WHO REGIONAL OFFICE
FOR AFRICA

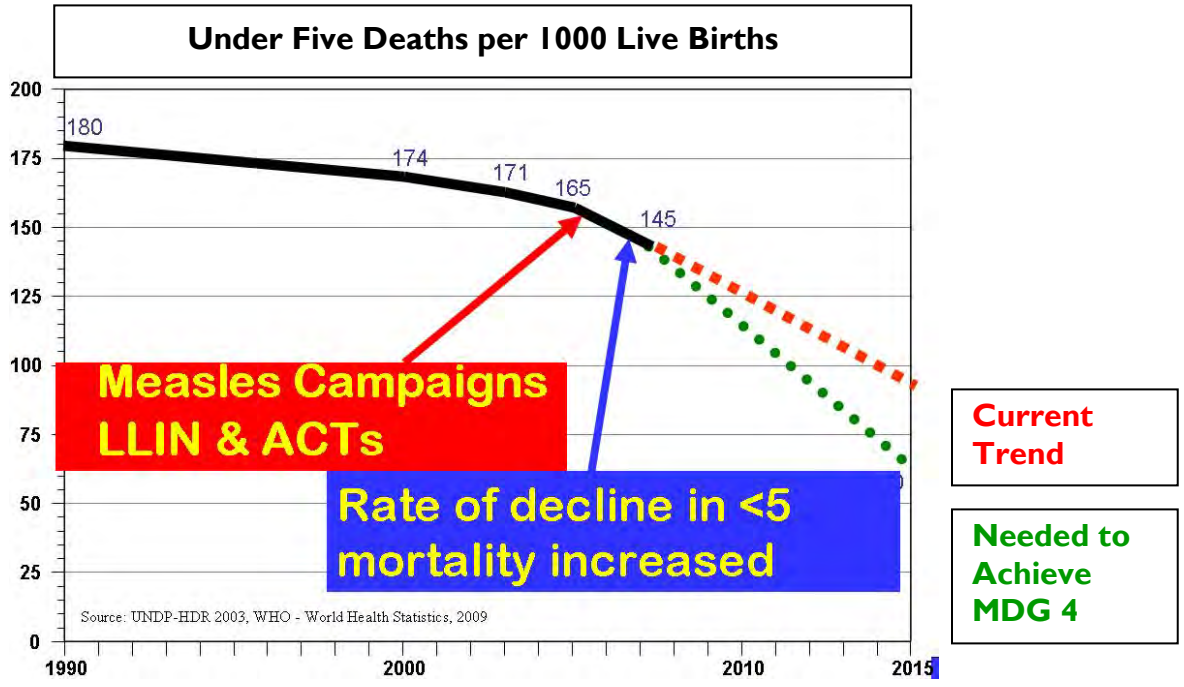
USAID FROM THE AMERICAN PEOPLE | Africa's Health in 2010

USAID GRANT TO WHO/AFRO
AFRO-G-00-04-0001 (2005-2009)
FINAL EVALUATION - MAY 5-29, 2009

PROGRESS TOWARD MILLENNIUM DEVELOPMENT GOAL 4: REDUCE UNDER FIVE MORTALITY BY 2/3rds BETWEEN 1990 & 2015

(NOTE: THE INCREASED SLOPE ASSOCIATED WITH 4 STRATEGIES)

1. Mass Measles Campaigns
2. Procurement and Distribution of 173 Million Long Lasting Insecticide Treated Nets (LLINs)
3. Introduction of Rapid Diagnostic Test for Malaria
4. Increased use of Artemisinin Combination Therapy for treatment of Malaria (ACTs)



MESSAGE TO READERS:

This joint USAID and WHO/AFRO evaluation of the 2005-2009 USAID $37 Million Grant to WHO/AFRO is a long document and not meant for cover to cover reading. It is made up of four different sections:

Section 1: Executive Summary and Recommendations
Section 2: Context of the Evaluation: Actors, Schedule of Work
Section 3: Description of the ten (10) program areas funded by the grant
Section 4: Reports of country visits to:

- Democratic Republic of Congo
- Ethiopia
- Kenya
- Liberia

Readers are encouraged to read those sections that address their areas of action or interest. To facilitate reader's access to the Executive Summary and Recommendations, the Acronym pages have been placed at the end of the document.

Stanley O. Foster MD, MPH
Evaluation Team Leader
June 2009

Visuals are an important part of this report. They are best visualized in color. Therefore, this report can be viewed and downloaded from the website of USAID's Development Experience Clearinghouse:
www.dec.usaid.gov

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THANKS

The evaluation team extends its thanks to WHO, USAID, Country Ministries of Health, UNICEF, and CDC and their staff who provided the information, data, and graphics included in this report. We also express our gratitude to Antonia Wolff at AED's Africa's Health in 2010 for the skillful editing of this report.

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY AND RECOMMENDATIONS

USAID GRANT TO WHO/AFRO

During the last five years, 2004-2009, the United States Agency for International Development (USAID) has provided the World Health Organization Regional Office for Africa (WHO/AFRO) a grant of $37 million dollars to strengthen WHO/AFRO capacity to support African Nations in achieving the Health Millennium Development Goals (MDGs 4, 5, and 6). Thirty-four million dollars came from the USAID Africa Bureau and three (3) million dollars from USAID Missions. A majority of funds are used to support development of norms, standards and tools and provide technical assistance at Country, Inter-Country, and Regional levels.

GRANT EVALUATION MAY 5-30, 2009

This evaluation was carried out to achieve the following objectives:

- Assess progress in achieving 10 program components funded by the grant.
- Review management and fiscal processes and results.
- Identify the need for and the opportunities of a follow-on grant 2010-2014.

Evaluation Process

- Week 1 – Briefings by USAID Africa Bureau health team and one-on-one discussions with key partners (e.g. Selected USAID Cooperating Agencies, Centers for Disease Control and Prevention (CDC), and the World Bank (WB)).
- Week 2 - Briefings by WHO Africa Regional Director and his staff (background materials, presentations, one-on-one discussions).
- Week 3 – Visits to Democratic Republic of Congo, Ethiopia, Kenya, and Liberia.
- Week 4 – Data compilation and analysis, draft report, and debriefing.

MAJOR FINDINGS

1. WHO/AFRO IS A KEY ACTOR IN HEALTH DEVELOPMENT IN AFRICA

Facilitates Annual Regional Committee Meetings where Regional Health Policies are established.
Establishes Norms, Standards, and Tools for Promotion, Prevention, and Treatment.
Serves as a technical advisor to Ministries of Health.
Supports Ministry of Health requests for technical assistance through:

- Posting of National Professional Officers (NPO) and International Professional Officers (IPO) at country level.
- Technical assistance from Inter-Country Support Teams (ICST) based in Libreville, Gabon; Ouagadougou, Burkina Faso; and Harare, Zimbabwe.
- Technical support from WHO Regional Office in Brazzaville, Congo.

Provides leadership and technical coordination at country level:

- UN Agencies (WHO, UNICEF, UNFPA, UNIFEM, UNAIDS, World Bank, UNDP, UNEP, FAO,).
- NGO, Bilateral and Multilateral Health Sector Partners.
- Academic and Regional Institutions.
- Health Task Forces (e.g.; Immunization, Reproductive Health).

Assists countries in identifying funding sources, preparing quality grant submissions and addressing implementation bottlenecks.

2. PROGRESS TOWARD MDGs 4, 5, 6

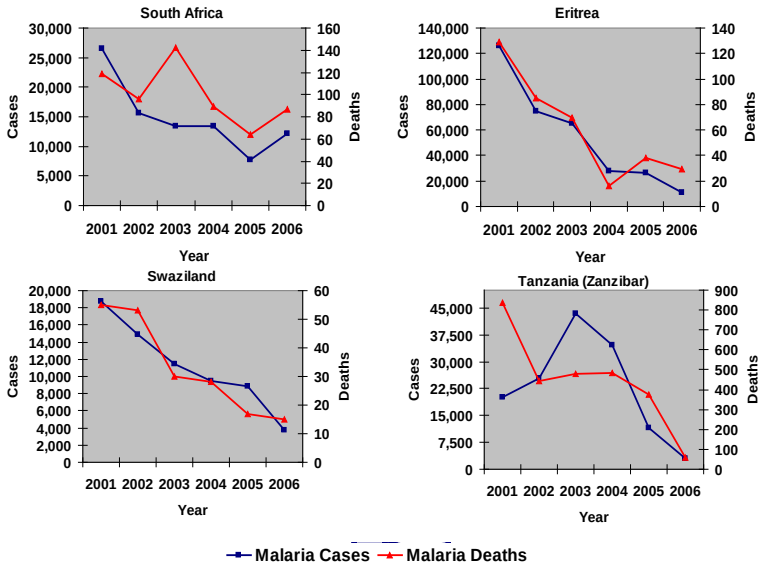
MDG 4: Significant progress in reducing Under-Five mortality (p6)
MDG 5: Little progress toward reducing maternal mortality (p7)
MDG 6: Significant progress in Malaria, moderate progress in HIV, and limited progress with TB (p8)

MDG 4: Reduce <5 Mortality by 2/3rds by2015 (Baseline 1990)

MALARIA

WHO with its partners (the President's Malaria Initiative, Roll Back Malaria Partnership, and Multilateral and Bilateral Partners) introduced and coordinated a new malaria strategy in Africa. This strategy includes promotion of insecticide treated bednets (173 Million Long Lasting Insecticide Treated Bednets procured between 2004 and 2008); introduction of Rapid Diagnostic Tests for diagnosing malaria; and replacement of ineffective malaria drugs, Chloroquine and Sulfadoxine-Pyrimethamine (Fansidar), with effective Artemisinin-based Combination Therapy (ACTs). Malaria morbidity and mortality are falling. Figure 1.

FIGURE 1: Malaria Morbidity and Mortality



MEASLES

The Measles Initiative (American Red Cross, CDC, UNICEF, United Nations Foundation, and WHO) campaigns have reached 90% of target age children in most countries. The new strategy provides a second dose opportunity for all children nine months to 14 years in Year 1 and follow up second opportunities to children nine months to five years every two to three years. Measles morbidity and mortality are falling. Figure 2.

FIGURE 2: Measles Deaths in Africa 2002-2007

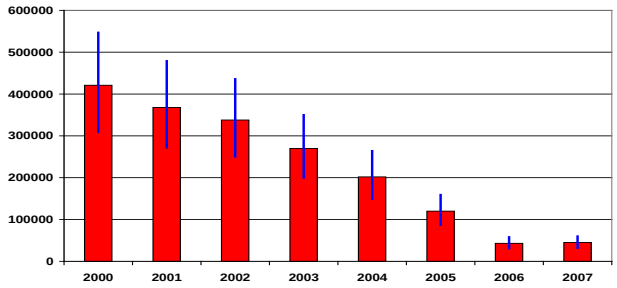
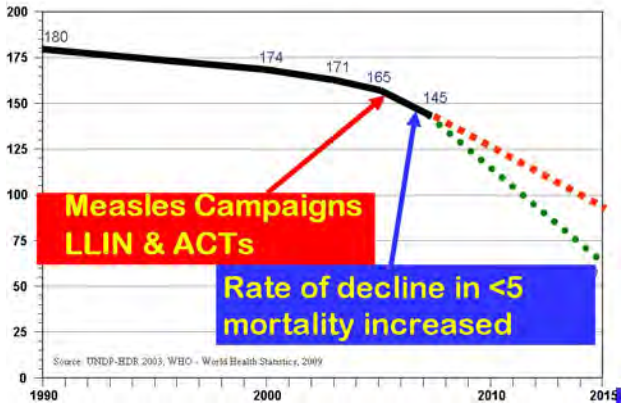


FIGURE 3: Under Five Mortality in Africa

UNDER-FIVE MORTALITY

The rate of decline in Under Five mortality has accelerated and is expected to fall further in the next five years, Figure 3. This decrease will be verified by the next rounds of country Demographic and Health Surveys. Figure 3.



MDG 5: Reduce Maternal Mortality Ratio by 2015

ACCESS TO MATERNAL HEALTH SERVICES

Current levels of contraceptive use, prenatal care, tetanus toxoid coverage, delivery by trained attendant, access to emergency obstetrical care (EmOC), and postnatal care are extremely low and incompatible with the achievement of MDG 5. Figure 4 provides data on the 4 countries visited by the evaluation team.

ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE

In many countries, there is a lack of access to facilities with quality Emergency Obstetrical Care (EmOC).

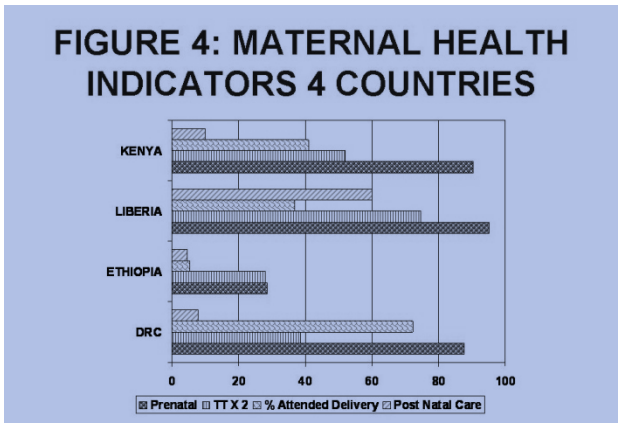
A recent survey of 751 health facilities (Health Centers and Hospitals) in Ethiopia found that only 83 (11%) met quality standards for EmOC. Figure 5.

AVAILABILITY OF SAFE DELIVERY PRACTICES

Figure 6 provides data from the same survey on practices available by type of facility. Major gaps are identified.

CESAREAN SECTION RATES

Reductions in Maternal Mortality Ratio require that 10-15% of deliveries be by Cesarean Section. Figure 7 from Ethiopia show unacceptably low rates of delivery by C-section.



Figures 5-7 come from a UNICEF/WHO/UNFPA Survey carried out in Ethiopia in 2009.

FIGURE 5: STATUS OF FACILITES MEETING OBSTETRICAL STANDARDS

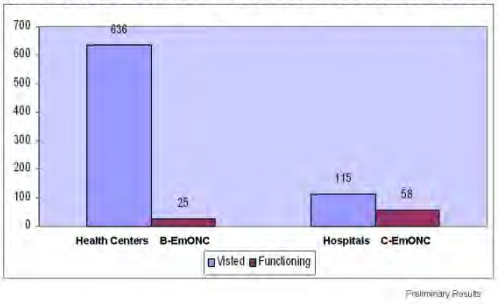


FIGURE 6: Delivery Practice

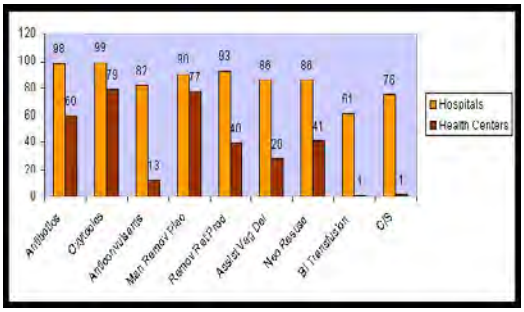
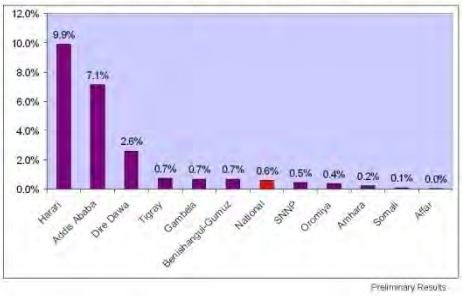


Figure 7: % Births delivered by C-Section by Region, Ethiopia; Expected 10-15%



MDG 6: AIDS, TB, and MALARIA

AIDS

WHO works with Countries and partners to develop and update National HIV/AIDS Strategic Plans.

WHO supports countries in accessing and implementing Global Health Initiatives (GFATM, PEPFAR, GAVI).

WHO is working with countries to integrate PMTCT services in all ANC and reproductive health services.

Over 20 million Africans are living with AIDS, Figure 8.

Given the implementation of ART programs, HIV infected individuals are living longer and prevalence rates are increasing.

Incidence rates are beginning to decline.

TB

Increasing percentage of TB cases tested for HIV. Figure 9.

Increasing percentage of cases of HIV/TB co-infection on dual therapy. Figure 10.

Progress is slow in diagnosing and treating non HIV TB. Figure 11.

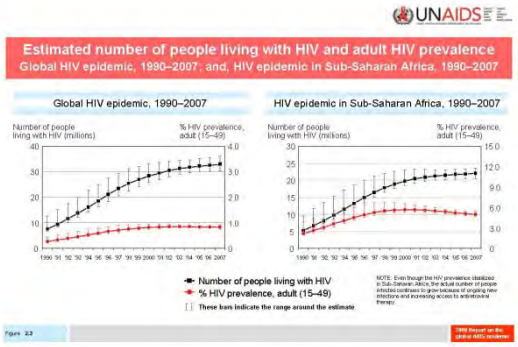
Multi Drug Resistant TB is increasing.

MALARIA

See page 5–the section on Malaria.

Progress toward the MDG targets reflects investments by many donors and, most important of all, national governments. The USAID grant to AFRO is one contribution among many.

Figure 8



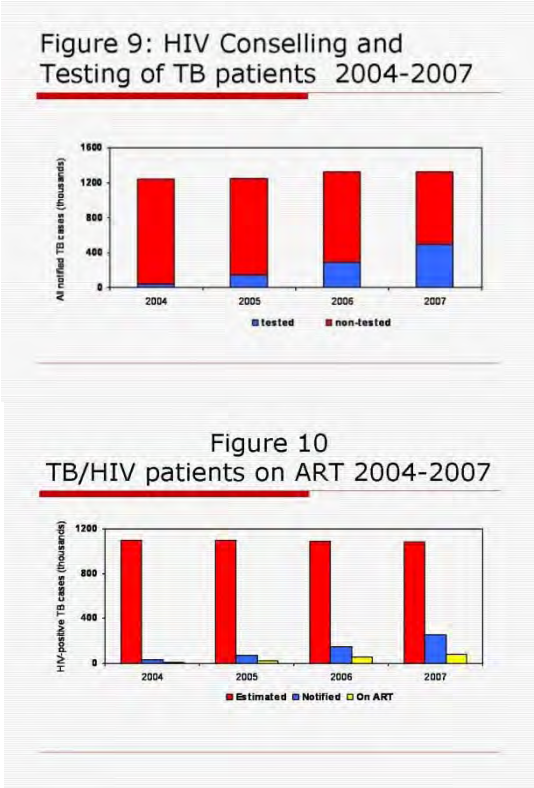
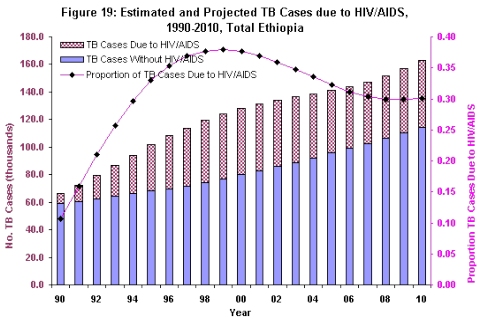


Figure 11



3. STRENGTHS OF WHO/AFRO AND COMPLEMENTARITY TO USAID: EVALUATION TEAM FINDINGS

STRENGTHS OF WHO/AFRO

Highly qualified personnel serving at three levels

- Country – National and International Professional Officers serving at country level
- Inter-Country – Technical Resource at 3 locations capable of immediate response to countries.
- WHO Regional Office with responsibility for policy, norms, standards, monitoring and evaluation, research, and assistance to countries.

Leader and coordinator of technical assistance at the country level

- Interviews with USAID, UNICEF, CDC and ministries of health officers revealed near unanimous recognition of the unique role of WHO as a technical bridge and policy resource to Ministries of Health.

Major Change of WHO Presence in Africa

- Evolution from small office to major development partner (750 staff in Nigeria and 180 staff in Ethiopia.)
- Regional Director's delegation of authority to Divisional Directors, Inter-Country and Country Level.
- Recognized resource of leadership and expertise in response to epidemics including surveillance, laboratory strengthening, and epidemic control.

KEY FINDINGS OF THE EVALUATION

This report documents significant contribution to and improvements in health status by African countries, WHO, and development partners.

The evaluation team is unanimous in its conclusion that the USAID Grant has contributed significantly to WHO/AFRO's effectiveness in strengthening the capacity of African countries in improving the health of their people.

The progress made by WHO, African countries and partners during the last five years and the changing health priorities require a reassessment of needs and opportunities for the next USAID Grant to WHO. An extension of the current grant format is not appropriate.

ISSUES AND RECOMMENDATIONS FOR 2010-2014 USAID GRANT TO WHO

(i=Issue; R=Recommendation): These have been numbered 1-15 to facilitate ongoing dialogue and monitoring. The WHO and USAID focal points should be in regular contact to facilitate exchange and identify and resolve "bottlenecks."

i.1	The USAID Grant primarily supports WHO staff working at country, inter-country, and regional levels to strengthen country capacity to effectively implement health promotion, prevention and treatment strategies. While it is difficult to tie inputs to specific results, the data presented in Section Three (Program Areas) and Section Four (Country Reports) show clearly that WHO technical assistance is strengthening country health programs. The evaluation team is unanimous in concluding that the USAID grant support is increasing the access, quality, and effectiveness of health programs in African Countries.
R-1	USAID recognizes the uniqueness of its grant in strengthening WHO technical country, inter-country and regional team's capacity. (See 3 column table on page 15). USAID formally commend WHO/AFRO and its member countries for the improvements of health and well-being in Africa.

i.2	Current USAID Grant expires September 30, 2009.
R-2	USAID should extend the WHO/AFRO grant for 5 years (2010-2014).

i.3	The WHO/AFRO decentralization of programs to the Division level is commended. Current communication between the various divisions and the focal point at USAID Washington (currently Mary Harvey) in terms of proposals, dialogues, and reports are intermittent and unsynchronized.
R-3	WHO/AFRO appoints a contact person to coordinate communication between WHO AFRO and the USAID focal point.

i.4	WHO/AFRO is the only organizational entity able to collate, analyze, and disseminate surveillance data coming from African countries. Progress is being made in 33 of 46 countries. The Communicable Disease Surveillance Plan for 2009-2013 has an excellent set of objectives for strengthening surveillance at the country level (Sections 4.1-4.3); it lacks, however, specific objectives for Disease Surveillance and Response at the Regional Level..
R-4	WHO and CDC carry out a joint review of the Communicable Disease Surveillance Plan and develop specific objectives for Surveillance and Response at the Regional Level. This review should assess the feasibility of tracking completeness of reporting at district and country levels, weekly surveillance of priority and epidemic diseases, and development of a weekly online epidemiologic bulletin to provide surveillance feedback at the regional level. This review should also reexamine the country surveillance framework developed close to ten years ago and assess appropriate allocation of resources to the country level for disease surveillance and response.

i.5	Only a few programs, e.g., Malaria, Measles, and HIV have adequate data to monitor incidence, prevalence, and program impact. Most indicators submitted in the program proposal (requested by USAID as standard indicators) and in materials provided to the evaluation team are process indicators: policies workshops held, policies developed, technical assistance provided, training courses carried out, and number of people trained.

	Such indicators, without evidence of changed performance at the operational level, are of minimal value. Policy and capacity strengthening are of no value unless services are provided in a timely manner and meet quality standards. One country reported on training for use of Zinc when Zinc was not available in country. Capacity strengthening should only be implemented when and where materials promoted in the training are available at service delivery levels for immediate use after training.
R-5	Future work plans and program reports should provide a balanced set of objectives and indicators including process, outcome, and impact. Process inputs need to be linked to expected outcomes and impacts. In reporting to USAID, expenditures need to be linked to activities and results.

i.6	African countries are making incredible progress in several areas: immunization, malaria, and, in part, HIV. Three areas are, however, identified as major obstacles to the achievement of the MDGs: **Maternal Health** including timing of births, prenatal care, safe delivery, access to quality emergency obstetrical care, and post-partum care. **Neonatal Care** – Given that an increasing proportion of <5 mortality is neonatal, neonatal care needs to be improved including the availability of antibiotics at the level of delivery. **Tuberculosis** – Progress is being made with TB-HIV co-infection. Non-HIV TB is an increasing issue which threatens the health and development of the continent..
R-6	WHO/AFRO carefully assess these three issues to identify areas for program strengthening.

i.7	The 2005-2009 Grant with its ten program areas is overly complex and does not maximize the potential for synergies within the WHO/AFRO USAID partnership.
R-7	In the 2010-2014 USAID Grant to WHO, decrease the number of program areas from ten to six . Select program areas for future partnership that best meet the following criteria: Clear documentation of the health need Evidence that the program is, in fact, effectively addressing the health need A clear vision of program goals, objectives, strategies, and monitoring and evaluation plan that will be undertaken over the next five years A full recognition of the roles and budgetary needs at the Country Ministry, the Country WHO Office, the Inter-Country Teams, and WHO/AFRO Definitive plans to maximize the WHO/AFRO USAID partnership including those of USAID's collaborating partners.

i.8	Maximum impact on health occurs when personnel and resources are provided at the country level. The team commends the WHO/AFRO policy on resource allocation as admirable and appropriate.
R-8	Budgetary allocations for the 2010-2014 USAID Grant should follow the current WHO financial allocation guidelines. 60% at Country level 20% at Inter-Country Level 20% at WHO Regional Office Level

i.9	A number of positions to be funded by the USAID grant have remained vacant for

	prolonged periods of time.
R-9	Annual reports should include a listing of positions that were designated for USAID support and the names of the persons filling those positions. Filling of currently vacant positions to be funded by the 2010-2014 USAID Grant should follow the guidelines recommended for the 2010-2014 USAID Grant above (Recommendations 7 and 8 above).

i.10	Since the introduction of IMCI, non-pneumonia cases of fever have been treated as malaria. The malaria indicator surveys using Rapid Diagnostic Tests (RDTs) are showing that only a small percentage of fever cases (10-30%) are in fact malaria (varies by country & season). Further reductions in under-five mortality beyond measles, pertussis, malaria, pneumonia and under-nutrition will require an improved understanding of unexplained fevers. A hospital study from Kenya on which blood cultures were obtained provides useful information (N Engl J Med. 2005 Jan 6; 352(1):39-47). In that study, Streptococcus pneumoniae, non-typhoidal salmonella, Haemophilus influenzae, Escherichia Coli, and Staphylococcus aureus were the most frequent isolations.
R-10	WHO should develop, with academic and research institutions, a strategy for assessing non-malaria causes of fever. This information will be needed to upgrade the IMCI protocol and, more importantly, IMCI effectiveness.

i.11	Pneumonia accounts for a significant proportion of non-malaria cases of fever. Several countries are not using the IMCI guidelines for diagnosis and treatment of pneumonia.
R-11	Diagnosis and treatment of pneumonia will significantly decrease under five mortality and contribute to the achievement of MDG 4. Cases meeting the IMCI definition for pneumonia should be treated with antibiotics. WHO has just issued new recommendations for the treatment of pneumonia at the level of first contact (community or health facility) (Lancet Infectious Diseases 9:185-196.).

WHO recommendations for early antimicrobial treatment of childhood pneumonia have been effective in reducing childhood mortality, but the last major revision was over 10 years ago. The emergence of antimicrobial resistance, new pneumonia pathogens, and new drugs have prompted WHO to assemble an international panel to review the literature on childhood pneumonia and to develop evidence-based recommendations for the empirical treatment of non-severe pneumonia among children managed by first-level health providers. Treatment should target the bacterial causes most likely to lead to severe disease, including Streptoccocus pneumoniae and Haemophilus influenzae.

The best first-line agent is amoxicillin, given twice daily for 3-5 days, although co-trimoxazole may be an alternative in some settings. Treatment failure should be defined in a child who develops signs warranting immediate referral or who does not have a decrease in respiratory rate after 48-72 hours of therapy. If failure occurs, and no indication for immediate referral exists, possible explanations for failure should be systematically determined, including non-adherence to therapy and alternative diagnoses. If failure of the first-line agent remains a possible explanation, suitable second-line agents include high-dose amoxicillin-clavulanic acid with or without an affordable macrolide for children over 3 years of age.

i.12	Choices as to priorities in health are increasingly determined by fund availability and

	allocation, rather than need.
R-12	WHO/AFRO increase its presence at decision level for Global Health Initiatives.

i.13	WHO/AFRO prepares comprehensive reports on each program component that serve the needs of multiple donors. Given the ever changing environment within USAID, these reports will contribute to the advocacy for continued funding of WHO/AFRO when they are referenced more directly to the contribution of the USAID grant and to the overall performance of the program component..
R-13	When submitting the comprehensive annual report to USAID, highlight the contribution of USAID funds to the results achieved by each component.

i.14	Many in WHO country offices are not aware of the scope of USAID health portfolio at the country level.
R-14	WHO /AFRO alert its country offices of potential opportunities of synergies through ongoing communication and collaboration with USAID and its cooperating partners.

i.15	Many in USAID are not aware of the strengths of WHO as a development partner at the country level.
R-15	USAID alert its missions of opportunities to collaborate with WHO.

6. CHALLENGES

The global economic crisis is having an adverse effect on health in Africa.

As the number of cost effective interventions available for health promotion, prevention, and development increase, development of sustainable strategies for implementation will be required. Ethiopia's training and deployment of 30,000 Health Extension Workers has great potential and merits careful monitoring.

Based on the Paris, Accra, and Ouagadougou declarations, the importance of partner leadership and coordination remains a challenge. WHO/AFRO has been tasked with leading the dialogue on Harmonization for Health in Africa among U.N. agencies in the African region.

7. CONCLUSION

The evaluation of the USAID Grant to WHO/AFRO for the period 2004 to 2009 was carried out in a participatory way jointly by USAID and WHO/AFRO team led by an independent expert. The evaluation report summarizes in the few pages here documents significant contributions to improvements in health status by African countries, WHO, and development partners. **T**he USAID Grant has contributed to WHO/AFRO's effectiveness in strengthening the capacity of African countries in improving the health of their people. The progress made by WHO, African countries and partners during the last five years and the changing health priorities require a reassessment of needs and opportunities for the next USAID Grant to WHO.

To consolidate achievements to date and accelerate efforts by African countries toward reaching the MDGs, it will be critical for WHO/AFRO and USAID to coordinate efforts with other UN and health development partners. The coordination between WHO/AFRO and USAID has been good. However, the potential for realizing a greater mutual benefit has not yet been fully tapped. To do so requires additional effort by the Bureau for Africa at USAID and WHO/AFRO to facilitate linkages at country, regional, and central levels to promote joint activities that further the common agendas of the two organizations. Similarly, the staff at each level within WHO/AFRO should take full advantage of the technical and financial contributions of USAID and its implementing mechanisms to the development and implementation of health programs in African countries.

II. WHO/AFRO AND USAID

WHO/AFRO - under the direction of the Regional Director Dr. Luís Gomes Sambo, is the recognised technical leader for health in Africa. Dr. Sambo has decentralised decision making to the Division Directors, Inter-country Teams (Libreville, Gabon; Ouagadougou, Burkina Faso; Harare, Zimbabwe) and to the WHO country offices. Each level has its own specific responsibilities.

Regional Office – Brazzaville

- Develop norms, standards, policies, guidelines
- Set the regional strategy
- Document and share best practices
- Provide technical support and back-stopping
- Plan, monitor, and evaluate the regional strategies

Inter-country Teams

- Provide technical and managerial support and contribute to strengthening capacity
- Engage with key partners at the sub-regional level
- Generate health knowledge and information and report back to CO and Regional Office (RO)
- Plan, monitor, and evaluate programs

WHO Country Offices

- Provide technical support in health and contribute to sustainable capacity strengthening
- Promote effective advocacy for the health dimension in socioeconomic and development process
- Support to Government to coordinate health partners at country level
- Coordinate technical and financial support from IST, RO, and HQ
- Plan, implement, monitor and evaluate WHO country activities

USAID - as the primary conduit of non-military foreign assistance for the U.S. Government, USAID supports health development through multiple channels:

- Bilateral Agreements at the country levels – USAID Missions in countries
- Regional programs managed by Regional Bureaus, and
- Specialized technical projects administered by the Global Health Bureau

In addition, a part of USAID's portfolio is devoted to special initiatives including the President's Emergency Program for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI).

Among the regional programs, the Bureau for Africa has provided support to WHO/AFRO in a series of grants (1994-1998, 1999-2003, and 2004-2009). As indicated on the next page, the current grant and the subject of this evaluation supports WHO infrastructure (primarily personnel) at country, inter-country, and regional levels.

WHO/AFRO AND USAID COLLABORATION BY LEVEL		
LEVEL	**WHO FUNCTION**	**USAID GRANT**
Community	• Promote Universal Access	
Country	• Provide technical support to health • Promote effective advocacy for the health dimension in socioeconomic and development process • Support to Government to coordinate health partners at country level • Coordinate technical and financial support from ICST, RO, and HQ. • Plan, implement, monitor and evaluate WHO country activities • Provide technical and managerial support and contribute to sustainable capacity building	Technical Assistance 1. National Professional Officers 2. Inter-Country Support Team Members 3. WHO/AFRO Team Members Country Support
Inter-Country	• Engage with key partners at the sub-regional level • Provide TA in response to country requests • Facilitate inter-country and cross-border collaborative activities • Generate health knowledge and information and report back to country and region • Plan, monitor, and evaluate programs	Inter-Country Support Team Members and Technical Support
Region	• Develop norms, standards, policies, guidelines • Set the regional strategy • Liaise with WHO Headquarters, governing bodies, and partners • Oversee and control quality of Inter-Country Support teams and Country Office • Document and Share best practices • Provide technical support and back-stopping • Plan, monitor, and evaluate the regional strategies	Program Area Support o Surveillance and Response (IDSR) o Family Planning and Reproductive Health o Newborn, Child, Adolescent Health o Immunisation, Nutrition o Malaria, HIV, TB o System Strengthening

III. OBJECTIVES OF THE EVALUATION

GOALS

1. Assess and document the accomplishments and lessons learned over the last five years of the grant.
2. Review the grant financing and management arrangements as well as monitoring and reporting of activities implemented under the grant.
3. Provide guidance on ways to design a new five year grant in light of the findings of the assessment and changes within WHO/AFRO and the region as a whole.

Objectives identified in the Grant Scope of Work

1. Controlling malaria within the context of Roll Back Malaria (RBM) so that by the year 2030, malaria will neither be a major contributor to mortality and morbidity, nor of significant socioeconomic consequence in Africa.
2. Contributing to the reduction in childhood morbidity and mortality from common childhood illnesses such as pneumonia, diarrhea, malaria, measles, and malnutrition.
3. Strengthening immunisation systems within the current context of polio eradication and disease control initiatives in Africa, to reach a higher level of sustainable routine immunisation coverage.
4. Controlling tuberculosis with an emphasis on community-based action as well as TB/HIV activities in selected countries.
5. Contributing to an effective IDSR system that enables improved forecasting and detection of epidemics, enhanced quality of planning, rational resource allocation, and improved monitoring and evaluation of intervention programs.
6. Improving maternal and newborn health through increased accessibility to skilled attendance during pregnancy and childbirth.
7. Contributing to reduction of maternal mortality through the repositioning of family planning programs into maternal and child health programs.
8. Contributing to the reduction in childhood morbidity and mortality by scaling up pediatric HIV/AIDS prevention and control interventions.
9. Contributing to the achievement of MDG-4 and MDG-5 through improved nutrition for vulnerable groups including pregnant women, lactating mothers, infants and young children.

For Reference: MDG 4, MDG 5, MDG 6

MDG4 -Reduce child mortality Reduce by two-thirds, between 1990 & 2015, the under-five mortality rate.

