirus (HPV) vaccine was introduced in three countries, the typhoid conjugate vaccine in two countries, and the *Neisseria meningitidis* A conjugate vaccine (MenAfrivac®) in Guinea-Bissau. The first malaria vaccine (RTS,S) recommended by WHO to prevent malaria in children was introduced in Kenya and Malawi, where nearly 1.5 million children were vaccinated through a WHO-coordinated pilot programme. This resulted in a substantial decrease in hospitalizations for severe malaria, and a drop in child deaths.

7 COUNTRIES
ELIMINATED AT LEAST 1
NEGLECTED TROPICAL DISEASE (NTD)

REGIONAL
COVID-19 VACCINATION
coverage increased from:
20% (June 2022)
to
30% (June 2023)

Political commitment was leveraged to improve the health of women, children and adolescents. The national and regional dialogues facilitated by WHO and sister UN agencies led to the endorsement of a ministerial commitment for educated, healthy and thriving adolescents and young people in 25 countries in West and Central Africa. To improve the delivery of child health interventions, the WHO-led review of the Integrated Management of Childhood Illness strategy guided 18 countries to explore innovative ways of strengthening its implementation, and to build implementation capacity.

PROTECTING PEOPLE FROM HEALTH EMERGENCIES

WHO AFRO's operationalization of three dedicated flagship programmes — PROSE (Promoting Resilience of Systems for Emergencies), TASS (Transforming African Surveillance Systems), and SURGE (Strengthening and Utilizing Response Groups for Emergencies) — continued to build the requisite physical and organizational infrastructure to monitor, contain and eliminate disease risks across the continent. The operationalization of a subregional emergency hub in Nairobi resulted in substantially reduced response lead times in the deployment of essential supplies to graded emergences – from 25 days in July 2022 to two days in January 2023.

Operationalization of the TASS flagship programme improved the integrated disease surveillance and response (IDSR) capabilities of Member States. The timeliness of surveillance reporting improved sixfold, from 11% to 64%.

Widespread cholera outbreaks necessitated a swift and decisive response, and WHO AFRO helped deploy more than 16 million doses of oral cholera vaccine during campaigns in Cameroon, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi and Mozambique. By the end of the review period, WHO AFRO had also supported countries to contain acute outbreaks of Ebola in both the Democratic Republic of the Congo and Uganda, Marburg in Equatorial Guinea and United Republic of Tanzania, and yellow fever outbreaks in 12 countries. **Notably, the Ebola outbreaks were contained within three months in the Democratic Republic of the Congo, and within four months in Uganda**.

Mental health and psychosocial support (MHPSS) is integral to emergency preparedness and response. WHO AFRO provided MHPSS support to all 47 Member States, as well as targeted support to North-east Nigeria, South Sudan, Ethiopia, Mozambique and the Democratic Republic of the Congo.

PROMOTING HEALTH AND WELL-BEING

In line with the growing emphasis on disease prevention and health promotion, **WHO and partners worked with Member States to prioritize multisectoral action to advance UHC**. Efforts included engaging communities, supporting countries to bolster their climate change-related interventions, accelerating interventions to meet the 2030 nutrition targets, and tackling tobacco use and other risk factors for noncommunicable diseases (NCDs).

Notable water, sanitation, and hygiene (WASH) advances were recorded in 26 countries during the reporting period. These included strengthening WASH monitoring capacities, developing WASH accounts for national benchmarking, and improving WASH services at health facilities. Twenty-nine countries developed health promotion strategies and policies, with eight implementing multisectoral and multidisciplinary strategies to address risk factors and the social determinants of health.

In terms of strengthening nutrition and food security, **WHO contributed to the development of the African Strategic Framework for Food Systems Transformation, implementation of the road map of the African Year of Nutrition 2025, and the adoption of the Abidjan Declaration on Nutrition**. WHO also supported capacity building in malnutrition case management and provision of medical treatment packages for children suffering from complicated wasting.

To boost tobacco control, WHO provided technical and legal support to countries to develop tobacco control laws and regulations, enforce smoke-free laws, and address the rising use of electronic nicotine delivery systems (ENDS) and heated tobacco products. In Kenya, the second phase of the alternative livelihoods project saw an increase in the number of farmers switching from growing tobacco to high-iron beans, from 2000 in 2022, to 3000 in 2023. The increase has boosted nutrition and food security, raised household income for farmers, reduced child labour, and improved school attendance.

INTEGRATED ACTION FOR BETTER HEALTH

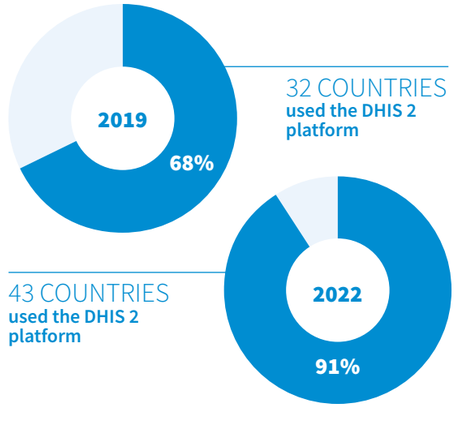
In the face of the growing antimicrobial resistance threat, WHO AFRO and partners deployed efforts to fight microbes that are becoming resistant to the drugs traditionally used to treat them. Over the review period, seven countries developed and validated their antimicrobial resistance (AMR) strategies, bringing the total to 45 (96%). Coordinated support to 42 Member States to track AMR through the Country Self-Assessment Survey (TrACSS) provided updated individual country profiles on progress made and key gaps in the implementation of national action plans (NAPs), with the findings now guiding remedial action.

Enrolment in the Global Antimicrobial Resistance and Use Surveillance System (GLASS) has improved Member States' understanding of AMR and its impact. Five countries have used national AMR data to develop policy briefs for evidence-based decision-making. The UN Multi-partner Trust Fund has enabled countries to develop national AMR plans, strengthen AMR surveillance systems, and promote AMR-related research. The collaboration between the regional quadripartite organizations (FAO, WHO, WOAH, UNEP) improved AMR governance across sectors, by ensuring threats were addressed in a coordinated and comprehensive manner.

Leadership of laboratory services was enhanced in five central African countries, through training and mentoring of 21 heads of laboratories, who were also provided with small grants to implement pilot projects using the "One Health" approach. In addition, seven countries developed laboratory policies, plans and strategies detailing priority actions, while 45 laboratories from 27 countries participated in proficiency testing and are following up with the requisite remedial actions.

Work to improve the availability of quality health information included the consolidation of the 2022 Atlas of African Health Statistics during the review period. Since the first month of its launch in December 2022, the Atlas has been downloaded almost 25 000 times.

WHO AFRO developed and promoted electronic systems for data collection to ensure rapid, accurate, reliable, and efficient collection and reporting of health data to bolster health information systems. The number of countries using the DHIS2 platform increased from 32 (68%) in 2019 to 43 (91%) in 2022, resulting in improved availability, quality, and access to routine health data.



The Secretariat strengthened research capacity in the Region through the assessment of research information systems and conduct of research. Results from COVID-19 seroprevalence surveys and vaccine effectiveness studies in 31 countries served to sustain momentum for vaccination in countries. The Organization contributed to the establishment of an mRNA Hub at Afrigen in Cape Town, South Africa. **Going forward, the science of mRNA research and key applications relevant to the Region will inform efforts to fight other diseases, such as HIV and tuberculosis.**

In collaboration with the International Telecommunication Union (ITU), Member States were supported to embrace digital solutions by building institutional capacity and strengthening governance. **Four countries developed national digital health strategies, while 17 others developed road maps to strengthen the use of telemedicine.** The road maps will guide the adoption and scaling up of digital technologies in countries.

PROVIDING BETTER SUPPORT TO COUNTRIES

The Secretariat undertook initiatives to strengthen its leadership and administrative systems to improve their effectiveness and efficiency. The automation of administrative systems significantly shortened turnaround times, while the implementation of innovative procurement measures yielded cost savings of US$ 1.1 million.

Improving staff well-being and creating a respectful work environment have been the focus of the WHO AFRO leadership. The flexible working arrangements policy that was effectively rolled out on 1 May 2023 has modernized workforce management, while the drive towards a respectful workplace has been promoted through enhanced communication among managers, staff association representatives, and the full time Ombudsman.

Partnerships and resource mobilization were strengthened through recruitment, training, and deployment of external relations officers. As a result, US$ 500 million was mobilized at country level. The number of clearance requests related to the Framework of Engagement with Non-State Actors (FENSA) increased from 64 in 2020 to 112 in 2022, and a total of 202 partner agreements were cleared in 2022 – a 3% increase compared to 2021. Donor reporting significantly improved with 95% of reports submitted and overdue reports reduced to only 5%.

US$ 1.1 MILLION
COST SAVINGS
due to the implementation of innovative procurement measures

THE NUMBER OF FENSA CLEARANCE REQUESTS **INCREASED FROM:**

64 – 2020 **TO** 112 – 2022

LOOKING AHEAD

The Organization will continue to be guided by the aspirations of Member States, its Transformation Agenda, the Thirteenth General Programme of Work, 2019–2025 (GPW 13) and the Sustainable Development Goals (SDGs) to support countries towards the attainment of UHC and enhanced health security. The Secretariat will work with partners to support and advocate for fast-tracking the development and implementation of COVID-19 recovery plans.

WHO in the African Region will strive to sustain efforts towards ending polio and galvanize political commitment to develop and implement the requisite policies and regulations to control risk factors for NCDs. Supporting countries to operationalize PHC as an approach to building health systems and community resilience will be a core component of our work.

INTRODUCTION

This report covers the work of the WHO Secretariat in the African Region between July 2022 and June 2023. In addition to COVID-19 pandemic response actions, WHO working closely with partners, supported countries in the African Region to make progress towards universal health coverage (UHC), protect more people from health emergencies and ensure more people enjoy better health and well-being.

The report, which highlights key results, challenges, and priority actions for the coming year, is presented in six chapters.

1 CHAP

Provides an overview of the Transformation Agenda which aims at making the Secretariat more responsive, results-driven, accountable, and appropriated resourced to deliver on its mandate. **Progress towards Polio eradication in the region is also presented in this chapter.**

2 CHAP

Highlights the progress towards universal health coverage, focusing on the results of WHO AFRO's support to Member States to bring services closer to the people, **strengthen health systems and institutional capacity to deliver health interventions**, and mitigate financial barriers to accessing services.

3 CHAP

Is dedicated to the Secretariat's **work to protect African populations from the adverse impact of health emergencies, highlighting achievements in strengthening preparedness**, readiness, prevention, and response to health emergencies.

4 CHAP

Provides an overview of the advances made towards promoting health and well-being, through disease prevention and health promotion. It highlights multisectoral action to address the environmental, social, and economic determinants of health.

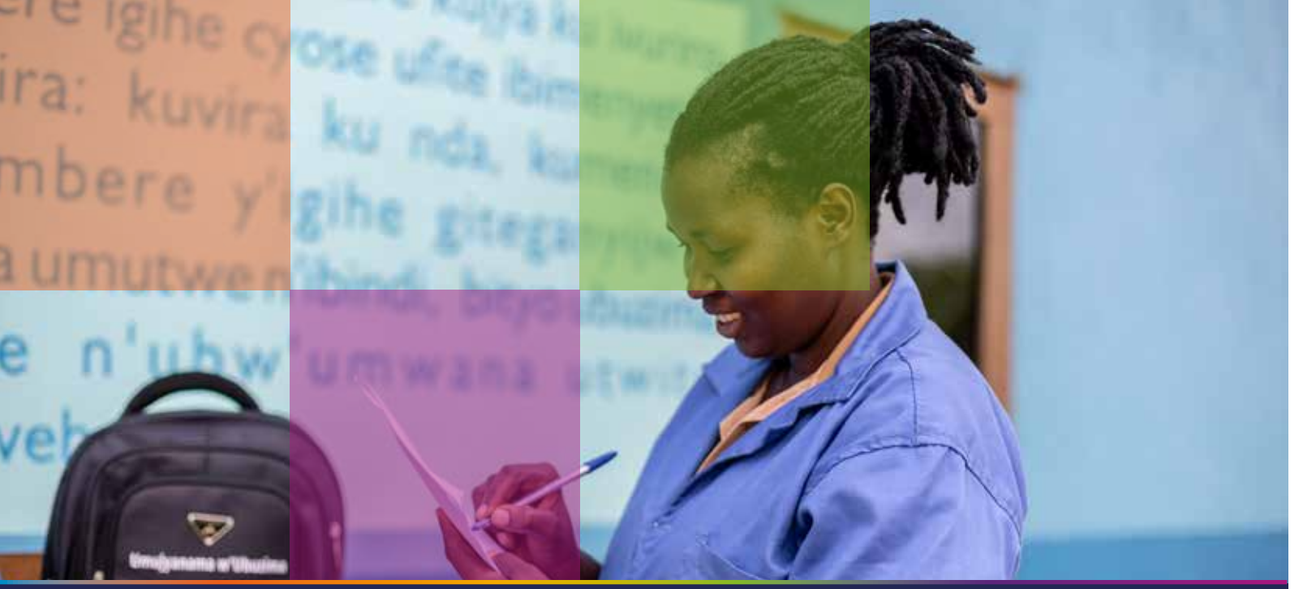
5 CHAP

Discusses the region's results in tackling the growing threat of antimicrobial resistance, **strengthening laboratory and data systems, research, and innovation**.

6 CHAP

Presents the Secretariat's achievements in providing better support to Member States, including progress in **becoming more fit-for-purpose, and optimally managing financial, human, and material resources**.

The **final section** of the report presents the major challenges faced during the reporting period and recommendations to guide WHO AFRO's actions through the next year.



CHAPTER 1
TRANSFORMATION OF THE WHO SECRETARIAT

Initiatives and activities aimed at strengthening a culture of efficient and effective strategy management, teamwork, accountability, integrity, equity, and innovation within the WHO Secretariat in the African Region were implemented during the reporting period.

1.1 RESULTS OF THE TRANSFORMATION AGENDA

Activities aimed at **enhancing WHO impact at country level,** including leadership training for WHO Representatives and senior WHO country office staff were implemented. Thirty-one WHO Representatives and senior staff participated in the Pathway to Leadership for Health Transformation (PLHT) training programme. The skills of the participants in teamwork, communication and coaching were enhanced, thereby contributing to improved overall performance.

Eight WHO Representatives and senior staff participated in a five-day capacity-building workshop on policy dialogue to improve WHO engagement in UN country programming, including the 2030 Agenda for Sustainable Development and the UN Sustainable Development Cooperation Framework (UNSDCF).

The enhanced leadership skills of WHO country office staff strengthened their participation in UN and broader developmental partner coordination platforms, resulting in stronger commitment to, and investment in health at country level. Policy dialogue with a broad range of national authorities, bilateral and multilateral partners, civil society, academia, and the private sector guided the development of WHO Country Cooperation Strategies in 13[3] Member States. This contributed to consensus building on strategic approaches to attaining national health priorities, GPW 13 and SDG targets.

The positive experience of building leadership skills among WHO staff is now being extended to ensure that this opportunity also benefits staff of ministries of health and other country-level stakeholders. In this regard, WHO has established collaboration with universities in Ghana and South Africa to implement the PLHT training programme. There are plans to extend this capacity to six more universities in five countries.[4]

Building the **leadership capacity of female staff in the WHO Secretariat** in the African Region was a key priority during the reporting period. Senior women leaders with extensive experience in global development were invited to share experiences with female WHO AFRO staff as part of the "Women in Leadership Speaker Series". WHO AFRO also launched the "Women in Leadership Masterclass: Power Up Your Executive Presence" initiative, designed to support women leaders to realize their professional goals and increase their influence and impact. To date, 19 female staff have benefited from professional coaching sessions offering targeted guidance and skills development to help women thrive in the workplace.

In 2020, WHO AFRO, in partnership with the UN Volunteers (UNV) programme, launched the Africa Women Health Champions Initiative (AWHC). The aim of the initiative was to recruit 100 young professional women to support WHO's work across the technical programmes. As of 30 June 2023, this project had attracted more than 120 young professionals across the Region.

Strengthening team performance was another aspect of the Transformation Agenda that was implemented during the reporting period. Team performance assessment was undertaken for 21 teams within the Regional Office and in several WHO country offices. Following the discussion of the results of the team performance assessment, many staff members were motivated to identify areas for personal growth. Requests for coaching and mentoring sessions increased by 20% during the review period. Improved overall performance, as evidenced by enhanced attainment of key performance indicators, better stakeholder engagement, more collaborative partnerships, among others, was observed among the beneficiary teams.

WHO's effectiveness and efficiency in providing technical support were enhanced through the implementation of the **functional review recommendations** for each country. Multicountry assignment teams (MCATs), a cost-effective and innovative strategy for delivering technical assistance to Member States, were enhanced. Close to 60% of all requests for technical support received by WHO AFRO during the reporting period were provided by MCAT staff.

