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GLOSSARY

ADE:	Antibody Dependent Enhancement
AGM :	Annual General Meeting
AHM :	Assembly of Health Ministers
AIDS :	Acquired Immune Deficiency Syndrome
ASGO:	African Society of Gynaecologists and Obstetricians
CBC :	Communication for Behaviour Change
CBI :	Community-Based Intervention
CDC :	Centre for Disease Control
CFR :	Case Fatality Rate
CSO :	Civil Society Organisation
CTD :	Common Technical Document
CVA :	Cardiovascular Accident
DHIS2:	District Health Information Software 2
DHS:	Demographic and Health Surveys
DQR:	Data Quality Review
DRC:	Democratic Republic of Congo
ECOWAS :	Economic Community of West African States
ECOWAS :	Economic Community of West African States
ELISA :	Enzyme-Linked Immuno Assay
EmOC:	Emergency Obstetrics and Neonatal Care
EPI :	Expanded Programme on Immunization
EQA :	External Quality Assessment
EQUIST :	Equitable Impact Sensitive Tool
FDA:	Food and Drug Authority
FGPH:	ECOWAS Best Practice Forum
GBD:	Global Burden of Disease
GEPT:	Global Emerging Pathogens Treatment
GHI:	Global Hunger Index
GMP:	Good Manufacturing Practices
H3Africa :	Human Heredity and Health in Africa
HIV :	Human Immunodeficiency Virus
HPV :	Human Papilloma Virus
IATA :	International Air Transport Association
IDF :	International Diabetes Federation
IDSR :	Integrated Disease Surveillance and Response
IEC-CBC :	Information Education Communication – Communication for Behaviour Change
I-HAB:	Institute of Human Virology
IHR :	International Health Regulations
IMCI :	Integrated Management of Childhood Illnesses
ISO :	International Standards Organisation
LLINS :	Long-lasting Insecticidal Nets
MCM :	Modern Contraception Methods
MCV1 :	Measles-Containing Vaccine
MDG:	Millennium Development Goals
MEP :	Moving Evidence into Policy
MH:	Mobile Health
MICS :	Multiple Indicator Cluster Surveys
MMR :	Maternal Mortality Rate
MTA:	Materials Transfer Agreement
NACA:	National Agency for the Control of HIV and AIDS

NACAHF -DD :	Network of Champions for Adequate Health Financing and Demographic
NCD:	Non Communicable Diseases
NCDC:	National Centre for Disease Control
NCI:	National Coordinating Institution
NEPAD:	New Partnership for Africa's Development
NHIS :	National Health Information System
NMCP:	National Malaria Control Programme
NMCQL:	National Medicines Quality Control Laboratories
NMRA:	National Medicines Regulatory Authority
NNHS:	National Nutrition and Health Survey
NTDs:	Neglected Tropical Diseases
OIE :	World Animal Health Organisation
OP:	Ouagadougou Partnership
PC :	Preventive Chemotherapy
PPP:	Public Private Partnership
QMS:	Quality Management System
RCSDC:	Regional Centre for Surveillance and Disease Control
REDISSE:	Regional Disease Surveillance and Systems Enhancement
RTA :	Road Traffic Accident
SANBI :	South African National Bioinformatics Institute
SAP-ECOLINK :	Systems, Applications and Products
SDG:	Sustainable Development Goals
SLIPTA :	Stepwise Laboratory Improvement Process Towards Accreditation
SMC :	Seasonal Malaria Chemoprevention
SML:	Small and Mid-sized Libraries
SRHAY :	Sexual Reproductive Health of Youth and Adolescents
STEPS :	STEPwise approach to Surveillance
SWEDD:	Sahel Women's Empowerment and Demographic Dividend
TAG-V:	Technical Advisory Group on Vaccination
TB:	Tuberculosis
UA	Unit of Account
UNAIDS:	United Nations Programme on HIV and AIDS
UNICEF:	United Nations Children's Fund
UNIDO:	United Nations Industrial Development Organization
USAID:	United States Agency for International Development
VHF :	Viral Haemorrhagic Fever
WAEMU:	West African Economic and Monetary Union
WAHIDN:	West African Health Information Documentation Network
WAHO :	West African Health Organisation
WAHO:	West African Health Organisation
WAHRNet :	West African Health Research Network
WAPCP:	West African Postgraduates College of Pharmacists
WHO:	World Health Organisation
WIRA:	Women In Reproductive Age
YAH :	Youth and Adolescents Youth

INTRODUCTION

Established on 9 July 1987 by the Heads of State and Government by Protocol A/P2/7/87, the West African Health Organisation (WAHO) is the specialised institution of the Economic Community of West African States (ECOWAS) in charge of health issues, with a political mandate to ensure regional coordination of health related matters in the ECOWAS region.

Its main mission is the attainment of the highest possible standard and protection of health of the peoples in the sub-region through the harmonisation of the policies of the Member States, pooling of resources, and cooperation with one another and with others for a collective and strategic combat against the health problems of the sub-region.

Since its inception, WAHO has developed three Strategic Plans, the latest of which covers the period 2016-2020. The latest Strategic Plan is structured around 3 strategic axes and 13 Priority Programmes, which are implemented based on annual work plans.

This report will provide an account of the main activities carried out during 2018, as well as the results achieved. It focuses on six (6) main areas, which are:

- Health status of the ECOWAS region.
- Implementation of the main recommendations of the 19th Ordinary Session of the Assembly of Health Ministers of ECOWAS.
- Management-related activities.
- Results of the implementation of the 13 priority Programmes ,
- Update on finance and administrative issues,
- Challenges.

I. THE HEALTH SITUATION IN ECOWAS REGION IN 2018

This chapter aims to summarize the burden and trends of communicable and non-communicable diseases and the risk factors that characterized the ECOWAS region in 2018. In addition, it describes the health status of mothers, new-borns, children, adolescents, young people and the elderly.

I.1. Communicable and Non-Communicable Diseases

This section focuses on the epidemiological situation of communicable and non-communicable diseases with greater impact on morbidity and mortality in the ECOWAS region.

I.1.2. Communicable Diseases

In ECOWAS countries, thousands of people have been affected continuously by epidemics particularly of viral haemorrhagic fevers, cholera, meningitis, and measles. The resulting morbidity and mortality are very important.

⇒ Cholera

Five years after 2014, when ECOWAS recorded a significant cholera outbreak with a total of 68,348 reported cases and 1114 deaths (fatality of 1.6%) in 8 countries (Benin, Côte d'Ivoire, Ghana, Guinea-Bissau, Liberia, Niger, Nigeria, Togo), in 2018 the region experienced the second largest epidemic with a total of 64,678 cases, causing 1215 deaths (2.2% fatality). (Fig 1)

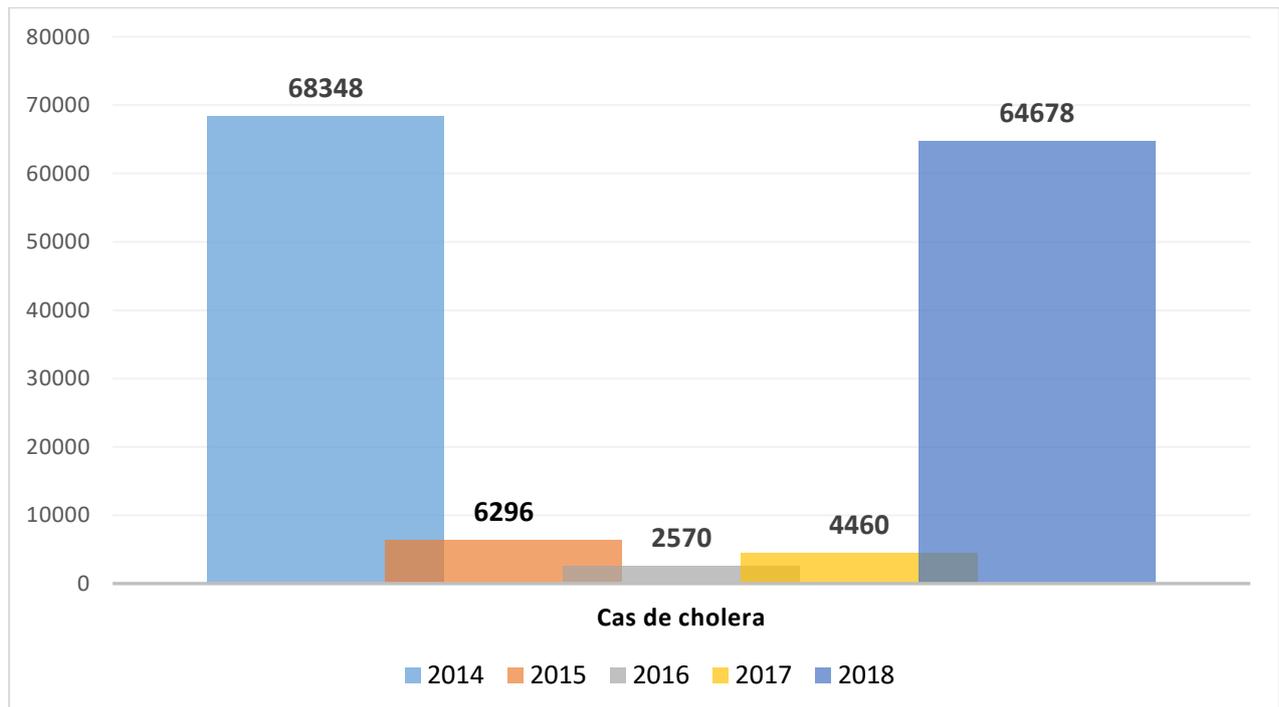


Figure 1: Cholera cases declared in ECOWAS Countries, 2014 – 2018. Source: Regional Health Information Sharing Platform, WAHO

In 2014, Nigeria and Ghana had 95% of declared cases (Nigeria 53% and Ghana 42%) and 90% of all deaths observed.

In 2018, the cholera epidemic particularly affected Nigeria and Niger. Nigeria declared a total of 50 719 cases including 1136 deaths with a case fatality rate of 2.2% reported from 20 States

(Adamawa, Anambra, Bauchi, Borno, Ebonyi, FCT, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kogi, Kwara, Nasarawa, Niger, Plateau, Yobe, Sokoto and Zamfara). Of the confirmed cases, 26.3% were aged 5-14 years.

On 15 July 2018, an outbreak of cholera was officially declared by the Ministry of Public Health of Niger. As of 31 December 2018, Niger declared 3822 cases (14% of these were cases in Nigerian residents seeking care in Niger) with 78 deaths (case fatality rate 2.4 %) have been reported from twelve health districts in four regions: Dosso, Maradi, Tahoua, and Zinder. Four affected districts (Aguié, Guidam Roumji, Madarounfa, and Maradi commune) in Maradi Region and two affected districts (Birni Koni, and Mabalza) in Tahoua Region are on the border with Nigeria, while Gaya District in Dosso Region is close to the border with both Benin and Nigeria.

In 2015, 2016 and 2017, respectively, 6296, 2570 and 4460 cases of cholera were reported, indicating the persistence of the circulation and transmission of *Vibrio cholerae* in the ECOWAS region. The seasonality of the cholera outbreak in 2014 and 2018 is virtually the same. The cases were mainly concentrated between week 29 and week 45 (Fig 2 below).

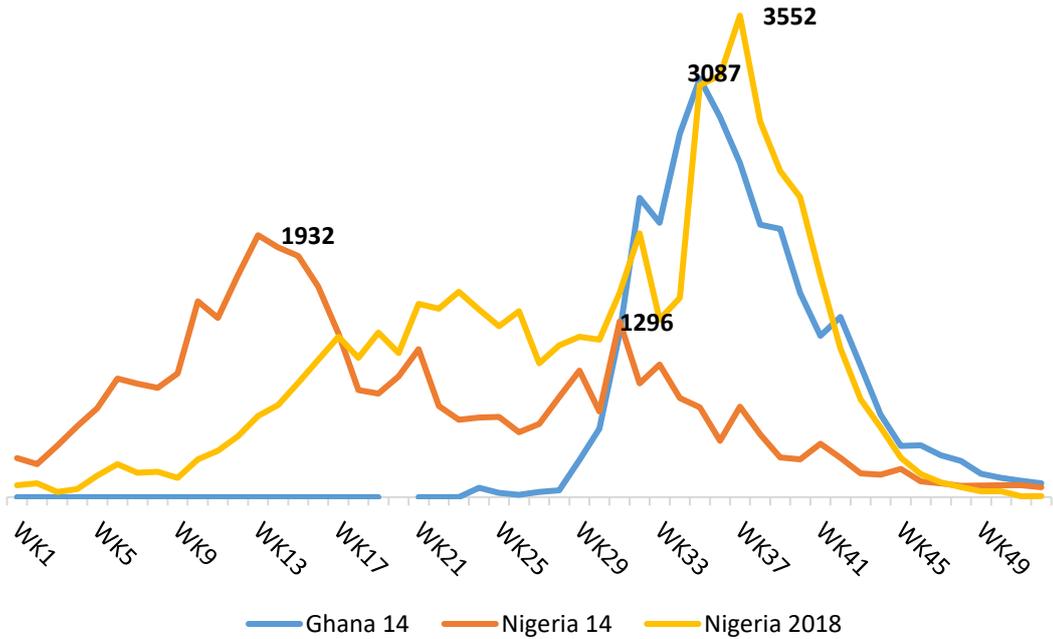


Figure 2: Comparison of the weekly evolution of cholera cases in Ghana and Nigeria between 2014 and 2018. Source: Regional Health Information Sharing Platform

Long-term cholera control is possible in ECOWAS Region. Senegal appears to have eliminated transmission, with zero cases reported in the five consecutive years. As part of multisector collaboration, countries must continue to work to detect and characterize cholera epidemics, identify high-risk areas and vulnerable populations to guide prevention and control measures, and promote health and hygiene education in the community, including the provision of better access to potable water and sanitation.

Vaccination is effective at preventing cholera. It provides about 85 % protection within the first 6 months, which decreases to 50 - 62 % during the first year, and to less than 50 percent after 2 years.

Vaccination started immediately after the first cases is a very good tool to prevent the rapid spread of the disease.

Therefore, early detection, targeted vaccination of the at-risk population, and timely and adequate access to patient care are proven measures that all countries must adopt to combat cholera outbreaks.

WAHO will continue to assist Member States to get quick access to vaccines through the region’s security stock.

⇒ **Meningitis**

The **African meningitis belt** is a region in sub-Saharan Africa where the rate of incidence of meningitis is very high. It consists of part of or all of, from West to East, Senegal, The Gambia, Guinea-Bissau, Guinea, Mali, Burkina Faso, Ghana, Niger, Nigeria, Cameroon, Chad, Central African Republic, Sudan, South Sudan, Uganda, Kenya, Ethiopia, Eritrea. The "belt" has an estimated 300 million people in its total area.

The most affected countries are Burkina Faso, Ethiopia, and Niger that account for 65% of all cases in Africa. During major epidemics, the attack rate range is 100 to 800 people per 100,000, with rates occasionally being as high as 1000 per 100,000. Young children have the highest attack rates during epidemics.

Fig. 3 shows the trend of meningitis cases notified by ECOWAS Member States in the past 5 years (2014-2018).

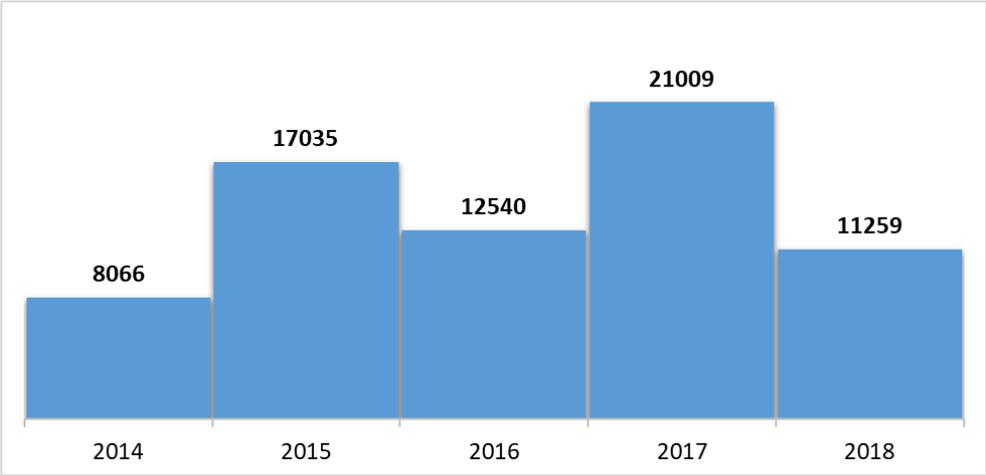


Figure 3: Trend of meningitis cases notified by ECOWAS, 2014 – 2018;
Source: Regional Health Information Sharing Platform, WAHO

In 2016: 12 550 cases were reported with a case fatality rate of 7.9%. The predominant organism was: *Staphylococcal pneumoniae* (SP) 34.8%, followed by *Neisseria meningitides* (NM) W 23.-%, NmC 12.3%, Hib 2.9% and NmX 2.3%; 38 districts reached the epidemic threshold (Benin – 3; Burkina Faso – 2; Côte d’Ivoire – 1; Ghana – 16; Niger – 3; Nigeria – 1; and Togo – 9)

In 2017: 21 009 cases were reported with a case fatality rate of 6.4%; the predominant organism was: *S. Pneumoniae* (33.0%); followed by NmX (19.1%); Hib (6.7) and Nm W (4.6%); 48 districts reached the epidemic threshold (Benin – 2; Burkina Faso – 1; Ghana – 5; Niger – 4; Nigeria – 35 and Togo – 1)

In 2018: 11 259 cases were reported with a case fatality rate of 5.97%. The predominant organism was: NmC (31.8%); followed by *S. Pneumoniae* (28.8%); NmX (11.9%) and NmW (9.4%); 15 districts reached the epidemic threshold (Ghana – 6; Niger – 1; Nigeria – 8).

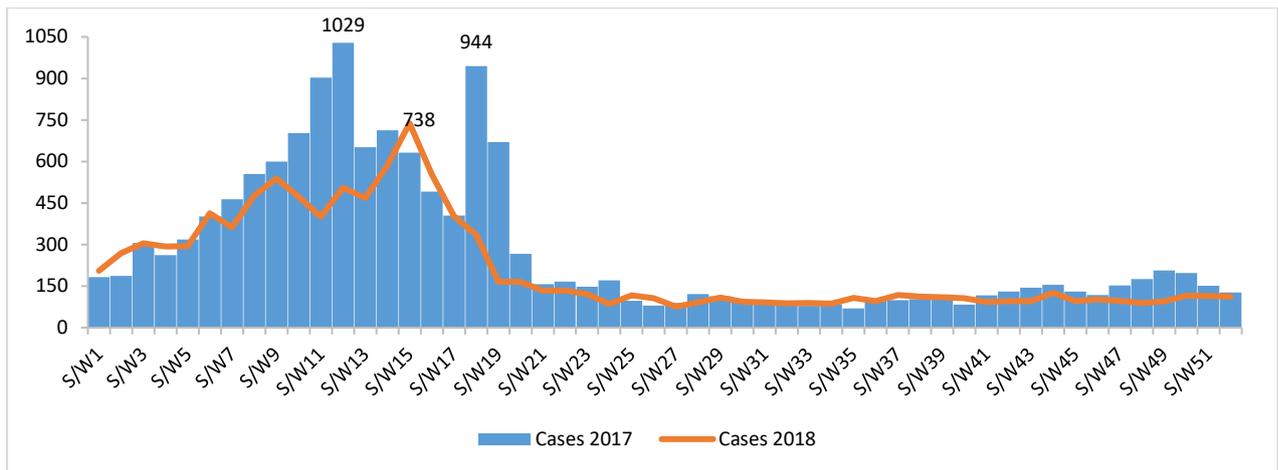


Figure 4: Trends of meningitis cases by week notified by ECOWAS Countries, 2017/18. Source: Regional Health Information Sharing Platform, WAHO

As shown in Fig. 4, the first trimester of the year is the period of great transmission of meningitis. In 2019, As of March 1, 2104 cases of meningitis were reported (CFR 6.7%) by Benin (102), Burkina Faso (703), Côte d’Ivoire (65), Ghana (421), Guinea (51), The Gambia (10), Mali (103), Niger (142), Nigeria (360) and Togo (147). Two districts in Nigeria (1) and Togo (1) reached the epidemic threshold and eleven districts crossed the alert threshold in 3 countries: Benin (3), Burkina Faso (4), Ghana (3) and Nigeria (1) – see Fig 5 below.

