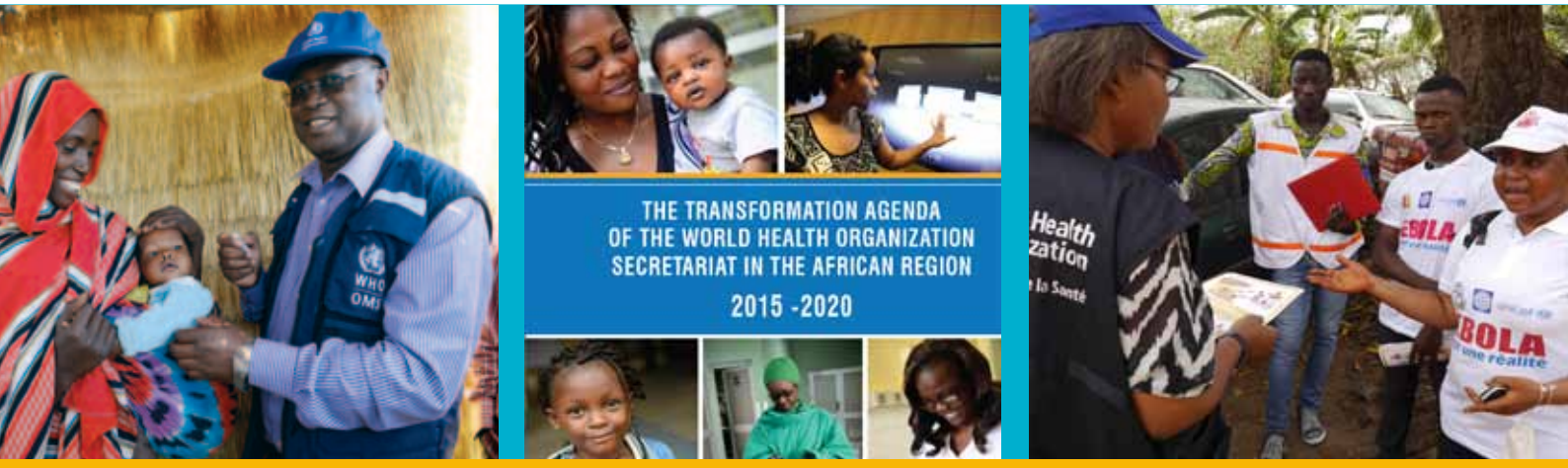
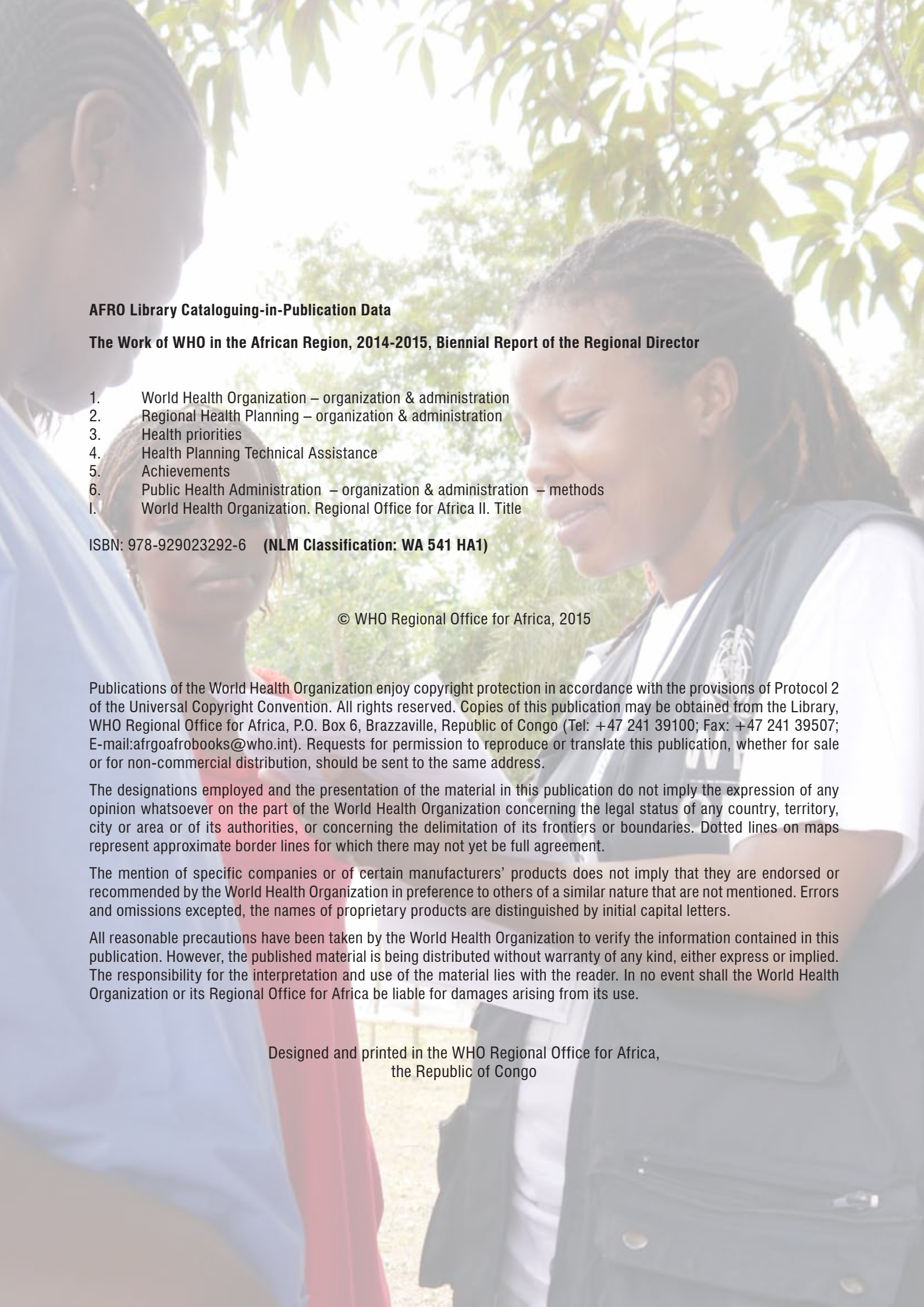
THE WORK OF WHO IN THE AFRICAN REGION



2014
2015

Biennial Report of the Regional Director

World Health Organization
REGIONAL OFFICE FOR Africa



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Abbreviations

AFP	:	acute flaccid paralysis
AHO	:	African Health Observatory
AMA	:	African Medicines Agency
APHEF	:	African Public Health Emergency Fund
ART	:	antiretroviral therapy
ARVs	:	antiretrovirals
CCS	:	country cooperation strategy
CP	:	convalescence plasma
cVDPV	:	circulating vaccine-derived poliovirus
CWB	:	convalescence whole blood
DDT	:	dichlorodiphenyltrichloroethane
DPT3	:	diphtheria pertussis Tetanus Vaccine (3rd dose in routine EPI)
ERC	:	Ethics Review Committee
ERF	:	Emergency Response Framework
EVD	:	Ebola virus disease
EVIPNet	:	Evidence-Informed Policy Network
FCTC	:	Framework Convention on Tobacco Control
GATS	:	Global Adult Tobacco Survey
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	:	General Programme of Work
GVAP	:	Global Vaccine Action Plan
GYTS	:	Global Youth Tobacco Survey
HAT	:	Human African Trypanosomiasis
HHA	:	Harmonization for Health in Africa
HPV	:	human papillomavirus
ICATT	:	Integrated Management of Childhood Illness Computerized Adaptation and Training Tool
ICPD	:	International Conference on Population and Development
IDSR	:	integrated disease surveillance and response
IHR	:	International Health Regulations (2005)
IMCI	:	Integrated Management of Childhood Illness
ISO	:	International Standards Organization
IST	:	Inter-Country Support Team
MCV1	:	Measles –containing vaccine (1st dose in routine immunization)
MDA	:	mass drug administration
MDSR	:	maternal death surveillance and response
MERS-CoV	:	Middle-East respiratory syndrome coronavirus
MDGs	:	Millennium Development Goals
MDR-TB	:	multidrug-resistant tuberculosis
MNCH	:	maternal, newborn and child health
MNT	:	maternal and neonatal tetanus
NCDs	:	noncommunicable diseases
NEPAD	:	New Partnership for Africa's Development
NHPSPs	:	National health policies, strategies and plans
NHWO	:	National Health Workforce Observatory
NIDs	:	National Immunization Days
NTDs	:	neglected tropical diseases
OCR	:	outbreak and crisis response
OPV	:	oral polio vaccine
PCT-NTDs	:	preventive chemotherapy for neglected tropical diseases
PCV	:	pneumococcal conjugate vaccine
PEI	:	Polio Eradication Initiative
PHE	:	public health events
PHEIC	:	public health emergency of international concern
PMDT	:	programmatic management of multidrug-resistant tuberculosis

PMPA	:	Pharmaceutical Manufacturing Plan for Africa
PMTCT	:	prevention of mother-to-child transmission
rGLC	:	Regional Green Light Committee
rSIS	:	real-time Strategic Information System
RMNCH	:	Reproductive, maternal, newborn and child health
RPM	:	Regional Programme Management
SDGs	:	Sustainable Development Goals
SEOCC	:	Sub-Regional Outbreak Coordination Centre
SHOC	:	Strategic Health Operations Centre
SIAs	:	supplementary immunization activities
SSFFC	:	substandard, spurious, falsely-labelled falsified and counterfeit
STEPs	:	stepwise approach for surveillance of risk factors
UNMEER	:	United Nations Mission for Ebola Emergency Response
UNDAF	:	United Nations Development Assistance Framework
VPD	:	vaccine-preventable diseases
WCO	:	WHO Country Office
WISN	:	Workload Indicators of Staffing Need
WMR	:	World Malaria Report
WPV	:	wild poliovirus

Dr Moeti meets with Ebola survivors in Port Loko, Sierra Leone

Executive Summary

The Regional Director is pleased to present this report on the work of WHO in the African Region for 2014 and the period January to August 2015. The report outlines the significant achievements made under the six categories of work of the 12th General Programme of Work, and reflects contributions from WHO country offices, the Regional Office and the three Intercountry Support Teams. It is the first report of the new Regional Director who was appointed in January 2015 for a five-year mandate (February 2015 – January 2020). Since assuming office, the Regional Director has launched the "The Transformation Agenda of the WHO Secretariat in the African Region" to accelerate the implementation of WHO reform in the African Region.

Combatting the Ebola virus disease and rebuilding health system resilience

WHO social mobilization expert in Guinea, educating the local community on Ebola

Since early 2014, the Region has grappled with the longest, most complex and widespread Ebola virus disease (EVD) epidemic in recorded history, which quickly spread through large urban communities with unprecedented severity. The epidemic, which began in rural Guinea in December 2013 was reported to WHO in March 2014. It spread to Liberia and Sierra Leone, and a few cases were reported in Mali, Nigeria, Senegal, Spain, the United Kingdom and the United States of America. In the three most-affected countries (Guinea, Liberia and Sierra Leone) the epidemic, unlike previous ones which were mostly limited to rural areas, was characterized by intense transmission in densely-populated urban areas from June 2014, peaking in September 2014.

The Strategic Operations Centre (SHOC) in the WHO Regional Office for Africa (AFRO) was activated and was able to monitor cases and deaths, track staff and commodity needs, and produce daily situation reports that were used to formulate appropriate response actions, inform the general public and the media on the outbreak, thus raising global awareness on the disease. WHO also helped the affected countries to establish Emergency Operation Centres.

As the epidemic evolved, WHO convened a Ministerial meeting of the Economic Community of West African States (ECOWAS) in Accra at which the Regional Office was requested to establish a Sub-Regional Ebola Outbreak Coordination Centre (SEOCC) in Guinea in July 2014. WHO relied on the operations of that centre to further strengthen the coordination of partners involved in the Ebola response, thus facilitating timely response to requests from the affected countries. SEOCC activities were later subsumed into those of the United Nations Mission for Ebola Emergency Response (UNMEER). The massive response to EVD under UNMEER is eloquent testimony of the coordination within the UN family.

On account of its magnitude, complexity and geographical scope, the EVD epidemic was declared a public health emergency of international concern (PHEIC) in August 2014. It peaked in September 2014, with an average of 150 – 200 cases reported per week. By the 2nd quarter of 2015, 20-30 cases were being reported per week and, for the very first time, well-defined transmission chains in specific and fewer geographical locations were identified in Liberia and Sierra Leone. On 3 September 2015, Liberia was declared Ebola-free.

By end-August 2015, a cumulative total of 3823 experts had been deployed by WHO, including 1244 deployed by the Regional Office to the severely-affected countries. By the end of September 2015, two hundred and twelve staff members of the WHO Secretariat in the African Region were still in the field. Several of these experts were stationed at the district level where they played critical roles in field coordination, epidemiological investigation, contact tracing and community engagement. At the central level, WHO staff members supported the national authorities in leading and coordinating the response, thus facilitating harmonized implementation among development partners and monitoring to ensure progress towards agreed results.

To ensure community cooperation with EVD control interventions, WHO deployed anthropologists as well as communication and behavioural science experts to identify the underlying social and cultural determinants of the epidemic. Their findings informed community engagement activities and decision-making, thereby helping to break transmission chains.

The actions of WHO and partners helped to stem the Ebola outbreaks in Mali, Nigeria and Senegal; halt the epidemic in Liberia; slow down transmission in Guinea and Sierra Leone; and prevent further spread beyond the Region. For the entire period up to end-September 2015, over 28 417 cases and 11 310 deaths had been reported including the deaths of over 535 frontline health workers. As of end-September 2015 only a few cases were being reported from Sierra Leone and Guinea and as at 17 October, no cases had been reported from Sierra Leone and Guinea for one week.

The WHO Regional Office contributed to the accelerated research and development of vaccines against EVD by building the ethical and regulatory capacities of Member States. As of August 2015, two candidate vaccines against EVD had completed phase I clinical trials in Gabon, Kenya and Mali, generating evidence of safety for further field clinical evaluation of these products. Two candidate vaccines were in phases II and III clinical trials, one of which produced 100% efficacy against EVD in ring vaccination conducted in Guinea.

The WHO Regional Office for Africa supported health systems recovery through technical advice in the development of the national recovery plans for the three severely-affected countries. The plans promote country ownership, ensure the effective integration of response and early-recovery activities, and align early recovery efforts with longer-term health systems development. These plans were unveiled at the 2015 spring meetings of the World Bank and the International Monetary Fund and presented to the July 2015 United Nations Secretary General's Pledging Conference where US$ 5 billion in donor pledges were made.

The Regional Office also supported capacity-building in 39 non-affected countries, including assessing EVD preparedness, developing national preparedness plans and training national staff.

Remarkable progress towards polio eradication

Remarkable progress was made towards polio eradication in the Region. On 25 September 2015, the WHO Director-General removed Nigeria, the then only remaining polio endemic country in the African Region, from the global list of polio endemic countries after more than 14 months of not confirming any wild poliovirus in the country – the last wild poliovirus case was reported in Nigeria in July 2014. WHO supported the implementation of interventions to interrupt polio transmission and prevent the importation of wild poliovirus (WPV), including usage of inactivated polio vaccine (IPV) to boost systemic immunity. For the African Region to be certified polio-free, another 2 years will be required to verify that there is no missed circulation of poliovirus in the region.

Continuous strides towards reduction of vaccine-preventable deaths

WHO supported Member States to implement the Regional Strategic Plan for Immunization 2014–2020, adopted by the Regional Committee in 2014. The pace of introduction of new vaccines was accelerated and by August 2015, all 47 Member States had introduced vaccines against hepatitis B and haemophilus influenza Type B; 35 countries had introduced the Pneumococcal Conjugate Vaccine; and 26 countries had introduced the rotavirus vaccine in their routine EPI programmes. To minimize the risk of meningitis epidemics which regularly afflict countries of the African meningitis belt, more than 64 million additional people were vaccinated against type A meningococcal meningitis, thus extending protection against epidemics of that serotype to more than 217 million people.

However, a large outbreak of meningococcal meningitis, mainly caused by Neisseria meningitides (Nm) serogroup C, was reported from Niger in January 2015. This was the first large-scale and fast spreading meningitis outbreak caused by Nm serogroup C to hit any country in the African meningitis belt. Over the past 40 years, serogroup C has caused only sporadic cases and a few localized outbreaks in Africa. Viewed against this historical pattern, the outbreak in Niger was an alarming development as vaccines against serogroup C were in short supply.

Progress in reducing the burden of communicable diseases

Member States made significant progress, with the support of WHO and partners, to scale up prevention and treatment interventions for HIV, TB and malaria. The result was a 56% decline in the number of AIDS-related deaths between 2005 and 2014.

In 2014, twenty-two countries in the Region recorded declines of more than 50% in AIDS-related deaths, compared to 2005. An additional 1.7 million people living with HIV initiated antiretroviral therapy in 2014, bringing the total number of persons on ART in the Region to over 10 million.