Multicountry assignment team (MCAT) coordination and planning meeting

In March 2023, the MCAT supporting Kenya, Mauritius, Rwanda, and Seychelles organized a coordination and planning meeting with the WHO Representatives of the four countries, the WHO country office (WCO) teams and the WHO AFRO MCAT coordinator. The meeting, whose objective was to ensure cohesive and effective coordination between WCO and MCAT teams, reviewed activities supported by MCAT staff. MCAT staff supported the following activities during the period under review:

KENYA: development of WHO Country Cooperation Strategy 2024–2029; development of quality standards for children and newborns; mapping of WHO core paediatric quality indicators; adaptation of the paediatric death audit guidelines to improve quality of care for children; validation of the national integrated early childhood development policy; technical support for mass drug administration (MDAs) for schistosomiasis and soil-transmitted helminthiases in five counties (98% coverage was attained);

MAURITIUS: technical support for the national dengue outbreak response; review of the National Adolescent Health Strategy for Mauritius; capacity-building for national trainers in adolescent health and well-being;

RWANDA: strategic guidance for the planning of upcoming antimalarial drug resistance survey; finalization of the Integrated Management of Childhood Illness in Health Facilities survey; capacity-building on maternal, perinatal and child death surveillance;

SEYCHELLES: preparations for the development of a WHO Country Cooperation Strategy; scoping mission for HIV/AIDS/EMTCT; training of trainers on Baby-friendly Hospital Initiative (BFHI); capacity-building on reproductive, maternal, neonatal, child and adolescent health (RMNACH) programme management.

1.2 POLIO ERADICATION IN THE WHO AFRICAN REGION

In August 2020, the Africa Regional Certification Commission (ARCC) for Polio Eradication officially declared the African Region free of wild poliovirus, a historic day for the continent.

Progress towards polio eradication in the Region suffered a setback in February 2022 when wild poliovirus imported from the remaining endemic reservoir in Pakistan, was confirmed in Malawi. This outbreak subsequently spread into neighbouring Mozambique.

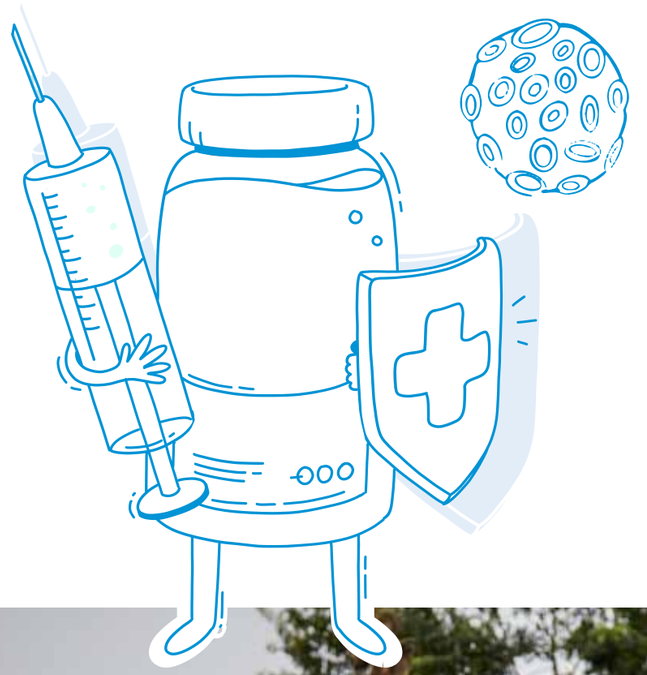
The disruptions of immunization services that accompanied the COVID-19 pandemic contributed to the resurgence of transmission of circulating vaccine-derived poliovirus in the Region. Between July 2022 and June 2023, the WHO African Region detected 1094 polioviruses in 22 countries (1090 circulating vaccine-derived polioviruses (cVDPVs) and four wild polioviruses (WPVs)).[5] Four countries[6] detected more than one type of poliovirus.

Member States of the African Region, with the support of WHO and Global Polio Eradication Initiative (GPEI) partners, have been implementing activities aimed at interrupting all poliovirus transmission in the Region. Efforts to interrupt the transmission of wild poliovirus are yielding results as the most recent WPV case in the Region was confirmed in August 2022.

Heads of State and other senior government officials reaffirmed their commitment to polio eradication during country-level visits as well as during high-level meetings held on the sidelines of the Seventy-second session of the Regional Committee for Africa and the Seventy-sixth World Health Assembly. These meetings provided an important opportunity for GPEI partners and other stakeholders to review strategy, discuss innovation as well as reaffirm accountability with national leaders.

Key polio eradication achievements during the review period include the following:[7]

- Twenty-three countries[8] in the African Region implemented supplementary immunization activities (SIAs), with more than 122 million children vaccinated against polio.
- Eighteen countries[9] carried out SIA campaigns with the novel oral polio vaccine type 2 (nOPV2) and administered over 90 million doses.
- All 47 countries in the Region have strong acute flaccid paralysis (AFP) surveillance in place, while 40 countries are now implementing environmental surveillance.
- Increased sensitivity of surveillance for poliovirus as demonstrated by increased non-polio AFP rate (NPAFP) from 6.4 per 100 000 children during the period July 2021–June 2022 to 6.7 per 100 000 children during the period July 2022–June 2023.
- Three new countries established environmental surveillance to complement AFP surveillance. By the end of June 2023, forty of the 47 countries in the Region had fully functioning environmental surveillance systems.
- WHO AFRO's Geographic Information Systems Centre boosted the capacity of countries to map cross-border communities, migratory routes, border crossings and transit routes. To enhance campaign quality, the Centre also deployed the geospatial tracking system (GTS), which captures and analyses spatial data on maps, providing real-time coverage information and locating missing settlements for improved vaccinations. The GTS was used in Congo,[9] Cameroon, and Nigeria.
- The availability of 16 polio laboratories allowed for the rapid determination of the origin and type of polioviruses found in stool and wastewater samples, while also tracking geographic spread.
- Six laboratories within the Regional Polio Laboratory Network were supported to conduct genetic sequencing through training and provision of additional testing technologies. By June 2023, a total of eight laboratories in the Region had poliovirus sequencing capacity.



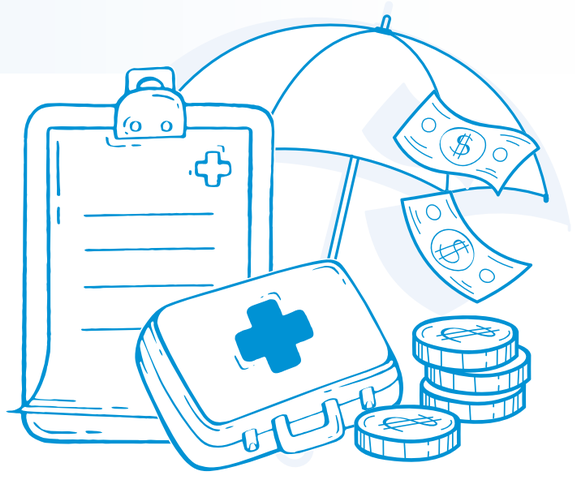
1.2.1 Polio transition

WHO AFRO is leveraging existing polio structures and assets to support other crucial public health priorities, notably disease surveillance, routine immunization strengthening, detection as well as response to other epidemic-prone diseases. The Polio Transition Secretariat, in collaboration with the GPEI, mobilized additional resources to continue supporting 10 high-risk polio countries, and implement a phased approach to transitioning integrated functions. A total of 37 low-risk countries were funded to maintain essential human resources, surveillance, laboratory services, and other integrated activities.

CHAPTER 2
PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) aims to ensure that everyone can access quality health services without facing financial hardship. Coverage of essential services in the African Region, as monitored by the UHC service coverage index, increased from 24 in 2000 to 46 in 2019.[10] This progress was slowed by the challenges that accompanied the COVID-19 pandemic, conflicts, public health emergencies due to disease outbreaks and climate change, as well as economic crises. By 2021, the UHC service coverage index in the African Region had decreased by two percentage points to 44, from its 2019 level.[11]

Financial hardship remains a significant challenge. There was a modest increase in the proportion of the population that devotes a large portion of household expenditure to health (greater than 25% of the total household expenditure) from 1.4% in 2000 to 1.9% in 2017.[12] This chapter highlights WHO AFRO's efforts to address the gaps in service delivery, financial protection and health system strengthening, and their contribution to the UHC agenda in the Region.



2.1 IMPROVED ACCESS TO QUALITY ESSENTIAL HEALTH SERVICES

2.1.1 Strengthening health sector governance

Establishing a legal foundation for UHC was strengthened at country level. WHO, in collaboration with the Inter-Parliamentary Union (IPU) and the International Labour Organization (ILO), initiated an assessment of legal frameworks for UHC in all 47 countries of the WHO African Region. To date, 11 countries[13] have completed the assessment and draft reports are being validated. The evidence generated is guiding national-level dialogue on updating laws to facilitate the attainment of UHC targets. A mechanism involving the Ministry of Health and parliamentarians for updating a law on health that was enacted in 2021; *"Loi 2020-37 Fevrier 2021: -Portant de la Sante des Personnes en Republic du Benin"* has been established in Benin through a process facilitated by WHO and IPU. Côte d'Ivoire organized a similar multistakeholder national dialogue with parliamentarians.

Twelve Member States[14] were supported to update their National Health Strategic Plans using inclusive whole-of-society and whole-of-government approaches. WHO provided technical support, guides and tools for evaluating the preceding national health sector strategies. The evidence generated informed the development and costing of the subsequent strategic plans including monitoring and evaluation frameworks. The updated strategies incorporate lessons from the COVID-19 pandemic and are intended to build responsive and resilient health systems.

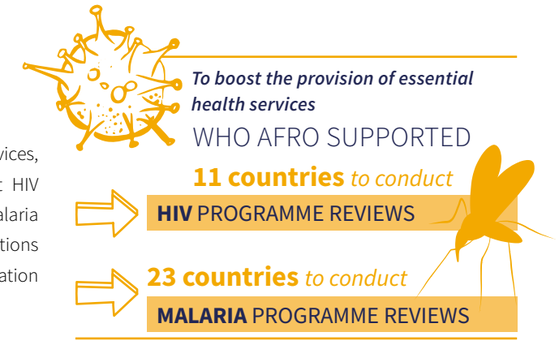
To promote peer learning and experience sharing, WHO facilitated a study visit by a high-level ministerial delegation from Gambia to Ghana. National authorities from the two countries exchanged experiences on ministry of health restructuring, national health insurance, postgraduate training of health professionals, and functionality of health districts.

Actions to build effective partnerships with the private sector to increase access to health services were implemented in several countries. Four countries (Cameroon, Côte d'Ivoire, Nigeria, Sierra Leone) established private sector engagement (PSE) committees at the national level within the ministry of health, while three countries (Ghana, Sierra Leone, Uganda) revised their memorandum of understanding with the private sector. These actions were facilitated by evidence generated from a multicountry study on engaging the private sector in health service delivery conducted by WHO. The findings and recommendations from the study were disseminated during a multicountry consultation workshop.

2.1.2 Provision of essential health services

To boost the provision of essential health services, WHO AFRO supported 11 countries[15] to conduct HIV programme reviews and 23 countries[16] to conduct malaria programme reviews. The findings and recommendations from these programme reviews guided the formulation of multiyear strategic programme plans.

Seventeen countries[17] were supported to conduct TB programme reviews and of that number, five[18] developed national TB strategic plans which are being used to support evidence-based TB programme implementation. The updated strategies were key in mobilizing domestic and international resources, including through funding proposals submitted by 30 countries[19] to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).



To accelerate malaria prevention and control, WHO AFRO supported five countries[20] to strengthen malaria epidemic preparedness through improved surveillance, investigation, and classification of cases. Six countries[21] were supported to develop integrated vector control strategies. The provision of evidence on the invasive vector Anopheles stephensi strengthened surveillance for the vector in seven countries.[22]

Five countries in the Region; Botswana, Eswatini, Rwanda, the United Republic of Tanzania and Zimbabwe have already achieved the 95-95-95 HIV targets and an additional eight counties are close to achieving them.[23] WHO, working closely with partners, supported these countries to develop, disseminate and implement new guidelines for HIV treatment and care, implement differentiated service delivery (DSD) packages and WHO's tuberculosis preventive treatment (TPT), along with the WHO advanced HIV disease package. Technical support was also provided for strengthening country-level capacity towards elimination of mother-to-child transmission (eMTCT) and expansion of the best service delivery models for reaching adolescent girls and young women (AGYW), young men and key populations (KPs) with combination HIV prevention, including pre-exposure prophylaxis, voluntary medical male circumcision (VMMC) and condom programming.

Six countries[24] were provided with guidance and technical support to develop national guidelines for pre-exposure prophylaxis and HIV testing algorithms.

Eswatini deploys innovative approaches to reduce HIV-related morbidity and mortality

Through concerted testing and treatment efforts, Eswatini became the first African country to achieve the global target of ensuring that 95% of people living with HIV know their status, 95% are receiving treatment, and 95% of those receiving treatment have their viral load suppressed. These successes resulted from the decentralization of integrated HIV and tuberculosis care and treatment to community primary health care clinics, and the training of nurses to initiate patient treatment with antiretrovirals. This enables people living with HIV to check their viral load every six months. Once the viral load is undetectable, they are tested annually. The strategy also helped identify those struggling to suppress their viral load, who were then supported to improve drug adherence. This strong government commitment saw infections decline by 66% between 2010 and 2019, and AIDS-related deaths by half.

95% OF PEOPLE
LIVING WITH HIV
know their status and are receiving treatment;
& have their viral load supressed.

HIV INFECTIONS
declined by
66%
between 2010 and 2019

To tackle TB drug resistance, six countries[25] were supported to conduct TB drug resistance surveys, and the findings were translated into TB drug resistance policy frameworks. Further, 29 countries[26] updated their multidrug-resistant TB treatment policies and guidelines.

In line with the targets of the Regional framework for integrating essential noncommunicable disease services in primary health care, WHO AFRO provided technical assistance to six countries[27] to integrate the WHO Package of Essential Noncommunicable (WHO PEN) disease interventions into primary health services, bringing to 27 the total number of countries supported to do so. In Niger, this support capacitated 47 primary health care facilities to implement WHO PEN, prompting nearly 2000 new hypertension and 455 new diabetes diagnoses and treatments.

WHO AFRO supported Burkina Faso, Liberia, Niger, Rwanda, and Togo to conduct STEPS surveys to generate evidence on trends and prevalence of NCD risk factors. The findings and recommendations from these surveys are informing the development of updated NCD policies and strategies.

A guidance framework for sickle-cell disease (SCD) treatment was developed to facilitate implementation of the Regional SCD strategy. Guinea and Mauritania are already implementing the recommendations from the framework to provide comprehensive care for people living with SCD. WHO provided technical and financial support for the scale-up of newborn screening for SCD in Ghana, Senegal, Mauritania, and Guinea in line with the guidance framework document.

Ghana and Zimbabwe received technical and financial support from WHO to increase access to integrated, quality, people-centred mental health services as part of the WHO Director-General's Special Initiative for Mental Health. In Zimbabwe, mhGAP training was rolled out to primary health care workers in two provinces, resulting in increased service coverage. In Ghana, mhGAP is being rolled out and a package of essential mental health services has been integrated into the National Health Insurance Scheme to provide financial protection for people with mental health conditions at the PHC level.

Kenya, United Republic of Tanzania and Mozambique are strengthening the mental health aspects of maternal and child health within the Nurturing Care Framework. Kenya and United Republic of Tanzania have convened partners, first to disseminate the WHO Guide for integration of perinatal mental health in maternal and child health services, then to contextualize the Guide to their specific country situations. Under the auspices of the WHO/UNICEF Joint Programme, Mozambique and Côte d'Ivoire are being provided with technical and financial support to strengthen the joint programming of child and adolescent mental health services in the two countries.

UGANDA
IS ONE OF THE FIRST
2 COUNTRIES GLOBALLY
TO IMPLEMENT THE SAFER INITIATIVE ROAD MAP

KEY ACHIEVEMENT IS THE
SUPPORT FOR THE ALCOHOL BILL
that has been tabled in Parliament

Uganda is one of the first two countries globally to implement the SAFER Initiative, which offers the best buys for alcohol harm reduction activities. WHO AFRO, in partnership with the Government of Uganda and INGOs, developed a SAFER Initiative Road map, prioritized activities and is now implementing them. A key achievement is the support for the Alcohol Bill that has been tabled in Parliament.

WHO, the Global Fund and UNAIDS, supported five high-impact countries[28] to strengthen the integration of NCD and mental health programming in their Global Fund proposals.

The COVID-19 pandemic caused major disruptions to routine immunization services, and this hampered polio eradication efforts, led to a resurgence of outbreaks of measles, and increased the incidence of diphtheria and pertussis. In 2022, the WHO African Region had 10.7 million unvaccinated and undervaccinated children.

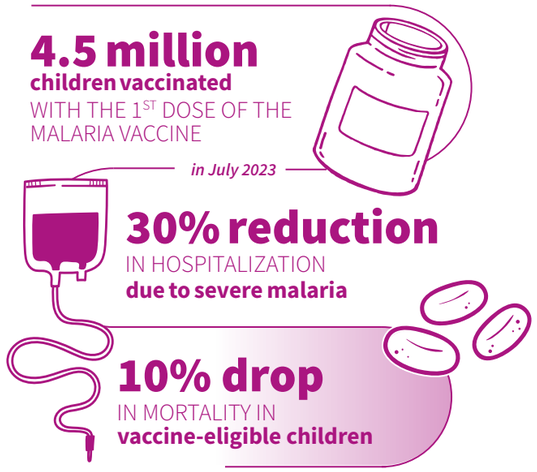
Immunization partners including WHO, UNICEF, Gavi, the Vaccine Alliance and IA2030 have designated 2023 as a year of intensified action to vaccinate children who missed immunization, restore immunization services to pre-pandemic levels and strengthen these services to achieve IA2030 targets.

