FAMILY AND REPRODUCTIVE HEALTH CLUSTER

BIENNIAL REPORT

Highlights of Achievements in 2016-2017
FAMILY AND REPRODUCTIVE HEALTH CLUSTER
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Highlights of Achievements in 2016-2017

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville•2018
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ACKNOWLEDGEMENTS

This biennium report was developed with contributions from the Family and Reproductive Health (FRH) staff in Brazzaville, Republic of Congo and Intercountry Support Teams (in Harare, Zimbabwe; Libreville, Gabon; Ouagadougou, Burkina Faso). We also acknowledge the support of WHO country office teams and all Regional Office Cluster Directors and their teams. We are very grateful to our many partners for their contributions and support to the work of the FRH Cluster.

Managing editor:

Design:
# ABBREVIATIONS

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ADI</td>
<td>Addis Declaration on Immunization</td>
</tr>
<tr>
<td>Af-STEER</td>
<td>Africa: Strategic Technical Engagement with Evidence for Results</td>
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<tr>
<td>AA-HA</td>
<td>Global Accelerated Action for the Health of Adolescents</td>
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<tr>
<td>AMR</td>
<td>Antimicrobial resistance</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EMTCT</td>
<td>Elimination of Mother-To-Child Transmission of HIV</td>
</tr>
<tr>
<td>ESA</td>
<td>Eastern and Southern Africa</td>
</tr>
<tr>
<td>ESBL</td>
<td>Extended Spectrum Beta-Lactamase</td>
</tr>
<tr>
<td>EMA</td>
<td>European Medicines Authority</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GFF</td>
<td>Global Financing Facility</td>
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<tr>
<td>GSWCAH</td>
<td>Global Strategy for Women’s, Children’s and Adolescents’ Health</td>
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<tr>
<td>IHRs</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>IMNCI</td>
<td>Integrated Management of Newborn and Childhood Illness</td>
</tr>
<tr>
<td>INFOSAN</td>
<td>International Food Safety Authorities Network</td>
</tr>
<tr>
<td>MCV</td>
<td>Measles-containing vaccine</td>
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<tr>
<td>MIYCN</td>
<td>Maternal, Infant and Young Child Nutrition</td>
</tr>
<tr>
<td>M(P)DSR</td>
<td>Maternal and Perinatal Death Surveillance and Response</td>
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<tr>
<td>MNT</td>
<td>Maternal and Neonatal Tetanus</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission (of HIV)</td>
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<tr>
<td>PSBI</td>
<td>Possible Serious Bacterial Infection</td>
</tr>
<tr>
<td>QoC</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>RAcE</td>
<td>Rapid Access Expansion</td>
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<tr>
<td>RMNCAH&amp;N</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition</td>
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<tr>
<td>RSPI</td>
<td>Regional Strategic Plan for Immunization 2014- 2020</td>
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<tr>
<td>SEK</td>
<td>Swedish Krona</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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Significant progress has been made from 2000 to 2015, by Member States towards meeting the Millennium Development Goals 4 and 5, particularly to “Reduce child mortality” and “Improve maternal health.” Despite the progress made, levels of maternal and child deaths remain high, mainly as a result of limited access to health services.

The 2016-2017 biennium corresponded also with the ushering of the SDGs, Member States continued to make strides to overcome the huge challenges facing them in improving women’s, children’s and adolescents’ health. Certainly, some progress was made in 2016-2017 but wide disparities between and within countries still need to be addressed in order to guarantee access to quality services, to all who need them, leaving no one behind.

The work of the FRH Cluster is grounded in global and regional strategies and frameworks, endorsed by Member States. The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) envisions a world in which every woman, child and adolescent, in every setting, realizes their rights to physical and mental health and well-being; has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies. This is also the aspiration of all Member States of the African Region.

The WHO in the African Region, through the leadership of the Regional Director, Dr Matshidiso MOETI, launched the AFRO Transformation Agenda which guided the work of our cluster as we supported countries in focusing on high impact results to improve the lives of the citizens of our Region. We are committed to accelerating the progress reported in improving women, newborns, children and adolescent’s health across the Region. We are convinced that our support to Member States in developing, implementing and evaluating effective policies and strategies on maternal and sexual and reproductive health, based on improved access to key interventions such as immunization and nutrition, can further improve health outcomes along the life course.

The achievements by the Member States highlighted in this biennium report would not have been possible without the commitment, of all FRH staff, the Intercountry Support Teams (IST) and, WHO country offices and other Regional Office clusters, and WHO headquarters.

We are very grateful to our esteemed partners at various levels for contributing to the attainment of the achievements, and we look forward to further collaboration in the new biennium 2018-2019.

Dr Felicitas Zawaira
Director, Family and Reproductive Health Cluster, WHO Regional Office for Africa
FOREWORD

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Dr Felicitas Zawaira
Director,
Family and Reproductive Health Cluster,
WHO Regional Office for Africa
EXECUTIVE SUMMARY

This 2016/2017 biennial report summarizes progress made towards achieving the goals and objectives of all the strategies and frameworks being implemented by Member States in the areas of newborn, child and adolescent health, and nutrition, reproductive and women’s health, and immunization and vaccine development consistent with the life-course approach to health. It also highlights the challenges faced by the Member States and the support provided to them by the Family and Reproductive Health Cluster’s programmes, in collaboration with partners. Lastly, it provides perspectives for 2018.

In the biennium 2016-2017, the African Region as a whole achieved prevention of mother-to-child transmission (PMTCT) coverage of 79% (13% higher than in 2014) and five countries (Botswana, Namibia, South Africa, Swaziland and Uganda) reached 95% antiretroviral (ARV) coverage in PMTCT which is the benchmark to undertake the elimination of mother-to-child transmission (EMTCT) validation process. To this end, a multi-agency Regional EMTCT Validation Team that will lead the elimination process in the Region has been established.

Immunization has consistently proven very effective as a public health intervention saving lives and preventing disabilities of millions by preventing several communicable diseases. In the biennium, 5 Member States introduced rotavirus vaccine, two introduced PCV, bringing the totals to 34 and 39 respectively. In addition, 11 introduced IPV, and an additional country introduced HPV. Thirty-two (32) countries are implementing sentinel site surveillance for rotavirus, invasive bacterial diseases providing evidence of the impact of vaccination and to detect outbreaks due to specific vaccine-preventable diseases.

For example by December 2017, a total of 125.5 million children had received measles vaccines. Vaccine preventable disease surveillance confirms diagnosis, assesses vaccine impact especially of newly introduced vaccines, PCV, rotavirus, meningitis and helps to detect outbreaks early enough response through vaccination campaigns. Surveillance Through the measles case-based surveillance by the network of 44 countries 8 successful responded to measles outbreaks through SIAs.

Research and development ensures that new medicines and vaccines become available to all. In 2016, Member States endorsed a new model and governance structure for the African Vaccine Regulatory Forum (AVAREF), with heads of NRAs assuming ownership and constituting a Steering Committee and an Assembly, broadening the scope to of the network to all countries of the continent and to all products beyond vaccines. Through a joint review AVAREF supported regulators of Ghana, Kenya and Malawi to review and give special approval for the use of the only malaria vaccine in a pilot.

Twenty countries were supported to develop integrated Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategic plans in line with the Global Strategy for Women’s, 

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1 The Regional Validation Team includes UNICEF, UNAIDS, UNFPA, AU, CDC, EGPAF and WHO.
2 Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d’Ivoire, Democratic Republic of Congo, Eritrea, Gambia, Guinea, Lesotho, Liberia, Mauritania, Rwanda, Senegal, Sierra Leone, South Sudan and Togo.
Children’s and Adolescents’ Health (GSWCAH 2.0). The plans have improved prioritization of interventions, for newborn and early childhood development, improved coordination of partners and facilitated mobilization and leveraging of domestic and external resources. Seven countries in the African Region are part of the Global Network for Operationalization of the WHO (MNH) Quality of Care (QoC) Standards. Member States have scaled up the IMCI through innovative and more cost-effective approaches, namely EPI/IMCI interactive tool, IMCI Computerized Adaptation and Training Tool (ICATT) and on-the-site IMCI training (IMCI-distance). At hospital level, Member States have conducted quality of care assessments and developed plans to guide systematic improvement in quality of care. FRH Cluster is leading the Working Group on the implementation of Adolescent health as the flagship programme, a priority of the Regional Director. In addition, in 2017, the first Africa Nutrition report was developed and launched.

More than 38 national SRH policies and strategies have been updated or developed in line with the WHO latest recommendations (2016) as a way of facilitating implementation of SRH activities and improving the quality and uptake of services.

Finally, Member States committed to scaling up quality maternal and neonatal health (MNH), Sexual and Reproductive Health (SRH) and to reduce timelines of clinical trials for development of new medicines and vaccines through their endorsement of v documents at the 67th RC. Implementation of the recommendations of these documents will lead to better access to health products and the improvement in MNH and sexual and reproductive health.
INTRODUCTION

Health lays the foundation for vibrant and productive communities, stronger economies, safer nations and a better world. The World Health Organization (WHO) is building a better future for people everywhere. In the African Region, the Family and Reproductive Health (FRH) Cluster, is supporting countries to end preventable maternal and child deaths; control vaccine-preventable diseases; improve nutrition, sexual and reproductive health; mainstream gender equity and human rights and promote healthy ageing. While promoting health through the life-cycle, the Cluster, through its three programmes, supports Member States to improve Child and Adolescent Health and Nutrition; Immunization and Vaccine Development as well as Reproductive and Women’s Health. In its programme implementation process, FRH is guided by various global and regional strategies endorsed by its Member States.

These frameworks include the 2030 Agenda for Sustainable Development, the Global Strategy for Women’s, Children’s and Adolescents’ Health, the Global Vaccine Action Plan (GVAP), the Global Financing Facility in Support of Every Woman Every Child and the global and regional movement to end child, early and forced marriage (CEFM), the Lancet Commission on Adolescent Health, the Global Accelerated Action for the Health of Adolescents (AA-HA) Implementation guidance and others.

The Member States of the African Region made significant investments and progress towards achieving the MDGs, specifically in meeting the maternal and child health, malaria and HIV targets. However, by the end of 2015, due to a number of challenges, no country had fully achieved all the health-related targets of the MDGs. In 2015, countries adopted the Sustainable Development Goals (SDGs). More specifically, SDG 3 targets 3.1 and 3.2 focus on reducing maternal mortality and ending preventable neonatal and child deaths respectively. The SDGs cover a much broader scope of sustainable development, are more ambitious, lay emphasis on equity, pay due attention to the social determinants of health and call for effective intersectoral collaboration.

The current level of health financing in the Region is inadequate to sustain health programmes. For example, in 2016 the African Union proposed that Government domestic funding for health should be at least USD 86 per capita. These resource requirements were estimated to be able to provide core PHC services. However, the scorecard published in 2016 showed that 4 countries spend less than US$ 10 per capita while 14 countries spend less than US$ 20 per capita.3

Achieving the SDG targets requires responsive health systems underpinned by available and equitably distributed health workforce (HWF). However, current evidence shows that Africa has a severe shortage of human resources. Analysis based on WHO’s minimum threshold of 2.3 HWF per

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1000 population put the shortage of physicians, nurses and midwives in 31 African countries at 800,000 by 2015. This situation is made worse when other aspects of human resources for health such as productivity and efficiency, misdistribution, motivation and migration of HWF are considered.

The African Region experiences an average of over 100 public health events per year, including outbreaks of diseases such as ebola, meningitis, Lassa fever, yellow fever and cholera, as well as the health effects of droughts, floods and food insecurity. The Region deals with more health events than any other WHO region. Responding to these public health events negatively impacts on the delivery of other essential health services, including for maternal, newborn, child and adolescent health, immunization and nutrition, as was witnessed during the Ebola outbreak of 2014.

