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The Work of WHO in the African Region

2004-2005

Biennial Report of the Regional Director



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The Regional Director has the honour of presenting to the Regional Committee the report on the activities of the World Health Organization in the African Region during the period 1 January 2004 to 31 December 2005.

*Dr Luis Gomes Sambo
Regional Director*

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ABBREVIATIONS

ACT	artemisinin-based combination therapy
ADB	African Development Bank
AIDS	acquired immunodeficiency syndrome
AMS	Activity Management System
APADOC	Alliance of Parents, Adolescents and the Community
ART	antiretroviral therapy
CCS	Country Cooperation Strategy
CMH	Commission on Macroeconomics and Health
COMESA	Common Market of Eastern and Southern Africa
DDT	dichlorodiphenyltrichloroethane
DFID	Department for International Development–UK
DHS	Demographic and Health Survey
DOTS	directly-observed treatment, short-course
DPT	diphtheria-pertussi-tetanus
ECA	Economic Commission for Africa
ECOWAS	Economic Community of West African States
EPI	Expanded Programme on Immunization
FAO	Food and Agricultural Organization
FCTC	Framework Convention on Tobacco Control
FGM	female genital mutilation
HIV	human immunodeficiency virus
ICT	information and communications technology
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
ITN	insecticide-treated net
MDG	millennium development goal
MICS	Multiple Indicator Cluster Survey
MTEF	medium-term expenditure framework
NCD	noncommunicable disease
NEPAD	New Partnership for Africa’s Development
NGO	nongovernmental organization
PMTCT	prevention of mother-to-child transmission
PRSP	poverty reduction strategy paper
RED	Reach Every District
SADC	Southern African Development Community

SIA	supplemental immunization activity
SPLM	Sudan People's Liberation Movement
STEPS	Stepwise approach for surveillance of risk factors
SWAp	sectorwide approach
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNIFEM	United Nations Development Fund for Women
UK	United Kingdom
WAHO	West African Health Organization
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

1. During the period 2004-2005, WHO revitalized and implemented specific policies and strategies for action through its regional and country offices. The WHO Regional Committee for Africa passed 15 resolutions and decisions with relevant application at national, regional and global levels. WHO also aligned its activities with country priorities by completing six additional Country Cooperation Strategies, bringing the total to 45.

2. With dwindling resources in most countries of the Region and the rapidly deteriorating health situation of the populations, special emphasis was put on mobilization of funds from other sources. The Organization's improved project management capacities at regional and country levels increased partners' confidence in WHO. Funding institutions chose WHO as the implementing agency for their country health projects which significantly contributed to Regional Office response to the increased demands of Member States. A total of 36 cooperation agreements were signed (23 at country level) with various funding agencies and partners. Partnerships with the African Union and regional economic communities were also rejuvenated.

3. The health systems in countries of the African Region continued to face poor stewardship, inadequate financing, human resource crises, and inadequate access to essential medicines and health technology, including access to safe blood. This situation contributed greatly to the prevailing poor health indicators, a major challenge to the achievement of the millennium development goals. In response, countries continued to undertake health reforms to promote universal access and improve the performance of health systems. WHO supported countries' initiatives by providing guidelines and tools, building capacity, enhancing health information systems, improving collaboration with other partners in health sector development and advocating for strengthening health systems.

4. WHO actions to fight HIV/AIDS, tuberculosis and malaria focused on providing technical support to countries for policy development and adaptation. The Regional Office mobilized technical and financial resources; scaled up access to care and treatment; strengthened partnerships at regional, subregional and national levels; supported the implementation and expansion of directly-observed treatment short-course in countries; strengthened country capacity to rapidly increase access to sustainable, high quality and cost-effective interventions; promoted operational research; and strengthened laboratory techniques for vaccine research.

5. Malaria continued to be one of the major diseases plaguing the Region in 2004 and 2005. In vivo monitoring of therapeutic efficacy of antimalarial drugs continued, covering 41 of the 42 malaria-endemic countries with a total of 188 sentinel sites. In response to the growing resistance to monotherapies, 25 countries were assisted to adopt artemisinin-based combination therapy as first-line treatment for malaria.

6. As a result of the WHO commitment to put 3 million people on antiretroviral therapy by the end of 2005, increased care and antiretroviral treatment served approximately 800 000 people by the end of that year. This represents 20% of the people needing the therapy. A total of 29 countries developed antiretroviral scale-up plans, and 19 countries adopted policies and strategies to strengthen TB and HIV care; 20 countries increased tuberculosis case detection and treatment success rates to 50% and 73%, respectively.

7. Control of communicable diseases was possible because effective control strategies and tools were available. The WHO Regional Office for Africa provided technical support to countries for using these strategies and tools to reduce morbidity and mortality. Substantial achievements in the control of communicable diseases were recorded during the biennium. Although several major outbreaks occurred, the regional capacity for epidemic response was strengthened, and the Regional Office provided technical support to affected countries within the shortest possible time. WHO also supported the establishment of a regional network of laboratories to support Member States' preparedness and response to major epidemics, pandemics and emergencies. All major outbreaks that occurred in 2004 and 2005 were laboratory-confirmed through this network.

8. In the African Region, 21 countries recorded a positive reduction in measles occurrence, with immunization efforts reaching approximately 99 million children. The rate of confirmed measles cases was 0.6 and 0.43 per 100 000 population in 2004 and 2005, respectively. By November 2005, 599 confirmed polio cases were reported in eight countries, signifying a decline of 24% from the 2004 figures. A total of 38 countries achieved and sustained certification for acute flaccid paralysis surveillance, while nine countries were accepted as polio-free by the African Regional Certification Commission. Elimination of maternal and neonatal tetanus was validated in 16 countries. More than 72% of the countries in the Region used the Reach Every District (RED) approach to diphtheria-pertussis-tetanus (DPT3) coverage, and 67% of districts using the approach had coverage above 80%.

9. Noncommunicable diseases represented one of the major challenges in the African Region. WHO responded by providing support to countries to set up surveillance systems for noncommunicable diseases, using the stepwise approach to risk factors and other sources. It also supported countries to develop and update national policies and programmes for implementing, at community level, activities on management of mental disorders and substance abuse. Health promotion capacity was boosted through training of multisectoral teams and nongovernmental organizations in addressing the broad determinants of health. The WHO Regional Office also provided assistance to governments and their partners to develop and implement cost-effective and gender-sensitive strategies to prevent and control injuries and disabilities, and to support communities in the rehabilitation of those with medium- or long-term disabilities.

10. WHO promoted continuum of care spanning pregnancy and child birth to childhood. It also promoted this continuum of care in the home (through empowering families), the community (through improving primary care facilities and bringing care closer to the home) and health facilities. Integrated Management of Childhood Illness (IMCI) was one of the key child survival strategies used in the African Region. Of the 46 countries in the Region, 44 had implemented the IMCI strategy by the end of 2005. WHO provided support to strengthen capacity of countries in reproductive health research, documenting and sharing best practices, training health-care providers, and building and strengthening partnerships for effective reproductive health programmes, including family planning. WHO also supported countries in the development and implementation of the "Road Map to accelerate the attainment of the millennium development goals related to maternal and newborn health" as well as the women's health strategy.

11. The occurrence of natural and man-made disasters continued to be a major concern in the Region. Almost 50% of Member States were either in a crisis or emerging from one. About 13 million people were internally displaced. There were outbreaks of acute aflatoxicosis as well as famine in some countries. WHO responded to these challenges by analysing the linkages between poverty and health and advocating for the inclusion of poverty issues as well as long-term strategic thinking in national and regional health development efforts. It also promoted the incorporation of effective environmental health in the development of national environment policies. WHO also addressed the

high morbidity and mortality associated with unsafe food, strengthened national capacity for emergency preparedness and response, and provided humanitarian support in crisis situations.

12. A review of the manner in which the Regional Office carries out its work has resulted in conceptualization of a new way of working across levels and programmes in WHO. A critical outcome of this review was a new policy document, “*Strategic orientations for WHO action in the African Region 2005–2009*”. For the next biennium, 2006-2007, the work of WHO in the African Region will be guided by the vision articulated in the *Strategic Orientations*. The five key elements of the vision were recorded as: strengthening WHO country offices; improving and expanding partnerships for health; supporting the planning and management of district health systems; promoting the scaling up of essential health interventions related to priority health problems; and enhancing awareness and response to the key determinants of health.

13. In order to give prompt quality support to countries, some of the technical and administrative functions of the Regional Office will be decentralized to Inter-country Support Teams. These teams will provide technical support to countries and also perform the administrative functions decentralized to them.

14. WHO will continue to assist Member States to work on the systematic implementation of effective interventions and will continue its advocacy to mobilize partners around the common goal of improving health outcomes in the Region.

INTRODUCTION

1. The 2004-2005 biennium is a significant period in the annals of the WHO Regional Office for Africa. Dr Ebrahim Malick Samba completed his long service to the African Region as Regional Director, and Dr Luis Gomes Sambo assumed the directorship in 2005. The biennium was also the last to be implemented under the Tenth General Programme of Work. Under this programme of work, efforts were focused on enhancing capabilities for transparency and accountability, supporting country teams, mobilizing funds from other sources, generating evidence-based information, participating in institutional decision-making, applying results-based management, strengthening knowledge, and disseminating reliable and timely information.

2. This report describes the activities and achievements of the WHO Regional Office for Africa in assisting Member States in their efforts to promote health, and prevent and control diseases. The first part of the report describes implementation of the Programme Budget 2004-2005, significant achievements of the major programmes and services, both enabling and constraining factors, lessons learnt and orientations for the next biennium (2006-2007). The second part gives a progress report on the implementation of 13 resolutions of the WHO Regional Committee for Africa.

3. The achievements of WHO would not be possible without the strong commitment and support of Member States and partners as well as the commitment of countries to tuberculosis and HIV control by their resolutions during the fifty-fifth session of the WHO Regional Committee for Africa. Thus, the declaration of tuberculosis as an emergency in the Region and the declaration of 2006 as the Year for Acceleration of the Prevention of HIV in the African Region have been instrumental in creating an enabling environment for WHO work in the Region.

4. To succeed in the various programme implementation and intervention efforts, WHO had to build strong management and coordination systems that recognize the diversity of the Member States. In addition, the Organization developed new mechanisms and strategies for interaction with other United Nations bodies, regional and subregional economic communities, the public sector, nongovernmental organizations and civil society organizations.

5. This report is produced with the aim of sharing information with Member States and partners on WHO's work in the African Region.

PART 1: PROGRAMME BUDGET 2004-2005 IMPLEMENTATION

SIGNIFICANT ACHIEVEMENTS

GENERAL PROGRAMME DEVELOPMENT AND MANAGEMENT

6. There are eight areas of work in General Programme Development and Management. Two are in the Regional Director's office: the Director-General, Regional Directors and Independent Functions area of work focuses on strategic orientations, and WHO's Presence in Countries is devoted to strengthening country offices. The six remaining areas of work are under the direct supervision of the Director, Division of Programme Management. These focus on partnerships and resource mobilization; evidence-based information, including promotion of research; implementation of resolutions of WHO Governing Bodies; and improvement of the quality of planning and monitoring processes.

Director-General, Regional Directors and Independent Functions (DGO)

7. New opportunities are being opened up for health development in the African Region. These include efforts such as the New Partnership for Africa's Development, the United Nations Millennium Development Goals and the Millennium Challenge Accounts. The WHO Regional Office for Africa is now in a more advantageous position to give valuable and timely support to countries to move their health agendas forward.

8. Upon assuming his duties in February 2005, the new Regional Director developed a new vision published as *Strategic orientations for WHO action in the African Region 2005-2009*. The five key elements of the strategic orientations are: strengthening WHO country offices; improving and expanding partnerships for health; supporting the planning and management of district health systems; promoting the scaling up of essential health interventions related to priority health problems; and enhancing awareness and response to the key determinants of health.

9. Implementation of the strategic orientations began with high-level visits were made to partners in order to strengthen partnerships. Discussions involved not only funding but other critical issues such as human resource development; research and development; and response to emergencies, particularly epidemics and humanitarian disasters. In order to ensure that the end recipients are the countries, the Regional Director made several high-level visits to Member States in the Region. The aim was to ensure that health agendas were discussed at the highest level so that promises are supported by material and financial investments from governments. A second aim of the country visits was to ensure commitment and resources from development partners who are operating at country level.

10. To ensure that essential interventions get to the right people at the right time, the Regional Office is collaborating with headquarters at technical, managerial and top management levels. This is the first time that a well-formulated plan for reaching the majority of people who need help has been so conceived and followed. Thus, while WHO is using the forum of its statutory meetings to debate, finalize and report on decisions and resolutions of the Organization, the forums also provide advocacy for the programmes of the Organization.

WHO's Presence in Countries (SCC)

11. The Country Cooperation Strategy has now been established as WHO's medium-term tool specifying the business of WHO at country level. It combines all the inputs from the various levels of the Organization in order to focus on the country as the main arena of operations.

12. In general, each Country Cooperation Strategy (CCS) has a four-to-six-year plan and provides strategic direction in line with the country's vision for health development. Because health is now being seen in a wider scope than previously, the CCS seeks cooperation with government rather than only the Ministry of Health.

13. By the end of 2005, 45 countries had implemented their CCSs. Most countries have focused on the following strategic areas: health systems strengthening (31/45), disease prevention and control (26/45), health promotion (16/45), emergency and humanitarian action (10/45), reproductive and adolescent health (8/45). By limiting the number of areas of work, WHO country offices will follow a new direction and use resources which will guarantee better tangible results. This will be closely monitored in coming years.

14. The 45 CCS documents were launched during the fifty-fifth session of the Regional Committee held in Maputo, Mozambique. It is noteworthy that the countries showed great interest in the documents as they present the ways and means for WHO work at country level. For the future, these documents need to be updated as new policies are put into place, new governance systems are developed, and the epidemiological and social situations of countries change.

15. One direct consequence of the CCS was that in cases where country offices chose new strategic directions, it became apparent that new competencies would be needed. In order to quickly bridge the potential gaps that would be created, the Regional Office embarked on the process of reprofiling to build the capacities of country offices.

16. Reprofiling became a major exercise in which all country offices of the Region increased their capacities. However, challenges remain. These challenges include determining what to do with professionals when their area of work is no longer required. Conversely, a major challenge for some offices will be the issue of financial support where dramatic increases in human resources are required. While reprofiling was not meant primarily to reduce staff numbers, it is evident that difficult decisions will have to be made in order to streamline offices and make them more efficient.

17. In the last year, one important emphasis for WHO at the three levels of the Organization has been building alliances within the United Nations system. This is important as the donor community and the UN are requesting harmonization and alignment of programmes towards one country programme and one direction. This new way of working with partners was strengthened by a resolution passed during the Fifty-eighth World Health Assembly. In order to facilitate the implementation of this resolution, sessions within the Regional Programme Meetings were dedicated to harmonization and its implications for the operations of WHO at country level. WHO representatives have also engaged UN country teams by utilizing the Country Cooperation Strategy to take the leadership in public health in their countries of assignment. Consequently, WHO now participates actively and in many cases takes the lead in the Common Country Assessment for the United Nations Development Assistance Framework at country level.

18. In three countries, the entire process of harmonization and alignment has moved forward with the development of joint assistance support agreements between partners, including the UN and

government. These agreements deal with several issues, including problems of lead technical agencies, overlap, double funding, and inequalities in support to certain aspects of country programmes. It is apparent from the documents reviewed that the preferred modality for financial assistance to these countries in the foreseeable future is the sectorwide approach (SWAp). Therefore, WHO will continue giving the necessary technical support for SWAps in these countries.

19. In order to give prompt quality support to countries, a decision was taken to decentralize some of the functions of the Regional Office to Intercountry Support Teams. These teams will provide technical support to countries and will also perform administrative functions decentralized to them.

Resource Mobilization, and External Cooperation and Partnerships (REC)

20. With dwindling resources in most countries of the Region and the rapidly deteriorating health situation of the populations, special emphasis was put on mobilizing funds from other sources. This was supported by intensive information and communication activities aimed at increasing awareness of health issues, promoting priority programmes and areas of work and, as a result, increasing the visibility of WHO in the Region.

21. The Organization's improved project management capacities at regional and country levels increased partners' confidence in WHO. Funding institutions chose WHO as the implementing agency for their country health projects. This has significantly contributed to Regional Office response to the increased demands of country offices and technical divisions.

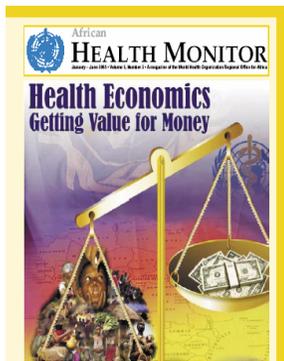
22. During the biennium under review, 36 cooperation agreements were signed (23 at country level) with various funding agencies and partners, including the World Bank; the African Development Bank; United States Agency for International Development; the Ford Foundation; United Nations Development Programme; International Atomic Energy Agency; German Agency for Technical Cooperation; Department for International Development (UK); Norwegian Agency for International Development; African Organization for Intellectual Property; nongovernmental organizations; and the governments of Belgium, France, Italy and Sweden. The agreements were for implementation of projects in Member States and totalled an approximate US\$ 50 million. In addition, DFID granted about US\$ 214 million. A four-year partnership agreement between WHO and the European Union was signed in July 2005; it amounts to around US\$ 18 million and will benefit six countries (Angola, Burkina Faso, Kenya, Malawi, Niger and Tanzania).

23. Partnerships were strengthened through numerous activities and participation in more than 20 health-related conferences, round tables, meetings, workshops and mutual partner visits. Partnerships with the African Union and regional economic communities were rejuvenated. A meeting was held in Brazzaville, Congo, in April 2005 with representatives from the African Union, Economic Commission for Africa and eight regional economic communities. The same partners also participated in the fifty-fifth session of the WHO Regional Committee for Africa. The WHO Regional Office for Africa was also represented in 11 regional and subregional meetings organized by the African Union.

24. Public information and communication activities at the Regional Office increased significantly in the last biennium as evidenced by various advocacy statements as well as user-friendly print and audiovisual materials. These contributed to provide governments, the donor community and the general public with a better understanding of WHO Regional Office recruitment policies, procedures and health interventions. Regional Office health agenda consultations and meetings attracted regional and international media interest. In particular, the fifty-fifth session of the WHO Regional Committee for Africa received excellent international media coverage. Overall, there was positive media

sentiment towards WHO's operations and achievements in the Region during the biennium as evidenced by the large number of positive stories published or broadcast by both the print and electronic media.

25. Various stakeholders have requested to be placed on the mailing list for the *African Health Monitor*, the health magazine of the Regional Office. This periodical is demonstrating a high and rising profile and has continued to serve as a status report on the priority programmes and activities of the Regional Office. The last issue of 2005 had the theme, "Health economics: Getting value for money"; it attracted positive reviews from the medical and popular press due to its refreshingly new interdisciplinary approach to health.



Evidence for Health Policy (GPE)

26. The main issues in Evidence for Health Policy included the weak culture for generating and utilizing evidence in decision-making; low investment in generation and dissemination of evidence for health at both regional and country levels; and the dearth of reliable, timely and usable information on vital registration, cost-effectiveness and efficiency of interventions. WHO responded by providing strategic direction and appropriate support to countries for the growth of evidence generation capacities in the Region.

27. One of the main achievements was the design and implementation of the regional integrated database. A new version of the health situation assessment database on health indicators was designed and tested; implementation is ongoing. The second edition of the pamphlet, "Basic Indicators", was produced. A process was set up for enhancing web publishing, including hosting of country web sites at headquarters in close collaboration with ICT and the Regional Office Web Committee. Guidelines for documentation of best practices in health were produced. The African Health Economics Advisory Committee was established, and the Strategic Health Economics Plan for the WHO African Region for the period 2006-2015 was drafted.

28. Technical documents were produced on the following subjects: status of national bioethics committees in the African Region; social health insurance in Kenya and Nigeria; cost of safe motherhood programmes in Ghana and Nigeria; cost of health promoting schools initiative in Uganda; efficiency of a sample of health facilities in Angola, Ghana, Kenya, Mali, Namibia and Sierra Leone; impact of disaster-related mortality on gross domestic product in the WHO African Region; effects of maternal mortality on gross domestic product in the WHO African Region; potential applications of health economics in HIV/AIDS control in Africa; and, determinants of health insurance ownership among South African women.

29. Some lessons were learnt about the need for accelerating the implementation of health information management systems to promote the generation and utilization of evidence in decision-making; intensifying efforts to strengthen health information management capacity at country level, including developing country web sites; leveraging regional health economics centres of excellence for short- and long-term health economics capacity strengthening; undertaking joint research and dissemination of research results with planners and economists in ministries of health and WHO country offices; and forging closer partnerships with the World Bank, International Monetary Fund and regional economic communities to accelerate harmonized support to countries.

30. For the biennium 2006-2007, adequate funds and human resources will be allocated to health information systems. Concerted efforts will be made to undertake studies and disseminate research results in close collaboration with counterparts in ministries of health and health-related ministries.

Governing Bodies (GBS)

31. All the governing bodies meetings were facilitated to enable participation of delegates from Member States and secretariat members in the Executive Board and World Health Assembly meetings. The Regional Committee meetings in Brazzaville, Republic of Congo in 2004 and Maputo, Mozambique in 2005 were successfully held. The rules of procedure and regulations were meticulously applied to ensure that due process was followed in the conduct of meetings.

32. During the governing bodies sessions, the ministers of health undertook important reviews and provided essential policy direction with the support of the WHO secretariat. For instance, substantive improvements in the selection and review of agenda items, quality of debates and technical documentation led to the adoption of some landmark resolutions and decisions.

33. A total of 15 resolutions were adopted by the Regional Committee during the biennium 2004-2005. These included: resolution AFR/RC54/R1 recommending the nomination of the Regional Director and its eventual endorsement by the Executive Board; resolution AFR/RC54/R9, "Road Map for accelerating the attainment of the millennium development goals relating to maternal and newborn health in Africa"; and resolution AFR/RC55/R6, "Acceleration of HIV prevention efforts in the African Region".

34. The two landmark resolutions on maternal and newborn health and HIV effectively provided the needed orientations and platforms for networking and coordination between WHO and its partners, including UNICEF, UNAIDS and the African Union. Procedural changes were also effected with the adoption of resolution AFR/RC54/R11 leading to new criteria for the designation of Member States of the African Region to serve on the Executive Board. The new arrangements introduced a system of subdividing the Region into three sub-groups; subsequently, Liberia, Madagascar, Namibia and Rwanda have benefited from the system and are serving on the Executive Board.

35. In appreciation of the method of work and value of daily morning meetings of African Region delegates at the World Health Assembly, the Regional Committee recommended that the practice be continued and that the relevant WHA agenda items be distributed to countries prior to the Health Assembly in order to prepare a common position to be presented in a common voice. This has led to the increasing influence of African delegates in re-orienting the direction of the global health agenda.

36. During the biennium, the high level of commitment of ministers of health and the significant renewed interest in the work of the governing bodies have raised the standards and output of these meetings. This has increasingly required a more analytical approach to the issues which has resulted

in a self-monitoring of the quality of the processes involved and documents produced.

37. The main challenge was the ever-growing requests for additional agenda items to be included in the annual sessions of the Regional Committee for Africa. Although all proposed agenda items were very relevant, time constraints meant that exhaustive debate was not always possible. The secretariat, with suggestions from the Regional Committee, continued to find ways of limiting the number of agenda items without compromising their importance.

38. The second challenge concerned how to allow partners more active involvement in the development and debate of technical papers within the statutory requirements of the WHO and the rules and procedures of the Regional Committee. Currently, the privileges accorded for attendance do not necessarily extend to participation; however, a useful approach has been to use round tables, panel discussions and special sessions as forums for non-statutory inputs. This has worked with a relative degree of success but could be improved in the future.

Programme Planning, Monitoring and Evaluation (BMR)

39. Implementation of Programme Budget 2004-2005 was based on the progress and experience acquired in the last two biennia to improve programme management practices in the Region. Integrated management of the Programme Budget guided all processes; however, achievement of uniform and consistent management processes could be facilitated by a programme management information system operating throughout the Regional Office as well as all of the country offices.

