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Biennial Report of the Regional Director

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Foreword

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

Dr Luis Gomes Sambo
Regional Director

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Abbreviations

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

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

Executive summary

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

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

3. The Programme Budget was implemented within a context of a gradual global financial and economic recovery. A few of the countries of the African Region recorded an average economic growth rate of 5-6% and the majority of governments made efforts to increase investments in the health sector towards achieving the health-related MDGs. Reduction in under-five mortality rate and in the burdens of vaccine preventable diseases, malaria, HIV and NTDs are examples of progress towards the attainment of the MDGs. Even so, the modest investments in health have yet to translate into better health outcomes and the progress has been slow and inadequate to enable attainment of the MDGs by 2015.

4. Providing leadership and engaging partners for joint action remain a primary role of WHO. Through WHO country representatives, the Organization facilitated dialogue among national authorities, health stakeholders and development partners. In line with

the Paris Declaration on Aid Effectiveness, Harmonization and Alignment, WHO also promoted coordination among health development partners under the leadership of the ministries of health. Joint programmes with other UN agencies led to improvement in the coherence of UN action on health, in the context of the UN Country Teams and the United Nations Development Assistance Framework (UNDAF).

5. The engagement of political, traditional and religious leaders of countries as well as international development partners led to improved health outcomes especially of immunization. This resulted in another consecutive year of successful interruption of the transmission of poliovirus in the countries of re-established transmission (Angola, Chad and Democratic Republic of the Congo), a significant reduction in WPV transmission in Nigeria and elimination of the threat of epidemics due to meningococcal A meningitis in the countries of the African meningitis belt.

6. Partnerships with bilateral and multilateral organizations, Regional Economic Communities, the European Union, Global Health Initiatives, foundations, civil society, nongovernmental organizations and academic institutions were strengthened. Through WHO leadership and coordination, the Harmonization for Health in Africa (HHA) partnership mechanism was used to further advance dialogue between ministers of finance and ministers of health. This has resulted in stronger collaboration between ministries of health and ministries of finance and definition of more innovative ways to increase health financing and service delivery with a view to accelerating progress towards Universal Health Coverage.

7. An important role of WHO is to help shape the research agenda and promote the generation, translation and dissemination of knowledge that informs health policy and action. The African Advisory Committee on Health Research and Development (AACHRD) is providing invaluable advice and helping to shape the research for health agenda in the African Region. Through training of young investigators and demonstration projects, important gaps in health needs of the Region are being addressed. Countries were supported to use research findings and new tools to strengthen priority programmes. For example, the integrated community case management of malaria, pneumonia and diarrhoea was informed by recent scientific evidence and knowledge. Through research, guidelines for the implementation of community-based maternal, newborn and child health programmes were developed. National capacity for conducting Stepwise surveillance of NCD risk factors was strengthened in 34 countries that are now generating data to guide actions.

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

9. WHO facilitated the development and adoption of evidence-based regional strategies that guide Member States in the definition of national policies and strategies to address public health priorities. In 2012, the Sixty-second session of the Regional Committee adopted a strategy for Disaster Risk Management (DRM), the roadmap for scaling up human resource for health, the Brazzaville Declaration on Noncommunicable Diseases, the health promotion strategy, the renewed HIV/AIDS strategy, a strategy for consolidation of the African Health Observatory, a policy on health and human rights, and a policy document on optimizing global health initiatives to strengthen national health systems. In 2013, policies and strategies for reproductive, maternal, newborn and child health (RMNCH) interventions, national patient safety, promotion of traditional medicine in health systems, strengthening the capacity for regulation of medical products, utilizing eHealth to improve health systems and controlling neglected tropical diseases were adopted.

10. In the area of providing technical support and catalyzing change WHO supported Member States to develop national policies through multisectoral task forces, to promote health in all policies and to develop legislation on specific risks such as alcohol and tobacco use. Technical support was provided for implementing polio supplementary immunization activities (SIAs), thereby reaching more than 300 million children aged below five years. In addition, more than 153 million people were vaccinated with the meningococcal A meningitis conjugate vaccine (MenAfriVacTM) within four years after its introduction.

11. Member States were supported to implement cost-effective interventions aimed at reducing the burdens of HIV/AIDS, tuberculosis and malaria. Fourteen priority countries scaled up male circumcision to reduce HIV infection. WHO also supported the expansion of antiretroviral therapy for prevention and treatment of HIV/AIDS as well as access to tuberculosis medicines through the Global TB Drug Facility (GDF). This has resulted in 24% reduction in incidence of new paediatric HIV infections, expansion of antiretroviral therapy (ART) for prevention and treatment, reduction of malaria incidence as well as improvement in tuberculosis treatment success rate in the Region.

12. Forty-three countries assessed their core capacity for implementation of the International Health Regulations with WHO support. There was significant improvement in disease surveillance capability of countries in the Region. Cumulatively 36 countries were supported to develop integrated national NTD master plans by the end of 2012 and to begin their implementation. Country capacity to address noncommunicable diseases has increased following WHO guidance and support. Twenty countries have now prioritized the prevention and control of noncommunicable diseases by creating units, programmes or departments in their ministries of health.

13. WHO further strengthened its strategic, technical and logistic support to Member States in response to emergencies that occurred in the Region. It coordinated support for the health components in armed conflicts in Central African Republic, South Sudan and Mali, drought in the Sahelian countries and disease outbreaks in several others, thereby minimizing morbidity and saving lives. Furthermore, WHO, in partnership with other key stakeholders, addressed the food and nutrition aspects of the crisis in the Sahel and in other parts of the Region.

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

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

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

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

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

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

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

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

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

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

1. Introduction

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

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

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

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

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

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

2. Context

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

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

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

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

10. Despite the progress made in reducing the burden of vaccine-preventable diseases, malaria, tuberculosis, HIV/AIDS and some neglected tropical diseases (NTDs) over the years, the burden of these communicable diseases remains unacceptably high. Countries, with technical support of WHO, have made efforts to introduce new vaccines and improve routine immunization coverage, resulting in a reduction of the burden of vaccine-preventable diseases. However, several countries are still experiencing outbreaks of measles while polio remains endemic in Nigeria. Several countries with sub-optimal population immunity, experience polio outbreaks due to importation of wild poliovirus. In 2013, Cameroon, Ethiopia and Kenya had polio outbreaks resulting from importations.

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

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

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

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

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

3. Implementation of the programme budget 2012-2013

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

17. The budget for the WHO African Region for 2012-2013 was 13.4% lower than the 2010-2011 budget. One of the consequences of the reduction of the budget allocation for the Region was a reduction of the budget allocation to some programmes addressing health priorities in the Region. The programmes whose budget allocation decreased significantly were Nutrition and food safety; Health systems; HIV/AIDS, tuberculosis and malaria; Child and maternal health; and Protection of the human environment. At the same time, WHO embarked on reform, worked with countries to prioritize and refocus on challenges, while making strenuous efforts to mobilize additional resources and ensure successful implementation of the Programme Budget.

18. The total funds received for the implementation of the Programme Budget 2012-2013 in the Region was US$ 1 283 408 000, representing a 17% increase compared with the approved budget. Overall, the implementation figures show significant differences across the 13 Strategic Objectives, in terms of the funds allocated, made available or implemented.

19. The variations in approved budget allocations and funding across the 13 Strategic Objectives persisted despite efforts to reduce the misalignment between health priorities and available resources. For example, while the funding for SO1 (including Polio), went justifiably beyond the allocation to 162% and for SO9 to 152%, that for SO2 (communicable

diseases) was only funded at 58% in a region with the highest burdens of HIV/AIDS, tuberculosis, malaria and other communicable diseases. Table 1 below shows how the Programme Budget 2012-2013 was financed and implemented as at 31 December 2013 by Strategic Objective.

TABLE 1: PROGRAMME BUDGET 2012-2013 IMPLEMENTATION RATES BY STRATEGIC OBJECTIVE AS AT 31 DECEMBER 2013 (IN US$000)

STRATEGIC OBJECTIVE (SO)	BUDGET APPROVED BY THE HEALTH ASSEMBLY (INITIAL ALLOCATION)	ALLOCATED BUDGET	TOTAL FUNDING AVAILABLE	% OF AVAILABLE FUNDS AGAINST APPROVED BUDGET	BUDGET IMPLEMENTATION (COMMITTED FUNDS)	% OF BUDGET IMPLEMENTATION AGAINST BUDGET APPROVED BY HEALTH ASSEMBLY	% OF BUDGET IMPLEMENTATION AGAINST AVAILABLE FUNDS
	(1)	(2)	(3)	(4)=(3/1)	(5)	6=(5/1)	7=(5/3
SO 1	484 082	789 061	777 032	161%	698 225	144%	90%
SO 2	147 467	127 458	85 774	58%	76 084	52%	89%
SO 3	18 948	20 380	17 490	92%	16 164	85%	92%
SO 4	77 084	80 569	79 340	103%	67 284	87%	85%
SO 5	91 271	106 268	79 418	87%	74 690	82%	94%
SO 6	20 286	20 277	18 144	89%	17 138	84%	94%
SO 7	10 746	12 741	9512	89%	9068	84%	95%
SO 8	12 719	13 711	11 434	90%	9673	76%	85%
SO 9	10 633	15 630	16 195	152%	11 871	112%	73%
SO 10	71 791	74 424	59 142	82%	52 060	73%	88%
SO 11	25 823	26 017	18 659	72%	16 671	65%	89%
SO 12	45 968	46 928	43 192	94%	42 849	93%	99%
SO 13	76 248	78 251	68 076	89%	67 219	88%	99%
TOTAL	1 093 066	1 411 715	1 283 408	117%	1 156 173	106%	90%

Source: GSM Organization-wide Implementation Report Budget 2012 – 2013

20. The overall implementation rate was 106% of the approved budget. The implementation rate for funds received was 90%. Out of the total funds received for the Region, staff costs consumed 35% while 65% of the budget was used for activities. Despite the high level of implementation of the available funds across the SOs, there is still room for improvement in the day-to-day management and implementation of activities, using workplans as the basis for the use of funds.

21. Overall, with 63% of Office Specific Expected Results fully achieved, the level of achievement of planned results increased compared with the previous biennium 2010-2011 when it was at 54%. Despite the efforts made, the Organization is still facing challenges in implementing the programme budget. These include a better alignment of available resources with the regional priorities and clear links between planned results and health outcomes at country level.

4. Significant achievements by strategic objective

4.1 SO1: Communicable diseases

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

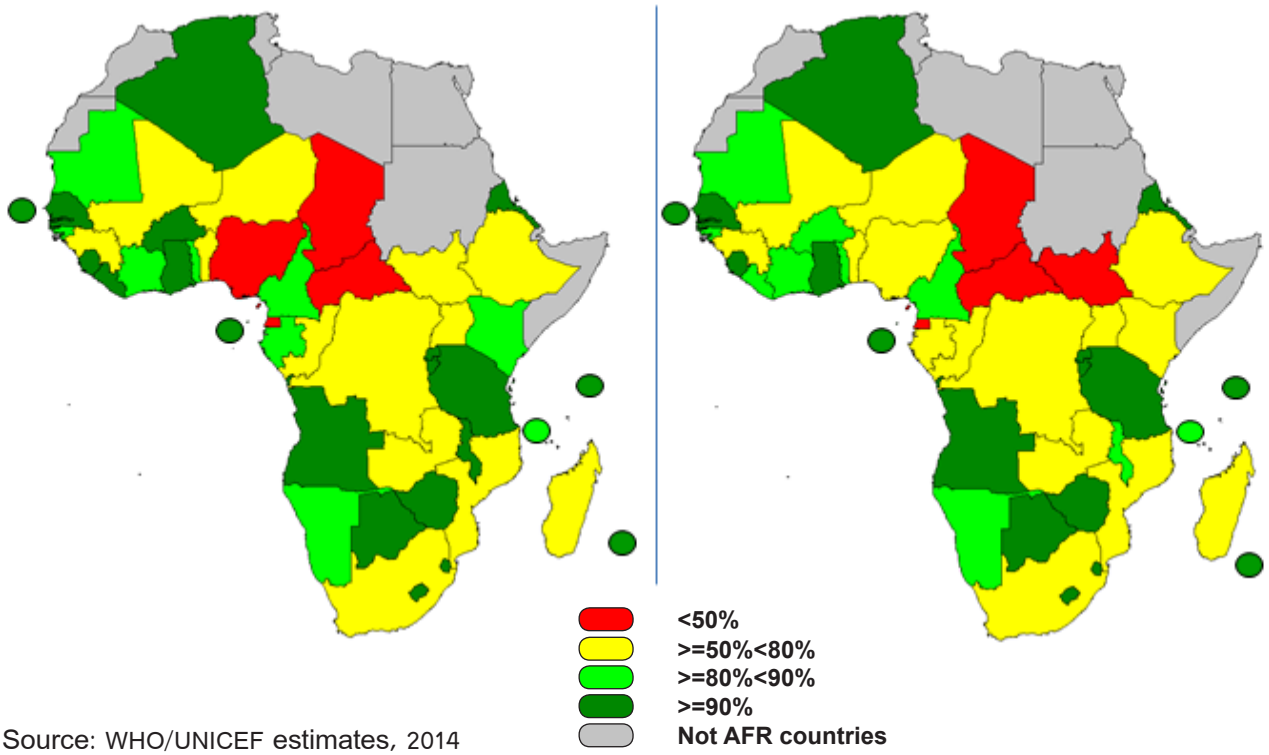
23. Eradication, elimination and control of vaccine-preventable diseases depend on high and sustained coverage with vaccines of the highest efficacy, safety and quality. Based on WHO/UNICEF estimates, immunization coverage rates, with three doses of Diphtheria Pertussis Tetanus-containing vaccine (DPT3) increased from 68% in 2012 to 75% in 2013 (Figure 1) and for measles-containing vaccine (MCV1) from 71% in 2012 to 74% in 2013. Coverage of the third dose of oral polio vaccine (OPV3) increased from 74% in 2012 to 77% in 2013. By the end of 2013, 18 Member States[1] had achieved the DPT3 coverage target of at least 90%. These figures are below the expected 90% national coverage rate due to inadequate funding for routine immunization, infrastructure problems, vaccine stock-outs, and limited human resource for delivery of immunization services. Supplementary immunization activities (SIAs) also play a critical role in boosting population immunity and contributing to the eradication, elimination and control of vaccine-preventable diseases.