The downward trend in regional TB incidence, which began in 2003, has been sustained. With the support of the regional Green Light Committee (rGLC), efforts to strengthen the capacity of countries to manage drug-resistant TB continued. Consequently, the proportion of confirmed MDT-TB patients started on second-line treatment increased to 30% by the end of 2014. Between 2000 and 2013, the estimated number of malaria cases per 1000 persons at risk of malaria declined by 34% and malaria mortality rates fell by 54% in the African Region. For the first time, WHO signed an agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria, which made funding available for the provision of technical assistance to countries as they develop concept notes for the new funding model. Implementation of these grants will assist Member States to further expand the coverage of activities targeting HIV/AIDS, TB, malaria, RMNCH and health systems.

On the whole, countries in the WHO African Region have made meaningful progress towards attaining the Millennium Development Goal 6 – *Combat HIV/AIDS, malaria and other diseases*. WHO contributed to this by providing normative and technical support and by leveraging partnerships for the implementation of cost-effective interventions. WHO also contributed to the progress made towards MDG 4 – *Reduce child mortality* and MDG 5 – *Improve maternal health*. For example, the under-five mortality rate in countries varies between 14 and 157 per 1 000 live births, with 10 countries having achieved the target of reducing under-five mortality by two thirds between 1990 and 2015. Maternal mortality varied between 53 and 1 100 per 100 000 live births, with only four countries achieving the target of reducing maternal mortality ratio by three quarters. However, the progress made in the Region is insufficient to reach the MDG targets.

Progress was also made in the fight against NTDs. Ghana was certified as free of Guinea worm disease transmission, bringing the total number of countries to 40. Chad, Ethiopia, Mali and South Sudan are the only remaining endemic countries in the Region. Angola and the Democratic Republic of Congo are awaiting Guinea worm verification for certification while Kenya is at the pre-certification stage. Given the impending closure of the African Programme on Onchocerciasis Control (APOC) in December 2015 and the need to build on the gains made over the past decades in onchocerciasis control and to sustain the momentum that African countries have achieved in NTD control and elimination, the Regional Director convened several meetings of key stakeholders that led to an agreement to establish a new NTD entity called the Expanded Special Project for Elimination of NTDs (ESPEN). This entity will be hosted in the WHO Regional Office for Africa and become operational in 2016. ESPEN will focus on providing technical support to endemic countries in their efforts to control and eliminate Preventive Chemotherapy Neglected Tropical Diseases (PC-NTDs).

Enhancing delivery and results through effective leadership and partnerships

Dr Moeti addressing delegates at an AU meeting in Addis Ababa

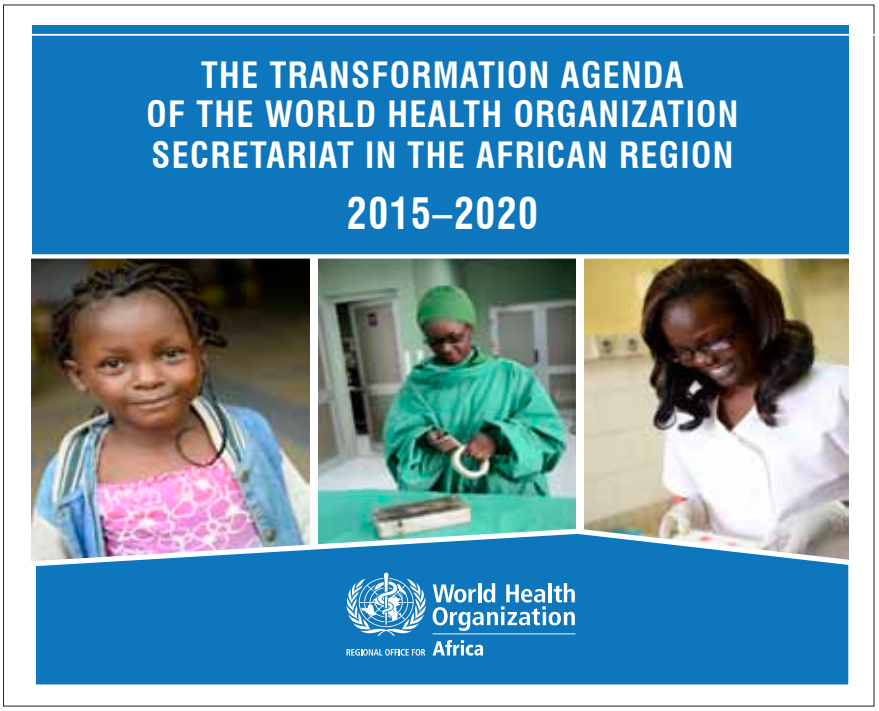
Partnership with bilateral and multilateral organizations, the African Union (AU), global health initiatives, foundations, civil society, and academic institutions was strengthened, resulting in the effective and efficient implementation of activities at country level. The WHO Regional Office for Africa and the AUC partnered to organize the First Meeting of African Ministers of Health Jointly Convened by the AUC and WHO in Luanda, Angola, in April 2014. One of

the achievements of that meeting was the adoption of the "Commitment on Accountability Mechanism to Assess the Implementation of Commitments made by African Ministers of Health" by which the ministers undertook to adhere to the timelines that had been set for implementation of decisions and declarations and to report on progress made to subsequent joint WHO-AUC meetings. WHO is also supporting the AUC in the establishment of the Africa Centre for Disease Control and the African Medicines Agency.

WHO coordinated the Harmonization for Health in Africa (HHA) mechanism which provided technical support, promoted government leadership, and ensured dialogue between regional health stakeholders towards the achievement of the health-related MDGs. At country level, WHO provided leadership in partner coordination, thus facilitating reduced transaction costs, harmonized implementation and effective monitoring of agreed deliverables. Joint programmes with other UN agencies were also coordinated to improve coherence within the United Nations Country Teams under the United Nations Development Assistance Framework (UNDAF).

Transforming the WHO Secretariat in the African Region into a reliable and trusted regional leader in health

Following her appointment, the new Regional Director launched the "The Transformation Agenda of the WHO Secretariat in the African Region" which is already being implemented. The objective of the Transformation Agenda is to ensure that the WHO Secretariat in the African Region evolves into the primary leader in health development in Africa and a reliable and effective protector of Africa's health stock. The Transformation Agenda has four focus areas, namely: pro-results values, smart technical focus, responsive strategic operations, and effective communication and partnerships. The pro-results values focus area seeks to foster the emergence of an organizational culture that is defined by the values of excellence, team work, accountability, integrity, equity, innovation and openness. The smart technical focus area will prioritize WHO's technical work in the African Region to be in line with regional priorities and commitments, ensuring that interventions are evidence-based and take into account lessons learned from experience. The responsive strategic operations area will ensure that the WHO Secretariat in the African Region evolves into an organization with enabling functions that efficiently support the delivery of programmes. Lastly, the effective communication and partnerships focus area seeks to foster a more responsive and interactive organization, internally among staff members and externally with stakeholders.



The Regional Office has been restructured under the Transformation Agenda with a view to realigning its organizational setup such that it more effectively addresses the priorities of the Region. Five technical clusters have been established as follows: (i) Communicable Diseases (CDS) Cluster to address HIV, TB, Malaria, NTDs and Public Health and Environment; (ii) Family and Reproductive Health (FRH) Cluster to work on Health throughout the Life-Course, including Maternal, Newborn, Child and Adolescent Health, Nutrition and Immunization, Vaccines and Biologicals; (iii) Noncommunicable Diseases (NCD) Cluster to work on NCD Risk Factors, NCD Management, Mental Health and Violence and Injuries; (iv) Health Systems and Services (HSS) Cluster to work on Health Policy, Financing and Access, Integrated Service Delivery and Health Information and Knowledge Management; and (v) Health Security and Emergencies (HSE) Cluster for Disease Surveillance and Emergency Risk Assessment, Outbreak and Disaster Response and Laboratory Support. Directors to lead three of these clusters have been newly recruited through a competitive selection process.

A new Programme for the Eradication of Polio was established in the Office of the Regional Director, to give it the requisite visibility and strong leadership for the polio end-game and legacy. A Unit for Health Promotion and Social and Economic Determinants was set up in the office of the Director for Programme Management, given the cross-cutting nature of this function.

A special meeting of all WHO Representatives in the Region was organized in April 2015 to secure their commitment to the Transformation Agenda. This meeting was followed by workshops organized for staff members at all WHO Country Offices, Regional Office Clusters

and Inter-country Support Teams. In the second quarter of 2015, a project was initiated to improve existing business processes, which include financial management, human resources, procurement, definition of optimal staffing required to conduct the work of WHO in the Region, and various models of service delivery which could be implemented to increase efficiency and cost-effectiveness.

An accountability framework project was initiated during the third quarter of 2015 to address systemic weaknesses in the control environment collectively, rather than focus on one audit recommendation at a time. As part of this project, the compliance functions and unit have been reorganized to enable better preventive action, staff training and imposition of sanctions when necessary. A training workshop was conducted in August 2015 for Administrative and Operations Officers from the Regional Office, ISTs and WHO Country Offices during which Key Performance Indicators (KPIs) with clearly defined linkages to staff performance evaluation were agreed upon, with a view to increasing transparency, accountability and risk management.

Moving into the future

"The Transformation Agenda of the WHO Secretariat in the African Region, 2015 – 2020" provides a framework for the future work of WHO in the African Region. The ultimate goal is to guarantee access to a basic package of essential health services in all Member States, and thus achieve universal health coverage with minimal financial, geographic and social obstacles. The idea is also to address the unfinished agenda of the MDGs and push towards the new Sustainable Development Goals (SDGs) in general and SDG 3 in particular, which seeks to "ensure healthy lives and promote well-being for all at all ages".

To that end, WHO will focus on the following five strategic priority areas:

(i) improving health security by tackling epidemic-prone diseases, emergencies and new health threats;

(ii) driving progress towards equity and universal health coverage through health systems strengthening;

(iii) pursuing the post-2015 development agenda while ensuring that the MDGs are completed;

(iv) tackling the social and economic determinants of health; and

(v) building a responsive and results-driven Secretariat.

The WHO secretariat will work with Member States, partners, donors and other key stakeholders, including regional economic communities, and through the political platform offered by the African Union and its Agenda 2063, to address these strategic priorities. Particular attention will be paid to: supporting countries to plan, implement and evaluate progress towards attainment of the health-related SDGs; investing in the expansion of knowledge generation and utilization for policy development and programming; and strengthening and coordinating partnerships.

The SDGs present an opportunity to scale up the well-known, effective interventions to address the unfinished agenda of the MDGs. WHO is ready to work with Member States to develop and implement national health policies and plans that address their priorities and to meet the SDG targets. Particular attention will be paid to equity and inclusiveness; implementing the UN Secretary-General's Global Strategy on Maternal, Child and Adolescent Health, with emphasis on adolescents; tacking the emerging burden of Noncommunicable Diseases; addressing the social determinants of health; engaging other non-health sectors to ensure synergy between their policies and the actions of the health sector; and moving towards Universal Health Coverage.

WHO will carry on contributing towards ending the EVD epidemic and rebuilding national health systems in the three severely-affected countries in West Africa. Efforts will be made to enhance the capacity of countries to prepare for and respond to epidemics and humanitarian crises, including improving IHR core capacities. WHO will also enhance regional-level capacity to respond to emergencies and continue to advocate for increased resource allocation to health security and emergencies.

As the African Region moves towards being certified polio-free by 2017, WHO will work with Member States to sustain the gains made and to monitor their national polio eradication emergency operational plans. It will also provide support to improve the quality of polio campaigns and surveillance, and ensure a timely and adequate response to any outbreaks of wild and circulating vaccine-derived polioviruses. Priority attention will be given to: introducing IPV into routine immunization services and switching from tOPV to bOPV; monitoring certification and containment activities to ensure that the Region meets the global milestones and targets for polio eradication; and implementing country polio legacy plans.

The efforts made to transform the WHO Secretariat in the African Region into a more responsive, results-focused, efficient and accountable organization will continue into the coming biennium. The Secretariat is committed to accelerating the development of resilient health systems that prevent and manage disease, ensure health security, and improve the health and well-being of the people in the WHO African Region.

Dr Matshidiso **Moeti**
WHO Regional Director for Africa

October 2015

1

Introduction

The report presents the work done by the WHO Secretariat in the African Region, which comprises the Regional Office, the Inter-country Support Teams and country offices. The work is presented under six (6) categories of work, as highlighted in the 12th GPW, namely: (i) communicable diseases; (ii) noncommunicable diseases; (iii) promoting health through the life-course; (iv) health systems; (v) preparedness, surveillance and response; and (vi) corporate services and enabling functions.

1. Introduction

1. This report – *The Work of WHO in the African Region, 2014-2015: Biennial Report of the Regional Director* – covers the work of WHO in the first 20 months of the first biennium (2014 – 2015) of the Twelfth WHO General Programme of Work (12th GPW).[1] The 12th GPW provides a high-level strategic vision of the work of WHO for the 2014–2019 period. It is the product of extended interaction between the WHO Secretariat and Member States and it outlines the leadership priorities and overall direction for more effective governance by Member States as well as a stronger role of guidance and coordination for WHO in global health governance. It also takes into consideration the lessons learnt from implementation of the 11th General Programme of Work and incorporates the three components of WHO reform: programmatic reform to improve people's health; governance reform to increase coherence in global health; and managerial reform in pursuit of organizational excellence.

2. The report presents the work done by the WHO Secretariat in the African Region, which comprises the Regional Office, the Intercountry Support Teams and country offices. The work is presented under six (6) categories of work, as highlighted in the 12th GPW, namely: (i) communicable diseases; (ii) noncommunicable diseases; (iii) promoting health through the life-course; (iv) health systems; (v) preparedness, surveillance and response; and (vi) corporate services and enabling functions. This is a departure from the format of previous reports of the Regional Director on WHO's work, which were presented under strategic objectives.

3. The report is organized into seven chapters as follows:

(i) Introduction
(ii) Context
(iii) Implementation of the WHO Programme Budget 2014 -2015
(iv) Significant achievements by category of work
(v) Progress made in the implementation of Regional Committee resolutions
(vi) Challenges and constraints
(vii) Conclusion.

4. The report also includes Annex 1: Budget allocations to the African Region (PB 2014-2015) by category of work and programme areas, with breakdowns for the Regional Office (RO) and country offices (CO).

5. This is the first report submitted to the WHO Regional Committee by the new Regional Director, Dr Matshidiso Moeti, who was elected by Member States at the end of 2014 and subsequently appointed by the WHO Executive Board in January 2015. Dr Moeti assumed office on 1st February 2015 and has since launched "The Transformation Agenda" which focuses on ensuring that WHO in the African Region evolves into an accountable and efficient organization in line with the expectations of Member States.

2

Context

The year 2014 heralded the beginning of the implementation of the first biennium of the 12th General Programme of Work 2014–2019. In that year, the largest ever outbreak of the Ebola virus disease (EVD) in human history had just been reported from Guinea. The disease rapidly spread to Liberia and Sierra Leone, with a few cases reported in Mali, Nigeria, Senegal, Spain, the United Kingdom and the United States of America.

2. Context

6. The year 2014 heralded the beginning of the implementation of the first biennium of the 12th General Programme of Work 2014-2019. In that year, the largest ever outbreak of the Ebola virus disease (EVD) in human history had just been reported from Guinea. The disease rapidly spread to Liberia and Sierra Leone, with a few cases reported in Mali, Nigeria, Senegal, Spain, the United Kingdom and the United States of America. Because of its magnitude, complexity and geographical spread the Ebola outbreak was subsequently declared a public health emergency of international concern (PHEIC) in August 2014. By the end of September 2015, over 28 417 cases and 11 310 deaths had been reported including the deaths of over 535 frontline health workers.

7. Unlike previous EVD outbreaks in the Region which mainly occurred in rural areas, the outbreak in West Africa was characterized by rapid transmission in both rural and urban areas especially in Liberia, Sierra Leone and Guinea. The health systems of these three countries were overburdened and the delivery of some key services such as immunization, malaria control and antenatal care were compromised.

Dr Moeti visiting an Ebola treatment centre in Sierra Leone

8. On account of the EVD outbreak in West Africa, Member States recommended the postponement of the Sixty-fourth session of the Regional Committee for Africa from September to November 2014. This also meant the postponement of the election of a new Regional Director to November 2014.

9. In response to the Ebola outbreak, WHO and Member States of the African Region reprogrammed their limited financial and human resources towards prevention, preparedness and response, at the expense of other health priorities. In addition to the EVD outbreak, the Region also experienced two other significant emergencies in the Central Africa Republic and South Sudan. These additional emergencies further contributed to the diversion of WHO resources away from key priorities.

10. The additional financial and human resources deployed in response to the EVD outbreak and humanitarian emergencies, provided an opportunity for the affected countries to strengthen their health systems, including supporting research and development of new medical products.