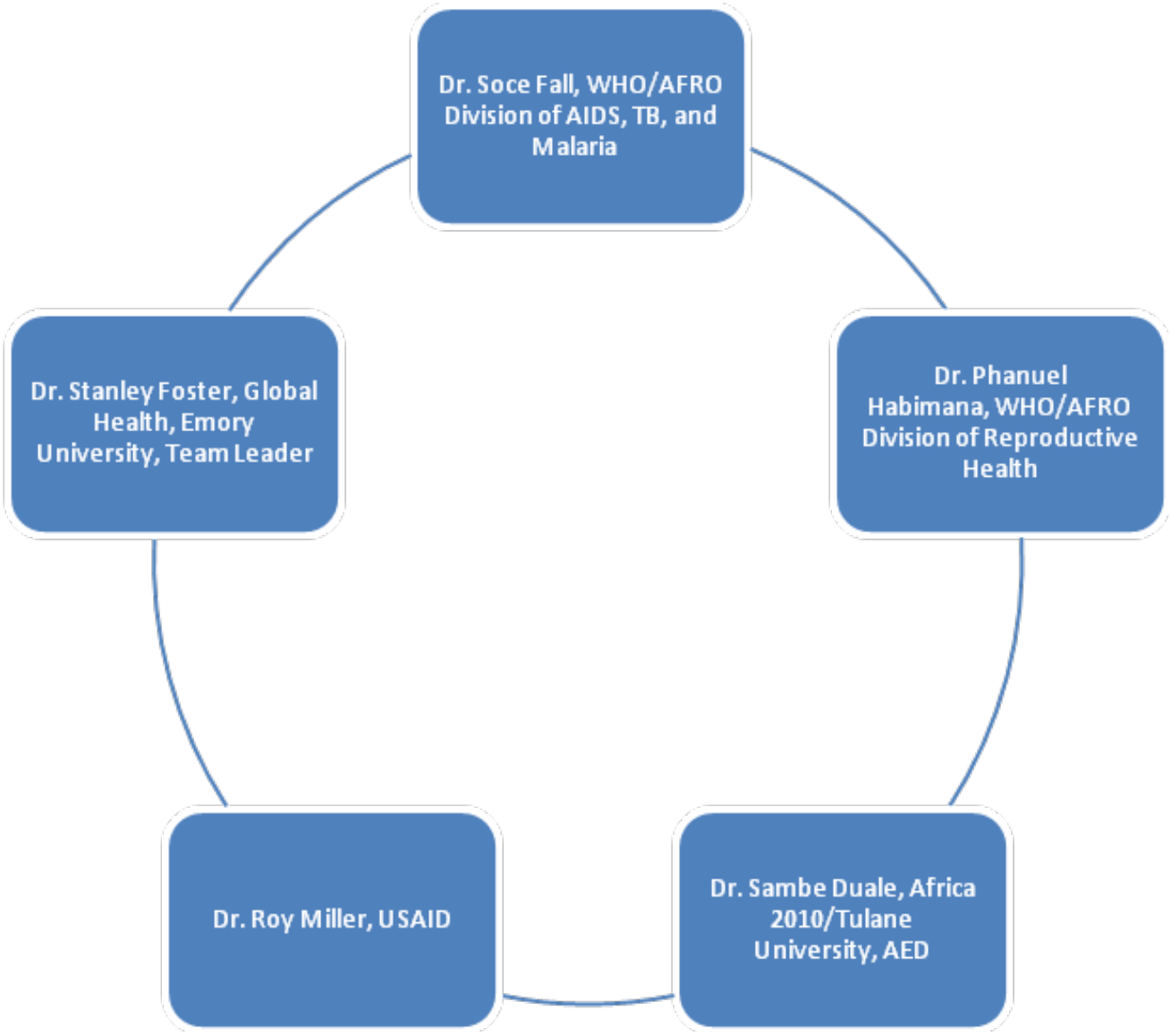
MDG 5-Improve maternal health Reduce by three quarters, between 1990 &2015, the maternal mortality ratio and **Achieve,** by 2015, universal access to reproductive health.

MDG 6 - Combat HIV/AIDS, Malaria, and other diseases have halted by 2015, the rise in HIV and begun to reverse the spread of HIV/AIDS.

IV. SCHEDULE OF THE EVALUATION

THE TEAM

In consultation between WHO and USAID, a five person team was selected for the review.



Schedule of Work

The review took place from May 5- June 30, 2009.

5-7 May
Briefings by USAID Africa Bureau health team and one-on-one discussions with key partners (e.g. Selected USAID Cooperating Agencies, U.S. Centers for Disease Control and Prevention, and the World Bank)

12 May
Plenary presentation of review objectives and scope of work
Briefing by Division of Finance
Briefing by Division of Health Systems Development (DSD)
Meeting with the Regional Director

13 May
Briefing by Division of AIDS, Tuberculosis, Malaria (ATM)
Briefing by Division of Reproductive and Family Health (DRH)
Briefing by Division of Communicable Disease Control and Prevention (DDC)
Briefing by the Director of Program and Management (DPM)

14 May
Attend an H1N1 briefing
Phone consultation with Inter-Country Support Team for West Africa in Ouagadougou, Burkina Faso
Interviews with Key Resource Persons
Team 1 departs for the Democratic Republic of Congo

14 May to 22 May
Team 1 to DRC and Liberia
Team 2 to Kenya and Ethiopia

25 May to 27 May
Writing of Draft Report

28 May
Debriefing with WHO/AFRO Staff

29 May
Follow Up Individual Unit Meetings

1 June to 30 June
Finalise Report

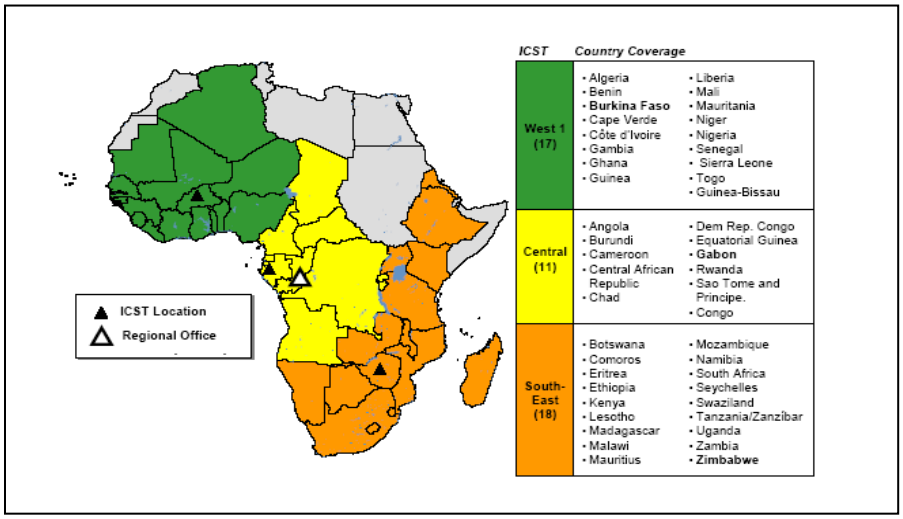
V. WHO/AFRO INTERCOUNTRY SUPPORT TEAMS (ISTs)

The three ISTs are an extension of the Regional Office and were created to provide high-level technical support to countries for addressing programmatic challenges. The core programs for each IST MDGs are the following: Health Systems, Disease Surveillance, Alert to Epidemics and Response, Emergencies and Humanitarian Action, Health Promotion, Maternal Health, Child Health, HIV/AIDS, Tuberculosis and Malaria. Inter-country support teams also include a strengthened managerial capacity through the provision of professional management and administrative support to countries.

ISTs support countries to scale up interventions towards attaining the MDG, strengthening partnerships with the various United Nations agencies, the Regional Economic Communities (RECs), and other partners for the common purpose of improving the health of the people in the African Region.

The ISTs are located in Harare, Zimbabwe, covering 18 Eastern and Southern African countries; Libreville, Gabon, covering 11 Central African countries; and Ouagadougou, Burkina Faso, covering 17 West African countries, Figure 1.

Figure 1: IST Locations and countries covered



ICST	Country Coverage	
West 1 (17)	• Algeria • Benin • **Burkina Faso** • Cape Verde • Côte d'Ivoire • Gambia • Ghana • Guinea	• Liberia • Mali • Mauritania • Niger • Nigeria • Senegal • Sierra Leone • Togo • Guinea-Bissau
Central (11)	• Angola • Burundi • Cameroon • Central African Republic • Chad	• Dem Rep. Congo • Equatorial Guinea • **Gabon** • Rwanda • Sao Tome and Principe. • Congo
South-East (18)	• Botswana • Comoros • Eritrea • Ethiopia • Kenya • Lesotho • Madagascar • Malawi • Mauritius	• Mozambique • Namibia • South Africa • Seychelles • Swaziland • Tanzania/Zanzibar • Uganda • Zambia • **Zimbabwe**

Current (May 2009) staff levels at ISTs are as follows:
IST Harare: 101 staff members (54 Professionals; 4 NPOs, 43 GS);
IST Libreville: 59 staff members (38 Professionals; 2 NPOs, 19 GS);
IST Ouagadougou: 72 staff members (46 Professionals; 3 NPOs; 23 GS);

Total number of staff members in the three ISTs: 232

Expected benefits of the ISTs
These include: improved quality and cost-effectiveness of support by leveraging a broader pool of expertise, reduced response time to requests for support, greater cross-fertilisation and collaboration across programs and country experiences, increased ability to respond to and engage with partners at sub-regional level, increased implementation rate of programs and greater achievement of expected results and technical platform adapted to specific sub-regional needs.

IST for West Africa
As part of the evaluation, the evaluation team held a conference call with the IST Coordinator and three IST team members in Ouagadougou.

What is the unique role of IST? Its comparative advantage in terms of work, responsibility, functions?
IST/WA supports 17 countries and acts as an interface to sub-regional organisations (WAHO, UEMOA, CILSS) and other UN agencies. The IST coordinator represents the RD at the UN Regional Directors Teams' meetings in Dakar. IST hosts 19 health programs, 72 staff (46 Professionals; 3 NPOs; 23 GS). On average 15% of IST staffs' time is spent in Ouagadougou and 85% at the country levels.

What are examples of country support provided by IST?
Making Pregnancy Safer (MPS): Development of the Sexual and Reproductive Health (SRH) Policy for the Republic of Liberia. The mission provided i) Transfer of skills in policy development; ii) key issues to consider; iii) prioritisation of strategies and interventions; iv) engaging stakeholders in the policy development process; v) definitions of roles in the implementation of the policy; and vi) identification of linkages between SRH Policy and other national health system development instruments. Country support missions also allow the staff to address cross-cutting issues, strengthen the collaboration between units, avoid duplication and maximise resources.

Meningitis: IST supported the 3 countries most affected by this season's outbreaks (2009) in terms of surveillance and response to the epidemics. In Nigeria, a sensitisation meeting was organised with State Ministers of Health from 26 northern States. They were briefed on the importance of their involvement and commitment, their role and responsibilities in the response to the epidemic, and in coordinating the various interventions of partners etc. This was followed by training on Standard Operating Procedures (SOPs) for meningitis surveillance for 4 staff members from each of the 26 States (surveillance officers, primary health care officers, lab technicians and clinicians). The IST conducted many supervisory visits for investigation at State and LGA levels in terms of case detection, case management, lab confirmation, mass immunisation and organisation of the epidemic response. The IST also provided support to Niger and Chad in terms of meningitis response. The IST is currently planning to hold a national workshop in Burkina Faso for the introduction of the new conjugate vaccine targeting the 1-29 year olds. If everything goes as expected, the campaign will be conducted Q4 2009.[1]

[1] Repeated in Surveillance Response section below.

Malaria: The last mission in Niger was to obtain evidence-based strategic orientation to the set of activities to be included in Round 9 Global Fund grant proposal. Two IST officers supported Ghana at the beginning of the process to develop a new strategic plan.

The Obama administration is favourable to finance development in Africa. Where do you think funds should be allocated? In USAID missions or WHO? If WHO, what are the comparative advantages?

Country presence and unique role as MOH advisor
Unique technical expertise of WHO on health issues
Many programs working in WHO (MPS, SRH, CAH, HIV, MAL, CDS/EPR, IVD, etc.)
Ready work-plans waiting to be funded
Knowledge in handling large donor contributions, in working with partners, in providing technical and financial reports

Can you tell us about the quality of your work in terms of quality assurance at health facility, community levels?

WHO contributes to quality assurance through: i) capacity building to develop human resources i.e., curricula development, training material etc.; ii) development of norms and standards and subsequent support for the adaptation and adoption of the tools at country level; and iii) generation of data, data analysis and feed back to inform decisions. For some programs, there are specific mechanisms for quality assurance.

Making Pregnancy Safer: Maternal death reviews are one way of monitoring and improving the quality of care. When the maternal death review reports are well analysed and feedback provided, decisions for improving the quality of care can be taken. In Mauritania, for example, the reports from the maternal death reviews motivated the government to make resources available to deploy specialists to the rural areas to increase accessibility and availability of emergency care.

ISTs are the first line of support to countries in the up-coming challenge to scale up their capacities to assure quality of generalised diagnosis and treatment of malaria and continue their monitoring of drug and insecticides resistance.

In terms of laboratory, the IST staff developed both the Internal and External quality assessment schemes to monitor national laboratory performances. For example:
Monitoring of antimicrobial resistance
Mapping the distribution of pathogens as well as their types and subtypes in the sub-region
Creating regional strain banks for onchocerciasis, meningitis and cholera at the WHO Multi Disease Surveillance Centre's laboratory.

IST West Africa:
Dr Bocar Touré, IST Coordinator
Dr Seipati Mothebesoane - Anoh, Making Pregnancy Safer program (MPS)
Dr Jean Olivier Guintran, Malaria program (MAL)
Dr Mamoudou H. Djingarey, Immunization and Vaccine-Preventable Diseases(IVD)

VI. WHO/AFRO PROGRESS TOWARD EXPECTED RESULTS

a. INTEGRATED DISEASE SURVEILLANCE & RESPONSE (IDSR)

CONTEXT

Reviewing WHO/AFRO in the context of the USAID Grant had as an initial step, an assessment of each of the 10 program components regarding their relative role within the larger framework of health development in Africa. From this analytic approach, IDSR, is pre-eminent in several respects:

- Data are key to the assessment, planning, implementation, monitoring, and evaluation of health activities
- At the time of the evaluation, there was no timely and publicly accessible summary of disease data by district or country at WHO/AFRO. Such data are essential to the identification and control of disease hazards.
- WHO/AFRO is the only organisational structure that has the mandate and capacity to provide such services
- Surveillance is the process by which cases of disease are identified, investigated, reported and shared. Surveillance is data for action and done correctly can significantly reduce morbidity and mortality.

IDSR is at the moment in a period of transition

- The unit at the regional office has lost four key personnel to appointments as WRs; their positions in the unit are just now being filled.
- The unit has recently been divided into separate units (surveillance & response)

OBJECTIVES OF IDSR[2]

- Integrating and coordinating vertical surveillance programs to generate high quality, timely and meaningful information for prompt public health action
- Promoting IDSR requires an investment in infrastructure at community, district, country, and Inter-country levels
- Supporting the building of International Health Regulations (IHR) core capacities and implementation at all levels
- Developing standards, norms, methodologies for disease recognition, reporting, and response
- Supporting a national public laboratory network including quality assurance schemes for priority pathogens
- Supporting introduction of IDSR in learning courses, research agenda, and practices
- Aiding health system development

SURVEILLANCE

- According to the 2009 Strategic Plan, 43 of 46 countries are in the process of implementing IDSR; 33 have functioning surveillance systems with weekly or monthly bulletins

[2] WHO/AFRO Communicable Disease Surveillance Program Overview.

- 72 laboratories in 45 countries are participating in bacteriology quality control; 15 laboratories are qualified to test influenza specimens by PCR.
- As part of the country review in Kenya, Kenya's IDSR was visited. With strong leadership from WHO, the system is functioning. The weekly report for May 10th was available at the time of the field visit, May 17. During the country review in Ethiopia, the Disease Prevention and Control (DPC) team in the WHO CO made a presentation to the evaluation team on the critical support that USAID has provided for IDSR implementation in the country over the years.
- In February of 2009, an independent review of Kenya's IDSR was carried out by a joint WHO (HQ &IST), UNICEF/ESARO, and CDC team. Findings were as follows: "Kenya has adapted IDSR strategy that was built on the AFP surveillance platform and progressively built a strong surveillance of 18 priority diseases/conditions since 2003. Furthermore through sentinel surveillance, other conditions are monitored for action such as meningitis, rotavirus, and influenza, AFP, measles, NNT, and YF. Public and most private facilities report regularly and result in appropriate action where required."[3]
- WHO regional surveillance data are maintained on a special server not accessible on the web. Transparency with open access is essential to effective regional disease surveillance and response.

EPIDEMIC RESPONSE

- WHO staff have strengthened national responses to epidemics (Meningitis in Nigeria & Burkina Faso, Measles in Burkina Faso, Cholera, Ebola, and Yellow Fever).
- **Meningitis:** IST supported the 3 countries most affected by this season's outbreaks (2009) in terms of surveillance and response to the epidemics. In Nigeria, a sensitisation meeting was organised with State Ministers of Health from 26 northern States. They were briefed on the importance of their involvement and commitment, their role and responsibilities in the response to the epidemic, and in coordinating the various interventions of partners etc. This was followed by training on Standard Operating Procedures (SOPs) for meningitis surveillance for 4 staff members from each of the 26 States (surveillance officers, primary health care officers, lab technicians and clinicians). The IST conducted many supervisory visits for investigation at State and LGA levels in terms of case detection, case management, lab confirmation, mass immunisation and organisation of the epidemic response. The IST also provided support to Niger and Chad in terms of meningitis response. The IST is currently planning to hold a national workshop for Burkina Faso for the introduction of the new conjugate vaccine targeting the 1-29 year olds. If everything goes as expected, the campaign will be conducted Q4 2009.

[3] Kenya External Surveillance Review – Jan-Feb 2009.

- Figure 1 shows the meningitis epidemic curve for 2007-2009. Figure 2 shows the increased timeliness of reporting for 2007, 2008, and 2009.

Figure 1

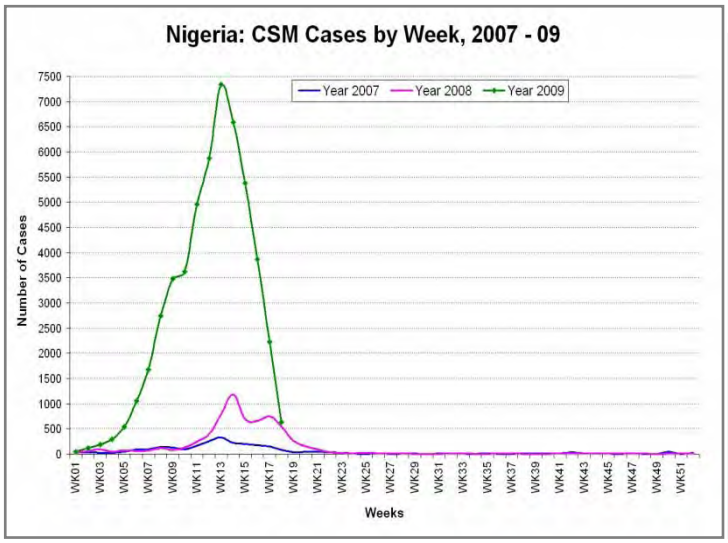
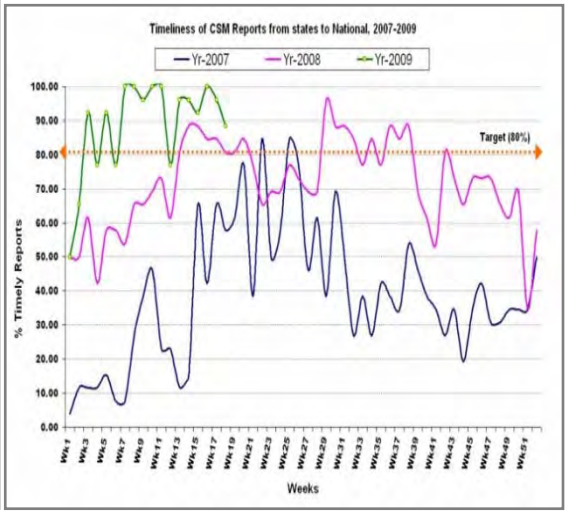


Figure 2



- Epidemic preparedness for H5N1 has been skillfully adapted to H1N1 risk. An evaluation team member attended one of the daily H1N1 briefings and was very impressed by the agenda and careful deliberations.

RECOMMENDATIONS

- Once the new staff are on board, convene a joint WHO/CDC review of IDSR to address the following:

  Review the 2009-2013 Surveillance Strategic Plan regarding its ability to meet the requirements of the International Health Regulations and the Objectives stated above at country, Inter-country, and regional levels.

  Identify the steps needed to have real time collection of reporting (district and country) and disease on a weekly basis at the regional level.

  Explore the benefits to WHO/AFRO of a weekly on-line Epidemiologic Bulletin for advocacy, epidemic alerts, sharing of country data, and continuing education.

  Review plan to maintain laboratory quality control.

  Effective regional surveillance is dependent on effective surveillance at the country level. The review team needs to identify the country level elements essential for effective surveillance and response. Allocation of up to 20% of IDSR grant funds for country level surveillance should be considered.

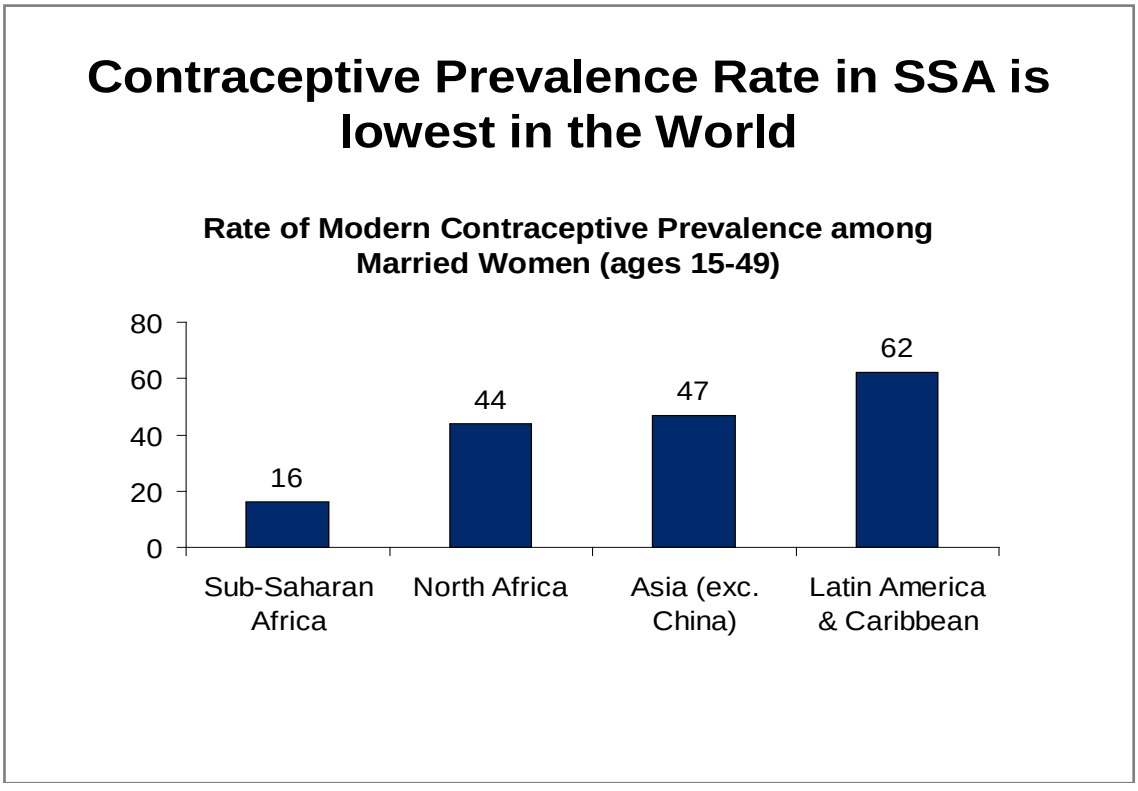
b. REPRODUCTIVE HEALTH & FAMILY PLANNING

CONTEXT

The primary focus of WHO/AFRO's work in Reproductive Health (RH) and Family Planning (FP) was established when the WHO Regional Committee of Health Ministers for Africa adopted the 10 year framework for Repositioning Family Planning ***"Repositioning Family Planning in Reproductive Health Services – Framework for Accelerated Action 2005-2014"*** through Resolution AF/RC54/R2 in 2004. High levels of fertility not only threaten the health of the mother and child; the resulting rapid population growth places undue stress on the economy, the education sector and the agriculture sector. Following adoption of the resolution, WHO developed evidence-based guidelines and tools to support countries in the development of the necessary skills in SRH service delivery and to implement this 10 year RFP framework. Special attention has been given to adolescent health.

Epidemiology

As seen in the following chart, the use of modern methods of contraception in Africa is lower than any other region of the world.



The contraceptive prevalence rate in USAID focus countries is shown in the following Table 2:

Trends in Modern Contraceptive Prevalence Rates in Selected Countries in sub-Saharan Africa

	1st Survey	2nd Survey	3rd Survey	4th Survey
DR Congo	4.0 (2001)	6.0 (2007)		
Ethiopia	6.3 (2000)	13.9 (2005)	35.0 (2008)	
Kenya	17.9 (1989)	27.3 (1993)	31.5 (1998)	31.5 (2003)
Madagascar	5.1 (1992)	9.7 (1997)	18.3 (2003)	26.9 (2008)
Malawi	7.4 (1992)	26.1 (2000)	28.1 (2004)	
Mali	1.3 (1987)	4.5 (1992)	5.7 (2001)	6.9 (2006)
Nigeria	3.5 (1990)	8.6 (1999)	8.2 (2003)	9.7 (2008)
Rwanda	12.9 (1992)	5.7 (2000)	10.3 (2005)	27.4 (2007)
Tanzania	6.6 (1992)	13.3 (1996)	16.9 (1999)	20.0 (2004)
Uganda	2.5 (1988)	7.8 (1995)	18.2 (2000)	17.9 (2006)
Zambia	8.9 (1992)	14.4 (1996)	22.6 (2001)	32.7 (2007)

Note: Data for Nigeria 1999, Rwanda 2007 and Zambia 2007 are from DHS reports. Data for DR Congo 2001 are from MICS. The 2008 figure for Ethiopia is an estimate based on service statistics.

All other data points are from DHS Surveys (Statcompiler).

Objectives

1. Improve country capacity to adopt and implement a strategic approach for sexual and reproductive health (SRH) and repositioning family planning
2. Integrate FP, PMTCT and MNCH services at district & country levels
3. Strengthen linkages between SRH and STIs/HIV
4. Strengthen regional capacity to provide support to countries to scale up family planning services

Achievements

Improve country capacity to adopt and implement a strategic approach to sexual and reproductive health

WHO developed an advocacy toolkit and has conducted two sub-regional workshops reaching 19 countries to introduce the tools and train teams from the countries in their application at country level. Sixteen consultants were oriented on the process of supporting countries in Adolescent Health and Development. This orientation focused upon expansion of Adolescent Friendly Health Services (AFHS) in general and prevention of unwanted pregnancies and provider initiated counselling and testing for HIV in particular. A regional consultation of experts on community-based interventions on adolescent health (ADH) was held in February 2008 in Accra, Ghana. Thirty-one participants came from WHO, UNICEF, Population Council, UNFPA, London School of Hygiene and Tropical Medicine, MOHs, NGOs and Youth Associations from Burkina Faso, Mozambique,

Tanzania, Zimbabwe, Namibia, Mauritania, Senegal, Ghana and Kenya. Based on the experiences shared at the consultation, including the tools developed and used for the community component in project implementation, the outline and format for a guideline on community interventions for youth-friendly health services has been drafted, and the guideline is currently under development.

A training of trainers in FP was done in Gabon, Cameroon and Lesotho**.** The development of updating the national strategic plan in SRH was done in Angola, Lesotho and Rwanda, and it is ongoing in Botswana.

Integrated FP, PMTCT and MNCH services at country and district levels and strengthened linkages between SRH and STIs/HIV

WHO and UNFPA developed an implementation framework for the Integration of SRH, FP, MIP, PMTCT and NUT. The last version is being finalized and will soon be ready for the countries to utilise to hasten the process of integration of programs and services. A total of 20 experts, including partners, were oriented on integration of FP into MNCH services in 2007. In 2008, support was provided to Burkina Faso, Togo and Zambia for the implementation of this framework.

Technical assistance was provided in the development of the training manual on FP called: Contraceptive Technology in Cameroon. The material will be pre-tested before the end of 2009.

HIV/AIDS and FP are part of the minimum package of AFHS. The process of implementing this package has begun in several countries including DRC, Gabon, and Sao Tome and Principe.

Strengthened regional capacity to provide support to countries to scale up FP services

The Regional Office has recruited 2 Regional Advisors for Reproductive Health Research (RHR) and Reproductive Health Training (RHT)/Family Planning respectively, who took up the posts in 2007. The presence of these two medical officers, backed up by the three ISTs, has facilitated the timely availability of technical assistance in response to country needs including acceleration of the implementation of FP programs and hastening the progress of integration of FP and STIs /HIV programs into RH services.

Technical support was provided to countries on ADH through the recruitment of a Regional Advisor from 2004-2007.

Barriers

One of the barriers to successful implementation of SRH programs and FP is the persistence of traditional beliefs and customs. Bringing about behaviour change in the context of the sexual practices of families requires arduous and continuous efforts.

The unmet need for FP services is very high in most African countries. One of the limiting factors in meeting this unmet need is the provision and distribution of FP commodities. This is a problem not only of resources but also of logistics.

Opportunities

The new Administration in the United States has relaxed some of the restrictions on the use of funding for RH and FP and has indicated that financial resources in this area will be increased. The

availability of resources coupled with effective advocacy may accelerate efforts to slow the rapid growth of population in many African countries.

The shift in the focus of advocacy efforts for FP to emphasise the negative effects of rapid population growth on the ability of a country to feed its people and to sustain economic growth is beginning to break down some of the opposition to family planning on the part of African officials.

c. MATERNAL AND NEWBORN HEALTH

CONTEXT

The levels of maternal, newborn and child morbidity, mortality and malnutrition in the African Region remain unacceptably high despite the availability of proven effective interventions. The maternal mortality estimates for 2005 indicate that the decline between 1990 and 2005 in SSA was only 0.1% per year. In order to start reversing this trend, a ***Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Africa*** (Road Map) was developed by partners in February 2004. The "Road Map" was adopted by the African Health Ministers at the WHO Regional Committee RC54 in 2004, making it the key regional strategy for maternal and newborn mortality reduction in the African Region.

The main thrust of the "Road Map" is to increase the availability of skilled care attendance and to strengthen the capacity of individuals, families and communities to improve maternal and newborn health. Converging around the "Road Map" partners, including USAID and cooperating agencies, have deployed resources to improve maternal and newborn health.

However, progress in scaling up maternal and newborn health interventions is hampered by the lack of technical capacity in the development and implementation of maternal and newborn health programs as well as the insufficient and inadequate resource allocation at the country level.

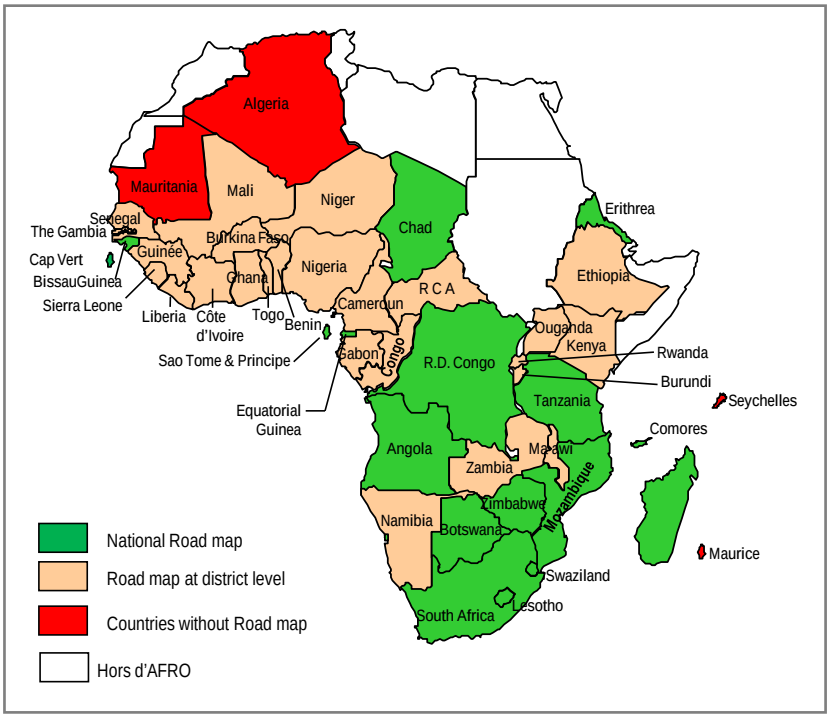
In response to the above challenges, the USAID grant focused on the capacity for the implementation of key maternal and newborn mortality reduction interventions at the regional, sub regional and country levels.

KEY ACHIEVEMENTS

1. Strengthen capacity for the implementation of the Road Map for maternal and newborn mortality reduction at country level

Capacity for MPS activities at country level was strengthened by recruiting and maintaining NPOs in Angola, Mozambique, Nigeria, and Tanzania during the period 2004-2007 and since 2008 in Ethiopia and Nigeria. To date, in these 4 countries, the Road Map is elaborated, adopted, and costed; the Road Map is being implemented through a joint budget plan involving all partners.

Since adopting the Road Maps for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in 2004 by MOH, most of the WHO/AFRO countries have been supported to develop/update their national maternal and newborn mortality reduction strategies bringing the total number of countries with a national Road Map to 42, as shown in the Figure below.



In order to strengthen supervision, monitoring, and evaluation, support has been provided to build the capacity of participants from eleven francophone countries[4] on **Maternal and Perinatal Deaths Review (MDR)**. The maternal and newborn mortality audits, at facility and community levels provide the opportunity to undertake a systematic and critical analysis of the quality of medical care including the procedures used, adherence to established standards of care and the failure to timely access and receipt of appropriate care. As a positive outcome of the workshop, some countries have started the institutionalisation of MDR at facility and community levels and many countries are requesting orientation on MDR.

MOH program managers and WHO staff from 15 countries[5] were introduced to the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines.

Scale up of EmONC training in 15 countries.[6]

Capacity built on Focused Antenatal Care (FANC) for 58 participants from eight countries including Gabon, Ghana, Kenya, Mali, Niger, Rwanda, Tanzania and Zambia.

Capacity strengthening on newborn care: Five inter-country workshops for Maternal and Child Health Managers and Policy makers from Ministry of Health and partners at country level, covering 31 countries have been conducted for capacity strengthening in integration of newborn health into maternal and child health services. As a result, countries have adapted IMCI materials to include the **early** newborn health (the first seven days of life) and many have revised their Road Maps to articulate the newborn component; 5 have conducted situation analysis for newborn care.

[4] Mauritania, Mali, Burundi, Cameroon, CAR, Congo, DRC, Gabon, Madagascar, Rwanda, Chad.

[5] Kenya, Namibia, Angola, Ghana, Malawi ,Mozambique, Nigeria ,Swaziland, Botswana, Sierra Leone, South Africa, Tanzania, Uganda, Eritrea. Ethiopia.

[6] Benin, Burkina Faso, Ethiopia, Gabon, Gambia, Ghana, Guinea Bissau, Madagascar, Mozambique, Niger, Nigeria, Senegal, Tanzania, Uganda and Zimbabwe.

In addition, TOTs capacity strengthening was conducted for 80 experts from 13 countries on the **essential newborn care** (ENC) course. As a result, 10 countries have organised national ENC trainings for 20-25 health workers each. Seven countries have scaled up the training to district/provincial levels.

A consensus has been reached on the Essential Competencies for a skilled attendant in the African region. The list of competencies has guided the revision of midwifery curricula in Malawi, Tanzania, Nigeria and Ethiopia.

PMTCT Capacity strengthening at regional and national levels

Prevention of mother to child transmission of HIV is a critical component in the implementation of 3 key strategic orientations in WHO/AFRO, all endorsed by Member States in the African Region: the Road Map For Accelerating the Attainment of the Health related MDGs for Maternal and Newborn Health; the Child survival strategy; and the HIV prevention strategy . The efforts towards prevention of HIV infection among infants are guided by UN recommendations. PMTCT interventions are entry points for HIV-positive pregnant women and their families to access care, antiretroviral therapy and psychosocial support services. Through the support of the Regional Advisor, partially paid by the USAID grant (complemented by WHO funds), 17 countries[7] were supported in scaling up PMTCT activities including integration of PMTCT into maternal, newborn and child health services, access to antiretroviral therapy, training in the adaptation of the WHO PMTCT generic curriculum and the development of roll-out plan for training. The presence of the regional PMTCT Advisor has been instrumental in the support to partner initiatives for scaling up PMTCT in 7 countries (Rwanda, Malawi, Zambia, Tanzania, Burkina Faso, Cote d'Ivoire and Cameroon) that are receiving logistical support through the UNITAID initiative. Nine countries are receiving CIDA support for comprehensive PMTCT implementation.

2. Development of guidance tools

The following tools have been developed in collaboration with partners including USAID and its cooperating agencies:

A Framework for the integration of PMTCT, FP, MIP and NUT into MNCH services

A guide for use by French-speaking providers titled «Recommandations pour la pratique clinique (RPC) des soins obstétricaux et néonataux d'urgence (SONU)[8]en Afrique »

A guide for the operationalisation of the Road Map for accelerated reduction of maternal and newborn mortality in French

A framework for developing integrated health promotion actions at community level was finalized in collaboration with HPR/DNC.

[7] Angola, Burkina Faso .Cameroon, Kenya, Lesotho, Mali, Malawi, Nigeria, Senegal, Cote d'Ivoire, DRC, CAR, Uganda, Swaziland, Tanzania, Zambia and Zimbabwe.

[8] Soins Obstétricaux et Néonataux d'Urgence.

3. Advocacy on reduction of maternal and newborn mortality at regional and country levels

Nomination of Goodwill Ambassador

Since her nomination in 2002 as Regional MNH Goodwill Ambassador, Gertrude Mongella undertook different missions to increase awareness of maternal health situation in the African Region with the support of USAID including i) accompanying the Regional Director and DRH to the African Union (AU) to advocate for maternal health resulting in the establishment of the AU/AFRO working group on maternal health. This group developed the AU Road Map for maternal mortality reduction in Africa; ii) presentation of an advocacy speech on renewed focus on newborn health at the Healthy Newborn Partnership meeting in Addis Ababa. This brought the plight of Africa's newborns to the forefront.

