The Work of WHO in the African Region

2012
2013

Report of the Regional Director

World Health Organization
REGIONAL OFFICE FOR Africa

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To the Sixty-third session of the Regional Committee for Africa,

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FOREWORD

The Regional Director has the honour of presenting to the Regional Committee the report on the work of the World Health Organization in the African Region during the biennium 2012-2013.

Dr Luis Gomes Sambo
Regional Director

CONTENTS

Page

LIST OF FIGURES

ABBREVIATIONS

AACHRD	African Advisory Committee on Health Research and Development
ACLEM	African Centre for Laboratory Equipment Maintenance
AFP	Acute Flaccid Paralysis
AHO	African Health Observatory
ANI	Accelerating Nutrition Improvements
APOC	African Programme for Onchocerciasis Control
APHEF	African Public Health Emergency Fund
ART	Antiretroviral Therapy
ARV	Antiretroviral medicine(s)
AVW	African Vaccination Week
CEWG	Consultative Expert Working Group on Research and Development: Financing and Coordination
CoIA	Commission on Information and Accountability
DPT3	3rd Dose of Diphtheria Pertussis Tetanus in routine EPI
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
ECOWAS	Economic Community of West African States
eMTCT	elimination of Mother-to-Child Transmission
EPI	Expanded Programme on Immunization
ERF	Emergency Response Framework
EVIPNet	Evidence Informed Policy Network
FANC	Focused Antenatal Care
FCTC	Framework Convention on Tobacco Control
GAPPD	Global Action Plan for Pneumonia and Diarrhoea
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLAAS	Global Analysis and Assessment of Sanitation and Drinking Water
GLP	Global Learning Programme
GPW	General Programme of Work
GSHS	Global School Health Survey
HELDS	Health and Environment Linkages Data Management System
HHA	Harmonization for Health in Africa
HPV	Human Papillomavirus
iCCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations (2005)
IMCI	Integrated Management of Childhood Illness

IMPACT	Integrated Management of Pregnancy and Childbirth
IPSAS	International Public Sector Accounting Standards
ISO	International Standards Organization
ITNs	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
MCV	Measles-containing vaccine
MDA	Mass drug administration
MeTA	Medicines Transparency Alliance
mhGAP	Mental Health Gap Action Programme
MNCH	Maternal, Newborn and Child Health
MNT	Maternal and Neonatal Tetanus
MOSS	Minimum Operational Security Standards
MTCT	Mother-to-child transmission
MTSP	Medium Term Strategic Plan
NCDs	Noncommunicable Diseases
NMRAs	National medicines regulatory authorities
NTDs	Neglected Tropical Diseases
PCT-NTDs	Preventive Chemotherapy on NTDs
PHE	Public Health Events
PMDT	Programmatic Management of Multidrug-resistant TB
PMTCT	Prevention of Mother-to-Child Transmission
REC	Regional Economic Communities
RED	Reaching Every District
rGLC	Regional green light mechanism
r-SIS	Real-time Strategic information System
RMNCH	Reproductive, Maternal, Newborn and Child Health
SANAs	Situation analyses and needs assessments
SHPPS	School-based Health Policy and Programme Study
SIAs	Supplementary Immunization Activities
SIDS	Small Island Developing States
SLIPTA	Stepwise Laboratory Improvement Process towards Accreditation
SSFFC	Substandard, spurious, falsely-labelled, falsified and counterfeit
STEPs	Stepwise approach to surveillance of NCD risk factors
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
WAHO	West African Health Organization
WPV	Wild Poliovirus

EXECUTIVE SUMMARY

1. The work of WHO in the biennium was guided by the 11th General Programme of Work 2006–2015, the MTSP 2008–2013, Country Cooperation Strategies (CCS) and the Strategic Directions for WHO in the African Region 2010–2015. This report covering the Programme Budget 2012-2013 is presented under each of the strategic objectives, namely, SO1: Communicable diseases; SO2: HIV/AIDS, Tuberculosis and Malaria; SO3: Chronic noncommunicable conditions, mental disorders, violence and injuries; SO4: Child, adolescent and maternal health, and ageing; SO5: Emergencies, disasters, crises and conflicts; SO6: Risk factors for health conditions; SO7: Social and economic determinants of health; SO8: Healthier environment; SO9: Nutrition, food safety and food security; SO10: Health services; SO11: Medical products and technologies; SO12: Leadership, governance and partnership; and SO13: Efficient and effective WHO.

2. For better understanding of WHO deliverables this Executive Summary highlights the achievements according to the Organization's core functions, namely: (a) providing leadership in matters critical to health and engaging in partnerships where joint action is needed; (b) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; (c) setting norms and standards and promoting and monitoring their implementation; (d) articulating ethical and evidence-based policy options; (e) providing technical support, catalyzing change and building sustainable institutional capacity; (f) monitoring the health situation and assessing health trends.

3. The Programme Budget was implemented within a context of a global financial and economic crisis that affected the availability of resources to health including to WHO. In countries of the African Region, an average of 5-6% economic growth rate was recorded and the majority of governments made efforts to increase investments in the health sector towards achieving the health-related MDGs. Reductions in infant mortality rate and in the burdens of malaria and HIV are examples of progress towards the attainment of the MDGs. However, progress has been slow and not enough to enable attainment of the 2015 goals.

4. A primary role of WHO is to provide leadership and engage partners for joint action. Through WHO country representatives, the Organization facilitated dialogue among national authorities, health stakeholders and development partners. In line with the Paris Declaration on Aid Effectiveness, Harmonization and Alignment, they also promoted coordination among health development partners under the leadership of the ministries of health. Joint programmes with other UN agencies in countries led to improvement in the coherence of UN action on health, in the context of the UN Country Teams and the United Nations Development Assistance Framework (UNDAF).

5. The engagement of political, traditional and religious leaders of countries as well as international development partners has led to improved health outcomes especially of immunization, resulting, for example, in the interruption of the transmission of poliovirus in the re-established countries (Angola, Chad and Democratic Republic of the Congo) and the reduction of the threat of epidemics due to meningococcal A meningitis in West Africa.

6. Partnerships with bilateral and multilateral organizations, Regional Economic Communities, the European Union, Global Health Initiatives, foundations, civil society, nongovernmental organizations and academic institutions were strengthened. WHO led and coordinated action by the Harmonization for Health in Africa (HHA) partnership mechanism and advanced dialogue between ministers of finance and ministers of health. This has strengthened focus on effective health financing mechanisms and service delivery, with a view to accelerating progress towards Universal Health Coverage.

7. An important role of WHO is to help shape the research agenda and stimulate the generation, translation and dissemination of knowledge to inform health policy and action. The African Advisory Committee on Health Research and Development (AACHRD) has been reconstituted and is providing invaluable advice on research for health in the African Region.

8. Countries were supported to use research findings and new tools to strengthen priority programmes. For example the integrated community case management of malaria, pneumonia and diarrhea was informed by recent scientific evidence and knowledge. Research in Kenya to address major causes of mortality in children below five years of age led to the development of guidelines for implementation of community-based maternal, newborn and child health programmes. National capacities of 34 countries for conducting Stepwise surveillance of NCD risk factors were strengthened and these countries are now generating data to guide actions.

9. In setting norms and standards, WHO supported Member States to develop or adapt guidelines in several priority programmes. For example, WHO launched consolidated guidelines for the use of antiretroviral medicines to treat and prevent HIV infections. A framework which integrates paediatric tuberculosis into Directly Observed Treatment, Short course (DOTS) was developed. Furthermore, tools for implementation of the Regional Disaster Risk Management (DRM) strategy were developed.

10. WHO facilitated the development and adoption of evidence-based regional strategies that guide Member States in the definition of national policies and strategies to address public health priorities. In 2012, the Sixty-second session of the Regional Committee

adopted the Regional Disaster Risk Management (DRM) strategy, the roadmap for scaling up human resource for health, the Brazzaville Declaration on Noncommunicable Diseases, the health promotion strategy, the renewed HIV/AIDS strategy, a strategy on consolidation of the African Health Observatory, a policy on health and human rights, and an orientation document on optimizing global health initiatives to strengthen national health systems. In 2013 the following policies and strategies were developed, reviewed by the Programme Subcommittee and submitted to the current Regional Committee meeting: policies and plans for reproductive, maternal, newborn and child health (RMNCH) interventions as well as for national patient safety; strategies for promoting traditional medicine in health systems; strengthening the capacity for regulation of medical products; utilizing eHealth to improve health systems; and controlling neglected tropical diseases.

11. In the area of providing technical support and catalysing change WHO supported Member States to develop national policies through multisectoral task force, to promote health in all policies and to develop legislation on specific risks such as alcohol and tobacco use. Technical support was provided for implementing polio supplementary immunization activities (SIAs), reaching more than 300 million children aged below five years. More than 103 million people were vaccinated with the meningococcal A meningitis conjugate vaccine (MenAfriVacTM) within two years after its introduction.

12. Member States were supported to implement cost-effective interventions aimed at reducing the burdens of HIV/AIDS, tuberculosis and malaria. Fourteen priority countries scaled up male circumcision to reduce HIV incidence. WHO also supported the expansion of antiretroviral therapy for prevention and treatment of HIV/AIDS as well as access to tuberculosis medicines through the Global TB Drug Facility (GDF).

13. Forty-three countries assessed their core capacity for implementation of the International Health Regulations with WHO support. However, none of the countries attained the minimum International Health Regulations core capacities by the deadline of June 2012, resulting in the submission of an application for a two-year extension. There was significant improvement in disease surveillance capacity of countries in the Region. Cumulatively 36 countries were supported to develop integrated national NTD master plans by the end of 2012. Country capacity to address noncommunicable diseases has increased following WHO guidance and support. Twenty countries have now prioritized prevention and control of noncommunicable diseases by creating units, programmes or departments in their ministries of health.

14. WHO further strengthened its strategic, technical and logistic support to Member States in response to emergencies that occurred in the Region. It coordinated support for the health components in armed conflicts, drought in the Sahelian countries and disease outbreaks

in several countries, thereby minimizing morbidity and saving lives. Furthermore, WHO in partnership with other key stakeholders, addressed the food and nutrition aspects of the crisis in the Sahel and other parts of the Region.

15. In order to strengthen health systems, technical support was provided for the development or revision of national health policies and strategic plans. In addition, technical support was provided for the development of strategic and action plans for national medicines, laboratory and blood policies as well as for institutional development plans for National Medicines Regulatory Authorities (NMRAs). The African Health Observatory is now operational with 23 country analytical profiles and four country statistical atlases now accessible through its portal for monitoring the health situation and assessing health trends. In addition, an Atlas of African Health Statistics 2012 and 2013 was produced and disseminated to countries, providing information for decision-making. Tuberculosis prevalence surveys were conducted in Ethiopia, Nigeria, Rwanda and Tanzania and the results were used to improve control and surveillance. Countries were supported to use a web-based TB electronic data system as part of data collection for the Global TB report 2012-2013.

16. WHO established a regional Strategic Information System (rSIS) with retrospective data and projections on communicable and noncommunicable diseases and conditions. The rSIS database is being rolled out and will allow for the availability of real time data for action. In collaboration with the African Network on Vector Resistance (ANVR), WHO collected data on insecticide resistance in the Region during the 2012-2013 biennium. The data is being used in operationalizing the Global Plan on Insecticide Resistance Management (GPIRM).

17. Overall, the implementation of the Programme Budget 2012-2013 through the 13 strategic objectives (SOs) was supported by the enabling functions and corporate services of the WHO Secretariat. The implementation of the results-based management approach and related framework was evident in the alignment of technical results, financial resources and related expenditures in operational plans for the 2012-2013 biennium. The WHO Regional Director's delegation of authority to Senior Managers in the Region has placed decision-making and responsibility for delivery of results at the same level and strengthened compliance and oversight functions. In addition, as a project management tool, the Global Management System has improved financial reporting against technical results presented in this report.

18. WHO's reform programme provides the opportunity to improve performance while enabling the Organization to adapt to the changing global health context and emerging new priorities. During the Twelfth General Programme of Work 2014–2019, WHO will focus on the following priorities:

(a) Advancing universal health coverage: enabling countries to sustain or expand access to essential health services and financial protection and promoting universal health coverage as a unifying concept in global health.

(b) Health-related Millennium Development Goals — addressing remaining and future challenges: accelerating the achievement of the current health-related goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases.

(c) Addressing the challenge of noncommunicable diseases and mental health, violence and injuries, and disabilities.

(d) Implementing the International Health Regulations: ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005).

(e) Increasing access to essential, high-quality and affordable medical products (medicines, vaccines, diagnostics and other health technologies).

(f) Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries.

INTRODUCTION

1. This report covers the work of WHO in the African Region for the period January 2012 to August 2013 of the 2012-2013 Biennium. It presents the achievements in implementing the Programme Budget 2012-2013, the last biennium of the Medium Term Strategic Plan (MTSP) 2008–2013.

2. Each biennial Programme Budget takes into account the lessons learnt from previous ones, while ensuring continuity towards achieving the results of the MTSP 2008–2013 as well as comparability. Given the context of the global financial crisis the Programme Budget 2012-2013 has been adjusted to focus more on key priorities.

3. The report reflects the work carried out by country offices, the technical support provided by the three Intercountry Support Teams (ISTs) and the policy and strategic support provided by the Regional Office. It also reflects the findings of the Medium Term Review and subsequent monitoring exercises of the implementation of the Programme Budget, which are part of the Organization's performance assessment framework.

4. This report is organized into seven sections as follows:

    1. Introduction
    2. Context
    3. Implementation of the Programme Budget 2012-2013
    4. Significant achievements by Strategic Objectives
    5. Progress made in the implementation of Regional Committee resolutions
    6. Challenges, constraints and lessons learnt
    7. Conclusion.

5. The annexes to the report comprise Table 1, WHO Medium Term Strategic Plan 2008–2013: Statement of Strategic Objectives and Table 2, Approved Programme Budget 2012-2013: Allocation by Strategic Objective, source of financing and distribution between WHO country offices and the Regional Office (in US$000s).

2. CONTEXT

6. The implementation of the Eleventh General Programme of Work 2006–2015 started during a period of optimism resulting from the rapid global economic growth and the availability of considerable financial resources. Since 2008, the successive biennial programme budgets have been implemented within a context of the global financial and economic crisis. However in the African Region, an average economic growth rate of 5-6% was recorded and the majority of governments made efforts to increase investments in the health sector towards achieving the health-related MDGs. Reductions in infant mortality rate and in the burdens of malaria and HIV are examples of progress towards the attainment of the MDGs. However, progress remains slow and inadequate to enable attainment of the 2015 goals.

7. The financial crisis has adversely impacted on socioeconomic conditions and health financing at country level and by international partners. Within the constraints, most of the partners made efforts to maintain their commitments to health financing. Some countries of the African Region are experiencing significant improvements in annual rates of economic growth some of which are beginning to reflect in improved health financing. Notwithstanding these gains, the majority of countries have yet to achieve the Abuja target of allocating 15% of the national budget to health and the MDG financing target of US$ 44 per capita health spending. The quest for more flexible and predictable funding for WHO has led to WHO reform, and intensified efforts to mobilize resources and address regional health priorities.

8. Although countries continue to invest in health, a number of areas critically need improvement. They include financing; strengthening the health workforce; improving information systems and disease surveillance; improving access to essential medicines, vaccines and other health products; and investing in research and innovation.

9. Globalization has significantly influenced public health, including through promotion of the consumption of certain goods that are harmful to health and migration of the health workforce to developed countries in search of better opportunities. In addition, health development in countries of the Region is influenced by a multiplicity of factors, including diversity of new players in global health, availability of new tools and demographic, epidemiological and environmental changes.

10. Despite the progress made in reducing the burden of malaria, tuberculosis, HIV/AIDS and some neglected tropical diseases (NTDs) over the years, the burden of these communicable diseases remains unacceptably high. Countries, with technical support of WHO, have made efforts to introduce new vaccines and improve routine immunization coverage, resulting in

a reduction of the burden of vaccine-preventable diseases. However, several countries are still experiencing outbreaks of measles while polio remains endemic in Nigeria and wild poliovirus (WPV) circulates in Chad and Niger, and more recently in Kenya, specifically among Somali refugees.

11. The Region is experiencing a rise in the burden of noncommunicable diseases including mental health problems, violence and injuries, and is projected to experience a 15% increase in deaths from noncommunicable diseases in the next two decades.