11. In other areas of public health, the Region continued to record high maternal and child mortality rates and a rising burden of communicable and noncommunicable diseases. These challenges notwithstanding, the Region made gains in the achievement of MDGs such as reduction in deaths attributable to malaria and improved access to HIV and TB therapies.

12. Investment in health by Member States remained low. The High-Level Taskforce on Innovative International Health Financing for Health Systems estimated that by 2009 a low-income country needed to spend, on average, US$ 44 per capita (US$ 60 by 2015) to strengthen its health system and to provide an essential package of health services.[2] By the end of 2014, only 22 countries[3] (47%) in the Region were spending more than US$ 60 on health per person per year. Further evidence of low domestic investment in health was reflected in the limited number of countries which have met the 2001 African Union Abuja Declaration[4] target of allocating at least 15% of national budgets to the health sector.

13. Out-of-pocket expenditure on health, as a percentage of total health expenditure, was more than 20% in 36 countries[5] implying that people in these countries are exposed to high risk of catastrophic health expenditure and impoverishment. As a result of such under-investment, high dependence on direct out-of-pocket health spending and reliance on external funding for health, national health systems remain weak and lack the capacity to ensure universal access to health services for the needy.

14. Member States were still confronted with the protracted challenge of building strong and resilient health systems, capable of responding to major disease outbreaks and emergencies. The critical elements of health systems such as the health workforce, surveillance and information systems, access to quality essential medicines, vaccines and other health products, and investment in research and innovation, require additional investment in order to guarantee the expansion and sustainability of access to essential health services.

15. In the January 2014 – August 2015 period, there were many opportunities that significantly influenced the health status of people in the Region. For example, Member States introduced new national legislations, health policies and strategic plans were revised, and the heath sectors of some Member States were reformed. New diagnostics, medicines, vaccines and interventions were made accessible, new health initiatives and partners came on board and advances were made in health information technology.

16. At country level, new partners continued to emerge. Consequently, additional funding, facilities and other resources became available, contributing to health development. Partnership with bilateral and multilateral donors, civil society and foundations were reinforced in a number of Member States, resulting in improved access to health. Major health activities and initiatives were also implemented in partnership with the regional economic communities and the African Union, exemplified by the AU deployment of health workers to support the Ebola response in West Africa.

17. The January 2014 - August 2015 period recorded an increase in WHO funding although most of these funds were earmarked for polio, the EVD response in West Africa and the humanitarian emergencies in the Central African Republic and South Sudan. The WHO Financing Dialogue[6] contributed to improved and early release of funding for priority programmes in the Region thus enabling early implementation of activities. It is within this overall context that PB 2014-2015 was implemented.

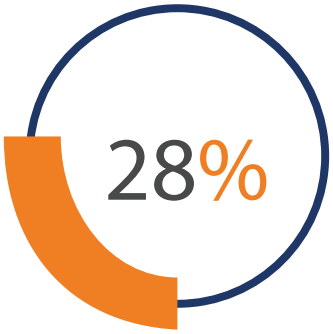
18. Implementation of a new aspiration to turn WHO in the African Region into a more transparent, accountable and efficient organization, through a program termed "the Transformation Agenda for the WHO Secretariat in the African Region",[7] started in February 2015. This agenda sets out the vision and strategy for change and is aimed at improving the performance of the WHO Secretariat as it supports its Member States to improve health outcomes. The Transformation Agenda has four focus areas, namely: pro-results values, smart technical focus, responsive strategic operations, and effective communications and partnerships. Each of these focus areas is closely aligned with specific outcomes of the WHO reform programme.

3

Implementation of the WHO Programme Budget 2014-2015

The WHO Programme Budget for 2014-2015, totalling US$ 3 977 000 000, was adopted by the sixty-sixth World Health Assembly. Of this amount, a total of US$ 1 120 000 000 (28%), was allocated to the African Region.

THE WHO PROGRAMME BUDGET FOR 2014-2015 ALLOCATION



100%

The WHO Programme Budget for 2014-2015, totalling **US$ 3 977 000 000,** was adopted by the **Sixty-sixth World Health Assembly.**

28%

Of this amount, a total of **US$ 1 120 000 000** was allocated to the **WHO African Region.**

3. Implementation of the WHO programme budget 2014-2015

19. The WHO Programme Budget for 2014-2015, totalling US$ 3 977 000 000, was adopted by the Sixty-sixth World Health Assembly. Of this amount, a total of US$ 1 120 000 000 (28%), was allocated to the African Region.[8] As a result of the EVD outbreak and the humanitarian emergencies experienced by the Region, PB 2014-2015 was increased by 60%, bringing the total allocated budget for the Region to US$ 1 798 519 000 (Table 1).

20. Out of the total budget of US$ 1 798 519 000 allocated to the Region, funds actually received as at 31 August 2015 were US$1 700 132 000 representing 95% of the budget allocation. By end-August 2015, budget implementation stood at US$ 1 237 784 000, representing 73% of funds received.

21. The distribution of budget allocations to the various categories of work was uneven, with the greatest share going to emergency programmes (polio eradication and outbreak and crisis response (OCR)) which received 40% (US$ 447 500 000) of the regional budget. Most of these funds went to the poliomyelitis eradication programme. The remaining 60% of the regional allocation (US$ 672 500 000) was distributed across the other categories.

22. Similarly, the distribution pattern of available funds mirrored budget allocation across all categories of work. The level of funding available for emergency programmes was highest at US$ 995.5 million, with the funds highly earmarked. This restriction placed on the use of funds for specific activities deprives the Region of the flexibility to adequately address regional priorities agreed upon with Member States. The utilisation rate of available resources varied across categories of work, ranging from 66% for category 3 to 81% for category 4.

23. Table 1 presents a breakdown of PB 2014-2015 implementation. As highlighted in this table, overall implementation of PB 2014-2015 remains on target, despite the EVD outbreak and humanitarian emergencies. However, there is need to ensure strategically balanced allocations and funding of regional priorities.

Table 1: Budget implementation for PB 2014-2015
As of 31 August 2015 (US$ 000)

CATEGORY	TABLE 1: BUDGET IMPLEMENTATION FOR PB 2014-2015 AS AT 31 DECEMBER 2014 (IN US$ 000)						
	APPROVED BUDGET BY WHA	ALLOCATED PB	TOTAL AVAILABLE FUND	% FUNDING AGAINST APPROVED BUDGET	BUDGET IMPLEMEN-TATION	% IMPLEMEN-TATION AGAINST APPROVED BUDGET	% IMPLEMEN-TATION AGAINST FUNDS
	(A)	(B)	(C)	(D=C/A)	(E)	(F=E/A)	(G=E/C)
Category One Communicable diseases	266 700	272 531	270 210	101%	195 851	73%	72%
Category Two Noncommunicable diseases	56 500	58 024	53 424	95%	42 069	74%	79%
Category Three Promoting health through life-course	92 000	110 645	108 982	118%	72 190	78%	66%
Category Four Health systems	71 300	82 117	79 044	111%	63 857	90%	81%
Category Five Preparedness, surveilance & response	55 500	57 557	59 558	107%	43 840	79%	74%
Category Six Corporate services & enabling functions	130 500	131 000	132 993	102%	98 359	75%	74%
Total Base Programmes	672 500	711 873	704 211	105%	516 165	77%	73%
Emergency Programmes							
05 - (Polio & OCR)	447 500	1 086 646	995 921	223%	721 619	161%	72%
Total Emergency Programmes	447 500	1 086 646	995 921	223%	721 619	161%	72%
Grand Total	1 120 000	1 798 519	1 700 132	152%	1 237 784	111%	73%

* Excludes Emergency Programmes (Polio and OCR)

4

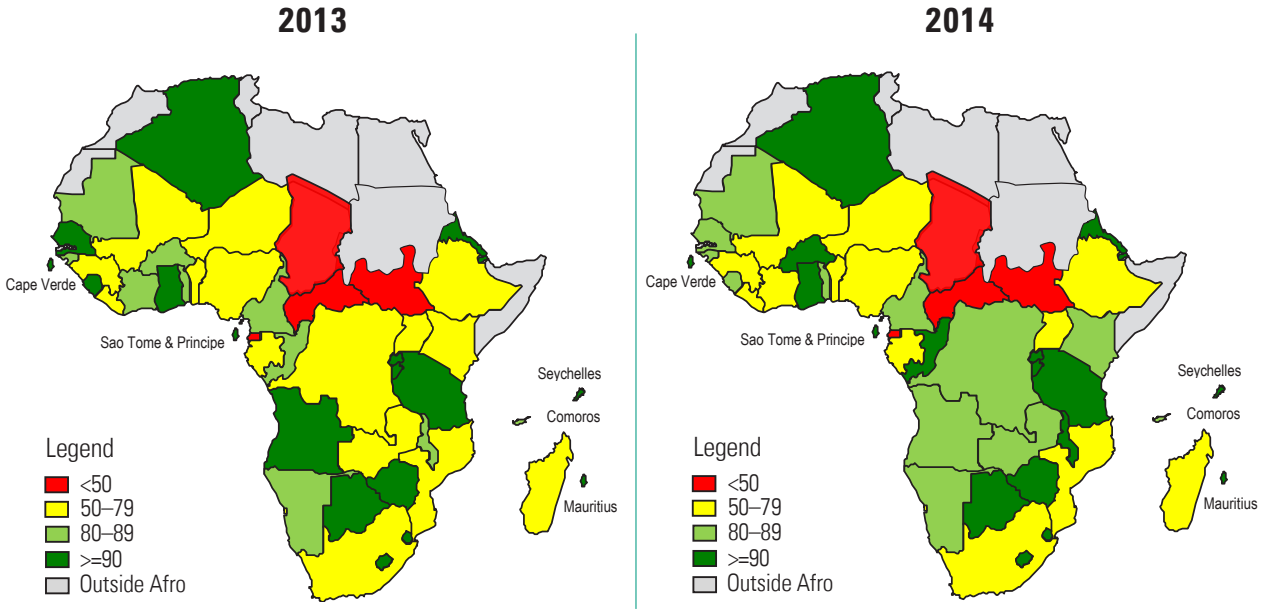
Significant achievements by category of work

4.1 Category 1: Communicable Diseases

24. Under this category WHO supported Member States to reduce the burden of communicable diseases including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases. The support that WHO and partners provided enabled Member States to implement activities which raised and sustained coverage of some proven interventions, resulting in a reduction of the burden of some communicable diseases.

25. Member States endorsed the Regional Immunization Strategic Plan 2014-2020, which set targets and milestones[9] against which immunization performance is being measured in the quest to control vaccine-preventable diseases (VPDs). Based on the WHO UNICEF Estimates,[10] coverage with three doses of Diphtheria-Tetanus-Pertussis-containing vaccine (DTP3) and the first dose of Measles-Containing Vaccine (MCV1) for the Region was 77% and 73% respectively for 2014, compared to 76% and 73% for both vaccines for-2013.[11] By the end of 2014, 18 countries[12] had achieved the Global Vaccine Action Plan (GVAP) target of at least 90% coverage with DPT3, fifteen[13] of them for two consecutive years (figure 1). During the reporting period, an estimated 87.9 million children received the measles vaccine in 19 countries,[14] through Supplementary Immunization Activities (SIAs).

Figure 1: Immunization coverage with three doses of Diphtheria-Tetanus-Pertussis containing vaccine (DTP3)[15] for countries of the WHO African Region.

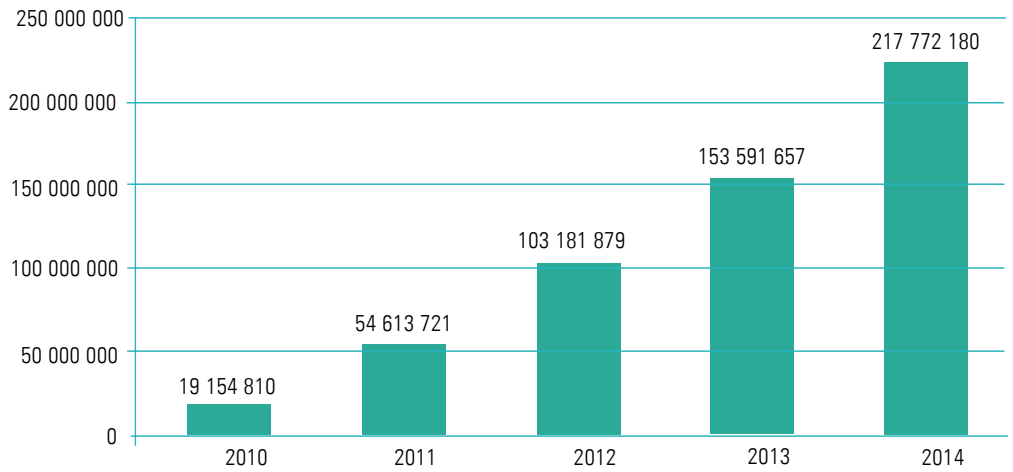


Source: WHO and UNICEF: WHO/UNICEF estimates of National Immunization Coverage 2014, August 2015 revision. Geneva: WHO; 2015

26. The pace of introduction of new vaccines into national immunization programmes was maintained and by August 2015, all Member States had introduced vaccines against hepatitis B and Haemophilus influenza Type B. During the reporting period, 8 additional countries[16] introduced Pneumococcal Conjugate Vaccines (PCV) bringing to 35 the total number of countries using this vaccine in their routine EPI programmes. Sixteen additional countries[17] introduced rotavirus vaccines bringing to 26 the users of this vaccine in routine childhood immunization.The human papillomavirus (HPV) vaccine was introduced nationwide in Botswana, Seychelles and South Africa. With 35 (74%) countries validated for the elimination of maternal and neonatal tetanus (MNT), progress towards elimination is on course. Inactivated polio vaccine was introduced by 10 countries[18] to further boost population immunity against poliomyelitis.

27. To minimize the risk of meningitis epidemics which regularly afflict countries of the African meningitis belt, more than 64 million people (an additional 42%) from Côte d'Ivoire, Ethiopia, Mauritania, Nigeria and Togo, were vaccinated in campaigns using MenAfriVac™, bringing the total number reached since 2010 to over 217 million. Figure 2 reflects trends in the rapid scale up of the number of doses delivered to the population. Consequently, the threat of meningococcal A meningitis epidemics in the Region has been significantly reduced.

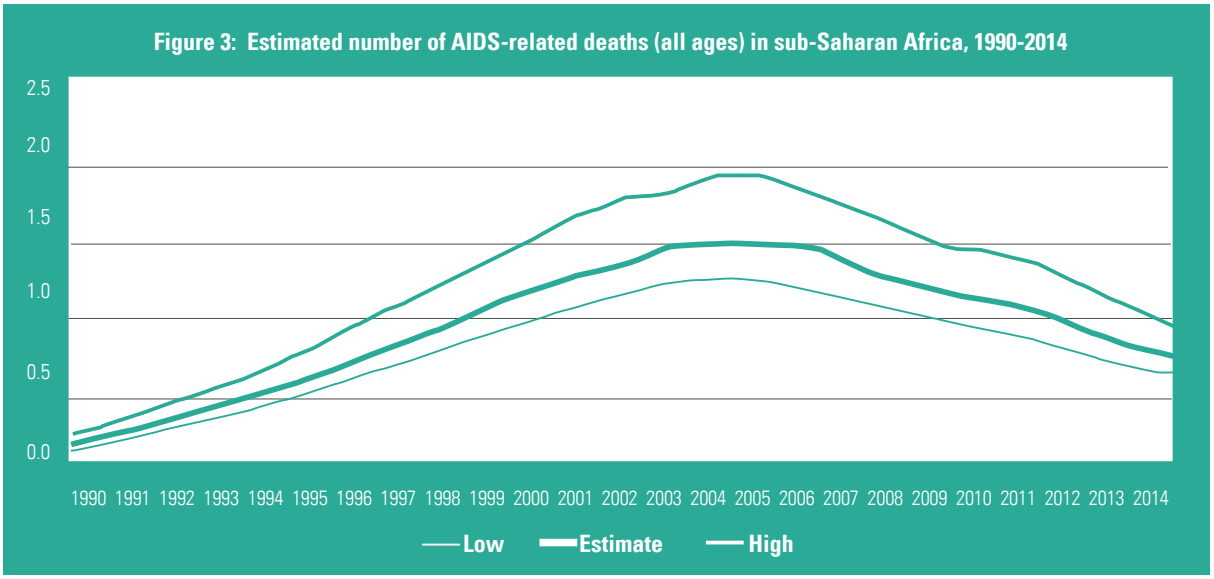
Figure 2: Cumulative doses of the conjugate meningites A vaccine (MenAfriVac) administered to populations in the countries of the African Meningitis Belt from 2010 to 2014



Source: IST West Africa Data, 2015

28. However, a large outbreak of meningococcal meningitis, mainly caused by Neisseria meningitides (Nm) serogroup C, was reported from Niger in January 2015. This was the first large-scale and fast spreading meningitis outbreak caused by Nm serogroup C to hit any country in the Africa meningitis belt. Over the past 40 years, serogroup C has caused only sporadic cases and a few localized outbreaks in Africa. Viewed against this historical pattern, the outbreak in Niger was an alarming development as vaccines against serogroup C were in short supply.