Increasing advocacy for maternal and newborn health at country level

MPS supported countries to increase public awareness and draw support from the highest level of decision-makers using various means. Twelve countries[9] were supported to develop REDUCE/ALIVE advocacy tools and national advocacy plans. Countries are now using the tool to increase awareness and commitment at the highest level. As a result, MNCH strategies (Road Map) are part of the Poverty Reduction Strategic Plan (PRSP). Thirteen[10] countries were supported in institutionalisation of the **National Safe Motherhood** day or week. Madagascar was supported to hold a **Presidential Initiative Forum** for briefing 3,000 women's leaders on RH.

4. Documentation and dissemination of "Best Practices in Making Pregnancy Safer"

A number of best practices[11] on improvement of quality of MNCH care including community participation were documented. This was done in three Francophone countries (Rwanda, Mauritania and Guinea); 5 Anglophone countries (Eritrea, Uganda, Nigeria, Zambia, Tanzania) and one Lusophone country *(*Mozambique*)* .

The findings are used to guide policy or to improve MNCH program implementation. As an example the "Maama Kit" which was first implemented in Uganda has now been adopted in Mozambique. In Uganda, the evaluation of the "Maama Kit" was found very useful in ensuring that mothers deliver children in a clean and safe environment and the MOH decided to incorporate it under the Essential Medicine List.

The major lessons learnt drawn from the documentation of the various best practices are as follows:

Leadership and high level commitment, as well as the determination to succeed, can drastically reduce maternal mortality. The SOROTI MPS initiative was implemented in Uganda and after

[9] Burkina Faso, Cameroon, Ethiopia, Ghana, Mali, Niger, Nigeria, Senegal, Tanzania,Togo, Uganda and Zambia.

[10] Angola, Uganda, Mali, Ethiopia, Benin, Burkina Faso ,Cameroon,Kenya, Chad ,Comoros ,Eritrea ,Gabon ,Mauritania.

[11] Rwanda experience in scaling up MNH interventions; Eliminating Female Genital Mutilation Through Community Initiatives: Eritrean success story; Implementing the MPS initiative in Soroti district ,UGANDA; Maama kit for making child birth clean and safer; Building zero tolerance for Maternal and infant deaths in Nigeria ; Delegation of competence in major obstetric surgery: Experience of mid-level providers in Mozambique.

only five years MMR was reduced from 885/100,000 live births in 2000 to 221/100,000 live births in 2006.

Referral networks, established with the full participation of the community, have ensured that complications and emergencies are responded to promptly.

Community involvement and participation since the planning stage is critical for the success of MPS implementation.

5. Operational Research

A study on the situation analysis of obstetric fistula in the Gambia has been conducted in collaboration with the MOH and UNFPA. The survey covered 5,000 households in urban and rural areas of the Gambia. The facility survey included all health facilities where delivery care is provided. The general objective was to identify the magnitude of fistula prevalence, evaluation and quality of EmONC facilities, and assess the awareness of communities of obstetric fistula and the associated socio-cultural factors which contribute to the occurrence of fistula. Findings of the study include:

The highest incidence of fistula (80 %) was in rural areas.

Fistula was found to be a stigmatizing factor in all of the Gambia.

Decision-making power of a woman to go to a health institution was 20.1% (versus 42% for the husband and 16 % for the mother in law).

Only 1.7% to 20% of pregnant women knew danger signs. Transportation, absence of 24 hours services in the health facilities, human resources shortage were the major barriers to access to EmONC.

Transportation, absence of 24 hours services in the health facilities, human resources shortage were the major barriers to access to EmONC.

All the three delays were associated with the occurrence of fistula (decision-making, perception of the community and traditional healers that a married woman who dies in child birth would go to heaven).

Two formative Research Studies on Maternal and Newborn Care at the community Level have been conducted in Tanzania and Zambia. The studies explored issues and community practices from the time a woman gets pregnant through delivery and care of the newborn. The two reports are available and show the importance of this approach in improving the policies and programs defined at country level for better health of mother and babies. The assessment tool which was one of the main outputs of this study is available for use by countries.

A Household Survey (HSS) tool has been developed to measure coverage and delivery channels of key evidence-based interventions along the MNCAH continuum of care. The tool has been field-tested in Tanzania. The tool aims at measuring coverage and delivery channels of key evidence-based interventions along the MNCAH continuum of care and explores various factors that might be attributed to maternal, neonatal and child health from the community point of view. The tool is now ready for broader use.

6. The capacity of health workers to work with communities using proven orientations and guidelines

In collaboration with partners and with USAID support, the following activities were undertaken: The WHO/AFRO "**Maternal and Newborn Health: Framework for the Promotion and Implementation of Community-based interventions**" was developed and used to orient national RH Program Managers from 44 countries and partners on the comprehensive approach to birth and emergency preparedness and ways of working with individuals, families and communities for improved MNH. It was also utilised to develop the "Regional Framework for the Development of a Model Integrated Community-Based Health Promotion Intervention." In collaboration with the Health Promotion program, this framework has been field tested and is currently being utilised to improve the capacity of health workers working in communities.Trainers of trainers from 11 countries were oriented/trained on community involvement on MNH in Bamako, Mali.

Lesson learnt

The predictability of the USAID grant has been useful for better planning MPS activities

Prioritizing outcomes oriented interventions, especially EmONC and improved referral systems plus community involvement, can reduce maternal and newborn mortality in the short term

Guidance on clinical care is extremely important, particularly to achieving MDG 5, as quality of available services remains a major challenge

Challenges

In most African countries the **Maternal Mortality Ratio (MMR)** is still high. The proportion of births attended by skilled health personnel is increasing very slowly or not moving in many countries. This is linked to the difficulty experienced by countries to translate national MNH Road Maps into implementable plans at district level and reflects the human resources crisis and the weak health systems; it also reflects the insufficient financial resources allocated to MNH. In addition, the mobilisation and sustainability of community participation is still a major challenge. More advocacy and mobilisation are needed at the community level

Future Perspectives

In response to the above, the following strategic approaches are being pursued in supporting countries:

Provide guidance at national and sub national levels for accelerated operationalisation of the Road Map at district level (planning, costing, implementing and monitoring of MNCH interventions)

Increase the availability and the quality of skilled care

Increase the availability and utilisation of maternal and newborn health services at all levels particularly at community level

Scale up PMTCT interventions

Increase advocacy for resources mobilisation for MNH

Increase advocacy for inclusion of MNH in global funding sources, such as, GFTAM and GAVI

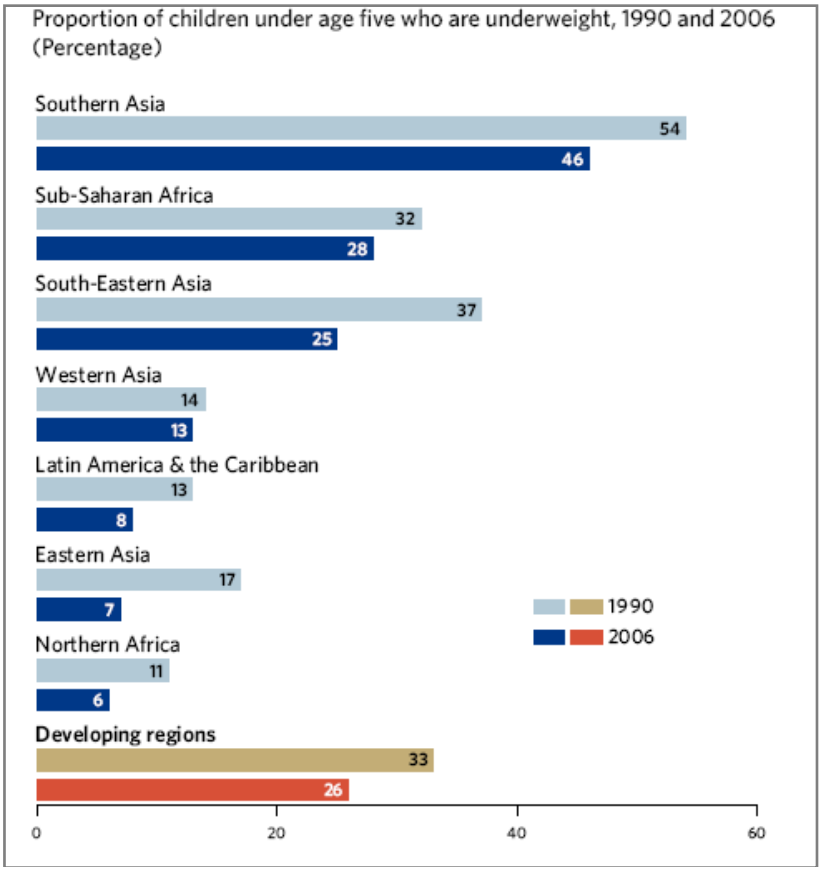
Scale up and share documented MNH best practices

Strengthen monitoring and evaluation, and strategic information for policy formulation, program development as well as resource mobilisation

d. MATERNAL AND YOUNG CHILD NUTRITION INCLUDING MICRONUTRIENTS

CONTEXT

In the original grant of September 2004, nutrition was identified as a part of the Population/FP and Maternal and Newborn Health segment of the proposed work plan. Within this broader envelope, nutrition played only a very small role. Maternal and young child nutrition, including micronutrients, did not become a distinct component of the USAID Grant until the 4th amendment. This component has been funded at a level of $300,000 in each of the last two years of the grant. Although many countries in Africa have experienced declining mortality among children under 5, the nutritional status of children under 5 has not improved and, in some cases has deteriorated. The graph extracted from the MDG Report 2008 shows how much less improvement in the nutritional status of children in SSA has been relative to other regions of the world.



It is generally accepted that nutrition is a factor that contributes to both under five and maternal mortality. Malnourished children are more susceptible to infectious diseases than their well-nourished counterparts and, in turn, children suffering from one of the more common childhood illnesses are likely to become malnourished. Women suffering from anaemia are at greater risk of dying during childbirth than women who are not anaemic.

OBJECTIVES

The objectives of the nutrition activities under the USAID grant are:

Increase national capacity to effectively prevent and manage HIV/AIDS through appropriate infant feeding practices
Develop integrated micronutrient deficiency control programs
Integrate the Essential Nutrition Actions (ENA) into maternal newborn and child health
Support training in the management of severe malnutrition.

KEY ACHIEVEMENTS

Toward increased national capacity

Regional consultants from 12 countries were trained on infant and young child feeding counselling and engaged to support the national training of trainers. Ultimately, this led to the training of over 8,500 health workers in more than 33 countries. In the interest of sustainability, WHO/AFRO is currently improving the capacity of tutors in health training institutions (pre-service) and promoting the use of the model chapter on infant and young child feeding. Although training at the pre-service level is not new, the current approach of training tutors to empower them as agents of change in their institutions to champion curriculum review and to use the model chapter in their teaching is novel.

A core group of experts from nine countries (Kenya, Lesotho, Malawi, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe) were trained at regional and national levels to provide high quality technical assistance to countries to scale up PMTCT and Pediatric HIV/AIDS treatment within the context of improving nutrition, child health and survival.

Thirteen countries (Congo, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) were supported to integrate nutrition into HIV/AIDS programs and guidelines and also developed action plans to accelerate the implementation of the Durban Recommendations on Nutrition and HIV. Nutrition and HIV program managers from 20 countries (Algeria, Benin, Burkina Faso, Burundi, Cameroon, CAR, Chad, Cote d'Ivoire, Congo, DRC, Gabon, Guinea, Guinea Bissau, Madagascar, Mali, Mauritania, Niger, Rwanda, Senegal and Togo) were supported to develop work plans for integrating nutrition into HIV/AIDS programs.

Guidelines/framework for integrating Nutrition into HIV/AIDS programs and funding proposals were adapted and used for integrating nutrition into the GFATM Round 4 allocation and Round 6 proposals in Zambia and Mozambique respectively. This resulted in the approval of US$1.2million to Zambia from Round 4, allocation of US$ 6million to Mozambique in Round 6, and Cape Verde for Nutrition activities for people living with HIV (PLHIV) at the country level.

Ghana, Nigeria, Tanzania and Zambia conducted national assessments of the level of implementation of the Global Strategy on IYCF with support from WHO/AFRO.

The draft manual on implementing community activities on infant and young child feeding was field-tested in Kisii District, Nyanza Province, Kenya. The manual is based on the experience from India and provides clear guidance on designing and implementing a community intervention for improving infant and young child feeding within the constraints of an existing health system.

Representatives of 12 countries were trained on the implementation and monitoring of the

International Code of Marketing of Breastmilk Substitutes. Training sessions for the development of national guidelines on facility-based management of severe malnutrition were organised in Botswana, Madagascar, Niger, and Tanzania. Sixteen countries (Botswana, Burkina Faso, Ethiopia, Eritrea, Gabon, Ghana, Liberia Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe) were sensitised and given technical orientation on the revitalisation of Nutrition Surveillance.

Eleven countries were supported to develop implementation plans for Baby Friendly Hospital Initiative (BFHI) in the context of HIV/AIDS.

Develop integrated micronutrient deficiency control programs

Burundi and Comoros developed action plans for the control of iodine deficiency disease (IDD). Cameroon conducted an assessment of its IDD program. Nigeria was certified as having achieved the goals of sustained elimination of IDD. A Regional Committee document on IDD in the African Region containing a situation analysis and articulating the way forward was adopted by Ministers of Health at the 2008 Regional Committee.

Malawi conducted a micronutrient survey to collect and analyse micronutrient information useful for policy and program development. Tanzania and Zambia reviewed maize fortification policies and plans.

Integrate the Essential Nutrition Actions (ENA) into maternal newborn and child health

Twenty-two countries developed action plans on promoting optimal foetal growth and development. The purpose was the integration of ENA into their National Road Maps for reducing maternal and newborn deaths.

Support training in the management of severe malnutrition

Training for the development of national guidelines on facility-based management of severe malnutrition were organised in Botswana, Madagascar, Niger, and Tanzania. Sixteen countries[12] were sensitised and given technical orientation on revitalization of Nutrition Surveillance.

Gambia, Malawi, Namibia and Nigeria were supported to organise national TOT on the management of severe malnutrition. South Africa, Swaziland, Zambia and Zimbabwe were supported to build capacity on the integrated approach to the management of severe malnutrition in emergency and development context.

Personnel

Two NPOs/Nutrition were recruited for Ghana and Mozambique. The NPO/NUT/Mozambique unfortunately left last year and the post will soon be filled. The use of USAID funds for the initial recruitment of the two NPOs was influential in convincing other countries to recruit NPOs/NUT. Ethiopia successfully recruited a NPO/NUT for nutrition with WHO country office funds. The presence of NPO/NUT is already making a difference, such as the active involvement of WHO country office in addressing the malnutrition and food crisis in Ethiopia.

[12] Botswana, Burkina Faso, Ethiopia, Eritrea, Gabon, Ghana, Liberia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

Barriers

An effective approach to reducing malnutrition must be multi-sectoral, addressing issues related to the supply of high-quality, affordable food. Those issues involve the Ministry of Finance, the Ministry of Agriculture and the Ministry of Industry, in addition to the Ministry of Health. Limited nutrition strategies to Ministries of Health will fail especially in food insecure populations.

Limited resources are available for nutrition intervention at all levels and too great a share of those resources is devoted to interventions that have had only limited effectiveness. In particular, growth monitoring and promotion, although conceptually sound, has not been shown to be sustainable for long periods of time (monitor and mother fatigue sets in rapidly). More importantly, if the inputs for corrective action on the part of the mother are not readily available, (for example, a nutritious affordable complementary food), the growth monitoring becomes a frustration rather than a help. Because of the adoption of a new set of standards for monitoring growth by WHO, WHO/AFRO is devoting time and resources to the introduction of the new standard and its proper use in growth monitoring and promotion that might be better utilised.

Many countries have become infatuated with the use of Ready-to-Use-Therapeutic-Foods (RUTF) to rehabilitate malnourished children. This has diverted scarce resources from prevention activities to treatment.

Opportunities

Crises often breed opportunities. The global rise in food prices a year ago and the ensuing increase in the number of people who were recognised as being food insecure have sparked renewed interest by donors to address food insecurity. Some donors (USA, for example) recognise that nutrition issues should be addressed along with food insecurity issues. An opportunity exists to elevate nutrition on the global agenda and capture resources for this major underlying cause of mortality. Forty to 60% of under-five mortality risk is attributed to undernutrition.

WHO/AFRO is already considering the inclusion of nutrition indicators in its integrated surveillance and response systems. If made operational, this action will increase the visibility of malnutrition as an underlying cause of poor health in children and women.

Other health programs are moving toward community case management. Many nutrition interventions; for example, the promotion of breastfeeding and even the rehabilitation of the severely malnourished, might be more effective if included in programs to introduce community case management. This presents an opportunity for WHO/AFRO and other stakeholders in nutrition to reach out to communities.

e. CHILD AND ADOLESCENT HEALTH (CAH)

CONTEXT AND EXPECTED RESULTS

In response to the high infant and child mortality rates in the African region, WHO/AFRO has been supporting countries to improve child survival through scaling up of newborn health interventions, supporting implementation of the Integrated Management of Childhood Illness (IMCI) strategy, promoting adolescent health and strengthening partnerships for maternal, newborn and child health. The IMCI strategy aims to reduce under-five morbidity, disability, and mortality from common childhood illnesses such as pneumonia, diarrhoea, malaria, measles and malnutrition.

During the period, 01 October 2004 to date, USAID has provided substantial financial support to WHO/AFRO for improvement of Child Health in the region. The expected results for the USAID support during the fiscal years 2004 to 2009 were to:
Support priority countries to strengthen capacity to support scale-up of child survival interventions
Improve health systems delivery to scale-up newborn and child survival interventions
Improve the family and community component of child survival
Strengthen effective monitoring and evaluation of child and adolescent health

KEY ACHIEVEMENTS

The following paragraphs summarise WHO/AFRO's main achievements with support from USAID from 01 October 2004 to 30 April 2008 and articulate the challenges and lessons learnt during the report period.

During the period under review, WHO was able to support ***seven staff members*** who are crucial for providing the necessary technical support for scaling-up newborn and child survival interventions in the African Region. The seven staff included a CAH Regional Advisor (regional level) one medical officer for eastern and southern Africa and one CAH Medical Officer based in Ouagadougou, Burkina Faso (sub-regional level). These three assignees are responsible for scaling up child survival interventions and improving Family and Community practices. The medical officer based in Harare, Zimbabwe provides technical support to the 18 countries in the East and Southern Africa sub-region while the medical officer based in Ouagadougou, Burkina Faso provides support to 17 West African countries. At country level, the USAID Grant supports salaries of three CAH NPOs and their secretaries in Ethiopia, DRC and Nigeria. The NPOs enabled the WHO country offices to provide timely support to national governments and partners for improving newborn and child survival. In addition to salary support, the officers were also supported with secretarial services, office running costs and duty travel costs.

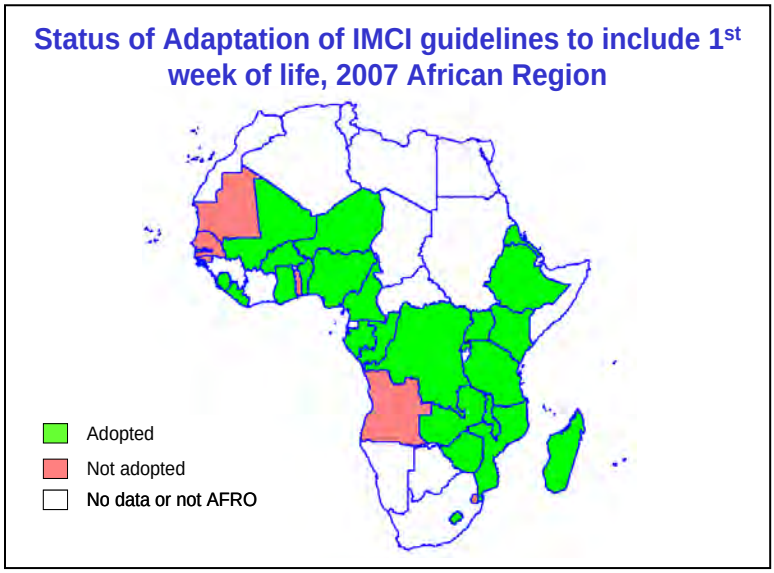
During the report period, WHO successfully implemented the majority of the planned activities and achieved most of the expected results. Key achievements over the period are highlighted below:

Development of national child health policies and strategies:
The Regional Child Survival Strategy for the African Region developed by WHO, UNICEF and the World Bank and adopted by the 56th Regional Committee of Health Ministers in August 2006 builds on IMCI and broadens the approach. It advocates implementation at scale of a package of key cost effective child health interventions.

To date, 21 countries in the region have been supported to develop, finalise or review child health policies and strategies. Mozambique, Nigeria and Tanzania have developed and costed integrated Maternal, Newborn and Child Survival strategies and plans.

Expansion of IMCI Implementation in Countries
WHO/AFRO has assisted 21 countries to expand the geographic coverage of IMCI implementation to 50% of the districts. IMCI pre-service training was being implemented in 13 countries in 2004; this increased to 25 countries by 2008. The expansion of this strategy has contributed to improved capacity for child health in countries.

At the beginning of the grant period, no country in the African region had included care of newborns during the first week of life in their IMCI guidelines. Having reviewed the increasing importance of neonatal health, WHO supported 9 countries to address care during the first week of life, including Botswana, Burundi, Cameroon, Chad, Gabon, Lesotho, Nigeria, Swaziland, Tanzania and Zambia. Data indicate that as of 2007, 21 countries had adapted their IMCI guidelines to include the first week of life, see map below.



Inclusion of IMCI Pre-service training in additional schools: IMCI pre-service training was being implemented in 13 countries in 2004; this increased to 25 countries by 2008. The expansion of this strategy has contributed to improved capacity for child health care in countries.
Benin, Ethiopia, Ghana, Kenya, Mali, Mauritania, Nigeria, Tanzania, Uganda Zambia and Niger were supported in IMCI Pre-service training. In Ethiopia, an assessment of pre-service training of Integrated Management of Newborn and Childhood Illness (IMNCI) was done and the results were disseminated at a national pre-service IMNCI review meeting in March 2008. Pre-service training in IMCI is now being included in 90 health training institutions in 25 countries.

Assessment of Integrated Management of Newborn and Childhood Illness Pre-service training in Ethiopia, March 2008.
WHO supported Ethiopia to evaluate the pre-service IMCI teaching in Ethiopia in November 2007. Twenty-nine health professionals at training institutions that have started IMNCI training were included in the survey. The survey included 34 academic programs. Thirty out of 34 (88.2%) of the programs have integrated IMNCI in their curriculum. All academic programs had at least one full-time staff for IMNCI classroom instruction (range 1-12) and 82% of the programs use the mixed approach to teach pre-service IMNCI. Staggered teaching of IMNCI concepts over a period of time with a concentrated consolidation period of IMNCI re-enforcement. IMNCI questions were included in written exams by all programs (100%) and practical exams by 19 (55.9%). All students and instructors (100%) rated IMNCI concept as very relevant or extremely relevant. IMCI pre-service training is well integrated in health professional training schools in Ethiopia.

Improved Family and Community Component of child survival:
Technical support was provided to Guinea Bissau and Congo for development of a Community IMCI strategic plan. Countries were also supported to promote effective key family and community practices: Burkina Faso, DRC, Eritrea, Ethiopia, Ghana, Guinea Bissau, Kenya, Madagascar, Malawi, Mali, Niger, Nigeria, Senegal, Togo and Zambia. Over 80 districts initiated Community IMNCI implementation in Ethiopia during the report period.

Specific support included training of community health workers (CHWs) on IMCI, specifically pneumonia, diarrhea and malaria: Mozambique was supported to develop training and Information, Education and Communication (IEC) materials for training of CHWs on Essential Newborn Care. Following development of the materials, two training courses were conducted. In Ethiopia, a simplified IMNCI training material was developed for Health Extension Workers (HEWs); trainings have been conducted to rapidly scale up the training of HEWs in IMNCI and thereby improve accessibility of the service at community level. WHO supported the participation of 10 persons from five countries, plus the WHO medical officer for east and southern Africa to participate in a conference that reviewed community case management of pneumonia, malaria and diarrhea, Madagascar, August 2008. WHO also supported the participation of officers from Angola and the medical officer CAH/ICST WA to participate in a national forum on CHW in March 2009 in Mali.

Capacity Strengthening

Child Health Program Management
WHO trained 27 Health Care Managers from 13 countries in Child Health Program Management in September 2008 in Ghana. The training course, developed by WHO, is designed to give managers essential knowledge and skills to improve program management. It provides step-by-step guidance for development of an implementation plan and management of the implementation process. It is noted that programs that are well managed are more likely to improve intervention coverage and therefore reduce child deaths.

Newborn Health care at health facility and community levels

Eleven countries were supported to implement neonatal survival activities: Eritrea, Gabon, Ghana, Lesotho, Madagascar, Malawi, Nigeria, South Africa, Swaziland, Tanzania and Zambia. Specific activities included:

Support to integrate and implement newborn strategy in the Road Map to accelerate attainment of maternal and newborn mortality reduction and child survival strategies in Malawi

Training of 12 program managers from 6 countries to plan for integrating Newborn Health into Maternal and Child Health programs.

Promoting the inclusion of Tetanus Toxoid in Immunisation Plus Days national campaigns for pregnant women in Nigeria. The WHO/CAH team in Nigeria through technical consultations and collaboration with the WHO EPI teams at national and state levels and their government counterparts advocated for and fast tracked the inclusion of Tetanus Toxoid (for pregnant women) as one of the interventions being implemented during the Immunisation Plus Days. This is very critical as a strategy for neonatal survival as neonatal tetanus still contributes about 10% to deaths of neonates in Nigeria. About half of pregnant women are not receiving any tetanus toxoid injection during their pregnancy (NDHS 2003).

Scale-up implementation of ENC in 5 countries: Eritrea, Madagascar, Malawi, South Africa and Zambia. The course is being translated into French for Francophone countries. Training of Trainers for Lusophone countries on ENC. Ghana has initiated training in ENC. WHO Nigeria facilitated a UNICEF supported Home-based Newborn Care national Training of Trainers course. Two regional WHO/UNICEF Training of Trainers courses were conducted to train health workers in Home-based Care of Newborns in Ethiopia and Mali.

Supporting scaling up of Anti-Retroviral Therapy (ART) services for HIV infected children: WHO has supported government efforts to accelerate capacity strengthening for service delivery through training of health professionals at ART sites (Health facilities) and an IMCI complementary course on HIV along with the Integrated Management of Adult/Adolescent Illness. In Nigeria, in 2008, WHO provided support for the training of additional 107 doctors, nurses and community health extension workers from 41 ART sites in 13 states (with total population of about 40 million people). When compared to a figure of 4,200 children on ART in 2006, the current figure of 12,566 (recent national report on health sector response to HIV and AIDS) is a remarkable improvement in the government's effort to scale up ART services to children living with HIV and AIDS.

Emergency Triage, Assessment, and Treatment (ETAT) training

Five countries (Ghana, Kenya, Malawi, Uganda and Zambia) were supported to conduct national training courses in Pediatric Emergency Triage, Assessment and Treatment.

Monitoring and Evaluation

Eight Health Facility Surveys were supported during the report period (Ethiopia, Ghana, Kenya, Mozambique, Niger, Senegal, Zambia & Zimbabwe).

In addition, a field test of the rapid Household Survey tools for Maternal, Newborn, Child and Adolescent Health (MNCAH) was conducted in Tanzania. This tool measures the coverage and delivery channels of key evidence-based interventions along the continuum of care.

Seven countries were supported to assess the quality of care provided to sick children in referral

health facilities (Ethiopia, Kenya, Mali, Mozambique, Niger, Nigeria and Senegal).

Partnerships

WHO is a major partner in national partnerships for Maternal, Newborn and Child Survival. Support has been provided to six countries for Maternal, Newborn and Child Survival partnerships.

USAID funds have also been used to provide technical support for Burkina Faso, Malawi and Mozambique to strengthen rapid scale up of maternal, newborn and child health interventions under a 3-year-grant that is funded by the Bill and Melinda Gates Foundation.

The aim of the grant is to achieve a maximum reduction in maternal, newborn and child mortality within a three year period through implementing national Road Maps for Reduction of Maternal and Newborn Mortality, implementing the national Strategic Plans for Accelerated Child Survival and strengthening partners' coordination. The 3 main UN agencies supporting national authorities to implement the grant are UNICEF, UNFPA and WHO.

The countries developed national implementation plans and funds have been disbursed. In Malawi, WHO dispatched a technical staff (Medical Officer, P4) based at ICST, East and Southern Africa, Harare to Malawi to help implementation in the next year.

WHO has partnered with the USAID -funded Africa 2010 of AED to conduct the assessment of utilisation of Oral Rehydration Therapy in five countries (Benin, Ethiopia, Mali, Senegal and Zambia). This assessment is on-going and its results will inform child health programs in the region.

Nigeria raises US$700,000 for implementation of Integrated Maternal, Newborn and Child Survival strategy

WHO and partners supported Nigeria to develop an Integrated Maternal, Newborn and Child Survival strategy which would prevent 57% of newborn deaths, 70% of the 1,000,000 annual deaths among children under-five years of age and about 62% pregnancy related deaths. The additional annual investment needed for the plan is US$7.57 per person per annum. WHO and partners also supported the development of a roll out guide for the IMNCH strategy which details steps needed to ensure full implementation of the strategy at the different levels of health care. With the support of WHO and other partners, Nigeria raised US$700,000 from the global Partnership for Maternal, Newborn and Child Health. The grant will assist 12 states roll out the implementation of the IMNCH strategy.

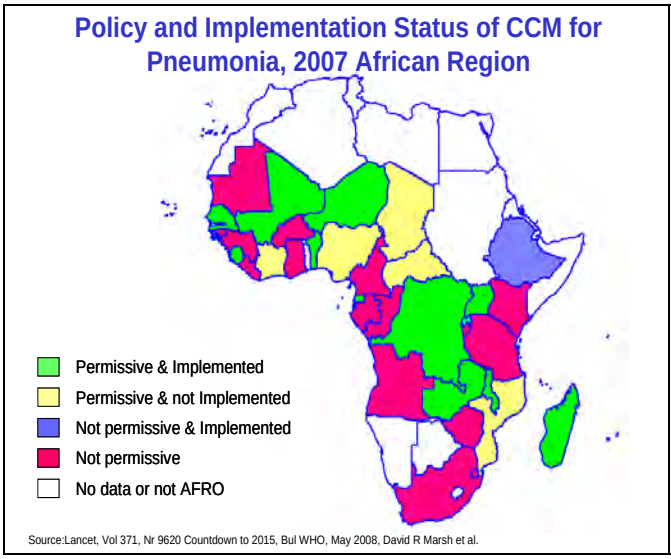
Scale-up of Child Survival Interventions

Support implementing integrated child survival packages in collaboration with Immunisation and Malaria programs: Twelve countries were supported to implement integrated child survival packages in collaboration with the Immunisation, Malaria, Reproductive and Nutrition programs.

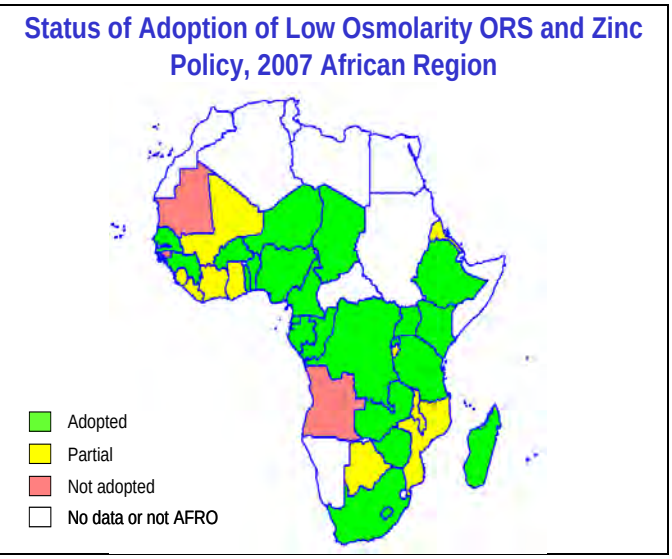
Using the network of WHO regional, inter-country and country staff in child health, WHO participated in the global survey on Community Case Management of Pneumonia in

October/November 2007. This survey of 38 countries indicated the status of Community Case **Management policies in the countries surveyed.**

The maps below indicate the status of Community Case Management for Pneumonia and adoption of low osmolarity ORS and Zinc Policy. Low osmolarity ORS and Zinc have also since been adopted in Angola. Zinc and low osmolarity ORS has been incorporated into the IMNCI training materials as of 2006 in Ethiopia even though the drug was not yet available in the country. Currently an Indian product, EmZinc, is registered in the country for import.



WHO Regional Office for Africa, 2007



WHO Regional Office for Africa, 2007

Challenges

Coverage of effective child survival interventions remains low, particularly, those that rely on functional health systems and 24 hour availability of clinical services such as care of ill newborn babies and children.[13] Underlying factors include general under-development and weak health systems with insufficient human and financial resources.

Inequalities in access also results in the rural and poor populations bearing the brunt of the highest child mortality rates. Most countries in the African region have fewer than 2.5 healthcare professionals per 1000 population.[14] These health workforce densities are below the critical threshold required for achieving health-related MDGs.

It has been suggested that annual per capita total health expenditures of less than US$45 is insufficient to ensure access to a very basic set of needed services.[4] A majority of the countries in the African region today, are far from their targets of 15% of total government expenditure to be

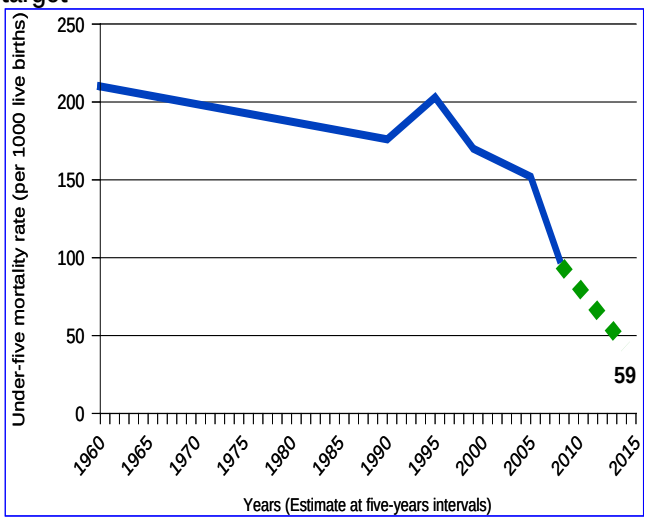
[13] Countdown Coverage Writing Group on behalf of the Countdown to 2015 Core Group: Countdown to 2015 for maternal, newborn and child survival: the 2008 report on tracking coverage of interventions, Lancet 2008:317:1247-58.
[14] Countdown Working Group on Health Policy and Health Systems: Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn and child health, Lancet 2008/371:1284-93.

spent on health. Actual health expenditures remain low. Other factors that limit the impact of child survival improvement include the HIV pandemic and armed conflict in some countries.[3]

Data show that only five countries in the WHO African region are on track to achieve MDG 4 on child mortality reduction.[2] Twenty-one countries in the region are making insufficient progress while the remaining 20 are not making progress.[2] Countries like Ethiopia, Malawi, Mozambique, Senegal and Tanzania, have made progress in child mortality reduction despite having Gross National Incomes of equal or less than US$350 per year. Although Ghana, Rwanda and Zambia are indicated as not making progress in reducing under-five mortality trends, recent data from DHS indicates that these three countries have also made progress in child mortality reduction

Graphs showing Progress in Child Survival, Rwanda and Zambia (Data from World Health Chart and Recent DHS, WHO/AFRO, 2008

Rwanda Under-five Mortality Trends and Projection to MDG target



Zambia Under-five Mortality Trends and Projection to MDG target

Lessons Learnt

The availability of high level technical expertise in WHO at various levels (regional, sub-regional and country) has facilitated timely and appropriate response to country requests for technical support. WHO's close collaboration with national governments and other development partners has resulted in exceeding expectations in a number of key areas of support at country level. Co-funding of activities with other partners has exceeded training targets.

More efforts are needed by national governments and partners to improve maternal, newborn and child survival outcomes because current efforts are way below what is required.

Conclusion

This review shows that the USAID grant benefited most of the countries of the WHO African region with high childhood disease burden. However, increased global, regional and national

investment in child health is needed to scale-up effective child survival interventions to levels that will have an impact towards reaching the MDG targets.

Available data indicates that making progress in child survival remains a huge challenge in the African region. Data also show that despite the dismal overall picture in under-five mortality trends, some countries are making significant progress. With increased global investment in child survival the situation in countries can be improved.

Proposed Priorities for future Grant

WHO will continue to advocate for increased investment in health systems in order to effectively reduce child mortality in countries of the African region. In collaboration with partners, WHO will support countries in mobilizing resources for scaling up of effective child survival interventions. The organisation will also assist countries in monitoring achievements and challenges in child survival, including documentation of success stories in the region.