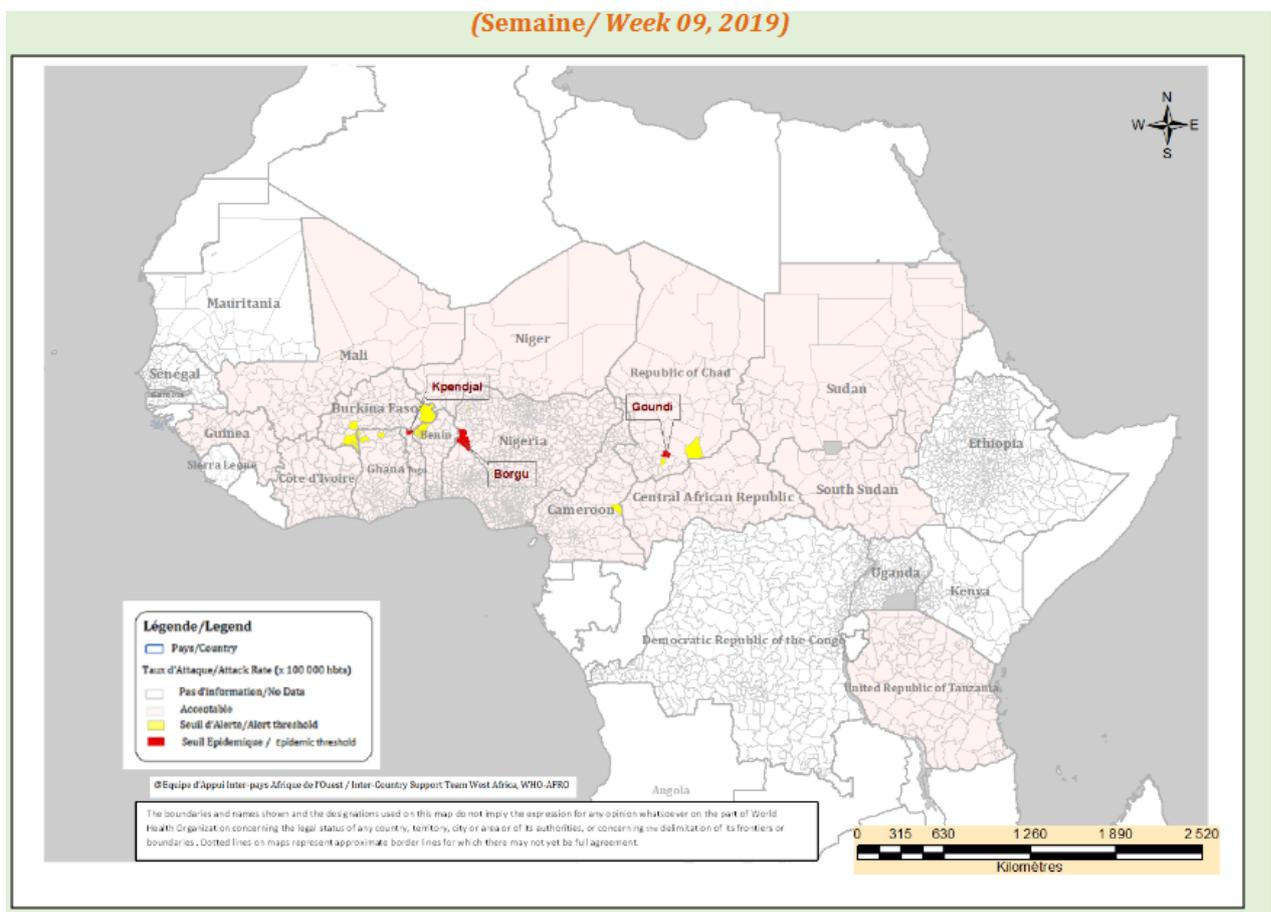


Figure 5: Weekly feedback bulletin on cerebrospinal meningitis; week 9 2019. Source: WHO

Some ECOWAS Members States, namely Benin, Burkina Faso, Côte d’Ivoire, Ghana, Mali, Niger, Nigeria and Togo are partially or entirely vaccinated with MenAfriVac.

However, MenAfriVac will only protect against disease caused by the group A meningococcus—the main cause of meningitis epidemics in Africa, accounting for about 80 to 85% of all cases. Meningitis cases caused by other groups, such as W135, X and C, also occur. Vaccines for other groups are either not yet available (X) or far too expensive for African countries (C, W, or Y in various combinations). It is hoped that a combination of ongoing research and development efforts and tiered pricing will contribute to making these vaccines available to developing countries in the future.

Countries are encouraged to strengthen case detection and notification. With suspected cases, there is a need to utilise lumbar puncture procedures liberally and to improve laboratory confirmation, particularly in districts that reach the epidemic alert threshold.

⇒ **Measles**

Although it is a disease targeted by elimination Programmes, these Programmes remain very ineffective and measles persists as an endemic disease in the ECOWAS region (see fig 6).

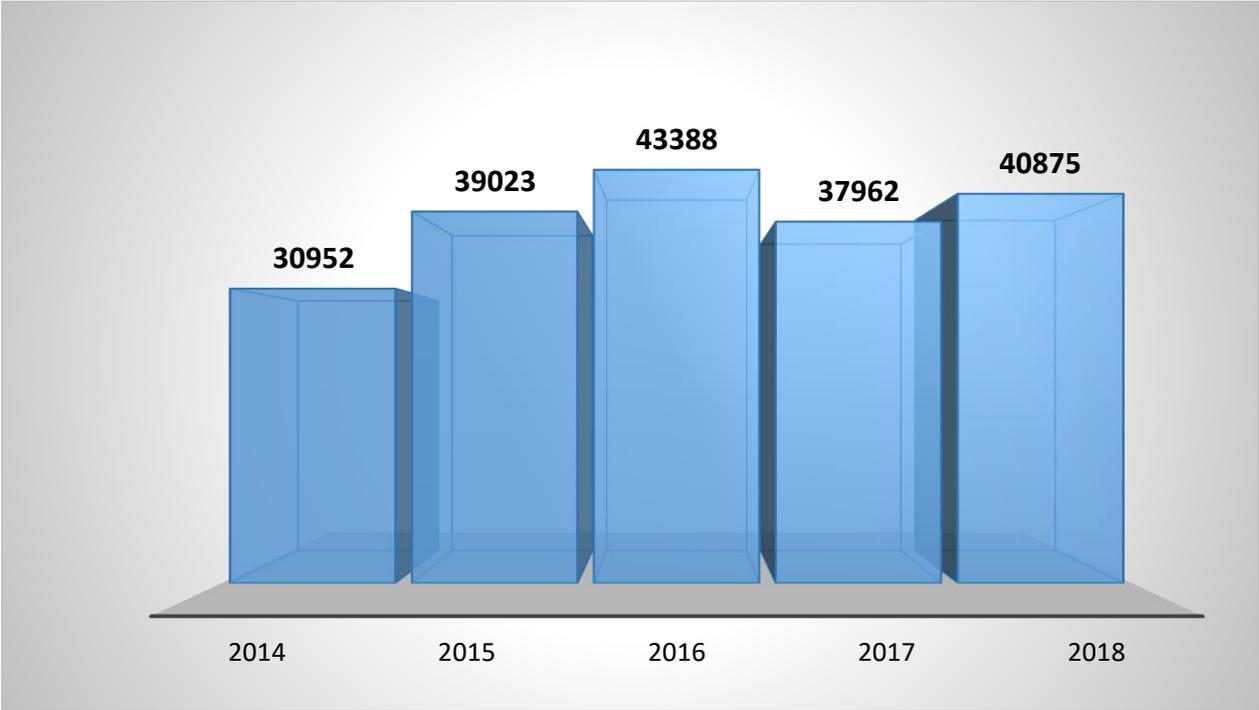


Figure 6: Cases of measles notified in ECOWAS, 2014-2018. Source: Regional Health Information Sharing Platform, WAHO

In 2018, a total of 40,875 cases and 209 measles-related deaths (0.4% fatality) were reported in 14 countries in the region. Cabo Verde is the only country in the region that has not reported measles cases in recent years. The countries reporting the most cases in 2018 were Nigeria (17,412), Niger (4,616), Burkina Faso (4,490) and Liberia (4,234). The weekly evolution of cases between 2017 and 2018 shows that cases peak are found in the first quarter of each year (Fig. 7).

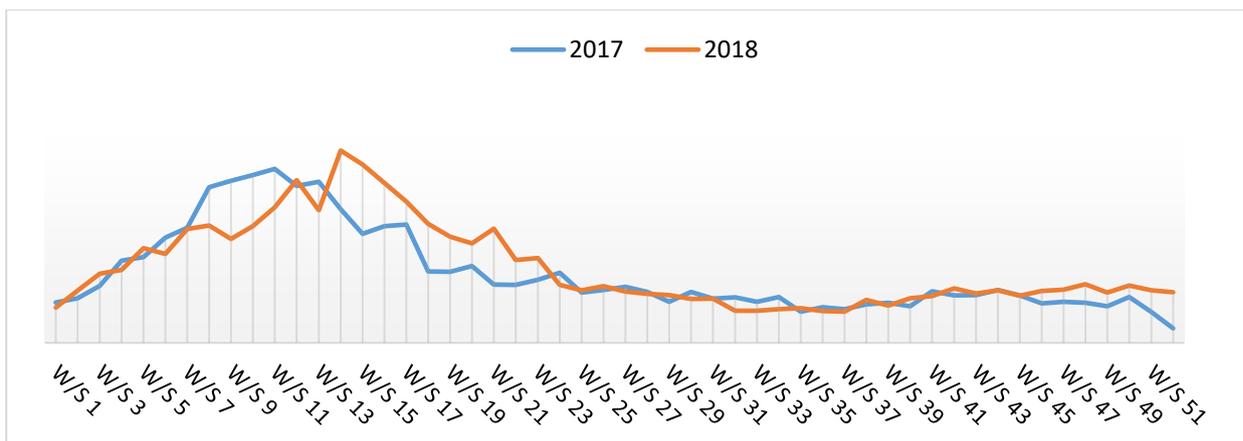


Figure 7: Annual trend of Measles notified cases among ECOWAS, 2017/18. Source: Regional Health Information Sharing Platform, WAHO

The elimination of measles is biologically and programmatically feasible, drawing on experiences of reducing measles mortality over the past decade.

The vaccination schedule of the ECOWAS Member States envisages a first dose of a measles-containing vaccine (MCV 1) between 9 and 11 months of the child's life (92% vaccine protection - WHO). Despite some improvements from 2013 to 2017, the national immunization coverage of MCV1 for protection against epidemics of measles in the ECOWAS Member States, is in general low. (See Fig 8 below).

According to the WHO position paper – 28 April 2017, two doses of measles vaccines are more effective than one dose for protection. In 2018, seven ECOWAS Member States (Burkina Faso, Cabo Verde, The Gambia, Ghana, Niger and Senegal) had introduced a second dose in their vaccination schedule but with a lower level of coverage than with MCV1.

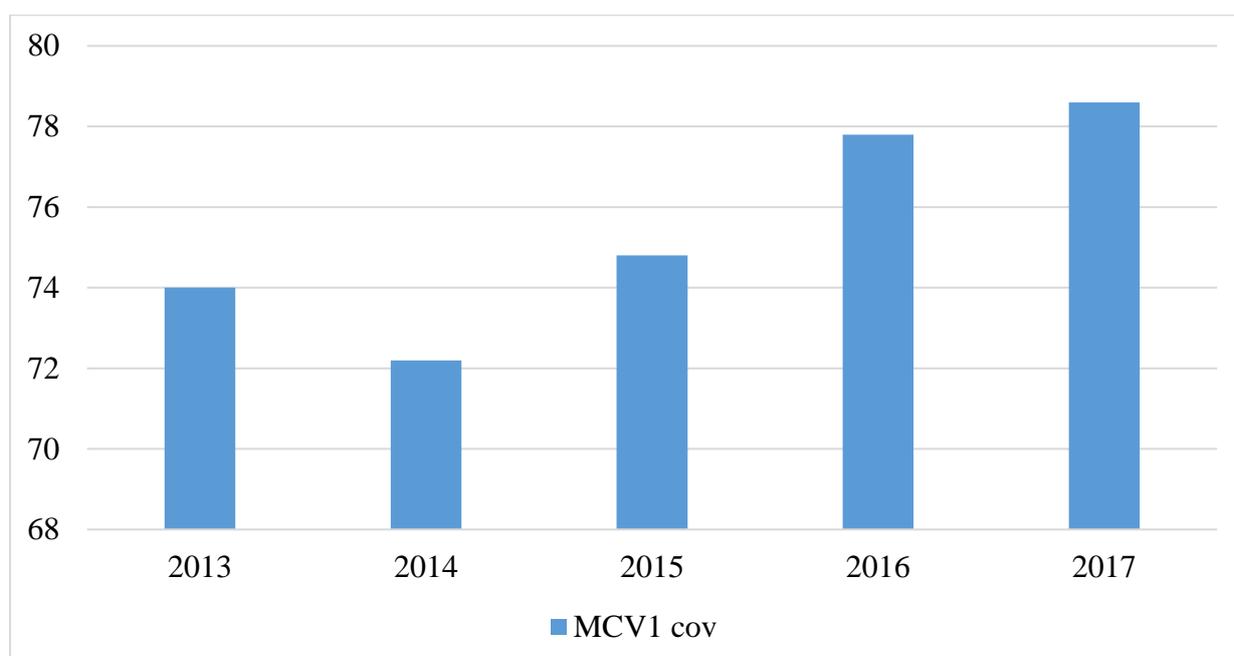


Figure 8: Coverage of measles-containing vaccine in ECOWAS region 2013 - 2017. Source: WHO / UNICEF

Elimination of measles is the responsibility of countries. To achieve this, they must aim to strengthen immunization systems whilst assuring and promoting equity in service delivery.

Priority interventions should include improving immunization coverage through the systematic implementation of a combination of approaches, offering a second measles vaccination opportunity, conducting sensitive disease surveillance, capacity building of health workers, improving the quality of immunization monitoring data, conducting sustained advocacy, health education, and health promotion activities, and mobilising local and international partners, in addition to intensifying operational research.

⇒ **Lassa fever**

Lassa fever, which occurs mainly in West Africa, is an acute viral haemorrhagic disease of which the pathogen is a virus of the Arenaviridae family. It is a zoonotic virus and the animal vector is primarily a rodent: the "plurimammary rat" (*Mastomys natalensis*).

According to the WHO, nearly 80% of Lassa fever are caused by rodent to human transmission after human exposure to the urine or faeces of contaminated rats. Human-to-human transmission (20% of cases) is possible after exposure to viruses contained in body fluids (blood, tissues, secretions or excretions) of an individual infected with Lassa virus or rarely through contamination of medical equipment.

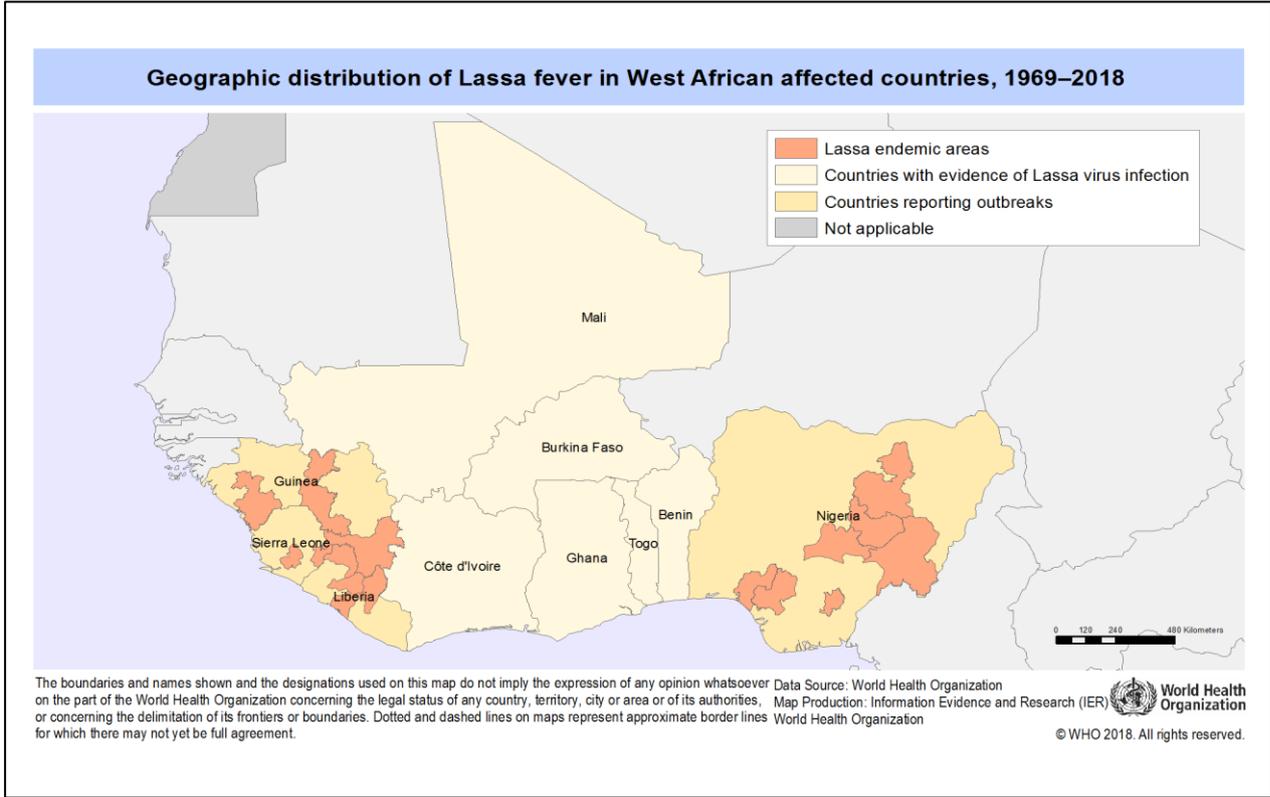


Figure 9: Geographic distribution of Lassa Fever in West African affected countries, 1969-2018. Source: WHO

Lassa fever is endemic in West Africa and since its discovery in 1969 in the village of Lassa in Nigeria (from which the virus takes its name), several epidemics have occurred, particularly in Sierra Leone, Liberia, Guinea and Nigeria. Viral circulation is also known throughout the ECOWAS region, except in 5 countries (Cabo Verde, Gambia, Guinea-Bissau, Niger and Senegal) where the status of infection remains unknown. Sporadic cases have been reported in other

ECOWAS Member States at risk of the disease (Benin, Mali, Ghana, Côte d'Ivoire, Burkina Faso, and Togo).

Data available to WAHO on the epidemiological situation of Lassa fever show a rapid increase in the number of confirmed cases and a geographical extension of the endemic area in the ECOWAS region.

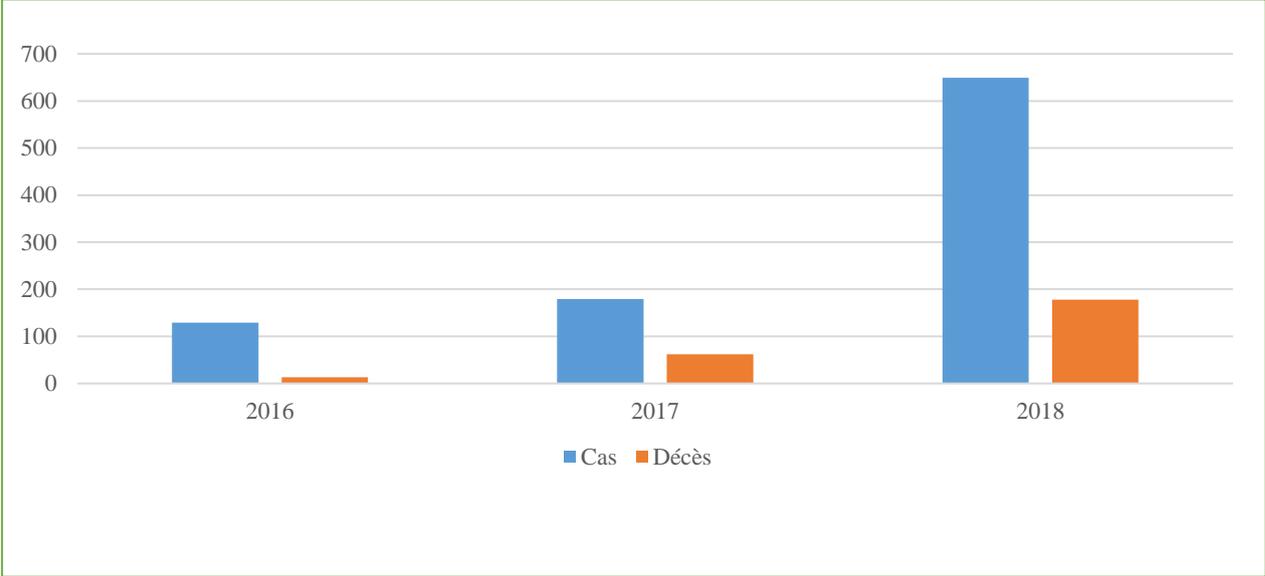


Figure 10: *Lassa Fever in ECOWAS Member States; 2016 - 2018 (Cases and deaths)*. Source: *Regional Health Information Sharing Platform*

Figure 10 shows that in the region, the incidence has increased fivefold from 129 to 649 confirmed cases between 2016 and 2018, while fatality has increased from 10.1% to 27% during the same period after a peak of 34.6% in 2017. The situation was as follows:

- 129 confirmed cases, including 13 deaths (case-fatality of 10.1%) were reported in 2016 by 4 ECOWAS countries (Benin, Liberia, Nigeria and Togo). Togo had just notified these first two cases.
- 179 confirmed cases, including 62 deaths (case-fatality of 34.6%), were reported in 2017 in 4 ECOWAS countries (Benin, Liberia, Nigeria, Sierra Leone).
- 649 confirmed cases, including 178 deaths (case-fatality of 27%), were reported in 2018 in 4 ECOWAS countries (Benin, Liberia, Nigeria, Sierra Leone).

