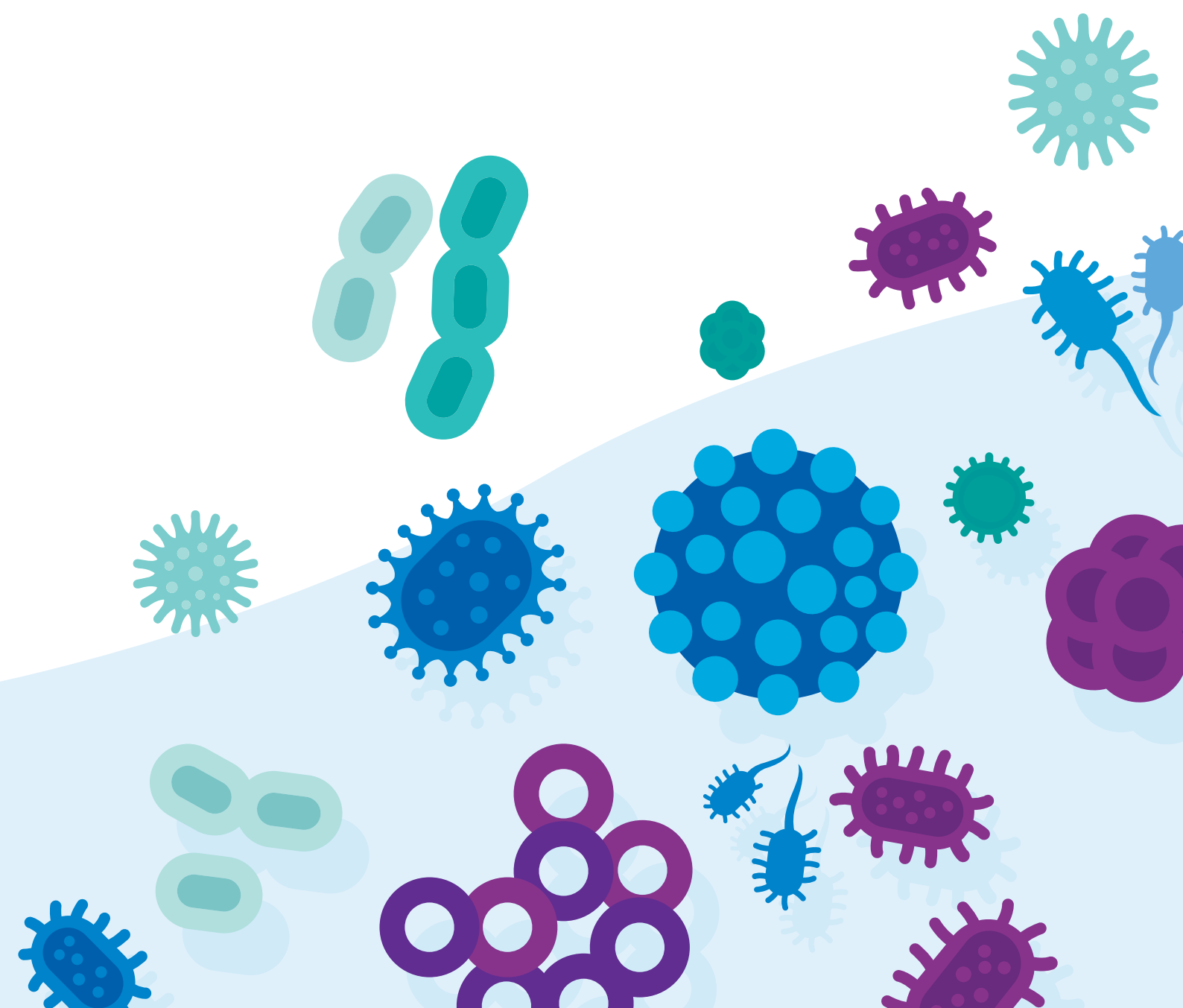


ANNUAL REPORT 2017

COMMUNICABLE DISEASES CLUSTER



ANNUAL REPORT 2017

**COMMUNICABLE
DISEASES CLUSTER**



**World Health
Organization**

REGIONAL OFFICE FOR **Africa**

Annual report 2017: Communicable Diseases Cluster

WHO/AF/CDS/03, 2019

© WHO Regional Office for Africa 2019

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Annual report 2017: Communicable Diseases Cluster. Brazzaville: WHO Regional Office for Africa; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Printed in the WHO Regional Office for Africa, Brazzaville, Congo

ACKNOWLEDGEMENTS

This annual report was developed with contributions from the following people:

This publication was developed by the CDS cluster and coordinated by Olufunmilayo LESI, Fatim Cham JALLOW, Juliane KOENIG and Pramod Kumar GROVER under the overall guidance of Magda ROBALO CORREIA E SILVER.

CDS staff, Brazzaville, Republic of Congo

Charles Ndika AKONG, Birkinsh AMENESHEWA, Ebenezer Sheshi BABA, Magaran Monzon BAGAYOKO, Didier Kapuku BAKAJIKA, Abate Mulugeta BESHAI, Emmanuel CHANDA, Akueley DEGANUS DA SILVA DURAO, Michel GASANA, Pramod Kumar GROVER, Jean de Dieu IRAGENA, Carole IVORA MAROUNDU, Andrew Deidu KORKOR, Steve KUBENGA BANZA, Hugues LAGO, Frank John LULE, Absalom MAKONI, Guy Kakumi Ka Ntombe MBAYO, Jescah MHIKE, Pauline Ngina MWINZI, Valerie NGANGA BANZOUZI, Yetema Noemie NIKIEMA NIDJERGOU, Simplicie NTSIBA MAMOUNA, Christiane Gilberte OBANGUE, Satiane Didolance ODIKA, Severine D.C. ORLANDO, Uffe Raunsholt POULSEN, Harilala Nirina RAZAKASOA, Maria REBOLLO POLO, Jackson Sophianu SILLAH, James SSEKITOOLEKO, Alexandre TIENDREBEOGO, Honorat Gustave Marie ZOURE.

UN volunteers

Juliane KOENIG, Launique LOUBASSOU-MASSAKA, Tom PEYRE-COSTA and Ameyo Bellya SEKPON

Intercountry support teams (Harare, Zimbabwe; Libreville, Gabon; Ouagadougou, Burkina Faso)

Evelyne AMANDA APENDA, Anderson CHINORUMBA, Abdoulaye DIARRA, Lamine DIAWARA, Charity Helen GARAPO, Khoti Wanangwa GAUSI, Rosewiter GWATIRINGA, Elizabeth Antango JUMA, Francine Ivette KABORE, Jesca Mandisa MASWERA, Fabian NDENZAKO, Andre Okumu NDONGOSIEME, Wilfred A.C. NKHOMA, Spes Caritas NTABANGANA, Adiele Nkasiobi ONYEZE, Andrea SOSSA MOUTSINGA, Abderhmane Kharchi TFEIL, Kouadio YEBOUE.

We also wish to acknowledge the support of Dr Matshidiso MOETI, Regional Director, Dr Joseph WAOGODO CABORÉ, Director for Programme Management, WHO Representatives and WHO Country Office teams; all of AFRO's Cluster Directors and their teams; and our many partners for their contributions and support to the work of CDS.

Design and Editorial:

Lushomo - lushomo.net

TABLE OF CONTENTS

Message from
the Director

iii

Executive
summary

iv

Section 1

INTRODUCTION TO THE COMMUNICABLE DISEASES CLUSTER (CDS)

CDS and the AFRO
Transformation Agenda

p3

Section 2

PUTTING THE HEALTH ISSUES IN CONTEXT

Malaria

p6

Neglected Tropical
Diseases (NTDs)

p7

Expanded Special
Project for Elimination
of Neglected Tropical
Diseases (ESPEN)

p7

Protection of the
Human Environment
(PHE)

p8

HIV, Tuberculosis
and Hepatitis (HTH)

p8

Section 3

INTRODUCING CDS TRANSFORMATION STRATEGY AND STRATEGIC ACTIONS

Strategic Action 1:
Professionalize CDS

p12

Strategic Action 2:
Prioritize CDS's efforts

p12

Strategic Action 3:
Position CDS as
a team player within
AFRO and WHO globally

p12

Strategic Action 4:
Establish CDS as a
partner of choice

p14

Strategic Action 5:
Strengthen
accountability for results

p14

Section 4-7

STRATEGIC OBJECTIVES

4

Strategic Objective 1:
Provide effective technical and policy leadership p17

5

Strategic Objective 2:
Support better data, mapping and surveillance p21

6

Strategic Objective 3:
Provide / facilitate implementation and technical support p27

7

Strategic Objective 4:
Support resource mobilization p31

Section 8

MANAGEMENT OF FINANCIAL RESOURCES FOR RESULTS

Management of financial resources for results p33

Section 9

MOVING FORWARD

Moving Forward: Perspectives for the 2018 – 2019 biennium p37

MESSAGE FROM THE DIRECTOR

Globally, transformative actions are being implemented across many sectors, to improve efficiency, effectiveness and impact, respond to the demands of the digital and technological era and satisfy the needs of populations, particularly marginalized, vulnerable and neglected groups.

Despite the impressive gains made in recent years, the lifting of nearly a billion people out of extreme poverty since 1990, for many billions, particularly women and children the world remains a very hard place to live in. Inequalities across and within countries continue to increase, policies to ensure inclusive growth are either non-existent or ineffective. Social and economic hardships are still preventing most people in developing countries from accessing basic health care and education services, safe drinking water and adequate sanitation, decent employment and housing.

Two years into the implementation of the Sustainable Development Goals adopted in 2015, major gaps in action and funding are threatening their achievement by 2030. We need to hasten the pace, strengthen the political will and commitment and find innovative funding mechanisms and partnerships.

In the health sector, there is an unprecedented momentum for partners to rally forces to achieve Universal Health Coverage, galvanized by the election of the new WHO Director General, whose vision is to ensure that access to health care shouldn't be a privilege of a few.

The winds of Transformation blowing in the African Region aim at ensuring that countries' health systems are strengthened to deliver quality health care services and that AFRO responds to the needs of its member states.

This report brings to its readers an illustration of work done by committed teams in the Communicable Diseases Cluster (CDS) during the first full year of implementation of the CDS Transformation Strategy, which is inspired by the AFRO

Transformation Agenda. We have endeavored to adjust our ways of working to maximize our productivity, improve the quality of the support provided to countries and partners and increase the impact of our actions. The CDS team has expanded significantly, we have been able to define and develop win-win initiatives across our networks, build new partnerships and demonstrate that business unusual can become a reality and deliver results.

On behalf of the team, I would like to thank WHO Representatives and all the staff in WHO Country Offices in the African Region, in other WHO Regions and in HQ for their support to the work of the CDS Cluster.

Our valued partners, old and new have been instrumental in this journey. We faced several challenges together and made significant accomplishments together. We remain extremely grateful for your support.

We believe that the changes initiated will take hold and consolidate, so that we can continue to contribute to improve the health of our populations.



A handwritten signature in black ink, appearing to read 'Dr Magda Robalo Correia e Silva'.