29. HIV/AIDS remained a major contributor to the high burden of communicable diseases in the Region. The scaling up of preventive interventions and treatment efforts by Member States with the support of WHO and partners, resulted in a 56% decline in the number of AIDS-related deaths between 2005 and 2014 (Figure 3). In 2014, 22 countries[19] in the Region recorded declines of more than 50% in AIDS-related deaths, compared to 2005.



Source: UNAIDS: UNAIDS Global Report 2015. Geneva: UNAIDS; 2015

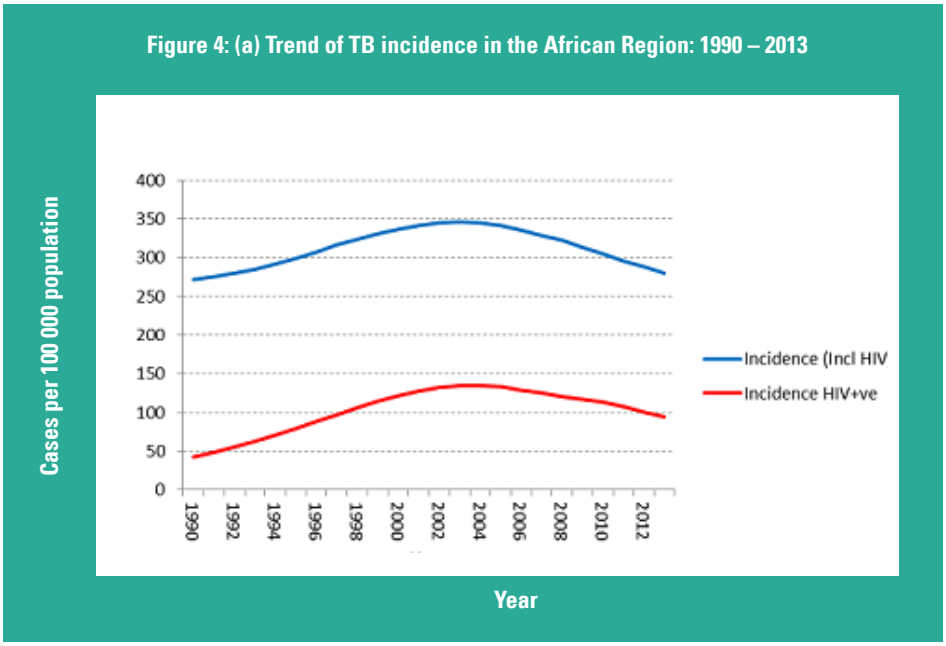
30. An additional 1.7 million people living with HIV initiated antiretroviral therapy in 2014 bringing the total number of persons on ART in the Region to more than 10 million.[20] Ten countries [21] 21 reported HIV treatment coverage rates of more than 50% while 33 countries[22] adapted the WHO consolidated guidelines and recommendations. These initiatives resulted in the remarkable progress made in the control and treatment of HIV/AIDS and implementation of related interventions in the Region.

31. With regard to tuberculosis (TB), of the 5.7 million cases of TB reported globally, 1.34 million (or 23%) were from the African Region.[23] Since the rise in regional TB incidence was halted in 2003, it has remained on a downward trajectory, with most countries having attained MDG target 6C.[24] TB incidence declined from 288 to 280 per 100 000 population between 2012 and 2013, while incidence within the HIV-positive population declined from 100 to 94 per 100 000 during the same period (Figure 4A). The regional TB case detection rate was estimated at 52% while the treatment success rate was 81% among 2012 patient cohort.[25] Twenty countries[26] in the Region attained the global target of 85% treatment success while 13 countries[27] attained a 70% TB case detection rate during the same period.

32. With the support of the regional Green Light Committee (rGLC), WHO built capacity for scaling up programmatic management of drug-resistant TB (PMDT). Twenty countries[28] have since been supported. During the January – December 2014 period, the number of confirmed MDR-TB patients started on second-line treatment rose from 7 667 to 9 849 cases. This represents 30% of the estimated total of 33 193 MDR-TB cases in the Region.[29]

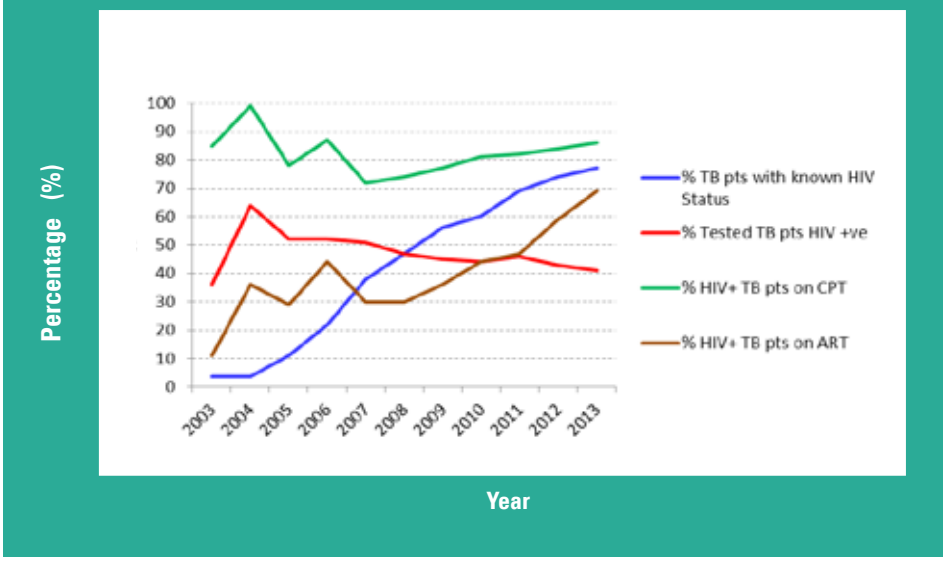
33. Six[30] of the nine TB high burden countries (HBC) experienced falling TB incidence while Uganda and Tanzania reduced their TB prevalence by 50% compared to 1990 levels. Eighteen countries[31] including the 3 HBCs (Ethiopia, Uganda and Tanzania) attained a 50% reduction in TB mortality in 2014 compared to 1990. These statistics point to an improvement in the efforts made by Member States to tackle tuberculosis, a major communicable disease in the Region.

Figure 4: (a) Trend of TB incidence in the African Region: 1990 – 2013



Source: UNAIDS: UNAIDS Global Report 2015. Geneva: UNAIDS; 2015

Figure 4: (b) Progress in the collaborative TV/HIV interventions in the African Region: 2003 – 2013



Source: UNAIDS: UNAIDS Global Report 2015. Geneva: UNAIDS; 2015

34. Considerable progress was also made in TB/HIV collaboration. The coverage of TB/HIV collaborative activities improved. Some 76% of TB patients were tested for HIV, and of those found to be HIV-positive, 68% were put on ARTs in 2013, compared to 59% in the previous year (Figure 4B).

35. The 2014 World Malaria Report (WMR), showed that between 2000 and 2013, the estimated number of malaria cases per 1000 persons at risk of malaria declined by 34% and malaria mortality rates declined by 54% in the African Region. Most of the estimated 625 million cases of malaria averted (66%) and 4.3 million deaths prevented (92%) were from the WHO African Region. Furthermore, a reduction of more than 75% in malaria incidence was documented in 9 countries.[32] A significant reduction of 50 to 75% in malaria incidence was recorded in Madagascar and Zambia, while Algeria and Cabo Verde reported fewer than 10 cases.

Figure 5: (a) Estimated number of malaria cases: WHO Region, 2000 – 2013

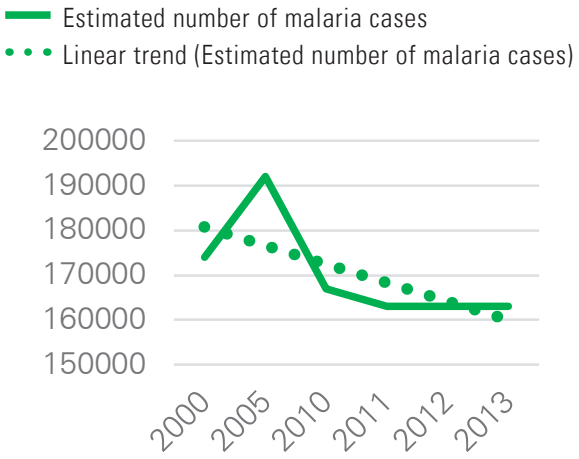
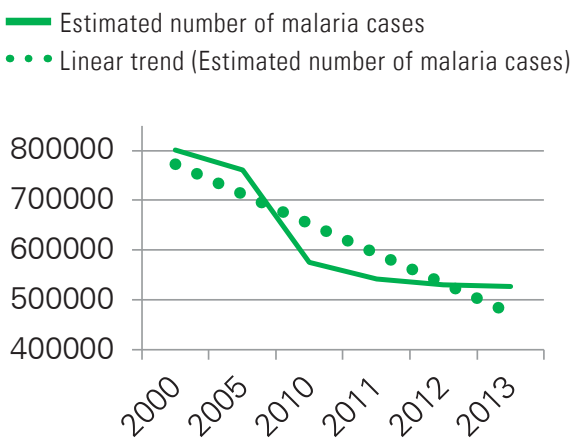


Figure 5: (b) Estimated number of malaria deaths in WHO African Region, 2000 – 2013



Source: WHO: World Malaria Report 2014. Geneva: WHO; 2014

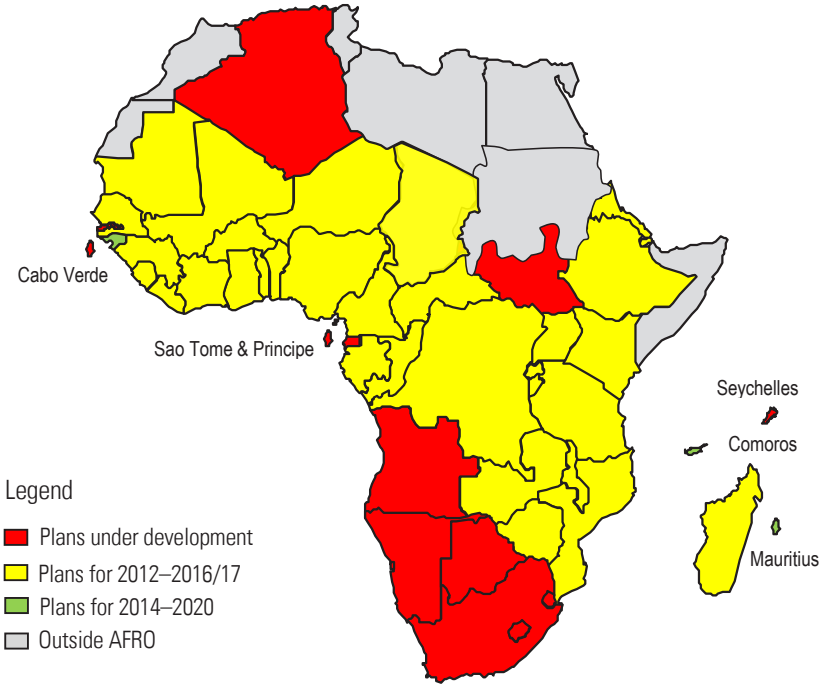
36. WHO supported the mobilization of resources for countries to strengthen data use for decision-making in malaria control. With financial assistance from the United Kingdom's Department for International Development (DFID), WHO supported evidence-based decision-making by Member States in order to further sustain and improve the gains of malaria control in the Region. This included providing technical support for programme reviews and planning to 12 countries[33] and for development of malaria strategic plans (MSP) to 19 countries.[34]

37. For the first time, WHO signed an agreement with the Global Fund (GF) that will let WHO access funds to provide technical assistance to countries in the development of Concept Notes (CNs) for the New Funding Model. Through this initiative, WHO provided technical support to 27[35] countries for the submission of 34 CNs for different programmes. Of this number, 28 CNs were approved by the GF on their first submission. The implementation of these grants will help Member States to further expand the coverage of activities targeting HIV/AIDS, TB, malaria, RMNCH and health systems.

38. Tackling neglected tropical diseases (NTDs) in the Region is an important component of the work under category one. WHO supported Member States in the control and elimination of lymphatic filariasis, onchocerciasis, schistosomiasis, soil transmitted helminthiasis and trachoma through preventive chemotherapy (PC), and Buruli ulcer, Guinea worm diseases, Human African Trypanosomiasis (HAT), leprosy and yaws through case management. Ten additional countries[36] were mapped for PC-NTDs in 2014, bringing the total number to 20. WHO also supported Angola, Ethiopia, Zambia and Zimbabwe to start mass drug administration (MDA) for NTDs, bringing the total number of countries implementing MDA to 26. Ten countries[37] demonstrated a break in transmission and have stopped MDAs in some districts. After more than seven rounds of mass treatment, Togo has stopped MDA for lymphatic filariasis (LF) at national level and is ready to be verified for lymphatic filariasis elimination.

39. Ghana was certified as free of Guinea worm disease transmission, bringing the total number of countries to 40. Chad, Ethiopia, Mali and South Sudan are the only remaining endemic countries in the Region. Angola and the Democratic Republic of Congo are awaiting Guinea worm verification for certification while Kenya is at the pre-certification stage. As of February 2015, ten countries[38] had established or improved their NTD coordination mechanisms in accordance with WHO guidance and six additional countries[39] had developed NTD Master and Operational Plans, bringing the total to 34 (Figure 6). These countries are now scaling up PC and case management (CM) of NTDs.

Figure 6: Status of developement of country NTD Master Plans



Source: WHO/AFRO: NTD Programme database, 2015.

40. Given the impending closure of the African Programme on Onchocerciasis Control (APOC) in December 2015 and the need to build on the gains made over the past decades in onchocerciasis control and to sustain the momentum that African countries have achieved in NTD control and elimination, WHO convened two meetings in April and July 2015 to seek consensus on the establishment of a new regional NTD entity. The Working Group meeting held in Johannesburg in April 2015 and the Stakeholders' Consultative Meeting on the Establishment of a New NTD Entity held in Geneva in July yielded a consensus among NTD Stakeholders on the framework for a new NTD Entity and the Transition Plan of Action for the period between APOC closure and full commencement of the operations of the new NTD Entity.

41. The new NTD Entity, now called the Expanded Special Project for Elimination of NTDs (ESPEN), will be hosted in the Regional Office for Africa and will focus on providing technical support to endemic countries in their efforts to control and eliminate Preventive Chemotherapy Neglected Tropical Diseases (PC-NTDs). To ensure the effective commencement of ESPEN operations by January 2016, a number of actions are currently being taken by the Regional Office in close collaboration with NTD partner institutions and endemic countries. These include: (i) regular updates to endemic countries on progress made towards APOC closure and the establishment of ESPEN; (ii) continued high-level advocacy with NTD stakeholders to raise financial resources for ESPEN; (iii) establishment of a transitional steering committee responsible for reviewing and approving the plan of action and budget of ESPEN; (iv) initiation of ESPEN staff recruitment; and (v) ongoing discussions with the World Bank and partners on the establishment of a Multi-donor Trust Fund.

Dr Moeti at the WHO Working Group Meeting on the Establishment of a new NTD Entity, April 2015

4.2 Category 2: Noncommunicable Diseases

42. The work of WHO under this category is aimed at reducing the burden of noncommunicable diseases, which include heart disease, cancers, lung disease, diabetes, and mental disorders, as well as disability and injuries. This is achieved through health promotion and risk reduction, as well as prevention, treatment and monitoring of these diseases and their risk factors.

43. During the reporting period, technical support was provided to eight Member States[40] to develop national integrated multisectoral NCD action plans. WHO led the UN Inter-Agency Task Force on NCDs to assess Kenya's capacity to respond to the NCD epidemic and supported finalization of the national multisectoral action plans. The work in Kenya was unique in that, for the first time in the Region, this new model for support was implemented. NCD prevention and control strategies were also integrated into national planning and development, including the United Nations Development Assistance Framework (UNDAF). This will ensure multisectoral implementation of NCD interventions with the support of all UN agencies.

