A Decade Of WHO Action In The African Region

Striving together to achieve health goals

By

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Regional Director 2005–2015

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REGIONAL OFFICE FOR Africa

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Foreword

When I took office in 2007, I made the health of women and the health of the African people my top priorities. I am pleased to note significant improvements in both of these priority areas, which I regard as a measure of how well WHO as a whole performs.

The African Region bears a heavy double burden of communicable and non-communicable diseases, compounded in many countries by enduring poverty and weak health systems. However, as this report so clearly documents, progress over the past decade has been remarkable. This decade of achievements coincides with the leadership of Dr Luis Gomes Sambo as the WHO Regional Director for Africa. Most important, the pace of progress has accelerated over just the past few years, with a strong momentum that shows no signs of slowing. I am confident that Dr Sambo will leave a solid legacy for the future of health in this Region.

Over these 10 years, the epidemics of AIDS and tuberculosis peaked. For a long time, the best that could be said about malaria was that the situation was stable, as it could hardly get any worse. The situation has now been turned around, with many countries in Africa reporting more than a 50% decline in malaria cases and deaths. The Region has set ambitious goals for controlling – even eliminating – a number of the neglected tropical diseases that have plagued this part of the world for centuries. Immunization rates have soared, deaths from measles have plummeted, and Africa now has a new vaccine that promises to make outbreaks in the Meningitis Belt a thing of the past.

Recent declines in maternal and child mortality have been equally impressive, with some African countries now showing the fastest rates of decline in the world. These achievements tell us the importance of national commitment to better health and ownership of health initiatives, especially when health is regarded by heads of state as a nation-building strategy. However, they also show the contribution that WHO makes, at many different levels, in guiding and facilitating this progress.

This report gives a record of the many networks, roadmaps, strategies and special campaigns that have been established by WHO to offer uniquely African solutions to this Region's unique health needs. Examples of innovations range from seasonal malaria chemoprevention to reduce the malaria burden, to overcoming the dire shortage of health care workers by training existing staff to deliver high-impact interventions. The report, with its focus on eight ways the Region has moved towards better health, is also a record of the importance of documenting successes, setbacks and best practices with solid data and evidence.

Much remains to be done. Progress is fragile. Work, especially on the strengthening of health systems, needs to continue. Better resilience is essential. The Region is particularly vulnerable to shocks from major global threats to health, including climate change, conflict, natural disasters, outbreaks, food insecurity and the spread of antimicrobial resistance.

I join others in congratulating Dr Sambo for the achievements over these past 10 years. This report is a tribute to his leadership and a record of the legacy he is leaving for the future health of the African people.

Dr Margaret Chan
Director-General
World Health Organization

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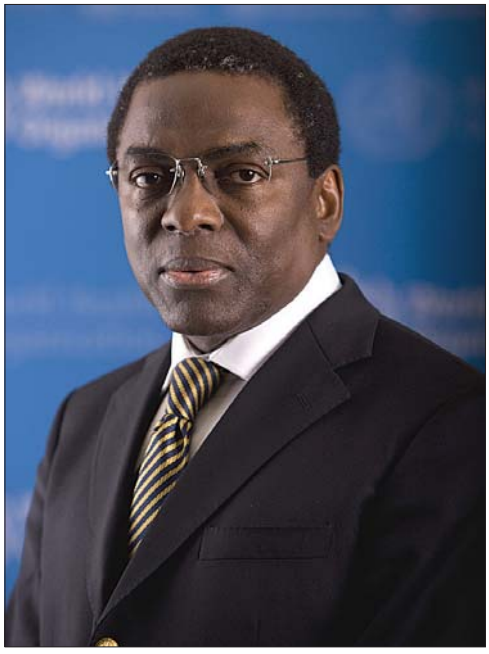
Preface



When I retire as WHO Regional Director for Africa in January 2015, I will have had the rare privilege of working for the World Health Organization, and serving the African Region, for 26 years. During this incredible journey, which I began as Unit Head in 1989, progressing to Regional Director in 2005, I have witnessed the unfolding of multiple new chapters in public health. The last decade, which is the time I have spent as Regional Director, is no exception. Tremendous gains have been made in tackling the many challenges the African Region has faced, such as the recurrent natural and man-made disasters, the very high disease burden, the health financing crises and the extreme poverty. The strain such issues and episodes have placed on national health systems is unimaginable; but the opportunities to respond to them, forcefully and effectively, have been great. This, in part, is thanks to the support of the late Dr J.W. Lee and Dr M. Chan, Director-General of WHO, the solidarity and support of my colleagues, Regional Directors of WHO and the unwavering support of the President and the Government of Angola. The wave of global and regional initiatives, like the Millennium Development Goals (MDGs), Health for All for the 21st Century: Agenda 2020, the NEPAD Health Strategy, as well as initiatives and resolutions taken by African ministers of health during Regional Committee Meetings have been pivotal. These all focused the world's attention on public health.

Together, WHO, Member States, and all the partners and players in public health in the African Region, have achieved a great deal – like the monumental increase in the number of HIV positive people who are now on life saving antiretroviral treatment. But we have also encountered many persistent challenges, not least of which is the fact that the African Region bears the highest burden of many diseases. These compromise people's health so much that far too many are unable to lead socially and economically productive lives. The inequitable access to health care and the uneven distribution of health outcomes it reflects, whereby those in greatest need have the worst health care provision, must not go on.

The highs and lows that the WHO/AFRO team, Member States and our partners have presided over during the past decade, have been covered annually in reports submitted to the Regional Committee. These are all available on the AFRO website (afro.who.int/, entitled 'The Work of WHO in the African Region: Report of the Regional Director'). The strategies designed and adopted by Regional Committees to address key public health problems are published in a document (http://www.afro.who.int/en/rdo/annual-and-biennial-reports.htm). Because of this, I have been mulling over the necessity for a 10-year synthesis. However, colleagues convinced me that for final accountability to the Member States that elected me, and the partners who supported our work, for institutional memory, and for posterity, I should write an account of the decade's work before I retire. That is why we embarked on this report.

It is for anyone and everyone interested in health and its centrality not only to how we feel and function within society, but also, crucially, how our societies respond and develop as a result. It is my hope that after reading this report, whether you are a member of the great African public, a health development partner, or you work for a national authority, you will be inspired to delve deeper into the issues at hand, and actively participate in the health solutions that we need to continue to develop and action.

Although my long journey at WHO is coming to an end, the war against diseases and their determinants is not over. In fact, it has barely begun. Therefore, I encourage whoever succeeds me, and my gallant WHO colleagues, to continue the valiant fight tenaciously, until the post-2015 promise of universal health coverage becomes a reality for every baby, child, teenager, adult and elderly person on our beautiful continent.

Dr Luis Gomes Sambo
World Health Organization Regional Director for Africa, 2005–2015

Introduction:

Eight ways we have moved towards better health

The African Region's public health load has been heavy, but WHO/AFRO has taken significant steps to ease it. Dr Luis Sambo outlines how…

1. RESTRUCTURED TO IMPROVE ORGANIZATIONAL EFFICIENCY AND EFFECTIVENESS

Key organizational and managerial reforms have been made during the past decade. I am happy that, with the support of the AFRO Executive Management, we were able to devolve more authority to Cluster Directors, WHO Country Representatives, inter-country support team (IST) Coordinators, and Programme Managers, leading to further empowerment and motivation. However, we also realized, with time, that devolution of power, although essential for efficiency and effectiveness, could expose the Organization to various risks. Therefore, I established a Compliance Team under my office, to critically review compliance with WHO financial and administrative rules and regulations. This has hastened implementation of internal and external audit recommendations.

In light of WHO General Programme of work, we were also able to improve the effectiveness of WHO country presence, through development of Country Cooperation Strategies, reinforce management and technical capacities, create three ISTs, establish a public health forum for Small Island Developing States (SIDS), and nurture a result-based management culture. Signing of Agreements with the Commission of African Union and Regional Economic Communities; and co-founding the Harmonization for Health in Africa (HHA) partnership, helped us provide coordinated, harmonized and aligned support to Member States.

(See Chapter 1 Restructuring WHO in Africa)

2. ENHANCED HEALTH DELIVERY

We gave policy, technical and normative guidance to Member States in their quest to reform national health systems, so they had the capacity to scale-up essential interventions needed to attain health-related Millennium Development Goals (MDGs) by 2015. The reform of health systems was guided by the 2006 Addis Ababa Declaration on Community Health, the 2008 Ouagadougou Declaration on PHC and Health Systems in Africa, the 2008 Algiers Declaration on Research for Health, and the 2014 Luanda Commitment on Universal Health Coverage in Africa. We also created the African Health Workforce Observatory and African Health Observatory, which facilitate production, archiving and sharing of information, evidence and knowledge.

(See Chapter 2 Strengthening health delivery)

3. PUT MOTHERS AND CHILDREN FIRST

WHO's guidance to Member States in their efforts to improve the health of children and women, has resulted in a number of gains. In order to generate research into inter-sectoral action required to address the root causes of high maternal mortality, the WHO Commission on Women's Health in the African Region was established in 2009. It produced a report, Addressing the Challenge of Women's Health in Africa, launched in 2012 by Her Excellency Mrs Ellen Sirleaf-Johnson, President of the Republic of Liberia, and Chair of the Women's Health Commission. We also supported countries to implement the WHO Road Map for Accelerating the Attainment of the Millennium Development Goals Relating to Maternal and Newborn Health in Africa, and the WHO Regional Strategy on Child Survival in 2006. The 2014 Luanda Ministerial Commitment on Ending Preventable Maternal and Child Deaths in Africa, calls for full implementation of policies, strategies and initiatives towards elimination of such deaths by 2035.

(See Chapter 3 Putting the health of mothers and children first)

4. PUSHED FOR MORE ACTION ON HIV/AIDS, TB AND MALARIA

WHO's contribution to the progress made in the fight against these diseases is significant. The key WHO Regional Committee resolutions adopted include HIV/AIDS: Strategy for the WHO African Region, 2012; Tuberculosis Control: the Situation in the African Region, 2005; and the 2009 Accelerated Malaria Control: Towards Elimination in the African Region. These, and many other resolutions, provided guidance that has helped Member States expand coverage of prevention, treatment and care interventions targeted at these diseases. WHO's provision of technical and normative support, has also contributed much to these efforts.

(See Chapter 4 Accelerated action on HIV/AIDS, TB and malaria)

5. PUSHED FOR CONTROL AND PREVENTION OF COMMUNICABLE DISEASES

Coordination of the response to public health events improved with the implementation of the Integrated Disease Surveillance Response strategy (IDSR) and International Health Regulations (2005). The establishment of the Strategic Health Operations Centre (SHOC) at the Regional Office in Brazzaville, and the ISTs in west, central, and east and southern Africa, have also helped considerably.

In addition, there are key achievements in the areas of immunization, disease surveillance and response, and neglected tropical diseases (NTDs). For instance, deaths from measles dropped by 88 percent between 2000 and 2012; and cases of polio plummeted by more than 90 percent between 2005 and 2013. Additionally, more than 153 million people in 12 countries are now protected against meningitis, thanks to the meningococcal A meningitis conjugate vaccine (MenAfriVac), which was launched in Burkina Faso in 2010.

(See Chapter 5 Intensifying the prevention and control of communicable diseases)

6. LIT THE FLAME BENEATH THE FIGHT AGAINST NON-COMMUNICABLE DISEASES

A strong policy and strategic environment is now in place to wage a spirited fight against non-communicable diseases (NCDs). This is the result of WHO/AFRO's endorsement of strategic documents on cardiovascular diseases, diabetes, cancer, sickle cell, avoidable blindness, oral health conditions, tobacco control and the harmful use of alcohol. The ministers also adopted the Brazzaville Declaration on Non-communicable Diseases Prevention and Control in the WHO African Region in 2011, and the 2014 Luanda Commitment on NCDs in Africa: Policies and Strategies to Address Risk Factors. All countries have a programme or department on NCDs, and have capacities to conduct, analyse and use the WHO STEPwise approach to chronic disease risk factor surveillance. As of June 2014, 42 African Region Member States had also ratified the WHO Framework Convention on Tobacco Control (FCTC).

(See Chapter 6 Non-communicable diseases)

7. UNDERLINED THAT THE ROOT CAUSES OF POOR HEALTH – WHERE YOU ARE BORN, LIVE AND WORK – MUST BE ADDRESSED

The social determinants of health require key actions to generate inter-sectoral response. In order to push for this, WHO has supported countries to implement various policy documents adopted by the WHO Regional Committee, for example, the 2008 Libreville Declaration on Health and Environment in Africa, and the 2012 Disaster Risk Management: a Health Sector Strategy for the African Region. Given the recurrent public health emergencies in the Region, WHO/AFRO also established the African Public Health Emergency Fund (APHEF) in 2011, and subsequently ratified by AU Heads of State. The purpose of APHEF is to mobilize funds from WHO Member States in the Region to support countries experiencing public health emergencies.

(See Chapter 7 Accelerating the response to the determinants of health)

8. EMPOWERED STAFF

The accomplishments contained in this report could not have been possible without a competent and motivated professional and general service staff. We acknowledged this by implementing a number of changes related to staff welfare and security.

(See Chapter 8 Looking after the team)

At the beginning of my first term with the former Director-General Dr H. Mahler and former Regional Directors Dr G.L. Monekosso and Dr E.M. Samba

WHO Regional Office for Africa, Brazzaville

Chapter 1

Restructuring WHO in the African Region

> "We shall strengthen partnerships and enter into an era of networks as never before. We will work with the Member States, African Union, Regional Economic Communities, and bilateral and multilateral partners to improve health dialogue, develop synergies and bring additional support to national and regional health development efforts. Enhancing the efficiency and effectiveness of WHO support to countries."
>
> *Dr Luis Sambo, 2005*[1]

CONTEXT

Some changes needed to be made to the way WHO was organized in the African Region in 2005. When I took office, leadership was top heavy and experts were concentrated at the Regional Headquarters in Brazzaville. This had created a culture where decision-making process was long and frustrating to Programme Managers. Meanwhile, Cluster Directors and WHO Country Representatives were only empowered with limited authority. As a result, much needed dialogue and collaboration with other partners involved in health development in the Region, including the Diplomatic Corps in Congo and other United Nations (UN) Agencies, was not as strong as required.

The insufficient communication about WHO/AFRO's work, not only within the organization, but also beyond it, meant efforts to improve health were not adequately disseminated. Crucially, there was no harmonized approach to supporting national health priorities and policy. Underlying this was the outdated agreement between the Organization of African Unity (OAU) and WHO. Signed in 1969, at a time when the OAU's focus was mainly on liberation from colonial rule and defending the sovereignty of newly independent African countries[2], the agreement no longer reflected the mandate of the OAU's successor, the African Union (AU).

The AU's mission is to accelerate the political and socio-economic integration of the continent, protect human rights and encourage international cooperation, including working with international partners to eradicate preventable diseases, promote health and sustainable development[3,4]. This renewed thinking dovetailed neatly with the UN's Delivering as One initiative. Launched in 2005, the initiative's aim was to make the UN system, particularly at country level, more cohesive, efficient and effective in order to achieve development goals[5]. The more joined up way of working which the WHO/AFRO team set in motion at the Regional Office echoed this, and a raft of achievements followed.

1.1: DEVOLVING LEADERSHIP

Achievements

One of the first big structural changes took place in 2006 when three Inter-Country Support Teams (ISTs) were established. These were part of an organizational reform strategy, which saw the Regional Director delegate financial and programme management, and human resources management, to Cluster Directors and their Programme Area Coordinators, WHO Representatives and IST Coordinators. Empowering different parts of the organization meant decisions could be made more quickly, flexibly and adapted to local contexts. The creation of ISTs also meant that the technical support offered to countries for the implementation of WHO norms and standards, and to strengthen health systems, was reinforced (see Box 1 Why we need ISTs).

Staffed by technical experts and administrative teams reassigned from Brazzaville, as well as newly recruited staff, the ISTs were launched with enthusiastic support and investment from host governments, who loaned and built offices to house them. The team in Harare, Zimbabwe, serves 20 countries in East and Southern Africa; Libreville, Gabon, caters to 10 countries in Central Africa; and Ouagadougou, Burkina Faso, supports 17 countries in West Africa. They collaborate so effectively with the UN Development Group, UN Regional Directors Teams in those sub-regions, and Regional Economic Communities, that they have been commended by Member States and the UN Joint Inspection Unit[6].

Four years after the ISTs were launched, the 2010 global financial crisis hit. Whilst this dented funding for priority programmes, the cuts and additional reform it led to were well managed, helping to get some good out of an otherwise bad news story. For instance, merging the Division of HIV/AIDS, Tuberculosis and Malaria, and some programmes of the Division of Prevention and Control of Non-Communicable Diseases, into the new Cluster of Prevention and Control of Communicable Diseases, has made it possible to tackle these health issues more holistically. The Divisions of Family and Reproductive Health, Healthy Environments and Sustainable Development, and parts of the Division of Prevention and Control of Non-Communicable Diseases, were also merged into the new Cluster of Health Promotion. This meant a far more coordinated approach could be taken to the way family and reproductive health, as well as the social determinants of health, were handled.

Remaining challenges

The devolution of leadership has had a positive impact throughout the organization, but there is still more to be done. Whilst the ISTs continue to work tirelessly to strengthen health systems, the lack of flexibility in WHO funding means resources cannot be easily allocated to the areas which Member States have flagged as priorities. Essentially, this means adequately catering for each country's unique health, economic and security situation is not being made. Indeed, as I pointed out during my inaugural speech as Regional Director, "If WHO funding was more flexible and predictable, we could address health issues in a more holistic manner using systems approach and providing more efficient support to Member States."[7]

The fact that this has not happened yet, has been brought into sharp focus during socio-political unrest and wars that have occurred in some countries. The colossal destruction which has taken place, including to health facilities, has placed an unimaginable strain on the already challenging job of implementing WHO's strategic directions in the African Region.

Box 1 Why we need ISTs

Dr Oladapo Walker, an IST coordinator for West Africa between 2008 and 2014, explains why Inter-Country Support Teams (ISTs) are so vital to the effective operation of WHO in the African Region.

"The WHO Country Offices (WCOs) can't cope with the health system and the complex humanitarian challenges countries are facing in the health sector without the support of ISTs. When I joined the organization in 1996, life was simpler. The development partners and non-governmental organizations at country level, were not as engaged or as many as they are now. Today, support for technical assistance, policy dialogue and data is wanted in near real time. The WCOs just don't have the human and financial resources to respond to these challenges in the field. This is the added advantage of the ISTs, as they have experts who can bridge the gap in near real time, and work in collaboration through the WCOs to support governments.

The recent Ebola outbreak in West Africa is a case in point. The West Africa IST was able to deploy experts on the ground within 24 hours, get colleagues to set up a diagnostic laboratory in the field, and review data in real time.

We need to keep the current strength of the ISTs without weakening the Country Offices, or else there will be no follow up to the work the ISTs instigate. We do not have the financial resources to have a full complement of staff at country level, we need ISTs to bridge the gap. The only challenge is ensuring the ISTs see themselves in a supportive capacity, not in competition with Country Offices. Our focus is on countries so we must continue to work together for their good."

It is vital to provide adequate funding and raise the profile of staff, particularly in the ISTs and WHO Country Offices (see 1.2 WHO country presence), so they can work effectively and flexibly responding to country health needs and requests for technical support.

1.2: WHO COUNTRY PRESENCE

Achievements

Empowering WHO Representatives (WR) through structural reform has increased the responsiveness of WHO across the Region, and led to a greater felt presence in individual countries. Not only do WRs enjoy more authority over budgets and local teams, but they also work closely with governments to address the health needs in their countries; a change which is helping to forge a more bespoke approach to the Region's hugely diverse needs. This was further enhanced at the Global Leadership Programme Workshops in 2006 and 2007, where WR leadership and management skills were honed.

A stronger presence in all 47 countries in the Region has also been helped through the implementation of the Country Cooperation Strategy (CCS). This takes into account each country's national health issues, and aligns them with WHO regional priorities and the global agenda in order to respond more directly to country needs.

The production and analysis of quarterly health reports produced at country level has also led to great improvement in policy orientation and accountability within countries. In addition, the capacity of WHO/AFRO to support the development and implementation of National

Health Policies (NHP) and National Health Sector Plans (NHSP) has improved for a number of reasons. These include the launch of the African Region Compendium of National Health Institutions and Experts, a valuable one stop listings resource; and 293 staff from 44 countries have been trained through the Global Learning Programme (GLP) to support NHP and NHSP policy dialogue, implementation and monitoring.

Last but not least, WHO/AFRO established an online forum for the Region's Small Island Developing States (SIDS) to exchange experiences. This meant the five SIDS (Cape Verde, Comoros, Mauritius, Sao Tome and Principe, and Seychelles) had a space where they could address their specific vulnerabilities, such as the emergence of chikungunya; and the increasing problem of drug, alcohol and tobacco abuse, particularly among the youth[8–10], and build sustainable resilience to them. As a result, the SIDS Network Web Community for collaborative work[11] was established in 2013 to disseminate reliable health evidence and health risks facing SIDS, and facilitate technical cooperation among the islands. Health ministers, WHO Country Offices and the Regional Offices' technical teams, can access the portal.

Remaining challenges

Much has been done to strengthen WHO presence at country level and empower WHO representatives to generate more opportunities to address country specific issues. But there is still a need to get under the skin of each country's very different health, economic and security situations in order to tackle them more fully and effectively. Optimizing the use of the CCS to help develop work and strategy across all levels of the organization, including the allocation of resources, would be a good starting point.

1.3: ADVOCACY, COMMUNICATION AND GOVERNANCE

Achievements

A nation's health is critical to its economic development. Raising awareness of this, so governments prioritize national health spending in order to see returns in every area of their country's development, is key to accelerating change throughout the Region. I have been on high-level missions to most African Member States since 2005 to argue this logic[12]. I have also visited many Western partner governments and taken part in international conferences to highlight Africa's health needs and priorities, and WHO strategies to address these. These have contributed to a growth in external resources from 8.5 percent in 2005 to 11.2 percent in 2012[12].

This kind of strategic and coordinated advocacy work was extended through the participation of African delegations at the World Health Assembly (WHA) and Executive Board (EB). Both, alongside the Secretariat, are instrumental in carrying out the work of WHO. I institutionalized daily coordination meetings of African delegates at EB and WHA[13] because this is one of the surest ways to influence the direction of global health policy, and mainstream regional public health concerns. A key way of obtaining influence was adopted in 2007[13] when the Regional Committee agreed that the head of delegation assigned an agenda item during the EB and WHA sessions, would speak on behalf of all Member States of the African Region. This way, a unified voice is articulated and the influence African delegates have on the global health agenda has increased.