Dr Magda Robalo Correia e Silva
Director

ACRONYMS

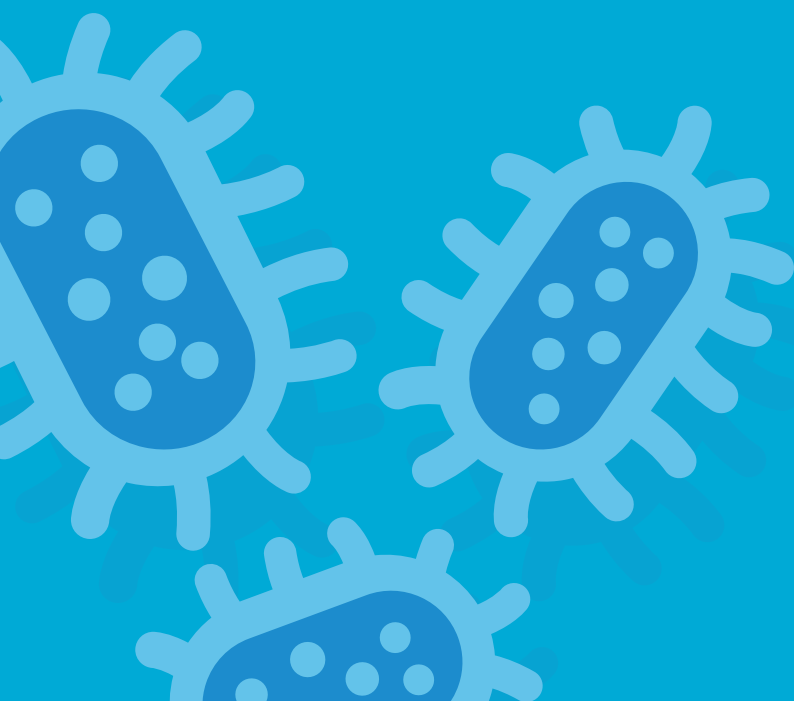
ALMA	African Leaders Malaria Alliance
AMREF	African Medical and Research Foundation
APOC	African Programme for Onchocerciasis Control
ART	Antiretroviral Therapy
CAN	Child and Adolescent Health and Nutrition
CDS	Communicable Diseases Cluster
CHAI	Clinton Health Access Initiative
CM-NTDs	Case Management NTDs
DFID	Department for International Development
DHIS2	District Health Information System 2
DRS	Drug Resistance Survey
E-8	Elimination 8
ECAMM	External Laboratory Competency Assessment of Malaria Microscopists
ESPEN	Expanded Special Project for Elimination of NTDs
FRH	Family and Reproductive Health
FWC	Family, Women's and Children's Health cluster
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSS	Global Health Sector Strategy
GTS	Global Technical Strategy
GWD	Guinea Worm Disease
HIS	Health Systems and Innovation cluster
HNAP	Health National Adaptation Process
HSS	Health Systems and Services
HTH	HIV, Tuberculosis and Hepatitis
HTM	HIV, Tuberculosis, Malaria and Neglected Tropical Disease cluster
ICASA	International Conference on AIDS and STIs in Africa
IST/CA	Inter-Country Support Team – Central Africa
IST/ESA	Inter-country Support Team – East and Southern Africa
IST/WA	Inter-Country Support Team – West Africa
IVM	Integrated Vector Management

KGWEP NCC	Kenya Guinea-Worm Eradication Programme National Certification Committee
KOICA	Korea International Cooperation Agency
KPI	Key Performance Indicator
MDA	Mass Drug Administration
MDP	Mectizan Donation Programme
MoF	Ministries of Finance
MoH	Ministries of Health
MOSASWA	Mozambique, South Africa, and Swaziland
MOZISWA	Mozambique, Zimbabwe and Swaziland
NTD	Neglected Tropical Diseases
OCEAC	Organization of Coordination for the Fight against Endemic Diseases in Central Africa
PC-NTDs	Preventive Chemotherapy for NTDs
PHE	Protection of the Human Environment
PLWH	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
RBM	Roll Back Malaria
RC67	67th session of the WHO Regional Committee for Africa
RMNCH	Reproductive, Maternal, Newborn and Child Health
RTI	Research Triangle Institute
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SIP	Strategic Implementation Plan
SLIPTA	Stepwise Laboratory Quality Improvement Process Towards Accreditation
SMC	Seasonal Malaria Chemoprevention
SOP	Standard Operating Procedures
TB	Tuberculosis
TES	Therapeutic Efficacy Studies
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHE	WHO Health Emergencies
WHO/AFRO	World Health Organization Regional Office for Africa

1

INTRODUCTION TO THE COMMUNICABLE DISEASES CLUSTER

Globally, 13 million people die each year from infectious diseases. In some countries, this equates to one in two deaths.



The 47 countries that are Member States of WHO in Africa are home to more than one billion women, children and men. They are living in communities that are making varied, sometimes fragile, but often significant gains towards combating communicable diseases.

The Communicable Diseases Cluster (CDS) of the World Health Organization (WHO) Regional Office for Africa (AFRO) consists of five teams working together to reduce the burden of infectious diseases. Working with a shared purpose within a common strategy, the combined efforts of the CDS teams are bringing considerable benefits to health cross the region.

The scale of the problems the CDS teams seek to address is hard to overstate. Globally, 13 million people die each year from infectious diseases. In some countries, this equates to one in two deaths.

HIV/AIDS, malaria and tuberculosis (TB) account for the overwhelming majority of deaths in the African Region. Added to these, a range of neglected tropical diseases (NTDs) and hepatitis also contribute to fatalities.

Weak health systems, slow economic growth, rapid urbanization and environmental change all amplify the impact of communicable diseases. Communicable diseases are also contributing to slowed development, strengthened cycles of underdevelopment and the consumption of limited financial resources. Populations who already face disadvantage – namely women, children, the elderly and the poor – are the most vulnerable.



VISION

An African Region free of the burden of communicable diseases



MISSION

To work with countries, partners and the wider WHO community to accelerate progress in reducing the impact of communicable diseases in the African Region, towards attaining the SDG targets.



PRINCIPLES

Foresighted
Proactive
Responsive
Results Driven
Meeting Needs
Transparent
Accountable

CDS and the AFRO Transformation Agenda

CDS is operating in a complex and fast-changing environment. New partnerships are supporting the work of health ministries civil society and networks. New funding models are changing the flow of resources into health efforts and the types of activity that can be sustained. Many partners are now demanding more visible results, accountability and clarity of purpose. CDS is showing leadership in combatting communicable diseases in the African region through increased focus, accountability, smart and innovative collaboration and efficiency. This document highlights the progress and achievements of the CDS toward these goals in 2017.

“CDS is showing leadership in combatting communicable diseases in the African region through increased focus, accountability, smart and innovative collaboration and efficiency.”

The cluster's programme of work stems from The Transformation Agenda of the World Health Organization Secretariat in the African Region, 2015–2020. The overview on the following page provides a framework of the Transformation Agenda, its visions, objectives, plans for implementation and accomplishments during the first phase.

The Transformation Agenda aims to ensure AFRO become more responsive and results-driven. It has four focus areas:

1. **Pro-results values** – seeking excellence, teamwork,

accountability, integrity, equity, innovation and openness;

2. **Smart technical focus** – setting priorities in-line with regional and country needs;
3. **Responsive strategic operations** – matching staffing to needs and aligning financing; and
4. **Effective communications and partnerships** – being a responsive and interactive organization.

The Transformation Agenda marked the beginning of deep-rooted changes within the African Regional Office, and within the many teams and clusters it comprises. For CDS, it provided an opportunity to develop a specific strategy with a number of strategic actions and objectives that cut across the work and systems of its constituent teams.

From this new CDS strategy, the teams developed costed five-year Strategic Implementation Plans (SIPs). These SIPs will ensure that the values guiding the transformation of the regional office will also shape the efforts of the regional, sub-regional and national WHO teams as they engage with local governments and various other partners. Each SIPs has been developed to accommodate the priorities of the 47 Member States, and is built around clearly defined milestones, assigned responsibilities and an assessment of potential risks.

In addition, these SIPs on HIV, TB, malaria, hepatitis, NTDs and the Protection of Human and Environment (PHE) are accompanied by a management plan from the CDS director's office. They outline carefully prioritized actions and expected results. The outputs and results are linked to the AFRO Key Performance Indicator (KPI) Framework.



WHO AFRO TRANSFORMATION AGENDA

1. Pro-results values
2. Smart technical focus
3. Responsive strategic operations
4. Effective communications and partnerships

CDS TRANSFORMATION STRATEGY

Strategic Actions

Professionalize
CDS

Prioritize
CDS actions

Position CDS as
a team player
within AFRO and
WHO globally

Establish CDS
as a partner of
choice

Strengthen
accountability
for results

Strategic Objectives

Provide effective
technical and
policy leadership

Support better
data, mapping and
surveillance

Provide/facilitate
implementation and
technical support

Support resource
mobilization

Main CDS Contributions

Malaria

NTDs

PHE

HIV,
Tuberculosis
and Hepatitis

ESPEN

CDS Cluster Accomplishments

Main Key Performance Indicators

Regional level

National level

Strategic Implementation Plans

Increasing focus on the following areas for which WHO has a clear competitive advantage:

- Providing technical support
- Programme reviews
- Establishing routine monitoring systems
- Building capacity
- Encouraging development of National policies based on WHO guidelines and best practices
- Providing normative guidance, and funding proposal assistance
- Leveraging the organization's relationship with health ministries

2

PUTTING THE HEALTH ISSUES IN CONTEXT

90% of worldwide malaria cases and 91% of malaria-related deaths occur in the WHO African Region.



Malaria

The majority of the world's malaria cases occur in sub-Saharan Africa. In 2016, an estimated 216 million cases of malaria occurred worldwide and caused 445 000 deaths. Ninety percent of those cases and 91% of those deaths occurred in the WHO African Region.¹ Fourteen countries in the African Region contribute to 80% of the global malaria burden (Fig.1). Annually, malaria reduces economic growth in high-endemic African countries by an average of 1.3%.² Countries across the region have led a massive effort to improve access to life-saving malaria control tools for those at risk of the disease. This includes enhanced use of cost-effective prevention and case-management services.

In 2016, six Member States (Algeria, Botswana, Cabo Verde, Comoros, South Africa, Swaziland) were identified as having the potential to eliminate local transmission of malaria by 2020. Although, for several countries, the transition from malaria control to elimination is now a real possibility, a resurgence was recently noted in some countries (Fig. 2).

Despite this, the financing available to the Malaria Programme amounts to less than half of what is required to meet the targets in the WHO Global Malaria Strategy. In many African countries, the average amount of funding per at-risk person has dropped in the last three years.¹

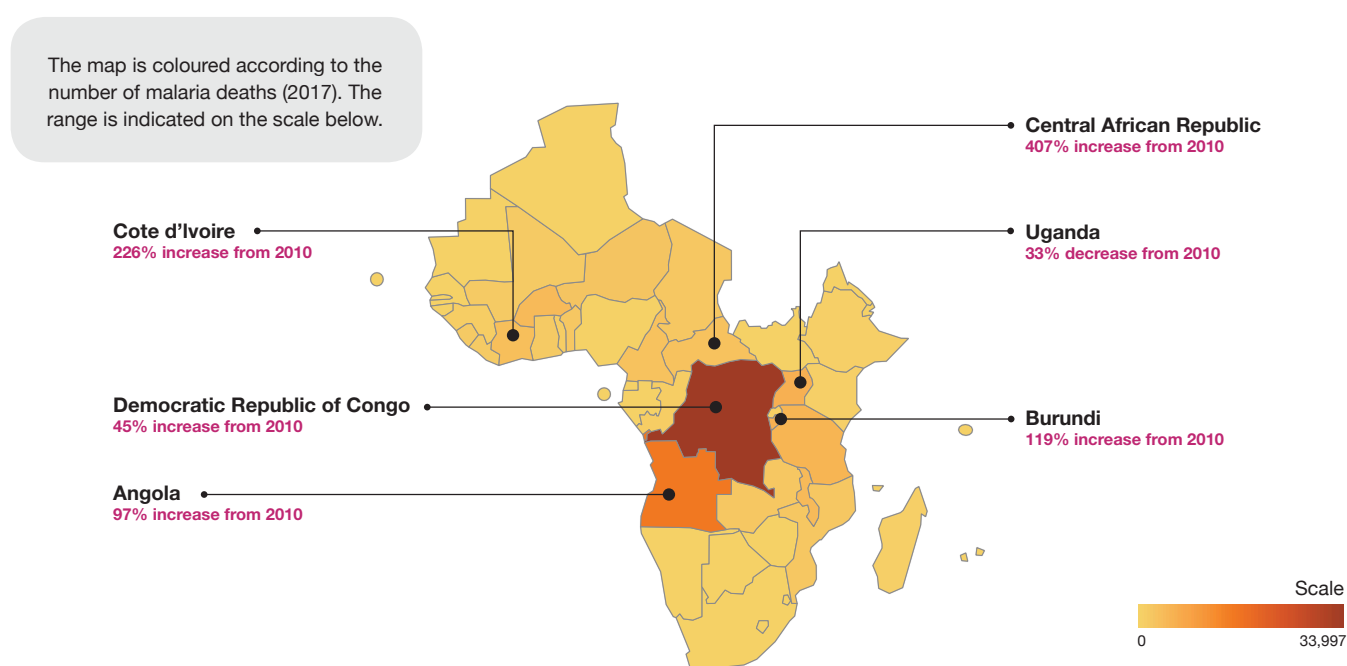
Figure 1. Countries in the AFRO region contributing to 80% of the global malaria burden



WHO/AFRO's role in malaria prevention, control and elimination

The framework for implementing the Global Technical Strategy (GTS) 2016 - 2030³ was adopted during the 66th session of the WHO Regional Committee for Africa and the 68th session of the World Health Assembly (WHA), with the vision of "a world free of Malaria".⁴ The framework describes three pillars of priority interventions and actions that the Member States should undertake to accelerate movement towards set targets in the Region.