WHO AFRO supported the vaccination of more than 87 million children aged six months to 15 years with supplementary doses of measles-containing vaccine (MCV) during 20 mass vaccination campaigns in 17 countries.[29]

Several countries were supported to introduce new vaccines. WHO AFRO supported three countries[30] to introduce the RTS,S malaria vaccine for the prevention of malaria among children. As of July 2023, more than 4.5 million children had been vaccinated with the first dose of the vaccine. Early results from the pilots showed a 30% reduction in hospitalizations due to severe malaria, and a 10% drop in mortality in vaccine-eligible children.

Three countries[31] were technically and financially assisted to introduce the human papillomavirus (HPV) vaccine, two[32] to introduce the typhoid conjugate vaccine and Guinea-Bissau to introduce the Neisseria meningitidis A conjugate vaccine (MenAfrivac®) in their routine immunization programmes.

WHO AFRO was also instrumental in seeing 46 of its 47 Member States increase coverage of the primary series of the COVID-19 vaccine. **The regional COVID-19 vaccination coverage increased from 20% in June 2022 to 30% in June 2023, while the number of countries with more than 70% coverage increased from two to four during the same period.** •



2.1.3 Service Delivery Systems

WHO provided technical support, tools, and frameworks to 12 countries[33] to update their essential health service packages to advance towards UHC.

Advocacy conducted during the World Patient Safety Day stimulated action by several Member States. Botswana developed a national patient and health providers' charter. Ghana developed a patient safety strategy, while Burkina Faso developed a road map for implementing the Global Patient Safety Action Plan 2021–2030. Fourteen countries [34] finalized and are implementing national quality strategies and plans, up from eight in 2021. **WHO technical expertise and tools also guided countries to improve hospital services**, with Guinea implementing reforms to improve hospital emergency and intensive care units.

WHO supported Sierra Leone to strengthen priority areas including mortality surveillance, PHC monitoring, and development of a comprehensive, cohort-based national essential health services package. Sierra Leone was also supported to adopt an integrated service delivery framework that would enable the country to achieve its "Framework of life-stages approach to health care delivery". The Framework was launched by His Excellency the Vice-President of the Republic of Sierra Leone in May 2023.

WHO strengthened the capacities of all 47 countries in the Region in implementing the operational framework for PHC, including the PHC care measurement framework and indicators. The guidance provided on the PHC operational framework enabled countries to align their health service delivery priorities.

As part of the Lancet Commission on the Future of Health and Economic Resiliency in Africa (FHERA), the Regional Director convened 58 experts from 19 countries to review and update the service delivery architecture in Africa. The experts recommended that primary care units be established as networks of complementary service provision, delivering the full range of first point-of-care services for individuals and families. They also recommended investing in hospitals as service provision modalities providing real-time holistic care, internship, training, research, and clinical governance functions, in both routine and emergency situations. Finally, the experts recommended that health oversight capacities be enhanced to ensure evidence-informed participatory decision-making during the provision of essential services demanded by individuals and families. The Regional Office is developing the needed follow-up tools and manuals to assist countries in implementing these recommendations. •

2.2 BETTER HEALTH FOR WOMEN, CHILDREN, ADOLESCENTS, AND OLDER PEOPLE

For the first time, almost all countries in the Region have adopted national policies, guidelines, and laws to notify and review all maternal deaths within 24 hours – raising maternal mortality to the highest level of alert. This was made possible through strong national commitment, coupled with advocacy and technical support provided by WHO, UNFPA and UNICEF. About 70% of countries in the Region also have a national policy, guideline or law requiring review of stillbirths and newborn deaths. Efforts to accelerate the implementation of actions to end stillbirths and preventable maternal and neonatal deaths in the Region included support provided by WHO to 31 countries[35] to set targets and develop or refine implementation plans for the Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) for the period 2023–2025. These efforts are aimed at scaling up progress towards the attainment of the SDG targets for reduction of maternal and newborn deaths.

WHO SUPPORTED

31 COUNTRIES

TO SET TARGETS AND DEVELOP OR REFINE ENAP AND EPMM

implementation plans for the period 2023-2025

Intensified advocacy, policy dialogue and technical support by WHO enabled three countries (Kenya, United Republic of Tanzania, and Mozambique) to develop country workplans for early childhood development (ECD) which when implemented, will increase the proportion of children attaining developmental milestones. The scoping review of the implementation of integrated management of childhood illness (IMCI) in the Region conducted by WHO AFRO and the evidence generated led to 18 countries,[36] together with partners including UNICEF, USAID, and Save the Children, joining forces to explore innovative ways of strengthening IMCI implementation. It resulted in an advocacy brief outlining priority action to revitalize IMCI and improve equitable access to quality integrated child and family-centred care for children in the context of PHC. During the review period, six countries[37] received technical support from WHO AFRO to institutionalize newborn, paediatric and adolescent quality of care programming in their health systems.

In collaboration with UNESCO, UNFPA, and UNICEF, WHO AFRO facilitated national and regional dialogues that led to the endorsement of a ministerial commitment for educated, healthy and thriving adolescents and young people in 25[38] countries in West and Central Africa. This followed a similar commitment made by East and Southern African countries in 2013 for the period 2013–2020 and updated in 2021 following a positive evaluation. Stakeholders and youth-led networks in at least 12 countries are leveraging this political goodwill to mobilize national commitments for adolescent well-being ahead of the SDG summit in September 2023, and the Global Forum for Adolescents in October 2023.

WHO AFRO provided intensified support to Member States to prevent women and girls from dying from unsafe abortion and improve access to contraception/family planning. Benin, Sierra Leone, and Liberia reviewed the policy and legal restrictions contributing to maternal deaths from unsafe abortion. **WHO is also providing technical support to countries to introduce or scale up self-care/digital innovations for family planning, long-acting reversible contraception, and task-sharing for the health workforce.**

To improve sexual and reproductive health and rights (SRHR) data systems, WHO updated the harmonized health facility assessment (HHFA) tool, which now includes a sexual and reproductive health module. Ghana has conducted this assessment, and similar efforts are ongoing in Burundi, Cameroon, Côte d'Ivoire, and the Democratic Republic of the Congo.

Discrimination based on age (known as ageism) can hinder progress towards universal health coverage and healthier populations. To combat ageism, WHO AFRO partnered with HelpAge International to run anti-ageism campaigns in 20 countries. Following these campaigns, Gabon prioritized the health of its older persons with initiatives including supportive laws, older persons' centres, and intergenerational cooperatives.

WHO AFRO PARTNERED

WITH *HELPAGE* INTERNATIONAL

TO RUN ANTI-AGEISM CAMPAIGNS in

20 COUNTRIES

2.3 TOWARDS MORE HEALTH WORKERS, IN THE RIGHT PLACES WITH THE RIGHT SKILLS

Over the period under review, capacity for data-driven health workforce planning and management was strengthened across Member States. National Health Workforce Accounts (NHWA) were established in six[39] countries and 20 countries reported health workforce data to WHO in 2022. In addition, end-user tools for health labour market analyses were developed and validated by Member States and experts. WHO supported six[40] countries to conduct health labour market analyses to better understand the forces driving health worker shortages and surpluses, skills mix, geographical distribution, and performance levels. The evidence generated informed multisectoral dialogue on health workforce development. In Zimbabwe, the evidence was used to revise health workforce policy and strategy, which unlocked domestic and international investments of up to US$ 100 million for retention of health workers. In Kenya, the evidence was used to advocate for increased budget allocations, leading to the recruitment of over 20 000 unemployed health workers in 2023. Ten countries are currently[41] being supported to use the tools for evidence-generation to inform sustainable health workforce investments.

US$ 100 OF DOMESTIC AND INTERNATIONAL INVESTMENT

FOR RETENTION OF HEALTH WORKERS

IN ZIMBABWE

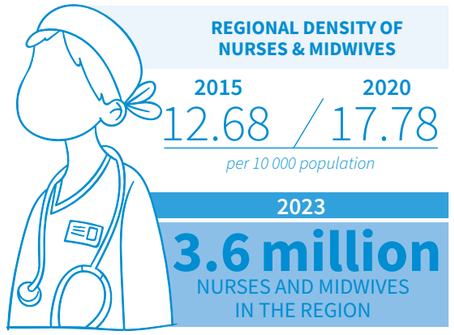
IN 2023, IN KENYA

RECRUITMENT OF

+20 000 UNEMPLOYED HEALTH WORKERS

The first comprehensive regional report on nursing and midwifery was published. It revealed that the average regional density of nurses and midwives per 10 000 population has improved by 40% since 2015, increasing from 12.68 per 10 000 population in 2015 to 17.78 in 2020. As a result, there are now 3.6 million nurses and midwives in the Region compared to 1.2 million in 2015.

Additionally, **regional best practices in health workforce planning, management and regional analysis were systematically documented and published in peer-reviewed journals to ensure their dissemination and contribution to knowledge globally.**[42]



Political commitment for community health workers (CHWs) was fostered through collaboration with Africa CDC, UNICEF, and other partners. WHO supported a high-level event on the sidelines of the Seventy-sixth World Health Assembly with ministers of health on community health workers. Working in collaboration with the AU Commission on Health, Humanitarian Affairs and Social Development (AU-HHS) and Africa CDC, WHO is engaged in the "2 million community health workers" initiative to support the implementation of commitments, and is technically supporting the mapping of CHW programmes on the African continent.

As part of initiatives to address the health workforce challenges besetting the African Region, WHO, in collaboration with partners and Member States, has developed a draft "African health workforce investment charter" that will help to align and stimulate investments to halve inequities in access to health workers, especially in African countries that have the greatest shortages. In November 2022, WHO convened a policy dialogue attended by officials of ministries of health and finance of 26 countries and key development, bilateral and multilateral and international financing partners, which built consensus on developing the charter. The draft charter has undergone the process of Member State consultation and has received public endorsements from key stakeholders. It will be launched in the latter half of 2023. Guided by the WHO African HWF investment charter, WHO is working in collaboration with partners and countries to stimulate more investment in the health workforce and foster alignment and negotiation between governments and other stakeholders to address the shortage of health workers.

2.4 EXPANDING PROTECTION AGAINST FINANCIAL HARDSHIP

During the Seventy-second Regional Committee for Africa in August 2022, ministers of health and delegates endorsed the report on "Financial risk protection towards universal health coverage in the WHO African Region", which analyses the status of financial risk protection in the Region. In line with the recommended priority actions, WHO is collaborating with partners to support Rwanda to improve evidence-based priority setting using health technology assessment (HTA) to evaluate the inclusion of cancers in the benefit package of its community-based health insurance scheme. This will increase access to services for NCDs for the population. In addition, WHO supported Nigeria to operationalize its National Health Insurance Act of 2022, which will remove financial barriers to health care for the population.

Further, WHO collaborated with the World Bank/Global Financing Facility to facilitate a meeting during which Madagascar and Comoros defined national road maps for strengthening strategic purchasing for primary health care, which will be supported by both agencies.

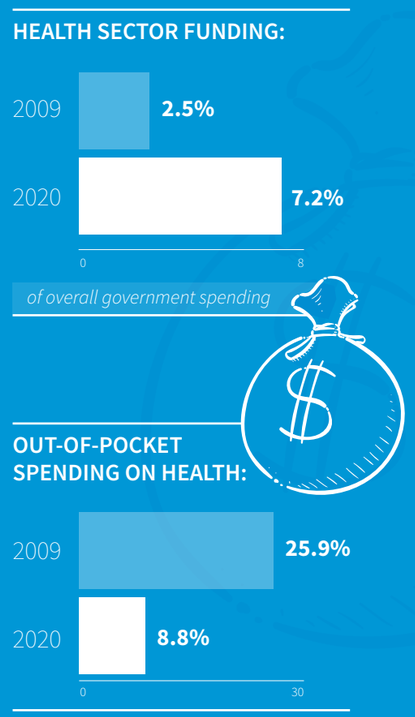
WHO AFRO with UNICEF (ESARO) and Harmonization for Health in Africa (HHA) partners co-convened a regional policy dialogue attended by health and finance officials from 20 countries[43] in East and Southern Africa. Following the dialogue, the participating countries developed plans that will serve as the basis for country dialogue to increase availability of resources for primary health care, guide the most efficient use thereof, and reduce financial barriers.

IMPACT CASE STUDY

WHO-supported evidence-based dialogue driving investment and UHC reforms in Zambia.

WHO AFRO's support for an assessment of Zambia's health financing systems revealed a well-established health financing policy environment, with increased health sector funding, from 2.5% of overall government spending in 2009, to 7.2% in 2020. Significant financial protection improvements were also noted, with a reduction in out-of-pocket spending on health as a percentage of current health expenditure, from 25.9% in 2009, to 8.8% in 2020.

Spurring the Government to make further improvements, the Zambia National Health Financing Dialogue in May 2023 brought together the Government, development partners and civil society players, facilitated by the African Union and the Southern African Development Community (SADC). The dialogue resulted in additional commitments, including to improve revenues for health through prioritizing allocations; generate more value for the money invested and increase financial risk protection; reduce inequalities in health access and outcomes by increasing government subsidies for the poorest citizens; and make contributions to national health insurance more affordable, especially for the informal sector



In collaboration with AUDA-NEPAD, the AU-HSS, UNAIDs and Africa CDC, WHO participated in the high-level AU summit of Heads of State and Government declaration on "Improving Health Financing and Sustaining Action to End AIDS and related Communicable and Noncommunicable Diseases in Africa" in February 2023. Key results included a commitment by Member States of the WHO African Region to provide active leadership in the HIV/AIDS response, champion science, mobilize domestic political and financial support, and elevate the dialogue on sustainable health security. At the end of the summit, a declaration on Health Financing and Sustaining Action to End AIDS and related Communicable and Noncommunicable Diseases was adopted, outlining a road map to 2030. The declaration further reaffirmed the 15% target on domestic financing for health as provided in the Abuja Declaration, while transitioning from dependence on partner funding.

WHO published a report titled "Analysis of the nature and contribution of innovative health financing mechanisms in the WHO African Region", which showed that the most common innovative financing mechanisms in the Region include excise taxes on tobacco products (43 countries); excise taxes on alcoholic beverages and spirits (41 countries); airline ticket levies (18 countries); and sugar-based beverages taxes (seven countries). The paper on "Evidence and lessons on health technology assessment and health benefit packages in the WHO African Region", also published during the period under review, highlights the fact that 26 of 32 responding countries have a formal process of collecting data for decision-making; however, only half of them have a legal requirement for doing so. Further, the links between health technology assessment processes and health benefit packages were seen to be weak, with only six countries using HTA data to inform benefit package decisions. A third report published by WHO: "Technical efficiency of health systems in the WHO African Region", indicates that African health systems have become more efficient, improving from 67% efficiency in 2014 to 80% efficiency in 2019. Based on the level of current health expenditures for 2019, this translated to collective savings of US$ 2.9 billion.

MOST COMMON INNOVATIVE FINANCING MECHANISMS:

- **EXCISE TAXES ON TOBACCO PRODUCTS** — 43 COUNTRIES
- **EXCISE TAX ON ALCOHOLIC BEVERAGES AND SPIRITS** — 41 COUNTRIES
- **AIRLINE TICKET LEVY** — 18 COUNTRIES
- **SUGAR-BASED BEVERAGES TAX** — 17 COUNTRIES

AFRICAN
HEALTH SYSTEM
EFFICIENCY IMPROVED FROM:

REPRESENTING
US$ 2.9 MILIION
OF COLLECTIVE SAVINGS

2.5 STRENGTHENING SUPPLY MANAGEMENT, INFRASTRUCTURE, AND ACCESS TO QUALITY MEDICAL PRODUCTS

To ensure sustainable access to quality medical products, WHO supported assessments in 23 countries[44] to identify strengths and weaknesses, and areas for improvement. Five countries[45] used the findings and recommendations from the assessments to prepare institutional development plans.

Forty (85%) of the national regulatory systems in the WHO African Region are currently operating at WHO Maturity Level 1 (the first step); one at Maturity Level 2; and only four (United Republic of Tanzania, Ghana, Nigeria, and South Africa) are at Maturity Level 3 (including South Africa for vaccines).

WHO supported capacity-building in the areas of market authorization, bioequivalence and clinical trials regulatory review and oversight in 15 countries[46].

National regulatory authorities from the Southern African Development Community were empowered on WHO reliance principles and mechanisms, while technical support was provided for the validation and launch of Nigeria's Supply Chain Master Plan 2021–2025, as well as Zambia's Medicines and Medical Supplies Agency (ZAMMSA) strategy for 2022–2026. In Nigeria, operational guidelines for State Drug Management Agency and standard operating procedures (SOPs) were also finalized and validated.

Regulatory harmonization efforts are ongoing in collaboration with AUDA-NEPAD and other partners. They include activities such as: support to various technical committees under the African Medicines Regulatory Harmonization (AMRH) initiative; introduction of the Coalition of Interested Parties on medicines regulatory affairs at regional level and in selected countries; and technical support to the African Union Commission for the operationalization of the African Medicines Agency. It is worth mentioning that as of June 2023, twenty-six countries had signed and ratified the treaty, which constitutes a challenge to achieving a harmonized African medicines market that will contribute to the strengthening of local production and pooled procurement. Efforts to promote technology transfer and strengthen local production are ongoing.