Working together (see Box 2 Working as a team to make a difference at country level) to pool resources and expertise to combat shared problems, and advocate more powerfully for

With Dr M. Chan at the occasion of my second term nomination by the Executive Board

inter-sectoral action in areas like primary health care, research and disease prevention, was also translated into political declarations in 2012[14]. Since then, WHO and partners have been supporting countries to turn these declarations into action.

Communication, both internal and external, is fundamental to all of this. Done well, it raises awareness of health issues, gets partners and the public on board to effect change, and helps maintain momentum. The recognition of this has driven the expansion of the communications and advocacy team, and the development of the Communications Strategy for the African Region. This involved revamping the WHO/AFRO website, setting up social media platforms like Twitter (twitter.com/WHOAFRO) and YouTube (youtube.com/user/WHOAfricanRegion), as well as establishing a network of communications officers, stationed from Mozambique to Cape Verde, to support countries in the event of emergencies. "Social media platforms have played a critical role during disease outbreaks such as Ebola, to share official WHO situation updates, activities and messages with partners, the public and other stakeholders," says Collins Boakye-Agyemang, Head of WHO/AFRO's Communications and Advocacy Unit. Publications and television programmes have also been produced. "TV programmes on mental health sensitized the public on mental health issues and the need to do away with stigma; and programmes on African Vaccination Weeks remind people that vaccination is a shared responsibility and encourages everyone to complete their vaccination schedule," explains Boakye-Agyemang.

Remaining challenges

Staff capacities to mobilize resources, communicate with donors, and report back, have started and must continue to be strengthened in order for achievements to be sustained. This means offering more support to the Communications and Advocacy Unit by taking on

Box 2 Working as a team to make a difference at country level

When Sierra Leone's Ministry of Health and Sanitation (MOHS) received reports of a significant number of cases of acute diarrhea and vomiting in people during the dry months in February 2012, this triggered an alert. But the laboratory capacity and disease reporting system in the country was weak, so the MOHS turned to WHO for help. WHO's representative in Sierra Leone, Dr Wondimagegnehu Alemu, reacted immediately by assigning staff from his office to work with the government and other health sector partners on the response. In addition, WHO facilitated the importation of laboratory reagents (chemical testing kits) to confirm the outbreak. WHO worked with the MOHS and partners to train health workers in cholera treatment and prevention and sent medical supplies to support specially established cholera treatment units. By mid-June, cases began to decrease to fewer than 40 a week. A massive drop from the 237 cases reported during the first week.

In late June, however, it began to rain. The epidemic spread rapidly to other districts and the number of cases reported rose to more than 2000 a week in early August. This was mainly due to unsafe water and poor sanitation, especially in the densely populated urban slums where people were at high risk of cholera infection. On 16 August, President Koroma declared the situation a public health emergency. Ten days later, with WHO support, the Ministry of Health established a Cholera Command and Control Centre (C4). Building on experience from the 2008 cholera outbreak in Zimbabwe, the centre coordinated the response among the many health partners involved in the relief effort. The Minister of Health and Sanitation, Honourable Ms. Miatta B. Kargbo, and WHO, co-chaired daily meetings at WHO's office in Freetown at which the partners discussed the day's case numbers and other information to plan activities.

The C4 was a turning point in the management of the cholera outbreak in the country. It brought key partners together for daily discussions on the identified hot spots based on statistics provided by surveillance teams in all the districts. This informed various teams, from those working in epidemiology and laboratory to those in communication and social mobilization, which contributed to the reduction and control of one of Africa's biggest cholera outbreaks.

advocacy and scientific writers, as well as graphic designers to continue to convey messages as clearly and powerfully as possible.

1.4: PUBLIC HEALTH ASSOCIATIONS AND PARTNERSHIPS

Achievements

Between 2008 and 2012, WHO/AFRO's support was instrumental in the launch of three vital public health associations: the African Health Economics and Policy Association (AfHEA), the African Federation of Obstetrics and Gynaecology (AFOG) and the African Federation of Public Health Associations (AFPHA). All three serve as platforms for engaging stakeholders and promoting the role of their specialists in Africa's health development process.

Launched in 2008, the AfHEA's focus is on health economics and policy, and advocating for the use of these in planning, policy development and decision making in countries. The AFPHA was established in 2011 to engage key stakeholders to influence policies and strategies,

A view of a Regional Committee Session

which will have a positive impact on the health of all African people. Meanwhile, the AFOG advocates for greater resources to be invested in maternal and newborn health.

Underpinning the outreach and advocacy work of these associations are new strategic alliances which were formed with key funding partners, as well as the enhancement of existing ones. These alliances were enhanced in 2006, when I held the first meeting between WHO Management and Members of the Diplomatic Corps in Congo. This is now an annual meeting, and policy dialogue between Member States and donor countries is more effective as a result. In addition, WHO Country Representatives became active players within UN Country Teams (UNCT). This means coordination among UN agencies has improved in line with the orientation of UN reform and the Delivering as One approach. The Paris Declaration on Aid Effectiveness, Harmonisation and Alignment (2005) inspired me to propose the formation of the Harmonization for Health in Africa (HHA). Spearheaded by WHO in 2006, it facilitates country-led health development and offers a means for partners to provide coordinated health support to governments. It has 16 members so far. Working relations have also been enhanced with traditional partners, including USAID, the CDC, the Bill and Melinda Gates Foundation, and DFID. New partnerships have been formed too, and collaboration with regional economic communities, civil society and global health initiatives has intensified. However, we still require more effective mechanisms to create greater impact in the health status of local communities.

The partnership between WHO and the African Union Commission (AUC) also gained new impetus, when both organizations signed an agreement in 2012 to replace the outdated 1969 agreement between WHO and the defunct Organization of African Unity. Partnership between the two organizations provides the necessary technical (from WHO) and political

(from the AUC) leverage for decisions to be implemented. Many decisions and resolutions which have an impact on the lives of populations are passed by the meetings of health ministers. It is important that these resolutions be followed through and implemented. The decisions taken by the ministers are now guiding the joint work of the two organizations.

For instance, the 1st African Ministers of Health Meeting, which was jointly convened by WHO and the AUC in Luanda, Angola, in April 2014, culminated in the adoption of the Luanda Declaration and eight commitments – including ending preventable maternal and child deaths, establishing an African Centre for Disease Control and Prevention, and creating an African Medicines Agency.

WHO has also forged a strategic partnership with the UN Economic Commission for Africa (UNECA). A joint health plan was in the making at the time of writing, and areas of cooperation include health financing to push for universal health coverage.

Remaining challenges

Strong public health associations and partnerships are vital for helping to turn ideas and plans into action. But their sustainability faces a number of challenges. Financial constraints mean that meeting the operating costs of the associations' offices and financing conferences to enable the vital exchange of ideas, as well as publishing books to disseminate those ideas, is a real problem. Given the relatively low salaries of researchers working in public health institutions in the Region, regular membership fee payment is also an issue, and this impacts on running costs.

When conferences do happen, their success hinges on adequate scientific papers being submitted. This can be challenging due to the limited numbers of health researchers in the Region. There needs to be a real push on increasing and retaining them, as well as improving publishing culture so findings can be communicated effectively.

Staffing issues within the HHA secretariat need to be dealt with, too. There is currently only one senior employee and one administrative assistant. Given that the number of HHA member agencies increased from 6 to 16 between 2006 and 2014, the capacity is not sufficient to get through the often heavy workloads very efficiently. The HHA partners platform needs to mature its foundation and improve/consolidate its mechanisms in order to align partners strategic approaches with national health policies and systems.

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Chapter 2

Strengthening health delivery

> "Since her assumption of office, the WHO Director-General has said, on many occasions, that the health of Africans is her priority; and that sustainable progress in health depends primarily on health systems strengthening."
>
> *Sambo, 2008*[1]

CONTEXT

As I explained in my 2005 inaugural speech as Regional Director, health systems which enable individuals, families and communities to access all levels of good, affordable care are a prerequisite for healthier populations and nationwide sustainable development. Unfortunately, weak leadership and governance of health systems was a problem for many African countries in 2005. Poor managerial processes in ministries of health, struggling against a backdrop of inadequate infrastructure, financing, human resources in the health arena, access to health technology and safe blood, hampered good policies being actioned. This meant that it would be even more of a challenge to achieve, as I hoped, "the health-related Millennium Development Goals by using a well-performing health system with qualified and motivated staff, providing quality and equitable services focused on the needs of communities including the vulnerable."[1]

Although there was a mountain of issues to tackle, the actions which have been put in place during the last decade mean they were not, and still are not, insurmountable.

2.1: NATIONAL HEALTH SYSTEMS

Achievements

Laying the foundations for improved health care across the Region required national health systems to be robust enough to respond to priority health concerns. In order to do this, all countries needed to have a coherent national health policy as the core foundation. The Regional Office deployed health systems experts throughout the Region to develop guidelines for the formulation of national health policies and strategic plans. As a result, the number of countries with national health policies increased from 31 to 44. Having these management tools allowed more national use of domestic funds and mobilized external resources to tackle national priorities. This contributed to strengthening of district health systems and improved the quality of health interventions, such as immunization against vaccine-preventable diseases and scale up of the management and prevention of common childhood illnesses like pneumonia, diarrhoea and malaria.

WHO teams across the African Region have been instrumental in supporting countries to develop and submit proposals to access much needed funds from Global Health Initiatives to enhance their health system performance. The result: 34 countries have benefitted from USD 514 million of funding from the Global Alliance for Vaccines and Immunization (GAVI) (see Box 1 How WHO/AFRO helped Ethiopia win GAVI funding), and additional donor investment.

In keeping with the new leadership's philosophy of devolving power and extending networks of health care provision, WHO/AFRO set about bolstering community health. Ethiopia hosted an international conference on Community Health in Africa in 2006. The central theme was to push for universal access to quality health care by urging governments to support community health development, decentralize health service governance and strengthen health districts. Since then, a number of countries, including Ethiopia, Ghana and Rwanda, have increased their community health workforce and improved access to health care as a result[2].

However, accessible, well-staffed and managed health systems are only effective if the right medication and technology is available to treat the problems with which patients present. The Commission on Health Research for Development went to the heart of this issue back in 1990 at the Nobel Conference in Sweden, when it revealed that only 5 percent of global health research investment was being directed to conditions which accounted for 95 percent of global disease[3]. In order for African Member States to really get to grips with their populations' health problems, they needed to counter this outrageous imbalance in global medical research and development by investing in priority research aimed at finding solutions to their most prevalent health problems.

The 2008 ministerial conference in Algiers, Narrowing the Knowledge Gap to Improve Africa's Health, was aimed at availing knowledge for achieving the MDGs and controlling neglected tropical diseases (NTDs). The conference resulted in the Algiers Declaration and provided a roadmap for enhancing home-grown health research systems in Africa.

The same year the Algiers Declaration was agreed, WHO and partners organized the First International Conference on Primary Health Care (PHC) and Health Systems in the African Region. This resulted in renewed commitment to making PHC, with health for all as its guiding principle, central to forging solid health care and accelerating attainment of the health MDGs. The evidence shows that PHC is one of the best approaches for health promotion[1] because it enables a multidisciplinary and inter-sectoral response to health issues. As I explained at the 2010 World Health Summit, "**in the African Region, weak health systems have been a hurdle to scaling-up coverage of essential health interventions. The renewed focus on Primary Health Care with its principles and values of social justice, equity, solidarity, effective community participation and multi-sectoral action, offers a sustainable approach to redesign national health systems in a flexible manner**."[4]

Most countries in the Region have now adopted health policies based on PHC values and principles in order to improve equity in access to quality health care.

Remaining challenges

For every area of achievement, there are improvements which urgently need to be made. Health research is still up against a host of tough obstacles. Some countries in the African Region have no legislation covering research, and investments in research and knowledge

management is severely limited making researchers far too dependent on external funding sources that end up driving the research agenda. The unfortunate result is that much of the Region's research effort winds up not addressing the public health needs of local populations. There is a dearth of active health researchers in many countries – not because the talent is not there, it is in abundance – but because of the woefully inadequate resources to train people and/or the funds to retain them. Again, this lack of investment also translates into poor access to health information and knowledge due to inadequate information technology resources, including low internet connectivity in many areas[5].

Poor governance and a lack of transparency in procurement systems, along with unreliable supply chains, widely variable and unaffordable prices, and weak regulatory capacity to ensure the quality and safety of medical products and technologies, has contributed to a situation where, even when relevant essential medication does materialize, 50 percent of people cannot get hold of it[6].

When community health services function properly, this is a proven way of getting essential medicines to people in need. Fortunately, areas of this type of intervention are certainly operating better than they were a decade ago, as with the Ethiopia HEP case (see Box 1). However, the ownership and participation which the community health concept is supposed to engender, by allowing communities to influence the policy, planning and operation of health services, and enjoy their delivery, has not really come to fruition. Instead, there is a proliferation of externally driven interests with limited capacity and who make no attempt to build on

Box 1 How WHO/AFRO helped Ethiopia win GAVI funding

The GAVI Alliance was launched in 2000, at a time when global immunization rates were stagnating, to fund vaccines for children in more than 70 of the world's poorest countries.

Just before I took office, Ethiopia was on a mission to achieve universal coverage of PHC through their Health Services Extension Programme (HEP). This is an innovative community based strategy focused on increasing access to health services and improving use. HEP was designed to deliver health promotion, immunization and other disease prevention measures, to address the main causes of maternal, neonatal and childhood morbidity and mortality.

Launched in 2002, evaluations of HEP confirmed its potential, but the programme needed to expand to meet the needs of those it was aiming to serve. Between 2003 and 2006, 9900 Health Extension Workers (HEWs) were working throughout Ethiopia, with two HEWs covering areas where they were responsible for around 5000 people. However, in order to fulfil the programmes potential, more than 30,000 HEWs had to be in place by 2008. Health centre services also needed to be expanded to reach 80 per cent of the population. So, when applications for GAVI funding opened in 2007, the Ethiopian Ministry of Health approached the WHO Country Office for help in applying for a cash injection which would accelerate their ability to scale up the programme by expanding PHC services.

WHO played a critical role in supporting the application, particularly by providing the required evidence base. It was successful. The programme was awarded USD76,493,933. By 2008, Ethiopia was just shy of its original target, with 24,500 new HEWs trained and deployed throughout the country. However, by 2010, 34,833 HEWs had been trained and were working in the field. The icing on the cake was the extension of PHC from 76.9 percent in 2005, to 90 percent in 2010.

already existing community resources and experiences[7]. This results in loose community ownership of health development which threatens the long-term impact of projects.

These kinds of issues are far from conducive to the creation of fully functioning, sustainable national health systems. Rather, they simply help fuel a situation where 47 percent of the population has no access to quality health services. This leads to unacceptable consequences – such as the 59 percent of pregnant women who risk their lives delivering babies without the help of skilled health workers[6].

2.2: UNIVERSAL HEALTH COVERAGE

Achievements

Put simply, universal health coverage (UHC) means that everyone, regardless of who they are, where they live or their financial situation, should have access to good quality services which address essential needs. However, despite the existence of proven interventions to deal with the most frequently occurring communicable and non-communicable diseases, Africa bears the heaviest burden of these diseases, harbouring 69 percent of the world's HIV cases, 80 percent of malaria cases and 26 percent of TB cases[2]. The continent is the least well served when it comes to accessing essential health services. For example, only 43 percent of pregnant women have four antenatal care visits compared with the global average of 55 percent[2].

Attaining UHC would help alleviate such issues by ensuring a range of services is available to all, from medicines and health workers to infrastructure and information. This will not happen overnight. However, during the 1st African Ministers of Health meeting, which was convened by the AUC and WHO in Angola in April 2014, a commitment was made to prioritize UHC on the continent as part of national health development efforts[2].

Highlighted as fundamental to achieving the health MDGs and sustaining them beyond 2015, not only should the international community's agreement that UHC is key to ending extreme poverty help drive the Luanda commitment, but also should the recent growth in Africa's economy, by enabling governments to increase health spending[2].

Skilled healthcare workers are obviously crucial to achieving UHC. In 2005, the African Health Workforce Observatory (AHWO) was established at the Regional Office and its partners to better understand and tackle the severe shortage of health workers in Africa. Many health professionals who train in sub-Saharan Africa end up migrating to Western countries, attracted by better working conditions and pay. Worryingly, research has found that migration of African trained physicians to America increased between 2002 and 2011 for all but one principal source country (source countries include Ghana, Nigeria, South Africa and Ethiopia). South Africa was the exception, with an 8 percent decrease in physician migration to the US[8].

Still, sub-Saharan Africa only has 3 percent of the global health workforce, but 11 percent of the world's population and 24 per cent of the global burden of disease[9]. Furthermore, countries like Liberia had just 1.37 doctors for every 100,000 people in 2008 (compared with 7.76 doctors per 100,000 people in 1973). This sits in sharp contrast to the USA, which enjoys 250 physicians per 100,000 people[8].

The background to this brain drain is rooted in the 1980s structural adjustment programmes which were implemented in the developing world by international financial institutions as part of the severe refinancing conditions. The resultant swingeing cuts to public health

services saw significant numbers of sub-Saharan African medical graduates migrate to the US between 1984 and 1995. This trend is not showing any real signs of reversing[8].

WHO data have long tracked these imbalances in the global health workforce and the creation of the AHWO, under my leadership, helped support countries to set up their own national observatories to monitor trends and to inform policy dialogue and decision making[9]. So far, 13 Member States have established observatories. A roadmap for increasing human resources for health, and the improved health service delivery which will come with it, was also endorsed by the Regional Committee for Africa[10] to guide Member States responses on ensuring availability, retention and performance of their health workforce.

However, even with the best will in the world, the effective implementation of UHC is resource dependent. In 2006, WHO/AFRO developed the Region's Health Financing Strategy to foster equitable, sustainable and efficient financing to achieve national health goals, including the health MDGs. Strategic planning and costing to prevent and control all major diseases, and fund the health systems required to enable this, has been aided by the United Nations One Health Tool (OHT). The tool offers a single framework which enables planners to consider the impact of diseases and the budgets required to tackle them holistically and develop strategies accordingly, rather than costing each disease in isolation. This more cohesive way of working is also echoed by the first Expenditure Atlas of the African Region. Published in 2011, the Atlas provides an overview of all national health expenditure and helps further efficient development of strategies of health financing.

Coordinated working to improve the availability of information, monitor health trends, and support the implementation of national strategies was also enhanced thanks to the establishment of The African Health Observatory (AHO) in 2010. This Region wide observatory facilitates the storage and sharing of data and statistics; production and sharing of information, evidence and knowledge, as well as providing a space where practitioners can gain support from others in the Region.

The AHO data and statistics web-based platform offers the best available health-related data and statistics on the African Region. It includes the Atlas of African Health Statistics that is updated yearly, and comprehensive statistical health profiles for each of the 47 countries in the Region. Another platform offers analytical country health profiles to inform policy and decision making on a wide range of areas. A key AHO publication is the African Health Monitor – a serial publication produced four times a year. AHO has provided support to countries to establish their own national health observatories (NHOs) that will also serve as collaborative platforms to strengthen national health information systems.

Rapid developments in communication technology during the past decade have also enabled the expansion of health coverage– particularly to under-resourced rural areas where lack of infrastructure and travel costs means health workers getting in, and patients getting out, is a constant challenge. Nine countries in the Region (Botswana, Cote d'Ivoire, Ghana, Kenya, Mauritius, Nigeria, Rwanda, South Africa and Tanzania) have developed national eHealth strategies in a bid to combat this, by exploiting the potential of ICT for health (see Box 2 How eHealth is aiding universal health coverage).

Remaining challenges

Despite the progress made, there is still much to be done before UHC can become a reality. Some of the biggest challenges include weak public–private partnerships and a lack of

Box 2 How eHealth is aiding universal health coverage

Miguel Peixoto, in charge of Health Data and Informatics at WHO/AFRO and the Regional Focal Point for eHealth, explains how eHealth can help contribute towards achieving universal health coverage.

"eHealth solutions can provide health workers with faster, secure access to patient information via tools like Electronic Medical Records to provide better health care. It's particularly useful in distant, impoverished rural areas as, instead of having to pay for transport to see a doctor in the nearest health facility, wasting time and eating into limited funds, patients can use mobile phones to contact health workers who will have all their medical records stored electronically and can at least begin the process of giving them potentially life saving advice before they reach them.

Countries that have implemented Electronic Medical Record Systems (EMRS) have stronger health systems which can deliver better health care by placing medical information in the right hands at the right time in a secure and standardized way. EMRS can also improve patient safety by providing a complete overview of clinical and medication history of each patient, helping to avoid potential errors. For example, some eHealth solutions allow midwives who are working in remote areas with patients located great distances apart, an efficient way of monitoring their patients' progress and being quickly alerted to any problems they may have.

It is also an empowering awareness raising tool. For instance, in Gambia in 2009, WHO, the Ministry of Basic and Secondary Education, and the Ministry of Health and Social Welfare, launched the *WHO Health Academy Project: using ICT to promote health in schools*. More than 1600 students from ten senior secondary schools participated and completed eLearning courses about substance abuse, food safety, staying fit, HIV/AIDS, and malaria.

The project was a real success because of country ownership and leadership; there was clear description and analysis of the most important health challenges addressed; and they were developed and implemented in a sustainable way. It also demonstrated how using innovative eLearning tools can reach remote areas and narrow the usual knowledge and access gap between rural and urban districts."

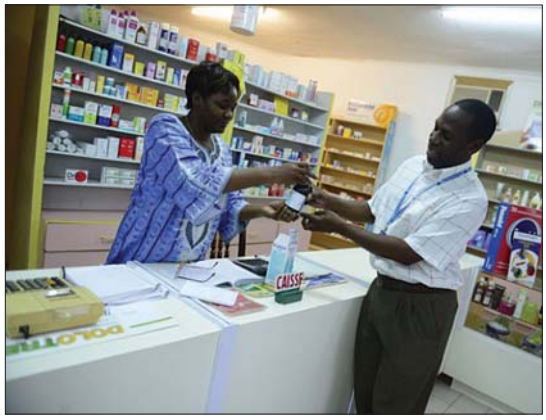
sustained political commitment[11], as well as poor coherent health financing policies which leads to limited, inequitable and inefficient funding for priority health problems.

Member States must tackle these issues head on with the support of WHO and other partners. For their part, it is vital that they, among other things, help countries to develop a framework to monitor UHC and generate and mobilize resources, which are badly needed to realize the vision[11].