40. To address these issues, the main strategy was staff capacity-building in programme management, including use of the Activity Management System (AMS). Tools and reference materials were developed for use as training packages. As a result, WHO country offices reported increased capacity to deliver WHO programmes. AMS was deployed in all country offices and the Regional Office through training sessions and installation of the updated version of AMS 3.0. With global private network connectivity, joint planning and interaction between country offices and the Regional Office effectively contributed to planning processes in the WHO African Region.

41. Training and on-going support to programme officers at both country and Regional Office level had an impact on programme planning, implementation, monitoring and reporting. During the biennium, training missions to countries resulted in wider use and acceptance of the AMS. This was especially evident during the preparation of workplans for 2006-2007. There was also increased AMS use by a broader group of administrative staff: while the target group was normally programme officers, this quickly grew to include administrative officers, administrative assistants and secretaries. This expansion has boosted the programme management process, and the experience will be used to introduce the Global Management System in the African Region.

42. Lessons learnt from this biennial experience include the fact that performance measurement and monitoring tools are yet to be part of the Organization's culture. This issue justifies sustained training or refresher courses for regional and country staff in daily operations of the results-based management approach, and such training should be conducted in intercountry workshops rather than during country missions.

Research Policy and Promotion (RPC)

43. Global research efforts produced knowledge that underpinned the health revolution of the twentieth century. Advances in knowledge, however, have not benefited countries in the African Region to the full extent possible. Research is not yet considered a real priority area and remained underfunded in the biennium. About 25% of health-related studies in countries are not subjected to some form of ethics review, nor are research findings utilized to boost health development.

44. The main objectives during the biennium were to foster a favourable research environment to support equitable health research; build up and strengthen research capability at country and regional levels; leverage WHO collaborating centres and the African Advisory Committee for Health Research and Development to support countries in developing health research policies and strategic plans, national coordination networking mechanisms, and bioethics review committees.

45. Algeria and Cape Verde were financially supported to conduct national workshops for updating national health research policies and plans. In addition, three pilot countries (Kenya, Malawi and Tanzania) implementing the Country Cooperation Strategy developed plans for information systems, evidence and research policy. Four new WHO collaborating centres were designated while seven were re-designated. A regional consultation on health research to achieve the millennium development goals was held in Brazzaville, Republic of Congo, in April 2004. The twenty-second meeting of the African Advisory Committee for Health Research and Development was held in October 2004. Countries were provided initial support from the European and Developing Countries Clinical Trials Partnership which held its first forum in Rome, Italy.

46. One lesson learnt was that achievement of health research results requires active participation from Regional Office divisions, countries and WHO collaborating centres. The focus should continue to be on achievement of the millennium development goals in countries.

47. Key orientations for the 2006-2007 biennium will be to promote dialogue between producers and users of research, and create demand for research to inform policy decisions; sensitize governments to allocate at least 2% of national health budgets to health research according to the Mexico Summit recommendations; decentralize WHO budgetary funds to country level while continuing to allocate sufficient resources at regional level for orientation, strategic support and facilitation of coherence between the three levels of WHO; and improve the impact of WHO collaborating centres.

Health Information Management and Dissemination (IMD)

48. In the health sector, information enriches and guides health workers, policy-makers, and the general public. It is a major tool in health promotion, and in disease prevention and control. Unfortunately, good, reliable and up-to-date information is not easily accessible, even when it exists. Obstacles to accessibility include poor communication, cost and the nature of the information to be conveyed.

49. The Health Information Management and Dissemination area of work is responsible for editing, translating, printing, disseminating and conserving all documentation produced in the Regional Office. It is the responsibility of WHO to provide timely evidence-based health and biomedical information for use by Member States, partners, staff and the general public.

50. During the period under review, all documents for the fifty-fourth and fifty-fifth sessions of the Regional Committee were edited, translated and sent to Member States in the three working languages of the Region. Upgrading of equipment in the Publication and Language Services Unit was completed, although staffing remained inadequate. At the same time, more manuals, handbooks, guidelines and training modules were published for use in the countries. More than 130 titles were published in all three languages (English, French and Portuguese), over 80 of them in 2005. Of particular importance were the 45 Country Cooperation Strategy documents which define the new framework for cooperation between Member States and their partners.



51. The Regional Office continued to work with the Special Programme for Research and Training in Tropical Diseases (headquarters) and the Forum for African Medical Editors to promote research, publishing and medical journals in the countries. Three training workshops were held for more than sixty medical editors from various countries in the Region.

52. The Regional Office library started to digitalize its holdings using AFROLIB which now has 1700 bibliographic entries. The opening of the library multi-media centre with 12 workstations has greatly eased user access to the Internet for bibliographic sources. The *African Index Medicus* was revived and now disseminates health and biomedical information. It is fully accessible on the Internet. The library continues to publish the monthly bulletin *Infodigest* and to support health districts through the well-established Blue Trunk Library by training health workers to use it to best advantage.

53. Collaboration with the Association for Health Information and Libraries in Africa continues, with training being intensified in country offices. There are plans to launch a global virtual library with the assistance of WHO headquarters. The Health InterNetwork Access to Research Initiative continues to benefit many institutions in the Region that cannot afford expensive subscriptions to good scholarly journals.

HEALTH SYSTEMS AND SERVICES DEVELOPMENT

54. The three areas of work of the Division of Health Systems and Services Development are Organization of Health Services, Essential Medicines, and Blood Safety and Clinical Technology. They support countries' initiatives through providing guidelines and tools, building capacity, enhancing health system knowledge databases, improving collaboration with other partners in health sector development, and advocating for strengthening health systems.

55. The health systems in the countries of the African Region continued to experience lack of good stewardship, inadequate financing, human resource crises, and inadequate access to essential medicines and health technology, including access to safe blood. This situation contributed greatly to the prevailing poor health indicators, a major challenge to the achievement of the millennium development goals and other agreed health development initiatives. In response, countries continued to undertake health reforms to promote universal access and improve the performance of health

systems. Consequently, they requested Regional Office technical guidance and support aimed at strengthening their health systems.

Organization of Health Services (OSD)

56. Guidelines were developed in a collaborative approach within WHO and availed to countries for use in formulating their national health policies and plans as well as operationalizing district health systems. Four countries (Burundi, Comoros, Gabon and Mauritania) developed their national health policies while Central African Republic, Madagascar and Swaziland reviewed their policies. Four countries (Burundi, Central African Republic, Ethiopia and Kenya) developed or reviewed their health strategic plans. Ghana reviewed the health plan of work for 2004, and Democratic Republic of Congo started health sector reforms.

57. Chad, Madagascar and Senegal formulated national policies for contracting of health services, while Burkina Faso embarked on developing a similar policy. Madagascar and Uganda are developing national hospital policies and Cameroon developed a strategic plan for strengthening hospitals.

58. A major focus was on building capacity of both WHO staff and key staff in countries to enable them to effectively carry out their work in health systems development. Two meetings were held: one for directors of medical services and secretaries general of health, and another for national programme officers.

59. Ten countries,¹ following the assessment of the operability of health districts, identified critical areas for improving service delivery and used the results to inform implementation plans. Madagascar improved the performance of 19 health districts through capacity building. Guinea produced training modules for district health management.

60. Ghana, Kenya and Zambia embarked on national social insurance development to establish alternative financing mechanisms for health care. National health account situation analyses were undertaken in Botswana, Namibia and Seychelles, while training was done in Chad, Ghana, Madagascar and Swaziland.

61. Ten countries² strengthened national health information by assessing their systems, developing policy and plan documents, and reviewing their health information collecting tools. The health service availability mapping tool was implemented in six countries³ to monitor and scale up health programmes. Twenty countries⁴ were funded by the Health Metrics Network for technical and catalytic financial support that enabled them to assess their national health information systems, develop plans, mobilize resources, disseminate and use health information for action, and monitor progress of their health information systems.

62. Human resources for health have gained considerable attention with the World Health Assembly resolution on migration of health workers. There were high-level consultations in Abuja in 2004 and 2005, another in Oslo with key global partners, one stakeholder consultation at the Regional Office in Brazzaville in July 2005, and one consultation of deans of medical schools and professional

¹ Burkina Faso, Cameroon, Republic of Congo, Eritrea, Ethiopia, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe.

² Burkina Faso, Cape Verde, Chad, Comoros, Republic of Congo, Namibia, Nigeria, Seychelles, South Africa, Tanzania (Zanzibar).

³ Ghana, Kenya, Nigeria, Rwanda, Tanzania and Zambia.

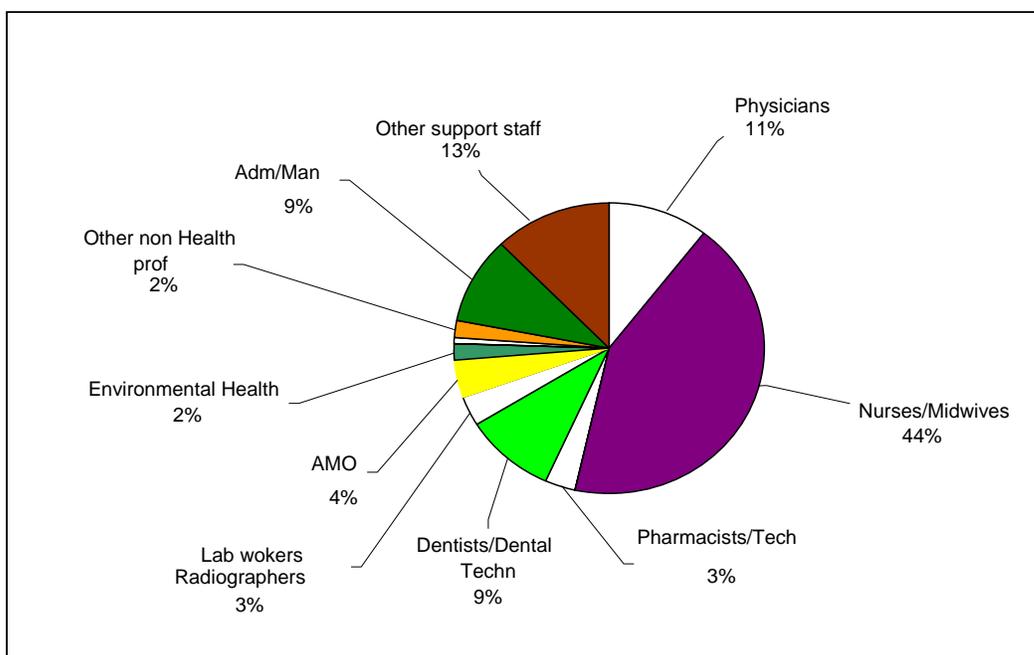
⁴ Benin, Cameroon, Comoros, Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Uganda, Zambia.

boards to determine the next steps for implementing the human resources for health agenda agreed upon in Abuja and Oslo.

63. Three medical schools⁵ and six nursing schools⁶ were evaluated. As a result of this exercise, one medical school produced a strategic plan, and other training institutions proposed reviewing their curricula.

64. Nineteen countries⁷ conducted in-depth situational analyses and reviewed or developed their human resources for health policies and plans. Cameroon was supported to develop an emergency human resources plan and start implementation. Support was provided to all the countries of the Region to assess the composition of the health workforce (see Figure 1). A total of 313 fellowships were awarded during the biennium, and 94.2% were tenable in Africa.

Figure 1: Composition of the health-care workforce in the WHO Africa Region, 2005



Essential Medicines: Access, Quality and Rational Use (EDM)

65. During the biennium, WHO was the implementing agency for the Sierra Leone Pharmaceutical Project funded by the African Development Bank. The project has led to the revision and adoption of the national drug policy and essential drug list, training of nationals in drug management, rational drug use, drug regulation, quality control and rehabilitation of health facilities. A level 1 quality control laboratory was also commissioned.

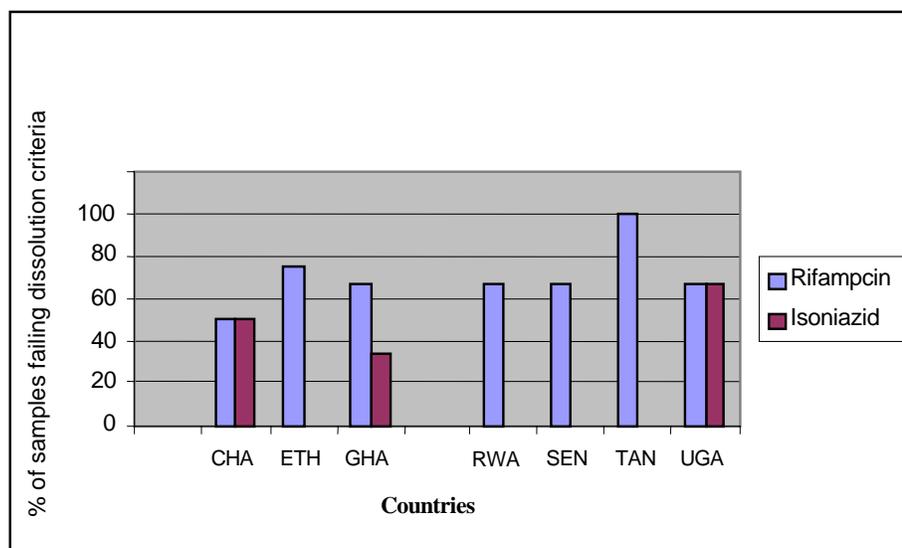
⁵ Faculty of Health Sciences, Ndjamena, Chad; Faculty of Medicine, Conakry, Guinea; Malawi College of Medicine, Blantyre, Malawi.

⁶ Muhimbili Faculty of Nursing, Tanzania; Rwanda School of Nursing; Kwazulu Natal Faculty of Nursing, South Africa; Ghana School of Nursing; Malawi College of Health Sciences; Kamuzu College of Nursing, Malawi.

⁷ Algeria, Botswana, Burkina Faso, Cape Verde, Central African Republic, Chad, Comoros, Ethiopia, Guinea, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Rwanda, Swaziland, Tanzania, Uganda.

66. The circulation of poor quality medicines is one of the main reasons for the development of bacterial resistance to commonly used medicines for treating tuberculosis. To ensure access to high quality medicines, samples of tuberculosis medicines (including rifampicin, isoniazid and combination rifampicin/isoniazid) were collected from seven countries for quality control (Figure 2). The result revealed deficiencies in active ingredients and dissolution profiles of some samples. Discussions with concerned national authorities were held and will continue for developing appropriate regulatory measures to address the problem of poor quality tuberculosis medicines.

Figure 2: Quality control of tuberculosis drugs, selected countries, 2004



Source: WHO/AFRO/EDM

67. Not much is known about the prices people pay for medicines and how these prices are determined from manufacturers and retailers. Using the standard methodology of WHO and Health Action International, the Regional Office organized two workshops on price surveys; subsequently, 13 countries in the Region were supported to undertake medicine price surveys. Findings of the surveys indicated that there is lack of consistency in the pricing of medicines within countries; large price variations exist for the same brand or generic entity within and between the private and public sectors; in some countries, there were significant price variations among public sector facilities. On the basis of the evidence gathered, countries were supported to organize national stakeholders' workshops. Appropriate interventions will be sought to lower medicine prices (policy, regulatory controls and advocacy) for individual countries and the Region.

68. An assessment of the situation of local production of traditional medicines was undertaken in seven countries⁸ in collaboration with the African Union Commission. It was noted that marketing authorizations have been issued for small-scale local production of traditional medicines for diabetes (Madagascar and Nigeria); HIV/AIDS (Democratic Republic of Congo); malaria (Burkina Faso, Democratic Republic of Congo, Ghana and Mali); sickle-cell anaemia (Benin, Burkina Faso and Nigeria); and hypertension (Nigeria).

⁸ Burkina Faso, Democratic Republic of Congo, Ghana, Madagascar, Nigeria, South Africa and Tanzania.

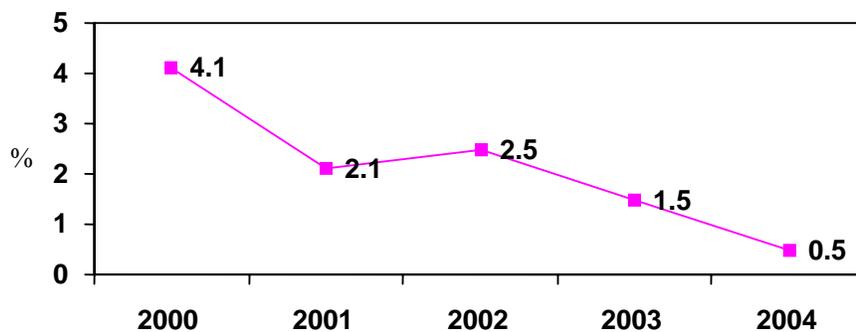
Blood Safety and Clinical Technology (BCT)

69. Seven additional countries⁹ were supported to develop national blood policies or implementation plans. As a result of policy development undertaken since the year 2000, 27 countries have engaged in the establishment of nationally coordinated blood programmes. The total number of blood units collected in the Region has increased from 2 070 000 in 2002 to 2 128 000 in 2004, and the number of countries collecting 100% of blood from voluntary donors increased from 10 to 12 during the same period. One of the countries in which significant progress was made in blood collection is Côte d'Ivoire where the number of units of blood collected increased from 77 972 in 2004 to 95 418 in 2005.

70. Two training workshops on quality management and one on quality audit were organized. Following the training, 23 countries appointed national quality managers. Eight countries established quality management programmes and 21 partially implemented their quality systems.

71. The screening for transfusion transmissible infections has improved with 90% of countries reporting 100% screening for HIV in 2004 against 86% of countries in 2002, and screening for hepatitis C was 54% in 2004 against 27% in 2002. A specific example of improvement in blood safety is demonstrated in Bobo Dioulasso, Burkina Faso, where HIV prevalence in blood collected dropped from 4.1% in 2000, to 2.5% in 2002 and 0.5% in 2004 as a result of WHO technical support (Figure 3).

Figure 3: HIV prevalence in blood units collected in Bobo Dioulasso, Burkina Faso, 2000-2004



Source: *Centre de transfusion de Bobo Dioulasso, Burkina Faso*

72. A regional quality assessment scheme for blood group serology was run by the National Blood Transfusion Service of Abidjan, Côte d'Ivoire, in which 21 countries participated. Corrective measures were taken in countries with low performance. An essential laboratory technology package was developed and implemented in two district hospitals in Republic of Congo. A telemedicine feasibility study was conducted in Benin. A centre of excellence in radiology was established in Yaounde, Cameroon, for west and central Africa.

HIV/AIDS, TUBERCULOSIS AND MALARIA

73. During the biennium 2004-2005, WHO's action to fight HIV and AIDS, tuberculosis and malaria focused on many activities. These included technical support to countries for adapting

⁹ Ethiopia, Lesotho, Madagascar, Mali, Namibia, Rwanda, and Tanzania (Zanzibar).

policies and tools, mobilization of technical and financial resources; scaling up access to care and treatment; strengthening partnerships at regional, subregional and national levels; support for the implementation and expansion of directly-observed treatment short-course in countries; strengthening country capacity to rapidly scale up access to sustainable, high-quality and cost-effective interventions; promotion of operational research; and strengthening laboratory techniques for vaccine research.

74. During the fifty-fifth session, the WHO Regional Committee for Africa passed resolutions on tuberculosis control, acceleration of HIV prevention efforts and declaring 2006 the Year for Acceleration of HIV Prevention in the African Region.

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV)

75. HIV prevalence continues to increase in most countries, indicating that prevention efforts are not making the required impact; hence, there is a need for intensified HIV prevention in the African Region. Access to care and treatment, including antiretroviral therapy (ART), in resource-limited countries has been limited, with less than 1% accessing ART at the end of 2002. Inadequate human resources and funding, weak health systems and poor coordination of stakeholders' efforts have limited implementation of interventions. To address this, WHO declared the lack of access to treatment an emergency and mobilized governments and partners to put 3 million people on ART by the end of 2005. Recognizing the importance of HIV/AIDS as a disease and the damage it is doing to the economic and social fabric of African society, it was decided to make 2006 the Year for Acceleration of HIV Prevention. WHO took the lead in forming an alliance with seven other United Nations agencies to formulate a joint plan and carry the programme forward.

76. WHO's response focused on normative guidance, technical support to countries for adapting policies and tools, capacity strengthening and mobilizing technical and financial resources. Partnerships were strengthened at regional, subregional and national levels with United Nations agencies, key stakeholders, nongovernmental organizations and associations of persons living with HIV/AIDS.

77. Main achievements at regional and country levels included efforts to scale up access to care and treatment. The result was that an estimated 800 000 people, representing about 20% of those in need, received ART by December 2005. Botswana, Namibia and Uganda achieved their 50% targets. Fourteen countries have HIV counselling and testing in over 50% of districts; 29 countries expanded their ART plans, 14 with a human resources component. Two knowledge hubs and a technical resource network were established to support countries in capacity-building.

78. Briefings on Integrated Management of Adolescent and Adult Illness were held in 25 countries, and 17 have adapted modules on the approach; 19 countries were supported to adapt policies and strategies to strengthen care for TB and HIV; 18 countries developed or adapted therapeutic home care guidelines while 19 countries adopted policies for using non-health workers in home care. A training package on prevention of maternal-to-child transmission was developed and 87 trainers were trained in adapting the package. The network of experts in sexually-transmitted infections was briefed on the new strategy, and five countries were supported to implement it. A total of 29 countries developed laboratory plans, allowing mobilization of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Multisectoral AIDS Programme (of the World Bank). A total of 13 countries were supported to strengthen antiretroviral drug quality control systems; 25 countries were

supported to develop Round 4 and 5 proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

79. Ten countries assessed their HIV surveillance systems and developed or updated protocols. The WHO African Region 2005 Update on HIV/AIDS Epidemiological Surveillance was produced. HIV prevention acceleration strategy and guidelines were developed, and 22 countries were strengthened in laboratory techniques for vaccine research and development.

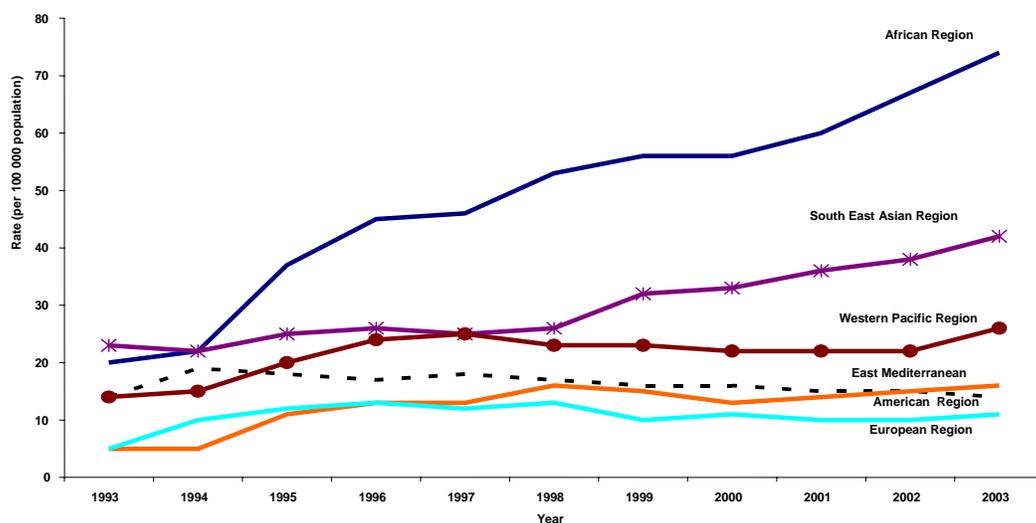
80. Lessons learnt were that government commitment and leadership are important for mobilizing national resources and sustaining programmes. Provision of ART in resource-limited settings is feasible through standardization, simplification and decentralization. Linking treatment and prevention can produce synergy for comprehensive response to HIV/AIDS.

81. For the 2006-2007 biennium, HIV prevention efforts will be accelerated. The emphasis will be on achieving universal access to prevention, treatment and care. The strategic information base will also be strengthened to direct evidence-based interventions. Partnerships will be strengthened at all levels to increase collaboration outside the health sector.