Specific considerations for future USAID funding include:

Strengthening WHO sub-regional and country capacity to provide timely and appropriate technical support to countries

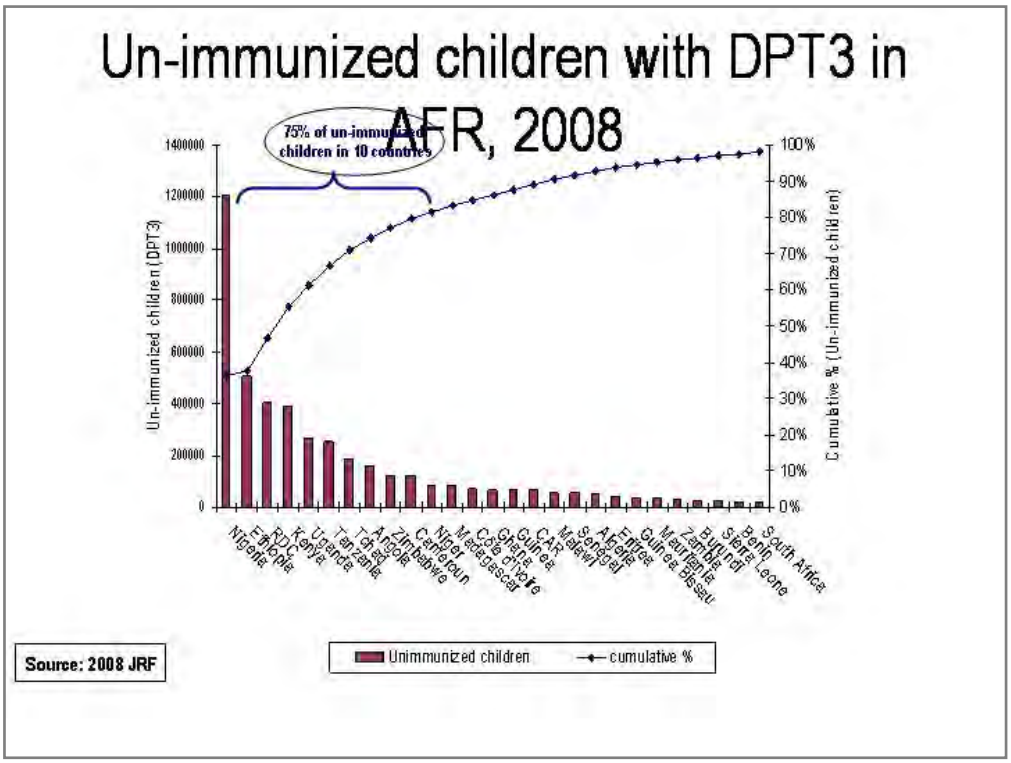
Strengthening national capacity to scale up interventions

Strengthening monitoring and evaluation of child survival strategies in countries to facilitate action where needed

f. VACCINE PREVENTABLE DISEASES (VPDs): STRENGTHENING ROUTINE IMMUNISATION ACTIVITIES

CONTEXT

In the African Region, communicable diseases are the main direct causes of child morbidity and mortality. Although the relative importance of these causes varies from country to country, on average more than 70% of child deaths are attributed to just a few mainly preventable causes, namely: acute respiratory infections, diarrhea, malaria, measles, HIV/AIDS, malnutrition and neonatal conditions. Many African children are still un-immunised against VPDs. The majority of those un-immunised children can be found in 10 African countries (e.g.; Nigeria, Ethiopia, DRC, Kenya, Uganda, Tanzania, Chad, Angola, Zimbabwe, and Cameroon). See graph below.



The Grant Expected Results

The primary goal of WHO/AFRO's immunisation program is to support Member States to implement sustainable interventions that will lead to the control of VPDs and thereby achieve maximum impact on child survival. The achievements of immunisation goals will significantly contribute to the MDG 4 of "reduction of under-five mortality by two-thirds (2/3) between 1990 and 2015."

The expected Results

Strengthened national immunisation systems through targeted support to Reach Every District (RED) approach, multi-year planning and integration

Improved logistics, vaccine planning, forecasting and management, particularly in support of integration with other programs

Quality and coverage of immunisation services improved in the target countries

Immunisation services integrated with other public health interventions at national and sub-national levels within the USAID supported countries

Best practices and leading gains in routine immunisation documented and disseminated to other countries of the region

Illustrative Activities Supported with the Grant

The USAID grant AFR-G-00-04-00001 served to support the posting of routine immunisation officers in Ethiopia, Ghana, Madagascar, Senegal and Uganda and provided them with seed money to ensure coordination with other grants available at country level and the promotion of collaboration with other partners supporting immunisation programs, particularly with USAID Missions. Support was also provided to Angola via a separate grant, to pay for a routine immunisation officer, a secretary and other related immunisation activities. Similar support is being provided to Liberia.

Grant-supported staff were mainly involved in activities aiming at strengthening immunisation systems. The key activities supported in the recipient countries include development or updating of immunisation comprehensive multi-year plans (cMYP); addressing data quality issues and a special emphasis put on the optimal implementation and the roll-out of the RED approach to all districts. The following are some of the illustrative activities supported with the grant:

80% of countries in the AFRO region were supported to develop or update their immunisation comprehensive multi-year plan (cMYP).

The RED field guide was revised to include innovative strategies to assist countries to reach all districts with the five RED approach components, and indicators to monitor implementation were developed.

WHO has supported the introduction of hepatitis B vaccine (44 of 46 countries) and Hib-containing vaccine (36 of 46 countries) into their routine immunisation programs.

17 countries were supported in training and implementation of data quality self-assessment tools.

7 inter-country training courses were held on vaccine management (3), vaccine regulation (1), vaccine procurement (1) and MLM (2).

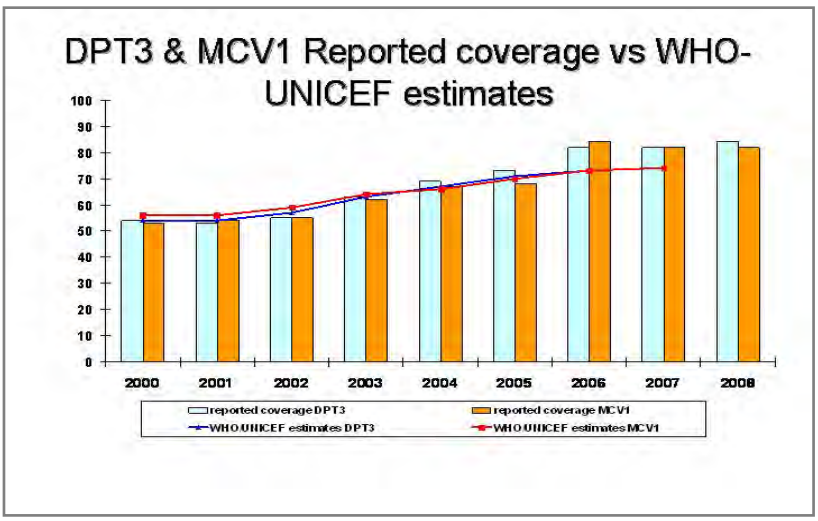
The second "African Vaccine Regulatory Forum" (AVAREF) meeting was held in September 2007 to build capacity of African regulators by fostering exchanges among them and with other national regulatory authorities, including the United States Food and Drug Agency (US FDA) and Health Canada.

2 regional vaccinology courses (Anglophone in August 2008 & Francophone in October 2008) were held to build capacity at country level in the field of vaccine development and research.

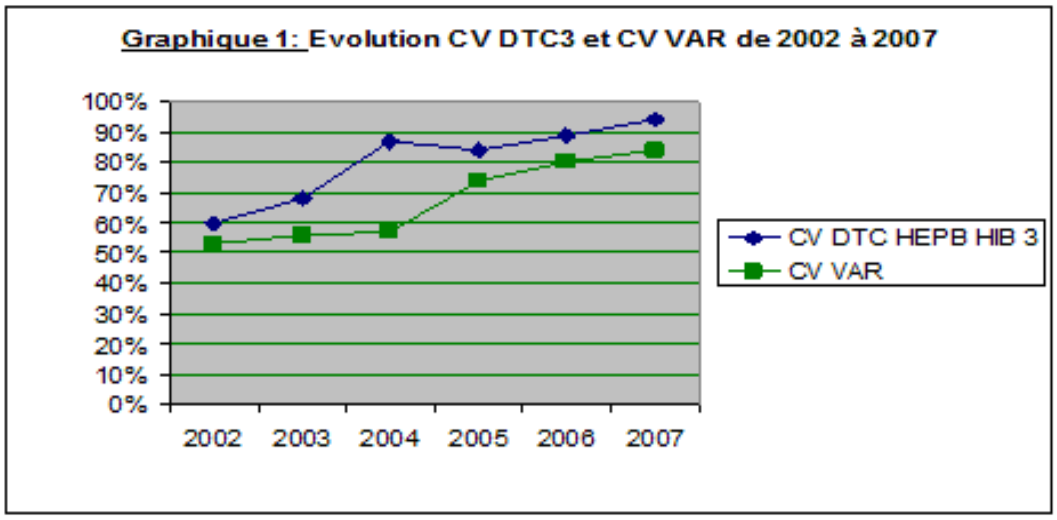
Countries were assisted to complement routine health services with childhood immunisation and vitamin A supplementation (32 countries), anti-helminthes (12 countries), ITNs (11 countries), promotion of breastfeeding, and use of ORT for diarrhea.

Achievements:

Since the adoption of the 2006-2009 Regional EPI strategic plan, significant progress in strengthening immunisation programs has been recorded. The Regional administrative DPT3-containing vaccine coverage has been maintained at above 80% for 2 consecutive years since 2006, largely due to the implementation of the RED approach. See graph below.



In Senegal, the DPT-HepB-Hib3 coverage increased from 60% in 2002 (DPT) to 94% in 2007 (pentavalent); MCV1 also increased from 53% in 2002 to 84% in 2007 (see graph below). During the same period, there was an increase in the number of vaccinated children. Measles cases decreased from 16,000 in 2002 (estimates) to only 9 confirmed cases in 2007.



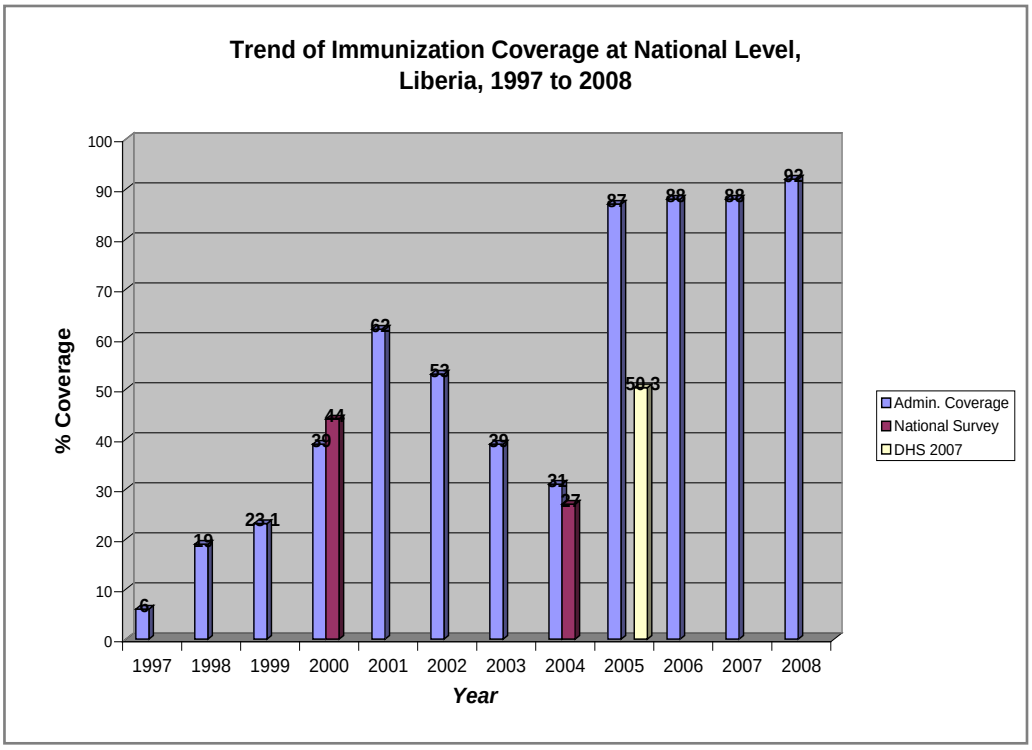
Madagascar has also seen an increase in routine immunisation coverage of all the antigens (see table below).

Table 1: Immunisation coverage (Madagascar DHS 2003-04 and EPI Coverage Survey 2008)

Antigens	Demographic Health Survey 2004			EPI coverage survey 2008		
	% Immunised with card	% Immunised with history	Card + History	% Immunised with card	% Immunised with history	Card + History
BCG	48,0	23,8	71,8	85,5%	8,7%	94,2%
Polio 0	19,3	9,0	28,3	41,3%	22,9%	64,2%
Polio 1	48,8	28,5	77,3	64,8%	25,4%	90,2%
Polio 2	46,4	24,3	70,7	63,3%	23,2%	86,5%
Polio 3	44,0	19,2	63,2	60,3%	20,7%	81,0%
DPTHepB1	47,7	23,6	71,3	66,9%	25,4%	92,3%
DPTHepB2	45,1	21,6	66,7	64,8%	23,1%	87,9%
DPTHepB3	42,7	18,7	61,4	61,1%	20,8%	81,9%
MCV1	41,7	17,3	59,0	61,4%	19,6%	81,0%

After the attainment of the Universal Childhood Immunisation (UCI) in 1990, **Liberia** was engulfed by civil war and immunisation services suffered to the extent that DPT-3 coverage dropped to as low as 6% in 1997. From 2005 to the present time, a rapid increase in the administrative coverage for routine immunisation has occurred. This impressive progress can be attributed to the following:

- The return of peace and the extension of political authority to all parts of the country.
- Increase in the number of health facilities that became operational and were providing immunisation services in the country from 173 to 448.
- Resuscitation and intensification of outreach activities nationwide starting in 2007 were funded mostly by USAID Liberia through the USAID Grant to WHO/AFRO.



Barriers and Opportunities to Reaching the IVD Goal and Objectives

Despite the tremendous progress made, African countries and their international partners, including WHO and USAID, will face a number of important challenges in fully attaining the IVD set of goals and objectives over the next five years. There are still far too many countries or districts within country in the Africa region with low immunisation coverage. Sub-optimal immunisation coverage levels in populous countries expose large number of un-immunised children to VPDs.

Low-performing countries and districts struggle with weak health systems, difficult geographic and cultural barriers, wars and civil unrest, depleted cadres of health workers, governmental reforms, and competition from other public health priorities (e.g. HIV). High immunisation drop-out rates and ineffective links between communities and health services exacerbate problems with immunisation coverage.

Ensuring a long-term financial sustainability and improved coordination mechanisms between various donors and governments will be critical for maintaining the gains in increasing routine immunisation coverage while continuing to introduce new vaccines.

USAID and WHO/AFRO future collaboration should focus on consolidating past gains in routine immunisation and systems strengthening. The emphasis should be on the institutionalisation and further expansion the RED approach, including community outreach interventions to reach the hard-to-reach children. To maximise its investments, WHO/AFRO should continue to mobilise resources for immunisation capacity building at all levels and to better target and coordinate that support toward lasting results. WHO/AFRO should capitalise on continued interest of IVD partners such as GAVI, UNICEF, CDC, Canadian CIDA, DFID, USAID, African Development Bank, Rotary, and International NGOs.

IVD/AFRO identified the following priority areas for future USAID Grant:

Reaching the un-immunised children
Introducing newer vaccines
Interrupting polio transmission
Improving immunisation monitoring and data quality

g. PEDIATRIC HIV/AIDS

CONTEXT

Though the majority of pediatric HIV infection is acquired as a result of vertical transmission during pregnancy and child birth, the risk of transmission of HIV through breastmilk poses an additional problem. In countries where the prevalence of HIV in pregnant women exceeds 35%, WHO estimates the contribution of HIV/AIDS to childhood mortality to be as high as 42%.

In the early 1990s, when the generic IMCI algorithms and guidelines were being developed, pediatric HIV/AIDS, while important, was not as overwhelming a problem as it has since become in some countries. Not only was the burden of pediatric HIV/AIDS not foreseen, but procedures and methods for the management and support of the affected child and his or her family were not so clearly defined. It has become very critical in high HIV prevalence settings for the health worker at the first level health facility to be able not only to recognise a child at risk of HIV infection or having symptomatic HIV infection, but also to confirm the HIV status of the child and therefore facilitate effective prevention and management.

Goals and Expected Results

The USAID Grant to WHO/AFRO to support Pediatric HIV program aimed to contribute to the reduction in childhood morbidity and mortality by scaling up pediatric HIV and AIDS prevention and control interventions. The expected results were improved capacity to implement Pediatric HIV prevention and control interventions; scaling-up of Prevention, Care, Treatment and Support services for children exposed and infected with HIV; and dissemination of validated HIV diagnosis algorithm for the presumptive diagnosis of pediatric HIV.

Illustrative Activities Supported with the Grant

The funds from the USAID grant were used for supporting positions as well as implementation of activities at inter-country and country levels. With support from USAID, WHO developed and updated various pediatric HIV strategies, tools and guidelines. These included review and updating of the IMCI HIV adaptation guide, development of the generic IMCI HIV algorithm for use in countries and development of the IMCI Complementary course on HIV.

The Grant provided 50% salary support for three IMCI NPOs in DRC, Ethiopia and Nigeria. The costs included in-country duty travel, secretarial support and supplies and communication. These NPOs were responsible for support to countries in activities related to infant feeding (including that in relation to HIV) and support to scale-up pediatric HIV/AIDS interventions.

The Grant supported the adaptation of IMCI guidelines to include and/or update HIV guidelines in 10 countries (Botswana, Cameroon, Chad, Ghana, Lesotho, Liberia, Nigeria, Sierra Leone, Swaziland and Uganda).

WHO/AFRO supported an IMCI complementary training course on HIV in selected countries (Ghana, Liberia, Nigeria, Sierra Leone, Uganda, Tanzania and Zambia). In addition, 24 participants from 9 countries were trained in a regional IMCI Complementary course on HIV.

Seven countries were assisted by WHO/AFRO to operationalise the PMTCT strategic orientations and new guidelines (Burkina Faso, Cameroon, Cote d'Ivoire, Malawi, Rwanda, Tanzania and Zambia).

WHO/AFRO has provided technical assistance and funding, together with the USAID–funded Africa's Health in 2010 Project to the African Network for the Care of Children Affected by HIV/AIDS (ANECCA), to conduct a study to validate the WHO algorithm for presumptive diagnosis of severe HIV/AIDS in infants less than 18 months of age requiring ART in settings of limited laboratory capacity. WHO is also supporting the validation of the IMCI Young Infant algorithm in Nigeria.

WHO/AFRO has established a good working collaboration with key partners in IYCF namely UNICEF, IBFAN, WAHO, LINKAGES, WFP, and PATH. These partners were actively involved in the Regional capacity building on the IYCF Counselling Course and in the multi-country workshops on implementation of BFHI in the context of HIV/AIDS.

WHO has used USAID Grant funds to enhance partnerships with a number of agencies and funding institutions and tap into additional funding for child survival. The examples of the partnership work undertaken by WHO/AFRO include:

Working with the AIDS, Tuberculosis, Malaria and Health Systems programs, to train national program managers in proposal writing for Round 8 of the GFATM proposal. The trained participants then assisted their countries in the proposal writing exercises. WHO has also supported a regional consultation on improving health system components of GFATM proposals as well as those of GAVI.

Provision of technical support to 6 countries where the UNITAID project is being implemented.

Complementing the PMTCT funds under the CIDA grant. Lesotho, Swaziland, Zimbabwe and Zambia are being supported by the CIDA grant and six additional countries are being supported to improve their monitoring and evaluation capacities.

Achievements:

The USAID Grant enabled WHO to develop normative guidance for use by policymakers and program managers on prevention and management of pediatric HIV/AIDS. It also provided support to countries in developing and implementing these standards through WHO country and regional offices.

Achievement of the results was facilitated by having on-site technical staff at inter-country and country levels. These staff members were able to provide high level technical expertise as needed. Collaboration with partners funding other HIV activities at country level also multiplied the effects of WHOs' efforts.

Barriers and Opportunities

Although significant strides have been made in the fight against HIV and AIDS, women and children remain the hidden faces of the epidemic. There is need to increase technical and material support for prevention, detection, treatment, care and support of HIV in children.

With on-going research and rapidly changing management options for care and treatment of children living with HIV and AIDS, there is need to revise guidance to countries for infant treatment of HIV. The WHO Reference Group for Pediatric HIV/ART and Care has called on countries to consider the following:

Review and update national testing and treatment guidelines for HIV in infants

Revise estimates and targets for the number of infants and children requiring treatment

Scale up diagnostic testing for HIV exposed infants

Revise forecasting, costing and procurement for diagnostics and drugs required. If these revised recommendations are followed, thousands of children lives will be saved.

WHO has effectively provided technical support for Nigeria to train 107 senior health professionals from 41 sites offering ART in 13 out of 36 states and the federal capital in the IMCI complementary course on HIV. Of the estimated 2.86 million PLHIV in Nigeria, 2006 estimates indicate that only 95,910 of these were on ART. Children constituted only 4.8% of the people on ART. To increase provision of ART to children, WHO provided technical support to the government to accelerate capacity building for service delivery through training of senior health professionals. In addition, WHO supported the adaptation of the WHO generic training materials on the IMCI complementary course on HIV. As part of the adaptation of training modules, Nigeria has also developed a video for the training course on pediatric HIV/AIDS.

Pediatric HIV/AIDS priority areas identified for future USAID Grant

Priorities identified by WHO/AFRO for future grants include:

Continued staff support to respond to country requests for provision of timely and appropriate technical assistance and implement current national pediatric HIV guidelines, in line with the revised recommendations for HIV prevention, testing, care and treatment services for children.

Strengthen monitoring and evaluation of pediatric HIV trends and response and use evidence-based advocacy to mobilise resources to scale-up pediatric HIV prevention, treatment, care and support.

Support research that aims at improving care of HIV exposed as well as HIV infected children.

h. MALARIA

CONTEXT

The African Region is the most affected by the disease accounting for 86% of the estimated 247 million malaria episodes and 91% of the malaria related deaths worldwide in 2006.[15] Malaria accounts for, on average 25% to 45% of all outpatient clinic attendances and between 20% and 45% of all hospital admissions. [16,17] Furthermore, it is estimated that malaria represents 17% of under-five mortality in the region.[18]

WHO/AFRO has continued to intensify its malaria control activities in support of countries to meet the Abuja Targets and MDGs in collaboration with other programs and partners. Progress is being made and the Malaria Control Unit has been tackling some of the most difficult programmatic and technical issues in all 43 malaria endemic countries in the region. Through intensified support to countries, progress is accelerating, though it is still not rapid enough. The objectives of the malaria Control Unit stated in the Agreement with USAID were:

To support countries in developing capacity for sustainable, nationwide delivery of comprehensive and affordable packages of malaria control interventions for prevention of infection and the effective case management of disease;

To build countries' capacity to plan and manage malaria control programs and to monitor, evaluate and report the implementation of activities, outcomes and impact at all levels of the health system;

To stimulate large-scale delivery of community-based interventions and promote linkages with the health system and other relevant sectors;

To support research, development and deployment of new and/or improved tools, strategies and interventions for malaria control; and

To build new strategic partnerships and strengthen existing ones for malaria control.

ACHIEVEMENTS

WHO has made a unique contribution in malaria control since the first partnerships (USAID/DFID/IMCI) to address priority communicable diseases, especially malaria in selected countries. WHO's unique role has been building consensus and brokering support for the most cost-effective interventions; identifying strategies for delivering the interventions; supporting countries to plan, implement and accelerate malaria control, surveillance, monitoring and evaluation. WHO has played this role by availing human resources at the regional, IST and country levels and providing consultants, high quality technical guidelines, and catalytic funding. WHO has been instrumental in operational research such as Home Management of Malaria (HMM) that is now implemented as a key strategy in several countries. As a result, countries have been able to scale up malaria control interventions. While the different annual reports show the detailed activities, below is a summary of some of AFRO's unique contribution in malaria control in Africa.

[15] WHO, *World Malaria Report 2008,* Geneva, World Health Organisation 2008.

[16] WHO, *Africa Malaria Report 2006*, Brazzaville, World Health Organisation, Regional Office for Africa, 2006.

[17] RBM/WHO/ UNICEF, *World Malaria Report 2005*, Geneva, World Health Organisation 2005.

[18] WHO, *World Health Statistics*, Geneva, World Health Organisation, 2008.

1. WHO key role in the development of guidelines and technical documents

WHO has developed several guidelines that have been adapted for use at country level. For example, all the countries that have changed the anti-malarial treatment policy have been supported by WHO to revise their malaria treatment, technical and training guidelines. Guidelines produced and being used at country level include: guideline for ACT implementation; guideline for national Strategic Planning; Case Management Operational Manual; Malaria Diagnosis, an operational guideline to strengthen malaria diagnostic services using microscopy and RDT (in collaboration with HQ); Algorithms for malaria case management at peripheral level using IMCI approach; guideline for scaling up community-based interventions (CBIs) in Malaria Control; guideline for malaria prevention and control during pregnancy; guideline for monitoring and evaluation; guideline for integration of ITN distribution with immunisation campaign; child survival interventions and finally guideline for comprehensive malaria review which is being used for the first time in Kenya from 24th May to 06th June 2009.

2. WHO key role in drug policy change and the adoption of ACTs:

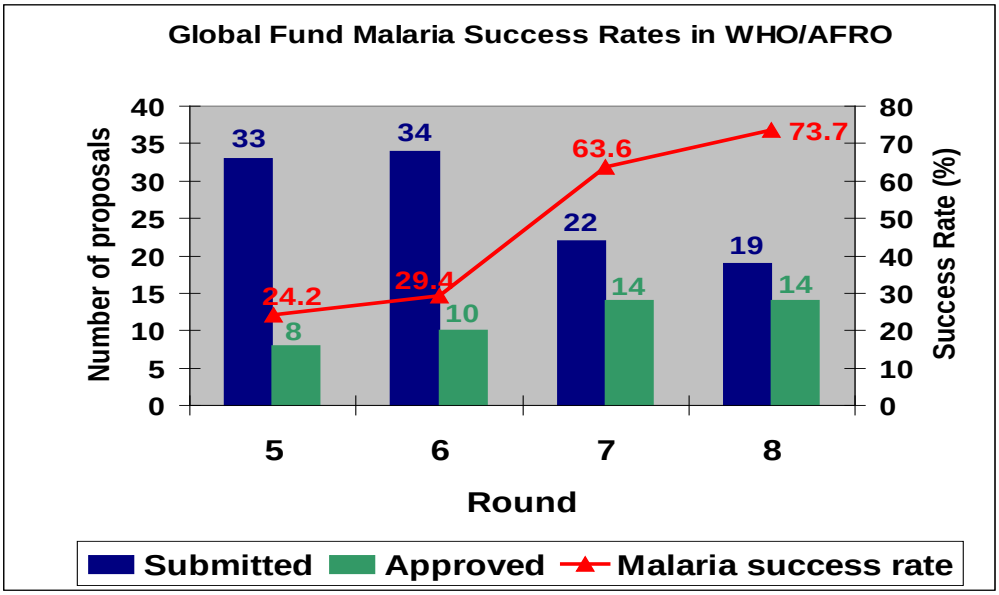
AFRO supported all countries to establish sentinels sites for monitoring anti-malarial drug resistance. The results from these studies were used to revise malaria treatment policy to ACT in all but 2 countries in the region. WHO provided guidelines, study protocols and funds for the studies and consultants who validated results and facilitated drug policy change. WHO also established sub-regional drug resistance networks that are a forum for capacity building and sharing experiences on drug resistance and treatment policy development. In addition, WHO established a malaria drug-resistance database for tracking of anti-malarial drug resistance. Presently, most of the networks are dormant and most countries are not monitoring drug resistance regularly since they shifted to ACTs. WHO's support is key if ACT resistance is to be detected and addressed.

3. WHO fostering partnerships for malaria control at country level

WHO facilitated the establishment of country level malaria control partnerships by setting up malaria coordination committees that play a crucial role in malaria control. For example, in Benin, the partners produce a monthly bulletin and hold monthly meetings coordinated by the WHO NPO. In Senegal, the WHO NPO is the Chairman of the CCM Technical Committee. Senegal was one of the first countries to get GFATM funds but the grant was cancelled because of poor performance and governance within the CCM. During round 4, the CCM was reconstituted and has a technical committee for the 3 diseases. Recently, the CCM in Senegal was recognised and rewarded for outstanding performance by the GFATM secretariat. In Madagascar, the WHO IPO has led the GFATM process with support from the Regional Office just after the political crisis. The country managed to secure funding from GFATM with 3 grants. The IPO supported the countries to mobilise additional funds from the Monaco Kingdom to scale up malaria control interventions in Sainte Marie Island. The successful evaluation of the project has led to a new commitment from Monaco to extend its collaboration with WHO in 8 African countries. The collaboration with PMI was very successful and joint missions were organised in Angola, Malawi, Mozambique, Senegal, Tanzania, Ghana, Benin, Ethiopia, Kenya, Liberia, Mali, Zambia and Madagascar and Liberia for assessment and planning.

1. WHO Support to countries for access to GFATM grant for malaria

WHO has supported countries to access Global Funds since round 1. Across successive rounds, WHO has provided technical support for proposal development in collaboration with key partners, mainly UNICEF and MACEPA. At the launch of each round, ***a training session*** is organised for country teams and consultants on WHO technical recommendations and GFATM proposal requirements. WHO has developed a comprehensive brief for GFATM proposal development that is used in these workshops. WHO provides ***support for proposal development*** through the NPOs and IPOs, missions conducted by the inter-country teams and consultants from the Regional Office since Round 7. ***Mock Technical Review Panel (TRP) and peer review of draft proposal*** 45 to 30 days before the submission have been conducted. The facilitators of the Mock TRP identify countries requiring extra support; this is usually provided by consultants and the WHO NPO. WHO was represented by 13 staff from HQ, RO, IST and WCO at the recent Mock TRP for Round 9. ***The African region has registered improved GFATM success rates from*** 24.2 % in round 5 to 29.4 in round 6, 63.6% in round 7 and 73.7% in round 8 for malaria. The funds secured by countries from GFATM have increased across the rounds because of the improvement in technical assistance: $488 millions for round 7 and $ 1.2 billion for round 8.



5. WHO Support to countries for integrated campaigns to boost ITNs coverage

WHO is a key player within the Alliance for Malaria Prevention (AMP) supporting the implementation of the integrated child survival strategy by linking ITN distribution to immunisation activities. In the initial stages, the Malaria Unit was the Secretariat for AMP and played a key role in identifying countries for the campaign; linking funding partners to countries running campaigns; and planning, implementation, monitoring and evaluation of the campaigns, etc. In addition, WHO has developed a framework of integration of priority disease control interventions at district and national levels that has been rolled out in Benin, Ghana, Tanzania, Uganda and Zambia. WHO has initiated integration of malaria control with the African Program for Onchocerciasis Control. There are plans for integration of onchocerciasis, filariasis and malaria control in Benin, Senegal, Tanzania

and Uganda. The outcome of the efforts has been an increased ITN possession and use in the African Region.

6. WHO Support for Home Management of Malaria

Given that 80% of malaria cases are first managed at home, WHO developed the Home Management of Malaria strategy based on lessons learnt in HMM feasibility studies in Burkina Faso, Ghana, Uganda, Nigeria, etc. WHO played a key role in taking HMM from research to policy. The HMM strategy is now being implemented in several countries. WHO helped countries to develop plans, and provided catalytic funding for pre-packaging medicines, training CHWs, and monitoring and evaluating the projects. To date, several countries have scaled up HMM using Global Funds. WHO provided guidelines for the documentation of best practices for all health interventions that have been used to document various practices especially at community level. WHO has supported Benin, Eritrea, Rwanda, Senegal, etc to document best practices in CBIs for malaria control.

7. WHO key role in strategic planning

WHO's role was critical in countries developing malaria strategic plans (MSPs). The evidence used for strategic planning was the situation analysis and RBM baseline surveys supported by WHO. The 1st generation malaria strategic plans (2000-2005) were developed with technical and financial support from WHO**.** The malaria strategic plans were instrumental in rallying partners and for resources mobilisation. WHO has supported the development of 2nd generation MSPs in 30 countries from 2006-2008 and will have a major role in ensuring that the country-level MSPs meet the standard of the GFATM NSA and other partners' requirements.

8. WHO support to Rwanda: from strategic planning to implementation and planning

Malaria has been the leading cause of morbidity and mortality in Rwanda with occasional epidemics in the high altitude areas. In the late 90s, malaria accounted for over 50% of the outpatient attendance, a case fatality rate of up to 6% in district hospitals with only 7% households owning at least a mosquito net in 2003. Rwanda had a shortage of health workers with doctors mostly based in the urban areas and yet 83% of the population is rural-based. To address the many challenges faced by Rwanda, WHO has consistently supported Rwanda in the following areas:

Policy development and planning: with WHO support, a situation analysis was conducted for the development of the first comprehensive malaria strategic plan in Rwanda (2005-2009). WHO supported Rwanda to undertake drug efficacy testing and for the adoption of ACT (Coartem in 2005) as well as the adoption of the HMM policy using ACTs, that is implemented in 18 highly endemic districts.

Resource Mobilisation and ***program implementation***: WHO has supported Rwanda to access financial resources from GFATM. Also WHO supported the implementation of ACT policy (development of training material, follow up through health facility survey etc).

Rwanda has organised a mass ITN distribution campaign combined with immunisation, where 1,364,897 LLINs were distributed. By mid-2007, 60% of children under five and 74% of the pregnant women slept under an ITN.

The implementation of a comprehensive package has led to increased coverage of malaria control interventions and to a reduction malaria cases and death by 75% in 2007.

9. WHO's key role in setting up Monitoring and Evaluation as a backbone to assess progress

- **USAID Grant contribution:** Successive USAID grants starting with the first one in 1993 enabled the Malaria Control Unit of WHO/AFRO to recruit an epidemiologist in 1994 during the Accelerated Implementation of Malaria Control (AIMC) Initiative which has evolved into «Roll Back Malaria (RBM)» in 1998.
- **WHO's Role in tools development for M&E:** Since the launch of RBM in 1998, WHO developed tools to guide countries to undertake situation analysis and conduct the RBM baseline surveys funded by the USAID Grant. This data fed into the 1st generation Malaria Strategic Plans.
- **WHO's Role in strengthening M&E Systems in the Region:** One of the early lessons for the region was that despite the large quantities of data being collected by various partners, the National Malaria Control Programs (NMCPs) were not prepared to use the data for monitoring and evaluation. In response, WHO/AFRO developed a concept of strengthening M&E through networking with other agencies and departments that also collect malaria data. AFRO initiated the process of strengthening M&E Systems in the Region in 2003 by developing a concept note with clear terms of reference, a checklist for assessing M&E Systems and a proposed database system that would be used by countries. The Evaluation was done in more than 15 countries and recommendations made on how countries could strengthen their M & E systems. Most of these recommendations are still relevant today. For example many NMCPs created an M&E Unit and recruited an epidemiologist and/or data manager. Lately, WHO/AFRO has spearheaded the development of a Checklist for developing comprehensive Surveillance, Monitoring & Evaluation (SME) plans, contributed to the GFATM M & E toolkit and is developing a compact malaria SME course. In addition, WHO/AFRO is working closely with WHO/GMP and CDC to strengthen malaria surveillance systems.
- WHO AFRO has played a crucial role in producing periodic reports: the Africa Malaria Report 2003 and the World Malaria Report 2005; the Abuja Progress Report 2004, the Africa Malaria Report 2006, The African Union (AU) Malaria Situation Reports 2006 and 2008, the World Malaria Report 2008 and is already working on the World Malaria Report 2009.

10. Catalytic role of WHO/AFRO in setting up Malaria Information System in Senegal through capacity building: a case in Monitoring and Evaluation

- **USAID Grant contribution:** The USAID grant enabled the recruitment of a Data Manager in the Malaria Control Unit in May 2001 to reinforce the M&E team that was headed by an Epidemiologist. With this human resource at hand, WHO/AFRO developed an application in EPI Info 6 called the «Roll Back Malaria Monitoring and Evaluation System» or in short (RBMME) in 2001/2002. AFRO made available the application to countries.
- **Catalytic technical support to Senegal and Role of NPO:** Two WHO/AFRO staff visited Senegal from 17 to 28 March 2003 to assess the M&E System and train 15 staff from the NMCP, the Health Information System (HIS), WHO Country Office, the University, on the RBMME system. A Focal Point from the Senegal HIS was designated to manage the RBMME. The NPO/MAL of Senegal worked closely with the NMCP for the identification and reassignment of

a district staff to head the M&E Unit. The NPO/MAL and the NMCP trained all district health information staff in 2003/2004 on the RBMME that was installed in all districts.

- **Contribution of the RBM M&E for provision of good and reliable malaria data in Senegal:** Following the installation of the RBMME system, all districts started progressively reporting to the National level. Senegal submits complete information on all districts to WHO/AFRO at least once a year, since 2004. Senegal is able to report good quality data to the GFATM using the RBM ME. Senegal's efforts to generate good data have been recognised with an award of USD 3 million from a GFATM partner in June 2008.