2.3: CONVENTIONAL AND TRADITIONAL MEDICINES

Achievements

Significant inroads have been made to the way medicines are regulated on the continent. Back in 2005, only 34 Member States had evidence based medicine policies. By 2014, this had risen to 43 countries and the majority had implemented these policies. Thirty-five countries had developed national Essential Medicines Lists (EML), and 22 countries had



standard treatment guidelines in place. This progression can, in part, be attributed to the strengthening of the National Medicines Regulatory Authorities (NRAs) between 2006 and 2013[12,13] (see Box 3 Steps to success: how WHO/AFRO helped strengthen medicines regulation).

Between 2005 and 2014, WHO AFRO organized three African Medicines Regulatory Conferences. The first was held in 2005 in Ethiopia, and the second in 2009, in Mozambique. The third, which was also the first Scientific Conference on Medicines Regulation in Africa, was held in South Africa in December 2013. These conferences helped countries identify challenges and develop strategies to improve the regulation of medical products. Progress of the regulation of medical products was reviewed and WHO together with the African Union are supporting the establishment of the African Medicines Agency (AMA).

Meanwhile, the ongoing global debate on Substandard/Spurious/Falsely-labelled/Falsified Counterfeit (SSFFC) medical products led to the creation of a Task Force on SSFFC in 2010. This was expanded to a Working Group in 2012 to delve more deeply into the issues these products present for the Region, and to enable African Member States to be better informed for debates on the world stage. In April 2013, key personnel from 32 countries were trained in workshops held in Nigeria and Tanzania as part of the Global Surveillance and Monitoring Project for SSFFC Medical Products. A rapid alert system was developed, strengthening the capacity of Member States to detect SSFFC medical products, initiate risk assessment and share information as quickly as possible. So far, notifications from African countries and the investigations which have followed, have led to important alerts about the circulation of fake anti-malarial products in West and Central Africa. National medicines regulatory authorities were informed immediately so they could take appropriate measures to protect public health.

African Traditional Medicine is also slowly being brought into the regulatory fold. On Traditional Medicine Day in August 2013, I reminded that, "current WHO estimates show that for 80 percent of the people in the developing world, traditional medicine is the main – and sometimes the only – source of health care. In our Region, traditional medicine has strong historical and cultural origins. It is regrettable that traditional medicine R&D has not been given adequate funding."[14]

Despite the lack of funds, there has been some progress. Forty countries had established national traditional medicine policies in 2013, compared to just 22 in 2005; and 29 countries had legal frameworks in place to guide the practice of traditional medicine. Thirty-nine countries had established a national office of traditional medicine, compared to 31 in 2005, and 24 had national traditional medicine programmes, compared to 15 in 2005[15–17].

Remaining challenges

Investment in the research and development (R&D) of traditional medicine needs to be increased by forging stronger partnerships involving governments, donors, the private sector and relevant stakeholders (see Box 4 Why traditional medicine must be recognized alongside conventional options). As I underlined on African Traditional Medicine Day, 2013, "this will

Box 3 Steps to success: How WHO/AFRO helped strengthen national medicines regulation

1. Staff able to implement basic regulation at National Medicines Regulatory Authorities (NRAs) increased by 50 percent between 2005 and 2011.
2. In 2011, 87 percent of NRAs were able to evaluate marketing authorization applications for pharmaceutical products – a massive step up from only 37 percent of staff in 2005.
3. Just 50 percent of NRAs reported having a pharmaceutical inspection service in 2005. By 2011, this had risen to 83 percent.
4. NRAs in 19 Member States were supported to develop the capacity to review clinical trial applications, approve clinical trials and inspect clinical trial sites.

Box 4 Why traditional medicine must be recognized alongside conventional options

Zimbabwe's Honourable Minister of Health and Child Care, Dr Pagwesese David Parirenyatwa, explains the importance of traditional medicine in his country.

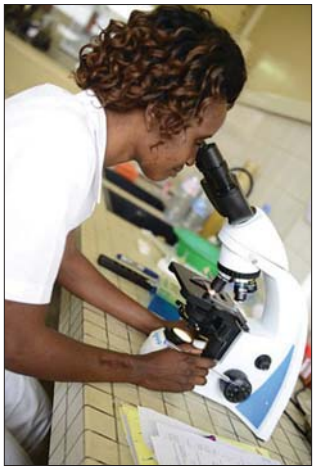
"Traditional medicine remains the first source of health care for the majority of the indigenous population of Zimbabwe and needs to be integrated into national health systems. The goal of recognizing and developing traditional medicine as part of conventional health systems can only be realized once traditional medicine products are included in national essential medicines lists for administration by appropriately trained medical practitioners; and qualified traditional medical practitioners are regulated. It is therefore important that countries invest in scientific research for traditional medicine practices and products to generate evidence on safety, efficacy and quality as well as reinforce regulations. WHO has proffered guidelines and strategies towards the achievement of this goal and enhanced its support in the past decade. Countries must adopt and use these tools to develop traditional medicine. WHO must therefore continue to provide the required technical support."

yield positive returns for the Region, where traditional medicine products have high acceptance. Governments need to include traditional medicine R&D in their national health research agenda and create budget lines to support the implementation of the traditional medicine strategy adopted by the WHO Regional Committee for Africa. For its part, WHO will continue to support countries in their endeavour to make traditional medicine a viable component of their national health systems."[14]

2.4: LABORATORY WORK

Achievements

The past 10 years have been a real turning point for laboratory services, with existing labs strengthened thanks to guidance on disease surveillance and response, and laboratory departments created in ministries of health in 20 countries. By 2014, more than 80 laboratories in 45 countries were participating in a regional External Quality Assurance (EQA) programme on HIV serology testing, haematology and clinical chemistry, enteric and meningitis pathogens,



malaria and TB microscopy, as well as on plague. More improvements came in the form of the 2011 Stepwise Laboratory Improvement Process Towards Accreditations (SLIPTA). Fifty-six laboratories audited in eight countries (Cameroon, Kenya, Mozambique, Nigeria, Rwanda, Tanzania, Uganda and Zambia) using the SLIPTA checklist have been recommended for international accreditation. Four laboratories were accredited against ISO 15189 standards in Kenya, Tanzania, Uganda and Togo in 2013. Cameroon and Kenya also saw their Centres of Excellence for Continuing Education in Diagnostic Imagining reactivated to improve radiological diagnostic services.

Regional laboratory networks have been established, too, including the Epidemic Dangerous Pathogens Laboratory Network (EDPLN) addressing class 4 pathogens (e.g. Ebola and Marburg). Meanwhile, the regional influenza laboratory network supports efforts to diagnose and treat influenza and other respiratory viruses type such as MERS-CoV.

With WHO's support, great progress has also been made across the Region to improve the availability, safety and access to safe blood products. Safe blood is critical in a whole range of emergency health situations. These include urgent transfusions required for women who suffer severe bleeding during or after childbirth, a tragically high number in the African Region, to victims of road traffic accidents, the consequences of which are among the main non-communicable diseases (NCDs) in the Region[18].

Fortunately, all 47 Member States have devised and updated their blood policies. Since 2014, all countries test for HIV, 42 for HBV and syphilis, and 41 for hepatitis C – more than double the number that were testing in 2005. Twenty-nine countries currently take part in an external quality assessment scheme for Transfusion Transmitted Infections (TTIs) and the number of blood donations has increased during the past decade, too. In my message on World Blood Donor Day in June 2014, I advised that, "collecting blood by voluntary unpaid donations through well-organized donor recruitment systems has been shown to be safer, more effective and more efficient than hospital-based family or replacement donations."[19]

Patient safety is, of course, at the heart of all these changes and, in 2009, the African Partnerships for Patient Safety (APPS) was launched. This involves forging partnerships between health care institutions, mostly hospitals, to improve patient safety in all areas, including organ donation, blood transfusion and transplantation. This area saw 18 specialists and policy-makers from 11 countries come together to share experiences during a regional consultation in 2009. The number of partnerships since the APPS launched has expanded from an initial six, to 17 countries in the Region. This expansion looks set to continue.

Remaining challenges

Despite the increase in blood donations, there is still not enough blood being collected and, to date, 34 countries have developed strategic plans which only meet 50 percent of blood requirements of the Region. The lack of availability and access to safe blood is often due to inadequate infrastructure, insufficient qualified health workers and communication difficulties, all of which make the organization of blood collection in some areas impossible[19]. A multi-pronged approach to health care and continued strengthening of partnerships is required to alleviate this.

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Chapter 3

Putting the health of mothers and children first

"The health of women in the Region is deplorable because every minute a woman dies in labour or suffers lifetime complications from pregnancy and delivery. I am hereby calling on all governments to reinforce their commitments and dedication to accelerating the reduction of maternal and newborn mortality as a fundamental right to life and development. We must also remember to actively involve women in all decisions related to their health and well-being [….]. 'A nation thrives when mothers survive; we must strive to keep them alive'. Though the task ahead may appear daunting, I encourage Africa to ensure that 'No Woman Dies While Giving Life'. Let us all work assiduously together to reduce ill health, improve lifestyles and reduce deaths in the African Region."

H.E. Mrs Ellen Johnson Sirleaf, President of the Republic of Liberia, 2012[1]

CONTEXT

Becoming, or being, a mother or a child in many parts of Africa in 2005 meant you were faced with a disproportionately high risk of chronic ill health or premature death. Of the 14 countries worldwide with an unacceptably high maternal mortality rate, estimated at around 1000 for every 100,000 live births, 12 were in Africa. There was only a 0.1 percent annual reduction of deaths during or after pregnancy and childbirth, this was unacceptably short of the 5.5 percent annual reduction needed to improve maternal health and achieve MDG 5 (improve maternal health).

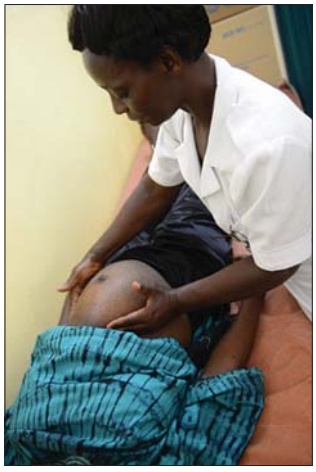
Meanwhile, for every 1000 live births, 38 babies were dying of mostly entirely preventable complications such as birth asphyxia, prematurity and neonatal sepsis. This was compounded by the fact that newborns were invisible in the global burden of disease estimates in 2005, which meant there were no focused interventions tailored to meet their needs during the earlier push of the MDGs. Mother-to-child transmission of HIV was also a grave concern, with only 15 percent of HIV-positive pregnant women receiving antiretrovirals (ARVs) to prevent transmission of the virus to their unborn child.

Entering adolescence on the continent was fraught with health issues, too. These included early marriage, pregnancy, violence, substance abuse and HIV infection. The problems teenagers faced were not helped by the fact that, in 2005, access to modern contraception was limited, with around only 20 percent of people using it.

Confronted with the unacceptably tough and tragic situation for mothers and children in the Region, WHO/AFRO took action to effect change. I often said, "We should not accept living for ever with the worst maternal and child health indicators of the world."[2]

3.1: MATERNAL AND CHILD MORTALITY

Achievements



Thanks to the support Member States received to implement the 2004 Road Map for Accelerating the Attainment of the Millennium Development Goals Relating to Maternal and Newborn Health in Africa, emergency obstetric and newborn care has been strengthened in 43 countries in the Region. Of those, 37 have actioned strategies to increase the level of emergency obstetric care, and 29 countries have included maternal death notification in the Integrated Disease Surveillance and Response (IDSR). This means that health ministers, WHO and other partners working on health in the Region, are more able to effectively monitor and respond to this tragic issue.

Countries were given further support to improve maternal and newborn interventions through tools and guidelines, such as the WHO Training Manual on Essential Newborn Care (ENC) and the Regional Framework for Elimination of Mother-to-Child Transmission of HIV. The Campaign for Accelerating Reduction of Maternal Mortality in Africa (CARMMA) launched in 2009 by the African Union, under the slogan, Africa Cares: No Woman Should Die While Giving Life, has also paid dividends. Just 4 years after its launch, 37 countries had been supported to launch national CARMMA campaigns, placing significant pressure on governments to act. Twenty-four countries removed financial barriers to maternity and child health services, resulting in increased access and stepping closer to achieving MDGs 4 (reduce child mortality) and 5. Impressively, Cape Verde, Equatorial Guinea, Eritrea and Rwanda are now on track to fulfil MDG5A on maternal mortality. Thirty four others have made progress, and 18 countries have reduced maternal deaths by 50 percent. In addition, the under 5 mortality rate decreased from 173 per 1000 live births in 1990, to 95 per 1000 live births in 2012[2]. (see Box 1 How Liberia reduced under-5 mortality)

Remaining challenges

Although the rewards from efforts made across the board are beginning to be seen, Africa still bears the burden of 47 percent of global under 5 mortality and 56 percent of maternal mortality[3]. As I highlighted during my speech **at the Official Opening of the Task Force on Reproductive, Maternal, Newborn and Child Health in April 2014**, "the under-5 mortality rate of 95 per 1000 live births is still far from the required 58 per 1000 live births to reach the Millennium Development Goal target. The current maternal mortality ratio is still unacceptably high. Indeed, the women and children in the African Region still face a very high disease burden and high death rates."[2]

A multi-pronged approach is required to tackle this. Improving health infrastructure to enable better public access to health care providers, securing more investment, modernizing health facilities and technologies, and increasing human resources are just some of the changes which urgently need to be actioned. Crucially, as I have emphasized, "African countries should keep pushing for primary health care at local level, involving families and communities and improving the access to quality health care. Universal health care is the new global movement that could lead us to improve maternal and child health outcomes."[2]

Box 1 How Liberia reduced under-5 mortality

Between 1990 and 2012 Liberia saw an amazing 70 percent reduction in under-5 mortality, effectively meeting its MDG4 target. This rapid reduction is attributed to a range of factors, from strong health leadership and governance which has implemented effective maternal, neonatal and child health (MNCH) policies, to the solid legal framework the country has in place for pharmaceutical management and the enhancement of the National Drug Service.

Impressively, the country did not allow weaknesses in its health-sector work force to hamper the delivery of care. Instead, resources were channelled into training the local health staff the country *does* have to deliver high impact interventions. Motivating health practitioners to work under often very challenging circumstances was helped thanks to the introduction of performance based incentives.

The Health Management Information System and District Health Information System were also enhanced to enable the collection and use of data to drive health system reform and improve evidence based planning and policy decision making. Crucially, basic preventative and curative MNCH services, such as vitamin A supplementation, women receiving at least four ante-natal care visits, a post-natal visit within 2 days of birth as well as contraceptive advice, were also provided.

All these successes in scaling up the coverage and accessibility of MNCH services were underpinned by the Liberian government's move to prioritize child health and allocate government and donor funds to MNCH.

3.2: NEWBORNS AND CHILDHOOD ILLNESS

Achievements

Child survival in the Region has steadily improved during the past decade, with 15 countries now on track to reach MDG 4, compared to only five in 2006. These developments are, in part, thanks to the capacity building and support WHO/AFRO and partners set in motion, from the Essential Newborn Care Course (ENCC) package aimed at preventing 75 percent of newborn deaths due to the preventable complications mentioned above (see Context), to guidelines for Postnatal Home Visits for Mothers and Newborns. The former has been taken up by 35 countries, and the latter implemented in 26.

An even larger number of countries have been supported to develop and implement WHO/AFRO's Strategy on Child Survival. Launched in 2006, 38 countries are on board and the pace of reducing under 5 child mortality has picked up, with a 45 percent decrease overall since the most recent data was released in 2013. There is also expanded coverage of the Integrated Management of Childhood Illness (IMCI), a WHO and UNICEF devised strategy for involving families, community health practices and health care workers in the care of children under 5. The strategy includes speeding up the referral of seriously ill children, and promotes improved nutrition and the correct implementation of prescribed treatment for children

being cared for at home. Twenty-eight countries are now casting the IMCI net wider to reach over 75 percent of target districts.

This improvement has been supported by a range of WHO-backed resources and guidelines, including Distance IMCI Learning Tools, Emergency Triage, Assessment and Treatment (ETAT), and Infant and Young Feeding (IYCF). Life saving studies in this area have also been carried out under my leadership. One of these revealed that newborns with signs of sepsis, a blood infection, could be treated with a simplified course of antibiotics if quickly identified by community health workers. Crucially, this kind of finding increases the options for access to early and effective life saving treatment at community level.

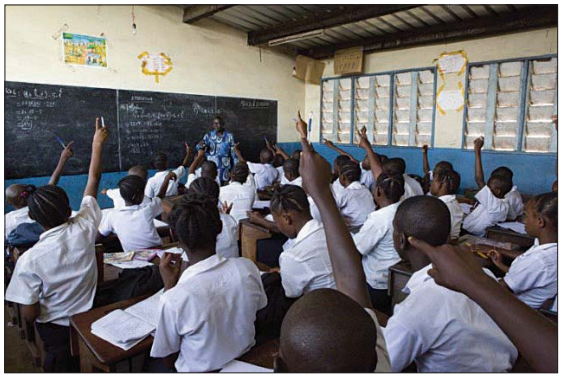
Remaining challenges

Despite the progress, most countries are still not on track to meet MDG 4 by 2015. This is due to a whole range of obstacles such as poor coordination among partners, limited number of skilled health workers, inadequate financial support, and other system issues which compromise the provision of obstetric and neonatal emergency care[4]. To address this, I established a task force on Reproductive, Maternal, Newborn and Child Health (RMNCHTF) in 2013 to creatively advise on the action to take to improve maternal, newborn, child and adolescent health now, and beyond 2015[2].

The task force, met for the first time in April 2014 and recommended increased investment in health at all levels; to re-design health systems in light of the changing environment, such as rapid urbanization; climate change; women's, children's, and adolescents' rights; and to promote inter-country collaboration between training institutions to meet the human resources needs in the most disadvantaged countries. It further advised on strengthening the capacity at grass root level to collect reliable data, and analyse and use such data effectively for improving reproductive, maternal, child and adolescent health services.

3.3: ADOLESCENT HEALTH

Achievements



Many teenagers across the continent have to contend with a barrage of unimaginably tough problems (see Context above). Although a regional strategy on adolescent health was launched in 2001, the number of challenges Member States and partners were attending to in other areas of health, meant little was done before 2006 for the strategy to have any real felt impact. Since then, there has been a wave of initiatives to implement adolescent health interventions. WHO/AFRO has helped accelerate this push by developing national policies and strategies, guidelines and tools alongside Member States. To help plan and track the implementation of these interventions, WHO assisted with the Regional adaptation of a set of adolescent indicators so they could be used across the continent. The Organization also collaborated with UNICEF and UNFPA to develop ways countries can identify priority adolescent health interventions.

A key intervention was the introduction of the HPV vaccine in 2013[5] to help prevent and control cervical cancer. So far, 20 countries have introduced the HPV vaccine into their adolescent health programmes either nationwide, or through pilot projects. In addition, 30 countries have developed their adolescent health policies or strategic plans; and 23 have introduced teenage friendly health service standards, such as Zimbabwe (see Box 2 Making our health service adolescent friendly).

Remaining challenges

As with most issues in this chapter, the scaling up of proven interventions is hindered by weak health infrastructure and inadequate community involvement. In order to stand any hope of moving forward, strategies and interventions must be defined and implemented with teenagers at the helm. The whole community, from parents and teachers to national authorities and civil society, need to be far more aware of adolescent health issues so they can respond to them appropriately and support teenagers in their care. Adolescent health interventions must also be expanded, and properly monitored and evaluated to ensure they are reaching those in need.

Box 2 Making our health service adolescent friendly

In Zimbabwe in 2009, 4.2 percent of girls between the ages of 15 and 19, and 10.6 percent aged 20 to 24, were HIV positive[6]. Pregnancies in the same age group had increased, with 24 percent of girls between the ages of 15 and 19 contending with unplanned pregnancies in 2010/11, compared to 21 percent in 2005. There were also high unsafe abortion rates, a lack of adolescent friendly health services and a high student drop-out rate partly due to the health issues.

To address this, the Zimbabwean Ministry of Health collaborated with WHO to launch a pilot project focusing on behaviour change among young people aged 19–22, and delivery of effective quality health services for them. Parirenyatwa Nursing School in Harare, Zimbabwe, was the testing ground. The main aim was to reduce unwanted pregnancies among nursing students at the school, but also to use this and HIV prevention as a way in to deal with other youth health issues.

Crucially, it was a student run programme, so teenagers were involved in the planning and monitoring of the project. This meant it was in tune with the needs of their peers, and patient confidentiality was prioritized. As a result, more than 75 percent of students used the service, which is still running, during the 2-year pilot. Here is what happened:

- Pregnancies reduced from 21 in 2009 to 2 in 2011. The total number of student nurses at Parirenyatwa, including men, was around 594 in 2009 and 450 in 2011.
- Unsafe abortions reduced from 5 in 2009 to one in 2011
- Students from other schools and nursing colleges within Harare and the university began to use the service.
- Similar services have been established at Harare Nursing School and Chitungwiza Nursing school, also in the capital. These are only open to student nurses and the Nursing Directorate has requested that remaining nursing schools in the country establish copycat services. However, Zimbabwe also has other youth friendly facilities that offer services to reduce unwanted pregnancies among teenagers and young adults.

3.4: MOTHER-TO-CHILD TRANSMISSION OF HIV

Achievements

With 70 percent of the world's new HIV infections occurring in sub-Saharan Africa, and 75 percent of HIV-related deaths[7], preventing the transfer of the virus from women to their babies is a critical way of reducing the spread of the disease. WHO has been instrumental in eliminating mother-to-child transmission by supporting countries in the African Region to scale up quality Prevention of Mother to Child Transmission of HIV (PMTCT) services (see Box 3 The difference PMTCT services make).

So far, 35 countries have implemented these services. In addition, the 2013 WHO guidelines on the use of antiretrovirals (ARVs) was distributed throughout the Region, with 21 priority countries receiving support to action the guidance[8]. A central recommendation was that all HIV-infected pregnant and breastfeeding women, and all infected children under 5, are given ART immediately.

The guidelines also recommend immediate antiretroviral therapy (ART) for HIV-infected children under 5, and HIV-infected pregnant and breastfeeding women. This should help further boost the increase in the number of HIV positive pregnant women who received ARVs to prevent the transmission of the disease to their babies from 15 percent in 2005, to 63 percent in 2012. Between 2009 and 2012 alone, the 29 percent increase in ARV for PMTCT is estimated to have reduced new HIV infections among children by 37 percent. Continued successful implementation of the 2013 guidelines will only reduce the number of new HIV infections further.

Box 3 The difference PMTCT services make

Mrs Chinnie V. M. Sieh has worked as a Prevention-of-Mother-to-Child Transmission Coordinator in Liberia for 2 years. She explains why the services are so important for pregnant HIV positive women.