By 2019, already at week 8, six (6) ECOWAS countries (Benin, Guinea, Liberia, Nigeria, Sierra Leone and Togo) had already reported 433 confirmed cases of Lassa fever, including 95 deaths (case-fatality of 22%). These figures are likely to increase because the Lassa fever season can continue until week 26 of 2019 and an outbreak of the disease is still active in the region.

In addition, the endemic nature of the disease and large-scale outbreaks is shifting towards Benin, which has been experiencing regular epidemics since 2016. Recently, the country experienced an epidemic that began in December 2018 and continued until 2019 with 9 confirmed cases (zero deaths). The first three confirmed cases all came from Kwara State (Nigeria), hence the importance of coordination and implementation of cross-border activities.

Currently in the region, the Lassa fever epidemic continues only in Nigeria (the most affected country with 96% of confirmed cases in the region). From January 1 to March 3, 2019, the CDC of Nigeria (NCDC) reported a total of 420 confirmed cases with 93 deaths (lethality rate of 22.1%) in 21 states – Fig 11.

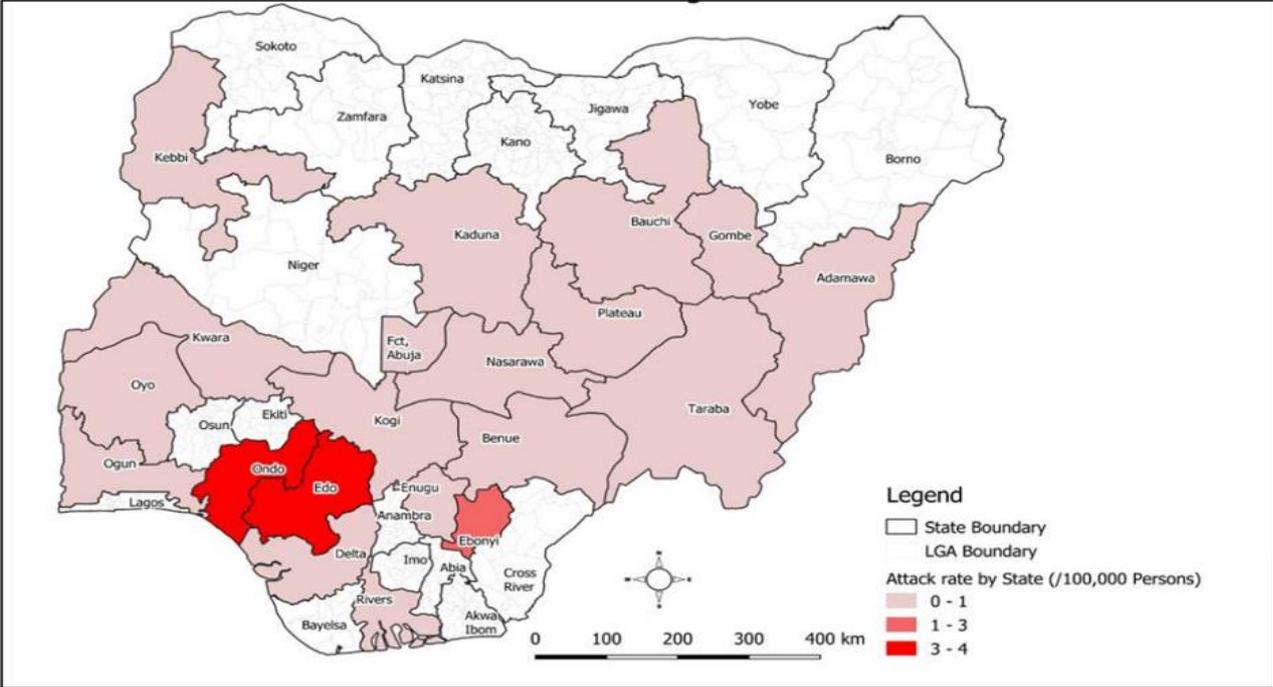


Figure 11: State Attack rate of confirmed Lassa fever cases in Nigeria as at 3 March, 2019. Source Nigeria CDC

However, under the leadership of the NCDC, satisfactory progress has been made in the response by the Nigerian health authorities.

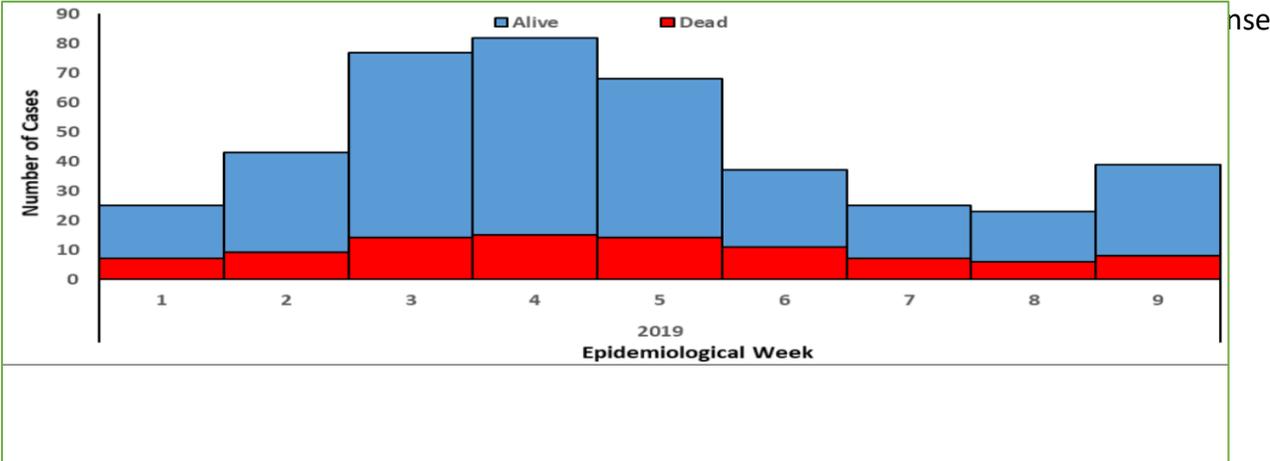


Figure 12: Lassa fever cases and related deaths, in Nigeria in 2019 from week 1 to week 9. Source: Nigeria CDC

The situation of Lassa fever in the ECOWAS region remains a concern due to the existence of several factors favouring the progression of the disease's endemicity. These include climatic conditions favourable to the survival of the virus outside its host, and the increase and dispersion of the rodent population (vector). Other contributing factors include poverty; low levels of environmental sanitation in high burden communities; insufficient training of health workers in

surveillance and diagnosis; and poor implementation of infection prevention and control measures in health facilities.

ECOWAS Member States must strengthen multisector collaboration based on the "One Health" approach (Human Health, Animal Health, Environment) for more effective disease prevention and control actions. Cross-border collaboration between Member States is also important. This includes the implementation of coordinated actions to:

- Strengthen preparedness and response capacities, particularly for early case detection, laboratory confirmation, case management as part of recommended nursing care, risk communication and community engagement.
- Promote good "community hygiene" to deter rodents from entering homes, for example by storing cereals and other foodstuffs in rodent resistant packaging, disposing of waste away from homes, keeping homes clean, having cats, and treating the bodies of people who have died from the disease in a safe way.
- Contribute more to research, particularly in the development of rapid diagnostic tests and vaccines, the objective being early and adequate management to increase survival rates. Nigeria, for example, is planning to participate in clinical trials to develop vaccines against Lassa fever in 2020.

⇒ **Yellow fever**

In 2016, two linked urban yellow fever outbreaks in Luanda (Angola) and Kinshasa (Democratic Republic of the Congo, DRC), led to wider international spread of the disease from Angola to countries as far as China, thus highlighting that yellow fever poses a serious global threat requiring new strategic thinking.

In urban outbreaks, population density, crowding, low levels of population immunity, daily population movements in and out of, and around, the city, as well as conditions conducive to high vector density such as several breeding sites in and around houses, all contribute to increasing transmissibility, thereby raising the risk of large-scale outbreaks. Urban outbreaks are characterized by their rapid amplification, the capacity for rapid international spread, and the multi-sectoral impact not only on public health but also on economic, social and political life. **The West African Ebola outbreak showed that when a pathogen spreads to capital cities it can amplify into a major epidemic on a scale never observed before.**

For Africa, a three-step approach was used to reclassify the 35 countries into different risk categories for yellow fever (high – moderate – potential). All the ECOWAS Member States were classified as high risk excluding Cabo Verde which was classified as potential.



Figure 13 : Yellow fever risk map in Africa. Source WHO

In 2018 only Nigeria was affected. The National Authorities declared an outbreak in September 2018 and from the onset of the outbreak to 31st December 2018, 78 confirmed cases were reported in 13 states (Kwara, Kogi, Kano, Zamfara, Kebbi, Nasarawa, Niger, Katsina, Edo, Ekiti, Rivers, Anambra, FCT, and Benue States) with 13 deaths.

Yellow fever preventive mass vaccination campaigns were conducted in 6 States (Borno, Kebbi, Niger, Plateau, Sokoto and the FCT) in the two weeks between between 22 November 2018 and 2 December 2018, bringing to 12 the total number of states covered by preventive mass vaccination campaign.

The public health goal for yellow fever remains:

- Protect at risk population, including introduction of yellow fever vaccine in routine immunization, and undertake mass vaccinations in at-risk populations,
- Contain outbreaks rapidly including case-based surveillance, laboratory testing, investigation and response, and vector surveillance and control.
- Prevent international spread: targeting travellers and improving IHR adherence (upon entry and departure).

⇒ **Dengue**

In West Africa, dengue virus circulation in human populations was reported for the first time in the 1960s in Nigeria. From 1970 to 2000, serotype 2 transmission predominated in the region, particularly in Senegal and Burkina Faso with sporadic case reports. Indeed, dengue serotype 1 and serotype 2 have been responsible for the majority of Dengue epidemics on the continent.

However, serotype 3 was detected on the continent after 2000 and has predominated in West Africa, particularly Burkina Faso (in 2003, 2004 and 2007) and Côte d'Ivoire (2008) before being responsible for the epidemics that occurred simultaneously in Senegal and Cape Verde in 2009.

Serotype 4 which had earlier not been associated with an epidemic in Africa first appeared in Angola. More recently, outbreaks of Dengue fever with haemorrhagic manifestations were reported in Burkina Faso in 2016, in Côte d'Ivoire in June 2017, and in Mali, Burkina Faso and Senegal in October 2017.

Thus the presence of the 4 serotypes in West Africa heralds an emergence of the severe and haemorrhagic forms of Dengue fever because of the theory of Antibody Dependent Enhancement (ADE) whereby pre-existing antibodies sometimes enhances facilitation of a disease.

In 2018 several ECOWAS Member States including Mali, Burkina Faso, Côte d'Ivoire, Ghana, Togo, Benin, Nigeria and Senegal reported cases of dengue. The real burden of the disease is unknown. From September to December 2018 Senegal declared 292 confirmed cases in 7 Districts (Fatick -34, Diourbel -205, Saint Louis - 32, Louga - 6, Thiès -4, Dakar - 10 and Matam -1).

Disappearance of the virus is improbable because of its maintenance in host vectors and the existence of human and animal reservoirs. Therefore prevention remains the effective means to limit its spread. This prevention is based on the establishment of programmes to control and eradicate potential mosquito vectors and the prospect of vaccination.

The situation analysis of capacity and gaps in West Africa showed that the region has some capacity in epidemiological and entomological surveillance and vector control. However, support is needed to bring this capacity to a level that would allow the timely detection of arbovirus infections and to achieve adequate preparedness for potential epidemics. Indeed controlling Aedes-transmitted arboviruses is a major 21st century challenge for global public health, exacerbated by widespread insecticide resistance in the vectors and a relentless growth in urban environments. This requires the implementation of harmonised entomologic surveillance, and Integrated Vector Management Programme of Aedes-transmitted arboviruses is essential to define, understand and prepare for potential future threats in West Africa.

In 2019, WAHO will set up an Integrated Vector Management Programme in collaboration with NEPAD and a monitoring Programme for entomological indicators of arbovirus diseases, especially dengue fever, for early detection of public health threats.

⇒ **Malaria**

Malaria remains the world's endemic parasitic disease, hence representing the most serious public health problem. In 2018, the general situation of the disease in the ECOWAS region was as follows:

ECOWAS: Home to 90% of malaria cases and 91% of malaria deaths in Africa

- 77% of deaths are under 5 years



- All countries in the region are affected by the plasmodium falciparum parasite
- Vectors: 11 species of Anopheles
- 3 countries with moderate transmission: Guinea, Liberia, Sierra Leone
- 5 highly endemic countries: Burkina Faso, Ghana, Mali, Niger, Nigeria.

Globally, almost 80% of all malaria cases were in 15 African countries and in India in 2017. Nearly 42 of all cases globally were accounted for by Nigeria (25%), and 6 others West African countries, in 2017 (Table 1).

Table 1: Percent Global Malaria Burden in West Africa

Country	Percentage
Nigeria	25%
Burkina	4
Ghana	4
Niger	4
Mali	3
Guinea	2
Benin	2
Total heavy burden West Africa	42 %
The remaining of the world	58%

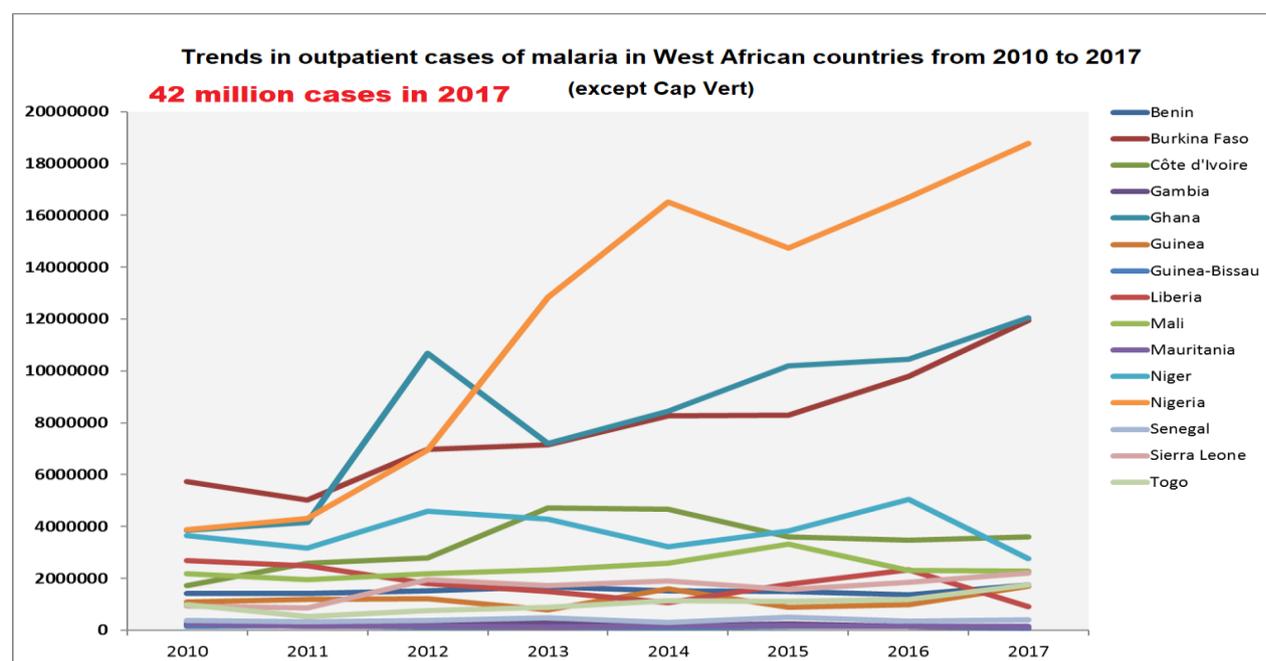


Figure 14: Trends in outpatient cases of malaria in West Africa, 2010 – 2017. Sources National Malaria Control Programmes

In recent years, major advances have been made in the development of new prevention and diagnostic tools and in new antimalarial drugs that are highly effective against drug-resistant parasites. Cabo Verde, The Gambia and Senegal have made great strides in malaria control. Gambia and some districts in Northern Senegal are now in pre-elimination phase (rates at or below 1 case per 1,000 people), and Cabo Verde had no indigenous case in 2018.

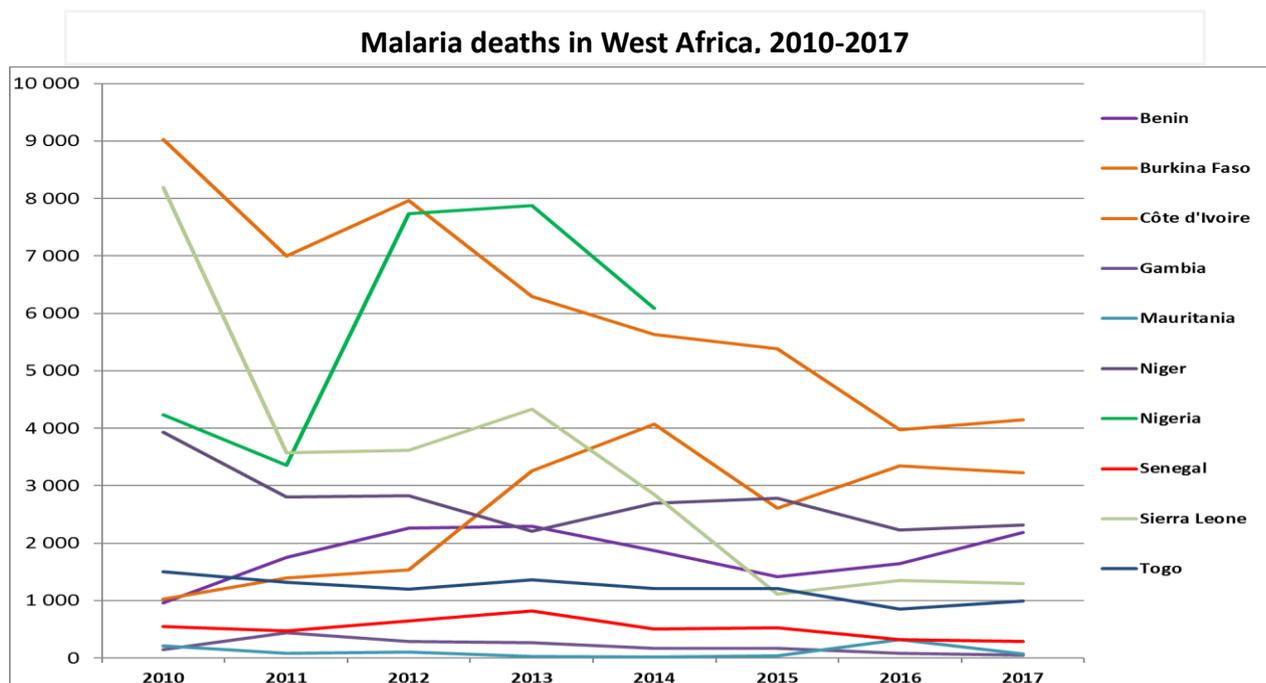


Figure 15: Malaria deaths in West Africa – 2010-2017. Sources National Malaria Control Programmes

Other countries, though with declining morbidity and mortality data, are still in the control phase of the disease.