During the period under review, the FRH Cluster performed its work within a complex, multifaceted context, moving from the MDG to the SDG era, amid continued weak health systems large number of disease outbreaks, and epidemics and humanitarian situations.

The current report highlights key achievements of the cluster in the biennium 2016-2017.
1. STRATEGIC OBJECTIVES OF THE FRH CLUSTER

WHO promotes the continuum of care spanning pregnancy and childbirth to childhood, adolescence and beyond, which also guides FRH in its support to Member States. This concept, which is illustrated in Figure 1 is also in line with FRH strategic objectives.

The FRH Cluster’s strategic objectives are:

(a) To improve the availability, accessibility and utilization of quality health care services along the life-cycle;

(b) To ensure achievement of universal immunization coverage within the WHO African Region;

(c) To ensure accountability, measurement and tracking mechanisms for reproductive, maternal, neonatal, child and adolescent health and immunization;
The FRH Cluster’s strategic objectives are:

1. To improve the availability, accessibility and utilization of quality health care services along the life-cycle;
2. To ensure achievement of universal immunization coverage within the WHO African Region;
3. To ensure accountability, measurement and tracking mechanisms for reproductive, maternal, neonatal, child and adolescent health and immunization;
4. To improve maternal, neonatal and child health in the African Region;
5. To support the elimination of mother-to-child transmission of HIV by 2030;
6. To improve adolescent health and development in the African Region;
7. To ensure universal access to sexual and reproductive health.

These are derived from the objectives of each of the three components or programme areas which make up the FRH cluster. These objectives have driven the support to Member States towards the achievements described in the report.
2. OPERATIONAL STRUCTURE OF THE FRH CLUSTER

The FRH cluster is composed of technical and administrative staff at the Regional Office (RO) including Intercountry Support Teams (ISTs) in the three AFRO regions (Central Africa, Eastern and Southern African and West Africa). FRH staff are organized around three major technical programmes at the Regional Office and IST levels as shown in Figure 2.

![Programmes of the FRH cluster and their components](image)

To achieve the overall goal of the cluster, the strategic objectives are translated into the following operational objectives under each programme.

### 2.1 IMMUNIZATION AND VACCINE DEVELOPMENT (IVD)

The programme’s support to the Member States is guided by the RSPI from which these operational objectives are derived.
The FRH cluster is composed of technical and administrative staff at the Regional Office (RO) including Intercountry Support Teams (ISTs) in the three AFRO regions (Central Africa, Eastern and Southern African and West Africa). FRH staff are organized around three major technical programmes at the Regional Office and IST levels as shown in Figure 2.

Figure 2: Programmes of the FRH cluster and their components

To achieve the overall goal of the cluster, the strategic objectives are translated into the following operational objectives under each programme.

2.1 Immunization and Vaccine Development (IVD)

(a) To support countries to develop, implement and monitor integrated, evidence-based policies, strategies and comprehensive action plans that increase access to and utilization of immunization services by all eligible populations.

(b) To support countries to reduce the high number of unvaccinated or not fully vaccinated people and address equity gaps linked to disparities in immunization coverage.

(c) To support countries in introducing new vaccines and strengthen the integration and/or collaboration of immunization services with other child/adolescent interventions.

(d) To support countries to build and strengthen their logistic and supply chain systems.

(e) To support countries to improve their immunization data and surveillance systems and monitor vaccine-preventable disease trends and coverage.

(f) To support countries to improve the sustainability of their national immunization programmes by mobilizing domestic and external resources.

(g) To support countries to strengthen their vaccine regulation systems.

(h) To support countries to implement research activities.

2.2 Child and Adolescent Health and Nutrition (CAN)

(a) To support countries to develop, implement and monitor integrated, evidence-based policies, strategies and comprehensive action plans that increase access to high-impact interventions, reduce risks and improve the overall health and nutrition of newborns, children, adolescents and adults at all levels of the health care delivery system with appropriate linkages to community resources.

(b) To support countries to adopt/adapt standards, norms and guidelines to improve the quality of care for children and adolescents and nutrition services for all age groups.

(c) To support countries in translating global nutrition guidelines and norms into actions to address the double burden of malnutrition throughout the life-cycle.

(d) To build the technical capacity of countries in the application of standards, guidelines and tools.

(e) To monitor trends in the health status of children and adolescents and the nutrition status of all age groups as well coverage and quality of interventions across countries of the WHO African Region.

(f) To support countries to mobilize domestic and external resources to improve the health of children and adolescents.

2.3 Reproductive and Women Health

(a) To raise awareness at high policy and political levels as well as at the community level on the social and economic burdens of maternal, neonatal and reproductive ill-health and mortality, including healthy and active ageing.
(b) To strengthen countries’ national capabilities for the development and application of appropriate health policies, strategies and guidelines to prevent morbidity and death, ensure proper care for mothers and newborns and address reproductive health needs of young people, adults and the elderly.

(c) To reinforce the institutional and community response to life-threatening conditions for mothers and newborns, and promote an integral, participatory and gender-sensitive approach to the establishment of quality basic reproductive health care for all individuals and families at all levels of the health care system, including for healthy and active ageing.

(d) To support Member States to develop and expand national programmes addressing sociocultural aspects of family and reproductive health, including the prevention of harmful traditional practices and the development of relevant community-based services.

(e) To promote evidence-based planning and service delivery for RMNH through the development of regional and national databases, the monitoring of health status and coverage of effective interventions and the promotion and support of operational research activities.
3. GLOBAL AND REGIONAL STRATEGIES AND FRAMEWORKS ADDRESSING FAMILY AND REPRODUCTIVE HEALTH

The achievements of Member states are based on the implementation of Global and Regional strategies and Frameworks which address family and reproductive health.

3.1 Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030

The Global Strategy (2016-2030) is a roadmap to realize the right to the highest attainable standard of health for all women, children and adolescents, to transform the future and to ensure every newborn, mother and child not only survives, but thrives. The new Strategy — builds on the success of the 2010 Strategy and its Every Woman Every Child movement as a platform to accelerate the health-related Millennium Development Goals and puts women, children and adolescents at the heart of the new UN Sustainable Development Goals.

3.2 Global Health Sector Strategy on HIV 2016–2021

Ending the AIDS epidemic will require acceleration of the response over the next five years and sustained action through to 2030 and beyond. The strategy promotes a people-centred approach, grounded in principles of human rights and health equity. It contributes to a radical decline in new HIV infections and HIV-related deaths, while also improving the health and well-being of all people living with HIV. It guides efforts to accelerate and focus HIV prevention, enables people to know their HIV status, provides antiretroviral therapy and comprehensive long-term care to all people living with HIV, and challenges pervasive HIV-related stigmatization and discrimination.
3.3 Regional Strategic Plan for Immunization 2014–2020

This strategic document addresses the challenges countries in the WHO African Region and their partners need to overcome to provide universal access to immunization for all eligible populations by 2020. It builds on lessons learned during 2009–2013 when the Global Immunization Vision and Strategy (GIVS) served as the framework for global and regional responses to address immunization gaps. It is a call for an unprecedented coalition of minds and means to ensure that every child born in the African Region has the chance to be protected against deadly diseases for which safe and effective vaccines exist or will be brought to the market between 2014 and 2020.

3.4 Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition

WHO’s nutrition activities in the African Region are positioned within and guided by the Comprehensive implementation plan on maternal, infant and young child nutrition (http://www.who.int/nutrition/publications/CIP_document/en/). The plan endorsed by the Sixty-fifth World Health Assembly (2012) focuses on achieving six global nutrition targets by 2025. In keeping with the life course perspective for nutrition and health, the targets seek to improve maternal, newborn, infant and young child health by reducing maternal anaemia and low birth weight, increasing rates of exclusive breastfeeding, and reducing stunting, wasting and childhood overweight.
3.5 Global Strategy and Action Plan for Healthy Ageing and the Regional Implementation Plan

The Global Strategy and Action Plan for Healthy Ageing is a significant step forward in establishing a framework for Member States, the WHO Secretariat and partners to contribute to achieving the vision that all people can live long and healthy lives. In 2013 Member states endorsed Resolution AFR/RC63/R1 to accelerate progress on Healthy Ageing. In 2016, the Sixty-sixth session of the Regional Committee adopted the regional implementation framework to provide programmatic and policy orientations to Member States to implement the global strategy and action plan on ageing and health for the 2016–2020 period.
4. HIGHLIGHTS OF ACHIEVEMENTS BY MEMBER STATES IN 2016-2017

This chapter highlights the key achievements made by the Member States, with the support of the FRH Cluster and in collaboration with our partners. It outlines some of the challenges and constraints encountered in 2016/2017. It is organized into thematic areas and underscores the collective efforts and contributions of all the Programme Areas. The chapter also deals with the life-cycle approach to health as enshrined in the FRH cluster strategy.

4.1 Maternal and Newborn Health

4.1.1 Interventions for improving the quality of care (QoC)

In many countries, equitable access, effective coverage and quality of health services are still not a reality, particularly for women and newborns. Hence, reducing maternal and newborn deaths and improving the quality of care are essential. To this end, a network for improving the quality of care for mothers, newborns, children and adolescents led by ten countries, eight of them in the African Region was launched in February 2017.

The goal of the network is to halve maternal and newborn mortality and stillbirths in health facilities within five years. This target will be reached through the operationalization of the WHO (MNH) QoC Standards. Implementation of the standards will enable Member States to achieve national targets of ending preventable maternal, newborn and child deaths and stillbirths, and to reduce disease and disabilities.

Member States were supported to formulate, country plans and to identify and map in-country partners to support the process. So far, five of the eight countries have finalized their plans, and identified priority actions for implementation. In addition, quality of care (QoC) assessments for maternal, newborn and child health care was undertaken, maternal and perinatal death surveillance and response strengthened, newly released WHO RMNCH guidelines disseminated and monitoring of the Every Newborn Action Plan is being implemented by the countries.

(a) Quality of care (QoC) assessments for maternal, newborn and child health care

Quality of care assessments for maternal, newborn and child health (MNCH) care were conducted during the biennium. These included service availability and readiness assessment in Benin, Ghana and Malawi; emergency obstetric care (EmOC) in Lesotho and Namibia; and hospital care in 21 countries. The activity included the quality of services and actions that are being taken to address the identified gaps.

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4 Bangladesh, Côte d’Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda.
5 Côte d’Ivoire, Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, Tanzania and Uganda.
6 Benin, Burkina Faso, Burundi, Chad, Congo, Côte d’Ivoire, Ethiopia, Ghana, Guinea-Bissau, Lesotho, Malawi, Mali, Niger, Nigeria, Rwanda, Sierra Leone, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
For example, in Guinea-Bissau, a country with one of the highest maternal mortality rates in the world (549 per 100,000 live births/UN estimations, 2017), the assessment revealed some of its major challenges such as: low availability and use of EmOC, largely linked to a chronic shortage of skilled and competent human resources; low quality of services, inadequate and dilapidated infrastructure and equipment; frequent stock out of essential basic medicines; absence of a functional referral system; and total absence of blood in the hospital’s blood bank. The country's major strength was a high level of commitment of health authorities to improve the quality of maternal, newborn and child health care.

Namibia was supported to conduct EmOC assessment to inform planning of maternal and newborn service delivery, in view of stagnating maternal and newborn mortality rates. Weak health worker competencies were identified in management of the common causes of maternal and newborn mortality. This information was used to design and implement competency-based training of nurses and midwives in EmOC.

(b) Strengthening maternal and perinatal death surveillance and response (M(P)DSR

Conducting mortality audits and reviews is a key strategy for reducing preventable deaths among mothers and babies. It helps health system managers to understand the causes and contributing factors and to take corrective actions to improve the quality of care. It is an important mechanism for ensuring that countries meet maternal and neonatal death and stillbirth reduction targets as laid out in the Sustainable Development Goals and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016 to 2030).