WHO supported the Zambia Medicines Regulatory Authority (ZAMRA) to develop national guidelines for marketing authorization of medical gases. Algeria's National Agency for Pharmaceuticals was also supported to develop and submit for approval guidelines on technical and regulatory requirements for local manufacturing and registration of bulk biosimilars from active substance/active biological products. These contributed to reducing the turnaround time for marketing authorization (product registration) from two years (2015) to one year during the review period. These processes contribute to better health outcomes by ensuring quality, safety and efficacy of the medical products used in the diagnosis, prevention, and treatment of health conditions.

To support sustainable access to essential medicines, nine[47] countries received technical support to develop national essential medical products lists to facilitate the procurement, dispensing and prescription of essential medicines, vaccines, and assistive products. Nine countries[48] also revised and improved their national pharmaceutical policies and operational plans, detailing priority investment areas. The Small Island Developing States (SIDS) Technical and Ministerial Meetings respectively, adopted the requirements for the first pooled procurement round for the SIDS initiative. The first round of tenders was completed, leading to more efficient selection of suppliers of quality medicines at better prices. Implementation of these measures helps save valuable resources through increasing efficiency in the selection and procurement of medical products in the Region.

2.6 ERADICATING, ELIMINATING, PREVENTING, AND CONTROLLING DISEASES

During the review period, WHO AFRO supported seven countries[49] to eliminate at least one neglected tropical disease as a public health problem. In the Democratic Republic of the Congo, local transmission of guinea-worm disease was interrupted, bringing to 42 the total number of countries certified for eliminating the disease in the Region. Trachoma was eliminated in Benin, Mali and Malawi, while lymphatic filariasis (LF) transmission was interrupted in seven countries.[50]

Interruption of transmission of human African trypanosomiasis (HAT) was monitored in all endemic districts of Senegal. HAT elimination has been validated in seven countries[51], while Burkina Faso, Mali and Niger successfully reduced the prevalence of soil-transmitted helminthiases (STH) to less than 2%. These results were achieved through WHO's support for mass drug administration campaigns. WHO also supported capacity-building in surgical management of complicated cases, case management of NTDs, facial hygiene, and environmental change to improve sanitation (the SAFE strategy), for trachoma. To ensure early detection and treatment of noma cases, WHO AFRO provided technical assistance for the development of an online training course for primary health care workers, and training of 740 health care workers from the 10[52] high-burden countries to boost timely diagnosis and management.

Maternal and neonatal tetanus (MNT) was eliminated in all countries except six,[53] while validation assessments for MNT elimination were conducted in three countries[54]. Four countries[55] that reported meningitis outbreaks were supported to plan and implement response activities including reactive vaccination campaigns.

In line with the Framework for the implementation of the global strategy to eliminate cervical cancer as a public health problem in the WHO African Region, efforts to increase HPV vaccination rates among girls are ongoing. There was a modest increase in regional HPV vaccination coverage from 26% in 2021 to 33% in 2022.[56] **Capacity-building was undertaken in 13 countries[57] to implement updated guidelines for the scale-up of cervical cancer screening services.**

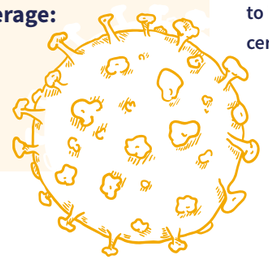
7 COUNTRIES
ELIMINATED AT LEAST 1

NEGLECTED TROPICAL DISEASE (NTD) WITTH WHO AFRO SUPPORT

740 HEALTHCARE WORKERS
WERE TRAINED TO
boost timely diagnosis and management of Noma cases.

HPV vaccination coverage:

26% (2021)
to
33% (2023)



2.7 MAINSTREAMING AND INTEGRATING GENDER, EQUITY, AND HUMAN RIGHTS

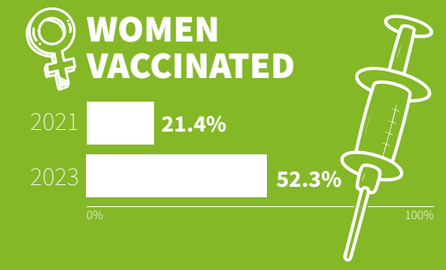
To promote equitable access to essential health services, WHO AFRO supported 43 Member States[58] to integrate gender, equity and human rights (GER) considerations into health planning and development, and in the implementation of their health policies, strategies, and guidelines. The interagency RESPECT framework for the prevention of gender-based violence was successfully rolled out in four countries.[59] This increased political commitment to gender, equity, and human rights, with the number of countries requesting WHO AFRO assistance increasing from 12 in 2021, to 17[60] in 2022. The scale-up of partnership and resource mobilization efforts also resulted in good outcomes, with more than US$ 3 million mobilized to support GER programmes and staffing in the Region. These achievements were made possible through technical assistance provided by WHO AFRO to build capacity, create awareness, and conduct advocacy and policy dialogues on the integration of GER into health actions.

WHO AFRO also engaged the Organization of African First Ladies for Development (OAFLAD) to support the "Free to Shine" initiative and facilitate WHO's participation in the Unifying Continental Campaign on gender equality. These were aimed at strategically positioning gender empowerment as a cross-cutting enabler of improved livelihoods and well-being at the regional level.

South Sudan leverages novel strategy to address gender inequity in COVID-19 vaccine coverage

In 2021, South Sudan, a country in a protracted crisis, experienced a huge disparity in COVID-19 vaccine coverage, with men accounting for 78.6% of vaccinated people. To address this challenge, WHO AFRO provided technical and financial assistance to develop and implement the COVID-19 Vaccination Optimization (ICVOPT) strategy.

From February 2022 to March 2023, gender awareness meetings were hosted, and women were consciously included in vaccination teams and named as vaccine champions. Rumours of fertility, breastfeeding and pregnancy-related vaccine side effects were also actively countered. These interventions resulted in an increase in women as a proportion of vaccinated people from 21.4% in June 2021 to 52.3% in February 2023.



CHAPTER 3
PROTECTING PEOPLE FROM HEALTH EMERGENCIES

WHO supported Member States to prepare for, rapidly detect and promptly respond to health emergencies. Member States were supported to implement priority actions recommended in the Regional strategy for health security and emergencies 2022–2030, which incorporates lessons from the COVID-19 pandemic and aims to reduce the health and socioeconomic impact of health emergencies. This chapter presents work done to build the preparedness, detection and response capacity of countries.

Progress in strengthening preparedness capacity is demonstrated by the steady improvement in the regional average score of 13 International Health Regulations (IHR) core capacities, from 42% in 2015 to 49% in 2021 and consequently 52% in 2022.[61] **There were also improvements in the timeliness of detection and response to health emergencies during the reporting period**.

3.1 PREPARING FOR ALL HAZARDS

WHO AFRO's operationalization of three dedicated flagship programmes — PROSE (Promoting Resilience of Systems for Emergencies), TASS (Transforming African Surveillance Systems), and SURGE (Strengthening and Utilizing Response Groups for Emergencies) — continued to build the requisite physical and organizational infrastructure to monitor, contain and eliminate disease risks across the continent.

The operationalization of a subregional emergency hub in Nairobi, with teams of experts and critical supplies, enhanced the capacity for timely deployment, within 72 hours, to graded health emergencies in nine[62] countries. With a stockpile of items valued at US$ 7.3 million, including personal protective equipment, cold chain reagents and Ebola, medical emergency and trauma kits, this pre-positioning of supplies substantially reduced response lead times – from 25 days in July 2022 to two days in January 2023. Two additional subregional emergency hubs are expected to be launched in Dakar and Pretoria. Once fully operational, the hubs will critically expand capacity to address ongoing epidemics and identify emerging threats.

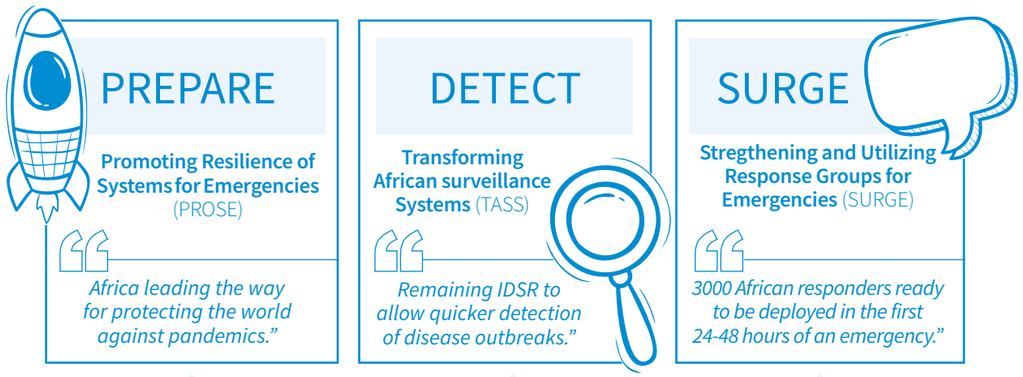
During the first quarter of 2023, the EPR Cluster provided technical support to six countries[63] to develop and implement health emergency plans, conduct risk assessments and strengthen their health systems. WHO AFRO also facilitated training sessions, tabletop exercises and assessments to enhance emergency preparedness and response capacities in these countries. Nonetheless, the initiative continues to face important challenges, including limited financial and human resources.

Given that disease threats do not stop at national borders, WHO AFRO worked closely with Member States, the Africa Centres for Disease Control (Africa CDC) and other key partners to strengthen cross-border coordination, information-sharing and technical assistance. This enhanced the capacity of Member States and regional institutions to respond rapidly and effectively to health emergencies by maximizing the impact of limited resources.

In partnership with WHO EMRO and Africa CDC, WHO AFRO developed and launched the Joint Emergency Preparedness and Response Action Plan (JEAP), 2023–2027. Through this plan, WHO and Africa CDC will support all African countries to build transnational emergency preparedness and response.

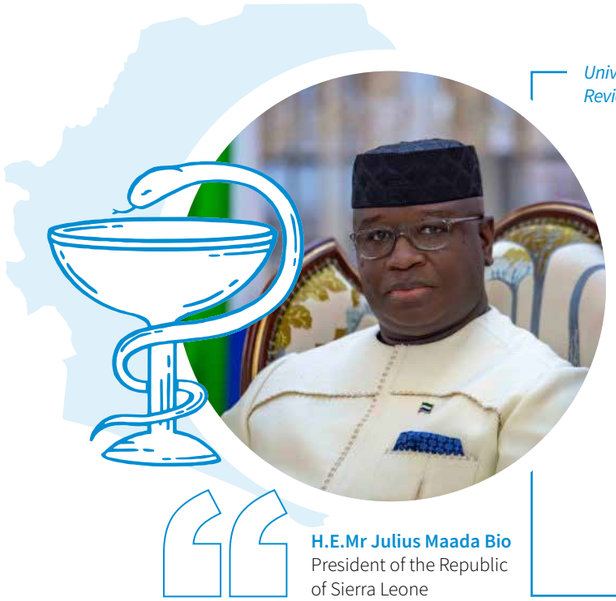
ARCHITECTURE FOR STRENGTHENING PREPAREDNESS, DETECTION AND RESPONSE IN THE AFRICAN REGION

The three EPR flagships are building the capacities of countries to prepare for, detect, and respond to shocks



REGIONAL OPERATIONS SUPPORT AND LOGISTICS HUBS

regional emergency Hubs to be established in Kenya, Senegal and South Africa



Universal Health and Preparedness Review in Sierra Leone, May 2023

"Health is important to us. We will intensify our activities so that we can have better results and share with the world. Our commitment to dealing with health issues is very strong and our human capital development agenda is one of the biggest pillars of my government."

H.E.Mr Julius Maada Bio
President of the Republic of Sierra Leone

To enhance country preparedness for health emergencies following the lessons learnt from the COVID-19 pandemic, **WHO announced in November 2021 a new mechanism, the Universal Health and Preparedness Review (UHPR), aimed at increasing accountability, solidarity and transparency among Member States in capacity-building for better health emergency preparedness**. By May 2023, five countries[64] around the world, including two in the African Region (Central African Republic, and Sierra Leone), had completed the pilot phase of this voluntary, Member State-led process.

Through the implementation of the Promoting Resilience of Systems for Emergencies (PROSE) flagship programme WHO AFRO supported 44 of the 47 Member States of the Region to prepare and submit funding proposals to the Pandemic Fund.

3.2 ASSESSING RISK AND SHARING INFORMATION

To improve detection, preparedness, and response to public health threats, WHO AFRO established an emergency data management platform for all Member States. Designed to specifically address gaps in the use of digital tools, the platform ensures real-time and prompt disease detection and monitoring through improved data collection, analysis, and use. This has increased the capacity of Member States to learn from their data, detect potential threats in good time and anticipate preparedness and response to reduce the impact of outbreaks on African populations.

Operationalization of the Transforming African Surveillance Systems (TASS) flagship programme improved the integrated disease surveillance and response (IDSR) capabilities of Member States. Between August 2022 and April 2023, the number of countries submitting weekly IDSR reports to WHO AFRO increased from 10 to 35, completeness of reporting improved from 21% to 74%, and timeliness of reporting from 11% to 64%.

Workshops were held to train teams from 43 Member States[65] on data management and analytics, diagnostic capacity, monitoring and evaluation and coordinating IDSR operations, including One Health **surveillance. Member States were supported to transition from paper-based to electronic surveillance systems**. The electronic system has streamlined the process of data collation and enhanced data flow to provide a holistic picture of case-based, event-based and indicator-based surveillance reporting. WHO supported countries to use public health intelligence tools to capture signals from the media and subsequently conduct verification confirmation and risk assessment grading as part of event-based surveillance (EBS).

In Kenya, WHO trained the Ministry of Health on the Epidemic Intelligence from Open Sources (EIOS) initiative[66]. Seven Member States started using EIOS during the review period,[67] thereby scaling up their event-based reporting system and IDSR strategies.

The African Emergency Operations Centre, established by the Regional Office in 2015 with the WHO Health Emergencies Programme, developed a dedicated website for the African Regional Public Health Emergency Operations Centres Network (AFR-PHEOC-NET). **The website improved communication, information-sharing, and the exchange of best practices among PHEOCs across the Region**.[68]

WHO AFRO also continued to develop governance arrangements and legal frameworks for PHEOCs, formulating SOPs and engaging in joint advocacy and policy dialogue with Africa CDC and other global, regional, and local stakeholders to ensure sustainability.

Simulation exercises were implemented to test the functional effectiveness of the PHEOCs, with PHEOC and incident management system staff in Cabo Verde, Niger and South Africa trained in public health emergency management.

APRIL 2023
35 COUNTRIES
SUBMITTED WEEKLY IDSR REPORTS

3.3 TIMELY AND EFFECTIVE RESPONSE TO HEALTH EMERGENCIES

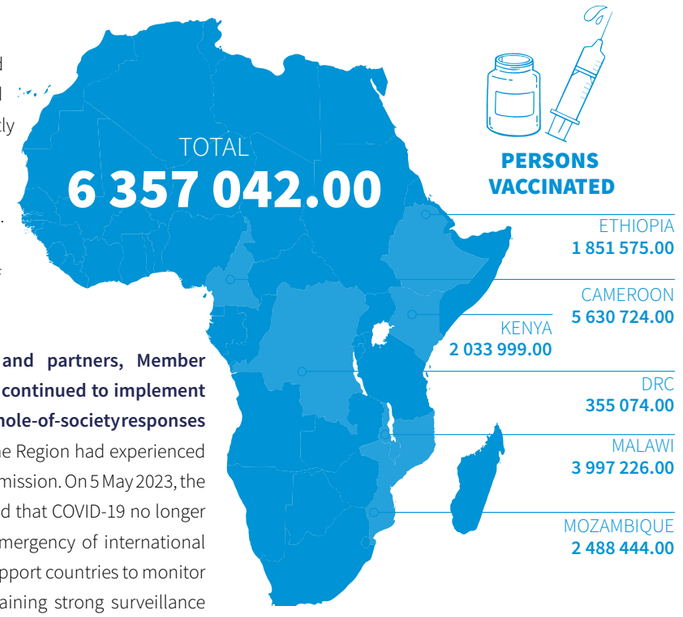
The WHO African Region continued to experience increases in new, emerging and re-emerging diseases. From July 2022 to June 2023, the Region responded to an average of 152 public health events each week. Of these events, an average of 131 were disease outbreaks while an average of 21 were humanitarian events.

At the end of January 2023, the Region was responding to five grade 3 events, 22 grade 2 events, one grade 1 event and 40 ungraded events. Response was also ongoing for two protracted grade 3 events and five protracted grade 2 events. At the end of June 2023, the Region was responding to three grade 3 events, four grade 2 events, two grade 1 events and 40 ungraded events. In June 2023, the Region was also responding to three protracted grade 3 events and 6 protracted grade 2 events.[69]

The re-emergence of Rift Valley fever in Mauritania, polio in Malawi and Mozambique, Ebola in the Democratic Republic of the Congo and Uganda, diphtheria in Niger and yellow fever and cholera in multiple countries, against the backdrop of ongoing pandemics and epidemics including COVID-19, Mpox and Marburg virus, highlighted the importance of strong response capacity at national and subnational levels to protect lives and livelihoods.