Not all national malaria strategic plans in ECOWAS countries are oriented towards elimination in accordance to Malaria Elimination framework. In fact, only a few have strengthened case surveillance in the context of the elimination of malaria to varying degrees, because they are getting close to the recommended thresholds for malaria Elimination.

Malaria diagnosis and treatment guidelines are available in all 15 countries. All the countries use confirmation (Rapid Diagnostic Test-RDT or Blood smear) of suspected cases before treatment regardless of the level of care, and in line with recommendations, Artemisinin-based Combination Therapy (ACT) is most commonly used in countries at the health centers. For severe malaria, quinine is progressively being replaced by injectable artemisunate.

As part of the implementation of the World Bank-funded Malaria and Neglected Tropical Diseases Project, 6 mass-campaign rounds were organized in 3 countries (Niger, Burkina Faso and Mali) to prevent the occurrence of seasonal malaria in children from 3 months to 59 months. Six million children were treated in these 3 countries in 2018. A total of 21,360,778 beneficiaries were affected including 114,352,306 females.

During the regional program review workshop in late 2018, several countries mentioned the need for strengthening the managerial and technical capacity of their programs, particularly the availability of qualified and motivated human resources. This lack of expertise in specific areas of malaria control varies from country to country.

In view of these findings, it is imperative that countries are supported to accelerate the fight to eliminate malaria, with special attention paid to the most affected countries, without ignoring the least affected.

A regional meeting of National Malaria Control Programs and partners working in the field of malaria was organized and the discussions led to the establishment of a Regional Coordination for

the elimination of malaria in the ECOWAS Region to be based at WAHO. A regional platform for vector control coordination is also being initiated.

It will be necessary to promote, mobilize and harness domestic resources and other opportunities in the private sector to ensure the sustainability of progress towards malaria elimination. The fight against malaria should also involve a multi-sectoral approach with emphasis on hygiene, sanitation, and behavioral change. Finally countries should encourage, promote and experiment new innovative approaches and tools through research. For example, gene drive and other molecular tools in treatment and vector control should be explored.

⇒ **HIV & AIDS and Tuberculosis**

The HIV epidemic in West Africa has distinct dynamics compared to the other regions of Sub-Saharan Africa. In 2017, it was estimated by UNAIDS that HIV prevalence among adults is 2.2% in the region, which is relatively lower than Southern Africa. This low to moderate national HIV prevalence ranges from less than 1% to a high of 4.5%. For instance there is wide variation in prevalence between countries, ranging from 0.5% in Niger and Senegal, through 1.7% in Sierra Leone, to 3.4% in Guinea-Bissau.

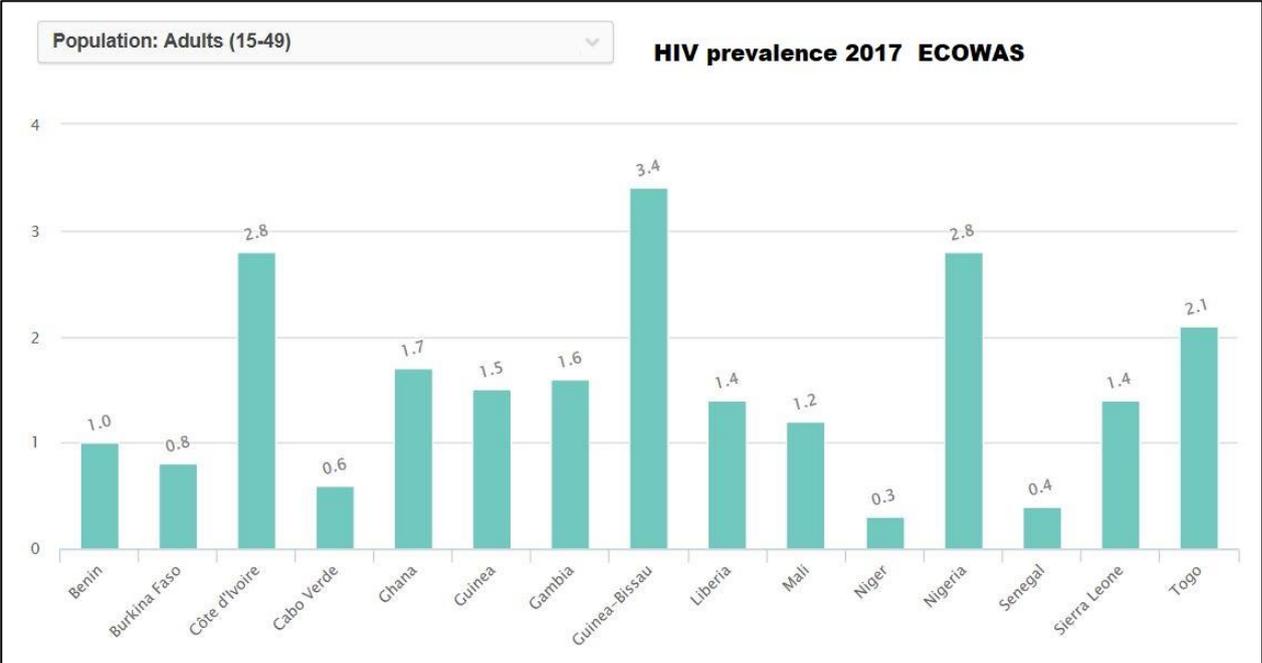


Figure 16: HIV prevalence in ECOWAS Member States in 2017. Source: National AIDS Programmes

In terms of incidence, Nigeria had the second largest HIV population in the world (NACA 2017), because taking into account its population, 3.1 million people were living with HIV in 2017 in the country. However in the latest survey for 2018, HIV prevalence among 15-49 year olds in Nigeria had reduced from 2.8% to 1.9% which is much lower than many other African countries.

Table 2: HIV Infections in ECOWAS Member States – Trends 2010-2017

COUNTRY	New HIV infections 2017	Change in new HIV infections since 2010	Trend of HIV related	Change in AIDS-related deaths since 2010	HIV prevalence Population:15-49 (2017)
Benin	4000 [2100 - 6800]	-8	2500 [1300 - 4500]	-3	1.0 [0.7 - 1.4]
Burkina Faso	4300 [2600 - 6700]	1	2900 [1900 - 4100]	-46	0.8 [0.6 - 1.0]
Cabo Verde	<200 [<100 - <500]	11	<100 [<100 - <100]	-53	0.6 [0.5 - 0.7]
Côte d'Ivoire	30 000 [13 000 - 56 000]	3	24 000 [15 000 - 37 000]	-30	2.8 [1.8 - 4.0]
The Gambia	1400 [<1000 - 1800]	-16	1100 [<1000 - 1400]	-9	1.6 [1.3 - 2.0]
Ghana	19 000 [15 000 - 24 000]	-8	16 000 [12 000 - 19 000]	-24	1.7 [1.4 - 2.0]
Guinea	8100 [5700 - 11 000]	-5	5100 [3900 - 6400]	7	1.5 [1.2 - 1.9]
Guinea-Bissau	2300 [1700 - 2900]	-27	1900 [1600 - 2200]	-5	3.4 [2.6 - 3.8]
Liberia	2300 [1700 - 3200]	-8	2500 [2000 - 3000]	-34	1.4 [1.1 - 1.7]
Mali	9900 [7300 - 12 000]	6	6300 [4900 - 7900]	26	1.2 [1.0 - 1.5]
Niger	1700 [1200 - 2200]	4	1800 [1400 - 2300]	-14	0.3 [0.3 - 0.4]
Nigeria	210 000 [110 000 - 320 000]	-5	150 000 [86 000 - 230 000]	-19	2.8 [1.8 - 4.0]
Senegal	1600 [<1000 - 2300]	-30	2100 [1500 - 2800]	14	0.4 [0.3 - 0.5]
Sierra Leone	3200 [2000 - 4800]	-34	2600 [2100 - 3200]	-11	1.4 [1.1 - 1.7]
Togo	4900 [2100 - 8300]	-27	4700 [2500 - 7700]	-32	2.1 [1.4 - 3.0]

Source: AIDS Info Summary HIV and AIDS data

The 90-90-90 targets – “90% of people living with HIV know their status, 90% of people living with HIV who know their status are on treatment, and 90% of people on treatment are virally suppressed”- was set to end the AIDS epidemic by heralding a shift in the world's approach to HIV treatment towards prioritizing maximal viral suppression among people living with HIV.

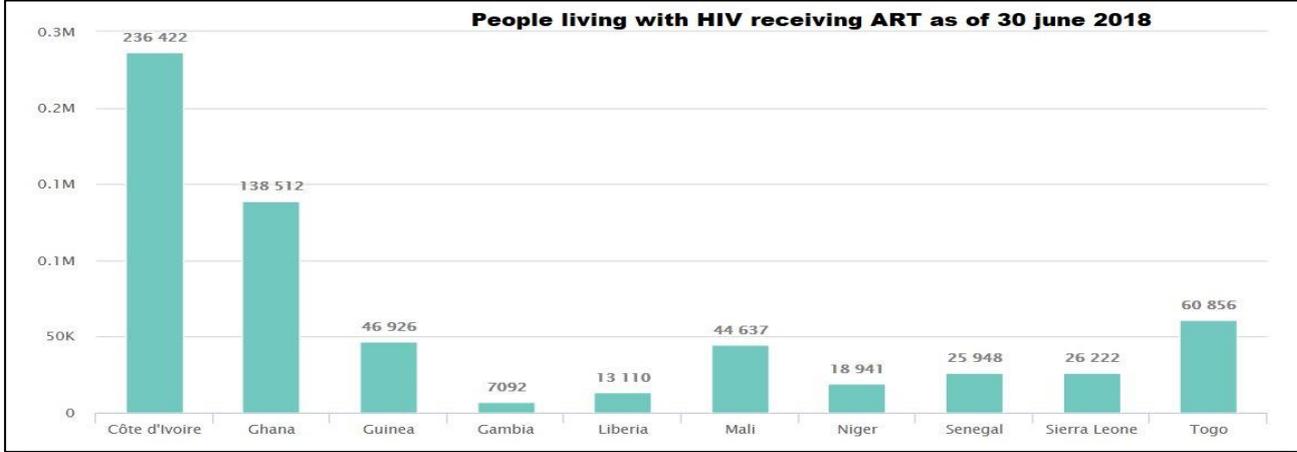


Figure 17: People living with HIV receiving ART as of 30 June 2018; Source AIDS Info; June 2018

Overall, less than half (48%) of those living with HIV were aware of their status in 2017.

In recent years, key populations have been identified as the main drivers of the epidemic, especially in societies where they seem to hide their sexual practices. According to UNAIDS, globally, these key populations make up to 45% of new HIV infections, although they represent a much smaller proportion of the total population. The lack of access to treatment of key populations contributes to spread of the epidemic. Therefore, in recognition of the high burden of HIV among this group, the fact that these groups are important to the dynamics of HIV transmission, and the fact that they are essential partners in an effective response to the epidemic, the Ministers of Health of the ECOWAS member States adopted the “Dakar Declaration on factoring key populations in the response to HIV and AIDS in ECOWAS Member States”, 2015.

On the other hand Tuberculosis is still the main opportunistic infection. The HIV epidemic contributes to the increase of the tuberculosis prevalence including the spread of Multi-resistant Tuberculosis.

⇒ **Neglected Tropical Diseases**

Neglected tropical diseases (NTDs) represent a significant burden in low-income countries. They are a group of diseases that place a constant and heavy burden primarily on the poorest, most marginalized and isolated communities in the world. In addition, efforts to control or eliminate these diseases have lacked sufficient investment in regards to their impact. For instance, NTDs receive only a small portion of global health financing and were not specifically mentioned in the Millennium Development Goals (MDGs). Ironically, these tropical diseases are common comorbidities with the three major global scourges of HIV infection, tuberculosis and malaria.

Countries in the ECOWAS region, especially in the Sahel are endemic to various neglected tropical diseases. The focus has been put on five diseases for which there are safe and effective drugs, and which makes it feasible to implement preventive chemotherapy (PC) for entire at-risk populations usually administered through mass campaigns. The five diseases are onchocerciasis (river

blindness), lymphatic filariasis (elephantiasis); schistosomiasis, soil-transmitted helminthiasis (round-worms, hook-worms and whip-worms), and blinding trachoma.

Togo for example is the first ECOWAS African country to have achieved the global elimination target for lymphatic filariasis. ECOWAS countries are also making steady progress regarding onchocerciasis, and moving towards elimination.

Numbers of Known Disease Endemic Health Districts and Health Districts Where Disease Transmission Has Stopped

Country	# Known endemic districts by September 2017				
	# Districts stopped PC (at least at district level for trachoma), by end FY17 SAR2				
	LF	Oncho	SCH	STH	Trachoma
Burkina Faso	70	6	70	70	48
	55*	0	0	0	29
Côte d'Ivoire	74	67	80	82	9
	0	0	0	0	1
Ghana	98	85	216	216	37
	83	0	0	0	37
Niger	31	NA	41	41	35
	11	NA	0	0	23
Sierra Leone	14	12	12	14	NA
	8	0	0	0	NA
Togo	8	32	35	28	NA
	8	0	0	0	NA
Total	295	266	454	451	129
	165 (56%)	0 (0%)	0 (0%)	0 (0%)	90 (70%)

#s in red are endemic districts and #s in black are districts that were endemic but have stopped treatment.

END neglected tropical diseases in AFRICA

Figure 18: Number of known disease endemic health districts and health districts where disease transmission has stopped;
Source: END Neglected Tropical Diseases in Africa

I.2.2. Non-Communicable Diseases

The scope of non-communicable diseases (NCDs) is very wide. As adopted in Brazzaville in 2011, it includes the diseases of the circulatory system, endocrine, nutritional and metabolic diseases, cancers, chronic respiratory diseases, oral diseases, musculoskeletal diseases, haemoglobin and neuropsychiatric disorders. Different ECOWAS Member States cover different subsets of these diseases. In some countries, Programmes such as sickle cell disease control, tobacco control and cancer control are located outside the National NCD Control Programmes. Most country Programmes as well as WAHO cover the four major NCDs – cardiovascular diseases, cancers, diabetes and chronic respiratory diseases – and their associated risk factors. WAHO is also active in the prevention, control and management of eye disorders and mental disorders in the region.

The major global NCD activity in 2018 was the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in September which concluded with a Political declaration on NCDs. The Heads of State and Government reaffirmed their commitment, in line with the 2030 Agenda for Sustainable Development, to reduce premature mortality from

NCDs by one third by the year 2030 through prevention and treatment and to promote mental health and well-being, by addressing their risk factors and the determinants of health.

In May 2018, the Director General of WHO called for a global plan of action to eliminate cervical cancer. The key strategies are the vaccination against human papillomavirus (HPV), screening and treatment of pre-cancerous lesions, early diagnosis and timely treatment of invasive cancer and palliative care.

According to the Global Burden of Disease (GBD) 2017 Study, the proportion of total deaths that occurred in all ages in the ECOWAS that were attributable to NCDs increased from 22.3% in 1990 to 30.8% in 2017. Cardiovascular diseases and cancers ranked as the fourth and seventh top cause of death respectively. Within countries, the proportion of deaths due to NCDs ranged from 24.3% in Niger to 68.3% in Cape Verde in 2017. The number of people dying from NCDs ranged from 446.4 per 100,000 population in Cape Verde to 850.4 per 100,000 in Guinea Bissau.

Also, high systolic blood pressure, high fasting blood sugar and high body mass index were among the top ten leading risk factors for death in West Africa in 2017.

⇒ **Hypertension**

Between 2003 and 2015, all ECOWAS Member States except Guinea Bissau conducted national and sub-national household surveys using WHO’s STEP wise approach to Surveys (STEPS) to estimate the magnitude and distribution of chronic NCD risk factors. The findings show that the prevalence of hypertension ranges from 19.0% in age group 15-64 years in Togo to 38.7% in age group 25-64 years in Cabo Verde.

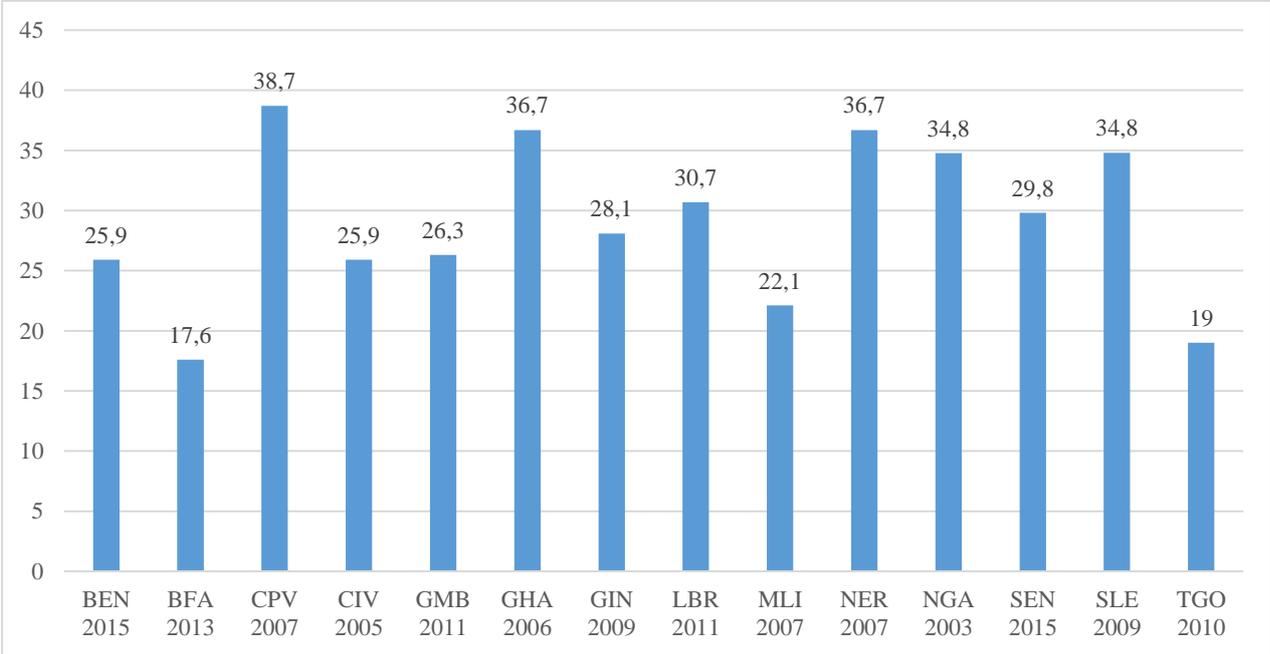


Figure 19: Prevalence of hypertension in ECOWAS Member States. Source: STEPS surveys, 2003-2015

Modelled estimates from the NCD Risk Factor Collaboration (NCD-RisC), a WHO Collaborating Centre on NCD Surveillance and Epidemiology coordinated at the Imperial College London show that the age-standardized prevalence of hypertension has been declining slowly or has been stable in the region from 1975 to 2015.





Figure 20: Age-standardized prevalence of hypertension in Ghana and Niger, 1975-2015.

Source: NID RisC (<http://ncdrisc.org/data-downloads-blood-pressure.html>)

Within countries, the trends in hypertension differ, for example, a downward and upward trend in Ghana and Niger respectively (Fig. 20). Indeed, Ghana is the only country in the region in which the prevalence in women declined over the period. Burkina Faso and Mali were among the top 5 (out of 200) countries in the world recording the highest increase in the prevalence among women over this period. In men, the prevalence increased in Burkina Faso, Guinea, Niger, Mali, Guinea Bissau and Cabo Verde over the period.

The major drivers for hypertension in the region are older age, overweight/obesity and arm circumference.¹ Obese women in Benin, Ghana and three other African countries have 5.3 times the odds of having hypertension as those with normal body mass index.²

On average, only about 22% of those with hypertension are previously aware of their condition.³ Less than 10% of hypertensives in the region have their blood pressure controlled.⁴ Those who tend to be aware of their hypertension are those who are currently married, have attained secondary or higher level education, are covered by health insurance or have visited a health facility in the last 6 months.

⇒ Diabetes

The NCD-RisC estimates that the prevalence of diabetes in men and women in West Africa ranges between 5% and 8%. In all countries, the prevalence has been increasing from 1999 to 2014. The highest prevalence countries are Sierra Leone, Cabo Verde, Gambia, Senegal and Mali while the lowest prevalence occurs in Nigeria and Niger.

The 6th Atlas of the International Diabetes Federation (IDF) had estimated that the prevalence of diabetes in adults aged 20-79 years in the ECOWAS region was 4.3% in 2013, ranging from 1.3% in Mali to 5.5% in Cape Verde. This prevalence translated into 6.3 million adults in the ECOWAS region being affected in 2013, but was projected to reach 13 million in 2035 at a slightly higher prevalence of 4.6%.