Maternal death surveillance and response (MDSR) is an approach used by a maternal death review committee (a group of experts) to investigate maternal deaths in real time to enable health facilities and other decision makers to take corrective actions. Since 2014, WHO has supported all countries to institutionalize MDSR and 38 of the 47 countries are reporting maternal deaths through the IDSR system on a weekly basis (see figure 3 below).
Maternal death surveillance and response system performance was reviewed in seven countries. The results showed that, although maternal death case counting is being conducted in these countries and the review committees are in place, the whole system needs to be strengthened. It was observed that many review committees do not meet regularly to undertake reviews to identify the root causes of death and, hence, make recommendations. By WHO standards, review committees should meet at least twice a year. Currently, however, only 46% of countries meet this standard.

An assessment was conducted in Côte d’Ivoire after four years of MDSR implementation. The results show the following strengths: (a) availability at all levels of the system of a database for maternal deaths; (b) wide use of ICT (smartphones) in 83 health districts and real-time notification of maternal deaths (60% of maternal deaths notified within 24 hours); (c) all health districts (100%) report maternal deaths. The weaknesses observed included: (a) a low reporting rate (1 266 maternal deaths were reported out of an expected total of 5 164; (b) a notification rate of 25%, against an expected target of 90%; (c) 88% of deaths notified occurred in health facilities; (d) maternal deaths occurring at community level and in the private sector and the army are not reported; (e) maternal death reviews are not systematic because, in most facilities, review committees are not in place; (f) communities are not involved especially in the identification of maternal deaths in the community; and (g) non-compliance with ICD10 classification for causes of maternal death. Recommendations were made and next steps defined.

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7 Burundi, Cameroon, Central African Republic, Chad, Côte d’Ivoire, Ghana and South Sudan.
Sometimes all you need to make a difference are simple solutions that are usually within reach. Below is an example from Botswana.

In Botswana, MDSR notification and review revealed that the country’s maternal mortality ratio (MMR) remained consistently high despite high coverage of high impact interventions. More than 99% of deliveries by skilled personnel in 2014/2015 occurred in health facilities. A national summit was organized in September 2016 to identify define actions to reduce maternal deaths. The summit brought together all district health management teams (DHMTs) including the matrons and medical superintendents of all hospitals as well as professional regulatory bodies for medical doctors, nurses and midwives. Each DHMT developed an implementation plan with a view to accelerating the reduction of maternal mortality.

Targeted interventions were defined for seven hospitals* that consistently reported high maternal mortality. The hospitals were supported to implement maternal death audits to determine the main causes and the contributing factors and to make recommendations for action.

Mentoring visits to the seven hospitals were undertaken to provide on-site support and supervision. In only one year (2017), a decline in institutional maternal mortality was observed in the seven target hospitals as shown in the Figure 4. The Botswana case study is an illustration that strong MOH leadership is critical to reducing MMR in countries. Provision of mentoring support to these facilities enabled effective on-site resolution of challenges, with domestication of interventions to address underlying and contributory factors at facility level.

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* Scottish Livingstone, Mahalapye, Sekgoma Memorial, Bobonong Primary, Letsholathebe II Memorial hospitals, Princess Marina Hospital and Nyangabwe Referral Hospitals.
In March 2017, Mali issued a ministerial decree making all maternal and perinatal deaths notifiable and MDSR implementation mandatory, bringing to 13 the number of countries in the subregion with such provisions in 2017. Most countries in the Region have been implementing MDSR but do not have the capacity and tools to conduct and track perinatal deaths or improve death audits. In this regard, WHO oriented national MNH staff from WHO and partners and MOH of 37 countries on the WHO Neonatal Mortality and Stillbirth Review Guide together with the ICD PM to build their capacity to strengthen perinatal deaths review and response in their countries.

Benin, Burkina Faso, Côte d’Ivoire, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sierra Leone and Togo.

Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d’Ivoire, DRC, Eritrea, Ethiopia, Ghana, Guinea, Bissau-Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, Swaziland, Togo, Tanzania, Uganda, Zambia and Zimbabwe.

Ghana: Maternal mortality ratio stands at 319/100,000 live births with high numbers of preventable maternal deaths and minimal decline in institutional MMR. The country did not meet the MDG 5 target. Effective maternal death review/audit followed by appropriate actions to address the avoidable factors identified is critical to ending these deaths.

WHO provided technical and financial support to the Ghana Health Service/Ministry of Health to conduct a situational analysis to assess the current system of Maternal Death Surveillance and Response (MDSR) to identify its achievements, challenges and gaps in order to address them. This was an important priority intervention in the current Health Sector Medium Term Strategic Plan that made recommendations for strengthening and expanding the MDSR system. Key stakeholders/partners like UNFPA, Society of Obstetricians and Gynecology of Ghana, teaching hospitals and the Christian Health Association of Ghana were supported.

The need to emphasize the response component as well as focus on quality of care improvements came to the fore. A baseline has been provided to the Ghana Health Service/Ministry of Health for plans to improve MDSR in the country and ultimately reduce preventable maternal deaths. Ghana has since committed to be part of the Global Network to improve quality of care for maternal and newborn health and has pledged to implement other activities.
4.1.2 Dissemination of newly released WHO RMNCH guidelines

(a) WHO recommendations and guidelines on management of possible serious bacterial infections (PSBI) in sick young infants when referral is not possible

Approximately 10% of newborn infants in the African Region develop signs of possible serious bacterial infections (PSBI) and require antibiotics. However, access to the life-saving antibiotics is not always possible as many newborns don’t get the gold standard care of admission to hospital for the required treatment due to various reasons. This contributes to the 38% of global neonatal deaths that occur annually.

To address this challenge, WHO commissioned a study in three countries in the WHO African Region (DRC, Kenya and Nigeria) and two countries in the South-East Asia Region (Bangladesh and India). The study evaluated simple, safe and effective antibiotic regimens for use at first-level facilities and in the community for young infants with possible serious bacterial infection (PSBI) whose families do not accept or cannot access referral level care. The results of the study informed the development of the WHO guidelines for managing possible serious bacterial infections (PSBI) in sick young infants when referral is not possible which was launched in September 2015. WHO has disseminated the guidelines to child health managers and representatives of paediatrics associations of 37 countries in the African Region, as part of policy dialogue for their adoption. This has led to country level dialogue, resulting in various levels of adoption of the guidelines. As part of building capacity for dissemination, 21 master trainers on PSBI were trained to support implementation research in the Democratic Republic of the Congo, Ethiopia, Malawi and Nigeria, as well as other countries needing their support.

(b) Dissemination of the 2016 WHO antenatal care (ANC) and the sexually transmitted infections (STI) guidelines

The 2016 WHO ANC guidelines recommended, among other things, that ANC should be performed through timely and appropriate evidence-based actions related to health promotion, disease prevention, screening and treatment and delivered as part of integrated care. The new ANC models recommend a minimum of eight contacts to reduce perinatal mortality and improve women’s experience of care. The proposed schedule is shown in front.

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11 Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d’Ivoire, DRC, Eritrea, Eswatini, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, Togo, Tanzania, Uganda, Zambia and Zimbabwe.
The WHO STI guidelines were last revised over 10 years ago, and countries have been demanding for technical guidance, especially in light of the linkages with HIV including dual testing, the increasing morbidity attributed to STIs especially syphilis, the increasing antibiotic resistance, and the global agenda towards dual elimination of MTCT of HIV and congenital syphilis. WHO developed and launched in 2016 new treatment guidelines for chlamydia, gonorrhea, herpes simplex and syphilis based on the latest available evidence. The guidelines detail new recommendations on the most effective treatments for these curable sexually-transmitted infections.

The 2016 WHO ANC and STI guidelines were disseminated to 38 countries, 23 of them in West and Central Africa and to 135 participants from 15 countries of the Eastern and Southern Africa (ESA) subregion. The country teams included programme managers/officers for Maternal and Neonatal Health and Sexual and Reproductive Health (STI focal point), focal points for Malaria in Pregnancy, programme managers/officers for HIV/TB or PMTCT, representatives from the various obstetrical and gynaecological societies and midwifery associations who also double as lecturers in medical training institutions. The new guidelines were also shared with 1500 obstetricians who attended the FIGO/SAGO Congress in November 2016.

The meeting resulted in the development of country action plans to operationalize the recommendations, beginning with in-country dissemination and policy dialogue including rallying partners together for a coordinated implementation. The need for multisectoral collaboration in moving this agenda forward was highlighted.

(c) Update of the WHO FANC training manual in line with the 2016 ANC recommendations
The launch of the new recommendations on ANC in November 2016 necessitated updates of the 2013 FANC training materials. To this end, the Regional Office brought together maternal and newborn health experts from academic institutions represented by SAGO, JHPIEGO, UNFPA and UNICEF, and the WHO maternal and health system cluster in a writing workshop in Brazzaville in May 2017. The participants expressed the wish to have the updated training materials adopted as a regional document guiding the implementation of antenatal care in the African Region. They also expressed the hope that, beyond strengthening the capacity of health
providers in the provision of ANC interventions, the training manual will play a role in
strengthening health systems as it should be used as a reference in the organization of ANC
services, including building linkages.

4.1.3 Monitoring the Every Newborn Action Plan (ENAP) implementation in the
WHO African Region

During the biennium under review, WHO supported the holding of meetings for 37 African
Region countries\(^\text{12}\) from the WHO West, Central and East and Southern Africa intercountry sub
regions to review the status of implementation of the Every Newborn Action Plan (ENAP) in the
Region and identify areas of focus for the 2018-2019 biennium. The review was based on the
strategic areas of focus of ENAP such as scaling-up of cost-effective interventions, quality of
care and monitoring. The picture below presents a snapshot of the status of some global ENAP
indicators in some countries of the ESA subregion. Of the 19 countries\(^\text{13}\) that responded to a
survey, nine\(^\text{14}\) have a standalone national newborn action plan while 15 have an integrated
RMNCAH plan.\(^\text{15}\) Twelve (12) countries\(^\text{16}\) do not have targets for stillbirth and 4 countries
(Botswana, Mozambique, South Sudan and Swaziland) do not have neonatal mortality rate
(NMR) targets in their respective strategies. Only 6 countries (Ethiopia, Malawi, Mozambique,
Rwanda, Uganda and Zambia) have incorporated newborn resuscitation, 4 (Ethiopia, Malawi,
Rwanda and Uganda) Kangaroo Mother Care and 4 (Ethiopia, Namibia, Uganda and Zambia)
neonatal sepsis for tracking indicators in HMIS for accountability and progress. These findings
will help in targeting actions in those countries.

\(^{12}\) Benin, Botswana, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d’Ivoire, DRC, Eritrea, Ethiopia,
Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria,
Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, Swaziland, Togo, Tanzania, Uganda, Zambia and Zimbabwe.

\(^{13}\) Botswana, Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Madagascar, Namibia, Rwanda,
South Sudan, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

\(^{14}\) Comoros, Ethiopia, Kenya, Madagascar, Malawi, Namibia, Rwanda, Tanzania and Zambia.

\(^{15}\) Botswana, Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Madagascar, Namibia, Rwanda,
South Sudan, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

\(^{16}\) Burundi, Comoros, Eritrea, Lesotho, Mozambique, Rwanda, South Sudan, South Africa, Swaziland, Uganda Zambia and
Zimbabwe.
During the meetings, participants from the countries were also oriented on the QoC Network for the implementation of the MNH standards, and the guidelines on the management of possible serious bacterial infections (PSBI) in young infants when referral is not possible. In planning for their next steps, most of the countries prioritized QoC, ENCC including KMC and M(P)DSR for monitoring perinatal deaths.
4.1.4 Prevention of mother-to-child transmission (PMTCT) of HIV

At the end of the biennium, 91% of countries (43/47) adopted 2015 WHO guidelines on ARVs including testing and ‘Treat All’ women and children infected with HIV and 67% of them (29/43) accessed Global Fund resources for the 2017-2019 period to implement the new guidelines. The PMTCT programme completed the INSPIRE research project in 2016 and published 19 papers in a JAIDS supplement to support scaling up EMTCT.