"These services get mothers started on ARVs early during pregnancy and this reduces the viral load and prevents mother-to-child HIV transmission. The services also mean exposed infants can be placed on prophylaxis for an extended period during breastfeeding to reduce the risk of them contracting the virus.

I have worked with the National AIDS & Sexual Transmitted Infections Control Program for four years. First as a Clinical Mentor at the Redemption Hospital in Bushrod Island, Monrovia, Montserrado County, where I set up the PMTCT programme and coached clinicians and mothers on PMTCT. Our success rate at the facility has been enormous. In fact, through the PMTCT programme, approximately 90 percent of babies tested negative for the virus. I was later elevated to the Coordinator position to ensure that we achieve MDGs 4, 5 and 6. Liberia has achieved MDG 4, and though our country appears to be making progress towards MDGs 5 and 6, we are not likely to achieve these by the target year of 2015. However, our PMTCT coverage did increase from 13 percent in 2009, to 64 percent in 2013.

But it's not just us doing all the hard work. Community based organizations, including support groups and volunteers, play a critical role in generating demand for PMTCT services, assisting HIV positive pregnant women to adhere to care and treatment, and tracing patients who miss appointments."

Remaining challenges

Not only are women in the Region dying unnecessarily during and after childbirth due to limited quality obstetric care, HIV is also still a significant cause of maternal deaths in sub-Saharan Africa. According to the 2013 maternal mortality estimates, the countries with the highest incidence include South Africa with 41.4 percent, Botswana with 23.5 percent, Swaziland with 18.5 percent, and Zambia with 15.4 percent.

Accessing ARVs if you are an HIV positive child also varies dramatically across the Region. In fact, as of December 2012, the only country that provided more than 95 percent of HIV positive children with ARVs was Botswana. Meanwhile, Democratic Republic of Congo managed 9 percent coverage, Nigeria 12 percent and Ethiopia 24 percent.

PMTCT must be scaled up across the Region to urgently address these shortfalls. But this can only be done if enough skilled health care workers are in place, and health systems are stronger and better resourced.

3.5: FAMILY PLANNING

Achievements

Family planning empowers women to take control of their fertility and plays a major role in decreasing maternal and newborn mortality and the transmission of HIV. Yet, despite playing a major role in reproductive health and primary health care, the heavy burdens in other areas of health in the Region, from the HIV/AIDS crisis to managing the health fall-out from conflicts, have meant that family planning has slipped down the list of most national health priorities[9].

Recognizing the need to place family planning back on the health agenda, WHO and partners developed a toolkit for pushing it up every Member State's priority list and provided the technical and financial support to implement family planning advocacy programmes and strategies across the Region. As a result, 22 countries have renewed their commitments to family planning and there was a 7 percent increase in the use of contraceptives between 2005 and 2012. This no doubt contributed to the drop in the number of births women *could* have had by the end of their reproductive years from 6.2, to 4.8 between 1990 and 2012[10].

More broadly, WHO/AFRO has supported other key initiatives to address women's health in the Region. The year 2009 saw the establishment of the Commission on Women's Health in the African Region, chaired by Liberia's President, Ellen Sirleaf-Johnson. A report, Addressing the Challenge of Women's Health in Africa, was launched in 2012 and its recommendations, which pivot around the need to adopt a human rights and multi-disciplinary approach to tackling women's health issues, were endorsed by ministers of health in 2013[11].

Remaining challenges

Human and financial resource constraints, which lead to the slow implementation of agreed strategies, remain a major challenge to establishing family planning services in the Region. This void has impacted on the availability of contraception. Indeed, it is estimated that more than 47 million women on the continent would like to stop or delay having children, but are unable to because they cannot access effective contraception methods, and where the choice is often limited or too expensive[12]. There is also a reluctance to use what available contraception there is because of a lack of information on the side effects, as well as cultural and religious opposition in some areas.

These barriers must be overcome by increasing good quality, effectively monitored family planning services, and reducing financial, religious, social and geographic blocks to them.

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Chapter 4

Accelerated action on HIV/AIDS, TB and malaria

"As Governments and Partners get involved in the Global Movement on Universal Health Coverage, HIV/AIDS, TB, and malaria related interventions should be scaled-up and reach those populations that are not yet covered. We should also advocate for increased domestic investments in the fight against the three diseases in particular, and in health systems in general."

Sambo, 2014[1]

CONTEXT

When I became Regional Director in February 2005, I made HIV/AIDS a top priority – with good reason. The epidemic proportions of HIV/AIDS in Africa had turned it into one of the biggest health crises the continent faced. The figures spoke for themselves: an estimated 23 million people on the continent were living with HIV[2]; 3 million new infections occurred annually; 50 percent of those were in young people between the ages of 15 and 24; more than 13 million children had been orphaned by HIV/AIDS[3]; around 90 percent of people did not know their HIV status; a measly 15 percent of pregnant women living with HIV received ARVs to prevent transmission of the virus to their babies; just 14 percent of people overall were receiving antiretroviral therapy (ART) and nearly 1.8 million adults and children died of AIDS in 2005. During the 2005 Consultation on Prevention of HIV Infections in the African Region, I said, "it is morally indefensible to allow millions of people living with HIV/AIDS to die, while effective medicines to turn HIV/AIDS into a chronic disease exist. "

Fortunately, regional and global partners were on our side. The international community made its first commitment at the G8 Summit in Gleneagles in 2005, Scotland, to achieve universal access to HIV prevention, treatment and care for all those in need. Three months later, this commitment was endorsed by all UN Member States at the UN Millennium Summit[4]. The 3 by 5 Initiative, launched by WHO Director-General in 2003 in a bid to place 3 million people living with HIV on antiretroviral therapy by 2005, was also coming to an end. The time was right to capitalize on these initiatives and build on the regional and global awareness and support they had galvanized.

Alongside HIV/AIDS, TB and malaria were also major threats to public health in the African Region. Over one million cases of TB were reported in 2005, and HIV/TB co-infection rates were on the increase – particularly in Eastern and Southern Africa. To complicate matters further, the continent was contending with 79 percent of the world's malaria burden, which represented around 192 million cases in 2005[5]. The huge toll all this was taking on

individual households, communities and nations, both in emotional and economic terms, was immense. Urgent action was needed on all fronts.

4.1: HIV/AIDS

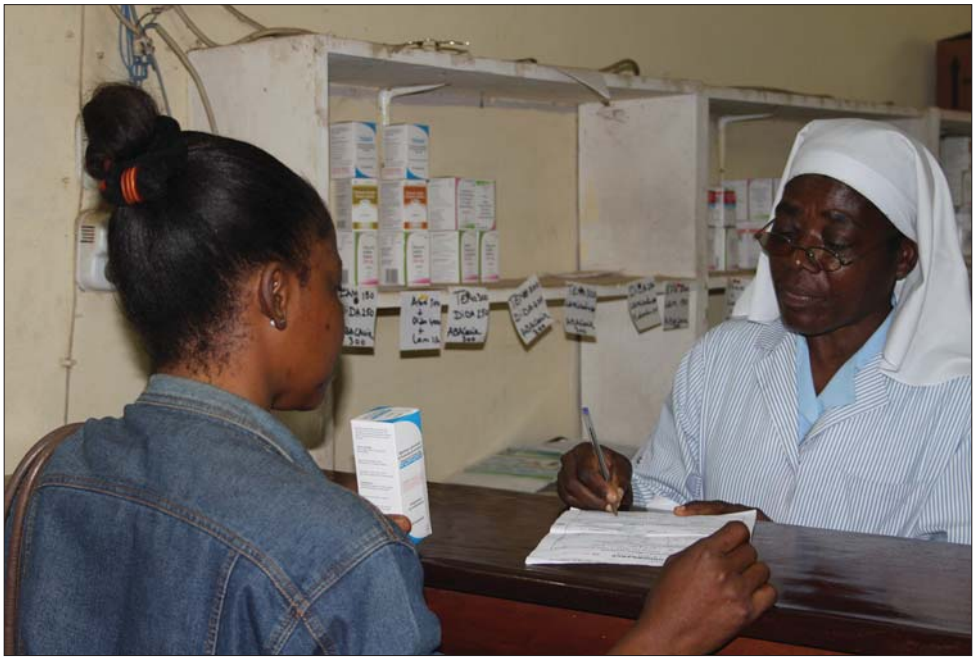
Achievements

The stark reality of HIV incidence on the continent prompted the WHO Regional Committee for Africa to declare 2006 the 'Year for Acceleration of HIV Prevention in the African Region', and the 'Strategy for Renewal and Acceleration of HIV Prevention'[6] was put in place. The 3 by 5 Initiative had already seen countries commit to a public health approach in the fight against HIV/AIDS by decentralizing services, and extending them beyond major cities to make treatment as widely available and easily accessible as possible to all in need. But, despite this progress, there was no time for complacency. The goal of the Strategy was to build on the efforts already made through a raft of actions. These included urging Member States to reinvigorate HIV treatment and prevention by establishing stronger and effective partnerships, leadership and coordination, strengthening health systems and increasing funding in the area. To underline the urgency of these goals, 53 African countries adopted the Brazzaville Commitment during a meeting at the Regional Headquarters in March 2006. This called on all Member States to take bold action to address bottlenecks that were impeding the implementation of HIV services.

By 2010, huge progress had been made. Access to antiretroviral therapy had shot up 50 fold from 100,000 in 2003, to 5.1 million. This meant nearly half of the 10.4 million people in need were now receiving treatment[7]. Universal access had been achieved in five countries, and 12 had more than 50% coverage – demonstrating the effectiveness of the public health approach, which was kick started by the 3 by 5 Initiative. During the same period, the percentage of pregnant women living with HIV who were receiving treatment to prevent mother-to-child transmission (PMTCT) increased from 15 percent to 60 percent. By the end of 2012, even more gains had been made. A total of 7.5 million people were now on life saving ART[8], and 3 percent more pregnant women were receiving treatment compared to just 2 years earlier. This PMTCT scale up contributed to the significant reduction in new HIV infections among children from 470,000 in 2005, to 260,000 in 2012. Voluntary male circumcision, a proven HIV prevention, had also increased on a massive scale – leaping from just 21,000 in 2008, to 5 million in 2013[9].

A resolution on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection, was made by the African Regional Committee, which called on Member States to make the WHO guidelines on the use of ARVs and related service delivery country specific for increased efficacy[10]. WHO/AFRO supported Member States to help bring context focused treatment to fruition via a range of support mechanisms. These include strengthening national laboratory capacity for HIV diagnosis and monitoring of patients on ART, developing national health sector strategic plans, developing monitoring and reporting systems for tracking the epidemic, as well as advocating for funding from global health initiatives such as the PEPFAR and the Global Fund to Fight AIDS, TB and Malaria. In addition, the use and adaption of WHO tools, such as the WHO Provider Initiated HIV Testing and the WHO Integrated Management of Adolescent and Adult Illness (IMAI) has contributed to services becoming more accessible at primary care level, therefore increasing adherence to ART[11].

The past decade has witnessed significant achievements in reducing the incidence of HIV on the continent. This is thanks to the concerted efforts by Member States and their regional and



global partners. Of course, none of the success would have been possible without the hard work, dedication and cooperation of health practitioners working in the field (see Box 1 This much I know about the African Region's HIV/AIDS burden…), and their patients. All concerned can take pride in the fact that there was a 26 percent reduction in new HIV infections between 2005 and 2012, and 34 percent less people died from AIDS related conditions during the same period. This means the Region is on track to achieving MDG 6A – halting and beginning to reverse the spread of HIV/AIDS by 2015.

Remaining challenges

The progress the African Region has taken in this area has paid dividends, but as long as sub-Saharan Africa still carries 70 percent of the global HIV burden, much remains to be done. The fight to stem the continuing high levels of new HIV infections and AIDS related deaths is made tougher by the virus' interaction with other communicable diseases like TB and malaria (see below), viral hepatitis and non-communicable diseases (see Chapter 6), such as cardiovascular disease and cancer.

Worryingly, the regional response is not sustainable because of the heavy reliance on external donor funding. Domestic resources must be allocated and investments made in health infrastructure in order to improve HIV prevention and care interventions. The high levels of gender inequity, stigma and discrimination, which are still associated with HIV infection, also need to be stamped out.

WHO must continue to lead the Region's health response to HIV/AIDS by supporting Member States and working in partnership with UNAIDS, GFATM, multilateral donors, the private sector and civil society. Alongside this, WHO needs to continue monitoring trends of the epidemic and the response to it, as well as rolling out norms, standards and guides across the Region for HIV prevention and treatment.

Box 1 "This much I know about the African Region's HIV/AIDS burden…"

Dr Elly Katabira, FRCP, was President of the International AIDS Society from 2010–2012 and is a pioneer in the fight against HIV/AIDS in the Region. He is currently Professor of Medicine at the College of Health Sciences, Makerere University, in Kampala, Uganda.

* *A decade ago, I was working in Mulago Hospital, Kampala, the teaching hospital for the College of Health Sciences*. I was head of the AIDS clinic that I founded in 1987, which has now been transformed into the Infectious Diseases Institute (IDI). In 2005, we were seeing 50−70 patients daily, including those admitted on the medical wards.

* *Many health workers had heard about antiretroviral drugs and how they could save people from dying from HIV/AIDS, yet very few knew how to use them*. They were very eager and anxious to dive into action. The challenge was to train them well and quickly enough to cope with the desired accelerated access to ART.

* *I was hopeful that the goal of achieving universal access to HIV prevention, treatment and care for those in need could be realized* – there had been so much suffering and loss of life that everybody was willing and ready to get involved. The challenge for us was how quickly we could give them the basic tools of HIV prevention, treatment and care to contribute effectively and safely.

**Certainly as a Region, we have done a lot in trying to bring down the HIV burden, and we continue to do so, yet we still contribute more than 70 percent of the global problem*. This can be very demoralizing to both the health workers who are implementing the drive to lower the HIV burden and the bilateral agencies, including governments, that are funding these drives. WHO need to continuously reassure all stakeholders that they are doing the right thing, but at the same time regularly review the HIV prevention and care strategies to ensure a sustainable success.

4.2: TB

Achievements

Back in 2005, sub-Saharan Africa was dealing with 25 percent of the world's TB cases[12]. Adding to this pressure was the growing incidence of HIV/TB co-infection, particularly in Eastern and Southern Africa. The WHO Regional Committee for Africa met in Maputo, Mozambique, in August that year and declared TB an emergency on the continent[13].

Member States were called upon to take urgent action to contain the growing epidemic by, among other things, increasing political commitment and national investment in TB programmes. Unfortunately this call to action did not deliver adequate national funding for TB programmes. Contending with heavily indebted, overstretched economies meant most Member States had neither the financial means, nor robust practical systems, or enough skilled health practitioners in place to meet the need. Funding from international donors had to be accessed and WHO/AFRO supported countries to gain assistance, especially from the Global Fund to Fight AIDS, TB and Malaria.

WHO/AFRO also intensified support to countries for the adaptation and implementation of the World Health Assembly's 2006 Stop TB Strategy which, broadly speaking, aims to ensure

all TB patients have access to high quality diagnosis and treatment by 2015. One of the central components of the 6-pronged strategy is the expansion of DOTS (directly observed treatment with short course), said to be the best curative method for TB. The 5-pronged approach covers political commitment with sustained financing; using bacteriology (studying bacteria samples) to detect cases; an uninterrupted, ongoing supply of anti-TB drugs; a standardized recording system that allows assessment of treatment; a standardized, health worker observed treatment regimen[14], WHO/AFRO, alongside partners and donors, supported countries to develop and implement the TB Strategy. By 2013, at least 36 countries had implemented community based DOTS activities. Most now have 100 percent DOTS coverage.

Poverty is one of the main drivers of the TB epidemic, with the majority of people afflicted being from the poorest most vulnerable communities. It is also fuelled by simultaneous HIV infection, with those living with the virus being most susceptible to TB, and often dying as a result. Because of this, WHO prioritized TB alongside HIV[15], promoting very successful collaborative TB/HIV interventions across the Region. For instance, 74 percent of TB patients were tested for HIV in 2012, compared to just 11 percent in 2005, while 55 percent of HIV positive TB patients accessed ARVs in 2012, compared to less than 10 percent in 2005.

Action was also taken to combat multi-drug resistant (MDR) TB, a major problem which further complicates treatment of the disease. To address the scarcity of medical doctors trained on TB I decided to create training courses for TB, TB/HIV and MDR-TB at the Regional Public Health Institute in Ouidah, Benin and Kemri, Kenya since 2012. So far, the courses have trained more than 200 health care workers from across the Region and significantly increased awareness of MDR-TB, and the capacity of treatment in the Region[16]. As Dr Mabumba Salongo, one of the 2012 Kemri course participants, said, "we have acquired knowledge, contacts and experience that will steer our programmes to another level." WHO also launched the Green Light Committee (GLC) in 2013 to improve access to second line TB medicines for MDR-TB treatment, meaning that African countries struggling to tackle MDR-TB had broader treatment options.

The Regional TB incidence has been declining since 2010 and has reached a plateau[16]. Impressively, this means WHO/AFRO has achieved the MDG 6C target[17]. The incidence of TB has fallen in five out of the nine countries that had a heavy burden of the disease, including Kenya and Tanzania. In 2012, three Member States, (Ethiopia, Uganda and Tanzania), had achieved the Stop TB target by halving the prevalence of TB since 1990, and four (Ethiopia, Mozambique, Uganda and Tanzania) had halved mortality rates during the same period. By the end of 2013, the increasing incidence of TB had been halted and TB treatment had also improved, with 15 countries achieving treatment success rates of 85 percent or more.

Remaining challenges

Despite the headway made, there is still an awful lot to achieve. On World Tuberculosis Day 2014, I reminded that, "every year nine million people globally get sick with TB. Unfortunately a third of them do not get the TB services that they deserve. Most of these three million people live in the world's poorest and most vulnerable communities, including those in the African Region. TB is curable but it remains a major public health problem. It is estimated that TB killed over half a million people in the Region last year."[18]

The poorest and most vulnerable in the African Region, including migrants, refugees, mining communities and prisoners, are most at risk of acquiring TB. These groups also have the least access to TB services which makes it enormously difficult to realize the goal of eliminating

the disease; or even making further headway with the Stop TB target of achieving a 50 percent reduction in incidence, prevalence and mortality, compared with 1990.

The number of drug-resistant cases reported annually by 44 countries has increased from 3501 in 2004 to 18,129 in 2012. However, this may not represent a rise in actual numbers, but instead reflect increased awareness as a result of the MDR-TB training courses. Even so, at the time of writing, the Region accounted for 75 percent of the world's HIV positive TB cases.

In order to achieve universal access to TB services, treatment must be expanded, prevention strengthened, and research intensified. Apart from having well-resourced health systems in place, this requires creativity and interdisciplinary collaboration in order to combat HIV/TB co-infection rates, collaborative activities must be scaled up. Indeed, it is the responsibility of all partners, under the leadership of Member States, to make this a reality.

4.3: MALARIA

Achievements

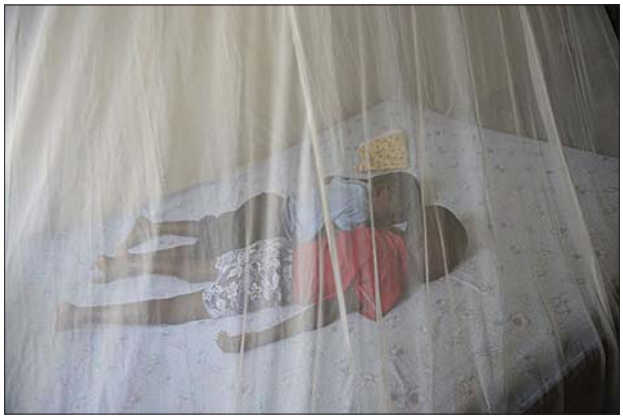
The global malaria burden has always been highest in the African Region, but the epidemic peaked in 2005. This, despite the 2000 Abuja Declaration on Malaria and the exponential increase in anti-malaria interventions which this instigated across the Region[19]. For instance, there were an estimated 192 million cases in 2005, with 80 percent of them occurring in sub-Saharan Africa. So, in 2005, the World Health Assembly resolved to reduce malaria by 50 percent by 2010, and 75 percent between 2000 and 2012.

In 2008, the UN Secretary-General, Ban Ki-moon, added his voice to the call for 100 percent coverage of malaria control interventions for all at-risk populations by the end of 2010 to halt malaria deaths. A number of alliances and initiatives were launched, including the 2009 African Leaders Malaria Alliance (ALMA), which was founded as a platform for coordinated action to end malaria deaths. In the same year, the WHO Regional Committee for Africa adopted a resolution on Accelerated Malaria Control: Towards Elimination in the African Region[20].

These regional and global commitments to malaria control and elimination, between 2005 and 2012, culminated in global funding for anti-malaria programmes increasing from less than USD 500million in 2005, to USD 1.84 billion in 2012. This represented a 368 percent increase in global investments in malaria control, with Africa receiving 68 percent of funds in 2012. This financial injection led to rapid expansion of malaria control interventions, and in July 2013 the Abuja Declaration of the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria called on all Member States to accelerate the implementation of the earlier Abuja Commitments, including maintaining and increasing malaria funding[21].

The proportion of the population sleeping under an insecticide treated bed net (ITN) is estimated to have increased from 2 percent in 2000 to 36 percent in 2012[19]. While those using indoor residual spraying (IRS) to kill mosquitoes increased from less than 5 percent in 2005 to 11 percent in 2011. In fact, implementation of the IRS policy is estimated to have protected 73 million people from malaria. But more needed to be done.

WHO's normative, technical and policy guidance support was instrumental to achievements made in the prevention and control of malaria. For instance, countries were supported to develop proposals for grants from The Global Fund to Fight AIDS, Tuberculosis and Malaria



in order to mobilize finance so interventions could be scaled up. By the end of 2011, 36 countries in the African Region had adopted **Intermittent Preventive Treatment of malaria in pregnancy** (IPTp), a full course of antimalarial medicine given to pregnant women to reduce complications for them and their babies, as national policy. By 2012, all countries in the Region had adopted a policy on the use of long lasting insecticide-treated nets (LLINs), and 27 countries implemented IRS policy. Meanwhile, six Member States in the Sahel Region engaged in cross border initiatives to control malaria and implemented the WHO policy on Seasonal Malaria Chemoprevention (SMC). This involves giving children courses of antimalarials during the malaria high season, when the rains come in the Sahel. It is shown to be 75 percent protective against uncomplicated and severe malaria in children under 5[22]. Although tragically large numbers of children are still dying of malaria, between 2000 and 2012, malaria death rates among children under 5 decreased by 54 percent and malaria incidence reduced across the Region's population by 31 percent.