24. The World Immunization Week and the African Vaccination Week (AVW) provided an opportunity to undertake advocacy and raise community awareness of the importance of vaccination. These events were commemorated by 35 countries in 2012 and 43 countries[2] in 2013. Over 75 million people received oral polio vaccine in 13 countries together with other public health interventions during the Second AVW in 2012. In 2013, under the theme: “Save lives. Prevent disabilities. Vaccinate,” over 36 million people in ten countries[3] received OPV, together with deworming, Vitamin A, screening for malnutrition, ITNs and preventive treatment of malaria in pregnancy.

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

26. The efforts of Member States, coupled with the technical support of WHO and the investment of partners, resulted in a significant reduction in the transmission of poliomyelitis in the Region. The number of wild poliovirus cases in 2012 was 128 (63% lower), reported in only three countries, namely Chad, Niger and Nigeria, compared with 350 cases in 12 countries[5] in 2011. By December 2013, three countries of re-established transmission (Angola, Chad and Democratic Republic of the Congo) had not confirmed any wild poliovirus case for 29, 18 and 24 months respectively. Although Nigeria reported WPV cases, these were fewer in number, 53 cases as of end-December 2013, compared with 122 cases for the same period in 2012.

Figure 1: Immunization coverage with the 3rd dose of Diphtheria Pertussis Tetanus-containing vaccine (DPT3) in the African Region in 2012 and 2013



Source: WHO/UNICEF estimates, 2014

27. With the support of WHO, 31 countries conducted SIAs against measles in 2012-2013, reaching a total of 133 million children. The SIAs saw the first use of measles-rubella vaccine in Cape Verde, Ghana, Rwanda and Senegal. In response to outbreaks, more than 6.9 million children received measles vaccine in the Democratic Republic of the Congo.

28. To contribute towards the elimination and control of other vaccine-preventable diseases, 7.7 million women of childbearing age received tetanus toxoid vaccine through SIAs in five countries.[6] Elimination of maternal and neonatal tetanus was validated in a cumulative total of 30 countries[7] in the Region by the end of December 2013.

29. To ensure the elimination of meningococcal meningitis due to *Neisseria meningitides* serogroup A, more than 98 million people in seven countries[8] were vaccinated with the meningococcal A meningitis conjugate vaccine (MenAfriVac™) in 2012 and 2013. This resulted in a cumulative total of more than 153 million persons vaccinated in the 4 years since its introduction. As a result of the introduction of MenAfriVacTM in the Region, no laboratory-confirmed case of meningococcal A meningitis was detected among the persons vaccinated. By the end of December 2013, some other countries had introduced pneumococcal conjugate vaccine (PCV) and vaccines against rotavirus. Four countries introduced PCV, while Burundi and Ethiopia introduced vaccines against rotavirus. Cumulatively, 27 countries[9] had introduced PCV by the end of the 2012-2013 biennium. Over the same period, 11 countries[10] in total had introduced vaccines against rotavirus.

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

31. Integrated Disease Surveillance and Response (IDSR) and the International Health Regulations (IHR) 2005 are vital to the control of communicable diseases and noncommunicable diseases in the Region. There was improvement in the disease surveillance capacity of countries in the Region. Between January 2012 and December 2013, 34 countries adapted the revised IDSR guidelines and training modules. Eight of these countries[11] commenced training at national and district levels, resulting in timely reporting and regular publication of epidemiological bulletins, better monitoring of health trends, which is expected to lead to improved detection and response to epidemics, and evidence-based public health decisions.

32. Forty-three countries[12] had conducted IHR core capacity assessment by December 2013. However, none of the countries had fully attained the minimum IHR core capacities by the deadline of 15 June 2012. As a result, countries of the Region applied for a two-year extension. During the Sixty-second session of the Regional Committee, Member States adopted a resolution calling for accelerated implementation of IHRs in the Region. Consequently, WHO convened two consultative meetings among partners, donors and countries to assess the unmet needs for IHR implementation. The action plans developed by countries during these meetings are being used to mobilize resources for IHR implementation. WHO supported the network of Emerging and Dangerous Pathogens (EDPLN),[13] resulting in diagnosis of viral haemorrhagic fevers in the Democratic Republic of the Congo, Nigeria and Mauritania.

33. Sixty-seven and 72 public health events were reported in the Region in 2012 and 2013 respectively. The majority of the events were outbreaks of cholera, meningitis, viral haemorrhagic fevers and zoonotic diseases. A regional consultation bringing together the sectors of animal, human and environmental health was held. At that consultation countries developed roadmaps for accelerated implementation of the 'One Health' approach. These roadmaps are being used to strengthen partnerships between the animal, human and environmental health sectors and to ensure coordinated action in response to zoonotic diseases.

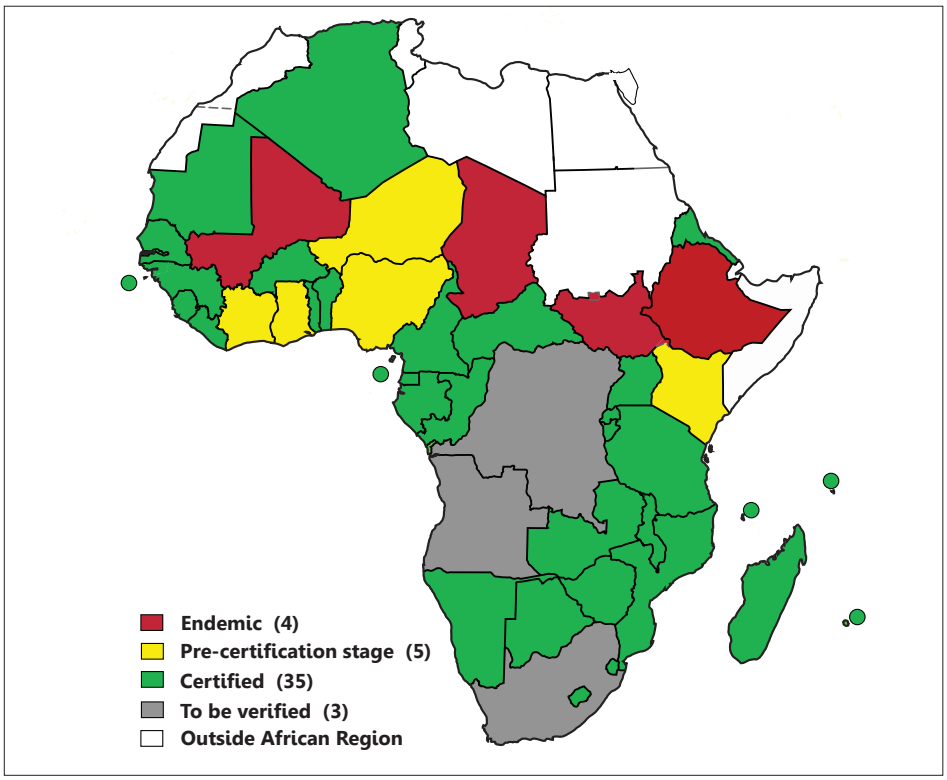
34. Inadequacy of financial resources remained a major challenge in addressing emergencies and disease outbreaks. Recognizing this, the Sixty-second session of the Regional Committee adopted the operational framework for the African Public Health Emergency Fund (APHEF). However, as of 31 December 2013,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

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

36. The annual incidence of guinea-worm disease, a neglected tropical disease targeted for eradication, has decreased by more than 99% since 2005. It decreased from 10 690 cases (including 5565 cases in South Sudan) in 2005 to 145 cases (including 113 cases in South Sudan) by December 2013. Only four countries,[14] remain endemic as of December 2013

(Figure 2). Although leprosy has been eliminated in all countries of the Region, intense transmission continued in a few districts in Comoros, Ethiopia and Nigeria. Detected cases of human African trypanosomiasis dropped from 9875 to 6314 in 2013. A clinical trial in Ghana confirmed the effectiveness of a single dose of Azithromycin as a cure for yaws, providing an opportunity for its use in the eradication of yaws.

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



Source: Member States of the WHO African Region andNTD Programme

37. Using the WHO African Region guide, a cumulative total of 36 countries[15] were supported to develop integrated national NTD master plans by the end of 2012. These plans provided a framework for harmonized planning and prioritization, budgeting and resource mobilization for national NTD programmes in the Region. Furthermore, stakeholders' meetings between Member States and partners recommended the establishment of country and regional NTD coordination structures as well as funding mechanisms to

mobilize additional resources for the country NTD master plans. These recommendations are in line with the Accra Call to Action adopted at the NTD stakeholders' meeting of June 2012. The 66th World Health Assembly adopted the Global Plan to Combat NTDs and a comprehensive resolution on the 17 neglected tropical diseases (WHA66.12 resolution). The Sixty-third session of the Regional Committee adopted a Regional NTD Strategy and a Regional NTD Strategic plan for the period 2014–2020.

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

4.2 SO2: HIV/AIDS, Tuberculosis and Malaria

39. Strategic Objective 2 aims at combating HIV/AIDS, tuberculosis and malaria, three diseases posing major challenges to public health in the WHO African Region. Although the Region accounts for only 10% of the world population, its contributions to the global burdens of HIV/AIDS, tuberculosis and malaria are 71%, 27% and 80% respectively, based on 2013 reports.

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

41. WHO supported Member States to adapt guidelines, strengthen their capacity to scale up high-impact interventions and mobilize resources including through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), for accelerating progress towards universal access to essential interventions against HIV/AIDS, tuberculosis and malaria. That has led to improved quality and coverage of HIV prevention and treatment.

42. The 2013 Global HIV/AIDS report shows that 25 of the 35.3 million people living with HIV/AIDS globally were in sub-Saharan Africa, 2.9 million of whom were children. That represents 88% of the global burden of paediatric HIV/AIDS. In addition, 1.6 million (70%) out of the 2.3 million new HIV infections occurred in sub-Saharan Africa and the overall HIV prevalence, though declining, remains high at 4.7% with wide intercountry variations. The same report revealed an overall 38% decline in new HIV infections between 2001 and 2012. Thirty-one countries[16] in the WHO African Region had reductions of more than 25%, with 14 of the same countries reporting declines of more than 50%.[17]

43. In order to guide implementation of the WHO Global Health Sector Strategy on HIV/AIDS 2011–2015, the Sixty-second session of the Regional Committee adopted a strategy for HIV/AIDS for the African Region. The strategy is being used to accelerate the implementation of HIV activities in order to contribute to the achievement of universal access and the attainment of the MDGs while addressing the determinants of health. By the end of 2013, forty countries had up-to date national HIV/AIDS policies and medium-term plans. The capacity of National AIDS Programme Managers to lead and coordinate their programmes was strengthened through the development of a training manual comprising 11 modules and the organization of workshops for 22 national programme managers.