Figure 2. Percent change in Malaria deaths per country in the AFRO region (World Malaria Report 2017)



1. World Malaria Report 2017. Geneva: World Health Organization; 2017. (http://www.unaids.org/sites/default/files/sg13_web_v4%20pdf%20-%20adobe%20reader.pdf).

2. Sachs J, Malaney P. The economic and social burden of malaria. *Nature*. 2002; 415 (6872):680-5 (<https://doi.org/10.1038/415680a>).

3. Global Technical Strategy for Malaria 2016-2030. Geneva: World Health Organization; 2015. (<http://www.who.int/malaria/publications/atoz/9789241564991/en/>).

4. 66th Session of the Regional Committee for Africa. Framework for implementing the Global Technical Strategy for Malaria 2016 - 2030 in the African Region: report for the Secretariat. World Health Organization Regional Office for Africa; 2016. (<http://apps.who.int/iris/handle/10665/251419>).

Malaria Programme goals for the biennium 2016-2017

The Malaria Programme's main goal was for countries to increase access to preventive interventions and first-line antimalarial treatment for confirmed cases in at-risk populations.

In 2017, the specific focus included support for countries to:

- Update/develop policies, guidelines and manuals;
- Build capacity for malaria prevention, control and elimination;
- Conduct programme reviews and strategic planning development;
- Strengthen malaria surveillance and data collection;
- Mobilize resources for malaria.

Neglected Tropical Diseases

Within CDS, two units are focusing on the challenges of Neglected Tropical Diseases (NTDs). The Expanded Special Project for Elimination of NTDs (ESPEN) focuses on five prevalent NTDs in Africa: lymphatic filariasis (LF), onchocerciasis (ONCHO), soil-transmitted helminthiasis (STH), schistosomiasis (SCH) and trachoma (TRA), which are amenable to preventive chemotherapy (PC-NTDs). Meanwhile, the NTD unit focuses on diseases that need to be addressed through individual case management (CM-NTDs)

Forty percent of people in Africa are affected by a tropical disease that has not been prioritized by the pharmaceutical or scientific community due to a range of economic and other factors. There are 20 NTDs that have been prioritized by WHO. All but one of these (Chagas disease) are prevalent in Africa to various degrees.

"40% of people in Africa are affected by a tropical disease that has not been prioritized by the pharmaceutical or scientific community due to a range of economic and other factors."

Some NTDs are rare, while others are quite common. Their exact prevalence and distribution is uncertain with many countries underreporting incidence.

WHO/AFRO's role in eradicating, eliminating and controlling CM-NTDs

As outlined in the Regional Strategic Plan for Neglected Tropical Diseases in the African Region (2014–2020) adopted by the Regional Committee in September 2013, WHO/AFRO's role is as follows:

1. To provide leadership and guidance to Member States in their efforts to control, eliminate and eradicate targeted NTDs;
2. To support the development and updating of evidence-based regional policies, guidelines and strategies on NTDs in accordance with WHO policy;
3. To provide support to Member States to strengthen their capacity to implement interventions to prevent, control and eliminate NTDs;
4. To support regional initiatives on research to increase the efficacy and cost-effectiveness of NTD-related interventions; and
5. To monitor progress in achieving regional and national NTD targets and provide support to Member States in collecting, validating, analyzing and using data to enhance programme performance.

CM-NTD Programme goals for the biennium 2016–2017

The overall NTD goal for the biennium 2016–2017 was to contribute to the achievement of NTD targets for 2020. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation describes the goals for six of the CM-NTDs as follows:

- To eradicate two CM-NTDs (dracunculiasis and yaws)
- To eliminate two other CM-NTDs as public health problems (human African trypanosomiasis, or HAT, and leprosy)
- To control two major CM-NTDs (Buruli ulcer and leishmaniasis).

Expanded Special Project for Elimination of Neglected Tropical Diseases

In 32 Member States, 74.5% people require PC for at least three diseases. In total, 592.1 million people in 45 countries in the African Region require PC for at least one disease.

WHO/AFRO's role in addressing PC-NTDs

ESPEN was launched in May 2016 as a partnership between WHO/AFRO, Member States and NTD partners to mobilize political, technical and financial resources in order to reduce the burden of PC-NTDs in Africa.

ESPEN Programme goals and strategic direction for the biennium 2016–2017

ESPEN's goals for the biennium 2016–2017 were to:

- Work towards achieving full coverage among populations requiring PC;
- Strengthening country NTD programmes;
- Enhancing the use of data for better decision-making;
- Building effective partnerships with countries and key stakeholders;
- Providing strategic advocacy, communication and resource mobilization efforts.

Protection of the Human Environment

Rapid social, economic and demographic change are affecting the human environment and the ecology for many vectors that transmit disease. An estimated 28% of premature deaths are attributable to unhealthy environments, and environmental risks account for 23% of the burden of disease in the African Region. Health and environmental challenges include the provision of safe drinking water; sanitation and hygiene services; water, soil and air pollution management; vector control and management of chemicals and waste; adequate and safe environmental health for children and women; and health safety in the workplace.

“An estimated 28% of premature deaths are attributable to unhealthy environments, and environmental risks account for 23% of the burden of disease in the African Region.”

A 2017 snapshot for the WHO African Region revealed that only 59% of the population has access to basic drinking water, 31% has access to basic sanitation, and 18% has access to basic handwashing facilities. It also revealed extreme disparities between and within countries (that is, between rural and urban settings). Responding to these

fast-changing conditions, predicting their health impacts, and mitigating the severity of their consequences are all part of the PHE team's portfolio.

WHO/AFRO's role in reducing the environmental burden of disease

The objective of the Regional Programme on the Protection of the Human Environment (PHE) is to help reduce the environmental burden of disease through regular assessment of the environmental risk factors to human health and the deployment of cost-effective preventive interventions. This work supports the Libreville Declaration on health and environment. More broadly, it makes cross-cutting contribution to the 2030 Agenda for Sustainable Development.

PHE Programme goals and strategic direction for the biennium 2016–2017

The collective expected outcome of the PHE unit is reduced environmental threats to health. The 2016–2017 PHE priorities and targets were to:

- Increase access to improved drinking Water, Sanitation and Hygiene (WASH);
- Reduce the health hazards caused by air pollution;
- Reduce the impact of climate change;
- Increase the effectiveness of vector-control interventions.

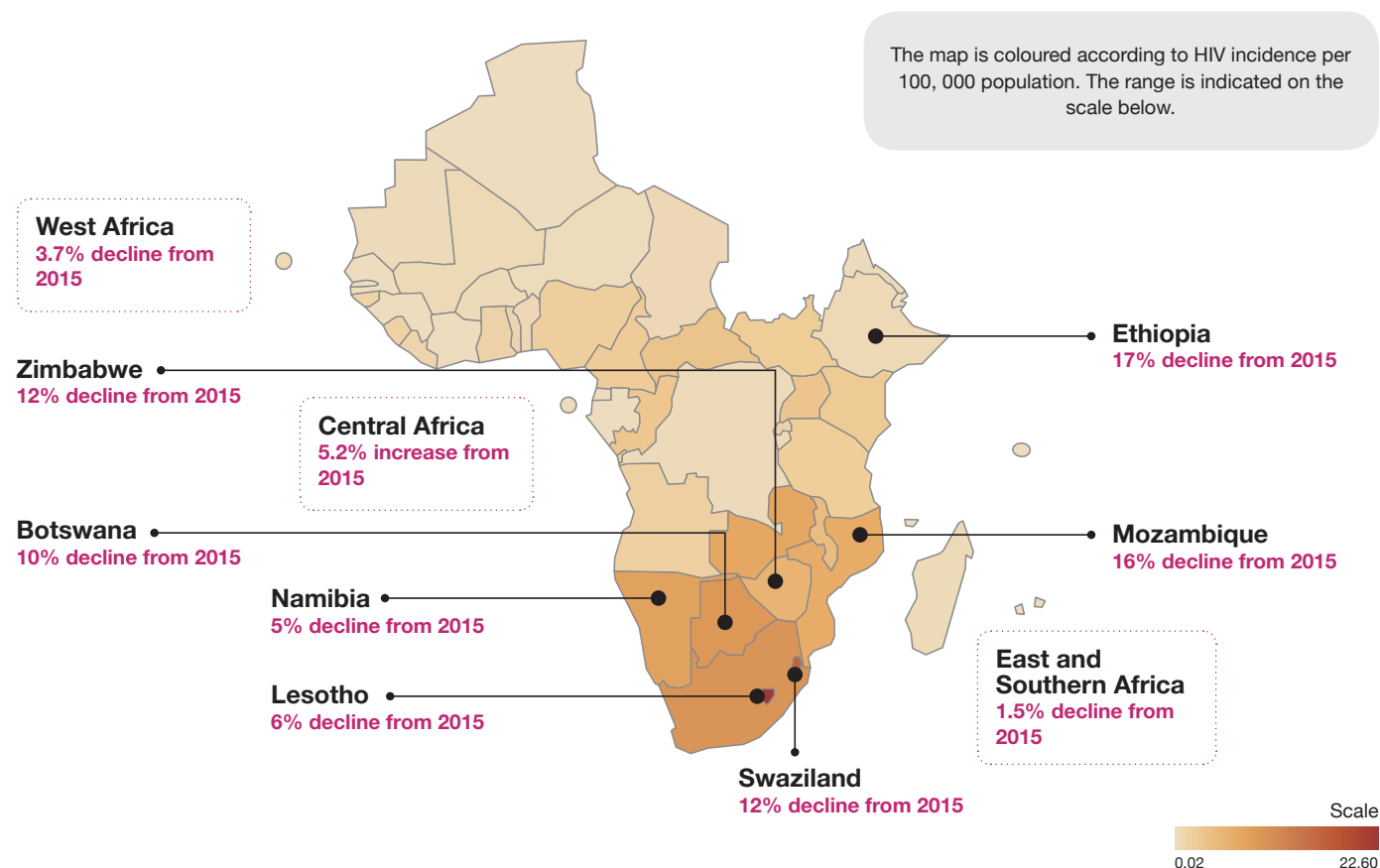
HIV, Tuberculosis and Hepatitis

Although the epidemiology, impacts and responses to HIV, tuberculosis and hepatitis differ, there are considerable benefits to harnessing the strategic similarities and overlaps between these three major diseases.

“AIDS-related deaths in the African Region were down from over 1.5 million in 2005 to about 720,000 in 2016.”

In 2016, remarkable progress was made in HIV control. More than half of all people living with HIV in Africa had access to life-saving HIV treatment. AIDS-related deaths in the region were down from over 1.5 million in 2005 to about 720,000 in 2016. Incident HIV infections also declined from 1.22 million in 2015 to 1.16 million in 2016 (Fig. 3). The cumulative

Figure 3. Percent change in HIV incidence per 100, 000 population in the African Region



number of voluntary medical circumcisions performed in 14 priority countries was 15 million by the end of the year.

In addition, 79% of HIV-positive pregnant women were provided with antiretroviral therapy (ART) to reduce mother-to-child transmission during pregnancy and delivery.

“While the African Region is home to only 13% of the world’s population, an estimated 24% of existing TB cases occur in the region. In a number of countries, drug-resistant TB has also emerged as a new threat to effective control.”

Despite a continuing steady decline in TB notifications, incidence and deaths, as shown by the latest available data (Fig. 4), the region remains with an epidemic-level TB burden, with some of the highest TB rates per capita. While the African Region is only home to approximately 13% of the world’s population, an estimated 24% of existing TB cases occur in the region. In a number of countries, drug-resistant TB has also emerged as a new threat to effective control.

In addition, most TB control programmes in the African Region are donor-dependent and report significant funding gaps. Uptake of new, WHO-recommended, rapid molecular testing tools is still too low, threatening the road to universal susceptibility testing as recommended in the SDG targets.

Levels of TB/HIV co-infection remain above 50%, reaching 70% in some countries, especially in East and Southern Africa. While successful roll-out of ART has significantly reduced HIV-related TB deaths, a growing number of People Living With HIV (PLHIV), due to ART, translates into an ever-increasing number of populations at risk of TB infection.