This shrinking map of malaria in the African Region certainly calls for celebration, but there is also no room for anyone to "take their foot off the gas". As I recently declared that, "the malaria burden in countries has been considerably reduced. Eleven countries with on-going malaria transmission have achieved reductions in malaria case incidence or malaria admission rates of 50 percent or more. An estimated 337 million cases and 3 million deaths have been averted between 2001 and 2012 in Africa. Despite the progress made, I believe there is still the need to do more."[23]

Remaining challenges

Whilst there have been great achievements, one stark fact underlines how much more urgently needs to be done: malaria still kills about one child in Africa every minute. Yet shockingly, global funding for malaria has been in decline since 2011, as has the expansion of anti-malaria interventions. This is a major threat to the sustainability of the malaria control effort in the Region. Indeed, as of 2012, there is a 51 percent worldwide funding gap for malaria control. This means that 2012 funding translated to about 2.5 USD per person at risk in the African Region. The sustainability of funding in the African Region is also threatened by global economic vagaries as less than 10 percent of funds spent on malaria control in the Region in 2012 came from domestic governments. Again, compared the 88 percent of domestic funding allocated to malaria control in the European and American Regions, the spending in the area of the world which suffers the greatest malaria burden is alarmingly low. It is no real surprise

that the African Region is nowhere near meeting the Roll Back Malaria 2015 targets of reducing the rate of malaria by 75 percent.

"The funding gap in malaria control in the African Region leaves Africa bleeding from malaria," says Issa Sanou, Acting Regional Advisor for Malaria, WHO/AFRO. "Every malaria case and every malaria-associated death in Africa is an indictment of the health system, an evidence of the failure of the health system to avail malaria prevention and case management services to those who need them, at the place and time they need them. To the patient, the malaria funding gap means more suffering, pain, poor school attendance and perhaps death. These deaths are avoidable given the availability of effective interventions. The malaria funding gap is, however, surmountable by raising more funds and maximizing the impact of money spent. Three steps are required enhanced domestic investments, improvement of the effective use of available resources, and maintenance of malaria high on the health and development agenda, particularly in the global post-2015 development agenda."

Box 2 Working together to stamp out malaria[21]

In 2009, the WHO resolution on Accelerated Malaria Control set out urgent steps which need to be taken to eliminate malaria. Here is a summary of the call to action

Member States should:

- Integrate malaria control in all poverty reduction strategies and national health and development plans.
- Support health systems strengthening for scaling up essential malaria prevention and control.
- Support ongoing research and development initiatives for new medicines, insecticides, diagnostic tools and other technologies for malaria control and elimination.
- Strengthen the institutional capacity of national malaria programmes for better coordination of all stakeholders and partners.
- Lead joint programme reviews, develop need-based and fully budgeted strategic and operational plans with strong surveillance.
- Strengthen health information systems, integrate disease surveillance and response, and undertake surveys to generate reliable evidence.
- Invest in health promotion, community education and participation, sanitation, and increase human resource capacity.
- Ensure rigorous forecasting, procurement, supply and rational use of affordable, safe medicines.
- Develop cross-border malaria control acceleration initiatives.

WHO/AFRO should:

- Facilitate high-level advocacy, coordination of partner action in collaboration with partner institutions.
- Support the development of new tools, medicines, applied technologies and commodities.
- Report every other year on the progress made in the implementation of accelerated malaria control in the African Region.

In light of the Global Technical Strategy (GTS) for malaria, currently under development for 2016–2025, partners must close the annual funding gap for malaria control and Governments should prioritize malaria control and elimination, and increase domestic funding (Box 2).

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Chapter 5

Intensifying the prevention and control of communicable diseases

CONTEXT

Great progress has been made in averting premature deaths from communicable diseases in the African Region over the past two decades, with deaths from illnesses like measles declining rapidly since 1990[1]. But, in contrast to global trends, which have seen the disease burden shift from communicable childhood diseases to non-communicable adult diseases as the leading loss of life in much of the world, communicable diseases still dominate in the African Region. HIV/AIDS, diarrhoeal diseases, malaria, tuberculosis and childhood diseases account for 88 percent of deaths from communicable diseases.

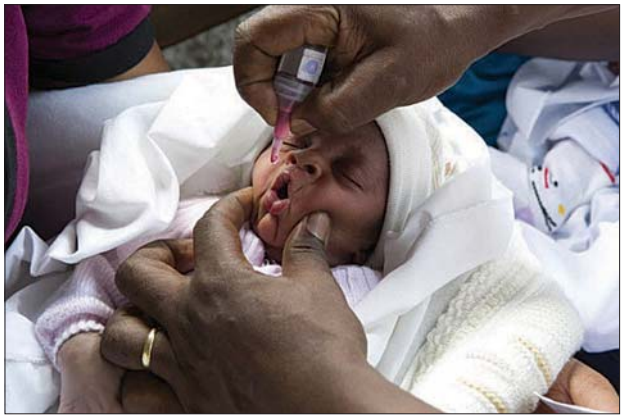
Neglected tropical diseases (NTDs), such as sleeping sickness, leprosy and Guinea worm disease, form another category of communicable diseases that were disproportionately high in the African Region in 2005. As the name suggests, they were largely overlooked despite affecting more than one billion people globally. Half of those affected lived in Africa, mainly in poor, rural communities. They, and their families, including children dropping out of school to look after ill parents, had to contend with disfigurement, disability and death, despite the fact that low cost, simple and effective treatments exist.

The ability of Member States to predict, assess and respond to NTDs, and other communicable diseases, is dependent upon each having a functioning disease surveillance system in place. When I took office in 2005, 43 Member States had assessed their systems in line with WHO's Integrated Disease Surveillance and Response Strategy (IDSR). This was launched in 1998 to improve the availability and use of data to deal more effectively with public health threats. Progress was made and 21 countries reached the target of training health workers in charge of IDSR in at least 60 percent of their districts, and around the same proportion of outbreaks in the Region received a response within 48 hours. But the increasing burden of epidemic prone diseases on the continent meant our team were faced with a Herculean task when it came to develop strategies to prevent and control them.

Building on the success of strong immunization programmes, which were in place in some parts of the Region, was key to moving forward. Intensifying vaccination in order to fill gaps in immunization coverage, seek additional financing to access traditional vaccines, roll out new vaccines and improve vaccine supply and distribution were just some of the issues our team set out to address.

5.1: IMMUNIZATION

Achievements



According to estimates, immunization averts 2.5 million premature deaths a year and protects millions from illness and disability[2]. Child vaccination programmes have had particularly impressive results, with routine immunization established across the African Region and deaths from illnesses like measles dropping by an estimated 88 percent between 2000 and 2012. This has been an accomplishment of governments and communities with effective partnerships from WHO, UNICEF and the Global Alliance for Vaccines and Immunization (GAVI). Meanwhile, polio has been closer to eradication. Thanks to massive efforts by African governments and communities, and effective advocacy by WHO and other partners of the Global Polio Eradication Initiative (GPEI), cases of polio due to wild poliovirus (WPV) plummeted by more than 90 percent between 2005 and 2013. As I explained during the 2012 African Vaccination Week, "as one of the most efficient and cost-effective public health interventions, vaccinations are critical to the attainment of the Millennium Development Goal 4."[3]

With this in mind, and the knowledge that advancing the development and use of high quality vaccines requires well-run national regulatory authorities to be in place, my office, on the advice of the Task Force on Immunization (TFI), an independent group of health experts tasked with advising WHO/AFRO on cost-effective ways of ensuring quality immunization in the Region, established the African Vaccine Regulatory Forum (AVAREF) in 2006. Operating in 19 countries, the network of authorities has the capacity to regulate vaccines and promotes robust standards throughout the African Region. In practice, the existence of AVAREF has meant, among other things, that regulatory reviews and approvals for the phase 3 clinical trial of the candidate malaria vaccine RTS,S/AS01 (the most advanced vaccine candidate against the deadly form of human malaria, *Plasmodium falciparum*), by seven countries was quick and efficient. It also meant all vaccines, including conjugate meningitis A, pneumococcal conjugate (to protect against pneumococcal infections like pneumonia), rotavirus, (to protect against the most common cause of severe diarrhoea among children) and HPV (which protects against cervical cancer) were licensed before use, an important requirement not widely practiced. In keeping with international standards, AVAREF also enables countries to monitor any side effects of new vaccines more rigorously and systematically following their introduction into national immunization programmes.

This is crucial, as, since 2005, a number of new vaccines have been introduced into national immunization programmes, such as hepatitis B and *Haemophilus influenza* type B vaccines. Other new vaccines, including pneumococcal conjugate (PCV) and rotavirus, have also been introduced in 30 and 20 countries, respectively. But one of the most revolutionary public health achievements in the Region during the past decade, if not this century, is the development and roll-out of a meningococcal A meningitis conjugate vaccine (MenAfriVac) to

combat the cyclical epidemics of the devastating illness (see Box 1 The story of Jean-Francois). It causes thousands of deaths every year during the dry season in what is known as the African meningitis belt, from Senegal to Ethiopia, when the Harmattan winds blow south from the Sahara.

MenAfriVac was developed, tested, licensed and introduced as a result of collaboration between African political leaders, scientists, public health officials and the Meningitis Vaccine Project (MVP), a partnership between WHO and PATH (an international health-focused NGO), and funded by the Bill and Melinda Gates Foundation. Not only is it the first time a vaccine has been designed specifically for the African Region and introduced there before anywhere else in the world; but also crucially, it represents the first step for a far-reaching preventive strategy to protect the estimated 450 million people at risk in the 'belt'. Launched in Burkina Faso in 2010, so far more than 153 million people in 12 countries have been vaccinated and there have been no confirmed cases of meningitis A among vaccinated populations since. It is an outstanding accomplishment. As Dr Margaret Chan, WHO Director-General, said when the vaccine was launched, "in fewer than 10 years, we have overcome obstacles that have in the past seemed insurmountable. With a one-time investment to vaccinate populations in all countries of the meningitis belt, nearly 150,000 young lives could be saved by 2015, and epidemic meningitis could become a thing of the past. This is within reach. We must not fail."[4]

The sustainability of all these measures is, of course, fundamental to their continued success. Fortunately, despite the inability of pharmaceutical companies in the developed world to rise to the challenge of producing the vaccine at an affordable price of less than USD 0.50 per dose, the team behind MenAfriVac developed an innovative plan to produce the product within budget. This means it is sustainable.

Yet more long lasting benefits in other areas of public health came off the back of the infrastructure which was deployed in the Region to support immunization in general, and the GPEI. The surveillance and laboratory networks for polio and other vaccine preventable diseases, have been used to strengthen integrated disease surveillance systems in most countries. Staff who were brought in to primarily support the implementation of the polio eradication initiatives and strategies, have also been at the centre of strengthening immunization systems and supporting the elimination and control of other vaccine preventable diseases. Additionally, they have been involved with the response to other major public health threats including the Ebola virus and Marburg virus outbreaks.

Remaining challenges

The political commitment and financial and technical resources that have been galvanized in the Region to alleviate suffering from vaccine preventable diseases during the past decade have been immense. But, with such a vast continent to serve and multiple obstacles to overcome, there are still significant gaps in vaccine coverage which need to be filled. As I put it during the 2012 African Vaccination Week, "further improvements in coverage, expansion of resource pools and large-scale introduction of new vaccines targeting an increasing number of infectious diseases, are needed to sustain the gains."[3]

The disparity of vaccine coverage is a real challenge, with extreme differences in the availability of routine immunization of children being one of the most urgent issues. For instance, 99 percent of children in Eritrea receive the correct dosage of diphtheria, tetanus and pertussis (DTP3), an essential component of childhood immunization programmes, but only 33

percent of children receive it in Equatorial Guinea. According to WHO-UNICEF coverage estimates, five countries still have less than 60 percent measles coverage and one country, Nigeria, continues to battle with endemic polio. This inequity gap in vaccine coverage, which has been narrowed in countries like Rwanda and Swaziland, is usually associated with lower education levels, low incomes and living in rural areas. These issues which can only be tackled using a robust inter-sectorial approach.

Box 1 The story of Jean-Francois

Dr Marc LaForce, Director of the Meningitis Vaccine Project, tells the story of a young man who inspired him to keep pushing to find a vaccine to combat the devastating meningitis epidemics in sub-Saharan Africa.

"Jean-Francois is a personal experience that affected me a great deal, and this occurred during the epidemic of meningitis in 2007 in Burkina Faso. At that time I was in Ouagadougou at the Yalgado Hospital seeing the infectious disease physician who was there and at the same time I met Jean-Francois and his mother. I chatted with his mother and heard a typical story. Jean-Francois was an 18 year old in perfect health. Captain of the soccer team at his school, first in his class, a role model to his family and to his friends who suddenly developed a high fever, headache, and was brought into the hospital a week before I saw him.

He was desperately ill, in coma, and teetered between life and death for three or four days before his temperature finally responded to treatment with antibiotics. I saw him on the seventh day as he was about ready to be discharged, was there when the infectious disease physician was talking to his mother. I'd had the opportunity to speak with him as well, and it was clear during my discussions that this is a young man who had lost a lot of mental faculties as a result of his illness. He was now stone deaf, and I remember the physician as he was discussing with his mother, telling her that being deaf was not easy in Africa.

We finished our consultations and returned to Geneva. I found his picture a couple of months later and I said, 'I wonder what happened?' So I called Rodrig Barry, our communications person who was with me at the hospital when we were there. He said he knew the family and I said, 'would you mind dropping by just to see how Jean-François was doing?' The following day I received a phone call from Rodrig, and he said, 'I have bad news'. He said, 'I got to the family and the family was in mourning'. And I said, 'what happened?' He said apparently after Jean-Francois had returned to the house the whole family had adjusted, they'd developed their own sign language and he was doing perfectly well. Two days before, he was out with his brothers and sisters playing soccer in the front yard, just fooling around with a ball and the ball rolled into the street. He never heard the truck that ran him over.

When he told me that, a profound sadness came over me, and also a sense that this was colossally unfair. You had a person who could have been the president of that country. Who all of a sudden was maimed by a disease that was preventable, and then killed from a complication of that particular disease. That clearly wasn't right. So that episode has certainly helped stir me, when times have been difficult, to say that no we really have to press on, we've got to finish with this so that this doesn't happen again."[5]

5.2: DISEASE SURVEILLANCE AND RESPONSE

Achievements

WHO Strategic Health Operations Centre

By 2006, most countries in the Region had started implementing the IDSR strategy and all of them were focused on WHO/AFRO's list of 19 priority diseases in 2001, which laid the foundations for tackling these cohesively. By 2010, 44 diseases were on the priority list. These include measles, yellow fever, pneumonia, acute watery diarrhoea, cholera, meningitis, malaria, TB, AIDS and leprosy. In 2007, this capacity for detecting and responding to threats to public health was reinforced when African Member States recommended that the International Health Regulations (IHR, 2005) be integrated into the ISDR strategy. This way, major non-infectious and infectious disease outbreaks could be responded to holistically, not only at a regional level, but also at an international level – working towards fulfilling the IHR recommendation that all countries should be able to detect and respond to disease outbreaks which may have an impact internationally, and report them to WHO for collective action.

Building on this mapping out of the continent's ability to respond to public health needs even further, WHO/AFRO developed and rolled out a number of other strategies and three key resolutions that are being implemented by Member States. The resolutions are: the establishment of centres of excellence for disease surveillance, public health laboratories, food and medicines regulation[6]; and the strengthening of Outbreak Preparedness and Response in the African Region in the Context of the Influenza Pandemic[7] as well as the implementation of IHR.

As of March 2014, following support from WHO, partners, donors and commitment from Member States, 44 countries had fully assessed their IHR capacity and developed plans to implement the regulations nationally. There was progress in other areas of health surveillance, too. For instance, the diagnosis of viral haemorrhagic fevers in seven countries, including

Liberia and Uganda, was the work of the WHO supported network of Emerging and Dangerous Pathogens (EDPLN). The enhancement of the AFR Influenza Laboratory Network also enabled Algeria to quickly diagnose the first human cases of MERS-CoV, which causes respiratory infections in humans and animals, on the continent.

The years 2013 and 2014 also saw outbreaks of polio, dengue fever, yellow fever, meningitis, cholera and viral haemorrhagic fever in various countries. The humanitarian crises in Central African Republic, Democratic Republic of Congo, Mali and South Sudan placed an enormous strain on already stretched public health systems. Fortunately the Strategic Health Operations Centres (SHOC) which we established in ISTs in 2013 (IST West and IST East and South) were instrumental to strengthen and coordinate responses to these kinds of public health emergencies, collecting critical data and information about what was happening on the ground in order to help inform the best response (see Chapter 1).

Remaining Challenges

Significant steps have been taken to forge a network of surveillance that is robust enough to respond to the multiple and hugely diverse public health demands which arise across the Region. However, there are still weaknesses which need to be addressed, and commitments that need to be actioned. Staff training on IDSR at a district level is inadequate in some countries and, despite the foundations being laid, no Member States were able to meet the June 2012 deadline for the attainment of the minimum capacities required by the IHR (2005). This means, among other things, that laboratory capacity is poor at sub-national and district levels, causing delays in the confirmation and monitoring of public health events which could spread internationally. In addition, there are not enough national rapid response teams to adequately cover essential disciplines during public health events and emergencies.

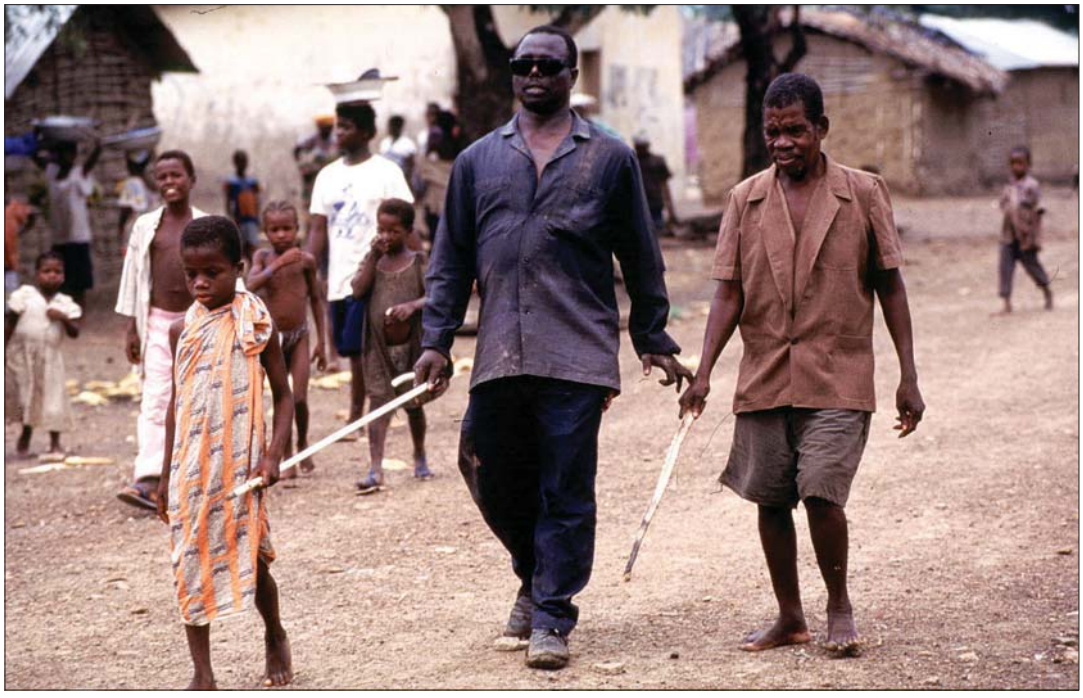
Moving forward, full IDSR/IHR implementation needs to happen in all Member States and the ability to quickly mobilize resources must be in place in the Region through the establishment of the African Public Health Emergency Fund. Continuing to collaborate with multisectoral partners through cross border initiatives is also fundamental for the attainment of a sustainable web of systems which can adequately assess and respond to health needs at a local, national and regional level.

5.3: NEGLECTED TROPICAL DISEASES

Achievements

"The world has the means to alleviate poverty through the reduction of NTDs burden that affects mostly the poor people living in the tropics and subtropical areas. For the African Region case, we need 2.5 billion USD to achieve the NTDs targets for 2020; translated into about 300 million USD a year. It is socially fair, technically feasible, financially affordable and politically commendable." Sambo, 2014[8]

These were my words during the celebration of the 40th Anniversary of the River Blindness Partnership OCP/APOC in June 2014. They underline the progress which has been made on neglected tropical diseases (NTDs), in as much as solutions to reduce them exist. However, they also point to the utterly unjust and unnecessary devastation NTDs still wreak today. Indeed, when I took office in 2005, NTDs, which include ancient, disabling illnesses like trachoma, onchocerciasis (river blindness), leprosy and lymphatic filariasis, were affecting over a billion people, costing developing countries billions of dollars every year and



perpetuating the cycle of poverty. The African Region, home to about half of those afflicted, was buckling under the weight of the then largely ignored diseases.

These statistics still stand. What has changed is the global awareness of NTDs and the pledges from powerful bodies and organizations, including governments in donor and endemic countries, civil society organizations, public and private foundations and pharmaceutical companies – to eliminate them. Through various strategies and high-level advocacy, we played our role in bringing together very important partners such as the World Bank, the Bill and Melinda Gates Foundation, the Sabin Institute and the entire APOC/Committee of Sponsoring Agencies.

In 2006, the WHO Global Strategy for combating NTDs was published. Three years later, the African Regional Office had a dedicated NTD programme in place, with seven team members, an NTD focal person was based in each of the ISTs and additional staff focused on the diseases were posted in six other countries to assess the situation in that area and report back. With teams in place, a Regional Strategic plan for NTDs in the WHO African Region for 2010–2015 was developed in 2009. One of the main aims was to improve collaboration with the long standing African Programme for the Control of Onchocerciasis (APOC) which was already supporting 31 countries and was well versed in what was required to tackle NTDs.

During the past decade, the WHO/AFRO NTD Programme has shifted from a specific control approach, to integrated and coordinated strategies for the eradication and elimination of NTDs by 2020 – WHO's deadline for combating 10 NTDs. Guinea worm disease and yaws have been targeted for eradication. In addition, human African trypanosomiasis (HAT), leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis and trachoma have been prioritized for elimination. Soil-transmitted helminthiasis (STH), Buruli ulcer and leishmaniasis are still targeted for control only, because no effective, affordable medicines exist.