Tuberculosis (TUB)

82. Since the late 1980s, tuberculosis incidence has risen significantly in the African Region, largely fuelled by the HIV/AIDS epidemic. At the beginning of the biennium 2004-2005, the Region had the highest prevalence rates of TB cases, and the highest TB notification rates¹⁰ in the world (Figure 4).

Figure 4: Trend of new smear-positive TB notification rates by WHO Region, 1993-2003



83. The majority of countries adapted the recommended directly-observed treatment short-course (DOTS) and made progress towards the World Health Assembly targets: to detect 70% of smear-

¹⁰ Global tuberculosis control: surveillance, planning, financing, Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.349).

positive TB cases and successfully cure 85% of them by 2005. However, success was still low with 46% detection and 70% cure. In addition, population coverage was still low, TB laboratory networks were underdeveloped, and the capacity of health systems to cope with the increased cases was inadequate.

84. WHO's response focused on support for DOTS implementation and expansion in countries, partnership building, implementing DOTS initiatives such as community TB care and public-private partnerships in TB control, scaling up collaborative TB/HIV interventions, and strengthening surveillance systems. Technical support to countries for resource mobilization and programme monitoring was also emphasized.

85. The main achievement was that virtually all countries are implementing DOTS programmes; 22 countries expanded DOTS to communities and 17 increased TB/HIV interventions. Over thirty countries secured TB grants from the Global Fund, and 33 countries secured free anti-TB drugs from the Global Drug Facility of the Stop TB Partnership. Although still low, case detection and treatment success rates have risen from 46% to 50% and 70% to 73%, respectively. Eight countries¹¹ attained treatment success rates of 80% or higher, and 11 countries¹² reached or exceeded the 70% cases detection rate for new smear-positive cases. In August 2005, the fifty-fifth session of the WHO Regional Committee for Africa declared TB an emergency in the Region, affirming commitment to combat the epidemic.

86. One lesson learnt is that scaling up of DOTS expansion initiatives is the key to rapid expansion of DOTS services in general. TB laboratory services must be concurrently decentralized as part of DOTS roll-out strategies. TB/HIV interventions should be incorporated in existing interventions to rapidly scale up coverage.

87. The focus during the 2006-2007 biennium will be on promoting universal access to quality DOTS services. This will include rapid scaling up of DOTS expansion initiatives, especially public-private partnerships and community TB care initiatives in all 34 high-burden TB countries in the Region, TB/HIV interventions, promotion of quality assurance schemes for TB bacteriology, advocacy, community mobilization, resource mobilization, and enhanced surveillance and monitoring.

Malaria (MAL)

88. The impact of malaria is greatest on impoverished and disadvantaged communities, and access to cost-effective interventions remains low due to high cost and weak delivery systems. Increased political commitment and partnership resulted in development of the framework for combating malaria to meet the Abuja and millennium development goal targets for 2005, 2010 and 2015.

89. During the 2004-2005 biennium, strategic approaches to malaria control aimed to strengthen country capacity to rapidly scale up access to sustainable, high-quality and cost-effective interventions and promote operational research. Main achievements included supporting 25 countries¹³ to change treatment policy to artemisinin-based combination therapy (ACT) as well as the development and dissemination of guidelines on combination therapy in Africa. Case management training manuals

¹¹ Algeria, Benin, Comoros, Eritrea, Mauritius, Sierra Leone, Tanzania and Zambia.

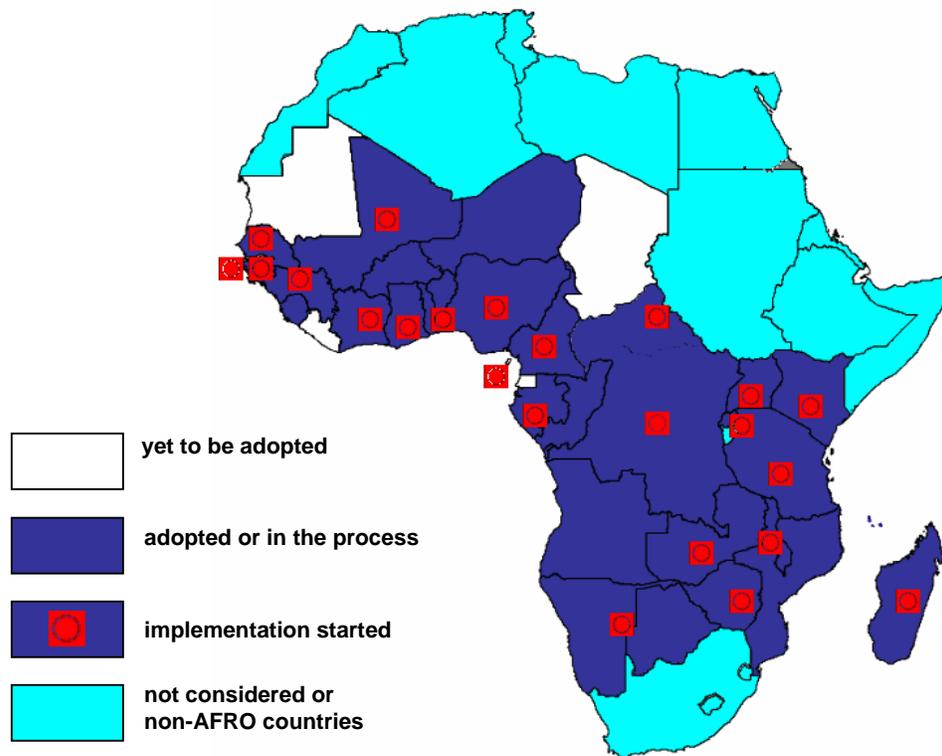
¹² Algeria, Angola, Benin, Cameroon, Gabon, Gambia, Guinea-Bissau, Lesotho, Madagascar, Namibia, and South Africa.

¹³ Angola, Benin, Burkina Faso, Cameroon, Chad, Republic of Congo, Côte d'Ivoire, Democratic Republic of Congo, Gambia, Ghana, Guinea-Bissau, Ethiopia, Kenya, Liberia, Madagascar, Mali, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Togo and Uganda.

were updated in 13 countries¹⁴ and pharmacovigilance on ACT was strengthened in Tanzania (Zanzibar) and Zambia. Surveys to assess ACT implementation were conducted in Burundi, Rwanda, Tanzania and Zambia.

90. Four countries (Ghana, Madagascar, Nigeria and Zambia) introduced home-based malaria management, and demonstration projects were evaluated in Ethiopia, Kenya and Rwanda. The Regional Office supported 19 countries to adopt and 11 countries to implement intermittent preventive treatment for pregnant women. Among the 30 countries that have adopted intermittent preventive treatment, two have attained the Abuja targets (Malawi 60% coverage and Zambia 68% coverage) according to selected district surveys (Figure 5).

Figure 5: Intermittent preventive treatment for pregnant women in the WHO African Region, 2005



Source: Ministries of health

91. Expanded community-based intervention strategies were developed in 19 countries¹⁵ and training modules for traditional health practitioners were piloted. Research on traditional medicines for malaria was supported in Kenya, Mozambique and Zambia, and mosquito-repellent plant

¹⁴ Benin, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Madagascar, Mali, Niger, Sao Tome and Principe, Sierra Leone, South Africa, Uganda and Tanzania.

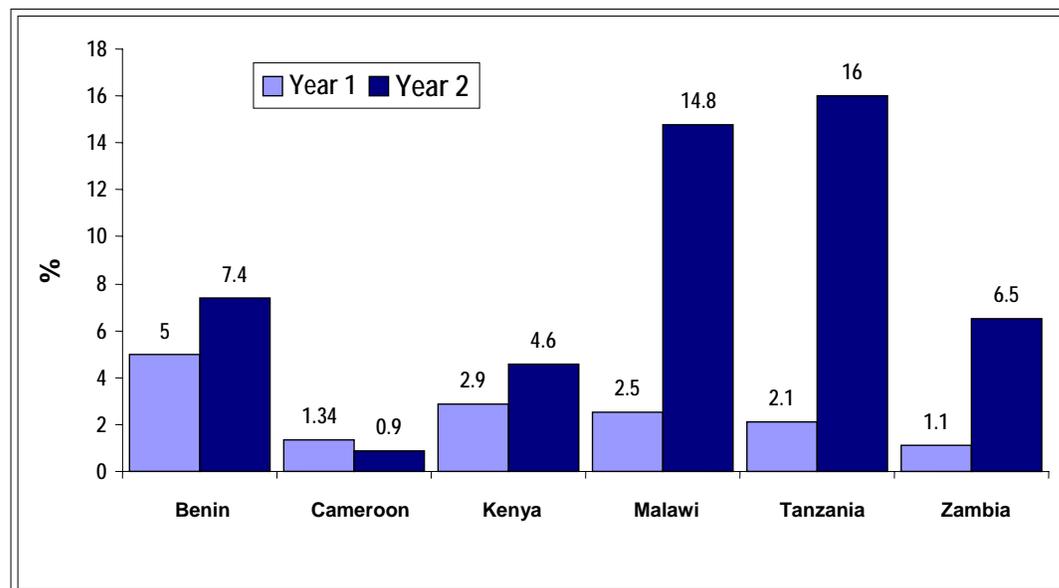
¹⁵ Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Republic of Congo, Côte d'Ivoire, Eritrea, Gabon, Ghana, Gambia, Guinea, Mali, Mauritania, Mozambique, Niger, Sierra Leone, Togo, Zimbabwe.

evaluations continued in Ethiopia and Kenya. Six countries¹⁶ were supported to train traditional health practitioners and traditional birth attendants for malaria control; traditional birth attendants in Kenya and Uganda were supported to provide intermittent preventive treatment for pregnant women and antenatal care.

92. A progress report on implementation of the Abuja Declaration Plan of Action identified considerable obstacles to meeting targets. Six countries¹⁷ were supported to strengthen routine monitoring and evaluation, and five countries (Angola, Burundi, Malawi, Senegal and Zambia) were facilitated with monitoring and evaluation for the Global Fund.

93. The Regional Office developed a standardized insecticide-resistance monitoring protocol, updated and disseminated guidelines for vector-resistance management, and supported Angola and Zimbabwe to adapt DDT guidelines. Thirteen countries¹⁸ were supported to scale up indoor residual spraying; they achieved 80% to 90% coverage and significantly reduced malaria cases. At the same time, effective coverage of insecticide-treated nets increased towards the Abuja targets due to increased resources and improved delivery through immunization services and antenatal clinics. Eritrea and Togo have reached the targets with 63% coverage. Progress continues in additional countries (Figure 6).

Figure 6: Proportion of children under five years sleeping under an ITN, selected countries



Sources: MICS and DHS Surveys; MICS: Multiple Indicator Cluster Survey; DHS: Demographic and Health Survey; Benin: MICS 1999 & DHS 2001; Cameroon: MICS 2000 & DHS 2004; Kenya: MICS 2000 & DHS 2003; Malawi: DHS 2000 & DHS 2004; Tanzania: DHS 1999 & DHS 2004; Zambia: MICS 1999 & DHS 2002/2003

94. One lesson learnt is that proactivity by WHO and partners as well as an increased resource base is essential for scaling up activities. In addition, integrated delivery of child survival interventions provides impetus for increased coverage.

¹⁶ Benin, Cameroon, Kenya, Mozambique, Niger, Uganda.

¹⁷ Burundi, Cameroon, Eritrea, Liberia, Senegal and Zimbabwe.

¹⁸ Angola, Botswana, Eritrea, Ethiopia, Madagascar, Mozambique, Namibia, Sao Tome & Principe, South Africa, Swaziland, Uganda, Zambia and Zimbabwe.

95. The major orientations for the 2006-2007 biennium will be to support equitable delivery of comprehensive and complementary packages of interventions; target vulnerable groups; facilitate the flow of resources to operational levels in countries; support country capacity-building efforts in programme management and delivery, and monitoring and evaluation. The Regional Office will collaborate with countries and partners to strengthen health systems to support scaling up interventions through mechanisms such as public-private partnerships.

PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

96. Control of communicable diseases is possible because effective control strategies and tools are available. The WHO Regional Office provided technical support to countries in using these strategies and tools to reduce morbidity and mortality. Substantive achievements in the control of communicable diseases have been recorded during the biennium 2004-2005. Although several major outbreaks occurred, the regional capacity for epidemic response has strengthened, with the Regional Office providing technical support to affected countries within the shortest possible time.

Communicable Disease Surveillance (CSR)

97. Although the existing national communicable disease surveillance systems in most Member States have improved with the implementation of the Integrated Diseases Surveillance and Response (IDSR), there is still room for improvement in providing information for prompt detection of epidemics, monitoring disease trends and assessing the impact of preventive and control interventions. The emergence of new diseases such as avian and human influenza due to the H5N1 virus remains a threat. In the African Region, countries are ill prepared. The revised *International Health Regulations (2005)* adopted by the Fifty-eighth World Health Assembly in May 2005 offers an opportunity to scale up national disease surveillance and response systems.

98. During the biennium under review, WHO responded by giving support to Member States to strengthen national capacities in terms of human resources, laboratories, data management, reporting, epidemic response, and monitoring of IDSR implementation feedback and training. Achievements included regular production of priority communicable disease trends for publication in the monthly *Communicable Disease Epidemiological Report* and the quarterly *Communicable Disease Bulletin*.

99. Five new countries embarked on Integrated Disease Surveillance and Response; thus, 43 Member States assessed their surveillance and response systems and prepared strategic plans to address any detected issues. Twenty-one countries reached the target of training health workers in charge of IDSR in at least 60% of their districts. Introduction of IDSR in national training institutions for mid level health personnel started in several countries. In collaboration with IDSR partners and countries, key operational research projects are being jointly implemented.

100. Timely technical support was provided to countries confronted with major epidemics such as cholera, meningitis, Ebola viral haemorrhagic fever, Marburg haemorrhagic fever, yellow fever, plague, typhoid fever and viral hepatitis E. Support was also provided to Member States to strengthen their national response capacity through training of national rapid response teams. In 2005, about 60% of outbreaks occurring in the African Region received response within 48 hours. A regional ad hoc expert panel and working group on pandemic influenza supported countries in the development of pandemic preparedness and response plans for the highly pathogenic avian influenza virus.

101. WHO supported the establishment of a regional network of laboratories to support Member States in their preparedness and response to major epidemics and pandemics. All major outbreaks that occurred in 2004 and 2005 were laboratory-confirmed through this laboratory network. The regional external quality assessment in bacteriology was extended to cover all national public health bacteriology reference laboratories; 69 laboratories are currently participating in this programme. Delegates of 40 Member States contributed actively to the adoption of the revised *International Health Regulations 2005* by the Fifty-eighth World Health Assembly.

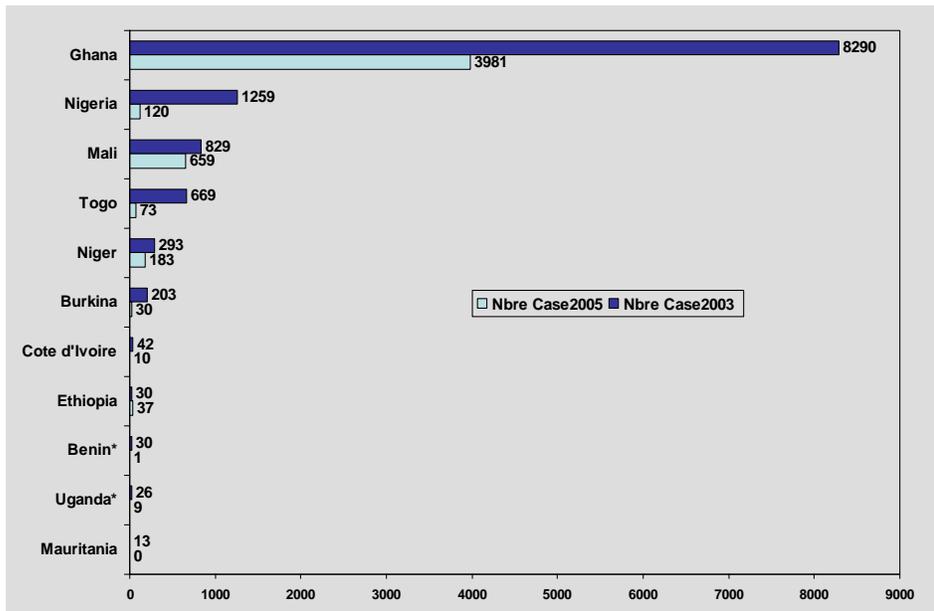
102. Lessons learnt were that countries that have made remarkable progress in the implementation of IDSR are those that have mobilized internal resources and attracted external financial resources. Availability of resources for supporting critical areas of surveillance has helped countries to progress quickly.

Communicable Disease Prevention, Eradication and Control (CPC)

103. The diseases targeted in the Communicable Disease Prevention, Eradication and Control area of work are known to affect mostly poor and neglected segments of the population. These diseases are usually given low profile in most affected Member countries. The main thrust of WHO response was to provide technical support to affected countries to build national capacity; develop appropriate strategies and plans of action to fight disease; monitor and evaluate control interventions; and conduct advocacy activities.

104. The incidence of guinea-worm disease decreased from 11 882 cases in 2003 to 5103 cases in 2005; this represents a 57% reduction in the biennium 2004-2005. Figure 7 shows the trend of the disease by country. Local transmission of the disease was interrupted in Benin, Mauritania and Uganda during the biennium.

Figure 7: Trend of guinea-worm disease incidence, WHO African Region, 2004-2005



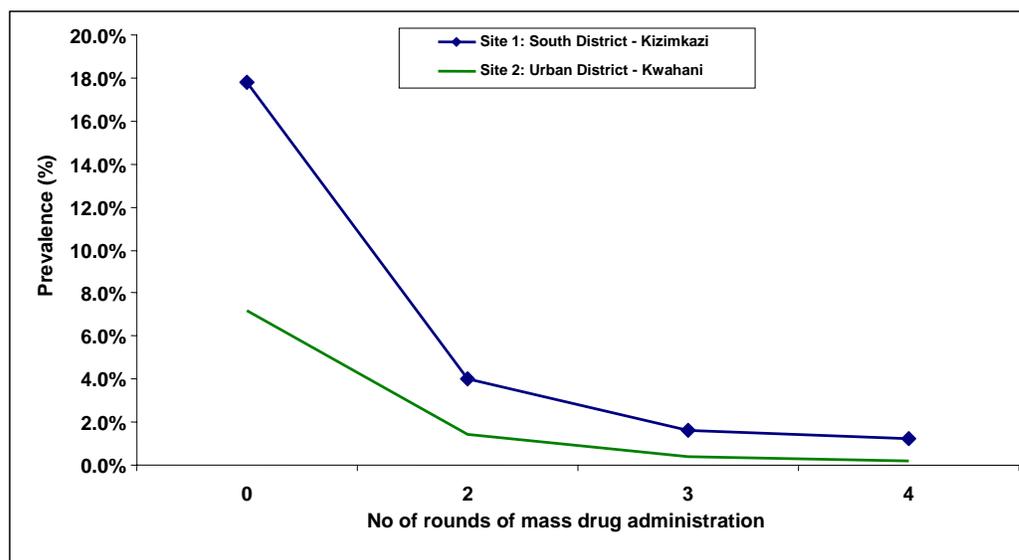
All cases notified in Benin and Uganda, in 2005 were imported.

105. In the leprosy programme, the elimination goal of 0.69 cases per 10 000 population was consolidated at regional level. Of the 46 countries, 38 achieved or consolidated their leprosy elimination goal at national level.

106. An additional seven countries¹⁹ (18% of the total endemic countries) commenced lymphatic filariasis elimination activities during the biennium. The cumulative population at risk in the 20 countries where disease mapping was completed was approximately 148.5 million (72%) out of a total population of 205.3 million. The number of people covered under mass drug administration increased by 4.0 million from 2003 to 2004 when the number treated was 20.3 million. Dramatic reduction in microfilariae prevalence (indication of interruption of transmission) has been achieved in some programmes where at least three consecutive rounds of annual treatments were sustained (Figure 8).

¹⁹ Cape Verde, Guinea, Guinea-Bissau, Liberia, Madagascar, Mozambique and Sierra Leone.

Figure 8: Microfilariae prevalence in two sentinel sites under mass drug administration, Tanzania, 2001-2004



Source: Ministry of Health, 2005

107. Situation analysis and initiation or scaling up human African trypanosomiasis case detection in priority areas were conducted in more than 20 of the 30 endemic countries. All 20 countries were supplied with drugs for case management. As a result, in 2004, 3 million people at risk were examined and 17 000 new cases were detected and treated; in 2005, 1.5 million people were examined and 7000 new cases were detected and treated.

108. All 10 confirmed Buruli ulcer endemic countries of the Region started case management with combined antibiotic treatment (rifampicin-streptomycin). Training modules on Buruli ulcer control programme management were finalized for distribution to all affected countries (10 confirmed endemic and 12 potentially endemic countries).

109. Commitment for controlling schistosomiasis and soil-transmitted helminths gained momentum, with countries either launching national worm control programmes or linking deworming activities with Child Health Days or vaccination campaigns. During the biennium, eight countries²⁰ launched national programmes and five countries (Angola, Burundi, Cape Verde, Guinea-Bissau and Rwanda) initiated or conducted disease assessment.

110. The Regional Office consolidated vector control through the integrated vector management approach. National capacity was strengthened in 12 countries, and guidelines and training modules were developed for use by countries.

111. Lessons learnt were that community participation is critical in achieving and sustaining the expected results; synergies between programmes can help reduce costs; and countries commit themselves to implementing disease control programmes if strong advocacy is conducted and the necessary support provided.

²⁰ Burkina Faso, Cameroon, Lesotho, Mali, Mozambique, Niger, Tanzania and Zambia.

112. For the 2006-2007 biennium, support will be provided to countries to ensure full implementation of the Geneva Declaration on the final phase of dracunculiasis eradication; eliminate leprosy at national level in all countries; complete the mapping of lymphatic filariasis; build or strengthen partnerships for sustainable programme implementation; implement the WHA resolution on Buruli ulcer surveillance and control and develop a Buruli ulcer control strategy for the Region; implement the Regional Committee resolutions on human African trypanosomiasis; and intensify and accelerate school deworming programmes.

Immunization and Vaccines Development (IVD)

113. In the biennium 2004-2005, the key issues for the Immunization and Vaccines Development area of work included increasing vaccinations to achieve over 80% coverage for DTP3 in more than 80% of districts; interrupting wild poliovirus transmission; reducing measles mortality; and introducing new vaccines.

114. WHO supported all countries in the Region to improve their routine immunization performance through the implementation of the Reach Every District approach. Particular focus was on technical and financial support to Angola, Democratic Republic of Congo, Ethiopia and Nigeria. Intensive support for immunization systems focused on logistics, communications, training needs assessment, and training for mid-level managers in the Expanded Programme on Immunization. More than 72% of the countries are now implementing this approach successfully. By November 2005, 67% of the districts had DTP3 coverage above 80% as compared to 49% during the previous biennium.

115. WHO provided technical assistance for data collection and monitoring, and conducted training in data quality self-assessment to assist countries to improve their data reporting. An additional 12 countries in the Region were supported to introduce new vaccines for hepatitis B and *Haemophilus influenzae* type b; of the 36 countries eligible, 30 are now part of the Global Alliance for Vaccines and Immunization.

116. Polio eradication efforts received intensive advocacy, programme, communications, logistics and systems support in the biennium. The remaining polio-endemic countries, those that experienced wild poliovirus transmission, and high-risk polio-free countries were supported to implement supplemental immunization activities (SIAs); all had coverage results above 90%. By December 2005, confirmed polio cases had declined by 11% compared to 2004 (i.e. 840 polio cases in eight countries in 2005 compared to 944 polio cases in 12 countries during the same period in 2004). In 2005, there was an almost 95% reduction in confirmed polio cases in the five countries (Burkina Faso, Central African Republic, Chad, Cote d'Ivoire and Mali) that had re-established polio transmission in 2004. While 38 countries in the Region achieved and sustained certification standard acute flaccid paralysis surveillance in 2005, polio-free documentation was accepted by the African Regional Certification Commission from nine countries.²¹

117. A total of 24 countries were supported to conduct measles SIAs to provide second opportunities for measles immunization, reaching a total of 104 million children. All except three of the targeted countries reported coverage of more than 90%. As of September 2005, 29 countries in the Region were implementing case-based surveillance for measles. The rate of confirmed measles cases was 0.6 and 0.43 per 100 000 population for the Region in 2004 and 2005, respectively. Most of the reported measles outbreaks, though small in size, were thoroughly investigated and subsequently attributed to low routine immunization coverage following SIAs.