12. Natural and man-made disasters, sociopolitical unrest and other crises occur frequently in the Region, causing death, injury, population displacement, destruction of infrastructure including health facilities and overburdening of the health systems of the neighbouring countries receiving refugees. The drought in countries of the Sahel in West Africa, the unrest in the Central African Republic, the war in Mali and the humanitarian crisis in the Horn of Africa are some of the major examples.

13. Despite these challenges, the public health outlook is bright. Opportunities are presented by the national health sector reforms, new players, new medicines, vaccines, advances in information technology and new interventions. The African Union, regional economic groupings, global health initiatives and alliances, coalitions and partnerships have influenced the progress made in tackling public health challenges such as child mortality, HIV/AIDS, tuberculosis and malaria. The level of funds available globally for health has also increased in the past 15–20 years, reflecting a higher prioritization of health in the global development agenda, despite the stagnation in the past two years.

14. The impact of the financial crisis and the overall changing environment triggered the WHO reform in which new directions and priorities have been articulated. Country needs will receive more attention in the definition of priorities through the governing bodies such as Regional Committees and the World Health Assembly. Thus, the oversight role of the governing bodies has been significantly strengthened and harmonized across the Organization.

15. Despite difficulties posed by earmarked funding, the ongoing reform including the financing dialogue with partners is expected to enable WHO to mobilize adequate and flexible funding to address the health priorities agreed with Member States.

3. IMPLEMENTATION OF THE PROGRAMME BUDGET 2012-2013

16. The WHO Programme Budget 2012-2013 was adopted by the World Health Assembly through resolution WHA64.3 with an approved budget allocation of US$ 3 958 979 000. The African Region was allocated US$ 1 093 066 000 comprising US$ 209 600 000 (19%) of Assessed Contributions (AC) and US$ 883 466 000 (81%) of Voluntary Contributions (VC). The Programme Budget was endorsed by Member States during the Sixty-first session of the Regional Committee in Yamoussoukro, Côte d'Ivoire.

17. The budget for the African Region for 2012-2013 is 13.4% lower than the 2010-2011 budget. One of the consequences of the reduction of the budget allocation for the Region is a reduction of the budget allocation to some programmes addressing health priorities in the Region. The programmes whose budget allocation decreased significantly were Nutrition and food safety; Health systems; HIV/AIDS, Tuberculosis and Malaria; Child and maternal health; and Protection of the human environment. At the same time, WHO embarked on reform, worked with countries to prioritize and refocus on challenges, while making strenuous efforts to mobilize additional resources and ensure a successful implementation of the Programme Budget. Overall, the implementation figures show significant differences across the 13 Strategic Objectives, in terms of the funds allocated, made available or implemented.

18. As shown in the table overleaf, the current budget of US$ 1 341 989 639 is 23% more than the initial approved budget allocation which reflects a significant increase in Strategic Objective 1, due to polio funds as well as other funds mobilized at country level for programmes related to SO 01 and SO 09. With the increase in the allocated budget, the relative distribution of allocations reflects a significant shift in favour of countries, allocated 77% of the budget, while the Regional Office allocation was 23%. This contrasts with the initial allocations of 66% to country offices and 34% to the Regional Office.

Programme Budget implementation by Strategic Objective as of 31 July 2013 (in US$ 000)							
Strategic Objective (SO)	Budget Approved by the Health Assembly* (1)	Allocated PB (2)	Total available funds (3)	% Available funds against Approved Budget (4)=(3/1)	Budget. implemen-tation (excluding July payroll) (5)	% of budget implemen-tation against Approved Budget 6=(5/1)	% of budget implemen-tation against Available Awards 7=(5/3)
SO 01	484 082	716 061	686 242	142%	502 750	104%	73%
SO 02	147 467	127 458	91 224	62%	56 848	39%	62%
SO 03	18 948	19 999	16 984	90%	9836	52%	58%
SO 04	77 084	83 068	75 261	98%	46 601	60%	62%
SO 05	91271	106 268	81 835	90%	57 631	63%	70%
SO 06	20 286	20 277	18 215	90%	11 141	55%	61%
SO 07	10 746	13 090	9 628	90%	6239	58%	65%
SO 08	12 719	13 721	11 283	89%	6760	53%	60%
SO 09	10 633	16 635	15 971	150%	6907	65%	43%
SO 10	71 791	75 416	60 843	85%	36 301	51%	60%
SO 11	25 823	25 818	17 651	68%	9920	38%	56%
SO 12	45 968	46 928	43 473	95%	31 870	69%	73%
SO 13	76 248	77 251	68 011	89%	47 785	63%	70%
Grand Total	**1 093 066**	**1 341 990**	**1 196 621**	**109%**	**830 588**	**76%**	**69%**

Source: GSM Organization-wide Implementation Report, Programme Budget 2012-2013.

* See Table 2 in Annex 2 for the breakdown of the approved budget by fund and organizational level.

19. The overall funds made available for implementation was US$ 1 196 620 766, representing 109% of the approved budget and 89% of the current allocated budget. Further analysis reveals that the amount available to the Regional Office is 71% of the initial approved budget, while that for country offices is 130%.

20. The VC component of the available funds is US$ 993 341 766 representing 83% of the total funding, while the AC component is US$ 203 279 000 (17%). This confirms the high level of dependence on Voluntary Contributions, earmarked for specific programmes. This state of dependence restricts the redistribution of funds to address regional health priorities in a balanced manner. The two least-funded Strategic Objectives are SO 02 and SO 11 which respectively received 62% and 68% of their approved budget. The average funding gap for SOs, excluding funds for Polio, was 36%.

21. The overall implementation rate is 76% of the approved budget. The implementation rate for funds actually received is 69%. Therefore, Budget Centres have been requested to accelerate the implementation of all available funds before the end of the Biennium 2012-2013.

4. SIGNIFICANT ACHIEVEMENTS BY STRATEGIC OBJECTIVE

4.1 SO1: Communicable diseases

22. Strategic Objective 1 aims at reducing the health, social and economic burden of communicable diseases. Routine immunization, polio eradication, neglected tropical diseases, integrated disease surveillance, research, international health regulations, and epidemic preparedness and response all contributed to this strategic objective.

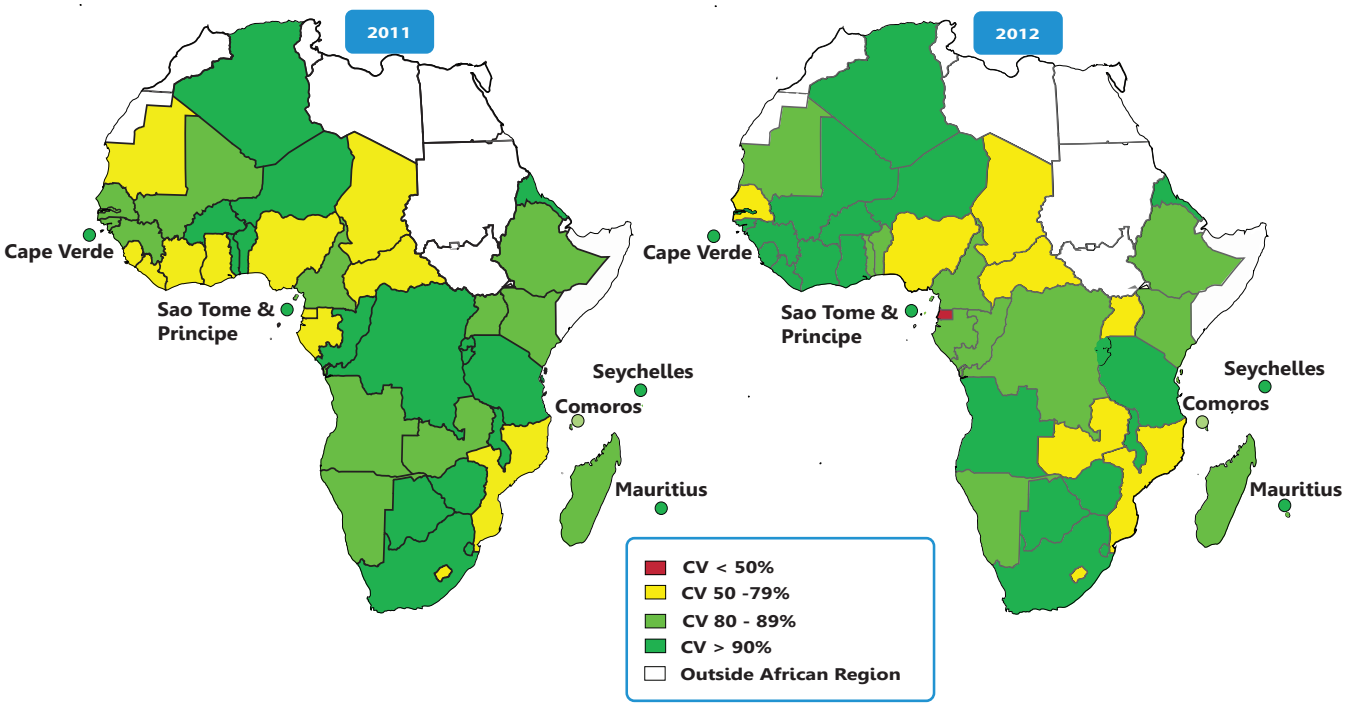
23. The bedrock of eradication, elimination and control of vaccine-preventable diseases is a high and sustained coverage with vaccines of the highest efficacy, safety and quality in the immunization programmes. Routine immunization coverage rates, with three doses of Diphtheria Pertussis Tetanus-containing vaccine (DPT3) and the first dose of measles-containing vaccine (MCV1) for the Region were 81% and 85% respectively at end-December 2012, compared with 85% and 86% in 2011 (Figure 1). Based on WHO/UNICEF estimates, coverage of DPT3 was 72% in 2011 and 2012 while coverage of measles-containing vaccine fell from 74% in 2011 to 73% in 2012. Coverage of the third dose of oral polio vaccine (OPV3) increased from 74% in 2011 to 77% in 2012. These figures were below the expected national coverage rate of 90% for both vaccines due to several factors that include inadequate funding for routine immunization, infrastructure problems, vaccine stock-outs, and limited human resource for delivery of immunization services. In addition to routine immunization, supplementary immunization activities (SIAs) continued to play a critical role in the eradication, elimination and control of vaccine-preventable diseases.

24. The World Immunization Week and the African Vaccination Week (AVW) are important events that serve as platforms for strong advocacy, raising community awareness of the value and importance of vaccination as well as improving access to vaccines. The two events were commemorated by 35 countries[1] in 2012 and by 40 countries in April and May 2013. Over 75 million people received oral polio vaccine in 13 countries[2] together with other high-impact public health interventions during the Second edition of the AVW in 2012. During the Third edition held in 2013, under the theme: "Save lives. Prevent disabilities. Vaccinate," over 32 million people in eight countries[3] received oral polio vaccine, some together with deworming, provision of Vitamin A, screening for malnutrition, distribution of ITNs and preventive treatment of malaria in pregnant women.

25. The Sixty-first session of the Regional Committee stressed the importance of polio eradication by calling upon all Member States where wild poliovirus (WPV) continues to circulate to declare the persistence of the disease a national public health emergency and to achieve sustained immunization coverage of at least 90%[4] with three doses of oral polio vaccine in routine immunization. This action is in line with the declaration by the World Health Assembly of polio as an emergency for global public health.

26. The efforts of Member States, coupled with the technical support of WHO and the investment of partners, have resulted in a significant reduction in the transmission of poliomyelitis in the Region. The number of wild poliovirus cases reported in 2012 was 63% lower (128 cases in only three countries: Chad, Niger and Nigeria) compared with 350 cases in 12 countries[5] in 2011. By June 2013, three re-established transmission countries (Angola, Chad and Democratic Republic of the Congo) had not had any confirmed wild poliovirus case for 23, 12 and 18 months respectively. Nigeria continued to report WPV cases, but these were fewer in number: 26 cases as of end-June 2013, compared to 52 cases for the same period in 2012.

Figure 1: Reported coverage with the 3rd dose of Diphtheria Pertussis Tetanus-containing vaccine (DPT3) in the African Region in 2011 and 2012



Source: Data from Member States of the WHO African Region

27. With the support of WHO, 15 countries[6] conducted SIAs against measles in 2012, reaching a total of 42.7 million children including the first use of measles-rubella vaccine in Rwanda. In response to outbreaks, more than 6.9 million children received measles vaccine in the Democratic Republic of the Congo.

28. To contribute towards the elimination and control of other vaccine-preventable diseases, 7.7 million women of childbearing age received tetanus toxoid vaccine through SIAs in five countries.[7] Elimination of maternal and neonatal tetanus was validated in a cumulative total of 30 countries[8] in the Region by the end of December 2012.

29. To ensure elimination of meningococcal meningitis due to Neiserria meningitidis serogoup A, more than 48 million people in seven countries[9] were vaccinated with the meningococcal A meningitis conjugate vaccine (MenAfriVac™) in 2012. This resulted in a cumulative total of more than 103 million persons vaccinated in the two years since its introduction. As a result of the introduction of MenAfriVac™ in the Region, no laboratory-confirmed case of meningococcal A meningitis was identified among vaccinated persons. Pneumococcal conjugate vaccine and rotavirus vaccines were introduced in 23 and 7 Member States, respectively[10] as of the end of 2012.

30. As part of monitoring of disease trends and vaccine impact for decision-making, WHO provided guidance as well as financial and technical support to 30 Member States to establish and strengthen surveillance of diseases targeted by these new vaccines. Laboratories in 30 Member States have developed adequate capacity for accurate confirmation and diagnosis of rotavirus and invasive bacterial diseases. As a result of WHO support, reported monthly data from these laboratories are used to strengthen disease control and prevention programmes.

31. Integrated Disease Surveillance and Response (IDSR) and the International Health Regulations (IHR) 2005 are vital to the control of communicable diseases and noncommunicable diseases in the Region. There was improvement in the disease surveillance capacity of countries in the Region. Between January 2012 and 31 March 2013, 14 countries[11] adapted the revised IDSR guidelines and training modules. Eight of these countries[12] commenced training at national and district levels, resulting in timely reporting and regular publication of epidemiological bulletins, better monitoring of health trends, which is expected to lead to improved detection and response to epidemics and evidence-based public health decisions.

32. Forty-three countries had conducted IHR core capacity assessment by March 2013. However, none of the countries had fully attained the minimum IHR core capacities by the deadline of 15 June 2012. As a result, countries of the Region applied for a two-year extension. During the Sixty-second Regional Committee, Member States adopted a resolution calling

for accelerated implementation of IHRs in the Region. Consequently, WHO convened two consultative meetings among partners, donors and countries to map the unmet needs for IHR implementation. The action plans developed by countries during these meetings are being used to mobilize resources for IHR implementation.

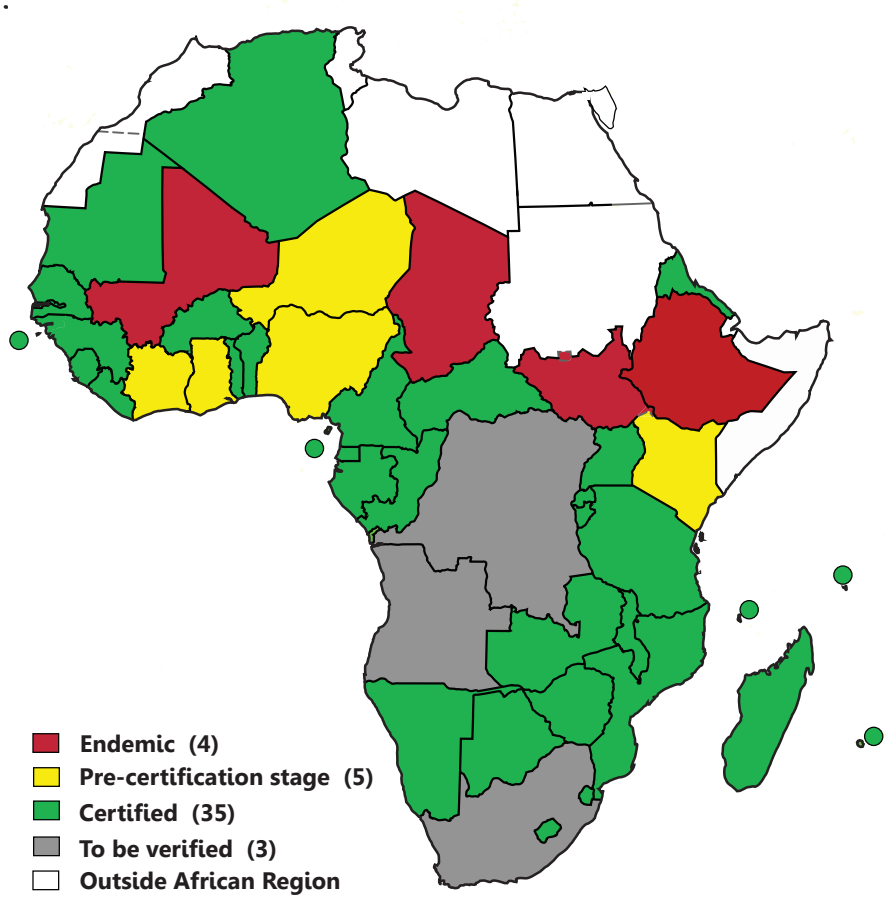
33. Between January 2012 and July 2013, over 100 public health events were reported in the Region, the majority of which were due to cholera, meningitis, viral haemorrhagic fevers and zoonotic diseases. A regional consultation involving the animal, human and environmental health sectors under the 'One Health' theme, was held. During the consultation country roadmaps for accelerated implementation of the 'One Health 'approach were developed. These roadmaps are being used to enhance partnerships between the animal, human and environmental health sectors and to ensure coordinated action in response to zoonotic diseases.