Between 2010 and 2012, 36 countries developed integrated national NTD master plans using the WHO/AFRO guide (see Box 2 The difference our NTD master plan will make). This involves providing a strong framework for harmonized planning, budgeting and mobilization of resources. The core emphasis of the plans includes ensuring the financial sustainability of national NTD programmes, scaling up access to treatment and improving the monitoring of NTDs. Missions were undertaken during the following 2 years to help countries finalize the launch of their master plans.

The mass drug administration (MDA) coverage for PC-NTDs has increased significantly during the last 10 years. For instance, MDA for lymphatic filariasis shot up from 32 million to 122 million between 2005 and 2012; leprosy prevalence dropped by 39 percent during the same period; and a clinical trial in Ghana, where the government provided USD 1 million for its national NTD programme in 2012, confirmed the effectiveness of a single dose of azithromycin to cure yaws. This holds the promise for yaws eradication by 2020.

The year 2012 also saw development partners, such as the Bill & Melinda Gates Foundation and the World Bank, endorse the London Declaration on Neglected Tropical Diseases, in which they pledged to enhance collaborative efforts and track the progress in tackling ten of the 17 NTDs which are on WHO's list to defeat by 2020.

As was explained during the opening of the Regional Consultative Meeting on NTDs in March 2013, "the new momentum that now exists towards the control and elimination of these diseases reached a high-point in January 2012, with the release of the WHO Global Roadmap for Implementation of NTDs and the launch of the London Declaration on NTDs.

Box 2 The difference our NTD master plan will make

In October 2013, in Lake Victoria Primary School playground in Entebbe, Uganda, children gathered to go on a parade with a local band and people prepared to perform songs, dances and poems. One of the poems was about the fight against NTDs, from which more than 11 million Ugandan's suffer[10]. The poem was fitting as the whole event had been organized to launch Uganda's NTD Master Plan. People gathered to listen to the Minister of Health, Dr Ruhakana Rugunda, the Regional Adviser for the WHO Regional NTD Programme, Dr Adiele Nkasiobi Onyeze, and partners of Uganda's NTD programme, as they delivered talks about the plan's goals.

Like other countries in the Region, Uganda had started controlling NTDs through the small-scale distribution of medicines for bilharzia and worms to treat school and pre-school children. By 2002, mass administration for NTDs had started in two districts, and by the end of 2011 this had been increased to cover all 54 districts in the country. However, more needed to be done to fulfill the vision of Uganda becoming NTD free by 2020. The implementation of the Uganda NTD Master Plan, it is hoped, will achieve this.

Rolling out between 2013 and 2017 (with forthcoming meetings due to extend this to 2020), the Master Plan was developed after NTD planning workshops, based on the WHO/AFRO guide on preparing NTD country plans, were held in Harare in September 2010 and March 2012. The main goal is to provide cost-effective, sustainable, pro-poor, community owned interventions for the prevention, control, eradication and/or elimination of 12 NTDs across Uganda so they will no longer be a threat to public health by 2020.

It is noteworthy that in January 2013 this year, the first anniversary of these historic events was celebrated with the launch of the second WHO Report on NTDs, entitled *Sustaining the Drive to Overcome the Global Impact of NTDs*, and the first report on the London Declaration on NTDs, *From Promises to Progress*, which indicated some progress in tackling NTDs, especially in the African region."[9]

Remaining Challenges

A huge amount of support to tackle NTDs has been pledged, but the challenge is to continue to turn these pledges into actions and sustain progress so the 2020 goal can be reached. More specifically, this means coordinating NTD partners so scarce resources are used as effectively as possible in countries; advocating for national governments to increase funding for NTD programmes; and having robust enough systems in place so NTDs can always be treated in highly endemic areas, even in the face of insecurity and wars.

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Chapter 6

Non-communicable diseases (NCDs)

> "Non-communicable diseases are on the rise in the African Region. At the same time, we face the unfinished business of major communicable diseases and maternal and child health problems. We have many priorities that compete for limited resources and time. However, we must take action to address the rising burden of NCDs in Africa."
>
> *Sambo, March 2013*[1]

CONTEXT

There tends to be a south–north divide when it comes to global perceptions of communicable and non-communicable diseases. With the south, the African Region in particular, being overwhelmingly associated with HIV/AIDS, malaria and TB; and the north being perceived as the main domain for mental health problems, heart disease and cancer – all under the non-communicable umbrella. Whilst it is true that, in contrast to regions like Europe and North America where the leading cause of premature death and disability are non-communicable diseases, and the African Region carries the weight of communicable, maternal and newborn disease[2]; increasing numbers of people are presenting with NCDs and the African Region is now confronting the double burden of these and communicable diseases.

The past decade, in particular, has seen a rapid increase in NCDs on the continent. In 2005, 30 percent of all deaths in the Region were due to NCDs. By 2010, this had gone up to 40 percent, with the main NCDs being cardiovascular diseases, chronic respiratory illnesses, diabetes, cancer, and the consequences of violence and road traffic accidents. Around 62 percent of people living in the African Region aged 45 plus, die from NCDs[3]. This, coupled with the huge task of combating communicable diseases, threatens to overwhelm already overstretched health services. Yet, despite the human and financial resources required to meet this challenge, both within the health service and beyond it, due to lost productivity and the domino effect this has on families and employers, governments and development partners have been slow to acknowledge NCDs as an issue worthy of significant action.

The good news is that many NCDs are triggered by lifestyle and behavioural choices, meaning there is clear scope for change. For instance, 40 percent of deaths from common cancers are preventable, as are 80 percent of deaths from cardiovascular diseases, diabetes, and chronic respiratory diseases[1]. The bad news is, the harmful use of alcohol, tobacco use and unhealthy food, all of which contribute to ill health and death from NCDs, hook people, especially the young, into behaviour patterns that can be hard to break. However, during the past decade, there has been growing momentum within the WHO African Region to control and prevent NCDs. This is beginning to pay off.

6.1: TOBACCO, ALCOHOL, DIET AND EXERCISE

Achievements

Determined to create an enabling environment to fight against NCDs, the Regional Office embarked on a mission of advocacy to develop partnerships, strengthen health systems and implement guidelines which were drawn up to address NCDs and their causes. As a result, Member States quickly committed to preventing and controlling NCDs and formed departments within their health ministries to address them. Annual occasions, such as World Mental Health Day, World Diabetes Day and World No Tobacco Day, were also launched to raise awareness.

Then, in 2011, NCDs were officially recognized as a global development issue when health ministers, regional experts, and civil society organizations gathered at WHO Regional headquarters in Congo and embraced the landmark Brazzaville Declaration on NCDs. The Declaration, which urged immediate action by stakeholders to tackle major NCDs such as diabetes, cardiovascular diseases and mental health issues, has been used worldwide and was bolstered by the Global NCD Action Plan for the Prevention and Control of NCDs (2013–2020). This provides a road map, as well as policy options for Member States, WHO, other UN organizations and intergovernmental organizations, NGOs and the private sector. During its collective implementation between 2013 and 2020, the road map will help meet nine voluntary global targets, including a 25 percent relative reduction in premature mortality from NCDs by 2025[4]. In addition, the 2014 Commitment on NCDs in Africa, which was developed by WHO and the African Union Commission, saw African health ministers pledge to prioritize NCDs and protect public health policies from interference from the alcohol, tobacco and food industries by reinforcing national laws and implementing comprehensive legislation and NCD policies.

Smoking is one of the most preventable causes of NCDs and was an early target for control. Back in 2005, only nine countries had ratified the 2003 WHO Framework Convention on Tobacco Control (WHO FCTC), which calls for a total ban on tobacco advertising. Meanwhile, just 12 Member States had measures in place to protect the public from passive smoking. By June 2014, 42 Member States had ratified the WHO FCTC, 27 had banned smoking in public places[1] and tobacco advertising, and 33 require cigarette packaging to carry health warnings – impressive progress. Joint cross country partnerships have also been established, with WHO/AFRO's support, to deal more cohesively with tobacco taxation, eliminate illicit trade and find alternative employment for tobacco growers.

Whilst smoking is one of the most preventable NCDs triggers, alcohol is one of the main causes of NCDs in the African Region. It also has a massive impact beyond the damage it does to the health of drinkers, creating a cascade of societal problems such as violence, road accidents and family neglect. Even though more countries in the Region were reporting an increase in drinking levels in 2005, there was no collective action to address the problem –

mostly because of weak national regulatory systems and no guidance on Regional policy. In a bid to address this, the Regional Strategy to Reduce Harmful Use of Alcohol was introduced and set out ten policy options, including bans on advertising, price increases and limits on availability. Since then, ten countries have been supported by WHO/AFRO to strengthen their alcohol policies in line with the strategy.

Obesity is usually seen as a Western problem, but socio-economic changes over the past few decades, and the globalization and liberalization of international trade and the growing shift to urban living which has come with it, has changed eating habits and fuelled an increase in obesity in the Region, particularly among women and children (see Box 1 Addressing childhood obesity in Mauritius). The landscape looked pretty bleak in 2005. People were eating less fruits and vegetables, and significant numbers were not doing enough exercise. Two issues were helping to perpetuate this – a lack of public awareness about the benefits of a healthy diet and regular exercise, plus weak national regulatory environments. Both problems were addressed through the Global Strategy on Diet, Physical Activity and Health (2004), and the Global Recommendations of Physical Activity for Health (2011), which were adopted by the World Health Assembly and underpin the support given to 12 Member States to develop strategies on obesity prevention.

Remaining challenges

The sleek and aggressive marketing of the idea that eating foods that are high in salt and sugar, drinking alcohol and smoking somehow equates to a more exciting, aspirational lifestyle, is a major challenge to public health in the African Region. Overcoming pervasive and

Box 1 Addressing childhood obesity in Mauritius

Mauritius is one of the countries in the Region that has witnessed rapid epidemiological transition in the past three to four decades. It has eradicated malaria and has controlled most communicable and vaccine preventable diseases, but it finds itself with increasing burden of non-communicable diseases. In fact, it has some of the highest rates of diabetes and cardiovascular diseases in the Region[5].

In order to address this NCD epidemic, the government has initiated a number of measures to reduce risk factors and promote healthy lifestyles. Some key elements of the NCD prevention and control strategy are aimed at reducing childhood obesity, which is a serious problem. The 2004 Mauritius National Nutrition Survey revealed that 8.1 percent of children aged between 5 and 11 were obese and 7.7 percent were overweight, while 7.3 percent of those aged between 12 and 19 were obese and 8.4 percent were overweight.

The government has taken a number of measures to combat this. These include creating greater awareness about the serious health, social and economic consequences of the condition and putting legislative and fiscal measures in place to reduce the amount of unhealthy foods children eat. For instance, in January 2010 the government introduced legislation to ban school canteens from selling sugar sweetened fizzy drinks and snacks high in calories, sugar, fat and salt. In 2012, a tax on sugar in sugar-sweetened drinks was introduced and this was increased in 2013. One of the outcomes of these measures has been a noticeable reduction in the consumption of sugar-sweetened drinks. The government expects that these measures will encourage healthy eating and bring about a reduction in childhood obesity and non-communicable diseases.

persuasive advertising is made harder by the industries selling these products, and their interference in national policy-making and implementation.

However, with more robust legislation in place, and an informed public, these challenges are not insurmountable. As I argued, "the risk factors for NCDs are driven by modern life styles and behaviours – in relation to which policy makers and people are, in general, poorly informed. Governments and parliaments – together with representatives of civil society organizations and consumer associations – have the responsibility to develop policies, set norms, and pass and enact legislation that protect public health and give individuals reliable facts to make informed choices."[1]

6.2: MANAGING NON-COMMUNICABLE DISEASES

Achievements

Having effective systems in place to manage NCDs is obviously key to their prevention and there have been lots of successes on this front during the past decade. Advocacy has been a particularly effective tool, helping to galvanize political commitment to NCDs and getting them placed higher up national priority lists as governments have realized the impact they have on economic growth and development.

WHO/AFR has reinforced these kinds of policy changes by providing training on how to develop and implement policies and plans in relation to the major NCDs, from mental health problems and sickle cell disease, to injury and disability. Deeper collaboration with partners like the World Diabetes Foundation, the World Heart Foundation and the Programme of Action for Cancer Therapy, has also meant that prevention and control of all these diseases has been strengthened. However, much work still needs to be done as these health problems continue to rise. For instance, as I explained, "the number of cancer cases and related deaths worldwide is expected to double over the next 20–30 years. African countries will be the most affected by the burden of cancer, but are of all developing countries the least able to cope with the challenges cancer presents."[6]

Remaining challenges

Adequate preparation to prevent and control non-communicable diseases is essential. However, it is only possible if the political commitment, which has been pledged at national, regional and international levels, is followed through with action and significant increases in the amount of resources that are allocated to NCD prevention.

Integration of NCD programmes with other programmes at all levels is inadequate, and not helped by a scarcity of human and financial resources to push forward cohesive ways of working. This hampers hopes of attaining universal health coverage and could limit access to essential medicines and technologies, which will enable better management of NCDs, particularly among the poorest and most vulnerable in society.

Looking ahead, it is crucial that WHO/AFRO continues supporting Member States so they can implement the Global NCD Action Plan (2013–2020), and achieve the 25 percent target to reduce the risk of premature death from some of the major NCDs.

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Chapter 7

Accelerating the response to the determinants of health

> "We now live in a world of unprecedented awakening of the consciousness of communities and civil society organizations in regard to environmental issues and their linkages to health. Governments are expected to therefore provide adequate response to the health problems caused by environmental risks. Latest WHO estimates show that nearly a quarter of the global burden of disease is attributable to avoidable environmental factors. That is the sad truth. In addition, the burden of disease attributable to the environment is not evenly distributed around the world. Developing countries, especially those in Africa, are the ones most seriously affected and the vulnerable and poor populations most hardly hit."
>
> *Sambo, 2008*[1]

CONTEXT

Where you live in the world has a major bearing on your health. It sounds obvious, but it is crucial to underline because the trajectory of our lives – birth, childhood, work environment and old age – is largely shaped by where we are born and live. In other words, these factors, and the distribution of money and power at local, national and global level that mould the structures – from education to health care systems – within which we function, are the social determinants of our health. These are also the key elements of health inequities. They lay the foundation for the unacceptable rifts in people's health, particularly the poor, women, children, displaced populations and the elderly, within and between countries.

Health equity is at the heart of WHO's principles. But, despite the great progress made in medicine and technology, gaps in health equity, globally and within the WHO/AFRO Region, have widened over the last few decades[2]. Health organizations and ministries cannot act alone to close these gaps. As the name highlights, the social determinants of health require societal wide solutions to tackle the interlaced connections between social, economic and health development – with sustained joint effort from multiple players, including governments, civil society and the private sector.

The environment, poverty and humanitarian crises are the overarching issues which contribute to the disproportionately high health inequity in the African Region. Combating it involves relevant Government policies and effective collaboration between organizations and experts working in health and health-related sectors.

For instance, when I addressed the First Interministerial Conference on Health and Environment in Africa in Libreville, Gabon in 2008[1], I highlighted the inextricable link between persistent malaria epidemics and environmental destruction, particularly deforestation and the mismanagement of water resources. These serious environmental issues are being exacerbated

by the highest urban growth Africa has witnessed in the last two decades. With urbanization expected to continue rising into 2050[3] as increasing numbers of people flock to cities in search of work and opportunities, the environmental determinants of health are only going to become more pronounced. Already, town planning is far from keeping apace of the huge demands on infrastructure, housing and sanitation. As a result, urbanization has largely equated to increased slum living where poverty, inequality and diseases like TB, have proliferated.

Poor and non-existent energy supplies within slum and rural areas mean people rely on wood and charcoal for heating and cooking. The high level of household pollution this causes, coupled with fumes from old cars and motorbikes which do not meet environmental protection standards, helps trigger diseases like asthma, bronchitis, pneumonia and lung cancer. In fact, respiratory diseases and lung cancer kill 1.5 million people globally every year, and the majority of deaths occur in Africa, with children and old people being the most vulnerable[1]. Toxic waste is also a major environment related health threat. "In the last two decades, we have learnt of huge quantities of toxic wastes dumped in Africa, sometimes even on the peripheries of major cities, in total disregard of all ethics," I said at the First Interministerial Conference on Health and Environment in Africa[1]. "The magnitude of a recent incident prompted WHO to intervene to assess the extent of damage and help take appropriate measures. Such practices should bother the conscience of humankind."

All these issues were intensified to an unimaginable degree during humanitarian crises that struck the African Region during the past decade. In fact, 21 countries reported emergencies in 1996, compared to 46 countries in 2009. Conflicts and social unrest displaced over 12 million in 2008. Between 2012 and 2014, 37 countries in the Region reported emergencies – including the armed conflict in Mali and the Sahel food crisis.

Dealing with this level of disruption would test the most robust, well-resourced health systems, let alone those already struggling to cope with everyday demands. Forthe past decade, the our team and partners have been striving to help Member States coordinate the most effective response to these determinants of health.

7.1: ENVIRONMENT

Achievements

The 2008 Libreville Declaration on Health and Environment, which came out of the First Interministerial Conference on Health and Environment in Africa, is the first official framework which African countries have used to address the environmental determinants of health. In 2013, 5 years after Member States began using it, the Health and Environment Alliance (HESA) commissioned an evaluation of the Declaration and found a number of key achievements. These include more advocacy on the links between health and the environment, more resources being allocated to explore those links, and stronger collaboration between the health and environment sectors. All this has paved the way for concrete action to be taken so countries are better equipped to handle the fallout from emergency situations, and take steps to curb and prevent health problems which are triggered as a result of more avoidable issues, like deforestation and the mismanagement of water systems.

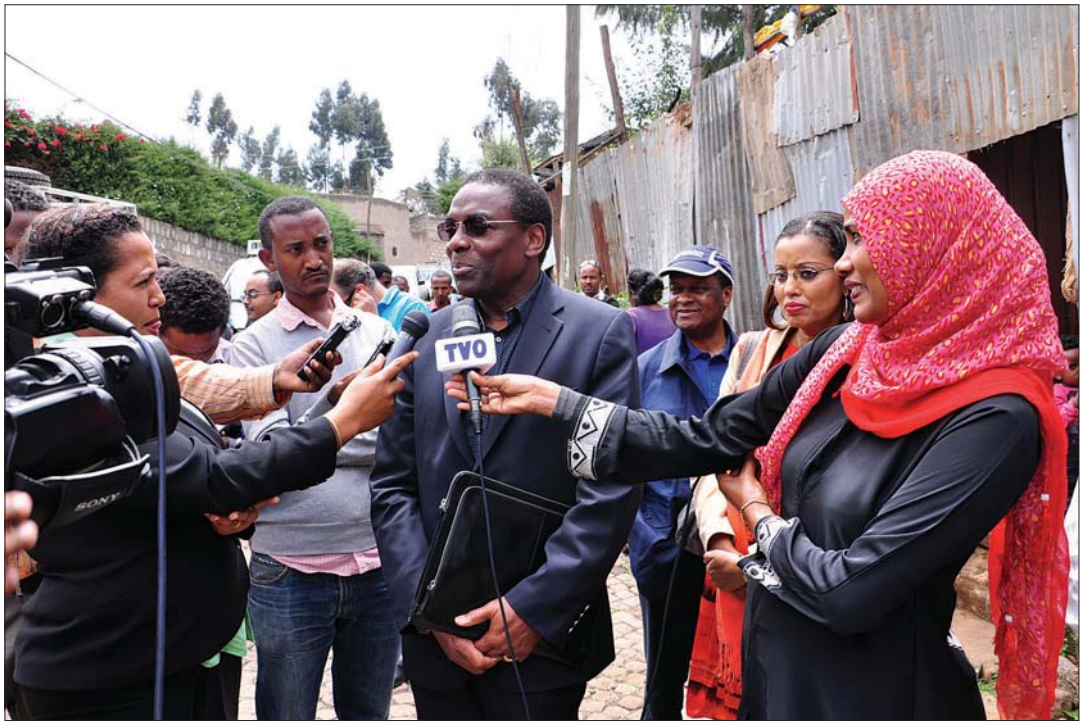
Remaining challenges

Progress made needs to be capitalized on and sustained through continued political commitment and the collaborative efforts of multi-sector agencies. Crucially, national health systems

need to be strengthened (see Chapter 2) so they can cope with current and new health risks that develop as a result of environmental problems, including climate change. In addition, those problems need to be curbed through the development of integrated policies which support environments that enhance, rather than damage, people's health.

7.2: POVERTY

Achievements



Addressing the press on the occasion of my visit to health extension workers in Addis Ababa, Ethiopia

Health is a human right, but poverty tramples all over that right. It exposes those at the bottom of the socioeconomic ladder to a catalogue of risks and situations which means they have to contend with the worst health, yet have the least means to alleviate their suffering. 'Less' is the word which describes their circumstances and health chances best. Less information; less health care; less nutritional food; less education; less household savings, often due to illness, which in turn leads to less learning ability, less productivity and less quality of life. All this makes the poverty cycle spin out of control, as well as the diabolical health outcomes which go hand in hand with it. Indeed, to borrow Kofi Annan's words, "the biggest enemy of health in the developing world is poverty."[4]

Our team set about turning less into more by supporting Member States to develop the health component of Poverty Reduction Strategies. This was underpinned by WHO assisting with the analysis of health equity, recording the experiences of different countries in establishing

multi-sectoral action which addressed specific health issues, such as disease outbreaks and adolescent health promotion. Strategies on food safety, nutrition and inter-sectoral action, including the programme on the Social Determinants of Health which delineates the priority interventions that should be handled by the health sector and those which should be managed by other sectors, are also being implemented to tackle the widespread health inequalities which poverty breeds.

Remaining challenges

The negative social determinants of health, particularly those borne as a result of poverty, can be avoided. However, this remains a gargantuan task which will only be achieved if multiple and complex factors are in play simultaneously. These include securing good governance to protect and promote health; empowering the public by informing them in order to ensure full participation in addressing the social determinants of health; engaging all sectors in addressing public health issues; building effective partnerships to increase resources – both economic and human – and technical capacity; and monitoring and evaluating the progress of the implementation of interventions and the impact of their outcomes.

7.3: HUMANITARIAN CRISIS

Achievements

The repeated floods, droughts, conflicts and disease outbreaks in many parts of the continent, as a result of natural and man-made disasters, create major challenges for national health systems. WHO's central role in emergencies is to mobilize partners to agree on the best course of action, support Member States to strengthen human and institutional capacities so they can save lives and function beyond the crisis.

In order to do this more effectively, the WHO Three Year Plan to improve Health Action in Crises (TYP) was actioned from 2004 to 2006. As a result, WHO had a more prominent presence in the field and advocated for investments in technical, logistic and financial capacities of countries. This investment also enabled WHO/AFRO to reach out and support other Regions in crisis, like the Philippines during the 2013 Hyian typhoon disaster.