¹ Amugsi DA, Dimbuene ZT, Asiki G, Kyobutungi C. Quantile regression analysis of modifiable and non-modifiable drivers of blood pressure among urban and rural women in Ghana. *Scientific reports*. 2018; 8 (1):8515. Epub 2018/06/06. doi: 10.1038/s41598-018-26991-4

² Yaya S et al. Differentials in prevalence and correlates of metabolic risk factors of non-communicable diseases among women in sub-Saharan Africa: evidence from 33 countries. *BMC Public Health*. 2018 Oct 11;18(1):1168

³ Adeloje D, Basquill C. Estimating the prevalence and awareness rates of hypertension in Africa: a systematic analysis. *PLoS One*. 2014;9(8):e104300

⁴ Bosu WK. The prevalence, awareness, and control of hypertension among workers in West Africa: a systematic review. *Glob Health Action*. 2015;8:26227. Epub 2015/01/28. doi: 10.3402/gha.v8.26227. PubMed PMID: 25623611; PubMed Central PMCID: PMC4306751.

However the 8th IDF Atlas subsequently estimated more conservatively that the prevalence of diabetes in ECOWAS countries ranged from 0.8% in Benin to 4.7% in Togo.⁵ Thirteen of the 15 ECOWAS countries had a prevalence of $\leq 2.0\%$. Based on these estimates, there were 3.5 million diabetics and 72,000 diabetes related deaths in ECOWAS countries in 2017.

A systematic review of empirical population-based studies in West Africa reported that the prevalence of diabetes ranged from 0.3% in Gambia in 1993 to 17.9% in Senegal.⁶ Another meta-analysis in 2017 estimated a pooled prevalence of 4.1% in Nigeria and an impaired fasting glucose of 5.8%.⁷ Nearly 40% of the diabetes in Nigeria was undiagnosed. The latter study estimated that the number of diabetes cases in Nigeria increased from 874,000 in 1990 to 4.7 million cases in 2015. A meta-analysis published in 2018 estimated an overall pooled prevalence of diabetes of 5.77% (95% CI 4.3-7.1) in Nigeria.

In nine countries whose STEPS survey involved biochemical measurements, the prevalence of diabetes varied widely from 2.6% in Togo to 22.5% in Niger. These studies cannot however be compared accurately as they were done at different dates in different countries and with different study populations.

⇒ **Overweight / Obesity**

In analysis of Demographic and Health Surveys (DHS) published in 2018, it emerged that the prevalence of overweight / obesity among women in Ghana (40.7%) and Togo (31.4%) ranked as the third and tenth highest out of 33 sub-Saharan African countries.⁸ In contrast, the prevalence among women in Burkina Faso ranked among the lowest.

In 2018, an analysis of at least three rounds of Demographic and Health Surveys (DHS) conducted between 1991 and 2014 among non-pregnant women in 24 African countries showed that there were statistically significant increasing trends in overweight in 17 countries and in obesity in 13 countries.⁹ In the nine ECOWAS countries included, the statistically significant increasing trend in overweight and obesity was observed in five and six countries respectively. Obesity levels doubled in Benin, Niger and Cote d'Ivoire and tripled in Burkina Faso and Mali over the survey periods. In Ghana and Niger, more than 40% of women were overweight or obese in the latest rounds of DHS, a figure that is among the highest on the African continent.

A recent meta-analysis which pooled prevalence across 43 studies published up to March 2016 confirmed that nearly 43% of Ghanaian adults were either overweight or obese.¹⁰

⁵ <https://www.idf.org/component/attachments/attachments.html?id=1405&task=download>

⁶ Sundufu AJ, Bockarie CN, Jacobsen KH. The prevalence of type 2 diabetes in urban Bo, Sierra Leone, and in the 16 countries of the West Africa region. *Diabetes/Metabolism Research and Reviews*. 2017;33(7):n/a-n/a. doi: 10.1002/dmrr.2904.

⁷ Adeloje D, Ige JO, Aderemi AV, Adeleye N, Amoo EO, Auta A, et al. Estimating the prevalence, hospitalisation and mortality from type 2 diabetes mellitus in Nigeria: a systematic review and meta-analysis. *BMJ Open*. 2017;7(5):e015424. Epub 2017/05/13. doi: 10.1136/bmjopen-2016-015424.

⁸ Yaya S, Ekholuenetale M, Bishwajit G. Differentials in prevalence and correlates of metabolic risk factors of non-communicable diseases among women in sub-Saharan Africa: evidence from 33 countries. *BMC Public Health*. 2018;18(1):1168.

⁹ Amugsi DA, Dimbuene ZT, Mberu B, Muthuri S, Ezeh AC. Prevalence and time trends in overweight and obesity among urban women: an analysis of demographic and health surveys data from 24 African countries, 1991-2014. *BMJ Open*. 2017;7(10):e017344. Epub 2017/10/29. doi: 10.1136/bmjopen-2017-017344.

¹⁰ Ofori-Asenso R, Agyeman AA, Laar A, Boateng DJBPH. Overweight and obesity epidemic in Ghana—a systematic review and meta-analysis. *2016;16(1):1239*. doi: 10.1186/s12889-016-3901-4.



⇒ Cancers

Based on data from cancer registries, WHO's International Agency for Research on Cancer estimates that there were 226,608 new cases of cancers and 151,319 cancer deaths in the ECOWAS region in 2018. The commonest cancers in the region, in descending order, are those of the breast, cervix, prostate, liver, colorectum, Non-Hodgkin's lymphoma, stomach and ovary.¹¹

Within countries, the proportion of the total new cases of cancers that were due to breast cancer ranged from 6.8% in The Gambia to 25.1% in Sierra Leone (Fig. 22). For cervical cancer, it ranged from 6.3% in Niger to 26.1% in The Gambia. For liver cancer, it ranged from 3.7% in Benin to 45.2% in The Gambia. For prostate cancer, it ranged from 2.0% in Niger to 17.2% in Cote d'Ivoire.

A meta-analysis in 2018 estimated that the incidence of breast cancer in West Africa from population-based cancer registries is 24.2 per 100,000 population.¹² It estimated that the incidence of breast cancer increased from 23.1 per 100,000 to 26.3 per 100,000 between 2000 and 2015 in Africa. Breast cancer affects younger women more than is commonly believed.

In more than 80% of cases, the average age at diagnosis is less than 50 years. About 53% of breast cancer patients present late in Africa with stage III/IV cancers. The delay between onset of symptoms and reporting is 8-12 months. A recent systematic review based on studies conducted in Ghana, Nigeria, Kenya, Libya and Egypt identified negative symptom interpretation, particularly the absence of pain, fear, belief in alternative medicine, social relations and networks, lack of trust and confidence in orthodox medicine, and access to healthcare as the factors contributing to late presentation of women with breast cancer.¹³

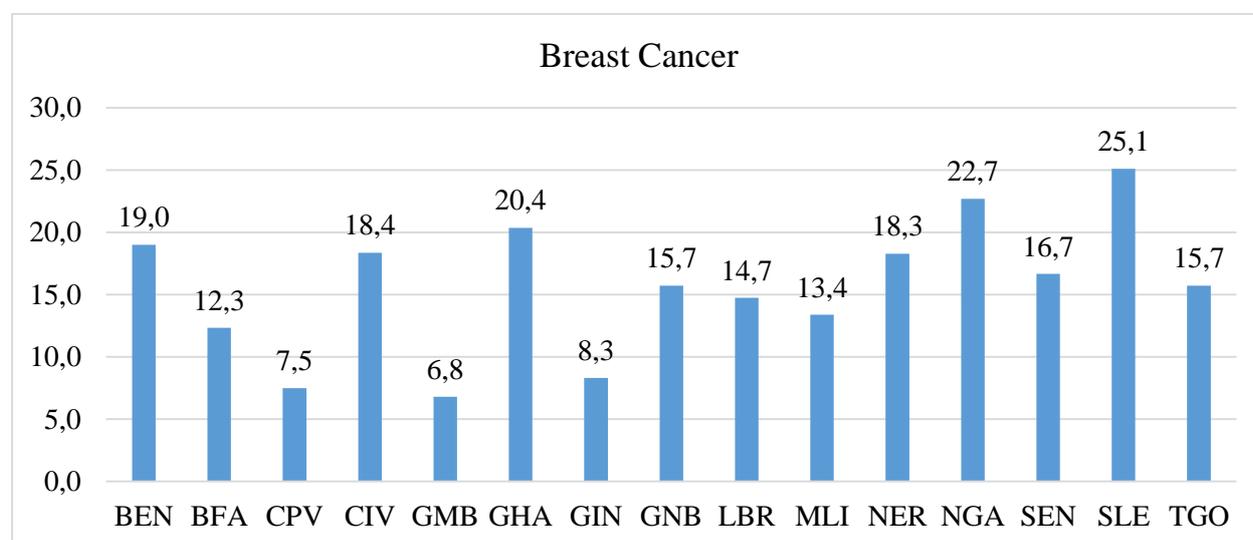


Figure 21: Percentage of total new cases of cancers due to breast cancer in 2018 in ECOWAS Region. Source: WHO- IARC. Fr 2018

⇒ Nutrition situation

While some progress has been made towards achieving the global nutrition targets and the SDGs, this progress has been slow. The Global Hunger Index (GHI) is a score derived from child

¹¹ <http://gco.iarc.fr/>

¹² Adedoye D, Sowunmi OY, Jacobs W, David RA, Adeosun AA, Amuta AO, et al. Estimating the incidence of breast cancer in Africa: a systematic review and meta-analysis. *Journal of global health*. 2018;8(1):010419. Epub 2018/05/10. doi: 10.7189/jogh.08.010419.

¹³ Donkor A, Lathlean J, Wiafe S, Vanderpuye V, Fenlon D, Yarney J, et al. Factors contributing to late presentation of breast cancer in Africa: a systematic literature review. 2015;8(2.2):1-10.

undernourishment, wasting, stunting and under-five mortality. The results are presented on a 100-point GHI Severity Scale, where 0 is the best score (no hunger) and 100 is the worst. In 2018, the GHI scores ranged from 15.2 in Ghana to 35.7 in Sierra Leone (Fig. 22).

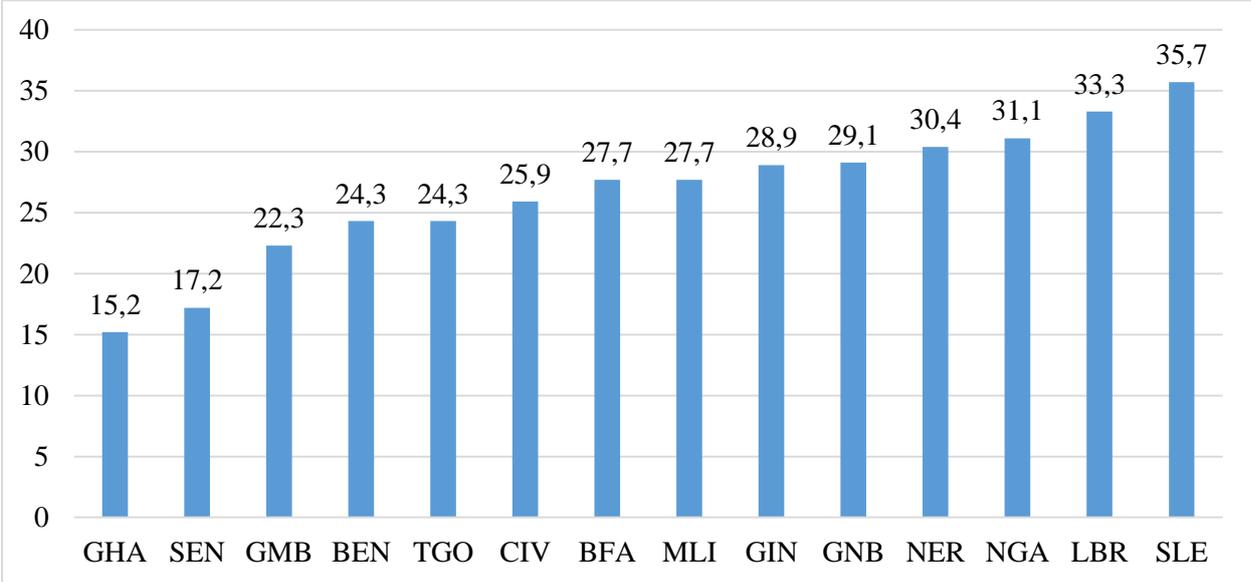


Figure 22: Hunger index 2018 ranked from lowest (best) to highest in the ECOWAS region. Source: <https://www.globalhungerindex.org/results/>

At the end of 2018, the Global Nutrition Report assessed that number of ECOWAS countries on course to achieve the targets were three (Côte d’Ivoire, Ghana, Liberia) for stunting, two (Benin, Ghana) for wasting, seven (Burkina Faso, Côte d’Ivoire, Ghana, Guinea-Bissau, Nigeria, Senegal, Sierra Leone) for child overweight and eight (Benin, Burkina Faso, Côte d’Ivoire, The Gambia, Guinea, Guinea-Bissau, Mali, Sierra Leone) for exclusive breastfeeding. No country was on course to achieving the targets relating to anaemia in women of reproductive age (WIRA), adult obesity (male or female), and adult diabetes (male or female).

The prevalence of anaemia in WIRA ranged from 33.3% in Cape Verde to 57.5% in The Gambia, and was higher than 40% in all ECOWAS countries with the exception of Cape Verde and Liberia. The coverage of four or more antenatal care visits with a skilled healthcare worker ranged from 34% in Burkina Faso to 87% in Ghana. Less than half of pregnant women in Burkina, Cote d’Ivoire, Mali, Niger and Senegal attend antenatal clinic 4 or more times.

The prevalence of under-five stunting in the ECOWAS region is highest in Nigeria, Niger and Sierra Leone and lowest in Ghana (Fig. 23). The prevalence of child underweight is highest in Nigeria, Niger and Mali. There is a downward trend in the countries with the highest prevalence. In Burkina Faso, for example, the prevalence of child stunting declined from 35.1% in 2009 to 21.2% in 2017. In Nigeria, it dropped from 41% in 2008 (DHS) to 36% in 2011 (MICS) to 32% in 2014 (NNHS) and 33% in 2015 (NNHS 2015). The prevalence of severe child wasting ranges from 0.7% in Ghana to 4.3% in The Gambia.

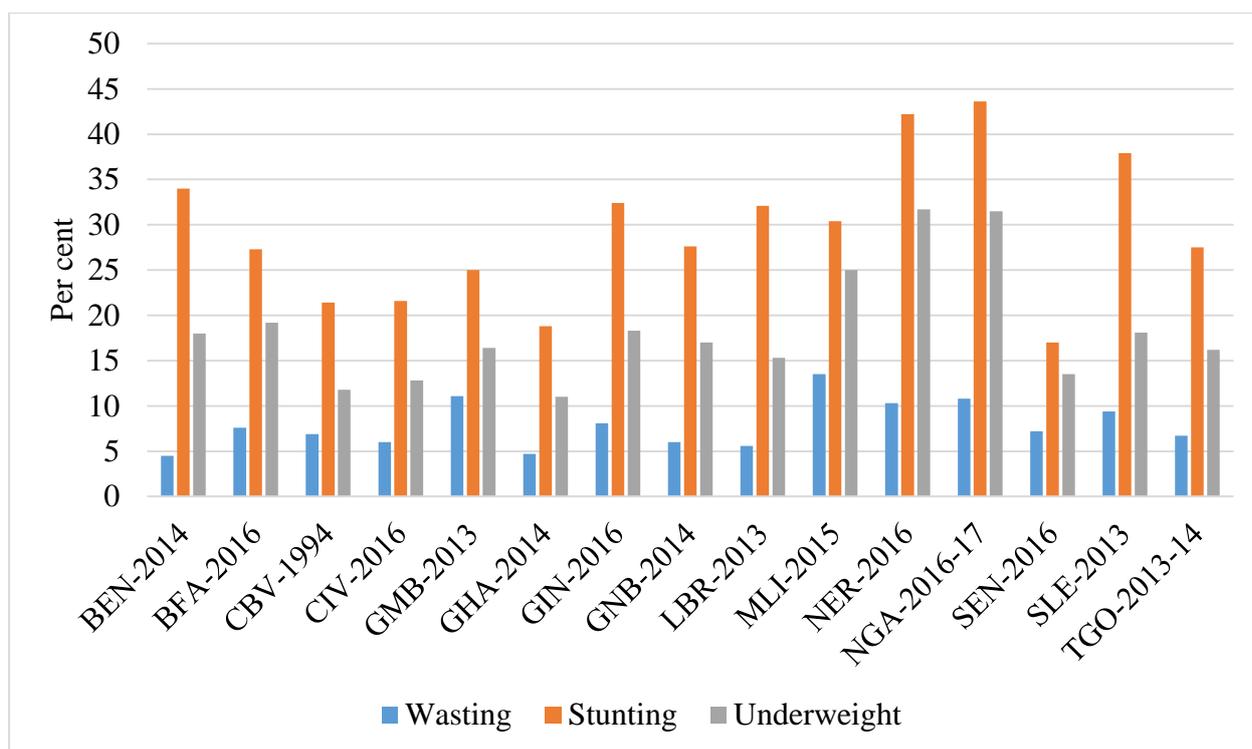


Figure 23: Prevalence of stunting, underweight and wasting in children under five years of age in ECOWAS region. Source: Global Nutrition Report 2018 and DHS reports

Micronutrient deficiency remains a major problem among pregnant women and children in the ECOWAS region but response is not adequate. In DHS surveys, 3%-21% of women report not taking any iron tablets or syrup during their last pregnancy. Among those who took iron supplements, only 25%-63% took them for ≥ 90 days. The proportion of children aged 6-59 months who received two full doses of vitamin A supplementation ranged from 9% in Togo to 99% in Burkina Faso, Mali and Sierra Leone (Fig. 24).

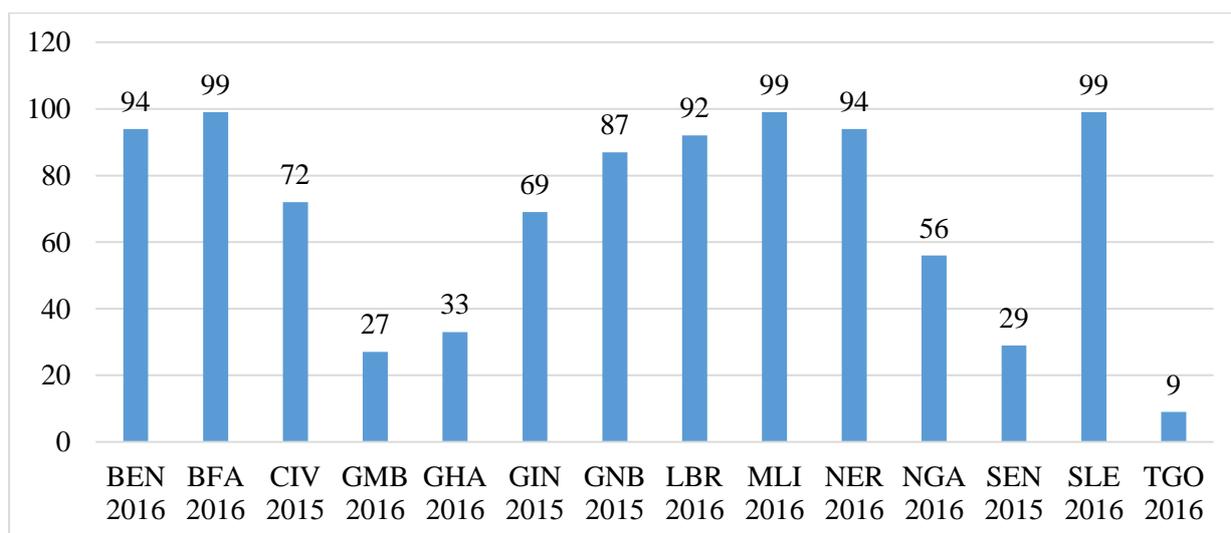


Figure 24: Vitamin A supplementation with two full doses in children in ECOWAS Region. Source: <https://data.unicef.org/resources/levels-and-trends-in-child-malnutrition-2018/>

Infant and young child feeding practices remain inadequate with less than 10% of children in the region being fed the minimum acceptable diet

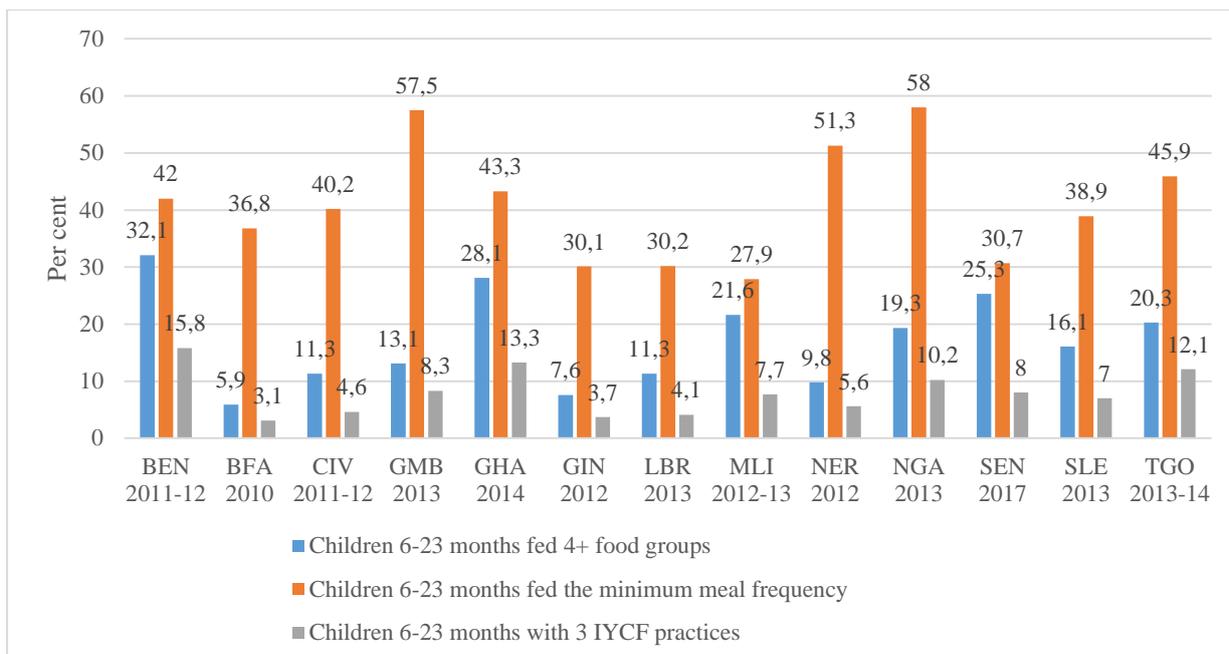


Figure 25: Infant and young child feeding practices in the region. Source: The DHS Programme STAT compiler. <http://www.statcompiler.com>.