34. Inadequacy of financial resources remained a major challenge in addressing emergencies and disease outbreaks. Recognizing this, the Sixty-second session of the Regional Committee adopted the operational framework for the African Public Health Emergency Fund (APHEF). However, as of 31 March 2013, only five Member States had made their annual contributions to this Fund.

35. The WHO African Region accounts for approximately half of the global burden of Neglected Tropical Diseases (NTDs) and most countries in the Region are co-endemic for at least four NTDs. Mass drug administration (MDA) for NTDs amenable to preventive chemotherapy (PCT-NTDs) increased significantly during the last biennium. For example, MDA for lymphatic filariasis increased from 69 million persons reached in 2009 to 113 million in 2012. However, with the exception of onchocerciasis, these coverage levels lag behind the milestones required to reach the 2020 elimination and control goals.

36. The annual incidence of guinea-worm disease, a neglected tropical disease targeted for eradication, has decreased by more than 95% from 10 690 cases (5565 in South Sudan) in 2005, to 542 cases (with 521 in South Sudan) by December 2012. Only four countries,[13] are still endemic as of July 2013 (Figure 2). The reported cases by May 2013 was 68 (55 cases in South Sudan) and that translates to 80% reduction when compared with the same period in 2012. Although leprosy has been eliminated at national level in all countries of the Region, intense transmission continued in a few districts in Comoros, Ethiopia and Nigeria. Human African trypanosomiasis detection dropped from 9875 cases to 7197 cases in 2012. A clinical trial in Ghana confirmed the effectiveness of a single dose of Azithromycin as a cure for yaws, providing an opportunity for its use in the eradication of yaws.

Figure 2: Status of guinea-worm disease eradication in Member States of the WHO African Region in July 2013



Source: Member States of the WHO African Region and NTD Programme

37. Using the WHO African Region guide, a cumulative total of 36 countries[14] were supported to develop integrated national NTD master plans by the end of 2012. These plans provided a framework for harmonized planning and prioritization, budgeting and resource mobilization for national NTD programmes in the Region. Furthermore, stakeholders' meetings between Member States and partners recommended the establishment of country and regional NTD coordination structures as well as funding mechanisms to mobilize additional resources for the country NTD master plans. These recommendations are in line with the Accra Call to Action adopted at the NTD stakeholders' meeting of June 2012. The 66th World Health

Assembly adopted the global action plan on NTDs and the Sixty-third session of the Regional Committee is expected to adopt a Regional NTD Strategy, a Regional NTD Strategic plan 2014–2020 and a resolution on NTDs.

38. Under Strategic Objective 1, WHO continued to provide support to Member States to scale up interventions through the development of plans, strategies and policies, capacity building and resource mobilization, in support of efforts towards the reduction of the burden of communicable diseases. Significant progress was recorded in the polio eradication initiative with all the three re-established countries recording no virus circulation for prolonged periods as of June 2013. Other areas of progress include the development of a Regional strategy and Strategic plan for NTDs; improvement of disease surveillance and operationalization of the African Public Health Emergency Fund.

4.2 SO2: HIV/AIDS, Tuberculosis and Malaria

39. Strategic Objective 2 aims at combating HIV/AIDS, tuberculosis and malaria, three diseases posing major challenges to public health in the WHO African Region. Although the Region accounts for only 10% of the world population, its contributions to the global burdens of HIV/AIDS, tuberculosis and malaria are 66%, 26% and 80% respectively, based on 2012 reports.

40. With support from WHO, Member States, in 2012 and 2013, adopted and implemented prevention, treatment, care and support interventions aimed at reducing the burdens of the three diseases. The availability of resources to countries from various global health initiatives has given Member States an opportunity to expand the coverage of these cost-effective interventions to meet the MDG6 targets.

41. WHO supported Member States to adapt guidelines, strengthen their capacity to scale up high-impact interventions and mobilize resources including through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), for accelerating progress towards universal access to essential interventions against HIV/AIDS, tuberculosis and malaria. Thirty-seven countries[15] are implementing HIV/AIDS interventions based on WHO guidelines. That has led to improved quality and coverage of HIV prevention and treatment. In 2013, the first WHO consolidated guidelines for the use of antiretroviral medicines to treat and prevent HIV infections were launched. These guidelines expand the eligibility for antiretroviral treatment with a CD4 threshold of 500 CD4 cells per ^{mm3} or less for adults, adolescents and older children. Member States were briefed, through two dissemination workshops, on the operational changes, costs and human resource needs for full implementation of these guidelines.

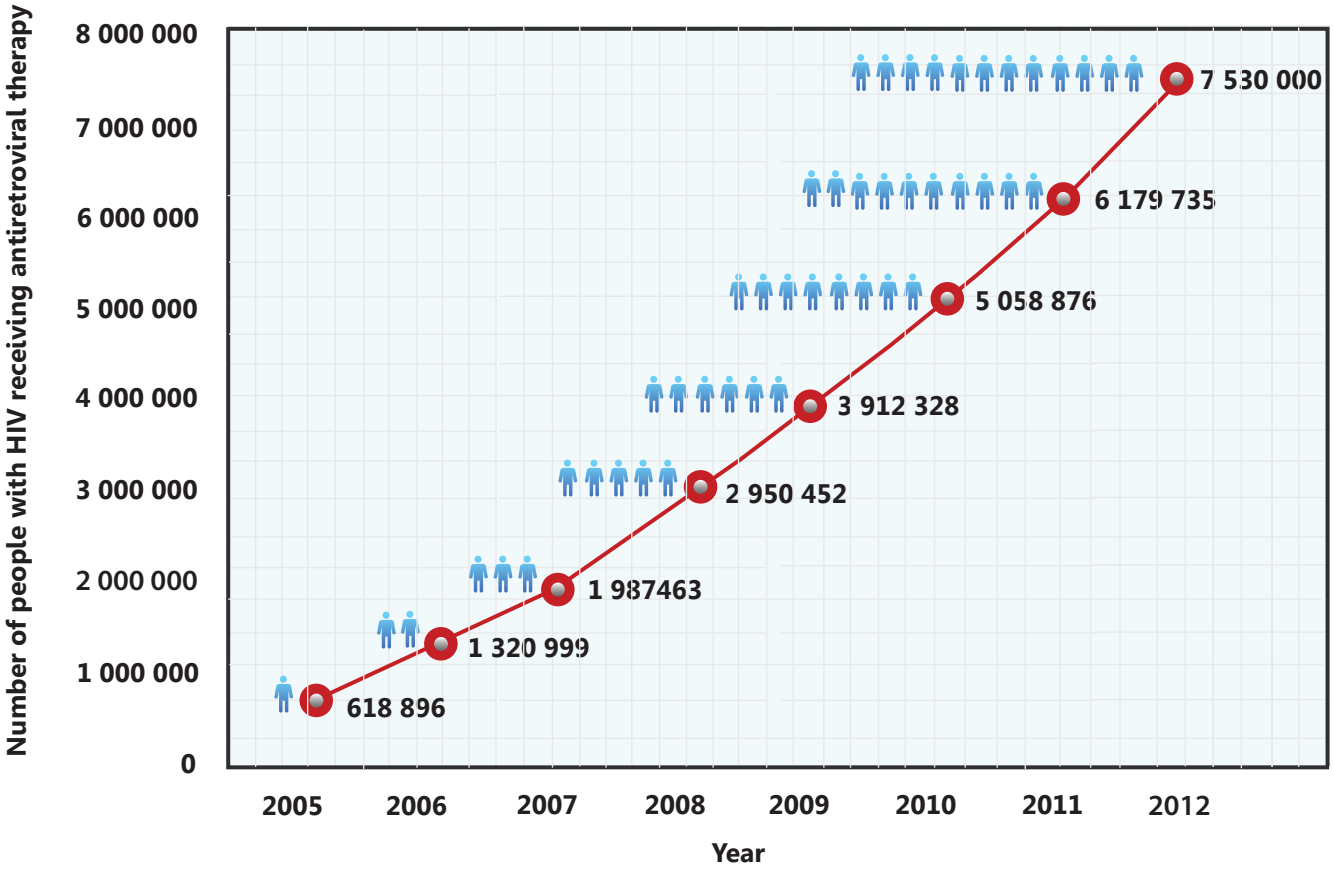
42. The 2012 Global HIV/AIDS report shows that 23.5 of the 34.2 million people living with HIV/AIDS globally were in sub-Saharan Africa, 3.1 million of whom were children, representing 80% of the global burden of paediatric HIV/AIDS. In addition, 1.7 million (68%) out of the 2.5 million new HIV infections occurred in sub-Saharan Africa and the overall HIV prevalence, though declining, remains high at 4.9% with wide intercountry variations. The same report revealed an overall 25% decline in new HIV infections between 2001 and 2011. Twenty-two countries[16] in the WHO African Region had reductions of more than 25%, with thirteen of the same countries reporting declines of more than 50%.[17]

43. In order to guide implementation of the *WHO Global Health Sector Strategy on HIV/AIDS, 2011–2015,* the Sixty-second session of the Regional Committee adopted a strategy for HIV/AIDS for the African Region. The strategy is being used to accelerate the implementation of activities against HIV in order to contribute to the achievement of universal access and the attainment of the MDGs while addressing the determinants of health.

44. Technical support was provided to 14 priority countries[18] to scale up male circumcision in order to reduce HIV incidence. More than 2 million male circumcisions were performed with coverage increasing from 7% to 10% between 2011 and 2012.

45. A strategic framework to eliminate new HIV infections among children by 2015 and to keep their mothers alive was developed to help countries reach 90% reduction in new infections. Twenty of the 21 priority countries[19] developed plans for the elimination of mother-to-child transmission (eMTCT) with WHO support. By the end of 2011, the percentage of pregnant women living with HIV who received ART to prevent MTCT had reached 59% as compared with 49% in 2009 and was estimated to be between 75% and 100% in six countries.[20] This has significantly contributed to the fall by 24% of new paediatric HIV infections in the Region between 2009 and 2011.

Figure 3: Persons Living with HIV who were receiving ART in sub-Saharan Africa from 2005 to 2012



Source: UNAIDS, Global Report; UNAIDS Report on the Global AIDS Epidemic, 2012

46. WHO provided support to Member States to expand antiretroviral therapy (ART) for prevention and treatment. As a result, more than 7.5 million patients received ART by the end of 2012 (Figure 3). Thus ART coverage increased from 49% in 2010 to 64% by the end of 2012. Coverage with ART was more than 80% in five countries[21] and between 50% and 79% in 17 others.[22] The improved access to ART has led to a reduction in AIDS-related deaths from 1.3 million in 2009 to 1.2 million in 2011.

47. The high TB burden in Africa is linked to poverty, TB/HIV co-infection and multidrug-resistant TB. Sixty-nine per cent of TB patients in the African Region were screened for HIV and 46% of eligible TB patients received ARVs[23] in 2011. That percentage marked a significant increase from 2010 when only 59% of TB patients were screened. According to the Global TB report published in 2012, increasing HIV screening and access to ARVs has led to declining TB mortality which is currently 26 per 100 000 population in the African Region.

48. Based on a systematic review of data from countries, WHO has assessed performance as well as progress towards achievement of national and regional TB control targets. Based on results published in 2012 the WHO African Region recorded 1 367 000 new TB cases in 2011. This represents 26% of all new cases notified worldwide in 2011. Over the same period 10 countries[24] attained the case detection rate of 70% while 19 countries[25] attained the treatment success rate target of 85%. Tuberculosis treatment success rate in the Region was 82% in 2011, and that is an improvement.

49. WHO provided support in strengthening implementation of DOTS, collaborative TB/HIV interventions, and programmes for drug-resistant TB. A framework to integrate paediatric TB into DOTS was developed by WHO and adapted by Member States. Thirty-seven countries were supported to access TB medicines through the Global TB Drug Facility (GDF). These interventions have led to the strengthening of human resource capacity, reduced stock-outs of TB medicines, and improved performance of programmes, leading to reduced TB transmission and ultimately reduced burden of TB.

50. The Stop TB strategy recommended by WHO in 2006 requires that countries establish drug-resistant TB management as part of programme implementation. WHO supported countries to set up systems for implementation of Programmatic Management of Multidrug-resistant TB (PMDT). During the biennium 2012-2013, WHO supported 13 countries to strengthen laboratory capacity for culture and drug sensitivity testing and access second-line TB medicines through the Regional green light mechanism (rGLC). However, implementation continues to face challenges mainly due to inadequate laboratory capacity for diagnosis and the high cost of second-line TB medicines.

51. The Secretariat of the Regional green light mechanism was established in 2012 and the rGLC committee appointed in February 2013. The rGLC's main task is to support implementation of PMDT by improving access to second-line medicines and coordinating country technical assistance missions. Thirteen countries[26] have been thus supported since January 2012. The Central TB reference laboratory of Uganda was supported to upgrade its capacity to a supranational reference laboratory in 2013. It will join the network of laboratories supporting external quality assurance for TB diagnosis in the Region.

52. In 2012, 80% of the 219 million malaria cases and 90% of the 660 000 malaria deaths worldwide were in Africa. An estimated 86% of deaths involved children below five years of age.

53. WHO supported the collection and validation of data for The African Leaders Malaria Alliance (ALMA) Scorecard.[27] The scorecard was used in all malaria endemic countries in Africa to monitor policy adoption, interventions, coverage, monotherapy and public sector funding of malaria control interventions. Support was provided for monitoring of insecticide resistance and efficacy of antimalarial medicines through training of national staff working in malaria programmes.

54. Data was collected for the World Malaria Report 2012 and support provided to seven countries for Malaria Indicator Surveys.[28] Surveillance bulletins were produced by 10 countries and one IST.[29] Six countries were supported to document best practices in malaria control.[30] The percentage of households owning at least one ITN increased to 53%. Forty-seven per cent of suspected malaria cases underwent a diagnostic test in the public sector. Rapid diagnostic tests accounted for 40% of all cases tested in the Region in 2011. An average of 44% of pregnant women in 25 countries received two doses of Intermittent Preventive Therapy for malaria in Pregnancy (IPTp).

55. The overall estimated incidence of malaria fell by 33% from 2000 to 2010 and the upward trend of the disease was reversed. Furthermore, 12 countries in the African Region are on track to reduce malaria incidence by at least 50-75% by 2015. Seven countries are implementing malaria control interventions and measures for pre-elimination of malaria.[31] In addition to this a number of subregional malaria initiatives were implemented. These include the Sahel countries malaria initiative, the Rwanda Malaria Elimination Forum, the SADC Malaria Elimination Initiative, the East African Community malaria initiative, the Small Island Developing States (SIDS) malaria commitment, and similar initiatives in Comoros, Equatorial Guinea (Bioko Island) and Madagascar.[32]

56. Malaria programme reviews were conducted with partners in 24 countries[33] during the biennium and provided information for the development of strategic plans, and monitoring and evaluation plans. The process of conduct of malaria programme reviews and development of plans led to enhanced dialogue with key partners and increased funding commitments.