To move towards elimination of mother-to-child transmission of HIV (EMTCT), the Regional Office prioritized the 21 countries that are hosting 70% of new HIV infections in children to transition from option B/B+ to ‘Treat All’ pregnant and breastfeeding women living with HIV and to update their EMTCT national plans. Countries were provided with technical assistance and engaged in policy dialogue to accelerate PMTCT interventions, introduce innovations such as Point of Care (POC) for early infant HIV testing, effective integration service delivery model and Path to Elimination. By the end of 2017, the African Region as a whole had achieved PMTCT coverage of 79% (13% higher than in 2014) and five countries (Botswana, Namibia, South Africa, Swaziland and Uganda) had reached 95% ARV coverage in PMTCT which is the benchmark to undertake the EMTCT validation process. To this end, the Regional Office has engaged key partners and established a multi-agency Regional EMTCT Validation Team that will lead the elimination process in the African Region. In 2017, the Regional Validation Team defined criteria and processes for recognition of the ‘Path to Elimination’ of MTCT of HIV and congenital syphilis in high burden countries, which has contributed to changes in the global validation guidance. In this respect, three countries (Uganda, Botswana and Zimbabwe) formed national validation teams to assess readiness for elimination validation.

17 Angola, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d’Ivoire, DRC, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Mauritius, Mozambique, Nigeria, Sao Tome and Principe, Senegal, South Sudan, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
Integration and Scaling up PMTCT through Implementation Research was conducted in three high burden countries (Malawi, Nigeria and Zimbabwe) to improve retention, access, quality, uptake and scale-up in the prevention of mother-to-child transmission. The results of the five-year initiative to enhance service delivery in health facilities and strengthen national programmes were published (19 papers) in a supplement of the Journal of Acquired Immune Deficiency Syndromes (JAIDS) in June 2017. WHO, across three levels, provided substantial support to the research teams which were all composed of partnerships between ministries of health, and national scientists based at local institutions. A key finding of this implementation research was that community peer support interventions with HIV-positive mentor mothers improved rates of retention in care. WHO disseminated these findings to Member States, community networks and partners, and advocacy was conducted to increase quality of care and retention in PMTCT which is less than 70% in African countries with high risk of HIV drug resistance. The results provided evidence for planning resource allocation prioritization.

4.2 Child and Adolescent Health

4.2.1 Strategic planning for RMNCAH

The WHO Regional Office for Africa used various fora to disseminate and orient Member States and partners on the Global Strategy for Women’s, Children’s and Adolescents’ Health (GSWCAH). The Sixty-sixth session of the WHO Regional Committee for Africa endorsed a technical paper to further commit and guide Member States on the implementation of the GSWCAH priority actions. Standard guide and tools for integrated review were provided to countries to support the development of integrated strategies for RMNCAH. Twenty countries18 were supported to develop integrated Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH&N) strategic plans that are informed by systematic RMNCAH-N programme reviews and are in line with the Global Strategy for Women’s, Children’s and Adolescents’ Health (GSWCAH).

The Regional Office, in collaboration with HQ and H6 partner agencies, oriented RMNCAH staff of H6 partners on RMNCAH Investment case development (Nairobi, March 2016), and also trained 30 consultants and 11 WHO/AFRO staff in RMNCAH strategic planning (Geneva, June 2016). The consultants were prequalified for engagement by all H6 partner agencies. With the help of trained WHO staff and consultants and informed by the review findings, countries developed RMNCAH strategic or investment plans that are in line with GSWCAH. In addition, Ghana, Kenya and Zimbabwe developed a national child and adolescent health policy and a child survival strategy for 2016-202. Initial findings show that the strategic plans have resulted in improvements in key areas such as:

- Integration and scaling up of PMTCT through implementation research
- Development of integrated RMNCAH strategies
- Improvement in quality of care
- Increased resource mobilization and leveraging of domestic and external resources
- Acceleration of progress towards the achievement of the Global Strategy for Women’s, Children’s and Adolescents’ Health

18 Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d’Ivoire, Democratic Republic of Congo, Eritrea, Gambia, Lesotho, Liberia, Guinea, Mauritania, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan and Togo.
in improved prioritization of interventions, inclusion of interventions for newborn and early childhood development and improved coordination of partners, and have also facilitated the mobilization and leveraging of domestic and external resources, including the Global Financing Facility (GFF).

### 4.2.2 Coordination and experience sharing to improve RMNCAH services

The five years of partnership between H6 agencies (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank) and the Governments of Canada and Sweden, which supported 10 countries \(^{19}\) in the African Region to accelerate progress towards the achievement of Millennium Development Goals 4 and 5, came to an end in 2016. The end-line evaluation of the joint programme showed the added value of the six UN agencies working together in the 10 beneficiary countries. Facility utilization of RMNCAH services increased as a result of strengthened national health systems, improvements in the availability of quality services, expansion of access to those most in need and high demand due to community engagement.

AFRO CAN and RWH programmes jointly organized annual RMNCAH review and planning meetings in 2016 and 2017. The meetings were organized for Central and West African countries on the one hand, and Eastern and Southern African countries on the other hand. The meetings brought together RMNCAH programme managers from ministries of health, WHO country office, IST, RO and HQ professional officers as well H6 partner agency representatives. At these meetings, participants were updated on key global initiatives, particularly the GSWCAH, WHO recommendations and tools such as the RMNCAH programme review tool, quality of care guidance and opportunities for resource mobilization. Countries’ achievements and challenges in terms of meeting impact and coverage targets were reviewed. The meetings also provided countries with the opportunity to share experiences and learn from each other, including networking.

### 4.2.3 Improving the quality of care for child health

Improving the quality of care is critical to achieving the objectives of the Global Strategy and needs greater focus in many countries. WHO supported 21 countries \(^{20}\) to assess the quality of RMNCAH services in hospitals and actions are being taken by the countries to address the identified gaps. The Quality of Care Network, which targets services for mothers, neonates, children and adolescents, was launched in February 2017. Initially, it involved nine countries, including seven in the African Region. The network aims to halve maternal and newborn deaths and stillbirths in health facilities within five years. Cameroon was also supported to conduct a national orientation on improving the quality of care for mothers, newborns and children and to pilot adapted tools in one urban district hospital.

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\(^{19}\) Burkina Faso, Cameroun, Côte d’Ivoire, Democratic Republic of Congo, Ethiopia, Guinea-Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe.

\(^{20}\) Benin, Burkina Faso, Burundi, Chad, Congo, Côte d’Ivoire, Ethiopia, Ghana, Guinea-Bissau, Lesotho, Malawi, Mali, Niger, Nigeria, Rwanda, Sierra Leone, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
In addition, Ghana, Nigeria, Zambia and Zimbabwe were supported to conduct a national orientation on improving the quality of care for mothers, newborns and children. MOH leadership of the quality improvement (QI) initiative as part of the existing health services has facilitated leveraging of key stakeholders’ support. Guinea and Zambia were supported to build the capacity of national trainers on Emergency Triage Assessment and Treatment (ETAT) to improve the quality of paediatric emergency care in referral hospitals.

Integrated Management of Childhood Illness (IMCI) remains the key strategy for improving the quality of care provided to sick children in first-level health facilities. The Regional Office provided technical support to the Global IMCI Strategic Review. Forty-three countries in the Region contributed to the review and in-depth analysis of IMCI implementation was undertaken in Ethiopia, DRC and Nigeria. Review findings were disseminated at various fora and lessons learned from the review are being used to devise innovative approaches for implementation. Member States were supported to adopt and use the IMCI Computerized Adaptation and Training Tool (ICATT) for IMCI pre-service training and IMCI-distance learning for in-service training of health workers. Thus, Botswana, Kenya, Senegal, Swaziland, Togo and Zimbabwe were supported to finalize their ICATT adaptation and to produce ICATT Training Players for use by pre-service and in-service training institutions. Furthermore, Zimbabwe was supported to build the capacity of tutors from health training institutions to strengthen IMNCI teaching using the ICATT application. In Botswana, training of lecturers and pre-testing of the ICATT training player were done for 3rd year nursing students in all six nursing training institutions, except in the University of Botswana, using the LCD projector mode. In Kenya, the ICATT training player was field-tested in one county (Marsabit) and will be rolled out to more counties. Swaziland and Zimbabwe are planning to scale up ICATT in pre-service training institutions in 2018. The adaptation of the ICATT tool in Cameroon has helped to strengthen the national capacities of 80 providers for IMNCI implementation.

Tanzania has managed to train over 7,000 health workers in Zanzibar and the mainland using the IMCI-distance learning for in-service training and ICATT has been rolled out to all pre-service health training institutions.

The Regional Office developed an EPI/IMCI interactive tool to build the capacity of front-line health workers in immunization practices and case management of sick children. A handbook and an electronic tool in three languages, namely French, English and Portuguese, were finalized.

Teams comprising EPI and child health programme managers and child health tutors from WHO and MOH of six countries (Congo, DRC, Ethiopia, Rwanda, Sao Tome and Principe and Sierra Leone) were trained on the tool. It was introduced and demonstrated to RMNCAH and EPI programme managers and WHO professional officers during the review and planning meetings and EPI programme managers meetings held in 2016.
4.2.4 Integrated community management of childhood illness

The WHO Regional Office for Africa supports countries to adapt and implement integrated community case management of childhood illnesses as a key strategy to increase access to life-saving treatments for children particularly where access to health facilities is not easy. WHO continued to provide support to the Rapid Access Expansion (RAcE) project for scaling up community-based management of malaria, diarrhoea and pneumonia in children in five countries (DRC, Malawi, Mozambique, Niger and Nigeria). Since the start of the project in 2013, over seven million cases of malaria, pneumonia and diarrhoea have been treated at community level in project sites in these countries. The RAcE project demonstrated that when community health workers are trained and supported, they can provide adequate treatment for malaria, diarrhoea and pneumonia. It brought about policy change in countries, such as the introduction of rapid diagnostic tests for malaria at community level, the use of amoxicillin dispersible tablets for pneumonia and the use of zinc for the treatment of diarrhoea. The project results are being used in countries to scale up integrated community case management of diarrhoea, malaria and pneumonia.

Democratic Republic of the Congo: RAcE and iCCM implementation dries tears in the DRC

In Tanganyika, one of the Democratic Republic of the Congo’s (DRC) provinces, three diseases, namely malaria, pneumonia and diarrhoea, cause 42% of deaths in children under five years. The people of the province live in remote areas where access to healthcare is challenging due to lack of transportation, physical barriers and poverty. In 2012, Global Affairs Canada provided a generous grant to WHO to fund the Rapid Access Expansion (RAcE) programme. The RAcE programme works with the ministry of public health to bring treatment to remote villages through the integrated community case management (iCCM) strategy.
Uganda: In January 2015, the Government of Uganda (GOU) received a two-year grant of US$ 4.6 million from the Global Fund to support the expansion of the ICCM programme to 33 additional districts, from the initial number of 34. This was the first time Uganda was awarded a Global Fund (GF) grant for ICCM using principal and sub- recipients outside the MOH. The MoH therefore commissioned a rapid assessment of the implementation of the GF ICCM grant with a view to sustaining the initiative. WHO/AFRO/IST/ESA provided technical leadership in conducting a rapid assessment of ICCM implementation in 15 districts under the US $4.6 million Global Fund grant as a requirement for the release of the second phase of the grant to further scale up ICCM in 18 additional districts.