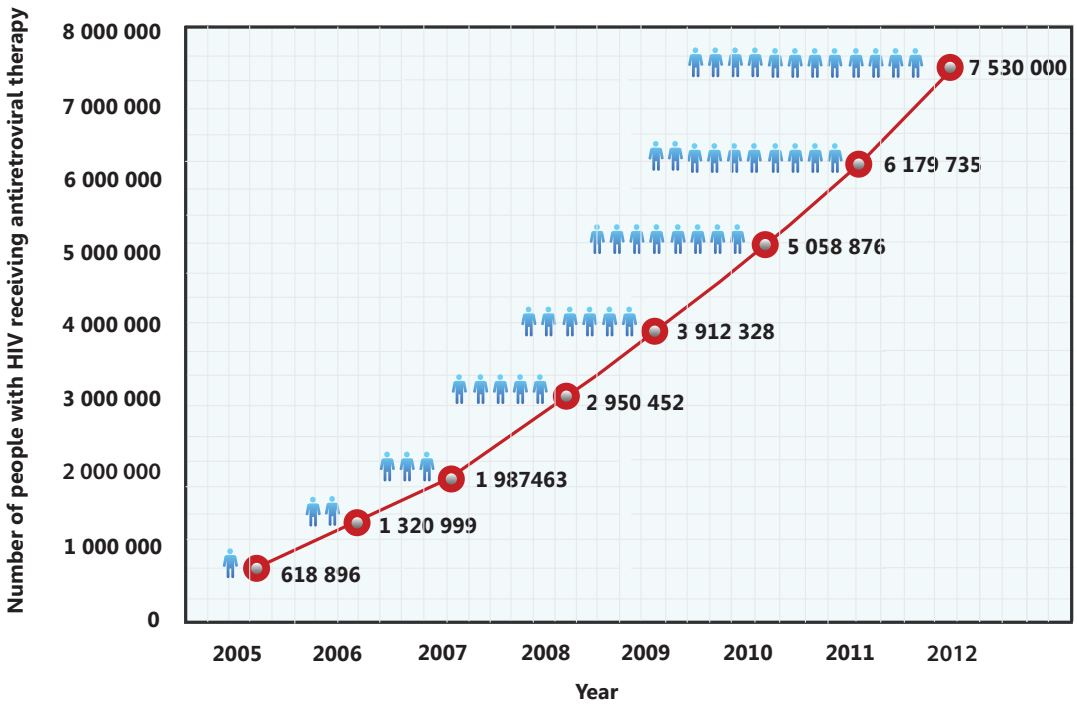
44. Technical support was provided to 14 priority countries to scale[18] up male circumcision in order to reduce HIV incidence. By the end of 2013, a cumulative total of 5 822 924 medical circumcisions had been performed with the coverage increasing from 7% by the end of 2011 to 28% by the end of 2013. This will contribute to a reduction in HIV incidence in these countries. Two consultations on Key Populations were organized in 2012 and 2013 to highlight and address the needs of these populations. It is expected that this will increase access of HIV services to key populations.

45 In 2013, the first WHO consolidated guidelines for the use of antiretroviral medicines to treat and prevent HIV infections were launched. Consequently, the Sixty-third session of the WHO Regional Committee for Africa adopted a resolution to guide implementation of the 2013 WHO Consolidated Guidelines on the use of ARVs. These guidelines expand the eligibility for antiretroviral treatment with a CD4 threshold of 500 CD4 cells per mm3 or less for adults, adolescents and older children. Member States were briefed, through two dissemination workshops, on the operational changes, costs and human resource needs for full implementation of these guidelines.

46. A strategic framework to eliminate new HIV infections among children by 2015 and to keep their mothers alive was developed to help countries reach 90% reduction in new infections. Twenty of the 21 priority countries[19] developed plans for the elimination of

mother-to-child transmission (eMTCT) with WHO support. By the end of 2011, the percentage of pregnant women living with HIV who received ART to prevent MTCT had reached 63% as compared with 49% in 2009. Twelve countries[20] had PMTCT coverage rates of 80% or more, with five[21] having reached the 2015 universal access target of 90%. This has significantly contributed to the decrease by 24% of new paediatric HIV infections in the Region between 2009 and 2011.

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



Source: UNAIDS Report on the Global AIDS Epidemic, 2012

47. WHO provided support to Member States to expand antiretroviral therapy (ART) for HIV/AIDS prevention and treatment. As a result, more than 7.5 million patients received ART by the end of 2012 (Figure 3). ART coverage thus increased from 49% in 2010 to 64% by the end of 2012. Ten countries[22] reached the Universal Access Coverage of more than 80% based on the WHO guidelines. The improved access to ART has led to a reduction of AIDS-related deaths from 1.3 million in 2009 to 1.2 million in 2012.

48. Two regional reports were published on HIV/AIDS. The reports showed that remarkable progress has been made in expanding and scaling up health sector HIV prevention, treatment, care and support interventions and services. These reports were used as advocacy materials to stimulate actions for the HIV response by countries.

49. The high TB burden in Africa is linked to poverty, TB/HIV co-infection and multidrug-resistant TB. More than 75% per cent of TB patients in the African Region were screened for HIV and 55% of eligible TB patients received ARVs in 2012.[23] That percentage marked a significant increase from 2010 when only 59% of TB patients were screened. According to the Global TB report published in 2013, increasing HIV screening and access to ARVs has led to declining TB mortality which is currently 26 per 100 000 population in the African Region.

50. Based on a systematic review of data from countries, WHO has assessed the performance as well as progress towards the achievement of national and regional TB control targets. Based also on results published in 2013, the WHO African Region recorded 1 282 355 new TB cases in 2012. This represents 27% of all new cases notified worldwide in 2012. By end of the biennium, 10 countries[24] had attained the case detection rate of 70% while 18 countries[25] attained the treatment success rate target of 85%. Tuberculosis treatment success rate in the Region was 91% in 2012, and that is a remarkable improvement.

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

52. The Stop TB Strategy recommended by WHO in 2006 requires that countries establish drug-resistant TB management as part of programme implementation. WHO supported countries to set up systems for implementation of Programmatic Management of Multidrug-resistant TB (PMDT). During the biennium 2012-2013, WHO also supported 16 countries[26] to strengthen laboratory capacity for culture and drug sensitivity testing for TB. Ten countries[27] were supported to implement TB drug resistance surveillance and nine countries to undertake TB prevalence surveys. However implementation continues to face challenges mainly due to inadequate laboratory capacity for diagnosis and the high cost of second-line TB medicines.

53. The Secretariat of the Regional green light mechanism was established in 2012 and the rGLC committee appointed in February 2013. The rGLC's main task is to support implementation of PMDT by improving access to second-line medicines and coordinating country technical assistance missions.

54. In 2012, 80% of the 207 million malaria cases and 90% of the 627 000 malaria deaths worldwide were in Africa. An estimated 77% of deaths involved children below five years of age.

55. Data was collected for the World Malaria Report 2013 and support provided to seven countries[28] for Malaria Indicator Surveys. Surveillance bulletins were produced by 10 countries and one IST. Six countries were supported to document best practices in malaria control. The percentage of households owning at least one Insecticide Treated Net (ITN) increased to 60% while the proportion of the population sleeping under an ITN was estimated at 36%. In 2012, forty countries in the African Region used Indoor Residual Spraying (IRS) for malaria control.

56. In 2012, with the support provided by WHO, 41 of 44 countries with ongoing malaria transmission reported the adoption of the policy of providing parasitological diagnosis for all age groups. Hence, 61% of suspected malaria cases underwent a diagnostic test in the public sector. Most of this achievement in testing is attributable to an increase in the use of Rapid Diagnostic Tests and its expansion to the community level. The artemisinin-based combination therapy (ACT) policy had been adopted by 42 countries by 2013 and the proportion of patients in the public sector potentially treated with ACTs reached 60% in 2012.

57. The overall estimated incidence of malaria fell by 31% from 2000 to 2010 and the upward trend of the disease was reversed. Furthermore, 12 countries in the African Region are on track to reduce malaria incidence by at least 50-75% by 2015. Seven countries[29] are implementing malaria control interventions and malaria pre-elimination measures. In addition, a number of national and subregional malaria initiatives were implemented. These include the Sahel countries malaria initiative, the Rwanda Malaria Elimination Forum, the SADC Malaria Elimination Initiative, the East African Community malaria initiative, the Small Island Developing States (SIDS) malaria commitment, and similar initiatives in Comoros, Equatorial Guinea (Bioko Island) and Madagascar.

58. Malaria programme reviews were conducted with partners in 16 countries[30] during the biennium. The reviews provided information for the development of strategic plans, and monitoring and evaluation plans. The process of conduct of malaria programme reviews and development of plans led to enhanced dialogue with key partners and increased funding commitments.

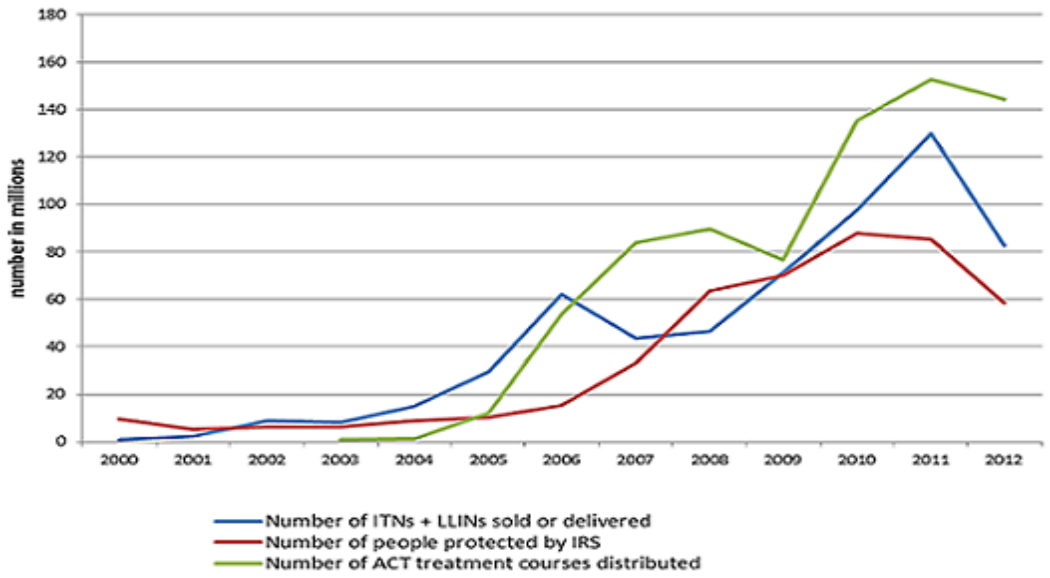
59. Guidance on integrated vector management including larviciding was provided to countries as a complementary intervention. Policy orientation on Intermittent Preventive Treatment of malaria in pregnancy (IPTp) was updated and disseminated. On average, 38% of pregnant women in 34 countries[31] received two doses of Intermittent Preventive Treatment of malaria in Pregnancy (IPTp). The Seasonal Malaria Chemoprevention Guideline was launched in 2012 and used to support the development of country implementation plans.[32] The Test, Treat, Track initiative manual and the malaria control and elimination surveillance manual[33] which were launched by the WHO Director-General in 2012 on the occasion of World Malaria Day were both disseminated. Support was provided to Member States for setting up antimalarial therapeutic efficacy testing.

60. In order to strengthen capacity in malaria surveillance, WHO, in 2012, supported participants from 10 countries[34] to attend an advanced malaria surveillance training. As a result, malaria control programmes updated or supplemented interventions with new knowledge for greater impact. Furthermore, technical assistance was provided to 11 countries[35] for the implementation of Integrated Community Case Management (iCCM) including capacity building for traditional health practitioners. This resulted in the involvement of additional partners in activities related to the scaling up of malaria control interventions and achieving universal coverage.

61 In furtherance of evidence-based planning, WHO developed an operational manual to support implementation of interventions by Member States. Sixteen countries were supported to conduct Malaria Programme Reviews and to develop their third generation national malaria strategic plans. Courses on planning and managing malaria control programmes were held in Benin and Ethiopia, bringing together 209 participants. Support for building the capacity of Traditional Health Practitioners in the control of malaria and other diseases was provided to Benin, Mali and Niger. Five countries[36] were supported to document best practices in malaria control.

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

Figure 4: Trends in the expansion of malaria interventions in the WHO African Region, 2000-2012

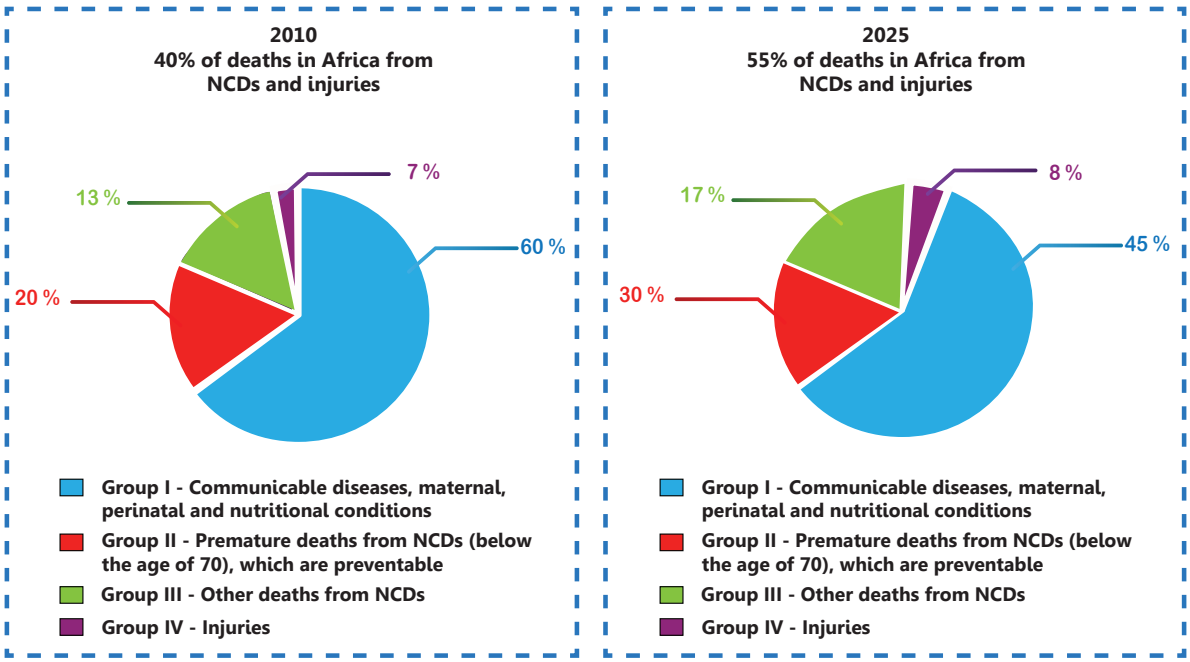


Source: Malaria Report 2013.