57. Guidance on integrated vector management was provided to countries including larviciding as a complementary intervention. Policy orientation on Intermittent Preventive Treatment of malaria in pregnancy (IPTp) was updated and disseminated. The Seasonal Malaria

Chemoprevention Guideline was launched in 2012 and used to support the development of country implementation plans.[34] The Test, Treat, Track initiative manual and the malaria control and elimination surveillance manual which were launched by the WHO Director-General in 2012 on the occasion of World Malaria Day were disseminated.[35] Support was provided to Member States for setting up antimalarial therapeutic efficacy testing.

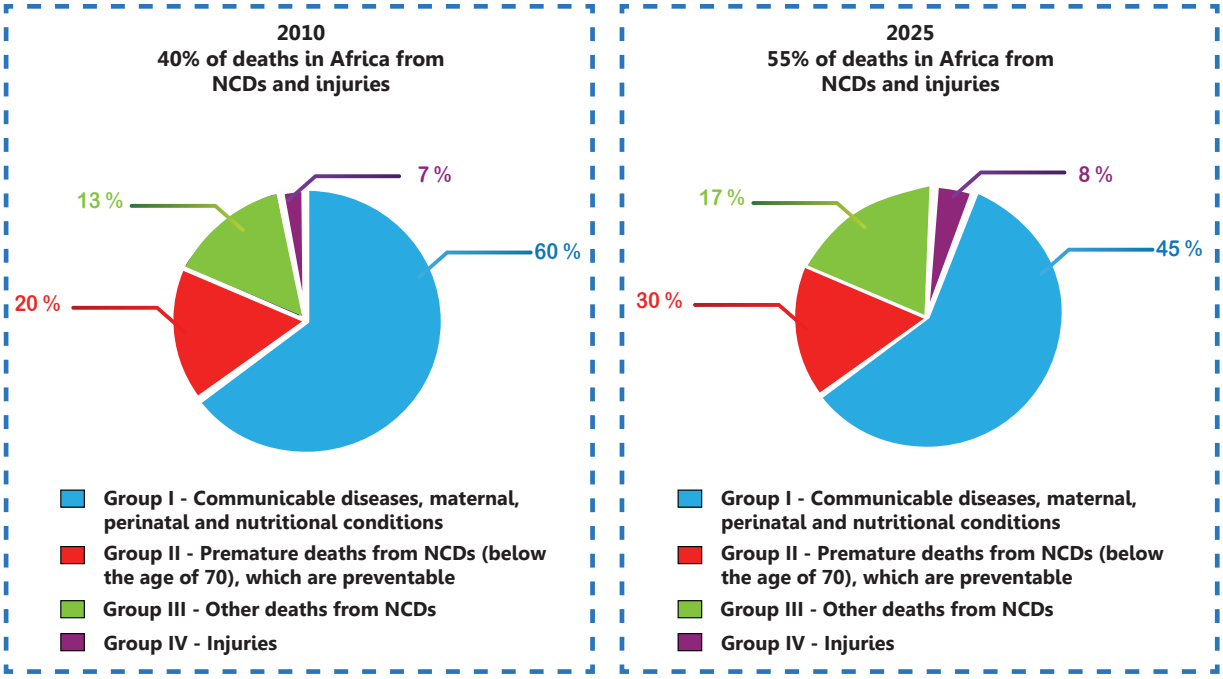
58. In order to strengthen capacity in malaria surveillance, WHO, in 2012, supported participants from 10 countries to attend an advanced malaria surveillance training.[36] As a result malaria control programmes updated or supplemented interventions with new knowledge for greater impact. Technical assistance was also provided to 11 countries for the implementation of Integrated Community Case Management (iCCM) including capacity building for traditional health practitioners.[37] This resulted in the involvement of additional partners in activities related to the scaling up of malaria control interventions and achieving universal coverage.

59. Under Strategic Objective 2, WHO supported Member States to scale up interventions through development of plans, strategies and policies, capacity building and resource mobilization in support of efforts towards reduction of the burdens of malaria, HIV and TB. The progress reported includes the reduction of malaria incidence and the development and dissemination of the first WHO consolidated guidelines for the use of antiretroviral medicines to treat and prevent HIV infections.

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

60. Strategic Objective 3 addresses the prevention, control and management of cardiovascular diseases, cancers, diabetes, chronic respiratory diseases, sickle-cell disease, violence, injuries and disabilities, oral diseases, blindness, deafness and mental disorders. Noncommunicable diseases (NCDs) represent a growing public health problem, placing a large social and economic burden on countries. These conditions are strongly associated with a number of risk factors such as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity as well as environmental factors. Should current trends continue, it is projected that deaths from noncommunicable diseases could increase by 15% over the next 10 years (Figure 4).

Figure 4: Comparison of estimated deaths in 2010 and projected NCDs deaths and injuries in 2025 in the African Region



Source: Global Status Report on Noncommunicable Diseases, 2010

61. The main strategic achievement regarding NCDs was the endorsement of the Brazzaville Declaration on NCDs and a related resolution, by ministers of health of countries of the African Region during the Sixty-second session of the Regional Committee in Luanda in November 2012. Thirty-five countries have redirected their policies and accelerated the implementation of prevention and control interventions. In addition, recommendations made during regional consultative meetings on NCDs and mental health served to strengthen the contribution of the Region to the development of four global strategic documents.[38]

62. Surveillance of NCDs has been enhanced through the development of a regional database involving 21 countries.[39] This e-database will feed into the African Health Observatory (AHO) and the Real-time Strategic Information System (r-SIS). The number of countries with national health information systems that captured information on the magnitude, causes and consequences of NCDs increased from 10 to 20 by December 2012. The ability of countries to capture the parameters mentioned helped national health authorities in decision-making.

63. A regional database and the regional fact sheet on road safety with data from 44 countries were produced in 2012. This informed normative guidance to Member States and provided a baseline for monitoring the Decade of action for road safety 2011–2020. In addition, the capacity of six countries[40] to collect data on violence and injuries was strengthened. Training on surveys for hearing impairment was provided for participants from most countries.

64. The capacity of countries to address NCDs has increased following WHO guidance and support. Twenty countries have now raised the priority given to NCD prevention and control by creating units, programmes or departments in their ministries of health. Twenty-seven countries are on track to finalize integrated action plans on the prevention and management of NCDs. Four countries[41] were supported to evaluate the status of prevention and control of NCDs at primary care level. Policies and plans for other noncommunicable conditions such as hearing impairment, deafness, noma as well as the issue of road safety have been developed and are being implemented in eight countries.[42] In addition, five countries[43] were supported to develop national cancer control action plans while four countries were supported[44] in the area of oral health.

65. Other achievements in noncommunicable diseases in the Region include the development of algorithms for integrated prevention and control of oral diseases and noma, eye disorders and cancer at primary care level,[45] building of evidence and documentation of best practices on WHO- Assessment Instrument for Mental health Systems (WHO-AIMS); sickle-cell disease and haemoglobinopathies research in Benin, Guinea and Zambia; and conduct of feasibility and effectiveness studies on the Mental Health Gap Action Programme (mhGAP).

66. Under Strategic Objective 3, WHO advocated for policy change and resource mobilization, developed tools and guidelines, provided technical support to Member States to strengthen surveillance, all towards efforts for accelerated control of NCDs. The major strategic achievement was the endorsement of the Brazzaville Declaration on NCDs and a related resolution, by the African Ministers of Health, at the Sixty-second session of the Regional Committee in Luanda, in November 2012.

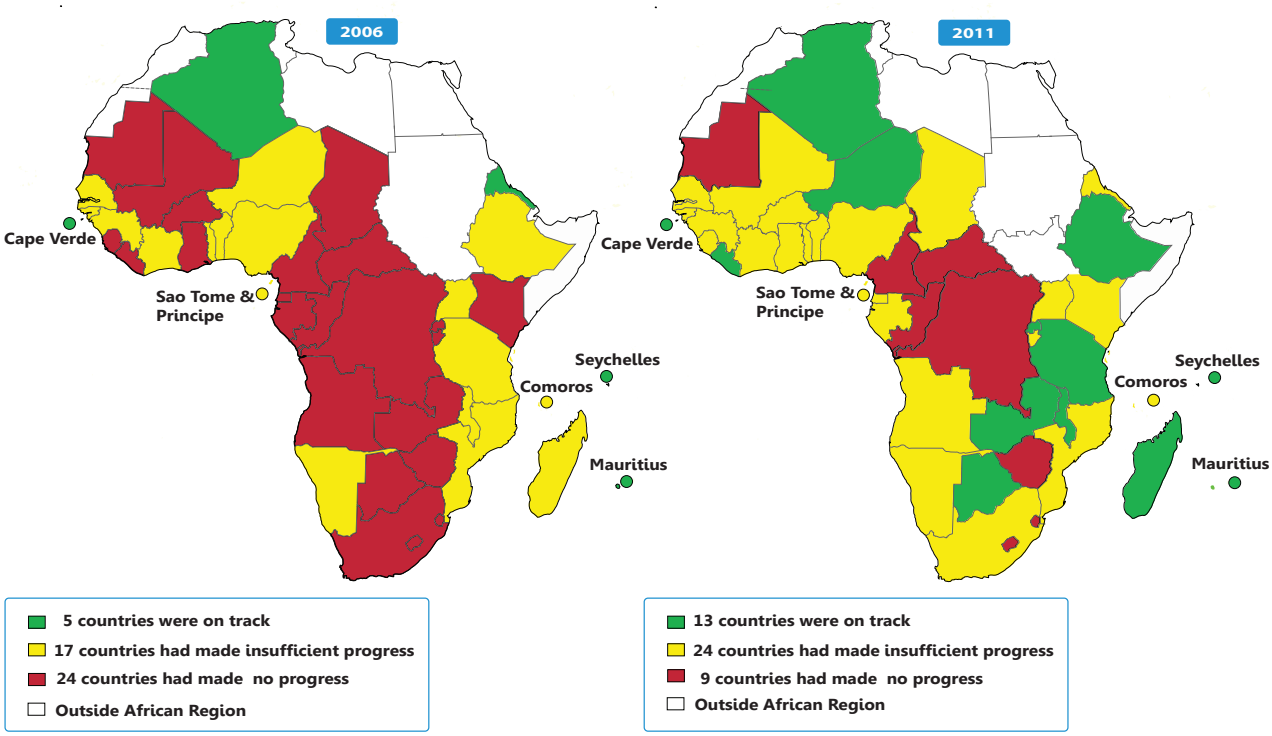
4.4 SO4: Child, adolescent and maternal health, and ageing

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

68. WHO supported Member States in addressing the challenges of scaling up reproductive, maternal, newborn and child health (RMNCH) interventions. The support included advocacy for policy change, development of guidelines and tools and implementation, monitoring and evaluation of life-saving interventions. This has significantly contributed to country progress towards achieving the targets of MDGs 4 and 5.

69. The 2012 Levels and Trends of Child Mortality Report showed that under-five mortality has dropped from 175 per 1000 live births in 1990 to 107 per 1000 live births in 2011.[46] Thirteen countries[47] are on track to achieve the MDG 4 target of reducing under-five mortality rates by two thirds between 1990 and 2015. Twenty-four countries are making progress towards this target, although it is insufficient; and nine countries have made no progress (Figure 5).

Figure 5: Progress towards Fourth Millennium Development Goal in the African Region, 2007 and 2012 reports



Source: United Nations Children's Fund, Progress for Children: a world fit for children statistical review, Number 6, UNICEF, New York, December 2007

Source: UNICEF, WHO, World Bank, UNDESA. Levels and Trends in Child Mortality: Report 2012- Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation, New York, UNICEF 2012

70. According to the 2012 estimates of maternal mortality, Eritrea and Equatorial Guinea are on track to attain their MDG 5 targets and 17 countries[48] have reduced their maternal mortality ratio by more than 50%.

71. Pneumonia and diarrhoea are major causes of mortality among children under-five years of age. To address these diseases and as a follow-up to the introduction and implementation of the Global Action Plan for Pneumonia and Diarrhoea (GAPPD) prevention and control in the WHO African Region, Kenya and Zambia received additional joint follow-up visits in 2012 to monitor the implementation of action plans. This culminated in capacity development for implementation research in Kenya, involving WHO and partners and joint WHO and partner support to Zambia. This led to the development of guidelines for implementation of community-based MNCH programmes with a special focus on Integrated Community Case Management (iCCM).

72. Advocacy for women's health was boosted with the development of a report entitled *Addressing the Challenge of Women's Health in Africa: report of the Commission on Women's Health in the African Region.* The report was launched in December 2012 by Her Excellency Mrs Ellen Johnson Sirleaf, President of the Republic of Liberia, in her capacity as the Honorary President of the WHO Commission on Women's Health in the African Region. The report has since been disseminated to countries and key partners. Countries of the African Region are expected to implement relevant recommendations of the report according to their specific contexts.

73. WHO has actively supported Member States in implementing the recommendations of the High Level Commission to advance women's and children's health. In implementing the ten recommendations of the High Level Commission on Information and Accountability (CoIA), thirty-nine[49] out of forty-one priority countries were given guidance and support to conduct national stakeholders' consultations on CoIA. Twenty-two countries[50] received catalytic funding and have developed their country roadmaps to guide the implementation of the recommendations. In response to the recommendations of the High Level Commission on Life-Saving Commodities for Women, WHO supported eleven countries[51] to develop and submit proposals to address various barriers to access to 13 life-saving commodities. The proposals are currently under review by the Secretariat of the Commission.

74. With the goal of rallying all stakeholders around the same plans, with governments taking the lead and partners aligning their efforts to a few agreed effective strategies and interventions, WHO supported 13 countries[52] to revise their Road maps For Accelerating the Reduction of Maternal and Newborn Mortality. In addition, four countries[53] developed reproductive health strategies and four other countries[54] updated their national child health strategies.

75. In order to reduce maternal and child mortality and help accelerate countries' progress towards achieving the MDGs, support in improving quality of care through guideline development and capacity building was given great emphasis. In this regard, capacity was built in eleven countries[55] in the use of the IMCI Computerized Adaptation and Training Tools. In addition, tools and guidelines including: Focused Antenatal Care (FANC) training materials; Integrated Management of Adolescents/Adult Illnesses/Integrated Management of Pregnancy and Childbirth/Prevention of Mother-To-Child Transmission (IMAI/IMPAC/PMTCT); and Regional Agenda for Accelerating Universal Access to Sexual and Reproductive Health services, have all been developed and disseminated.

76. Noting the heavy burden of cervical cancer and its contribution to high mortality among women in the Region, 26 countries[56] were provided with guidance for the introduction of the human papillomavirus (HPV) vaccine as a key strategy of the holistic approach to the prevention and treatment of cervical cancer. This new vaccine which targets girls aged nine to 13 years old has potential for reducing deaths from cervical cancer during women's reproductive and post reproductive years.

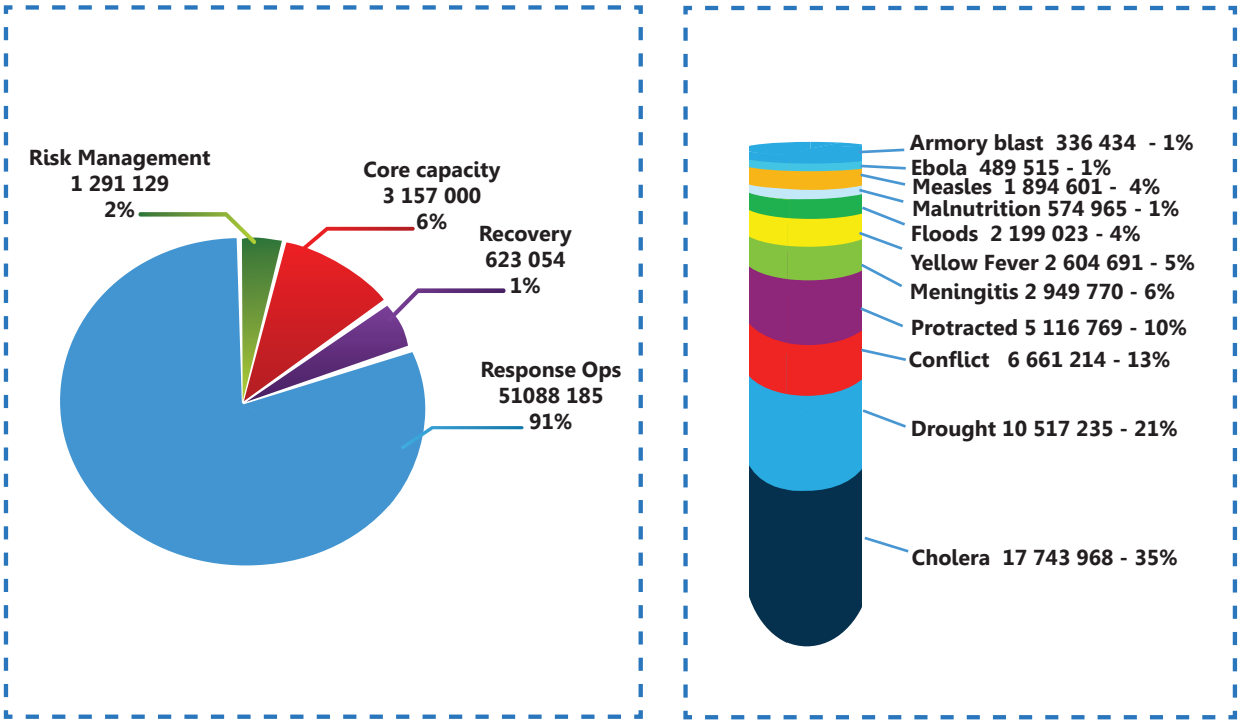
77. Under SO 04, WHO advocated for policy change, provided guidelines and tools, built the capacity of Member States, in addition to providing technical support, all aimed at reducing maternal, infant and child mortality in order to meet the MDGs.