11. Impact on malaria is being reported in some African countries

- Quick impact in malaria control as reflected by declining morbidity and mortality figures is possible when a comprehensive package of malaria prevention and control interventions is implemented at the same time.
- There are reports of an impact on the malaria burden being recorded in countries such as Eritrea, Zanzibar (Tanzania), Sao Tome and Principe, Rwanda, South Africa, Swaziland, Kenya, Madagascar, Zambia, Gambia, etc.

Figure 1: progress on Malaria Trends in South Africa, Eritrea, Swaziland, and Zanzibar from 2001-2006.

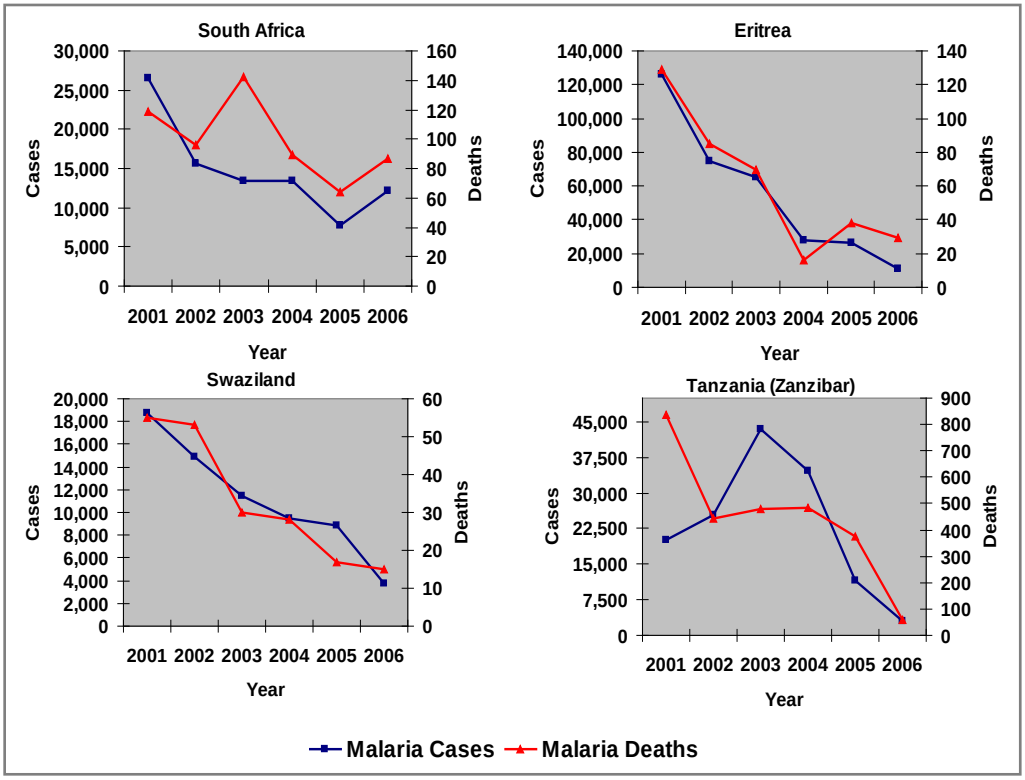
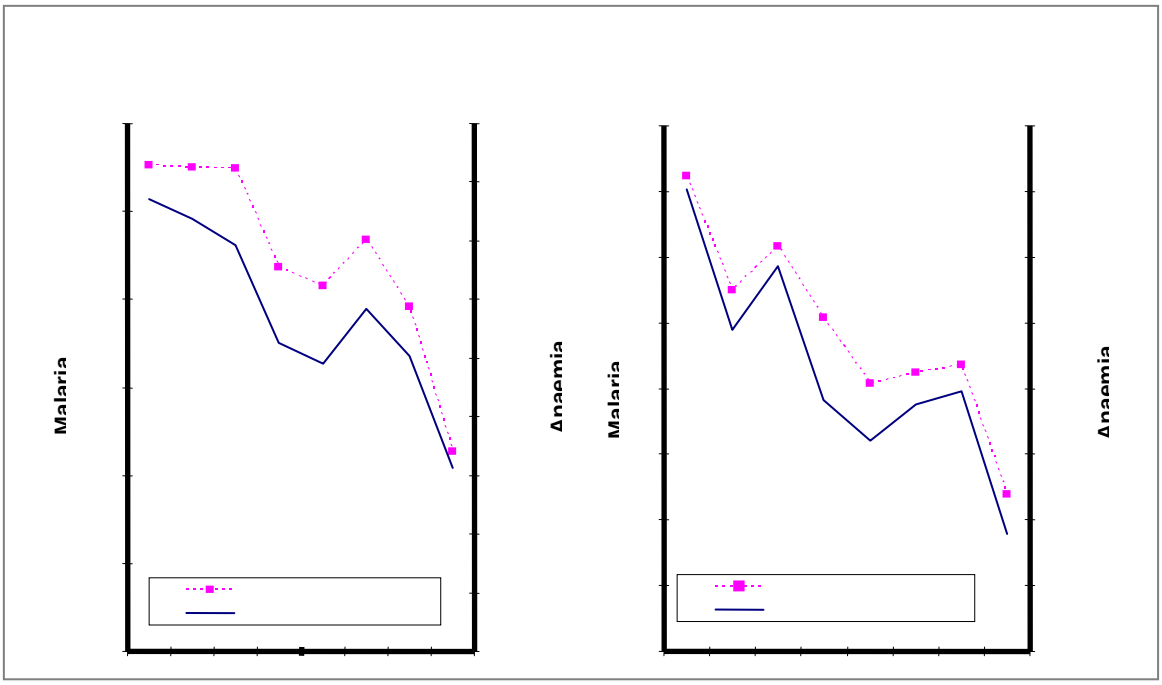


Figure 2: In-patient malaria and anaemia cases and deaths in children <5 years old by year, 1st and 2nd quarter 2000-2008, Zambia.



ISSUES AND CHALLENGES

- Due to weak health systems characterised by inadequate human resources, poor infrastructure, inadequate medicines and commodities procurement and supply management, weak parasitological diagnosis and community based service delivery capacity, many countries are failing to implement a comprehensive package of interventions. The weak health information and M&E systems also make it difficult to report on program performance and impact.
- Inadequate funding for malaria control is still an issue in some countries characterised by lack of domestic funds, difficult access to international funds for some countries or failure to appropriately manage the available funds.
- Partners' coordination is still a challenge despite the progress highlighted. In many cases, fragmented implementation of malaria control is a consequence of project based support disconnected from national strategies and programs. There is a need for clear allocation of partners' roles and responsibilities based on their mandates and comparative advantages and improved harmonisation and alignment with National Policies, strategies and plans in line with the '3 ones' principle of one coordination mechanism, one national strategic plan and one M&E framework.
- Requests for technical support are increasing and are not matched with adequate funding. As a result WHO and partners are facing a big challenge to keep adequate human resources to respond to countries needs.

Actions to be taken

Increase WHO human resource capacity to strengthen the collaborative work with key partners in order to:

- Support countries to accelerate the implementation of a comprehensive package of malaria control interventions progressively in the same geographical area and eventually cover the whole country for impact
- Support countries to access funds for universal coverage through existing funding initiatives as well as strengthening capacity to manage these additional resources
- Strengthen malaria medicines and commodities procurement and supply management systems, parasitological diagnostic and health information system (HIS) to monitor progress and measure impact of malaria control intervention
- Strengthen countries capacities for surveillance, monitoring and evaluation including adequate focus on drug and insecticide resistance monitoring
- Undertake joint program reviews with countries to timely identify and address bottlenecks in program implementation and to improve programs performance

PRIORITIES FOR FUTURE USAID GRANT

1. **Mobilise human and financial resources for malaria program (Region/country)**

2. **Strengthen surveillance, monitoring and evaluation**

   Strengthen malaria surveillance systems at all levels of the health system in the countries, at IST and WHO/AFRO

   Strengthen data management capacity at country and IST levels

   Build capacity for malaria SME by developing a training package and training SME staff at country level

   Ensure that all countries develop and implement comprehensive malaria SME plans

   Production of an annual progress report on malaria in the WHO African region

   Regular monitoring of drug resistance

   Production of quarterly bulletins on malaria surveillance and logistics

   Support countries for impact assessment, MIS and health facility survey (HFS)

3. **Support planning and accelerated implementation of quality malaria prevention and treatment interventions with focus on malaria diagnosis and treatment at health facility and community level**

4. **Strengthen community based interventions for universal coverage**

5. **Support to countries to mobilise more resources for universal coverage on malaria interventions**

i. TUBERCULOSIS:

BACKGROUND

The TB epidemic in the Region has reached emergency proportions. Currently, 22 high burden countries worldwide are responsible for 80% of total global TB burden of which 9 are in the African Region. Of the 15 countries with the highest estimated TB incidence rates per capita, 12 are in Africa. In 2007, TB notifications from the Region accounted for 30% of all notified cases in the world. The Region was the worst of three epidemiological regions where TB incidence was still rising. The emergence of multi-drug Resistance (MDR-TB) and Extensively Drug Resistance (XDR TB) has made TB case management more difficult. Access to 2nd line drugs for MDR/XDR-TB cases is still a big challenge because of the issue of affordability by countries.

WHO/AFRO and USAID have been collaborating to strengthen the TB program in Africa since 2004. An amount of US$6,814,207 was received from USAID during the last five years; this has enabled WHO/AFRO to recruit and retain staff in DRC, Kenya, Malawi, Tanzania, Uganda, Zambia and the Regional Office as well as implement activities identified during joint planning (TB/HIV, CTBC, MDR-TB, ACSM, Laboratory, TB in children). Five more countries whose activities were supported by this grant are Botswana, Burkina Faso, Cote d'Ivoire, Lesotho and Swaziland

Due to the emergence of MDR-TB and XDR-TB and the call for action made by member states, since 2007 AFRO added 2 new areas of focus in the grant: the implementation of a regional Advocacy, Communication and Social Mobilisation (ACSM) Strategy for TB and management of MDR and XDR-TB.

As a result of the implementation of the Directly Observed Therapy Short Course (DOTS) and new Stop TB Strategy: 10 countries reached or exceeded the 70% case detection rate for new smear-positive cases and eight countries have reached or exceeded the treatment success rate target (85%). Scale up of collaborative TB/HIV activities has been ongoing in most TB/HIV high prevalence countries. As a result TB patients counseled and tested for HIV increased from 22% to 38 % between 2006 and 2008.[19] The Prevention and Management of MDR-TB has improved in the countries: 36 countries have capacity for TB culture and DST services. However, in the African Region, the TB prevalence has increased from 333/100,000 in 1990 to 547/100,000 in 2008 while the disease incidence has likewise increased from 162 to 363/100,000.[20]

EXPECTED RESULTS FOR THE GRANT

1. Technical capacity to promote, coordinate and monitor implementation of community DOTS and TB/HIV activities strengthened in Regional Office and in focused countries;
2. Extent of drug resistant TB assessed in focused countries, programmatic management of drug resistant TB scaled up in the region and regional database on MDR-XDR TB developed and made accessible to stakeholders;
3. Advocacy, communication and social mobilisation in the Region;
4. The capacity of laboratory in the Region strengthened;
5. The capacity for management of TB in children in countries of the African Region strengthened.

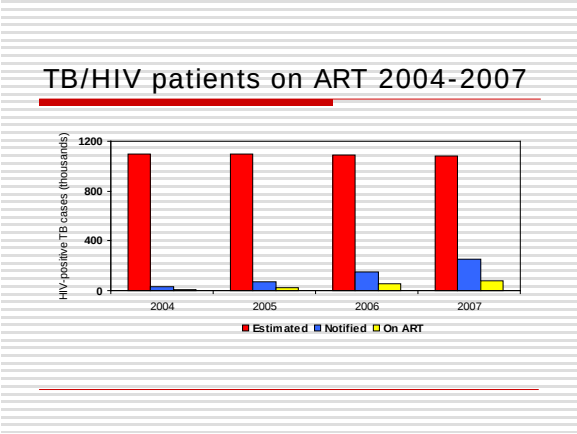
[19] WHO, Global TB report 2009 (in press).

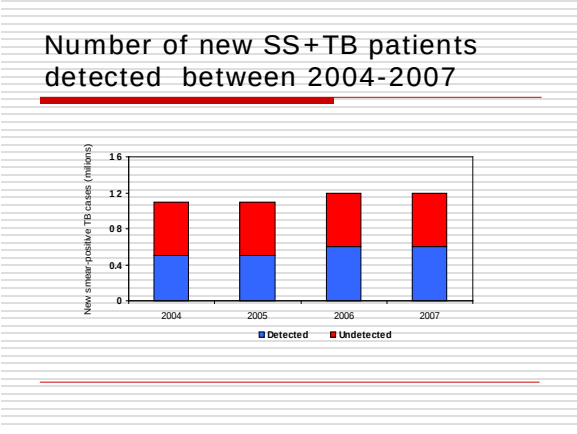
[20] WHO, Global TB report 2008.

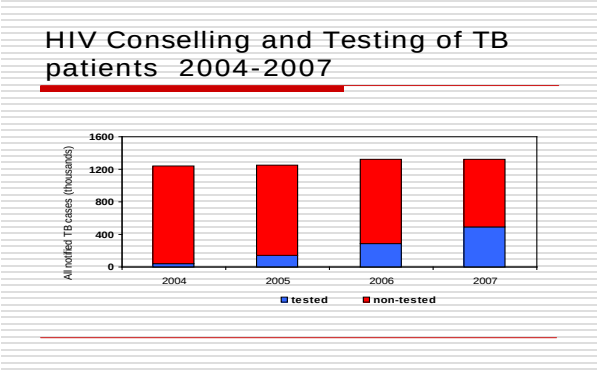
ACHIEVEMENTS

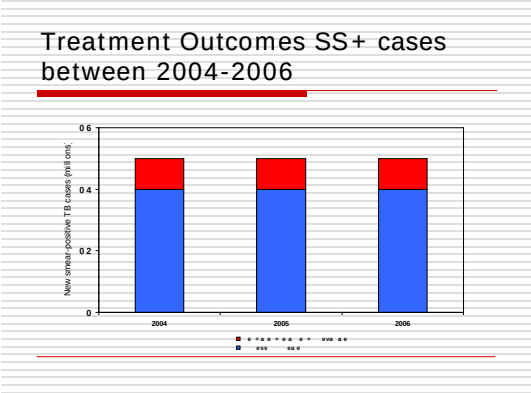
WHO unique role in TB control: WHO has continued to lead in the development of normative tools including: the strategy for DOTS expansion in the region, the TB HIV Strategy for the African Region, the framework for programmatic management of MDR-TB, and the ACSM strategy. All WHA and regional committee papers, which bind countries to cooperate and collaborate with partners operating in TB control, have been provided to countries. The stakeholders in TB control in Africa are all using guidelines, documents and principles set by WHO. WHO is therefore not just a partner but a leader in providing technical support to countries of the WHO African region. The TB program is the link between the various country TB Programs and partners who are all supporting countries but utilising WHO guidance tools and sometimes even WHO staff. In 2008, the regional office organised a regional meeting of all TB program managers and partners to strategise on ways of improving TB control activities and accelerating progress towards MDG targets. The meeting brought together 25 countries to a capacity building workshop in Brazzaville. The regional level also has the function of coordination of all IST activities, linkages with WHO HQ and partners, surveillance data collection and collation, program coordination, and fund raising.

WHO is the main link between countries and partners in rolling out the WHO policy of testing all TB cases for HIV and ensuring that those that meet the criteria have access to comprehensive care for HIV including: ARV and cotrimoxazole prophylaxis treatment (CPT). TB patients testing positive for HIV were 500,000 between 2004 and 2007. Those started on ART since 2004 have increased from 2000 to 154,000 by 2007. In 2007 alone, 77,000 TB patients were started on ARVs. National TB prevalence surveys are at various stages of planning in 12 countries of the region. These countries are part of the 21 global priority countries; WHO staff in the region are heavily engaged in developing proposals and making political and technical link with Ministries of Health to ensure success of these surveys. The countries include Ghana, Kenya, Malawi, Mali, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Uganda, Tanzania and Zambia. Collecting data for the global TB report would be completely impossible without the support of the WHO/AFRO regional offices, ICSTs and country offices. The number of countries reporting has increased from to 38 to 42 countries over the last 4 years.









WHO is leading country MDR/XDR-TB surveillance activities. XDR-TB has been reported in Botswana, Burkina Faso, Kenya, Lesotho, Mozambique, Namibia, South Africa and Swaziland. Surveys are planned in Mozambique, Ghana, Lesotho, Malawi, Tanzania and Zambia this year.

Achievements by expected result	
Expected results	**Achievements**
Technical capacity to promote, coordinate and monitor implementation of community DOTS and TB/HIV activities strengthened at regional Office and in focused countries	Staff: 4 Staff have been maintained at the RO and ICST (2 MO, SEC and AA). 6 NPOs have been maintained in selected countries (DRC, Kenya, Malawi, Uganda, Tanzania and Zambia) CTBC: 42 countries have been supported to plan for CTBC implementation by 2008 compared with 20 in 2004. We focused on 6 demonstration countries and 3/6 have reached country-wide coverage of CTBC (Malawi, Uganda and Zambia). TBHIV: 39 Countries are supported to implement TB/HIV collaborative activities by 2008 compared with 15 in 2004. TB patients counseled and tested for HIV increased from 2% to 37% between 2004 and 2007 *The number of countries implementing CTBC and TB/HIV surpasses the target of USAID AFRO agreement due to support from other partners including GF. AFRO supports GF application and monitoring of implementation. For the ongoing Round 9 applications WHO staff from AFRO, ICST and Country are supporting 26 countries*
-Extent of Drug resistant TB assessed in focused countries, programmatic management of drug resistant TB scaled up in the region and regional database on MDR-XDR TB developed and accessible to stakeholders	• 8 countries have been supported to complete/initiate TB drug resistance surveys, and concurrent second line anti-TB drug resistance surveillance to exclude XDR-TB. • 8 countries (Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Tanzania, DRC) have formal MDR/XDR programs and five of them (Kenya, Lesotho, Mozambique, Namibia, Tanzania and DRC) have since successfully applied to the Green Light Committee (GLC) for additional second line drugs to scale up the treatment programs • Regular reports from countries on MDR/XDR-TB instituted and Regional database of MDR/XDR-TB maintained. 4 countries (Botswana, Lesotho, Mozambique and Namibia) have since

	identified at least a case of XDR-TB. • 28 countries from the region reported a total of 8,652 MDR-TB cases during year 2007 • 16 countries reported 6463 MDR-TB cases in 2008. • 8 countries (Botswana, Burkina Faso, Kenya, Lesotho, Mozambique, Namibia, South Africa , and Swaziland, reported a total of 541 XDR-TB cases in April 2009
Advocacy, communication and social mobilisation in the Region	• A regional ACSM strategy has been drafted and is currently under peer review. The regional focal person has resumed work in June 2008. • TA to 5 countries with TB Global fund grants to implement ACSM strategies (Lesotho, Malawi, Ghana, Kenya, Namibia) • Format for documentation of ACSM activities developed and will be tested in 5 countries
The capacity of laboratory in the Region strengthens	Included in the last sub grant, activities are ongoing
The capacity for management of TB in children in countries of the African Region Strengthened	Included in the last sub grant, activities are ongoing

ISSUES AND CHALLENGES

- Inadequate human resources for scaling up TB activities (TB/HIV and CTBC, MDRTB). This prevents translation of increased funding to increased case detection and treatment success rates in the majority of countries.
- Low access to TB diagnosis and treatment mainly due to low coverage of the health sector upon which TB services depend; limited laboratory facilities for TB diagnosis and patient follow up.
- Few countries have policies and programs to survey and manage MDR-TB. Access to 2nd line drugs for MDR/XDRTB cases is still a big challenge.
- Negative effects of TB/HIV co-infection that lead to increasing TB incidence and death, and consequent reduction in treatment success rates.
- Twenty-six countries from the region reported a total of 8,624 MDR-TB cases during 2007. As of May 2008 six countries (Botswana, Lesotho, Mozambique, Swaziland, Namibia and South Africa) reported a total of 551 XDR-TB cases.
- Access to 2nd line drugs for MDR/XDR-TB cases is still a big challenge. It is mainly due to the issue of affordability by countries:
- Negative effects of TB/HIV co-infection that lead to increasing TB incidence and death, and consequent reduction in treatment success rates.

LESSONS LEARNT

- TA can be provided effectively and in a timely manner if the key staff at regional, IST and country levels are available and empowered.
- Capacity building in the country to improve ownership and leadership necessary to lead rapid and sustainable scale up of priority interventions is essential.
- WHO alone cannot fulfill all the needs of the countries; partnerships are required.

- Engagement of communities is essential to achieve high case detection and treatment outcomes in countries**.**

PRIORITIES FOR FUTURE USAID GRANT

We should strengthen countries to strive to reach the MDGs by focusing on all areas of the Stop TB Strategy

1. TB/HIV collaborative activities
2. Community TB care
3. MDR-TB surveillance and management
4. Laboratory
5. ACSM activities
6. Human resources at RO, IST and country levels

- Support to countries to mobilise resources through GFATM, GLC and other funding mechanisms

j. HEALTH SYSTEMS STRENGTHENING (HSS)

CONTEXT

Various cross-cutting health system issues and challenges hamper the progress towards the attainment of MDGs 4, 5 and 6. These include governance and leadership problems in managing the health sector, inadequate access and quality of a package of essential services and inefficient procurement and logistics management for medicines, equipment and other health commodities. The insufficient number, quality and poor distribution of the health workforce should also be addressed. In addition, there are no effective mechanisms for retention of staff. There is an urgent need to address these issues by accelerating health systems strengthening in order to achieve MDGs 4, 5 and 6.

A robust health system needs to ensure that it delivers effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed with optimum use of resources. It, therefore, must have a health workforce that is responsive, fair, efficient, well-distributed and results focused. The system must ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness. It must raise adequate funds to ensure universal access to services while protecting the people from financial catastrophe and impoverishment associated with paying for services.

WHO has developed a framework for health systems strengthening (HSS) comprised of building blocks which are interlinked and synergistic to each other when strengthened simultaneously. The blocks are service delivery, human resources, medicines and technologies, financing, information, and leadership and governance. The figure below illustrates the interaction of the building blocks with leadership and governance at the centre. At country level, the district health system is pivotal to improved health outcomes and achievement of the MDGs 4, 5 and 6.

Figure 1: The six health system building blocks with Leadership and Governance at the centre:

Source: *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO'S Framework for Action.*

Expected Results

A portion of the USAID Grant was provided to the WHO/AFRO DSD Division only in 2008. The expected results of the WHO/USAID collaborating program on HSS are to strengthen the human resource capacities of WHO/AFRO at the inter-country and country levels; support countries in the development of comprehensive strategic national health plans; and enhance National Health Service organisations and management via

strengthening integrated PHC services. Existing opportunities, such as Global Fund and GAVI funding grants, are to be exploited and countries supported to formulate sound proposals.

ACHIEVEMENTS

Human resource capacities of WHO/AFRO at the ISTs in West Africa strengthened through the recruitment of a medical officer for health systems.

Health Policy and Service Delivery (HPS) working capacity has been improved logistically by the procurement of office equipments to facilitate the work of the team.

In Sierra Leone, the process of developing the National Health Strategic Plan has been supported by WHO/AFRO at all levels leading to the completion of a situation analysis which will also form the basis for revising the National Health Policy.

Twenty seven participants representing Ministries of Health and program officers of WHO Country Offices from Benin, Burkina Faso, Cote D'Ivoire, Guinea, Mauritania, Niger and Togo were trained in developing GAVI and Global Fund Health Systems Strengthening proposals. This will contribute to mobilising more resources for strengthening national health systems.

Benin, Burkina Faso and Mauritania have formulated their GF proposals to strengthen health systems with the technical support of the IST/West Africa in collaboration with other partners.

Capacities of 30 participants from Benin, Burkina Faso, Cote D'Ivoire, Mali, Niger and Togo in monitoring and evaluation of health systems performance were improved with focus on the choice and use of indicators at district and national levels. This was accomplished through a 5 day training workshop organised in collaboration with the European Union in Niger.

Fifty four senior nurse managers and regulators were reoriented and supported to initiate the development of national strategic plans to strengthen the contributions of nursing and midwifery services to the performance of national health systems. The IST/WA contributed to this reorientation by emphasising the PHC Renewal.

Challenges

There were delays in the initiation phase of this component of the WHO/USAID collaboration partly due to late allocation of budget (18th December 2008) and administrative requirements of recruiting a Short Term Professional Staff for IST West Africa for 11 months.

Multiple competing responsibilities experienced by the Ministries of Health staff and WHO country offices overstretched their duties leading to some delays in implementing the planned activities. In addition, their capacities in analysing system-wide barriers, strategic planning and monitoring of performance are limited. The human resource capacities of Ministries of Health at central and district levels are generally weak.

Lessons learnt

- Working in partnership with programs of the Division of Health Systems and other WHO/AFRO divisions using team approach increases the quality and efficiency of technical support.
- Collaboration with other partners in health development also facilitates the implementation of activities at country level. Adequate preparation involving all the concerned parties enhances the quality of the technical support provided.

Proposed priorities for future grants

Funding for health system strengthening was initiated in 2008 in the WHO/USAID collaboration. It is therefore essential to maintain the support so as to realise the desired outcomes and impacts. The support needs to be augmented and expanded to ISTs of the other 2 sub-regions and the Regional Office for effective support to countries and for better harmonisation and coordination. The approach will be to enhance synergies between WHO and its various partners in implementing the Health Policies and Service Delivery

Programs. The implementation of the proposed priority areas below will contribute to achieving better health outcomes including the MDGs 4, 5 and 6 at country level.

Strengthen capacities in leadership and governance particularly through supporting countries in developing sound national health policies and realistic health strategic plans and operationalisation of the plans at district level.

Support the development of capacities in the organisation and management of health services using an integrated PHC approach with particular emphasis on community involvement and the social determinants on health.

Improve the capacities of countries in monitoring and evaluation of the performance of health systems in the context of implementing the "Ouagadougou Declaration on PHC and Health Systems in Africa: Achieving Better Health in Africa in the New Millennium."

Improve the capacity of the WHO Regional Office and ISTs in West, Central and Southeast Africa through increasing the number and quality of professional staff competent in strengthening health systems (policy analysis, policy development, health strategic planning, organisation and management of health services including referral systems, implementation, monitoring and evaluation, community involvement.)

VII. FINANCE

Funding for WHO/AFRO from the Africa Bureau of USAID (USAID/AFR) is in the form of a grant. In accordance with USAID grant agreement procedures, grant funds offer the recipient maximum flexibility – the recipient is not legally bound to use the funds in any particular manner. Nonetheless, in order to enable USAID/AFR to account for and report on the use of its funds, procedures have been put in place for developing a budget and reporting on expenditures.

The process put into place to secure the release of funds begins with the submission of a proposal by WHO/AFRO to USAID/AFR. That proposal contains a brief description of planned activities by each of the WHO/AFRO divisions requesting funds, including the identification of positions to be funded under the grant, and a budget for each program area. There is often an exchange between technical staff of the two organisations clarifying the intentions of the proposal and, at times, leading to desired revisions. In this last year of the grant, USAID asked the divisions for more detailed implementation plans than those appearing in the proposal itself. From the USAID perspective, these detailed explanations of how the funds will be used helps USAID staff to better understand how the work is done under the grant and, in turn, enables AFR/SD to justify the grant's continuation to its senior management. Quarterly, WHO/AFRO prepares a spreadsheet that accounts for the expenditures to date against the budgeted amounts. The spreadsheet displays the expenditures by division. It does not give the expenditures by activity within a division. USAID cannot determine which activities were implemented and which are pending from the spreadsheet. The financial status of the current grant is displayed in the following table.

STATUS OF FUNDS			
COMPONENT	**BUDGETED**	**DISBURSED**	**BALANCE as of 3/09**
USAID/Africa Bureau Funds			
RH/FP	1,308,362	991,196	317,166
MNH	2 450 000	2,276,947	173,053
Pediatric HIV	1,452,000	1,220,823	231,177
CAH (IMCI)	4,688,705	4,039,391	649,314
VPD	4,169,889	3,551,037	618,852
Malaria	5,079,598	4,288.030	791,568
Nutrition	600,000	466,138	133,862
Tuberculosis	6,814,207	5,008,056	1,806,151
Avian Influenza	1,309,000	962,208	346,792
IDSR	5,825,756	4,126,048	1,699,708
Health Systems	300,000	157,386	142,614
SUB-TOTAL	33,997,517	27,087,260	6,910,257
USAID Mission Funds			
Rwanda	320,000	217,185	102,815
D.R.C.	802,000	800,971	1,029
Liberia	1,747,061	945,061	802,000
Angola	250,000	250,000	0
Burundi	100,000	100,000	0
SUB-TOTAL	**3,219,061**	**2,313,217**	**905,844**
GRAND TOTAL	**37,216,578**	**29,400,477**	**7,816,101**

Annually, each division in WHO/AFRO that receives funds prepares a report describing the achievements of the last year both in prose and quantified in a series of process indicators as required by USAID. The format of this annual report has evolved over time to harmonise the reporting to the multiple donors supporting each division and thereby minimizing the reporting burden on WHO/AFRO. These reports indicate the funding from all sources for the program component in question. To carry out their work plans, the program managers commingle funds to carry out their work plans.

RECOMMENDATIONS

The annual reports provide good information on the progress of the divisional programs without identifying the particular contribution of WHO/AFRO to that progress. Efforts should be made to identify and highlight the role played by WHO/AFRO in bringing about the progress of the broader programs.

Of equal importance, these reports do not give a sufficient, explicit accounting of USAID's contribution to the divisional performance. When submitting the comprehensive annual report to USAID, WHO/AFRO should consider appending a section that recounts how USAID funds were applied and, where possible, specific results achieved with USAID funds.

The annual reports, as well as the five-year progress reports received during this assessment, indicate that activities have been completed but do not indicate what happened as a result of the activity. For example, in the FP/RH area, planned workshops in the use of the toolkit for repositioning family planning were carried out but there is no indication of whether the trainees were able to influence policy (for example, the addition of a line item in the budget for the purchase of contraceptive commodities) in their countries as a result of having been trained.

The notion of having a more detailed implementation plan within the first quarter following the start of the period covered by a grant amendment should be institutionalized.

MANAGEMENT

In accordance with USAID procedures, AFR/SD designates one of its technical staff as the Cognizant Technical Officer (CTO) for the grant, which has been carried out by Ms. Mary Harvey. During the period since the mid-term assessment, AFR/SD has attempted to form stronger relationships between its technical staff and their counterparts at WHO/AFRO. This effort has met with mixed results.

At WHO/AFRO, the division preparing the annual proposal to USAID manages its activities. As noted in the section on Budget and Expenditures, the divisions utilise funds from a number of sources in order to have a single divisional work plan. There is no single individual at WHO/AFRO charged with overseeing the grant in its entirety and assuring that the programs put forward by its divisions are mutually supportive. As stated in the recommendations, the evaluation team recommends that there should be a single focal point for the grant at both WHO/AFRO and AFR/SD.

As noted, USAID requires that there be a single CTO with the authority to sign official documents related to the grant. The notion of pairing technical counterparts from the two organisations can and should still be pursued.

RECOMMENDATIONS:

A single counterpart to the USAID CTO should be identified at WHO/AFRO with the responsibility of assembling the proposals and annual reports in a consistent format and the task of reviewing the quality of the pieces of the proposal and annual reports. That individual should also seek opportunities across the divisions to better integrate the activities undertaken by the separate divisions.

Procedures should be established to improve the links between the technical staff in AFR/SD and their counterparts at WHO/AFRO. Periodic teleconferences (perhaps monthly) should be scheduled and, where possible joint missions to countries or to regional gatherings should be organised. Putting faces to names and having the opportunity to exchange thoughts and ideas informally go a long way toward promoting constructive dialogue and action.

VIII. COUNTRY REPORTS

a. Democratic Republic of Congo (DRC)

CONTEXT

A joint USAID and WHO team undertook a final evaluation of the USAID Grant AFRO-G-00-04-0001 (2005-2009) to WHO/AFRO for communicable diseases programs and child and reproductive health. Following the Regional office visit, the team proceeded to visit the following countries: DRC, Liberia, Kenya, and Ethiopia. Dr Sambe Duale (Africa 2010 /Tulane University for USAID) and Dr Socé Fall (WHO) visited the DRC. The method of work was interviews with key informants and a review of documents. Consultations and discussions were carried out with key informants from WHO, USAID, Ministry of Health, CDC and UNICEF (see list on page 78).

WHO

Program areas

WHO has a strong presence in DRC because of the post conflict situation, the size of the country and the complexity and burden of preventable and treatable diseases. The WHO Country Office (WCO) in DRC, in collaboration with the Ministry of Health, developed the Country Cooperation Strategy (CCS) which covers the period 2008-2013. The CCS focuses on key strategic areas:

1. Institutional support for the health system strengthening including the operational level (Zone de santé);
2. Strengthening prevention and control of priority diseases; promotion of maternal, newborn and child health; healthy environment and humanitarian action in emergency situations.

Apart from the CCS, the WCO work is based on the biennial Plan of Action (POA). The current POA covers 2008-2009. The different program areas covered are as follow: HIV/AIDS, Malaria, TB, Health System Strengthening, EPI, IDSR, EPR, CAH, MPS, SRH, NUT, PHE, EHA.

WCO human resources for priority programs

Under the supervision of the WR, the work of WHO in DRC is organised around International Professional Officers (IPOs) and National Professional Officers (NPOs):

- IPOs: HIV (1), EHA (3), HAT (1), IVD (4), LEP (1)
- NPOs: 62 including 15 surveillance officers at provincial level for IVD and 7 logisticians and 10 medical coordinators for EHA.

For such a complex and big country, it is clear that WHO needs to place staff at national and provincial levels. For important programs such as Malaria, Nutrition, Sexual Reproductive Health, WHO does not have an IPO or NPO at national or provincial level. This critical gap needs to be addressed urgently.

Relationship with MoH and Partners

- During the mission, the team had an opportunity to meet with the Chief of Staff (Directeur de Cabinet) of the MoH, and staff working in disease control program, surveillance and malaria. WHO is seen as the number one partner for the MoH.
- WHO and the MoH have a close working relationship including a weekly meeting between the WR and Minister that takes place every Tuesday.
- Experts from WHO and MoH prepare for these weekly meetings seriously.
- There is a huge expectation from the government for WHO to support the MoH in terms of capacity building for government leadership, health policy development and long term health sector planning.

- They also identify health system strengthening taking in to account the decentralization process and focusing on various programs such as Emergency Health Action, Epidemic Preparedness and Response, Child and Maternal health, Prevention and Control of communicable diseases such HIV/AIDS, TB, Malaria and vaccine preventable diseases.
- The support provided by WHO in disease surveillance, epidemic preparedness and response (EPR), and immunisation is highly appreciated by the MoH and partners. The absence of an NPO for Malaria is seen as a critical bottleneck that needs to be addressed in order to provide support to the national malaria control program in the area of technical coordination of key actors, monitoring and evaluation, malaria case management including drug efficacy testing and pharmaco-vigilance.

USAID

Program priorities

The USAID health program in DRC covers the following areas: HIV/AIDS, TB, Malaria, Maternal and Child Health, Family Planning, Clean Water and Sanitation, and implementation of Primary Health CARE (PHC) interventions.

Assessment of WHO/AFRO

USAID is funding WHO/AFRO for polio surveillance and integrated disease surveillance. The work done by WHO/AFRO to strengthen the disease surveillance system at national and provincial levels through the development of modules, training and deployment of staff is highly appreciated. Meanwhile, the USAID team recognised that the funds allocated for PFA surveillance are not sufficient to sustain the integrated disease surveillance system. There is also a need for WHO/AFRO to make USAID collaboration in the area of disease surveillance more visible.

The USAID team expressed the need for more bilateral interactions between WHO/AFRO and USAID at head of agency and at experts' levels. There is room for more collaboration in the area of malaria control and maternal health as has been done for polio. The financial management system in WHO from HQ to WCO is seen as one of the key problems delaying fund availability after the transfer is made by USAID. It is expected that the new WHO Global Management System (GSM) will resolve this problem.

It is recognised that the role of WHO NPO is critical for the day to day technical support to the MoH programs. The USAID mission is expecting WHO to play a critical role in the future in the following areas: Health System Strengthening including long term strategic plan, disease control programs, partner mobilisation and coordination, capacity building including harmonisation of training modules to be used by partners, MDR-TB, ART and ACT resistance monitoring, reproductive health and disease surveillance. It was further noted that no other institution is able to support disease surveillance better than WHO/AFRO.

CDC

The CDC mission in DRC is working in the area of HIV (Global AIDS program) with a small portfolio for avian flu. The CDC Chief of Party highlighted the collaboration with WHO around Ebola fever outbreak, training sessions on avian flu, and participating within the HIV/AIDS committee.