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

63. Strategic Objective 3 addresses the prevention, control and management of cardiovascular diseases, cancers, diabetes, chronic respiratory diseases, sickle-cell disease, violence, injuries and disabilities, oral diseases, blindness, deafness and mental disorders. Noncommunicable diseases (NCDs) represent a growing public health problem, placing a huge socioeconomic burden on countries. These conditions are strongly associated with a number of risk factors such as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity as well as environmental factors. Should current trends continue, it is projected that deaths from noncommunicable diseases would increase by 15% over the next 10 years (Figure 5).

Figure 5: Comparison of estimated deaths in 2010 and projected NCDs deaths and injuries in 2025 in the African Region



Source: Global Status Report on Noncommunicable Diseases, 2010

64. The main strategic achievement regarding NCDs was the endorsement of the Brazzaville Declaration on NCDs, and a related resolution, by ministers of health of countries of the African Region during the Sixty-second session of the Regional Committee in Luanda in November 2012. Thirty-five countries have redirected their policies and accelerated the implementation of prevention and control interventions. In addition, the recommendations that were made during regional consultative meetings on NCDs and mental health informed four global strategic documents.[37]

65. Surveillance of NCDs has been enhanced through the development of a regional database involving 21 countries.[38] This e-database will feed into the African Health Observatory (AHO) and the Real-time Strategic Information System (r-SIS). The number of countries having national health information systems that provide information on the magnitude, causes and consequences of NCDs increased from 10 to 20 by December 2012. The ability of countries to capture the parameters mentioned helped national health authorities in decision-making.

66. A regional database and the regional fact sheet on road safety with data from 44 countries were produced in 2012. This informed normative guidance to Member States and provided a baseline for monitoring the Decade of action for road safety 2011–2020. In addition, the capacity of six countries[39] to collect data on violence and injuries was strengthened. Training in hearing impairment surveys was provided for participants from most countries.

67. The capacity of countries to address NCDs has been enhanced following WHO guidance and support. Twenty countries have now raised the priority given to NCD prevention and control by creating units, programmes or departments in their ministries of health. Twenty-seven countries are now on track to finalize integrated action plans for the prevention and management of NCDs. Four countries[40] were supported to evaluate the status of prevention and control of NCDs at primary care level. Policies and plans for other noncommunicable conditions such as hearing impairment, deafness, noma as well as the issue of road safety have been developed and are being implemented in eight countries.[41] In addition, five countries[42] were supported to develop national cancer control action plans while four countries[43] were supported in the area of oral health.

68. Other achievements in noncommunicable diseases in the Region include the development of algorithms for integrated prevention and control of oral diseases and noma, eye disorders and cancer at primary care level for seven countries;[44] building of evidence and documentation of best practices in the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS); sickle-cell disease and haemoglobinopathies research in Benin, Guinea and Zambia; and conduct of feasibility and effectiveness studies on the Mental Health Gap Action Programme (mhGAP).

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

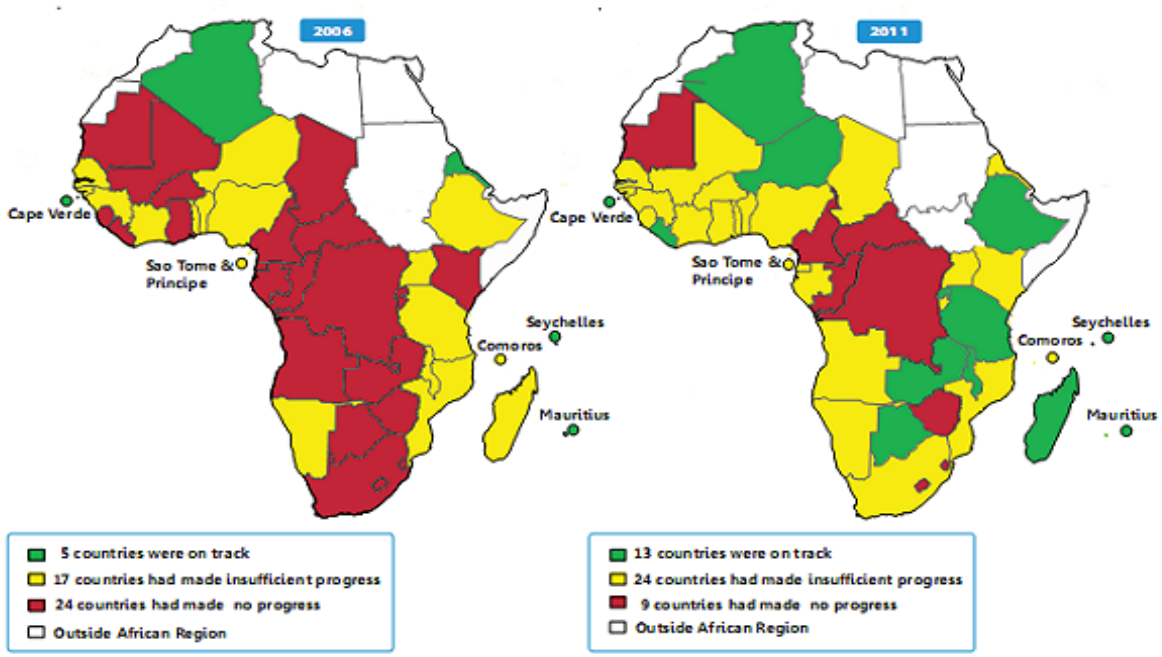
4.4 SO4: Child, adolescent and maternal health, and ageing

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

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

72. The 2012 Levels and Trends of Child Mortality report showed that under-five mortality in the Region dropped from 109 per 1000 live births in 2010 to 95 per 1000 live births in 2012.[45] Neonatal mortality in the African Region has decreased from 44 per 1000 live births in 1990 to 32 per 1000 live births in 2012. Fifteen countries are on track to achieve the MDG 4 target of reducing under-five mortality rates by two thirds between 1990 and 2015. Twenty five countries are making progress towards achieving this target, although it is insufficient; and six countries have made no progress (Figure 6).

Figure 6: Progress the towards Fourth Millennium Development Goal in the African Region, 2007 and 2012 reports



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

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

73. According to the 2013 estimates of maternal mortality, four countries[46] are on track to attain their MDG 5 targets and 17 countries[47] have reduced their maternal mortality ratio by more than 50%. Thirty-four countries have also made progress, while nine countries have made no progress. The contraceptive prevalence rate rose from 19% in 1990 to 27% in 2012.

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

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

76. WHO continued to support Member States in implementing the recommendations of the High Level Commission to advance women's and children's health. The ten recommendations of the High Level Commission on Information and Accountability (CoIA) were implemented. All the 42 priority countries[48] were given guidance and support to conduct national stakeholders' consultations on CoIA. Thirty-seven countries[49] received catalytic funding and have developed their country roadmaps to guide the implementation of the recommendations. In response to the recommendations of the High Level Commission on Life-Saving Commodities for Women, WHO supported 11 countries[50] to develop and submit proposals for addressing various barriers to accessing 13 life-saving commodities. Eight proposals were thus funded by the Secretariat of the Commission and are being implemented.

77. With the goal of rallying all stakeholders around the same plans, with governments taking the lead and partners aligning their efforts to a few agreed effective strategies and interventions, WHO supported 28 countries[51] to revise their Roadmaps For Accelerating

the Reduction of Maternal and Newborn Mortality. Following the Global Family Planning summit held in London in 2012, a total of 21 countries[52] renewed family planning (FP) and 13 countries[53] developed and implemented comprehensive national FP plans. Furthermore, four countries[54] developed reproductive health strategies and four other countries[55] updated their national child health strategies.

78. In order to reduce maternal and child mortality and help accelerate countries' progress towards achieving the MDGs, substantial emphasis was put on supporting the improvement of quality of care through guideline development and capacity building. In this regard, the capacity of 11 countries[56] in the use of the IMCI Computerized Adaptation and Training Tools was enhanced. In addition, tools and guidelines including Focused Antenatal Care (FANC) training materials; Integrated Management of Adolescents/Adult Illnesses; Integrated Management of Pregnancy and Childbirth; Prevention of Mother-to-Child Transmission (IMAI/IMPAC/PMTCT); and the Regional Agenda for Accelerating Universal Access to Sexual and Reproductive Health services, have all been developed and disseminated.

79. Noting the heavy burden of cervical cancer and its contribution to high mortality among women in the Region, 26 countries[57] were given guidance for introducing the human papillomavirus (HPV) vaccine as a key strategy in the holistic approach to the prevention and treatment of cervical cancer. This new vaccine, which targets girls aged nine to 13 years old, has the potential to reduce deaths from cervical cancer during women's reproductive and post-reproductive years. WHO, in collaboration with UNICEF and UNFPA, developed tools to support countries in assessing and identifying adolescent health interventions to be delivered along with the HPV vaccination.

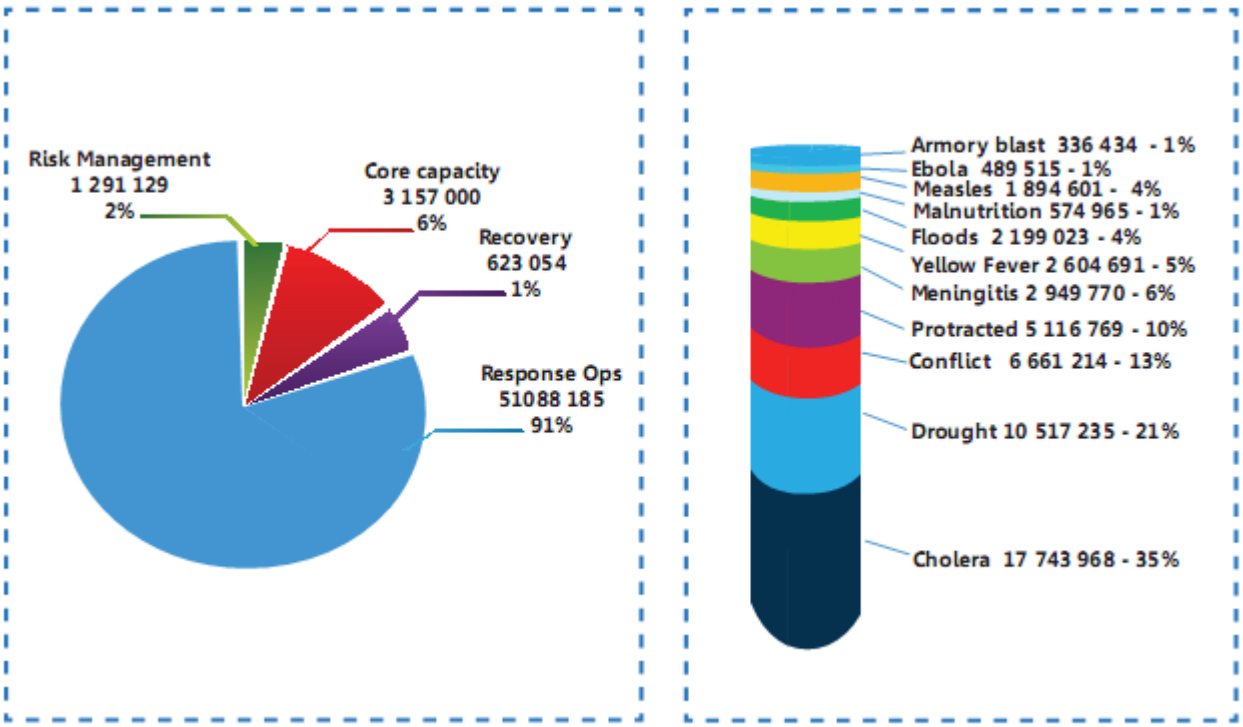
80. Under SO4, WHO advocated for policy change, provided guidelines and tools, built the capacity of Member States, in addition to providing technical support, all aimed at reducing maternal, infant and child mortality in order to achieve the MDGs.

4.5 SO5: Emergencies, disasters, crises and conflicts

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

82. A major development in Strategic Objective 5 (SO5) was the adoption at the Sixty-second session of the Regional Committee in Luanda, in November 2012, of the Regional Disaster Risk Management (DRM) strategy together with a related Resolution AFR/RC62/R1 urging Member States to, among other things: provide leadership and mobilize partners for the development of national roadmaps for implementation of the key interventions outlined in that regional strategy and to mobilize and allocate the necessary human, material and financial resources for the implementation of interventions. The DRM strategy represents a shift in the approach to disaster management from only response provision (Figure 7) to building national resilience for risk prevention and reduction.

Figure 7: Distribution of funds in response to disasters prior to the Disaster Risk Management Strategy



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

83. Between January 2012 and December 2013, a total of 18 significant events were reported in the African Region. These events, classified as weather-related (49%), disease outbreaks (30%), armed conflicts (20%), and accidents (1%), crippled health systems and disrupted socioeconomic activities in many of the affected countries in addition to loss of human lives. About 100 million people in 35 countries in the Region were affected by

these emergencies. The most significant events included the food crisis in the Sahel, floods in West and Central Africa, cholera outbreaks in eight countries,[58] outbreaks of Ebola in Democratic Republic of Congo and Uganda, Marburg in Uganda and dengue fever in Seychelles. Armed conflicts occurred in Central African Republic and Mali and have remained protracted in the Democratic Republic of Congo. There was explosion of an ammunition depot in Brazzaville, Congo, with devastating effects.