However, responding in a knee jerk fashion when disaster strikes is not good enough; prevention and preparedness is, as with our health, always better than cure. Confronted with recurrent disasters, the global community shifted to a more preventative strategy which involved managing disaster risk. Following this paradigm shift in the global approach to disasters, Member States were urged to improve their health emergency and disaster risk management programmes. In 2012, this new approach was officially endorsed by ministers of health in Luanda, Angola with the adoption of the Resolution on Disaster Risk Management. A number of tools were finalized and disseminated to support the implementation of this strategy. For instance, countries were supported to integrate health into national disaster risk reduction platforms, and training was conducted to build country technical expertise. WHO has also adapted its expert rosters and completed the testing of mechanisms, which will enable the rapid deployment of emergency experts to adequately support countries in need using the WHO Emergency Response Framework (ERF). Countries have also been encouraged to design health hazard maps using the E-Atlas/AFRO tool (see Box 1 Using maps to manage health hazards).

Remaining challenges

Member States have certainly made progress in their ability to respond more effectively to emergencies, but many weaknesses remain. First, there are clear gaps in the capacity of health ministries to manage inter-sectoral coordination – and this is fundamental to being able to respond to disasters adequately. The health sector disaster response plans mostly do not consider every potential hazard and the key elements to optimal disaster response (business continuity plan, standard operating procedures, triage system and evacuation procedure) have not yet been established in most countries. In addition, 15 countries in the Region do not have functional emergency units. Where they do exist, they are understaffed and under-resourced. Yet these units are essential for responding to major emergencies, when dealing with mass casualties. Tragically, the people who usually suffer most in crisis are those already living in poverty with limited access to basic services, and a lack of resources to recover from continuous trauma, so the poverty cycle simply keeps repeating.

Box 1 Using maps to manage health hazards[5]

Dr Matshidison Moeti, Assistant Regional Director for WHO/AFRO, explains the thinking behind the E-Atlas.

"Countries in the Region often struggle to meet their populations' basic health needs; natural disasters further plunge people into the abyss. Hence there is a felt need for disaster risk reduction. Lessons learnt from emergencies and disasters in Africa show that the health of the people is heavily affected and survivors may be left with deformities. The floods in ten West African countries, the drought in parts of Ethiopia, the landslide in Uganda, all demonstrated the need for better disaster preparedness capacity at national and community levels.

In order to safeguard the health of populations during disasters and emergencies, WHO has embarked on an improved disaster preparedness and response programme. The World Health Assembly in 2005 urged all Member States to build up the national capacity for emergency preparedness and disaster reduction /mitigation and response in order to reduce avoidable mortality and disability. In the 60th session of the WHO Regional Committee for Africa, action points for Emergency Preparedness and Response at National Level were adopted. A critical component of the preparedness action is the availability of a decision-making tool which will facilitate programme planning and response to emergencies at national levels.

The E-Atlas provides such a tool, with information on where and what types of natural hazards may occur and which communities are most likely to be affected. It will help in developing appropriate risk reduction programmes. Volume 1 of the WHO E-Atlas of Disaster Risk Mapping shows the spatial distribution of selected natural hazards in the African Region. It is the output of extensive geographic information analysis and the methodology could be used for future research. It could also be used to plan and prioritize areas for mitigation activities to minimize the effects of natural disasters.

The E-Atlas/AFRO provides a powerful tool for national decision-makers at all levels on vulnerability and risks of populations to natural hazards; hence a means for better plans to reduce mortality."

Governments and international humanitarian and development actors need to underline the importance of building resilience in countries and implementing the full Disaster Risk Management programme, rather than merely focusing on responding when emergencies occur. In other words, a holistic approach to disaster assessment and management needs to be reinforced and sustained in the Region.

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Chapter 8
Looking after the team

"The most valuable resource in the health sector is the workforce."

Sambo, 2005[1]

CONTEXT

It goes without saying that none of the many achievements seen within health care in the WHO African Region during the past decade would have been possible without the people who work tirelessly to help devise strategies, programmes and plans and turn them into actions. The WHO/AFRO team that I led during the 10 years consists of 2377 staff – from medical doctors, public health specialists, social scientists and librarians, to press officers and administrative staff – in 47 countries. They are the ones who delivered WHO outcomes in the Region. Their motivation, welfare and security is fundamental in ensuring that the WHO possible level of health for every child, woman and man with the best chance of leading healthier, longer lives, is fulfilled.

In 2005, the Regional Office had just completed transferring its headquarters from Harare, Zimbabwe, to Brazzaville. There had been a forced relocation from Brazzaville to Harare in 1997 due to civil war in Congo and, when the war stopped and conditions improved, the Office began the process of returning in 2001[2]. The already difficult logistical move was made harder by the financial crisis which impacted on staffing due to job cuts. A lot of work also needed to be done to bring the new office space and residential facilities up to scratch, particularly the information and communications infrastructure which was nowhere near the level required to enable staff to carry out their jobs efficiently.

Security was a concern too, simply due to basic measures which meet the UN Minimum Operating Security Standards not being in place. These included having an emergency power supply to maintain a functioning office at all times, and basic staff medical care.

8.1: STAFF MOTIVATION, WELFARE AND SECURITY

Achievements

A whole range of initiatives has been implemented during the last 10 years to create a happier and more productive workforce. For starters, over a thousand staff were on temporary contracts in 2006. This produced a sense of job insecurity, an inability to plan long term, and dampened motivation. By 2014, the number of people on temporary contracts had been reduced to 176. Outstanding staff and team recognition awards were introduced in 2008 to acknowledge exceptional work and bolster staff morale (see Box 1 What the team thinks), and salaries were aligned to introduce more equity amongst employees. Technology and

communication facilities were also upgraded to ensure fast, reliable on-line and telephone systems, as were generators. Meanwhile, a project to improve computing and telephony systems, so they all function at the same level no matter where employees are based, is due for completion in 2015.

In order to practice what they preach, and stay as fit and healthy as possible, the sports facilities have been expanded and upgraded for practice of soccer, gymnasium, tennis, basketball and handball. There is also an annual sports day when everyone competes – from directors to drivers – which helps build camaraderie. An upgraded health clinic for staff and dependants is under construction. Giving staff a platform to voice their opinions and air any grievances is also crucial for maintaining motivation and the ability to work as a team. This was enabled thanks to the introduction of a committee responsible for overseeing the adequacy of the staff

Box 1 What the team thinks

Some members of the WHO/AFRO team share their thoughts on a few of the changes which have been implemented during the past decade.

"Being given an Outstanding Staff award helped me lead my team with renewed energy." By Pascal Mouhouelo, Head Librarian, WHO/AFRO

"I joined the World Health Organization in 1991 on a temporary contract. By 2008 I'd been on a permanent contract for a few years and was promoted to be in charge of information dissemination within the library. With the retirement of the Chief Librarian in 2010, the Regional Director appointed me as acting Chief Librarian. This appointment brought me satisfaction and responsibility to lead a team and bring new energy to improving access to health information in our Region. Three years later I was made permanent Chief Librarian.

Before being promoted, the WHO Regional Director, Dr Sambo, gave an award of Outstanding Team to all the Library staff and a personal Outstanding Staff award to me 2 years afterwards. This internal recognition of good work was followed by another award given to me by the International Medical Library Association. I was honored by these and the professional promotion which contributed to my personal and family satisfaction. I informed my wife and children who humbly thanked the World Health Organization's Management in general, and it's Regional Director, in particular."

"Enhanced security makes us feel more secure." By Francis Gamba, Programme Budget Finance Officer

"The enhancements to the AFRO security system we've seen in the last ten years are noticeable. The CCTV system, the periodical evacuation drills, the bulk SMS and radio checks, and the baggage scanner at reception have all increased the feeling of security and safety amongst staff members. In the past there was no perimeter fence; anyone could enter the compound without any control. Now, we feel much safer and more protected."

"Using the staff gym is a great way to de-stress." By Mark Chimombe, IT Officer

"The introduction of WHO Sports facilities at the Regional Office has been great. I use the facilities at least three or four times a week in the mornings before going to work in order to sustain my mental and physical fitness during work hours. Family members residing in the compound have also really benefited from these facilities."

cafeteria and offices, as well as the empowerment of the Staff Association and Ombudsman at the Regional Office, and the creation of staff associations at WHO Country Offices and the Office of Ombudspersons in each Inter-Country Support Team. As for security and safety, an emergency communication centre, CCTV and Alert SMS systems have been put in place, all staff members have been issued with Walkie-Talkies, and the perimeter wall around the office and WHO villas and apartments, where international staff live, have been completed and reinforced. In addition, the worn-out tarmac roads within the WHO premises were repaired and upgraded.

Remaining challenges

Despite the increase in recruitment of female staff, 69.16 percent are male, and 76.74 percent of senior positions are occupied by men – a questionable gender imbalance in any organization, but particularly one which pushes for equity as a central guiding principle in all the work it does. This needs to be addressed in order to make the team more representative of the population it serves and fulfil one of the strategic directions of the Africa's Health-For-All Policy for the 21st Century: Agenda 2020. This calls for the creation of conditions that will enable women to participate in, benefit from and play a leadership role in health development[1].

Last but not the least, finance continues to be a major challenge and sustained adequate funds are of course necessary to ensure that the improvements to security, communication technology and the living quarters for staff in the Regional Office is maintained.

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Chapter 9
Looking ahead

The post-2015 global health agenda holds huge promise for the well-being of sub-Saharan Africans, but promises require unified efforts and actions in order to be fulfilled. Where the Region goes next to develop and meet future health goals is dependent on building upon the initiatives and lessons learned during the past decade, and fully assessing and incorporating current needs into the journey ahead. Universal Health Coverage (UHC) is the ultimate goal. Here is how it can be achieved:

The African Region has made progress during the past decade, but the journey is far from over. AFRO Executive Management team ran with the baton that was passed to them back in 2005, contributing to the impressive headway made in all areas of health across the Region. These include the hugely increased access to antiretroviral therapy, from 619,000 people being covered in 2005 to 7,524,000 at the time of writing, which has started reversing the trend of the HIV/AIDS epidemic and deaths from the disease. The critical role of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), US President's Emergency Plan for AIDS Relief (PEPFAR) and UNAIDS should be highlighted. This has also contributed to the fact that average life expectancy at birth is now 58 years old, as opposed to 50, which was the case in 2000[1]. Yet more encouraging news came in the way of the decline in under-5 mortality. In 2005, 129 children out of every 1000 live births had tragically died by their 5th birthday. By 2012 the numbers of children losing their lives almost before they had begun to live them, had dropped to 95 out of every 1000 live births. Added to this was the promising decline in the number of families grieving for the painful loss of their sisters, mothers, daughters and wives as a result of death during or after childbirth. Indeed, latest figures on maternal mortality reveal a decrease of 170 deaths for every 100,000 live births between 2005 and 2012[1,2].

The health and health related Millennium Development Goals (MDGs) have provided the overarching theme for much of the progress that has been made; and the policy and strategic guidance that has been provided by WHO and other partners has been instrumental in helping Member States get on track to achieve these, and the other successes covered in previous chapters. But, even with the 2015 deadline looming and the commitments and promises made by governments and partners at the beginning of the century, the MDGs are still very much unfinished business on the continent (see Box 1 Out of 47 countries . . .). The major challenges that are preventing countries from fully achieving set targets by 2015 are mainly the result of weaknesses within health systems and the coordination of the multi-sectoral response, plus the availability and management of funds. The lack of good quality data to enable full monitoring and evaluation of plans that have been put in place, has also impeded the ability of Member States to meet every MDG[3].

That said, there is over a year to go before the 31st December 2015 deadline and so progress can still be made. However, improvements in financial mobilization and management,

strengthening of health systems, implementation of effective interventions and coordination of programmes, need to be intensified in order for there to be any hope of hitting the deadline. It is also essential, right now, for all Member States to look beyond 2015 and anticipate and plan for future needs based on current evidence.

The umbrella post-2015 health goal has already been set – to achieve universal health coverage. [This means, as we have touched on in previous chapters, that everyone – regardless of gender, age, race or income – should have access to quality, essential health services without suffering financial hardship[4]. This will be achieved if two clear global targets are met:

- By 2030, at least 80 percent of the poorest 40 percent of the population have coverage to ensure access to essential health services.
- By 2030, everyone – and that means 100 percent of the population – has coverage to protect them from financial risk, so that no one is pushed into poverty or kept in poverty because of money they have to spend to meet their health needs.

The African Union (AU) position mirrors these global goals. Indeed, as far as the post-2015 health agenda is concerned, the AU declares, "we must improve the health status of people living in vulnerable situations such as mothers, newborns, children, youth, the unemployed, the elderly and people with disabilities by: reducing the incidence of communicable diseases, non-communicable diseases (e.g. mental health) and emerging diseases; ending the epidemics of HIV and AIDS, tuberculosis and malaria; reducing malnutrition; and improving hygiene

Box 1 Out of 47 countries . . .

There are 47 Member States in the WHO/AFRO Region. Despite their pledges, and those of their partners and stakeholders, to achieve the health and health-related MDGs, the persistent obstacles and challenges faced by the Region sadly mean no Member States are on track to meet all the health MDGs, and only a few are likely to meet some. Of the 47 countries, just . . .

. . . 16 are on track to, or have already achieved, target 4A by reducing the under-5 mortality rate by two-thirds between 1990 and 2015.

. . . 4 are set to reduce the maternal mortality ratio by three quarters between 1990 and 2015, and meet target 5A.

. . . 7 should achieve target 5B and provide universal access to reproductive health.

. . . 34 are set to have halted and begun to reverse the spread of HIV/AIDS, meeting target 6A by 2015.

. . . 7 have achieved the 2010 deadline of enabling universal access to treatment for HIV/AIDS for all those who need it, meeting target 6B.

. . . 12 are on track to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases, fulfilling target 6C.

. . . 11 should have halved the proportion of people who suffer from hunger and meet target 1C.

. . . 23 are set to halve the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015.

and sanitation. This can be achieved by: ensuring universal and equitable access to quality healthcare, including universal access to comprehensive sexual reproductive health and reproductive rights (e.g. family planning); improving health systems and health financing, and medical infrastructure, the local manufacturing of health equipment, (e.g. commitment to the Abuja Declaration); and setting up monitoring and evaluation, and quality assurance systems."[5].

IN PURSUIT OF UNIVERSAL HEALTH COVERAGE

The building blocks for achieving universal health coverage (UHC) in the Region are in place, and WHO/AFRO's efforts during the past decade have contributed a great deal to helping Member States lay these foundations. However, as we have seen throughout this report, for every achievement, a challenge remains. The major post-2015 priority for the WHO Regional Office for Africa is to put every ounce of energy into capitalizing on the work that has already been done in all the main areas of health in order to achieve universal coverage. That means equitable access to essential health care for everyone, in every corner of the African Region. So how will this happen? Here is what the WHO/AFRO Directors think *must* be done in order to achieve universal health coverage in their specialist areas . . ..

1. Form partnerships

Dr Luis Gomes Sambo, WHO Regional Director for Africa, shares his thoughts on how the formation of partnerships will help Member States attain UHC

"*In my view, a tight partnership between Member States, WHO and other health development partners is crucial for the achievement of the post-2015 UHC goal of ensuring that all people in the African Region have access to the needed quality health services without exposure to financial hardship. The Universal Declaration of Human Rights adopted and proclaimed by United Nations General Assembly resolution 217 A (III) of 10 December 1948, clearly indicates that everyone has the right to life (Article 3) and a standard of living adequate for the health and well-being of himself and of his family (Article 25). That was over 65 years ago. Despite subsequent commitments at various forums, such as the adoption of the Declaration of Alma-Ata in 1978 following the launch of the Health-for-All movement by the World Health Assembly in 1977, and efforts by national governments and partners, there are still millions of African people suffering and dying prematurely from preventable communicable and non-communicable diseases and injuries.*

Due to decades of underinvestment, national health systems are too weak to deliver quality health services to all those in need of health promotion, disease prevention, treatment and rehabilitative services. The situation has been exacerbated by a dearth of inter-sectoral action needed to address broad determinants of health to improve health equity, i.e. the settings in which people are born, grow, live, work and age. The underinvestment is mirrored by the fact that most countries have not achieved the African Union Abuja Declaration to allocate at least 15 percent of their national budgets to the health sector; and many partners have not fulfilled the commitment to raise official development assistance (ODA) to 0.7 percent of donors' gross national income. Although we do not yet know the exact amount of resources needed to attain UHC, low- and middle-income countries may have some difficulty making the requisite investment. It will require a strong and well-coordinated partnership between communities and national governments, non-governmental organizations (including philanthropic organizations), private sector and external health development partners. In a nutshell, although individual Member States have a paramount role to play, coordinated global health solidarity will be needed to keep the promise of UHC in order for all Africans to have access to better health and quality of life."

A few more words on partnerships

The African proverb, 'if you want to go fast, go alone. If you want to go far, go together', perfectly sums up the need for effective partnerships to accelerate support to Member States so they can achieve UHC.

For its part in ensuring everyone has access to good health care, WHO must nurture existing partnerships by continuing to actively participate in the UN Development Group and UN Regional Directors Team, as well as encouraging all WHO Country Teams (WCT) to 'deliver as one' by ensuring they carry on working with UN Country Teams (UNCT). In terms of what else is required to nurture existing partnerships, and form new ones, the "to do list" is long but comprehensive (see Box 2 Partnerships to-do list).

Box 2 Partnerships to-do list

Forming partnerships is central to achieving UHC in the African Region. Here is a checklist of what needs to be done by the Regional Office

1. Continue implementing the 2012 agreement between the Commission of African Union and the World Health Organization.
2. Sign and implement memoranda of understanding with all Regional Economic Communities.
3. Consolidate and expand the Harmonization for Health in Africa (HHA) with a special focus at country level.
4. Maintain close communication with WHO traditional partners, such as the United States Agency for International Development (USAID), CDC (Centers for Disease Control and Prevention), Bill and Melinda Gates Foundation, The Department for International Development (DFID), Japan International Cooperation Agency (JICA), Swedish International Development Cooperation Agency (Sida), Canadian International Development Agency (CIDA).
5. Strengthen recent partnerships with Swiss Cooperation, Monaco, Malta.
6. Form new health development partnerships with Brazil, Russia, India, China and South Africa (BRICS).
7. Rekindle South–South health related technical cooperation and document and disseminate best South–-South cooperation practices.
8. Continue supporting growth of existing regional professional associations, e.g. AfHEA, AFOG and AFPHA.
9. Continue supporting African Region Member States participation in the WHO financing dialogue with partners to give more flexibility to WHO over how voluntary contribution funds are spent.

2. Shape research

Dr Delanyo Dovlo, Director Health Systems and Services Cluster (HSS), explains why generating scientific knowledge within the African Region is fundamental to achieving UHC

"*There is a Nigerian proverb which says, 'a person who wants to rescue another in the dark, may end up causing more damage.' Scientific knowledge is the lamp that illuminates our efforts to help and ensures that our efforts are designed to produce fruitful results. Informed knowledge on the social context, disease trends and access to health services helps every stakeholder to achieve positive outcomes and avoid waste.*"

A few more words on research

As discussed in Chapter 2 (2.1), underinvestment in national home-grown research that addresses public health issues in African Member States, is a real threat to the sustainable achievement of UHC. This is because, as long as Member States are not in a position to generate enough of their own resources and funding to direct health research, which is relevant to their populations, the chronic imbalance in global health research investment, which the Commission on Health Research revealed in 1990, looms.

The knowledge gap, as the 2008 Algiers Declaration made plain, must be closed. Finalizing and implementing the regional strategy on research for health, to help countries develop functional national health research systems, will help close the gap. Once this is done, there will be a solid base from which Member States can generate scientific knowledge and promote its use in developing the technology, systems and services that are badly needed to achieve UHC. WHO/AFRO need to support countries to ensure there is adequate leadership and governance of health research; the means to finance it are sustainable and, when research is produced, it is used to enhance the performance of Africa's national health systems.

3. Monitor health situations and trends

Dr Derege Kebede, Programme Area Coordinator for African Health Observatory, shares his views on the key things that need to be accomplished within this area to fulfil the UHC goal

"*Being able to effectively monitor health situations and trends requires accurate and timely data and information. African countries need adequate policy and strategic frameworks to strengthen their health information systems and national health observatories. The resulting improvement in data sources and data quality enhances the policy dialogue with sector stakeholders and enables health strategies to be developed that promote an equitable and evidence based progress towards universal health coverage.*"

A few more words on health situations and trends

As mentioned in the introduction to this section, generating high quality data so progress made on the post-2015 agenda can be properly monitored, underpins the success of UHC. Without it, there will be no clear basis from which to move forward. The ongoing establishment of national health observatories, linked to the African Health Observatory, is a key way of ensuring national health information systems are solid enough to track health situations and trends effectively.

WHO Regional Office for Africa, in collaboration with stakeholders and international partners, will continue to support countries to do this by giving guidance and assistance on how to improve the frequency and quality of national health surveys, strengthen birth and death registration and improve the availability of demographic data, surveillance and service statistics. Other key areas of support will focus on strengthening the analysis, evaluation and use of data for decision making, as well as enhancing how improvements in health systems are monitored.

4. Strengthen health systems

Strong national health systems are a prerequisite to the attainment of UHC. Dr Delanyo Dovlo, Director Health Systems and Services Cluster (HSS), explains why

"*A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. A good health system is one which has effective leadership and stewardship systems that allocates and utilizes its resources and services to improve the health of the population in an*

efficient, responsive and equitable manner. Universal health coverage is only possible when health services and resources are directed equally towards the most vulnerable groups and deprived parts of a country. A good health system therefore enables all people to obtain the health services they need without encountering physical, cultural or financial barriers."

A few more words on strengthening health systems

Plenty of guidance exists on how countries can improve their health systems. The 2009 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium, outlines generic interventions countries can take to address the unrelenting regional challenges to health systems. The central thrust of the Declaration, as the title suggests, urges countries to align their national health policies with the primary health care (PHC) approach (see Chapter 2) in order to achieve UHC. The framework for implementing the Declaration proposes generic interventions countries can adopt to address the ongoing challenges to health systems[6]. Meanwhile, the 2006 Addis Ababa Declaration on Community Health in the African Region sets out how Member States can harness community participation in health development[7]; and the Road Map for scaling up the staffing levels required to improve the delivery of health services in the Region, from 2012 to 2025[8], coupled with the 2006 health financing strategy[9] offer further guidance on tackling the ongoing health workforce (see Chapter 2, 2.2) and funding issues.