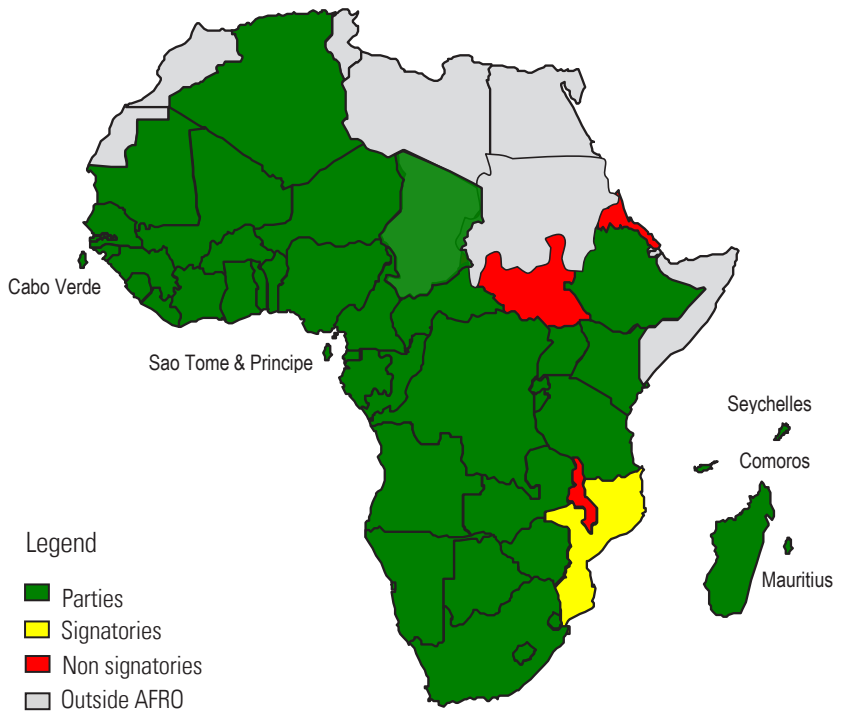
44. In the emerging area of mHealth, Senegal was supported to develop and implement an mHealth platform (mDiabetes) which is providing crucial information on the prevention and control of diabetes through mobile phones. This innovative platform was also used to raise awareness during the EVD outbreak.[41] mHealth is expected to make information on the prevention and control of NCDs more readily available to the public and will help to reverse the trend of the epidemic in the Region.

45. To improve the prevention and control of cervical cancer, 15 Member States[42] were supported to build capacity in implementing a comprehensive cervical cancer prevention and control programme. Ethiopia and Zimbabwe were supported to enhance the data quality of cancer registries and thus generate evidence for cancer control. Swaziland was supported to build capacity in cervical cancer screening and treatment. This will strengthen national level prevention and control of cancers and monitoring of the impact of interventions.

46. Based on global data, violence against women is of significant public health importance. Capacity-building on the prevention of violence and injuries was conducted in 24 Member States[43] with emphasis on the public health approach to the prevention and response to violence against women. The training covered key evidence-based actions including how to provide clinical care and services to survivors.

47. As a major risk factor, tobacco use is a critical element in the control of NCDs and efforts are being made by Member States, with WHO support, to mitigate it. Ethiopia and Zimbabwe were supported to ratify the WHO Framework Convention on Tobacco Control (WHO FCTC) bringing the number of countries that are parties to the Convention in the African Region to 43 (Figure 7).[44]

Figure 7: Status of ratification of the WHO Framework Convention on Tobacco Control in the African Region, August 2015



Source: WHO/AFRO: The WHO FCTC: Ten Years of Implementation in the African Region. Brazzaville: WHO/AFRO; 2014

48. Seven countries[45] enacted legislation and regulations which are in line with the WHO FCTC. Eleven countries[46] increased excise duty on tobacco products while Congo and Gabon ratified the Protocol to Eliminate Illicit Trade in Tobacco Products. All of these initiatives will further reduce tobacco use in the Region. The Region commemorated 10 years of implementation of the WHO FCTC at a regional meeting in Nairobi, (Kenya)[47] where the Nairobi Declaration on Implementation of the WHO Framework Convention on Tobacco Control in the African Region, 2015 was adopted.[48]

49. Alcohol use is also a risk factor for NCDs. Botswana, Kenya and Togo were supported to implement interventions for alcohol control. Data from these countries show that the alcohol industry applies marketing practices, intentionally targeted at children and adolescents, in order to promote alcohol use. These findings are being used by other countries to develop and enforce policies, legislations and regulations on restricting the marketing of alcohol.

50. Mauritius and South Africa were supported to develop initiatives to reduce salt intake and childhood obesity. Kenya was supported to build capacity in the application of WHO childhood obesity prevention tools and to develop policies and strategies using a multisectoral approach. This will contribute to the achievement of the Diet and Physical Activity targets set in the Global Action Plan for the prevention and control of NCDs 2013-2020.

51. Technical support was provided to Madagascar to assess the cost-effectiveness of salt fluoridation. The report shows the importance of strong multisectoral collaboration between ministries, salt producers and civil society in the use of the best cost-effective public health

interventions to control dental caries. In addition, nine countries[49] were supported to build capacity and develop a 3-year national action plan on the prevention, early diagnosis and treatment of Noma, a disfiguring disease of public health importance.

52. WHO developed an Eye Health Indicator catalogue[50] which has been used in Burkina Faso, Gabon and Zimbabwe. It also supported capacity-building in 19 countries[51] on the application of WHO tools to evaluate needs and gaps in eye health professionals. Niger has since used the tool for training. Botswana was supported to include eye health as part of the standard nursing and midwifery curricula. These tools will inform policy formulation and decision-making on eye health.

53. The capacity of Member States to monitor risk factors for NCDs and their trends continues to be strengthened. During the reporting period, six countries[52] were supported to conduct STEPS surveys. In addition, Namibia, Swaziland and Tanzania conducted the global school health survey (GSHS) that monitors the level of risky behaviours prejudicial to health among students. The data from these surveys has informed policies and strategies for the prevention and control of NCDs, and is used to monitor progress in the implementation of the Global Action Plan for the Prevention and Control of NCDs (2013-2020).

54. Cameroon, Kenya, Senegal and Uganda conducted the Global Adult Tobacco Survey (GATS), providing a baseline for adult tobacco use in those countries. Furthermore, nine more countries[53] conducted the Global Youth Tobacco Survey (GYTS) which provides trends on tobacco use among the youth. A regional database on tobacco control policies has also been set up to provide real-time information on country level progress on the implementation of the WHO FCTC.

55. Nutrition surveillance enables Member States to track the implementation of nutrition programmes under the comprehensive implementation plan on maternal, infant and young child nutrition (MIYCN). WHO supported 11 Member States[54] to strengthen their nutrition surveillance systems. Nutrition-monitoring services now cover almost 21 million women of reproductive age and 12 million children under the age of five.

Nine more countries conducted the Global Youth Tobacco Survey (GYTS) which provides trends on tobacco use among the youth.


baby

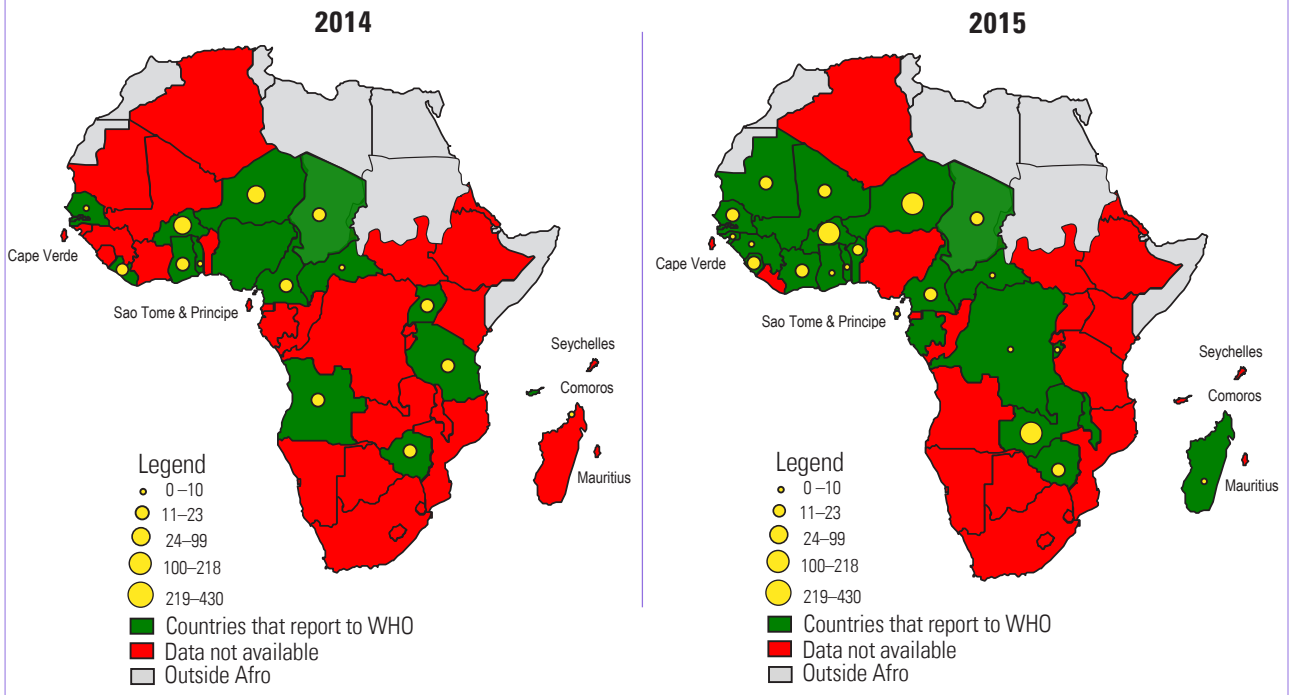
4.3 Category 3: Promoting health throughout the life-course

56. Under category three WHO provided guidance and support to Member States towards reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health (SRH); and promoting active and healthy ageing, taking into account the need to address the determinants of health and internationally agreed development goals, in particular the health-related Millennium Development Goals.

57. To improve WHO technical support to Member States, the Regional Director set up a Regional Task Force to serve as a Regional advisory team on Reproductive, Maternal, Newborn and Child Health policies. At its first meeting held in 2014, the Task Force identified gaps and made key recommendations, which included strengthening health systems, pursuing a multisectoral approach, improving coordination and increasing investments in health. These recommendations were shared with African Ministers of Health during the First Meeting of African Ministers of Health Jointly Convened by the AUC and WHO in Luanda in 2014, which adopted a commitment to end preventable maternal, newborn and child deaths by 2030.

58. WHO supported 17 countries[55] to strengthen maternal death surveillance and response (MDSR), bringing to 32 the number of countries implementing MDSR. MDSR links the health information system and quality improvement processes from the local to national levels and permits routine identification, notification, quantification and determination of the causes of death as well as the use of this information to address future maternal deaths. There has been an improvement in the quality of MDSR reporting. Twenty-two countries[56] in the first quarter of 2015 reported on maternal mortality through the IDSR system compared to 15 countries[57] during the same period in 2014. This is a concrete step towards ensuring timely notification of maternal deaths while taking action to prevent future deaths (Figure 8).

Figure 8: Maternal deaths reported in the first quarter of 2014 compared to maternal deaths reported in the first quarter of 2015



Source: WHO/AFRO: IDSR Quarterly Bulletins for March 2014 and March 2015. Brazzaville: WHO/AFRO; 2015

59. Building capacity in RMNCH interventions is crucial to leveraging resources for scaling up. In addition to the Global Fund support, 15 countries[58] were supported to mobilize resources through the RMNCH Trust Fund. These resources are supporting the implementation of interventions to improve RMNCH in Member States.

60. To assess progress made in sexual and reproductive health, 20 years after the 1994 International Conference on Population and Development (ICPD), WHO organized a consultation for 28 countries,[59] UN Agencies and stakeholders. The consultation made recommendations to address areas of the ICPD such as equity, gender equality and human rights; prevention of violence against women and girls, child marriage; reducing unmet need for family planning; and addressing the needs of adolescents.

61. Gender, equity and human rights are crucial to the promotion of health throughout the life-course. Mozambique, Rwanda, Tanzania and Zimbabwe mainstreamed gender, equity and human rights into their national plans while Ethiopia, Malawi and Zambia incorporated gender indicators into their national health management information systems. Eighteen Member States[60] strengthened their capacity for prevention and response to violence against women through regional workshops, with Botswana and Ethiopia establishing guidelines for gender mainstreaming.

62. Capacity-building for integration of gender, equity and human rights in health policies and programmes was conducted for seven countries.[61] This will help to curb discrimination against women and disadvantaged groups, and ensure that vulnerable groups have equal access to opportunities for achieving their full human development potential.

63. WHO supported a study in five sites located in the Democratic Republic of Congo, Kenya and Nigeria. The study compared the efficacy of three simple antibiotic regimens for treating severe infections in young infants. The results show that simplified antibiotic treatment of infection in young infants less than 2 months of age is as effective as standard treatment when referral is not feasible. Based on this outcome, WHO has developed new guidelines which will be rapidly disseminated for use in all countries of the Region. This will contribute to further reduction in neonatal deaths.

64. WHO supported teams from 21 countries[62] to develop and implement plans for improving the quality of care in maternal, newborn and child health services. Botswana, Côte d'Ivoire, Ethiopia, Lesotho and Namibia were supported to adapt the Integrated Management of Childhood Illness Computerized Adaptation and Training Tool (ICATT) as an innovative capacity-building option to rapidly scale up IMCI. Swaziland, Tanzania and Zimbabwe built capacity in IMCI through on-the-job self-directed learning. Support was provided to Eritrea, Ethiopia, Malawi and Namibia to

update and cost their child survival strategies and plans. Sixteen countries[63] adapted guidelines and developed plans to scale up child survival interventions at community level. Implementation of these new approaches will lead to improvements in child survival.

65. Benin, Botswana, Namibia and South Africa were supported to undertake comprehensive national reviews of reproductive, maternal, newborn, child and adolescent health and nutrition programmes over the reporting period. The findings of these reviews will provide guidance for effective programming, advocacy and resource mobilization for the post-2015 era.

66. To strengthen the monitoring and evaluation of adolescent health programmes, the capacities of 14 countries[64] were strengthened. WHO supported capacity-building efforts in 11 countries[65] intending to introduce the HPV vaccine as part of adolescent health. Burundi, Cameroon, Eritrea, Lesotho and Niger either developed or reviewed their national adolescent strategic plans. Benin, Burundi, Democratic Republic of Congo, Eritrea and Niger developed national standards for adolescent-friendly health services using the new global standards recommended by WHO. Implementation of these interventions will improve adolescent health.

67. Addressing the health problems associated with ageing is an integral part of promoting health throughout the life-course. To better understand the status of the elderly in the Region, a desk review and a survey on ageing in 8 countries[66] were conducted. The key findings include: lack of aggregate data on health and ageing; unavailability of policy documents on ageing; nongovernmental organizations more active than government on issues related to ageing; and inadequate preparedness of the health system to handle issues of the elderly. The report was used to guide the development of the regional strategy on "Health and Ageing".

68. In relation to social determinants of health, the capacity of 16 countries[67] was strengthened on the leadership and stewardship role of ministries of health (MoH). An assessment of the implementation status of health in all policies in Malawi, Mozambique and Zimbabwe was conducted. The findings, which underpin the importance of intersectoral actions for health and allocation of resources for interventions in non-health sectors, are being integrated into national policies and programmes.

69. The report on the status of implementation of the Libreville Declaration on Health and Environment for the period 2008-2013[68] was produced. The report shows that a total of 37 countries have established multisectoral and multidisciplinary Task Teams (CTTs) and completed situation analysis and need assessment (SANA) for the management of environmental health determinants. A total of 20 countries have developed national plans for joint action (NPJA) informed by SANA. The CTTs have provided opportunities for experts with different perspectives to engage effectively in a technical and scientific dialogue, and to reach consensus on the status and relative importance of environmental risk factors that impact on health, development and ecosystems preservation. In countries that have completed SANA, the management of health and environment issues has been integrated into development plans through adaptation of legislation and policies on health and environment.

70. The Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS 2014) report[69] was published with data from 36 countries in the WHO African region. WHO contributed to the GLAAS process in the Region, particularly through preparation of the tools, organization of the regional inception workshop and attendance of same workshop by the PHE focal person. The report shows that many countries have the policies, plans and strategies to reach vulnerable groups such as those living in poverty. However, less than 40% of countries monitor progress in sanitation and drinking water, access to and service provision for the poor. Fifteen per cent of countries have established and applied financial measures geared towards reducing inequalities in access to sanitation for the poor and 30% have done same for drinking water. This report will serve as a benchmark for Member States to develop national investment plans for reducing disparities between the rich and the poor.

71. As regards access to drinking water and adequate sanitation, all the Member States in the region were supported to participate in the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) through the organization of national data harmonization workshops. The JMP 2015 report[70] revealed that 15 countries[71] have achieved the target for safe water and 3 countries, (Algeria, Cabo Verde and Rwanda) have met the target for basic sanitation.

72. The regional insecticide resistance database was updated with data from 35 countries.[72] Based on this data, a regional atlas of insecticide resistance to malaria vectors in the African region was produced to guide Member States for evidence-informed malaria vector control. A Regional handbook on vector control in malaria elimination and a guide for the health component of health adaptation to climate change were developed.