84. Sectarian violence in Central African Republic from 5 December 2013 claimed 610 human lives in just one week and caused displacement of nearly 600 000 people in Bangui alone, with about 935 000 people displaced countrywide. From 15 December 2013, South Sudan experienced an armed conflict that started in the capital, Juba, and spread rapidly to seven States in the country, with an estimated 205 000 civilians displaced and 1000 deaths.

85. WHO provided strategic, technical, logistic and financial support to the affected countries in response to the emergencies and to save lives. For instance, WHO supported the development of a response framework to guide coordination of the health response in the Sahel food crisis. The framework was used for advocacy for fund mobilization for the affected countries. Applying the WHO Emergency Response Framework (ERF), the Organization promptly deployed a surge team in Central Africa Republic following the declaration of Grade 3 by the WHO Director-General. Through the Health Cluster coordination mechanisms in countries, WHO coordinated the health response to events reported, resulting in improved and accelerated action in disaster management.

86. In line with Resolution AFR/RC62/R1, the WHO African Region took the lead in developing six tools for the implementation of the DRM strategy. The tools are (a) Country Capacity Assessment (CCA); (b) Hospital Safety Index (HIS); (c) guidelines for conducting vulnerability risk assessment and mapping (VRAM); (d) standard operating procedures; (e) guidelines for recovery and transition framework; (f) core competencies for the development of training modules for health workers. The tools have been disseminated to countries for use. In November 2013 WHO also facilitated the regional consultation on development of training curriculum on emergencies for health workers with a view to improving emergency management capacity in the Region.

87. Capacity building for the implementation of the regional DRM strategy commenced in 2012. By November 2012, a total of 94 WHO focal points had been briefed on the WHO Emergency Response Framework (ERF) and the Regional Disaster Risk Management strategy and its related resolution. DRM country capacity assessments were conducted in countries of the Region and roadmaps for strengthening health disaster risk management capacity were developed and are being implemented in the countries.

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

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

90. Though progress has been made by countries in the implementation of the Regional Health Disaster Risk Management strategy (2012-2022), much needs to be done in building health system capacity and resilience to major disasters. The health contribution of countries to the national disaster reduction platforms is also weak and health is not always considered as a key area in Disaster Risk Reduction efforts.

4.6 SO6: Risk factors for health conditions

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

92. An updated strategy for health promotion in the African Region was adopted by the Sixty-second session of the Regional Committee. It focuses on promoting multisectoral interventions across priority public health conditions and calls for innovative financing to support the implementation of policies and related actions. Two orientation workshops on the new health promotion strategy were held in Botswana and Senegal for National Focal Points from the 47 countries of the Region.

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

94. WHO continued to build countries' capacities to estimate the burden of NCDs and the associated risk factors in the population, for the purpose of planning the prevention and control of these diseases. During the biennium, the national capacity to conduct the STEPwise surveillance of NCD risk factors was strengthened in four countries,[59] bringing to 35 the total number of countries with available baseline data on NCD risk factors in the Region. WHO, in collaboration with the Centers for Disease Control and Prevention (CDC) of the USA, trained national officers from the ministries of health and education of 12 countries[60] to conduct the Global School Health Survey (GSHS) in order to monitor the level of behavioural health risk factors among school children. A new survey tool, the School-based Health Policy and Programme Study (SHPPS) for monitoring the implementation of school health policies and programmes for both communicable diseases and noncommunicable diseases, was also introduced in the above countries.

95. Noting the need to strengthen intersectoral actions to effectively address NCD risk factors, WHO organized five national workshops and one subregional workshop for 10 countries[61] on the use of intersectoral approaches for the prevention of child obesity. Participants from eight other countries[62] drawn from the health, nutrition, education and trade sectors were also trained in the development of population-based salt intake reduction strategies using an intersectoral approach. The participating countries were then supported to initiate the development of national strategies for reduction of salt intake and/or prevention of childhood obesity. Participants from eight other countries[63] drawn from the health, nutrition, education and trade sectors were also trained in developing population-based salt intake reduction strategies using an intersectoral approach. A Training of Trainers' workshop was held for 12 participants on how to prevent child obesity focusing on the intersectoral approach. The staff trained will support countries in the Region to develop strategies for prevention of child obesity.

96. In order to strengthen evidence to inform decisions in key areas of policy development and legislation, WHO supported five countries[64] to participate in a research project aimed at collecting data on alcohol advertising. The preliminary results of this research show that exposure to alcohol advertising increases alcohol consumption among the youth,

hence the need to strengthen regulation in alcohol advertising. Six countries[65] are being supported to develop their national alcohol policies through multisectoral task forces, and Mozambique and South Africa were supported to develop legislative measures for control of harmful use of alcohol.

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

98. Member States were supported to develop and enact comprehensive legislation that is in keeping with the WHO Framework Convention on Tobacco Control (WHO FCTC). Ten more countries[66] enacted legislations banning smoking in public places, prohibiting tobacco advertising on national media and requiring tobacco products to bear health warnings. This has not only protected more people from the negative effects of tobacco but has also increased compliance with the WHO FCTC by Member States in the Region.

99. Nigeria is the first country in the Region to complete the Global Adult Tobacco Survey. The results show that about 10% of men and 1.1% of women use tobacco products and 17.3% of adults who work indoors are exposed to tobacco smoke at the workplace. Seven more countries[67] generated new tobacco control data bringing to 45 the total number of countries with data on tobacco use and exposure among youth. Comparable prevalence data on tobacco use has been provided by five other countries.[68] Currently a total of 25 countries[69] have trend data on tobacco use. These are being used as evidence to strengthen implementation of the WHO FCTC and introduce new laws and regulations that are in keeping with the Treaty.

100. Five countries[70] were supported in the emerging area of tobacco taxation and two of them, Kenya and Senegal, have increased taxes on tobacco products with a view to reducing the demand for tobacco. Joint workplans have been developed with two regional economic blocs, the Union Ecomomique et Monétaire Ouest-Africaine (UEMOA) and the East African Community (EAC), to address the issues of tobacco taxation, elimination of illicit trade in tobacco products and promotion of alternative livelihoods for tobacco growers.

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

4.7 SO7: Social and economic determinants of health

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

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

104. Eleven countries[71] were supported to hold national training workshops in order to accelerate the implementation of the regional strategy. The training focused on the leadership and stewardship roles of the ministries of health, coordination mechanisms for multisectoral actions including the setting up of task forces on social determinants of health, and partnership building for mobilizing technical and financial resources.

105. In order to analyse the proximal and structural determinants of health disparities within each country, WHO supported six countries[72] including four Small Islands Developing States (SIDS) in health equity analysis. The reports of the analysis documented the health impact of some key social determinants in the various countries. Mauritius, Sao Tome and Principe, and Seychelles shared their findings during the meeting of the ministers' health of SIDS, held in Sao Tome and Principe in April 2013. Liberia and Madagascar, held national consultations to explore the application of the results to health policy and programme development. The reports will further serve as advocacy tools for governments to address key determinants of health and adopt a health-in-all policies approach.

106. An analysis of the status of implementation of selected intersectoral actions including health in all policies in the African Region was conducted. The findings were applied in developing: (a) an analytical framework for intersectoral action for health; (b) WHO African Region Position Statement on Health in All Policies; and (c) preparation of nine case studies[73] on intersectoral action. These products were discussed at the 8th Global Conference on Health Promotion, held in Helsinki, Finland, in June 2013.

107. The nine country case studies captured experiences in the implementation of intersectoral actions to address key determinants of selected public health conditions. These demonstrate the importance of intersectoral action to achieve health outcomes and the need to engage sectors other than health to address priority public health conditions. Eight case studies on the implementation of the Five Priority Actions contained in the Rio Political Declaration on SDH adopted in 2011 at the World Conference on Social Determinants of Health were published.

108. For the first time ever, WHO conducted an orientation workshop for programme managers from nine countries[74] of Central Africa on mainstreaming equity, gender, and human rights into health programmes. As a result, the Republic of the Congo and the Democratic Republic of the Congo have started collecting sex- and age-disaggregated data and have integrated these into their routine health information systems. These data will help provide useful information for a number of key health programmes and facilitate health equity analysis. A similar workshop on integrating gender, equity and human rights into programmes was conducted in Harare, Zimbabwe for programme managers from six Anglophone countries[75] in 2013.

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

4.8 SO8: Healthier environment

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

111. During the reporting period, WHO supported countries to undertake their situation analyses and needs assessments (SANAs) for implementation of the Libreville Declaration and preparation of national plans of joint action (NPJA). To that end, 12 other countries[76] received WHO technical and financial support. Currently, a total of 34 countries[77] have either initiated or completed this process.

112. Country-specific information generated from the SANAs on environmental determinants of human health and the status of national management systems has continued to be processed through a regional computerized system known as the Health and Environment Linkages Data Management System (HELDS). In order to enhance the functionalities and performance of the HELDS, a second version of the system (HELDS 2.0) was produced and disseminated for use by countries. National experts from eleven countries[78] together with WHO country office staff were trained in the use of HELDS.

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

114. In addition, a detailed documentation of effective health and environment intersectoral projects that address the MDGs was carried out in six countries.[79] The initial findings of these assessments show that there has been increased collaboration and joint projects between ministries of health, ministries of environment and other relevant ministries.

115. A regional action plan for public health adaptation to climate change was developed in consultation with all the 46 Member States. Guidelines for the preparation of national adaptation plans were developed and all African countries received technical support to prepare their national climate change adaptation plans in accordance with the United Nations Framework Convention on Climate Change (UNFCCC).

116. WHO established an International Consortium of Technical and Scientific Institutions (Clim-HEALTH Africa) for the development and implementation of systems of early warning and early response to the public health impact of climate change. Clim-HEALTH Africa will contribute to the health objective of the Climate for Development in Africa Programme of the African Union. As part of the implementation of their HNAPS, five countries[80] were given financial support to carry out large-scale projects on the impact of climate change on malnutrition, diarrheal diseases and vector-borne diseases. Furthermore, since 2012, WHO has been supporting a five-year research initiative on population health

vulnerabilities to vector-borne diseases and community resilience under climate change conditions in five countries. These projects will help increase understanding of the local health effects of climate change, generate evidence and disseminate knowledge on appropriate local adaptation measures.

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

118. In September 2013 WHO launched the 2013 Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS)[81] using data received from 74 developing countries, including 35 in the African Region. The report shows that both developing countries and donors give insufficient attention to operations and maintenance of infrastructure for drinking-water, sanitation and hygiene (WASH) and to information systems for the planning and monitoring of the WASH programme.

119. Collaborating with UNICEF through their joint monitoring programme (JMP),[82] WHO provided technical assistance to Member States to monitor progress towards achieving the Millennium Development Goal on drinking water and sanitation (MDG 7, Target 7c).[83] According to the 2014 JMP report, using 2012 data,[84] the proportion of the total population of sub-Saharan Africa that has access to an improved drinking water source increased from 63% in 2011 to 64% in 2012. Access varied from 46% in Democratic Republic of the Congo to 100% in Mauritius. Coverage exceeds 90% in eight countries.[85] There is also discrepancy in access to safe drinking water between urban areas (85%) and rural (53%) areas. According to the same JPM report, in 2013, only 30% of the population in the Region used improved sanitation facilities. Access to drinking water and improved sanitation facilities remained unchanged from 2011 to 2012, varying from 9% in South Sudan and 10% in Niger to 97 % in Seychelles. Only Algeria and Cape Verde met the MDG targets for sanitation and five countries[86] are on track to do so. Angola, Benin and Ethiopia belong to the top 10 countries[87] in the world to have achieved the highest reduction in open defecation.

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

4.9 SO9: Nutrition, food safety and food security

121. Strategic Objective 9 aims to improve nutrition, food safety and food security throughout the life course in support of public health and sustainable development in the Region. In 2011 it was estimated that undernutrition was an underlying factor in 45% of global child deaths worldwide and the African Region remains the only Region where the number of stunted children in the past decade increased, the highest prevalence of stunting being in East and West Africa.[88]

122. In order to contribute to the MDG4 target of reducing under-five mortality, WHO supported countries to protect and promote appropriate infant feeding practices. This was done mainly through providing support to revise national Infant and Young Child Feeding (IYCF) strategic plans and policies in seven countries[89] and capacity building activities for IYCF in four other countries.[90] Support was provided to six countries[91] to strengthen their capacity to implement the new WHO Growth Chart and to Eritrea, Kenya and South Africa to enact national laws to create an enabling environment for optimal breastfeeding, thereby enforcing the International Code of Marketing of Breast-milk Substitutes.

123. WHO, working in partnership with other key stakeholders through the West and Central Africa Regional Directors Team (RDT), addressed the food and nutrition aspects of the crisis in the Sahel and other parts of the Region, focusing its actions on management of severe acute malnutrition. The Manual on Management of Severe Acute Malnutrition (2000) was revised and twelve countries[92] adopted the guidelines. Cape Verde and Mali participated in the joint UN agencies (WHO, UNICEF, FAO and WFP) project on consolidated school feeding and gardening programme in support of food security, food safety, nutrition and physical activity.