KEY ACHIVEMENTS THROUGH USAID GRANT

With the USAID grant, WHO has been able to strengthen, the immunisation program, polio surveillance as well as integrated disease surveillance. The technical support provided by WHO for the avian and swine influenza preparedness and response was highly appreciated. The same appreciation was made for the control of Ebola, cholera and meningitis outbreaks. With the USAID grant, WHO has been also able to recruit an NPO for TB and provide support to MoH for the improvement of TB diagnosis, DOTS expansion, TB/ HIV collaboration and well as access to resources through the GFATM and the TB GLC for access to second line

treatment for MDR-TB. WHO has played an important role in capacity building for IMCI at national and provincial levels.

UNICEF

According to Chief of the Health Section, WHO, UNICEF and USAID are the main partners supporting the immunisation program. WHO is providing technical support in surveillance and capacity building while UNICEF is in charge of communication and supplies. Furthermore, WHO is expected to play a critical role in building capacity for institutional reform, development of the health sector strategic plan and health system strengthening, immunisation and surveillance.

DEVELOPMENT COORDINATION

Donor coordination is identified under the name of GIBS (Groupe Inter Bailleurs Santé). The members are bilaterals (Canada, Japan, Germany, USA, Belgium, Sweden and European Union), multilaterals (UNDP, UNFPA, UNICEF, World Bank, WHO). GIBS has regular monthly meeting and is currently chaired by Canada.

The MoH has established a steering committee for the health system strengthening known as CNP (Comité Nationale de Pilotage) which includes partners and MoH services at national and provincial levels. The CNP is not yet fully functional and the first meeting was hosted by WHO in February 2009. Member of the GIBS are currently working with the MoH to revise the CNP Structure.

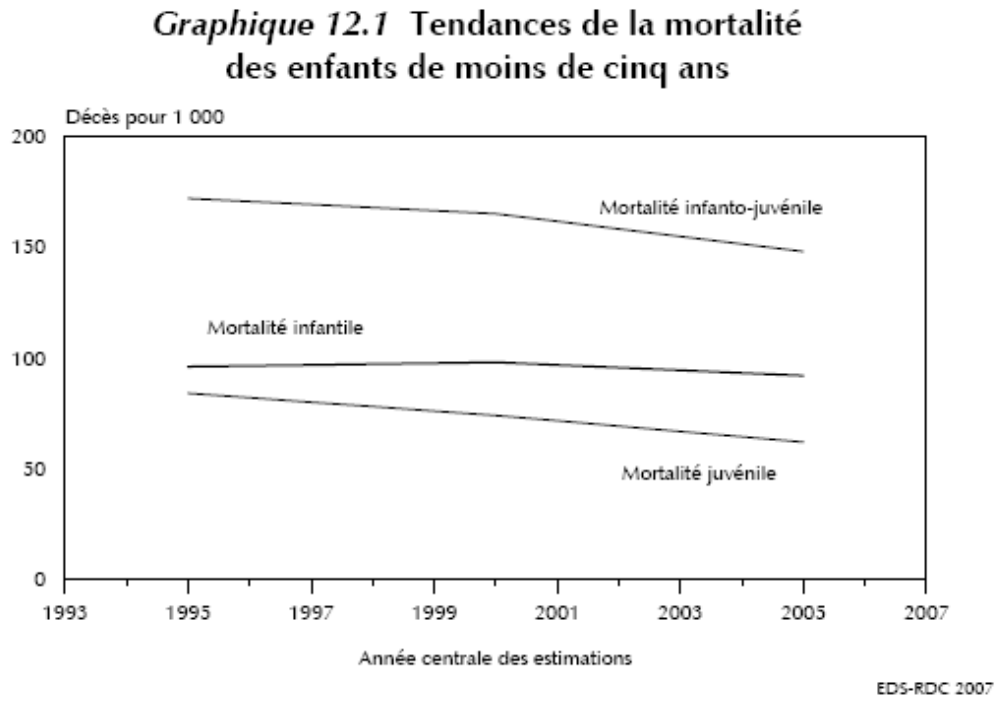
The GFATM grants are coordinated through the Country Coordination Mechanism (CCM), chaired by the MoH.

PROGRESS TOWARDS THE MDGs

MDG 4

The under five mortality rate is very high in DRC and has been stagnant from 1990 to 2005 with 205 deaths for 1,000 live births. Meanwhile the 2007 DHS indicated a reduction of the infant mortality rate from 190 deaths per 1,000 live births in 1990 to 148 deaths for 1,000 live births. The 2007 DHS revealed large differences in <5 mortality between rural and urban areas (177 against 122) and between the poorest and the richest quintiles (184 against 97).

Figure 1 Infant, Child, and Under-Five Mortality DRC



More than one third of child deaths are attributed to under-nutrition, 23% to pneumonia, 18% to diarrhea and 17 % to malaria.

Malaria

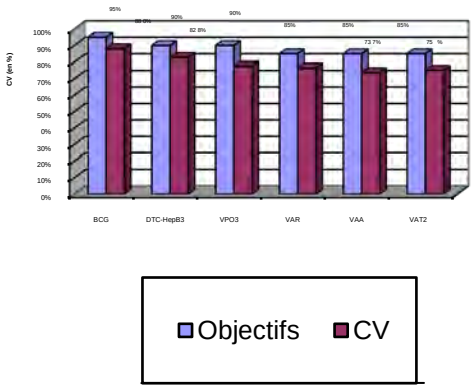
The DHS (2007) indicates that only 9% of the Households (HH) in DRC own at least one insecticide treated net and less than 1% of children with malaria have received ACT. Capacity to implement, monitor and evaluate malaria interventions is still weak in DRC; this was highlighted during the last RBM board meeting. In 2008, with various partners support, the country secured a USD400 million GFATM grant for malaria. The World Bank malaria booster program will also invest in DRC. It is expected that donors will help to increase malaria intervention coverage. Without strong technical presence of WHO and other technical partners, the risk of poor performance remains high.

Immunisation

In 2008, the measles vaccine coverage was 76.4 % and the oral polio vaccine coverage was 77.6% against the 90% national objectives. WHO support for the immunisation program was critical to maintain the coverage level. The main reasons undermining the attainment of the national objectives for immunisation were:

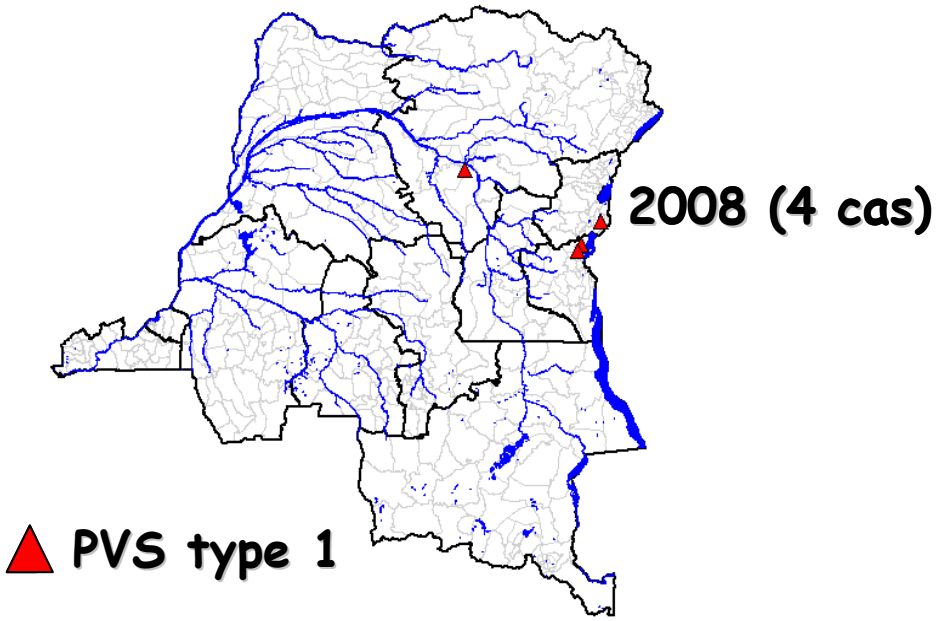
- stock out of antigens and other commodities
- poor planning and coordination at decentralized level
- non-implementation of the accelerated phase in the majority of the health zones
- lack of specific approaches to reach hard to reach populations

Figure 2: Immunisation coverage in DRC in 2009



Since the re-emergence of the wild polio virus in 2006, WHO has been organizing regular immunisation campaigns using OPVm type 1. The virus was still circulating in 2008. The campaigns were combined with Vitamin A and Mebendazole distribution.

Map 1: Distribution of Wild Polio virus in DRC from January to November 2008



NUTRITION

In DRC, 46% of under-five children are stunted and present chronic malnutrition and 24% present severe malnutrition. 71 % of under-five present anaemia and only 55% have received Vitamin A during the last six month before the survey (DHS 2007).

MDG 5: IMPROVE MATERNAL MORTALITY

MMR is very high in DRC and is estimated around 549 deaths for 100,000 live births. With their current health system, DRC will not be able to reach MDG 5. Major investments will be needed for Family Planning as well as for Health System Strengthening.

Table 1: Selected maternal health indicators in DRC

2007 DRC DEMOGRAPHIC HEALTH SURVEY		
TIME PERIOD	**INDICATORS**	**NUMBER**
Pre-Pregnancy	Modern Contraceptive use	7%
Prenatal	One visit	85%
	Four visits	47%
	Tetanus Toxoid x 2	71%
Delivery	Delivery by trained attendant	74%
Maternal mortality	Maternal mortality for 100,000 live births	549

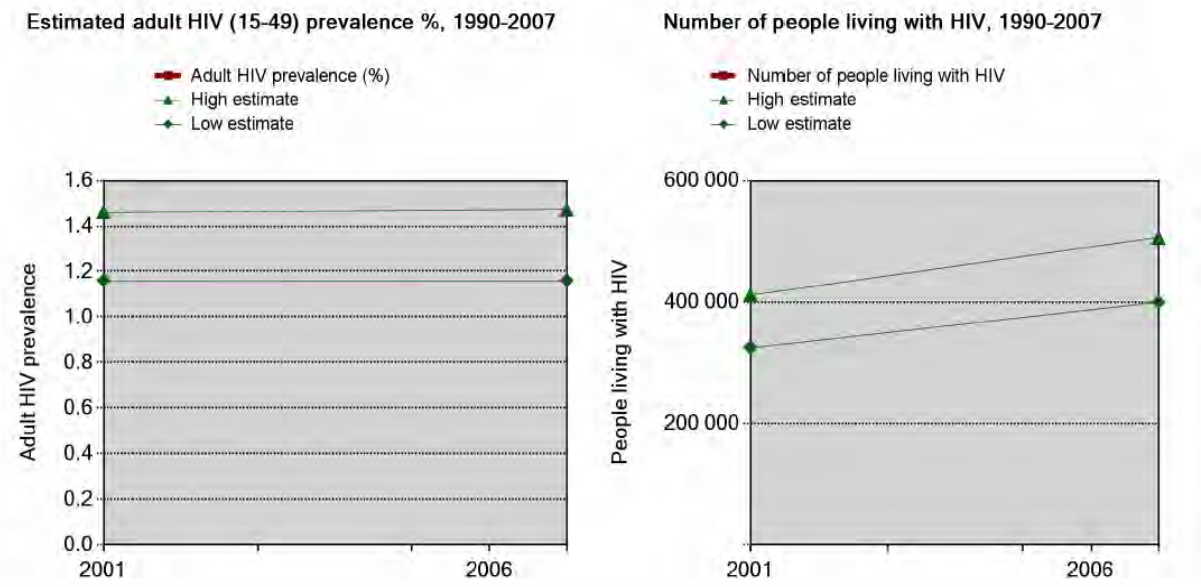
MDG 6: COMBAT HIV/AIDS, MALARIA, TB AND OTHER DISEASES OF PUBLIC HEALTH INPORTANCE

Table 2: HIV/AIDS Indicators in DRC

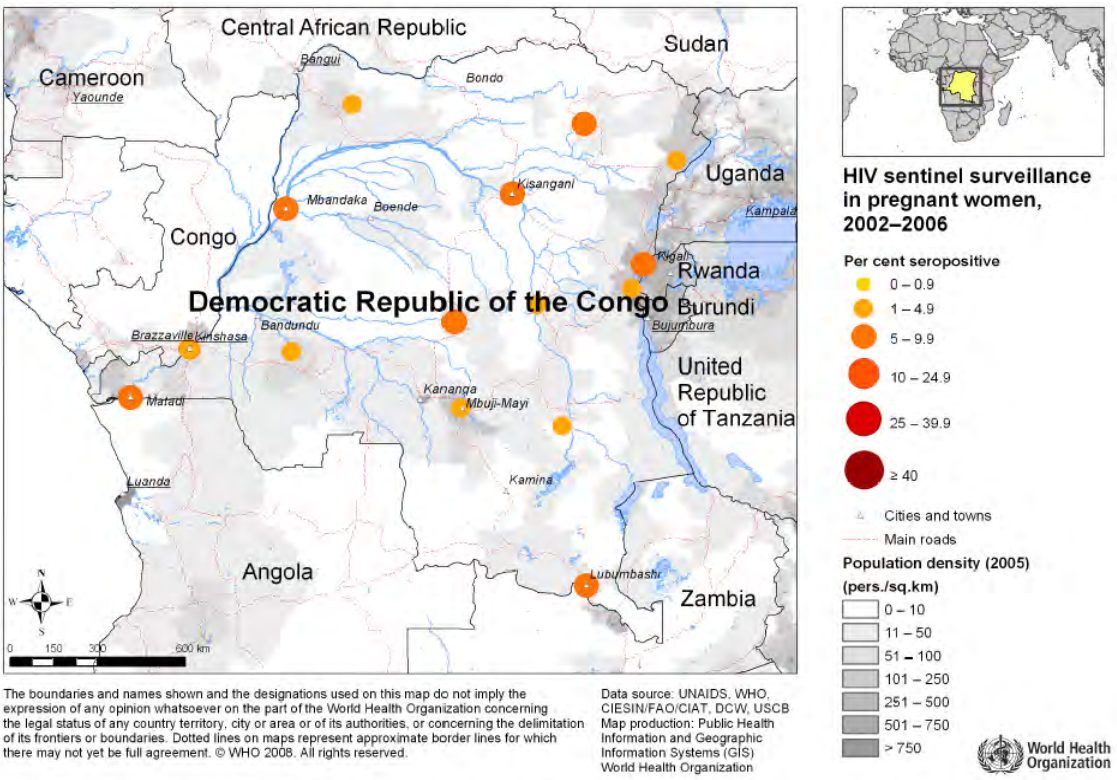
	Value	**year**
HIV/AIDS Indicators		
HIV prevalence estimate 14-49 years old	[1.2- 1.5]	2007
Facilities providing ANC with also HIV testing and counselling	5.1 %	2006
Estimated ART coverage (%)	[20 – 29]	2007
Estimated % of women living with HIV who received antiretroviral for PMTCT (%)	[8 – 10]	2007
Percentage of donors blood units screened for HIV in quality-assured manner	47%	2007

The gap is still huge regarding universal access to HIV/AIDS services towards the achievement of the MDG. Access to ART and PMTCT is still very low.

Figure 3: Trend in HIV prevalence in DRC



Map 2: HIV prevalence in pregnant women:



TUBERCULOSIS

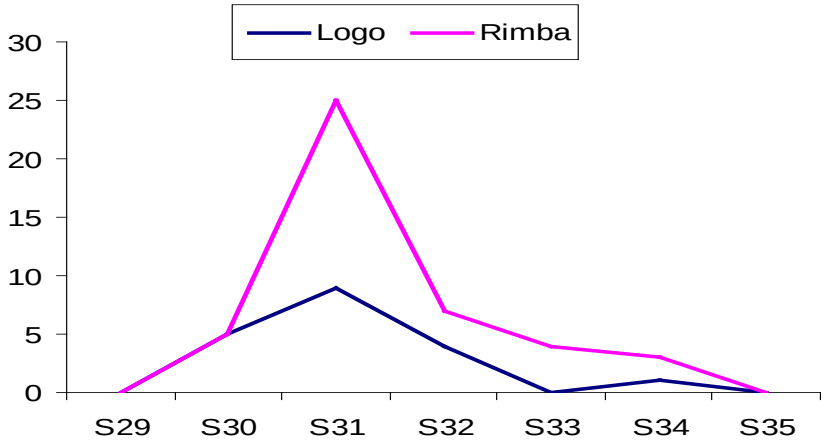
TB is still a major public health problem in DRC in 2008. The TB incidence has increased from 62,433 cases in 1990 to 245,333 in 2008. The TB case detection rate is 61% while the treatment success rate is 62 % (WHO Global TB report 2009). MDR/TB cases have been reported in 2007 and 2008. The country is trying to expand the DOTS strategy through the health centers. The numbers of health centers providing diagnosis and treatment have expanded from 991 to 1338 in 2008.

EPIDEMICS

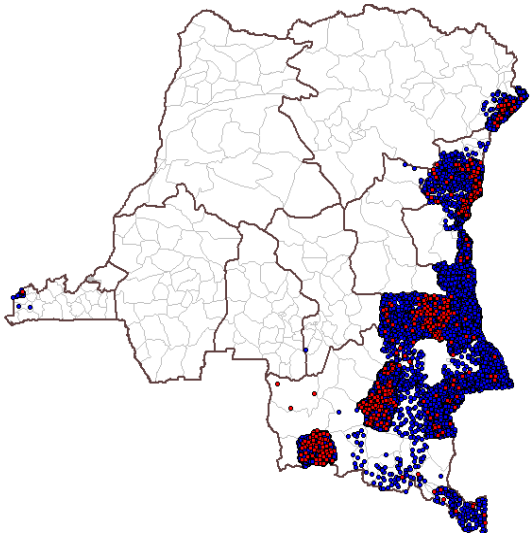
The country is exposed to epidemic outbreaks such as Cholera, hemorrhagic viral fever (Ebola Fever), meningitis, and pulmonary plague. The main problem encountered is the late detection of epidemics.

Figure 4: Cholera outbreak in DRC in 2007

Figure 5: Pulmonary Plague outbreak in DRC in 2007



Map 3: Zone de Santé affected by pulmonary plague in DRC:



CHALLENGES

As a post conflict country, the DRC is facing many challenges. The most prominent ones are the need to strengthen technical and financial capacity:

- strengthen the health system at national, provincial and zonal levels
- detect and control epidemics
- expand key interventions for HIV/AIDS, TB and Malaria
- accelerate child and maternal health program to reduce under five and maternal mortality.

WAY FORWARD FOR WHO

WHO is expected to do almost everything in DRC but is facing financial constraints in securing key NPO positions for Malaria, Maternal Health, CAH as well as health system strengthening. DRC's WCO will need more financial support from USAID and other partners in order to support the MoH for capacity strengthening, for government leadership, health policy development, long term health sector planning, and HHS. Given the decentralization process to Health Zones, priorities need to focus on various programs such as Emergency Health Action, epidemic preparedness and response, child and maternal health, prevention and control of communicable diseases such HIV/AIDS, TB, Malaria and vaccine preventable diseases.

ANNEX: List of key informants

WHO

1. Dr Mattieu Kamwa, WR
2. Dr Koffi Tsogbe, IPO/EPI
3. Dr Jean Pierre Lokonga, NPO/MPN
4. Dr Mayenga May Makita, EPI/surveillance
5. Dr Ekwanzala, NPO/DPC
6. Dr Brigitte Kini, NPO/CAH
7. Dr Nicolas Nkiere, NPO/TB
8. Dr Casimir Mazenga, NPO/HIV
9. Dr Isseu Touré, AFRO/PMTCT

USAID

10. Mrs Michelle Russell, Health Team Leader, USAID
11. Dr Emile Beni Bongo, Infectious Disease Program Manager, USAID
12. Dr. Astrid Lina Mvumbi Piripiri, Maternal and Child health, USAID

CDC

13. Dr Luca Flamigni, Chief of Party, CDC

UNICEF

14. Dr Celestino Costa, Chief Health Section, UNICEF

MINISTRY OF HEALTH

15. Dr Marcel Mukengeshayi, Directeur de Cabinet (Chief of Staff) /MOH
16. Dr Jean Claude Kanow Mamungayi, Head of Disease Control Division
17. Dr Leopold Lubula Mulumba, Bureau Surveillance and Epidemic Response
18. Mr Georges Minsami, Administrator, Direction for Surveillance
19. Dr. Jean Angbalu, Deputy Director, National Malaria Control Program.

b. Ethiopia

CONTEXT

- As described in the USAID Grant, a final joint WHO-USAID Evaluation is being carried out to assess progress toward grant objectives and to identify windows of opportunity for the probable follow-on grant for 2010-2014.
- Objectives of the Review and Methods are described in Sections IV and V of the full report.
- Four countries were selected for country visits including Ethiopia. A three person team, Dr. Phanuel Habimana – WHO Child & Adolescent Health; Dr. Roy Miller – USAID; and Dr. Stanley Foster, Professor of Global Health Emory University visited Ethiopia from May 21-May 23, 2009.
- Consultations were carried out with the Ministry of Health - Dr. Yibeltal Assefa, (Medical Services), Dr. Neghist Tesfaye (Health Promotion and Disease Prevention), Dr Naoud (IDSR); WHO - Dr. Fatoumata Nafo-Traore (WR) and her staff (see line listing at end of section); USAID - Meri Sinnitt (Chief Health, AIDS, Population, and Nutrition Office), Anita Gibson (Team Leader Health), Dr. Richard Reithinger (Malaria Advisor and Team Leader PMI); UNICEF Country Office - Assaye Kassie, (Child Survival Specialist); and CDC - Dr. Tom Kenyon (HIV/AIDS Country Director).

WHO

- Ethiopian Ministry of Health, UNICEF, USAID, and CDC all commended Dr. Fatoumata Nafo-Traore and her team for their unique roles in supporting the MoH in multiple ways:
    - Trusted source of technical guidance to the MoH
    - Effective partner in Policy Formulation and Planning
    - Resource on norms, standards, tools, and training materials (cooperatively with UNICEF)
    - Technical support of 180 WHO staff at WHO Office, Federal Ministry, and Regional levels.
    - Rapid response to Ministry requests for technical assistance from the WHO Mission in Ethiopia, the Inter-country Team in Zimbabwe, and the Regional Office in Brazzaville.
- All sources commended the availability, openness, and technical abilities of the WHO team.

UN COORDINATION

- Representatives of four UN Agencies (WHO, UNICEF, UNFPA, and the World Bank) meet regularly to coordinate their support of Ethiopia's Health system and strategies.

USAID

- USAID is a major partner both in technical and financial support to the Ethiopian Government.
- Financial support is summarised in Table 1.

TABLE 1: USAID SUPPORT TO ETHIOPIA

	FY 07	FY 08
HIV/AIDS	230,181,000	337,000,000
TB	1,200,000	2,433,793
Malaria	6,586,905	19,565,996
Other Public Health Threats	500,000	
MCH	7,056,305	13,187,667
FP/RH	16,881,651	17,950,455
Total	262,405,861	390,137,911

DEVELOPMENT PARTNERSHIPS

- Chaired for the current year by the WHO Representative, Dr. Fatoumata Nafo-Traore, and the USAID Chief of Health, AIDS Population, and Nutrition, Meri Sinnitt; the donor community meets regularly to share information and coordinate their assistance to the Ethiopian Government.
- Working under the Harmonisation guidance of the Rome Declaration of 2003, the Paris Declaration of 2005, and the Accra Agenda of 2008, Ethiopia and its development partners have committed themselves to working together to support the Ethiopian Government in their achievement of the MDGs.
- Within the Road Map Framework, a Gap Analysis was carried out to identify the barriers in the areas of maternal and child health.
- An assessment of 791 hospitals and health center as to meeting the standards for Emergency Obstetric Care was carried out jointly by the Ministry of Health, JHPIEGO, and Columbia University. Only 11% met standards.
- In August 2008, a compact was signed outlining a joint financial arrangement.

MILLENNIUM DEVELOPMENT GOALS (MDGs)

- Ethiopia is committed to achieving the MDGs
- Development partners are supporting the Ethiopian Government's commitment
- The Health Sector is responsible for MDGs 4, 5, 6

PROGRESS TOWARD THE MDGs - Given the low access to health services documented in the 2005 Ethiopian Demographic and Health Survey, Ethiopia has made significant progress over the last five years. The achievements represent the inputs of the Ethiopian Government and its development partners.

For Reference: MDG 4, MDG 5, MDG 6

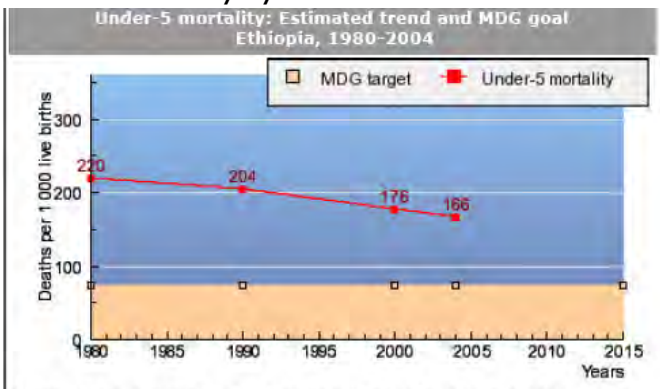
MDG4 - Reduce child mortality Reduce by two-thirds, from 1990 -2015, the under-five mortality rate.

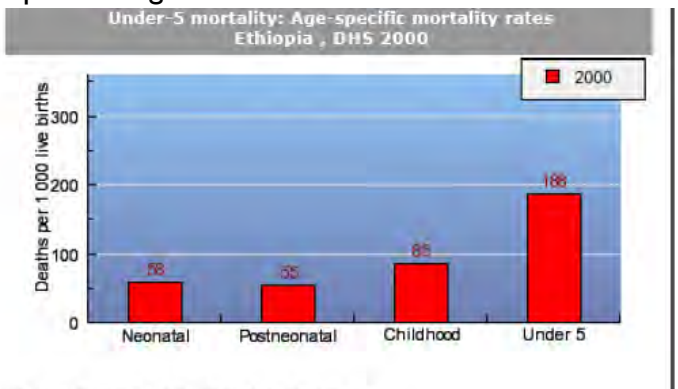
MDG 5 - Improve maternal health Reduce by three quarters, from1990-2015, the maternal mortality ratio and **Achieve,** by 2015, universal access to reproductive health.

MDG 6 - Combat HIV/AIDS, Malaria, and other diseases have halted by 2015, the rise in HIV and begun to reverse the spread of HIV/AIDS.

UNDER FIVE MORTALITY MDG 4

Under Five Mortality by Year from 1989 to 2005 are graphed in Figure below.



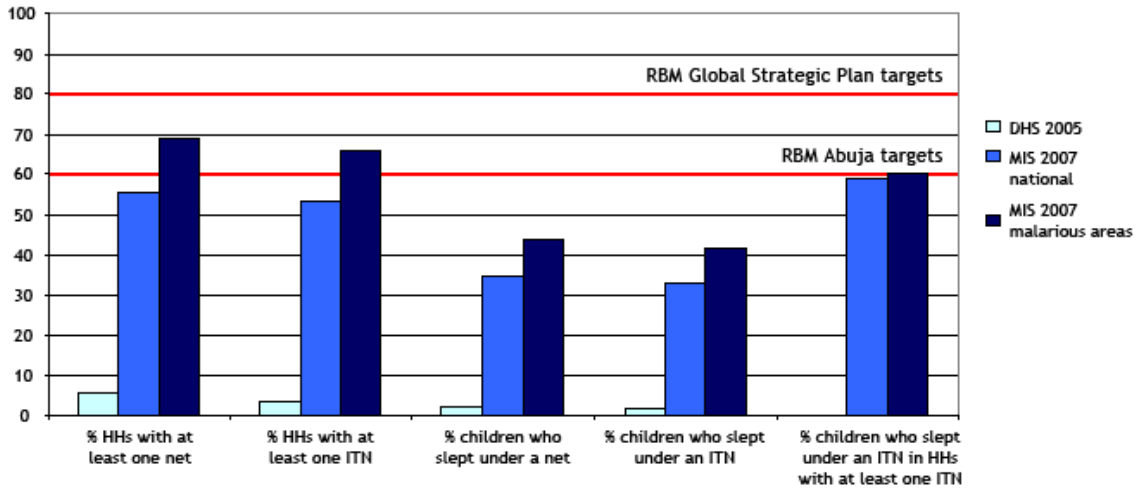


It is expected that the 2010 DHS will show decreased under-five mortality due to the addition of Health Extension Workers and reductions in malaria/measles morbidity, disability, and mortality.

MALARIA

- 20 million Long Lasting Insecticide Treated Bed Nets (LLINs) were distributed during the Measles Campaign in 2005. The progress in distribution of nets is truly impressive, see Table on net ownership below.

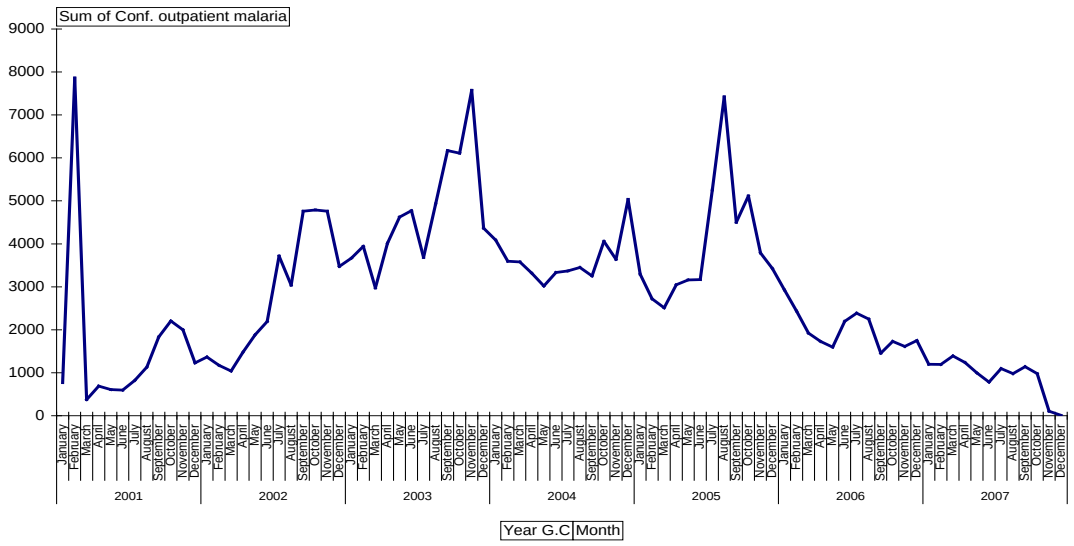
Figure 1: Net ownership and use among children under age five years, 2005 and 2007.



- Standard treatment with ineffective drugs due to resistance (Chloroquine and Sulfadoxine/Pyrimethamine) has been replaced with new effective tools for diagnosis (Rapid Diagnostic Tests-RDT) and treatment with Artemisinin combinations.
- As indicated by reported cases of malaria, incidence has fallen to an all time low, see Graph below on monthly confirmed malaria cases below. Insecticide spraying has been initiated in some areas.

Monthly confirmed outpatient malaria cases 2001 – 2007, Ethiopia.

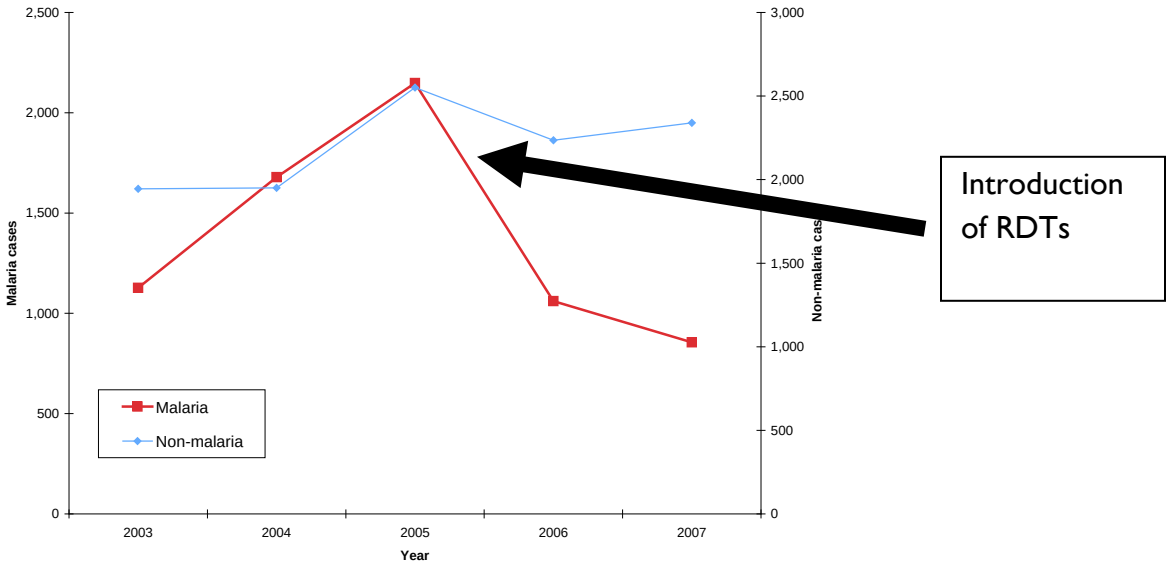
Source: Public outpatient facilities in Adama, Metehara, Bahirdar, Woreta, Arbaminch, Chiko, Alamata and AbiAdi



Proportion of febrile cases confirmed as malaria by RDTS has decreased, See Figure below.

Figure: In-patient malaria and non-malaria cases in children <5 years old, January-October 2003-2007, 7 in-patient facilities, Ethiopia.

Source: Public In-patient Facilities in Adama, Metehara, Bahirdar, Woreta, Arbaminch, AbiAdi & Alamata.



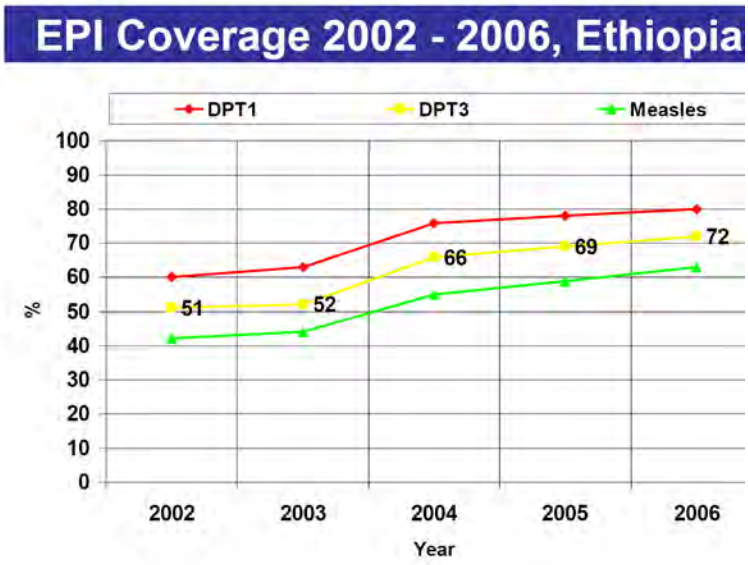
This graph documents the transition from where malaria was presumptively diagnosed as all fevers (2003-2005) to the use of RDTs for malaria diagnosis and ACTs for treatment- 2006-2007. These data raise serious questions as to the cause of 60% of fevers not due to malaria. There is a high priority to identify the non-malarious causes of fever and to identify treatable conditions. We know that a certain proportion of these fever cases are pneumonia, a condition that could be easily addressed by HEW use of an oral antibiotic. WHO has recently issued new guideline for the community and health facility treatment of pneumonia meeting the IMCI criteria for cough and difficult breathing (Lancet Infectious Diseases 2009, 9:185-196)

- Given the long term cyclical trends of malaria in Ethiopia, there is a cautious optimism of impact.

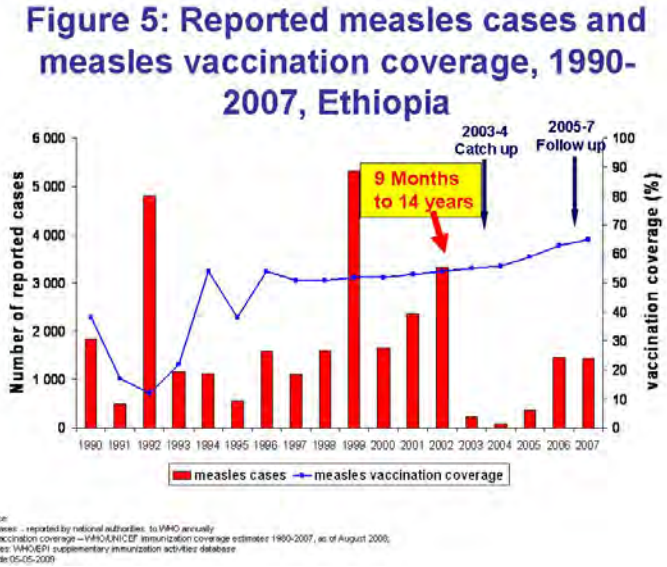
- As transmission rates drop, immunity will decrease. Mini epidemics can be expected.

MEASLES

- Routine immunisation coverage is increasing, (See Figure on EPI coverage below)



- Measles campaigns targeting children 9 months to 14 years were carried out in 2003 and 2004. Follow up catch up campaigns targeting 9-60 month children are ongoing.
- Coverage of the initial campaign was 97%.
- Measles, a major cause of morbidity and mortality, has significantly decreased, Figure below.