4.2.5 Capacity building for early childhood development

Eight countries were supported to build capacity through training of 59 trainers and 46 programme managers in adaptation and planning of early child development through multi-country workshops in Kenya and Tanzania. As a result, a total of 78 facilitators and 80 programme managers from 11 countries were trained to roll out early child development, representing excellent partnership and collaboration among UNICEF, PATH, AGDN, EGPAF and CRS to institutionalize early child development at the moment when countries in the subregion were updating their national and RMNCAH policies and strategies and service guidelines. Subsequently, Botswana, Kenya, Malawi, Tanzania and Zambia were supported to conduct national level training of trainers (TOT) to roll out CCD/ECD training.

4.2.6 Improvement of adolescent health across the Region

Following the publication by the African Health Observatory of the Atlas of African Health Statistics 2016, the Child and Adolescent Health and Nutrition Programme developed a Regional Atlas on Adolescent and Youth Health 2016 in order to provide countries with guidelines to improve the planning, implementation, monitoring and evaluation of their adolescent and youth health interventions.

The Regional Office, in collaboration with the Government of the Republic of Congo, convened a regional consultation to review progress in school health programmes in countries to strengthen national school health programmes in the African Region. Twenty-nine countries were supported to develop roadmaps to strengthen national school health programmes.

In 2016, WHO/AFRO and MCA conducted an intercountry capacity building training course using the updated WHO Orientation Programme on adolescent health for health-care providers in Namibia to train a pool of 26 resource persons from nine countries in delivering adolescent health training courses. Ethiopia was one of the countries that participated in this training, and as a follow-up action carried out a national adaptation of the WHO Orientation Programme, i.e. adapted the facilitator’s guide and the participants’ manual, as well as national implementation guides, standards and M&E framework for adolescent and youth health.

In addition, in December 2017, WHO built the capacity of 24 trainees, 19 from Ethiopia, 2 from Malawi, 2 from Nigeria and 1 from Kenya. The trainees included faculty staff from national training institutions, WHO’s and partners’ country staff from the ministry of health (FMOH) of Ethiopia, Kenya, Malawi and Nigeria. In the second week of training, there were a total of 35 participants comprising 9 regional focal points for adolescent health, 18 representatives of partner organizations in charge of cascade training for adolescent health in districts, and 9 faculty staff to support the implementation of the WHO/AFRO Flagship programme on adolescent health.

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22 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Congo, Côte d’Ivoire, DR-Congo, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Namibia, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Uganda, Zambia and Zimbabwe.

23 Ethiopia, Kenya, Lesotho, Mozambique, Namibia, Tanzania, Uganda, Zambia and Zimbabwe.
Regarding resource mobilization for adolescent health, nine countries with a high burden of HIV infection among adolescents were supported to develop the Global fund request to mobilize matching funds. As a result, Cameroon, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe were able to mobilize US$ 43 500 000 to accelerate action for HIV prevention, treatment and care among adolescent girls and young women.

4.3 Sexual and Reproductive Health

4.3.1 Guidance for sexual and reproductive health

A regional implementation framework for the global health sector strategy on sexually-transmitted infections (STIs) 2016-2021 was developed and adopted by the Sixty-seventh session of the Regional Committee (RC67) in August 2017. This framework provides guidance
and policy orientation to Member States for the implementation of the global strategy on STIs with the aim of eliminating STIs by 2030.

WHO/AFRO disseminated the WHO newly released guidelines and recommendations (2016) to Member States and partners, including for antenatal care and sexually-transmitted infections, and supported countries to roll out the recommendations. In this connection, the key achievements are the development and/or update of policies and strategies in line with the WHO latest recommendations on sexual and reproductive health (SRH) and family planning (FP). In total, more than 38 SRH policies/strategies were developed or updated, which contributes to facilitating the implementation of SRH activities and improving the quality and uptake of services.

4.3.2 Capacity building for SRH service providers

A total of 252 family planning trainers and more than 300 service providers were trained in 2017. It is expected that the updated trainers will cascade training to enable the countries to have a critical mass of skilled health-care providers for FP. This will contribute to improving the quality of care and, hence, contraceptive uptake.
In 2016-2017, the WHO Regional Office for Africa also leveraged partnerships and mobilized additional resources to support the implementation of SRH/FP activities in countries including the initiation, development and implementation of a WHO new project entitled “Africa: Strategic Technical Engagement with Evidence for Results (Af-STEER)”. This three-year project worth US$ 3,000,000 funded by BMGF focuses on post-partum FP and post-abortion contraception and provision of SRH/FP information and services for adolescents and youth. The targeted countries are Burkina Faso, Côte d’Ivoire, Ethiopia and Uganda.

At the same time, the Regional Office continued to ensure a close follow-up to monitor and facilitate the implementation of the WHO umbrella project (funded by BMGF) entitled “Strengthening FP and contraceptive services using WHO guidelines” in the ten targeted countries. It also helped to mobilize SEK 400 million from the Swedish International Development Agency for a joint United Nations SRH Regional Proposal for five countries of Eastern and Southern Africa for a three-year project (2018—2020).

**Zoom in on RMNCAH**

- Benin: Establishment of the first paediatric intensive/reanimation care unit
- Burkina Faso and Guinea: Free care for mothers and under-five children
- Burundi, Cameroon, Chad, Mauritania, Mali and Niger: High-level involvement in maternal deaths surveillance: Weekly presentation of maternal deaths data to the President (Mauritania), Monthly presentation of maternal deaths data to the President (Chad) and to the Office of the Minister of Health (Burundi, Cameroon, Niger and Mali)
- Sierra Leone: Child mortality in three regional hospitals decreased from 15% to 5% in the first six months of ETAT+ implementation which is being rolled out to all districts
- Rwanda and Tanzania: The Medical Eligibility Criteria (MEC) Wheel and other family planning guidelines are now available at facility level and are in use
- South Sudan: A National MDSR Committee and two state MDSR committees have been set up, and will be supported by WHO to ensure functionality, review and reporting; a presidential decree on notification is being prepared.

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25 Lesotho, Malawi, Uganda, Zambia and Zimbabwe.
4.4 Ageing through the life-course

The global population is ageing rapidly. In Africa, it is estimated that the number of people aged 60 years or above will increase from 46 million in 2015 to 147 million by 2050. Member States are yet to prioritize healthy ageing and address it in their national health and development agenda through a comprehensive multisectoral approach.

WHO developed a Regional implementation framework 2016-2020 in response to the comprehensive Global Strategy and Plan of Action on ageing and health. The framework endorsed by the Sixty-sixth session of the WHO Regional Committee for Africa is the main reference document on healthy ageing in the Region towards the UN decade for Healthy ageing commencing in 2020. It also provides programmatic and policy orientations to Member States, endorses the concepts and strategic orientations outlined by the global strategy and contains vision, strategic objectives and priority actions for 2016-2020 for the African Region.

WHO has oriented ten countries26 on the regional implementation framework and trained the country teams on institutionalization of healthy and active ageing policies, strategies and priority actions into national strategic planning processes. In addition to the ten countries, Benin, Congo, Gabon and Gambia are now using the information and knowledge acquired through the training to integrate or develop policies and national strategic plans on healthy ageing. Regular monitoring of the implementation of the Global Strategy and regional framework and action plan on ageing and health is ongoing to ensure that countries receive the support needed towards the UN Decade of Healthy Ageing commencing in 2020.

Zimbabwe: Strengthening health care for older people

WHO spearheaded the development of a National Healthy Ageing Strategic Plan 2017-2020 in collaboration with Ministry of Health and Child Care (MOHCC), Centre for Community Development Solutions (CCDS) and Help Age. Working with these partners, other priority areas of collaboration identified include assistance with a training curriculum for health care workers engaging with older persons, creation of awareness on HIV in old age, and promotion of HIV testing among older couples.

WHO is leading advocacy and support for implementation of these priorities as implementation of national healthy ageing plan is being rolled out nationwide.

4.5 Gender, equity and human rights integrated into WHO’s institutional mechanisms and programme deliverables

Resolution WHA60.25 adopted the Strategy for integrating gender analysis and actions into the work of WHO (document EB120/6; WHA60.25) and urged the Director-General to ensure the Secretariat’s capacity to analyze the role of gender and sex in health, monitor and address systemic and avoidable gender-based inequalities in health and ensure full implementation of the strategy. To this end, 45 (24 females and 21 males) WHO staff from the Regional Office, Intercountry Support Teams (ISTs) and Ghana, Malawi, Nigeria, Swaziland, Uganda and United Republic of Tanzania country offices were trained on gender mainstreaming during the biennium.

In addition, four Family and Reproductive Health programme officers from the Regional Office had intensive training on the WHO equity, gender and human rights barrier assessment tools. The knowledge and new skills acquired are contributing to the quality of technical support provided to countries for integration of gender, equity and rights into institutional mechanisms and programme deliverables in the African Region.

Gender focal points in the Family and Reproductive Health Department and counterparts working on Social Determinants of Health (SDH) in health promotion programmes in the Regional Office and country offices collaborate effectively by planning and implementing joint activities. The annual gender, equity and rights focal points meetings are also established mechanisms for coordinating activities at the three levels of WHO. These efforts are promoting cooperation and efficiency in the use of resources by reducing duplication and enhancing cross-country collaboration and learning as well as support for regional leadership.
4.6 Immunization and Vaccine Development

4.6.1 Routine immunization and introduction of new vaccines

Regional immunization coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine (DTP3) remained the same as for the previous biennium at 72% (WHO/UNICEF estimates, July 2018). Similarly, coverage with the first dose of measles-containing vaccine (MCV1) also remained at 70%. These coverage figures are well below the coverage target of 90% set in the Global Vaccine Action Plan (GVAP) and Regional Strategic Plan on Immunization (RSPI). Member States will have to strive to reach and maintain the GVAP and RSPI coverage targets to minimize the frequency and size of outbreaks of VPDs.

Capacity building and technical assistance to strengthen routine immunization resulted in 20 countries reaching ≥90% DPT3 coverage compared to seventeen countries the previous biennium. The 95% national MCV coverage target for measles elimination was reached in eight countries during this biennium (2017 WUENIC data). National DPT3 and MCV1 coverage are presented in the figure below:

Routine immunization coverage levels for key vaccines, number of children vaccinated and unvaccinated as well countries with the highest number of unvaccinated with DTP3 are shown in the Figure 7.

27 Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Comoros, Eritrea, Gambia, Ghana, Lesotho, Mauritius, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Togo, United Republic of Tanzania, Zambia

28 Botswana, Cabo Verde, Eritrea, Ghana, Rwanda, Seychelles, Tanzania, Zambia
Routine immunization coverage levels and % of districts with at least 80% DTP3 coverage are shown in the Figure 8.

Analysis of 2017 districts reported data in the JRF indicates 4 countries\(^{29}\) have achieved at least 80% coverage in 100%, and number of those with at least 80% progressed from 14 in the last biennium to 20 in the current biennium while the ones with less than 80% decreased from 26 to 22 during the same period.

\(^{29}\) Gambia, Rwanda, Sao Tome and Principe, Swaziland
In the 2016-2017 biennium, significant progress was made in the introduction of new vaccines. WHO supported several countries in decision-making to introduce new vaccines, apply for Gavi funding, prepare for introduction, introduce new vaccines, monitor and implement the introduction and use results from these evaluations to improve the overall immunization system.

Despite the global shortage of inactivated polio vaccine (IPV) and human papillomavirus vaccine (HPV), WHO continued to support countries to ensure readiness for introduction once vaccines became available.

All countries introduced new and under-utilized vaccines into their routine immunization programmes.