73. Data on chemicals of public health importance from 40 countries[73] was disseminated to Member States and published on the WHO-AFRO website. The potential sources of exposure and existing capacity for management of these chemicals were assessed. The assessment revealed that the Region's chemical management capacity is still low. Only 38% of the responding Member States have comprehensive legislations and policies on chemical management, 32% have developed the capacity for surveillance of chemical events, 50% have established reference laboratories for detecting most of the chemicals and only 25% have poison control centres or toxicology units that provide poison information and management of cases. This data will serve as a springboard for the establishment of national chemical observatories.

74. Funds were mobilized for assessment of the impact of climate change on water, sanitation and hygiene (WASH), and water and vector-borne diseases in 10 countries.[74] Capacity for management of industrial chemicals was strengthened in nine countries[75] through workshops. Capacity was built in Ethiopia, Madagascar, Malawi, Tanzania and Zambia for climate change vulnerability and adaptation risk assessment. Nine countries[76] completed a project on DDT reporting, through which the health-environment system for regular reporting on status of DDT to the Secretariat of the Stockholm Convention was established. National guidelines for integrated vector management were revised in Eritrea, Madagascar and Sao Tome and Principe.

4.4 Category 4: Health systems

75. The work of this category supports the strengthening of national health systems with a focus on the organization of integrated service delivery; financing to achieve universal health coverage (UHC); strengthening of human resources for health; health information systems; facilitating transfer of technologies; promoting access to affordable, quality, safe and efficacious health technologies; and promoting health systems research. UHC is defined as equitable access to affordable, accountable, appropriate health services of assured quality by all people.[77]

76. National health policies, strategies and plans (NHPSPs) provide the platform for government leadership and partner coordination needed to address priority health problems and to improve health outcomes, including those related to the MDGs. Capacity to develop comprehensive and costed national health policies, strategies and plans (NHPSP) was strengthened at both regional and national levels. Fourteen countries[78] were supported to develop comprehensive and costed NHPSP, including monitoring and evaluation frameworks, bringing the total to 42.[79] Furthermore, a three-year plan to strengthen monitoring and evaluation at the regional level was developed. Implementation of these plans will enable better coordination and accountability for health in countries.

77. The severity of the Ebola virus disease epidemic in West Africa has been attributed, in large part, to the weakness of the health systems of the affected countries. In a bid to forestall such catastrophes in the future WHO supported Guinea, Liberia and Sierra Leone to develop costed recovery plans to build resilient health systems. These plans have been well-received and attracted a total of US$ 5.18 billion from donors in pledges.

78. Health financing is central to the implementation of all health interventions. The Region supported 15 countries[80] to develop or revise their financing strategies. Best practices on health financing for UHC from Rwanda, Ghana, Burundi and Gabon were collated and disseminated to inform action in other countries. A second Atlas on Health Expenditure in the African Region[81] was published. It provided an overview of national health expenditures to guide priority-setting and planning in all countries.

79. Cabo Verde and Tanzania were supported to develop comprehensive Human Resource for Health policies/strategies, while core teams of eight countries[82] were trained to review their staffing norms, using the Workload Indicators of Staffing Need tool. National health workforce observatories (NHWO) were established in six additional countries,[83] bringing the total to 19.[84] The NHWOs have improved generation and use of evidence in policy development, planning and decision-making.

80. The African Health Observatory continued to act as the repository for country-level data on health status and trends, health systems, priority programmes and services, health determinants and progress towards the MDGs. This data has been used in policy dialogue and decision-making. Five countries[85] were supported to develop eHealth strategies to facilitate the use of information technology for health systems strengthening, including service delivery. Seven countries[86] assessed the state of eHealth with the support of WHO to inform the development of eHealth policies.

81. The regional competency based curricula and the professional regulatory framework for nursing and midwifery[87] were developed as a move towards harmonization and for providing standards for training and practice in the region. Furthermore, Chad, Comoros and Equatorial Guinea were supported to scale up the education of their health workers as a means towards increasing the supply of a skilled health workforce. Capacity was built on patient safety and quality of care in Eritrea, Swaziland and Zambia. This will contribute to improvement of infection control in health facilities.

82. WHO supported an additional five countries to establish knowledge translation platforms and facilitated their access to the Evidence-Informed Policy Network (EVIPNet), thus bringing the total number of countries with a national platform to twelve in 2014.[88] This will further improve access to evidence for policy development and decision-making. The Regional Ethics Review Committee (ERC) was reconstituted and has reviewed 19 research proposals from 7 countries[89] to date, leading to improved adherence to research ethics principles.

83. The African Regional Health Report 2014,[90] the Atlas of African Health Statistics 2014[91] and a special issue of the African Health Monitor on immunization in the African Region[92] were published to inform the health development agenda. In addition, WHO staff members

in the African Region published 34 articles in peer-reviewed scientific journals in the areas of immunization, communicable disease prevention and control, health systems and national health research systems.[93] The African Index Medicus was updated and documents were uploaded into the WHO Repository for Information Sharing.

84. Access to safe medicines requires strong pharmaco-vigilance systems to enhance public trust in health products. Fifteen countries[94] were supported to develop and implement multi-stakeholder work plans for vaccine safety and pharmaco-vigilance in order to improve reporting of adverse events and ensure that all health products are monitored throughout their shelf life.

85. The establishment of the African Medicines Agency (AMA) was endorsed by Ministers of Health in Luanda, Angola, in April 2014. In line with the Ministerial commitment, the African Union Commission (AUC) and WHO set up a Task Team for the establishment of AMA, with the AUC, WHO and NEPAD Planning and Coordinating Agency as its secretariat. The Task Team held its first meeting in Addis Ababa and adopted its terms of reference and a four-year action plan (2015-2018) for the operationalization of AMA.

86. Local manufacture of pharmaceuticals, if well promoted, can improve access to safe, effective and affordable health products for the countries of the Region. Within the context of the African Union's Pharmaceutical Manufacturing Plan for Africa (PMPA), WHO supported Ethiopia and Tanzania to develop pharmaceutical manufacturing plans. Implementation of these plans will enhance local production and lead to improved access to health products.

87. In partnership with the European Commission and the African, Caribbean and Pacific Group of States (ACP), WHO supported countries to improve access to quality and affordable medicines. A regional plan of action (2014-2017)[95] has been developed in collaboration with Member States to minimize the spread of substandard, spurious, falsely-labelled, falsified and counterfeit (SSFFC) medical products. The Region is second only to the European Region in reporting SSFFC medical products to the WHO rapid alert system and taking steps to remove them from circulation. Eleven countries[96] revised their national essential medicines lists while Cameroon, Ghana and Zambia revised their standard treatment guidelines.

88. WHO provided technical assistance to implement the "Stepwise Laboratory Improvement Process Towards Accreditation" (SLIPTA). This has resulted in the accreditation of seven laboratories to ISO 15189:2007 standards: four in Tanzania, and one each in Kenya, Uganda and Togo. Forty-two laboratories out of the 144 audited in 16 countries received recommendation for ISO 15189:2007 accreditation. A tool entitled "*Guidance for Establishing a National Health Laboratory System*"[97] was designed to help countries develop an integrated and coordinated laboratory component for national health policy and strategic plans. In relation to blood safety, by the end of August 2015, all countries were able to carry out 100% HIV testing of all blood units collected by national blood transfusion services.[98]

4.5 Category 5: Preparedness, Disease Surveillance and Response

89. The work of WHO under this category supported preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters thus contributing to global Health Security.

90. Between January 2014 and August 2015, the African Region experienced a total of 133 public health events (PHEs) in 37 Member States (Figure 10). These PHEs included the largest ever, most severe and complex outbreak of Ebola virus disease in the history of mankind. This outbreak was retrospectively identified as having begun in rural Guinea in December 2013 and reported to WHO in March 2014.

91. By September 2015 cases of EVD had been reported from six countries in the Region (Guinea, Liberia, Sierra Leone, Nigeria, Mali and Senegal) as well as in Spain, the United Kingdom and the United States of America. Unlike previous outbreaks which were mostly limited to rural settings, this outbreak was unique and characterized by intense transmission in densely-populated urban areas. By 30 September 2015, a cumulative total of 28441 cases and 11 310 deaths had been reported of which 535 were health workers (Table 2).

Table 2: Number of EVD cases and deaths per country in West Africa as at 30 September 2015

COUNTRY	CUMULATIVE NUMBER		HEALTH CARE WORKERS	
	CASES	**DEATHS**	**CASES**	**DEATHS**
Guinea	3809	2533	211	115
Liberia	10 672	4808	378	192
Sierra Leone	13 931	3955	447	221
Mali	8	6	2	2
Nigeria	20	8	11	5
Senegal	1	0	0	0
Total	**28 441**	**11 310**	**1049**	**535**

Source: WHO Database 2015

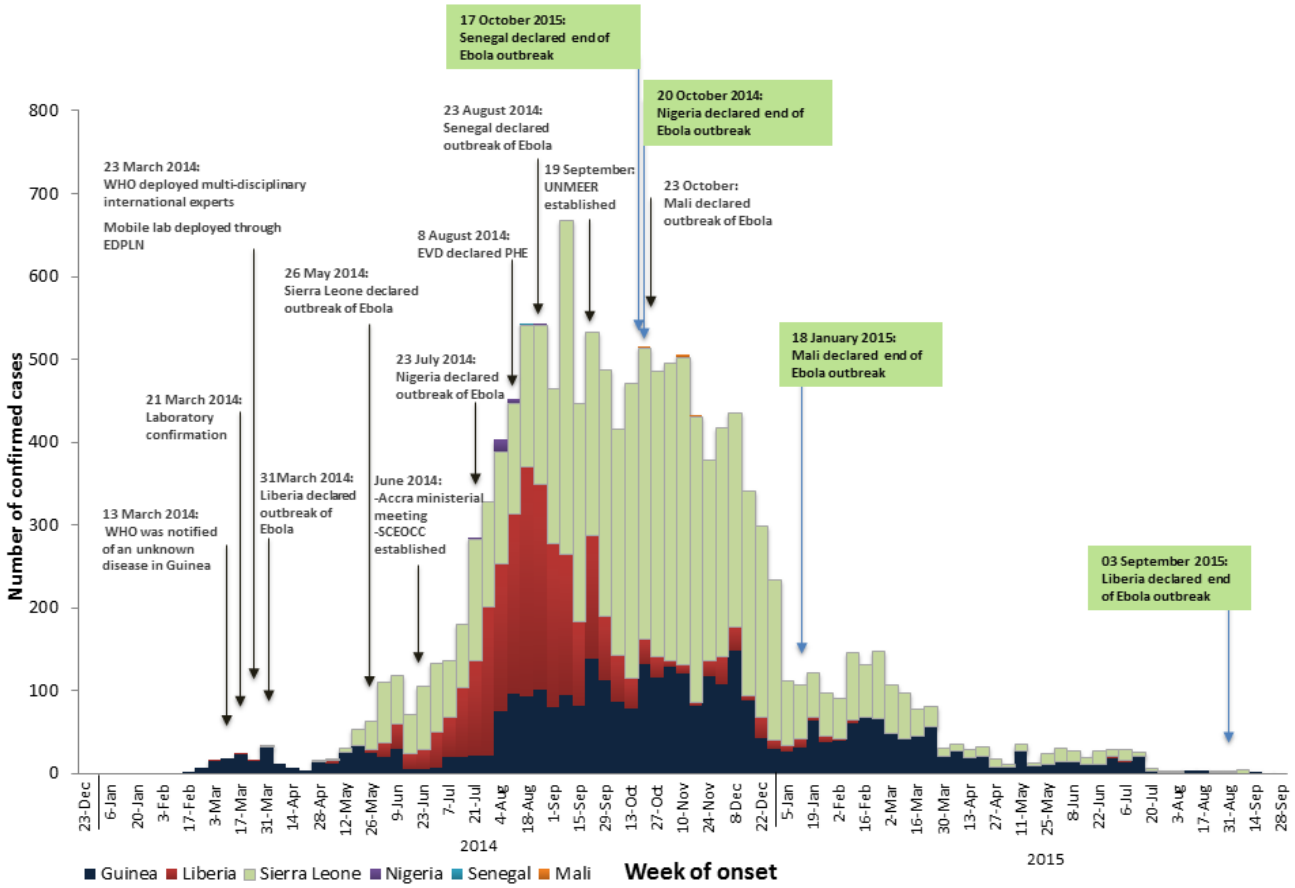
92. WHO led the global response on several fronts, including surveillance and contact tracing, case management, research and development of medicines, preparedness, behavioural communication and community dialogue. By end-August 2015, a cumulative total of 3823 experts had been deployed by WHO, including 1244 deployed by the Regional Office to the severely-affected countries. These experts provided technical support at the central, district and community levels.

93. Furthermore, using WHO internal tools such as the Strategic Health Operations Centre (SHOC) and rSIS, the Organization was able to coordinate the Ebola response, monitor cases and deaths, track staff and commodity needs, and produce daily situation reports that informed the general public and the media on the outbreak, thus raising global awareness of the disease.

94. As the outbreak evolved, WHO convened a Ministerial meeting of the Economic Community of West African States (ECOWAS) in Accra at which it was requested to establish a Sub-Regional Ebola Outbreak Coordination Centre (SEOCC) in Guinea. Through SEOCC operations the coordination of partners involved in the Ebola response was strengthened and WHO was able to provide a timely response to requests from the affected countries. In addition, WHO supported the affected countries to establish functional emergency operation centres.

95. To tackle community resistance to EVD, WHO deployed anthropologists and experts in communication and behavioural science to identify the underlying social and cultural determinants driving the outbreak. Socio-anthropological studies identified harmful cultural practices and beliefs and weak health systems as factors fuelling the outbreak. These findings informed community engagement activities and decision-making, resulting in the halting or reversal of EVD transmission. All the above interventions led to the successful interruption of EVD transmission in Liberia, Mali, Nigeria and Senegal as well as a significant reduction in the number of cases and related deaths in Sierra Leone and Guinea.

Figure 9: Chronology of events and epidemiological curve of EVD in West Africa from December 2013 to August 2015



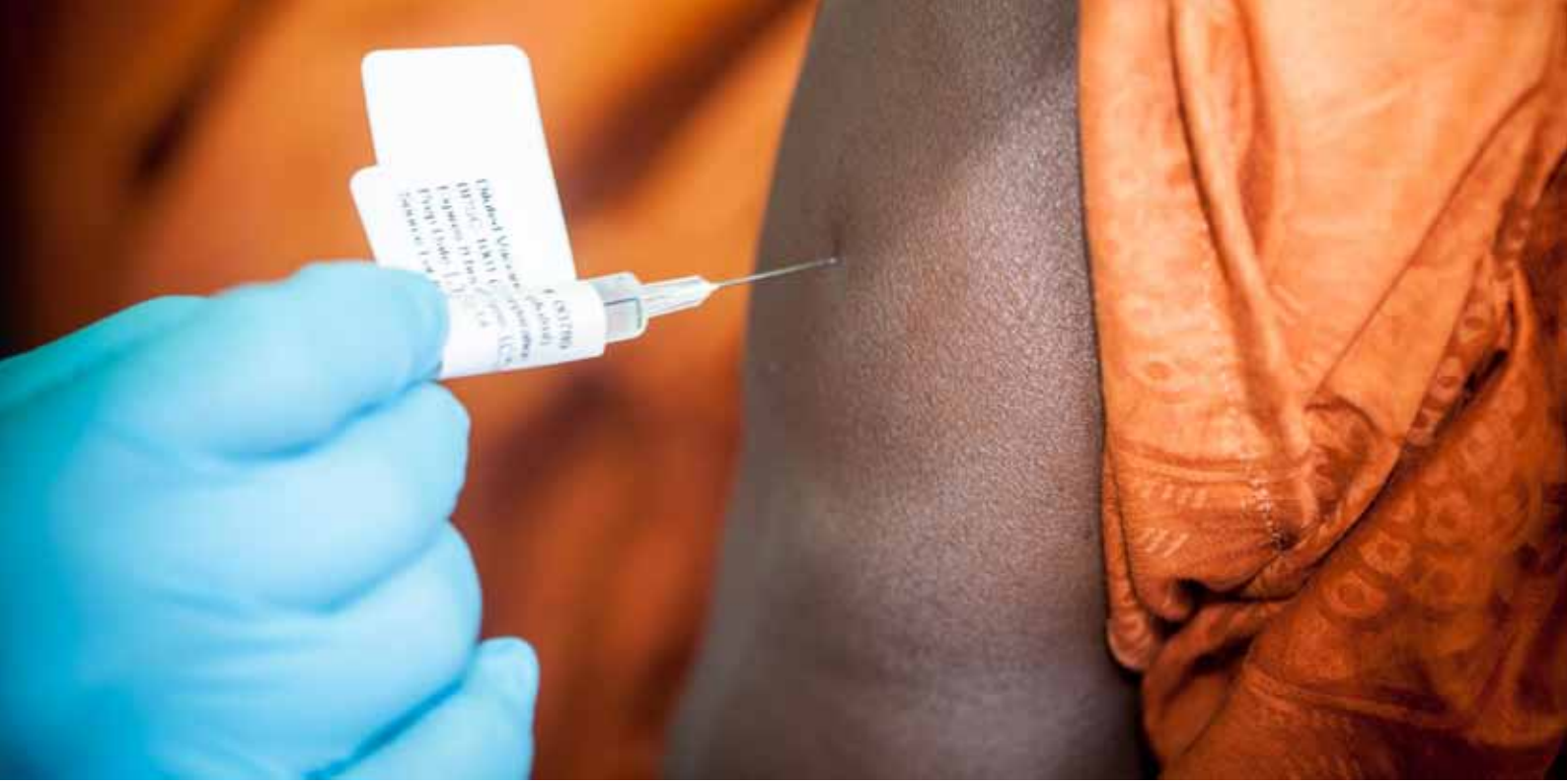
Source: WHO/AFRO: SHOC. Brazzaville: WHO/AFRO; 2015

96. WHO supported capacity-building in 39 unaffected countries, including the development of national preparedness plans and staff training. Furthermore, national laboratory diagnostic capacities for EVD and MERS-CoV were reinforced and 16 countries were provided with reagents and supplies for diagnosis of these diseases. Personal protection equipment and guidelines for managing the outbreak were provided to Member States in the Region to enhance infection control. Assessments of EVD preparedness were subsequently conducted in 11 out of 14 priority countries, using a consolidated checklist that had been developed in consultation with other partners.