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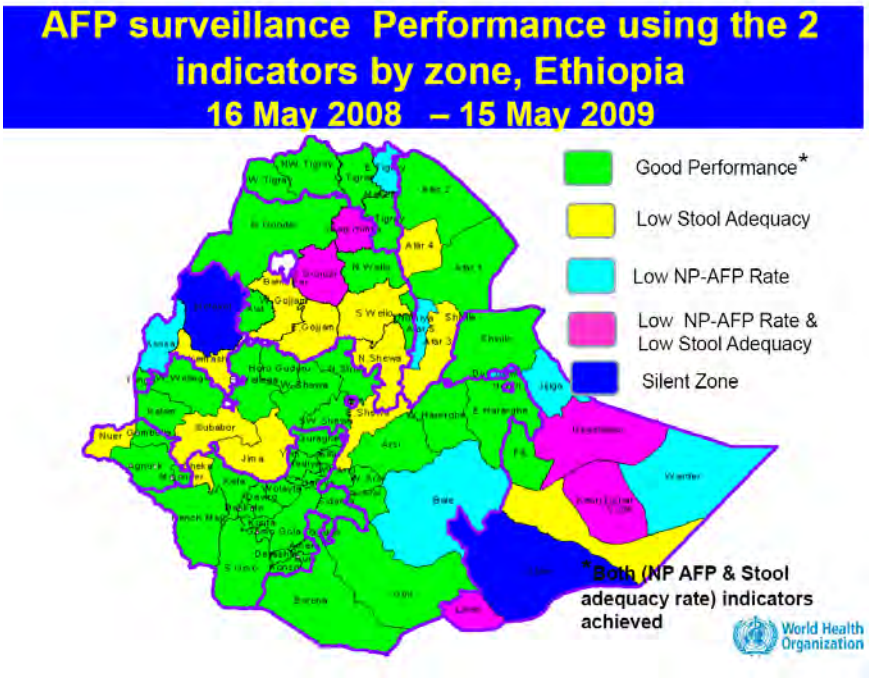
POLIO

- Endemic transmission has been stopped
- Five polio importations from neighboring countries have been controlled
- Preemptive Polio Days are being carried out along border areas adjacent to Sudan and Somalia
- Acute Flaccid Paralysis Surveillance is meeting good standards in most zones, Figure below.



UNDERNUTRITION

- Undernutrition is responsible for 50-60% of child deaths.
- Food insufficiency, rising food prices, and poverty all contribute to undernutrition and excess under-five mortality.
- The table below summarises the 2005 DHS findings on Nutritional Status.

Table 11.11 Nutritional status of children

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Ethiopia 2005

Background characteristic	Height-for-age			Weight-for-height			Weight-for-age			Number of children
	Percentage below -3 SD	Percentage below -2 SD[1]	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[1]	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[1]	Mean Z-score (SD)	
Age in months										
<6	1.3	8.1	(0.1)	1.0	6.4	0.3	0.0	4.4	0.2	389
6-8	3.8	26.6	(1.0)	1.8	10.3	(0.2)	4.8	19.1	(1.0)	243
9-11	12.3	32.7	(1.4)	0.5	14.2	(0.6)	13.8	38.2	(1.6)	211
12-17	18.6	46.3	(1.7)	4.3	18.8	(0.9)	15.0	47.5	(1.8)	510
18-23	31.2	61.7	(2.2)	2.6	16.6	(0.8)	14.9	48.2	(1.9)	326
24-35	27.7	51.3	(1.9)	1.7	9.0	(0.6)	12.7	42.2	(1.7)	901
36-47	30.5	52.5	(2.1)	2.4	8.5	(0.7)	13.2	40.9	(1.7)	1,016
48-59	31.3	54.1	(2.1)	2.4	8.5	(0.6)	9.5	42.6	(1.7)	989
Sex										
Male	24.1	47.2	(1.8)	2.8	11.4	(0.6)	11.5	38.9	(1.6)	2,317
Female	24.2	45.8	(1.8)	1.7	9.6	(0.5)	10.7	37.9	(1.5)	2,269

- 46% of Ethiopian children are stunted and 38% are underweight.

HEALTH EXTENSION WORKERS AND INCREASED ACCESS

- The Ethiopian Government, with the support of partners, has developed a visionary and innovative strategy to extend access and care to the community level. The government has trained 30,000 Health Extension Workers (HEWs) of which 17,000 have been deployed.
- Each HEW is responsible for 500 households. When plans for recruitment of 10 community volunteers per HEW have been implemented, there will be a Primary Health Care presence of one community volunteer for each 50 households.
- Two HEWs are grouped at the health post level with a small facility, if available.

- Each Health Center supports 5 health posts, 10 HEWs, and a 5,000 population. Listed below are the described tasks for each HEW.
  - Individual
    - Child: Low Birth Weight, Immunisation, ITNs, Breastfeeding, ORS and anti-malarials
    - Adolescents: Adolescent Pregnancy, Alcohol and Drug Abuse, HIV and STIs
  - Family
    - First Aid and Self Care, Antenatal Care, Assisted Delivery, Contraceptive Methods, Tetanus Toxoid, ITNs, Presumptive Treatment of Malaria in Pregnancy (currently SP, ITN, Sanitation and Hygiene)
  - Community
    - Facilities for Waste Disposal, Safe Water, Basic Demographic Data, Economic Support for Health Posts
  - Health Post
    - Preventive and Promotive Services, Referrals, Health Post Maintenance and Upgrading

- Given that neonatal mortality accounts for a significant proportion of infant mortality (56/113-58%) and under five mortality (56 of 188-31%), expansion of IMCI to IMNCI, if implemented, will further decrease under five mortality. To be effective, injectable antibiotics will need to be available at the level where babies are delivered (community/health facility). (See Bang, Journal of Perinatology 2003, 25: S1-S122)
- Provided challenges of motivation, support-a-vision, and logistics can be resolved, the potential for major decreases in child mortality and achievement of MDG 4 is possible.

MDG 5 – IMPROVE MATERNAL HEALTH

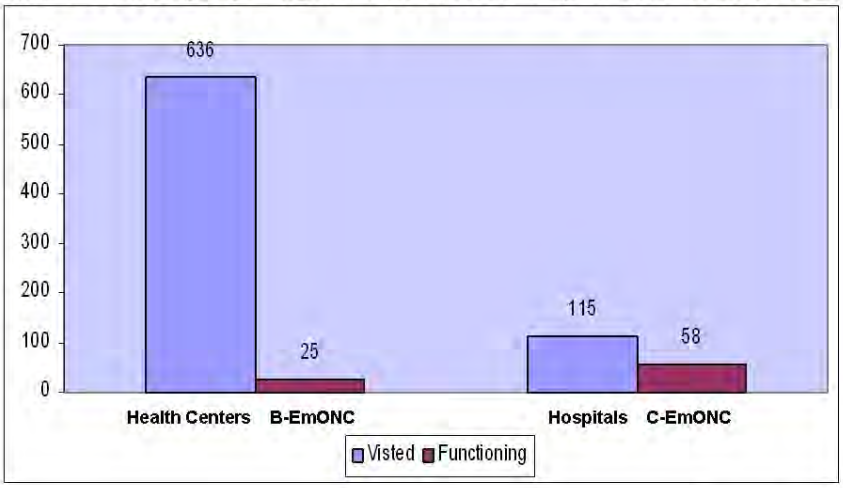
- Results from the 2005 DHS summarise the many barriers that stand in the way of achieving the goal of a 2/3^{rds} reduction in maternal mortality, Table below.

TABLE: 2005 ETHIOPIA DEMOGRAPHIC HEALTH SURVEY

TIME PERIOD	INDICATOR	NUMBER
Pre Pregnancy	Modern Contraceptive Use	14%
Prenatal	1 Visit	28%
	Tetanus Toxoid x 2	28%
Delivery	Delivery by Trained Attendant	6%
Maternal Mortality Ratio	Maternal Deaths per 100,000 live births	673
Post Partum	Care in first 2 days	5%

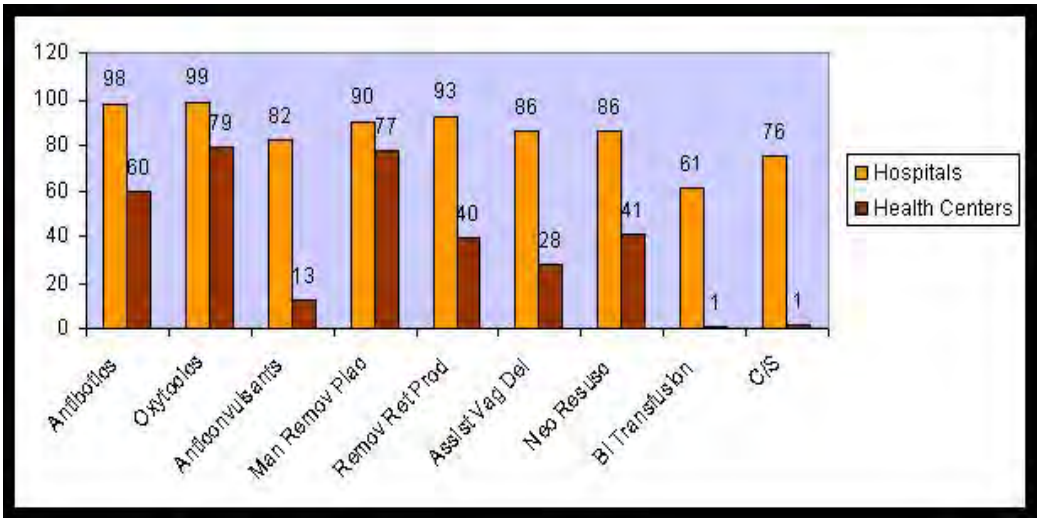
- Current infrastructure does not have the capacity to achieve this MDG objective.
- A recent UNICEF, USAID, WHO survey of 791 health centers and hospitals found that only 11% of facilities were capable of providing quality Emergency Obstetric and Newborn Care (EmONC).

FIGURE 5: STATUS OF FACILITES MEETING OBSTETRICAL STANDARDS



Preliminary Results

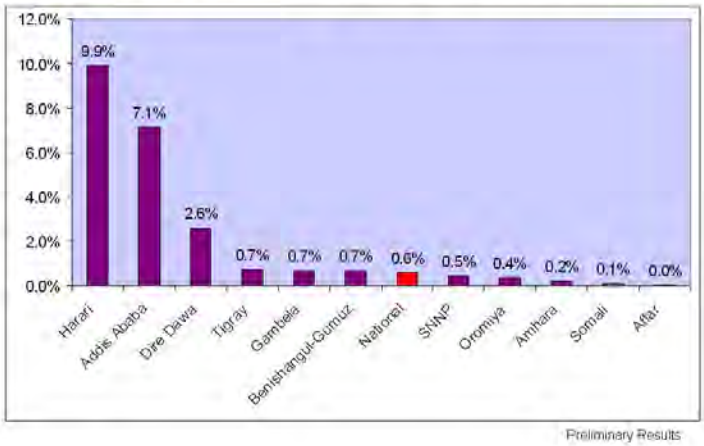
AVAILABILITY OF ESSENTIAL PROCEDURES FOR EmOC



Cesarean Section Rates

- Reductions in Maternal Morality Ratio require that 10-15% of deliveries be by Cesarean Section. See Figure below from Ethiopia show unacceptably low rates of delivery by C-section.

Figure 7: % Births delivered by C-Section by Region, Ethiopia; Expected 10-15%



Reducing Maternal Mortality Ratio (MMR) will require:

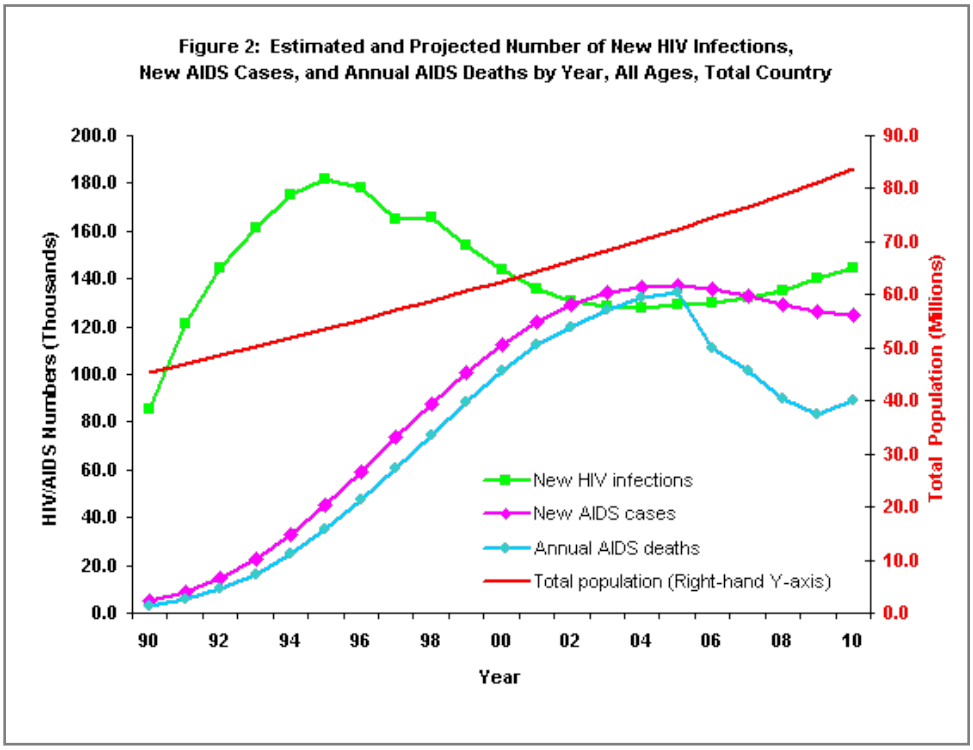
- Community care for pregnancy and delivery
- EmONC will require a significant upgrade of EmONC facilities
- Plans for transport for the 10-15% who need EmONC will need to be developed
- Training of HEWs in contraceptive counselling and supply has the potential to significantly increase timing between births, reduce unplanned pregnancies, abortions, and maternal mortality
- Increase in USAID/RH funding from 10 to 17 million dollars and US Funding of UNFPA will make additional resources available for this challenge
- Maternal Mortality Ratio estimate, as measured by DHS Surveys have shown a decrease in MMRs (871 for 1994-2000) and (673 for 1998-2004). However, the confidence intervals for both estimates overlap so there is not adequate evidence for a MMR decline
- Given the conditions of EmONC determined in the recent survey, it is doubtful that the 2010 DHS will show a significant decrease in MMR

MDG 6 COMBAT HIV/AIDS, MALARIA, TB & OTHER DISEASES OF PUBLIC HEALTH IMPORTANCE

HIV AIDS

- The President Emergency Program for AIDS Relief (PEPFAR) has identified Ethiopia as one of 15 target countries accounting for half of HIV infections
- Through 2009, the US Government has provided over 1billion dollars for HIV/AIDS promotion, prevention and treatment

- Estimated and projected incidence figure provide a picture of the gravity of the HIV/AIDS problem in Ethiopia, see Figure below.



  - As can be seen in the graph, the introduction of ART in 2006 has significantly reduced the number of AIDS deaths (the turquoise line) and slightly decreased incidence (the purple line). This needs to be confirmed through a comparison of incidence trends in the pending report of the ANC-based HIV surveillance conducted in 2007. (ANC 2007).
  - Not shown are the devastating costs to the infected individuals, their families, and their children. The 2009 estimate is over 1 million AIDS orphans.
  - Current strategies are focusing on 'hot spots' e.g., high risk populations. In these 'hot spots,' HIV prevalence of sex workers is (37%), Truckers (27%), Traveling Merchants (15%) and Soldiers (12%).[21]
  - Among prenatal women tested for HIV, 6-10% are positive.
  - Ethiopia has set a goal for universal access to ARTs by 2010.
  - During the period July 2008-December 2009, 2,282,972 persons were tested; 70,972 were HIV positive, 3.1%.

[21] Tom Kenyon – personal communication.

The Table below summarises progress in ART administration for the end of Ethiopia Year 2001 (January 9, 2009).

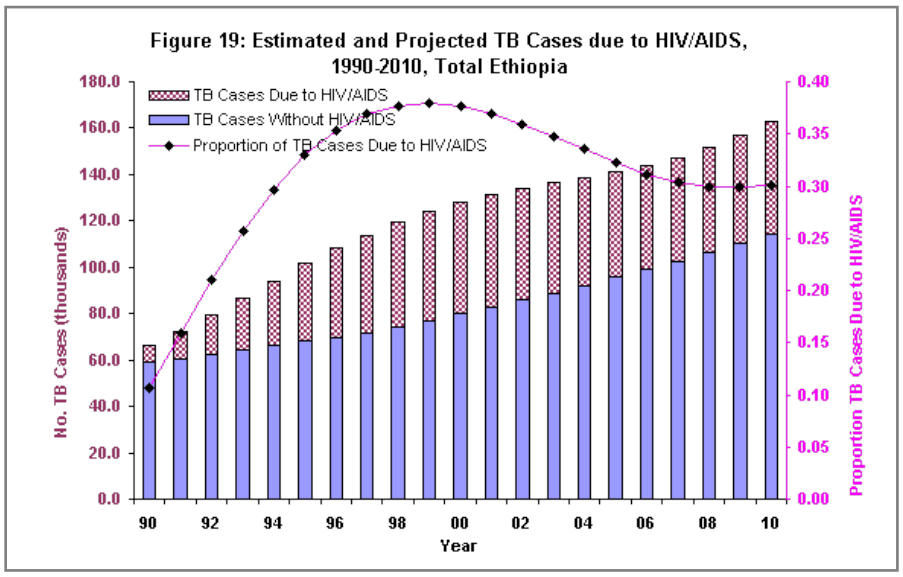
HIV/AIDS ENROLLED. NEW STARTS AND CUMULATIVE
TAHAS 2001 (January 9,2009)

Age Category	Cumulative at Ever Enrolled	New Started During Months	Cumulative Ever Started ARDs
Infants <18 mo	2,513	49	712
19-59 Months	6551	73	2,711
5-14 Years	11,563	176	5,738
Non Pregnant <14	168,089	2,385	92,323
Pregnant Females	8,556	105	2,141
Males >14	125,204	1,707	76,723
Unspecified	95		99
	322,571	4,495	180,447

(MALARIA, SEE MDG 4)

TUBERCULOSIS

- Co-infections of HIV and TB are common
- Estimates of TB and HIV associated TB are presented in the Figure below



- While progress is being made in screening and treating HIV infected individuals with TB, the national ability to address TB is inadequate to meet the current needs.

ATTRIBUTION OF BENEFITS TO PARTNERS

- Partners are frequently required, sometimes by law, to demonstrate the impact of their contributions.
- Progress presented in this report represents the cumulative impact of the Ethiopian Government, UN agencies, US Government agencies and other multilateral and bilateral partners. The US is providing multiple resources through PEPFAR, the President's Malaria Initiative, USAID, and CDC. Other bilaterals include UK-DFID, Canada-CIDA, Swedish CIDA, and Italy.

- As relevant to this evaluation, WHO provides an important role in numerous key areas:
  - Technical Advice to the MoH
  - Facilitator for coordinated action among UN Agencies (WHO, UNICEF, UNFPA, World Bank)
  - Serves as a source of administrative and technical leadership to the international partner (donor) group.
  - Provides technical expertise to the MoH in terms of Policy Analysis and Dialogue.
  - Provides technical support through international and NPOs at the national and regional levels.
  - Supports capacity strengthening through the assignment of NPOs.
- The assessment team strongly believes that WHO is an essential contributor to health development in Ethiopia.

CHALLENGES

1. BUSINESS PROCESS ENGINERING

- Over the last 36 months, the Ethiopian Government has embarked on a major reorganisation within the framework of Business Process Engineering as first promoted by Michael Hammer and James Champy.[22]
- It is based on the principle of making maximum use of available resources. It is demand-driven and customer-focused.
- It is also cost-driven.
- The initial phases have interrupted implementation, resulting in a significant loss of technical staff and have left many questions unanswered.
- Partners are recognizing the need to support the implementation of the plan, ongoing for the last two months.
- A recent visit of Adama in Oromia Region provided a very positive report on implementation at the zonal level.[23]
- As requested by the MoH to WHO and other partners, this will require input from professional staff, e.g., NPOs to upgrade the capacity of new, less experienced staff at national and regional levels.
- Second, it will require an ongoing process of evaluation to document successes and identify and solve problems.

2. TUBERCULOSIS

- The magnitude and seriousness of Tuberculosis has been described above
- Through PEPFAR, the issue of HIV-TB co-infection is being addressed
- Non HIV Tuberculosis is an increasing problem
- Leadership and funds for Tuberculosis are a high priority

3. PNEUMONIA AND IMCI

- The recent introduction of Malaria RDTs has documented that a significant percentage of fever cases are not malaria
- Significant data, generated by the Save the Children US, has documented the ability of HEWs to diagnose and treat pneumonia correctly
- While more data are needed on the non-malaria causes of fever, addition of pneumonia diagnosis and treatment will significantly decrease under-five mortality and accelerate progress toward achievement of MDG 4
- WHO has recently identified amoxicillin as the drug of choice for community treatment of pneumonia

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[22] http://books.google.com/books?id=F27TuE8ChwUC&dq=Michael+Hammer&printsec=frontcover&source=bl&ots=TNS4OQJlio&sig=e-2HEFq-2hpc9ih-3PvrajF3YqA&hl=en&ei=bKxPSqPlHpSYtge228isBA&sa=X&oi=book_result&ct=result&resnum=11.

[23] Senait Kebede MD, MPH personal communication.

WHO recommendations for early antimicrobial treatment of childhood pneumonia have been effective in reducing childhood mortality, but the last major revision was over 10 years ago. The emergence of antimicrobial resistance, new pneumonia pathogens, and new drugs have prompted WHO to assemble an international panel to review the literature on childhood pneumonia and to develop evidence-based recommendations for the empirical treatment of non-severe pneumonia among children managed by first-level health providers. Treatment should target the bacterial causes most likely to lead to severe disease, including Streptoccocus pneumoniae and Haemophilus influenzae.

The best first-line agent is amoxicillin, given twice daily for 3-5 days, although co-trimoxazole may be an alternative in some settings. Treatment failure should be defined in a child who develops signs warranting immediate referral or who does not have a decrease in respiratory rate after 48-72 hours of therapy. If failure occurs, and no indication for immediate referral exists, possible explanations for failure should be systematically determined, including non-adherence to therapy and alternative diagnoses. If failure of the first-line agent remains a possible explanation, suitable second-line agents include high-dose amoxicillin-clavulanic acid with or without an affordable macrolide for children over 3 years of age.

4. ENSURING QUALITY OF HEW SERVICES

- The Ethiopian Government, with its training of 30,000 emergency field workers, has, in just a few years, increased access to primary health care at the community level; it is an exceptional innovation. Few countries, if any, have made such a dramatic change in such a short period of time. Congratulations!
- The clear challenge is to assess and upgrade quality of these workers through supportive supervision and continuing education.
- The proposed monthly meeting at Health Centers and the quarterly meetings at the Woreda level have the potential to share stories, identify and solve problems and upgrade quality.
- Developing an effective strategy to meet these needs is recommended.

ETHIOPIA CONTACTS

Name	Function
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Dr Sirak Hailu	NPO/CAH
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USAID	
Meri Sinnitt	Chief, Health, AIDS, Population, Nutrition
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Anita Gibson	Team Leader Health
CDC	
Dr. Thomas Kenyon	Country Director
UNICEF	
Assaye Kassie	Child Survival Health Specialist

NOTE: The Review Team would like to thank the many individuals who took the time to share their time and information with the Review Team. We apologize if any of the data included in this report varies with reality.

c. Kenya

CONTEXT

This report is being prepared as a part of an evaluation of the work done by WHO/AFRO under a five-year grant from the Africa Bureau of USAID. The objectives of the grant were:

1. Controlling malaria within the context of Roll Back Malaria (RBM) so that by the year 2030, malaria will neither be a major contributor to mortality and morbidity, nor of significant socioeconomic consequence in Africa.
2. Contributing to the reduction in childhood morbidity and mortality from common childhood illnesses such as pneumonia, diarrhea, malaria, measles, and malnutrition.
3. Strengthening immunisation systems within the current context of polio eradication and disease control initiatives in Africa, to reach a higher level of sustainable routine immunisation coverage.

Kenya is one of four countries visited during the course of this assessment along with Ethiopia, DRC and Liberia. The assessment team members visiting Kenya were: Dr. Stanley Foster, Professor of Global Health Emory University; Dr. Roy Miller, USAID/Africa Bureau; and Dr. Phanuel Habimana, Child and Adolescent Health, WHO/AFRO.

MAJOR FINDINGS

In its effort to abide by the 2005 Paris Declaration on Aid Effectiveness calling for the harmonisation of aid efforts, the donor community supporting health programs has established a number of coordination mechanisms at global and country level. The WHO office in Kenya exemplifies the role that WHO can and should play as both coordinator and technical leader at country level. WHO/Kenya continues to play its traditional role as the primary Technical Advisor to the MoH by establishing standards and norms for health care delivery in Kenya while taking on the additional responsibility of serving as the secretariat for the Health Donors Working Group, currently chaired by GTZ. In both contexts, the work of the WHO Country Office is appreciated by its partners and viewed as essential to advance the health objectives set by the Government of Kenya.

METHODOLOGY

During its three days in Kenya, the assessment team met with the technical staff at WHO en masse and held a series of in-depth conversations with the directors of a number of key MoH divisions. The conversations addressed progress made in advancing the health status of Kenyans brought about, in part, by technical or financial support from WHO. The team also interviewed selected stakeholders: the MoH, USAID, and CDC. And, as the sub-regional offices of both UNICEF and USAID are in Nairobi, interviews were conducted with representatives of those offices. These interviews were not specific to Kenya but are discussed briefly in this report.

THE KENYA COUNTRY OFFICE OF WHO

The Kenya Country Office is led by a WHO Representative, Dr. David Okello. The technical staff advises the health sector on technical issues in health and offers training to fill gaps in service provision as identified by the Government of Kenya. The Office also provides assistance in scaling up essential health services. The key functions of WHO are

- Provision of norms and standards for key technical program areas
- Support to training and skills enhancement and other forms of health worker capacity building
- Support to pre-service training
- Offer technical guidance in the elaboration of country policies, strategies and the development of operational tools
- Networking to enable appropriate information flow
- Advocacy for key health goals

- Mobilisation of resources for key interventions in the health sector

The technical team in the Kenya Country Office is comprised primarily of NPOs (15 of the 23 current officers). The NPOs are among the very best and most experienced health professionals in Kenya, often selected from among the leaders in the MoH. The Assessment Team was duly impressed with the technical competence of the NPOs. During discussions both with colleagues in the WHO Country Office and the MoH, this migration of Ministry staff to WHO was seen positively rather than negatively. For the individuals involved, the assignment to the WHO Country Office is a positive career step, sometimes leading to international postings within WHO and elsewhere. From the Ministry standpoint, the migration of staff paves the way for advancement of others in the Ministry without losing the knowledge and experience of those involved as they become the advisors to their replacements within the Ministries. Moreover, in both WHO and the Ministries, the knowledge of the nuances of the local scene ingrained in the NPOs made them more effective at times than their international colleagues.

USAID IN KENYA

USAID/Kenya is the second largest US bilateral program in Sub-Saharan Africa. The only larger program is in South Africa, but that program is devoted entirely to HIV/AIDS while the Kenya program addresses a broad range of health problems and programs. The program budget for the USAID/Kenya program is as follows.

HEALTH PROGRAM BUDGET

PROGRAM AREA	**FY 07**	**FY 08**
HIV/AIDS	337,918,000	501,879,000
TUBERCULOSIS	1,500.000	1,984,000
MALARIA	6.050,000	19,838,000
MATERNAL AND CHILD HEALTH	2,360,000	5,521,000
REPRODUCTIVE HEALTH AND FAMILY PLANNING	7,661,000	13,200,000
TOTAL	355.489,000	542,422,000

PROGRESS TOWARDS THE MILLENNIUM DEVLOPMENT GOALS (MDGs)

In general, the health sector has primary responsibility for MDGs 4, 5 and 6.

Goal 4: Reduce by 2/3 the Under-Five Mortality rate between 1990 and 2015.

The following table shows the disturbing trend in infant, child and under 5 mortality in Kenya.

Table 8.1 Early childhood mortality rates

Neonatal, postneonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Kenya 2003

Years preceding the survey		Neonatal mortality (NN)	Postneonatal mortality[1] (PNN)	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-five mortality ($_5q_0$)
0-4	1998-2003	33	44	77	41	115
5-9	1993-1997	32	41	73	40	110
10-14	1989-2002	31	42	73	35	105

[1] Computed as the difference between the infant and the neonatal mortality rates

Although not published, the most recent Kenya DHS, conducted in 2008, is expected to show a significant decrease in under-five mortality. This decrease in mortality is believed to be due to decreases in measles and malaria morbidity, disability, and mortality.

Goal 5: Reduce by ¾ the maternal mortality ratio between 1990 and 2015
Estimates of maternal mortality ratios is problematic at best and it is only in recent years that surveys like the DHS have included modules to make such estimates. *WHO/Kenya Country Cooperation Strategy: 2008-2013* cites a 1990 baseline maternal mortality ratio of 590 with an estimate of 414 in 2003. The recent DHS should provide a more current estimate of this indicator. The same can be said for the other key indicators in the table below drawn for the 2003 DHS.

2003 KENYA DEMOGRAPHIC HEALTH SURVEY		
TIME PERIOD	**INDICATOR**	**NUMBER**
Pre Pregnancy	Modern Contraceptive Use	44%
Prenatal	1 Visit	88%
	Tetanus Toxoid x 2	52%
Delivery	Delivery by Trained Attendant	42%
Maternal Mortality	Maternal Deaths per 100,000 live births	414
Post Partum	Care in first 2 days	10%

Goal 6: Combat HIV/AIDS, Malaria and other diseases
The WHO/Kenya Country Cooperation Strategy: 2008-2013 reports on the HIV prevalence among 15-24 year old pregnant women as being 5.1% in1990, 13.4% in 1999/2000 and 10.6 % in 2003. The same document sets malaria prevalence in persons above 5 years of age as 30% in 2003. A soon to be published Malaria Indicator Survey done in 2007, focused on children under five. Prevalence of malaria in children in the malaria prone areas as determined by different tests is as follows.

AGE GROUP	**Percentage with Positive Rapid Diagnostic Test**	**Percentage with Microscopy Slide Positive for PF**
1-11 Months	2.9	1.2
12-23 Months	5.3	1.8
24-35 Months	7.8	3.3
36-47 Months	10.9	5.0
48-59 Months	11.5	5.0
TOTAL	7.6	3.3

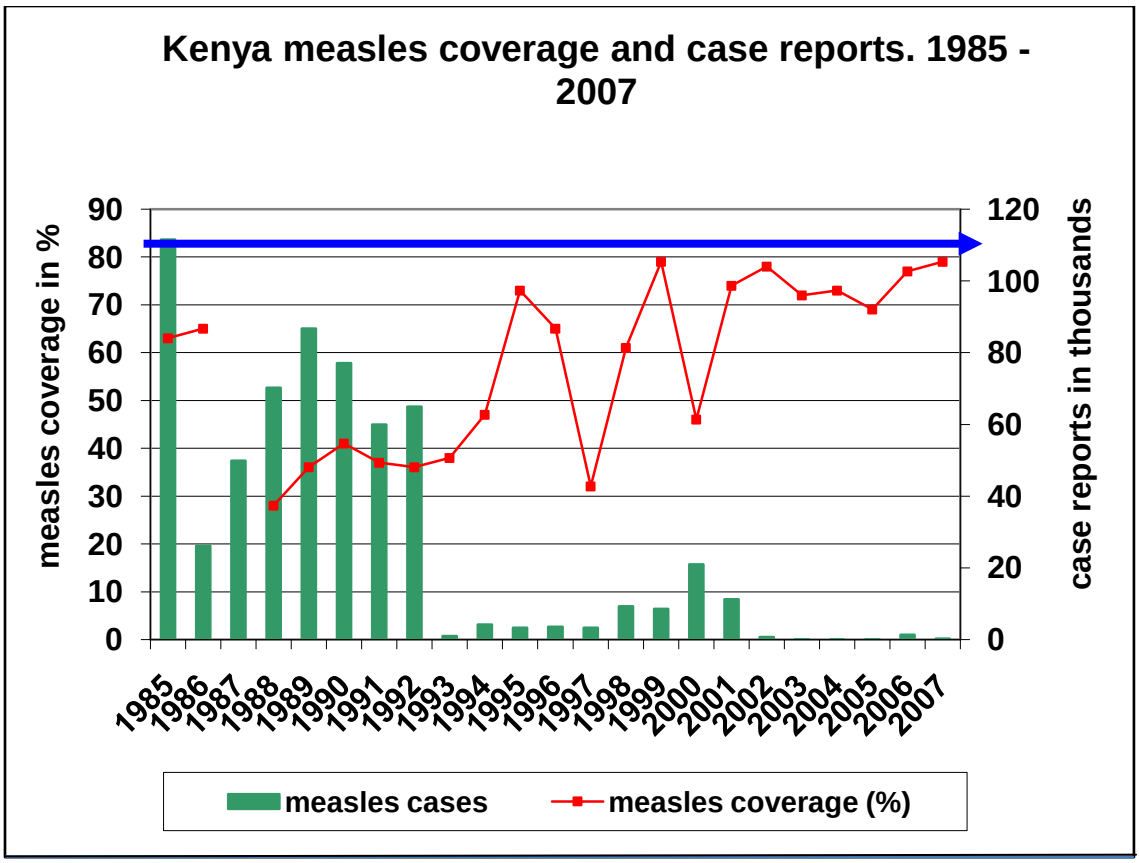
HEALTH SITUATION AND PROGRAMS

The threats to the health of the Kenyan population are similar to those of their neighbors in sub-Saharan Africa. Communicable diseases continue to contribute heavily to the disease burden while concern is growing that non-communicable diseases are becoming more prevalent and are not being adequately addressed. It is believed that the primary causes of death in children are pneumonia, diarrhea, and malaria with an underlying contributing factor of malnutrition.

EPI

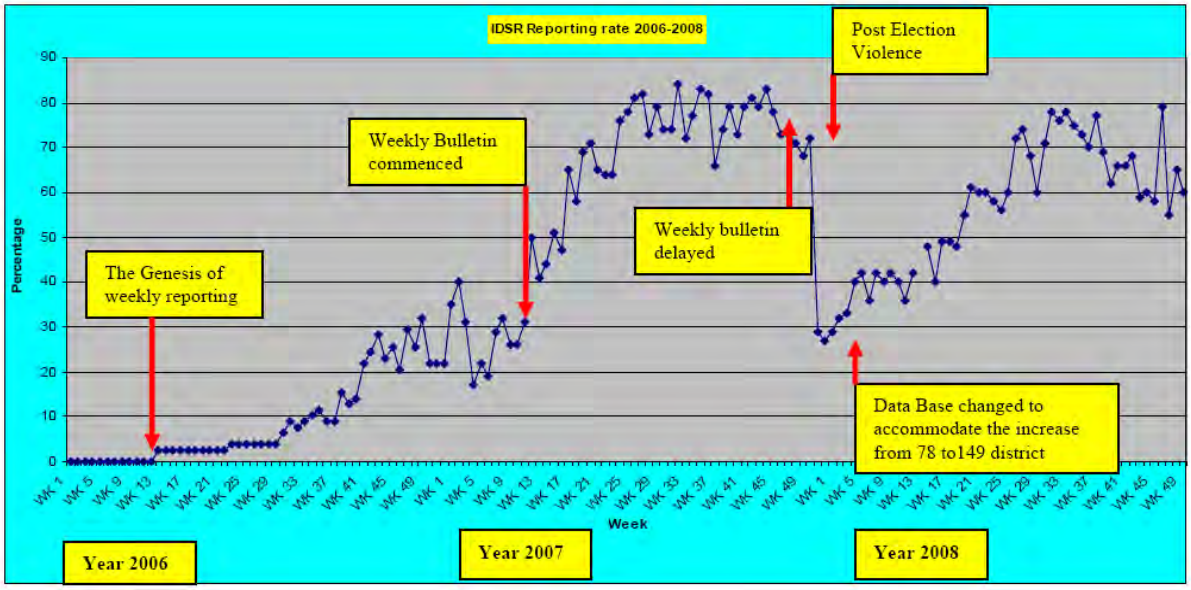
WHO provides technical assistance both in vaccine delivery and in the development of a surveillance system that provides data to document vaccine coverage and disease incidence. An example of the kind of reporting

that becomes possible as a result of WHO technical support is given in the following table, taken from the External Surveillance Review 23rd January – 2nd February 2009.