(a) Five additional countries introduced Rotavirus vaccine bringing the total to 34 countries
(b) All countries have introduced PCV with exception of eight, Algeria and Mauritius having introduced PCV in the 2016/17 biennium.
(c) Sao Tome and Principe introduced HPV vaccine despite the global HPV vaccine shortage
(d) Six countries introduced Meningococcal vaccine
(e) Eleven countries introduced IPV bringing the total to 37 countries with South Africa having introduced sequentially and the rest in combination with OPV.
(f) Namibia 2nd dose of Measles making the total number of countries with MCV2 to 26
(g) Twelve countries introduced a Rubella containing vaccine into their programmes
(h) Although 10 countries have introduced Hepatitis B birth dose into their EPI programmes, none introduced Hep B birth dose in the biennium
(i) Burundi introduced a DTP booster dose to become the 8th country in the region with the DTP booster dose

Thirty-two countries are implementing sentinel site surveillance for rotavirus, invasive bacterial diseases that meet set regional and global standards – this platform is being used to provide evidence on disease burden, to monitor impact of vaccination and to detect outbreaks due to specific vaccine-preventable diseases (VPDs). Evaluation of the impact and effectiveness of rotavirus vaccine and PCV on disease burden was expanded to include 15 countries. Available data from these evaluations show substantial reduction in rotavirus diarrhoea hospitalization, paediatric bacterial meningitis, invasive pneumococcal diseases and pneumonia in countries

30 Côte d’Ivoire, Liberia, Lesotho, Sao Tome and Principe, Seychelles
31 Cape Verde, Chad, Comoros, Equatorial Guinea, Gabon, Guinea, Seychelles and South Sudan
32 Burkina Faso, Central African Republic, Chad, Ghana, Mali, Niger
33 Angola, Congo, Cape Verde, Guinea Bissau, Equatorial Guinea, Liberia, Lesotho, Mali, Sao Tome and Principe, Swaziland, Uganda
34 Algeria, Botswana, Burundi, Cameroon, Gambia, Kenya, Lesotho, Malawi, Namibia, São Tome and Principe, Swaziland, Zambia
35 Algeria, Burundi, Cape Verde, Gambia, Mauritius, Seychelles, South Africa, Zimbabwe
using these new vaccines in routine immunization. However, coverage of PCV and rotavirus vaccine remains low at 65% and 43% respectively.

Recent estimates show that 135 000 rotavirus hospitalizations and 21 000 rotavirus deaths in children <5 years of age were prevented in the 29 African countries that introduced rotavirus vaccine into their national immunization by the end of 2017. Overall, all-cause diarrhoea hospitalizations among children <5 years of age decreased from 17% to 5.7% with larger declines observed among children <1 year of age and during the rotavirus season (Mwenda JM et al, In Press, Vaccine 2018).

In a cost-effectiveness analysis of the rotavirus vaccination programme conducted after vaccine introduction in Malawi, rotavirus gastroenteritis was found to cause significant reduction in economic burden and the rotavirus vaccination programme was highly cost-effective (Bar-Zeev N, et al, in Press, Vaccine 2018). Support was provided to seven countries to evaluate the risk of intussusception (IS) in children eligible for rotavirus vaccination. Analysis of pooled multi-country data show no association of IS and rotavirus vaccination in the Region (Tate J & Mwenda JM et al, in Press, New England Journal of Medicine, 2018).

Given the documented evidence of large public health benefits and the absence of increased risk of intussusception following vaccination with rotavirus vaccine (RV1), these recent findings of the safety of rotavirus vaccine in Africa are quite reassuring. These data, showing tremendous public health benefit of vaccination with these new vaccines, will help to guide policy decisions on vaccine use in countries that have not yet introduced rotavirus vaccines and PCV in routine EPI.

Recent DHS in many countries in the Region showed that boys and girls have equal access to vaccines. However, differences in coverage persist between countries (80% of all unvaccinated children in the Region reside in 10 countries36) and also within countries.

Furthermore, the DHS show that immunization coverage in children living in rural areas was generally lower than for those in urban areas. Children born of mothers with a low level of education had lower coverage compared to those who are well educated. By tackling education and poverty, countries can reduce inequities.

To support country efforts to improve immunization coverage and equity, effective vaccine management (EVM) assessments were conducted in 43 out of 47 countries in the region with an average of 2 country assessments. Results show that efforts have been made, but there are still improvements to be made in the country's vaccine supply chain. To date 6 countries have achieved a composite score of 80% on all the criteria of EVM.

The figure below shows the performance of composite country scores between two assessments conducted in 2009 and 2017.

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36 Nigeria, Ethiopie, DRC, Angola, South Africa, Uganda, Chad, Niger, Sud Soudan and Mali.
There are initiatives targeting specific vaccine-preventable diseases in the Region. These include poliomyelitis eradication, measles elimination and control of other diseases. In addressing measles elimination, Member States undertake SIAs periodically to supplement routine immunization. In 2017, a total of 125.5 million children received measles vaccination during SIAs. As of December 2017, a total of 44 countries were conducting measles case-based surveillance with laboratory confirmation, and 8 countries successfully responded to measles outbreaks with support from WHO. The second dose of measles-containing vaccine provided in the second year of life is an additional opportunity for children who missed vaccination at 9 months and also further boosts immunity for those who failed to fully develop immunity after the first dose. The second dose of measles-containing vaccine (MCV2) and the rubella-containing vaccine were introduced by 26 and 20 countries respectively.

Maternal and neonatal tetanus (MNT) remains a major public health problem despite the availability of a good vaccine, improved health care to ensure supervised delivery and proper umbilical cord hygiene. Member States have undertaken to eliminate MNT by 2020. A total of 38 countries have attained the validation of elimination of neonatal tetanus as of end-2017.

4.6.2 Research and vaccine development

The next generation of vaccines against Ebola and cholera were tested in the Region to ensure better efficacy, safety and mode of administration. This is a remarkable achievement because two years ago there was only a remote possibility of developing a vaccine against Ebola Virus Disease. In January 2016, WHO recommended pilot implementation of the first and, to date,
the only vaccine against malaria in young children. This follows completion of a large-scale phase 3 clinical trial in the Region and a positive scientific opinion from the European Medicines Agency (EMA).

Through an AVAREF joint review process, the NRAs of the three countries reviewed a risk management plan and the EMA Article 58 reports and issued special approval for the importation and use of the malaria vaccine in the pilot. Starting in 2019, Ghana, Kenya, and Malawi will provide the malaria vaccine (known as RTS,S/AS01 or Mosquirix®) to young children in selected areas through routine immunization services. The vaccine will be evaluated for use as a complementary malaria control tool to the core package of existing preventive, diagnostic and treatment measures.

In addition, norms and standards that are harmonized with international and regional regulatory standards were set and guidance provided to strengthen regulatory systems that ensure the oversight of clinical trials and product licensure based on efficacy, safety and quality.

4.6.3 Immunization and VPD surveillance data improvement

Data of the highest quality remain crucial for decision-making and public health action. Since November 2016, the African Region has taken steps to ensure that Member States are not only aware of the new WHO data quality review method but also that EPI and HMIS staff as well as in-country partners are trained on the process. For GAVI eligible countries from the African Region, the first round of training for 16 countries took place in Kampala in November 2016 and the second for 20 countries in May 2017. The third round targeted eight non-GAVI eligible countries and two GAVI eligible countries that missed the first round.

The 46 trained Member States are now in the process of conducting their in-depth assessment of the information system and for the development of strategic and annual data quality improvement plans. So far, twelve countries (Benin, Burkina Faso, Cameroon, Central Africa Republic, Dr Congo, Ghana, Kenya, Mali, Nigeria, Swaziland, Tanzania and Zimbabwe) have been supported to conduct the in-depth assessment for the development of a strategic and annual data quality improvement plan. These plans are being included in cMYP and annual EPI plans of action and monitored by data improvement teams to be established in each country.

The regular Joint Reporting Form (JRF) peer review workshops were organized to further improve the quality of data reported in the JRF, while capacity for data analysis and data quality desk reviews was also strengthened. All countries have conducted data triangulation focusing on survey data, outbreak reports, vaccine availability and use, etc. as recommended during the December 2016 Regional Immunization Technical Advisory Group (RITAG) meeting.
Rwanda achieved MCV1 coverage levels of 95% - 97% from 2015 to 2016, and MCV2 levels of 87% and 90% in 2015 and 2016 respectively. The country introduced rubella-containing vaccine into the routine immunization schedule following the measles-rubella catch-up campaign in 2013 which achieved 102% administrative coverage at national level, and 90% of the districts achieved coverage of 95% or more. Rwanda conducted its nationwide measles-rubella follow-up mass vaccination campaign in October 2017 and achieved 102% administrative coverage at national level, with 28 out of the 30 districts reporting coverage of 95% or more. Rwanda sustained low measles incidence between 2014 and 2017, with incidence levels of 5 per million in 2016, 0.1 per million in 2015 and 0.5 per million in 2014. The country met the performance targets for the two principal measles surveillance performance indicators consistently. The country will meet the measles elimination goal by 2020 if its performance is maintained at the current levels.

Chad is one of the countries in the Region with low routine immunization coverage and a high number of unimmunized children. In addition to other strategies being implemented to increase coverage and equity, the country conducted the assessment of Missed Opportunities for Vaccination (MOV) in six districts and identified 15 simple actions to be implemented. These include: ascertaining by health workers the vaccination status of each child attending a health facility (HF); training of health workers; ensuring availability of vaccines at all levels providing relevant information to mothers; etc.

To document achievements made in implementing these correctives measures in addressing MOV, the country developed vouchers which were given to parents coming to the HF for any health issue and whose children were missing doses of vaccines. They were referred to the vaccination units and vaccinated. The number of non-vaccinated children visiting the HF that were vaccinated was calculated by counting the number of vouchers received at the vaccination unit. This simple strategy has contributed to an increased number of children vaccinated in the six districts, thus contributing to an increase in vaccination coverage at national level.

Ghana: Morbidity and mortality rates due to vaccine-preventable diseases (VPDs) in Ghana were very high in the early to late 2000s. Measles in particular was responsible for the death of many children, especially children under one year. The measles vaccination coverage rate was less than 70%. Ghana developed a five-year rolling plan of accelerated control of measles in accordance with the WHO/AFRO EPI strategic plan, with a focus on reducing measles mortality to near zero. WHO played a major role, both technical and financial, in the implementation of the plan.

The control of VPDs in Ghana has moved from strength to strength. Specifically, the implementation of the Global Measles and Rubella Strategic Plan 2012-2020, which was supported by WHO, increased the coverage of the first dose of measles-rubella (MR) from 93% in 2014 to 95% in 2016. The country is on course to further improve on this coverage in 2017. The second dose of MR vaccination has also improved remarkably through the concerted efforts of WHO, CDC Second Year of Life (2YL) Project and UNICEF.

WHO supported the Government to develop a measles and rubella elimination strategic plan which has contributed to improving vaccination quality and coverage. As part of the implementation of this plan, low performing districts and sub-districts were targeted and supported, both technically and financially.

It is worth noting that, through the collaborative efforts of Government, WHO and other partners, the number of suspected and confirmed measles cases in the country has reduced dramatically. In 2017, a total of 32 confirmed cases of measles were reported. This represents a good performance especially as 319 confirmed cases were reported in 2013. It is heartwarming to state that the country has not recorded any death due to measles in the past 15 years. The once feared childhood killer is gradually being eliminated from the country through the efforts of WHO, the Government of Ghana and other health partners.
As of December 2017, 16 rounds of RES and 6 rounds of RIC strategies had been implemented, reaching more than 250 000 and 50 000 children respectively in security-compromised areas in Borno state. In addition, the special intervention teams in transit points vaccinated children with about 2.4 million doses; 397 370 children vaccinated by this special intervention team were profiled, which revealed that 21 664 came from neighbouring countries and states while the remaining 375 706 from inaccessible areas within the state.

(b) An estimated total of 1.2 million sick children under-five were reached with appropriate and timely treatment for pneumonia, diarrhoea and malaria, with identification of malnutrition and referral of those with danger signs and sick newborns.

(c) Pregnant women were identified and referred to health facilities for antenatal care and skilled delivery attendance.