²¹ Botswana, Gambia, Kenya, Lesotho, Malawi, Rwanda, Senegal, Swaziland and Zambia.

118. Tetanus toxoid SIAs in selected high-risk districts of 17 countries reached more than 8 million women of child-bearing age. Elimination of maternal and neonatal tetanus was validated in 16 countries at the end of 2005. However, the quality of neonatal tetanus surveillance remained low.

119. The routine vaccination activities and disease control efforts were highly successful owing to the strong partnerships at global, regional and country levels as well as the high degree of political commitment, early technical preparations and intensive monitoring of activities. Polio officers in all countries were actively involved in supporting routine EPI activities, and the 2004-2005 biennium had increased funding for routine immunization activities.

120. The Regional Yellow Fever Strategic Plan was endorsed in 2004. Stockpiles from the Global Alliance for Vaccines and Immunization were used to conduct preventive vaccination campaigns in a few countries. However, the shortage of laboratory reagents and the lack of funding for preventive and outbreak response vaccination activities posed major challenges for yellow fever control.

121. In the 2006-2007 biennium, countries will continue to receive support to sustain the gains made through high routine immunization coverage. Sustained advocacy efforts are needed to ensure that routine EPI activities are adequately financed. Capacity-building efforts will continue to maintain high quality disease surveillance. Advocacy will be important to ensure continued government and partner commitment to polio eradication and accelerated disease control efforts.

Research and Product Development for Communicable Diseases (CRD)

122. Some of the infectious diseases faced by Africa today lack effective diagnostic, preventive or treatment options. In addition, some of the available tools and strategies are showing signs of fatigue (e.g. development of drug resistance) due to many factors. The Research and Product Development area of work, therefore, focused on building capacities in the countries of the Region for planning, implementing and evaluating operational research projects so that data generated can be translated into action. Support was also given to the development and evaluation of new products (medicines, vaccines, diagnostics), particularly for diseases that afflict poor and marginalized populations.

123. WHO's response has been to build local capacity in disease-endemic countries for conducting research and transforming it into action for better health for all. The approach has been to build partnerships and network with disease-control, research and development communities.

124. In the 2004-2005 biennium, the Regional Office collaborated with partners to strengthen research capacity in 22 countries where 41 projects were implemented. A priority operational research agenda in Integrated Disease Surveillance and Response was developed that included cost and cost-effectiveness of IDSR; assessment and validation of performance of a latex test for *Neisseria meningitidis* W135 identification in the field; and risk factors for high mortality in meningococcal meningitis in the Sahel.

125. The in vivo monitoring of therapeutic efficacy of antimalarial medicines continued and now covers 41 of the 42 malaria-endemic countries of the Region with a total of 188 sentinel sites. Because of evidence-based data, 25 countries adopted artemisinin-based combination therapy for treatment of malaria as a response to high resistance to monotherapies. This was an example of knowledge and research findings being translated into policy and practice. The regional database on

therapeutic efficacy of antimalarial drugs was updated and provided a basis for the global drug resistance report recently published by headquarters.²²

126. The operational plan for integration of communicable disease interventions at national and district levels was piloted in four countries. Integration may be an effective strategy for scaling up coverage of cost-effective interventions.

127. A lesson learnt was that implementation of a composite operational research workplan is dependant on a good coordination mechanism.

128. For the 2006-2007 biennium, focus will be on building and sustaining local health research capacity for tackling the challenges of scaling up delivery of effective interventions through partnerships and linkages between national programmes, research institutions, and bilateral and multilateral research initiatives. Focus will be on the generation of new knowledge and tools, intervention methods and implementation approaches using advocacy for research and products especially oriented towards the poor.

PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

129. Noncommunicable diseases (NCDs) represent major challenges to global development worldwide. In the African Region, the situation is compounded by the challenges posed by infectious diseases and poverty. As information becomes available, it is becoming clear that the African Region faces a higher noncommunicable disease burden than most other regions in the world. Prevalence of risk factors for NCDs is very high, with 30% of the population in most countries at risk of high blood pressure and from tobacco use (Table 1). It is possible to control NCDs by controlling population exposure to risk factors.

130. Violence, injuries and disabilities were on the rise during the 2004-2005 biennium. The road traffic death rate in the African Region was 28 per 100 000 population compared to 20 per 100 000 population in other low-income areas. Mental and neurological disorders as well as substance abuse rose, affecting especially those living in poverty or in emergency situations. Health promotion offered the opportunity to address social determinants of health by empowering individuals and communities to take action to improve their health.

Surveillance, Prevention and Management of Noncommunicable Diseases (NCD)

131. The major issue in this area of work is that the real magnitude of noncommunicable diseases in the African Region is not known, and the potential for their prevention is not well understood. NCDs are not given the priority they deserve. Most countries do not have a national NCD programme; surveillance systems are almost nonexistent; and the scarce resources available are almost exclusively used to treat established cases.

132. The most prominent NCDs are cardiovascular disease, cancer, diabetes and chronic respiratory disease, and they are linked by common preventable behavioural risk factors. The main risk factors are unhealthy diet, tobacco use, lack of physical activity and excessive alcohol consumption. During the biennium, the WHO Regional Office responded by providing support to countries to set up surveillance systems for NCDs using cancer registries and the stepwise approach to

²² WHO, Susceptibility of *Plasmodium falciparum* to antimalarial drugs: Report on global monitoring 1996-2004, Geneva, World Health Organization, 2005 (WHO/HTM/MAL/2005.1103).

risk factors (STEPS); integrate the most important NCDs into existing surveillance systems for communicable diseases; and develop national NCD and oral health programmes using data arising from STEPS surveys and other sources.

133. A total of 40 participants from 16 countries²³ were trained in conducting surveys on NCD risk factors. Ten countries²⁴ completed the survey of risk factors for NCD and five countries (Botswana, Comoros, Ghana, Namibia and Uganda) prepared to undertake it. Heads of NCD units from the five countries were trained in the use of data arising from STEPS to prepare national NCD programmes; STEPS focal persons were also trained in data management, including preparation of the report for advocacy and information to the general public.

134. Participants from 13 countries²⁵ were informed about the concrete activities pertaining to NCD prevention and control in Mauritius; they then drafted national plans for the primary prevention of NCD in their countries. More than 30 000 women were screened for cervical cancer in WHO reference centres in Angola, Guinea and Tanzania and in national centres supported by WHO in six countries.²⁶

Table 1: Prevalence (%) of risk factors for cardiovascular disease, selected countries, 2005

	Mauritius	Algeria	Republic of Congo	Eritrea	Cameroon
Tobacco use	20.20	12.8	14.4	8	4
Alcohol use	15.9	5.1	62.5	39.6	11
Obesity	11.5	16.4	8.6	3.3	18
Elevated blood pressure	29.6	29.1	32.5	16	25
Elevated blood sugar	19.5	2.9	-	-	6

135. Two international meetings on advocacy for control of sickle-cell disease were held and produced declarations that were widely disseminated in the Region. InfoBase, a database on NCD risk factors, was made available to Member countries. The network of African NCD initiative was reinforced with the creation of a collaborative workspace web site allowing the exchange of experiences between countries.

136. A regional conference on oral health was organized with the World Dental Federation and attended by delegates from 57 countries (18 from the African Region); participants adopted a programme for oral disease prevention and control in Africa. The NOMA programme was strengthened in Benin, Burkina Faso, Mali and Niger and set up in Democratic Republic of Congo, Lesotho, Uganda and Zambia with contributions from the Winds of Hope Foundation.

²³ Algeria, Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Gabon, Guinea, Mali, Niger, Sao Tome and Principe, and Togo.

²⁴ Algeria, Cameroon, Republic of Congo, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Mauritius, Mozambique and Seychelles.

²⁵ Cameroon, Republic of Congo, Gabon, Kenya, Lesotho, Madagascar, Mauritius, Mozambique, Rwanda, Seychelles, Tanzania, Uganda and Zimbabwe.

²⁶ Algeria, Republic of Congo, Mali, Mauritania, Mauritius and Zimbabwe.

137. During the 2006-2007 biennium, the WHO Regional Office will continue to support countries to undertake STEPS surveys and use data for advocacy and action; undertake research on the socioeconomic implications of NCDs to make them relevant outside the health sector; and prioritize primary prevention interventions.

Mental Health and Substance Abuse (MNH)

138. The portion of the global burden of disease attributable to mental, neurological and substance use disorders is growing especially in the African Region where families and communities are faced with poverty, natural disasters, conflict situations, displacement and the consequences of chronic diseases such as HIV/AIDS. In the biennium under review, the WHO Regional Office responded by supporting countries to develop and update national policies and programmes for implementing, at community level, activities on management of disorders related to mental health and substance abuse.

139. Six countries²⁷ prepared reports on the situation regarding the human rights of people suffering from mental and neurological disorders and substance abuse; appropriate strategies were developed and further improved during an intercountry meeting. These are to be implemented at country level.

140. Legal and mental health experts from 16 countries²⁸ were trained to develop or review mental health legislation based on WHO tools and regional and international human rights standard rules. These experts are now providing support to their own countries as well as others that want to review or develop mental health legislation.

141. Namibia launched a mental health policy, Lesotho and Gambia reached the final stages, and Central African Republic and Mauritania completed the consultation stage. A total of 24 professionals from 12 countries²⁹ were trained to design and conduct studies for the management of alcohol and illicit drugs abuse, a major public health problem in the Region, especially among youth.

142. Guinea undertook a special initiative to provide mental health services among displaced populations from Guinea-Bissau, Cote d'Ivoire, Liberia and Sierra Leone. Due to the increasing number of people suffering from epilepsy, a workshop was organized for reinforcing skills and capacity of medical officers, nurses and social workers to improve diagnosis, treatment and psychosocial rehabilitation. The report entitled *Epilepsy in the African Region: bridging the gap* was published and disseminated. All 46 countries in the African Region contributed data for the *Mental Health Atlas 2005*; 18 countries contributed to the *Atlas on Child and Adolescent Mental Health Resources 2005*; and 36 countries contributed to the *Atlas of Epilepsy Care in the World 2005*. These reports were published and distributed.

143. Lessons learnt were that successful results depend on realistic indicators, availability of funds, commitment and training of human resources, good collaboration and joint preparation of activities orientated towards the main needs of different population groups, especially the most vulnerable.

144. For 2006-2007, the WHO Regional Office will identify focal points in the ministries of health for better management of mental health and substance abuse issues; negotiate for additional voluntary funds to implement the planned activities; finalize the translation of tools and guidelines into WHO

²⁷ Algeria, Benin, Cape Verde, Namibia, Nigeria and Zimbabwe.

²⁸ Angola, Benin, Cameroon, Cape Verde, Republic of Congo, Democratic Republic of Congo, Ghana, Mali, Mauritania, Mozambique, Rwanda, Senegal, South Africa, Togo, Zambia and Zimbabwe.

²⁹ Algeria, Benin, Burundi, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Gabon, Guinea, Madagascar, Mali, Senegal.

working languages; and strengthen the mental health team at regional level.

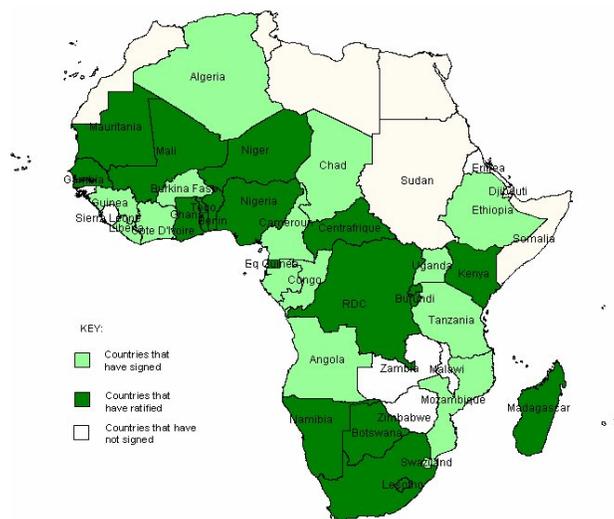
Tobacco (TOB)

145. WHO's first global treaty, the Framework Convention on Tobacco Control (FCTC), was adopted at the Fifty-sixth World Health Assembly in May 2003. The adoption of the Convention marked the beginning of a new phase in building an effective international legal system to counter the increasing use of tobacco globally. The Convention entered into force on 27 February 2005 and became binding law for the 115 contracting parties, including 22 Member States of the African Region. A major challenge is to continue to build awareness and political support for ratification or accession of the Convention by Member States as well as national capacity for implementation. This next phase will require close collaboration with Member States.

146. In the African Region, WHO responded by assisting countries in strengthening national capacities for advocacy to support ratification and in preparation for implementation of the FCTC. Technical support was also provided to strengthen capacity of research coordinators in tobacco survey methods.

147. Response to the FCTC was favourable in the WHO African Region. After participation in advocacy meetings presenting evidence on the dangers of tobacco, 39 Member countries in the Region signed the Convention. All countries participated in the four subregional awareness-raising and capacity-building workshops; thereafter, 22 countries ratified or acceded to the Convention by December 2005 (Figure 9).

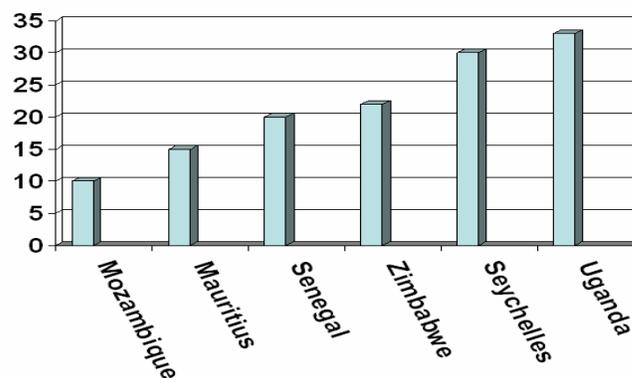
Figure 9: Status of ratification of the Framework Convention on Tobacco Control in the African Region, 2005



148. Six countries drafted tobacco control bills, and 20 drafted national plans of action on tobacco control. Some countries enforced tobacco control based on this legislation. Nongovernmental organizations from nine countries were trained in advocacy for tobacco control. Support was also provided to NGOs to initiate advocacy activities for support of FCTC at country level.

149. During the 2004-2005 biennium, participants from 28 countries were trained in administering the Global Youth Tobacco Survey and the Global School Personnel Survey. Results from 25 countries which completed the surveys show prevalence rates for tobacco use that range from 10% in Mozambique to 33% in Uganda (Figure 10). The findings from the tobacco survey were used by countries in planning, developing, implementing and evaluating their comprehensive tobacco control programmes. Innovative research for tobacco control in the Region was promoted and initiated. The first such study on tobacco and poverty in the African Region was initiated in Nigeria in November 2005.

Figure 10: Prevalence levels (%) of tobacco use among 13–15-year-olds, selected countries, 2004



150. One lesson learnt was that it is important for countries to allocate more Regular budget funds for tobacco control activities because availability of funds from other sources is not guaranteed. Also, good communication with all levels is a key to increase visibility of the programme and achieve positive results. Collaboration and integration of activities with other programmes require re-enforcement.

151. During the 2006-2007 biennium, WHO will continue to explore ways of mobilizing further resources to enable implementation of activities planned under the Framework Convention on Tobacco Control.

Health promotion (HPR)

152. Increasing urbanization, demographic, environmental and other changes stimulated by globalization of markets and communications, and complex emergencies require approaches that deal with the broader determinants of health. The WHO report, *Reducing risks, promoting healthy life* (2002), documented major risks, such as poor diet and nutrition, tobacco use, excessive alcohol consumption, physical inactivity, poor hygiene, lack of safety and unsafe sex, reducible through health promotion.

153. During the biennium, the Regional Office took guidance from the Regional Health Promotion Strategy. Contributions were made to strengthening capacity, developing policies, generating

evidence for health promotion, promoting intersectoral action and integrated approaches, raising awareness about determinants of health, and increasing community participation and partnerships.

154. Capacity for health promotion was boosted through training of multisectoral teams and NGOs representing 15 countries³⁰ on addressing the broad determinants of health. A team approach was used to ensure more involvement from non-health sectors. Following the training, five countries (Burkina Faso, Cameroon, Lesotho, Rwanda, and Seychelles) expanded implementation of health promotion. During the biennium, six countries³¹ started developing national health promotion policies, while five countries (Cameroon, Democratic Republic of Congo, Malawi, Kenya and Tanzania) reviewed existing health promotion documents. Nigeria introduced a health promotion course based on the regional strategy and guidelines.

155. Community participation in six WHO priority programmes³² was enhanced through orientation of national HP focal persons from 40 countries on implementation of a package of integrated activities at community level, set to start in 2006. Integrated implementation should result in efficiency and improved impact of interventions. Joint support was provided to interventions in Benin and Zambia based on the school as a setting for addressing noncommunicable diseases, besides developing general healthy behaviours among youth. The initiative enables a wide range of actors to collaborate in implementing comprehensive health promotion.

156. Model health promotion projects were implemented in countries such as South Africa where community-level interventions for addressing noncommunicable diseases were supported. Communities were mobilized to work with various sectors to prevent or control selected noncommunicable diseases. Likewise, implementation of APADOC was supported in Namibia, Mozambique and Zimbabwe. APADOC uses health promotion methods to build alliances between adolescents, parents and communities for the prevention of HIV/AIDS and related problems through integrated risk management.

157. Building of strategic health promotion partnerships continued through collaboration with Education International, resulting in implementation of school-based HIV/AIDS prevention projects in 15 countries.³³ Ministries of health and education supported teachers and pupils to implement activities. WHO provided training and materials for the projects. Collaboration with HelpAge International progressed, focusing on activities relating to active ageing in Ethiopia, Tanzania, Zambia and Zimbabwe. The collaboration is in line with a strategy on ageing developed by the African Union with WHO.

158. Evidence for health promotion was generated in 16 countries³⁴ through research on factors that constitute health risks to school children. Some of the study results are being used for planning interventions, for example in Zambia and Zimbabwe.

159. During the 2006-2007 biennium, the WHO Regional Office will focus on consolidating health promotion in priority programmes.

³⁰ Angola, Burkina Faso, Cameroon, Ethiopia, Gabon, Guinea-Bissau, Liberia, Malawi, Mauritania, Namibia, Seychelles, Swaziland, Tanzania, Togo and Uganda.

³¹ Eritrea, Lesotho, Nigeria, Rwanda, Senegal and Seychelles.

³² IMCI, RPA, MAL, TUB, VPD, and CSR.

³³ Botswana, Burkina Faso, Cote d'Ivoire, Guinea, Lesotho, Malawi, Mali, Namibia, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

³⁴ Angola, Botswana, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Mozambique, Namibia, Rwanda, Senegal, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

Injuries and Disabilities (INJ)

160. The most important causes of unintentional injuries are road traffic crashes, drowning, falls and burns. Injuries from armed conflict, interpersonal violence (including the use of firearms, and other forms of youth and urban violence) gender-based violence, suicide and attempted suicide, and violence against children remain high. Disabilities, including blindness, are a serious problem. The inadequate response to these challenges within countries is linked to the lack of capacity and poorly defined or absent policy frameworks.

161. During the 2004-2005 biennium, the WHO responded by providing assistance to governments and their partners to develop and implement cost-effective and gender-sensitive strategies to prevent and control injuries and disabilities, and to support communities in the rehabilitation of those that suffer medium- or long-term disability.

162. *The World Report on Road Traffic Injury Prevention* was successfully launched in six countries,³⁵ and World Health Day 2004 on Road Safety was commemorated with national events in all Member States. Several countries launched national level interventions to reduce road traffic fatalities and injuries.

163. A comprehensive report was produced on blindness control programmes, and resources were put in place to initiate the programme at regional level. A regional meeting on the Standard Rules for the Equalization of Opportunities of Persons with Disabilities was held. Another meeting brought together senior ministry of health personnel from 14 countries to discuss programming for the prevention and control of injuries and violence.

164. Some countries have tightened legislation affecting traffic safety (e.g. Algeria, Kenya, Rwanda and Uganda), others have increased traffic law enforcement (e.g. Benin, Cameroon, South Africa), while yet others have strengthened information systems (e.g. Ethiopia and Ghana). Some Member States (e.g. Kenya and South Africa) have reported reduced rates of traffic crashes.

165. Lessons learnt show that joint projects such as those with the African Union need careful and advanced planning to ensure the same programme objectives and to avoid contradictions at implementation stage.

166. During 2006-2007, WHO will assist Member States to work on the systematic implementation of effective interventions such as enforcement of traffic speed limits, banning drink-driving, and use of seat belts and bike helmets.

FAMILY AND REPRODUCTIVE HEALTH

167. During the 2004-2005 biennium, the WHO Regional Office for Africa assisted Member States towards attaining Millennium Development Goals (MDGs) 3, 4 and 5 by improving maternal, newborn, child and adolescent health; tackling the deadly triad of HIV/AIDS, tuberculosis and malaria in women; managing common causes of childhood illness and mortality, gender-based violence and harmful traditional practices; improving access to quality health services by women and men of all ages; and improving nutritional status of all family members. During 2005, the Integrated Management of Childhood Illness (IMCI) team from Harare joined the Division of Family and Reproductive Health in Brazzaville; also, Nutrition was constituted as an area of work.

³⁵ Kenya, Mozambique, Namibia, Nigeria, Tanzania, South Africa.

Child and Adolescent Health (CAH)

168. In the African Region, over 12 000 children aged 0-5 years die every day from preventable or treatable causes. Six diseases account for over 70% of these deaths. In some countries, as many as 80% of those who die are never cared for by health workers, and significant numbers of those who seek care succumb as a result of poor quality care. Newborns remain the forgotten children of Africa, with their deaths considered as “normal”. Adolescents continue to be victims of HIV, substance abuse, and unprotected sex resulting in teenage pregnancy, unsafe abortion, sexually-transmitted diseases and death.

169. In the biennium, WHO responded to this situation by promoting the continuum of care spanning from pregnancy and child birth to childhood. It also ensured that the continuum of care covered the home (through empowering families), the community (through improving primary care facilities and bringing care closer to the home), and referral health facilities.

170. The Integrated Management of Childhood Illness (IMCI) is one of the key child survival strategies in the African Region. (Figures 11 and 12 show progress in IMCI implementation during the last two biennia.) Among the 46 countries in the Region, 44 implemented the IMCI strategy by the end of 2005. Other achievements in Child and Adolescent Health during the biennium included the following: 12 countries³⁶ attained 50% IMCI coverage at district level; 11 countries³⁷ developed Community-IMCI national plans and four countries (Burkina Faso, Burundi, Guinea and Niger) developed Community-IMCI district plans, increasing the number of countries with national and district plans to 28 and 20, respectively; six countries³⁸ introduced IMCI pre-service teaching, increasing the number of countries with pre-service IMCI training to 23; seven countries³⁹ initiated or finalized child health strategies and policies. A regional child survival consultation was conducted simultaneously with the Reproductive Health Task Force meeting to share countries’ experiences and demonstrate continuum of care.

Figure 11: Status of IMCI implementation, WHO African Region, 2002-2003

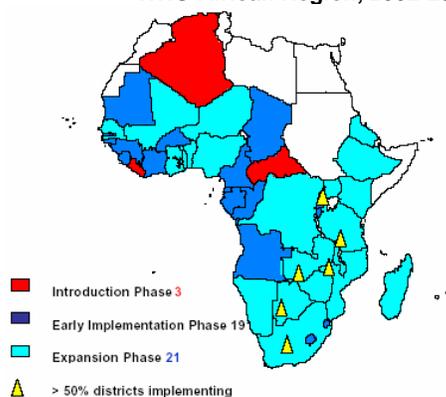
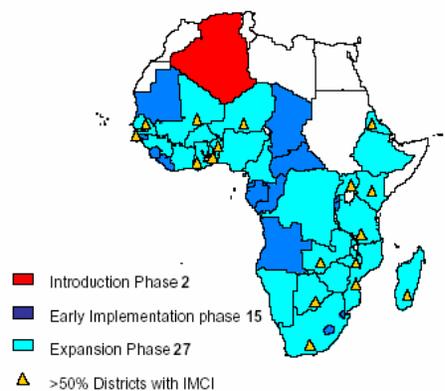


Figure 12: Status of IMCI implementation, 2004-2005



³⁶ Botswana, Gambia, Lesotho, Madagascar, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia.