I.2. Mother, New-born, Child, Adolescents, Youth and Elderly Health

I.2.1. Maternal and New-born Health

I.2.1.1. Maternal deaths

Maternal deaths are reported weekly or monthly to WAHO through the regional health information sharing platform.

In 2018, with the exception of Cape Verde and Nigeria for which data are lacking, the remaining thirteen (13) ECOWAS countries reported a total of 5167 maternal deaths in health care setting, compared to 5092 deaths reported in 2017 by all 15 countries. There was an increase in the number of deaths in 2018 (fig. 28). Although underestimated, this information shows that maternal deaths remain one of the main public health problems in the region with an average weekly rate of 100 maternal deaths.

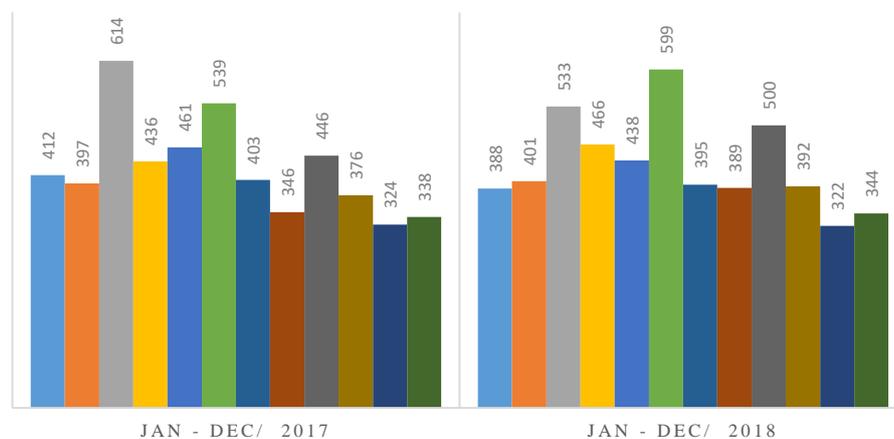


Figure 26: Maternal deaths reported by all ECOWAS countries per month, 2017/2018 The Regional Health Information Sharing Platform (RHIP).

The main causes of death reported in countries' health statistics were postpartum anaemia, eclampsia, postpartum haemorrhage, uterine rupture, sepsis, labour obstruction and anaesthetic complications. It has also been noted that the risk of maternal death is highest during labour, delivery and the days following delivery.

These causes serve to confirm the importance of skilled assistance during child birth as well as post-natal care. However, the availability of skilled birth attendants cannot be the only strategy to reduce the high maternal mortality rates in the countries of the region. Other strategies that can bring about change in maternal and child health include improving emergency

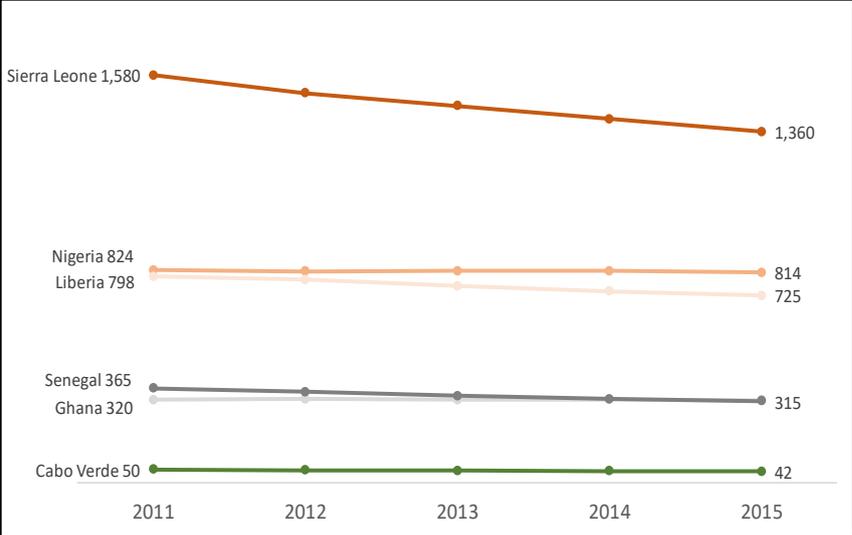


Figure 27: Trend in Maternal mortality ratio, 2011 - 2015, in countries with highest and lowest level of MMR. Source: WHO

obstetric and neonatal care (EmOC) and reducing the barriers to women's access to quality care. In this regard, many efforts have been made in ECOWAS countries, including: free access to EmOCs, training of health providers in emergency obstetric care, strengthening of maternal health care systems, development of community-based initiatives to increase women's use of ante-natal care and assisted delivery, and providing surgical equipment to health centres to treat complications as well as initiatives to encourage health providers to do their jobs effectively. These efforts have yielded some progress, albeit insignificant (Fig 27).

It is therefore essential to take measures to ensure equitable access to health care services. Despite concentrations in large cities, a large majority of the population remains rural. Such rural populations must be taken into account and be the focus of interventions that must make a significant impact in reducing maternal deaths. The latest information available in this regard shows a huge gap between rural and urban areas in terms of assisted childbirth (Fig 28).

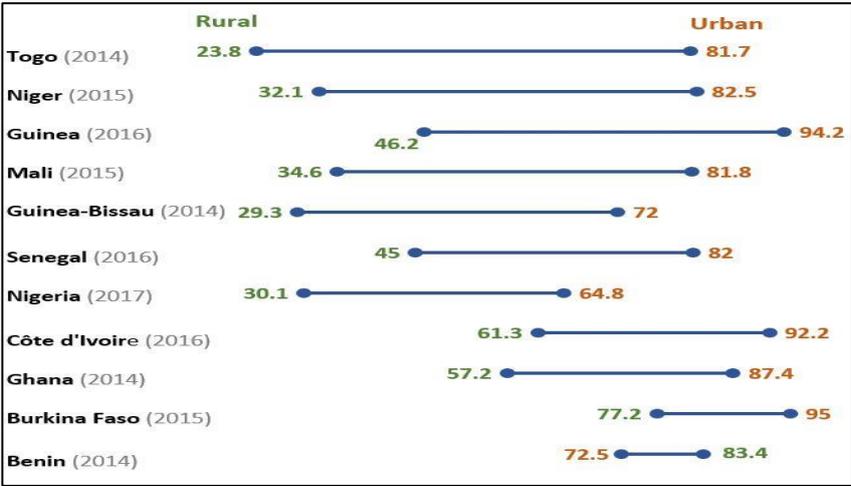


Figure 28: Proportion of births attended by skilled health personnel, Urban and rural Source: WHO

I.2.1.2. Family planning in West Africa

To combat maternal mortality, family planning is seen as one of the most effective and proven strategies. Indeed, women and couples who have access to family planning and in particular to modern methods of contraception are better able to avoid unwanted pregnancies and to space births. As a result of these methods, women are much less likely to die during childbirth, or to be exposed to long-term health problems. However, the data show that ECOWAS countries, at the global level, have the lowest levels of family planning use. Indeed, none of the countries has a contraceptive prevalence rate higher than 50% and the majority of countries have contraceptive prevalence levels between 10 and 20%. However, levels of unmet needs are high and about one in three women has an unmet need. On the other hand, total demand levels remain low: less than 40% in Guinea, Niger, Nigeria, Gambia and Mali.

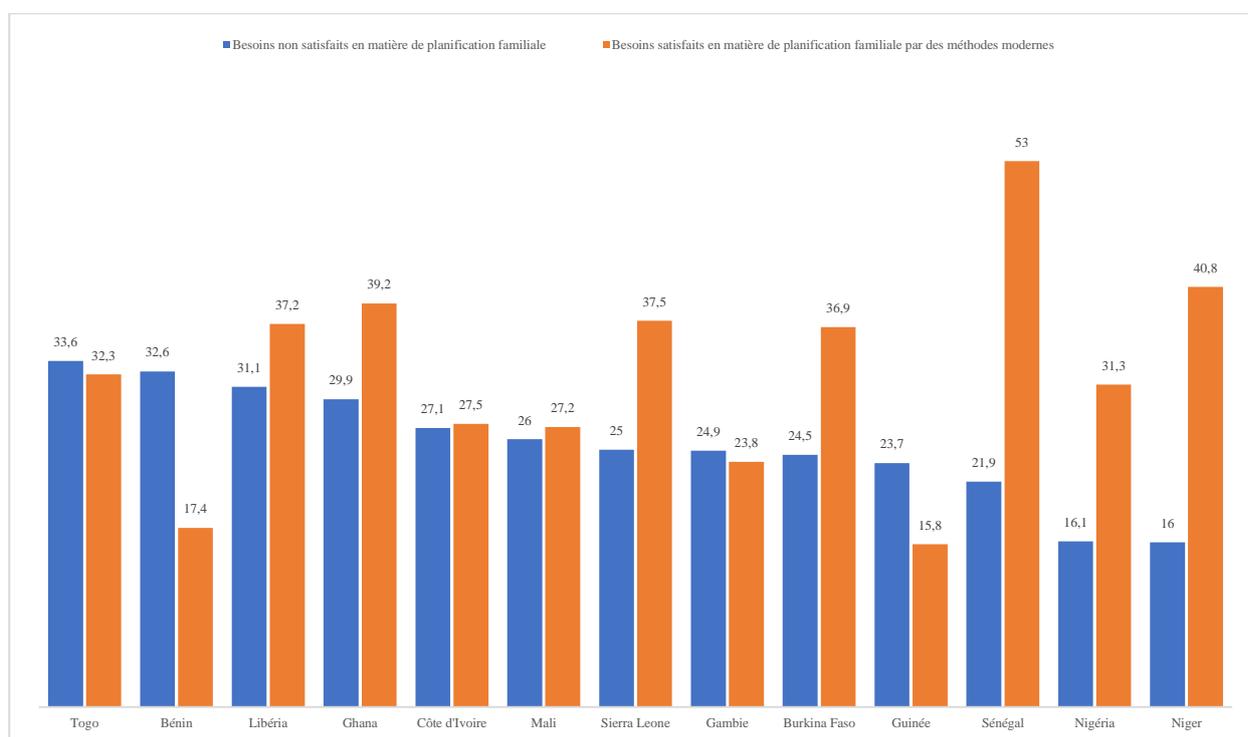


Figure 29: Met and unmet family planning needs Source: DHS Programme, statcompiler.com

I.2.1.3. Neonatal deaths

Although neonatal mortality rates are high in almost all countries in the region with the exception of Cape Verde, there has been a downward trend between 2000 and 2017 in all countries.

During the period 2000-2017, neonatal mortality rate fell the most in Guinea and Mali by 22.6 and 21.4 points respectively. In most other countries, this decrease is between 10 and 19 points. However, the neonatal mortality rate in most countries is well above 12 deaths per 1000 (SDG 3)

Table 3: Rate of neonatal deaths

Country Name	Neonatal mortality rate (per 1000)			
	2000	2010	2017	Difference between 2000-2017
Benin	40,1	35,2	32,7	7,4
Burkina Faso	41	30,7	25,4	15,6
Cabo Verde	17,2	14,9	10,4	6,8
Cote d'Ivoire	45,4	37,9	33,5	11,9
Gambia	40,7	32,3	27,6	13,1
Ghana	36,3	30,9	24,2	12,1
Guinea	46,7	30	24,1	22,6
Guinea-Bissau	55	44,9	37,3	17,7
Liberia	44,7	29,6	25,1	19,6
Mali	56,8	40,8	35,4	21,4
Niger	43,1	31,6	26	17,1
Nigeria	48,1	38	32,9	15,2
Senegal	38,2	26,1	20,5	17,7
Sierra Leone	50,5	41,3	33,5	17
Togo	36,1	28,9	25,4	10,7

Source: UNICEF

In 2018, a total of 9938 cases of neonatal deaths were reported on the regional platform by 10 of the 15 countries in the region, with 3590 cases in Burkina Faso and 2604 in Benin (Fig. 30)

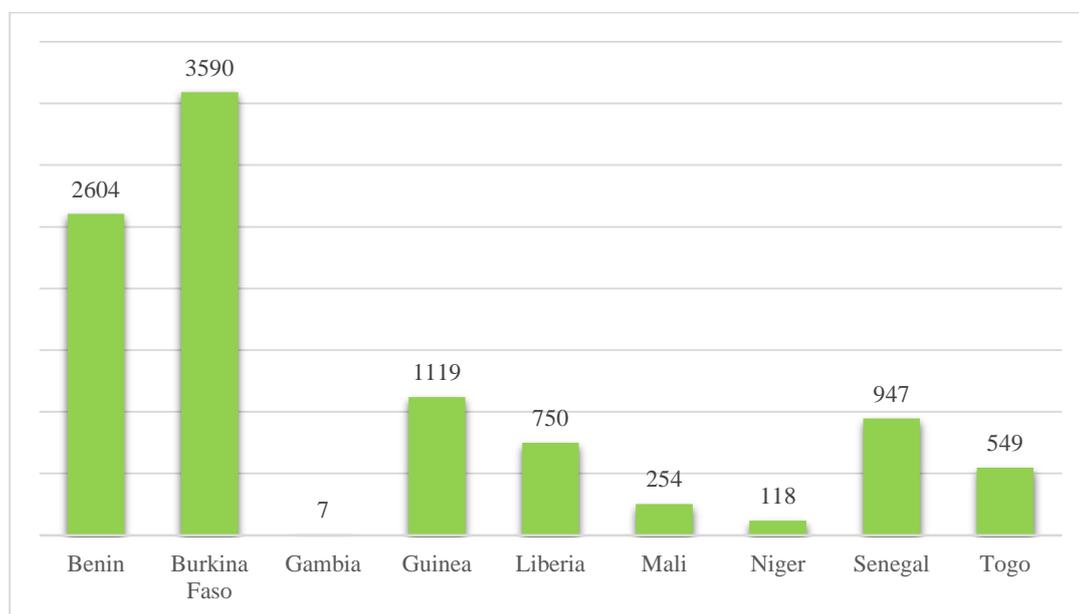


Figure 30: Number of neonatal deaths reported in 2018 per country. Source: The Regional Health Information Sharing Platform (RHIP).

I.2.2. Mother, Child, Adolescent, Youth and Elderly People's Health

I.2.2.1. Update on Child Health

With the combined efforts of countries and their partners, the under-five mortality rate declined by more than half between 1990 and 2015. But despite this progress, only three ECOWAS countries (Cape Verde, Liberia and Niger) were able to achieve MDG 4, which called for a reduction of at least two-thirds in child mortality between 1990 and 2015. Under-five mortality therefore continues to be a concern for the region.

To achieve MDG3 on child health (ending preventable child deaths and reducing under-five mortality to less than 25 deaths per 1000 live births by 2030), there is a need to build on the progress made towards the MDGs and place greater emphasis on interventions that have been proven to be successful and can be scaled up.

High impact child health interventions include equitable access to safe drinking water, hygiene conditions, adequate sanitation facilities, good nutrition, optimal coverage in integrated management of childhood illness (IMCI) and universal access to immunization. Immunization remains one of the most cost-effective public health interventions of all time. Despite this, the universal access to vaccination called for by African ministers through the Addis Declaration of February 2016 is still far from being a reality in the region. Thus, there is witnessing a stagnation, even a decline in vaccination coverage, which should be at least 90%.

I.2.2.2. Status of adolescent and young people's health

The demographic weight of adolescents and young people and the specific health problems and needs they face require special attention. The current generation of young people aged 10 to 24 is just under 1.8 billion people, out of a world population of 7.3 billion. Nearly 90% of these young people live in developing countries. With more than 350 million inhabitants, the ECOWAS has more than 33% of young people aged 10 to 24.

The 2015 Adolescent and Youth Health Status Analysis (AYH) conducted by WAHO sufficiently described the health status of this target group in the region. The situation did not change much in 2018. It is characterised, among other things, by:

- the fact that too many adolescents continued to be neglected, victimised, killed and needlessly suffer from preventable causes,
- new and increasing HIV infections (2nd cause of death) among adolescents;
- a high fertility rate (115 per 1000, more than twice the overall average level) among adolescent girls, with early unwanted pregnancies, leading to a high-risk abortion rate (26 per 1000, compared to 9 per 1000 in Asia, excluding East Asia)
- the use of psychoactive substances (tobacco (18%), alcohol, and drugs)
- violent death (MVA, suicide, inter-personal violence).

I.2.2.3. Older People's Health

Old age and the elderly are a real public health issue, whose current importance and socio-economic influence are being discovered in our societies, with implications for healthcare systems. As a result of technological, economic and medical science progress (albeit slow), the demographic weight (as well as the number) of older people is increasing year by year and quite rapidly in the ECOWAS region, as shown in Table below.

The total number of elderly people in the ECOWAS region is projected to increase from 16,702,328 in 2017 to 53,100,234 in 2050, then to 253,320,473 in 2100, according to projections from the same sources. The 15 West African countries that make up ECOWAS will face a health and developmental challenge, namely the rapid ageing of the population, to be undoubtedly accompanied by the high costs of medical care for the elderly. This target group, the elderly, must be treated in the same way as children and young people and must not be neglected.

WAHO has undertaken a situational analysis of the status of elder health in the ECOWAS Member States with a view to contributing to the improvement of their health care and social well-being in the region. This situational analysis revealed a profile of epidemiological transition with persistent infectious diseases coupled with the emergence of chronic non-communicable diseases. Predominant amongst these chronic non-communicable diseases are cardiovascular diseases, with high blood pressure followed by diabetes, eye diseases, bone and joint diseases and cognitive disorders in that order. Mortality is linked to stroke, septic shock, malaria and cancer.