The following achievements were made:

(a) WHO initiated a strategy for deployment of rapid access vaccination teams to reach eligible children in partially accessible locations with the support of the civilian Joint Task Force. The strategy was later expanded and branded the Reaching Every Settlement (RES) strategy.

(b) WHO supported positioning of special teams at strategic transit points and nomadic routes to ensure that every child is vaccinated and protected against childhood diseases.

(c) WHO deployed 58 hard-to-reach teams to 1565 settlements to provide an integrated package of MNCH services in areas far from the reach of health facilities.

(d) 800 community resource persons (CORPs) within the communities and IDPs camps across the 25 LGAs in Borno state were trained on preventive, promotive and case management of common childhood illness (Integrated community case management- iCCM and community- integrated management of childhood illness -IMCI) to deliver key essential MNCH health services in a comprehensive approach.

(e) The capacity of the health-care providers at the PHC was strengthened to improve quality health services, birth preparedness and complications readiness, referral and supportive supervision.

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(e) The capacity of the health-care providers at the PHC was strengthened to improve quality health services, birth preparedness and complications readiness, referral and supportive supervision.
WHO organized the first ever *Ministerial Conference on Immunization in Africa* in February 2016 that culminated in the signing of the *Addis Declaration on Immunization* (ADI). Thereafter, at the *28th African Union Summit*, Heads of States from across Africa endorsed the ADI and an ADI Roadmap entitled “*Roadmap for Implementing the Addis Declaration on Immunization: Advocacy, Action, and Accountability*” was officially launched at the 1st WHO Africa Health Forum in Kigali, Rwanda, in June 2017 by the Regional Director.

In 2016, twenty countries\(^{38}\) attained the RSPI coverage target of >90% for DTP3 vaccine and 17 countries\(^{39}\) achieved MCV1 coverage of at least 90%.

- Pneumococcal conjugate vaccines (PCV) and rotavirus vaccines are now introduced in 38 and 33 countries respectively.
- To mitigate the consequences of a substantial reduction of available resources due to the GPEI ramp-down and closure and countries transitioning from Gavi support, the IVD programme developed a WHO business case for immunization.

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\(^{38}\) Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Comoros, Eritrea, Gambia, Ghana, Lesotho, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Tanzania, Zambia and Zimbabwe.

\(^{39}\) Algeria, Botswana, Burundi, Cabo Verde, Comoros, Eritrea, Gambia, Lesotho, Mauritius, Mozambique, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Tanzania, Zambia and Zimbabwe.
**4.7 Nutrition and Food Safety**

**4.7.1 Implementation and monitoring of action plans based on the maternal, infant and young child nutrition (MIYCN) comprehensive implementation plan**

WHO, in collaboration with other UN agencies, provided technical assistance to 16 countries to review and/or update national nutrition policies/strategies or action plans in line with the maternal, infant and young child nutrition (MIYCN) comprehensive implementation plan. For all countries, the alignment involved inclusion of some or all of the six global nutrition targets for 2025. In some cases, WHO tools were used to support costing (Swaziland, Mozambique and Tanzania) and to set SMART targets towards 2025 based on country-specific factors. For Burundi and the Central African Republic, nutrition objectives were integrated into national reproductive health plans to ensure that nutrition interventions are delivered along with maternal and child health interventions in the critical early years of life. In Botswana, Lesotho, Namibia and Swaziland, nutrition indicators were integrated into national NCD prevention plans, thus recognizing the need to address the double burden of malnutrition.

Capacity building for the application of WHO tools and processes targeted both WHO country office and ministry of health staff. Personnel from 15 countries in ESA were trained to use WHO tools for costing nutrition plans (one-Health tool), setting nutrition targets, and tracking implementation and expenditure. In Kenya, Zambia and Zimbabwe, district nutritionists were trained on the costing of plans, setting of targets and monitoring of programme performance. As part of Accelerating Nutrition Improvements (ANI) in sub-Saharan Africa (a project funded by the Government of Canada), best practices in scaling up nutrition actions were developed and documented in Ethiopia, Uganda and Tanzania. This helped, inter alia, to secure budgetary allocations for nutrition at district level in Tanzania, develop local solutions for complementary feeding in Uganda and conduct advocacy for adolescent nutrition in Ethiopia with a view to improving child and maternal nutrition.

As part of the ANI project, WHO provided support to 11 countries to incorporate nutrition indicators into national health information systems in order to strengthen surveillance, monitoring and evaluation. Nutrition data were integrated into existing health facility tools and national health information systems. Six countries now include nutrition indicators in weekly or quarterly health reports prepared by MOH personnel who were trained through the project. Success was founded on partnership and consensus building with other agencies and NGOs.

In addition, aligned with the 2030 Agenda for Sustainable Development, particularly SDG2 and SDG3, and the 2016-2025 UN Decade of Action on Nutrition, WHO’s nutrition strategy aims for “A world free from all forms of malnutrition where all people achieve health and well-being”. To this end, AFRO and HQ Nutrition and WHE teams conducted a workshop for country-based staff.

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41 Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe.
42 Burkina Faso, Rwanda, Senegal, Sierra Leone, Uganda and Zimbabwe.
on an operational model integrating nutrition and health emergency response. Thirty-three WHO emergency and nutrition officers participated from 14 countries in crisis or at risk thereof (Eritrea, Ethiopia, Kenya, South Sudan, Uganda, Tanzania, Nigeria, Niger, Chad, Cameroun, CAR, Burundi, Mali and the Democratic Republic of Congo). The initiative helped to redefine WHO’s work in emergency nutrition within the revised WHO Emergency Response Framework.

The launch of the nutrition report sparked a popular media discussion on the double burden of malnutrition that could importantly sensitize the population on the problems associated with obesity. Although many countries revised nutrition policies recently, the upper end of the double burden of malnutrition is not fully reflected in planned actions. Systematic efforts towards action on the double began in 2017 with desk research on food consumption and NCD risk factors. It revealed gaps in the data required to develop guidance on limiting the consumption of unhealthy foods as well as in the policies and actions in place to control the marketing of unhealthy foods. Following the approach used in other WHO regions, the Regional Office initiated the consultative process of developing a nutrient profiling model to guide policies on the marketing of foods and nonalcoholic beverages especially to children. This work is continuing in 2018.
4.7.2 Norms and standards on maternal, infant and young child nutrition, population dietary goals and breastfeeding

For WHO norms and standards to be used, it was necessary that WHO staff have the required expertise and competency to apply them. Training workshops on management of severe acute malnutrition were conducted in 2016 (English) and 2017 (French) for a total of 33 country staff (19 of them women). This training has been an effective means of improving life-saving skills based on updated WHO modules, and has led to improvements in quality of care in Burundi, Ethiopia, South Sudan, Swaziland and Togo.

**Ethiopia: Addressing quality of care for management of severe acute malnutrition (SAM): A story from Somali region of Ethiopia**

In 2017, severe acute malnutrition (SAM) affected 285 000 children in Ethiopia (26% or 73 000 of them from Somali Region). Of these, 9% required hospitalization to treat medical complications. Enhancing quality of SAM treatment was central to WHO’s nutrition response strategy to increase uptake of services and save lives among hospitalized under-five SAM patients with and without medical complications.

WHO supported 33 stabilization centres (SCs) to upgrade the quality of care with a focus on building resilient health systems for effective and timely response to high caseloads of SAM with medical complications. Interventions included facility-based training on SAM management (130 health workers); deployment of 18 mentors to conduct weekly or biweekly mentorship/on-the-job coaching for SC staff; deployment of additional health workers (two nurses per health facility); distribution of SAM medical kits (two kits/facility); and reorganization of the stabilization centres with access to improved water supplies and sanitation facilities.

With improvements in human resource capacity and care facilities, admissions of SAM cases with medical complications did increase (from 31 at week 31 to 69 at week 48) but so did the average score on quality of care (70 at week 48 compared to 58 at week 31).

4.7.3 Control of risks and reduction of the burden of foodborne diseases

Antimicrobial resistance (AMR) in foodborne pathogens is on the increase in the Region. The WHO Global Surveillance Report 2014 notes that the Region is among those with national reports of 50% or higher resistance to three of the most commonly reported bacterial strains that cause infections in humans. The report further notes that major gaps exist in surveillance and data sharing on AMR in food producing animals and the food chain.
The WHO, in collaboration with FAO and the World Organization for Animal Health (OIE), trained 36 epidemiologists and laboratory scientists on isolation, antibiotic susceptibility testing and molecular characterization of foodborne pathogens. Those trained came from 13 countries drawn from national institutions representing food, animal and human health sectors. As a result of the skills acquired, baseline data through country projects on the antimicrobial resistance of extended spectrum beta-lactamase (ESBL) — E. coli was generated and disseminated in two countries, raising from 14 to 16 the total number of countries in the Region that have baseline data on AMR in selected foodborne pathogens from at least two of the three relevant sectors (animal, food and human sectors). The data have been used to inform policy, develop guidelines on the prudent use of antibiotics in food producing animals and/or foster cross-sectoral collaboration. For example, in the Gambia the data were used for advocacy and sensitization of high-level decision makers on risk factors for AMR, and this led to the development of AMR prevention and control measures. Regulatory frameworks were strengthened through Food Safety Bills. For example, Nigeria initiated institutional reforms for improved food safety management, and Togo improved its food inspection services with the establishment of risk-based food inspection procedures. Multisectoral national food safety strategic plans were formulated in three countries to lay the foundation for enhanced cross-sectoral collaboration among relevant ministries, particularly public health, animal health and agriculture.

4.7.4 International standards and scientific advice for effectively managing foodborne risks

A status review of International Health Regulation (IHR) core capacities for food safety showed that Africa had achieved only 50% of the required attributes by 2016. The need was thus identified to continue strengthening food safety core capacities as defined under IHR 2005. The capacities of 19 countries in the International Food Safety Authorities Network (INFOSAN) were enhanced through joint training with FAO for the 8 West African Economic and Monetary Union (WAEMU) countries, and with the INFOSAN Secretariat for the other 11 countries. In addition, an emergency training simulation exercise between INFOSAN emergency contact points and IHR National Focal Points was conducted in 13 countries, resulting in strengthened national networks in 6 countries and increased membership in the INFOSAN in the Region.

National codex structures improved in 5 countries with three (Senegal, Madagascar and Ghana) benefitting from the Codex Trust Fund.
The use of Codex guidelines to improve food safety standards in Member States was assessed. Among the 23 countries that provided information, 12 had adopted the General Standard for Contaminants and Toxins in Food and Feed compared to partial adoption by 5 countries. The General Standard for the Labelling of Pre-packaged Foods was reportedly used by 16 countries.

4.8 Partnerships in FRH work across the biennium

Achieving good health requires much more than just one or two simple interventions; it requires an integrated range of preventive strategies; therapies and technology to diagnose and treat ill-health; and provision of opportunities for those who need health care to access it.

Making this happen effectively depends on good partnerships between communities, providers, organizations carrying out interventions, governments, technical agencies and international partners. In the last decade, global health partnerships have provided substantial resources to support health programmes, including RMNCAH, Immunization and Nutrition programmes in the African Region. They have brought much needed political and technical focus to priority interventions and diseases. However, there are concerns that the increasing number of initiatives have focused their efforts on issues, themes or diseases rather than on more comprehensive approaches to health, such as health systems development. This has increasingly become very difficult for countries to manage and further complicates international partners’ harmonization efforts at all levels and alignment with national systems and priorities. Much progress is needed in addressing these challenges in order to accelerate progress towards achieving the SDG targets. The FRH Cluster is most grateful to partners and had the opportunity to work with several of them to deliver concrete results in countries. The list below highlights key partners that supported the work of the FRH Cluster during the biennium.

Senegal adopted a decree operationalizing the National Codex Committee and the Government undertook to further harmonize national standards with Codex standards and to establish the coordination unit to set up a database to support standards development processes.
The use of Codex guidelines to improve food safety standards in Member States was assessed. Among the 23 countries that provided information, 12 had adopted the General Standard for Contaminants and Toxins in Food and Feed compared to partial adoption by 5 countries. The General Standard for the Labelling of Pre-packaged Foods was reportedly used by 16 countries.