³⁷ Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Ghana, Kenya, Lesotho, Madagascar, Nigeria, Rwanda.

³⁸ Botswana, Burkina Faso, Eritrea, Gambia, Guinea, Swaziland.

³⁹ Democratic Republic of Congo, Ethiopia, Madagascar, Mozambique, Nigeria, Tanzania and Zambia.

171. Three IMCI health facility surveys were conducted in Malawi, Mozambique and Niger. Improvement in health workers' knowledge and skills in managing childhood illnesses was observed. Regional and subregional staff capacity was built for proposal development, resource mobilization, rights-based planning, and adolescent health programme implementation. Community-based newborn health assessment studies were initiated in Tanzania and Zambia to design evidence-based newborn health strategy. The Alliance of Parents, Adolescents and the Community approach was introduced in eight countries⁴⁰ and strengthened in 11 countries.⁴¹

172. The lesson learnt is that WHO has a catalytic role in facilitating government stewardship and leadership in health; both partners are crucial for ensuring sustainability.

173. For the biennium 2006-2007, WHO will continue its advocacy to mobilize partners around the common goal of child mortality reduction. In addition, it will support countries to form maternal, newborn and child health forums that will promote continuum of care; and strengthen community level delivery of services to increase access and coverage.

Research and Programme Development in Reproductive Health (RHR)

174. Weak research and programme management capacity, inadequate information on national reproductive health status and ineffective family planning programmes constrain delivery of reproductive health services in the African Region. Reproductive system cancer, especially cervical cancer, and sexually-transmitted infections, including HIV/AIDS, are on the increase. Inadequate access to and use of effective contraceptives resulting in a low contraceptive prevalence rate of 13% for married women, a high total fertility rate of 5.5 children per woman, and high rates of unwanted pregnancies contribute to unsafe abortions and maternal deaths.

175. During the 2004-2005 biennium, the WHO Regional Office aimed at strengthening the capacity of countries to conduct reproductive health research, document and share best practices, train reproductive health providers, build and strengthen partnerships for effective reproductive health programmes, including family planning.

176. There were several achievements in the biennium. The Effective Care Research Unit in East London, South Africa was assessed and proposed as a WHO collaborating centre. Nationals from seven countries,⁴² including the WHO country office focal persons, were trained in conducting operational research. The Regional Office supported the creation of a regional reproductive health and HIV/AIDS research and training network. Eight Member countries⁴³ participated in the Global Survey on Maternal and Perinatal Health.

177. A 10-year framework for repositioning family planning was developed and adopted at the fifty-fourth session of the WHO Regional Committee for Africa; it was subsequently disseminated to countries. To operationalize this framework, a regional conference involving 23 countries⁴⁴ and partners was organized, following which national action plans were developed, and a network of

⁴⁰ Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, Togo.

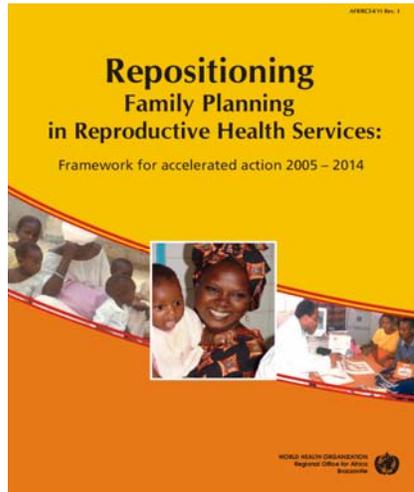
⁴¹ Botswana, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Swaziland, Tanzania, Zambia and Zimbabwe.

⁴² Benin, Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal.

⁴³ Algeria, Angola, Democratic Republic of Congo, Ethiopia, Kenya, Niger, Nigeria and Uganda.

⁴⁴ Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Democratic Republic of Congo, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone and Togo.

African women from 17 countries⁴⁵ was created to promote family planning. The WHO and United Nations Population Fund Strategic Partnership Programme was launched to improve the quality of family planning and sexually-transmitted infection services. Global generic family planning guidelines were updated and used by nine countries.⁴⁶ Medical eligibility criteria guidelines were translated into Portuguese and printed. A total of 17 countries⁴⁷ were oriented on the use of hormonal contraception in the context of HIV. Cervical cancer screening demonstration projects were initiated in six countries⁴⁸ and follow-up action plans were developed.



178. The Implementing Best Practices initiative was launched for sharing experiences and implementing best practices in reproductive health; 12 countries⁴⁹ participated and five (Ethiopia, Kenya, Tanzania, Uganda, Zambia) started implementing activities. An information document, “Reproductive cloning of human beings: Current situation”, was developed and presented at the fifty-fifth session of the Regional Committee. A formative research protocol in maternal and newborn care at community level protocol was developed and implementation started.

179. The Mauritius Institute of Health was supported to review and update curriculum for reproductive health training. The advocacy kit, *Guidelines on contraceptives logistics management*, and a medical eligibility criteria wheel were developed for repositioning family planning. A total of 44 countries were oriented on the evidence-based reproductive health care approach and use of the WHO Reproductive Health Library; 90 master trainers were trained on this approach. The Regional Office collaborated in the development of the West African Health Organization regional strategy on commodity security.

180. Lessons learnt included the fact that there is need to integrate family planning into maternal and child health services. Partnerships improve the impact of support given to countries. Support should be given to countries to document and scale up best practices, and to conduct operations research.

⁴⁵ Benin, Burkina Faso, Cameroon, Chad, Côte d’Ivoire, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo and Tunisia.

⁴⁶ Benin, Cameroon, Mozambique, Nigeria, Rwanda, South Africa, Tanzania (including Zanzibar), Zambia and Zimbabwe.

⁴⁷ Angola, Botswana, Burkina Faso, Cameroon, Central African Republic, Cote d’Ivoire, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

⁴⁸ Madagascar, Malawi, Nigeria, Tanzania, Uganda, Zambia.

⁴⁹ The main participating countries were Ethiopia, Kenya, Tanzania, Uganda and Zambia; while Benin, Cameroon, Mozambique, Nigeria, Rwanda, South Africa and Zimbabwe were observers.

Making Pregnancy Safer (MPS)

181. High maternal and newborn morbidity and mortality continue to prevail in most countries of the African Region. Malaria and HIV/AIDS constitute the leading indirect causes of morbidity and mortality in pregnant women. Less than 50% of deliveries are attended by skilled birth attendants.

182. In the biennium under review, the WHO Regional Office supported countries in the development and implementation of the “Road Map to accelerate the attainment of the millennium development goals related to maternal and newborn health”. It aims to increase the availability of and access to quality skilled care and empower individuals and communities for improved maternal and newborn health.

183. There were notable achievements. Fifteen partners accepted the Road Map and 18 countries⁵⁰ developed and are implementing national Road Maps. A core of 20 experts were trained to provide technical assistance to countries for the development and implementation of country-specific Road Maps. A total of 21 countries⁵¹ reached consensus on minimum midwifery competencies and developed plans of action to strengthen skilled care to address the poor quality of maternal health care and increase the availability of skilled attendants.

184. Midwifery tutors and instructors from eight countries⁵² were oriented on the assessment of midwifery education and practice. The results will form the basis for curricula revisions. Competency-based emergency obstetric care was integrated into pre-service midwifery training curricula in Nigeria, Tanzania and Uganda. In Nigeria, 54 midwifery tutors and instructors from midwifery schools in 25 states received competency-based training in emergency obstetric care. A total of 80 health professionals in 16 countries⁵³ were trained in maternal death review methodologies, bringing the total to 120 professionals trained in 24 countries. National plans for the institutionalization of maternal death reviews were also developed. The fourth Regional Reproductive Health Task Force meeting in 2005 included a special session on newborn health to promote continuum of care, i.e. care from pregnancy, through child birth and postpartum period and from the community to health facility. Key outputs of the meeting were the revised regional tool for integration of maternal, newborn and child health programmes and services, and expansion of the Task Force to include newborn and child health.

185. Programme managers in 24 countries were oriented in scaling up prevention of mother-to-child transmission (PMTCT) and increasing access to antiretroviral therapy. Subsequently, Cameroon, Côte d’Ivoire, Malawi and Rwanda reviewed their national PMTCT plans. A total of 87 health professionals in 15 countries⁵⁴ were oriented in the adaptation of the WHO generic PMTCT training package. Development of national PMTCT training curricula and adaptation of national curricula with roll-out plans were undertaken in six countries.⁵⁵ The roll-out of PMTCT in Zambia and psychosocial support in HIV-infected pregnant women and families in Zimbabwe were documented as best practices. Improved access to care, treatment and support for HIV-infected mothers and babies was

⁵⁰ Burundi, Cameroon, Central African Republic, Comoros, Côte d’Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Lesotho, Madagascar, Malawi, Niger, Togo, Zambia, and Zimbabwe.

⁵¹ Benin, Burkina Faso, Cote d’Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Lesotho, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, South Africa, Tanzania, Togo, Uganda, and Zimbabwe.

⁵² Ethiopia, Gambia, Ghana, Liberia, Malawi, Nigeria, Sierra Leone, Tanzania.

⁵³ Benin, Burkina Faso, Côte d’Ivoire, Ethiopia, Gambia, Ghana, Guinea, Liberia, Malawi, Mali, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Togo.

⁵⁴ Botswana, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, New Sudan, New Sudan/SPLM, Swaziland, Tanzania, Uganda, Zambia.

⁵⁵ Ethiopia, Kenya, Mozambique, Namibia, Uganda and Tanzania (Zanzibar).

observed in Cameroon, Lesotho, Namibia and Zimbabwe.

186. Reproductive health policies and programmes were reviewed in six countries⁵⁶ to strengthen the Malaria in Pregnancy component. A total of 35 programme managers were trained in the development of an integrated plan of action for prevention and management of malaria in pregnancy in eight countries.⁵⁷ Fifteen experts from 12 countries⁵⁸ were trained to integrate malaria in pregnancy into maternal, neonatal and child health services.

187. For the 2006-2007 biennium, strong partnerships will be promoted for a comprehensive approach within and outside WHO and will include involvement of communities. Coordinated support will be provided to countries in the implementation of the Road Map and for scaling up key interventions for maternal, neonatal and child health.

Women's Health (WMH)

188. Sexual and gender-based violence, practice of female genital mutilation (FGM), gender inequity, poverty and weak earning capacity of women are major impediments to improved women's health.

189. During the 2004-2005 biennium, the WHO Regional Office was committed to support countries in the implementation of the women's health strategy and the Regional Committee resolution AFR/RC53/R4 for the attainment of the millennium development goals. WHO, UNICEF, United Nations Population Fund and the Inter-African Committee signed a letter of intent to promote the elimination of all forms of female genital mutilation and other harmful practices, and strengthen interagency collaboration and coordination.

190. The Regional Office provided technical support to the Democratic Republic of Congo, Liberia and Uganda to train health professionals in the prevention and management of sexual and gender-based violence. A study was conducted on the quality and responsiveness of health services to meet the needs of women facing the "Triple Threat" crisis in Botswana, Lesotho, Malawi, Swaziland, and Zambia: the Triple Threat being described as poverty and food insecurity, weakened governance capacity, and HIV/AIDS prevalence.

191. In order to promote institutionalization of gender across all sectors, WHO provided technical support to the Ministry of Health Uganda to develop a plan of action and establish the National Health Sector Gender Team which was later supported to conduct a stakeholders' meeting. The first issue of the *Gender and Health Newsletter* was produced. Following a consultation of gender and women's health focal persons from five countries (Ethiopia, Rwanda, Tanzania, Uganda and Zimbabwe), they were supposed to develop workplans on integrating gender concerns into health policies and programmes. In collaboration with gender and health officers of six regional economic communities,⁵⁹ a joint workplan was developed to reinforce partnerships and synergy for gender integration in health. In collaboration with the WHO Kobe Centre, Japan, gender-sensitive indicators were identified and are being tested in Tanzania.

⁵⁶ Cameroon, Central African Republic, Republic of Congo, Gambia, Mali and Mozambique.

⁵⁷ Cameroon, Central African Republic, Chad, Republic of Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon, Sao Tome and Principe.

⁵⁸ Benin, Burkina Faso, Republic of Congo, Kenya, Malawi, Mozambique, Nigeria, Sao Tome and Principe, Senegal, Togo, Uganda and Zimbabwe.

⁵⁹ West African Health Organization (WAHO); Common Market for Eastern and Southern Africa (COMESA); Economic Community for West African States (ECOWAS); New Partnership for Africa's Development (NEPAD); Economic Commission for Africa (ECA); and African Union.

192. Various achievements were made in the elimination of harmful traditional practices, especially female genital mutilation. Partnerships were consolidated between the Regional Offices of WHO and UNICEF, the African Division of UNFPA, and the Inter African Committee on harmful traditional practices, with a clear definition of roles and responsibilities. The focal point in Burkina Faso was presented a national award for supporting the elimination of FGM. Six countries⁶⁰ integrated prevention and management of FGM into their nursing and midwifery curricula. Advocacy was intensified with the Inter African Parliamentary Group on FGM elimination.

193. One lesson learnt was that WHO's catalytic and leadership roles in health are critical for understanding the complexity of women's health and its importance in achieving the millennium development goals.

194. During the 2006-2007 biennium, continued support will be provided to Member States to roll out the Women's Health Strategy and its resolution; integrate gender into health policies and programmes; and accelerate FGM elimination.

Nutrition (NUT)

195. Malnutrition, a major public health challenge in the African Region, is directly or indirectly associated with over 60% of morbidity and mortality in children 0-5 years of age in Africa. Less than 30% of infants in Africa are exclusively breastfed during the first six months of life; complementary feeding, often nutritionally inadequate, frequently begins too early or too late. Vitamin A, iodine, iron and micronutrient deficiencies occur, especially among children under 5 years, children 6-9 years of age and women of reproductive age. Undernutrition is high in the Region, especially among displaced persons, refugees and people living with HIV/AIDS. Chronic conditions, such as obesity, diabetes, cardiovascular disease and certain diet-related cancer, account for 28% of morbidity and 35% of mortality.

196. In response to the above issues, WHO has developed the Global Strategy on Infant and Young Child Feeding and the Global Strategy on Diet, Physical Activity and Health. At the end of the 2004-2005 biennium, there were major achievements in nutrition in the WHO African Region. Support was provided for the development and implementation of the following policies, strategies and programmes: national policy and plan of action on nutrition in 13 countries;⁶¹ framework on priority action for infant feeding and HIV in 11 countries;⁶² national strategy on infant and young child feeding in nine countries,⁶³ making a total of 21 countries; integrated programme on the control of micronutrient deficiency in Cameroon, Cape Verde and Mauritania; and school feeding programme in Benin and Zambia. Figure 13 shows the increase in the number of countries implementing the Infant and Young Child Feeding strategy.

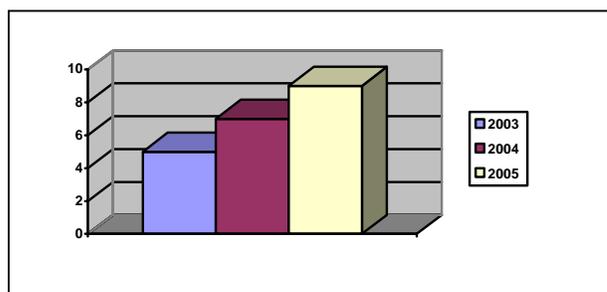
⁶⁰ Burkina Faso, Ethiopia, Ghana, Mali, Nigeria and Tanzania.

⁶¹ Benin, Botswana, Burkina Faso, Burundi, Cameroon, Democratic Republic of Congo, Ghana, Guinea, Namibia, Niger, Nigeria, South Africa, Togo.

⁶² Benin, Burkina Faso, Burundi, Cote d'Ivoire, Democratic Republic of Congo, Gabon, Madagascar, Mali, Niger, Senegal and Togo.

⁶³ Angola, Cape Verde, Democratic Republic of Congo, Gabon, Guinea-Bissau, Mozambique, Nigeria, Sao Tome and Principe, Uganda.

Figure 13: Number of countries implementing Infant and Young Child Feeding strategy, WHO African Region



Source: NUT, WHO Regional Office for Africa

197. The capacity of over 5000 health workers to counsel mothers on breastfeeding and HIV was improved in nine countries,⁶⁴ bringing the total number of countries to 20. The capacity of health workers to manage severe malnutrition was also improved in ten countries.⁶⁵ Development and field testing of new tools included an Infant and Young Child Feeding counselling course, HIV and infant feeding counselling cards, revised Baby Friendly Hospital Initiative tools, and regional nutrition databank with data from 46 countries. The Code of Marketing of Breastmilk Substitute was enacted in Botswana, Cape Verde and Malawi; monitored in Ghana and Nigeria; and drafted in Mozambique and South Africa.

198. Partnerships were strengthened with the African Union, United Nations Children's Fund, Food and Agriculture Organization of the United Nations, European Community Studies Association, West African Health Organization, Helen Keller International, International Baby Food Action Network, United States Agency for International Development, World Food Programme for development of the African Regional Nutrition Strategy. A joint statement was produced from the consultation on nutrition and HIV, and joint funding of country activities was undertaken.

199. One lesson learnt is that it is important to ensure sustainability of activities. Infant and Young Child Feeding and nutrition training activities need to be incorporated in pre-service curricula. Resource mobilization at national and district levels is critical for implementation of activities.

200. During the 2006-2007 biennium, WHO will continue providing support to Member States to develop and implement nutrition policies and strategies to alleviate the effects of malnutrition on children and mothers, including addressing nutritional needs throughout the life-course.

HEALTHY ENVIRONMENTS AND SUSTAINABLE DEVELOPMENT

201. Poverty, conflicts and risks associated with contaminated water and food, poor sanitation and poor environmental conditions are key determinants of health in Africa. In Africa, 340 million people live on less than US\$ 1 a day, while 45% have no access to safe water and adequate sanitation. Diseases associated with poor environmental conditions, unsafe water and food kill one in every five

⁶⁴ Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Eritrea, Gabon, Mali, Niger, Senegal.

⁶⁵ Benin, Burkina Faso, Cote d'Ivoire, Gabon, Guinea, Mali, Mauritania, Niger, Senegal, Togo.

children before age five. This situation, which has negative implications for the achievement of the millennium development goals, is compounded by both natural and man-made emergencies.

202. In the 2004-2005 biennium, the Regional Office responded to these challenges by addressing the determinants of health. The aims were to strengthen the analysis of linkages between poverty and health, and advocate for inclusion of issues relating to poverty as well as long-term strategic thinking in national and regional health development efforts; incorporate effective environmental health in the management of the human environment and in the development of national policies and actions; address the high morbidity and mortality associated with unsafe food; and strengthen national capacity for emergency preparedness and response and provide humanitarian support in crisis situations.

Sustainable Development (HSD)

203. Investing in health, particularly the health of the poor, is central to the achievement of the millennium development goals in the African Region. Good health status, an important goal in its own right, is central to creating and sustaining the capabilities of poor people to escape from poverty. Therefore, the Sustainable Development area of work advocates for all partners in national development to place health at the centre of all development processes and frameworks and to allocate more resources to health.

204. During the period under review, a document⁶⁶ was produced to clarify the linkages between all the current frameworks and initiatives that have a bearing on health and development. These include the millennium development goals, poverty reduction strategy papers, medium-term expenditure frameworks, sectorwide approaches and the New Partnership for Africa's Development. The regional strategy on poverty and health for the African Region was distributed to Member countries and other development partners. Kenya and Mozambique were provided with technical assistance in the preparation of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Kenya was assisted in relation to a proposed national social health insurance scheme. Mozambique was assisted to revise the poverty reduction strategy, including resource estimation. Cape Verde was assisted in the formulation of the health sector medium-term expenditure framework. Ghana was provided with support to finalize and publish the report *Ghana Macroeconomics and Health Initiative* about scaling up health investments for better health. Uganda was assisted to set up a national task force on macroeconomics and health.

205. A situation analysis and perspectives on the health-related millennium development goals was prepared and discussed by health ministers at the fifty-fifth session of the WHO Regional Committee for Africa where a resolution was adopted to guide countries in their efforts to achieve the MDGs. Thirteen countries were brought together to discuss how to tackle the social determinants of health that hinder efforts to achieve the MDGs. Kenya was supported to start the process of working with the Commission on Social Determinants of Health. A paper on health inequalities was also prepared and presented to the fifty-fifth session of the Regional Committee, and ministers of health made recommendations on how the Region should move forward. Contributions were made to the draft guidelines for development of national health policies and plans.

206. These achievements were possible due to the growing recognition and appreciation of the WHO programmes by countries. There is clearly a continuing need to advocate for health as a main

⁶⁶ "Linkages between macro-policy issues (PRSPs, SWAps, MTEFs, CMH) and health policy implementation including health financing".

component of national development and to marshal more resources into the health sector. There is need for more advocacy and technical expertise in the countries and in WHO to mainstream health into the poverty reduction strategy papers, medium-term expenditure framework and other development frameworks and processes.

207. For the 2006–2007 biennium, WHO will continue to provide technical support to countries for health in development in the context of poverty reduction strategy papers, medium-term expenditure frameworks, sectorwide approaches and millennium development goals, and by promoting universal coverage, equity, human rights and the social determinants of health as the main avenues to achieve the MDGs.

Protection of Human Environment (PHE)

208. Environment-related conditions are major contributors to the high disease burden in the African Region. Efforts aimed at environmental improvements and protection could have a positive effect on disease prevention and health improvement. However, most countries of the Region still lack comprehensive policies, regulations and capacities to adequately implement environmental health programmes. To improve these environmental conditions, WHO focused its efforts on facilitating the implementation of the regional strategy on environmental health at country level, through incorporation of effective health dimensions in national development policies and action plans as well as technical support for capacity-building.

209. To take forward the above agenda, several technical guidelines were formulated to guide work at country level. These guidelines concerned environmental and occupational health policy, environmental health hazards mapping, environmental health impact assessment, and healthy settings. Ten countries were supported to undertake reviews or formulate their national environmental health policies.

210. Technical support was also provided to seven countries⁶⁷ to facilitate implementation of health and environment activities. Activities on water and sanitation were strengthened with distribution of tools on participatory hygiene and sanitation transformation. A poisons centre was established in Dakar as a follow-up to a regional workshop for the management of chemicals in which 11 countries participated. Through intercountry and country workshops, policy-makers were sensitized on risks posed by increased air pollution. Situation analyses and training in air pollution monitoring were conducted in Benin, Nigeria and Seychelles.

211. To promote healthy environments for children, national profiles on children's environmental concerns were completed in 13 countries. Children environmental health indicators were piloted in Kenya, and healthy environments for children activities were piloted in four countries. A training workshop was held for health-care providers, and a consultative meeting on children and environmental health was conducted. A settings approach continued to be promoted with provision of technical and financial support to countries for implementation of healthy cities projects in Douala (Cameroon), Kigali (Rwanda), Windhoek (Namibia) and Pointe Noire (Republic of Congo).

212. Advocacy and capacity-building activities for occupational health were undertaken in collaboration with the International Labour Organization. Consolidated country profiles were generated in Kenya, Tanzania and Uganda. A workshop was held in Mauritius on the importance of labour inspection to occupational health safety. Namibia and St Helene were supported in

⁶⁷ Republic of Congo, Gabon, Mali, Mozambique, Rwanda, Sao Tome and Principe, and Togo.

occupational health activities. Dissemination of information was improved, particularly through web sites. Support was given to eight countries to adapt health mapper tools to environmental health hazards mapping, and 16 environmental health officers were trained in these techniques. Two regional collaborating centres were established in South Africa. A four-year strategic plan (2006-2009) was developed to boost progress in the Region, and this will be effectively implemented.

213. During the 2006-2007 biennium, close and continuous interaction between the three levels of the Organization and within the different regional programmes will be facilitated for efficient use of resources and better programme outcomes. Partnerships at all levels will be strengthened to accelerate programme implementation at country level.