124. Supporting countries to strengthen their nutrition surveillance systems was another key area of focus of WHO. In this regard, 11 countries[93] implemented the Accelerating Nutrition Improvements (ANI) project to boost routine nutrition surveillance and strengthened Multisectoral Coordination Teams for Nutrition. In addition Chad, Comoros and Madagascar received support to strengthen nutrition surveillance in emergency situations.

125. Food safety is a major concern to countries of the Region. As part of WHO's response to food safety concerns, seven manuals, guidelines and tools were published and disseminated. These manuals, guidelines and tools were on foodborne disease (FBD) surveillance, food safety, nutrition and food hygiene for schools, management of severe acute malnutrition with food safety component. In addition, the WHO Five Keys to Safer Food concept was implemented in seven countries[94] as part of food hygiene education and was incorporated into training manuals for the Management of Severe Acute Malnutrition in six other countries.

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

4.10 SO10: Health services

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

128. Technical support was provided to six countries[95] to revise their national health policies and strategic plans in order to guide their national health development process and its funding. Through the Global Learning Programme (GLP) on building the capacity of WHO staff in strategic planning and policy dialogue, 18 WHO country office teams[96] were trained, thus bringing to 46 the total number of WHO country teams trained, and thereby enhancing WHO participation in building systems and services through sound national policies and plans.

129. A guide for costing National Health Strategic Plans (NHSPs) was developed and used to cost NHSPs in 13 countries[97] and to adjust the content of the plans with the resources projected for their implementation. The first Expenditure Atlas of the African Region was published. It provided an overview of national health expenditures in all the countries and enabled comparison between countries. Capacity building in the methodology for conducting National Health Accounts was carried out in 26 countries.[98] As a result, several

countries are using the data gathered to track health expenditure and formulate health financing strategies. Technical support was provided to 19 countries[99] that have started to implement interventions towards universal health coverage.

130. A roadmap for scaling up the health workforce in the African Region for the period 2012–2025 was adopted by the Regional Committee. A framework for implementing this HRH regional roadmap to meet the need for Universal Health Coverage was adopted during the fourth regional consultation on Human Resources for Health (HRH) held in Brazzaville in December 2013. In order to address the health work force crisis and reduce its impact on health service delivery, national policies and strategic plans were developed by seven Member States[100] with the support of WHO. National HRH observatories were established in six countries[101] for improved HRH evidence. In collaboration with the Region's professional associations, academic institutions, WHO collaborating centres, ministries of health, regional economic communities (RECs) and other partners, WHO developed a Professional Regulatory Framework to promote a common approach to nursing and midwifery regulation and education in the Region.

131. The African Health Observatory's integrated data warehouse and platforms on data and statistics, analytical profiles, publications and networking are fully operational. To improve the evidence base for national policy making, 22 country analytical profiles and a regional profile have been added to its portal.[102] Four country statistical atlases[103] and four issues of the African Health Monitor were produced, covering the subjects of health systems, reproductive health, disease control and health determinants. In addition, the Atlas of African Health Statistics 2012 was produced and disseminated to countries.

132. Five countries developed national eHealth strategies and policies. To strengthen national information systems (NHIS), national health observatories (NHOs) prototypes were developed for Cape Verde and Congo while Cameroon and Rwanda have started to develop their NHOs. To improve the monitoring of health systems strengthening a scorecard of the health system in Liberia and Senegal and civil registration and vital statistics systems were assessed in Burkina Faso and Liberia. The institutional capacity of Member States in the registration and use of HINARI to improve access to health information in the African Region, was strengthened.

133. The Evidence Informed Policy Network (EVIPNet), a WHO knowledge translation platform in seven countries, promoted research and evidence gathering that has influenced changes in national policies on major public health practices. The African Advisory Committee on Health Research and Development (AACHRD) is providing invaluable advice and helping to shape the research for health agenda. Demonstration projects were

identified to help address gaps in health needs that disproportionately affect developing countries. To improve national health research capacity, 70 young African investigators from 16 countries were trained in research grant writing in 2013.

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

4.11 SO11: Medical products and technologies

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

136. In order to contribute to improving the availability, quality and rational use of essential medicines, six countries[104] updated their national medicine policies with WHO support. In addition, strategic plans for national medicines were developed by Burkina Faso and Swaziland while Zimbabwe developed a five-year strategy on medicines and medical supplies and Benin evaluated its national medicines policy implementation plan (2006–2010).

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

138. WHO and UNDP provided support to the Economic Community of West African States (ECOWAS) through the West African Health Organization (WAHO) for developing a regional policy and guidelines on flexibilities in the Trade-related Aspects of Intellectual Property Rights (TRIPS). This will enable Member States to update their national policies and legislation and maximize the use of the opportunities provided by TRIPS flexibilities to improve access to medicines. Furthermore, the regional economic communities[105]

of West, Central, Southern and East Africa received WHO support to implement the African Medicines Registration Harmonization Initiative. WHO established a Regional Working Group on Substandard, Spurious, Falsely-labelled, Falsified Counterfeit (SSFFC) medicines for better understanding of the regional implications and contributions to the ongoing global debate on this subject.

139. Under WHO coordination the following important tools and guidelines were developed: (a) framework for regulation of traditional medicine practitioners, practices and products; (b) framework for collaboration between practitioners of traditional medicine and conventional medicine; (c) tool for documenting traditional medicine practices; (d) policy guidance for the protection of indigenous knowledge in African traditional medicine; and (e) a sui generis legislative framework for the protection of indigenous knowledge in African traditional medicine. These tools provide insights for countries, guiding them in operationalizing their national traditional medicine policies and strategies.

140. In collaboration with WHO, the African Union developed the plan of action for implementation of the renewed Decade of African Traditional Medicine (2011–2020) and the Pharmaceutical Manufacturing business plan for Africa both of which were adopted by the African Union Summit of Heads of State and Government in Addis Ababa in July 2012. These tools are being used to enhance the role of traditional medicine in health systems and to promote local production. The West African Health Organization (WAHO) Herbal Pharmacopoeia for the ECOWAS subregion was developed in 2013 to guide the harmonization of technical specifications and quality control standards.

141. Forty-five countries have developed national laboratory quality and blood policies. Out of these 45 countries, six[106] adopted policies during the current biennium and, as a result, progress has been made in the quality and quantity of blood donation. More than half of the needs for blood units safe for transfusion according to WHO standards have currently been met in the Region. WHO contributed to the review of the national blood policy in Burkina Faso. An assessment of the implementation of the Regional Strategy for Blood Safety shows that the status of blood transfusion services was known in 42 countries[107] and that more than 80% of blood donations in 21 countries[108] were voluntary and non-remunerated. Forty-two countries[109] were on record as conducting 100% HIV testing of all blood units, while 40 countries[110] tested for HBV and syphilis, and 39 for HCV.[111] Programmes for strengthening injection safety capacity have been initiated in 20 countries.[112]

142. WHO Guidance for Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) was published and partnerships established with the African Society for Laboratory Medicine (ASLM) and CDC/GAP-Atlanta for its implementation. As of 2013, 56 laboratories in eight countries[113] had applied the SLIPTA approach and three public health laboratories had been accredited in four countries.[114] Twenty laboratory experts from both the veterinary and public health laboratories in eight central African countries[115] were trained in ISO 15189 standards.

143. Biosafety officers from four countries[116] were trained in biorisk management and transportation of infectious substances according to IATA and WHO shipping regulations. In order to support countries to strengthen their health laboratory services and shift from disease-specific focus towards integrated, coordinated laboratory systems, the "Guidance for Establishing a National Health Laboratory System (NHLS)'' was disseminated to countries. Congo developed a roadmap for strengthening the NHLS while Eritrea and Sao Tome and Principe developed their national laboratory policies and strategic plans. With CDC support, the African Centre for Laboratory Equipment Maintenance (ACLEM) in Enugu, Nigeria, was established as a Centre of Excellence to perform Biosafety Cabinets maintenance, certification and repair services.

144. The guidance for developing national patient safety policies and plans was finalized. The African Partnerships for Patient Safety (APPS) was extended to five countries.[117] As a result, these countries have now included patient safety in their national health development plans. With WHO support, a ministerial meeting on patient safety for 20 countries[118] was organized to raise awareness of, and intensify interventions on, patient safety.

145. The capacities of the national medicines regulatory authorities (NMRAs) were strengthened by establishing institutional development plans and carrying out training of professionals within the framework of the network of African Vaccine Regulatory Forum (AVAREF). Furthermore, the capacity of 21 Member States[119] for oversight of vaccine clinical trials was strengthened. As a result, seven countries are providing ethics and regulatory oversight and ensuring the safety of participants in a phase 3 clinical trial of a malaria vaccine.

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

4.12 SO12: Leadership, governance and partnership

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

148. WHO sustained advocacy for increased investment to strengthen national health systems and promote health by undertaking high-level missions to 29 countries within and outside the Region. In addition, through the Regional Director's participation in 14 major international conferences, he raised awareness of regional health needs, priorities and strategies, and WHO support to Member States. The themes of the conferences include future approaches to funding, partnerships and access to health care in Africa; moving towards global health equity; saving mothers — giving life; the new era in HIV/AIDS treatment and prevention; noncommunicable diseases risk factors; immunization; human resources for health; and value for money, sustainability and accountability in the health sector. This contributed to sustained partner support for WHO's work in the African Region and domestic investments for health development.

149. The heads of WHO country offices (HWCOs) in the Region ensured that health remained an integral part of national development and aid cooperation. They facilitated dialogue between governments, health stakeholders and development partners. In line with the Paris Declaration on Aid Effectiveness Harmonization and Alignment, they spearheaded coordination among health development partners under the leadership of the ministries of health. Furthermore, they led the public health agenda within UN country teams and ensured that UNDAPs/UNDAFs reflected national health priorities. Joint programmes with other UN agencies in 21 countries led to improvement in the coherence of UN action in health, improved harmonization, alignment with national plans and other partners' efforts, and better health sector coordination,

150. The WHO reform emphasizes response to country needs and underscores the importance of the Country Cooperation Strategy (CCS) as the key instrument for WHO cooperation with Member States. Technical support was provided to thirty-nine countries to review their CCSs. By end of 2013 all countries had a valid CCS. The 46 country offices were restructured to improve efficiency and further strengthen WHO's presence in countries. Agreement was reached with the Government of Algeria, resulting in the elevation of the WHO Liaison Office in that country to a fully-fledged WHO Country Office. Advantage

was taken of meetings, including two Regional Programme Meetings (RPM), to inform all staff about the ongoing WHO reform and the planning, implementation and monitoring of WHO programmes. This has improved coherence in policy orientation and accountability at all levels.

151. The fourth meeting of ministers of health of Small Island Developing States (SIDS) composed of Cape Verde, Comoros, Mauritius, Sao Tome and Principe, and Seychelles, was successfully held in Sao Tome and Principe in April 2013, culminating in the adoption of a Communiqué. The Communiqué contains commitments by these Member States to address the social determinants of health, noncommunicable diseases and their risk factors, malaria, and universal health coverage. The SIDS Network Web Community for collaborative work was established in 2013 with the support of the African Health Observatory portal to facilitate continuous sharing of experiences.

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

153. The Sixty-second Regional Committee extensively discussed several agenda items including the ongoing WHO reform and adopted resolutions on disaster risk management; accelerating HIV/AIDS prevention and control; the roadmap for scaling up human resources for health; the strategy for health promotion; strengthening national health information systems through the African Health Observatory; health and human rights; the Brazzaville Declaration on Noncommunicable Diseases; and the implementation of International Health Regulations 2005. The Regional Committee welcomed and accepted the request of the Republic of South Sudan to be reassigned to the WHO African Region. The request was also accepted by the Sixty-sixth session of the World Health Assembly. The Sixty-third Regional Committee adopted six resolutions[120] including a resolution on the proposed changes to the rules of procedure of the Regional Committee in addition to adopting the new terms of reference for the Programme Subcommittee. This resolution thus implements Decision 9 of the 65th World Health Assembly urging harmonization of the rules and practices of the Regional Committees within the context of the WHO reform. Implementation of the resolutions is expected to improve national capacity to prevent, manage and monitor priority diseases.

154 Partnerships were also strengthened through the participation of WHO and partners in joint meetings, missions and activities. WHO continued to strengthen and diversify partnerships with bilateral organizations (USAID, CDC, CIDA, DFID, French Cooperation, Switzerland), multilateral organizations (World Bank, European Union, GAVI, Global Fund, African Development Bank, African Union), regional economic communities (COMESA, SADC, ECOWAS, ECCAS, IGAD, CEN-SAD), United Nations Development Group for Africa (UNDGA) and Foundations (Bill and Melinda Gates, Rotary, Hewlett) with a view to achieving better health for people in Africa. Regional Coordination Mechanism through consultations, dialogue, advice and synergies was improved, fostering new partnerships towards better health for people in Africa. WHO also signed MOUs with six new partners, including NGOs. Partnerships with civil society, NGOs, the private sector and academic institutions were initiated and/or strengthened.

155. WHO led and coordinated action by the 16 members (including two associate members) of the Harmonization for Health in Africa (HHA) partnership mechanism, to further advance dialogue between ministers of finance and ministers of health to improve financing of the health sector in countries. HHA organized an interministerial meeting that adopted the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector, a framework to guide the action of countries and partners in accelerating progress towards Universal Health Coverage. A pool of HHA resource persons was trained to provide an integrated and harmonized response across member agencies in the Region in the area of planning and budgeting (NHSP) using the OneHealth tool.