FIVE INTERCONNECTED SYSTEMS OF CORE CAPABILITIES AND SOLUTIONS

Ongoing protracted conflicts, along with droughts attributed to climate change, accelerated food insecurity, not only directly threatening health, but also interrupting health-seeking behaviour such as vaccination. The occurrence of outbreaks such as measles is evidence of this situation.



With support from WHO and partners, Member States of the African Region continued to implement whole-of-government and whole-of-society responses to COVID-19. By June 2023, the Region had experienced five waves of SARS-CoV-2 transmission. On 5 May 2023, the WHO Director-General declared that COVID-19 no longer constituted a public health emergency of international concern. WHO continues to support countries to monitor the pandemic through maintaining strong surveillance and laboratory capacities while continuing to strengthen COVID-19 vaccination.

By the end of the review period, WHO AFRO had supported countries to contain acute outbreaks of Ebola in the Democratic Republic of the Congo and Uganda, Marburg in Equatorial Guinea and United Republic of Tanzania, yellow fever outbreaks in 12[70] countries and cholera in 14[71] countries. This support for the coordination of response efforts included the establishment of an incident management system for the Ebola outbreaks and the deployment of technical experts, supplies and logistics. Notably, the Ebola outbreaks were contained within three months in the Democratic Republic of the Congo and within four months in Uganda.

For yellow fever, WHO AFRO established a command centre in Ouagadougou in Burkina Faso to support affected countries. This contributed to a significant decline in transmission, from 202 cases in 12 countries to only six cases in four countries in the last six months of 2022. For cholera, nearly 16.4 million vaccines were administered during reactive campaigns between July 2022 and June 2023, while millions more people benefited from the provision of safe water and sanitation services.

Cholera response in Niger:
August - September 2022

In just 28 days, from the time Niger first reported 10 suspected cases of cholera on 1 September 2022, the outbreak was declared over, with no deaths reported. In the interim, WHO deployed 15 personnel to the affected region and activated expert responders.

Multiple factors contributed to the success of the response. The SURGE team, which had received six weeks of training, was deployed within 48 hours of being notified of the first three cases. The mobile laboratory deployed by the team's two laboratory focal points enabled on-site diagnosis and allowed the team to train local laboratory technicians to diagnose cholera. This cut diagnosis time from three weeks to 48 hours. The SURGE team received regular updates on the regional security situation and collaborated efficiently with national authorities, various NGOs active in the health sector and the WHO mission team.

1 SEPTEMBER 2022
10 SUSPECTED CASES
OF CHOLERA

28 DAYS AFTER
OUTBREAK WAS DECLARED OVER

SURGE TEAM WAS DEPLOYED
48 HOURS AFTER
being notified of the 1st
3 cases

2 LABORATORY FOCAL POINTS
enabled on-site diagnosis

SURGE team collaborated efficiently
with national authorities
NGOs and WHO mission team

Integrating mental health and psychosocial support within emergency response is a key component of WHO support to Member States experiencing acute and protracted health emergencies.

Mental health and psychosocial support (MHPSS) is integral to emergency preparedness and response. WHO AFRO provided MHPSS support to all 47 countries, as well as targeted support to North-east Nigeria, South Sudan, Ethiopia, Mozambique and the Democratic Republic of the Congo. In Ethiopia, WHO AFRO deployed international and national MHPSS technical officers, procured and distributed 2750 mhGAP manuals, provided mhGAP training for PHC workers and mobile health and nutrition teams, procured and distributed essential psychotropic medications and has supported the training and deployment of Self Help Plus, a low-intensity psychological intervention. While the need for essential mental health services remains high, huge strides have been made in establishing a sustainable mental health care system. The three most affected regional health bureaus have reported increased numbers of people accessing services, from about 3000 in January 2023 to 8000 in June 2023.

In Niger, the Directorate of Surveillance and Response to Epidemics (DSRE) assembled a crisis cell and deployed three investigation teams from the EPR cluster to assess yellow fever, diphtheria and Rift Valley fever cases. Investigation teams successfully sampled all 26 suspected diphtheria cases, also confirming a yellow fever and a Rift Valley fever case. This helped contain disease spread thanks to the discovery of eight additional suspected diphtheria cases and 54 contacts, all of whom received prophylaxis. A further 16 contacts and 10 animals were also sampled as part of the investigation into the Rift Valley fever case.

As a marker of progress from the third flagship project, SURGE, WHO AFRO engaged with countries to identify and train 1090 additional national emergency responders in 14[72] countries. This significantly boosted the number of available high-calibre African responders, improving capacity for rapid containment of outbreaks.

During the review period, national SURGE teams were deployed to respond to emergencies in Botswana, the Democratic Republic of the Congo, Ethiopia, Malawi, Mauritania, Niger, Rwanda, Togo and the United Republic of Tanzania. A further 250 WHO staff across various disciplines were identified to provide back-up support for emergency response efforts.

WHO AFRO and key partners[73] also conducted six regional cholera readiness training workshops for 28[74] high-risk countries during the review period. This had fourfold benefits, including the training of 240 staff (government and partners), the strengthening of preventive measures in hotspots in all Member States, the development of national preparedness plans in three countries[75], and early detection and rapid control of cholera in Niger specifically.

Working with Africa CDC and UNICEF, WHO AFRO also supported the convening of an intersectoral ministerial meeting on cholera and climate-related emergencies in Malawi in March 2023. This led to the endorsement of a joint communique by ministers for health, water and sanitation and environment of African Union (AU) Member States that are also members of SADC. The results included costed country road maps to address cholera epidemics and the climate crisis in SADC Member States.

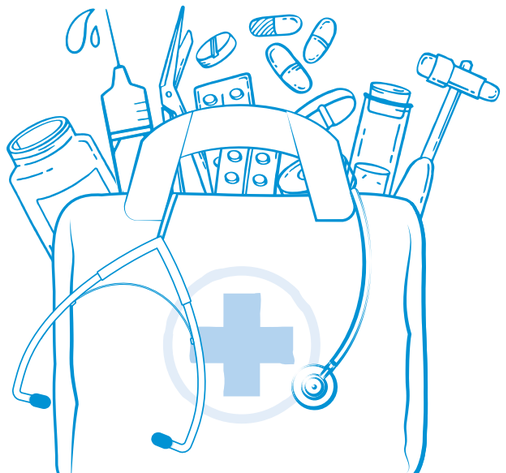
WHO AFRO & KEY PARTNERS
conducted
6 REGIONAL CHOLERA READINESS TRAINING WORKSHOPS
for:
28 HIGH-RISK COUNTRIES
including:
THE TRAINING OF **240 STAFF**

CHAPTER 4
PROMOTING HEALTH AND WELL-BEING

Providing strong enabling environments for individuals, families and communities to take control and make more informed health decisions is key to promoting population health and well-being. WHO and partners supported Member States to promote healthy lives and well-being and prevent disease by addressing root causes.

4.1 ENGAGING COMMUNITIES TO PROMOTE HEALTH, ADDRESS SOCIAL DETERMINANTS AND RESPOND TO EMERGENCIES

Community engagement is a critical component of a whole-of-society approach to assuring health and well-being. During the review period, WHO AFRO supported several activities in this regard. **Six[76] countries impacted by cholera outbreaks were supported to develop community engagement strategies,** including information, educational and communications brochures, flyers and billboards. In Malawi, WHO coordinated partners to establish functional community engagement technical working groups at the national and subnational levels. These were instrumental in bringing the outbreak under control.



Engaging with religious groups: the power of community engagement in readiness & during outbreak response

Religious beliefs can impact how communities respond to public health measures during an outbreak and the Malawi cholera outbreak is a good example. The Bandas lived in Mchezi and were members of the Zionist Christian Apostolic church, which believes in faith healing. Joseph, head of the household, was a hardworking blacksmith, and his wife, Grace, was a housewife and mother to their six young children.

Though well aware of the cholera outbreak that affected many families in Lilongwe and surrounding districts, Joseph never believed he was in any danger of contracting cholera – until one day in early March 2023, when he developed symptoms. He went to church to pray before he succumbed to the disease. Grace and their children also fell seriously ill but refused to seek medical care. She died too, leaving six young orphans.

WHO and Malawi's Ministry of Health, concerned about the widespread loss of life among the church membership owing to resistance to life-saving public health interventions, organized meetings with church leaders and local chiefs. It was the first time that Government and partners had taken time to listen to their concerns, they said.

The WHO risk communication and community engagement (RCCE) team learnt that the church was against the use of chlorine for water purification. Respecting their position, WHO demonstrated the use of water filters and how to prepare oral rehydration solutions as effective alternatives. Church members were invited to taste the samples and agreed to start implementing the interventions – a simple public health measure that saved many lives.

Community feedback mechanisms (CFM) were developed for use in preparedness and response to outbreaks, with 45 health promotion officers trained in their use. **The two-way feedback mechanism created between service providers and communities has enhanced trust**. The result is a final approach that ensures equitable access to assistance and services, taking into account factors such as gender and inclusion, as well as power dynamics and protection needs.

In respect of health promotion, 29 countries[77] developed strategies and policies. In 25 countries,[78] multisectoral coordination mechanisms were set up, with eight countries[79] already implementing multisectoral and multidisciplinary strategies to address risk factors and the social determinants of health. Côte d'Ivoire developed a national health promotion training guide targeting non-health sectors. Behavioural science studies have been launched in Burkina Faso, Namibia, and Zambia, supported by a grant from the Rockefeller Foundation. Lessons on what facilitates and hinders adoption of health-promoting practices from this 14-month project will inform roll-out to other African countries.

WHO and partners provided technical support to Douala in Cameroon to develop a city profile, through multidisciplinary and multisectoral civic engagement at municipality level. Stakeholders discussed potential solutions to address key health determinants and public health problems and to define priorities. In an early result, the mayor of Douala city developed a local ordinance on access to safe water, adequate sanitation and housing.

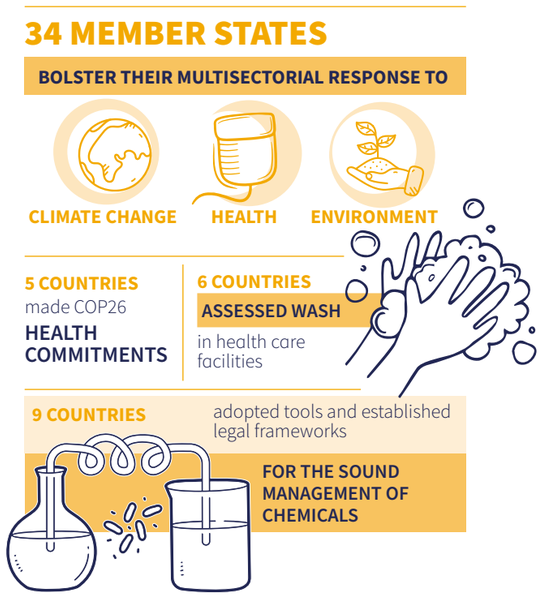
4.2 PROMOTING ENVIRONMENTAL HEALTH AND PROACTIVE MITIGATION OF/ADAPTATION TO CLIMATE CHANGE

WHO's collaboration with other UN agencies and development partners has supported 34 Member States[80] to bolster their multisectoral responses to climate change, health, and the environment. The adoption by the Seventy-second session of the WHO Regional Committee of the Updated Regional strategy for the management of environmental determinants of human health in the African Region 2022–2023 extended the window of opportunity for renewed country action.

Eight countries[81] developed or updated national environmental health policies and five countries [82]made UN Climate Change Conference (COP26) health commitments to build climate-resilient and sustainable low-carbon health systems. This brought the Region's participation in the COP26 initiative to 24 countries[83] out of 65 globally.

Five Sahelian countries[84] received joint support from WHO, UNICEF and the French Development Agency (AFD) to improve WASH monitoring capacities. Fifteen countries[85] developed WASH accounts for national benchmarking, cross-country comparisons and to provide evidence to inform better planning, financing, management and monitoring of WASH services and systems. Six countries[86] assessed WASH in health care facilities and were supported to improve WASH services in line with WHO's WASH-FIT tool.

In addition, nine countries[87] receiving support from WHO, the UN Environment Programme and the Africa Institute, adopted tools and established legal frameworks for the sound management of chemicals. Having identified key pollutants, Gabon, Madagascar, Mali and Senegal initiated their safe collection, transport and storage prior to final disposal abroad.



4.3 ADDRESSING THE BURDEN OF MALNUTRITION AND ENSURING FOOD SAFETY

To date, few countries in Africa are on track to achieve the 2030 nutrition targets. While 17 countries[88] are on track to achieve the wasting target of below 5% prevalence among under-fives, only six countries[89] are on course to achieve the target of stunting, none for anaemia and low birth weight, 20 for exclusive breastfeeding and none for childhood overweight and obesity. Furthermore, the Region faces an alarming deterioration of the food security situation in the Greater Horn of Africa, Madagascar, and the Sahel countries, which is affecting the most vulnerable, including women, young children and internally displaced people, putting them at risk of disease and acute malnutrition.

WHO SUPPORT

BENIN, CÔTE D'IVOIRE & GUINEA

ESTABLISHED MULTISECTORAL MECHANISMS TO RESPOND TO FOOD SAFETY EMERGENCIES

IN GUINEA
25 EXPERTS
were trained in food safety risk assessment

WHO AFRO trained about 50 EXPERTS
for potential deployment to provide clinical services

More than
24 800 MEDICAL TREATMENT PACKAGES
for managing complicated wasting in children were also distributed to countries

Therefore, addressing malnutrition in all its forms as well as food safety issues were high on WHO AFRO's agenda during the year in review. WHO strengthened its partnerships with the AU, contributed to the development of the African Strategic Framework for Food Systems Transformation, implemented the road map of the African Union Year of Nutrition 2025 and adopted the Abidjan Declaration on Nutrition. These actions were aimed at accelerating national investment, implementation, and coordination to improve nutrition and food security. WHO AFRO joined the WHO food security task force to develop the "Food insecurity and health strategic framework for readiness and response", providing guidance for adapting health and nutrition actions in response to increased malnutrition and health risks due to food insecurity. The framework has been disseminated widely in countries facing food insecurity in the Greater Horn of Africa, Madagascar, and the Sahel, resulting in the implementation of appropriate public health measures for rapid response and early recovery.

With WHO support, Benin, Côte d'Ivoire and Guinea established multisectoral mechanisms to respond to food safety emergencies. These have facilitated information-sharing and ensured a rapid, coordinated response to food safety emergencies. In Guinea, in collaboration with the UN's Food and Agriculture Organization, 25 experts were trained in food safety risk assessment. Côte d'Ivoire, Guinea, Malawi, and Senegal were also supported to strengthen country capacity on different aspects of the Codex Alimentarius (food code) standards and practice.

To boost countries' capacity to manage severely malnourished children with medical complications, WHO AFRO trained about 50 experts for potential deployment to provide clinical services or to cascade capacity-building for health workers in countries and in emergency settings. More than 24 800 medical treatment packages for managing complicated wasting in children were also distributed to countries.

To advance the prevention and management of obesity over the life course, 10 obesity high-burden countries[90] were identified for intensified support. Among these, Botswana, Eswatini, Mauritius, Seychelles, and South Africa have received support from the Secretariat to adapt and implement the WHO acceleration plan to STOP obesity, adopted by the World Health Assembly in May 2022.

For the prevention and management
OF OBESITY OVER THE LIFE COURSE

10 OBESITY HIGH-BURDEN COUNTRIES
were identified for intensified support

4.4 TACKLING TOBACCO USE AND OTHER RISK FACTORS FOR NONCOMMUNICABLE DISEASES

Reducing risk factors involves enacting policies and regulations, promoting fiscal measures and building capacity for implementation. Along with unsafe food, other risk factors targeted included alcohol consumption, unhealthy diets, lead in paint, tobacco use, violence and injuries.

To boost tobacco control, WHO provided technical and legal support to six countries[91] to develop tobacco control laws and regulations while building capacity towards the enforcement of smoke-free laws in 16[92] countries. WHO AFRO also assisted six countries[93] to measure the contents and emissions of tobacco products and to address the rising use of products such as electronic nicotine delivery systems (ENDS) and heated tobacco.

Sierra Leone passed a comprehensive tobacco control law, while the tobacco control bills of South Africa and Zambia are pending parliamentary endorsement. Support to Burkina Faso, Côte d'Ivoire and Mauritius was focused on packaging and labelling.

The alternative livelihoods project in Kenya, which has garnered global attention, moved to the second phase of implementation. This increased the number of enrolled farmers who switched from tobacco to high-iron beans from 2000 in 2022 to 3000 by the end of the review period. This boosted nutrition and food security, increased household income for the farmers sixfold, reduced child labour and improved school attendance. It is also positively contributing to environmental conservation and overall population health protection.

Meanwhile, a brief entitled "Policy, system and practice response to alcohol consumption during the COVID-19 pandemic in seven countries of the WHO African Region"[94] revealed the need to amend existing regulatory frameworks on the sale and distribution of alcohol, especially in respect of new challenges, such as online sales and home delivery, which increased exponentially during the pandemic. Liberia and Sierra Leone developed national alcohol policies to reduce use. Chad, Sao Tome and Principe and Uganda began developing legislation on alcohol control, and Kenya began revising its taxation policy to reduce affordability and accessibility.