However, all this guidance only holds meaning if it is actioned. The 2014 Luanda Commitment on Universal Health Coverage in Africa reignited the flame beneath these strategies, when all 54 African Union Member States (out of which 47 are WHO African Region Member States) pledged to put the necessary structures and processes in place by 2025 so they can attain UHC. An inordinate amount needs to be done. This includes increasing the coverage of health services so the entire population becomes healthier and poverty, which is deeply entwined with poor health, is reduced in the process, providing a vital boost to African people and regional productivity. Health coverage mechanisms, which ensure people's health outcomes are not dependent on their finances, nor their finances dependent on their health, also need to be improved. It is up to governments and partners, including WHO/AFRO, to make this a reality.

5. Put mothers and children first

Dr Tigest Ketsela, Director of Health Promotion, explains why prioritizing the health of mothers and children is vital to achieving UHC and regional development

"*Women and children constitute a large segment of any population and are among those that are marginalized. Addressing the health needs of this specific group is therefore imperative to achieve the goal of universal health coverage. Today's children are tomorrow's leaders. Investing in child survival, good health and development is a sure way of having a better tomorrow. Women's well-being, in addition to being a human rights issue, has a direct bearing on child health and development. A child with a mother has a better chance of surviving than one without. More importantly, a child with an empowered mother not only survives but also thrives and reaches his/her full potential to be a productive citizen. Putting mothers and children first is therefore fundamental to the socio-economic development of any society.*"

A few more words on putting mothers and children first

'The hand that rocks the cradle is the hand that rules the world.' This is a well-known line from William Ross Wallace's old poem which celebrates motherhood, and it's one which world leaders have been paying a little more attention to during the past decade. Thanks to

civil society, NGOs, WHO and partners banging this particular drum louder and louder, they have had no choice but to pay attention. As H.E. Mrs Ellen Johnson Sirleaf, President of the Republic of Liberia, said back in 2012, 'the health of women in the Region is deplorable because every minute a woman dies in labour or suffers lifetime complications from pregnancy and delivery.'[10] This cannot go on. For all the reasons Dr Tigest asserts, and for the simple reason that it is inhumane for women to needlessly risk their lives *giving* life, because essential health interventions are not available in the places they happen to live.

Member States have already made some progress in reducing levels of maternal and under-5 mortality (see Chapter 3), but accelerated inter-sectoral action is required in order for the gains made to be extended and sustained. For instance, implementation of the 2006 regional child survival strategy, which aims to scale up a set of effective interventions, must be driven forward. The essential interventions include ensuring integrated management of childhood illness; newborn care, infant and young child feeding, including micronutrient supplementation and deworming; prevention of malaria using insecticide-treated nets and intermittent preventive treatment of malaria; immunization of mothers and children; prevention of mother-to-child transmission of HIV; and management of common childhood illnesses and care of children exposed to or infected with HIV[11]. The 56th session of the WHO Regional Committee for Africa resolution urges Member States to develop policies and effective partnerships, including support from WHO, so all this can happen[12].

Again, the 2014 Luanda Commitment on ending preventable maternal and child deaths in Africa, underlined the urgency of this and the necessity for policies and strategies to be actioned so the health of women and children in every country in the Region is guaranteed[13]. Not only did all Member States commit to this, but they also pledged to invest in human resources for health and contribute to addressing the critical social, behavioural, economic and environmental determinants of health. Special emphasis has been placed on girls' education and gender equality, including women's empowerment and male participation towards eliminating preventable maternal, newborn and child deaths by 2035. Last, but not least, all Member States committed to accelerate the implementation of the African Union plan of action towards ending preventable maternal, newborn and child deaths, and the recommendations of the report of the WHO Commission on Women's Health in the African Region[14]. May these pledges be met.

6. Accelerate action on HIV/AIDS, malaria and TB

Huge progress has been made in the fight against these diseases, but they are still among the biggest threats to health on the continent. Dr Emil Jones Asamoah-Odei, Programme Area Coordinator for Communicable Diseases, explains why this is and the key things that need to be done if UHC is ever to be achieved in these areas

"*Despite the unprecedented success in the control of HIV/AIDS, TB and malaria during the last ten years, the burden of the three diseases is still high. This is linked to many factors such as poverty, stigma and discrimination, drug resistance, co-existence with other infectious diseases, humanitarian crises and the weak systems which limit access to services for TB, HIV and malaria prevention and treatment. We need to sustain the momentum of scaling up the interventions which we know are effective. Given the resources available to perform our functions, we will need to largely focus on countries that account for the greatest burden of HIV/AIDS, TB and malaria. Progress towards universal health coverage will require overall commitment to health systems strengthening; increasing integration of primary care services and taking action within and beyond the health sector in order to address the social and economic determinants of disease, including expansion of social protection and overall poverty reduction.*"

A few more words on accelerating action on HIV/AIDS, malaria and TB

This is a huge area of public health and the task of achieving UHC in relation to each of these diseases is Herculean. However, the impressive progress that has been made during the past decade proves that, with the right support in place, attaining UHC is a challenge that *can* be met.

In order to ensure universal coverage of preventative interventions, testing, counseling and treatment of HIV/AIDS, WHO should maintain leadership in the health sector response to the disease. Supporting Member States and working with the increasing number of partnerships from the UN, multilateral donors, the private sector, and civil society, with an emphasis on South–South cooperation, is key. Rolling out norms, standards and guides in the Region for HIV prevention and early detection, counseling and early treatment for all in need, will remain a priority for the Secretariat. To underpin this, WHO must continue tracking the progress of HIV response and monitoring trends of the epidemic.

As discussed in Chapter 4, TB is killing people on an epidemic scale in the Region, with over half a million estimated to have lost their lives as a result of the disease in 2013[15]. Yet it is a curable disease. Universal coverage of TB services must be achieved so people stop dying needlessly. This requires an expansion of treatment, and stronger prevention and increased research – none of which will happen without innovative, multisectoral and integrated approaches within and outside the health sector. Collaborative TB/HIV initiatives also need to be scaled up to decrease the suffering of people who are at risk of, or affected by, both diseases. This can only be done if well resourced, coordinated health systems are in place, and all partners, under the leadership of Member States, assume responsibility to make this a reality.

As for achieving universal coverage of malaria prevention and treatment, faced with the 51 percent worldwide funding gap for malaria control, countries must do their upmost to increase domestic funding and close the gap in line with the Global Technical Strategy (GTS) for malaria (2016–2025). This is so there can be sufficient testing of fever cases for malaria, enough malaria medicines, long-lasting insecticide-treated nets (LLINs), and indoor residual spraying (IRS) in the right areas and at the right time. Parasite resistance to malaria medicines and insecticides also needs to be monitored, and this can only be done properly if there are enough good quality data to target interventions.

7. Control communicable and non-communicable diseases

Dr Francis Kasolo, Director of the Disease Prevention and Control Cluster, explains why, when it comes to controlling communicable and non-communicable diseases, having solid health systems in place is as important as having an informed public

"*The large and growing burden of communicable and non-communicable diseases is now a common storyline. One may die from a disease or condition not because it is not treatable, but because of the absence of basic diagnostic support to detect the medical problem early. The insidious nature of NCDs complicates this. Out-of-pocket payments for the diagnosis and treatment of diseases trap poor households in cycles of catastrophic expenditure, impoverishment, and illness, particularly in countries lacking social protection and health insurance. There has been a call for universal health coverage to combat this issue. However, UHC by itself will not be sufficient. There is also the need to ensure that the public is well informed in order to prevent themselves from acquiring diseases and to adopt positive health care seeking behaviours. This calls for effective health systems, including having sufficient numbers of skilled health workers, the ability for people to get to the health centre, and functioning health facilities – a pre-requisite for effective and comprehensive UHC, with quality health services available to all.*"

A few more words on communicable and non-communicable diseases

A raft of public health issues sits under these umbrellas – from neglected tropical diseases (NTDs) to drinking too much alcohol. As Dr Kasolo highlights, dealing with these problems effectively requires a multi-faceted approach which is as much about informing and empowering people, as it is about ensuring that a range of health and socio-economic systems are in place to take the necessary preventative and curative action.

Enhancing disease surveillance and response (IDSR) and having enough trained staff to implement this at district level is vital, as is attaining the minimum International Health Regulations (IHR) core capacities required under the International Health Regulations (2005). WHO/AFRO will continue to get behind this in order to strengthen regional capacity for surveillance and response. This also includes continuing to maintain the ability to respond adequately to emergencies, as well as making sure the right numbers of national rapid response teams are in place to fully cover public health events.

The Regional Strategy on NTDs in the WHO African Region[16] must be implemented so NTDs can be properly prevented and treated. The 2011 Brazzaville declaration on the prevention and control of non-communicable diseases also needs to be fully implemented[17], as does the 2014 Luanda commitment on NCDs in Africa. People also need to be empowered with information so they can look after their own health, as well as that of their families and communities. One of the most effective ways of achieving this is through ICT (see Chapter 2 How eHealth is aiding universal health coverage). In addition, platforms for advocacy must be provided, as well as implementing policies and regulatory frameworks to protect individuals, families and communities from tobacco use, problem drinking and eating unhealthy foods (see Chapter 6: Addressing childhood obesity in Mauritius).

The 1st African Ministers of Health meeting jointly convened by the AUC and WHO in Luanda, galvanized commitments from all Member States who promised to give NCDs the prominence they deserve and ensure that the WHO global action plan for the prevention and control of NCDs 2013–2020 is 100 percent implemented through the National NCD multisectoral plans. Member States also pledged to mobilize resources to protect public health policies from interference by vested interests of the alcohol, tobacco and food industries through enforcement of national laws and policies.

8. Immunize every child

Dr Deo Nshimirimana, Director of the Immunization and Vaccine Development Cluster, shares his thoughts on what it will mean for the future health of the continent if every child is immunized

"*The increasing vaccination coverage in the WHO African Region, particularly over the last 10 years, has had a considerable impact on reducing incidence and mortality due to vaccine preventable diseases. It is expected that there will soon be a reduction in the incidence of adult onset complications of vaccine preventable disease such as cancers of the cervix and of the liver. The reduced incidence of acute and long-term complications of vaccine preventable diseases will result in reduced demands on national health systems as well as increased productivity and economic growth. The results of the increased vaccine coverage in the African Region are very much in line with the ultimate goal of universal health coverage.*

Recent experiences in increasing vaccination coverage in most countries in the African Region, including in many hard to reach areas and amongst the most marginalized and vulnerable populations, demonstrate that universal health coverage is within reach. In addition, as a result of the gains in increasing access to vaccines, over 100 million Africans in the meningitis belt are now fully protected from epidemic

meningitis, while childhood mortality due to measles reduced by close to 90% in the African Region between 2000 and 2012."

A few more words on immunizing every child

In order for every child to be immunized, the Regional Immunization Strategic Plan 2014–2020 needs to be implemented to address the gaps in organization, coordination and management of immunization activities, inadequacy of vaccines and cold storage capacity. Limited service delivery points, and inappropriate communication strategies resulting in low community awareness and inadequate access and utilization of immunization services, also requires urgent attention[18]. The main aims of the plan are to increase and sustain high vaccination coverage; complete the interruption of poliovirus transmission and ensure virus containment; eliminate measles and advocate for the elimination of rubella and congenital rubella syndrome; and attain and maintain elimination/control of other vaccine-preventable diseases.

For this to happen, immunization must be integrated into national health policy, as well as emergency responses. There also needs to be a concerted and sustained drive to ensure everyone benefits from new vaccines. This will be helped through increases in domestic financing, enhancing partnerships and improving monitoring and the quality of data collected. Vaccine safety and regulation is also vital, as is promoting innovative research to develop vaccines that meet the diverse needs of the Region's population (see Chapter 5, 5.1).

9. Speed up response to the determinants of health

Dr Tigest Ketsela, Director of Health Promotion, shares her views on why getting on top of the determinants of health is so fundamental to achieving UHC

"*Universal health coverage is meant to ensure that all people get the health services they need without suffering from financial hardship. However, there is a need to improve the conditions people are born, live, work and age in for universal health coverage to become a reality. Health care is just one determinant of population health and addressing health systems issues will only partially address poor health outcomes. It is only through addressing the root causes of ill health (determinants of health) that we can achieve the goal of universal health coverage*."

A few more words on the determinants of health

The regional strategy on the determinants of health pivots around helping Member States reduce health inequities by taking a whole government approach[19]. This means multiple sectors must be involved in tackling all the issues which lead to health and well-being problems – from addressing environmental concerns which trigger poor health outcomes, to investing in early childhood development to make sure equity for all gets off to a good start.

Fast-tracking implementation of the regional strategy on health promotion to combat preventable diseases, will involve scaling up existing multisectoral health promotion interventions to contribute to reducing the leading causes of preventable deaths, disabilities and major illnesses. The Regional Office hopes that priority interventions will, among other things, strengthen health ministry leadership; ensure good health governance including developing healthy public policies, legislation and regulations; support the ability of Member States to gather evidence, strengthen partnerships, and advocate for sustainable health promotion financing options[20].

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Chapter 10

A final word on the MDGs

Dear Reader,

Countries in the African Region have made more progress over the past 10 years towards achievement of the health and health-related MDGs but many are still not on track despite the commitments made by governments and partners. According to the UN Statistics Division (UNSD) and World Health Statistics 2014, of the 47 countries, the number of countries that are on track to achieve or that have achieved each target is 16 for target 4A (*Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate*); four for target 5A (*Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio*); seven for target 5B (*Achieve, by 2015, universal access to reproductive health*); 34 for target 6A (*Have halted by 2015 and begun to reverse the spread of HIV/AIDS*); 10 for target 6B (*Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it*); 12 for target 6C (*Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases*); 11 for target 1C (*Halve, between 1990 and 2015, the proportion of people who suffer from hunger*); and 23 for target 7C (*Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*).

In spite of these efforts, progress is not sufficient to ensure full achievement by 2015. Challenges arise from weaknesses of national health systems mainly related with low density of health workers, limited access to quality medicines and other essential technologies, inadequate financial management and fragile multisectoral response, and weak community ownership. Furthermore, untimeliness and limited quality of data for monitoring and evaluation have hindered the effectiveness of follow-up.

I believe that although we are one year away from the deadline more progress is still possible if governments, in collaboration with all stakeholders and international partners, hasten to scale-up a number of priority public health interventions. *First*, focus on areas where progress has been limited and explore innovative and quick means to ensure improvement without losing the gains already made. Countries should invest adequately to translate their health policies into concrete actions and learn from the best practices of country cases in the Region.

Second, reallocate domestic resources to meet the 2001 Abuja target of allocating at least 15% of the national budget to the health sector and take measures to improve the functioning of their health financing system. In addition, they should strengthen existing structures and mechanisms for sustainable, effective and efficient mobilization and utilization of internal and external resources. Partners should improve the predictability and harmonization of resource allocation to country priorities as spelled out in the Paris Declaration on aid effectiveness and harmonization.

Third, accelerate the implementation of the 2008 Ouagadougou and Algiers declarations by improving access to, and the quality of, health services. They should guarantee the quality and

quantity of the health workforce and ensure equitable access to essential medical products, vaccines and technologies.

Fourth, countries and their partners should sustain the gains and scale up interventions to reach the necessary reductions in maternal, new born and under-five mortality, as well as further reductions in the burden of HIV/AIDS, malaria and tuberculosis. They should address major health and environment priorities such as the provision of safe drinking water and sanitation, and should own and implement the Pan-African Programme for Public Health Adaptation to Climate Change.

Fifth, ministries of health should proactively participate in the policy dialogue for the national development of priority setting, especially in macroeconomic analysis and strategic planning and budgeting. There is a need to increase dialogue between the ministry of health and oversight ministries such as finance and planning, collaboration between the public sector and the private sector, and South–South collaboration.

Sixth, countries should: (a) improve the frequency, quality and efficiency of national health surveys; (b) strengthen birth and death registration; (c) improve the availability of demographic data, surveillance and service statistics; (d) enhance monitoring of health systems strengthening; and (e) strengthen the analysis, evaluation and use of data for decision-making. They should also consider establishing national health observatories linked to the African Health Observatory to strengthen their national health information systems.

As Member States prepare the transition to post-2015 health goal of Universal Health Coverage, they ought to ensure inclusion of the unfinished health MDG agenda. The urgent need to ensure that health is placed at the centre of development cannot be understated. Moving forward we must strive to ensure that every baby, child, teenager, adult and elderly person in Africa have access to the quality essential health services they need without enduring financial hardship.

Luis Gomes Sambo

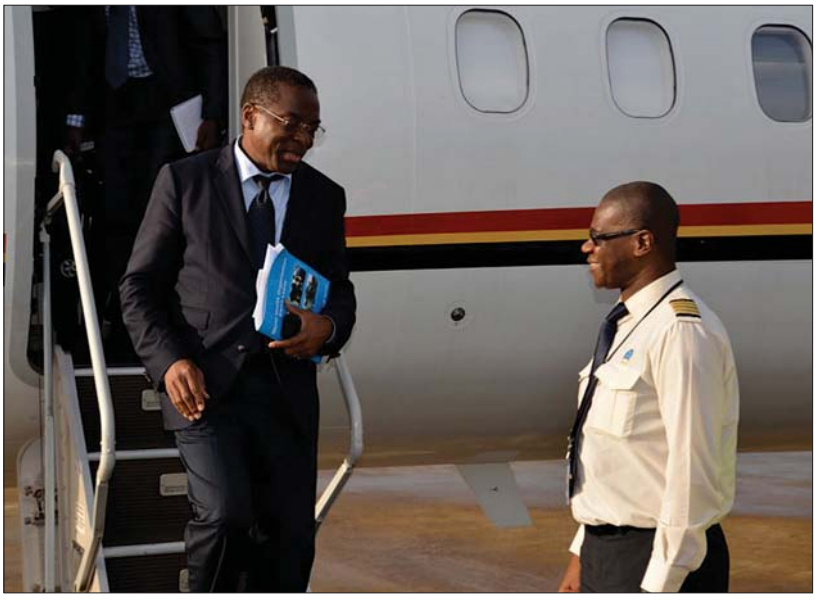
Special Addendum

Added 7th August 2014

THE EBOLA OUTBREAK

RESPONSE TO THE EBOLA OUTBREAK IN WEST AFRICA

After this Report was written and just as it was going to press we were struck by an outbreak of Ebola virus disease (EVD) in West Africa, which WHO had been actively monitoring and providing support to Governments and communities. This has been the largest ever Ebola outbreak in human history which shows disturbing signs of spreading at an increasing rate. Since March 2014, the outbreak has been occurring in Guinea, Liberia, Sierra Leone and, recently, in Nigeria. As at 31 July 2014, a cumulative total of over 1400 cases and 740 deaths have been reported from these countries. In this outbreak, the average case fatality rate is 60%, ranging from 45 to 70%, and a significant number of health care workers have been infected, over half of whom have died. It is a complex outbreak due to the following factors: transmission occurring in countries that have generally weak health systems; the geographical distribution of the outbreak covers rural, urban and cross-border areas; and significant community resistance to reporting and treatment of the disease due



Advocacy mission to Guinea, Conakry during the Ebola outbreak

to strong traditional beliefs and cultural practices including fear and denial of its existence. It is therefore a serious public health emergency that threatens global health security.

In response to this development, WHO moved rapidly and decisively to articulate partnership support to Governments in order to interrupt further spread of this deadly infection. The main partners involved include the Center of Diseases Control (CDC) Atlanta, Medecins Sans Frontiers (MSF), UNICEF, Institut Pasteur, International Federation of the Red Cross and Red Crescent Societies (IFRC), EUROLAB, PLAN and other bilateral and multi-lateral agencies. To date the following specific actions have been taken:

1. *Country support:* WHO has been working closely with the Ministries of Health and partner organizations in the affected countries since the onset of the outbreak by providing technical, materials and financial support.
2. *Staff deployments:* Since the start of this outbreak, more than 280 WHO staff and international experts have been sent to the affected countries through the WHO-based Global Outbreak Alert and Response Network. These people have been providing their expertise in logistics, surveillance, clinical management, infection control, laboratory support, anthropology and communications, including social mobilization.
3. *EVD outbreak response plans:* WHO is contributing to the development and finalization of the West Africa Ebola Response Plan in conjunction with the governments of Guinea, Liberia, Nigeria and Sierra Leone. This will assist in scaling up the global, regional and national response to the outbreak.
4. *Resource mobilization:* WHO has supported countries to access the various funding sources including providing financial support through the African Public Health Emergency Funds (APHEF).
5. *Establishment of the Sub Regional Ebola Coordinating Center (SEOCC):* The SEOCC was established in Conakry Guinea and acts as a coordinating platform to enable WHO and major partners to consolidate, harmonize and streamline the technical, material and financial resources mobilized to the affected West African countries. Every day at noon, Brazzaville time, a teleconference is held between the three levels of WHO and relevant stakeholders including partners and donors from more than 20 organizations. The purpose is to review the progress on response to the outbreak and advise on the appropriate action to control this disease in a timely manner.
6. *Leadership and high level advocacy for accelerating the response to the outbreak:*
    a. On 2–3 July 2014, WHO convened an emergency meeting of ministers of health and partners from more than ten West African countries in Accra, Ghana. The meeting issued a final communiqué with important recommendations based on the seriousness of the epidemic; the meeting recommended WHO to establish a Sub-Regional Ebola Outbreak Coordination Center. It also adopted a Sub-Regional Outbreak Response Strategy to guide the development of country operational Ebola response plans. The participants pledged to undertake coordinated regional interventions to respond to the Ebola outbreak.
    b. This meeting was followed by missions of Dr Fukuda, Assistant Director General in charge of Health Security to Sierra Leone and Guinea.
    c. In late July, I visited Guinea, Liberia and Sierra Leone, and met with Presidents, Ministers of Health, other government officials and partner organizations to sensitize and advise regarding intensification of community based interventions, finalization of national Ebola response plans and coordinated partnerships in support of Governments; and exploring the best ways to rapidly contain the outbreak, while advising on measures to strengthen weak health systems.

Inauguration of the Sub-Regional Ebola Outbreak Coordination Centre, Conakry

d. On first August, Dr Margaret Chan, the WHO Director General, participated in a high level meeting in Conakry on response to the EVD outbreak with the Manu-River Union (Guinea, Liberia, Sierra Leone and Cote d'Ivoire) Heads of State. The summit took important political and strategic decisions to contain the Ebola epidemic in West Africa with particular emphasis on cross-border interventions and the important call for increased domestic and international emergency support.

In summary, WHO is giving its highest priority to the control of this outbreak and will take all further actions that it can in overcoming the severe challenges that this infection is posing to areas within the Region. Further updates on our continuing action in this regard will be reported to the 64th Session of the Regional Committee and a full report on it will be elaborated and made available at the end of the epidemic.

World Health Organization

REGIONAL OFFICE FOR Africa