Table 4: Weight (%) of persons aged 60 years and over in ECOWAS countries from 2017 to 2095

Country	Benin	Burkina Faso	Cabo Verde	Côte d'Ivoire	The Gambia	Ghana	Guinea	Guinea-Bissau	Liberia	Mali	Niger	Nigeria	Senegal	Sierra Leone	Togo
2017	5	3,9	6,9	4,8	3,8	5,3	5,2	4,9	4,9	4,0	4,2	4,5	4,7	4,2	4,6
2020	5,1	3,9	7,3	4,8	3,9	5,5	5,3	5,0	5,0	3,9	4,2	4,5	4,7	4,2	4,7
2025	5,3	4,1	8,8	4,9	4,2	5,9	5,4	5,1	5,3	3,8	4,3	4,6	4,9	4,3	5,0
2030	5,6	4,4	10,2	5,0	4,5	6,5	5,6	5,3	5,7	4,0	4,2	4,8	5,3	4,7	5,4
2035	6,0	4,8	11,4	5,2	4,8	7,3	5,8	5,7	6,2	4,4	4,0	5,1	5,8	5,2	6,0
2040	6,4	5,3	12,9	5,5	5,3	8,1	6,2	6,3	6,8	4,8	4,0	5,5	6,5	5,9	6,7
2045	6,9	5,9	15,3	5,9	5,8	8,9	6,8	7,2	7,5	5,2	4,0	6,0	7,4	6,7	7,4
2050	7,4	6,5	18,2	6,3	6,4	9,8	7,6	8,1	8,2	5,6	4,1	6,4	8,3	7,6	8,1
2055	8,1	7,1	21,3	6,9	7,1	10,6	8,5	9,1	8,9	6,1	4,2	6,9	9,2	8,5	8,6
2060	8,9	7,9	24,0	7,6	8,0	11,5	9,6	9,9	9,9	6,7	4,7	7,4	10,0	9,5	9,2
2065	9,7	8,8	26,2	8,3	9,0	12,4	10,7	10,7	11,2	7,7	5,3	8,2	10,9	10,8	10,1
2070	10,5	9,9	28,0	8,9	10,2	13,4	12,0	11,7	12,4	8,9	6,0	9,2	12,1	12,3	11,1
2075	11,4	11,1	29,6	9,6	11,6	14,7	13,3	12,9	13,7	10,1	6,8	10,2	13,5	13,6	12,1
2080	12,3	12,3	31,1	10,4	13,0	15,8	14,6	14,1	15,0	11,4	7,7	11,3	14,8	14,9	13,0
2085	13,2	13,5	32,5	11,3	14,3	16,9	16,0	15,3	16,3	12,7	8,8	12,4	16,0	16,1	13,8
2090	14,1	14,7	33,6	12,1	15,7	17,9	17,4	16,4	17,6	14,2	9,9	13,6	17,3	17,3	14,7
2095	15,0	16,0	34,6	13,0	17,0	19,0	18,8	17,5	19,0	15,6	11,1	14,8	18,5	18,4	15,6

Source: United Nations, Department of Economic and Social Affairs, Population Division (2017). *World Population Prospects: The 2017 Revision*.

II. REVIEW OF 2018 ACHIEVEMENTS

This chapter aims to report on the implementation of the recommendations of the 18th Session of the Assembly of ECOWAS Health Ministers, the management-related activities conducted by WAHO General Directorate and present the main achievements from implementation of priority Programmes.

II.1. Implementation of the main recommendations of the 19th session of the ECOWAS Assembly of Health Ministers

The nineteenth Ordinary Session of the Assembly of Health Ministers of ECOWAS held in June 2018 in Banjul made three (03) recommendations to WAHO. The status of implementation of these recommendations is summarised in the table below:

Table 5: Status of Implementation of recommendations from the 19th AHM

Recommendations	Level of completion	Activities undertaken
Develop and make available to the Ministries of Health a reporting template which will be used for the handing over exercise between an outgoing Liaison Officer and the incoming one.	Implemented	Template developed and will be presented at the various AHM meetings
Prepare and submit to the next Assembly of Health Ministers, a presentation on public health-related problems of road traffic accidents in the region.	Implemented	Presentation prepared and included on the AHM agenda
The Committee of monitor country implementation of all resolutions adopted by the Assembly of Health Ministers.	Implementation underway	WAHO is considering developing a compendium of resolutions to be sent to countries to update them on implementation.

II.2. Management-related activities

As was the case in previous years, the General Directorate of WAHO in 2018 conducted activities aimed at strengthening the position of the institution regionally and internationally, advocate on key health issues as well as leverage on strategic partnerships and resource mobilisation. It is against this background that the General Directorate participated in the statutory meetings of the Community and visited the Political Authorities of the Member States and the Technical and Financial Partners.

II.2.1. Statutory meetings:

The General Directorate participated in all the regular sessions of the Authority of Heads of State and Government, the Council of Ministers, the Assembly of Health Ministers, the meeting

of the Mediation and Security Council of ECOWAS and the sessions of the Administration and Finance Committee.

II.2.2 Meetings with the Political Authorities of Member States:

The General Directorate visited all countries in 2018 with the exception of Guinea which is pencilled in for May 2019. During the visits, the DG met with many political authorities (Heads of State, Speakers of Parliament, Ministers and Heads of Institutions). The meetings focused on the following, amongst others:

- Discussions and gathering of views and policy direction on priority health issues of countries in the region,
- Contacting newly appointed Ministers,
- Information on WAHO's activities,
- Advocacy on key health issues, including funding,
- Implementation of Community resolutions and decisions on health.

II.2.3. Meetings with Technical and Financial Partners

In furtherance of its mandate aimed at strategically and collectively finding solutions to the health issues of the region, the General Directorate intensified collaboration with its Technical and Financial Partners. In this regard, the Director General undertook several visits and also engaged in video-conferencing sessions, telephone and Skype discussions.

II.3. Outcomes of the implementation of Priority Programmes

The annual action plan provided for two hundred and fifty-eight (258) activities for a budget of UA 40,625,810, of which UA 26,150,569 was mobilised. As at 31 December 2018, the physical implementation rate was 78%, with a financial implementation rate of 81.77% or UA 21,382,862. The main achievements garnered in the implementation of the thirteen (13) priority Programmes are as follows:

II.3.1. Health Information and Research for Health

The overall objective of this Programme is “to improve the production, dissemination and use of information and health research in the ECOWAS region”. Activities conducted in the community for 2018 yielded the following results:

- Capacity building in research methodology for eighteen (18) young researchers,
- Information on epidemic-prone diseases in the context of the One Health approach,
- Training of twenty (20) health information system managers from 10 ECOWAS countries (Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Guinea, Guinea-Bissau, Mali, Niger, Senegal) on the new modules of the routine health information system,
- Training of fifteen (15) officials from the Ministry of Health of The Gambia in data quality review using the DHIS2 DQR module,

- Training of twenty-four (24) national health data warehouse administrators in the management and deployment of DHIS2 servers to make countries independent in the management of integrated databases and to ensure that they are independent,
- Training of thirty-one (31) database administrators in the integration and interoperability of different databases according to the "One Health" concept,
- Technical support to four (4) countries (The Gambia, Guinea Bissau, Guinea and Sierra Leone) on the use of the DHIS2 data quality assessment module.
- Production of a documentary on the Canadian Initiative "Innovation for the Health of African Mothers and Children",
- Publication of weekly epidemiological bulletins,
- Provision of technical assistance to national HIS platforms on DHIS2 platform and server management (Benin, Burkina Faso, Nigeria, Togo) ,
- Technical and financial support to Cabo Verde for migration to the DHIS2 platform for the management of NHMIS data,
- Capacity building of thirty (30) health policy researchers and analysts in data analysis and communication of reproductive, maternal, new-born and child health outcomes from demographic and health surveys,
- Technical and financial support to Burkina Faso for the implementation of a pilot telehealth site based on the MH (Mobile Health),
- Capacity building for twelve (12) managers to use videoconferencing equipment and, sharing of experiences on other innovative solutions such as WEBEX and, CISCO TELEPRESENCE,
- Selection of six (6) research projects on the demand side of Sexual and Reproductive Health service and contracting with six (6) research institutions,
- Funding of research projects on:
 - o Identification of priority areas and interventions in maternal and child health in 6 ECOWAS countries (Benin, Burkina Faso, Ghana, Nigeria, Mali, Senegal)" ;
 - o Use of evidence in Ghana's hospitals;
 - o Factors that influence compliance with the 2nd and 3rd doses of Seasonal Malaria Chemo-prevention (SMC) in Burkina Faso, Mali and Niger,
- Analysis of technical issues, and proposal of solutions to the challenges and problems related to the use of insecticide-treated mosquito nets (ITNs) for the prevention of malaria among pregnant women and children in the ECOWAS region,
- Capacity building of fifty (50) managers from Burkina Faso and Nigeria in knowledge transfer and research focused on identifying barriers and potential solutions in consultation with stakeholders to improve the implementation of health actions,

- Training of forty (40) researchers from Nigeria in the use of social media to share research results,
- Capacity building for nine (9) young researchers from Benin, Côte d'Ivoire, Ghana, Gambia, Mali and Nigeria in writing research protocols,
- Financial support was also provided to countries to:
 - o fund one PhD thesis by one student from Ghana, on Public Health, in Cape Town, South Africa.
 - o establish a formal framework for dialogue between researchers and policy makers in Nigeria for the use of evidence in maternal and child health decision-making.
 - o support the West African Health Research Network (WAHRN) in the implementation of its activities and facilitate collaboration between researchers and share research results.
- Development of a documentation policy and a Strategic Plan for the West African Health Documentation and Information Network (WAHDIN),
- Capacity building of thirty (30) personnel in the resource units, including twenty-three (23) lecturers and seven (07) librarians, in documentation research, in the use of the Zotero software, in critical reading of scientific documents and in the use of the PMB documentary software.

II.3.2. Disease Control

This Programme aims at reducing the prevalence of communicable and non-communicable diseases. Activities conducted under this programme focused mainly on regional coordination and capacity strengthening of countries in the control of HIV/AIDS, malaria, tuberculosis, neglected tropical diseases and non-communicable diseases. Interventions yielded the following results:

⇒ Malaria:

- Six (6) mass-campaign activities were organized in 3 countries (Niger, Burkina Faso and Mali) to prevent the occurrence of seasonal malaria in children from 3 months to 59 months. Six million children were treated in these 3 countries in 2018. A total of 114,352,306 beneficiaries were affected including 21,360,778 females.
- A regional meeting of National Malaria Control Programme (NMCP) and partners working in the field of malaria was organized and the discussions led to the establishment of a Regional Coordination for the elimination of malaria in the ECOWAS Region, with a Regional Secretariat to be based at WAHO;
- A regional platform for vector control coordination has been initiated.

⇒ HIV/AIDS and Tuberculosis:

- A review was commissioned by WAHO, UNAIDS and USAID West Africa to assess the level of implementation of the Dakar Declaration's. It showed that out of the 15

countries, only 4 countries (Côte d'Ivoire, Burkina Faso, Mali and Togo) have developed a roadmap to start its implementation;

- Development of roadmaps to accelerate the implementation of the Dakar Declaration on "key populations" in their respective countries;
- Establishment of a regional platform with to contribute to the fight against HIV AIDS in key populations.

⇒ **Neglected Tropical Diseases:**

- WAHO supported the organization of seven (7) hydrocele surgery camps, including 3 in Burkina Faso, 2 in Mali and 2 in Niger. These camps helped in treating a total of 1134 cases of hydrocele and training of 12 doctors from the Health District on case management of hydrocele.

⇒ **Non-Communicable Diseases:**

The main results achieved by WAHO in NCDs included the following:

- Identification of the situation on cervical cancer in the region and strategies for accelerated control Mapping of the status of implementation of recommendations towards improved nutrition surveillance
- Identification of the situation of eye disorders and the response with gaps and best practices
- Adoption of the regional Mental Health Plan by the ECOWAS Assembly of Health Ministers
- Analysis of the distribution of the different human papilloma virus (HPV) types in healthy women and in cervical cancer patients in the region.

II.3.3. Epidemics and Health Emergencies

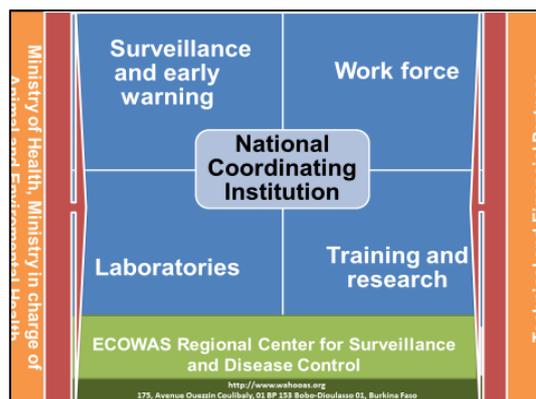
The objective is to build the capacities for surveillance, disease prevention, response and resilience to epidemics and emergencies. Activities undertaken in 2018 yielded the following results:

⇒ **Establishment of the Regional Centre for Surveillance and Disease Control**

The 47th Session of the Authority of Heads of State and Government of ECOWAS held on May 19, 2015 in Accra, Ghana, approved the establishment of the ECOWAS Regional Centre for Disease Surveillance and Control (ECOWAS/RCDSC) with the Headquarters in Abuja-Nigeria. The objective of the RCDSC is to strengthen Member States' health systems and enhance the region's capacity for epidemics prevention, diagnosis and control.

Against this background, the President of the ECOWAS Commission, in conjunction with WAHO, was mandated to take the necessary steps to expedite the implementation and operationalization of the ECOWAS –RCDSC. Moreover, partners were invited to support the process.

ECOWAS – RCDSC is a Specialized Agency of ECOWAS under the authority of WAHO. Its primary mission is to identify, assess and report current and emerging threats posed to human health by diseases and prepare response. The ECOWAS-RCDSC will mainly interact with Member States through a network of competent scientific and technical facilities in the 15 countries.



To this end, each Member State is expected to identify a National Coordinating Institution (NCI) with a Coordinator which shall formally interact with ECOWAS-RCDSC and ensure networking of structures to be involved in disease surveillance and early warning and response systems across the Community.

In order to implement the Heads of State and Government's decision, WAHO embarked on series of actions leading to the following key achievements:

- Approval of the Regulation and Standard Operating Procedures;
- Provision of an office building to serve as the ECOWAS-RCDSC’s “legal office” and “administrative address”;
- Signing of the Headquarters agreement between the President of the ECOWAS Commission and the Federal Minister of Foreign Affairs of the Federal Republic of Nigeria to consolidate the legal status of the ECOWAs-RCDSC.
- Establishment of the Board of Directors of the Centre, and approval of its internal regulations. Based on the proposal of the Board, ECOWAS authorities approved the recruitment of a minimum staff and validated the work plan of the Centre for 2017-2018. Under this arrangement, part of the professional staff of the ECOWAS RCDSC have already been recruited and the process for the recruitment of other members of staff is ongoing following approval by the ECOWAS Council of Ministers in December 2018.
- Development and validation of a regional strategic plan for the preparation and response to epidemics and emergencies;
- Evaluation of the National Coordinating Institutions of thirteen (13) ECOWAS countries (except The Gambia and Mali). Harmonised capacity building plans have been provided.
- Development of capacity strengthening plans for the NCI;
- Development and validation of the Regional Plan on Risk Communication.



⇒ **Work force and training**

- Induction and training of the ECOWAS Regional Rapid Response Team;
- Development and validation of a Standard Operating Procedure for deployment of the Rapid Response Teams;
- Organisation of a simulation exercise on support for the management of a yellow fever outbreak in Lagos;
- Training of one hundred and ninety-nine (199) human and animal health staff from thirteen (13) countries (except Cape Verde and Nigeria on field epidemiology);
- Training of seventy-seven (77) Members of Emergency Medical Teams of Ghana, Senegal, Nigeria and Guinea;
- Establishment of the Regional “One Health” Policy Coordination Platform, and adoption of 2017-2018 roadmap.

⇒ **Regional Reference Laboratories Network**

The ECOWAS Regional Reference Laboratories Network has been adopted by ECOWAS Authorities to cover the region's biological diagnostic needs. The following results were achieved:

Accreditation process

- The ISO 15189 accreditation process for the 12 regional reference laboratories is ongoing and will be continued in 2019;
- Training and certification of twenty-seven (27) Stepwise Laboratory Improvement Process towards Accreditation (SLIPTA) auditors to evaluate and assist laboratories in strengthening their quality system.

Fight against antimicrobial resistance

- Situational analysis on antimicrobial resistance in West Africa taking into account the One Health approach;
- Establishment of a working group to finalize the roadmap for the operationalization of the regional RAM observatory in West Africa.

Metrology and Maintenance of laboratory equipment

- Training and certification of twenty-seven (27) professionals from regional reference laboratories (Côte d'Ivoire, Nigeria, Ghana, Burkina Faso and Senegal) by the two accredited metrology laboratories in Africa (Accra and Tunis). These professionals are now able to calibrate their basic equipment (micropipettes, weighing scale, thermometer, etc.) and implement a metrology management policy that is essential for the accreditation of medical laboratories according to the ISO 15189 standard.
- Delivery of twelve (12) calibration and maintenance kits to the LRRS for preventive maintenance of their devices and some calibration of their devices.
- Training of fifteen (15) officers from five (5) countries (Guinea, Guinea Bissau, Liberia, Sierra Leone and Togo / 3 per country) in the maintenance of biomedical equipment at the Cotonou Regional Training Centre.

Transport of infectious substances

- Training of eighteen (18) professionals from the national reference laboratories of eight (8) ECOWAS member countries on techniques and procedures for the safe transport of biological substances according to IATA standards.

Biological diagnosis of arboviruses and viral haemorrhagic fevers

- Training of twenty (20) staff members from the reference laboratories of five (5) ECOWAS countries (Burkina Faso, Niger, Mali, Cape Verde, The Gambia) by the experts of the WHO Collaborating Centre for Arboviruses and FHV on techniques and strategies for biological diagnosis of dangerous pathogens such as dengue, yellow fever, Zika, Lassa fever etc.

Support to National reference laboratories

- Strengthening of three (3) national reference laboratories (Niger, Gambia and Cape Verde) by the provision of serological diagnostic (ELISA) and molecular diagnostics (PCR) equipment as well as reagents and consumables;
- Support to three (3) member countries (Mali, Burkina Faso and Niger) by the acquisition of mobile laboratories for early diagnosis and effective control of epidemic-prone diseases in the most remote households. (Delivery expected end of March 2019).

Capacity building of district laboratories

- Strengthening of forty-seven (47) health district laboratories of forty-seven (47) new epidemiological surveillance centres in five (5) countries (Guinea, Guinea Bissau, Liberia, Sierra Leone and Togo);
- Training of ten (10) national trainers and one hundred and sixty (160) laboratory technicians on the following modules: Biosecurity and transport of samples; Preventive maintenance of laboratory equipment; Laboratory data management; Diagnosis of diseases with epidemic potential;
- Organisation of an External Quality Assessment (EQA) session for the beneficiary countries (Guinea, Guinea Bissau, Liberia, Sierra Leone and Togo) of the REDISSE Project;
- Development of National plans for the maintenance of laboratory equipment for all five (5) beneficiaries countries (Guinea, Guinea Bissau, Liberia, Sierra Leone and Togo).

Establishment of the Regional Biobank

- Preparation and validation of the regulation establishing the ECOWAS Regional Biobank by the Assembly of Health Ministers of;
- Assessment of the technical and organizational capacities of the Regional Biobank according to international standards by recognized experts in the field (Institute of Human Virology, H3Africa Bio repository (I-HAB), Global Emerging Pathogens Treatment Consortium (GET consortium) South African National Bioinformatics Institute (SANBI) University of the Western Cape Town, South Africa;

- Preparation of a roadmap for operationalization of the Regional Biobank ;
- Support for the establishment of a computerized biological resource management system (BAOBAB-LIMS).

Establishment of the mechanisms of governance and operationalization of the Regional Network of reference laboratories of ECOWAS member countries

- Validation of the Regional Strategic Plan for Laboratories and the Plan for Strengthening Reference Laboratories of ECOWAS Member Countries by the Assembly of Health Ministers;
- Development and validation of the directive regulating the transfer of Biological samples and the materials transfer agreement (MTA) models;
- Development and validation of the regional roadmap on biomedical waste management;
- Analysis of the entomological situation of arboviruses;
- Development of the procedure manual of the Regional Laboratory Network;
- Finalization of technical and commercial discussions with DHL Express to ensure the rapid and secure transport of biological samples in the ECOWAS region (Contract signing procedures in progress).

II.3.4. Health Promotion

This Programme aims to contribute to strengthening health promotion in development policies in Member States. The activities undertaken resulted in the following:

- Commencement of relevant strategic interventions to support the ongoing efforts to reform hospitals.