Through the Global Alliance to Eliminate Lead Paint, WHO AFRO worked with government and industry stakeholders in seven countries[95] on regulatory and voluntary actions to phase out lead in paint. In addition, communities in 11[96] countries were made aware of the dangers of lead poisoning and precautionary measures they should adopt.

6 COUNTRIES
received technical and legal support to
DEVELOP TOBACCO CONTROL LAWS AND REGULATIONS

16 COUNTRIES
have stronger capacities for the
ENFORCEMENT OF SMOKE-FREE LAWS

6 COUNTRIES
received WHO AFRO assistance to
MEASURE THE CONTENTS AND EMISSION OF TOBACCO PRODUCTS

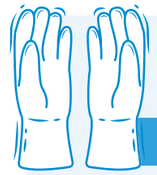
4.5 PREVENTING VIOLENCE AGAINST CHILDREN AND ENHANCING ROAD SAFETY AND REHABILITATION SERVICES

The work on healthy settings initiatives seeks to promote healthy cities, markets, and schools. This includes measures for disability inclusion and age-friendly policies and improved rehabilitation services. WHO AFRO supported the United Republic of Tanzania to mainstream disability in the health sector, through engagement with organizations of persons with disabilities (OPDs). In addition, five countries[97] developed national strategic plans for rehabilitation services and six[98] integrated rehabilitation modules in routine health information systems to enhance data availability for planning of services.

Initiatives have been developed to prevent violence against children and improve the response to child maltreatment, including parenting strategies in Côte d'Ivoire,[99] Namibia, United Republic of Tanzania, and Zimbabwe.

Mortality due to road traffic injuries is still a major problem in the Region, with an average mortality rate estimated at 56 and 58 per 100 000 population in 2015 and 2019 respectively. Technical support was provided to five countries[100] to improve data on road traffic accidents, to inform planning and advocacy. Important advances towards improved road safety include the signing by Senegal of the African Road Safety Charter and finalization by Eswatini of its road safety strategy.

Following a review of drowning prevention policies in Ghana, Malawi, Uganda and the United Republic of Tanzania, these countries received support to develop draft national drowning prevention strategies



5 COUNTRIES
developed national strategic plans for
REHABILITATION SERVICES

6 COUNTRIES
integrated rehabilitation modules in
ROUTINE HEALTH INFORMATION SYSTEMS

5 COUNTRIES
receive technical
SUPPORT TO IMPROVE DATA ON
ROAD TRAFFIC ACCIDENTS

CHAPTER 5
INTEGRATED ACTION FOR BETTER HEALTH

WHO AFRO leveraged health technology and digital solutions to adapt its programmes, improve availability of quality data and foster an evidence-based culture. This was achieved by strengthening research, embracing innovation and using digital technologies. These efforts served to advance countries towards improved access for their populations to a full range of quality health services, when and where they need them.

5.1 COMBATING ANTIMICROBIAL RESISTANCE (AMR)

In the face of the growing AMR threat, WHO AFRO and partners deployed efforts to fight microbes becoming resistant to the drugs traditionally used to treat them. Over the review period, **WHO supported seven countries[101] to develop and validate their AMR strategies, bringing the total to 45 (96%) countries** – leaving only two countries[102] yet to develop national action plans (NAPs) on AMR.

Four[103] more countries joined the Antimicrobial Resistance and Use Surveillance System (GLASS), the first global collaborative effort to standardize AMR surveillance, bringing to 37 the number of countries in the African Region that have registered.

Enrolment in GLASS has improved understanding by Member States of AMR and its impact. Five countries[104] have used national AMR data to develop policy briefs for evidence-based decision-making. The UN Multi-partner Trust Fund has enabled countries to develop national AMR plans, strengthened AMR surveillance systems and promoted AMR-related research. The collaboration between the regional quadripartite organizations – the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Organisation for Animal Health (WOAH) and WHO – improved AMR governance across sectors by ensuring that threats were addressed in a coordinated and comprehensive manner.

Coordinated support to 42 Member States to track AMR through country self-assessment surveys (TrACSS) provided updated individual country profiles on progress made and key gaps in the implementation of NAPs; these findings are guiding the development of remedial actions. The joint inspections of waste management systems by environmental and medical inspectors also promoted the safe disposal of antimicrobials.

Capacity was built to strengthen AMR stewardship and antimicrobial consumption. The training of 85 manufacturing inspectors of antimicrobial products will promote good manufacturing practices; the training of personnel from 17 countries[105] on best practices in optimizing antimicrobial use and 53 health workers from three countries[106] on implementing practical, cost-effective and sustainable antimicrobial stewardship programmes in health care facilities will further serve to curb AMR. Regional antimicrobial stewardship training modules for multidisciplinary health facility teams were developed and piloted in Ghana, Nigeria, and Zambia.

Awareness and understanding of AMR in the Region continues to be strengthened. Guided by the One Health approach, collaboration among the regional quadripartite organizations and Africa CDC has continued with the joint commemoration of the World Antimicrobial Awareness Week. Last year's joint commemoration took place in Dakar in Senegal, hosted by the Government of Senegal and its One Health platform. In addition, education and awareness activities targeting young people so that no one is left behind, have led to the training of over 899 youth ambassadors from 30 secondary schools in the Lagos and Osun States of Nigeria. These young persons are now equipped with tools that enable them to serve as advocates against the threat posed by AMR within their communities.

5.2 STRENGTHENING LABORATORY SERVICES

The WHO African Region continues to improve the quality of diagnosis of Buruli ulcer (BU) through the Buruli ulcer laboratory network (BU-LABNET), which is providing support to 13 laboratories across nine endemic countries[107] in the Region. The Secretariat conducted collaborative research to improve diagnostic approaches for BU and integrate other NTDs in the PCR-based platform for case confirmation in the different laboratories of the network. The Secretariat is also harmonizing SOPs to ensure that all laboratories in the network utilize standardized procedures for PCR-based diagnosis of BU.

Routine malaria diagnosis (rapid diagnostic tests (RDT) and microscopy in health facilities) and surveillance systems continue to be strengthened across Member States. Through collaborative efforts with designated WHO collaborating centres, an external competency assessment for malaria microscopists (ECAMM) was conducted. Forty-one microscopists from Sao Tome and Principe, Mali, United Republic of Tanzania, and Uganda were trained and certified over four ECAMM courses.

Nine facilitators were trained as ECAMM facilitators in the WHO African Region. The Secretariat also supported the conduct of therapeutic efficacy tests (TET or TES) in six countries[108] to ensure that malaria treatments remained effective and efficient, safeguarding the health of vulnerable populations. The ESPEN Laboratory provided laboratory equipment to countries through the network of WHO country offices, which greatly strengthened the diagnostic capabilities of health care facilities.

In early 2020, at the start of the COVID-19 pandemic, only two African countries – Senegal and South Africa – had the capacity to test for the novel coronavirus using genomic sequencing methods. However, numerous countries have since renovated, built, or equipped laboratory facilities. Currently, all the countries in the Region have PCR testing capacity, including at subnational level in some of the countries. The establishment of the regional COVID-19 sequencing laboratory network significantly contributed to improving genomic surveillance on the continent, facilitating the identification and tracking of virus evolution for effective response strategies.

By mid-2023, over 90% of Member States in the African Region had in-country sequencing capability that serves a public health function, while the remaining 10% have access to timely specimen referral.

9 ECCAM FACILITATORS
were trained in the WHO AFRO region

THERAPEUTIC EFFICACY TESTS
were conducted in
6 COUNTRIES
to ensure malaria treatments remained effective and efficient

BY MID-2023,
+90%
of the AFRO member states
have in-country COVID-19 sequencing capability

of the laboratories, and also serves as the starting point for operational collaboration between participants from the human and animal health sectors of the same countries.

Guideline adherence is paramount to effective laboratory governance. WHO support to seven countries[110] and regional health communities (West African Health Organization; East, Central and Southern Africa Health Community) included provision of technical assistance, particularly for the development of laboratory policies, plans and strategies, enhancing expertise and driving collaborations. The Secretariat organized the WHO Africa Medical Devices Forum to disseminate regulatory guidelines for medical devices, including in-vitro diagnostics utilized by countries.

To ensure quality assurance of microbiology and antimicrobial susceptibility testing in national reference laboratories, the Secretariat conducted two rounds of laboratory proficiency testing in collaboration with South Africa's National Institute for Communicable Diseases. Forty-five laboratories from 27 countries[111] that took part in the programme are following up with the requisite remedial actions.

To strengthen disease surveillance, the community-based surveillance initiative (CBRI) also enhanced the scale-up of cost-effective, easy-to-use diagnostics to enhance case detection. Countries are repurposing this improved testing capacity to address outbreaks such as recent viral haemorrhagic fevers and Mpox outbreaks, as well as for AMR and One Health surveillance.

As part of applying the lessons learnt and preparing for the next pandemic, 25 participants from five central African countries[109] completed a comprehensive and competency-based Global Laboratory Leadership Programme (GLLP), designed to strengthen laboratory systems through enhanced leadership skills. Twenty-one graduates were granted stipends to implement personal leadership projects in laboratory management, guided by mentors using the One Health approach. This training yielded 20 new laboratory leaders who are now implementing the lessons learnt in their respective national health systems. It has enabled road maps to be drawn for the development

APPLYING THE LESSONS LEARNT,
& PREPARING FOR THE **NEXT PANDEMIC**

25 participants from **5 central African countries**
completed a comprehensive and competency-based Global Laboratory Leadership Programme (GLLP)

21 GRADUATES
FROM GLLP
were granted stipends to implement
leadership projects in laboratory MANAGEMENT

45 LABORATORIES
are following up with the requisite remedial actions to ensure quality assurance of
MICROBIOLOGY AND ANTIMICROBIAL SUSCEPTIBILITY

5.3 IMPROVING ACCESS AND AVAILABILITY OF QUALITY INFORMATION FOR ACTION

Leveraging data to respond to challenges is a critical pillar in developing strategies to prepare for future shocks. To help achieve this, WHO published the 2022 Atlas of African Health Statistics during the review period. The Atlas brings together a wide range of health and related data and statistics across the SDGs into a single interlinked source, including country profiles. Since the first month of its launch in December 2022, the Atlas has been downloaded almost 25 000 times on both WHO's International Repository for Information-Sharing (IRIS) and the integrated African Health Observatory (iAHO) page.

WHO AFRO also provided technical and financial support to countries to generate evidence to strengthen service delivery systems. This support included conducting harmonized health facility assessments in three countries,[112] which provided information on readiness and availability of services. The monitoring of essential services conducted under the four rounds of the PULSE survey, the last being in March 2023, showed a decrease in the magnitude and extent of disruptions. Member States are using successful strategies, including community communications, to mitigate service disruption. Thirty-five countries[113] have participated in all four rounds of the survey. Moreover, AFRO held a regional meeting with all 47 countries on monitoring and evaluation of primary health care (PHC), which resulted in the creation of profiles and country road maps for enhancing monitoring and evaluation capacities to monitor holistic PHC.

Four new platforms were introduced on the integrated Africa Health Observatory (iAHO), expanding its reach as a hub for evidence and regional information: the Regional Master Facility List (RMFL), Africa Health Workforce Observatory, the Essential Health Package toolkit and Sub-national unit functionality. These join the COVID-19 information hub and the African Health Observatory Platform on Health Systems and Policies as standalone platforms hosted on the iAHO.

Country capacity for developing knowledge products was strengthened through cascade training held in Cameroon and Uganda for 11 countries.[114] These resulted in the development and dissemination of 44 knowledge products, including analytical factsheets, knowledge factsheets, blogs, policy briefs and infographics.

Importantly, WHO AFRO developed and promoted electronic systems for data collection to ensure rapid, accurate, reliable and efficient collection and reporting of health data, to bolster health information systems. These electronic systems are helping to phase out cumbersome paper-based systems that increase the burden of reporting on health workers and are prone to errors.

The number of countries using the DHIS2 platform increased from 32 (68%) in 2019 to 43 (91%) in 2022, resulting in improved availability, quality, and access to routine health data. Development of an electronic tool for medical certification of cause of death was completed and has been adopted for use by seven countries.[115] In addition, development of an online tool for training medical doctors on accurate diagnosis of cause of death has been completed and is now being rolled out in the Region. Seven countries[116] updated their health information system plans, which will strengthen the generation, analysis, and use of data, and align partner support.

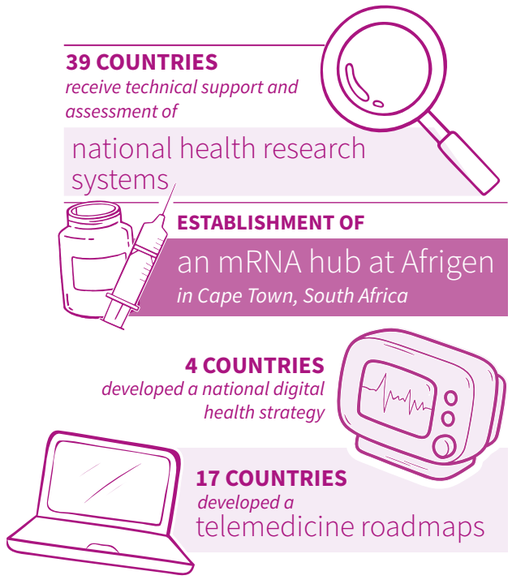
The Region has successfully initiated the development of the regional data hub, which will play a crucial role in integrating data and data systems from all disease programmes and other health-related sources across the 47 Member States. To date, data sets such as HIV, malaria and immunization have been integrated into the hub. This regional data hub will be seamlessly connected to the global data hub, ensuring a comprehensive and interconnected information network, and it will also be connected to the 47 Member States in the Region.

Progress has been accomplished through the development of a modern data architecture framework that is specifically designed to accommodate artificial intelligence and facilitate the swift generation of knowledge products at country level. This achievement sets the foundation for leveraging advanced technologies and enables the Regional Office to derive actionable insights from the wealth of available data.

5.4 RESEARCH, INNOVATION, AND DIGITAL HEALTH FOR IMPROVED OUTCOMES

COVID-19 seroprevalence and vaccine effectiveness studies were conducted in 31 countries.[117] The policy recommendations were sent to countries to sustain and enhance the momentum for vaccination in the face of widespread lower disease risk perception. The WHO Secretariat provided technical support for an assessment of national health research systems in 38 countries[118] across the Region using a tool to rank countries within socioeconomic groupings. Additionally, nine countries[119] were assisted to revise their national health policies and legal frameworks to support a stronger commitment to accommodate emerging technologies.

The work on mRNA technologies for vaccine development made impressive progress and garnered global interest. In collaboration with scientists in the Region, WHO contributed to the establishment of an mRNA Hub at Afrigen in Cape Town in South Africa. The hub, led by local scientists, produced the first batches of mRNA COVID-19 vaccines in Africa in 2022. This helped to advance the Organization's goal of improving access to essential medicines, vaccines, diagnostics, and devices for PHC. The mRNA hub has since expanded its operations and is now supporting the transfer of mRNA technology to 17 international vaccine manufacturing partners from low--and middle-income countries across the world, including five African countries.[120] Leveraging work on health product manufacturing, the Science Team – see next paragraph – has also identified 25 priority pathogens in the Region. The science of mRNA research and key applications relevant to the Region will inform efforts to fight other diseases, such as HIV and tuberculosis, into the future.



Building infrastructure for accurate and appropriate diagnostic testing, along with local vaccine manufacturing capacity, are major advances towards readiness for the next pandemic. To support countries towards these goals, WHO AFRO established a Science Team. It is tasked with coordinating a science agenda that promotes research, development and competencies in science for the discovery of new tools for disease prevention and control, while improving medicine and medical device regulatory systems. This has been an important focus area in establishing the linkage between health emergency preparedness and health systems strengthening.

To spur innovations and effective use of digital technologies, the Secretariat supported Member States to embrace digital solutions by building institutional capacity and strengthening governance. To this end, the eHealth strategy jointly developed by WHO and the International Telecommunication Union (ITU), the framework setting out how countries can strengthen their health innovation ecosystems,[121] coupled with training in digital leadership[122] and telemedicine, have guided the development of national digital health strategies in four countries[123] and telemedicine road maps in 17 countries[124] within the last year.

These will guide the adoption and scaling up of digital technologies in countries.

Use of digital interventions in conducting campaigns has shown positive results that must be scaled up and sustained. To this end, five Member States[125] developed analytical tools to assess the economic and social impact of innovations and further developed costed road maps for facilitating the digitization of campaigns.

Cross-country learning on digital innovations was fostered through innovation platforms which are functional in 12 countries.[126] For example, Botswana was supported to develop and pilot an integrated digital innovation platform, aimed at coordinating partnership-driven scale-up of locally relevant health innovations for sustainable impact. Ghana, for its part, set up a National Vaccine Institute to facilitate innovation and vaccine production.

CHAPTER 6
PROVIDING BETTER SUPPORT TO COUNTRIES

Supporting Member States to achieve the UHC agenda requires strong leadership, partnerships and administration; the appropriate resources and support systems for timely and agile management of the Organization's finances; and technologies. To achieve this, work during the review period focused on strengthening leadership and administrative systems.