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

157. Coordination within HHA was strengthened through Conference calls of the Steering Committee members, biennial steering committee meetings and annual HHA Regional Directors' meeting. The coordination was also strengthened at country level, where HHA activities were facilitated by WHO Representatives as conveners in the light of the decision of the HHA Regional Directors in October 2012. HHA activities at country

level are now jointly planned, implemented, monitored and reported by HHA members who are more aware of HHA policies, objectives and activities. This has resulted in a harmonized and efficient HHA partners' support for health system strengthening.

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

159. Collaboration with the African Union Commission (AUC) and the United Nations Economic Commission for Africa (ECA) was strengthened. An agreement between WHO and AUC was approved by the Sixty-fifth World Health Assembly and signed in 2012 to replace the previous one signed between WHO and the Organization of African Unity. A WHO-AUC joint plan of action 2012-2013 was developed and implemented. WHO supported the development of the AUC publication entitled: *50 Years of Health and Development.*

160. WHO supported the development of the constitution of the African Federation of Obstetrics and Gynecology (AFOG) and its launch during the World Congress of Obstetrics and Gynecology in October 2012. On that occasion, the Regional Director delivered an inaugural address, underscoring the potential roles of AFOG in advocacy for allocation of more resources by governments for maternal and newborn health, strengthening the capacity for skilled maternal and neonatal care, supporting operational research aimed at scaling up key interventions for maternal and newborn health, along with monitoring of the quality of maternal and neonatal care in countries. Executive members of the African Federation of Public Health Associations (AFPHA) were supported to develop a strategic plan and to participate in the 13th Congress of the World Federation of Public Health Associations in 2012 in Addis Ababa.

161. Training in donor communication and resource mobilization was provided for 120 staff from 12 countries.[121] This activity contributed to an increase in the resources mobilized, compared with the preceding biennium.

162. Public understanding of the work of WHO and health issues was promoted through regular production and dissemination of information materials. The online availability of most of these materials contributed to a 39% increase in the number of visits to the WHO African Region web site from 38 484 in 2010-2011 to 53 681 in the 2012-2013 biennium.

The introduction of electronic newsletters by WHO Offices across the Region improved branding and visibility. Social media platforms such as *Twitter* and *YouTube* were set up and used to raise awareness of the work of WHO in the Region.

163. Staff improved their knowledge and learned effective communication and resource mobilization techniques through capacity building workshops. A network of communication officers was established and it provided support to South Sudan and Central African Republic during the humanitarian crisis in the two countries. The work of this network contributed to improving the awareness of people affected by disease outbreaks and emergencies, promoted health and reduced the spread of diseases and other health hazards.

164. In a nutshell, Strategic Objective 12 advocated for increased domestic and external investments in health systems; improved coordination among health development partners; enhanced WHO partnership and resource mobilization with health stakeholders and supported reviews of CCSs.

4.13 SO13: Efficient and effective WHO

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

166. The programme management function was strengthened by training 94 staff members in charge of planning and providing direct assistance to all Budget Centres on a daily basis. This continuing support has contributed to a better utilization of the result-based management framework and improved the management of workplans through effective use of the GSM.

167. The end-of-biennium assessment report showed a smooth implementation of planned activities in 2012-2013, which led to more measurable results that, among other things, enhanced WHO accountability and transparency. The systematic issuance of periodic monitoring reports such as the Budget Monitoring Report (BMR) and the Award Distribution Report served as alert tools for Budget Centres. These reports have improved oversight of

Programme Budget implementation and thus simplified the reprogramming of workplans to ensure better alignment of available funds with planned costs and adjusted budget allocations whenever needed.

168. The Region complied with the revised reporting requirements for closure of the 2012-2013 biennium. The changes made ensured that WHO financial reports were in accordance with International Public Sector Accounting Standards (IPSAS). This includes a requirement for reporting and certifying specific elements as set forth in the Regional Director's representation letter, based on submissions from all the 47 heads of WHO offices in the Region. This has improved the transparency, accountability and standards of financial reporting. Reports on performance, compliance and implementation are now submitted to the Programme Subcommittee, in line with the WHO reform agenda.

169. The main bank accounts were fully reconciled. However eight out of 270 imprest accounts in countries had items outstanding for over 90 days. This marks a significant improvement compared with previous years. Replenishment levels for the country imprest accounts were reviewed to maintain minimum cash/bank balances at the country levels thus minimizing the risk of loss of purchasing power due to exchange rate fluctuations or emergencies.

170. Management of salary workplans and the distribution of staff costs to appropriate funding sources have improved through continuous follow-ups and support provided to budget centres. Award distribution and monitoring were efficiently managed to ensure that funds were utilized within prescribed periods to avoid losses.

171. Guidance and support was provided for Intercountry Support Teams and country offices to implement human resource policies. The staff evaluation compliance rate through ePMDS improved significantly to 82% in 2013, following the launch of the tool in 2013. Efforts were made to recruit more females in WHO offices in the African Region in fulfilment of the Organization's gender balance policy despite persistent problems such as challenging duty stations and lack of spousal employment opportunities. Nine staff members who had provided more than 30 years of service to WHO were recognized with award of certificates by the Director-General and the Regional Director. Refresher courses were organized in various areas of administration and recurrent training was mainstreamed.

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

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

174. The capacity of ICT staff was strengthened to facilitate the work of WHO. It ensured that staff members were on the same page and there was commitment to the roll-out of global projects. This will translate into more efficient support to technical programmes. A WHO global email system was introduced and all staff in the African Region now have a single email domain (@who.int). Work has begun for the Global Synergy (WHO Common and standard workstation configuration). The new CISCO Unified Communications Manager (CUCM) telephone and communication system is under deployment. These initiatives will significantly improve communication and further reduce expenditure on travel and meetings.

175. Actions are underway to improve value for money within the Organization, the main objective being to ensure procurement at competitive prices with best quality and timely delivery to all budget centres across the African Region. Inventories were conducted to compile capitalized asset inventory data. This important requirement of IPSAS had been mentioned as a weakness in several previous audit reports of the Organization. The current fixed assets of the Organization was estimated at US$ 39 749 527 as at December 31, 2013.

176. Editing services, translation and interpretation in the Region's three languages, and printing services, were all delivered in support of technical programmes. Language services were also provided for the Regional Committee sessions. A guide for the use of French was published and disseminated and the roster of language consultants has been expanded to meet increasing demand. In an attempt to make efficiency savings, capacity for in-house publishing has increased.

177. Administrative and logistics services provided effective support to conferences and statutory meetings organized during the year, including the Sixty-second and Sixty-third Regional Committees meeting.

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

179. The rapidly changing security situation and threat levels in many WHO country offices were monitored and appropriate advisories issued. As a result, staff personal security awareness has increased. The Minimum Operational Security Standards (MOSS) compliance level further improved by 70%. A roster of security officers efficiently provided support whenever required. Five WHO country offices[122] received adequate funding to meet MOSS compliance. The recent crises in Central African Republic and South Sudan prompted the provision of security support to ensure staff safety and security while maintaining programme delivery in a volatile security context.

5. Progress made in the implementation of regional committee resolutions

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

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

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

182. As of 31 December 2013, 25 countries[123] in the Region had developed or reviewed their adolescent and youth health policies or strategic plans, representing five more countries than in 2012. Tools, guidelines and standards for assessing and implementing adolescent-friendly health services were developed, helping 23 countries to develop adolescent-friendly health service standards and to implement the related action plans. Situation analyses and coverage assessments were conducted as part of capacity building in five countries.[124] Countries were guided to introduce HPV vaccine as a key element in the holistic approach to prevention of cervical cancer. Twenty countries received support from the Gavi Alliance and started introducing the HPV vaccine either nationwide or through demonstration projects.

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

183. Concerned by the unacceptably high level of maternal mortality in sub-Saharan Africa, the Regional Committee adopted Resolution AFR/RC/58/R1 in September 2008. The resolution requested the Regional Director "to establish a Commission on Women's Health to generate evidence on the role of improved women's health in socioeconomic

development". In 2009, the Regional Director established the Commission on Women's Health in the African Region, composed of a team of 16 multidisciplinary experts with extensive skills and knowledge in different disciplines.

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

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

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

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

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

188. This contributed to a decrease in under-five mortality from 175 per 1000 live births in 1990 to 107 per 1000 live births in 2011. In 2012, 15 countries in the WHO African Region were on track to reduce child deaths by two thirds between 1990 and 2015, compared with five countries in 2006 when the regional child survival strategy was adopted. Twenty-five countries are making progress, although the progress is insufficient; and six countries have made no progress.

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

189. The Sixty-first session of the Regional Committee adopted the Framework for Public Health Adaptation to Climate Change through Resolution AFR/RC61/R2. The framework aims to guide the formulation and implementation of the health component of national climate change adaptation plans. By this resolution Member States requested WHO to establish a Pan African Programme for Public Health Adaptation to Climate Change. In response, the Pan African Programme for Public Health Adaptation to Climate Change was established in 2012 as an overarching platform to provide a coordinated health sector response to climate change adaptation needs of African countries.

190. WHO has provided technical support to countries for the implementation of the Pan-African Programme through establishing an international consortium for climate change and health in Africa to support African countries to manage the negative effects of climate change on public health. In order to enhance the health sector representation in climate change-related policy and strategy development, public health experts from ten African countries were trained in climate change diplomacy and sponsored to participate in the United Nations Conference on Climate Change (COP19). To date, 42 countries in the Region have developed their heath sector plans of adaptation to climate change. Currently, four countries[125] are implementing large-scale pilot projects on the impact of climate change on nutrition, diarrheal diseases and vector-borne diseases.

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

191. Regional Committee Resolution AFR/RC61/R4 urged all Member States where poliovirus continues to circulate to declare poliomyelitis a national public health emergency and to systematically engage all political and traditional leaders at all levels to ensure that all children are reached during routine immunization and SIAs, in order to ensure successful interruption of all remaining transmission of poliovirus. Member States where transmission is endemic (Nigeria) or re-established (Angola, Chad, Democratic Republic of the Congo) were urged to implement priority actions in emergency plans to ensure interruption of poliovirus transmission within the shortest possible time. In addition, all Member States were urged to specifically mobilize adequate resources, strengthen

cross-border collaboration in enhancing the quality of immunization and surveillance activities, improve the quality of SIAs and strengthen independent monitoring, attain routine immunization coverage of at least 90% with three doses of OPV, enhance acute flaccid paralysis surveillance and ensure that response activities are implemented within four weeks of confirmation of any poliomyelitis case.

192. A total of 24 Member States in the African Region, with a total under-five population of nearly 300 million implemented at least two rounds of SIAs. Four countries108 have prepared and are vigorously implementing their national polio eradication emergency plans, with the support of WHO. The engagement of political, traditional and religious leaders at national and subnational levels as well as increased attention to ensuring high quality micro-planning, training of vaccinator teams and supervision as well as innovative social mobilization and communication activities have resulted in improved quality of SIAs. Emphasis on ensuring improved accountability of key stakeholders, particularly at the operational level in the highest risk areas, has also contributed to improved quality of priority polio eradication activities, including both immunization and surveillance, in these areas.

193. As a result, the number of confirmed wild poliovirus cases in the WHO African Region declined from 350 in 12 Member States in 2011 to 80 in four Member States in 2013. Angola, Chad and Democratic Republic of the Congo, which had poliovirus transmission re-established, have been able to interrupt transmission.[126] Based on WHO/UNICEF estimates, by the end of 2013, 16 Member States[127] had achieved the OPV3 coverage target of at least 90% while 38 Member States achieved the target of non-polio acute flaccid paralysis detection rate of at least two per 100 000 in the population aged below 15 years.

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

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

195. Thirty-two countries[128] were supported to develop measles elimination strategic plans towards achieving the 2020 measles elimination goal. WHO supported countries to improve coordination and resource mobilization activities and a total of US$ 21 million was mobilized locally in twenty-six[129] of the 31 Member States[130] that conducted follow-up SIAs in 2012 and 2013, when a total of 133 021 154 children were vaccinated. Twenty-two of these 31 Member States were supported to conduct coverage surveys for validation of their administrative coverage figures. All the SIAs included key child survival interventions such as provision of anti-helminthics, vitamin A and insecticide-treated nets.

196. By the end of 2013, eight (17%) Member States[131] had achieved the target of at least 95% coverage of the first dose of measles-containing vaccine in routine immunization. Twenty four of the 31 countries (77%) that conducted follow-up SIAs in 2012–2013 attained a coverage of 95%. The confirmed incidence of measles has been reduced to less than one per 1 million population in sixteen[132] (36%) of the 44 Member States that are reporting, based on the use of case-based surveillance systems. Of these 44 reporting Member States, twenty (45%)[133] achieved both targets for the quality of measles surveillance (i.e. non-measles febrile rash illness rate of at least two per 100 000 population and at least 80% of districts notifying at least one suspected case of measles per year) in 2013.