Chronic hepatitis B and C affect a significant proportion of Africans (60 and 10 million respectively), with increasing mortality and deaths from liver cirrhosis and cancer. Less than 5% of those infected with hepatitis have been diagnosed or treated. Although the regional coverage of the third dose of the hepatitis B vaccine has reached 77% in the past decade (thus reducing the proportion of new hepatitis B infections among children younger than five from 4.3% to 1.6%), further scale-up of preventive interventions and

the establishment of testing and treatment are required to achieve elimination by 2030.

WHO/AFRO's role in addressing HIV, tuberculosis and hepatitis

The framework for implementation of HIV, TB, Hepatitis in the African Region has been adopted at the Regional committees by African Member states and the World Health Assembly. CDS's main role for HIV/AIDS and hepatitis aligns with the WHO Global Health Sector Strategies for HIV and Viral Hepatitis (2016–2021), which aims at ending the HIV/AIDS and hepatitis epidemics as public health concerns by 2030. The cluster's main role for tuberculosis aligns with The End TB Strategy adopted by the World Health Assembly (WHA) in May 2014.

HTH Programme strategic direction for the biennium 2016–2017

The 2016–2017 biennium plan for both HIV and hepatitis

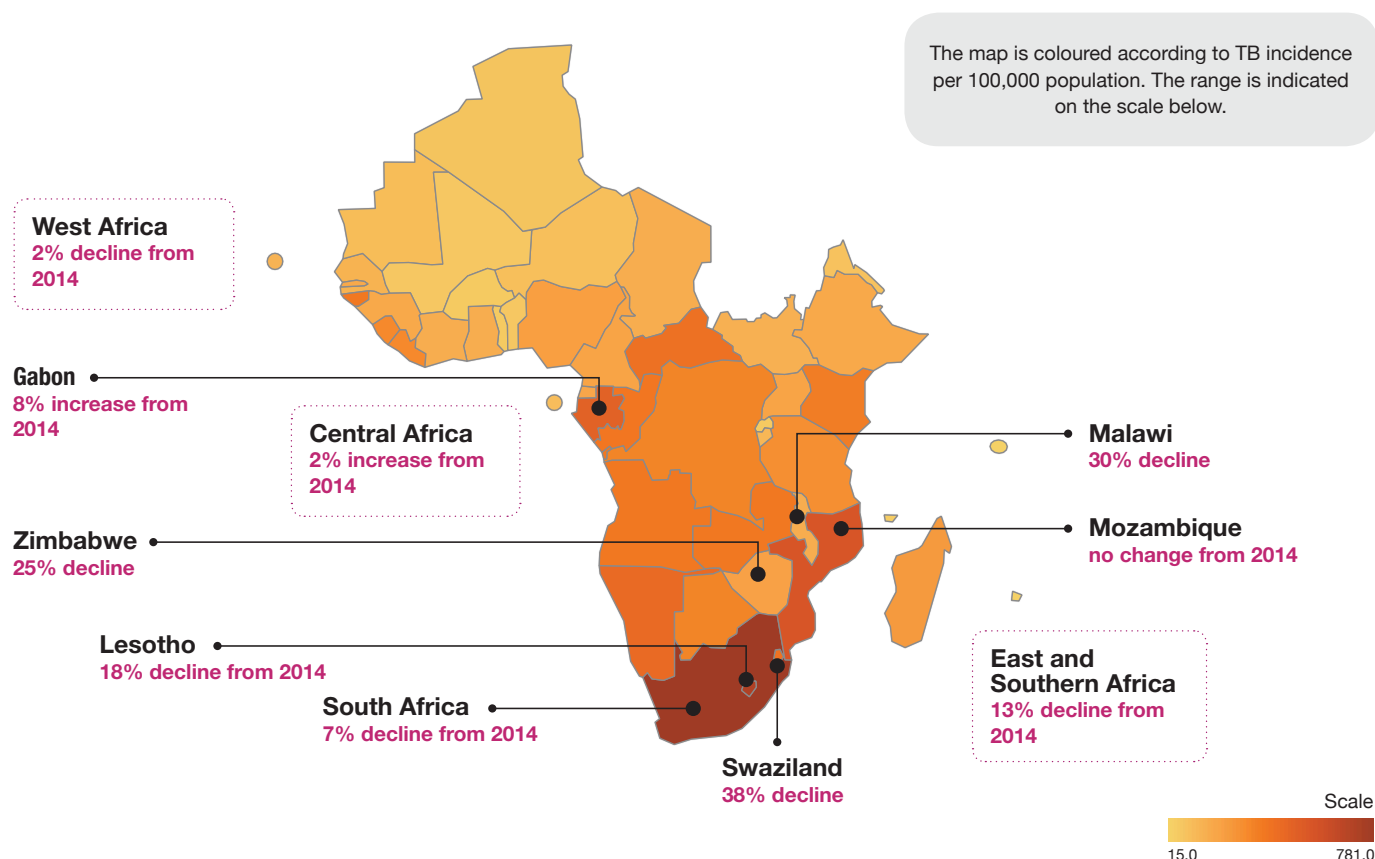
followed the five strategic directions addressing a specific set of interventions, as outlined in the Global Health Sector Strategies for HIV and Viral Hepatitis, respectively. The strategic directions are as follows:

- Strategic information for focus and accountability;
- Interventions for impact;
- Delivery for equity and quality;
- Financing for sustainability;
- Innovation for acceleration.

In accordance with The End TB Strategy, the 2016–2017 goals and strategic directions focused on globally addressing unfinished business from the Millenium Development Goal (MDG) era and mainstreaming the SDG and End TB goals, strategies and targets within national medium-term TB control plans. These goals encompassed three key pillars, namely:

- Rolling out integrated, patient-centred care and prevention of TB;
- Adopting bold policies and supportive systems;
- Intensifying research and innovation.

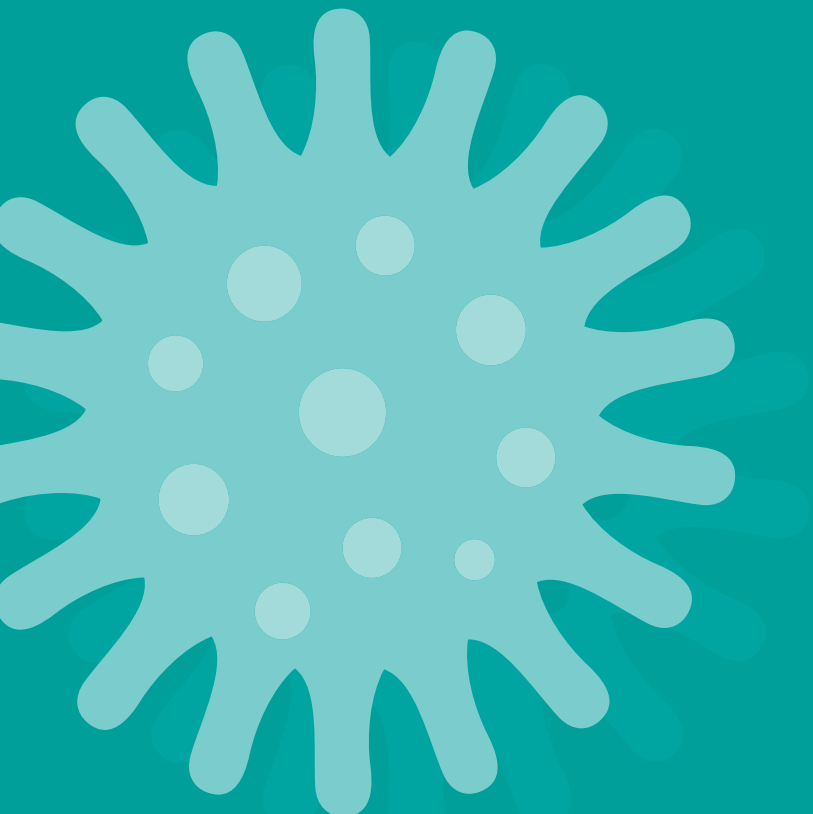
Figure 4. Percent change in TB incidence per 100, 000 population per country in the AFRO region



3

INTRODUCING CDS TRANSFORMATION STRATEGY AND STRATEGIC ACTIONS

CDS sought to establish itself as a partner of choice, widely recognized as providing best-in-class service, and as a key player behind the success of its partners.



Throughout 2017, CDS was adapting its work around the WHO/AFRO Transformation Agenda. The primary purpose of the CDS Transformation Strategy (2016–2020) was to mainstream the Transformation Agenda into the cluster's work.

Through discussions with a wide range of stakeholders, CDS has identified challenges and concerns that can be addressed through the following Strategic Actions:

1. Professionalize CDS
2. Prioritize CDS actions
3. Position CDS as a team player within AFRO and WHO, globally
4. Establish CDS as a partner of choice
5. Strengthen accountability for results.

The strategy also includes four Strategic Objectives that are expected to revitalize cluster programmes to be more impactful:

1. Provide effective technical and policy leadership
2. Support better data, mapping and surveillance
3. Facilitate implementation and quality technical support
4. Support resource mobilization.

Strategic Action 1: Professionalize CDS

Under this area of work, from 2016 and through 2017, CDS has been improving systems, workflow and general management. One of the priorities for this strategic area was to support the programme leads in joint planning, learning and skills development. Particularly, the work around the teams' Strategic Implementation Plans (SIPs) provided many opportunities for team leads to shape each team's activities so they supported and drew on the efforts of the others.

Resource coordination and management were improved by four new positions – the Technical Support Coordinator, the Programme and Administrative Officer, the Programme Officer and the Grant Management Officer – as well as bi-weekly meetings with the Inter-country Support Teams (ISTs) and quarterly meetings with professional and general category staff. These weekly meetings allotted time to planning, budgeting and reporting on implementation status.

Human resource capacity also increased after 20 new staff members (management, technical, and communication) were recruited and trained, while five others were reassigned. New tools have been created that allow managers and programme leads to plan activities, allocate resources, share materials, and coordinate technical assistance.

Strategic Action 2: Prioritize CDS's actions

The cluster aims to tackle health issues that occur on a large scale and cause extreme suffering. Driven by extreme socio-economic disparities across the region and the scarcity of available resources, the challenges of communicable diseases are distributed unevenly across countries and communities. Prioritizing CDS's efforts is key. As part of the efforts to plan and prioritize the development of the Budget Plan 2018-2019, the SIPs were created in mid-2017. Developed by each of the teams within CDS, they outline a number of actions and results, along with a budget.

The SIPs include increasing focus on areas for which WHO has a clear competitive advantage, such as providing technical support, building capacity, providing normative guidance, and leveraging the organization's unique relationship with health ministries. In the sections that follow, there are many examples illustrating how the activities within SIPs were shaped by this improved understanding of the cluster's niche value.

Strategic Action 3: Position CDS as a team player within AFRO and WHO, globally

Almost all of CDS's impact comes, not through direct interventions, but through supporting Member States and working with a range of partners (Fig. 5). Many CDS projects are implemented in partnerships where one of the niche roles for the cluster is that of coordinating and convening diverse stakeholders. The WHO/AFRO Transformation Agenda recognizes the importance of teamwork and collaboration. For CDS in 2017, this included developing new ways of collaborating within teams, with other clusters, across WHO in general, with the Member States and with various other stakeholders. This also involved working in a more agile and integrated way across offices, projects and reporting lines.

Working across clusters for heightened impact was a recurring theme for 2017. As the teams used their new systems for joint planning, they mapped out linkages and interdependencies with the work of other parts of WHO. For example, there were collaborative works with other clusters, particularly:

- Family and Reproductive Health (FRH) – including the Reproductive, Maternal, Newborn and Child Health (RMNCH) and Child and Adolescent Health and Nutrition (CAN) programmes in the review of malaria programmes;

- WHO Health Emergencies (WHE) and Health Systems and Services (HSS) – actively working with these clusters in the implementation of the Department for International Development (DFID) supported project; and
- Laboratory strengthening efforts with the Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) and HSS.

Beyond Brazzaville, this renewed effort in strengthening partnerships in 2017 included work with WHO Inter-Country Support Team – Central Africa (IST/CA), in-country partners and regional and global partners (Roll Back Malaria, or RBM, and the Organization of Coordination for the Fight against Endemic Diseases in Central Africa, or OCEAC). This partnership supported the conducting of malaria programme reviews in Central African Member States.