4.5 SO5: Emergencies, disasters, crises and conflicts

78. Strategic Objective 5 focuses on actions that minimize the adverse impact on health of emergencies, disasters, conflicts and other humanitarian crises by responding effectively to the health and nutrition needs of vulnerable populations affected by such events. These actions include adequate preparedness, timely response to disasters and emergencies as well as recovery efforts.

79. A major development in Strategic Objective 5 (SO5) was the adoption at the Sixty-second session of the Regional Committee in Luanda, in November 2012, of the Regional Disaster Risk Management (DRM) strategy together with a related Resolution AFR/RC62/R1 urging Member States to, among other things: provide leadership and mobilize partners for the development of national roadmaps for implementation of the key interventions outlined in that regional strategy and to mobilize and allocate the necessary human, material and financial resources for the implementation of interventions. The DRM strategy represents a shift in the approach to disaster management from only response provision (Figure 6) to building national resilience for risk prevention and reduction.

Figure 6: Distribution of funds in response to disasters prior to the Disaster Risk Management Strategy



Source: WHO-AFRO/DPR/DPC Monthly EHA projects and report monitoring.

80. Between January 2012 and early 2013, a total of 17 significant events were reported in the African Region. These include drought, floods, disease outbreaks, armed conflicts and explosion of an ammunition depot. Over 60 million people in 33 countries in the Region were affected by these emergencies. Some of the significant events included food crisis in the Sahel, floods in West and Central Africa; cholera outbreaks in eight countries;[57] Ebola in Democratic Republic of Congo and Uganda; Marburg in Uganda and dengue fever in the Seychelles. Armed conflicts occurred in Central African Republic and Mali and have remained protracted in the Democratic Republic of Congo. Explosion of an ammunition depot occurred in Brazzaville, Congo, with devastating effects. These events which may be classified as weather-related (60%); disease outbreaks (30%); armed conflicts (9%); and accidents (1%); disrupted socioeconomic activities in many of the affected countries in addition to loss of human life.

81. WHO provided strategic, technical, logistic and financial support to the affected countries in response to the emergencies and to save lives. For instance, WHO was instrumental in developing a response framework document to guide coordination of the health response in the Sahel food crisis. The framework was used for advocacy for fund mobilization for the affected countries. Through the health cluster coordination mechanisms in countries, WHO coordinated the health response to reported events, resulting in improved and accelerated actions in disaster management.

82. In line with Resolution AFR/RC62/R1, the WHO African Region took the lead in developing six tools for the implementation of the DRM strategy. These tools include the Country Capacity Assessment tool (CCA); Hospital Safety Index tool (HIS); guidelines for conducting vulnerability risk assessment and mapping (VRAM); standard operating procedures; guidelines for recovery and transition framework; and core competencies for the development of training modules for health workers. The tools have been disseminated to countries for use.

83. The process of country capacity building for the implementation of the regional DRM strategy commenced in 2012. By November 2012, focal points from 34 countries had been briefed on the global Emergency Response Framework (ERF) and the regional Disaster Risk Management strategy and a related resolution. DRM country capacity assessments were conducted and roadmaps for strengthening health DRM capacity were developed and are being implemented in Tanzania and Uganda.

84. At the regional level, WHO built strong partnerships with regional institutions including the Disaster Management Training and Education Centre for Africa (DiMTEC) in South Africa and the regional economic communities (RECs). In addition, WHO contributed to the report of the Fourth Africa Regional Platform on DRR and the Fifth Africa Drought Adaptation Forum, whose conclusions were adopted at the Global Platform in Geneva in May 2013.

85. Under Strategic Objective 5, WHO built and strengthened partnerships, supported the development of policies, plans and strategies, mobilized resources and provided technical support to Member States to minimize the health impact of emergencies, disasters, conflicts and other humanitarian crises. The main achievement was the adoption by African ministers of health, at the Sixty-second session of the Regional Committee in Luanda, in November 2012, of the Regional Disaster Risk Management (DRM) strategy together with a related Resolution AFR/RC62/R1 and subsequent development of tools for implementing the strategy in the Region.

4.6 SO6: Risk factors for health conditions

86. Strategic Objective 6 addresses the key risk factors and their determinants that are responsible for the increasing burden of noncommunicable diseases in the Region. These risk factors are tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity as well as environmental factors particularly chemicals, radiation and food contaminants. The drivers of these risk factors include epidemiological and economic transition, globalization of trade and marketing, rapid unplanned urbanization, changes in food consumption patterns, and cultural beliefs and values.

87. An updated strategy for health promotion in the African Region was adopted by the Sixty-second session of the Regional Committee. It focuses on promoting multisectoral interventions across priority public health conditions and calls for innovative financing to support the implementation of policies and related actions.

88. A multi-stakeholder dialogue addressing the risk factors for noncommunicable diseases was convened in Johannesburg, South Africa, in March 2013. The dialogue brought together participants from 43 countries of the Region, composed of governments, nongovernmental organizations, civil society and other partners. Participants in this dialogue recognized the growing trends in physical inactivity, high consumption of unhealthy diets, harmful use of alcohol and tobacco use and emphasized the importance of working across sectors to address the key risk factors and improve health outcomes at the individual and community levels.

89. WHO continued to build countries' capacities to estimate the burden of NCDs and the associated risk factors in the population, for planning the prevention and control of these diseases. During the biennium, the national capacity for conducting the STEPwise surveillance of NCD risk factors was strengthened in Lesotho, Rwanda and Tanzania, bringing to 34 the total number of countries with available baseline data on NCD risk factors in the Region. WHO, in collaboration with the Centers for Disease Control and Prevention (CDC) of the USA, trained national officers from the ministries of health and education of 12 countries[58] to conduct the Global School Health Survey (GSHS) in order to monitor the level of behavioural health risk factors among school children. A new survey tool, the School-based Health Policy and Programme Study (SHPPS) for monitoring the implementation of school health policies and programmes for both communicable and noncommunicable diseases, was also introduced in the above countries.

90. Noting the need to strengthen intersectoral actions to effectively address NCD risk factors, three workshops were conducted for 10 countries[59] on coordination of intersectoral approaches to the prevention of child obesity. The participating countries were then supported to initiate the development of national strategies for reduction of salt intake and/or prevention of child obesity. Participants from eight other countries[60] drawn from the health, nutrition, education and trade sectors were also trained in developing population-based salt intake reduction strategies using an intersectoral approach.

91. In order to strengthen evidence to inform decisions in key areas of policy development and legislation, five countries[61] participated in a research project aimed at collecting data on alcohol advertising. The preliminary results of this research show that exposure to alcohol advertising increases alcohol consumption among the youth, hence the need to strengthen regulation in alcohol advertising. Six countries[62] are being supported to develop their national alcohol policies through multisectoral task forces, and Mozambique and South Africa were supported to develop legislative measures for control of harmful use of alcohol.

92. WHO enhanced its technical support to countries to improve integrated drug dependence treatment and care systems. In this regard, WHO and the United Nations Office for Drug Control (UNODC) joint programme supported Côte d'Ivoire and Senegal to initiate drug control activities with joint collaboration of the health and drug control sectors; Kenya developed comprehensive and evidence-based guidelines for management of drug use including standard operating procedures for methadone substitution therapy, and needle and syringe exchange; Benin and Togo conducted joint training to improve the capacity of health professionals to treat drug dependence; and Senegal is being supported to develop its National Observatory for Drug Use. These pilot initiatives will be used to guide other countries in developing or improving their drug control programmes.

93. Member States were supported to develop and enact comprehensive legislation that is in keeping with the WHO Framework Convention on Tobacco Control (WHO FCTC). Ten more countries[63] enacted legislations banning smoking in public places, prohibiting tobacco advertising on national media and requiring tobacco products to bear health warnings. This has not only protected more people from the negative effects of tobacco, but has also increased compliance with the WHO FCTC by Member States in the Region.

94. Nigeria is the first country in the Region to complete the Global Adult Tobacco Survey. The results show that about 10% of men and 1.1% of women use tobacco products and 17.3% of adults who work indoors are exposed to tobacco smoke at the workplace. Seven more countries[64] generated new tobacco control data bringing to 45 the total number of countries

with data on tobacco use and exposure among youth. Comparable prevalence data on tobacco use has been provided by an additional five countries.[65] Currently a total of 24 countries have trend data on tobacco use. These are being used as evidence to strengthen implementation of the WHO FCTC and introduce new laws and regulations that are in keeping with the Treaty.

95. Five countries[66] were supported in the emerging area of tobacco taxation and two of them, Kenya and Senegal, have increased taxes on tobacco products with a view to reducing the demand for tobacco. Joint workplans have been developed with two regional economic blocs, the *Union Ecomomique et Monétaire Ouest-Africaine (UEMOA)* and the East African Community (EAC), to address the issues of tobacco taxation, elimination of illicit trade in tobacco products and promotion of alternative livelihoods for tobacco growers.

96. Under this Strategic Objective, WHO initiated a dialogue which identified intersectoral approach to addressing the rising trends of physical inactivity, high consumption of unhealthy diet, harmful use of alcohol and tobacco use. At the same time Member States were supported to strengthen NCD surveillance, improve monitoring of NCD programmes and enhance interventions including the provision of drug dependence treatment and care systems.

4.7 SO7: Social and economic determinants of health

97. Strategic Objective 7 seeks to address social and economic response to health determinants in order to produce good health outcomes across population groups. The priority interventions in this Strategic Objective are highlighted in the Strategy for addressing key determinants of health in the African Region, adopted by the Sixtieth session of the WHO Regional Committee in Malabo, Equatorial Guinea, in 2010.

98. The work of WHO during this biennium focused on increasing Member States' awareness of the benefits of addressing key determinants to improve health outcomes; supporting countries to conduct health equity analysis; documenting experiences in intersectoral action and building capacity to implement the Regional strategy for addressing key determinants of health.

99. Eleven countries[67] were supported to hold national training workshops in order to accelerate the implementation of the regional strategy. The training focused on the leadership and stewardship roles of the ministries of health, coordination mechanisms for multisectoral actions including the setting up of task forces on social determinants of health, and partnership building for mobilizing technical and financial resources.

100. In order to analyse the proximal and structural determinants of health disparities within each country, WHO supported five countries[68] including three Small Islands Developing States (SIDS) in health equity analysis. The reports of the analysis documented the health impact of some key social determinants in the various countries. Mauritius, Sao Tome and Principe, and Seychelles shared their findings during the meeting of the ministers health of SIDS, held in Sao Tome and Principe in April 2013. The other two countries, Liberia and Madagascar, held national consultations to explore the application of the results to health policy and programme development. The reports will further serve as advocacy tools for governments to address key determinants of health and adopt a health-in-all policies approach.

101. An analysis of the implementation status of selected intersectoral actions including health in all policies in the African Region was conducted. The findings were applied in developing: (a) an analytical framework for intersectoral action for health; (b) WHO African Region Position Statement on Health in All Policies; and (c) preparation of nine case studies[69] on intersectoral action. These products were discussed at the 8th Global Conference on Health Promotion, held in Helsinki, Finland, in June 2013.

102. The nine country case studies captured experiences in the implementation of intersectoral actions to address key determinants of selected public health conditions. These demonstrate the importance of intersectoral action to achieve health outcomes and the need to engage sectors other than health to address priority public health conditions.

103. For the first time ever, WHO conducted an orientation workshop for programme managers from nine countries[70] of Central Africa on mainstreaming equity, gender, and human rights into health programmes. As a result, the Republic of the Congo and the Democratic Republic of the Congo have started collecting sex- and age-disaggregated data and have integrated these into their routine health information systems. These data will help provide useful information for a number of key health programmes and facilitate health equity analysis.

104. Under this Strategic Objective WHO advocated for addressing key health determinants to improve health outcomes and strengthened the capacity of countries through training, technical support and sharing of best practices. All these were aimed at supporting Member States to achieve good health outcomes across population groups.

4.8 SO8: Healthier environment

105. Strategic Objective 8 seeks to promote a healthier environment, intensify primary prevention, and influence public policies in all sectors in order to address the root causes of environmental threats to health. In the African Region, this objective is pursued through implementation of the Libreville Declaration on health and environment in Africa.

106. During the reporting period, WHO supported countries to undertake their situation analyses and needs assessments (SANAs) for implementation of the Libreville Declaration and the preparation of national plans of joint action (NPJA). To that end, an additional 12 countries[71] received WHO technical and financial support. Currently, a total of 34 countries[72] have either initiated or completed this process.

107. Country-specific information generated from the SANAs on environmental determinants of human health and the status of national management systems has continued to be processed through a regional computerized system known as the Health and Environment Linkages Data Management System (HELDS). In order to enhance the functionalities and performance of the HELDS, a second version (HELDS 2.0) was produced and disseminated for use by countries. National experts from eleven countries[73] together with WHO country office staff were trained in the use of HELDS.

108. An evaluation of the implementation of the Libreville Declaration, five years after its adoption, was undertaken in collaboration with the United Nations Environment Programme and the African Development Bank. This evaluation included a self-assessment by countries through the preparation of national profiles; an in-depth evaluation in five countries selected at random; and an assessment of the support provided by partners.

109. In addition, a detailed documentation of effective health and environment intersectoral projects that address the MDGs was carried out in six countries.[74] The initial findings of these assessments show that there has been increased collaboration and joint projects between ministries of health, ministries of environment and other relevant ministries.

110. A regional action plan for public health adaptation to climate change was developed in consultation with all the 46 Member States. Guidelines for preparation of national adaptation plans were developed and all African countries received technical support to prepare their national climate change adaptation plans in accordance with the United Nations Framework Convention on Climate Change (UNFCCC). Canada, Germany, Norway and the United Kingdom of Great Britain and Northern Ireland provided funding for implementation of

climate change and health adaptation projects in line with the plans, with technical support from WHO. These projects aim to strengthen climate change resilience in the area of water and sanitation, nutrition and vector-borne diseases.

111. WHO established an International Consortium of Technical and Scientific Institutions (Clim-HEALTH Africa) for the development and implementation of early warning and early response systems to the public health impact of climate change. Clim-HEALTH Africa will contribute to the health objective of the Climate for Development in Africa Programme of the African Union.

112. WHO intensified its efforts to mobilize financial resources to support specific health and environment projects at country level. A *"Strategic Approach to Stimulate Investments on Health and Environment Linkages as a Contribution to Sustainable Development"* was pilot-tested in Cameroon, the Democratic Republic of the Congo and Gabon. As a result, Cameroon produced a five-year National Investment Plan as a joint contribution of the health and environment sectors to the sustainable development objectives of the country. This plan, which has been included in government budgets starting from 2013, focuses on scaling up access to safe drinking water and sanitation, sound management of chemicals and adaptation to climate change. Democratic Republic of the Congo, Gabon and Kenya prepared project proposals to scale up coverage of health and environment interventions.

113. WHO published the UN Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) report in 2012 using data received from 74 developing countries, including 35 in the African Region. This report shows that both developing countries and donors give insufficient attention to operations and maintenance of infrastructure for drinking-water, sanitation and hygiene (WASH) and to information systems for the planning and monitoring of the WASH programme.