Emergency Preparedness and Response (EHA)

214. The occurrence of natural (disasters and epidemic outbreaks) and man-made (war, civil strife) crises results in situations that threaten the lives and well-being of large numbers of people. Within the African Region, over 20 countries are either in crisis or emerging from crisis. About 13 million people are internally displaced. These disasters lead to extreme poverty, unhygienic conditions and health problems.

215. To address the crisis situations, Regional Office activities during the period under review focused on national capacity building, provision of essential technical and material support, production and dissemination of key technical guidelines and publications, and mobilization of funds from other sources to support response activities.

216. Technical support was provided to 20 countries⁶⁸ through ad hoc missions. Support was also provided to the Southern African Development Community Emergency Preparedness and Response Management Committee. To strengthen emergency preparedness and disaster reduction capacities, technical support was provided to Namibia for training in national and provincial emergency management structures for disaster preparedness.

217. With the financial support from the three-year plan, 12 new focal points were recruited for Central African Republic, Chad, Democratic Republic of Congo, Liberia and Uganda as well as for the subregions of west Africa, Great Lakes region and southern Africa. Personnel were also recruited for the Horn of Africa Initiative (Ethiopia, Kenya, Somalia, Sudan, Uganda) to assist in the development and implementation of the plan of action. An induction briefing was organized for new recruits, focal points already in the field and WHO country representatives; it took place in December 2004 in Brazzaville, Republic of Congo with collaboration from headquarters and colleagues from the European and Eastern Mediterranean Regions of WHO. A meeting to share lessons learnt was held in Mombasa, Kenya in October 2005.

218. Material and financial support was provided directly to some countries⁶⁹ for health kits and assessment of ad hoc projects. All the countries involved in the Consolidated Appeal Process received mission or technical support. To reinforce collaboration with key stakeholders and support countries in the mobilization of funds, the Regional Office participated in various meetings. These included a round table for the reconstruction of the health system in Democratic Republic of Congo (Kinshasa);

⁶⁸ Burkina Faso, Burundi, Central African Republic, Chad, Republic of Congo, Democratic Republic of Congo, Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mauritania, Niger, Senegal, Sierra Leone, Swaziland, Zambia and Zimbabwe (Horn of Africa countries were also assisted).

⁶⁹ Burkina Faso, Cote d'Ivoire, Democratic Republic Congo, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Madagascar, Mali, Nigeria, Sierra Leone, Uganda and Zimbabwe.

an international meeting on the reconstruction of Liberia (New York); funds mobilization meetings in Cairo, Copenhagen and Geneva; the Africa Parliamentarian Meeting on Refugees in Africa (Cotonou).

219. Lessons learnt include the fact that the main enabling factors have been effective collaboration and support from the different levels of the Organization, mobilization and effective use of funds from other sources, and commitment of focal points and partners. A main constraint is that most countries do not have skills, structures and means for effective management of crises.

220. During the 2006–2007 biennium, effective collaboration will be fostered to improve results, mobilize more resources, and strengthen preparedness of countries in the Region.

Food Safety (FOS)

221. Resolution AFR/RC53/R5 of the Regional Committee pertains to food safety and guided the work of WHO which addressed the following key issues: limited capacity for food-borne disease surveillance; poor participation of countries in the work of the Codex Alimentarius Commission; outdated food legislation; limited education in food safety; and lack of awareness about the public health implications of unsafe food and exposure to mycotoxins, especially, aflatoxins.

222. During the 2004-2005 biennium, there were a number of outbreaks, including two outbreaks of acute aflatoxicosis in Kenya. The country was provided with technical support for investigation, management and control of the outbreak. The Regional Office also organized an expert group meeting in May 2005 which made recommendations for prevention and control of aflatoxin exposure, management of acute exposure, capacity-building and appropriate methods of analysis.

223. WHO and the Food and Agriculture Organization convened the First Pan-African Conference on Food Safety for Africa in October 2005. The 42 countries present unanimously adopted a resolution recommending a five-year strategic plan for food safety in Africa. WHO also participated in the Second Global Forum for Food Safety Regulators and meetings of the Codex Alimentarius Commission in particular the Codex Coordinating Committee for Africa. A total of 28 countries⁷⁰ received support from the Codex Trust to attend several Codex meetings. The workshop on the procedures and work of the Codex was jointly organized with FAO and attended by the National Codex Committees of Kenya, Tanzania and Uganda. A workshop on effective food control systems for Africa was attended by participants from 28 countries.

224. The third and fourth regional training courses on food-borne disease surveillance were held in Yaounde, Cameroon in December 2004 and 2005, respectively. A regional guide for microbiological monitoring of food was prepared. The Global Environment Monitoring System and Food Contamination Monitoring and Assessment Programme were introduced in six countries.⁷¹ Several countries conducted food safety capacity-building training workshops on food-borne disease surveillance, the Hazard Analysis Critical Control Points, food inspection, Codex Alimentarius and prosecution courses for inspectors.

⁷⁰ Angola, Benin, Burkina Faso, Botswana, Burundi, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Seychelles, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

⁷¹ Burkina Faso, Cameroon, Chad, Madagascar, Senegal and Togo.

225. A regional guide for the development and implementation of food law was prepared at the Regional Office. Several countries prepared or drafted national food safety action plans and policies. The WHO Five Keys for Safer Foods was piloted in Botswana, Republic of Congo and Mozambique. An adaptation of the WHO five keys manual, *Bring Food Safety Home*, was drafted for African schools. Information and advocacy materials for food safety were developed and disseminated, including a regional newsletter. Information was collected from countries to document national food safety activities.

226. The achievements made were due to collaboration and cooperation with other partners, availability of additional resources, and increased awareness and political will. The major constraints included delayed release of funds for activities and the increased workload in some countries due to disease outbreaks. One clear lesson learnt in the biennium was that cooperation and collaboration of all stakeholders at national, regional and international levels result in more efficient delivery and use of resources.

227. During the biennium 2006-2007, WHO will continue advocacy, build capacity for food safety, mobilize resources and provide support for food-borne disease surveillance. The Regional Office will also contribute to revision of food legislation, preparation of national action plans, implementation of Codex standards, broadened participation in Codex and promotion of consumer education.

ADMINISTRATION AND FINANCE

228. The successful implementation of WHO's technical programmes with countries partly depends upon effective delivery of support services by the Division of Administration and Finance. The Divisions' delivery of these services in 2004-2005 was provided by the following areas of work: Human Resources Development; Budget and Financial Management; and Infrastructure and Informatics Services.

229. These services were provided to operations of the Regional Office in Brazzaville and Harare. With the development of the *Strategic orientations for WHO action in the African Region 2005-2009*, it was decided to consolidate Regional Office activities in Brazzaville. It was also decided to decentralize some activities and technical and administrative functions to Intercountry Support Teams. Therefore, preliminary planning was undertaken for immediate decentralization, and planning began for the implementation of the Global Management System in the African Region.

Human Resources Development (HRS)

230. The Human Resources Development area of work deals with all human resources issues concerning WHO staff in the African Region, both at the Regional Office and in the 46 country offices. During the 2004-2005 biennium, the main challenge was timely action to provide human resources services. Particular action was needed for establishment, classification and reclassification of posts; selection and recruitment of staff; issuance of contracts; administration of benefits and entitlements; staff development and learning; and provision of medical services for 2600 staff members. Other important challenges were related to the reprofiling exercise initiated in the African Region and the human resources gap exercise for the Global Management System.

231. To address the above challenges, WHO streamlined procedures, improved the computerized and automated systems, developed a staff development and learning strategy, increased interaction with

technical divisions and country offices, developed a reprofiling methodology, and finalized a briefing and induction package.

232. Among the major achievements during the 2004-2005 biennium were the reprofiling exercises conducted in four country offices (Kenya, Malawi, Nigeria and Tanzania), organization and conduct of three reprofiling workshops for WHO representatives and administrative officers of all country offices, finalization of a briefing and induction package for staff, finalization of a staff development and learning strategy, organization of training activities at the Regional Office (Brazzaville and Harare), and support to country offices for staff training and development.

233. In the context of human resources management reform, in particular contractual reform, steps were taken to proceed with the establishment of fixed-term posts for long-term functions performed by temporary staff. Participation of 52 senior staff members in the Global Leadership Programme was also supported.

234. The main facilitating factors during the biennium were the support provided by top management; the financial and technical support received from headquarters for staff development and learning; and the positive interaction with technical divisions, country offices and headquarters. Shortage of funds and professional staff as well as lack of human resources development capacity in most country offices were among the major constraining factors.

235. During the 2006-2007 biennium, efforts will focus on streamlining and decentralization functions and activities to intercountry and country levels. The regional staff development and learning strategy will continue to be implemented, with special emphasis on training related to the Global Management System and support to the country offices. Active support to the reprofiling exercise will continue in the Region, and schedule of visits to country offices will be implemented.

Budget and Financial Management (FNS)

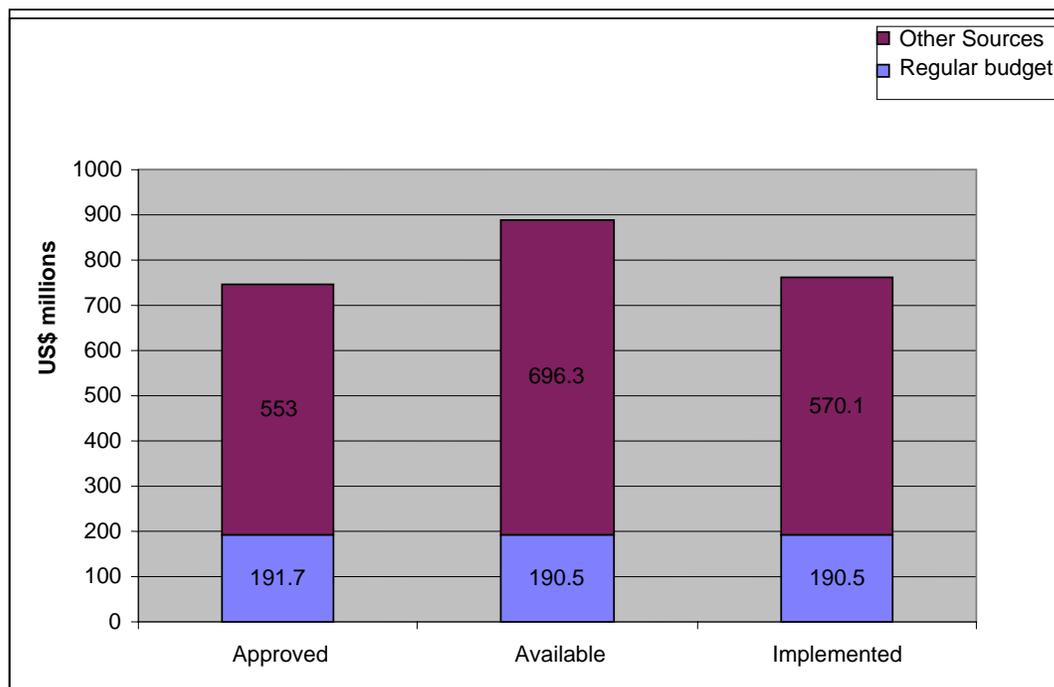
236. The Budget and Financial Management are of work is responsible for all the financial activities of the Region, including ensuring timely implementation of the Programme Budget and provision of services to staff and suppliers. During the 2004-2005 biennium, these activities were done in a semi-automated manner. The volume of work in the Region greatly affected the ability of the area of work to provide timely support. Budget and Financial Management is accountable for funds allocated to programme implementation and for ensuring that the funds are spent in accordance with the Financial Rules and Regulations of the Organization. Recent audits revealed that improvements are needed in the areas of accountability and adherence to procedures. Nevertheless, the goal continues to be to provide appropriate, timely financial support to programme managers, staff and suppliers.

237. With regard to implementation of the budget, it is noted that the Programme Budget was approved by the World Health Assembly in May 2003 under resolution WHA56.32. The amount of funds from other sources was adjusted by the Executive Board in January 2004, resulting in an integrated adjusted approved budget of US\$ 744.7 million for the African Region as compared to US\$ 544.7 for the biennium 2002-2003. This comprised US\$ 191.7 million Regular budget funds and US\$ 553 million from other sources (Figure 14).

238. For implementation, the African Region received all of its Regular budget allocation with the exception of US\$ 1.2 million held by the Director-General. As for funds from other sources, the African Region was successful in receiving more than its share of the adjusted approved funds, US\$

696.3 million versus US\$ 553.0 million, a 26% increase over projections. For the biennium, therefore, 119% of the approved budget was available for implementation, an excess of US\$ 112.2 million over the approved budget (US\$ 886.9 million versus US\$ 744.7 million). The Region implemented 102% of its approved budget as compared to 86% of the funds actually available during the biennium. This difference is due to the timing of the receipts from other sources and the fact that normally 20% of the funds from other sources that are raised are carried over to the next biennium. In comparison, the total Regular budget (100%) was implemented during the biennium. While the target was met for funding from other sources, it should be noted that only four areas of work (IVD, HIV, MAL and EHA) accounted for 80% of the Voluntary funds, making it difficult to implement activities in other critical areas of work given the limited funding available from the Regular budget.

Figure 14: WHO African Region Programme Budget implementation, 2004-2005



239. Major achievements included support to countries in treasury management and oversight functions; preparation of budget tables for inclusion in the 2006-2007 Programme Budget document; preparation for implementation of the Regional Programme Budget document; opening of allotments to enable implementation; continual improvement of services being provided; successful management of Programme Budget implementation despite budget constraints; upgrading the Accounting and Information Management System for countries; and the provision of online access to allotments and personal accounts data.

240. One lesson learnt is the need to enhance the capacity of WHO in financial management to support countries. Better budget monitoring, especially at country level, is also needed to prevent over-expenditure. Thorough review of workplans is necessary for smooth implementation of the Programme Budget.

241. During the 2006-2007 biennium, the WHO Regional Office will increase oversight functions, given the increased delegated authority to countries and divisions; increase budget monitoring

reporting; support country offices to perform reviews and training; thoroughly review workplans; and provide assistance in the preparation of Programme Budget 2008-2009.

Infrastructure and Informatics Services (IIS)

242. The Infrastructure and Informatics Services area of work is responsible for providing administrative and logistical services; delivery of efficient, cost-effective procurement services; and appropriate information technology infrastructure and systems.

243. In administrative and logistical services, the main challenge was continually improving working and living conditions in both Brazzaville and Harare. Particular focus was on delivery of efficient and cost-effective travel services as well as maintenance and operating expenses. The progressive return of the Regional Office to Brazzaville is still seen as a major challenge in terms of office accommodation, housing, and office supplies and equipment for staff.

244. During the 2004-2005 biennium, overall information and communications technology operations at the Regional Office and in countries were strengthened with the development of necessary tools and properly skilled support staff. This was critically important due to the increased level of automation and growing reliance on electronic communication throughout the Region. The trend is expected to continue with the forthcoming deployment of the Global Management System in the Regional Office and country offices.

245. The goal was to apply best practices in all aspects of general management at all organizational levels in support of WHO's international leadership role in health matters. The country connectivity project, which strengthens the telecommunications capacity of country offices, was successfully completed, and all 46 country offices were connected to the WHO global private network. The network provided all countries in the Region with reliable voice mail, e-mail and Internet connection, with video-conferencing and tele-conferencing as frequently-used options. In addition, the African Regional Office Computerized Imprest Account Management System was developed for country office financial transaction management and later globally adopted by WHO headquarters and all regions as a standard financial system for use in all WHO country offices.

246. Improvements in living and working conditions in the Regional Office were noticed since the transfer of personnel and equipment from Harare to Brazzaville. All Regional Office electrical installations were modernized. Essential administrative and logistical support was provided for about 30 meetings held at the Regional Office in the 2004-2005 biennium. In order to maximize efficiencies in travel costs, the provisions of paragraph 80 of the *WHO Manual on Travel* were implemented. A review of all contracted services was undertaken, and significant savings in operating expenses are expected for the Organization.

247. The e-procurement system definitely streamlined the procurement cycle and allowed access to lower prices of goods. The Integrated Services System successfully streamlined the management of security for the 400 staff members at the Regional Office. The system was made available on the Intranet and can be accessed by any staff member; it was also introduced in all country offices.

248. The printing sub-unit provided support to meetings and conferences at regional and country level. The rehabilitation of the in-house print shop began with a first allocation of more than US\$ 500 000 for setting up a preparation section using computer-to-film and computer-to-plate technology.

249. Lessons learnt indicate need for basic information technology skills development and training for WHO staff to take full advantage of technologies being deployed and enhance staff productivity. In administration and logistics, a number of contracted services were not cost-effective for the Organization and an overall review became crucial.

250. During the biennium 2006-2007, support will be provided for deployment of the Global Management System in the Regional Office and in countries; this should enhance efficiency in administrative functions. Significant attention will also be given to expansion of the use of collaborative tools, such as Microsoft Sharepoint, throughout the Region for maximizing efficiency. The focus will also be on sustainable implementation of the WHO global e-procurement system which allows shorter ordering time and access to competitive prices. In line with headquarters, a new system of access control has been designed for the apartments, the main office and Regional Office premises and will be implemented. The construction of a new functional conference hall is scheduled to begin in 2006.

FACTORS IN PROGRAMME BUDGET IMPLEMENTATION

Enabling factors

251. The work of WHO in the African Region during the 2004-2005 biennium was facilitated by the commitment of ministries of health to address their respective public health problems, specifically to achieve the millennium development goals and tackle the social determinants of health. The financial support from international initiatives for regional priorities offered opportunities for continuous fruitful cooperation with external partners. Partnerships between the World Health Organization and the African Union; regional economic communities; United States Agency for International Development; Canadian International Development Agency; Global Fund to Fight AIDS, Tuberculosis and Malaria; United Nations Children's Fund; and many other agencies were instrumental in the progress made.

252. Many other factors facilitated programme implementation in the Region during the biennium. Among these are the close collaboration among various stakeholders and WHO at national and global levels; collaboration between headquarters, the Regional Office and country offices; staff commitment; positive stewardship from Regional Office management, and strong team spirit and networking among WHO staff. Improved human resources and the empowerment of staff at all levels also contributed to the implementation of activities.

253. Various factors also facilitated achievements. These include timely communication with countries using the global private network; progressive understanding by WHO staff of the results-based management approach; expansion of result-based management and Activity Management System training to administrative support staff; and strong commitment and support from the management.

Constraining factors

254. The implementation of the 2004-2005 Programme Budget in the African Region faced some constraints. Although there was an increase in funds from 2002-2003 to 2004-2005, operations in the Region depended heavily on funds from Other Sources. Inadequate human resources at national level delayed responses and implementation of activities in some countries. Emergency situations and natural disasters in the Region also hindered implementation of some activities.

255. A major challenge for programme management in the African Region is instilling a culture of results-based management supported by consistent and uniform processes for planning, implementation, monitoring and reporting. Country Cooperation Strategies developed in the framework of the Country Focus Initiative still need to be integrated into strategic and operational plans at country level, a task that is both difficult and new to WHO.

256. Other constraining factors included insufficient human and financial resources for all activities, especially evaluation; lack of integration of information systems throughout the Organization, including an on-line interactive integrated financial system linking the Regional Office and country offices; and delayed global guidance documents. The implementation of the Global Management System is expected to address this challenge in 2007. Given the division of financial management functions between Harare and Brazzaville, another challenge was the provision of accounting and financial services from both locations.

THE WAY FORWARD

257. For the next biennium, 2006-2007, the work of WHO in the African Region will continue to be guided by the vision articulated in the *Strategic orientations for WHO action in the African Region 2005-2009*. Thus, the focus will be on strengthening WHO country offices; improving and expanding partnerships for health; supporting the planning and management of district health systems; promoting the scaling up of essential health interventions related to priority health problems; and enhancing awareness and response to key determinants of health.

258. Specifically, adequate funds and human resources will be allocated to health information systems; concerted efforts will be made to undertake studies and disseminate study results in close collaboration with counterparts in health and health-related ministries. Mechanisms will be instituted to enhance use of research evidence to inform policy decisions; sensitize governments to allocate at least 2% of national health budgets to health research according to the Mexico summit recommendations; and improve the impact of WHO collaborating centres.

259. WHO will support acceleration of HIV prevention efforts and will also scale up prevention, treatment and care to achieve universal access. The strategic information base will also be strengthened to direct evidence-based interventions. Partnerships will be strengthened at all levels to extend collaboration outside the health sector. Regarding tuberculosis control efforts, the focus will be on promoting universal access to quality DOTS services. This will include rapid scaling up of DOTS expansion initiatives, especially public-private partnerships and community TB care initiatives in all 34 high-burden TB countries in the Region. Also, scaling up of TB/HIV interventions will be promoted. The major orientation of malaria control for the 2006-2007 biennium will be to support equitable delivery of comprehensive intervention packages, maximize complementary functions and target vulnerable groups.

260. Countries will continue to receive support to sustain the gains made through high routine immunization coverage. Sustained advocacy efforts are needed to ensure that routine EPI activities

are adequately financed. Capacity-building efforts will continue to maintain high quality disease surveillance. Advocacy will be important to ensure continued government and partner commitment to the polio eradication and accelerated disease control efforts.

261. Support will be provided to countries to: ensure full implementation of the Geneva Declaration on dracunculiasis eradication; eliminate leprosy at national level in all countries; complete the mapping of lymphatic filariasis; build or strengthen partnerships for sustainable programme implementation; implement the WHA resolution on Buruli ulcer surveillance, and control and develop a Buruli ulcer control strategy in the Region; implement the Regional Committee resolutions on human African trypanosomiasis; and intensify or accelerate school deworming programmes.

262. With regards to noncommunicable diseases, the WHO Regional Office for Africa will continue to support countries to undertake STEPS surveys and use data for advocacy and action; support countries to undertake research on socioeconomic implications of noncommunicable diseases to make them relevant outside the health sector; and prioritize primary prevention interventions in countries. The Regional Office will also identify focal points in ministries of health for better management of mental health and substance abuse issues. WHO will assist Member States to work on the systematic implementation of effective interventions such as limiting traffic speed, banning drink-driving, and using seat belts and bike helmets.

263. WHO will continue advocacy to mobilize partners around the common goal of reducing child mortality. In addition, it will support countries to establish maternal, newborn and child health forums that will promote continuum of care as well as strengthen community-level delivery of services to increase access and coverage. Strong partnerships within and outside WHO, including involvement of communities, will be promoted for a comprehensive approach and coordinated support to countries in the implementation of the Road Map and scaling up of key interventions for maternal, neonatal and child health. Continued support will be provided to Member States to roll out the Women's Health Strategy; integrate gender into health policies and programmes; and accelerate the elimination of female genital mutilation. WHO will also continue providing support to Member States to develop and implement nutrition policies and strategies to alleviate the effects of malnutrition on children and mothers, including addressing nutritional needs throughout the life-course.

264. WHO will continue to provide technical support to countries for health in development in the context of national poverty reduction strategy papers; sectorwide approaches; millennium development goals; and by promoting universal coverage, equity, human rights and the social determinants of health as the main avenues to achieve the MDGs. The Organization will continue to advocate and build capacity for food safety; provide support for the revision of food legislation and preparation of national action plans; encourage implementation of Codex standards and effective participation in Codex; and support promotion of consumer education.

265. The successful implementation of WHO's technical programmes with countries partly depends on effective delivery of support services. In order to give prompt quality support to countries, a decision was taken to decentralize some of the functions of the Regional Office to intercountry teams. These teams will give technical support to countries and perform the administrative functions decentralized to them.

PART 2: PROGRESS REPORT ON THE IMPLEMENTATION OF REGIONAL COMMITTEE RESOLUTIONS

ELIMINATION OF LEPROSY IN THE AFRICAN REGION

266. At its forty-fourth session, the Regional Committee adopted resolution AFR/RC44/R5 Rev.1 calling upon the Regional Director to target activities towards improving leprosy control in the 10 most endemic countries by: providing training in management at district level using training modules; developing monitoring and evaluation tools; providing direct consultants' support; encouraging NGOs to sustain financial support to programmes; and promoting health systems for capacity building in Member States.