97. In collaboration with partners, WHO also supported research and development (R&D) of new diagnostics, experimental treatments and vaccines for EVD. It engaged countries, manufacturers, sponsors, investigators, regulatory authorities and partners, coordinating them through its R&D Team Leaders. The African Vaccine Regulatory Forum (AVAREF), a network of national regulatory authorities and ethics committees, served as a platform for meeting the regulatory requirements for R&D.

98. Guidance for compassionate use of unlicensed products was also provided to countries, ensuring that only products which are effective, safe and meet quality standards are eventually deployed. By August 2015, two candidate vaccines against EVD had completed phases 1 and 2 clinical trials and were in phase 3 trials in the three EVD-affected countries. Interim analysis of the phase 3 results of one candidate vaccine showed 100% efficacy in Guinea. As a result, the ring vaccination strategy using this vaccine was extended to Sierra Leone to help end the outbreak.

99. Recognizing the successful use of immune serum therapy against some diseases and its potential in managing EVD, Guinea, Liberia and Sierra Leone were supported to implement this treatment option. WHO provided guidelines and technical support for the emergency use and clinical trials of convalescent whole blood (CWB) and convalescent plasma (CP) therapies. CWB and CP transfusions were included in a package of interventions provided to EVD patients. Countries were also supported to acquire and use mobile transfusion units for this purpose. Consequently, CWB and CP transfusions were included in a package of interventions provided to EVD patients, to improve treatment outcome.



100. Apart from the EVD outbreak in West Africa, WHO also responded to other emergencies during the reporting period, namely: the humanitarian crisis in South Sudan and the Central African Republic, and flooding in Mozambique and Malawi. The Emergency Response Framework (ERF) was used to manage response to the humanitarian crisis in South Sudan and the Central African Republic. The four critical functions of WHO under the ERF were performed with 90% of ERF performance standards being achieved. In addition, other public health events, such as cholera outbreaks in Ghana, Malawi, Mozambique, South Sudan and Tanzania, Marburg outbreak in Uganda and a separate EVD outbreak in the Democratic Republic of Congo were reported.

101. The African Public Health Emergency Fund (APHEF) was critical in providing the initial seed money to mount the response to these public health events. However, to retain its relevance, the Fund will have to be replenished. From the establishment of APHEF in 2012 to July 2015, 13 of the 47 Member States had contributed a total of US$ 3 619 438, and US$ 196 380 562 was still pending. From January to December 2014, only 6 (six) countries contributed US$ 1 263 735 to the Fund and from January to July 2015, only 4 (four) countries contributed US$ 580 202. A total of US$ 2 300 676 was disbursed to 11 countries during the reporting period.

102. The implementation of high quality interventions is crucial to the interruption of polio transmission and prevention of the importation of wild poliovirus (WPV). Regional coverage with the 3rd dose of the oral polio vaccine (OPV3) was 79% in 2014. In Nigeria for instance, OPV3 coverage increased from 63% in 2013 to 66% in 2014. The quality of polio SIAs was high in countries[99] that experienced outbreaks in 2014. The independent assessment conducted in 2015 declared that the outbreaks have stopped but there was need to intensify surveillance. In some countries, such as Nigeria, SIAs in 2014 and 2015 incorporated the use of the inactivated polio vaccine (IPV) to boost systemic immunity, with more than 4 million IPV doses administered

between June 2014 and April 2015. Most of the countries in the Region attained the two surveillance indicators (i.e. non-polio AFP rate and stool adequacy) compared to 2013. AFP surveillance was supplemented with environmental surveillance in Angola, Cameroun, Chad, Nigeria and Kenya to detect polioviruses in sewage.

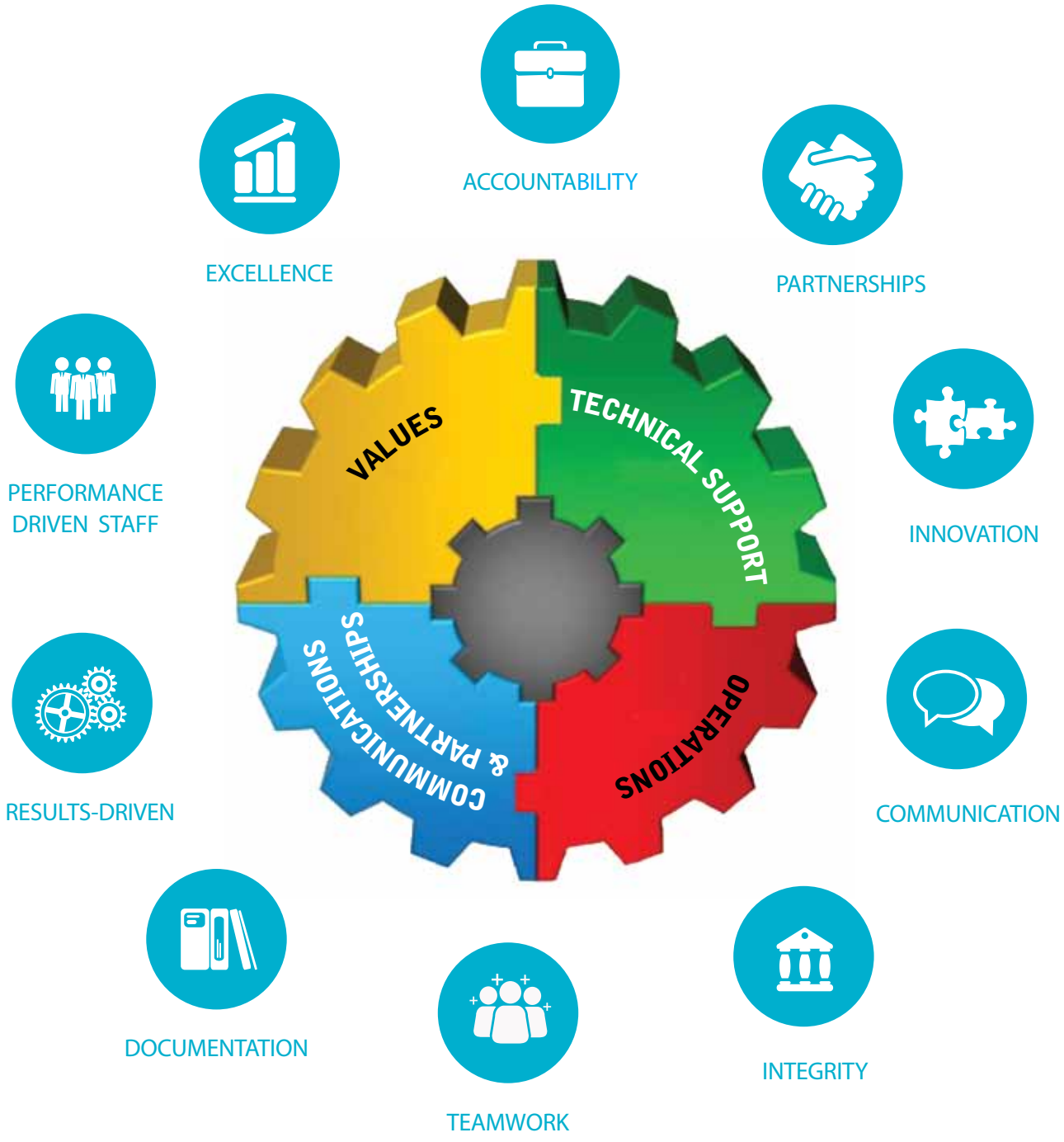
103. Improved delivery of polio-related activities in 2014 - 2015 resulted in Nigeria being removed from the list of polio endemic countries on 25 September 2015. Furthermore, for the first time in polio eradication history, there was no confirmed wild poliovirus case in the whole WHO African Region in 2015. However, it is important to note that for the African Region to be certified polio-free, another 2 years will be required to verify that there is no missed circulation of poliovirus in the Region. Consequently, it is only in 2017, at the very earliest, that polio eradication certification is possible.

104. On 20 September 2015, the Global Certification Commission (GCC) for Polio Eradication certified that wild poliovirus type 2 has been eradicated globally. Recognizing the interruption of wild poliovirus transmission in countries, WHO through the African Regional Certification Commission (ARCC), supported Member States to compile documentation for polio-free status. The ARCC met in June 2015 to evaluate progress on polio eradication in the Region. The complete documentation has been presented by 32 countries, of which 29 have been accepted. Out of the remaining 18 countries, four[100] have been selected to present their complete documentation to the ARCC in November 2015. As for phase-1 laboratory containment of type-2 poliovirus, twelve countries[101] had conducted laboratory surveys and inventory activities as of September 2015.

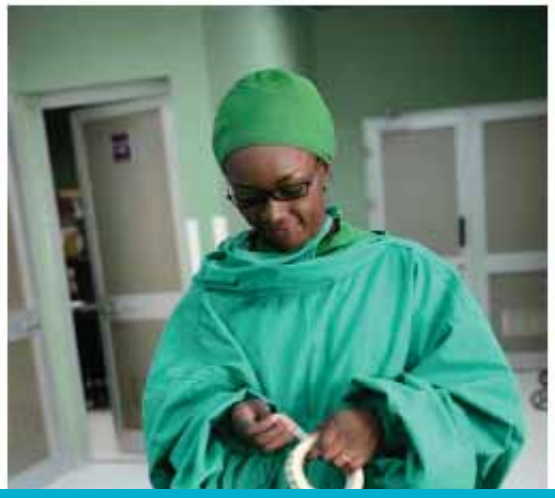
Documentation of PEI best practices was conducted in eight countries, so that lessons learnt could improve implementation of other public health interventions.

105. An important aspect of the Polio Eradication Initiative (PEI) is planning on the use of polio resources post-eradication. The documentation of PEI best practices was conducted in eight countries, so that lessons learnt could improve implementation of other public health interventions. An AFRO inter-cluster working group was established in June 2015 to develop a Regional Polio Legacy Plan. It held its planning meeting in South Africa in July 2015. The working group also met with global partners and donor agencies on 25 August 2015 in Brazzaville to fast-track development of country plans for legacy / transitional planning. The outcomes will be used to strengthen immunization in general and to support other disease elimination and control programmes of Member States.

4 transformation focus areas



THE TRANSFORMATION AGENDA OF THE WORLD HEALTH ORGANIZATION SECRETARIAT IN THE AFRICAN REGION 2015 – 2020


4.6 Category 6: Corporate services and enabling functions

106. Under this category, organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO were provided.

107. The Regional Director undertook several missions to Member States, partners and donors, and also hosted the annual meetings of the diplomatic corps accredited to the Republic of Congo, to raise awareness on the work of WHO and advocate for their continued support to the Organization. In line with the new aspiration of transforming WHO in the African Region into a more transparent, accountable and efficient organization, a program termed "The Transformation Agenda of the WHO Secretariat in the African Region"[102] was developed. This agenda sets out the vision and strategy for change and is aimed at improving the performance of the WHO Secretariat as it supports its Member States to improve health outcomes. As part of the Transformation Agenda, an accountability and internal strengthening framework project is being implemented to address all systemic weaknesses in the control environment collectively, rather than tackling one audit recommendation at a time.

108. Partnerships were expanded and strengthened through WHO participation in events and activities organized by the African Union, the regional economic communities and other partners. For example, WHO organized a follow up meeting with the AUC to reflect on the progress in implementation of the outcomes of the First Meeting of African Ministers of Health Jointly Convened by the AUC and WHO in Luanda, Angola, in April 2014. At the follow-up meeting, WHO and AUC agreed on a new plan of action to accelerate work on the establishment of the Africa Medicines Agency and the Africa Centre for Disease Control and Prevention, and to address the emerging burden of noncommunicable diseases.

109. Partnerships were also expanded through collaboration with bilateral and multilateral donors, the private sector and civil society. WHO coordinated the Harmonization for Health in Africa (HHA) mechanism which provided technical support, promoted government leadership, and ensured dialogue between stakeholders on strengthening and achievement of the health-related MDGs.

110. A regional consultation on the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health was co-organized by the South African government, the World Health Organization and the Partnership for Maternal, Newborn and Child Health in May 2015. During this consultation the draft 2016-2030 Global Strategy was reviewed and inputs from Member States were incorporated. The revised Strategy will serve as the regional framework for accelerating progress in maternal newborn child and adolescent health in the post-2015 period.

111. The visibility of WHO at country level was increased through the Organization's involvement in various health development agenda, including commemoration of the World Malaria Day, World TB day, World Diabetes Day, World AIDS Day and the World Health Day.

112. The WHO country offices (WCOs) in the Region implemented aspects of the managerial reforms through the institutionalization of bottom-up planning for programme budget 2014-2015. Furthermore, 36 countries[103] reviewed, extended or renewed their country cooperation strategies (CCS), ensuring that changes in national health planning and priorities are incorporated into this document and that the local health situation is taken into account in future WHO priority-setting. Tools for developing CCS in countries in fragile situations and for integrating hazards emergency risk assessment, country emergency risk management and WHO readiness were disseminated to countries.

113. The first meeting of Heads of WHO country offices from Angola, Chad, Democratic Republic of Congo, Ethiopia, South Africa and Nigeria was organized in March 2014. This meeting afforded the Heads of these offices an opportunity to share experiences in the management of large country offices. The structure and functioning of WCOs, the definition of a generic organizational framework and the issue of deputy Heads of WHO country offices in the specific context of these offices were discussed and ways of improving their management efficiency were agreed upon.

114. Efficiency in the planning, implementation and monitoring of WHO programmes at country level improves the chances of success. For better coherence in policy orientation and accountability at country level, the Regional Programme Management (RPM) meetings were held in September 2014 and April 2015. These meetings discussed public health emergencies and humanitarian crisis, important issues related to planning, implementation and monitoring of WHO programmes and the Transformation Agenda.

115. The capacity of the Organization to mobilize additional resources was enhanced through training on donor communication and resource mobilization for 90 staff members from 12 WCOs and the Intercountry Support Team in West Africa. As a result, proposals were written by staff members which attracted additional resources to support the work of the Organization.

116. Compliance was strengthened significantly in the Region to improve risk management in all operations. Compliance reviews were conducted in IST/ East and Southern Africa and some WHO country offices in procurement, travel and donor reporting. Information was provided to country representatives (WRs) and Cluster Directors about identification and assessment of risks in the context of developing a global WHO risk register. In parallel, budget centres have completed internal control self-assessments. Local risk management committees are in place to periodically review and update risks and mitigations, and to strengthen internal control. There was significant improvement in the closure of audits, evident in the reduction of the number of outstanding audit recommendations by 57%.

117. An accountability and internal strengthening framework project is being implemented to address all systemic weaknesses in the control environment collectively, rather than tackling one audit recommendation at a time. Quality assurance functions in finance, human resource and procurement have been inserted into the end-to-end processes to put more emphasis on preventive controls as opposed to detective controls, since the overriding goal is to avoid non-compliance. Specific training in these areas was made mandatory for all relevant staff in order to enhance capacity and to maximize outputs in a transparent, cost-effective and efficient manner.

118. To further enhance transparency and accountability, key performance indicators across programmatic and administrative areas have been jointly agreed upon between the Regional Office and Country Offices. The indicators are directly linked to individual and budget centre performance, with the latter being published in a management dashboard accessible to all staff from Q4/2015.

119. An internet knowledge base has been developed where staff can obtain guidance on internal control frameworks, rules, regulations and standard operating procedures. This repository also includes the latest information on best practices, checklists and templates with regular updates.