114. WHO in collaboration with UNICEF published the 2013 report on the Joint Monitoring Programme on access to safe drinking water and sanitation using 2010 data. The report showed that access to safe drinking water has slightly improved in the Region from 62% in 2008 to 63% in 2011. It also shows that rural safe drinking water coverage (52%) lags far behind urban drinking water coverage (85%). Similarly, the use of improved sanitation facilities increased from 33% to 34% over the same period, again with a major discrepancy between urban areas (47%) and rural areas (26%).

115. Under this Strategic Objective, WHO provided policy guidance and technical support and strengthened the capacity of Member States to implement the Libreville Declaration on health and environment in Africa.

4.9 SO9: Nutrition, food safety and food security

116. Strategic Objective 9 aims to improve nutrition, food safety and food security, throughout the life-course in support of public health and sustainable development in the Region. In 2011 it was estimated that undernutrition was an underlying factor in 45% of global child deaths and the African Region remains the only Region with an increase in the number of stunted children for the past decade, the highest prevalence of stunting being in East and West Africa.[75]

117. In order to contribute to the MDG4 target of reducing under-five mortality, WHO supported countries to protect and promote appropriate infant feeding practices. This was done mainly through support to revise national Infant and Young Child Feeding (IYCF) strategic plans and policies in Botswana, Central African Republic and Chad and capacity building activities for IYCF in four additional countries.[76] Support was provided to six countries[77] to strengthen their capacity to implement the new WHO Growth Chart and to Kenya and South Africa to enact national laws to create an enabling environment for optimal breastfeeding, thereby enforcing the International Code of Marketing of Breast-milk Substitutes.

118. WHO in partnership with other key stakeholders through the West and Central Africa Regional Directors Team (RDT) addressed the food and nutrition aspects of the crisis in the Sahel and other parts of the Region, focusing its actions on management of severe acute malnutrition. The Manual on Management of Severe Acute Malnutrition (2000) was revised and twelve countries[78] adopted the guidelines. Cape Verde and Mali participated in the joint UN agencies (WHO, UNICEF, FAO and WFP) project on consolidated school feeding and gardening programme in support of food security, food safety, nutrition and physical activity.

119. Supporting countries to strengthen their nutrition surveillance systems was another key area of focus of WHO. In this regard, 10 countries[79] implemented the Accelerating Nutrition Improvements (ANI) project to boost routine nutrition surveillance and strengthened Multisectoral Coordination Teams for Nutrition. In addition Chad, Comoros and Madagascar received support to strengthen nutrition surveillance in emergency situations.

120. Food safety is a major concern to countries of the Region. As part of WHO's response to this issue, two manuals, namely *Integrated Foodborne Disease Surveillance in the African Region and How to Develop Food Safety Policies and Strategic Plans* were developed and the former was used for training of technicians from the agriculture and health sectors of four countries[80] in foodborne disease surveillance. In addition, the *WHO Five Keys to Safer Food* concept[81] was implemented in seven countries[82] as part of food hygiene education and incorporated into training manuals for the Management of Severe Acute Malnutrition in six other countries.[83]

121. Under this Strategic Objective Member States were supported to improve nutrition, especially Infant and Young Child Feeding practices, develop policies on food safety, improve food security and strengthen their nutrition surveillance systems.

4.10 SO10: Health services

122. Strategic Objective 10 focuses on the provision of normative and technical support to countries to improve health services through enhanced governance, financing, staffing and management, informed by reliable and accessible evidence generated by research and health information systems. Actions taken derive from the WHO Strategic Directions (2010–2015), the frameworks for implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems and the Algiers Declaration on Narrowing the Knowledge Gap.

123. Technical support was provided to six more countries[84] to revise their national health policies and strategic plans in order to guide their national health development process and its funding. Through the Global Learning Programme (GLP) on building the capacity of WHO staff in strategic planning and policy dialogue, 18 additional WHO country office teams[85] were trained, thus bringing to 46 the total number of WHO country teams trained, and thereby enhancing WHO participation in building systems and services through sound national policies and plans.

124. A guide for costing National Health Strategic plans (NHSPs) was developed and used to cost NHSPs in 13 countries[86] and to adjust the content of the plans with the resources projected for their implementation. The first Expenditure Atlas of the African Region was published. It provided an overview of national health expenditures in all the countries and enabled comparison among countries. Capacity building on the methodology for conducting National Health Accounts was carried out in 26 countries.[87] As a result, several countries are using the data gathered to track health expenditure and formulate health financing strategies. Technical support was provided to 19 countries[88] that have started to implement interventions towards universal health coverage.

125. A road map for scaling up the health workforce in the African Region (2012–2025) was produced and adopted by the Regional Committee. In order to address the magnitude of the health work force crisis and reduce its impact on health service delivery, national policies and strategic plans were developed by seven Member States[89] with the support of WHO. National HRH observatories were established in six countries.[90] In collaboration with the Region's professional bodies associations, academic institutions and regional economic communities (RECs), a Professional Regulatory Framework was developed to promote a common approach to nursing and midwifery regulation and education in the Region.

126. The African Health Observatory's integrated data warehouse and platforms on data and statistics, analytical profiles, publications and networking are fully operational. A total of 22 country analytical profiles and a regional profile have been added to the African Health Observatory's portal.[91] Uganda and Ethiopia have developed national eHealth strategies and policies. Cape Verde, Congo and Sierra Leone have developed their national health observatories (NHOs). A resolution on NHOs was adopted by the Sixty-second session of the Regional Committee for Africa to support national health information systems.

127. Four country statistical atlases[92] and four issues of the African Health Monitor were produced by the African Health Observatory, covering the subjects of health systems, reproductive health, disease control and health determinants. In addition, the Atlas of African Health Statistics 2012 and 2013 were produced. These were widely disseminated to countries in the Region, providing information for decision-making.

128. The Evidence Informed Policy Network (EVIPNet), a WHO knowledge translation platform in seven countries, has promoted research and evidence gathering that influenced changes in national policies on important public health practices. The African Advisory Committee on Health Research and Development (AACHRD) was reconstituted and is providing important advice on the research for health agenda in the African Region of WHO. During the meeting of the African Advisory Committee on Health Research and Development (AACHRD), held in Cape Town, in 2012, South Africa stressed the need for collective efforts to enhance the research and innovation agenda in the Region as key drivers of health, equity and development, and pledged to host and finance the next meeting of an annual African research forum to deepen the debate on this subject.

129. Under Strategic Objective 10 Member States were supported to revise their national health policies and strategic plans, define health research agendas, strengthen human resources for health and enhance their health information systems through the African Health Observatory and national health observatories.

4.11 SO11: Medical products and technologies

130. Strategic Objective 11 focuses on improving access to and the quality and rational use of medical products and technologies in Member States through technical support and policy guidance for the development, implementation and monitoring of comprehensive national policies and strategies.

131. In order to contribute to improving the availability, quality and rational use of essential medicines, six countries[93] updated their national medicine policies with WHO support. In addition, strategic plans related to national medicines were developed by Burkina Faso and Swaziland while Zimbabwe developed a five-year strategy on medicines and medical supplies and Benin evaluated its national medicines policy implementation plan (2006–2010).

132. Fifteen countries were supported to strengthen their pharmaceutical systems and improve access to quality medicines through the EC/ACP/WHO partnership on pharmaceutical policies. In addition Ghana, Uganda and Zambia developed a workplan to implement activities to promote the Medicines Transparency Alliance (MeTA), a global initiative focused on improving access to quality-assured medicines in developing countries by increasing transparency and accountability in the pharmaceutical sector.

133. WHO and UNDP provided support to the Economic Community of West African States (ECOWAS) through the West African Health Organization (WAHO) to develop a regional policy and guidelines on flexibilities in the Trade-related Aspects of Intellectual Property Rights (TRIPS). This will enable Member States to update national policies and legislation and maximize the use of the opportunities provided by TRIPS flexibilities to improve access to medicines. Furthermore, the regional economic communities[94] of West, Central, Southern and East Africa received WHO support to implement the African Medicines Registration Harmonization Initiative. The Regional Director established a Working Group on Substandard, Spurious, Falsely labelled and Falsified Counterfeit (SSFFC) medicines to better understand the regional implications and contributions to the ongoing global debate on this subject.

134. Under WHO coordination the following important tools and guidelines were reviewed and finalized by multidisciplinary expert groups: (a) the Regional framework for regulation of traditional medicine practitioners, practices and products; (b) the Regional framework for collaboration between practitioners of traditional medicine and conventional medicine; and (c) A tool for documenting traditional medicine practices. These tools provide insights for countries, guiding them in operationalizing their national traditional medicine policies and strategies.

135. With WHO collaboration, the African Union developed the plan of action for implementation of the renewed Decade of African Traditional Medicine (2011–2020) and the Pharmaceutical Manufacturing business plan for Africa that were adopted by the African Union Summit of Heads of State and Government in Addis Ababa in July 2012. These tools are being used to enhance the role of traditional medicine in health systems and to promote local production. The West African Health Organization (WAHO) Herbal Pharmacopoeia for the ECOWAS subregion was developed with the support of WHO to guide the harmonization of technical specifications and quality control standards.

136. Forty-three countries have adopted national laboratory and blood policies. Out of the 43 countries, six have adopted policies during the current biennium[95] and, as a result, progress has been made in the quality and quantity of blood donation. More than half of the needs for blood units safe for transfusion according to the WHO standards have currently been met in the Region. Assessment of the implementation of the Regional Strategy for Blood Safety shows that the status of blood transfusion services was known in 37 countries and that more than 80% of blood donations in 21 countries[96] were voluntary and non-remunerated. Programmes for strengthening injection safety capacity have been initiated in 20 countries.[97]

137. WHO Guidance for Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) was published and partnerships established with the African Society for Laboratory Medicine (ASLM) and CDC/GAP-Atlanta for its implementation. As of 2012, 32 laboratories in eight countries[98] had applied the SLIPTA approach and three public health laboratories had been accredited in Tanzania, Togo and Uganda. Twenty laboratory experts from both the veterinary and public health laboratories in eight central African countries[99] were trained on ISO 15189 standards.

138. Biosafety officers from Rwanda, Senegal and Zambia were trained on Biorisk management and transportation of infectious substances according to IATA and WHO shipping regulations. Eritrea was supported to develop its laboratory service policy guidelines and protocols of procedures at different levels of health facilities. With WHO and CDC support, the African Centre for Laboratory Equipment Maintenance (ACLEM) in Enugu, Nigeria, was established as a Centre of Excellence to perform Biosafety Cabinets maintenance, certification and repair services.

139. The WHO Guidelines for developing national patient safety policies and plans was finalized. The African Partnerships for Patient Safety (APPS) has started in five countries[100]. As a result, these countries have now included patient safety in their national health development plans. With WHO support, a ministerial meeting on patient safety for 20 countries[101] was organized to raise awareness of, and intensify interventions on, patient safety.

140. The capacities of the national medicines regulatory authorities (NMRAs) were strengthened through establishing institutional development plans, and training of professionals within the framework of the network of African Vaccine Regulatory Forum (AVAREF). The capacity of 21 Member States[102] for oversight of vaccine clinical trials was also strengthened. As a result, seven countries[103] are providing ethics and regulatory oversight and ensuring the safety of participants in a phase 3 clinical trial of a malaria vaccine.

141. Under Strategic Objective 11, WHO provided policy guidance, developed tools and guidelines for country-specific situations and supported the strengthening of Member States' capacity for the development of policies, strategies and plans for improving access to and the quality and rational use of medical products and technologies.

4.12 SO12: Leadership, governance and partnership

142. Strategic Objective 12 concerns WHO's role in providing leadership, strengthening governance and fostering partnership for health development. It also addresses coherence between the various levels of the Organization.

143. The Regional Director continued advocacy for increased investment in strengthening national health systems to promote health by undertaking high-level missions to 13 countries in the Region and abroad. In addition, he participated in 10 international conferences to raise awareness of regional health needs, priorities and strategies, and WHO support to Member States. The themes of the conferences included future approaches to funding, partnerships and access to health care in Africa; moving towards global health equity; saving mothers — giving life; the new era in HIV/AIDS treatment and prevention; noncommunicable diseases risk factors; immunization; human resources for health; and value for money, sustainability and accountability in the health sector.

144. The heads of WHO country offices (HWCOs) in all countries of the Region focused on health as an integral part of national development and aid cooperation. They facilitated dialogue between governments, health stakeholders and development partners. In line with the Paris Declaration on Aid Effectiveness Harmonization and Alignment, they promoted coordination among health development partners under the leadership of the ministries of health. Furthermore, they were at the forefront of the public health agenda within UN country teams and ensured that UNDAPs/UNDAFs reflected national health priorities. Joint programmes with other UN agencies in 21 countries led to improvement in the coherence of UN action on health.

145. The ongoing WHO reform, which emphasizes response to country needs, underscores the importance of the Country Cooperation Strategy (CCS) as the key instrument for WHO cooperation with Member States. Technical support was provided to thirty-eight countries to review their CCS documents. Restructuring was carried out in 46 country offices to improve efficiency and further strengthen WHO's presence in countries. By an agreement with the Government of Algeria, the status of the WHO Liaison Office in that country was raised to a fully-fledged WHO Country Office.

146. An evaluation of the work of WHO Intercountry Support Teams (ISTs) was carried out in 2012. The main recommendations, all of which are being implemented, include increasing the capacity of ISTs to expedite technical support to countries; adequate staffing of ISTs to meet the needs of countries; strengthening the capacity of National Programme Officers; ensuring cost effective outsourcing to consultants; and improving coordination of planned missions to countries.

147. The Sixty-second Regional Committee extensively discussed the ongoing WHO reform and adopted public health resolutions on disaster risk management; accelerating HIV/AIDS prevention and control; the road map for scaling up human resources for health; the strategy for health promotion; strengthening national health information systems through the African Health Observatory; health and human rights; the Brazzaville Declaration on Noncommunicable Diseases; and the implementation of the International Health Regulations (2005). The Regional Committee welcomed and accepted the request of the Republic of South Sudan to be reassigned to the WHO African Region; this request was accepted by the Sixty-sixth session of the World Health Assembly.

148. Public understanding of WHO's work and of health issues was promoted through regular production and dissemination of information materials. The availability of most of these materials online contributed to a 12% increase in the number of visits to the WHO African Region web site between 2011 and 2012. Social media platforms such as *Twitter* and *YouTube* were set up and used to further raise awareness of the work of WHO in the Region. The capacity of staff in country offices and the Regional Office in communication was strengthened through training.

149. A network of Communications Officers was established to provide surge capacity and support to countries in the event of public health or humanitarian emergencies. Their interventions will contribute to improving the awareness of people affected by disease outbreaks and emergencies so as to limit the spread of disease and other health hazards.

150. The Organization continued to strengthen and diversify partnerships with bilateral organizations (USAID, CDC, CIDA, DFID, French Cooperation), multilateral organizations (World Bank, European Union, GAVI, Global Fund, African Development Bank, African Union), regional economic communities (COMESA, SADC, ECOWAS, ECCAS, IGAD, CEN-SAD) and Foundations (Bill and Melinda Gates, Rotary, Hewlett) with a view to achieving better health for people in Africa. Partnerships with civil society, NGOs, the private sector and academic institutions were initiated and/or strengthened.

151. WHO led and coordinated action by the Harmonization for Health in Africa (HHA) partnership mechanism in further advancing dialogue between ministers of finance and ministers of health to improve financing of the health sector in countries. HHA organized an interministerial meeting that adopted the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector, a framework that will guide the action of countries and partners in accelerating progress towards Universal Health Coverage.

152. As a follow up to the Tunis meeting, the World Bank and the U.S. State Department Office of Global Health Diplomacy, in collaboration with other HHA partners co-hosted a high-level dialogue between ministers of finance and ministers of health to explore policy options ensuring that investments in health produce sustainable systems and results, with more reliance on domestic funds. To that end, closer collaboration between ministries of health and finance as well as more innovative ways to increase health financing, such as through taxation on alcohol, cell phones, tobacco, etc., and efficient use of resources, will be required to ensure universal access. Countries with rich endowment of valuable natural resources were called upon to translate them into health and social development.

153. WHO's continued engagement in joint UN action at the regional level through the United Nations Development Group (UNDG) has contributed to support to UN country teams, especially in the development of UNDAFs and harmonized and more efficient action on health. The Organization led the health cluster and engaged in collaborative action both on Nutrition and on Emergency and Humanitarian Action. The capacity of health sector stakeholders in the management of severe acute malnutrition was enhanced during the drought crisis in the Sahel. In addition, WHO played a leading role in the subregional control of cholera in three West African countries.