267. Subsequently, in November 1999 the International Conference on Leprosy Elimination held in Abidjan, Côte d'Ivoire, recommended the year 2005 as the target for leprosy elimination at national level in all Member States. Elimination of leprosy is defined as the reduction of prevalence rate to 1 case per 10 000 inhabitants.

268. The 2004-2005 biennium focused on the achievement of the elimination goal at national level in all Member States. Strategies and interventions were developed in the 10 most endemic countries to strengthen and integrate leprosy elimination activities at district level; intensify social mobilization activities to change the image of leprosy in communities in order to cover the remaining so-called "leprosy pockets"; develop, implement, and evaluate an intensified leprosy elimination plan and innovative interventions in all countries that have not reached the elimination goal; and widely implement leprosy elimination monitoring in order to verify achievements at national level.

269. More than 80% of planned activities were implemented in all the targeted countries with a high level of efficacy and efficiency resulting in the major outcomes summarized in Table 2.

Table 2: Leprosy situation in the African Region at the beginning of 2005*

Indicators	Number of cases	Prevalence rate and proportions
Prevalence	43 764	0.63 cases per 10 000
Detection	45 161	6.54 cases per 100 000
New case MB**	31 452	69.64%
New case with disability grade 2	4538	10.05%
New case (female)	10 076	22.31%
New case (child)	4346	9.62%
Relapse	447	
Prevalence / detection ratio		0.96

*Source: 2004 annual report compiled from data received from the ministries of health of 39 Member States of the WHO African Region

**MB: *Mycobacterium leprae*

270. The leprosy elimination goal was consolidated at regional level and prevalence was reduced from 0.91 to 0.63 per 10 000 people. Six countries reached the elimination goal at the beginning of the year 2005. By the end of the same year, four more countries (Angola, Central African Republic, Comoros and Guinea) reached the elimination goal. A total of 42 countries have, so far, achieved the goal of leprosy elimination.

271. A number of factors facilitated the implementation of the resolution including high political commitment at national level in all Member States; availability of multidrug therapy and its provision free of charge; strengthening partnerships with NGOs working in the leprosy area. The constraints include insecurity and difficulty of access in many districts; poor coverage of health services; low level of collaboration; frequent rescheduling of activities in some countries; and decrease in budgetary allocation.

272. As at the end of 2005, in spite of the significant achievements in the Region, four countries (Democratic Republic of Congo, Madagascar, Mozambique and Tanzania) still had high prevalence of leprosy. Member States of the WHO African Region should maintain political commitment to the elimination of leprosy and sustain leprosy elimination activities. The Regional Director intends to propose a strategy to sustain leprosy activities after the elimination goal is reached.

HEALTH AND ENVIRONMENT: A STRATEGY FOR THE AFRICAN REGION

273. The Regional Committee by its resolution AFR/RC52/R3 requested the Regional Director to improve the capacity of WHO to effectively provide technical support to Member States for the development and implementation of policies on health and environment; and to support the improvement of the capacity of countries to implement and monitor programmes and action plans.

274. The Protection of Human Environment area of work of the Regional Office was expanded, and its capacity was strengthened to cover areas such as vector ecology and management. A total of four collaborating centres were established, and two others are in the process of being established. The budget of the area of work was increased.

275. Technical support was provided to countries to develop or update national environmental health policies. Eleven countries completed the exercise and ten are in the process of doing so. Technical support is being provided to countries to develop their capacity in specific programme areas such as water quality monitoring and treatment, air pollution and waste management. Promotion of integrated delivery of interventions through the healthy settings approach and children's environmental health was continued. In order to provide a comprehensive and coherent framework for implementation of the regional strategy, a four-year strategic plan (2006-2009) was developed.

276. Despite the progress made in the implementation of the resolution, acceleration of the implementation will be possible only if national authorities restructure health and environment services and set up efficient intersectoral coordination mechanisms at country level.

POVERTY AND HEALTH: A STRATEGY FOR THE AFRICAN REGION

277. The Regional Committee at its fifty-second session passed resolution AFR/RC52/R4 urging the Regional Director: to provide technical support to Member States for the development of national health policies and programmes for poverty reduction; to increase support, through training institutions, to national professionals in the field of health and development in order to strengthen

their capacities for policy analysis, monitoring and evaluation; and to assist in mobilizing additional resources for the implementation of this strategy.

278. Some countries received technical support to develop or improve the health component of their poverty reduction strategy papers. Some others were given financial support to implement community-based poverty and health programmes. Others received financial support to carry out studies or reviews on access to health services by the poor; public health financing and expenditure directed at the poor, including sectorwide approaches; and equity issues and out-of-pocket health expenditure by the poor. The African Advisory Committee on Health and Poverty, a body of experts set up to advise the Regional Director on issues regarding health and poverty, held a meeting in Brazzaville in December 2004. The Committee reviewed and finalized two guidelines, one for incorporating poverty and health concerns in national health sector strategic plans and poverty-reduction strategies, and the other for designing poverty monitoring and evaluation systems.

279. An African Region working partner in the area of poverty and ill-health was identified. It has been given a seed grant and its curriculum has been evaluated. Furthermore, a poverty and health training module was developed and used in a workshop on evidence and information for policy-making.

280. The Poverty and Ill-Health programme is collaborating with Regional Office programmes on environmental health and food safety to draw up resource mobilization proposals.

281. A report on the progress made in implementing this strategy was presented to the fifty-fifth Regional Committee meeting in Maputo in 2005. However, there is need to consider extending the period of reporting on the progress in addressing the poverty issue beyond the fifty-fifth Regional Committee meeting as required by resolution AFR/RC52/R4. This is necessary because poverty continues to be a problem and development partners are still willing to support activities in this area. Unfortunately, for various reasons, including lack of resources, only a few countries include poverty and health in their plans of action. In addition, there is need to ensure that the health component effectively addresses the health needs of the poor in countries. The Poverty and Ill-Health programme in the Regional Office will continue to support countries in that regard if and when requested to do so.

MACROECONOMICS AND HEALTH: THE WAY FORWARD IN THE AFRICAN REGION

282. The Regional Committee by its resolution AFR/RC53/R1 requested the Regional Director to continue advocating for increased investments in health as an effective way of reducing poverty and accelerating economic development; to support countries to strengthen their existing institutional arrangements for planning, implementing and monitoring the Commission on Macroeconomics and Health (CMH) recommendations; to monitor and document lessons emerging from the implementation of the CMH recommendations in different countries and facilitate sharing of lessons learned; and to provide support to regional institutions that train health economists and conduct health economics research.

283. The CMH report was disseminated widely among countries and various stakeholders. A web page was created on the Regional Office Intranet to enhance information sharing and facilitate advocacy. Stakeholders in Malawi, Senegal, Swaziland, and Uganda were sensitized to the importance of macroeconomics and health and the need to scale up cost-effective interventions to improve the health status of the poor. Due to sustained advocacy, countries are now more aware of the need to link sectoral policies with their macroeconomic policies. In addition, development partners

such as the World Bank have acknowledged the need for more resources to build and retain human resources for health with a view to strengthening health systems to facilitate the achievement of health-related millennium development goals.

284. Technical support was provided to nine countries.⁷² Ghana finalized a health investment plan. Kenya, Mozambique, Senegal and Uganda drew up plans of action. The Rwanda Macroeconomics and Health Task Force linked its work with sectorwide approaches. Uganda established a Macroeconomics and Health Task Force. Ethiopia received support to conduct studies on accelerated expansion of primary health care and a minimum health services package; poverty and health; and unit cost analysis methodologies for primary health care services; and to prepare the terms of reference for conducting a unit cost analysis.

285. A comprehensive report summarizing the experiences of countries and lessons learned in the implementation of the CMH recommendations was published and disseminated. The report contains contributions from countries, including Ghana, Rwanda and Senegal.

286. The African Advisory Committee on Health Economics was constituted to advise the Regional Director on strategies for health economics capacity-building in the African Region. During its inaugural meeting in November 2004, the Committee developed a strategic health economics plan for the WHO African Region, 2006-2015. Efforts are currently underway to mobilize financial support for the implementation of the strategic plan.

287. In spite of the efforts made so far, seed funding for countries willing to implement the CMH recommendations remains inadequate. Furthermore, countries are grappling with the problems of insufficient technical capacity, low level of advocacy and sensitization, multiplicity of processes, and lack of clarity about the linkages between the processes.

288. Plans are under way to engage international partners and advocate for more resources for the health sector. In addition, ministries of health will be supported to strengthen the health component of the poverty reduction strategies; to effectively advocate and participate in intersectoral actions and macroeconomic policy discussions; and to advocate for the inclusion of social dimensions in macroeconomic policy discussions and a reallocation of resources to the benefit of priority areas.

STRENGTHENING THE ROLE OF HOSPITALS IN NATIONAL HEALTH SYSTEMS IN THE AFRICAN REGION

289. The Regional Committee by its resolution AFR/RC53/R2 requested the Regional Director to provide adequate support to countries in their hospital development initiatives; and to establish a regional expert committee to provide technical guidance on hospital development.

290. WHO and other development partners provided technical support to 10 countries to improve the performance of their hospitals by: (i) developing their National Hospital Policy (Madagascar, Uganda); (ii) undertaking hospital reforms and developing strategic plans (Cameroon, Niger); (iii) strengthening health information systems (Namibia, Seychelles); (iv) developing a health-care package at the regional hospital level (Mauritania); (v) setting up processes of establishing hospital autonomy (Malawi); and (vi) strengthening the stewardship role of hospitals (Benin, Ethiopia).

⁷² Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Senegal, Swaziland, and Uganda.

291. The Regional Office participated in conducting pilot studies on various issues, such as efficiency change, technical progress and productivity growth among municipal hospitals (Angola); technical efficiency of public district hospitals and health centres (Ghana); measurement of the technical efficiency of public health centres and hospitals (Kenya); technical efficiency of district hospitals (Namibia); and technical efficiency of peripheral health units in the Pujehun district of Sierra Leone. The Regional Office also undertook a situation analysis of national research bioethics committees in the WHO African Region.

292. The Regional Office is in the process of producing various tools to compile ongoing activities in the hospital sector. The tools will help identify gaps, build on existing good practices and collect information for evidence-based reforms.

293. An expert working group has been identified and will organize a series of consultative meetings on the strengthening of hospitals. The first meeting will be held in Brazzaville from 16 to 21 October 2006. The objective of the meeting is to find ways and means of expediting the implementation of measures to strengthen the role of hospitals in national health systems.

WOMEN'S HEALTH: A STRATEGY FOR THE AFRICAN REGION

294. The Regional Committee by its resolution AFR/RC53/R4 requested the Regional Director to provide technical support to Member States for the development of policies and implementation of agreed conventions and declarations towards the attainment of international goals on women's health; to continue to advocate for a strategic approach to the reduction of morbidity and mortality in women, including effective intervention in the Safe Motherhood Initiative, regional plans for the elimination of female genital mutilation and other harmful traditional practices, prevention of violence, and education of the girl-child; to mobilize governments, UN agencies, NGOs and other stakeholders to organize symposia, conferences and workshops to refocus women's health in the national development agenda; to support public and private institutions and national experts to carry out research on identified priorities and document findings and best practices for use by Member States in the full implementation of cost-effective approaches for improved women's health; and to maintain WHO's commitment to building gender perspective into policies and programmes.

295. Ethiopia, Ghana and Nigeria reported on the women's health section of the Convention on the Elimination of Discrimination Against Women with WHO support. Mozambique reviewed the implementation of sexual and reproductive health and Democratic Republic of Congo, Guinea and Liberia conducted activities related to the prevention and management of sexual and gender-based violence. In 2005, WHO assessed women's access to quality health services in five countries (Botswana, Lesotho, Malawi, Swaziland and Zambia), and the assessment tool was revised based on the findings.

296. By December 2004, 18 countries⁷³ had developed their national women's health profiles through the use of national research teams involving experts from various institutions. During the biennium, three major international days⁷⁴ on women-related issues were celebrated by countries. In 2004, Nigeria expanded the programme on female functional literacy for health promotion through microcredit and health education in 11 states.

⁷³ Algeria, Burkina Faso, Cape Verde, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Lesotho, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Seychelles, South Africa, Tanzania, Zimbabwe.

⁷⁴ International women day (8 March), Zero tolerance of FGM international day (6 February) and Fight violence against women day (25 November).

297. In October 2005, six regional economic communities⁷⁵ received WHO technical support for integrating gender and health into their work. A memorandum of understanding was signed by four leading agencies⁷⁶ involved in the elimination of all forms of violence, including FGM and other harmful practices. The African Inter-Parliamentary Union met in December 2005 and addressed the issues of violence against women and elimination of FGM. The meeting undertook to promote FGM eradication within the next generation. Six partners⁷⁷ agreed to work together to support the acceleration of FGM elimination in the context of women's human right to health and life.

298. Ghana, Guinea and Tanzania conducted research on the social determinants of FGM. Multidisciplinary collaborative groups on FGM were established in 10 countries⁷⁸ and a Women's Health FGM database was developed. An evaluation of five years of implementation of the Regional Plan of Action to Accelerate the Elimination of FGM in Africa was carried out in 15 countries.⁷⁹ The evaluation showed that all countries had initiated activities to eliminate FGM and some countries were already seeing a decrease in FGM prevalence. Six countries⁸⁰ trained a core group of health professionals in the prevention and management of FGM using WHO training manuals.

299. In collaboration with headquarters and WHO Kobe Centre, a core of 40 leading gender-sensitive indicators were identified and will be field-tested in Tanzania. An expert group of five countries (Ethiopia, Rwanda, Tanzania, Uganda and Zimbabwe) reviewed their plans of action to build gender concerns into health programmes.

300. The constraints on women's health interventions include inadequate human and financial resources, and lack of research culture. Using selected indicators to monitor implementation of activities is essential to the attainment of the MDGs.

FOOD SAFETY AND HEALTH: A SITUATION ANALYSIS AND PERSPECTIVES

301. The Regional Committee by its resolution AFR/RC53/R5 requested the Regional Director to continue advocacy for inclusion of food safety in overall national development goals and strategies to provide technical support for the development and implementation of food safety policies and legislation; to promote food safety research and surveillance; and to strengthen collaboration with other international partners and relevant bodies to make scientific decisions on food safety and health issues relating to new technologies, including genetically-modified foods.

302. Advocacy was undertaken through establishing networks, organizing and participating in food safety forums and preparing briefs on topical food safety matters for Member States, the African Union and regional groupings. Several food safety information and advocacy materials were developed and disseminated. Publication of a regional newsletter started and information was collected from countries to document national food safety activities. A number of briefing notes were prepared and shared with Member countries, regional groupings and the African Union.

⁷⁵ WAHO, COMESA, ECOWAS, NEPAD, ECA, UNAIDS and African Union.

⁷⁶ The World Health Organisation through its Regional Office for Africa; the United Nations Children's Fund through its Regional Bureau for West and Central Africa (WCARO); the United Nations Population Fund (UNFPA) through its African Division and the Inter-African Committee (IAC) on Harmful Traditional Practices affecting women and children.

⁷⁷ USAID, UNFPA, UNICEF, Inter-African Committee on Harmful Traditional Practices (IAC), Population Council and Tostan.

⁷⁸ Burkina Faso, Cameroon, Chad, Democratic Republic of Congo, Ghana, Kenya, Mali, Niger, Nigeria and Tanzania.

⁷⁹ Burkina Faso, Cameroon, Chad, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Mali, Niger, Nigeria, Senegal and Tanzania.

⁸⁰ Burkina Faso, Ethiopia, Ghana, Mali, Nigeria and Tanzania.

303. WHO in collaboration with FAO established the International Food Safety Authorities Network for rapid distribution of information meant to protect public health. Seven INFOSAN notes were issued, the most recent being on the H5N1 strain of the avian influenza virus. Another section, INFOSAN Emergency, dedicated to food safety emergency situations, issued an alert on *Salmonella agona* in infant formula in December 2004, resulting in the detection and retrieval of the affected products from some countries in the Region. In 2004, the Second Global Forum for Food Safety Regulators was held, bringing together 32 countries that also met with WHO on the sidelines to discuss issues concerning food safety in Africa. The First Pan-African Conference on Food Safety was jointly held by WHO and FAO in 2005, bringing together over 185 participants from 45 Member countries. The conference adopted a resolution recommending a nine-point five-year strategic plan for food safety in Africa for adoption by United Nations food and health agencies and the African Union. Funds are being mobilized for the implementation of the resolution.

304. A number of countries were given technical support to strengthen food law enforcement. A regional guide for the development and enforcement of food law was drafted.

305. Two training courses on food-borne disease surveillance were held as part of global activities for the surveillance, isolation and identification of pathogens in food (Global Salm-Surv). A regional guide for microbiological monitoring of food was prepared. Technical support was provided to, Benin, Republic of Congo, Gambia and Seychelles to conduct activities to strengthen the surveillance and microbiological monitoring of foods. The Global Environment Monitoring System/Food Contamination Monitoring and Assessment Programme was introduced in six countries. Technical support was provided for investigating and controlling several food-borne diseases, including the outbreak of acute aflatoxicosis in Kenya. The Regional Office organized a consultation in 2005 and published a report and scientific papers to increase awareness of the public health importance of aflatoxins as well as surveillance activities for their prevention and control.

306. Stronger partnerships were forged with international organizations, especially FAO and UNIDO, through various collaborative food safety projects. The establishment of the Codex Trust enhanced the participation of Member States in international standard setting. Twenty-eight countries received support from the Codex Trust to attend a number of Codex meetings. The Regional Office participated in the international standard setting work of the Codex Alimentarius Commission and provided technical support to CCAFRICA in drawing up a strategy for improving food safety systems. CCAFRICA discussed the Fifty-eighth World Health Assembly resolution on *Enterobacter sakazakii* and other pathogens in infant formula. The recommendation for research to generate data specific for Africa will be addressed in 2006-2007. UNIDO, FAO and WHO organized a course on biosecurity for Member countries in 2005. The WHO headquarters report, *Modern food biotechnology, human health and development*, was distributed in 2005.

307. Increased awareness, political will and partnerships facilitated the implementation of the resolution. The main constraint was insufficient financial resources.

REPOSITIONING FAMILY PLANNING IN REPRODUCTIVE HEALTH SERVICES: FRAMEWORK FOR ACCELERATED ACTION, 2005-2014

308. The Regional Committee by its resolution AFR/RC54/R2 requested the Regional Director to continue to advocate for a strategic approach to the reduction of maternal morbidity and mortality and the pivotal role of family planning; provide technical support to Member States for the planning, implementation, monitoring and evaluation of the framework for repositioning family planning in

reproductive health services; and develop relevant guidelines for use by Member States to advocate for and accelerate the implementation of the framework.

309. The 2005-2014 Framework was well received by governments and partners as a useful tool for strengthening family planning services in the context of the Road Map for accelerating the reduction of maternal and newborn morbidity and mortality. Reproductive health programme managers from all 46 Member States were given orientation on the Framework which has been printed and disseminated to all countries.

310. A regional conference involving 23 countries⁸¹ was organized in February 2005 by WHO, USAID, Advance Africa, AWARE-RH, POLICY Project, WAHO and other collaborators, with the assistance of the Ministry of Health of Ghana to revitalize family planning through operationalizing the Framework. A network of African women from 17 countries⁸² was also established for the promotion of family planning. Another meeting is planned for countries of east, central and southern Africa, subject to the availability of funds.

311. WHO, in collaboration with USAID, developed a family planning advocacy tool kit for use by countries. WHO and UNFPA launched a strategic partnership programme for technical support to countries; through its financial support, generic global family planning guidelines were updated and have been used by nine countries.⁸³ Medical eligibility criteria guidelines for family planning were translated into Portuguese and printed. Guidelines on contraceptive logistics management and a medical eligibility criteria wheel are being developed. The Mauritius Institute of Health was supported to review and update its family planning curriculum to include all reproductive health components in annual training programmes.

312. The main constraint on operationalizing the Framework was inadequacy of funds to support countries. Future plans include integration of the Framework into maternal, newborn and child health services.

PRIORITY INTERVENTIONS FOR STRENGTHENING NATIONAL HEALTH INFORMATION SYSTEMS

313. The Regional Committee by resolution AFR/RC54/R3 requested the Regional Director to provide support to Member States to enable them to implement priority interventions for strengthening national health information systems; promote technological options that facilitate networking, communication, access, use and feedback of health information; and provide support to countries for resource mobilization and capacity building in national health information systems.

314. Support was provided to nine countries⁸⁴ to carry out a comprehensive evaluation of national health information systems and to identify weaknesses and needs in terms of human, financial and material resources. Other countries were supported to review and update national essential health indicators; adopt a national health information system policy that is part of the national health policy; and develop a strategic plan to strengthen the health information system. Service availability mapping

⁸¹ Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Cote d'Ivoire, Democratic Republic of Congo, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone and Togo.

⁸² Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo and Tunisia.

⁸³ Benin, Cameroon, Mozambique, Nigeria, Rwanda, South Africa, Tanzania (including Zanzibar), Zambia, and Zimbabwe.

⁸⁴ Botswana, Cameroon, Cape Verde, Comoros, Ghana, Namibia, Senegal, Tanzania and Uganda.

using the Palm Top, GPS and the Geographic Information System Health Map was implemented in seven countries⁸⁵ to ensure the dissemination and effective use of data collected for strategic planning and day-to-day operations.

315. A management information system and data warehouse were developed in the Regional Office to enhance health information accessibility, use and feedback. The global private network has enabled WHO country offices and Regional Office divisions to directly update the databases and discuss analyses, estimations and projections.

316. As part of the efforts to mobilize resources and build capacity in national health information, the Health Metrics Networks, an innovative global partnership launched in May 2005 during the World Health Assembly, provided support to the Regional Office to organize three workshops for 41 countries in the Region. Network partners include countries, multilateral and bilateral agencies, foundations, other global health partnerships and technical experts.

317. A total of 24 countries submitted proposals to the Health Metrics Network. Twenty countries⁸⁶ were funded in 2005 to assess their health information systems, develop plans, mobilize resources, disseminate and use health information for action, and monitor the progress of strengthening their information systems. The total financial support was more than US\$ 2 million in the first year and about US\$ 500 000 in the second year.

318. Countries should continue to establish or strengthen their national health information system units and increase investment for health information systems using the Health Metrics Network.

OCCUPATIONAL HEALTH AND SAFETY IN THE AFRICAN REGION: SITUATION ANALYSIS AND PERSPECTIVES

319. The Regional Committee by its resolution AFR/RC54/R4 requested the Regional Director to provide technical support for the development and strengthening of occupational health and safety policies, legislation and programmes; sustain dialogue with ILO and call for the collaboration and participation of other international agencies such as UNEP and UNIDO to provide technical support to countries; promote and support research and surveillance to inform national policies and implementation plans; and support resource mobilization and development of partnerships to address occupational health and safety.

320. Technical support was provided to Botswana, Comoros, Gambia, Namibia and Swaziland for developing occupational health and safety policies and reviewing the curricula of training institutions. Botswana and Namibia have completed the development of their occupational health and safety policies and are awaiting endorsement by their respective governments. St Helena was supported to provide training in occupational therapy. Seven countries⁸⁷ underwent orientation and training in the implementation of the resolution and in working in cooperation with ILO to address common issues identified.

321. In order to promote and support research and surveillance to inform national policies and implementation plans, meetings were held with collaborating centres in the African Region:

⁸⁵ Central African Republic, Ghana, Kenya, Nigeria, Rwanda, Uganda, and Zambia.

⁸⁶ Benin, Cameroon, Comoros, Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Uganda and Zambia.

⁸⁷ Benin, Botswana, Burkina Faso, Ghana, Nigeria, Uganda and Zimbabwe.

University of Benin, University of Cape Town and National Institute of Occupational Health Laboratories. Areas of further research were thus identified. The various centres were given tasks to perform, basic occupational health service being a priority task.

322. As a result of the dialogue initiated between ILO and WHO in 2003, a Statement of Intent on WHO/ILO Joint Effort for Occupational Health in Africa was signed by the ILO and WHO Regional Directors for Africa and the Eastern Mediterranean. The signing of the Statement of Intent was followed by joint meetings with ILO in Cairo on developing a consolidated country profile; with South Africa on improving information flow and dissemination to countries and workplaces in particular; and with Seychelles on the role that labour inspectors should play to enhance occupational health and safety.