Historically, efforts against NTDs have been piecemeal and short-lived, but coordination and collaboration are key to sustaining efforts over the long-term. An example of an improved, holistic approach in targeting NTDs is found in ESPEN.

ESPEN serves as the convener for all PC-NTD partnerships working in Africa, and has developed a partner matrix in order to map supported activities and identify funding and

technical gaps. This serves to reduce duplication and to ensure efficient use of available resources. It has also led to stronger coordination mechanisms in countries and among NTD partners.

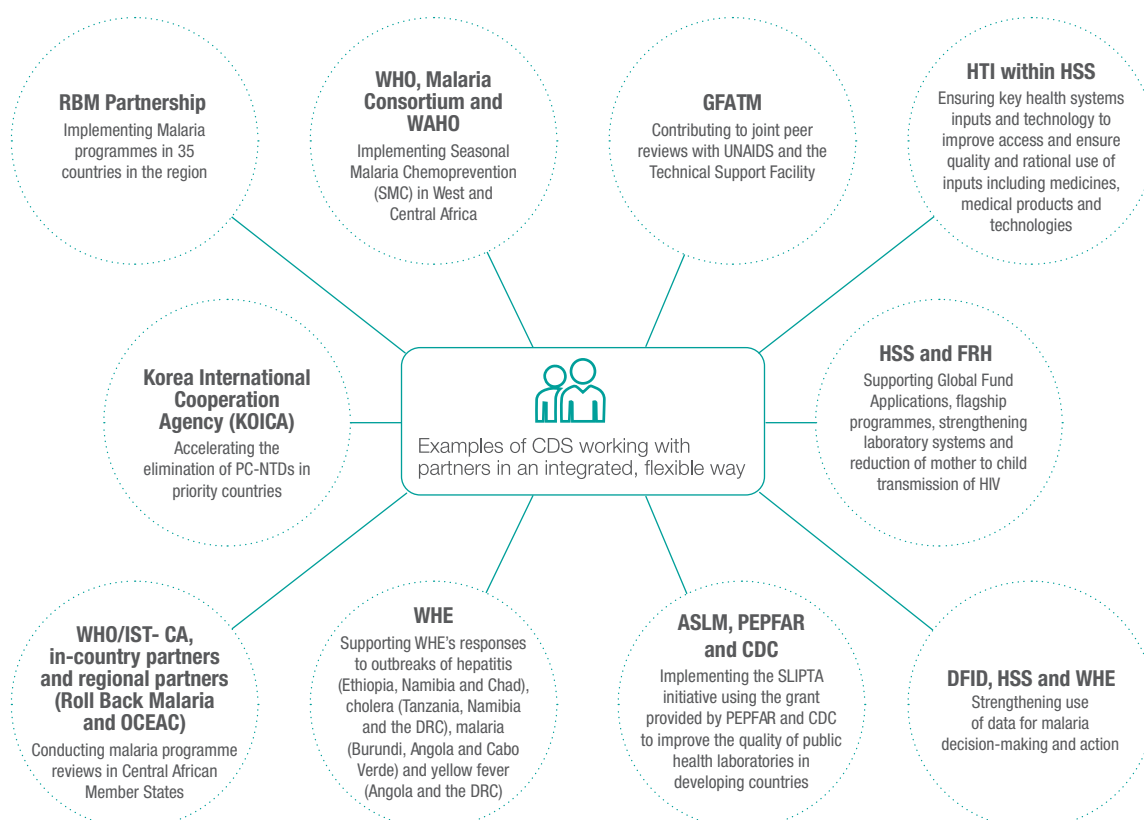
Additionally, CDS has supported WHE's responses to hepatitis outbreaks in Ethiopia, Namibia and Chad, cholera outbreaks in Tanzania, Namibia and DRC, malaria outbreaks in Burundi, Angola, Cabo Verde, and yellow fever outbreaks in Angola and DRC.

Strategic Action 4: Establish CDS as a partner of choice

As part of an ongoing shift in operational focus towards partnership and strategically adding value to joint efforts, 2017 marked the initiation and consolidation of many partner initiatives. CDS sought to establish itself as a partner of choice, widely recognized as providing best-in-class service, and as a key player behind the success of its partners.

In the following examples and others, CDS is showing a shift in institutional culture. While the team still works towards helping countries achieve the highest possible levels of health and contributing to the broader development

Figure 5. Regional and WHO inter-cluster partnerships



agenda, it is now playing a more specific and defined role in operations where there are many actors and complex processes at play.

One example is how CDS is working alongside the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) – CDS contributes to the Fund's joint peer reviews with UNAIDS and the Technical Support Facility. So far, these joint peer reviews, which support countries in reviewing their funding application drafts and provide inputs for improvement before final submission, have been organized for 22 countries (Fig. 6).

“Throughout 2017, there was ongoing activity between WHO country offices and all 47 Member States. Close partner ties were maintained and deepened.”

For the acceleration of malaria elimination in Southern Africa, in 2017, CDS worked hand-in-hand with international development partners from the Principality of Monaco and the United Kingdom, the United States President's Malaria Initiative, the Global Fund, and International NGOs such as the Clinton Health Access Initiative (CHAI), the Roll Back Malaria Partnership (RBM), the African Leaders Malaria Alliance (ALMA), Elimination 8 (E-8), the Mozambique, South Africa and Swaziland Project (MOSASWA) and the Mozambique, Zimbabwe, Swaziland (MOZISWA) Project. At a more technical level, the Malaria Programme also collaborated with the African Medical and Research Foundation (AMREF) in Nairobi, Kenya and also the UCAD in Senegal (for francophone countries), to strengthen laboratory quality assurance and control activities in a number of countries in the sub-region.

Strategic Action 5: Strengthen accountability for results

The CDS accountability framework operates on two levels. Firstly, the Cluster Director is monitored and held accountable for overarching transformational actions that accelerate change. Secondly, the management team is held accountable for the targets, priority actions and milestones to which each disease programme commits.

Figure 6. Countries where joint peer reviews were conducted by CDS, UNAIDS and Technical Support Facility



“The CDS Transformation Strategy establishes high-level targets for each disease. The disease-specific action plans take these high-level targets and derive activities, targets and milestones.”

The Key Performance Indicator (KPI) accountability framework cuts across programme areas, with specific milestones, measurable outcomes and linkages to HR management. This is inclusive of interim and 2020 targets, and is aligned with the AFRO-wide KPI framework.

The CDS Transformation Strategy establishes high-level targets for each disease. The disease-specific action plans take these high-level targets and derive activities, targets and milestones. The plans also allow CDS management and disease-specific teams to continuously monitor implementation progress and to collect and share strategic information for both internal and external use. This includes presenting information for routine course correction and in formats required by donors and other stakeholders, such as an analysis of evolving risks and priorities that emerge during periodic review. Over the year of 2017, performance management measures started to evaluate individual performance and how well CDS team members contributed to the work plans of other clusters, WHO more widely and external partners, based on the cluster and AFRO-wide KPIs.

4

STRATEGIC OBJECTIVE 1: PROVIDE EFFECTIVE TECHNICAL AND POLICY LEADERSHIP

The leadership WHO provides in developing normative guidance goes beyond written standards. In 2017, a number of countries adopted new policies and guidelines, which WHO monitors and supports.



One of the key roles of CDS is the setting of standards across the continent on preventing, managing, controlling and eliminating communicable diseases.

This normative guidance is taken as a benchmark for all 47 Member States and serves to ensure that all people accessing health services or benefiting from public health initiatives are receiving the best possible service.

The leadership WHO provides in developing normative guidance goes beyond written standards. In 2017, a number of countries adopted new policies and guidelines, and WHO was involved in monitoring and supporting their implementation (Fig. 7).

In order to provide effective technical and policy leadership, in 2017 CDS:

1. **Strategically supported defining priorities** from regional to national and sub-national level;
2. **Provided leadership** in translating/adapting guidelines and policies to the national context;
3. **Engaged with governments** to actively advocate for adoption of new policies, in science and technology;
4. **Provided effective support** in the development of prioritized, implementable national strategies; and
5. **Monitored and followed up** on the implementation of normative guidance in member countries.

Figure 7. Supporting countries through regional frameworks and policy guidance



National policies, guidelines and strategies

The PHE team supported six countries to develop the health component of National Adaptation Plans to climate change. These health national adaptation processes (HNAPs) include the integration of adaptation to climate change into national health planning, strategies, process, implementation and monitoring and evaluation (M&E) of health programmes. The same team provided support to 10 countries for developing policy instruments for workers' health, including national policies for protection of occupational health (Fig. 8). PHE has also developed a strategy for safe and judicious use of insecticides for effective evidence-based vector control in selected countries. So far, a total of 24 countries have developed insecticide resistance management plans (Fig. 9).

The NTD team helped Kenya, Uganda, Ethiopia and South Sudan, as well as Somalia and Sudan to update their National Action Plan 2017–2018 for Improved Surveillance and Accelerated Control of Leishmaniasis. These plans drew upon a WHO/AFRO set of tools and included game-changing approaches to data management and monitoring (including working with District Health Information System 2, or DHIS2).

There are many countries developing national strategic plans on hepatitis with the help of the HTH team. So far, nine of the

22 priority countries have gone through their epidemiological data and developed national strategies. In most of these settings this has marked an important step for finally giving hepatitis – a disease that has often been overlooked – the attention and resources it requires. Fifteen of the 22 priority countries in the African Region (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Mauritania, Nigeria, Rwanda, South Africa, South Sudan, Uganda and Rwanda) have national action plans for hepatitis prevention and control aligned with the hepatitis regional framework for actions. Following the dissemination of WHO's consolidated guidelines on HIV treatment, countries rapidly shifted their HIV policies to adopt "Treat All" recommendations to allow prompt uptake of antiretroviral therapy (ARV) among HIV positive patients, regardless of CD4 cell count. Thirty-two Member States adopted the policy and were implementing the "Treat All" recommendations. As a result, ART expanded to reach over 13.8 million people in the Region by July 2017, representing coverage of 54%.

"There are many countries developing national strategic plans on hepatitis with the help of the HTH team. So far, nine of the 22 priority countries have gone through their epidemiological data and developed national strategies."

Figure 8. Countries where the PHE team assisted in developing HNAPs, strategies for vector control and policy instruments for workers' health

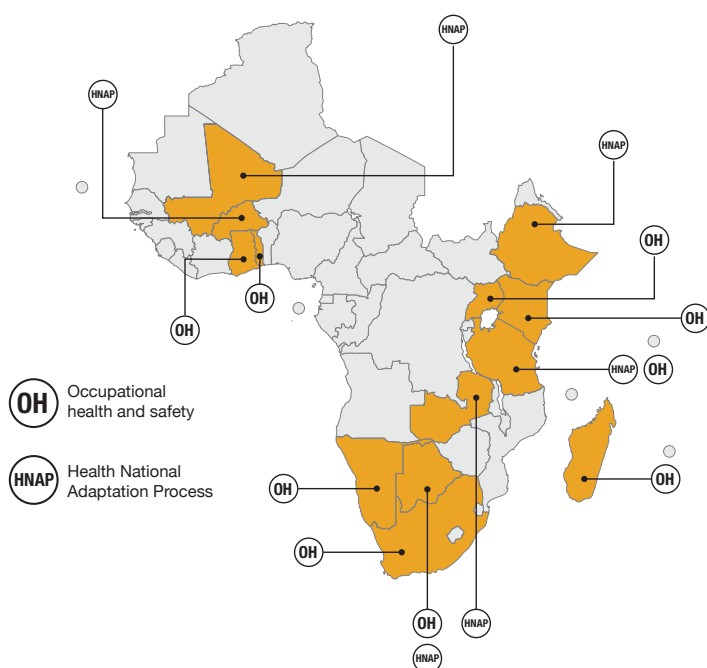


Figure 9. Countries where insecticide resistance management plans have been developed





5

STRATEGIC OBJECTIVE 2: SUPPORT BETTER DATA, MAPPING AND SURVEILLANCE

Typically, in the past, programme reviews would focus on a single disease area. In 2017, programme reviews in Botswana, Lesotho, Swaziland and Zimbabwe included four disease areas simultaneously: HIV, STIs, TB and viral hepatitis.



Objective 2 of the CDS strategy is to support improved evidence collection and monitoring and evaluation (M&E). The SDGs reinforce the need for disaggregated health data collection, analysis and use for decision-making and advocacy. This recognizes that impactful programme design relies on good quality and timely data. Within the 2030 Agenda, strengthening country health information systems is a priority, and is also strongly recognized as an area of WHO leadership.