154. In a nutshell, Strategic Objective 12 advocated for increased domestic and external investments in national health systems; contributed to improved coordination among health development partners; supported countries to review CCS documents; evaluated the performance of Intercountry Support Teams; successfully organized the Sixty-second Regional Committee meeting that adopted major public health strategies; and produced and disseminated WHO information materials.

4.13 SO13: Efficient and effective WHO

155. Strategic Objective 13 seeks to provide effective and efficient support to technical programmes towards the achievement of expected results. This support is provided in functional areas that include Programme Management; Budget and Finance; Administrative Services; Human Resources; Information Technology; Procurement and Supply Services; as well as Translation; Interpretation and Printing services.

156. On the planning function, the Secretariat worked with the 56 Budget Centres to enhance the management of workplans at WCO, IST and Regional Office levels. Ninety-four staff members were trained to expand the utilization of the result-based management framework. This has improved the effectiveness of workplan management through the use of GSM and has thus led to more measurable results that, among other things, enhance WHO accountability.

157. The Mid-Term Review showed a smooth implementation and management of workplans in 2012. In addition, the monthly Budget Monitoring Reports (BMR) has improved the oversight of Programme Budget implementation. The reprogramming of workplans has been simplified to enable Budget Centres to align funds available with planned costs and adjusted budget allocations whenever needed.

158. In 2012, the African Region contributed to the production of Organization-wide financial statements that, for the first time ever, comply with the International Public Sector Accounting Standards (IPSAS). This is a significant achievement as IPSAS-compliant financial statements make for greater transparency, accountability and a higher standard of financial reporting.

159. The Region's main bank accounts and over 270 imprest accounts were reconciled. This marks an improvement over previous years. The Organization's liabilities to staff and suppliers of goods and services are up-to-date and the Region's migration of current and long-term assets into GSM was more than 90% complete as at the end the of the reporting period.

160. There was a considerable improvement in the management of staff costs in human resource plans and allocation of expenditures to appropriate funding sources. Procedures for making cash available to country office bank accounts for timely programme implementation were revised. Imprest account replenishments have been improved so that excess cash does not lie idle and transaction costs are kept low. The Regional Office has been able to clear the backlog of staff insurance claims and pending contributions to the pension fund.

161. With regard to human resource management, though the funding shortage persists, the downsizing exercise that started in 2011 slowed in 2012. The Human Resources Management (HRM) function has primarily, since the beginning of the 2012-2013 biennium, focused its work on the implementation of the new management structure in the regional office, Intercountry Support Teams and in country offices. The performance assessment of human resources has improved across the Region as a result of the roll-out of the electronic e-PMDS, a simpler staff evaluation tool.

162. Contributions were provided to implement the WHO reform agenda in staff employment conditions for better alignment of contracting practices to the Organization's funding realities. Furthermore, hundreds of staff members were trained at regional level to increase their capacity to perform human resource and management transactions in GSM.

163. Regional teams are working with WHO headquarters to implement global desktop management and email in the African Region. This integration and pooling of services should reduce IT maintenance costs and allow staff to perform more analytical functions.

164. The renovation of the ICT infrastructure is progressing at the Regional Office level, including the deployment of a wireless network on the Regional Office campus. Managed firewalls are now implemented in all locations, thereby improving security and bandwidth protection. New tools like "GoToMeeting" have been introduced to strengthen staff collaboration.

165. Administrative and logistics services have provided effective support to conferences and statutory meetings organized during the year, including the Sixty-second and Sixty-third Regional Committees. Translation and interpretation in the Region's three languages and printing and documentation services were delivered.

166. Targeted investments in infrastructure have improved the living and working conditions of staff members and their families, despite the limited budget resources. Physical Security has been tightened at the Regional Office by improving perimeter barriers and installing surveillance cameras.

167. There is ongoing monitoring and assessment of the rapidly changing security situation and threat levels in many country offices. Financial support was provided to the WHO Country Offices of Burkina Faso, Mali and Nigeria in order to achieve compliance with the Minimum Operating Security Standards (MOSS).

5. PROGRESS MADE IN THE IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

168. Several resolutions have been passed by Member States and the progress of their implementation is being monitored closely by the WHO Secretariat. For each resolution, the progress is presented in this chapter in one paragraph that reviews the resolution, followed by a summary of activities and results.

5.1 AFR/RC51/R3: Adolescent health: a strategy for the African Region

169. The 2001 Regional Committee resolution on adolescent health requested the Regional Director to provide technical support to Member States to develop national policies and programmes on adolescent health; and advocate and mobilize resources to implement these programmes.

170. As of 31 December 2012, 25 countries[104] in the African Region had developed adolescent health strategies and/or strategic plans. A draft regional report on the status of adolescent health in the WHO African Region was developed in 2012. Tools, guidelines and standards for implementing adolescent-friendly health services have been developed. Situation analyses and coverage assessments have been conducted as part of capacity building in five countries.[105] Countries have been guided to introduce HPV vaccine as a key element in the holistic approach to prevention of cervical cancer.

5.2 AFR/RC58/R1: Women's health in the WHO African Region: A call for action

171. Concerned at the unacceptably high level of maternal mortality in sub-Saharan Africa, the Regional Committee adopted Resolution AFR/RC/58/R1 in September 2008. The resolution requested the Regional Director "to establish a Commission on Women's Health to generate evidence on the role of improved women's health in socioeconomic development". In 2009, the Regional Director established the Commission on Women's Health in the African Region, composed of a team of 16 multidisciplinary experts with extensive skills and knowledge in different disciplines.

172. The Commission gathered evidence on the key factors influencing women's health and recommended appropriate actions by governments and all sectors of society in order to achieve sustainable improvement in women's health. The report entitled: *Addressing the challenge of women's health in Africa: report of the Commission on Women's Health in the African Region*, was launched in December 2012 by H.E. Ellen Johnson Sirleaf, President of the Republic of Liberia, in her capacity as Honorary President of the Commission.

173. The report is being disseminated to countries and key partners during continental gatherings and international forums.

5.3 AFR/RC56/R2: Child survival: a strategy for the African Region

174. This resolution called on WHO, in collaboration with relevant partners, to support countries to scale up child survival interventions through strengthening national capacity to effectively develop policies, strategies and plans and implementing and monitoring activities that address issues of child survival in the context of health-care delivery systems.

175. In terms of policy adoption, so far 38 countries have developed national child survival policies, strategies and plans and 17 countries[106] are implementing the integrated community case management of pneumonia, diarrhoea and malaria. On scaling up Integrated Management of Childhood Illness (IMCI), 27 countries were implementing IMCI in more than 75% of the target districts in 2011 compared with 22 countries in 2009.[107]

176. This contributed to a decrease in under-five mortality from 175 per 1000 live births in 1990 to 107 per 1000 live births in 2011. In 2011, 13 countries in the WHO African Region were on track to reduce child deaths by two-thirds between 1990 and 2015, compared with five in 2006 when the regional child survival strategy was adopted. Twenty-four countries are making progress, although insufficient; and nine countries have made no progress.

5.4 AFR/RC61/R2: Framework for public health adaptation to climate change in the African Region

177. The Framework for Public Health Adaptation to Climate Change was adopted by African ministers of health at the Sixty-first session of the Regional Committee in September 2011. Ministers requested the Regional Director to advocate for the use of the Framework as the basis for coordinating partners' actions and to facilitate access by countries to financial resources made available to developing countries, especially climate change funds, to secure the required funding for implementation of national action plans.

178. A plan of action for implementing the Framework in Africa for the period 2012–2016 was developed and endorsed by 38 Member States. A scientific and technical advisory committee has been established and has held one meeting. Climate change vulnerability assessments and resource mobilization were undertaken. WHO attended the 17th and 18th Conference of the Parties to the United Nations Framework Convention on Climate Change.

5.5 AFR/RC61/R4: Poliomyelitis eradication in the African Region

179. Resolution AFR/RC61/R4 urged all Member States where poliovirus continues to circulate to declare poliomyelitis a national public health emergency and to systematically engage all political and traditional leaders at all levels to ensure that all children are reached during routine immunization and SIAs, to successfully interrupt all the remaining transmission of poliovirus. Member States where transmission is endemic (Nigeria) or re-established (Angola, Chad, Democratic Republic of the Congo) were urged to implement priority actions in emergency plans to ensure interruption of poliovirus transmission within the shortest possible time. In addition, all Member States were urged to specifically mobilize adequate resources, strengthen cross-border collaboration in enhancing the quality of immunization and surveillance activities, improve the quality of SIAs and strengthen independent monitoring, attain routine immunization coverage of at least 90% with three doses of OPV, enhance AFP surveillance and ensure response activities are implemented within 4 weeks of confirmation of any poliomyelitis case.

180. A total of 24 Member States in the African Region, with a total under-five population of nearly 300 million implemented at least two rounds of SIAs. Four countries[108] have prepared and are vigorously implementing their national polio eradication emergency plans, with the support of WHO. The engagement of political, traditional and religious leaders at national and subnational levels as well as increased attention to ensuring high quality micro-planning, vaccinator team training and supervision as well as innovative social mobilization and communication activities resulted in improved quality of SIAs. Emphasis on ensuring improved accountability of key stakeholders, particularly at the operational level in the highest risk areas also contributed to improved quality of priority polio eradication activities, including both immunization and surveillance, in these areas.

181. As a result, the number of confirmed wild poliovirus cases in the WHO African Region declined from 350 in 12 Member States in 2011 to 128 in three Member States in 2012. The three Member States in the African Region (Angola, Chad and Democratic Republic of the Congo) with re-established poliovirus transmission were able to interrupt transmission.[109] Sixteen Member States achieved the target OPV3 coverage of at least 90% while 32 Member States achieved the target of non-polio Acute Flaccid Paralysis (AFP) detection rate of at least two per 100 000 in the population aged below 15 years.

5.6 AFR/RC61/R1: Measles elimination by 2020: a strategy for the African Region

182. Resolution AFR/RC61/R1 set a measles elimination goal for 2020 and urged Member States to develop and implement national strategic plans for achieving this goal in line with the Regional Strategic Plan. Member States were urged to provide adequate resources; mobilize national and international stakeholders from public and private sectors as well as local communities; and coordinate the measles elimination efforts. Member States were also urged to specifically generate reliable and updated population data for monitoring measles immunization coverage.

183. Thirty[110] countries were supported to develop measles elimination strategic plans towards achieving the 2020 measles elimination goal. WHO supported countries to improve coordination and resource mobilization activities and a total of US$ 14.9 million was mobilized locally in 12 Member States[111] for follow-up SIAs in 2012 when a total of 37 927 595 children were vaccinated. Nine of these 12 Member States[113] were supported to conduct coverage surveys for validation of their administrative coverage figures. All the SIAs included key child survival interventions such as provision of anti-helminthics, vitamin A and insecticide-treated nets.

184. By the end of 2012, eight[112] (17%) Member States had achieved the target of at least 95% coverage with measles-containing vaccine 1 in routine immunization. Ten of the 12 countries [113] (83%) that conducted follow-up SIAs attained a coverage of 95%. The confirmed incidence of measles has been reduced to less than one per million population in seventeen[114] (39%) of the 44 Member States reporting the use of case-based surveillance systems. Of these 44 reporting Member States, twenty-two[115] (52%) achieved both targets for the quality of measles surveillance (i.e. non-measles febrile rash illness rate of at least two per 100 000 population and at least 80% of districts notifying at least one suspected case of measles per year).

6. CHALLENGES, CONSTRAINTS AND LESSONS LEARNT

6.1 Challenges and constraints

185. The major challenge facing the WHO Secretariat and Member States in implementing the Programme Budget has been how to scale up the effective interventions available and contribute to the desired health outcomes in the light of the weakness of health systems and the global financial crisis that has affected some priority programmes.

186. In many countries, the prevailing conditions do not make for significant increase in the coverage of essential services related to priority programmes such as immunization, HIV/AIDS, tuberculosis, malaria, maternal and child health and noncommunicable diseases. Where significant progress has been made, the challenge of sustaining the achievements remained.

187. Sociopolitical unrest and wars occurred in Central African Republic, Mali and Nigeria causing death, injury, population displacement and the destruction of infrastructure including health facilities. The resulting insecurity posed a formidable challenge to the work of WHO in implementation of the Programme Budget. For example immunization and disease surveillance were affected, resulting in inadequate implementation of polio eradication activities.

188. A major constraint has been the global financial crisis that has resulted in diminished resources available to WHO and further translated into inability to adequately deliver in some important programme areas. The earmarking of Voluntary Contributions has limited the WHO Secretariat's flexibility in consistently allocating resources to the priorities agreed with Member States, leaving under-funded areas such as health systems strengthening and addressing the risk factors and key determinants of health. While the increase in the number and diversity of actors in health development has helped mobilize additional financial and technical resources, it has in some cases led to fragmentation, poor coordination and duplication of support to countries, thereby increasing transaction costs.

189. Other constraints WHO faced in the Region included identification of more opportunities for resource mobilization including strengthening capacity and timely reporting to donors, as well as fluctuations in transaction costs and the challenges of working with partners who have different mandates and interests. In addition, the effective contribution of Member States to the APHEF, an innovative way to mobilize resources within the Region, and its operationalization need to be accelerated.

6.2 Lessons learnt

190. Close collaboration and adequate communication across the three levels of WHO, accompanied by the clear definition of roles and responsibilities, has improved internal cohesion and efficiency, as well as the timely delivery of support to countries. Through joint work, synergies have been realised in the use of technical and financial resources across programmes and units. For example several WHO programmes are jointly supporting countries to implement a comprehensive approach to the prevention and treatment of cervical cancer, including the introduction of HPV vaccine.

191. Working in collaboration with UN agencies and other partners through mechanisms such as UNDAFs at country level and Harmonization for Health in Africa at regional level has facilitated more harmonized and coherent support to Member States. An example is reduction of the threat of epidemics due to meningococcal A meningitis in West Africa, through introduction of the MenAfriVac™ and the interruption of the transmission of poliovirus in the three countries where transmission is re-established. Another example is the coordinated action by the Harmonization for Health in Africa (HHA) partnership mechanism that has advanced dialogue between ministers of finance and ministers of health and strengthened effective health financing mechanisms and service delivery. These recommendations are in line with the Accra Call to Action adopted at the NTD stakeholders' meeting of June 2012. Further examples are the Accra Call to Action by stakeholders, the global action plan on NTDs adopted by the Sixty-sixth World Health Assembly as well as the Regional Strategic plan for NTDs expected to be adopted at the Sixty-third session of the Regional Committee to contribute to the efforts towards the control of NTDs.

192. WHO will therefore continue to pursue and expand partnerships and alliances including engaging better with civil society organizations, professional associations and academic institutions to tackle the health priorities of the Region.

193. Cost-saving measures have been introduced in response to shortfalls in financial resources due to the financial crisis including reductions in the number of meetings organized, reduction in travels and increased use of communication technology, timely initiation of travel requests resulting in reduced travel costs. All these have yielded positive results and strengthened the culture of collective accountability among staff and will be expanded and pursued at country, sub-regional and regional levels.

194. Furthermore, the work of the Regional Office Compliance Team has strengthened accountability, improved the timeliness of attention to audit recommendations and improved adherence to WHO financial rules and regulations. The culture of audit, compliance and supervision is improving the overall management of WHO in the Region. Meanwhile, the financing dialogue initiated with partners in the context of financing the implementation of the programme budget is expected to improve both the financing and effectiveness of WHO.

7. CONCLUSION

195. The Programme Budget 2012-2013 is the last for the Eleventh General Programme of Work, which spanned an initial period of increased resource availability for health, interrupted by the global financial crisis. WHO and its Member States had to adapt to this reality and the changing global health context. At the same time, they had to accelerate action to address the high burden of communicable diseases and increased levels of child and maternal mortality. Account has been taken of emerging priorities such as noncommunicable diseases and additional effort is being made to strengthen health systems.

196. This report demonstrates that significant progress has been made, in the various Strategic Objectives, in providing normative and policy support, generating evidence and data for decision-making and action, and providing technical support towards the scaling up of effective interventions. This effort has contributed to health outcomes in countries. Member States decided to mobilize additional financial resources and established the African Public Health Emergency Fund that is now operational. Additional efforts are required to improve financing of the health sector, service delivery and equity, towards universal health coverage.