6. Challenges, Constraints and Lessons Learnt

6.1 Challenges and constraints

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

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

199. Sociopolitical unrest and wars in Central African Republic, Mali, South Sudan and Nigeria caused deaths, injuries, population displacement and destruction of infrastructure including health facilities. The resulting insecurity posed a formidable challenge to the work of WHO in implementing the Programme Budget. For example immunization and disease surveillance were affected, resulting in inadequate implementation of polio eradication activities.

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

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

6.2 Lessons learnt

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

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

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

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

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

7. CONCLUSION

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

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

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

Annexes

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

TABLE 2: APPROVED PROGRAMME BUDGET 2012-2013: ALLOCATION BY STRATEGIC OBJECTIVE, SOURCE OF FINANCING AND DISTRIBUTION BETWEEN WHO COUNTRY OFFICES AND THE REGIONAL OFFICE (IN US$000S)

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

ENDNOTES

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

15. Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
16. Benin, Botswana, Burkina Faso, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Zambia and Zimbabwe.
17. Botswana, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Ghana, Liberia, Malawi, Namibia, Niger, Nigeria, Senegal, Togo and Zambia.
18. Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
19. Angola, Botswana, Burundi, Cameroon, Chad, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
20. Botswana, Ghana, Liberia, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Swaziland, Togo, Zambia and Zimbabwe.
21. Botswana, Ghana, Namibia, Sierra Leone and Zambia.
22. Botswana, Cape Verde, Eritrea, Kenya, Namibia, Rwanda, South Africa, Swaziland, Zambia and Zimbabwe.
23. Global Tuberculosis report 2013; World Health Organization, 2013.
24. Angola, Botswana, Ethiopia, Ghana, Kenya, Lesotho, Sao Tome and Principe, Seychelles, Tanzania and Zambia.
25. Algeria, Benin, Burundi, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Liberia, Malawi, Mauritius, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania and Zambia.
26. Benin, Congo, Eritrea, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Nigeria, South Africa, South Sudan, Swaziland, Uganda, Zambia and Zimbabwe.
27. Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia.
28. Botswana, Burundi, Chad, Comoros, Côte d'Ivoire, Eritrea and Zimbabwe.
29. Botswana, Cape Verde, Namibia, South Africa, Swaziland, Tanzania (Zanzibar) and Zimbabwe.
30. Benin, Burkina Faso, Cape Verde, Eritrea, Chad, Congo, Democratic Republic of Congo, Gabon, Ghana, Equatorial Guinea, Mauritania, Mali, Liberia, Niger, Sierra Leone and Zimbabwe.
31. Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
32. http://www.who.int/malaria/publications/atoz/smc_policy_recommendation_en_032012.pdf.
33. http://www.who.int/malaria/test_treat_track/en/.
34. Central African Republic, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Liberia, Malawi, Mozambique, Nigeria, Tanzania and Togo.
35. Angola, Benin, Congo, Côte d'Ivoire, Democratic Republic of Congo, Malawi, Mali, Mozambique, Niger, Nigeria and Senegal.
36. Eritrea, Ethiopia, Gambia, Sierra Leone and Togo.

37. The Global Action Plan for the prevention and control of noncommunicable diseases 2013–2020; the comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases; the Updated 2013–2020 Global Action Plans for mental health and the Universal Eye Health – a Global action plan 2014–2019.
38. Algeria, Benin, Burkina Faso, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Lesotho, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Sao Tome and Principe and Zambia.
39. Mozambique, Namibia, Nigeria, Sierra Leone, South Africa and Uganda.
40. Benin, Côte d'Ivoire, Guinea and Sierra Leone.
41. Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal and Togo.
42. Burkina Faso, Mozambique, Niger, Tanzania and Zimbabwe.
43. Cape Verde, Côte d'Ivoire, Mozambique and Rwanda.
44. Benin, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Sierra Leone and Togo.
45. Levels and Trends in child mortality, Report 2012, compiled by the UN Interagency Group for child mortality estimation; UNICEF 2010.
46. Cape Verde, Equatorial Guinea, Eritrea and Rwanda.
47. Gambia (50%), Guinea (50%), Togo (51%), Mali (51%), Niger (52%), Sao Tome and Principe (54%), Benin (55%), Algeria (56%), Burkina Faso (57%), Malawi (59%), Cape Verde (61%), Angola (62%), Madagascar (62%), Rwanda (63%), Ethiopia (64%), Eritrea (73%), and Equatorial Guinea (81%).
48. Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
49. Angola, Benin, Burkina Faso, Botswana, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
50. Burkina Faso, Cameroon, Democratic Republic of Congo, Ethiopia, Guinea, Kenya, Lesotho, Malawi, Swaziland, Tanzania and Uganda.
51. Benin, Burkina Faso, Burundi, Cameroon, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe..
52. Angola, Benin, Botswana, Cameroon, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Guinea, Madagascar, Malawi, Mauritania, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, Tanzania (mainland), Togo, Uganda and Zimbabwe.
53. Burkina Faso, Chad, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Mali, Niger, Swaziland, Tanzania and Zambia.
54. Angola, Burundi, Nigeria and Swaziland.
55. Burundi, Comoros, Lesotho and Malawi.

56. Eritrea, Ethiopia, Kenya, Lesotho, Malawi, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
57. Benin, Botswana, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Ghana, Gambia, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
58. Congo, Democratic Republic of Congo, Ghana, Guinea, Guinea-Bissau, Niger, Sierra Leone and Uganda.
59. Burkina Faso, Lesotho, Rwanda and Tanzania.
60. Ghana, Kenya, Mozambique, Namibia, Rwanda, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
61. Botswana, Ghana, Kenya, Lesotho, Mauritius, Namibia, Seychelles, Togo, Zambia and Zimbabwe.
62. Ethiopia, Ghana, Kenya, Mauritius, Namibia, Nigeria, Seychelles and South Africa.
63. Ethiopia, Ghana, Kenya, Mauritius, Namibia, Nigeria, Seychelles and South Africa.
64. Burundi, Kenya, Malawi, Namibia and Zambia.
65. Ghana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe.
66. Burkina Faso, Congo, Ghana, Guinea, Madagascar, Mali, Niger, Rwanda, Seychelles and Togo.
67. Côte d'Ivoire, Kenya, Mozambique, Niger, Sao Tome and Principe, Senegal and Zambia.
68. Côte d'Ivoire, Namibia, South Africa, Uganda and Zambia.
69. Algeria, Botswana, Burkina Faso, Congo, Côte d'Ivoire, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda, Tanzania, Zambia and Zimbabwe.
70. Ghana, Kenya, Senegal, Uganda and Zambia.
71. Botswana, Cameroon, Equatorial Guinea, Kenya, Madagascar, Namibia, Senegal, Swaziland, Uganda, Zambia and Zimbabwe.
72. Liberia, Madagascar, Mauritius, Sao Tome and Principe and Seychelles.
73. Botswana, Kenya, Lesotho, Mozambique, Namibia, Rwanda, Swaziland, Uganda and Zimbabwe.
74. Burundi, Cameroon, Central Africa Republic, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon and, Sao Tome and Principe.
75. Botswana, Kenya, Lesotho, Uganda, Zambia and Zimbabwe.
76. Benin, Burkina Faso, Côte d'Ivoire, Gambia, Guinea, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa and Togo.
77. Angola, Botswana, Benin, Burundi, Cameroon, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania and Togo.
78. Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Ethiopia, Gabon, Guinea, Kenya, Lesotho and Mali.
79. Ethiopia, Gabon, Kenya, Lesotho, Mali and Sierra Leone.
80. Ethiopia, Kenya, Malawi, Mali and Tanzania.
81. The UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) that reports on the progress and blockages with respect to inputs to drinking-water and sanitation.

82. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) focuses on monitoring the outcomes of the sector- the number of people that have access to safe water and basic sanitation.
83. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.
84. WHO / UNICEF Progress on Sanitation and Drinking-water: 2014 Update, WHO, Geneva and UNICEF, New York.
85. Botswana, Comoros, Gambia, Mauritius, Namibia, Sao Tome and Principe, Seychelles, South Africa.
86. Angola, Botswana, Mauritius, Rwanda and South Africa.
87. Angola, Bangladesh, Benin, Cambodia, Ethiopia, Haiti, Nepal, Pakistan, Peru and Viet Nam.
88. Black RE, Victoria CG, Walker SP, and the Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013; published online June 6. http://dx.doi.org/10.1016/S0140-6736(13)60937-X.
89. Botswana, Burundi, Central African Republic, Chad, Ghana, Niger and Sierra Leone.
90. Central African Republic, Chad, Tanzania and Zambia.
91. Cameroon, Guinea-Bissau, Kenya, Malawi, Sierra Leone and Zimbabwe.
92. Angola, Central African Republic, Chad, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Mali, Mauritania, Niger, Sierra Leone and Tanzania.
93. Burkina Faso, Ethiopia, Mozambique, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.
94. Five Keys To Safer Food Manual-www.who.int/foodsafety/publications/consumer/manual_keys.pdf.
95. Burkina Faso, Côte d'Ivoire, Gambia, Kenya, Liberia and Sierra Leone.
96. Angola, Botswana, Cape Verde, Central Africa Republic, Comoros, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Namibia, Sao Tome and Principe, Senegal, South Africa and Swaziland.
97. Burkina Faso, Cape Verde, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Liberia, Mauritania, Mozambique, Senegal, Sierra Leone, Togo and Zambia.
98. Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Democratic Republic of Congo, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Malawi, Mauritania Mozambique, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, Tanzania, Togo, Uganda, Zambia and Zimbabwe.
99. Benin, Botswana, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Mozambique, Niger, Rwanda, South Africa, Tanzania, Uganda and Zambia.
100. Burundi, Guinea-Bissau, Mali, Mozambique, Senegal, Uganda and Zambia.
101. Burkina Faso, Burundi, Côte d'Ivoire, Ethiopia, Nigeria and Senegal.
102. Botswana, Burkina Faso, Burundi, Cape Verde, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Liberia, Malawi, Mauritania, Mozambique, Namibia, Niger, Sierra Leone, Swaziland, Uganda, Zambia and Zimbabwe.
103. Cape Verde, Congo, Rwanda and Sierra Leone.
104. Benin, Burkina Faso, Cameroon, Liberia, Mali and Swaziland.
105. Economic Community of West African States/West African Health Organization (ECOWAS/WAHO), Economic and Monetary Union of West Africa (UEMOA), Economic Community of Central African States (ECCAS), East African Community (EAC) and Southern African Development Community (SADC).

106. Burkina Faso, Burundi, Democratic Republic of Congo, Eritrea, Mauritius and Seychelles.

107. Algeria, Angola, Benin, Burkina Faso, Burundi, Botswana, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

108. Algeria, Benin, Botswana, Burundi, Cape Verde, Côte d'Ivoire, Kenya, Lesotho, Malawi, Mauritius, Namibia, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

109. Algeria, Angola, Benin, Burkina Faso, Burundi, Botswana, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

110. Algeria, Angola, Benin, Burkina Faso, Burundi, Botswana, Cameroon, Cape Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

111. Algeria, Angola, Benin, Burkina Faso, Burundi, Botswana, Cameroon, Cape Verde, Central African Republic, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

112. Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Ethiopia, Gabon, Gambia, Ghana, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, South Africa, Togo and Uganda.

113. Cameroon, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Mozambique, Nigeria and Tanzania.

114. Kenya, Rwanda, Tanzania and Togo.

115. Burundi, Cameroon, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon and, Sao Tome and Principe.

116. Algeria, Gambia, Rwanda and Senegal.

117. Burundi, Côte d'Ivoire, Mozambique, Rwanda and Zambia.

118. Algeria, Benin, Burkina Faso, Cape Verde, Comoros, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Liberia, Senegal, Sierra Leone, Togo and Tunisia.

119. Botswana, Burkina Faso, Cameroon, Central African Republic, Ethiopia, Gabon, Gambia, Ghana, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

120. Healthy ageing; Regional strategy for enhancing the role of traditional medicine in health systems; Addressing the challenge of women's health in Africa; Utilizing e-Health solutions to improve national health systems; Regional strategy on neglected tropical diseases; WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

121. Cameroon, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Kenya, Malawi, Nigeria, Senegal, South Africa and Tanzania.

122. Benin, Burkina Faso, Guinea-Bissau, Mali and Nigeria.

123. Benin, Botswana, Burkina Faso, Central African Republic, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Guinea, Madagascar, Malawi, Mali, Namibia, Niger, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

124. Chad, Ethiopia, Malawi, Tanzania and Uganda.

125. Ethiopia, Kenya, Malawi and Tanzania.

126. As at June 2013, Angola had spent 23 months without a confirmed wild poliovirus case, Chad had spent 12 months and Democratic Republic of Congo had spent 18 months.

127. Algeria, Botswana, Burundi, Cape Verde, Eritrea, Gambia, Ghana, Lesotho, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, United Republic of Tanzania and Zimbabwe.

128. Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia and Zimbabwe.

129. Botswana, Burundi, Cameroon, Cape Verde, Congo, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Kenya, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, Zambia and Zimbabwe.

130. Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda and Zimbabwe.

131. Algeria, Cape Verde, Eritrea, Malawi, Mauritius, Rwanda, Seychelles and Swaziland.

132. Algeria, Botswana, Cape Verde, Comoros, Gabon, Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mozambique, South Africa, Swaziland and Zimbabwe.

133. Benin, Botswana, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Lesotho, Madagascar, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Togo, Uganda and Zimbabwe.