In 2017, in order to support better data, mapping and surveillance, CDS has:

1. **Supported the establishment of routine monitoring systems**, which include the collection of disaggregated data and health equity analysis;
2. **Assisted in the interpretation of robust country data**, in order to design the most impactful programmatic responses for each disease; and
3. **Identified and supported country programme reviews and evaluations** to assess what is working and what needs to change.

Through the year, ESPEN strengthened the NTD information system by compiling PC-NTD data into an integrated database. The ESPEN data portal has made available hundreds of district-level maps and site-level data on endemicity and implementation of preventive chemotherapy. This information is used by country programme managers and stakeholders at national and global levels to assess progress on control and elimination efforts and to decide on areas that need special attention. The compilation of onchocerciasis epidemiological data from 1974 to 2015 has now begun and is expected to provide an extensive dataset to endemic countries and their partners, which could be used for guiding decisions on the most appropriate treatment strategies for achieving elimination. In 2017, a mobile data collection system was set up under the control of the WHO/AFRO information technology team (Fig. 10).



Figure 10. ESPEN Mobile Data Collection System



Country Case Study

Cameroon: Strengthening malaria surveillance and data management

Authorities from the Cameroonian Ministry of Health joined 77 programme directors, monitoring and evaluation officers and data managers from 24 different countries at a capacity-building workshop on malaria surveillance hosted by the WHO Inter-Country Support Teams of Central and West Africa (WHO IST/CA and IST/WA).

After gaining knowledge on generating and using malaria data for decision-making, the officials from Cameroon decided to replicate the training at the national level. A provincial-level workshop was organized to strengthen malaria data management, with the goal of improving the quality and use of malaria data for decision-making at a more localized level.

At both trainings, participants updated their malaria monthly routine data, graphed the results of key malaria indicators, and produced dashboards illustrating these indicators. Malaria bulletins are now produced on a regular basis, and Cameroon has received support from the WHO Country Office in finalizing its annual malaria bulletin for 2016. In addition, the original training contributed to the development of the World Malaria Reports for 2017, which contain country profiles reflecting the malaria situation in each country.

Programme reviews

Programme reviews serve to assess the status of implementation of national programme plans. They inform course-correction and the development of new medium-term plans as current ones expire. Other reviews have been conducted on demand by donor partners to set baselines before the commencement of grant-supported programmes. CDS plays a key role in these multi-stakeholder programme reviews. In 2017, this role included consolidating a number of final reports that became a published record of programme performance and, where feasible, reporting on impacts of interventions implemented over time.

“CDS plays a key role in multi-stakeholder programme reviews. In 2017, this included consolidating a number of final reports into a published record of programme performance and impacts of interventions over time.”

To inform country re-orientation of national strategic plans aligning with The End TB Strategy and other global and regional TB strategies, comprehensive programme reviews were conducted in Botswana, Ethiopia, Guinea Bissau, Kenya, Madagascar, Niger, Senegal, Swaziland and Lesotho. CDS also provided technical support to Southern African countries to commence national TB prevalence surveys and to finalize protocols and preparations to undertake community surveys. Patient cost surveys to determine TB-related costs were supported in six countries.

Typically, in the past, programme reviews would focus on a single disease area. In 2017, programme reviews in Botswana, Lesotho, Swaziland and Zimbabwe included four disease areas simultaneously: HIV, STIs, TB and viral hepatitis. It was learned that conducting joint programme reviews (Fig. 11), as done in these countries including review of Prevention of Mother-to-Child Transmission (PMTCT) of HIV, was a best practice to strengthen the integration of programmes, facilitating the development of joint strategic priorities. This not only enhanced synergy across the programmes but was also seen to be a cost-effective use of time and resources.

Establishing routine monitoring systems

Routine monitoring systems have contributed to effective and efficient allocation of limited resources through data-driven programme planning, and through evaluation of the progress and impact of control measures.

“Preventive Chemotherapy for NTD mapping has also enabled health programmes in 45 countries to focus on at-risk communities and increase PC coverage.”

The NTD database portal, Country Integrated NTD Database and DHIS2 tool have been rolled out to countries, strengthening their capacity in M&E and surveillance. In 2017, Human African Trypanosomiasis sentinel site surveillance

was strengthened in 10 countries. PC-NTD mapping has also enabled health programmes in 45 countries to focus on at-risk communities and increase PC coverage. Additionally, surveillance of Guinea worm disease was strengthened through WHO support and the publicity around a cash reward for reporting.



Country Case Study

Kenya: Certified free of Guinea worm disease (GWD)

Thanks to a strategic three-pronged approach that began in 2012, Kenya is now the 41st country in the WHO African Region to be certified free of Guinea worm disease (GWD). This approach has included:

1. Monitoring and Reporting
2. Research
3. Education

In terms of monitoring and reporting, methods for identifying GWD were strengthened through the use of surveillance hotlines for reporting cases and incentivizing the reporting through a cash reward, promoted nationally. Concurrent with the reporting, research was conducted in the form of case studies, documentation and investigation of rumours within 24 hours of a GWD report. In terms of education, health staff were trained in being sensitive to GWD and standard operating procedures (SOPs).

These activities, conducted through the Ministry of Health (MoH) with the aim of preparing the country for certification, were led by a seven-member Kenya Guinea Worm Eradication Programme National Certification Committee (KGWEP NCC), established in November 2014. This committee was supported by WHO/AFRO.

Figure 11. Overview of joint programme reviews






Phases of Joint Programme Reviews

- 1 Planning and preparation
- 2 Data collection
- 3 Analysis and interpretation of findings
- 4 Report writing
- 5 Reporting back to policy makers, national authorities, partners and wider stakeholders





Methods

-  Direct observations
-  Key informant interviews
-  Record reviews
-  Exit interviews of clients

Advantages of the joint review

-  Saves costs and time and builds capacity
-  Enhances synergy and fosters integrated service delivery between programmes that are reviewed together
-  Enhances collaboration between agencies and across WHO/AFRO clusters

Key challenges

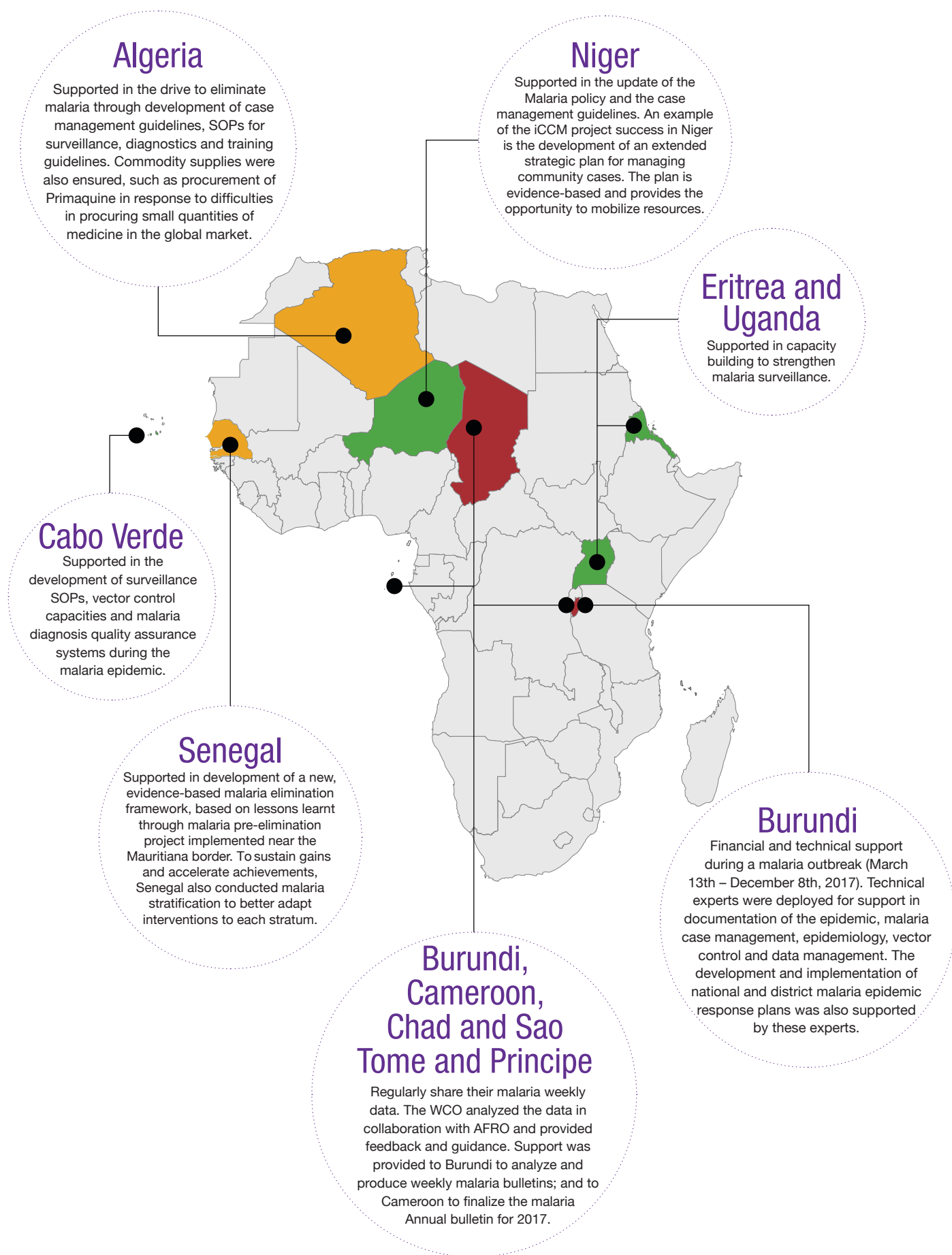
-  Juggling multiple interests and partners with competing priorities
-  Limited human and financial resources to cover all areas
-  Insufficient information to review all necessary topics
-  Insufficient quantitative data, resulting in subjective analysis and interpretation

In 2017, malaria surveillance systems were strengthened in the wake of a resurgence of malaria in some countries (Angola, Cape Verde, Burundi, Democratic Republic of Congo, Botswana, Comoros, Madagascar, Namibia, South Sudan, South Africa and Uganda). At least 11 countries were supported to produce regular malaria bulletins to monitor trends in malaria cases and deaths. The collection of improved quality data was also supported. Countries in the Southern African Development Community (SADC) region, jointly and with support from WHO and other partners, produced the 2017 SADC Malaria Report, which outlined the status of malaria control and elimination. Malaria drug resistance monitoring was also strengthened through technical and/or financial support. Therapeutic Efficacy Studies (TES) for antimalarial medicines were conducted in 2017 and five countries were supported in developing TES protocols, conducting studies, and/or analyzing their data. Figure 12 presents other country specific examples of strengthened malaria surveillance systems in the AFRO region.

“By the end of 2017, anti-TB Drug Resistance Surveys (DRS) were successfully supported in 10 countries.”

Lack of accurate estimates of the burden of TB in some countries has affected the extent to which national programmes accurately measure progress towards the new global targets. The solution to this has been to support national programmes in mobilizing financial resources, conducting national TB prevalence surveys and strengthening surveillance and M&E systems. Anti-TB Drug Resistance Surveys (DRS) were successfully supported in 10 countries by the end of 2017.

FIGURE 12. Examples of country-specific support in strengthening regional and national capacities for malaria



6

STRATEGIC OBJECTIVE 3: FACILITATE IMPLEMENTATION AND QUALITY TECHNICAL SUPPORT

In 2017, CDS received financial contributions from various sources to provide support to member states.



CDS's work increases the chance of success in health programme implementation by facilitating the design of robust programmes. This includes ensuring that plans are feasible, reflect the latest science and technological innovations, and can overcome challenges and delivery delays.

In order to provide and facilitate implementation and technical support CDS accomplished the following in 2017:

1. **Acted as a facilitator and coordinator of rapid technical assistance, or provided assistance itself**, by accessing and managing a dynamic and current roster of experts;
2. **Provided or facilitated access to surge capacity** during crises and emergencies; and
3. **Helped to ensure that national disease programmes were designed** to incorporate best practices.