323. Other organizations (SADC, ECOWAS, ADB and UNIDO) participated in the workshop held in Benin to discuss the implementation of the resolution on occupational health and safety.

324. Cooperation with collaborating centres has contributed to finding ways of improving the delivery of occupational health and safety services. The silicosis elimination project in South Africa, Zambia and Zimbabwe is on track. In South Africa and Tanzania, a pilot project on the prevention of needle-stick injuries has been piloted and will be replicated in other countries in the Region and beyond. The project on enhancing the handling of chemicals control banding will also be piloted to control avoidable injuries and illnesses related to chemical substances.

325. Collaboration with ILO led to the development of a consolidated country profile as a tool for collecting data and information. The data and information collected are meant for informing policy formulation and developing strategies and implementation plans. The consolidated country profile has been distributed to countries for use.

326. The area of work is also part of interdivisional efforts to contribute to the improvement of the health, safety and welfare of workers within the WHO African Region and in WHO country offices.

CHILD SEXUAL ABUSE: A SILENT HEALTH EMERGENCY

327. The Regional Committee by its resolution AFR/RC54/R6 requested the Regional Director to continue to play a leadership and advocacy role for integrated prevention, care and management of child sexual abuse; to provide technical support to Member States for reporting on ratified United Nations conventions and treaties related to child sexual abuse and exploitation; to support Member States in their efforts to adapt the agenda for action on child sexual abuse for implementation at national and subnational levels; and to mobilize resources and encourage partnerships with relevant United Nations agencies, especially UNICEF, UNESCO and UNIFEM, for the implementation of this agenda for action, including the development of special child-care and community surveillance centres.

328. To strengthen advocacy for the prevention of child sexual abuse, a high-level west and central African regional consultation on violence against children was held in Bamako, Mali, in May 2005, bringing together participants from 24 African countries. The Consultation provided an overview of the magnitude, causes and consequences of violence against children. It came up with clear and specific recommendations that helped in drawing up the Global Study on Violence Against Children. Declarations from the west and central African media informed the Early Warning Network to fight and monitor violence against children.

329. A capacity-building workshop on the Convention on the Rights of the Child was held for 20 WHO regional, subregional and country office staff in the Child and Adolescent Health area of work. The orientation included issues related to the United Nations Convention on the Rights of the Child, essential needs of children, standards, violence against children and child sexual abuse. Special attention was given to street children, child soldiers, child prostitution and child trafficking, all identified as major violations of the Convention. Cameroon, Gambia and Lesotho participated in the workshop and incorporated the rights-based approach into national programme planning and implementation. At least 25 nationals were trained in Lesotho in the application of the convention principles and in analysis of the draft adolescent sexual and reproductive health policy.

330. The WHO training package, “Working with Street Children”, was used by NGOs in nine countries.⁸⁸ The training brought together participants working on the problem of street children. The regional agenda against child sexual abuse generated response to this silent emergency by prompting advocacy to improve the visibility of the problem, provide a cohesive agenda for action and facilitate resource mobilization to enable countries to implement appropriate interventions.

331. WHO is committed to supporting countries to put child sexual abuse high on government agendas. Families must be empowered to play their primary role of preventing and reporting. Ultimately, governments have the responsibility to prevent this crime and punish perpetrators in order to protect African children.

ACHIEVING THE HEALTH MILLENNIUM DEVELOPMENT GOALS: SITUATION ANALYSIS AND PERSPECTIVES IN THE AFRICAN REGION

332. The Regional Committee by its resolution AFR/RC55/R2 requested the Regional Director to engage in technical and policy dialogue with international financial institutions regarding the impact of their policies on poverty and health; support the training, recruitment and retention of health professionals in countries; provide technical support to countries in scaling up interventions to achieve MDGs 4, 5 and 6; and support countries in the monitoring and evaluating the achievement of the MDGs.

333. Since the resolution was adopted quite recently (August 2005), implementation has been limited. However, in planning for activities during the 2006-2007 biennium, WHO is considering a more structured process of engaging various partners involved in achieving the health MDGs, including international financial institutions. The process has already started with United Nations and regional intergovernmental agencies, and various memoranda of understanding have already been prepared. Visits were undertaken to various agencies and countries to discuss the health and development agenda and mobilize resources for the African Region.

334. Countries were supported to finalize and adopt their human resources for health strategic plan (Cape Verde and Mauritania) and emergency plan (Cameroon). Seven countries⁸⁹ were supported to start the process. Malawi, Ghana, Rwanda, South Africa and Tanzania were supported to review their pre-service nursing and midwifery training, institutions and educational programmes through internal and external evaluations. Chad, Guinea and Malawi were supported to review pre-service training and programmes for colleges of medicine. Data on human resources for health were collected from all 46 countries of the Region for establishing a regional database and contributing to *The world health*

⁸⁸ Angola, Ethiopia, Ghana, Kenya, Lesotho, Sierra Leone, Uganda, Zambia and Zimbabwe.

⁸⁹ Benin, Botswana, Central African Republic, Guinea, Liberia, Sierra Leone and Swaziland.

report 2006: Working together for health. Partnerships were strengthened with NEPAD, some African civil society organizations and international partners to address the human resources crisis.

335. All countries have adopted the MDGs and are mainstreaming them into poverty reduction strategies, sectorwide approaches, medium-term expenditure frameworks and annual budgets. The move by donors in favour of budget support, debt forgiveness and harmonization presents opportunities for achieving the MDGs. The NEPAD Initiative provides another window of opportunity. The WHO is strengthening support to countries through reprofiling, decentralizing, focusing on universal access and coverage, and addressing the social determinants of health inequalities. However, the international community's commitment to achieving the MDGs in Africa is still limited, and increased awareness and advocacy are needed at country level.

336. A task force is being set up to coordinate the Regional Office's efforts to support countries in the implementation of the resolution. An advisory note is being prepared to remind ministers and WHO country representatives of the salient features of the strategy for the African Region; it takes into consideration the issues and recommendations contained in the report of the United Nations Millennium Project. A process has begun in the context of the NEPAD Bending the Arc project to galvanize WHO and private sector involvement in achieving the MDGs in Africa.

337. In the context of NEPAD, WHO will provide technical support for achieving various donor-supported initiatives while promoting national sectorwide approaches to health development and partnership. Technical support will also be provided for developing more realistic but ambitious health components of poverty reduction strategy papers and medium-term expenditure frameworks, undertaking advocacy and allocating more resources to proven priority health interventions.

338. Countries in the African Region still need to significantly accelerate progress in achieving the MDGs. Some health indicators in the African Region remain relatively poor or are actually worsening as compared to other regions. Countries should be supported to set up good monitoring and evaluation mechanisms to assess the progress made and to indicate the needs for policy re-direction in order to achieve the MDGs. Through its health information system programme and the Health Metrics Network, WHO is supporting countries to improve their monitoring and evaluation systems accordingly.

CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS: A STRATEGY FOR THE AFRICAN REGION

339. The Regional Committee by its resolution AFR/RC55/R3 requested the Regional Director to provide technical support to Member States for the development of national policies and strategic plans for human African trypanosomiasis (HAT) control; and to advocate for additional resources at national and international levels for the implementation of HAT and tsetse control activities in endemic Member States.

340. The Intercountry Support Team for the east and southern Africa subregion received support for drawing up standardized guidelines for the control of sleeping sickness-related to *Trypanosoma brucei rhodesiense*. The guidelines will be submitted for review in 2006 to the national HAT control programme managers and experts of countries concerned. Technical support was provided to Angola to develop a project proposal for funding by Belgium Technical Cooperation, and Kenya was supported to draft a strategic plan for HAT elimination by 2015.

341. Human African trypanosomiasis remains a major public health concern in the Region. Some partners are still willing to support activities such as the ADB-funded Pan-African Tsetse and Trypanosomiasis Eradication Campaign, an initiative to eradicate tsetse flies in countries endemic for animal and human trypanosomiasis, and the WHO-Sanofi/Aventis ongoing partnership which provides free drugs and catalytic funds for HAT control.

342. Factors that hampered the implementation of the resolution include insecurity and sociopolitical upheavals which impeded control activities, especially in highly-endemic countries. Under-reporting the incidence of HAT by national control programmes resulted in underestimation of the disease burden and hindered planning and resource allocation.

343. The endemic countries should put greater emphasis on yearly case detection in all the active foci. They should report quarterly to the Regional Office on their HAT control activities in order to facilitate the monitoring and evaluation of control in the Region as well as guide WHO and other partners in providing technical and financial support.

ANNEX

Budget implementation by area of work, WHO African Region, 2004-2005

Table 1: Budget implementation, all sources and levels

Serial	Area of work*	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Adjustments/ Reprogramming	Funds available	Implementation expenditure	% over approved budget (6/3)	% over funds available (6/5)
1	2	3	4	5	6	7	8
01.1.01	CSR	25,601,000	(2,432,000)	23,169,000	21,073,000	82	91
01.2.01	CPC	46,316,000	1,358,000	47,674,000	41,391,000	89	87
01.3.01	CRD	6,585,000	(5,983,000)	602,000	529,000	8	88
01.4.01	MAL	43,140,000	5,609,000	48,749,000	38,083,000	88	78
01.5.01	TUB	21,511,000	(5,130,000)	16,381,000	10,524,000	49	64
02.1.01	NCD	5,905,000	(784,000)	5,121,000	4,840,000	82	95
02.2.01	TOB	2,449,000	(165,000)	2,284,000	1,782,000	73	78
02.3.01	HPR	6,512,000	(903,000)	5,609,000	5,453,000	84	97
02.4.01	INJ	974,000	1,154,000	2,128,000	1,847,000	19	87
02.5.01	MNH	4,251,000	(2,536,000)	1,715,000	1,465,000	34	85
03.1.01	CAH	16,240,000	1,833,000	18,073,000	14,918,000	92	83
03.2.01	RHR	5,099,000	1,074,000	6,173,000	5,196,000	102	84
03.3.01	MPS	12,626,000	(7,213,000)	5,413,000	4,861,000	38	90
03.4.01	WMH	2,397,000	(1,139,000)	1,258,000	1,166,000	49	93
03.5.01	HIV	120,939,000	(49,916,000)	71,023,000	36,460,000	30	51
04.1.01	HSD	6,116,000	(1,694,000)	4,422,000	4,087,000	67	92
04.2.01	NUT	2,791,000	(1,563,000)	1,228,000	1,060,000	38	86
04.3.01	PHE	7,578,000	(1,758,000)	5,820,000	5,683,000	75	98
04.4.01	FOS	3,189,000	(2,275,000)	914,000	904,000	28	99
04.5.01	EHA	40,296,000	(13,824,000)	26,472,000	22,072,000	55	83
05.1.01	EDM	11,767,000	(3,125,000)	8,642,000	7,877,000	67	91
05.2.01	IVD	182,956,000	213,202,000	396,158,000	359,238,000	196	91
05.3.01	BCT	4,103,000	(317,000)	3,786,000	3,100,000	76	82
06.1.01	GPE	12,187,000	(8,044,000)	4,143,000	3,121,000	26	75
06.2.01	IMD	3,944,000	1,300,000	5,244,000	5,012,000	127	96

Table 1 continued...

Serial	Area of work*	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Adjustments/ Reprogramming	Funds available	Implementation expenditure	% over approved budget (6/3)	% over funds available (6/5)
1	2	3	4	5	6	7	8
06.3.01	RPC	4,415,000	(3,536,000)	879,000	826,000	19	94
06.4.01	OSD	39,035,000	357,000	39,392,000	33,749,000	86	86
07.1.01	GBS	1,363,000	630,000	1,993,000	1,993,000	146	100
07.2.01	REC	2,391,000	3,197,000	5,588,000	4,028,000	168	72
08.1.01	BMR	1,301,000	614,000	1,915,000	1,646,000	127	86
08.2.01	HRS	5,423,000	2,084,000	7,507,000	6,304,000	116	84
08.3.01	FNS	8,572,000	920,000	9,492,000	9,342,000	109	98
08.4.01	IIS	17,778,000	11,363,000	29,141,000	25,973,000	146	89
09.1.01	DGO	1,701,000	373,000	2,074,000	1,674,000	98	81
10.1.01	SCC	67,284,000	7,987,000	75,271,000	73,031,000	109	97
11.1.01	ERH	0	0	0	0		
12.1.01	ITF	0	0	0	0		
13.1.01	REF	0	1,425,000	1,425,000	972,000		
14.1.01	SEF	0	0	0	0		
Totals		744,735,000	142,143,000	886,878,000	761,280,000	102	86

* See page 71 for areas of work.

Table 2: Budget implementation, Regular budget and funds from other sources

Serial	Area of work*	Regular Budget					Other Sources				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
01.1.01	CSR	7,601,000	9,629,000	9,629,000	127	100	18,000,000	13,540,000	11,444,000	64	85
01.2.01	CPC	4,316,000	4,193,000	4,193,000	97	100	42,000,000	43,481,000	37,198,000	89	86
01.3.01	CRD	585,000	360,000	360,000	62	100	6,000,000	242,000	169,000	3	70
01.4.01	MAL	3,140,000	2,781,000	2,781,000	89	100	40,000,000	45,968,000	35,302,000	88	77
01.5.01	TUB	2,511,000	1,673,000	1,672,000	67	100	19,000,000	14,708,000	8,852,000	47	60
02.1.01	NCD	4,905,000	3,619,000	3,617,000	74	100	1,000,000	1,502,000	1,223,000	122	81
02.2.01	TOB	949,000	983,000	983,000	104	100	1,500,000	1,301,000	799,000	53	61
02.3.01	HPR	5,512,000	5,199,000	5,199,000	94	100	1,000,000	410,000	254,000	25	62
02.4.01	INJ	474,000	792,000	792,000	167	100	500,000	1,336,000	1,055,000	211	79
02.5.01	MNH	2,751,000	1,349,000	1,349,000	49	100	1,500,000	366,000	116,000	8	32
03.1.01	CAH	4,240,000	2,364,000	2,364,000	56	100	12,000,000	15,709,000	12,554,000	105	80
03.2.01	RHR	3,099,000	3,106,000	3,106,000	100	100	2,000,000	3,067,000	2,090,000	105	68
03.3.01	MPS	5,126,000	4,098,000	4,098,000	80	100	7,500,000	1,315,000	763,000	10	58
03.4.01	WMH	1,397,000	960,000	960,000	69	100	1,000,000	298,000	206,000	21	69
03.5.01	HIV	5,939,000	4,808,000	4,808,000	81	100	115,000,000	66,215,000	31,652,000	28	48
04.1.01	HSD	3,616,000	2,444,000	2,444,000	68	100	2,500,000	1,978,000	1,643,000	66	83

Table 2: Budget implementation, Regular budget and funds from other sources

Serial	Area of work*	Regular Budget					Other Sources				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
04.2.01	NUT	2,791,000	1,027,000	1,027,000	37	100	0	201,000	33,000		16
04.3.01	PHE	6,578,000	4,536,000	4,536,000	69	100	1,000,000	1,284,000	1,147,000	115	89
04.4.01	FOS	1,689,000	810,000	810,000	48	100	1,500,000	104,000	94,000	6	90
04.5.01	EHA	3,296,000	2,962,000	2,962,000	90	100	37,000,000	23,510,000	19,110,000	52	81
05.1.01	EDM	3,767,000	2,404,000	2,404,000	64	100	8,000,000	6,238,000	5,473,000	68	88
05.2.01	IVD	1,956,000	1,074,000	1,074,000	55	100	181,000,000	395,084,000	358,164,000	198	91
05.3.01	BCT	3,103,000	2,298,000	2,298,000	74	100	1,000,000	1,488,000	802,000	80	54
06.1.01	GPE	2,187,000	1,954,000	1,954,000	89	100	10,000,000	2,189,000	1,167,000	12	53
06.2.01	IMD	3,944,000	4,602,000	4,602,000	117	100	0	642,000	410,000		64
06.3.01	RPC	915,000	698,000	698,000	76	100	3,500,000	181,000	128,000	4	71
06.4.01	OSD	28,035,000	25,093,000	25,093,000	90	100	11,000,000	14,299,000	8,656,000	79	61
07.1.01	GBS	1,363,000	1,993,000	1,993,000	146	100	0	0	0		
07.2.01	REC	2,391,000	2,092,000	2,092,000	87	100	0	3,496,000	1,936,000		55
08.1.01	BMR	801,000	625,000	625,000	78	100	500,000	1,290,000	1,021,000	204	79
08.2.01	HRS	2,423,000	2,277,000	2,277,000	94	100	3,000,000	5,230,000	4,027,000	134	77
08.3.01	FNS	3,572,000	3,451,000	3,451,000	97	100	5,000,000	6,041,000	5,891,000	118	98

Table 2: Budget implementation, Regular budget and funds from other sources

Serial	Area of work*	Regular Budget					Other Sources				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
08.4.01	IIS	12,778,000	14,905,000	14,903,000	117	100	5,000,000	14,236,000	11,070,000	221	78
09.1.01	DGO	1,701,000	1,674,000	1,674,000	98	100	0	400,000	0		0
10.1.01	SCC	52,284,000	67,699,000	67,698,000	129	100	15,000,000	7,572,000	5,333,000	36	70
11.1.01	ERH	0	0	0			0	0	0		
12.1.01	ITF	0	0	0			0	0	0		
13.1.01	REF	0	0	0			0	1,425,000	972,000		68
14.1.01	SEF	0	0	0			0	0	0		
Totals		191,735,000	190,532,000	190,526,000	99	100	553,000,000	696,346,000	570,754,000	103	82

* See page 71 for areas of work.

Table 3: Budget implementation, country and Regional Office levels

Serial	Area of work*	Countries					Regional Office				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
01.1.01	CSR	9,464,000	11,656,000	10,208,000	108	88	16,137,000	11,513,000	10,865,000	67	94
01.2.01	CPC	20,824,000	7,670,000	6,214,000	30	81	25,492,000	40,004,000	35,177,000	138	88
01.3.01	CRD	208,000	92,000	92,000	44	100	6,377,000	510,000	437,000	7	86
01.4.01	MAL	19,218,000	19,705,000	14,125,000	73	72	23,922,000	29,044,000	23,958,000	100	82
01.5.01	TUB	8,758,000	10,627,000	6,349,000	72	60	12,753,000	5,754,000	4,175,000	33	73
02.1.01	NCD	2,467,000	1,528,000	1,420,000	58	93	3,438,000	3,593,000	3,420,000	99	95
02.2.01	TOB	553,000	334,000	258,000	47	77	1,896,000	1,950,000	1,524,000	80	78
02.3.01	HPR	4,825,000	4,675,000	4,653,000	96	100	1,687,000	934,000	800,000	47	86
02.4.01	INJ	671,000	1,131,000	990,000	148	88	303,000	997,000	857,000	283	86
02.5.01	MNH	2,640,000	649,000	637,000	24	98	1,611,000	1,066,000	828,000	51	78
03.1.01	CAH	4,348,000	4,660,000	3,373,000	78	72	11,892,000	13,413,000	11,545,000	97	86
03.2.01	RHR	2,646,000	3,036,000	2,210,000	84	73	2,453,000	3,137,000	2,986,000	122	95
03.3.01	MPS	3,269,000	2,892,000	2,864,000	88	99	9,357,000	2,521,000	1,997,000	21	79
03.4.01	WMH	952,000	473,000	423,000	44	89	1,445,000	785,000	743,000	51	95
03.5.01	HIV	86,895,000	46,161,000	24,062,000	28	52	34,044,000	24,862,000	12,398,000	36	50

Table 3: Budget implementation, country and Regional Office levels

Serial	Area of work*	Countries					Regional Office				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
04.1.01	HSD	3,822,000	2,125,000	1,916,000	50	90	2,294,000	2,297,000	2,171,000	95	95
04.2.01	NUT	1,866,000	462,000	454,000	24	98	925,000	766,000	606,000		79
04.3.01	PHE	4,461,000	3,668,000	3,616,000	81	99	3,117,000	2,152,000	2,067,000	66	96
04.4.01	FOS	1,292,000	285,000	285,000	22	100	1,897,000	629,000	619,000	33	98
04.5.01	EHA	35,011,000	20,626,000	17,461,000	50	85	5,285,000	5,846,000	4,611,000	87	79
05.1.01	EDM	8,330,000	4,206,000	3,654,000	44	87	3,437,000	4,436,000	4,223,000	123	95
05.2.01	IVD	84,804,000	178,981,000	166,507,000	196	93	98,152,000	217,177,000	192,731,000	196	89
05.3.01	BCT	1,563,000	1,011,000	994,000	64	98	2,540,000	2,775,000	2,106,000	83	76
06.1.01	GPE	2,145,000	1,137,000	732,000	34	64	10,042,000	3,006,000	2,389,000	24	79
06.2.01	IMD	295,000	417,000	417,000	141	100	3,649,000	4,827,000	4,595,000		95
06.3.01	RPC	3,704,000	58,000	58,000	2	100	711,000	821,000	768,000	108	94
06.4.01	OSD	26,616,000	28,659,000	24,877,000	93	87	12,419,000	10,733,000	8,872,000	71	83
07.1.01	GBS	0	0	0			1,363,000	1,993,000	1,993,000	146	100
07.2.01	REC	395,000	36,000	36,000	9	100	1,996,000	5,552,000	3,992,000	200	72
08.1.01	BMR	200,000	0	0	0		1,101,000	1,915,000	1,646,000	150	86
08.2.01	HRS	0	0	0			5,423,000	7,507,000	6,304,000	116	84

Table 3: Budget implementation, country and Regional Office levels

Serial	Area of work*	Countries					Regional Office				
		Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (5/3)	% over funds available (5/4)	Approved budget as per WHA 56.32 and EB 113/42 Add.1	Funds available	Implementation expenditure	% over approved budget (10/8)	% over funds available (10/9)
1	2	3	4	5	6	7	8	9	10	11	12
08.3.01	FNS	0	0	0			8,572,000	9,492,000	9,342,000	109	98
08.4.01	IIS	0	0	0			17,778,000	29,141,000	25,973,000	146	89
09.1.01	DGO	0	0	0			1,701,000	2,074,000	1,674,000		81
10.1.01	SCC	64,698,000	71,131,000	69,379,000	107	98	2,586,000	4,140,000	3,652,000	141	88
11.1.01	ERH	0	0	0			0	0	0		
12.1.01	ITF	0	0	0			0	0	0		
13.1.01	REF	0	0	0			0	1,425,000	972,000		68
14.1.01	SEF	0	0	0			0	0	0		
Totals		406,940,000	428,091,000	368,264,000	90	86	337,795,000	458,787,000	393,016,000	116	86

* See page 71 for areas of work.

Areas of Work

BCT	Blood Safety and Clinical Technology
BMR	Programme Planning, Monitoring and Evaluation
CAH	Child and Adolescent Health
CPC	Communicable Disease Prevention, Eradication and Control
CRD	Research and Product Development for Communicable Diseases
CSR	Communicable Disease Surveillance
DGO	Director-General, Regional Directors and Independent Functions
EDM	Essential Medicines: Access, Quality and Rational Use
EHA	Emergency Preparedness and Response
ERH	Exchange Rates Hedging
FNS	Budget and Financial Management
FOS	Food Safety
GBS	Governing Bodies
GPE	Evidence for Health Policy
HIV	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
HPR	Health Promotion
HRS	Human Resources Development
HSD	Sustainable Development
IIS	Infrastructure and Informatics Services
IMD	Health Information Management and Dissemination
INJ	Injuries and Disabilities
ITF	Information Technology Fund
IVD	Immunization and Vaccines Development
MAL	Malaria
MNH	Mental Health and Substance Abuse
MPS	Making Pregnancy Safer
NCD	Surveillance, Prevention and Management of Noncommunicable Diseases
NUT	Nutrition
OSD	Organization of Health Services
PHE	Protection of Human Environment
REC	Resource Mobilization, and External Cooperation and Partnerships
REF	Real Estate Fund
RHR	Research and Programme Development in Reproductive Health
RPC	Research Policy and Promotion
SCC	WHO's Presence in Countries
SEF	Security Fund
TOB	Tobacco
TUB	Tuberculosis
WMH	Women's Health