II.3.5. Medicines, Vaccines and other medical products:

This Programme aims to enhance access by the populations to essential medicines, vaccines and other pharmaceuticals. The interventions carried out during the year yielded the following results:

- Adoption of the harmonised regional Common Technical Document (CTD) by the 19th Ordinary Session of the ECOWAS Assembly of Health Ministers held in the Gambia in June, 2018. This document is a reference for drug regulation for the 15 countries of ECOWAS. On this basis, WAEMU has incorporated the CTD into their legislation to enable the WAEMU countries to update the processes for the registration of medicines;
- Validation of one hundred and sixty-three (163) regional documents (guidelines, operational Procedures Manual and standardized) which cover the seven (7) major medicines regulatory areas, to support implementation of the CTD and the medicines harmonisation process in the region;
- Training of forty-six (46) staff members of the National Medicines Regulatory Harmonisation Authorities (NMRAs) from the fifteen (15) Member States on Medicines Dossier Assessment for registration approval using the Harmonised CTD;

- Jointly assessment of the applications of two (2) Dossiers for Market Authorization by the NMRAs of the fifteen (15) ECOWAS Member States. At the end of process these two medicines can be granted a market authorization from the fifteen (15) ECOWAS States;
- Training of twenty-three (23) experts from the fifteen (15) NMRAs on Good Manufacturing Practices (GMP) and Inspections. This training was followed by a joint inspection conducted by Expert Working Group for GMP/Inspection to the two (2) pharmaceutical industries that submitted their dossiers for the joint assessment;
- Assessment of sixty-five (65) Local Pharmaceutical Manufacturers for Good Manufacturing Practices (GMP) and Inspections across the region under the ECOWAS/UNIDO project; (25 Nigeria, 25 Ghana, 5 Cote d'Ivoire, 4 Senegal, 3 Togo, 1 Benin, 1 Mali, 1 Cape Verde);
- Validation of a regional GMP roadmap (a tool for drive quality production in ECOWAS) developed by UNIDO Experts by NMRAs and other stakeholders;
- Training of thirty-four (34) Quality Control Managers and Technicians of the National Medicines Quality Control Laboratories (NMCQL) on Good Laboratory Practices for medicines quality control;
- Assessment of the Quality Management System (QMS) of the fifteen (15) NMRAs in the ECOWAS Member States, followed by development and validation of a roadmap to improve the QMS in the fifteen NMRAs and training of thirty-seven (37) NMRAs Staff;
- Supported to the "GHANA Food and Drug Authority (FDA) to strengthen its Quality Management System to obtain ISO 9001: 2015 certification;
- Completion of a Draft Legal document on Sub-standard and Falsified Medicines, situational assessment of status of SF in ECOWAS in 2019.

II.3.6. Traditional Medicine

The Programme's objective is to promote the integration of Traditional Medicine into health systems with a view to enhancing its contribution towards attainment of universal health coverage in the region. The results hereinafter were equally obtained consequent upon the implementation of activities planned in the course of 2018.

- Promotion of dialogue between practitioners of traditional medicine and orthodox medicine through organisation of the 10th Scientific Congress of Traditional Medicine Practitioners and Conventional Medicine Practitioners, under the theme: "Reducing Maternal and Child Mortality and Morbidity in the ECOWAS Region";
- Finalisation and validation of the harmonized manual on the protection and utilization of indigenous medical knowledge in ECOWAS;
- Conduct of toxicity, microscopic, macroscopic, and phytochemical studies on 30 medicinal plants for the treatment of emerging diseases, identified for Volume 2 of the ECOWAS Herbal Pharmacopeia.

II.3.7. Maternal, Neonatal, Child, Adolescent, Youth and Elderly Health

The programme seeks to promote maternal, neonatal, infant, adolescent, youth and elderly health within the ECOWAS region. In 2018, the following results were chalked up:

- Technical support to Senegal and The Gambia to organise the Ouagadougou partnership campaign,
- Technical support to Guinea and Nigeria to use RapidSMS to reduce Maternal mortality,
- Financial support to seven (7) countries (Benin, Burkina Faso, Guinea Bissau, Niger, Sierra Leone and Mali) for the purchase of contraceptives, to meet 90% of the gap that existed in the two countries.
- Technical support to the EmOC Champion teams of Togo and Guinea to replicate the EmOC training in the respective regions of their countries,
- HIV testing of 6,335 people, enrolment of 800 new users of Modern Contraceptive Methods (MMC) and 111,000 condoms distributed during the Cross-border Advocacy Campaign on Family Planning and Testing Niangoloko (Burkina Faso) - Ouangolodougou (Côte d'Ivoire),
- Financial support to seven (7) countries (Benin, Burkina Faso, Ghana, Guinea-Bissau, Niger, Sierra Leone and Mali) to implement 111 capacity-building activities in on sexual and reproductive health and family planning,
- Capacity building for thirty (30) contraceptive procurement officers from the eight (8) francophone ECOWAS countries in supply chain management,
- Technical and financial support for organisation of the Ouagadougou Partnership (OP) review to achieve the goal of reaching 2.2 million additional users of modern contraceptive methods by 2020,
- Support to 26 members of the Upscaling Committee of Burkina Faso, Mali and Niger to participate in the Forum on Good Health Practices Forum,
- Training of 67 actors from different ministries in Burkina Faso and Mali in IEC-CCC, Gender, Human Rights and Reproductive Health,
- Financial and technical support provided to Mali for development and dissemination of the national strategy on adolescent and youth sexual and reproductive health (SRHAY),
- Financial support provided to Mali for the purchase of contraceptive products and to finance fourteen (14) activities to boost the supply and demand for contraceptives,
- Support to eleven (11) participants from Mali to attend the annual review of Reproductive Health Programmes,
- Financial support to three CSO consortia in Burkina Faso, Mali and Niger for the implementation of a project on political advocacy and social mobilisation,
- Technical support to Benin for organisation of the workshop on Integrated Management of Childhood Infections (IMCI),

- Technical and financial support to the Togo National Immunisation Technical Advisory Group (NITAG) to enhance its functioning;
- Technical support to the NITAG of Burkina Faso for evaluation of its 2017 annual work plan and development of the 2018-2019 work plan,
- Contribution to the training of a regional pool of experts for the establishment and capacity building of NITAGs,
- Contribution to the development of the NITAG training document,
- Financial support to Guinea and Guinea Bissau to strengthen the routine Expanded Programme on Immunisation (EPI),
- Award of ten (10) scholarships for vaccinology training at the “*Université Nazi Boni de Bobo-Dioulasso*”,
- Development of a reference manual for teaching IMCI in health worker training institutions,
- Technical and financial support to Burkina Faso and Togo for the development of guidelines for systematic medical examinations in secondary schools,
- Financial support to Burkina Faso, Niger, Ghana, Guinea, Guinea Bissau, Sierra Leone, The Gambia, and Liberia for the implementation of SHRAY project activities,
- Financial and technical support for the participation of young people from 13 ECOWAS countries in the third ECOWAS Forum on Good Practices in Health and in the 5th International Conference on Family Planning,
- Organisation of a regional workshop to share experiences on training in IMCI in health training institutions,
- External evaluation of the Consultative Committee for Immunization in Senegal (CCVS),
- Technical and financial support to seven (7) young people from Senegal, Sierra Leone, The Gambia, Nigeria, Togo, Côte d'Ivoire and Burkina Faso to participate in the International Conference on Family Planning in Kigali,
- Situation analysis of older people’s health,
- Preparation and validation of a draft regional strategic plan for healthy ageing in the ECOWAS region,
- Technical support to Niger for the development of its multi-sectoral national strategic plan on healthy ageing.

II.3.8. Medical Infrastructure and Equipment

The programme aims to improve the availability and quality of health infrastructure and equipment. The results achieved in 2018 are as follows:

- Construction of a Health Centre along the border of Liberia and Sierra Leone;

- Financial support for the training of 15 biomedical equipment maintenance technicians of the Federal Ministry of Health of Nigeria;
- Medical Equipment Support to Regional Hospital, Kara, Togo.

II.3.9. Health System Governance.

The overall objective of this programme is to “contribute to the improvement of Health Systems Governance”. In 2018, the following results were chalked up:

- Preparation and validation by the AHM of the strategic axes of interventions of hospital reforms in ECOWAS Member States.

II.3.10. Human Resources for Health

The aim of this programme is to facilitate the training, utilization and free movement of health professionals in the ECOWAS region. The implementation of activities for 2018 yielded the following results:

- Capacity building of three (3) managers from Burkina Faso in hospital management and universal health coverage;
- Harmonisation and validation of tools and guides for assessing nursing and midwifery student placements;
- Training of fifty (50) trainers from basic schools and internship supervisors in the use of harmonised tools (internship journal and guide, care plan and partogramme) developed for learners from basic training schools (nurses and midwives) in Francophone ECOWAS countries;
- Training of twelve (12) pharmacists from the Ministries of Health and Pharmaceutical Councils in pharmaceutical management and logistics in disaster situations;
- Development of a regional plan for basic and specialist training in the ECOWAS region;
- Development of modules on prosthetics and speech-language pathology, audiology and speech-language pathology, medical rehabilitation, health promotion/education, veterinary medicine, nutrition and dietetics, health informatics and health logistics);
- Harmonisation and validation of harmonised curricula for specialised training in the allied health- professions of the ECOWAS region (Environmental health, Physiotherapy, Optometry, Radiography and medical imaging, Medical entomology, Medical physics, Dental technology, Biomedical engineering, Medical laboratory science, Mental health and psychiatry, Prosthetics and speech therapy, Audiology and speech therapy, Medical rehabilitation, Health promotion / education, Veterinary medicine, Nutrition and dietetics, Health information / Medical informatics and Health logistics);
- Establishment of three Centres of Excellence for Master's degrees in Nursing and Obstetrics (Master's degree in Health Sciences Pedagogy, at INFAS in Abidjan, Master's degree in Reproductive Health, at INSP in Niamey and Master's degree in Health Services Management, at INFSS in Bamako. For the first cohort, 104 scholarship

recipients were selected in the 6 countries (Burkina Faso, Chad, Côte d'Ivoire, Mali, Niger, Mauritania, Niger);

- -Training, in collaboration with WHO AFRO, of a group of consultants on the establishment and capacity building of NITAGs.

II.3.11. Technical Assistance to Member States

The programme aims to contribute to the improvement of management and logistic capacities of Member States. The results chalked up by the interventions were:

- Technical assistance to Benin, Burkina Faso and Cape Verde to improve the management of national health information platforms;
- Technical assistance to the Ministry of Health of Togo for the installation and configuration of computer servers for NHIS data management with DHIS2;
- Financial support for two studies on the EQUIST country application of the MEP project (Benin, Burkina Faso, Ghana, Mali, Nigeria, Senegal) and the use of evidence in hospitals in Ghana;
- Provision of PPP technical assistance to Burkina Faso, Guinea, Niger and Togo to identify promising projects;
- Development of internship guides, manuals, educational tools and evaluation sheets for clinics and the community;
- Financial and technical support for the organisation of the 30th Annual General Meeting (AGM) and the 60th Scientific Symposium of the West African College of Pharmacists (WAPCP), in Banjul, Gambia;
- Financial support to the "African Society of Gynaecologists and Obstetricians" (SAGO) for the organisation of the meeting of its Board of Advisors;
- Financial support to Niger, Cabo Verde, Burkina Faso and Gambia for the implementation of the capacity building plan for their national coordinating institutions,
- Financial support to Nigeria to strengthen Lassa fever detection capacity;
- Technical and financial support to Liberia, Sierra Leone and Côte d'Ivoire for the revision and development of strategic plans and various health policies.

II.3.12. Strategic Partnership and Policy Harmonisation

This programme aims to strengthen strategic partnership and harmonisation of policies to improve the coordination of interventions and facilitate the implementation of regional policies, standards and legislation. Highlights of achievements for 2018 are as follows:

- Development of a roadmap to enhance Private Health Sector Regulation;
- Development of a roadmap to implement the Commitment by Parliamentarians of ECOWAS, Mauritania and Chad on Adequate Health Financing, Demographic Dividend and Population and Development Policies;

- Establishment of the Federation of Networks of Champions in Advocacy for Adequate Health Financing and Demographic Dividend;
- Drafting of a regional guidebook on the development of a national community intervention strategy (CBI);
- Finalisation of a Royal Netherlands-funded €6.6 million project to support the strengthening of Adolescent and Youth Sexual and Reproductive Health (SHRAY).

II.3.13. WAHO Institutional Capacity Building

The objective of this programme is to strengthen WAHO's institutional capacity to address challenges related to inadequate human and financial resources, institutional communication deficit and the use of information and communication technology and coordination of interventions at regional level. The outcomes of the implementation of this programme were the following:

- Acquisition and installation of office equipment and materials;
- Training of staff in various fields and particularly on the use of the SAP and ECOLINK software;
- Launch of a new WAHO website;
- Receipt, configuration and installation of IT equipment for staff;
- Installation and configuration of about twenty virtual servers;
- Wiring of the offices of the various buildings for improved network;
- Finalisation of DHIS2 dashboard as a web portal that will be integrated into the WAHO website for periodical publishing of select data from the regional data warehouse;
- Acquisition and installation of network equipment, storage and data security backup,
- Recruitment of a project management assistant for digital development at WAHO and in the ECOWAS region, Secured Funding for recruitment of a Senior Special Advisor funded by BMGF and a Special Advisor (SA) for Capacity Development funded by USAID.

III. FINANCE

WAHO's 2018 budget amounted to a total amount of 47,625,562 UA and broken down as follows:

- 702 691 UA for the Governing Bodies, i.e. 1.49%,
- 5 438 553 UA for general administration, representing 11.53%,
- 40 625 810 UA for Programmes, representing 86.13% and,
- 403 508 UA for contingencies, representing 0.86%.

Table 6: Total Budget for 2018

Description	Approved Budget for 2018 in UA	of % budget
ECOWAS	16 947 344	35.1%
External funding	30 223 217	64.1%

Resource mobilisation by source is summarised in the table hereunder:

Table 7: Financial resource mobilized

Description	Approved Budget for 2018 in UA	Mobilised at 31 December, 2018 in (UA)	Mobilisation rate
ECOWAS	16 947 344	15 012 332	88.58%
External funding	30 223 217	16 152 994	53.45%

On the basis of the resources mobilised, this budget was implemented at an overall rate of 82.1%, including 87.4% for administration against 54% in 2017 and 81.77% for programmes against 73% in 2017.

The following table provides a summary of the status of budget implementation in 2018:

Table 8: Level of budget implementation

Description	Mobilised at 31 December, 2018 in (UA)	Mobilised at 31 December, 2018 in (UA)	Rate of Execution
Governing bodies	702 691	435 791	62.02%
Administration	4 296 096	3 754 997	87.40%
Programmes	26 150 569	21, 382,862	81.77%

IV. UPDATE ON ADMINISTRATIVE PERFORMANCE AT WAHO

The year 2018 saw the arrival of a new Director General and the continuation of the ECOWAS institutional reforms. Accordingly, the position of Deputy Director General of WAHO has been abolished and the professional structure of the Institution has also been revised. This reform restructures WAHO into five (5) Technical Departments and a Strategic Unit under the Director General.

The year 2018 also saw continued efforts to improve the security of the work environment, strengthen human resources capacity and strengthen WAHO's administrative and financial management. The details are as follows:

- Recruitment of seven (7) permanent staff members, including five (5) Professionals and two (2) General Service staff. In addition to these permanent staff, there are eight (8) Consultants to support project implementation.
- Retirement of three (3) permanent staff members including a Departmental Director, a Senior Professional and a General Services staff.

- Resignation of one (1) Contract staff and two (2) Consultants.

During the year WAHO continued to work to address the issue of inadequate office space. The construction of the extension to the administrative block, initially planned for six months, saw some delays which made it impossible to carry out the rest of the renovation works on the buildings. The new building is about 95% completed. To revamp the working environment, it is envisaged that in 2019,

- the construction of the extension to the headquarters building
- the renovation of the roof of the administrative building, the annexes, the Kabba-Joiner Conference Hall.
- the construction of the Staff Recreational facilities, the new car park within the headquarters compound for the staff,
- the reconstruction of the front fence wall and closing or covering the gutters of the front of the headquarters.

WAHO implemented several cost cutting measures aimed at continuously improving efficiency in resource utilization. Among other things, road transport between Bobo-Dioulasso and Ouagadougou has been largely outsourced. However, where a group of staff members or participants are travelling on the same date from Bobo to Ouagadougou. WAHO mini bus is used to convey them instead of renting several vehicles.

Participation in missions has also been scrutinised and restricted to the minimum number of days actually required for the activity. Moreover, all activities have been limited to 3 days and, in any case, not more than 5 under exceptional circumstances. The highlight of a new prudent management of finances was the introduction of a “cashless missions” policy removing the previous practice of moving large amounts of cash around the region during missions.

V. CHALLENGES IN 2018

In addition to the challenges related to the health situation in the ECOWAS region and, as in previous years, in 2018, WAHO faced a number of challenges, including the following:

- Limiting the growth of WAHO's annual budget,
- Communication and transport difficulties in the region,
- Rampant outbreaks of epidemics (particularly Lassa fever) and consequently their management,
- The moratorium on staff recruitment.

Some other important challenges that WAHO faces and must overcome in the short term in order to effectively play its leadership role are: The Protocol A/P2/7/87 creating the West African Health Organization signed by the Head of States and Government on 9 July 1987 in Abuja stated the need to pool resources and cooperation among Member States to find collective and strategic solutions to the health problems in ECOWAS.

Therefore, among the key resources that must be “pooled” are certainly “human resources” and “highly qualified national institutions”. WAHO must respond within the boundaries of the existing rules to:

- a) Operationalize participation of local staff/experts in regional interventions and thus exploit existing ECOWAS competencies.
- b) Access and utilise “highly qualified national institutions” in critical regional interventions.

Among ECOWAS Institutions, WAHO has a respectable pedigree in financial resource mobilization. For example, in 2017, WAHO mobilized more than 70% of all the resources mobilized by ECOWAS. This is not only a result of the more important funders choosing to fund several regional projects through Regional Economic Communities, but also the hard work of WAHO in providing a regional framework for health interventions in ECOWAS. WAHO must therefore ensure:

- ⇒ Effective coordination of interventions at regional and national levels particularly for partner-funded activities at the national level; and
- ⇒ More effective procurement processes.

VI. LOOKING AHEAD

WAHO reaffirms its commitment to continue to support Member States in finding solutions to the health problems of the people of the Region. WAHO reaffirms its commitment to continue to support Member States in finding solutions to the health problems of the people of the Region:

- Undertaking an evaluation of the 2016-2020 Strategic Plan, preparatory to producing the next 5-year Strategic Plan
- Recruiting staff to fill vacant positions,
- Improving relations with policy makers and other health stakeholders in Member States;
- Paying special attention to Member States with very fragile health systems;
- Strengthening its leadership role in finding sustainable solutions to the region's health problems,
- Strengthening its working relationships with partners, for a synergy of interventions,
- Initiating actions to monitor the implementation of the resolutions, decisions and recommendations of the various governing bodies;
- Streamlining and aligning interventions to the five thematic areas of focus agreed during the AHM in Banjul.

Some activities are strategic because of their catalytic effect in all other regional and national activities. The reason, among others, is that such activities can improve the critical need for human resources and/or facilitate the effective implementation of networks to ensure the sustainability of interventions.

2019 is critical to achieve concrete results on implementation of a coordination mechanism on malaria control in collaboration with key partners, including Sahel Malaria Elimination

Initiative, African Leaders Malaria Alliance (ALMA) and Roll Back Malaria for more synergetic actions particularly on vector control management.

To achieve this WAHO need to:

- Recruit relevant staff for the ECOWAS Regional Centre for Surveillance and Disease Control in order to fully operationalise it.
- Ensure an adequate institutional support for the National Coordination Units to enable them to perform their role.
- Ensure an effective regular communication between the National Coordinating Units including conference calls and production and dissemination of information on major epidemics/public health events.
- Strengthen the regional and national capacity on human resources including support to countries to accelerate the training of field epidemiologists.
- Ensure effective functioning of the Regional Laboratory network, including signing of contracts with the regional laboratories and centres of excellence to support the diagnosis and investigation of epidemic-prone diseases in the region; signing of contracts with the major carriers to ensure rapid and secure transport of biological samples, including during epidemic outbreaks; as well as operationalise the networking platform of the reference laboratories.
- Improve access to quality medicines.

CONCLUSION

In 2018, the ECOWAS region experienced a health situation marked by recurrent epidemics of meningitis, measles, cholera, yellow fever and Lassa fever in some Member States. At the operational level, several activities were undertaken in a bid to find lasting solutions to the region's health problems. In the same vein, a lot of effort was made to strengthen relations with the Member States and partners.

Nevertheless, the health systems of the region remains fragile with relatively poor health indicators and high disease burdens.

Consequently, WAHO will continue to pursue even stronger interventions in 2019, focused on a few priority themes, with a view to consolidating the results achieved for more population impact. WAHO therefore calls on all the member states and partners to support us in this endeavour.