120. As a result of the EVD outbreak and the humanitarian crisis, some operational plans at the Regional Office and in the EVD-affected countries were reprogrammed to free up funds for the response. Furthermore, the deployment of staff to Ebola-affected countries caused some delays in the implementation of other planned activities.

121. The Regional Office also contributed to the development of PB 2016-17, starting with the identification of priority programmes through an improved bottom-up planning approach, informed by national priorities as outlined in the CCS and in consultation with National Authorities. The process is consistent with WHO reform and was strongly requested by Member States.

122. Managerial and administrative functions were strengthened, thus ensuring more efficient procedures and an improved human resources policy. WHO country presence was strengthened in terms of financial and human resources, staff capacity-building and the delegation of more authority from the regional to the country levels.

123. The imprest and General Ledger accounts were fully reconciled. Awards under Regional Office management were regularly reviewed to ensure timely implementation and reporting. To further support response to the EVD outbreak, affected countries were provided guidance and support through the analysis of cashbooks, award expenditure analyses and workflow approvals.

124. Infrastructural improvements on the premises of country offices led to better staff safety and security. Furthermore, as mentioned in numerous audit reports, a project to strengthen control of fixed assets is underway which, when finished, will ensure regional compliance with financial rules and International Public sector Accounting Standards.

125. The ICT infrastructure in the Regional Office and some countries was upgraded. The global emails in all countries were successfully migrated to the new platform and the unified communications, telephones and local networks project was implemented in the Regional Office and countries. A number of applications were developed as per specifications from clusters and in support of the Ebola response. End-user support was strengthened resulting in reduced lead time to resolve user issues and weekly training sessions on productivity tools were introduced in the Regional Office.

126. Communication support was provided to Ebola-affected countries and to the Central African Republic and South Sudan. This surge capacity was provided through the WHO networks of global and regional communication officers trained to provide risk or emergency communications. The deployment of these staff members improved global awareness of Ebola and subsequently helped galvanize the global response.

127. Communication material in the form of media releases, messages, feature stories, audio-visual spots were shared online with journalists as part of the commemoration of the African Vaccination Week, World Malaria Day, World Health Day and World AIDS Day. These public health messages also promoted advocacy for prevention and control of various diseases.

5

Progress made in the implementation of Regional Committee resolutions

In past sessions of the Regional Committee, Member States have passed several resolutions, the implementation of which is monitored by the Secretariat. The progress reports of some of the resolutions are presented in this chapter. Each report summarizes the resolution, the activities which were implemented, and the results or impact achieved.

5.1 AFR/RC53/R6 – Scaling up interventions against HIV/AIDS, TB and Malaria in the WHO African Region

128. This resolution urged Member States to develop and implement appropriate policies, strategies and legislation in order to provide an enabling environment for scaling up interventions against HIV, TB and malaria. Furthermore, the resolution called on WHO to provide the necessary technical support for the development and implementation of strategic plans to address the three diseases.

129. All countries in the Region have developed and reviewed their health sector strategic plans for responding to HIV/AIDS, including the adaptation of the WHO consolidated guidelines by 35 Member States. With WHO technical support, countries have adapted and implemented the Stop TB Strategy including the scale-up of collaborative TB/HIV interventions and programmatic management of drug-resistant TB. This has resulted in increased access to HIV testing, TB screening and co-trimoxazole preventative therapy. The ART coverage among co-infected patients in the Region increased from 29% in 2005 to 68% by the end of 2014.

130. Further, WHO continues to support Member States to access GFATM resources for the scale-up of interventions against HIV, TB and Malaria through technical support, including programme reviews, epidemiological analysis and the development of related concept notes.

5.2 AFR/RC61/R4 – Poliomyelitis Eradication in the African Region

131. The resolution urged all Member States with wild poliovirus circulation to declare its persistence a national public health emergency and successfully interrupt transmission. Furthermore, Member States were urged to implement priority actions through emergency plans to ensure interruption of poliovirus transmission within the shortest possible time.

132. Polio supplementary immunization activities (SIAs) were conducted in the Region in 2014 and 2015 with particular focus on the remaining polio-endemic country, Nigeria, and in countries that had experienced polio outbreaks. West and Central African countries conducted preventive polio SIAs in 2014 and 2015 to mitigate the risk of importations. Acute flaccid paralysis (AFP) surveillance was strengthened in the Region with an increasing monthly trend of reported AFP cases and responses organized against confirmed poliovirus outbreaks.

133. As a result of these actions, wild poliovirus transmission was interrupted for more than a year in Nigeria and the country was removed from the global list of endemic countries in September 2015. In addition, all polio outbreaks in Central Africa were declared to have been stopped as no case of wild poliovirus has been detected in the entire African Region since July 2014.

5.3 AFR/RC62/R2 – HIV/AIDS: Strategy for the African Region

134. The resolution urged Member States to scale up and broaden interventions for HIV prevention, testing and treatment.

135. With WHO training and technical support, Member States adapted policies and strategies, mobilized additional resources, broadened coverage and improved the implementation quality of HIV testing and treatment.

136. By August 2015, all the countries in the Region had updated their national strategic plans in line with the regional HIV strategy. Fourteen countries had scaled-up voluntary medical circumcision for HIV prevention, 21 priority countries scaled-up prevention of mother-to-child interventions and all countries had safe blood transfusion programmes. HIV treatment has been rapidly expanded in all 47 countries and 69% of HIV/TB co-infected individuals are receiving antiretroviral therapy.

5.4 AFR/RC62/R8 – Implementation of International Health Regulations (2005) in the African Region

137. The resolution called on Member States to revise national IHR (2005) plans to focus on priorities to achieve the minimum IHR core capacities by June 2014; mobilize resources; strengthen coordination and collaboration in relevant sectors in the context of "One Health"; integrate IHR related interventions; ensure integrated disease surveillance and response (IDSR) and disaster risk management (DRM); promote cross-border collaboration; monitor implementation of IHR, work with WHO in interpreting and applying international travel and trade requirements related to yellow fever and other diseases; and regularly report IHR implementation progress to WHO.

138. By the end of August 2015, Algeria, Gabon, Rwanda and Senegal had been supported to conduct assessments of IHR core capacities and to develop plans of action. All the countries in the Region did not meet the minimum IHR core capacity standards and 20 (43%) have since requested a two-year extension, while 26 (57%) are yet to communicate their intentions.

5.5 AFR/RC63/R7 — The WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection; recommendations for a public health approach — implications for the African Region

139. The resolution called on Member States to adapt their national antiretroviral therapy (ART) guidelines to the new WHO consolidated guidelines on the use of ARVs according to the specific context of each country. It also urged Member States to increase investment in the HIV response and to design appropriate programmes which would increase opportunities for initiating antiretroviral therapy.

140. By the end of August 2015, thirty-five countries had adapted their national guidelines to the WHO consolidated guidelines and were implementing the recommendations. The consolidated guidelines contributed to the rapid scale up HIV treatment and by the end of 2014, about 10.7 million people were receiving lifesaving antiretroviral therapy in the African Region. Member States adopted the public health approach to providing treatment and they developed innovative service delivery models which combine strengthened decentralized HIV services and working with communities.

5.6 AFR/RC63/R6— Regional Strategy on Neglected Tropical Diseases in the WHO African Region

141. The resolution urged countries to provide leadership and ensure ownership by establishing and strengthening national NTD programmes. Member States were further urged to institute coordination mechanisms, while forging multisectoral collaboration to address functional gaps that constrain programme interventions, and to promote linkages between NTDs and other health programmes.

142. All endemic countries in the Region (except Algeria, Cabo Verde and Seychelles) have national NTD programmes and various coordination mechanisms at different levels of functionality. Seventy per cent of the countries in the Region have updated their master plans and operational plans in alignment with the NTD Regional Strategic Plan 2014-2020 and global targets to control, eliminate or eradicate NTDs by 2020.

143. Several countries in the Region have been supported to map the PC-NTDs and have begun implementing PC interventions, with a cumulative 26 countries implementing MDA. Togo has stopped MDA for lymphatic filariasis at national level, while Ghana became the 40th country to be declared free of Guinea worm disease.

5.7 AFR/RC64/R6 – African Public Health Emergency Fund

144. The resolution called on Member States to undertake advocacy for the African Public Health Emergency Fund (APHEF) at the appropriate levels within the countries, including in parliaments, so as to ensure the payment of national contributions.

145. Five countries (Benin, Chad, Gambia, Liberia and Seychelles) contributed to APHEF in 2014. As of end-July 2015, only eight of the 47 Member States had contributed a total of US$ 3 619 438 since APHEF was established in 2012. Of the expected annual total contribution of US$ 50 000 000, only US$ 1 770 740 (3.6%) was actually contributed in 2012, US$ 1 621 123 (3.2%) in 2013 and US$ 220 068 in 2014.

146. A total of US$ 1 326 073 from APHEF was provided as immediate financial assistance to nine countries, at their request, for the management of declared public health emergencies. These are the Central African Republic (improving access to quality health care in three districts including rehabilitation of the Bangui Paediatric Hospital), South Sudan (strengthening emergency surgical services for war-related and other surgical emergencies in conflict-affected areas), Burundi and Zimbabwe (provision of immediate health care to populations affected by floods), Guinea, Democratic Republic of Congo, Liberia, and Sierra Leone (for controlling the Ebola outbreak), and Cameroon (to provide emergency health intervention to Central African Republic refugees).

6

Challenges and Constraints

147. Several challenges and constraints were encountered in the work of WHO for the period January 2014 to August 2015. These mainly related to investment in health systems, response to emergencies and humanitarian crises, coverage of effective health interventions, sustaining effective partnerships and resource mobilization.

148. Despite the economic growth experienced by some countries and increased investment in health, resources were not sustained to build resilience in health systems and to scale up critical interventions. Domestic investment in health by national governments remained low. Health financing, the health workforce, information systems and disease surveillance, access to essential medicines, vaccines and other health products, and investment in research and innovation were inadequate. This affected the pace of adoption of new technologies and interventions. Meanwhile, Member States continue to face the challenge of different priorities competing for limited resources.

149. The African Region experiences many public health emergencies, due to natural or man-made causes, including droughts, annual floods, outbreaks of communicable diseases and conflicts. There are major gaps in the capacity and preparedness of countries, with the health systems of most countries being unable to organize a fast, effective and adequate response to these emergencies. Furthermore, these emergencies tend to divert scarce resources away from planned activities thereby compromising the ability of countries to address other key health priorities. The current challenge is how to work with Member States to build their core capacities to fulfil their obligations under the International Health Regulations (2005) and to build strong and resilient health systems that assure health security.

150. The coverage of proven interventions against major communicable and noncommunicable diseases has failed to reach the levels required to eradicate, eliminate or control these diseases. The challenge is how to engage Member States and partners to mobilize the resources needed, to scale up and to improve efficiency in the implementation of policies and strategies, with a view to raising and sustaining coverage beyond current levels, thereby propelling countries towards meeting the MDGs and SDGs. Member States shall be required to make concrete political and financial commitments and investments towards these ends.

151. The number of partners in health has grown in the countries of the Region, thus increasing available resources and opportunities. This has, however, resulted in the challenge of effectively coordinating the multiple health initiatives at country level, which affects the efficiency and delivery of public health programmes. The challenge is to support Member States to strengthen national ownership, leadership and capacity to more effectively coordinate partners for more efficient implementation of programmes. There is need to enhance alignment and harmonization of the support provided by development partners and donors in order to improve aid effectiveness and address the health priorities of Member States.

152. There was criticism of the performance of the WHO Regional Office for Africa in its response to the EVD epidemic. The Secretariat was deemed to lack the capacity or organizational culture to deliver a full emergency public health response. The challenge is for the Secretariat to fully engage in the WHO Reform in Emergency so that the required resources are mobilized to effect the significant changes that are required to mount a comprehensive and rapid response, whenever and wherever there arises an emergency that impacts public health and outstrips national capacity. It is critical that the WHO Regional Office for Africa rapidly expands its capacity to detect health-related alerts and coordinate responses at national and regional levels while linked with global mechanisms.

153. Resource mobilization for health, especially in emergencies, remains a major challenge, as exemplified by the slow response of countries in making financial contributions to the Africa Public Health Emergency Fund. More commitment is needed from Member States to ensure the allocation of more domestic resources to address emergencies as well as make contributions to APHEF so that adequate resources are available for a timely response to emergency situations. With regard to APHEF, the challenge is for the Secretariat to come up with more innovative and effective approaches for encouraging Member States and others to contribute.

7

Conclusion

Conclusion

154. This report reflects the work of WHO during the first 20 months of the 2014-2015 Programme Budget. It also reflects the first experience with the bottom-up approach to priority-setting, which forms the basis for more focused and relevant implementation between the Secretariat and Member States, which will be improved in future. The report highlights key achievements and progress made, much of which is echoed in the progress made on the MDGs.

155. Much of the Organization's effort was directed towards supporting the response to the Ebola epidemic in West Africa. This experience has prompted a determination to intensify support for preparedness and response, working with partners and other health security initiatives. The Secretariat in the African Region will play an active part in the reform of WHO's work on emergencies and epidemics

156. WHO will carry on contributing towards ending the EVD epidemic and rebuilding national health systems in the three severely-affected countries in West Africa. Efforts will be made to enhance the capacity of countries to prepare for and respond to epidemics and humanitarian

crises, including improving IHR core capacities. WHO will also enhance regional-level capacity to respond to emergencies and continue to advocate for increased resource allocation to health security and emergencies.

157. WHO will continue to work with other health partners to advocate for improved domestic health financing, improve priority-setting and support the scaling up of proven and cost-effective health interventions by Member States in order to ensure improved health for the people of the African Region.

158. The WHO Secretariat will work with Member States, partners, donors and other key stakeholders, including regional economic communities, and through the political platform offered by the African Union and its Agenda 2063, to address country priorities. Particular attention will be paid to supporting countries to plan, implement and evaluate progress towards the attainment of the health-related SDGs and universal health care with a focus on equity and inclusiveness. Countries will be supported to implement the UN Secretary-General's Global Strategy on Maternal, Child and Adolescent Health, tackle the emerging burden of noncommunicable diseases; address the social determinants of health; and engage other non-health sectors to ensure synergy between their policies and the actions of the health sector.

159. The efforts made to transform the WHO Secretariat in the African Region into a more responsive, results-focused, efficient and accountable organization will continue into the coming biennium. The Secretariat is committed to accelerating the development of resilient health systems that prevent and manage disease, ensure health security, and contribute to the improvement of health outcomes in the WHO African Region.

8

Annex

Annex 1 Provides an overview of Budget allocations to the African Region (PB 2014-2015) by category of work and programme areas, with breakdowns for Regional Office (RO) and Country Offices (CO) (US$ 000).

Annex 1: Budget allocations to the African Region (PB 2014-2015) by category of work and programme areas, with breakdowns for Regional Office (RO) and Country Offices (CO) (US$ 000)

CATEGORIES AND PROGRAMMES	TOTAL	RO SHARE	CO SHARE
1 - Communicable diseases	266 724	69 583	197 141
HIV/AIDS	42 059	12 197	29 862
Malaria	25 235	7318	17 917
Neglected tropical diseases	19 477	6038	13 439
Tuberculosis	16 823	4879	11 945
Vaccine-preventable diseases	163 130	39 151	123 979
2 - Noncommunicable diseases	56 536	23 218	34 117
Disabilities and rehabilitation	888	799	89
Mental health	2301	1565	736
Noncommunicable diseases	48 079	19 232	28 847
Nutrition	3866	1160	2706
Violence and injuries	1402	463	939
3 - Promoting health through the life-course	91 986	31 108	60 878
Gender, equity and human rights mainstreaming	2338	1637	701
Health and the environment	12 865	6047	6818
Healthy ageing	703	562	141
Reproductive, maternal, newborn, child and adolescent health	68 817	19 957	48 860
Social determinants of health	7263	2905	4358
4 - Health systems	71 510	31 805	39 705
Access to medical products & strengthening regulatory capacity	11 581	4864	6717
Health system information and evidence	14 692	7346	7346
Integrated people-centred health services	30 000	13 500	16 500
National health policies, strategies and plans	15 237	6095	9142
5 - Preparedness, surveillance and response	55 023	17 004	38 019
Alert and response capacities	8269	4052	4217
Emergency risk and crisis management	37 285	7457	29 828
Epidemic- and pandemic-prone diseases	4926	2315	2611
Food safety	4542	3179	1363
6 - Corporate services / enabling functions	130 334	67 301	63 033
Leadership and governance	45 797	13 739	32 058
Management and administration	67 337	36 362	30 975
Strategic communications	5200	5200	0
Strategic planning, resource coordination and reporting	5200	5200	0
Transparency, accountability and risk management	6800	6800	0
Emergencies	447 887	36 504	411 383
Outbreak and crisis response	39 630	7926	31 704
Polio eradication	408 257	28 578	379 679
GRAND TOTAL	**1 120 000**	**276 523**	**844 276**
% SHARED	**100%**	**25%**	**75%**

9

Endnotes


DETECTO

Endnotes

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