In continuation of the partnership with the Global Fund, WHO has received over US\$ 50 million in 2017 under the catalytic investments to implement several global and regional strategic initiatives during 2017-2019. The strategic initiatives cover malaria and TB elimination, capacity building (Fig. 13) and south-south collaboration, HRH, pre-qualification of medicines and IVDs. These initiatives are being implemented by various departments in HTM, HIS and FWC clusters in HQ with a close coordination with regional and country offices. The CDS Cluster in AFRO is coordinating the implementation of the Regional proposal on strategic initiative RSSH 1.3 "Technical Support, South-to-South Collaboration, Peer Review and Learning" with other clusters (HSS and FRH) with the Regional Task Force platform.

CDS in collaboration with UNEP mobilized US\$10.5 million with which a project to develop an integrated chemical surveillance was launched in 10 countries. Technical support for health and water sectors in assessment and planning of climate resilient water supply resulted in provision of clean and reliable water to 1 million people in Ethiopia through upgrading of water supply utilities.

A project on alternative vector control methods was concluded proposing a systematic alternative approach for a better management of vector control programs in the region in addition to technical and material strengthening of programs. A similar project funded by UNEP-GEF worth US\$9.5 million was launched in six countries.

In 2017, the newly-established ESPEN laboratory provided evidence to assist countries in scaling down interventions, especially for onchocerciasis, after many years of Mass Drug Administration (MDA) (Fig. 14). During 2017, five manuscripts with co-authorship from the laboratory staff were submitted for publication. With WHO technical support using funds from UNIDO, six countries (Benin, Guinea, Mali, Niger, Senegal and Togo) assessed the use and management of mercury in the health system and a synthesis report of the outcome was produced.

The WHO malaria vaccine pilot implementation programme was launched on the eve of World Malaria Day 2017 during Africa Vaccination Week, with preparations underway for pilot implementation in Ghana, Kenya and Malawi to begin in 2018.



Country Case Study

Angola, DRC and Rwanda: Making advances in new diagnostic tools

The low uptake of new, WHO-recommended, rapid molecular testing tools for TB has been of great concern. In addition, low usage of these tools threatens the road to universal susceptibility testing, as recommended in the SDG targets. Rapid molecular testing should be used in place of bacteriological testing of TB cases and to assess the susceptibility of MDR-TB cases to second-line medicines.

It is due to this concern that the advances made in the types of diagnostic tools used in the DRC, Rwanda and Angola have been warmly welcomed. In Rwanda and the DRC, molecular testing has been scaled up through the use of GeneXpert and Line Probe Assay (LPA), the accreditation of the National Reference Laboratory (NRL) and the analysis of sample referral systems. In Angola, WHO provided laboratories with assessments and recommendations on the use of GeneXpert, supported the design of new diagnostic algorithms, and contributed to the development of an updated guideline on diagnosis.

FIGURE 13. Examples of health systems strengthening through capacity building in Member States in the African Region



Authorities from the Cameroonian Ministry of Health joined 77 programme directors, monitoring and evaluation officers and data managers from 24 different countries at a capacity-building workshop on malaria surveillance hosted by the WHO Inter-Country Support Teams.



Ghana was provided with technical support in building public health response capacities for chemical incidents in the extractive industries.



The capacity of core teams in 40 countries to diagnose malaria was enhanced through a WHO external laboratory competency assessment for malaria microscopists (ECAMM).



The Neglected Tropical Diseases (NTD) database portal, Country Integrated NTD Database and DHIS2 tool have been rolled out to countries, strengthening their capacity in M&E and surveillance.



Faced with the threat of drug and insecticide resistance, WHO also continued to support countries to improve the capacity of health workers and supported development of insecticide resistance management plans.



ESPEN ran a series of activities that included training for representatives of 17 countries on control of infected snails, intermediate hosts for schistosomes; trained representatives of 19 countries on LF monitoring and assessment; and built capacity of 49 programme officers, data managers and NGO representatives on distribution of medicines.



The African Network on Vector Resistance (ANVR) is being used as a platform to strengthen the capacity of countries to use national insecticide resistance management plans. This includes training country entomologists on routine monitoring of insecticide resistance status.



Updates to the WHO Guidelines for Drinking-water Quality and Guidelines for Indoor Air Quality were rolled out in Member States through a multisectoral approach to capacity building. For example, professionals from 10 countries attended a PHE training workshop on the use of the Guidelines for Indoor Air Quality.



The capacity of at least 17 countries was strengthened through the technical assistance, which included development of insecticide resistance management plans.



PHE provided technical support, in collaboration with WHO/HQ, to Ghana, Mozambique and Nigeria for implementing measures under the Minamata Convention on Mercury.

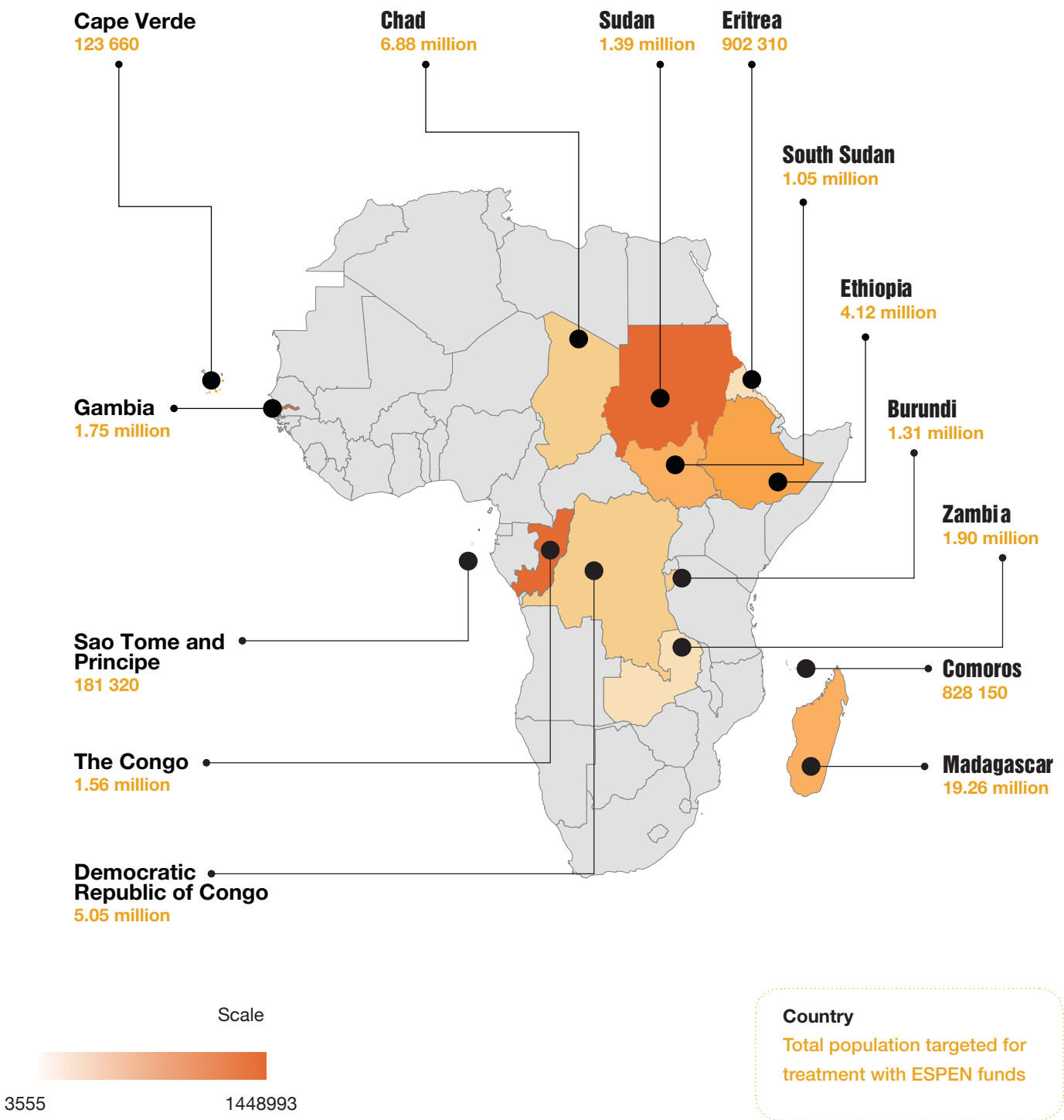


Technical support, including a regional PHE workshop, was provided to countries affected by El Niño in East and Southern Africa. As a result, regional and national health sector El Niño response plans that prioritized resource mobilization were developed.



Malaria programmes in 35 countries in the region were provided with technical assistance to develop funding proposals to the Global Fund from February to August 2017, in collaboration with RBM Partnership.

FIGURE 14. Map of total population targeted for treatment with ESPEN funds, 2017



18
countries

ESPEN provided direct support to 18 countries to scale up MDA according to their needs, targeting at least 30 million people for treatment through direct financial support.

ESPEN conducted subnational level data analysis identifying all endemic districts not currently treating with mass drug administration (MDA); shared the analyses with countries for verification and submission of proposals for direct support; and then provided direct support to catalyze scale-up of the programme.

7

STRATEGIC OBJECTIVE 4: SUPPORT RESOURCE MOBILIZATION

WHO/AFRO is facilitating procurement by countries of donated medicines for five PC-NTDs.



In the current funding environment, domestic and external resource mobilization is of increased importance. There is recognition that CDS needs to support country programmes by advocating for greater domestic resources for health, as well as access to international funds. This includes engaging with Ministries of Finance (MoF) and Ministries of Health (MoH) and using country cooperation strategies to better effect.

In 2017, in order to support resource mobilization, CDS has:

1. **Engaged with MoH and MoF and advocated for greater domestic funding**, based on presenting robust investment case;
2. Supported countries to access external finance through technical assistance for proposal development; and
3. **Participated in funding dialogues with key donors**, coordinating through HQ and Donor Capitals.

The NTD Programme Area works within strong public-private partnerships. For example, the pharmaceutical companies Sanofi S.A. and Bayer AG donate the best available treatment for NTDs and WHO supplies these medicines, together with the material needed for their administration, with the support of MSF/Logistique. A partnership with American biopharmaceutical company, Gilead Sciences, Inc. was also formed in 2016, in which the company agreed to provide US\$ 20 million in funding and drug donations over five years to address visceral leishmaniasis (VL). These efforts will improve access to diagnostic services and treatment for VL in South Sudan and Sudan, among other countries worldwide. Additionally, a memorandum of agreement between EMS, a Brazilian pharmaceutical firm, and WHO was developed in 2017 in which EMS has committed to providing the required quantities of Azithromycin for MDA in confirmed yaws-endemic countries. Donation will start from 2018.

As another example, the partnership between AFRO and the Korea International Cooperation Agency (KOICA) was strengthened during the biennium in a new regional proposal

for accelerating the elimination of PC-NTDs in priority countries.

Funding proposal assistance

Malaria programmes in 35 countries in the region were provided with technical assistance to develop funding proposals to the Global Fund from February to August 2017, in collaboration with RBM Partnership. The support included peer review meetings for the Global Fund. WHO also provided support to 12 countries implementing Seasonal Malaria Chemoprevention (SMC) in West and Central Africa, during a meeting co-organized in Ouagadougou by WHO, Malaria Consortium and West African Health Organization (WAHO). The purpose of the meeting was to share lessons learnt in the countries and to define the next steps to better coordinate and mobilize the necessary resources for countries in 2017–2018.

WHO/AFRO is facilitating procurement by countries of donated medicines for the five PC-NTDs. On behalf of WHO/AFRO, ESPEN supports country NTD programmes in preparing application dossiers for countries with low capacity and clearing applications when they are in good order. The review of the application is done in close collaboration with the Regional Programme Review Group for PC-NTDs (PC-RPRG). At the end of 2017, ESPEN was able to receive, review and clear applications from 38 countries (86%) for PC implementation in the subsequent year, while in 2016 applications for only 33 (75%) were cleared. This increase was possible thanks to ESPEN staff being in place in the first semester of 2017.

In collaboration with WHO/HQ, AFRO/CDS/HTH developed a proposal for funding voluntary medical male circumcision services through the Bill and Melinda Gates Foundation. Subsequently, US\$2.9 million was raised to be disbursed over three years. Additionally, HTH supported 32 countries in applying for HIV/TB funding from the Global Fund.

8

MANAGEMENT OF FINANCIAL RESOURCES FOR RESULTS

All programmes were provided financial support with aggregated financing from various flexible and voluntary contributions.