IDSR

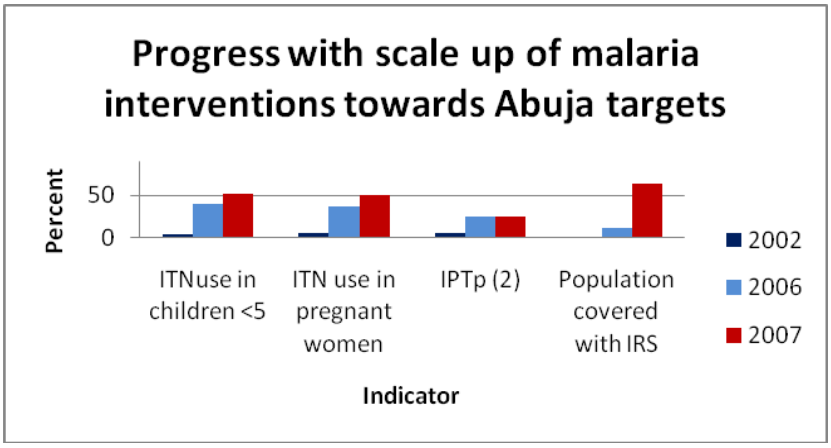
Given the tendency for vertical disease control programs, such as the HIV/AIDS or national malaria programs, to establish their own surveillance systems to meet the needs of various donors and their own program managers, a number of distinct surveillance systems grew up in Kenya. In 2000, WHO took the lead in an effort to develop integrated surveillance, starting with the development of standard case definitions and resulting in a national strategy for the years 2003-2007. The malaria program was the first large donor-funded program to commit to the integrated system. The following chart shows the steady improvement of the reporting in the context of the IDSR system.



One of the more interesting innovations in surveillance reporting is the use of the cell phone to report data. Efforts are underway with a leading cell phone service provider to develop a system whereby data entered into a template in the field can be uploaded directly into a database at central level.

MALARIA

According to the Health Management Information System, in 2007 clinically diagnosed malaria was responsible for 30% of outpatient consultations, 15% of hospital admissions and 3-5% of inpatient deaths. There is a documented 44% decrease in under five mortality in sentinel districts. This decline is attributed to the increased use of insecticide treated nets and improved methods of malaria diagnosis (RDTs) and treatment (Artemisinin-based Combination Therapy). In the highly endemic Kenyan Coast, a 28-63% decline in pediatric malaria admissions was reported between 1992 and 2006. Malaria admissions have decreased in sentinel districts by 56% between 1999 and 2006. The overall progress in malaria interventions is apparent in the following table.



SUMMARIES OF INTERVIEWS WITH STAKEHOLDERS

The Ministry of Public Health and Sanitation

The assessment team met with Dr. S. K. Sharif, Acting Director of Public Health and Sanitation in the Ministry of Public Health and Sanitation. He cited his excellent working relationship with WHO noting that WHO has

greater flexibility than the Ministry to respond to situations as they arise. He noted that the budget allocated to health by WHO is "off-budget"; that is, it does not flow through the Kenya budget system and, therefore, is not deducted from his government allowance as is the support from other donors. He indicated that WHO pushes the agenda forward for new health initiatives that are not always within the purview of the Ministry and its other partners.

USAID

The assessment team met with the USAID Population, Health and Nutrition Officer, Lynn Adrian, and Shiela Macharia, a member of her staff. During the efforts to maintain donor support to Kenya following the disputed election, USAID and WHO, as co-chairs of the Health Donors Working Group met regularly with government officials and, in the process developed a strong working relationship. USAID indicated that they are generally in agreement with WHO on policies and technical approaches and that by virtue of its unique relationship with the MoH, WHO is in a strong position to influence the government on those policies and approaches.

When asked about the Inter-country Support Teams, USAID was not aware of their role in backstopping the country office. USAID views the WHO Country Office as its counterpart.

Centers for Disease Control

The assessment team met with Dr. John Mermin, the Director of CDC/Kenya, Dr. Tom Boo, a Senior Technical Advisor to the Global AIDS Program and Dr. Joseph Odhiambo, a Senior Technical Advisor for TB/HIV. The role of CDC in Kenya has grown from being largely Technical Advisors to the Ministry or USAID, to managing a $200 Million program. The relationship between CDC and WHO was characterised as underutilised, but quite important. In particular, CDC expressed concern that certain activities may be double funded and thought that, in its function as a coordinating body, WHO could promote transparency of joint plans.

The Regional Offices of USAID and UNICEF

The assessment team met with Dr. Cornelia Davis, Senior Technical Advisor for Infectious Diseases in the USAID East Africa Office. Dr. Davis noted that WHO was an integral partner to the Ministries of Health in all countries but that the level of interaction between the USAID regional office and the WHO offices varied and was often associated with funding patterns. Dr. Davis singled out WHO's expertise in disease surveillance as an asset across the region. She mentioned the problem that arises in dealing with cross-border issues because bordering countries like Sudan and Somalia are not a part of WHO/AFRO, rather they are part of WHO's Eastern Mediterranean Office.

The team met with Dr. Tesfaye Shiferaw, the Regional Advisor for Child Survival and Development in UNICEF's East and Southern Africa Region office. Dr. Shiferaw identified WHO as the normative agency in health, often serving as the secretariat for committees dealing with health issues. He was quite positive about the relationship between the two organisations noting, in particular, that WHO, the World Bank, UNICEF and UNFPA have signed a memorandum of understanding regarding the approach to maternal health in the region. Given its coordinating function, Dr. Shiferaw added that it would be good for UNICEF if WHO was strengthened.

CHALLENGES

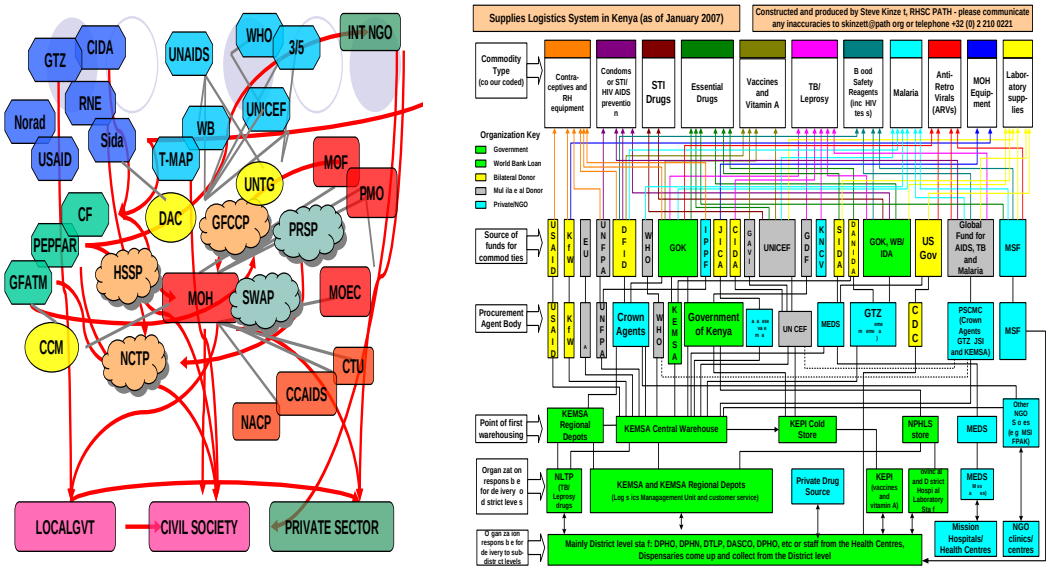
Political Context

After a disputed election in December 2007 and the civil unrest that followed, negotiations led to the formation of a coalition government in which power was to be shared by the two main parties. Two of the changes made by the coalition government in their efforts to share power greatly affect the delivery of health services. First, the Central Ministry of Health was divided into two separate ministries, the Ministry of Medical

Services and the Ministry of Public Health and Sanitation. Second the number of districts, the governmental unit responsible for developing implementation plans for the delivery of health services, was increased from 78 districts in 2003 to 220 districts today. As each new district has to have staff capable of district level management as well as the requisite facilities, the addition of the new districts places a substantial burden on the budget for health while expanding the need for training and support-a-vision (a positive approach to what is commonly called supervision). This change was not accompanied by a health budget increase to pay for the development of the capacity of the new districts.

Overall, the health sector is experiencing a shortage of health workers. Estimates show that there are approximately 17 doctors per 100,000 people and 120 nurses per 100,000 in Kenya. However, analyses of regional distribution within the country indicate serious disparities.
The following diagram illustrates the challenge of working in this new environment.

Unworkable Coordination by the MOH



Policy Issue

The Malaria Indicator Survey (MIS) revealed that a relatively low proportion of children tested positive for malaria using a Rapid Diagnostic Test (7.6%). This strongly suggests the need to better understand the causes of the non-malaria fevers and to provide the appropriate treatments. Pneumonia is suspected to be a major cause of fever; however, Kenyan policy prohibits the use of antibiotics by CHWs. Therefore, many children are not receiving the proper treatment for their illnesses.

Commodity Issue

The Government of Kenya has included line items in their budget for commodities including vaccines and contraceptives. Delays in making the funds available have caused major stock outs of essential commodities, jeopardizing the successes achieved to date in selected programs.

Donor Issue

Funds from the Global Fund do not arrive in country in a timely manner. The Ministry of Public Health and Sanitation mentioned the amount of work required to secure funds from the Global Funds while the only real

benefit is the commodities provided. WHO contributes to the writing of the proposal but does not receive any support when the funds do arrive.

THE FUTURE

The priorities for the future shared by the WHO Representative after consultation with his staff are:

1. Maternal Newborn and Child Health
2. Tracking the health trends
3. Strengthening health systems

DOCUMENTS

- Division of Malaria Control, Ministry of Public Health and Sanitation, Kenya National Bureau of Statistics and National Coordinating Agency for Population and Development. 2009. Draft Report. 2007 Kenya Malaria Indicator Survey. Nairobi, March 2009.
- Ministry of Health. 2006. Integrated Management of Childhood Illness (IMCI) Health Facility Survey Report: Kenya. Nairobi: Ministry of Health.
- Ministry of Public Health and Sanitation and the Ministry of Medical Services. 2009. Child Survival and Development Strategy: 2008-2015. Nairobi: January 2009.
- WHO and UNICEF. 2009. External Surveillance Review: Kenya 23rd January-2nd February 2009, Final Report. Nairobi: UNICEF AND WHO.
- WHO/Kenya. 2008. Country Cooperation Strategy 2008-2013. Nairobi: WHO.
- WHO/Kenya. 2009. Kenya Disease Surveillance and Response Program Review. Nairobi: May 19, 2009
- WHO/Kenya. Undated. Who we are, What we do, How We Work. Nairobi, WHO.

KENYA CONTACTS

Name	Function
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Dr Humphrey Karamagi	Technical Officer/Health Systems Development
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Dr. Assumpta Muriithi	NPO/Child and Adolescent Health
Ministry of Public Health and Sanitation	
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d. Liberia

Context:
As part of the final evaluation of USAID's Grant AFR-G-00-04-00001 to WHO/AFRO for Disease Control and Reproductive Health Programs for the Period 2004-2009, Dr. Sambe Duale, member of the Evaluation Team, together with Dr. Jackson Sillah from the WHO/AFRO Malaria Program visited Liberia from 21 to 25 May, 2009.

The USAID Grant was dedicated largely to the support of additional WHO/AFRO staff at its regional and inter-country support team (IST) offices. The funding is also used to recruit national program officers (NPOs) placed either at the WHO office in country or in a relevant department of the national ministry of health. The balance of the financial support is used to fund program activities including training, the preparation and dissemination of technical documents, direct technical assistance to countries, and some monitoring and evaluation activities.

The final evaluation is being carried out to assess progress toward grant objectives, document grant accomplishments, and lessons learned, and to identify future areas of collaboration between USAID and WHO in support of health sector development in African countries. Since USAID/Liberia has used this grant mechanism to provide funds to support disease control, Liberia was chosen among the four countries to be visited as part of the final review of the grant. Liberia also offers an opportunity to assess WHO's role in re-building health systems in a post-conflict country.

Dr Duale and Dr. Sillah's visit in Liberia was organised and facilitated by the WHO Country Office (WCO) under the leadership of Dr. Nestor Ndayimiririje, WHO Representative (WR). The review team members met and held discussions with the WR and WCO staff, Ministry of Health and Social Welfare (MOHSW) officials and program managers, USAID health team, UNICEF representative and health staff, the USAID-funded BASICS Project staff, and other key informants (list in annex.). The WCO, MOHSW and UNICEF also provided key documents and briefing materials for the review.

State of the Health Sector in Liberia:
The review team met with Dr. Moses Pewu, Acting Deputy Minister and Chief Medical Officer (CMO) of the MOHSW. He was the officer in charge while the Minister and the CMO were in Geneva for the World Health Assembly. Dr. Pewu spoke highly of the support being provided by WHO, USAID and other partners to the MOHSW for the implementation of the National Health Policy and Plan. The MOHSW relies heavily on WHO to advise on policies and technical directions on all priority health issues and programs.

Fourteen years of war adversely affected all fabrics of the Liberia's national life, including the health sector. The country is currently transitioning from relief to development. The government is currently putting in place the relevant mechanisms to ensure transitioning from short-term relief and welfare development strategies to long-term sustainable health system development; i.e. the development of National Health Policy and Plan, restructuring of County Health Teams, setting up coordination and consultation mechanisms with partners, and the establishment of an office for financial management. Despite these positive developments, a lot still needs to be done to move towards reaching the Millennium Development Goals (MDGs).

The country's health indicators, though improving, remain unsatisfactory. According to the 2007 Liberian Demographic Survey, childhood mortality has decreased substantially. Infant mortality has declined from 139 per 1,000 live births to 71 per 1,000 live births; under-five mortality has also declined from 219 to 110 per 1,000 live births, representing a halving of the 1992-1996 infant and under-five mortality rates. Notwithstanding, Maternal Mortality Rate in 2007 is 994 deaths per 100,000 live births, representing one of the highest in the world.

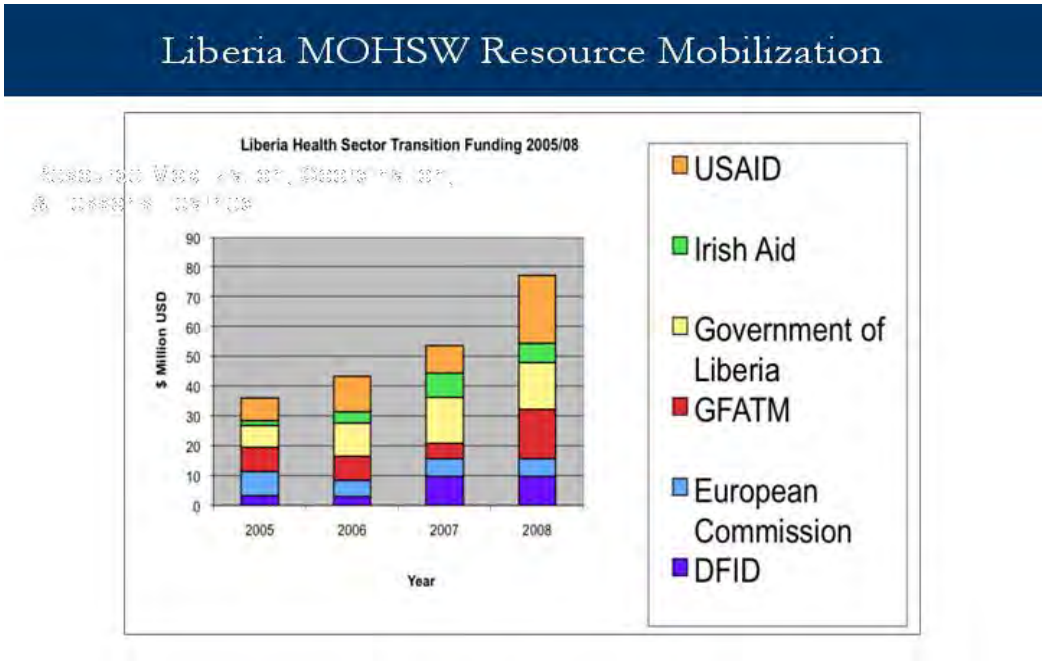
The country is affected by endemic diseases, including the diseases of epidemic potential, e.g. Lassa fever, cholera, acute bloody diarrhea, yellow fever and onchocerciasis. Malaria is the leading cause of morbidity and mortality, and accounts for over 12% of all deaths and 38% of both out-patient and in-patient diagnoses.

HIV/AIDS prevalence rate is estimated at 1.5% among the general population (LDHS 2007); and 5.4% among pregnant women attending antennal clinics (ANC/HIV Sentinel Surveillance Report 2007). Increased reports of rape incidence accelerate HIV/AIDS infection amongst survivors of sexual exploitation and abuse. Women and girls have been the main victims of rape and sexual abuse without regard to age.

Access to modern health care services declined from approximately 35% in 1990 to 26% during the war years (1990-2003). Current estimates, however, indicate an increase in access from 26% (1990-2005) to 41% (2008), which is attributed to provision of the lion share of health care services by international non-governmental organisations (INGOs), and facilitated by donor support. Despite significant improvements in access, the health sector continues to be plagued by several challenges. Prominent among these are limited infrastructure, insufficient quantity of quality drugs, inadequate health finances, and, more importantly, the inadequate number of qualified health workers of all categories and at all levels.

Health Sector Partners

The MOHSW is working in partnership with a number of UN Agencies, bilateral and multilateral organisations and INGOs to implement the National Health Plan. USAID, WHO, UNICEF, UNDP, DFID, European Union are among the key partners which have supported the MOHSW to develop and implement the national health plan.



The ministry has set up mechanisms for coordination and regular consultation with partners. The coordination mechanisms include the Health Sector Coordinating Committee (HSCC), the Liberia Coordinating Mechanism (LCM) for the GFATM, the Technical Coordination Committee of the LCM, the National Task Force on Influenza A (H5N1, H1N1), and the Pool Fund Steering Committee. The Minister and/or one of the deputy ministers chair most of the coordinating mechanisms meetings. The WHO representative (WR) regularly co-chairs some of the meetings.

In July 2008, The MOHSW organised a National Health Conference for the review of the implementation of the National Health Development Plan for the first two years (2007-2008). The conference brought together 250 participants, including high government officials and representatives of UN Agencies, other international bilateral and multilateral organisations and NGOs among others. The primary focus of the conference was two-fold: (i) to review progress made in the implementation and (ii) to strategise and evolve practical means of facilitating and enhancing implementation of the plan. A the end of three days of intense deliberations, the conference highlighted the major challenges facing the health sector, and proposed a number of concrete recommendations for fast-tracking implementation of the national health plan. Another National Health Conference will be held again in July this year.

The MOHSW has also instituted a regular review of health system performance where representatives of the ministry and partners visit designated counties and hold discussions with stakeholders.

USAID Liberia Health Portfolio

The review team met with Dr. Tanu Duworko and Dr. Augustine Mulbah, members of the USAID Liberia Health Team and Dr. Filiberto Hernandez, PMI/CDC Resident Advisor.

The USAID Health portfolio has been transitioning from emergency/humanitarian interventions implemented by international NGOs to supporting the GOL's efforts to rehabilitate the health systems, and to provide basic package of health services (BPHS) to all Liberians. Maternal, newborn and child health, voluntary family planning and reproductive health services, malaria, HIV/AIDS and gender-based violence are among the priority health problems being addressed within the USAID health portfolio in Liberia.

A new bilateral project has just started to support primary health care in five counties. A consortium of US PVOs led by John Snow Inc will provide the technical and managerial support for the implementation of the project. The project will also support the rehabilitation of two health training institutions.

USAID Liberia has also invested the last three years in activities to improve immunisation by providing a grant to WHO. The USAID Liberia funding to WHO for scaling up routine immunisation are channeled through the AFR-G-00-04-00001 Grant to WHO/AFRO. The USAID Liberia health team meets regularly with WCO staff to discuss the implementation of the Grant activities.

Liberia is also a PMI focus country. A jump start funding of $2.5 million was provided in FY07. The PMI budget allocation for Liberia in FY08 was in the amount of $12.4 million. Both CDC and USAID have posted PMI Advisors in Liberia. A PMI work planning exercise for FY10 was held with the MOHSW National Malaria Control Program (NMCP) with partners including WHO. The exercise was completed just a day before this review team's visit. The exercise was to align PMI areas of interventions with the NMCP Strategic Plan 2008-2013. The PMI team agreed with the NMCP on key activities for the 2010 operational plan. The areas for PMI support in 2010 would include purchasing malaria commodities (LLINS, ACTs), implementation of community case management, expanding Indoor Residual Spraying (IRS), strengthening IEC/BCC activities, and procurement and supply chain management. The development of human resource would be critical for the effective implementation of malaria activities.

WHO in Liberia

The review team had meetings with Dr. Nestor Ndayimirije, WHO Representative and key staff of the WHO country office. The team was also provided with reports, briefing notes and other relevant documents on the work of WHO in support of the MOHSW and its partners. Dr. Fatoma Bolay, the Advisor on disease prevention and control (DPC), was the designated point person for this review.

WHO is considered by the MOHSW and its partners as the leading technical agency on health sector matters. WHO is regularly called upon by the MOHSW to advise on policies and norms related to priority health issues and programs. The demand on WHO is so great that the WR and the WCO staff, especially the NPOs, are overstretched.

The WCO Program of Technical Cooperation with the Government of Liberia covers almost all the diseases and health systems issues. The WCO has made significant headway in supporting a number of essential capacity building activities, and the restoration of basic decentralized support systems at the level of the counties. The USAID Grant to WHO/AFRO has played a part in the contribution of WHO to some key health sector achievements in Liberia over the last three years, especially in the area of routine immunisations, integrated disease surveillance and response, and the Road Map for the reduction of maternal newborn and child mortality.

Some key activities and achievements include:

- The development of a National Road Map for accelerating the reduction of maternal and newborn mortality; the Road Map identifies key interventions at policy/environment level; health facility level and community level; this was done with the support of the West African Inter-country Support Team (IST WA) in April 2007.
- The introduction, adaptation and rolling out of IMCI began in 2006. Liberia-specific modules developed in 2007 are being used to train health care providers; IMCI implementation currently covering five counties (Montserrado, Cape Mount; Gbarpolu, Margibi, Bong); this is in collaboration with NGOs and led by the Government; more than 100 health workers have been trained in IMCI;
- Documentation for Polio free certification to the African Regional Certification Commission (ARCC) in October 2008. The country successfully presented its report and was declared polio free.
- The development of a Child Survival Strategy which is being finalized in 2009, also in collaboration with the IST WA.
- Newly developed national guidelines on the management of severe acute malnutrition (SAM) are being used by all partners in the nutrition cluster.
- The development of a comprehensive Sexual and Reproductive Health Policy with the support of the ICT/WA in April 2009.
- The development of a national Gender Based Violence Plan of Action in 2007 which was launched by the President of the Republic of Liberia.
- AFRO and HQ through WCO have provided a series of capacity strengthening events for communicable disease control (e.g. Malaria Case Management Training (2004-2008), National Strategic Plan Development (2005), Drug efficacy study (2006), Global fund Application (2006). A United Nations Conference on Trade and Development (UNCTAD) donation has facilitated the availability of ACTs and the monitoring of use of the UNCTAD donated drugs (2007-2008), Laboratory Assessment Missions from IST, and support the establishment of a National Reference Laboratory. A WHO Staff has been seconded to assist with the process (2008 – Current), and support the planning and assessment of PMI activities.

With financial and technical support from WHO, Liberia began the implementation of Integrated Disease Surveillance and Response (IDSR) strategy in 2000. A number of steps in the IDSR implementation process were realised ranging from sensitization of stakeholders, adaptation of technical guidelines and training modules, training of national level trainers and the subsequent training of county health team (CHT) members, district surveillance officers (DSOs) and officers in charge (OICs) from all 15 counties. The MOHSW has also adopted a strategy to involve community focal points in the detection and immediate reporting of priority diseases. Most of these focal points are volunteers who are mainly traditional and spiritual healers. With the threat of influenza A (H1N1), efforts are being made to update knowledge and skills of all involved in

surveillance at all levels. The Emergency and Response Division of the MOHSW produces weekly and monthly epidemiological bulletins.

UNICEF in Liberia

The review team met with Ms. Rozanne Chorlton, UNICEF Representative. She has had an open discussion with the team and provided valuable perspectives and documents on the work of UNICEF and other UN agencies in Liberia. She recognised the leadership role that WHO has to play in the health sector in Liberia. She feels that the WR and the WCO professional staff are currently overstretched. She would like WHO and USAID to support the strengthening of the WCO human resource capacity, especially in the area of HIV/AIDS prevention and control. The team also met with Ms. Kinday Ndure-Samba, an international program officer for nutrition.

The current five year (2008-2012) Program of Cooperation between UNICEF and the Government of Liberia seeks to contribute to the reduction of child mortality and vulnerability and the development of a safe, secure and peaceful environment for children of Liberia. The UNICEF programs and projects are based on the United Nations Development Assistance Framework (2008-2012) prepared in response to the Liberia Poverty Reduction Strategy 2008-2011.

UNICEF works closely with WHO and other strategic partners to support the MOHSW in the implementation of the national health plan with a special focus on maternal and child health and nutrition, water, sanitation and hygiene, HIV/AIDS, malaria, sexual and gender based violence. UNICEF also support basic education and gender equality programs.

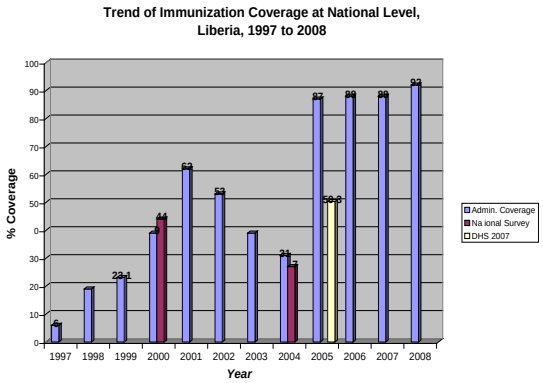
Progress Towards Meeting the Millennium Development Goals (MDGs)

Considerable efforts are being made by the Government of Liberia towards meeting the MDGs with the combined support of UN agencies, bilateral and multi-lateral agencies, and NGOs. UNICEF Liberia assesses the likelihood of attaining the MDGs 4, 5 and 6 at the current national health plan implementation pace to be "probable" for Goal 4 of reducing child mortality, "unlikely" for Goal 5 of decreasing, maternal mortality, and mixed for Goal 6 of combating HIV/AIDS, malaria and other diseases.

As discussed earlier, the country's health indicators, though improving, remain unsatisfactory as evidenced by the 2007 Liberian Demographic Survey. Major challenges to attaining MDGs include the eroded primary health care management and the little integration at community level for child survival interventions, poor infrastructure and inadequate financing of health system, and the health workforce crisis.

Routine Immunisation for Vaccine-Preventable Childhood Illnesses in Liberia

After the attainment of the Universal Childhood Immunisation (UCI) in 1990, Liberia was engulfed by civil unrest and immunisation services suffered to the extent that DPT-3 coverage dropped to as low as 6% in 1997. With the return of relative peace following the national election coupled with the polio eradication initiative and the return of NGOs to counties when more health facilities became operational, the administrative coverage rose gradually reaching a peak of 62% in 2001.



However, by the end of 2001, increased tension in some of the counties led to the displacement of people and relocation of health workers. Consequently, a downward trend in administrative coverage of DPT-3 started in 2002 and by 2004 when the coverage had dropped to 31%. From 2005 to the present time, a rapid increase in the administrative coverage for routine immunisation has occurred. This impressive progress can be attributed to the following:

- The return of peace and the extension of political authority to all parts of the country.
- Increase in the number of health facilities that became operational and were providing immunisation services in the country from 173 to 448.
- Resuscitation and intensification of outreach activities nationwide (in the past two years this was funded mostly by USAID Liberia through the USAID Grant to WHO/AFRO.)
- Regular receipt of GAVI support for immunisation strengthening (Funds used for Health Facility, County and National level operational support, vaccine distribution, Training, Reproduction of data tools, etc.)
- The expansion of cold chain capacity including installation of solar refrigerators in most parts of the country.
- Improved logistics support (provision of vehicles and motorbikes) for outreach immunisation activities (ongoing placement or replacement of motorbikes in health facilities throughout the country with funds from USAID Liberia through the USAID Grant to WHO/AFRO). Improved monitoring of immunisation services including supervision and quarterly review meetings.

Issues and Future Perspectives

The MOHSW has taken measurable steps to assume leadership in the health sector. Continued technical and financial support from partners such as WHO, USAID and UNICEF are critical for Liberia to move towards reaching the MDGs. The discussions held with health sector stakeholders during this review visits have raised a number of issues and needs to be considered in the dialogue between WHO and USAID on future collaboration in support of the MOHSW efforts. The following are some of the critical issues:

- Ways and means for addressing the Liberia Health workforce crisis, including motivation of MOHSW staff and national professionals working with UN agencies
- Scaling up efforts to deal with maternal, newborn and child health
- Policy and guidelines on quality community-based interventions
- Development of laboratory network and national reference laboratory
- Quality information for monitoring and evaluating health interventions and progress toward MDGs

Beefing up staffing and capacity in WCO in Liberia will be critical for WHO to meet its mandate and to fully play its role as the leading technical agency on health matters.

List of Key Informants in Liberia

Ministry of Health and Social Welfare

1. Dr. Moses Pewu, Acting Deputy Minister and Chief Medical Officer
2. Dr. Louise Kpoto, Head Emergency Preparedness and Response Program
3. Torbert G. Nyenswah, Deputy Program Manager, NMCP
4. Paye K. Nyansaiye, Assistant Program Officer for Technical Services, NMCP
5. Dr. Saye D. Baayo, Director of Family Health Division (met him together with three of his collaborators)

World Health Organisation

1. Dr. Nestor Ndayimirije, WHO Representative
2. Dr. Fatoma Bolay, Disease Prevention and Control Advisor (NPO and the designated point person for this grant review visit)
3. Dr. Peter Clement, Emergency and Humanitarian Action Advisor (IPO and covers disease surveillance)
4. Dr. Musu Duworko, Family Health Program Advisor (NPO)
5. Dr. Zakari Wambai, EPI Medical Officer
6. Mr. Eric Johnson, HEC Advisor (NPO)
7. Mr. Ukam Oyene, APOC Technical Advisor (IPO for Oncho)
8. Dr. Seipati Anoh, Making Pregnancy Safer, Advisor, IST West Africa (on TDY in Monrovia during this review)
9. Dr. Amos Petu, Health Economics Advisor, WCO Nigeria (on TDY with Dr. Anoh of IST)

UNICEF

1. Rozanne Chorlton, UNICEF Representative
2. Ms. Kinday Samba, Nutrition Program Officer

U.S. Agency for International Development

1. Dr. Tanu Duworko, CTO for the Basic Health Care Package Project
2. Dr. Augustine Mulbah, Responsible for EPI activity
3. Dr. Filiberto Hernandez, PMI/CDC Resident Advisor

BASICS Project

1. Dr. Rose Macauley, COP

Documents Provided for the Review

1. Government of Liberia- MOHSW. Final Draft National Strategy for Child Survival in Liberia 2008 – 2011, December 2008.
2. MOHSW and WHO - Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia, November 2007.
3. MOHSW, Draft Operational Plan to Reduce Maternal and Neonatal Mortality in Liberia, March 2008.
4. 2008 WHO Liberia Country Office Report.
5. 2008 WHO Liberia Country Office Report.
6. MOHSW NMCP: National Malaria Strategic Plan 2009-2013
7. UNICEF Liberia Briefing Packet.
8. United Nations Development Assistance Framework Liberia 2008-2012.
9. Liberia Coordinating Mechanism (LCM) - January 21, 2009 meeting report.
10. Liberia Coordinating Mechanism (LCM) - February10, 2009 meeting report.
11. MOHSW Pool Fund Steering Committee - January 30, 2009 meeting report.
12. Technical Coordination Committee of the LCM - April 22, 2009 meeting report.

13. Dr. Nestor NDAYIMIRIJE, WR and Convener of UNDAF Outcome Group 5- HIV/AIDS Prevention and Control - The 1st Quarter 2009 Report (AS OF 18 APRIL 2009).
14. MOHSW National Task Force on Influenza A H1N1 – May 6, 2009 Meeting Minutes.
15. K. Karsor Kollie , IDSR follow up training of health workers and community surveillance focal points (Montserrado, Grand Bassa, Bargibi, Nimba, Grand Gedeh counties), Report of the training sessions conducted March--April 2008.

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X. ACRONYMS

ACSM	Advocacy, Communication and Social Mobilisation
ACTs	Artemisinin-Based combination Therapies
ADH	Adolescent Health
AED	Academy for Educational Development
AFP	Acute Flaccid Paralysis
AFRO	World Health Organisation Regional Office for Africa
AI	Avian Influenza
AIDS	Acquired Immunodeficiency Syndrome
AIMC	Accelerated Implementation of Malaria Control Initiative
ANC	Antenatal Care
ANECCA	African Network for the Care of Children Affected by HIV/AIDS
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ATM	AIDS, Tuberculosis, Malaria
AVAREF	African Vaccine Regulatory Form
BFHI	Baby Friendly Hospital Initiative
CAH	Child and Adolescent Health
CBIs	Community-based Initiatives
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CIDA	Canadian International Development Association
CILSS	Comité Inter-Etats de Lutte contre la Sécheresse au Sahel
CLC	Canadian International Development Agency
CNP	Comité Nationale de Pilotage
cMYO	Updated Comprehensive Multiple Year Plan
CO	Country Office WHO
CTBC	Community TB Care
CTO	Cognizant Technical Officer (USAID)
DDC	Division of Communicable Diseases Prevention and Control
DFID	UK Department of International Development
DHS	Demographic Health Survey
DNC	Division of Non-communicable Diseases
DOTS	Directly Observed Therapy Short Course Strategy
DRC	Democratic Republic of Congo
DSD	Division of Health Systems and Services Development
DPM	Director of Program Management
DPT3	Diphtheria, Pertussis and Tetanus
DRH	Division of Reproductive and Family Health
EHP	Essential Health Package
EmONC	Emergency Obstetric and Newborn Care
EmZinc	Zinc Supplement used to treat Diarrhea
ENA	Essential Nutrition Actions
ENC	Essential Newborn Care
EPI	Expanded Program on Immunisation
EU	European Union
FANC	Focused Antenatal Care
FP	Family Planning
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to fight AIDS, TB and Malaria

GIBS	Groupe Inter Bailleurs Santé
GMP	Global Malaria Program
GIVS	Global Immunisation Vision and Strategy
GLC	Green Light Committee (Treatment of TB Resistance)
GS	General Services
GTZ	German Government Program for Sustainable Development
HepB	Hepatitis B Vaccine
HH	Household
HIB	Hemophilus influenzae B Vaccine
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMM	Home Management of Malaria
HPN	Health, Population and Nutrition
HQ	Headquarters (WHO Geneva)
IBFAN	International Baby Food Action Network
IDD	Iodine Deficiency Disorder
IDS	Integrated Disease Surveillance
IDSR	Integrated Diseases Surveillance and Response
IHR	International Health Regulations
IMCI	Integrated Management of Childhood illness
IMNCI	Integrated Management of Neonatal and Childhood Illness
IPO	International Professional Officer
IPTp	Intermittent Preventive Treatment in pregnancy
IST	Inter-country Support Team
JHPIEGO	Johns Hopkins Non-Profit Health Organisation
LGA	Local Government Area - Nigeria
MACEPA	Malaria Control and Evaluation Partnership in Africa
MAL	Malaria
MCH	Maternal and Child Health
MDR	Maternal & Perinatal Death Review
MDR-TB	Multi-Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MLM	Mid-Level Management
MNBH	Maternal and Newborn Health
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MPS	Making Pregnancy Safer
MSP	Malaria Strategic Plan
NGO	Non Governmental Organisation
NMCP	National Malaria Control Program
NNT	Neonatal Tetanus
NPO	National Professional Officer
NUT	Nutrition
OIC	Officers in Charge
ORS	Oral Rehydration Solution
PCR	Polymerase Chain Reaction
PATH	Program for Appropriate Technology in Health
PHC	Primary Health Care
PLWHA	People Living With HIV and AIDS
PMI	United States President's Malaria Initiative

PMTCT	Prevention of Mother-to-Child transmission in HIV
POA	Plan of Action
PRSP	Poverty Reduction Strategic Paper
PVO	Private Voluntary Organisation
RDT	Rapid Diagnostic Test (for Malaria)
RBM	Roll Back Malaria
REC	Regional Economic Community
RED	Reaching Every District Approach
RH	Reproductive Health
RHR	Reproductive Health Research
RHT	Reproductive Health Training
RO	Regional Office (WHO)
RUTF	Ready to use therapeutic food
SADC	Southern Africa Development Community
SIDA	Swedish International Development Cooperation Agency
SOPs	Standard Operating Procedures
SP	Sulphadoxine Pyrithramine
SPP	Strategic Partnership Program
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TB/HIV	TB HIV Co-infection
TOT	Training of Trainers
TUB	Tuberculosis
UEMOA	Union Economique et Monetaire Ouest Africaine
UN	United Nations
UNAIDS	Joint UN Program for HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
USFDA	US Food and Drug Administration
VPD	Vaccine Preventable Diseases
WAHO	West African Health Organisation
WB	World Bank
WCO	World Health Organisation Country Office
WFP	World Food Program
WHO	World Health Organisation
WHO/AFRO	World Health Organisation, Regional Office for Africa
WR	WHO Country Representative
YF	Yellow Fever
XDR-TB	Extensively Drug Resistant TB strain