5.5 MITIGATING THE IMPACT OF COVID-19 ON HEALTH DEVELOPMENT

The WHO Secretariat in the African Region provided important support to the Region's COVID-19 response. Over 150 technical partnerships were built, including with civil society organizations (CSOs), in response to COVID-19. These partnerships are now extended to addressing other epidemics in the Region. The knowledge built across countries on mapping and quantifying essential supplies on the four pillars of laboratory; infection prevention and control (IPC); case management; and continuity of essential health services has equipped Member States to tackle the next pandemic. Also on hand at the country level are the strengthened (1) information management, research, and documentation culture; (2) sustainable IPC programmes, (3) operational research in RCCE; and (4) partner coordination and collaboration, supporting responses to the over 100 emergencies reported yearly on the continent.

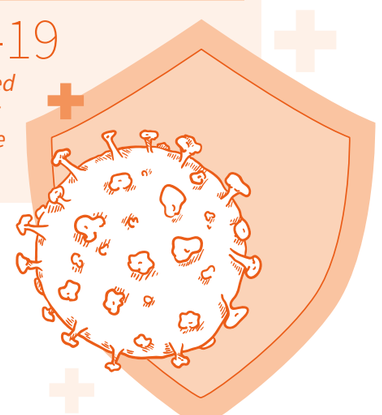
The importance of putting communities at the centre of preparedness for future pandemics and epidemics while also promoting and providing health as part of a strong PHC strategy is a legacy of the COVID-19 response in the Region. The WHO AFRO COVID-19 response team developed an innovative community-based response initiative (CBRI). The CBRI helped reduce COVID-19 cases and deaths through early detection and interruption of transmission in the community.

OVER 150

TECHNICAL PARTNERSHIPS BUILT IN RESPONSE TO

COVID-19

are now extended to address other epedemics in the Region



6.1 LEADERSHIP, GOVERNANCE, AND ADVOCACY FOR HEALTH

In the area of planning, monitoring, evaluation and budget management, increased emphasis was placed on bottom-up planning and priority-setting. During the review period, all 47 Member States, with the support of WHO country offices, successfully identified their priorities for the 2024–2025 biennium, which informed regional-level priorities and resource allocation.

A landmark decision during the Seventy-sixth World Health Assembly was the decision by all WHO Member States to increase assessed contributions (AC) by 20%, starting from the Programme budget 2024–2025. The WHO Secretariat, for its part, has intensified activities aimed at ensuring that financial, human and administrative resources are managed in an efficient, effective, results-oriented and transparent manner.

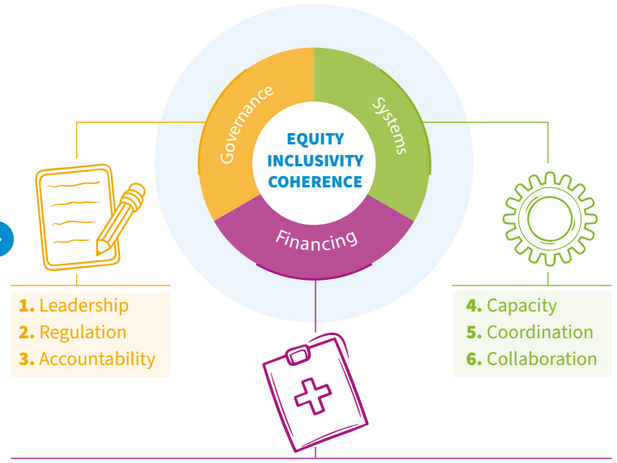
The second edition of the Tool for African Region Results (TAR II), which is expressed in dashboards and other relevant formats, was also successfully introduced. **This resulted in increased availability and use of evidence for planning, decision-making and resource allocation**. These combined achievements set the stage for improvements in results-based reporting and timely utilization of resources, highlighting the changes engendered by the efforts of WHO AFRO.

10 PROPOSALS TO BUILD A SAFER WORLD TOGETHER

Based on indepedent reviews, synthesizing + 300 recommendations...

...developed in consultation with Member States and partners, presented at the World Health Assembly May 2022

Strengthening the Global Architecture for Health Emergency Preparedness, Response & Resilience (HERP)



1. Leadership
2. Regulation
3. Accountability

4. Capacity
5. Coordination
6. Collaboration

7. Finance-Health coordination
8. Preparedness financing (incl. Pandemic fund)
9. Response financing

Since 2016, when, as a result of various challenges, WHO AFRO fell behind other regions in its efforts at compliance with internal controls and administrative systems, the Organization has progressively closed the gaps. The Regional Office for Africa is now at par with other regional offices in the current reporting period.

WHO AFRO expanded access to a range of digital services to speed up and automate workflows, including improving internet connectivity, which enabled the Organization to provide the requisite technical support to conduct the hybrid Seventy-second Regional Committee session in Lomé, Togo in August 2022. In a bold step towards creating a paperless office, the business enterprise software system, Bizagi, was introduced to automate administrative processes, significantly improving turnaround times and reducing spending thanks to reduced use of stationery.

Through the online conference interpretation internship programme, an innovative and creative concept which has been declared a flagship programme of the Region, more than 428 young interns from 19 Member States[127] were mentored to enhance their conference interpreting skills in all three official languages of the Region. The interns have so far provided interpretation support to 16 technical units in over 25 multilingual meetings, while 28 junior interpreters, (16 women and 13 men from nine[128] countries) have been added to the AFRO roster of interpreters.

The reporting period also confirms the firm commitment of AFRO leadership to diversity, equity and inclusion (DEI) through the consistent increase in gender balance and geographical representation among its workforce. The representation of women in overall staffing consistently improved, moving from 31% in 2018 to 33.8% during the reporting period.

To date, all Member States of WHO in the African Region are represented in the Secretariat: Seychelles, the only Member State which did not have any international staff member, is now represented as of 30 June 2023.

A flexible working arrangement policy was introduced effective 1 May 2023, allowing staff to telework outside the duty station for up to a month at a time and up to three months in a calendar year. This is an effort to modernize workforce management and to attract and retain talent. WHO AFRO further invested in creating a respectful work environment across the Region, including through stronger communication between staff association representatives and management, as well as through the deployment of a full time Ombudsman in the Regional Office.

Contracting and procurement services also improved, through the implementation of innovative measures such as the establishment of long-term agreements (LTAs) for recurrent operational expenditures, the use of a catalogue for goods procurement and legal clearance of agreements to avoid litigation. These measures have reduced procurement lead times and budget centre workloads, promoted the efficient use of resources and ensured value for money. The cumulative cost saving between 2022 and April 2023 was US$ 1.1 million.

Among the meaningful results during the reporting period is that WHO AFRO continued its seven-year run of satisfactory audit conclusions. There was also improvement in the timely implementation of audit recommendations. In 2022, forty-three per cent of the 16 open internal audit reports were successfully closed and internal controls systematically mainstreamed.

428 YOUNG INTERNS
were mentored to become

CONFERENCE INTERPRETERS IN
ALL 3 OFFICIAL LANGUAGES

In 2022,

43% **OF THE 16 OPEN INTERNAL AUDIT REPORTS**
were successfully closed

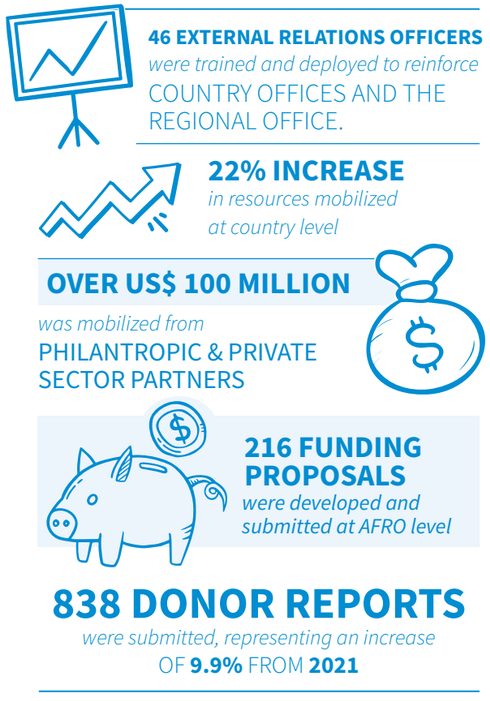
85%
OF THE REGIONAL WORKFORCE ATTEND AT LEAST **2 PRSEAH SESSIONS**

WHO AFRO's work to prevent and respond to sexual exploitation, abuse and harassment (PRSEAH) is anchored on the WHO value of integrity. During the reporting period, the Organization trained 61 regional trainers on PRSEAH. These trainers have in turn reached 100% of the WHO AFRO workforce, along with 1 031 798 community members and implementing partners. A total of 85% of the regional workforce attended at least two PRSEAH sessions during the reporting period. Nine Member States[129] that began implementing the SURGE project were granted access to the WHO PRSEAH eLearning platform to train their staff.

6.2 PARTNERSHIPS, RESOURCE MOBILIZATION OPPORTUNITIES AND GOVERNING BODIES

In line with the WHO global resource mobilization strategy and in the context of the Transformation Agenda, WHO AFRO worked to significantly improve external relations across the Region. This included recruiting and deploying international external relations and partnerships officers; showing a greater return on investment while diversifying the donor base; demonstrating greater accountability and quality and timely reporting; increasing participation in UN joint resource mobilization efforts; improving relations with traditional and non-State actors (NSAs); and adopting innovative digital resource mobilization tools.

Forty-six (46) external relations officers were trained and deployed to reinforce country offices and the Regional Office. During 2022–2023, over US$ 500 million was mobilized at country level, an increase from the US$ 412 million that had been mobilized during the 2021–2022 period. This represented a 22% increase in resources mobilized at country level. Thanks to increased partnerships with NSAs, over US$ 100 million was mobilized from philanthropic and private sector partners.



Several training activities on the Framework of Engagement with Non-State Actors (FENSA) were conducted for country offices. The process for FENSA clearances was streamlined in conjunction with the relevant finance and legal departments and a tracker implemented for live monitoring of the status of reviews and approvals of agreements. As a result, the number of FENSA clearance requests increased by 73%, from 64 in 2020 to 112 in 2022.

A total of 202 partner agreements were reviewed for legal and financial considerations and cleared in 2022, marking a 3% increase compared to 2021. At AFRO level, 216 funding proposals were developed and submitted and 71 UN-to-UN partnerships and UN joint programmes signed.

Five high-level missions were organized as part of the roadshow of the WHO Regional Director for Africa at the Seventy-sixth United Nations General Assembly (UNGA-76, New York), the World Health Summit (WHS, Berlin), Sweden (Stockholm), Canada (Ottawa) and the United States (New York, Washington and Atlanta). A total of 112 partner field visits took place at regional and country levels, along with six briefing sessions on ongoing projects and collaborations. A road map for action to address partner coordination needs and capacity requirements in 28 countries[130] and a scorecard on the status of country coordination were developed.

To enhance accountability, donor reporting improved significantly, with 2022 recording the highest number of donor reports submitted. Overall, 838 (95%) donor reports were submitted, representing an increase of 9.9% from 2021. Of the 838 reports, 42% were submitted on time (a significant decrease in overdue reports to 5% since 2018). Bimonthly report monitoring and the increased use by WHO staff of the interactive and user-friendly donor reporting dashboard enabled real-time tracking of the status of donor reporting as from 2018. These measures will improve WHO AFRO's accountability and relations with donors, building a solid foundation for donor sustainability.

Success stories were showcased and awareness created on the impact of WHO AFRO programmes and donor contributions, emphasizing the positive changes to the lives of beneficiaries. The major improvements for AFRO donor visibility included a 20% increase in the number of donors acknowledged, a 30% increase in published media posts and a 600% increase in the number of related photo stories. In addition, the number of videos increased fivefold, from three to 15, while 334 articles and press releases recognizing partners were published.

In respect of governing bodies, the first hybrid session of the Regional Committee for Africa was organized with over 500 active participants comprising both delegates and observers. Twenty briefings and coordination meetings for Member States were also held during statutory meetings.

A fruitful collaboration between WHO and Harmonization for Health in Africa (HHA) partners led to several key achievements. They include the following:

- WHO AFRO's collaboration with the ITU, and the Eastern and Southern Africa Regional Office (ESARO) of UNICEF boosted the digital health capacity of 15[131] countries.
- WHO AFRO's collaboration with the World Bank, the Global Fund, the United States Agency for International Development and other partners facilitated policy dialogue on health workforce investment among 26 countries[132] and development partners, resulting in an agreement on specific actions to address persistent challenges.

6.3 COMMUNICATION

By reorienting its efforts from reactive to proactive communication, WHO AFRO expanded audience reach and improved the quality of its communication and information products. These included press releases, videos, photo stories, feature articles, social media posts and biweekly newsletters.

Although the number of media briefings during the period decreased, from 33 in 2021–2022 to 17 in 2022–2023, largely owing to reduced COVID-19-related media engagements, the Regional Office still reached a very wide audience on other public health issues.

There was also significant social media growth, with close to a 10% increase in WHO AFRO Twitter followers and a similar increase in Facebook followers. More engaging multimedia content has been achieved through a focus on clearer messaging, robust campaigns for health days and the use of quality images. Another important contributor has been the wider variety of multimedia visual content, such as infographics, GIFs and short animations.

The newsletters, whose main audience includes national authorities; technical partners; financial partners and donors; academia and the media, are sent out to 12 000 recipients via the Poppulo distribution platform. During the review period, subscribers increased by 22%, from 28 000 to 34 000. Some 1.6 million messages were sent through the platform between June 2022 and May 2023. Half of all ministers of health in the African Region regularly opened and read the newsletters. Although webpage views decreased by 4.18%, average time on-page increased by 11.08%.

CHALLENGES

Despite the achievements registered during the 2022–2023 reporting period, the Organization's work was constrained by several challenges.

The COVID-19 pandemic exposed the fault lines in already weak health and logistical systems. This led to the reversal and/or stagnation of the public health gains made and continues to impede delivery of essential health services, including the effective implementation of primary health care.

There is a lack of sufficient and effective policies and regulations for the reduction of risk factors for NCDs, such as alcohol consumption, unhealthy diets, unsafe food, tobacco use, violence and injuries. This is exacerbated by interference from related industries and is a persistent challenge to efforts to adopt and implement effective measures to prevent and control NCDs.

Weak multisectoral collaboration and inadequate community engagement and participation in the planning, delivery, and evaluation of health services continue to hinder a whole-of-government and whole-of-society approach to public health management and negatively impact the sustainability and uptake of health services in the Region.

The suboptimal capacity of national authorities to generate and manage strategic health data continues to impede the production of timely and good quality public health information required for planning and decision-making.

Nineteen countries are still reporting polio cases despite ongoing investments. Inadequate planning and logistics for response campaigns, reaching all children in high-risk areas, conflict and insecurity, vaccine hesitancy owing to misinformation and community fatigue exacerbated by pandemic-related experiences are among the persistent challenges. The ongoing shortage of nOPV2 vaccines has further complicated response efforts in the Region and globally.

There is a limited budget allocation to fully staff the new structures designed for country offices and technical clusters for WHO in the African Region to perform to its full capacity and for optimal productivity.

RECOMMENDATIONS

Looking ahead, WHO AFRO will build on the achievements of 2022–2023 and explore new opportunities and ground-breaking strategies for improving public health outcomes in the Region in 2023–2024 and beyond. In doing so, the Organization will continue to be guided by the aspirations of Member States, its Transformation Agenda, GPW 13 and the SDGs to support countries towards the attainment of UHC.

SPECIFICALLY, WHO AFRO WILL CONTINUE TO:

1. Advocate for and provide technical assistance to Member States and health partners to fast-track the development and implementation of COVID-19 recovery plans in the region. The organization will continue to support broader health system resilience-building and the health security agenda, as part of its contribution to the attainment of the SDGs.

2. Sustain efforts towards ending polio, WHO will strengthen laboratory sequencing capacity, sustain the workforce for "last-mile efforts", and leverage technology and innovative solutions for greater impact and surveillance sensitivity.

3. Implement sustained and high-level advocacy to galvanize Member States to develop and implement the requisite policies and regulations to control risk factors for NCDs. The organization will also continue to engage the appropriate industries with a view to agreeing on sustainable and mutually beneficial solutions for reducing risk factors for NCDs.