Resource coordination, implementation of planned activities and human resource capacity were improved during 2017 and overall for the biennium. Contributing to these improvements were a number of factors including the restructuring of the cluster, improved planning, timely recruitments and reassignment of the staff resources, and monitoring of the implemented activities for timely delivery.

For the biennium 2016-2017, CDS' planned costs were 101% of its allocated programme budget, with all programmes fully planned for staff costs and activities. For ESPEN, a newly started program under the non-PB category 50, the planned costs were 49% of its allocations due to challenges in creation of category 50 in the work plans across the regional office, ISTs and countries.

In terms of available resources, all programmes were funded with aggregated financing from various flexible and voluntary contributions of US\$50 million. Part of these resources available for implementation in biennium 2018-19 were later carried forward in December 2017, leaving around US\$38.8 million for 99% implementation of staff costs and activities in 2016-2017.

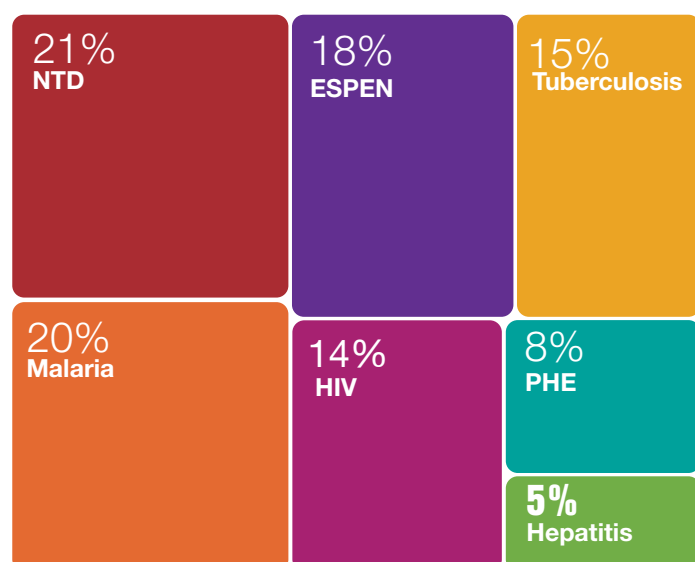
The major programmes contributing to the overall availability of funds in the biennium 2016-2017 were NTD (21%), Malaria (20%), HIV (14%), Hepatitis (<5%), TB (15%) and ESPEN (18%) (Fig. 15).

“As mandated for its advisory role, CDS programmes required significant funding for salary and activity costs.”

For delivery of projected results, salary costs in 2016 and 2017 accounted for just under 50% of implementation expenses. Other categories of expenditure included travel (26%, including travel of meeting participants), contractual services (16%) and others (8%) (Fig. 16).

The major programmes contributing to the overall implementation of the CDS cluster were Malaria (23%), HTH (HIV and Hepatitis) (21%), TB (15%) and NTD (20%) (Fig. 17).

Figure 15. Financing share of programmes 2016-2017 (Total US\$50 million*)



*Around US\$ 11.2 million carried forward towards the end of 2017 for 2018-2019 work plans.

Figure 16. Implementation by expenditure type to staff costs and activities for biennium 2016-2017 (Total US\$38.7 million)

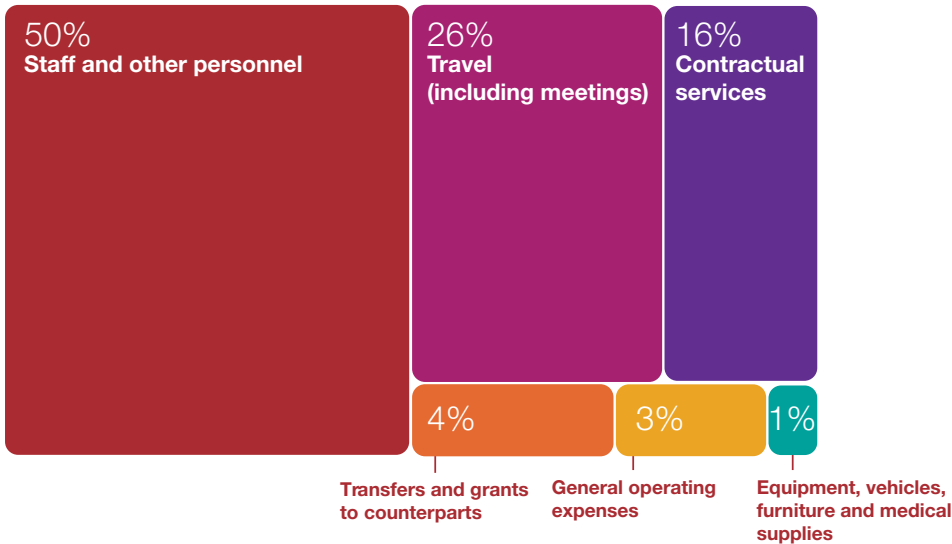
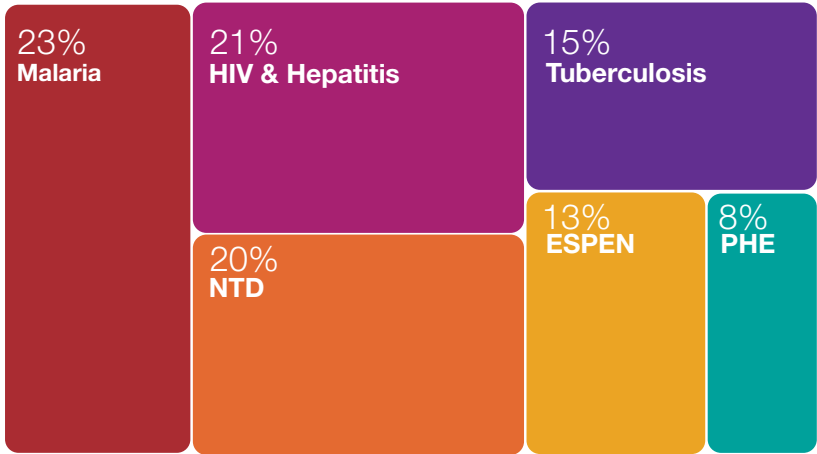


Figure 17. Implementation share of programmes for 2016-2017 (Total US\$38.7 million)





9

MOVING FORWARD: PERSPECTIVES FOR THE 2018–2019 BIENNIUM

The second phase of the Transformation Agenda will put people in the centre of change and the ongoing WHO global, managerial, programmatic and governance reforms will bring additional impetus to CDS's performance.

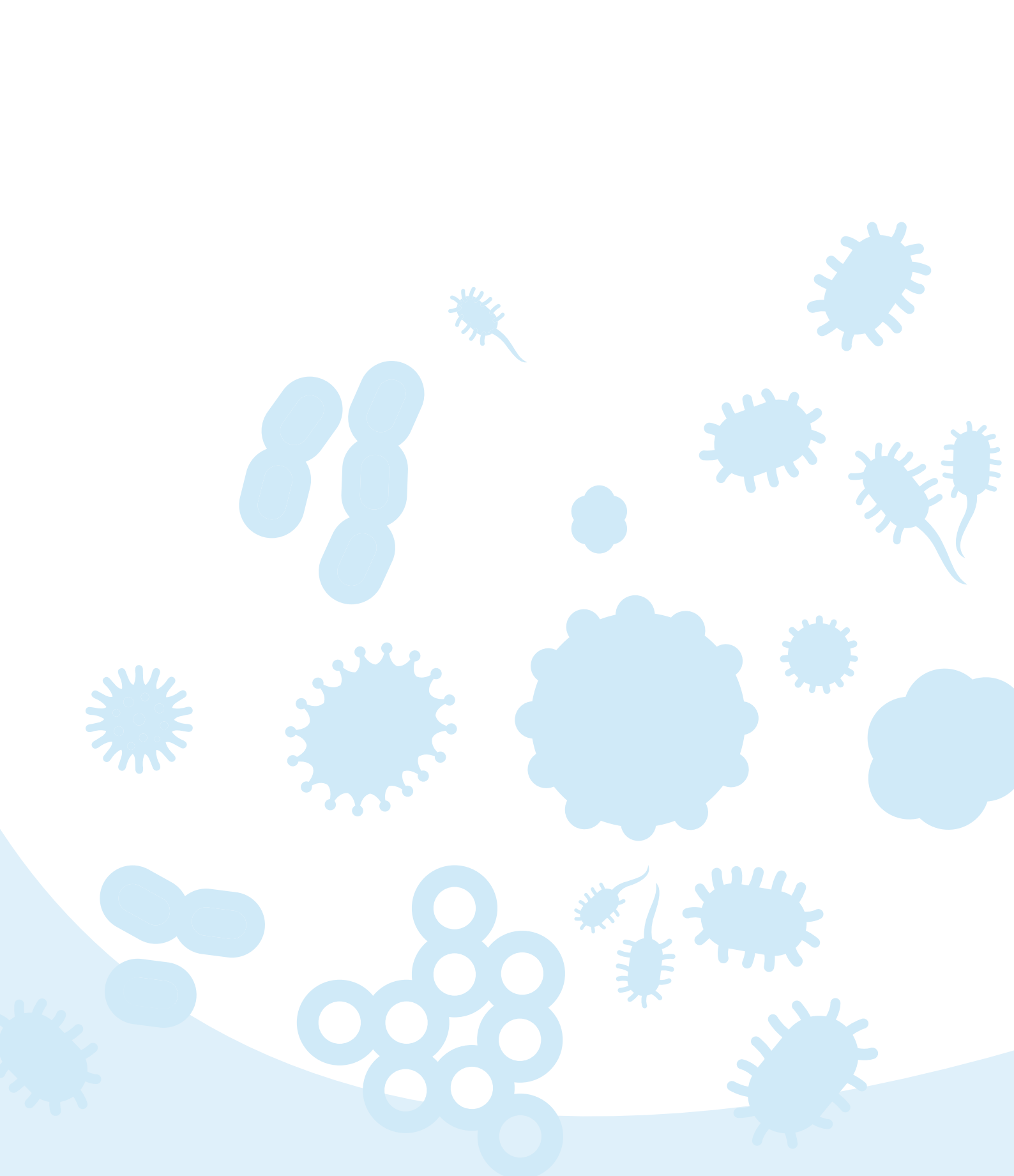


The biennium 2018-2019 will see a continuation of activities that have already delivered positive results in the first phase. These activities will honor various ongoing commitments to meet the goals of the Transformation Agenda and SDGs, particularly as they relate to communicable diseases and public health and the environment. Moving forward in the context of the various strategic objectives and expected outcomes of the Agenda, the CDS programmes will focus its efforts around:

1. Increasing international and domestic resource mobilization, which initially will also involve efficient reviews of country requests for support and the development of annual plans for action.
2. Improving technical support and building staff capacity. New technologies and approaches for targeted testing, burden assessment and treatment monitoring will be introduced in some cases. Staff will be required to deliver a range of technical support for implementing new and existing disease-specific strategies and frameworks throughout the region.
3. Updating and developing policies, guidelines and manuals. Some programmes will provide support for the continuing transition of national policies and strategies (e.g. from the Stop TB to the End TB Strategy). Others will finalize the improved protocols for case finding, mapping and treatment, and implement elimination or eradication strategies in some cases.

4. Continued collaborations across all levels of the WHO and across clusters, and work with partners/stakeholders in disease prevention and control. For example, the PHE team at the Inter-Ministerial Conference on Health and Environment (IMCHE3), supported by WHO and UNEP, will seek commitment from Member States, partners and stakeholders for enhanced joint policies and actions on health and environment in Africa.
5. Building capacity for disease prevention, control and elimination, by scaling up rapid interventions in countries. This will involve conducting active case searches, mapping and assessments, containing infections and improving roll-out of treatment. Drug resistance will also need to be addressed as a key barrier against disease elimination in some cases (e.g. Malaria and TB).
6. Strengthening surveillance and data collection. As a key example, the DHIS2 tool for integrated monitoring and evaluation of NTDs and HIV will be implemented in some Member States. This dashboard will also allow for effective data sharing across the region. Introduction of surveillance and data collection for viral hepatitis will also begin.

The second phase of the Transformation Agenda will put people in the centre of change and the WHO global, managerial, programmatic and governance reforms are already underway. Strengthened communication, shifting focus towards results-delivery and broader engagement between Member States and partners are key in driving progress in the above areas over this next phase of the transformation journey.



**World Health
Organization**

REGIONAL OFFICE FOR

Africa