### Partnerships in FRH work across the biennium

Achieving good health requires much more than just one or two simple interventions; it requires an integrated range of preventive strategies; therapies and technology to diagnose and treat ill-health; and provision of opportunities for those who need health care to access it. Making this happen effectively depends on good partnerships between communities, providers, organizations carrying out interventions, governments, technical agencies and international partners. In the last decade, global health partnerships have provided substantial resources to support health programmes, including RMNCAH, Immunization and Nutrition programmes in the African Region. They have brought much needed political and technical focus to priority interventions and diseases. However, there are concerns that the increasing number of initiatives have focused their efforts on issues, themes or diseases rather than on more comprehensive approaches to health, such as health systems development. This has increasingly become very difficult for countries to manage and further complicates international partners’ harmonization efforts at all levels and alignment with national systems and priorities. Much progress is needed in addressing these challenges in order to accelerate progress towards achieving the SDG targets. The FRH Cluster is most grateful to partners and had the opportunity to work with several of them to deliver concrete results in countries. The list below highlights key partners that supported the work of the FRH Cluster during the biennium.

<table>
<thead>
<tr>
<th>Within WHO</th>
<th>Within UN System</th>
<th>Beyond the UN system</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CDS Cluster (HIV, PMTCT, RAcE, Childhood TB)</td>
<td>- UNICEF</td>
<td>- BMGF (PSBI, Af-Steer, child health Redesign, quality of care)</td>
</tr>
<tr>
<td>- HSS Cluster (AVAREF, Quality of care)</td>
<td>- UNFPA</td>
<td>- Global Fund (RMNCAH in GF concept notes, adolescent girls and young women catalytic funds)</td>
</tr>
<tr>
<td>- NCD Cluster (Adolescent health, etc.)</td>
<td>- UNAIDS</td>
<td>- GAVI</td>
</tr>
<tr>
<td></td>
<td>- UN WOMEN</td>
<td>- USA (USAID, CDC)</td>
</tr>
<tr>
<td></td>
<td>- UNESCO (adolescent health)</td>
<td>- France (Muskoka) (RMNCAH, Nutrition)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sweden (SRH and HIV) Canada (Nutrition - ANI, iCCM - RAcE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Luxembourg (RMNCAH)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- African Union (ADI, eMTCT, RMNCH)</td>
</tr>
</tbody>
</table>
5. NARRATIVE ON 2016/2017 BUDGET

The FRH was funded using assessed contributions and other flexible funds (Assessed Contributions (AC) and Country Voluntary Contributions Account (CVCA)) as well as Voluntary contributions (specified and non-specified funds). For the 2016-2017 biennium, a total amount of US$ 47,931,586 budget space was allocated but, during implementation, more funds were mobilized and more space was added, which brought the planned costs to US$48,961,033. Of that amount, US$ 45,643,005 was award budgeted. A total of US$ 42,575,591 comprising activities and HR costs was utilized, representing 92% of the funds received and award budgeted. All reports on activities funded by voluntary contributions were submitted to donors on time.
6. CHALLENGES

Insufficient financial and human resources remain major challenges for the Cluster, especially for programmes such as Nutrition, Food Safety, Gender and Ageing. Both units of CAN and RWH had insufficient resources that did not permit them to carry out all planned activities. Internal collaboration within and across clusters in WHO AFRO as well as with WHO/HQ was helpful. In addition, to the extent possible, external partnerships for technical and financial support were mobilized to mitigate the inadequate resources. Critical staff are still required at the regional and country office levels while funding for priority strategic and catalytic RMNCAH-N activities remains a major issue. Thus, high workloads with shortage of human resources were important limitations to the capacity of the Budget centre to deliver results. Additional challenges in the implementation of the FRH agenda in countries during the biennium included:

(a) Coordination of multiple initiatives and actors around RMNCAH-N.
(b) Inadequate multisectoral collaboration and coordination that negatively impacts the procedural base, resilient, robust and effective food safety control system in achieving ‘farm-to-plate’ concept and reducing the burden of foodborne diseases.
(c) Insufficient government funding with no or poor in-country resource mobilization.
(d) Limited flexible funding and unpredictability in funding which compromise need-based prioritization.
(e) Unavailability of experts and tools in the Region as well as guidelines in Portuguese which delays or hinders timely adoption of WHO recommendations in the Portuguese-speaking countries.
(f) Non-prioritization of healthy ageing and lack of focal persons in the ministry of health and most WHO country offices.
(g) Inadequate implementation of measles elimination strategies including gaps in routine immunization coverage, delayed SIAs (due to gaps in local resource mobilization and country commitments) which poses a risk to meeting the 2020 measles elimination goals.
(h) Lack of adequate funding for conducting VPD surveillance activities (especially measles and tetanus) which poses a major risk to the attainment of the elimination goals.
7. PERSPECTIVES FOR 2018

The FRH perspectives for 2018 is reflected in its work plan below. It will definitely continue to support countries in domesticating key guiding documents and implementing them in order to improve health for women, newborns, children and adolescents across the Region. It is organized to:

(a) Provide more direct technical support to priority countries for focus efforts in the various FRH areas.
(b) Build the capacity of selected country staff in programme review, and assessment, strategic planning and document writing to enable them to write concept notes, reports and plans, hence reducing the time spent at regional and IST levels for more investment in technical support.
(c) Engage more in grant proposal writing to generate funds for implementation of activities in view of funding constraints in the Organization.
(d) Support the countries to implement high impact interventions and collect data and reports that show, more clearly, the added value of WHO cooperation.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.001</td>
<td>Increased capacity of countries to deliver key HIV interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support</td>
</tr>
<tr>
<td>01.005</td>
<td>Implementation and monitoring of the global vaccine action plan with emphasis on strengthening service delivery and immunization monitoring in order to achieve the goals of the Decade of Vaccines</td>
</tr>
<tr>
<td>01.005</td>
<td>Intensified implementation and monitoring of strategies for measles and rubella elimination, hepatitis B control, and maternal and neonatal tetanus elimination facilitated</td>
</tr>
<tr>
<td>01.005</td>
<td>Research priorities and comprehensive reviews of vaccination policies for new vaccines and other immunization-related technologies defined and agreed, in order to develop and introduce vaccines of public health importance and overcome barriers to immunization</td>
</tr>
<tr>
<td>02.005</td>
<td>Countries enabled to develop and monitor implementation of action plans to tackle malnutrition in all its forms and achieve the global nutrition targets 2025 and the nutrition components of the Sustainable Development Goals</td>
</tr>
<tr>
<td>02.005</td>
<td>Norms, standards and policy options for promoting population dietary goals and the global nutrition targets 2025 and nutrition-related Sustainable Development Goals developed, adopted and integrated into current national health and development plans</td>
</tr>
<tr>
<td>02.006</td>
<td>Countries enabled to control the risk and reduce the burden of foodborne diseases</td>
</tr>
<tr>
<td>02.006</td>
<td>Scientific advice in food safety to support the work of the Codex Alimentarius Commission and Member States to develop food safety standards, guidelines and recommendations</td>
</tr>
<tr>
<td>03.001</td>
<td>Countries enabled to improve maternal health through further expansion of access to, and improvement in the quality of, effective interventions for ending preventable maternal deaths from pre-pregnancy to postpartum and perinatal deaths (stillbirths and early neonatal deaths), with a particular focus on the 24-hour period around childbirth</td>
</tr>
<tr>
<td>03.001</td>
<td>Countries enabled to implement and monitor effective interventions to cover unmet needs in sexual and reproductive health</td>
</tr>
</tbody>
</table>
### Programmes and Outputs

<table>
<thead>
<tr>
<th>Programme</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.001 31RMC</td>
<td>3.1.3: Countries enabled to implement and monitor integrated strategic plans for newborn and child health, with a focus on expanding access to high-quality interventions to improve early childhood development and end preventable newborn and child deaths from pneumonia, diarrhoea and other conditions</td>
</tr>
<tr>
<td>03.001 31RMC</td>
<td>3.1.4: Countries enabled to implement and monitor integrated policies and strategies for promoting adolescent health and development and reducing adolescent risk behaviours</td>
</tr>
<tr>
<td>03.001 31RMC</td>
<td>3.1.5: Research undertaken and evidence generated and synthesized for newborn, child and adolescent health and related programmatic research for designing key interventions</td>
</tr>
<tr>
<td>03.002 32AGE</td>
<td>3.2.1: Countries enabled to develop policies, strategies and capacity to foster healthy ageing across the life-course</td>
</tr>
<tr>
<td>03.002 32AGE</td>
<td>3.2.2: Countries enabled to deliver older person-centred and integrated care that responds to the needs of women and men and to tackle health inequities in low-, middle- and high-income settings</td>
</tr>
<tr>
<td>03.002 32AGE</td>
<td>3.2.3: Evidence base and monitoring and evaluation strengthened, informing policies and actions to address key issues relevant to the health of older people</td>
</tr>
<tr>
<td>03.002 32AGE</td>
<td>3.2.4: Age-friendly environments developed and maintained in countries in line with the WHO strategy and plan of action on ageing and health</td>
</tr>
</tbody>
</table>
## 8. SUMMARY OF 2018/2019 BUDGET WITH FUNDING GAPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Fund Group Description</th>
<th>Budget Space Allocated</th>
<th>Funds Available</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 1COMD</td>
<td>HIV and hepatitis</td>
<td>1 143 000</td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td></td>
<td>0</td>
<td>412 220</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>313 500</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1 504 269</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccine-preventable diseases</td>
<td>0</td>
<td>536 131</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1 214 801</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>3 249 294</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccine-preventable diseases</td>
<td>28 818 000</td>
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<tr>
<td></td>
<td></td>
<td>0</td>
<td>4 907 974</td>
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<tr>
<td></td>
<td></td>
<td>0</td>
<td>1 312 000</td>
<td></td>
</tr>
<tr>
<td>01 1COMD Total</td>
<td></td>
<td><strong>29 961 000</strong></td>
<td><strong>13 450 189</strong></td>
<td><strong>16 510 811</strong></td>
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<tr>
<td>02 2NCD</td>
<td>Nutrition</td>
<td>2 376 000</td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td></td>
<td>0</td>
<td>45 148</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1 017 468</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food safety</td>
<td>1 620 000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>242 000</td>
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</tr>
<tr>
<td>02 2NCD Total</td>
<td></td>
<td><strong>3 996 000</strong></td>
<td><strong>1 304 616</strong></td>
<td><strong>2 691 384</strong></td>
</tr>
<tr>
<td>03 3PHL</td>
<td>Reproductive, maternal, newborn, child and adolescent health</td>
<td>12 960 000</td>
<td>0</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>3 920 686</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>272 287</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>7 029 586</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ageing and health</td>
<td>540 000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>65 000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equity, social determinants, gender equality and human rights</td>
<td>575 100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>279 500</td>
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<tr>
<td>03 3PHL Total</td>
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<td><strong>14 075 100</strong></td>
<td><strong>11 567 059</strong></td>
<td><strong>2 508 041</strong></td>
</tr>
<tr>
<td>Grand Total</td>
<td>FRH Budget centre</td>
<td><strong>48 032 100</strong></td>
<td><strong>26 321 864</strong></td>
<td><strong>21 710 236</strong></td>
</tr>
</tbody>
</table>

The total planned costs for 2018/2019 of the FRH budget centre is US$48 032 100. Out of that budget, US$26 321 864 (54.8%) has been mobilized so far. The Cluster is working with key partners to mobilize the remaining gap in order to fully implement the 2018/2019 work plan that will not only strengthen and sustain the 2016/2017 achievements but also support health improvement in Africa in the coming years.