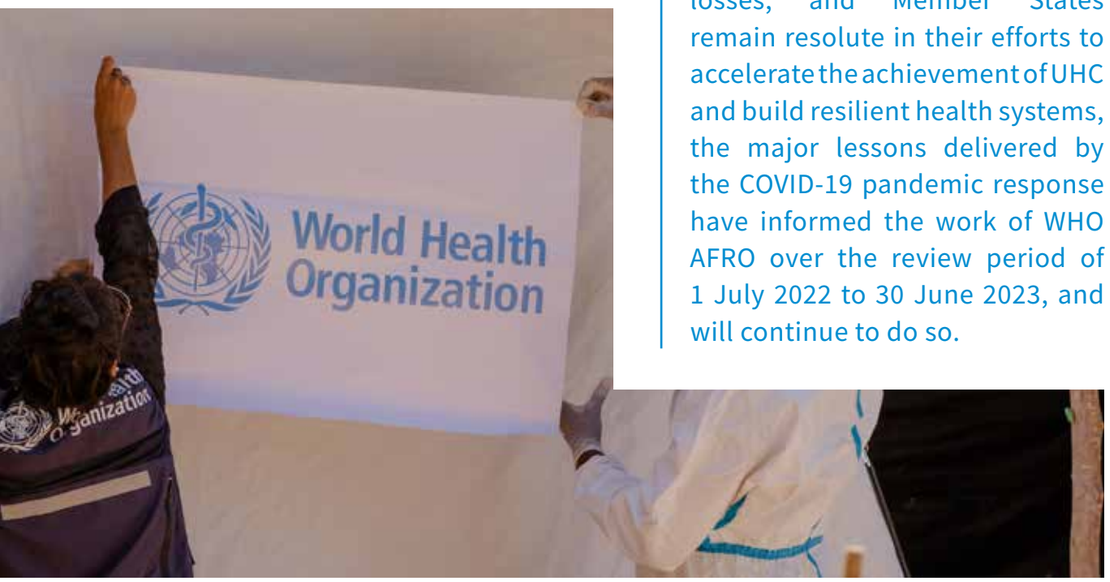
4. Work with its collaborating centres, research institutions, partners and Member States to support research aimed at exploring innovative mechanisms to ensure equity in service delivery and increase coverage of health interventions, understanding and characterizing emerging pathogens, their vectors and transmission dynamics, with a view to creating innovative strategies to limit their transmission.

5. Advocate for whole-of-government and whole-of-society approaches which prioritize multi sectoral collaboration and community engagement and participation as one of the key ingredients for accelerating the implementation of primary health care in the Region.

6. Build the capacity of Member States to generate, manage, disseminate and use public health data in planning and implementation of public health programmes.

CONCLUSION

As the African Region continues to recover from pandemic-related losses, and Member States remain resolute in their efforts to accelerate the achievement of UHC and build resilient health systems, the major lessons delivered by the COVID-19 pandemic response have informed the work of WHO AFRO over the review period of 1 July 2022 to 30 June 2023, and will continue to do so.



The Transformation Agenda is delivering enduring improvements to the effectiveness of the Secretariat, as evidenced by WHO's enhanced country-level engagement and gender diversity, as well as advances towards an enabling environment to improve staff performance, and improved efficiency and effectiveness. Acknowledging the changing contexts in countries and in global health and institutionalizing the Transformation Agenda-related successes will guide ongoing requisite adaptations to ensure an agile, responsive Secretariat. Strong partnerships have had a critical part to play in the successes recorded in this report. In terms of the next steps, the Secretariat will enhance these partnerships, especially with NSAs who have proven to be effective implementers during the pandemic response.

Notable achievements have been registered in several areas. These include strengthening health sector governance and service delivery systems, scaling up coverage of health interventions and the response to AMR, the control and elimination of NTDs and the improvement of child and maternal health. In addition, more timely detection and control of epidemics has been achieved and prevention efforts continue to increase.

Despite the successes, however, there is still a long journey ahead to meet global health targets, with Member States still not fully operationalizing some of the approaches that are key to improving health and addressing the drivers of inequality. Examples of these include multisectoral collaboration to tackle social determinants of health; PHC to ensure services are available to people when and where they need them; and addressing the risk factors of NCDs to counter the growing disease burden.

As we look to the future, the Secretariat will pursue the listed six areas to recover losses and accelerate progress. There will be a renewed focus on struggling countries and populations, supported by digital technologies to increase service coverage and improve quality of care. Efficient utilization of resources and implementation of programmes will also be prioritized.

Continental self-sufficiency, through boosting local manufacturing of vaccines and other medicines and medical devices, continues to be a priority. The Secretariat will support the mobilization of resources, the provision of expertise and the leveraging of regional economic communities for a more efficient subregional approach. It will also support Member States to strengthen regulatory and research capacity to support local manufacturing.

ANNEX 1. BUDGET ALLOCATION AND RESOURCE UTILIZATION

Over the reporting period, the WHO African Region mobilized 87% of planned resources. The Region spent slightly over US$ 1.2 billion, a significant percentage of which was from voluntary contributions (85%) – see Table 1. The Region only utilized 57% of mobilized resources.

TABLE 1.
Summary of WHO/AFRO Budget Allocation and Resources Utilization
June 2022 to May 2023

Budget in terms of Planned cost *(2022-2023)*	Total resources received *(Jan 2022 to May 2023)*		Resource utilization (US$) *(June 2022 to May 2023)*			
	In US$	As % of planned	Assessed contribution (US$)	Voluntary contribution (US$)	Total resource utilization (US$)	Total resource utilization rate
REGIONAL OFFICE						
653 435 991	564 084 916	86.3	68 495 943	203 739 493	272 235 436	48.3
COUNTRY OFFICES						
1 802 233 062	1 578 746 154	87.6	111 414 232	835 656 108	947 070 340	60.0
GRAND TOTAL						
2 455 669 053	**2 142 831 070**	**87.3**	**179 910 175**	**1 039 395 601**	**1 219 305 776**	**56.9**

ENDNOTES

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3 Angola, Côté d'Ivoire, Equatorial Guinea, Eritrea, Eswatini, Lesotho, Liberia, Madagascar, Mauritius, Sao Tome Principe, Sierra Leone, Tanzania, South Sudan.

4 Chad, Rwanda, Seychelles, Zambia, Zimbabwe.

5 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Togo, United Republic of Tanzania and Zambia.

6 Democratic Republic of the Congo, Republic of Congo, Mozambique and Malawi.

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8 Algeria, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Congo, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea-Bissau, Madagascar, Malawi, Mauritania, Mozambique, Niger, Nigeria, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

9 Algeria, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea-Bissau, Mauritania, Mozambique, Niger, Nigeria, Togo, Uganda, Zambia. https://www.afro.who.int/photo-story/geo-tracking-system-enhances-polio-response-congo.

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13 Angola, DRC, Ethiopia, Ghana, Guinea-Bissau, Equatorial Guinea, Mozambique, Malawi, Nigeria, Sierra Leone, and South Africa.

14 Burundi, Cameroon, Central Africa Republic, Chad, Cote D'Ivoire, Eritrea, Gambia, Ghana, Liberia, Sao Tome & Principe, Niger, Zambia.

15 Burundi, Central Africa Republic, Cote d'Ivoire, Democratic Republic of the Congo, Lesotho, Namibia, Nigeria, Senegal, South Africa, South Sudan, United Republic of Tanzania.

16 Angola, Benin, Cameroon, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Namibia, Niger, Rwanda, Sao Tome Principe, Sierra Leone, United Republic of Tanzania, Togo, Uganda, Zanzibar.

17 Burkina Faso, Cameroon, Central African Republic, Congo, Democratic Republic of the Congo, Gambia, Guinea, Kenya, Lesotho, Madagascar, Mali, Namibia, Rwanda, Senegal, South Sudan, Togo, Zimbabwe.

18 Congo, Kenya, Namibia, Senegal, South Africa.

19 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Gambia, Ghana, Guinea-Bissau, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

20 Angola, Botswana, Madagascar, South Sudan, United Republic of Tanzania.

21 Eritrea, Gambia, Rwanda, Senegal, Uganda, United Republic of Tanzania.

22 Ethiopia, Eritrea, United Republic of Tanzania, Kenya, South Sudan, Uganda, and Nigeria.

23 Joint United Nations Programme on HIV/AIDS (UNAIDS), 2023. The Path that Ends AIDS.

24 Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Guinea, Niger.

25 Burundi, Chad, Côte d'Ivoire, Madagascar, Niger, Senegal.

26 Botswana, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

27 Burkina Faso, Liberia, Mali, Namibia, Niger, Zimbabwe.

28 Ghana, Mozambique, United Republic of Tanzania, Zambia, Zimbabwe.

29 Cameroon, Congo, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea, Lesotho, Liberia, Madagascar, Namibia, Niger, Nigeria, South Africa, Togo, Uganda, Zambia, Zimbabwe.

30 Ghana, Kenya Malawi.

31 Burkina Faso, Cabo Verde, Sierra Leone.

32 Liberia, Zimbabwe.

33 Ethiopia, Liberia, South Africa, Lesotho, Zimbabwe, Namibia, Uganda, Eswatini, Seychelles, Burkina Faso, Kenya, Botswana

34 Botswana, Burkina Faso, Burundi, Cameroon, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Namibia, Nigeria, Seychelles, South Sudan, Zanzibar,

35 Angola, Benin, Botswana, Burkina Faso, Burundi, Chad, Comoros, Eritrea (Online), Eswatini, Ethiopia, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

36 Angola, Burkina Faso, Cabo Verde, Cameroon, Eswatini, Ethiopia, Kenya, Madagascar, Malawi, Nigeria, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia.

37 Ethiopia, Gabon, Kenya, Rwanda, United Republic of Tanzania, Zambia.

38 Angola, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo.

39 Cabo Verde, Cameroon, Gabon, Malawi, Uganda, Zimbabwe

40 Kenya, Ghana, Malawi, Mali, Uganda, Zimbabwe.

41 Côte d'Ivoire, Eswatini, Ghana, Mali, Malawi, Mozambique, Nigeria, United Republic of Tanzania, Uganda, Zambia.

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43 Angola, Botswana, Burundi, Comoros, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa (from UNICEF), South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe (and Somalia).

44 Algeria, Angola, Benin, Botswana, Burundi, Cabo Verde, Comoros, Democratic Republic of the Congo, Ethiopia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Sao Tome and Principe, Uganda, Kenya, Nigeria, Rwanda, South Africa, United Republic of Tanzania (including Zanzibar).

45 Kenya, Nigeria, Rwanda, South Africa, Zanzibar.

46 Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

47 Benin, Burundi, Chad, Gabon, Gambia, Malawi, Nigeria, Rwanda, Sierra Leone.

48 Côte d'Ivoire, Gambia, Guinea, Lesotho, Mauritania, Mauritius, Namibia, South Sudan, United Republic of Tanzania.

49 Benin, Equatorial Guinea, Togo, Ghana, Malawi, Democratic Republic of the Congo and Mali.

50 Benin, Cameroon, Comoros, Eritrea, Mali, Sao Tome and Principe, and Uganda.

51 Côte d'Ivoire and Togo in 2020; Benin, Rwanda and Uganda (gHAT) in 2021 and Equatorial Guinea and Ghana in 2022.

52 Niger, Nigeria, Senegal, Togo, Burkina Faso, Guinea-Bissau, Benin, Democratic Republic of the Congo, Mali, Côte d'Ivoire.

53 Angola, Central African Republic, Guinea, Mali, Nigeria, and South Sudan.

54 Guinea, Nigeria, and Cameroon

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

59 Ethiopia, Kenya, Uganda and Zimbabwe.

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62 Botswana, Democratic Republic of the Congo, Ethiopia, Malawi, Mauritania, Niger, Rwanda, Togo and the United Republic of Tanzania.

63 Benin, Cameroon, Ghana, Mauritius, Rwanda and Uganda.

64 Central African Republic, Iraq, Portugal, Sierra Leone and Thailand.

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

66 EIOS is a multistakeholder collaboration launched in 2017..

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71 Burundi, Cameroon, Democratic Republic of the Congo, Eswatini, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, South Sudan, United Republic of Tanzania, Zambia, Zimbabwe

72 Botswana, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Ethiopia, Kenya, Mauritania, Namibia, Niger, Nigeria, Rwanda, Togo and the United Republic of Tanzania.

73 ECOWAS, MSF and UNICEF.

74 Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

75 Burundi, Ghana and Niger.

76 Ethiopia, Kenya, Malawi, Mozambique, Zambia and Zimbabwe.

77 Benin, Botswana, Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Uganda, Zambia and Zimbabwe.

78 Botswana, Burkina Faso, Cabo Verde, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa and Uganda.

79 Angola, Botswana, Cabo Verde, Gabon, Gambia, Senegal, South Africa and Uganda.

80 Algeria, Benin, Burkina Faso, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

81 Algeria, Comoros, Guinea, Madagascar, Nigeria, Sierra Leone, South Africa and Zimbabwe.

82 Burkina Faso, Congo, Gabon, Liberia and Zambia.

83 Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Togo, Uganda, United Republic of Tanzania and Zambia.

84 Burkina Faso, Chad, Mali, Mauritania and Niger.

85 Benin, Burkina Faso, Chad, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Uganda, Zimbabwe.

86 Eritrea, Ethiopia, Guinea, Liberia, Mali and Rwanda.

87 Ethiopia, Gabon, Kenya, Madagascar, Mali, Senegal, United Republic of Tanzania, Zambia and Zimbabwe.

88 Angola, Burundi, Cameroon, Algeria, Kenya, Liberia, Lesotho, Mozambique, Malawi, Rwanda, Sao Tome and Principe, Eswatini, United Republic of Tanzania, Uganda, South Africa, Zambia and Zimbabwe.

89 Côte d'Ivoire, Ghana, Kenya, Sao Tome and Principe, Eswatini and Zimbabwe.

90 Algeria, Botswana, Eswatini, Gabon, Lesotho, Mauritius, Mauritania, Namibia, Seychelles and South Africa.

91 Burkina Faso, Côte d'Ivoire, Mauritius, Sierra Leone, South Africa and Zambia.

92 Burkina Faso, Chad, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Kenya, Madagascar, Mauritania, Mauritius, Niger, Nigeria, Rwanda, Senegal and Uganda.

93 Burkina Faso, Côte d'Ivoire, Gabon, Kenya, Senegal and Uganda.

94 Burkina Faso, Côte d'Ivoire, Gabon, Kenya, Senegal, Uganda and Zimbabwe.

95 Burundi, Eswatini, Guinea, Liberia, Mali, South Africa and South Sudan.

96 Burundi, Eswatini, Guinea, Madagascar, Mali, Niger, Rwanda, South Africa, South Sudan, Togo and Zambia.

97 Burkina Faso, Guinea-Bissau, Seychelles, Uganda and Zambia.

98 Burkina Faso, Democratic Republic of the Congo, Ethiopia, Rwanda, Uganda and United Republic of Tanzania.

99 Se donner la main pour protéger les enfants de la violence | OMS | Bureau régional pour l'Afrique (who.int).

100 Côte d'Ivoire, Malawi, Nigeria, Senegal and Zambia.

101 Algeria, Central African Republic, Comoros, Gambia, Lesotho, Sao Tome and Principe and South Sudan.

102 Equatorial Guinea and Guinea-Bissau.

103 Cabo Verde, Niger, Rwanda and Senegal.

104 Burkina Faso, Kenya, Mali, Malawi and Uganda.

105 Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Nigeria, Rwanda, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

106 Ghana, Nigeria, and Zambia.

107 Benin, Cameroon, Côte d'Ivoire, Ghana, Democratic Republic of the Congo, Togo, Liberia, Nigeria and Gabon.

108 Eritrea, Mauritania, South Sudan, Namibia, United Republic of Tanzania and Togo.

109 Central African Republic, Chad, Congo, Democratic Republic of the Congo and Gabon.

110 Botswana, Comoros, Congo, Eritrea, Madagascar, Rwanda and Seychelles.

111 Algeria, Angola, Burkina Faso, Cameroon, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Malawi, Mali, Mauritius, Mozambique, Rwanda, Senegal, Seychelles, United Republic of Tanzania, Togo, Uganda and Zimbabwe.

112 Ghana, Uganda and Zambia.

113 Angola, Benin, Botswana, Burundi, Cabo Verde, Cameroon, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia,Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, South Africa, South Sudan, Togo, Uganda and Zambia.

114 Burkina Faso, Burundi, Cabo Verde, Cameroon, Côte d'Ivoire, Ghana, Kenya, Mozambique, Niger, Nigeria and Uganda.

115 Côte d'Ivoire, Guinea-Bissau, Zambia, Senegal, Eswatini, Eritrea and South Sudan.

116 Côte d'Ivoire, Eritrea, Eswatini, Guinea-Bissau, Senegal, South Sudan and Zambia.

117 Algeria, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

118 Algeria, Angola, Benin, Botswana, Burundi, Cabo Verde, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda, and Zambia.

119 Burkina Faso, Côte d'Ivoire, Eritrea, Gabon, Ghana, Kenya, Uganda, Senegal and South Africa.

120 Egypt, Kenya, South Africa, Nigeria and Senegal.

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123 Algeria, Cameroon, Guinea and Niger.

124 Botswana, Benin, Cabo Verde, Comoros, Democratic Republic of the Congo, Malawi, Ghana, Guinea-Bissau, Kenya, Madagascar, Mozambique, Nigeria, Senegal, United Republic of Tanzania, Togo, Uganda and Zambia.

125 Benin, Democratic Republic of the Congo, Kenya, Niger and Nigeria.

126 Botswana, Benin, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Kenya, Madagascar, Mali, Mauritius, Nigeria, Rwanda and United Republic of Tanzania.

127 Angola, Benin, Burkina Faso, Cabo Verde, Cameroon, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Mali, Mozambique, Nigeria, Senegal and Togo.

128 Benin, Cameroon, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Mozambique and Togo.

129 Botswana, Chad, Congo, Ethiopia, Kenya, Nigeria, Rwanda, Namibia and United Republic of Tanzania.

130 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros,Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique and Namibia.

131 Benin, Central African Republic, Chad, Congo, Côte d'Ivoire, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

132 Benin, Congo, Côte d'Ivoire, Ghana, Guinea-Bissau, Kenya, Malawi, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, Togo, United Republic of Tanzania and Zambia.


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