197. In conclusion, the work of WHO contributed to generating health outcomes and impact at global and regional levels through the WHO core functions. The fundamental role of governments and the significant contributions of international and national health partners are worthy to note. The next Programme Budget will be implemented in the context of the reform of WHO, as articulated in the Twelfth General Programme of Work. Work towards attaining the MDGs will be accelerated in collaboration with partners, building on the progress made in areas such as child mortality reduction. The managerial reforms being undertaken, including improving compliance and achieving greater efficiency in the use of resources, will be consolidated. WHO will work with Member States and health development partners to advocate for appropriate attention to health in the post-2015 development agenda and will provide support to countries towards the achievement of their health goals.

ANNEXES

Table 1: WHO Medium-Term Strategic Plan 2008–2013: Statement of Strategic Objectives	
01	To reduce the health, social and economic burden of communicable diseases.
02	To combat HIV/AIDS, malaria and tuberculosis.
03	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
04	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
05	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
06	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
07	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrates pro-poor, gender-responsive, and human rights-based approaches.
08	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.
09	To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.
11	To ensure improved access, quality and use of medical products and technologies.
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

Table 2: Approved Programme Budget 2012-2013: Allocation by Strategic Objective, source of financing and distribution between WHO Country Offices and the Regional Office (in US$000s)

SO	Regional Office / ISTs			Country Offices			Total African Region		
	AC	VC	Total	AC	VC	Total	AC	VC	Grand Total
SO 01	7225	124 815	132 040	13 594	338 448	352 042	20 819	463 263	484 082
SO 02	5858	54 592	60 450	5827	81 190	87 017	11 685	135 782	147 467
SO 03	4375	3106	7481	6692	4775	11 467	11 067	7881	18 948
SO 04	7382	22 021	29 403	13 679	34 002	47 681	21 061	56 023	77 084
SO 05	2306	20 436	22 742	1994	66 535	68 529	4300	86 971	91 271
SO 06	4364	3950	8314	6986	4986	11 972	11 350	8936	20 286
SO 07	3219	1918	5137	3110	2499	5609	6329	4417	10 746
SO 08	1994	3130	5124	4079	3516	7595	6073	6646	12 719
SO 09	2345	2557	4902	3443	2288	5731	5788	4845	10 633
SO 10	10 865	14 190	25 055	14 949	31 787	46 736	25 814	45 977	71 791
SO 11	3071	5073	8144	3533	14 146	17 679	6604	19 219	25 823
SO 12	5455	9194	14 649	31 319	0	31 319	36 774	9194	45 968
SO 13	18 213	31 490	49 703	23 723	2822	26 545	41 936	34 312	76 248
Total	**76 672**	**296 472**	**373 144**	**132 928**	**586 994**	**719 922**	**209 600**	**883 466**	**1 093 066**

END NOTES

1. All countries except Burkina Faso, Cape Verde, Comoros, Gambia, Guinea-Bissau, Lesotho, Mali, Mauritania, Mozambique, Namibia and Rwanda.
2. Benin, Burundi, Cameroon, Central Africa Republic, Democratic Republic of Congo, Ethiopia, Gambia, Kenya, Malawi, Mali, Rwanda, Sierra Leone and South Africa.
3. Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Liberia, Mali and Sierra Leone.
4. Resolution AFR/RC61/R4, Poliomyelitis eradication in the African Region. In: *Sixty-first session of the WHO Regional Committee for Africa, Yamoussoukro, Côte d'Ivoire, 29 August-2 September 2011, Final report,* Brazzaville, World Health Organization, Regional Office for Africa, 2011 (AFR/RC61/14) pp. 12-14.
5. Angola, Central African Republic, Chad, Congo, Democratic Republic of Congo, Côte d'Ivoire, Gabon, Guinea, Kenya, Mali, Niger and Nigeria.
6. Burundi, Cameroon, Chad, Eritrea, Guinea, Guinea-Bissau, Kenya, Namibia, Niger, Rwanda, Sao Tome and Principe, Sierra Leone, Uganda, Zambia and Zimbabwe.
7. Angola, Ethiopia, Guinea, Madagascar and Niger.
8. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Comoros, Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea-Bissau, Lesotho, Liberia, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
9. Benin, Cameroon, Chad, Ghana, Nigeria, Senegal and South Sudan.
10. PCV (Benin, Botswana, Burundi, Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Tanzania, Uganda, Zimbabwe); Rotavirus vaccine (Botswana, Ghana, Malawi, Rwanda, South Africa, Tanzania and Zambia).
11. Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Ghana, Guinea, Kenya, Lesotho, Seychelles, Tanzania, Uganda and Zimbabwe.
12. Cameroon, Central African Republic, Chad, Ghana, Guinea, Seychelles, Uganda and Zimbabwe.
13. Chad, Ethiopia, Mali and South Sudan.
14. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
15. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Democratic Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
16. Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Kenya, Malawi, Mali, Mozambique, Namibia, Niger, Rwanda, Sierra Leone, South Africa, Togo, Swaziland, Zambia and Zimbabwe.
17. Botswana, Burkina Faso, Central African Republic, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Malawi, Namibia, Rwanda, Togo, Zambia and Zimbabwe.
18. Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
19. Angola, Botswana, Burundi, Cameroon, Chad, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
20. Botswana, Ghana, Namibia, South Africa, Swaziland and Zambia.

21. Botswana, Namibia, Rwanda, Swaziland and Zambia.
22. Benin, Burkina Faso, Burundi, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Malawi, Mali, Sao Tome and Principe, Senegal, South Africa, Uganda and Zimbabwe.
23. Global TB Report 2012.
24. Angola, Botswana, Ethiopia, Ghana, Kenya, Lesotho, Sao Tome and Principe, Seychelles, Tanzania and Zambia.
25. Algeria, Benin, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Gambia, Ghana, Kenya, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, Sierra Leone, Tanzania and Zambia.
26. Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ghana, Kenya, Madagascar, Malawi, Mozambique, Nigeria, Liberia, Swaziland, Senegal and Zimbabwe.
27. http://www.alma2015.org/alma-scorecard-accountability-and-action.
28. Botswana, Burundi, Chad, Comoros, Côte d'Ivoire, Eritrea and Zimbabwe.
29. Benin, Burundi, Cameroon, Chad, Comoros, Democratic Republic of Congo, Kenya, Sao Tome and Principe, Senegal, Uganda and IST/ESA.
30. Benin, Eritrea, Ethiopia, Gambia, Ghana and Sierra Leone.
31. Botswana, Cape Verde, Namibia, South Africa, Swaziland, Tanzania (Zanzibar) and Zimbabwe.
32. Algeria, Botswana, Cape Verde, Eritrea, Madagascar, Namibia, Rwanda, Sao Tome and Principe, South Africa, Swaziland,Tanzania and Zambia.
33. Angola, Benin, Cameroon, Central African Republic, Comoros, Democratic Republic of Congo, Côte d'Ivoire, Eritrea, Gabon, Gambia, Guinea, Guinea-Bissau, Madagascar, Mali, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, South Africa, South Sudan, Swaziland, Tanzania, Uganda and Zimbabwe.
34. http://www.who.int/malaria/publications/atoz/smc_policy_recommendation_en_032012.pdf.
35. http://www.who.int/malaria/test_treat_track/en/.
36. Central Africa Republic, Equatorial Guinea, Ethiopia, Côte d'Ivoire, Liberia, Malawi, Mozambique, Nigeria, Tanzania and Togo.
37. Angola, Benin, Congo, Democratic Republic of Congo, Côte d'Ivoire, Malawi, Mali, Mozambique, Niger, Nigeria and Senegal.
38. The Global Action Plan for the prevention and control of noncommunicable diseases 2013–2020; the comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases; the Updated 2013–2020 Global Action Plans for mental health and the Universal Eye Health – a Global action plan 2014–2019.
39. Algeria, Benin, Burkina Faso, Equatorial Guinea, Comores, Congo, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Lesotho, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Sao Tome and Principe, and Zambia.
40. Mozambique, Namibia, Nigeria, Sierra Leone, South Africa and Uganda.
41. Benin, Côte d'Ivoire, Guinea and Sierra Leone.
42. Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal and Togo.
43. Burkina Faso, Mozambique, Niger, Tanzania, and Zimbabwe.
44. Cape Verde, Côte d'Ivoire, Mozambique and Rwanda.
45. Benin, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Sierra Leone and Togo.
46. Levels and Trends in child mortality, Report 2012, compiled by the UN Interagency Group for child mortality estimation; UNICEF 2010.
47. Algeria, Botswana, Cape Verde, Ethiopia, Liberia, Madagascar, Malawi, Mauritius, Niger, Rwanda, Seychelles, United Republic of Tanzania and Zambia.

48. Gambia (50%), Guinea (50%), Togo (51%), Mali (51%), Niger (52%), Sao Tome and Principe (54%), Benin (55%), Algeria (56%), Burkina Faso (57%), Malawi (59%), Cape Verde (61%), Madagascar (62%), Angola (62%), Rwanda (63%), Ethiopia (64%), Eritrea (73%), and Equatorial Guinea (81%).
49. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Comoros, Côte d' Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe.
50. Angola, Benin, Botswana, Cameroon, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Guinea, Madagascar, Malawi, Mauritania, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Tanzania (mainland), Togo, Uganda and Zimbabwe.
51. Burkina Faso, Cameroon, Democratic Republic of Congo, Ethiopia, Guinea, Kenya, Lesotho, Malawi, Swaziland, Tanzania and Uganda.
52. Burkina Faso, Chad, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Mali, Niger, Swaziland, Tanzania and Zambia.
53. Angola, Burundi, Nigeria and Swaziland.
54. Burundi, Comoros, Lesotho and Malawi.
55. Eritrea, Ethiopia, Kenya, Lesotho, Malawi, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
56. Benin, Botswana, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Ghana, Gambia, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
57. Congo, Democratic Republic of Congo, Ghana, Guinea, Guinea-Bissau, Niger, Sierra Leone and Uganda.
58. Ghana, Kenya, Mozambique, Namibia, Rwanda, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
59. Botswana, Ghana, Kenya, Lesotho, Mauritius, Namibia, Seychelles, Togo, Zambia and Zimbabwe.
60. Ethiopia, Ghana, Kenya, Mauritius, Namibia, Nigeria, Seychelles and South Africa.
61. Burundi, Kenya, Malawi, Namibia and Zambia.
62. Ghana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe.
63. Burkina Faso, Congo, Ghana, Guinea, Madagascar, Mali, Niger, Rwanda, Seychelles and Togo.
64. Côte d'Ivoire, Kenya, Mozambique, Niger, Sao Tome and Principe, Senegal and Zambia.
65. Côte d'Ivoire, Namibia, South Africa, Uganda and Zambia.
66. Ghana, Kenya, Senegal, Uganda and Zambia.
67. Botswana, Cameroon, Equatorial Guinea, Kenya, Madagascar, Namibia, Senegal, Swaziland, Uganda, Zambia and Zimbabwe.
68. Liberia, Madagascar, Mauritius, Sao Tome and Principe and Seychelles.
69. Botswana, Kenya, Lesotho, Mozambique, Namibia, Rwanda, Swaziland, Uganda and Zimbabwe.
70. Burundi, Cameroon, Central Africa Republic, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon and, Sao Tome and Principe.
71. Benin, Burkina Faso, Côte d'Ivoire, Gambia, Guinea, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa and Togo.
72. Angola, Botswana, Benin, Burundi, Cameroon, Comoros, Congo, Democratic Republic of Congo, Côte d'ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania and Togo.
73. Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Ethiopia, Gabon, Guinea, Kenya, Lesotho and Mali.
74. Ethiopia, Gabon, Kenya, Lesotho, Mali and Sierra Leone.

75. Black RE, Victora CG, Walker SP, and the Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013; published online June 6. http://dx.doi.org/10.1016/S0140-6736(13)60937-X.
76. Central African Republic, Chad, Tanzania and Zambia.
77. Cameroon, Guinea-Bissau, Kenya, Malawi, Sierra Leone and Zimbabwe.
78. Angola, Central African Republic, Chad, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Mali, Mauritania, Niger, Sierra Leone and Tanzania.
79. Burkina Faso, Ethiopia, Mozambique, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.
80. Comoros, Madagascar, Mauritius and Seychelles.
81. Five Keys To Safer Food Manual-www.who.int/foodsafety/publications/consumer/manual_keys.pdf.
82. Chad, Cote d'Ivoire, Gabon, Guinea, Mali, Mauritius and Togo.
83. Côte d'Ivoire, Gambia, Mali, Mauritania, Niger and Senegal.
84. Burkina Faso, Côte d'Ivoire, Gambia, Kenya, Liberia and Sierra Leone.
85. Angola, Botswana, Cape Verde, Central Africa Republic, Comoros, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Namibia, Sao Tome and Principe, Senegal, South Africa and Swaziland.
86. Burkina Faso, Cape Verde, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Senegal, Sierra Leone, Togo and Zambia.
87. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Democratic Republic of Congo, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Malawi, Mauritania Mozambique, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
88. Benin, Botswana, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Mozambique, Niger, Rwanda, South Africa, Tanzania, Uganda and Zambia.
89. Burundi, Guinea-Bissau, Mali, Mozambique, Senegal, Uganda and Zambia.
90. Burkina Faso, Burundi, Côte d'Ivoire, Ethiopia, Nigeria and Senegal.
91. Botswana, Burkina Faso, Burundi, Cape Verde, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Liberia, Malawi, Mauritania, Mozambique, Namibia, Niger, Sierra Leone, Swaziland, Uganda, Zambia and Zimbabwe.
92. Cape Verde, Congo, Rwanda and Sierra Leone.
93. Benin, Burkina Faso, Cameroon, Liberia, Mali and Swaziland.
94. Economic Community of West African States/West African Health Organization (ECOWAS/WAHO), Economic and Monetary Union of West Africa (UEMOA), Economic Community of Central African States (ECCAS), East African Community (EAC) and Southern African Development Community (SADC).
95. Burkina Faso, Burundi, Democratic Republic of Congo, Eritrea, Mauritius and Seychelles.
96. Algeria, Benin, Botswana, Burundi, Cape Verde, Cote d'Ivoire, Kenya, Lesotho, Malawi, Mauritius, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
97. Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Ethiopia, Gabon, Gambia, Ghana, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Togo and Uganda.
98. Cameroon, Cote d'Ivoire, Ethiopia, Kenya, Lesotho, Mozambique, Nigeria and Tanzania.
99. Burundi, Cameroon, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon and, Sao Tome and Principe.
100. Burundi, Côte d'Ivoire, Mozambique, Rwanda and Zambia.
101. Algeria, Benin, Burkina Faso, Cape Verde, Comoros, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Liberia, Senegal, Sierra Leone, Togo and Tunisia.
102. Botswana, Burkina Faso, Cameroon, Central Africa Republic, Ethiopia, Gabon, Gambia, Ghana, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

103. Burkina Faso, Gabon, Ghana, Kenya, Malawi, Mozambique and Tanzania.
104. Benin, Botswana, Burkina Faso, Central African Republic, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Guinea, Madagascar, Malawi, Mali, Namibia, Niger, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
105. Chad, Ethiopia, Malawi, Tanzania and Uganda.
106. Burkina Faso, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Liberia, Madagascar, Malawi, Mali, Mauritania, Niger, Nigeria, Rwanda, Senegal, Togo and Uganda.
107. Benin, Botswana, Burkina Faso, Central African Republic, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda and Zambia.
108. Angola, Chad, Democratic Republic of Congo and Nigeria.
109. As at June 2013, Angola had spent 23 months without a confirmed wild poliovirus case, Chad had spent 12 months and Democratic Republic of Congo had spent 18 months.
110. Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Democratic Republic of Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mauritania, Mauritius, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia and Zimbabwe.
111. Burundi, Cameroon, Eritrea, Guinea-Bissau, Kenya, Namibia, Niger, Sao Tome and Principe, Sierra Leone, Uganda, Zambia and Zimbabwe.
112. Algeria, Cape Verde, Eritrea, Malawi, Mauritius, Rwanda, Seychelles and Swaziland.
113. Burundi, Cameroon, Chad, Guinea, Kenya, Namibia, Niger, Sao Tome and Principe, Sierra Leone, Uganda, Zambia and Zimbabwe.
114. Algeria, Botswana, Cape Verde, Comoros, Gabon, Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mozambique, South Africa, Swaziland and Zimbabwe.
115. Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda and Zimbabwe.